# Shaping Care Together

# Equality and Inequalities Impact Assessment

**Report produced by The Inclusion Team, NHS MLCSU and Arden & Gem CSU**

**March 2026**

# Contents

1.0 Introduction ... 4
2.0 Programme Overview ... 6
3.0 Methodology ... 8
4.0 Equality Legal Requirements ... 9
4.1 Public Sector Equality Duty – application ... 10
4.2 What is Due Regard? ... 11
4.3 What is Conscious Consideration? ... 11
4.4 Calculating Due Regard ... 12
5.0 High Level Demographic Profile ... 14
5.1 Hospital Locations ... 14
5.2 Population Density ... 22
5.4 Protected Characteristics ... 27
5.5 Deprivation ... 66
5.6 Health Inequalities and the Wider Determinants of Health ... 72
6.0 Service Performance Data ... 82
6.1 The Current Position ... 83
6.2 Current Key Performance Data ... 83
7.0 Consultation and Engagement Intelligence ... 98
7.1 The Current Position ... 99
7.2 Public Consultation: July – October 2025 ... 101
7.2.1 Background ... 101
7.2.2The consultation process ... 101
7.2.3 Profile of respondents who engaged ... 102
7.2.4 Consultation representativeness against local population benchmarks ... 104
7.3 Inclusive Engagement Undertaken ... 105
7.4 Equality Analysis – Headline Findings (Full Analysis Appendix One) ... 109
7.4.1 Headline equality and health inequality findings ... 111
7.4.2 Due regard actions, mitigations, monitoring and escalation ... 113
8.1 Key Headline Findings ... 118
8.2 Alignment with the Independent Consultation Report ... 120
9.0 Equality Impact Assessments (EIAs) ... 124
9.1 Purpose of this section ... 124
9.2 EIAs to date ... 125

9.3 What decision-makers should take from Section 9 ... 135
10.0 Workforce Considerations ... 136
10.1 Key Messages for Decision-makers ... 136
11.0 Conclusions ... 139
11.1 Demographic Profiling ... 139
11.2 Service Performance Data ... 143
11.3 Consultation and Engagement ... 144
11.4 Equality Impact Assessments ... 146
12.0 Recommendations ... 150
12.1 Decision-Making and Due Regard ... 150
12.2 Co-design of Mitigations ... 150
12.3 Performance Data ... 151
12.4 Equality Impact Assessments and Due Regard ... 151
12.5 Equality and health Inequality benefits ... 151
12.6 Engagement and Consultation ... 151
12.7 Travel, Arrival and Time-Critical Access ... 151
12.8 Older People and Frailty ... 152
12.9 Waiting Environment and Dignity ... 152
12.10 Children, Young People and Families ... 152
12.11 Accessible Information and Communication ... 153
12.12 Carers and Associate Discrimination ... 153
12.13 Workforce Equality ... 153
12.14 Health inequalities monitoring and escalation framework ... 153
12.15 Monitoring, Escalation and Post Implementation Review ... 154
12.16 Triggers Points and Escalation ... 154
List of Appendices ... 155

# 1.0 Introduction

This Equality and Inequalities Impact Assessment (EIIA) has been prepared to support decision-making on the Shaping Care Together urgent and emergency care proposals. It summarises the equality and health inequality evidence and sets out the key issues, mitigations and monitoring considerations that decision-makers should consider when having due regard to the equality aims in section 149 of the Equality Act 2010 and the NHS duties to reduce health inequalities.

It is intended to help decision-makers understand how impacts may fall differently across places and groups, what actions can reduce disproportionate impact, and what monitoring is needed during implementation to prevent inequalities widening.

Where earlier EIAs identified evidence gaps, Section 9.2 sets out how this report closes or reduces those gaps and what residual actions remain for implementation

This EIIA:

- Provides an analytical assessment of performance and demographic data under the equality lens to understand impact (Sections 5 and 6)
- Provides an equality impact analysis of the SCT Public consultation through an equality lens (section 7)
- Provides a gap analysis of previous EIAs undertaken and where this impact assessment has been addressed
- Provides an overview of risks and mitigations, monitoring arrangements and escalation triggers that will be incorporated into the implementation phase of the programme (all sections)

**Summary for decision-makers**

This decision involves place-based trade-offs. Selecting one site for a consolidated Emergency Department is likely to reduce travel burden and practical access barriers for communities closer to that site, while increasing travel time, cost and journey complexity for communities further away. These trade-offs matter because longer or more complex journeys can amplify barriers for some protected characteristic groups and people experiencing deprivation.

The strongest mechanism for unequal impact is travel and time-critical access, followed by parking and safe drop-off, access and wayfinding, and the waiting environment. Impacts are more likely to be amplified for older people and people with frailty, disabled people including people with sensory, cognitive and mental health needs, unpaid carers, people experiencing deprivation or transport poverty, pregnant and postnatal people, and families with young children.

Consultation feedback shows that people judge the proposals through a combined lens of journey time and confidence that, on arrival, the receiving site has enough capacity, staffing and a safe environment, including child-friendly flows and accessible communication during waits.

The programme also has potential to deliver equality and health inequality benefits, dependent on delivery. These include improved clinical sustainability and resilience, a more consistent urgent and emergency care offer, and an opportunity to improve accessibility, reasonable adjustments and the
physical environment at the selected site, which would particularly benefit groups currently facing barriers.

Decision assurance depends on the decision being accompanied by a small number of deliverable commitments and a monitoring and escalation framework. Minimum commitments should cover a transport and access mitigation plan, parking and safe drop-off, step-free access and supported wayfinding, waiting environment standards including low-stimulus provision, Accessible Information Standard compliant communications, and a clear route for reasonable adjustments.

Maternity and neonatal service reconfiguration is outside the scope of this consultation. However, pregnancy and maternity remain a protected characteristic and is relevant to urgent and emergency care pathways. The decision should therefore be accompanied by clear time-critical escalation routes for pregnant and postnatal emergencies presenting to urgent and emergency services, and safeguarding assurance for children and families within a co-located model.

Where consultation equality monitoring bases are small or under-represented for some groups, this does not prevent decision-making, but it increases the importance of targeted follow-up engagement and robust post-decision monitoring so emerging disproportionate impacts are identified early and addressed.

**Health inequalities duty decision assurance**

Decision makers have had regard to the duties in the NHS Act 2006 to reduce inequalities in access to services and in health outcomes. The evidence indicates a high baseline of inequality across the footprint, with deprivation and vulnerability unevenly distributed and closely linked to urgent and emergency care need.

Consultation analysis shows that the strongest mechanism for unequal impact is travel time, distance, affordability and journey complexity, further compounded by parking, safe drop-off and arrival, wayfinding, the waiting environment and accessible communication. Whichever site is selected, there is a foreseeable risk of disproportionate impact for communities furthest away unless mitigations are practical outside office hours and deliverable during implementation.

Decision assurance therefore depends on the chosen option being accompanied by a defined mitigation package and an equality and health-inequalities monitoring framework with escalation triggers, so that emerging disproportionate impacts are identified early and addressed through governance.

**How to use this report**

Section 2 summarises the programme context and what is in scope. Sections 3 and 4 set out the approach and the relevant equality and health inequality duties. Sections 5 to 8 provide the demographic context, service and performance signals, and consultation and engagement intelligence. Section 9 summarises the EIA evidence base. Sections 10 to 12 draw together key findings and set out recommendations and monitoring expectations. Appendix 1 provides the detailed consultation equality analysis.

## 2.0 Programme Overview

**Background and why change is required**

Shaping Care Together is a joint Programme led by NHS Cheshire and Merseyside Integrated Care Board, NHS Lancashire and South Cumbria Integrated Care Board and Mersey and West Lancashire Teaching Hospitals NHS Trust. It focuses on addressing longstanding urgent and emergency care challenges across Southport, Formby and West Lancashire, with an aim to deliver sustainable, high-quality care and reduce health inequalities.

The Programme has developed over time in response to repeated reviews and clinical recommendations, spanning more than two decades. These have consistently highlighted fragilities in the local hospital model and recommended service consolidation and new care models. Following external support in 2021 and organisational change in 2023 intended to stabilise services, the system has continued to face persistent pressures.

The key drivers for change include difficulty recruiting and retaining key clinical staff, reliance on temporary staffing, constraints linked to buildings and clinical dependencies, and performance and flow pressures. The Programme also reflects wider system issues, including increasing demand, financial constraints with no new recurrent funding, and an Ageing population with more complex needs. The overall aim is to provide a safer, more resilient and clinically sustainable urgent and emergency care model for the future, while using workforce and estate resources more efficiently.

**What is in scope and what is not in scope**

This phase of work relates to urgent and emergency care services across Southport and Formby District General Hospital and Ormskirk District General Hospital West Lancashire District General Hospital. The central service change being considered is the co-location of a 24 hour Adult and Children's Accident and Emergency Services on a single site, supported by associated clinical and operational requirements. The following are in scope:

- The urgent and emergency care model, its clinical dependencies, staffing model, estate and the operational arrangements needed to deliver safe care on the chosen single site.
- The impact assessments and assurance work that inform due regard, including an equalities and health inequalities assessment, a quality impact assessment, and travel and access considerations.
- The mitigations and monitoring required to address risks that may fall unevenly across places, Protected Characteristic groups, and carers.

Maternity and neonatal services are not within the scope of this consultation. They are subject to separate national and regional review and service change processes. Interdependencies have been recognised and considered where relevant, including to understand concerns raised by the public, however this does not predetermine the outcome of those separate processes.

## The story so far

The Programme has followed a structured major service change approach, combining clinical review, evidence gathering, engagement and assurance, as follows:

- Early evidence and clinical development during 2024, including development of the clinical vision and model, and external clinical and assurance checkpoints.
- Publication of the case for change in 2024, setting out workforce, estate and sustainability challenges and the drivers for change.
- A period of extensive pre-consultation engagement in 2024 to gather insights from patients, the public, staff and stakeholders, and to shape the options appraisal.
- Pre-consultation evidence development during late 2024 and early 2025, including an integrated impact assessment, a quality impact assessment, travel and access work, and a long list to short list options appraisal.
- Assurance and approval during 2025, including the development of consultation materials and joint committee approval to proceed to formal public consultation.

## Governance and assurance

Programme management is coordinated through a Programme Delivery Group that oversees key workstreams, including clinical, workforce, estates, finance, business intelligence and communications and engagement. Supporting groups provide focused oversight, including clinical leadership and assurance, travel and access work, and engagement oversight.

The Programme delivery arrangements report into a Programme Board, with formal decision-making through the joint committee arrangements across the two Integrated Care Boards. This governance route is designed to ensure alignment with NHS service change guidance, statutory consultation duties and due regard under the Public Sector Equality Duty.

**What it has meant so far**

The Programme has treated equality, health inequalities and inclusion as core to design and decision-making. This has included early and iterative impact assessment work to identify who may be more likely to experience disadvantage and to shape engagement, mitigation planning and monitoring.

The Programme has also strengthened partnership-working across commissioners, the provider trust, local authorities, the ambulance service, community services and the voluntary, community and faith sectors. This supports wider work to improve access to urgent care closer to home, reduce avoidable hospital attendance, and improve discharge and admission avoidance pathways, alongside the work on emergency department configuration.

**Next stages**

The next stages involve completing the post consultation evidence review and final decision-making steps. This includes updating and triangulating evidence from consultation feedback, clinical review, modelling and impact assessments, so that decision-makers can have due regard to impacts and mitigations and record their consideration in decision papers.

Subject to a final decision, implementation planning is expected to progress in phases.

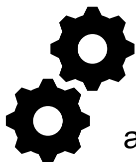
Years one and two are expected to focus on detailed business case development, including the strategic, clinical, economic and financial case, and the delivery approach, governance, risk and benefits plans.

Years three to five are expected to focus on construction and delivery, including detailed clinical pathways, operational processes, workforce models, digital and estate plans, and supporting enablers such as standard operating procedures and transport protocols.

Engagement and scrutiny are expected to continue throughout, including ongoing involvement of staff, patients, communities, local authorities and scrutiny committees.

# 3.0 Methodology

The purpose of this document is to provide a view of the current position of how well the Programme is informed around equality in relation to the proposed changes to be made within the Shaping Care Together (SCT) Programme in order to support positive, proactive due regard to the relevant equality aims, and consider potential actions where there may be gaps.



The methodology has consisted of:

- A review of relevant documents and data provided to the team around engagement activity to date, Equality Impact Assessment work conducted and recent engagement data provided and applying equality, diversity and inclusion (EDI) expertise/insight to consider impact, due regard and also highlighting key headline Equalities themes that need to be carefully considered when the Programme is making key decisions.
- Conversations with the EDI team within the Programme to understand what has been delivered to date.
- A high-level review of key summary documents and analysis produced to determine the extent to which due regard has been applied.
- A high-level review of engagement and Equality, Diversity and Inclusion methods and activities deployed within the Programme, in order to analyse the extent to which due regard has been discharged.
- Pinpointing where gaps may exist within the EDI methods deployed to date.

## 4.0 Equality Legal Requirements

All public sector bodies have a duty to meet the requirements of the Equality Act 2010 including the Public Sector Equality Duty (PSED). Decision-makers are required to have 'due regard' to the three aims of the general duty:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act
- Advance equality of opportunity between people who share a relevant Protected Characteristic and those who do not
- Foster good relations between people who share a relevant Protected Characteristic and those who do not.

We refer to these as the three aims of the PSED.

The first aim of the PSED covers all nine Protected Characteristics:

- Age
- Disability
- Gender reassignment
- Marriage and Civil Partnership (in employment only)

- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual Orientation

The second and third aims apply to the Protected Characteristics set out above, except for Marriage and Civil Partnership.

In addition to the Protected Characteristic groups listed above, there are additional groups that experience health inequalities and face disadvantage in society. These groups are known as health inclusion groups and include, but are not exclusive of:

- Carers
- People living in rural areas
- Asylum seekers and refugees
- People experiencing homelessness
- People experiencing socio-economic deprivation

Health inclusion groups are not directly protected under the Equality Act 2010 and the PSED, however, people who possess health inclusion group characteristics are more likely to experience multiple interacting risk factors for poorer health outcomes, such as stigma, social exclusion, discrimination, poverty, violence, and complex trauma.

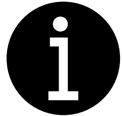
Under the National Health Service Act 2006, NHS England (section 13G) and integrated care boards (ICBs) (section 14Z35) are under a duty to have regard to the need to:

- Reduce inequalities between persons with respect to their ability to access health services, and
- Reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services (including the effectiveness of the services, the safety of services, and quality of the experience undergone by patients).

The health inequalities duties are not limited to groups sharing a Protected Characteristic, as is the case for the PSED. Any group experiencing health inequalities is covered.

Guidance on the PSED and the health inequalities duties has been published by the Equality and Human Rights Commission (EHRC) (Technical guidance on the Public Sector Equality Duty: England | EHRC) and NHS England (NHS England » Equality and health inequalities legal duties). We summarise some key considerations below.

## 4.1 Public Sector Equality Duty – application



The three aims of the Public Sector Equality Duty (PSED) are distinct and require different types of consideration. The duty to eliminate unlawful discrimination, for example, is fundamentally very different to the need to advance equality of opportunity.

All three elements of the PSED need to be carefully considered and fulfilled when designing and administering public services.

### 4.2 What is Due Regard?

Due regard means that an organisation that is subject to the PSED must consciously and actively consider the three aims of the general duty. Organisations must demonstrate and evidence how they work to meet their public sector equality duty obligations when making decisions and in other day-to-day activities.

In practice, a specific description of what constitutes as having due regard is not defined within law and there are different practices or tools that may be used in relation to meet the requirements of legislation, including Equality Impact Assessments (EIA). The completion of an EIA is not a specific legal requirement in England, however, meeting the requirements of the PSED is a legal requirement, and the Inclusion team believes that conducting an EIA is one of the most efficient and meaningful ways to meet it.

### 4.3 What is Conscious Consideration?

The process of ‘due regard’ is not prescribed in legislation. Helpful principles have been established via equalities case law. The most important are summarised below:

**The Brown, Bracking and Gunning Principles**

Equalities case law provides a broad indication of how public bodies are expected to approach the equality aims in the Public Sector Equality Duty in practice. The principles established in case law are not additional legal requirements, but they are useful to guide organisations on embedding equality considerations early, keeping an open mind, and maintaining a clear decision record showing how equality issues and mitigations were conscientiously considered.

**The Brown Principles**

The Brown Principles were established as a result of a legal case brought against the Secretary of State for Work and Pensions by R Brown in 2008. While the case predates the Equality Act 2010 and the Public Sector Equality Duty, the principles of the case are relevant to current legislative requirements.

**The Bracking Principles**

The Bracking Principles draw upon and expand upon the Brown Principles and were established as a result of a legal case brought against the Secretary of State for Work and Pensions by Bracking (and others) in 2013.

**The Gunning Principles**

The Gunning Principles establish what constitutes and fair and lawful consultation by public bodies and are frequently referred to as a legal basis for judicial review decisions:

- **Consultation must take place at a time when proposals are still at a formative stage** and a final decision has not yet been made, or predetermined, by decision-makers
- **Sufficient information to allow for intelligent consideration and response must be provided**, including the reasons for proposals. The information provided must relate to the consultation and must be available, accessible and easily interpretable for consultees to provide an informed response
- **Adequate time must be given for people to consider a proposal, participate and respond.** The length of time given for a consultee to respond can vary depending on the subject and extent of the impact of the consultation
- **Conscientious consideration must be given to the consultation responses before a decision is made**. Decision-makers should be able to provide evidence that they took consultation responses into account.

Equality, Diversity and Inclusion (EDI) practitioners tend to consider a number of factors when applying due regard to a given situation. Some of these include:

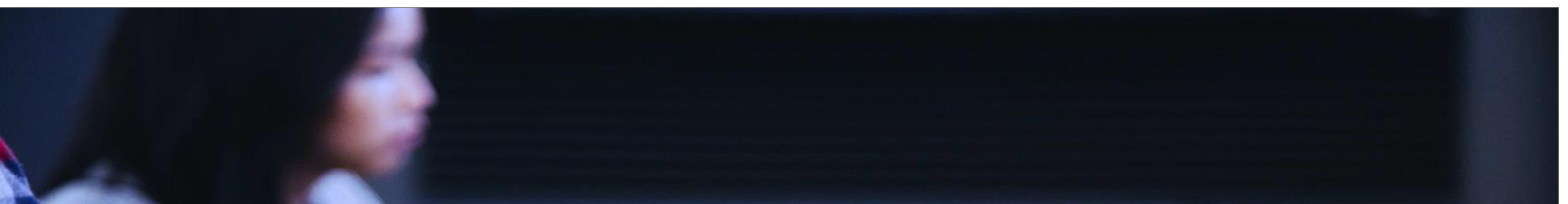
- How relevant the situation being considered is to the three aims of the Public Sector Equality Duty
- The scale and potential impact/s that a decision could have upon long term life outcomes. Health care provision is a fundamental part of people's lives, and inequalities in provision of services have considerable impacts upon life expectancy and quality of life
- What issues of inequality could present if equality requirements are not carefully considered. For example, wider societal inequalities relating to pregnancy means that women from some ethnic groups may experience higher risks during pregnancy and birth. Should commissioners and providers fail to consider this context when developing services, already disadvantaged groups may experience compounded impacts that result in poorer outcomes.

## 4.4 Calculating Due Regard

A transformation agenda of this scale and complexity is likely to significantly impact patients, families and the workforce across a large and complex geographical area.

Several sensitive and specialised services are in scope for transformation, with multiple, interdependent elements under consideration; it is likely that any proposed changes will meet with scrutiny from the wider health and social care system, MPs, local government, and the media. Bearing all of this in mind, it is essential that the Programme can demonstrate compliance with the Public Sector Equality Duty to stakeholders.

What may effectively fulfil the Public Sector Equality Duty in one element of the Programme may not be the best approach in another part of it. Working out where the Programme is currently demonstrating good practice and exercising due regard to the Duty and where it may need to consider additional steps to fill gaps is a key aspect of this report.



# 5.0 High Level Demographic Profile

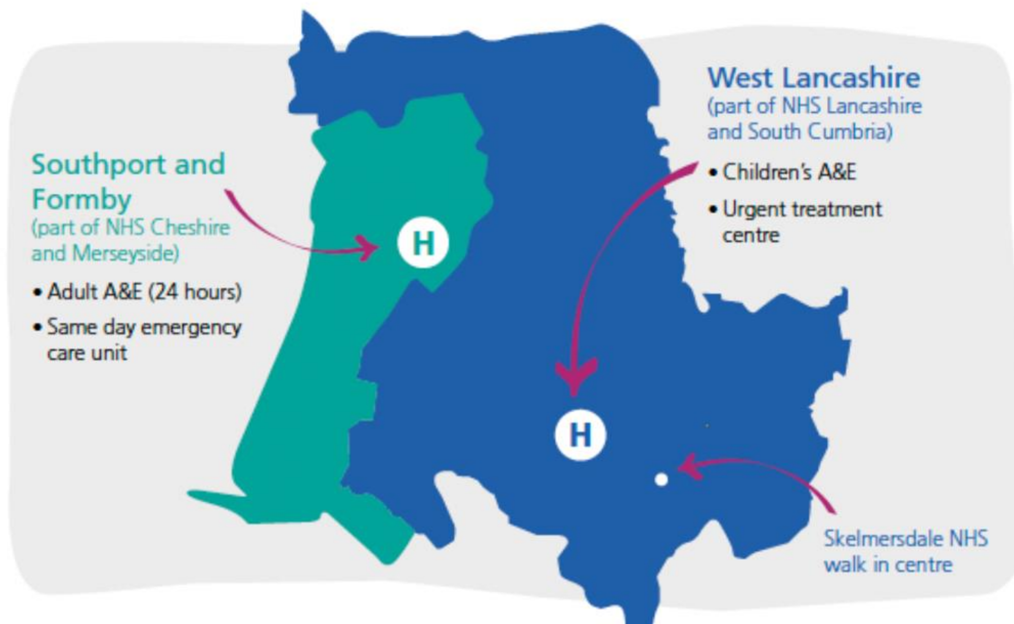
In order to assist with the key decision-making process, it is important to have an understanding of the demographic profile of the surrounding area and region where the hospitals are located in order to provide the necessary background context to the proposals being made and how this may impact certain groups of people.

## 5.1 Hospital Locations

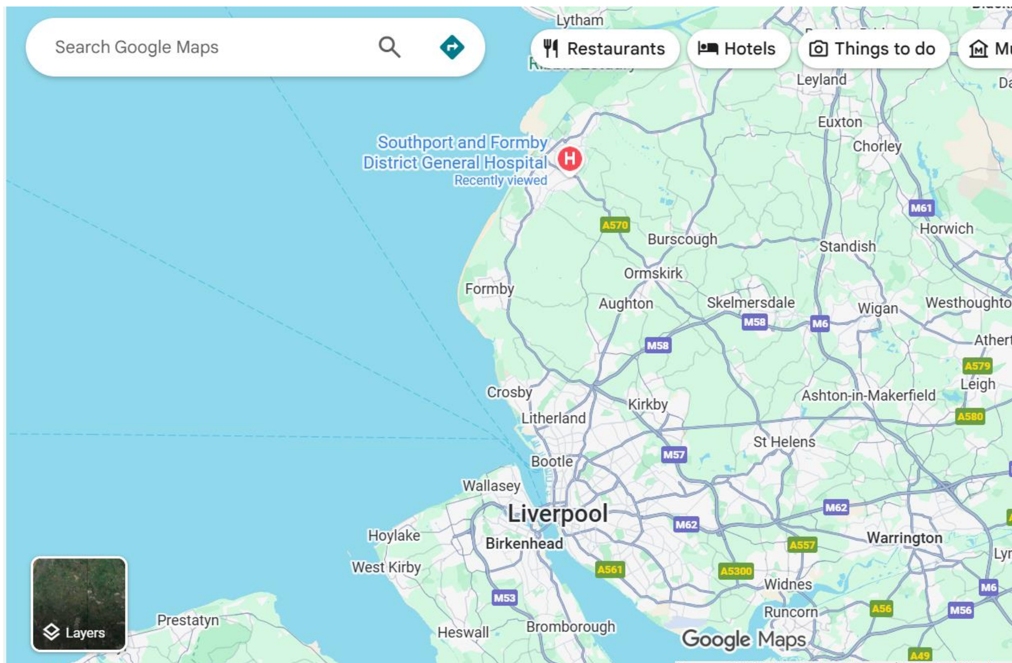
This equalities and inequalities impact assessment and the decisions to be made are about Southport and Formby District General Hospital and Ormskirk District General Hospital both of which are part of Mersey and West Lancashire NHS Teaching Hospitals. Skelmersdale is also relevant as there is a Walk-in-centre (WIC) during the daytime that offers an alternative option for healthcare provision and there is Urgent Treatment Centre (UTC) at the Ormskirk District General Hospital site as shown in the below map.

Southport and Formby District General Hospital is part of NHS Cheshire and Merseyside area and Ormskirk District General Hospital is part of NHS Lancashire and South Cumbria area (as well as Skelmersdale).

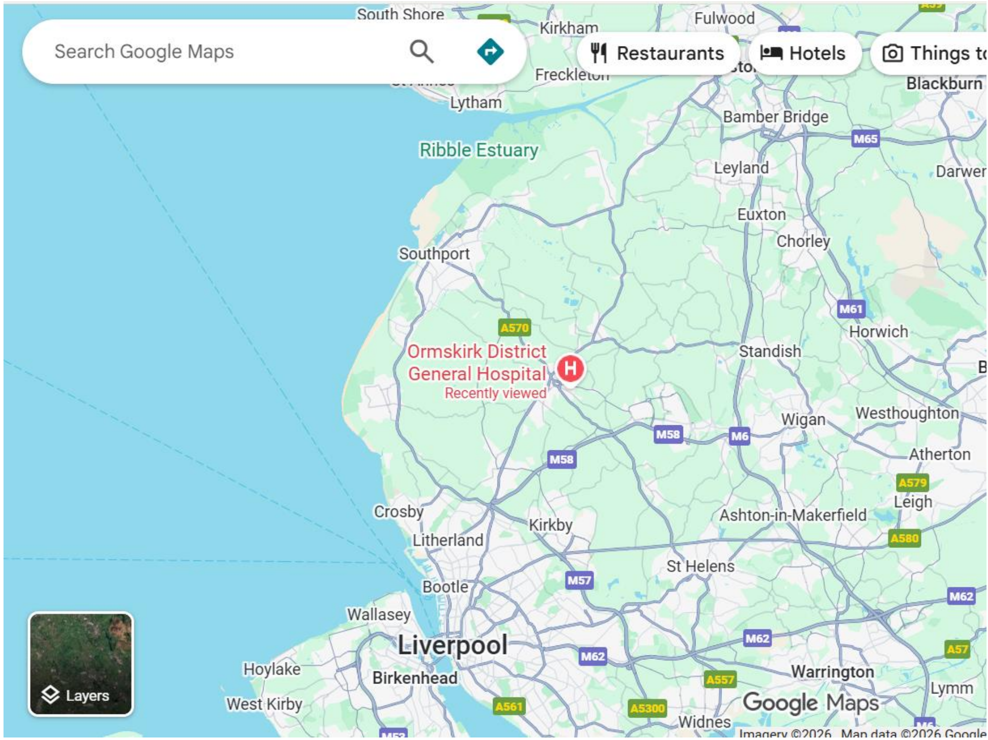
The hospital locations and WIC and UTC facilities are shown on the map below:



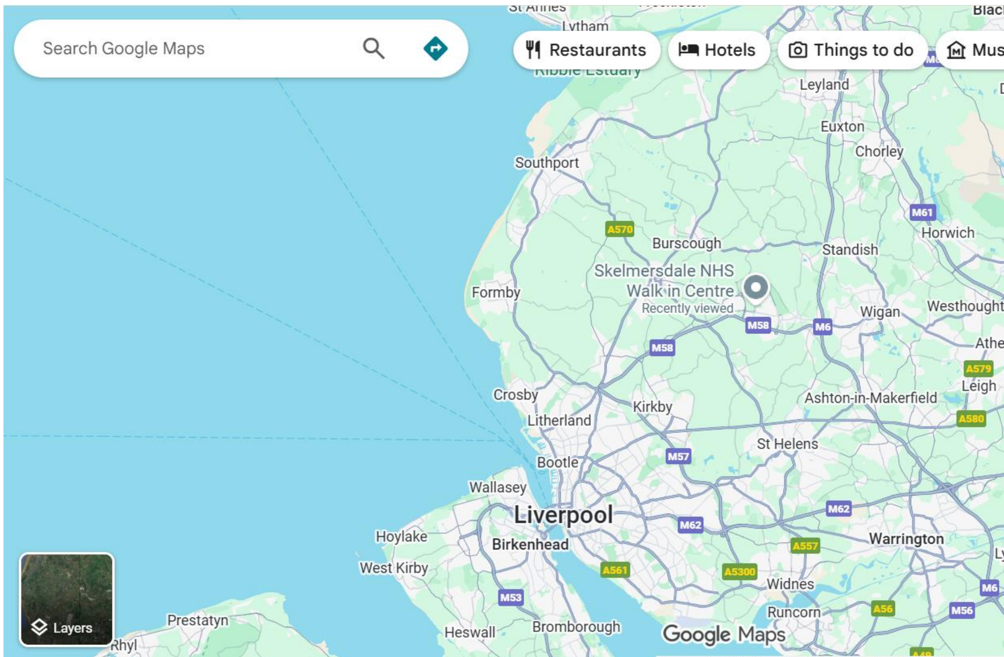
**Location of Southport and Formby District General Hospital**
The location of the hospital is shown on the map below:




**Location of Ormskirk District General Hospital**
The location of the hospital is shown below on the map below. Ormskirk also has an Urgent Treatment Centre. Whilst there are no proposals to alter the provision of the UTC, it has a relevance to the decision-making process, as it offers an alternative route to Urgent Care during the daytime. Its location is shown on the map below:




**Location of Skelmersdale Walk-in Centre**
Whilst there are no proposals to alter the provision at Skelmersdale, it has a relevance to the decision-making process, as it offers an alternative route to obtaining walk-in Urgent Care during the daytime.  Its location is shown on the map below:

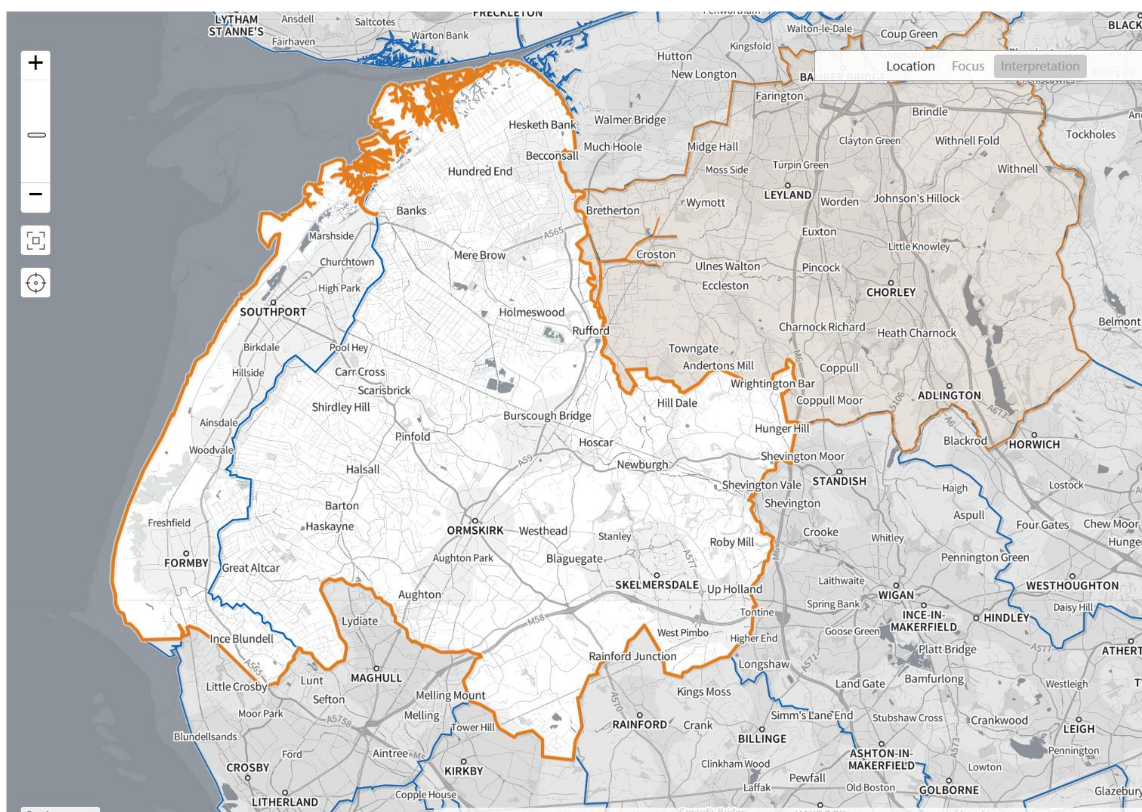



**STRATA Area Used** (for geographic demographic profiling)

Within this report various demographic information has been pulled from various sources, for example, Census 2021 data.

Within the suite of tools used, the STRATA atlas that can be used to provide accurate demographic profiling data across mapped areas has been utilised - https://app.stratasoftware.net/place/#7/52.672/-2.175/rs-selected,rh-0,rdr-t.

The geographic area used within the STRATA tool is shown below which is very close to both of the hospitals' catchment areas and so this does provide relevant and accurate geographic dispersal.




## Census Data – Areas Used

Census 2021 data has been used in the process of generating demographic profiling as it provides the most robust and dependable demographic information.

Census 2021 data can be broken down into various geographic areas, but there are limits to what is available, and the ways in which it can be broken down. In producing profiling information for a Programme such as SCT, there will be a relevant similar geographic regions to the SCT catchment area, and in the process of profiling, the closest match to the relevant geographic region will need to be sourced. In most cases however it won't be exact.

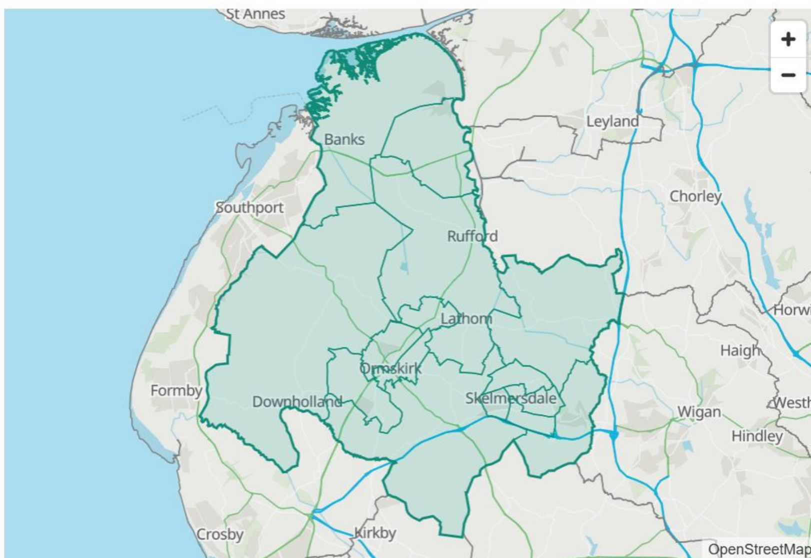
For the Shaping Care Together Programme, the closest match for the geographic catchment area of the Programme, is to use 2 different sets of geographic Census 2021 local authority areas. These are:

- the West Lancashire Local Authority Area
- the Sefton Local Authority area.

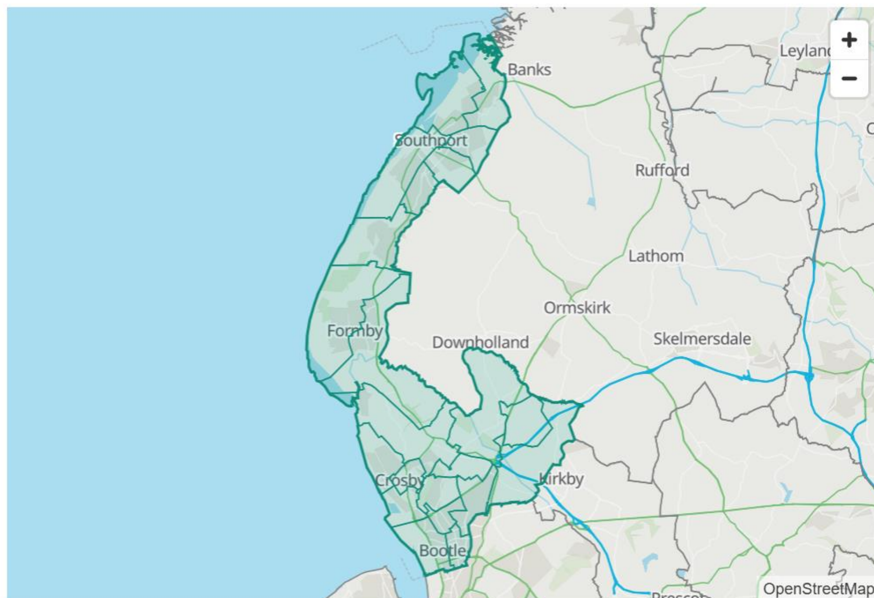
By referring to these two data sets, we are able to provide the closest demographic profiling information for the geographic area of the Programme. This report focuses on Southport and Formby District General Hospital and Ormskirk District General Hospital. For demographic profiling we have used Sefton local authority and West Lancashire local authority because Census and other official population datasets are most consistently available at local authority level. Southport and Formby sit within Sefton local authority, so Sefton provides the closest consistent and auditable proxy for the Southport and Formby catchment in the absence of a single official “Southport and Formby” population dataset.

The geographic areas of the two sets of Census 2021 data used are shown on the maps below for information. This provides clarity to those reviewing the information about exactly what areas are covered by the statistics. The maps below therefore show the West Lancashire and also Sefton Local Authority Census areas.

**West Lancashire – Local Authority Area** (used for Census 2021 data demographic profiling)



**Sefton – Local Authority Area** (used for Census 2021 data demographic profiling)



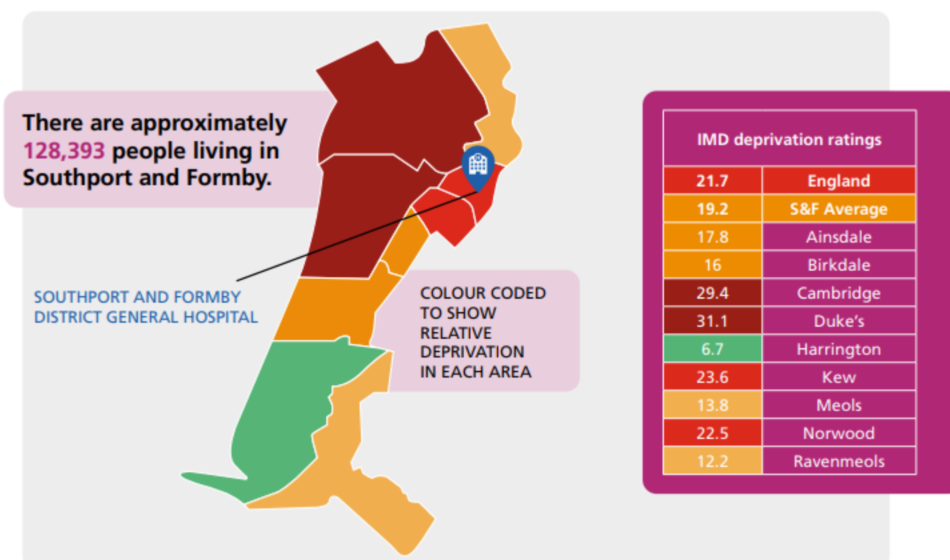
## Demographic and place-based context for Southport and Formby

The following section provides some additional information in relation to the Southport and Formby area, which is within the Sefton area. This in helpful information as there is some difference between North Sefton and South Sefton, and so it provides additional context to the use of the Sefton Census statistics.

### Headline points

- Southport and Formby is a predominantly coastal and semi-rural area within Sefton, with a population of around 128,393.
- Overall, the area is often described as relatively affluent, but there are notable social inequalities within the place.
- Deprivation varies substantially by ward. Harrington is relatively prosperous, while Cambridge and Duke's have higher deprivation levels than both the Southport and Formby average and the England average.
- Income patterns mirror this. Harrington has the highest average income. Cambridge and Duke's have the lowest and are below national and local averages.
- The local population profile is ageing faster than the national average, with a significant increase in people aged over 65 expected by 2036, increasing demand for urgent and emergency care and long-term care.
- Additionally whilst there are affluent areas across West Lancashire, some of the most deprived areas are located across this patch too, particularly areas such as Digmoor, Tanhouse, Moorside and Birch Green

### Extractable ward level deprivation information




| IMD deprivation ratings | |
|---|---|
| 21.7 | England |
| 19.2 | S&F Average |
| 17.8 | Ainsdale |
| 16 | Birkdale |
| 29.4 | Cambridge |
| 31.1 | Duke's |
| 6.7 | Harrington |
| 23.6 | Kew |
| 13.8 | Meols |
| 22.5 | Norwood |
| 12.2 | Ravenmeols |



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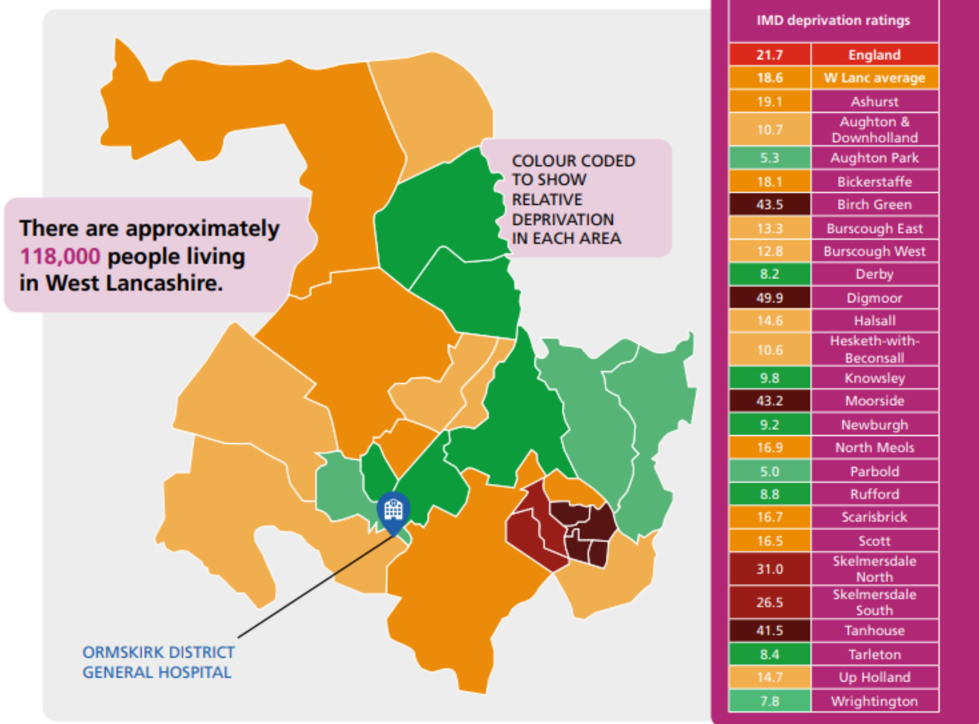



| IMD deprivation ratings | |
|---|---|
| 21.7 | England |
| 18.6 | W Lanc average |
| 19.1 | Ashurst |
| 10.7 | Aughton & Downholland |
| 5.3 | Aughton Park |
| 18.1 | Bickerstaffe |
| 43.5 | Birch Green |
| 13.3 | Burscough East |
| 12.8 | Burscough West |
| 8.2 | Derby |
| 49.9 | Digmoor |
| 14.6 | Halsall |
| 10.6 | Hesketh-with-Beconsall |
| 9.8 | Knowsley |
| 43.2 | Moorside |
| 9.2 | Newburgh |
| 16.9 | North Meols |
| 5.0 | Parbold |
| 8.8 | Rufford |
| 16.7 | Scarisbrick |
| 16.5 | Scott |
| 31.0 | Skelmersdale North |
| 26.5 | Skelmersdale South |
| 41.5 | Tanhouse |
| 8.4 | Tarleton |
| 14.7 | Up Holland |
| 7.8 | Wrightington |

## 5.2 Population Density

The overall population density for the area is considered below. This is important as it provides a benchmark to compare against the relevant SCT geographic Census 2021 statistics. The overall England statistics are therefore provided as a comparator.

The Census 2021 population density information (shown in the three tables that follow below) illustrates that West Lancashire is a lot less densely populated than Sefton is, with the overall figure for West Lancashire being 338.8 people per square kilometre, which is below the overall England figure of 433.5. In contrast, Sefton has a population density of 1783.4 and is therefore considerably more densely populated than West Lancashire.

**Population Density - England Comparator**

### Population density

| | Persons |
|---|---|
| | England<br>Country |
| | density |
| Usual residents per square kilometre | 433.5 |

In order to protect against disclosure of personal information, records have been swapped between different geographic areas and counts perturbed by small amounts. Small counts at the lowest geographies will be most affected.

Source: ONS - 2021 Census (TS006)

**Population density information**

**Description:** Population density is the number of usual residents per square kilometre [1]

[1] Nomis - 2021 Census 2021 Area Profile - England Country

## Population Density - West Lancashire

**Population density**

| | Persons |
|---|---|
| | West Lancashire<br>Local Authority |
| | density |
| Usual residents per square kilometre | 338.8 |

In order to protect against disclosure of personal information, records have been swapped between different geographic areas and counts perturbed by small amounts. Small counts at the lowest geographies will be most affected.

Source: ONS - 2021 Census (TS006)

**Population density information**

**Description:** Population density is the number of usual residents per square kilometre [2]

## Population Density - Sefton

**Population density**

| | Persons |
|---|---|
| | Sefton<br>Local Authority |
| | density |
| Usual residents per square kilometre | 1,783.4 |

In order to protect against disclosure of personal information, records have been swapped between different geographic areas and counts perturbed by small amounts. Small counts at the lowest geographies will be most affected.

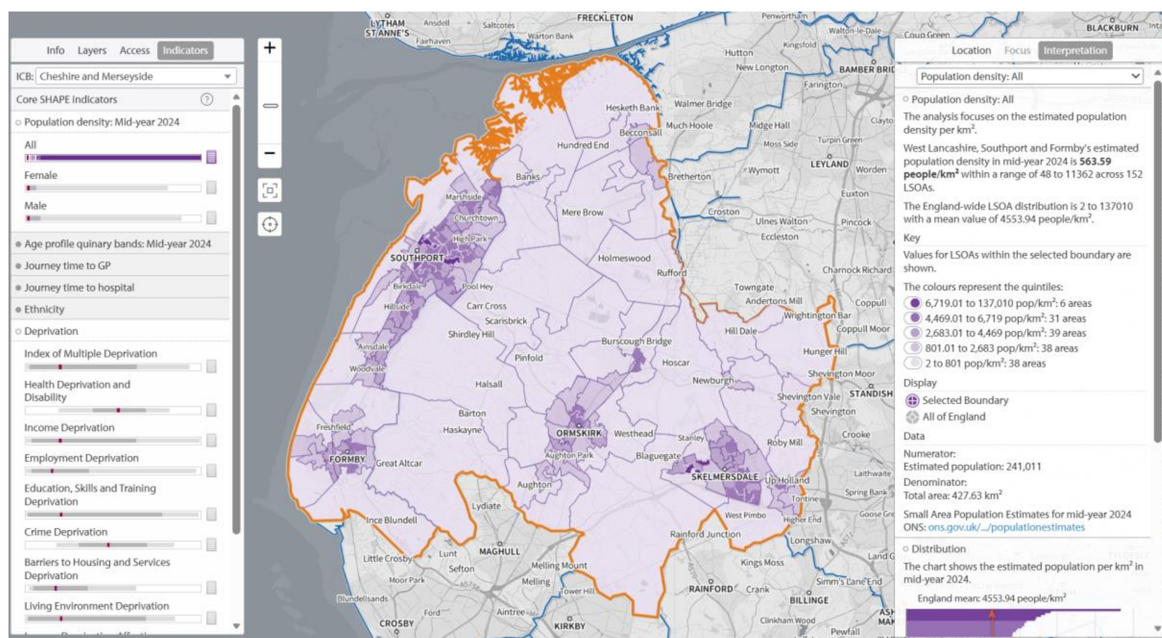
Source: ONS - 2021 Census (TS006) [3]

The map below shows the pattern of the population density across the region. The deeper the purple shading the more densely populated the area. As the map shows, there is a higher density of population around the two hospital locations of Southport and Formby District General Hospital and Ormskirk District General Hospital, with the population being more densely populated around Southport and Formby District General Hospital where a north/south

[2] Nomis - 2021 Census 2021 Area Profile - West Lancashire Local Authority

[3] Nomis - 2021 Census 2021 Area Profile - Sefton Local Authority

strip of denser population can be observed. There is also a cluster or higher density around Skelmersdale.



[4]

## 5.3 General Health Demographics

As well as considering the different specific Protected Characteristics, it's important to have a sense of the general health demographics across the region where decisions are being made about critical healthcare provision (A&E and urgent care).

Across England, 48.5% of the population has very good health and 33.7% has good health. 12.7% has fair health, 4.0% has bad health and 1.2% very bad health.

[4] SHAPE Place • Population density: Mid-year 2024 • Population density: All

### 5.3.1 General Health

**England Comparator - Health**

## Health

### General health

| | Persons | |
|---|---|---|
| | England Country | |
| | count | % |
| All usual residents | 56,490,046 | 100.0 |
| Very good health | 27,390,829 | 48.5 |
| Good health | 19,040,735 | 33.7 |
| Fair health | 7,147,346 | 12.7 |
| Bad health | 2,248,255 | 4.0 |
| Very bad health | 662,881 | 1.2 |

In order to protect against disclosure of personal information, records have been swapped between different geographic areas and counts perturbed by small amounts. Small counts at the lowest geographies will be most affected.

Source: ONS - 2021 Census (TS037)

**General health information**

**Description:** A person's assessment of the general state of their health from very good to very bad. This assessment is not based on a person's health over any specified period of time. [5]

The table above shows general health across England as a comparison to be used against the Census 2021 statistics on health for the Sefton and West Lancashire areas (shown below).

[5] Nomis - 2021 Census 2021 Area Profile - England Country

## Sefton – Health

### Health

#### General health

| | Persons | |
|---|---|---|
| | Sefton Local Authority | |
| | count | % |
| All usual residents | 279,233 | 100.0 |
| Very good health | 129,449 | 46.4 |
| Good health | 90,164 | 32.3 |
| Fair health | 40,057 | 14.3 |
| Bad health | 14,953 | 5.4 |
| Very bad health | 4,610 | 1.7 |

In order to protect against disclosure of personal information, records have been swapped between different geographic areas and counts perturbed by small amounts. Small counts at the lowest geographies will be most affected.

Source: ONS - 2021 Census (TS037)

**General health information**

**Description:** A person's assessment of the general state of their health from very good to very bad. This assessment is not based on a person's health over any specified period of time. [6]

In terms of Sefton, the table above shows the Census 2021 statistics for general health across the locality. There are slightly fewer people who have very good health (46.4%) compared to the England figure of 48.5%. The figure for good health in Sefton is slightly lower at 32.3%. The figures for bad health and very bad health are higher, with 5.4% of the population having bad health (compared to the England figure of 4.0%), and very bad health, 1.7% compared to the England figure of 1.2%. It's worth noting as well that circa 20,000 people across the Sefton area have either bad health or very bad health, which is a considerable amount of people.

[6] Nomis - 2021 Census 2021 Area Profile - Sefton Local Authority

## West Lancashire – Health

### Health

#### General health

| | Persons | |
|---|---|---|
| | West Lancashire Local Authority | |
| | count | % |
| All usual residents | 117,430 | 100.0 |
| Very good health | 56,460 | 48.1 |
| Good health | 38,918 | 33.1 |
| Fair health | 15,404 | 13.1 |
| Bad health | 5,114 | 4.4 |
| Very bad health | 1,534 | 1.3 |

In order to protect against disclosure of personal information, records have been swapped between different geographic areas and counts perturbed by small amounts. Small counts at the lowest geographies will be most affected.

Source: ONS - 2021 Census (TS037)

**General health information**

**Description:** A person's assessment of the general state of their health from very good to very bad. This assessment is not based on a person's health over any specified period of time. [7]

The table above shows health in the West Lancashire area. General health statistics are more in line with the England pattern, and so overall, general health is slightly better across the West Lancashire region than for Sefton, with a higher proportion of people having very good health, and good health, and a lower proportion having bad health, and very bad health. It's important to note that the difference is small and therefore marginal.

## 5.4 Protected Characteristics

The below analysis uses ONS 2021 Census data. The Census, and questions/categories used, predated recent Supreme Court case of *For Women Scotland Ltd v Scottish Ministers* [2025] UKSC 16 which clarified the meaning of the Protected Characteristics of sex, sexual orientation and gender reassignment. However, this remains the best data available for this analysis.

[7] Nomis - 2021 Census 2021 Area Profile - West Lancashire Local Authority

## Sex

This section considers the Protected Characteristic of Sex (gender). The England comparator below has been included which shows that across England there is an even split between men and women, with slightly fewer men compared to women (49% men compared to 51% women).

### Sex - England Comparator

**Sex**

| | Persons | |
|---|---|---|
| | England Country | |
| | count | % |
| All usual residents | 56,490,048 | 100.0 |
| Female | 28,833,712 | 51.0 |
| Male | 27,656,336 | 49.0 |

In order to protect against disclosure of personal information, records have been swapped between different geographic areas and counts perturbed by small amounts. Small counts at the lowest geographies will be most affected.

Source: ONS - 2021 Census (TS008)

[8]

### Sex - West Lancashire

**Sex**

| | Persons | |
|---|---|---|
| | West Lancashire Local Authority | |
| | count | % |
| All usual residents | 117,429 | 100.0 |
| Female | 61,002 | 51.9 |
| Male | 56,427 | 48.1 |

In order to protect against disclosure of personal information, records have been swapped between different geographic areas and counts perturbed by small amounts. Small counts at the lowest geographies will be most affected.

Source: ONS - 2021 Census (TS008)

[9]

[8] Nomis - 2021 Census 2021 Area Profile - England Country

[9] Nomis - 2021 Census 2021 Area Profile - West Lancashire Local Authority

As shown above, West Lancashire has very similar pattern in terms of the gender split compared to England overall, although both areas have slightly more women than men compared to the England statistics.

### Sex - Sefton

**Sex**

| | Persons | |
|---|---|---|
| | Sefton Local Authority | |
| | count | % |
| All usual residents | 279,233 | 100.0 |
| Female | 143,990 | 51.6 |
| Male | 135,243 | 48.4 |

In order to protect against disclosure of personal information, records have been swapped between different geographic areas and counts perturbed by small amounts. Small counts at the lowest geographies will be most affected.

Source: ONS - 2021 Census (TS008)

**Information: Sex**

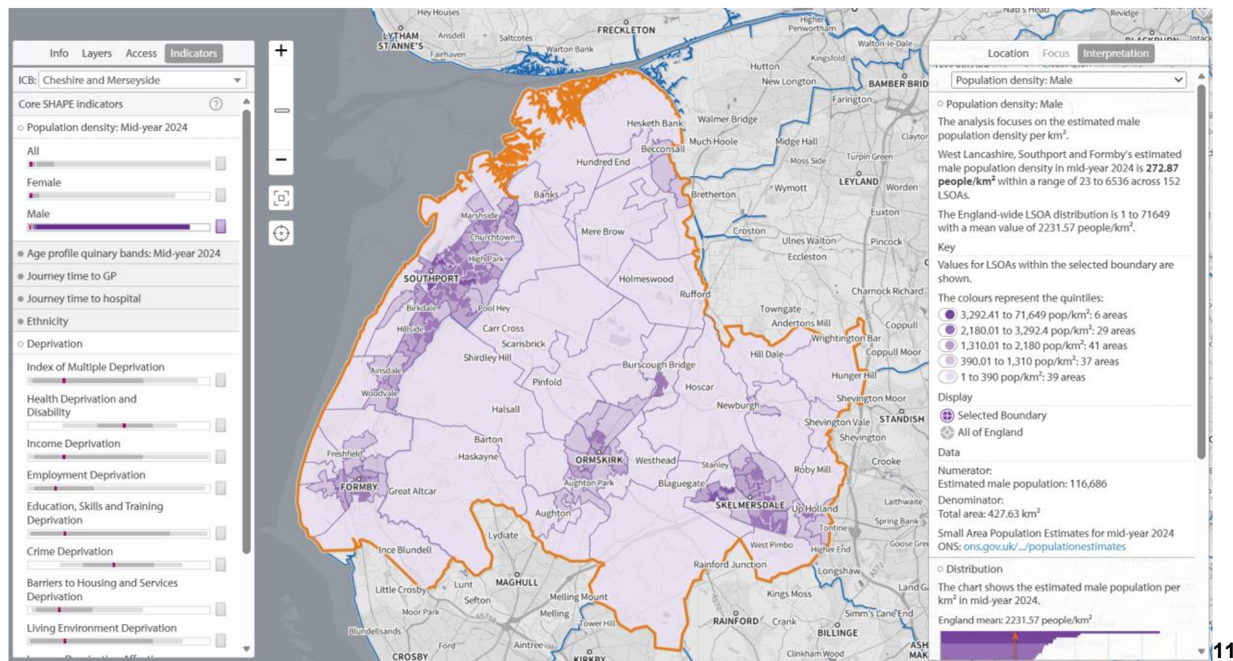
**Description:** This is the sex recorded by the person completing the census. The options were "Female" and "Male". [10]

As shown above, Sefton has very similar pattern in terms of the gender split compared to England overall, although both areas have slightly more women than men compared to the England statistics.

[10] Nomis - 2021 Census 2021 Area Profile - Sefton Local Authority

## Sex – geographic distribution

### Males – geographic distribution

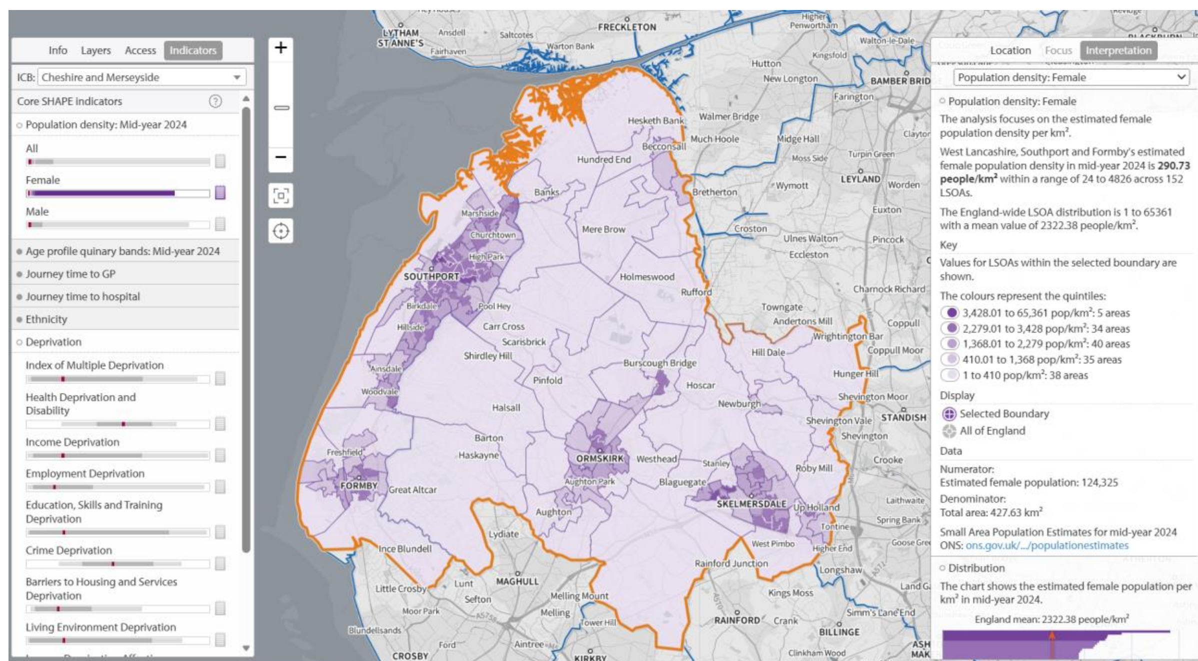


[11]

The map above shows the density of the male population and how this is spread geographically – the deeper the purple, the more densely populated the area is for men. As the map above shows there is a higher density of men located in the areas where there is a higher density of population generally (as expected), and in particular, in close proximity to the two hospital locations as well as the Skelmersdale Walk-in-centre and Ormskirk UTC.

[11] SHAPE Place • Population density: Mid-year 2024 • Population density: Male

## Females – geographic distribution




[12]

A similar pattern for females is observed in the map above in terms of where women are located, which aligns with where the overall population is denser.

## Age

The following section considers the Protected Characteristic of Age and the demographic profile across the area. The England comparator has been included below, to show that there is a 'population bulge' in the Age categories of 35 – 49 and 50 – 64. This shows therefore that approximately 40% of the population in England is aged 35-64.

