East Midlands Clinical Senate

Clinical Senate Review of the Community Services provided at the Feilding Palmer Community Hospital

Report of the Independent Clinical Senate Review Panel (29th June 2023)

July 2023

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Glossary of abbreviations

ICB	Integrated Care Board
ICS	Integrated Care System
IPC	Infection Prevention and Control
LLR	Leicester, Leicestershire and Rutland
LPT	Leicestershire Partnership Trust
MDT	Multi-Disciplinary Team
PCN	Primary Care Network
UHL	University Hospitals Leicester

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1. Foreword by Dr Ben Pearson, Clinical Review Panel Chair

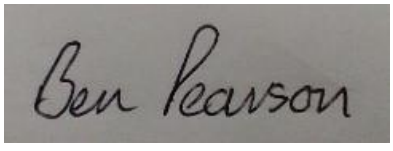
Clinical Senates have been established as a source of independent and objective clinical advice and guidance to local health and care systems, to assist them to make the best decisions about healthcare for the populations they represent.

Clinical Senates are minimally staffed and built on the voluntary engagement and goodwill of local clinicians and other health and care professionals to ensure that the wider NHS can benefit from this expertise and experience.

We would like to thank the Leicester, Leicestershire and Rutland (LLR) Integrated Care Board (ICB) and Leicestershire Partnership NHS Trust (LPT) for engaging with the Clinical Senate to bring independent, external advice and guidance to support the development and evaluation of the proposed service model for a community healthcare hub in LLR. It is with thanks to all colleagues who presented on the day and supported the panel's walk around of Feilding Palmer Hospital. The conversations with panel members in the afternoon were of great value.

It is also with thanks to our clinical review panel for their participation and continuing commitment and whose expertise was drawn from both the East Midlands and West Midlands Clinical Senates to ensure that the full potential of independent clinical advice could be maximised.

We wish the system success with its transformation plan, and we would be happy to offer further assistance if in any way required.



Dr Ben Pearson
Clinical Senate vice Chair

2. Clinical Senate Review Panel summary and key recommendations

The Clinical Senate wish to thank all who gave their time to take part in this review. The panel clearly saw the passion and dedication in all representatives present from the sponsoring organisations to drive improvement in community services for the local area which was commended. The information provided and conversations had during the day were very open and insightful which was greatly appreciated by the panel.

There was clearly a large quantity of work undertaken to get this programme to its current position. The engagement across a broad range of stakeholders from very early on in the programme was highly commended by the panel and taken as recognition of the importance of agencies and stakeholders beyond the NHS in the effective delivery of community services. The panel heard about an array of plans and work in the pipeline to bring innovation to the delivery of services to the local area, demonstrating a determination to do things differently. The drive to ensure patients receive the best possible services locally and support care closer to home was unquestionable with the wider delivery of community services across LLR providing valuable experience and support to influence plans in this locality. Patient travel was a clear and recurrent theme which the system wished to address by bringing care closer to home which aligned to national recommendations.

Overall, the panel were impressed and took assurance in what they heard through the day. However, this report details some areas of concern which the panel strongly recommend the system explore in more detail to support future work on this programme. The core of these concerns was the fundamental challenges and constraints presented by the Feilding Palmer building. The panel were concerned whether these can be realistically overcome or mitigated in a robust and affordable manner to deliver high quality care in the approach described during the review. The other main concern was regarding the lack of granularity of the plans. Many options appeared to still be on the table for consideration regarding service provision for the proposed refurbished site. This inhibited clarity on the actual content and functionality of the proposed community hub, meaning that limited conclusions could be drawn on its short and long term viability.

The system demonstrated an understanding of population health management. The panel would encourage the system to take this to the next level to refresh their thinking and ensure that population health was sufficiently profiled to allow for service delivery to be targeted to meet the priority needs of the whole population. The panel would encourage further exploration with local public health colleagues to consider potential hidden needs, those of the most vulnerable groups within the population and ways to avoid the risk of widening the health inequalities gap. The panel also encourages the system to change the focus of its messaging from an explanation of what was being lost to a positive message about what would be gained.

The workforce and infrastructure ramifications of the proposed plans are significant. The panel expressed concern regarding if these had been worked through in detail alongside planned service delivery to see if suitable solutions and mitigations were firmly in place.

Finally, the panel were unanimous in their conclusion that the 10-bed inpatient facility at the Feilding Palmer site should be permanently closed.

3. Background and advice request

3.1 Description of current service model

Admissions to the 10 bedded inpatient facility (including one palliative care suite) within Feilding Palmer hospital were suspended at the beginning of the Covid-19 pandemic in response to a review against the national Infection Prevention and Control (IPC) guidance. This had an impact on outpatient appointments and the community hospital beds. The specific challenges at Feilding Palmer are described in the case for change below.

3.2 Case for change

The Leicester, Leicestershire and Rutland (LLR) system would like to consult with the public to permanently close the inpatient ward, creating a community healthcare hub providing more outpatient activity, diagnostics and procedures to support more patients locally by bringing care closer to home which would reduce travel and waiting times[1].

Since the pandemic, when face to face activity was reduced due to social distancing and strict IPC measures, the services delivered from Lutterworth have reduced. This has had an impact on outpatient appointments and the community hospital beds at Feilding Palmer.

The Challenge

There are several key challenges for the inpatient facilities at the Feilding Palmer hospital which was built in 1899 (with later extensions) as summarised below:

Area	Challenge
Estates	- Beds do not meet all regulatory requirements. - Site does not give the flexibility of modern health care. - Backlog maintenance - £1.544m over the next 10 years (75% of this within the next 4 years).

[1] The case for change has been described to the Clinical Senate in written form and is copied verbatim here. This helps to shape the Terms of Reference at the outset of the process, which engages the Clinical Senate and the exact nature and ask of the clinical review team.

Clinical	- IPC standards cannot be met (bed spacing, sluice/dirty utility, handwashing and ward size). - Patient privacy and dignity challenges hindering provision of properly segregated single sex areas and wards.
Workforce	- Not an attractive location for staff (lack of managerial support onsite). - Building and environment makes it an unsuitable place to deliver inpatient care. - Filling shifts on the inpatient ward were always a challenge. - Workforce preferred to provide care in more modern facilities. - 2 Registered Nurses (RN) and Health Care Assistants (HCA) for a 10 bedded unit is significant resource. This is against a system context of high turnover, retention of staff, carrying high vacancies.
Financial	- Inefficient workforce model: 2 RNs and 2 HCAs for 10 beds. - Running costs are high – disparity to other LLR facilities – not an effective use of taxpayers' money.

When the ward was open, at any one time there were only 2 or 3 Lutterworth patients occupying the beds in Feilding Palmer with the remaining beds being occupied by patients from elsewhere in LLR.

Despite the temporary closure of the inpatient ward, patients from Lutterworth can access a wide variety of services based upon their care needs. Patients requiring medical rehabilitation with significant 24/7 nursing care are supported in an alternative LLR community hospital bed or, in a 'Pathway 3' reablement bed for patients with lower medical needs. The Home First service in LLR also provides integrated health and social care crisis response and reablement services. For patients requiring reablement, they deliver intensive, short-term care for up to six weeks. Home First services are accessed via Locality Decision Units, with health and

social care services working based on trusted assessment and delivering coordinated packages of care.

Population Growth

Within the next 5-10 years, there will be significant housing growth within Lutterworth because of the Lutterworth East Sustainable Urban Extension[2] (SUE), resulting in 2,750 additional dwellings (an estimated 6,710 residents). This will increase Primary Care activity and demand for outpatient activity. Patients are currently travelling out of Lutterworth to other hospital sites within LLR and across the borders into Coventry and Warwickshire to receive their outpatient care (40 minutes to Leicester (LRI), 20 minutes to Rugby (Hospital of St. Cross), 27 minutes to Coventry (University Hospitals Coventry and Warwickshire)).

Prior to Covid-19 the following services were running from the facility:

- 10 community inpatient beds
- Cardiology outpatient appointments
- General surgery outpatient appointments
- Gynaecology outpatient appointments
- Community paediatric outpatient appointments
- Physiotherapy
- Out of Hours access

The LLR proposal is to repurpose the inpatient ward space to provide an enhanced procedure suite along with additional consulting rooms. The specialties that could be carried out from the facility are:

- Ophthalmology
- Gynaecology
- Trauma and Orthopaedics
- Cardiology

[2] SUE is defined as separate neighbourhoods that incorporate local centres, employment and other facilities, whilst being integrated with existing communities and built-up areas, supporting the town as a whole.

- General Internal Medicine
- Rheumatology
- Dermatology
- Respiratory medicine
- General surgery
- Physiotherapy
- Urology
- Out of Hours access
- Community paediatrics

A formal options appraisal process has been conducted which has concluded that the preferred way forward is to permanently close the inpatient beds at Feilding Palmer to allow for a refurbishment of this site which will bring about an expansion of outpatient activity and diagnostics, support access to specific pathways and enable strategic alliances to function.

3.3 Scope and limitations of review

The areas in scope of the review are all community services provided by the LLR system which changes to the service provision of the Feilding Palmer facility could potentially impact upon. The clinical review team acknowledge that the inpatient beds at the Feilding Palmer site have been closed for over 3 years with this service need being met elsewhere in the system. Thus, the focus was not on determining if these beds should reopen but firmly on if sufficient, robust and appropriate services had been put in place and/or included in the community healthcare service plans to fully meet the needs of the Lutterworth population served by LLR.

