South West Clinical Senate

Stage Two Clinical Review Report

Bath, Swindon and Wiltshire Maternity Transformation Proposal

25th June 2018

Draft

Document Title: Stage Two Clinical Review Report: Bath, Swindon and Wiltshire Maternity Transformation Proposal

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Final

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Signed off by: Dr Sally Pearson, South West Clinical Senate Chair

File path:

1 Executive Summary

1.1 Chair's Summary

This report has been produced by the South West Clinical Senate for Bath and North East Somerset, Swindon and Wiltshire (BSW) Sustainability and Transformation Partnership (STP) and provides recommendations following a Clinical Review Panel (CRP) that convened on 19th June 2018 to review the BSW STP proposals for transformation of their maternity services.

This was an independent clinical review carried out to inform the NHS England stage 2 assurance checkpoint which considers whether proposals for large scale service change meet the Department of Health's 5 tests for service change prior to going ahead to public consultation, which in this case is planned for September 2018. The Senate principally considers tests 3 and 5; the evidence base for the clinical model and the 'bed test' to understand whether any significant bed closures can meet one of 3 conditions around alternative provision, treatment and bed usage.

I would like to thank the clinicians who have contributed to this review process, providing their commitment, time and advice freely. In addition I would like to thank the BSW STP for their organisation and open discussion during the review.

The clinical advice within this report is given by clinicians with a shared interest to the STP in developing the best services for the population, contributing through the value of peer experience and with the intention of supporting further developments of clinically sound service models. This report sets out the methodology and findings of the review and is presented to BSW STP with the offer of continued support.

Dr Sally Pearson, Clinical Chair, South West Clinical Senate

1.2 Recommendations

The Clinical Review Panel (CRP) concluded that it broadly supports the direction of travel for maternity services across BSW but that further work is needed prior to consultation to demonstrate sufficient evidence in order for the CRP to give its assurance that the clinical model is robust.

The reconfiguration of delivery beds that the model focuses on should be presented as part of the wider Maternity Services Transformation plan that exists for maternity services with the patient journey at the centre. The CRP have questioned the rationale for the closure of 2 Free-Standing Maternity Units (FMUs) rather than all four FMUs given the strong case for change around under-utilisation and the benefits of Alongside Maternity Units (AMUs). The detail of the two proposed alongside units which is currently lacking, is critical to understanding the impact the proposed model will have, as is the articulation of the benefits and opportunities in retaining 2 FMUs to achieve 'better births' across the BSW STP footprint.

This report draws attention to a number of recommendations to provide further information prior to the stage 2 assurance meeting planned for 31st July. These are summarised as follows;

Clinical Evidence Base

1. The Pre-Consultation Business Case (PCBC) should be re-drafted into a considerably shorter and more concise document to clearly include;

    a. How the proposals contribute to the wider vision for maternity services including the equitable service offer for women across the system.
    b. Description of the clear links to the wider Local Maternity Transformation (LMT) plan as context for the proposals; showing how key elements of it deliver the anticipated benefits of the plan .
    c. The service now and how it will change in the future.
    d. Pathways in the proposed model across the whole STP using patient stories.
    e. The future model of care in each community location currently hosting an FMU.
    f. The model and workforce for home births
    g. The overall workforce model now and in the future by location and anticipated births.

    The presentation to the CRP was commended and could be used as a basis for this shorter document.

2. The case for two remaining Freestanding Maternity Units (FMUs) was not well articulated and the clinical evidence was considered to lend itself to a case to have no FMUs rather than two. The CRP was unconvinced that there would be sufficient low risk demand for the remaining two FMUs. The case for retaining two FMUs must therefore be made stronger by demonstrating that resources will in this model be deployed to deliver the recommendations of the 'Better Births' review.

3. The proposed clinical service model for the Alongside Maternity Units (AMUs) at the Royal United Hospital Bath (RUH) and Salisbury Foundation Trust (SFT) must be described to include modelling for numbers of patients (to include demographic modelling that covers high risk patients), workforce modelling and the subsequent

impact on the remaining FMUs and their sustainability. The wider model of care cannot be fully considered without detail of the AMU model provided.

