

Liverpool Clinical Commissioning Group

Healthy Liverpool Programme

Review of Services Provided by Liverpool Women's NHS Foundation Trust

**A review by Northern England Clinical
Senate**

May/June 2017

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1. Introduction

1.1 Liverpool Clinical Commissioning Group (LCCG) has produced a Pre-Consultation Business Case (PCBC) following a review of services provided by Liverpool Women's NHS Foundation Trust. The PCBC sets out the options appraisal process and the resultant short list of reconfiguration options for public consultation. As part of the preparation for public consultation it was decided to request an independent review by the Northern England Clinical Senate of relevant aspects of the PCBC. The review is focused primarily on assessing whether the ongoing provision of:

- Consultant and midwife led obstetric services
- Gynaecology services including gynaecological oncology services
- Neonatal services

are best undertaken at the current Liverpool Women's Hospital (LWH) site or whether another site or multiple sites in Liverpool might be better placed to provide these services in the future.

1.2 The Terms of Reference agreed for the review include the following objectives:-

Aims and Objectives of the Clinical Review:

To ascertain, using the clinical evidence base and clinical standards described in the PCBC work to date, whether the clinical case for change, option appraisal development and proposals for consultation offer the best clinical options for sustainable, high quality and optimal patient experience for future Liverpool Women's services.

Main Objectives of the Clinical Review:

- Assess the validity of the case for change and the service change proposals.
- Comment on the clinical appropriateness & sustainability (or not) of all four options in the PCBC.
- Consider whether the preferred option supports the strategic intent and policy direction of women's services nationally and women and children's services locally (Cheshire and Merseyside footprint as LWH serves a wider population than Liverpool).
- Comment on the sustainability and clinical risk of the 'workarounds' currently in place and referenced in the PCBC.

A copy of the full Terms of Reference is included as **Appendix 1**.

1.3 Clinical Senate Review Team Members

Chair: Prof Andrew Cant, Chair Northern Clinical Senate, Consultant in Paediatric Immunology & Infectious Diseases, Newcastle upon Tyne Hospital NHS FT.

Derek Cruickshank, In Hospital Clinical Lead for the Better Health Programme and the Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby Sustainability and Transformation Plan & Secondary Care Doctor, Sunderland CCG (Formerly Consultant Gynaecology/Oncologist, James Cook University Hospital).

Sundeep Harigopal, Consultant Neonatal Paediatrician, Newcastle upon Tyne Hospital NHS FT.

Lesley Heelbeck, Head of Midwifery, Gateshead Hospital NHSFT.

Robin Mitchell, Clinical Director NECN, formerly Consultant in Anaesthetics and Intensive Care Medicine.

Helen Simpson, Consultant Obstetrician, South Tees NHS FT.

Sharon English, Lead Clinician for Neonatal Services, Leeds Children's Hospital.

Gareth Hosie, Consultant Paediatric Surgeon, Newcastle Upon Tyne Hospitals NHS FT.

Managerial and business support to the panel was provided by Roy McLachlan, Associate Director for Clinical Networks and Senate, Northern England, and Karen Pellegrino, PA to the Northern England Clinical Senate.

2. Background

2.1 LWH is a purpose built hospital which opened in 1995, located in Crown Street, Liverpool. It provides a range of local services for women and babies and regional tertiary specialist services for the residents of Liverpool and its surrounding areas of Cheshire and Merseyside.

2.2 LWH is one of only two stand-alone specialist Trusts in the country providing care exclusively to women and babies. In 2015/16 LWH delivered over 8600 babies, provided gynaecological care to over 5800 patients and delivered intensive care to over 1000 babies (**see appendix 4**).

2.3 In 2016, LCCG established formal governance arrangements to undertake a full option appraisal process regarding the future location of services provided on the Crown Street site. The reason for doing this was to ensure the long term viability of services provided out of LWH. A long list of options was established and through a decision making process including developing criteria, scoring options against these criteria and gradually reducing the number of options based on the scoring. A short list of four options, with a preferred option identified, has been agreed for formal public consultation. The four options are:-

- Develop and enhance the Crown Street site with an adult Intensive Care Unit, blood bank, CT/MRI/IR and neonatal refurbishment (known as option C1).
- Minimal enhancement to the Crown Street site to minimise emergency transfers (blood bank, leased CT) and neonatal refurbishment (known as option C2).
- Relocation of services to a new build on the Alder Hey site, with access to diagnostics and Adult ICU (known as option D1).
- Relocation of services to a new build on the Royal Liverpool Hospital (RLH) site with access to the full range of adult services, including diagnostics, ICU and specialists (known as option D3-N).

2.4 The Cheshire and Mersey Critical Care Network (CMCCN) has issued a statement indicating there would not be support for establishing a new adult critical care unit at Alder Hey Hospital (**Appendix 2**).

The North West Neonatal Operational Delivery Network (NWNODN) has also issued a statement advocating the co-location of maternity, neonatal intensive care and paediatric subspecialty (including neonatal surgery) as being the only configuration of services that is fully compliant with all national standards (**Appendix 3**). However their review also puts forward several suggestions for mitigating risks should neonatal intensive care be co-located on an adult hospital site.

2.5 The juxtaposition of these two sets of standards is at the core of the challenge facing LCCG in coming to a decision regarding the future location of services.

3. Methodology

3.1 Early in the process for managing the Clinical Senate review it was suggested that representatives from LCCG meet with members of the review panel in the North East to spend time briefing them about the background to the PCBC, the option appraisal process that was followed, and some of the detail behind the long and short lists generated.

This meeting took place on 25th May, 2017 in Durham. A copy of the presentation given to the members of the review panel is given as Appendix 4.

3.2 In advance of this meeting the members of the review panel were sent six documents:-

- Copy of the latest version of the PCBC (dated January 2017).
- Copy of section 11 of Healthy Liverpool – the Blueprint; this is the section regarding the Hospitals Programme.
- Copy of the latest statements from CMCCN and NWNODN which were tabled at a meeting of the Programme Board on 12th May, 2017.
- Copy of a letter from the Chair of the Medical Staff Committee at LWH to the Chief Executive and Medical Director of the Foundation Trust dated 13th February, 2017 outlining support for the PCBC.
- Copy of a letter from the Chief Executive of Alder Hey NHS Foundation Trust to the Chief Officer of LCCG dated 10th March, 2017 outlining detailed feedback on the options appraisal contained in the PCBC.

Towards the end of the meeting on 25th May it was agreed that the only additional document for the panel to consider in advance of the review was the Operational Plan for LWH 2017-19.

3.3 The review panel met representatives of LCCG, NHS England's Assistant Regional Director of Specialised Commissioning, the Medical Director and a Clinical Director from LWH in Liverpool on the evening of 7th June for a further briefing and update prior to a series of meetings with clinical representatives of LWH and AH on 8th June. The programme for these meetings and attendees are included as **Appendices 5 and 6** respectively. A brief tour of limited parts of the LWH site was possible on the morning of 8th June but time constraints meant that it was not possible to visit other sites in the city; the panel particularly noted a request to visit Alder Hey but this was not possible in the time available.

3.4 A draft of this report was sent to LCCG to check for accuracy on 30th June 2017.

4. Issues/Views expressed during review

In this section it is only intended to highlight significant issues/views expressed during the review. It is not intended to give an extensive record of the wide ranging and very helpful discussion which took place in each of the planned sessions.

4.1 Key Issues/Views – Commissioners

4.1.1 The interdependences between Obstetrics and Gynaecology mean that splitting these services would lead to significant clinical risk.

4.1.2 There are currently eight regional providers of Neonatal care at varying levels. Commissioners clearly see Liverpool as a fixed future point for Level 3 Neonatal services.

4.1.3 It was noted that the Neonatal surgery service at Alder Hey currently does not meet National Specifications for Neonatal Intensive Care. The panel understood that following a clinically led options appraisal, the C&M Neonatal ODN and NHS England Specialised Commissioning have endorsed the option to create a Single Neonatal Service, staffed by a single workforce, operating across the two sites (AH and LWH) and that work is now underway to implement this service change. The panel recognised that this would bring continuing challenges of sustainability of staffing.

4.1.4 Neonatal services at LWH do not meet national service specifications because necessary support services and co-located services are not provided on the LWH site.

4.1.5 Also recognised that the direction of travel should be towards having co-location of Gynaecology, Urology and Colorectal services under the umbrella of 'Pelvic Surgery'.

4.1.6 It was noted that a review of Maternity services across the wider area is under way.

4.1.7 There is also a prevailing view that it would not be possible to provide critical care for Obstetric patients at Alder Hey with a clear statement to this effect coming from the Adult Critical Care ODN (**see Appendix 3**)

4.2 Key Issues/Views – LWH

4.2.1 Obs/Midwifery

4.2.1.1 Trust colleagues felt that their service has a very good reputation, but that the challenges faced would make this very difficult to maintain. A key dilemma faced by commissioners was balancing the needs of increasing numbers of complex obstetric cases and the needs of complex neonates, given the current configuration of services across two sites. It was acknowledged that a compromise, 'least bad' rather than an 'ideal' solution was likely.

4.2.1.2 Noted that current obstetric consultant cover of 112 hours a week needs to be extended by recruiting more consultants when investment allows, to fulfil national standard.

- 4.2.1.3** Threshold for transferring women to the Royal Liverpool is high because of the distance to a level 3 Intensive Care Unit (ICU) and the important need to transfer with all the risks involved. This means that women stay on an High Dependency Unit (HDU) facility at LWH longer than may be clinically optimal to try to avoid the need to transfer. If a mother is transferred to RLH, the baby cannot be transferred at the same time as well.
- 4.2.1.4** The lack of a blood bank on the site means that 6 units of O negative blood are stored for emergency haemorrhage. It was noted that the group specific blood can be obtained within an hour with cross matching taking an additional 20 minutes. The trust has been at the forefront in adopting cell salvage techniques, which, while commendable, is not a replacement for an on-site blood transfusion lab.
- 4.2.1.5** Any intra-operative bowel damage requires input from Gynae Oncology or the Colorectal team from the Royal Liverpool Hospital.
- 4.2.1.6** Key diagnostic services such as cross sectional imaging falls far short of the standard expected in a unit of this size (8600 births p.a.). There is currently no CT or MRI facility on site at LWH and no resident Radiographer out of hours. Waits for a Radiographer out of hours were reported as being typically an hour. Imaging is, therefore, limited to plain films only. Reporting is limited to 3 PAs per week with no prospective cover. Only Alder Hey has a full range of imaging available for neonates.