Specifically, the clinical review team was asked to review the information provided by Leicester, Leicestershire and Rutland (LLR) ICB, with support from Leicestershire Partnership NHS Trust (LPT) to consider the following key areas:

- *Is the refurbishment of the Feilding Palmer facility and revised community service model likely to address the challenges reported at the Feilding Palmer*

facility and deliver a positive impact on the quality of care of the local population and are there any factors that have not been considered?

- *Has the closure of the 10 bed inpatient facility at the Feilding Palmer site been appropriately mitigated in the planned expansion of the community services across LLR (with specific reference to community clinics expansion at the Feilding Palmer site)?*
- *Does it align to best practice, national guidance and direction of travel for the provision of community services?*
- *Are there any unintended consequences or risks that have not been identified and mitigated in the proposal (including any impact on populations currently accessing the services provided or peripheral service provision)?*
- *Has it considered the demographics of the population served, taking into account the needs of that specific population and ensuring equity of access and a positive impact on health inequalities?*
- *Does the proposed model appropriately consider predicted demand for services and provide sufficient flexibility and adaptability to meet these needs?*

4. Methodology and governance

4.1 Details of the approach taken

The sponsoring organisations (Leicester, Leicestershire and Rutland (LLR) ICB with support from Leicestershire Partnership NHS Trust) engaged with the Clinical Senate on 16th February 2023 (Jo Clinton, Head of Strategy and Planning and Carrie Harris, Planning Manager (Strategy and Planning), Leicester, Leicestershire and Rutland Integrated Care Board (ICB)) and Emma Orrock (Head of Clinical Senates). It was agreed that a full day's review would be required (9.30am to 4.30pm) to assess the proposed permanent closure of the Feilding Palmer inpatient beds and planned community hub and subsequently, the 29th of June 2023 was identified for the clinical review panel. Panel members and patient representatives were identified from the East Midlands and West Midlands Clinical Senate Councils and Assembly memberships.

On the 21st of June the Clinical Senate received direct correspondence from an individual stating they represented the local group called The Mary Guppy Group. The Head of Clinical Senates informed the ICB with permission from the Group. This is a fairly rare occurrence for the Clinical Senate to be contacted directly by a local group representing patients and the public, however, it was agreed that the additional papers provided in their email correspondence would be shared with the panel for their consideration along with the covering email. The ICB advised the Clinical Senate that The Mary Guppy Group are a member of their steering group and the ICB plan had been presented to the group as part of their local pre-engagement. The panel were asked to give appropriate consideration to the additional evidence with particular involvement from the Senate panel's patient representatives. The Clinical Senate thanked the individual for their correspondence and confirmed to them that the Clinical Senate had been engaged on a very specific basis through an agreed Terms of Reference as an independent clinical advisory body who will provide an opinion on the ICB's proposed model. The Senate review report is not published by the Clinical Senate until the express permission of the sponsoring organisations is given and as set out in the agreed Terms of Reference. As the body who has statutory responsibility for public and patient engagement the Senate directed the individual accordingly to the ICB.

The panel member representing Local Authorities had to withdraw from the panel less than 24 hours before the review meeting, preventing the identification of an alternative representative. A Local Authority Director of Adult Social Care who is also a West Midlands Clinical Senate Council member reviewed key elements of the evidence submitted and provided some key questions to the Head of Clinical Senates prior to the review (which was discussed in advance with the panel Chair). These were fed into the question and answer session on the day to ensure that key Local Authority input was still provided to the review.

A draft report was sent to the panel members and the sponsoring organisations to check for matters of accuracy. The final report was submitted to the Senate Council (and ratified on 20th July 2023).

This report was then submitted to the sponsoring organisations, Leicester, Leicestershire and Rutland (LLR) ICB and Leicestershire Partnership NHS Trust on 21st July 2023. This was somewhat earlier than the timeline agreed in the Terms of Reference due to the quick turnaround by the Senate team and sponsoring organisations within the process.

The East Midlands Clinical Senate will publish this report on its website once agreed with Leicester, Leicestershire and Rutland (LLR) ICB and Leicestershire Partnership NHS Trust. The anticipated publication date is 31st August 2023.

4.2 Original documents used

The full list of documents provided by the sponsoring organisations for the clinical review panel can be found in Appendix B. The documents covered the clinical case for change and various elements of service provision in Lutterworth where Feilding Palmer is located. Documents from the original submission and an additional submission on 23rd June following feedback from the panel pre-meet on 16th June are detailed. Three additional documents received on behalf of The Mary Guppy Group are also itemised in Appendix B.

5. Key findings from the clinical review

The Clinical Senate panel Chair opened the day with thanks to the sponsoring organisations for hosting the clinical review team. The Chair extended thanks to the review panel for dedicating their time to attend and sincere appreciation to the sponsoring organisations for the significant amount of work that was evident to the panel in the breadth and volume of evidence submitted.

The Chief Officer of Strategy and Planning (LLR ICB) opened the executive presentation by providing some context for the current position. They described Lutterworth as a market town with around 11,000 residents, served by two GP practices with 16,600 registered patients between them. They described a large development which was planned on the east side of the town that would include a minimum of 2,750 new homes and approximately 6-7,000 new residents. This represented a considerable population increase over the next 15 to 20 years. This was a key driver for the changes to the provision of community services, ensuring that a plan was in place which was both right for the current population and would meet future needs.

The Chief Officer talked about the strategic direction for the ICB which had transferred over from the CCG as being care closer to home. The “Home First” programme was discussed with the focus being on services such as mental health, end of life care and integrated teams. The purpose of the service redesign was to ensure that the strategic vision was delivered effectively at a local level. Patient travel was identified as a core element of this work. Post Covid-19, a new community model for Lutterworth was deemed a priority with a steering group put in place. This involved key community groups as stakeholders. It ensured that the model of care was co-designed with the local population engaged throughout the process to design a community hub that would increase usage of the Feilding Palmer facility across a broader range of the population. They stated that the involvement of a large number of people in the development of the proposal had led to a lot of support clinically and from the community. They stated that the need for an alternative use of the facility and different ways to deliver services had come about in part because of a recognition that only 2 to 3 patients from the local area were using the inpatient

facility pre-Covid-19 with the rest coming from the wider LLR area. This did not align to care closer to home. The new service model for Lutterworth would expand primary care to support both the capacity needed following the housing expansion and also the new roles and services primary care are now asked to provide. The new model would also expand outpatient capacity and capacity for services such as minor procedures closer to home.

The Director of Strategy and Partnerships went on to state that LPT own the Feilding Palmer building which they want to repurpose as a health campus with all NHS services on site. They stated that an alliance was already being built. They described the impact of the Covid-19 pandemic and the “wake up call” it had given the team with the total inability to meet the IPC guidance on that site. It had afforded them the opportunity to rethink how care was provided in this facility given the stark and considerable challenges the facility presented. These challenges were described in detail and were extensive. They covered a multitude of core NHS service requirements from privacy and dignity to the basic challenge of not being able to move a bed around the facility; requiring patients to be moved onto trolleys in order to move them around the site. It was stated that these constraints were such that no options existed to make internal alterations to the building that would enable it to comply with modern healthcare requirements such as IPC and privacy and dignity. This meant that the delivery of inpatient care from this facility was not possible. The running costs of the facility were described from both a maintenance and ongoing resourcing perspective to demonstrate that it was a very expensive and inefficient model that did not represent value for money. This included the workforce needed to run the facility where it was stated that there were constant challenges attracting staff to work at the facility, leading to a lack of consistency in staffing which did not impact positively on service delivery. It was stated that there is a strong commitment to having good community hospitals to align with the changing population and changing ways of working.

It was stated that partners such as adult social care were involved in conversations regarding wrap around services. It was stated that alternative community hospital provision was in place for patients who needed that level of care. There was a detailed description of the services which could be located in the community campus

once in place. A clear desire to ensure flexibility was articulated. This was stated as critical to future proof services due to the local needs changing rapidly over time along with the evolving available and recommended clinical enhancements.

A local GP partner provided a detailed explanation of the current set up of primary care in Lutterworth with both practices being part of a PCN along with three other practices in LLR covering 47,000 patients in total. They stated that both local practices and the PCN were supportive of the proposed model. They described their personal experience of working in the Feilding Palmer facility and reiterated the low usage of this facility by the local population with bed usage stretching across the entirety of LLR to make it work historically. They described the extensive travel currently required by a large proportion of Lutterworth patients for outpatient services both within LLR and into neighbouring ICS geographies with very poor public transport links to support patients. They described particular services such as ophthalmology, rheumatology and mental health where treatment was often required every few weeks. This required regular travel by patients with conditions that impacted on their ability to do so easily. They stated that a large number of such procedures could be conducted locally if often low-tech equipment or facilities such as a clean room were installed in the community hub, or if wrap around services were present in the locality. This would support many agendas including a significant decrease in the carbon footprint of the services. A description of the Lutterworth population was provided with the new housing development expected to mirror that of developments seen in the last 10-15 years, bringing a further influx of families and patients under 75. Their needs are predicted to be heavily weighted towards primary care and diagnosis with less need for inpatient care and step-down care. It was stated that the volume of patients that would make use of the services in a community hub for outpatient services or diagnostics would vastly exceed any need for inpatient services even if it were viable. This would increase the value for money of the site significantly.