---

[12] SHAPE Place • Population density: Mid-year 2024 • Population density: Female

## England comparator

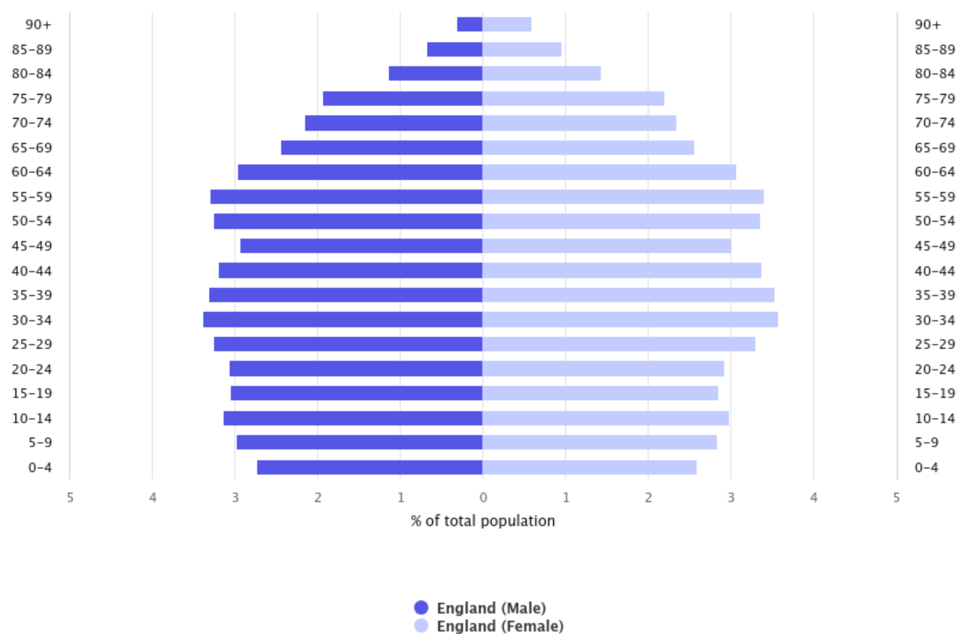
### Age

| | Persons | |
|---|---|---|
| | England<br>Country | |
| | count | % |
| All usual residents | 56,490,047 | 100.0 |
| Aged 4 years and under | 3,076,950 | 5.4 |
| Aged 5 to 9 years | 3,348,700 | 5.9 |
| Aged 10 to 15 years | 4,057,441 | 7.2 |
| Aged 16 to 19 years | 2,574,781 | 4.6 |
| Aged 20 to 24 years | 3,414,452 | 6.0 |
| Aged 25 to 34 years | 7,667,865 | 13.6 |
| Aged 35 to 49 years | 10,978,438 | 19.4 |
| Aged 50 to 64 years | 10,970,119 | 19.4 |
| Aged 65 to 74 years | 5,564,143 | 9.8 |
| Aged 75 to 84 years | 3,464,857 | 6.1 |
| Aged 85 years and over | 1,372,301 | 2.4 |

Source: ONS - 2021 Census (TS007B)

**Age information**

**Description:** A person's age on Census Day, 21 March 2021 in England and Wales. [13]



[14]

[13] Nomis - 2021 Census 2021 Area Profile - England Country
[14] Public Health Outcomes Framework - Data | Fingertips | Department of Health and Social Care

## Age - Sefton

### Age

| | Persons | |
|---|---|---|
| | Sefton<br>Local Authority | |
| | count | % |
| All usual residents | 279,233 | 100.0 |
| Aged 4 years and under | 13,508 | 4.8 |
| Aged 5 to 9 years | 15,071 | 5.4 |
| Aged 10 to 15 years | 18,264 | 6.5 |
| Aged 16 to 19 years | 11,062 | 4.0 |
| Aged 20 to 24 years | 13,500 | 4.8 |
| Aged 25 to 34 years | 32,374 | 11.6 |
| Aged 35 to 49 years | 49,087 | 17.6 |
| Aged 50 to 64 years | 61,604 | 22.1 |
| Aged 65 to 74 years | 33,385 | 12.0 |
| Aged 75 to 84 years | 22,027 | 7.9 |
| Aged 85 years and over | 9,351 | 3.3 |

Source: ONS - 2021 Census (TS007B)

**Age information**

**Description:** A person's age on Census Day, 21 March 2021 in England and Wales. [15]

[15] Nomis - 2021 Census 2021 Area Profile - Sefton Local Authority

[16]

**Sefton**

As the graph and table above shows, Sefton has a similar population distribution across Age as the overall England distribution. The distribution shows however that there are proportionally more 50-64 year olds (22.1%) compared to the England figure of 19.4%. The distribution bar chart above also shows the black line for the England figure, and this shows overall, that there are proportionally more older people in Sefton compared to England.

[16] Public Health Outcomes Framework - Data | Fingertips | Department of Health and Social Care

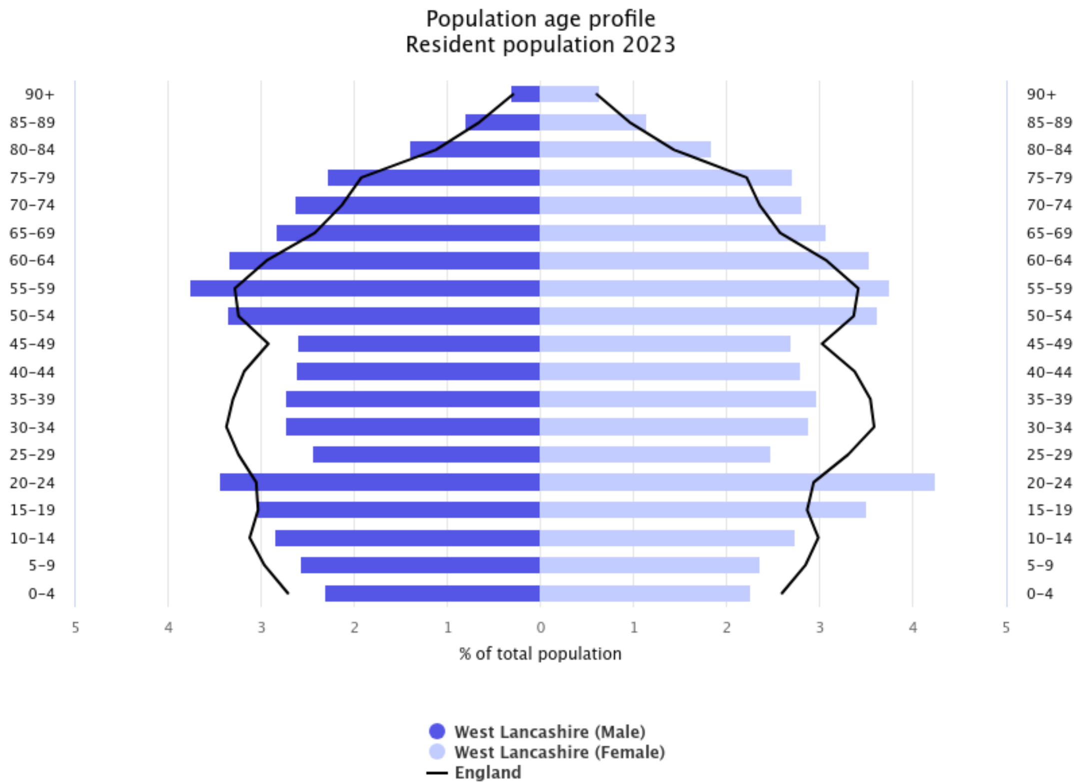
## Age - West Lancashire

### Age

| | Persons | |
|---|---|---|
| | West Lancashire<br>Local Authority | |
| | count | % |
| All usual residents | 117,431 | 100.0 |
| Aged 4 years and under | 5,246 | 4.5 |
| Aged 5 to 9 years | 6,022 | 5.1 |
| Aged 10 to 15 years | 7,828 | 6.7 |
| Aged 16 to 19 years | 7,606 | 6.5 |
| Aged 20 to 24 years | 8,100 | 6.9 |
| Aged 25 to 34 years | 12,369 | 10.5 |
| Aged 35 to 49 years | 19,471 | 16.6 |
| Aged 50 to 64 years | 25,066 | 21.3 |
| Aged 65 to 74 years | 13,706 | 11.7 |
| Aged 75 to 84 years | 8,931 | 7.6 |
| Aged 85 years and over | 3,086 | 2.6 |

[17]

[17] Nomis - 2021 Census 2021 Area Profile - West Lancashire Local Authority



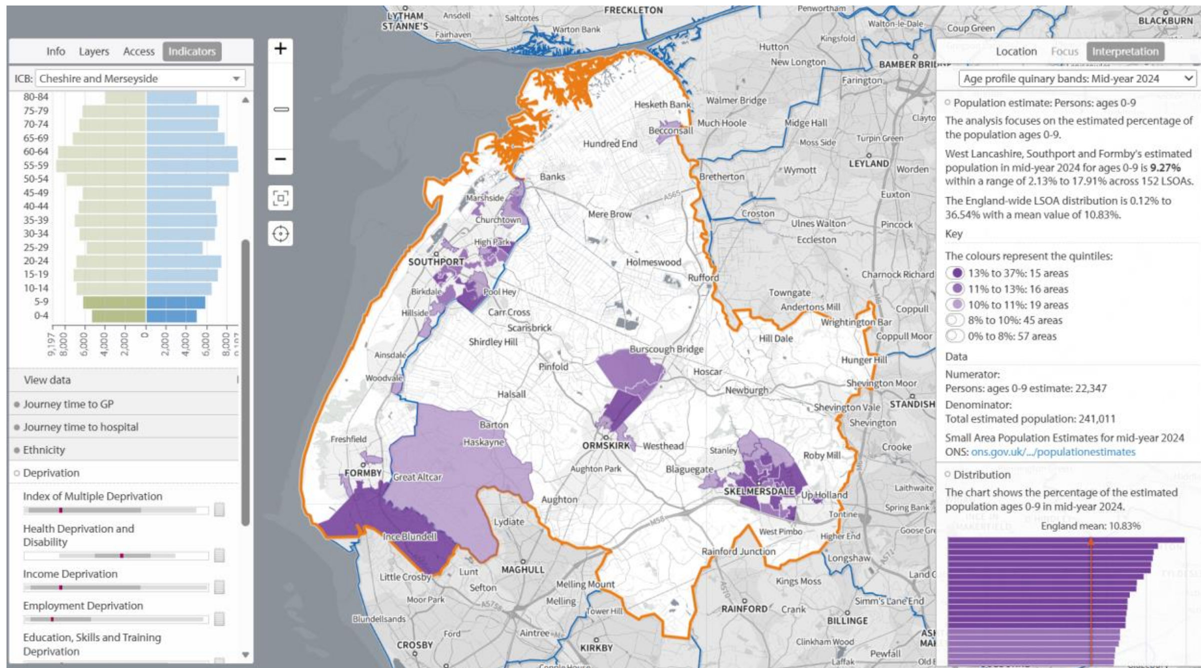

**18**

As the table and graph above show, West Lancashire is similar with a higher proportion of its population in the older Age categories) but this is less significant than in Sefton in terms of the distribution of older people. Sefton also has a much higher population count.

Sefton therefore has a more significant older population both in terms of actual numbers of older and the proportion of the population that are older compared to West Lancashire. For example, Sefton has 33,385 people Aged between 65-74 years, compared to 13,706 for West Lancashire. This is important to note as Age is a Protected Characteristic and there is a more significant older population within Sefton (which is the area close to Southport and Formby District General Hospital, than there is to West Lancashire (which is close to Ormskirk District General Hospital).

[18] Public Health Outcomes Framework - Data | Fingertips | Department of Health and Social Care

## Younger people - Geographic Distribution: 0 – 9 Years

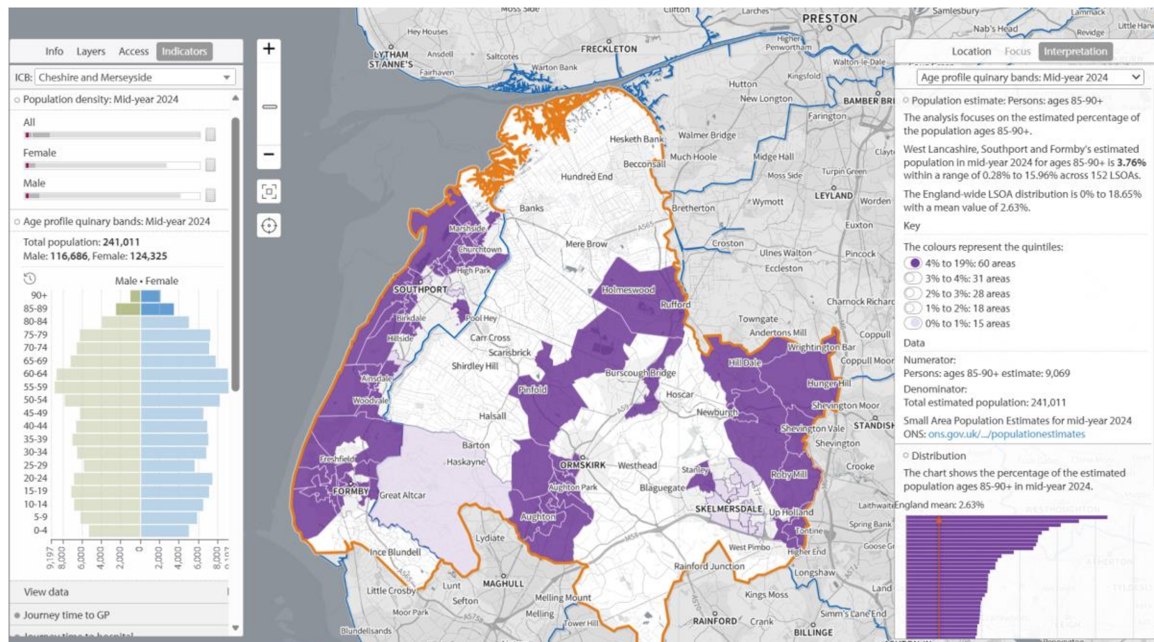



19

The map above shows the geographic distribution of younger people (aged 0-9 years). The areas shaded in purple show where there are more dense clusters of 0-9 year olds. This shows there is a significant cluster to the Southwest of the area (close to Formby centre). There are also significant clusters around the two major hospital locations, as well as the UTC and Walk-in Centre in Skelmersdale. These may show the clusters are more significant around Ormskirk District General Hospital UTC and Skelmersdale Walk-In Centre than for Southport and Formby District General Hospital.

[19] SHAPE Place • Southport and Formby • West Lancashire

## Older people - Geographic Distribution: 85 + years

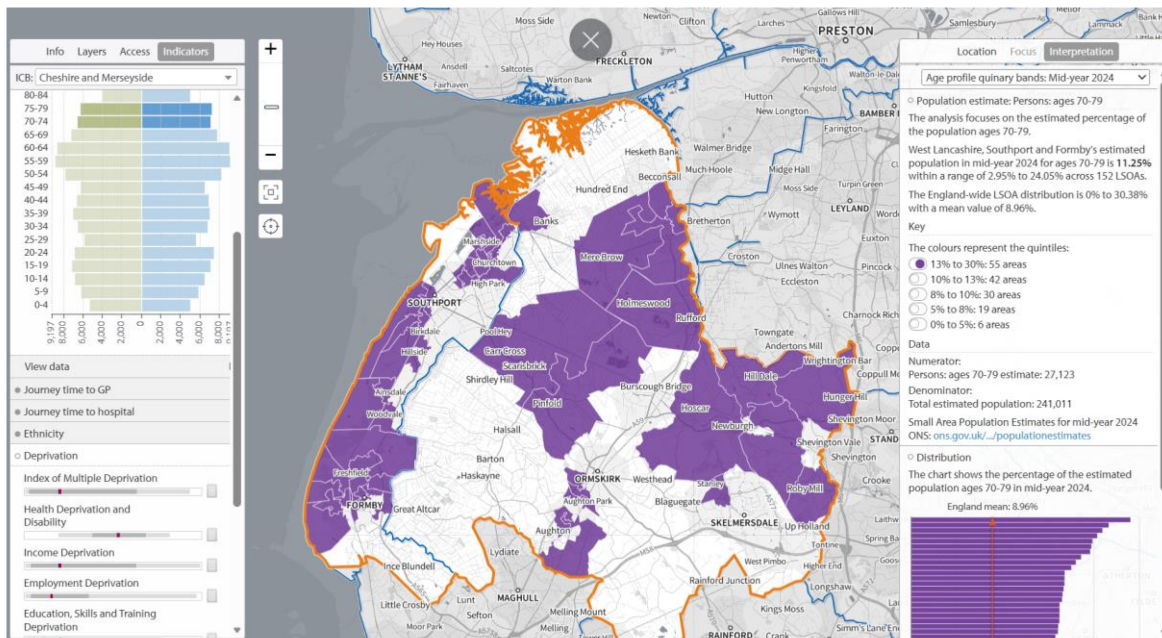



[20]

The map above shows the geographic distribution of older people who are 85+ years of age. The areas shown in purple are where there is a higher density of 85+ years. This is important to consider in terms of the two hospital locations as decisions that are made need to be carefully considered in terms of how they will impact on this group (as well as other vulnerable Protected Characteristic groups, for example, younger people). As the map shows, there are three strips of more densely populated areas for the 85+ year olds and these cluster around the two main hospital sites as well as close to Skelmersdale. There is therefore a relatively balanced spread of older people across the area.

[20] SHAPE Place • Southport and Formby • West Lancashire

## Older people - Geographic Distribution: 70-79




[21]

As the map above shows, there is a similar pattern of more dense geographic dispersal for 70-79 year olds as there is for the 85+ age group, with clustering close to the two main hospital sites as well as north of Skelmersdale.

[21] SHAPE Place • Southport and Formby • West Lancashire

### Ethnicity

The Protected Characteristic of Ethnicity is considered in the next section.

### England – comparator

**Ethnic group, national identity, language and religion**

**Ethnic group**

| | Persons | |
|---|---|---|
| | England Country | |
| | count | % |
| All usual residents | 56,490,048 | 100.0 |
| Asian, Asian British or Asian Welsh | 5,426,392 | 9.6 |
| Black, Black British, Black Welsh, Caribbean or African | 2,381,724 | 4.2 |
| Mixed or Multiple ethnic groups | 1,669,378 | 3.0 |
| White | 45,783,401 | 81.0 |
| Other ethnic group | 1,229,153 | 2.2 |

In order to protect against disclosure of personal information, records have been swapped between different geographic areas and counts perturbed by small amounts. Small counts at the lowest geographies will be most affected.

Source: ONS - 2021 Census (TS021)

**Ethnic group information**

**Description:** The ethnic group that the person completing the census feels they belong to. This could be based on their culture, family background, identity or physical appearance.
Respondents could choose one out of 19 tick-box response categories, including write-in response options.

[22]

Referring to the England comparator, there is a predominantly White population of 81% across England. The largest ethnic minority group in England is Asian at 9.6%, followed by Black 4.2%, Mixed 3.0% and the Other Ethnic group being 2.2%.

[22] Nomis - 2021 Census 2021 Area Profile - England Country

## Ethnicity - Sefton

### Ethnic group, national identity, language and religion

#### Ethnic group

| | Persons | |
|---|---|---|
| | Sefton Local Authority | |
| | count | % |
| All usual residents | 279,233 | 100.0 |
| Asian, Asian British or Asian Welsh | 4,294 | 1.5 |
| Black, Black British, Black Welsh, Caribbean or African | 1,509 | 0.5 |
| Mixed or Multiple ethnic groups | 4,056 | 1.5 |
| White | 267,540 | 95.8 |
| Other ethnic group | 1,834 | 0.7 |

In order to protect against disclosure of personal information, records have been swapped between different geographic areas and counts perturbed by small amounts. Small counts at the lowest geographies will be most affected.

Source: ONS - 2021 Census (TS021)

#### Ethnic group information

**Description:** The ethnic group that the person completing the census feels they belong to. This could be based on their culture, family background, identity or physical appearance.
Respondents could choose one out of 19 tick-box response categories, including write-in response options.

[23]

The Sefton area has a lower minority ethnic population than in England, with much smaller percentage populations across the various ethnic groups. For example, 1.5% Asian compared to 9.6% across England and 0.5% Black compared to 4.2% across England. The Mixed Ethnic population is however slightly higher at 1.5% when comparing the percentage figure to England – which is 3%.

[23] Nomis - 2021 Census 2021 Area Profile - Sefton Local Authority

## Ethnicity – West Lancashire

### Ethnic group, national identity, language and religion

#### Ethnic group

| | Persons | |
|---|---|---|
| | West Lancashire Local Authority | |
| | count | % |
| All usual residents | 117,429 | 100.0 |
| Asian, Asian British or Asian Welsh | 1,232 | 1.0 |
| Black, Black British, Black Welsh, Caribbean or African | 388 | 0.3 |
| Mixed or Multiple ethnic groups | 1,547 | 1.3 |
| White | 113,795 | 96.9 |
| Other ethnic group | 467 | 0.4 |

In order to protect against disclosure of personal information, records have been swapped between different geographic areas and counts perturbed by small amounts. Small counts at the lowest geographies will be most affected.

Source: ONS - 2021 Census (TS021)

**Ethnic group information**

**Description:** The ethnic group that the person completing the census feels they belong to. This could be based on their culture, family background, identity or physical appearance.
Respondents could choose one out of 19 tick-box response categories, including write-in response options.

[24]

The West Lancashire area also has lower minority ethnic population than in England, and also a slightly lower minority ethnic population than the Sefton area. For example, 1.0% Asian and only 0.3 Black. Similarly to the Sefton area, there is however a 1.3% mixed population, compared to the England comparative figure of 3%.

## Ethnicity – Geographic dispersal

Where different ethnic groups are located is an important factor to consider in relation to the decisions to be made (as this is also a Protected Characteristic under the Equality Act 2010), and in particular, how this maps against areas of deprivation. This is because the combination of high levels of deprivation and Ethnicity generates a significant potential for high levels of health inequality.

[24] Nomis - 2021 Census 2021 Area Profile - West Lancashire Local Authority

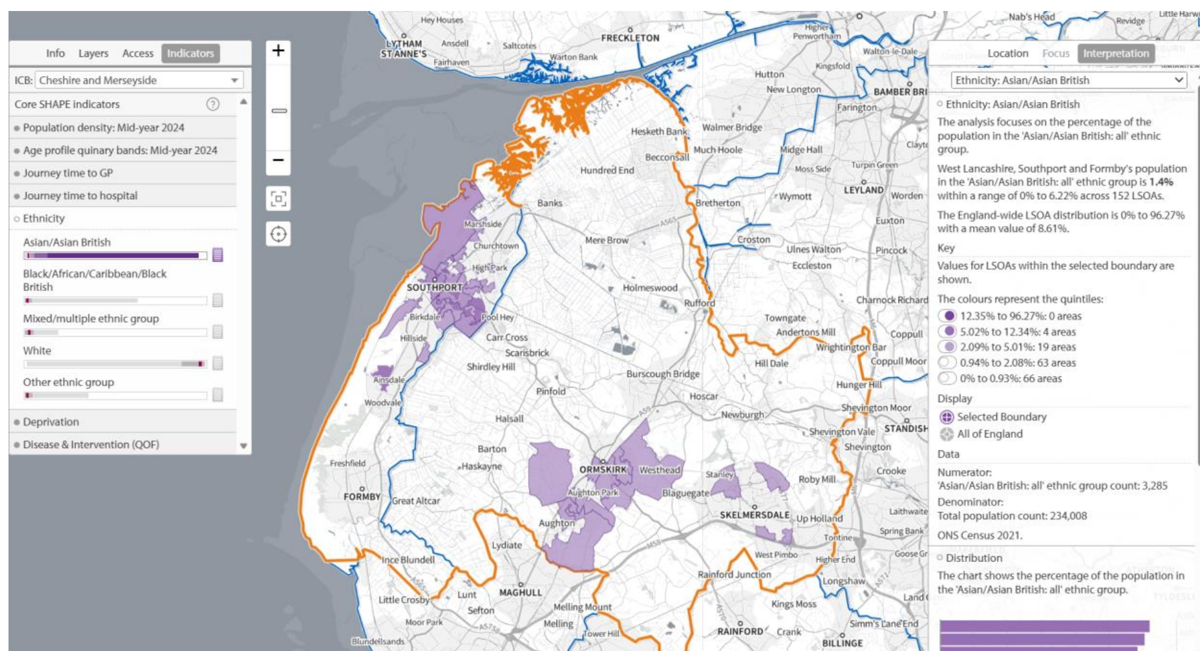
The series of maps below shows the main different ethnic categories from the Census 2021, including, Asian/Asian British, Black/African/Caribbean/Black British, Mixed/multiple ethnic group and Other ethnic group.

The maps show the ethnic groups represented in shades of purple, with the darker the purple, the more significant the ethnic population is within that shaded area.

Whilst there is some variation across the different ethnic groups, there is a very similar general clustering of higher ethnic populations to the clusters of higher levels of deprivation (shown on previous maps in this section). This demonstrates that there is likely to be a correlation between low socio-economic groups and also more densely populated ethnic areas – which is consistent with wider research that shows that ethnic minority groups are often also in low socio-economic groups, and that the combination of low socio-economic status and non-White British Ethnicity can generate issues of inequality (including health inequality). For example, the Report an Anatomy of Inequality in the UK shows this striking correlation[25]

As stated, there is slight variation in demographic distribution across the different ethnic groups and these are now considered separately below:

### Asian/Asian British – Geographic Distribution




[26]

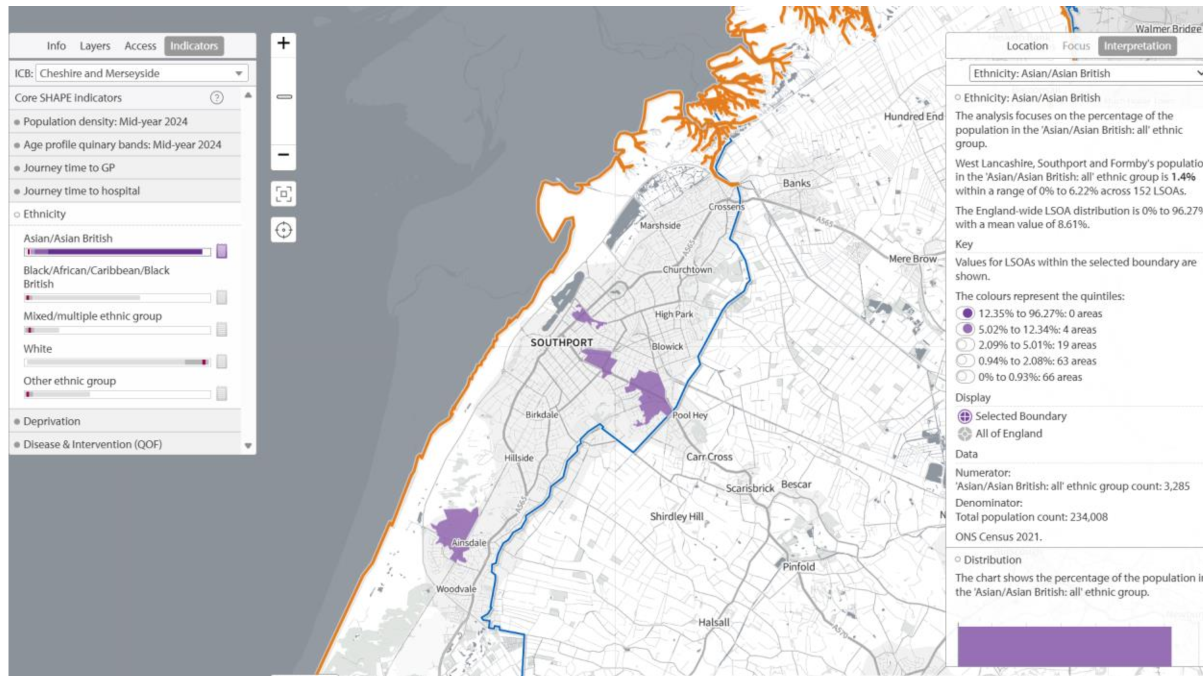
The clusters of the Asian/Asian British population that are shown as purple shading (with the darker shading showing more densely populated areas) correspond to the locations of

[25] https://researchonline.lse.ac.uk/id/eprint/28344/1/CASEreport60.pdf

[26] SHAPE Place • Ethnicity • Ethnicity: Asian/Asian British

Southport and Formby, Ormskirk District General Hospital and Skelmersdale which are also the areas of most significant deprivation (as shown within other sections of this report).

The most densely populated areas are in close proximity to Southport and Formby District General Hospital. This is shown on the revised map below that screens out the less densely populated Asian/Asian British areas. The map has also been enlarged to emphasise the specific location of the more densely populated clusters.




27

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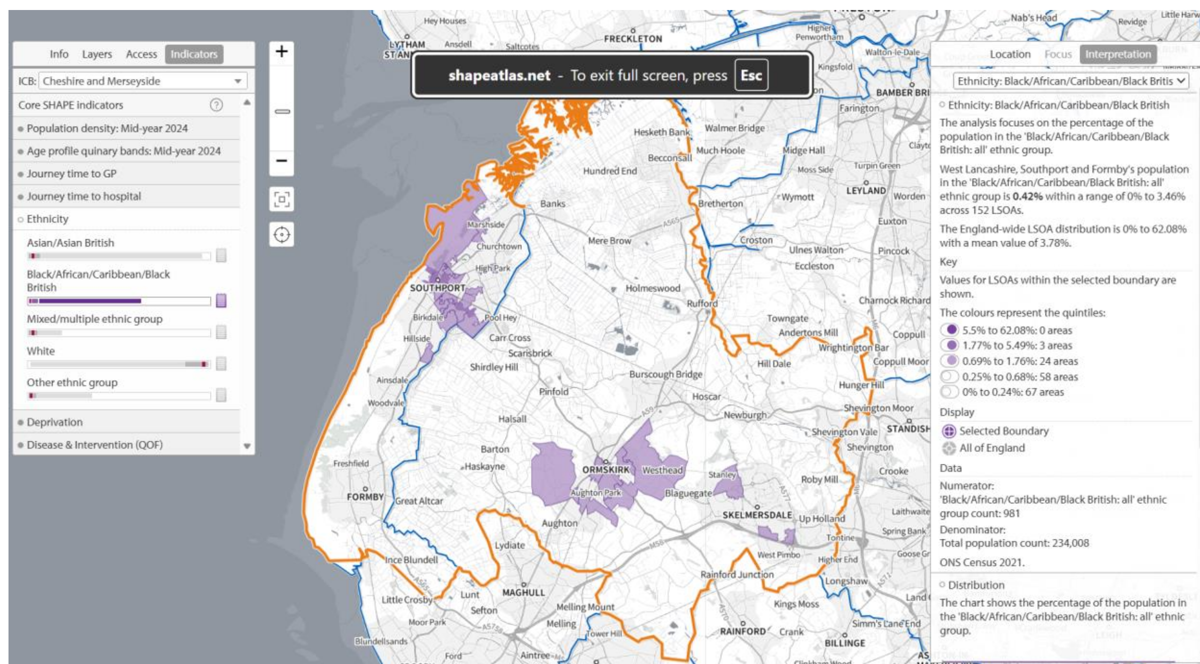
[27] SHAPE Place • Ethnicity •

## Black/African/Caribbean/Black British - **Geographic Distribution**




28

There are clusters of Black/African/Caribbean/Black British in close proximity to Southport and Formby District General Hospital, Ormskirk District General Hospital, UTC and Skelmersdale Walk-in Centre (which also corresponds to the clusters of areas of highest deprivation). The most densely populated cluster is located next to Southport and Formby District General Hospital. This is shown on the enlarged map below:

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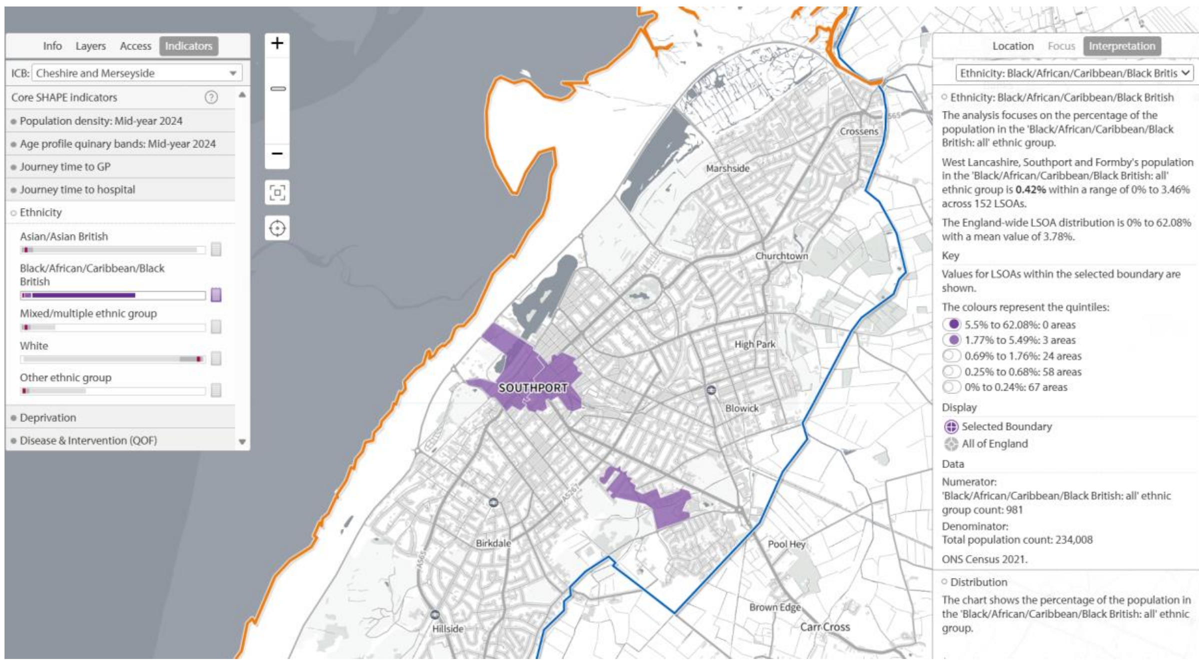
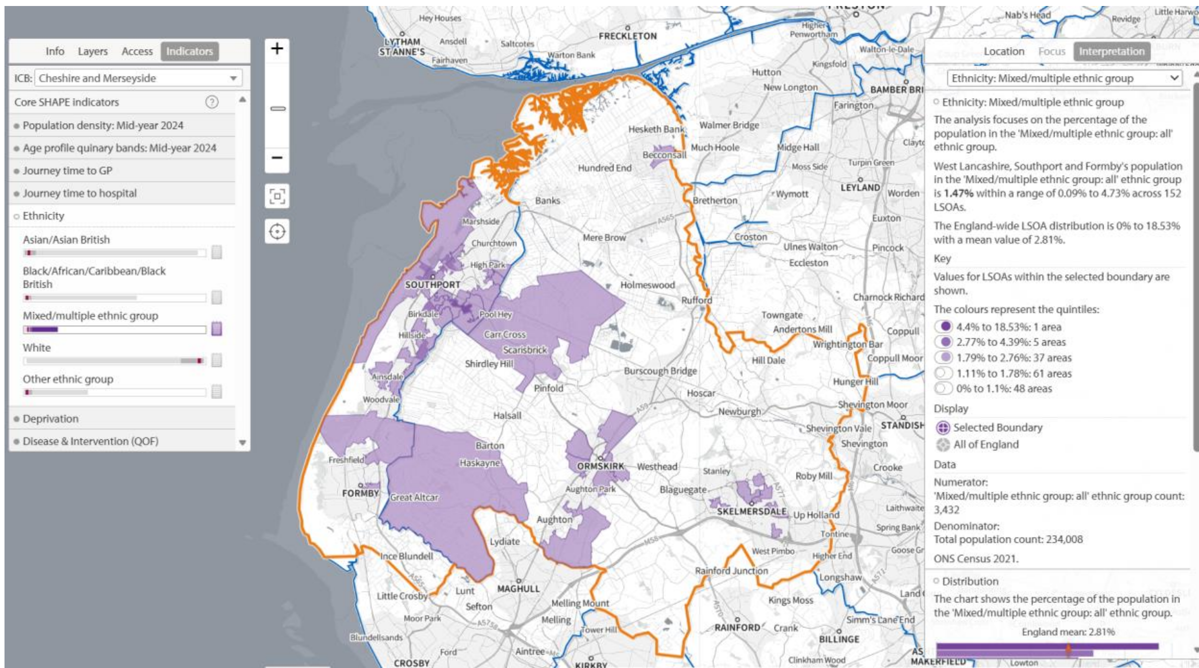
[28] SHAPE Place • Ethnicity •




[29]

## Mixed/multiple ethnic group - **Geographic Distribution**

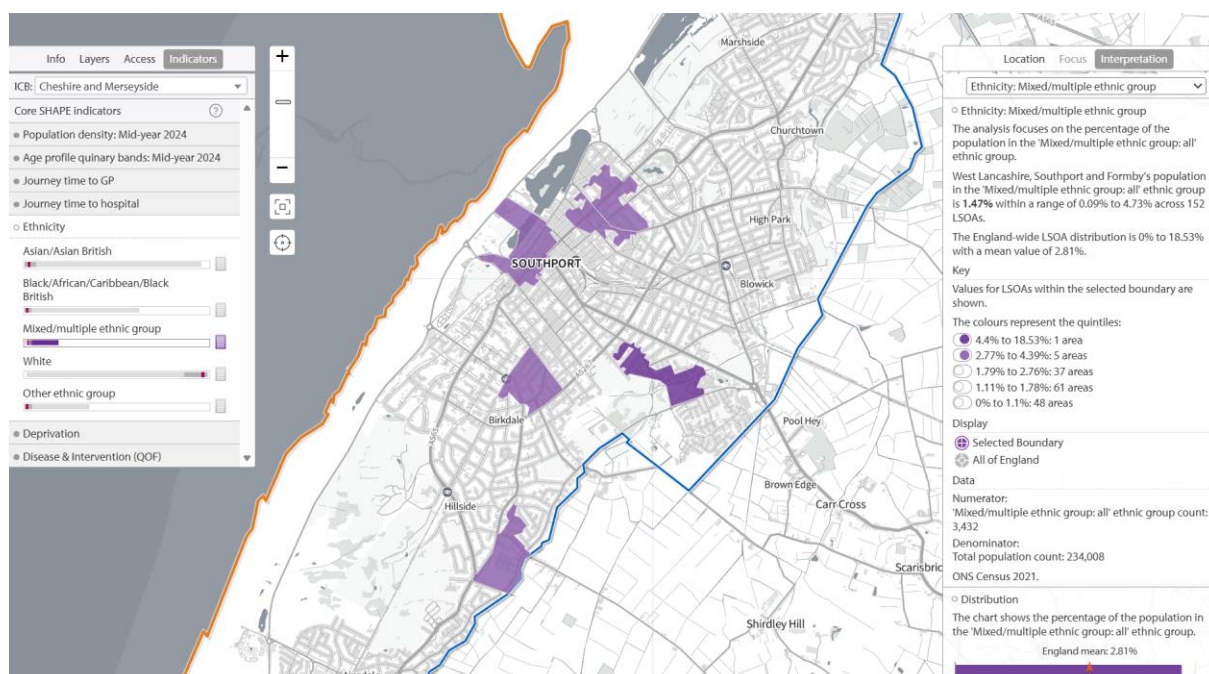



[29] SHAPE Place • Ethnicity •

[30]

In terms of the mixed/multiple ethnic group (shown above) this again shows a similar pattern of being clustered around the hospital sites of Ormskirk District General Hospital and Southport and Formby District General Hospital as well as also close to Skelmersdale Walk-in Centre. There is also an area to the Southwest of the region (shown as a section of lighter purple) close to Formby where there is a less densely populated area of mixed/multiple Ethnicity.

The most densely populated spots are close to Southport and Formby District General Hospital, as shown in the map below (where the lesser densely populated areas have been removed, leaving the most densely populated ethnic clusters, the areas where this is present has also been enlarged).

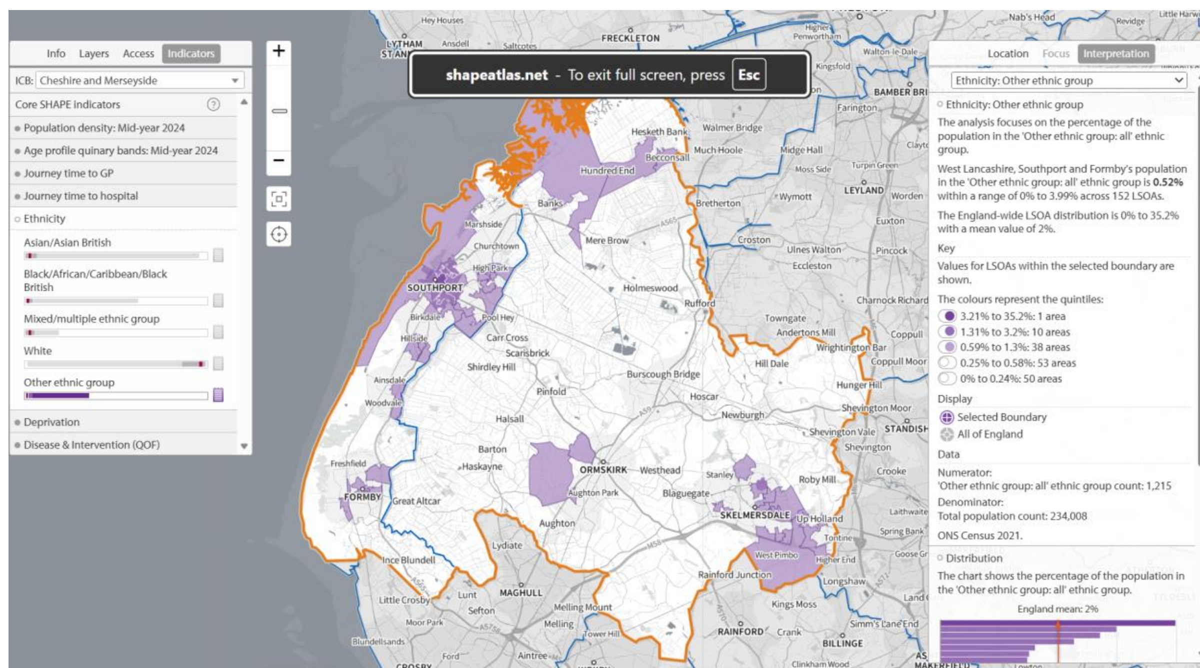



[31]

30 SHAPE Place • Ethnicity • Ethnicity: Mixed/multiple ethnic group

31 SHAPE Place • Ethnicity • Ethnicity: Mixed/multiple ethnic group

## Other ethnic groups - **Geographic Distribution**

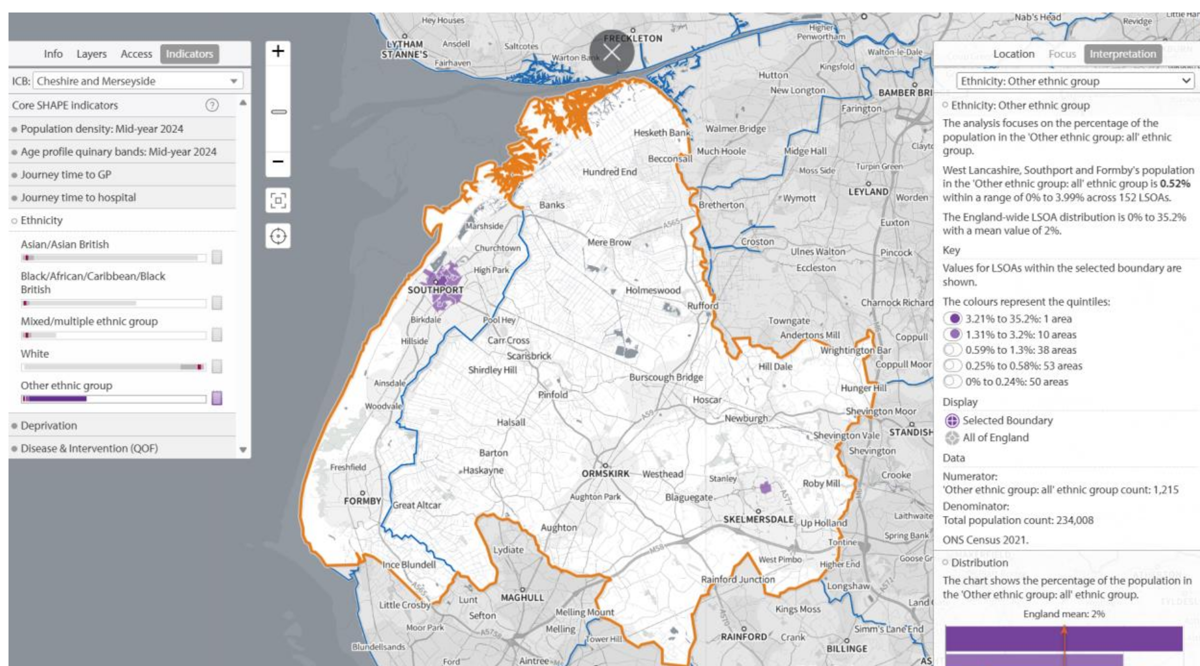



[32]

The ‘other ethnic group’ shows again a similar pattern of being in close proximity to the existing sites of the two hospitals and also Skelmersdale Walk-in Centre.

The most densely populated area for the ‘other ethnic group’ is in close proximity to Southport and Formby District General Hospital as well as a small cluster next to Skelmersdale - which is demonstrated on the revised map below, by screening out the less densely populated ‘other ethnic’ areas.

[32] SHAPE Place • Ethnicity • Ethnicity: Other ethnic group




[33]

## Disability

Disability is also important to consider, as Disability is a Protected Characteristic covered by the Equality Act 2010 and issues of significant inequality for disabled people are often also accompanied by issues of deprivation. It is therefore important to consider how this looks within the local area where significant decisions are being made about healthcare provision that could affect this very vulnerable group.

Comparing the local demographics to the overall Census 2021 statistics for England is a helpful comparator. The table below shows the statistics for disability across England. This shows that 17% of the total population has a disability according to the 2021 Census 2021 statistics. In addition, there is 6.8% of the population that has a long term physical or mental-health issues but day-to-day activities are not limited. 76% of the population does not identify as being disabled under the Equality Act.

[33] SHAPE Place • Ethnicity • Ethnicity: Other ethnic group

## England Comparator - Disability

**Long term health problem or disability**

| | England Country count | England Country % |
|---|---|---|
| All usual residents | 56,490,048 | 100.0 |
| Disabled under the Equality Act: Day-to-day activities limited a lot | 4,140,357 | 7.3 |
| Disabled under the Equality Act: Day-to-day activities limited a little | 5,634,153 | 10.0 |
| Not disabled under the Equality Act: Has long term physical or mental health condition but day-to-day activities are not limited | 3,856,029 | 6.8 |
| Not disabled under the Equality Act: No long term physical or mental health conditions | 42,859,509 | 75.9 |

Persons

In order to protect against disclosure of personal information, records have been swapped between different geographic areas and counts perturbed by small amounts. Small counts at the lowest geographies will be most affected.

Source: ONS - 2021 Census (TS038)

**Disability information**

**Description:** People who assessed their day-to-day activities as limited by long-term physical or mental health conditions or illnesses are considered disabled. This definition of a disabled person meets the harmonised standard for measuring disability and is in line with the Equality Act (2010).

[34]

## Sefton – Disability

The disability statistics for Sefton can be found in the table below. This shows that in comparison to England there is a higher proportion of the population that identifies as being disabled and limited a lot in their daily activities (10.7%), compared to the 7.3% wider England statistic. The statistic for being disabled and limited a little is also slightly higher in Sefton at 11.2% compared to the England figure of 10%.

**Long term health problem or disability**

| | Sefton Local Authority count | Sefton Local Authority % |
|---|---|---|
| All usual residents | 279,234 | 100.0 |
| Disabled under the Equality Act: Day-to-day activities limited a lot | 29,863 | 10.7 |
| Disabled under the Equality Act: Day-to-day activities limited a little | 31,271 | 11.2 |
| Not disabled under the Equality Act: Has long term physical or mental health condition but day-to-day activities are not limited | 19,258 | 6.9 |
| Not disabled under the Equality Act: No long term physical or mental health conditions | 198,842 | 71.2 |

Persons

In order to protect against disclosure of personal information, records have been swapped between different geographic areas and counts perturbed by small amounts. Small counts at the lowest geographies will be most affected.

Source: ONS - 2021 Census (TS038)

**Disability information**

**Description:** People who assessed their day-to-day activities as limited by long-term physical or mental health conditions or illnesses are considered disabled. This definition of a disabled person meets the harmonised standard for measuring disability and is in line with the Equality Act (2010).

[35]

[34] Nomis - 2021 Census 2021 Area Profile - England Country

[35] Nomis - 2021 Census 2021 Area Profile - Sefton Local Authority

### West Lancashire - Disability

The Census 2021 figures for West Lancashire are shown below, which shows 8.9% of those in West Lancashire identify as being 'Disabled and limited a lot' which is less compared to Sefton (10.7%), but this is more than the England figure of 7.3%. The percentage of residents who are disabled and limited a little in West Lancashire is 10.5% which is similar to the Sefton figure of 11.2%.

**Long term health problem or disability**

| | West Lancashire Local Authority (Persons) | |
|---|---|---|
| | count | % |
| All usual residents | 117,428 | 100.0 |
| Disabled under the Equality Act: Day-to-day activities limited a lot | 10,398 | 8.9 |
| Disabled under the Equality Act: Day-to-day activities limited a little | 12,378 | 10.5 |
| Not disabled under the Equality Act: Has long term physical or mental health condition but day-to-day activities are not limited | 8,435 | 7.2 |
| Not disabled under the Equality Act: No long term physical or mental health conditions | 86,217 | 73.4 |

In order to protect against disclosure of personal information, records have been swapped between different geographic areas and counts perturbed by small amounts. Small counts at the lowest geographies will be most affected.

Source: ONS - 2021 Census (TS038)

**Disability information**

**Description:** People who assessed their day-to-day activities as limited by long-term physical or mental health conditions or illnesses are considered disabled. This definition of a disabled person meets the harmonised standard for measuring disability and is in line with the Equality Act (2010).

[36]

### Unpaid Carers

Unpaid care is an important demographic to consider as people who are caring for someone who is disabled, are also protected under the Equality Act 2010, through something termed 'Associate Discrimination'. It is therefore very important to also consider any impacts of service changes on carers. In addition, research shows that people who have caring responsibilities are often also within lower socio-economic groups (due to being unable to work whilst providing high levels of ongoing personal care) and so are often also disadvantaged. For example, the recent report released by Carers UK **"Poverty and financial hardship of unpaid carers in the UK"** [37]**.**

[36] Nomis - 2021 Census 2021 Area Profile - West Lancashire Local Authority

[37] https://www.carersuk.org/reports/poverty-and-financial-hardship-of-unpaid-carers-in-the-uk/

### England Comparator - Unpaid Care

**Provision of unpaid care**

| | Persons England Country count | % |
|---|---|---|
| All usual residents aged 5 and over | 53,413,098 | 100.0 |
| Provides no unpaid care | 48,734,833 | 91.2 |
| Provides 19 hours or less unpaid care a week | 2,303,725 | 4.3 |
| Provides 20 to 49 hours unpaid care a week | 969,769 | 1.8 |
| Provides 50 or more hours unpaid care a week | 1,404,771 | 2.6 |

In order to protect against disclosure of personal information, records have been swapped between different geographic areas and counts perturbed by small amounts. Small counts at the lowest geographies will be most affected.

Source: ONS - 2021 Census (TS039)

**Provision of unpaid care information**

**Description:** An unpaid carer may look after, give help or support to anyone who has long-term physical or mental ill-health conditions, illness or problems related to old age.
This does not include any activities as part of paid employment.
This help can be within or outside of the carer's household. [38]

As the England table above shows, 91.2% of people across England do not provide any unpaid care, with 4.3% providing 19 hours or less, 1.8% providing 20 to 49 hours and 2.6% of the England population provides 50 or more hours of unpaid care each week.

[38] Nomis - 2021 Census 2021 Area Profile - England Country

## Sefton - Unpaid Care

### Provision of unpaid care

| | Persons | |
|---|---|---|
| | Sefton Local Authority | |
| | count | % |
| All usual residents aged 5 and over | 265,725 | 100.0 |
| Provides no unpaid care | 236,703 | 89.1 |
| Provides 19 hours or less unpaid care a week | 13,169 | 5.0 |
| Provides 20 to 49 hours unpaid care a week | 6,495 | 2.4 |
| Provides 50 or more hours unpaid care a week | 9,358 | 3.5 |

In order to protect against disclosure of personal information, records have been swapped between different geographic areas and counts perturbed by small amounts. Small counts at the lowest geographies will be most affected.

Source: ONS - 2021 Census (TS039)

**Provision of unpaid care information**

**Description:** An unpaid carer may look after, give help or support to anyone who has long-term physical or mental ill-health conditions, illness or problems related to old age.
This does not include any activities as part of paid employment.
This help can be within or outside of the carer's household.

[39]

The table above for Sefton shows there is a higher proportion of unpaid carers, with 10.9% of the population providing unpaid care than across England (8.7%). In terms of those who provide 50 hours more care a week (the most vulnerable group), 3.5% of the Sefton population provides this compared to 2.6% across England.

[39] Nomis - 2021 Census 2021 Area Profile - Sefton Local Authority

### West Lancashire - Unpaid Care

**Provision of unpaid care**

| | West Lancashire Local Authority (Persons) | |
|---|---|---|
| | count | % |
| All usual residents aged 5 and over | 112,183 | 100.0 |
| Provides no unpaid care | 100,874 | 89.9 |
| Provides 19 hours or less unpaid care a week | 5,533 | 4.9 |
| Provides 20 to 49 hours unpaid care a week | 2,215 | 2.0 |
| Provides 50 or more hours unpaid care a week | 3,561 | 3.2 |

In order to protect against disclosure of personal information, records have been swapped between different geographic areas and counts perturbed by small amounts. Small counts at the lowest geographies will be most affected.

Source: ONS - 2021 Census (TS039)

**Provision of unpaid care information**

**Description:** An unpaid carer may look after, give help or support to anyone who has long-term physical or mental ill-health conditions, illness or problems related to old age.
This does not include any activities as part of paid employment.
This help can be within or outside of the carer's household. [40]

The table above for West Lancashire shows that there is a very similar proportion of unpaid carers to Sefton (just over 10%), which shows a pattern therefore of a slightly higher proportion of unpaid carers in the local area compared to the England Census 2021 statistic (8.7%.)

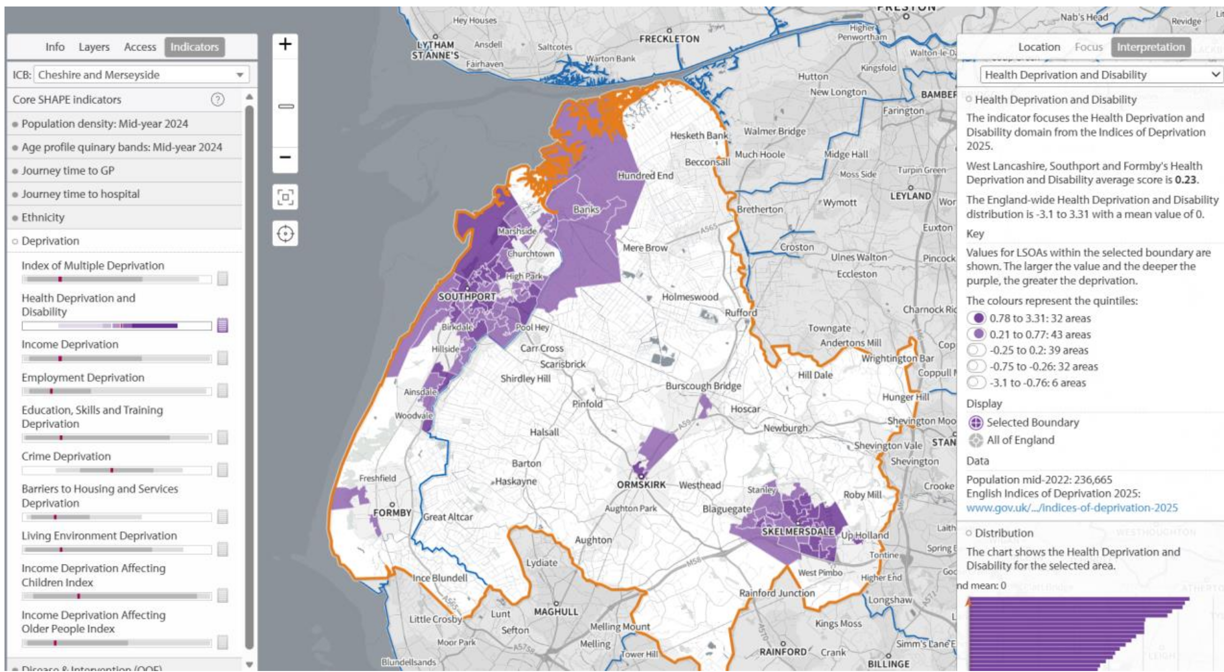
### Disability and Deprivation - Geographic dispersal

It is important to understand where disability deprivation is located, in relation to the geography of hospital locations where changes to services and their locations are being considered. The reason being, when low income and disability is combined, the impact is significant as using public travel is that much harder for disabled people, and low income often means that accessing private transport, or hiring a taxi is not financially accessible, so moving services further away from groups such as this has significant impact.

The map below shows where health deprivation and disability are located. The larger the value and the deeper the purple is showing on the map, the more significant the disability deprivation.

The pattern of deprivation and disability is again very similar to where general deprivation is located within the area, with the most significant prevalence of this being within close proximity to Southport and Formby District General Hospital, with another significant cluster around Skelmersdale and then a smaller cluster around Ormskirk District General Hospital.

[40] Nomis - 2021 Census 2021 Area Profile - West Lancashire Local Authority




[41]

## Sexual Orientation

The following section considers the Protected Characteristic of Sexual Orientation. The England comparator table below shows that across England there are 89.4% who identify as being Straight or Heterosexual, with 3.2% of people selecting an identity other than Straight or Heterosexual.

[41] SHAPE Place • Deprivation • Health Deprivation and Disability

## England Comparator - Sexual Orientation

### Sexual Orientation

| | Persons | |
|---|---|---|
| | England Country | |
| | count | % |
| All usual residents aged 16 and over | 46,006,957 | 100.0 |
| Straight or Heterosexual | 41,114,478 | 89.4 |
| Gay or Lesbian | 709,704 | 1.5 |
| Bisexual | 591,690 | 1.3 |
| Pansexual | 45,435 | 0.1 |
| Asexual | 26,614 | 0.1 |
| Queer | 13,928 | 0.0 |
| All other sexual orientations | 72,380 | 0.2 |
| Not answered | 3,432,728 | 7.5 |

In order to protect against disclosure of personal information, records have been swapped between different geographic areas and counts perturbed by small amounts. Small counts at the lowest geographies will be most affected.

Source: ONS - 2021 Census (TS079)

**Sexual orientation information**

**Description:** Classifies people according to the responses to the sexual orientation question. This question was voluntary and was only asked of people aged 16 years and over.

[42]

## Sefton – Sexual Orientation

The table below shows the Census 2021 statistics for Sefton. This shows that Sefton has very similar Census 2021 statistics in terms of the amount of people saying they are Straight or Heterosexual. In addition, the pattern across the other categories is also very similar, for example, 1.4% of the population identifying with being Gay or Lesbian (which is similar to the England figure of 1.5%).

[42] Nomis - 2021 Census 2021 Area Profile - England Country

### Sefton - Sexual Orientation

**Sexual Orientation**

| | Persons | |
|---|---|---|
| | Sefton Local Authority | |
| | count | % |
| All usual residents aged 16 and over | 232,390 | 100.0 |
| Straight or Heterosexual | 212,421 | 91.4 |
| Gay or Lesbian | 3,301 | 1.4 |
| Bisexual | 2,024 | 0.9 |
| Pansexual | 160 | 0.1 |
| Asexual | 98 | 0.0 |
| Queer | 25 | 0.0 |
| All other sexual orientations | 210 | 0.1 |
| Not answered | 14,151 | 6.1 |

In order to protect against disclosure of personal information, records have been swapped between different geographic areas and counts perturbed by small amounts. Small counts at the lowest geographies will be most affected.

Source: ONS - 2021 Census (TS079)

**Sexual orientation information**

**Description:** Classifies people according to the responses to the sexual orientation question. This question was voluntary and was only asked of people aged 16 years and over. [43]

### West Lancashire – Sexual Orientation

The table below shows the Census 2021 statistics for West Lancashire, and the pattern is also very similar to Sefton and England.

[43] Nomis - 2021 Census 2021 Area Profile - Sefton Local Authority

**Sexual Orientation**

| | West Lancashire Local Authority | | England Country | |
|---|---|---|---|---|
| | count | % | count | % |
| All usual residents aged 16 and over | 98,332 | 100.0 | 46,006,957 | 100.0 |
| Straight or Heterosexual | 89,277 | 90.8 | 41,114,478 | 89.4 |
| Gay or Lesbian | 1,240 | 1.3 | 709,704 | 1.5 |
| Bisexual | 1,246 | 1.3 | 591,690 | 1.3 |
| Pansexual | 85 | 0.1 | 45,435 | 0.1 |
| Asexual | 76 | 0.1 | 26,614 | 0.1 |
| Queer | 20 | 0.0 | 13,928 | 0.0 |
| All other sexual orientations | 100 | 0.1 | 72,380 | 0.2 |
| Not answered | 6,288 | 6.4 | 3,432,728 | 7.5 |

Persons

In order to protect against disclosure of personal information, records have been swapped between different geographic areas and counts perturbed by small amounts. Small counts at the lowest geographies will be most affected.

