London Clinical Senate

# London Clinical Senate Review

# North Central London Start Well Programme

***Start Well: Ensuring the best care for pregnant women and people, babies, children, young people, and their families***

## London Clinical Senate Council Report

**22nd November 2023**

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# Foreword

On behalf of the London Clinical Senate, we are pleased to share the final report of our review of North Central London's Start Well Programme: *Start Well: Ensuring the best care for pregnant women and people, babies, children, young people, and their families.*

The review panel recognises the extensive work that has informed these proposals. We would like to thank the North Central London team who attended the senate review meeting for their presentation of the proposals in the Pre-Consultation Business Case and answering the panel's questions. We would also like to commend North Central London Integrated Care System's ambition to improve the quality of services at the start of life for its whole population.

We have made several recommendations, some which we anticipate will be addressed as the plans progress: during consultation, after consultation and as the Final Business Case is developed.

We would also like to thank all the review panel members for their contributions in appraising the proposals. Without the time, expertise, and diligence of our review members it would not have been possible to produce this report.

Finally, a big thank you to Professor Geeta Menon, Vice Chair of the Senate Council and the Senate management team of Emily Webster and Gillian Foreshew.

**Dr Mike Gill**

**Chair London Clinical Senate**

**Dr David Parkins**

**London Clinical Senate Council Member**

# 1. EXECUTIVE SUMMARY

The London Clinical Senate review panel commends North Central London Integrated Care Board (ICB) for the work, engagement, and proposals to improve services for families, babies, and children. The opportunity to give children and their families the best start in life is vitally important and provides an opportunity to address inequalities of provision and outcomes.

The panel considered the proposals given the changing demographics in North Central London and the ambition for quality improvement within the context of staffing pressures. They considered two key questions:

**1) Is the case for change supported by evidence and best practice guidance?**

**2) Are the changes proposed supported by evidence and best practice guidance to improve the quality and outcomes for the population served?**

The panel concluded that the case for change was supported by evidence and best practice guidance. There was a clear articulation of the drivers for change and strong ambition for improvement which was informed by national policy and best practice guidance.

They considered that proposals to consolidate services on fewer sites could provide opportunities to improve the quality of care and outcomes for the population as well as the potential to better manage staffing pressures. The panel noted that whilst workforce is a key driver for change, it is also a key enabler in offering and promoting choice to provide a high-quality service for all.

The review panel therefore recommends continued attention to workforce planning, further evidencing demand and capacity mapping, and detailing the specific service improvements aims across the Integrated Care System (ICS). These will be important to assure the ambitions are met as the business case iterates.

The recommendations and the discussion which informed them are detailed in this report, with many applying to the Pre-Consultation Business Case (PCBC) and others at subsequent planning stages.

# 2. KEY RECOMMENDATIONS

**London Clinical Senate Review**
**Start Well Recommendations**

## A) VISION AND CASE FOR CHANGE

R1. The Case for Change is clearly articulated; it could be strengthened further to emphasise why the status quo is likely to be unsustainable and to describe how the proposals provide greater opportunities for improvement.

R2. Improvements to quality and safety are clear drivers of the case for change and would benefit from greater specificity; there may be opportunities to co-produce these with public and patients. It is important that they are regularly tracked and monitored, including to alert to and facilitate the mitigation of unintended consequences.

R3. There are several quality and safety improvement projects that are in progress alongside the proposed service reconfiguration e.g., addressing variation in stillbirth rates and improving access to perinatal mental health care. Clearly referencing these as aligned but independent pieces of work would add clarity.

*Outcomes & Equity*

R4. The PCBC and discussion on the day emphasised that the proposed changes would improve service provision and outcomes for the whole population, with focussed improvement on the most vulnerable groups and communities. This could be articulated more fully in the PCBC and the Decision-Making Business Case (DMBC):

- Further describe how access will be improved for all populations e.g., more care and assessment being provided closer to home (community or virtual); integration with place-based services including primary care and pre-natal, post-natal and health visiting, pre-surgery, post-surgery.
- Provide further specificity on how inequities and inequalities will be positively addressed for the most vulnerable populations e.g., prioritising continuity of care and local access.

R5. Continue work on the Integrated Impact Assessment to ensure that where access to care is negatively impacted by the proposed changes, specific mitigating actions are clearly articulated. For example, timely presentation and transport issues and costs for the populations potentially most disadvantaged, particularly CORE20plus and those with protected characteristics.

*Workforce*

R6. There is potential to explore and describe further North Central London's role as an anchor institution with possibility of recruiting, developing, and educating people from local communities.

R7. Organisational development (OD) work during the consultation and implementation phase can help to ensure that staff contribute to and strengthen plans throughout the change

process, that their wellbeing is supported, and the risk of attrition is reduced. Illustrating links to the NCL People Plan, and associated OD is likely to support this.

R8. Further describe how continued liaison with education providers and staff while the changes are implemented will maintain continuity of training and optimise opportunities to further improve skills and experience.

R9. Continue to develop thinking on workforce: opportunities exist aligned to the *Long Term Workforce Plan* (2023), new roles, new ways of working, and lead employer contracts. Ensure effective dovetailing between funding recently made available to meet standards as well as investment aligned specifically to Start Well.

*Estates & Environmental Sustainability*

R10. The midwifery and neonatal integrated impact assessment includes sustainability. There is opportunity to build on this to specify how the proposals will further all NHS providers to improve environmental sustainability and net zero. This aligns to the role as an anchor institution, community models and digital opportunity.

*Data & Digital*

R11. Ensure that improving data quality in maternity and supporting digital alignment (e.g., integration with other information systems and move to a single records system) are prioritised. This should support the proposals and enable implementation of different care models and specialist outreach. It should also include mitigations for digitally excluded populations.

**B) COMMUNICATIONS AND ENGAGEMENT**

*Patient & Public Engagement*

R12. The PCBC is clear on the ambition to work with more disadvantaged and deprived populations. It is important that the communication plan demonstrates multi channelled and sustained communication on what might be different or is different, and why.

R13. During implementation there should be opportunities for service users to co-design and influence the way services are delivered at Place and Neighbourhood level (with their linkages to Primary Care, Community Services, Schools, and Social Care). Some of the priorities are articulated in the Three-Year Delivery Plan for maternity and neonatal services.

*Communication with clinicians and wider stakeholders*

R14. Ensure that there is connectivity between risk registers held at ICS level and provider level, which inform the proposals and monitor the transition and early years of implementation to provide assurance that ambitions are met, and unintended consequences are rapidly highlighted for mitigating action.

R15. A different provider configuration could disrupt established relationships with local authorities and their teams e.g., Health Visiting and Children and Young People's health. It would be helpful to reference plans for approach during implementation.

## C) MATERNITY AND NEONATAL

*Activity and Capacity*

R16. Provide further detail on the methodology and confidence of changed activity flows for the potential scenarios A and B.

*Patient Flows*

R17. Continue engagement with neighbouring ICBs and trusts where proposed changes might impact on flows, namely at St Mary's, Northwick Park and Homerton but wider as necessary. Outline the additional activity flows for receiving trusts in each potential scenario and what would be required to effectively serve patients e.g., facilities and staffing.

R18. Include details of in-utero transfers, transfer rates and repatriation pathways within the PCBC demonstrating the safety considerations that have informed the pathway and proposal.

*Facilities*

R 19. Include detail on birthing facilities within each site, and the anticipated additional facilities required based on the projected activity associated with scenarios A and B. The panel understands this has commenced but it was not included in the PCBC which was shared.

R 20. There are opportunities within both options A and B for keeping mothers and babies together, provide care at home for moderate to late preterm infants i.e., home NGT feeding, phototherapy services and virtual hospital at home. Provide additional detail in the modelling of all neonatal cot numbers, including transitional care cots, family integrated facilities and neonatal community outreach facilities to demonstrate potential quality and safety improvements.

*Service model/ patient pathway*

R21. Include an indication of the likely patient pathway in relation to all sites under the proposed scenarios and including the proposed closed site. Clarify:

- Where antenatal and post-natal facilities will be available including high risk clinics, scanning, and screening.
- The implications for other services e.g., Emergency Department presentations if Early Pregnancy Assessment Units close.

R22. Further articulate the opportunities enabled by the collaborative model between primary, community, and hospital care and services that would become available in the community e.g., phototherapy and postpartum care - (See R4).

*Workforce*

R23. Further develop and respond to the clinical co dependencies and workforce implications as stated in Figure 20 of the PCBC:

- Decoupling the obstetric workforce from the gynaecology workforce on emergency presentations and the impact on the workforce who might continue to work across both specialities.
- Workforce distribution to achieve safe and sustainable services.

- Impact on wider services such as imaging, specialist nurses and pathology.

## D) EDGWARE BIRTH CENTRE

R24. Ensure that the total service demand is reflected in the PCBC include the number of times people were booked to birth at the Edgware Birth Centre but were redirected due to staffing/ capacity issues.

R25. The closure of the birthing suites at the Edgware Birth Centre would release resources. Ensure there is a clear read across as to how investment will improve quality of provision and realise the greater equity of outcomes. For example, services for high-risk pregnancies and increasing the support available to vulnerable communities.

R26. Clearly articulate how choice (midwifery led centre, home births, obstetric unit) will be enhanced by the service changes particularly for those communities most affected by the change, either through service location or other vulnerabilities and inequalities.

R27. Strengthen proposals to ensure that choice for low-risk women and birthing people is maximised. Demonstrate how choice for people with low-risk pregnancies will be promoted, how opportunities for home births will be enabled and promoted, and how a home from home environment in birth settings might be further developed through facilities available e.g., birthing pools and cultural environment.

R28. Consider strengthening the language around choice for maternity and neonatal care, not only in relation to the Edgware Birth Centre but to the full range of options. The importance of language was a key theme shared from the engagement work to date.

## E) PAEDIATRIC SURGERY

*Model and Pathway*

R29. Describe any mitigations regarding capacity pressures on Great Ormond Street Hospital (GOSH) recognising the wider role GOSH provides as a specialist provider for all of London and surrounds. This should mitigate potential unintended impact for other children relying on GOSH who live outside NCL.

R30. Including greater specificity in patient pathways defining the conditions that would go to Great Ormond Street Hospital and University College London Hospital would be helpful.

*Workforce*

R31. Further detail on the processes and activity levels to ensure the expertise and experience of workforce in the district general hospital (DGH) areas is maintained, particularly around immediate airway management, and emergency and elective paediatric surgery (for older children).

R32. Increasing specialisation and training may affect the future workforce competences required to manage other surgical conditions in children in their local hospitals. Further detail would be helpful on how the plans will mitigate this risk and maintain and sustain sufficient paediatric surgical expertise on all hospital sites in the future.

R33. Describe further the educational opportunities the planned changes can provide, recognising that the London region is a major training provider. Work with educators and trainees to secure best training opportunities from the changes needs to continue.

R34. Explore opportunities for common continuing professional development (CPD) and training arrangements across Trusts alongside consideration of rotations and joint appointments.

R35. Describe further how alternative options e.g., surgeons, anaesthetists, nurses, AHPs and other healthcare professionals rotating and upskilling at other centres have been explored to ensure that all opportunities have been considered and maximised.

*Population impact and improvements*

R36. Further describe how the *North Central London Population and Integration Strategy* underpins and interfaces with the proposed improved clinical outcomes of children's surgery. Indicate how clinical outcomes and overall system children population improvement will be tracked, measured, and monitored.

R37. Include further detail on the communication strategy with NCL residents about the new model and pathway, particularly focussing messaging and communications regarding babies and young children requiring the most complex care. There may be an inclination to try and bypass the DGH and go direct - for reasons of seeking direct access and costs of transport which would be counterproductive.

# 3. CONTEXT TO THE REVIEW

In 2021 the North Central London Integrated Care System, co-sponsored by NHS England Specialised Commissioning (London), began working on the Start Well programme. This was initiated to understand if, as a system, they were:

- Delivering the best services to meet the needs of children, young people, pregnant people, and babies.
- Learning from, and responding to, national and international best practice, clinical standards, and guidelines
- Reducing inequalities in provision and health outcomes[1].

A case for change was published in June 2022, which set out opportunities for improvement in maternity and neonatal services and children and young people's services. Public engagement took place over the summer of 2022, and the themes from this were published in September 2022. Clinical engagement took place over this period to consider the feedback.

In November 2022 (with a short update in March 2023), the North Central London Integrated Care Board agreed several recommendations and agreed to proceed to an options appraisal for proposed future care models for maternity, neonates and children and young people's surgery (planned and emergency).

