# Consultation Plan for Redesign of Liverpool's Orthopaedic and Trauma services

**This document has been prepared by NHS Liverpool CCG as a joint framework to engage with Liverpool, South Sefton and Knowsley communities.**

| COMPLETE SECTIONS A-D AT THE START OF PROCESS AS A PLANNING TOOL | |
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| **NAME OF PROJECT:- ORTHOPAEDIC Services** | **Manager:** |
| **SECTION 1 - Background and Purpose** | |
| **1. Details of the service / provision -** Describe clearly the current situation | |
| **Managers Answer:**<br>**Orthopaedics**<br>Orthopaedics covers injuries and diseases of the body's muscles, skeleton and related tissues including the spine, joints, tendons and nerves.<br><br>Within Liverpool, adult Orthopaedic services are provided by both University Hospital Aintree and the Royal Liverpool and Broadgreen hospital. These services provide emergency and non-emergency care, that may:<br>• diagnose injuries or disorders using X-rays, blood tests or other tests<br>• treat injuries or conditions with medication or surgery<br>• recommend exercises or physiotherapy to restore movement, strength and functionality<br><br>Some of the most common operations orthopaedic surgeons carry out include:<br>• repairing fractured bones – such as broken arm or wrist, broken ankle, broken collarbone , broken hip, broken leg, broken ribs<br>• arthroscopy – a minimally invasive (keyhole) technique, where tools are inserted into a joint to diagnose and repair damaged joint tissue, such as cartilage damage<br>• repairing damaged muscles, torn tendons or torn ligaments<br>• arthroplasty – surgery used to replace or resurface joints, usually because of arthritis; hip replacements and knee replacements are two widely used and highly effective operations<br>• surgery to correct bony deformity – procedures to correct deformities of the spine or limbs that either limit function or would cause long-term problems if left untreated. Examples are fusion surgery (where bones are welded together to heal into a single, solid bone) and osteotomy (correcting a bony malalignment to help prevent degeneration of an adjacent joint)<br><br>**Overview of how Orthopaedic services are provided in Liverpool** | **Engagement groups comments:** |

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| In additional to serving Liverpool patients, orthopaedics services in Liverpool are regularly used by people in Knowsley and South Sefton.<br>The configuration of services across Liverpool are described below.<br><br>**RLBUH**<br><br>Within the Royal Liverpool and Broadgreen hospital, orthopaedic services sit within the Trauma Orthopaedics and Rheumatology Clinical Business Unit. The Royal Liverpool University Hospital is a major provider of orthopaedic trauma in Cheshire and Merseyside. In addition to providing elective and non-elective services to the local population it also acts as the largest tertiary referral centre for orthopaedic trauma within the North West.<br><br>The department consists of 30 Consultant surgeons (26 wte) with various different sub-speciality interests, covering the whole of orthopaedics. The department can treat all orthopaedic injuries irrespective of the complexity or body part. There are 7 lower limb surgeons, 3 upper limb surgeons, 2 hand surgeons, 3 foot and ankle surgeons, 3 limb reconstruction surgeons and 4 spinal surgeons.<br><br>Twenty one of the thirty orthopaedic surgeons regularly undertake trauma surgery and the department operates a team based approach to trauma such that at any time there are 7 consultants available to manage trauma covering all sub-specialities. This ensures that patients can be operated on when they need it rather than when the right consultant is available and also allows patients with multiple trauma injuries to be operated on by multiple sub-specialists at once when required.<br><br>The directorate offers a regional limb reconstruction service which supplies hospitals throughout Cheshire and Mersey as well as Greater Manchester, Lancashire, The Isle of Man and North Wales. The limb reconstruction service works very closely with the plastic surgeons from Whiston Hospital to form the Mersey ortho-plastic group.<br><br>The lower limb service specialise in the treatment of all complex lower limb trauma and work closely with the limb reconstruction service to be able to provide surgery to all aspects of lower limb trauma including peri-prosthetic fractures and complex soft tissue injuries.<br><br>The department has an extended multi-disciplinary team with two Consultant orthogeriatricians, three Consultant musculoskeletal radiologists and a specialist in musculoskeletal microbiology. Further it has 3 trauma co-ordinators and a large team of specialist nurses and extended scope physiotherapists as well as a highly experienced ward and clinic team.<br><br>The department has two fellowship trained pelvic and acetabular surgeons who form part of the North West Pelvic and Acetabular Group. They are able to offer a percutaneous approach to the fixation of many fractures, allowing a much speedier recovery for the patients. | |

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| The service has 4 spinal consultants who undertake all aspects of spinal trauma including cervical trauma. The spinal service operates a 24/7 rota for the management of these injuries.<br><br>The combination of shoulder and elbow surgeons together with the hand and wrist surgeons offer the largest unit within the region and again can treat all aspects of upper limb injuries (including brachial plexus injuries). Again, working with the plastic surgeons from Whiston, they offer a service for the most complex upper limb injuries (with the exception of re-implantations).<br><br>The Trust has three foot and ankle Consultant surgeons who have a great deal of experience in managing complex mid-foot and hind-foot conditions including Lisfranc injuries and talus and os calcis fractures.<br><br>Working closely with the sarcoma service, the Trust offers a metastatic bone service working in a multi-disciplinary way to investigate and manage any long bone or spinal metastases as part of the cancer network.<br><br>Finally, as the regional vascular unit is situated in the Royal Liverpool Hospital, the Trust is in a position to deal with orthopaedic injuries that present with significant vascular compromise.<br><br>**Referral Management**<br><br>Referrals are currently triaged by advanced therapists. Booking of appointment is managed by the health records booking team.<br><br>**Outpatient Services**<br><br>Fracture clinic appointments are managed and booked through a virtual fracture clinic service managed on the Royal Liverpool site. Appointments are provided at a designated fracture clinic on the Royal Liverpool site.<br><br>Elective clinics (scheduled/non-emergency procedures) are currently provided in the Orthopaedic centre on the Broadgreen hospital site. With the exception of hand clinics which are provided on the Royal Liverpool site in fracture/ spinal clinics. All spinal clinics are provided at the Royal Liverpool hospital in a spinal clinic.<br><br>**Elective Inpatient Care**<br><br>The majority of elective orthopaedic care and limb reconstruction services are provided at the Broadgreen hospital site utilising an average of 6 elective lists per day and having access to 30 elective beds. Broadgreen hospital does not currently have Level 3 bed (ICU) and therefore all patients undergoing surgery on the Broadgreen site require pre-operative assessment to assess fitness for surgery to be undertaken on the Broadgreen site.<br><br>**Orthopaedic Trauma** | |

Orthopaedic trauma care and spinal surgery is provided at the Royal Liverpool hospital which has high dependency and intensive care unit beds. The department utilises 2 trauma lists per day on average and has access to 42 trauma beds on the Royal Liverpool site.

## Aintree Overview

Orthopaedic Services at Aintree Hospital sit within the Surgical Specialities Clinical Business Unit and are supported by a, Clinical Director, a Major Trauma Clinical Director and a Clinical Business Manager

Aintree Hospital is a major provider of Orthopaedic Trauma in the Cheshire and Merseyside region. It provides elective, complex elective, trauma and major trauma services to the local population and the population of the North West. The Department consists of 18 Consultant Surgeons with various sub specialty interests. The Department consists of 4 upper limb surgeons, 3 foot and ankle surgeons, a spinal surgeon, 1 full time trauma surgeon and 9 lower limb surgeons.

Sixteen of the Orthopaedic Surgeons regularly undertake Trauma Surgery and are on the Trauma Rota. Five surgeons lead on the major trauma rota and are available 9-5 Monday to Friday to perform major trauma ward rounds and attend the trauma calls. At the weekend there are two consultants on call. One manages the trauma list. One manages the major trauma ward round; trauma calls and reviews patients on the ward.

The lower limb services specialise in treatment of all complex lower limb trauma and elective work. Consultants have interests in hip, knee and foot and ankle surgery. The Department undertakes complex soft tissue knee injuries and peri-prosthetic fractures.

The Department has an extended multi-disciplinary team with 2 consultant ortho-geriatricians (1 WTE), Consultant musculoskeletal radiologists and a microbiologist with a specialist interest (based at the RLUH). There are 3 trauma co-ordinators who provide service throughout the week and weekends.

There are 3 surgeons trained in pelvic and acetabular trauma surgery and form part of the North West Pelvic and Acetabular Group.

The spinal surgeon at Aintree does not participate on the trauma or spine on-call rota. He undertakes elective surgery but does not undertake spine trauma cases.

At Aintree 4 upper limb surgeons cover specialist interests with shoulder, elbow and hand. There is 1 full time elective hand surgeon. The unit does not have scheduled attendance by a plastic surgeon. There are links with St Helens and Knowsley NHS Trust Plastic Surgeons who attend as needed.

The 3 foot and ankle consultant surgeons have extensive experience in managing complex foot and ankle conditions including complex traumatic conditions.

At Aintree trauma and elective activity is provided on the one site.

### Referral Management and Outpatient Services

The Trauma & Orthopaedic department has a devolved Outpatient Service (this means that the outpatient service is part of and is managed by the orthopaedic department), which comprises of a Patient Appointment Centre, clinic clerks and nursing establishment.