4.2.2 Neonatal Services

- 4.2.2.1** Noted that the unit acts as a Neonatal Intensive Care Unit (NICU) for the wider area of Cheshire and Merseyside as well as for the City of Liverpool. The range of care includes neonatal intensive care, pre-operative, post-operative care, (surgery at Alder Hey with the baby returning to LWH for post-operative care in case of pre-term) management of antenatally diagnosed congenital malformations, and congenital cardiac care until transfer to Alder Hey.
- 4.2.2.2** Currently there is 0.5 WTE Consultant Neonatal input at Alder Hey with the joint appointment of a surgeon pending. No specialist surgeon or paediatric surgeons on site at LWH.
- 4.2.2.3** As set out in 4.2.1.6 above, diagnostic services and facilities fall short of the standard expected.
- 4.2.2.4** There are no dedicated support services available at LWH (physiotherapy, Occupational Therapy, Psychology, Dietetics and Speech and Language Therapy). Such support services are available at Alder Hey. This does not meet current service specifications.
- 4.2.2.5** Current estate facilities for Neonatal services at LWH are too small and the consequent crowding leading to considerable challenges for infection control with, for example, MRSA rates quite high. Average occupancy rate is also high at 84% (21,000 in-patient days).
- 4.2.2.6** Access to other medical specialties is on a good will basis with no service level agreements in place.

4.2.3 Gynaecology

- 4.2.3.1** Services noted as being the only stand-alone Gynaecology service in the UK including a dedicated Gynaecology emergency department. The service is an accredited specialist referral Centre for endometriosis and Gynaecological Cancer Centre.
- 4.2.3.2** There is no CT or MRI on site and no blood bank.
- 4.2.3.3** An Royal College of Obstetricians and Gynaecologists (RCOG) report in 2015 recommended there should be weekly joint operating lists at RLH; this has not been achieved.
- 4.2.3.4** Gynaecology services are needed to support complex Obstetrics particularly in the case of major haemorrhage.
- 4.2.3.5** The strategic direction is for all specialist cancer services in the City to be centralised on the Central University Hospital Teaching Campus. Gynaecological cancer services should be alongside all other cancer services.
- 4.2.3.6** If Maternity services were at Alder Hey, Gynaecology would be unable to support Obstetrics to the same standard as currently.

4.2.4 Anaesthetics/Theatres

- 4.2.4.1** Services feel very isolated with little or no backup therefore, operating effectively as a stand-alone tertiary service.
- 4.2.4.2** Recruitment to a service isolated in this way is very challenging. The example cited is an attempt to recruit into 2 consultant posts where none of the local trainees who had worked at LWH applied for the posts citing dangerous isolation as the reason. With a significant proportion of the current consultant team approaching retirement this presents a serious challenge over the next few years if vacancies to recruit following pending retirements are to be filled.
- 4.2.4.3** All laboratory services are provided through RLH with no on site facilities.
- 4.2.4.4** The possibility of a single service, City wide Anaesthetic service has been mooted. Views expressed that there was a missed opportunity to fully develop a single campus for all major hospital services which would offer the only safe, sustainable solution.

4.3 Views/ Key Issues expressed during review – Alder Hey

4.3.1 Neonatal

- 4.3.1.1** Acknowledged that currently the service at Alder Hey does not, and is unlikely to ever meet, national standards. There are a number of derogations in place. Long term, the future of services at Alder Hey is secure by virtue of investment in a state of the art new building in the last two years providing a fixed point for children, community, general and specialist services in the city. A full range of diagnostic and support services for Neonatal patients is also available.
- 4.3.1.2** Alder Hey Children’s Hospital NHS FT’s preferred option would be for Maternity and Neonatal services to be co-located at Alder Hey with consideration being given to options of Gynaecology moving to other potential sites in the City. Noted that it would not be feasible to carry out Neonatal surgery at LWH either currently or if located at RLH because of the risks associated with the specialised nature of the equipment and the skills of the trained personnel involved.
- 4.3.1.3** The Trust felt that an emphasis on delivering family central care and a seamless women’s and children’s service would be in line with national and local policy of direction of travel: the Trust’s view is that the preferred option does not support this.
- 4.3.1.4** The Trust would also like to see a strategy developed for the first 1000 days of life across the City. (The panel understands a Maternity/First 1000 days workgroup exists within the Healthy Liverpool programme).
- 4.3.1.5** The considerable risks of transferring large numbers of Neonatal patients between hospital sites was highlighted.
- 4.3.1.6** The possibility of developing a supported birth unit at Alder Hey for low to medium risk mothers expecting high risk births to be explored along with upgrading/extending family support facilities.
- 4.3.1.7** Not confident that staffing in Neonatal service at Alder Hey is sustainable in the long term.

4.3.2 Process

- 4.3.2.1** The panel’s attention was drawn to concerns that the Alder Hey Trust has with aspects of the process followed in leading to a preferred option and the production for a Pre Consultation Business Case (PCBC). 3 specific aspects were identified.
- Terms of reference that were not considered to be wide ranging enough to include all Women’s and Children’s services and also primarily focused on the financial sustainability of LWH.
 - The options appraisal process undertaken over a period of a few months in mid-2016.
 - A perceived unbalanced weight of input for children’s and Neonatal services to the options appraisal process and the level of service user input to deciding on the weightings of the discussions and critical success factors decided upon in the option appraisal process.

- 4.3.2.2** After discussion and questioning it was agreed that the option appraisal process itself was not in question given the comprehensive and inclusive nature in working down from an extended long list of 20 options, a final long list of 8 options to the short list of 4 options.
- 4.3.2.3** The panel acknowledged that within the Executive Summary of the PCBC, section 2.1 'case for change' appears to focus on the health and clinical reasons before clearly indicating in the final paragraph that the financial sustainability is also a factor.
- 4.3.2.4** Within the PCBC (Appendix 1 – paragraph A1.3) the membership of the Clinical Reference Group (CRG) included five clinical representatives from Alder Hey and the Clinical Director for Neonates from LWH. Further, also in Appendix 1 of the PCBC (paragraphs A1-5, A1-7 and A1-8) two clinicians from Alder Hey were invited to the 22 April workshop (but did not attend), nine representatives from Alder Hey attended the 20 May workshop and six from Alder Hey attended 24 June workshop. The panels understanding from paragraph A2.2 of the PCBC is that the development of the options appraisal framework including Critical Success Factors and weightings was undertaken in this period and would consider the scale of representation outlined above to be reasonable.
- 4.3.2.5** Any comment on the breadth of services included in the original review would be outside the remit of the panel.

5. Discussion

The sub sections below contain analysis and discussion relating to the 4 objectives mentioned in the terms of reference (**Appendix 1**).

5.1 Validity of the Case for Change and the proposals

Validity of the case for change and the proposals the clinical case for change is set out in section 6.3 of the PCBC. Overall the panel felt that there was a strong clinical case for change and would point to the following by way of support:

- The current isolated position of both Women's and Neonatal services at LWH means both services have very significant clinical risks. The balance of clinical opinion favours a move to RLH central campus with a dedicated new build and increased investment in NICU provision to support Paediatric Surgery at Alder Hey.
- Recruitment into Anaesthetic Consultant posts is a highly critical risk which would be mitigated if Obstetrics and Gynaecology services were co-located with a major acute adult hospital site with full intensive care facilities. Providing anaesthetic services from a much expanded pool of consultants (and trainees) would do much to address the resilience of the service. In addition, on-site availability of dedicated Critical Care expertise would greatly improve the quality of care available to the most seriously ill patients of LWH. There is also a need for co-location of Gynaecological Cancer Surgery with the full spectrum of 'Specialist Cancer Surgical Services' to meet Cancer standards and achieve optimal Cancer outcomes in a sustainable way.
- Change is needed to ensure safety, quality and clinical sustainability. Particular aspects that need to be addressed include provision of CT/MRI facilities, blood bank and Level 3 critical care services, all of which would be expected in a hospital such as LWH.
- Moving alongside the RLH would ensure these critical services are available for women.
- The increasing complexity of care needed for women means there is an increasing need for higher levels of critical care.
- Moving to a central site would mean Gynaecology patients who develop complications would be seen as part of the routine hospital at night process.

It should be noted, however, that the preferred option would be a compromise for Neonatal Services with the proposed configuration of Neonatal Services still not meeting national service specifications. The difficulty of developing a solution which co-locates neonatal surgery with a Neonatal Intensive Care Unit is fully acknowledged. The current specification would not be addressed with the preferred option and there remains a considerable development risk to developing a single neonatal service, including surgery, across two sites.

5.2 Clinical appropriateness of all four options in the PCBC.

| | |
|---|--|
| <p>C1 Develop and enhance Crown Street site</p> <ul style="list-style-type: none"> • Neonatal estate needs upgrading. • Does not improve risks of isolation from paediatrics. • Does not reduce transfers of neonates and women. • Would need to develop adult ICU service, but staffing would be a challenge – almost certainly not feasible • Would require a significant refurbishment in support. • Does not solve anaesthetic services. • Does not address Neonatal standards. • Improvement in estate. • Does not address issue for co-location of specialised surgical Cancer services (e.g. Urology, Colorectal, Vascular and Plastics) with Gynae Oncology. | <p>C2 Minimal enhancement of Crown Street site</p> <ul style="list-style-type: none"> • No real risk reduction for women or neonates. • No transfusion service. • Neither service meets service specification. • Does not reduce transfers of neonates. • Does not reduce transfers of women. • Does not solve anaesthetic services • Does not address issue for co-location of specialised surgical Cancer services (e.g. Urology, Colorectal, Vascular and Plastics) with Gynae Oncology. • Improvement in estate. |
| <p>D1 Relocate to Alder Hey</p> <ul style="list-style-type: none"> • Risks for women would not be reduced. • Would require adult ICU service to be set up at Alder Hey – staffing this would be challenging to the point where it is not feasible and not supported by the Critical Care Network. • Does not solve anaesthetic services issues especially recruitment. • Will not improve multi-disciplinary support for adults. • Neonatal service would be improved significantly by having single site medical, surgical and paediatric care would meet service specification. • Transfers and risks would be minimised for neonates. • Would improve staffing levels for neonatal services. | <p>D3-N Relocate to RLH site</p> <ul style="list-style-type: none"> • The Neonatal Network advocates co-location. Whereas a single neonatal intensive care service operating over two sites is not the optimal configuration, the Neonatal Network considers that this can be an acceptable solution and has provided suggestions to mitigate the risks for sick neonates on an adult site. However, considerable investment is required to support this service and the longer term strategy should be to move to a single site. Such a move is likely to help with longer term sustainability of staffing. • Serious concerns about staffing and sustainability of 2 NICUs at RLUH and Alder Hey – both Alder Hey and neonatal team at LWH expressed concerns about staffing. • Addresses anaesthetic services shortfalls, including recruitment. • Maternity and Gynae service would be significantly improved. • Risks for women would be reduced significantly. |