The options appraisal process, with clinical and patient involvement, commenced in December 2022 and culminated in an options appraisal workshop in May 2023; the outputs of which have been put together into two Pre-Consultation Business Cases (PCBC). One covering Maternity and Neonatal services with an appendix covering the Edgware Birth Centre and the other covering Paediatric Surgery. The Clinical Senate were asked to review the clinical aspects of proposals, namely:

- The options for having four obstetric led birthing units co-located with four neonatal units (three of which will be level 2 and one will be level 3), instead of the current five. This excludes the specialist Neonatal Intensive Care Unit at Great Ormond Street Hospital.
- The option of no longer having a stand-alone midwifery unit at Edgware.
- Surgical activity for low volume specialties and very young children to be consolidated into a centre or centres of expertise.

[1] Extracted from background within the review Terms of Reference document.

# 4. APPROACH TO THE REVIEW

The review was undertaken by the London Clinical Senate and chaired between Dr Mike Gill, Chair of the London Clinical Senate and Dr David Parkins, London Clinical Senate Council member.

Representatives from the London Clinical Senate and North Central London discussed the scope of the review and agreed the approach in a Terms of Reference document (Appendix G).

The Clinical Senate reviewed the draft PCBC in advance of submission of the final PCBC to NHS England in accordance with the major service change assurance processes.

The Clinical Senate were asked to pay particular attention to the following questions:

1. Is the case for change supported by evidence and best practice guidance?
2. Are the changes proposed supported by evidence and best practice

In accordance with the agreed timeline, the draft PCBCs were provided to the Clinical Senate on Monday 3 July 2023.

To ensure an independent panel with a breadth of experience, representatives for the panel were invited from the London Clinical Senate Council as well as subject matter experts from within London and beyond.

All panel invitees were asked to sign a confidentiality agreement and declare their interests; members considered conflicted did not contribute to the review. Whilst most review panel members were able to attend on the day, some were unable due to unforeseen circumstances. Provision was made for these review panel members to contribute electronically (Appendix D).

As noted above, the chairing of the panel was shared between Dr Mike Gill, who chaired the introduction and children's surgery and Dr David Parkins who chaired the Maternity and Neonatal section supported by Emily Webster, London Clinical Senate Senior Programme Manager. This was in recognition of Mike Gill's potential conflict of interests in any discussion regarding Maternity and Neonatal. He is a non-Executive Director of the Homerton Healthcare NHS Foundation Trust, and patient flows to this trust are potentially impacted by one of the proposals. To maintain transparency and impartiality, Mike Gill did not take part in the discussion during the review or later in the day when the review team discussed any recommendations and Dr David Parkins and Professor Geeta Menon (London Clinical Senate Council Vice Chair) provided the sign off for this section of the report.

Council Members Sanjiv Sharma and Mike Greenberg were active members of the NCL Programme team and therefore did not participate in any Council discussions and approval of the review content.

Upon receipt of draft PCBCs as well as other supporting documentation from North Central London (Appendix C), draft Key Lines of Enquiry (KLOE) (Appendix A) were produced by the Senate team. These were developed with reference to the London Clinical Senate Principles and the 5 NHS key tests for changes, as outlined in the Terms of Reference.

The KLOEs were discussed in a panel pre-meet on 3rd July, with subject matter experts commenting and enriching the KLOEs to facilitate a rounded exploration. They were then shared with North Central London colleagues who responded to these in their presentation and during the review panel.

The review was held via Microsoft Teams on 12th July 2023. The review was split into several sessions, with the format being a presentation from representatives of North Central London ICB followed by questions from the review panel, and finally an opportunity for the review panel to deliberate and draw together its conclusions (Appendix B).

# 5. FINDINGS OF THE SENATE REVIEW PANEL

This Senate report follows the structure of the Senate review panel day: firstly, considering the overarching programme and then exploring the specific proposals in turn: Vision and Case for Change, Maternity and Neonatal including Edgware Birth Centre and Paediatric surgery.

An outline of the proposal is given before reflecting the panel's discussion and exploration. The recommendations are included in the relevant sections of the report.

# 6. VISION AND CASE FOR CHANGE

The Start Well case for change considers changes across three key areas: maternity, neonatal and children, and young people's services.

It has been grounded within the population health strategy of the NCL ICB and informed by engagement with public and health care professionals.

The proposed benefits or opportunities for improvement from the maternity and neonatal care model are described as:

- **Equality-** equality of access to maternity services with care delivered in the community or virtually where possible.
- **Training and development opportunities**- supporting training and development opportunities for staff through delivering sustainable volumes of neonatal activity at all neonatal units.
- **Clinically sustainable services-** ensuring all units are a designated Local Neonatal Unit or Neonatal Intensive Care Unit.
- **Environment-** ensuring all units are in fit for purpose facilities and are designed to provide a positive birth experience.
- **Capacity-** investing in capacity for neonatal and maternity services to ensure that there is enough capacity available so that units are running at less than the 80% recommended occupancy rate[2].

The Start Well case for change identified opportunities for improvement for children and young people's service are described as:

- Reducing long waits for elective care.
- Improving transition to adult services.
- Recruitment and retention of the paediatric workforce.

[2] Informed by NCL Start Well. Start Well Clinical Senate Review meeting. Slide pack Wednesday 12 July 2023. Slide 29. Aligned to Neonatal Service Specification ambition of 80% occupancy https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/01/e08-serv-spec-neonatal-critical.pdf

- Meet national recommendations for the environment of paediatric surgical care.
- Meeting the increasing demand for emergency care.
- Improving long-term conditions management.
- Organisation of paediatric surgical care[3].

The panel were assured that the proposed changes are directly informed by national quality standards and their interpretation and application to the needs of the NCL population.

The high-level proposals in the case for change are:

- Reduce maternity and neonatal services locations to 4 from 5.
- Close the standalone midwifery led birthing suites at Edgware Birth Centre.
- Consolidate paediatric surgical services across NCL to Great Ormond Street Hospital and University College London Hospital.

The review panel observed that whilst there is a strong case for change, the challenges experienced in NCL (e.g., workforce and estates) are also challenges elsewhere in the country. Given this, they recommend that the rationale as to why the current circumstances and configuration would not be sufficient in the future are clearly stated, including and strengthening the argument as to why such a substantial service reconfiguration is the most appropriate response.

**Recommendation 1.** The Case for Change is clearly articulated; it could be strengthened further to emphasise why the status quo is likely to be unsustainable and to describe how the proposals provide greater opportunities for improvement.

Extensive work has been undertaken to present a considered, detailed, and persuasive case for change. There are also opportunities to provide greater specificity on the improvements that would be seen from a patient perspective. The patient pathways provided as part of the review pack documentation begins to articulate this and could be further strengthened with additional detail.

**Recommendation 2.** Improvements to quality and safety are clear drivers of the case for change and would benefit from greater specificity; there may be opportunities to co-produce these with public and patients. It is important that they are regularly tracked and monitored, including to alert to and facilitate the mitigation of unintended consequences.

The panel also noted that there are areas included in the PCBC relevant to quality and safety of maternity services, which are being addressed through aligned projects. For example, addressing variation in still birth rates, particularly the higher stillbirth rate in Haringey and variation in perinatal mental health care. It would be helpful if this were more explicitly detailed in the PCBC.

[3] Informed by NCL Start Well. Start Well Clinical Senate Review meeting. Slide pack Wednesday 12 July 2023. Slide 39

**Recommendation 3.** There are several quality and safety improvement projects that are in progress alongside the proposed service reconfiguration e.g., addressing variation in stillbirth rates and improving access to perinatal mental health care. Clearly referencing these as aligned but independent pieces of work would add clarity.

Finally, during the presentation and verbally during the review, further information was provided to the panel. Some of this information has been extracted and referenced in the report, and the senate panel recommends that this is incorporated into the PCBC to strengthen it.

## 6.1 Outcomes and equity

Representatives from NCL effectively articulated the local population demographics at the meeting. They demonstrated a clear and detailed understanding about the significant inequalities that exist across their population and the ICB commitment to addressing these was clear.

NCL consider that the reconfiguration has the potential to contribute to a wider population health approach for addressing health inequalities. The panel heard their ambition to develop a core offer and level up in deprived areas. Examples where this had taken place in other service areas were given e.g., mental health.

The premise of the reconfiguration proposals is that ready access and a consistent offer of maternity services across NCL are key to addressing inequalities by equitably embedding safe services and providing opportunities to provide care closer to people's homes including continuity of care.

However, some of the proposals move secondary care services away from those areas in NCL where there are inequalities and deprivation; fewer centres less close to home could make access more difficult for some families unless this is counterbalanced with an improved community offer.

An Integrated Impact Assessment (IIA) is in progress and NCL are working through some of the mitigations needed. Areas that the panel noted would require particular attention are:

- Travel times- including the impact of timing of appointments and time off work.
- Travel costs- considering applicable congestion charge and Ultra-low emission zone charge- including promotion of reimbursement arrangements for applicable groups. The panel also reflected on the *Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK* (MBRRACE) reports, noting that the early postnatal period is a particular risk period for maternal morbidity and mortality, with deprived populations being at higher risk. They endorsed the ambition in NCL to continue current arrangements for post-natal care whilst prioritising continuity in the post-natal period for those at risk of adverse outcomes.

The panel supported that where possible services should be provided close to home and in the community. The Panel noted that the London geography compared to the rest of the country meant that travel times were comparatively shorter and different public transport routes were available, though these were comparatively more expensive.

Effective delivery of the reconfiguration will require interfaces between multiple teams to work together to deliver an integrated service with enhanced outcomes. This will involve effective distribution of staff to provide skilled support focussing particularly on people with protected characteristics e.g., minority ethnic backgrounds, disabilities, and socially vulnerable groups. Effective implementation may benefit from additional codesign.

Wider experience of managing integrated pathways was shared by NCL verbally, this included:

- Mature relationships across clinical leadership within NCL with the development of integrated care in a range of areas across the ICB.
- Virtual wards demonstrating pre-hospital integration with potential applicability in utilisation in maternity, neonatal and paediatric services.
- Well established Local Maternity and Neonatal Network (LMNS) which has input into Start Well and teams supporting each other through industrial action.
- Nursing and midwifery working to the published People Strategy which focuses on the concept of one workforce.
- The role of Family Integrated Care is developing / being embedded in the neonatal service and is supported by care co-ordinators, which this is an area of focus nationally, regionally and at Local Maternity and Neonatal Service level.

The senate review panel considered that there was sound knowledge, infrastructure, and approach to improve outcomes for all and to address inequalities. They recommend reference to this within the PCBC as well as providing increased granularity about how the opportunities to address inequality of outcomes can be maximised.

**Recommendation 4**. The PCBC and discussion on the day emphasised that the proposed changes would improve service provision and outcomes for the whole population, with focussed improvement on the most vulnerable groups and communities. This could be articulated more fully in the PCBC and the Decision-Making Business Case (DMBC):

- Further describe how access will be improved for all populations e.g., more care and assessment being provided closer to home (community or virtual); integration with place-based services including primary care and pre-natal, post-natal and health visiting, pre-surgery, post-surgery.

- Provide further specificity on how inequities and inequalities will be positively addressed for the most vulnerable populations e.g., prioritising continuity of care and local access.

**Recommendation 5.** Continue work on the Integrated Impact Assessment to ensure that where access to care is negatively impacted by the proposed changes, specific mitigating actions are clearly articulated. For example, timely presentation and transport issues and costs for the populations potentially most disadvantaged, (particularly CORE20plus and those with protected characteristics.

## 6.2 Workforce

Workforce is a driver for change. The PCBC proposes consolidating staff on a fewer number of sites to maintain safe, equitable staffing levels and service quality. However, workforce is also an enabler of change as appropriately trained staff will be critical to ensuring that the proposed new models can maintain and promote choice, particularly around birthing and birthing locations.

The panel observed that the changes have the potential to be more attractive to clinical staff, as they seek to resolve some longstanding difficulties of under resourcing; a pattern of which is replicated across the country. They also noted positive aligned work underway in NCL[4].

A service reconfiguration of this scale has significant workforce implications, the opportunities for which are outlined within the PCBC. The operationalisation of changes to maternity, neonatal and paediatric surgery are likely to involve redistribution of staff to other units within NCL, which can be unsettling and create uncertainty as the proposals are developed and consulted upon. This does present risk in a context where retaining clinical staff with cost of living and transport costs is difficult, and there is a current staffing shortfall across the ICB.

The review panel considered the implementation of an effective Workforce and Organisational Development (OD) strategy would be fundamental to the success proposals. The programme team are encouraged to consider the 6 high impact actions in recently published *NHS equality, diversity, and inclusion improvement plan* (June 2023) when addressing this.

Recommendations which cross cut all proposed changes are provided below, and service specific workforce issues pertaining to parts of the maternity, neonatal and paediatric proposals are addressed in the relevant sections of this report (see 8.7 and 10.2).

[4] See section 8.3 in this review for further detail.

**Recommendation 6.** There is potential to explore and describe further North Central London's role as an anchor institution with possibility of recruiting, developing, and educating people from local communities.

**Recommendation 7.** Organisational development (OD) work during the consultation and implementation phase can help to ensure that staff contribute to and strengthen plans throughout the change process, that their wellbeing is supported, and the risk of attrition is reduced. Illustrating links to the NCL people plan, and associated OD is likely to support this.

