Yorkshire and the Humber
Clinical Senate

Clinical Senate Review for Leeds CCG on Neonatal and Maternity Services

Final Draft

July 2018

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Yorkshire and the Humber Clinical Senate
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0.1	May 2018	First draft based on emailed comments and teleconference discussions	Jo Poole
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Chair's Foreword

1.1 The Yorkshire and the Humber Clinical Senate thanks Leeds CCG for involving the Senate in the review of maternity and neonatal service proposals. This is a significant service development for the Leeds healthcare system which has been in development for some time. I hope it has been valuable to bring an independent clinical perspective to the proposals and I would like to thank the expert clinicians who have worked with us on this review.

1.2 We have focused our attention on the areas which we advise need further consideration by the commissioners to ensure that their service model proposals are robust and well described

2. Summary of Key Recommendations

2.1 The Senate confirms that the proposals to create centralised care for both neonatal care and obstetric services are aligned with national guidance. In both these areas we confirm that there is a clear clinical evidence base which supports the reconfiguration and we are supportive of the proposals.

2.2 We recognise however that whilst this proposal increases choice regarding the creation of a Midwifery Led Unit (MLU) and the increasing support of the home birth option it is decreasing choice by removing a service for the 4000 women who actively chose to give birth in St James Hospital (SJH) every year. .

2.3 We also have particular concerns that these proposals impact most on those mothers who live near to the SJH site. This population has a high level of deprivation with a high number from the low socioeconomic group, BME and travellers who have the highest level of poor health and worse pregnancy outcomes. The Senate acknowledges the work that you have done to date to engage with the hard to reach groups but this has been with limited success. We advise commissioners to continue to develop different approaches to engagement and ensure you create opportunity for discussion and address the challenges of moving this population's obstetric care further from their community.

2.4 The Senate provides support to the overall model but our independent clinical assessment of the clinical modelling has raised some issues regarding the deliverability and sustainability of the service. These are particularly regarding the workforce assumptions and modelled capacity. Our recommendations are listed below and we advise commissioners to consider the following points.

Recommendation: *To consider proposals for creating neonatal consultant resident on call posts and for commissioners to ensure that proposed staffing models are compliant with the latest clinical standards*

Recommendation: *To increase the proposals for obstetric cover at night and weekends. Given the high risk population and potential for multiple deliveries occurring concurrently to consider proposals for obstetric consultant resident on call posts and for commissioners to ensure that proposed staffing models are compliant with the latest clinical standards*

Recommendation: *To work with the West Yorkshire and Harrogate Integrated Care System (ICS) and Local Area Workforce Board (LAWB) in the development of workforce proposals particularly with regard to new roles and workforce transformation*

Recommendation: *To work with the Operational Delivery Network (ODN) to model neonatal activity and ensure planned capacity is adequate.*

Recommendation: *To improve the explanation of the proposals for transitional care.*

Recommendation: *To further develop your plans during consultation for engaging with the hard to reach communities*

Recommendation: *To consider further what other levels of service you can provide to those SJH communities to help mitigate the loss of the SJH obstetric service.*

Recommendation: *To deliver your ambition of creating additional family space and parent accommodation that aligns with the neonatal national service specification.*

Recommendation: *To address the public concerns regarding accessibility and car parking in your proposals.*

Recommendation: *To learn lessons from Liverpool Women's Hospital and other units of a similar size*

3. Background

Clinical Area

3.1 Leeds Teaching Hospitals NHS Trust currently provides an obstetric unit at both the Leeds General Infirmary (LGI) and St James Hospital site (SJH) site. Both hospitals also provide a neonatal unit; the neonatal unit at LGI provides intensive care, high dependency and special care for babies and the neonatal unit at SJH provides special care only. Leeds are currently working on plans to provide patients with state of the art healthcare which centres around the redevelopment of Leeds General Infirmary to include a purpose-built new healthcare building that will become the gateway to adult services at this City centre site, a remodelling of Leeds Children's Hospital and maximising the use of other sites across the Trust.

3.2 The proposed reconfiguration of the provision of maternity and neonatal care in Leeds, which the Senate is being consulted on, sits within this wider context of development. The proposal is to centralise all neonatal provision within the Children's Hospital at LGI, therefore mitigating some longstanding concerns and challenges of staffing the current split provision.

3.3 As there is clear interdependency between obstetric-led care and neonatal care, a centralisation of neonatal care to the Leeds Children's Hospital requires the alignment of obstetric-led maternity care on the same site. This also provides the opportunity to provide the population with better access to non-medicalised birthing options. The proposal from the CCG is for the centralisation of obstetric-led care into a single unit at LGI with an alongside midwifery-led unit. The options that the CCG are planning to consult the public on are around the possible configurations of outpatient services across the 2 sites.

