Delivering Quality Healthcare for Hertfordshire (DQHH)

East and North Hertfordshire Maternity Services Full Business Case – executive summary

“Improving the health and welfare of mothers and their children is the surest way to a healthier nation.”

Professor Al Aynsley-Green, National Clinical Director for Children
1. **Executive Summary**

1.1 **Introduction**

The purpose of this full business case (FBC) is to present to the Trust and PCT boards and the East of England Strategic Health Authority (SHA), a case for change and to secure approval for the development of maternity services on the Lister Hospital site.

This document identifies and demonstrates the preferred option for the capital investment required for the consolidation of maternity services in east and north Hertfordshire. It is based on the strategic objectives and development plans contained in the Delivering Quality Healthcare for Hertfordshire (DQHH) business case (2007), which served as the strategic outline case for this project, and the subsequent outline business case (OBC) approved by the SHA in October 2008.

Once approval had been received, the detailed design process began to refine the requirements for the service. In the early stages of the design process, it became apparent that there was a clinical need for some enhancements to the scheme originally proposed. Namely greater refurbishment and improvement to the neonatal unit, an additional two birthing rooms in the consultant-led unit, and a separate but co-located day assessment unit. These developments are detailed further in section 1.9 of this summary.

1.2 **Strategic context**

The centralisation of women’s and children’s services onto the Lister Hospital site is one of the significant elements of delivering DQHH. It is based on the principles of ensuring service safety, viability and improving clinical outcomes for patients.

As part of DQHH it was agreed that women’s and children’s services would be developed as one of the initial phases of the overall masterplan for the Trust, this was to cover:

- centralisation of obstetric, gynaecology and paediatric services onto the Lister site
- construction of a Children’s Assessment Unit (CAU) in Lister A&E for all paediatrics, now complete and fully operational
- extending the existing Lister maternity unit, thus providing additional capacity and, improving both the choice and quality of settings for birthing women
- consolidation of level 1 and 2 neonatology services on the Lister hospital site
- the continued provision of ante and post natal outpatient care at the Lister, QEII and Hertford County sites and extending it to other care settings in the community

The business case incorporates the development of separate but co-located consultant-led and midwife-led birthing units in a newly constructed building adjacent to and connected with the existing maternity building.

The plan is to also expand the neonatal unit and inpatient services. The development of a separate centralised day assessment unit (DAU) in close proximity to the other maternity services has also been planned.

The proposal is consistent with national policy drivers for maternity and neonatal services and responsive to local service delivery proposals. In particular the Hertfordshire Primary Care Trusts review of the models of care required for pregnant women when acute services transfer from Hemel Hempstead to Watford and from the QEII to Lister.
The review, on behalf of the National Clinical Advisory Team, was carried out by Professor Allan Templeton, consultant obstetrician and gynaecologist, and Angela Canning, senior midwife.

The key recommendations of the Templeton Review relevant to this Trust include:

- welcoming the decision to centralise birthing services at the Lister Hospital in Stevenage and in particular, the proposed development of a co-located midwife-led unit
- encouragement for the enhancement of local midwifery-led community antenatal and postnatal services at Hemel Hempstead, St Albans and on the QEII site in Welwyn Garden City; the latter when maternity services are centralised at the Lister Hospital
- highlighting wider experience which indicates that community-based midwifery care makes an enormous contribution to the quality of maternity care
- support for the existing policy in Hertfordshire on home births, where current rates are above the national average

The full report is available on the PCT websites: www.enherts-pct.nhs.uk and www.wherts-pct.nhs.uk

1.3 Service objectives

1.4 Case for change

There are a number of key factors, both clinical and non-clinical which influence the reasoning behind moving from a multi-site service to a single-site acute maternity service at the Lister site as opposed to at the QEII. These include:

- it has proved unfeasible to expand the service or develop midwifery-led services at the QEII due to the lack of physical flexibility. This means the Trust is unable to provide choice to local women.
a fragmented service has resulted in differences in care pathways, limited use of staff rotation between sites and the lack of the critical mass required to facilitate service developments and improvements in quality.

some services, such as neonatal services, have already begun to consolidate under a previous consultation (Better care for sick children). All high-risk neonatal care is now centralised at the Lister site and level one provision cannot be sustained long term at the QEII. For more information on this consultation, please refer to the Trust website at www.enherts-tr.nhs.uk

there are a number of issues that have arisen through patient feedback, namely the lack of en-suite bathrooms within the delivery suite, lack of facilities for partners or carers to stay with early labouring women, concerns about low staffing levels, insufficient parent facilities in the neonatal unit and insufficient dedicated bereavement rooms.