**Recommendation 8.** Further describe how continued liaison with education providers and staff while the changes are implemented will maintain continuity of training and optimise opportunities to further improve skills and experience.

**Recommendation 9.** Continue to develop thinking on workforce: opportunities exist aligned to the *Long Term Workforce Plan* (2023), new roles, new ways of working, and lead employer contracts. Ensure effective dovetailing between funding recently made available to meet standards as well as investment aligned specifically to Start Well.

## 6.3 Estates and environmental sustainability

The proposals acknowledge that some of the estates across NCL fall short of modern standards. Reference is made to the need to improve maternity and neonatal facilities at the Whittington hospital site to provide ensuite facilities, space around neonatal intensive care cots and lack of space for parents and carers. It is anticipated that investment is required in other elements of the estate, the detail of which was being worked up at the time the panel completed the review.

Paediatric surgical sites are also not uniformly able to provide dedicated paediatric theatres or child-friendly environments. Only University College London Hospital (UCLH) and Great Ormond Street Hospital (GOSH) provide dedicated paediatric lists, dedicated paediatric theatres and paediatric recovery areas; Barnet hospital, Royal Free hospital and Whittington hospital do not have dedicated paediatric theatres or recovery areas which is in part driven by the low volumes of planned activity and pressures of managing adult surgery[5]. Consequently, some sites are struggling to manage their activity or are having to manage activity in a way that does not meet best practice guidance. There are also productivity implications for Trusts; dedicated paediatric lists provide opportunities to improve efficiencies of planned surgery[6].

The Edgware Birth Centre is considered fit for purpose as a birthing facility from an estates perspective. The case for change proposes maximising activity by no longer

[5] Paediatric Surgery Pre-Consultation Business Case. 2 Case for Change. Section 3.4 p35
[6] Paediatric Surgery Pre Consultation Business Case. 2 Case for Change. p6

offering it as a birthing facility but maintaining and expanding antenatal and postnatal care.

The panel were persuaded that there was a clear driver to reconfigure services to enable care to be provided in the most optimal way to meet national standards and improve patient experience. The panel noted NCL's inclusion of sustainability in the integrated impact assessment against the domains of:

- Carbon impact and protected air quality
- Building carbon impact
- Anchor institution[7]

This inclusion is important and commended, with the potential to build on this as the work progresses.

**Recommendation 10.** The midwifery and neonatal integrated impact assessment includes sustainability. There is opportunity to build on this to specify how the proposals will further all NHS providers to improve environmental sustainability and net zero. This aligns to the role as an anchor institution, community models and digital opportunity.

## 6.4 Data and digital

There was discussion at the panel meeting about the digital elements to the programme; the panel considered that further information on digital alignment and strategy would be helpful as a key enabler to the reconfiguration ambitions.

The panel were advised that different maternity information systems are in place across the NCL trusts and that data quality is a recognised issue. The Local Maternity and Neonatal System (LMNS) has a digital lead midwife who is supporting improvements around digital for units including data quality and information sharing across the patch.

There may be opportunities to align local apps e.g., Mother and Baby App to the wider NHS App. NCL are encouraged to explore and define the opportunities associated with this.

Wider input from the ICB and trusts to ensure that maternity priorities are addressed in the digital space, would enhance the potential benefits of reconfiguration.

**Recommendation 11.** Ensure that improving data quality in maternity and supporting digital alignment (e.g., integration with other information systems and move to a single records system) are prioritised. This should support the proposals

[7] Maternity and Neonatal Pre-Consultation Business case. Section 6.6 Sustainability p100

and enable implementation of different care models and specialist outreach. It should also include mitigations for digitally excluded populations.

# 7. COMMUNICATIONS AND ENGAGEMENT

The communications and engagement of this programme is commended by the London Clinical Senate.

The case for change has been underpinned by a 2-year process of systematic engagement, which has enabled it to be informed by soft intelligence and co-production. The model pathways included as part of the pack of resources are helpful in articulating the proposals.

The panel heard that engagement on the case for change over the summer of 2022 had shown that 75% agreed or strongly agreed with opportunities for improvement.

Methods of engagement undertaken by the programme team include:

- Clinical reference group
- Patient and Public Engagement Group including Maternity Voice Partners
- Youth Summits- particularly for Paediatric proposals including role play of opportunities for improvement, TikTok style videos have informed care models. Reverse youth mentoring- with some site visits.

## 7.1 Patient and Public Engagement

The panel were pleased to welcome the chair of Patient and Public Engagement Group (PPEG) to the review meeting and discuss the role of the group, its impact and further potential.

The panel were advised that there had been transparency and open sharing of information, with the PPEG tasked with the evaluation of the access criteria in the options appraisal.

The following feedback and learning from the group was shared:

- There was public appetite to travel for planned care but not for urgent care.
- People want to be supported to have maternal choice but expressed a desire to have quick access to specialist care should it be required.
- During engagement events, the main concern was maternity with a focus on communication including patients where English is not first language. The importance of constructive and positive language was also expressed e.g., preference for the word “onward care” to discharge.
- For many people, navigating the healthcare system should include more support.

The panel considered that while there was positive evidence of co-production, there should be continued exploration as to how representative the group was and how it might be strengthened. The chair and other members of the NCL team conveyed that there had been challenges in finding people able to give the time required, hence a significant effort had been made to reach different people, providing opportunities for individuals who had contributed to a group setting to join the PPEG. Going forward, new people with wider representation and fresh perspectives were considered important to build on these solid foundations.

The panel encourage NCL to build and extend on this input in future phases of the proposals, considering the feedback regarding the importance of communication and language, and connecting this back to work regarding addressing issues arising from the Inequalities Impact Assessment.

**Recommendation 12.** The PCBC is clear on the ambition to work with more disadvantaged and deprived populations. It is important that the communication plan demonstrates multi channelled and sustained communication on what might be different or is different, and why.

**Recommendation 13.** During implementation there should be opportunities for service users to co-design and influence the way services are delivered at Place and Neighbourhood level (with their linkages to Primary Care, Community Services, Schools, and Social Care). Some of the priorities are articulated in the *Three-Year Delivery Plan for maternity and neonatal services.*

## 7.2 Communication with clinicians and wider stakeholders

There has been effective engagement within NCL led by the Clinical Reference Group to develop the proposed model, which is well positioned within the wider ICB ambitions. There is also attendance from neighbouring ICBs and regions on the Start Well programme board to ensure implications for patients flows into and out of NCL are considered.

The panel also explored consideration impact on trainees and understood that this was via the deaneries as well as general staff engagement on specialities. Trainees have been part of the engagement process particularly anaesthetics, obstetrics, gynaecology and paediatrics and the programme team are also exploring the planning of rotations with them. NCL advised training could be improved through the process and the panel recommend articulating this.

The foundation of communication is strong. Areas that the panel identified would benefit from further attention as the programme progresses, are detailed below:

- It is essential to continue communication with neighbouring trusts and services that might be impacted by cross boundary flows. This is particularly

the case for maternity and neonatal care and is explored in greater detail in this section of the report.

- Changes in provision can have unintended consequences upon provider sustainability and local services e.g., closure of a maternity department may impact the sustainability of a Trust or a specific service where there are co-dependencies. Risk registers are clearly referenced within the PCBC. It will be important that this work is supported by effective communication across the constituent organisations, with space for their discussion and action as appropriate.

**Recommendation 14.** Ensure that there is connectivity between risk registers held at ICS level and provider level, which inform the proposals and monitor the transition and early years of implementation to provide assurance that ambitions are met, and unintended consequences are rapidly highlighted for mitigating action.

**Recommendation 15.** A different provider configuration could disrupt established relationships with local authorities and their teams e.g., Health Visiting and Children and Young People's health. It would be helpful to reference plans for approach during implementation.

# 8.0 MATERNITY AND NEONATAL

## 8.1 Case for change and opportunities for improvement

The case for change and opportunities for maternity and neonatal care were logical and clearly presented by the review panel. There are clear contexts to the proposals, which are consistent with national drivers, including:

- *NHS Long term plan*- developing maternity and neonatal services alongside interdependent services for children and young people.
- *Ockenden report,* December 2020 and March 2022- urgent and sustainable maternity wide workforce plan.
- *Better Births*, February 2012 - safer, more personalised, kinder, and family friendly.
- *Neonatal Critical Care review*- need to ensure that neonatal services are set up to meet challenges of current and future standards of care.

These national drivers have been considered in the context of the local drivers, particularly demographic changes, population health opportunities to progress equity of outcomes and temporary changes during the pandemic. For example:

- *The number of live births in NCL has been declining across all boroughs. There are more children being born within the more deprived areas of NCL. Between 2018 and 2020, there were more than three times as many births in*

*the 20% most deprived areas compared to the 20% least deprived areas. Over half of all births in NCL in 2019/20 were in the 40% most deprived areas.*

- *Matching neonatal care capacity and demand: neonatal units in NCL, particularly the NICU (level 3) units are at capacity and frequently occupied more than the recommended 80%, and in some months at 100% occupancy. This results in babies having to go to NICU (level 3) units outside of NCL.*

- *Considering the sustainability of the Royal Free Hospital SCU (level 1) unit: Royal Free Hospital neonatal unit looks after fewer babies compared to the other units in NCL and does not accept babies born under 34 weeks' gestation. The number of admissions into this unit has been declining by 12% every year since 2018/19 and the occupancy of the unit in 2021/22 was 37%, meaning over half of its cots were not occupied on any given day.*

- *Minimising avoidable admissions to neonatal units: access to neonatal outreach programmes depends on where you live in NCL. The existing provision is inconsistent between NCL boroughs and does not represent equitable access. For example, in Islington, phototherapy (used for the treatment for jaundice) is available in the community whereas for babies living elsewhere, they would likely have to stay in hospital for treatment*[8]*.*

The drivers have been effectively discussed with public and clinicians to develop a local case for change, which is summarised as:

- Ensuring equality in maternity service provision and experience.
- Better utilisation of maternity capacity offered in NCL.
- Supporting maternity workforce sustainability.
- Matching neonatal care capacity and demand.
- Minimising avoidable admissions to neonatal units.
- Considering the sustainability of the Royal Free Hospital SCU (level 1) unit.
- Addressing workforce vacancies and variation in access to Allied Health Professionals (AHPs) across neonatal units.
- Considering the sustainability of Edgware Birth Centre.
- Having the right maternity and neonatal estate[9].

The review panel concurred that action was needed to ensure the ongoing quality and sustainability of maternity and neonatal services. They also considered including a rationale as to why the current circumstances and configuration would not be sufficient in the future, would further strengthen the case (see R1).

[8] Case for Change, p7

[9] Pre-Consultation Business Case, Maternity and Neonatal. Section 2 Case for Change. Extracted from pages 6-7

The PCBC provides a good account as to the ways in which many of these ambitions can be met through the proposals put forward. However, the panel also considered some additional detail would be important to enable a fuller understanding of the options, their implications and to further specify benefits. For example: how will resources be redirected to better support Core 20 populations to enable greater equality in maternity service provision and experience? And how will the maternity and neonatal estate be impacted and improved through the plans? The specifics of these are addressed under the relevant sections of the report.

## 8.2 Proposals and option appraisal

The maternity and neonatal care models proposed are consistent with *Getting it Right First Time* (GIRFT) recommendations, where effective relationships and joint working across neonatology, obstetrics and maternity deliver the best outcomes for babies.

The proposals articulate and evidence that whilst there is sufficient activity in NCL to just sustain 5 Local Neonatal Units, current staffing levels mean it is only possible to maintain 4 Local Neonatal Units.

This was considered a realistic assessment by the panel in view of the national staffing context. However, they also stressed ongoing attention to the workforce strategy and organisational development were imperative to the success of the proposals.

Specifically, the PCBC proposes there should be:

- Four obstetric led birthing units with alongside midwifery led units and co-located with four neonatal units (one level 3 and three level 2).

The level 3 unit at University College London Hospital (UCLH) was treated as a fixed point and the specialist Neonatal Critical Care Unit (level 3) at Great Ormond Street Hospital (GOSH) was out of scope of the proposals.

If implemented, this would result in the closure of a consultant led obstetric unit, alongside a midwife led unit and co-located Neonatal Unit.

The panel considered that the PCBC was thorough in its assessment of the options. UCLH and GOSH were taken as fixed points for neonatal given that they provide level 3 Neonatal Care. This is a logical placing of the level 3 units, from which assessment of the four remaining hospital sites against 3 overarching criteria flows[10]:

- Quality of care: Activity outflows
- Workforce: Implementation and delivery/ Training opportunities
- Access to care: Average and maximum travel time/ Core 20 Average and maximum travel time/ General accessibility to care.

[10] Maternity and Neonatal Pre-Consultation Business Case. Section 5.13. Options for consultation Figure 63 (page 92).