Source: ONS - 2021 Census (TS079)

44

## Marriage and Civil Partnership

The following section considers the 2021 Census 2021 statistics for Marriage and Civil Partnership. This shows that, across England, there is 44.7% of the population who are married or in a civil partnership.

## England Comparator – Marriage & Civil Partnership

**Legal partnership status**

| | England Country | |
|---|---|---|
| | count | % |
| All usual residents aged 16 and over | 46,006,957 | 100.0 |
| Never married and never registered a civil partnership | 17,450,122 | 37.9 |
| Married or in a registered civil partnership | 20,561,642 | 44.7 |
| Married | 20,464,074 | 44.5 |
| In a registered civil partnership | 97,568 | 0.2 |
| Separated, but still legally married or still legally in a civil partnership | 1,033,518 | 2.2 |
| Divorced or civil partnership dissolved | 4,171,639 | 9.1 |
| Widowed or surviving civil partnership partner | 2,790,036 | 6.1 |

Persons

In order to protect against disclosure of personal information, records have been swapped between different geographic areas and counts perturbed by small amounts. Small counts at the lowest geographies will be most affected.

Source: ONS - 2021 Census (TS002)

**Legal partnership status information**

**Description:** Classifies a person according to their legal marital or registered civil partnership status on Census Day 21 March 2021. It is the same as the 2011 census variable "Marital status" but has been updated for Census 2021 to reflect the revised Civil Partnership Act that came into force in 2019.

45

[44] Nomis - 2021 Census 2021 Area Profile - West Lancashire Local Authority

[45] Nomis - 2021 Census 2021 Area Profile - England Country

## Sefton – Marriage and Civil Partnership

The table below shows the statistics for Sefton. This shows that there is a slightly lower percentage of the total population who are married or in a civil partnership (43%) compared to the England figure of 44.7.

### Legal partnership status

| | Sefton Local Authority (Persons) | |
|---|---|---|
| | count | % |
| All usual residents aged 16 and over | 232,390 | 100.0 |
| Never married and never registered a civil partnership | 86,727 | 37.3 |
| Married or in a registered civil partnership | 99,885 | 43.0 |
| Married | 99,541 | 42.8 |
| In a registered civil partnership | 344 | 0.1 |
| Separated, but still legally married or still legally in a civil partnership | 4,923 | 2.1 |
| Divorced or civil partnership dissolved | 22,505 | 9.7 |
| Widowed or surviving civil partnership partner | 18,350 | 7.9 |

In order to protect against disclosure of personal information, records have been swapped between different geographic areas and counts perturbed by small amounts. Small counts at the lowest geographies will be most affected.

Source: ONS - 2021 Census (TS002)

**Legal partnership status information**

**Description:** Classifies a person according to their legal marital or registered civil partnership status on Census Day 21 March 2021. It is the same as the 2011 census variable "Marital status" but has been updated for Census 2021 to reflect the revised Civil Partnership Act that came into force in 2019.

In Census 2021 results, "single" refers only to someone who has never been married or in a registered civil partnership.

[46]

## West Lancashire – Marriage and Civil Partnership

West Lancashire has a slightly higher proportion of its population who are married or in a civil partnership at 45.2% compared to Sefton (43%) and also compared to the overall England comparator (44.7%).

[46] Nomis - 2021 Census 2021 Area Profile - Sefton Local Authority

### Legal partnership status

| Persons | West Lancashire Local Authority | |
|---|---|---|
| | count | % |
| All usual residents aged 16 and over | 98,334 | 100.0 |
| Never married and never registered a civil partnership | 36,581 | 37.2 |
| Married or in a registered civil partnership | 44,439 | 45.2 |
| Married | 44,316 | 45.1 |
| In a registered civil partnership | 123 | 0.1 |
| Separated, but still legally married or still legally in a civil partnership | 1,779 | 1.8 |
| Divorced or civil partnership dissolved | 8,715 | 8.9 |
| Widowed or surviving civil partnership partner | 6,820 | 6.9 |

In order to protect against disclosure of personal information, records have been swapped between different geographic areas and counts perturbed by small amounts. Small counts at the lowest geographies will be most affected.

Source: ONS - 2021 Census (TS002)

[47]

[47] Nomis - 2021 Census 2021 Area Profile - West Lancashire Local Authority

## Religion and Belief

## Religion and Belief – England Comparator

**Religion**

| | Persons | |
|---|---|---|
| | England Country | |
| | count | % |
| All usual residents | 56,490,048 | 100.0 |
| No religion | 20,715,664 | 36.7 |
| Christian | 26,167,899 | 46.3 |
| Buddhist | 262,433 | 0.5 |
| Hindu | 1,020,533 | 1.8 |
| Jewish | 269,283 | 0.5 |
| Muslim | 3,801,186 | 6.7 |
| Sikh | 520,092 | 0.9 |
| Other religion | 332,410 | 0.6 |
| Not answered | 3,400,548 | 6.0 |

In order to protect against disclosure of personal information, records have been swapped between different geographic areas and counts perturbed by small amounts. Small counts at the lowest geographies will be most affected.

Source: ONS - 2021 Census (TS030)

[48]

In terms of Religion and Belief, the table above shows that across England the largest religion or belief is Christianity, with 46.3% of the population identifying themselves as Christian. The next largest religion or belief is Muslim (6.7%). There is also 1.8% of the population identifying as Hindu, Sikh 0.9%, Jewish 0.5% and Buddhist 0.5%.

[48] Nomis - 2021 Census 2021 Area Profile - England Country

## Sefton - Religion and Belief

### Religion

| | Persons | |
|---|---|---|
| | Sefton Local Authority | |
| | count | % |
| All usual residents | 279,233 | 100.0 |
| No religion | 79,905 | 28.6 |
| Christian | 179,806 | 64.4 |
| Buddhist | 681 | 0.2 |
| Hindu | 1,095 | 0.4 |
| Jewish | 364 | 0.1 |
| Muslim | 2,257 | 0.8 |
| Sikh | 133 | 0.0 |
| Other religion | 980 | 0.4 |
| Not answered | 14,012 | 5.0 |

In order to protect against disclosure of personal information, records have been swapped between different geographic areas and counts perturbed by small amounts. Small counts at the lowest geographies will be most affected.

Source: ONS - 2021 Census (TS030)

[49]

In terms of Sefton, the table above shows that compared to the Census 2021 statistics for England overall, there is a significantly higher proportion of the population who identify as being Christian at 64.4% compared to the England figure of 46.3%. This equates to 179,806 people that identify as being Christian. Across other religions or beliefs there are small percentage population counts, with the largest being Muslim at 0.8%, which equates to 2,257 people. Compared to England therefore, religious beliefs other than Christian are much lower. For example, England overall has 6.7% that identify as being Muslim compared to 0.8% for Sefton.

[49] Nomis - 2021 Census 2021 Area Profile - West Lancashire Local Authority

**West Lancashire - Religion and Belief**

## Religion

| | West Lancashire Local Authority (Persons) | |
|---|---|---|
| | count | % |
| All usual residents | 117,427 | 100.0 |
| No religion | 37,018 | 31.5 |
| Christian | 72,269 | 61.5 |
| Buddhist | 262 | 0.2 |
| Hindu | 241 | 0.2 |
| Jewish | 70 | 0.1 |
| Muslim | 507 | 0.4 |
| Sikh | 94 | 0.1 |
| Other religion | 357 | 0.3 |
| Not answered | 6,609 | 5.6 |

In order to protect against disclosure of personal information, records have been swapped between different geographic areas and counts perturbed by small amounts. Small counts at the lowest geographies will be most affected.

Source: ONS - 2021 Census (TS030)

[50]

West Lancashire (shown in the table above) is similar to Sefton in terms of having a high proportion of the population that identifies as being Christian (61.5%), which is a significantly higher proportion than across England. In contrast to Sefton, West Lancashire has a lower proportion of the population that is Muslim (0.4%), compared to 0.8% in Sefton. This is a lot lower however than the percentage across England, where the percentage is higher, at 6.7%.

**Gender Identity**

In relation to Gender Identity, the table below shows the 2021 Census 2021 statistics across England. 0.2% of the population identifies as being a different gender to the one they were assigned at birth. Whilst this figure is small, this does collectively amount to a significant number of people (113,760.). Trans Men, Trans Women and people who identify as Non Binary are all also a small percentage each at 0.1% of the population.

[50] Nomis - 2021 Census 2021 Area Profile - West Lancashire Local Authority

## Gender Identity – England Comparator

### Gender Identity

| | Persons | |
|---|---|---|
| | England Country | |
| | count | % |
| All usual residents aged 16 and over | 46,006,958 | 100.0 |
| Gender identity the same as sex registered at birth | 43,002,331 | 93.5 |
| Gender identity different from sex registered at birth but no specific identity given | 113,760 | 0.2 |
| Trans woman | 45,684 | 0.1 |
| Trans man | 46,513 | 0.1 |
| Non-binary | 28,710 | 0.1 |
| All other gender identities | 17,177 | 0.0 |
| Not answered | 2,752,783 | 6.0 |

In order to protect against disclosure of personal information, records have been swapped between different geographic areas and counts perturbed by small amounts. Small counts at the lowest geographies will be most affected.

Source: ONS - 2021 Census (TS070)

Gender identity estimates from Census 2021 are official statistics in development. This reflects their innovative nature and the evolving understanding of measuring gender identity, along with the uncertainty associated with these estimates. To support appropriate use, please refer to the Sexual Orientation and Gender Identity Quality Information page before using these estimates.
https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/sexuality/methodologies/sexualorientationandgenderidentityqualityinformationforcensus2021

**Gender identity information**

**Description:** Classifies people according to the responses to the gender identity question. This question was voluntary and was only asked of people aged 16 years and over.

[51]

## Gender Identity – Sefton

### Gender Identity

| | Persons | |
|---|---|---|
| | Sefton Local Authority | |
| | count | % |
| All usual residents aged 16 and over | 232,390 | 100.0 |
| Gender identity the same as sex registered at birth | 221,174 | 95.2 |
| Gender identity different from sex registered at birth but no specific identity given | 340 | 0.1 |
| Trans woman | 157 | 0.1 |
| Trans man | 162 | 0.1 |
| Non-binary | 85 | 0.0 |
| All other gender identities | 50 | 0.0 |
| Not answered | 10,422 | 4.5 |

In order to protect against disclosure of personal information, records have been swapped between different geographic areas and counts perturbed by small amounts. Small counts at the lowest geographies will be most affected.

Source: ONS - 2021 Census (TS070)

Gender identity estimates from Census 2021 are official statistics in development. This reflects their innovative nature and the evolving understanding of measuring gender identity, along with the uncertainty associated with these estimates. To support appropriate use, please refer to the Sexual Orientation and Gender Identity Quality Information page before using these estimates.
https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/sexuality/methodologies/sexualorientationandgenderidentityqualityinformationforcensus2021

**Gender identity information**

**Description:** Classifies people according to the responses to the gender identity question. This question was voluntary and was only asked of people aged 16 years and over.

**Comparability with 2011:** Not comparable. This variable is new for Census 2021 and there is no comparability with the 2011 Census.

[52]

The table above shows the Census 2021 statistics for Gender Identity for Sefton. This shows a similar small proportion of the population identifying as being a gender different to what they were assigned at birth, at 0.1% which equates to 340 people.

---

[51] Nomis - 2021 Census 2021 Area Profile - England Country

[52] Nomis - 2021 Census 2021 Area Profile - Sefton Local Authority

### Gender Identity – West Lancashire

**Gender Identity**

| | Persons | |
|---|---|---|
| | West Lancashire Local Authority | |
| | count | % |
| All usual residents aged 16 and over | 98,333 | 100.0 |
| Gender identity the same as sex registered at birth | 93,034 | 94.6 |
| Gender identity different from sex registered at birth but no specific identity given | 136 | 0.1 |
| Trans woman | 63 | 0.1 |
| Trans man | 65 | 0.1 |
| Non-binary | 66 | 0.1 |
| All other gender identities | 36 | 0.0 |
| Not answered | 4,933 | 5.0 |

In order to protect against disclosure of personal information, records have been swapped between different geographic areas and counts perturbed by small amounts. Small counts at the lowest geographies will be most affected.

Source: ONS - 2021 Census (TS070)

Gender identity estimates from Census 2021 are official statistics in development. This reflects their innovative nature and the evolving understanding of measuring gender identity, along with the uncertainty associated with these estimates. To support appropriate use, please refer to the Sexual Orientation and Gender Identity Quality Information page before using these estimates.
https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/sexuality/methodologies/sexualorientationandgenderidentityqualityinformationforcensus2021

[53]

West Lancashire shows a similar pattern to Sefton (as shown in the table above) with 0.1% of the population identifying as being a different gender to the one assigned at birth.

### Relationship between equality impacts and health inequalities

The equality analysis indicates that protected characteristic impacts are closely connected to health inequalities mechanisms, particularly travel and access, arrival and waiting environment. Older people, disabled people, carers, pregnant people and families with young children are more likely to experience amplified burden from increased travel time, journey complexity and parking constraints. These same groups are also more likely to experience harm from poor waiting environment standards and inconsistent delivery of reasonable adjustments. This section should therefore be read alongside the health inequalities duty section, as the duty is discharged through practical mitigation and monitoring that reduces barriers for groups experiencing higher vulnerability, regardless of whether they share a protected characteristic. The mitigation package should be framed to address both equality and health inequalities requirements through the same mechanism based commitments and measurable monitoring triggers.

[53] Nomis - 2021 Census 2021 Area Profile - West Lancashire Local Authority

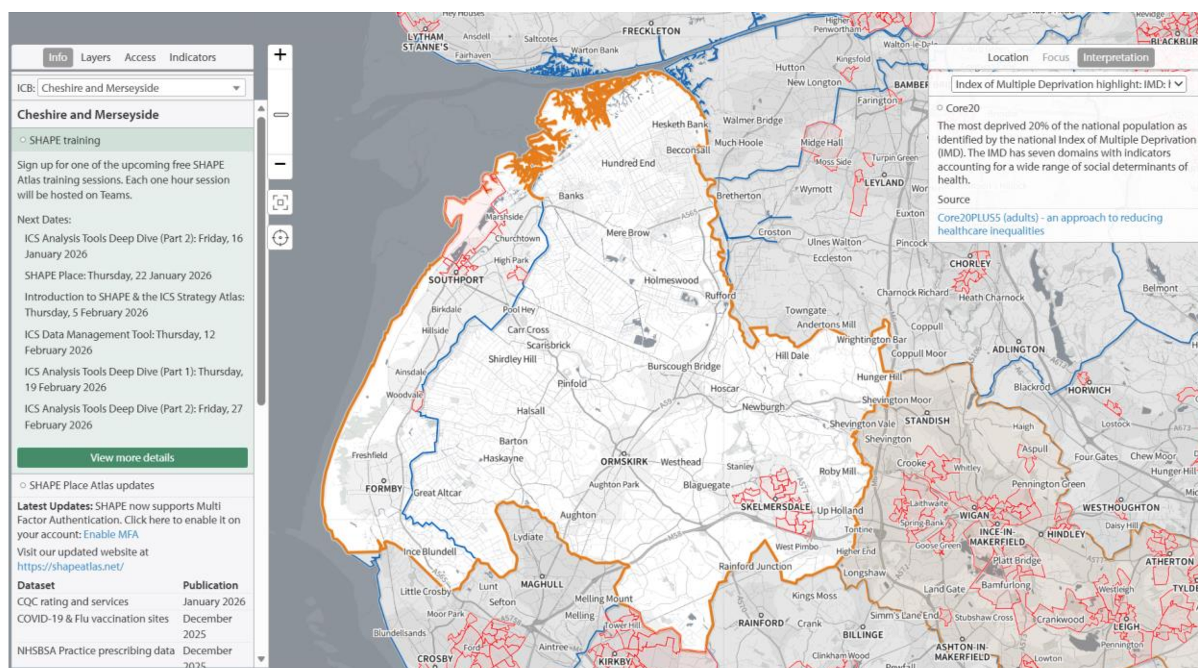
## 5.5 Deprivation

There is a significant amount of deprivation within the local area, and in particular, close to the current two general hospital locations at Ormskirk District General Hospital and Southport and Formby District General Hospital. In addition, deprived areas are located close to the Skelmersdale Walk-in Centre.

This is important to consider in relation to the potential impact on equality groups from the decisions being made because most issues of inequality are linked to lower socio-economic groups and in particular, health inequality. When low socio-economic status is combined with a particular Protected Characteristic, this can often generate inequalities.

It is therefore important for the Programme to consider this context and to understand where deprivation is situated, and therefore how this will impact upon a particular proposal being made in terms of services being relocated.

**Core20Plus5 - most deprived 20%**




54

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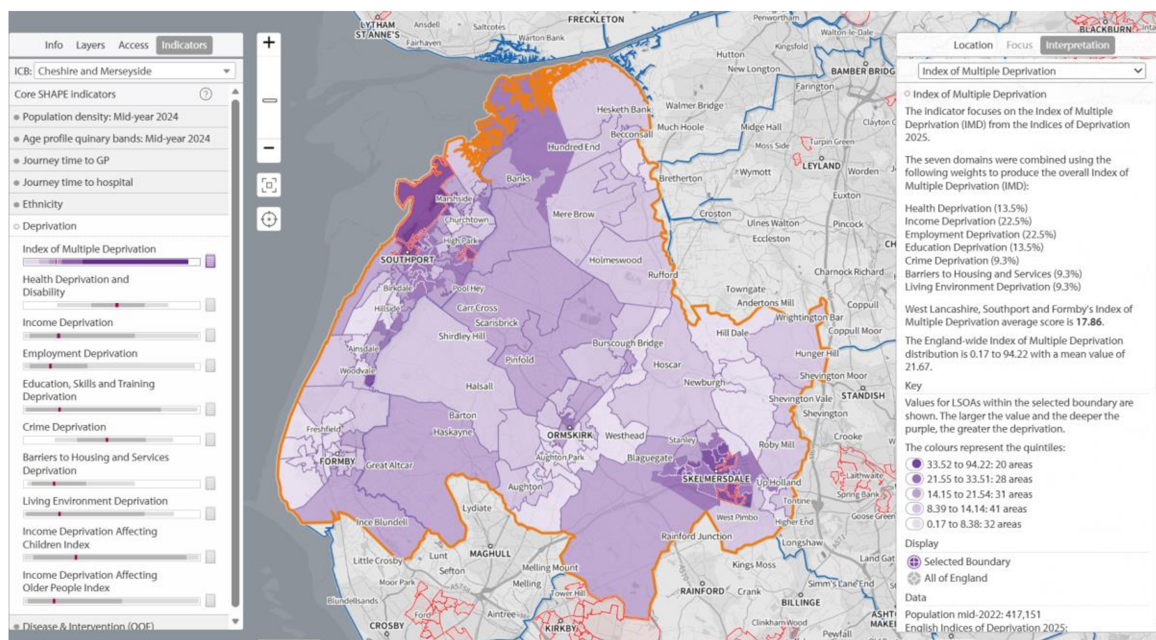
[54] https://app.shapeatlas.net/place/E54000008#11/53.6128/-2.8827/l-imd2/b-02G,b-01V/o-n,a/m-CCG,ml-CCG/rs-selected,rh-0,rdr-t

Core20Plus5 is an NHS initiative to tackle health inequality. To discover more about Core20Plus5 please refer to the following link: [https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-Programme/core20plus5/](https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-Programme/core20plus5/)

The map below shows where the most deprived 20% of the population is located within the area (shown in red outlines) as defined by CORE20PLUS.

This shows that the most significant deprived areas, are located close to the Southport and Formby District General Hospital and also Skelmersdale Walk-in Centre. This is important to note because according to CORE20PLUS5, the Southport and Formby District General Hospital and Skelmersdale Walk-In Centre are both located next to very deprived communities whose travel distance is therefore less than for more affluent communities. Moving services away from this location will therefore impact significantly upon those communities.

**Index of Multiple Deprivation**




[55]

The Index of Multiple Deprivation is one of the most accurate indicators of income levels and therefore also deprivation levels. The map above shows the local area and the deprivation

[55] SHAPE Place • IMD: high 10%

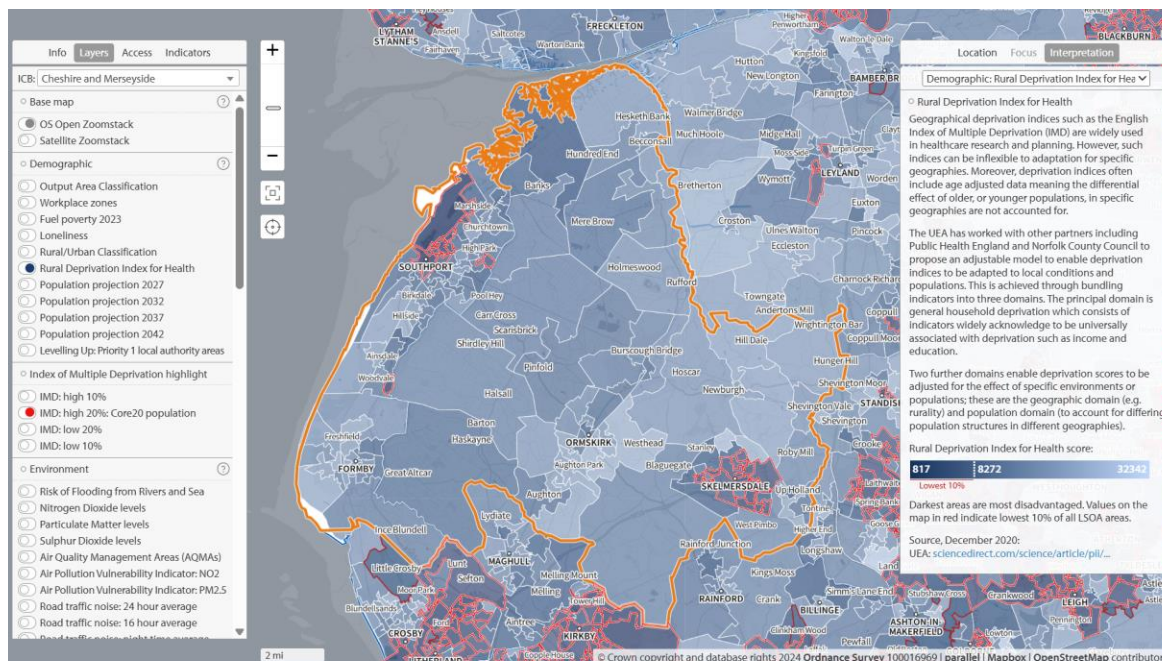
levels marked in shades of purple. The darker the shade of purple, the higher the levels of deprivation and the lighter the shade of purple shows the less deprived areas. In addition, the top 10% most deprived areas are marked in red outlines.

The map shows, that there are fairly high levels of deprivation spread across a large proportion of the area (as indicated by the deeper shades of purple). It is however more concentrated around the Southport and Formby District General Hospital where a large section of deep purple can be observed to the northwest of the Hospital. A section of deep purple can also be observed in close proximity to Ormskirk District General Hospital. The 10% most deprived areas (shown in red outlines) are also located close to Southport and Formby District General Hospital and in addition Skelmersdale Walk-in Centre.

This is important to note as, in terms of the potential impact upon issues of inequality and health inequality, moving services away from the Southport and Formby District General Hospital location to, for example, Ormskirk District General Hospital, presents as having a higher potential to cause considerable detrimental impact on a number of vulnerable groups than moving services away from Ormskirk District General Hospital.

The fact that Skelmersdale is also much further away from Southport and Formby District General Hospital - being located to the east of Ormskirk District General Hospital - means that this also does not present the potential to offset the detrimental impact of moving services away from Southport and Formby.

## Rural Deprivation Index for Health

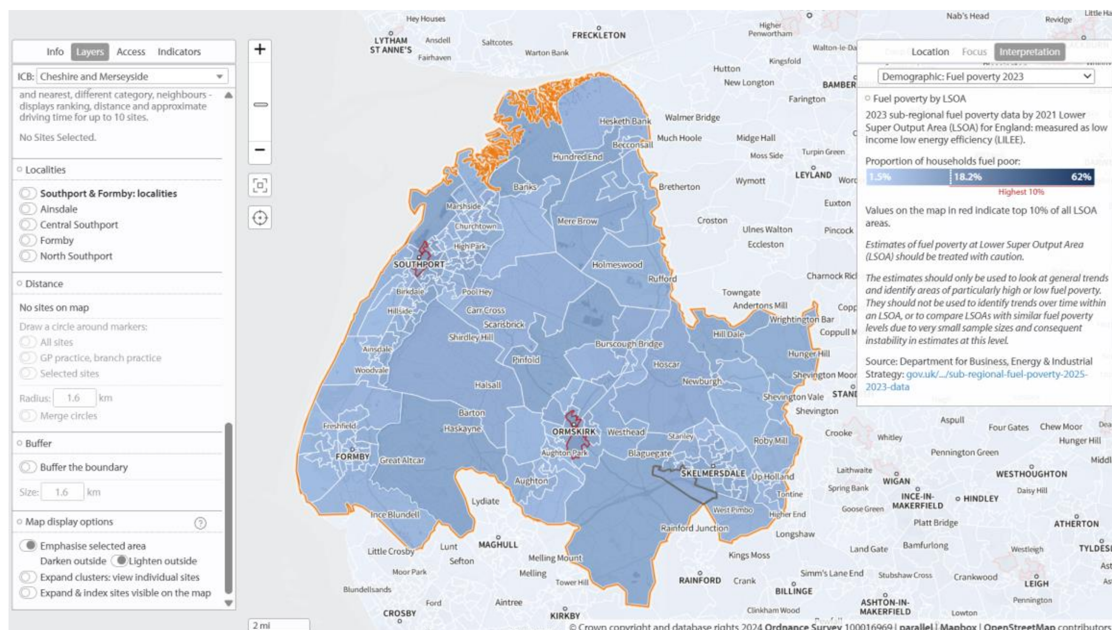


The Rural Deprivation Index for Health (shown above) is another helpful indicator for considering areas of increased deprivation. The map shows the Rural Deprivation Index for Health. The darker the shade of the blue, the more significant the deprivation, with the darkest shades of blue showing the most deprived areas. In addition, the red outlines show the top 20% most deprived areas (as calculated by CORE20PLUS5).

The patterns of deprivation shown are therefore very similar again, with a significant concentration to the west and northwest of Southport and Formby District General Hospital and also, in close proximity to Ormskirk District General Hospital and Skelmersdale Walk-in Centre.

## Fuel Poverty

Fuel poverty is another useful indicator of where areas of deprivation are located as shown on the map below. The darker shades of blue show where there are higher levels of fuel poverty, with the darkest shades showing where it is most significant. This is also very helpful in terms of understanding the potential impact of increased travel for people located in certain locations. In terms of hotspots where fuel poverty is most significant, the map shows that the locations of the most significant poverty are near to Southport and Formby District General Hospital, Ormskirk District General Hospital and Skelmersdale Walk-in Centre, showing that moving services from any of these locations will have an impact upon groups affected by fuel poverty.



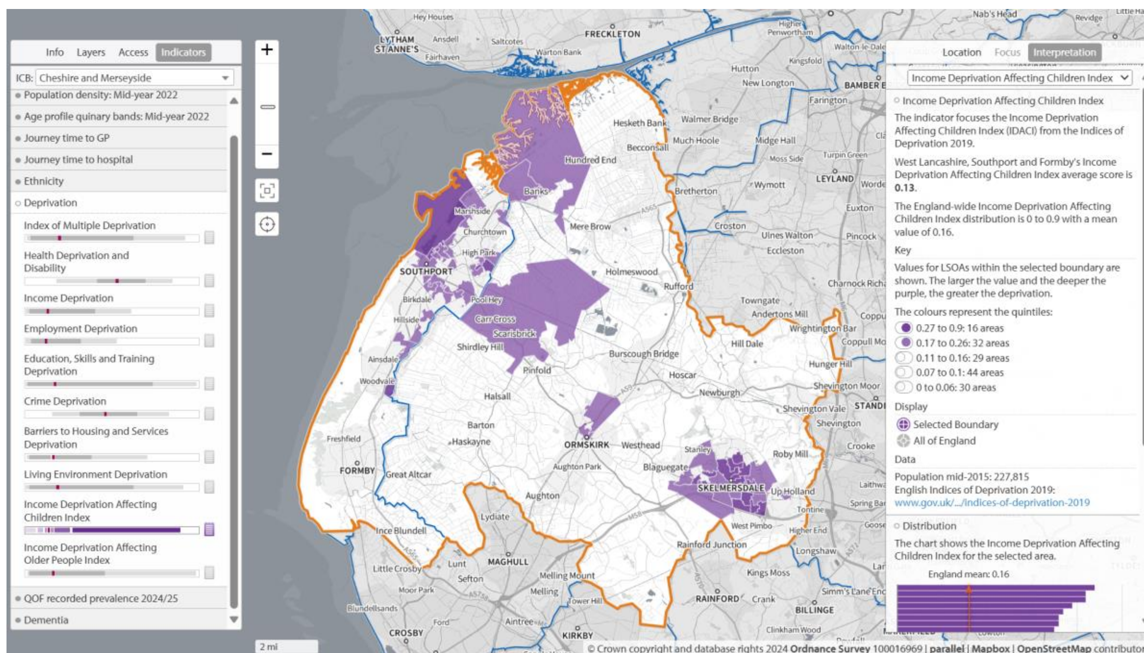

[56] https://app.shapeatlas.net/place/E54000008#11/53.6128/-2.8827/l-rdi,l-imd2/b-02G,b-01V/o-n,a/m-CCG,ml-CCG/rs-selected,rh-0,rdr-t

[57]

## Income Deprivation Affecting Children

The map below shows income deprivation that affects children (who have a Protected Characteristic under Age) and its locations in the area. This is an important indicator to consider in terms of where income deprivation may affect children more significantly and its location (in relation to the two hospitals where service changes are being considered).

The areas shaded in purple show where income deprivation occurs, with the darker purple showing where this is more significant. This shows a pattern again of the clustering of deprivation affecting children being close-to current hospital sites. It is, however, more significant close to Southport and Formby District General Hospital than it is to Ormskirk District General Hospital, with another significant cluster around Skelmersdale. In terms of moving services, in terms of how deprivation affecting children is mapped, moving services from Southport and Formby District General Hospital has the potential to have a higher impact on deprived groups.




[58]

## Income Deprivation Affecting Older People

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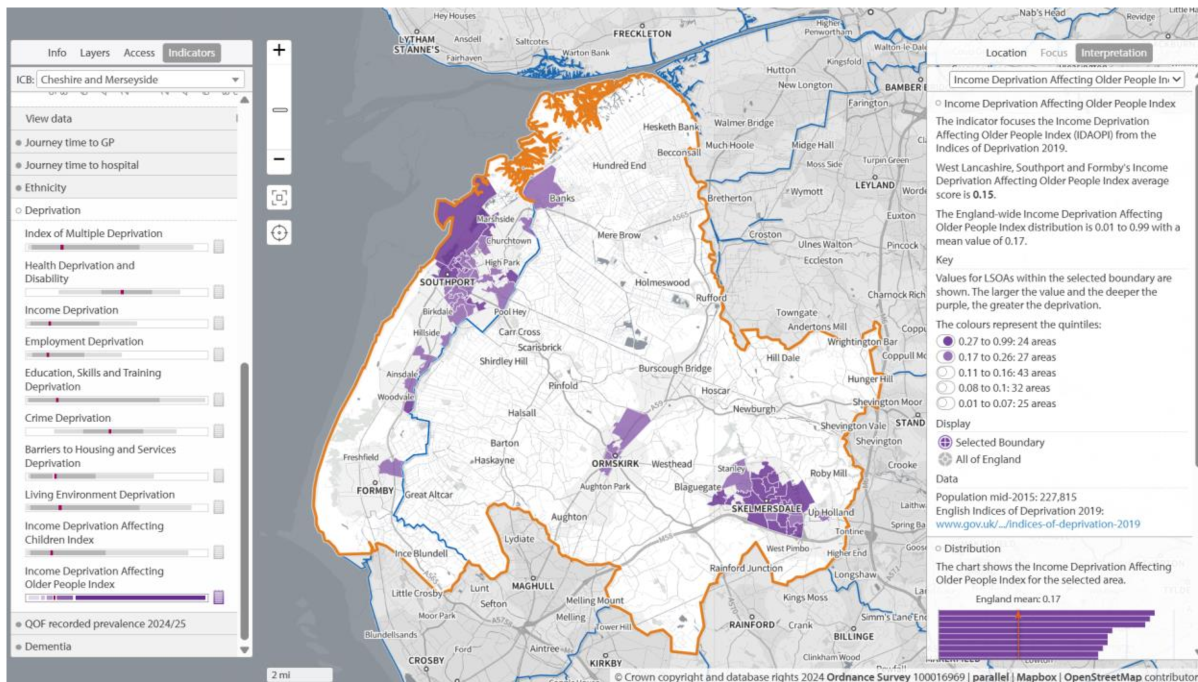
[57] https://app.shapeatlas.net/place/E54000008#11/53.6128/-2.8827/l-fp/b-02G,b-01V/o-n,a/m-CCG,ml-CCG/rs-selected,rh-0,rdr-t

[58] SHAPE Place • Deprivation • Income Deprivation Affecting Children Index

Income deprivation affecting older people (who have a Protected Characteristic in relation to Age) is another important indicator to consider in terms of where this may be more prevalent geographically.

This shows a similar pattern geographically, with a higher prevalence in close proximity to Southport and Formby District General Hospital, Ormskirk District General Hospital and Skelmersdale Walk-in Centre.




## Health inequalities evidence and implementation relevance

Detailed health inequalities evidence shows material variation in deprivation, health deprivation and disability, and wider determinants across the footprint. The purpose of including this evidence is to inform practical action and to target mitigations and monitoring to where vulnerability is concentrated. The key implementation implications are that travel and access mitigations must prioritise the areas with higher vulnerability, that reasonable adjustment delivery must be consistent and auditable, and that monitoring must be able to detect whether access, experience and outcomes are diverging by place and by vulnerability. Where some groups are underrepresented in consultation responses, decision makers should place greater weight on mechanism-based risk, triangulation with other evidence sources and a stronger requirement for follow up engagement and robust monitoring during implementation.

## 5.6 Health Inequalities and the Wider Determinants of Health[59]

This report supports decision makers to meet the statutory health inequalities duties under the NHS Act 2006, alongside the Public Sector Equality Duty. The health inequalities duties require having regard to the need to reduce inequalities in access and inequalities in outcomes achieved for patients, including effectiveness, safety and quality of experience. These duties apply to any groups experiencing health inequalities and are not limited to protected characteristics.

The urgent and emergency care configuration decision is health inequalities relevant because baseline deprivation and vulnerability are unevenly distributed across the footprint, and because the decision creates place based trade offs in travel and access that can widen or narrow inequalities depending on how the model is delivered. The report therefore focuses on the mechanisms most likely to drive unequal impact and sets out minimum decision commitments and monitoring arrangements needed to evidence the ongoing duty through implementation.

The following section provides an overview of health inequalities and wider determinants of health across the SCT area.

Health inequalities are **avoidable, unfair and systematic differences in health** between different groups of people. Health inequalities such as life expectancy, prevalence of long-term conditions or access to healthcare services are closely linked to what are known as the 'wider determinants of health' - these are a diverse range of social, economic and environmental factors, which impact on people's health such as quality of housing, education, and unemployment.

Our health is determined by a complex mix of factors including income, housing and employment, lifestyle and access to health care and other services. A combination of these factors can lead to a difference in health status and significant health-related inequalities.

The data in this section relates to both health inequalities and the wider determinants of health and includes:

- Life expectancy
- Mortality rates
- Obesity
- Substance misuse
- Smoking
- Wider determinants of health including housing, education, environment and employment.

[59] SHAPE Place • Deprivation • Income Deprivation Affecting Older People Index

## Life expectancy

Life expectancy is the average number of years a person would expect to live. Life expectancy can be affected by several factors including characteristics of sex, Ethnicity and disability, access to healthcare, behavioural risks, and other wider determinants of health such as education, housing, income, and employment. Life expectancy is closely related to the overall level of deprivation in an area.

The tables below show life expectancy statistics for Sefton and West Lancashire. The colour coding shows where figures are worse (red), similar (yellow) or better (green).

The tables show that the life expectancy at birth in England in 2022 is 79.3 years for males and 83.2 years for females, which provides a benchmark to compare the statistics for Sefton and West Lancashire against.

## Life Expectancy - Sefton

Better 95% Similar Worse 95% Not applicable Quintiles: Best Worst Not applicable

Recent trends: – Could not be calculated; No significant change; Increasing & getting worse; Increasing & getting better; Decreasing & getting worse; Decreasing & getting better

Benchmark Value — Worst, 25th Percentile, 75th Percentile, Best

| Indicator | Period | Sefton | | | England | | | |
|---|---|---|---|---|---|---|---|---|
| | | Recent Trend | Count | Value | Value | Worst | Range | Best |
| **Overarching indicators at birth** | | | | | | | | |
| A01b - Life expectancy at birth (Male, 3 year range) | 2021 - 23 | – | - | 78.0 | 79.1 | 73.1 | | |
| A01b - Life expectancy at birth (Female, 3 year range) | 2021 - 23 | – | - | 81.7 | 83.1 | 78.9 | | |
| A01b - Life expectancy at birth (Male, 1 year range) | 2023 | – | - | 78.5 | 79.3 | 73.4 | | |
| A01b - Life expectancy at birth (Female, 1 year range) | 2023 | – | - | 82.1 | 83.2 | 78.2 | | |
| A02a - Inequality in life expectancy at birth (Male) | 2021 - 23 | – | - | 12.1* | 10.5* | 17.2 | | |
| A02a - Inequality in life expectancy at birth (Female) | 2021 - 23 | – | - | 11.3* | 8.3* | 14.9 | | |
| **Overarching indicators at age 65** | | | | | | | | |
| A01b - Life expectancy at 65 (Male, 3 year range) | 2021 - 23 | – | - | 18.2 | 18.7 | 16.1 | | |
| A01b - Life expectancy at 65 (Female, 3 year range) | 2021 - 23 | – | - | 20.8 | 21.1 | 18.7 | | |
| A01b - Life expectancy at 65 (Male, 1 year range) | 2023 | – | - | 18.6 | 18.8 | 16.3 | | |
| A01b - Life expectancy at 65 (Female, 1 year range) | 2023 | – | - | 20.9 | 21.3 | 18.7 | | |
| A02a - Inequality in life expectancy at 65 (Male) | 2021 - 23 | – | - | 6.3* | 5.6* | 9.7 | | |
| A02a - Inequality in life expectancy at 65 (Female) | 2021 - 23 | – | - | 6.6* | 5.0* | 9.7 | | |

[60]

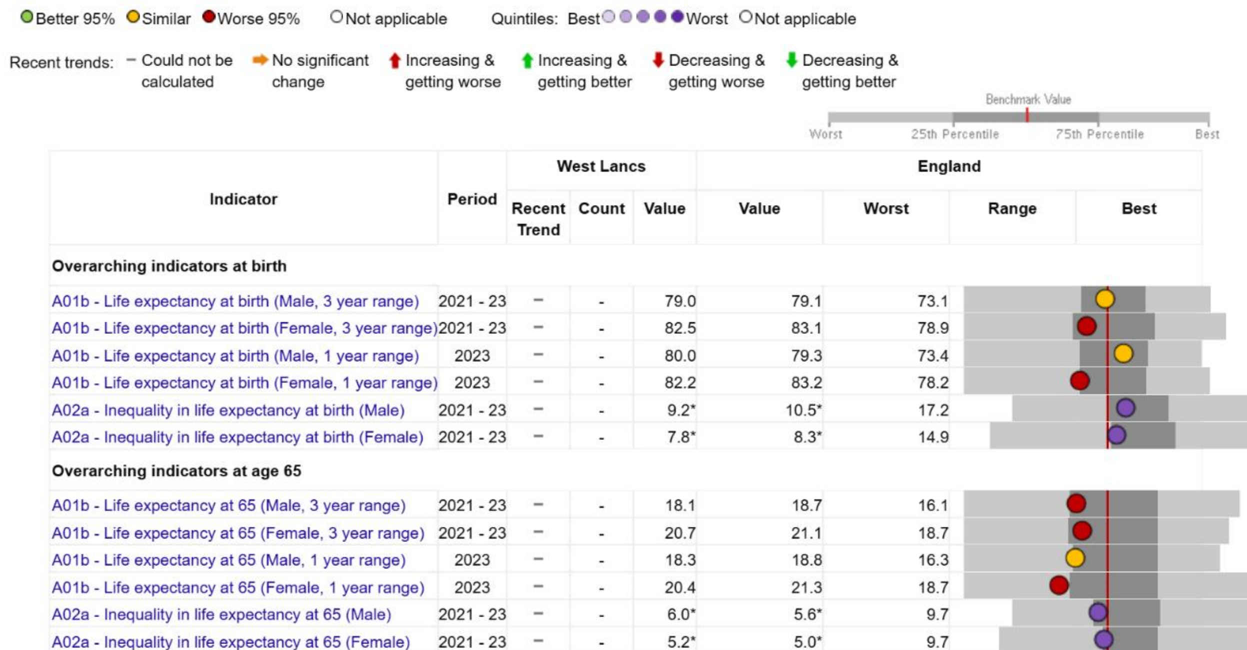
In terms of Sefton (which aligns more closely with Southport and Formby District General Hospital), the table above shows that the life expectancy for both males and females at birth, is lower in Sefton than it is for England overall.

In addition, life expectancy for both men and women at age 65, is lower in Sefton when compared to England overall. The life expectancy is also proportionally lower for women in Sefton than it is for men, compared to the wider England statistic. This is the case both when

[60] Public Health Outcomes Framework - Data | Fingertips | Department of Health and Social Care

measured at birth, and also at aged 65. This is strong indicator therefore that overall health inequality is worse in Sefton, compared to England overall. This gap is also wider for women, which may suggest therefore, that more significant issues of health inequality in women may have contributed to the lower life expectancy compared to men.

## Life Expectancy - West Lancashire



Better 95% Similar Worse 95% Not applicable Quintiles: Best Worst Not applicable

Recent trends: – Could not be calculated; No significant change; Increasing & getting worse; Increasing & getting better; Decreasing & getting worse; Decreasing & getting better

Benchmark Value; Worst; 25th Percentile; 75th Percentile; Best

| Indicator | Period | West Lancs | | | England | | | |
|---|---|---|---|---|---|---|---|---|
| | | Recent Trend | Count | Value | Value | Worst | Range | Best |
| **Overarching indicators at birth** | | | | | | | | |
| A01b - Life expectancy at birth (Male, 3 year range) | 2021 - 23 | – | - | 79.0 | 79.1 | 73.1 | | |
| A01b - Life expectancy at birth (Female, 3 year range) | 2021 - 23 | – | - | 82.5 | 83.1 | 78.9 | | |
| A01b - Life expectancy at birth (Male, 1 year range) | 2023 | – | - | 80.0 | 79.3 | 73.4 | | |
| A01b - Life expectancy at birth (Female, 1 year range) | 2023 | – | - | 82.2 | 83.2 | 78.2 | | |
| A02a - Inequality in life expectancy at birth (Male) | 2021 - 23 | – | - | 9.2* | 10.5* | 17.2 | | |
| A02a - Inequality in life expectancy at birth (Female) | 2021 - 23 | – | - | 7.8* | 8.3* | 14.9 | | |
| **Overarching indicators at age 65** | | | | | | | | |
| A01b - Life expectancy at 65 (Male, 3 year range) | 2021 - 23 | – | - | 18.1 | 18.7 | 16.1 | | |
| A01b - Life expectancy at 65 (Female, 3 year range) | 2021 - 23 | – | - | 20.7 | 21.1 | 18.7 | | |
| A01b - Life expectancy at 65 (Male, 1 year range) | 2023 | – | - | 18.3 | 18.8 | 16.3 | | |
| A01b - Life expectancy at 65 (Female, 1 year range) | 2023 | – | - | 20.4 | 21.3 | 18.7 | | |
| A02a - Inequality in life expectancy at 65 (Male) | 2021 - 23 | – | - | 6.0* | 5.6* | 9.7 | | |
| A02a - Inequality in life expectancy at 65 (Female) | 2021 - 23 | – | - | 5.2* | 5.0* | 9.7 | | |

[61]

The table above shows life expectancy for West Lancashire (which aligns more closely with Ormskirk District General Hospital). When comparing the statistics for life expectancy at birth, to England overall, this shows a better proportional life expectancy for men compared to Women - with a similar figure to England overall. Women's life expectancy at birth is however lower than for England, which aligns more with the values for Sefton (although this is slightly better than for Sefton). Life expectancy at 65, for both men and women, is also worse than England (similar to Sefton).

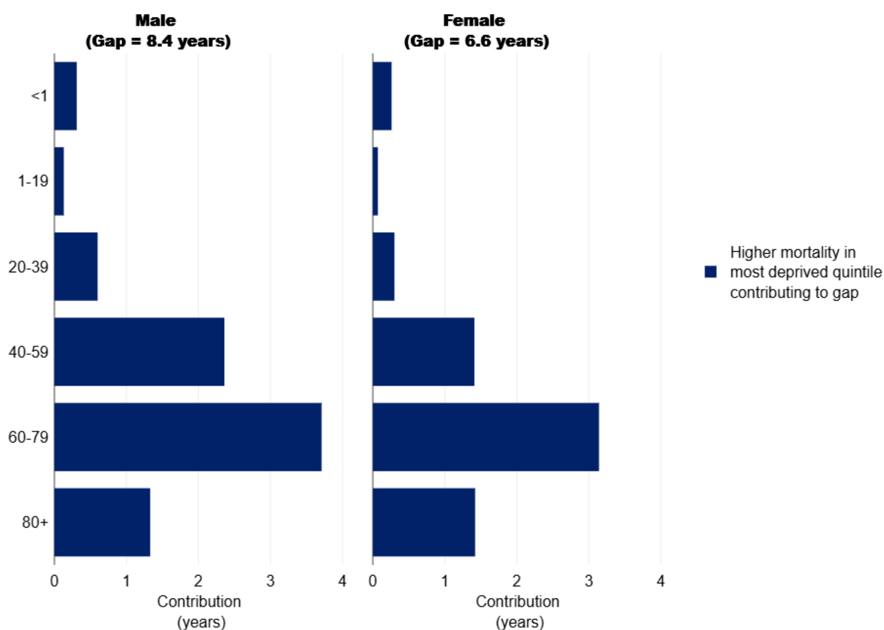
The statistic in relation to inequality in life expectancy at 65 is better than for Sefton and is around the benchmark value (slightly below it). This is an indicator than Sefton has worse health inequality for both men and women than for West Lancashire.

## Health Inequality gap

[61] Public Health Outcomes Framework - Data | Fingertips | Department of Health and Social Care

### Breakdown of the life expectancy gap between the most and least deprived quintiles of England by age group, 2022 to 2023

### Health Inequality - England (for comparison)




[62]

### Inequalities (life expectancy) between the most and least deprived quintile of England, 2022 to 2023

| | Male | Female |
|---|---|---|
| Life expectancy most deprived quintile | 74.3 | 79.2 |
| Life expectancy least deprived quintile | 82.8 | 85.8 |
| Gap | 8.4 | 6.6 |

[63]

[Segment Tool]

The bar chart and table below show the breakdown of life expectancy by comparing the gap between the most and least deprived quintiles in England age. This is important insight for the Programme to consider as this provides an overall strategic indicator of the extent to which health inequalities may have a detrimental impact. People suffering health inequalities are more vulnerable and are therefore likely to be affected more significantly by any decisions being made about healthcare provision, its location, travel times, ability to use public transport easily and cheaply etc.

The bar chart below for England shows that the life expectancy gap between the most and least deprived quintiles of England by age group, 2022 to 2023. This shows that the gap in life

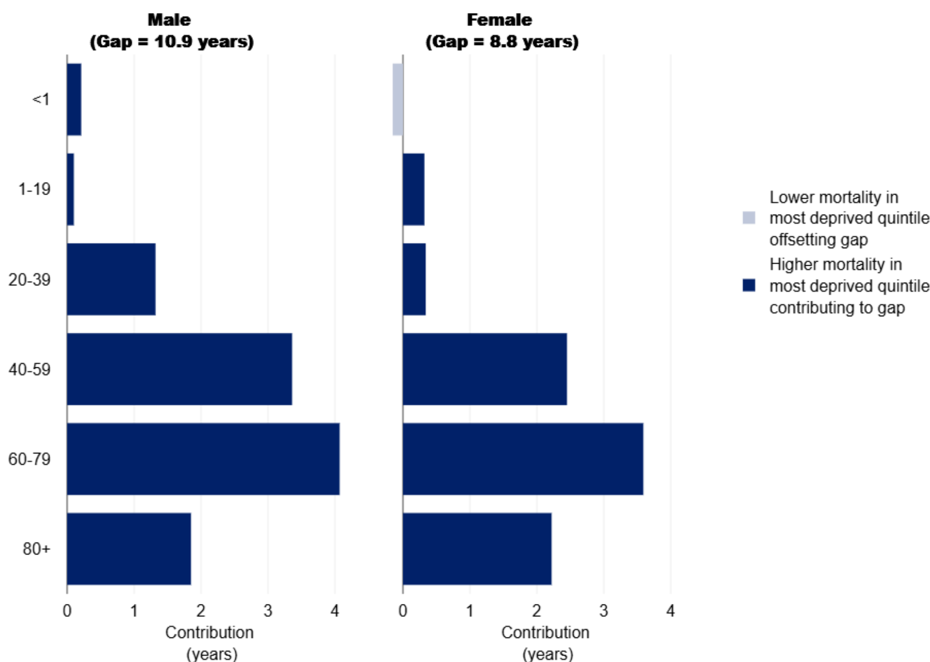
[62] https://analytics.phe.gov.uk/apps/segment-tool/
[63] https://analytics.phe.gov.uk/apps/segment-tool/

expectancy between the least and most deprived communities is 8.4 years for males and 6.6 years for females. The graph also shows that the most significant contributor to this gap is men and women aged 60-79 years.

The 40-59 age group is the second largest contributor to this gap. It also shows that males, aged 40-59 are a much higher contributor to the gap than females, showing therefore that health inequality for men within deprived communities may be more significant than for women.

### Life expectancy gap – Sefton

#### Breakdown of the life expectancy gap between the most and least deprived quintiles of Sefton by age group, 2022 to 2023




#### Inequalities (life expectancy) between the most and least deprived quintile of Sefton, 2022 to 2023

| | Male | Female |
|---|---|---|
| Life expectancy | 78.4 | 81.8 |
| Life expectancy in England | 79.3 | 83.2 |
| Gap | 0.9 | 1.4 |

[64]

The graph above shows the life expectancy gap for Sefton. The gap in life expectancy between the least and most deprived communities in Sefton is 10.9 years for males and 8.8 years for females. This is higher than the England figure of 8.4 years for men and 6.6 years for women. When comparing Sefton to England overall, it therefore has a worse gap in life expectancy health inequalities. The graph also shows that the most significant contributor to this gap is men and women aged 60-79 years, which is the same as for England.

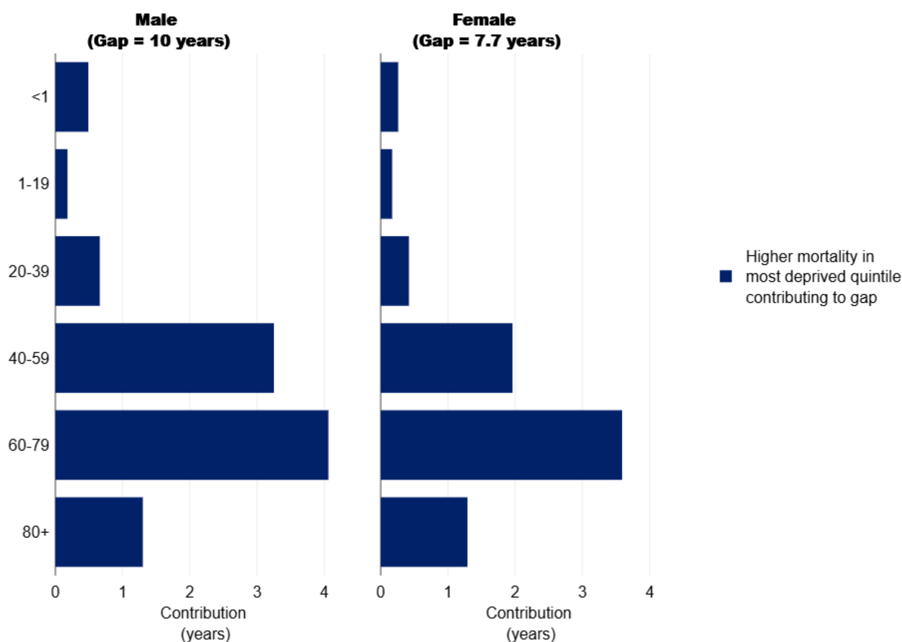
[64] Segment Tool

The 40-59 age gap also shows that males are a much higher contributor to the gap than females, showing therefore that life expectancy health inequalities for males within deprived communities may be more significant. What does stand out as being different, when comparing the graphs to England equivalent (above) is that there is a larger life expectancy inequality for 40 -59 year old males which shows that health inequality is more prevalent for men aged 40 - 59.

The other difference to note, is that the life expectancy gap for the 80+ age group is around 2 years for both men and women, compared to England which is closer to 1/1 ½ years, with women being having more than 2 years gap. This suggests therefore that the health inequality gap (between the least and most deprived communities) is more significant in Sefton, compared to England overall.

## Life Expectancy – West Lancashire

### Breakdown of the life expectancy gap between the most and least deprived quintiles of West Lancashire by age group, 2022 to 2023




[65]

### Inequalities (life expectancy) between the most and least deprived quintile of Lancashire, 2022 to 2023

[65] Segment Tool

| | Male | Female |
|---|---|---|
| Life expectancy | 77.6 | 81.8 |
| Life expectancy in England | 79.3 | 83.2 |
| Gap | 1.7 | 1.4 |

*N.B. Information on West Lancashire for this indicator is not available, so the statistics for Lancashire have bene provided.*

The graph below shows the life expectancy gap for West Lancashire. This shows that the gap in life expectancy between the least and most deprived communities in West Lancashire is 10 years for males and 7.7 for females. This is higher than the England figure of 8.4 for men and 6.6 for women but lower than the Sefton figures. When comparing West Lancashire to England overall, it therefore has a worse life expectancy inequality gap. The graph also shows that the most significant contributor to this gap is men and women aged 60-79 years, which is the same as for England. The gap in years for this age group is also very similar to Sefton.

The 40-59 age group shows that males are also a higher contributor to the gap than females, showing therefore that life expectancy health inequality for males within West Lancashire is more significant. What also stands out (similar but less pronounced as for Sefton) as being different - when comparing the graphs to England equivalent above - is that there is a larger life expectancy health inequality gap for 40-59 year old males compared to females.

**Wider Determinants of Health**

The tables below show the wider determinants of health both Sefton and West Lancashire compared to England. This is important insight for the Programme, as it shows where there are prevailing disparities that are contributing towards issues of health inequality.

The tables show a number of indicators that are helpful for generating an understanding in relation to issues of inequality. For example, pupil absence from school, leads to lower attainment, which longer term leads to lower levels of income and a higher likelihood of disadvantage in adult life, and when this is connected to a Protected Characteristic, this becomes and Equality issue under the PSED.

The coloured dots show whether the figures represented are better (green), similar (yellow) or worse (red) comparing them to the England values.

**Wider determinants of Health – Sefton**

| Indicator | Period | Sefton | | | England | | | |
|---|---|---|---|---|---|---|---|---|
| | | Recent Trend | Count | Value | Value | Worst/ Lowest | Range | Best/ Highest |
| B01b - Children in absolute low income families (under 16s) | 2023/24 | ↑ | 8,912 | 18.6% | 19.1% | 40.7% | | |
| B01b - Children in relative low income families (under 16s) | 2023/24 | ↑ | 10,559 | 22.1% | 22.1% | 44.6% | | |
| B03 - Pupil absence | 2023/24 | – | 1,005,235 | 7.9% | 7.1% | 9.7% | | |
| B08d - Percentage of people in employment New data | 2024/25 | → | 120,200 | 74.0% | 75.7% | 61.0% | | |
| B09a - Sickness absence: the percentage of employees who had at least one day off in the previous week | 2021 - 23 | – | - | 1.2% | 2.2% | 9.2% | | 0.3% |
| B09b - Sickness absence: the percentage of working days lost due to sickness absence | 2021 - 23 | – | - | 0.8% | 1.2% | 7.4% | | 0.1% |
| B12a - Violent crime - hospital admissions for violence (including sexual violence) | 2021/22 - 23/24 | – | 375 | 48.4 | 34.2 | 170.5 | | 6.3 |
| B12b - Violent crime - violence offences per 1,000 population New data | 2024/25 | → | 9,422 | 33.2 | 31.4 | 14.1 | | |
| B12c - Violent crime - sexual offences per 1,000 population New data | 2024/25 | → | 688 | 2.4 | 3.1 | 1.4 | | |
| B13a - Reoffending levels: percentage of offenders who reoffend | 2022/23 | – | 516 | 27.0% | 26.2% | 12.0% | | |
| B13b - Reoffending levels: average number of reoffences per reoffender | 2022/23 | – | 1,677 | 3.25 | 4.04 | 2.06 | | |
| B14a - The rate of complaints about noise | 2023/24 | – | 951 | 3.4* | 5.9* | 68.1 | | 0.5 |
| B14b - The percentage of the population exposed to road, rail and air transport noise of 65dB(A) or more, during the daytime | 2021 | – | 7,570 | 2.7%* | 4.3%* | 19.0% | | 0.7% |
| B14c - The percentage of the population exposed to road, rail and air transport noise of 55 dB(A) or more during the night-time | 2021 | – | 18,510 | 6.7%* | 8.4%* | 27.8% | | 1.5% |
| B15a - Homelessness: households owed a duty under the Homelessness Reduction Act | 2023/24 | ↑ | 1,186 | 9.6 | 13.4 | 30.6 | | |
| B15c - Homelessness: households in temporary accommodation | 2023/24 | ↑ | 107 | 0.9 | 4.6 | 51.9 | | 0.0 |
| B17 - Fuel poverty (low income, low energy efficiency methodology) | 2023 | – | 14,367 | 11.3% | 11.4% | 21.3% | | |
| 1.01i - Children in low income families (all dependent children under 20) | 2016 | ↓ | 9,025 | 16.8% | 17.0% | 32.5% | | |

[66]

The table above is for Sefton which covers the area associated with Southport and Formby District General Hospital. This shows that across this set of indicators, most of the indicators are very similar to those for England. The following aspects, are of particular note:

- Children under 16 in absolute and relative low-income families is increasing (similar to West Lancashire).
- Homelessness is also increasing (similar to West Lancashire).
- Pupil absence is worse (similar to West Lancashire).
- Hospital admissions for violent crime is higher.
- The number of children (under 20) in low income families is reducing.

## Wider Determinants of Health - West Lancashire

[66] Public Health Outcomes Framework - Data | Fingertips | Department of Health and Social Care

Better 95% · Similar · Worse 95% · Not applicable — Quintiles: Best ● ● ● ● ● Worst · Not applicable

Quintiles: Low ● ● ● ● ● High · Not applicable

Recent trends: – Could not be calculated · → No significant change · ↑ Increasing & getting worse · ↑ Increasing & getting better · ↓ Decreasing & getting worse · ↓ Decreasing & getting better

Benchmark Value · Worst/Lowest · 25th Percentile · 75th Percentile · Best/Highest

| Indicator | Period | West Lancs | | | England | | | |
|---|---|---|---|---|---|---|---|---|
| | | Recent Trend | Count | Value | Value | Worst/ Lowest | Range | Best/ Highest |
| B01b - Children in absolute low income families (under 16s) | 2023/24 | ↑ | 3,690 | 18.8% | 19.1% | 40.7% | | |
| B01b - Children in relative low income families (under 16s) | 2023/24 | ↑ | 4,313 | 22.0% | 22.1% | 44.6% | | |
| B03 - Pupil absence | 2023/24 | – | 398,826 | 8.0% | 7.1% | 9.7% | | |
| B08d - Percentage of people in employment New data | 2024/25 | ↑ | 52,000 | 75.1% | 75.7% | 61.0% | | |
| B09a - Sickness absence: the percentage of employees who had at least one day off in the previous week | 2021 - 23 | – | - | * | 2.2% | 9.2% | | 0.3% |
| B09b - Sickness absence: the percentage of working days lost due to sickness absence | 2021 - 23 | – | - | * | 1.2% | 7.4% | | 0.1% |
| B12a - Violent crime - hospital admissions for violence (including sexual violence) | 2021/22 - 23/24 | – | 110 | 31.7 | 34.2 | 170.5 | | 6.3 |
| B12b - Violent crime - violence offences per 1,000 population New data | 2024/25 | → | 2,474 | 20.6 | 31.4 | 14.1 | | |
| B12c - Violent crime - sexual offences per 1,000 population New data | 2024/25 | → | 268 | 2.2 | 3.1 | 1.4 | | |
| B13a - Reoffending levels: percentage of offenders who reoffend | 2022/23 | – | 73 | 18.2% | 26.2% | 12.0% | | |
| B13b - Reoffending levels: average number of reoffences per reoffender | 2022/23 | – | 229 | 3.14 | 4.04 | 2.06 | | |
| B14a - The rate of complaints about noise | 2023/24 | – | 503 | 4.2* | 5.9* | 68.1 | | 0.5 |
| B14b - The percentage of the population exposed to road, rail and air transport noise of 65dB(A) or more, during the daytime | 2021 | – | 4,000 | 3.5%* | 4.3%* | 19.0% | | 0.7% |
| B14c - The percentage of the population exposed to road, rail and air transport noise of 55 dB(A) or more during the night-time | 2021 | – | 10,270 | 9.0%* | 8.4%* | 27.8% | | 1.5% |
| B15a - Homelessness: households owed a duty under the Homelessness Reduction Act | 2023/24 | ↑ | 298 | 6.3 | 13.4 | 30.6 | | |
| B15c - Homelessness: households in temporary accommodation | 2023/24 | ↑ | 32 | 0.7 | 4.6 | 51.9 | | 0.0 |
| B17 - Fuel poverty (low income, low energy efficiency methodology) | 2023 | – | 5,705 | 11.4% | 11.4% | 21.3% | | |
| 1.01i - Children in low income families (all dependent children under 20) | 2016 | ↓ | 3,010 | 13.5% | 17.0% | 32.5% | | |

[67]

The table above is for West Lancashire which covers the area associated with Ormskirk District General Hospital and Skelmersdale Walk-In Centre. The table shows that across this set of particular indicators, a number of the values are very similar to those for England. The following aspects are also of note:

- Children under 16 in absolute and relative low income families is increasing.
- Homelessness is increasing.
- Pupil absence is worse.
- Percentage of employed people is improving.
- The number of children (under 20) in low income families is reducing.

