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Rapid Health Impact Assessment of Aintree Hospitals NHS Trust proposal to build an Elective Care Centre at the University Hospital Aintree site

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PROVIDING INTELLIGENCE FOR THE PUBLIC HEALTH

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Executive Summary

Introduction and background to the assessment

The Liverpool Public Health Observatory has been commissioned to undertake a Health Impact Assessment (HIA) of the North Mersey Future Healthcare Programme (NMFHP) on behalf of the Merseyside Primary Care Trusts' (PCTs) Directors of Public Health.

This HIA is focused on one of the NMFHP's proposals, i.e. implementation of the proposal to build an Elective Care Centre (ECC) at the University Hospital Aintree (UHA) site and the transfer of services currently provided at the Walton Hospital site to the new centre.

It is intended that once HIAs of all the other elements of the NMFHP have also been completed, a final report will be produced examining the health impacts of the NMFHP as a whole.

Aims of the assessment

The overall aim of this HIA was to maximise the health benefits which could result from implementation of the proposal to build an ECC at the UHA site and the transfer of services currently provided at the Walton Hospital site to the new centre. In order to do this the following objectives had to be achieved:

- Identify and profile the population groups who will be affected by the proposal.
- Identify the potential positive and negative health impacts of the proposal and set out clearly who will be affected by these impacts.
- Make recommendations for the elimination or mitigation of negative impacts (or compensation for those affected).
- Make recommendations for the maximisation of positive impacts.

Obtaining information on impacts

In order to identify the ways in which the proposal could affect the key determinants of health, two one-day stakeholder workshops were held. Representatives from the affected communities were invited to attend one of these workshops. The workshops were supplemented by two interviews with people not able to attend these workshops but who indicated a willingness to express their views and whose organisations had not already been represented at the workshop.

Findings

Around 40 participants from a number of different organisations took part in the HIA. As those invited were asked to invite other colleagues and/or staff, it is not really appropriate to calculate a response rate but Aintree Hospitals NHS Trust representatives made up just over half of both those invited and who participated.

Most of the positive impacts during the construction phase related to determinants that could broadly be labelled economic (impacts on wealth creation and distribution, employment, education and training opportunities) and social (impacts on family support, community networks and public participation / social inclusion), i.e. the positive impacts on health that would arise if local people were employed (and local businesses used more) during the construction phase. These positive impacts would be lost if people (and businesses) from outside of the area were employed during this phase. In addition, potentially negative impacts on community safety and the physical environment that are common to all construction projects were identified and need to be considered.

Positive impacts on the same determinants as the construction phase were identified during the operational phase. In addition, opportunities for positively impacting on health-related behaviour, the physical environment and public service provision were identified. The negative impacts identified during the operational phase mainly related to potential negative impacts for local people on supply and demand for services, especially if the ECC became a Centre of Excellence, or paradoxically, if it failed to provide the quality of services that patients could choose elsewhere. The access to the ECC was also potentially a major problem, in terms of impacts on delays and accidents and also in terms of inadequate public transport provision – it was felt that public transport provision would need to increase significantly to maximise positive impacts.

In addition, the HIA identified a number of issues and impacts that could not neatly fit into either the construction or operational phase. Some staff felt they needed to be consulted more in the design of the ECC, in terms of how it will actually look and how it will thus impact on their working conditions and consequently, patient care. It was suggested that the Trust needs to communicate more (or perhaps through different channels) with its own staff about what the ECC aims to achieve and what assumptions it is based upon.

It was not only staff though who feel that they should be involved. It was felt that local people could work with the Trust by perhaps providing art work to decorate the ECC, and also by such schemes as “sponsor a brick”, “name the centre”, etc. This can be done again with local staff and wider via local schools, local community groups, through the local press, etc. It was also suggested that local people need to feel they have some sense of ownership, or at least patients do.

Finally, it is important that the Walton site does not become neglected once services are transferred to the new ECC and that should there be any period of time that the building is left empty following this transfer, that the site does not become neglected and there is adequate security on this site. In addition, it would be beneficial to inform businesses around Walton about what is planned to replace the current Walton Hospital as soon as practically possible so businesses can plan accordingly.

Conclusion

The greatest potential for negative impacts unsurprisingly is during the construction phase. This not only surrounds largely unavoidable impacts such as increases in noise and dust but also impacts which should be avoidable, particularly regarding the economic and social benefits that will accrue if the workforce is employed locally to carry out this work.
Nearly all of the positive impacts on the other determinants of health identified from the construction phase depend on local people being employed during this phase.

If local people are used, positive impacts will not only be felt during the construction of the ECC but hopefully for many years to come. The local population, whether this is by definition Warbreck and Fazakerley or Liverpool or even North Merseyside as a whole could benefit enormously from the economic boost that such work could bring.

Indeed, the construction of this ECC is seen as an ideal opportunity to act as a focus for bringing about change for the local populations of Warbreck and Fazakerley in particular (and perhaps to a lesser extent, North Liverpool and all other areas that will be served by the ECC in North Merseyside) and offers the NHS a great opportunity to bring about beneficial health impacts for all, both through it's role as a Corporate Citizen but also by ensuring that once built, the ECC acts as a hub for promoting health, providing community facilities (if possible), improving transport links, etc as well as carrying out the functions one automatically associates with such a centre, e.g. x-rays, operations, etc.

However, major concerns were raised with regard to accessing the ECC. It was highlighted that currently public transport is felt to be inadequate and that the new ECC will increase the pressure on the Longmoor Lane entrance to the site. Currently this is a dual carriageway and as such is a major road. It does not have a pedestrian crossing close to the entrance, certainly not by the entrance to Fazakerley Station. In particular, there must be a request for a crossing to coincide with and be part of the planning application as the two need to go hand in hand.

It is important therefore to liaise with both MerseyTravel and Liverpool City Council and also with the bus and train companies about improving both the frequency of public transport and also the safety around the site entrance. The ECC may provide an excellent opportunity for the NHS to exert some influence on bus companies to provide better bus services to many parts of Liverpool that are currently either directly inaccessible to the site or infrequently so.

Finally, a recurrent theme throughout this Rapid HIA was the need for involving staff and patients as much as possible in the design of the ECC. This was reflected in the supplementary findings and in various discussions about impacts.

Recommendations

Based on the above, around 40 different recommendations have been made to maximise potential positive and mitigate potential negative impacts (see page 28). These are summarised here under broad themes and headings as follows:

Construction phase

- Economic – Recommendations are made for the NHS as a whole and relevant local authorities and agencies to ensure that local people are suitably trained to take advantage of potential employment opportunities.
- Social – Recommendations are made for the Contractor and Aintree Hospitals NHS Trust to do all they can to maximise site security and safety of both workers and those living and working near to the site.
- Physical – Recommendations are made for the Contractor and Aintree Hospitals NHS Trust that the negative impacts associated with construction are minimised.

Operational phase

- Economic – Recommendations are made for Aintree Hospitals NHS Trust and the NHS as a whole to ensure that local people are suitably trained to take advantage of potential new employment opportunities and that Trust staff are able to benefit fully from training opportunities. The Trust also needs to ensure that where legally and practically possible, local businesses are used for sourcing of local goods.
- Social – Recommendations are made for Aintree Hospitals NHS Trust and the NHS as a whole to maintain and enhance current local social networks.
- Health-related behaviour - Recommendations are made for how Aintree Hospitals NHS Trust can promote health-related behaviour amongst staff, patients, visitors and possibly the local community as well.
- Physical environment – Recommendations are made for how Aintree Hospitals NHS Trust can enhance the design of the ECC.
- Public service provision - Recommendations are made for how Aintree Hospitals NHS Trust can enhance its own service provision and for liaising with other agencies so that transport provision and access and safety are also improved.

Other issues

- It is reiterated that in designing the ECC, Aintree Hospitals NHS Trust must take on board the views of both staff and patients.

Introduction and background to the assessment

The Liverpool Public Health Observatory has been commissioned to undertake a Health Impact Assessment (HIA) of the North Mersey Future Healthcare Programme (NMFHP) on behalf of the Merseyside Primary Care Trusts' (PCTs) Directors of Public Health.

This HIA is focused on one of the NMFHP's proposals. It is intended that, once HIAs of all the elements of the NMFHP have been completed, a final report will be produced examining the health impacts of the NMFHP as a whole.

Aims and objectives of this assessment

The overall aim of this HIA was to maximise the health benefits which could result from implementation of the proposal to build an Elective Care Centre (ECC) at the University Hospital Aintree (UHA) site and the transfer of services currently provided at the Walton Hospital site to the new centre. In order to do this the following objectives had to be achieved:

- Identify and profile the population groups who will be affected by the proposal.
- Identify the potential positive and negative health impacts of the proposal and set out clearly who will be affected by these impacts.
- Make recommendations for the elimination or mitigation of negative impacts (or compensation for those affected).
- Make recommendations for the maximisation of positive impacts.

What is Health Impact Assessmet?

HIA has been defined as:

> "… the estimation of the effects of a specified action on the health of a defined population." (Scott-Samuel, 1998, p704).
>
> And:
>
> "… any combination of procedures or methods by which a proposed policy or program may be judged as to the effect(s) it may have on the health of a population." (Ratner et al, 1997, p68).

The purpose of HIA is to assess the health consequences of a policy, programme or project and to use this information in the decision-making process. HIA is a multi-disciplinary activity that cuts across the traditional boundaries of health, public health, social sciences and environmental science and is seen as a useful tool in assessing the health impacts of key policy decisions.

HIA considers both positive and negative impacts. The overall aim of the process is to maximise the positive and minimise the negative outcomes for any proposal. The actions of all public and private organisations have direct or indirect impacts on the health of the nation. HIA is one way of ensuring that the overall, long term health and well-being of the population is one of the main criteria which is routinely taken into account during planning and decision making. As a minimum can we ensure that a decision won't harm people?

The Government's commitment, stated in *Saving Lives – Our Healthier Nation, is to:*

> "… make health impact assessment a part of the routine practice of policy-making in Government … [to] apply the approach right across Government" (Department of Health, 1999, p55).

The Acheson Report (1998) on inequalities in health, recommended that:

> "… as part of health impact assessment all policies likely to have a direct or indirect effect on health should be evaluated in terms of their impact on health inequalities". (p30)

HIAs, therefore, need to consider the distribution of both positive and negative impacts within the population. Those groups who are already multiply disadvantaged and have the worst health status are more vulnerable to the effects of any negative impacts which might result from the proposal under consideration (Acheson, 1998).

There is an emphasis on tackling health inequalities and enabling the full participation of those likely to be affected by the policy or project. Qualitative as well as quantitative methods of investigation can be used in HIA.

There are three types of HIA:

Prospective Health Impact Assessmet

Such assessments are carried out during the development of a policy, programme or project to estimate the potential impacts of the proposed activity on the health and well-being of defined human populations. The assessment should contribute to the decision making and planning processes.

Concurrent Health Impact Assessmet

Such assessments are carried out during the implementation of the policy, programme or projects to assess how the unfolding activity is affecting the health and well-being of the defined populations. This would allow changes to be made to the activity to maximise health gain opportunities.

Retrospective Health Impact Assessmet

Such assessments are carried out after the proposals have been carried out to assess the actual impacts on the health and well-being of the defined populations. The information obtained from such assessments can contribute to the overall body of knowledge about health impacts and, therefore, help to inform future prospective HIAs.

The focus of Health Impact Assessmet

HIA is designed to identify aspects of a proposal or activity that could affect or have affected the health and well-being of defined populations. These health impacts are most likely to occur because the proposal or activity affects the key determinants of health rather than because the proposal impacts directly on human health (though this may happen occasionally, e.g. exposure to physical or chemical hazards).

HIA is therefore focused on the changes to the key determinants of health that are either predicted to occur as a result of the proposed activity or have occurred as a result of the activity (see Box 1). HIA is not concerned with effects that would occur anyway

irrespective of the proposal or the activity being assessed. Exceptions to this rule would include the consideration of a 'do nothing option' as part of the terms of reference for the HIA, i.e. "how will the health of a defined population be affected if we continue on our present course and take no action?" Another exception would be the consideration of possible cumulative impacts resulting from the implementation of the proposal in an environment that is already affecting the health of a defined population significantly.

BOX 1: EXAMPLES OF KEY DETERMINANTS OF HEALTH

Economic
- Wealth creation
- Wealth distribution
- Employment opportunities
- Education and training

Social
- Family support
- Community networks
- Public participation / social inclusion
- Community safety

Personal
- Health-related behaviour

Physical
- Natural environment
- Built environment and open space
- Provision of housing

Public service provision
- New health premises and ways of working
- Access
- Transport

All impact assessments, including HIA, are aids to decision-making, not a substitute for political judgement. Indeed, political judgement involves complex considerations that go far beyond the anticipated impacts of a proposal. An impact assessment will not necessarily generate clear-cut conclusions or recommendations. It does, however, provide an important input by informing decision-makers of the consequences of policy choices. Any impact assessment should enable informed political judgements to be made about the proposal and identify trade-offs in achieving competing objectives. The HIA can be seen as an effective and valuable communication tool. Consultations with interested parties will generate useful discussion and bring in valuable information and analysis.

The North Mersey Future Healthcare Programme

Health services in North Mersey have historically been fragmented. Currently, North Mersey comprises five PCTs (Knowsley, South Sefton, Central, North and South Liverpool), three Metropolitan Borough Councils (Liverpool, Knowsley and Sefton), two large university hospital Trusts, six specialist Trusts and an Ambulance Service Trust. Thus, the definition of the health care population of North Mersey is complex as it varies from the core of around 700,000 for the combined catchment of the general adult hospitals up to several million for some regional and sub-regional services contained within the teaching hospitals and specialist Trusts.

The North Merseyside health economy is unusual in the range of specialist trusts located in the area. However, health services in North Merseyside have historically been fragmented and been of poor functional suitability. In particular:

- There has been low investment in primary care infrastructure as evidenced by low numbers of GPs per 1000 population and primary care expenditure of significantly less than the national average.
- North Merseyside has one of the lowest spends per head of population in mental health services in the country.
- North Merseyside hospitals have a combined backlog maintenance requirement of over £60 million and most hospital inpatient facilities do not meet the NHS Consumerism standards (Both the Royal Liverpool & Broadgreen and Aintree Hospitals NHS Trusts currently have no more than 20% of their beds in single occupancy rooms).
- The estate for Mental Health, Children's services, and the two adult acute hospitals is not adequate to meet the expected demand for activity in the next ten years, nor does the quality of buildings meet current standards of patient privacy and dignity.

Nationally, it has been acknowledged that one of the major challenges facing the NHS is to focus on the longer-term transformation of services to meet the changing needs and expectations of patients. Thus the NHS Confederation has developed the Future Health Care Network.

Locally, a major review of adult acute hospital services began in North Mersey in 2001 out of which the NMFHP developed. This aims to redesign the NHS on North Mersey so that services are better able to meet the challenges set out in the NHS Plan, to implement National Service Frameworks, improve and make more responsive Cancer services, reduce waiting lists, problems of access and long waiting times for immediate admission to acute hospital beds and to bring major Capital Investment into North Mersey health services.

