NHS
Cheshire and Merseyside

Women's Hospital Services in Liverpool

Options Appraisal and Next Steps

29 January 2026

Introduction

The NHS C&M Women's Services Programme was established in 2023 following an independent review of hospital services in Liverpool.

The aim of the programme is to address the clinical risks currently present in gynaecology and maternity hospital services in Liverpool.

Following the development of a case for change, an options appraisal process has been completed which has assessed a range of options for dealing with the clinical risks.

The options have then been subject to high level estates and financial modelling, which has been reviewed by the Programme Board and presented to the Women's Services Committee in November 2025.

An Equalities Impact Assessment of the options has also been completed.

This presentation summarises the options work to date.

Engagement, governance and decision-making also need to be considered by the Board.

Clinical Risks the Programme is Seeking to Resolve

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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. A&E), 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 get the 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 some 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.

As the case for change demonstrated, women from deprived populations and ethnic minority groups are disproportionately affected by the current configuration of services.

Current Programme Timescales

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Phase 1 (autumn 2024 - spring 2025)

- Publish case for change
- Carry out public engagement and analyse feedback
- Start design work for potential future model of care

Phase 2 (spring - summer 2025)

- Undertake more detailed design work
- Clinical engagement to scope potential options
- Options appraisal process
- High level modelling for options

AUTUMN 2025 - TAKE STOCK

Phase 3 (winter 2025 – summer 2026)

The detail of what happens in Phase 3 will be determined by the outcomes of Phase 2 and the options that are developed.

Supported by the Lived Experience Panel

2014 - 2015

LWFT formally declares clinical sustainability issues in response to concern from clinical staff, and begins to plan future of city's health services for future generations of women and babies.

2016

LWFT and Liverpool CCG undertake a 'summer of listening' with patients and public to gather views about the future direction of services.

2017

LWFT identify a preferred option to co-locate with the RLH. Validated by an independent clinical senate. Trust demonstrates the availability and affordability of capital funding

2017

A draft business case is published by Liverpool CCG detailing future options with a preferred option of moving to a new Women's Hospital next to the new Royal Liverpool Hospital.

2018

LWFT continues to apply for capital funding for the preferred option, while developing the current neonatal estate to keep babies as safe as possible.

2019

LWFT holds a clinical summit with NHS system partners to look at ways to reduce clinical risks, while still working on securing the preferred option.

2019

NHS England convenes an urgent process with system partners to agree ways to reduce clinical risk while the preferred option is progressed.

2020

LWFT applies for capital funding to further reduce risk on site by bringing a CT scanner, robotic surgery and a blood bank to Crown Street.

2020

Plans to refresh the Future Generations business case are put on hold due to the COVID-19 pandemic. The government announce plans to build 8 new hospitals.

2021

LWFT submits an Expression of Interest to the new hospitals building programme

2022

LWFT refreshes the case for change and counterfactual case, begins refresh of business case and re-starts the service change assurance process with NHSE.

2023

NHS Cheshire and Merseyside accepts the recommendations of the Liverpool Clinical Services Review and establishes the Women's Services Programme.

2023

Women's Services Committee and Provider led Programme Board established; programme is mobilised.

2024

Clinical Case for Change developed with engagement from system clinicians, Lived Experience Panel and local stakeholder organisations including Healthwatch.

2024

NHS C&M publishes the case for change and undertakes a 6 week period of public engagement.

2025

Independent engagement report demonstrates a good level of understanding of the case for change and support for the need to make changes.

2025

Options appraisal process with engagement from system clinicians, Lived Experience Panel and local stakeholder organisations including Healthwatch.

2025

First phase estates and financial modelling of options presented to Women's Services Committee.