[67] Public Health Outcomes Framework - Data | Fingertips | Department of Health and Social Care

## Infant Mortality

Child life expectancy is also another key indicator to consider and assists decision-makers to develop a rounded picture of health inequalities in their local area.

## Infant Mortality - Sefton

Better 95% Similar Worse 95% Not applicable

Recent trends: – Could not be calculated; No significant change; Increasing & getting worse; Increasing & getting better; Decreasing & getting worse; Decreasing & getting better

Benchmark Value; Worst; 25th Percentile; 75th Percentile; Best

| Indicator | Period | Sefton | | | England | | | |
|---|---|---|---|---|---|---|---|---|
| | | Recent Trend | Count | Value | Value | Worst | Range | Best |
| **Stillbirth rate** | | | | | | | | |
| Stillbirth rate | 2022 - 24 | – | 32 | 4.5 | 3.9 | 6.9 | | |
| **Infant mortality rate** | | | | | | | | |
| Infant mortality rate | 2022 - 24 | – | 31 | 4.3 | 4.2 | 8.7 | | |

[68]

The table above for Sefton shows that both stillbirth and infant mortality levels are similar to England rates, although stillbirth rates are edging towards being worse by being below the benchmark.

## Infant Mortality - West Lancashire

Better 95% Similar Worse 95% Not applicable

Recent trends: – Could not be calculated; No significant change; Increasing & getting worse; Increasing & getting better; Decreasing & getting worse; Decreasing & getting better

Benchmark Value; Worst; 25th Percentile; 75th Percentile; Best

| Indicator | Period | West Lancs | | | England | | | |
|---|---|---|---|---|---|---|---|---|
| | | Recent Trend | Count | Value | Value | Worst | Range | Best |
| **Stillbirth rate** | | | | | | | | |
| Stillbirth rate | 2022 - 24 | – | 13 | 4.4* | 3.9 | 6.9 | | |
| **Infant mortality rate** | | | | | | | | |
| Infant mortality rate | 2022 - 24 | – | 10 | 3.4* | 4.2 | 8.7 | | |

[69]

The statistics above for West Lancashire shows that both stillbirth rate and infant mortality rates are similar to the overall England figures.

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[68] Mortality Profile | Fingertips | Department of Health and Social Care

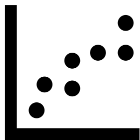
[69] Mortality Profile | Fingertips | Department of Health and Social Care

# 6.0 Service Performance Data

Data enables decision-makers to clearly understand a situation and to make informed, evidence-based decisions.

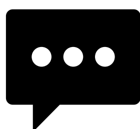
Robust data collection and analysis allow for realistic investigation of a problem and supports people to generate rational, reasoned solutions.

Data is an essential component in inclusive decision-making and is a vital element in meeting the general aims of the Public Sector Equality Duty. EDI practitioners advise that detailed collation and analysis of two core types of data are required to ensure that organisations meet their equality duties:



**Quantitative Data**

Numbers-based, countable, or measurable information that tells us how many, how much, or how often. Examples of data include patient activity statistics, the number of staff working in a department, service performance data, outcome measurements, service satisfaction, survey data etc. The key with this type of data will be the extent to which this data can be broken down (or disaggregated) by a person's Protected Characteristic in order to determine how the data differs across people with different Protected Characteristics. For example, do certain groups have people have poorer outcomes from a specific health service.



**Qualitative Data**

Non-numerical information that describes and observes things. Examples of this type of data include descriptions of emotions, experiences and behaviours such as patient feedback collected via a questionnaire. Qualitative data is interpretation-based and descriptive.

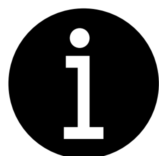
Detailed analysis of a number of quantitative and qualitative datasets will be necessary for the Programme to demonstrate that it is as informed as possible, with regard to equality and inclusion issues, when planning and making decisions and can evidence work done to consider possible solutions / mitigation to improve poorer outcomes for particular demographic groups.

Using data to gain an understanding of the patients who are likely to be impacted on by service transformation, and staff working within each service, will help to ensure that future service provision provides inclusive care and that service providers cater for the needs of staff. Profiling data relating to patients and staff will help to identify potential negative or positive impacts that may arise due to decisions made about future service specifications.

Data that relates to the Protected Characteristics of patients and staff is key to identifying and understanding the needs of different people accessing or working within health services. Where this is deemed necessary and relevant to the Public Sector Equality Duty, accessing and analysing this data will allow the Programme to assess which groups may be impacted both positively and negatively by any change in provision.

## 6.1 The Current Position

The Programme's current position around data is as follows:



**Equality Performance Data**

The is a collection of equality analysis data in relation to A&E performance. This is required, in order to meet the requirements of the Public Sector Equality Duty (PSED). In terms of what would be required as a baseline to meet the legal requirements, this would mean the services provided by Urgent and Emergency care, specifically accessing urgent and emergency services analysing key performance indicators across the different protected characteristics to determine whether performance is consistent or differs across different types of people. This in turn should then inform performance improvement over time.

Section 6.2 below, is recent performance analysis that was conducted for the purposes of this assessment. It is based on nationally constituted performance metrics in relation to A&E that relates to whether those who present at the Accident and Emergency department are seen a certain timeframe.

This intelligence is essential for the programme to inform critical decisions that have the potential to have a considerable impact on vulnerable people who are protected under the Equality Act. This evidence therefore enables the decisions being made to be fully informed in terms of understanding clearly, where the risks lie in relation to the Protected Characteristics and how that impact can be mitigated for, at the point that the decisions are being made, and not retrospectively (in line with important caselaw precedent referred to at the start of this report).

**Monitoring and Triggers**

There is monitoring of equality performance thresholds, however triggers and escalations are recommended to further strengthen monitoring. This will strengthen the current position on meeting the requirements of the Public Sector Equality Duty.

## 6.2 Current Key Performance Data

In terms of current available data, the following data from the emergency department has been extracted and analysed below. The analysis is using the waiting time breaches at the Emergency Department (ED).

### Emergency Department (ED) Performance Baseline and Equality Analysis

**Purpose and context**

Performance data Equality and Health inequality analysis- Equalities and inequalities impact assessment for the Southport and Ormskirk emergency care consultation

**Purpose and context**

This insert summarises baseline Emergency Department activity and performance using available 15-minute, 4-hour and 12-hour breach data. It applies an equality and health inequality lens to identify which groups are already more likely to experience long waits and potential disadvantage. The aim is to support due regard under the Public Sector Equality Duty and to inform the performance narrative and monitoring commitments in the Equality Considerations Report.

The two sites are not directly comparable in this dataset because Ormskirk ED activity in this extract is predominantly for children under 16, while Southport ED activity in this extract is predominantly adults aged 16 and over. Cross-site differences are presented only as context and must not be interpreted as evidence of relative performance between options. The decision-relevant insight is the within-site variation across groups, which indicates where unequal experience is already present and where additional disadvantage could occur if demand, travel, congestion or pathways change.

**Data source and scope**

The data source is the ED performance extract dated 20 February 2026. The dataset provides counts of attendances and breach events for Southport ED and Ormskirk ED. It includes breakdowns by age group, gender, ethnicity, religion or belief, deprivation decile and system alert flags. Alert flags act as a partial proxy for disability and additional needs such as learning disability, autism, interpreter required and mental health act.

Limitations in this extract include suppressed small numbers, incomplete recording for some protected characteristics and no 12-hour breach breakdowns for Ormskirk. These limitations are addressed by focusing the analysis on robust within-site patterns and by setting out an appropriate monitoring approach.

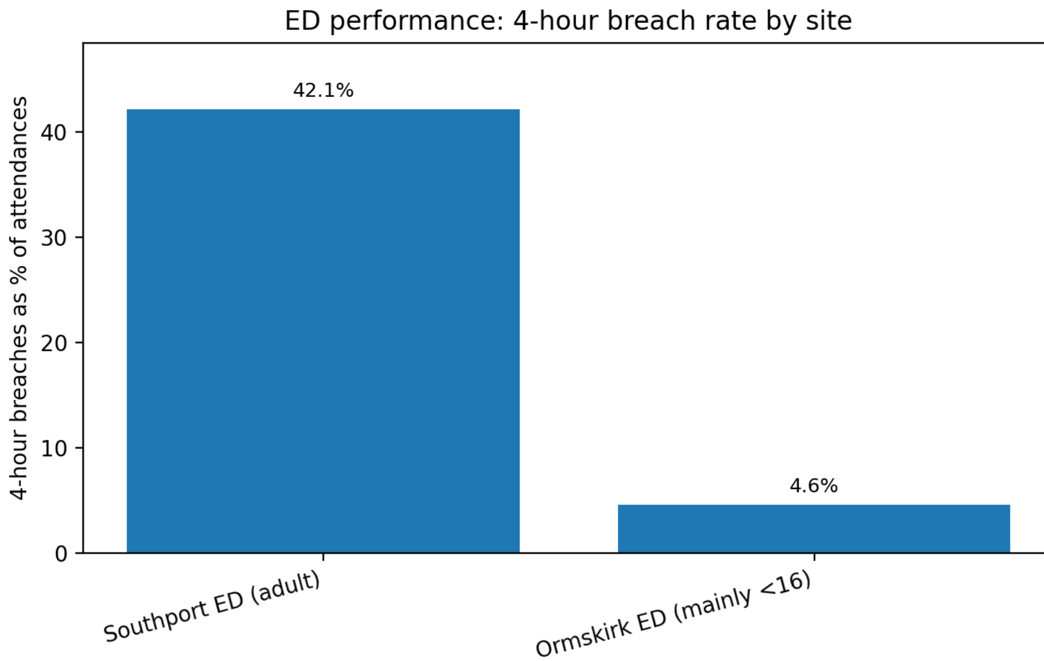
Headline baseline performance context

| Site | Attendances | 15-minute breaches | 15-minute breach rate | 4-hour breaches | 4-hour breach rate |
|---|---|---|---|---|---|
| Southport ED adult | 53,200 | 14,834 | 27.9% | 22,411 | 42.1% |

| Ormskirk ED mainly under 16 | 27,690 | 3,149 | 11.4% | 1,271 | 4.6% |
|---|---|---|---|---|---|

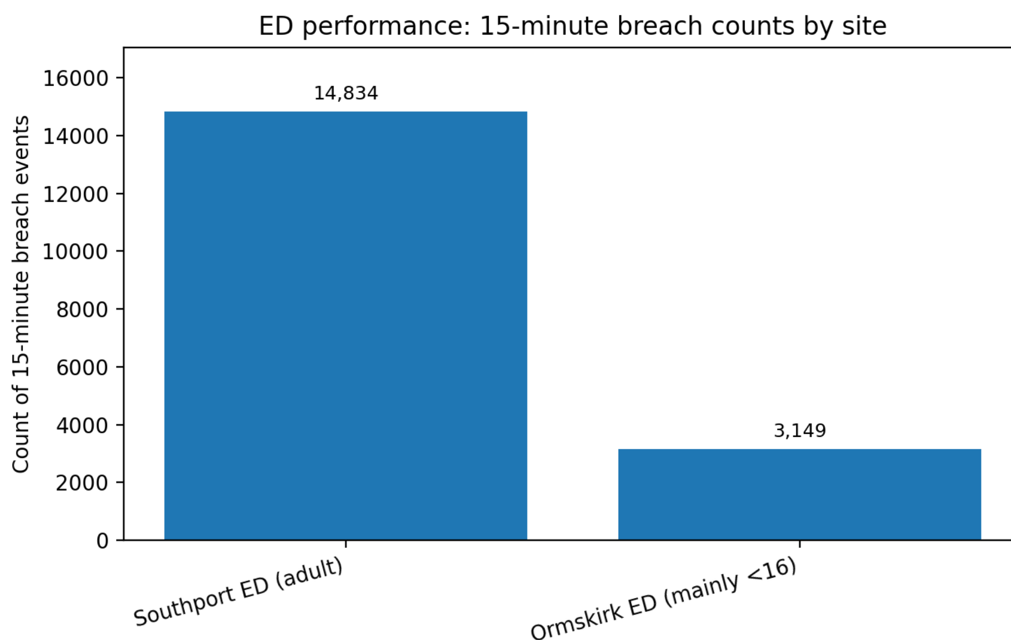
Southport ED also has 12-hour breach data in this extract with 10,137 12-hour breaches, which is 19.1% of attendances. 12-hour breach breakdowns are not available for Ormskirk in this extract.

Figure 1 4-hour breach rate by site




**Interpretation:** Baseline context on performance pressure in this extract. Do not interpret as like for like because populations and pathways differ.

## Figure 2 15-minute breach counts by site




**Interpretation:** Shows the volume of recorded 15-minute breach events in this extract. Use as an early signal of flow pressure, not as a direct site comparison.

### Disaggregated performance signals and inequality mechanisms

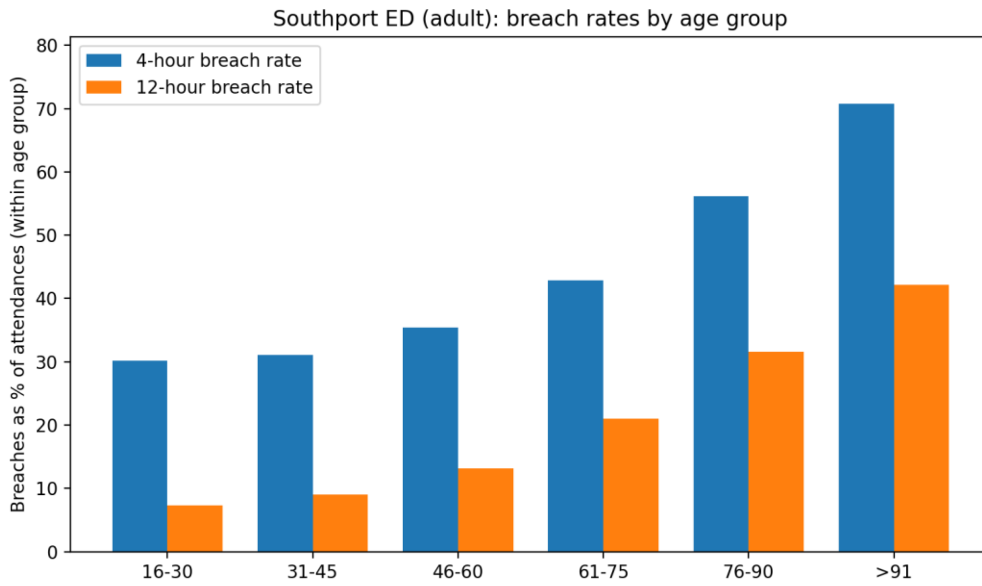
### Southport ED adult

#### Age

- Within Southport adult ED, breach exposure increases sharply with age. This is most pronounced for the longest waits and is therefore a clear equality signal.
- Age 76 to 90 has a 4-hour breach rate of 56.2% and a 12-hour breach rate of 31.6% within the age group.
- Age over 91 has a 4-hour breach rate of 70.8% and a 12-hour breach rate of 42.1% within the age group.
- Older people are disproportionately represented in the longest waits. Ages 76 to 90 account for 25.2% of attendances but 41.7% of 12-hour breaches. Ages over 91 account for 4.0% of attendances but 8.9% of 12-hour breaches.

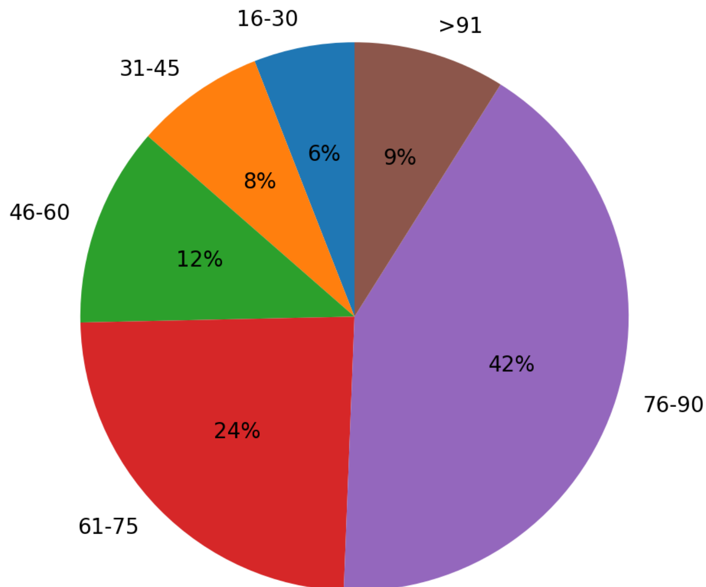
The above is particularly pertinent because older people are more likely to experience frailty, cognitive impairment, sensory impairment and mobility needs, and are at higher risk of avoidable harm, distress and loss of dignity when waits are prolonged.

### Figure 3 Southport adult ED breach rates by age group




**Interpretation**: Shows a steep age gradient in breach exposure in Southport adult ED, especially for 12-hour breaches.

### Figure 4 Southport adult ED share of 12-hour breaches by age group



### Colour key for the chart

Colours are used only to distinguish age groups and correspond to the labels shown on the pie chart. Percentages are rounded to whole numbers

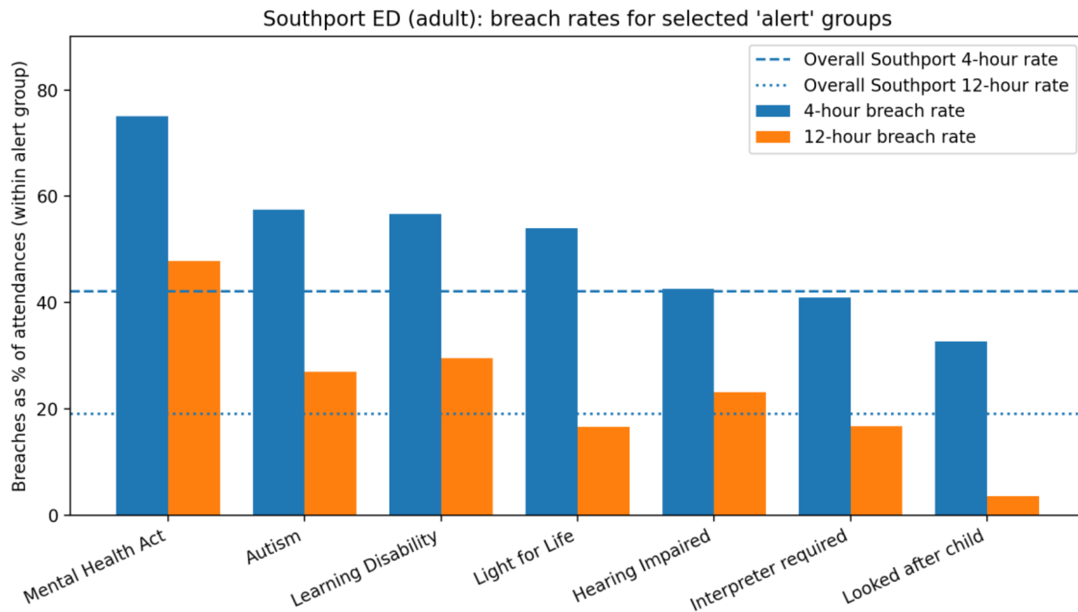
| Age group label | Colour on chart |
| --- | --- |
| 16–30 | Blue |
| 31–45 | Orange |
| 46–60 | Green |
| 61–75 | Red |
| 76–90 | Purple |
| >91 | Brown |

**Interpretation:** Shows that older age groups account for a disproportionate share of 12-hour breaches in Southport adult ED.

### Disability and additional needs proxy using alert flags

The dataset includes ED alert flags that act as a proxy indicator for some additional needs, including learning disability, autism, mental health act, sensory impairment and interpreter requirement. Alert flags are not a complete measure of disability prevalence because recording practice varies. However, among those flagged, breach exposure is materially higher than the overall Southport adult ED rates, indicating a higher risk of disadvantage from long waits and unsuitable environments.

*Figure 6 Southport adult ED breach rates for selected alert groups*




**Interpretation:** Shows higher breach exposure among several alert groups compared to overall Southport rates. Alert flags are a partial proxy and rely on consistent recording.

**Selected alert group breach exposure in Southport adult ED:**

| Alert group | Attendances flagged | 4-hour breach rate | 12-hour breach rate | Equality interpretation |
|---|---|---|---|---|
| Learning Disability | 490 | 56.7% | 29.6% | Higher breach exposure indicates higher risk of disadvantage from delay and crowding. Requires specific mitigations and monitoring. |
| Autism | 289 | 57.4% | 27.0% | Higher breach exposure indicates higher risk of disadvantage |

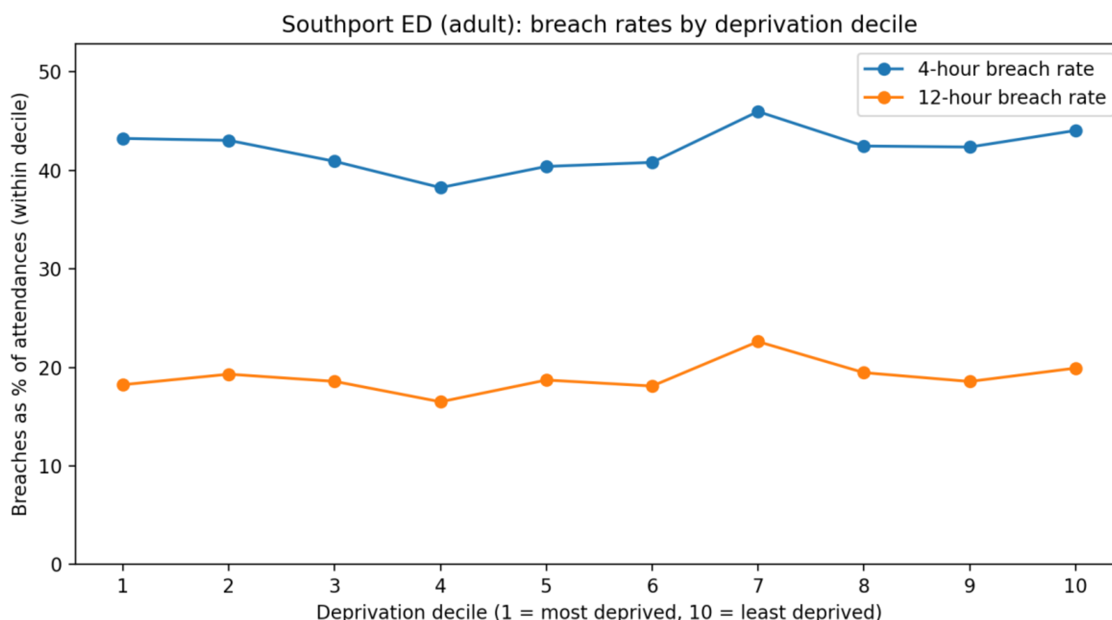
| | | | | |
|---|---|---|---|---|
| | | | | from delay and crowding. Requires specific mitigations and monitoring. |
| Mental Health Act | 205 | 75.1% | 47.8% | Higher breach exposure indicates higher risk of disadvantage from delay and crowding. Requires specific mitigations and monitoring. |
| Interpreter required | 317 | 41.0% | 16.7% | Higher breach exposure indicates higher risk of disadvantage from delay and crowding. Requires specific mitigations and monitoring. |
| Hearing Impaired | 134 | 42.5% | 23.1% | Higher breach exposure indicates higher risk of disadvantage from delay and crowding. Requires specific mitigations and monitoring. |
| Light for Life | 126 | 54.0% | 16.7% | Higher breach exposure indicates higher |

| | | | | |
|---|---|---|---|---|
| | | | | risk of disadvantage from delay and crowding. Requires specific mitigations and monitoring. |
| Looked after child | 196 | 32.7% | 3.6% | Higher breach exposure indicates higher risk of disadvantage from delay and crowding. Requires specific mitigations and monitoring. |

**Deprivation**

Deprivation is a core health inequality driver and is associated with higher emergency care need and complexity. In this extract, Southport adult ED shows variation in breach rates across deprivation deciles but not a simple linear gradient. This should be interpreted cautiously and reinforces the need to monitor long waits and access barriers by deprivation following any change.

*Figure 5 Southport adult ED breach rates by deprivation decile*




**Interpretation:** Shows variation in breach exposure by deprivation decile. Pattern is not linear in this extract so interpret cautiously and monitor post decision.

**Data completeness and recording as an equality risk**

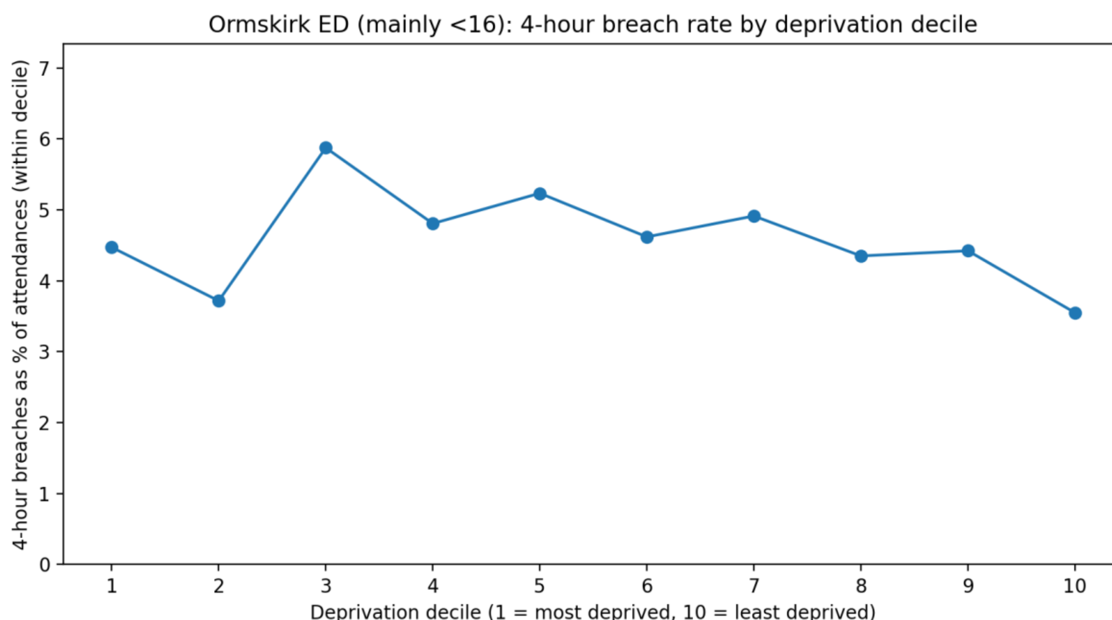
Equality analysis is constrained by the completeness of protected characteristic recording. In Southport adult ED, ethnicity has a combined Not set, Not stated or Unknown proportion of 9.8% in this extract. Religion or belief has missing or unknown values of 27.7% in this extract. Improving the completeness and consistency of equality data recording supports due regard because it enables more accurate monitoring and targeted action.

**Ormskirk ED mainly under 16**

The dataset is dominated by under 16 activity at Ormskirk. The overall 4-hour breach rate is low in this extract. Numbers for adult age bands and many protected characteristic categories are small and in places suppressed, so robust disaggregation is limited for Ormskirk in this dataset.

Health inequality monitoring remains important for Ormskirk because deprivation is closely linked to emergency care need and vulnerability. The chart below shows modest variation by deprivation decile in this extract.

*Figure 7 Ormskirk ED 4-hour breach rate by deprivation decile*




**Interpretation:** Shows modest variation in 4-hour breach exposure by deprivation decile for Ormskirk ED in this extract.

**Performance measures to support due regard and post-decision monitoring**

The table below sets out measures that are more equality sensitive than a simple cross-site comparison. It summarises what is available in this extract and what should be monitored following a decision to demonstrate ongoing due regard.

| Measure | Why it is equality relevant | What it shows in this dataset | What we will monitor post decision |
|---|---|---|---|
| 4-hour breach rate | Captures exposure to prolonged waits linked to avoidable harm and distress, often experienced unequally by age, disability and deprivation. | Available. Southport 42.1% overall with strong age and alert group gradients. Ormskirk 4.6% overall in this extract with modest deprivation variation. | Monitor quarterly overall and by age bands, deprivation decile and key alert flags. Apply escalation triggers with minimum denominators and rolling averages for small groups. |
| 12-hour breach rate | Tracks extreme tail waits where harm, | Available for Southport only in this | Monitor quarterly overall and by age |

|  |  |  |  |
|---|---|---|---|
|  | distress and loss of dignity risk are highest, disproportionately affecting older and disabled people. | extract. 19.1% overall with steep age gradient and higher rates for several alert groups. | and alert flags. Escalate if 12-hour breaches rise from baseline or if the burden shifts further towards older and disabled groups. |
| 15-minute breach events | Early signal of front door flow and safety pressure that can affect access for vulnerable groups and those needing communication support. | Available. Southport 27.9% and Ormskirk 11.4% in this extract. Not like for like across sites. | Monitor quarterly . Use as a trigger for review of triage, streaming and escalation for high-risk cohorts. |
| Percent waiting over 6 hours and over 8 hours | More equity sensitive than 4 hours and better reflects long waits that drive avoidable harm, especially for older and disabled people. | Not available in this extract. | Add to dashboard post decision and monitor overall and by age, deprivation and alert flags with agreed thresholds. |
| 95th percentile total time in ED | Captures the tail of the distribution and is a strong proxy for who experiences the longest waits. | Not available in this extract. | Add to dashboard and review quarterly by site and key equality groups. |
| Left without being seen or did not wait | Direct access barrier indicator. Higher rates can signal inequity, particularly for deprived communities, carers and people with mental health needs. | Not available in this extract. | Monitor monthly overall and by deprivation and age. Escalate if rates rise or if any group shows disproportionate increase. |
| Ambulance handover delays | Risk at the interface between ambulance and ED. Delays disproportionately affect frail older | Not available in this extract. | Monitor percent over 30 and 60 minutes. Review impacts on vulnerable cohorts and escalate when |

| | people and those with complex needs. | | thresholds are breached. |
|---|---|---|---|
| Decision to admit to ward transfer time | Measures exit block and boarding associated with harm and reduced dignity, with unequal impact on vulnerable groups. | Not available in this extract. | Monitor boarding time and percent boarded over 4 hours. Escalate for sustained breach or when linked to incidents affecting vulnerable cohorts. |
| Equality data completeness | Enables accurate due regard and equitable monitoring. Missing data can mask inequality and undermine assurance. | Available. Ethnicity missing or unknown 9.8% and religion or belief missing or unknown 27.7% in Southport adult ED in this extract. | Monitor completeness monthly. Implement improvement actions and accountability for recording in operational governance. |

### Monitoring and escalation triggers

Escalation triggers must be linked to action, not just reporting. Because some equality group denominators are small, escalation should be applied in a way that is statistically and operationally credible.

- Apply escalation triggers when the group denominator is 50 or more attendances per month for that measure, or use a rolling three month average where denominators are smaller.
- Trigger a review when the breach rate for any high-risk group increases by 5 percentage points or more over two reporting periods, or when the gap between that group and the overall ED rate widens by 5 percentage points or more, subject to the denominator rule above.
- Where quantitative denominators are small, triangulate with qualitative signals including PALS, complaints themes and incidents relating to delay, communication barriers, distress or safeguarding.

### Equality and health inequality implication

This baseline indicates that older people and people with additional needs flagged by learning disability, autism and mental health act at Southport ED are already experiencing poorer timeliness, including very long waits. These are groups with protected characteristics and closely associated health inequality risk factors. This increases the importance of designing the

future model to prevent any widening of gaps in access, experience and outcomes, and to show how mitigations will be delivered and monitored in practice.

**Due regard summary on current ED performance and outcomes**

Having had due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations, the baseline ED performance data indicates an existing risk of unequal experience for some protected groups. The strongest signals in this extract are for older people and for people with additional needs flagged by learning disability, autism and mental health act at Southport ED. This means that any decision must be accompanied by specific, and deliverable mitigations that protect timely care and reduce avoidable distress for these groups, including reasonable adjustments, low stimulus waiting areas and support for carers. The programme must also commit to ongoing disaggregated monitoring so that any widening of gaps in performance for these groups is identified early and acted upon through governance. The above monitoring, mitigations and escalation triggers will enable the programme to do this.

**Operational mitigations and commitments**

- Reasonable adjustments. Consistent identification and delivery of reasonable adjustments for people with learning disability, autism, sensory impairment and communication needs, including quiet spaces and communication support.
- Older people and frailty. Strengthen frailty assessment, rapid assessment and escalation processes and ensure environments and staffing models minimise harm from prolonged waits.
- Accessible communication. Ensure interpreter access and accessible information are available without delay and embedded in flow processes.
- Carer involvement. Provide clear support for carers and ensure carer involvement is enabled, particularly for people with learning disability, autism and cognitive impairment.
- Safeguarding and vulnerability. Maintain and monitor pathways for looked after children and other vulnerable cohorts with clear escalation routes.

**Decision relevance box**

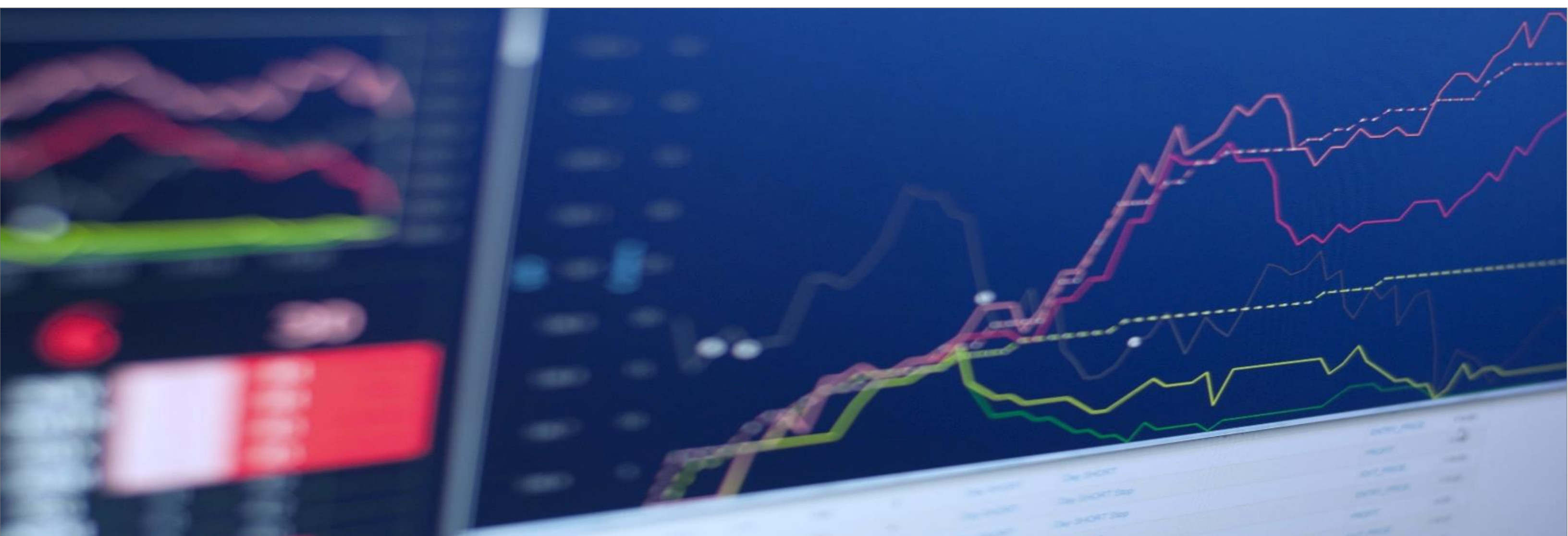
**What the evidence shows**
Southport ED shows a high baseline 4-hour breach rate of 42.1% and a 12-hour breach rate of 19.1% in this extract. Breach rates rise sharply with age and are materially higher for people flagged with learning disability, autism and mental health act. Ormskirk ED shows a low 4-hour breach rate of 4.6% in this extract, but activity is predominantly for children under 16 so headline comparisons are not like for like.

**Who is most at risk of disadvantage**
Older people, especially those aged 76 and over, and people with disability-related needs captured through alert flags including learning disability, autism and mental health act.

These groups are at higher risk of longer waits, distress and poorer experience if demand or congestion increases.

**What the programme must commit to during implementation.**
A clear plan to protect and improve timeliness for the higher risk groups above, including reasonable adjustments, low stimulus waiting space and clear carer support. A credible capacity and flow plan for the chosen option that demonstrates how additional demand will be managed to avoid worsening corridor care and long waits.

**What must be monitored and escalation triggers**
Quarterly disaggregated reporting of 4-hour and 12-hour breaches for Southport adult ED and related flow measures and experience signals, with clear escalation when gaps widen. Escalation should be triggered where the breach rate for any high-risk group increases by 5 percentage points or more over two reporting periods, or where the gap between that group and the overall ED rate widens by 5 percentage points or more, applying a minimum denominator rule and rolling averages for small groups.



# 7.0 Consultation and Engagement Intelligence

Communications and engagement intelligence gathered from engagement activities with patients, staff and other stakeholders is vital for informing the decision-making of the Programme. Intelligence gathered as part of the Programme's communications and engagement processes should therefore be interrogated, with equality-related themes identified and used to inform the decisions made as part of the development of future service models.

As part of this process, the Programme may also identify the need to gather additional intelligence relating to specific Protected Characteristic groups who may be more likely to be impacted by a decision – for example, people from different ethnic groups who are more likely to experience higher risks of complications at birth that result in a need for neonatal services. Conducting additional engagement with these groups will help the Programme to capture meaningful intelligence that can be used inform the next phase of service model design.

Key areas of consideration for capturing equality considerations and expressing due regard under the Public Sector Equality Duty when undertaking engagement work include:

- **Equality profiling** (also known as equality monitoring): collecting information about the Protected Characteristics of participants e.g. asking questions as part of a survey about a person's Protected Characteristics, such as their Age and Sex. This should be carefully considered and communicated so that people understand why the information is being collected.

- **Representative sampling**: this refers to the extent to which a sample of people with different Protected Characteristics who have been invited and involved in a particular engagement activity is representative of the wider population. If the sample is not representative, some groups, and their views, may be under-represented in the feedback and therefore decisions might not be based on the whole local population's needs.

  To achieve a representative sample of participants, it's recommended that organisations actively consider:

  Breadth of engagement methodology: how many different methods have been used and how far-reaching those were in terms of the types of people who were engaged within the engagement process.

  Depth of engagement methodology: the extent to which the consultation and engagement drills down into equality and inclusion issues so that meaningful and robust evidence and data is generated across and within different Protected Characteristic groups.

- Disaggregated analysis**:** robust equality analysis involves breaking down communication and engagement intelligence by the Protected Characteristics to assess whether there are any themes relating to feedback from particular groups and helps to provide insight relating to potential impacts on each Protected Characteristic group.

- Equality and inclusion extraction: this refers to the notion that equality and inclusion issues are identified and extracted out of communication and engagement intelligence following analysis that has been conducted. This helps to ensure that decision-makers are made aware of the issues, and that equality considerations are actively embedded within the decision-making process.

## 7.1 The Current Position

**Background and why engagement was required**

The consultation and wider engagement activity has been undertaken to support a lawful, transparent and inclusive decision-making process for a major service change. It has enabled people who are likely to be affected, including patients, carers, staff and local communities, to understand the proposals, to express views, and to raise concerns and ideas that can shape mitigations and implementation planning.

The engagement approach has been informed by an equalities and health inequalities assessment to identify groups who may be more likely to experience disadvantage, and to ensure targeted outreach and accessible participation routes.

### The story so far

Engagement has taken place over more than one phase, starting with pre-consultation work and followed by a formal public consultation.

Pre-consultation engagement consisted of a 10-week programme of activity designed to gather early insights and potential solutions from patients, the public and staff. Activities included a public survey, roadshows, public meetings, focus groups and staff briefings and workshops, reaching around 3500+ people.

Formal public consultation launched in July 2025 and ran for 13 weeks. It sought views on two location options for co-locating 24-hour adult and children's Accident and Emergency services on a single site and reached over 7800 people which equates to 3.3% of the population.

### How people could take part and how inclusion was supported

The consultation used multiple routes to participate, with an emphasis on clear information, adequate time, and accessible options for different needs. It included both online and offline participation routes to reduce the risk of digital exclusion, and targeted outreach where participation gaps were identified.

- Consultation survey available online and in hard copy, with an easy read version available.
- Fourteen public events, including online public meetings, in-person public meetings and roadshow drop-in sessions.
- Public and staff focus groups to explore issues in more depth.
- Community outreach activity across local venues, including additional activity in West Lancashire.

- Dedicated feedback channels including an email inbox and a voicemail system, alongside written submissions.
- Independent polling to provide a broadly representative sample alongside open participation routes.

Marketing and promotion included a large-scale household leaflet drop to 110,000 addresses, distribution of materials through community venues and stakeholder networks, and digital communications that reached more than 273,000 people. The consultation website had more than 26,000 visits and regular updates were shared through stakeholder newsletters.

**Assurance, scrutiny and continuous improvement**

The consultation approach included pre-consultation, midpoint and closing reviews to monitor whether the approach was working as intended and to support adjustments during delivery. This included additional engagement activity and enhanced outreach where required.

Engagement and consultation activity was supported by a clear governance route and ongoing engagement with local authority scrutiny, including Health Overview and Scrutiny Committee engagement and joint scrutiny arrangements for the Programme.

**How feedback was analysed and used**

An independent organisation analysed consultation feedback from surveys, written submissions, events, polling and social media. This helped ensure an objective and comprehensive assessment of views and themes.

Feedback was then reviewed through a structured process by clinical and managerial leaders across the partner organisations. This supported a consistent approach to identify what could be assured, what required mitigation, and what required a change in Programme plans or implementation approach.

**What it has meant so far**

The consultation has produced a clear evidence base about what matters most to people and where impacts may fall unevenly. Key themes included travel and access, parking and arrival, the waiting environment, confidence in delivery, and the need to understand service interdependencies. This evidence base has informed mitigation planning, including work with partners on travel and access, development what to consider during implementation, and a clearer monitoring and escalation approach.

**Next stages**

The next stages are to complete the post consultation review and to support decision-makers to have due regard to the equality and health inequality aims, with a clear decision record. This includes confirming mitigations and monitoring requirements, and setting out the commitments that should be in place before any change is implemented.

## 7.2 Public Consultation: July – October 2025

### 7.2.1 Background

Building on the development of a case for change, a pre-consultation engagement exercise and then an options appraisal process were conducted to help the Programme make recommendations on which option, or options, should be included in the public consultation.

A Shaping Care Together consultation document was produced that set out the vision and the proposals on how to turn the vision into reality. The consultation to get people's views on the proposals was launched on 4 July and ran until 3 October 2025.

### 7.2.2The consultation process

The Shaping Care Together public consultation offered patients, staff, stakeholders and members of the public a number of ways to share their views including:

Online survey – this could be accessed through the Shaping Care Together website. The survey contained closed questions to gauge levels of support for the proposals and open-ended questions to give respondents the opportunity to express their opinions in their words.

Paper survey – this mirrored the questions asked in the online response form. An Easy Read version was also available.

Written feedback – letters, emails and long form submissions were sent to the Shaping Care Together email and freepost address. Petitions were also submitted by email or post.

Meetings – a number of public meetings, stakeholder meetings, collaborative events and focus groups were held during the consultation period and reports on these were included as part of the consultation process.

Representative telephone and online survey – a telephone and online survey of 507 local residents, broadly representative by geography and demographics was conducted across Southport, Formby and West Lancashire.

Social media – comments were received through partner organisations' Facebook and X channels.

- A total of more than 7,840 people actively engaged with the Programme during the consultation period. This included:
- 5,009 online and hard copy survey responses received.
- 14 public events saw over 800 people reached:
- 2 online public meetings with over 120 attendees
- 6 in-person public meetings with over 500 attendees
- 6 roadshow 'drop-ins'
- 507 people contacted via independent polling exercise; a representative sample of the population across the areas
- 7 public focus groups with 52 attendees
- 2 staff focus groups
- 800+ people engaged across 53 different community venues in West Lancashire
- 382 pieces of feedback to the Get Involved inbox
- 6 presentations at collaborative forums
- 170 voicemails messages about SCT received
- 2 All-Staff NHS Trust Brief Live sessions with 100+ people

The options The Shaping Care Together consultation document (referred to from now on as ‘the consultation document’) set out the Programme’s vision and proposals for change. The proposals involved substantial developments or changes in the way urgent and emergency care services are provided and the Programme wanted to consult with the public on these before making any final decisions.

**The options put forward were:**

Southport and Formby District General Hospital option: Option one brings children’s and adult A&E together on a single site in Southport, relocating the children’s A&E from Ormskirk District General Hospital and extending it to an all-day service (24-hours).

Ormskirk District General Hospital option: The other option brings services together at Ormskirk District General Hospital, relocating the adult ED from Southport to Ormskirk and extending the current children’s ED to an all-day service (24-hours).

The Programme’s preferred option was the Southport option.

Attitudes towards the proposals for each of these options varied throughout the consultation often based on the respondent’s location. The findings, therefore, are summarised thematically by question and then by location.

### 7.2.3 Profile of respondents who engaged

This section provides a validated summary of the demographic profile of respondents using the equality monitoring fields from the consultation survey dataset. Equality monitoring questions were optional. The consultation sample is self selected and should not be presented as statistically representative. They may also not directly correlate with all ONS 2021 Census data used for population analysis in section 5, due to the questions/categories used in the consultation reflecting more recent legal developments (see section 5.1 above).

Where Sefton is referred to in relation to respondents who engaged, this is a grouping of short post codes for the areas of Southport, Formby and Maghull and where West Lancashire is referred to this is a grouping of short post codes for the areas of Skelmersdale, Ormskirk and Northern Parishes.

**Age**

Responses were older skewed. Respondents aged 61 years and over made up 42.2 percent of responses, while respondents aged under 31 made up 7.2 percent. This indicates younger perspectives may be underrepresented and should be triangulated through targeted youth engagement during implementation phase.

### Sex

Women were more likely to respond than men. Female respondents were 71.3 percent and male respondents were 25.0 percent. Prefer not to say and missing responses were 3.7 percent combined.

### Disability and impairment

There were 711 respondents who reported being disabled, representing 14.2 percent of respondents. This is below Census based benchmarks for Sefton and West Lancashire, indicating likely under representation of disabled people in the consultation sample. The survey also collected impairment types. Impairment groups overlap, one person may select more than one impairment.

- Longstanding illness or condition: 976 (19.5%).
- Mental health condition: 342 (6.8%).
- Physical impairment or mobility issues: 470 (9.4%).
- Social or communication impairment including autism: 129 (2.6%).
- Learning difficulty or cognitive disorder: 171 (3.4%).
- Blind or visual impairment: 61 (1.2%).
- Deaf or hearing impairment: 209 (4.2%).
- Other impairment or condition: 263 (5.3%).

### Gender reassignment

The gender reassignment question has a small base for 'Yes' and should be treated as low confidence for subgroup comparisons. Yes responses were 12 (0.2 percent). Prefer not to say responses were 154 (3.1 percent) and missing responses were 71 (1.4 percent).

### Marriage and civil partnership

The most common category was Married, 2937 respondents (58.6 percent). Other categories included Living with a partner 657 (13.1 percent), Single 581 (11.6 percent), Widowed 301 (6.0 percent), Divorced or civil partnership dissolved 220 (4.4 percent), In a civil partnership 41 (0.8 percent). Missing and prefer not to say responses were 5.4 percent combined.

### Ethnicity

Respondents were predominantly White. White total was 94.9 percent. Non White and other ethnicities were 2.3 percent. Missing or not stated ethnicity was 2.8 percent. This indicates under representation of racialised communities compared with local benchmarks and requires targeted follow up engagement during implementation phase.

### Pregnancy and maternity

Pregnancy and maternity responses were 318 (6.3 percent) for 'Yes'. The survey question relates to respondents who are pregnant or have been pregnant in the last 12 months. There

is no direct Census benchmark for this characteristic in this context and programme assurance should draw on service user profiling and pathway clarity requirements.

**Religion or belief**

Most respondents were Christian, 2863 (57.2 percent). The next largest group was No religion, 1589 (31.7 percent). Other (free text) was 74 (1.5 percent). Missing or prefer not to say responses were 8.9 percent combined, which reduces confidence in comparisons for this characteristic.

**Sexual orientation**

Most respondents were Heterosexual or straight, 4369 (87.2 percent). Prefer not to say was 337 (6.7 percent) and missing was 113 (2.3 percent). Bisexual was 69 (1.4 percent), Gay woman or lesbian 52 (1.0 percent), Gay man 40 (0.8 percent), Other 22 (0.4 percent), Asexual 7 (0.1 percent).

**Unpaid carers**

Unpaid carers were 1808 (36.1 percent). This is substantially higher than Census unpaid care estimates, noting definitions differ so this is not a direct like for like comparison.

**Armed forces**

Armed forces status was collected. Yes responses were 159 (3.2 percent). No responses were 4667 (93.2 percent). Prefer not to say was 99 (2.0 percent) and missing was 84 (1.7 percent).

### 7.2.4 Consultation representativeness against local population benchmarks

This section compares consultation respondent demographics to Census based benchmarks where directly comparable measures are available. Comparisons are indicative. Consultation questions do not perfectly match Census definitions and some characteristics are not directly comparable.

| Characteristic | National benchmark | Sefton benchmark | West Lancashire benchmark | Consultees |
|---|---|---|---|---|
| Ethnicity, White total | 81.0% | 95.8% | 96.9% | 94.9% |
| Ethnicity, non White and other ethnicities | 19.0% | 4.2% | 3.1% | 2.3% |
| Disability, disabled or limited day to day activities | 17.8% | 20.6% | 18.7% | 14.2% |
| Caring responsibility, provides unpaid care | 8.9% | 10.7% | 10.0% | 36.1% |

| | | | | |
|---|---|---|---|---|
| Religion, Christian | 46.3% | 64.4% | 61.5% | 57.2% |
| Veteran status, previously served in UK armed forces | 3.8% | 4.7% | Not available | 3.2% |
| Sexual orientation, straight or heterosexual | 89.4% | 91.4% | Not available | 87.2% |
| Gender reassignment, survey question sex reassignment reporting yes | Not directly comparable | Not directly comparable | Not directly comparable | 0.2% |
| Ethnicity, missing or not stated | Not applicable | Not applicable | Not applicable | 2.8% |

**Key points for consideration**

Women and older adults are over represented in the consultation responses, which can amplify themes linked to caring roles and access needs and risks missing younger and male perspectives unless triangulated.

Disabled people and non White and other ethnicities are under represented compared with local benchmarks. This increases the importance of inclusive design, targeted follow up engagement, and monitoring during implementation phase.

Some characteristics have small bases or are not directly comparable with Census measures. These should be treated as low confidence and managed through targeted engagement and monitoring rather than treated as evidence of no impact.

Armed forces status was collected. Representativeness is broadly similar to national benchmarks but should still be interpreted cautiously.

## 7.3 Inclusive Engagement Undertaken

The programme consultation approach aimed to maximise inclusion and reduce barriers to participation. It combined population-level communications with targeted engagement activity focused on groups more likely to be under-represented or to face participation barriers. This supports due regard to the Public Sector Equality Duty by taking proportionate steps to remove barriers, broaden participation, and identify and respond to under-representation during the consultation period.

**What the programme did to support inclusive participation**

- Multiple ways to take part. Online and offline routes were provided, including a paper survey that mirrored the online survey, with accessible formats such as Easy Read available.
- Accessible and flexible opportunities to engage. Public Q&A sessions were held in multiple locations and included both daytime and evening sessions, alongside online sessions, to increase accessibility for people with work, caring responsibilities, mobility constraints, or transport limitations.

- Population-level reach. A broad communications approach was used, including leaflet distribution, digital reach, stakeholder newsletters and media coverage, supported by a stakeholder toolkit including posters, survey and events information, and public FAQs.
- Online and in person events, including public events, drop-in sessions and road shows.
- Telephone polling of more than 500 people to reach out to underrepresented groups including 10% from Black Asian Minority Ethnic (BAME) communities.

**Local venue-based engagement during consultation**

In-person discussions were held with 836 people, and 1,537 consultation materials were handed out across community venues during the 13-week consultation period.

Venues used to distribute materials and hold local discussions included the following.

| | |
|---|---|
| About the Town (community support), Skelmersdale | Hesketh Bank Community Cafe |
| Appley Bridge Village Hall | Hilldale Village Hall |
| Artz Centre Birch Green | Hope Street (community support venue), Ormskirk |
| Artz Centre Up Holland (drop-in) | Kingsbury Primary Special School (at Skelmersdale Library) |
| Ashley Dalton MP (Ecumenical Centre Office) | Little Achievers Nursery |
| Ashurst Health Centre, Skelmersdale | Mere Brow Village Hall |
| Aughton Village Hall | Nifty Fifties (The Hub at Banks) |
| Birch Green Artz Centre (community hub), Skelmersdale | Ormskirk Library |
| Birchwood Crisis Centre, Skelmersdale | Ormskirk Medical Practice |
| Birchwood West Lancs Foyer | Park Children's Centre, Skelmersdale |
| Bright Beginnings Nursery, Birleywood | Parbold Library |
| Burscough Family Hub | Parbold Village Hall |
| Burscough Health Centre | PULSE, Skelmersdale |
| Burscough Leisure and Wellbeing Hub | Sandy Lane Health Centre, Skelmersdale |
| Burscough Library | Skelmersdale Family Hub |
| Burscough Town Council | Skelmersdale Library |
| Eavesdale Family Hub, Skelmersdale | Skelmersdale Walk-in Centre |

| | |
|---|---|
| Ecumenical Centre, Skelmersdale | Tanhouse Community Centre, Skelmersdale |
| Eden Tearoom and Galleries, Newburgh | Tarleton Library |
| Evermoor Hub, Digmoor | The Elms Medical Practice |
| Excel GP Surgery, Upholland | The Hub at Banks |
| Excel Primary Care, Birleywood | The Nest (WLBC Health and Wellbeing service) |
| Family Hub event, Skelmersdale Concourse | Twinkle House, Skelmersdale |
| Family Hub summer event (Richmond Park, Burscough) | Upholland Community Hub |
| Greenhill Community Hub | West Lancashire Borough Council Town Hall, Ormskirk |
| Hall Green Surgery, Upholland | West Lancashire Pensioner's Forum, Ormskirk |
| Hants Lane Clinic | |

**Targeted engagement linked to protected characteristics and inclusion groups**

- Disability and long-term conditions. Targeted engagement included work with disability and condition-related organisations, including groups supporting people with learning disability and autistic people, Deaf communities, and people with long-term conditions. This was complemented by accessible participation routes and available accessible formats.
- Race, ethnicity, and faith communities. Engagement was undertaken through community and faith networks, including faith forums and local community organisations, to increase reach into ethnic minority communities.
- Age and working patterns. Targeted digital promotion, including targeted social media advertising, was used as part of the communications mix to increase reach among younger and working-age adults alongside traditional engagement methods.
- Pregnancy and maternity, carers and single parents, and socio-economic disadvantage. Targeted activity included outreach through community partners supporting families and single parents and through venues and services supporting people experiencing deprivation and crisis, recognising participation barriers linked to time, digital access, transport, and caring responsibilities.

**Additional outreach where under-representation was identified**

Organisations identified through the equality analysis and response monitoring as supporting groups that were under-represented were contacted to signpost people to consultation materials and ways to get involved.

- Single parents and families, with additional focus in Skelmersdale and Southport.

- Trinity SNAP group.
- Southport Ormskirk Sefton MVP.
- Parenting 2000.
- Baby Sensory Group.
- Roots and Shoots Southport.
- Home Start Southport.
- NCT local branches.
- People without access to their own transport.
- NWAS Patient Engagement Manager.
- Care Home Managers Group.
- People experiencing deprivation or crisis, with focus in Skelmersdale and Southport.
- Hope Street.
- Ormskirk Foodbank.
- Southport Foodbank.
- Compassion Acts.
- Community Link Foundation.
- Southport Salvation Army.
- West Lancs Crisis Centre.
- Sefton Support Group.
- Sefton Advocacy Service.
- Divine Days CIC.
- Care homes.
- Care Home Managers Group.
- Religious minorities.
- Southport Mosque.
- Sefton Faith Forum.
- Torch Trust.
- Ethnic minority communities.
- Southport African Caribbean Heritage Association.
- Equality Voice Network Sefton.
- Equalities Forum Sefton CVS.
- Disabled people and people with long-term conditions.
- Mencap Liverpool.
- Trinity SNAP.
- Hope’s Therapy Dogs.
- People First.
- Merseyside Society for Deaf People.
- West Lancs and Merseyside Myeloma.
- Sefton Support Group.

**Evidence of efforts to increase representation during the consultation**

- **Mid-point review and responsive adjustment.** Engagement activity was monitored during the consultation period. Where under-representation was identified, the approach was strengthened through additional targeted outreach and adjustments to the engagement programme.
- **High overall participation compared with typical consultations**. Overall engagement levels were reported as higher than typically seen in comparable NHS consultations, supporting confidence in breadth of reach while maintaining a focus on any remaining under-representation and differential impact.

**Due regard and how decision-makers should use this evidence**

This engagement approach provides evidence that the programme took proportionate steps to support inclusive participation and reduce known barriers. Decision-makers should consider the consultation findings alongside who responded and who may be under-represented, ensure mitigations address differential impacts identified through consultation and equality analysis, and commit to continued targeted engagement through mobilisation and implementation.

**PSED due regard assurance**

The consultation and engagement approach included targeted activity to reach all protected characteriscs.. This provides assurance that the programme has had due regard to the need to advance equality of opportunity by reducing barriers to participation and responding where under-representation was identified. Decision-makers should ensure that commitments on mitigation, accessible communications and ongoing targeted engagement are carried forward into mobilisation and implementation.

**PSED due regard assurance**

The consultation and engagement approach included targeted activity to reach specific groups sharing certain protected characteristics and others at higher risk of exclusion. This provides assurance that the programme has had due regard to the need to advance equality of opportunity by reducing barriers to participation and responding to under-representation. Decision-makers should ensure commitments on mitigation and ongoing engagement are carried forward into mobilisation and implementation.

## 7.4 Equality Analysis – Headline Findings (Full Analysis Appendix One)

Disaggregated analysis has been conducted on the data from the public consultation, which means that the data has been analysed across the different Protected Characteristics, to

determine the extent to which there are differences in the way that people have responded to the questions.

For example, a survey question may have been, do you agree with the proposal? The generic results might be, that 70% of respondents agree with the proposal and 30% disagree. When this is broken down to consider only disabled people's responses, for example, this may show that 70% of disabled people disagree with the proposal and 30% agree (an inverse response). This shows therefore that disabled people have an opposing view to the overall majority of respondents, but this is hidden amongst the generic analysis if it's not broken down in this way. Disaggregating the data and analysing it in this way is important insight to assist in discerning any equality issues from a consultation process.

The headline findings from the consultation findings Equality Analysis are detailed below (the complete analysis is also included in Appendix 1:

### Consultation equality analysis summary (Appendix 1)

This section summarises the equality and health inequality evidence from the public consultation on the two options to host a collocated emergency department. It is designed to support decision makers to evidence due regard under the Public Sector Equality Duty by setting out the key mechanisms through which unequal impact may arise, the groups most likely to be at risk of disadvantage, and the minimum mitigations and monitoring that should be committed during implementation phase.

### Consultation activity and evidence sources

The consultation ran from 4 July to 3 October 2025 and used multiple engagement routes including an online and paper survey with open and closed questions, an Easy Read version, written submissions, meetings and focus groups, feedback channels, and an independent polling exercise intended to be broadly representative by geography and demographics.

5,009 consultation survey responses and 507 independent polling responses.

The equality analysis draws on disaggregated survey results by geography and protected characteristics where bases allow, open text thematic analysis to identify mechanisms of disadvantage and proposed mitigations, and confidence grading where subgroup bases are small.

### Who took part and representativeness

Equality monitoring questions were optional and are used to understand participation and interpret differential impacts. The survey is self-selected and should not be described as statistically representative. Where groups are underrepresented, the analysis places more weight on mechanism based findings, triangulation with other evidence, and a stronger requirement for monitoring during implementation phase.

- Older adults were more likely to respond, with 61 years and over making up 42.2 percent of responses.

