HAVE YOUR SAY

Where care and treatment happens at Liverpool University Hospitals

Public consultation: 7 June to 2 August 2022

Breast surgery

General surgery

Nephrology

Urology

Vascular

HAVE YOUR SAY

Where care and treatment happens at Liverpool University Hospitals

This booklet sets out proposals for the following services:

Introduction

Liverpool University Hospitals NHS Foundation Trust (LUHFT), which manages Aintree University Hospital, Broadgreen Hospital, Liverpool University Dental Hospital and the Royal Liverpool University Hospital, is proposing some changes to the following five services:

- **Breast surgery**
- **General surgery**
- **Nephrology**
- **Urology**
- **Vascular**

Between 7 June and 2 August 2022, the NHS is holding a **public consultation about these proposed changes**.

The main areas which use LUHFT services are Knowsley, Liverpool, South Sefton, and Southport and Formby, however some patients come from outside these areas. Everyone is invited to take part in the consultation, regardless of where you live.

Please read through this booklet and complete the questionnaire to share your views.

You can complete the questionnaire online at www.futureLUHFT.nhs.uk or request a paper copy – contact details are on page 12 of this booklet, along with information about online events, where you will be able to learn more about the proposals and share your views.

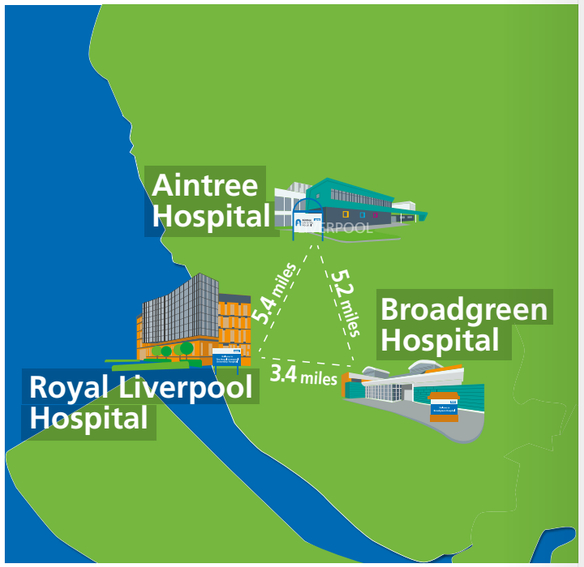
Background

In 2019, Aintree University Hospital NHS Foundation Trust and the Royal Liverpool and Broadgreen University Hospitals NHS Trust merged to form a single organisation – **Liverpool University Hospitals NHS Foundation Trust (LUHFT).**

The business case for the merger explained how bringing single service teams together could improve patient experience and outcomes, create opportunities for people to take part in clinical trials, maximise research and development, and help attract and retain the best staff. LUHFT now manages four hospital sites: Aintree University Hospital, Broadgreen Hospital, Liverpool University Dental Hospital, and the Royal Liverpool University Hospital. The Dental Hospital is not affected by any of the proposals described in this booklet.

Because they used to be run by separate organisations, the different hospitals duplicate some of the same services. At the point they merged, over 20 clinical services were duplicated.

This isn't a good use of resources, and it means that specialist staff, equipment and expertise is often spread thinly between hospitals. Also, patients don't always get the same quality of care – or experience – at different sites.



Since it merged, LUHFT has been reviewing services to explore how it can improve care by bringing services together.

This means looking at how to make the most of specialist skills, resources and equipment, and using the different sites in the most effective way, both for patients and staff.

Where care takes place – the wider plan for Aintree, Broadgreen and the Royal

This public consultation sets out proposals for five separate clinical services, which are explained in more detail from page 13 onwards. However, these proposals are also part of a wider plan to better organise services across the three hospital sites at Aintree, the Royal Liverpool, and Broadgreen.

For **Aintree University Hospital**, this would mean focusing more on urgent and emergency care. It is already the Major Trauma Centre for Cheshire and Merseyside, and located alongside trauma-related neurology services delivered by The Walton Centre (which is also on the Aintree campus). Aintree brings together professionals highly skilled in caring for people who need this type of care.

Meanwhile, the new **Royal Liverpool University Hospital**, co-located with the new Clatterbridge Cancer Centre in Liverpool city centre, would mainly focus on complex planned (also known as elective) care, including cancer care.

Alongside this, **Broadgreen** would mainly provide rehabilitation, as well as some planned orthopaedics care.

It's important to note that Aintree and the Royal Liverpool would both still have an accident and emergency (A&E) department if the changes went ahead – there are no plans to change this.

The new Royal

A new Royal Liverpool University Hospital – which will replace the existing hospital building – is due to open in 2022. When we talk about services being in the 'Royal Liverpool Hospital' in this booklet, we mean that they will be in the new hospital.

The new hospital will be very different to the current one, which opened in the late 1970s. The ways that the NHS can treat people have changed massively since then, and the new building has been designed to meet the needs of modern health care. As a result, a lot of work has taken place to plan out where different services will go when the move happens.

All the changes set out in this consultation have a strong clinical case, which means that doctors, nurses and other specialists have designed these proposals to further improve clinical care.

The creation of LUHFT as a single organisation, and the opening of the new hospital, has created an opportunity to make the most of the space available across Aintree, Broadgreen, and the Royal Liverpool hospitals, so that all services can provide the best quality of care for patients.

The journey so far

The work to bring services together began ahead of LUHFT becoming an organisation. The first service to integrate was trauma and orthopaedics in 2019, with the orthopaedic trauma service (for unplanned care) now located at Aintree, and an elective centre (for planned care) on the Broadgreen site.

More recently, proposals to create a Comprehensive Stroke Centre at Aintree – which would mean a single hyper-acute stroke service for the crucial first 72-hours of stroke care – were put out to public consultation during winter 2021/22, with a final decision due by summer 2022.

The proposals we're consulting on

See page 10 for details of what people have told us so far about bringing teams from different hospitals together.

Who is involved in this work, and how will a decision be made?

This public consultation is being held by four Clinical Commissioning Groups (CCGs) – the NHS organisations responsible for planning local health services at the time this consultation starts: NHS Knowsley CCG, NHS Liverpool CCG, NHS South Sefton CCG and NHS Southport and Formby CCG.

NHS Liverpool CCG is coordinating the consultation, because Liverpool has the most patients using Liverpool University Hospitals services, but this consultation is open to everyone.

CONSULTATION CLOSES

When this consultation closes on 2 August 2022, the feedback will be considered and might inform changes or improvements to these proposals. The NHS will oversee the writing of a consultation report, but it will be produced by an external organisation.

CONSULTATION REPORT

Once this report is available, it will be used to produce a final business case, which will need to be agreed by Liverpool University Hospitals.

BUSINESS CASE

The business case will then be presented to NHS commissioners (the organisations which plan local services) and to NHS England, which will decide whether the change should go ahead – it will consider the findings of the consultation report to do this.

INTEGRATED CARE BOARD

As CCGs are due to be abolished at the end of June 2022, the Integrated Care Board (ICB) for Cheshire and Merseyside will be the new commissioning organisation which will make the final decision.

FINAL BUSINESS CASE

Following this, local authority overview and scrutiny committees (OSCs) will be asked to look at the final business case – including the consultation report – to decide whether the change is in the best interests of their populations. A single OSC has been created for this piece of work, made up of representatives from Knowsley, Liverpool, and Sefton councils.

FINAL DECISION

We hope to have a final decision about these services by autumn 2022. When we announce this decision, we will also publish the report from the public consultation.

How does the public consultation process work?

Public consultation is an opportunity to share your views, and help ensure we have all the information we need to make a final decision about how services should look in the future.

We want to know whether you feel there are any alternatives we should have considered – and if so, why? – or whether you think the proposals could be improved.

We also want to understand how you feel that the proposal would impact on people, and whether this would be a positive or negative effect, or whether it wouldn't make any difference.

This consultation will run for eight weeks – from 7 June to 2 August 2022.

How to share your views

To take part in this public consultation and share your views on the proposed changes to any (or all) of the five services, visit page 12 for details.

www.futureLUHFT.nhs.uk

What have people told us so far?

The NHS has been talking to local people about bringing Liverpool's hospital teams together for a number of years. These discussions have helped us to better understand the issues that matter to people, and we've tried to reflect this in the way we've designed this public consultation.

Healthy Liverpool Programme, 2016

In early 2016, NHS Liverpool CCG carried out a large-scale engagement to ask people what they thought about the main priority areas for the **Healthy Liverpool** programme, which was the city's strategy to improve health and services at that time.

The agreed priorities included ways to improve care and the future sustainability of hospital services. This involved proposals to bring together hospital teams which were on different sites, to develop single services, with the aim of reducing duplication and improving standards. In a survey, participants were asked to rank their priorities around treatment from a list of five options, and the most important was 'being offered the same, high standard of treatment regardless of where my treatment takes place', very closely followed by 'being seen by the right staff who are experts in the treatment/ management of my condition'. Short travel time for one off appointments, such as surgery was the least important, however, generally participants did want care as close to home as possible.

Orthopaedic and ENT Consultation, 2017

In the summer of 2017, the local NHS also ran a consultation about proposed changes to **orthopaedic and ENT** (ear, nose and throat) services across Aintree, Broadgreen, and the Royal Liverpool University hospitals. Consultation feedback showed support for the changes, and the majority of people who responded believed the proposal would improve the quality of care patients receive. Some concerns were raised over public transport and this feedback helped the trust to understand what arrangements would need to be put in place to support access. Changes went ahead during autumn 2019.

LUHFT Merger, 2019

In spring 2019, while they were still two separate organisations, Aintree University Hospital NHS Foundation Trust (AUHFT) and the Royal Liverpool and Broadgreen University Hospitals NHS Trust (RLBUHT) engaged staff, members, patients, the public and wider partners, about their **proposed merger**. Feedback from patients, carers and the public covered a number of themes which are also relevant to this public consultation, including staff and resources, and transport and access. There was broad and widespread agreement that patients using the two trusts' services should have access to the same standard of care, and access to the same range of specialties.

One Liverpool

Finally, **One Liverpool** – the city's current health and care strategy – also sets out the need for bringing adult hospital services together to reduce duplication, improve quality of care and patient experience.

Links to more detailed reports on these pieces of work are available at: www.futureLUHFT.nhs.uk

How to share your views

You can take part in this public consultation and share your views on the proposed changes to any (or all) of the five services in the following ways:

Fill in a questionnaire at

www.futureLUHFT.nhs.uk

If you would like a paper copy of the questionnaire, or need it in a language other than English, or in a format such as braille or large print, contact NHS Liverpool Clinical Commissioning Group (CCG) using the details below.

EMAIL US: future.LUHFT@nhs.net

CALL US: 0151 247 6406

TEXT US: 07920 206 386

Our email account and phone lines are monitored Monday to Friday, 9.00am to 5.00pm (Please note: NHS Liverpool CCG is organising this consultation on behalf of all the CCGs and hospital trusts involved, so we're the point of contact for all enquiries, not just those from Liverpool residents.)

Join an online meeting

We're also organising a number of **online meetings**, which will be a chance to hear more about the proposals set out in this booklet, and to take part in some focus-group discussions. Visit **www.futureLUHFT.nhs.uk** for details of when these events are taking place and how to sign up.

Stay updated

You can also register your email address at **www.futureLUHFT.nhs.uk** to receive updates direct to your inbox.

HAVE YOUR SAY

Breast surgery

Breast surgery

HAVE YOUR SAY **Where care and treatment happens at Liverpool University Hospitals www.futureLUHFT.nhs.uk**

About the service

Liverpool University Hospitals breast services deal with both benign (non-cancerous) breast problems, and breast cancer – the teams treat more than 750 cancer cases each year.

They provide a full range of diagnostic, treatment and support services, including one-stop diagnostic clinics, breast cancer removal, reconstructive and cosmetic procedures, family history assessment and patient support clinics.

How and where is care currently delivered?

Liverpool University Hospitals breast services take place at three locations:

- **The Marina Dalglish Breast Unit at Aintree Hospital**

- **Broadgreen Hospital**

- **The Linda McCartney Centre at the Royal Liverpool Hospital**

Each location provides different types of care:

- Clinics to diagnose patients take place at both Aintree Hospital and the Royal Liverpool Hospital.
- Breast screening for women aged 50 to 70, as part of the National Breast Screening Programme, is based at Broadgreen Hospital, and via mobile units.
- Breast surgery currently takes place at Broadgreen Hospital and the Royal Liverpool Hospital. Before the COVID-19 pandemic, breast surgery took place at Aintree Hospital and the Royal Liverpool Hospital. However, because of the pandemic a series of temporary changes were put into place, to allow services to continue and minimise disruption for patients. In autumn 2021, the majority of breast surgery was moved to Broadgreen Hospital, with a small number of more complex patients being treated at the Royal Liverpool Hospital. This arrangement is part of the plan to recover services after COVID-19. Currently, no breast surgery is taking place at Aintree Hospital. This is a temporary change – the purpose of this public consultation is to put forward a permanent proposal for the future of breast surgery at Liverpool University Hospitals.

