

Protecting Essential Hospital Services at The Queen Elizabeth Hospital, King's Lynn

An evidence-based public-interest briefing opposing unsupported closure or downgrading of A&E, intensive/critical care and maternity services for West Norfolk, North Cambridgeshire, South Lincolnshire and surrounding communities.

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Working Purpose of This Paper

This paper is intended to support public, political, parliamentary, regulatory, and community opposition to any proposal to close or materially downgrade Accident and Emergency, intensive/critical care, or maternity services at The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust. It will develop an evidence-based case that these services are essential to the safety, equality, and resilience of the communities served by the hospital, and that any closure or downgrade would require rigorous clinical, equality, travel-time, capacity, consultation, and risk analysis before it could responsibly proceed.

The paper should be capable of being adapted into: a public consultation response, a briefing for MPs and councillors, supporting evidence for a petition to Parliament, a submission to NHS England or the Secretary of State, and a public campaign document for residents, patients, staff, community groups, and local media.

Evidence Status and Use of Data

This draft combines verified public data, local reporting, national clinical evidence, and campaign modelling assumptions. Where QEH-specific data is not publicly available, the paper identifies the missing evidence and recommends that it be requested from QEH, East of England Ambulance Service, the Norfolk and Waveney ICB, NHS England, or the Norfolk and Waveney University Hospitals Group.

The final draft should clearly distinguish verified facts from illustrative calculations, reported public concern, clinical research evidence, and unanswered questions for decision-makers. Any figures relating to mortality, lives saved, receiving-hospital

capacity, emergency journey times, redundancy costs, whole-system savings or maternity risk should be traceable to a source, formal NHS disclosure, or clearly labelled as a modelling request.

One-Page Public Summary

Protect QEH King's Lynn: keep essential A&E, intensive/critical care and maternity services local. The Queen Elizabeth Hospital King's Lynn serves a large rural and cross-county population across West and North Norfolk, North Cambridgeshire and South Lincolnshire. Published 2024/25 figures record 94,033 Emergency Department attendances, 31,979 inpatients treated and 1,772 babies born, showing that QEH is an essential acute hospital for the communities it serves. [1][2]

Closing or downgrading A&E, ICU/critical care or maternity would not remove demand from the NHS. It would move that demand to Norwich, Peterborough, Cambridge, ambulance services, primary care, community care and social care. For many residents, especially older people, disabled people, pregnant women, low-income households, unpaid carers and rural communities, that could mean longer journeys, higher costs, reduced family support and greater difficulty accessing urgent help.

The biggest safety concern is time. In emergencies such as cardiac arrest, stroke, sepsis, severe breathing problems, major trauma, obstetric emergencies and neonatal emergencies, minutes can affect survival and long-term recovery. If local QEH services were removed, patients may face ambulance response time, on-scene care, longer travel to another hospital, handover delay and then assessment before treatment. NHS decision-makers must prove that any alternative would be safe before any closure is considered.

Maternity must be protected as a separate issue. Pregnancy and birth involve repeated appointments, triage, scans, labour, emergency obstetrics, postnatal care and neonatal support. QEH maternity was rated Good overall by the Care Quality Commission in 2024, and the service should be improved and supported rather than removed without clear evidence that families would be safer elsewhere. [6][7]

The campaign is not asking for unsafe services to be left unchanged. It is asking for transparency, investment and proper public involvement. If there are concerns about buildings, staffing, governance, patient flow or safety, the answer should be rebuilding, recruitment, retention, clinical improvement and oversight — not removing essential services from a rural population that depends on them.

Public ask: Use the core campaign message below: no removal of essential A&E, ICU/critical care or maternity services unless the NHS publishes clear, independent

evidence that the alternative would be safe, accessible, equitable, resilient, fully funded and no more costly to the wider system.

Immediate action: sign and share the petition, submit patient or family testimony, ask local councillors and MPs to intervene, and call on QEH, EEAST, the ICB, NHS England and the hospital group to publish the full data before any final decision is made.

Short Briefing for MPs and Councillors

Purpose: This briefing asks elected representatives to oppose any closure or material downgrading of A&E, ICU/critical care or maternity services at QEH King's Lynn unless NHS decision-makers publish clear, independent evidence proving that alternative provision would be safe, accessible, equitable, fully funded and capable of meeting present and future demand.

Why this matters: QEH serves around 375,000 people across West and North Norfolk, North Cambridgeshire and South Lincolnshire. The detailed activity baseline is set out below; in short, this is a major local acute hospital, not a marginal service. [1][2]

Main concerns: Closure or downgrading could increase travel time for time-critical emergencies, reduce ambulance availability in rural areas, displace demand to Norwich, Peterborough and Cambridge, increase pressure on maternity and critical care capacity, worsen inequality for older, disabled, pregnant, low-income and car-free residents, and shift costs to primary care, social care, unpaid carers and the wider NHS.

Immediate questions to ask NHS bodies: What services are being considered for closure or downgrade? What evidence exists on safety, travel time, ambulance response, handover, receiving-hospital capacity, maternity triage, ICU/HDU capacity, workforce, equality impact, public consultation and whole-system cost? What alternatives to closure have been appraised, including investment, rebuilding, recruitment and retention at QEH?

Requested actions: elected representatives should use the core campaign message below when writing to QEH, the ICB, NHS England and ministers, and should request publication of the full clinical, equality, ambulance, capacity and financial modelling before any decision.

Executive Summary

Status note: This is a working evidence briefing. It is suitable for campaign planning, public engagement and initial representations, but several data requests must be answered before it should be treated as a final evidential report.

Recent CQC findings have identified serious concerns in urgent and emergency care and medical services, including patient safety, medicines management, patient monitoring, governance, staffing, training compliance, and organisational oversight. Those findings justify urgent improvement, oversight, investment, and accountability. They do not, without more, justify the removal of essential emergency, critical care, or maternity services from the community that depends on them. [4][5]

The central case of this paper is that closure or material downgrading would risk increasing travel times, ambulance pressure, clinical deterioration, avoidable harm, and health inequalities unless decision-makers can prove otherwise. The burden should therefore rest on the decision-making bodies to publish transparent evidence showing that any proposed alternative provision would be safe, equitable, deliverable, resilient and fully funded.

Core Argument to Be Developed

Any proposal to close or downgrade A&E, ICU/critical care, or maternity at QEH should be opposed unless the NHS can demonstrate, through published and independently scrutinised evidence, that the change would not worsen access, outcomes, mortality risk, ambulance performance, maternity safety, emergency resilience, or equality of provision for the hospital's catchment population.

At this stage, the paper should focus on building the strongest possible public-interest case before any final decision is made. The central argument is that, in this specific geography and population context, closure or downgrading should not proceed unless decision-makers can show that safety, travel times, equality impacts, alternative capacity, consultation responses, and foreseeable risk to life have all been fully assessed and publicly explained.

Accountability position: National NHS rules and public-service responsibilities do not create an automatic entitlement for every individual hospital to provide A&E, ICU or maternity services. The stronger campaign argument is that NHS England, the ICB and relevant providers must ensure safe, timely and equitable access for the population. For QEH, the question is whether removing local services from a large rural and cross-county catchment would still meet that system-level responsibility once travel time, ambulance availability, equality impacts, receiving-hospital capacity and future demand are properly assessed.

Accountability, consultation and equality concerns

Service-change responsibility: NHS bodies must be able to show that any proposed reconfiguration is clinically safe, evidence-based, transparent, properly consulted on and consistent with reducing inequalities in access and outcomes.

NHS service-change and commissioning responsibilities

Even where individual hospitals are not guaranteed particular services, NHS bodies still have responsibilities to plan safe, equitable and accessible care for the population. Those responsibilities provide a strong public-accountability basis for challenging any closure or downgrade that has not been properly evidenced, consulted on or assessed for local impact.

Campaign concern: Closing A&E, ICU/critical care or maternity at QEH may disproportionately affect rural populations, deprived areas, older residents, disabled people, pregnant women, people without private transport and communities already facing poorer access to services.

Argument: If closure appears to be moving ahead before the evidence, consultation and impact assessment are complete, the public, councillors, MPs, scrutiny committees, NHS England and the Secretary of State should be asked to intervene before any final decision is made.

Risk to life and patient safety

Decision-makers should be required to show that any proposed change would not create foreseeable and avoidable risks for time-critical patients, including those needing resuscitation, stroke care, sepsis treatment, critical care, emergency obstetrics or neonatal support.

Campaign concern: If closure would materially increase time to assessment, stabilisation or definitive treatment, the NHS must publish risk modelling before claiming patients would remain safe.

Equality and access concerns

A full equality assessment should consider age, disability, pregnancy and maternity, deprivation, rurality, car ownership, public transport, caring responsibilities, digital exclusion and social isolation.

Campaign concern: Closure may have unequal effects on older patients, disabled patients, pregnant women, babies, low-income households and people in isolated rural communities.

Past NHS service-change disputes

Past NHS service-change disputes show that campaigns are strongest where they identify weaknesses in evidence, consultation, travel-time modelling, alternative provision, equality assessment or local scrutiny.

Examples often discussed in public campaigns and NHS service-change debates include:

- Lewisham Hospital case (2013)
- Huddersfield A&E challenge
- Grantham A&E temporary closure challenge

Data-driven arguments: usage, time-critical risk and evidence gaps

The quantitative case should focus on verified usage data, national clinical evidence about time-critical care, and the specific local data that NHS decision-makers must disclose before any closure or downgrade is considered.

This draft should avoid claiming a precise number of lives saved or deaths caused unless QEH-specific diagnosis, ambulance, outcome and transfer data is published.

A&E usage at QEH

QEH's Emergency Department activity is included in the full baseline below. For the emergency-care argument, the key verified point is that QEH handles substantial annual emergency demand and therefore any replacement model must be tested against real activity, not assumptions. [1][2]

Local mortality and lives-saved evidence gap

Public data does not currently provide a verified number of QEH patients whose lives are saved each year by local A&E, ICU/critical care, maternity, neonatal care or emergency stabilisation. It also does not provide a verified estimate of deaths or serious harms that would result from diversion to Norwich, Peterborough or Cambridge. This should be presented as a critical evidence gap and a reason to demand disclosure, not as a campaign figure that has already been proven.

The clinical argument remains strong without unsupported estimates. National evidence shows that time to treatment affects survival and functional outcomes in cardiac arrest, stroke, sepsis, trauma and maternity/neonatal emergencies. For QEH, the necessary next step is local modelling: how many patients fall into time-critical categories, how quickly they currently reach QEH care, how long they would take to reach alternative hospitals, and what effect that delay would have on mortality, disability, deterioration and serious harm.

Replacement evidence: existing datasets to request

The NHS already holds or publishes datasets that can replace unsupported estimates with stronger evidence. Appendix A contains the detailed data-request table, and Appendix E contains FOI templates if the information is not provided voluntarily.

Dataset or source	QEH relevance	How it strengthens the paper
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QEH annual report and facts-and-figures data	QEH-specific summary activity and scale are set out in the master baseline section, including emergency, inpatient, maternity, bed, workforce and income figures.	Provides verified baseline demand and scale, replacing unsupported assumptions about service use.
NHS England A&E Attendances and Emergency Admissions	Provider-level data is published monthly and includes attendances, admissions, four-hour performance and admission waits.	Can show QEH demand over time and compare QEH with Norfolk and Norwich, North West Anglia and Cambridge University Hospitals.
Emergency Care Data Set	Patient-level urgent and emergency care dataset capturing why people attend emergency departments, treatment, demographics, clinical condition, chief complaint and 12-hour waits from arrival.	Supports a request for QEH-specific breakdowns by age, diagnosis, ambulance arrival, chief complaint, time-critical conditions, admission and delay.
Hospital Episode Statistics	Contains patient-level hospital activity including admissions, outpatient appointments and historic A&E attendances, with diagnoses, operations, age, ethnicity, admission/discharge method and geography.	Can support analysis of QEH emergency admissions, older patients, diagnosis groups, postcode origin and outcomes over time.
Ambulance Quality Indicators	EEAST-level response-time and system performance data for ambulance services.	Shows regional ambulance pressure and provides the basis for requesting QEH-catchment response, conveyance and handover data.
Ambulance Clinical Outcomes	National ambulance dataset covering stroke, cardiac arrest, STEMI heart attacks and sepsis, including survival and time-to-treatment indicators.	Replaces unsupported “lives saved” claims with recognised NHS outcome measures that should be extracted for EEAST and QEH-related pathways.
CQC inspection reports	QEH-specific ratings: urgent and emergency care and medical care require improvement; maternity is rated Good overall; critical care was rated Good in 2022.	Supports the argument for improvement, investment and oversight rather than assuming closure is the appropriate

		response to quality concerns.
NHS maternity and neonatal datasets	QEH births are already published; further maternity triage, neonatal admissions, transfers and outcomes should be requested from QEH and national maternity datasets.	Supports a maternity-specific case based on actual births, triage, neonatal dependency, travel time and receiving-unit capacity.
Receiving-hospital performance data	Provider-level data exists for Norfolk and Norwich, North West Anglia and Cambridge University Hospitals.	Shows whether alternative hospitals are already under pressure and whether displaced QEH demand could worsen waiting times and capacity.

Campaign implication: Use disclosed QEH, EEAST, ICB and NHS England data wherever possible, and use Appendix A and Appendix E to obtain missing evidence.

Summary accountability test: Before any closure or downgrade is proposed, the NHS should publish evidence on safety, access, equality, ambulance resilience, receiving-hospital capacity, staffing, costs and future demand.

The detailed questions to ask each body are concentrated in Appendix A, while Appendix E provides request wording that can be adapted for formal disclosure.

Core message: Do not remove essential A&E, ICU/critical care or maternity services from QEH King's Lynn unless the NHS publishes clear, independent evidence proving that patients will be safer, access will not worsen, ambulance cover will not be reduced, receiving hospitals can cope, equality duties will be met, staff and linked services will be protected, and the whole-system cost will not increase. This message should be used consistently in the public summary, media lines, petition wording, MP and councillor briefings, scrutiny submissions and FOI follow-up.