the current two-storey building at the Lister is of a reinforced concrete and steel frame construction and is in reasonable condition, as is the single-storey neonatal and delivery wing; however refurbishment and decoration is overdue in many locations, particularly in the support facilities. The building will also benefit from alterations and refurbishment with regards to air-tightness, thermal performance and reduction of backlog maintenance.

the requirement to meet the European Working Time Directive (EWTD) would necessitate an increase in the numbers of medical staff required for a two-site service. The consolidation of maternity services onto one site mitigates against this. There are also opportunities to redress the balance within the maternity and neonatal care workforce between intermediate bands and lower staff bands.

1.5 Future activity projection

Activity modelling for both maternity and neonatal services has been conducted using the DQHH activity modelling database as a baseline which included past activity levels, future population trends and the impact of housing developments.

There has been an increase in demand on the QEII site as a result of changes to Hemel Hempstead and issues relating to patient choice may now result in a potential loss of catchment areas when the service moves to the Lister site. The potential long term affects of these have been assessed and included as alternative scenarios to assess the robustness of the original forecasts.

The Trust has adopted the projection of future birth activity to be around 5,500 births per annum in 2012/13. Additional to these figures it is projected that home birth will remain static which is currently at approximately 4.6%. This assumes a loss of activity from districts to the south of the county and a cumulative growth of 2.3% in deliveries within the planning horizon of 2012/13.

The new facilities have therefore been sized to accommodate 54 ante and postnatal beds, 17 delivery rooms (three with water birth facilities) and 30 neonatal cots. There will also be three induction/early labour rooms within the CLU. This configuration is needed to offer more flexibility for the future.

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1 Better care for sick children in east and north Hertfordshire consultation report – 10 February 2005
1.6 Workforce

The SHA, in its Looking to the Future review, has recommended that trusts should move to a 1:30 midwife to birth ratio over the next 2-3 year period. This ratio of midwife to birth is seen as imperative to achieving 1:1 maternity care in line with national guidance. This guidance applies irrespective of where services continue to be delivered either in a new maternity unit or in the current facilities. Within the neonatal unit, it is planned that the workforce profile will achieve BAPM guidance which is currently under review by the NHS neonatal taskforce.

It is accepted that this may not necessarily be achievable in the short term. However it needs to be considered within the context of a holistic maternity service whose workforce structure is both affordable and sustainable.

The current establishment of midwives was set in the early 1990’s. The criteria used were activity based and the number of midwives required to ‘safely’ staff the maternity unit. At the time, it was felt that there should be at least eight midwives per shift in a maternity unit.

A review of maternity services was carried out in 2008 and a business case to address the immediate low staffing ratios in midwifery has been developed by the women’s & children’s directorate. This has now been submitted to the PCT to aid with the commissioning process. The expectation is that this will be implemented in advance of the service changes proposed in this business case.

The move to one site would allow the service to be sustainable in the medium term and enhance the Trust’s ability to reach the above target in the long term.

Consolidation of maternity services will help to ensure:

- delivery of the NHS Plan, national policy guidance pertaining to maternity services and the recommendations of the Neonatal Review
- concentration of expertise (experience and skill) for the most effective delivery of services and improvement in local provision
- recruitment and retention of staff
- minimise inappropriate transfers of infants to other neonatal care units and eliminate inter-site transfer of infants. Therefore reducing the need for a minimum of one specialist qualified nurse to travel with the baby
- greater consultant availability to support maternity services as per Royal College guidance
- change the way care is delivered in order to achieve EWTD
- better outcomes for patients
- establish a ‘critical mass’ to make best use of specialist skills and expertise to focus care on:
  - sick and premature babies
  - women with complex premature births
- sharing of specialist skills and knowledge to aid the recruitment and retention of staff through increased job satisfaction
- improve the autonomy of midwives and developing their skills within the midwife-led unit, resulting in increased job satisfaction and supporting recruitment and retention

1.7 Option development

Five options were developed for review. Three of these were shortlisted for further consideration:

- do minimum - no service change, with facilities remaining on two sites
- part new build single-storey, re-use best of existing unit (option 2b)
- part new build two-storey, re-use best of existing unit (option 4h)

A non-financial appraisal workshop was held in June 2008 to analyse these in more detail. This was attended by clinicians; patients; facilities staff; the project team including health care planners; patient liaison and representatives from the Strategic Health Authority (SHA).