How many patients use the service?

The table below shows which areas the majority of patients who use breast services come from, and whether they use Aintree Hospital or the Royal Liverpool Hospital (they don't reflect the patients currently using Broadgreen as this is a temporary change).

The figures shown are for 2019/20 (rounded to the nearest whole number). Where there are only a very small number of patients from a particular area, we have included them in 'other'.

Aintree Hospital

CCG area	Number of patients and %
NHS Liverpool CCG	105 (21%)
NHS Knowsley CCG	51 (10%)
NHS South Sefton CCG	189 (38%)
NHS Southport and Formby CCG	87 (18%)
NHS West Lancashire CCG	50 (10%)
NHS Wirral CCG	2 (<1%)
Other	11 (2%)
TOTAL	493 Patients

Royal Liverpool Hospital

CCG area	Number of patients and %
NHS Liverpool CCG	599 (64%)
NHS Knowsley CCG	59 (6%)
NHS South Sefton CCG	66 (7%)
NHS Southport and Formby CCG	79 (9%)
NHS West Lancashire CCG	13 (1%)
NHS Wirral CCG	26 (3%)
Other	88 (10%)
TOTAL	930 Patients

It's important to note that across both Aintree (when surgery was taking place there) and the Royal Liverpool Hospital, 84% of operating theatre activity for breast surgery is for day cases (meaning an overnight hospital stay is not required). This is well above the national average of 68%, and a national target of 75%.

Why is change needed?

Breast cancer is the most common type of female cancer in the UK. With over 55,000 women (and 370 men) diagnosed each year, this accounts for 15% of all new cancer cases. Nationally, rates for breast cancer are projected to rise by 2% by 2035.

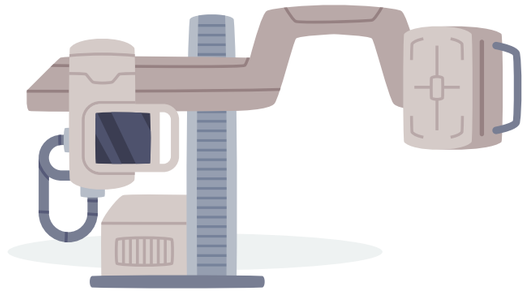
Specific challenges for our local services include:

Duplication and inefficiency

Currently, people are referred to either Aintree Hospital or the Royal Liverpool Hospital if their GP suspects a potential breast problem, as there are two separate systems. There is lots of demand for appointments at both hospitals, and people often wait for a different amount of time, depending on which site they are referred to.

Shortage of radiology support

There is a national shortage of breast radiographers and breast radiologists. These are specialists who use images of the breast to diagnose and treat patients. The way that our local services are organised doesn't give us the best opportunity to address this.



Differences in capacity

The national target is that all people who are referred with a breast problem should be seen within two weeks. Currently, Aintree Hospital and the Royal Liverpool Hospital try to arrange extra capacity to deal with increases in referrals, but both are struggling to see everyone within this time frame – locally there has been a 20% increase in referrals in the last six months.

Why is change needed?

Radio Pharmacy requirements

Radio Pharmacy services (preparing radioactive materials for diagnosis and treatment) are based on the Royal Liverpool Hospital site, which has a machine for creating radioisotope. This is needed for procedures carried out on approximately 70% of those undergoing breast cancer surgery. It must be transported to the hospital where the procedure is performed, or the patient needs to attend the Royal Liverpool Hospital for an injection the day before their procedure, so this can cause potential delays when the surgery is taking place elsewhere.

Workforce issues

There are differences in the mix of staff between Aintree and the Royal sites, both in clinical and administrative roles.

Differences in patient pathways

The process that patients follow ahead of their operation are run slightly differently at Aintree Hospital and the Royal Liverpool Hospital. At Aintree, patients have their pre-op (pre-operative) appointment, then go to give consent for their operation and to see a breast care nurse on a set day of the week. At the Royal, most patients have all of this on the same day.

Patients who use Aintree might also need to make more visits for diagnostic tests. This is due to the skills mix of the team working at Aintree, and time pressures at the site.

There is a difference in mastectomy (an operation to remove the breast) and drain care (managing the tubes which drain fluid away after a mastectomy) pathways between the two sites. Aintree offers a nurse who does community visits to look at all drains, and follows up with patients who have had an operation by phone. The Royal relies on district nurses for drain care, and all patients who have had an operation get a phone call from the breast team the following day.

The Royal offers home visits to those with breast cancer who are very frail, however Aintree does not offer this.

The proposed solution for the future

After looking at a number of potential options, it is proposed that in the future all surgery and operating theatre activity for breast services takes place at the Royal Liverpool Hospital.

At the start of this section about breast services, we explained that surgery currently takes place at the Royal Liverpool Hospital and Broadgreen Hospital – at the moment it isn't taking place at Aintree as a result of temporary COVID-19 changes. If the permanent change set out in this booklet went ahead, breast surgery would not return to Aintree in the future. It would continue at Broadgreen on a temporary basis for now, but in the longer-term, breast surgery would only take place at the Royal Liverpool Hospital.

Diagnostic and outpatient services would take place at both Aintree Hospital and the Royal Liverpool Hospital.

Breast screening for women which is part of the national programme would remain at Broadgreen Hospital.

What impact would this have on patient care?

Streamlining care and improving standards

A single surgical pathway would be created, taking the best practice from each of the two current units. Creating a larger single team, bringing together a greater range of skills, and allowing all patients to be given the best quality of care.

Managing demand and capacity better

A single point of referral would mean that patients could choose to go to whichever site had capacity for their diagnostic tests. It would reduce duplication, helping to better manage capacity and demand across Aintree and the Royal Liverpool hospitals.

Smoother arrangements for pre-operative assessment

The proposed model would give all breast patients the opportunity for part of their pre-operative assessment to happen by telephone or face-to-face, with the option of then attending either Aintree or the Royal Liverpool for their relevant tests.

Dedicated breast day and inpatient ward

If the change to one site went ahead, all breast patients would have access to a dedicated breast ward and specialty trained nurses.

Drawing together best practice

Taking the best of existing systems and practices from each hospital site could help to enhance patient care, particularly in those areas where the service is currently failing to meet national standards.

Patient support

Under the proposed model, a breast consultant would be on call seven-days-a-week, able to provide out-of-hours telephone advice to patients from any site who have a concern.

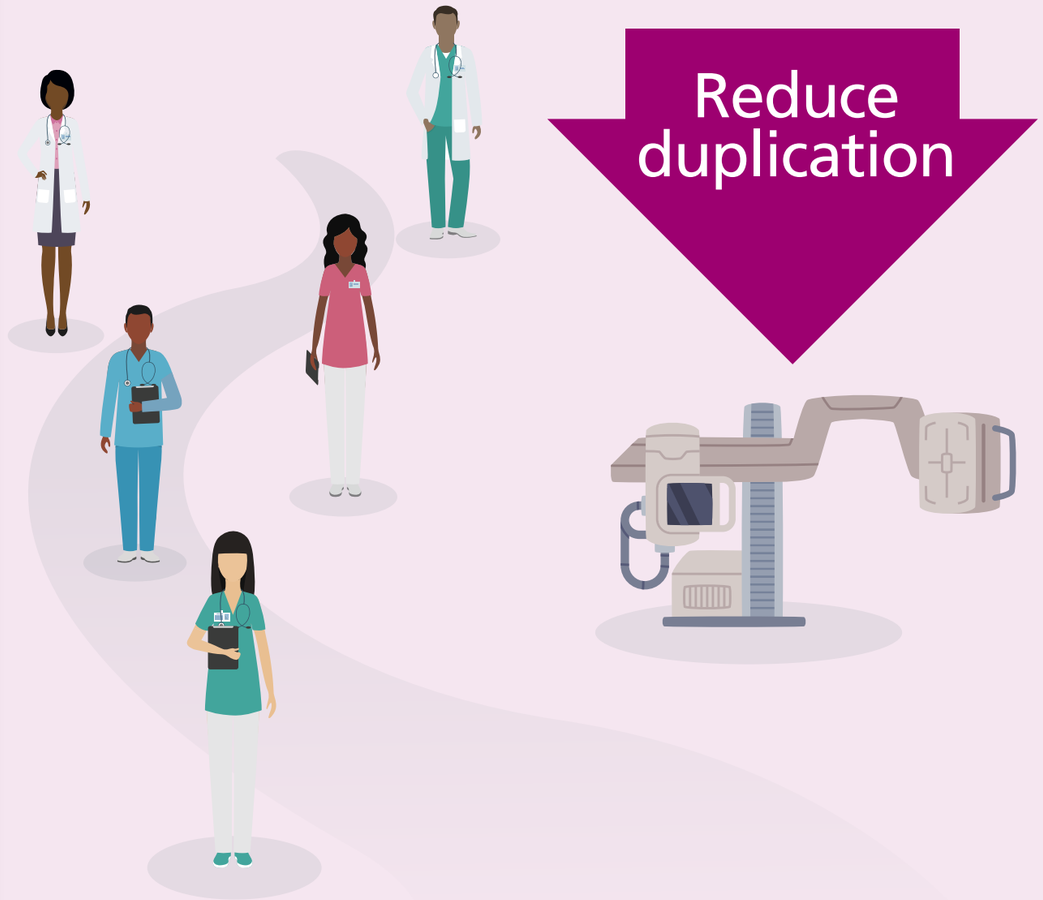
Wider impact benefits

Addressing workforce challenges

A single, larger service would be more attractive to potential staff. It would also open up training opportunities for staff at all levels, making the service more sustainable.

Reducing duplication

Operating on one site rather than two would mean that equipment wouldn't need to be duplicated, reducing maintenance costs, and creating savings from ordering of equipment and supplies.



How would patient access change if this proposal went ahead?

If this change went ahead, in the future all breast surgery would take place at the Royal Liverpool Hospital.

This would mean that some people who might have had their treatment at Aintree Hospital in the past (before temporary changes were made as a result of COVID-19) might have to travel further for their care. Currently, patients are also travelling to Broadgreen for their surgery, under the temporary changes.

However, patients who would have previously used Aintree would have better access to Saturday operating slots under these proposals, which would provide more choice for people who might find it harder to attend during the week.

If the change went ahead, outpatient and diagnostic care would continue to take place at both Aintree and the Royal Liverpool hospitals, so access to this would not be impacted. However, there will be a single point of referral, so patients will be able to choose between Aintree and the Royal Liverpool, depending on which has an appointment that suits them best. Similarly, screening as part of the National Breast Screening Programme would continue to take place at Broadgreen Hospital.

Have any other options been considered?

A summary of the other short-listed options that were looked at is as follows:

OPTION	SUMMARY
Do nothing	Continuing with the service as it currently is wouldn't provide any opportunity to address the challenges around duplication, capacity issues, and differences in patient experience.
All surgery moves to Aintree Hospital	Although this would mean a single patient pathway, there is no dedicated breast ward or theatre capacity at Aintree. Radioisotope would need to be transferred from the Royal Liverpool Hospital site, creating potential delays for cancer surgery.
Cancer surgery takes place at the new Royal Liverpool Hospital, and non-cancer at Aintree Hospital	The clinical issues that come from being two separate services would continue. Plus, the same facilities and equipment would be needed at both sites which would continue to create duplication in costs. This solution would not address ward and theatre issues.
Move all breast services to Aintree Hospital	Diagnostics and screening are currently delivered across three sites. Although this option would mean having all staff on one site, and bring some savings, it would remove the link with specialist cancer services that the Royal Liverpool Hospital has with Clatterbridge Cancer Centre. The estate would need to be increased to meet the increase in patient numbers. The change could mean the loss of staff.
Move all breast services to the Royal Liverpool Hospital	This option would mean moving diagnostic services away from the north of Liverpool, where there is the greatest demand for these services, and therefore impacting on patient access and experience. A single unit would give opportunities for better collaboration, and the benefits this brings for clinical safety and patient outcomes, but like the option of moving the whole service to Aintree, the relocation could lead to some staff leaving the service. It would also present some estate issues.

Further details are provided in the pre-consultation business case (PCBC), which is available at: www.futureLUHFT.nhs.uk

What would the cost be?

The proposed changes for breast services are not expected to create additional costs, because the new facilities which would be required are already part of plans for the new Royal Liverpool Hospital. In addition, bringing services together will also provide opportunities to reduce duplication.

No expected additional costs

Reduce duplication

How to share your views

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General surgery

Focusing on the abdominal area and intestines, including the gastrointestinal tract, liver, colon and pancreas.