Comparison Method for Previous Hospital Campaigns

This paper compares QEH with previous NHS service-change disputes only where the comparison is relevant to decision-making quality, not because the hospitals are identical. The strongest comparators are rural, coastal or dispersed-population hospitals where travel time, ambulance resilience, service interdependence, older age profile, deprivation and alternative capacity were central issues. Urban examples such

as Lewisham remain useful as process precedents, but they should not be presented as direct geographic equivalents to West Norfolk.

Consolidated Maternity Case: Displacement, Access and Safety

Maternity services should be considered separately from general emergency care because pregnancy, birth and postnatal needs are not one-off events. They involve repeated antenatal appointments, scans, triage calls, urgent assessment for bleeding or reduced fetal movements, induction, labour, emergency obstetrics, theatre access, anaesthetics, neonatal support, postnatal checks and safeguarding. Removing local provision would therefore create repeated clinical, financial and practical barriers over many months, not just a single longer journey at the point of labour.

For maternity, the relevant baseline is QEH's 1,772 babies born in 2024/25. The wider hospital activity and catchment figures are set out once in the "Known activity at QEH" section below. [2]

There is also positive regulatory evidence for retaining and improving the service. The Care Quality Commission rated QEH maternity services as "Good" overall on 1 March 2024 after a focused inspection, noting improvement in culture, teamwork, leadership, listening to concerns, focus on women and babies, and awareness of inequalities affecting less privileged groups and people from ethnic minority backgrounds. Although the safe domain still required improvement, the overall direction of travel supports investment, improvement and protection of the service rather than removal. [6][7]

NHS England's national maternity triage specification describes maternity triage as a safety-critical clinical environment and the emergency front door for urgent and unscheduled maternity care. It emphasises safe, timely and responsive care, reduction of inequalities, accountability, appropriate staffing, facilities, estates and consistently resourced services. This supports the argument that any proposal affecting QEH maternity must explain how pregnant and newly postnatal women would receive timely urgent assessment if local maternity triage were removed or downgraded. [23]

Clinical evidence on maternity closures and travel time must be used carefully, but it is still relevant. A BMJ Open systematic review of high-income countries found some evidence that obstetric unit closures or longer travel distance/time may increase babies born before arrival, and that this may be associated with increased perinatal or neonatal mortality, although the evidence was not consistent across all studies. A Welsh birth-outcomes study found that, for every 15-minute increase in travel time to the birth hospital, there was an increased risk of early and late neonatal death, and that travel time of at least 45 minutes to place of birth was associated with higher odds of

early neonatal death. These findings do not prove a precise QEH mortality figure, but they show that longer travel is a legitimate safety issue requiring local modelling. [24][25]

The potential impact on QEH families should therefore be treated as one consolidated maternity-access case. It includes longer journeys in labour; greater risk of giving birth before arrival; delayed assessment for bleeding, reduced fetal movements, high blood pressure, pre-eclampsia symptoms, infection or premature labour; higher costs from repeated antenatal and postnatal journeys; reduced partner and family support; and more difficulty visiting or caring for a baby admitted away from home. These risks are likely to fall most heavily on women without cars, low-income families, young parents, disabled women, women with complex pregnancies, rural households and families already managing childcare or caring responsibilities.

Risk-to-life evidence for maternity and neonatal services

Maternity risk-to-life arguments must be evidence-based and cautiously stated. Public evidence does not allow a precise QEH-specific estimate of additional maternal, fetal or neonatal deaths without local activity, postcode, acuity and transfer modelling. However, national and UK-relevant evidence shows that delay and distance can be clinically material in maternity emergencies, especially where urgent triage, obstetric theatre access, blood products, anaesthetics, neonatal resuscitation or neonatal intensive care may be needed.

Evidence and questions decision-makers must answer: Before any maternity closure or downgrade is considered, NHS bodies should publish QEH maternity triage activity, births by postcode area, emergency obstetric transfers, neonatal admissions, ambulance maternity calls, babies born before arrival, travel-time modelling to Norwich, Peterborough and Cambridge, impact on neonatal and paediatric services, staffing plans, receiving-unit capacity, and equality impacts for pregnancy and maternity as protected characteristics.

Economic impact on patients if QEH maternity services closed

The economic impact of maternity closure is part of the wider maternity-access case above. Because maternity care involves repeated journeys rather than a single attendance, any displacement to Norwich, Peterborough or Cambridge would create cumulative costs across pregnancy, birth, postnatal care and neonatal visiting.

Illustrative travel-cost and journey-time estimates requiring verification: Public travel information illustrates the potential scale of the burden from King's Lynn itself, but the figures in this paragraph should not be treated as final verified evidence until each route, timetable and tariff has been checked for the final version. Indicative examples suggest travel to Norfolk and Norwich University Hospital may be around 51

minutes by car, around 2 hours 6 minutes by bus, and approximately £110–£140 by taxi one way. Indicative examples suggest travel to Peterborough City Hospital may be around 45 minutes by car, around 1 hour 46 minutes by bus, and around £75–£90 by taxi one way. Indicative examples suggest travel to Addenbrooke's Hospital / the Rosie Hospital may be around 1 hour 2 minutes by car, around 1 hour 12 minutes by train in the best case, over 3 hours by bus, and around £95–£120 by taxi one way. These figures start from King's Lynn; families living in Hunstanton, coastal villages, rural West Norfolk, Fenland or South Lincolnshire may face longer, less direct and more expensive journeys.

The NHS Healthcare Travel Costs Scheme may help some patients on qualifying benefits or low incomes, but it is not a complete solution. NHS guidance states that help with travel costs depends on eligibility, a referral for specialist care, and a separate appointment visit. It does not cover visiting someone in hospital, and escort or carer travel costs are only claimable where a healthcare professional says the escort is medically necessary. This means partners, grandparents, unpaid carers and relatives who provide practical maternity support may receive no travel reimbursement. [19]

Campaign implication: The patient-cost element of the maternity case should be included in the overall maternity impact assessment, with specific modelling of repeated journeys, childcare, lost wages, partner attendance, neonatal visiting and the position of families without cars or on low incomes.

Emergency Travel-Time, Ambulance Response and Risk to Life

The most serious risk created by closing or downgrading emergency services at QEH is not inconvenience, but delay in reaching life-saving assessment, stabilisation and treatment. For patients with cardiac arrest, suspected stroke, heart attack, sepsis, severe breathing difficulty, major trauma, obstetric haemorrhage or neonatal emergency, minutes can determine survival, disability, recovery time and long-term harm.

Known activity at QEH

QEH's published 2024/25 figures show 94,033 Emergency Department attendances, 31,979 inpatients treated, 1,772 babies born, approximately 500 inpatient beds, 3,723 whole-time-equivalent staff and £325.4 million total income. The Trust serves a population of around 375,000 people across West and North Norfolk, North Cambridgeshire and South Lincolnshire. Together, these figures establish the baseline scale of a major rural and cross-county acute hospital. [1][2]

Current ambulance response data

East of England Ambulance Service states that Category 1 incidents are immediately life-threatening and should receive a mean response of seven minutes and a 90th percentile response within 15 minutes. Category 2 emergencies should receive a mean response of 18 minutes and a 90th percentile response within 40 minutes, although NHS England has temporarily adjusted the Category 2 mean target to 25 minutes. Current reported East of England performance remains above these standards: April 2026 figures reported Category 1 at 8 minutes 11 seconds and Category 2 at 27 minutes 20 seconds. [10][11]

Consolidated case: travel time, ambulance delay and risk to life

Emergency access is a complete pathway, not a simple car journey from King's Lynn to another hospital. The relevant safety test is the total time from the original 999 call or patient decision to seek help through to assessment, stabilisation and definitive treatment.

With QEH services in place, patients can receive local emergency assessment, resuscitation, diagnostics, maternity triage, critical-care input and stabilisation before onward specialist transfer where needed. If those services were removed, the pathway would add longer conveyance to Norwich, Peterborough, Cambridge or another receiving hospital, plus any additional handover, triage and treatment delay at a busier site.

That cumulative delay is the campaign's strongest safety point. Regional ambulance response performance is already above the standard for some categories, so a closure model must not add a longer hospital-bound journey and then assume risk is unchanged. For time-critical conditions such as cardiac arrest, stroke, sepsis, major trauma, obstetric emergencies and neonatal emergencies, decision-makers must publish evidence showing whether added time would affect survival, disability, deterioration, failed resuscitation, delayed thrombolysis, sepsis progression, obstetric harm or neonatal harm.

The second risk is ambulance resilience. Longer journeys would keep ambulances and crews away from West Norfolk and surrounding communities for longer, delaying availability for the next emergency call. This matters especially in rural, coastal and cross-county areas where ambulance cover is already stretched by distance and where alternative crews may also face longer travel.

Rush-hour ambulance delay evidence

Publicly available searches did not identify QEH-specific ambulance response-time data broken down by rush hour, school-run periods, roadworks or poor weather. That absence is important: any safe closure proposal should not rely only on regional

monthly averages, because those averages can hide local peaks, rural outliers and road-corridor delays.

Evidence on traffic and emergency response supports the need to model peak-period conditions. Research using London lockdown data found that reduced road traffic was associated with faster emergency response times. This draft uses that evidence only to support the general principle that traffic affects emergency response; QEH-specific rush-hour and road-corridor data should still be requested from EEASt and the ICB before any final conclusion is drawn.

For the QEH catchment, the rush-hour risk is likely to arise from known local constraints rather than inner-city gridlock: peak commuter traffic, school-run traffic, agricultural vehicles, tourist traffic, collisions, roadworks, poor weather, and congestion on corridors such as the A47, A10, A17 and A149. Live road and roadworks references should be checked immediately before publication because conditions change frequently; for final drafting, these claims should be supported by Norfolk County Council, National Highways or other official live-road sources. [32]

Campaign implication: EEASt, the ICB and the hospital group should publish QEH-catchment ambulance response and conveyance data by time of day, day of week, season, postcode sector, incident category, road corridor and receiving hospital. The model should include rush hour, school-run periods, summer coastal traffic, bank holidays, winter weather, flooding, roadworks and collision-diversion scenarios, with average, 90th percentile and worst-case call-to-door and call-to-treatment times.

Specific evidence ask: For emergency access, the core campaign message requires NHS decision-makers to publish a full ambulance pathway model comparing current QEH access with each possible alternative hospital.

Verified professional medical evidence supporting retention and improvement

Professional standards support the paper's central position: any service change must be justified by patient safety, access, capacity, staffing and outcomes, not by unsupported assumptions that centralisation will automatically improve care. The Royal College of Emergency Medicine warns that emergency-care reconfiguration can create illusory savings, worsen problems for rural and vulnerable groups through increased transport time, and harm patients if additional attendances are pushed into already crowded emergency departments. [34][35][36]

Maternity and critical-care professional sources point in the same direction. RCOG and CQC maternity material emphasise safe, equitable and responsive maternity care, proper triage, staffing and attention to inequalities. Intensive Care Society and Faculty of Intensive Care Medicine guidance treats critical care as a core, interconnected acute

service requiring safe staffing, outreach, transfer arrangements and network planning. These sources support retention and improvement at QEH unless any alternative model can be proven safe, staffed, accessible and resilient. [37][38][39][40]

Clinical evidence and mortality modelling: why minutes matter

Clinical literature supports the argument that additional delay before emergency assessment, stabilisation and treatment can worsen survival and long-term outcomes. The evidence is strongest for out-of-hospital cardiac arrest, stroke, sepsis, major trauma and some maternity/neonatal scenarios. This does not allow a precise estimate of extra deaths at QEH without local diagnosis, ambulance, transfer and outcome data, but it does show that delay is clinically material and must be modelled before any closure or downgrade.

Cardiac arrest: Studies of out-of-hospital cardiac arrest show that ambulance response time is a major predictor of survival. One English study found that a one-minute reduction in ambulance response time was associated with a 24% improvement in the odds of survival to hospital discharge. This matters for QEH because removing local emergency services could increase the time before a patient reaches hospital-based resuscitation, diagnostics, critical care support or post-resuscitation treatment. [26]

Stroke: Stroke evidence is commonly summarised as “time is brain.” Studies report that untreated ischaemic stroke can involve very rapid brain-cell loss, and registry evidence links each minute of delay in thrombolysis to reduced survival and worse functional outcomes. For QEH users, longer travel to an alternative hospital could therefore affect not only survival, but also disability, mobility, independence and care needs after stroke. [27]

Sepsis: Sepsis is highly time-sensitive. A systematic review and meta-analysis found that each hour of delay in door-to-antibiotic treatment was associated with increased mortality in adult sepsis patients. Later meta-analytic evidence also supports mortality benefit where antibiotics are given within three and six hours of recognition or emergency department arrival. Any closure model must therefore assess whether longer journeys would delay sepsis recognition, blood tests, intravenous antibiotics, fluids, monitoring, escalation and critical care. [28][29]

Major trauma: NICE guidance and NHS trauma-network arrangements recognise that major trauma pathways depend on rapid pre-hospital triage, immediate life-saving interventions and transfer to the right level of care. English trauma-network evidence found that secondary transfer was associated with delayed urgent surgery and higher crude mortality compared with direct transfer to a major trauma centre. While QEH is not a major trauma centre, local emergency stabilisation and correct onward transfer may still be important for seriously injured patients across a rural catchment. [30][31]

Maternity and neonatal emergencies: The maternity evidence must be stated cautiously. A BMJ Open systematic review found some evidence that obstetric unit closures or longer travel distances may increase babies born before arrival and may be associated with increased perinatal or neonatal mortality, although findings were not consistent across all studies. For QEH's dispersed catchment, the relevant risk is not only death but delayed obstetric triage, emergency caesarean section, treatment of haemorrhage, neonatal resuscitation, and repeated long journeys for antenatal and postnatal care. [24]

Required NHS modelling: Decision-makers should publish diagnosis-specific survival and harm modelling for cardiac arrest, stroke, heart attack, sepsis, respiratory failure, major trauma, obstetric emergencies and neonatal emergencies. This should include current QEH Category 1 and Category 2 ambulance arrivals, serious walk-in emergencies, current call-to-door and call-to-treatment times, projected times to Norwich, Peterborough and Cambridge, ambulance handover and turnaround, receiving-hospital capacity, and expected deaths, serious incidents, disability, deterioration and delayed treatment under each option.