It was stated that there was an increasing body of evidence regarding the risks of deconditioning for elderly patients in inpatient facilities with a strong emphasis on the importance of mobilising these patients at the earliest opportunity to enable a return to their homes. The benefits of adjacencies between primary care and consultants to

enhance and expand the work carried out in primary care was described. The benefits of a community healthcare services campus for patients were described with travel, parking and waiting times specifically mentioned. There was a description of how the proposed model meets each of the five key tests of the NHS.

Following the executive presentation there was a question and answer session with the panel which is summarised below.

The panel heard that work was being done to look at the potential for a one stop shop approach and how the community diagnostic strategy fits with the integrated care strategy. A specific example was given regarding the cardio-respiratory pathway. A programme was planned for implementation in the next two months at PCN level in 17 locations across LLR. This would deliver key diagnostics local to home. Current services such as echocardiograms and ultrasounds were being delivered by independent sector providers. It was stated that this gave sufficient capacity across the county but was not as local as it could be which the new provision would address. It was stated that there were no radiology services locally at the time of the review, but other close neighbours had this service. The desire to utilise more mobile imaging services and expand this was expressed. Currently, mobile services could be anywhere in LLR which could have significant travel implications. Thus, plans would bring mobile services to more local destinations. The development process was likened to building a jigsaw around the area to piece together the services in an appropriate manner. This was said to be supported by patients and GP feedback and would also support reductions in waiting times. It was stated that though the plans would not introduce one stop shops in their purest sense, it would bring diagnostics and outpatient clinics closer to home which would reduce the frequency that patients had to travel outside of the local area in their pathway.

The panel asked if the expansion of the community services and aspirations described would include traditional community services in the shared spaces. It was stated that the healthcare hub would include all community services. Community nursing offices were currently in Enderby, but the plans would allow space for health and social care to be brought together which would increase the scope for an MDT

approach. It was stated that the extensive travel time was strongly linked to the high level of vacancies in the Community Nursing team. It was hoped that having this local touch-down point would help address this. The panel heard that the “Home First” partnership worked collaboratively in a virtual ward approach. This was available for several pathways with a desire to expand this into falls and care homes being articulated. A pilot for palliative care was mentioned to support reduced entry into acute care. The core aim of the virtual wards was to prevent unnecessary hospital admissions and increase step-down care away from this setting. It was stated that the number of beds across LLR had been increased prior to last winter with another increase planned prior to this winter which will further support an increased offer across the board for patients.

The panel heard that Lutterworth is close to the centre of England, surrounded by excellent transport routes which results in it being a massive distribution hub for businesses which continues to expand. This was felt to attract a population that would not be largely home workers, rather would have jobs in this industry and their warehouses. It was stated that whilst Rugby was in a different ICS boundary, they were also focussed on place-based plans to expand care in their local area and reduce the patient footfall into the large acute trusts, supporting the patient choice agenda. The panel heard that clinical networks were under development across disease specific areas to support IT connectivity and the sharing of diagnostic data; further supporting the patient choice agenda. This was a Midlands wide project.

The panel enquired about the support to families to reduce their travel for patients in palliative or end of life care. The panel heard that an integrated specialist palliative care team was in place which worked with the community nursing team. It was stated that there were beds available 11 miles away in Hinckley and also facilities in Market Harborough to support these patients along with the nursing home support in place locally. The specialist Hospice LOROS existed across the other side of Leicester which some patients choose to use. Historically, there was one bed in Feilding Palmer for this service which was not efficient to run. The loss of this very limited resource had not been missed due to the provision of MDT style wrap around care in the community. If the patients’ needs were greater than the current provision could support, it would also be too great for Feilding Palmer to have met historically and the

patient would need to enter hospice care. The panel heard that terminal care was available in residential care homes. Both care homes and nursing homes were on a framework to support and upskill staff to manage such patients. The number of beds in these settings has increased in the last 18 months and there is a commitment to support further development.

The panel heard that the Local Authority was a key member of the steering group which included domiciliary care, public health and prevention services with the prevention agenda being a core part of plans as they progress. It was stated that the co-location of services would be a positive step with health and social care being on one site and no longer scattered as they currently are. It was stated that the panel walk around of the Feilding Palmer site would help demonstrate that it could accommodate all the services suggested.

The panel heard that the system executive team meet fortnightly. This group includes the Chief Executive Officers, Directors of Strategy and Directors of Finance from the three constituent NHS organisations (ICB, LPT and UHL). Discussions include the affordability of proposals in the current climate, a look at financial modelling and the prioritisation of work programmes. It was stated that this project had been identified as the top priority for capital spend and had been deemed affordable. There was a description of the Leicester Royal Infirmary re-organisation in progress and the commitment to sustainability across all three organisations. It was stated that if 50% of the Lutterworth outpatient activity was repatriated back to the local area, this would save over 300,000 miles travelled by patients a year. This looked beyond the NHS saving and into what it means for the patient experience. It was stated that there was experience of community diagnostics being provided more locally, having been achieved recently in neighbouring areas. This was stated to demonstrate that the benefits are achievable.

The panel heard that the evidence submitted for this review was focused on a part of the overarching LLR community services plans that Feilding Palmer link into and the system had not described the full list of community services which are already in place in LLR in homes or schools for example. With the population health in mind and the predicted future population makeup, the system stated they were clear on

the opportunities in primary and secondary prevention across the life course of the population. They stated that they planned to increase services such as health visitors as the population changes over time. It was stated that conversations around such areas were occurring. The current population was described as higher than the national average for over 65 years of age in the largest GP practice, thus a high number of long-term conditions and chronic disease existed which require diagnostics and outpatient facilities. The gradient in deprivation prevalent in LLR was mentioned along with a desire to avoid generalist strategy conversations around health inequalities by ensuring they are instead appropriately nuanced. The importance of ensuring that strategic plans include how the progression and advancement of multi-morbidity affects patients was mentioned.

The panel heard that ophthalmology was the service with greatest need for outpatient capacity (quoted at one-third of all outpatient activity), making it a critical service to provide locally. There was a discussion regarding the staffing needs and skill mix to realise the aspirations around activity increases. It was stated that LLR did not have a problem recruiting staff and that staff liked to work close to home but there was an issue attracting medical staff to the Feilding Palmer site in its current state. It was stated that a revamp of this site was hoped to address staff willingness to work there.

The panel heard that the system had invested a lot of time in community engagement to talk through proposals and ensure parties understood the model. Originally the local MP had concerns about the possible closure of the site/beds but they are now supportive of a model that provides more community based clinics following a detailed explanation of the rationale behind it. Regardless of the facility in use, it was explained that given the size and needs of the local population there is no need for an inpatient facility in Lutterworth as demonstrated by local utilisation of the beds in the Feilding Palmer facility pre-Covid-19.

The panel heard a description of the community pharmacy provision in Lutterworth. Both pharmacies close at 6pm on weekdays with only one being open on a Saturday until 3pm. There was no pharmacy provision on Sundays. GP practices do not have a dispensing service. There have not yet been discussions with these pharmacies regarding the plan to expand services and the availability of the medications

necessary for patients attending these services. The closure of community pharmacies being seen nationally was identified as a risk by the system. There was a discussion about the significant cost increase of outpatient prescriptions outside the acute setting. The system was looking at ways to meet this need beyond community pharmacy and stated that community pharmacy commissioning moving to ICBs will help the development of future plans. A pilot was being introduced to look at delivering medications directly to patients' homes for specific drugs.

The panel heard that the system did not have any concerns regarding ensuring that the workforce can increase to meet demand and service expansion. They articulated a clear commitment to increase services in line with population increases and demand. Support from the alliance and repatriation of the workforce was mentioned with staff groups operating more as an MDT. It was stated that the workforce plan was being led by UHL. It was stated that new ways of recruiting must be employed as traditional methods were less effective. It was stated that not all care needed to be consultant led and that different ways of working such as GPs with specialist interests (GPwSI) and Advanced Practice for non-medical clinicians was being developed to support growth in the community facility. The use of the independent sector such as high street optometrists was also described. The evaluation of activities unnecessarily carried out in theatres was described with support to move this activity into a more appropriate setting with the workforce being used more effectively. It was stated that current experiences of changing the workforce had given the system confidence that their plans were achievable. A medium to long term view was being progressed to look at ways of growing talent and developing the local community to become the workforce of the future.

The panel enquired about the support in the system to ensure that rehabilitation in care homes was robust to avoid the conversion of patients into residents. The panel heard that community beds were still available for the right patients to use. It was stated that the region was recognised as high performing in terms of short delays for patients exiting acute care with good sustainable outcomes. It was stated that LLR currently had a 350 gap in acute beds which would, in part, be addressed through effectively using rehabilitation facilities and ensuring patients were sent into the correct services. It was stated that there was a lot of work needed to improve this. It

was stated that evidence has shown that rehabilitation in care homes in LLR had good outcomes and a drive to continue to improve this was articulated. A new procurement to increase discharge to assess beds and strengthen reablement in care homes was mentioned. It was stated that Local Authority colleagues were being brought into this process to make the assessment more robust.