History of the Programme

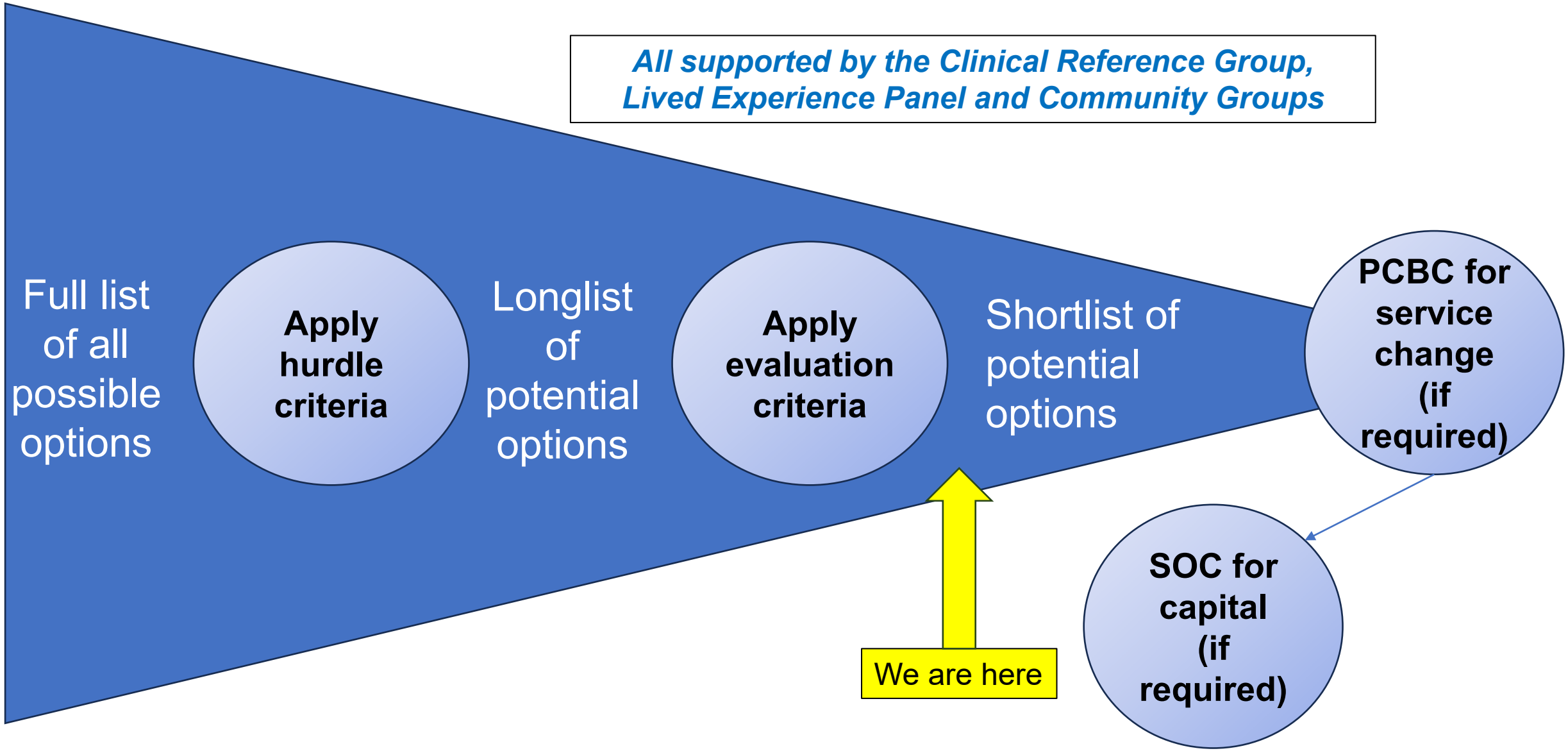
Case for change and options appraisal work has been completed four times since 2014/15 (x2 LWFT, x1 LCCG with external support from FTI Atkins, x1 by NHS C&M).

The preferred option has been the same each time – i.e. colocation of gynaecology, maternity and neonatal services on an adult acute site. This has been supported by published evidence on the colocation of acute hospital services (South East Clinical Senate).

There have been clinical senate reviews of the case for change and the counterfactual case; the case for change has been described as ‘compelling’ (North West and North East Clinical Senates).

There have been three ‘stage 1’ change assurance meetings with NHS England to present the strategic and clinical case for change; the issues are well understood at regional level.

Summary of the Options Process



“Short-er” List Descriptions

Option No	Service Scope	Model for Delivery
1	BAU / Counterfactual	The status quo - services and clinical risks largely remain as they are. Includes ongoing annual service improvements at LWH. The counterfactual may come to pass with some loss of services and staff.

