# Patient and Public Engagement Plan for Liverpool Women's Hospital Services Pre-Consultation Engagement

**This document has been prepared by NHS Liverpool CCG and provides a framework for other CCGs to use to plan engagement with their communities.**

| NAME OF PROJECT:- Liverpool Women's and Babies' Services Pre-Consultation Engagement with Patients and Public | Manager: |
|---|---|
| **SECTION 1 - Background and Purpose** | |
| **DATE and VERSION OF THIS DOCUMENT…Sarah Dewar 31/5/16 v7 – incorporating changes proposed by engagement group** | |
| **1. Details of the service / provision** - Describe clearly the current situation | |
| **Managers Answer:**<br>Liverpool Women's is a standalone Foundation Trust based in Liverpool that provides the following range of services:<br><br>• Neonatology - supporting premature and poorly newborn babies<br>• Maternity - supporting pregnant women and new mums<br>• Gynaecology - supporting women with health issues affecting their reproductive system<br>• Anaesthetics, theatres and critical care - supporting women through and after surgery<br>• Reproductive medicine - supporting people to conceive – fertility treatment<br>• Genetics - supporting people to understand their family medical history through their genes, and how this might affect their diagnosis/treatment.<br><br>Liverpool Women's provides services to more than 60,000 patients per year. These services are accessed principally by the women of Liverpool, South Sefton and Kirkby, alongside specialised women's, genomics and babies' critical care services commissioned by NHS England, serving a much greater population. | **Engagement groups comments:**<br>OK |
| **2. What is being considered?** eg Policy? Service redesign? Patient information? Change of service? Change of service location/access? Removal of service? Change of provider? Define what is in scope and what is out of the scope of the engagement. | |
| **Managers Answer:**<br>A reconfiguration of services is being considered which may affect the way services are delivered and location. No specific proposals are being put forward at this stage, but the reasons for change and the benefits will be set out on which people are to be asked for comment.<br><br>The review of women's and babies' services are being carried out as part of the Healthy Liverpool programme which aims to transform health in the city. The Healthy Liverpool programme (HLP) is driving a city-wide transformation of care, including proposals to reconfigure hospital services to bring together specialist provision in order to improve clinical | **Engagement groups comments:**<br>**OK – language difficult for public** |

outcomes, patient experience and ensure the local hospital system remains financially sustainable.

The following principles for care in women's and babies' services have been identified:

- Partnerships for Care Delivery – services need to be integrated around the needs of patients, working across organisational and site boundaries to provide the best care.
- Care Closer to Home – where appropriate services should be offered outside of hospital in community settings.
- Digitally Supported Care – ensuring that information sharing is in place for seamless care across settings and using technology to support self-care.
- Focus on Workforce – working in partnership to share expertise across clinical teams and support services and ensuring we have the right skills.

Changes being considered to reduce risks and raise standards in the current situation are:-

a. How to achieve co-location of Level 2 High Dependency Unit (HDU) with a Level 3 Critical (Intensive) Care Unit – to meet nationally set standards of care.
b. How to ensure 24/7 access and reduced waiting for haematology / pathology for analysing blood samples and tests such as CT and MRI scans, and for specialist and emergency surgery and blood transfusions as LWH does not have its own facilities for these.
c. How to reduce emergency ambulance transfers for mothers and babies with complex cases in order to meet national standards of care. There are currently too many transfers between LWH and the specialist services they need - which are at other hospital sites.
d. How to provide the necessary capacity for critically ill babies' care given the current facility is under sized for current and future needs and improve family accommodation.
e. Whether more routine care can be delivered closer to where people live.
f. How improvements can be made in a way which makes the services financially secure to serve Liverpool people in the future.

**3. Why is this being considered?** eg transformation programme? End of contract? In response to an issue?
**State what is the legitimate aim** of the service change / redesign i.e.:

- Demographic needs and changing patient needs changing
- Increase referrals
- Value for money
- areas of improvement and potential gaps in service identified by….

If it is responding to patient or other input please list who, how and when the issues came to light.

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| **Managers Answer:**<br>Since the Liverpool Women's was established 21 years ago models of care and clinical standards have evolved, which has meant that services have continually needed to adapt and change in order to provide the best care.<br><br>Liverpool Women's is one of only two stand-alone women's hospital trusts in the country.<br><br>The clinical case for change has been driven primarily by local clinicians but also by national and local strategic drivers.<br><br>The Five Year Forward View, published in October 2014 by NHS England, set out the requirement to consider new models of care, including those relevant to the delivery of specialised care and maternity care. For specialised care, such as critically ill babies', complex gynaecology and cancer care, there is evidence that consolidating services can lead to improvements in outcomes. For maternity services, the Forward View signalled a national review of maternity service models. There was also an intention to review the funding of maternity care, which could enable more midwife led services to be developed.<br><br>Locally, the Healthy Liverpool programme (HLP) is driving a city-wide transformation of care, including proposals to reconfigure hospital services to bring together specialist provision in order to improve clinical outcomes, patient experience and ensure the local hospital system remains financially sustainable.<br><br>**Clinical Case for Change**<br>The Care Quality Commission considers that the services provided by Liverpool Women's are good. The 2015 CQC report states: "Overall we found that the hospital provided effective care with outcomes comparable with or above expected standards. Patients were very positive about the care and treatment they received at the hospital."<br><br>However, there are particular clinical challenges that have to be addressed to further improve care, patient experience and to comply with national clinical standards.<br><br>The National Maternity Review: Better Births; Improving Outcomes of Maternity Services in England, published on 23rd February 2016, was tasked by NHS England with setting out recommendations for how maternity services should be developed to meet the changing needs of women and babies. The review, conducted by an independent panel of NHS staff, professional bodies and user groups, recommends a range of measures to drive safer, more personalised and family-friendly maternity care.<br><br>As stated by the CQC, services provided by Liverpool Women's are safe and of good quality. However, for some services | **Engagement groups comments:**<br><br>OK – more detail needed on figures as highlighted<br>Clarification regarding co-location of sites in Birmingham example to be added…confirmed not same site<br><br>NB legitimate aim is legal requirement |

safety is maintained through the mitigating actions of clinicians. The key clinical high risk areas that have been identified are summarised below:

- Adult critical care – the Trust currently provides a Level 2 High Dependency Unit (HDU) facility on site, which national standards require should be co-located/on the same site with a Level 3 Critical Care Unit. As LWH does not have a Level 3 critical care unit, women who require this level of care have to be transferred by ambulance to the nearest Level 3 critical care unit, which includes the Royal Liverpool Hospital (RLH) and Aintree Hospital. External transport transfers present an increased risk to patients.

- Haematology / Pathology – the Trust does not have a 24/7 pathology service for processing blood samples, meaning support is required by the Royal Liverpool Hospital. Also, Liverpool Women's doesn't have a blood bank, it relies on transferring patients to the Royal Liverpool Hospital for emergency transfusions, requesting emergency supplies from the Royal, or using a special procedure whereby the blood a patient is losing is cleansed and used as an interim blood transfusion. If a solution is not found to this issue there is a concern that LWH will not be able to provide high risk maternity and gynaecology services in the future.