Participants worked in groups and were asked to score each possible location against agreed criteria. The groups were facilitated by members of the project team. Experts were available to answer technical questions during the group appraisal sessions.

The following seven criteria were used to review the service options (derived from the project objectives).

- quality of care
- accessibility
- sustainability
- feasibility and capacity
- quality of the physical environment
- deliverability
- human resources

As the appraisal was conducted using non-financial criteria it did not take into account financial and economic issues. Option 4h was the preferred option from this perspective. Subsequent to the approval of the OBC, some enhancements have been made to the scheme; however these would affect both options 2b and 4h. A further review identified that the results of the original option appraisal are still valid.

1.8 The preferred option

Option 4h involves the development of a two-storey new build extension to the north of the existing maternity department. The new build is planned to encompass a consultant-led unit on the ground floor and the midwife-led unit on the first floor. The new build will be linked to the existing building via a new central core.

The current inpatient, outpatient and refurbished neonatal accommodation (all within the existing building) would be retained with the latter expanded for increased cot numbers. A new maternity day assessment unit (DAU) is also planned within the existing building using an area that is currently allocated as office space.
The table below outlines the rationale behind creating the new maternity unit.

<table>
<thead>
<tr>
<th>Department</th>
<th>Main aims/objectives</th>
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<tbody>
<tr>
<td><strong>Midwife-led unit (MLU)</strong></td>
<td>- empower women who are giving birth to make informed choices concerning their care by providing a wide range of birthing environments&lt;br&gt;- ensure privacy and dignity at all times and for all women during labour and postnatal recovery&lt;br&gt;- accommodate the psychological needs of mothers and their families&lt;br&gt;Also to provide the following:&lt;br&gt;- midwife-led care with the midwife as the lead practitioner&lt;br&gt;- facilities to support normal births including water births&lt;br&gt;- one-to-one care for women in established labour&lt;br&gt;- short term postnatal care prior to discharge home</td>
</tr>
<tr>
<td><strong>Consultant-led unit (CLU)</strong></td>
<td>- empower women who are giving birth to make informed choices concerning their care&lt;br&gt;- ensure privacy and dignity at all times and for all women&lt;br&gt;- accommodate and manage acute obstetric problems that develop during pregnancy and childbirth including critical care (level two) medical care.&lt;br&gt;- undertake planned obstetric procedures and operations&lt;br&gt;- accommodate the psychological needs of mothers and their families and to provide:&lt;br&gt;- a safe and suitable environment during childbirth&lt;br&gt;- medical and midwifery care for women during childbirth, including facilities for supporting normal birth&lt;br&gt;- one to one care for women in labour&lt;br&gt;- facilities for diagnosis, assessment, monitoring care and treatment&lt;br&gt;- comprehensive birthing facilities in order to accommodate women’s choices in childbirth, including one birthing pool room&lt;br&gt;- 24 hour anaesthetic cover</td>
</tr>
<tr>
<td><strong>Day assessment unit (DAU)</strong></td>
<td>- promote privacy, dignity and confidentiality&lt;br&gt;- accommodate the psychological needs of women and their families&lt;br&gt;- reduce admissions to the antenatal inpatient unit and reduce disruption to women’s lives&lt;br&gt;- optimise assessment and patient flow&lt;br&gt;- provide facilities for diagnosis, assessment, monitoring care and treatment</td>
</tr>
</tbody>
</table>
| Neonatal (NICU) | -promote good health with high quality care for babies using a family centred approach. 
| | -provide an environment which promotes developmental care 
| | -promote high quality care for babies requiring specialist support 
| | -promote a family-centred approach to care delivery with parent participation 
| | -maximise the use of resources 
| | -develop and maintain expertise in neonatal care |

The benefits of the preferred option are:

- purpose built delivery units designed around the needs of mothers, their families and their babies
- provide local women with a real choice of care settings
- an environment which provides the required space, facilities and clinical adjacencies to optimise quality of care
- a facility which will deliver the new models of care and allow standardisation of clinical practice
- provides space for future service expansion should this be required
- consolidation of acute care onto one site thus improving operational efficiency
- improved working environment for staff
- complies with the site wide development control plan

The clinical design of the new-build, the substantially reconfigured neonatal unit and DAU services were derived from design development workshops facilitated by AD Architects.

These were well attended by clinical staff, members of the project team, healthcare planners and patient group representatives. At every stage of the process, agreement was reached by the attendant groups prior to moving onto the next stage in the design process. The scale of engagement and input in to the design by clinical, support and user groups is evidence of the level of ownership and support that this scheme has engendered.