About the service

General surgery focuses on the abdominal area and intestines, including the gastrointestinal tract (part of the digestive system), liver, colon, pancreas and other major parts of the endocrine (hormonal) system of the body. It is split into the following areas:

- **Colorectal surgery,** which focuses on the lower gastrointestinal tract such as the colon and rectum, including operations for colon and rectal cancer, inflammatory bowel disease, anal cancer, prolapses, haemorrhoids and intestinal polyps, as well as bowel screening services;

- **Upper gastrointestinal ('upper GI') surgery,** which is performed on the oesophagus and stomach and includes addressing issues such as oesophago-gastric (gullet and stomach) cancers, reflux, hiatus hernia, Barrett's oesophagus and ulcer disease;

- **Hepato-pancreatobiliary ('HPB') surgery,** where hepatobilary surgery focuses on the liver, and pancreatobiliary surgery focuses on the pancreas, bile duct and gallbladder.

Emergency general surgery can include conditions such as:

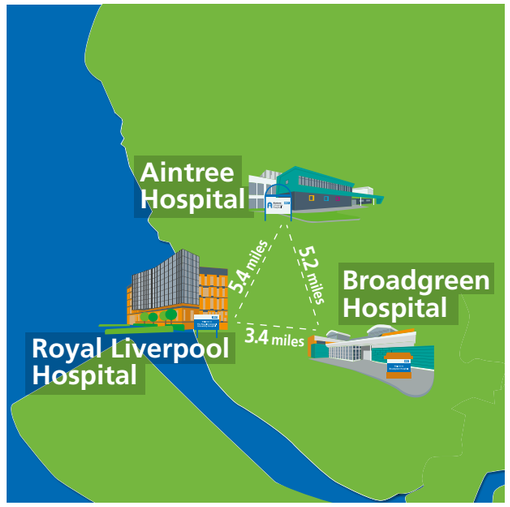
- Acute diverticulitis - *when a bulge or pocket in the bowel lining becomes inflamed or infected*
- Appendicitis - *painful swelling of the appendix*
- Cholecystitis - *inflammation of the gallbladder*
- Pancreatitis - *inflammation of the pancreas*
- Incision and drainage of abscesses

These conditions are generally as a result of trauma to internal organs.

How and where is care currently delivered?

Currently, general surgery happens at Aintree Hospital and the Royal Liverpool Hospital, which both provide planned (elective) and emergency care.

Broadgreen Hospital provides planned care only.



How many patients use the service?

These figures from 2019/20 show how many people were admitted for either emergency or planned surgery, at both Aintree Hospital and the Royal Liverpool Hospital, and which areas those patients came from.

Fewer than 10% of patients admitted as an emergency need major emergency surgery. Often people with abdominal and pelvic pain have investigation and observation but no surgical procedure – however, because they are under the care of a consultant surgeon they are included in the data.

Around 250 people a year also use Broadgreen Hospital for planned (elective) care. More information about where these patients come from is available at www.futureLUHFT.nhs.uk or by contacting NHS Liverpool CCG using the details on page 42.

Aintree Hospital, emergency (unplanned) admissions

CCG area	Number of patients and %
NHS Liverpool CCG	1281 (38%)
NHS Knowsley CCG	478 (14%)
NHS St Helens CCG	41 (1%)
NHS South Sefton CCG	1129 (34%)
NHS Southport and Formby CCG	59 (2%)
NHS Halton CCG	34 (1%)
NHS West Lancashire CCG	67 (2%)
NHS Wirral CCG	56 (2%)
NHS West Cheshire	26 (1%)
NHS Warrington	18 (1%)
Other	165 (5%)
TOTAL 3354 patients	

Aintree Hospital, planned (elective) admissions

CCG area	Number of patients and %
NHS Liverpool CCG	217 (39%)
NHS Knowsley CCG	76 (14%)
NHS St Helens CCG	29 (5%)
NHS South Sefton CCG	173 (31%)
NHS Southport and Formby CCG	12 (2%)
NHS Halton CCG	9 (2%)
NHS West Lancashire CCG	11 (2%)
NHS Wirral CCG	6 (1%)
NHS West Cheshire	-
NHS Warrington	5 (1%)
Other	19 (3%)
TOTAL 557 patients	

Royal Liverpool Hospital, emergency (unplanned) admissions

CCG area	Number of patients and %
NHS Liverpool CCG	1599 (83%)
NHS Knowsley CCG	52 (3%)
NHS St Helens CCG	13 (1%)
NHS South Sefton CCG	52 (3%)
NHS Southport and Formby CCG	7 (<1%)
NHS Halton CCG	10 (1%)
NHS West Lancashire CCG	10 (1%)
NHS Wirral CCG	26 (1%)
NHS West Cheshire	7 (<1%)
NHS Warrington	5 (<1%)
Other	112 (6%)
TOTAL 1917 patients	

Royal Liverpool Hospital, planned (elective) admissions

CCG area	Number of patients and %
NHS Liverpool CCG	407 (58%)
NHS Knowsley CCG	77 (11%)
NHS St Helens CCG	23 (3%)
NHS South Sefton CCG	25 (4%)
NHS Southport and Formby CCG	19 (3%)
NHS Halton CCG	19 (3%)
NHS West Lancashire CCG	9 (1%)
NHS Wirral CCG	27 (4%)
NHS West Cheshire	14 (2%)
NHS Warrington	15 (2%)
Other	68 (10%)
TOTAL 703 patients	

Percentages are rounded up or down to the nearest whole number, so might not add up to 100%.

Why is change needed?

Admissions for emergency general surgery make up the biggest group of surgical admissions to UK hospitals, and these procedures make up a large percentage of all surgical deaths.

During some common procedures, up to half of patients will have complications, which can also mean a much longer stay in hospital than expected.

Only a small number of patients – less than 10% – who are referred to general surgery as an emergency need an operation. Moving patients through the service quickly and efficiently relies on a range of factors, including having good triage (initial assessment) in place, and ensuring there is timely access to senior staff who can make decisions about care.

Under current arrangements, care is split into two different models – one at Aintree Hospital and one at the Royal Liverpool Hospital. This is inefficient, and means that patients get a different experience, depending on which hospital they are treated at. Outcomes for patients are not the same at both sites, and at the moment neither site is able to meet best practice guidelines for care across all areas of general surgery (known as 'sub-specialties').

Specific challenges for colorectal surgery:

- There is **rising demand for services**, with the local population facing worse health outcomes across a number of areas compared to the national average. In Cheshire and Merseyside there has been a 6% increase in rates of colorectal cancer over the past ten years, compared to a 2% rise nationally, and many of these cancers are detected at a late stage. This makes it particularly important that services are able to provide the best care possible to patients, but the way that general surgery is currently organised makes it difficult to do this.

- There is strong evidence that patients receive better care when they are treated by a doctor who carries out a procedure more regularly. This means seeing enough patients with a particular condition; **but the current volume of patients having planned colorectal surgery at both Aintree Hospital and the Royal Liverpool Hospital is far lower than the national average.**

- **Currently, not all surgeons are trained in certain techniques which can improve care**. For example, laparoscopic colorectal surgery is a type of keyhole procedure which can mean a lower risk of complications and a shorter stay in hospital, but rates across Liverpool University Hospitals sites are low.

- **Because colorectal surgeons also have to provide cover for emergency procedures, this takes them away from planned colorectal work**, and also makes it harder to give junior doctors enough experience in colorectal surgery as their specialist area.

- Although together the Royal Liverpool Hospital and Aintree Hospital cover the full range of techniques and expertise across their teams, **not all procedures are available at both hospitals**, which means it can sometimes be necessary to transfer patients between sites. This can cause delays and impact on patient experience.

Why is change needed?

Specific challenges for gastrointestinal ('upper GI') surgery:

- As with colorectal surgery, **with upper GI surgery happening across two locations, the overall number of patients that the teams see is split**. Again, it's widely accepted that units which see more patients get better outcomes, because doctors have the opportunity to do the same procedures more regularly. The Association of Upper Gastrointestinal Surgeons of Great Britain and Ireland (AUGIS) has set out that services managing upper GI cancer should serve a minimum patient population of between one to two million people – this can't be achieved with services split in the way they are currently.

- A smaller unit which doesn't have a 'critical mass' of specialists doesn't help **create opportunities for innovation and research**.

- A smaller pool of specialists can make rotas more intense and put additional pressure on staff. It can be **hard to find and retain staff**.

- As with other specialist areas within general surgery, the difference in how patients are treated at the two current sites means that **people in different areas of the city aren't always getting the same quality of care**.

- Local benign (non-cancer) upper GI services don't currently perform well for the number of procedures carried out as day cases, the amount of time patients need to stay in hospital, or on waiting times.

Specific challenges for hepato-pancreatobiliary ('HPB') surgery:

- **Because liver and pancreas surgery happen across two sites, the workforce is split**. There should be five surgeons at each unit, but neither Aintree Hospital nor the Royal Liverpool Hospital can currently comply with this.

- The current split in HPB services – and the fact that both hospitals have a different way of managing patients – can make it **difficult for other hospitals to refer patients for care**, particularly as patients might need a treatment that only happens at one of the two sites.

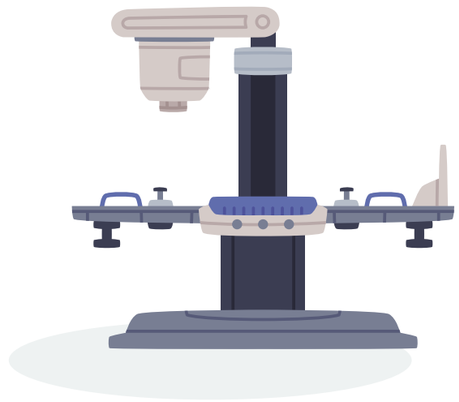
Specific challenges for emergency general surgery:

- A laparotomy is an operation which involves opening the abdomen (tummy) to investigate pain and find the cause of the problem. The Royal College of Anaesthetists and The Royal College of Surgeons carries out an audit of these procedures, to see how different hospitals are performing. This shows that although Aintree and the Royal Liverpool have both made improvements in recent years, neither are currently meeting the national standard for getting patients into surgery within six hours of arrival at hospital.

- There are other national recommendations and standards about how long patients should stay in hospital following emergency laparotomy procedures. Although both sites have been able to achieve the national average in previous years, historically lengths of stay have been below the standard. Neither Aintree nor the Royal Liverpool meet the Royal College of Surgeons' recommendation that all patients should be reviewed by a consultant within 14 hours of admission.

- At Aintree, emergency general surgery cover is provided by consultants whose time is fully dedicated to emergency (unplanned) admissions – they don't do elective (planned) procedures alongside these emergencies. However, at the Royal Liverpool Hospital, the same surgeons perform both elective and emergency operations. This is not in line with best practice, as these surgeons are specialists in particular areas of the body, rather than in dealing with emergencies.

- Because of the lack of a rapid access service for people who need treatment quickly, lots of procedures and operations (like uncomplicated hernia, appendicitis, abscess) happen as inpatient procedures, when they could be done as day cases. This increases the burden on theatre and emergency surgical and anaesthetic teams, and means that patients have to stay in hospital overnight.



The proposed solution for the future

Following a process to look at potential options for general surgery services, a single 'preferred' option has been identified.

The principle for the change is to bring similar services and patients onto the same site, meaning that Aintree Hospital would focus on emergency surgery, while the Royal Liverpool Hospital would carry out planned surgery.

Under the proposal, Aintree Hospital would have a single emergency care unit for emergency general surgical admission, and provide care seven-days-a-week, in line with best practice. Ambulances would take patients who required emergency surgery straight to Aintree.

Meanwhile, the Royal Liverpool Hospital would specialise in planned care, including complex benign (non-cancer) and cancer cases (such as elective upper GI, HPB and colorectal surgery). General surgical emergency cover would still be provided at the Royal Liverpool Hospital for occasional patients who might need emergency surgery but are not well enough to be transferred. This could include patients admitted to the Royal Liverpool Hospital for other conditions, or those who present at the hospital's accident and emergency department.

Planned (elective) care would no longer take place at Broadgreen Hospital. The majority of patients who would currently use Broadgreen would be treated at the Royal Liverpool Hospital instead, as this will be the site focusing on planned care, however a small number might go to Aintree Hospital if this would be the best place for their particular condition.

Both Aintree Hospital and the Royal Liverpool Hospital would have on-site support from anaesthesiology, radiology (diagnostic and interventional), and intensive care.

What impact would this have on patient care?

Improving efficiency and reducing cancellations

Separating planned (elective) and emergency (non-elective) general surgery would allow both parts of the service to be managed more efficiently, improve availability of staff for reviews before and after operations, allow patients to be seen more quickly, and ensure that emergency demands don't disrupt planned care (for example, by causing operations to be cancelled).