RLH

1 day of operating per week – complex gynaecology and rare deliveries. Critical Care.

LWH

The status quo – some specialist services may be at risk long term.

Aintree

Clinics, ad hoc outreach, rare deliveries

Option 2 – Do Minimum - Highest risk women and services co-located (integrated) on RL site - more services at all sites

RLH

More high risk women treated / cared for than option 1.
Defined group of high risk deliveries (circa 30 deliveries pa - surgical only - no choice to labour)
Neonatal presence for deliveries.
More high risk gynaecology surgery (75-100 cases pa).
Acute take review / support to ED.

LWH

Vast majority of gynaecology, maternity and neonatal remains.
Increased presence of acute specialties including critical care support for women requiring enhanced care.

Aintree

More clinics / acute take review / support to ED.

THIS IS THE ONLY VIABLE OPTION IN THE MEDIUM TERM

Option 2 – Key Service Details

6 bedded enhanced care unit, with improved facilities and accommodation, on the LWH site – cohorting 4 existing beds (2 maternity, 2 gynaecology) and 2 additional beds to accommodate future demand.

Appropriate accommodation and capacity (beds / theatres / critical care) provided at the RLH site for additional gynaecology operations and high-risk births. This would include additional neonatal support for births (staff, kit, transport).

Greater investment in obstetric physician time (from 1 day to 5 days p.w.)

Investment in visiting AHPs and therapist staff not currently provided for at LWH (e.g. OT, nutrition, SALT).

Investment in adult acute medical time to manage the required input to LWH (e.g. colorectal, urology, cardiology).

Consultants of the day (one for gynaecology and one for maternity) and increased consultants on call (gynaecology, maternity and neonatology) to enable cover at non-LWH sites (including attending EDs / completing ward rounds).

Increase outreach midwifery to 24/7 – for visiting non-LWH sites.

New role for outreach specialist gynaecology – for non-LWH sites – in particular for older women post op.

Dedicated ambulance resource for inter-site transfers.

Option 6a – All Inpatient Gynaecology, Maternity and Neonatology on RL Site – integrated into existing buildings

RLH

Critical Care.
All inpatient gynaecology – complex and non-complex.
24/7 non-elective gynaecology.
All inpatient maternity (obstetrics and midwifery) and neonatology.
Alongside midwifery led unit.
MAU.

