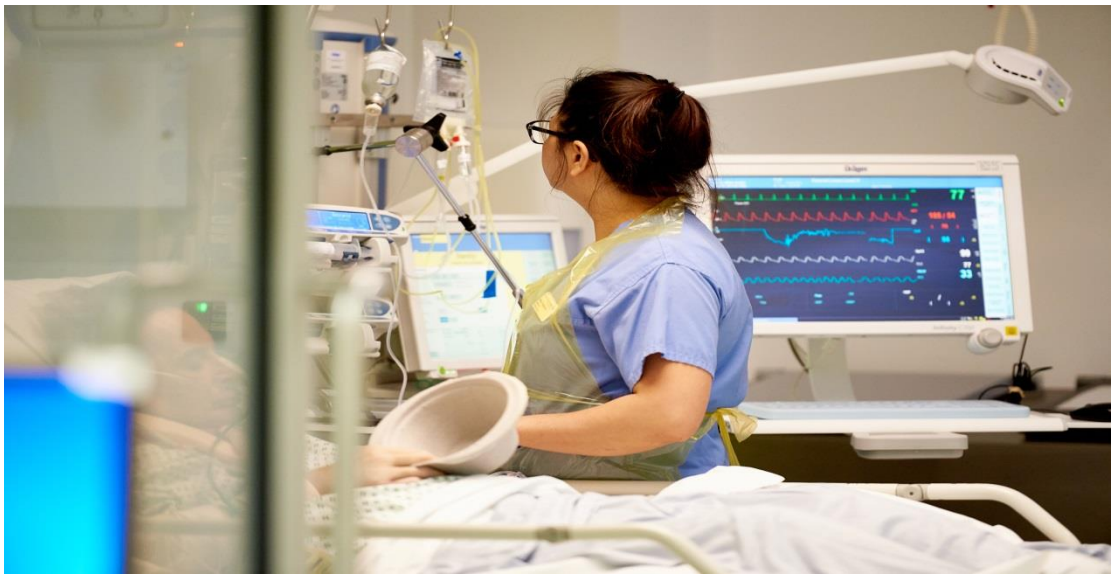
East Midlands Clinical Senate

University Hospitals of Leicester NHS Trust and West Leicestershire CCG

Acute reconfiguration



Report of the Independent Clinical Senate Review Panel (5th July 2018)

July 2018

Confidential

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Glossary of abbreviations

STP	Sustainability and Transformation Partnership
LLR	Leicester, Leicestershire and Rutland
BCT	Better Care Together
UHL	University Hospitals of Leicester NHS Trust
LRI	Leicester Royal Infirmary
GH	Glenfield Hospital
LGH	Leicester General Hospital
ICU beds	Intensive Care Unit beds
PCBC	Pre Consultation Business Case
GIRFT	Getting it Right First Time
NHSI	NHS Improvement

Contents

1. Foreword by Dr Julie Attfield, Clinical Review Panel Chair

Clinical Senates have been established to be a source of independent, strategic advice and guidance to local health and care systems, to assist them to make the best decisions about healthcare for the populations they represent.

Leicester, Leicestershire and Rutland (LLR) works collectively under the umbrella of "Better Care Together" and is one of five Sustainability and Transformation Partnerships (STPs) in the East Midlands.

The Clinical Senate recognised the challenges the LLR STP faces in delivering their model of care. It particularly understood the need for University Hospitals of Leicester NHS Trust (UHL) to reconfigure its current three acute hospital sites onto two, as the system is contending with a challenging operational situation. It was also acknowledged that this is a very long transformation programme that will ultimately bring about a clinically sustainable solution for the local population.

The Clinical Senate was pleased to be able to assist the LLR STP again, and wishes to thank all the constituent members of the STP for their time and input on the day, and particularly to UHL for hosting the clinical review team, which was held at the same location as the local NHS 70th birthday celebrations.

The panel were absolutely in support of the proposed reconfiguration of services from three sites onto two, and on this basis, recommends that the STP proceeds. The report highlights the strength of argument for the change, particularly from a workforce and sustainability perspective. The panel did raise certain issues that need some further work, all of which are highlighted in the report.

I would like to wish the LLR STP good luck with its aspiration to deliver a sustainable, clinically effective and affordable service in the future.

Dr Julie Attfield
Clinical Senate Vice-Chair

2. Clinical Senate Review Panel summary and key recommendations

The panel were unanimously in support of the overall acute reconfiguration proposed by UHL, which would see three hospital sites reduce to two (Leicester Royal Infirmary [LRI] and Glenfield Hospital [GH]). The clinical sustainability and workforce benefits were clearly articulated by UHL, with a wealth of evidence expressed and supportive professional opinion. Where available, there was reference to relevant national guidance and generally, the level of evidence considered by the panel did not extend beyond this in the hierarchy of evidence. The panel also praised the LLR STP, as clinical leadership was clearly evident. Clinical leadership across the whole health and care system will be vital for the LLR STP to achieve its ambition for improving standards of care.

Whilst the panel's full conclusions and advice is detailed in the report, the main feedback provided by the panel (in the time that had been allowed) was to:

- Seek assurance that a safe level of emergency provision on the LRI site (which houses the Emergency Department) is made available for those surgical services largely located away from the LRI site.
- Give further consideration to the impact of increased co-morbidities and complexity on the Glenfield Hospital site once the services move.
- Describe UHL's dedicated ambulance service for the safe transfer and transporting of patients between sites more clearly prior to public consultation.
- Describe the suggested improved clinical outcomes which will be a consequence of the two site consolidation, making transparent the suggested impacts on both quality and key performance indicators (i.e. NHS RightCare data, GIRFT, Model Hospital and other benchmarks).
- Consider and describe mitigation to address the bed bridge gap if there is not the forecasted reduced need associated with frailty and multi-morbidity, or failure to realise the benefits of UHL's own efficiencies programmes.
- To expand the detail in onward communication on the role of the Treatment Centre, and consider whether there may be further efficiencies gained in theatre productivity.

3. Background and advice request

In Leicester, Leicestershire and Rutland, a major health and social care reconfiguration programme called Better Care Together (BCT) is already in place, and this has now effectively become the STP for LLR. It is proposed that the reconfiguration of services across three hospital sites makes it possible to consolidate and strengthen specialist teams to improve care and patient outcomes.

The current bed model starts from UHL's base position of 1,994 acute beds as at April 2018. UHL's bed modelling shows that the Trust will require a maximum of 2,275 acute beds over a 5 year period if nothing is done to mitigate the growth in required beds. UHL has identified a number of schemes to mitigate the bed gap by 2022/23, including the specialty transformation programme and the frailty and multi-morbidity programme.

The clinical review team was specifically asked to consider:

1. Does the clinical senate endorse, or not, UHL's plans to deliver a 2 site acute solution based on clinical sustainability, workforce and clinical outcomes?

2. Does the 5 year bed bridge (transient flexible bed base) deliver a robust and clinically safe solution in the acute trust, or not?

3. The clinical models that will be put in place in the community to support this bed transition

3.1 Description of current service model

There are currently three acute hospitals in Leicester (Leicester Royal Infirmary, Glenfield Hospital and Leicester General Hospital), which is a result of history rather than a planned strategy. The current three-site hospital configuration is considered suboptimal in clinical performance terms, which has a direct impact on patient outcomes and experience. This results in duplication of services, which is inefficient. Clinical resources are therefore spread too thinly making services operationally unstable.

Many elective (planned) and outpatient services currently run alongside emergency services and as a result, when emergency pressures increase, it is elective patients who suffer delays and last minute cancellations. By focusing resources on two acute sites (as opposed to three), outcomes for patients can be improved through increased consultant presence and earlier regular senior clinical decision-making.

The Leicester Royal Infirmary houses the Emergency Department and associated medical services; the Glenfield Hospital has the cardiac and respiratory services; and as a consequence of the proposed reconfiguration, the acute services remaining at the Leicester General Hospital will be moved to the LRI and GH, as summarised in the table below:

Clinical service	**Site currently located**	**Future location**
Renal and transplantation	Leicester General Hospital	Glenfield Hospital
Elective Orthopaedics	Leicester General Hospital	Glenfield Hospital
Elective Gynaecology	Leicester General Hospital	Leicester Royal Infirmary
Urology	Leicester General Hospital	Glenfield Hospital

The first project reflecting the move from three to two acute sites was supported through a successful capital bid from the first wave of funding from the STP. The move of Level 3 ICU beds and associated clinical services (Hepatobiliary [HPB], General Surgery and transplant services using Level 3 ICU beds) from the LGH to the LRI (General Surgery) and GH (HPB and transplant). This first clinical move was not part of this Clinical Senate Review.

3.2 Case for change

The current arrangement of services across three sites is considered suboptimal in terms of clinical performance, service stability, patient experience and financial sustainability. Furthermore, the estate backlog of works is increasing yearly as the oldest buildings on the LGH site require the highest investment, adding to the Trust's structural deficit.

UHL has significant workforce recruitment and retention challenges, their vacancy rates average 7.5% and this includes a nursing rate that ranges between 12% and 15% throughout the year. In contrast, their recent experience of opening a brand new emergency department showed a sustained drop in staff sickness, increased staff morale and improved recruitment levels.

The proposed outcomes of the reconfiguration onto two sites will include a dedicated children's hospital, maternity hospital, Treatment centre and expanded ICU, as well as improved clinical adjacencies for acute services within both Leicester Royal Infirmary and Glenfield Hospital. It is proposed that these changes will enable the delivery of transformed models of care which will provide an efficient clinical service, enhance patient experience, improve staff recruitment and retention rates, protect elective work from the emergency pressures of the Trust, and as a consequence, improve clinical outcomes.

3.3 Scope and limitations of review

UHL's proposal is to move the remaining acute services from the LGH to the LRI and GH. This will include the Level 2 ICU beds which will support the remaining services at the LGH during the transition period; renal services (renal inpatients will be fast-tracked to move as soon as possible after the transplant service moves with the Level 3 beds); orthopaedics, urology, gynaecology, neuro-rehab and brain injury; and a number of outpatient and day-case services.

It is acknowledged that the Diabetes Centre of Excellence and Direct Access Imaging will remain on the LGH site; and Stroke Rehabilitation will move into an alternative building on the LGH site managed by the Leicestershire Partnership Trust.

The clinical case for the move of maternity and neonatal services has previously been the subject of a separate East Midlands Clinical Senate review.

4. Methodology and governance

4.1 Details of approach taken

The sponsoring organisation (Head of UHL Reconfiguration Programme) engaged with the Clinical Senate on 22nd March 2018. It was agreed that a half day panel in Leicester would be held on the afternoon of 5th July 2018. Panel members were identified from the Clinical Senate Council and Assembly and a patient representative was also confirmed.

A pre-panel teleconference was scheduled for 29th June to review the supporting evidence. The Clinical Senate was forewarned that there would be a delay to the supporting evidence being submitted. It was received and disseminated on 28th June, which meant that panel members did not have the opportunity to read the supporting evidence ahead of the pre-panel teleconference call. However, the panel was satisfied that it appeared as if everything was included in UHL's submission, particularly due to the level of communication between the sponsor and the senate office, which assisted greatly in the overall process.

It is a limitation of this review, that the panel members' consideration of the information was restricted to 4 working days, and that the review panel time was scheduled for half a day (5 hours). Therefore, the findings of the review were limited in that context.

A draft report was sent to the panel members and the sponsoring organisation to check for matters of accuracy.

The final report was submitted to the Senate Council (and ratified on 19th July 2018). This report was then submitted to the sponsoring organisation, UHL, on 20th July 2018.

East Midlands Clinical Senate will publish this report on its website once agreed with UHL.

4.2 Documents used

The full list of documents provided by the sponsoring organisation can be found in Appendix B. The main submission included:

- UHL's Pre Consultation Business Case (PCBC).
- Appendices linked to the PCBC.
- Workforce Strategy.

5. Key findings

The panel understood the LLR's whole system plan and aspiration to consolidate from three to two acute hospital sites for financial and clinical sustainability, and that the Trust's ICU strategy is a key driver for consolidation. It was understood that a first wave of capital funding has already been secured. This allows UHL to move their Level 3 ICU beds (patients requiring advanced respiratory support alone or monitoring and support for two or more organ systems), and associated clinical services from the LGH to the LRI and GH.

The outcome of this clinical senate review will inform UHL's PCBC, which will be submitted to NHS England in mid-September, following the CCG Governing Board's approval of the PCBC, and prior to the first Regional Review Panel on 10th October 2018 (as agreed at the outset in the Terms of Reference, which can be found at Appendix A). This second wave of capital funding will enable UHL to consolidate and expand their ICU bed capacity, and move the remaining services outlined above (a percentage will also be allocated for clinical equipment and UHL has a managed equipment service across sites). The consolidation of level 3 ICU beds will begin in 2020. In the interim period, the services left at Leicester General Hospital will be isolated. However, the panel was informed that there is sufficient capacity to provide level two ICU care in this period. Assurances that sufficient medical and nursing staff can be maintained to effectively run both ICU sites during the transition is important, although the move of Level 3 ICU beds and associated clinical services did not form part of this Clinical Senate Review.

UHL has completed its bed modelling using standard methodology recommended by NHS Improvement. UHL's current bed model starts from a base position of 1,994 acute beds as at April 2018. UHL's maximum bed capacity is 2,048 (the maximum number that the Trust can accommodate). UHL's plan is to increase their physical bed stock from 1,994 to 2,048.

However, UHL has predicted that it requires a minimum of 2,151 and a maximum of 2,275 beds over a five year period by taking into account both demographic growth and growth in activity. This means that UHL has a maximum future bed gap of 281 (2,275-1,994) by 2022/23, and a minimum future bed gap of 157 (2,151-1,994). UHL's original model was based on 85% occupancy, resulting in a maximum bed gap

of 281 beds. Revising this figure to current occupancy levels of 88% reduces the bed gap to 157.

The panel understood that there is not a requirement for more community hospital provision in Leicester City, and that UHL's plan is reliant on a set of efficiencies that have been modelled and will need to be delivered across the whole Trust (a minimum bed impact expected by 2022/23 is 98, as well as by the wider system's frailty and multi-morbidity programme. The panel heard that co-morbidity impacts resource use exponentially and that patients aged 20-44 with four or more co-morbidities use the same amount of secondary care resource as 80 year old patients with four or more co-morbidities. UHL described their local model of targeting very high, high, and medium risk categories of patient cohorts, which is anticipated to mitigate the growth of between 57 and 67 acute beds.