Following the question and answer session, the panel were taken on a tour of the Feilding Palmer facility. The panel then split into two groups to meet with a range of staff involved in the community service. The Senate had requested to meet frontline clinicians and staff who had been or would be impacted by the closure of the Feilding Palmer beds and the proposed future model. It was noted that the afternoon groups did not include any such staff and were smaller than had been detailed to the Senate. The themes of these conversations are provided below:

- The panel heard that the proposal was not what would be desired for community services in the area if the current estate did not exist. Partners were clearly united in agreeing on the proposal but it was felt to be more of the best compromise rather than best option.
- The panel heard all members of staff agree that Feilding Palmer was not fit for purpose and a clear desire for care to be delivered locally, closer to home.
- The panel heard that regardless of which option was progressed, staff felt there was a gap in Lutterworth community services which needed addressing.
- The panel heard that the system is looking at outpatients through a different lens and consequently looking at a different workforce. The panel heard a variety of mechanisms including training pathways and supporting advanced practice being explored to create the workforce needed. This was described as a need to “think outside of the box”.
- The panel heard about work to address digital technology issues where problems are foreseen in the immediate future but improvements are occurring. The staff were clear that they will face difficulties as they “push the envelope further” but the benefits in progressing services made it an important step.

- The panel heard lengthy descriptions of ways to run services differently in terms of procedures and pathways, locations/co-location and workforce that were being discussed internally and worked through.
- The panel did not see or hear any data or information specific to Lutterworth patients. However, the panel heard that 7 other sites in LLR had successfully delivered community services closer to home for their locality which was felt by staff to demonstrate it was possible in Lutterworth.

The day concluded with high level feedback from the panel Chair which is detailed in section 6 below.

6. Conclusions and advice

The Chair drew the day to a conclusion, consolidating the panel's opinions from the written evidence and information gathered on the day. The panel looked to answer the questions posed in the Terms of Reference that had been agreed with the sponsoring organisations. The aim of the conversations throughout the day had been to provide the clarity and detail necessary to convince the panel that the proposals are the right way forward for the system. The questions posed in the Terms of Reference and challenges faced are multifaceted. Thus, the panel's conclusions below are split into the key defined areas. The passion and desire to drive change was clear across all members present from the system. This was laudable. However, upon speaking to individuals, the clarity on the specifics and, in essence, what the system would be consulting the local population on seemed less clear.

The Closure of the 10 Bed Inpatient Facility at the Feilding Palmer Site and mitigations

The panel were fully assured that the Feilding Palmer site was not fit for modern day healthcare, that the inpatient beds should remain closed and that there was no need identified for an inpatient facility in this locality. No evidence was submitted which indicated that these beds were fully utilised or in the right place for either the Lutterworth population or wider LLR area. The panel fully appreciated the enormity of the constraints presented by this site on multiple levels including fundamental "deal breaker" issues such as compliance with IPC guidance, privacy and dignity and even equitable access and patient safety due to the basic layout of the building.

The panel were not completely clear on what services specifically had been provided by this inpatient facility historically. Only a high-level snapshot of previous inpatient diagnoses had been provided. Thus, the panel could not be fully assured that the loss had been completely mitigated in the wider LLR service provision. However, the panel felt confident in the services described across LLR and the availability of appropriate community beds to be unconcerned on this point, whilst acknowledging that this did not address the patient travel issues described during the day in the short term.

The Refurbishment of the Feilding Palmer Site

The Feilding Palmer site was clearly an asset to the system which should be made best use of. The panel heard a clear emphasis on what could be done differently with the building with a clear steer towards increased outpatient activity. The panel heard many options for delivering outpatient care differently and would encourage the system to ensure that these ideas are forward thinking including things such as Patient Initiated Follow Up as opposed to the traditional NHS follow up mechanisms. The panel explored with both groups during the afternoon how community services would work if Feilding Palmer did not exist and would something different be required in this locality with a resounding “Yes” clearly heard. However, it is a Victorian building with all the significant challenges and constraints that come with its age and design. These appear to be particularly acute in this situation which led to concern from the panel regarding if anything of sufficient capacity and flexibility could realistically be created, to bring the site up to the necessary standards for today and most definitely for the future. There was concern that persistent problems with the fundamental structure could hamper the level of service delivery the system clearly aspires to.

The panel expressed concerns that the cost to refurbish this building to the necessary standard to deliver high quality modern healthcare across the services described would be significant. Caution must be applied to ensure this is not underestimated, with the potential to unintentionally overpromise and underdeliver. Likewise, the ongoing cost of the facility to both maintain it and allow evolution of services as populations, demands, pathways, best practice, technologies etc change in the next 5/10/15 years was also likely to increase. It was clear that if money were no object, the plans would be very different. However, all partners had reviewed the proposed options, with refurbishment being the preferred compromise, strongly driven by the constraints of the building and affordability which the panel felt was very understandable and pragmatic. The panel reflected that there may be additional options not described which would make best use of a refurbished facility with stronger future proofing in mind. The panel suggested that the system would benefit from challenging itself on the cost effectiveness of the model now and over the next 15 years, evaluating the true value for money and both patient and staff needs of fitting everything within the plan into one Victorian building. The panel encouraged

the system to reflect upon a strongly forward-facing view and question if the future direction of travel for the delivery of outpatient services in the next 10-20 years is reflected boldly and robustly enough in its current plans.

The system's proactiveness to use the "wake-up call" following the necessary closure of the facility during Covid-19 to reflect and rethink healthcare provision in the locality was laudable. The panel agreed that there is a gap in community service provision in Lutterworth and also agreed with the principles discussed during the day regarding the need to provide community services differently to meet the nuanced needs of the local population. This needs to be both for now and for a carefully forecasted future population.

The Revised Community Services Model

The panel commended the collaborative nature of the system's processes which had ensured that a broad range of partners had been included in the development work from its infancy. The work with the alliance was clearly integrated and well established. The alliance was understood to be a central pool of UHL staff who then operate as a roving team to support a range of off-site services to provide a standard approach. The panel strongly believed that the engagement and collaborative work was an asset to this programme and would be a very positive factor in the future success of working differently. It was recognised that a large proportion of community care takes place outside of the NHS. Thus, involving key stakeholders beyond the NHS to look at wider local providers in the community was clearly an important and vital step.

The panel acknowledged the success of LLR in establishing a convincing community rehabilitation and reablement service, wrapping MDT teams around the patients and the "Home First" model. The panel believed that this would naturally be beneficial to the population of Lutterworth and the experience of the system would support this work. However, the panel did not feel that they had seen a detailed model specific to Lutterworth. The panel noted a general lack of data in the evidence provided meaning that the granular detail relating directly to Lutterworth patients was missing. The panel urged the system to ensure that data and narrative presented in any future business case and consultation documentation clearly explains the information from

both an LLR and Lutterworth perspective in great detail. The panel were impressed with the level of understanding shown with regard to population health management and demography of the population. However, the panel suggested that a fresh look at the available data would be beneficial to robustly map out the population's needs now and at 5 year intervals into the future. The final offer put forward should reflect the needs of the entire population with clear initiatives to ensure services are nuanced and targeted to bridge the health inequalities gap, supporting those most in need. With this as the cornerstone, plans would be focused on the changing needs of the population, rather than the risk of focussing the plans on what can be accommodated and provided in the available estates first and foremost.

The panel heard a vast array of potential options for services to be delivered from the redesigned community hub covering a huge number of outpatient services, social care services etc. The panel heard that the vision was for all health and social care services to be co-located in one hub. In light of this the panel expressed concerns on a number of points:

- the size and the fundamental footprint and structure of the actual building was such that there were significant concerns regarding its ability to house the quantity of services in a flexible and adaptable manner that would not result in the facilities becoming outgrown or outdated rapidly.
- the current lack of clarity of the specific location of services. Thus, the interdependencies and effect of co-location of services was a significant unknown which poses risks and potential unintended consequences if not clearly defined with input from the services and stakeholders involved to carefully work this through.
- the ability of the infrastructure of the town and site to cope with the influx of traffic and people if the planned increase in activity was realised.
- the fundamental structure of the building and potential risks around equitable access for all patients. The panel considered the scenario where you have a wheelchair user and a patient using crutches attempting to pass each other in the corridors. Would the building be able to cope with a large increase in footfall?

- the risk of widening health inequalities, particularly hidden ones, which are known to be prevalent in the incumbent population if services are not carefully targeted.

The panel were supportive of the overarching plan and need to redesign community services. However, there was a lack of clarity and granularity of detail regarding all aspects of the final proposed hub to assure the panel that this option was both viable and the right way forward. The high volume of options still under consideration combined with uncertainty about the exact outpatient services and procedures to be provided with phased timescales, left the panel unclear on what the local population would be consulted on. The panel strongly suggested that this detail is firmly and robustly articulated in preparation for the business case and that a final option is presented which includes the definitive list of services which would be located on the site. The panel also suggested that prior to any further consultation, any documentation was carefully worked through to ensure that all the questions heard previously or envisaged are answered in detail to provide a coherent and very specific picture to patients. This would avoid further confusion, allowing patients to understand their specific circumstances at a pathway/service level and determine what the implications for them would be, even if this would be travel to a service out of Lutterworth. The panel also recommended that consultation shifts its focus from what was happening following the loss of a facility to be focused on what will be gained by the proposals and the positive impact for the locality to support a shift in mindset.