5.3 Alignment with strategic intent and policy direction nationally and taking into account potential changes in and around Liverpool.

| | |
|--|--|
| <p>C1 Develop and enhance Crown Street site</p> <ul style="list-style-type: none"> • Does nothing to address co-location of services or centralisation of NICUs. • No future proofing around reconfiguration of regional services due to limited estate. • Does not fit with national direction • Does not fit with level minimum. • Need to develop support services. | <p>C2 Minimal enhancement of Crown Street site</p> <ul style="list-style-type: none"> • Does nothing to address co-location of services or centralisation of NICUs. • Does not fit with national direction. • Does not fit with level minimum. |
| <p>D1 Relocate to Alder Hey</p> <ul style="list-style-type: none"> • Meets service specification for neonates, not for Obstetrics or Gynaecology. • Would fit with Neonatal model of care regarding potential reduction in number of units. • Not supported by CCN, | <p>D3-N Relocate to RLH site</p> <ul style="list-style-type: none"> • Against national directive that neonates should be co-located with surgery and other paediatric specialities. • Meets service specification for complex Obstetrics and Gynaecology. • Helps with service requirements for Anaesthetics. • Supports local strategy for complex pelvic surgery. • Aligns with the views of the Cheshire and Merseyside Adult Critical Care network (reference Appendix 3, paragraph 4). • Helps with national direction to centralise services. • Helps with local vision to centralise where appropriate. • Does not take into account Neonatal ODN direction of travel. |

5.4 Sustainability and clinical risk of current 'workarounds'.

| Workaround/clinical risk | Sustainability | Clinical risk |
|---|--|---|
| Colocation with adult L3 CCU – reliance on transfers. | <ul style="list-style-type: none"> Reliant on Ambulance availability. Staffing an issue as staff taken from LWH. | <ul style="list-style-type: none"> Risk of deterioration/death prior to/during a transfer. |
| No access to blood bank or critical pathology services-transfer patients, request emergency transfusions. | <ul style="list-style-type: none"> Not sustainable given increased complexity of patient comorbidities. Potential delays with inappropriate transfers. | <ul style="list-style-type: none"> Significant risk (including death) for mothers and babies. Cell salvage techniques well developed – but cannot mitigate risk entirely. |
| Dependence on colorectal, vascular, urology cardiology and complex diagnostics. | <ul style="list-style-type: none"> Not sustainable with increase complexity of patients comorbidities and increased specialisation. | <ul style="list-style-type: none"> High clinical risk for Gynae Oncology patients. |
| Reliance on patient transfers to meet clinical standards – AHCH and RLBHHT, including neonatal surgery. | <ul style="list-style-type: none"> Wasteful and poor quality of experience for patients. | <ul style="list-style-type: none"> National data supports poorer outcomes in neonates that undergo transfer. |
| Current neonatal facility is under size, proximity of cots may contribute to MRSA levels. | <ul style="list-style-type: none"> Perhaps insufficient space for future proofing. Floor space and layout may need redeveloping. Increase in capacity and estate would make it sustainable. | <ul style="list-style-type: none"> Footprint of neonatal unit could allow reconfiguration of clinical areas. Risk is moderate with apparently high infection rates. Transfer risks remain even if estate is developed. |

6. Conclusions

- 6.1** The panel fully recognised the dilemma faced by commissioners in trying to reconcile safe and sustainable services over multiple sites in Liverpool. The only long term solution which would fully address safety and sustainability would be to move all adult and paediatric services to the new build RLH single central site. Given the considerable investment at Alder Hey and the new build Royal Liverpool Hospital, this solution is likely to be considered very difficult in the short to medium term, but would be in line with the centralising approach being considered and implemented in other parts of the UK.
- 6.2** The review panel considered on balance that the preferred option is aligned with the strategic intent and policy direction for women's services nationally and does sufficiently take into account potential changes being planned in women's and children's services in and around Liverpool;
- 6.2.1** Care for women and neonatal patients is getting more complex and increasingly requires increased working across multiple disciplines to ensure safe standards of practice.
- 6.2.2** The current situation at LWH is potentially unsafe because of a lack of a full range of imaging services, the lack of a blood bank, the lack of Level 3 adult critical care services on site and poor access to colorectal surgery. The potential risks for women and babies are high.
- 6.2.3** The Cheshire and Mersey Critical Care Network is very clear that it would not be possible to create a sustainable effective small adult critical care facility at the Alder Hey site.
- 6.2.4** Neonatal Services at LWH are very good in spite of the cramped accommodation. Infection rates are unacceptably high. There are significant challenges in not being co-located with the neonatal surgical service at Alder Hey.
- 6.2.5** The panel noted that the North West Neonatal Operational Delivery Network 'strongly advocates the co-location of maternity, neonatal intensive care and paediatric subspecialty (including neonatal surgery) services' (reference Appendix 2 paragraph 4).
The Neonatal Network also appears to accept that it should be possible to have a single neonatal service working across two sites in Liverpool. A strong transfer service is currently in place and it should be noted across the UK small sick neonates with for example necrotising enterocolitis needing surgery are transferred from level 3 neonatal intensive care units to distant paediatric surgical units. Further work and investment is needed to ensure surgical input to LWH/RLH is enhanced and at the same time there would need to be investment to ensure that neonatal intensive care at Alder Hey was in place that could effectively care for the increased numbers of younger, more complex neonatal patients.
- 6.2.6** The development work outlined in 6.2.5 also needs to be addressed in the short term and Specialised Commissioning in NHS England could usefully do some further early work with LWH and Alder Hey neonatal services on transfer arrangements and risks involved by defining the speed of transfers needed for different conditions.

Post review note

The panel understands this work has commenced, jointly led by LWH and AH to develop and deliver the single service neonatal service across the two sites. It is anticipated that any capital and revenue implications will be considered as part of this work.

6.2.7 A split of Obstetrics and Gynaecology would not be supported by the review panel.

6.2.8 The dilemma faced by commissioners is that of reconciling a situation where currently the risks for women are on balance greater than the risks for neonatal patients (and this in no way underestimates both sets of risks). The views of the Operational Delivery Networks are key and differ, adding to the dilemma.

6.2.9 Further work is also needed to address staffing sustainability in Anaesthetics at LWH and Neonatal service at LWH and Alder Hey. For the latter even the considerable investment being considered may not be sustainable in the long term.

6.3 On balance the review panel agrees there is no ideal solution but, taking into account the differing views with each medical speciality, that the option to move LWH services to the RLH site offers the best sub optimal solution. In a city where there are two stand-alone new build hospitals (one for adults and one for children) with a lifespan of twenty years plus this would be the next best option to colocation (bringing adults and children's services together on one site) which is not possible in the short to medium term. Although not ideal, on the balance of risks, the panel agrees that option D3-N offers the most appropriate way forward.

6.4 In summary the review panel;

- Agrees with the validity of the case for change and the service change proposals.
- Considers option D3-N to be the most appropriate and sustainable of all four options.
- Considers the preferred option does support the strategic intent and policy direction of women's services nationally and women's and children's services locally.
- Does not consider the current 'workarounds' and inherent clinical risks to be sustainable.

Independent Clinical Review

TERMS OF REFERENCE

Title: Review of services provided by Liverpool Women's NHS Foundation Trust

Sponsoring Commissioning Organisation: Liverpool Clinical Commissioning Group (LCCG)

Lead Clinical Senate: Northern England Clinical Senate

Terms of reference agreed by:

Roy McLachlan
on behalf of Northern England Clinical Senate and
Chris Grant and Helen Murphy
on behalf of LCCG

Date: 23 May 2017

Clinical Senate Review Team Members

Chair: Prof Andrew Cant, Chair Northern Clinical Senate, Consultant in Paediatric Immunology & Infectious Diseases, Newcastle upon Tyne Hospital NHS FT.

Derek Cruickshank, In Hospital Clinical Lead for BHP/STP & Secondary Care Doctor, Sunderland CCG (Formerly Consultant Gynaecology/Oncologist, James Cook University Hospital).

Sundeep Harigopal, Consultant Neonatal Paediatrician, Newcastle upon Tyne Hospital NHS FT.

Lesley Heelbeck, Head of Midwifery, Gateshead Hospital NHSFT.

Roy McLachlan, Associate Director Northern England Clinical Senate.

Robin Mitchell, Clinical Director NECN, formerly Consultant in Anaesthetics and Intensive Care Medicine.

Helen Simpson, Consultant Obstetrician, South Tees NHS FT.

Sharon English, Lead Clinician for Neonatal Services, Leeds Children's Hospital.

Gareth Hosie, Consultant Paediatric Surgeon, Newcastle Upon Tyne Hospitals NHS FT

Background Information

The purpose of the 'Review of Services Provided by Liverpool Women's NHS Foundation Trust' Pre-Consultation Business Case (PCBC) is to set out the options appraisal process and the resultant short list of reconfiguration options for public consultation, subject to approval from the Committees in Common. The PCBC sets out a compelling case for change with clear options for the future and provides a robust evidence base to proceed to consultation.

The rationale for considering how and where services are provided, and in particular the co-dependencies between services, is to ensure the long term viability of the provision of women's and neonatal services in Liverpool.

- There is a need to improve the health of people in Liverpool and ensure that healthcare services are meeting public expectations.
- The needs of the population are changing and LWH is being presented with more complex cases which have clinical inter-dependencies with other services that are not provided on the Crown Street site.
- An increasing number of patients, both mothers and babies are being transferred to acute sites across the city to ensure they get the best possible care to meet their needs. In the case of neonates, this can result in mother and baby being separated.
- Whilst services being provided at LWH are safe, this is due to workarounds being put in place and in the longer term a safer and more sustainable solution is required.
- There are workforce challenges as it is becoming increasingly difficult to recruit in some clinical specialisms such as neonatal care and anaesthetics and also to staff rotas.