The bed bridge includes a significant projected reduction in emergency presentations, which was argued as realistic based on early indications of the impacts of revised community models, and improvements achieved elsewhere (i.e. Frimley Health and Care STP). The model also required a suggested step change in internal (UHL) productivity and efficiency across specific services and pathways.

The panel were informed that UHL had already borne witness to a sustained drop in staff sickness, increased staff morale, and improved recruitment levels due to the opening of a brand new emergency department, and that their reconfiguration plans are expected to have a positive impact on their recruitment and retention rates in the round.

The panel heard that the proposed outcomes of the reconfiguration onto two sites will also include a dedicated children's hospital, maternity hospital (subject to a separate clinical senate review in January 2018), and Treatment centre.

The panel were informed that Right Care, GIRFT and Model Hospital[1] data and information is being used to design what good services look like. However, this detail

[1] The Model Hospital is a new digital information service provided by NHS Improvement to support the NHS to identify and realise productivity opportunities.

though cited in the revised clinical models of care was not explicitly provided to the panel.

The panel understood that for the clinical services under consideration in this second wave of proposed reconfiguration (Renal, Orthopaedics, Gynaecology, and Urology), there are a number of common themes that would positively impact on the services moving, including: improved clinical adjacencies, easier to cover medical rotas, less fragmentation, improved continuity of care, and improved efficiencies.

The panel would require assurance that sufficient car parking plans have been developed, to ensure that appropriate patient and public access is made available at the LRI and GH sites once the remaining services on the LGH site have moved.

6. Conclusions and advice

The panel were unanimously in support of the acute reconfiguration proposed by UHL, which would see three hospital sites reduce to two. The panel understood that consolidation will enable UHL to have a clinically sustainable model of care, and that this is an acceptable concept that the STP aspires to achieve. The panel also commended the LLR STP, as clinical leadership was clearly evident, and the workforce benefits were clearly evidenced by the weight of professional opinion and drawing upon (where this was available) relevant national guidance.

The areas of feedback highlighted by the panel for further consideration should be taken in the context of the time that had been allowed for this clinical review.

The panel would seek assurance that a safe level of emergency provision on the LRI site (which houses the Emergency Department) is made available for those surgical services largely located away from the LRI site. There is the potential for medical risk at the Glenfield Hospital site if there are unexpected medical complications. It was acknowledged that the Glenfield Hospital site already houses the cardiac and respiratory services and that the majority of emergencies would still go to the LRI site for treatment.

UHL may wish to give further consideration to the impact of increased co-morbidities and complexity on the Glenfield Hospital site once the services move, and this becomes an acute site for more specialised surgery. It was understood that these complexities already exist in UHL's patients at the LGH, and that consolidation of these surgical patients is likely to facilitate better medical cover.

The work undertaken regarding the transfer and transporting of patients between sites (the physical and clinical aspects of moving a patient) was not made evident to the panel. It is understood that UHL has a dedicated ambulance service, and it would be beneficial to reference this further in relation to the two site model.

The panel questioned the viability of achieving an increased workforce, particularly regarding the aspiration for significantly increased level two/three intensive care provision. Whilst the panel agreed that the narrative around clinical and workforce

sustainability had been made clear by UHL, the use of information was less clear in elucidating improved clinical outcomes.

It was also noted that the changes around pathology and radiology demand and the subsequent revised working practices should be brought into UHL's evidence submission.

The panel suggested that increased theatre capacity had not been sufficiently described[2]. Although UHL reassured the panel that they had worked with an external company who specialises in finding clinical efficiencies through demand and capacity modelling. It was agreed that UHL would subsequently share its data analysis with the clinical review team[3].

The panel queried UHL's level of confidence in their calculations and projections to bridge their bed gap over the next five years. It was unclear to the panel what the bed bridge (transient flexible bed base) would look like if UHL does not improve markedly through its frailty and multi-morbidity and efficiencies programmes, and any required mitigation.

The panel was not privy to the detail behind UHL's bed modelling projections associated with community transformation. The panel queried whether Frimley Health and Care STP is a peer comparator, and whether UHL will realistically deliver the required reduction in bed growth through internal efficiencies.

Finally, the panel agreed that it would be beneficial if UHL could expand on the role of its Treatment centre which was alluded to in their presentation[4].

[2] Clarification regarding theatre capacity was subsequently provided by UHL. UHL's programme will increase the total number of theatres by 7 additional theatres – from 50 to 57. UHL will still be working to improve the efficiencies of their theatre stock.
[3] This was undertaken by NHSI supported by Four Eyes Insight and Deloitte. Their data analysis was submitted to the Clinical Senate on 18th July 2018. It is understood that UHL are currently deciding how the next steps improvement in efficiency will be undertaken.
[4] UHL submitted their clinical operational policy to the Clinical Senate on 18th July 2018.

7. Recommendations

7.1.1 Recommendation 1

The panel recommends that UHL proceeds with its acute reconfiguration plans with support from the clinical senate.

7.1.2 Recommendation 2

It was recommended by the panel that the work undertaken by UHL regarding its dedicated ambulance service for the transfer and transporting of patients between sites, is described much more clearly prior to public consultation, including how UHL meet national pathways and standards (i.e. for managing chest pain).

7.1.3 Recommendation 3

The panel recommended that UHL provides clarity on its Treatment centre, including the benefits and efficiencies of having a dedicated Treatment centre, which is one of the proposed outcomes of the Glenfield Hospital reconfiguration.

7.1.4 Recommendation 4

The panel recommended that further work is carried out on UHL's bed bridge modelling, which should include detailing the required mitigation if UHL does not make its efficiency improvements.

7.1.5 Recommendation 5

UHL should articulate in association with this change, the discernible impact on clinical outcomes, beyond the strong sustainability and workforce benefits.

Appendix A: Clinical Review Terms of Reference

CLINICAL REVIEW: TERMS OF REFERENCE

Title: University Hospitals of Leicester NHS Trust - Acute Reconfiguration

Sponsoring Organisation: University Hospitals of Leicester NHS Trust (UHL) and West Leicestershire CCG on behalf of the LLR STP

Clinical Senate: East Midlands

NHS England regional or area team: Central Midlands

Terms of reference agreed by:

Name: E Orrock & J Attfield **on behalf of Clinical Senate and**

Name: John Jameson & Toby Sanders **on behalf of sponsoring organisation**

Date: 30th May 2018

Clinical review team members

Chair: Julie Attfield, Clinical Senate vice-chair

Panel members:

Name	Role	Organisation
Edd Wallis	Acting Cardiology Manager (pan trust)	ULHT
Dr S N Joachim	Clinical Director, Theatres, Anaesthesia, Critical Care, and Pan-Trust Chronic Pain	Pilgrim Hospital United Lincolnshire Hospital NHS Trust
Bozena Smith	Occupational Therapist	Derby Teaching Hospitals NHS FT
Keith Spurr	Patient representative	Clinical Senate Council
Suha Deen	Histopathologist	Nottingham University Hospitals NHS Trust
Claire Greaves	Chief Scientist	Nottingham University

		Hospitals NHS Trust
Jasmine Murphy	Consultant in Dental Public Health	Public Health England East Midlands
Richard Elliott	Consultant Anaesthetist	Royal Derby Hospital
Sue Glendenning	Gynaecology Matron	United Lincolnshire NHS Trust
Sarah Layzell	GP associate dean	HEE
Bernadette Armstrong	Extended Scope Physiotherapist	Northamptonshire Healthcare NHS Foundation Trust
Liz Marder	Consultant Paediatrician	Nottingham Children's Hospital
Dr Jane Williams	Children's Clinical Lead	NHS England (Central Midlands DCO)
Mr Surajit Basu	Consultant Neurosurgeon	Nottingham University Hospitals NHS Trust
Andy Marshall	ENT Surgeon	Nottingham University Hospitals NHS Trust

Aims and objectives of the clinical review

The reason for this request is to support the completion of a Pre-Consultation Business Case (PCBC) that will be used to enable UHL to secure capital funding in order to deliver the reconfiguration of three acute hospitals onto two sites. The senate review will form part of the NHS England Assurance process. The clinical review team is specifically being asked to consider:

1. Does the clinical senate endorse, or not, UHL's plans to deliver a 2 site acute solution based on clinical sustainability, workforce and clinical outcomes? (Clinical services to be moved to the LRI and GH sites are described below)

2. Does the 5 year bed bridge (transient flexible bed base) deliver a robust and clinically safe solution in the acute trusts, or not?

3. The clinical models that will be put in place in the community to support this bed transition

Scope of the review

The development of 3 acute hospitals in Leicestershire is a result of history rather than a planned strategy. The current three-site hospital configuration is suboptimal in clinical performance terms, which has a direct impact on patient outcomes and experience. This results in duplication and sometimes triplication of services, which is inefficient. Clinical resources are therefore spread too thinly making services operationally unstable.

Many elective (planned) and outpatient services currently run alongside emergency services and as a result when emergency pressures increase, it is elective patients who suffer delays and last minute cancellations. By focusing resources on two acute sites, outcomes for patients can be improved through increased consultant presence and earlier regular senior clinical decision-making.

The Leicester Royal Infirmary (LRI) houses the Emergency Department and associated medical services; the Glenfield Hospital (GH) has the cardiac and respiratory services; and as a consequence of the proposed reconfiguration the acute services remaining at the Leicester General Hospital (LGH) will be moved to the LRI and GH.

The first project reflecting the move from 3 to 2 acute sites was supported through a successful capital bid from the first wave of funding from the STP: the move of Level 3 ICU beds and associated clinical services (Hepatobiliary, General Surgery and transplant services using Level 3 ICU beds) from the LGH to the LRI and GH. This first clinical move will not be part of this Clinical Senate Review.

The proposal is therefore to move the remaining acute services from the LGH to the LRI and GH. This will include the Level 2 ICU beds which will support the remaining services at the LGH; renal services (which will be fast-tracked to move as soon as possible after the transplant service moves with the Level 3 beds); orthopaedics, urology, gynaecology, neuro-rehab and brain injury; and a number of outpatient and day-case services.

NB: the clinical case for the move of maternity and neonatal services has been the subject of a separate East Midlands Clinical Senate review.

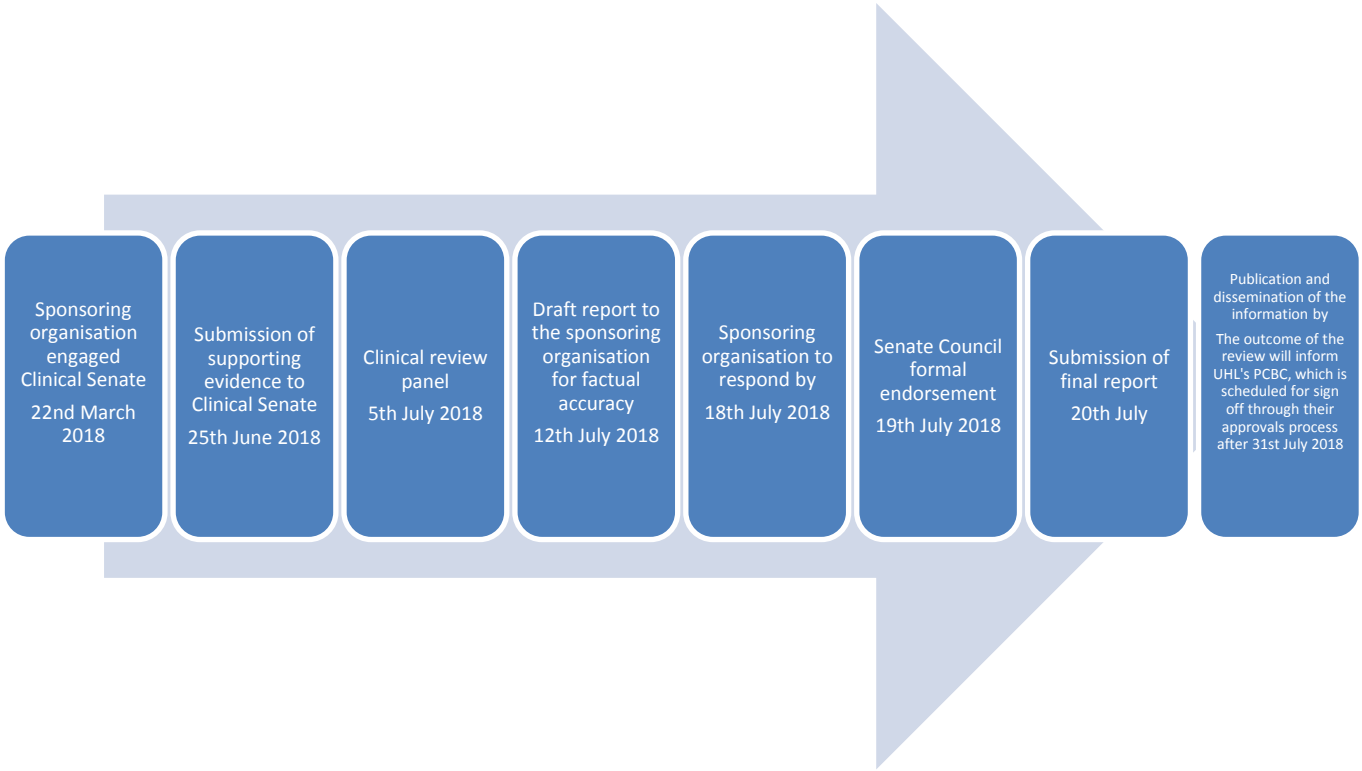
When reviewing the case for change and options appraisal the Clinical Review Panel should consider (but is not limited to) the following questions:

- Will these proposals deliver real benefits to patients (access/clinical outcomes/quality[5])? For example, do the proposals reflect:
    - The rights and pledges in the NHS Constitution?
    - The goals of the NHS Outcomes Framework?
    - Up to date clinical guidelines and national and international best practice e.g. Royal College reports?
- Is there evidence that the proposals will improve the quality, safety and sustainability of care? For example:
    - Do the proposals align with local joint strategic needs assessments, commissioning plans and joint health and wellbeing strategies?
    - Does the options appraisal consider a networked approach - cooperation and collaboration with other sites and/or organisations?
    - Is there a clinical risk analysis of the proposals, and is there a plan to mitigate identified risks?
    - Do the proposed changes address/reduce clinical risks identified through any national peer review?
- Do the proposals meet the current and future healthcare needs of their patients?
- Do the proposals demonstrate good alignment with the development of other health and care services?
- Do the proposals support better integration of services?
- Do the proposals consider issues of patient access and transport? Is a potential increase in travel times for patients outweighed by the clinical benefits?
- Will the proposals help to reduce health inequalities?

