

Response to the CCG's Review of Women's and Neonatal Services regarding the clinical case for change

Lack of adult critical care on site

Number of patients requiring adult critical care is very small and their needs are safely managed

Patient transfers between hospitals

Transfers of patients are a common occurrence and protocols are in place to ensure safety

Inability to support women with complex health needs

Clinics and care pathways provide specialist support in all areas of healthcare for women

Inadequate space for current neonatal facility

Present neonatal facility can be expanded

Availability of haematology/pathology services

Services can be increased to meet demand

Save the Women's Hospital Campaign/Merseyside Keep Our NHS Public

April 2017

Available at <http://www.labournet.net/other/1612/clinical1.pdf>

Contents

Forward.....	3
Lack of adult critical care on site.....	4
Patient transfers between hospitals.....	6
Inability to support women with complex health needs.....	8
Inadequate space for current neonatal facility.....	9
Availability of haematology/pathology services.....	11
Conclusions.....	12
Summary.....	13
References.....	15

Forward

Numerous statements from NHS “bosses” have confirmed their plans to move the Liverpool Women’s Hospital to the site of the Royal Liverpool Hospital, with the claim that this will result in better health outcomes for women.

Most notably the CCG have published their “Review of Services Provided by Liverpool Women’s NHS Foundation Trust Pre-Consultation Business Case” with four options for the future of the Women’s Hospital. It goes on to indicate their preferred option is to “Relocate women’s and neonatal services to a new hospital building on the same site as the new Royal Liverpool Hospital.”

Unfortunately the clinical case on which this option is based and which has been widely accepted by health workers throughout the city, is deeply flawed. A close examination of the arguments - which many of those endorsing the case for closure have not done - shows the arguments to be based on misinformation and misunderstanding of the current situation.

Indeed the clinical arguments for the option to “Make major improvements to Liverpool Women’s Hospital on the current Crown Street site” along with the added advantages of its current location far outweigh the “preferred option”.

One would expect the medics to look for the evidence that the preferred option would result in better health outcomes and then proceed accordingly. However, as can be seen in the following pages, it would appear they have decided that the hospital should close and a new one be built, and then produced “the evidence” to support this contention.

Lack of adult critical care (ICU) on site

According to the Liverpool CCG, the Trust, currently provides a Level 2 High Dependency Unit (HDU) facility on site at Liverpool Women's Hospital (LWH) which National Standards require should be located with a Level 3 Critical Care Unit. As LWH does not have a Level 3 unit, women who require this level of care have to be "blue-lighted" to the Royal Liverpool University Hospital (RLUH).

This statement is not altogether accurate. Guidelines for the Provision of Intensive Care Services (Edition 1 2015) state:

"All acute hospitals carrying out elective surgery must be able to provide Level 2 care. Patients with a predicted surgical mortality in excess of 10% should have access to facilities for Level 3 dependency on site. Hospitals admitting emergencies should normally have all levels of care on site. Analysis of the delivery of Critical Care is complicated by the term itself, incorporating as it does a mix of Level 2 and Level 3 care, and hence encompassing speciality-specific high dependency care which may lie partially outside the remit of general Intensive Care units."

There is a speciality-specific high dependency unit at LWH.

The Core Standards for Intensive Care Units (2013) which apply to all units capable of looking after Level 2 or Level 3 critically ill patients go on to state:

"If a unit usually provides Level 2 care, it must be capable of the immediate provision of short term Level 3 care without calling in extra staff members in order to provide optimal care. The unit should be capable of providing up to 24 hours of Level 3 care prior to a patient being safely transferred to a more suitable unit. The staff of a Level 2 unit should have the competencies required to provide this level of care."