- Complex health conditions – for the increasing number of women patients with complex needs, support is required from specialities that are not located on the Crown Street site, including the following specialisms - colorectal, vascular, urology, cardiology and complex diagnostics. In the case of babies who require surgery after birth, they have to be transferred by ambulance to Alder Hey Children's Hospital (AHCH) for surgery, after which they are returned to Liverpool Women's Babies' Intensive Care Unit (NICU) or they are treated at the Paediatric ICU at AHCH; in both cases this is non-compliant with national standards and clinical best practice.

Patient transfers between hospitals in the City:

Transfers from LWH to other Liverpool NHS Trusts

| | 2012/13 | 2013/14 | 2014/15 |
|---|---|---|---|
| Aintree University Hospital | 13 | 7 | 6 |
| Alder Hey Children's Hospital | 211 | 193 | 194 |
| Broadgreen Hospital | 2 | 1 | 0 |
| Liverpool Heart and Chest | 0 | 4 | 1 |
| Royal Liverpool Hospital | 174 | 190 | 157 |
| The Walton Centre | 1 | 2 | 2 |
| Total | 401 | 397 | 360 |

Over 96% of emergency ambulance journeys 'out' are either to Alder Hey Children's Hospital or the Royal Liverpool Hospital

Transfers from other Trusts to Liverpool Women's

| | 2012/13 | 2013/14 | 2014/15 |
|---|---|---|---|
| Aintree University Hospital | 173 | 152 | 150 |
| Alder Hey Children's Hospital | 52 | 46 | 53 |
| Liverpool Heart and Chest / Broadgreen | 3 | 2 | 0 |
| Royal Liverpool Hospital | 150 | 164 | 143 |
| The Walton Centre | 0 | 2 | 1 |
| Non Liverpool providers | 115 | 130 | 104 |
| Total | 493 | 496 | 451 |

- The current critically ill babies' facility is under size for current and future needs. Expansion is needed, requiring an interim and a long term solution for the necessary space to provide safe, optimum care. There is little family accommodation so overnight stays and support for families is restricted.

As stated, patient transfers are mainly due to lack of availability of diagnostics, surgical and critical care. Although these transfers are managed safely, they affect the most unwell patients; this practice does not support good patient experience and it is non-compliant with national clinical standards.

Despite these significant clinical challenges, clinicians take effective mitigating actions to ensure that services are safe, although these issues do not make for optimal care for those patients who are affected.

The clinically-led work conducted by Liverpool Women's demonstrates a clear clinical case for change. The scale of this change will be influenced by a number of factors, including the needs of patients; individual service requirements to deliver the best care; recognition of clinical dependencies – which services have to be located on the same site; compliance with national clinical standards and best practice and alignment with national clinical strategies and models of care.

Both the Trust and commissioners have concluded that services cannot continue to be delivered in isolation from other services. Change is needed to ensure that patients with highly complex needs can receive joined up care which includes other acute (urgent/short-term) services, such as complex diagnostics, blood bank, cardiology, colorectal surgery, paediatric surgery and intensive care.

The case for change also recognises the need to consider the requirements of patients that do not have acute needs, including low risk maternity, gynaecology, reproductive medicine and genomics.

The clinical case for change makes it clear that some of the services within the scope of the review need to be delivered from an acute setting; whilst for others it may be appropriate to consider other settings, including home and community. The review will assess the full range of options.

**The needs of patients have changed**

It's now 21 years since Liverpool Women's Hospital opened its doors on Crown Street, and in that time the health needs of patients have changed. In some cases this is because of advances in medicine that have also transformed the lives of women and their families, however these developments also create a need for new – often very specialist – ways of

providing care.

The main changes we have seen are:

- More women are having babies later in life; in the last decade alone the number of women over 40 having babies at Liverpool Women's has doubled(tbc). As women get older pregnancy can be more complex, which means they are more likely to need specialist care. Not all of this care is available at Liverpool Women's; in some cases patients have to be treated elsewhere, which can mean transferring them by ambulance to other local hospitals. While staff at Liverpool Women's work hard to make sure this is managed safely, it doesn't offer women the best experience of care.

- An increasing number of babies who wouldn't have survived in the past – perhaps because they were born too early, or had serious health problems – are now surviving. This means there are a greater number of babies needing very specialist care, which means more space is required to care for them. Babies who need surgery have to be transferred by ambulance from the Women's Hospital to Alder Hey Children's Hospital for their operations.

- Women with health problems who would have been unable to have children in the past are now able to do so. Having an existing condition can mean more complex care is needed during pregnancy. This puts more pressure on services, and also means that care sometimes needs to come from specialists and teams who aren't based at Liverpool Women's. For example, someone with a heart condition might need care from cardiology specialists at the Royal Liverpool Hospital.

- Women are living for longer and with more complex health needs, there is more demand for gynaecological services and more of this is to support women.

- Gynaecological cancers are increasing, and doctors are carrying out more complex surgery to treat them. Sometimes this means that specialists from other hospitals need to be involved in caring for these patients.

**Financial Challenges**

These issues are also set in the context of the financial challenges facing the NHS at this time. Liverpool Women's itself faces significant financial challenges. The Trust's forecast deficit for 2015/16 is £7.3m; a figure which is set to grow year on year. Financial sustainability is a key consideration in this review of women's and babies' services and proposals that emerge must address this challenge, as well as securing the continuation of high quality, safe services for women and babies. The following are key financial factors driving the need to review services.

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| • The maternity tariff – the Trust maintains that the current national maternity tariff is insufficient for the complexity of patients served, leading to a maternity service line deficit of £5.8M in 2015/16. As a small specialist Trust the organisation is unable to compensate for or cross-subsidise this from other services, unlike other typical multi-speciality trusts that include maternity services.<br><br>• Insurance premiums have increased significantly as a result of negligence claims being made against a former doctor which puts extra pressure on finances.<br><br>While the clinical case and changing needs are paramount in the reasons for considering change, any changes made must make effective use of resources to ensure high levels of service provision in the future. | |
| **4. What is the benefit to the patient/public that is expected from the change?** How does this respond to JSNA or other needs/opportunities? What options for improvement have been considered? What is the evidence for the approach? | |
| **Managers Answer:**<br><br>**Benefits**<br>1. Reduce ambulance transfers, make care safer and reduce separation of mother and baby– provide quicker and simpler access to specialised clinical staff for patients having complications – ensuring a comprehensive team is on hand around the patient and that national standards for care can be met<br><br>2. Increase space and capacity for critically ill babies' care unit to reduce infection, provide for the increase in the number of babies needing this care and provide more family accommodation to improve care and meet national standards<br><br>3. Reduce waiting time and achieve better 7 day access for diagnostics such as CT and MRI scans and blood tests. There are currently no such facilities at women's – meaning patients and blood have to be moved to/from the Royal to enable care to continue.<br><br>4. Reduce waiting and improve 7 day services for things like specialist/ emergency surgery and blood transfusions.<br><br>5. More routine care provided closer to people's homes where appropriate<br><br>6. Make the services financially secure for Liverpool people for the future . | **Engagement groups comments:**<br>OK |