The NMFHP Strategic Investment Framework (SIF) was submitted to the Department of Health in April 2004. On 27 July, the NMFHP was one of 15 new developments approved by the Department of Health (subject to public consultation and agreement by the Cheshire and Merseyside Strategic Health Authority who have stated that one criterion for acceptance is for HIAs to be undertaken). The total cost for the bid is around £1 billion. The NMFHP should become operational in 2005-2006 with a ten-year timescale in which to deliver health improvements. The 'whole system' approach (in which the focus is on the patient and their pathway through the whole healthcare system – e.g. from primary care and across all specialties and service providers) is seen as a key element.

Integral to the NMFHP, Local PCTs have recognised the need to invest in the primary care estate, to enable greater provision of services close to patients' homes. Despite high levels of hospital access, the population has demonstrated support for more local access:

- The provision of Walk In Centres in Liverpool and South Sefton has resulted in 158,000 attendances for unplanned care outside Accident and Emergency Departments.
- Despite this, the primary care estate remains predominantly traditional, with poor quality premises for many GPs. One PCT, for example, has plans to refurbish or replace over 90% of GP Practices/Health Centres in the next 10 years.

A summary of the NMFHP is given in Box 2 (taken from the SIF). The NMFHP should become operational in 2005-2006 with a ten-year timescale in which to deliver health improvements.

BOX 2: SUMMARY OF SHORTLISTED OPTIONS

Sponsoring Organisation:	**Capital Scheme Options:**
1. Royal Liverpool and Broadgreen University Hospitals NHS Trust	• Refurbishment of Royal Liverpool University Hospital (RLUH). • Rebuild RLUH on current site. • Rebuild RLUH on a new site (yet to be determined).
2. Aintree Hospitals NHS Trust	• Minor upgrade and reconfiguration of existing estate. • Build Elective Care centre. • Build Elective Care centre and new ward block, with associated modernisation of existing ward block.
3. Royal Liverpool Children's Hospital NHS Trust	• Backlog maintenance only. • Redevelopment of Alder Hey Hospital on existing site, with or without use of adjacent land. • Redevelopment on a new site. • Co-location of services with other services, either on the Alder Hey site or with another Trust. • Reconfigure Children's Services across the North West (together with Manchester Children's Hospital).
4. Mersey Care NHS Trust	• Establishment of up to 8 Local Community Resource Centres. • Continue provision of existing services with intensive care being provided by the private sector in Manchester. Reprovide older people's and adult services in Southport and provide 20 crisis team managed beds across the catchment area. New development for people with complex learning difficulties.
5. Liverpool & Sefton Local Improvement Finance Trust	• Three phases of investment in up to 20 new premises, including Local NHS centres providing access to a wider range of health and community services.

Common to all Government policies is the need to "modernise" service and increase "patient choice". This will be achieved largely through adoption of the "new model of care" in which a "whole system" approach to patient care is taken, i.e. focus is on the patient and their pathway through the whole healthcare system – e.g. from primary care and across all specialties and service providers.

From 1st October 2005, the NMFHP has entered a new phase, in which the capital schemes are governed by individual Trust Boards, allowing the Strategic Health Authority to move from its current role as partner, to its new role as approving body. The current likely options are thus being developed as separate Outline Business Cases (OBCs) although all four OBCs should be interlinked parts that redesign services as a whole and be underpinned by current redevelopments in primary care.

This HIA is focused on the proposal to build an ECC at Aintree Hospital and transfer services currently provided at the Walton Hospital site to the new centre. The OBC will consist of a number of possible options with a preferred option clearly identified. The HIA will only be undertaken on the preferred option to be put forward in the OBC. It is expected that the OBC for this scheme will be submitted by the Trust in September/October 2005

The proposed Elective Care Centre at the University Hospital Aintree

Aintree NHS Trust manages two hospitals – University Hospital Aintree, which is a large teaching hospital providing Accident and Emergency services and a wide range of acute and non-acute specialities, and Walton Hospital which provides some types of day surgery and outpatient clinics, x-ray services and some support services including physiotherapy, a pharmacy and medical records.

Aintree Hospitals NHS Trust proposes to move all acute hospital services from Walton to the UHA site. The scheme also includes provision for upgrading the existing outpatients department at UHA to modern standards. The Trust believes that this will:

- Improve the quality of facilities the Trust is able to offer their patients.
- Maintain and improve patient safety.
- Make better use of resources, including staff time and expensive medical equipment.
- Ensure that high quality staff continue to be attracted to work at the Trust.

The proposal is that all staff working at Walton would be transferred to the Aintree site (this is about 450 members of staff).

The Trust's main commissioners are South Sefton, North Liverpool and Knowsley PCTs, who collectively account for around 80% of the Trust's total income. These three PCTs serve a combined population of some 426,000 people (South Sefton PCT=160,240, North Liverpool PCT=107,530 and Knowsley PCT=158,439), the majority of whom look towards Aintree for hospital care.

The Aintree Site

The UHA site covers some 37 hectares accommodates the majority of acute services provided by Aintree Hospitals NHS Trust, in hospital buildings constructed in a number of phases between the 1960s and 1990s. It can therefore be seen as being in two parts, with the "new" part of the site accommodating the main hospital buildings and acute clinical services, and the Walton Centre for Neurology and Neurosurgery. The "old" part of the site is mainly used for non-acute (mental health) services, administration and support services, and has buildings dating back as far as the early 1900s, together with more recent additions.

A professional design team incorporating architects, engineers and surveyors has been appointed to develop plans for the Elective Care Centre to be based to the North West of the UHA site (the "old" part). Currently it is proposed that the building will comprise some 9,000m^2 of accommodation (see Box 3). The timetable for the project is summarised in Box 4. The estimated cost of the scheme including associated works is around £35 million.

BOX 3: PROPOSED CONTENT AND ACTIVITY OF THE AINTREE ELECTIVE CARE CENTRE

Ground Floor:	**First Floor:**	**Second Floor:**
• Main entrance	• Outpatient Department	• Day Surgical Unit
• Café	• Clinics	• Theatres
• Retail	• Medical Records	• Recovery
• Pharmacy		• Pre-Discharge
• Radiology		• Pre-Operative Assessment
• Breast Screening		• Admissions Lounge
• Ophthalmology		• Seminar Room
• Pathology		

Proposed activity

- 11,000 Surgical Day Cases will be treated per year in the following specialties: General Surgery, Urology, Orthopaedics, ENT, Ophthalmology and maxillo-facial surgery.
- 100,000 outpatients will be treated each year.

BOX 4: PROPOSED TIMETABLE FOR THE PROJECT

Date:	**Activity:**
Autumn 2005	• Completion of Public Consultation
Autumn 2005	• Approval of Outline Business Case
Spring 2007	• Approval of Full business Case
Summer 2007	• Start of Construction
Summer 2009	• Opening of Facilities of UHA

Within the immediate vicinity of the proposed site for the ECC, aside from the main site of UHA itself, are various other health-related premises belonging to Aintree Hospitals NHS Trust and Mersey Care NHS Trust, the Walton Centre for Neurology and Neurosurgery (The UK's only neuroscience NHS Trust which itself used to also be based on the Walton site), Ennerdale Nursing Home, Woodlands Hospice and a veterinary surgeon. There are also a number of shops and businesses within five minutes walking distance, to the north west and north-east of the site, along Longmoor Lane (those to the north east by the junction with Lower Lane which is the road where the main hospital entrance site is situated to the east) (See Box 5)

BOX 5: LOCAL SHOPS AND BUSINESSES NEAR TO THE AINTREE SITE ON LONGMOOR LANE

North West of the site:	**North East of the site (near junction with Lower lane):**
• Supermarket	• Grocery store / local shop
• 2 fish and chip / takeaway shops	• Florist
• Sandwich shop	• Hairdresser
• 2 pubs	• “Sun centre”
• 2 electrical/hardware shops	• Dentist
• Tan and beauty salon	
• 2 Estate agents	
• 2 Newsagents	
• Betting shop	
• Hairdresser	
• Barbers	

The Walton site

Walton Hospital is some two miles distant from UHA and provides a limited range of elective outpatient, diagnostic and day surgery services. It is located on the A59 Rice Lane, a major route into Liverpool from the north. As part of the Trust’s strategy to

centralise all acute services on the UHA site, the range of services provided at Walton has steadily decreased as a result of various developments at UHA over recent years.

The site occupies a land area of some 4 hectares and has a gross internal area of 10,246m². Following the disposal of part of the site for housing development, almost the entire building stock used for the provision of services is well over 30 years old, with some elements of the site infrastructure being much older. The remaining buildings at Walton provide poor quality facilities, and the costs associated with maintaining the site are increasing. The ongoing construction works related to the housing development also have a significant negative impact on the quality of the patient environment and make access and car parking difficult.

Possible options for the future use of the Walton Site include one or all of the following:

- A Walk in Centre.
- Community Diagnostic Facilities (inc, pathology, blood testing, ultrasound, x-ray).
- Mental Health Support facilities.

Final decisions about the future use of the site will take into account responses to the public consultation which commenced on 12th July and is due to end on 4th October. The full consultation document is available on the Trust's website at www.aintreehospitals.nhs.uk

It is important to note that Public Consultation constitutes a separate and independent process to HIA although both should inform future decision making.

Public Consultation concerns the future provision of services currently provided at Walton and the future of that site for new kinds of healthcare services, whereas HIA aims to identify aspects of a proposal that could affect the health and well-being of defined populations and to produce recommendations in order to maximise positive and minimise negative health impacts of the proposal.

Other developments

The health economy faces the need collectively to meet and sustain a range of national targets and priorities, the most significant of which are:

- Public Service Agreement and NHS Plan Targets e.g. reducing inequalities in health outcomes, access to health services, etc.
- National Service Frameworks Targets.
- Reducing death rates from cancer (NHS Cancer Plan).
- Extending patient choice (central tenet of Government's plan or system reform).
- New partnership requirements as embodied in "*Keeping the NHS Local: A New Direction of Travel*"
- The Wanless Reports and "*Choosing Health*" (Public Health White Paper).
- Strategic Health Authority Local Delivery Plan 2003-2006.

There is a need to ensure full integration of health, social care and other agencies (transport, housing, education, leisure etc) to transform the health and well being of the people in North Mersey. Indeed, it is believed that the time is right for an investment such as the NMFHP now because of a number of opportunities that have arisen, including:

- The culture of service improvement and change generated by the NHS Plan.
- Development of "whole system" working across the health economy.
- Broader strategic co-ordination from the new Strategic Health Authority.
- The clear remit for local health and service improvement given to PCTs under "Shifting the Balance of Power".
- The associated national profile of sustained investment in the NHS.
- A national commitment to investment in NHS infrastructure.
- A significant programme of urban regeneration on Merseyside.
- Liverpool's forthcoming status as European Capital of Culture.
- The impact of policies relating to social exclusion, which enable different thinking about investment across sector boundaries to achieve health improvement.
- The establishment of Local Strategic Partnerships for each Local Authority has provided the vehicle through which PCTs can integrate their estate plans with local regeneration.
- Local Improvement Finance Trust (LIFT) Boards have been working with Local Authorities to identify potential sites for new Primary Care premises. These links have helped NHS Trusts to establish relationships with the Local Authorities to explore options for hospital site redevelopment. The potential for LIFT to deliver maximum benefit would be undermined without parallel investment in service change and capital investment in hospital facilities.

The HIA methodology

Setting the terms of reference

A small project management group (See Box 6) was set up to oversee the implementation of the HIA of the proposal to build an ECC at Aintree Hospital. The purpose of the project management group was to determine the Terms of Reference (TOR) for the assessment and to provide advice and support as the assessment develops, i.e. to ensure the quality of the work and to ascertain the scope of the study.

BOX 6: PROJECT MANAGEMENT GROUP MEMBERSHIP

Professor Susan Milner	HIA Supervisor	North Liverpool PCT
Nigel Fleeman	Researcher	Liverpool Public Health Observatory
David Hounslea	Project Manager ECC	Aintree Hospitals NHS Trust
Nicky Colcutt	Project Co-ordinator ECC	Aintree Hospitals NHS Trust

The scope of the HIA

The scope of the HIA was determined by time and resources constraints.

Although it could be argued that the ECC could have an impact well beyond the immediate area, time and resource constraints dictate that the assessment should identify those geographical areas that are most likely to be affected by the development. A 'zoning' approach was adopted as follows.

Primary focus:

- Aintree Hospital site and immediate surroundings
- Walton Hospital site and immediate surroundings

Secondary focus (as part of a wider community perspective):

- Warbreck ward.
- Fazakerley ward.

The HIA covered both the construction and operation phase of the development.

The HIA considered impacts that may occur up to 20 years from now.

Individuals, organisations or departments within organisations were identified as key stakeholders and thus important sources of information in relation to the HIA. As a community consultation exercise was taking place at the same time, individuals and organisations identified for this purpose were used as starting point. All those invited are listed in Appendix 1.

Outputs for the assessment were agreed to consist of a report for the Trust (which it was envisaged could then be inserted into an appendix to the OBC) and a summary of the findings for participants.

Obtaining information on impacts

In order to identify the ways in which the proposal could affect the key determinants of health, two one-day stakeholder workshops were held. Representatives from the affected communities were invited to attend one of these workshops (see Appendix 2 for a copy of the invitation letter). All those who accepted the invitation to participate were sent preparation materials in advance of the workshop. These materials covered aspects of the proposal, a brief community profile and information about HIA (see Appendix 3 for a copy of the preparation of the materials which includes a copy of the programme for the workshop).

During the workshop participants taken through a structured process in small facilitated groups in which they were asked key questions about how the proposal might affect the determinants of health. This information was recorded on specially designed proforma (as described in the preparation materials in Appendix 3)

Workshops were facilitated by Nigel Fleeman, Dympna Edwards (Director of Public health, North Liverpool PCT) and members of the IMPACT team, IMPACT being a unit based at the University of Liverpool specialising in HIA. (See Appendix 1 for the list of those individuals or organisation invited to attend and those who were able to participate)

The workshops were supplemented by two interviews with people not able to attend these workshops but who indicated a willingness to express their views and whose organisations had not already been represented at the workshop.

Profile of the area

An integral part of any HIA is the identification of those groups who may be affected by the proposal being assessed. These affected groups may have in common a geographical location, a shared interest or a shared identity.

Following on from the identification of the affected groups it is common practice to provide a profile of them, which includes a range of demographic and social data. This allow the assessors to determine if there are any particular characteristics within the affected groups that could either make them more resistant or more vulnerable to the health impacts that may result from the proposal being assessed.

As Aintree Hospitals NHS Trust provides acute health care to 330,000 people living in North Merseyside and the surrounding areas as well as providing a number of specialist services to a much larger catchment area reaching North Wales and the Isle of Man, there are clearly a number of different populations potentially affected by the Trust and thus the ECC proposal.

However, it is largely the populations of North Merseyside that will be most affected by any move of services from Walton to the proposed EEC. Therefore, for the purposes of this profile, some basic background information was presented on the North Merseyside population (see Appendix 3).

In addition, information on both patient activity and staffing levels was provided by the Trust.

Aintree Hospitals NHS Trust has delivered consistently increasing levels of activity over recent years. In the three years between 1999/2000 and 2002/2003, inpatient and day case grew by 13% and outpatient attendances grew by over 9%. Most recent data shows that around two fifths of this day case and outpatient activity takes place at Walton (10,385 [38.8%] of all 26,385 day cases and 100,000 [45.7%] of all 218,716 outpatient appointments).