Unintended Consequences

In support of the principles laid down during the review visit the panel wished to highlight the following potential risks and unintended consequences to ensure they were on the system's radar:

- workforce was a large factor with many potential unintended consequences and risks from repatriating staff or changing staff working patterns. UHL are carrying many vacancies. If specialist support from the acute provider was required at the community hub or staff moved across to support services in Lutterworth, there would be a risk to the stability of acute services where vacancies are more challenging to fill.

- whilst the panel heard a high level of confidence regarding LLR's ability to recruit staff, a lot of faith was placed on the attractiveness of a revamped/refurbished site. There was a risk that this may not have the intended positive impact, with the changes not creating the level of interest required to secure the necessary workforce. The panel were not assured that there was any mitigation should the latter be the case.
- the panel highlighted the risk of widening the health inequalities gap through the provision of all health and social care services in one very specific location which may benefit the majority of the population but not represent targeted enough service delivery to support the most vulnerable and in need members of the community.
- the panel felt that engagement overall had been very good. However, more clarity and detail needed to be provided to ensure support services such as pharmacy and social care had sufficient time and capability to put in place mechanisms within their own services to adapt and evolve as needed for the change in service provision within Lutterworth. Otherwise, gaps in care and service provision will negatively impact on the overall provision of community services.

Workforce

Workforce was a recurrent theme throughout the day. The panel were assured to hear the innovative system thinking regarding both programmes to build a new workforce for the future and thinking about effective and appropriate use of the current workforce to deliver the right care in the best location. The panel acknowledged the large numbers of vacancies being carried by organisations and shortages across several professional groups nationally. However, the panel felt that it had not heard or seen sufficient detail nor evidence to share the system's level of confidence that the expansion of services planned could be robustly staffed now nor safeguarded for the future.

7. Recommendations

7.1.1 Recommendation 1

The panel recommend that the inpatient facility on the Feilding Palmer site remains closed permanently and that future plans for community service provision in Lutterworth do not include inpatient facilities (based on current evidence of provision and population need).

7.1.2 Recommendation 2

The panel recommend that the system reflect on the volume of potential services planned for delivery from the Feilding Palmer site; to take a future view, working through each service and consider all aspects from finance, infrastructure, patient demand and volume, required adjacencies and implications to patient experience and need. The outcome should determine what is viable, cost effective and sensible for the present and future of community services. This should consider the national steers and best practice.

7.1.3 Recommendation 3

The panel suggest that the system refreshes an analysis of the local population health data to look at the present and future population modelling to understand the nuances in less visible population health needs and health inequalities. This should inform decisions regarding patient needs and service provision to ensure no future plans unintentionally widen the health inequalities gap.

7.1.4 Recommendation 4

The panel recommend that the system ensure that the data and narrative presented in the business case and consultation documents is highly detailed, covering both the wider LLR geography but very specifically the Lutterworth patient population. This should provide a significant degree of clarity for patients to understand the impact on them as individuals and for all involved in the project to have a robust understanding of what is proposed.

7.1.5 Recommendation 5

The panel suggest that workforce development considerations are expanded to include the impact on the wider system of repatriation of staff into Lutterworth (with particular reference to the acute provider) and mitigation for potential ongoing unwillingness to work at the Feilding Palmer site post refurbishment.

Appendix A: Clinical Review Panel Terms of Reference

CLINICAL REVIEW TERMS OF REFERENCE

Title: Clinical Senate Review of the Community Services Provided at the Feilding Palmer Community Hospital

Sponsoring Organisation(s): Leicester, Leicestershire and Rutland (LLR) ICB with support from Leicestershire Partnership NHS Trust

Clinical Senate: East Midlands

NHS England region: Midlands

Terms of reference agreed by:

Name: Emma Orrock/Ben Pearson **on behalf of clinical senate and**

Name: Jo Clinton/Sarah Prema and David Williams **on behalf of sponsoring organisation(s)***

Date: 6th April 2023

Clinical review team members

Chair: Dr Ben Pearson, Consultant Geriatrician and Executive Medical Director, Derbyshire Community Health Services (DCHS) NHS Foundation Trust and Clinical Senate vice Chair

Panel members:

Name	Role	Organisation
Anne-Maria Newham	Deputy Chief Executive Officer	Nottinghamshire Healthcare Foundation Trust
Claire Greaves	Divisional Director, Ambulatory Care Division	Nottingham University Hospitals NHS Trust

* Written email confirmation approving these TORs must be received by the Head of Clinical Senates from each sponsoring organisation by the named person in these TORs or their nominated deputy/deputies.

Ian Lawrence	Clinical Director for integration Chief Clinical Information Officer	Derbyshire Community Health Services Foundation Trust (DCHS)
Jane Youde	Consultant Physician	University Hospitals of Derby and Burton NHS Foundation Trust
Jason Evans	Acting Chief Officer for Integrated Urgent & Emergency Care, West Midlands Region	Black Country ICB
Jo Watson	Assistant Director of Nursing & Workforce	NHS England
Kat Telford	Medical Educator	University of Nottingham
Kerry Bareham	Nurse Consultant	St Barnabas Lincolnshire Hospice
Mandy Clarkson	Deputy Director Public Health	NHS Midlands
Paul Jenks	Chair, Community Pharmacy Lincolnshire Chair, National Pharmacy Competency Group Vice Chair, Lincolnshire Primary Care Advisory Group	Lincolnshire Community Pharmacy
Paul Midgley	Patient and Public Involvement representative	East Midlands Clinical Senate Council
Salil Parkar	Therapy lead Inpatients	NHS Birmingham Community Healthcare NHS Foundation Trust

Sarah Raistrick	GP	NHS Coventry and Warwickshire ICB
Saul Hill	Integrated Community Manager	Derbyshire Community Health Services NHS Foundation Trust
Susan Edge	Patient and Public Involvement representative	East Midlands Clinical Senate
Suzanne Avington	Associate Director Allied Health Professionals	Nottinghamshire Healthcare NHS Trust

Background

Prior to the COVID-19 pandemic the following services were running from the Feilding Palmer facility:

Services
10 community inpatient beds
Cardiology outpatient appointments
General Surgery outpatient appointments
Gynaecology outpatient appointments
Community Paediatric outpatient appointments
Physiotherapy
Out of Hours access

Admissions to the 10 bedded inpatient facility within Feilding Palmer Hospital (including one palliative care suite) were suspended at the beginning of the Covid-19 pandemic in response to a review against the national Infection Prevention and Control (IPC) guidance. This had an impact on outpatient appointments and the community hospital beds.

The facilities at Feilding Palmer do not meet all regulatory requirements. The Victorian Cottage Hospital still retains much of the feel of an historic building which does not give the flexibility of modern health care. The layout of the building is reported by the sponsoring organisations to be not conducive to the provision of modern health care standards, with small, cramped corridors and reduced ability for patient flow. The IPC guidelines also affect the ability to meet current standards on

space and ward size thus affecting bed availability at Feilding Palmer. The building presents issues to patient privacy and dignity due to the lack of properly segregated single sex wards. Mitigations to address these issues would lead to a further reduction in the number of beds.

The hospital operates a high-cost staffing model because of the low number of beds (closer to the cost of a High Dependency Unit). To maximise productivity and reduce waiting lists, activity is being consolidated at alternative sites. This is because there are insufficient nurses and doctors to run clinics that are not at full capacity or wards which have low patient to nurse ratio. The inpatient facility at Feilding Palmer is reported to be an unattractive location for the workforce due to the size of the ward with poor in-patient provision and a feeling of isolation as there is a lack of senior managerial support onsite. The building and environment make it an unsuitable place to deliver inpatient care, and filling shifts on the inpatient ward has always presented a challenge. The workforce preferred to provide care in more modern facilities. When the beds were open to admissions (pre-COVID) the number of local patients occupying them was between 2 or 3 (25-33%), with the remaining beds being used by other patients within LLR.

As part of the design process for a proposed future service model, the system has undertaken significant engagement over the last 18 months to involve the population across Leicester, Leicestershire, and Rutland. Key projects are reported to have seen qualitative information gained from patients, service users, staff, and carers, including work with communities including those with protected characteristics. A local community campaign group attends each steering group, which is leading the project, and a stakeholder briefing has been provided following each meeting. This has been shared with Parish, Town and County Councillors, patient groups including local Patient Participation Groups, voluntary sector organisations, local MP's office, Steering Group members and other key stakeholders. Agreement to this approach has been confirmed by all representatives.

In addition, there are predicted further demands on services within Lutterworth once the 2,750 Lutterworth East Sustainable Urban Extension (SUE) dwellings (an estimated 6710 residents) are populated resulting in an increase in Primary Care

activity, demand for outpatient activity and an ageing population and, therefore, an increase of people with more complex care needs/conditions associated with ageing. The LLR system would like to repurpose the facility to create a community healthcare hub to support more patients locally to access diagnostics and outpatient appointments, reduce waiting lists by bringing care closer to home. This is a request on a local footprint which has clinical support (local GP and secondary care), local MP support, Primary Care Network (PCN) support and wider ICS partner support. Community capacity is available and has been tested due to temporary bed closures since June 2020 in response to Covid-19.