The PCBC concluded that North Middlesex and Barnet Hospital must remain as closure would lead to significant outflows to non NCL sites that would be unable to take additional activity.

The options under consideration include four maternity and neonatal units, all of which have an obstetric unit and a co-located midwifery-led unit as well as a local neonatal unit (level 2). The two options for consideration were:

- **Option A-** Whittington hospital continues to provide maternity and neonatal care. Maternity and neonatal care is no longer provided at the Royal Free hospital.
- **Option B-** The Royal Free hospital continues to provide maternity and neonatal care (and their neonatal unit is upgraded to a level 2 local neonatal unit). Maternity and neonatal care is no longer provided at Whittington hospital.

For ease of reference, the current service provision and potential options for the future are detailed in the table below:

| **Location** | **Current Maternity Provision** | **Current Neonatal Provision** | **Option A** | **Option B** |
|---|---|---|---|---|
| **Barnet Hospital** (Royal Free London NHS Foundation Trust) | Obstetric led and co located midwifery led unit<br><br>Home Birthing Service | Local neonatal unit (Level 2) | No change | No change |
| **North Middlesex Hospital** (North Middlesex University Hospital NHS Foundation Trust) | Obstetric led and co located midwifery led unit<br><br>Home Birthing Service | Local neonatal unit (Level 2) | No change | No change |
| **Royal Free Hospital** (Royal Free London NHS Foundation Trust) | Obstetric led and co located midwifery led unit<br><br>Home Birthing Service | Special care neonatal unit (Level 1) | **No** Obstetric led and co located midwifery led unit. **No** special care neonatal unit (Level 1) | Consultant led obstetric unit with co located Local Neonatal Unit (level 2) and alongside midwife led unit |
| **Whittington Hospital (**Whitington Health NHS Trust**)** | Obstetric led and co located midwifery led unit<br><br>Home Birthing Service | Local neonatal unit (Level 2) | Consultant-led obstetric unit with co-located LNU (level 2) and alongside midwife-led unit | **No** Obstetric led and co located midwifery led unit<br>**No** Local neonatal unit (Level 2) |
| **University College London Hospital** (University College London Hospital NHS Foundation Trust) | Obstetric led and co located midwifery led unit<br><br>Maternal medicine specialist centre Foetal medicine centre<br><br>Home Birthing Service | Neonatal Intensive care unit (Level 3) | No change | No change |
| **Great Ormond Street Hospital** (Great Ormond Street Hospital for Children NHS Foundation Trust) | | Specialist Neonatal I Intensive care (level 3) | No change | No change |

The senate review panel were assured that appropriate drivers, engagement, and processes had supported the development of the proposal.

The panel commend the Programme team on the thorough option appraisal process, the criteria for which were informed by well evidenced national best practice standards alongside the input of the Patient and Public Engagement Group. There is a balanced, considered approach to the options with the relative merits and disbenefits highlighted.

From a neonatal perspective, the proposals predominantly impact the moderate to late preterm infants with proposals A and B enabling different models of care provision to existing neonatal cot occupancy i.e., special cot activity to transitional care cot activity with carer present or provided at home with outreach services.

The maternity and neonatal proposals result in the movement of approximately 2,500 deliveries. This is a significant service reconfiguration and extensive work has been undertaken and continues to be worked on to model and propose how this can be most effectively considered and achieved.

Having been assured of the process, the panel focussed their attention on the detail of the proposals, and this is further explored in the sections that follow.

## 8.3 Activity and capacity

From a maternity perspective, a significant amount of detail on activity and capacity is provided in the options appraisal, where there is a transparency in the assessment of the proposed models against different criteria.

An introduction to this section, would be helpful to orientate the reader and align some of the key messages. This could include:

- The current number of births per site against the current utilisation of units. This would highlight and evidence the statements made elsewhere in the PCBC that for some sites utilisation of their midwifery-led units is around 30% or under, whilst obstetric-led units are under significant pressure.
- Detailing the relationship between the projected demographic changes, and the rationale/ methodology of calculations for current and future activity flows.

Whilst much of the data included in other figures (e.g., in the PCBC Figure 33 includes current deliveries 21/22 and Figure 39 includes future deliveries), extracting the themes as above would provide more ready assurance that all aspects have been covered. It would also support the case for change and strengthen the argument that the status quo is not sustainable in the longer term.

The panel were unable to comment as to whether the projected future need could be met in the proposed locations as detailed implementation plans were contingent on finalising the capital requirements. They welcomed the inclusion of this at further

iterations, noting that associated work is likely to be required to consider interdependencies and to mitigate against unintended consequences.

The review panel explored with NCL the current neonatal activity with reference to cots, occupancy levels and neonatal care days.

During discussion it was articulated that there are currently 123 cots in NCL, with modelling indicating that 126 or 129 cots would be required to serve the current population based on an 80% occupancy rate in line with evidence. This information would, like the maternity data, benefit from being clearly included as part of the introduction to activity.

The panel noted that the levels of occupancy across the ICB in 2022/23 were[11]:

- Barnet: 73%
- North Middlesex: 61%
- Royal Free: around 43%
- University College London Hospital 85% (up to 100% in some instances)
- Whittington: 64%

It was apparent that Royal Free is poorly utilised because of low activity and delivery rates, which are unlikely to increase or be increased. They also noted the respiratory care days and occupancy as detailed in Figure 11 of the PCBC.

The panel recognised a clear case for change and recommended including the current and projected neonatal data for both options (i.e., include Whittington data).

**Recommendation 16.** Provide further detail on the methodology and confidence of changed activity flows for the potential scenarios A and B.

## 8.4 Patient Flows

The panel considered the implications of the proposed models on patient flows from three key areas:

- **Within NCL**: Whether changes could be managed from all perspectives- activity, workforce, facilities, and inequalities.

- **Inflows to NCL**: whether any potential inflow increase would need to be managed.

- **Outflows from NCL:** Whether NWL could manage the additional activity if the Royal Free hospital maternity and neonatal units close and whether NEL could manage activity if Whittington hospital maternity and neonatal units close.

[11] Pre-Consultation Business Case. Maternity and Neonatal. Figure 10 p34

The discussion regarding the NCL flows and implications are woven throughout this report.

The panel noted that inflow numbers were unlikely to materially change given that specialist provider organisations and services were not planned to change.

However, they observed that the outflows to neighbouring ICBs would require consideration.

North Central London recognised that it would be essential to continue with conversations and gain the support of aligned trusts and ICBs to ensure that the impact of plans can be managed from a pan London perspective. The detail of this will require further articulation in the consultation business case.

The panel also explored the impact on neonatal outreach provision, noting that part of the proposal was to roll out community neonatal provision across all NCL boroughs. This is being led through the virtual ward programme and is in place in Islington through the Whittington Health team and roll out has commenced through North Middlesex University Hospital (NMUH) for Enfield.

The review panel concluded that the PCBC would benefit from:

- Further clarity in the modelling of neonatal cot numbers in the case for change and reconfiguration proposals with reference to in utero transfers outside of NCL and repatriation pathways to services closer to home where possible.
- Including further details about potential impacts on transfer rates and how this will be managed for safety.

**Recommendation 17.** Continue engagement with neighbouring ICBs and trusts where proposed changes might impact on flows, namely at St Mary's, Northwick Park and Homerton but wider as necessary. Outline the additional activity flows for receiving trusts in each potential scenario and what would be required to effectively serve patients e.g., facilities and staffing.

**Recommendation 18.** Include details of in utero transfers, transfer rates and repatriation pathways within the PCBC demonstrating the safety considerations that have informed the pathway and proposal.

## 8.5 Facilities

Having the right maternity and neonatal estate is a key driver in the case for change and strongly supported by the panel. Given that at the time of reviewing the PCBC, the full detail of the facilities proposals was not available, the panel focussed on principles within their assessment:

Improvements in facilities are required across the ICB with CQC reports indicating that some facilities are lacking and noted that Whittington Health maternity and neonatal facilities do not meet modern best practice standards. It will be important that future iterations of the business case specify the current facilities available and future proposals e.g., number of types of birthing suites and beds, how a home from home environment can be promoted, and the number and types of cots and their location.

**Recommendation 19.** Include detail on birthing facilities within each site, and the anticipated additional facilities required based on the projected activity associated with scenarios A and B. The panel understands this has commenced but it was not included in the PCBC which was shared.

**Recommendation 20**. There are opportunities within both options A and B for keeping mothers and babies together, provide care at home for moderate to late preterm infants i.e., home NGT feeding, phototherapy services and virtual hospital at home. Further detail in the modelling of all neonatal cot numbers, including transitional care cots, family integrated facilities and neonatal community outreach facilities would be helpful to demonstrate potential quality and safety improvements.

## 8.6 Service model/ patient pathway

The panel welcomed the principles behind the overarching service models and the inclusion of patient pathways as part of the pack of papers that had been provided.

They recommend that these pathways are included in the consultation documents, as they offer a clear illustration of the potential changes. There was a helpful discussion at the panel day which looked at some of the granularity behind the proposals. For example:

- What services will remain at the hospital sites for the closed birthing units?
- How will the high risk and consultant led antenatal clinics for this cohort be provided in the hospital and community?
- How will the Early Pregnancy Assessment Units and triage be provided, and what are the implications for Emergency Departments and patient experience?
- How might the new model be an opportunity to address the Care Quality Commission observations that there can be long waits to assessment, and how can care be most appropriately provided outside of Emergency Departments?
- Further information on scanning and screening facilities.
- Further information on anaesthetics implications.
- The implications for workforce on these pathways considering the new models and new ways of working.

The panel were advised that many pathway questions were being explored through the Clinical Reference Group and the Maternal Medicine Network who have agreed it would be possible to continue with outreach clinics at the site that no longer provided intrapartum care.

They recommend that further consideration of the feasibility of the proposed splitting of gynaecology and obstetric rotas on the site that closes, as well as how interventional radiology can be facilitated to continue is explored by this clinical reference group. Inclusion of this detail will be important to evidence so that the implications have been fully considered, and consequences and risks brought out and managed and this will be an important consideration during any subsequent implementation planning for a preferred option.

Finally, the panel considered that there could be greater articulation of the opportunities enabled through a collaborative model with primary and community care, highlighting the addition of services in the community.

**Recommendation 21.** Include an indication of the likely patient pathway in relation to all sites under the proposed scenarios and including the proposed closed site. Clarify:

- Where antenatal and post-natal facilities will be available including high risk clinics, scanning, and screening.
- The implications for other services e.g., Emergency Department presentations if Early Pregnancy Assessment Units close.

**Recommendation 22**. Further articulate the opportunities enabled by the collaborative model between primary, community, and hospital care and services that would become available in the community e.g., phototherapy and postpartum care (See R4).

## 8.7 Workforce

The PCBC clearly outlines the staffing challenges:

- The Royal College of Obstetricians and Gynaecologists (RCOG) recommendations for labour ward cover is not currently met in Barnet, University College London or Royal Free hospitals based on 2021/2022 delivery numbers.
- There is an ambition to staff neonatal units in NCL according to British Association of Perinatal Medicine (BAPM) which describe the optimum activity and staffing levels for neonatal units to maintain skills and experience of looking after neonates.
- The Operational Delivery Network nursing workforce tool shows significant variation on meeting standards across units.

- There is a shortfall of midwives across the system.
- Workforce shortages are resulting in North Middlesex operating at reduced cot occupancy levels to meet BAPM standards.
- The Allied Health Professional workforce is fragile with the NCL Allied Health Professional Academy involved in the programme at system level.

There are several initiatives currently underway to address these challenges, which include:

- Maintaining capital nurses and midwifes in North Central London.
- Active recruitment programmes, including international recruitment of midwives and nurses.
- Long term plan funding applied to increasing neonatal nursing workforce in place and now reducing vacancy rate.
- Recruitment and retention of anaesthetic workforce gradually is improving.

The panel were persuaded that providing services across a reduced number of sites, four rather than five units, presented an opportunity to reconfigure the workforce to better meet Royal College Standards (of 8 WTE middle grades covering a service 24/7) alongside exploring new ways of working to improve quality of services.

The panel also noted information provided in the PCBC focussing on the movement of staff by option (Figure 39 PCBC) and the movement of staff between units (Figure 41 PCBC).

The panel recognised that work is in progress by the Clinical Reference Group developing a matrix of co-dependency, informed by the South East Clinical Senate's co-dependency document currently focussing attention to maternal medicine and radiology. The panel encourage that this work continues, including all interdependencies (pathology, pharmacy, imaging, specialist nurses, emergency obstetrics) but particularly interventional radiology as the key co-dependent service noting that there will be a bigger workload for the sites that pick up additional services. It will be important that engagement with these staff groups is effectively built into programme.