Access to Level 3 Critical Care (ICU) must be suitable for all obstetric patients and preferably on site. Units without such provision on site must have an arrangement with a nominated Level 3 critical care unit (ICU) and an agreed policy for the stabilisation and safe transfer of patients to this unit when

required. Portable monitoring with the facility of invasive monitoring must be available to facilitate the safe transfer of obstetric patients to the Intensive Care Unit. (Guidance on the Provision of Obstetric Anaesthesia Services 2015) While the Standards state it is preferable to have a Level 3 care unit on site it recognises that not all obstetric units do have such a unit and so should have an appropriate policy in place for the safe transfer of patients. The RLUH is the nominated Level 3 unit for LWH as part of local critical care arrangements therefore adhering to the Standards for Intensive Care Units.

The Pre-Consultation Business Case (PCBC), recently published by the CCG, maintains that the lack of a level 3 Intensive Care Unit at LWH means that clinical standards are not being met and if services were to remain at the Crown Street site then the four bedded High Dependency Unit would need to be upgraded to a six bedded Intensive Care Unit.

Appendix 17 of the PCBC states that this would not meet the approval of the Cheshire and Merseyside Critical Care Network (CMCCN). They claim that national standards would not be met due to the geographical and specialist nature of LWH Crown Street site.

The Care Standards for Intensive Care (2015) apply to all units capable of looking after level 2 or level 3 critically ill patients, whether they are called Intensive Care Units (ITU) Critical Care Units (CCU) or High Dependency Units (HDU) and no distinction is made between them. LWH has a HDU on site and complies with these standards.

Appendix 17 goes on to state the disadvantages of small CCUs which include the education and training requirements for medical and nursing staff and the clinical governance processes required to deliver high quality critical care. As LWH has a level 2 Critical Care Unit, these processes will already be in place. They also cite the cost effectiveness of developing a small CCU at LWH but upgrading the present 4 bedded HDU to a 6 bedded ITU would be more economically viable than building a new hospital, given that they already have staff trained in the necessary competencies to deliver critical care.

The proposal of a two site level 3 neonatal critical care service cited in the PCBC could be applied to an intensive care service governed over two sites between RLUH and LWH. The development of the Advanced Critical Care Practitioner (ACCP) role would attract staff. Furthermore ACCPs are now forming part of the trainee medical rota (Faculty of Intensive Care Medicine

2017). A two site critical care service would enhance skills in maternity care and enable staff to be managed more effectively. Midwives would acquire and enhance their knowledge from an attachment to general critical care and outreach critical care nurses would benefit from time spent in a speciality specific unit. This proposal would involve clinicians working across different locations and would be in line with proposals outlined in the Healthy Liverpool Programme (HLP) by creating a collaborative service delivery and ensuring patients receive the highest standard of care. A strong partnership already exists between RLUH and LWH, several consultant anaesthetists work between the two trusts in close collaboration (Surgery, theatres and operations. RLH).

Patient transfers between hospitals

The CCG clinical case for change states: “in 2014/15 over 550 women were transferred to or from LWH during their care predominantly from or to RLUH”. They also state that in the same time period over 250 babies were transferred between LWH and Alder Hey Hospital. They state that patient transfers were mainly due to lack of availability of diagnostics, surgical and critical care.

In response to a FOI submitted 31/08/16 regarding the women transferred to RLUH their records show that 3 women went directly to Level 3 ITU and 1 woman went to Level 2. Their records also show that 2 patients were transferred to Aintree Level 3 ICU and 1 woman transferred to Level 2 at Aintree because the Level 2 care at LWH was not sufficient to meet their needs. One patient was transferred to Wirral University Hospital and one to Whiston. Of the 550 transfers only 7 needed Level 3 ICU. The transfers to hospitals other than the RLUH or Aintree were because of a lack of Critical Care beds locally. If LWH is re located to RLUH site transfers would still take place if critical care beds were not available at the Royal.

The same FOI response stated that in the same time period there was a total of 138 women with a severity of illness to require an ambulance transfer to RLUH and a further 10 women with a severity of illness were transferred to Aintree Hospital. These, added to the 2 women transferred to other hospitals (one to Arrowe Park and one to Whiston) make a total of 150 women with a sufficient level of acuity of illness to require an ambulance transfer. The Trust states that 550 women were transferred in total which leaves 400 transfers to or from LWH, which it is presumed were for diagnostic or surgical purposes. A transfer

of one mile from one hospital to another could take as much time as across the RLUH site to another building.