Improved mortality

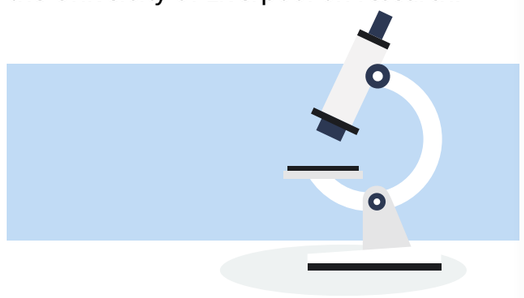
For planned care, bringing the service together will create a more robust workforce and increase availability of specialist surgeons, with the benefits this brings for patient safety and quality of care. For example, there is evidence of a significantly lower 30-day mortality rate for those emergency colonic procedures performed by sub-specialist consultant colorectal surgeons, compared with procedures performed by non-colorectal specialists. Because the new model would double the number of patients seen in the combined unit than are currently seen at two separate sites, this is expected to improve mortality rates. This means saving the lives of more colon, rectal and anal cancer patients.

More equal access to emergency general surgery

Having dedicated emergency care means that patients can be reviewed at an early stage by senior staff, when considering things such as need for admission, targeting of investigations and a decision as to whether it is appropriate to operate. In the past, a consultant would take on care for an emergency patient and provide treatment around their planned care commitments. Developing emergency general surgery has reduced both deaths and the amount of time people need to spend in hospital, as well as making it easier to treat patients in ways which mean they don't always need to be admitted to hospital. If these changes went ahead, all Liverpool University Hospitals' general surgery patients would have access to this model, not just those treated at Aintree Hospital.

Research and innovation

Centralising cancer services at the Royal Liverpool Hospital would provide an opportunity to further collaborate with the University of Liverpool on research.



Quicker and improved emergency care

A seven-day-a-week service for those referred for emergency general surgery should reduce pressure on emergency departments and mean that patients are seen more quickly. A key effect of this would be avoiding people being admitted to hospital unnecessarily – reducing the amount of time patients have to spend in hospital reduces the risk of complications for individuals, and also brings down waiting times.

Staff development

It would be easier to plan cover across the two sites, and make better use of the specialist workforce. There would also be more scope for developing staff, such as training them in clinical procedures using the latest minimally invasive and robotic services, which improve outcomes and patient experience. Also, because the specialties which come under general surgery would each see a greater number of patients, junior doctors would have more consistent opportunities to get experience in specific specialist areas. Developing the workforce in this way is really important for ensuring that we have the clinicians to care for our population in the future.

Reducing hospital admissions

Separating out emergency and planned surgery would allow teams to develop better processes (pathways) for carrying out more procedures as day cases, with the benefits that this brings for patients.

Raising clinical standards

For planned care, each specialist area would have designated wards. Bringing the service together will help with organising diagnostic tests, reviewing patients and improving clinical standards. The two sites would be able to adopt best practice guidelines for care, which would improve patient outcomes, patient experience, and provide quicker access to care.

Have any other options been considered?

A summary of the other short-listed options that were looked at is as follows:

OPTION	SUMMARY
Do nothing	By continuing to do emergency and planned surgery at both Aintree Hospital and the Royal Liverpool Hospital, there would be no opportunity to address the differences in patient experience, outcomes and access that currently exist. In addition, the new Royal Liverpool Hospital does not have enough emergency theatre provision for the service, which would impact on the hospital's emergency department (accident and emergency).
Implement the current Aintree model for emergency general surgery across both hospitals (Aintree and the Royal Liverpool)	This option would mean that emergency general surgery was provided in a more streamlined way. However, it would require additional space at the new Royal Liverpool Hospital, reducing space for other Liverpool University Hospitals services. Duplication and workforce issues would remain. This model would mean recruiting more dedicated emergency general surgery surgeons. Alternatively, if existing staff were used, it would mean that they were no longer focused on a specific area of planned care.
Implement the current Royal Liverpool model for emergency general surgery across both hospitals (Aintree and the Royal Liverpool)	Again, this option would provide a more streamlined approach. However, the planned allocation of space and theatres at the new Royal Liverpool Hospital would not be adequate. Also, Aintree is currently seen to have a more efficient model of care out of the two hospitals, so this would be a step backwards. Duplication and workforce issues would remain. This model would also require surgeons currently delivering emergency general surgery at Aintree to retrain (as they have not taken part in advanced sub-specialty work for a number of years) and require those who currently provide sub-speciality surgery at both hospitals to also cover emergency surgery. This would impact on the capacity for planned care.

Further details are provided in the pre-consultation business case (PCBC), which is available at: www.futureLUHFT.nhs.uk

What would the cost be?

To make the change, there would need to be some additional investment in staffing, to bring in additional consultants. This would cost approximately £515,000 extra a year. If these changes went ahead, the extra costs would be built into Liverpool University Hospitals financial plans from 2022/23 onwards.

How to share your views

You can take part in this public consultation and share your views on the proposed changes to any (or all) of the five services in the following ways:

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www.futureLUHFT.nhs.uk

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CALL US: 0151 247 6406

TEXT US: 07920 206 386

Our email account and phone lines are monitored Monday to Friday, 9.00am to 5.00pm (Please note: NHS Liverpool CCG is organising this consultation on behalf of all the CCGs and hospital trusts involved, so we're the point of contact for all enquiries, not just those from Liverpool residents.)

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You can also register your email address at **www.futureLUHFT.nhs.uk** to receive updates direct to your inbox.

Nephrology

Kidneys

HAVE YOUR SAY

Where care and treatment happens at Liverpool University Hospitals www.futureLUHFT.nhs.uk

Nephrology

About the service

Nephrology services focus on caring for people with kidney problems and treating the diseases that can cause them. The service is sometimes referred to using the term ‘renal’, which relates to kidney care.

The nephrology service based at Liverpool University Hospitals NHS Foundation Trust (LUHFT) serves a population of about two million people throughout Merseyside, as well as parts of Cheshire, Lancashire and North Wales.

How and where is care currently delivered?

Nephrology is currently provided at both Aintree University Hospital and the Royal Liverpool Hospital.

The service provides all aspects of kidney care — acute kidney injury, chronic kidney disease, renal replacement therapy (dialysis), conservative management of patients who choose not to have dialysis/ transplant, and kidney transplant surgery.

The service also provides a number of weekly dialysis sessions based at satellite clinics across the region, which help to bring care closer to home for more patients. These clinics are based at Broadgreen, St Helens, Warrington, Halton, Aintree, Waterloo and Southport hospitals. There is also a specialist obstetrics outreach clinic based at the Liverpool Women’s Hospital, to help support women with kidney problems during pregnancy.

In addition to this, there is a small community-based team which supports some patients with home therapies (dialysis at home).

Outpatient clinics are also provided at the Royal Liverpool, Aintree, Whiston, St Helens, Warrington, and Southport hospitals, for patients with kidney disease.

How many patients use the service?

The figures below from 2019/20 show how many people were admitted for either emergency or planned nephrology care, and which areas those patients came from.

Emergency (unplanned) care

CCG area	Number of patients and %
NHS Liverpool CCG	414 (47%)
NHS South Sefton CCG	188 (22%)
NHS Knowsley CCG	105 (12%)
NHS St Helens CCG	23 (3%)
NHS Southport and Formby CCG	20 (2%)
NHS West Lancashire CCG	15 (2%)
NHS Halton CCG	12 (1%)
NHS Warrington CCG	8 (1%)
NHS Wirral CCG	7 (1%)
Other	81 (9%)
TOTAL 873	

Planned care

CCG area	Number of patients and %
NHS Liverpool CCG	289 (32%)
NHS Knowsley CCG	113 (12%)
NHS South Sefton CCG	112 (12%)
NHS Southport and Formby CCG	89 (10%)
NHS St Helens	64 (7%)
NHS West Lancashire CCG	61 (7%)
NHS Halton CCG	40 (4.5%)
NHS Warrington CCG	38 (4%)
NHS Wirral CCG	10 (1%)
Other	96 (10.5%)
TOTAL 912	

Please note: these percentages have been rounded up for ease

Why is change needed?

There are a number of reasons why the nephrology service is not working as well as it could. Each of these issues are explained in more detail below:

Rising demand

Renal disease is increasing in the local population. There are strong links between the number of patients requiring renal replacement therapy (dialysis) and wider factors, including ethnicity, ageing population, social deprivation, and the prevalence of other long-term conditions such as diabetes, high blood pressure, and cardiovascular diseases (CVD).

Liverpool has higher than average levels of all of these things, which means that demand for renal (kidney) services – especially dialysis – is already high, and will continue to increase. To continue to support these growing patient numbers, the service needs to plan for the future now.

Inequitable access to dialysis care

The nephrology service currently provides dialysis to around 750 patients a year, across Aintree, the Royal Liverpool, and Broadgreen hospitals. Dialysis is a vital procedure that removes harmful waste products and excess fluid from the blood when the kidneys stop working properly.

However, because each hospital developed their treatment pathways for dialysis patients separately, before merging into one organisation in 2019, the way that they provide this treatment continues to vary. There also continues to be differences in the staff expertise available at each site. This means that different patients can experience variations in the quality of care they receive.

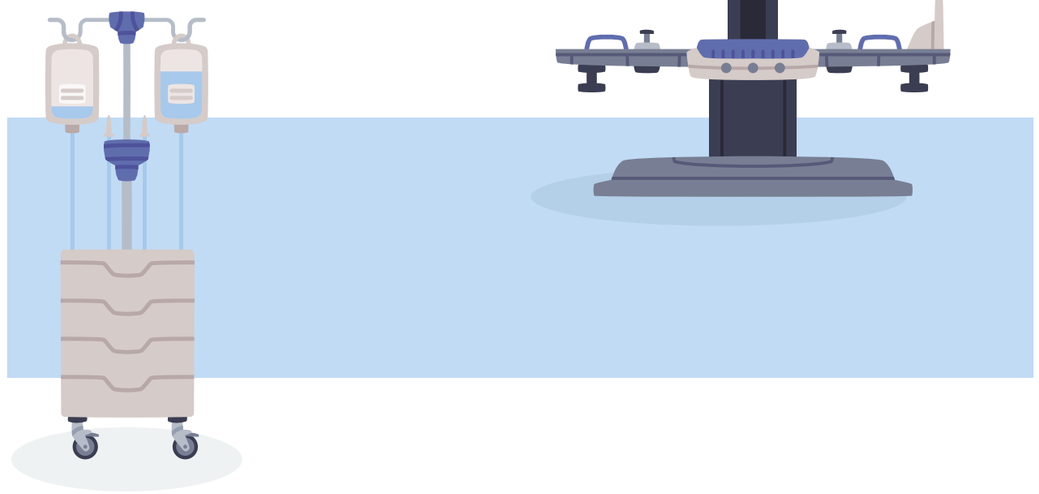
Clinicians involved in nephrology believe that the service should be reorganised so that all kidney patients can receive the same, high-quality care – whichever hospital they are treated at.

Why is change needed?

Inequitable access to transplants

There are also variations in care for patients awaiting a kidney transplant. Patients treated at Aintree University Hospital tend to have lower uptake of kidney transplants compared to patients being treated at the Royal Liverpool Hospital, because transplant services are based at the Royal.

NHS Blood and Transplant data from 2018 shows that the average waiting time for a kidney transplant for patients at Aintree University Hospital is 837 days, compared to just 613 days for patients at the Royal Liverpool Hospital. This is because patients at Aintree who need a transplant have to be referred to a transplant surgeon at the Royal Liverpool, and this can lead to further delays in their care.



Variation in research and clinical trials

Likewise, both sites have active programmes of clinical research for nephrology. However, different studies and research focus have been developed at each hospital over the years.

This means that the trials available to patients at each site can differ. In some cases, patients might benefit from taking part in a clinical trial running on a different site to the one they're being treated at, but aren't able to under the current arrangements.

Failure to meet national standards

Neither Aintree University Hospital or the Royal Liverpool Hospital currently meet national guidelines for permanent access to dialysis for patients who need haemodialysis (HD), which is when a dialysis machine is used to externally filter and clean the blood.

In addition, Aintree is currently failing to meet standards around timely access for patients to start peritoneal dialysis (PD), which is a way of filtering the blood without the need for a dialysis machine. This is mainly due to limited surgeon availability and limited theatre time to insert the catheter which is required for the procedure.

Both hospitals also have different models of care for managing patients with acute kidney injury. Harmonising the best practice across both hospital sites is required to ensure that all patients treated by the service get the same quality of care and the best outcomes possible.

Staff shortages

The way that the nephrology service is currently set up means that consultants, nurses and other clinical specialists are spread too thinly across multiple hospital sites. This can lead to some patients receiving a poorer quality of care than others.

For example, Aintree University Hospital is currently unable to provide 24-hour access to a nephrology-led care for patients requiring acute haemodialysis (dialysis) services. Instead, they are only able to provide this service 8am - 6pm. Outside of these hours, dialysis for inpatients at Aintree is provided in the Critical Care Unit, where patients do not have specialist nephrology care.

Likewise, nursing levels do not always meet NHS recommendations for renal care at either Aintree or the Royal Liverpool. Both hospitals struggle to achieve the 1:3 patient to staff ratio which is recognised as best practice for renal patients. Instead, they tend to rely on rotating staff between wards to ensure sufficient cover, and using agency staff to fill the gaps, which can make it difficult to achieve continuity of care for patients.