Role of the Senate

3.4 The advice from the Senate will be used by Leeds commissioners, in partnership with Leeds Teaching Hospitals NHS Trust, to refine any proposals in order to ensure that future

capacity meets clinical quality and safety standards and demand. The advice will also be used by the local maternity system to be assured that the proposed changes will not place additional unplanned pressure on neighbouring sites.

3.5 In their discussions the Senate has focused on providing a response to the following questions:

- Can the Clinical Senate confirm that the clinical evidence base supports the proposed maternity service reconfiguration?
- Can the Clinical Senate confirm that the clinical evidence base supports the proposed Neonatal Service reconfiguration?
- In addition can the Clinical Senate provide an independent clinical assessment to review the clinical modelling that has been undertaken by the Trust, to transform and configure the maternity services within the proposed centralised unit? Does this modelling reflect best practice pathways and is it deliverable and sustainable?

Process of the Review

3.6 The Terms of Reference were agreed in April and are available at Appendix 3. The supporting documentation was received by the Senate and distributed to the Clinical Panel in late April. During May the Senate working group shared comments on the documents by email and supplemented this with several clinical discussions by teleconference and a teleconference with the commissioners to provide opportunity to further improve our understanding of the proposals. Once consensus was reached on the draft report it was sent to the commissioner for comment on 12th June.

3.7 Commissioners are given 10 working days to respond with any comments on the accuracy of the report. The report is to be ratified by the Senate Council at their July meeting.

4. Recommendations

We fully support the recommendations within the National Maternity Review, Better Births.[1]

We have addressed each of the questions in turn.

Question 1: Can the Clinical Senate confirm that the clinical evidence base supports the proposed maternity service reconfiguration?

4.1 The Senate confirms that the clinical evidence base supports the proposed maternity service reconfiguration. Throughout the Proposals for Change document the CCG have referenced a range of national documents and demonstrated that their proposals are broadly in line with the national guidance. The Senate has referred to the NICE quality standards on

[1] National Maternity Review: Better Births. Improving Outcomes of Maternity Services in England. A Five Year Forward View for Maternity Care

Intrapartum Care[2] and Preterm Labour and Birth[3], and NICE guidelines on Safe Midwifery Staffing[4] in considering our response. In addition we have considered the Royal College of Obstetricians and Gynaecologists service standards[5] which set out a framework for commissioners and service providers of high level maternity service standards that aim to improve outcomes and reduce variation in maternity care.

4.2 The Senate confirms that the proposal to create centralised neonatal care and maternity care, including a high risk consultant led unit with an alongside low risk midwifery led unit at the LGI site is aligned with national guidance. There is a recognition however that whilst this proposal increases choice regarding the creation of an MLU and the increasing support of the home birth option it is removing a service for the 4000 women who give birth in St James Hospital every year. The hospital serves a particularly deprived community and our recommendations to mitigate the impact on this community are included within our response to your third question. Our comments regarding the workforce and capacity modelling are also included within the later section.

4.3 The creation of an MLU is very much supported by the Senate and we agree that a service of the size in Leeds should be able to give women the full choice offer. We agree with the evidence that you have presented which states that high levels of clinical interventions are experienced in obstetric units, with no improvements in birth outcomes for low risk mothers. The Cochrane review of 2016 supports this conclusion[6] as does the Sutcliffe article in the Journal of Advanced Nursing[7] which concludes that midwife led care for low risk women is better for a range of maternal outcomes, reduces the number of procedures in labour and increases satisfaction with care.

4.4 Within your Proposals for Change document you have referred to the option of creating a standalone MLU on the St James site but agreed not to pursue this due to national evidence that standalone sites often fail to attract the anticipated activity to keep them cost effective. The Senate agrees with the argument that you have presented of the underutilisation due to public concerns regarding access to an obstetric unit in the event of complications. There is experience of this within Yorkshire and the Humber with the stand alone MLU in Dewsbury currently operating at below modelled activity. We also recognise that there is a risk with a standalone MLU at SJH that mums will present there who are not eligible, particularly with the population that it serves. We note the additional information you provided to us which references the feedback you have received from other MLUs of a similar size and the discussions you have had with YAS, EMBRACE and other clinical colleagues who do not support the standalone MLU model. We have no further comment on your conclusions.

Question 2: Can the Clinical Senate confirm that the clinical evidence base supports the proposed Neonatal Service reconfiguration?