**Recommendation 23.** Further develop and respond to the clinical co dependencies and workforce implications as stated in Figure 20 of the PCBC:

- Decoupling the obstetric workforce from the gynaecology workforce on emergency presentations and the impact on the workforce who might continue to work across both specialities.
- Workforce distribution to achieve safe and sustainable services.
- Impact on wider services such as imaging, specialist nurses and pathology.

# 9.0 EDGWARE BIRTH CENTRE

## 9.1 Proposal

An appendix to the Maternity and Neonatal Services PCBC covers the proposed changes to the Edgware Birth Centre and considers the benefits, limitations, and long-term sustainability of the future of this unit. It recognises that the birthing suites at the site are underutilised and recommends the closure of the birthing suites and investing the resource into improving other maternity and neonatal services. This proposal is independent of any decision to move from 5 to 4 maternity and neonatal units.

The Birth Centre is situated in a deprived part of the borough of Barnet in a purpose-built unit in Edgware Community Hospital and is managed by the Royal Free NHS Foundation Trust.

It is a base for community midwifery team who provide a range of services from the centre including labour and birth care, home births and antenatal and postnatal clinics. There is also an ultrasound service on the site of the Community Hospital which is shared with other services. Midwives who support births are not based at the centre 24 hours 7 days a week, there is a telephone triage system operating at night time.

The PCBC outlines there is falling demand for standalone midwife-led care due to reducing birth rates in NCL and increasingly complex births, which would not be suitable for the stand-alone birthing centre.

Fewer than 50 women and pregnant people (less than 1 a week) gave birth at the Edgware Birth Centre over each of the last three years, with 34 births recorded in 2022/23 out of a total of 18,876 across NCL[12]. The PCBC cites evidence that standalone midwifery-led units need to deliver 350 births a year to be economically viable, which would require an additional 300+ births[13]. NCL considers that given the overall trends, it would be difficult to significantly increase the number of people using the birthing suites at Edgware Birth Centre. The panel noted that the local population may not be significant beneficiaries of the centre given the association between deprivation and high-risk births for which obstetric led care is clinically recommended.

North Central London verbally advised that in the last 12 months there had been 34 occasions where the service was temporarily unavailable due to both staffing challenges and the London Ambulance Service cover which could have impacted on birthing numbers.

It is stated that if Edgware Birth Centre closes, the resources released would be reinvested to use the space more efficiently and to expand other ante- natal and

[12] Edgware PCBC, section 4.3)

[13] Insights from the clinical assurance of service reconfiguration in the NHS: the drivers of reconfiguration and the evidence that underpins it – a mixed-methods study, Imison et al, 2015 (Edgware PCBC, section 4.2)

post- natal services. There are also plans to ensure that home birth services are enhanced across NCL.

The panel explored the engagement that had taken place and the views of the staff including the Edgware midwives and the Clinical Reference Group. It was noted that leaders and staff felt conflicted, given the birth centre is a high-quality service providing choice, but one where demand is reducing.

## 9.2 Panel views

The review panel considered that whilst maximising choice for women and pregnant people through the birth centre was important, they recognised a persuasive argument in the case for change for better utilisation of the estate, matching demand and capacity and ensuring sustainability and equity of outcomes.

The panel considered that the proposals were evidence based, well-articulated and persuasive. Their recommendations focus on strengthening the mitigating actions to ensure that choice for women and birthing people assessed as low risk is maximised and there is timely access and appropriate care for women and birthing people assessed as high risk.

The panel expressed that the proposed closure of the service may appear to be conflicting regarding patient choice; they recognised the service is not demonstrating value for money and that there was a persuasive argument for investing resources to support quality improvement across all NCL.

They were persuaded by the evidence of falling demand, and recognised it was unlikely that this would increase. They did, however, note from discussion on the panel day the number of times the birth centre has closed in the last 12 months due to staffing capacity issues. They do not consider that this will materially impact on the proposals, but feel it is important to include this information in the PCBC for transparency.

**Recommendation 24.** Ensure that the total service demand is reflected in the PCBC include the number of times people were booked to birth at the Edgware Birth Centre but were redirected due to staffing/ capacity issues.

The panel explored how many people might opt for a home birth if the birthing suites at the Edgware Birth Centre were closed. It was acknowledged that total numbers were low across all boroughs and could be absorbed within current services.

The panel considered it was important to ensure that home birth is a robust choice going forwards and recommended that the ways in which this would be further promoted and supported were built into the business case documentation. It is essential that this is clearly planned and outlined to maximise the available choice.

Similarly, the panel would like to hear of any facilities upgrades that might enable a more “homely” model which can be integrated into other midwifery led and obstetric units. e.g.  increase in birth facilities such as birthing pools in the co-located birthing units, potentially transferring the birthing pools. This should be supported by midwives to support in providing the cultural environment of home away from home with the birthing units for patients to allow for a smooth transition.

Whilst every intention may be made to offer choice, there may be occasions when pregnant people’s wishes around birth sit outside recommended clinical guidelines. It was noted that the NHSE regional midwifery team are undertaking work to understand the differing perspectives and how to support better care in these circumstances. As part of wider clinical safety and quality, NCL might wish to consider how this learning can be most effectively tailored for the local population.

**Recommendation 25.** The closure of the birthing suites at the Edgware Birth Centre would release resources. Ensure there is a clear read across as to how investment will improve quality of provision and realise the greater equity of outcomes. For example, services for high-risk pregnancies and increasing the support available to vulnerable communities.

**Recommendation 26.** Clearly articulate how choice (midwifery led centre, home births, obstetric unit) will be enhanced by the service changes particularly for those communities most affected by the change, either through service location or other vulnerabilities and inequalities.

**Recommendation 27.** Strengthen proposals to ensure that choice for low-risk women and birthing people is maximised. Demonstrate how choice for people with low-risk pregnancies will be promoted, how opportunities for home births will be enabled and promoted, and how a home from home environment in birth settings might be further developed through facilities available e.g., birthing pools and cultural environment.

**Recommendation 28.** Consider strengthening the language around choice for maternity and neonatal care, not only in relation to the Edgware Birth Centre but to the full range of options. The importance of language was a key theme shared from the engagement work to date.

# 10. PAEDIATRIC SURGERY

The Paediatric Surgery PCBC outlines proposals for paediatric surgery as follows:

- To develop a care model and pathways for complex and low volume surgery (less than 10% of total activity).
- University College London Hospital (UCLH) to be the centre of expertise for day case surgery, approximately 600 per year some of which they already see,

- Great Ormond Street Hospital (GOSH) to be the centre of excellence undertaking emergency and planned inpatient procedures totalling 700 per year.

The panel considered that there is a case for consolidation into fewer units to maintain and improve outcomes in surgery and noted this involved formalising pathways with changes affecting a comparatively small numbers of patients. They recognised and supported the ambition, whilst seeking further assurance around maintaining skills in District General Hospitals, longer term sustainability and maintenance of appropriate skills into the future. They also considered that it will be important that local / neighbourhood input to address inequalities.

The detail of these reflections are provided in the sub sections that follow.

## 10.1 Model and pathway

The proposed model and pathway were explored.

Children (age range <3 years old, <5 for general and urology surgery) would attend their local District General Hospital (DGH) for emergency care and subsequently be referred to a surgical centre if appropriate. This will sit alongside a review regarding the high number of lower acuity presentation of children (and adults) across Emergency Departments as part of an NCL wide review of Urgent Care.

The key difference to the current model is that the tertiary centre would be responsible for providing a bed and facilitate rapid transfer from the initial receiving DGH. Ambulances transferring a sick child from monitoring at home would be via DGH and not direct to GOSH. The panel noted that there would need to be management of parental expectations for children who under this model would be seen at GOSH as the ambulance service will not be taking patients directly there.

The centres of expertise will have to carefully manage capacity, and the panel were encouraged that the North Thames paediatric network have been closely involved.

The panel noted that the availability of capacity for surgery at the centres could provide a natural rate limiting step to accessing centres and ensuring that appropriate cases were transferred. How the centre might support the DGH to stabilise patients prior to transfer to specialist surgical bed was explored.

The proposal plans for transfers back to the DGH if the patient requires a longer length of stay. Panel were advised that this would be a rarity (for children with a medical problem not surgical) or children with complex needs known well by their local teams (and small surgical component) meaning that no additional capacity is needed at DGHs.

The panel noted ongoing education and support for all parts of the pathway will be needed. They were given assurance that Child and Adult Mental Health Services

(CAMHS) had been involved through the Children, Young People's, Maternity and Neonatal Board for NCL.

**Recommendation 29.** Describe any mitigations regarding capacity pressures on Great Ormond Street Hospital (GOSH) recognising the wider role GOSH provides as a specialist provider for all of London and surrounds. This should mitigate potential unintended impact for other children relying on GOSH who live outside NCL.

**Recommendation 30.** Including greater specificity in patient pathways defining the conditions that would go to Great Ormond Street Hospital and University College London Hospital would be helpful.

## 10.2 Workforce

The panel considered it would be helpful if the PCBC could describe and articulate workforce considerations more fully, particularly in the context that London is a major training provider.

A historical rate limiting factor to paediatric surgery is paediatric anaesthetics. However, the current best practice is for specialist paediatric surgeons rather than general surgeons to operate. Consequently, sustaining paediatric surgery on multiple sites is more complex and requires detailed planning regarding maintaining and developing the appropriate skilled workforce on these sites.

There was discussion about maintenance of paediatric airway experience. The panel were advised by NCL of plans for Continued Professional Development to assure this and this will need to be picked up as part of implementation planning.

Other risks and mitigations noted were:

- deskilling of DGH staff that may not be able to maintain the required level of expertise.
- public confidence in local DGHs may be damaged. This may be mitigated by ongoing communication of clear well described pathways the community can review and understand as the changes are consulted on and implemented.

**Recommendation 31.** Further detail on the processes and activity levels to ensure the expertise and experience of workforce in the district general hospital (DGH) areas is maintained, particularly around immediate airway management, and emergency and elective paediatric surgery (for older children).

**Recommendation 32.** Increasing specialisation and training may affect the future workforce competences required to manage other surgical conditions in children in their local hospitals. Further detail would be helpful on how the plans will mitigate this risk and maintain and sustain sufficient paediatric surgical expertise on all hospital sites in the future.

**Recommendation 33.** Describe further the educational opportunities the planned changes can provide, recognising that the London region is a major training provider. Work with educators and trainees to secure best training opportunities from the changes needs to continue.

**Recommendation 34.** Explore opportunities for common continuing professional development (CPD) and training arrangements across Trusts alongside consideration of rotations and joint appointments.

**Recommendation 35.** Describe further how alternative options e.g., surgeons, anaesthetists, nurses, AHPs and other healthcare professionals rotating and upskilling at other centres have been explored to ensure that all opportunities have been considered and maximised.

## 10.3 Population impact and improvements

The centres of expertise are in the middle of London, which for many communities will result in a greater travel distance. The panel acknowledge that it would be difficult to nominate different centres as the paediatric anaesthetic workforce is consolidated at GOSH and UCLH to support other pathways e.g., cancer. As patients will only be travelling to the centres of excellence for planned care and a single intervention, the panel considered that increased patient travel could be justified due to workforce constraints.

However, it is important to understand and articulate the travel considerations. Information was given on patient costs with public transport and taxis to travel to the centres of excellence; it will be important to include the congestion charge and ULEZ in the costings. Ensuring that equalities of outcome are addressed through paediatric proposals will be vital for the whole pathways' success.

**Recommendation 36.** Further describe how the *North Central London Population and Integration Strategy* underpins and interfaces with the proposed improved clinical outcomes of children's surgery. Indicate how clinical outcomes and overall system children population improvement will be tracked, measured, and monitored.

**Recommendation 37.** Include further detail on the communication strategy with NCL residents about the new model and pathway; particularly focussing messaging and communications regarding babies and young children requiring the most complex care. There may be an inclination to try and bypass the DGH and go direct - for reasons of seeking direct access and costs of transport which would be counterproductive.

# APPENDICES

## Appendix A- Key Lines of Enquiry (KLOE)

The Clinical Senate developed Key Lines of Enquiry with reference to the *London Clinical Senate Principles.*

**London Clinical Senate review of Start Well: maternity, neonatal, children and young people's services in North Central London**

**DRAFT- Key Lines of enquiry for 12th July**

**V0.2**

**1) Overall questions the sponsor has asked the London Clinical Senate to explore:**

1.1 Is the case for change supported by evidence and best practice guidance?
1.2 Are the changes proposed supported by evidence and best practice guidance to improve the quality and outcomes for the population served?