In parallel to the changes taking place at the Lister hospital, the full range of outpatient care will continue at the QEII and within the wider health community, including:

- antenatal and postnatal outpatient care on site including routine ultrasound
- postnatal support groups, drop-in clinics
- consultant-led and midwife-led clinics
- parent education classes
- neonatal clinics
- gynaecology clinics

As a result of this, mothers from the southern part of our catchment area will continue to receive the majority of their care locally.

1.9 Developments since outline business case approval

The OBC was approved by the Trust and PCT boards in July 2008 and the SHA in October 2008.

The maternity services reconfiguration scheme has developed since OBC approval as a result of ongoing clinical engagement, in the following ways:

- two additional birthing rooms were added to the consultant-led unit (CLU) immediately prior to the start of the 1:200 design development process. It was felt that this would provide the Trust with the opportunity for greater future flexibility
particularly in light of the recently witnessed changes in the proportion of high-risk versus low-risk pregnancies.

During the detailed design development process it also became apparent that:

- the neonatal unit would require substantial reconfiguration for it to be clinically viable as opposed to the 'light-touch' refurbishment originally planned for in the OBC. The decision to expand the scope of work is based on service complexity and clinical risk. This has resulted in an increase in cot numbers with the whole unit being fitted out to a higher specification than originally planned.
- there was a requirement for additional inpatient beds within the existing unit as outlined in the Safer Childbirth (minimum standards for the organisation and delivery of care in labour), jointly published by the royal colleges, 2007
- for the maternity day assessment unit (DAU) to operate effectively in managing complex pregnancies and reducing unnecessary antenatal admissions it needed to be enhanced to provide centralised care where required. The decision was taken to create an area specifically for this purpose whilst retaining adjacencies to CLU, midwife-led unit (MLU) and inpatient wards. The new DAU therefore now includes:
  - a six-bed monitoring bay
  - a consult/exam room with scanning facilities
  - a counselling room (to be shared with the inpatient area)
- as a result of the detailed planning and design process carried out subsequent to OBC, it was concluded the building and refurbishment process will need to be managed in two phases. This will ensure that there is as little service disruption, with minimal clinical risk as possible during the transition from the existing to the new service.
  - phase 1 - new build CLU and MLU
  - existing birthing and neonatal activity will then be decanted into the above new build
Phase 2 - the existing maternity and neonatal areas will be reconfigured and refurbished to re-provide dedicated obstetric theatre suites enhanced by dedicated recovery and critical care level two provision; and, additional and updated capacity in the neonatal unit.

The alteration to the scheme will result in:

- a phased transition of services from current locations to the final configuration with fewer decants and disruptions ensuring higher levels of clinical safety
- a substantially improved physical environment for the care of labouring women and neonates during the transitions
- efficient operational flows for patients and facilities management (FM) services
- a significant enhancement to the graduated model of care planned for both labouring women and neonates in line with national best-practice guidance

At present construction is due to commence in July 2009 with the unit becoming operational in May 2011.

1.10 Affordability and economic appraisal

The Trust has refined the gross revenue savings identified in the OBC as a result of the consolidation of maternity and associated paediatric services. These now stand at £1.544m per annum, an increase in saving from OBC of £334,000.

Savings will be released in relation to obstetric and paediatric medic posts and some administration costs. The consolidation of services will also allow the Trust to achieve CNST level 3. Savings will be achieved as a result of these proposals by the more efficient use of
staff as set out in the earlier workforce section. The additional midwife posts created under the CQUIN initiative to deliver 1:1 care will be factored in as part of this process.

At the OBC approval stage, the capital charges and interest payments for this project were quoted as £1.29m. Subsequent to that time through the design process, it is apparent that the scope of the project has been substantially enhanced as outlined in section 1.9 above. This has increased capital costs but has been largely offset by lower capital cost inflation assumptions as a result of the economic downturn. A combination of a significant reduction in the CNST premium and the lower interest rate assumption gives an overall net annual saving of £1.544m for a full year. Full details are set out in section 10 of this business case.

Capital costs of the preferred option are estimated at £16.4m which is higher than that highlighted at OBC (£15.4m). The increase in costs is 14% at a constant price base and 6% after capital cost inflation is accounted for. This is outside the 10% tolerance limit set by the SHA/Department of Health. The business case therefore outlines in detail the reasons for the increase in costs, and seeks approval of the revised sum on this basis.