The future proposed service model will focus on preventable care for those people living with long term conditions, who will be actively supported to manage their own care and avoid acute exacerbations of disease wherever possible. The journey for patients needs to be seamless and easy to navigate and discharges from services need to be coordinated and well communicated. To achieve this vision both the shape of community services and the workforce delivering them needs to change. The proposed new model, to replace the bed provision, is based around the following services:

- Neighbourhood community nursing
- Home First services
- Community bed-based care
- Specialist palliative care
- Outpatient services

Aims and objectives of the clinical review

The system has a timeline in place for design, consultation, PCBC development and implementation of a new service model. The LLR system has proactively engaged with the Clinical Senate to commission a clinical review as an element within the overall timeline to bring independent, external advice and guidance to support the development and evaluation of the proposed service model. The system request that the Clinical Senate assess the proposed future service model and proposed closure of the 10 inpatient community beds in the Feilding Palmer facility, considering the current service provision and challenges, predicted needs of the population going forwards and national direction of travel/guidance to determine if it represents the

best and most appropriate provision of high-quality care closer to home for the local population.

The Clinical Senate review team has been asked to review the information provided by Leicester, Leicestershire and Rutland (LLR) ICB, with support from Leicestershire Partnership NHS Trust to consider the following key areas:

- *Is the refurbishment of the Feilding Palmer facility and revised community service model likely to address the challenges reported at the Feilding Palmer facility and deliver a positive impact on the quality of care of the local population and are there any factors that have not been considered?*
- *Has the closure of the 10 bed inpatient facility at the Feilding Palmer site been appropriately mitigated in the planned expansion of the community services across LLR (with specific reference to community clinics expansion at the Feilding Palmer site)?*
- *Does it align to best practice, national guidance and direction of travel for the provision of community services?*
- *Are there any unintended consequences or risks that have not been identified and mitigated in the proposal (including any impact on populations currently accessing the services provided or peripheral service provision)?*
- *Has it considered the demographics of the population served, taking into account the needs of that specific population and ensuring equity of access and a positive impact on health inequalities?*
- *Does the proposed model appropriately consider predicted demand for services and provide sufficient flexibility and adaptability to meet these needs?*

Scope of the review

The areas in scope of the review are all community services provided by the LLR system which changes to the service provision of the Feilding Palmer facility could potentially impact upon.

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

- Will these proposals deliver real benefits to patients (access/clinical

outcomes/quality[3])? For example, do the proposals reflect:

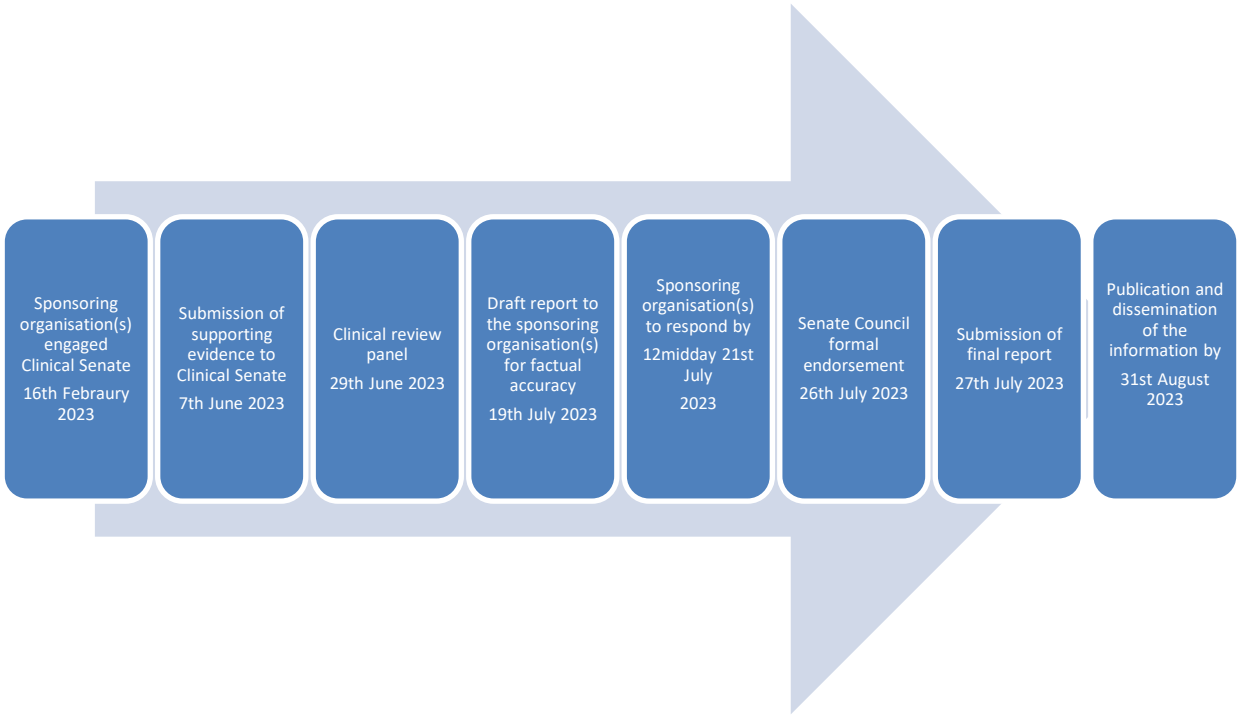
  - The rights and pledges in the NHS Constitution?
  - The goals of the NHS Outcomes Framework?
  - Up to date clinical guidelines and national and international best practice e.g. Royal College reports?

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

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

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

Timeline



Reporting arrangements

The clinical review team will report to the Clinical Senate Council which will agree the report and be accountable for the advice contained in the final report.
Clinical Senate Council will report to the sponsoring organisation(s) and this clinical advice will be considered as part of the NHS England assurance process for service change proposals (if appropriate).

Methodology

The sponsoring organisation(s) has agreed to collate and provide the following supporting evidence to the Clinical Review Panel, and to reference the evidence base wherever possible when drawing on clinical guidelines and national best practice. The evidence submitted will be meaningful and credible. To support the development of the evidence submission, the sponsoring organisation(s) will have consulted the Suggested Minimum Evidence Requirements document provided by the Senates team as part of the review process. *The duty is on the sponsoring organisation(s) to make sure the supplied material is only relevant to the review.*

- Clinical case for change and a summary of the current position and proposed alternative service/care model

- Information pertaining to/copies of any evaluation criteria used to shape the proposals/options appraisal required for the Pre-Consultation Business Case such as the hurdle criteria (please see document provided entitled “Suggested Minimum Evidence Requirements” where relevant)
- Impact of withdrawing/reconfiguring services, including risk register and mitigations
- How proposals reflect clinical guidelines and best practice, the goals of the NHS Outcomes Framework and Constitution
- Alignment with local authority joint strategic needs assessments and a narrative around health inequalities and demographics e.g. HEAT Tool (Health Equity Assessment Tool) and Equality Impact Assessment (EIA)
- Evidence of alignment with organisational/system plans
- Evidence of how any proposals meet future healthcare needs, including activity modelling, pathways, and patient flows
- Demonstrate how patient access and transport will be addressed
- Demonstrate how any implications on the Ambulance Service will be addressed
- Consideration to a networked approach
- Education and training requirements
- Implications on workforce (to be able to demonstrate alignment to new ways of working, and to describe how the future workforce will look to support any new models of care/reconfiguration proposed)
- Implications for the workforce (to describe how the workforce will be engaged, supported and motivated to work in new ways and in new places that support any new models of care/reconfiguration proposed)
- Implications for the clinical support services and those staff (e.g. clinical engineering, radiology, pharmacy)
- SHAPE (Strategic Health Asset Planning and Evaluation) Place Atlas, which helps organisations to consider the evaluation of the impact of service configuration on proposals and assess the optimum location of services
- Core service inspection reports (i.e. CQC)
- Public, patient and staff engagement plans and particularly, evidence of patients’ experiences of services

- Evidence of consideration to the sustainability and environmental impact of these proposals
- Clinical framework for presenting evidence and considering multiple site single service models of care (recommended clinical framework can be found here: Midlands Clinical Senates - Proactive Projects (midlandssenates.nhs.uk))

All evidence should be submitted three weeks prior to the review date as specified in the TORs. Any allowances to this should be agreed with the Head of Clinical Senates (or one of their deputies) and only in exceptional circumstances can we consider a late submission. Any evidence received within 48 hours of the review will likely not be shared with panel members and may not be considered within the review process unless prior agreement with the Head of Clinical Senates (or one of their deputies).

Report

A draft clinical senate report will be circulated within 14 working days of the final meeting - to team members for comments, to the sponsoring organisation(s) for fact checking.

Comments/corrections must be received within a further 1.5 working days.

The final report will be submitted to the sponsoring organisation(s) by 27th July 2023.

Communication and media handling

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

Disclosure under the Freedom of Information Act 2000

The East Midlands 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 you send to us, may be considered for release following a request to us under the Freedom of Information Act 2000 unless the information is exempt.

Resources

The senate(s) office will provide administrative support to the review team, including setting up the meetings, taking minutes and other duties as appropriate.

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

Accountability and Governance

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

The East Midlands Clinical Senate is a non-statutory advisory body and will submit the report to the sponsoring organisation(s).