### 2) General Key Lines of Enquiry

| Theme | Areas of exploration | Notes |
|---|---|---|
| **Inequalities** | 2.1 Are the needs of the population and any health inequalities addressed - How will the planned reconfigurations improve health outcomes for the populations covered?<br>2.2 What is the potential impact of increased travel times (ambulance, patient transport, and private transport; public transport for visitors).<br>2.3 How have patient flows in and out of the ICS, influenced service requirements and plans? Do these flows indicate that access to services and pathways for people outside NCL need to change? | |
| **Engagement** | 2.4 How have patients, staff and wider stakeholders been involved to date? What has been the feedback and how has this ben addressed?<br>Can the full list of engagement be provided (referenced in PCBC as an appendix) | |
| **Workforce** | 2.5 Is there a coherent and realistic workforce strategy that takes account of the full range of the clinical workforce, training and education, and the opportunities provided by new roles and ways of working?<br>2.6 How might the recent Framework 15 long term workforce plan impact? | |

| | | |
|---|---|---|
| | 2.7 How will the change affect workforce retention? Fig 13 shows a 24% NN nursing vacancy rate at Barnet and North Middlesex. How might the proposals help to address this?<br>2.8 Has leadership & management skills or training been made available to senior staff particularly for those representing at board level?<br>2.9 Do the proposals address the issues raised in the CQC reports regarding the leadership and safety of services?<br>2.10 How might the proposals create workforce capacity to do things differently? | |
| **Unintended consequences** | 2.11[14] Co-dependencies of related clinical services: Has the impact on all providers been fully articulated?<br>What are the anticipated improvements? How will they be measured, sustained and course corrected as needed?<br>What contingency plans are being considered/ put in place? | |
| **Digital** | 2.12 How will the services and deliver seamless clinical information sharing?<br>2.13 What digital opportunities are described in the proposals to improve outcomes?<br>2.14 What is the ICB digital strategy? How might this improve communication, particularly regarding paediatric surgery. How will digital strategy facilitate improved communication? | |
| **Research and innovation** | 2.15[15] How will the proposals support Research, Innovation and Quality improvement? | |

**3) Specific Key Lines of Enquiry**

| Theme | Areas of exploration | Notes |
|---|---|---|
| **Maternity and Neonatal** | 3.1 Do the clinical pathways described represent best practice and evidence?<br>3.2 Do the proposals deliver improved and high-quality patient outcomes? Do they meet the recommendations in recent Maternity service reviews (Ockenden and Kirkup)<br>3.3 Do the proposals reduce variation and improve care?<br>3.4 The PCBC notes the high rates of stillbirth in Haringey. What are understood | • |

[14] Updated numbering from original document
[15] Updated numbering from original document

| | | |
|---|---|---|
| | to be the contributory factors? What action is being taken to address this and how does it relate to the proposals?<br>3.5 How has perinatal mental health input influenced the options? What is the current provision per site.<br>3.6[16] Does the current and future activity and capacity modelling demonstrate that planned capacity including beds/cots will be sufficient to ensure it meets demand with minimal transfers of care?<br>3.7[17] What are the number of maternity beds and average occupancy rate at each unit?<br>3.8 Has consideration been given to changing the capacity of each maternity unit?<br>3.9 What are the estates implications for options A and B?<br>3.10 Additional neonatal data would be helpful. Section 5.9.1 provides data on total number of neonatal care days. What about numbers of costs? Term admissions to the units? What is the activity breakdown for respiratory care and HD days? Could it push activity to the upper limit of BAPM standards? How does the data indicate that additional level 2 and not level 3 capacity is required?<br>3.11 What is the flow of NN babies to surrounding beds?<br>3.12 Is there a clear and deliverable workforce plan to deliver the proposed changes.<br>3.13 How will the proposals support primary and community services in supporting better health and wellbeing of mothers' families and babies (including pre-pregnancy, pregnancy, post pregnancy and early years)<br>3.14 How will the proposals support primary and community services to enable better health and wellbeing of mothers' families and babies (including pre-pregnancy, pregnancy, post pregnancy and early years) | |
| **Stand Alone Maternity Unit** | 3.15 How do the proposals support improved choice for mothers including home births, and midwifery led birthing centres? | |
| **Paediatric Surgery** | 3.16[18] Do the clinical pathways described represent best practice and evidence? | • |

[16] Updated numbering from original document

[17] 3.7-3.15 Updated numbering from original document

[18] 3.16-3.21 Updated numbering from original document

| | | |
|---|---|---|
| | 3.17 Do the proposals deliver improved and high-quality patient outcomes?<br>3.18 Do the proposals reduce variation and improve care? e.g. in any given paediatric inpatient location –the time taken to respond to a resuscitation call by a Registrar grade doctor?<br><br>3.19 Does the current and future activity and capacity modelling demonstrate that planned capacity including beds/cots will be sufficient to ensure it meets demand with minimal transfers of care. P30 refers to 18% patients transferred out of NCL. What was the rationale, where did they go and what impact will the proposed model have on this?<br>3.13[19] Is there a clear and deliverable workforce plan to deliver the proposed changes.<br>3.20 Will the co-location of the various key clinical support specialties and services support the proposed model?<br>3.21 Are there any risks to optimal inpatient services where rapid access to specified medical or surgical specialities or interventional radiology is not possible? | |

## 4) Senate Principles key lines of enquiry

| Key Line of Enquiry | Areas of exploration | Notes |
|---|---|---|
| **Senate Principles** | 4.1 How will the proposals promote population health management and integrated working across health and care, ensuring a seamless patient journey?<br>4.2 Are the proposals patient-centred and co-designed with patient experience, patient involvement and staff engagement and involvement?<br>4.3 How will the proposals reduce inequalities including all inequalities e.g., between people who share a protected characteristic and those who do not, as well inequalities that may arise from geography and deprivation?<br>4.4 Where relevant do the proposals demonstrate parity of esteem between mental and physical health for people of all ages? | |

[19] This question has been duplicated – is also sitting as number 3.12

| | | |
|---|---|---|
| | 4.5 How do the proposals support self-care, health, and wellbeing where appropriate?<br>4.6 How will the proposals Improve standards and outcomes- this includes use of evidence and research, application of national guidance, best practice, and innovation?<br>4.7 How will the proposals ensure value- this includes issues such as affordability, cost effectiveness and efficiency, long term sustainability, implications for service users and the workforce and consideration of unintended consequences?<br>4.8 How is environmental sustainability and moves to carbon neutral included in the plans and developments? | |

**5) Subject Matter Experts- Questions**

| Area | Panel Leads | Supplementary Questions |
|---|---|---|
| **Anaesthetics** | Catherine Lloyd | • What planning, modelling and discussion has been held with the anaesthetic workforce, particularly in the different stages of training? |
| **Covid 19 and learning** | All | • In addition to the Marmot publication have there been any post pandemic lessons learnt relevant to this proposal? |
| **Midwifery** | Manjit Roseghini<br>Stacey Robinson<br>Rachael Glasson | |
| **Neonatology** | Sundeep Harigopal<br>Victoria Puddy | • Will the co-location of the various key clinical support specialties and services support the proposed model?<br>• Are there any risks to optimal inpatient services where rapid access to specified medical or surgical specialities or interventional radiology is not possible? |
| **Nursing** | Sherry Manning | |
| **Obstetrics** | Katerina Tvarozkova<br>Anita Banerjee (paper based) | • Has a new Interventional Radiology provision been considered to address emergency patients across all NCL? |
| **Paediatrics (Intensivist, Community, Surgical and General)** | Tim Haywood<br>Marianne Leach<br>Mary Small<br>Chandresan Sinha<br>Judith Umeadi | |
| **Patient and Public Voice** | Lucy Brett<br>Chelsea Tudhope<br>Derrick Edgerton<br>Oonagh Heron<br>Sarah Espenhahn | |
| **Pharmacy** | Jas Khambh | • What is the impact of the changes on pharmacy? |

| | | |
|---|---|---|
| | | • How is the medication and prescribing systems working for staff and patients?<br>• How are incidents managed and learning shared? |
| **Primary and Community Care** | Kuldhir Johal | • How does the introduction of virtual ward/hospital at home impact on the overall plans for planned and unplanned care for both paediatric and maternity services – in relation to the details behind the proposed care models with specific reference to staffing models, technologies used, population coverage and interactions with primary care networks – community model alignment? |
| **Public Health/ Health Inequalities** | Robert Pears | • How has the Children's Core20PLUS5 influenced the approach to addressing inequalities? |
| **Social Care** | All | • What is the impact on the staff of the wrap around services such as social care? |
| **Travel, Transport and Ambulance** | Tim Edwards | • How are staff affected by travel costs due to the change and cost of living crisis?<br>• Would the change positively or adversely impact the patient transports service?<br>• How will patient transport/transfer times be affected?<br>• What are the starting point/ assumptions underpinning travel time calculations?<br>• As there are no dedicated maternity parking spaces, the total number of spaces is used as a proxy measure. Can this be strengthened looking at parking capacity/ ratio of spaces to activity?<br>• Is there additional information on the types, numbers and frequency of public transport? (e.g. 10 bus lines, 2 tubes)<br>• GOSH is within congestion charge zone and UCH is on the border - has this been accounted for in car journeys along with parking costs? |

# Appendix B – Panel Day Agenda

**London Clinical Senate Review**
**North Central London Start Well**
**Wednesday 12th July 2023**
**AGENDA**
**Chairs: Dr Mike Gill, Chair London Clinical Senate**
**Dr David Parkins, London Clinical Senate Council Member**

**Microsoft Teams meeting**
Click here to join the meeting
**Or call in (audio only)**
+44 113 486 0108,,394523441# United Kingdom, Leeds
Phone Conference ID: 394 523 441#

| Time | Item | Details | Lead |
|---|---|---|---|
| **09:00**<br>**09:20** | **Clinical Senate review panel only. Pre-Meet**<br>- *Welcome and introductions*<br>- *Key tasks and advice requested*<br>- *Confidentiality and register of interests*<br>- *Notes* | **Refer to papers:**<br>Terms of Reference<br>Key Lines of Enquiry<br>Panel membership | **Dr Mike Gill, Chair, London Clinical Senate** |
| **09:20** | **North Central London presenting team join the meeting** | | |
| **09:20**<br>**09:45** | **Vision and programme context**<br>- *ICB Context*<br>- *Population demographics*<br>- *Programme in the context of the ICS*<br>- *Overview of current services*<br><br>**Start Well - Background**<br>- *Programme update*<br>- *Governance*<br>- *Options appraisal process* | **Presentation followed by question and answers** | **NCL presenters:**<br>• **Sarah Mansuralli,** Start Well SRO and ICB Chief Development & Population Health Officer<br>• **Chris Caldwell,** ICB Chief Nursing Officer<br>• **Jo Sauvage,** ICB Chief Medical Officer<br>• **Anna Stewart,** Start Well Programme Director |
| **09:45**<br>**10:30** | **Patient involvement and engagement**<br>- *Phases of engagement*<br>- *PPEG*<br>- *Approach to youth engagement*<br>- *How engagement has influenced the programme*<br>- *IIA engagement*<br>- *Next steps* | **Presentation followed by question and answers** | **NCL presenters:**<br>• **Sarah Mansuralli**<br>• **Mandeep Kaur**, PPEG Chair<br>• **Chloe Morales-Oyarce,** Acting Assistant Director Communications and Engagement<br>• **Alice O'Brien,** Programme Manager |
| **10:30**<br>**10:45** | **BREAK (15 mins)** | | |
| **10:45**<br>**13:05** | **Maternity and neonatal services (including Edgware): proposals**<br>- *Case for change*<br>- *New care models* | **Presentation followed by question and answers** | **NCL presenters:**<br>• **Michelle Johnson,** Start Well Clinical Lead and ICB Deputy Chief Clinical Officer |

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|---|---|---|---|
| | - *Care model benefits*<br>- *Options being considered* | | **Panel for questions:**<br>• **Giles Kendall,** Clinical Lead Neonatology North Central London<br>• **Grenville Fox,** London Neonatal ODN Clinical Director<br>• **Carolyn Paul,** Obstetric lead, Whittington Health<br>• **Tim Wickham,** Clinical lead for Women's and Children's, Royal Free London<br>• **Mark Livingstone**, NCL AHP Council<br>• **Patrick Hunter,** Clinical Lead NCL LAS<br>• **Mayyah Bilal,** NCL Head of Maternity Commissioning, Service Development & Improvement<br>• **Simon Caplan,** GP Clinical Non-Executive North Central London Integrated Care Board<br>• **Liz Carty,** Deputy Postgraduate Dean NHSE Workforce, Training & Education Directorate |
| **13:05**<br>**13:35** | **LUNCH (30 mins)** | | |
| **13:35**<br>**15:05** | **Paediatric surgery: proposals**<br>- *Case for change*<br>- *New care models*<br>- *Care model benefits*<br>- *Options being considered* | **Presentation followed by question and answers** | **NCL presenters:**<br>• **Michelle Johnson**<br><br>**Panel for questions:**<br>• **Sanjiv Sharma**, Medical Director, GOSH<br>• **Erum Jamall,** Clinical Director Children and Young People's Services, Whittington Health<br>• **Sara Stoneham,** Clinical Lead paediatrics, UCLH<br>• **Patrick Hunter,** Clinical Lead NCL LAS<br>• **Kate Plunkett Reed,** NTPN Director<br>• **Shye-Wei Wong,** Consultant paediatrician, Royal Free Hospital<br>• **Liz Carty,** Deputy Postgraduate Dean NHSE Workforce, Training & Education Directorate |
| **15:05**<br>**15:20** | **BREAK (15 mins)** | | |
| **15:20**<br>**17:00** | **Clinical Senate Panel to join new Invitation with Teams Link**<br><br>**Panel discussion and deliberation** | | |