- Women were more likely to respond than men, female 71.3 percent and male 25.0 percent.
- Disabled people were 14.2 percent of respondents, lower than Census based benchmarks in Sefton and West Lancashire.
- Respondents were predominantly White, with non-White and other ethnicities 2.3 percent, lower than local benchmarks.
- Unpaid carers were 36.1 percent of respondents, higher than Census based benchmarks, noting that question definitions differ.

### 7.4.1 Headline equality and health inequality findings

Across the consultation evidence, geography is the dominant determinant of perceived impact. Respondents tend to rate the option closest to them more positively and the option that increases travel burden more negatively. This place-based pattern is consistent across multiple domains and is the main driver of foreseeable differential impact risk whichever option is selected.

#### Primary equality mechanisms

- Travel time, distance and affordability is the clearest and strongest measurable driver of unequal impact.
- Parking, drop off and arrival safety is a secondary but material mechanism that compounds travel burden.
- Access to buildings and services, including wayfinding and navigation, creates predictable barriers for some groups.
- Waiting environment is a material equality mechanism. Crowding, noise, limited seating or toilets, and lack of quiet space can create predictable disadvantage.

#### Place based travel and parking trade offs

- The travel trade off is sharply place based. This indicates that whichever site is selected there is a foreseeable risk of disproportionate impact for the communities furthest away unless mitigations are effective.
- Travel negative ratings by area show a strong trade off. Sefton 11.8 percent negative for the Southport option and 74.0 percent negative for the Ormskirk option. West Lancashire 85.8 percent negative for the Southport option and 3.8 percent negative for the Ormskirk option.
- Parking shows the same pattern. Sefton 24.3 percent negative for the Southport option and 45.3 percent negative for the Ormskirk option. West Lancashire 67.6 percent negative for the Southport option and 11.5 percent negative for the Ormskirk option.

#### Groups most likely to experience amplified disadvantage

- Disabled people and people with specific impairments, where longer and more complex journeys increase reliance on others and increase the need for predictable reasonable adjustments.

- Older people and people with frailty, where longer journeys, uncertainty and poor connectivity increase access barriers.
- Unpaid carers and people attending with dependants, where longer travel increases cost and practical burden and affects discharge and support.
- Pregnant people and families with young children, where travel, arrival and waiting environment concerns link to time critical access and perceived safety.
- People experiencing deprivation and transport poverty, where affordability and practical journey options can affect timely presentation.
- Minority ethnic communities and other protected groups with smaller response bases, where participation is lower and targeted engagement is needed to strengthen insight, in next phase of the programme.

**What this means for due regard**

The consultation analysis indicates foreseeable risk of disproportionate impact whichever option is chosen because geography driven differences in travel time, distance and cost are the primary inequality mechanism, with parking and arrival, access and wayfinding, and the waiting environment acting as compounding mechanisms for some groups. Due regard is best evidenced when the decision is accompanied by deliverable commitments during implementation phase that reduce these mechanisms of disadvantage, plus governance linked monitoring with clear escalation triggers.

**Minimum mitigations required during implementation phase**

- Transport and access mitigation plan including public transport options, shuttle feasibility, evening and weekend practicality, simple travel cost support routes, and accessible journey planning in print and online.
- Parking and arrival plan including accessible bays close to entrances, a safe drop off zone with staff support, improved lighting and safe routes, fair payment and concessions approach, and step free routes.
- Accessible information and reasonable adjustments route compliant with the Accessible Information Standard, including Easy Read, large print, interpreting routes and staff training so adjustments are delivered consistently.
- Waiting environment minimum standards including seating, accessible toilets, quiet low stimulus space, sensory considerations, clear information while waiting, and family friendly arrangements where feasible.
- Carer support route including clear information, rest facilities, support for lone carers, and practical support at arrival and discharge.
- Families and maternity pathway clarity, including clear accessible communications on how urgent maternity presentations are managed and confirmation that obstetric emergencies follow agreed pathways to the most appropriate MWL site.

**Monitoring, escalation and governance**

- Routine reporting disaggregated by locality and deprivation, triangulated with equality indicators where data allows.

- Minimum metrics include arrival mode, travel related complaints and concerns by locality, did not wait and left without being seen by locality and time of day, incidents and safety reports linked to access and waiting areas, and reasonable adjustment requests and evidence of delivery where recorded.
- Escalate to Programme governance where there is sustained worsening in access or experience for a locality or group proxy across two consecutive reporting periods, or where complaints and incidents indicate avoidable harm linked to travel, arrival, access, reasonable adjustments or waiting environment.

### 7.4.2 Due regard actions, mitigations, monitoring and escalation

The consultation analysis indicates foreseeable risk of disproportionate impact whichever option is chosen. Due regard is best demonstrated when the decision is accompanied by deliverable mitigations, plus a monitoring framework linked to Programme governance.

Minimum commitments and monitoring framework.

| Equality mechanism and risk | Who is most at risk | Programme commitments during implementation phase. | Minimum monitoring metric | Escalation trigger |
|---|---|---|---|---|
| Travel time, distance and cost | Communities furthest from the chosen site, amplified for older people, people with a disability, carers, pregnant women, low-income households | Transport and access mitigation plan, includes public transport options, shuttle feasibility, evening and weekend practicality, clear eligibility for support, simple travel cost routes, accessible journey planning in print and online | Travel-related complaints and concerns by locality, plus reasonable adjustment requests linked to travel, plus arrival mode where available | Sustained deterioration in access signals for a locality or group, rising delayed presentation themes, rising ambulance reliance linked to inability to travel |
| Parking and safe drop off | People with a disability, frail older people, pregnant women, carers, families with young children | Accessible parking and drop off plan, sufficient accessible bays near entrance, safe drop off zone, lighting, step free routes, practical assistance on request, concessions and fair | Parking complaints and arrival themes, incidents linked to arrival routes, reasonable adjustment | Sustained rise in parking and arrival complaints, increase in safety incidents linked to |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| | | approach to fines where delays are unavoidable | requests linked to parking and drop off | arrival or transfers |
|---|---|---|---|---|
| Access to buildings and wayfinding | People with a disability, (sensory impairments, learning disability, physical disability) people with dementia, neurodivergent people | Clear step free arrival routes, supported wayfinding on request, signage in accessible formats, staff briefing on arrival support | Feedback and complaints tagged to access and wayfinding, incidents related to navigation and safety | Increase in incidents or complaints indicating people cannot safely access clinical areas or cannot navigate arrival routes |
| Waiting environment and crowding | People with a disability, neurodivergent people, people with a mental health condition, , frail older people, families with children | Minimum waiting environment standards, seating, toilets, quiet space, sensory considerations, clear information on expected waits, safe separation for children where feasible | Patient feedback, PALS and complaints tagged to crowding, dignity and distress, plus incident reports and reasonable adjustment requests linked to waiting | Increase in did not wait or left without being seen themes linked to distress, increase in safety incidents in waiting areas |
| Accessible information and communication | People with a disability including sensory impairments, , people needing materials in alternative formats, people with language needs, people who are digitally excluded | Accessible Information Standard compliant communications and signage, Easy Read and large print, BSL and interpreter access, staff training for consistent response, clear route to request reasonable adjustments | Accessible information compliance audit results, complaints relating to information needs, evidence of reasonable adjustment delivery | Repeated failures to meet information needs, increasing complaints about communication barriers |
| Pregnancy, maternity, | Pregnant women, | Clear time critical pathways and | Escalation events and | Any serious incident |

| children and safeguarding | postnatal emergencies, families with young children (this is currently out of scope). | escalation routes, safe streaming and safeguarding assurance, family friendly facilities and clear signage | safety incidents linked to delayed access or pathway confusion, feedback from families | theme linked to access delay or pathway confusion for pregnant women or children |
|---|---|---|---|---|
| Carer involvement and support | Unpaid carers, including lone carers and carers supporting disabled people | Clear carer information offer, support to request practical assistance at arrival and during waiting, links to carers services, test travel support outside office hours | Carer feedback themes, complaints mentioning carer burden, uptake of support offer | Evidence carers cannot access or sustain support role, increasing complaints about inability to attend or support discharge |
| Evidence gaps and targeted inclusion | Ethnicity groups with low representation, trans respondents, other small base groups | Targeted follow up to form part of the participation group in implementation phase, engagement and mitigation testing in trusted settings, translation and accessible formats, triangulate with service data after implementation | Engagement reach and feedback themes, differential experience and outcomes where data allows | Persistent evidence gaps or repeated concerns without corrective action |

**Evidence gaps and targeted follow up engagement**

Some groups are under-represented in the consultation responses, so the Programme should strengthen ongoing due regard through targeted follow up engagement focused on testing mitigations and ensuring implementation is safe and accessible, during the next phase of the project and via the Participation Group.

Work with VCSE, community and faith partners to engage with different communities, using translated materials and trusted settings.

Hold targeted disability and impairment engagement sessions, including British Sign Language access and Easy Read, to test travel, arrival and waiting environment mitigations, as part of the Participation Group to support an inclusive design and involvement model.

Undertake specific validation with carers' organisations, including lone carers, to test transport practicality outside office hours and the impact of longer waits and journeys.

Use service data and lived experience feedback after implementation to monitor differential access, experience and outcomes where data quality allows, and publish findings through Programme governance routes.

**Health inequalities duty and decision implications**

Under the National Health Service Act 2006, NHS England and integrated care boards have a duty to have regard to the need to reduce inequalities in access to health services and reduce inequalities in outcomes achieved for patients, including effectiveness, safety and quality of experience. This decision is being taken in a high baseline inequality context. Deprivation and vulnerability are unevenly distributed across the footprint and overlap with higher concentrations of older people, disabled people, unpaid carers and some minority ethnic groups. This matters for urgent and emergency care because groups experiencing higher vulnerability are more likely to rely on emergency care and to experience greater barriers when access becomes more time consuming, more complex or less affordable. Life expectancy inequality gaps are worse than national benchmarks, indicating the system is operating in an environment where decisions on access and experience can plausibly widen or narrow existing gaps.

The consultation equality analysis indicates the dominant mechanism for unequal impact is travel time, distance, affordability and journey complexity, and that this is strongly place based. Parking, safe drop off and arrival routes compound travel burden and are material for disabled people, frail older people, pregnant people, carers and families with children. Wayfinding and navigation can disadvantage people with cognitive impairment, learning disability, sensory impairment, or those attending in distress. Waiting environment standards can disproportionately affect autistic people, people with learning disability, people with anxiety or trauma and frail older people if crowding, noise and seating are not well managed. Accessible information and reasonable adjustments are cross cutting mechanisms that determine whether communication needs and practical support are identified early and met consistently.

The travel and parking trade off is sharply place based. This indicates that whichever site is selected there is foreseeable risk of disproportionate impact for communities furthest away unless mitigations are effective and practical outside office hours. Travel negatives indicate a strong trade off, with Sefton reporting 11.8 percent negative for the Southport option and 74.0 percent negative for the Ormskirk option, and West Lancashire reporting 85.8 percent negative for the Southport option and 3.8 percent negative for the Ormskirk option. Parking shows a similar pattern, with Sefton reporting 24.3 percent negative for the Southport option and 45.3 percent negative for the Ormskirk option, and West Lancashire reporting 67.6 percent negative for the Southport option and 11.5 percent negative for the Ormskirk option. The duty therefore requires decision makers to consider how these place based burdens interact with the uneven

distribution of deprivation, disability, older age and caring responsibilities, and to ensure mitigations and monitoring are targeted to where vulnerability is concentrated.

Existing Emergency Department performance evidence indicates inequality signals by age and by additional needs flags. Breach rates increase with age and higher breach rates are seen for groups flagged with learning disability, autism and mental health act, indicating risk of poorer experience and higher distress. Ormskirk activity in the available extract is predominantly for children under 16 and is not directly comparable. The decision relevant insight is that unequal experience is already present for some groups and any change in location, demand, travel or pathways could widen gaps unless mitigations are built in and monitored.

Decision assurance is strengthened when mitigations are planned and committed alongside the configuration decision rather than left entirely to later design work. The minimum commitments required whichever option is selected are a transport and access mitigation plan that works nights, weekends and bank holidays and includes accessible journey planning, a parking and arrival plan that ensures accessible bays and safe drop off close to entrances, Accessible Information Standard compliant communications and signage with a clear route to request and deliver reasonable adjustments, waiting environment minimum standards including a quiet or low stimulus space and clear information while waiting, a carer support route that is practical outside office hours, and clear time critical pathway arrangements for pregnancy and postnatal emergencies and safeguarding for children and families.

The health inequalities duty is continuous and must be evidenced during implementation. A monitoring and escalation framework should be embedded in governance so emerging disproportionate impacts are identified early and acted upon. Reporting should be disaggregated by place and deprivation and, where data quality allows, by age bands and disability related flags, and triangulated with patient experience, PALS, complaints and incidents. Escalation triggers should be linked to action. Where group denominators are small, use rolling averages and qualitative triangulation. Trigger review and corrective action where breach rates or gaps for high risk groups increase over consecutive periods, supported by agreed denominator and triangulation rules.

# 8.0 Patient Experience Data

This section considers the key findings for the Patient Experience intelligence that has been generated to date from the programme. This is important information to inform the Equality Considerations Report.

**Source documents**

The documents that have been used in order to generate the key patient experience headline findings to date have been:

- Equality and Inequality Analysis for the Urgent and Emergency Care programme of Shaping Care Together, version 3.1 draft, 16 June 2025.
- Shaping Care Together Consultation Report,
- Patient experience evidence from the Equality and Inequality Analysis

The EIA work reviewed another identifies that quality of experience is a core outcome under the PSED and it recognises that, at the stage it was written, people could mainly comment on current experience rather than detailed future design proposals. N.B. (please note EIIA is just a different way of labelling an EIA).

## 8.1 Key Headline Findings

The key headline findings on patient experience are therefore as follows:

**What people told us about current experience**

- Participants frequently discussed quality of experience, often alongside safety and quality of care.
- Waiting times, the quality and cleanliness of facilities, and staff behaviour were common themes, particularly during periods of extreme pressure.
- People also raised discharge arrangements that do not take account of local logistics and the need for better communication about service availability.

**Experience risks if one site becomes busier**

- A repeated concern was that co-location could worsen experience if adult and children's emergency care is accommodated within existing space without major estate and flow changes.
- Participants expected to see evidence of investment in additional space and facilities, including waiting areas, drop-off zones and parking.
- People were concerned that higher patient volumes could increase waiting times and stress for patients, carers and staff, especially for vulnerable people and those at risk of sensory overload.

**Children's experience and safety in shared environments**

- Many participants said children should be protected from distressing adult behaviours in emergency departments and described shared entrances and waiting areas as unacceptable for children's welfare.
- A clear expectation was expressed for separate entrances and separate waiting areas for adults and children.
- Parents and carers raised the experience needs of children with SEND, autism, ADHD and sensory sensitivities and described the importance of a calm environment to avoid stress and trauma.

**Disability and carer experience issues raised in engagement**

- Carers described the difficulty and safety risk of dropping off a wheelchair user or a person with severe disability and then leaving them at the entrance while searching for parking.
- Participants raised concern that busy sites increase the risk of disabled bays being misused, reducing access for people who need them most.
- People with mental health conditions and sensory impairments were described as at risk of distress, reluctance to attend and poorer experience in crowded and overstimulating environments, particularly where they have limited support.

**Learning from PALS complaints**

- The EIA includes a review of PALS complaints between April 2024 and March 2025. It notes that equality characteristics were not available, limiting the ability to identify patterns by protected characteristic.
- Complaints with possible equality and inequality implications linked to disability included a lack of comfort for an elderly wheelchair user and a visually impaired patient feeling unsupported while attending emergency care.
- A carer complaint described a breakdown in communication for a suicidal patient, resulting in leaving without the help they felt was needed, with a potential mental health and disability implication.
- Other complaints related to time waiting in emergency care, staff attitude and the quality of the waiting area. The EIIA notes these appear to occur during periods of extreme pressure and does not conclude differential treatment on equality grounds from the information available.

**Due regard summary for this Equality and Inequalities Impact Assessment**

- The EIIA evidence indicates that patient experience impacts are not evenly distributed. Groups more likely to experience disadvantage from poor environments, poor access or poor communication include disabled people, people with mental health and sensory needs, children and families and unpaid carers.
- Programme commitments to reduce inequality in experience.
- Separate adult and children's access and waiting arrangements where feasible, with a child friendly environment and safeguarding built into design.
- A disability inclusive arrival and waiting environment offer, including safe drop-off, protected disabled parking close to entrances, accessible toilets, seating and practical support for people attending alone.
- Low stimulus and quieter spaces for people with autism, learning disability, dementia, anxiety mental health needs, with staff awareness of reasonable adjustments.

- Clear communication during waits, including predictable information about what will happen next and where possible real time waiting time information.
- Evidence that capacity and flow changes will prevent overcrowding, corridor care and long waits becoming the default patient experience.
- What should be monitored after implementation.
- Patient experience feedback, complaints and incidents tagged to waiting environment, communication needs, dignity and safeguarding.
- Reasonable adjustment requests and evidence of delivery, including adjustments related to arrival, parking, waiting and communication.
- PALS themes for disability related barriers and evidence of lessons learned and improvements.
- Signals that children's environments are safe and appropriately separated from adult flows, including complaints and incidents.

## 8.2 Alignment with the Independent Consultation Report

The Independent Consultation produced by Centre for Health Communication Research reinforces and expands the experience themes identified in the EIIA. It provides more detailed descriptions of waiting conditions, dignity and communication, and sets out a clear public expectation that any option must be accompanied by design changes that meet different needs.

The alignment table is provided on the next page in landscape format to support easier pasting into the main Equality Considerations Report.

**Alignment table**

| Patient experience theme | EIIA evidence summary with reference | Consultation Interim Report summary with reference | Equality implication and due regard point | Programme commitments to reflect |
|---|---|---|---|---|
| Crowding, waiting environment and dignity | Concerns that co-location without more space would reduce quality of experience and increase waiting times and stress, with overcrowding highlighted as a risk (PCBC EIIA section 11, pages 46 to 47). | Waiting environments described as too small and congested, particularly at Southport, with people sitting on floors or in corridors. Respondents ask for larger waiting areas, seating, ventilation and natural light (Consultation Interim Report concluding comments and question 10 narrative). | Risk of unequal experience for disabled people, frail older people, children and carers who are less able to tolerate long waits in crowded spaces. Due regard requires assessment and mitigation of environment driven disadvantage. | Deliverable estate and flow changes, accessible layouts, adequate seating and ventilation, and an approach that prevents corridor care and unsafe crowding. |
| Communication during waits and managing anxiety | Need for better communication about service availability is raised as part of experience, alongside pressure and staff behaviour (PCBC EIIA section 11 and section 12, pages 46 to 52). | Respondents report limited updates during waits and ask for real time information such as waiting time screens to reduce anxiety and help carers plan | Communication gaps can disproportionately affect people with learning disability, autism, dementia, sensory needs, and carers. Due regard requires accessible, timely and predictable information. | Clear communication standards, accessible formats, staff training and where feasible real time waiting information and help points. |
| Adult and children's separation and child welfare | Participants called for separate entrances and waiting areas. Safety and experience concerns relate | Consistent request for separation of adult and children's areas and child friendly layouts that minimise | Children, families and disabled children are at increased risk of distress and harm in shared environments. Due regard requires | Separate flows and spaces for children and adults where feasible, with child friendly facilities and |

| | | | | |
|---|---|---|---|---|
| | to children being exposed to distressing adult behaviours (PCBC EIIA section 11 and section 10, pages 41 to 47). | exposure to alcohol, mental health or substance misuse presentations (Consultation Interim Report concluding comments). | safeguarding and child welfare to be built into design and operations. | clear escalation routes. |
| Low stimulus provision and neurodiversity | Sensory overload risk described for vulnerable people and children with autism and ADHD (EIIA section 10 and section 11, pages 42 to 46). | Request for quiet or low stimulus areas for autism, learning disability and mental health needs (Consultation Interim Report concluding comments). | Higher risk of unequal experience for autistic people, people with learning disability and people with anxiety or trauma. Due regard requires reasonable adjustments and trauma informed environments. | Quieter spaces, sensory considerations and a reasonable adjustment route that is visible and operational. |
| Disability inclusion in waiting areas, toilets and equipment | PALS complaints include lack of comfort for a wheelchair user and a visually impaired patient feeling unsupported (EIIA section 13, pages 52 to 53). Engagement highlighted drop off and parking stress and limited support at reception (PCBC EIIA section 10, pages 41 to 42). | Requests for wheelchair spaces, larger accessible toilets, help points and concerns about lack of equipment or staff confidence in using it | Risk of disadvantage for disabled people and carers if facilities and staff capability do not meet needs. Due regard requires proactive design and operational mitigations. | Accessible toilets near waiting areas, wheelchair space, appropriate equipment and staff training, plus practical support on arrival. |
| Wayfinding, signage and layout | Accessibility features and the ability to cope at | Reports of confusing signage and | Wayfinding barriers can disproportionately | Improved wayfinding, consistent |

| | | | | |
|---|---|---|---|---|
| | sites are discussed within experience and access themes (EIIA section 11 and section 12, pages 46 to 52). | difficulty finding departments, with requests for clearer signage, site maps and marked drop off bays (Consultation Interim Report Southport narrative and concluding comments). | affect people with cognitive impairment, learning disability, sensory impairment, and those attending in distress. Due regard requires accessible navigation. | signage, maps and clear help points aligned to accessible information standards. |
| Parking and safe drop off as part of the experience | Suggested solutions include investment in drop off zones and parking. Carers describe stress and safety risks when leaving a person to find parking (PCBC EIIA section 10 and section 11, pages 42 to 46). | Parking described as extremely difficult at both sites. Respondents expect a parking plan including disabled spaces close to entrances and safe drop off points near emergency care (Consultation Interim Report Southport narrative and concluding comments). | Parking and drop off disproportionately affect disabled people, frail older people, pregnant people and carers. Due regard requires mitigation for groups with reduced mobility or support. | Safe drop off, protected disabled bays close to entrances, and practical support for people attending alone or with a dependent. |
| Protecting what works for children and families | Participants rated quality of experience at Ormskirk Children's ED highly, with variable views on Southport (PCBC EIIA section 11, page 46). | Ormskirk children's and maternity services described positively, increasing anxiety about any move that could change the child | Risk of loss of a valued child friendly experience for some communities. Due regard requires ensuring the model does not create worse experience for children and | Child friendly design standards, family friendly facilities and clear paediatric pathways regardless of site. |

| | | friendly environment or reduce access (Consultation Report by area themes and concluding comments). | families in specific places. | |
|---|---|---|---|---|
| Learning from complaints and continuous improvement | EIIA highlights limitations in equality data in PALS but identifies disability linked complaints and records a lessons learned approach (EIIA section 13, pages 52 to 53). | Public feedback strongly links experience to confidence in plans and expects practical design change and ongoing attention to quality (Consultation Report concluding comments). | Due regard includes using feedback and complaints to identify inequality risks and respond early, including improving data capture where feasible. | Complaint and feedback learning cycles, improved recording of reasonable adjustments, and reporting to governance. |

# 9.0 Equality Impact Assessments (EIAs)

## 9.1 Purpose of this section

This section summarises the Equality Impact Assessments completed to date and sets out a clear line of sight from earlier evidence gaps to the additional analysis and assurance now available for decision-makers

The programme has already undertaken a number of EIAs and already has mitigations and reassurances in place as highlighted in the programme response to the consultation feedback, such as transport solutions, separate waiting areas, car parking expansion and ongoing targeted engagement (see appendix 2 of the Decision-Making Business Case).

However, the PSED is a continuous and ongoing duty and a final decision is yet been made on the proposals. This impact assessment provides the opportunity to check for any potential gaps in that previous analysis, including in light of consultation responses, and if so address those gaps prior to a decision being made.

The following section outlines the potential gaps within previous EIAs for transparency, which as above have been addressed and mitigated throughout this report.

## 9.2 EIAs to date

This section considers the EIAs that have been completed on the programme to date, and the key headline findings from the previous assessment work.

In addition, it considers to what extent the EIA's that were completed showed due regard to the PSED in the way that they were completed and in considering this, the stage of the programme that they were conducted at is taken into consideration. So, for example, the expectation for showing due regard to the PSED for assessment work that is completed at the beginning concept stages of the programme will be much lower than the expectation at later stage. At every stage of a process however (from concept stage onwards) there is a need to demonstrate due regard under the Public Sector Equality Duty, which EIA is affective at doing.

In terms of what has been administered by the Programme to date the following sections articulate what has been done:

**Pre-Consultation Engagement EIA – May 2024**

This assessment work was conducted prior to going out to Public Consultation on the need to make a change to the current service provision.

**Key messages from the Initial Equality Impact Assessment (EIA)**

The approach taken by the Programme was to engage with the need to conduct an EIA at an early stage. This was commenced following the case for change and at the point pre-consultation on the possible options. The EIA has been evaluated, and the following key messages have been identified from the report:

- **Purpose and legal context**
  The document supported compliance with the Equality Act 2010 and the Public Sector Equality Duty (PSED). This was a pre-consultation EIA, designed to identify potential equality risks before any service changes are decided and prior to going out to consultation to assist that process to be effective and to meet the legal requirements effectively. The approach taken was to then have a post-consultation EIA report that would later assess consultation feedback and confirm whether PSED duties are being met.

- **Why change is needed**
  The EIA communicates why change is needed (the purpose behind why changes are required) stating that urgent and emergency care services in Southport and Formby Ormskirk (West Lancashire) are under significant pressure due to:
    - An ageing population and increasing frailty
    - Rising emergency admissions (around 9% higher than the England average)
    - Workforce shortages and financial constraints

- Non-equitable service provision between local areas.

The document also articulates how current service models contribute to:
- A&E overcrowding and corridor care
- Poor patient flow and multiple ward moves
- Worse outcomes for frail older people
- Low staff morale and sickness absence.

- **Health inequalities are a major driver**
  The EIA communicates how people in priority wards in West Lancashire attend urgent and emergency care more frequently and experience significantly worse outcomes for conditions. For example, heart disease, stroke, heart attacks and COPD. These differences reflect clear health inequalities linked to deprivation and long-term conditions.

- **What "Shaping Care Together" aims to achieve**
  The EIA communicates how the Programme does not aim to reduce services, but to:
  - Use resources more effectively
  - Remove inefficiencies and duplication
  - Improve sustainability and patient outcomes

  Key ambitions include:
  - Reduced waiting times
  - Fewer cancelled procedures
  - Better urgent care closer to home
  - 24/7 emergency care for all ages

- **Equality risks identified**
  The EIA identifies the following as being the most significant equality risks:

  <u>Children and young people:</u>
  - Emergency care is not provided 24/7, unlike adult services. This is flagged as a risk of unlawful indirect age discrimination towards children (under the Protected Characteristic Age within the Equality Act 2010).

  <u>Older people and people with a disability:</u>
  - Greater reliance on emergency care.
  - Increased need for accessible buildings, clear signage, transport support and carers.

  <u>Travel and access issues:</u>
  - The distance from emergency and urgent health services and reliance on public transport may disadvantage elderly, disabled and low-income patients.

- **Protected Characteristics must shape consultation**

The document highlights a strong emphasis upon the need for inclusive consultation, and targeted engagement with community groups as well as the need for reasonable adjustments (e.g. easy read materials, interpreters, accessible venues).

- **Consultation is critical**
  The need for meaningful engagement with affected communities was expressed as being essential within the EIA, in order to:
  - Identify unintended discrimination
  - Understand access barriers
  - Shape decisions effectively before they are made
  - Consultation data must be capable of being disaggregated by Protected Characteristic.

  Key risks requiring mitigation
  - Key risks requiring mitigation
  - Lack of 24/7 emergency care for children and young people
  - Accessibility risks if services are relocated or redesigned without full disability audits
  - Additional pressure from tourists and non-residents using services in Southport

**EIA and due regard**

This section considers the EIA that was produced and the extent to which due regard under the Public Sector Equality Duty was demonstrated.

As mentioned already in this report, the Shaping Care Together Programme is concerned with the reconfiguration of sensitive health services, including Urgent and Emergency care. People are at their most vulnerable when accessing these services and in addition, the services provided are often connected to preserving someone's life. This means that in terms of equality, potential impacts can be significant.

The Programme commenced early EIA work following the case for change being produced and prior to going out to public consultation to gather intelligence for consideration as possible options for service change.

The following aspects were considered in the evaluation of the Shaping Care Together EIA:

**Evidence-based**: The EIA has some level of evidence base, by drawing on some demographic data and it also mentions generic issues of inequality from the data and current position – for example, limited access to A&E for children at a particular site. The demographic profiling does not go into any depth and predominantly makes some high-level strategic observations which are helpful but limited.

There is no detailed performance data disaggregated across the Protected Characteristics. When the document mentions the specific characteristics, most of the content is subjective logic/narrative and is no rooted within data, evidence and robust analysis.

**Objective judgement:** There is some level of objective evaluation presented and evidence sitting behind why particular impacts are being communicated, there is however also a significant amount of subjective evaluation (particularly where the Protected Characteristics are broken down within the assessment) that is not rooted within evidence and data.

**Disaggregated data:** There is some level of data/evidence being broken down across different groups that relates to the potential impacts on different Protected Characteristic groups within the assessment, but it is limited and it does not draw from a breadth of different data sources.

**Breadth and depth of data:** There is very limited data used within the EIA.

**Representative samples:** There is no reference to any service performance data, patient user data, complaints data and so the sample data used is not representative as it has not been included within the assessment.

**Insightful and persuasive data and evidence:** The data and logic referred to is insightful and it is persuasive by listing the possible potential impacts with some evidence sitting behind this, however, as mentioned, the data and evidence used is limited and it therefore cannot be fully persuasive, as it is not based on robust datasets and analysis.

**Gaps in the EIA**

In terms of gaps in the assessment, the following were identified:

- **Disaggregated performance data:** There is some generic performance data analysis and within this, there are some general high level equality issues communicated. There is, however, no detailed performance data analysis that relates to service performance, broken down across the Protected Characteristics. This is a weakness that could have presented some risk. The Programme was however at an early stage, and the assessment was more about informing the consultation process, which it did assist in informing.

- **Staff data:** There was no staff data analysis at this stage of the Programme, which may have presented some risk. That being said, this was at an early stage in the Programme, and it is negligible whether staff data was necessary for informing the process at this stage of the Programme.

This EIIA (March 26) – addresses these gaps set out as set out in this report.

**Interim EIA: Interim Report for Equality and Inequality Analysis for the Urgent and Emergency Care phase of Shaping Care Together (produced by Freshwater Consultancy). – January 25**

The purpose of the equality and inequality analysis that was conducted was two-fold:

**i.** To provide information to those deciding what will be consulted upon in order to have due regard and consider whether there will be a need for options to be subject to mitigations for impacts, and

**ii.** To provide an opening Equality Impact Assessment for the consultation.

In terms of the scope, whilst this was very helpful and was focused upon assisting the Programme with the upcoming public consultation, its scope was narrow.

**Key messages from the interim EIA**

The Equality Impact Assessment identifies that the **current configuration of urgent and emergency** care services results in unequal access, experience, and outcomes for different population groups, and that without careful redesign and mitigation, proposed changes could reinforce or worsen existing health inequalities.

- **Age-related inequality**
  Children and young people are disproportionately disadvantaged by the current model, as emergency care for this group is not provided on a 24/7 basis, unlike adult services. This difference in service availability represents a significant equality risk and may amount to unlawful indirect Age discrimination if not addressed. Older people are also particularly affected due to higher rates of frailty, long-term conditions, and emergency care usage, making them more vulnerable to delays, overcrowding, inappropriate ward placement, and multiple moves within hospital settings.

- **Disability and access barriers**
  Disabled People experience multiple and compounding barriers when accessing urgent and emergency care, including physical accessibility, communication needs, sensory environments, and reliance on carers. The EIA highlights that any service redesign or relocation carries a high risk of excluding disabled people if accessibility is not designed in from the outset. A failure to undertake full disability access audits or provide reasonable adjustments would significantly undermine compliance with the Equality Act 2010.

- **Geographical and socio-economic inequality**
  The EIA communicates that there are clear inequalities in health outcomes and service use between areas, particularly between deprived wards in West Lancashire and more affluent communities. Higher rates of emergency admissions for conditions such as heart disease, stroke, and COPD indicate that current service arrangements do not meet needs equitably.

These inequalities mean that service changes must be assessed not only for clinical efficiency but also for their impact on populations with greater health needs.

- **Transport, travel, and caring responsibilities**

Changes to service configuration risk disproportionately impacting people who do not drive, including older people, disabled people, lower-income households, and carers. Increased travel distances, reliance on public transport, and the need for partners or carers to accompany patients may create additional barriers to timely access and worsen patient experience. Women, who are more likely to have caring responsibilities, may be particularly affected.

- **Risk of discrimination and poorer experience of care**

The EIA recognises that some protected groups - including ethnic minority communities, Disabled people, transgender people, and LGBQ+ people have historically reported issues less and so there may be significant issues of hidden discrimination.

- **Favourable treatment or poorer experiences within NHS services**. Without targeted engagement, staff awareness, and monitoring, service changes could inadvertently perpetuate discrimination, reduce trust, and discourage timely use of urgent and emergency care.

- **Consultation and participation inequalities**

The assessment highlights a risk that voices from protected groups may be under-represented in the consultation unless proactive steps are taken. Meaningful engagement with children and young people, disabled people, older people, ethnic minorities, and LGBTQ+ communities is essential to meet the Public Sector Equality Duty, particularly the requirement to advance equality of opportunity and encourage participation where it is disproportionately low.

**Overall equality impact**

Overall, the EIA concludes that equality considerations are central to the service redesign, and must not be peripheral. Addressing these issues presents an opportunity to reduce existing inequalities and improve access, safety, and experience for protected groups. Failure to do so would carry risk, including non-compliance with the Public Sector Equality Duty.

**EIA and due regard**

This section considers the EIA that was conducted and the extent to which due regard under the Public Sector Equality duty was demonstrated. The evaluation of the EIA showed the following:

**Evidence-based:** The EIA is evidenced-based and in terms of data the following is included:

- Demographic profiling has been conducted across the Protected Characteristics, including deprivation. This includes geographic profiling of demographic location across the various Protected Characteristics. There is some analysis of the data included in the assessment but also some gaps in the analysis.

- Demographic profile data across the Protected Characteristics of the people that took part in the engagement process is included within the assessment, but it has not been analysed. The demographic profiling of the consultation participants, is not compared to the demographic profiling of the area in question, to determine the extent to which the sample collected is representative of the wider community.

- A summary of the key messages coming through from both quantitative and qualitative data from the consultation that was undertaken in 2024 is included. This is generally expressed as a high-level summary across the different Protected Characteristics. It is, however, difficult to ascertain the data evaluation methodology that has been used and so therefore what the summary is resting on. It is hard to discern therefore from the report, the extent to which the evidence base that the summary sections rests upon is robust.

**Objective Judgement:** The assessment is objective based on judgements being made around potential equality impacts. The assumptions made about potential impact, and also the key messages that relate to the Protected Characteristics look to be mainly resting upon robust data and evidence. As stated however, it is difficult to determine what data has been utilised within the process of determining potential impacts within the assessment and also how the data being considered has been analysed and interpreted (the methodology used).

**Disaggregated data:** The assessment looks to have disaggregated some data (the consultation data) but no other data seems to have been included.

**Breadth and depth of data:** The data used for an assessment of this scale looks to be limited in terms of the breadth and depth. It is, however, as mentioned, difficult from the document to accurately discern what data has been applied from the consultation that was conducted in 2024 as there is no detail of this within the assessment. In terms of how the analysis has been articulated within the assessment it appears to be limited mainly to the engagement data. There is a good use of demographic profiling data, although the analysis in places is limited. Further analysis on this could help provide a rounded picture of the demographics both across the population generally and then also comparing this to the engagement data. In terms of the depth, it is difficult to determine the extent to which there is a depth of analysis sitting behind the analysis summary that is contained within the EIA report.

**Representative samples:** There is no analysis contained within the assessment as to the extent to which the data was representative. The data that is referred to is from the public engagement in 2024, and whilst the assessment includes the profiling of those who engaged, this does not look to have been compared to local population data to make a valid judgement on the extent to which the consultation sample was representative across the Protected Characteristic groups.

**Insightful and persuasive data and evidence:** The data and logic referred to is insightful and it is persuasive by listing the possible potential impacts with some evidence sitting behind this, however, as mentioned, the data and evidence used is limited and so this limits the extent to which it is persuasive, as it does not seem to be based on a robust breadth and depth of data.

**Pre consultation Business Case Final EIA (Freshwater) – June 2025**

Key Headline Messages

The report produced by Freshwater provides analysis of the Equality, Diversity and Inclusion (EDI) impacts of reconfiguring Urgent and Emergency Care services in Southport and Formby District General Hospital and Ormskirk District General Hospital. This supported the Pre consultation business case. The key headline EDI findings identified in the analysis report are as follows:

**Accessibility:**

- Elderly, disabled, and deprived communities may face challenges accessing Urgent and Emergency services if relocated further from their locality.
- Poor public transport and high taxi costs exacerbate accessibility issues, especially for Skelmersdale and Southport residents.
- Parking and drop-off facilities at both sites are inadequate and these need improvement.

**Disadvantage and Vulnerability:**

- Vulnerable groups, including single parents, disabled individuals, and elderly residents, may experience increased stress and difficulty accessing services. These groups are likely to be more affected by any potential changes.
- Deprived communities may struggle with transportation costs and accessibility and this needs to be carefully considered within the proposals being put forward.

**Safety and Quality of Experience:**

- Concerns about children sharing waiting areas with adults exhibiting disruptive behaviours (e.g., mental health issues, intoxication).
- Overcrowding and insufficient space at Emergency Departments could negatively impact the quality of care and experience and this needs to be carefully considered.

**Staff Concerns:**

- Staff may face longer commutes and poor public transport options depending on the chosen site.
- Parking and safety concerns for staff at both sites needs addressing.

**Positive Impacts Identified:**

- The co-location of Adult and Children’s ED services could improve efficiency, integration, and accessibility for some populations. For example, some staff have to travel between different sites to fulfil their duties, which is inefficient.
- Reduced travel time may occur for certain groups depending on the chosen site location.
- There is the opportunity to enhance facilities and services at the selected site which will bring considerable benefits.

**Mitigation Strategies:**

A number of potential mitigation strategies are considered to respond to the potential adverse impacts on various groups of people:

**Transport Solutions:**

- Free shuttle bus services between Southport and Ormskirk hospital sitesfor patients and staff will alleviate the issues for vulnerable groups who are more adversely affected by increased travel.
- Collaboration with local authorities and transport providers to improve connectivity.

**Safety Concerns**

- Separate entrances and waiting areas for adults and children offers mitigation for these safety concerns.

**Accessibility Enhancements:**

- Increased disabled parking spaces and improved drop-off facilities
- Accessibility audits post-decision to address specific needs.

**Estates Improvements:**

- Expand parking, waiting areas, and Urgent and Emergency facilities to accommodate increased patient flow.
- Where investing into making improvements to current facilities patients, staff and EDI groups need to be involved in the design to ensure spaces are inclusive and accessible.

**Other Key EDI Insights:**

- Southport has a high elderly population, while Skelmersdale has significant deprivation.
- Ethnic diversity is limited, but minority groups may face unique challenges.
- Vulnerable groups, including disabled individuals and carers, require tailored support.

This EIIA (March 26) – addresses these gaps set out as set out in this report.

**EIA and due regard**

This section considers the EIA that was conducted and the extent to which due regard under the Public Sector Equality Duty was demonstrated. The evaluation is based on the following:

**Evidence-based**: The EIA is evidence-based and in terms of data the following are included:

- Demographic profiling has been conducted across the Protected Characteristics and this also includes deprivation which is pertinent to this assessment. It includes geographic profiling of the demographic locations across the various different Protected Characteristics. There is some analysis of the data included in the assessment but also some gaps in the analysis.
- Demographic profile data across the Protected Characteristics of the people that took part in the engagement process is included, but this was not considered in terms of the extent to which the sample was representative (normal practice).

- A summary of the key messages from both the quantitative and qualitative data from the consultation is included. It is, however, hard to ascertain the methodology that has been used and so therefore the extent to which the evidence base here is robust.

**Objective Judgement:** The assessment looks to be mainly objective. The assumptions made about potential impact and also the key messages that relate to the Protected Characteristics seem to be based on robust data and evidence. However, it is difficult to determine exactly what data has been used and how it has been interpreted; i.e. the methodology used. For example, there are no appendices showing the data sources.

**Disaggregated data:** The assessment looks to have disaggregated the engagement data from the consultation conducted in 2024. In addition, there has been an analysis of qualitative data.

**Breadth and depth of data:** The engagement data used for an assessment of this scale looks to be considerable. engagement. It is, however, difficult to determine the types of data have been applied, the amount of data and how it has been analysed. In addition, there are some areas that are limited - for example, some additional qualitative data has been collected, but the sample is very small, and it does not appear to have been targeted to any specific equality group.

There is a good use of demographic profiling data, although the analysis is also in places limited, and the assessment would have benefited from expanding this analysis so that there is solid coverage across the available data sources for the protected characteristic demographics.

In terms of the depth, there appears to be a depth to the analysis with drilling down in qualitative data. It is, however, difficult to determine the extent of this (very similar to the interim EIA that was completed), as it is not clear what data has been used and the approach to how it has been analysed. Articulating this could help the reader and decision-makers have a clear understanding of the foundation that the data analysis is resting upon.

**Representative samples:** There is no analysis included as to the extent to which the engagement data collected was representative of the wider population and the Protected Characteristics. The data that is referred to is from the consultation in 2024 and whilst the assessment includes information about the profiling of those who were engaged, the assessment does not go on to analyse this against the local population data to make a valid judgement on the extent to which the consultation samples gathered were representative or not across the Protected Characteristic groups. This would assist with considering where additional targeting may be required in order to fill any gaps that may be present within the data.

**Insightful and persuasive data and evidence:** The data and logic referred to is insightful and it is persuasive by listing the possible potential impacts, with what looks to be evidence sitting behind this – although it is difficult to ascertain exactly what type and how much data has been used and how it has been analysed. The assessment refers to engagement data, but there is no performance data referred to or analysed and so is limited in the extent to which it is persuasive.

### 9.3 What decision-makers should take from Section 9

Decision-makers should note that earlier EIAs were proportionate to the stage of programme development and that this report strengthens the evidence base for the current decision by addressing the main evidence gaps and translating key themes into deliverable commitments and a monitoring and escalation approach.

For decision papers, the key requirement is a clear line of sight between the evidence on who may be affected, the trade-offs that have been weighed, the mitigations that are being committed alongside the decision, and how the programme will monitor and act during implementation if disproportionate impacts emerge.

# 10.0 Workforce Considerations

In terms of the decisions that are being made, and in terms of due regard and the Equality Act 2010 and the Public Sector Equality Duty, it is important that careful consideration is given to the potential impacts upon staff. The following section is a summary of the findings from staff survey data. The data used includes:

- NHS Staff Survey equality analysis by site, Southport and Formby District General Hospital and Ormskirk District General Hospital.
- Workforce Race Equality Standard report 2024 to 2025 and action plan.
- Equality Delivery System assessment report 2025.
- Interim consultation findings and earlier engagement insight.
- Annual report workforce headline profile.

## 10.1 Key Messages for Decision-makers

The workforce equality position is not neutral between sites. Staff survey results show a higher baseline risk of bullying, harassment and discrimination at the Southport site than at the Ormskirk site. Consolidation concentrates more staff into one environment and so this is likely to amplify these risks unless mitigations are carefully put in place.

**Race**

Race equality gaps exist at Trust level and are relevant to major service change. There is a recruitment gap for Ethnic Minority candidates which is evident in the data collected. In addition ethnic minority staff report higher rates of bullying, harassment and discrimination and a lower confidence in fair career progression. These issues can affect retention, wellbeing and the ability to deliver consistent care adequately, which impacts therefore not only the staff but the patients who are receiving care.

**Sex**

The workforce is predominantly female and a significant proportion work less than full-time. Any relocation, rota change and shift pattern change risks disproportionate impact on women, carers and people who rely on flexible working.

Staff have raised practical issues during the engagement about: travel time, public transport, parking, congestion and on-site safety. These issues will have more of an impact in terms of generating issues of inequality for lower paid roles, staff without access to a car, staff with a disability and staff with caring responsibilities.

**What the evidence shows**

Staff experience differs by site. Southport and Formby District General Hospital staff reports higher bullying, harassment and discrimination than Ormskirk District General Hospital staff on

several indicators. This is decision relevant because consolidation can increase exposure and may reduce psychological safety for some protected groups if the culture risk is not actively managed.

Paediatric staff safety and experience needs explicit consideration if services are collocated into a mixed adult emergency department environment. The risk is a step-change in exposure to discriminatory behaviour, and a need therefore for clear safeguarding, security and de-escalation support.

Workforce demographics means relocation risks are likely to be gendered and linked to caring responsibilities. Longer travel time and less predictable journeys can affect staff retention and wellbeing, especially where flexible working is limited by service need.

Health and wellbeing support is described as a strength, but equality targeting in workforce metrics can be strengthened. This matters during mobilisation when stress and sickness absence can rise and may not be evenly distributed across staff groups.

**Who is most at risk of disadvantage**

- Women, carers and staff who work less than full time, due to childcare and caring logistics and limited flexibility in start and finish times
- Disabled staff and staff with long term conditions, due to reliance on reasonable adjustments, parking proximity, safe access routes, fatigue and predictable stress impacts during change.
- Ethnic minority staff, due to existing gaps in discrimination experience, bullying and confidence in fair progression, and because discrimination grounds are more frequently cited as ethnic background at the Southport site.
- Lower paid staff, staff without access to a car and some internationally recruited staff, due to reliance on public transport and affordability pressures linked to longer travel.

**Option specific equality implications**

If collocated at Southport:

- Higher baseline culture risk based on Staff Survey indicators, particularly bullying and discrimination. Consolidation may amplify these issues unless culture and leadership mitigations are in place before implementing a change.
- Disproportionate impact risk for ethnically minoritised and female staff, given reported discrimination grounds include ethnic background and gender more often at Southport.
- Specific workforce safety risk for paediatric staff moving into an adult emergency department environment, requiring explicit safeguarding, security and de-escalation planning.

**If collocated at Ormskirk:**

- Lower baseline culture risk on the available Staff Survey indicators. Consolidation still carries stress, workload and retention risks if estate capacity, flow and facilities are not adequate, which can create indirect equality impacts through sickness absence and reduced flexibility.

- Travel disadvantage risk for staff currently based nearer Southport who would need to switch site, with higher travel costs or reliance on limited public transport. This is likely to affect lower paid staff and staff without access to a car more.

## Due regard messages for the decision-makers

- **Eliminate discrimination and harassment:** Recognise the higher baseline risk signals at Southport and set out concrete actions to prevent these risks being amplified by service consolidation.
- **Advance equality of opportunity:** Ensure equitable access to flexible working, reasonable adjustments, safe travel to work arrangements, and fair access to development and progression, in the context of known WRES gaps.
- **Foster good relations:** Invest in psychologically safe team cultures and inclusive leadership as teams and service models are brought together.

## Important considerations before implementing decisions made

- A Workforce Equality Mobilisation Plan, including a site-specific culture and safety plan and a clear package of mitigations for travel to work, parking, on site safety and flexible working.
- A specific Paediatric Workforce Safety Plan if consolidating services at Southport, covering staffing model, safeguarding, security, de-escalation support and Protected Characteristic risk management.
- A Workforce Data and Monitoring Plan tracking impacts by Protected Characteristic and staff group, including retention, sickness absence, incident reporting, staff experience and access to development.

## Monitoring and escalation triggers

- Retention and turnover in urgent and emergency care and supporting teams, monthly escalation if turnover rises materially or significant differential leaver patterns emerge.
- Sickness absence, with stress and musculoskeletal signals, monthly escalation if stress or musculoskeletal absence rises following mobilisation, or if there is a disproportionate impact by staff group.
- Violence and aggression incidents and bullying and harassment incidents, monthly escalation if rates rise or if protected groups show disproportionate reporting.
- WRES indicators and relevant staff survey measures for emergency department teams, quarterly escalation if discrimination and harassment gaps widen or confidence in fair progression falls.
- Flexible working and reasonable adjustment outcomes, monthly escalation if approval rates fall or response times increase for any protected group.

# 11.0 Conclusions

**Overall conclusion for decision-makers**

This decision involves place-based trade-offs. Selecting one site for a consolidated Emergency Department is likely to reduce travel burden and practical access barriers for communities closer to that site, while increasing travel time, cost and journey complexity for communities further away.

The strongest mechanisms for unequal impact are travel and time-critical access, followed by parking and safe drop-off, access and wayfinding, and the waiting environment. These impacts are more likely to be amplified for older people and people with frailty, disabled people including people with sensory, cognitive and mental health needs, unpaid carers,

people experiencing deprivation or transport poverty, pregnant and postnatal people, and families with young children.

The programme also has potential to deliver equality and health inequality benefits, dependent on delivery. These include improved clinical sustainability and resilience, a more consistent urgent and emergency care offer, and an opportunity to improve accessibility, reasonable adjustments and the physical environment at the selected site.

Decision assurance depends on the decision being accompanied by a clear and deliverable mitigation package and a monitoring and escalation framework so that emerging disproportionate impacts are identified early and addressed during implementation.

Sections 11.1 to 11.4 summarise the key conclusion themes from population profiling, service performance signals, consultation and engagement, and EIA evidence. The specific recommendations and monitoring expectations are set out in Section 12.

## 11.1 Demographic Profiling

Demographic profiling provides essential context on who lives in the footprint and where vulnerability and need are concentrated. It helps decision-makers understand how place-based trade-offs in travel, cost and access may affect different groups and communities.

Key messages from the demographic profiling are set out below.

### Overall population health

Sefton has poorer general health than both England and West Lancashire, with a higher proportion of people reporting bad or very bad health, with around 20,000 people in these categories.

West Lancashire aligns more closely with the England rates, with marginally better overall health than Sefton, though differences are small.

This indicates greater baseline vulnerability in Sefton, and this is particularly relevant for urgent and emergency care decisions.

### Sex (gender)

- Both Sefton and West Lancashire have a slightly higher proportion of women than men compared to England overall.
- Population density for both men and women clusters around Southport & Formby, Ormskirk District General Hospital, and Skelmersdale, reflecting where services are currently located.
- There is no material gender imbalance. However, women experience poorer health outcomes in parts of the footprint and are more likely to have caring responsibilities. Place-based changes in travel and waiting conditions can therefore affect women differently, depending on locality and circumstances.

### Age

The population profile shows a clear "older skew", particularly in Sefton.

**Sefton has**:

- A higher proportion and absolute number of people Aged 50–64 and 65+ than England overall and West Lancashire.
- A much larger older population in close proximity to Southport & Formby compared to Ormskirk District General Hospital.
- West Lancashire also has an older population profile, but less pronounced than Sefton.
- Children (0–9) cluster mainly around Skelmersdale and Ormskirk District General Hospital, with smaller clusters near Southport & Formby.

**Key message:** Moving services away from Southport & Formby disproportionately impact older people, a protected group under the Equality Act.

### Ethnicity

The area is significantly less ethnically diverse than England overall:

- Sefton: Has a small Ethnic Minority population (e.g. 1.5% Asian).
- West Lancashire: an even smaller ethnic minority population (e.g. 1% Asian).

Despite low overall numbers, ethnic minority populations are geographically concentrated as follows:

- Close to Southport & Formby District General Hospital.
- Around Ormskirk District General Hospital and Skelmersdale Walk-In Centre

**Potential Ethnicity-related Deprivation**

These clusters of Ethnic Minority populations overlap strongly with the areas of highest deprivation. Research consistently show a correlation between certain ethnic groups and low income, and the combination of low income and Ethnicity generates significant disadvantage, for example, An Anatomy of Inequality in the UK [70]. The assumption can be made therefore that these areas are likely to have ethnic minority populations that are also economically deprived and this needs careful consideration as there is the potential to compound health inequality risks for ethnic minority populations within these areas. Moving services away from both Southport and Formby District General Hospital and Ormskirk District General Hospital has the potential to generate significant issues of inequality and therefore detrimental impact upon Ethnic Minority populations. This requires carefully considered mitigation.

## Disability

There are higher levels of disability across the region than the England average, especially in Sefton.

- Sefton has a notably higher proportion of people with a Disability and limited a lot in their daily activities.
- West Lancashire has lower levels of Disability than Sefton but these are still above England levels.

**Disability deprivation is spatially concentrated near:**

- Southport & Formby District General Hospital
- Skelmersdale Walk-In Centre.
- To a lesser extent, Ormskirk District General Hospital.

**Key message:** disabled people are disproportionately affected by service relocation, particularly away from Southport & Formby District General Hospital.

## Unpaid carers

- Both Sefton and West Lancashire have a higher proportion of unpaid carers than in England overall.
- Sefton has a higher proportion of people providing 50+ hours of care per week, the most vulnerable subgroup.
- Carers are frequently collocated with areas of disability and deprivation, increasing cumulative disadvantage.

**Key message:** Unpaid carers are disproportionately affected by service relocation, particularly away from Southport & Formby District General Hospital.

## Sexual Orientation

Patterns broadly mirror England rates, with:

- Small proportions identifying as LGB+

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70 https://www.google.com/search?q=ana+anatomy+of+nequaliy+in+the+UK&rlz=1C1GCGW_enGB1190GB1190&oq=ana+anatomy+of+nequaliy+in+the+UK&gs_lcrp=EgZjaHJvbWUyBggAEEUYOTIHCAEQABjvBTIHCAIQABjvBTIKCAMQABiABBiiBDIHCAQQABjvBTIHCAUQABjvBdIBCDcwMDZqMGo3qAIAsAIA&sourceid=chrome&ie=UTF-8

Although numbers are small, this remains a Protected Characteristic and requires due regard.

### Gender Identity

Patterns broadly mirror England rates, with:

- Very small proportions identifying with a different Gender Identity to the one assigned at birth (0.1% locally).

Although numbers are very small, this still remains a Protected Characteristic and requires due regard.

### Religion and Belief

Sefton and West Lancashire are much more religiously homogeneous than England overall:

- Around 60–65% Christian, compared to 46% nationally.
- Other faith groups are present in very small numbers, with limited geographic spread.

### Deprivation and health inequality

High levels of deprivation are concentrated around Southport & Formby District General Hospital and Skelmersdale Welk-In Centre, which is demonstrated by the following data:

- Index of Multiple Deprivation.
- Core20Plus5.
- Fuel poverty.
- Income deprivation affecting children and older people.

These same areas also have higher concentrations of:

- Older people.
- Disabled people.
- Ethnic minority residents.
- Unpaid carers.

**Key message:**

- Moving services away from Southport & Formby District General Hospital presents a higher risk of widening health inequalities than moving services in the opposite direction.

### Life expectancy and inequality

- Life expectancy is lower in both Sefton and West Lancashire than in England overall, especially for women.
- Life expectancy inequality gaps are significantly wider, particularly in Sefton among men aged 40–59 and 60–79.

This again reinforces that moving services away from Southport and Formby District General Hospital has the potential to have a more detrimental impact in terms of deprivation linked vulnerability.

### Overall summary

The population most affected by service change is older, more deprived, more disabled, and more reliant on unpaid care, with these groups disproportionately concentrated around

Southport and Formby District General Hospital. This means that moving services away from this location that will increase travel or reduce access to these vulnerable groups carry the greatest risk of exacerbating health inequalities.

## 11.2 Service Performance Data

Service performance data should be enhanced to strengthen decision assurance and to support ongoing equality and health inequality monitoring.

The following key messages come from the performance data analysed:

### Overall message

Robust, disaggregated equality data supports decision assurance by helping decision-makers understand who is affected, how impacts arise, and whether mitigations are working. Current Emergency Department performance data that has been analysed indicates marked differences by age and by additional needs flags, and this should inform the monitoring framework during implementation.

### Key messages

Data is central to inclusive decision-making and to understanding whether impacts and mitigations are affecting groups differently.

Both quantitative and qualitative evidence, disaggregated where possible by age bands, disability-related flags and place, helps to identify where experience differs and where corrective action may be needed during implementation

Without routine, disaggregated analysis, decisions risk being only partially informed, especially where vulnerable groups are concerned.

**Current equality performance analysis needs to be strengthened**

Current equality-related performance analysis should be strengthened

Equality-related performance data should be strengthened and used consistently during implementation. Monitoring triggers and escalation routes should be agreed so that emerging gaps between groups can be identified early and addressed through corrective action.

**Existing ED performance shows significant inequality at Southport ED**

Southport ED has a high baseline 4-hour breach rate (41.8%). Breach rates increase sharply with age, rising from around 30% in younger adults to 70% for people aged over 91. This demonstrates a strong baseline inequality risk for older people.

**People with additional needs (disabled people) experience the poorest timeliness**

The clearest unequal performance signals are for people flagged with:

- Mental Health Act
- Learning disability
- Autism

These groups experience high breach rates, which can indicate higher risk of distress and poorer experience. This should inform the equality monitoring framework and service improvement priorities during implementation.

**Other Protected Characteristics show weaker or inconclusive signals**

- Sex: Male and female breach rates are broadly similar.
- Ethnicity: No clear inequality signal is identified, but confidence is low due to small numbers and incomplete recording.
- Deprivation: Variation exists but no consistent gradient is evident for this single metric.

**Ormskirk District General Hospital ED data cannot be directly compared**

Ormskirk District General Hospital ED shows a very low breach rate (4.5%), but activity is overwhelmingly for children under 16. Small numbers and suppressed data mean additional equality analysis is limited for this site. Headline comparisons between sites should therefore be treated with caution.

Service changes could widen existing gaps if baseline inequality signals are not addressed and monitored. The available data indicates that older people and people with additional needs already experience poorer timeliness and experience risks in emergency care, and these signals should be tracked through implementation.

**Decisions could worsen inequalities**

Decisions to move service location could worsen issues of inequality for:

- Older people and people with additional needs who live closer to - and therefore currently use - Southport ED who are already experiencing poorer access and outcomes.

Any change in service model, location, or demand could widen existing gaps unless mitigations are built in and monitored.

## 11.3 Consultation and Engagement

Consultation and engagement intelligence is key evidence for transparent and inclusive decision-making on major service change. It helps explain how people experience access and what mitigations they consider most important, and it should inform both the decision and implementation planning.

The key headline points to be made about how the Programme has performed on this to date are as follows:

- The Programme undertook extensive, multi-phase engagement, including pre-consultation and a formal public consultation (July–October 2025), using a wide range of accessible and inclusive methods.
- Engagement reached over 7,840 people across surveys, events, focus groups, community outreach, polling and written feedback, supported by strong marketing and governance arrangements.

- Equality considerations were embedded through equality profiling, representative sampling, disaggregated analysis, and equality issue extraction, in line with the Public Sector Equality Duty.
- Independent analysis of feedback helped ensure objectivity, with findings reviewed through structured clinical and managerial processes to provide reassurance, mitigation and potential change.
- The consultation evidence shows the decision about where people would prefer services to be located is primarily geography-driven: respondents tend to favour the option closest to where they live, with perceived benefits and burdens varying significantly by location.
- Travel is the dominant inequality mechanism, particularly for Sefton* and West Lancashire communities that will potentially be more significantly disadvantaged by key health services being moved away from Southport and Formby District General Hospital to Ormskirk District General Hospital.
- Parking, safe drop off and arrival arrangements are secondary but still material drivers of unequal impact, following the same geography based pattern.
- Groups most likely to experience amplified negative impacts include older people, disabled people, unpaid carers, pregnant people and families with young children.
- Travel burden intersects with deprivation, transport poverty, rurality and car ownership, increasing the risk of widening health inequalities if mitigations are not effective.
- Disabled people were under-represented in responses compared with Census 2021 benchmarks, while carers were over-represented; some Protected Characteristic groups have small sample sizes, reducing confidence in findings for those groups.

**Key message**

The analysis concludes that either option carries foreseeable risk of disproportionate impact (with moving services away from Southport and Formby District General Hospital being more detrimental of the 2 options), meaning due regard must be undertaken and demonstrated through deliverable mitigations and robust monitoring.

**Main implications**

- It’s important that key decision-makers explicitly evidence due regard by linking the final decision to the consultation equality analysis (as well as this complete report), with a clear audit trail showing how risks were identified, weighed and mitigated.
- Mitigations should be planned and committed alongside the decision rather than left entirely to later design work. Priority areas include travel, parking and safe drop-off, arrival and wayfinding, waiting environments, and accessible information and communication.
- Deliverable commitments are required, particularly around transport support, accessible parking, wayfinding, waiting environments and reasonable adjustments.

- Ongoing engagement is needed in the next phases of the Programme and also during implementation, including targeted follow up with underrepresented groups (e.g. Disabled people, some Ethnic Minority groups, Trans respondents, Carers).
- A formal monitoring and escalation framework should be embedded into programme governance, with agreed metrics and triggers to identify emerging disproportionate impacts during implementation.
- Some issues (notably pregnancy, maternity, children and safeguarding pathways) are currently out of scope, but still present time critical access and safety implications that require clarity.

**Main risks**

- Decision assurance risk: mitigations and monitoring are not clearly committed alongside the decision, reducing confidence that disproportionate impacts will be identified and addressed during implementation.
- Inequality and health inequality risk: increased travel times and costs could lead to delayed attendance, increased ambulance reliance, and widening inequalities for vulnerable groups.
- Operational risk: inadequate parking, drop off, access or waiting environments may create safety incidents, distress, or increased "did not wait" events.
- Reputational risk: perceptions that geography based disadvantage or equality impacts have not been adequately addressed may undermine public confidence in the decision.
- Evidence risk: underrepresentation of some protected groups limits confidence in findings and creates a need for targeted follow-up to avoid blind spots in implementation.
- Delivery risk: mitigations that are not practical outside office hours (e.g. transport support for carers) may fail in real world conditions.