Fracture clinic appointments and elective clinics are managed and booked through the devolved Patient Appointment Centre and appointments are held on the Aintree hospital site.

### Elective Inpatient Care

Elective orthopaedic care services are provided at the Aintree hospital site utilising an average of 2 elective lists as well as 1 day case list per day and having access to 24 elective beds.

### Orthopaedic Trauma

At Aintree trauma services are provided by 18 surgeons, utilising 1 trauma list per day supported access to the major trauma centre theatre on a daily basis. There are 30 orthopaedic trauma beds.

The table below provides an overview of services provided at each acute site.

| | Orthopaedic Trauma | Tertiary centre for orthopaedic trauma | Lower limb surgery | Upper limb surgery | Hand surgery | Foot and ankle surgery | Spinal surgery | Pelvic surgery | Sarcoma Service | Limb reconstruction | Plastic surgery | Fracture clinic |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Aintree University Hospital | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | | Not on site | ✓ |

| Royal Liverpool and Broadgreen hospital | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
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### Major Trauma

Currently both Aintree University Hospital and Royal Liverpool and Broadgreen hospital have been providers of major trauma services as part of a collaborative model. This position has changed with the commencement of Aintree Hospital as the single receiving site for major trauma in Cheshire and Merseyside from 1st April 2017.

The establishment of Aintree Hospital as the single receiving site and the potential for increased volumes of complex single trauma to be transported to the site, alongside major trauma cases has implications for the elective inpatient services at Aintree.

### Demand for services

In 2015/16, elective inpatient admissions (excluding spinal) totalled 3,300 admissions across the two Trusts, a figure that is expected to increase to circa 3,350 by 2017-18. Day case activity in the same period totalled 6,395 admissions across the two Trusts, a figure that is expected to increase to circa 6,500 by 2017-18:

The table below shows patient activity broken down by CCG area.

| CCG | Orthopaedic Trauma | % | Elective Orthopaedics | % |
|---|---|---|---|---|
| Liverpool | 2215 | 61% | 5354 | 55% |
| South Sefton | 712 | 20% | 1689 | 17% |
| Knowsley | 261 | 7% | 1417 | 15% |
| Other * | 446 | 12% | 1235 | 13% |
| TOTAL | **3634** | **100%** | **9695** | **100%** |

## Ear, Nose and Throat (ENT) Services

Ear, Nose and Throat (ENT) services diagnose and treat diseases of the ear, nose, throat and the head and neck along with providing Head & Neck cancer specialist treatment.

The current ENT services in Liverpool are split across The Royal Liverpool and Broadgreen Hospitals NHS Trust and Aintree University Hospital NHS Foundation Trust. Each Trust offers outpatients services, inpatient care and day case services. The inpatient and day case activity at RLBUHT takes place at Broadgreen Hospital (BGH).

The Regional Head and Neck Cancer Service is provided by Aintree Hospital and services are spread across a number of other hospitals in the region.

The volume of ENT activity split by BGH/AUH site is shown below.

| RLBUHT Broadgreen Site ENT Inpatient and Daycase Activity. 15/16 | | AUH Inpatient and Daycase Activity 15/16 | |
|---|---|---|---|
| Inpatient | Day case | Inpatient | Daycase |
| 204 | 919 | 910 | 1039 |

**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:**
A provider led reconfiguration of services is being considered which would affect the way Orthopaedic and ENT services are delivered and the access/ location of services. This will be the first public consultation to consider a single service proposal.

**Preferred option**
The Orthopaedic clinicians from both University Hospital Aintree and Royal Liverpool and Broadgreen hospital Trusts have developed a consistent clinical view that joint working is essential to improve patient outcomes and to sustain trauma and orthopaedic services in the local health economy.

Having completed a feasibility study, a joint working group of Orthopaedic Consultants and management from both Trusts, have proposed a future model that would consolidate and integrate Orthopaedic Services across both sites to create a single Liverpool Orthopaedic and Trauma Service. The preferred model seeks to deliver high quality care

**Engagement groups comments:**

**Prior to consultation the financial cost will need confirming and will be included in consultation materials.**

| by integrating services and proposes a redesign to develop a specialist Orthopaedic centre at Broadgreen Hospital, delivered by one consultant team. This would mean:-<br><br>• Orthopaedic elective and inpatient day case work would be based at Broadgreen Hospital, with beds ring-fenced beds. This allows for almost all orthopaedic inpatient activity to be undertaken at a single site.<br>• Orthopaedic outpatient clinics would continue be provided at Aintree and Broadgreen, with complex sub-speciality clinics at Broadgreen only.<br>• Inpatient Trauma care would continue be to provided on the Aintree Site<br>• Out-patient orthopaedic fracture clinics would continue to be provided across both sites – Aintree and the Royal.<br>• Both Trusts A&E departments would continue to deliver trauma care.<br>• Broadgreen would continue to provide the limb reconstruction service<br><br>In order to accommodate the changes to Orthopaedic services, there will have to be a change to the way inpatient and day case Ear, Nose and Throat (ENT) services are provided. Reconfiguring ENT services has already been identified as an area that could benefit by adopting a single service approach and this would be phased as oart of the orthopaedics redesign.<br><br>At the moment these services are split across Broadgreen and Aintree. As with Orthopaedics, this means there is some duplication. The proposal is to move all inpatient and day case ENT services to Aintree, which is already home to the Regional Head and Neck Cancer Service and carries out the majority of inpatient and day case ENT work. All outpatient services would be unaffected.<br><br>**How does this differ to the current service configuration?**<br>The main configuration changes arising from the preferred model are as follows:-<br><br>• Elective and inpatient day cases/surgery would no longer be provided at University Hospital Aintree<br>• Orthopaedics sub-speciality clinics would no longer be provided at University Hospital Aintree<br>• Elective and inpatient day case surgery would no longer be provided at the Royal hospital site – it would move to Broadgreen.<br>• Under the preferred option an additional 33 beds would be required at Aintree and 13 at Broadgreen, whilst a reduction of 41 orthopaedic beds would be achieved at the Royal site. | |
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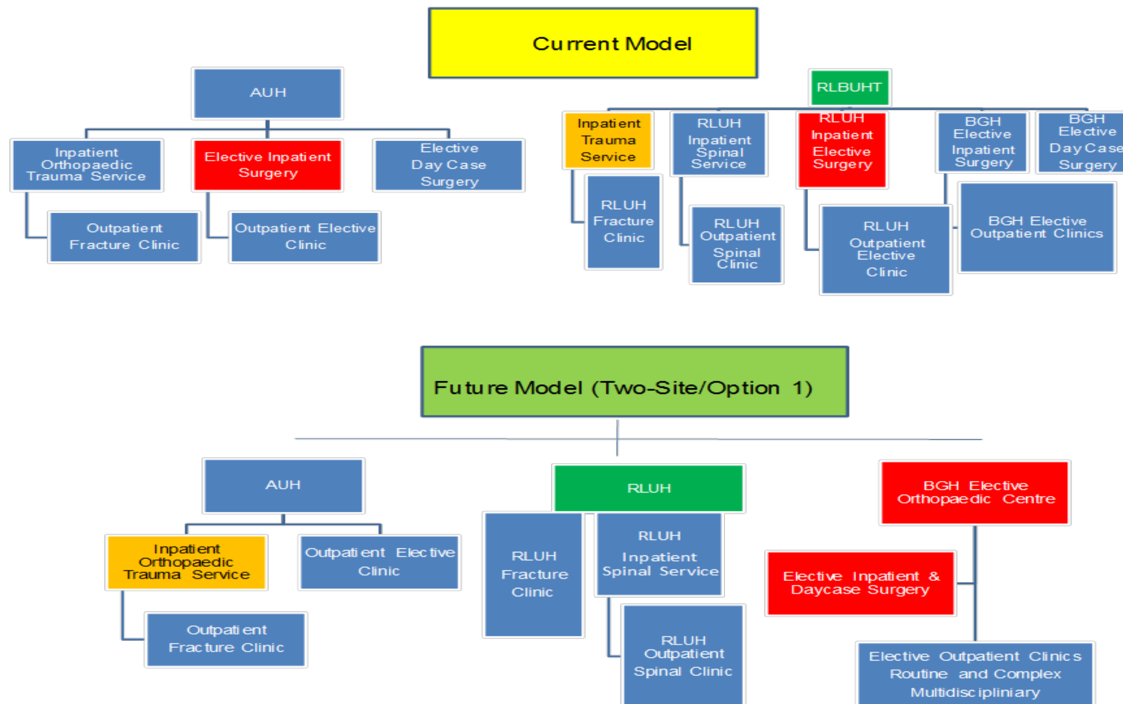
- Adoption of best practice across providers would mean the virtual fracture clinic model currently in operation at Royal Liverpool and Broadgreen University Hospital would be adopted by across the service. This is led by a Consultant Surgeon, Advanced Therapy Practitioners and an administrator. All patients who have attended Accident and Emergency and have been treated for an orthopaedic injury are assessed based on clinical history and review of diagnostics. The patients are then contacted by telephone and are either discharged to their GP, or offered a booked sub specialty follow up appointment in fracture clinic. This has resulted in reduced waits for follow up as it has reduced unnecessary visits and ensures "right first time" review by the correct sub-specialty. This has shown a 25% reduction in New Fracture Clinic attendances since commencement in January 2016
- Inpatient and day case ENT services would no longer be provided at Broadgreen Hospital.