**7. What are you trying to achieve by engaging with people - what are the engagement objectives..?**
EG Informing those affected of a determined change? Influencing the change itself? Understanding how to address equalities issues? Be clear about what people can influence. Can the process / plans change as a result of the feedback and if so how much?

| **Managers Answer:** | **Engagement groups comments:** |
|---|---|
| 1. Increase understanding among public, patients and VCSEs of the issues prompting a review of Women's and Babies' care *(staff engagement subject to a separate plan).*<br>2. Understand whether Liverpool people recognise and support the reasons for changing how and where care is provided<br>3. Understand whether Liverpool people support the benefits change is trying to achieve<br>4. Understand what Liverpool people feel is most important to achieve from the changes<br>5. Provide an understanding of Liverpool people's views on objectives 1-4 in order to inform consideration of future service configuration options.<br>6. Align the findings from the Liverpool engagement with responses from parallel exercises in Knowsley and Sefton in order for relevant communities and patients to inform planning.<br>7. Develop an audience for the full public consultation which will follow the NHS England assurance process, particularly in terms of social media presence and email/postal addresses of interested parties/individuals. | OK – info regarding possible solutions discussed – may be helpful but also challenging to enable people to engage with or without it…final decision to not ask questions re possible solutions and that this will be covered in formal consultation |

**8. Who is involved in planning the engagement?**
Is there an ongoing interest group involved? Clinicians, voluntary sector etc… (NB ask engagement re volunteers to get input as early as poss in process).

| **Managers Answer:** | **Engagement groups comments:** |
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| NHS Liverpool CCG, LWH, Sefton and Knowsley CCGs, Liverpool CCG Engagement Group including healthwatch, patient voices and CCG lay member with lead for engagement, Oversight Board, Liverpool Overview and Scrutiny Committee, Committees in Common. | |

**9. What patient insight/research/experience data is there already available?**
Have patients been involved so far? Or in the last year? What does this insight tell us? Are there relevant patient groups or other networks that exist – eg Breathe Easy. **What evidence regarding equality issues exists?**

| **Managers Answer:** | **Engagement groups comments:** |
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| LWH conducted an engagement with Liverpool people during the summer of 2015. This involved 800 people and found that<br>• People value the staff and feeling safe the most;<br>• People feel that Liverpool Women's is a special place because of the way care is provided and because of the staff; | The importance of the workforce engagement with critical / affected teams was noted.<br>Suggestion to include more on results of LWH engagement from 2015 (done) |

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| • Having all services under one roof and a range of specialist clinics are important to people<br>LWH workforce were also engaged. This phase of engagement will cover the case for change and benefits of change and introduce some potential solutions being developed for consideration/future consultation. | |
| **Assessment of Background and Purpose proposals**<br>**1= Not clear needs a lot of further work**<br>**2 =Some issues need more clarity**<br>**3 = Clearly thought out and planned** | **SCORE =2** |

**SECTION 2 - Gauging Impact, Scale and Risk**

1. **Who is affected by what is being considered?**
   Patient groups / Carers / Community members / Staff / Providers, Other professional stakeholders, Geography – eg location of service or access by a specific geographic community? Others?

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| **Managers Answer:**<br>The following are affected by and will be engaged with during this engagement - Patients, prospective patients, families and carers, women of childbearing age including teenagers, mothers, fathers, transgender men - as residents of Liverpool, South Sefton and Knowsley. Specialist services commissioned by NHS England serve people in Cheshire, wider Merseyside and the Isle of Man.<br>VCSEs<br>Politicians<br>Governance structure groups including Oversight Board, Committee in Common and Overview and Scrutiny Committee<br>LWH staff and staff of other NHS Trusts locally are also affected and engagement with staff will be subject to a separate plan/s. | **Engagement groups comments:**<br><br>OK – clarify those affected who will be engaged with (done)<br>NB this section legal duty |

2. **Equality Pre-Assessment**
   **Is the service specifically designed to serve people with one or more protected characteristic*?** Eg for deaf people
   Review evidence regarding possible detriment to the following groups. **List effects of this change against each of the groups with protected characteristics* and whether any may be discriminated against (must consider directly and indirectly) or particularly affected by the change?**
   **(Duty to prevent this – see below and p13 for definitions)**
   **Might any vulnerable groups** be particularly affected /disadvantaged?**

**Managers Answer:**

The service is not for one target group. As specific changes are not proposed at this stage, a full EIA will be conducted at the next stage of engagement/consultation. For the purposes of this engagement, all relevant communities will be invited to share their views, the assessment below indicates groups we think may face particular impact and wish to engage with during this phase of engagement in order to understand any potential impacts.

| | | If yes - describe issue | | |
|---|---|---|---|---|
| | | Discrimination? | Equality of Opportunity-life chances? | Foster good relations? |
| i.Race* | Y | Traditionally have poorer health outcomes and access services less/less effectively. No clear evidence therefore engagement will seek views of different racial groups in order to understand any impact. | Traditionally have poorer health outcomes and access services less/less effectively. No clear evidence therefore engagement will seek views of different racial groups in order to understand any impact. | Traditionally have poorer health outcomes and access services less/less effectively. No clear evidence therefore engagement will seek views of different racial groups in order to understand any impact. |
| ii. Age* | Y | Services are predominantly for women of childbearing age and babies although women of all ages receive gynaecology and genetics services. | | |
| iii. Sex* | Y | Majority of services are for women so changes would disproportionately affect them. Also need to include women who have lived through FGM and are/maybe users of services. | Majority of services are for women so changes would disproportionately affect them. | Majority of services are for women so changes would disproportionately affect them. |
| iv. Disability* | Y | Factors of importance may | Factors of importance may | Factors of importance may |

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| | | vary, location may disproportionately affect this group – although these are not known at this stage this group will be engaged in order to understand impact better | vary, location may disproportionately affect this group – although these are not known at this stage this group will be engaged in order to understand impact better | vary, location may disproportionately affect this group – although these are not known at this stage this group will be engaged in order to understand impact better |
| v. Religion and belief* | N | | | |
| vi. Sexual orientation* | N | | | |
| vii. Gender reassignment* | Y | Increase in transgender male support service use so views will be sought from this group to understand perspectives | Increase in transgender male support service use so views will be sought from this group to understand perspectives | Increase in transgender male support service use so views will be sought from this group to understand perspectives |
| viii. Marriage/civil partnership* | N | | | |
| ix. Pregnancy and Maternity* | Y | Services predominantly for this population | Services predominantly for this population | Services predominantly for this population |
| x. Homeless people** | N | Likely to access services less | | |
| xi. Single parents** | Y | May have different priorities / increased difficulty in accessing services and will be engaged through process | May have different priorities / increased difficulty in accessing services and will be engaged through process | |
| xii. People with learning difficulties** | N | | | |
| xiii. Low incomes** | Y | Larger proportion of population in this group, impact not clear and so will be involved through engagement process. | Larger proportion of population in this group, impact not clear and so will be involved through engagement process. | |
| xiv. Addictions** | N | | | |
| xv. Veterans** | N | | | |
| xvi. Offenders** | N | | | |