This service review is focused primarily on assessing whether the ongoing provision of these services is best undertaken at the current LWH Crown Street site or whether another site or multiple sites in Liverpool might be better placed to provide these services in the future.

Aims and Objectives of the Clinical Review:

To ascertain using the clinical evidence base and clinical standards described in the PCBC work to date, whether the clinical case for change, option appraisal development and proposals for consultation offer the best clinical options for sustainable, high quality and optimal patient experience for future Liverpool Women's services.

Main Objectives of the Clinical Review:

- Assess the validity of the case for change and the service change proposals.
- Comment on the clinical appropriateness & sustainability (or not) of all four options in the PCBC.
- Consider whether the preferred option is aligned with the strategic intent and policy direction of women's services nationally and also sufficiently takes into account potential changes being planned in women and children's services in and around Liverpool given that LWH serves a wider population including Cheshire and Merseyside.
- Comment on the sustainability and clinical risk of the 'workarounds' currently in place and referenced in the PCBC.

Scope of the Review:

In Scope

The scope of the Senate review is to look at the clinical evidence base and options appraisal that underpin the options for public consultation.

The scope of this PCBC is the services that are currently provided by LWH from its hospital site on Crown Street – with the exception of fertility services which are currently provided at the Hewitt Fertility Centre (HFC) and the Genetics service, both of which will require consideration separately once a decision with respect to other services has been made.

The services in scope of this review therefore are:

- Consultant and midwife led obstetrics services;
- Gynaecology services including gynaecological oncology (cancer) services;
- Neonatal services.

Out of Scope

This review does not consider the organisational form of the future provider of women's and neonatal services in Liverpool. It was recently announced that the Boards of the RLBH, AUH and LWH had agreed in principle to the creation of one organisation. A business case for AUH and RLBH is under development for submission to NHSI, which must set out in detail the benefits to patients and how they will be achieved. The next steps for LWH in terms of their organisational form will be considered following this review of the best way to deliver services.

Timeline:

May – July 2017

Reporting Arrangements

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

Methodology

The clinical review team will look over the PCBC and all data and information provided by the CCG. The review team will come together for a half day with CCG representatives who will present the relevant sections of the PCBC and other pertinent evidence/data. This will be by way of preparing the review panel in advance of a visit to Liverpool. This visit will be a one day face to face meeting to discuss further the information received as a review panel and meet with the CCG clinicians and managers to clinically test out the PCBC. The review panel will also offer meet representatives of appropriate user engagement groups. The timeframe would be for CCG information to be circulated in May 2017 with the face to face meeting in Liverpool on Thursday 8 June 2017.

Key Process and Milestones

- a. Finalise Terms of Reference 25 May 2017.
- b. Information for review submitted by Commissioner and distributed to review team 17 May 2017.
- c. Review panel to meet CCG representatives 25 May 2017.
- d. Requests for clarification and/or further information from Commissioners 1 June 2017.
- e. Panel review visit to Liverpool 8 June 2017.

Report

A draft clinical senate assurance report will be circulated within 15 working days from the face to face meeting by the clinical review team to the sponsoring organisation for factual accuracy.

Comments/correction to be received within 10 working days.

The final report will be submitted to the sponsoring organisation following the Northern England Senate Council meeting in July 2017.

Communication and Media Handling

The Clinical Senate aims to be open and transparent in the work that it does. The Clinical Senate would request that the sponsoring commissioning organisation publish any clinical advice and recommendations made.

All media enquiries will be handled by the sponsoring organisation.

Name of Communication Lead Sponsoring Commissioner: Helen Murphy

The detailed arrangements for any publication and dissemination of the clinical senate assurance report and associated information will be decided by the sponsoring organisation.

Resources

Administrative support to the review team, including setting up the meetings and other duties as appropriate, will be shared between the Clinical Senate and the sponsoring commissioner.

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

Accountability and Governance

The clinical review team is part of the Northern England Clinical Senate accountability and governance structure.

The Northern England Clinical Senate is a non-statutory advisory body and will submit the report to the sponsoring commissioning organisation.

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

Functions, Responsibilities and Roles

The **sponsoring organisation** will:

- I. Provide the clinical review panel with relevant information, this will include the PCBC in which is contained the case for change, options appraisal and relevant background and current information, identifying relevant best practice and guidance, service specifications. LCCG will provide any other additional background information requested by the clinical review team.
- II. Respond within the agreed timescale to the draft report on matter of factual inaccuracy.
- III. Undertake not to attempt to unduly influence any members of the clinical review team during the review.
- IV. Submit the final report to NHS England for inclusion in its formal service change assurance process.

Clinical Senate Council and the sponsoring organisation will:

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

Clinical Senate Council will:

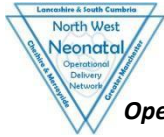
- I. Appoint a clinical review team; this may be formed by members of the senate, external experts, and / or others with relevant expertise. It will appoint a chair or lead member.
- II. Advise on and endorse the terms of reference, timetable and methodology for the review.
- III. Consider the review recommendations and report.
- IV. Provide suitable support to the team.
- V. Submit the final report to the sponsoring organisation.

Clinical Review team will:

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

Clinical Review Team members will undertake to:

- I. Commit fully to the review and attend all briefings, meetings, interviews, panels etc that are part of the review (as defined in methodology).
- II. Contribute fully to the process and review report.
- III. Ensure that the report accurately represents the consensus of opinion of the clinical review team.
- IV. Comply with a confidentiality agreement and not discuss the scope of the review nor the content of the draft or final report with anyone not immediately involved in it. Additionally they will declare any potential conflicts, to the chair or lead member of the review panel.



Appendix 2

North West Neonatal
Operational Delivery Network

Cheshire & Merseyside 
Neonatal Network

Working together to provide the highest standard of care for babies and families

'How to optimise critical care for neonates on an adult site'

N. V. Subhedar, J. Maddocks, NW Neonatal ODN

Background

The Role of the North West Neonatal Operational Delivery Network (NWNODN) is to focus on coordinating neonatal pathways to ensure consistent, equitable access to high quality specialist neonatal care. Neonatal care delivery also needs to comply with national standards, including National Service Specifications for Neonatal Critical Care, Neonatal Surgery and Congenital Heart Disease.

The current configuration of services within Cheshire and Merseyside with a stand-alone maternity service site providing tertiary maternity care and a stand-alone tertiary paediatric service does not deliver optimal care for premature and sick babies who require these services. It is unlikely that these services will be co-located in the short- or medium-term.

The NWODN has recently completed projects that have recommended single service models for NW Transport, Neonatal Surgery (supported by neonatal critical care on the AH site) and Neonatal Intensive Care. These recommendations have been endorsed by the NWODN Board.

The NWODN strongly advocates the co-location of maternity, neonatal intensive care and paediatric subspecialty (including neonatal surgery) services to deliver the highest quality neonatal care to newborn babies requiring intensive care. This is the only configuration that is fully compliant with all national standards.

Mitigating risk for sick neonates on an adult site

What are the ways of mitigating risk for neonates if maternity/neonatal care is not co-located with paediatric specialties at AH?

1. Safety

- Minimising neonatal transfers by ensuring urgent on-site access to paediatric specialist services (including general surgery), investigations (including imaging) and treatments (e.g. mobile ECMO).
- Improving timely access to transport services.
- Improving access to on-site paediatric pathology services.

2. Quality

- Improving access to non-urgent specialist reviews (including various paediatric subspecialists, allied health professionals, psychologists) and specialist investigations.
- Establishment of on-site MDT meetings, including extending joint antenatal counselling sessions.
- Minimising separation of mothers and babies by facilitating early discharge of mothers with provision of postnatal care/accommodation at AH.
- Better use of telemedicine links with AH for clinical and non-clinical indications.

Appendix 3



Cheshire & Mersey Major Trauma
Operational Delivery Networks

Re: LWH options and adult critical care requirements

Since its inception (in 2000)) of Cheshire & Mersey Critical Care Network (CMCCN) (latterly Cheshire & Mersey Adult Critical Care Operational Delivery Network) has worked with the staff of LWH to improve their identification and management of acute deterioration/critical illness in pregnant and recently delivered women.

The location of LWH services without direct access to the full facilities of an acute general hospital, including direct access to level 3 care (intensive care) has posed clinical and logistical problems and presents an increasing level of clinical risk.

At the request of LCCG CMCCN has provided the following points of clarification relevant to the options contained in this pre-public consultation business case:

The preferred option stated (relocation to the new Royal Liverpool Hospital site with a direct physical link) is the only one of the four which will provide LWH acute obstetrics and gynaecology services with direct access to the full range of acute services and associated facilities required to care for acutely deteriorating/critically ill women. This must include 24/7 provision of adult level 2 and level 3 critical care on-site.

The other options under consideration do not meet the standards required for provision of adult critical care. Due to the geographical situation and specialist nature of the LWH Crown Street site and the Alder Hey Hospital these options will be unable to comply with the standards required for provision of level 2 and level 3 adult critical care.

The standards required for provision of adult critical care (level 2 and level 3) include:

- Co-dependent adult acute care services cognisant with an acute general hospital^{1,2,3,4}. This includes 24/7 acute medical, surgical and anaesthetics services as well as support services and diagnostics.
- Sufficient and sustainable multi- professional staff competent to deliver level 2 and level 3 critical care on-site 24/7^{1,2,3,4}.
- Critical care (level 2 and 3) is delivered by a full multi-disciplinary team and should meet education and training standards for the specialty (critical care) and those professional groups^{1,2,3,4}.

Any change to adult critical care facilities in Cheshire & Mersey requires clinical approval of the relevant business case from the Cheshire & Mersey Joint Operational Delivery Networks Board. Other than the stated preferred option (relocation to the new Royal Liverpool Hospital site with a direct physical link) the options contained in the pre-consultation business case will not meet the required standards^{1,2,3,4} and subsequently would not receive this approval.

CMCCN has also been asked to provide consideration of 'small' critical care units (< 6 adult critical care beds). Although these do still exist in the UK they have the following disadvantages (not in any particular order):

- High quality critical care benefits from exposure to best practice and innovation; small units are less likely to be able to provide this
- Unlikely to attract or retain experienced staff
- Unlikely to meet education and training requirements for medical and nursing staff
- Not cost effective and lacks flexibility
- Would not be commissioned due to the requirement to be compliant with national standards ^{2,3,4}.