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[2] Intrapartum Care, Quality Standard (QS105), NICE February 2017
[3] Preterm Labour and Birth, Quality Standard (QS135) NICE October 2016
[4] Safe Midwifery Staffing for Maternity Settings, NICE guideline (NG4) February 2015.
[5] Providing Quality Care for Women, A Framework for Maternity Service Standards, RCOG, November 2016
[6] Midwife Led Continuity Models of Care Compared with Other Models of Care for Women During Pregnancy, Birth and Early Parenting, Cochrane Database of Systematic Reviews 2016
[7] Comparing Midwife Led and Doctor Led Maternity Care: A systematic Review of Reviews; Sutcliffe K et al, Journal of Advanced Nursing, Vol 68, Issue 11, Nov 2012, pages 2376-2386

4.5 The Senate confirms that the clinical evidence base supports the proposed neonatal service reconfiguration. The Proposals for Change document references the national neonatal guidance and again specialised commissioners have demonstrated that their proposals are in line with this guidance. In considering our response the Senate has referred to the British Association of Perinatal Medicine (BAPM) service standards for hospitals providing neonatal care[8] and the NICE neonatal specialist care quality standards.[9]

4.6 The Senate confirms that the proposal to create centralised neonatal care and maternity care, at the LGI site is aligned with the national guidance. We recognise that this model will provide the following key benefits in line with national recommendations:

- Improving compliance with staffing standards across the consultant, middle grade and nursing workforce by improving staff efficiency due to the removal of the split site rota
- Improving the availability of neonatal intensive care cots to reduce intra Network transfers and removing the significant number of neonatal transfers between the two sites
- Providing equity for all babies in accessing on site specialist paediatric support services and in accessing the cardiac services.
- Addressing concerns from obstetric staff on the risks of the large obstetric unit at SJH only being supported by a Special Care Baby Unit on site.

4.7 We do not agree that the merger of the 2 units will make any difference to the ability of the neonatal service to participate in the NHS Improvement Initiative ATAIN and we note that the Trust is already involved in this initiative.

4.8 Our comments regarding the workforce and capacity modelling are included within our response to your third question.

Question 3: In addition can the Clinical Senate provide an independent clinical assessment to review the clinical modelling that has been undertaken by the Trust, to transform and configure the maternity services within the proposed centralised unit? Does this modelling reflect best practice pathways and is it deliverable and sustainable?

4.9 The Senate provides support to the overall model but recommends that commissioners consider the following points.

Workforce Modelling

4.10 The Proposals for Change document and the supplementary papers provided to the Senate provides information on your current workforce and the planned utilisation of that workforce in the new model. There is general reference to how the merged unit will address the current workforce shortages and free up staff time but there is a lack of detailed information to support this. We agree that there are efficiencies to be gained in the

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[8] British Association of Perinatal Medicine (BAPM) standards Service Standards for Hospitals Providing Neonatal Care, 3rd edition, August 2010

[9] Neonatal Specialist Care Quality Standard (QS4), NICE, October 2010

centralisation of the services however our view is that some workforce risks remain and that these need to be addressed to ensure that services will remain sustainable.

4.11 Our observation is that there is not a clear estimate on the workforce needed to staff your current 2 site model and insufficient detail to assess that these will meet national standards in your centralised model. There is also a lack of other workforce solutions suggested like non training grade doctors, resident consultants in neonates, physician associates, or advanced nurse practitioners.

4.12 We have particular concerns with the obstetric workforce modelling, particularly the overnight obstetric cover. We are more assured of the neonatal staffing model and the planned daytime obstetric workforce.

Neonatal - Consultant and Junior Doctor Workforce

4.13 We do not agree that there is a national shortage of Neonatal Consultants and we are unaware of any consultant posts that you have tried and failed to recruit to. We do agree that there is a lack of paediatric middle grades. We agree that the proposals to consolidate the neonatal services onto one site will alleviate some of the current pressures on the consultant and middle grade rota and improve the current workforce situation. We note however the information recorded at the Operational Delivery Network Peer Review visit in March 2016 which states that if the current numbers of Tier 2 and consultant staff only covered one site, staffing levels would still be tenuous. With 4000 days of intensive care we advise that the Trust take this opportunity to create resident on call posts in line with the recommendations in the BAPM guidance[10] to develop a gold standard service. The Department of Health 2009 neonatal toolkit[11] also states in section 2.3.8 that “providers demonstrate that they are working towards increased direct consultant presence during intensive care, including a strategy to move to 24-hour cover for neonatal intensive care units”. Manchester have developed the resident roles and you may wish to learn from their experiences.

Recommendation: *To consider proposals for creating neonatal consultant resident on call posts and for commissioners to ensure that proposed staffing models are compliant with the latest clinical standards*

Neonatal Nursing Workforce

4.14 The Senate welcomes the significant improvement that has been made to the neonatal nursing workforce. This includes improving the welfare of staff through a range of initiatives including:

- Improved induction
- Designated supervisory roles
- Clear career progression and support particularly in intensive care areas
- Psychologist input to improve sickness rates

[10] British Association of Perinatal Medicine Optimal Arrangements for Neonatal Intensive Care Units in the UK including Guidance on their Medical Staffing . A Framework for Practice June 2014
[11] Department of Health “Toolkit for High Quality Neonatal Services”

- Development of a one year in-house qualified in speciality (QIS) course with 15 nurses supported through this course each year with the aim of all new staff being QIS within eighteen months of recruitment

4.15 The Senate welcomes the confirmation that the Trust will have an additional 25 band 5 nurses in place shortly and will be fully established in November of this year. It is noted that retention rates are improving.