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| **Engagement groups comments:**<br><br>ok<br><br>NB this section legal duty | |
| **3. How many people are affected?**<br>eg how many people currently use this service?, does it affect all over 16's or 2-3 people having a rare procedure or one neighbourhood population, or the whole city? | |
| **Managers Answer:**<br>61967 people used LWH services from December 2014-November 2015. 52700 of these were women and the majority were aged 20-40. | **Engagement groups comments:** |
| **4. Is there a change to both the service and the location involved?** If location change how will transport access be considered? Is a full accessibility assessment needed (available from Merseytravel - ask Sarah Dewar) | |
| **Managers Answer:**<br>At this stage a range of possible solutions are being explored which include relocating services and where is not yet known. These possible solutions will be reviewed in light of the engagement results on the case for change and the benefits. Specific service changes / locations etc will be set out at formal consultation stage with a range of options. | **Engagement groups comments:**<br>OK |
| **5. Is the change proposed likely to elicit a variety of strong viewpoints?**<br>If no describe how you have decided this, and if Yes, describe in what way & by whom? | |
| **Managers Answer:**<br>Yes the discussion of the future of LWH services will be contentious. There has been public debate as a result of discussion on the hospitals circumstances which tends to centre around the potential for / fear of hospital closure. There is a strong public campaign to Save the Women's and a variety of views regarding the case for change and the benefits of any change. There are significant concerns relating to the perception of dangers to NHS services and privatisation of services. There are also potential impacts for other NHS Trusts in the area presented by some of the solutions and the views of different providers may differ. | **Engagement groups comments:**<br>Contentious nature noted. |

**6. What Scale and Proportion of Engagement is Appropriate?**
Assess what level of engagement activity is appropriate .
Significant changes will require approval at GB level. Do LA safeguarding / scrutiny panels need to be involved?
Reconfiguration requires NHSE involvement see guidance as p1.
Please note here if this process is feeding into a wider service reconfiguration and forward this to lead for that service.

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| **Managers Answer:**<br>The aim is to involve 6000 in the pre-consultation engagement broken down by CCG area including a representative sample of the population. In addition, specific/relevant protected groups will be invited to share their views in a qualitative way. | | **Engagement groups comments:**<br>Query whether numbers achieveable |
| **7. Does this change present a minor, moderate or high risk to LCCG?** Please describe why? This helps determine if it goes to committee or GB etc..(both manager and engagement group complete this) | **Minor**<br>**Moderate**<br>**High - YES**<br>**Why…….**Due to public concerns regarding future of the hospital,**.** | **High -** |
| | Assessment of Impact Scale and Risk Proposals<br>1= Not clear needs a lot of further work<br>2 =Some issues need more clarity<br>3 = Clearly thought out and planned | **SCORE = 2** |

**SECTION 3 - Information and Communication**

**1. What information is/needs to be available to communicate?**
How will what is being considered be described to people? Online/paper/face to face?
**Information should include**…
a summary; discussion of the issues; how it addresses health needs; benefits of what is being considered for patients/public, an outline of options considered; relevant information already taken into account or known; assessment of impact on different groups- must include assessment and any mitigation proposed to eliminate negative impact/discrimination (see B2); assessment of risks of change, stakeholder involvement; transition plans; budgetary implications; contingency arrangements as appropriate; info on penalties for non-delivery and exit strategy; statement regarding availability of info in alternative formats; list of those being consulted; clear description of how responses will be used; proposed timetable.
Is info clear and appropriate for the audience? Is the language plain English? Are alternative formats needed? Identify each stakeholder group and map the different methods as appropriate to that group.
Is the rationale, evidence and benefit of what is being considered clear?

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| **Managers Answer:**<br>**The following information will be prepared to share with public during this engagement:-**<br>Summary of context for the engagement and who is involved – with more detail on this for those requiring it on line/in print on request<br>Summary of reasons for considering changes to Women's and Babies' services<br>More detailed description of the case for change on website/available to post<br>Summary of benefits – including which are required to meet standards and which are locally desired.<br>Detailed description of each benefit on website and available to post<br>Case studies demonstrating the current scenarios experienced and the scenarios desired/required by standards<br>Budgetary implications<br>Timeline for this process and longer term decision making<br>Information in alternative languages/formats | **Engagement groups comments:**<br>Confused – reword to make clearer…done |
| **2. What are the key questions you are seeking views on?**<br>These should relate to the objectives. Is it clear? Open not leading questions etc.. | |
| **Managers Answer:**<br><br>1. Please tell us about your interest in women's and babies' services…<br>- I have used/am using these care services<br>- Someone close to me is/has used this services<br>If yes please tick which A. maternity B. Gynaecology C. Surgery D. Fertility treatment E. Critically ill babies F. Genetics<br>If yes please describe your experience of using these care services:<br>Very positive /Positive / Neutral / Negative / Very negative<br><br>Please explain why if you wish to…<br><br>- Local resident who hasn't used these care services<br>- I work with people who use these care services<br>- Other – please state<br><br>2. Do you think that the clinical issues reported by Liverpool Women's clinicians and the need to improve safety make good reasons for changing these care services? | **Engagement groups comments:** |

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| - yes I think these are good reasons for change<br>- I am not sure these are good reasons for change<br>- I do not think these are good reasons for change<br><br>3. Do you think that the changing needs of patients in recent years make good reasons for changing these care services?<br>- yes I think these are good reasons for change<br>- I am not sure these are good reasons for change<br>- I do not think these are good reasons for change<br><br>4. How important do you think the following things are in improving services?<br>(online – please put these aims in the order you think is important with 1 most important and 5 least important)<br>(paper – please tick the TWO aims from the following that you think are most important)<br>- Patient safety and achieving good standards / high quality care<br>- Services being financially secure to serve local people for the future<br>- Routine care being as close to home as possible<br>- As many of these services as possible being on one site<br>- Having a good experience when receiving care<br><br>Other comments and demographic questions to be included. | **Confusing (been reworded)** |
| **5. What level of response would you want to achieve in terms of engagement? And what output do you need?**<br>Numbers of people / range of stakeholders / etc<br>What % of those that currently use the service?<br>Do you need qualitative / quantitative data or both? Think through who is going to use the feedback and what they will be looking for. | |
| **Managers Answer:**<br>10% of current service users 6000, 1000 family members, feedback representative of population<br>Quant and qual – qual from particular target groups<br>Staff subject to separate process | **Engagement groups comments:**<br>Ok query whether achievable |