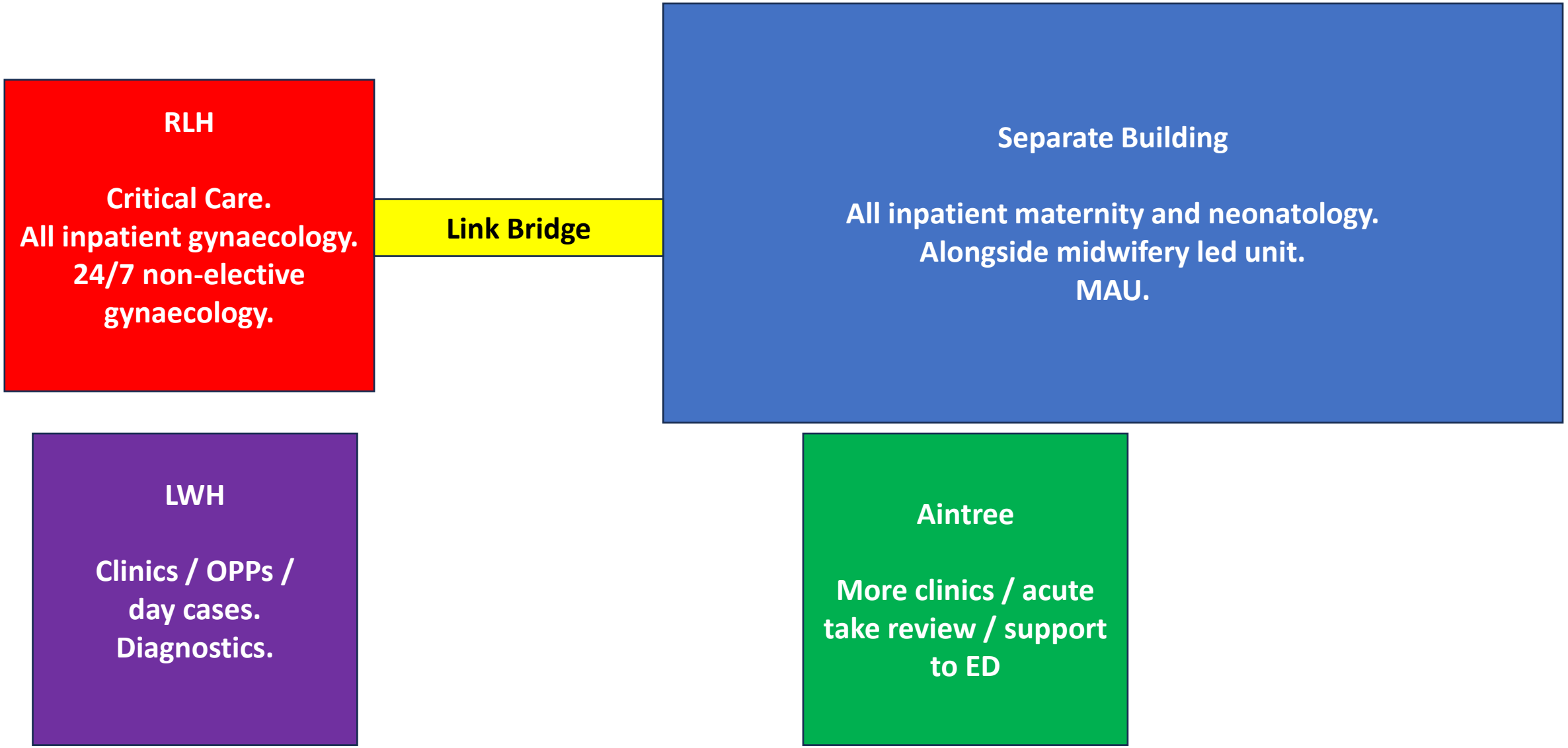
LWH

Clinics / OPPs / day cases.
Diagnostics.