Some of these transfers were to the LWH but this is to be expected as it is a regional centre for high risk maternity care. Some of these may have been taken to the wrong hospital in the first place as initially the situation may have been unclear. This however is not a problem caused by a lack of facilities or staff at LWH.

While transfers of patients occur routinely in many hospitals, they are relatively uncommon at the Women's Hospital. Furthermore Standards and Guidance for Intra and Inter Hospital Critical Care Transfers (2012) are in place to assist organisations to develop formal policies for the safe transfer of patients. It is recognised that the transfer of patients may be necessary to access clinical and specialist treatment and should not be taken lightly.

Cheshire and Mersey Adult Critical Care Operational Delivery Network have produced comprehensive pathways to deal with acutely unwell pregnant or recently pregnant women to ensure the optimal site for their care (Cheshire and Merseyside Strategic Clinical Networks).

LWH carries out a range of diagnostic and investigative procedures, which include x-ray, ultrasound, hysterosalpingograms, bone densitometry mammography and NT scans. They do not have a CT/MRI scan or a PET scanner, so a patient needing one of these procedures would be transferred to RLUH. LWH carried out 9,479 gynaecological procedures last year. Even if 400 women per year needed transfer to RLUH for diagnostic or surgical purposes - and the reality is far less given the transfers into LWH - this would represent 4.2% of gynaecology patients.

The PCBC outlines the details for the option to relocate LWH to RLUH and which is the “preferred option” of the CCG. This “preferred option” for a new build would be significantly smaller than the Crown Street site. The rationale is that activity would be reduced at LWH by establishing a Free-standing Midwife Led Unit (FMLU) for low risk mothers. It has been reported that 22 percent of mothers admitted to a FMLU have had to be transferred to consultant led units (BBC News). This would increase the overall number of transfers.

Another option of the PCBP details enhancement of LWH at the Crown Street site. These plans include improving the availability of diagnostic services which

would significantly reduce the numbers of transfers and allow key standards to be met. This would involve a high level of investment but according to their financial analysis the capital cost would be low compared to the cost of a new build.

Inability to support women with complex health needs

Pregnancy over 35 comes with “more risks” but this is not the same as “high risk”. As long as the mother-to-be is in good health, then pregnancy should be straightforward. They are more likely to have more ante-natal scans and monitoring. Older mothers tend to be better educated, more financially stable, confident and settled in themselves. Older women do conceive (whether naturally or via medical treatment) and enjoy healthy pregnancies.

The age in which women are having their first baby has increased over the past few decades, due to a variety of social, professional and financial factors and this trend is unlikely to be reversed dramatically. Although having a baby at very advanced maternal age (48+) is uncommon in the UK, the advances in assisted reproductive technologies are contributing to increasing numbers of women giving birth outside “normal” reproductive years.

There are increasing numbers of women giving birth who have health problems. It is therefore more important than ever for women to have access to safe, high quality maternity services regardless of age (Knight 2016). The LWH provides such services and is recognised as one of the best maternity service providers in the country.

Many women, young or older, have more complex needs. At the LWH there are specialist clinics held either weekly or monthly where a consultant obstetrician and consultant in the relevant specialism will plan the treatment necessary to ensure optimal care. These include:

- *Renal clinic
- *Hypertension clinic
- *Cardiac clinic
- *Neurology clinic
- *Haematology / Thrombophilia clinic
- *Bariatric clinic

- *Medical/Endocrine clinic
- *Young Women's clinic
- *Pregnancy Support clinic
- *Pre Term clinic
- *Mental Health Clinics
- *Links clinics – provide support to women who have experienced domestic violence, homelessness or female genital mutilation. They also support women who do not have English as a first language and provide interpreters.
- *Gynaecology specialist clinics provide a service for urogynaecology – bladder and prolapse conditions. LWH are the specialist regional centre for cancer services known as gynaecology oncology within the Merseyside and Cheshire Cancer Network.