These issues around staff shortages can also mean that there are fewer staff available to support home therapy options, which can be a more flexible and convenient way for some patients to receive their care.

The proposed solution for the future

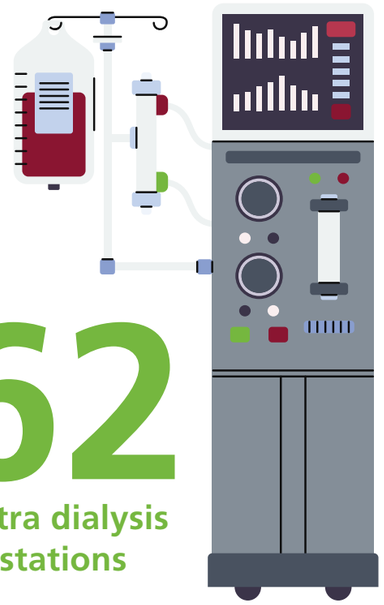
After exploring several potential options for improving nephrology services, the following 'preferred' option has been identified:

The proposed solution is to create a single Merseyside and Cheshire Regional Renal Service, based at the Royal Liverpool Hospital.

This new renal centre would be purpose-built, to provide both planned and emergency renal care, and would offer more capacity for the service. It would include an increase in beds for kidney care, and more dedicated beds for transplant patients. A larger number of dialysis stations (62 in total) is also planned.

Centralising renal care in this way would mean that Aintree University Hospital would no longer have any inpatient renal beds (inpatient beds are for treatment requiring an overnight stay in hospital), but it would still have a renal consultant presence and retain the ability to provide dialysis for patients at the hospital with renal failure.

The satellite sites based at Broadgreen, St Helens, Warrington, Halton, Aintree, Waterloo, and Southport would continue to operate just as they do now.



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extra dialysis stations

However, by reducing duplication between Aintree and the Royal Liverpool, more resources and staff time could be freed up to help enhance the offer at these units – meaning more patients could receive care closer to home.

It would also allow the service to provide an expanded Community Dialysis Team, able to support more patients with dialysis at home than is currently possible.

Increased resources

What impact would this have on patient care?

Clinicians involved in delivering this service believe that making these changes would offer a number of key benefits for patients and the quality of care they are able to receive:

Better health outcomes

Ensuring that patients are cared for by doctors and nurses who are specialists in nephrology would lead to shorter hospital stays, reduced chance of readmission to hospital, and reduced mortality rates.

More equitable care

Reorganising nephrology staff to work as a single, unified team providing all aspects of kidney care would help address current variations in care, and ensure that all patients receive timely access to life-saving transplants and other treatments.

More efficient use of staff

Reducing the number of different hospital sites that the nephrology inpatient team are spread across would help streamline the service, address staffing issues, and help improve capacity within the service.

Enhanced patient experience

Centralising the service would also help free up staff time in order to support more patients to access dialysis at home, and improve their quality of life.

Drawing together best practice

Taking the best of existing systems and practices from each hospital site could help to enhance patient care, particularly in those areas where the service is currently failing to meet national standards.

More space

Reshaping the service in this way would also help to address the estates issues, as more space will be available for the service at the Royal Liverpool Hospital, as part of a new, purpose-built facility.

Co-location with related services

Moving all renal care to the Royal Liverpool would mean that patients would benefit from closer collaboration between the nephrology team and a number of other supporting services such as interventional radiology (imaging and diagnostic testing), and transplant care.

Better use of resources

Reducing duplication in the service would also create financial savings, as expensive equipment wouldn't need to be purchased for two separate hospital sites, which could be reinvested into improving other parts of the service.

Future sustainability

Improving capacity in the service now would also help ensure that it is able to continue to meet growing patient numbers from across the region in the future.

Wider impact benefits

In addition, making these changes would also provide a number of important benefits for nephrology staff:

More opportunities for learning and development

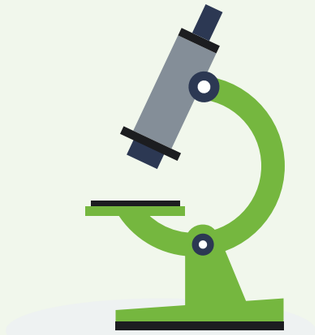
Working as part of a larger unit would provide more opportunities for collaboration, learning, career progression and specialisation for staff.

Improved recruitment and retention

Improving the working environment would support staff recruitment and retention, and help to make the service more resilient for the future.

Better for innovation and research

Being part of a larger, specialist unit would provide more opportunities for research and development, which benefits both staff and patients.



How would patient access change if this proposal went ahead?

These plans would mean that in the future all inpatient renal care would be based at the new Royal Liverpool Hospital.

However, any patients presenting at Aintree University Hospital with life-threatening renal emergencies would continue to benefit from fast access to an on-site nephrology consultant and dialysis presence. Once stabilised, the patient would then be transferred to a renal bed at the Royal Liverpool Hospital, where they would receive ongoing care from a larger specialist nephrology team.

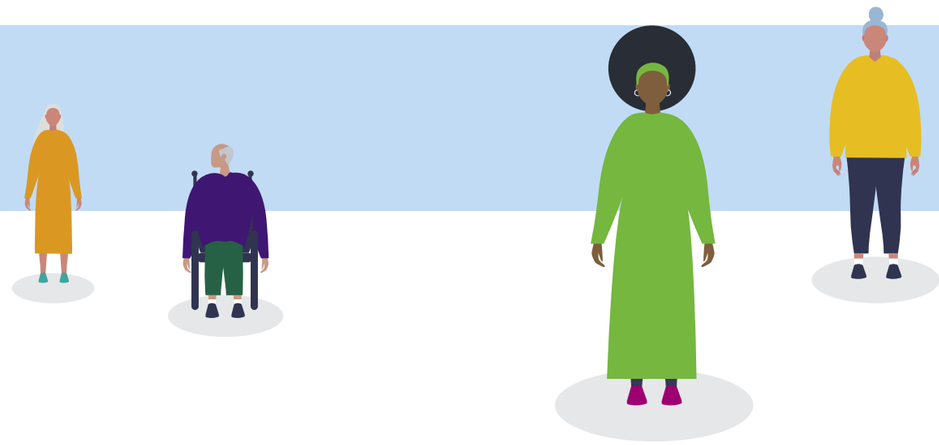
For some patients, this might mean travelling further for planned or emergency renal care than they do now. This might also mean that people visiting them in hospital would need to travel further too.

We understand that for some people, particularly those who rely on public transport, the idea of a longer journey to visit someone in hospital might be a concern. However, nephrology clinicians believe this option to be the strongest because it would create a single, centralised 'expert' hub with a more resilient, combined workforce, and would mean that the service is able to offer the same high-quality care to all patients.

How many patients could be affected?

The figures below from 2019/20 show the number of patients accessing nephrology services across the two hospital sites, and highlights the number of patients at Aintree University Hospital who could be affected by the change of location:

CCG area	Number of patients seen at Aintree Hospital	Number of patients seen at the Royal Liverpool Hospital
NHS Liverpool CCG	295	408
NHS South Sefton CCG	274	26
NHS Knowsley CCG	127	91
NHS Southport and Formby CCG	95	14
NHS St Helens CCG	4	83
NHS West Lancashire CCG	63	13
NHS Halton CCG	3	49
NHS Warrington CCG	1	45
NHS Wirral CCG	2	15
Other	81	96
TOTAL	945	840



Have any other options been considered?

Two other possible solutions were also considered for the future of the service, as part of an options appraisal process.

OPTION	SUMMARY
Do nothing – make no changes to the way that the service is currently run	Doing nothing would involve continuing with the existing nephrology service model across all three hospital sites. This option was considered to be the weakest because it would provide no scope for addressing current or future pressures on the service, for reducing variations in service, or for improving the overall quality of patient care.
All nephrology services move to Aintree University Hospital	This option would involve the majority of the nephrology services being based at Aintree University Hospital, instead of at the Royal Liverpool Hospital, with satellite units continuing as they are now. Although moving the service onto the Aintree site would offer some of the same benefits around reducing duplication and standardising care, a major problem with this option is that nephrology services would no longer be co-located with transplant services which are based at the Royal Liverpool Hospital. This would mean that any patients needing a kidney transplant would have to be transferred from Aintree to the Royal Liverpool Hospital for surgery, which would cause unnecessary delays and complications in their care. In addition, Aintree's renal unit is not currently fit for purpose. Upgrading it would be both costly and impractical as it does not offer adequate space to meet growing patient demand.

Full details are provided in the pre-consultation business case (PCBC), which is available at: www.futureLUHFT.nhs.uk

What would the cost be?

Making these changes to help improve nephrology care would not require a significant amount of extra investment – these plans are mainly about using existing resources in a more efficient way.

Capital costs

Since the cost of creating the new renal centre would already be covered within existing plans as part of building the new Royal, there are no additional costs for upgrading nephrology facilities.

Ongoing costs

However, there would be an additional staffing cost of £82,432 per year to cover the employment of extra renal dietetic specialists, required to achieve standards of care for dialysis patients.

There would also be an additional staffing cost of £235,060 per year to cover the employment of three physician associates and one advanced nurse practitioner, required to maintain the seven-day service across both the Royal Liverpool and Aintree sites.

These costs would be built into Liverpool University Hospital's financial plans from 2022/23 onwards, but part of this cost would also be offset by a number of efficiencies gained through better ways of working and reducing duplication.

How to share your views

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Urology

Urinary tract and male genital tract

About the service

Urology services provide care for conditions that affect the urinary tract and male genital tract. This includes treatment for prostate, bladder, kidney and testicular cancer, and some very common but debilitating conditions such as kidney stones, lower urinary tract symptoms, and urinary sepsis.

How and where is care currently delivered?

Liverpool's urology inpatient care (any treatment requiring an overnight stay in hospital) is currently delivered across two separate units – one based at the Royal Liverpool Hospital, and one at Aintree University Hospital.

Although a single leadership team has been in place since November 2020, when the two hospitals merged into a single organisation, both units have continued to function as mostly separate services, which provide the same type of operations and procedures.

The main exception to this is the provision of some complex, specialist cancer cases.

For example, radical prostatectomy (removal of the whole prostate gland) and radical cystectomy (removal of the whole bladder) are cancer treatments that have only been provided at the Royal Liverpool Hospital, which has acted as a specialist centre for the whole region for 15 years as part of a national programme to improve cancer surgery outcomes.

Outpatient clinics for the service are provided at both Broadgreen Hospital and Aintree University Hospital.

How many patients use the service?

Typically, more than 80% of all patient attendances for urology happen in outpatient services. These are currently provided at both Aintree University Hospital and at the Royal Liverpool Hospital.

The chart below shows how many people were treated as urology inpatients (care which involves an overnight stay in hospital) at both Aintree and the Royal Liverpool during 2021/22:

Number of urology inpatients

Hospital	Planned care	Emergency care
Aintree University Hospital	422	719
Royal Liverpool Hospital	928	967

Where urology inpatients travel from, and to which hospital

CCG area	Number of patients and % for Aintree Hospital	Number of patients and % for the Royal Liverpool Hospital	Total
NHS Liverpool CCG	601 (39%)	804 (59%)	1405
NHS South Sefton CCG	595 (39%)	24 (2%)	619
NHS Knowsley CCG	198 (13%)	66 (5%)	264
NHS Wirral CCG	11 (1%)	21 (2%)	32
NHS St Helens	6 (<1%)	26 (2%)	32
NHS West Lancashire CCG	24 (2%)	11 (1%)	35
NHS Southport and Formby CCG	31 (2%)	22 (2%)	53
NHS Halton CCG	1 (<1%)	11 (1%)	12
NHS West Cheshire CCG	4 (<1%)	11 (1%)	15
NHS Warrington	10 (1%)	15 (1%)	25
Wales	2 (<1%)	49 (4%)	51
Other	51	295	346
TOTAL	1534	1355	2889

Please note: these figures are taken from 2019/20, and have been rounded up/down to the nearest whole number.

Why is change needed?

There are a number of reasons why the urology service is not working as well as it could:

Rising demand

The urology service has seen a steady growth in patient numbers over recent years, which means that it is now struggling to cope with the current levels of demand for treatment and care.

For example, between 2016 to 2019, the number of patients referred for an urgent urology appointment because of suspected cancer increased by nearly 18%.

This increase in demand is partly due to the growth of cancer screening programmes, which are helping to identify more people with early-stage cancers that need treatment than ever before. It could also be partly due to lifestyle factors such as the growing levels of obesity across the population, which is linked to a number of urological conditions such as kidney stones.

Patient waiting times

This growing demand for care has seen the length of time that patients wait for routine treatment by the urology service increase, both for general elective (planned) procedures and for a cancer diagnosis.

It's a problem that has also been made worse by the temporary suspension of many planned procedures during the COVID-19 pandemic.

As a result of these issues, the service is currently failing to meet a number of NHS standards and targets as demonstrated by the table on the opposite page.