The Trust have stated in their Strategic Outline Case that: "A substantial increase in capacity will be required if this level of performance is to be maintained in the future."

Aintree Hospitals NHS Trust currently employs just over 4,000 people (over 3,500 whole time equivalent), of which around 300 (7.5%) are based at Walton.

Findings

In total, 103 invites were sent out to 99 people (as some people were invited twice) and 37 people participated in the Rapid HIA from a variety of different organisations. As they were asked to invite other colleagues and/or staff, it is not really appropriate to calculate a response rate. Participants were from a number of different organisations although Aintree Hospitals NHS Trust representatives made up the majority of both invites (52 [53%]) and participants (20 [54%]) (see Appendix 1 for the full list of both people invited and who attended the workshops or participated in an interview).

Following analysis of the data provided by stakeholders during the workshops and interviews, a number of potential positive and negative impacts on the key determinants of health were identified. Impacts were thought likely to occur during construction and operation phases. The following tables (Tables 1-4) set out the positive and negative impacts on the key determinants of health during both phases of the proposed project. The tables also includes a statement of how the key determinant of health affected by the proposal may affect the health of the population. Where the impact is negative mitigation measure are suggested and where the impact is positive enhancement measure are suggested.

TABLE 1: POSITIVE IMPACTS DURING CONSTRUCTION

Impacts on the determinants of health	Population group(s)	Consequences for health (in brief)	Enhancement measures
<u>Economic</u> • Wealth creation • Wealth distribution • Employment opportunities • Education and training Construction work offers employment, education and training opportunities for people in North Liverpool and with it wealth creation and distribution. Local businesses also have the potential to benefit from wealth creation – directly as in local suppliers of materials used in construction, scaffolding, etc and indirectly in terms of shops and services nearby that construction workers may use, e.g. food shops. <u>Social</u> • Family support • Community networks • Public participation / social inclusion If local people are employed, extra income from families could increase a sense of feeling in control over personal/family circumstances and increase the solidity of family units. It could also lead to increased socialisation opportunities (as socialising often costs money) and thus enhanced community networks.	Local residents particularly those unskilled and unemployed. Local businesses and their employees. Local residents and families, particularly those who are unskilled and unemployed. Local businesses and their employees.	Employed people generally have better health than unemployed, experiencing less morbidity, mortality and social exclusion. Wealthier regions/communities generally have greater levels of health than poorer regions/communities. But the actual pattern of wealth distribution across the different groups within society directly affects their respective levels of well-being. Inequalities in wealth distribution cause inequalities in health across these groups. Improving the learning opportunities for vulnerable groups like young people and the unemployed will substantially improve health for them and reduce inequalities. A sense of control over personal/family circumstances, e.g. in decision-making affecting income, working and living conditions and in their discretion to act, can enhance one's health. Meaningful social contacts, e.g. with families, friends and community groups, are also good for health.	• The NHS as a whole and relevant local authorities and agencies need to ensure that local people are suitably trained to take advantage of potential employment opportunities. o Ensure there are local modern apprenticeship schemes in place and work with specialist agencies such as JET. • In awarding construction contracts, the Trust should ensure that employment of local people is a key consideration – especially firms that have a track record of training local people. o As far as is practically and legally possible, the Trust should specify in contracts that local suppliers are used. o As far as is practically and legally possible, the Trust should ensure firms carrying out construction work offer skills training opportunities for local people. • Ensure a strategic overview of construction projects is taken to enable sustainable employment opportunities for local people. o At the very least the NHS as a whole should ensure that the construction of new health premises are staggered to maximise sustainable employment opportunities. • If it is not possible to employ local people, it is important that that local people know the reasons for this (e.g. local people with the skills are already employed elsewhere; belief that free trade laws do not allow for the Trust to specify local workers are employed, etc).

TABLE 2: NEGATIVE IMPACTS DURING CONSTRUCTION

Impacts on the determinants of health	Population group(s)	Consequences for health (in brief)	Mitigation measures
<u>Economic</u> • Wealth creation • Wealth distribution • Employment opportunities • Education and training Firms contracted to carry out construction work may choose or indeed be obliged to employ people that do not live locally (by local, this may even preclude them being from Liverpool or indeed the North West, never mind Warbreck or Fazakerley). This means that much of the wealth produced will end up leaving the local economy. Alternatively, firms may wish to employ local people (it would after all presumably be more economical for them to do so) but local people may lack the necessary skills to carry out the work.	Local residents particularly those unskilled and unemployed. Local businesses and their employees.	Employed people generally have better health than unemployed, experiencing less morbidity, mortality and social exclusion. Wealthier regions/communities generally have greater levels of health than poorer regions/communities. But the actual pattern of wealth distribution across the different groups within society directly affects their respective levels of well-being. Inequalities in wealth distribution cause inequalities in health across these groups. Improving the learning opportunities for vulnerable groups like young people and the unemployed will substantially improve health for them and reduce inequalities.	• Mitigation measures are essentially the same as the enhancement measures above in Table 1.
<u>Social</u> • Family support • Community networks • Public participation / social inclusion People being employed from outside the area may cause resentment within the local area; this may make the community feel disempowered and resentful to those employed in the construction of the ECC and resentful to policy makers who they may also blame. This could reduce public participation and social engagement and strain all community networks.	Local residents.	A sense of control over personal/family circumstances, e.g. in decision-making affecting income, working and living conditions and in their discretion to act, can enhance health. Meaningful social contacts, e.g. with families, friends and community groups, are also good for health.	

TABLE 2 (CONTINUED): NEGATIVE IMPACTS DURING CONSTRUCTION

Impacts on the determinants of health	Population group(s)	Consequences for health (in brief)	Mitigation measures

<u>Social</u>
• Community safety
 	
Contractors by the very nature of their work are at risk of accidentally injuring themselves.
 	
When contractors stop working, the site will be a source of fascination for bored children and teenagers who may accidentally harm themselves or deliberately harm others using materials available such as bricks.
 	
Increased amount of traffic could not only cause delays through increased congestion but also increase the risk of road traffic accidents.
 	
Loss of firm floor space, i.e. more uneven surfaces causing particular problems for those with mobility problems, whether on foot or in wheelchairs.
	Contractors.
	
	Local people, especially teenagers and children.
	
	Vulnerable groups, namely children, elderly and people with mobility problems.
		Injuries caused accidentally or inflicted by others have obvious negative impacts on physical health and can also negatively impact on mental health and well-being.
		
		Protection from accidental injury and crime is necessary for individual and community health and wellbeing. Fear of crime can be just as damaging as crime itself.
		
		Delays can increase levels of stress. Stress can lead to depression, anxiety and suppression of the immune system, increasing the risk of infections and diseases.
		
		Accidents have obvious negative impacts on physical health and can also negatively impact on mental health and well-being.
		
		Fear of accidents can also negatively impact on health if it results in reduced physical activity.
		
		For children, independent mobility to explore the environment is associated with the development of life skills and the generation of self-esteem, a sense of identity and the development of a creative capacity to take personal identity.
			• The Contractor and Trust must ensure that current legally obliging health and safety standards are adhered to.
			• There is a need for the Trust to provide security including CCTV.
			  o If possible, and if the local people are suitably skilled, this could be provided by local people.
			• The Trust could try to recruit more special constables to patrol the area or specific police time could be bought directly by the Trust.
			• The Contractor and Trust must ensure that construction site traffic is kept as far away from other traffic as possible and that movement of such traffic occurs at specified times (preferably not at peak times and certainly not when children are going to and from school).
			  o Separate entrances to the site for pedestrians and traffic may help.
			  o Steady, flat flooring must be in place where needed.

TABLE 2 (CONTINUED): NEGATIVE IMPACTS DURING CONSTRUCTION

Impacts on the determinants of health	Population group(s)	Consequences for health (in brief)	Mitigation measures
<u>Physical</u> • The natural environment It was felt that for the most part, the increase in noise and dust will be minimal (and as the old building where the ECC is proposed has already been demolished, this problem is further minimised). However, the construction is taking place close to a few vulnerable groups of people to dust. Noise may also be a problem for these residents as well as the residents in the local doctor's residence.	Vulnerable groups are particularly affected, namely: Residents of the nearby Ennerdale Nursing Home and Woodlands Hospice and patients of Westmoreland GP Practice. Doctors living in the local doctors' residence.	Increased levels of dust and noise exacerbate both stress and physical symptoms, particularly those susceptible to respiratory problems. Stress can lead to depression, anxiety and suppression of the immune system, increasing the risk of infections and diseases. Sleep disturbance can increase stress which can negatively affect work performance and family relationships. Stress can indirectly impact on health by promoting an increase in behaviours that are health damaging such as smoking, excessive alcohol use, over- or under-eating and other risk taking behaviours. These may be conscious or subconscious acts of attempts to alleviate stress.	• The Contractor and Trust must ensure that construction site traffic is kept as far away from other traffic as possible and that movement of such traffic occurs at specified times (preferably not at peak times and certainly not when children are going to and from school). o Strict hours for when work and deliveries are permissible should be enforced to minimise noise levels. o As some doctors will work night shifts the Trust could look at ensuring the doctor's residencies are as sound proof as practically possible. • The use of fans in nearby premises may alleviate some of the problems of dust. • The Trust must liaise with other UHA site users as much as possible and ensure that they are kept informed of developments at all times (particularly where these developments may be more disruptive than usual).

TABLE 3: POSITIVE IMPACTS DURING OPERATION

Impacts on the determinants of health	Population group(s)	Consequences for health (in brief)	Enhancement measures
<u>Economic</u> • Wealth creation • Wealth distribution • Employment opportunities • Education and training If the ECC becomes a centre of excellence, capacity will increase and there will thus be positive impacts on all the economic determinants: wealth creation and distribution (from an influx of patients and people into the Trust), employment opportunities (to meet the increased capacity and possibly elsewhere in the Trust from the income generated) and education and training (assuming education and training of staff is a function of the ECC or at the very least is provided by the Trust elsewhere on this site if not). An increase in number of people attending the centre brings with it an increase in people who may potentially use the surrounding shops and services and thus has potential positive impacts for wealth creation (whether this happens or not will depend to a large extent what facilities are provided on site at the Trust and whether carers decide to wait around for patients while they are being operated on).	Employees of the Trust Patients attending the Trust Local businesses nearby	Employed people generally have better health than unemployed, experiencing less morbidity, mortality and social exclusion. Wealthier regions/communities generally have greater levels of health than poorer regions/communities. But the actual pattern of wealth distribution across the different groups within society directly affects their respective levels of well-being. Inequalities in wealth distribution cause inequalities in health across these groups. Improving the learning opportunities for vulnerable groups like young people and the unemployed will substantially improve health for them and reduce inequalities.	• The Trust should enhance links with local schools and colleges to ensure that local people are able to benefit from any new job opportunities: o Anticipate skill mix and train people accordingly. o Make and market the NHS as an attractive place to work for local people. • The opportunities to use the existing training facilities on the UHA site should be maximised. o The ECC could also be used for would-be staff to gain work-experience if possible. • Facilities such as childcare need to provided hand in hand with any new jobs. • Ensure that the Trust takes its role as a Corporate Citizen seriously and tries to ensure local business are used for sourcing of local goods.

TABLE 3 (CONTINUED): POSITIVE IMPACTS DURING OPERATION

Impacts on the determinants of health	Population group(s)	Consequences for health (in brief)	Mitigation measures
<u>Social</u> • Family support • Community networks • Public participation / social inclusion If more people are treated as day cases, there will be less disruption to home life. Community networks should also be improved for people who work at the ECC. Patient choice should also increase public participation.	Patients. Friends/relatives of patients. Trust employees.	People are social beings. Meaningful social contacts are good for health, e.g. with families, friends and community groups. Individual health is also enhanced by a feeling of control over one's life circumstances, in this case for patients choosing where they would like to go for their health care.	• If more people are being treated as day cases, this means there is less disruption to home life and social networks. o It is also important to ensure that vulnerable people in particular have adequate social networks in place already once they have been discharged in case of any post-operative problems. • Community networks and social inclusion are enhanced for staff as long as the Trust provides education and childcare facilities, i.e. increasing opportunities for people to be able to work.
<u>Personal</u> • Health-related behaviour The site is currently a no-smoking site and this should therefore be beneficial to all who work on and visit the site. While the exact nature of the facilities within the ECC is currently unknown, there is great potential for much further health promoting initiatives to be developed here. It was noted that there are a lack of any leisure facilities for young people in Fazakerley at the moment. Thus it was questioned whether there was anything that the Trust could do to remedy this situation?	Patients. Friends/relatives of patients. Trust employees.	Individuals may place themselves at increased risk of ill health through their health related behaviour patterns. Smoking is considered to be the biggest single preventable cause of death. Poor diet and a lack of physical activity are two other major causes of poor health that it is felt that individuals can change.	• The Trust should reinforce no-smoking measures within the ECC (e.g. information on smoking cessation services and other health promoting services, etc). • The Trust should ensure that healthy food is available at the café and consider ensuring that only healthy options are available in any vending machines. • The Trust needs to preserve "green areas" around the ECC: o Encourage people to walk while they wait for patients? o Open up access to the woodlands if practical? • If it is viable to include some community facilities, such as a gym, the Trust should consult with the community (and patients and staff) about what community facilities they may want in the ECC.

TABLE 3 (CONTINUED): POSITIVE IMPACTS DURING OPERATION

Impacts on the determinants of health	Population group(s)	Consequences for health (in brief)	Mitigation measures
<u>Physical</u> • Natural environment • Built environment and open space It is assumed that the ECC will be developed as "environmentally friendly" as is possible. The design of the ECC is also important for staff and patients.	Patients. Friends/relatives of patients. Trust employees. Local residents.	Population health is affected by the natural environment - air, soil and water quality, ecosystem, noise, smells, views, waste disposal. These factors are themselves affected by the way we use our natural resources, consume our energy and the pollution and waste we produce.	• Environmental standards already exist which must be adhered to but there may be opportunity to go further, considering things like energy efficiency, disposal of waste, etc. • The Trust needs to ensure that the ECC also provides a pleasant environment and is a "healthy building", i.e. that the building provides enough natural light, etc. • The Trust needs to preserve "green areas" around the ECC – see above. • In designing the ECC, the Trust must take on board the views of both staff and patients.
<u>Public service provision</u> • New health premises and ways of working. If the ECC becomes a centre of excellence, there will be positive impacts on new health premises and ways of working resulting in commissioning of services for many years to come. High calibre staff will be attracted and there will be a better skill mix. Better retention and recruitment should follow. Positive impacts on new health premises and ways of working may also arise from developments on the Walton site, depending how this is used.	Patients. Friends/relatives of patients. Trust employees. Local residents.	New health premises and service reconfigurations can have an immediate and direct effect on the target population by increasing access to, and quality of, health services for patients (which should result in improved health outcomes) and improving working conditions for staff. But they can also have unintended negative consequences by reducing access for patients and worsening working conditions for staff.	• It is anticipated that as skill mix changes, there will be more scope for nurses to do some operations currently carried out by doctors – this may require training. o There is a need to ensure that staff are trained at the Trust – centralised resources exist and should be maximised. • It is felt beneficial to keep some health services on the Walton site whether these are provided by The Trust or another NHS organisation.