Obstetric Consultant and Junior Doctor Workforce

4.16 It is noted that the Trust aims to have 20 Consultant Obstetricians in post and that there are 19 consultants contributing to the obstetric rota at present. We recognise that the current rotas across 2 sites are unsustainable and that centralisation of services will create efficiencies in the usage of staff. Based on their clinical experience the panel are less clear however that the achievement of 24 hour 7 day a week obstetric consultant presence on the high risk birth unit, with the continued consultant cover to the non-acute services, will be achievable within the current envelope of 20 consultants.

4.17 The clinical view of the panel is that for a unit of this size, with the potential of multiple high risk pregnancies throughout the 24 hour period, commissioners would be advised to increase the Consultant presence overnight from the current proposals of 1 consultant on call. We note that more investment is required to achieve Consultant resident overnight but we recommend this approach is considered. The Royal College of Obstetricians and Gynaecologists (RCOG) publication may be of assistance in your discussions[12]. We recognise that obstetric cover is an ongoing discussion at the Trust and we recommend that the Senate concerns are considered within that discussion.

4.18 Sustainability of the workforce is a key function of the West Yorkshire and Harrogate Integrated Care System (ICS) and Local Area Workforce Board (LAWB) where maternity services are a priority area. Commissioners are encouraged to engage with the ICS and LWAB in their workforce planning for this service particularly with regard to new roles and workforce transformation.

Recommendation: *To increase the proposals for obstetric cover at night and weekends. Given the high risk population and potential for multiple deliveries occurring concurrently to consider proposals for obstetric consultant resident on call posts and for commissioners to ensure that proposed staffing models are compliant with the latest clinical standards*

Recommendation: *To work with the West Yorkshire and Harrogate Integrated Care System (ICS) and Local Area Workforce Board (LAWB) in the development of workforce proposals particularly with regard to new roles and workforce transformation*

[12] Royal College of Obstetricians and Gynaecologists, Providing Quality Care for Women, Obstetrics and Gynaecology Workforce 2016

4.19 We agree that the current modelling demonstrates that there should be sufficient day time cover for the 4 different obstetric areas. If you change the on call pattern of the Obstetric Consultants, however, this will potentially have an impact on the day time cover you have available. This will need to be considered as you develop your proposals for obstetric cover at night and weekends.

Midwifery Nursing Workforce

4.20 The Senate notes that your current midwife to birth ratio is 1:27 which meets the nationally recommended staffing levels. We note that this includes specialty roles. We support the proposals to develop a Consultant Midwife and other clinical leadership roles.

4.21 In discussion you have confirmed that you have undertaken extensive work on your community model. This is not evidenced within the documents we have received and we understand that the detail of this is within a different work stream. It is a clear theme within the patient engagement to date that the public want care closer to home in small dedicated teams and the community provision is integral to the success of the inpatient model. We have therefore considered the community service within our response. To understand the integrated model it would be helpful to have more clarity on how the centralisation is going to be able to provide continuity of carer There is no detail behind the assertion that the efficiencies of the single site will allow this to be achieved other than stating that centralisation enables you to roster midwifery teams to ensure they are in the right place at the right time. From the information available to us our view is that there would need to be a significant increase in workforce to enable continuity of carer to be delivered.

4.22 We also note that it is the aim of the model to increase community choice and increase the rate of home births but the information provided to us does not provide any detail on how the midwifery workforce will be remodelled to achieve that.

4.23 There is also no mention of the support to disadvantaged groups or those who are disabled, have learning disabilities, mental health problems or are substance misusers. The relationship with social services is not addressed in the information we have received.

Associated Services

4.24 The proposals do not provide any information on the workforce modelling of the supporting services in anaesthesia, theatre staff and gynaecology. In further discussion commissioners confirmed that all of these services are engaged with these proposals and are developing their workforce in order to support the centralised service. We understand that Gynaecology services are staffed separately to obstetrics with their own tier of registrars and assessment units (except Tier 1 cover). Anaesthetic services are engaged and are developing obstetric PAs into the anaesthetics appointments. Leeds clinicians confirmed that they have their own designated emergency theatre team and are confident of anaesthetic cover for that.

Cultural Issues

4.25 We note from discussions with you that rotating staff across the 2 sites impacts negatively on their morale. We advise however that larger units also have issues including the difficulties in creating a sense of belonging for staff. Commissioners will wish to consider how they plan to minimise this effect on culture and how you can help the 2 workforces to merge. Even though these are sites under one Trust there can be very different ways of working and culture in those 2 units and this needs to be addressed to ensure smooth transition and good staff morale. We are also not clear what assumptions are being made about staff willingness to move from SJH to LGI and how this is being managed.