Bed Test

4. Whilst the 4 delivery beds in the two FMUs to be closed are to be re-provided by 5 beds (an increase of 25%) in the RUH AMU, there is not currently enough detail given about the AMU to be assured that it will be set up and the beds re-provided. If assurance can be given that the RUH AMU will be created and that external capital applied for will be provided before the two FMUs are closed then the bed test would be met. No detail on delivery bed numbers at SFT has been provided and must be included as part of the proposed service model. The alongside unit provision needs to be guaranteed for the model to work.

5. The 9 community post-natal beds run at only 5% utilisation. The CRP agreed that not all of these beds will be required in the new model of care but the PCBC needs to include the detail on the enhanced community care offer for post-natal and breast-feeding support that these beds currently contribute to, to enable the CPR to provide assurance that the bed test has been met.

Some further detail around the recommendations above can be found underlined in section 6.2 of this report.

2 Background

In January 2018 BSW finalised its Maternity Transformation plan which outlined the STP intention to develop options for the future of maternity services alongside the RUH Bath maternity services redesign to help deliver the recommendations from National Better Births guidance and address the better births gap analysis conducted in 2016.

The intention is for improved outcomes and experience across the STP, safe and consistent services, parity of access and value for money. The key drivers for change are variation in provision, mismatch between workloads and staffing levels, environmental improvements required and some under-utilisation of services.

The Local Maternity System (LMS) for the STP area, known as the B&NES, Swindon and Wiltshire (BSW) LMS, includes the three acute hospital trust maternity services in Bath, Swindon and Salisbury, one Alongside Midwifery Unit in Swindon and four Freestanding Midwifery Units in Paulton, Trowbridge, Chippenham and Frome as well as antenatal and post-natal clinic provision in Shepton Mallet and some community post-natal bed provision. These units provide care for a population of about 1.5 million people which includes 12,200 women and families each year.

3 Senate Engagement to Date

In advance of the requirement for formal clinical review via panel, the Clinical Senate undertook a desktop review of the BSW STP's draft PCBC and Case for Change in May 2018. This desktop review was undertaken by a sub-panel of the CRP. The report can be found in appendix 5.

The report feedback is summarised as follows and asked for more information and clarity within the PCBC to include;

- The overarching vision for maternity services in the STP, in relation to Salisbury and Swindon and areas in addition to Bath.
- The possibility of an alongside unit in Salisbury
- The model for home births and capacity to enhance this service.
- The options for extended roles for midwives and support staff.
- The review of community post-natal beds.
- The rationale for retaining 2 free-standing midwifery units and their location.
- How continuity of care will be addressed.
- The extent of clinical engagement to date from across the system (beyond Bath RUH and Wiltshire CCG).

The Clinical Senate Manager was also present at the NHSE early assurance meetings in November 2017 and on 13th March 2018.

4 The Review Process

The Clinical Senate Review Process is used across England to provide independent clinical review of large-scale service change to ensure there is a clear clinical basis underpinning any proposals for reconfiguration. Reviews are undertaken to inform the NHS England assurance process which signs off proposals for change prior to public consultation.

The Senate's CRP reviewed the final PCBC document provided by the STP to detail their proposals ahead of the panel meeting (appendix 4) and also referred to the desktop review as well as national guidance, specifically the Better Births Maternity Review (appendix 6) and the Kirkup Report on the Morecambe Bay investigation (appendix 7). The panel also fed in comments, based on their pre-reading documentation, to the Senate which were shared with the STP in preparation for the panel itself and which contributed to the panel's key lines of enquiry (KLOES) used to guide discussion at the panel meeting. These supported the generic KLOES for clinical review processes developed from a national guidance document on conducting senate reviews (appendix 8).

The Senate Manager and Clinical Chair held a preliminary meeting with the STP team on 6th June before hearing its proposals for change presented formally at the clinical review panel meeting on 19th June. The review meeting provided opportunity for the STP's clinical team to present its proposals and for the panel to discuss the proposals, ask questions and raise concerns. The agenda can be found in appendix 3.