[5] Quality (safety, clinical effectiveness and patient experience)

The Clinical Review Panel should assess the strength of the evidence base of the case for change and proposed models. Where the evidence base is weak then clinical consensus, using a voting system if required, will be used to reach agreement. The Clinical Senate Review should indicate whether recommendations are based on high quality clinical evidence e.g. meta-analysis of randomised controlled clinical trials or clinical consensus e.g. Royal College guidance, expert opinion.

Timeline



Reporting arrangements

The clinical review team will report to the clinical senate council which will agree the report and be accountable for the advice contained in the final report.

Clinical Senate Council will report to the sponsoring organisation and this clinical advice will be considered as part of the NHS England assurance process for service change proposals.

Methodology

The sponsoring organisation has agreed to collate and provide the following supporting evidence:

- Case for change and a summary of the current position and proposed alternative service/care model
- Impact of withdrawing/reconfiguring services, including risk register and mitigations
- How proposals reflect clinical guidelines and best practice, the goals of the NHS Outcomes Framework and Constitution
- Alignment with local authority joint strategic needs assessments and a narrative around health inequalities and demographics
- Evidence of alignment with STP plans
- Evidence of how any proposals meet future healthcare needs, including activity modelling, pathways, and patient flows
- Demonstrate how patient access and transport will be addressed
- Consideration to a networked approach
- Education and training requirements
- Implications on workforce (to be able to demonstrate alignment to new ways of working, and to describe how the future workforce will look to support any new models of care/reconfiguration proposed)
- Implications for the workforce (to describe how the workforce will be engaged, supported and motivated to work in new ways and in new places that support any new models of care/reconfiguration proposed)
- Implications for the clinical support services and those staff (e.g. clinical engineering, radiology, pharmacy)

Report

A draft clinical senate report will be circulated within 5 working days of the final meeting - to team members for comments, to the sponsoring organisation for fact checking.

Comments/ corrections must be received within a further 4 working days.

The final report will be submitted to the sponsoring organisation by 20th July 2018.

Communication and media handling

The Clinical Senate will publish the final report on its website once it has been agreed with the sponsoring organisation. The sponsoring organisation is responsible for responding to media interest once in the public domain.

Resources

The East Midlands clinical senate will provide administrative support to the review team, including setting up the meetings, taking minutes and other duties as appropriate.

The clinical review team will request any additional resources, including the commissioning of any further work, from the sponsoring organisation.

Accountability and Governance

The clinical review team is part of the East Midlands Clinical Senate's accountability and governance structure.

The East Midlands clinical senate is a non-statutory advisory body and will submit the report to the sponsoring organisation.

The sponsoring organisation remains accountable for decision making but the review report may wish to draw attention to any risks that the sponsoring organisation may wish to fully consider and address before progressing with their proposals.

Functions, responsibilities and roles

The **sponsoring organisation** will

- provide the clinical review panel with all relevant background and current information, identifying relevant best practice and guidance. Background information may include, among other things, relevant data and activity, internal and external reviews and audits, impact assessments, relevant workforce information and projection, evidence of alignment with national, regional and local strategies and guidance (e.g. NHS Constitution and outcomes framework, Joint Strategic Needs Assessments, CCG two and five year plans and commissioning intentions)
- respond within the agreed timescale to the draft report on matters of factual inaccuracy

- undertake not to attempt to unduly influence any members of the clinical review team during the review
- submit the final report to NHS England for inclusion in its formal service change assurance process

Clinical senate council and the sponsoring organisation will

- agree the terms of reference for the clinical review, including scope, timelines, methodology and reporting arrangements

Clinical Senate council will

- appoint a clinical review team; this may be formed by members of the senate, external experts, or others with relevant expertise. It will appoint a chair or lead member
- endorse the terms of reference, timetable and methodology for the review
- endorse the review recommendations and report and
- provide suitable support to the team

Clinical review team will

- undertake its review in line with the methodology agreed in the terms of reference
- follow the report template and provide the sponsoring organisation with a draft report to check for factual inaccuracies
- submit the draft report to clinical senate council for comments and will consider any such comments and incorporate relevant amendments to the report. The team will subsequently submit final draft of the report to the Clinical Senate Council
- keep accurate notes of meetings

Clinical review team members will undertake to

- Commit fully to the review and attend all briefings, meetings, interviews, panels etc. that are part of the review (as defined in methodology)
- contribute fully to the process and review report
- ensure that the report accurately represents the consensus of opinion of the clinical review team

- comply with a confidentiality agreement and not discuss the scope of the review or the content of the draft or final report with anyone not immediately involved in it. Additionally they will declare, to the chair or lead member of the clinical review team and the clinical senate manager, any conflict of interest prior to the start of the review and /or which may materialise during the review

Appendix B: Summary of documents provided by the sponsoring organisation as evidence to the panel

- Reconfiguration of Acute and Maternity services at University Hospitals of Leicester NHS Trust Pre Consultation Business Case June 2018
- Local Digital Roadmap 2016-2021
- Clinical Services and Reconfiguration Strategy 2018-2023
- Better Care Together: The strategic plan of the Leicester, Leicestershire and Rutland Sustainability and Transformation Partnership
- Estate Strategy 2018-2023
- IT Strategy 2018-2023
- Clinical models of care and Bed Bridge Approach
    - Gynaecology and Gynaecology Oncology
    - Orthopaedic Surgery
    - Nephrology and Renal Transplant Service
    - Urology
    - Clinical support and Imaging
    - Critical Care
- Workforce Strategy and Plan 2018-2023
- Full Business Case Relocation of Level 3 ICU and associated services off the LGH site June 2018

Appendix C: Clinical review team members and their biographies, and any conflicts of interest

Name	Role	Organisation	Conflict of interest
Dr Julie Attfield	Executive Director of Nursing	Nottinghamshire Healthcare NHS Trust	None
Mr Edd Wallis	Acting Cardiology Manager (pan trust)	United Lincolnshire Hospitals NHS Trust	None
Dr S N Joachim	Clinical Director, Theatres, Anaesthesia, Critical Care, and Pan-Trust Chronic Pain	Pilgrim Hospital United Lincolnshire Hospitals NHS Trust	None
Bozena Smith	Occupational Therapist	Derby Teaching Hospitals NHS Foundation Trust	None
Keith Spurr	Patient representative	Clinical Senate Council	None
Suha Deen	Histopathologist	Nottingham University Hospitals NHS Trust	None
Claire Greaves	Chief Scientist	Nottingham University Hospitals NHS Trust	Patient in review area (LE12) Not currently requiring UHL services To remain having discussed with Emma [Orrock]
Jasmine Murphy	Consultant in Dental Public Health	Public Health England East Midlands	None

Richard Elliott	Consultant Anaesthetist	Derby Teaching Hospitals NHS Foundation Trust	Worked in Leicester 25 years ago No relationship with current staff Remain
Sue Glendenning	Gynaecology Matron	United Lincolnshire Hospitals NHS Trust	None
Sarah Layzell	GP associate dean	Health Education England	None
Bernadette Armstrong	Extended Scope Physiotherapist	Northamptonshire Healthcare NHS Foundation Trust	None
Dr Liz Marder	Consultant Paediatrician	Nottingham Children's Hospital	None
Dr Jane Williams	Children's Clinical Lead	NHS England (Central Midlands DCO)	Non-pecuniary Trustee Rainbows Children's Hospice Declared at UHL Acute Review by writing
Mr Surajit Basu	Consultant Neurosurgeon	Nottingham University Hospitals NHS Trust	None
Mr Andy Marshall	ENT Surgeon	Nottingham University Hospitals NHS Trust	None

Clinical Senate Support Team

Ms Emma Orrock – Head of East Midlands Clinical Senate, NHS England

Biographies

Dr Julie Attfield RMN, BSc (Hons), MSc, PhD

Executive Director of Nursing

Nottinghamshire Healthcare NHS Trust

Julie is the Executive Director of Nursing for Nottinghamshire Healthcare NHS Foundation Trust. The Trust is a major provider of mental health, intellectual disability and community healthcare services for the people of Nottinghamshire. It sees in the region of 190,000 people every year and its 8,800 staff carry out a wide range of roles; working together to provide integrated and coordinated care. Julie began her career as a Registered Mental Health Nurse, and has since worked as a clinician, senior manager and director within mental health services in the East Midlands.

Between these appointments, Julie spent time as a lecturer in Nursing at the University of Nottingham, before returning to the NHS. Julie's role prior to taking up this position was Director of Nursing and Operations at Lincolnshire Partnership NHS Foundation Trust and the Executive Director of Forensic Services in the Trust. Julie has made a number of professional contributions and gained accolades including holding the title of Queen's Nurse, being a Senior Fellow of the Institute of Mental Health and company secretary for the National Mental Health Nurse Directors Forum. Julie is professionally known particularly for her research into the use of care pathways in mental health, service redesign, quality improvement and governance.

Mr Edd Wallis

Edd is currently working as chief physiologist at United Lincolnshire Hospitals NHS Trust and honorary chief physiologist at Kettering General Hospital NHS Trust. Edd has a special interest in complex implantable cardiac devices holding international professional accreditation from the European Society of Cardiology. Edd has also recently been awarded chartered scientist status by the United Kingdom Science Council and holds full membership with the Society of Cardiological Science and Technology and the Society of Critical Care Technology. A graduate of the NHS Leadership Academy, Edd holds a postgraduate certificate in healthcare leadership following a successful project in clinical service redesign and organisational development.

Edd is a professional assessor with the Academy of Healthcare Science and a training officer with the National School of Healthcare Science with extensive experience teaching and assessing both undergraduate and post graduate healthcare science students. Edd also has 6 years' experience working as a volunteer critical care technician with L.I.V.E.S providing expert pre-hospital medical support to the local ambulance service and is a certified advanced life support provider with the Resus Council UK.

Dr Suganthi Joachim

Suganthi has been a Consultant Anaesthetist at Pilgrim Hospital, Boston for 17 years. Suganthi is actively involved in service improvement, management, education and training. She has extensive experience in perioperative care of patients undergoing elective and emergency surgery. As Suganthi works in Pilgrim Hospital, Boston which is 60miles from Nottingham, her objective includes delivering high quality and safe care closer to home and safe transfer of children needing tertiary care. Her work involves anaesthetising the elderly on the Vascular, trauma and emergency lists. She has special interest in paediatric anaesthesia and has been the clinical lead for this area since 2001. Suganthi is a member of the East Midlands General paediatric surgery network and she has undertaken peer reviews and is a member of the commissioning guide development group for Paediatric Torsion. Suganthi has been a Foundation Programme Director from 2004-2016 and is currently a member of the Chapter development group of the Royal College of Anaesthetists for Guidance on Provision of Anaesthetic Services post-operative care. Currently Suganthi is Clinical Director for Theatres, Anaesthesia, Critical Care and Pain at ULHT. She is also the trust Lead for General Paediatric Surgery and one of the Board directors for the Lincolnshire Refugee Doctors Project.

Ms Bozena Smith

Bozena is an occupational therapist with over thirty years' experience. Bozena holds a Masters' degree in Rehabilitation and has worked in Nottingham, Lancashire and Derbyshire in varied roles as a clinician, manager and researcher. Bozena's current post is Divisional Therapy Manager and Professional Lead Occupational Therapist at Derby Teaching Hospitals (DTH) NHS Foundation Trust. Bozena's clinical experience includes trauma and orthopaedics, hand therapy, medicine for the elderly, rheumatology, cardiac rehabilitation, chronic pain management and chronic fatigue

syndrome; Bozena set up the latter in Derby as part of a Government investment programme. Bozena worked at Nottingham University as a researcher on a European study entitled ‘Collaborative evaluation of rehabilitation in stroke across Europe’ and is named as co-author of a number of papers arising from this study.

Bozena has played an active role in the transformation of services. For example, Bozena reviewed and redesigned Specialist Rehabilitation services at DTH. The merger of seven Neuro-rehabilitation services will be operationalised in summer 2018 in a newly built department. Bozena has also led on a review of Therapy Services at DTH and made recommendations to the Trust for a restructured Therapy Service. Bozena is jointly leading a Southern Derbyshire wide group of Occupational Therapists from Health and Social Care to facilitate seamless working across organisational boundaries to support initiatives such as Discharge to Assess and Trusted Assessors.

Mr Keith Spurr

Patient Representative - East Midlands Clinical Senate Council

Keith is a retired experienced HR Advisor/Business Partner providing generalist HR support to organisations of varying sizes, within all types of industry for 40 years. Keith was an accredited Trade Union Representative when he represented ex-employees at Tribunals liaising with solicitors, courts, CMDs, PHRs and Full Hearings. Therefore, Steve has experience as both a manager and as a Trade Union representative and can appreciate both sides of the “table” whilst at the same time represent individuals and groups as required. Steve has worked with organisations as part of their change programme. Steve is diabetic Type 1 and had a TIA 25 years ago. He is the Diabetes UK Champion for the South Lincolnshire Area and a diabetic “voice”.

Suha Deen

Suha is a consultant/ visiting professor in Histopathology, Nottingham University Hospitals. Suha has been involved in a local merger in Nottingham and another merger further afield with Leicester. Suha is used to undergoing and introducing change at the forefront level. Passionate about improving service quality and patient safety, Suha has always focused on maintaining and improving quality in a cost effective way. Suha is also a member of the East Midlands Clinical Senate. Suha has

worked with the RCPath at different capacity and with the support of colleagues, Suha participated in raising the profile of Pathology and currently Suha is East Midlands Regional Advisor.