4.26 The Trust needs to ensure it has an approach that nurtures and values the workforce.

Capacity and Activity

4.27 It is noted that the Senate is being asked to provide assurance on the sustainability of the proposed bed modelling. We are however unable to provide that assurance from the information presented. We recommend that the Trust works with the Neonatal Operational Delivery Network to model their capacity and ensure that the proposed 74 cots are sufficient both for the Leeds population and also for Leeds to fulfil their role as a Network tertiary centre by accepting under 27 week babies from across the Network and having sufficient capacity for cardiac babies. In discussion you confirmed that you are planning to build the physical space to expand the cot numbers if required.

Recommendation: *to work with the ODN to model neonatal activity and ensure planned capacity is adequate.*

4.28 Page 32 of the proposals state that transitional care cots will reduce from 19 – 8 cots yet there is not an associated increase in the number of special care cots. Further discussion with clinicians confirmed that this is not expressed well in the paper and the intention is that there will be a 34 bedded special care and transitional care ward where 8 of those beds will be ring fenced to allow mums to be resident overnight. The impact of the geographical isolation of this unit within the department on the staffing also needs to be considered.

Recommendation: *to improve the explanation of the proposals for transitional care.*

4.29 The proposed model suggests a decrease in the number of maternity beds. The additional information you supplied discusses the reasons why you expect to deliver the efficiencies in care and the panel has no further comment on these assumptions.

4.30 You have confirmed that your modelling takes into account your activity for specialised services and that women with significant co-morbidities are usually admitted directly to cardiac, neurosurgery or other specialised services and do not utilise significant maternity capacity.

Equity of Access for the Public

The Impact on the SJH population

4.31 This move will significantly impact on those mothers who live near to the SJH site. This population has a high level of deprivation with a high number from the low socioeconomic group, BME and travellers who have the highest level of poor health and worse pregnancy outcomes. Within the proposals you discuss the difficulties of reaching this population with the result that complications are often identified later in pregnancy. Your proposals also specifically reference the stillbirth rate in Leeds in 2017 and the early analysis of the emerging themes which has identified links to deprivation and ethnicity including that 23% of the mothers were of Black African or Pakistani ethnicity. There is a higher incidence of the BME population around SJH and moving women to LGI might reduce the likelihood of attendance for reduced foetal movements which could adversely affect the still birth rate. The Senate acknowledges the work that you have done to date to engage with the hard to reach groups but this has been with limited success. We advise commissioners to continue to develop different approaches to engagement and ensure you create opportunity for discussion and address the challenges of moving this population's obstetric care further from their community. We understand from the postcode data provided that 1724 women from the SJH neighbouring postcodes deliver in SJH. We note that all the specialist clinics – diabetes, renal, liver and haematology for example are all delivered at the LGI.

4.32 It would be helpful to understand where these mothers near to the SJH site receive their antenatal care as this will impact on the decision making around the location of the outpatient service. We recommend that you have further discussions with these deprived communities regarding what other levels of service you can provide around SJH. Examples may include providing obstetric outreach into the communities. We note that such proposals are referenced on page 35 on your document.

Recommendation: *To further develop your plans during consultation for engaging with these hard to reach communities*

Recommendation: *To consider further what other levels of service you can provide to those SJH communities to help mitigate the loss of the SJH obstetric service.*

The Options for Outpatient Services

4.33 The consideration of the SJH population plays heavily into the options on the location of the outpatient services. We recognise that these options will be open to public consultation and we accept that there are pros and cons to each of the options. It is clear that retaining the outpatient services at SJH better serves that local population and the car parking facilities there are better, however, a centralised outpatient service at the LGI site will use staff more efficiently. In the additional information you have supplied to us you have confirmed that if the public feedback is to retain an outpatient service on both sites then you can continue to staff the services, albeit with the current inefficiencies in split site working. It may be helpful to review the DNA rate at each hospital in the new service as a model which increases DNA rates at LGI hospital (potentially from the SJH population) may offer an equally inefficient service as split site working. If the outcome is to retain some outpatient

services at SJH commissioners will need to ensure that this does not become the poor relation of the LGI services and there is access to all the associated services and social care.

4.34 As discussed in paragraph 4.32 there is opportunity here to deliver outpatient care in a primary care setting closer to home.

4.35 We do not agree with the comments in the proposed public literature regarding the additional expense of ultrasound machines as being an issue, this is more about the availability of a sonography workforce to run the service.

Parent Facilities

4.36 We agree that the new Children's Hospital will provide a much improved environment for parents. The additional information you have supplied confirms that your ambition is to provide family centred parental spaces either immediately next to the baby's cot in the NICU or as part of the transitional care unit, or elsewhere within the Leeds Children's Hospital. The Senate is pleased that the ambition is for the model to align with the Bliss Service Quality Indicators[13]

Recommendation: *To deliver your ambition of creating additional family space and parent accommodation that aligns with the neonatal national service specification*

Car Parking and Transport

4.37 It is very clear from the literature that the lack of car parking at the LGI site is a key issue for the public. With the particularly deprived population around SJH we are concerned that the expectation to travel to the LGI is creating more inequality for a lower socioeconomic group of patients. We note that the paper doesn't quantify the additional car parking spaces that will be created at LGI or whether those will be ring fenced for the labour ward. In discussion however you have confirmed that there will be 160 car park spaces that will be dedicated to children's and maternity services. We are agreed that this number of spaces should deal with the acute need and is a significant improvement. There are proposals to have emergency parking as part of the car parking proposals.