What alternative sites would add

Illustrative alternative-site journey estimates requiring verification: Indicative public journey data suggests that King's Lynn to Norfolk and Norwich University Hospital is around 41 miles and approximately 51 minutes by car, with public transport around two hours or more depending on route. Other likely destinations, including Peterborough City Hospital and Addenbrooke's Hospital in Cambridge, would also involve substantial cross-county travel for many patients. These figures must be verified against current route-planning, ambulance and transport data before publication. In a closure scenario, the relevant comparison is not QEH versus an ideal alternative, but QEH access now versus ambulance response plus a much longer conveyance to a more distant hospital.

Indicative time-to-care comparison if QEH A&E or ICU closed

The following comparison is indicative and should be treated as a campaign model, not a substitute for NHS ambulance data. It uses published ambulance response standards and reported regional performance, plus public road journey estimates from King's Lynn. The true NHS model must include blue-light driving, on-scene time, handover delay, traffic, roadworks, weather, bed availability and receiving-hospital pressure.

Scenario	Estimated road journey from King's Lynn	Likely emergency access implication
Current QEH pathway	Local access to QEH; exact ambulance conveyance time varies by starting location.	Patient can receive local A&E assessment, resuscitation, diagnostics, maternity triage, stabilisation, critical care input

		or onward specialist transfer where needed.
Norfolk and Norwich University Hospital	Approximately 41 miles and around 51 minutes by car from King's Lynn in reported journey data; other sources give roughly 53–59 minutes depending on route and destination point.	Closure could add around one hour of hospital-bound travel from King's Lynn before handover and treatment, with longer times possible in rush hour, roadworks, poor weather or congestion on the A47 corridor.
Peterborough City Hospital	Precise public journey data should be formally modelled by the NHS; road access from King's Lynn is substantial and cross-county, especially for rural villages east, north or coastal of King's Lynn.	Would shift emergency demand into another acute system and may be less suitable for patients north or east of King's Lynn unless capacity, travel and handover evidence proves otherwise.
Addenbrooke's Hospital, Cambridge	Approximately 56 miles and around 1 hour 24 minutes by car from King's Lynn in reported journey data, including mild traffic delay.	Likely to be too distant as a routine replacement for local emergency access for many time-critical patients, unless used for specialist pathways after stabilisation or where clinically appropriate.

Rush-hour, congestion and poor-weather risks are addressed in the consolidated travel-time and ambulance-delay argument above and in the road-network section below. The key point is that emergency planning must model average, 90th percentile and worst-case journey times, not only normal daytime car journeys.

Road network, traffic and poor-weather risk

The road network around King's Lynn and the wider QEH catchment makes emergency access particularly sensitive to disruption. Routes towards Norwich, Peterborough and Cambridge rely on strategic corridors such as the A47, A10, A17, A149 and surrounding rural roads. These routes are affected by commuter peaks, tourist traffic, agricultural vehicles, freight, school traffic, collisions, roadworks, flooding, fog, ice, high winds and diversions. For emergency-care planning, the relevant question is not the best-case journey time on a clear road, but whether the system remains safe during predictable periods of congestion and disruption.

Local transport evidence supports this concern. The King's Lynn Transport Strategy identifies daily congestion and delay at the A17/A47 Pullover Roundabout, notes that

the A149 King's Lynn eastern bypass carries daily traffic levels above the standard of the road, and identifies the need for A47 dualling between Tilney and East Winch to improve safety and capacity. Norfolk County Council's Local Transport Plan also recognises that transport affects access to services, social isolation, health and wellbeing. These local documents show that transport weakness is already acknowledged by public authorities and should be part of any hospital impact assessment. [32][16]

Roadworks and closures are not exceptional events. Norfolk County Council and National Highways publish roadworks and traffic information, and the King's Lynn Transport Strategy identifies existing congestion, road-capacity and safety issues affecting key local corridors. Any live-traffic or roadworks examples should be checked against official sources immediately before publication because conditions change daily. [32]

Poor weather adds a further rural risk. Flooding, surface water, coastal weather, fog, ice and winter darkness can slow ambulance and private journeys, especially on rural roads and routes with limited diversion options. Older patients, pregnant women, disabled patients and families without private transport are likely to be most affected because they have fewer practical alternatives when travel becomes difficult or unsafe.

These road and weather conditions should feed directly into the consolidated ambulance pathway model above. They can affect response to the patient, travel from scene to hospital, crew turnaround and availability for the next call, which is why average car journey estimates are not enough to judge patient safety.

Campaign implication: Any proposal to close or downgrade QEH services must publish road-network modelling that includes rush hour, school-run periods, bank holidays, summer coastal traffic, agricultural traffic, roadworks, collisions, flooding, fog, ice, snow, high winds, night-time travel and diversion scenarios. A safe decision cannot be based only on average car journey times in normal conditions.

Campaign position

Until NHS decision-makers publish the emergency access and mortality-risk modelling required by the core campaign message, any claim that alternative provision would be safe should be treated as unproven.

Alternative Provision and Barriers for Current QEH Service Users

Any proposal to close or downgrade essential services at QEH must first identify where current patients would go instead. This section focuses on access barriers for current

QEH users, while the staffed-capacity case for Norwich, Peterborough and Cambridge is addressed later.

Likely receiving hospitals

The most likely receiving hospitals would include Norfolk and Norwich University Hospital, Peterborough City Hospital, Addenbrooke's Hospital in Cambridge, and possibly other specialist or urgent-care sites depending on the service affected. The immediate question for patients is whether those alternatives would be understandable, reachable and safe in practice.

Access barriers summarised

For many current QEH users, especially those in rural and coastal communities, alternative hospitals would mean substantially longer and less reliable journeys. Practical access barriers would therefore need to be assessed before any service loss is proposed.

Barriers for current service users

1. **Private transport:** Many households cannot assume access to a reliable car, fuel money, parking money, or someone able to drive at short notice.
2. **Public transport:** Rural bus links are often limited, indirect, infrequent, or unavailable in the evenings, overnight, and at weekends. This is particularly serious for outpatient, maternity, visiting, and discharge journeys.
3. **Ambulance availability:** Longer conveyances would reduce local ambulance cover for the next emergency; this is addressed in detail in the emergency travel-time and ambulance-delay section.
4. **Older and disabled patients:** Longer travel may create practical barriers; the detailed equality analysis is in the catchment and Appendix C sections.
5. **Pregnancy and maternity:** The detailed access and safety argument is set out in the consolidated maternity section; alternative provision must still account for repeated appointments, triage, labour, neonatal care and family support.
6. **Low-income households:** Fuel, taxis, parking, childcare and lost wages may deter attendance; the cost detail is covered in the travel-cost section.
7. **Carers and families:** Relatives often provide transport, communication, advocacy, food, clothing, discharge support, and emotional support. Greater distance weakens that support network.
8. **Cross-county complexity:** QEH serves communities across Norfolk, Cambridgeshire, and Lincolnshire. Moving services elsewhere could create confusion over pathways, referrals, discharge arrangements, and responsibility between systems.

Access and alternative-pathway questions

1. Which hospitals, urgent-care sites or specialist pathways would current QEH patients be expected to use?
2. How would patients know where to go, especially overnight, at weekends, during pregnancy or in time-critical emergencies?
3. What transport, communication and triage arrangements would protect patients from delay or confusion?

Conclusion: Alternative provision remains unproven unless decision-makers publish detailed modelling showing that patients can access other services safely and that receiving hospitals can absorb QEH activity without worsening delay, equality of access, maternity safety or ambulance cover.

Receiving-Hospital Capacity: Norwich, Peterborough and Cambridge

Closure or downgrading of QEH A&E, ICU/critical care or maternity would not remove the demand identified in the QEH baseline; it would displace that demand to other hospitals, most likely Norfolk and Norwich University Hospital, Peterborough City Hospital and Addenbrooke's Hospital in Cambridge. The test is whether those providers have enough staffed emergency, inpatient, critical-care, theatre, diagnostic, maternity, neonatal and ambulance-interface capacity to absorb QEH activity without worsening outcomes, waits or resilience.

Illustrative A&E displacement calculation requiring verification: QEH reported 94,033 Emergency Department attendances in 2024/25. If even part of that activity were displaced, the receiving hospitals would face a significant additional burden. For illustration only, one-third of QEH's annual Emergency Department attendances would equal more than 31,000 extra attendances per year, or around 85 additional attendances per day, before counting maternity, critical care transfers, admissions, diagnostics, follow-up appointments, relatives, visitors and ambulance turnaround effects. This calculation is not a forecast; the exact displacement pattern must be modelled by the NHS using patient origin, condition, acuity, pathway and receiving-hospital capacity.

Current pressure at likely receiving hospitals

Receiving provider	Recent published A&E pressure indicators	Implication if QEH demand is displaced
Norfolk and Norwich University	Recent published figures show substantial monthly A&E attendances,	Additional West Norfolk demand could worsen crowding, waits, ambulance handovers, bed

Hospitals NHS Foundation Trust	performance below the historic four-hour standard, and hundreds of 12-hour waits in recent reporting periods.	pressure and elective cancellation risk, especially because NNUH already serves a large rural county population.
North West Anglia NHS Foundation Trust / Peterborough City Hospital	Recent published figures show A&E performance below the four-hour standard, more than 21,000 monthly attendances in some reporting periods, and hundreds of 12-hour waits.	Displaced QEH demand could add pressure to Peterborough and Hinchingsbrooke pathways, increasing waits for existing Cambridgeshire and Lincolnshire patients as well as former QEH users.
Cambridge University Hospitals NHS Foundation Trust / Addenbrooke's Hospital	Recent published figures show major A&E attendance pressure, performance below the four-hour standard, and hundreds of 12-hour waits in recent reporting periods.	Addenbrooke's is a regional specialist centre and major trauma centre. Using it as a routine replacement for QEH local emergency access risks crowding specialist capacity that should remain available for complex regional cases.

Provider-specific impact: Norfolk and Norwich University Hospital

Norfolk and Norwich would likely receive a significant share of displaced QEH activity because it is the nearest large acute hospital to the east of King's Lynn and already acts as a major regional provider. The June 2026 A&E figures in this draft should be verified against NHS England's A&E Attendances and Emergency Admissions dataset before publication. If confirmed, they would show substantial attendances, four-hour performance below the standard, and 12-hour waits. Adding QEH emergency activity would risk worsening crowding, ambulance handovers, bed occupancy and planned-care disruption. [8]

There is also a strategic risk. Norfolk and Norwich is part of the developing Norfolk and Waveney acute hospitals group model with QEH and James Paget. Removing meaningful emergency or critical care capacity at QEH would not simply strengthen the group; it could concentrate risk at Norwich, leaving the wider system less resilient during winter pressures, infection outbreaks, staffing shortages, severe weather, road disruption or major incidents.

Provider-specific impact: Peterborough City Hospital and North West Anglia

Peterborough City Hospital would be a likely receiving site for some patients from North Cambridgeshire, Fenland, South Lincolnshire and the western side of the QEH catchment. Published A&E figures for North West Anglia NHS Foundation Trust should be verified against NHS England's A&E Attendances and Emergency Admissions dataset before publication. The current draft treats those figures as evidence to be checked, but the planning question remains: any additional QEH demand could worsen waits for both former QEH patients and existing Peterborough/Hinchingsbrooke patients unless receiving capacity is fully modelled and funded. [8]

The effect would not be limited to A&E. Additional emergency admissions could increase bed pressure, compete for critical care capacity, affect diagnostics, delay surgery, and create extra demand on maternity, neonatal, paediatric and ambulance services. For Fenland and South Lincolnshire communities, Peterborough may look geographically plausible, but the campaign should require proof that the route, capacity, staffing and handover arrangements are safe in normal conditions and during peak pressure.

Provider-specific impact: Addenbrooke's Hospital and Cambridge University Hospitals

Addenbrooke's is a major regional specialist hospital and major trauma centre. It should not be treated as a routine substitute for local emergency access at QEH without strong evidence. Published A&E figures for Cambridge University Hospitals should be verified against NHS England's A&E Attendances and Emergency Admissions dataset before publication. The central issue is whether adding routine displaced QEH demand would crowd specialist capacity that is needed for complex regional care. [8]

Cambridge may remain appropriate for specialist pathways, but that is different from expecting it to replace QEH as the local emergency front door for West Norfolk and surrounding communities. For many patients, especially elderly, frail, pregnant, disabled, low-income or rural residents, the journey to Cambridge would be too long and too uncertain to be treated as a safe ordinary alternative without detailed modelling.

Maternity-specific impact on Norwich, Peterborough and Cambridge

The receiving-hospital impact of maternity displacement should be read alongside the consolidated maternity-access section above. The issue is not only QEH's 1,772 births in 2024/25, but the full pathway of triage, antenatal assessment, emergency obstetrics, theatres, postnatal care, neonatal care and safeguarding demand that would move with those families.

Receiving maternity provider	Relevant data found	Implication if QEH maternity demand is displaced
Norfolk and Norwich University Hospital	CQC rated maternity services “Good” in February 2024. NNUH reported more than 5,000 service users accessing maternity care each year, and CQC records 5,199 babies born between April 2021 and March 2022. These figures should be verified against current CQC/NNUH documents before publication.	NNUH may be the most obvious alternative for many West Norfolk families, but absorbing QEH maternity work would mean additional births, triage attendances, scans, emergency obstetrics, theatre use, postnatal beds and neonatal demand on a unit already serving Norfolk, North Suffolk and Waveney.
Peterborough City Hospital / North West Anglia	North West Anglia reported maternity provision across Peterborough and Hinchingsbrooke. CQC rated Peterborough maternity “Good” in June 2023 and recorded 4,111 trust deliveries from March 2022 to February 2023. Local reporting of NHS England maternity data states around 5,740 babies were delivered at North West Anglia in the year to March 2025, a 20% increase over ten years. These figures should be verified against current CQC/NHS England/North West Anglia documents before publication.	Peterborough may be relevant for Fenland, North Cambridgeshire and South Lincolnshire families, but the data suggests an already large and growing maternity workload. Additional QEH births and urgent maternity attendances could require more midwives, obstetricians, anaesthetists, theatre capacity, postnatal beds and neonatal capacity.
Addenbrooke’s / The Rosie Hospital, Cambridge	The Rosie is a tertiary maternity unit with a level 3 neonatal intensive care unit accepting infants from 22+0 weeks. It serves local Cambridgeshire communities and provides specialist high-risk obstetrics and fetal and maternal medicine for the whole Eastern region. CQC rated maternity “Requires improvement” in 2023, citing staffing concerns and delays in triage, although well-led was rated good. The	Cambridge should be protected for complex specialist and tertiary care, not used as a routine replacement for local maternity access. Displacing routine QEH maternity care to Cambridge could crowd specialist capacity, worsen triage delays and increase travel burdens for families from West Norfolk, Fenland and South Lincolnshire.