Claire Greaves

Chief Scientist, Head of Medical Physics and Clinical Engineering

Claire qualified as a Nuclear Medicine Physicist in 1987 and worked in Nuclear Medicine in several hospitals across the UK. Claire moved to the East Midlands in 2007 working at UHL before becoming Head of Medical Physics and Clinical Engineering in Nottingham in 2015 and more recently taking the post of the Chief Scientist providing senior professional leadership for scientists across NUH. Claire advises on Nuclear Medicine nationally as a member of the British Nuclear Medicine Society Council and Professional Standards Committee, and is working with the Academy of Healthcare Science to develop standards for scientific services. Claire is passionate about providing high quality, state of the art, cost effective healthcare, and believes that new technologies will support dramatic changes to healthcare offering great opportunities to patients and clinicians. HCS working with patients, healthcare providers, industry and academia will play a pivotal role in enabling the health service to realise its full potential and deliver services that are fit for the future.

Jasmine Murphy

Jasmine is a Consultant in Dental Public Health at Public Health England. Jasmine has previously worked in Public Health in a variety of organisations including: Primary Care Trusts, Health Protection Agency, Strategic Health Authority and local government. Her current role includes leadership on dental public health, children and young people and health inequalities where she provides commissioning advice and support to NHS England on NHS dental services, specialist dental public health advice and support to public health colleagues working in local authorities, healthcare public health advice for services affecting children and young people and also has an advocacy role for wider aspects of Public Health. Jasmine is involved with the Local Dental Network and also the East Midlands Maternity and Children's Clinical Network in supporting the public health agenda through the delivery of commissioned services. Through her focus on population public health, she seeks to raise the profile and awareness of how strategic decisions can impact upon health inequalities.

Richard Elliott

Richard qualified in1980 (Wales), and has been a Consultant Anaesthetist in Derby since 1992. Richard is a senior member of the team that planned the new Royal Derby Hospital, combining the previous Derby Royal Infirmary and Derby City Hospitals. Richard has 6 years' experience as Service Director/Lead Clinician Critical Care. Richard is the current lead for Pre-operative Assessment and short stay patient flow.

Sue Glendenning

Sue has worked in the NHS for over 30 years as a nurse, midwife and within family planning enjoying a varied career. Sue is educated to masters' level and underwent the Senior Operational Leaders Course with the NHS Leadership Academy.
Sue trained at both St James Hospital and Leeds General Infirmary and spent a lot of her early career at Harrogate District Hospital. In more recent years, Sue has moved around and was Maternity Matron at the Queen Elizabeth Hospital Kings Lynn Norfolk where she supported achievement within the MDT of Level 2 CNST, establishment of a Midwife Led Birthing Unit and was appointed as a Supervisor Of Midwives.

Sue is currently Gynaecology Matron for Trust wide Services at United Lincolnshire NHS Trust and has undertaken a full nursing review to support their services on an improvement journey in line with the Trust's 2021 Strategy. Sue is a member of the Clinical Cabinet working to progress the local STP and a recent member of the Clinical Senate.

Dr Sarah Layzell

Sarah is a practicing inner city Nottingham GP. After qualifying in Southampton in 1991, she trained in acute medicine. Sarah soon switched to General Practice and was appointed as partner to her practice in 1997. After several roles with the Primary Care Trust involving prescribing, she became a GP trainer and then Programme Director with the Nottingham GP training programme. Sarah has pursued her academic interest in Interprofessional Medical Education and has published widely on the subject. Sarah is a Fellow of the Royal College of General Practitioners and has postgraduate qualifications in Prescribing Sciences and holds a Masters (MSc) in Medical Education. Sarah currently combines her clinical job with the role of Head of

School for Primary Care for Nottingham and Derbyshire and also holds the post of Associate Postgraduate Dean for Health Education East Midlands (Recruitment and Training Hubs).

Bernadette Armstrong - MSc MCSP SRP

Bernadette is an Extended Scope Physiotherapist – practicing as a musculoskeletal specialist, working for Northamptonshire Healthcare Foundation Trust (NHFT) in the Integrated Musculoskeletal service (IMSK). She has worked for the NHS for 27 years and also has her own private practice. She is a clinical lead for IMSK NHS physiotherapists in Northamptonshire, specialising in spinal and lower limb problems with a particular interest in the knee. She works across trusts in Primary and Secondary care and has been involved in GP and registrar teaching and mentoring. Bernadette played a key role as an Extended Scope Practitioner in the locally commissioned spinal service, which has now evolved into an AQP (Any Qualified Provider) service. As a Physiotherapy representative she has been involved in the set-up of the Total Hip and Knee pathway across primary and secondary care and is currently auditing the physiotherapy outcomes. She is an active member of the NHF Trust's Leadership forum and the NHS East Midlands Clinical Senate. Bernadette completed an MSc in Physiotherapy with Nottingham University in 2010 and her dissertation on Patellar Dislocation Primary Management was published in 2012 in the respected journal "The Knee". This was a collaborative project between Orthopaedics, A&E and Physiotherapy departments, and has led to international interest in her work. She served on the committee of ACPOMIT (Association of Physiotherapy Orthopaedic Medicine and Injection therapy) as a CPD and PR officers and has also taught at Coventry University on the Injection Therapy masters module for Physiotherapists.

Dr Liz Marder
Consultant Paediatrician
Community & Neurodisability
Nottingham Children's Hospital

Liz is a Consultant Paediatrician in Community Child health working in inner city Nottingham. Her main clinical responsibilities include providing general paediatric clinics in the community, and specialist clinics in paediatric neurodisability. Liz runs a service for children with Down Syndrome and for assessment of children with

suspected Autistic Spectrum Disorder. Liz is co-founder of the Down Syndrome Medical Interest Group UK and Ireland. After leading on the Children's workstream for the Nottinghamshire next stage review, she has been clinical lead for Nottinghamshire Children's Health network, and sat on the Regional Children's Clinical reference group. Liz was Pathway Lead Clinician for Children and Young People, Nottingham University Hospitals NHS Trust, with responsibility for quality and development of services for Children and Young People across the Trust. Liz is Lead for the Trust Medical Mentoring Programme, and she sits on the ethics of clinical practice committee. Liz is on the Royal College of Paediatrics and Child Health Medical Managers committee, and is part of the Colleges invited review team.

Dr Jane Williams

Jane is a Consultant Paediatrician working in Community child health, paediatric neurodisability and neurorehabilitation. Jane has held Consultant Posts in Birmingham Children's Hospital and currently Nottingham Children's Hospital. Jane was Clinical Director to the East Midlands Maternity and Children's Network 2014-2018 and now is Children's Lead (NHS England Central Midlands). Jane was Chair British Academy Children's Disability (2007-11), has sat on NICE guidelines groups, edited text books and published various papers on child health.

Mr Surajit Basu

Surajit is Consultant Neurosurgeon and Lead, Functional Neurosurgery Service at Nottingham University Hospitals. Surajit has been a member of adult neurosurgery clinical reference group and continues as a member of the East Midlands Clinical Senate Assembly. Surajit is an elected member of the council of Society of British Neurosurgeons and has keen interest in methods of quality assurances, patient safety and patient reported outcomes. His research interests are in neuromodulation and neuropathic pain conditions. He also leads the neurosurgical research (clinical trials) in Nottingham University Hospitals.

Mr Andrew Marshall

Consultant ENT Surgeon

GIRFT Clinical Lead for ENT

Nottingham University Hospitals

Andrew is a Consultant ENT surgeon in Nottingham, his practice is in implantation otology and paediatric ENT. Andrew has an interest in medical management and service improvement.

East Midlands Clinical Senate

Leicester, Leicestershire and Rutland Sustainability and Transformation Partnership and University Hospitals of Leicester NHS Trust

Maternity Services

Report of the Independent Clinical Senate Review Panels (16th January 2018 and 28th September 2018)

September 2018

Confidential

england.eastmidlandsclinicalsenate@nhs.net

Glossary of abbreviations

LLR	Leicester, Leicestershire and Rutland
STP	Sustainability and Transformation Partnership
UHL	University Hospitals of Leicester
CLG	Clinical Leadership Group
AHSN	Academic Health Science Network
PPI	Patient Participation Involvement
CCG	Clinical Commissioning Group
LRI	Leicester Royal Infirmary
LGH	Leicester General Hospital
ATAIN	Avoiding Term Admissions Into Neonatal units
EMNODN	East Midlands Neonatal Operational Delivery Network

Contents

Executive Summary

The clinical review panel of 16th January 2018 strongly supported the proposal to consolidate maternity and neonatal services onto the Leicester Royal Infirmary site, although the panel recommended that the LLR STP collate a source file of the supporting evidence that has been gathered during the process over the past decade as appendices, including: an obstetric workforce plan, evidence of liaison with Health Education England regarding workforce implications, a detailed analysis of neonatal care and patient flows, and evidence of consultation with women.

UHL is now in the process of developing its Pre-Consultation Business Case which is a requirement of NHS England for major service change. As a consequence of the NHS England assurance process, UHL has been asked to re-engage the clinical senate to give an independent clinical opinion on the original panel's recommendation (above), and its findings and conclusions are outlined in sections 7 and 8 below.

This report lays out in chronological order the key findings and recommendations of the clinical review panels on 16th January and 28th September, 2018.

1. Foreword by Dr Neill Hepburn, Clinical Senate Co-chair

Clinical Senates have been established to be a source of independent, strategic advice and guidance to local health and care systems, to assist them to make the best decisions about healthcare for the populations they represent.

Leicester, Leicestershire and Rutland is one of five evolving Sustainability and Transformation Partnerships in the East Midlands.

The Clinical Senate recognised the challenges the LLR STP faces about how it provides care to its local population. Their vision to create a system that recognises the need for women and families to have choice in the care they receive and to ensure that their care is personalised, safe and sustainable, is commended.

The Clinical Senate was pleased to be able to assist (on two occasions) the LLR STP with its proposal around maternity services, and wishes to thank West Leicestershire CCG and University Hospitals Leicester for their time and input.

It was recognised that a significant amount of work had been undertaken, and the panel was able to support the LLR STP's preferred model of care, which would see a single site acute maternity centre at the Leicester Royal Infirmary. Once a final decision has been reached, there needs to be clear communication with patients and the wider public on how the services will work in practice.

Dr Neill Hepburn
Clinical Senate Co-chair

(January, 2018)

Dr Julie Attfield
Clinical Senate Vice-chair

(September, 2018)

2. Clinical Senate Review Panel summary and key recommendations

It was agreed with LLR STP in the Terms of Reference that the panel would provide an independent clinical opinion on the equity and quality in access of the proposed reduction in acute sites providing maternity services.

Maternity services are currently provided at Leicester Royal Infirmary and Leicester General Hospital, plus a midwife-led birthing centre in Melton Mowbray.

The LLR STP is proposing to deliver the recommendations outlined in Better Births and to be cognisant of lessons learnt from Morecombe Bay. The LLR STP is clear that there is the potential for the birth rate to increase and the need to make the best use of limited skilled staff.

The LLR STP Better Care Together strategic plan is to reduce from three to two acute sites to ensure future clinical sustainability and affordability, which will impact on maternity and neonatal services due to:

- Centralisation of intensive care units away from Leicester General Hospital
- Removal of blood bank facilities on this site
- Transfer of surgical specialties including gynaecology

The preferred model of care would see a single site acute maternity and neo-natal centre at the Leicester Royal Infirmary. (It is understood by the panel that neonatal services shall not be supporting a midwife led centre at the Leicester General Hospital, which may be considered and is subject to the outcome of consultation).

The panel was able to support the LLR STP's plan to centralise their maternity facility, as it was deemed sensible on a clinical basis and addresses the drivers around medical workforce. The panel also supported the proposed closure of the midwife-led birthing centre in Melton Mowbray.

The panel was pleased to see that demographics and health inequalities had been sufficiently addressed.

It was recommended (by the clinical review panel on 16th January, 2018) that the LLR STP collates all supporting evidence of work undertaken previously, and has a clear sequenced plan that can easily be communicated to patients and the public when the STP are ready to go out to consultation.

The clinical review panel on 28th September 2018 made a further two recommendations subsequent to reviewing the detail around the clinical model.

3. Background and advice request

Leicester, Leicestershire and Rutland (LLR) Sustainability and Transformation Partnership (STP) commissions and provides healthcare services for over one million people.

The STP recognises that it has to change how it provides care to its local population to prevent services deteriorating in quality and becoming unaffordable.

The STP recognises the need to consolidate acute services in Leicester, and the proposal to reduce the number of acute hospitals is predicated on the belief that patients will be better served by shifting the balance of care from acute hospitals to community facilities and people's homes, where it is safe to do so.

The LLR STP Better Care Together strategic plan is to reduce from three to two acute sites to ensure future clinical sustainability and affordability, which will impact on maternity and neonatal services due to:

- Centralisation of intensive care units away from Leicester General Hospital
- Removal of blood bank facilities on this site
- Transfer of surgical specialties including gynaecology

The aim of the LLR STP plan is to give women choice in how they give birth in safe well-supported environments.

The proposed changes for the provision of hospital care will be subject to formal public consultation before any final decisions are made, and the Clinical Senate was commissioned prior to this to provide an independent clinical opinion on the equity and quality of access of the proposed reduction in acute sites relating to maternity services, and whether the proposal is clinically capable of delivering, and is aligned, to, the recommendations in Better Births (Terms of Reference - appendix 1).

3.1 Description of current service model

University Hospitals Leicester (UHL) currently provides four birth options for women in LLR. These are:

- Home births
- A standalone midwifery birthing centre (St Mary's in Melton Mowbray)
- Co-located midwifery birthing centres
- Joint medical and midwifery delivery units

Joint medical and midwifery delivery units and co-located midwifery birthing centres are provided at both the Leicester Royal Infirmary (LRI) and Leicester General Hospital (LGH).

3.2 Case for change

The rationalisation of acute hospital services in Leicester is a key driver for change, particularly in relation to:

- Centralisation of intensive care units away from Leicester General Hospital
- Removal of blood bank facilities on this site
- Transfer of surgical specialties including gynaecology

The proposal by the LLR STP is to remodel maternity services to create a new maternity hospital at the LRI and, subject to the outcome of consultation, a midwife led unit at the LGH may be considered. Furthermore, it proposes to close the birthing unit at St Mary's in Melton Mowbray.