At the review panel, the Clinical Chair emphasised to the STP that the Clinical Senate regards its role as being a supportive one, raising legitimate clinical concerns aimed at strengthening the clinical case for change, identifying potential gaps and ensuring that the model is as robust and well thought-out as possible through frank and open clinician to clinician discussion.

5 BSW STP's Maternity Transformation Proposal

Following a shortlisting process using benefits criteria, the preferred option presented describes development of an Alongside Midwifery Unit (AMU) at both RUH Bath and at SFT, the reduction from four to two Freestanding Midwifery Units (FMUs) that are run from community hospitals (preferred locations yet to be decided following travel impact assessment however initial assessment suggests that Chippenham and Frome will continue to do deliveries) and antenatal/postnatal care to continue in all four existing community locations in addition to the current services in Shepton Mallet. The proposal describes an enhancement of its home birth service. 9 community post-natal beds will be removed and 4 delivery beds will move location from the two free-standing units that will stop providing a delivery service to the Bath alongside unit which will have 5 delivery beds in total. A joint bid for capital expenditure has been put in to fund the AMUs at RUH and SFT. The AMU at Salisbury hospital is being developed based on additional increases in the Salisbury area dependent upon armed forces relocation.

This is expected to be a cost neutral option in terms of staffing and service running costs that will address the current disparity in service utilisation.

The STP team's intention is to go out to public consultation in September 2018.

6 Panel Discussion and KLOES

6.1 Presentation

The STP Clinical and Managerial team delivered a comprehensive presentation describing how the proposed model seeks to bring together their LMT plan with an existing workstream at RUH Bath to develop its maternity services. The focus of the proposals centres around the reconfiguration of services rather than the wider work in delivering the maternity transformation plan. The vision described was for a safe and positive birth experience for all mothers across the STP.

The team clearly described a long term decrease in the number of births at its 4 FMUs with an increase in births at the RUH despite initiatives to increase uptake in the FMUs which currently support only 12-16% of all births (RUH activity). As a result there are midwives on duty without work at these birth centres and staff are being redeployed at short notice to the RUH. In response to this the STP have put forward a national bid for funding for AMUs at the RUH and SFT that would draw its staff from the FMUs. In Wiltshire a military repatriation of around 4500 troops and 2500 dependents, bringing with it additional housing and an anticipated 200+ births a year, is expected. In response to this an AMU at SFT is proposed and this is now being brought into the overall STP model for maternity care as recommended by the desktop review.

The evidence for AMUs was clearly articulated; reducing risk where transfer rates for first time mothers from midwife led units are 30% nationally, provision of greater choice with the security of an obstetric unit close by, workforce exposure with an obstetric unit close by. The AMU at the Great Western in Swindon operates an opt out service which is reported as working well. There are 38-50 births a month in the 4 FMUs at the moment. The 9 post natal beds in the community only have 5% utilisation rates and it is considered that the breast feeding and post natal support provided can be delivered via other post natal support mechanisms in the community as it already is to the majority of women.

Phase one of the travel impact scenario work had been completed with phase two to follow. Currently 92.8% low risk women can access a maternity led unit within 30 minutes. In the proposed model this will change to 92.3%, which is considered to be a negligible difference. For high risk women access remains the same with 78% having access to obstetric care within 30 minutes.

There are no savings attached to the reconfiguration which is expected to be cost neutral. The key outcome will be an increase in midwife led care through the AMUs. There is also £400k ringfenced from national funding to deliver maternity transformation more widely.

The changes proposed under the model for consultation are predominantly to deliveries and not to ante and post-natal care. The inclusion of the day assessment at RUH has been removed from the PCBC.

6.2 Panel Discussion

Overall Observations

The panel noted that whilst it was felt that the final version of the PCBC provided to them following the desktop review was lacking in clarity with the weight of focus remaining on the RUH Bath, the presentation from the clinical team to the CRP was extremely helpful in clarifying the model and portrays a stronger picture with the inclusion of both AMUs.