	Rosie supported around 5,500 births per year and CQC recorded 5,573 births from April 2021 to March 2022. These figures should be verified against current CQC/CUH documents before publication.	
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Illustrative maternity displacement calculation requiring verification: The headline birth-displacement calculation is retained here once only for capacity modelling. If all QEH births were moved elsewhere, receiving systems would need to absorb up to 1,772 additional births per year before triage, antenatal, postnatal and neonatal activity. This is not a prediction of where patients would go; the actual distribution must be modelled using patient postcode, risk profile, existing pathways, patient choice, transport availability and receiving-unit capacity.

Campaign implication: Receiving-provider modelling should focus on whether Norwich, Peterborough and Cambridge have enough staffed maternity, theatre, neonatal and triage capacity to absorb QEH activity without worsening safety or access.

Capacity modelling required for receiving maternity units

The table below keeps the numerical capacity scenario in one place so the same maternity displacement calculation is not repeated elsewhere in the paper.

Displacement scenario	Additional births displaced from QEH	Indicative impact on each receiving unit
Equal split between Norwich, Peterborough and Cambridge	1,772 births per year	Approximately 591 additional births per year per provider, before triage, antenatal, postnatal and neonatal activity.
Half to Norwich, quarter to Peterborough, quarter to Cambridge	1,772 births per year	Approximately 886 additional births per year at Norwich and 443 per year at each of Peterborough and Cambridge.
Half to Peterborough, quarter to Norwich, quarter to Cambridge	1,772 births per year	Approximately 886 additional births per year at Peterborough and 443 per year at each of Norwich and Cambridge.

Specialist-risk concentration at Cambridge	Unknown without local case-mix modelling	If complex pregnancies, fetal medicine, extreme prematurity or neonatal intensive care cases are disproportionately directed to Cambridge, the burden may fall on the Rosie's specialist capacity rather than just its birth numbers.
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Operational consequences of displaced demand

1. **Longer ambulance cycles:** Crews travelling to Norwich, Peterborough or Cambridge would spend longer away from West Norfolk; the detailed safety case is set out in the emergency travel-time section.
2. **Greater handover pressure:** Receiving hospitals would need to absorb additional ambulance arrivals, increasing the risk of handover delays and queues outside emergency departments.
3. **Emergency department crowding:** Extra demand could reduce four-hour performance, increase decision-to-admit waits, and worsen patient flow.
4. **Critical care competition:** If QEH ICU capacity were lost, critically ill patients would compete for beds at regional centres that already serve wider populations and specialist pathways.
5. **Maternity and neonatal pressure:** Closing or reducing QEH maternity would shift antenatal triage, labour, emergency obstetrics, neonatal care and postnatal demand elsewhere, increasing pressure on units that may already face staffing and capacity constraints.
6. **Elective-care disruption:** Higher emergency admissions at receiving hospitals can reduce bed availability for planned surgery, diagnostics and outpatient pathways.
7. **Regional resilience risk:** Removing QEH capacity would leave the East of England system with less flexibility during winter pressure, major incidents, infection outbreaks, industrial action, severe weather or road disruption.

Campaign implication: The NHS should publish one regional operational model showing how displaced QEH demand would be managed across ambulance services, receiving hospitals, critical care, maternity, diagnostics and patient flow.

Future Service Need Over the Next 25, 50 and 100 Years

Any decision about QEH must be assessed not only against today's demand, but also against future need. The strongest official local projections currently run to around 2043, while national projections extend further. Therefore, 50-year and 100-year conclusions should be framed as scenario planning rather than precise forecasts. However, the available data points clearly in one direction: the QEH catchment is likely

to face rising pressure from ageing, multimorbidity, rurality, social care demand, emergency admissions, critical care need and transport inequality.

Norfolk's JSNA projects that between 2022 and 2032 Norfolk's population will increase by roughly 8%, with residents aged 65 or over increasing by around 48,000 and the share of the population aged 65+ rising from 25% to 28%. Norfolk older-people JSNA material also states that by 2040 the number of people aged 85+ is expected to rise by 67%, reaching nearly 52,900. This is highly relevant because older residents use more urgent care, inpatient care, diagnostics, rehabilitation, pharmacy, ambulance, community and social care services. [15][57]

Fenland, which forms part of the wider QEH-affected geography, is also projected to grow. Cambridgeshire JSNA material states that Fenland's population was almost 102,500 in 2021, had grown by 7.6% since 2011, and was forecast to grow by around 15.2% by 2031, with further growth of 7.4% between 2031 and 2041. Fenland also has higher deprivation, lower life expectancy, higher disability prevalence and worse mortality indicators than England for several conditions. This combination suggests future demand will not simply be larger but more complex. [58]

Lincolnshire data points in the same direction. Public reporting and Lincolnshire strategy material state that Lincolnshire's population is older than average, with around 23% to 24% aged 65 or over, and that by 2043 the population aged 65+ is expected to rise by around 41%, while those aged 85+ are expected to rise by around 94%. South Lincolnshire communities in the QEH catchment are therefore likely to contribute to rising need for emergency, critical, maternity, community and social care pathways. [59][60]

Twenty-five-year planning view

A 25-year view is the most useful planning horizon for the campaign because it is close enough to be supported by current local demographic projections, but long enough to test whether closure is strategically sensible. By the late 2040s and early 2050s, the QEH catchment is likely to have more older residents, more people living with multiple long-term conditions, more frailty, greater social care need, and more pressure on ambulance and emergency pathways. Decisions made now could therefore remove capacity just as the local population becomes more clinically complex.

For A&E, the 25-year risk is increased presentations for falls, stroke, sepsis, heart failure, respiratory disease, dementia-related crises, medication problems and urgent frailty care. For ICU and critical care, the risk is higher demand for respiratory support, sepsis management, cardiac escalation, post-operative monitoring and complex step-down care. For maternity, birth numbers may fluctuate, but service need will still be shaped by deprivation, transport barriers, complex pregnancy, neonatal care, safeguarding and the need for urgent maternity triage close to home.

Campaign implication: NHS decision-makers should not be allowed to rely only on short-term budget pressure or current-year activity. They should publish a 25-year demand model for the whole QEH catchment, including population ageing, 85+ growth, emergency admissions, ambulance demand, maternity triage, critical care need, social care capacity, workforce supply, housing growth, deprivation and travel barriers.

Implications for A&E, ICU/critical care and maternity

1. **A&E and urgent care:** An older and more medically complex population is likely to increase emergency presentations for falls, frailty, stroke, sepsis, heart failure, respiratory disease, diabetes complications, dementia-related crises, infections and medication problems.
2. **ICU and critical care:** Ageing and multimorbidity are likely to increase demand for respiratory support, sepsis management, post-operative critical care, cardiac escalation, renal support, high-dependency monitoring and safe step-down pathways.
3. **Maternity and neonatal care:** Future maternity need should be assessed through the consolidated maternity case, including triage, complex pregnancy, neonatal care, deprivation, travel distance and repeated access, not by annual birth numbers alone.
4. **Ambulance services:** More older residents, rural isolation and longer alternative journeys would increase the importance of the ambulance pathway modelling set out in the emergency travel-time section.
5. **Community and social care:** Growth in the 85+ population is likely to increase delayed discharge risk, rehabilitation need, care-package demand, unpaid-carer pressure and the consequences of admitting patients far from home.

Fifty-year planning view

Over the next 50 years, the campaign should assume continued pressure from population ageing, longer survival with chronic disease, growth in dementia and frailty, greater demand for community and social care, and more frequent need for integrated urgent and emergency pathways. The NHS Long Term Workforce Plan recognises that England's population is growing and ageing, that the number of people aged over 85 is estimated to grow by 55% by 2037, and that without action the NHS could face a workforce shortfall of 260,000 to 360,000 staff by 2036/37. In that context, removing local acute capacity from QEH would be a high-risk long-term decision unless there is overwhelming evidence that equivalent or better capacity will exist elsewhere. [33]

One-hundred-year resilience view

A 100-year projection cannot credibly assign precise local numbers for QEH using current public data. However, long-term resilience planning should consider that climate change, coastal flooding risk, heatwaves, severe weather, population ageing,

digital exclusion, workforce shortages, housing growth, road disruption and changing disease patterns may all increase the value of local acute capacity. For a rural and coastal catchment, the strategic question is whether the NHS should preserve local emergency, critical care and maternity infrastructure as a resilience asset, rather than remove it on the basis of short-term financial pressure.

Campaign implication: NHS decision-makers should publish a long-term service-needs assessment covering at least 25 years, with scenario modelling to 50 and 100 years. This should include population ageing, 85+ growth, deprivation, births, maternity triage, emergency admissions, ambulance demand, critical care need, social care capacity, climate and road disruption, workforce supply and the risk of losing local acute infrastructure in a large rural catchment.

Catchment, Equality and Access Impacts

QEH serves a dispersed cross-county population across West and North Norfolk, North Cambridgeshire and South Lincolnshire, rather than an urban area with several nearby equivalent hospitals. Any decision to remove or downgrade services must therefore assess whether patients can actually reach safe care, not just whether another hospital exists on a map.

The local geography matters. King's Lynn and West Norfolk is one of the least densely populated local authority areas in the East of England. Census 2021 analysis shows that the district had a median age of 47, higher than the East of England and England, and that the number of residents aged 65 to 74 increased between 2011 and 2021. Older populations tend to rely more heavily on urgent, emergency, inpatient, diagnostic and ambulance services, so removing local acute capacity would not affect all communities equally.

Parts of the wider catchment also face marked deprivation and poorer health outcomes. Fenland, which sits within the wider population likely to be affected by QEH service changes, has relatively high deprivation, lower life expectancy than the England average, higher reported disability, and worse mortality indicators for several conditions including cardiovascular disease, respiratory disease and COPD. These are exactly the types of communities most likely to be harmed by longer emergency journeys and reduced access to local acute care.

The equality assessment should cover older people, disabled people, people with long-term conditions, pregnant women and new parents, low-income households, people without cars, unpaid carers, digitally excluded residents, isolated rural communities and cross-county patients whose care and discharge may involve more than one authority or NHS system.

For these reasons, comparisons with urban hospital closure disputes must be used carefully. Lewisham is important as a process and campaign example, but QEH's strongest comparators are rural, coastal, and dispersed-population hospitals where travel time, ambulance resilience, older age profile, deprivation, transport poverty, and alternative hospital capacity are central to patient safety.

Campaign implication: Any proposal should publish a single full catchment, equality and access impact assessment covering road travel, public transport, deprivation, age, disability, pregnancy and maternity, car ownership, unpaid caring, digital exclusion, social isolation, travel costs and receiving-hospital access.

Older, disabled and long-term-condition access risks

Older age, disability and long-term conditions are among the most important clinical-access risks within the wider equality case. Decision-makers should identify the evidence needed to protect these groups before any service is removed or downgraded.

For older residents, the issue is not only emergency attendance. Older patients are more likely to need ambulance response, urgent assessment after falls, stroke care, sepsis treatment, respiratory support, medication review, diagnostics, emergency admission, rehabilitation, discharge planning, community nursing and social care. Longer journeys to Norwich, Peterborough or Cambridge could also make visiting, advocacy and discharge support harder for relatives and unpaid carers.

For disabled residents and people with long-term conditions, loss of local services could create additional barriers before care is even reached. These may include difficulty travelling in pain or breathlessness, reliance on accessible transport, difficulty transferring between buses and trains, sensory or communication needs, digital exclusion, carer dependence, anxiety caused by unfamiliar hospitals, and higher risk if treatment or review is delayed. These barriers are particularly serious for people with cardiovascular disease, respiratory disease, diabetes, neurological conditions, frailty, dementia, mobility impairment or complex medication needs.

For these groups, the required evidence should include age-band activity, diagnosis groups, ambulance conveyance by postcode, patient transport use, disability prevalence, car ownership, public transport availability, missed appointments, discharge delay, social care need and carer support. Appendix C turns this into a checklist for scrutiny and consultation.

Campaign implication: NHS bodies should show how older residents, disabled patients and people with long-term conditions would be protected from worse access, longer journeys, weaker carer support and delayed discharge.

Additional health demands in the QEH catchment

Modelling should also include wider urgent-care pathways that may be affected by the loss of local acute capacity, alongside demographic projections and equality impacts discussed above.

1. **Frailty, falls and dementia:** urgent assessment, rehabilitation, discharge planning and family support.
2. **Respiratory disease and COPD:** oxygen, imaging, antibiotics, ventilation support and critical-care escalation.
3. **Cardiovascular disease:** chest pain, heart attack, stroke, heart failure, arrhythmia and cardiac arrest pathways.
4. **Cancer complications and urgent oncology care:** infection, neutropenic sepsis, bleeding, dehydration, severe pain and treatment complications.
5. **Children and paediatric urgent care:** breathing problems, fever, dehydration, injury, allergic reactions, safeguarding concerns and sudden deterioration.
6. **Mental health crisis and self-harm presentations:** urgent assessment, intoxication, confusion, safeguarding and crisis-support pathways.
7. **End-of-life and palliative emergencies:** symptom control, pain relief, oxygen, crisis admission, carer support and discharge planning.
8. **Seasonal and coastal population pressure:** summer tourism, bank holidays, visitor demand and less predictable journey times.
9. **Agricultural, industrial and road-traffic injuries:** machinery, falls, crush injuries, workplace incidents, road collisions, imaging, surgery, stabilisation and transfer.
10. **Digital exclusion and access barriers:** reliance on face-to-face access where online systems, transport, language support or family help are limited.

Campaign implication: Closure or downgrade modelling should include these additional pathways so the NHS does not underestimate QEH's wider safety-net role.