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| **6. Capacity building…**<br>Will any stakeholders need time/support to better understand the issues before they are able to input? How can this be built in to the process (links to information),<br>How can ongoing engagement with those interested and involved be achieved?<br>Data needs to be entered into corporate database and handled appropriately (eg consent for future use, electronic storage). | |
| **Managers Answer:**<br>Stakeholders will need an explanation of the reasons why change is being looked at, this hasn't been shared with the public previously in any detail. Written and face to face communication will be needed to enable this understanding. Case studies will be used to make the scenarios easier to identify with for people responding. A record will be kept of those wishing to participate in future discussions/consultation. | **Engagement groups comments:**<br>Confusing - reworded |
| 7. **How will input and responses be sought?** - online? Face to face? Via a third party – either their communication channels or groups? Paper based? Social media?<br>Wherever possible the engagement should be arranged through My NHS contact system– this is how the CCG will demonstrate it has met its duties and is a very important part of process… | |
| **Managers Answer:**<br>For Liverpool CCG -<br>Online<br>Social media to share opportunity<br>Email / letter contact to those previously engaged with Healthy Liverpool<br>Face to face questionnaire<br>Group discussion/ similar via voluntary sector partners<br>Events - 4 in Liverpool, 1 in evening<br>VCSE partners will be invited to make proposals for certain groups<br>Face to face briefings with other stakeholders such as interest groups and politicians will be scheduled<br>Reports to OSC with opportunity for input. | **Engagement groups comments:**<br>**ok** |
| **8. Does this method/s exclude or adversely affect anyone?**<br>Will anyone not be able to take part? eg if all on-line. May the engagement itself distress anyone with protected characteristics* or any vulnerable groups**(see B2) eg someone affected by service/ bereavement.<br>If so what support can be put in place? | |
| **Managers Answer:** | **Engagement groups comments:** |

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| All materials will be made available in a variety of formats. The website is accessible. VCSE partners will be invited to support participation of particular equality groups and/or those less likely to engage through online/events. | **ok** |
| 9. **Test the process** – eg if it is a survey, test it with someone who is not involved in the process, see if the language is clear on a poster etc….describe here how you will do this.. | |
| **Managers Answer:**<br>Volunteers will be asked to test the communications materials and questions. | **Engagement groups comments:**<br>**ok** |
| **10.Communications Channels**<br>How will the opportunity to input be made known to people? What is the communication plan?<br>Think about the audience and where they will receive information / places they will be / trusted information sources for them eg charity / workplace / community networks / support groups…<br>Consider whether anyone would be excluded by the chosen channels | |
| **Managers Answer:**<br>A full communications plan has also been developed. During the engagement we will utilise the following channels:<br>• Social media – We will use the Healthy Liverpool Facebook account, and also the Healthy Liverpool Twitter account to promote the engagement.<br>• Websites – the Healthy Liverpool website will provide additional content about the engagement – sign-posted from social media posts, and an online version of the engagement questionnaire.<br>• Current contacts involved in HLP/previous engagement<br>• Direct at clinics/in hospitals<br>• Media relations – We will produce a press release to launch the engagement, and issue subsequent releases during the engagement period, with the aim of generating coverage in the media.<br>• Emails to networks of partners<br>• Partner communications channels (both internal and external) - We will share content for websites, intranet and social media channels with communications teams in local NHS trusts, the local authority, housing associations, Healthwatch and other organisations so that they can help spread the word about the engagement with staff and the public.<br>• Screens in GP practices – We will utilise the 'Envisage' TV screens in GP practices to share information about the | **Engagement groups comments:**<br>**ok** |

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| engagement.<br>• Printed materials – We are producing a leaflet about the engagement (incorporating a questionnaire) which will be distributed to key locations across the city, including libraries, leisure centres, hospitals, GP practices, and children's centres. | |
| Assessment of Information and Communication Proposals<br>1= Not clear needs a lot of further work<br>2 =Some issues need more clarity<br>3 = Clearly thought out and planned | **SCORE = 3** |
| **SECTION 4 - Understanding & Using Input Received** | |
| **1. How will responses be analysed?**<br>Who is responsible for receiving info? Who is responsible for analysing responses and reporting on this? If major reconfiguration an independent analysis of findings is recommended. Advice from CSU can be sought if unsure.<br>What process will be used for utilising feedback that wasn't expected – eg about a different programme area | |
| **Managers Answer:**<br>Information will be received by NHS Liverpool CCG. An external provider will be contracted to analyse the data and report on the findings. | **Engagement groups comments:**<br>**ok** |
| **2. How will responses be used?**<br>Will a group need to convene to review responses and decide how to incorporate? And who will document this? A report must be written which describes the engagement process and responses. Ensure equalities implications and responses from vulnerable groups and people with protected characteristics are recorded, action to address defined, included in specification, shared with relevant providers and that this process is transparently reflected and recorded in documentation and final reports. | |
| **Managers Answer:**<br>The report of the engagement will be considered by the formal governance process established for this project, namely the oversight board and the Committees in Common. The findings will be considered in the review process to influence the options and presented for formal consultation. | **Engagement groups comments:**<br>**ok** |
| **3. How will responses, and how they have been used, be fed back to participants and wider community?** | |

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| **Managers Answer:**<br>Feedback will be via partners, email, web, social media, media and VCSEs. | **Engagement groups comments:**<br>**ok** |
| **4. Timelines**<br>When do you need the responses in order to be able to analyse them, consider how to incorporate them and use them to change the final proposal?<br>How long will the engagement process take to give everyone a fair chance to get involved? CSU can advise.<br>How will changes be followed through and shared with relevant partners/providers | |
| **Managers Answer:**<br>Planning the engagement From…April 2016……..to……June 2016……<br>Conduct the engagement From……4th July 2016……..to……15th August 2016<br>Close the engagement…15th August 2016<br>Analyse responses……September 2016…….<br>Incorporate responses into pre-consultation business case and formal consultation proposals…October/November 2016<br>Write up response analysis and how this has changed the recommendations (must include Equality assessment, response and mitigation) October/November 2016<br>Feed back to engagement participants / wider community…Oct/Nov 2016<br>Feedback to providers / other partners…Oct/Nov 2016<br>Provision for advancing equality and engagement…following formal consultation | **Engagement groups comments:**<br>Timescales noted to be extremely tight for reporting and groups queried whether achievable. |
| Assessment of Understanding and Using Input received Proposals<br>1= Not clear needs a lot of further work<br>2 =Some issues need more clarity<br>3 = Clearly thought out and planned | **SCORE = 2** |
| **ASSESSMENT OF ENGAGEMENT AND E&D PLANS**<br>**Completed by engagement group** | |
| **1. Background and Purpose**<br>**2. Impact Scale and Risk**<br>**3. Information and Communication**<br>**4. Understanding and Using Input**<br><br>**Refer up to QSOC if moderate/high risk**<br><br>**Scores of 6/12 or less = proposal comes back to engagement group** | **Score =2**<br>**Score = 2 Level = High**<br>**Score =3**<br>**Score =2**<br>**TOTAL SCORE = 9/12**<br>**YES / NO** |