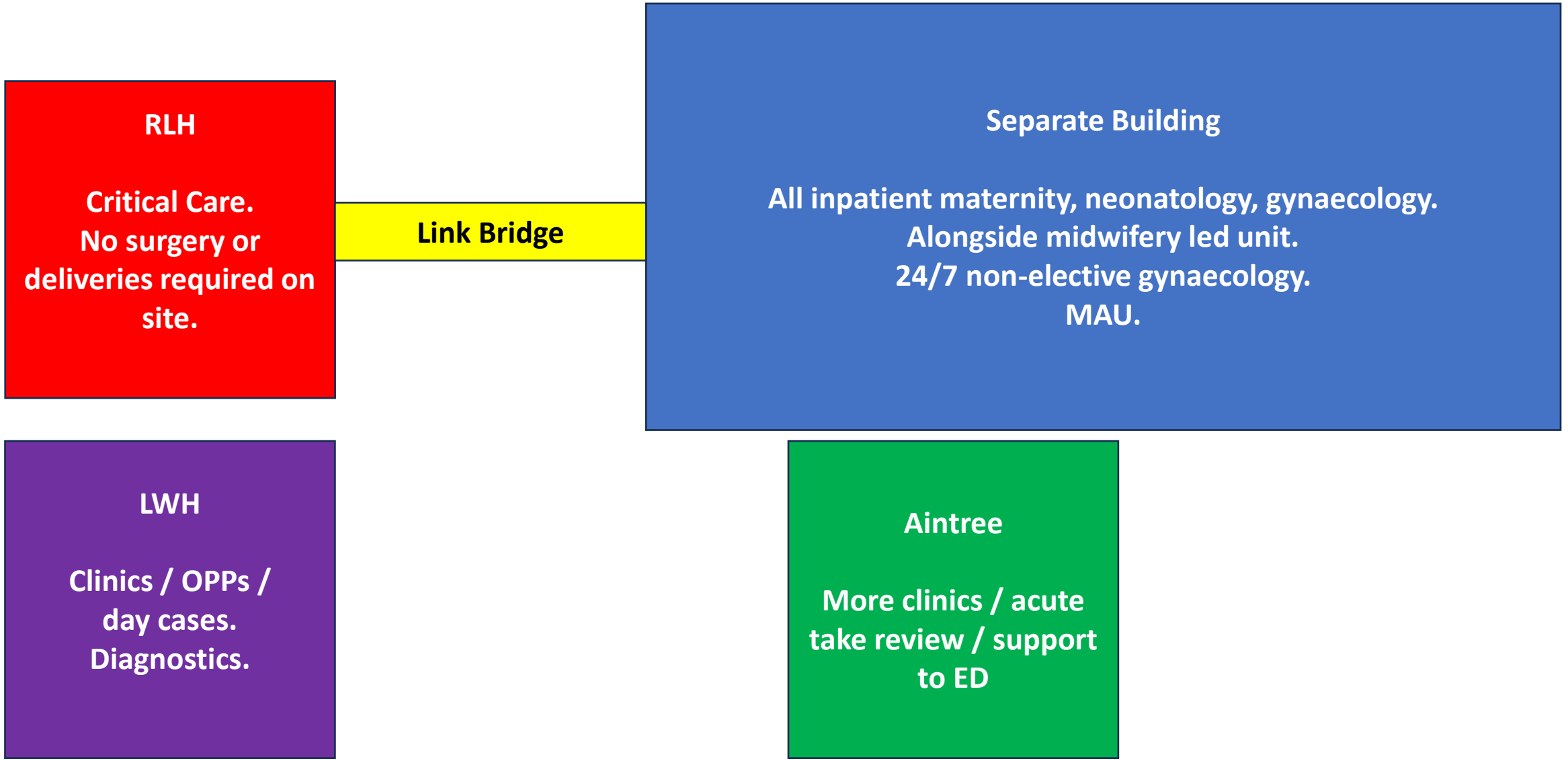
Aintree

More clinics / acute take review / support to ED.

Option 6b – Hybrid - All inpatient gynaecology integrated, maternity and neonatology on RL site in a separate building.



Option 6c – All inpatient gynaecology, maternity and neonatology on RL site in a separate building – Do Maximum



Long List Rankings from Workshop 2 – High Clinical Consensus

Option	Description	Table Number							
	Rank 1 = best Rank 6 = worst	1	2	3	4	5	6	7	8
1	BAU / Counterfactual	6	6	6	6	6	6	6	4
2	Do Minimum - Highest risk women and services co-located (integrated) on RL site - more services at all sites	5	4	5	5	4	5	5	5
4	Co-locate all inpatient gynaecology and only highest risk maternity on RL site - integrated	4	5	4	4	5	4	4	6
6a	All Inpatient Gynaecology, Maternity and Neonatology on RL Site – integrated into existing buildings	3	3	3	3	3	3	3	2*
6b	Hybrid - All inpatient gynaecology integrated, maternity and neonatology on RL site in a separate building	2	2	2	1 *	2	2	2	2*
6c	All inpatient gynaecology, maternity and neonatology on RL site in a separate building – Do Maximum	1	1	1	1*	1	1	1	1

SPLITS GYNAE AND MATERNITY EMERGENCY PATHWAYS - REMOVED AFTER WORKSHOP 2 FOLLOWING DISCUSSION WITH CLINICIANS & WSC

Option 6a – ‘test to fit’ exercise

The *test-to-fit* exercise for option 6a confirms that all major functional elements can be accommodated within the RLH estates envelope with some compromises.

Existing derogations within the RLH would need to be accepted e.g. there would be some compromises on standard room sizes (all single rooms are approximately 4sq.m. under sized) and there is no isolation provision on a typical ward.

For neonatal services:

- ***A typical IC / HD cot space allowance is sized at 20.q.m. The test to fit exercise indicates a range of around 12q.m. to 15sq.m.***
- ***A typical special care cot space is around 11.5sq.m with a test to fit range of 8sq.m. to 11sq.m.***

The existing size and shape of the Royal Liverpool Hospital building would mean some services may need to be configured differently and / or require different staffing models e.g. maternity wards.