In addition sophisticated clinical governance processes are required to deliver high quality critical care; these are much harder, if not impossible to deliver in a small unit geographically separate from an acute adult general hospital as proposed in the Crown Street and Alder Hey options.

Within the NW small critical care units have closed because they were unsustainable (for example Halton, Chorley) with others' sustainability in question.

LWH does not comply with the standards for level 3 critical care provision ^{1,2,3,4} and is at increasing risk of not being able to provide level 2 critical care. Women requiring level 3 critical care need to be transferred to another hospital, itself a high risk clinical activity.

CMCCN and CMMTN (Cheshire & Mersey Major Trauma Operational Delivery Network) in collaboration with Cheshire & Mersey Neonatal Network (part of the North West Neonatal Operational Delivery Network) and Cheshire & Mersey Strategic Clinical Networks (now North West Coast Strategic Clinical Networks) have produced pathways for the acutely ill/critically ill woman⁶ and the pregnant major trauma patient⁷ to try to streamline the complex pathways resulting from the geographically separate location of specialist acute services across Liverpool and mitigate against further serious clinical incidents, as far as possible given the current situation.

Failure to relocate LWH to an adult acute hospital site (a direct physical link for patient trolley/bed transfer is essential) would severely worsen the already precarious situation for acutely ill/critically ill women at LWH and as a newly commissioned service would carry prohibitive risk.

References

1. CMCCN Service Specification for Adult Critical Care (incorporating D5) (2016)
2. D5 National Clinical Reference Group Service Specification for Adult Critical Care (2016)
3. 20160607 900472 NHS Critical Care Core Service Framework v1 08 (Published on internet July 2016) Care Quality Commission assessment tool for adult critical care (2016)
4. Guidelines for the Provision of Intensive Care Services (GPICS) (2015)
[https://www.ficm.ac.uk/sites/default/files/GPICS%20-%20Ed.1%20\(2015\)_0.pdf](https://www.ficm.ac.uk/sites/default/files/GPICS%20-%20Ed.1%20(2015)_0.pdf)
5. Enhanced Care for the Sick Mother Standards in Maternal Critical Care (Joint Royal Colleges and Intensive Care Society, final draft, 2016)
6. Acutely Unwell/Critically Ill Pregnant or Recently Pregnant Woman (2015)
7. Pregnant Major Trauma Pathway (2015)

Sarah Clarke
Director & Lead Nurse
CMCCN

October 2016

Review of services provided by
Liverpool Women's NHS
Foundation Trust

Northern Clinical Senate
25th May 2017



Healthy Liverpool Programme Hospital Transformation Team

rlim
Liverpool
Clinical Commissioning Group

- Dr Fiona Lemmens- Clinical Director
- Dr Chris Grant- Programme Director
- Helen Murphy- Programme Manager

rlim
Liverpool
Clinical Commissioning Group

Healthy Liverpool Programme

Healthy Liverpool Programme



A health care system in Liverpool that is person-centred, supports people to stay well and provides the very best in care

Case for Change

Poor Health



30% of people in Liverpool live with one or more long-term conditions.



93,000 people in Liverpool are affected by mental health issues.

Lifestyle



Over half of adults in Liverpool are overweight or obese.

Health Inequalities



Men in Liverpool live 3.1 years less and women 2.8 years less than the England average.



The difference in life expectancy between areas of the city can vary by more than 10 years.

Case for Change

Ageing population

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By 2021 there will be 9% (5,700) more people living beyond the age of 65 with the biggest growth in those aged 70-75 and 85+.

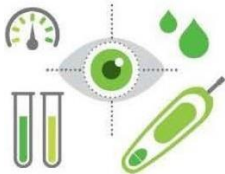
• /

Almost 26,000 older people have a long-term illness that limits their day-to-day activities a lot.

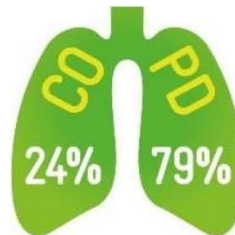


By 2021 there will be a 10.7% increase in the number of people living with dementia.

Access and Variation

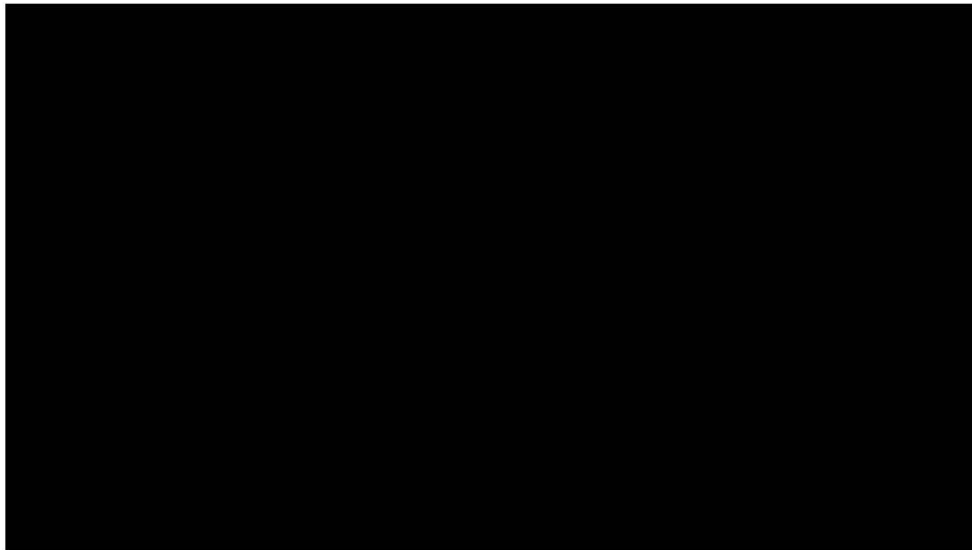


The number of people with diabetes receiving the recommended care processes to manage their condition varies between 20% and 80% depending on where they live in Liverpool.

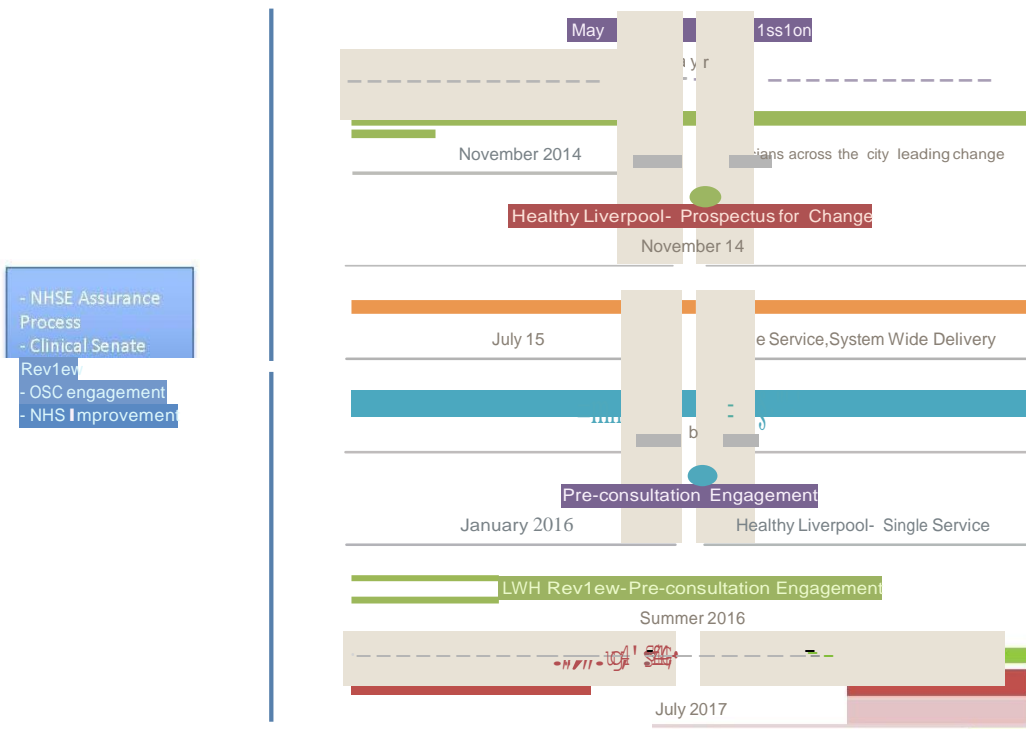


The number of patients with Chronic Obstructive pulmonary disease offered rehabilitation varies between 24% and 79% in the city.

Healthy Liverpool animation



Healthy Liverpool Journey



Centralised University Teaching Hospital Campus
Single Service, City Wide Delivery
 Delivered through centres of academic, clinical and service excellence



Aims:

The Best Hospital Care System in the country
 All Patients to receive the right care in the right place first time
 A safe health care system that is clinically and financially sustainable
 To maximise patient outcomes



Principles of Care:

Single service teams
 Services delivered to best practice standards
 Eliminate unwarranted variation of services
 Local whenever practicable, central when necessary

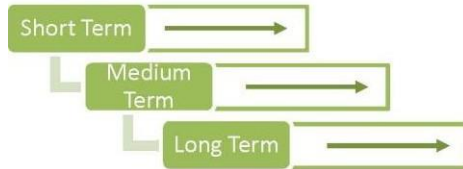


Added Value:

World class academic research and development
 Commercial application and opportunity
 Economic and social benefits
 Long-term workforce and training solutions

The Journey at Pace

Now



Sustainable and engaged workforce

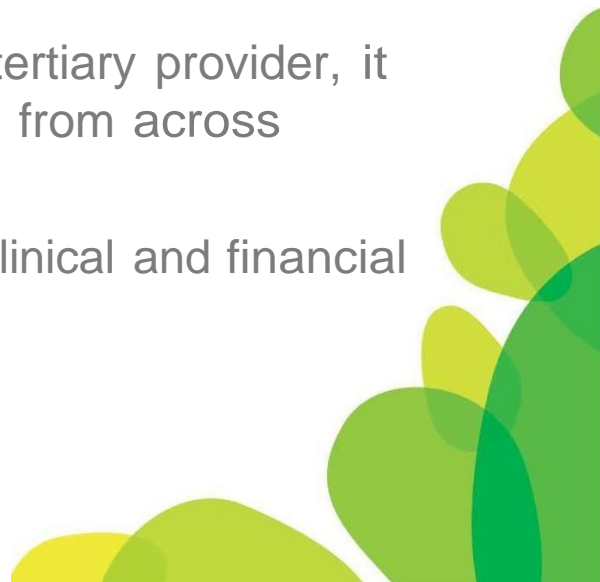
Transformation of primary care and community services