TABLE 3 (CONTINUED): POSITIVE IMPACTS DURING OPERATION

Impacts on the determinants of health	Population group(s)	Consequences for health (in brief)	Mitigation measures
<u>Public service provision</u> • Access • Transport Provision of bus services from most of the communities is felt to be inadequate – the ECC could therefore act as a "lever" to improve the situation.	Patients. Friends/relatives of patients. Trust employees. Local residents.	There are particular concerns about the impacts of over reliance on the private car, increased air travel on air pollution and climate changes, use of land to support transport demands and road traffic accidents. A lack of public transport also increases the risk of social exclusion (which has negative impacts on both mental and physical health) and reduces access to health services.	• There is a need for continued discussions between the Trust with both Merseytravel and the bus companies about services to communities who currently cannot access the site by bus or can do so infrequently.

TABLE 4: NEGATIVE IMPACTS DURING OPERATION

Impacts on the determinants of health	Population group(s)	Consequences for health (in brief)	Mitigation measures
<u>Social</u> • Public participation / social inclusion • Community safety If the ECC becomes a centre of excellence, there could actually be some negative impacts on patient choice for local people, i.e. increase in demand from other areas lengthens waiting times. Currently Walton Hospital has people working there as volunteers. If they are not able to continue their voluntary work at the ECC, either because of new ways of working or because they are unable to access the ECC as easily (as many volunteers are elderly) this could have negative impacts on their public participation and social inclusion. Concerns were raised about the safety of people going to and from the ECC at night or when it is dark in the winter months.	Patients, particularly those living locally and currently served by the Trust. Volunteers working at the Trust on the Walton site	Individual health is enhanced by a feeling of control over one's life circumstances, in this case for patients choosing where they would like to go for their health care. Positive and negative impacts of employment largely apply whether one is paid or works voluntarily – see impacts of employment on health above. Protection from accidental injury and crime is necessary for individual and community health and wellbeing. Fear of crime can be just as damaging as crime itself.	• If other providers of health services are unable to "compete" with the ECC and thus provide a high quality service for their local population, arguably all the Trust can do is try to ensure there is sufficient capacity to meet increasing demand. • However, across North Merseyside (at least) it does highlight the importance of some strategic overview of commissioning and provision of services being maintained. • The Trust should ensure that voluntary opportunities are maintained at Aintree and that as far as possible, those working in this capacity at Walton are given every opportunity to carry on doing so at Aintree. o The Trust should try to increase voluntary opportunities, perhaps for more vulnerable groups. • Currently it is only intended that the ECC will operate during normal working hours. Nevertheless it is clearly important that access to and from the ECC is well lit, especially as people will still be entering and leaving in the dark (especially in winter). o The Trust should increase the level of security during these periods.

TABLE 4 (CONTINUED): NEGATIVE IMPACTS DURING OPERATION

Impacts on the determinants of health	Population group(s)	Consequences for health (in brief)	Mitigation measures
<u>Public service provision</u> • New health premises and ways of working. Concern was expressed that there may be negative impacts on new health premises and ways of working if the ECC is not big enough – will space be too cramped, meaning working conditions are poor, the patient experience is negatively impacted upon and patient confidentiality be at risk? If working conditions are felt to be inadequate and patients find the experience to be poor, then there is a risk to losing both staff and patients and consequently status which could result in a downward spiral of losing more and more staff and patients. The fact that the new ECC was close to the main UHA site was not necessarily seen as advantageous either. It was felt that currently Walton Hospital lacks the "hustle and bustle" of the main site which is beneficial to both staff and patients. It was also questioned as to whether the site of the ECC does increase access to emergency back-up if needed as ambulances may wrongly assume that backup is available at the ECC (as it was felt is often the case at present at Walton) and because of the close proximity, see incidents at the ECC as less of a priority.	Patients. Friends/relatives of patients. Trust employees. Local residents.	New health premises and service reconfigurations can have an immediate and direct effect on the target population by increasing access to, and quality of, health services for patients (which should result in improved health outcomes) and improving working conditions for staff. But they can also have unintended negative consequences by reducing access for patients and worsening working conditions for staff.	• In designing the ECC, the Trust must take on board the views of both staff and patients • The quality and functionality of the space available at the ECC should at least match that currently available at Walton Hospital. • The Trust needs to ensure that there is adequate backup provided by the ambulances at the new site. o There is a need to ensure that the ambulance services do not think the ECC has emergency backup on site and that ambulances are still as urgently required from the new ECC to the main UHA site as from anywhere else.

TABLE 4 (CONTINUED): NEGATIVE IMPACTS DURING OPERATION

Impacts on the determinants of health	Population group(s)	Consequences for health (in brief)	Mitigation measures
<u>Public service provision</u> • Access • Transport <u>Social</u> • Community safety Worry that there will not be enough space for parking for both staff and patients/visitors. The ECC will increase usage of the Longmoor Lane entrance to the site. Increased amount of traffic could not only cause delays through increased congestion but also increase the risks of accidents i.e. negative impacts on both access and community safety More people may also come from Fazakerley Train Station opposite the entrance. Currently there is no crossing here and this is raised as a major safety issue. Provision of bus services from most of the communities is felt to be currently inadequate. Most buses stop along Lower Lane which is some walk away from the ECC.	Patients. Friends/relatives of patients. Trust employees. Local residents.	Improved access to health care facilities should increase opportunities for improved health outcomes. Delays can increase levels of stress (see above for the impacts of stress on health) whilst accidents have obvious negative impacts on physical health and can also negatively impact on mental health and well-being. Fear of accidents can also negatively impact on health if it results in reduced physical activity. For children, independent mobility to explore the environment is associated with the development of life skills and the generation of self-esteem, a sense of identity and the development of a creative capacity to take personal identity. Improved access to health care facilities should increase opportunities for improved health outcomes.	• Appropriate staff car parking is needed on the UHA site. But the Trust also needs to encourage staff to access the ECC by other modes of transport. o The Trust should consider greater use of park and ride schemes. o The Trust should encourage cycling by providing adequate facilities for cyclists, i.e. showers, etc. • Suitable waiting facilities need to be provided for friends and relatives wishing to wait at the ECC while their loved one is being cared for. • The ECC could act as a “lever” to improve provision of bus services. o There is a need for increased discussions between the Trust with both Merseytravel and the bus companies about funding services to communities who currently cannot access the site by bus or can do so infrequently. o Increase the number of buses going through the UHA site and provide a bus stop nearer to the ECC. • The Trust needs to request for a crossing to coincide with and be part of the planning application. o Contacts at TravelWise (Merseytravel) and Liverpool City Council (Transport department) will support this application and should be used. o Another entrance to the site may be required? • Clear signposting is needed from all entrances to the UHA site which can be understandable to all (i.e. also to people who have very little understanding of written English).

Supplementary findings

In addition, the HIA identified a number of issues and impacts that could not neatly fit into either the construction or operational phase. Essentially these could be labelled design and patient care issues.

Regarding design, some staff felt they needed to be consulted more in the design of the ECC, in terms of how it will actually look and how it will thus impact on their working conditions and consequently, patient care. It was suggested that the Trust needs to communicate more (or perhaps through different channels) with its own staff about what the ECC aims to achieve and what assumptions it is based upon (e.g. around future health trends, technology and capacity – these assumptions are largely laid out in section 2.24 of the Aintree SOC).

It was not only staff though who feel that they should be involved. It was felt that local people could work with the Trust by perhaps providing art work to decorate the ECC, and also by such schemes as "sponsor a brick", "name the centre", etc. This can be done again with local staff and wider via local schools, local community groups, through the local press, etc. It was also suggested that local people need to feel they have some sense of ownership, or at least patients do. While Aintree Hospitals NHS Trust Patient and Public Involvement (PPI) Forum is currently involved in the ECC project, there is additional scope for including PPI Forums more in the planning stage and building closer links with PPI Forums, the patient council, Patient Advice and Liaison Services and the hospital volunteers. It was also suggested that there could be a closing event at Walton for Hospital and an open day at the new site in which local people are invited.

Concerns were also raised about the plan to open the ECC with only 4 of the 6 operating theatres in use. This was not only a "service issue" regarding differing opinions about the "right" level of activity, but to do with concerns that after having built the ECC, if it was then decided to open up the 2 other operating theatres, this would require extra construction work. However, the ECC is already being designed so as to ensure there is minimum disruption should extra operating theatres be required.

The extent to which there are new ways of working was also questioned, not so much within the Trust but within the whole health system as a whole – is there scope for working more with primary care, for example? There was also some debate about the new ways of working and patient care from plans being proposed about the way patients are seen pre-operation, during operation and afterwards. Some felt this would improve both staff's work experience and the quality of patient care whereas others were less sure.

Finally, it is important that the Walton site does not become neglected once services are transferred to the new ECC and that should there be any period of time that the building is left empty following this transfer, that the site does not become neglected and there is adequate security on this site. In addition, it would be beneficial to inform businesses around Walton about what is planned to replace the current Walton Hospital as soon as practically possible so businesses can plan accordingly.

Conclusion

The greatest potential for negative impacts unsurprisingly is during the construction phase. This not only surrounds largely unavoidable impacts such as increases in noise and dust but also impacts which should be avoidable, particularly regarding the economic and social benefits that will accrue if the workforce is employed locally to carry out this work.

Nearly all of the positive impacts on the other determinants of health identified from the construction phase depend on local people being employed during this phase.

If local people are used, positive impacts will not only be felt during the construction of the ECC but hopefully for many years to come. The local population, whether this is by definition Warbreck and Fazakerley or Liverpool or even North Merseyside as a whole could benefit enormously from the economic boost that such work could bring.

Indeed, the construction of this ECC is seen as an ideal opportunity to act as a focus for bringing about change for the local populations of Warbreck and Fazakerley in particular (and perhaps to a lesser extent, North Liverpool and all other areas that will be served by the ECC in North Merseyside) and offers the NHS a great opportunity to bring about beneficial health impacts for all, both through it's role as a Corporate Citizen but also by ensuring that once built, the ECC acts as a hub for promoting health, providing community facilities (if possible), improving transport links, etc as well as carrying out the functions one automatically associates with such a centre, e.g. x-rays, operations, etc.

However, major concerns were raised with regard to accessing the ECC. It was highlighted that currently public transport is felt to be inadequate and that the new ECC will increase the pressure on the Longmoor Lane entrance to the site. Currently this is a dual carriageway and as such is a major road. It does not have a pedestrian crossing close to the entrance, certainly not by the entrance to Fazakerley Station. In particular, there must be a request for a crossing to coincide with and be part of the planning application as the two need to go hand in hand.

It is important therefore to liaise with both MerseyTravel and Liverpool City Council and also with the bus and train companies about improving both the frequency of public transport and also the safety around the site entrance. The ECC may provide an excellent opportunity for the NHS to exert some influence on bus companies to provide better bus services to many parts of Liverpool that are currently either directly inaccessible to the site or infrequently so.

Finally, a recurrent theme throughout this Rapid HIA was the need for involving staff and patients as much as possible in the design of the ECC. This was reflected in the supplementary findings and in various discussions about impacts.

Recommendations

Construction phase

Economic

1. The NHS as a whole and relevant local authorities and agencies need to ensure that local people are suitably trained to take advantage of potential employment opportunities.
   1.1. Ensure there are local modern apprenticeship schemes in place and work with specialist agencies such as JET.
2. In awarding construction contracts, the Trust should ensure that employment of local people is a key consideration – especially firms that have a track record of training local people.
   2.1. As far as is practically and legally possible, the Trust should specify in contracts that local suppliers are used.
   2.2. As far as is practically and legally possible, the Trust should ensure firms carrying out construction work offer skills training opportunities for local people.
3. Within the NHS and other sectors, there is need for decision makers to take a strategic overview of construction projects is taken to enable sustainable employment opportunities for local people.
   3.1. At the very least the NHS as a whole should ensure that the construction of new health premises are staggered to maximise sustainable employment opportunities.
4. If it is not possible to employ local people, it is important that that local people know the reasons for this (e.g. local people with the skills are already employed elsewhere; belief that free trade laws do not allow for the Trust to specify bcal workers are employed, etc).

Social

1. See recommendations 1-4 above.
2. The Contractor and Trust must ensure that current legally obliging health and safety standards are adhered to.
3. There is a need for the Trust to provide security including CCTV.
   3.1. If possible, and if the local people are suitably skilled, this could be provided by local people.
4. The Trust could try to recruit more special constables to patrol the area or specific police time could be bought directly by the Trust.
5. The Contractor and Trust must ensure that construction site traffic is kept as far away from other traffic as possible and that movement of such traffic occurs at specified times (preferably not at peak times and certainly not when children are going to and from school).
   5.1. Separate entrances to the site for pedestrians and traffic may help.
   5.2. Steady, flat flooring must be in place where needed.

Physical

1. The Contractor and Trust must ensure that construction site traffic is kept as far away from other traffic as possible and that movement of such traffic occurs at specified times (preferably not at peak times and certainly not when children are going to and from school).
   1.1. Strict hours for when work and deliveries are permissible should be enforced to minimise noise levels.

1.2. As some doctors will work night shifts the Trust could look at ensuring the doctor's residencies are as sound proof as practically possible.
2. The use of fans in nearby premises may alleviate some of the problems of dust.
3. The Trust must liaise with other UHA site users as much as possible and ensure that they are kept informed of developments at all times (particularly where these developments may be more disruptive than usual).

Operational phase

Economic

1. The Trust should enhance links with local schools and colleges to ensure that local people are able to benefit from any new job opportunities.
   1.1. The NHS as a whole and relevant local authorities and agencies need to anticipate skill mix and train people accordingly.
   1.2. The NHS as a whole and relevant local authorities and agencies need to make and market the NHS as an attractive place to work for local people.
2. The opportunities to use the existing training facilities on the UHA site should be maximised.
   2.1. The ECC should also be used for would-be staff to gain work-experience.
3. Facilities such as childcare need to provided hand in hand with any new jobs.
4. There is a need to ensure that the Trust takes its role as a Corporate Citizen seriously and as far as is practically and legally possible tries to ensure local businesses are used for sourcing of local goods.

Social

1. If more people are being treated as day cases, this means there is less disruption to home life and social networks. It is thus important to ensure that vulnerable people in particular have adequate social networks in place already once they have been discharged in case of any post-operative problems.
2. Community networks and social inclusion are enhanced for staff as long as the Trust provides education and childcare facilities, i.e. increases opportunities for people to be able to work.
3. If other providers of health services are unable to "compete" with the ECC and thus provide a high quality service for their local population, arguably all the Trust can do is try to ensure there is sufficient capacity to meet increasing demand.
4. However, across North Merseyside (at least) it does highlight the importance of some strategic overview of commissioning and provision of services being maintained.
5. The Trust should ensure that voluntary opportunities are maintained at Aintree and that as far as possible, those working in this capacity at Walton are given every opportunity to carry on doing so at Aintree.
   5.1. The Trust should try to increase voluntary opportunities, perhaps for more vulnerable groups.
6. Currently it is only intended that the ECC will operate during normal working hours. Nevertheless it is clearly important that access to and from the ECC is well lit, especially as people will still be entering and leaving in the dark (especially in winter).
   6.1. The Trust should increase the level of security during these periods.

Personal

1. The Trust should reinforce no-smoking measures within the ECC (e.g. information on smoking cessation services and on other health promoting services, etc).
2. The Trust should ensure that healthy food is available at the café and consider ensuring that only healthy options are available in any vending machines.