### 11.4 Equality Impact Assessments

Equality Impact Assessments (EIAs) are a core mechanism for demonstrating due regard to the Equality Act 2010 and the Public Sector Equality Duty (PSED). They must be evidence based, proportionate, and integrated into decision making, not treated as a procedural formality. The SCT Programme involves high risk, high impact changes to urgent and emergency care, meaning the threshold for robust equality evidence and analysis is high.

The key headline conclusions in terms of EIA are as follows:

#### Key equality risks consistently identified

Across the pre-consultation EIA, interim EIA, and Freshwater EIA, the same core risks recur:

**Age**

- Children and young people are affected differently by the current model because children's emergency provision is not currently 24/7 at Ormskirk. Both options propose

24/7 children's emergency care. Decision-makers should consider remaining risks for children and families, including travel burden for some localities and the need for safe, child-friendly environments and safeguarding arrangements at the selected site.
- Older people are disproportionately affected due to higher emergency care use, frailty, and sensitivity to delays, travel, and inaccessible environments.

**Disability**
- Disabled people face compounding barriers: physical access, communication needs, sensory environments, reliance on carers, and transport.
- Any reconfiguration that does not embed accessibility and reasonable adjustments from the outset is likely to create avoidable barriers for disabled people and carers, increasing the risk of unequal access and experience. Accessibility-by-design and a clear route to request and deliver reasonable adjustments should therefore be core implementation commitments

**Geography, deprivation, and transport**
- Clear inequalities exist between deprived areas (e.g. parts of Sefton, West Lancashire and Skelmersdale) and more affluent areas, demonstrating worse health outcomes and higher emergency admissions.
- Increased travel distances, poor public transport, and high costs disproportionately affect low income households, disabled people, older people, and carers.

**Safety and experience of care**
Significant concerns were raised about:
- Children sharing ED spaces with adults experiencing mental health crises or intoxication.
- Overcrowding, inadequate parking, and site capacity limits.

**Participation and hidden discrimination**
- There is a risk that protected groups are under-represented in consultation and may experience "hidden" discrimination if engagement is not targeted and inclusive.
- Advancing equality of opportunity requires proactive engagement, not passive consultation. [

## Strengths and weaknesses of EIAs to date

The EIAs completed to date provide assurance around that the 3 PSED aims which have been at the forefront of the programme. The key strengths are as follows:

**Strengths**
- EIAs were started early, before consultation, which supports early identification of potential impacts and mitigation needs.
- Equality risks are clearly identified and consistently framed across assessments.
- Later EIAs (including Freshwater) show improving objectivity and structure.

**Key gaps**

- There was limited disaggregated performance data across Protected Characteristics in previous EIAs. Which has been subsequently addressed through this final EIA.
- Insufficient analysis of whether consultation samples were representative of local populations.
- There is heavy reliance on engagement data, with limited transparency about methodology.
- There was minimal use of staff data and service performance data in earlier stages.

**Positive opportunities identified (through the EIA work conducted)**

- Co-location of adult and children's EDs could improve integration, efficiency, and sustainability, if properly designed.
- Some groups may benefit from reduced travel times depending on the chosen site.
- Reconfiguration offers an opportunity to actively reduce existing inequalities, not just manage risk.

**Mitigations, monitoring and escalation triggers**

The EIA work conducted shows that mitigations are critical, including:

- Transport solutions (e.g. shuttle services, improved public transport links)
- Separate adult and children's waiting areas
- Accessibility audits and inclusive design
- Expanded parking and improved estates
- Ongoing, targeted engagement with protected groups.

The programme has already undertaken a number of EIAs and already has mitigations and reassurances in place as highlighted in the programme response to the consultation feedback, such as transport solutions, separate waiting areas, car parking expansion and ongoing targeted engagement (see appendix 2 of the Decision-Making Business Case).

However, the PSED is a continuous and ongoing duty and a final decision is yet been made on the proposals. This impact assessment provides the opportunity to check for any potential gaps in that previous analysis, including in light of consultation responses, and if so address those gaps prior to a decision being made.

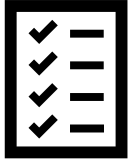
The following mitigations are suggested for implementation post decision:

| Main equality mechanism | Who is most at risk | Minimum commitment during implementation phase | Minimum monitoring and escalation trigger |
|---|---|---|---|
| Travel time, distance and cost | People furthest from the chosen site, amplified for | Transport and access plan that is practical at night | Monitor travel related feedback and reasonable |

| | | | |
|---|---|---|---|
| | older people, disabled people, carers, pregnant women, and low income households | and weekends, includes accessible journey planning, and sets out simple routes for travel support where applicable | adjustment requests by locality. Escalate where sustained deterioration or delayed presentation themes emerge |
| Parking, safe drop off and arrival routes | Disabled people, frail older people, pregnant women, carers, and families with children | Accessible parking and safe drop off design with step free routes to the correct entrance, on request assistance, and clear wayfinding | Monitor parking and arrival complaints and safety incidents. Escalate where sustained rises occur or where incidents indicate unsafe access |
| Waiting environment and separation for children | Children and families, disabled people including neurodiversity and learning disability, people with mental health needs, and frail older people | Minimum waiting environment standard including seating, toilets near waiting, quieter space and sensory considerations, and safe separation for children where feasible | Monitor PALS, complaints and incident themes including distress and safety in waiting. Escalate where did not wait themes rise or where safety incidents increase |
| Accessible information and reasonable adjustments | Disabled people including sensory impairments, people needing alternative formats, language needs, and digital exclusion | Accessible Information Standard compliant communications and signage, interpreter and BSL access, and a clear route to request and deliver reasonable adjustments | Monitor AIS compliance and complaints linked to communication barriers. Escalate where repeated failures are identified |

# 12.0 Recommendations

Urgent and Emergency Care service changes carry foreseeable risks of disproportionate impact for older people, disabled people, unpaid carers, families with children, and people experiencing deprivation or transport barriers.



Decision assurance is strengthened when mitigations are deliverable and linked to a clear monitoring and escalation framework. Priority areas include time-critical access, the waiting environment, reasonable adjustments and travel, supported by disaggregated monitoring and clear routes for action through programme governance.

The recommendations below focus on strengthening clarity, deliverability and monitoring so that equality and health inequality impacts are understood, mitigated and monitored throughout implementation.

How these recommendations should be applied. Recommendations are grouped into decision commitments and implementation and monitoring expectations. Decision commitments are the minimum actions that should be confirmed alongside the configuration decision and reflected in decision papers. Implementation and monitoring expectations are actions that should be developed with partners and communities during implementation and tracked through the equality monitoring framework.

## 12.1 Decision-Making and Due Regard

Whichever option is selected, impacts will fall differently across places and groups, mainly through travel, access and the experience of waiting. Decision papers should therefore summarise the main equality and health inequality impacts, set out the trade-offs that have been considered, and confirm the mitigation and monitoring commitments that will be taken forward.

Decision commitment. The final decision paper should set out the key place-based impacts alongside clinical safety and sustainability considerations, and clearly state the minimum mitigation package and the equality monitoring approach that will accompany the decision.

Decision commitment. Decision papers should explain the rationale for any increased travel time for some communities and groups and describe the mitigations that will be implemented to reduce disproportionate impact, including how these mitigations will work outside office hours.

## 12.2 Co-design of Mitigations

Implementation and monitoring expectation. Mitigations should be designed to address the practical barriers that drive disproportionate impact, with a clear focus on travel and time-critical access, arrival and wayfinding, waiting environment standards, and reasonable adjustments.
Implementation and monitoring expectation. The detailed design of mitigations should be co-produced with the groups most affected, including older people, disabled people, unpaid carers,

families with young children, and people experiencing deprivation or transport poverty, so that mitigations are realistic and deliverable in practice.

### 12.3 Performance Data

Decision commitment: Agree a minimum equality monitoring set for urgent and emergency care that will be used during implementation and post-implementation review. This should include ED timeliness and flow measures and patient experience measures, disaggregated where possible by age bands, disability-related flags and place.

Implementation and monitoring expectation: Build routine reporting that can identify whether gaps between groups widen or narrow over time. Where denominators are small, use appropriate approaches such as rolling averages, grouping where clinically appropriate, and triangulation with qualitative feedback and incidents.

### 12.4 Equality Impact Assessments and Due Regard

Implementation and monitoring expectation. Continue to update equality analysis at key decision points and during implementation, using the best available evidence at each stage. Ensure that equality analysis is clearly linked to the decisions being taken, the mitigations agreed, and the monitoring framework.

### 12.5 Equality and health Inequality benefits

Decision commitment. Decision-makers should also consider the potential equality and health inequality benefits of the preferred option, dependent on delivery. Decision papers should summarise the expected benefits, the conditions required to realise them, and the measures that will be used to monitor whether benefits are delivered for groups more likely to face barriers.

### 12.6 Engagement and Consultation

Whilst extensive consultation and engagement have been conducted during the lifetime of the Programme, there are some areas of under-representation and gaps that need to be filled in the next phases of the Programme where equality intelligence needs to be more accurate and refined.  For example, disabled people, LGBTQ+, younger people, ethnic minority groups and religious groups.  Targeted engagement and consultation should be actioned going forward in order to take reasonable steps to improve equalities data for the under-represented protected characteristics.

### 12.7 Travel, Arrival and Time-Critical Access

The geographic movement of sensitive health services and the potential impacts this will have on various vulnerable groups requires the development and funding of a specific transport and access mitigation plan, recognising that ED attendance is often unplanned, urgent and outside of normal transport hours.  The transport and access mitigation plan should address in particular:

- Night-time, weekend and bank holiday travel.
- People unable to travel independently (older people, disabled people, carers, families with children).
- Cost barriers for low-income households.

- Monitoring delayed attendance, increased ambulance conveyance, and "did not attend/did not wait" rates by locality and Protected Characteristic.

## 12.8 Older People and Frailty

Decision commitment: Confirm how older people and frailty pathways will be supported in the chosen configuration, recognising that older people already experience longer waits and poorer outcomes in emergency care. Implementation should include early frailty identification at the front door, rapid access to senior decision-makers, safe waiting arrangements, and monitoring of timeliness and outcomes for older age bands to ensure inequalities do not widen.

- Early frailty identification at the front door of the ED.
- Rapid access to senior decision-makers.
- Safe seating, toilets and hydration in waiting areas.
- Close monitor and escalation for ED timeliness and outcomes for older age bands (e.g. 75+, 85+) to ensure changes do not widen existing inequalities.

## 12.9 Waiting Environment and Dignity

Implementation and monitoring expectation. Respond to equality-related issues raised in relation to waiting environments, including setting minimum standards for dignity, safety and accessibility

Set minimum equality-focused standards for ED waiting environments, covering:

  - Seating availability and suitability.
  - Toilet access and cleanliness.
  - Noise, lighting and crowding.
  - Safe space for distressed patients.
  - Use patient experience, PALS and complaints data disaggregated by Protected Characteristic in order to identify predictable equality harms linked to crowding and long waits.
- Low-stimulus/quiet waiting areas.
- Clear visual and verbal information on waits and next steps.
- Support for carers to remain with patients.
- Strengthen processes for flagging and delivering reasonable adjustments for people with learning disability, autism, sensory impairment and mental health needs.
- Monitor ED performance and experience for disability-related flags (e.g. learning disability, autism, Mental Health Act) and escalate if gaps widen.

## 12.10 Children, Young People and Families

- Ensure patient pathways provide safe, dignified separation between children and adults where clinically appropriate.

Mitigate risks where possible associated with:

- Children waiting in crowded or distressing adult ED environments.
- Longer travel times for families with young children.
- Clearly communicate paediatric escalation routes and time-critical pathways to avoid confusion and delay.

### 12.11 Accessible Information and Communication

Ensure all communications comply with the Accessible Information Standard, including:

- Easy Read and large print materials.
- Interpreter and BSL access
- Clear, simple signage and wayfinding.]
- Staff working at ED front doors are trained to identify and respond consistently to communication needs, especially during peak pressure.

### 12.12 Carers and Associate Discrimination

Recognise unpaid carers as a group at heightened risk of adverse impacts due to:

- Travel burden.
- Longer waits.
- Difficulty remaining with the person they support.

Provide clear information on carer support, parking, waiting arrangements and discharge planning, and monitor carer-related complaints and feedback.

### 12.13 Workforce Equality

It is important to investigate further with the workforce how significant changes to service locations will impact upon staff, assess the level and specifics of impact and mitigate for the potential adverse impacts upon the workforce, in particular, in relation to:

- Women, carers and staff working less than full-time.
- Staff from racialised communities.
- Disabled staff requiring predictable adjustments.
- Lower-paid staff reliant on public transport.

Ensure that there is careful monitoring of workforce indicators (sickness absence, retention, incidents, bullying and harassment) by Protected Characteristic during the process of implementing changes and following completion.

### 12.14 Health inequalities monitoring and escalation framework

A governance linked monitoring framework is required to evidence the continuous health inequalities duty during implementation and post implementation review. Measures should capture inequalities in access and inequalities in outcomes and experience. Access measures should include indicators sensitive to travel and arrival barriers and disaggregated by place and deprivation, and where possible by age bands and disability related flags. Outcomes and experience measures should include breach rates and long waits by age bands and relevant flags, plus triangulation with qualitative signals such as patient feedback, PALS, complaints and incidents related to delay, communication barriers, distress or safeguarding. Data quality should be monitored, including completeness of equality and additional needs recording, because missingness can mask inequality. Escalation triggers must be linked to action, apply credible denominator rules such as minimum attendance thresholds or rolling averages, and set expectations for corrective action and reporting back through programme governance. The framework should include clear accountability, timescales and a mechanism for publishing learning and actions so there is a transparent duty assurance record.

## 12.15 Monitoring, Escalation and Post Implementation Review

Implementation and monitoring expectation. Introduce an Equality Monitoring Framework across partner organisations that tracks a small number of high-value measures and supports timely escalation and corrective action.

- ED waiting times and breaches.
- Those who leave the ED without being seen.
- Patient experience themes linked to equality issues, e.g. access, distress and dignity.
- Agree clear escalation triggers where:
  - Gaps between groups widen.
  - Performance deteriorates for high risk populations.
- Commit to a post-implementation EIA review to confirm whether mitigations are effective and to address any unintended consequences

## 12.16 Triggers Points and Escalation

Decision and implementation expectation: Agree a small set of clear, measurable escalation triggers and responsibilities within the Equality Monitoring Framework. Triggers should be realistic, based on routinely available data, and designed so that actions can be taken quickly if disproportionate impacts emerge.

# List of Appendices

Appendix 1:   Equality Analysis of Consultation

# APPENDIX ONE

## SCT Equality and health inequalities analysis of consultation

Version 5.4.6 final 25 February 2026

## Dataset SCT Consultation Survey data

## Evidence map used in this appendix

- Consultation survey dataset SCT Consultation Survey 1201 Additions, closed and open text fields with equality monitoring
- Consultation interim report version 06 dated 10 December 2025, used for triangulation of key themes
- Consultation main report
- Pre consultation equality impact assessment dated 14 May 2025, used for baseline risks and mitigations
- Draft EIIA version 3.1, used for wider inequality mechanisms beyond consultation responses

This appendix primarily reports the consultation survey evidence. Other sources are used to triangulate and to support due regard where consultation subgroup bases are small.

# Contents

1 Introduction ....4
2 Executive summary ....5
2.1 Consultation equality findings summary ....5
2.2 Due regard conclusion from consultation evidence ....6
2.3 Priority mitigations and monitoring triggers ....6
2.4 Monitoring metrics for the decision and implementation ....7
3 Methods and interpretation rules ....7
3.1 Open text analysis approach and audit trail ....8
3.2 Equality evidence used to shape consultation design and question framing ....8
3.3 Confidence grading and treatment of small bases ....9
3.4 Distinguishing evidence, judgement, and programme commitments ....9
4 Option trade off summary by place based population ....9
5 Participation profile ....11
5.1 Age participation ....11
5.2 Age participation number of respondents ....12
5.3 Disability participation ....12
5.4 Disability participation breakdown by impairment ....13
5.5 Sex participation ....13
5.6 Sex participation number of respondents ....14
5.7 Pregnancy and maternity participation ....14
5.8 Pregnancy and participation number of respondents ....14
5.9 Ethnicity participation ....15
5.10 Ethnicity participation number of respondents ....16
5.11 Religion or belief participation ....16
5.12 Religion or belief participation number of respondents ....17
5.13 Sexual orientation participation ....17
5.14 Sexual orientation participation number of respondents ....18
5.15 Gender reassignment participation ....18
5.16 Gender reassignment participation number of respondents ....19
5.17 Marriage and civil partnership participation ....19
5.18 Marriage and civil partnership participation number of respondents ....20
5.19 Unpaid carer status participation ....20
5.20 Armed forces participation ....21
5.21 Armed forces participation number of respondents ....21
6 Consultation representativeness summary, national and local comparisons ....22
7 Headline quantitative findings ....26
7.1 Travel by area percent negative ....26
7.2 Parking by area percent negative ....27
7.3 Access to buildings and services by area percent negative ....28
7.4 Waiting areas by area percent negative ....29
7.5 Cross cutting inequality mechanisms and decision implications ....29
7.6 Parking and drop off, additional burden ....29
8 Evidence summary for other protected characteristics and inclusion groups ....29
8.1 Travel ....30
8.2 Access ....33
8.3 Waiting areas ....34
9 Priority group analysis with confidence grading ....37

10 SCT disability and impairment analysis ........................................................................................39
10.1 Core mitigations and monitoring for all impairment groups .......................................................39
10.2 Evidence gaps and how they will be addressed..........................................................................39
10.3 Mitigation certainty .....................................................................................................................40
10.4 Longstanding illness or condition ...............................................................................................41
10.5 Mental health condition ..............................................................................................................43
10.6 Physical impairment or mobility issues .......................................................................................45
10.7 Social or communication impairment .........................................................................................47
10.8 Learning difficulty or cognitive disorder ......................................................................................49
10.9 Blind or visual impairment ..........................................................................................................51
10.10 Deaf or hearing impairment ......................................................................................................53
10.11 Other impairment or condition ..................................................................................................55
11 Open Questions ..................................................................................................................................57
11.1 Travel time and distance .............................................................................................................60
Public transport, would not be able to attend A and E in Southport as disabled and cannot use public transport nor do I have a car.I could not afford a taxi to get there but could get to Ormskirk in a taxi. not move A and E to Southport ..........................................................................................................60
12 SCT consultation disability and impairment open text analysis .........................................................61
12.1 Cross cutting themes across all impairment types .......................................................................61
12.2 Longstanding illness or condition ................................................................................................62
12.3 Mental health condition ...............................................................................................................65
12.4 Physical impairment or mobility issues ........................................................................................68
12.5 Social or communication impairment ..........................................................................................71
12.6 Learning difficulty or cognitive disorder .......................................................................................74
12.7 Blind or visual impairment ...........................................................................................................77
12.9 Deaf or hearing impairment .........................................................................................................80
12.10 Other impairment or condition ...................................................................................................83
13 Mitigation and monitoring dashboard ...................................................................................................7
14  Summary for the main EIA ..................................................................................................................92
15 Protected groups ..................................................................................................................................93
16.1 Purpose and project context ........................................................................................................96
16.2 About the polling ..........................................................................................................................96
16.3 Headline results from the polling .................................................................................................97
16.4 Equality and health inequalities interpretation .............................................................................98
16.5 Signals by protected characteristics and inequality proxies .........................................................98
16.6 Implications for programme decision making and due regard ....................................................100
16.7 Actions, mitigations, and monitoring required .............................................................................100
16.8 Travel cost support options .........................................................................................................101
16.9 Limitations and next steps ...........................................................................................................102

## 1 Introduction

This appendix provides the equality and health inequality analysis of the Shaping Care Together public consultation on two options for a co-located emergency department (ED), bringing adult and children's ED together on a single site either at Southport and Formby District General Hospital (relocating the children's ED from Ormskirk) or at Ormskirk District General Hospital (relocating the adult ED from Southport). It is designed to inform the consultation and due regard sections of the main equality report, and to support decision making under the Public Sector Equality Duty.

The analysis draws on the consultation survey dataset including closed question ratings for each option and open text responses. Closed questions have been analysed by protected characteristic and inclusion group using percent negative, defined as responses of poorly or not well at all, and by area because place is the main driver of access burden. Open text responses have been grouped into cross cutting equality themes such as travel time, public transport, parking, cost, waiting environment, safety, maternity, carers, and reasonable adjustments. Where subgroup bases are small, findings are treated as low confidence and are handled through future targeted engagement, triangulation, and monitoring recommendations.

Findings are triangulated with the consultation report themes, pre consultation equality impact assessment risks, the draft inequality impact assessment for wider inequality mechanisms, and the Survation telephone polling undertaken during consultation. The polling is used as additional insight on awareness and sentiment and is interpreted alongside the survey data rather than as a replacement for protected characteristic analysis, because it does not capture the same equality monitoring detail.

The headline finding is a place based trade off. People living in Sefton tend to rate Southport more favourably on travel and access while people living in West Lancashire tend to rate Ormskirk more favourably. Age, disability, pregnancy and unpaid caring responsibilities amplify the access burden because these groups are more likely to depend on others, use public transport, need reasonable adjustments, or face greater cost and safety barriers. The mitigations section therefore prioritises transport and access planning, accessible information and reasonable adjustments, safe arrival and waiting environments.

**Please note:** Pregnancy and maternity are protected characteristics and people raised concerns about the relationship between children's services, neonatal services and maternity. The SCT consultation decision does not include maternity or neonatal service reconfiguration, which sit within separate regional and national reviews. The programme will therefore focus on clear public information and accessible communications that explain how obstetric emergencies are managed, including confirmation that obstetric emergencies continue to follow agreed pathways to the most appropriate service.

The document is structured to support a clear line of sight from evidence to impacts, then mitigations and monitoring. These are proposed mitigations and programme commitments. They will need to be finalised through the next design and mobilisation phase.

The contents section sets out the main chapters. Each chapter uses consistent headings and interpretation rules.

Public law and due regard note. This appendix is evidence to support decision makers to meet the Public Sector Equality Duty under section 149 of the Equality Act 2010 and the NHS duty to reduce health inequalities. The duty belongs to the decision maker and must be exercised before and at the point of decision with an open mind. This appendix does not replace that duty and should be read alongside the full consultation report, clinical evidence, quality impact work, and the implementation plan.

Consultation responses are an important source of evidence about likely impacts and mitigations. Consultation is not a vote and responses should not be treated as a referendum. Decision makers must weigh this evidence alongside clinical quality, safety, deliverability, and affordability evidence, and must be able to explain why the final decision gives appropriate weight to equality and health inequalities considerations.

Where the appendix describes mitigations, it uses clear language to distinguish what is already committed, what is planned subject to final design and assurance, and what is under consideration. Where a mitigation is required to avoid or minimise disproportionate impact, this is stated as a minimum requirement and is linked to monitoring measures and escalation triggers.

# 2 Executive summary

- Geography and travel burden are the dominant inequality mechanisms, with clear option trade offs for Sefton and West Lancashire communities
- Age, disability, pregnancy and unpaid caring responsibility amplify the access burden
- Where subgroup bases are small, findings are treated as low confidence and are addressed through targeted engagement and implementation monitoring in the next phase of the programme.
- Mitigations should prioritise transport and access planning, accessible information, reasonable adjustment routes, and monitoring by protected characteristic and place
- **Potential equality benefits of co location include a single 24 hour emergency access point for adults and children, reduced internal transfers between sites, and the opportunity to design safer and more accessible arrival and waiting environments. These benefits are contingent on implementation and must be evidenced through design assurance and monitoring.**

## 2.1 Consultation equality findings summary

Consultation responses show that geography and travel are the dominant mechanisms shaping unequal impact. Respondents living in Sefton consistently rated Southport higher for travel and access, while respondents living in West Lancashire consistently rated Ormskirk higher. Open text responses reinforce this place based trade off and highlight additional issues affecting protected groups. These include the experience of travelling in an emergency, affordability and transport options for those without a car, and the practical challenges of attending with children or providing unpaid care.

## 2.2 Due regard conclusion from consultation evidence

The consultation evidence indicates that either co-location option carries a risk of disproportionate impact. The main risk relates to longer travel times and more complex journeys for communities furthest from the co-located site, with amplified impacts for older people, disabled people, pregnant people and unpaid carers. Due regard therefore requires that any decision is accompanied by a transport and access mitigation plan, an Accessible Information Standard and reasonable adjustments approach, and a monitoring framework with clear escalation triggers. **The monitoring approach will sit within programme quality and performance governance. The framework and escalation triggers will be agreed as part of the decision, metrics and reporting arrangements finalised during the implementation phase.**

## 2.3 Priority mitigations and monitoring triggers

- Implementation phase: Transport and access plan. Agree actions with local authorities and transport providers. Explore a free shuttle bus between sites and key rail and **bus nodes (subject to feasibility with partners).** Seek to include evening and weekend provision. Include park and ride where feasible. Provide clear information on taxi options, Patient Transport Services and the Healthcare Travel Costs Scheme. Publish ambulance travel time assumptions and modelling caveats.
- Implementation phase: Parking and arrival plan. Expand Blue Badge and accessible bays close to entrances. Create an enhanced drop off zone with staff support. Improve lighting and safe walking routes. Review payment processes and concessions. Reduce the risk of unfair fines linked to unavoidable delays. Consider staff off site parking with a shuttle to protect patient and carer spaces.
- Implementation phase: Accessible information and reasonable adjustments route. Comply with the Accessible Information Standard. Provide Easy Read, large print, British Sign Language and interpreter access. Make journey planning information accessible online and in print. Provide quiet space and sensory adjustments. Ensure staff are trained to respond consistently.

Implementation phase: Families and children. Provide separate entrances and waiting areas for adults and children where possible. Provide family friendly facilities and clear safeguarding routes.

Implementation phase: Pregnancy and maternity communications. Provide clear public information and accessible communications that explain how obstetric emergencies are managed, including confirmation that obstetric emergencies continue to follow agreed pathways to the most appropriate service.

- Implementation phase: Carer support route. Provide clear information and rest space. Provide practical support for lone carers. Coordinate with carers services and VCSE partners. Include a clear route for carers to request support at arrival and during waiting.

- Implementation phase: Workforce equality and travel plan. Address recruitment and retention risks. Support safe and affordable staff travel. Address parking and late shift safety. Support flexible working and reasonable adjustments. Maintain ongoing staff engagement during implementation.

**Note.** Owners, timing points, metrics and escalation triggers for these routes are set out in section 13. Where this appendix uses the term must, the corresponding delivery and assurance actions are recorded in that dashboard.

## 2.4 Monitoring metrics for the decision and implementation

**Escalation rule.** Escalate to programme governance if monitoring shows a sustained worsening in access or experience for any locality, deprivation group, or protected group proxy across two consecutive reporting periods, or if serious incidents, complaints, or qualitative feedback indicate avoidable harm linked to travel, access, or waiting environment.

- Travel time and mode of arrival for patients by area, deprivation and disability status, quarterly review
- Attendance patterns and time of presentation by area and deprivation, quarterly review
- Patient experience and complaints themes with equality monitoring, quarterly review
- Reasonable adjustments and accessible information compliance indicators, quarterly review
- Workforce metrics including vacancy, turnover and staff experience for both sites, quarterly review

## 3 Methods and interpretation rules

- Participation profile and representativeness
- Protected characteristic analysis and priority groups
- Disability and impairment analysis
- Open text analysis and cross cutting themes
- Mitigation and monitoring dashboard, and reference sources
- Survation polling analysis

*This appendix supports due regard decision making under the Equality Act 2010 and supports the NHS duty to reduce inequalities*

- Percentages are reported as percent negative for comparability across options and questions
- Small numbers are suppressed to reduce disclosure risk and avoid unstable estimates
- Prefer not to say and missing are reported for completeness but are not treated as equality groups in interpretation

## 3.1 Open text analysis approach and audit trail

This appendix includes analysis of free text consultation responses to identify equality and health inequalities mechanisms, groups most likely to experience disadvantage, and suggested mitigations. The approach prioritises transparency and proportionality.

- A structured thematic framework was used, aligned to the consultation questions and the Equality Act protected characteristics, alongside wider inclusion factors such as caring responsibilities, deprivation and digital exclusion.
- Responses could be used  to more than one theme, reflecting that people often describe multiple barriers in a single response.

#### Quality assurance sense check

- A sample of coded responses per major theme was manually re reviewed to confirm consistent application of the coding rules.
- Differences in interpretation were resolved by applying the written rules and prioritising the plain meaning of the response.
- All quotations used are anonymised and edited only to remove identifying detail without changing meaning.
- The codebook and anonymised extracts log are retained within the programme evidence pack to support audit and challenge.
- Open text findings are reported as themes and illustrative quotations. They are not a statistically representative sample and should be interpreted alongside the closed question results and place based patterns.
- Open text often describes travel and access barriers without explicitly stating a protected characteristic. Where this occurs, the analysis focuses on the mechanism and then identifies which protected groups are most likely to be affected using the quantitative subgroup patterns and wider evidence.

## 3.2 Equality evidence used to shape consultation design and question framing

The consultation materials and questions were designed using known equality and health inequalities risks from earlier programme work and local intelligence. This ensured that the survey captured the main mechanisms of potential disadvantage and allowed respondents to propose mitigations.

- The survey focused on travel, parking and arrival, building access, and waiting environment because these are predictable inequality mechanisms for urgent and emergency care access.
- Equality monitoring questions were included to enable analysis by protected characteristics and inclusion groups, alongside place and deprivation proxies.
- Open text prompts were included to capture barriers, lived experience, and suggested mitigations for groups who may face access barriers or rely on reasonable adjustments.
- Accessible formats and channels were used, including paper and Easy Read routes, to reduce exclusion and improve representativeness.
- The analysis approach in this appendix is designed to support decision makers to weigh equality impacts alongside quality, safety, and deliverability evidence, without treating consultation as a vote.

## 3.3 Confidence grading and treatment of small bases

Some protected characteristics and inclusion groups have low response volumes in the consultation survey. This is expected in general population consultations and does not remove the Public Sector Equality Duty to give due regard.

- Small bases are suppressed to reduce disclosure risk and avoid unstable estimates.

Suppression threshold and confidence grading. Results are suppressed where the subgroup base is below 30. Confidence is graded by base size: High 200 plus, Medium 100 to 199, Low 30 to 99, and Insufficient below 30.

- Where subgroup bases are small, findings are treated as indicative only and are interpreted through the place based mechanism analysis.
- Low confidence findings trigger targeted follow up engagement and operational monitoring after the decision, including complaints, patient experience, reasonable adjustment data, and service performance measures where available.
- Evidence gaps are treated as a risk to be managed through monitoring and mitigations, not as evidence of no impact.

## 3.4 Distinguishing evidence, judgement, and programme commitments

This appendix uses a consistent decision facing structure.

- Evidence. Quantitative survey results and coded qualitative themes, supported by the evidence map sources.
- Judgement. Interpretation of likely mechanisms of disadvantage and the groups most at risk, based on the evidence and the limitations set out in section 3.
- Commitments. Actions stated as minimum requirements only where there is an identified owner, an implementation and a monitoring measure with an escalation route recorded in section 13.
- Assurance. Where evidence is low confidence, the response is targeted follow up engagement (during implementation and operational monitoring rather than treating the gap as no impact).

## 4 Option trade off summary by place based population

This table summarises which site was rated higher within each area for the main access domains. Percentages show the proportion of respondents who rated one site higher than the other, among those who rated both sites for that question.

| Area | Travel Q7 | Parking Q8 | Access Q9 | Waiting area Q10 | Overall Q1 |
|---|---|---|---|---|---|
| Sefton | Southport 81.0% | Southport 50.7% | Southport 55.0% | Southport 46.5% | Southport 75.2% |
| West Lancashire | Ormskirk 90.4% | Ormskirk 71.0% | Ormskirk 72.4% | Ormskirk 77.6% | Ormskirk 81.0% |

Place based patterns are also visible at town level. Southport and Formby respondents mostly rated Southport higher, while Ormskirk, Skelmersdale and Maghull respondents mostly rated Ormskirk higher.

## 5 Participation profile

This section describes who responded using the equality monitoring fields from the consultation survey.

### Area participation

| Area | Count | Percent |
|---|---|---|
| West Lancashire | 2773 | 55.4% |
| Sefton | 1910 | 38.1% |
| Other | 203 | 4.1% |
| No Postcode Available | 123 | 2.5% |

Most respondents were in West Lancashire, 55.4 percent of responses. The next largest group was Sefton, 38.1 percent.

### Town participation

| Town | Count | Percent |
|---|---|---|
| Southport | 1513 | 30.2% |
| Skelmersdale | 1254 | 25% |
| Ormskirk | 874 | 17.4% |
| Northern Parishes | 645 | 12.9% |
| Formby | 311 | 6.2% |
| Other | 203 | 4.1% |
| No Postcode Available | 123 | 2.5% |
| Maghull | 86 | 1.7% |

Most respondents were in Southport, 30.2 percent of responses. The next largest group was Skelmersdale, 25.0 percent.

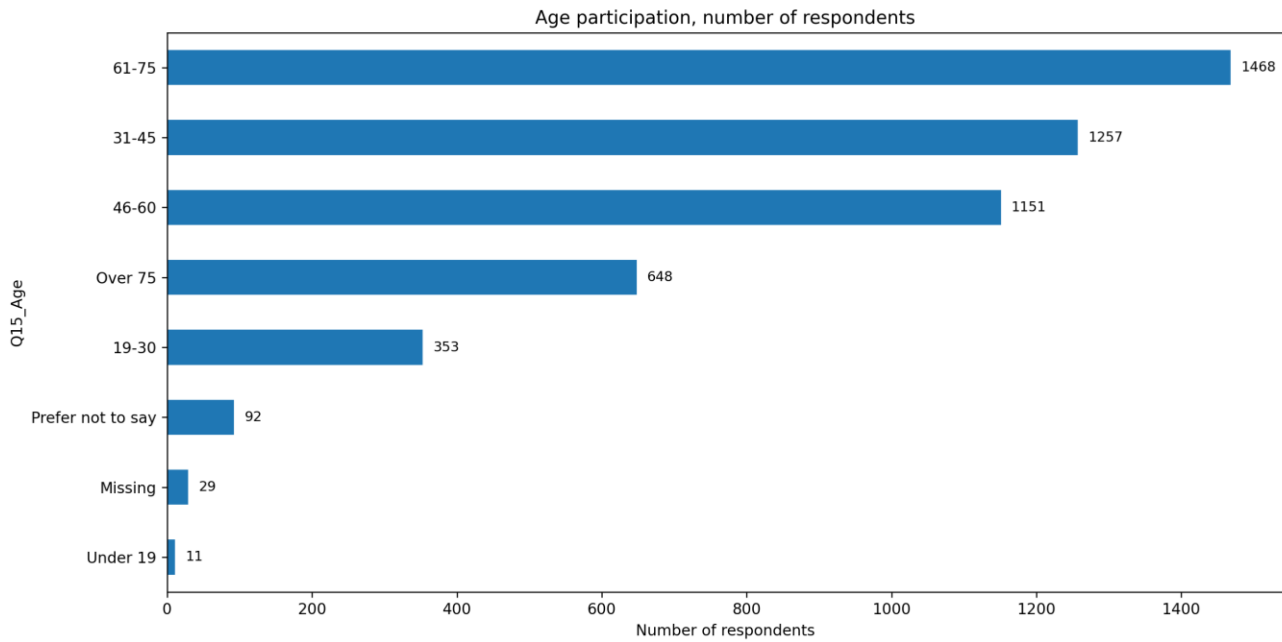
## 5.1 Age participation

| Age | Count | Percent |
|---|---|---|
| 61-75 | 1468 | 29.3% |
| 31-45 | 1257 | 25.1% |
| 46-60 | 1151 | 23% |
| Over 75 | 648 | 12.9% |
| 19-30 | 353 | 7% |
| Prefer not to say | 92 | 1.8% |
| Missing | 29 | 0.6% |
| Under 19 | 11 | 0.2% |

Most respondents were in 61-75, 29.3 percent of responses. The next largest group was 31-45, 25.1 percent. Missing or prefer not to say responses were 2.4 percent, which reduces confidence in comparisons for this characteristic. Responses were older skewed, aged 61 and over were 42.2 percent, younger people under 31 were 7.2 percent. This suggests younger perspectives may be under represented, and findings should be triangulated with targeted youth engagement and local insight.

Charts show number of respondents selecting each category. Where there are many categories, the top categories are shown and the remainder are grouped as Other.

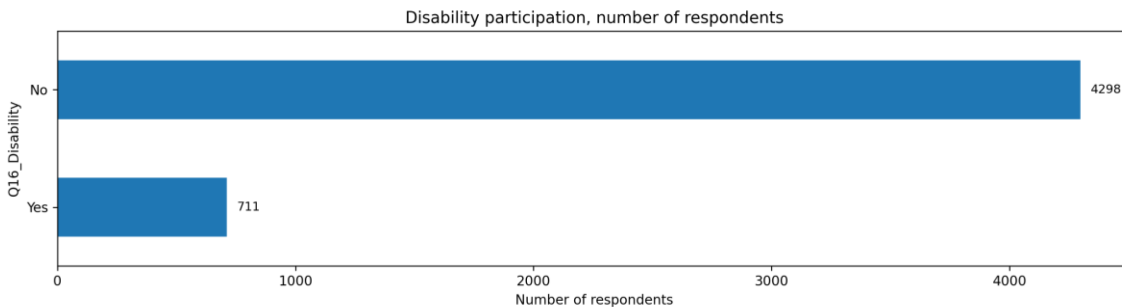
## 5.2 Age participation number of respondents




## 5.3 Disability participation

| Disability | Count | Percent |
|---|---|---|
| No | 4298 | 85.8% |
| Yes | 711 | 14.2% |

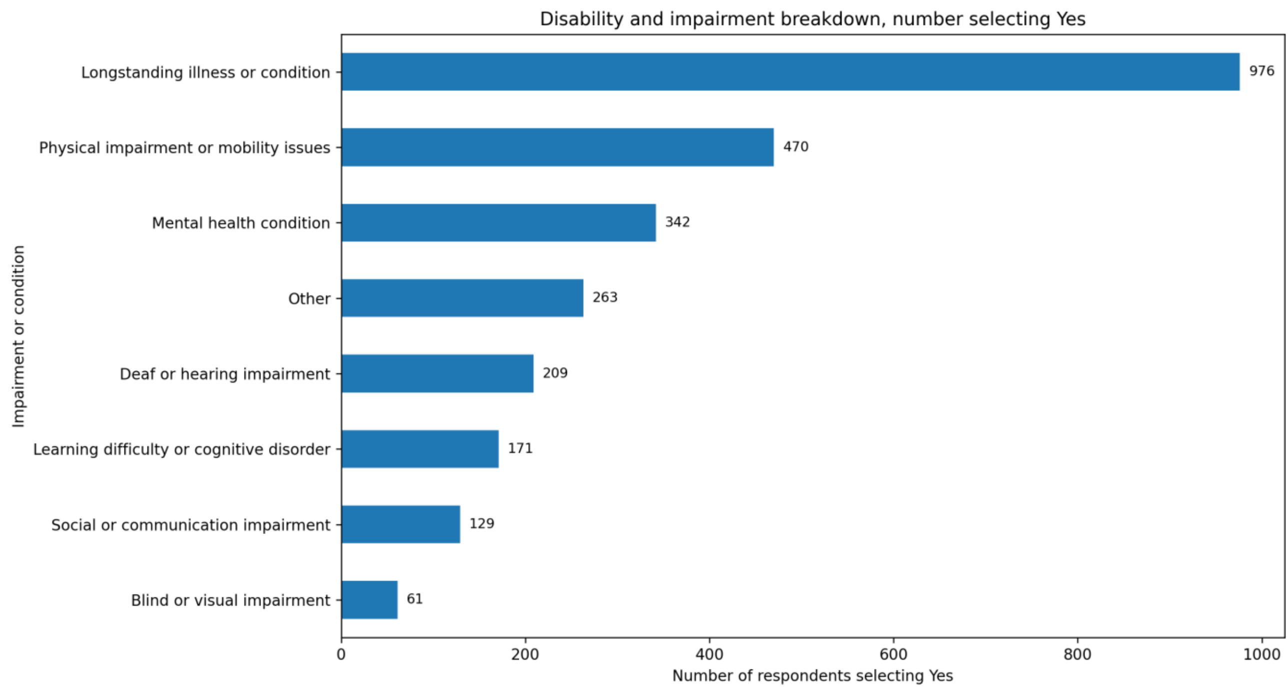
Most respondents were in No, 85.8 percent of responses. The next largest group was Yes, 14.2 percent.




## 5.4 Disability participation breakdown by impairment

This section breaks down the disability and impairment question into the main impairment types recorded in the survey.

Counts are the number selecting Yes. Percent is calculated as percent Yes among those who answered each impairment item.

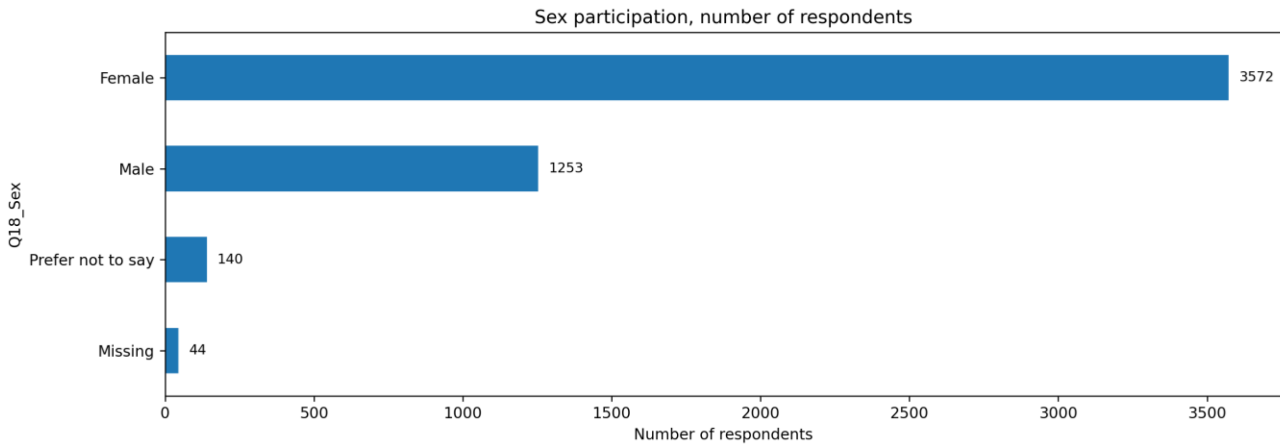



## 5.5 Sex participation

| Sex | Count | Percent |
|---|---|---|
| Female | 3572 | 71.3% |
| Male | 1253 | 25% |
| Prefer not to say | 140 | 2.8% |
| Missing | 44 | 0.9% |

Most respondents were in Female, 71.3 percent of responses. The next largest group was Male, 25.0 percent. Missing or prefer not to say responses were 3.7 percent, which reduces confidence in comparisons for this characteristic. Women were more likely to respond than men, female 71.3 percent, male 25.0 percent. This can amplify themes linked to caring roles and access needs, and it risks missing male specific experience unless triangulated.

## 5.6 Sex participation number of respondents

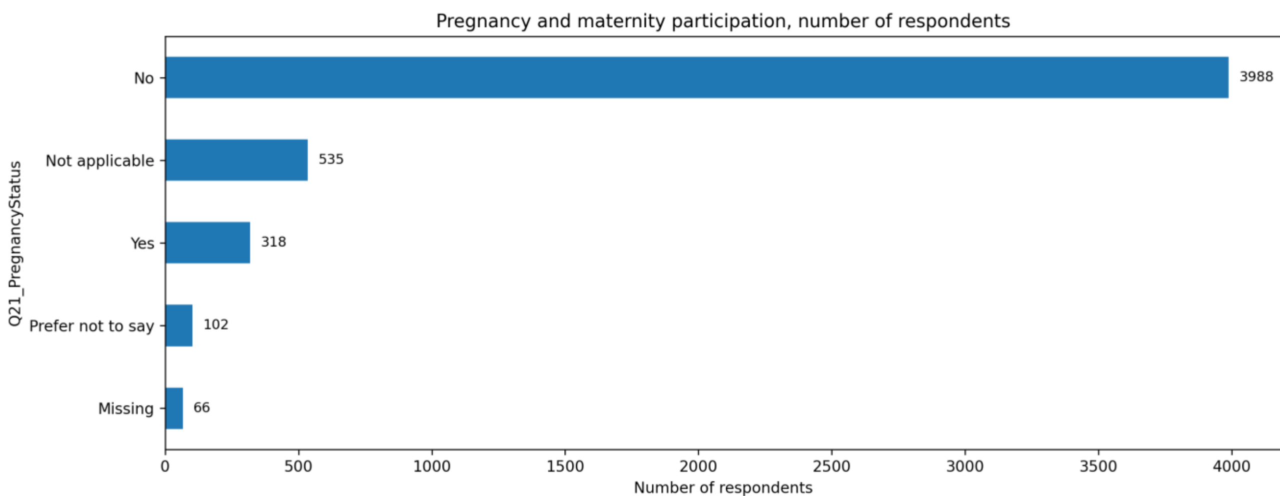



## 5.7 Pregnancy and maternity participation

| Pregnancy and maternity | Count | Percent |
|---|---|---|
| No | 3988 | 79.6% |
| Not applicable | 535 | 10.7% |
| Yes | 318 | 6.3% |
| Prefer not to say | 102 | 2% |
| Missing | 66 | 1.3% |

Most respondents were in No, 79.6 percent of responses. The next largest group was Not applicable, 10.7 percent. Missing or prefer not to say responses were 3.3 percent, which reduces confidence in comparisons for this characteristic.

## 5.8 Pregnancy and maternity participation number of respondents

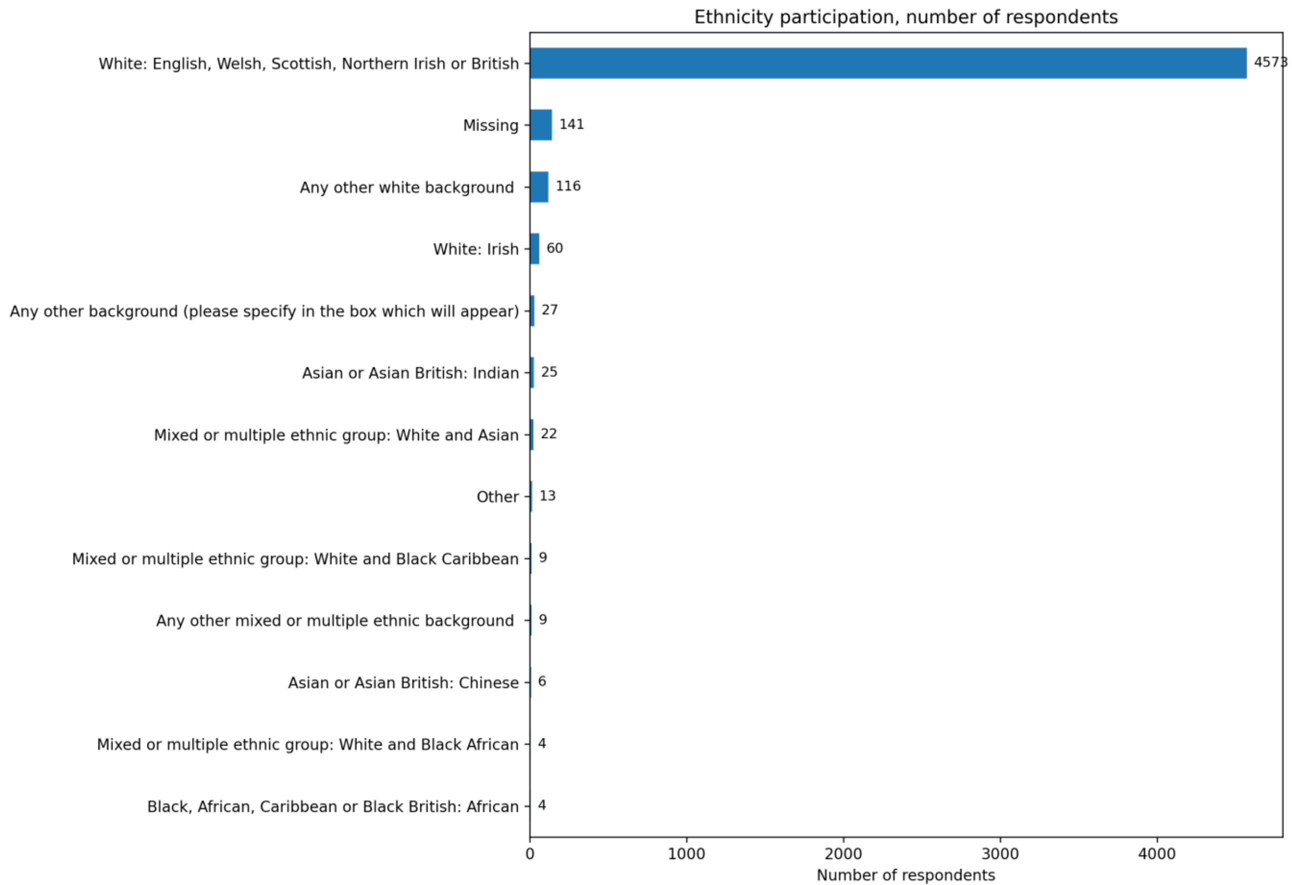


## 5.9 Ethnicity participation

| Ethnicity | Count | Percent |
|---|---|---|
| White English, Welsh, Scottish, Northern Irish or British | 4573 | 91.3% |
| Missing | 141 | 2.8% |
| Any other white background | 116 | 2.3% |
| White Irish | 60 | 1.2% |
| Any other background (please specify in the box which will appear) | 27 | 0.5% |
| Asian or Asian British Indian | 25 | 0.5% |
| Mixed or multiple ethnic group White and Asian | 22 | 0.4% |
| Any other mixed or multiple ethnic background | 9 | 0.2% |
| Mixed or multiple ethnic group White and Black Caribbean | 9 | 0.2% |
| Asian or Asian British Chinese | 6 | 0.1% |
| Black, African, Caribbean or Black British African | 4 | 0.1% |
| Mixed or multiple ethnic group White and Black African | 4 | 0.1% |
| Other | 13 | 0.3% |

Most respondents were in White English, Welsh, Scottish, Northern Irish or British, 91.3 percent of responses. The next largest group was Missing, 2.8 percent. Missing or prefer not to say responses were 2.8 percent, which reduces confidence in comparisons for this characteristic. Responses were predominantly White British, 91.3 percent, minority ethnic groups had low bases. This limits what can be concluded about differential impact by ethnicity from closed question analysis alone, and warrants targeted engagement and triangulation with local population data.

## 5.10 Ethnicity participation number of respondents

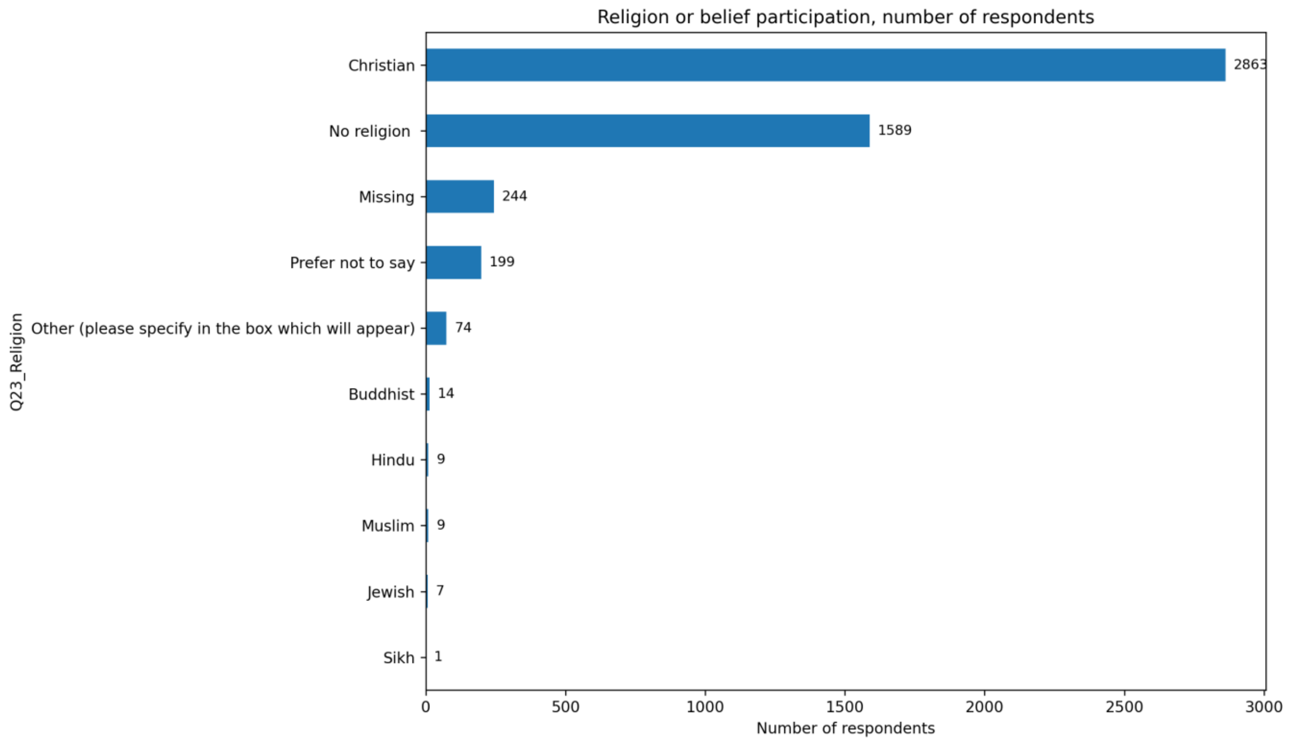



## 5.11 Religion or belief participation

| Religion or belief | Count | Percent |
|---|---|---|
| Christian | 2863 | 57.2% |
| No religion | 1589 | 31.7% |
| Missing | 244 | 4.9% |
| Prefer not to say | 199 | 4% |
| Other (please specify in the box which will appear) | 74 | 1.5% |
| Buddhist | 14 | 0.3% |
| Muslim | 9 | 0.2% |
| Hindu | 9 | 0.2% |
| Jewish | 7 | 0.1% |
| Sikh | 1 | 0% |

Most respondents were in Christian, 57.2 percent of responses. The next largest group was No religion, 31.7 percent. Missing or prefer not to say responses were 8.9 percent, which reduces confidence in comparisons for this characteristic.

## 5.12 Religion or belief participation number of respondents

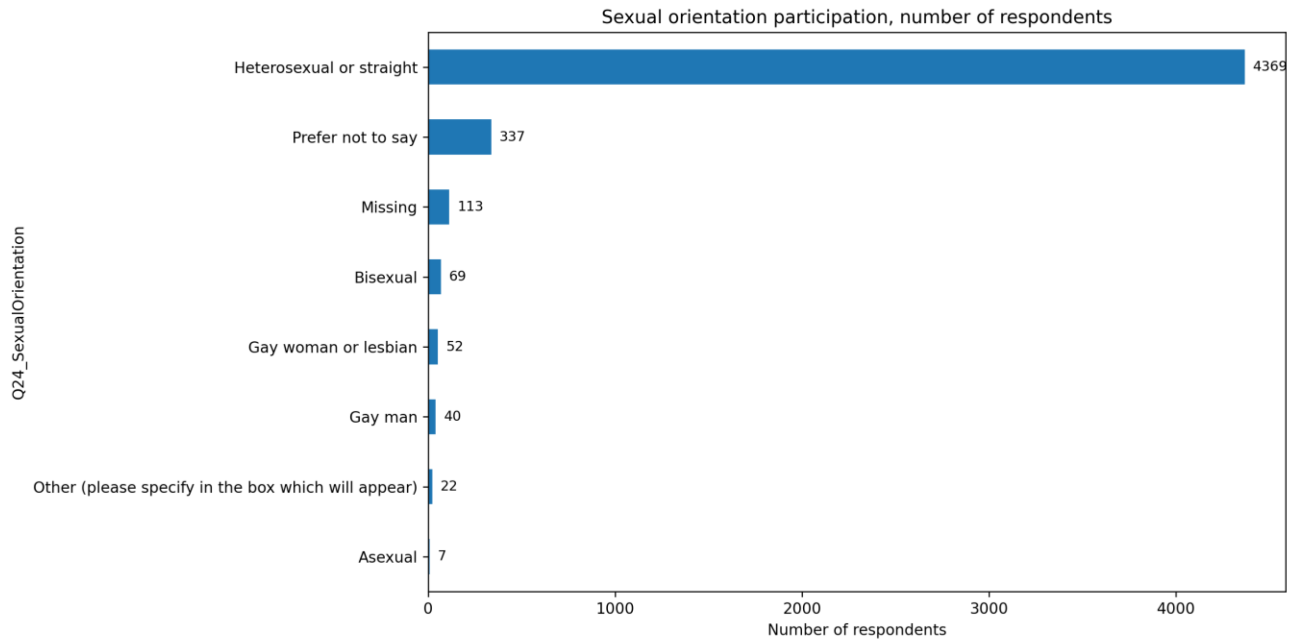



## 5.13 Sexual orientation participation

| Sexual orientation | Count | Percent |
|---|---|---|
| Heterosexual or straight | 4369 | 87.2% |
| Prefer not to say | 337 | 6.7% |
| Missing | 113 | 2.3% |
| Bisexual | 69 | 1.4% |
| Gay woman or lesbian | 52 | 1% |
| Gay man | 40 | 0.8% |
| Other (please specify in the box which will appear) | 22 | 0.4% |
| Asexual | 7 | 0.1% |

Most respondents were in Heterosexual or straight, 87.2 percent of responses. The next largest group was Prefer not to say, 6.7 percent. Missing or prefer not to say responses were 9.0 percent, which reduces confidence in comparisons for this characteristic.

## 5.14 Sexual orientation participation number of respondents

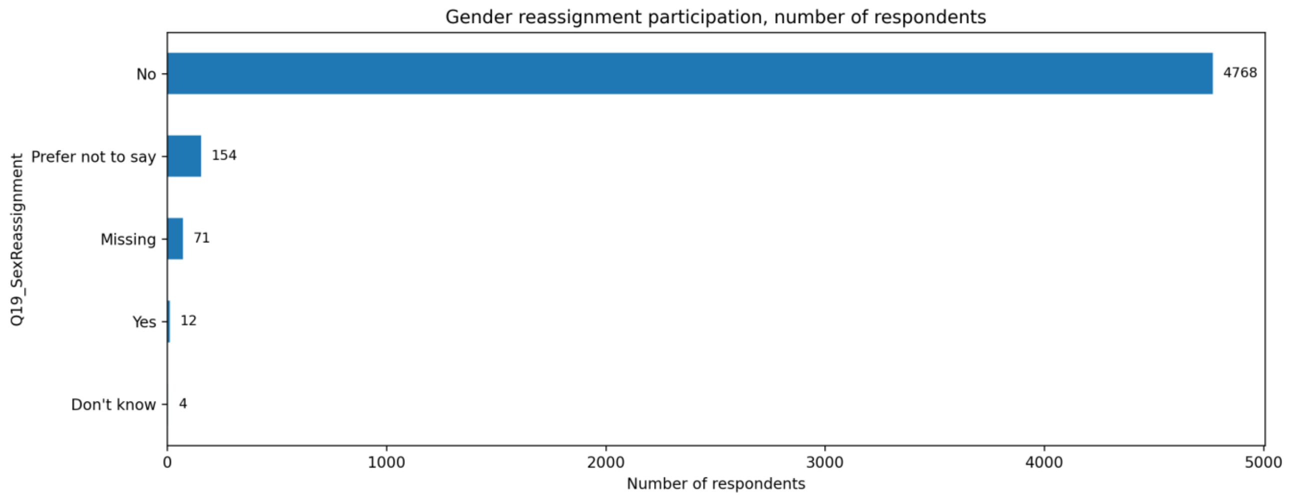



## 5.15 Gender reassignment participation

| Gender reassignment | Count | Percent |
|---|---|---|
| No | 4768 | 95.2% |
| Prefer not to say | 154 | 3.1% |
| Missing | 71 | 1.4% |
| Yes | 12 | 0.2% |
| Don't know | 4 | 0.1% |

Most respondents were in No, 95.2 percent of responses. The next largest group was Prefer not to say, 3.1 percent. Missing or prefer not to say responses were 4.5 percent, which reduces confidence in comparisons for this characteristic.