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

Functions, responsibilities and roles

The **sponsoring organisation(s)** will

- provide the clinical review panel with all relevant background and current information, identifying relevant best practice and guidance. Background information may include, among other things, relevant data and activity, internal and external reviews and audits, impact assessments, relevant workforce information and projections, evidence of alignment with national, regional and local strategies and guidance
- respond within the agreed timescale to the draft report on matters of factual inaccuracy
- undertake not to attempt to unduly influence any members of the clinical review team during the review. Additionally, all communication (verbal and written) throughout the whole process should be addressed to the Head of Clinical Senates or an appropriate identified deputy
- submit the final report to NHS England for inclusion in its formal service change assurance process (if appropriate)
- arrange and bear the cost of a suitable venue and light refreshments (as advised by the senate(s) office) for the panel

Clinical senate council and the sponsoring organisation(s) will

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

Clinical senate council will

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

Clinical review team will

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

Clinical review team members will undertake to

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

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

The following evidence was submitted by the sponsoring organisations for this review on 7th June and disseminated to the panel on the same day:

- 1.1 Summary of Current Position and Case for Change.pdf
- 1.2 Lutterworth Reference Pack.pdf (updated version sent on 8th June)
- 2.1 Risk Assessment Paper 2020.pdf
- 2.2 Feilding Palmer Risk Register Report June 2020.pdf
- 2.3 Equality Assessment.pdf
- 3.1 Draft LLR ICB 5YJFP.pdf
- 4.1 Joint Strategic Needs Assessment Overview.pdf
- 4.2 Equality Impact Assessment.pdf
- 4.3 Lutterworth PHM.pdf
- 5.1 Lutterworth Insights.pdf
- 5.2 Draft Lutterworth Comms and Engagement Strategy.pdf

Following the panel pre-meet on 16th June and subsequent feedback to the sponsoring organisations, the following additional evidence was submitted to the Senate on 22nd June and disseminated to the panel on 23rd June (the slight delay was due to the senior team in the Senate being committed elsewhere that afternoon and evening):

- A0 – Additional Information – Summary of Documents.pdf
- A1 – Lutterworth Communications and Engagement Strategy V3 210623.pdf
- A2 – LLR Digital Strategy.pdf
- A2.1 – Patient use of digital technology.pdf
- A3 – Emergency Readmissions.pdf
- A4 – Review of best practice.pdf
- A5 – UHL 5 Year Strategic Workforce Plan.pdf
- A6 – Pre-Pandemic Case Mix.pdf
- LLR Clinical Senate Presentation – 29June23.pptx (this was updated and recirculated on 27th June)

Additional documents submitted by Mr David Fish of The Mary Guppy Group and were disseminated to the panel on 22nd June:

- Clinical Senate 29623 v4.docx
- Lutterworth plan pre-consult business case v2.docx
- 2000 Survey Feb 2022 v3.docx

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

Name	Role	Organisation	Conflict of interest
Anne-Maria Newham	Deputy Chief Executive Officer	Nottinghamshire Healthcare Foundation Trust	Anne-Maria was the Director of Nursing at LPT in 2019.
Ben Pearson	Executive Medical Director, Responsible Officer and Caldicott Guardian	Derbyshire Community Health Services	None
Claire Greaves	Divisional Director, Ambulatory Care Division	Nottingham University Hospitals NHS Trust	None
Ian Lawrence	Clinical Director for integration Chief Clinical Information Officer	Derbyshire Community Health Services	Ian provides ad hoc consultancy for the Royal College of General Practitioners (RCGP) GP Development Service
Jane Youde	Consultant Physician	University Hospitals of Derby and Burton NHS Foundation Trust	None
Jason Evans	Acting Chief Officer for Integrated Urgent & Emergency Care, West Midlands Region	Black Country ICB	None
Jo Watson	Assistant Director of Nursing & Workforce	NHS England	None
Kat Telford	Medical Educator	University of Nottingham	None

Kerry Bareham	Nurse Consultant	St Barnabas Lincolnshire Hospice	None
Mandy Clarkson	Deputy Director Public Health	NHS Midlands	None
Paul Jenks	Chair, Community Pharmacy Lincolnshire Chair, National Pharmacy Competency Group Vice Chair, Lincolnshire Primary Care Advisory Group	Community Pharmacy Lincolnshire	None
Paul Midgley	Patient and Public Involvement representative	East Midlands Clinical Senate Council	None
Salil Parkar	Therapy lead Inpatients	NHS Birmingham Community Healthcare NHS Foundation Trust	None
Sarah Raistrick	GP	NHS Coventry and Warwickshire ICB	None
Saul Hill	Integrated Community Manager	Derbyshire Community Health Services	None
Susan Edge	Patient and Public Involvement representative	East Midlands Clinical Senate	None
Suzanne Avington	Associate Director Allied Health Professionals	Nottinghamshire Healthcare NHS Trust	None

Clinical Senate Support Team

Emma Orrock – Head of Clinical Senates, NHS England

Carly Mellors – Senior Programme Manager, East Midlands and West Midlands Clinical Senates, NHS England

It was agreed between Emma Orrock, Head of Clinical Senates, and Jo Clinton, Head of Strategy and Planning, Leicester, Leicestershire and Rutland ICB, that Gail Rose, Deputy Director of Clinical Delivery, NHS England, could observe the review day process.

Biographies

Anne-Maria Newham

Previous Executive Director of Nursing AHPs and Quality

Anne-Maria has worked in the NHS for over 38 years holding several roles including Ward Manager, Neonatal Sister, Children's Intensive Care Manager, Director of Children's Community Health Services, Chief Nurse in Derbyshire CCG, Director of Nursing, AHPs and Quality for Lincolnshire Partnership Foundation Trust, interim Chief Executive Officer at Lincolnshire and until recently, Executive Director of Nursing AHPs and Quality at Nottinghamshire Healthcare Foundation Trust. In 1996 she was instrumental in setting up the first Children's Intensive Care Unit in Leicester. She was awarded a Florence Nightingale Leadership award in 2011 and Travel Scholarship in 2014 looking at End of Life Care. She was voted Inspirational leader by the Leadership Academy in 2014 and shortlisted as Clinical Leader of the year by the Health Service Journal 2017. After receiving a Winston Churchill Fellowship in 2015 she travelled to New Zealand to understand their progressive integrated care system and bring the findings back to the UK. She has published widely in several journals and is currently on the editorial board of the British Journal of Nursing. In 2017 she was invited to speak at the 2nd Nursing World Conference in Las Vegas and in 2018 in Rome. Anne-Maria was awarded an MBE in the 2018 Queens Birthday Honours for services to Nursing.

Ben Pearson

Executive Medical Director, Responsible Officer and Caldicott Guardian

After gaining a zoology degree from Durham University, Ben trained in medicine at Kings College London, qualifying in 1993. He worked in London, Lincoln and Nottingham and took up a consultant post in geriatric and general (internal) medicine at Derby in 2004. Leading the development of acute medical services, Ben introduced senior clinical decision making and ambulatory care for acute medicine.

Ben was the secondary care doctor on the Mansfield & Ashfield and Newark & Sherwood CCG Governing Body from pre-authorisation until May 2019, serving for 7 years. In 2010, he was awarded a Master's degree in clinical medical education.

In June 2019, Ben took up his current position as Executive Medical Director for Derbyshire Community Health Services NHS Foundation Trust. He is the trust Responsible Officer and Caldicott Guardian. Ben is the Vice Chair of the Joined-Up Care Derbyshire System Quality Group and a Vice Chair of the Clinical and Care Professionals Leadership Group. Within a diverse portfolio Ben has a particular interest in developing clinical governance and quality and performance management methodology.

Claire Greaves

Divisional Director, Ambulatory Care Division

Claire is a Consultant Clinical Scientist with many years of experience working in a range of different NHS Trusts. Claire specialises in Nuclear Medicine and leads the Medical Physics & Clinical Engineering (MPCE) service in Nottingham University Hospitals NHS Trust but has had a broader role as Clinical Director for the Science and Technology Pathway comprising: Bowel Cancer Screening, MPCE, Sterile Services, and the Trent Simulation and Clinical Skills Centre. Claire is also the Chief Scientist at NUH. Claire is an Honorary Associate Professor in the University of Nottingham School of Medicine. Over her Career, Claire has supported a number of national committees (British Nuclear Medicine Society, Institute of Physics in Engineering in Medicine, Administration of Radioactive Substances Advisory Committee) and has been a Technical Advisor for UKAS supporting the development of BS70000 and the accreditation systems for scientific services. Claire is currently supporting the regional and ICS work relating to Diagnostics.

Ian Lawrence

Clinical Director for integration

Chief Clinical Information Officer

Ian is the Clinical Lead for Team up Derbyshire which is a wide ranging ‘bottom up’ programme that uses strengths-based approaches to integrate neighbourhood teams across General Practice Community Health and adult Social Care.

He is also the Chief Clinical Information Officer at Derbyshire Community Health Services Foundation Trust (DCHS).

Ian is GP by background but left direct clinical practice in 2019, he has been a GP partner in rural North Wales and in Derbyshire. He led the integration of three GP practices into DCHS.

Ian was a CCG Governing Body member from 2011 to 2015 and retains a strong system leadership role with a particular focus on community service integration.
He volunteers every summer with Festival Medical Services, a charity who provide voluntary medical cover at Music Festivals and use the proceeds to support charities worldwide.