They also have a 24 hour gynaecology Emergency Room and Early Pregnancy Assessment Unit, giving rapid access to medical treatment and ultra sound scanning for women who experience a gynaecology emergency especially in the early stages of pregnancy.

Enhancement of LWH at the Crown Street site would ensure that these clinics remain on site but no specific mention is made of the whereabouts of these clinics in the PCBC if the “preferred option” of a new build is chosen.

LWH is the largest hospital in Europe to exclusively care for the health of women. It is the recognised provider in Cheshire and Merseyside of high risk maternity care including foetal medicine, the highest level of neonatal care, complex surgery for gynaecology cancer, reproductive medicine and laboratory and medical genetics. Relocation to RLUH would reduce and fragment these services. The CCG in their review of Women's Services have focused on a minority of patients who have needed transfer but have failed to take into account the remaining 50 thousand plus patients who use services at LWH and have failed to evaluate the environmental issues in relocation.

This view is echoed by Professor Wendy Savage:

“Birth is a major psychosocial transition for a woman and her family and the setting in which this takes place is very important in providing a good experience which enables her to take on the important task of becoming a mother”.

Inadequate space for current neonatal facility

The CCG state the current facility is under size for current and future needs. Expansion is needed, requiring an interim and a long term solution for the necessary space to provide safe, optimum care.

At present there are 54 cots, 16 are for intensive care of the newborn, 12 are for high dependency, 20 for low dependency and 6 cots for transitional care. LWH state they need to increase in size from 1,257m² to 2,331m² to meet demand. They also wish to reduce transfers to other hospitals. This could be achieved by enlarging the present unit rather than moving all services to RLUH.

It is agreed that newborns should not be separated from mothers but all babies needing surgery would be transferred to Alder Hey. This is the regional centre for neonatal surgery, one of only 5 in the country, providing care to neonates requiring surgery born in Liverpool and from wider areas in the Northwest and North Wales. Citing the number of neonates transferred as an excuse for relocation adjacent to the Royal is irrelevant. Separation from the mother would only occur if the mother was too ill to be discharged following the birth otherwise the mother would be transferred with her baby to Alder Hey. LWH have close links with Alder Hey, a midwife regularly visits for post delivery assessments, promotion of breast feeding and supporting new parents.

The review of questions and answers from public meetings on the review of women's and babies' services stated that LWH were not meeting certain National Standards including Principle 6 of the Toolkit for Neonatal Services. Principle 6 (DOH 2013) states:

“Babies requiring surgical care receive the same level of care, support resources and specialist input as they would receive in a medical neonatal service.”

Principle 6 goes on to recommend that in the future neonatal surgery services should be located in the same hospital site as specialist paediatric (including surgery and anaesthesia), maternity and neonatal intensive care services.

The “preferred option” of building a new hospital outlined in the PCBC would not meet this standard as neonates needing surgical intervention would still need to be transferred.

The vision of a two site Neonatal Intensive Care Unit operated over two sites and governed jointly by LWH and Alder Hey Hospital (AH) was proposed in the PCBC. This would support obstetric and neonatal services at LWH and surgical care of neonates at AH. It would reduce transfers of neonates following a surgical intervention who still require intensive care. Maintaining LWH at the Crown Street site would be more cost effective than building a new hospital.

Availability of haematology/pathology services

In the review of Women's and Neonatal Services the CCG states the Trust does not have 24/7 pathology services for processing blood samples, meaning support is required by the RLUH. If a solution is not found there is a concern that LWH will not provide high risk maternity and gynaecology services.