Social isolation and hidden access barriers

Social isolation is a practical access barrier within the wider equality case. A journey that looks manageable on a map may be unrealistic for someone who lives alone, has no car, is digitally excluded, cannot afford taxis or fuel, depends on an unpaid carer, or has limited mobility.

ONS Census 2021 data shows that King's Lynn and West Norfolk had a median age of 47, higher than both the East of England and England, and was the joint least densely populated local authority area in the East of England. Norfolk's JSNA also highlights an ageing population, social isolation among adult social care users, loneliness among adults, and particular loneliness risks for older people living alone, bereaved people,

unpaid carers, people with reduced mobility, people with long-term conditions and people affected by poor transport or digital exclusion. [12][13][14]

This matters for care before, during and after admission. Distance can delay attendance, weaken family advocacy, make visiting harder, complicate discharge planning and increase pressure on community health and social care services.

Campaign implication: Social isolation, living alone, unpaid caring, digital exclusion and public transport gaps should be treated as access risks in the main equality impact assessment, not as separate afterthoughts.

Travel-cost burden for families, carers and visitors

Distance creates a direct financial burden for patients, relatives and unpaid carers, especially where repeated journeys to Norwich, Peterborough or Cambridge would be needed.

Illustrative travel-cost estimates requiring verification: Public journey data illustrates the burden. From King's Lynn, public transport to Norfolk and Norwich University Hospital is reported at around two hours by bus, with driving around 51 minutes and taxis estimated at over £100 one way. Public transport to Peterborough City Hospital is reported at around 1 hour 46 minutes by bus, with driving around 45 minutes and taxis estimated at around £75–£90 one way. Public transport to Addenbrooke's Hospital can be around 1 hour 12 minutes by train in the best case, but bus-only journeys can exceed three hours, and taxis are estimated at around £95–£120 one way. These figures are indicative only and should be verified against current public transport timetables, route planners and local taxi providers before publication. They begin from King's Lynn itself; journeys from coastal villages, rural settlements, South Lincolnshire, Fenland or North Norfolk may be longer, less direct and more expensive.

The NHS Healthcare Travel Costs Scheme can help some eligible patients with reasonable travel costs to specialist NHS treatment, but it is limited. It generally depends on qualifying benefits or the NHS Low Income Scheme, requires a referral for specialist care, and does not cover ordinary hospital visiting. The NHS also states that travel costs for an escort can only be claimed where a healthcare professional says an escort is medically necessary. This means many relatives, carers and visitors who provide essential informal support may receive no reimbursement at all. [19]

For low-income families, the real cost may include fuel, parking, taxi fares, rail or bus fares, food, childcare, time off work, lost wages, overnight stays, phone costs and repeated journeys. For older or disabled relatives, the difficulty may be physical as much as financial: long walks through stations, transfers between buses and trains, poor evening services, limited rural connections, and the stress of unfamiliar hospitals can make visiting impossible.

The costs are not incidental: fewer visits and weaker carer involvement can affect communication, discharge planning and recovery, especially for patients who rely on family advocacy or practical support.

Campaign implication: Any equality assessment should include a family and carer travel-cost model covering fuel, parking, public transport, taxis, childcare, lost wages, overnight stays and repeated visits.

Patient, family and carer testimonials: evidence to collect

Personal testimony should be included alongside clinical and statistical evidence because it shows how service change would affect real people in the QEH catchment. Testimonials should be gathered with consent, anonymised where requested, and checked for accuracy before publication. The paper should avoid inventing stories or presenting unverified claims as fact.

Testimonies should focus on the practical and clinical value of local access: rapid A&E assessment, ambulance conveyance to QEH, emergency surgery, sepsis treatment, stroke care, cardiac care, maternity triage, neonatal care, intensive care, discharge support, and the ability of relatives or carers to attend the hospital. Evidence should also capture what would have happened if the patient had instead needed to travel to Norwich, Peterborough or Cambridge.

Employer Responsibilities and Cost to the NHS if Services Close

QEH's responsibilities as an employer would be central to any closure or major service change. Closure of A&E, ICU/critical care or maternity would affect staff roles, work location, rotas, training, professional development, recruitment, retention, morale, sickness absence and the ability to maintain interdependent services. It may also create direct NHS costs through consultation, redeployment, redundancy, legal advice, agency staffing, recruitment, relocation, retraining, estates changes and duplicated capacity at receiving hospitals.

The workforce and income elements of the master QEH baseline show the scale of the employment issue. Any removal of core acute services would affect a major local workforce, not a small isolated team.

NHS redundancy arrangements are nationally regulated. NHS Employers states that eligible staff made redundant under Agenda for Change should receive one month's pay per year of reckonable service, up to a maximum of 24 months' pay, subject to national salary floor and cap rules. Staff generally need at least two years' continuous NHS service to qualify. This means service closure can create substantial cash costs if

suitable alternative employment is not available, especially for experienced nurses, midwives, healthcare staff, managers, administrators and support workers with long NHS service. [63]

Closure may also create costs even where redundancies are avoided. Staff may need redeployment, retraining, pay protection, new rotas, travel reimbursement, relocation support, recruitment support, occupational health input, union consultation time, HR capacity and legal advice. Receiving hospitals may need additional posts, induction, accommodation, parking, digital access, training places and supervision capacity. These transitional costs should be disclosed before any decision is presented as a saving.

Public searches did not identify a verified QEH-specific estimate of the cost of closing A&E, ICU or maternity. Local reporting in 2024 stated that QEH had a budget deficit of almost £22 million, but also quoted the Chief Executive as saying there had been no discussions around redundancies at that time. A separate Freedom of Information request from October 2024 sought QEH documents on job losses, redundancy budgets and employment-law costs, showing that these are legitimate questions for public disclosure, but it did not provide a final published cost figure in the search results reviewed.

Campaign implication: NHS decision-makers should publish a full workforce and financial impact assessment before any closure or downgrade is considered. This should include staff numbers by service, vacancy rates, agency spend, redeployment options, redundancy exposure, pay protection, training and retraining costs, recruitment impact, staff travel impact, legal and HR costs, receiving-hospital staffing requirements, transitional costs and whether the closure would genuinely save money once displacement and implementation costs are included.

Wider NHS Economic Costs if QEH Services Close

Closure or downgrading should not be assumed to save money for the wider NHS. The financial question is whether displaced activity would create higher costs in ambulance services, receiving hospitals, community care, social care, patient transport and implementation.

NHS England's National Cost Collection is the key source for estimating average NHS unit costs, including admitted patient care and other services. Parliamentary material based on 2024/25 National Cost Collection data reported non-elective bed-day costs of £791 for long-stay non-elective admissions and £806 for short-stay non-elective admissions, with elective inpatient bed days at £1,198. These figures show why additional emergency admissions, delayed discharges or longer stays at receiving hospitals can quickly create substantial costs. [17][18]

Illustrative system-cost risk requiring verification: The financial issue is separate from operational capacity. Any claimed saving must be tested against additional ambulance, receiving-hospital, critical-care, maternity, community-care, social-care, patient-transport and implementation costs. This is a risk framework, not a final cost estimate; the figures must be confirmed through NHS England cost data, provider costing, ICB finance papers and formal option appraisal.

Critical care costs are especially important. Any ICU/HDU cost range used in this draft should be treated as illustrative until checked against NHS England National Cost Collection data and provider-level costing. If QEH critical care capacity were removed, any apparent local saving would need to be offset against the cost of staffed critical care capacity at receiving hospitals, critical care transfers, retrieval teams, longer stays caused by delayed stabilisation, and higher-cost specialist care. [17]

Planned care could also be affected. NHS England publishes cancelled elective operation statistics because emergency pressure can reduce the beds, theatres and staff available for planned surgery. If Norwich, Peterborough or Cambridge had to absorb additional QEH emergency admissions, this could increase the likelihood of cancelled operations, longer waiting lists, delayed diagnostics and lost theatre productivity. These costs would fall on the wider NHS and on patients already waiting for care.

Maternity system costs should be read alongside the consolidated maternity section and receiving-hospital maternity modelling above.

1. **Ambulance costs:** longer conveyance distances, longer crew time, higher fuel and vehicle use, and reduced availability for the next call.
2. **Hospital handover costs:** longer queues outside receiving hospitals and more time before crews can return to service.
3. **Emergency department costs:** additional attendances, crowding, staffing, diagnostics and escalation capacity.
4. **Inpatient bed costs:** more emergency admissions and delayed discharges, with non-elective bed days costing hundreds of pounds per day.
5. **Critical care costs:** ICU/HDU bed days, retrieval, transfer and regional capacity costs.
6. **Maternity and neonatal costs:** extra births, triage, theatres, neonatal cots, postnatal care and community follow-up.
7. **Elective-care costs:** cancelled operations, lost theatre time, longer waiting lists and breach-management costs.
8. **Social care and community costs:** delayed discharge, reduced family support, rehabilitation needs and increased pressure on local authority services.

Primary care, community care, social care and ICB cost pressures

Closure or downgrading of QEH services would also create costs outside hospital provider budgets. Primary care, community services, social care and the Integrated Care Board would be expected to absorb displaced demand, additional follow-up needs, more complex discharge planning, higher patient transport needs and greater pressure from people who cannot easily access distant hospitals.

For primary care, the risk is that patients who would previously have accessed QEH A&E, maternity triage, diagnostics or specialist follow-up may instead present to GP practices, urgent same-day services, NHS 111, out-of-hours services or community pharmacies. This could increase appointments, administrative work, safety-netting, repeat contacts, referrals, complaints and safeguarding work, particularly in rural and deprived communities where access to transport is limited.

For community health and social care, the main cost risk is delayed discharge and avoidable deterioration. The Health Foundation and King's Fund figures cited in this draft should be verified against their original publications before final release. The planning question is clear even before exact local figures are obtained: delayed discharge reduces hospital bed availability, worsens patient flow, increases pressure on ambulance handovers and A&E admissions, and can increase infection risk, mobility loss, mental health harm and care-package demand.

Service loss at QEH could worsen this problem because patients admitted further from home may have less family support, more complex transport home, weaker links with local community teams, and more difficult coordination with Norfolk, Cambridgeshire or Lincolnshire social care. This can increase the likelihood of longer stays, failed discharge, readmission, care-package delays, rehabilitation needs and additional pressure on local authorities.

Illustrative ICB financial context requiring verification: The ICB cost issue is particularly important because Norfolk and Waveney already faces financial pressure. Any ICB budget, efficiency or deficit figures used in this briefing must be verified against the ICB's own financial papers, board reports or formal consultation documents before publication. In the meantime, the campaign should require a whole-system financial model showing whether any apparent saving from QEH service closure would be outweighed by additional cost in primary care, GP out-of-hours, community services, social care, ambulance services and receiving hospitals.

Campaign implication: The ICB should publish a whole-pathway financial model showing whether closure would genuinely save money once primary care appointments, out-of-hours contacts, NHS 111 activity, community nursing, rehabilitation, social care assessments, care packages, delayed discharges,

readmissions, patient transport, ambulance hours, receiving-hospital expansion and cross-county coordination costs are included.

Campaign implication: NHS decision-makers should publish a system-wide economic impact assessment showing whether any claimed QEH saving would be outweighed by extra ambulance, receiving-hospital, critical care, maternity, community, social care, patient transport and implementation costs.

Cost and Risk for the Norfolk and Waveney University Hospitals Group

QEH is now part of the Norfolk and Waveney University Hospitals Group, formed in May 2025. The Group brings together Norfolk and Norwich University Hospitals NHS Foundation Trust, James Paget University Hospitals NHS Foundation Trust and The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust. Each Trust remains a separate statutory organisation, but the Group has a Group Board, single Group Chair or Interim Group Chair, Group Chief Executive, joint executive and non-executive directors, and an Executive Managing Director for each hospital. [61][62]

The Group's own stated purpose is important for the campaign. Public Group material says the model is intended to combine streamlined decision-making with locally focused delivery of care, improve experience and outcomes, implement safe and sustainable care models, level up access and outcomes, improve cancer outcomes, strengthen service resilience, enhance staff development and training, and use estates and digital transformation to improve services. A decision to remove core acute services from QEH would need to be tested against those stated aims. [61][62]

The economic issue is therefore not only the cost to QEH as a single hospital. If activity is shifted away from King's Lynn, the Group may face higher costs at Norwich or James Paget through extra staffing, beds, theatres, diagnostics, critical care capacity, maternity and neonatal capacity, ambulance handovers, digital configuration, estates pressure, cross-site management and transfer arrangements. Closing a service at one site may simply move, duplicate or increase cost elsewhere within the same Group.

The Group model was publicly justified partly on the basis that closer working would help tackle large-scale challenges with a unified approach while maintaining locally focused care. Norfolk and Waveney Group documents also describe the region as having around 1.2 million people, a significant elderly population, high prevalence of long-term conditions, health inequalities, rurality and deprivation. Those are the same factors that make removing QEH local acute capacity risky and potentially costly.

Illustrative Group financial context requiring verification: The financial scale of the Norfolk and Waveney University Hospitals Group matters, but any contract-value or

procurement-value claims in this briefing must be verified against the relevant procurement notice, ICB papers or Group financial documents before publication. The campaign should request the original contract documents and financial assumptions so any claim about acute service scale, geographical coverage or patient access is based on primary evidence rather than summary reporting.

Campaign implication: The Group should publish a Group-level cost, capacity and resilience assessment before any QEH closure or downgrade is considered. This should show whether any claimed saving at QEH would be offset by higher costs at Norfolk and Norwich, James Paget, ambulance services, community providers, social care and the ICB. It should also explain how closure would be consistent with the Group's stated commitments to local delivery, access, resilience, staff development, safe sustainable services and geographical coverage.

Economic Impact on Staff and the Local Economy

Closure or downgrading of A&E, ICU/critical care or maternity at QEH would not only affect patients. It would also affect local employment, household income, training, recruitment, volunteering, procurement, local businesses and the wider resilience of King's Lynn and West Norfolk. QEH is an anchor institution: a large, place-based organisation whose workforce, purchasing power, buildings and services support both health and the local economy.

The same workforce and income baseline also matters for the local economy. QEH is one of the area's major employers and service anchors, so closure or downgrading would have consequences beyond the hospital site for workers, households, suppliers and local businesses.