| Scores 7/12 and above, refinements to be made by manager with engagement support | |
|---|---|
| **OVERALL COMMENTS** | |
| I confirm that the engagement plan has been updated and reflects the comments of the group and the considered level of risk<br><br>**Signed…**  **…….Dave Antrobus, Lay member NHS Liverpool CCG, Lead for Engagement.** | |
| **COMPLETE SECTION E. FOLLOWING THE ENGAGEMENT PROCESS** | |
| **Information to be considered as part of a final EA report**<br>Must be submitted to SMT /Committee/Governing body as part of final approval and sent to Engagement lead for records and publishing on website | |
| **1. Describe the change now being proposed following equalities considerations and engagement activity.** | |
| **Managers Answer:**<br>A shortlist of options has been drawn up for consultation with the public. As of January 2017, four options had been assessed against the criteria of improving service quality, feasibility including workforce and public opinion issues, financial sustainability and fit with strategy. One preferred option, of building a new Women's hospital on the site of the Royal came out of the assessment. A full public consultation is required before a decision can be taken. Further work on financing is also required ahead of going to public consultation. | **Engagement groups comments:**<br><br>NB this section legal duty |
| **2. Is the service specifically designed to serve people with one or more protected characteristic*?** Eg for deaf people | |

| Managers Answer: | Engagement groups comments: |
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| No | NB this section legal duty |

**3. Equality and Diversity Duty – Pre Equalities Assessment, updated following engagement activities**

In the table indicate for each protected characteristics*/vulnerable groups**(B2) any possible detriment identified in further research and/or through the engagement.

**Are any vulnerable groups** particularly affected /disadvantaged?**

| Managers Answer: | Engagement groups comments: |
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| Services provided by Liverpool Women's Hospital are not for one specific group.<br><br>This is a Pre-Consultation Assessment. It incorporates the latest intelligence and potential issues identified during this phase of engagement. These will be checked during the next stage of the process which will be the formal consultation itself. The final assessment will be produced following the consultation and will reflect these and any further issues identified in that process. Further details regarding Sefton and Knowsley residents views will also be sought during the consultation. | NB this section legal duty |

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| | | Discrimination? | Equality of Opportunity-life chances? | Foster good relations? |
|---|---|---|---|---|
| i.Race* | Y | Women living in disadvantaged or minority groups and communities are significantly less likely to access services early or maintain contact throughout their pregnancies. They are also less likely to breastfeed. In consequence, the outcomes for their own and their babies' health and well-being are worse than for the population as a whole. It is important that services are designed to meet their needs.<br><br>Under options that move services away from the city centre, BME communities will encounter a disproportionate negative impact in accessing services due to the BME community experiencing:<br><br>1) Disproportionate increase in travel time, | Women from some ethnic minority groups have expressed concern over feeling uncomfortable accessing care in a mixed-sex hospital and that this would have a significant adverse impact on their patient experience. Under options that move services from the women's hospital, mitigations must be in place to ensure that women from these minority groups can experience the same quality of care as the general population by allowing patient preference for gender of clinician and providing women's only spaces and clinics. Provision of training to staff to support asylum seekers and refugees is essential. Fast and appropriate interpretation services must be in place. Signposting to financial and social support would be beneficial.<br><br>The 2016 engagement survey indicated that fewer BME respondents recognised the clinical case for change, whereas this wasn't so clear in the qualitative responses and this wasn't statistically significant. | |

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| | | when compared to the rest of the population, as higher users of public transport.<br>2) Higher levels of harassment on public transportation<br>Both of which may entail unlawful discrimination.<br>Census data suggests that people from Black and Minority Ethnic (BME) communities tend to live in central Liverpool. People from the Black and Somali communities tend to live particularly close to LWH's Crown Street site, while people from the Chinese community tend to reside between the LWH and RLH campuses. People from South Asian communities are more dispersed throughout Liverpool. In this context, options that increase travel times may entail unlawful discrimination.<br>Liverpool is an assessment and dispersal area for | | | | |

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| | | asylum seekers and refugees, assessing around 3000 people in 2013. Liverpool has declared itself a City of Sanctuary. 1350 people were seeking asylum and resident in Liverpool in 2013, living in north and central liverpool. The four options are unlikely to make a significant difference in terms of access.<br><br>This population are identified by Faculty of Public Health as one of the most vulnerable groups in our society. Pregnancy requiring assessment and psychological distress and frequently noted conditions among women arriving in the city. Studies have shown poor antenatal care and pregnancy outcomes amongst refugees and asylum seekers. Asylum seeking, pregnant women are seven times more likely to develop complications during childbirth and three times more likely to die than the general population. There are indications that | | | | |

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| | | this population are already reporting negative experiences at LWH and changes to staff training are required. Understanding of other health conditions such as rheumatic fever, HIV, TB, mental health problems etc. are required to ensure good care from first presentation. Consideration of other adaptions may be beneficial during any new build/reconstruction. | | | | |
| ii. Age* | Y | Age group Liverpool<br>Under 16 17%<br>16-29 26%<br>29-64 44%<br>65+ 14%<br>Elderly individuals could be adversely impacted by longer travel times to access services compared to other age groups due to lower mobility and potentially higher financial constraints. In this context, options that increase travel times may entail unlawful discrimination. | A variety of communications methods must be used to ensure all service users receive information regarding the service reconfiguration and related public consultation events. Methods of communication must be used that target community members, particularly the elderly, who may not have regular access to computer based outreach campaign | | | |
| iii. Sex* | Y | In 2011, approximately 51% of the Liverpool population | Options that increase travel times may hinder equality of opportunity | | | |

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| | | were women while 49% were men. Given that gynaecology and obstetrics services are focused on women, a reconfiguration of women's and neonatal services will have a greater direct impact on women than men. Women as mothers are also directly impacted by the reconfiguration of neonatal services Women as mothers and carers, and often as lower income earners, may face a higher opportunity cost of time and be less able financially to afford travel. In this context, options that increase travel times may entail unlawful discrimination. | by creating a disadvantage for women. In this context, these options must provide mitigations to ensure women have equal ability to access services | | | |
| iv. Disability* | Y | People with physical disability and mobility impairments may find access to services at a new location more difficult and need additional help with navigation. New build facilities must ensure good access and facilities in clinics and wards for people with learning and physical disability and sensory | | Engagement for the public regarding potential service reconfiguration is an opportunity to foster good relations between those with disabilities and those without. It will give a chance | | |

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| | | impairment and ensure appropriate provision for carers as required.<br>People with disabilities live across Liverpool and access is not thought to be significantly affected by the proposed changes. Co-location of LWH services with other acute services may improve care for people with disabilities where specialist care may be required more frequently due to increased complexity.<br><br>Transport barriers encountered by disabled people affect their participation in society, including their access to health care provision. Car access tends to be lower for disabled people. People with disabilities are less likely to drive and more likely to be dependent on public transport.<br>Both RLH and AH are more accessible for disabled individuals when compared to LWH. | | for those with disabilities to be a part of larger community events, and share their experiences and opinions, leading to a greater understanding by those who do not have a disability on the needs and experiences of those who do. | | |