4.38 It is noted that your documentation make assumptions about patients using public transport and we question how realistic that is for heavily pregnant women, families with very young children and very deprived populations.

4.39 A final point to note is that colleagues within Yorkshire Ambulance Services have confirmed that this model will not increase the demand on ambulance services.

Recommendation: *To address the public concerns regarding accessibility and car parking in your proposals*

Patient Engagement

[13] Neonatal Service Quality Indicators, BLISS June 2017

4.40 Pages 40 - 43 of your proposals summarise the engagement that you have had with the public on maternity and neonatal services to date. One of the conclusions that you draw from this engagement is that people have told you they would like a single obstetric unit providing 24 hour 7 day a week consultant presence. We question that conclusion having read those reports. The feedback centres on the request for small teams who know the families and have more time to spend with them. Most of the previous engagement does not mention the proposals to move to a single obstetric site.

Reduced inter hospital transfers

4.41 We agree that by bringing the services together onto one site there will be a significant reduction in the numbers of neonatal transfers and the associated risks. Patient safety and experience will be improved. We understand that the majority of these transfers are due to LGI stepping babies down to the Level 1 unit at SJH to create more level 3 and 2 cots at LGI and similarly to transfer babies on the Level 1 unit at SJH who deteriorate and need transfer to a higher level of care at LGI. It is very stressful for parents when their babies are transferred to another hospital and we fully support service changes which will reduce the transfers and improve patient safety and experience.

The Model

4.42 We wish to make the following specific comments on the model:

4.43 The proposals make reference to the proposed postnatal outreach teams working from the MAU hub to deliver aspects of care in a woman's own home, such as baby observations, infection screening and intravenous antibiotics. Issues like the re-siting of the cannula, the regularity of infant observations and antibiotic prescribing need thinking through in this approach.

4.44 It is noted that the current elective caesarean section rate is 11%. The proposals are for the C section unit to close at 5pm and you have confirmed that outside of these hours the patients will be transferred to the enhanced recovery area to facilitate next day discharge where this is possible.

4.45 Your additional information has confirmed that the minor procedures suite is as a result of a request from anaesthetic colleagues. It will be situated next to the planned 3 main theatres and will add flexibility for times when the acute service is very busy. It is not intended however to be used as a fully specified theatre.

4.46 Within the additional information you supplied you have confirmed the measures you have in place to manage the risks to infection which include increased side room capacity and zoned areas within the wards.

Other Comments

4.47 Liverpool Women's Hospital serves a smaller number of births (8600) but is of a similar size to the planned Leeds unit and was achieved following a merger across sites. We recommend that commissioners and clinicians learn lessons from their experiences.

Recommendation: *to learn lessons from Liverpool Women's Hospital and other units of a similar size*

4.48 We note that your list of spokespeople for this project on page 61 of your proposals document does not include a clinician from the neonatal service and we suggest that one is identified.

5. Summary and Conclusions

5.1 The Senate confirms that the proposals to create centralised care for both neonatal care and obstetric services are aligned with national guidance. In both these areas we confirm that there is a clear clinical evidence base which supports the reconfiguration and we are supportive of the proposals.

5.2 We recognise however that whilst this proposal increases choice regarding the creation of an MLU, and the intention to increase support of the home birth option, it is decreasing choice by removing a service for the 4000 women who give birth in St James Hospital every year.

5.3 We have particular concerns that these proposals impact most on those mothers who live near to the SJH site. This population has a high level of deprivation with a high number from the low socioeconomic group, BME and travellers who have the highest level of poor health and worse pregnancy outcomes. The Senate acknowledges the work that you have done to date to engage with the hard to reach groups but this has been with limited success. We advise commissioners to continue to develop different approaches to engagement and ensure you create opportunity for discussion and address the challenges of moving this population's obstetric care further from their community.

5.4 The Senate provides support to the overall model but our independent clinical assessment of the clinical modelling has raised some issues regarding the deliverability and sustainability of the service. These are particularly regarding the workforce assumptions and modelled capacity. We advise commissioners to address our recommendations to ensure the robustness of the model.