Urological cancer care waiting times	LUHFT patients 04/19–03/20	England average 04/19-03/20
Achievement of 2 week wait - between referral to seeing a specialist	**87.1%**	**94.5%**
Achievement of 31 day wait - from diagnosis to treatment	**85.8%**	**95.3%**
Achievement of 62 day wait - from referral to treatment	**60%**	**72%**
Source: NHS England		
Outpatient referral to treatment times		
Achievement of 18 week wait - % of patients waiting less than 18 weeks to be seen	**74.9%**	**82%**
Achievement of 52 week wait - % of patients waiting more than 52 weeks	**0%**	**0.1%**
Average number of weeks patients waited	**8.5 weeks**	**7.3 weeks**
Source: NHS England		
Inpatient referral to treatment times		
Achievement of 18 week wait - % of patients waiting less than 18 weeks to be seen	**75.7%**	**72.1%**
Achievement of 52 week wait - % of patients waiting more than 52 weeks	**0%**	**0.4%**
Average number of weeks patients waited	**9.1 weeks**	**9.9 weeks**
Source: NHS Digital		

Getting diagnosed and treated quickly can make a real difference to patient outcomes, particularly in cancer treatment, so it's important to make the best use of resources to bring down waiting times and achieve better wait time standards.

Why is change needed?

Future sustainability

Not only is there already high demand for urology services, but this trend is also expected to continue over the next few years.

13.8%
Predicted increase of cancer referrals over the next decade

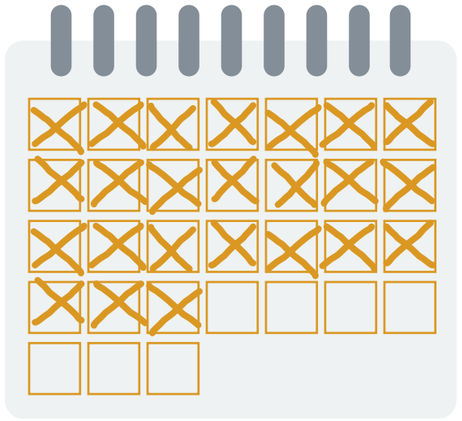
Data from the Office of National Statistics (ONS) predicts that the total number of cancer referrals will increase by 13.8% over the next ten years. It also indicates that the number of newly diagnosed prostate cancers is likely to rise by 1.8% per year (17.8% over ten years), bladder cancer by 2.1% per year (21% over ten years), and kidney cancer by 1.3% per year (13.4% over ten years).

In order to meet these rising levels of demand for urology, we need to plan for the future now.

Variations in care

The way that urology is currently organised means that people might receive a different standard of care, depending upon which hospital they are seen in – Aintree, Broadgreen or the Royal Liverpool.

This can mean that urology patients at each hospital might have different waiting times for their treatment, and they might also have access to different clinical equipment and facilities too.



Doctors and nurses working in urology believe that if the service was organised in a different way they could offer the same high level of care to all patients – wherever they live.

Clinical workforce issues

The urology service performs some of the most complex urological procedures in the region, and ensuring that the right specialist staff are in the right place at the right time is crucial to patient safety.

Evidence shows that patients receive the best surgical care when this is provided by a very specialist clinical team who regularly perform the same procedures. However, the way that urology is currently structured, with specialist consultants and nurses spread thinly across three hospital sites, means that this is not always possible.

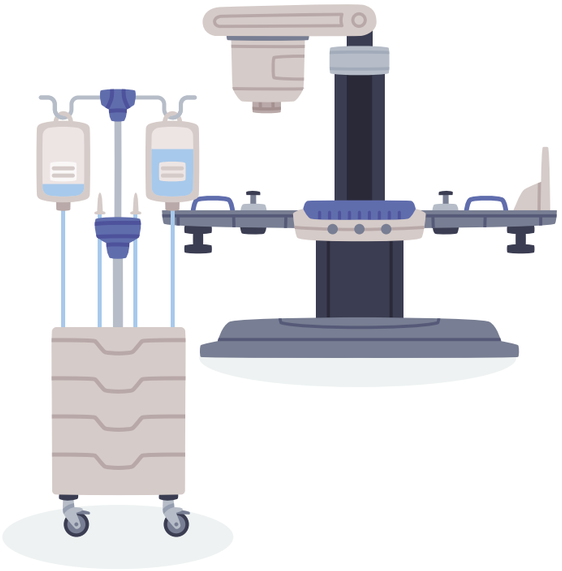
For example, it can be difficult to find enough consultants to work across both hospital sites, and to cover both emergency and planned operations. Because of this, the service often has to rely on locum shifts (temporary staff cover).

Caring for urology patients often requires specialist nursing skills, for procedures such as washing out the inside of the bladder, but spreading urology inpatient care across two sites means that patients aren't always cared for by urology nurses who are trained in these skills.

Duplication of resources

Urological care requires a lot of specialised equipment which is expensive to buy and maintain, and at the moment this has to be provided at both the Royal Liverpool and Aintree.

Reducing duplication of care across these hospital sites would save a significant amount of money, which could be better invested into growing the service in a way that would reduce patient waiting times.



The proposed solution for the future

After exploring several different options, the following solution has been identified as the preferred option for urology services: **that all inpatient care would take place at a single unit based at the new Royal Liverpool Hospital**.

Outpatient services and day case procedures would continue to take place at both the Royal Liverpool Hospital and Aintree University Hospital, but would no longer take place at Broadgreen Hospital.

Clinicians in the urology service feel that this is the best option because **it would provide access to a single, centralised 'expert' hub** able to offer high quality inpatient care and surgery around the clock, whilst also enabling patients to continue to receive less complex outpatient care in a hospital site closer to home.

Inpatients

Royal Liverpool Hospital

Day case

Royal Liverpool and Aintree sites

Outpatients

Royal Liverpool and Aintree sites

What impact would this have on patient care?

Clinicians in the urology service believe that making these changes would offer a number of key benefits for patients and the quality of care they receive:

Better patient outcomes

Ensuring that patients are cared for by doctors and nurses who are specialists in urology, which would lead to improved health outcomes.

Improved patient experience

Delivering the service across fewer sites will help to streamline services and provide better continuity of care.

Reduced patient waiting times

Reducing the number of different hospital sites that the urology team are spread across would help address staffing and capacity issues, meaning more patients could be seen more quickly.

A more equitable service

Bringing all surgery and inpatient care onto a single hospital site would help address current variations in care, and ensure that all patients receive the same high standard of care.

Future sustainability

Improving capacity in the service would help ensure that it is able to meet growing patient numbers in the future.

Drawing together best practice

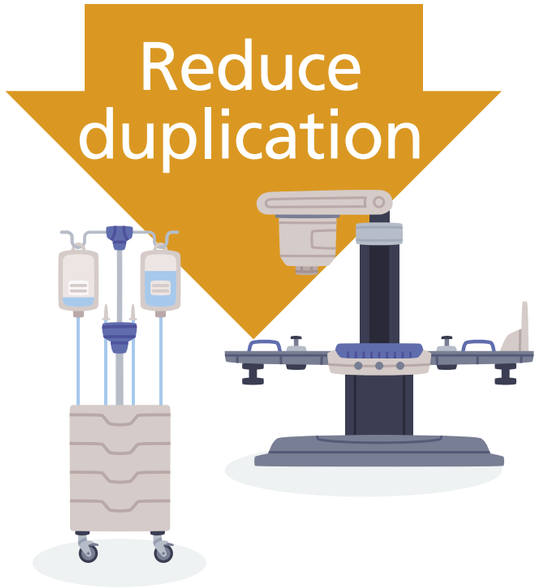
Providing greater opportunity to improve patient care by taking the best of existing practices from each hospital.

More resilient service

Bringing together all surgery and inpatient care onto one site would make it much easier to provide 24-hour expert emergency cover from urologists for all patients.

Better use of resources

Creating a substantial reduction in duplication of expensive specialist equipment would free up resources that could be better invested into other aspects of care.



Wider impact benefits

In addition, it would provide a number of important benefits for urology staff and improvements to their working environment:

Improved staff recruitment and retention

Working as part of a larger unit would provide more opportunities for training, learning, career progression and specialisation for staff.

Better for innovation and research

Being part of a larger unit would provide more opportunities for research and development, which can benefit both staff and patients.

Greater collaboration

Offering greater potential for collaboration between urology and a number of other inter-dependent services located on the same site such as radiology (imaging), oncology (cancer treatment), nephrology (kidneys), histopathology (body tissue) and more.

What would this mean for the way people use services?

Changes to emergency and inpatient care

If these changes went ahead, urology patients who require any form of emergency assessment or surgery or inpatient care (care requiring an overnight stay) would access this at the new Royal Liverpool Hospital in the future.

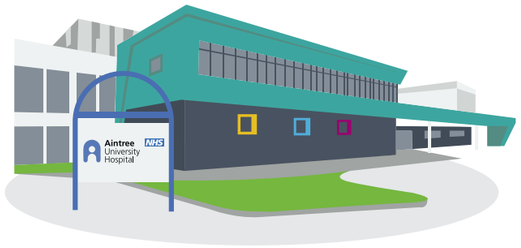
This would be delivered from a new 42-bed unit, divided between an elective (planned) and non-elective (unplanned) care zone – each with its own specialist nurse team. The number of beds needed for planned and emergency care can vary, so the unit would be designed to be used flexibly to allow the team to make the most of all the beds available, depending on what is needed.

For patients who would currently have their inpatient care at Aintree, moving this treatment to the Royal Liverpool might mean travelling slightly further away from where they live to have an operation in the future. This might also mean that people visiting them in hospital would need to travel further too.

We understand that for some people, particularly those who rely on public transport, the idea of a longer journey to visit someone in hospital might be a concern. However, we believe that improving standards of care and health outcomes for patients outweighs this short-term inconvenience.

Changes to day case care

An increasing number of urology procedures that used to require a hospital stay can now be done as day cases or in outpatient settings. This includes a lot of penoscrotal surgery (penis and scrotum), cystoscopy (a procedure to look inside the bladder using a small camera), biopsy (taking a small sample of body tissue for examination), and stent (a small internal plastic tube that allows the kidneys to drain better) changes.



Under these proposals, these kinds of procedures would be performed at Aintree Hospital as day cases, to help free up theatre and bed space at the new Royal Liverpool Hospital.

However, day case procedures which are more complex and more likely to see patients needing a hospital admission afterwards will be provided at the new Royal Liverpool Hospital. This is to prevent them requiring a transfer for access to specialist equipment and care. Instead, after their procedure, they will be looked after in a 20-room facility alongside the theatre.

This includes treatments such as ureteroscopy (a procedure which involves a small camera being passed through the urethra and bladder), and laser stone fragmentation (a procedure which breaks up kidney stones with small shock waves).

If the changes went ahead, most patients who would currently go to the Royal for their day case urology care would be treated at Aintree instead. Similarly, some patients having day case procedures with a higher risk of hospital admission afterwards, would be treated at the Royal.

For some, this might mean a slightly longer journey to hospital, depending on where they live. But again, we believe that the improved patient outcomes out-weigh the inconvenience this might cause.

Changes to outpatient care

Under these proposals, urology outpatient clinics would no longer be provided at the Urology Centre at Broadgreen Hospital. Instead, they would take place across both Aintree University Hospital and at the new Royal Liverpool Hospital.

Some of the main outpatient services, including cancer diagnostics (imaging tests) and continence (bladder and bowel function) services, would be located at both Aintree and the Royal Liverpool.

Most other urology outpatient services such as andrology (male reproduction), reconstructive urology (surgical repairing), and urodynamics (tests used to check the function of your bladder and urethra) would be located at Aintree.

However, some of the outpatient procedures more likely to result in a hospital admission would take place at the new Royal Liverpool, such as complex cancer care, and stone services, including lithotripsy (using pressure waves to break up stones).

Like urology inpatient and day case care, these changes to outpatients would also mean that some people might have a slightly longer journey to their appointment than they do currently.

Have any other options been considered?