# Appendix C- Documentation provided by North Central London ICB

| Folder No | Folder Name | Description |
|---|---|---|
| 1 | Case for Change | Full version of the Start Well case for change |
| 1 | Case for Change | Shorter summary version of the case for change |
| 2 | Engagement report | Start Well Engagement Report September 2022 |
| 3 | Care models (updated) | Final care models |
| 4 | Board Paper | November Board paper |
| 5 | CQC reports | 1. North Middlesex 2019 |
| 5 | CQC reports | 2. North Middlesex 2018 |
| 5 | CQC reports | 3. Royal Free maternity 2020 |
| 5 | CQC reports | 4. Royal Free maternity 2021 |
| 5 | CQC reports | 5. UCLH December 2019 |
| 5 | CQC reports | 6. Whittington Health 2023 |
| 6 | Population Health Strategy | 1. Full population health strategy |
| 6 | Population Health Strategy | 2. Summary population health strategy |
| 7 | NCL Maternity overview | NCL Maternity JHOSC |
| 8 | GIRFT paediatric surgery report | GIRFT paediatric surgery |
| 9 | Pre consultation business case | 1. 230703_Maternity and Neonatal _Clinical Senate<br>2. 2307.03_ Edgeware Clinical Senate_v0.1<br>3. 230703_ Paediatric surgery Clinical Senate _v0.1 |

# Appendix D– London Clinical Senate Review Panel membership and declarations of interest

| Name | Roles | Interests Declared |
|---|---|---|
| **Anita Banerjee**<br><br>(Contributed electronically outside of panel day) | Obstetric Physician Guys and St Thomas' Hospitals NHS Foundation Trust | None |
| **Lucy Brett** | Chair PPV Group | Nothing Noted |
| **Derrick Edgerton** | Patient and Public Voice member, London Clinical Senate Patient and Public Voice Group | None |
| **Tim Edwards** | Consultant Paramedic Clinical Directorate London Ambulance Service NHS Trust | None |
| **Sarah Espenhahn** | Maternity Service User Voice Lead for London, NHS England (PPV role) | None |
| **Michael Gill** | Chair London Clinical Senate | Non-Executive Director, Homerton Hospital (as detailed, Mike did not chair the maternity and neonatal section of this review) |
| **Rachael Glasson** | Deputy Regional Chief Midwife, NHS England South West | Nil |
| **Sundeep Harigopal** | Clinical Lead , Northern Neonatal Network<br>Consultant Neonatologist, RVI, Newcastle Hospital NHS Foundation Trust | Nothing noted |
| **Tim Haywood** | Consultant Paediatric ICU and Anaesthesia, Leeds Teaching Hospitals | None |
| **Oonagh Heron** | Patient and Public Voice member, London Clinical Senate Patient and Public Voice Group | None |
| **Kuldhir Johal** | Clinical IT and Digital Lead of the North West London ICB for Hillingdon | GP Educator Brunel Medical School- Oct.22 Financial Professional<br><br>Oakland Medical Centre- Oct.22 Locum GP<br><br>Clinical Lead Colne Union PCN- Feb.23 Financial - Professional<br><br>Council Member London Clinical Senate 01/12/22 Non financial - advisory role<br><br>Clinical Lead EMIS and IT Lead for |

| | | |
|---|---|---|
| | | Hillingdon Borough for NWL ICS- Oct 22 Financial - Professional - Employee NWL ICS<br><br>NWL ICS Clinical Lead for Respiratory and Post COVID syndrome since April 2023 for 1 year<br><br>Eastbury Surgery 04/08/1998 - 31/12/2022 Financial - Professional GP Partner - GMS Practice<br><br>North Connect PCN 24/08/2014- 31/12/2022 Non financial Member practice<br><br>Hillingdon GP Confederation Member Practice 2017 - Present Non Financial- Professional Member practice<br><br>Hillingdon Hospital Trust 1992- Oct 2022 Indirect Interest Married to Emergency Medicine Consultant<br><br>London Ambulance Service - NWL ICS 2016 - Present Non-financial - Professional Chair of LAS CQRG<br><br>NWL CCG CO@home Sep 20 to May 22 Non Financial- Professional Primary Care Clinical Lead<br><br>AAK Property and Eastbury Road Limited properties 2004 Present Financial - Personal Property Owner Eastbury Surgery |
| **Jas Khambh** | Chief Pharmacist & Clinical Director, Medicines Optimisation & Pharmacy Procurement, NHS London Procurement Partnership | None |
| **Marianne Leach** | Consultant Paediatrician, St Georges University Hospital | No conflict of interest |
| **Catherine Lloyd** | Consultant Obstetric Anaesthetist, St Georges Hospital NHS Foundation Trust | None |
| **Sherry Manning** | Divisional Director & Associate Director of Nursing Women & Children's Division, Newham University Hospital, Barts Health NHS Trust | None |
| **Mark Mason** | Medical Director, Heart, Lung and Critical Care Clinical Group, Royal Brompton | My wife is employed as a nurse at Great Ormond Street NHS FT |
| **Geeta Menon** | Vice Chair, London Clinical Senate Postgraduate Dean WTE NHSE | Nothing noted |

| | | |
|---|---|---|
| **David Parkins** | Chair - London Eye Health Network NHS England - London | None |
| **Robert Pears** | Public Health Consultant and Consultant lead for Children and Young People, London OHID | None |
| **Victoria Puddy** | Consultant Neonatologist UHS, UHS Neonatal Mortality, Risk and Patient Safety Lead | None –<br>Additional Job roles:<br>I don't believe that these roles have a conflict of interest but shared for transparency. Thames Valley & Wessex Neonatal ODN Clinical Lead since 2012. Neonatal Critical Care Clinical Reference Group, Clinical Member since 2019 |
| **Stacey Robinson** | Lead Midwife, London Ambulance Service | Nothing noted |
| **Manjit Roseghini** | Director of Midwifery for assurance, Co-chair for LMNS South West London, Integrated Care System | None |
| **Chandrasen Sinha** | Consultant Paediatric Surgeon & Care Group Lead, St Georges Hospital | Nothing noted |
| **Mary Small** | Consultant Paediatrician CHFS Surrey And Border Partnership Trust | Nothing noted |
| **Chelsea Tudhope** | Lived Experience Practitioner | Nothing noted |
| **Katarina Tvarozkova** | Consultant Obstetrician, Somerset NHS Foundation Trust | Nothing noted |
| **Judith Umeadi** | Consultant Paediatrician & Named Doctor for Child Protection, ELHT. Honorary Clinical Lecturer, School of Medicine UCLan | None |
| **Gladys Xavier**<br><br>(Contributed electronically outside of panel day) | Director of Public Health & Commissioning, London Borough of Redbridge | Nothing noted |

**Notes**

All panel members completed Confidentiality forms and Register of Interests forms.
Some members noted "None" on their forms
Some forms were left blank – this has been transcribed as "Nothing noted"
Where details were written, this has been transcribed into the report

# Appendix E - Presentation Panel

| Name | Roles |
|---|---|
| **Sumayyah Bilal** | NCL Head of Maternity Commissioning, Service Development & Improvement |
| **Chris Caldwell** | ICB Chief Nursing Officer |
| **Simon Caplan** | GP Clinical Non-Executive North Central London Integrated Care Board |
| **Liz Carty** | Deputy Postgraduate Dean NHSE Workforce, Training & Education Directorate |
| **Grenville Fox** | London Neonatal ODN Clinical Director |
| **Patrick Hunter** | Clinical Lead NCL LAS |
| **Erum Jamall** | Clinical Director Children and Young People's Services, Whittington Health |
| **Michelle Johnson** | Start Well Clinical Lead and ICB Deputy Chief Clinical Officer |
| **Mandeep Kaur** | PPEG Chair |
| **Giles Kendall** | Clinical Lead Neonatology North Central London |
| **Mark Livingstone** | NCL AHP Council |
| **Sarah Mansuralli** | Start Well SRO and ICB Chief Development & Population Health Officer |
| **Chloe Morales-Oyarce** | Acting Assistant Director Communications and Engagement |
| **Alice O'Brien** | Programme Manager |
| **Carolyn Paul** | Obstetric Lead, Whittington Health |
| **Kate Plunkett Reed** | NTPN Director |
| **Jo Sauvage** | ICB Chief Medical Officer |
| **Sanjiv Sharma** | Medical Director, GOSH |
| **Anna Stewart** | Start Well Programme Director |
| **Sara Stoneham** | Clinical Lead paediatrics, UCLH |
| **Tim Wickham** | Clinical Lead for Women's and Children's, Royal Free London |
| **Shye-Wei Wong** | Consultant paediatrician, Royal Free Hospital |

# Appendix F -Glossary

| Glossary of Terms | |
|---|---|
| **AHP** | Allied Health Professionals |
| **BAPM** | British Association of Perinatal Medicine |
| **CQC** | Care Quality Commission |
| **DGH** | District General Hospital |
| **GOSH** | Great Ormond Street Hospital |
| **ICB** | Integrated Care Board |
| **IIA** | Integrated Impact Assessment |
| **LAS** | London Ambulance Service |
| **LMNS** | Local Maternity & Neonatal Network |
| **LNU** | Local Neonatal Unit |
| **MBRRACE** | Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK |
| **NICU** | Neonatal Intensive Care Unit |
| **NCL** | North Central London |
| **NEL** | North East London |
| **NMUH** | North Middlesex University Hospital |
| **NWL** | North West London |
| **ODN** | Operational Delivery Networks |
| **OHID** | Office for Health Improvement and Disparities |
| **PCBC** | Pre-consultation Business Case |
| **PPEG** | Patient and Public Engagement Group |
| **Senate review panel/ panel** | The senate review panel. See appendix D for details of members. |
| **RCOG** | Royal College of Obstetricians and Gynaecologists |
| **SRO** | Senior Responsible Officer |
| **UCLH** | University College London Hospital |
| **WTE** | Whole Time Equivalent |

# Appendix G- Terms of Reference

**London Clinical Senate**

**Terms of Reference**

Review of the NCL Start Well Programme:  Start Well: Ensuring the best care for pregnant women and people, babies, children, young people, and their families

**Date: 30th June 2023**

**Email: england.londonclinicalsenate@nhs.net**

**Web: www. Londonsenate.nhs.uk**

## INDEPENDENT CLINICAL REVIEW: TERMS OF REFERENCE

| | |
|---|---|
| **Title** | Review of the NCL Start Well Programme: Start Well: Ensuring the best care for pregnant women and people, babies, children, young people, and their families |
| **Sponsoring Organisation:** | North Central London ICB |
| **Clinical Senate:** | London Clinical Senate |
| **NHS England regional or team:** | NHS England- London |
| **Terms of reference agreed on behalf of the London Clinical Senate by:** | Dr Mike Gill, Chair, London Clinical Senate Council |
| **Terms of reference agreed on behalf of NCL ICB** | Sarah Mansuralli, Chief Development and Population Health Officer (Start Well, SRO)<br><br>Michelle Johnson, Deputy Chief Clinical Officer (Start Well, Clinical Lead) |
| **Date** | 30th June 2023 |

Contents

## 1. Background

Since November 2021, NCL as a system has been working together on the Start Well programme which aims to ensure hospital-based maternity, neonatal, and children and young people's services fully meet the needs of those who use them.

Co-sponsored by the NHSE Specialised Commissioning (London) Start Well was initiated to understand if as a system we are:

- delivering the best services to meet the needs of children, young people, pregnant people and babies
- learning from, and responding to, national and international best practice, clinical standards and guidelines
- reducing inequalities in provision and health outcomes.

A case for change was published in June 2022 which set out opportunities for improvement in maternity and neonatal services and children and young people's services. Public engagement took place over the summer of 2022 with the themes published in September 2022. In the summer and autumn of 2022 there was extensive clinical involvement in the development of best practice care models to reflect the opportunities for improvement identified in the case for change, engagement themes and national published best practice.

In November 2022 (and a short update in March 2023) the ICB Board agreed a number of recommendations which were focused on the implications of adopting the proposed best practice care models where this could potentially lead to changes in how services are organised.

The board paper recommended as a next step to proceed to an options appraisal in respect to the implementation of the proposed future care models for maternity, neonates and children and young people's surgery (planned and emergency).