The CRP felt however that the model cannot focus on the proposed reconfiguration alone as other work being undertaken as part of the maternity transformation plan is integral to the success of the model and understanding of overall pathways. A revised and clearer PCBC should bring both together giving an overview of maternity services now and in the proposed model; clearly describing each service and pathway. The potential number of deliveries in the new model and how many women will be eligible for each area should be included. This might in turn provide further information on patient pathways that cross STP borders.

FMUs

The CRP understood the case for change to reduce the number of FMUs across BSW given that the current 4 FMUs have low utilisation rates with staff in place but often not being utilised or staff transferred at short notice to the RUH acute maternity service. However, it was observed that the clinical logic to close two FMUs could equally apply to all 4 FMUs which led to questioning of the overall clinically viability of the FMUs. The options appraisal which discounted the option to stop deliveries at all 4 FMUs only considered services for the RUH population rather than for the STP as a

whole. The CRP noted that the proposed model would not represent an equitable range of choices for women across the system, with many women not having a realistic choice of a delivery in an FMU

The location of the remaining two FMUs is not considered overly significant to the quality of patient care and access as going from 4 to 2 reduces risks by channelling more patients to acute sites with alongside obstetric units. High risk patients would be attending an acute trust and access figures are already very low at the FMUs. Many mothers would also currently go past the proposed AMUs to get to an FMU.

There is however concern around the potential to increase the numbers of low risk patients using the remaining FMUs given the population demographic of older mothers and increasing obesity. It is important that transfer rates are low and in order to achieve this all patients must be properly assessed as being low risk. There is also the potential that the AMU at RUH Bath will fill up quickly and that consideration of this links into the staffing utilisation of the remaining 2 FMUs. Women are not currently using the FMU services fully so there is no clear argument that the remaining two would be used any more. Instead it is considered more likely that more women than those currently managed in 2 of 4 FMUs will choose to go to the AMUs. The anticipated percentage uptake of the FMUs with only two units needs to be provided with an analysis of what is needed for sustainability with consideration of closure of the remaining FMUs in the future. Any potential impact or opportunity this may have upon the community hospitals hosting the FMUs should be considered.

It was suggested that the remaining FMUs will be updated/redecorated to improve the environment and help increase uptake but this is not detailed in the PCBC. The impact on staff in the FMUs that stop doing deliveries should also be taken into account in terms of motivation and competencies.

AMUs

Other than the existence of AMUs in the future, information has not been provided about the scale and scope of the AMU services. The number of proposed beds at the RUH Bath AMU has been increased from the draft PCBC from 4 to 5 although the working behind this not described. The number of delivery beds and provision at SFT is unknown. The CRP discussed that despite low utilisation rates at the FMUS that there are risks to closing these units prior to the AMUs being up and running and that commitment to the release of funding for the AMUs is required to ensure delivery of the maternity transformation plan. A risk assessment also needs to include the possibility that the RUH AMU in particular won't receive capital funding and the options in this scenario. The bed test for the closure of the delivery beds is met under the proposed model but on the basis that there will be an AMU at RUH. The AMU at SFT is expected to principally manage an increase in military repatriation demand. An implementation plan for the AMUs that consider the running of services as the new one is set up needs to have started to be outlined prior to consultation.

Community Clinics

The opportunity to deliver on the guidance laid out in 'better births' through the release of staff from 2 FMUs needs to be clearly articulated and isn't at present. By mapping the model against better births it may be possible to demonstrate how midwives are being upskilled in the new model and how the continuity of carer provision will be strengthened via the new AMUs and remaining 2 FMUs. The target is for 20% of the population to be provided with a continuity of carer but there is

potential to go beyond this. The CRP agreed that patient stories for example would help to describe the care pathway in different scenarios.

The model describes that no changes will be made to ante and post-natal care provision as part of this consultation proposal but at the same time opportunities for delivering better births have been alluded to through the reallocation of staff resource. In addition £400k protected for the delivery of maternity transformation was cited.