LWH does have an on-site laboratory facility providing a range of testing and blood transfusion support, which is available from 8:45 am to 9:00 pm. Outside of these hours the service is covered by RLUH. There is a Transfusion laboratory situated on the site at LWH. Routine ante-natal blood grouping and antibody testing is carried out at the laboratory at RLUH on samples sent from LWH. The labs supply several blood components such as fresh frozen plasma, platelets, albumin solutions, prophylactic anti-D and clotting factor concentrates.

The Guidance on the provision of Obstetric Anaesthesia Services (2016), state that a supply of O-rhesus negative blood should be available to the delivery suite at all times for emergency use and that the transfusion laboratory be situated on the same site as maternity which it is. Blood gas analysis (with the facility to measure serum lactase) and the facility for rapid estimation of haemoglobin and blood sugar should be available on the delivery suite. The Guidance also states that haematology and biochemistry services must be available to provide rapid analysis of blood and other bodily fluids. The RLUH is in close proximity to LWH to provide these services out of hours.

If the demand becomes too great for RLUH laboratories to deal with, then another solution must be found. Rather than using this as an excuse to build a new hospital – upgrading the facilities on site and staffing them accordingly would be far cheaper than building a new hospital.

Conclusions

The CCG's Review of Women's and Neonatal Services insinuates that safety is maintained through the mitigating actions of clinicians. However their Annual Accounts and Quality report 2015/2016 states that they received an overall rating of "good" by the CQC and were described as "caring, effective and well-led". They were ranked amongst the very best maternity service providers in the country and were particularly praised for their focus on supporting mothers with breast-feeding, ranked 2nd best in the country. LWH was ranked the safest in the UK by patients for providing safe and high quality care and were second best hospital overall in the national inpatient survey conducted by the CQC. Indeed the clinical case for change is weak and lacking any consideration of the needs of women of Liverpool and beyond.

The CCG, in their review of Women's and Neonatal Services, state that LWH is not fit for purpose and does not adhere to clinical standards. However none of the four options determined in the PCBC would be compliant with all clinical standards, although they recognise that it is not unusual for trusts to comply fully with all standards.

The CCG review highlighted an increase of women with complex needs giving birth and needing high risk obstetric care. It therefore makes more sense to expand the existing Crown Street site rather than building a more expensive, smaller hospital on the site of the Royal and establishing a FMLU.

The LWH Trust commenced a review of services in 2014 which continued through a 'Summer of Listening' in 2015 with the people of Merseyside to gain their views. The main feedback was:

- *People value our staff and feeling safe the most;
- *People feel that LWH is a special place because of the way care is provided and because of our staff;
- *Having all services under one roof and a range of specialist clinics are important to people in any future developments.

It appears that the Trust's Board have not done much listening. If the suggestions of relocating the LWH were to be met, the services will fragment and Liverpool Women's Hospital would no longer be a special place.

** Total capital costs for full refurbishment of the Women's hospital on site - £42.6m; to close the hospital and build a new one - £104.3m. No monies have as yet been identified to meet the costs.*

Summary

Liverpool has six acute hospital trusts*, four of which are specialist and two of those have been rated “outstanding” by the CQC. However the emergence of austerity as the driving political ideology along with the cutbacks in funding for the NHS means that one of these has to close. The Liverpool Women’s Hospital, although less than twenty years old, but being deeply in debt, becomes the obvious candidate.

Thus began construction of the case for closure. However the excellent care provided by the Women’s Hospital was evident in the 2014 refurbishment according to their own website:

“Liverpool has announced that the £10m transformation of its maternity service has now been completed...Liverpool Women's facilities match any in the UK”

Hence senior medics in Liverpool, including those in the Women’s Hospital, began talking of the need to “co-locate” next to an acute facility that provided a range of services and that the Women’s Hospital was no longer “fit for purpose”. The alternative, as put forth in the preferred option in the Pre-Consultation Business Case, was the closing of the Women’s Hospital and building of a new hospital next to the new Royal. A range of evidence from various sources was then interpreted and phrased in such a way as to support the arguments for this option.