The ability of UHL to provide adequate staffing across acute sites and its ability to provide safe care in the longer term has been questioned in two previous external reviews (the Darzi Review in 2010 and in 2012/13 all three CCGs commissioned an independent review of maternity services). The STP informed the panel that already, there are times when patient safety is compromised by the availability of resources, particularly in neonatology and obstetrics and this is currently being managed by temporarily closing either LRI or LGH to admissions. This is not considered by the LLR STP as a sustainable long-term solution.

Key workforce challenges relate to some significant medical and nursing staffing shortages for maternity and neonates, which are exacerbated by the services being split across sites. Additionally, demand for maternity services is expected to increase. The maternity facilities at UHL were designed to cater for approximately 8,500

deliveries per year, but deliveries now total approximately 10,500 per year. During the next 30 years, the number of women in their reproductive years is predicted to increase by 8%.

3.3 Scope and limitations of review

The proposal is to remodel maternity services to create a new maternity hospital at the LRI and, subject to the outcome of public consultation, a midwife led unit at the LGH may be considered. Furthermore, it proposes to close the birthing unit at St Mary's in Melton Mowbray.

The proposals are that all women in LLR will be provided with the following birth options:

- A new maternity hospital located at LRI with obstetric led inpatient maternity services in a shared care unit (both midwives and doctors)
- A midwifery birth centre provided adjacent to the obstetric unit as a part of the new maternity hospital at the LRI
- An additional midwifery birth centre could be piloted at the LGH remaining for the long term if there are enough births to ensure clinical sustainability (and subject to public consultation)
- Home birth supported by a Home Birth Midwifery team (where appropriate for low risk births)

4. Methodology and governance

4.1 Details of approach taken

The sponsoring organisation (STP Deputy Programme Director) engaged with the Clinical Senate on 6th December 2017. There had been an earlier approach in August as the STP intended to hold its own Clinical Leadership Group (CLG) for maternity services prior to the independent Clinical Senate Review Panel.

The maternity services CLG took place on 3rd October and the Clinical Senate contributed to this process by providing a subject matter expert, for the formative stages by helping to sense check the proposals. In order to manage conflicts of interest, this Senate Assembly member could not participate in the independent review.

It was agreed that a half day panel (afternoon) in Leicester would be held on 16th January 2018. Due to the pressurised timeline, panel members were identified as early as possible from both the Clinical Senate and the East Midlands Maternity and Children's Clinical Network. Patient representatives were also confirmed.

A pre-panel teleconference was scheduled for 4th January to review the supporting evidence. The STP were not able to provide the panel with the detailed information[1] [2], although it was agreed that the original slide deck presented to the CLG in October could be shared. A confidential, high-level document describing the overall STP plan was also shared with panel members. Feedback was provided to the STP on additional supporting information that would be required in advance of the panel.

4.2 Original documents used

Supporting evidence was submitted by the sponsoring organisation and disseminated to panel members on 5th January. The pre-reading included:

- Updated slide deck

[1] Detailed information was supplied by Leicester City CCG following the report. This was received and disseminated to the panel on 5th February.
[2] The Birthrate Plus report was received on 28th February and subsequently disseminated to the panel on 6th March.

- Transformational plan for maternity services
- Better Births Action Plan

Additional information was provided on 10th January, although the Birthrate Plus information requested was not made available to the panel.

Background information was also provided by the Senate Office:

- National Maternity Review Better Births (A Five Year Forward View for maternity care)
- Implementing Better Births: Continuity of Carer (Five Year Forward View December 2017)

A draft report was sent to the panel members and the sponsoring organisation to check for matters of accuracy.

The final report was submitted to the Senate Council (and ratified on 8th February 2018) for it to ensure that the clinical review panel met and fulfilled the Terms of Reference.

This report was then submitted to the sponsoring organisation, the LLR STP, on 9th February 2018.

The supplementary clinical review took place on 28th September 2018, and the findings and conclusions of this clinical review panel are documented in sections 7 and 8 in this report.

An updated draft report was sent to the panel members and the sponsoring organisation to check for matters of accuracy.

The final report was submitted to the Senate Council (and ratified on 4th October 2018).

This report was then submitted to the sponsoring organisation, UHL, on 5th October 2018.

East Midlands Clinical Senate will publish this report on its website as agreed with the sponsoring organisations, the LLR STP and UHL, in the Terms of Reference.

5. Key findings from the clinical review on 16th January

The LLR STP has a compelling case for change to address longstanding problems of quality and affordability. The proposed consolidated model will address issues of co-dependencies (as the acute hospitals in Leicester re-configure) and workforce, which are currently most acute in neonatology.

It was noted that the LLR STP's proposal is dependent on capital funding; although a new build is anticipated. This has been a longstanding issue with an interim solution concluded in 2011/12 (consolidation was not possible at the time due to cost).

However, all supporting evidence should be collated to demonstrate that the LLR STP has a robust case for change, which should include Birthrate plus data (the workforce planning system). It is recognised that single site consolidation will help to alleviate the drivers around medical workforce, although a formal staffing model has not yet been produced.

The LLR STP needs to be able to describe and evidence: liaison with Health Education England regarding impact on workforce and training, patient flows and activity modelling and, impact on transitional care.

This is a complex change process and the LLR STP should describe it in detail and its impact on patients and staff during the change process including appropriate mitigations.

Access could potentially be more difficult if services are consolidated on the LRI site, and consideration should be given to staff travelling on public transport working a 12 hour shift pattern.

The panel commended the LLR STP for its strong narrative regarding population health inequalities and demographics.

6. Conclusions and advice

The plan to centralise onto one site (facility) was deemed sensible by the panel on a clinical basis. Centralisation would address the drivers around co-dependencies and medical workforce. Furthermore, it was agreed that closing St Mary's at Melton Mowbray would be a clinically appropriate decision; it is under-utilised (on average there is only one birth taking place every 2.5 days) and essentially, the standard of care resembles that available for a home birth.

The panel agreed that the STP had a strong narrative around demographics and health inequalities and this was seen as very positive.

The panel observed that a detailed bundle of evidence had not been provided to the panel to support the case for change, and recommend the LLR STP collate all the previous work undertaken for earlier reviews to support their case.

It was advised that the Clinical Senate normally requires detailed evidence in order to be able to make recommendations and provide a clinical opinion. It was agreed that insufficient documentation, including previous analyses, had not been provided to support this independent clinical review panel process. It is likely that the LLR STP will be challenged at some point so they should prepare a full evidence pack to support their proposals. This should include: an obstetric workforce plan; evidence of liaison with Health Education England regarding workforce implications; a detailed analysis of neonatal care and patient flows, and evidence of consultation with women.

6.1 Recommendations

6.1.1 Recommendation 1

The panel found the LLR STP plan to centralise acute maternity services at the LRI site is clinically appropriate and recommend they proceed to public consultation.

6.1.2 Recommendation 2

The panel recommend that the LLR STP collate a source file of the supporting evidence that has been gathered during the process over the past decade as

appendices. This should include: an obstetric workforce plan; evidence of liaison with Health Education England regarding workforce implications; a detailed analysis of neonatal care and patient flows, and evidence of consultation with women.

6.1.3 Recommendation 3

A sequenced plan which describes simply how the services will change during the transition from the existing service to the new model, and describing the risks and appropriate mitigation, needs to be available when the LLR STP is ready to go out to public consultation.

6.1.4 Recommendation 4

It was noted that whilst Better Births and the proposed acute reconfiguration are inter-related, this policy directive is not driving the single site model. The panel therefore recommended that the proposal describes how the recommendations of Better Births have been incorporated into the plan.

6.1.5 Recommendation 5

A further recommendation was made by the Senate Council in its role as the group that is responsible for the formulation and provision of advice working with the broader Clinical Senate Assembly. The Senate Council recommended that the proposal describes how Safer maternity care (October 2016, November 2017) has been incorporated into the plan.

Appendix A: Terms of Reference

CLINICAL REVIEW: TERMS OF REFERENCE

Title: Review of Maternity Services and Community Services

Sponsoring Organisation: Leicester, Leicestershire and Rutland STP

Clinical Senate: East Midlands

NHS England regional or area team: Central Midlands

Terms of reference agreed by:

Name: E Orrock/N Hepburn **on behalf of Clinical Senate and**

Name: N Bridge/T Sanders **on behalf of sponsoring organisation**

Date: 10th January 2018

Clinical review team members

Chair: Dr Neill Hepburn

Panel members:

Name	Role	Organisation	Community Services &/or Maternity Services
Bozena Smith	Divisional Therapy Manager, Integrated Care Division, Professional Lead Occupational Therapist	Derby Teaching Hospitals NHS Foundation Trust	Community Services
Dr Jane Youde	Clinical Director for Rehabilitation Medicine and the Department of Medicine for the Elderly	Derby Teaching Hospitals NHS Foundation Trust	Community Services
Mr Keith Spurr	Patient	Clinical Senate	Community

	representative	Council	Services & Maternity Services
Santhanam Sundar	Consultant Oncologist	Nottingham University Hospitals NHS Trust	Maternity Services
Suha Deen	Consultant gynaecological pathologist/visiting professor	Nottingham University Hospitals NHS Trust	Community Services
Dr Steve Lloyd	GP/ Chair	NHS Hardwick CCG	Community Services
Mr Fred Higton	Patient representative	Clinical Senate Council	Maternity Services
Matt Day	Consultant	Public Health England	Maternity Services & Community Services
Dr Molla Imaduddin Ahmed	ST7 Paediatrics	Health Education East Midlands	Maternity Services & Community Services
Tammy Coles	Health and Wellbeing Manager	Public Health England - East Midlands	Maternity Services
Joy Kirby	Regional Maternity Lead (Midlands & East)	NHS England	Maternity Services
Janet Ashworth	Consultant Obstetrician, Sub-specialist in Fetal and Maternal Medicine, ACD Clinical Lead of Obstetrics Part of the Maternity Transformation Board (LMS)	Derby Teaching Hospitals NHS Trust	Maternity Services
Suzanne Miller	Regional Officer	Royal College of Midwives	Maternity Services
Dawn Thomas	Maternity	Lincolnshire East	Maternity

	Transformation Manager	CCG	Services
Tony Dinning	Director, Trent Perinatal and Central Newborn ODN's	London Road Community Hospital Derby	Maternity Services

Aims and objectives of the clinical review

The clinical review team needs to have a clear focus on what it is being asked to do. Its focus should be on the areas agreed with the sponsoring organisation - the foundation of which is to test if there is 'a clear clinical evidence base' underpinning the proposals.

Maternity Services

The aim of the clinical review is to test if there is a clear clinical evidence base underpinning the proposals and to provide an independent clinical opinion on the equity and quality in access of the proposed reduction in acute sites, and whether the proposal is clinically capable of delivering, and is aligned to, the Better Births recommendations.

Women's services are currently provided at LRI (Leicester Royal Infirmary) and LGH (Leicester General Hospital), plus a midwife-led birthing centre in Melton Mowbray.

LLR STP is proposing to deliver the recommendations outlined in Better Births and to be cognisant of lessons learnt from Morecombe Bay. LLR STP is clear that there is the potential for the birth rate to increase and the need to make the best use of limited skilled staff.

The buildings used to deliver services are old and, in some cases, not fit for purpose. The LLR STP Better Care Together strategic plan is to reduce from three to two acute sites to ensure future clinical sustainability and affordability.

Community Services

The aim of the review is to test if there is a clear clinical evidence base underpinning the proposals and to provide an independent clinical opinion on the equity and quality in access of the proposed community services model, which is designed to support the acute trust.

Leicester, Leicestershire and Rutland STP are not proposing to reduce the number of community beds. The aim is to ensure that the services are first in place (and integrated) and to be aligned to the concept of Home First.

Scope of the review

[Clinical areas under consideration to be clearly defined]

- Maternity Services
- Community Services

When reviewing the case for change and options appraisal the Clinical Review Panel should consider (but is not limited to) the following questions:

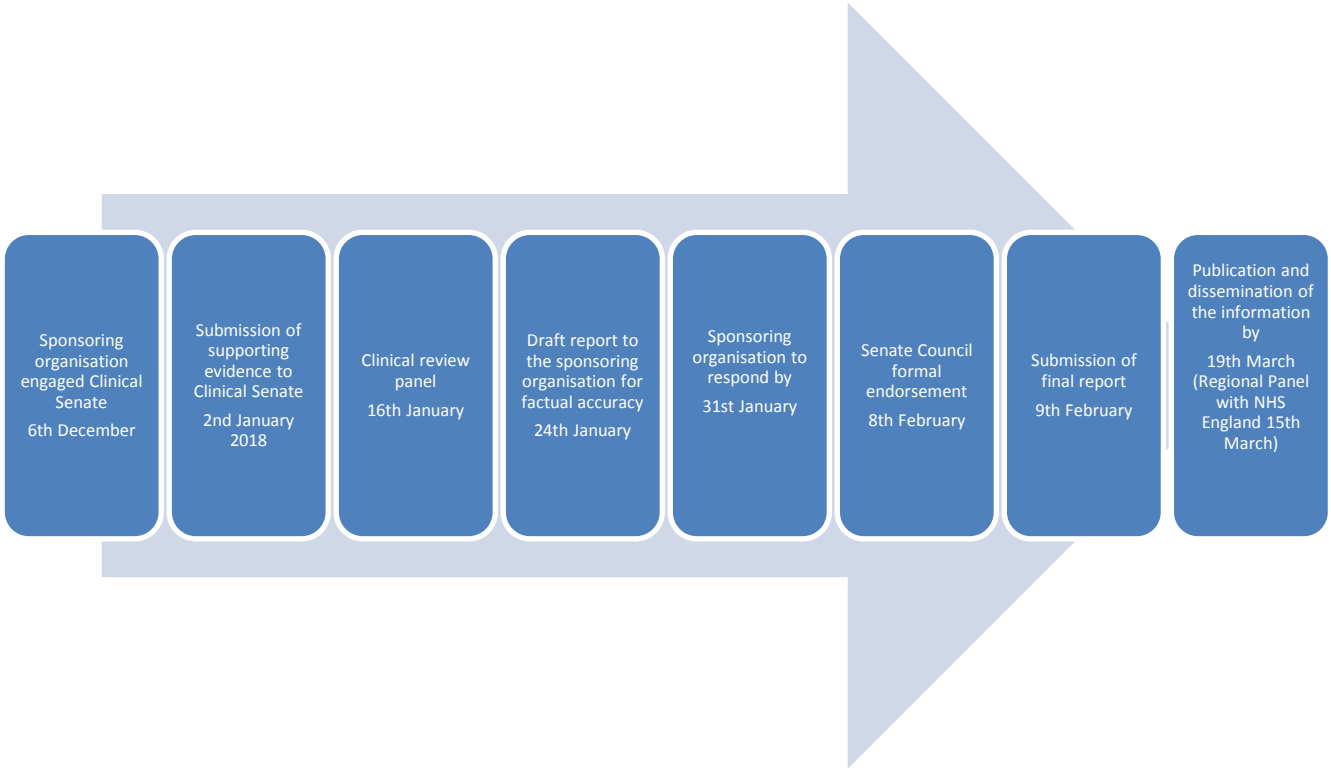
- Will these proposals deliver real benefits to patients (access/clinical outcomes/quality)?
- Is there evidence that the proposals will improve the quality, safety and sustainability of care?
- Do the proposals reflect up to date clinical guidelines and national and international best practice e.g. Royal College reports?
- Do the proposals reflect the goals of the NHS Outcomes Framework?
- Do the proposals reflect the rights and pledges in the NHS Constitution?
- Do the proposals align with local joint strategic needs assessments, commissioning plans and joint health and wellbeing strategies?
- Do the proposals meet the current and future healthcare needs of their patients?
- Is there a clinical risk analysis of the proposals, and is there a plan to mitigate identified risks?
- Do the proposals demonstrate good alignment with the development of other health and care services?
- Do the proposals support better integration of services?
- Do the proposals consider issues of patient access and transport? Is a

potential increase in travel times for patients outweighed by the clinical benefits?