These changes are summarised in the figure below.



| Other potential solutions considered<br>Other potential solutions considered for orthopaedic services but ultimately scored less favourably in the options appraisal and feasibility study included:-<br><br>• **A split site option**<br>This option was a variation on the preferred option but with most elective and day case activity taking place at Boadgreen and a smaller percentage at Aintree. This option was discounted as there would be a shortage of theatre space and reduced opportunity to deliver increased elective activity and reduced waiting time for theatre. It would also have workforce and procurement efficiency implications, due to the need to maintain a staffed and equipped theatre at the AUH site. Where a single elective site option, would provide greater benefits in terms of staff training, flexibility and equipment procurement savings.<br><br>• **Single site using existing facilities**<br>This option proposed all orthopaedic trauma is done at AUH and all orthopaedic inpatient day case and elective work is conducted on the Aintree site through use of existing facilities and associated reconfiguration of theatre and ward space with upgrade of theatre facilities to laminar flow. However this was discounted as it would require major reconfiguration of other services between both organisations. If all non-orthopaedic query lower limb fractures ambulance transfers were taken to Aintree then there may be a requirement for an addition 3-16 medical beds on the Aintree site. The medical bed impact and NWAS/Emergency pathways are currently under review.<br><br>• **Single site with an inpatient new build at Royal Liverpool and Broadgreen hospital**<br>This option proposed the development and build of an elective and trauma orthopaedic unit, this would require 12 operating theatres, 10 of which are laminar flow and 138 beds, with associated access to therapy services, diagnostic and radiology services. This would also require the transfer of a satellite unit for head injuries including neurological intensive care unit as well as the facility to treat major injuries not involving the head or skeleton. This option as discounted based on feasibility as it would require wider strategic service reconfiguration.<br><br>• **Single site with inpatient new build at Aintree University Hospital**<br>This option proposed development and build of an elective orthopaedic unit, this would require eight operating theatres, six of which are laminar flow, 55 in-patient beds, a day case ward and associated access to therapy services, diagnostic and radiology services. This also involved a comprehensive trauma service and fracture outpatient clinic at Aintree (within existing build), delivery of existing fracture clinic at the | |
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| Royal Liverpool University Hospital. This would require 4 operating theatres, all of which were laminar flow, 83 in-patient beds and associated access to therapy services, diagnostic and radiology services. Additional 33 in-patient beds required over and above current ortho-geriatric establishment on Aintree site. Again this was discounted based on feasibility.<br><br>• **ENT options**<br>The clinical consensus from ENT consultants was that there were no other options that could be identified apart from the base case (do nothing) of ENT inpatient and day case services staying at BGH.<br><br>**Wider service implications**<br>**General surgery**<br>General surgery is a surgical specialty that focuses on abdominal contents including esophagus, stomach, small bowel, colon, liver, pancreas, gallbladder and bile ducts, and often the thyroid gland. General surgery in Liverpool is provided by both University Hospital Aintree and Royal Liverpool and Broadgreen hospital Trusts.<br><br>The Royal Liverpool and Broadgreen hospital Trusts currently provide this service from both sites, patients move between the Royal and Broadgreen for services depending on the acuity of the treatment, the patients' health and the dependencies with other services. To accommodate the Orthopaedic service reconfiguration it is intended that general surgery services would only be provided from the Royal site. This would free up six theatre sessions on the Broadgreen site, two inpatient and three day case beds.<br><br>**Urology**<br>Urology services diagnose, treat and monitor disorders of the urinary tract and the external genital organs, which can include kidney, ureter, urethra, bladder, and prostate issues. They also conduct related surgery.<br>As part of the redevelopment of the Royal site, the intention is to relocate in patient and day case surgery to the royal site due to the specialist nature of the surgical equipment required and the complexity of care provided, for example there are benefits to being close to the new clatter bridge centre given the cancers both services treat.<br><br>The relocation of urology services would enable the theatre space required for the orthopaedic reconfiguration.<br><br>Proposed changes to general surgery and urology will not involve the services moving outside of RLBUHT, and will not impact on patient choice, as choice of site is not currently offered, so although they will be referenced they will not form part of the consultation itself. | |

## Financial implications

Both AUH and RLBUHT finance departments have committed resource to the reconfiguration as it is recognised that to enable the long term strategic reconfiguration of services between organisations there will be a requirement for some enabling investment. This is currently being finalised and assessed and the current estimate is investment in the region of £2.3 million*. This is made up of the following revenue and capital costs:-

- BGH Laminar flow upgrade:
- Capital costs for BGH Post operative care service delivery
- Image intensifier at AUH
- NWAS patient transfer costs

* work is ongoing to look at reducing these costs further as the Trusts feel initial estimates are high.

The capital costs are currently included in the capital projections for both trusts for 2017/18.

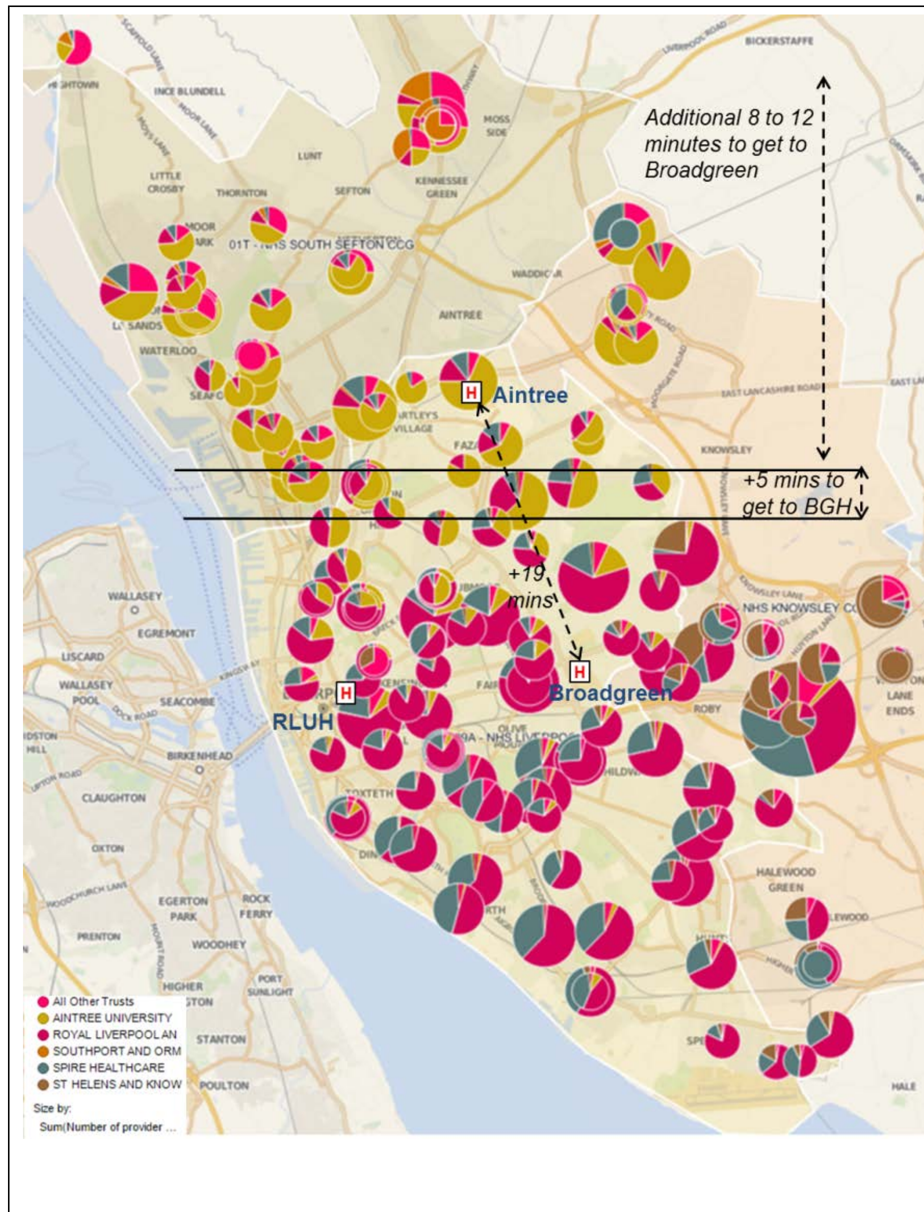
## Travel implications for patients

The vast majority of patient interactions with orthopaedic and ENT services are as out-patients and these are not planned to change. However, all options under consideration would mean that some patients requiring inpatient surgery would face a longer journey for their care.

Using actual activity for each GP Practice and the Practice location as a proxy for the patients' home address, the average additional distance patients would have to travel by car for orthopaedic inpatient and day case procedures has been calculated. The assessment for the preferred option is that 59% of patients attending for inpatient or day case surgery would be advantaged or unaffected by the proposed change. 41% of patients will have to travel an average of an additional 2.3 miles to access services.

- The majority of patients (57%) are registered with a GP in Liverpool - 36% of these patients will have to travel an average of an additional 2.0 miles
- 30% of patients are registered with a GP in Sefton - 61% will have to travel an additional 3 miles
- 12% are registered with a GP in Knowsley - 37% will have to travel an additional 1.9 miles.