The most complex and contentious of the arguments concerns the lack of a critical care or intensive care level three on site. The number of patients needing level three critical care is small and their needs are safely managed. However the Cheshire and Merseyside Critical Care Network deem the situation for seriously ill mothers to be “precarious”. Upgrading the High Dependency at the Women’s Hospital to a Level Three critical care unit would resolve the situation at a fraction of the cost of building a new hospital.

**Liverpool Heart and Chest Hospital NHS Foundation Trust (rated outstanding); The Walton Centre NHS Foundation Trust (rated outstanding); Liverpool Women’s NHS Foundation Trust; Alder Hey Children’s Hospital NHS Foundation Trust; Aintree University Hospital NHS Foundation Trust; Royal Liverpool and Broadgreen University Hospital NHS Trust.*

Another issue used to justify the movement of the Women's Hospital is transfers. However the development of an Intensive Care Level Three unit and improving the availability of diagnostic services, currently carried out at the Royal, would significantly reduce the number of transfers.

Women with complex needs are seen as a reason for the move. Yet the wide range of clinics currently available at the Women's Hospital ensures that women with complex needs have appropriate treatment plans in place to provide optimal care.

Neonatal facilities are another issue with a shortage of space in existing facilities which in addition to providing routine care provide specialised care for babies from throughout the Northwest and North Wales. All of these needs can be met by expanding the existing facilities.

Finally there is the lack of haematology/pathology services 24/7. Many of the analytical procedures are done at the Royal as a matter of routine. Procedures needed outside of regular hours or requiring specialised equipment can be accommodated by increasing capacity or sending to the Royal which is only minutes away. Similar solutions can be found to provide for blood supplies.

However, with each of the areas above, a close examination of the arguments shows they lack credibility and in no way justify the need to close the Women's Hospital and build a new one on the site of the Royal Liverpool Hospital.

References

Association of Anaesthetists of Great Britain and Ireland (AAGBI). 2010 Blood transfusion and the anaesthetist: Management of massive haemorrhage, London.

BBC News 8/12/16

Midwife led units see 1 in four women transferred to consultant led units.
www.bbc.co.uk

Cheshire and Merseyside Strategic Clinical Networks 2015
Acutely Unwell/ Critically Ill Pregnant or recently pregnant Woman.

Faculty of Intensive Care Medicine 2017.
www.ficm.ac.uk

Liverpool Clinical Commissioning Group 2015
Healthy Liverpool
www.liverpoolccg.nhs.uk/

Guidelines for the Provision of Anaesthesia Services. 2016
Royal College of Anaesthetists, London.

Inter Hospital Transfer. 2009
AAGBI. London

Knight, Marion. 2016
Cited in: British Journal of Obstetricians and Gynaecologists release:
Pregnancy complications in older women.

Liverpool Clinical Commissioning Group 2017
Review of Services Provided by Liverpool Women's NHS Foundation Trust
Pre-Consultation Business Case
www.liverpoolccg.nhs.uk/

Liverpool Women's Hospital Annual Report of Quality and Accounts 2015-2016
www.liverpoolwomen.nhs.uk

National Health Service Liverpool CCG Governing Body. 2016
Review of Women's and Neonatal Services. Report no GB 17-16

North West Critical Care Networks. 2012
Standards and Guidance for Intra and Inter Hospital Critical Care Transfers.
Version1.1

Professor Wendy Savage
Personal Communication

Royal College of Anaesthetists. 2015
Chapter 9
Guidance for the Provision of Obstetric Anaesthesia Services, London

Royal Liverpool Hospital
Surgery, theatres and operations
www.ribuht.nhs.uk

The Faculty of Intensive Care Medicine. 2003
Core standards for intensive care units. Edition 1
www.ficm.ac.uk

Toolkit for high quality neonatal services (Principle 6)
Dept of Health. 2013

Save the Women's Hospital Campaign/Merseyside Keep Our NHS Public
c/o News for Nowhere, 96 Bold Street, Liverpool L1 4HY (Postal Address Only)
email: KeepOurNHSPublicMerseyside@yahoo.com