The economic risk would be particularly serious if specialist roles were moved out of King's Lynn. A&E, ICU and maternity depend on linked teams: consultants, resident doctors, nurses, midwives, healthcare assistants, anaesthetists, operating department practitioners, theatre teams, pharmacists, porters, cleaners, administrators, estates staff, security, catering, diagnostics, pathology, radiology, neonatal staff, paediatrics, educators and managers. Downgrading one service can destabilise recruitment and retention across others, because staff may leave if career progression, training, specialist work or overnight emergency support is removed.

The wider local economy would also be affected. Staff wages support local shops, childcare providers, transport, housing, hospitality and services. Hospital visitors buy food, fuel, parking, accommodation and local goods. Suppliers and contractors provide maintenance, cleaning, catering, equipment, logistics, construction, digital services and professional support. If activity is transferred to Norwich, Peterborough or

Cambridge, some of this spending, employment and career opportunity may move with it.

The Health Foundation, The King's Fund and NHS Employers all recognise the NHS as an anchor institution or anchor employer that can improve local wellbeing through good employment, inclusive recruitment, skills development, procurement, social value and support for local communities. Removing core acute services from QEH would run against that anchor role unless decision-makers can show how local jobs, training pathways, apprenticeships, career progression, supplier spending and community wealth would be protected. [64][65][66]

Campaign implication: Any closure proposal should include a full economic impact assessment covering staff posts at risk, recruitment and retention, training and apprenticeships, staff commuting, local wage loss, supplier spending, voluntary contribution, effects on town-centre and local businesses, and the economic consequences of moving activity to Norwich, Peterborough or Cambridge.

Public Opinion, Local Reaction and Democratic Concern

Early public and political reaction indicates significant alarm about any possibility of closing or downgrading A&E, intensive care or maternity at QEH. Local reporting has described senior discussions about possible closure of all three departments, while also noting that the hospital group says no final decision has been made and that people in West Norfolk would continue to have access to “urgent and emergency care”. The concern is that this phrase could still permit a scaled-down service, such as a minor injuries unit, urgent treatment centre, or smaller emergency department unable to manage trauma, cardiac arrest or stroke. [67][68]

Reported local reaction has been strongly critical. Lynn News reported that West Norfolk politicians were “appalled” by the possibility of losing the three departments, and quoted local campaign figures warning that downgrading QEH would reduce it to little more than a “cottage hospital”. The same reporting connected public alarm to the prospect of patients needing life-saving care facing journeys of more than an hour to Norwich, Cambridge or Peterborough. [68]

There is also cross-political concern. Local reports record North West Norfolk MP James Wild seeking urgent reassurance about any intention to downgrade QEH, while South West Norfolk MP Terry Jermy has emphasised the need for care and services to be of the highest quality. The issue therefore already engages democratic accountability across party lines, local government, parliamentary representation and NHS scrutiny structures. [68][69]

However, the paper should distinguish between media-reported reaction and systematic evidence of public opinion. To strengthen the campaign, organisers should collect petition signatures, public statements, patient testimonies, staff testimony where appropriate, parish and town council motions, councillor statements, MP correspondence, survey responses, and written objections from affected communities. This would convert public concern into a structured democratic evidence base.

Campaign implication: Public opinion should be documented, not assumed. The campaign should create a transparent evidence pack showing who is concerned, why they are concerned, how far they live from QEH, what alternative hospital they would be expected to use, whether they have transport, and how closure would affect emergency access, maternity access, caring responsibilities, visiting, discharge and recovery.

Campaign Actions Based on Public Concern

Public concern should be converted into organised, evidence-based action. This section summarises the main actions; the timed sequence is set out later under Next Step Recommendations, while Appendix D provides the distribution list and Appendix E provides FOI templates.

1. **Launch a clear petition:** The petition should call for A&E, ICU/critical care and maternity services to remain at QEH unless NHS decision-makers publish evidence proving that closure would be safe, equitable and fully funded.
2. **Collect patient, family and carer testimony:** Gather short statements from people who used QEH for emergency care, maternity, critical care, cancer complications, frailty, stroke, sepsis, breathing problems or end-of-life emergencies, with consent and anonymisation where requested.
3. **Map affected communities:** Ask supporters to provide their postcode area, nearest alternative hospital, travel options, car access, public transport availability, disability or caring barriers, and likely cost of repeated travel.
4. **Request formal data disclosure:** Ask QEH, the ICB, NHS England and ambulance services to publish Category 1 and 2 activity, ambulance conveyance data, QEH emergency admissions, ICU capacity, maternity triage activity, travel-time modelling and receiving-hospital capacity.
5. **Engage MPs and councillors:** Send a concise briefing to MPs, county councillors, borough councillors, parish councils and town councils asking them to oppose any downgrade unless a full impact assessment is published.
6. **Use health scrutiny routes:** Ask local authority health scrutiny bodies to place the issue on their agenda, require NHS leaders to attend in public, and consider referral to the Secretary of State if proposals are unsafe or inadequately evidenced.

7. **Build a public evidence pack:** Combine petition numbers, testimonials, local travel examples, clinical evidence, demographic data, ambulance response concerns, receiving-hospital pressure and road-risk evidence into a single campaign dossier.
8. **Hold public meetings:** Organise meetings in King's Lynn, Hunstanton, Downham Market, Wisbech, Fakenham, Swaffham, March, Sutton Bridge, Long Sutton and rural communities so evidence is collected across the whole catchment.
9. **Use local media and case studies:** Provide journalists with verified stories, travel examples, maps, clinical evidence and quotes from residents, not just slogans.
10. **Demand investment before removal:** Frame the campaign around improvement: if CQC concerns identify staffing, governance, training, safety or estate issues, the answer should be investment, recruitment, rebuilding and oversight—not removal of essential services.

Immediate next step: create a campaign evidence form that supports the core message by collecting postcode area, service used, travel barriers, car access, public transport options, maternity or emergency experience, and consent to use testimony.

Appendices

The appendices are supporting campaign materials. They are organised as follows: Appendix A contains detailed data requests; Appendix B contains the campaign risk register; Appendix C contains the equality impact framework; Appendix D contains the distribution list; and Appendix E contains Freedom of Information request templates.

Appendix A: Detailed Data Requests for Final Draft

This appendix sets out the detailed data requests that should be sent to East of England Ambulance Service, the Norfolk and Waveney ICB, QEH, NHS England and the Norfolk and Waveney University Hospitals Group. It is supporting material for the campaign rather than part of the main argument. The purpose is to obtain QEH-specific extracts from existing NHS datasets so the campaign can test travel times, clinical risk, capacity, cost, equality impacts and displacement effects using evidence rather than assumptions.

Organisation to request data from	Requested data	Why this matters
East of England Ambulance	Category 1 and Category 2 incidents in the QEH catchment by postcode sector, time of day,	Shows how many life-threatening and serious

Service NHS Trust	day of week, month, season, diagnosis group and outcome.	emergencies currently rely on local access to QEH.
East of England Ambulance Service NHS Trust	Current response time, on-scene time, conveyance time, handover time and ambulance turnaround time for patients taken to QEH.	Establishes the current emergency pathway before any comparison with Norwich, Peterborough or Cambridge.
East of England Ambulance Service NHS Trust	Modelled call-to-door and call-to-treatment times if QEH A&E, ICU or maternity services closed, including routes to Norfolk and Norwich, Peterborough City Hospital and Addenbrooke's.	Tests whether alternative provision would add clinically significant delay for cardiac arrest, stroke, sepsis, trauma, respiratory failure and maternity emergencies.
East of England Ambulance Service NHS Trust	Rush-hour, school-run, bank holiday, summer coastal traffic, night-time, winter weather, roadworks, flooding and collision-diversion modelling.	Prevents decision-makers relying on best-case journey times that do not reflect rural road conditions.
East of England Ambulance Service NHS Trust	Projected impact on ambulance availability in West Norfolk, North Cambridgeshire and South Lincolnshire if crews travel further to alternative hospitals.	Shows whether longer conveyances would reduce ambulance cover for the next emergency call.
Norfolk and Waveney ICB	Full option appraisal for retaining, improving, rebuilding, downgrading or closing QEH A&E, ICU/critical care and maternity services.	Shows whether closure is being compared fairly against investment and improvement options.
Norfolk and Waveney ICB	Equality impact assessment covering age, disability, pregnancy and maternity, deprivation, rurality, car ownership, public transport, carers and social isolation.	Tests whether the proposal properly considers those most likely to be harmed by longer journeys.
Norfolk and Waveney ICB	Whole-system financial model covering QEH, ambulance services, Norwich, Peterborough, Cambridge, primary care, community care, social care and patient transport.	Tests whether closure would genuinely save money or simply move costs elsewhere in the NHS and local authority system.

Norfolk and Waveney ICB	Receiving-hospital capacity models for A&E, beds, ICU/HDU, maternity, neonatal care, theatres, diagnostics, staffing and ambulance handovers.	Shows whether Norwich, Peterborough and Cambridge could safely absorb displaced QEH activity.
QEH King's Lynn NHS Foundation Trust	QEH activity by service: Emergency Department attendances, emergency admissions, critical care admissions, maternity triage, births, neonatal admissions, transfers out and outcomes.	Provides baseline evidence of current local demand and clinical dependency on QEH services.
QEH King's Lynn NHS Foundation Trust	Staffing, vacancies, agency spend, retention, recruitment, redundancy exposure, redeployment options, training impact and cost of service closure.	Shows the workforce and employer cost of removal, not just the headline service budget.
Norfolk and Waveney University Hospitals Group	Group-level assessment of whether removing QEH services is consistent with local delivery, resilience, geographical coverage, staff development and safe sustainable care.	Tests closure against the Group's own stated purpose and the need for balanced services across Norfolk and Waveney.
NHS England	Service-change assurance records, clinical senate advice, maternity network advice, urgent and emergency care assurance, and any national review of QEH options.	Shows whether national service-change safeguards have been followed before any proposal is advanced.

Dataset priority for final draft: Prioritise QEH-level emergency care, ambulance, maternity, receiving-hospital capacity, financial and equality data.

Recommended wording principle: Ask each body for the QEH-specific or QEH-catchment extract, the period covered, definitions used, extraction method, suppression rules and whether figures include postcode sector, age band, diagnosis group and time-to-treatment indicators.

Recommended next step: Send the Appendix A requests first as voluntary disclosure requests, then use the Appendix E FOI templates if information is refused, delayed or incomplete.

Lessons from Hospital Closure and Downgrade Campaigns Elsewhere

Previous NHS service-change disputes show that proposed closures and downgrades can be stopped, delayed, withdrawn, or substantially altered where campaigners identify weaknesses in the evidence base, consultation process, travel-time modelling, equality assessment, alternative capacity, local authority scrutiny, MP involvement, or escalation to national decision-makers.

Rural and dispersed-area case studies: what worked

The most useful comparisons for QEH are campaigns involving rural, coastal or dispersed populations where travel time, ambulance resilience, service interdependence, consultation quality and receiving-hospital capacity were central. The practical lessons are consolidated here so they are not repeated later: define any replacement service precisely; insist that urgent treatment centres or “A&E Local” models are not treated as equivalent to full A&E without evidence; use inclusive petitions and testimony; involve MPs, councillors and scrutiny bodies early; challenge receiving-hospital and ambulance capacity; and make a positive case for investment, rebuilding, staffing and safe local provision.

Grantham and District Hospital, Lincolnshire

Grantham is a useful rural Lincolnshire comparator because its A&E was reduced to daytime-only opening in 2016 due to staffing challenges, followed by years of local campaigning. A 24/7 Urgent Treatment Centre opened in October 2023, replacing the limited-hours A&E. Official trust material says the change followed public consultation and that the UTC provides enhanced diagnostics and stabilisation before transfer where needed. Local reporting also records ongoing calls for a return to full A&E, including concern that thousands of UTC patients were subsequently admitted or transferred elsewhere. The lesson for QEH is that campaigners must be precise: a 24/7 urgent treatment centre may improve local access, but it is not the same as full A&E, critical care or maternity provision unless the NHS proves equivalent safety, stabilisation and escalation pathways. [41][42][43]

Huddersfield Royal Infirmary, West Yorkshire

Huddersfield is not as rural as QEH, but it is important because a major public campaign opposed plans affecting A&E and acute services. Campaigners used petitions, public mobilisation, scrutiny, evidence gathering and legal pressure. The Trust now records that a new 24/7 purpose-built A&E at Huddersfield Royal Infirmary opened in May 2024, connected to CT, MRI, theatres and ward areas. This shows that sustained campaigning can help change the direction from closure or downgrading towards

retained and improved emergency provision. For QEH, the useful lesson is to combine public pressure with a specific positive demand: retain local emergency access and invest in a safer, better facility rather than accepting downgrade by default. [44][45][46]

Withybush Hospital, Pembrokeshire

Withybush is a strong rural and coastal Welsh comparator because campaign arguments have focused on long travel times, loss of local services, ambulance pressure, digital exclusion and the effect on a geographically isolated population. A Senedd petition opposing the removal of Withybush A&E recorded 40,045 signatures and was debated in the Senedd. More recent reporting describes a 2026 petition exceeding 10,000 signatures and campaigners using both online and paper petitions so older residents and those without reliable internet access could participate. The lesson for QEH is that petitions are strongest when they are inclusive, geographically representative, linked to parliamentary or scrutiny routes, and supported by resident testimony about travel, safety and access. [47][48][49]

Shrewsbury and Telford / Shropshire and mid-Wales

Shropshire is a cautionary comparator rather than a straightforward campaign win. The Independent Reconfiguration Panel's 2023 report examined concerns about reconfiguration across Shropshire, Telford and Wrekin and mid-Wales, including provision for mid-Wales residents, capital constraints, the "A&E Local" model, emergency ambulance capacity, transfers between hospital sites, travel and transport, and changing population demographics. The Panel ultimately supported the programme subject to recommendations. For QEH, the lesson is that scrutiny can force decision-makers to address the right questions, but it will not necessarily stop change unless the campaign can show that the alternative model is unsafe, inaccessible, underfunded or inadequately evidenced. [50][51]

Lewisham Hospital: a leading example

Lewisham Hospital is one of the clearest examples of a hospital downgrade being prevented. In 2013, plans to downgrade Lewisham's A&E and maternity services were quashed by the High Court. The court found that the Secretary of State had acted outside his powers and in breach of the National Health Service Act 2006 because the contested changes affected a neighbouring hospital that was outside the relevant administration process. The Court of Appeal later upheld the ruling. Although QEH is not at this stage and this paper is not being framed as a judicial review, Lewisham remains important because it shows that service closures can be defeated where the process, powers, evidence, consultation, or local commissioning support are flawed. [19][20][21]

Warning case studies: where rural service loss has been criticised as harmful or a mistake

These warning case studies do not prove that every NHS reconfiguration is unsafe. They show that, in rural or dispersed areas, service loss can later be criticised where replacement models underestimate travel time, ambulance availability, patient understanding, public transport, receiving-hospital capacity, community services and the difference between urgent care and full emergency care.