The following map provides the additional travel times for elective patients, calculated using car travel times.


Additional 8 to 12 minutes to get to Broadgreen
+5 mins to get to BGH
+19 mins
Aintree
Broadgreen
RLUH
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| For patients who do not have access to a motor vehicle. Then access to public transport between their local hospital and the inpatient care provider hospital is essential.<br><br>A full public transport accessibility map is being produced and will be available for the public consultation. The impact of travel on patients and relatives is an area that will be explored in the consultation process. | |
| **3. Why is this being considered?** eg transformation programme? End of contract? In response to an issue?<br>**State what is the legitimate aim** of the service change / redesign i.e.:<br>- Demographic needs and changing patient needs changing<br>- Increase referrals<br>- Value for money<br>- areas of improvement and potential gaps in service identified by….<br>If it is responding to patient or other input please list who, how and when the issues came to light. | |
| **Managers Answer:**<br>The proposed reconfiguration of orthopaedic service is being considered for a multitude of reasons, which are explained below.<br><br>• **Managing fluctuations in Demands**<br>One of the major issues at present is the fluctuation in trauma demand. Being totally variable there are times when Aintree is inundated with trauma while the Royal is relatively quiet and there are times when the opposite is true. Having all of the capacity in one place with the required number of surgeons will optimise the efficiency by reducing delays, cancellations and length of stay. Having all the trauma capacity in one place will also help balance the competing needs of major trauma, tertiary referral trauma as well as the needs of the local patients including fractured neck of femur and ambulatory trauma. It makes the service more likely to meet national standards including CQUINS, BPT and BOAST.<br><br>• **Reducing variation and improving quality**<br>The proposed option will enable trauma and elective surgery to be managed, in the main, on separate sites. This will allow both aspects to be managed efficiently and ensures that orthopaedic trauma and other emergency demands do not impinge upon the ability to deliver elective orthopaedic care. This also reduces the inconvenience, upset and disruption cancelled surgery can cause to affected patients. | **Engagement groups comments:**<br><br>NB legitimate aim is legal requirement<br><br>. |

One of the major problem Aintree has been facing since all major trauma activity was directed there in July 2016 is the fact that this demand exceeds capacity resulting in a loss of elective activity. This is exacerbated by 'winter pressures' and can lead to further activity being cancelled due to lack of beds. The provision of a dedicated elective unit on a separate site will completely mitigate this and allow us to deliver elective activity on plan as well as reducing waiting times and cancellations.

- **Improving quality of care**
  Currently Trusts are required to run full on-call rotas at The Royal and Aintree hospitals with a reduced rota at BGH. There are enhanced demands on the rota at Aintree due to the requirements to meet MTC standards. Whilst the consultant rotas are easy to staff at the Royal where there are more consultants they are difficult to staff at Aintree. The situation is worse for juniors where SpR level trainees must be resident on 2 sites and junior numbers have fallen by over 50% in the last 5 years.

  The plan will allow the majority of the out of hours cover to the Aintree site whilst maintaining safe levels of cover for the Royal and Broadgreen significantly improves the ability to have the right people in the right place with completely sustainable rotas. These proposed rotas also facilitates 7 day working with consultant cover at all sites 7 days per week and a significant increase in the number of consultants dealing with trauma at the weekend. The improved rotas for junior staff will not only ensure they remain compliant and will encourage juniors to choose to come to the unit so that staff levels can be maintained.

- **Unbalanced Consultant Skill Mix**
  Changes in the provision of major trauma has caused an unbalanced skill mix amongst consultant surgeons with both centres have several consultants with a specialist interest in major trauma (as well as several who do not). Currently Aintree do not have enough staff with a stated interest in major trauma, yet there are several at the Royal who have that interest yet no longer treat those patients. The preferred option will allow the most seriously injured patients to be treated by consultants with a stated and proven sub-speciality interest in this area.

- **Meeting National Standards and Maintaining Local Services for Liverpool South Sefton and Knowsley Residents**
  Liverpool is surrounded by other specialist centres providing orthopaedic services; namely Oswestry, Wrightington and Manchester (MRI and Salford Royal). A large amount of tertiary referral work from Cheshire and Merseyside currently goes to these centres (especially to the first two, respectively).

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| The British Orthopaedic Assosictaion in the publication Getting It Right First Time (GIRFT) sets out the requirements for a specialist orthopaedic centre and currently there are several Aintree and the Royal do not meet. If GIRFT is fully introduced there is a very good chance that neither hospital will continue to be commissioned for complex and specialist work and Trusts may well approximately 20% of their activity to the other centres which would be detrimental to Liverpool, South Sefton and Knowsley patients who may be affected by increased travel. Conversely if the preferred option is implemented, the Trust will be on a much better footing to compete with the other specialist centres and retain services for the local population.<br><br>• **Improved Value for Money**<br>Historically both trusts have completed with each other, with some key services duplicated, leading to inefficiencies and a shortage of clinical expertise, impacting on workforce sustainability, training and education. The aim of the single service is to secure long-term clinical and financial sustainability of services in the city. The redesign of orthopaedic services offers improved value for money due to a reduction of waste through duplication of multidisciplinary pathways, a reduction in the cost of moving to 7-day services and an expected reduction in patient's length of stay. There are additional efficiencies which are anticipated through improved theatre scheduling, which provides an opportunity to deliver an additional 750 cases per year through the BGH theatres.<br><br>Delivery of a ring fenced elective service on separate sites from emergency services will reduce the risk of patients being cancelled on the day of surgery due to emergency pressures and a lack of beds. This means that the efficiency and throughput through the elective centre will increase, with additional activity at no extra cost.<br><br>**ENT**<br>For specialist services, there is a strong body of evidence that an increasing number of clinical services are better concentrated in fewer centres undertaking higher volumes of activity. By creating a single Ear Nose and Throat / Head and Neck Service for the city, medical staff will see more patients. This way of working is linked to better results for patients because doctors, surgeons and nurses get better at doing things when they do them more often.<br><br>By moving to Aintree, patients will have access to higher care / critical care beds, should complications arise, which are not available at Broadgreen. | |

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| **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>1. Trauma surgery will be performed by consultants with specific major trauma expertise<br>2. People will receive the best standard of care wherever they live in the city,<br>3. Orthopaedic and ENT services will be co-ordinated and delivered in ways that achieve the best results for patients<br>4. Increased likelihood of retaining services near to the local population, maintaining access.<br>5. Access to the right clinicians, 7 days a week<br><br>In order to measure these expected benefits, providers will put mechanisms in place to measure patient experience feedback, this will be analysed and fed back to their boards and CCG through the quality framework. | **Engagement groups comments:** |
| **5. What are you trying to achieve by engaging with people - what are the engagement objectives..?**<br>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:**<br>The aim of this consultation is to inform service design to ensure orthopaedic and ENT services are delivered in a way which achieves the highest clinical standards and that people find acceptable and accessible.<br><br>The objectives for the consultation are to:-<br>1. Increase understanding among patients and public of the issues prompting the review of Orthopaedic and ENT services<br>2. Share the potential solutions that have been considered in the review and present the preferred option.<br>3. Understand whether people recognise and support the reasons for changing how and where care is provided<br>4. Understand how the preferred option may impact on the local population and their views of the proposed change<br>5. Understand whether there are differences of view among different communities and whether any adjustments \ mitigations can be made to the proposed option, especially regarding meeting Equalities duties. The biggest difference for patients – in some cases - will be additional travel. | **Engagement groups comments:** |

<table>
<tr><td>6. Provide people with a range of mechanisms to share their views about proposals for these services.</td><td></td></tr>
<tr><td colspan="2">6. Who is involved in planning the engagement?<br>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).</td></tr>
<tr><td>Managers Answer:<br>NHS Liverpool CCG, Royal Liverpool and Broadgreen hospital, Aintree University Hospital, NHS Sefton CCG, NHS Knowsley CCG, Liverpool CCG Engagement Group including Liverpool Healthwatch, patient voices and CCG lay member with lead for engagement, MTCC oversight board, Liverpool Overview and Scrutiny Committee, Knowsley Overview and Scrutiny Committee, South Sefton Overview and Scrutiny Committee and Committees in Common.</td><td>Engagement groups comments:</td></tr>
<tr><td colspan="2">7. What patient insight/research/experience data is there already available?<br>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?</td></tr>
<tr><td>Managers Answer:<br>The principles of moving hospitals to a single service city wide approach, has been part of ongoing discussions with Liverpool communities over the last two years under the umbrella of Healthy Liverpool.<br><br>Initial engagement took place between June 15-August 15 regarding the case for change and principles of Healthy Liverpool. More than 14,000 people responded to this call to action, giving us a good deal of feedback.<br><br>The survey sought to assess whether people recognised the issues Healthy Liverpool set out for our city and which the programme aims to address. 80% of survey respondents agreed with them, with 18% agreeing with some of them. 85% of respondents supported the priority areas set out for the Hospitals programme but felt more detail was required.<br><br>From January to March 2016 Liverpool communities were asked to comment on the next stage of Healthy Liverpool planning and in more detail about each of the programme areas. The specific aims for the hospital programme were:-<br>a) Understand how Liverpool people feel about a co-ordinated service approach across the city to create one team and service for specialist areas.<br>b) Understand how Liverpool people feel about hospital specialists working more closely with Community Care Teams and others</td><td>Engagement groups comments:</td></tr>
</table>