Delivery at scale of the benefits of digital and living well transformational programmes

rEm
Liverpool
Clinical Commissioning Group

Liverpool Women's NHS
 Foundation Trust

- Gynaecology, obstetrics, genetics, fertility treatment and neonatal services at the Crown Street site
- As the regional specialist tertiary provider, it serves women and babies from across Cheshire & Merseyside
- The review it is to secure clinical and financial sustainability



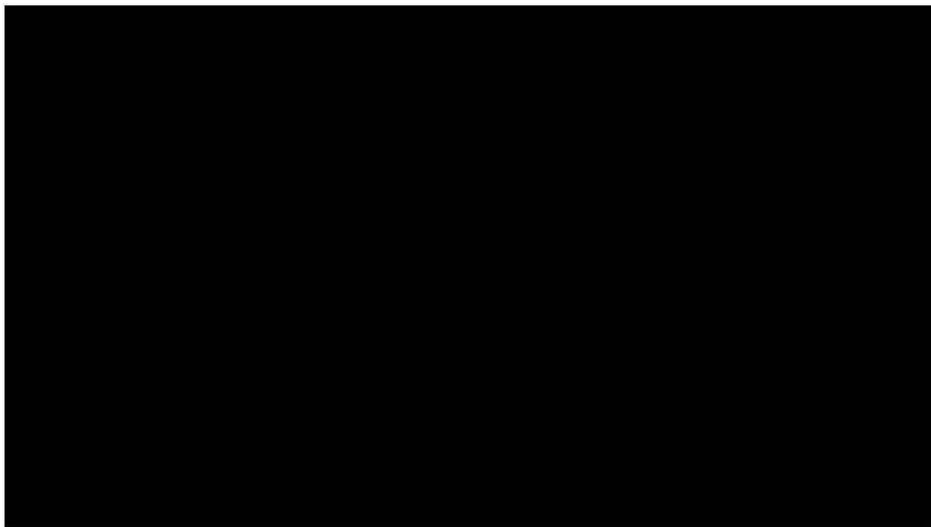
- LWH is one of only two stand alone specialist Trust's in the country providing care exclusively to women and babies
- In 2015/16 LWH delivered over 8600 babies
- Provided gynaecological care to over 5800 patients
- Delivered intensive care to over 1000 babies



Liverpool Women's NHS Foundation Trust Case For Change

Healthy Liverpool animation

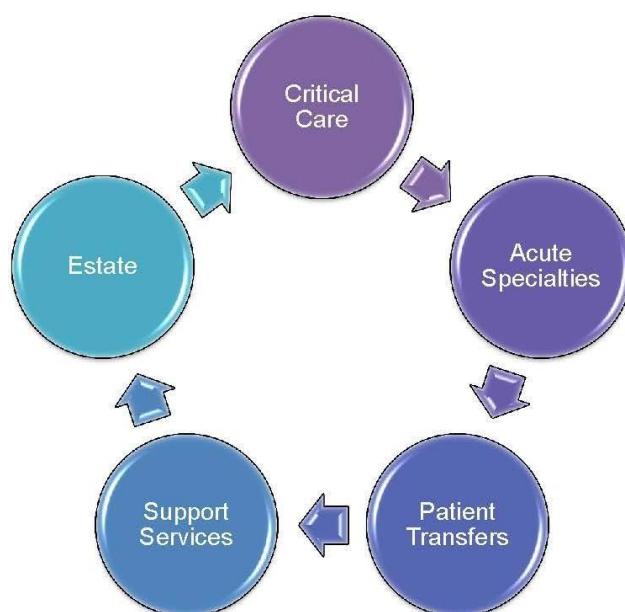
"why women's and new-borns' services need to change"



Case for Change



Clinical Case for Change



Liverpool Women's NHS Foundation Trust

Future Generations Strategy

Liverpool Women's NHS Foundation Trust

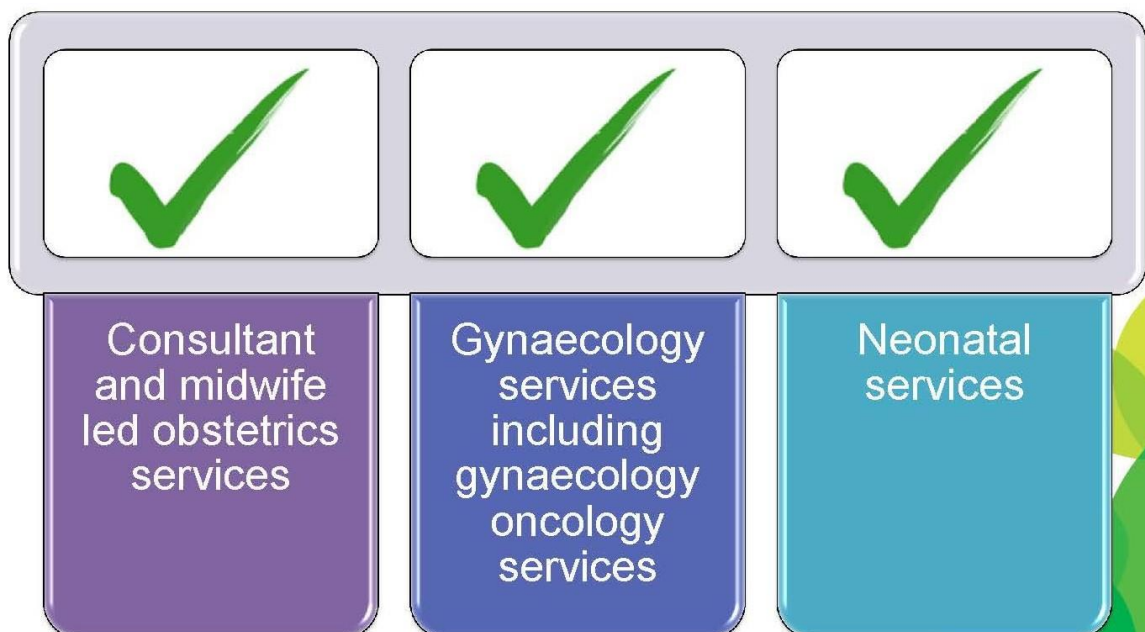


| | | | |
|--|--|---|---|
| <p>strategic options appraisal of future services provision, following a stakeholder orientated approach to option appraisal</p> <p>Findings from 2 stakeholder</p> | <p>move of their services to the new Royal Liverpool Campus Site as being their preferred way forward</p> <ul style="list-style-type: none"> This was published in a strategic options appraisal case – | <p>production of this Strategic Options Appraisal Business Case, neonatal consultants raised concerns with the outcome and the potential impact on their service and</p> | <p>Generations Strategy, a number of strengths and weaknesses of LWH's current clinical model are noted</p> <ul style="list-style-type: none"> The document explained the clinical risks and specific |
| <p>allowed LWH to develop a shortlist of options</p> <ul style="list-style-type: none"> Strengths and weaknesses of each of the shortlisted options were considered by LWH and evaluated at multi-stakeholder event | | <p>see additional clinical evidence</p> <p>This led LWH to establish the Future Generations Programme to obtain and review clinical evidence</p> <p>The resulting Future Generations Clinical Strategy was produced in October 2015</p> | <p>have been developed to attempt to mitigate these risks</p> <ul style="list-style-type: none"> Future Generations Business Plan was published December 2015, it reconfirmed relocating all services to the Royal Liverpool Hospital campus as being the preferred option |

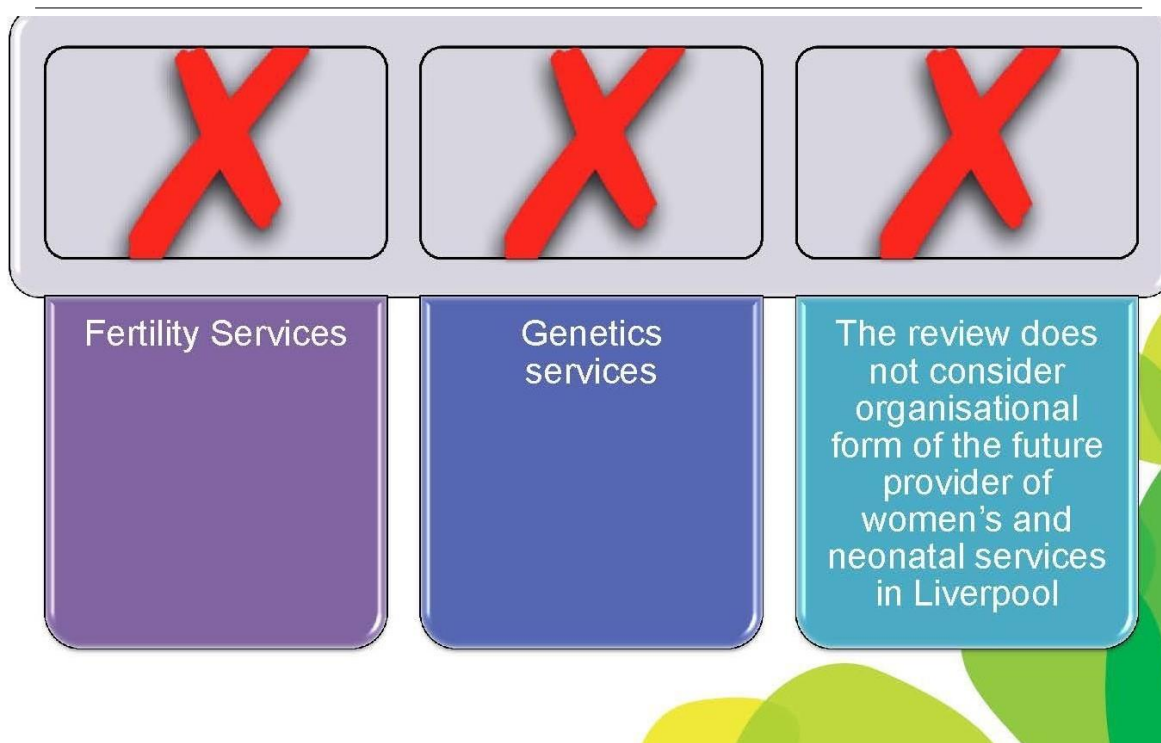
Liverpool Women's NHS Foundation Trust

Commissioner led review

Services in Scope of this Review



Services out of scope



Process

Key Meetings

- Options Development workshops-supported by FTI Consulting
- Clinical Reference Group- chaired by Dr Mike Bewick
- Programme Oversight Board – chaired by Dr Andrew Loughney
- Estates workshops