The main reason for the increase in capital costs is the extended level of work now assumed in NICU. The revenue impact of this increase has been included in the affordability analysis highlighted above. The increase in costs has no impact on the option appraisal as both options would be similarly affected.

As a result of the proposed phased approach, the construction period is now expected to take six months longer than originally planned due to clinical risk and patient safety. This will have a detrimental impact on the ability of the Trust to deliver savings as quickly as first anticipated, compounded by the Trust having to pay interest on its Interest Bearing Debt (IBD) before the scheme is operational.

For the purposes of this analysis the Trust has assumed that its income will remain constant based on the capacity of the unit reflecting the current levels of activity the Trust is delivering.

All current guidance has been followed in constructing the financial and economic appraisal, principally the Capital Investment Manual (CIM) and the Green Book. The DH Generic Economic Model (GEM) has been used to develop the economic appraisal of each option.

1.11 Risk

A risk assessment has been undertaken by the project team, the directorate of women and children’s services and the P21 contractor.

The process of risk assessment is:

- risk identification – develop a risk register covering key risk areas and individual risks within these areas
- risk assessment – assessing each of the options against the risk register, evaluating the impact, probability and exposure using a simple scale of one (low) to five (high). The overall exposure to risk is then a product of the impact of risks and the likelihood of them occurring
- risk monitoring – the process of regularly reviewing all risks to ensure effective control, mitigation and action planning
developing a risk management plan – a plan to manage all the risks identified in the risk register for the preferred option, including responsible persons and a monitoring mechanism.

The risk register includes all risks from Medicinq Osborne’s (MO) generic construction risk register and as such all risks included in this respect have been reviewed by the maternity project team. Those construction risks that have an impact on the delivery of patient services or that could impact upon patient, visitor or staff safety have been delegated to staff within the Trust to mitigate. Residual third party risks, i.e. those owned by MO will continue to be monitored by the programme board throughout the life of the project to ensure that they are being managed effectively and do not present a potential threat to the Trust's activity or reputation.

As a result of this the Trust has developed a risk management plan. It consists of a continuous process of risk review, assessment, and escalation where required. To make sure that the highest level of scrutiny and control is exercised, the project risk register is a permanent agenda item on the maternity reconfiguration steering group. Alongside this, risk management is likewise a permanent feature of both the DQHH programme co-ordinating team and the DQHH programme board where both project and wider programme risk reports are presented. The aim is to maintain optimum risk management performance.

1.12 Project management

As the project forms part of the DQHH programme, it will be managed through the governance structure established for the implementation of DQHH, through the DQHH programme board ultimately reporting to the Trust board. The Trust DQHH programme board will also act as the evaluation steering group for post project evaluations, which are outlined in further detail in section 12 of this business case.

The maternity reconfiguration steering group, supported by the project team, has taken responsibility for the implementation and delivery of the project brief, including preparation of business cases, design and procurement processes and communication. It consists of clinical and service directors, finance, human resources and the Trust project team.

The Trust has also engaged a comprehensive consultant support team through its designated ProCure21 (P21) contractor. The benefits of the P21 procurement route are set out elsewhere. The exceptions to this are:

- the project manager who is a direct appointment
- the QS will be initially engaged under P21 and will prepare the cost plan, provide design costing advice and assist with the preparation of sub-contract packages but will then transfer to a direct Trust appointment and will negotiate the Guaranteed Maximum Price (GMP) with the P21 contractors’ surveyors/estimators.

1.13 Project timetable

The key milestones for the continued development of this project are outlined below:

<table>
<thead>
<tr>
<th>Date</th>
<th>Milestone</th>
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<tbody>
<tr>
<td>January 2009</td>
<td>Completion of detailed design development</td>
</tr>
<tr>
<td>March 2009</td>
<td>Submission of FBC</td>
</tr>
<tr>
<td>Date</td>
<td>Event</td>
</tr>
<tr>
<td>--------------</td>
<td>--------------------------------------------</td>
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<tr>
<td>April 2009</td>
<td>Completion of GMP</td>
</tr>
<tr>
<td>June 2009</td>
<td>Approval of FBC</td>
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<tr>
<td>July 2009</td>
<td>Start construction phase 1</td>
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<tr>
<td>September 2010</td>
<td>Complete construction phase 1</td>
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<tr>
<td>October 2010</td>
<td>Decant delivery suite and neonatal unit</td>
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<tr>
<td>October 2010</td>
<td>Start construction phase 2</td>
</tr>
<tr>
<td>April 2011</td>
<td>Complete construction phase 2</td>
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<tr>
<td>May 2011</td>
<td>Fully commission new unit and transfer services from QEII</td>
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### 1.14 Estates strategy

The site masterplan and estates strategy is currently being progressed by the Trust and will review in detail:

- land ownership and title matters
- building age/condition profiles
- utilisation/functional suitability/quality assessments
- key performance indicators
- backlog maintenance
- energy performance and environmental management
- statutory compliance

The masterplan sets out the principal developments for the Lister site in terms of location and size.