APPENDICES

Appendix 1

LIST OF INDEPENDENT CLINICAL REVIEW PANEL MEMBERS

Council Members

Clinical Senate Review Chair: Dr Nicola Jay, Consultant Paediatrician Allergy & Asthma, Sheffield Children's Hospital NHS Foundation Trust

John Whelpton, lay member

Assembly Members

Dr Simon Clark
Consultant in Neonatal Medicine, Sheffield Teaching Hospitals NHS Foundation Trust

Co-opted Members

Dr Karen Selby
Consultant Obstetrician & Gynaecologist & Deputy Clinical Director, Sheffield Teaching Hospitals NHS Foundation Trust

Mrs Jane Allen
Consultant Obstetrician & Gynaecologist & Clinical Director for Women's Health, Hull & East Yorkshire Hospitals NHS Foundation Trust

Dr Elizabeth Pilling
Consultant Neonatologist, Sheffield Teaching Hospitals NHS Foundation Trust & Yorkshire & the Humber Neonatal ODN Clinical Lead

Paula Schofield
Head of Midwifery, Sheffield Teaching Hospitals NHS Foundation Trust

Janet Cairns
Head of Midwifery, Hull & East Yorkshire Hospitals NHS Foundation Trust

Appendix 2

PANEL MEMBERS' DECLARATION OF INTERESTS

Name	Job Title	Organisation	Date of Declaration	Reason for Declaration	Date of Response	Proposed way of Managing Conflict
Simon Clark	Consultant Neonatologist	Sheffield Teaching Hospitals NHS Foundation Trust	27th April 2018	Simon's previous role was as Head of School for Paediatrics and he has been involved previously in discussions with Leeds Teaching Hospitals regarding their workforce.	May-18	Simon's knowledge of workforce issues due to his work with the Deanery provides insight into the workforce challenges but does not create any conflict with his professional and clinical expertise with the Leeds review. The Senate have agreed that his participation in the review can continue with this issue logged.

Appendix 3

NHS
Yorkshire and the Humber
Clinical Senate

CLINICAL REVIEW

TERMS OF REFERENCE

TITLE: Maternity and Neonatal Services on behalf of Leeds CCG

Sponsoring Organisation: Leeds CCG

Terms of reference agreed by: Jane Mischenko Lead Strategic Commissioner: Children & Maternity Care, Leeds CCG and Joanne Poole, Senate Manager, Yorkshire and the Humber Clinical Senate

Date: 2nd May 2018

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1. CLINICAL REVIEW TEAM MEMBERS

Clinical Senate Review Chair: Dr Nicola Jay, Senate Council member and Consultant Paediatrician Allergy & Asthma, Sheffield Children's Hospital NHS Foundation Trust

Citizen Representatives: John Whelpton

Senate Review Clinical Team Members:

Dr Karen Selby
Consultant Obstetrician & Gynaecologist & Deputy Clinical Director, Sheffield Teaching Hospitals NHS Foundation Trust

Mrs Jane Allen
Consultant Obstetrician & Gynaecologist & Clinical Director for Women's Health, Hull & East Yorkshire Hospitals NHS Foundation Trust

Dr Simon Clark
Consultant in Neonatal Medicine, Sheffield Teaching Hospitals NHS Foundation Trust

Dr Elizabeth Pilling
Consultant Neonatologist, Sheffield Teaching Hospitals NHS Foundation Trust & Yorkshire & the Humber Neonatal ODN Clinical Lead

Paula Schofield

Head of Midwifery, Sheffield Teaching Hospitals NHS Foundation Trust

Janet Cairns
Head of Midwifery, Hull & East Yorkshire Hospitals NHS Foundation Trust

2. AIMS AND OBJECTIVES OF THE REVIEW

Question:

- Can the Clinical Senate confirm that the clinical evidence base supports the proposed maternity service reconfiguration?
- Can the Clinical Senate confirm that the clinical evidence base supports the proposed Neonatal Service reconfiguration?
- In addition can the Clinical Senate provide an independent clinical assessment to review the clinical modelling that has been undertaken by the Trust, to transform and configure the maternity services within the proposed centralised unit? Does this modelling reflect best practice pathways and is it deliverable and sustainable?

Objectives of the clinical review (from the information provided by the commissioning sponsor):

The advice will be used by Leeds commissioners, in partnership with Leeds Teaching Hospitals NHS Trust, to refine any proposals as required in order to ensure that future capacity meets clinical quality and safety standards and demand.

The advice will also be used by the local maternity system to be assured that the proposed changes will not place additional unplanned pressure on neighbouring sites.

Scope of the review:

Leeds Teaching Hospitals NHS Trust is currently working on ambitious plans to provide patients with state of the art healthcare that has the flexibility to respond to their changing needs over time. The proposals – called ‘Building the Leeds Way’ - centre around the redevelopment of Leeds General Infirmary to include a purpose-built new healthcare building that will become the gateway to adult services at this City centre site, a remodelling of Leeds Children’s Hospital and maximising the use of other sites across the Trust. The proposed reconfiguration of the provision of maternity and neonatal care in Leeds sits within this wider context of development. This includes the proposal to centralise all neonatal provision within the Children’s Hospital. There is clear interdependency between obstetric-led care and neonatal care and a centralisation of neonatal care to the Leeds Children’s Hospital requires the alignment of obstetric-led maternity care on the same site.