| | |
|---|---|
| c) Understand attitudes to travelling for care and use of digital healthcare<br><br>To understand how patients prioritise their needs and wishes, a variety of questions were asked in the survey and at the discussion groups. These questions were designed to examine patients perspectives on the importance of types of service, location and quality of services.<br><br>A total of 1,385 individuals completed the hospitals survey, with 1,741 individuals taking part in group discussions. Some individuals will have taken part in both activities.<br><br>Survey participants were given a list of 5 issues relating to their priorities around treatment and the most important were ranked as being offered the same, high standard of treatment regardless of where treatment takes place, very closely followed by being seen by the right staff who are experts in the treatment/management of their condition. Short travel time for one off appointment such as surgery was the least important, however most people did want to travel a maximum of 15-30 minutes for an appointment.<br><br>The consensus in the discussion groups was that having the highest standard of treatment and being seen by the best staff for their ailment was more important than the location of treatment. However, generally participants did want care as close to home as possible. This was especially important for the elderly, those with multiple/long term conditions and those without transport. Therefore there was a lot of support for specialists to be working with local teams in GP surgeries and health centres.<br><br>Patient experiences recorded on patient opinion have been analysed as an external source of insight, however this was limited as only 7 stories have been recorded during the period. Those patients who shared their experiences spoke of helpful, friendly staff and repositive positive experiences of orthopaedic services. In contract a coupel of people reported feeling let down by care standards.<br><br>Further work was carried out with Knowsley and Sefton communities in March 2017 regarding the principles of single service. This was a replica of the above work that was carried out in Liverpool.<br><br>Findings from the engagement were larley in line with the views of Liverpool communities. There was overwhelming support for the proposal for hospitals working together and reviewing how services are provided to the public, with 82% (n=914) being in favour. It was found patients want hospital services to be delivered locally, providing they can be guaranteed being seen by the 'right staff' who are experts in the treatment or management | |

| | |
|---|---|
| of their condition. The priority for 'high standard of treatment' does however override the requirement for shorter travelling times. | |
| **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 = 3** |
| **SECTION 2 - Gauging Impact, Scale and Risk** | |
| **1. Who is affected by what is being considered?**<br>Patient groups / Carers / Community members / Staff / Providers, Other professional stakeholders, Geography – eg location of service or access by a specific geographic community? Others? | |
| **Managers Answer:**<br>The following are affected by and will be engaged with during this consultation - Patients, prospective patients, families and carers - as residents of Liverpool, South Sefton and Knowsley. Specialist services commissioned by NHS England serve people in Cheshire, wider Merseyside, greater Manchester, Lancashire 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>Aintree staff, the Royal Liverpool and Broadgreen hospital staff and staff of other NHS Trusts locally are also affected and consultation with staff will be subject to a separate plan/s. | **Engagement groups comments:**<br><br>NB this section legal duty |
| **2. Equality Pre-Assessment**<br>**Is the service specifically designed to serve people with one or more protected characteristic*?** Eg for deaf people<br>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?**<br>**(Duty to prevent this – see below and p13 for definitions)**<br>**Might any vulnerable groups** be particularly affected /disadvantaged?** | |

**Managers Answer:**

What follows is a pre equalities assessment, which highlights potential impacts of the proposed reconfigurations. These impacts will be tested in the consultation, prior to a formal and final equalities assessment being produced.

| | | Discrimination? | Equality of Opportunity-life chances? | Foster good relations? |
|---|---|---|---|---|
| i.Race* | Y | **Orthopaedics**<br>Traditionally BME communities have poorer health outcomes and access services less/less effectively.<br>Also there is a lower percentage of female drivers within certain racial groups which would have a negative impact if services were not. provided locally. However there is no clear evidence therefore engagement will seek views of different racial groups in order to understand any impact<br><br>The health needs of BME groups are differential rather than disproportional.<br><br>**ENT**<br>ENT activity data for the period 2015-2016 indicates that there is low take-up of ENT services from black and minority ethic patients.<br>Current data indicates that 11% of patients were from a BME group and the majority of patients identified as coming from the following categories:<br><br>Any other ethnic group - 3.0%<br>White - any other white - 2.1%<br>Black/Black British-Any other Black background - 0.9%<br>Other Ethnic Group – Chinese - 0.9%<br>White – Irish - 0.7%<br>Asian/Asian British-any other Asian background - 0.6% | To ensure that Orthopaedic and ENT services are accessible and inclusive, measures will be put in place to engage BME groups, to ensure services are developed in line with the health needs of this community. | Hearing from voices that have traditionally experienced barriers to engagement, we hope to promote good relations between groups and raise awareness of the needs of BME patients. |

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| | | The potential for inequality in accessing services for BME patients, and for those from different socioeconomic backgrounds, is recognised and needs to be considered in develop of pathways for their care. | | |
| ii. Age* | Y | **Orthopaedics**<br>Osteoporosis, a condition treated with elective orthopaedic care, becomes more likely the older that people get. Around 50% of people over the age of 75 are affected by the condition, and after the age of 50 one in two women and one in five men will break a bone as a result of poor bone health arising from osteoporosis.<br><br>Evidence surrounding specialised orthopaedics services in adults points towards older people having a disproportionate need for revision joint procedures in later life, thereby increasing the demand for elective orthopaedic care with older people<br><br>Older people are more predisposed to osteomyelitis than the general population as they disproportionally suffer from associated disorders (such as diabetes).<br><br>The NHS website reports that most people who have a total knee replacement are over 65 years old. The most common reason for knee replace surgery is osteoarthritis. NHS Choices 2015.<br><br>Local data indicates that 72% of orthopaedic appointment at RLBUHT is over the age of 50, while 64% of appointments at Aintree are for patients aged 50+.<br><br>**ENT**<br>Age-related damage to the cochlea is the single biggest cause of hearing loss. Numbers of people with hearing loss rise sharply from age 50 onwards. | A majority of Orthopaedic services are used by older people, so changes to services will disproportionately affect them.<br><br>In comparison, the majority of people using ENT service at broadgreen and within the younger age bracket.<br><br>To ensure that services are accessible and inclusive, measures will be put in place to engage both groups, to ensure services are developed in line with the health needs of this community. | Hearing from voices that have traditionally experienced barriers to engagement, we hope to promote good relations between groups and raise awareness of the needs of older people. |

| | | | | | |
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| | | Ménière's disease is a rare disorder that affects the inner ear. It can cause vertigo, tinnitus, hearing loss, and a feeling of pressure deep inside the ear. In the UK, it's estimated that around one in 1,000 people have Ménière's disease. Ménière's disease most commonly affects people aged 20-60 and it's thought to be slightly more common in women than men.<br><br>Most people have experienced short periods of tinnitus after being exposed to loud noises, such as after a music concert. In the UK, more persistent tinnitus is estimated to affect around six million people (10% of the population) to some degree, with about 600,000 (1%) experiencing it to a severity that affects their quality of life. Tinnitus can affect people of all ages, including children, but is more common in people aged over 65.<br><br>ENT activity data for the period 2015-2016, indicates that 17% of Liverpool patients accessing ENT elective services were aged 65+ collectively.<br><br>Obstructive sleep apnoea (OSA) is a relatively common condition where the walls of the throat relax and narrow during sleep, interrupting normal breathing. This may lead to regularly interrupted sleep, which can have a big impact on quality of life and increases the risk of developing certain conditions. Being 40 years of age or more – although OSA can occur at any age, it's more common in people who are over 40.<br><br>Otosclerosis is a condition in which there's abnormal bone growth inside the ear. It's a fairly common cause of hearing loss in young adults. Most people with otosclerosis notice hearing problems in their 20s or 30s. One or both ears can be affected. | | | |

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| | | Data indicates that 10% of Liverpool patients using elective ENT services were from the 20-24 age bracket. The data also indicates that the number of Knowlsey patients accessing elective ENT services is few, with only 123 cases in 2015-2016 activity period. Of which, 24% of patients who accessed ENT services were aged between 45 and 54 collectively. | | |
| iii. Sex* | Y | **Elective orthopaedics**<br>Rheumatoid arthritis is an inflammatory condition that usually affects multiple joints. It causes severe inflammation of the joints. The inflammation is so severe that the functioning of the extremities can become severely limited. It affects 0.3–1.0% of the general population and is more prevalent among women.<br><br>Likewise, women are more at risk of developing osteoporosis than men because the hormone changes that occur in the menopause directly affect bone density.<br><br>**Orthopaedic trauma**<br>Young males are more likely to suffer trauma.<br><br>**ENT**<br>Obstructive sleep apnoea can occure in women due to the menopause – the changes in hormone levels during the menopause may cause the throat muscles to relax more than usual.<br><br>Current data indicates that there is a slight preponderance in male to female access, with 51% of Liverpool women accessing ENT services compared to 49% of Liverpool men. Knowlsey patients are comparable to Liverpool with 54.5% of females patients accessing ENT services compared to 45.5% of male patients. | Data from the Royal Liverpool Hospital indicates that a high percentage of women use elective orthopaedics services, so changes to services will disproportionately affect them.<br><br>To ensure that services are accessible and inclusive, measures will be put in place to engage women, to ensure services are developed in line with the health needs of this group. | Hearing from voices that have traditionally experienced barriers to engagement, we hope to promote good relations between groups and raise awareness of the needs of women and men. |