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| v. Religion and belief* | Y | Hindu, Muslim and Sikh groups report community members experiencing discrimination on public transportation. Options which increase average travel times to access care may have a disproportionately adverse impact on individuals from these communities and may create indirect discrimination of these religious groups in terms of ability to access care. | Similar to women of certain ethnic minority groups, women of certain religious groups have expressed concern over services that are not separated by patient gender and the significant adverse impact this would have on their patient experience. Under options that move services from the women's hospital, mitigations must be in place to ensure that women from these religious groups can experience the same quality of care as the general population by allowing patient preference for gender of clinician and providing women's only spaces and clinics. | The 2016 engagement survey indicated that fewer Buddhist respondents may have recognised the clinical case for change. This wasn't statistically valid but this issue could be explored more in consultation seeking to increase input in this community. | | |
| vi. Sexual orientation* | Y | Some indications from responses to 2016 engagement that bisexual respondents may not have recognised the case for change as strongly although numbers of responses were small, the engagement with the community should seek to be larger for the consultation. | Services must be inclusive and offer opportunity for LGBT individuals to feel as comfortable and welcome in accessing these services as non-LGBT individuals | Engagement and consultation with the public must seek to involve members from the LGBT community and ensure the opinions and needs of this population are addressed. These engagement events offer a chance to bring together individuals from | | |

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| | | | | different backgrounds and Protected Characteristics to share opinions and serve to promote better understanding and relationships between different communities in the region. | | |
| vii. Gender reassignment* | Y | Options that specify a "women's hospital" or a "family hospital" for services may cause unintended discrimination against individuals who do not identify with the gender advertised or who do not conform to the traditional model of 'family care'. Some clinics provide gender-specific or gender segregated services. An example of the former may be a clinic performing prostate examinations. Similarly clinics dealing in genito-urinary infections may have sessions for men and sessions for women, or separate entrances. It would be unacceptable to require | Services must be inclusive and offer opportunity for transgender individuals to feel as comfortable and welcome in accessing these services as non-transgender individuals. | Engagement and consultation with the public must seek to involve members from the transgender community and ensure the opinions and needs of this population are addressed.<br><br>Training for all staff to enable understanding and appropriate care is required. Staff who work in services which link into recognised | | |

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| | | a trans woman to use a waiting room for men in the former case, or for a trans man to share a female clinic waiting area in the latter case. If an examination needs to be conducted in specific room because it contains appropriate equipment, but which would not ordinarily be used for a person of that gender (for example, a trans man needing to be examined in a room ordinarily used for the examination of women), this should be clearly explained to the patient and sensitively managed.<br>Single gender accommodation in any option must make provision for people to be accommodated in the ward of the gender to which they present\identify.<br>Bathroom and other facilities similarly with a need for care in sensitive situations associated with procedures.<br>Many trans patients who are on long term hormone therapy may be required to | | pathways for addressing gender variance e.g. urology, endocrinology, etc. should familiarise themselves with local pathways for addressing gender reassignment. This is also true of services which may frequently interact with trans patients e.g. outpatients, surgical wards, emergency departments, etc. The current (at time of authoring) protocol can be found here: https://www.england.nhs.uk/wp-content/uploads/2013/10/int-gend-proto.pdf | | |

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| | | stop taking their medication for many weeks prior to any elective surgical procedure. There is the potential for this to have an impact on their outward appearance, and should not disadvantage them from appropriate accommodation within a hospital ward. | | | | |
| viii. Marriage/civil partnership* | Y | In 2011, 47% of people aged 16 and above in England were married or in a civil partnership. Most children continue to be born to parents who are either married or in a civil partnership, although it is increasingly common for children to be born to parents who are not married or in civil partnership. In Liverpool, marriages and civil partnerships are less common than in England overall. In 2011, only 32% of people aged 16 and above were married or in a civil partnership in Liverpool. In 2014, only 37% of babies were born to parents who were married or in a civil | | | | |

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| | | partnership in Liverpool. | | | | |
| ix. Pregnancy and Maternity* | Y | Pregnancy and maternity impact women of childbearing age (often considered to be women who are 15 to 44 years old). Women of childbearing age are likely to be a significant majority of obstetric patients, although younger and older women could also seek obstetric care. Pregnant women may have more difficulty travelling for care, as such options that increase travel times may cause unintended discrimination. Of particular concern are pregnant teenagers who are further limited in their ability to travel for care, resulting in further unintended discrimination towards this sub-set of the protected characteristic. Among women who are pregnant, expectant teenagers will require particular support. Teenage pregnancies can pose higher health risks for the mother and the neonate and pregnant teenagers may | Sub-sets of the pregnant population may face further difficulty in accessing services under options that increase travel times; pregnant teenagers must be provided with additional support to be able to access services as easily as others. | | | |

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| | | experience unique challenges and anxieties particularly if the pregnancy was not planned or if the news of the pregnancy cannot be shared with family and friends. Pregnant teenagers may also face societal discrimination and have difficulties advocating for themselves to get the care they need as expecting mothers.<br><br>Although the incidence of teenage pregnancy varies across Liverpool, central Liverpool reported one of the highest teenage pregnancy rates from 2008 to 2010, with 92.5 pregnancies per 1,000 women aged 15-17. Figure A19-4 below illustrates that teenage pregnancies tend to occur in distinct pockets in the central and south-eastern parts of the city. | | | | |
| x. Homeless people** | N | | | | | |
| xi. Single parents** | Y | Comparatively, mothers who are not married or in a civil partnership tend to be younger than mothers who | | | | |

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| | | are married or in a civil partnership. Approximately one third of mothers who are not married or in a civil partnership are also not in a cohabiting relationship with the father of the baby. Young, single mothers may be more likely to experience financial problems or suffer from social exclusion and mental health issues. They may be more vulnerable, less able to travel, and perhaps less confident in accessing care at a "family hospital". All of these factors together are likely to contribute to lower patient experience and a lesser ability to travel to access services. | | | | |
| xii. People with learning difficulties** | Y | It is estimated that approximately 10,000 people in Liverpool live with a learning disability . Under options that move service location, learning disabled or cognitively impaired individuals may have a harder time understanding the implications of the service reconfiguration and how to access services, | | Engagement for the public regarding potential service reconfiguration is an opportunity to foster good relations between those with learning disabilities and those without. It | | |

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| | | which, if these individuals are left unsupported may create discrimination. | | will give a chance for those with learning disabilities to be a part of larger community events, and share their experiences and opinions, leading to a greater understanding by those who do not have a learning disability on the needs and experiences of those who do. Those with learning disabilities often find it difficult to express their needs or are unable to understand how to access services to address their needs. It will take careful, multi-organisational planning to ensure individual with learning | | |

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| | | | | disabilities are supported to not only come to engagement events, but prepare and aid them in sharing their opinions and experiences in these community engagement settings, and in cases where they are unable to do so, have advocates present to share for them | | |
| xiii. Low incomes** | Y | socio-economic factors are known to be significant contributors to health inequalities, patient experience and health outcomes.<br>In particular:<br>For maternity, social deprivation has been linked with low levels of antenatal care, low birth weight, unintended and teenage pregnancy, and high levels of maternal mortality.<br>For neonatal care, social deprivation has been linked with higher death rates | | | | |