How this will be used for maternity transformation that will support the uptake and utilisation of the FMUs and development of community clinics needs to be clearly linked in and described (eg. by providing more scans in the community). The PCBC needs to assess the likelihood of this additional funding and the capital required for the AMU being secured and include plans to mitigate the risks if the funding is reduced or withdrawn.

Other initiatives were also referred to in addition to the investment in settings, which included a single point of access for information, agreeing a single procurer for delivery packs across the STP, the launch of a 'Dad's app' and the Bluebell home birth team, which would benefit referencing in the PCBC to demonstrate how the wider vision for maternity services will ultimately come together. The CRP felt there was some confusion in the cross over between the reconfiguration of delivery beds and the LMT plan which could be better knitted together to strengthen the case for improved maternity services across the STP.

Clinical hubs were also referenced by the clinical team but not included in the PCBC. The term clinical hub is widely used with much variation in definition across the NHS which can be confusing for patients. If clinical hubs are going to be created and referred to then clarity is required around what they are and can deliver.

The concept of an MDT with services wrapped around that as demonstrated at a Wiltshire GP Practice is core to national maternity transformation plans and should become the norm. It might however be misleading to call it a hub. The PCBC should clearly state what services there are now and will be and what they will be called and offer.

How the provision at Shepton Mallet compares to the ante and post-natal services at the two FMUs where deliveries are stopped should also be clarified.

Post-natal provision should be clearly described in the context of removing 9 community beds. The CRP fully supports the proposal that these beds are not used or required but information around post-natal care and the alternative service model for community beds that already exists needs to be provided.

Home births

Whilst the PCBC describes an enhanced home birth service in the new model, further discussion at the CRP suggested that the home birth team (drawn from the FMU workforce) would not be any different following the changes being proposed. The CRP felt that there is significant potential to improve the home birth offer by improving staff's levels of confidence in this service and setting up a robust on call offer as a result of on call staff no longer being sent to RUH at short notice.

Workforce

The benefits of releasing staff from the two FMUs needs to be better articulated both in terms of how the AMUs will work and what they will offer but how the workforce will deliver Better Births. Detail of the workforce for the AMU at SFT and where it will be drawn from needs to be provided. Staffing numbers need to be detailed for both the current and future models for all delivery locations, describing how many staff will be released from the two FMUs stopping deliveries in particular. This also needs to include what midwives at the two community locations stopping deliveries will be doing that is different. Clear plans for the rotation of staff across the service are needed.

Peri-natal Mental Health

The CRP felt that there is an opportunity for the community units to act as a hub linking to the community peri-natal mental health teams described during the LMS presentation. Consideration to the influx of new military families and potential for low grade mental health capacity should be taken into account.

Clinical Engagement

There was clear evidence of clinical engagement from the panel presenting to the CRP and wide involvement of clinical groups in the development of the options . The CRP noted that the PCBC referenced some reporting on culture and safety. It was observed that ongoing engagement with community midwifery staff will be needed to ensure engagement and co-design as the model is developed to implementation.

7 Conclusion

The CRP reported that what is being proposed is a fantastic opportunity to improve maternity services across the BSW STP but that currently the PCBC does not sufficiently describe the whole picture and that there is insufficient evidence for assurance at the present time. It was agreed that a revised PCBC would be shared with the Clinical Senate on July 6th to address the issues raised and provide further evidence as well as documenting more clearly some of the information presented during review to the senate.

8 Next Steps

The summary recommendations were shared verbally with the STP at the end of the panel meeting in order that they could start work immediately to develop the further information requested by the panel. It was agreed that the STP would share their updated PCBC and public consultation document with the CRP for a further desktop review for Clinical Senate sign off prior to the Phase 2 Assurance Meeting with NHSE on 31st July. This report will be shared in draft version with the STP for fact checking and with the CRP prior to sign off by the Senate Council in mid July.

9 Reporting Arrangements

The CRP team will report to the Clinical Senate Council which will agree this final report and be accountable for the advice contained therein. The report will be shared with the STP and NHS England Assurance Team. BSW STP will own the report and be expected to make it publicly available via its governing body or otherwise after which point it will also become available on the Clinical Senate website.