3. The Trust needs to preserve “green areas” around the ECC.
   3.1. The Trust may be able to encourage people to walk while they wait for patients.
   3.2. The Trust could consider opening up access to the woodlands if practical (this poses potential security problems).
4. If it is viable to include some community facilities, such as a gym, in the building of the ECC, the Trust should consult with the community (and patients and staff) about what community facilities they may want.

Physical

1. Environmental standards already exist which must be adhered to but there may be opportunity to go further, considering things like energy efficiency, disposal of waste, etc.
2. The Trust needs to ensure that the ECC also provides a pleasant environment and is a “healthy building”, i.e. that the building provides enough natural light, etc.
3. The Trust needs to preserve “green areas” around the ECC – see above.
4. In designing the ECC, the Trust must take on board the views of both staff and patients.

Public service provision

1. In designing the ECC, the Trust must take on board the views of both staff and patients
2. The quality and functionality of the space available at the ECC should at least match that currently available at Walton Hospital.
3. The Trust needs to ensure that there is adequate backup provided by the ambulances at the new site.
   3.1. There is a need to ensure that the ambulance services do not think the ECC has emergency backup on site and that ambulances are still as urgently required from the new ECC to the main UHA site as from anywhere else.
4. It is anticipated that as skill mix changes, there will be more scope for nurses to do some operations currently carried out by doctors – this may require training.
   4.1. There is a need to ensure that staff are trained at the Trust – centralised resources exist and should be maximised.
5. It is felt beneficial to keep some health services on the Walton site whether these are provided by The Trust or another NHS organisation.
6. Appropriate staff car parking is needed on the UHA site. But the Trust also needs to encourage staff to access the ECC by other modes of transport.
   6.1. The Trust should consider greater use of park and ride schemes (e.g. as operates to the Walton Centre for Neurology and Neurosurgery from Aintree Racecourse).
   6.2. The Trust should encourage cycling by providing adequate facilities for cyclists, i.e. showers, etc.
7. Suitable waiting facilities need to be provided for friends and relatives wishing to wait at the ECC while their loved one is being cared for.
8. The Trust needs to request for a crossing to coincide with and be part of the planning application.
   8.1. Contacts at TravelWise (Merseytravel) and Liverpool City Council (Transport department) will support this application and should be used.
   8.2. Another entrance to the site may be required?
9. Clear signposting is needed from all entrances to the UHA site which can be understandable to all (i.e. also to people who have very little understanding of written English).
10. The ECC could act as a “lever” to improve provision of bus services.

10.1. There is a need for continued discussions between the Trust with both Merseytravel and the bus companies about services to communities who currently cannot access the site by bus or can do so infrequently.

10.2. Increase the number of buses going through the UHA site and provide a bus stop nearer to the ECC.

Other issues

1. In designing the ECC, the Trust must take on board the views of both staff and patients.

References

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Appendix 1: List of people and organisations invited to take part in the Rapid HIA and a list of those who participated

Invited

Name	Surname	Title and Organisation
A.	Aboud	Ophthalmology, Aintree Hospitals NHS Trust
Kate	Ardern	Head Of Public Health, Cheshire and Merseyside Health Authority
Jayne	Ashley	Sustainable Development Policy Officer, North West Regional Assembly
Matthew	Ashton	Public Health Development Specialist, Knowsley PCT
John	Ashton, CBE	Regional Director of Public Health, Government Office for the North West
Sharon	Avery	Ward Nurse Manager, DSU A, Aintree Hospitals NHS Trust
Peter	Ballard	UNISON Staff Side Chairman, Aintree Hospitals NHS Trust
Rob	Barnett	Secretary, Liverpool Local Medical Committee
S.	Barton	Assistant Chief Executive, Aintree Hospitals NHS Trust
Leonie	Beavers	Director of Strategy, North Liverpool PCT
J.	Birrell	Chief Executive, Aintree Hospitals NHS Trust
Jane	Blocksage	Nurse Manager, Ophthalmology Outpatients Department, Aintree Hospitals NHS Trust
Paul	Brickwood	Director of Finance and Commissioning, Knowsley PCT
C.	Buchanan	General Manager, Medicine, Aintree Hospitals NHS Trust
Hannah	Chellaswamy	Director of Public Health, Southport & Formby PCT
D.	Clark	Clinical Director, Ophthalmology, Aintree Hospitals NHS Trust
J.	Clarke	Adlam Park Tenants and Residents, Association
Jim	Conalty	Chair of Aintree Hospitals NHS Trust Patient Forum
G.	Corcoran	Clinical Director, Palliative Care, Aintree Hospitals NHS Trust
Stephen	Crooks	General Manager, Surgery, Aintree Hospitals NHS Trust
Maria	Dengler-Harles	Optometry, Aintree Hospitals NHS Trust
John	Densham	Chair of Southport & Formby PCT Forum
Brigid	Doyle	DSU Manager, Aintree Hospitals NHS Trust
Melanie	Doyle	Orthoptics, Aintree Hospitals NHS Trust
J.	Dray	Chair, Trust Board, Aintree Hospitals NHS Trust
Dympnae	Edwards	Director of Public Health, North Liverpool PCT
B.	Eyes	Divisional Medical Director, Support Services, Aintree Hospitals NHS Trust
Martin	Feld	Chair, Knowsley Professional Executive Committee
Angela	Forshaw	Neighbourhood Manager, Alt Valley Neighbourhood Management Area
Jackie	Fowler	pre op, Aintree Hospitals NHS Trust
Brian	Fraser	Chair, South Sefton PEC
Margaret	Goddard	Chair, North Liverpool PEC
T.	Gorman	General Manager, Accident & Emergency Deprtment, Aintree Hospitals NHS Trust
W.	Horton	Clinical Director, Day Surgical Unit, Aintree Hospitals NHS Trust

Invited - continued

Name	Surname	Title and Organisation
E. C.	Howard	Clinical Director, Anaesthesia/Operating Theatres, Aintree Hospitals NHS Trust
Mr.	Hsuan	Ophthalmology, Aintree Hospitals NHS Trust
Dave	Hanratty	Councillor, Fazakerley
J.	Harrison	Clinical Director, Critical Care Services
Sue	Harvey	Public Health Development Manager, Public Health Team, Central Liverpool PCT
Jill	Jackson	Health & Safety Executive, Magdalen House
Margaret	Jackson	Director of Human Resources, Aintree Hospitals NHS Trust
S.	Jackson	Clinical Director, ENT
Mr.	Kamal	Ophthalmology, Aintree Hospitals NHS Trust
Graham	Kyle	Consultant Ophthalmologist, Aintree Hospitals NHS Trust
Joan	Lang	Councillor, Warbreck
S.	Long	General Manager, Support Services, Aintree Hospitals NHS Trust
E.	Lynch	Sparrow Hall Community & District Association
I. A.	MacFarlane	Clinical Director, Diabetes, Aintree Hospitals NHS Trust
D.	Machin	Clinical Director, Urology, Aintree Hospitals NHS Trust
Bridget	Maher	Clinical Director, Acute Medicine, Aintree Hospitals NHS Trust
Ian B	Marsh	Ophthalmology, Aintree Hospitals NHS Trust
Mike	Marsh	North Liverpool PPI Forum
Bryan	McAvoy	Cavendish Tenants and Residents Association
Kim	McNeil	Ward Manger,DSU B, Aintree Hospitals NHS Trust
Linda	Milligan	Directorate Manager, Nephrology, Aintree Hospitals NHS Trust
Cath	Morris	Chair of South Sefton PPI Forum
R.	Morton	Area 10 Fazakerley Residents Association
Pamela	Peel	Fazakerley Tenants and Residents Association
B.	Pennie	Clinical Director, Orthopaedics, Aintree Hospitals NHS Trust
Dave	Phillips	Walton Neighbourhood Committee Services, Liverpool City Council
G.	Poston	Clinical Director, General Surgery, Aintree Hospitals NHS Trust
John	Prescott	Project Manager, North Mersey Future Healthcare Project
Pat	Roberts	Outpatients Department, Aintree Hospitals NHS Trust
Richard	Roberts	Councillor, Warbreck
E.	Rodrigues	Clinical Director, Cardiology, Aintree Hospitals NHS Trust
Simon	Rogers	Clinical Director, Maxillo Facial Unit, Aintree Hospitals NHS Trust
Steven	Rotheram	Councillor, Fazakerley
George	Sands	Deputy Chair, Board of Governors, Aintree Hospitals NHS Trust
Sunil	Sapre	Sefton Local Medical Committee
Jean	Seddon	Councillor, Warbreck
Yvonne	Shanks	Radiology, Aintree Hospitals NHS Trust
Anil	Sharma	Clinical Director, Medicine for the Elderly, Aintree Hospitals NHS Trust

Invited - continued

Name	Surname	Title and Organisation
Philip	Simms	Divisional Medical Director, Accident & Emergency Department, Aintree Hospitals NHS Trust
Carol	Smith	Audiology, Aintree Hospitals NHS Trust
Jack	Spriggs	Councillor, Fazakerley
R.	Sturgess	Clinical Director, Gastroenterology, Aintree Hospitals NHS Trust
Terry	Sweeney	Estates and Facilities Director, Aintree Hospitals NHS Trust
Robert	Thompson	Clinical Director, Rheumatology & Rehabilitation, Aintree Hospitals NHS Trust
Margaret	Titherington	Nurse Manager, Maxillo Facial Unit, Aintree Hospitals NHS Trust
Linda	Turner	Public Health Specialist, South Sefton PCT
Paul	Unsworth	Inspector, Lower Lane Police Station
Charles	Van-Heyningen	Clinical Director, Clinical Laboratories, Aintree Hospitals NHS Trust
B.	Walsh	Formosa Tenants and Residents Group
C.	Warburton	Clinical Director, Thoracic Medicine, Aintree Hospitals NHS Trust
R.	Ward	Divisonal Medical Director, Surgery, Aintree Hospitals NHS Trust
Ron	Watson, CBE	Sefton Chamber of Commerce and Industry, 16-18 Stanley Street
Peter	West	Director of Commissioning and Service Improvement, North Liverpool PCT
Stephen	Weston	General Manager, Radiology, Aintree Hospitals NHS Trust
Eileen	White	Merseyside Coalition of Disabled People, Lime Court Centre
G.	Williams	Richard Kelly Daneville Tenants and Residents Association
Barry	Williams	Director of Commissioning and Modernisation, South sefton PCT
Monica	Winstanley	PALS Manager, Aintree Hospitals NHS Trust
B.	Woodcock	Clinical Director, Haematology, Aintree Hospitals NHS Trust
Brian	Woster-Davis JP OBE	Chair, Patients Council, Aintree Hospitals NHS Trust
Margaret	Yarwood	Coordinator, Link Forum Support
		AGAR Neighbourhood Residents Association
		Station Commander, Aintree Community Fire Station
		Fazakerley Ambulance Station
		North West Development Agency

Workshop Attendees including facilitators (Groups A and B in August and Groups C-E in September)

Name	Surname	Title and Organsiation	Group
Debbie	Abrahams	IMPACT, University of Liverpool	E
Kate	Ardern	Head Of Public Health, Cheshire and Merseyside Health Authority	E
Jayne	Ashley	Sustainable Development Policy Officer, North West Regional Assembly	E
Matthew	Ashton	Public Health Development Specialist, Knowsley PCT	C
Carol	Baker	Deputy General Manager, Radiology, Aintree Hospitals NHS Trust	C
Jane	Blocksage	Nurse Manager, Ophthalmology Outpatients Department, Aintree Hospitals NHS Trust	A
Mary	Buckley	Ophthalmology, Aintree Hospitals NHS Trust	B
Hannah	Chellaswamy	Director of Public Health, Southport & Formby PCT	B
Nicky	Colcutt	Estates Department, Aintree Hospitals NHS Trust	C
John	Densham	Chair, Southport & Formby PPI Forum	C
Dympna	Edwards	Director of Public Health, North Liverpool PCT	A
Nigel	Fleeman	Liverpool Public health Observatory	B/D
Maureen	Flinn	Deputy Ward Manager, Surgery Day Ward, Aintree Hospitals NHS Trust	E
Angela	Forshaw	Alt Valley Neighbourhood Manager	D
Debbie	Fox	IMPACT, University of Liverpool	C
Rondell	Getty	Hearing Therapist, Aintree Hospitals NHS Trust	E
Sophie	Grinnell	IMPACT, University of Liverpool	
Sue	Harvey	Public Health Development Manager, Central Liverpool PCT	E
David	Hounslea	Project Manager, Estates Department, Aintree Hospitals NHS Trust	A/E/D
Geoff	Jackson	Team Leader, Alt Valley Neighbourhood Services	D
Jenny	Jowett	Royal Liverpool Children's NHS Trust	A
Mr.	Kamal	Ophthalmology, Aintree Hospitals NHS Trust	A
Jenny	Kemp	Member of Aintree PPI Forum and Aintree Patients Council	D
Graham	Kyle	Consultant Ophthalmologist, Aintree Hospitals NHS Trust	B
Mike	Marsh	North Liverpool PPI Forum	B
Kim	McNeil	Ward Manger, DSU B, Aintree Hospitals NHS Trust	B
Linda	Milligan	Directorate Manager, Nephrology, Aintree Hospitals NHS Trust	B
Sue	Milner	Deputy Director of Public Health, North Liverpool PCT	C/D/E
Andrew	Pennington	IMPACT, University of Liverpool	E
G.	Poston	Clinical Director, General Surgery, Aintree Hospitals NHS Trust	A
Morag	Reynolds	Public Health Development Lead for Primary Care, South Sefton PCT	D
Yvonne	Shanks	Radiology Manager, Walton Hospital, Aintree Hospitals NHS Trust	E

Workshop Attendees including facilitators (Groups A and B in August and Groups C-E in September) - continued

Name	Surname	Title and Organsiation	Group
Carol	Smith	Senior Chief Audiologist, Aintree Hospitals NHS Trust	D
Peter	Storey	Lab Manager, Clinical Laboratories, Aintree Hospitals NHS Trust	D
Andrea	Tilston	Deputy Ward Manager (DSUA)	D
Margaret	Titherington	Maxillofacial Outpatients Manager, Aintree Hospitals NHS Trust	C
Linda	Turner	Public Health Specialist, Southport & Formby PCT	C
Charles	VanHeyningen	Clinical Director, Clinical Laboratories, Aintree Hospitals NHS Trust	C
Jenny	Williamson	Ophthalmology, Aintree Hospitals NHS Trust	A
Monica	Winstanley	PPI/PALS Manager, Aintree Hospitals NHS Trust	D
Brian	WosterDavis JP OBE	Chair of Patients Council, Trust Governor and Member of Clinical Governance Board, Aintree Hospitals NHS Trust	D

Interviews

Name	Surname	Title and Organisation
Francine	Barrow	Practice Manager at Woodlands GP Practice
Margaret	Goddard	Chair of North Liverpool Professional Executive Committee and senior partner at Woodlands GP Practice
Paul	Unsworth	Inspector (Warbreck and Fazakerley), Lower Lane Police Station

Appendix 2: Copy of the invitation letter sent to potential participants

XX XXXXXX
XXXX XXXXXX
XXXXXXXXXXXXX
XXXXXXXX XXXXXXXXX
XXXXXXXX XXXX
XXXXXX
XX XXX

29 July 2005

Dear XXXXX,

Liverpool Public Health Observatory

Rapid Health Impact Assessment of the proposal to build an Elective Care Centre at Aintree Hospital

Invitation to participate in a stakeholder workshop

The North Mersey Future Healthcare Programme (NMFHP) is currently being developed. This aims to redesign the NHS in the North Mersey area so that we are better able to meet the challenges facing the service. The programme will bring major capital investment into North Mersey health services.