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| | iv. Disability* | Y | **Orthopaedics**<br>There is evidence suggesting that people with HIV may have a disproportionate need for elective orthopaedic surgery. Particularly as:-<br><br>➢ Low bone mineral density is prevalent in people with HIV<br>➢ Inflammatory arthropathy and avascular necrosis is common in HIV patients<br><br>Orthopaedic surgery may also be necessary for people with cerebral palsy to correct problems with bones and joints<br><br>**ENT**<br>There is no statistical evidence on the disabilities of people accessing ENT services at Broadgreen Hospital. However certain disabilities will require treatment and diagnosis by ENT. It can be assumed that a proportion of patients currently accessing ENTservices are being treated for an ENT disorder relating directly to a disability.<br><br>There is evidence that disorders of the ear, nose and throat are high within people with Down syndrome and it is predicted that ENT specialists may treat these disorders in people with Down syndrome with increasing frequency as life expectancy for this population increases. | Proposed changes to 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. | Hearing from voices that have traditionally experienced barriers to engagement, we hope to promote good relations between groups and raise awareness of the needs of people with disabilities. | |
| | v. Religion and belief* | Y | **Orthopaedics**<br>There is evidence linking limited exposure to sunlight to increased risk of sustaining a fracture following a trauma. Religious faiths that cover themselves are therefore at greater risk of fractures and will be involved through engagement process. | To ensure that services are accessible and inclusive, measures will be put in place to engage South Asian people, to ensure services are | Hearing from voices that have traditionally experienced barriers to engagement, we hope to promote good relations between groups and | |

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| | | | developed in line with the health needs of this community. | raise awareness of the needs of South Asian people and the wider community. |
| vi. Sexual orientation* | N | | | |
| vii. Gender reassignment* | Y | **Orthopaedics**<br>Trans men (female-to-male) and trans women (male-to-female) may be at risk of developing osteoporosis because of the need to take hormones that change the balance of oestrogen and testosterone in the body. The risk of developing osteoporosis may increase if sex hormone replacement is discontinued, or if levels of replacement are too low. Evidence is limited but there may be a disproportionate need and this will be explored within the consultation. | To ensure that services are accessible and inclusive, measures will be put in place to engage with the trans gender community to ensure services are developed in line with the health needs of this community. | Hearing from voices that have traditionally experienced barriers to engagement, we hope to promote good relations between groups and raise awareness of the needs of pthe trans gender community |
| viii. Marriage/civil partnership* | N | | | |
| ix. Pregnancy and Maternity* | N | | | |
| x. Homeless people** | N | | | |
| xi. Single parents** | N | | | |
| xii. People with learning difficulties** | Y | **Orthopaedics**<br>People with learning disabilities have a greater prevalence of some of the risk factors associated with osteoporosis than other people.<br><br>Contributory factors include their possible lack of weight-bearing exercise, delayed puberty, entering menopause at an earlier- | Proposed changes to location may disproportionately affect this group – although these are not known at this stage this group will | Hearing from voices that have traditionally experienced barriers to engagement, we hope to promote good relations |

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| | | than-average age for women, poor nutrition, being underweight and use of anti-epilepsy medication. The report notes that<br><br>**ENT**<br>Auditory Processing Disorder is catogrised as a learning disability. Auditory processing disorder (APD) is a hearing or listening problem caused by the brain not processing sounds in the normal way.<br><br>In adults and children, the condition may be associated with damage to the brain from a head injury, stroke, brain tumour or meningitis.<br><br>Some cases in adults have also been linked to age-related changes in the ability of the brain to process sounds and progressive conditions affecting the nervous system, such as multiple sclerosis. | be engaged in order to understand impact better.<br><br>To ensure that services are accessible and inclusive, measures will be put in place to engage people with learning disabilities, to ensure services are developed in line with the health needs of this community. | between groups and raise awareness of the needs of people with learning disabilities. | |
| | xiii. Low incomes** | Y | **Orthopaedics**<br>Deprivation is associated with greater need for total hip and knee replacement surgery. Additionally, more deprived patients remain in hospital longer, without morbidity, because of a lack of social support available to them in the community.<br><br>Evidence suggests that malnutrition increases the risk of developing osteomyelitis, as a weakened immune system makes it more likely for infections to spread to the bones.  Osteomyelitis is more likely to occur if for some reason an individual's bones are susceptible to infection. Pre-existing health conditions, such as diabetes, can cause this.<br><br>The low number of people with access to private transport is well documented in merseyside, especially in the context of accessing services. This is exacerbated in some areas by variable access to public transport. | Proposed changes to 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.<br><br>To ensure that Orthopaedic and ENT services are accessible and inclusive, measures will be put in place | Hearing from voices that have traditionally experienced barriers to engagement, we hope to promote good relations between groups and raise awareness of the needs of people from deprived communities. |

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| | | | to engage people from deprived communities, to ensure services are developed in line with the health needs of this community. | |
| xiv. Addictions** | Y | **Orthopaedics**<br>People with addictions are at greater risk of suffering orthopaedic trauma while inebriated. People with addictions are likely to have a disproportionate need for services and will be involved throughout the consultation process.<br><br>**ENT**<br>Head and neck cancer is a relatively uncommon type of cancer. Around 10,000 new cases are diagnosed in the UK each year. There are more than 30 areas within the head and neck where cancer can develop.<br><br>The main causes of head and neck cancers can be attributed to lifestyle choices such as smoking and drinking alcohol .<br><br>Leukoplakia is a white patch that develops in the mouth.The condition is usually painless, but is closely linked to an increased risk of mouth cancer.<br><br>Tobacco (smoking and chewing it) and heavy alcohol consumption are the two main risk factors for leukoplakia. Men are twice as likely as women to develop leukoplakia, and most cases affect older adults who are 50-70 years of age. | To ensure that services are accessible and inclusive, measures will be put in place to engage people with addictions, to ensure services are developed in line with the health needs of this community. | Hearing from voices that have traditionally experienced barriers to engagement, we hope to promote good relations between groups and raise awareness of the needs of people with addictions. |

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| | | Obstructive sleep apnoea can occur/develop due to regular alcohol consumption – drinking alcohol, particularly before going to sleep, can make snoring and sleep apnoea worse. | | |
| xv. Veterans** | Y | **Orthopaedics**<br>Long-term physical conditions such as musculoskeletal disorders are common within the veteran population. The condition can cause falls and fractures which may result in veterans receiving care from orthopaedic services.<br><br>**ENT**<br>Hearing loss and impairment, including persistent ringing and buzzing in the ears are common effects of harmful noise from gunfire, heavy weapons, noisy engine rooms and aircraft. Veterans may seek medical intervention from ENT services with regards to hearing loss. | To ensure that Orthopaedic and ENT services are accessible and inclusive, measures will be put in place to engage ex-military personnel, to ensure services are developed in line with the health needs of this community. | Hearing from voices that have traditionally experienced barriers to engagement, we hope to promote good relations between groups and raise awareness of the needs of ex-military personnel. |
| xvi. Offenders** | N | | | |

**Engagement groups comments:**

NB this section legal duty

**3. How many people are affected?**
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: | Engagement groups comments: |
|---|---|
| In 2015/16, elective inpatient admissions for orthopaedics (excluding spinal) totalled 3,300 admissions across the two Trusts. Day case activity in the same period totalled 6,395 admissions across the two Trusts.<br><br>Activity by CCG area is broken down below. | |

| CCG | Orthopaedic Trauma | % | Elective Orthopaedics | % |
|---|---|---|---|---|
| Liverpool | 2215 | 61% | 5354 | 55% |
| South Sefton | 712 | 20% | 1689 | 17% |
| Knowsley | 261 | 7% | 1417 | 15% |
| Other | 446 | 12% | 1235 | 13% |
| TOTAL | **3634** | **100%** | **9695** | **100%** |

The breakdown for patients accessing ENT services is broken down below by CCG area.

| **CCG** | **ENT** | **%** |
|---|---|---|
| Liverpool | 953 | 89% |
| Knowsley | 123 | 11% |
| TOTAL | **1076** | **100%** |

**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:**
There is a change to both the service and the locations of services (see section 1) and these changes will form part of the consultation.

**Engagement groups comments:**

**5. Is the change proposed likely to elicit a variety of strong viewpoints?**
If no describe how you have decided this, and if Yes, describe in what way & by whom?

**Managers Answer:**
The configuration of Orthopaedic and ENT services may be likely to elicit strong view points for the following reasons:

- NHS England have highlighted that the Sefton politicians may be against the change to orthopaedic services as elective surgery will be moved from AUH to BGH, increasing travel time for Sefton patients.
- There is much public debate on the development of the new Royal Hospital and fear the hospital bed base is not large enough to meet demand. The proposed option may be viewed as driven purely to reduce beds.
- There is a strong public campaign to Save Our NHS and concerns relating to the perception of dangers to NHS services and privatisation of services.