10 Appendices

10.1 The BSW STP Presenting Team

Name	Title, organisation
Sarah Merritt	Head of Nursing and Midwifery, RUH
David Walker	Consultant Obs and Gynae, GWH
Kate O'Brien	Consultant Obs and Gynae, SFT
Sandy Richards	LMS project midwife
Daisy Curling	BaNES GP
Lucy Davis	Wiltshire GP
Sally Johnson	Public Health, Wiltshire
Alison West	Associate Director of Quality, Wilts CCG
Lucy Baker	Interim Director of Commissioning, Wilts CCG
Rhiannon Hills	Divisional Manager, Women and Children's Division, RUH
Fiona Coker	Head of Maternity and Neonatal, SFT

10.2 The Review Panel

The review panel comprised members of the Clinical Senate Council, Assembly and clinicians brought in specifically for this panel.

Panel Role	Name	Title
Chair	Sally Pearson	Clinical Chair, South West Clinical Senate

1. Clinical Lead Maternity Network	Ann Remmers	Clinical Lead South West Clinical Maternity Network/South West Clinical Senate Council
2. Acute Midwife	Kay Davis	Senior Midwifery Manager / Matron Community Midwifery Services Ante-Natal Services & Safeguarding Acute Midwife, Gloucestershire Hospitals NHS Foundation Trust
3. Acute Midwife	Ailish Edwards	Midwifery Matron for Community and Birth Centre, Weston General Hospital
4. Community Midwife	Margaret Smith	Community Team Leader, Blue Team Midwives, Wellspring HLC, North Bristol Trust
5. GP	Amelia Randle	GP, Somerset CCG/ South West Clinical Senate Assembly
6. Consultant Obstetrician	Dhushyanthan Mahendran	Consultant Obstetrician, Gloucestershire Hospitals NHS Foundation Trust/ South West Clinical Senate Assembly
7. Consultant Paediatrician	Sian Harris	Consultant Paediatrician, Royal Cornwall Hospitals NHS Foundation Trust/ South West Clinical Senate Assembly
8. Health Visitor	Helene Gibson	Clinical Lead for Public Health Nursing, Bristol Community Health
9. Consultant peri-natal psychiatrist	Kathryn Bundle	Consultant Peri-natal Psychiatrist, Southern Health NHS Foundation Trust
10. Patient/citizen representation	Joanna Parker	South West Clinical Senate Citizens' Assembly, (Healthwatch, South Gloucestershire)
11. Public Health Consultant	Maggie Rae	Public Health Consultant, Public Health England/ South West Clinical Senate
12. Out of area Commissioner	Sharon Matson	Out of Area Commissioner; Head of Commissioning for Women and Children, Devon CCGs
13. Out of Speciality Senate Council Consultant	David Halpin	Consultant Physician, Royal Devon and Exeter Hospitals/ Vice Chair, South West Clinical Senate
14. RCM Lead	Karen Edwards	South West Regional Lead for Maternity, Royal College of Midwives

Review panel biographies are available upon request. No COIs were declared.

The following appendices are available by email upon request from sarah.redka@nhs.net

Appendix 10.12 is included below as an addendum to the original report following re-submission of the PCBC to the Clinical Review Panel as agreed.

10.3 Clinical Review Panel Agenda

10.4 Pre-Consultation Business Case

10.5 Desktop Review Report

10.6 Better Births: National Maternity Review

10.7 The Report of the Morecambe Bay Investigation, Kirkup, 2015

10.8 KLOEs

10.9 STP Slides

10.10 Terms of Reference for Clinical Review Panel

10.11 Timeline

10.12 Clinical Review Panel Report Addendum

24th July 2018

A revised PCBC was submitted to the Clinical Review Panel by the STP on 6th July for a further desktop review to address the recommendations made by the panel on 19th June.