The Clinical Senate will focus their review on the maternity and neonatal reconfiguration proposals within the wider context of the “Building the Leeds Way” proposals. The Senate will answer the above questions based on the information provided in the documentation and the clinical panel will supplement their understanding of the model through discussion with commissioners.

3. TIMELINE AND KEY PROCESSES

Receive the Topic Request form: 14th April 2018

Agree the Terms of Reference: by first week in May 2018

Receive the evidence and distribute to review team: 25th April 2018

Teleconferences:

The first Clinical Panel discussions w/c 7th May

Second Clinical panel teleconference w/c 14th May

Teleconference with commissioners and clinicians from Leeds and the clinical panel w/c 21st May

Draft report submitted to commissioners: 8th June 2018

Commissioner Comments Received: within 10 working days of the draft report being received

Senate Council ratification; at the July 2018 Council meeting

Final report agreed: following Council ratification

Publication of the report on the website: to be agreed with commissioners

4. REPORTING ARRANGEMENTS

The clinical review team will report to the Senate Council who will agree the report and be accountable for the advice contained in the final report. The report will be given to the sponsoring commissioner and a process for the handling of the report and the publication of the findings will be agreed.

5. EVIDENCE TO BE CONSIDERED

The review will consider the following key evidence:

- Leeds proposals for Change: Proposals to engage and consult on the reconfiguration of maternity and neonatal services (and embedded documents)
- Travel impact assessment 17th April 2018
- Letter from specialised commissioning dated December 2017
- Quality Surveillance Programme Peer Review visit dated 9th November 2017
- Yorkshire and the Humber ODN Meeting Report dated 7th March 2016

- Table showing the postcode of where women currently give birth
- Additional information in response to questions raised in the 22nd May teleconference
- Supplementary Paper for the Clinical Senate

The review team will review the evidence within this documentation and supplement their understanding with a clinical discussion.

6. REPORT

The draft clinical senate report will be made available to the sponsoring organisation for fact checking prior to publication. Comments/ correction must be received within 10 working days.

The report will not be amended if further evidence is submitted at a later date. Submission of later evidence will result in a second report being published by the Senate rather than the amendment of the original report.

The draft final report will require formal ratification by the Senate Council prior to publication.

7. COMMUNICATION AND MEDIA HANDLING

The final report will be disseminated to the commissioning sponsor and NHS England (if this is an assurance report) and made available on the senate website. Publication will be agreed with the commissioning sponsor.

8. RESOURCES

The Yorkshire and the Humber clinical senate will provide administrative support to the clinical review team, including setting up the meetings 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.

9. ACCOUNTABILITY AND GOVERNANCE

The clinical review team is part of the Yorkshire and the Humber Clinical Senate accountability and governance structure.

The Yorkshire and the Humber 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 their proposals.

10. FUNCTIONS, RESPONSIBILITIES AND ROLES

The **sponsoring organisation** will

i. provide the clinical review panel with agreed evidence. Background information may include, among other things, relevant data and activity, internal and external reviews and audits, impact assessments, relevant workforce information and population projection, evidence of alignment with national, regional and local strategies and guidance. The sponsoring organisation will provide any other additional background information requested by the clinical review team.
ii. respond within the agreed timescale to the draft report on matter of factual inaccuracy.
iii. undertake not to attempt to unduly influence any members of the clinical review team during the review.
iv. submit the final report to NHS England for inclusion in its formal service change assurance process if applicable

Clinical senate council and the **sponsoring organisation** will:

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

Clinical senate council will:

i. appoint a clinical review team, this may be formed by members of the senate, external experts, and / or others with relevant expertise. It will appoint a chair or lead member.
ii. endorse the terms of reference, timetable and methodology for the review
iii. consider the review recommendations and report (and may wish to make further recommendations)
iv. provide suitable support to the team and
v. submit the final report to the sponsoring organisation

Clinical review team will:

i. undertake its review in line the methodology agreed in the terms of reference
ii. follow the report template and provide the sponsoring organisation with a draft report to check for factual inaccuracies.
iii. 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.
iv. keep accurate notes of meetings.

Clinical review team members will undertake to:

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

iv. comply with a confidentiality agreement and not discuss the scope of the review nor 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 materialise during the review.

END

Appendix 4

EVIDENCE PROVIDED FOR THE REVIEW

The CCG and Trust provided the following documentation to the Senate for consideration:

- Leeds proposals for Change: Proposals to engage and consult on the reconfiguration of maternity and neonatal services (and embedded documents)
- Travel impact assessment 17th April 2018
- Letter from specialised commissioning dated December 2017
- Quality Surveillance Programme Peer Review visit dated 9th November 2017
- Yorkshire and the Humber ODN Meeting Report dated 7th March 2016
- Table showing the postcode of where women currently give birth
- Supplementary Paper for the Clinical Senate V5 May 2018
- Additional information in response to questions raised in the 22nd March teleconference