NHS
University Hospitals of Liverpool
Group

Women's Hospital Services in Liverpool

Clinical model update

A refinement of Option 2 to strengthen safety at Crown Street and services across the city

November 2026

Introduction and history

Risk 1 - Acutely deteriorating women cannot be managed on site at Crown Street reliably, which has resulted in adverse consequences and harm.

Risk 2 - Women presenting at other acute sites (e.g. ED), being taken to other acute sites by ambulance, or being treated for conditions unrelated to their pregnancy or gynaecological condition at other acute sites, do not receive holistic care they need.

Risk 3 - Failure to meet service specifications and clinical quality standards in the medium term could result in a loss of women's services from Liverpool.

Risk 4 - Recruitment and retention difficulties in key clinical specialties are exacerbated by the current configuration of adult and women's services in Liverpool.

Risk 5 - Women receiving care from women's hospital services, their families, and the staff delivering care, may be more at risk of psychological harm due to the current configuration of services.



These risks exist in the context of a significantly deprived population.
Women from deprived populations and ethnic minority groups are disproportionately affected by the current configuration of services.

Introduction and history

National Learning (Ockenden, Thirlwall, Amos etc)

2014–2023

Independent Review of Women's Services

Liverpool Clinical Services Review - 2022
Case for change;
clinical senates describe the case as 'compelling'.

2023–2025

ICB Women's Services review and Case for Change

Feb 2026

ICB Options Appraisal

Option 6 preferred - co-location with Acute. But deemed a longer-term solution. Medium term alternatives to mitigate risks required – Option 2

May 2026

OBC for Medium Term Solution (Option 2)

Two-site interim model only viable short- to medium-term response.

The original model was associated with significant enabling investment, with approximately £2 million capital and £6 million recurrent revenue investment identified within the case.

Jun–Jul 2026

Public engagement

Oct - Nov 2026

Clinical Review of Option 2

Clinical Workshop to review current position, including Public Engagement exercise and National Reviews

Recap: what Option 2 recommended

A two-site interim model while full co-location remains the long-term ambition

Crown Street / LWH

- Vast majority of Maternity, Neonatal and Gynaecology care retained
- Enhanced Care Unit and increased acute-specialty input
- 24/7 outreach and stronger senior clinical cover

Royal Liverpool Hospital

- Circa 30 planned higher-risk caesarean births
- 75–100 additional complex Gynaecology procedures
- Dedicated theatre, recovery, ward/HDU and neonatal support

City-wide support

- Acute review and support at RLH and Aintree
- Dedicated inter-site transfer arrangements
- Wider adult acute, therapy and consultant input

May 2026 OBC | **£6.2m recurrent revenue** | **£2.0m capital** | **All five core risks remained in full or in part**

Workshop – Clinical Justification

- The WHSIL programme was developed in response to risks identified through ICB-led reviews of Liverpool women's services.
- While full co-location with an acute hospital remains the long-term ambition, the May 2026 Outline Business Case proposed a strengthened two-site model as an interim solution.
- Following public engagement and the publication of the Amos, Ockenden and Thirlwall reviews, the clinical model has been reviewed to ensure that it continues to align with national safety recommendations, maximises care at Crown Street and is able to mitigate clinical risk to women across the Liverpool City.

What did the review consider?

- Consideration of improvements already made and/or to be implemented
- Consideration of new risks because of two-site model – moving high risk deliveries to RLH does not mitigate all the risk, and creates potential alternative risk
- Preference to retain Crown Street services wherever safe to do so
- Ockenden, Amos and Thirlwall raised expectations on what Providers and Commissioners should do to deliver safest care possible
- City wide requirements to ensure 24/7 support to women, babies and families is met

Why this is reasonable now

The model presented in May was not “wrong”. The overall case for change remains valid.

Risk remains, but the Crown Street baseline and national context have changed

The refined proposal reflects the cumulative effect of safety improvements, national learning, public feedback and a multidisciplinary review of how those measures work together.

The refined model does not replace the ambition for co-location. It strengthens the interim model while the longer-term solution continues to be developed

Workshop Considerations – Safety at Crown Street has already been strengthened

Delivered improvements are changing the baseline; two further actions are in progress

1 DELIVERED

24/7 Medical Emergency Team

Multidisciplinary response to deterioration

2 DELIVERED

24/7 resident obstetric consultant

Continuous senior obstetric decisions

3 DELIVERED

Emergency theatre capacity

One additional emergency list each day

4 DELIVERED

Strengthened anaesthetic workforce

Additional emergency-response staffing

5 IN PROGRESS

Blood transfusion capability

Robot in development to improve access

6 IN PROGRESS

Recognition of deterioration

MEWS/NEWS and Martha's Rule work

Benefit: a stronger on-site response, earlier senior input and greater ability to retain care safely at Crown Street

The refined model: an evolution of Option 2

Most components are retained; the main change is where planned higher-risk maternity care is delivered

Crown Street / LWH

- Planned higher-risk births remain at Crown Street*
- Targeted ECU with critical-care in-reach
- Increased obstetric physician and adult acute input
- Immediate access to established neonatal services

Royal Liverpool Hospital

- Complex gynaecology needing co-located ICU remains at RLH
- Two additional gynaecology theatre sessions
- Inpatient, recovery and critical-care capacity
- Weekend theatre business case dependency

City-wide model

- 24/7 maternity outreach across acute sites
- Enhanced maternity, gynaecology and neonatal on-call support
- Urgent/emergency transfer through enhanced existing provision
- Reduced planned cross-site maternity transfer

Same risks • same long-term ambition • stronger Crown Street capability • targeted use of RLH

Priority actions and investment

Three priority safety interventions, supported by a more targeted investment requirement

Financial Implications

£6.2m → £3.6m

recurrent revenue

£2.0m → £0.5m

capital plan requirement

Next step: review the financial model with C&M ICB and agree the contractual route and phasing.

1

24/7 city-wide maternity support

Continuous midwifery outreach across Liverpool acute sites

2

Enhanced Care Unit at Crown Street

Finalise beds, staffing and critical-care in-reach

3

Enhanced city wide medical on-call arrangements

Obstetrics, neonatology and gynaecology

Implementation is phased: clinical priority first, then readiness and dependency.

Implementation pathway

Model finalisation and contract negotiation now; phased mobilisation from April 2027

Now–Q4 2026/27

- Finalise and clinically agree the model
- Confirm workforce, ECU and critical-care in-reach
- Secure funding and contractual arrangements for 27/28 and beyond

Q1 2027

- Commence mobilisation of priority components
- Roll out of Martha's Rule/MEWS/NEWS scores
- Start Estates work to expand Crown Street ECU

Q2 2027

- Implement additional obstetric/midwifery cover for the city.

Q3 2027

- Roll out of enhanced speciality input to LWH from RLH
- Mobilisation of city-wide medical cover - Gynaecology

Q4 2027/28

- Roll out of enhanced neonatal cover city-wide

Full delivery expected over 12–18 months, primarily dependent on workforce & funding availability

Residual risks, dependencies and the ask

The refined model strengthens mitigation, but does not remove the inherent risk of a multi-site configuration

Residual multi-site risk

The long-term ambition remains full co-location

Workforce availability

Recruitment, rota sustainability and competency

Critical-care interface

Governance, response standards and escalation thresholds

RLH theatre capacity

Weekend theatre business case is essential

Transfers and public confidence

Clarify urgent/emergency transport and the public narrative

The ask

- Note the progress and the continued case for change
- Support the refined clinical model and the three implementation priorities
- Support continued work with the ICB on the financial and contractual model
- Note the residual risks, dependencies and long-term co-location ambition