Structural and MEP (Mechanical, Electrical and Public Health) constraints – e.g. birthing pools, theatre ventilation and drainage on Level 9 would require further investigation in subsequent design stages.

Detailed design work would be required with clinical teams in order to test this option further.

Next Steps in the Development of Estates Options would be……

- **Validation of Clinical Model:** Confirm final Schedule of Accommodation numbers and departmental adjacencies.
- **Technical Feasibility Studies (6a only):** Structural and MEP surveys, particularly for Level 9 birthing and theatre functions.
- **Illustrative Design Work:** For 6b and 6c as comparisons to 6a.
- **Cost Refinement:** Develop elemental cost plan and phasing allowances to improve accuracy.
- **Stakeholder Engagement:** Ongoing collaboration with clinical leads, estates, and infection control teams.

This would require a commitment to a project team and significant resources.

Conclusion

The conclusion of the options appraisal process is that co-location of inpatient gynaecology and maternity services with other adult acute services is the only way to resolve the risks.

Based on the high-level modelling to date all options have significant financial consequences.

Option 2

- would achieve co-location for a very small proportion of women using inpatient gynaecology and maternity services (less than 1%).
- is the only option viable in the short to medium term – it is clinically an improvement on the status quo - however - all the risks remain in full or in part.

Options 6a - 6c

- would achieve co-location for the vast majority of inpatient and emergency gynaecology and maternity services; the exceptions are those women presenting, or inpatient, at other sites.
- resolve the risks for the long term for the vast majority of women.

Without moving to Options 6a–6c, the most serious equality and health inequality risks for women and babies will remain.

Even in pursuing long term capital options, option 2 (or a version of option 2) would be required in the meantime.

Engagement, Governance and Decision-Making for Option 2

- Independent legal advice suggests that pursuing option 2 would still require a degree of public engagement.
- It is recommended that a 6 week period of engagement takes place in the summer 2026.
- Final decision making about changes in access (specifically high risk births and increased gynaecology operating at RLH) could take place in the autumn 2026.

Ongoing Risks & Issues

- The health inequalities present in these services will continue and ongoing population health issues make this more challenging e.g. obesity, increases in endometriosis, later pregnancies, poor health literacy.

- Clinical staff involved in these services continue to deliver services in a configuration that would not be tolerated elsewhere – with no clear long term commitment to change and ongoing risks to themselves and patients.

- The counterfactual case is still a real risk – could lead to diminution of services in Liverpool / C&M.

- The credibility of the ICB / NHS could be questioned if, having completed the work for a fourth time, there was no commitment to a long-term solution.

- There are business continuity risks for the outstanding work of the programme e.g. developing business case(s), management of the engagement programme for option 2.

Next Steps for the Programme

- The provider to produce a business case for Option 2
- Agree the process and indicative timescales for public engagement on option 2
- Engage with NHSE regarding support for achieving safe and sustainable women's services in the longer term.
- Consider the long-term solution in the context of wider strategic plans and the benefits for the Liverpool and C&M system.

Recommendations to the Board

- Note the work completed to date and that all options for change have significant financial consequences for the C&M system.
- Note that the Women's Services Committee was assured that the options process has been completed appropriately.
- Note the Equality Impact Assessment of the options considered to date.
- Include a commitment to achieving the long-term sustainability of women's services in Liverpool within the ICB's medium term plan.

Cheshire and Merseyside Cancer Alliance

Lung Cancer Screening Programme:

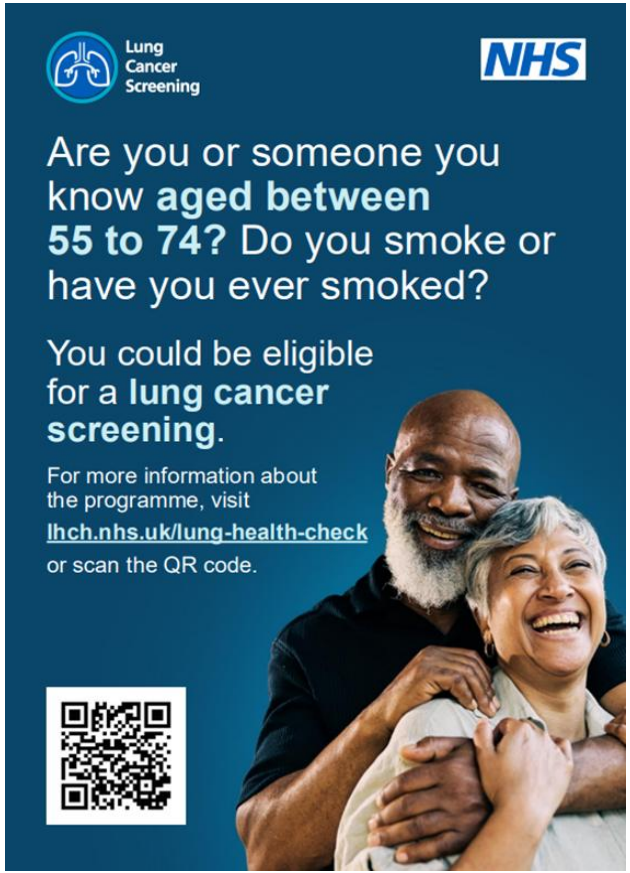
Phase 5 – Cheshire East and Cheshire West

ICB Board Presentation – 29th January 2026

Jon Hayes, Managing Director, Cheshire and Merseyside Cancer Alliance

NHS

Summary



Purpose of presentation:

To seek board approval to commence Phase 5 roll-out of the lung cancer screening programme.

Phase 5 will extend the programme to Cheshire East and Cheshire West, thus completing the full roll-out across Cheshire and Merseyside.

Background and Context

- Pioneered in Liverpool and Manchester then adopted as a national pilot.
- Rolled out across Liverpool, Knowsley and Halton in 2021, followed by St Helens, Sefton, Wirral and Warrington.
- In June 2023, the Government announced the national roll out of the Lung Cancer Screening Programme (LCSP) across England - The programme is now a section 7a mandated screening programme and no longer a pilot.
- NHS England is committed to achieving national rollout of at least 50% by March 2026, 100% by March 2030 (C&M 2025/26 rollout on track for 57%).
- Delivery of Lung Health Checks and Low Dose CT scans is funded by targeted funds from NHSE.
- The programme is a significant contributor to the ambition to improve early diagnosis and survival for those diagnosed with cancer.

Cheshire and Merseyside LCSP – outcomes to date

80.4% diagnosed at early stage

80% treated with curative intent

46 other cancers identified

7758 referrals to smoking cessation

43% set a quit date

48.4% quit at 4 weeks

31.6% quit at 12 weeks

*Uptake/Conversion Data extracted from North of England CSU 2025/26 Month 8 Data Quality Report
Smoking Cessation Data courtesy of LHCH – Jan 2026

Phase 5 Anticipated Impact and Benefits

- 117K Eligible Patients
- >500 cancers found
- 400 lung cancers diagnosed at early stage
- 320 treated with curative intent
- 4500 smoking cessation referrals

Health Inequalities and Patient Experience

- Prioritises areas with the highest rates of lung cancer diagnosis, mortality, smoking prevalence and deprivation
- Directly supports early diagnosis, prevention and reducing health inequalities
- Make Every Contact Count (MECC) interventions
- Equitable access to a national screening programme for outlying Places

Strategic Alignment- Supports ICB Objectives

- Tackling health inequalities.
- Improving population health and access
- Enhancing productivity and value for money
- Enabling broader social and economic development.

*Anticipated activity based on Jan 2026 population, NEC M8 uptake/conversion rates

Phase 5 Recommendation – Ask of Board

Recommendation - Contract Modification

- Delivery through permitted modification to existing LHCH contract.
- Total 2025/26 contract value: £179.6m.
- Phase 5 cost: £12.7m over two years—within 25% PSR modification threshold.

Why Direct Award to LHCH?

- LHCH already delivers Phases 1–4 across the system
- Requirement for a fully integrated end-to-end MDT model

The Board is asked to approve:

- The recommendations made by CMCA, ICB Executive Committee, and FIRC to allow a permitted modification to the LHCH contract for delivery of Phase 5 LCSP services.