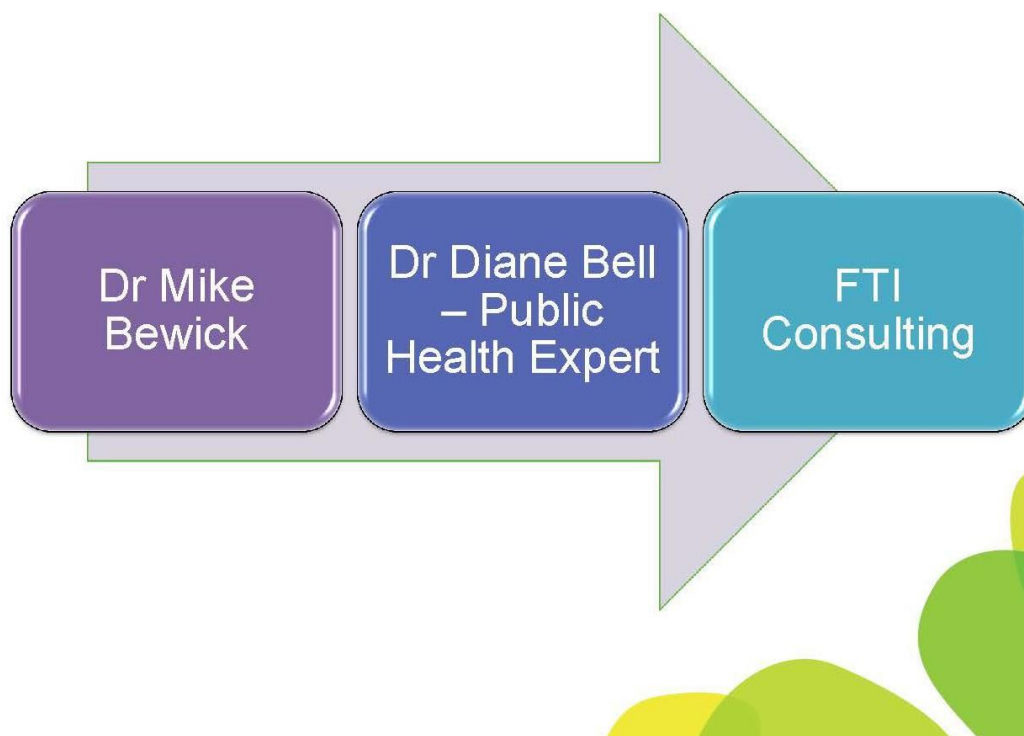
Options Appraisal Process

- Critical Success factors
- Weightings
- Workshops
- Long list
- Short list

Key Stakeholders

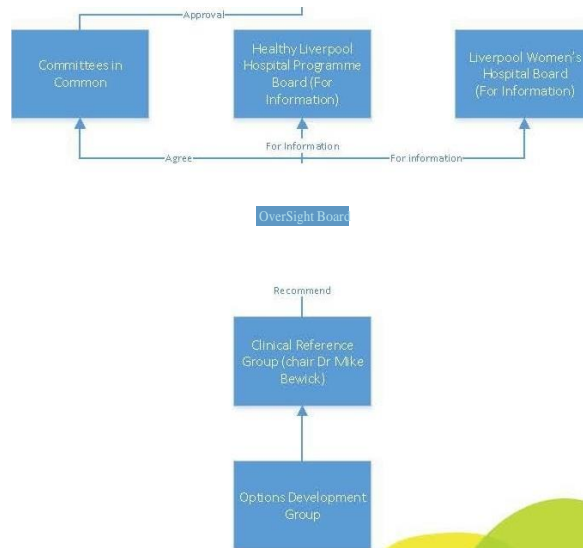


The external review team



GematK.e p-LWHReveN

Joint Governance Body (Sign off) by 3 CCG's (Liverpool, Sefton & Knowsley)



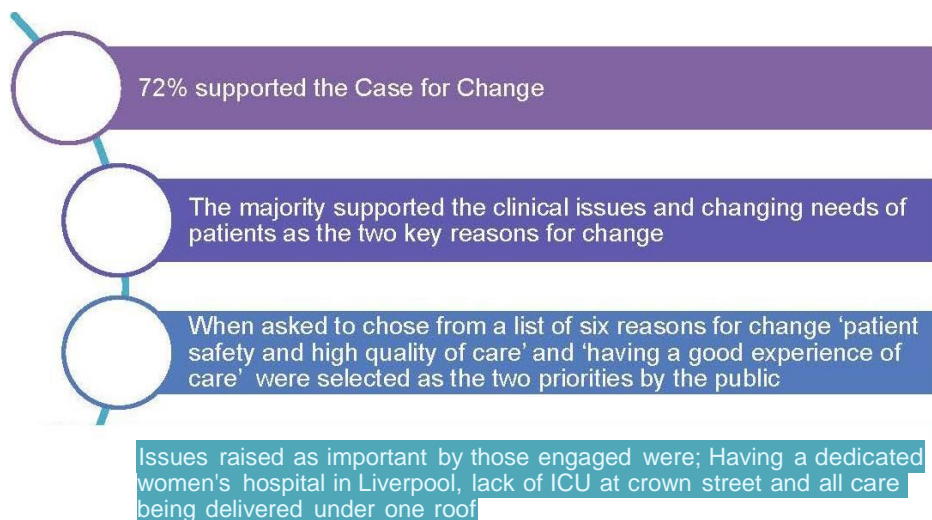
Meetings of Key Working Groups

| April | May | June | July | September | October |
|--|--|---|--|--|---|
| 22 April ODG Workshop 1 (Framework) | 20 May ODG Workshop 2 (Scoring 1) | 24 June ODG Workshop 4 (Estates/Finance) | 20 July ODG Workshop 4 (Estates / Finance) | 8 Sept ODG Workshop 5 (Scoring C2) | 14 Oct POB 5 (Confirm Options) |
| 14 April CRG 1 (Framework) | 6 May POB 1 (Confirm Long List) | 03 June CRG 3 (Short List) | 1 July POB 3 (Review Analysis) | 15 Sept ODG Workshop 6 (Estates / Finance) | |
| 29 April CRG 2 (Long List) | | 24 June CRG 4 (Confirm Options) | 21 July POB 4 (Review Analysis) | | |
| | | 10 June POB 3 (Review Options) | | | |

Liverpool Women's NHS Foundation Trust

Commissioner led review – Pre-consultation Engagement

Pre-consultation engagement *June 2016*



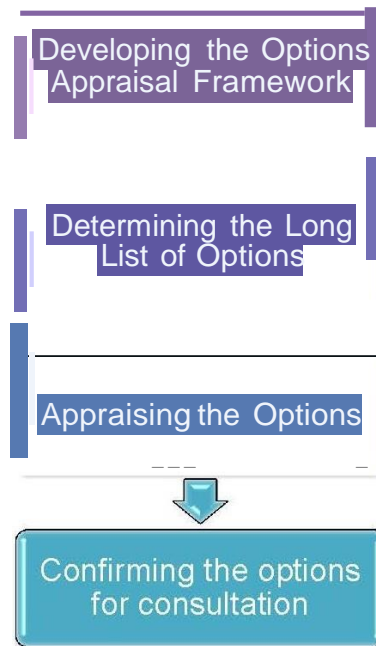
Common themes from community groups:

- Attendees wanted to see the Crown Street site built upon and improved
- Those engaged respected and were ready to support the clinicians' reasons for change
- There was some concern that the reasons for change may focus on critical cases rather than the needs of the majority of the patients

Liverpool Women's NHS
Foundation Trust

Commissioner led review –
Developing the Options Appraisal Framework

Options Appraisal Process



Developing the Critical Success Factors

- D A critical success factor should reflect something that is a Key priority for the service reconfiguration. The option can then be tested against that priority to see how well it meets the criteria.
- D In addition, CSFs should allow options to be differentiated from each other i.e. there is no point including CSFs that all options will meet with equal scoring.
- D However if there is a minimum standard, then this should be considered a 'hurdle' criteria that would rule an option out at an earlier stage.
- D CSFs should also reflect range of priorities for the service reconfiguration and therefore we tend to consider CSFs under four categories:

Quality

Feasibility

Financial
Sustainability

Strategic fit

The Critical Success Factors

| Category | CSF # | Description |
|---------------------------------|-------|--|
| Quality 35% | | The proposed option will maintain or improve the health and wellbeing of the whole population receiving services |
| | 2 | The proposed option will allow services to maintain or improve clinical outcomes and maintain or exceed clinical standards |
| | 3 | The proposed option will allow services to deliver a positive patient experience for patients and their families |
| | 4 | The proposed option will improve clinical sustainability |
| | 5 | The proposed option will increase scope for research and innovation |
| Feasibility 20% | 6 | Recognise current and future workforce requirements and allow for appropriate education and training |
| | 7 | Include plans for sufficient estate for delivery of optimal services now and in the future |
| | 8 | Be likely to be acceptable to patients, families and the wider public |
| Financial Sustainability 30% | 9 | The proposed option contributes to achievement of recurrent financial sustainability for all services |
| | 10 | The proposed option is financially deliverable given likely funding constraints |
| Strategic Fit 15% | 11 | The proposed option aligns with the goals of the Healthy Liverpool Programme |
| | 12 | The proposed option supports delivery of local, regional and national policy |

Weightings

- The options were scored in each CSF (and sub criteria) leading to an overall score per CSF category
- An overall assessment of each option was then determined, using a weighting to assess the relative importance of the criteria
- The weighting used is shown here.
- We also performed a sensitivity analysis as part of the options appraisal process, to understand how a change in the weightings might affect the overall outcome.

| Category | Weighting |
|--------------------------|-----------|
| Quality | 35% |
| Feasibility | 20% |
| Financial sustainability | 30% |
| Strategic fit | 15% |