- Will the proposals help to reduce health inequalities?
- Does the options appraisal consider a networked approach - cooperation and collaboration with other sites and/or organisations?

The Clinical Review Panel should assess the strength of the evidence base of the case for change and proposed models. Where the evidence base is weak then clinical consensus, using a voting system if required, will be used to reach agreement. The Clinical Senate Review should indicate whether recommendations are based on high quality clinical evidence e.g. meta-analysis of randomised controlled clinical trials or clinical consensus e.g. Royal College guidance, expert opinion.

Timeline



Reporting arrangements

The clinical review team will report to the clinical senate council which will agree the report and be accountable for the advice contained in the final report.

Clinical Senate Council will report to the sponsoring organisation and this clinical advice will be considered as part of the NHS England assurance process for service change proposals.

Methodology

The sponsoring organisation has agreed to collate and provide the following information:

- All background review information i.e. outcome of the internal CLGs (Clinical Leadership Group), Equality Impact Assessment, current model activity and workforce numbers
- Any stakeholder /patient engagement
- Case for Change
- Evidence base (i.e. Better Births)
- New clinical model for Maternity Services and Community Services
- Risk Action Plan, including mitigation
- Copy of the local authority Joint Strategic Needs Assessment for Leicester City and Leicestershire County Councils

The Clinical Review will consist of a face-to-face panel with a presentation from Leicester, Leicestershire and Rutland STP.

Report

A draft clinical senate report will be circulated within 6 working days of the final meeting - to team members for comments, to the sponsoring organisation for fact checking.

Comments/ corrections must be received within a further 5 working days.

The final report will be submitted to the sponsoring organisation by 9th February.

Communication and media handling

The Clinical Senate will publish the final report on its website once it has been agreed with the sponsoring organisation. The sponsoring organisation is responsible for responding to media interest once in the public domain.

Resources

The East Midlands clinical senate will provide administrative support to the review team, including setting up the meetings, taking minutes and other duties as appropriate.

The clinical review team will request any additional resources, including the commissioning of any further work, from the sponsoring organisation.

Accountability and Governance

The clinical review team is part of the East Midlands Clinical Senate's accountability and governance structure.

The East Midlands clinical senate is a non-statutory advisory body and will submit the report to the sponsoring organisation.

The sponsoring organisation remains accountable for decision making but the review report may wish to draw attention to any risks that the sponsoring organisation may wish to fully consider and address before progressing with their proposals.

Functions, responsibilities and roles

The **sponsoring organisation** will

- provide the clinical review panel with all relevant background and current information, identifying relevant best practice and guidance. Background information may include, among other things, relevant data and activity, internal and external reviews and audits, impact assessments, relevant workforce information and projection, evidence of alignment with national, regional and local strategies and guidance (e.g. NHS Constitution and outcomes framework, Joint Strategic Needs Assessments, CCG two and five year plans and commissioning intentions)
- respond within the agreed timescale to the draft report on matters of factual inaccuracy
- undertake not to attempt to unduly influence any members of the clinical review team during the review
- submit the final report to NHS England for inclusion in its formal service change assurance process

Clinical senate council and the sponsoring organisation will

- agree the terms of reference for the clinical review, including scope, timelines, methodology and reporting arrangements

Clinical senate council will

- appoint a clinical review team; this may be formed by members of the senate, external experts, or others with relevant expertise. It will appoint a chair or lead member
- endorse the terms of reference, timetable and methodology for the review
- endorse the review recommendations and report and
- provide suitable support to the team

Clinical review team will

- undertake its review in line with the methodology agreed in the terms of reference
- follow the report template and provide the sponsoring organisation with a draft report to check for factual inaccuracies
- submit the draft report to clinical senate council for comments and will consider any such comments and incorporate relevant amendments to the report. The team will subsequently submit final draft of the report to the Clinical Senate Council
- keep accurate notes of meetings

Clinical review team members will undertake to

- Commit fully to the review and attend all briefings, meetings, interviews, panels etc. that are part of the review (as defined in methodology)
- contribute fully to the process and review report
- ensure that the report accurately represents the consensus of opinion of the clinical review team
- comply with a confidentiality agreement and not discuss the scope of the review or the content of the draft or final report with anyone not immediately involved in it. Additionally they will declare, to the chair or lead member of the

clinical review team and the clinical senate manager, any conflict of interest prior to the start of the review and /or which may materialise during the review

Appendix B: Summary of documents provided by the sponsoring organisation as evidence to the original panel

i. Better Care Together: a Partnership Plan (December 2017) (confidential document)

ii. LLR Maternity Transformation – Clinical Senate presentation 2018

iii. Better Births Action Plan

iv. Transformational Plan for Maternity Services

v. Additional information requested by the Clinical Senate: lessons learnt from Morecombe Bay and the local authority Joint Strategic Needs Assessments (Leicester City and Leicestershire County Councils)

Appendix C: Clinical review team members and their biographies, and any conflicts of interest

Name	Role	Organisation	Conflict of interest
Dr Neill Hepburn	Co-chair East Midlands Clinical Senate	United Lincolnshire Hospitals NHS Trust	None
Mr Matt Day	Consultant	Public Health England	None
Dr Molla Imaduddin Ahmed	ST7 Paediatrics	Health Education East Midlands	None
Dr Santhanam Sundar	Consultant Oncologist	Nottingham University Hospitals NHS Trust	None
Mr Keith Spurr	Patient representative	Clinical Senate Council	None
Mr Fred Higton	Patient representative	Clinical Senate Council	None
Janet Ashworth	Consultant Obstetrician, Sub-specialist in Fetal and Maternal Medicine, ACD Clinical Lead of Obstetrics Part of the Maternity Transformation Board (LMS)	Derby Teaching Hospitals NHS Trust	Indirect non-pecuniary. Risk of small numbers of cross-border patients transferring to Derbyshire Trusts for care

Joy Kirby	Regional Maternity Lead (Midlands & East)	NHS England	None
Suzanne Miller	Regional Officer	Royal College of Midwives	None
Dawn Thomas	Maternity Transformation Manager	Lincolnshire East CCG	None
Mr Tony Dinning	Director, Trent Perinatal and Central Newborn ODN's	London Road Community Hospital Derby	None

Clinical Senate Support Team

Ms Emma Orrock – Head of East Midlands Clinical Senate, NHS England

Biographies

Dr Neill Hepburn MBA MD FRCP

Neill is a Consultant Dermatologist and the Medical Director at United Lincolnshire Hospitals NHS Trust. Neill qualified from Manchester University in 1984 and trained in dermatology in the Army and at the Edinburgh Royal Infirmary during which time he was awarded the MD for his work on leishmaniasis. As an Army doctor he saw active service in Northern Ireland, First Gulf War and with the United Nations in Angola. Arriving in Lincoln in 1997 he set up the 'hub and spoke' dermatology service for Lincolnshire. As Clinical Director for Medical Specialties he integrated the separate services across the county. Neill was appointed as the Deputy Medical Director in 2012 with particular responsibly for appraisal, revalidation and professional standards.

Tony Dinning

Director, CNN & TPN

A children's renal nurse specialist by background, Tony started his career at Addenbrooke's Hospital as a general nurse student in 1983. Tony has held various children's clinical posts in Cambridge, Bristol and Nottinghamshire. Tony's management experience spans some 20 years as a charge nurse, nurse manager, and latterly within the Networks.

Mr Matt Day FFPH

Consultant in Healthcare Public Health

Matt provides public health leadership to the NHS through his current and previous role. Matt served as vice-chair of the national specialised commissioning network and led for PHE on NHS clinical policy in cancer and mental health initiating and chairing the first ever national prevention reviews for specialised mental health on smoking, CAHMS, obesity, and new psychoactive substances. Locally, Matt is leading on service reconfiguration work for the Clinical Senate and STP leaders, and manages a team responsible for public health screening, dental public health, and specialised services advice to the NHS. Matt has published extensively on cancer and public health leadership and workforce. Matt has recently been appointed as a member of the national ACRA Technical Advisory Group, which advises Ministers on health resource allocation.

Dr Molla Imaduddin Ahmed

Specialist Registrar Paediatrics

Molla (Imad) is a paediatric registrar at Health Education East Midlands, currently working at Peterborough City Hospital. Imad represented the trainees from East Midlands on the RCPCH trainees committee (2014-2017), which works on matters of relevance to trainees nationally. Imad is a fellow of the Royal Society of Public Health and has been awarded “certificated change agent’ by Horizons group at NHS quality and School for healthcare radicals. Imad chaired the East Midlands Trainees group on quality assessment of postgraduate training and the East Midlands (South) Paediatric ST4-8 trainees committee.

Imad is a member of the East Midlands Children’s Clinical steering group and was a member of the East Midlands Clinical Senate panel conducting an independent review of health and social care in Lincolnshire (June 2014), vascular services in Hertfordshire and Essex (December 2014) and Leicestershire Better Care Together programme (August 2015).

Mr Keith Spurr

Patient Representative – East Midlands Clinical Senate Council

Keith is a retired experienced HR Advisor/Business Partner providing generalist HR support to organisations of varying sizes, within all types of industry for 40 years. Keith was an accredited Trade Union Representative when he represented ex-employees at Tribunals liaising with solicitors, courts, CMDs, PHRs and Full Hearings. Therefore, Steve has experience as both a manager and as a Trade Union representative and can appreciate both sides of the “table” whilst at the same time represent individuals and groups as required. Steve has worked with organisations as part of their change programme. Steve is diabetic Type 1 and had a TIA 25 years ago. He is the Diabetes UK Champion for the South Lincolnshire Area and a diabetic “voice”.

Dr Fred Higton

BSc PhD MRSC C Chem C Sci

Patient Representative – East Midlands Clinical Senate Council

Fred studied Chemistry at Royal Holloway College, University of London, where he gained both a degree and a PhD. Fred then worked for over 35 years in the pharmaceutical industry, mostly for The Boots Company plc, developing medicines and consumer products before establishing his own pharmaceutical consultancy. Fred is also a professional cartoonist and caricaturist. He suffered a serious stroke in 2011 and since then he has worked as a volunteer and patient representative. Fred volunteers with the Stroke Association and Stroke Research Partnership Group. Fred is a member of the Clinical Senate and was also a founder member of the East Midlands PPI Senate. Fred sits on the CLAHRC Patient Public and Partners Council and Partners Board and also works with the Institute of Mental Health and Nottingham Hearing Biomedical Research Centre.

Dr Santhanam Sundar

Santhanam Sundar is a Consultant Clinical Oncologist specialising in the treatment of Urological and Gynaecological cancers. Santhanam Sundar has been appointed at Nottingham University Hospitals NHS trust since April 2003. Santhanam Sundar obtained his European Certification in Medical Oncology in 2002 and MSc (Oncology) from the University of Nottingham in 2001. Santhanam Sundar became a fellow of Royal College of Radiologists in 2001 and a Member of Royal College of Physicians in 1997. Santhanam Sundar passed his UK General Medical Council exams in 1996 and United States Medical Licensure exams in 1995. Santhanam Sundar has published extensively and presented studies at National and International conferences.

Dawn Thomas

Maternity Transformation Manager

Dawn is a Registered Midwife, with 31 years' experience. Dawn has spent the majority of her career as a midwife working in the community setting supporting women throughout their pregnancy, labour and the postnatal period. In 2007, Dawn took over the management of the Lincoln and Gainsborough Community Midwife teams, and during the later year she acted into the Role of Matron for the Community

Midwifery Service at United Lincolnshire NHS Trust. Dawn's great passion was providing support and advocacy for women to achieve their birth choices. Dawn has supported many women to achieve home births, including twins which at first glance did not seem possible. In addition to supporting women during and after pregnancy, Dawn has spent much of her time supporting her team members to ensure the smooth running of the service as well as nurturing a happy and healthy team.

Dawn has over 18 years' experience as a Supervisor of Midwives and held the position of contact supervisor for the Trust from 2012 to 2015. Dawn has met with many mothers during this time as part of the 'Birth After Thoughts' service, which is a listening and information service for women with unresolved issues about their pregnancy or birth .

Dawn joined the Better Births in Lincolnshire Transformation team in November 2017, and is leading on Perinatal Mental Health and Neonatal elements of the Better Births in Lincolnshire plan. Over the next 18 months, Dawn is looking forward to working with the team on all elements of the plan.