Grantham: urgent treatment centre demand and transfers after A&E downgrade

Grantham provides a practical warning for QEH because its full A&E was reduced before a 24/7 urgent treatment centre later replaced the limited-hours A&E. Local reporting of an FOI response stated that 46,339 people attended Grantham UTC in 2025; 3,227 were discharged to a ward at Grantham Hospital and 2,532 were transferred to another hospital. Campaigners argued that the number of transfers was significantly higher than the number estimated before the downgrade and showed that local urgent-care demand remained substantial. For QEH, the lesson is that any proposed UTC, urgent-care hub or smaller emergency model must publish expected transfers, actual transfer capacity, ambulance availability, admissions, escalation routes and whether patients needing resuscitation, ICU, maternity or emergency surgery would be safely managed. [42][43]

Withybush: rural coastal downgrading, public safety concern and longer journeys

Withybush is a strong warning example because repeated service changes have been criticised by local campaigners and elected representatives as damaging for a rural coastal population. In 2026, local reporting stated that Hywel Dda University Health Board approved removal of emergency general surgery from Withybush, with patients expected to travel elsewhere for emergency operations. Reporting also described more than 4,000 consultation responses and a later petition exceeding 11,000 signatures, with campaigners arguing that repeated downgrading had become a public-safety issue and that every added minute and every service removed increased risk to life. For QEH, the lesson is to require evidence on what happens after service loss: emergency surgery transfers, ambulance demand, patient outcomes, travel time, public transport, carer burden and whether rural communities experience cumulative “salami slicing” of services. [47][48][49][52][53][54]

Shropshire and mid-Wales: terminology, transfers and ambulance standby risk

The Shrewsbury and Telford case shows how a reconfiguration can proceed despite continued concern, but still generate important warnings for QEH. The Independent Reconfiguration Panel reviewed issues directly relevant to rural and cross-border communities, including mid-Wales access, capital funding limits, the “A&E Local” model, ambulance response, transfers between hospital sites, travel and transport, and demographic change. Local reporting of the Panel’s recommendations highlighted that emergency ambulance capacity for transfers would need regular review and that the term “A&E Local” should stop because it risked patient misunderstanding and safety. For QEH, this supports a strong demand that NHS bodies define any replacement service precisely and model the ambulances, staff and protocols needed if seriously ill walk-in patients require transfer to a full emergency department. [50][51][55][56]

Additional post-change data requests

1. **Post-downgrade transfer data:** for any comparator hospital, request the number of urgent-care or UTC attendances later transferred to another hospital, admitted to a ward, admitted to HDU/ICU, or requiring emergency surgery.
2. **Forecast-versus-actual comparison:** request original NHS estimates of transfers, admissions and demand, then compare them with actual post-change figures.
3. **Ambulance impact:** request post-change ambulance conveyance distances, crew hours, handover delays, transfer waits, standby requirements and call-response effects in the affected area.
4. **Patient safety incidents:** request serious incidents, maternal incidents, neonatal incidents, delays to surgery, delays to transfer, and mortality or harm reviews linked to service change.
5. **Public understanding:** request evidence on whether patients understood the difference between A&E, UTC, SDEC, “A&E Local,” emergency surgery and critical care availability.
6. **Receiving-hospital pressure:** compare forecast and actual post-change pressure against the main receiving-capacity model.
7. **Equity and travel burden:** request post-change data on patient complaints, missed appointments, delayed attendance, travel-cost hardship, public transport barriers, carer burden and impact on older, disabled, pregnant and low-income residents.

Reasons for opposing closure before any final decision

1. **Patient safety:** Decision-makers must show that emergency, critical care, and maternity patients would remain safe if services moved elsewhere.

2. **Travel-time risk:** The campaign should require detailed modelling of ambulance and private-car journeys from King's Lynn, West Norfolk, North Cambridgeshire, South Lincolnshire, coastal communities, and rural villages.
3. **Alternative hospital capacity:** NHS bodies must prove, using the receiving-capacity model, that alternative hospitals could absorb displaced demand without worsening delays or outcomes.
4. **Equality impact:** Any proposal must assess the disproportionate effect on older people, disabled people, pregnant women, babies, low-income households, people without cars, and rural communities.
5. **Ambulance resilience:** Longer conveyances would remove ambulances from the local area for longer periods, increasing risk for the next emergency call.
6. **Interdependence of services:** A&E, ICU/critical care, anaesthetics, emergency surgery, maternity, paediatrics, diagnostics, and ambulance services are connected. Removing one service can destabilise others.
7. **Public consultation:** Any proposal must be open, evidence-based, early enough to influence the outcome, and not presented as a decision already made.
8. **Local authority scrutiny and ministerial escalation:** Health scrutiny committees, MPs, councillors, NHS England and the Secretary of State should be asked to intervene if the process is unclear, unsafe, incomplete or unsupported by evidence.
9. **Investment before removal:** If CQC concerns relate to staffing, governance, estate condition, training, medicines management, or patient monitoring, the proper response should be urgent improvement and investment—not withdrawal of essential services from the population.

Strategic lesson for the QEH campaign

The strategic lesson is to repeat one disciplined campaign message: opposition is strongest when it demands proof, transparency, consultation, realistic modelling and independent scrutiny before any closure or downgrade.

The combined case in one sentence

Combined case in one sentence: The core campaign message is that QEH A&E, ICU/critical care and maternity should remain local unless the NHS can prove that any alternative would be safe, timely, equitable, resilient, fully funded and capable of meeting present and future demand.

Positive Alternative: Investment and Improvement at QEH

The campaign should not be framed only as opposition to closure. The positive alternative should be retention, investment, rebuilding, staffing support, clinical governance improvement and long-term strengthening of QEH as a rural acute hospital serving West Norfolk, North Cambridgeshire and South Lincolnshire.

If CQC concerns, estate condition, financial pressure or workforce gaps are used to justify service change, the campaign should argue that those issues create a case for improvement rather than removal. The alternative proposal should include estate investment, safer staffing, recruitment and retention plans, improved training, stronger clinical leadership, better patient flow, ambulance handover improvement, maternity triage strengthening, critical care resilience and transparent public reporting.

Option Appraisal for QEH Service Futures

Option	Potential benefit	Main risk	Evidence required before decision
Retain current services while improving quality	Maintains local emergency, critical care and maternity access.	Requires investment, staffing and governance improvement.	Quality improvement plan, staffing plan, estates plan and outcome monitoring.
Invest, rebuild and strengthen QEH as a rural acute hub	Addresses safety and estate concerns while preserving access.	Requires capital, workforce and system commitment.	Full business case, workforce plan, clinical model and affordability assessment.
Partial downgrade or replacement with urgent treatment model	May maintain some local urgent access.	May not provide full resuscitation, ICU escalation, maternity triage, emergency surgery or ambulance-receiving capability.	Clear service specification, transfer modelling, safety evidence and patient communication plan.
Full closure of A&E, ICU/critical care or maternity	May appear to reduce site-level costs.	Risks longer travel, ambulance pressure, receiving-hospital crowding, maternity	Independent clinical, equality, ambulance, financial and whole-system capacity assessment.

		risk and health inequality.	
Networked specialist support while retaining local access	Could improve specialist input without removing local front-door care.	Requires staffing, digital systems, protocols and transfer pathways.	Network model, clinical governance, remote specialist support, escalation pathways and outcome measures.

Stakeholder Map

The campaign should identify and engage everyone affected by or responsible for the decision, including patients, families, unpaid carers, QEH staff, ambulance crews, GPs, community nurses, social care teams, maternity networks, paediatric and neonatal services, councillors, MPs, parish and town councils, local businesses, voluntary organisations, transport providers, Healthwatch, scrutiny committees, NHS England, the ICB and the Norfolk and Waveney University Hospitals Group.

Appendix B: Campaign Risk Register

This appendix summarises key campaign risks, likely impacts, evidence needed and mitigations demanded. It is supporting material for campaign planning and scrutiny discussions rather than part of the main narrative argument.

Risk	Likely impact	Evidence needed	Mitigation demanded
Longer emergency travel times	Delayed assessment and treatment for time-critical patients.	Ambulance call-to-door and call-to-treatment modelling.	Retain local emergency access or prove alternatives are safer.
Receiving-hospital overcrowding	Longer waits, handover delays and reduced regional resilience.	A&E, bed, ICU, maternity and staffing capacity data.	Funded expansion before any transfer of demand.
Maternity access loss	Longer journeys, delayed triage and increased family burden.	Births, triage, neonatal and emergency obstetric data by postcode.	Retain local maternity triage and birth capacity unless safer alternative is proven.

Health inequality	Greater harm to older, disabled, pregnant, low-income and rural residents.	Equality impact assessment and transport/car ownership data.	Publish mitigation before consultation closes.
Workforce destabilisation	Loss of staff, training, morale and linked services.	Vacancy, turnover, redeployment and redundancy exposure data.	Retention and workforce investment plan.

Implementation Challenge Checklist

1. What services would close, reduce or remain, and from what date?
2. What would happen overnight, at weekends, during winter pressure and during major incidents?
3. How many extra ambulances, crews, beds, staff, theatres, diagnostics, maternity places and ICU/HDU beds would be funded elsewhere?
4. How would patients know whether to attend QEH, a UTC, another emergency department, maternity triage or NHS 111?
5. What transition plan would protect patients during implementation?
6. What contingency plan would apply if receiving hospitals cannot absorb demand?
7. How would outcomes, incidents, complaints, transfers, births before arrival and ambulance delays be monitored after any change?

Appendix C: Equality Impact Framework

This appendix is now a checklist for formal equality analysis. The detailed equality and access argument sits in the main catchment section; this table identifies affected groups, likely impacts and evidence required.

Group affected	Potential impact	Evidence required
Older people	Greater emergency, inpatient, frailty, discharge and visiting burdens.	Age-band activity, admissions, ambulance use and discharge outcomes.
Disabled people and people with long-term conditions	More difficult travel, communication, carer dependence and repeated access needs.	Equality data, patient transport use, complaints and missed appointments.

Pregnancy and maternity	Detailed impact covered in the consolidated maternity section: repeated access, urgent triage, birth, neonatal care, family support and travel burden.	Maternity triage, births, neonatal admissions and travel-time modelling.
Low-income households	Higher fuel, taxi, parking, childcare and lost-wage costs.	Deprivation, car ownership, travel-cost hardship and public transport data.
Rural and coastal communities	Longer and less reliable journeys, especially in poor weather or limited bus provision.	Postcode travel modelling, bus frequency, road disruption and ambulance data.
Unpaid carers and families	Reduced visiting, advocacy, discharge support and recovery help.	Carer impact assessment and family travel-cost evidence.

Consultation Quality Checklist

1. Was the consultation launched before a preferred outcome was effectively fixed?
2. Are all realistic options presented, including retention and investment?
3. Are clinical, equality, ambulance, travel, financial and capacity models published in accessible form?
4. Are rural, older, disabled, low-income and digitally excluded residents able to respond?
5. Are public meetings held across the whole QEH catchment, not only in King's Lynn?
6. Are receiving hospitals, ambulance services, primary care, social care and councils included?
7. Will decision-makers publish how consultation responses changed the final proposal?

Post-Change Evaluation Demand

If any service change is implemented, the NHS should publish a pre-agreed evaluation framework before the change begins. It should measure deaths, serious incidents, cardiac arrest outcomes, stroke treatment times, sepsis treatment times, ambulance response and conveyance times, handover delays, transfers, ICU/HDU admissions, maternity triage delays, emergency caesareans, births before arrival, neonatal

admissions, complaints, missed appointments, patient travel costs, carer burden, receiving-hospital crowding, cancelled operations and delayed discharges.

Formal Conclusion

On the evidence currently available, closure or significant downgrading of QEH A&E, ICU/critical care or maternity services would be difficult to justify without a much stronger published evidence base. The master baseline shows that QEH is a heavily used rural and cross-county acute hospital, and the earlier sections explain why travel, ambulance, maternity, equality, cost and receiving-capacity issues must be modelled before any irreversible decision.

The case is also strengthened by the interdependence of A&E, ICU/critical care, maternity, diagnostics, theatres, anaesthetics, neonatal care, paediatrics, ambulance services, community care and social care. Removing one core service may shift cost and risk into the receiving-hospital capacity and wider-system pathways analysed above.

The most responsible course is therefore not closure on the basis of short-term pressure, but investment, improvement, rebuilding, transparency and full modelling. Before any irreversible proposal is advanced, NHS decision-makers should publish evidence covering clinical safety, ambulance times, road disruption, maternity and neonatal risk, receiving-hospital capacity, workforce impact, equality duties, patient and carer costs, whole-system NHS costs and future demand over 25, 50 and 100 years.

Limitations of This Draft

This paper relies on public sources, local reporting, national clinical evidence and campaign modelling. It should be updated when formal NHS modelling, board papers, consultation documents, Freedom of Information responses, ambulance data and QEH service-level activity data are obtained.

The draft does not claim to calculate exact additional deaths, exact closure savings, exact receiving-hospital spare capacity, exact ambulance delay under every route condition, or exact maternity/neonatal risk. Its purpose is to show that these questions are material and must be answered before decision-makers can responsibly propose closure or downgrading.

The final version should remove, revise or clearly label any claim that cannot be traced to a published source, formal NHS disclosure, recognised clinical evidence, or a clearly identified campaign modelling assumption.

Citation standard for final publication: Every numerical, clinical, financial, demographic or service-capacity claim in the final version should be linked to a published source, formal NHS disclosure, Freedom of Information response, recognised clinical evidence, or clearly labelled campaign modelling assumption. Claims that cannot be verified should be removed, softened or converted into questions for decision-makers.