## 5.16 Gender reassignment participation number of respondents

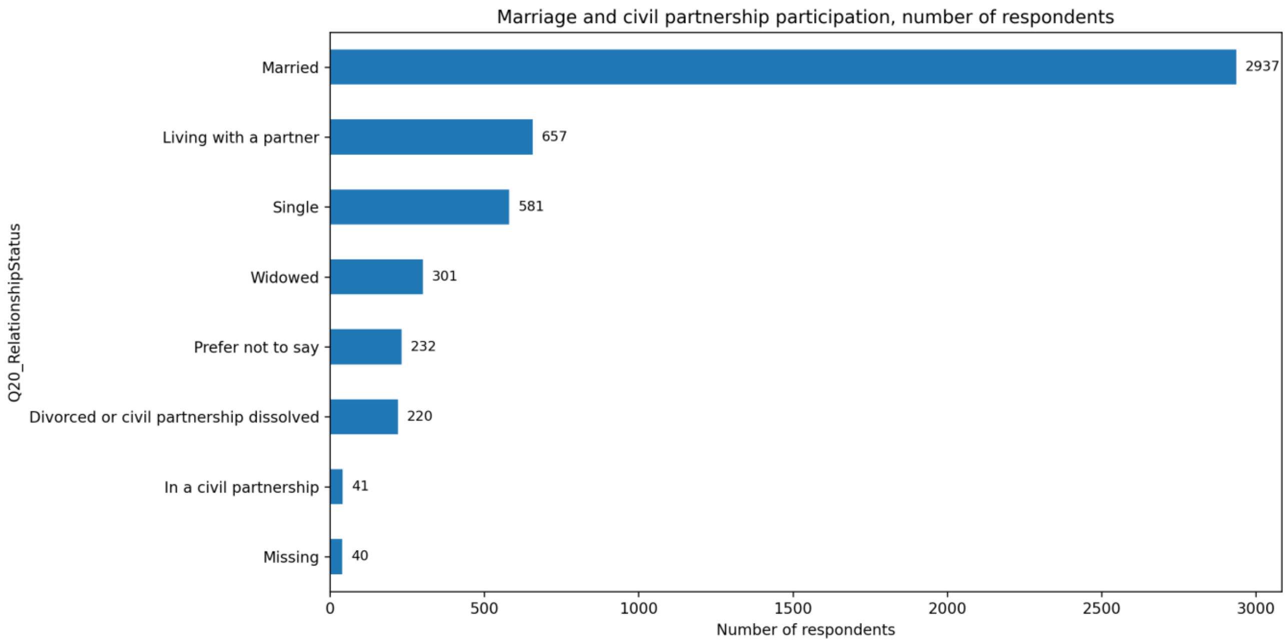



## 5.17 Marriage and civil partnership participation

| Marriage and civil partnership | Count | Percent |
|---|---|---|
| Married | 2937 | 58.6% |
| Living with a partner | 657 | 13.1% |
| Single | 581 | 11.6% |
| Widowed | 301 | 6% |
| Prefer not to say | 232 | 4.6% |
| Divorced or civil partnership dissolved | 220 | 4.4% |
| In a civil partnership | 41 | 0.8% |
| Missing | 40 | 0.8% |

Most respondents were in Married, 58.6 percent of responses. The next largest group was Living with a partner, 13.1 percent. Missing or prefer not to say responses were 5.4 percent, which reduces confidence in comparisons for this characteristic.

## 5.18 Marriage and civil partnership participation number of respondents

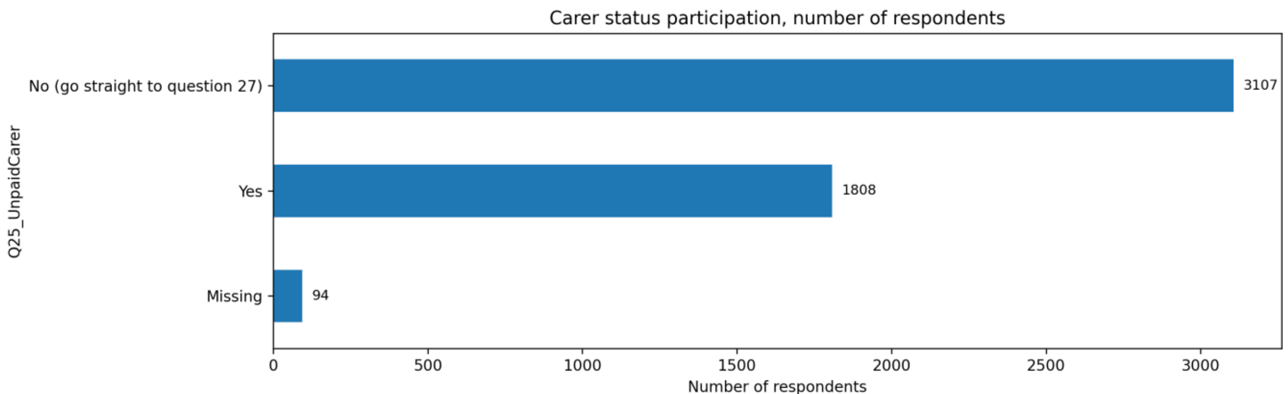



## 5.19 Unpaid carer status participation

| carer status | Count | Percent |
|---|---|---|
| No | 3107 | 62% |
| Yes | 1808 | 36.1% |
| Missing | 94 | 1.9% |

Most respondents were in No (go straight to question 27), 62.0 percent of responses. The next largest group was Yes, 36.1 percent. Missing or prefer not to say responses were 1.9 percent, which reduces confidence in comparisons for this characteristic.

Carer status participation number of respondents

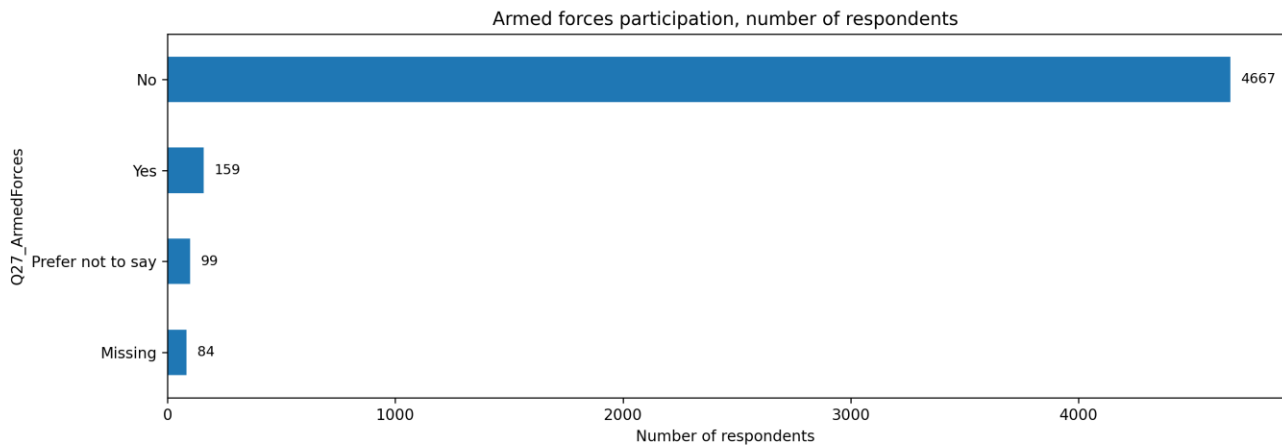


## 5.20 Armed forces participation

| Armed forces | Count | Percent |
|---|---|---|
| No | 4667 | 93.2% |
| Yes | 159 | 3.2% |
| Prefer not to say | 99 | 2% |
| Missing | 84 | 1.7% |

Most respondents were in No, 93.2 percent of responses. The next largest group was Yes, 3.2 percent. Missing or prefer not to say responses were 3.7 percent, which reduces confidence in comparisons for this characteristic.

## 5.21 Armed forces participation number of respondents



## 6 Consultation representativeness summary, national and local comparisons

The gender reassignment question in this survey is not directly comparable with Census gender identity, so the comparison is presented cautiously and bases are treated as low confidence.

Notes on comparators, local figures use Census 2021 for Sefton and West Lancashire. Disability and caring comparators are age standardised proportions from Census 2021 topic summaries. Consultation categories are self reported and do not perfectly match Census definitions, interpret differences with caution.

| Characteristic | National benchmark | Sefton benchmark | West Lancashire benchmark | Consultees |
|---|---|---|---|---|
| Ethnicity, White total | 81.0 percent | 95.8 percent | 96.9 percent | 94.8 percent |
| Ethnicity, non White and other ethnicities | 19.0 percent | 4.2 percent | 3.1 percent | 2.4 percent |
| Disability, disabled or limited day to day activities | 17.8 percent | 20.6 percent | 18.7 percent | 14.2 percent |
| Caring responsibility, provides unpaid care | 8.9 percent | 10.7 percent | 10.0 percent | 36.1 percent |
| Religion, Christian | 46.3 percent | 64.4 percent | 61.5 percent | 57.2 percent |
| Veteran status, previously served in UK armed forces | 3.8 percent | 4.7 percent | Not available | 3.2 percent |
| Sexual orientation, straight or heterosexual | 89.4 percent | 91.4 percent | Not available | 87.2 percent |
| Gender reassignment, survey question (Yes) | Not directly comparable | Not directly comparable | Not directly comparable | 0.2 percent |
| Ethnicity, missing or not stated | Not applicable | Not applicable | Not applicable | 2.8 percent |

Consultation respondents were broadly similar to the local ethnicity profile, but more White than the national benchmark (94.8 percent White; 2.4 percent minority ethnic; 2.8 percent missing or not stated). Disabled people appear under represented compared with local benchmarks, consultees 14.2 percent, Sefton 20.6 percent, West Lancashire 18.7 percent. Carer status appears over represented compared with Census unpaid care estimates (consultees 36.1 percent compared with around 10.7 percent and 10.0 percent locally), but the survey and Census questions are not like for like, so interpret this difference with caution. This pattern means findings should be interpreted carefully for under represented groups and triangulated with targeted engagement and other evidence.

| Impairment or condition | Yes count | Percent yes of answered |
|---|---|---|
| Longstanding illness or condition | 976 | 19.5% |
| Mental health condition | 342 | 6.8% |
| Physical impairment or mobility issues | 470 | 9.4% |

| Impairment or condition | Yes count | Percent yes of answered |
|---|---|---|
| Social or communication impairment | 129 | 2.6% |
| Learning difficulty or cognitive disorder | 171 | 3.4% |
| Blind or visual impairment | 61 | 1.2% |
| Deaf or hearing impairment | 209 | 4.2% |
| Other | 263 | 5.3% |

This table shows the number of respondents who selected each impairment or condition. Groups overlap, one person can select more than one impairment. The most commonly selected were Longstanding illness or condition 19.5%, Physical impairment or mobility issues 9.4%, Mental health condition 6.8%, Other 5.3%. These bases explain where the impairment specific analysis has higher confidence and where results should be treated as indicative.

Note on interpretation. The impairment or long term condition question is broader than the Equality Act definition of disability, and respondents may report an impairment without identifying as disabled in the separate disability question. These results are therefore used to explore potential adjustment needs and access barriers, not to estimate Equality Act disability prevalence.

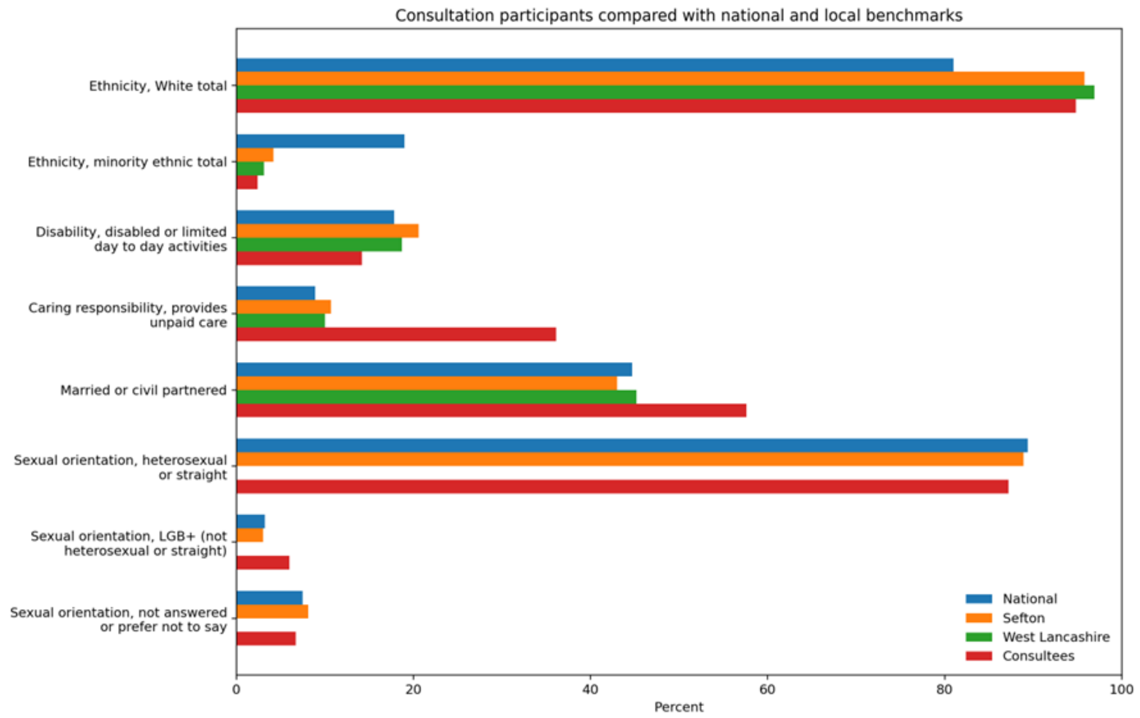
## Headline interpretation

- Ethnicity, consultees were more White than the national population. Once missing responses are removed, consultees were also more likely to identify as White than Sefton and West Lancashire. This indicates under representation of racialised communities and a need for targeted follow up engagement in the next phase of the programme (inclusive design).
- Disability, consultees reporting disability were lower than local and national Census based estimates. This indicates likely under representation of disabled people.
- Caring responsibility, consultees reporting caring responsibilities were far higher than Census unpaid care estimates. This suggests the consultation reached many carers, though definitions differ so this is not a direct like for like comparison.
- Sexual orientation, consultees reporting straight or heterosexual was lower than the local and national Census figures, suggesting some over representation of LGB plus respondents or differences in disclosure.
- Gender reassignment: the survey question is not directly comparable with Census gender identity. Numbers are very small, so no meaningful quantitative comparison is presented. The programme will ensure inclusive, safe engagement routes and monitoring for trans and non-binary people during implementation.

## Mitigations and further actions for implementation phase.

- Targeted follow up engagement with racialised communities, work with local VCSE, faith and cultural organisations, use translated materials and trusted community settings, part of the inclusive design work in the relevant phase of the programme.

- Pan disability involvement in the next phase of the programme to ensure inclusive design and accessibility.
- Disability and impairment engagement and accessibility assurance, provide reasonable adjustments for participation, including British Sign Language access and Easy Read, and use disability organisations and carers networks to validate mitigations on travel, arrival and waiting
- Strengthen monitoring and feedback loops, publish an equality monitoring dashboard for implementation, review complaints and patient experience by protected characteristic and postcode, and agree escalation triggers where access or experience deteriorates for any group


Consultation participants compared with national and local benchmarks
Ethnicity, White total
Ethnicity, minority ethnic total
Disability, disabled or limited day to day activities
Caring responsibility, provides unpaid care
Married or civil partnered
Sexual orientation, heterosexual or straight
Sexual orientation, LGB+ (not heterosexual or straight)
Sexual orientation, not answered or prefer not to say
National
Sefton
West Lancashire
Consultees
0
20
40
60
80
100
Percent

## 7 Headline quantitative findings

### Preference index by area

| area | Base | Ormskirk rated higher | Rated equally | Southport rated higher | Ormskirk rated higher percent | Rated equally percent | Southport rated higher percent |
|---|---|---|---|---|---|---|---|
| West Lancashire | 2584 | 2092 | 322 | 170 | 81% | 12.5% | 6.6% |
| Sefton | 1727 | 220 | 209 | 1298 | 12.7% | 12.1% | 75.2% |
| Other | 180 | 121 | 28 | 31 | 67.2% | 15.6% | 17.2% |
| No Postcode Available | 93 | 52 | 12 | 29 | 55.9% | 12.9% | 31.2% |

This shows a strong place based trade off. In West Lancashire, 81% rated Ormskirk higher, only 6.6% rated Southport higher. In Sefton, 75.2% rated Southport higher, only 12.7% rated Ormskirk higher. Decision making should treat this as a material equity issue, and mitigations should be specific to the populations who face the longest travel, highest cost, and weakest public transport links under each option.

### Overall rating by area percent negative

| area | Southport base | Southport percent negative | Ormskirk base | Ormskirk percent negative |
|---|---|---|---|---|
| No Postcode Available | 105 | 51.4% | 106 | 25.5% |
| Other | 198 | 58.6% | 201 | 13.9% |
| Sefton | 1893 | 14.9% | 1826 | 56% |
| West Lancashire | 2688 | 73.2% | 2732 | 8.7% |

West Lancashire shows higher negative rating for Southport, Southport 73.2 percent, Ormskirk 8.7 percent. Other shows higher negative rating for Southport, Southport 58.6 percent, Ormskirk 13.9 percent. Sefton shows higher negative rating for Ormskirk, Southport 14.9 percent, Ormskirk 56.0 percent. This indicates an option related access risk for this group, and mitigations should be treated as requirements rather than nice to have.

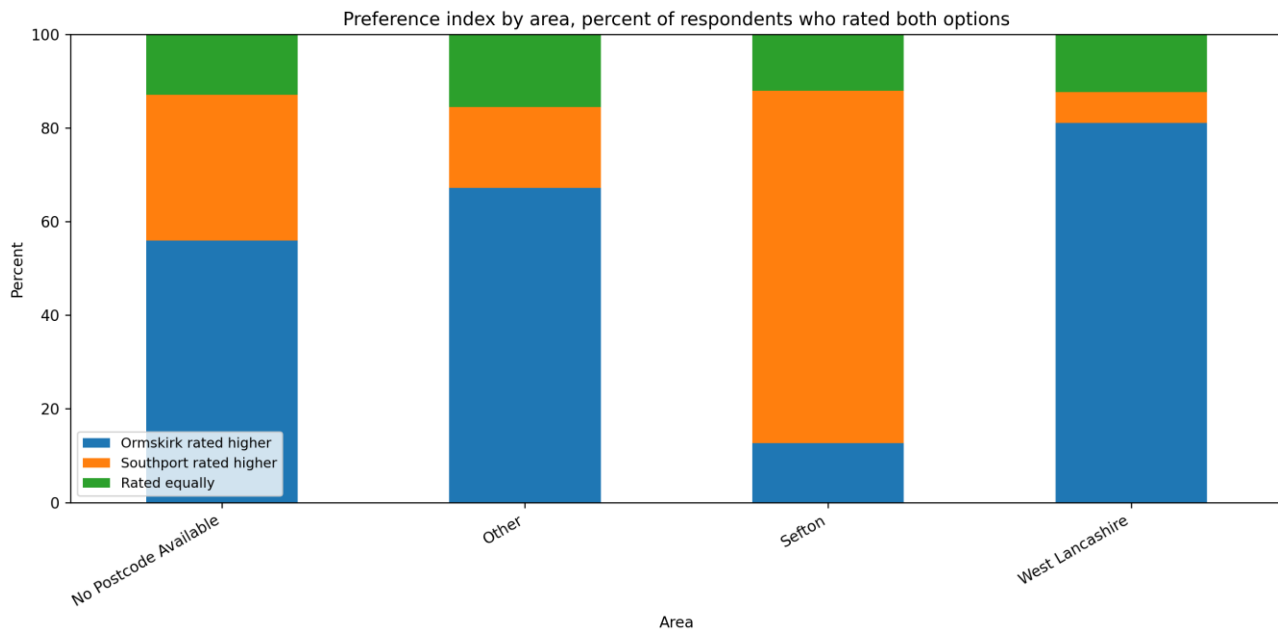
## 7.1 Travel by area percent negative

| Travel by area | Southport base | Southport percent negative | Ormskirk base | Ormskirk percent negative |
|---|---|---|---|---|
| No Postcode Available | 99 | 56.6% | 101 | 27.7% |
| Other | 197 | 68% | 199 | 11.6% |
| Sefton | 1893 | 11.8% | 1844 | 74% |
| West Lancashire | 2725 | 85.8% | 2742 | 3.8% |

West Lancashire shows higher negative rating for Southport, Southport 85.8 percent, Ormskirk 3.8 percent. Sefton shows higher negative rating for Ormskirk, Southport 11.8 percent, Ormskirk 74.0 percent. Other shows higher negative rating for Southport, Southport 68.0 percent, Ormskirk 11.6

percent. This indicates an option related access risk for this group, and mitigations should be treated as requirements rather than nice to have.

Preference index by area percent of respondents who rated both options




### Decision relevance and due regard summary for travel

- Evidence shows a strong place based travel trade off between Sefton and West Lancashire, with travel as the main driver of perceived disadvantage.
- Groups most at risk include disabled people, older people, unpaid carers, pregnant people, and people experiencing deprivation or low car access.
- Minimum commitments include a transport and access plan, clear information on routes, and practical support for those facing travel cost and complexity.
- Monitoring must include travel related experience and complaints by locality and deprivation, with escalation if disadvantage worsens across two consecutive reporting periods.

## 7.2 Parking by area percent negative

| area | Southport base | Southport percent negative | Ormskirk base | Ormskirk percent negative |
|---|---|---|---|---|
| No Postcode Available | 99 | 53.5% | 102 | 24.5% |
| Other | 198 | 56.1% | 200 | 15% |
| Sefton | 1884 | 24.3% | 1847 | 45.3% |
| West Lancashire | 2726 | 67.6% | 2746 | 11.5% |

West Lancashire shows higher negative rating for Southport, Southport 67.6 percent, Ormskirk 11.5 percent. Other shows higher negative rating for Southport, Southport 56.1 percent, Ormskirk 15.0 percent. No Postcode Available shows higher negative rating for Southport, Southport 53.5 percent,

Ormskirk 24.5 percent. This indicates an option related access risk for this group, and mitigations should be treated as requirements rather than nice to have.

### Decision relevance and due regard summary for parking and arrival

- Evidence shows parking and arrival is a secondary but material access mechanism, with higher negative ratings for the option further away in each place.
- Groups most at risk include disabled people, people with mobility impairments, older people, unpaid carers, and families attending with dependants.
- Minimum commitments include accessible parking close to entrances, safe drop off arrangements, and support for people who cannot manage long walks from parking.
- Monitoring must include arrival experience, blue badge accessibility, and complaints, with escalation where barriers create avoidable harm or exclusion.

## 7.3 Access to buildings and services by area percent negative

| area | Southport base | Southport percent negative | Ormskirk base | Ormskirk percent negative |
|---|---|---|---|---|
| No Postcode Available | 98 | 37.8% | 98 | 14.3% |
| Other | 198 | 43.4% | 201 | 8.5% |
| Sefton | 1889 | 10.9% | 1847 | 30.2% |
| West Lancashire | 2727 | 54.7% | 2739 | 4.3% |

West Lancashire shows higher negative rating for Southport, Southport 54.7 percent, Ormskirk 4.3 percent. Other shows higher negative rating for Southport, Southport 43.4 percent, Ormskirk 8.5 percent. No Postcode Available shows higher negative rating for Southport, Southport 37.8 percent, Ormskirk 14.3 percent. This indicates an option related access risk for this group, and mitigations should be treated as requirements rather than nice to have.

### Decision relevance and due regard summary for access to buildings and services

- Evidence shows access to buildings and services follows the same place based pattern as travel and parking, indicating risk of practical access barriers for those further away.
- Groups most at risk include people needing step free access, people with sensory or cognitive impairments, and people requiring reasonable adjustments and clear wayfinding.
- Minimum commitments include accessible routes, signage, staff support for navigation, and an effective reasonable adjustment process aligned to Accessible Information Standard requirements.
- Monitoring must include reasonable adjustment requests and fulfilment, plus patient experience by protected groups and locality.

## 7.4 Waiting areas by area percent negative

| area | Southport base | Southport percent negative | Ormskirk base | Ormskirk percent negative |
|---|---|---|---|---|
| No Postcode Available | 104 | 44.2% | 103 | 13.6% |
| Other | 196 | 46.9% | 200 | 6% |
| Sefton | 1893 | 22.2% | 1850 | 29.9% |
| West Lancashire | 2730 | 66.9% | 2738 | 5.7% |

**Decision relevance and due regard summary for waiting environment**

- Evidence shows waiting environment is an equality mechanism not a comfort issue, particularly for neurodivergent people, people with mental health needs, frailty, and families.
- Groups most at risk include autistic people, people with learning disability, people with anxiety, PTSD or dementia, and people who need quieter space or support.
- Minimum commitments include quieter spaces, clear information, appropriate seating and toilets, and staff training to recognise and respond to distress and reasonable adjustment needs.
- Monitoring must include incidents, complaints, and feedback linked to waiting environment, with escalation if there is a sustained increase or evidence of avoidable harm.

## 7.5 Cross cutting inequality mechanisms and decision implications

*Travel time, distance, and cost are the main mechanisms driving unequal impacts, with a clear place based trade off between Sefton and West Lancashire depending on the option*

## 7.6 Parking and drop off, additional burden

- Disability, older age, pregnancy and caring responsibilities increase likelihood of relying on others and needing reasonable adjustments
- The decision should be supported by a transport and access mitigation plan, accessible information, reasonable adjustment routes, and monitoring by place and protected characteristic

## 8 Evidence summary for other protected characteristics and inclusion groups

Closed question analysis is shown within Sefton and within West Lancashire because place is the main driver of impact and can confound patterns if results are pooled.

Percent negative includes responses of poorly and not well at all. Bases are the number of respondents in the subgroup who provided a rating for Southport for that domain. Small bases should be interpreted with caution.

## 8.1 Travel

*Travel shows the strongest trade off. In Sefton, negative ratings are consistently higher for Ormskirk across all groups, for example age 61 and over is 79.5 percent for Ormskirk compared with 8.2 percent for Southport. In West Lancashire, negative ratings are consistently higher for Southport across all groups, for example age under 45 is 90.2 percent for Southport compared with 2.5 percent for Ormskirk. This supports a requirement for a transport mitigation plan under either option, including support at evenings and weekends.*

### Decision relevance and due regard summary

Travel is the dominant equality and health inequalities mechanism in the consultation and shows the strongest place based trade off between Sefton and West Lancashire. The decision therefore creates a predictable access risk for different communities depending on the chosen site, with amplified impacts for older people, disabled people, unpaid carers and pregnant people. To demonstrate due regard, the programme needs a transport and access mitigation plan, clear reasonable adjustment routes, accessible information, and a monitoring dashboard that can detect and respond to unequal impacts quickly.

### What the evidence shows

- Place based trade off in travel negativity
- Sefton, travel negative is 11.8 percent for Southport and 74.0 percent for Ormskirk
- West Lancashire, travel negative is 85.8 percent for Southport and 3.8 percent for Ormskirk

Clear amplification for age, caring responsibility and disability within place

- Sefton, age 61 and over travel negative is 8.2 percent for Southport and 79.5 percent for Ormskirk
- West Lancashire, age under 45 travel negative is 90.2 percent for Southport and 2.5 percent for Ormskirk
- Sefton, unpaid carers travel negative is 9.1 percent for Southport and 77.7 percent for Ormskirk
- Disabled people show strong option related differences and the appendix notes disability increases reliance on adjustments and accessible transport

- Qualitative responses repeatedly link travel to affordability, reliance on others, and complexity of public transport, with travel and distance the most common theme within impairment based open text analyses

## Who is most at risk of disadvantage

- Disabled people, including people with mobility, sensory, cognitive or mental health related impairments, because longer travel and complex journeys increase reliance on others and increase the need for predictable adjustments
- Older people and people with frailty, where longer journeys, uncertainty, and poor transport connectivity increase access barriers
- Unpaid carers and families attending with dependants, where longer travel increases practical burden and cost and may affect ability to attend and support discharge
- Pregnant people and families with very young children, where travel concerns link to time critical access and perceived safety
- People experiencing deprivation, low car access, and constrained finances, where affordability and travel practicality can affect timely presentation

## What must be monitored and escalation triggers

Monitor monthly with quarterly deep dives, reported by locality and deprivation, and where possible triangulated with disability and other equality indicators, using an equity dashboard.

## Core monitoring measures

- Emergency attendances and admissions by postcode and deprivation quintile, and by locality
- Arrival mode, ambulance and walk in, by locality and time of day
- Did not wait and left without being seen by locality, plus breach reasons where available
- Complaints, PALS and patient feedback themes tagged to travel burden, affordability, access barriers and reasonable adjustment issues
- Incidents or safety reports linked to access, communication and wayfinding

## Escalation triggers

- Sustained increase in did not wait or left without being seen in particular localities compared with baseline, or widening gaps by deprivation and place
- Recurrent complaints themes about inability to reach the site, unaffordable travel, lack of evening or weekend options, or unsafe travel at night
- Evidence that reasonable adjustments for access and travel are not being delivered consistently, or repeat contacts indicate unmet need

## Parking and drop off

## Decision relevance and due regard summary

Parking and drop off compound travel burden and are a material access mechanism, particularly for people who cannot use public transport, require accessible bays, or attend with dependants. Parking shows the same place based trade off as travel, meaning the decision creates predictable arrival and cost pressures depending on where people live. The programme should treat accessible arrival and parking arrangements as part of the minimum access offer, supported by monitoring and escalation routes.

## What the evidence shows

- Place based trade off in parking negativity
  - Sefton, parking negative is 24.3 percent for Southport and 45.3 percent for Ormskirk
  - West Lancashire, parking negative is 67.6 percent for Southport and 11.5 percent for Ormskirk
- Parking concerns are amplified for carers and disabled people
  - Sefton, unpaid carers parking negative is 21.3 percent for Southport and 48.8 percent for Ormskirk
  - Disabled people show a material negative difference for parking, Southport 48.3 percent negative and Ormskirk 25.4 percent negative
- Pregnancy and maternity respondents report high parking negatives under the Southport option within the priority group summary tables
- Open text includes repeated references to limited parking, accessible arrival, safe drop off, and the need for accessible bays and clear routes from arrival points

## Who is most at risk of disadvantage

- Disabled people, including those who require Blue Badge bays, close drop off, step free routes, supported transfers, and predictable arrival support
- Older people and people with frailty or fluctuating conditions, where longer walks from parking and poor arrival routes increase fatigue and safety risk
- Unpaid carers and parents attending with children or dependants, where safe drop off and proximity materially affects ability to access care
- Pregnant people and families with very young children, where arrival convenience and safety are linked to time critical access concerns
- People on low incomes, where parking charges and reliance on taxis can create a real access barrier

## What must be monitored and escalation triggers

Monitor monthly with quarterly deep dives, with a specific thematic lens on arrival, parking, drop off safety, and reasonable adjustments delivery.

## Core monitoring measures

- Complaints, PALS and patient feedback themes linked to parking availability, cost, drop off safety, distance to entrances, lighting, wayfinding and accessible bays
- Incidents or safety reports linked to arrival routes, falls, near misses, or unsafe crossing and lighting issues
- Reasonable adjustment requests linked to arrival and parking, and evidence of delivery, including supported transfers and mobility assistance where recorded

#### Escalation triggers

- Sustained rise in parking and arrival related complaints, particularly where people report missed care due to inability to park, unaffordable charges, or unsafe drop off routes
- Any pattern of safety incidents linked to arrival, including repeated themes on lighting, crossings, distance, or lack of accessible bays
- Evidence that arrival related reasonable adjustments are not being delivered consistently, or repeated feedback indicates barriers are persisting

## 8.2 Access

> *Access to buildings and services also shows a clear trade off. In Sefton, Ormskirk is rated more negatively than Southport for access for most groups. In West Lancashire, Southport is rated more negatively than Ormskirk. This underlines the need for post decision accessibility audits, co design with disabled people and carers, and clear wayfinding and arrival support.*

### 8.2.1 Decision relevance and due regard summary

#### What the evidence shows

- Access ratings show a place based trade off, with different localities reporting higher negative ratings depending on the option.
- Qualitative responses highlight barriers linked to navigation, signage, drop off, accessible routes, and confidence in arriving safely.
- These mechanisms interact with disability, age, caring responsibilities and anxiety, and therefore require assured mitigations.

#### Who is most at risk of disadvantage

- Disabled people and people with mobility, sensory, cognitive or mental health needs, including neurodivergent people.

- Older people, pregnant people, carers and people who need support to navigate unfamiliar environments.
- People who require accessible information, interpreting or staff support to arrive and move through the site.

### What must be in place during implementation phase

- Accessibility audits and co design, including patient groups, disabled people and carers, with actions tracked to completion.
- Wayfinding, signage, drop off and support arrangements, including a clear arrival plan for those who need assistance.
- Accessible information and reasonable adjustment processes that are embedded into routine pathways and staff briefing.

### What must be monitored and escalation triggers

- Complaints and incidents related to navigation, access routes, falls risk, and missed adjustments, reviewed monthly.
- Feedback from PLACE and patient participation routes, plus equality informed walkarounds during implementation phase.
- Escalate if repeated themes indicate barriers to access or unequal experience for disabled people, older people or carers.

## 8.3 Waiting areas

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*Waiting areas show smaller differences in Sefton, but still show higher negative ratings for Ormskirk than Southport. In West Lancashire, Southport is rated much more negatively than Ormskirk for waiting areas. Qualitative evidence highlights a need for quiet space, seating, accessible toilets, sensory considerations, and separation of adult and child waiting where feasible.*

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### Decision relevance and due regard summary

Waiting environment is a material equality mechanism, not a comfort issue. Where waiting areas are crowded, noisy, lack seating, have limited toilets, or do not offer quiet space, this can create predictable disadvantage for disabled people, neurodivergent people, people with mental health needs, frail older people, and families with children. The evidence shows a place based pattern in negative ratings for waiting areas, so the decision should be supported by minimum waiting environment standards and a monitoring approach that can identify and respond to unequal experience and safety risks early.

### What the evidence shows

- Waiting areas show a place based trade off. In Sefton, waiting areas are rated 22.2 percent negative for Southport and 29.9 percent negative for Ormskirk.
- In West Lancashire, waiting areas are rated 66.9 percent negative for Southport and 5.7 percent negative for Ormskirk.
- Other areas show higher negative rating for Southport, with 46.9 percent negative for Southport and 6.0 percent negative for Ormskirk.
- For people with no postcode available, waiting areas are rated 44.2 percent negative for Southport and 13.6 percent negative for Ormskirk.
- Disabled people show higher negative rating for waiting areas for the Southport option within the priority group summary, with 49.1 percent negative for Southport and 17.5 percent negative for Ormskirk.
- Open responses highlight dignity, seating, toilets, noise and crowding, and the need for quiet low stimulus spaces and clear information while waiting.

### Who is most at risk of disadvantage

- Disabled people, including people with mobility impairment, fatigue, sensory impairment, learning disability, autism, or cognitive impairment, where crowded and unpredictable environments can cause distress or pain and can reduce ability to communicate needs.
- People with mental health needs, anxiety, dementia or neurocognitive conditions, where noise, crowding and long waits can escalate distress and increase risk of leaving before being seen.
- Frail older people and people with long term conditions, where lack of seating, toilets and support increases discomfort, falls risk and poor experience.
- Pregnant people, postnatal families and families with young children, where waiting environment links to dignity, safeguarding and perceived safety.
- Unpaid carers and people attending with dependants, where poor waiting environment increases practical burden during long waits.

### What must be monitored and escalation triggers

Core monitoring measures

- Patient feedback, complaints and PALS themes linked to waiting, crowding, dignity, privacy, toilets, seating, sensory needs, and child and family suitability.
- Incidents and safety reports linked to waiting areas, including distress escalation, aggression, safeguarding concerns, falls, near misses, and security involvement.
- Did not wait and left without being seen, monitored by locality and time of day, with thematic review of stated reasons where available.
- Requests for waiting related reasonable adjustments, including need for quiet space, communication support, and assistance, with evidence of delivery where recording allows.

- Environment assurance through walk rounds and PLACE style checks for seating availability, accessible toilets, signage, quiet space operation and wayfinding.

Escalation triggers

- Sustained increase in complaints or feedback describing crowding, lack of seating, lack of toilets, inability to access quiet space, poor dignity or unsafe waiting conditions.
- Recurring pattern of incidents linked to distress escalation, aggression, safeguarding, falls, or near misses associated with waiting areas.
- Sustained rise in did not wait or leaving before being seen where feedback links this to the waiting environment.
- Evidence that waiting related reasonable adjustments are not being delivered consistently, or repeated feedback indicates barriers are persisting.

| Characteristic | Sefton base | Sefton Southport negative % | Sefton Ormskirk negative % | West Lancashire base | West Lancashire Southport negative % | West Lancashire Ormskirk negative % |
|---|---|---|---|---|---|---|
| Age Under 45 | 381 | 26.5 | 24.4 | 1061 | 70.2 | 4.4 |
| Age 46-60 | 424 | 25.2 | 34.7 | 653 | 70.0 | 6.7 |
| Age 61 and over | 1043 | 19.4 | 29.5 | 963 | 60.5 | 5.8 |
| Sex Female | 1273 | 22.6 | 28.6 | 2013 | 67.7 | 5.4 |
| Sex Male | 562 | 20.3 | 32.4 | 623 | 63.6 | 5.9 |
| Ethnicity White British | 1732 | 21.5 | 29.9 | 2511 | 67.0 | 5.6 |
| Ethnicity Other ethnicities | 123 | 24.4 | 27.7 | 152 | 63.2 | 5.2 |
| Unpaid carer | 727 | 22.1 | 33.6 | 981 | 68.2 | 5.5 |
| Not an unpaid carer | 1133 | 21.7 | 27.6 | 1711 | 66.2 | 5.8 |
| **Characteristic** | **Sefton base** | **Sefton Southport negative %** | **Sefton Ormskirk negative %** | **West Lancashire base** | **West Lancashire Southport negative %** | **West Lancashire Ormskirk negative %** |
| Age Under 45 | 382 | 20.7 | 26.5 | 1060 | 60.9 | 3.5 |
| Age 46-60 | 422 | 10.7 | 31.6 | 654 | 54.6 | 4.9 |
| Age 61 and over | 1041 | 7.7 | 30.6 | 960 | 48.0 | 4.2 |
| Sex Female | 1270 | 12.3 | 29.5 | 2015 | 55.9 | 3.8 |
| Sex Male | 562 | 6.6 | 32.2 | 618 | 50.0 | 5.0 |
| Ethnicity White British | 1730 | 10.8 | 30.5 | 2507 | 54.4 | 4.0 |

| Characteristic | Sefton base | Sefton Southport negative % | Sefton Ormskirk negative % | West Lancashire base | West Lancashire Southport negative % | West Lancashire Ormskirk negative % |
|---|---|---|---|---|---|---|
| Ethnicity Other ethnicities | 123 | 10.6 | 24.4 | 152 | 56.6 | 5.9 |
| Unpaid carer | 725 | 9.5 | 31.7 | 975 | 57.7 | 4.4 |
| Not an unpaid carer | 1132 | 11.6 | 29.3 | 1715 | 53.0 | 4.2 |
| Characteristic | Sefton base | Sefton Southport negative % | Sefton Ormskirk negative % | West Lancashire base | West Lancashire Southport negative % | West Lancashire Ormskirk negative % |
| Age Under 45 | 382 | 34.0 | 36.0 | 1062 | 68.0 | 7.8 |
| Age 46-60 | 424 | 22.9 | 47.6 | 655 | 68.9 | 13.6 |
| Age 61 and over | 1033 | 21.1 | 47.7 | 956 | 66.2 | 13.4 |
| Sex Female | 1266 | 25.6 | 45.8 | 2014 | 68.0 | 10.7 |
| Sex Male | 560 | 20.2 | 44.6 | 618 | 66.7 | 12.9 |
| Ethnicity White British | 1724 | 24.1 | 45.3 | 2507 | 68.1 | 11.4 |
| Ethnicity Other ethnicities | 123 | 22.8 | 42.9 | 150 | 60.0 | 9.7 |
| Unpaid carer | 723 | 21.3 | 48.8 | 978 | 69.8 | 12.4 |
| Not an unpaid carer | 1129 | 25.9 | 43.2 | 1711 | 66.3 | 10.8 |
| Characteristic | Sefton base | Sefton Southport negative % | Sefton Ormskirk negative % | West Lancashire base | West Lancashire Southport negative % | West Lancashire Ormskirk negative % |
| Age Under 45 | 382 | 21.2 | 58.8 | 1059 | 90.2 | 2.5 |
| Age 46-60 | 422 | 11.4 | 73.6 | 654 | 83.8 | 4.5 |
| Age 61 and over | 1044 | 8.2 | 79.5 | 960 | 82.0 | 4.5 |
| Sex Female | 1273 | 13.2 | 72.0 | 2011 | 85.9 | 3.5 |
| Sex Male | 562 | 7.7 | 79.6 | 621 | 84.7 | 4.0 |
| Ethnicity White British | 1733 | 11.9 | 74.1 | 2508 | 86.0 | 3.6 |
| Ethnicity Other ethnicities | 122 | 8.2 | 75.4 | 150 | 82.0 | 6.5 |
| Unpaid carer | 727 | 9.1 | 77.7 | 978 | 87.1 | 3.4 |
| Not an unpaid carer | 1132 | 13.4 | 72.1 | 1707 | 85.0 | 4.0 |

## 9 Priority group analysis with confidence grading

### Disabled people

### 9.0.1 Summary table

| Theme | Southport base | Southport percent negative | Ormskirk base | Ormskirk percent negative | Confidence | Interpretation |
|---|---|---|---|---|---|---|
| Travel | 700 | 54.1% | 693 | 35.4% | High | Material difference |
| Parking | 695 | 48.3% | 693 | 25.4% | High | Material difference |
| Access to buildings and services | 699 | 39.5% | 698 | 17.5% | High | Material difference |
| Waiting areas | 701 | 49.1% | 698 | 17.5% | High | Material difference |

*Waiting areas shows higher negative rating for Southport, Southport 49.1 percent, Ormskirk 17.5 percent. Parking shows higher negative rating for Southport, Southport 48.3 percent, Ormskirk 25.4 percent. Access to buildings and services shows higher negative rating for Southport, Southport 39.5 percent, Ormskirk 17.5 percent. This indicates an option related access risk for this group, and mitigations should be treated as requirements rather than nice to have.*

Interpret these results alongside the place based analysis, because geography is the dominant driver of ratings. The consistent finding is that disability amplifies travel, arrival and environment burdens under whichever option increases journey time and complexity for the respondent’s locality.

# 10 SCT disability and impairment analysis

### 10.0.1 How to interpret these tables

- Impairment groups are not mutually exclusive. Respondents could select more than one impairment type, so groups overlap.
- Preference compares Southport and Ormskirk ratings within the same respondent for each domain, using the response scale coded to a numeric score.
- Percent negative shows the proportion rating each option as poorly or not well at all, by impairment group.
- Small numbers are suppressed where the base is below 30. Where suppression applies, results are indicative only.
- Results reflect consultation responses and are not a representative sample of the population.

## 10.1 Core mitigations and monitoring for all impairment groups

These actions apply across all impairment groups and are not repeated under each impairment type.

## 10.2 Evidence gaps and how they will be addressed

The consultation provides robust insight into key equality mechanisms, however there are known evidence gaps, particularly around socioeconomic status and some protected characteristics with low response bases. These gaps do not mean there is no impact. They mean the programme must take additional steps to meet due regard.

**Pre implementation actions to strengthen insight**

- Ensure Participation group plans and supports inclusive design
- Targeted engagement in localities with lower awareness or lower participation, using trusted community routes and accessible formats.
- Focused sessions with groups likely to face compounded barriers, for example disabled people on low incomes, carers and racialised communities without access to a car, older people using public transport, and minority ethnic communities with language needs.
- Testing of travel and information materials with people who have communication needs and sensory needs, including those who require reasonable adjustments.

**Post implementation operational datasets to compensate**

- Activity and performance, attendances by postcode and deprivation, did not wait, ambulance conveyance, and appropriate proxies for delayed presentation.
- Patient experience and safety, complaints themes, PALs contacts, incidents and near misses linked to access, communication, safety and waiting environment.
- Accessible information and reasonable adjustments, volume and type of adjustments requested, time to deliver, repeat contacts linked to unmet need.

- Workforce and process, compliance with accessible information processes and staff training completion.

**Intersectional monitoring using available proxies**

- Postcode mapped to deprivation combined with age bands and disability or reasonable adjustment indicators where available.
- Caring responsibility indicators combined with travel burden proxies and negative experience measures.
- Locality combined with protected characteristic signals from the consultation to prioritise monitoring and mitigation in the highest risk places.

**Escalation triggers**

- Sustained increase in access related complaints, transport issues, or safety concerns.
- Rise in did not wait or other access proxies among defined cohorts or localities compared with baseline.
- Evidence that reasonable adjustments and accessible information needs are not being delivered consistently.

## 10.3 Mitigation certainty

To ensure internal consistency across programme materials and avoid overstatement, mitigations in this appendix are described using three levels of certainty.

- Committed. Use only where the programme has confirmed delivery responsibility.
- Planned subject to final design and assurance. Assured through the Travel Advisory Group or the relevant delivery group prior to implementation including Public participation Group (further targeted engagement and inclusive design).
- Under consideration. Use where consultees suggested a mitigation but it is not committed..

Where a mitigation is essential to meet due regard, this is stated as a minimum requirement, alongside the governance route and the monitoring triggers that will confirm effectiveness.

### 10.3.1 Core mitigations

- Publish a clear route to request reasonable adjustments for urgent and planned attendance, including support with travel, arrival, parking and waiting
- Comply with the Accessible Information Standard for all consultation and during implement inclusive communications, including Easy Read, British Sign Language and interpreter access, and clear journey planning information

- Deliver a transport and access mitigation plan, include shuttle bus options between sites and key transport nodes, include evening and weekend coverage, and provide clear information on patient transport and taxi support
- Design safe arrival arrangements, include an enhanced drop off zone, accessible bays close to entrances, safe pedestrian routes and lighting, and clear concessions and payment processes
- Ensure waiting environments include seating, quiet space, accessible toilets, sensory considerations, and staff awareness of adjustments, and separate adult and child waiting areas where feasible
- Complete post decision accessibility audits and co design estates changes with disabled people, carers and other inclusion groups, including wheelchair users and people with sensory impairments
- Provide staff training on reasonable adjustments, cultural competence and inclusive communication, and ensure visible zero tolerance routes for discrimination and harassment
- Publish clear ambulance travel time assumptions and update them during implementation, using plain English and accessible formats

### 10.3.2 Core monitoring measures

- Reasonable adjustment requests by impairment type where recorded, and evidence of delivery
- Complaints and patient feedback themes tagged to access, communication, waiting environment and travel burden
- Incidents or safety reports related to communication and wayfinding
- Equity dashboard that combines place and disability where available

## 10.4 Longstanding illness or condition

Participation, number selecting Yes 976

### 10.4.1 Top areas within this impairment group

| Area | Count |
|---|---|
| West Lancashire | 495 |
| Sefton | 447 |
| Other | 23 |
| No Postcode Available | 11 |

Responses in this subgroup were concentrated in West Lancashire 495, and Sefton 447 where shown.

### 10.4.2 Preferences and option specific negative responses for each domain

| Domain | Preference base | Ormskirk rated higher percent | Southport rated higher percent | Rated equally percent | Southport base | Southport percent negative | Ormskirk base | Ormskirk percent negative |
|---|---|---|---|---|---|---|---|---|
| Overall rating | 886 | 45.9% | 41.1% | 13% | 949 | 43.8% | 950 | 32.4% |
| Travel | 918 | 51.2% | 39.8% | 9% | 958 | 49.3% | 955 | 37.6% |
| Parking | 869 | 41.4% | 26.7% | 31.9% | 958 | 45.8% | 953 | 29.2% |

| Domain | Preference base | Ormskirk rated higher percent | Southport rated higher percent | Rated equally percent | Southport base | Southport percent negative | Ormskirk base | Ormskirk percent negative |
|---|---|---|---|---|---|---|---|---|
| Access to buildings and services | 859 | 43.7% | 28.1% | 28.3% | 959 | 33.2% | 955 | 17.2% |
| Waiting areas | 807 | 48.1% | 23.8% | 28.1% | 962 | 45.8% | 957 | 17.7% |

### 10.4.3 Analysis narrative

- For Overall rating, Southport has higher negative responses by 11.4 percentage points within this impairment group
- For Travel, Southport has higher negative responses by 11.7 percentage points within this impairment group
- For Parking, Southport has higher negative responses by 16.6 percentage points within this impairment group
- For Access to buildings and services, Southport has higher negative responses by 16.0 percentage points within this impairment group
- For Waiting areas, Southport has higher negative responses by 28.1 percentage points within this impairment group

### 10.4.4 Equality mechanism for this impairment type

- People with longstanding conditions may have fluctuating symptoms, fatigue, pain, and higher reliance on consistent access and predictable journeys
- Longer travel time and complex parking can increase non attendance risk and may delay presentation for time sensitive conditions

### 10.4.5 Recommendations and mitigations

- Core mitigations apply, see Core mitigations and monitoring for all impairment groups
- Consider rest points and step free routes, and make it easy to request support to reduce the impact of fatigue, pain or fluctuating symptoms

### 10.4.6 Monitoring measures

- Core monitoring measures apply, see Core mitigations and monitoring for all impairment groups
- Monitor patient feedback for themes on fatigue, waiting environment and travel burden

## 10.5 Mental health condition

Participation, number selecting Yes 342

### 10.5.1 Top areas within this impairment group

| Area | Count |
|---|---|
| West Lancashire | 209 |
| Sefton | 115 |
| Other | 15 |
| No Postcode Available | 3 |

Responses in this subgroup were concentrated in West Lancashire 209, and Sefton 115 where shown.

### 10.5.2 Preferences and option specific negative responses for each domain

| Domain | Preference base | Ormskirk rated higher percent | Southport rated higher percent | Rated equally percent | Southport base | Southport percent negative | Ormskirk base |
|---|---|---|---|---|---|---|---|
| Overall rating | 317 | 62.1% | 24.6% | 13.2% | 336 | 56.5% | 337 |
| Travel | 323 | 65.3% | 26.9% | 7.7% | 338 | 61.8% | 334 |
| Parking | 292 | 55.5% | 15.1% | 29.5% | 339 | 51.9% | 335 |
| Access to buildings and services | 296 | 59.1% | 18.6% | 22.3% | 339 | 43.4% | 336 |
| Waiting areas | 286 | 64% | 13.3% | 22.7% | 339 | 55.5% | 336 |

### 10.5.3 Analysis narrative

- For Overall rating, Southport has higher negative responses by 36.3 percentage points within this impairment group
- For Travel, Southport has higher negative responses by 36.1 percentage points within this impairment group
- For Parking, Southport has higher negative responses by 33.7 percentage points within this impairment group
- For Access to buildings and services, Southport has higher negative responses by 31.8 percentage points within this impairment group
- For Waiting areas, Southport has higher negative responses by 43.0 percentage points within this impairment group

### 10.5.4 Equality mechanism for this impairment type

- People with mental health conditions may experience heightened distress in crowded waiting environments and during longer journeys
- Uncertainty, sensory overload, and perceived safety can affect willingness to attend and experience of care

### 10.5.5 Recommendations and mitigations

- Core mitigations apply, see Core mitigations and monitoring for all impairment groups
- Consider quiet space, clear reassurance, and trauma informed communication, to reduce distress and avoid escalation during waiting and assessment
- Provide quiet space and trauma informed approaches, and clear information on what to expect and how long the wait is likely to be

### 10.5.6 Monitoring measures

- Core monitoring measures apply, see Core mitigations and monitoring for all impairment groups
- Monitor patient feedback for themes on waiting environment, distress, and staff communication

## 10.6 Physical impairment or mobility issues

Participation, number selecting Yes 470

### 10.6.1 Top areas within this impairment group

| Area | Count |
|---|---|
| West Lancashire | 247 |
| Sefton | 205 |
| Other | 11 |
| No Postcode Available | 7 |

Responses in this subgroup were concentrated in West Lancashire 247, and Sefton 205 where shown.

### 10.6.2 Preferences and option specific negative responses for each domain

| Domain | Preference base | Ormskirk rated higher percent | Southport rated higher percent | Rated equally percent | Southport base | Southport percent negative | Ormskirk base | Ormskirk percent negative |
|---|---|---|---|---|---|---|---|---|
| Overall rating | 427 | 49.2% | 37.7% | 13.1% | 457 | 45.7% | 456 | 29.8% |
| Travel | 444 | 53.6% | 36.9% | 9.5% | 462 | 51.7% | 456 | 36.8% |
| Parking | 421 | 45.6% | 23.8% | 30.6% | 458 | 46.9% | 457 | 27.8% |
| Access to buildings and services | 419 | 46.3% | 29.1% | 24.6% | 460 | 35.4% | 456 | 18.6% |
| Waiting areas | 406 | 46.3% | 23.9% | 29.8% | 461 | 45.6% | 459 | 18.3% |

### 10.6.3 Analysis narrative

- For Overall rating, Southport has higher negative responses by 15.9 percentage points within this impairment group
- For Travel, Southport has higher negative responses by 14.9 percentage points within this impairment group
- For Parking, Southport has higher negative responses by 19.1 percentage points within this impairment group
- For Access to buildings and services, Southport has higher negative responses by 16.8 percentage points within this impairment group
- For Waiting areas, Southport has higher negative responses by 27.3 percentage points within this impairment group

### 10.6.4 Equality mechanism for this impairment type

- Mobility impairments increase reliance on accessible transport, close parking, step free routes, and assistance on arrival
- Longer travel and poor drop off arrangements increase barriers and can reduce independence

### 10.6.5 Recommendations and mitigations

- Core mitigations apply, see Core mitigations and monitoring for all impairment groups

- Ensure step free routes from arrival points, wheelchair availability, and practical assistance for transfers, with drop off and blue badge capacity tested at peak times
- Provide step free routes, wheelchair availability, and accessible bays near entrances, plus assistance for transfers if needed

### 10.6.6 Monitoring measures

- Core monitoring measures apply, see Core mitigations and monitoring for all impairment groups
- Monitor patient feedback for themes on drop off, transfers, mobility support and accessible toilets

## 10.7 Social or communication impairment

Participation, number selecting Yes 129

### 10.7.1 Top areas within this impairment group

| Area | Count |
|---|---|
| West Lancashire | 83 |
| Sefton | 40 |
| No Postcode Available | 3 |
| Other | 3 |

Responses in this subgroup were concentrated in West Lancashire 83, and Sefton 40 where shown. This matters because the travel and access impacts differ sharply between Sefton and West Lancashire, so subgroup findings should be interpreted in that context.

### 10.7.2 Preferences and option specific negative responses for each domain

| Domain | Preference base | Ormskirk rated higher percent | Southport rated higher percent | Rated equally percent | Southport base | Southport percent negative | Ormskirk base | Ormskirk percent negative |
|---|---|---|---|---|---|---|---|---|
| Overall rating | 123 | 63.4% | 24.4% | 12.2% | 127 | 62.2% | 129 | 24% |
| Travel | 122 | 68% | 24.6% | 7.4% | 125 | 66.4% | 126 | 24.6% |
| Parking | 113 | 59.3% | 17.7% | 23% | 127 | 54.3% | 126 | 20.6% |
| Access to buildings and services | 115 | 58.3% | 17.4% | 24.3% | 127 | 52% | 127 | 16.5% |
| Waiting areas | 110 | 63.6% | 14.5% | 21.8% | 127 | 57.5% | 126 | 16.7% |

### 10.7.3 Analysis narrative

- For Overall rating, Southport has higher negative responses by 38.2 percentage points within this impairment group
- For Travel, Southport has higher negative responses by 41.8 percentage points within this impairment group
- For Parking, Southport has higher negative responses by 33.7 percentage points within this impairment group
- For Access to buildings and services, Southport has higher negative responses by 35.5 percentage points within this impairment group
- For Waiting areas, Southport has higher negative responses by 40.8 percentage points within this impairment group

### 10.7.4 Equality mechanism for this impairment type

- Communication impairments can make complex journeys, wayfinding, and busy environments harder to navigate
- Clear information, predictable processes, and staff awareness are key to reducing barriers

### 10.7.5 Recommendations and mitigations

- Core mitigations apply, see Core mitigations and monitoring for all impairment groups
- Ensure staff have access to communication support tools, including supported conversations, easy read and interpretation options, and avoid reliance on phone only communication
- Use easy read journey planning and on site information, allow carer accompaniment, and train staff in communication support and reasonable adjustments

### 10.7.6 Monitoring measures

- Core monitoring measures apply, see Core mitigations and monitoring for all impairment groups
- Monitor use of interpretation and communication support, including any delays or unmet need, through patient feedback and incident reporting

## 10.8 Learning difficulty or cognitive disorder

Participation, number selecting Yes 171

### 10.8.1 Top areas within this impairment group

| Area | Count |
|---|---|
| West Lancashire | 95 |
| Sefton | 66 |
| Other | 8 |
| No Postcode Available | 2 |

Responses in this subgroup were concentrated in West Lancashire 95, and Sefton 66 where shown.

### 10.8.2 Preferences and option specific negative responses for each domain

| Domain | Preference base | Ormskirk rated higher percent | Southport rated higher percent | Rated equally percent | Southport base | Southport percent negative | Ormskirk base | Ormskirk percent negative |
|---|---|---|---|---|---|---|---|---|
| Overall rating | 164 | 57.3% | 27.4% | 15.2% | 170 | 55.9% | 170 | 22.9% |
| Travel | 163 | 60.7% | 29.4% | 9.8% | 170 | 61.2% | 169 | 29% |
| Parking | 157 | 52.9% | 20.4% | 26.8% | 171 | 53.8% | 170 | 25.9% |
| Access to buildings and services | 155 | 54.8% | 21.3% | 23.9% | 171 | 46.8% | 171 | 14.6% |
| Waiting areas | 152 | 58.6% | 12.5% | 28.9% | 171 | 57.3% | 170 | 17.1% |

### 10.8.3 Analysis narrative

- For Overall rating, Southport has higher negative responses by 33.0 percentage points within this impairment group
- For Travel, Southport has higher negative responses by 32.2 percentage points within this impairment group
- For Parking, Southport has higher negative responses by 27.9 percentage points within this impairment group
- For Access to buildings and services, Southport has higher negative responses by 32.2 percentage points within this impairment group
- For Waiting areas, Southport has higher negative responses by 40.2 percentage points within this impairment group

### 10.8.4 Equality mechanism for this impairment type

- Cognitive and learning impairments increase risk when information is complex, environments are overstimulating, or processes are inconsistent
- Carer involvement and clear reasonable adjustment routes reduce inequity

### 10.8.5 Recommendations and mitigations

- Core mitigations apply, see Core mitigations and monitoring for all impairment groups

- Provide easy read information and clear wayfinding, and enable carers to support communication and decision making where appropriate
- Use easy read journey planning and on site information, allow carer accompaniment, and train staff in communication support and reasonable adjustments

### 10.8.6 Monitoring measures

- Core monitoring measures apply, see Core mitigations and monitoring for all impairment groups
- Monitor complaints and patient feedback for themes on understanding, wayfinding and support with decision making

## 10.9 Blind or visual impairment

Participation, number selecting Yes 61

### 10.9.1 Top areas within this impairment group

| Area | Count |
|---|---|
| West Lancashire | 31 |
| Sefton | 28 |
| Other | 2 |

Responses in this subgroup were concentrated in West Lancashire 31, and Sefton 28 where shown..

### 10.9.2 Preferences and option specific negative responses for each domain

| Domain | Preference base | Ormskirk rated higher percent | Southport rated higher percent | Rated equally percent | Southport base | Southport percent negative | Ormskirk base | Ormskirk percent negative |
|---|---|---|---|---|---|---|---|---|
| Overall rating | 55 | 49.1% | 40% | 10.9% | 61 | 42.6% | 59 | 37.3% |
| Travel | 58 | 51.7% | 39.7% | 8.6% | 61 | 47.5% | 60 | 40% |
| Parking | 53 | 50.9% | 20.8% | 28.3% | 61 | 52.5% | 59 | 28.8% |
| Access to buildings and services | 57 | 47.4% | 28.1% | 24.6% | 61 | 32.8% | 60 | 18.3% |
| Waiting areas | 49 | 51% | 26.5% | 22.4% | 61 | 45.9% | 60 | 20% |

### 10.9.3 Analysis narrative

- No material option difference was identified across the core domains within this impairment group at higher confidence thresholds. Interpretation should still consider place based travel burden and individual circumstances.

### 10.9.4 Equality mechanism for this impairment type

- Visual impairments increase reliance on safe drop off, accessible wayfinding, clear signage, and staff support
- Poor lighting, complex layouts, and unclear communications increase safety risk and anxiety

### 10.9.5 Recommendations and mitigations

- Core mitigations apply, see Core mitigations and monitoring for all impairment groups
- Provide high contrast and tactile wayfinding, audible announcements where used, and meet and greet support from arrival points when needed
- Provide supported wayfinding, clear high contrast signage, and staff support from arrival to clinical area on request

### 10.9.6 Monitoring measures

- Core monitoring measures apply, see Core mitigations and monitoring for all impairment groups
- Monitor patient feedback for themes on signage, wayfinding and staff support from arrival points

## 10.10 Deaf or hearing impairment

Participation, number selecting Yes 209

### 10.10.1 Top areas within this impairment group

| Area | Count |
|---|---|
| Sefton | 105 |
| West Lancashire | 97 |
| Other | 6 |
| No Postcode Available | 1 |

Responses in this subgroup were concentrated in Sefton 105, and West Lancashire 97 where shown.