Liverpool Women's NHS Foundation Trust

Commissioner led review – The Options

Extended long list of options

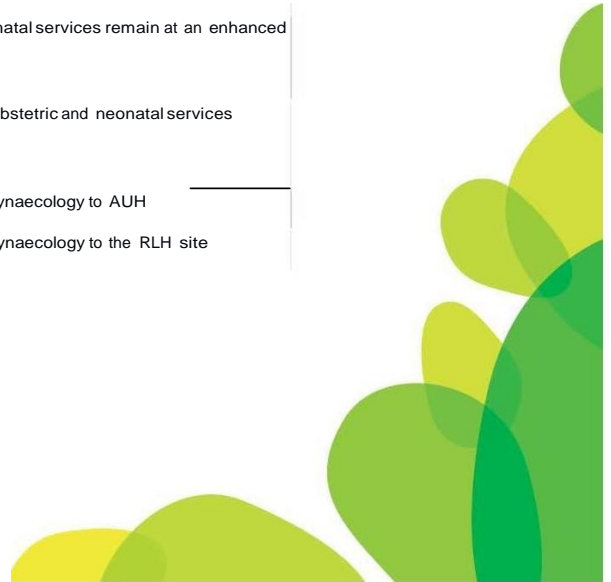
DeSCOpeOs

Clinical Commissioning Group

| No. | Description | CCG |
|-----|---|-----|
| 1 | Do nothing - community-based local maternity network supported by specialists and acute providers in Liverpool | A |
| 2 | Develop a | C |
| 3 | Develop all services at Mersey LWH services | O1 |
| 4 | Relocate all services to RLH | O3 |
| 5 | Relocate all services to AUH | O2 |
| 6 | Relocate | |
| 7 | Develop new gynaecology and obstetrics services / Relocate non-elective gynaecology to RLH / Relocate obstetrics and neonatal | |
| 8 | Deliver elective services to AUH / Relocate obstetrics and neonatal services to LWH | E1 |
| 9 | Relocate gynaecology to AUH / Relocate obstetrics and neonatal services to AH | F1 |
| 10 | Relocate gynaecology services to RLH / Deliver obstetrics and neonatal services at LWH | E2 |
| 11 | Relocate gynaecology at LWH / Relocate obstetrics and neonatal services to AH | F2 |
| 12 | Deliver gynaecology to RLH / Relocate obstetrics and neonatal services to AH | |
| 13 | Relocate gynaecology to RLH / Relocate obstetrics and neonatal services to AUH | |
| 14 | Relocate gynaecology to AUH / Relocate obstetrics and neonatal services to RLH | |
| 15 | Relocate a surgical delivery suite at AH with a NICU for immediate surgical or cardiac input | |
| 16 | Develop | |
| 17 | Develop a Merseyside maternity network | |
| 18 | Non-NHS gynaecology services at LWH / Relocate obstetrics and neonatal services to Broadgreen Hospital | |
| 19 | Deliver gynaecology services to Broadgreen Hospital | |
| 20 | Relocate | |

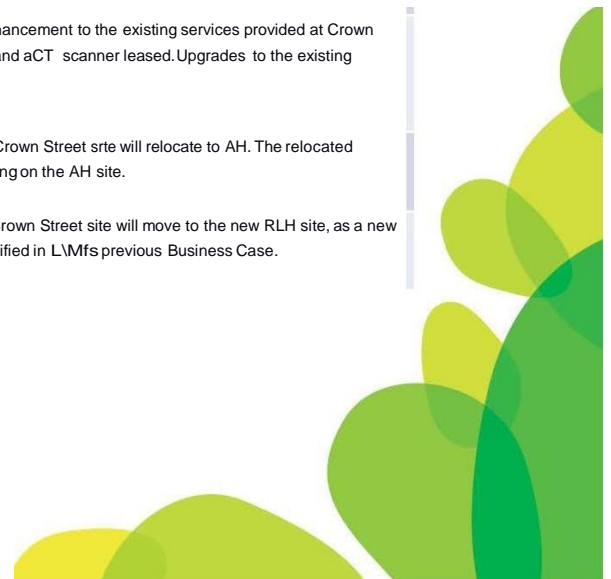
Clinically led long list of options

| Rev. No. | Description of option |
|----------|--|
| C | Develop and enhance the Crown Street site |
| D1 | Relocate all services to AH Relocate |
| D2 | all services to AUH Relocate all |
| D3 | services to the RLH site |
| E1 | Relocate gynaecology to AUH while obstetric and neonatal services remain at an enhanced Crown Street |
| E2 | Relocate gynaecology services to the RLH site while obstetric and neonatal services remain at an enhanced Crown Street |
| F1 | Relocate obstetrics and neonatal services to AH and gynaecology to AUH |
| F2 | Relocate obstetrics and neonatal services to AH and gynaecology to the RLH site |



Final Options for Public Consultation

| Option | Summary description |
|--|---|
| C1: Develop and enhance LWH's current Crown Street site. | The services that are currently envisaged to be part of an 'enhanced Crown Street' include: an adult ICU; bloodbank; improved access to diagnostics including staff to deliver CT/IVIRI scans on site or in a mobile format; additional IR services; and neonatal support services. |
| C2: Provide minimal upgrades to LWH's current Crown Street site to enable safer care and minimise emergency transfers. | This option will involve a minimum enhancement to the existing services provided at Crown Street. A blood bank will be provided and a CT scanner leased. Upgrades to the existing neonatal service will be made. |
| D1: Relocate all services to the AH site (new build). | All services currently provided on the Crown Street site will relocate to AH. The relocated services will be located in a new building on the AH site. |
| D3-N: Relocate all services to the new RLH site (new build). | All services currently provided at the Crown Street site will move to the new RLH site, as a new build. This is the preferred option identified in LWH's previous Business Case. |



Where are we now?

NHS England stage 2 assurance identified a financial case is required to show how this will be funded

LWH working with NHS I on an outline business case

Finance Oversight Board established-NHS E and NHS I in attendance

Timescales for outline business case to be completed-end July 2017

NHS E assurance process- following OBC

Formal public consultation- following stage 2 assurance NHS E

Objectives of the Clinical Senate Review

- Assess the validity of the case for change and the service change proposals
- Comment on the clinical appropriateness and sustainability of all four options in the PCBC
- Consider whether the preferred option supports the strategic intent and policy direction of women's services nationally and women and children's services locally
- Comment on the sustainability and clinical risk of the 'workarounds' currently in place and referenced in the PCBC

Parallel pieces of work

- Improving Me- Cheshire and Merseyside Women's and Children's Services Vanguard
- NWNODN review
- LWH Operational Plan 2017-18





Questions & Discussions

ITINERARY – LWH Women's and Neonatal Review

Title: CLINICAL SENATE REVIEW
Date: Thursday 8 June 2017
Time: 8.00am – 4.30pm

| Time | Item | Location | Details |
|-------|-------------------------------------|--|---|
| 08:00 | Arrival at LCCG | LCCG, Lewis's Building, Renshaw Street, L1 2SA | Senate panel members to meet with Chris Grant, Fiona Lemmens and Helen Murphy at LCCG reception, 3 rd Floor. Meeting room 2 reserved for the day and can be used to leave bags, etc whilst off-site. |
| 08:10 | Travel to LWH | | Taxi to collect from front of Watson Building (to the right of LCCG as you leave the main entrance) |
| 08:20 | Arrival at Liverpool Women's NHS FT | LWH, Crown Street L8 7SS | Met by Devender Roberts and Jeff Johnson |
| 08:30 | Introduction | Large Meeting Room | <p>Associate Medical Director – Devender Roberts</p> <p>Executive team – Vanessa Harris – Director of Finance Jeff Johnston – Director of Operations Michelle Turner – Director of OD & Workforce Doug Charlton – Director of Nursing & Midwifery</p> <p>Deputy Director of Nursing & Midwifery Julie King</p> <p>Deputy Director of Finance Jenny Hannon</p> |

| | | | |
|-------|--|--|--|
| 8:40 | Obstetric Risks on an isolated site - Including Q&A | Large Meeting Room | Clinical Director for Maternity - Mark Clement Jones Interim Head of Midwifery – Fiona Bryant Governance Facilitator – Sian McNamara |
| 9:40 | Neonatal Risks on an isolated site - Including Q&A | Large Meeting Room | Clinical Director for Neonates – Bill Yoxall Head of Neonates – Jennifer Deeney |
| 10:40 | Refreshments | | |
| 10:55 | Gynaecological Risks on an isolated site - Including Q&A | Large Meeting Room | Clinical Director for Gynaecology John Kirwan Nursing Lead |
| 11:25 | Anaesthetic and Theatre Risks on an isolated site - Including Q&A | Large Meeting Room | Clinical Director for Anaesthetics - Edwin Djabatey Nursing Lead ODA |
| 11:55 | Clinical Tour | Neonatal Unit Delivery Suite HDU Facilities | Devender Roberts Bill Yoxall Ed Djabatey |
| 12:30 | Working Lunch | Large Meeting Room | |
| 13:30 | Travel back to LCCG | | |
| 13:45 | Meetings with Alder Hey staff | Meeting room 2, LCCG, Lewis's Building, Renshaw Street, L1 2SA | Medical Director - Steve Ryan Associate medical director - Graham Lamont Consultant Urologist - Harriett Corbett Consultant Paediatric Surgeon - Jo Minford Director of Strategy - Debbie Herring |
| 14:45 | Panel time | Meeting room 2, LCCG, Lewis's Building, Renshaw Street, L1 2SA | |
| 15:45 | Refreshments | | |
| 16:00 | Feedback | Meeting room 2, LCCG, Lewis's Building, Renshaw Street, L1 2SA | |
| 16:30 | Close of day – travel to Lime Street Station for train at 17:10 | | |

Appendix 6

LWH Review List of Attendees Thursday 8th June 2017

| Attendees |
|---|
| LWH Mark Clement Jones - Clinical Director for Maternity Fiona Bryant Interim - Head of Midwifery Sian McNamara - Governance Facilitator Jenny Buldon - |
| LWH Bill Yoxhall - Clinical Director for Neonates Jennnifer Deeney - Head of Neonates Sue O'Neil - Chris Stewart - Val Irving - |
| LWH John Kirwan - Clinical Director for Gynaecology Chris McGale - Nursing Lead |
| LWH Edwin Djabatey - Clinical Director for Anaesthetics Nicky Maggs - Nursing Lead |
| Alder Hey Steve Ryan - Medical Director Graham Lamont - Associate Medical Director Harriet Corbett - Consultant Urologist Jo Minford - Consultant Paediatric Surgeon Debbie Herring - Director of Strategy |