Note on illustrative figures requiring verification

Note on illustrative figures requiring verification: Several figures in this briefing are included to show the potential scale of the issue, but should not be treated as final verified evidence until confirmed from primary sources. These include journey times, taxi-cost estimates, receiving-hospital A&E pressure figures, receiving-hospital maternity and birth figures, ICU/HDU cost ranges, ICB budget or deficit figures, and Norfolk and Waveney University Hospitals Group contract-value claims.

These figures remain useful for campaigning because they help identify what decision-makers must test: whether patients and families can actually travel to alternative hospitals, whether receiving hospitals have spare capacity, whether ambulance journeys would become longer, whether ICU or maternity capacity would need to be funded elsewhere, and whether closure would save money or simply move costs to other parts of the NHS and social care system.

For final publication, each illustrative figure should either be replaced with verified data or kept clearly labelled as an indicative example. Journey times and road-disruption assumptions should be checked against official or current travel sources; taxi prices should be checked with local providers; receiving-hospital A&E and maternity figures should be checked against NHS England, CQC and provider documents; ICU/HDU costs should be checked against NHS England National Cost Collection and provider costing; ICB and Group financial claims should be checked against board papers, procurement notices or formal financial reports.

Recommended verification requests: ask QEH, EEAST, the Norfolk and Waveney ICB, NHS England, the Norfolk and Waveney University Hospitals Group, receiving hospitals, Norfolk County Council, National Highways and relevant local transport providers to confirm the data behind these figures before the paper is released as a final public document.

Appendix D: Proposed Distribution List for the Campaign Paper

This appendix identifies public bodies, elected representatives, NHS decision-makers, patient voice organisations, charities, professional bodies and local media that may

need to receive the campaign paper or a shorter briefing. Because roles change over time, the final distribution list should be checked against current official websites before sending. Local reporting by the Eastern Daily Press, Lynn News, Cambs Times and Greatest Hits Radio has already covered the possible loss of A&E, intensive care and maternity services, so local and regional media should be treated as important recipients as well as contextual sources. [67][68][69][70]

Recipient group	Examples to include	Purpose of sending	Action requested
Members of Parliament	North West Norfolk, South West Norfolk, North Norfolk, South Holland and the Deepings, North East Cambridgeshire, South Cambridgeshire and other MPs whose constituents may use QEH.	MPs can raise the issue with ministers, NHS England, the ICB and Parliament.	Ask for written questions, ministerial meetings, parliamentary debate support, public statements and pressure for full disclosure before any decision.
Local councils and scrutiny bodies	Borough Council of King's Lynn and West Norfolk, Norfolk County Council, Norfolk Health Overview and Scrutiny Committee, Fenland District Council, Cambridgeshire County Council, Lincolnshire County Council, South Holland District Council, town councils and parish councils across the catchment.	Councils can scrutinise NHS proposals, pass motions, represent residents and escalate concerns.	Ask for urgent agenda items, formal motions opposing unsupported closure, public questioning of NHS leaders and referral or escalation where appropriate.
NHS decision-makers	QEH Chair, Chief Executive, executive directors and non-executive directors; Norfolk and Waveney ICB Chair, Chief Executive and Board; Norfolk and Waveney University Hospitals Group Chair, Chief Executive, Group Board and hospital	These bodies are responsible for planning, funding, assurance, consultation, safety and service-change decisions.	Ask them to confirm no closure will proceed without full public consultation, equality assessment, ambulance modelling, capacity modelling and whole-system

	managing directors; NHS England regional team.		financial assessment.
Receiving hospitals	Norfolk and Norwich University Hospitals NHS Foundation Trust, North West Anglia NHS Foundation Trust, Peterborough City Hospital, Cambridge University Hospitals NHS Foundation Trust, Addenbrooke's Hospital and The Rosie Hospital.	These providers may be expected to absorb displaced emergency, maternity, ICU, neonatal and inpatient demand.	Ask whether they have spare staffed capacity and what additional funding, beds, theatres, maternity capacity, neonatal cots, diagnostics and ambulance interface capacity would be required.
Patient voice and public involvement organisations	Healthwatch Norfolk, Healthwatch Cambridgeshire and Peterborough, Healthwatch Lincolnshire, local Patient Participation Groups, Local Maternity and Neonatal Voices Partnerships and patient experience groups.	These organisations can collect patient experience evidence, identify access barriers and scrutinise consultation quality.	Ask for help gathering testimony, reaching seldom-heard residents and ensuring consultation is accessible.
Charities and community organisations	Age UK Norfolk, carers' organisations, disability charities, maternity and neonatal charities, baby-loss charities, rural community groups, transport-access organisations, poverty-support groups, food banks, faith groups and voluntary-sector forums.	These groups can evidence the real-world impact on older people, disabled residents, pregnant women, carers, low-income households and isolated rural communities.	Ask them to share the petition, collect testimony, identify affected groups and provide written statements on likely impact.
Clinical and professional bodies	Royal College of Emergency Medicine, Royal College of Obstetricians and Gynaecologists, Royal College of Midwives, Intensive Care Society, Faculty of Intensive Care Medicine, British Medical	Professional bodies can provide clinical standards, workforce evidence and scrutiny of whether proposed	Ask for relevant guidance, public statements, professional concern, or advice on safe emergency, maternity and critical-care

	Association regional representatives and NHS staff-side organisations.	alternatives are safe.	provision in rural areas.
Emergency, transport and resilience organisations	East of England Ambulance Service, Norfolk County Council highways and transport teams, National Highways, relevant bus and rail providers, local resilience forum contacts and patient transport services.	These organisations hold evidence on ambulance response, road disruption, public transport, severe weather and emergency resilience.	Ask for route modelling, rush-hour data, winter disruption analysis, public transport feasibility and emergency-planning implications.
Local and regional media	Lynn News, Eastern Daily Press, BBC Norfolk, ITV Anglia, local radio, Fenland Citizen, Lincolnshire local media and Local Democracy Reporters.	Media coverage can bring public attention to access, safety, maternity, ambulance and economic concerns.	Send a short briefing, key statistics, case studies, quotes and clear asks rather than the full paper only.

Recommended sending approach: use the full paper for NHS bodies, scrutiny committees and MPs; use a shorter 6–8 page briefing for councillors, charities and professional bodies; and use a one-page summary for residents, media and petition supporters.

Next Step Recommendations for the Campaign

The recommendations below set out a simple timetable for action. They should be read with the campaign actions above, which explain the substance of what needs to be done.

Immediate actions: next 7 days

1. **Agree the campaign's core ask:** QEH A&E, ICU/critical care and maternity must remain open unless the NHS publishes evidence proving that any alternative would be safer, accessible, fully funded and equitable.
2. **Prepare a petition:** Draft petition wording suitable for local signatures and a possible parliamentary petition, focused on retaining essential services and requiring full public disclosure before any decision.

3. **Create a resident evidence form:** Collect postcode area, service used, travel barriers, car access, public transport options, maternity or emergency experience, and consent to use testimony.
4. **Send urgent data requests:** Use the data-request table in this paper to write to EEAST, QEH, the ICB, NHS England and the Norfolk and Waveney University Hospitals Group.
5. **Contact MPs and councillors:** Send a short briefing and ask elected representatives to oppose any downgrade unless full clinical, equality, financial and travel-time modelling is published.

Short-term actions: next 2 to 4 weeks

1. **Build a public evidence pack:** Combine QEH usage data, ambulance evidence, journey times, maternity impacts, social isolation evidence, economic costs, receiving-hospital pressure and public testimony.
2. **Hold public meetings across the catchment:** Prioritise King's Lynn, Hunstanton, Downham Market, Wisbech, Fakenham, Swaffham, March, Sutton Bridge, Long Sutton, Spalding and rural villages.
3. **Seek parish, town, borough and county council motions:** Ask councils to formally oppose closure or downgrade without full evidence and consultation.
4. **Engage health scrutiny committees:** Request a public agenda item, require NHS leaders to attend, and ask scrutiny members to demand the missing data.
5. **Collect professional and staff evidence:** Where safe and appropriate, collect anonymised staff concerns about safety, capacity, recruitment, retention and interdependent services.
6. **Develop media materials:** Prepare a press briefing, journey-time examples, case studies, maps, and a one-page summary for local media.

Medium-term actions: next 1 to 3 months

1. **Publish the final research paper:** Release a polished version with contents, references, executive summary, key data tables and campaign recommendations.
2. **Submit formal representations:** Send the paper to QEH, the ICB, NHS England, MPs, councillors, health scrutiny bodies and relevant maternity, emergency and critical care networks.
3. **Escalate unanswered questions:** If data is not disclosed, use Freedom of Information requests and ask MPs and scrutiny committees to request the same information formally.
4. **Prepare a parliamentary route:** Use petition signatures, public testimony and the evidence pack to support a request for parliamentary attention, ministerial engagement or debate.

5. **Develop alternative proposals:** Argue for investment, rebuilding, staffing support, governance improvement and service improvement at QEH rather than closure or downgrading.
6. **Monitor decision-making:** Track board papers, ICB papers, Group papers, consultation documents, NHS England assurance processes and public statements for signs that decisions are being made before evidence, consultation and modelling are complete.

Core campaign message

Core campaign message for all materials: “Do not remove essential A&E, ICU/critical care or maternity services from QEH King’s Lynn unless the NHS publishes clear, independent evidence proving that patients will be safer, access will not worsen, ambulance cover will not be reduced, receiving hospitals can cope, equality duties will be met, staff and linked services will be protected, and the whole-system cost will not increase.”

Appendix E: Freedom of Information Request Templates

The following appendix contains FOI-style templates that can be adapted and sent to relevant public bodies if information is not provided voluntarily. These templates are supporting material rather than part of the main argument. Each request should ask for information in spreadsheet format where possible, covering the most recent five financial years and any forward modelling undertaken for proposed service change. Personal data should not be requested; data can be provided in anonymised, aggregated or postcode-sector form where necessary.

Template 1: QEH service activity, outcomes and workforce

Suggested request: Please provide aggregated data for The Queen Elizabeth Hospital King’s Lynn NHS Foundation Trust for the last five financial years, broken down by month where available, covering: Emergency Department attendances; ambulance arrivals; emergency admissions; Category 1 and Category 2 ambulance arrivals where held; ICU/HDU admissions; critical care bed days; transfers out to other hospitals; maternity triage attendances; births; emergency caesarean sections; neonatal admissions; babies born before arrival; serious incidents; complaints relating to delay, transfer or access; staffing numbers; vacancies; agency spend; sickness absence; turnover; redeployment modelling; redundancy exposure; and any service-change option appraisal or risk assessment concerning A&E, ICU/critical care or maternity.

Template 2: EEAST ambulance response, conveyance and modelling

Suggested request: Please provide aggregated ambulance data for incidents within the QEH catchment for the last five financial years, including Category 1 and Category 2

incidents, response times, on-scene time, conveyance time, handover time, turnaround time, destination hospital, incident postcode sector, time of day, day of week, month and outcome category where held. Please also provide any modelling of ambulance impact if QEH A&E, ICU/critical care or maternity services were closed or downgraded, including modelled routes to Norfolk and Norwich University Hospital, Peterborough City Hospital and Addenbrooke's Hospital under normal conditions, rush hour, school-run periods, summer coastal traffic, roadworks, collision diversions, flooding, fog, ice, snow and winter pressure.

Template 3: Norfolk and Waveney ICB option appraisal, finance and equality

Suggested request: Please provide all documents, datasets, board papers, committee papers, modelling, option appraisals, equality impact assessments, financial assessments, risk registers, consultation planning documents and correspondence held by Norfolk and Waveney ICB relating to any potential closure, downgrade, reconfiguration or replacement of A&E, ICU/critical care or maternity services at QEH. Please include modelling of alternative provision, receiving-hospital capacity, ambulance impact, primary care impact, community care impact, social care impact, patient transport impact, whole-system cost, health inequalities, rural access and projected demand over 25 years or longer.

Template 4: NHS England assurance, clinical advice and service-change process

Suggested request: Please provide any NHS England documents, correspondence, assurance records, clinical senate advice, maternity network advice, urgent and emergency care advice, service-change assurance documentation, risk assessments or ministerial briefings relating to any proposed closure, downgrade, reconfiguration or replacement of QEH A&E, ICU/critical care or maternity services. Please include any assessment of consultation requirements, patient safety, equality impacts, ambulance resilience, receiving-hospital capacity, maternity safety, critical care provision and compliance with national service-change expectations.

Template 5: Receiving hospitals capacity and displacement impact

Suggested request: Please provide aggregated data and modelling for Norfolk and Norwich University Hospitals NHS Foundation Trust, North West Anglia NHS Foundation Trust and Cambridge University Hospitals NHS Foundation Trust showing whether each provider could absorb displaced QEH activity. Please include Emergency Department attendances, four-hour performance, 12-hour waits, ambulance handovers, emergency admissions, bed occupancy, ICU/HDU occupancy, maternity triage, births, emergency caesareans, neonatal cot capacity, staffing vacancies, cancelled operations, planned-

care impact and any assessment of additional funding, staffing or estates capacity required if QEH services were closed or downgraded.

Template 6: Local authority and transport evidence

Suggested request: Please provide transport and access evidence relevant to hospital access from West Norfolk, North Cambridgeshire and South Lincolnshire to QEH, Norfolk and Norwich University Hospital, Peterborough City Hospital and Addenbrooke's Hospital. This should include bus and rail journey times, service frequency, evening and weekend availability, car ownership data, road-collision and roadworks information, congestion evidence, flooding or severe-weather disruption, rural isolation evidence, patient transport availability and any equality or health-impact assessment relating to access to hospital services.

Working Bibliography and Evidence Register

Bibliography formatting note: Each entry in this evidence register should be finalised with source type, full URL, publication date, publisher/organisation and access date. Where a source currently links to a landing page rather than an exact report, dataset or article, the final publication version should replace it with the most precise available link.

Local reporting, including Lynn News, should be retained as contextual evidence of public concern and political reaction only. Any local media claim should be cross-checked against official NHS, CQC, ICB, EEA or parliamentary sources before being treated as a factual foundation in the final draft.

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