The current likely options for service (hospitals and primary care) re-designs are now being developed as separate outline business cases (OBCs). One OBC will focus on a proposal to build an elective care centre at Aintree Hospital and to transfer services, currently provided at the Walton Hospital site, to the new centre. It is expected that the OBC for this scheme will be submitted by the Trust in September/October 2005

A 12 week statutory community consultation process has just started on the principle of removing current services from the Walton Hospital site and re-providing them at the Aintree Hospital site (though the consultation does not specifically state that a new centre will be built).

The Strategic Health Authority, who will receive the OBC, has stated that a Health Impact Assessment (HIA) must be undertaken on the OBC before it is submitted. HIA is a way of identifying potential positive and negative impacts on the health and well-being of those directly and indirectly affected by the proposal. In order to identify these impacts we need to seek the views of a wide range of stakeholders. We intend to do this in the form of a one-day HIA workshop. You (or your organisation/group) have been identified as a stakeholder for this proposal and we would like to invite you (and up to two members of staff who come under your directorate) to attend one of our workshops so that you can give us your views on how this proposal may impact on

health. The HIA does not replace the statutory consultation process. Both forms of stakeholder consultation are necessary and are designed to complement each other.

Two workshops have been set up and you can attend whichever one is the most convenient for you. They are -

Wednesday 31st August 2005 at Oakmere Conference Centre* (10am-4pm)
Or
Friday 9th September 2005 at Oakmere Conference Centre* (10am – 4pm)

* *Directions will be sent to all participants in advance of the workshop*

We hope you are able to take part in one of the workshops as your views are vital in helping us to plan future services.

If you suffer from mobility problems and need help in getting to the venue please let us know. We may be able to reimburse individuals attending the workshops, who are not employed in the statutory sector, for travel and/or childcare costs. If you have colleagues, friends or relatives who, you feel, could contribute to these discussions on service developments, you may bring them along with you to the workshop (maximum of 2 please). We would need to know their details so that we can plan the workshop and cater for the correct number of participants on the day.

If you are not able to attend either of the workshops but would like to send a representative or nominate another friend or colleague to attend in your place please provide their details on the enclosed reply slip.

If you are not able to attend either of the workshops, we may wish to seek your views in a face-to-face interview, in your place of work, your home or another location of your choice. Please indicate, on the reply slip, if you would be willing to be interviewed if you cannot attend either of the workshops.

Please complete the enclosed reply slip and return it, in the sae provided, by **Friday 29 July 2005.** If you have any queries about this invitation please feel free to contact me on 0151 234 5096

Yours sincerely,

Professor Susan J Milner
Assistant Director of Public Health
HIA Supervisor
North Liverpool PCT

Liverpool Public Health Observatory

Rapid Health Impact Assessment of the proposal to build an Elective Care Centre at Aintree Hospital

Invitation to participate in a stakeholder workshop

Name
……

Job Title (if applicable)……..……

Organisation (if applicable)……

Address……

……

……

Telephone ……Fax

……

E mail

……..

(Please tick as appropriate)

I would like to attend the stakeholder workshop on (choose one) - .

Wednesday 31st August 2005 ?

Friday 9th September 2005 ?

I would like to bring the following people with me to the workshop (maximum of 2 please). Please give their name(s).

……

……

I am not able to take part in either of the workshops. **?**

I am not able to participate, but suggest that the following person should participate on my behalf (Please give name and contact details).

……

……

I am not able to attend either of the workshops but would be willing to offer my views in an interview **?**

I require help to get to the venue **?**

I would like to reclaim travel and/or childcare expenses **?**

Do you have (or does anyone you will be bringing with you have) any special dietary requirements? (Please give details)

……

……

……

Do you have (or does anyone you will be bringing with you have) any special needs? (Please give details)

……

……

……

Please return your completed form to Nigel Fleeman, in the SAE provided by **17th August**.

Thank you

Appendix 3: Copy of the preparation materials sent out to participants in advance of the workshops

Rapid Health Impact Assessment of the proposal to build an Elective Care Centre at the University Hospital Aintree

Stakeholder Workshop

Oakmere Conference Centre, Walton

Preparation Materials

Produced by the Health Impact Assessment Project Management Group

About this material

This material has been provided to you in advance of the stakeholder workshop by way of background information on:

- The plans for the proposed Elective Care Centre (ECC) at the University Hospital Aintree (UHA) site.
- A profile of the affected areas.
- An introduction to Health Impact Assessment (HIA).
- The proposed outline for the workshop.

It is essential that all participants have read this material before the workshop. This will allow us to use the limited time we will have during the workshop to map out the potential effects the ECC proposal will have on the health and wellbeing of people affected by it. We will also make recommendations for how positive health impacts could be enhanced and negative health impacts eliminated or mitigated.

It should take no more than one hour to read this background material. This will allow you to take part fully in the activities of the workshop and ensure that you are able to make your full contribution to the HIA of the ECC proposal at the UHA site.

Please bring this document with you to the workshop. You may want to refer to it during the day.

These materials have been produced by the Health Impact Assessment Project Management Group (and collated by the Researcher). The Health Impact Assessment Project Management Group constitutes the following:

- Professor Susan Milner, HIA Supervisor, North Liverpool PCT
- Nigel Fleeman, Researcher, Liverpool Public Health Observatory
- David Hounslea, Project Manager ECC, Aintree Hospitals NHS Trust
- Nicky Colcutt, Project Co-ordinator ECC, Aintree Hospitals NHS Trust

1. The proposed Elective Care Centre at the University Hospital Aintree

1.1 Introduction

Aintree NHS Trust manages two hospitals – UHA, which is a large teaching hospital providing Accident and Emergency services and a wide range of acute and non-acute specialities, and Walton Hospital which provides some types of day surgery and outpatient clinics, x-ray services and some support services including physiotherapy, a pharmacy and medical records.

Plans for developments at the University Hospital Aintree (UHA) and the re-use of Walton Hospital are part of a wider programme of investment and modernisation in the local NHS called the North Mersey Future Healthcare Programme (NMFHP).

Public Consultation on this proposal commenced on 12th July and is due to end on 4th October. The full consultation document is available on the Trust's website at www.aintreehospitals.nhs.uk

It is important to note that Public Consultation constitutes a separate and independent process to Health Impact Assessment (HIA) although both should inform future decision making.

Public Consultation concerns two issues:

- The future provision of surgical, outpatient and diagnostic services currently provided at Walton.
- The future of that site for new kinds of healthcare services.

HIA aims to identify aspects of a proposal that could affect the health and well-being of defined populations and to produce recommendations in order to maximise positive and minimise negative health impacts of the proposal.

Thus this HIA is focused on the proposal to build an Elective Care Centre (ECC) at Aintree Hospital and the transfer of services currently provided at the Walton Hospital site to the new centre.

1.2 Background

Health services in North Merseyside have historically been fragmented. Currently, North Merseyside comprises five Primary Care Trusts (PCTs) (Knowsley, South Sefton, Central, North and South Liverpool), three Metropolitan Borough Councils (MBCs) (Liverpool, Knowsley and Sefton), two

large university hospital Trusts, six specialist Trusts and an Ambulance Service Trust.

The NMFHP was set up to take a strategic approach to health investment across NHS organisations in North Merseyside. Investment in local healthcare services and facilities is needed to combat the high levels of poor health in an area where life expectancy is less than the national average and where deaths from cancer are among the highest in the country.

Aintree Hospitals NHS Trust was established on 1 April 1992. It is a large, complex organisation providing acute health care to 330,000 people living in North Merseyside and the surrounding areas and it also provides a number of specialist services (in respiratory medicine, rheumatology, maxillo-facial surgery and liver cancer surgery) to a much larger catchment area, with patients travelling from as far away as North Wales and the Isle of Man.

The Trust has a substantial partnership with the University of Liverpool School of Medicine and is a recognised centre for multi-disciplinary health research. High quality research is undertaken at Aintree, focused on diseases of both national and local importance.

The Trust employs over 3,500 whole-time equivalent staff, has fixed assets of over £150 million and an annual turnover of approximately £180 million.

1.3 The Elective Care Centre proposal

Aintree Hospitals NHS Trust proposes to move all acute hospital services from Walton to the University Hospital Aintree site. The scheme also includes provision for upgrading the existing outpatients department at UHA to modern standards.

The Trust believes that this will:

- Improve the quality of facilities the Trust is able to offer their patients.
- Maintain and improve patient safety.
- Make better use of resources, including staff time and expensive medical equipment.
- Ensure that high quality staff continue to be attracted to work at the Trust.

A professional design team incorporating architects, engineers and surveyors has been appointed to develop plans for the Elective Care Centre. Currently it is proposed that the building will comprise some 9,000m^2 of accommodation (see Table 1-1 and Figures 1-1 and 1-2) to be based to the North West of the UHA site (bottom right hand corner of Figure 1-2).

The estimated cost of the scheme including associated works is around £35 million.

Table 1-1: Proposed content of the Aintree Elective Care Centre

Ground Floor	***First Floor***	***Second Floor***
• Main entrance • Café • Retail • Pharmacy • Radiology • Breast Screening • Ophthalmology • Pathology	• Outpatient Department • Clinics • Medical Records	• Day Surgical Unit • Theatres • Recovery • Pre-Discharge • Pre-Operative Assessment • Admissions Lounge • Seminar Room

Timetable for Project

- *Completion of Public Consultation* Autumn 2005
- *Approval of Outline Business Case* Autumn 2005
- *Approval of Full business Case* Spring 2007
- *Start of Construction* Summer 2007
- *Opening of Facilities of UHA* Summer 2009

Activity to be undertaken in the proposed **Elective** *Care Centre*

- 11,000 Surgical Day Cases will be treated per year in the following specialties: General Surgery, Urology, Orthopaedics, ENT, Ophthalmology and maxillo-facial surgery.
- 100,000 outpatients will be treated each year.

Possible options for the future use of the Walton Site

- A Walk in Centre.
- Community Diagnostic Facilities (inc, pathology, blood testing, ultrasound, x-ray).
- Mental Health Support facilities.

Final decisions about the future use of the site will take into account responses to the public consultation.

Figure 1-4 shows some photographs of the Walton Hospital site, which clockwise (from top left hand corner) show what one can see as one enters the entrance on Rice Lane and proceeds in a clockwise direction.

Figure 1-1: Artist’s impression of the proposed Elective Care Centre

Figure 1-2: Aerial photograph of the site for the proposed Elective Care Centre

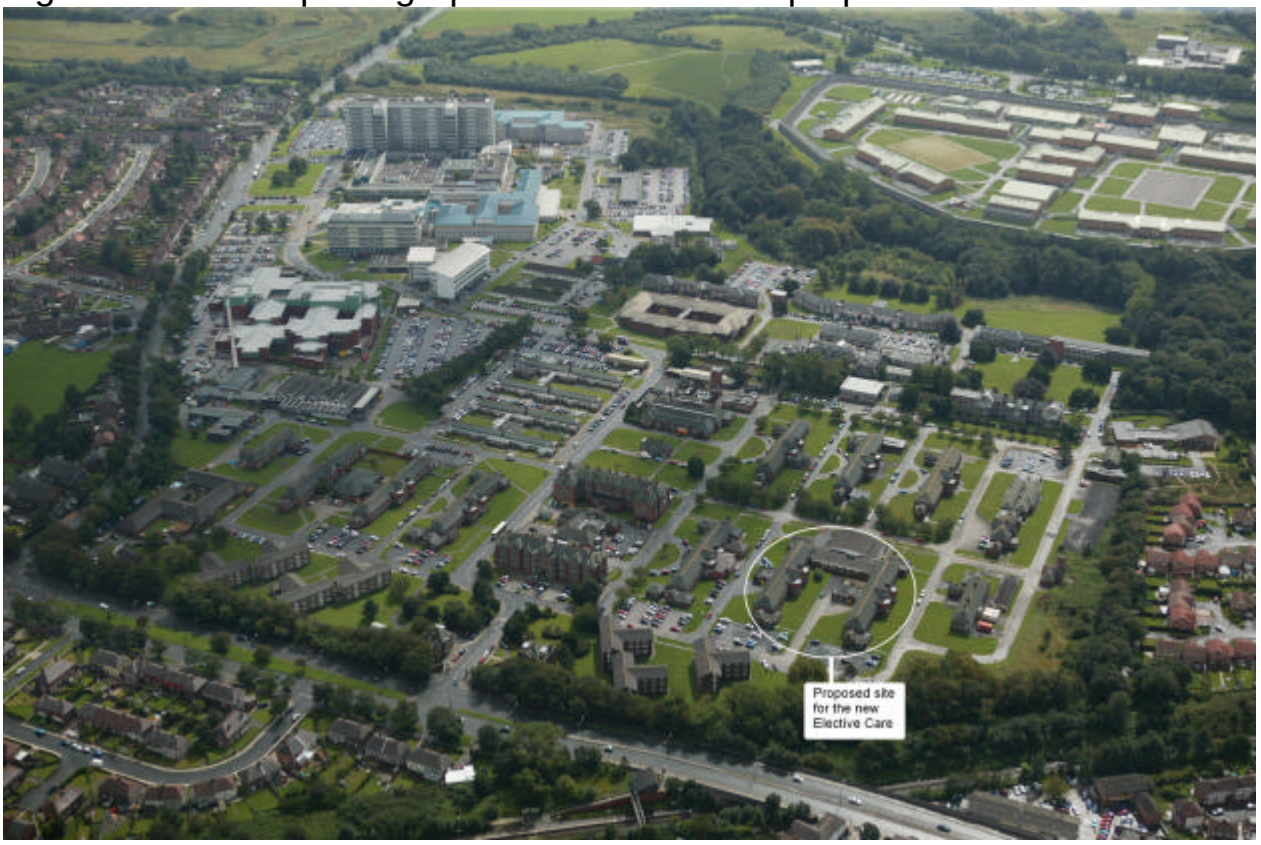

Figure 1-3: Some photographs of the Walton Hospital site

1.4 Frequently asked questions (and answers provided by Aintree University Hospitals NHS Trust)

How will patients benefit from the proposals in the Consultation?
Patients receive treatment in a purpose designed building offering a better patient experience. In primary care, local people could benefit from a range of new community based services at Walton.

Will these proposals lead to a reduction in services available to local people?
No, the same or even more hospital care will still be provided locally. In addition there could be community based services introduced at Walton.

Will any jobs be at risk?
It is unlikely any jobs will be at risk. It is expected that the number of staff employed by the Trust will rise over the coming years and new services being offered by local PCTs at Walton may also require additional staff.

What would happen if we did nothing?
The facilities at Walton would become more overcrowded as patient numbers increase. It would become a less attractive place for staff to work and train. The Walton site would not be released to develop new services.