**Engagement groups comments:**

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- The future of services at southport Hospital is unknown and there is much public debate on the issues. The reconfiguration of Liverpool's orthopaedic and ENT services may be linked in the public's perception with these issues – particularly in Sefton.

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

</td></tr>
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**Managers Answer:**<br>Engagement which is both wide and deep is required to achieve the necessary involvement; that is that provides opportunity for the diverse communities of the city to participate and for patient views to shape the redesign.

</td><td>

**Engagement groups comments:**

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**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)

</td><td>

**Moderate**<br>**Why…….**<br>The redesign is expected to improve quality of service and with the exception of additional travel for some patients – there will be minimum impact to service delivery.

</td><td>

**Moderate**

</td></tr>
<tr><td colspan="2">

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

</td><td>

**SCORE = 3**

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**SECTION 3 - Information and Communication**<br>**THIS SECTION HSOULD BE READ IN CONJUNCTION WITH THE ORTHOPAEDICS AND ENT COMMUNICATIONS PLAN**

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**1. What information is/needs to be available to communicate?**<br>How will what is being considered be described to people? Online/paper/face to face?<br>**Information should include…**<br>a summary; discussion of the issues; how it addresses health needs; benefits of what is being considered for patients/public, an

</td></tr>
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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?

| Managers Answer: | Engagement groups comments: |
|---|---|
| The following information will be prepared to share with the public during the public consultation;<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 Orthopaedic and ENT services<br>• Detail of the preferred option and summary of other potential solutions considered – along with reasons they were less favourable<br>• Summary of patient benefits<br>• Accessibility maps for each hospital site.<br>• Detailed description of each benefit on website and available to post<br>• Budgetary implications<br>• Timeline for this process and decision making<br>• Accessibility maps to highlight potential travel implications<br>• Information in alternative languages/formats | |

**2. What are the key questions you are seeking views on?**
These should relate to the objectives. Is it clear? Open not leading questions etc..

| Managers Answer: | Engagement groups comments: |
|---|---|
| 1. What is your postcode?<br><br>2. Please tell us about your interest in these services. (Tick all that apply)<br>- I have used/am using Orthopaedic services in Liverpool<br>- I have used/am using Ear, Nose and Throat services in Liverpool<br>- Someone close to me is/has used Orthopaedic services in Liverpool | |

| | |
|---|---|
| - Someone close to me is/has used Ear, Nose and Throat Liverpool<br>- A resident of Liverpool, Sefton or Knowsley who hasn't used these care services<br>- I work with people who use these care services (but not in the NHS)<br>- I work in the NHS<br>If so please tick where you work<br>A. Aintree University Hospital<br>B. Royal Liverpool and Broadgreen University Hospitals<br>C. Other<br>- Other – Please state<br><br>3. Do you think that the doctors have come up with the best plan to provide a more effective and cost efficient service?<br>- Yes<br>- Don't know<br>- No<br>If no, please tell us why and if you preferred one of the other potential solutions that was explored and discounted, please tell us which you would have liked<br><br>4. If the proposed changes take place, how might they affect you?<br>- They wouldn't affect me<br>- I would have to travel further<br>- I would have a shorter distance to travel<br>- They would affect me in another way<br>Please specify ………..<br><br>5. If you have to travel further will this be :<br>- Not a problem for one off procedures such as surgery<br>- It would present some problems but I could manage<br>- It would be very difficult fo me . . . . please tell us why<br>- I would not be able to use the service . . . please tell us why<br><br>6. Please tell us how you would usually travel to a hospital appointment<br>- Own Car<br>- Get a lift | |

- Taxi
- Bus –if bus, do you have a free bus/travel pass
- Train - if train, do you have a free bus/travel pass
- Bicycle
- Walk
- The Patient transport service (through the ambulance service)
- Other – please tell us…………..

7. How long would you be prepared to travel for one off procedures such as surgery?
   - Up to 15 minutes
   - 15 – 30 minutes
   - 30 – 45 minutes
   - 30 - 60 minutes
   - No preference

8. Any other comments

Standard demographic questions to follow.

**3. What level of response would you want to achieve in terms of engagement? And what output do you need?**

Numbers of people / range of stakeholders / etc

What % of those that currently use the service?

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:**

This consultation will seek to activity engage between 5-10% of current service users across Liverpool, Sefton and Knowsley.

| CCG | Elective Orthopaedics Activity | 10% of patients | 5% of patients |
|---|---|---|---|
| **Liverpool** | **5354** | **533** | **267** |
| **South Sefton** | **1689** | **165** | **83** |
| **Knowsley** | **1417** | **145** | **73** |

**Engagement groups comments:**

| Other | 1235 | - | - |
|---|---|---|---|
| TOTAL | 9695 | 843 | 423 |

| CCG | Elective ENT Activity | 10% of patients | 5% of patients |
|---|---|---|---|
| Liverpool | 953 | 95 | 48 |
| Knowsley | 123 | 12 | 6 |
| TOTAL | 1076 | 107 | 54 |

Those groups identified within the equality pre assessment will actively be targeted alongside a more general approach to involving potential service users and members of the public.

4. **Capacity building…**
   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),
   How can ongoing engagement with those interested and involved be achieved?

Data needs to be entered into corporate database and handled appropriately (eg consent for future use, electronic storage).

**Managers Answer:**
Stakeholders will need an explanation of the reasons why change is being looked as 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.

**Engagement groups comments:**

5. **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?

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:**

- Online – all content will direct people back to NHS Liverpool CCG's engagement page on EHQ.
- Social media to share opportunity
- Email / Letter contact to those previously engaged with Healthy Liverpool
- Face to Face briefings with other stakeholders such as interest groups and politicians will be offered

**Engagement groups comments:**

<table>
<tr><td>
- Distribution to individuals registered on the CCG mailing list's<br>
- Distribution to individuals on Trusts mailing lists and their members<br>
- Distribution to idnividuals on Healthwatch mailing lists – Liverpool, Sefton and Knowsley<br>
- Providers will share communication materials/questionnaire with patients attending relevant clinics.<br>
- Community research volunteers will be mobilised to support face to face survey completion with patients in hospital trusts and community clinics,helath centre's etc.<br>
- VCSE engagement partners will be commissioned in Liverpool to engaged with equality groups<br>
- It is not proposed to hold specific orthopaedic/ENT public events. Instead existing forums and groups will be approached and the engagement team will attend their meetings to speak with attendees about the proposals and gather feedback. Specific groups for each area are will be identified through conversations with each area's Healthwatch. As further information is known an activity plan/meeting schedule will be produced.
</td><td></td></tr>
<tr><td colspan="2">6. 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?</td></tr>
<tr><td>Managers Answer:<br>Not holding separate engagement evenst for this consultation is considered a way of ensuring individuals who have an interest in health and wellbveing but who do not attend consultation events are given an opportunity to hear about the proposals and share their feedback. By taking the consultation to communities it is envisages more people will share their thoughts and the consultation ill have greater visability.<br><br>NHS Liverpool CCG's website is accessible with Browse Aloud functionality. In Liverpool VCSE partners will be invited to support participation of particular equality groups and/or those less likely to engage through online/events.<br><br>All information will be available in alternative language/formats upon request.</td><td>Engagement groups comments:</td></tr>
<tr><td colspan="2">7. 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..</td></tr>
<tr><td>Managers Answer:<br>LCCGS panel of lay readers will be asked to test the communications materials and consultation questions</td><td>Engagement groups comments:</td></tr>
</table>