A number of different potential solutions were considered for urology services:

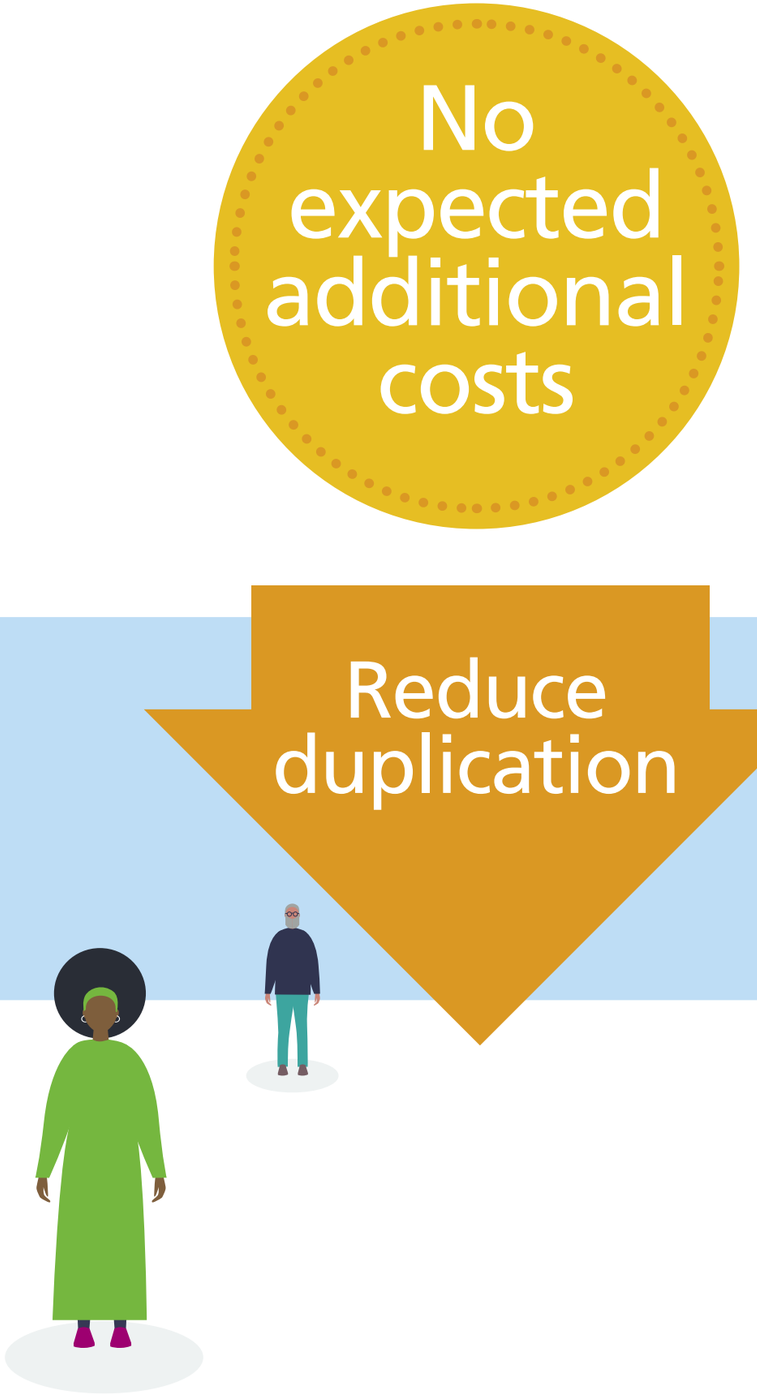
OPTION	SUMMARY
Do nothing – make no changes to the way that the service is currently run	This option was considered to be the weakest, as it provides no scope for addressing current or future pressures on the service, reducing patient waiting times, or improving the quality of patient care, with resources still spread thinly across three sites.
Deliver all inpatient care at the new Royal, and outpatient care at Broadgreen and Aintree	This option provides scope for reducing patient waiting times for both planned and unplanned care, and for ensuring that all surgery patients have access to the same specialist facilities and staff. However, it would mean patients from north Liverpool with urological emergencies being diverted to the new Royal, and those who go to Aintree's A&E would also need transferring to the Royal Liverpool. In addition, staff would still be dispersed across three sites, reducing their availability for inpatients. Staff rotas and continuity of care would still be difficult, and equipment would still need to be duplicated too.
Deliver planned inpatient care at the new Royal, emergency care at Aintree, and outpatient care at Broadgreen and Aintree	This option also provides scope for reducing patient waiting times for both planned and unplanned care. However, there would still be duplication of surgical equipment across two sites, and urology specialists would still be dispersed across three sites, meaning staff rotas and continuity of care would still be difficult. It would also mean patients from south Liverpool with urological emergencies being diverted to Aintree, and those who go to the Royal Liverpool's A&E would also need transferring to Aintree.
Deliver all inpatient care at Aintree, and outpatient care at both Aintree and Broadgreen	This option allows many of the same advantages as the previous two options, but with the single inpatient site at Aintree instead of at the new Royal. However, moving the existing large urology inpatient service from the Royal Liverpool to Aintree would put significant demand on ward and theatre space in the hospital. Also, if there was no urology presence on the new Royal Liverpool site it would introduce new complications to other areas of care. For example, different arrangements would be needed to cover urological referrals, particularly from renal (kidney) medicine.
Deliver all inpatient care at the new Royal, and develop a new urology centre for outpatients at Broadgreen	This option also allows many similar advantages around reducing patient waiting times for both planned and unplanned care and ensuring that all surgery patients have access to the same specialist facilities and staff. However, if all outpatient services were based at Broadgreen, this would mean that north Liverpool patients would have to travel further for routine appointments as there would no longer be any urology care at Aintree.
Deliver all inpatient and outpatient care at the new Royal Liverpool Hospital	Having a single site for all urology services is the chosen model for many units within the country because it enables the greatest integration and streamlining of care. This option also provides scope for reducing patient waiting times for both planned and unplanned care and ensuring that all surgery patients have access to the same specialist facilities and staff. However, it would also reduce outpatient care to just one city-centre hospital site, taking care further away from home for many patients who attend a clinic. This large increase in urology outpatient activity would require additional space at the new Royal Liverpool – which is not feasible under current plans for the site.

Full details are provided in the pre-consultation business case (PCBC), which is available at: www.futureLUHFT.nhs.uk

What is the cost of making this change?

The proposed changes are not expected to incur any additional costs because the new facilities are already covered within the costs of building the new Royal Liverpool Hospital.

In addition to this, there would also be some efficiency gains created through reducing duplication of equipment, and by organising staff rotas in a better way.



How to share your views

You can take part in this public consultation and share your views on the proposed changes to any (or all) of the five services in the following ways:

Fill in a questionnaire at

www.futureLUHFT.nhs.uk

If you would like a paper copy of the questionnaire, or need it in a language other than English, or in a format such as braille or large print, contact NHS Liverpool Clinical Commissioning Group (CCG) using the details below.

EMAIL US: future.LUHFT@nhs.net

CALL US: 0151 247 6406

TEXT US: 07920 206 386

Our email account and phone lines are monitored Monday to Friday, 9.00am to 5.00pm (Please note: NHS Liverpool CCG is organising this consultation on behalf of all the CCGs and hospital trusts involved, so we're the point of contact for all enquiries, not just those from Liverpool residents.)

Join an online meeting

We're also organising a number of **online meetings**, which will be a chance to hear more about the proposals set out in this booklet, and to take part in some focus-group discussions. Visit **www.futureLUHFT.nhs.uk** for details of when these events are taking place and how to sign up.

Stay updated

You can also register your email address at **www.futureLUHFT.nhs.uk** to receive updates direct to your inbox.

Vascular

Arteries, veins and lymphatic system

HAVE YOUR SAY **Where care and treatment happens at Liverpool University Hospitals www.futureLUHFT.nhs.uk**

About the service

Liverpool Vascular and Endovascular Service (LiVES) provides both emergency care and planned treatment to patients with blood vessel disorders (diseases of the arteries, veins and lymphatics).

The service cares for patients from across Merseyside, as well as a growing number of patients requiring this specialist care from elsewhere in the north of England, the Isle of Man and North Wales.

How and where is care currently delivered?

The LiVES service works as a single team, but based across several different local hospital sites.

The main site for the service is the Royal Liverpool University Hospital. This is where all emergency referrals into the service are sent, and all inpatient care (treatment that requires an overnight stay in hospital) is provided. Meanwhile, routine outpatient appointments and day cases are delivered from four smaller satellite sites based at Aintree University Hospital, Whiston Hospital, Southport Hospital and Liverpool Heart and Chest Hospital.

How many patients use the service?

The chart below shows which areas patients come from for treatment by the service. The figures shown are for 2019/2020:

Emergency (unplanned) care

CCG area	Number of patients and %
NHS Liverpool CCG	143 (43%)
NHS Knowsley CCG	41 (12.5%)
NHS St Helens CCG	38 (11.5%)
NHS South Sefton CCG	31 (9%)
NHS Southport and Formby CCG	26 (8%)
NHS Halton CCG	11 (3%)
NHS West Lancashire CCG	10 (3%)
NHS Wirral CCG	4 (1%)
NHS Warrington CCG	3 (1%)
Wales	2 (1%)
Other areas	23 (7%)
TOTAL	**332**

Planned care

CCG area	Number of patients and %
NHS Liverpool CCG	213 (35%)
NHS Knowsley CCG	81 (13%)
NHS South Sefton CCG	80 (13%)
NHS St Helens	54 (9%)
NHS Southport and Formby CCG	52 (9%)
NHS West Lancashire CCG	23 (4%)
NHS Halton CCG	21 (3%)
Wales	13 (2%)
NHS Wirral CCG	11 (2%)
NHS Warrington CCG	7 (1%)
Other areas	53 (9%)
TOTAL	**608**

Please note: these percentages have been rounded up for ease.

Why is change needed?

There are a number of reasons why the vascular service is not working as well as it could, and therefore not providing patients with the best possible quality of care. Each of these issues are explained in more detail below.

Lack of theatre and bed space

The single biggest challenge within the current LiVES service is that it doesn't have enough operating theatre space, or enough dedicated beds, to support the number of patients requiring care.

The LiVES service currently delivers most of its daily emergency and inpatient care from the Royal Liverpool Hospital. Only day case operations take place at Aintree University Hospital.

This lack of available theatre and bed space puts considerable strain on the service and its ability to effectively meet patient demand for the service. It also makes it difficult to effectively plan for any future increase in demand, which is expected as a result of a growing number of people living with diabetes, and an ageing population.

Staff shortages for interventional radiology

It can be difficult for the vascular service to attract and keep staff, particularly within interventional radiology (IR), which is a key support service for LiVES.

Interventional radiologists use X-rays, CT and ultrasound imaging to guide instruments through the body in order to diagnose and treat patients in the least invasive way possible. Having 24-hours-a-day, seven-days-a-week access to interventional radiology is widely considered to be essential to the smooth running of vascular care services.

The LiVES service does not currently have access to around-the-clock interventional radiology support at the Royal Liverpool Hospital. This is because there are not enough vascular IR consultants available.

This lack of access to the right imaging staff and equipment can lead to delays in treatment, and can mean that the overall experience of care that some patients have isn't as good as it could be.

Hospital transfers

LiVES is an internationally recognised vascular unit, delivered by a highly skilled and experienced team of consultants, radiologists and other specialist staff. Because of this, the service takes patient transfers from other hospital units from across the region and beyond, including from other parts of the north of England, the Isle of Man and North Wales.

These transfers are mainly for diabetes and stroke patients requiring arterial reconstruction, limb amputation or carotid endarterectomy (removal of fatty deposits in the carotid artery). Many of these patients arrive in the service with very complex medical and rehabilitation needs which require a lengthy period in an operating theatre, and a long hospital stay during their recovery afterwards too.

Arranging the transfer of very sick patients between hospital sites can be complex and time-consuming to arrange and can cause delays to their emergency care while theatre and bed space is found.

Reducing the need for patient transfers between different Liverpool hospital sites by putting vascular services alongside other related services such as stroke, diabetes and orthopaedics based on the Aintree site, would help to alleviate this problem.

There is currently a stroke unit at the Royal Liverpool Hospital, however there are plans underway to create a single Comprehensive Stroke Centre at Aintree University Hospital, subject to the outcome of a public consultation and final decision-making.

How the service currently performs against national standards

Based on data from the National Vascular Registry (NVR) for 2018 – 2020, the LiVES service is one of the busiest vascular units in the country and achieves good outcomes for its patients.

However, the service is performing poorly when it comes to length of time between referral and treatment. This is largely due to a lack of theatre space, lack of patient beds, and staffing shortages.

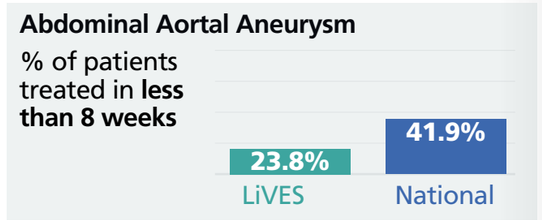
Because of this, the service is currently failing to meet national standards and has been put into special measures (an NHS improvement process for services where there are serious concerns about the quality of care) for three key procedures. These include:

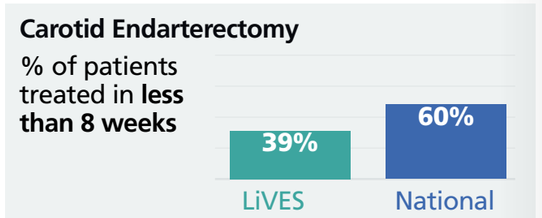
- **Abdominal Aortal Aneurysm (AAA)** – a bulge or swelling in the aorta, the main blood vessel that runs from the heart down to the chest and stomach, which can rupture (burst) and cause life-threatening bleeding.