Will the UHA site be able to cope with extra staff, patients and visitors?
UHA is a large and spacious site and any new facilities would be accompanied by an increase in car parking provision.

Will any services at UHA be affected?
There will be no adverse impact on any services. Services will benefit since clinicians will no longer be required to work across two sites.

How many staff will be affected?
Approximately 300 staff will move from Walton to UHA.

2. Profile of the affected areas

2.1 Introduction

An integral part of any HIA is the identification of those groups who may be affected by the proposal being assessed. These affected groups may have in common a geographical location, a shared interest or a shared identity. Following on from the identification of the affected groups it is common practice to provide a profile of them, which includes a range of demographic and social data. This will allow the assessors to determine if there are any particular characteristics within the affected groups that could either make them more resistant or more vulnerable to the health impacts that may result from the proposal being assessed.

As Aintree Hospitals NHS Trust provides acute health care to 330,000 people living in North Merseyside and the surrounding areas as well as providing a number of specialist services to a much larger catchment area reaching North Wales and the Isle of Man, there are clearly a number of different populations potentially affected by the Trust and thus the ECC proposal.

However, it is largely the populations of North Merseyside that will be most affected by any move of services from Walton to the proposed EEC. Therefore, for the purposes of this profile, some basic background information has been presented on the North Merseyside population.

Box: Summary information

- There are over 700,000 people in North Merseyside, with 440,000 people residing in Liverpool.
- Around 15,000 people live in Warbreck and Fazakerley, the electoral wards within which both Walton Hospital and UHA are based. There are marginally more males than females in these wards.
- Both Warbreck and Fazakerley have proportionally more lone-parent families than either Liverpool or North Merseyside as a whole.
- In 2000, Warbreck was one of the top 10% most deprived wards and Fazakerley was one of the top 5% most deprived wards in England whereas in 2004 Liverpool as a whole was one of the top five most deprived Local Authority areas regardless of how deprivation was measured.
- Fazakerley in particular has a lower employment rate than for Liverpool as a whole (which is in itself much lower than that for North Merseyside).
- Health and social care work is one the largest industries of employment alongside wholesale and retail trade, repairs.
- Most male workers are employed full time as are just over half of all female workers although nearly a fifth of Warbreck male workers work part time, 16-30 hours, proportionately more than Liverpool or North Merseyside as a whole.
- Around half of the people in Liverpool travel less than 5km to work and most travel by car or bus although a fifth of Warbreck residents walk to work.
- Public health data shows that in general, people in North Merseyside have shorter life expectancy than the national average.
- Nearly a quarter of people report a limiting long-standing illness and around an eighth report they are an unpaid carer for another person.
- Warbreck and Fazakerley wards have a greater proportion of people without qualifications than has Liverpool or North Merseyside as a whole.
- Crime rates in both Warbreck and Fazakerley wards are lower than for Liverpool as a whole.

2.2 Population and housing

According to the 2001 Census, just over 15,000 people live within the electoral wards which both Walton Hospital and UHA are based (Warbreck [6,392] and Fazakerley [9,028] wards respectively), accounting for 3.6% of the total Liverpool population.

Over 400,000 people are resident in the three PCT areas which currently most rely on Aintree Hospitals NHS Trust. According to the NMFHP Strategic Investment Framework (2004), North Liverpool PCT has a registered population of 112,773, Knowsley PCT 158,666 and South Sefton PCT158,770.

The North Mersey Future Healthcare Programme (NMFHP) as a whole covers a population of over 700,000 residing in three Local Authorities (Liverpool [439,473], Knowsley [150,459] and South Sefton [282,958]).

Within the region there are slightly more females than males, although within Fazakerley there are almost equal numbers of both sexes and within Warbreck there are actually slightly more males (Table 2-1).

Table 2-1: Proportion of North Merseyside population by sex

	Warbreck	***Fazakerley***	***Liverpool***	***Knowsley***	***Sefton***
Male	54.1	49.7	47.7	47.2	47.2
Female	45.9	50.3	52.3	52.8	52.8
All People	100.0	100.0	100.0	100.0	100.0

Source: 2001 Census (from www.neighbourhood.statistics.gov.uk/)

The age profile of North Merseyside varies slightly by local authority with Sefton having comparatively more people aged 75 and over whilst Liverpool has comparatively younger people, particularly aged 16-24 (and this is more marked in Warbreck and, in particular, Fazakerley) (Table 2-2).

Table 2-2: Proportion of North Merseyside population by age

	Warbreck	***Fazakerley***	***Liverpool***	***Knowsley***	***Sefton***
Aged 15 and under	18.8	22.0	20.1	22.9	20.2
Aged 16-24	20.4	23.1	20.2	11.0	9.6
Aged 25-34	16.9	15.2	13.7	13.6	11.6
Aged 35-44	15.6	15.3	14.6	15.6	14.8
Aged 45-54	12.5	11.1	12.2	12.4	13.5
Aged 55-64	9.1	8.3	9.4	9.6	11.4
Aged 65-74	8.0	8.9	8.6	9.1	10.2
Aged 75-84	4.2	4.9	5.1	4.6	6.4
Aged 85 and over	1.2	1.4	1.6	1.2	2.3
All People	100.0	100.0	100.0	100.0	100.0

Source: 2001 Census (from www.neighbourhood.statistics.gov.uk/)

The North Mersey Public Health and Intelligence Specialist Group have produced a report to support the Primary Care and Health Improvement element of the NMFHP. According to this, the proportion of the population aged over 50 years is expected to increase, by 2009, from approximately 30% to 32% in Liverpool, 29% to 33% in Knowsley and 36% to 40% in Sefton.

Ethnically, whilst Liverpool as a whole has proportionally more non-whites than North Mersey as a whole, the ethnic mix of both Warbreck and Fazakerley is more typical of the region as a whole (Table 2-3).

Table 2-3: Proportion of North Merseyside population by ethnicity

	Warbreck	***Fazakerley***	***Liverpool***	***Knowsley***	***Sefton***
White	97.5	98.4	94.3	98.4	98.4
Mixed	1.0	0.8	1.8	0.8	0.6
Asian or Asian British	0.5	0.2	1.1	0.2	0.4
Black or Black British	0.5	0.2	1.2	0.2	0.2
Chinese or Other	0.6	0.4	1.6	0.3	0.4
All People	100.0	100.0	100.0	100.0	100.0

Source: 2001 Census (from www.neighbourhood.statistics.gov.uk/)

The majority of people within North Merseyside are either living alone or a lone parent family. Both Warbreck and Fazakerley have proportionally more lone-parent families than either Liverpool or North Merseyside as a whole (Table 2-4).

Table 2-4: Proportion of North Merseyside population by lone person/parent households

	Warbreck	***Fazakerley***	***Liverpool***	***Knowsley***	***Sefton***
Lone non-pensioner household	21.9	17.4	21.1	29.0	30.6
Lone pensioner household	14.8	16.4	15.8	14.4	17.2
Lone parent households	18.9	21.0	16.3	17.3	11.8
Other households with two or more people	44.3	45.2	46.7	39.4	40.5
All Households	100.0	100.0	100.0	100.0	100.0

Source: 2001 Census (from www.neighbourhood.statistics.gov.uk/)

Table 2-5: Proportion of North Merseyside population by communal and non-communal residencies

	Warbreck	***Fazakerley***	***Liverpool***	***Knowsley***	***Sefton***
Communal	11.5	5.8	3.0	0.7	1.7
Non-communal	88.5	94.2	97.0	99.2	98.2
All people	100.0	100.0	100.0	100.0	100.0

Source: 2001 Census (from www.neighbourhood.statistics.gov.uk/)

Very few people within North Merseyside as a whole live in Communal residencies. However, as a proportion, in comparison, both Warbreck and Fazakerley wards have more people living in such accommodation (Table 2-5). Communal residencies include such establishments as prisons, large

hospitals and residential and nursing homes, some small hotels and guesthouses if they have a capacity of 10 or more guests.

2.3 Deprivation and the local economy

The former Department of the Environment Transport and the Regions (DETR) commissioned the Social Disadvantage Research Centre (SDRC) at the Department of Social Policy and Social Work at the University of Oxford to produce indices of deprivation based on 33 items of data for all wards in England, which were released in 2000. This enabled wards to be ranked from 1 (most deprived) to 8,414 (least deprived). Based on these Indices of Multiple Deprivation (IMD 2000), Warbreck was one of the top 10% most deprived wards (ranking 431) whereas Fazakerley wass one of the top 5% most deprived wards (ranking 262).

The Office of the Deputy Prime Minister (ODPM) commissioned the SDRC to update the IMD 2000 for England and the new Indices of Deprivation 2004 have been produced and published and are available on the website at super output area (SOA) level and local authority level.

Six summary measures of the overall Index of Multiple Deprivation (IMD) have been produced at this level, which describe different aspects of multiple deprivation in each area. Each of these is designed to capture a particular way in which a local authority may experience multiple deprivation. No single summary is favoured over another, as there is no single best way of describing and comparing multiple deprivation at this geographic level. More specifically:

- **Local Concentration** - shows the severity of multiple deprivation in each authority, measuring 'hot-spots' of deprivation;

- **Extent** - the proportion of a district's population that lives in the most deprived Super Output Areas in England;

- **Average Scores** and **Average Ranks** - two ways of depicting the average level of deprivation across the entire district;

- **Income Scale** and **Employment Scale** - the number of people experiencing income and employment deprivation retrospectively.

SOAs have a minimum population of 1,000 and an average population of 1,500. The North Mersey Public Health and Intelligence Specialist Group have found that of the 100 most deprived SOAs in England, Liverpool and Knowsley have 33.

There are 354 local authorities and districts (LADs) in England where again a rank of 1 indicates the LAD is most deprived. As can be seen from Table 2-6, on all measure, Liverpool, in particular and Knowsley both rate poorly on all measures and Sefton is also one of the top 10-20% most deprived areas.

Table 2-6: Indices of Deprivation - Local Authority Summaries

	Liverpool	***Knowsley***	***Sefton***
Local Authority Summaries, Average Score	49.78	46.57	26.12
Local Authority Summaries, Rank of Average Score	1	3	78
Local Authority Summaries, Average Rank	27801.06	27073.98	18928.16
Local Authority Summaries, Rank of Average Rank	5	8	99
Local Authority Summaries, Extent	0.71	0.64	0.27
Local Authority Summaries, Rank of Extent	5	8	78
Local Authority Summaries, Local Concentration	32430.24	32435.36	31552.98
Local Authority Summaries, Rank of Local Concentration	2	1	42
Local Authority Summaries, Income Scale	134895	45685	48945
Local Authority Summaries, Rank of Income Scale	2	38	33
Local Authority Summaries, Employment Scale	64451.5	20869.5	24800.75
Local Authority Summaries, Rank of Employment Scale	2	30	15
Local Authority Summaries, IMD LA Population	441096	151365	282884

Source: Office of the Deputy Prime Minister (from www.neighbourhood.statistics.gov.uk/)

According to the 2001 Census, there were 325,484 people aged 16-74 in full-time or part-time employment in North Merseyside. It is noticeable that Fazakerley in particular has a lower employment rate than for Liverpool as a whole (which is in itself much lower than Knowsley or Sefton) (Table 2-7). About 3% of the Liverpool workforce lived in the wards of Warbreck and Fazakerley.

Table 2-7: Number and proportion of people employed in North Merseyside

	Warbreck	***Fazakerley***	***Liverpool***	***Knowsley***	***Sefton***
People aged 16-74 in employment	2218	2786	154817	54352	116315
Total population aged 16-74	5274	7393	345595	107330	201184
Percentage in employment	42.1	37.7	44.8	50.6	57.8

Source: 2001 Census (from www.neighbourhood.statistics.gov.uk/)

Just over an eighth was employed in health care and social work and around a twelfth in construction (Table 2-8). Proportionately, health and social care work is one the largest industries of employment alongside wholesale and retail trade, repairs. In Warbreck, public administration and defence, social security is also a significant industry of employment.

Most male workers are employed full time (Table 2-9) as are just over half of all female workers (Table 2-10), although nearly a fifth of Warbreck male workers work part time, 16-30 hours, much more than North Merseyside as a whole.

Table 2-8: Proportion of North Merseyside people (aged 16-74) employed by sector

	Warbreck	***Fazakerley***	***Liverpool***	***Knowsley***	***Sefton***
Manufacturing	11.5	13.0	10.6	15.1	10.3
Electricity, gas and water supply	0.7	0.4	0.4	0.7	0.5
Construction	7.2	7.4	6.0	7.4	6.3
Wholesale and retail trade, repairs	15.7	17.9	15.7	17.2	18.7
Hotels and restaurants	3.7	5.7	5.4	4.2	4.3
Transport, storage and communications	6.5	8.3	7.7	9.0	6.7
Financial intermediation	4.2	4.2	4.9	4.1	5.5
Real estate, renting and business activities	9.3	8.6	10.2	8.9	9.6
Public administration and defence, social security	15.8	7.8	7.5	6.8	9.3
Education	5.9	6.2	10.2	7.0	8.8
Health and social work	13.3	14.0	15.3	14.0	14.2
Other community, social and personal service activities	5.8	5.9	5.6	5.1	4.9
Other	0.4	0.4	0.4	0.7	1.0
All People	100.0	100.0	100.0	100.0	100.0

Source: 2001 Census (from www.neighbourhood.statistics.gov.uk/)

Table 2-9: Proportion of North Merseyside male workers (aged 16-74) employed part time and full time and average number of hours worked

	Warbreck	**Fazakerley**	**Liverpool**	**Knowsley**	**Sefton**
Part-time: 1-5	0.3	0.3	0.5	0.3	0.5
Part-time: 6-15	8.2	2.4	3.3	2.2	3.2
Part-time: 16-30	18.1	8.2	7.6	5.9	7.0
Full-time: 31-37	19.2	20.5	23.2	22.5	19.0
Full-time: 38-48	41.4	52.9	48.3	52.4	49.6
Full-time: 49 or more	13.0	15.8	17.1	16.7	20.6
All males aged 16-74 in employment	100.0	100.0	100.0	100.0	100.0
Average (mean) hours worked	36.9	40.1	40.2	40.8	41.1

Source: 2001 Census (from www.neighbourhood.statistics.gov.uk/)

Table 2-10: Proportion of North Merseyside female workers (aged 16-74) employed part time and full time and average number of hours worked

	Warbreck	**Fazakerley**	**Liverpool**	**Knowsley**	**Sefton**
Part-time: 1-5	0.9	1.0	1.4	1.4	1.6
Part-time: 6-15	10.2	9.3	10.7	10.5	11.8
Part-time: 16-30	32.5	32.1	29.7	31.8	32.1
Full-time: 31-37	27.2	30.3	29.0	29.1	26.4
Full-time: 38-48	25.2	24.4	24.1	23.3	22.9
Full-time: 49 or more	4.0	2.8	5.1	4.1	5.2
All females aged 16-74 in employment	100.0	100.0	100.0	100.0	100.0
Average (mean) hours worked	30.9	30.7	31.0	30.5	30.3

Source: 2001 Census (from www.neighbourhood.statistics.gov.uk/)

Around half of the people in Liverpool travel less than 5km to work (Table 2-11) and most travel by car or bus although a fifth of Warbreck residents walk to work (Table 2-12).