Suzanne Miller RN RM MA

Suzanne is the Royal College of Midwives' Regional Officer to the East Midlands. Suzanne qualified as a nurse in 1986 and a midwife in 1991 working in different clinical roles in the NHS for 21 years before joining the RCM working in the West and East Midlands for the last 10years. Having been a Supervisor of Midwives, Suzanne has a particular interest in professional regulation and represents the RCM working with the Nursing & Midwifery Council in addition to her regional role.

Dr Janet Ashworth BM BS BMed Sci (hons) DM FRCOG

Janet is a Consultant Obstetrician and Sub-specialist in Fetal and Maternal Medicine at Derby Teaching Hospitals NHS Foundation Trust since 2003, and Assistant Clinical Director, Lead Obstetrician since 2012.

Janet graduated in 1990 from the University of Nottingham and received a Doctorate of Medicine from there in 1998, with research in vascular physiology in high risk pregnancy.

Janet is a Member of the RCOG from 1999 and fellow since 2011, and a member of the Derbyshire LMS steering group.

Joy Kirby RM RN BSc (Hons) PgCert MA

Joy has been a practicing midwife for 35 years, and continues to provide clinical care for pregnant women and their babies. Between 1996 and April 2017, Joy was employed by NHS England (Midlands and East) as the Local Supervising Authority Midwifery Officer. The LSAMO was responsible for ensuring that the statutory function of midwifery supervision provided to all midwives practicing within the LSA boundary met the required standards. Statutory Supervision was a public protection function and the LSAMO's role was independent both of NHS commissioners and NHS Trusts providing maternity services.

Joy's current role is Regional Maternity Lead for NHS England Midlands and East. Joy provides strategic midwifery leadership and professional guidance regionally, and across the health system. Joy works with a broad range of stakeholders including commissioners, improving quality of care, supporting the regional Chief Nurse on matters relating to maternity providers and the provision of specialist subject knowledge relating to midwifery and Maternity services.

Dr Julie Attfield RMN, BSc (Hons), MSc, PhD
Executive Director of Nursing
Nottinghamshire Healthcare NHS Foundation Trust

Julie is the Executive Director of Nursing for Nottinghamshire Healthcare NHS Foundation Trust. The Trust is a major provider of mental health, intellectual disability and community healthcare services for the people of Nottinghamshire. It sees in the region of 190,000 people every year and its 8,800 staff carry out a wide range of roles; working together to provide integrated and coordinated care. Julie began her career as a Registered Mental Health Nurse, and has since worked as a clinician, senior manager and director within mental health services in the East Midlands. Between these appointments, Julie spent time as a lecturer in Nursing at the University of Nottingham, before returning to the NHS. Julie's role prior to taking up this position was Director of Nursing and Operations at Lincolnshire Partnership NHS

Foundation Trust and the Executive Director of Forensic Services in the Trust. Julie has made a number of professional contributions and gained accolades including holding the title of Queen's Nurse, being a Senior Fellow of the Institute of Mental Health and company secretary for the National Mental Health Nurse Directors Forum. Julie is professionally known particularly for her research into the use of care pathways in mental health, service redesign, quality improvement and governance.

Dr Liz Marder
Consultant Paediatrician Community & Neurodisability
Nottingham Children's Hospital

Liz is a Consultant Paediatrician in Community Child health working in inner city Nottingham. Her main clinical responsibilities include providing general paediatric clinics in the community, and specialist clinics in paediatric neurodisability. Liz runs a service for children with Down Syndrome and for assessment of children with suspected Autistic Spectrum Disorder. Liz is co-founder of the Down Syndrome Medical Interest Group UK and Ireland. After leading on the Children's workstream for the Nottinghamshire next stage review, she has been clinical lead for Nottinghamshire Children's Health network, and sat on the Regional Children's Clinical reference group. Liz was Pathway Lead Clinician for Children and Young People, Nottingham University Hospitals NHS Trust, with responsibility for quality and development of services for Children and Young People across the Trust. Liz is Lead for the Trust Medical Mentoring Programme, and she sits on the ethics of clinical practice committee. Liz is on the Royal College of Paediatrics and Child Health Medical Managers committee, and is part of the College's invited review team.

Linda Hunn
Acting Director / Lead Nurse East Midlands Neonatal Operational Delivery Network

Linda is a Registered General Nurse and a Registered Midwife and is qualified in speciality for neonatal intensive care. Linda also holds an MSc in Public Services Management. Linda has worked extensively across midwifery, neonates and transitional care for many years in Cambridge and across the Midlands. Linda ensures that the baby and family are integral to all Network projects and works collaboratively with parents to achieve that aim. As Lead Nurse for the Network, she

is constantly striving to ensure consistency and to ensure that the highest possible level of care is delivered across all the constituent Network Neonatal Units. Linda has participated in numerous national projects, standards and documents related to neonatal care. Linda is passionate about the importance of nursing development and standards, and actively encourages education and development opportunities for nurses at all levels. She particularly focuses on the importance of preparing nurses appropriately to undertake management roles.

Dr Ben Pearson BSc, MBBS, FRCP, MMedSci (Clin. Ed.)
Consultant Geriatrician and Divisional Medical Director for Integrated Care, University Hospitals of Derby and Burton
Secondary Care governing body member, Mansfield & Ashfield and Newark & Sherwood Clinical Commissioning Groups

After gaining a zoology degree from Durham University, Ben trained in medicine at Kings College London, qualifying in 1993. He worked in London, Lincoln and Nottingham and took up a consultant post in geriatric and general (internal) medicine at Derby in 2004. Leading the development of acute medical services, Ben introduced senior clinical decision making and ambulatory care for acute medicine. Ben is the secondary care doctor on the Mansfield & Ashfield and Newark & Sherwood CCG Governing Body. In 2010, he was awarded a Master's degree in clinical medical education. Ben writes for the RCP Geriatric Medicine specialist exit examination and is a member of the Society for Acute Medicine and British Geriatrics Society.

Mr Robert Haughney
Consultant Obstetrician and Gynaecologist
Lead Gynaecologist for Cancer Care
Lead Obstetrician for Perinatal Mental Health and Vulnerable Women
Kettering General Hospital NHS Foundation Trust
Head of Post Graduate School of Obstetrics and Gynaecology
Health Education England - East Midlands

Robert graduated MBChB from Sheffield in 1990, trained in Sheffield and North West Deanery and was appointed as a Consultant in Obstetrics and Gynaecology in 2001 in Kettering. Robert passed MRCOG in 1997 and was awarded FRCOG in 2010.

Robert was college tutor in Kettering from 2002 to 2009 when appointed training programme director for East Midlands (south). Robert was asked to be acting Head of School in 2016, and was then appointed into that substantive role in July 2018.

Robert sits on the part 3 MRCOG Examination Committee, the National Recruitment Committee for Obstetrics and Gynaecology, and the RCOG Specialist Education Advisory Committee.

Robert is a part 3 MRCOG examiner and he teaches and facilitates internationally on the RCOG's Training the Trainers course (having been course convenor from 2013 - 2016).

7. Key findings of the supplementary Clinical Review Panel

The Maternity unit at UHL is currently split over two sites: Leicester Royal Infirmary and Leicester General Hospital. The medical staff work across both sites. The Leicester Royal Infirmary delivers 6,000 babies per annum and is supported by a level 3 neonatal unit. The Leicester General Hospital has around 4,250 deliveries and has a level 1 neonatal unit.

It is envisaged by UHL that on a single site there would be two delivery suites staffed separately with a Consultant, a middle grade doctor and a junior doctor. In view of the number of deliveries and complexity of cases this staffing number is the minimum required in daytime, and out of hours there will need to be two middle grade doctors with a resident consultant.

The original panel on 16th January 2018 had heard UHL's longer term proposal to consolidate and collocate maternity and neonatal services onto the Leicester Royal Infirmary site following a broad options appraisal. Such consolidation of maternity services was previously recommended in the Next Stage Review report published in 2010; however capital funding was not available at that time. UHL is now in the process of developing its Pre-Consultation Business Case which is a requirement of NHS England for major service change. The clinical senate had been commissioned previously to give a clinical opinion on the longer term proposal to collocate maternity and neonatal services. As a consequence of the recent NHS England assurance process, UHL has been asked to re-engage the clinical senate to give an independent clinical opinion on one of the original panel's recommendations, and its findings and conclusions are outlined in this section and section 8 below.

Obstetrics workforce plan

The panel heard that UHL plan to run two labour wards side by side as opposed to one large delivery unit. Specialist nursing staff and nurse practitioners will be supported by a gynaecology consultant and by junior medical staff. Experienced Advanced Nurse Practitioners can also provide training opportunities for junior staff. UHL acknowledge that this would be the largest single site maternity and neonatal unit in the country and that co-locating onto one site is likely to be beneficial to recruitment. The panel were also informed that the band 7 nurses "on the shop floor"

are keen to support staff recruitment. UHL will also have the opportunity to design and build into its new maternity hospital access to car parking, as the capital funding will enable this new build to happen. The panel were informed that this will be an iterative process over the next four to five years, and that workforce will be reviewed continually in the interim to ensure that the correct workforce is modelled. The panel were also informed by UHL that Sheffield Teaching Hospitals Jessop Wing Maternity Unit has 7,000 deliveries per annum and with significantly less staffing resource. This element has not been corroborated by the clinical review team, although it was recognised that reviewing other large providers who have merged two units into one is a useful exercise for UHL to undertake when developing their plans and considering staffing and workforce.

UHL explained to the panel that 33 additional neonatal nurses are required and that they had successfully managed to recruit to 41 nursing posts in a shorter period of time, primarily due to an enhanced induction programme and because UHL has two universities feeding into its recruitment programme.

UHL acknowledged the importance of clinical leadership to service transformation and the time commitment that it can take out of clinical work. UHL is of the view that leadership from a medical perspective is the responsibility of the clinical directors and heads of service including the head of midwifery who each would take responsibility for different models of care.

Evidence of liaison with Health Education England

The School of Obstetrics and Gynaecology will need to assess the number of trainees placed in a combined unit, as the current third tier (old style senior registrar) level may go once consultants are resident. This is certainly considered positive in terms of educational supervision. The proviso for units like these is that care must be taken that trainees do not get “lost” in such a big unit. UHL confirmed that withdrawing senior trainees would not be the right thing to do, that trainees should have the opportunity to engage with the resident consultant present, to learn, and to be responsible with appropriate support.

Analysis of neonatal care and patient flows

The Neonatal Service currently has 42 cots, made up of:

- 10 Intensive Care Cots at the LRI
- 8 High Dependency Cots at the LRI
- 12 Special Care Cots at the LRI
- 12 Special Care Cots at the LGH

UHL's planned five year model would be to deliver (at the LRI site):

- 10 Intensive Care Cots
- 8 High Dependency Cots
- 12 Special Care Cots

UHL plan to introduce a new flexible 14 cot transitional care unit at the LRI to replace the existing 12 special care cots at the LGH.

In reaching these cot numbers, UHL explained that they had taken the middle ground in terms of what they believe to be reasonable based on a slight decrease in delivery rates. UHL were of the opinion that the modelling tools can sometimes be unrealistic in terms of numbers.

The panel understood that the high birth areas are close to the hospital sites and that potentially this demographic could be disproportionately affected by out of area transfers.

UHL explained that work had been undertaken in children's services looking at capacity and flow and the relationship with the paediatric department. The entire discharge pathway has been significantly enhanced although UHL recognised that further work is required in terms of transitioning babies. UHL was clear however that the current two-site model does not benefit transition. The intention is that the refurbished children's hospital will improve transitional care.

Evidence of engagement with women

UHL explained that significant engagement had been undertaken with women in developing its proposal. UHL acknowledged that patients had responded more

positively about delivery and care at the Leicester General Hospital, although explained that this is primarily because the majority of the issues with the Leicester Royal Infirmary site is related to car parking and access and this will be less of an issue with the new building. The new build maternity hospital will be adjacent to the multi-storey car park and parking for neonates will be specifically identified. UHL explained that public transport links are better with the LRI site and that the PCBC contained the travel impact assessments and the additional requirements of the travel plan. This was acknowledged by the panel as this does cross reference with the clinical senate review panel held on 5th July 2018 (although the panel convened was made up of different clinicians). UHL agreed that the communications regarding how the fabric of the building will be enhanced is important.

8. Conclusions and advice of the supplementary Clinical Review Panel

The panel acknowledged that engagement with the clinical senate has been an iterative process and that a greater level of detail around the IT strategy, access and car parking had mainly been covered in the clinical review panel on 5th July, 2018. However, this panel did not review maternity services as this specialty had already been reviewed on 16th January, 2018. It will therefore be important to cross reference this report with the wider acute reconfiguration clinical senate report.

The panel accepted UHL's ambition to become paper light and to be electronic wherever possible was submitted as evidence to the clinical review panel held on 5th July, 2018.

Obstetrics workforce plan

The panel were of the opinion that the obstetrics workforce plan appeared to be well thought out. The main area of concern was in relation to out of ours cover and having sufficient middle grade doctors in order to be able to safely cover gynaecology services at night. The more significant concern was around neonatal nurse recruitment and UHL's ability to recruit and train the required number of nurses. The panel recognised that this is a national issue and an immense challenge, although UHL does sit below the national average currently for a tertiary centre. The focus for UHL will need to be on transforming roles and continuing to grow its own workforce locally by attracting nurses straight from the local universities, and by clearly demonstrating how they can train and mentor their nurses once recruited. The panel acknowledged that the high level strategic plan does contain specific references to neonates which was reassuring to the panel, although an outline recruitment strategy including a staged response over the next four to five years demonstrating how UHL will recruit and train their nurses will be required.

Evidence of liaison with Health Education England (HEE)

The panel concluded that there is evidence of sufficient and positive liaison with HEE. It was acknowledged that bringing together two maternity units is likely to improve training in terms of continuity of care and supervision and is highlighted in

the 2018 GMC Survey outcomes for Women's and Children's, provided as evidence to the panel.