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| | | amongst infants and neonates, as well as mental and/or physical health problems in children throughout infancy.<br>For gynaecology, socio-economic deprivation has been linked to poor outcomes for gynaecological cancer. ,<br>Liverpool is one of the more deprived local authority areas in England. 45% of neighbourhoods in Liverpool are amongst the most deprived 10% of neighbourhoods nationally. Liverpool is also the local authority with the largest number of neighbourhoods in the most deprived 1% of all neighbourhoods nationally. There is no adverse travel impact (i.e. increase in travel time) for more deprived populations under options that move services away from LWH's current Crown Street site. However, people from socio-economically deprived backgrounds may experience greater financial constraints or have less | | | | |

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| | | information about services, which could limit their ability to access services. | | | |
| xiv. Addictions** | N | | | | |
| xv. Veterans** | N | | | | |
| xvi. Offenders** | N | | | | |

*=Protected characteristic
**=Vulnerable group

**4. Equality and Diversity Duty –**

A) Describe the issues identified for protected characteristics*/vulnerable groups**(B2) List who was involved in the engagement reflecting these groups? What solutions were identified as possible mitigation?
B) What action has been taken to remove the discrimination /disadvantage,
C) advance equality of opportunity and
D) foster good relations?
E) Describe how these requirements have changed service design / specification? List the recommendations to ensure proposal meets PSED , demonstrate why does/ doesn't meet Equalities Act 2010.
F) How will impact be monitored? Include a timeline showing who is responsible for what, when.

**Managers Answer:**

All of the groups identified above were engaged in the process during the summer of 2016. A number of issues were identified from analysing responses of those groups and also from desk research. A full description of the issues is set out in the Pre-Consultation Engagement Report and also in the Pre-Consultation Business Case, particularly Appendices 18 and 19, both documents can be found on the Women's and Babies services page of the Healthy Liverpool Website. www.liverpooltalkshealth.info/liverpool-womens-hospital-review-of-services.

It is not possible at this stage to assess compliance with PSED. The final assessment will be produced following the process of formal consultation. The current data will be used to inform the full and final EIA. At that stage mitigations will also be described along with how proposals comply with PSED.

**Engagement groups comments:**

NB this section legal duty

**5. Knowledge and learning**

What were the main findings from the engagement that aren't relating to equalities? How have plans been amended in response to issues raised?

**Managers Answer:**

There was a positive reaction to the case for change, with the majority of participants agreeing that the issues addressed were good reasons for change.

• The qualitative data showed that more participants agreed with the 'clinical need for change' than those who recognised the issues set out about 'the changing needs of patients'. This was different to the result of the quantitative data. However, across all groups it was thought that the issues described were good reasons to change and this was felt particularly strongly with reference to the lack of an intensive care unit (ICU) and need for an improved neonatal clinic.

• The personal rating of service delivered by Liverpool Women's Hospital has a significant influence on people's alignment with reasons for change. There was a relationship between having a good experience at Liverpool Women's Hospital and thinking there were not good reasons for change.

• A clear top 2 priorities for change to achieve emerged: 'Patient safety and high quality care' (91%) and 'Having a good experience of care' (51%) - this was common from both the qualitative and quantitative data. Other priorities in order of importance were: Services being financially secure (22%), Services being located on one site (17%), Routine care being closer to home (12%) and Travel times (2%).

• Participants were eager that LCCG explore options that did not involve Liverpool Women's Hospital site closing. This was because of a number of reasons including; proximity to home, excellent standard of care and the benefits perceived of a Women's only hospital.

• Several themes ran throughout most community engagement qualitative feedback. In summary it was found that attendees:

- o Generally supported the need for change but many would like to see the current Liverpool Women's Hospital site built upon and improved
- o Respected and are ready to support the clinicians reasons for change
- o Were concerned that the reasons for change may focus on critical cases rather than the needs of the majority of patients.

**Engagement groups comments:**

NB this section legal duty

**6. Feedback**

Have you feedback to respondents and the wider community on the outcome of the engagement and how their involvement has been incorporated into final decision making. If you included in decision making you will need to explain why.

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| **Managers Answer:**<br>The feedback was collated into the report August and September 2016. The findings were considered by the team writing the Pre-Consultation Business Case and reviewed particularly against the shortlist of options being assessed. The priorities and issues raised by people in the engagement were used to provide a score for public acceptability which formed part of the feasibility element of the assessment of each option.<br>The engagement report has been published on the website. It was sent by email to everyone who provided contact details asking to be kept informed about the engagement and/or Healthy Liverpool on 23rd September and those contactable only by post were advised of its publication and given a phone number to call to request a copy. VCSEs who supported the engagement were asked to also share the feedback report in their communities as part of their work on the topic.<br>The website is and will continue to be used to update members of the public on the process and progress towards consultation. | **Engagement groups comments:** |
| **7. Specifications and Delivery**<br>How you can build ongoing public and patient engagement and equalities duties into specifications for providers, along with opportunities for volunteering, peer support etc..(see social value strategy)… | |
| **Managers Answer:**<br>Future plans for LWH services will be subject to formal consultation. Specifications for services are not being rewritten at this stage. Volunteers will be involved in facilitating the formal consultation and should services be revised once final plans are known it would be possible to review use of volunteers and also to review the specifications for services as appropriate. | **Engagement groups comments:** |
| **8. Procurement**<br>Consider how those involved in the engagement or in relevant groups could support the commissioning – assisting in final specification drafting, procurement and selection, contribute to programme groups and in monitoring delivery etc… so participation is an ongoing process. | |
| **Managers Answer:**<br>No procurement envisaged at this stage, however if any changes to facilities or services arise, public/patient volunteers would be sought to contribute to the process and in particular if any facilities are redesigned, input from service users with particular needs will be sought. | **Engagement groups comments:** |

| A. ASSURANCE and REPORTING | |
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| **PROJECT LEAD – include all engagement and equalities considerations and actions in any reports regarding change and seeking decisions.** | |
| **CCG ENGAGEMENT AND EQUALITIES LEAD/S -** | |
| **Recommend report to QSOC** | **YES** |
| **Recommend report to Governing Body** | **YES** |

**DEFINITIONS**

***Groups with legally protected characteristics** - Race, Age, Sex, Disability, Religion and belief, Sexual orientation, Gender reassignment, Marriage/civil partnership, Pregnancy and Maternity

****Vulnerable Groups** - Homeless people, single parents, people with learning difficulties, low incomes, addictions, veterans, offenders…

**Direct Discrimination** - when someone is treated less favourably than another person because of a protected characteristic they have or are thought to have, or because they associate with someone who has a protected characteristic. Associative Discrimination is direct discrimination against someone because they associate with another person who possesses a protected characteristic. Perceptive Discrimination is direct discrimination against an individual because others think they possess a particular protected characteristic. It applies even if the person does not actually possess the characteristic.

**Indirect Discrimination** -Indirect Discrimination can occur when you have a condition, rule, policy or even a practice in your organisation that applies to everyone but particularly disadvantages people who share a protected characteristic.