Jane Youde
Consultant Physician/Clinical Lead for Enhanced Care in Care Homes Derbyshire and Deputy Chair of the Gender Equality Network
Jane has been a Consultant in Medicine for the Elderly in Derby since 1999 with a special interest in falls. She has had many posts locally, regionally and nationally including being the Clinical Director for Rehabilitation and Elderly Care Business Unit, clinical lead for the Falls and Bone Health QIPP work stream for East Midlands SHA and involved with the Older People with Frailty work stream for East Midlands AHSN. She was a collaborator in the writing of the BGS Fit for Frailty guidance and has been the co-chair of the British Geriatric Society Falls Section. She has been the secondary care representative on the Nottingham West CCG Board.
She was involved in the National Falls Audit in different roles for over 10 years and involved in many of the QI projects associated with this. She has been the Clinical Director for Audit and Accreditation for the Royal College of Physicians and oversaw the delivery and development of the 3 National Audit programmes and the 5 accreditation programmes hosted by the RCP. She is currently Clinical Lead for ENCH as part of Ageing Well in Derbyshire.

Jason Evans
Acting Chief Officer for Integrated Urgent & Emergency Care, West Midlands Region
Jason is Acting Chief Officer for West Midlands Integrated Urgent and Emergency Care (IUEC) Service, for Black Country ICB. He has over 25 years of experience in community development, public health and NHS senior management.
His current role includes responsibility for implementing national best practice for IUEC and responding to policy requirements of NHS England for 999 and 111 services. The role includes ensuring delivery of national and regional targets for 999 and 111 services and instigating performance management strategies where

expectations are not met. This work is delivered on behalf of the commissioning partners of the IUEC Alliance and 16 Clinical Commissioning Groups.
Jason also holds the executive lead for Emergency Preparedness Resilience and Response (EPRR) for Black Country ICB, which included coordinating the ICS COVID-19 Incident Coordination Centre and being SRO for EU-Exit.

Jo Watson

Assistant Director of Nursing and Workforce

Jo is a children's nurse with over 20 years' experience working with children and young people. Jo has experience of working in a number of different areas across both acute and community sectors. Jo spent a significant period working at Birmingham Children's Hospital as Deputy Head of Nursing where she developed a number of new services including a Hospital at Home team and a regional long-term ventilation team. Jo was Lead Nurse for Paediatrics at University Hospitals of Derby and Burton and oversaw the merger of both trusts within all children's areas.
Jo completed her first Masters at the University of Manchester in Advancing Nursing Practice in 2012. Since then, she has completed a Post Graduate Certificate in Strategic Workforce Planning and is currently completing a further Masters in NHS Leadership at the University of Birmingham on the Elizabeth Garrett Anderson Programme, with the NHS Leadership Academy.

Kat Telford

Medical Educator

Kat is a junior doctor and medical educator who graduated from St Georges Medical School in London in 2018 and undertook her foundation training in Nottinghamshire and Lincolnshire. Since then Kat has progressed her academic portfolio and currently works for the University of Nottingham as an Assessment team Medical Education Fellow.

Kerry Bareham

Nurse Consultant

Kerry is a Nurse Consultant in Specialist Palliative Care for St Barnabas Hospice in Lincolnshire. She holds qualifications in advanced practice as a SPQ District Nurse, Independent Prescribing, and an MSc in Frail Older People.

Kerry is extremely proud to be a Queens Nurse and is passionate about raising the profile of nursing and the very real difference that high quality community nursing and person-centred care has on improving outcomes and tackling health inequalities for people throughout their life.
Her specialist areas of interest include palliative and end of care, long term conditions management, frailty and championing diversity.

Mandy Clarkson
Deputy Director Public Health
Mandy is a consultant in health care public health and Deputy Director, providing advice and support to the NHS at regional and local system levels. She is a registered adult nurse, with a background mostly in community nursing. Mandy began her public health career in health protection before training in the East Midlands and subsequently working in various local authority and NHS roles.

Paul Jenks
Chair, Community Pharmacy Lincolnshire
Chair, National Pharmacy Competency Group
Vice Chair, Lincolnshire Primary Care Advisory Group
After registering as a pharmacist in 1997, Paul worked for several years as a pharmacist manager on Lincolnshire's East Coast before undertaking several different field and national roles.

He currently leads a team at the Boots Support Office in Nottingham, looking after the professional and clinical development needs of colleagues across the UK.

He joined Lincolnshire Local Pharmaceutical Committee (now Community Pharmacy Lincolnshire) as a committee member in 2008 and was elected as Chair in 2010 – a role in which he continues to work, representing around 120 pharmacy contractors across a large, rural county and working closely with key stakeholders including local authority commissioners, the ICB and ICS.

He also works as a local tutor for the Centre for Pharmacy Postgraduate Education, producing HEE funded training solutions for pharmacy professionals, and has recently finished his second and final term as Vice-Chair of the Royal Pharmaceutical

Society Membership Committee. He is a member of the Royal Pharmaceutical Society Community Pharmacy Expert Advisory Group and is Chair of the national Pharmacy Competency Group.

Paul Midgley

Patient and Public Involvement representative

Paul has been involved in patient leadership since 2006 when he was appointed to the board of Principia CIC (Practice Based Commissioning Group for Rushcliffe, Notts).

Paul is a patient member on the Nottingham & Nottinghamshire ICS Digital Notts and Greener Notts boards, East Midlands Clinical Senate Council, Rushcliffe Primary Care Network (PCN) Board, chair of Rushcliffe PCN PPG Chairs Group, and chair of Musters Medical Practice PPG.

Previous voluntary roles have included Notts CCG PPEC member, prioritisation panel at Nottinghamshire Healthwatch and various committees at Principia and NHS Rushcliffe CCG including the Clinical Reference Group and Finance and Performance committee.

In working life, Paul has recently set up his own business providing NHS insight services. Prior to this, Paul was a Principal Consultant within Wilmington Healthcare's Thought Leadership Group, where he chaired joint NHS and industry events around service transformation and supported partnership-based improvement projects.

Paul spent over 15 years after graduating from Leeds University with a BSc in Biotechnology working in various commercial roles with the Pharmaceutical Industry prior to leaving in 2000 to set up his own training consultancy, which was acquired by Wilmington plc in 2013.

Salil Parkar

Therapy Lead Inpatients

Salil is a physiotherapist by profession – with specialism in Stroke and Neurology. He has experience of working as clinician mainly in Community Hospital and Outpatients. His current role involves Clinical and Operational leadership for Therapy

teams across community hospitals at Birmingham Community Health Care NHS Foundation Trust.
Salil is an events officer for the Chartered Society of Physiotherapy – Black Asian and Minority Ethnic network. He is also the co-chair for NHS Midlands – AHP Ethnic Minority Network.

Sarah Raistrick
GP
Sarah is a GP based in Coventry. Prior to qualifying as a GP, she was a surgical registrar (MRCS) and holds MRCGP, DRCOG and DFFP and Advanced University Diploma in Primary Care Mental Health.
She is a generalist but is especially interested in minor surgery and mental health (including peri-natal and teenage mental health) as well as AF and COPD. She is involved in working with local community leaders to embed primary care within the community, focussing on population health models and building on community assets and individuals' own resources and networks to improve health.

Saul Hill
Integrated Community Manager
Saul is an Integrated Community Manager and Wound Clinic Service Manager for Derbyshire Community Healthcare Services NHS Foundation Trust. A major provider of complex wound care services to the people of Derbyshire with 65,000 service user contacts per year, the service is an integral part of the Trust's Integrated Community Services.
After serving in the British Armed Forces, Saul began his career as a Registered Podiatrist, and has since worked as a clinician and senior manager within Community Health Services focusing on clinical research, multidisciplinary team working, and integrated care systems. Between these appointments Saul has published widely, lectured at the University of Salford, and holds a position on the Medicines and Medical Devices Committee for the Royal College of Podiatry.

Susan Edge

Patient and Public Involvement representative

Susan was involved in the further, adult and work-based learning sector for over 30 years and gained significant experience of quality assurance and quality improvement. Subsequently she was the Patient and Public Involvement member of her local clinical commissioning group's governing body for 8 years and was also a public contributor for the National Institute for Health Research.
Currently co-chair of the East Midlands Patient and Public Involvement Senate, hosted by the East Midlands Academic Heath Science Network, Susan is also a lay partner for Health Education England in the East Midlands. She is a member of the Education, Training and Practice Committee of the UK Council for Psychotherapy.

Suzanne Avington

Associate Director Allied Health Professionals

Suzanne is a physiotherapist by background. She has worked in the NHS for 27 years across a variety of rehabilitation services across secondary and primary care. She has worked at University of Nottingham as a lecturer on the BSc programme for Physiotherapy for a short period before taking up new clinical and leadership roles within therapy services in the community at the advent of Intermediate Care. Her clinical specialisms at the time were neurological rehabilitation, stroke, falls and older person's care.

She has had always had a keen interest in the effective working of the wider multidisciplinary team which has led to project lead roles in integration and of professional support to the Allied Health Professionals. In her current role as Associate Director for AHPs she is accountable for AHP Governance, including quality, workforce capacity and capability, education, professional standards and regulation for 10 of the 14 AHP professions.

She is currently Chair of the Nottingham and Nottinghamshire ICS AHP Council and an inaugural member of the AHP faculty.

Suzanne is also a registrant assessor for Physiotherapy with the Health Care Professional Council.