Analysis of neonatal care and patient flows

The panel were of the opinion that UHL may fall short in terms of how many cots will be required. The panel understood that there is not a recognised modelling process to determine the number of cots required and that UHL will need to work with Specialised Commissioning and the EMNODN to correctly model the number of cots required in the future collocated model, including understanding how the ATAIN programme may impact on future capacity modelling.

The potential inequalities of out of network referrals were also highlighted to UHL. The previous panel on 16th January 2018 had noted the striking epidemiology as the high birth areas are close to the hospital sites in Leicester, and it will be important for UHL to ensure that this demographic is not disproportionately affected by out of area transfers, although babies going out of the EMNODN network area should be less than 5% of transfers out.

Evidence of engagement with women

The panel recognised the need for a conducive and accessible maternity unit on the LRI site and that women should be involved in the development and design through the capital programme. The design and the experience of patients accessing the new unit will be important. The panel acknowledged that staff transport had previously been raised and accepted that this is included in UHL's PCBC.

Recommendations

8.1.1 Recommendation 1

The panel recommends that an outline recruitment strategy is developed, including a staged response over the next four to five years demonstrating how UHL will recruit and train their nurses.

8.1.2 Recommendation 2

The panel recommends that UHL works with Specialised Commissioning and the EMNODN to correctly model the number of cots required in the future.

Appendix D: Clinical Review Panel Terms of Reference (28th September)

CLINICAL REVIEW: TERMS OF REFERENCE

Title: UHL Acute Reconfiguration - supplementary maternity review

Sponsoring Organisation: University Hospitals of Leicester NHS Trust

Clinical Senate: East Midlands

NHS England regional or area team: Central Midlands

Terms of reference agreed by:

Name: E Orrock /J Attfield **on behalf of Clinical Senate and**

Name: J Hammond **on behalf of sponsoring organisation**

Date: 22nd August 2018

Clinical review team members

Chair: Julie Attfield, Clinical Senate vice-Chair

Panel members:

Name	Role	Organisation
Matt Day	Consultant	Public Health England
Liz Marder	Consultant Paediatrician	Nottingham Children's Hospital
Janet Ashworth	Consultant Obstetrician, Sub-specialist in Fetal and Maternal Medicine, ACD Clinical Lead of Obstetrics	University Hospitals of Derby and Burton
Linda Hunn	Acting Director / Lead Nurse	East Midlands Neonatal ODN
Ben Pearson (will	Consultant Geriatrician	University Hospitals of

contribute by email)		Derby and Burton
Keith Spurr	Patient representative	Clinical Senate Council
Robert Haughney (will contribute by email)	Consultant/ Head of Service Obstetrics and Gynaecology	Kettering General Hospital/ Health Education England

Aims and objectives of the clinical review

The clinical senate was previously commissioned by the Leicester, Leicestershire and Rutland (LLR) STP to review Maternity Services and by University Hospitals of Leicester NHS Trust (UHL) and West Leicestershire CCG on behalf of the LLR STP to review UHL's plans to reconfigure three acute hospitals onto two sites.

It has subsequently been agreed to hold a supplementary review to look in some more detail at the clinical model for Maternity Services, to address specific points raised by the original panel on 16th January 2018.

All other recommendations made by the original panels regarding Maternity Services and UHL Acute Reconfiguration will be picked up by NHS England through the assurance process and does not require further senate input or review.

Scope of the review

- Maternity Services

For Maternity Services, the original panel recommended that the LLR STP collates a source file of all supporting evidence gathered during the process over the past decade as appendices. This is requested below under methodology.

When reviewing the case for change and options appraisal the Clinical Review Panel should consider (but is not limited to) the following questions:

- Will these proposals deliver real benefits to patients (access/clinical outcomes/quality[3])? For example, do the proposals reflect:
    - The rights and pledges in the NHS Constitution?
    - The goals of the NHS Outcomes Framework?

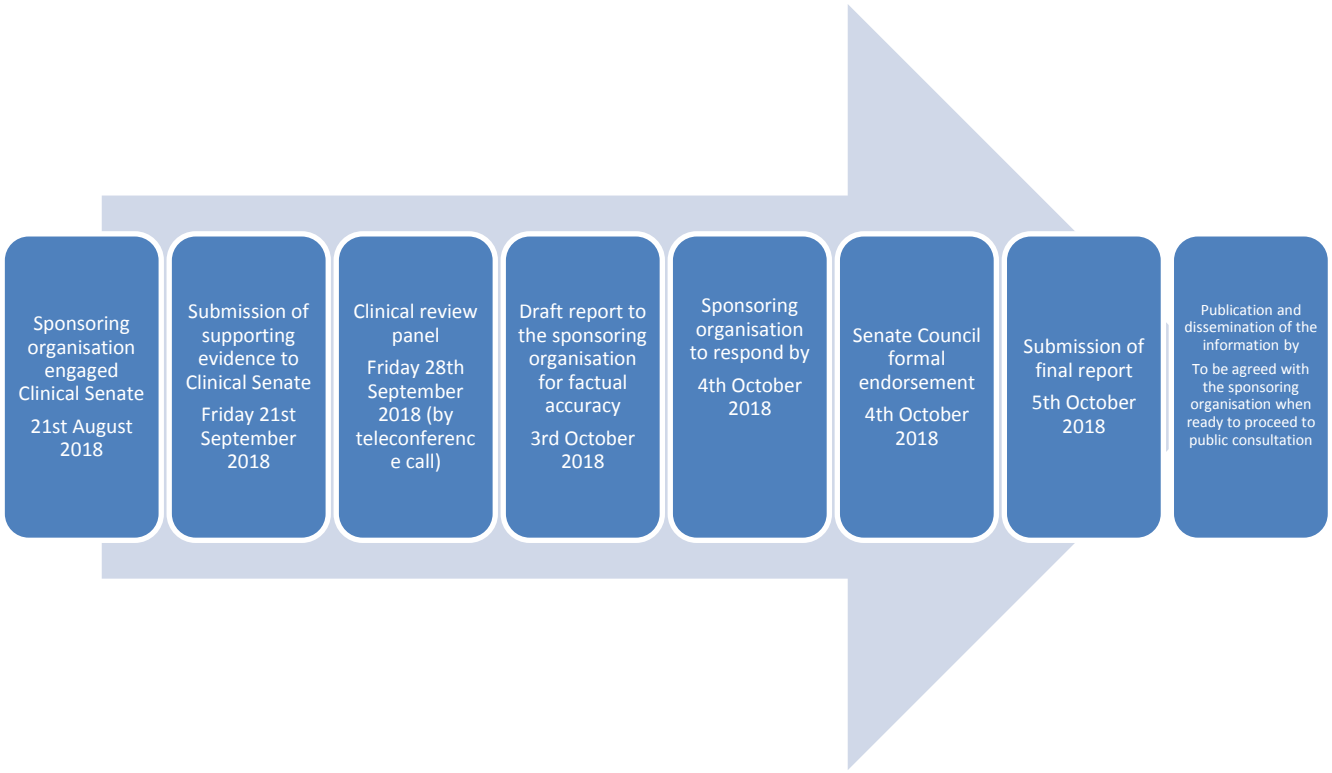
[3] Quality (safety, clinical effectiveness and patient experience)

    - Up to date clinical guidelines and national and international best practice e.g. Royal College reports?

- Is there evidence that the proposals will improve the quality, safety and sustainability of care? For example:
    - Do the proposals align with local joint strategic needs assessments, commissioning plans and joint health and wellbeing strategies?
    - Does the options appraisal consider a networked approach - cooperation and collaboration with other sites and/or organisations?
    - Is there a clinical risk analysis of the proposals, and is there a plan to mitigate identified risks?
- Do the proposals meet the current and future healthcare needs of their patients?
- Do the proposals demonstrate good alignment with the development of other health and care services?
- Do the proposals support better integration of services?
- Do the proposals consider issues of patient access and transport? Is a potential increase in travel times for patients outweighed by the clinical benefits?
- Will the proposals help to reduce health inequalities?
- Do the proposals consider the workforce requirements and transformation required to deliver this new model?

The Clinical Review Panel should assess the strength of the evidence base of the case for change and proposed models. Where the evidence base is weak then clinical consensus, using a voting system if required, will be used to reach agreement. The Clinical Senate Review should indicate whether recommendations are based on high quality clinical evidence e.g. meta-analysis of randomised controlled clinical trials or clinical consensus e.g. Royal College guidance, expert opinion.

Timeline



Reporting arrangements

The clinical review team will report to the clinical senate council which will agree the report and be accountable for the advice contained in the final report.

Clinical Senate Council will report to the sponsoring organisation and this clinical advice will be considered as part of the NHS England assurance process for service change proposals.

Methodology

The sponsoring organisation has agreed to collate and provide the following supporting evidence:

- An obstetric workforce plan
- Evidence of liaison with Health Education England regarding workforce implications
- A detailed analysis of neonatal care and patient flows
- Evidence of engagement with women.

It has been agreed that this clinical review panel will be a desktop (virtual) review and with a supported telephone conference call with the sponsoring organisation, as two previous half day panels have already been convened to more fully consider the reconfiguration proposals.

Report

A draft clinical senate report will be circulated within 3 working days of the final meeting - to team members for comments, to the sponsoring organisation for fact checking.

Comments/ corrections must be received within a further 1 working day.

The final report will be submitted to the sponsoring organisation by 5th October 2018.

Communication and media handling

The Clinical Senate will publish the final report on its website once it has been agreed with the sponsoring organisation. The sponsoring organisation is responsible for responding to media interest once in the public domain.

Resources

The East Midlands clinical senate will provide administrative support to the review team, including setting up the meetings, taking minutes and other duties as appropriate.

The clinical review team will request any additional resources, including the commissioning of any further work, from the sponsoring organisation.

Accountability and Governance

The clinical review team is part of the East Midlands Clinical Senate's accountability and governance structure.

The East Midlands clinical senate is a non-statutory advisory body and will submit the report to the sponsoring organisation.

The sponsoring organisation remains accountable for decision making but the review report may wish to draw attention to any risks that the sponsoring organisation may wish to fully consider and address before progressing with their proposals.

Functions, responsibilities and roles

The **sponsoring organisation** will

- provide the clinical review panel with all relevant background and current information, identifying relevant best practice and guidance. Background information may include, among other things, relevant data and activity, internal and external reviews and audits, impact assessments, relevant workforce information and projection, evidence of alignment with national, regional and local strategies and guidance (e.g. NHS Constitution and outcomes framework, Joint Strategic Needs Assessments, CCG two and five year plans and commissioning intentions)
- respond within the agreed timescale to the draft report on matters of factual inaccuracy
- undertake not to attempt to unduly influence any members of the clinical review team during the review
- submit the final report to NHS England for inclusion in its formal service change assurance process
- arrange and bear the cost of suitable accommodation (as advised by the Clinical Senate office) for the panel and any panel members

Clinical senate council and the sponsoring organisation will

- agree the terms of reference for the clinical review, including scope, timelines, methodology and reporting arrangements

Clinical senate council will

- appoint a clinical review team; this may be formed by members of the senate, external experts, or others with relevant expertise. It will appoint a chair or lead member
- endorse the terms of reference, timetable and methodology for the review
- endorse the review recommendations and report and
- provide suitable support to the team

Clinical review team will

- undertake its review in line with the methodology agreed in the terms of reference
- follow the report template and provide the sponsoring organisation with a draft report to check for factual inaccuracies
- submit the draft report to clinical senate council for comments and will consider any such comments and incorporate relevant amendments to the report. The team will subsequently submit final draft of the report to the Clinical Senate Council
- keep accurate notes of meetings

Clinical review team members will undertake to

- Commit fully to the review and attend all briefings, meetings, interviews, panels etc. that are part of the review (as defined in methodology)
- contribute fully to the process and review report
- ensure that the report accurately represents the consensus of opinion of the clinical review team
- comply with a confidentiality agreement and not discuss the scope of the review or the content of the draft or final report with anyone not immediately involved in it. Additionally they will declare, to the chair or lead member of the clinical review team and the clinical senate manager, any conflict of interest prior to the start of the review and /or which may materialise during the review

Appendix E: Summary of documents provided by the sponsoring organisation as evidence to the supplementary panel

- Evidence of liaison with Health Education England regarding workforce implications:
    - Evidence of liaison with HEE
    - Education evidence table
    - Neonatal medicine UHL survey
    - O&G UHL survey
    - GMC Survey Outcomes for W&C
    - Notes from OG meeting
    - Medical Education slide W&C
    - November 2017 W&C Education Quality and Performance Update

- A detailed analysis of neonatal care and patient flows:
    - Pathways of care document
    - EMNODN Care Pathway 2018
    - Clinical Senate response (Appendix)
    - CQC Quality Report 2016- 2017
    - Network Review Neonatal Unit November 2014
    - Peer Review Visit Report October 2017
    - Network Review Neonatal Unit November 2012
    - Central Newborn Network Annual Report 2016/17

- Obstetrics Workforce Plan

- Evidence of engagement with women:
    - Healthwatch
    - Healthwatch Leicester In Mum's Words
    - Local Maternity Services
    - Maternity draft communications and engagement plan
    - Record of engagement
    - Engagement log

- UHL Strategic Workforce plan

Appendix F: Clinical review team members and their biographies, and any conflicts of interest (28th September)

Name	Role	Organisation	Conflict of interest
Julie Attfield	Executive Director of Nursing	Nottinghamshire Healthcare NHS Trust	None
Matt Day	Consultant	Public Health England	None
Liz Marder	Consultant Paediatrician	Nottingham Children's Hospital	None
Janet Ashworth	Consultant Obstetrician, Sub-specialist in Fetal and Maternal Medicine, ACD Clinical Lead of Obstetrics	University Hospitals of Derby and Burton	Indirect non-pecuniary. Risk of small numbers of cross-border patients transferring to Derbyshire Trusts for care
Linda Hunn	Acting Director / Lead Nurse	East Midlands Neonatal ODN	None
Ben Pearson (will contribute by email)	Consultant Geriatrician	University Hospitals of Derby and Burton	None
Keith Spurr	Patient representative	Clinical Senate Council	None
Robert Haughney (will contribute by email)	Consultant/ Head of Service Obstetrics and Gynaecology	Kettering General Hospital/ Health Education England	None

Clinical Senate Support Team

Ms Emma Orrock – Head of East Midlands Clinical Senate, NHS England