Work in progress includes planning site infrastructure including access/parking proposals and the energy strategy as two significant components.

The need for a robust and up to date estates strategy is recognised by the Trust. DQHH and the masterplan effectively complete this for the Lister site.

The maternity scheme is the first Trust commissioned design and building scheme within the masterplan and as such it is essential that the completed project is robust and in keeping with the overall estates strategy and delivery of DQHH.

### 1.15 Equipment strategy

During November and December 2008 an audit of the current equipment in both the Lister and the QEII maternity departments was undertaken by external consultants – SB Purchase. They examined and listed all the group three items.

Following the audit, the group two and three equipment listed on the room data sheets have been assessed for cost. This comes to an approximate total of £1.9m (excl VAT) at current prices.
The items regarded as suitable for transfer were then netted-off from the total equipment cost. This has reduced the estimated cost of equipment to £806,000.

1.16 Procurement

In order to achieve the timeframe set out in the DQHH business case, the project will be delivered through ProCure21 (P21). This is an established Department of Health (DH) procurement route which provides the Trust cost certainty using a Guaranteed Maximum Price (GMP) and reduces time to completion by not having to take the scheme through the Official Journal of the European Union (OJEU) process.

The Trust has previously completed seven other P21 projects with its preferred Principle Supply Chain Partner (PSCP), Medicinq Osborne.

1.17 Benefits realisation

The project team, together with the maternity services reconfiguration steering group have worked through a process of clarifying the benefits of this scheme. The responsibility for realising these benefits and timescales have been identified in the benefits realisation plan outlined in section 16 of this business case.

Benefits of service consolidation include:

- opportunities to align the best in current clinical practice at both sites
- an opportunity to improve the range of care settings and physical environments in support of patient choice and to address quality issues within current facilities
- more flexible capacity to deal with variability in demand
- more effective and efficient use of midwifery and neonatal nursing capacity and skills
- better quality care and management of clinical risk by reducing the need to transfer sick infants across sites
- contribute to the effectiveness of the local neonatal services network
- better opportunities for staff training

1.18 Conclusion and recommendations

The period since the approval of the OBC to date has been witness to an intense and exhaustive level of activity ranging from initial 1:200 level drawings through to the agreement on loaded 1:50 level design and preparation for GMP and FBC.

It has been marked by an exemplary level of engagement and advisory input by:

- obstetric and gynaecology consultants
- consultant anaesthetists
- all levels of midwives
- neonatal unit consultants and nurses
- theatre support staff
- administrative and clerical support staff
- clinical support functions such as pharmacy, radiology and infection control
- project team members including capital projects
- local branches of the National Childbirth Trust (NCT), the Stillbirth and Neonatal Death Society (SANDS), Maternity Services Liaison Committee (MSLC) and the East of England perinatal network
- members of the public
- the wider design team partnership brought together by Medicinq-Osborne which included architects; consultants in healthcare planning, structural, mechanical and
Changes in the scheme since OBC have only been allowed where patient-level benefits have been clear and will result in improvements to:

- the quality of patient care
- the level of patient privacy and dignity
- clinical effectiveness
- ease of access to patients by clinicians

Fundamentally this business case re-confirms that:

- consolidation of maternity and neonatal services on the Lister site present the only guarantee of ensuring long-term service safety and viability
- option 4h continues to be the best option for delivering that consolidation
- this scheme will enable the Trust to develop the infrastructure to enable it to meet national best practice standards for maternity and neonatal services
- this scheme further offers the Trust the flexibility for future growth and service development in an environment of continuously changing demographics and rapid improvements in medical technology
- this scheme is affordable and sustainable

In conclusion, it is recommended to approve the development of this ‘state-of-the art’ maternity and neonatal service for the future of mothers and babies in Hertfordshire.

“Our top priority must be to provide safe, high quality care for all new parents and their babies.”

Sheila Shribman, National Clinical Director for Children, Young People and Maternity Services