The options appraisal would specifically test a number of areas of the care models in comparison to the current configuration:

- the options for having four obstetric led birthing units co-located with four neonatal units (three of which will be level 2 and one will be level 3), instead of the current five. This excludes the specialist NICU at GOSH.
- the option of no longer having a standalone midwifery unit
- Surgical activity for low volume specialties and very young children be consolidated into a centre or centres of expertise

From December 2022 an options appraisal has been taking place with clinical and patient involvement. This culminated in an options appraisal workshop in May 2023, the outcome of which has been put together into a pre-consultation business case. The clinical aspects of which are being put forward to the clinical senate for review.

## 2. Aims of the review and advice requested

The Clinical Senate will review the draft PCBC in advance of submission of the final PCBC to NHSE in accordance with the major service change assurance processes.

The Senate will pay particular attention to the following questions:

1. Is the case for change supported by evidence and best practice guidance?
2. Are the changes proposed supported by evidence and best practice guidance to improve the quality and outcomes for the population served?

This planned approach will enable NCL ICB to make best use of Clinical Senate advice and recommendations, integrating them where appropriate into the final version of the PCBC, prior to the assurance process.

In accordance with the agreed timeline, the draft PCBC will be provided to the clinical senate no later than midday Monday 3 July 2023.

## 3. Scope of the review

"Planning, assuring and delivering service change for patients" (NHS England, updated March 2018) requires NHS England to be assured that any proposal for major service change or reconfiguration satisfies four tests set by the Government in 2010:

- Strong public and patient engagement
- Consistency with current and prospective need for patient choice
- Clear, clinical evidence base
- Support for proposals from commissioners

In 2017 the NHS Chief Executive introduced a 5th new patient care test for hospital bed closures, specifying that alternative provision is in place before any beds are closed.

The clinical senate's advice will be focused on the third test of clinical evidence and the fifth 'beds' test as relevant. It is also cognisant of London Mayor's tests and encourages commissioners to consider their response to these in developing their Consultation Business Case

The London Mayors 6 tests, introduced 6 tests in 2017 were designed to ensure that the changes are in the best interests of Londoners. These are conditions that must be met before the mayor will support any major health and care transformation or service reconfiguration in London.

The 6 areas, which are considered post consultation are:

- Health and healthcare inequalities
- Hospital Beds
- Financial investment and savings
- Social care impact
- Clinical Support
- Patient and Public Engagement

These were refreshed in late 2022, with key changes being:

- Strengthening the health inequalities test and additional supplementary question that highlights the role of the NHS
- Recognising new opportunities afforded through the use of digital healthcare within the Hospital Beds test.

The case for change is very broad and many of the areas identified as opportunities for improvement are being taken forward through other change programmes within the ICS i.e. peri-natal mental health is being considered as a key workstream in the mental health programme, resulting in increased capacity from 2023/24.

For the purposes of the senate review, it would be helpful if the focus could be on the implications of adopting the proposed best practice care models where this could potentially lead to changes in how services are organised and the three areas specifically covered by the options appraisal process.

In particular we would value feedback from the panel on both workforce and clinical interdependencies.

## 4. Principles for improving quality and outcomes

The Clinical Senate Council has also agreed a set of principles which it believes are essential to improving quality of care and outcomes. The Council seeks evidence of, and promotes, these principles in the issues it considers and the advice that it provides.

They are:

- Promoting **integrated working across health and across health and social care** and ensure a seamless patient journey
- Being **patient-centred and co-designed** (this includes patient experience, patient involvement in development and design of services)
- Reducing **inequalities** (this involves understanding and tackling inequalities in access, health outcomes and service experience, between people who share a protected characteristic and those who do not, and being responsive to the diversity within London's population)
- Demonstrating **parity of esteem between mental and physical health** for people of all ages
- Supporting **self-care** and **health and wellbeing** Improving **standards and outcomes** (these include use of evidence and research, application of national guidance, best practice and innovation)
- Ensuring **value** (achieving the best patient and population outcomes from available resources)
- Demonstrate how **environmental sustainability and moves to carbon neutral** are included in plans and developments. This includes reference to the National ambition to reach carbon Net zero by 2040 and the London Health Board ambition to ensure that every Londoner breathes safe air.

## 5. Review Panel

The clinical senate will complete review via Microsoft TEAMS.

### Chair

The panel will be chaired by: Dr Mike Gill, Chair of the London Clinical Senate Council

### Membership

Membership of the review panel will be multi-professional. Its members will have expertise in the services and pathways being considered. Subject to agreement with the Chair, membership will include expertise independent of North Central London and from individuals that are unrelated to the changes proposed. Advice on membership will be sought from the London Clinical Senate Council with relevant expertise, and professional bodies as necessary.

The review panel will seek advice from other independent experts on specific issues if indicated. The review panel will not include anyone who has been involved in the development of the proposals being considered or associated with the bodies.

### Conflict of Interests

All review panel members will be required to formally declare any interests (which will be noted in the review report) and sign a confidentiality agreement.

## 6. Method and Approach

In determining the review approach and formulating advice the Clinical Senate Council and Review Panel will draw on the following, which includes guidance on testing an evidence base:

- Clinical Senate Review Process: Guidance Notes, NHS England, August 2014
- NHS England's Service Change Toolkit
- Planning, assuring and delivering service change for patients, NHS England, March 2018

The review is expected to involve the following steps:

**Step 1:** **Establish the review panel**

**Step 2**: **Brief the review panel** and circulate key documentation

**Step 3**: Hold a **review panel meeting** to:
a. agree the overall methodology applied to formulate the advice
b. identify issues that need to be explored, clarified or validated to assist in formulating the advice
c. agree any further information/documentation required to inform the review

**Step 4:** Hold an expert **review panel. This will be a full day via Microsoft TEAMS on Wednesday12th July** to undertake the following:
a. Meet and discuss the proposals/solutions with stakeholders (commissioners and providers) involved in their development to explore key lines of enquiry
b. Provide an opportunity for stakeholders impacted by the proposals to share views with the review panel
c. Debate findings within the review panel and finalise conclusions
d. Identify any outstanding issues and agree the process for following up (and further review panel discussion as agreed necessary)

**Step 5:** **Prepare a report** setting out overall findings, conclusions, advice and any recommendations. This will be circulated to the review panel and if required, a meeting agreed to discuss matters of accuracy and agree amendments.

The sponsoring organisations will be provided with a copy of the draft report for a factual accuracy check.

**Step 6:** Once agreed by the review panel**, share the report with the Clinical Senate Council** who will:
- Ensure the terms of reference have been met
- Comment on any specific issues where identified by the review panel
- Agree that the report can be issued

Subject to the schedule of Council meetings the Senate Council Chair may undertake this on the Council's behalf.

**Step 7:** **Issue the report.**

## 7. Documentation required by the Clinical Review Panel

In formulating advice, the review panel will review documentation that has both informed and been developed by commissioners.

Where possible relevant sections/pages of documents should be highlighted where the whole document does not apply to the proposals or context of a Clinical Senate review.

The documentation that it is anticipated will inform this review is listed below. follows. Further requirements may be confirmed following establishment of the review panel.

- The draft Pre-Consultation Business Case (PCBC)
- The Case for Change (rationale for the proposed change and evidence base)

- Proposed clinical models (description, rationale and evidence base)
- Supporting activity and workforce data and modelling, patient flows and pathways, patient transport, performance against key quality indicators benchmarking data/patient experience data – available information should be provided initially, and any further specific requests will be discussed
- Relevant Care Quality Commission (CQC) inspection and Getting it Right First Time (GIRFT) reports
- Schedule of evidence and best practice that have informed the proposals
- Equality impact assessment
- Alignment to ICB plans
- Relevant Trust Clinical Strategies
- Process used to develop the proposals including staff, service user and public involvement
- Summary of outcomes of patient and public engagement
- Summary of outcomes of stakeholder engagement, including neighbouring trusts and services
- Programme risk log
- Assessment regarding sustainable healthcare considerations and carbon footprint

The review panel will formulate the advice requested based on consideration and triangulation of the documentation provided, discussion with key stakeholders and panel members' knowledge and experience. The advice will be provided as a written report.

## 8. Timeline

The figure below details the milestones in the review process.

- **Convene a go/ no go meeting for 1 May 2023. Documentation availability is confirmed.**
- **Clinical senate to convene panel.**
- **NCL ICB submit draft PCBC and associated appendices to clinical senate for review no later than 3 July.**
- **Panel Review Wednesday 12 July. To be undertaken over Microsoft TEAMS.**
- **W/c 7 August 23 draft clinical senate report and recommendations issued to North Central London ICB for MoA check.**
- **4 September 2023 final report issued.**

## 9. Risks

It is essential that the processes through which the Clinical Senate formulates advice are robust and the approach outlined is designed to do this. Recruiting the appropriately experienced review panel members who are available on the key dates set for the review and ensuring adequate time to prepare for key activities are the most critical elements and pose the greatest risk. Every effort will be made to mitigate this risk.

## 10. Reporting arrangements

The review panel will report to the Clinical Senate Council who will agree the report and be accountable for the advice contained in the final report.

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

## 11. Report

A final draft report setting out the advice will be shared with the sponsoring organisation to provide an opportunity for checking factual accuracies prior to completion. Comments/corrections must be received within 5 working days.

**Communication and media handling**

North Central London will be responsible for publication and dissemination of the report. The expectation is that it will be made publicly available as soon as possible following completion. The London Clinical Senate will post the report on their website at a time agreed with the sponsoring organisation.

Communication about the clinical review and all media enquiries will be dealt with by the sponsoring organisation.

If helpful, the Clinical Senate will support the sponsoring organisation in presenting the review's findings and explaining the rationale for the advice provided e.g. at a key stakeholder meeting subject to discussion and availability of review panel members.

**Disclosure under the Freedom of Information Act 2000**

The London Clinical Senate is hosted by NHS England and operates under its policies, procedures, and legislative framework as a public authority. All the written material held by the Clinical Senate, including any correspondence sent to us, may be considered for release following a request to us under the Freedom of Information Act 2000 unless the information is exempt.

## 12. Resources for the review

The London Clinical Senate will recruit review panel members and cover members' reasonable expenses. It will also provide management support to the review panel, including coordinating all communication relating to the review, documentation sharing, meeting organisation and report production.

The sponsoring organisation will identify a named contact to coordinate the provision of documentation and any other information requested and to assist in coordinating stakeholders' participation in the review at a local level. The sponsoring organisation will also organise accommodation for meetings and the review panel day.

If during the course of the review the review panel identifies any additional requirements to formulate the advice requested, the review Chair or Clinical Senate Senior Project Manager will, if necessary, discuss these with the sponsoring organisation and may seek resources for this.

## 13. Accountability and Governance

The review panel is part of the London Clinical Senate's accountability and governance structure.

The Clinical Senate is a non-statutory advisory body and will submit the review report and its advice on the proposals to the sponsoring organisation. The sponsoring organisation remains accountable for decision making. The review report may draw attention to specific issues, including any risks, which the Clinical Senate believes the sponsoring organisation should consider or address.

If the Clinical Senate identifies any significant concerns through its work which indicate risk to patients it will raise these immediately with relevant senior staff in the organisation(s) involved. Please note that depending on the nature of the issues identified the Clinical Senate Council may be obliged to raise these with the relevant regulatory body(ies). Should this situation occur, the Clinical Senate Council Chair will advise the Chief Executives, Clinical Leads and Chief Officers of the provider and commissioning organisations involved.

## 14. Functions, responsibilities and roles

**The sponsoring organisation will:**

- Provide the review panel with the proposed PCBC, and associated resources.

- 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 review panel during the review.
- Submit the final report to NHS England for inclusion in its formal service change assurance process.

The **London Clinical Senate Council and the sponsoring organisation** will:

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

The **London Clinical Senate Council** will**:**

- Appoint a review panel which may be formed of members of the Senate, external experts, and/or others with relevant expertise.
- Endorse the terms of reference, timetable and methodology for the review.
- Consider the review recommendations and report (and may wish to make further recommendations).
- Provide suitable support to the review panel.
- Submit the final report to the sponsoring organisation.

The **review panel** will:

- Undertake its review in line with the methodology agreed in the terms of reference.
- Submit the draft report to the London Clinical Senate Council for comment, consider any such comments made and incorporate relevant amendments into the report. Review panel members will subsequently submit a final draft of the report to the London Clinical Senate Council.
- Keep accurate notes of meetings.

The **review panel members** will undertake to:

- Commit fully to the review and attend/join all briefings, meetings, interviews, panels etc. that are part of the review (as defined in the methodology).
- Contribute fully to the process and review report.
- Ensure that the report accurately represents the consensus of opinion of the review panel.
- Comply with the 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.
- Declare to the review panel Chair any conflict of interest prior to the start of the review and/or any that materialise during the review.

## 15. Contact details of key personnel coordinating the review process

**For the London Clinical Senate:**

Senior Programme Manager

Email address: emilywebster@nhs.net

**For NCL ICB:**

Name: Anna Stewart

Title Programme Director

E mail: anna.stewart3@nhs.net