In summary the Clinical Senate recommend that the PCBC move forward to stage two assurance for subsequent public consultation. The case for change to maternity services across the STP is clear and the direction of travel is supported by the Clinical Senate and CRP. However, there is not considered to be any clinical evidence for specifically retaining two FMUs over having none . There may well be compelling patient access or financial drivers that support the retention of these facilities but these need to be set out more clearly. The document should demonstrate that a model with no FMUs has been considered and the reasons for rejecting it. The whole proposal with the creation of 2 AMUs meets the bed test. Proceeding to close two FMUs prior to the creation of the AMUs requires a more detailed risk mitigation plan. Overall, the model would still benefit a clearer description of its community maternity care and homebirth model. **These issues should be addressed prior to consultation.**

The CRP noted that a much improved document had been provided within the timescale. It was recognised that the PCBC has a wider purpose beyond the tests being considered by the clinical senate and the difficulties in considerably further shortening the document whilst still providing all the information required by the wider NHSE Assurance Process.

The overall feedback from the CRP concluded that the revised PCBC addressed the original recommendations as follows;

1. A revised PCBC should include;

a. **How the proposals contribute to the wider vision for maternity services including the equitable service offer for women across the system.**
The revised business case is much improved and addresses the needs for maternity services across the STP. However the case is still skewed towards the services in the Bath area. Whilst the argument for no requirement for significant change in services supporting the Swindon area is made, the projected increase in births in the Salisbury area, due to changes in military deployments, is not addressed. The proposals do not create equity across the STP as there is no choice of an FMU in the Swindon and Salisbury area and the driver for this inequity is not sufficiently explained.

b. **Description of the clear links to the wider Local Maternity Transformation (LMT) plan as context for the proposals; showing how key elements of it deliver the anticipated benefits of the plan.**
The links to the LMT plan are now sufficiently clearer.

c. **The service now and how it will change in the future.**
This has been significantly improved through use of clear graphics

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d. **Pathways in the proposed model across the whole STP using patient stories.**
Patient stories have been included but don't demonstrate the whole model, just the choice of delivery and could therefore be added to.

e. **The future model of care in each community location currently hosting an FMU**
This is still weak. The model of care in each of the community locations is still not clearly stated. In particular it should be provided for those with no FMU in the future to be clear that withdrawing the FMU will not impact on the viability of the remaining facility.

f. **The model and workforce for home births**
Little additional information has been supplied and this would help paint a clearer picture of the overall model across the STP.

g. **The overall workforce model now and in the future by location and anticipated births**
Little additional information has been supplied. The role of Early Years Practitioner which was not covered in initial review has been introduced but more information on the role and how it will impact. It raises questions about quality, training, support and recruitment that haven't been addressed and should be included.

2. **The FMU Model**

There is no convincing clinical evidence or rationale for retaining 2 FMUs over having no FMUs. There may well be compelling patient access or financial drivers that support the retention of these facilities but these need to be set out more clearly. The document should demonstrate that a model with no FMUs has been considered and the reasons for rejecting it. The scoring of the options made the assumption that in order to score 4 against the criteria "aligns with the national agenda" an option would require at least 1 obstetric unit, a dedicated homebirth service, and at least 2 midwife led birth options. The rationale for this assumption needs further explanation. The document should demonstrate that a model with no FMUs has been considered and the reasons for rejecting it.

3. **The AMU Model**

The AMU model could still be described in more detail. There remains concern that the funding for the AMUs will not be achieved. Whilst the case for change is clear and it is recognised that the FMUs are currently under-utilised, a more detailed risk mitigation plan must be provided to consider the impact on the wider maternity model if the AMUs are not set up and FMUs are closed prior to their creation.

4. **The Bed Test – Delivery Beds**

The CRP is satisfied that the whole proposal with the creation of 2 AMUs meets the bed test. Proceeding to close two FMUs prior to the creation of AMUs, despite the current under-utilisation of FMU beds, would require a more detailed risk mitigation plan.

5. **The Bed Test – Post-Natal Beds**

The CRP is satisfied that the current under-utilisation of these beds means they do not need to reprovided. However it is noted that the description provided of wider community based maternity services for enhanced postnatal or breastfeeding support is still limited.

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