Table 2-11: Proportion of North Merseyside workers (aged16-74) travelling to work and average distance travelled

	Warbreck	***Fazakerley***	***Liverpool***	***Knowsley***	***Sefton***
Works mainly at or from home	5.3	4.7	5.6	5.5	7.5
Less than 2km	28.9	20.3	18.0	18.7	20.9
2km to less than 5km	24.5	25.0	29.5	19.1	19.1
5km to less than 10km	26.6	32.1	28.1	27.8	18.2
10km to less than 20km	5.9	7.2	7.9	18.4	17.5
20km to less than 30km	1.9	2.4	2.3	2.1	7.0
30km to less than 40km	0.5	0.5	0.8	1.6	1.8
40km to less than 60km	1.0	0.9	1.9	1.3	2.0
60km and over	1.3	1.9	2.1	1.8	2.0
No fixed place of work	4.2	5.0	3.7	3.7	3.9
All People	100.0	100.0	100.0	100.0	100.0
Average distance (km) travelled to fixed place of work	8.4	10.7	11.5	11.9	14.0

Source: 2001 Census (from www.neighbourhood.statistics.gov.uk/)

Table 2-12: Mode of transport used to travel to work by North Merseyside workers (aged 16-74)

	Warbreck	***Fazakerley***	***Liverpool***	***Knowsley***	***Sefton***
People who work mainly at or from home	5.2	4.7	5.6	5.5	7.5
Train	5.3	2.8	3.0	4.1	5.8
Bus, Mini Bus or Coach	20.6	22.7	21.2	13.3	8.0
Motorcycle, Scooter or Moped	0.5	0.9	0.6	0.8	0.8
Driving a Car or Van	36.7	43.6	47.6	54.0	55.9
Passenger in a Car or Van	6.6	8.9	7.5	9.0	7.2
Taxi or Minicab	1.2	1.8	1.3	1.9	1.5
Bicycle	1.9	2.0	1.7	1.7	2.9
On foot	20.5	11.7	10.6	9.3	9.5
Other	1.4	0.9	0.9	0.7	0.8
All people aged 16-74 in employment	100.0	100.0	100.0	100.0	100.0

Source: 2001 Census (from www.neighbourhood.statistics.gov.uk/)

2.4 Health

Public health data shows that in general, people in North Merseyside have shorter life expectancy than the national average (by around 3 years in Liverpool and Knowsley and 1 year in Sefton) and that for all the major killers, such as coronary heart disease (CHD), respiratory diseases and cancer, mortality rates are higher than the national average. For example, the age-standardised mortality rates for CHD are higher in all the North Merseyside LADs than the national average (except for Sefton females aged under 65) (Table 2-13).

Age standardised rates describe the rate of events that would occur in a chosen standard population if that population were to experience the age specific rates of the subject population (for example, the population of North Mersey or one of its LADs). In this case the standard population generally

used for the direct method is what is known as the "European Standard Population".

Table 2-13: Directly Age Standardised Mortality Rates per 100,000 Population for Coronary Heart Disease in North Merseyside 1999-2001 Pooled

	Liverpool	*Knowsley*	*Sefton*	*Cheshire & Merseyside*	*England & Wales*
Males under 65 years	81.41	71.68	59.79	62.61	52.82
Females under 65 years	25.17	29.58	13.19	16.92	13.69
Males aged 65-74 years	1209.04	1006.92	1011.79	926.73	796.80
Females aged 65-74 years	476.85	399.94	410.98	384.63	328.53

Source: Mersey Public Health and Intelligence Specialist Group

Perhaps reflecting this, nearly a quarter of people report a limiting long-standing illness (Table 2-14) and around an eighth report they are an unpaid carer for another person (Table 2-15).

Table 2-14: Proportion of people in North Merseyside with/without a limiting long-term illness

	Warbreck	*Fazakerley*	*Liverpool*	*Knowsley*	*Sefton*
With a Limiting Long-Term Illness	26.9	27.5	24.6	24.7	22.2
Without a Limiting Long-Term Illness	73.1	72.5	75.4	75.3	77.8
All People	100.0	100.0	100.0	100.0	100.0

Source: 2001 Census (from www.neighbourhood.statistics.gov.uk/)

Table 2-15: Proportion of people in North Merseyside providing unpaid care to another

	Warbreck	*Fazakerley*	*Liverpool*	*Knowsley*	*Sefton*
All people who provide unpaid care	11.0	11.5	11.0	11.5	11.6
All people who do not provide care	89.0	88.5	89.0	88.5	88.4
All People	100.0	100.0	100.0	100.0	100.0

Source: 2001 Census (from www.neighbourhood.statistics.gov.uk/)

Nevertheless, most people in North Merseyside report good health although the proportion is notably smaller in Warbreck and Fazakerley wards (Table 2-16).

Table 2-16: Proportion of North Merseyside people reporting good and ill health

	Warbreck	*Fazakerley*	*Liverpool*	*Knowsley*	*Sefton*
Good Health	59.7	60.9	64.5	65.0	67.0
Fairly Good Health	25.0	22.9	21.7	21.3	21.7
Not Good Health	15.3	16.2	13.8	13.6	11.2
All People	100.0	100.0	100.0	100.0	100.0

Source: 2001 Census (from www.neighbourhood.statistics.gov.uk/)

2.5 Education

As can be seen from Table 2-17, Warbreck and Fazakerley wards have a greater proportion of people without qualifications than has North Merseyside as a whole.

Table 2-17: Proportion of North Merseyside people aged 16-74 with and without educational qualifications

	Warbreck	*Fazakerley*	*Liverpool*	*Knowsley*	*Sefton*
No qualifications	45.6	47.9	37.8	43.0	31.0
Level 1 qualifications	16.7	17.2	14.5	16.8	17.3
Level 2 qualifications	17.4	16.9	16.4	17.9	20.7
Level 3 qualifications	5.5	5.2	10.5	5.9	7.3
Level 4 / 5 qualifications	8.3	7.0	15.2	9.9	16.7
Other qualifications: Level unknown	6.5	5.8	5.6	6.6	7.0
All People aged 16-74	100.0	100.0	100.0	100.0	100.0

Source: 2001 Census (from www.neighbourhood.statistics.gov.uk/)

However, according to Liverpool City Council's, school children living in Warbreck ward achieved slightly higher GCSE and Key Stage 2 pass rates in 2003 than did the whole of Liverpool (Table 2-18). Fazakerley school children also did better than Liverpool as a whole at Key Stage 2 but not GCSE.

Table 2-18: Proportion of Liverpool students attaining five or more GCSEs of at least C grade and attaining at least level 4 at English and Maths in 2003

	Warbreck	*Fazakerley*	*Liverpool*
Five or more passes at least GCSE grade C	41.4	35.4	40.0
Level 4 or higher at English	74.0	74.6	71.1
Level 4 or higher at Maths	70.2	74.0	68.3

Source: Liverpool City Council Strategic Information & Research Team, Education, Library & Sports Services*

2.6 Crime

Crime rates in both Warbreck and Fazakerley wards are lower than for Liverpool as a whole (Table 2-19).

Table 2-19: Crime rates in Liverpool, March 2002 – April 2003

	Warbreck	*Fazakerley*	*Liverpool*
All crime, rate per 1,000 persons	136.2	129.1	168.2
Domestic burglary, rate per 1,000 households	24.9	20.9	35.9
Robbery, rate per 1,000 persons	1.9	2.2	4.2
Youth annoyance, rate per 1,000 persons	53.8	47.3	51.5

Source: Liverpool City Council Citysafe Data Team*

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* Taken from Ward Profile Series (April 2004), Tables 7.1 and 8.1, available from:

- http://www.liverpool.gov.uk/Images/PMD%20112%20-%20Ward%20Profile%20-%20Warbreck_tcm21-29287.pdf
- www.liverpool.gov.uk/Images/ PMD%20096%20-%20Ward%20Profile%20-%20Fazakerley_tcm21-29271.pdf

3. What is Health Impact Assessment?

3.1 Introduction

The purpose of HIA is to assess the consequences for human health of a policy, programme or project and to use this information in the decision making process. HIA involves any combination of procedures or methods by which a proposed policy, programme or project may be judged as to the effect(s) it may have on the health of a population."

There are three types of HIA:

Prospective HIA.

Such assessments are carried out during the development of a policy, programme or project to estimate the potential impacts of the proposed activity on the health and well-being of defined human populations. The assessment should contribute to the decision making and planning processes.

Concurrent HIA

Such assessments are carried out during the implementation of the policy, programme or projects to assess how the unfolding activity is affecting the health and well-being of the defined populations. This would allow changes to be made to the activity to maximise health gain opportunities.

Retrospective HIA.

Such assessments are carried out after the proposals have been carried out to assess the actual impacts on the health and well-being of the defined populations. The information obtained from such assessments can contribute to the overall body of knowledge about health impacts and, therefore, help to inform future prospective HIAs.

3.2 The focus of HIA

An HIA is designed to identify aspects of a proposal that could affect (or has affected) the health and well-being of defined populations. These health impacts are most likely to occur because the proposal affects the key determinants of health, rather than because the proposal impacts directly on human health (though this may happen occasionally, e.g. exposure to physical or chemical hazards).

We know what type of things affect our health – examples are listed in Table 3-1 and Table 3-2.

Table 3-1: The key determinants of health

Individual Risks	***Environmental/Social Risks***
• Inherited disease susceptibility. • Physiological variations. • Biological threats, (e.g. infection). • Pre-conceptual/*in utero* exposure to risk factors. • Lifestyle risk factors.	• Pollution. • Education. • Income. • Employment. • Access to transport. • Ethnicity. • Social class. • Area of residence. • Access to services.

This will be a rapid, prospective HIA and the stakeholder workshop you will be attending will help us to identify the potential effects the proposal will have on the key determinants of health.

In looking at impacts, the following needs to be borne in mind (both during the construction of the ECC and once the ECC has been built and its services are operational):

- What is the nature of the impact?
- Will the impact occur straight away or over time?
- Will the impact be temporary or permanent?
- How certain can we be that the impact will happen?
- Can this impact be measured (quantified) precisely, imprecisely, or not at all? (It should be noted that HIA is not intended as a precision prediction tool but is rather a broad mapping exercise to ensure that health is considered in the decision making process and often in practice, very little information can be precisely quantified)
- Which population groups will be affected by the impact?
- What enhancement/mitigation factors can be taken?

Key consideration needs to be given to the population groups affected by the proposal and to any health inequalities that may result if any population groups are particularly affected (positively or negatively). Population groups can be defined geographically (e.g. the immediately affected wards of Warbreck and Fazakerley, North Mersey as a whole, etc) or by other means (such as age, sex, employment status, health status, etc).

This information will be recorded in a matrix (see page 22 for an example).

Table 3-2: Examples of key determinants of health

Determinant	***Explanatory note***
<u>Economic</u> Wealth creation Wealth distribution	Wealthier regions/communities have greater levels of wellbeing than poorer regions/communities (generally speaking). But the actual pattern of wealth distribution across the different groups within society directly affects their respective levels of well-being. Inequalities in wealth distribution cause inequalities in wellbeing across these groups.
Employment opportunities	Employment is generally considered to be better for your wellbeing than unemployment. However, not all jobs are good wellbeing, e.g. occupational diseases and accidents, work related stress, are worse in certain types of jobs. You should also take into account the sustainability of the jobs created and which groups within the community will be able to access them.
Education and training	Education is directly linked with the social and economic conditions associated with quality of life and wellbeing. Improving the learning opportunities for vulnerable groups like young people and the unemployed will substantially improve wellbeing for them and reduce inequalities.
<u>Social</u> Family support	Strong, independent and responsible individuals grow best in nurturing, positive and supportive environments that offer positive role models and encourage healthy citizenship
Community networks	People are social beings. Meaningful social contacts are good for wellbeing, e.g. wth families, friends and community groups. This includes access to cultural/leisure facilities.
Community safety	People need to feel safe and secure in order to be healthy. Protection from accidental injury and crime is necessary for individual and community wellbeing. Fear of crime can be just as damaging as crime itself.
Public participation / social inclusion	Individual wellbeing is enhanced by a feeling of control over one's life circumstances, e.g. in decision-making affecting income, working and living conditions and in their discretion to act.
<u>Personal</u> Health-related behaviour	Individuals may place themselves at increased risk of ill health through their health related behaviour patterns. Consider whether the proposal encourages healthier behaviours and discourages unhealthy ones.
<u>Physical</u> Natural environment	Population wellbeing is affected by the natural environment - air, soil and water quality, ecosystem, noise, smells, views, waste disposal. These factors are themselves affected by the way we use our natural resources, consume our energy and the pollution and waste we produce.
Built environment and open space	The quality of buildings, parks, land-use per se, access to green open space, can contribute to feelings of well-being.
Provision of housing	Well-being is affected by the houses we live in – the quantity and quality of housing stock and tenure (private and social) and its affordability.
<u>Public service provision</u> Access	Access issues especially for vulnerable groups such as ethnic minorities, disabled, homeless need to be considered. Access needs to be considered in terms of location and transport and physical access to buildings, for example.
Transport	In additions to access, there are particular concerns about the impacts of over reliance on the private car, increased air travel on air pollution and climate changes, use of land to support transport demands and road traffic accidents.
New health premises and ways of working	New premises and service reconfigurations can have an immediate and direct effect on the target population (including access). But could there be any unintended negative consequences of the proposal on any population group (including staff and patients)? For example, cleanliness issues or finance issues on patient care, etc?
<u>Other</u>	The above list is not an exhaustive list of determinants, just examples of some of the key ones likely to apply to most (healthcare) proposals.

Example of matrix used for recording information about health impacts

(1) Description of impact	*(2) Type*	*(3) Immediacy*	*(4) Duration*	*(5) Certainty*	*(6) Measurable*	*(7) Populations*	*(8) Enhancement / mitigation measures*
	☺ ☠ 0 ?	I L	T P	D P S	C E Q		

The matrix is essentially completed as follows:

1. Describe in column (1) the nature of the impact

2. Denote in the column (2) whether there will be a positive impact [☺], negative impact [☠], no impact [O] or Unsure [?]

3. Denote in column (3) whether this will happen immediately [I] or after a certain amount of time [L]

4. Denote in column(4) whether this will be a temporary [T] or permanent [P] effect

5. Denote in column(5) how certain you are this will happen – definite [D], probable [P] or speculative [S]

6. Denote in column (6) whether it would be possible to predict the size of the impact – calculable [C], estimable [E] or no, is not possible to measure, qualitative [Q]

7. Denote in column (7) which population groups the impact will affect

8. Describe in column (8) what mitigation factors can be made to enhance positive impacts and to minimise negative impacts

4. The proposed outline for the workshop

	Time	***Duration (minutes)***
Registration (Tea and coffee)	9:30	30
Introduction to workshop • Housekeeping rules • Introductions • What is HIA?	10:00	30
Presentation about the proposal	10:30	30
Break for tea/coffee	11:00	10
Introduction to tasks	11:10	5
Group work: Identifying impacts – construction phase	11:15	90
Lunch	12:45	45
Group work: Identifying impacts – operational phase	13:30	90
Break for tea/coffee	15:00	20
Feedback/discussion and general discussion about the day's findings	15:20	30
Closing remarks (Sue Milner)	15:50	10
Close	16:00	

5. Directions to Oakmere Conference Centre

Please find directions to Oakmere Conference Centre enclosed.

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