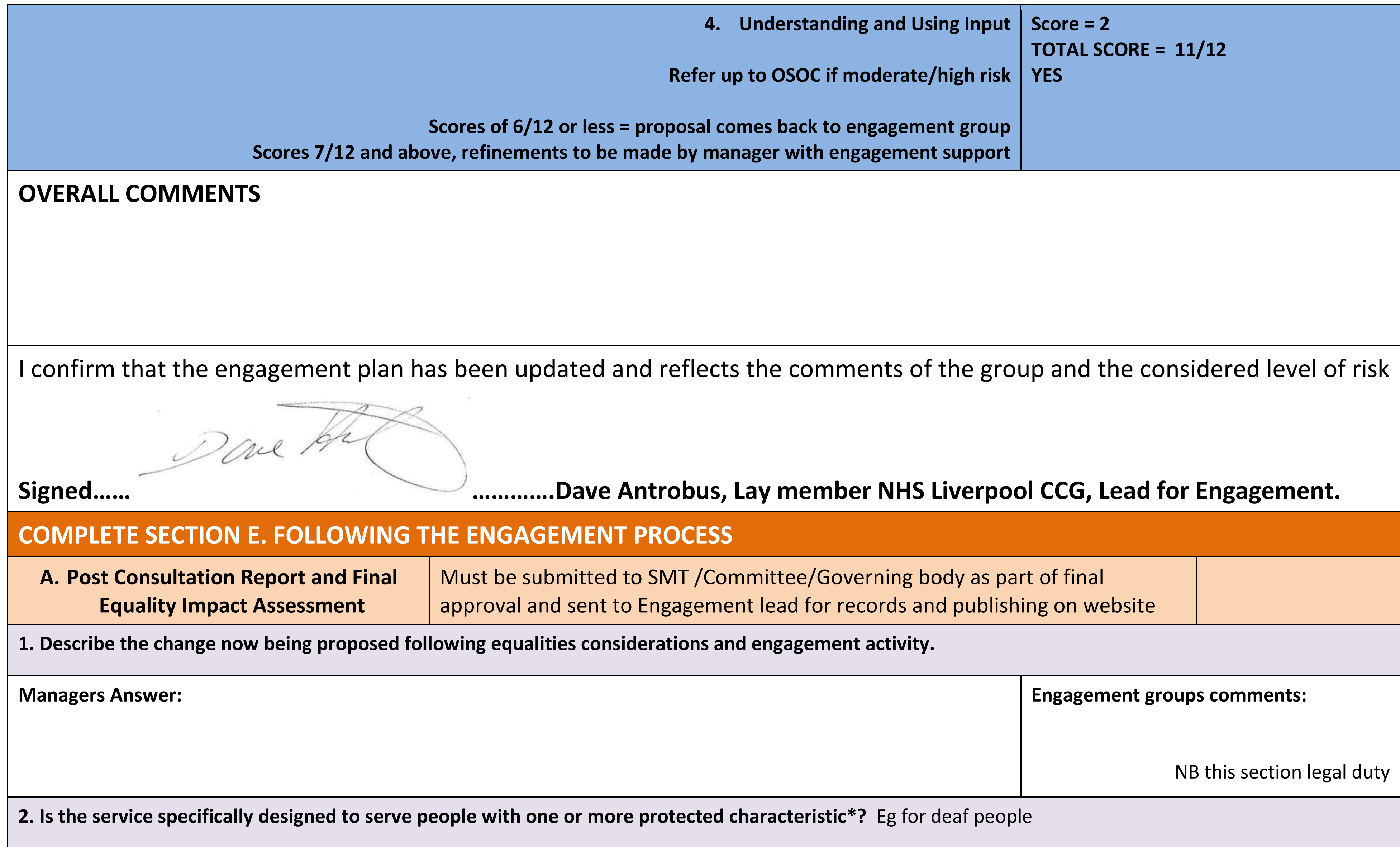
<table>
<tr><td colspan="2">8. Communications Channels<br>How will the opportunity to input be made known to people? What is the communication plan?<br>Think about the audience and where they will receive information / places they will be / trusted information sources for them eg charity / workplace / community networks / support groups…<br>Consider whether anyone would be excluded by the chosen channels</td></tr>
<tr><td>Managers Answer:<br>See supporting communications plan</td><td>Engagement groups comments:</td></tr>
<tr><td>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</td><td>SCORE = 3</td></tr>
<tr><td colspan="2">SECTION 4 - Understanding & Using Input Received</td></tr>
<tr><td colspan="2">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</td></tr>
<tr><td>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 from the collective engagement activity.</td><td>Engagement groups comments:</td></tr>
<tr><td colspan="2">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.</td></tr>
<tr><td>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, each of Knowsley, South Sefton and Liverpool CCGs governing bodies and governance routes. For Liverpool this is the engagement group, QSOC, hospital programme</td><td>Engagement groups comments:</td></tr>
</table>

| board, GB and OSC. The findings will be considered in the review process to influence the final decision making process. | |
|---|---|
| **3. How will responses, and how they have been used, be fed back to participants and wider community?** | |
| **Managers Answer:**<br>Feedback will be via partners, email, web, social media and VCSEs | **Engagement groups comments:** |
| **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:** | **Engagement groups comments:** |

| **PLANNING THE ENGAGEMENT FROM:-** | **Nov 16 – May 17** | |
|---|---|---|
| **Approval and overview of plans** | **date** | **purpose** |
| LCCG Patient Engagement and Experience Group | 7/4/17 | For approval of the plans |
| Transaction Comms and Engagement Sub-group | TBC - April | For input and overview |
| LCCG Quality Safety and Outcome Committee | 2/5/17 | For overview as redesign considered a medium risk |
| Oversight Board | 5/5/17 | For approval of the plans |
| Committees in Common | TBC - May | For information |
| Sefton EPEG | 10/5/17 | For information & input into reaching communities |
| Sefton Counil Public Engagement and Consultation Panel | 15/5/17 | For information & input into reaching communities |
| Joint OSC for Liverpool, Sefton & Knowsley | TBC – expected June | For sign off of plans and approval to proceed to consultation |
| **CONSULTATION** | | |
| Conduct the engagement from | 26/7/17 | This will be subject to the e;ection outcome |
| Close the engagement | 15/9/17 | |

| **PRODUCING CONSULTATION REPORT** | | |
|---|---|---|
| Collation, analysis and first draft of report | 13/11/17 | |
| Final report available | 20/11/17 | |
| **INCORPORATE RESPONSES INTO FINAL DECISIONS** | | |
| HLP Hospitals Transformation Board | TBC | For consideration of findings |
| HLP Programme Board | TBC | For Information |
| Oversight Board | TBC | For consideration of findings and review of implications/development of mitigations that may be required to inform the business case. Following this meeting the business case will be updated and the final EIA will be produced. |
| Transaction Comms and Engagement Sub-group | TBC | For information |
| LCCG Patient Engagement and Experience Group | TBC | For information |
| Write up response analysis and how this has changed the final decision (must include Equality assessment, response and mitigation):- | Nov/Dec 17 | |
| **FEEDBACK** | | |
| Feed back to engagement participants / wider community: | Dec 17 | |
| Feedback to providers / other partners: | Dec 17 | |

| | |
|---|---|
| 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** | **Score =3**<br>**Score = 3 Level = Moderate**<br>**Score = 3** |



| 4. Understanding and Using Input<br>Refer up to OSOC if moderate/high risk<br><br>Scores of 6/12 or less = proposal comes back to engagement group<br>Scores 7/12 and above, refinements to be made by manager with engagement support | Score = 2<br>TOTAL SCORE = 11/12<br>YES |
|---|---|

**OVERALL COMMENTS**

I confirm that the engagement plan has been updated and reflects the comments of the group and the considered level of risk

**Signed……  ………….Dave Antrobus, Lay member NHS Liverpool CCG, Lead for Engagement.**

**COMPLETE SECTION E. FOLLOWING THE ENGAGEMENT PROCESS**

| **A. Post Consultation Report and Final Equality Impact Assessment** | 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:** | **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

<table>
<tr><td>Managers Answer:<br>Y/N – if yes describe</td><td>Engagement groups comments:<br><br>NB this section legal duty</td></tr>
<tr><td colspan="2">3. Equality and Diversity Duty – Full Equalities Assessment<br>In the table indicate for each protected characteristics*/vulnerable groups**(B2) any possible detriment identified in further research and/or through the engagement.<br>Are any vulnerable groups** particularly affected /disadvantaged?</td></tr>
<tr><td>Managers Answer:</td><td>Engagement groups comments:<br><br>NB this section legal duty</td></tr>
</table>

| | | Mark which groups are affected and for those which are - state how and what the issues are that were identified. | |
|---|---|---|---|
| i.Race* | Y/N | | |
| ii. Age* | Y/N | | |
| iii. Sex* | Y/N | | |
| iv. Disability* | Y/N | | |
| v. Religion and belief* | Y/N | | |
| vi. Sexual orientation* | Y/N | | |
| vii. Gender reassignment* | Y/N | | |
| viii. Marriage/civil partnership* | Y/N | | |
| ix. Pregnancy and Maternity* | Y/N | | |
| x. Homeless people** | Y/N | | |
| xi. Single parents** | Y/N | | |
| xii. People with learning difficulties** | Y/N | | |
| xiii. Low incomes** | Y/N | | |
| xiv. Addictions** | Y/N | | |
| xv. Veterans** | Y/N | | |
| xvi. Offenders** | Y/N | | |
| | | | |

**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.

<table>
<tr><td>Managers Answer:<br><br>A) List which Groups were involved in the consultation reflecting those identified above.<br>B) List the solutions identified to mitigate the detriment<br>C) How is discrimination to be eliminated…?<br>D) How is equality of opportunity to be advanced…?<br>E) How are good relations between different groups to be fostered..?<br>F) How will the impact be monitored? By whom and when?</td><td>Engagement groups comments:<br><br>NB this section legal duty</td></tr>
<tr><td colspan="2">5. Knowledge and learning<br>What were the main findings from the engagement that aren’t relating to equalities? How have plans been amended in response to issues raised?</td></tr>
<tr><td>Managers Answer:</td><td>Engagement groups comments:<br><br>NB this section legal duty</td></tr>
<tr><td colspan="2">6. Feedback<br>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.</td></tr>
<tr><td>Managers Answer:</td><td>Engagement groups comments:</td></tr>
<tr><td colspan="2">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)…</td></tr>
</table>

| **Managers Answer:** | **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:** | **Engagement groups comments:** |

| **B. ASSURANCE and REPORTING** | |
|---|---|
| **PROJECT LEAD – include all engagement and equalities considerations and actions in any reports regarding change and seeking decisions.** | **YES/NO** |
| **CCG ENGAGEMENT AND EQUALITIES LEAD/S -**<br>**Recommend report to SMT / PCC**<br>**Recommend report to Governing Body** | <br>**YES/NO**<br>**YES/NO** |

**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.