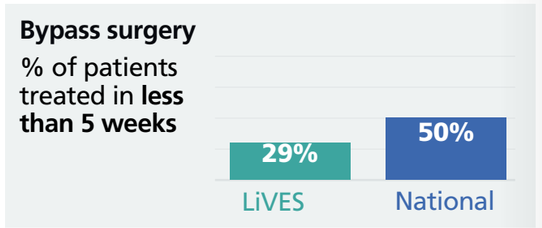
- **Carotid Endarterectomy (CEA)** – a surgical procedure to remove a build-up of fatty deposits which cause narrowing of a carotid artery (the main blood vessels that supply blood to the neck, face and brain).

- **Critical Limb Ischaemia (CLI)** – this is the stopping or restraint of blood to critical limbs, and failure to treat it quicky can result in limb amputation.

The diagram below shows in more detail how the LiVES service is performing on patient waiting time targets, compared against the national average in several key areas of vascular care:







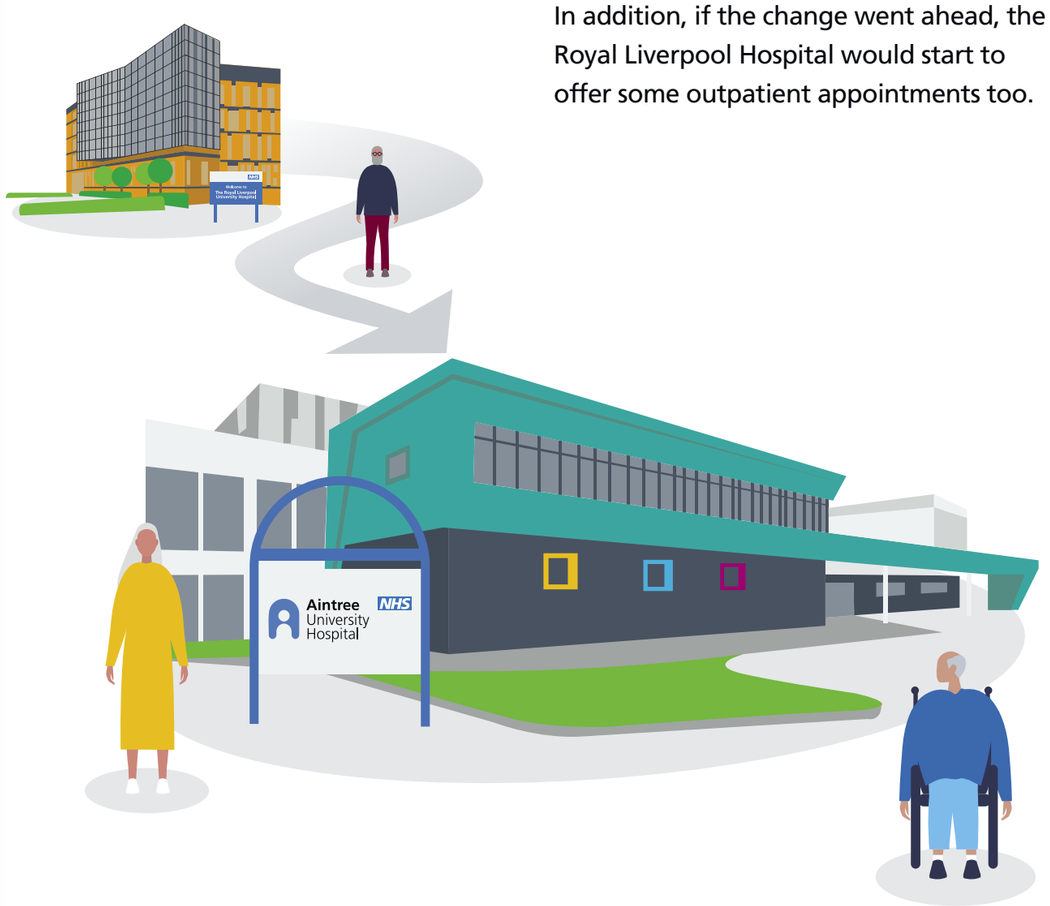
The proposed solution for the future

The preferred solution for the future is to **move all emergency and inpatient vascular care from the Royal Liverpool Hospital to Aintree University Hospital.**

This would provide more space for the service to expand into and enable the service to fully address the current clinical challenges it faces around staffing, theatre space, bed space, and timely access to diagnostic testing.

Under these plans, there would be no changes made to any of the current outpatient clinics for this service, which would continue to be offered at Whiston Hospital, Southport Hospital, and Liverpool Heart and Chest Hospital, as well as on the Aintree University Hospital site.

In addition, if the change went ahead, the Royal Liverpool Hospital would start to offer some outpatient appointments too.



Expansion plans – a closer look

The proposed expansion plans are as follows:

Proposed change	Current provision at the Royal Liverpool Hospital	Future proposed provision at Aintree Hospital
An extra hybrid operating theatre space dedicated to vascular care	- 1 open theatre - 1 dedicated vascular hybrid theatre - Plus a small amount of extra capacity in a second hybrid theatre (alternate Thursdays only)	**- 1 open theatre** **- 2 dedicated vascular hybrid operating theatres**
Additional bed space for the service	A total of 37 beds	**A total of 44 beds:** **- 33 vascular beds** **- 7 intermediate care beds** **- 4 critical care beds**
Better access to diagnostic testing	Currently, the service has some access to MR, CT, and X-ray facilities	**The service would have greater pre-agreed access to MR, CT and X-ray facilities**
Development of a new purpose-built unit for the service	The current unit has: - a dedicated vascular clinic area - a vascular laboratory with office space and additional storage facilities	**The new unit would include:** **- a brand new outpatient facility** **- a vascular laboratory** **- more office space for administrative staff**
Lower Limb Prosthetic Centre would be expanded	The Lower Limb Prosthetic Centre (Donald Todd) at Aintree currently provides outpatient clinics only	**The Lower Limb Prosthetic Centre (Donald Todd) at Aintree would be expanded to provide inpatient care as well**

Future proposed provision at Aintree Hospital:

What impact would this have on patient care?

Clinicians involved in delivering vascular services believe that making these changes would offer a number of **key benefits** for patients, including:

Improving timely access to care

By increasing theatre capacity with an extra emergency operating theatre, which will lead to fewer delays in investigations and treatments.

Enhancing the quality of emergency vascular care provision

By co-locating the service alongside the trauma centre for Cheshire and Merseyside, which has been based at Aintree University Hospital for a number of years.

Reducing the need for patient transfers between different hospital sites

By putting vascular services alongside related services such as stroke, diabetes and orthopaedics, which are also based on the Aintree site.

Reduce
patient transfers

Helping meet national care standards

By addressing bed and theatre capacity issues and reducing the amount of time it takes to treat patients.

Increasing capacity and access to diagnostic testing facilities

Which will reduce delays in care, shorten lengths of stay in hospital, and improve medical outcomes for patients.

Providing access to a lower limb prosthetic inpatient facility

Which is already based on the Aintree site, allowing a better experience for patients requiring amputation and rehabilitation care.

Wider impact benefits

Increasing opportunities for learning and development amongst staff

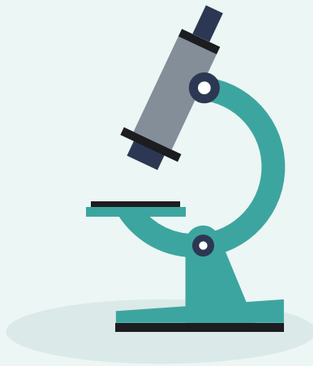
Because working as part of a larger unit would provide more opportunities for collaboration, learning, career progression and specialisation for staff.

Improving staff retention and recruitment

By improving the working environment for staff, which would help to make the service more resilient for the long term.

Supporting the LiVES centre to become a centre of excellence

By creating greater opportunities for research and development.



How would patient access change if this proposal went ahead?

Changes for those receiving emergency and inpatient care

Because this change would involve moving care from the Royal Liverpool Hospital to Aintree University Hospital, it would mean that some patients would have a shorter journey to access their care, while others would have a longer journey, depending on where they live.

Patients who are based at other hospitals such as Southport, Whiston, or Liverpool Heart and Chest Hospital would still need to be transferred by ambulance in an emergency situation, just as they are now.

Redirecting these transfers to Aintree instead of the Royal Liverpool would not increase the number of transfers or make them more complex. However, the increase in bed and operating theatre capacity that would be possible on the Aintree site would mean these transfers could happen more quickly.

The chart below shows the total number of patients seen by the LiVES service for inpatient care at both Aintree and the Royal Liverpool (2019/20) who could be affected by this change

CCG Area	Aintree Planned	Aintree Emergency	Royal Liv Planned	Royal Liv Emergency
NHS Liverpool CCG	76	3	137	140
NHS Knowsley CCG	22	1	59	40
NHS South Sefton CCG	35	1	45	30
NHS St Helens CCG	5	0	49	38
NHS Southport and Formby CCG	8	0	44	26
NHS West Lancashire CCG	3	1	20	9
NHS Halton CCG	0	0	21	11
NHS Wirral CCG	1	0	10	4
Other	3	0	70	28
TOTAL	153	6	455	326

Changes for those receiving outpatient care

If these plans went ahead, it would also mean that the Royal Liverpool Hospital would start to provide some outpatient clinics alongside each of the existing clinic sites based at Aintree University Hospital, Southport Hospital, Whiston Hospital, and Liverpool Heart and Chest Hospital.

This change would offer greater patient choice of clinic locations for routine outpatient appointments in the future, and is likely to improve access to the service for a number of patients, particularly as the Royal Liverpool Hospital is based close to the city centre and therefore offers a wide range of public transport connections.

Patients who are currently attending outpatient clinics at other hospitals, such as Southport, Whiston, or Liverpool Heart and Chest, would continue to do so – there would be no change to how they access this care.

Have any other options been considered?

A brief summary of each of the alternative options that were considered for vascular services is provided below.

OPTION	SUMMARY
Do nothing – make no changes to the way that the service is currently run	This option would involve leaving the vascular service to continue to operate as it currently does, then moving it into the new Royal Liverpool Hospital when it opens. However, under plans for the new hospital, the service would have even less bed and operating theatre capacity than it currently does. This option wouldn't address any of the current capacity challenges, and could make them worse. It would also not enable any improvements to be made to patient care in the areas currently falling short of national standards. As a result, this option was deemed the least viable option.
Develop the Northern Aortic Centre at Liverpool Heart and Chest Hospital	This option would involve a formal collaboration with Liverpool Heart and Chest Hospital, so that more patients needing aortic procedures (the aorta is the body's main artery) would be treated there. One of the strengths of this option is that it would build on an existing arrangement that Liverpool University Hospitals has in place with Liverpool Heart and Chest Hospital, as the regional referral centre for complex thoraco-abdominal aneurysms and aortic dissections. In addition, moving more aortic procedures to Liverpool Heart and Chest Hospital could also help free up more theatre capacity and beds for other vascular patients based at the Royal Liverpool Hospital. However, this option doesn't offer as many benefits as the preferred option of relocating the service to Aintree University Hospital. This is because it would also involve splitting clinical teams across two sites, which would introduce some new clinical risks and staffing complications. It also wouldn't put the service alongside other inter-dependent services based at Aintree, such as trauma, orthopaedics, diabetes and stroke care.

Further details are provided in the pre-consultation business case (PCBC), which is available at: www.futureLUHFT.nhs.uk

What would the cost be?

The costs for this proposal to go ahead would include a one-off extra investment of £12.5million for the changes required to clinical spaces and equipment, including the creation of an extra theatre space at Aintree University Hospital.

It would also require some additional, ongoing costs associated with extra staffing (including an increase in on-call vascular consultants), plus some extra equipment and theatre consumables.

These costs would be fully financed within Liverpool University Hospitals NHS Foundation Trust's existing annual budget, but spread over the next few years.

£12.5m investment

How to share your views

You can take part in this public consultation and share your views on the proposed changes to any (or all) of the five services in the following ways:

Fill in a questionnaire at

www.futureLUHFT.nhs.uk

If you would like a paper copy of the questionnaire, or need it in a language other than English, or in a format such as braille or large print, contact NHS Liverpool Clinical Commissioning Group (CCG) using the details below.

EMAIL US: future.LUHFT@nhs.net

CALL US: 0151 247 6406

TEXT US: 07920 206 386

Our email account and phone lines are monitored Monday to Friday, 9.00am to 5.00pm (Please note: NHS Liverpool CCG is organising this consultation on behalf of all the CCGs and hospital trusts involved, so we're the point of contact for all enquiries, not just those from Liverpool residents.)

Join an online meeting

We're also organising a number of **online meetings**, which will be a chance to hear more about the proposals set out in this booklet, and to take part in some focus-group discussions. Visit **www.futureLUHFT.nhs.uk** for details of when these events are taking place and how to sign up.

Stay updated

You can also register your email address at **www.futureLUHFT.nhs.uk** to receive updates direct to your inbox.