### 10.10.2 Preferences and option specific negative responses for each domain

| Domain | Preference base | Ormskirk rated higher percent | Southport rated higher percent | Rated equally percent | Southport base | Southport percent negative | Ormskirk base | Ormskirk percent negative |
|---|---|---|---|---|---|---|---|---|
| Overall rating | 192 | 42.2% | 41.7% | 16.1% | 205 | 41% | 200 | 30.5% |
| Travel | 199 | 44.7% | 44.2% | 11.1% | 204 | 46.6% | 203 | 44.3% |
| Parking | 188 | 42.6% | 26.6% | 30.9% | 202 | 48.5% | 199 | 35.2% |
| Access to buildings and services | 184 | 42.4% | 32.6% | 25% | 204 | 35.8% | 203 | 23.2% |
| Waiting areas | 174 | 42% | 27% | 31% | 204 | 46.1% | 204 | 25% |

### 10.10.3 Analysis narrative

- For Overall rating, Southport has higher negative responses by 10.5 percentage points within this impairment group
- For Parking, Southport has higher negative responses by 13.3 percentage points within this impairment group
- For Access to buildings and services, Southport has higher negative responses by 12.6 percentage points within this impairment group
- For Waiting areas, Southport has higher negative responses by 21.1 percentage points within this impairment group

### 10.10.4 Equality mechanism for this impairment type

- Hearing impairments increase reliance on accessible communication, hearing loops, visual calling systems, and staff practice
- Miscommunication can lead to safety risks, poor experience, and delays

### 10.10.5 Recommendations and mitigations

- Core mitigations apply, see Core mitigations and monitoring for all impairment groups
- Ensure clear access to interpretation, hearing loops where available, and visual calling systems or other accessible communication methods

- Provide hearing loop coverage and a reliable visual calling system, and ensure staff check communication needs on arrival

### 10.10.6 Monitoring measures

- Core monitoring measures apply, see Core mitigations and monitoring for all impairment groups
- Monitor access to interpretation and communication support, including any delays or failures to provide requested support

## 10.11 Other impairment or condition

Participation, number selecting Yes 263

### 10.11.1 Top areas within this impairment group

| Area | Count |
|---|---|
| West Lancashire | 140 |
| Sefton | 113 |
| Other | 7 |
| No Postcode Available | 3 |

Responses in this subgroup were concentrated in West Lancashire 140, and Sefton 113 where shown.

### 10.11.2 Preferences and option specific negative responses for each domain

| Domain | Preference base | Ormskirk rated higher percent | Southport rated higher percent | Rated equally percent | Southport base | Southport percent negative | Ormskirk base | Ormskirk percent negative |
|---|---|---|---|---|---|---|---|---|
| Overall rating | 240 | 50% | 38.8% | 11.2% | 258 | 43.4% | 256 | 31.2% |
| Travel | 255 | 54.1% | 40.4% | 5.5% | 259 | 49% | 259 | 36.3% |
| Parking | 238 | 44.5% | 28.6% | 26.9% | 259 | 44% | 257 | 29.2% |
| Access to buildings and services | 236 | 44.1% | 31.4% | 24.6% | 260 | 31.2% | 257 | 18.3% |
| Waiting areas | 231 | 49.8% | 22.9% | 27.3% | 259 | 45.2% | 257 | 16.7% |

### 10.11.3 Analysis narrative

- For Overall rating, Southport has higher negative responses by 12.2 percentage points within this impairment group
- For Travel, Southport has higher negative responses by 12.7 percentage points within this impairment group
- For Parking, Southport has higher negative responses by 14.8 percentage points within this impairment group
- For Access to buildings and services, Southport has higher negative responses by 12.9 percentage points within this impairment group
- For Waiting areas, Southport has higher negative responses by 28.5 percentage points within this impairment group

### 10.11.4 Equality mechanism for this impairment type

- Other impairments may include a wide range of needs. The reasonable adjustment route should be flexible and responsive
- Monitoring should capture what adjustments are requested and whether they are delivered consistently

### 10.11.5 Recommendations and mitigations

- Core mitigations apply, see Core mitigations and monitoring for all impairment groups
- Use individual reasonable adjustment plans where available and ensure consistent recording and review of adjustment needs

### 10.11.6 Monitoring measures

- Core monitoring measures apply, see Core mitigations and monitoring for all impairment groups
- Monitor patient feedback for emerging themes and ensure reasonable adjustment recording is reviewed

## 11 Open Questions

### Open questions cross cutting equality themes and signals by group updated January 2026

This subsection summarises cross cutting themes in all open text fields across the consultation survey. It is intended to support due regard by identifying the main inequality mechanisms and how they present for protected groups and disadvantaged groups. The disability and impairment detail that follows remains relevant, but the counts and themes below provide a whole population view.

### 11.0.1 Open text fields included and response volumes

- Q2 detail, responses 3405
- Q11 impacts explanation, responses 3009
- Q12 mitigation suggestions, responses 2718
- Q13 additional evidence, responses 1539
- Any open text across Q2, Q11, Q12, Q13, respondents 3832 out of 5009

Themes are coded using a transparent keyword approach, with a response able to contribute to more than one theme. Percentages are the share of open text respondents whose response included the theme. This approach is designed for transparency and consistency and should be interpreted as indicative signals rather than a definitive qualitative count.

### Cross cutting themes across open text responses

| Theme | Mentions | Percent of open text respondents |
|---|---|---|
| Travel time and distance | 2482 | 64.8% |
| Children and families | 1617 | 42.2% |
| Parking and drop off | 1192 | 31.1% |
| Waiting environment and dignity | 1246 | 32.5% |
| Workforce and staffing | 793 | 20.7% |
| Public transport | 1788 | 46.7% |
| Cost and affordability | 723 | 18.9% |
| Accessibility and reasonable adjustments | 454 | 11.8% |
| Emergency time critical risk | 429 | 11.2% |
| Older people and frailty | 307 | 8.0% |
| Pregnancy and maternity | 313 | 8.2% |
| Trust process and fairness | 336 | 8.8% |

Free text responses concentrated on practical access issues that drive unequal impact. The most common themes were travel time and distance at 64.8 percent, public transport at 46.7 percent, children and families at 42.2 percent, waiting environment and dignity at 32.5 percent, and parking and drop off at 31.1 percent. Other themes included capacity and quality, workforce and staffing, cost and affordability, and reasonable adjustments. This pattern reinforces that the main inequality mechanisms are access barriers, cost, and the ability to safely attend in an emergency.

### Key equality signals from open text by group

| Group | Key mechanism | Evidence from open text coding | Implication for mitigations |
|---|---|---|---|
| Age under 45 years | Higher emphasis on children, maternity and personal safety barriers | Children and families mentioned in 59.6% and pregnancy and maternity in 15.2%, personal safety and security in 14.5%, open text base 1178 | Mitigations should include family friendly arrival and waiting arrangements, and safer travel options including evening and weekend coverage. Provide clear public information and accessible communications that explain how obstetric emergencies are managed, including confirmation that obstetric emergencies continue to follow agreed pathways to the most appropriate MWL site |
| Age 61 years and over | Greater emphasis on cost, parking and frailty needs | Cost and affordability mentioned in 20.4%, parking and drop off in 31.4%, older people and frailty in 10.2%, open text base 1680 | Mitigations should include transport support, parking concessions, seating and toilet provision, and staff support for frail patients and companions |
| Sex female respondents | Caring roles, waiting environment and safety concerns more prominent | Children and families mentioned in 46.7% compared with 28.0% for male respondents. Waiting environment and dignity 34.6% and personal safety and security 11.1%, open text base female 2759 | Mitigations should strengthen family and carer support, improve waiting environment and dignity, and ensure safe arrival and departure arrangements |
| Pregnancy status yes | Maternity related emergency risks and dependence on child and family pathways.<br><br>**Please note**: Pregnancy and maternity are protected characteristics and people raised concerns about the relationship between children's services, neonatal services and maternity. The SCT consultation decision does not include maternity or neonatal | Pregnancy and maternity mentioned in 24.0% and children and families in 67.2%, capacity and quality 27.5%, open text base 229 | The programme will focus on clear public information and accessible communications that explain how obstetric emergencies are managed, including confirmation that obstetric emergencies continue to follow agreed pathways to the most appropriate MWL site |

| Group | Key mechanism | Evidence from open text coding | Implication for mitigations |
|---|---|---|---|
| | service reconfiguration, which sit within separate regional and national reviews. | | |
| Disabled under Equality Act | Higher emphasis on affordability, waiting experience and reasonable adjustments | Cost and affordability mentioned in 25.4% and waiting environment and dignity in 35.9%. Accessibility and reasonable adjustments 14.6%, open text base 582 | Mitigations should include a clear reasonable adjustment route, Accessible Information Standard compliance, support for non drivers, and options that reduce cost barriers such as transport help and concessions |
| Unpaid carers | Cost, parking, access adjustments and emergency time critical concerns | Cost and affordability mentioned in 21.6% and parking and drop off in 33.8%. Accessibility and reasonable adjustments 14.0%, emergency time critical risk 12.7%, open text base 1463 | Mitigations should include carer friendly information, parking and cost concessions, rest facilities, and practical support at arrival and discharge |
| Ethnicity other than White British | Low response base means limited signal, themes broadly similar but under representation is a risk | Open text base 215. Travel time and distance mentioned in 63.7% and public transport in 42.3%. Explicit references to language support were rare across all responses | Mitigations should include accessible information and interpreting routes, targeted follow up engagement with community networks, and monitoring of complaints and feedback for emerging inequity |
| Sexual orientation LGB plus | Higher emphasis on personal safety and dignity signals, though bases are smaller than heterosexual responses | Personal safety and security mentioned in 15.2% compared with 9.7% for heterosexual responses. Waiting environment and dignity 35.5%, open text base 138 | Mitigations should reinforce privacy and dignity in the waiting environment, inclusive communication, and zero tolerance approaches to harassment |
| Gender reassignment trans | Very low response base so no reliable theme comparison, due regard still applies | Open text base 9, too small for robust analysis. No explicit themes on trans specific access were detected in free text | Mitigations should include privacy and dignity, staff training and a clear route for reporting discrimination, and monitoring of patient feedback for any emerging issues |
| Religion other than Christian or no religion | Some emphasis on access adjustments and public transport, base is | Accessibility and reasonable adjustments mentioned in 16.3% and | Mitigations should include inclusive communication, support for faith needs where relevant such as |

| Group | Key mechanism | Evidence from open text coding | Implication for mitigations |
| --- | --- | --- | --- |
| | moderate but still smaller than main groups | public transport in 50.2%, open text base 251 | quiet space, and ongoing monitoring through patient feedback and community insight |

This table summarises which protected characteristics and inclusion groups most often raised key inequality mechanisms in their own words. Figures are based on keyword theme coding so they indicate prominence rather than importance and are interpreted alongside the quantitative closed question analysis.

Some protected groups have small response bases in equality monitoring and free text, particularly ethnic minority groups, trans respondents, and LGB plus respondents. Where bases are small, findings are indicative only. Due regard is still required and mitigations and monitoring should not rely on consultation volume alone.

Illustrative anonymised quotes from open text responses

## 11.1 Travel time and distance

- Public transport, would not be able to attend A and E in Southport as disabled and cannot use public transport nor do I have a car.I could not afford a taxi to get there but could get to Ormskirk in a taxi. not move A and E to Southport
- Parking and drop off, poor infrastructure improve bus service especially at night. No public transport from Formby to either hospitals and non of a night. Car parking is difficult and expensive.
- Waiting environment and dignity, Cost I currently cannot drive so Ormskirk for an emergency is a problem. Last October I was in A&E waiting standing up as there were no seats available after breaking my arm More waiting room areas
- Children and families, Southport is too far away and most of our population use public transport. Ormskirk always was the best option. Southport is too far away and not easy to access. Stay adults and children in Ormskirk.
- Accessibility and reasonable adjustments, I had to pay £50 in taxis as a disabled non driving parent with chronically ill children at least once a week for a while
- Pregnancy and maternity, We need a maternity unit in the area. If children department moved to Southport we would potentially lose maternity services. The potential of losing maternity services if the move to Southport happens.
- Trust process and fairness, I feel the decisions have already been made and this survey is a complete waste of time and effort. Leave things as they are!
- Personal safety and security, Moving the children’s A and E further afield from a densely populated area such as Skelmersdale is dangerous
- Ethnicity and workforce, Lots of hospital staff live in Southport and moved here from India to work at the hospital, some do not drive

- Older people and transport, Southport has a larger elderly population who find it hard to travel, not everyone has a car and transport links need to be improved

## 12 SCT consultation disability and impairment open text analysis

This report summarises what people with different impairment types said in the open ended questions.

Open text fields analysed

- Q11 impacts explanation Q11 Impact Explanation
- Q12 mitigation suggestions Q12 Mitigation Suggestions

Important notes

- Impairment types overlap. One person may appear in more than one impairment section
- Themes are derived using a transparent keyword approach. A response can contribute to more than one theme
- Quotes are anonymised and shortened where needed
- Where the number of open text responses in an impairment group is small, findings are indicative only

### 12.1 Cross cutting themes across all impairment types

Q11 impacts explanation responses analysed 1146

**Top themes in Q11 impacts explanation**

| Theme | Count mentioning | Percent of responses |
|---|---|---|
| Travel and distance | 616 | 53.8% |
| Waiting and crowding | 415 | 36.2% |
| Parking and drop off | 322 | 28.1% |
| Public transport reliability | 198 | 17.3% |
| Children and families | 193 | 16.8% |
| Ambulance and urgent transport | 179 | 15.6% |
| Workforce and capacity | 153 | 13.4% |
| Access and mobility | 133 | 11.6% |
| Cost and affordability | 127 | 11.1% |
| Safety and clinical risk | 98 | 8.6% |

The most common themes were Travel and distance 53.8 percent, Waiting and crowding 36.2 percent, Parking and drop off 28.1 percent. These themes describe where people anticipate disadvantage, mainly travel burden, affordability, and access barriers. Mitigations should focus on transport support, accessible information, reasonable adjustments, and monitoring by place and protected characteristic.

Q12 mitigation suggestions responses analysed 1048

### Top themes in Q12 mitigation suggestions

| Theme | Count mentioning | Percent of responses |
|---|---|---|
| Travel and distance | 234 | 22.3% |
| Waiting and crowding | 210 | 20% |
| Parking and drop off | 146 | 13.9% |
| Workforce and capacity | 135 | 12.9% |
| Children and families | 134 | 12.8% |
| Public transport reliability | 108 | 10.3% |
| Ambulance and urgent transport | 75 | 7.2% |
| Cost and affordability | 60 | 5.7% |
| Access and mobility | 59 | 5.6% |
| Communication and information | 41 | 3.9% |

The most common themes were Travel and distance 22.3 percent, Waiting and crowding 20.0 percent, Parking and drop off 13.9 percent. These themes describe where people anticipate disadvantage, mainly travel burden, affordability, and access barriers. Mitigations should focus on transport support, accessible information, reasonable adjustments, and monitoring by place and protected characteristic.

### Cross cutting narrative

- Across impairment types, the main issues relate to travel time and distance, parking and drop off, and the cost and complexity of getting to the site
- People often link longer journeys to fatigue, pain, anxiety, and reliance on carers, and describe risk of delayed presentation for urgent conditions
- Communication and information needs recur, including clear journey planning information and accessible formats
- Waiting environment themes include crowding, seating, toilets and quiet space, particularly relevant for sensory and anxiety related needs

## 12.2 Longstanding illness or condition

Open text bases Q11 615 and Q12 573

### Q11 impacts explanation top themes

| Theme | Count mentioning | Percent of responses |
|---|---|---|
| Travel and distance | 329 | 53.5% |
| Waiting and crowding | 221 | 35.9% |
| Parking and drop off | 172 | 28% |
| Public transport reliability | 107 | 17.4% |
| Ambulance and urgent transport | 98 | 15.9% |
| Children and families | 94 | 15.3% |
| Workforce and capacity | 76 | 12.4% |
| Cost and affordability | 67 | 10.9% |

The most common themes were Travel and distance 53.5 percent, Waiting and crowding 35.9 percent, Parking and drop off 28.0 percent. These themes describe where people anticipate disadvantage,

mainly travel burden, affordability, and access barriers. Mitigations should focus on transport support, accessible information, reasonable adjustments, and monitoring by place and protected characteristic.

### Q12 mitigation suggestions top themes

| Theme | Count mentioning | Percent of responses |
|---|---|---|
| Travel and distance | 127 | 22.2% |
| Waiting and crowding | 103 | 18% |
| Parking and drop off | 74 | 12.9% |
| Children and families | 66 | 11.5% |
| Workforce and capacity | 66 | 11.5% |
| Public transport reliability | 58 | 10.1% |
| Ambulance and urgent transport | 35 | 6.1% |
| Access and mobility | 32 | 5.6% |

The most common themes were Travel and distance 22.2 percent, Waiting and crowding 18.0 percent, Parking and drop off 12.9 percent. These themes describe where people anticipate disadvantage, mainly travel burden, affordability, and access barriers. Mitigations should focus on transport support, accessible information, reasonable adjustments, and monitoring by place and protected characteristic.

## 12.2.1 What people said in their own words, examples from Q11

### Theme Travel and distance

- A&E always busy sometimes cannot get in security do not. Remove the alcoholic / druggies so feels un safe . Parking not enough spaces so all need addressing
- The people of West Lancashire need full A& E services at Ormskirk rather than a 10 mile journey to Southport. This must be for both adults and children!@
- There is a need for greater space at both hospitals, both parking and clinics. If anything it is Ormskirk that is better although it is obviously less busy.

### Theme Waiting and crowding

- A&E always busy sometimes cannot get in security do not. Remove the alcoholic / druggies so feels un safe . Parking not enough spaces so all need addressing
- It's simple. Waiting areas should be commensurate with expected volume (the norm). This could be expanded, when required, if adjoining wards had Waiting areas that cold be "borrowed"
- There is a need for greater space at both hospitals, both parking and clinics. If anything it is Ormskirk that is better although it is obviously less busy.

### Theme Parking and drop off

- I can only comment on Southport A&E's facilities as I have no experience of Ormskirk A&E although I have experienced the difficulties in both getting there and parking

- A&E always busy sometimes cannot get in security do not. Remove the alcoholic / druggies so feels un safe . Parking not enough spaces so all need addressing
- There is a need for greater space at both hospitals, both parking and clinics. If anything it is Ormskirk that is better although it is obviously less busy.

### 12.2.2 What people suggested as mitigations, examples from Q12

#### Theme Travel and distance

- Ensure some bus routes pass the hospital access at Southport or pharmacies ie Bus service from Ormskirk. Better air circulation in waiting areas to reduce infection ie Norovirous.
- AE ormskirk can travel many ways, had both childrens and adult's AE prior and it was good. Enough demand fir both really to have children and adult's AE
- Visit Ormskirk hospital to see how A and E operate. A and E in Southport are so busy and I had a horrendous experience when I was there

#### Theme Waiting and crowding

- The waiting area and treatment areas will have to be enlarged if either hospital is to be the sole A&E. This will likely be more easily accomplished at Southport.
- More space, more comfortable chairs, better vending machines or free supply of water/ tea urns etc. More e efficient handover from ambulance staff to hospital registration. More space
- Aside from keeping the current set-up. Keeping children and adults separate to avoid anxiety for children. Child friendly waiting area. Calm staff and enough staff. Safe car parks.

### 12.2.3 Interpretation and recommendations

- Core interpretation and recommendations apply, see Core mitigations and monitoring for all impairment groups

## 12.3 Mental health condition

Open text bases Q11 206 and Q12 189

### Q11 impacts explanation top themes

| Theme | Count mentioning | Percent of responses |
|---|---|---|
| Travel and distance | 122 | 59.2% |
| Waiting and crowding | 82 | 39.8% |
| Parking and drop off | 57 | 27.7% |
| Children and families | 41 | 19.9% |
| Workforce and capacity | 35 | 17% |
| Public transport reliability | 33 | 16% |
| Ambulance and urgent transport | 31 | 15% |
| Cost and affordability | 29 | 14.1% |

The most common themes were Travel and distance 59.2 percent, Waiting and crowding 39.8 percent, Parking and drop off 27.7 percent. These themes describe where people anticipate disadvantage, mainly travel burden, affordability, and access barriers. Mitigations should focus on transport support, accessible information, reasonable adjustments, and monitoring by place and protected characteristic.

### Q12 mitigation suggestions top themes

| Theme | Count mentioning | Percent of responses |
|---|---|---|
| Waiting and crowding | 42 | 22.2% |
| Children and families | 33 | 17.5% |
| Travel and distance | 32 | 16.9% |
| Workforce and capacity | 28 | 14.8% |
| Parking and drop off | 26 | 13.8% |
| Public transport reliability | 11 | 5.8% |
| Communication and information | 9 | 4.8% |
| Safety and clinical risk | 9 | 4.8% |

The most common themes were Waiting and crowding 22.2 percent, Children and families 17.5 percent, Travel and distance 16.9 percent. These themes describe where people anticipate disadvantage, mainly travel burden, affordability, and access barriers. Mitigations should focus on transport support, accessible information, reasonable adjustments, and monitoring by place and protected characteristic.

### 12.3.1 What people said in their own words, examples from Q11

### Theme Travel and distance

- The people of West Lancashire need full A& E services at Ormskirk rather than a 10 mile journey to Southport. This must be for both adults and children!
- Southport is not a viable option for elderly and frail residents of skelmersdale, travelling time and cost implications add to the difficulties faced by someone requiring emergency medical …

- My wife & I are registered disabled & the parking facilities, access & waiting areas at Southport, although not perfect, are far superior to those at Ormskirk.

**Theme Waiting and crowding**

- Never site has the parking or the hospital space to take on both. They also don't have the services in the hospitals to take on the extra patients.
- My wife & I are registered disabled & the parking facilities, access & waiting areas at Southport, although not perfect, are far superior to those at Ormskirk.
- There is often so many folks in the waiting area that patients have to stand. The chairs are not suitable. Two toilets at Southport are not enough.

**Theme Parking and drop off**

- Never site has the parking or the hospital space to take on both. They also don't have the services in the hospitals to take on the extra patients.
- My wife & I are registered disabled & the parking facilities, access & waiting areas at Southport, although not perfect, are far superior to those at Ormskirk.
- Ormskirk is easy to navigate around and parking is easy for all, including people with disabilities. Southport is difficult to find wards and parking is not easy

### 12.3.2 What people suggested as mitigations, examples from Q12

**Theme Waiting and crowding**

- Plan a way to increase parking spaces further (build a multi storey?!) and look at how access to urgent/walk in care can be made available to people in …
- Better seating available and a more spacious waiting area. More stringent triage that sign posts people to more appropriate options such as urgent care centre etc
- You can't the hospital is to big and provides to much the waiting times are ridiculous. By using Ormskirk and providing more staff children can be seen quicker …

**Theme Children and families**

- Improve the current hospitals as they are Add each A and E to the opposing hospitals to have children and adult A and E at both locations.
- You can't the hospital is to big and provides to much the waiting times are ridiculous. By using Ormskirk and providing more staff children can be seen quicker …
- We need Children’s A&E back in Southport. I can not see why there couldn’t be Children's facilities at both sites. The NHS needs more investment.

### 12.3.3 Interpretation and recommendations

- Core interpretation and recommendations apply, see Core mitigations and monitoring for all impairment groups

- Strengthen trauma informed and sensory mitigations, including quiet space, clear information on what to expect, and options to reduce distress during waits

## 12.4 Physical impairment or mobility issues

Open text bases Q11 330 and Q12 306

### Q11 impacts explanation top themes

| Theme | Count mentioning | Percent of responses |
|---|---|---|
| Travel and distance | 190 | 57.6% |
| Waiting and crowding | 119 | 36.1% |
| Parking and drop off | 92 | 27.9% |
| Public transport reliability | 57 | 17.3% |
| Ambulance and urgent transport | 54 | 16.4% |
| Access and mobility | 53 | 16.1% |
| Cost and affordability | 52 | 15.8% |
| Children and families | 51 | 15.5% |

The most common themes were Travel and distance 57.6 percent, Waiting and crowding 36.1 percent, Parking and drop off 27.9 percent. These themes describe where people anticipate disadvantage, mainly travel burden, affordability, and access barriers. Mitigations should focus on transport support, accessible information, reasonable adjustments, and monitoring by place and protected characteristic.

### Q12 mitigation suggestions top themes

| Theme | Count mentioning | Percent of responses |
|---|---|---|
| Travel and distance | 78 | 25.5% |
| Waiting and crowding | 63 | 20.6% |
| Parking and drop off | 53 | 17.3% |
| Workforce and capacity | 36 | 11.8% |
| Children and families | 35 | 11.4% |
| Public transport reliability | 29 | 9.5% |
| Cost and affordability | 25 | 8.2% |
| Access and mobility | 24 | 7.8% |

The most common themes were Travel and distance 25.5 percent, Waiting and crowding 20.6 percent, Parking and drop off 17.3 percent. These themes describe where people anticipate disadvantage, mainly travel burden, affordability, and access barriers. Mitigations should focus on transport support, accessible information, reasonable adjustments, and monitoring by place and protected characteristic.

### 12.4.1 What people said in their own words, examples from Q11

#### Theme Travel and distance

- Getting to Ormskirk from Southport can take quite a while in busy times and has taken as long as an hour. This is not good in an Emergency
- The people of West Lancashire need full A& E services at Ormskirk rather than a 10 mile journey to Southport. This must be for both adults and children!@
- I have never visited Southport as this is a further distance and I've always been happy with Ormskirk so have never needed to change to a different service

#### Theme Waiting and crowding

- having A&E at only one hopsital for children & adults would increase crowding at whichever site. Ambulance availability would possibly be reduced resulting in longer call out times.
- My wife & I are registered disabled & the parking facilities, access & waiting areas at Southport, although not perfect, are far superior to those at Ormskirk.
- It depends on the day and time. At night, with very long waits, little information, no amenities and poor communication options any A&E waiting provisions are inadequate.

#### Theme Parking and drop off

- My wife & I are registered disabled & the parking facilities, access & waiting areas at Southport, although not perfect, are far superior to those at Ormskirk.
- Multi storey car parks, 24hr access cafe in A&E, separate children's area away from the adult trauma unit. More staff at all ground levels NO more managers that …
- 1. Bus routes to Ormskirk from Southport are poor, 2. Car Parking is more limited at Ormskitrk, 3. Therer is more room for expansion at Southport

### 12.4.2 What people suggested as mitigations, examples from Q12

#### Theme Travel and distance

- Although it is crucial to have teaching hospitals there is evidence by the lack of parking and attendance of patient appointments that this has overtaken patient care time
- AE ormskirk can travel many ways, had both childrens and adult's AE prior and it was good. Enough demand fir both really to have children and adult's AE
- This time scale of 5 years seems sxtensive It is clear A&E Southport needs massive improvements to cramped existing faciltiies If the planned works are not thought out

#### Theme Waiting and crowding

- NO COST PARKING-people are ILL PUT IN A NEW DIRECT DUAL CARRIAGWAY SOUTHPORT TO ORMSKIRK MAKE BOTH WAITING AREAS MORE RELAXED AND COMFY FOR BOTH PATIENTS AND CARERES
- In southport they can't see what's happening in the waiting room, I have personally witnessed an elderly person slipping out of a wheelchair, nobody came out to help …
- As above, more waiting areas, parking options, whether paid or travel office for those in benefits, better staff, council on board for reduced roadworks for important routes.

### 12.4.3 Interpretation and recommendations

- Core interpretation and recommendations apply, see Core mitigations and monitoring for all impairment groups
- Strengthen mobility mitigations, including accessible bays near entrances, step free routes, wheelchair availability, and arrival assistance

## 12.5 Social or communication impairment

Open text bases Q11 84 and Q12 77

### Q11 impacts explanation top themes

| Theme | Count mentioning | Percent of responses |
|---|---|---|
| Travel and distance | 52 | 61.9% |
| Waiting and crowding | 29 | 34.5% |
| Parking and drop off | 22 | 26.2% |
| Children and families | 20 | 23.8% |
| Ambulance and urgent transport | 18 | 21.4% |
| Workforce and capacity | 16 | 19% |
| Access and mobility | 13 | 15.5% |
| Safety and clinical risk | 12 | 14.3% |

The most common themes were Travel and distance 61.9 percent, Waiting and crowding 34.5 percent, Parking and drop off 26.2 percent. These themes describe where people anticipate disadvantage, mainly travel burden, affordability, and access barriers. Mitigations should focus on transport support, accessible information, reasonable adjustments, and monitoring by place and protected characteristic.

### Q12 mitigation suggestions top themes

| Theme | Count mentioning | Percent of responses |
|---|---|---|
| Travel and distance | 14 | 18.2% |
| Children and families | 13 | 16.9% |
| Waiting and crowding | 12 | 15.6% |
| Workforce and capacity | 9 | 11.7% |
| Parking and drop off | 8 | 10.4% |
| Ambulance and urgent transport | 6 | 7.8% |
| Safety and clinical risk | 6 | 7.8% |
| Public transport reliability | 5 | 6.5% |

The most common themes were Travel and distance 18.2 percent, Children and families 16.9 percent, Waiting and crowding 15.6 percent. These themes describe where people anticipate disadvantage, mainly travel burden, affordability, and access barriers. Mitigations should focus on transport support, accessible information, reasonable adjustments, and monitoring by place and protected characteristic.

### 12.5.1 What people said in their own words, examples from Q11

#### Theme Travel and distance

- I have a mental health condition as well as a mobility condition so I hardly ever go to Southport unless via ambulance as I'm terrified of traveling the …
- Travel to Ormskirk. Takes almost two hours by public transport - why would you go there when getting to the Royal in Liverpool/Preston hospital takes an hour?n
- When I went to Southport A&E I was unconscious and taken in my SiL’s car so I have no idea what it was like. The journey was fast …

#### Theme Waiting and crowding

- There should be hygienic yet more comfortable seating available in the waiting areas. Sittinf on a thin sheet of plastic for potentially 10 hours becomes painful.
- Travel mention previously Car Park at Southport is horrendous, Ormskirk a lot simpler with alternatives public car parks etc Spent 7 hours once waiting at Southport, waiting room …
- The building and allocated space at Ormskirk feels spacious and modern. It is always clean. Southport on the other hand, none of these things.

#### Theme Parking and drop off

- Ormskirk is easy to navigate around and parking is easy for all, including people with disabilities. Southport is difficult to find wards and parking is not easy
- Travel mention previously Car Park at Southport is horrendous, Ormskirk a lot simpler with alternatives public car parks etc Spent 7 hours once waiting at Southport, waiting room …
- It is a long way to travel to Southport in an emergency, and there is often no parking next to the A&E department

### 12.5.2 What people suggested as mitigations, examples from Q12

#### Theme Travel and distance

- Having one Hospital for both Emergency departments! Increased Car Park capacity. Larger Waiting Areas. *Reduced wait times. *More staff. Better transport between sites. *MORE AMBULANCES! *not restricted to …
- If A and E was moved to Ormskirk it would be more central for everyone and it's much easier to drive out of Southport especially in summer than …
- Regular express bus service to Ormskirk hospital - not just from Southport Hospital (takes 45 mins to get there bu public transport1)

#### Theme Children and families

- Have both adults and children's at Southport a&E as it has more room, staff and parking and good provision for disabled people.
- You can't because they way people are now they go for the slightest thing and then there the mental health side and alcohol side do you want children …
- Keeping children's an and e in ormskirk and opening an additional unit in Southport.

### 12.5.3 Interpretation and recommendations

- Core interpretation and recommendations apply, see Core mitigations and monitoring for all impairment groups
- Strengthen easy read information, allow carer accompaniment, and train staff on communication support and reasonable adjustments

## 12.6 Learning difficulty or cognitive disorder

Open text bases Q11 113 and Q12 102

### Q11 impacts explanation top themes

| Theme | Count mentioning | Percent of responses |
|---|---|---|
| Travel and distance | 64 | 56.6% |
| Waiting and crowding | 47 | 41.6% |
| Children and families | 37 | 32.7% |
| Parking and drop off | 35 | 31% |
| Workforce and capacity | 30 | 26.5% |
| Safety and clinical risk | 23 | 20.4% |
| Public transport reliability | 22 | 19.5% |
| Ambulance and urgent transport | 20 | 17.7% |

The most common themes were Travel and distance 56.6 percent, Waiting and crowding 41.6 percent, Children and families 32.7 percent. These themes describe where people anticipate disadvantage, mainly travel burden, affordability, and access barriers. Mitigations should focus on transport support, accessible information, reasonable adjustments, and monitoring by place and protected characteristic.

### Q12 mitigation suggestions top themes

| Theme | Count mentioning | Percent of responses |
|---|---|---|
| Waiting and crowding | 27 | 26.5% |
| Travel and distance | 25 | 24.5% |
| Parking and drop off | 21 | 20.6% |
| Workforce and capacity | 20 | 19.6% |
| Public transport reliability | 16 | 15.7% |
| Children and families | 15 | 14.7% |
| Cost and affordability | 10 | 9.8% |
| Access and mobility | 8 | 7.8% |

The most common themes were Waiting and crowding 26.5 percent, Travel and distance 24.5 percent, Parking and drop off 20.6 percent. These themes describe where people anticipate disadvantage, mainly travel burden, affordability, and access barriers. Mitigations should focus on transport support, accessible information, reasonable adjustments, and monitoring by place and protected characteristic.

### 12.6.1 What people said in their own words, examples from Q11

### Theme Travel and distance

- Travel to Ormskirk. Takes almost two hours by public transport- why would you go there when getting to the Royal in Liverpool/Preston hospital takes an hour?n
- Anytime I have been to Southport hospital it has been awful. Understaffed, very very busy. Very long waiting times. It would take us over 45 minutes to get …
- Ormskirk is by far the best option, they have the out of hours department that’s fantastic if you need an appointment urgent for adults and children alike.

### Theme Waiting and crowding

- Anytime I have been to Southport hospital it has been awful. Understaffed, very very busy. Very long waiting times. It would take us over 45 minutes to get …
- There should be hygienic yet more comfortable seating available in the waiting areas. Sittinf on a thin sheet of plastic for potentially 10 hours becomes painful.
- There isn’t room for children and adults - the population is doubled in the last 10 years with all the new houses - no room no parking spaces …

### Theme Children and families

- Ormskirk is by far the best option, they have the out of hours department that’s fantastic if you need an appointment urgent for adults and children alike.
- There isn’t room for children and adults - the population is doubled in the last 10 years with all the new houses - no room no parking spaces …
- My grandsons mum doesn't drive. Hes 2 and being investigated for non verbal autism. The commute from skelmersdale would be hellish to Southport

## 12.6.2 What people suggested as mitigations, examples from Q12

### Theme Waiting and crowding

- As above, more waiting areas, parking options, whether paid or travel office for those in benefits, better staff, council on board for reduced roadworks for important routes.
- Better seating available and a more spacious waiting area. More stringent triage that sign posts people to more appropriate options such as urgent care centre etc
- Where possible restrict waiting room where possible to the patient and if necessary one "caring person" not casts of thousands, whole families and groups of teenagers.

### Theme Travel and distance

- As above, more waiting areas, parking options, whether paid or travel office for those in benefits, better staff, council on board for reduced roadworks for important routes.
- If A and E was moved to Ormskirk it would be more central for everyone and it's much easier to drive out of Southport especially in summer than …
- A better road network into Southport from Skelmersdale. Southport is a seaside resort and the road we have now gets very congested

## 12.6.3 Interpretation and recommendations

- Core interpretation and recommendations apply, see Core mitigations and monitoring for all impairment groups
- Strengthen easy read information, allow carer accompaniment, and train staff on communication support and reasonable adjustments

## 12.7 Blind or visual impairment

Open text bases Q11 47 and Q12 43

### Q11 impacts explanation top themes

| Theme | Count mentioning | Percent of responses |
|---|---|---|
| Travel and distance | 29 | 61.7% |
| Waiting and crowding | 17 | 36.2% |
| Ambulance and urgent transport | 14 | 29.8% |
| Parking and drop off | 12 | 25.5% |
| Public transport reliability | 12 | 25.5% |
| Children and families | 8 | 17% |
| Cost and affordability | 8 | 17% |
| Equality and reasonable adjustments | 6 | 12.8% |

The most common themes were Travel and distance 61.7 percent, Waiting and crowding 36.2 percent, Ambulance and urgent transport 29.8 percent. These themes describe where people anticipate disadvantage, mainly travel burden, affordability, and access barriers. Mitigations should focus on transport support, accessible information, reasonable adjustments, and monitoring by place and protected characteristic.

### Q12 mitigation suggestions top themes

| Theme | Count mentioning | Percent of responses |
|---|---|---|
| Children and families | 11 | 25.6% |
| Waiting and crowding | 11 | 25.6% |
| Travel and distance | 10 | 23.3% |
| Public transport reliability | 8 | 18.6% |
| Ambulance and urgent transport | 6 | 14% |
| Workforce and capacity | 6 | 14% |
| Parking and drop off | 5 | 11.6% |
| Access and mobility | 4 | 9.3% |

The most common themes were Children and families 25.6 percent, Waiting and crowding 25.6 percent, Travel and distance 23.3 percent. These themes describe where people anticipate disadvantage, mainly travel burden, affordability, and access barriers. Mitigations should focus on transport support, accessible information, reasonable adjustments, and monitoring by place and protected characteristic.

### 12.7.1 What people said in their own words, examples from Q11

### Theme Travel and distance

- I refer to previous answers ……… non driver and hospital apps are made by taxi or PT Both hospitals buildings are on a par with each other
- I don't drive so getting to Ormskirk is difficult on public transport when you have a disability. So parking for me not an issue at either.

- Lack of transport when not requiring an ambulance could mean £20 each way in a taxi to Southport. Ormskirk would be less than £10

### Theme Waiting and crowding

Parking at Southport is poor as it is; you can never find a space, even now, for adult A and E.

- Southport & ormskirk waiting areas would need to be made larger if either hospital took over as main a&e
- Southport A&E waiting times are a disgrace. There is too much demand, not enough space and not enough resources

### Theme Ambulance and urgent transport

- I don't drive so getting to Ormskirk is difficult on public transport when you have a disability. So parking for me not an issue at either.
- Lack of transport when not requiring an ambulance could mean £20 each way in a taxi to Southport. Ormskirk would be less than £10
- Ormskirk has all round better facilities and transport links therefore major problems are bound to arise for people traveling to Southport

## 12.7.2 What people suggested as mitigations, examples from Q12

### Theme Children and families

- You can't the hospital is to big and provides to much the waiting times are ridiculous. By using Ormskirk and providing more staff children can be seen quicker …
- Rebuild Southport hospital to make it a more modern and welcoming hospital if that's where Children's will go but at the moment it's not the place to put …
- Elderly care facilities should be provided at both sites in addition to children's services. Children are invariably accompanied to hospital not so with elderly.

### Theme Waiting and crowding

- Move adult A and E to Southport. There seems to be a large hospital with a lot of empty space. Sensibly refurbished it could be outstanding
- You can't the hospital is to big and provides to much the waiting times are ridiculous. By using Ormskirk and providing more staff children can be seen quicker …
- Stop those parking who have no right to? (Boring but, if that IS the reason, it could save having to provide (expensive) new parking spaces

## 12.7.3 Interpretation and recommendations

- Core interpretation and recommendations apply, see Core mitigations and monitoring for all impairment groups
- Strengthen wayfinding mitigations, including supported wayfinding on request, clear signage, and safe drop off at the correct entrance

## 12.9 Deaf or hearing impairment

Open text bases Q11 143 and Q12 134

### Q11 impacts explanation top themes

| Theme | Count mentioning | Percent of responses |
|---|---|---|
| Travel and distance | 71 | 49.7% |
| Waiting and crowding | 46 | 32.2% |
| Parking and drop off | 32 | 22.4% |
| Ambulance and urgent transport | 23 | 16.1% |
| Public transport reliability | 19 | 13.3% |
| Workforce and capacity | 19 | 13.3% |
| Children and families | 17 | 11.9% |
| Wayfinding and signage | 15 | 10.5% |

The most common themes were Travel and distance 49.7 percent, Waiting and crowding 32.2 percent, Parking and drop off 22.4 percent. These themes describe where people anticipate disadvantage, mainly travel burden, affordability, and access barriers. Mitigations should focus on transport support, accessible information, reasonable adjustments, and monitoring by place and protected characteristic.

### Q12 mitigation suggestions top themes

| Theme | Count mentioning | Percent of responses |
|---|---|---|
| Travel and distance | 35 | 26.1% |
| Waiting and crowding | 31 | 23.1% |
| Public transport reliability | 19 | 14.2% |
| Parking and drop off | 16 | 11.9% |
| Workforce and capacity | 15 | 11.2% |
| Children and families | 12 | 9% |
| Ambulance and urgent transport | 11 | 8.2% |
| Cost and affordability | 9 | 6.7% |

The most common themes were Travel and distance 26.1 percent, Waiting and crowding 23.1 percent, Public transport reliability 14.2 percent. These themes describe where people anticipate disadvantage, mainly travel burden, affordability, and access barriers. Mitigations should focus on transport support, accessible information, reasonable adjustments, and monitoring by place and protected characteristic.

### 12.9.1 What people said in their own words, examples from Q11

#### Theme Travel and distance

- The people of West Lancashire need full A& E services at Ormskirk rather than a 10 mile journey to Southport. This must be for both adults and children!@
- Getting there, one road to Southport, you travel on it on a busy day, you ain't going to get to a&e in an life and death situation
- I couldn’t get an ambulance to get to Southport A&E. Neighbour had to drive me. I was really ill and found it scary to have to drive so …

#### Theme Waiting and crowding

- southport hospital our part too small without taking anything away, can't get there on swift journey. buildings are not important its the service. waitings times at southport hospital ...
- Need proper access to A and E and good facilities while in the building because we have to wait quite a while to get seen too
- Southport A&E is absolute nightmare. Waiting times are awful, not enough staff to cope, travel and cost of travel is too high for poorest in society,

#### Theme Parking and drop off

- Southport Hospital offers a far larger footprint for the extension of parking facilities and new hospital buildings (either on the existin site or nearby)
- the southport option gives a larger area with more parking ormskirk is difficult to navigate with 1 way streets and many traffic lights
- The car parking at Southport has a greater capacity and is more accessible/closer to the buildings/their access points and provides good/closer access for disabled patients although the number ...

### 12.9.2 What people suggested as mitigations, examples from Q12

#### Theme Travel and distance

- This time scale of 5 years seems sxtensive It is clear A&E Southport needs massive improvements to cramped existing faciltiies If the planned works are not thought out
- Transfer services to Ormskirk so A+E, Maternity services and ITU are all on one site. Southport residents can travel into Liverpool or Aintree for their emergency services.
- Offer 24hr urgent care service at Ormskirk to reduce demand at Southport and additional journey time / distance for Ormskirk residents, except for the most serious emergencies.

#### Theme Waiting and crowding

- More space, more comfortable chairs, better vending machines or free supply of water/ tea urns etc. More e efficient handover from ambulance staff to hospital registration. More space
- Where possible restrict waiting room where possible to the patient and if necessary one "caring person" not casts of thousands, whole families and groups of teenagers.
- More space needs to be created in A&E with chairs for patients. A visible board for deaf/HoH people so they don’t miss their name being called

### 12.9.3 Interpretation and recommendations

- Core interpretation and recommendations apply, see Core mitigations and monitoring for all impairment groups
- Strengthen communication mitigations, including visual calling systems, hearing loop coverage, and staff checks for communication needs on arrival

## 12.10 Other impairment or condition

Open text bases Q11 181 and Q12 164

### Q11 impacts explanation top themes

| Theme | Count mentioning | Percent of responses |
|---|---|---|
| Travel and distance | 104 | 57.5% |
| Waiting and crowding | 57 | 31.5% |
| Parking and drop off | 56 | 30.9% |
| Public transport reliability | 52 | 28.7% |
| Children and families | 41 | 22.7% |
| Ambulance and urgent transport | 34 | 18.8% |
| Workforce and capacity | 29 | 16% |
| Access and mobility | 19 | 10.5% |

The most common themes were Travel and distance 57.5 percent, Waiting and crowding 31.5 percent, Parking and drop off 30.9 percent. These themes describe where people anticipate disadvantage, mainly travel burden, affordability, and access barriers. Mitigations should focus on transport support, accessible information, reasonable adjustments, and monitoring by place and protected characteristic.

### Q12 mitigation suggestions top themes

| Theme | Count mentioning | Percent of responses |
|---|---|---|
| Travel and distance | 37 | 22.6% |
| Waiting and crowding | 29 | 17.7% |
| Workforce and capacity | 28 | 17.1% |
| Parking and drop off | 27 | 16.5% |
| Children and families | 26 | 15.9% |
| Public transport reliability | 20 | 12.2% |
| Ambulance and urgent transport | 16 | 9.8% |
| Cost and affordability | 10 | 6.1% |

The most common themes were Travel and distance 22.6 percent, Waiting and crowding 17.7 percent, Workforce and capacity 17.1 percent. These themes describe where people anticipate disadvantage, mainly travel burden, affordability, and access barriers. Mitigations should focus on transport support, accessible information, reasonable adjustments, and monitoring by place and protected characteristic.

### 12.10.1 What people said in their own words, examples from Q11

### Theme Travel and distance

- Getting to Ormskirk from Southport can take quite a while in busy times and has taken as long as an hour. This is not good in an Emergency
- Having travelled to both locations and experienced the places, when taking account of the proposed changes, it is still clear that the Southport option will meet needs better.
- The journey to Southport can be very difficult at busy times with only one real route from Skelmersdale, on the other hand Ormskirk from Formby has several routes.

#### Theme Waiting and crowding

- Never site has the parking or the hospital space to take on both. They also don't have the services in the hospitals to take on the extra patients.
- Parking availability at Southport can be very poor. The waiting area at Southport was unclean and some members of staff were not professional and were uncaring and rude.
- Travel can be difficult and slow to Ormskirk. There are no enough car parking spaces at Southport . Car parking is too expensive and disproportionately effects financially disadvantaged ...

#### Theme Parking and drop off

- Never site has the parking or the hospital space to take on both. They also don't have the services in the hospitals to take on the extra patients.
- Parking availability at Southport can be very poor. The waiting area at Southport was unclean and some members of staff were not professional and were uncaring and rude.
- Travel can be difficult and slow to Ormskirk. There are no enough car parking spaces at Southport . Car parking is too expensive and disproportionately effects financially disadvantaged ...

### 12.10.2 What people suggested as mitigations, examples from Q12

#### Theme Travel and distance

- 2 a and e departments easing the pressure on access and parking at both sites. Better rural bus services. Lcc taking better care of pavements around hospitals
- As above, more waiting areas, parking options, whether paid or travel office for those in benefits, better staff, council on board for reduced roadworks for important routes.
- I fear that combining both would make waiting times even longer, for both adults and children, A&E is fine as it is my grandchildren have been there

#### Theme Waiting and crowding

- Give those waiting to be seen and/or treated some information about your triage process, how patients are prioritised and an indication of how long they may have to ...
- As above, more waiting areas, parking options, whether paid or travel office for those in benefits, better staff, council on board for reduced roadworks for important routes.
- I fear that combining both would make waiting times even longer, for both adults and children, A&E is fine as it is my grandchildren have been there

### 12.10.3 Interpretation and recommendations

- Core interpretation and recommendations apply, see Core mitigations and monitoring for all impairment groups

## 12.11 Intersectional snapshot older people (Age)

| Theme | Southport base | Southport percent negative | Ormskirk base | Ormskirk percent negative | Confidence | Interpretation |
|---|---|---|---|---|---|---|
| Travel | 2066 | 43.6% | 2048 | 42.1% | High | No material difference |
| Parking | 2051 | 42.6% | 2049 | 30.6% | High | Material difference |
| Access to buildings and services | 2062 | 26.9% | 2051 | 17.5% | High | Material difference |
| Waiting areas | 2070 | 38.6% | 2049 | 17.6% | High | Material difference |

*Waiting areas shows higher negative rating for Southport, Southport 38.6 percent, Ormskirk 17.6 percent. Parking shows higher negative rating for Southport, Southport 42.6 percent, Ormskirk 30.6 percent. Access to buildings and services shows higher negative rating for Southport, Southport 26.9 percent, Ormskirk 17.5 percent. This indicates an option related access risk for this group, and mitigations should be treated as requirements rather than nice to have.*

## 12.12 Intersectional snapshot unpaid carer

| Theme | Southport base | Southport percent negative | Ormskirk base | Ormskirk percent negative | Confidence | Interpretation |
|---|---|---|---|---|---|---|
| Travel | 1781 | 54.1% | 1765 | 33.5% | High | Material difference |
| Parking | 1777 | 49.2% | 1762 | 27.4% | High | Material difference |
| Access to buildings and services | 1776 | 37.2% | 1764 | 15.6% | High | Material difference |
| Waiting areas | 1785 | 48.3% | 1765 | 17.1% | High | Material difference |

*Waiting areas shows higher negative rating for Southport, Southport 48.3 percent, Ormskirk 17.1 percent. Parking shows higher negative rating for Southport, Southport 49.2 percent, Ormskirk 27.4 percent. Access to buildings and services shows higher negative rating for Southport, Southport 37.2 percent, Ormskirk 15.6 percent. This indicates an option related access risk for this group, and mitigations should be treated as requirements rather than nice to have.*

## 12.13 Intersectional snapshot pregnancy and maternity

| Theme | Southport base | Southport percent negative | Ormskirk base | Ormskirk percent negative | Confidence | Interpretation |
|---|---|---|---|---|---|---|
| Travel | 314 | 78.7% | 316 | 9.5% | High | Material difference |
| Parking | 316 | 68% | 316 | 9.2% | High | Material difference |
| Access to buildings and services | 314 | 59.2% | 314 | 5.7% | High | Material difference |
| Waiting areas | 315 | 61.6% | 315 | 6% | High | Material difference |

*Travel shows higher negative rating for Southport, Southport 78.7 percent, Ormskirk 9.5 percent. Parking shows higher negative rating for Southport, Southport 68.0 percent, Ormskirk 9.2 percent. Waiting areas shows higher negative rating for Southport, Southport 61.6 percent, Ormskirk 6.0 percent. This indicates an option related access risk for this group, and mitigations should be treated as requirements rather than nice to have.*

## 12.14 Intersectional snapshot ethnicity (Race)

| Theme | Southport base | Southport percent negative | Ormskirk base | Ormskirk percent negative | Confidence | |
|---|---|---|---|---|---|---|
| Travel | 80 | 37.5% | 79 | 50.6% | Low | |
| Parking | 81 | 40.7% | 78 | 26.9% | Low | |
| Access to buildings and services | 81 | 30.9% | 76 | 22.4% | Low | |
| Waiting areas | 81 | 43.2% | 78 | 23.1% | Low | |

*Waiting areas shows higher negative rating for Southport, Southport 43.2 percent, Ormskirk 23.1 percent. Parking shows higher negative rating for Southport, Southport 40.7 percent, Ormskirk 26.9 percent. Travel shows higher negative rating for Ormskirk, Southport 37.5 percent, Ormskirk 50.6 percent. This indicates an option*

*related access risk for this group, and mitigations should be treated as requirements rather than nice to have.*

## 12.15 Intersectional snapshot female (Sex)

| Theme | Southport base | Southport percent negative | Ormskirk base | Ormskirk percent negative | Confidence | Interpretation |
|---|---|---|---|---|---|---|
| Travel | 3514 | 58.4% | 3493 | 28.7% | High | Material difference |
| Parking | 3511 | 52.1% | 3501 | 23.6% | High | Material difference |
| Access to buildings and services | 3514 | 39.4% | 3498 | 13.3% | High | Material difference |
| Waiting areas | 3519 | 50.1% | 3500 | 13.8% | High | Material difference |

*Waiting areas shows higher negative rating for Southport, Southport 50.1 percent, Ormskirk 13.8 percent. Travel shows higher negative rating for Southport, Southport 58.4 percent, Ormskirk 28.7 percent. Parking shows higher negative rating for Southport, Southport 52.1 percent, Ormskirk 23.6 percent. This indicates an option related access risk for this group, and mitigations should be treated as requirements rather than nice to have.*

### Protected characteristics narrative, proportional depth

This section provides a short due regard narrative for each protected characteristic.

### Age

- Closed questions show a clear place based trade off. In Sefton, age 61 and over rated travel more negatively for Ormskirk than for Southport, 79.5 percent negative for Ormskirk compared with 8.2 percent for Southport
- In West Lancashire, age under 45 rated travel much more negatively for Southport than for Ormskirk, 90.2 percent negative for Southport compared with 2.5 percent for Ormskirk
- Open text from younger adults more often references children and family needs and personal safety barriers. Open text from older adults more often references affordability, parking, and frailty

- Mitigation focus includes transport support, safe arrival and drop off, clear journey planning information, seating and toilets, and carer support for frail patients
- Where travel time increases there is higher risk of unequal access and delayed presentation
- Mitigation focus is transport and access planning, safe drop off, and clear reasonable adjustment routes

### Disability

- Disabled people are more likely to need reasonable adjustments, accessible transport, predictable parking and accessible information
- Changes that increase travel time or complexity increase risk of unequal access and reduced independence
- Mitigation focus is reasonable adjustment pathways, accessible information compliance, and accessible transport options

### Sex

- Closed questions show that sex differences are smaller than place based differences. In Sefton, both women and men rated travel far more negatively for Ormskirk than for Southport. In West Lancashire, both women and men rated travel far more negatively for Southport than for Ormskirk
- Open text indicates that women more often raise family and caring responsibility and waiting environment issues. Men and women both raise concerns about journey time and public transport
- Mitigation focus includes safe and dignified waiting environments, good lighting and drop off arrangements, and carer friendly information and support
- Mitigation focus is inclusive communications and monitoring of experience and complaints

### Pregnancy and maternity

- Closed questions show that impacts for pregnant respondents are strongly place based. In West Lancashire, pregnant respondents rated travel very negatively for Southport, 94.6 percent negative, compared with 2.5 percent negative for Ormskirk, and rated waiting areas 72.8 percent negative for Southport compared with 5.4 percent negative for Ormskirk
- In Sefton, pregnant respondents show similar negative travel ratings for both sites, around 36 percent, and lower negative waiting ratings for Ormskirk than for Southport, 11.6 percent negative compared with 30.4 percent
- Open text includes concerns about time critical presentation in pregnancy and early postnatal periods. Pregnancy and maternity are protected characteristics and people raised concerns about the relationship between children's services, neonatal services and maternity. The SCT consultation decision does not include maternity or neonatal service reconfiguration, which sit within separate regional and national reviews. The programme will therefore focus on clear public information and accessible communications that explain how obstetric emergencies are managed, including

confirmation that obstetric emergencies continue to follow agreed pathways to the most appropriate service.

- Mitigation focus includes accessible arrival and parking, and targeted communications for pregnant people and families
- Increased travel time may increase clinical and safety risk for a minority of patients
- Mitigation focus is safe drop off, parking, and clear communications on urgent access routes

### Ethnicity

- Closed questions show similar place based patterns for White British and other ethnicities. In West Lancashire, travel remains more negative for Southport than for Ormskirk for other ethnicities, 82.0 percent negative for Southport compared with 6.5 percent for Ormskirk, bases are smaller so interpret with caution
- Open text includes limited explicit reference to language needs, however one response highlighted the workforce context for staff recruited from abroad who may not drive
- Mitigation focus includes accessible information in multiple formats, translation and interpreting routes on request, and targeted engagement with community networks to test the practicality of transport mitigations
- Monitoring should include complaints and experience themes related to communication and perceived discrimination, and should use equality monitoring data where recording allows
- Small bases for some categories reduce confidence, so due regard is supported through targeted engagement routes and monitoring after implementation
- Mitigation focus is accessible information and culturally competent communication

### Religion or belief

- Consultation responses do not indicate a distinct pattern by religion that differs from the overall place based pattern, and smaller bases limit confidence for some groups
- Mitigation focus includes inclusive communications, culturally competent care, and provision of quiet space and privacy where feasible
- Monitoring should include patient experience and complaints themes linked to dignity, privacy, and communication
- Small bases for some categories mean monitoring and inclusive engagement are important

### Sexual orientation

- Response bases are smaller, and the consultation does not provide a robust signal that differs from the overall place based pattern
- Due regard should still be evidenced through mitigations that protect privacy, dignity, and safety for all, and through zero tolerance approaches to discrimination and harassment
- Monitoring should include patient experience and complaints themes, and should improve the completeness of equality monitoring where possible

- Small bases reduce confidence, so due regard is supported through inclusive engagement and monitoring

### Gender reassignment

- Very small response base means no reliable subgroup analysis can be drawn from consultation returns
- Due regard should be evidenced through privacy and dignity safeguards, inclusive communication, staff training, and clear reporting routes for discrimination
- Monitoring should include thematic review of feedback and complaints, and improve recording where patients choose to share this information
- Due regard is maintained through inclusive engagement routes and monitoring of safety and experience signals post implementation

### Marriage and civil partnership

- Patterns are likely to be mediated by age and caring roles rather than marital status itself, interpret with caution
- Mitigation focus includes carer friendly arrangements, accessible parking and drop off, and clear information to support people who attend with a partner or family member
- It is not expected to be a primary driver of access impact compared with geography, age and disability

### Evidence gaps and further work

- Socioeconomic status is not directly captured in the survey, so inequalities related to deprivation should be triangulated using deprivation and travel time evidence
- Some protected characteristics have small subgroup bases, particularly gender reassignment, some ethnic minority categories, and sexual orientation, so findings are indicative and require targeted engagement and monitoring
- Survey responses are self selected and may reflect strength of view and digital access, so conclusions should be considered alongside other evidence sources

Health and social care systems support organisation

| Theme | Risk group | Mitigation action | Owner | Metric | Frequency | Escalation | Decision relevance |
|---|---|---|---|---|---|---|---|
| Travel time and affordability | Communities facing longer travel, amplified for older people, disabled people, carers | Implementation point during implementation phase Transport and access mitigation plan covering public transport options, shuttle feasibility, drop off arrangements, and cost support routes | Programme senior responsible owner and provider chief operating officer | Travel related complaints and concerns by area and recorded equality characteristics, plus reasonable adjustment requests linked to travel | Quarterly | Programme board and quality committee | Option specific |
| Parking and safe drop off | Disabled people, pregnant people, women frail older people, families with young children | Implementation phase: Accessible parking and drop off plan, and a clear reasonable adjustment route and explore on site assistance. | Provider chief operating officer and estates | Parking related complaints, reasonable adjustment requests linked to parking, and access incidents | Quarterly | Provider quality governance | Option specific |
| Accessible information and communication | Deaf and disabled people, people needing alternative formats, people with language needs | Implementation phase Accessible information standard compliant communications pack, staff briefing, signage and journey planning support | Provider accessible information lead and ICB equality team | Accessible information standard audit results and complaints relating to information needs | Quarterly | Contract review and quality governance | Both options |
| Waiting environment and crowding | Disabled people, neurodiverse people, people with anxiety, families with children | implementation phase Waiting environment review covering seating, quiet space, toilets, sensory considerations and safety | Provider operations lead and estates | Patient feedback themes and incident reports linked to crowding, plus reasonable adjustment requests linked to waiting | Quarterly | Programme Governance Quality committee | Both options |
| Ongoing due regard | Seldom heard groups underrepresented in the survey | implementation phase and reviewed quarterly Targeted engagement and triangulation with service use and outcomes | Programme team with Healthwatch and voluntary community sector partners | Engagement reach, feedback themes and any differential outcome dashboard where available | Quarterly | Programme board | Both options |

| Theme | Risk group | Mitigation action | Owner | Metric | Frequency | Escalation | Decision relevance |
|---|---|---|---|---|---|---|---|
| | | (inclusive design) PPG | | | | | |

## 13 Mitigation and monitoring dashboard

This dashboard translates consultation risks into specific actions, owners, and measures. Each mitigation should have a named lead, a delivery timeframe, and an escalation route through programme governance. Metrics should be reported routinely and reviewed for differential experience by place and protected characteristic where data allows.

## 14 Summary for the main EIA

- Consultation evidence indicates geography and travel burden are the dominant equality and health inequality mechanisms, there is a place based trade off depending on the option
- Closed question ratings show that in Sefton, negative travel ratings are much higher for Ormskirk than for Southport, and in West Lancashire, negative travel ratings are much higher for Southport than for Ormskirk
- Age, disability, pregnancy, and unpaid caring responsibility amplify access impacts because these groups are less able to travel independently and more likely to need reasonable adjustments
- Where subgroup bases are small, findings are treated as low confidence, due regard is supported through targeted engagement and post decision monitoring
- A transport and access mitigation plan, Accessible Information Standard compliance, clear reasonable adjustment routes, and a governance linked monitoring dashboard are required to demonstrate due regard through implementation and review

## 15 Protected groups

### Age

The survey shows higher negative experiences for younger adults at Southport and higher negative experiences for older adults at Ormskirk Travel parking access and waiting areas all show this pattern The mechanism relates to travel burden and mobility limitations Mitigations include better transport support priority parking and accessible waiting areas Monitoring involves repeated review of experience data and complaints

### Disability

- Closed questions show a consistent place based trade off, with disability amplifying access and travel impacts. In Sefton, disabled respondents rated travel more negatively

for Ormskirk than for Southport, 75.2 percent negative for Ormskirk compared with 12.8 percent for Southport

- In West Lancashire, disabled respondents rated travel more negatively for Southport than for Ormskirk, 87.1 percent negative for Southport compared with 4.6 percent for Ormskirk. Disabled respondents also rated access more negatively for Southport than non disabled respondents, 62.0 percent negative compared with 53.6 percent
- Open text adds emphasis on reasonable adjustments, sensory needs, predictable pathways, waiting environment, and affordability
- Mitigation focus includes a clear reasonable adjustment route, Accessible Information Standard compliance, accessible parking and drop off, quiet space and seating, and staff training to deliver consistent adjustments

### Sex

Females report higher negatives at Southport particularly for travel and waiting Males report higher negatives at Ormskirk The mechanism relates to caring roles and travel patterns Mitigations include safe waiting environments good lighting and drop off points Monitoring includes reviewing trends by sex

### Pregnancy and maternity

Pregnant respondents report very high negative experiences for Southport due to travel and waiting The mechanism relates to clinical safety and convenience Mitigations include priority entry parking close access and clear triage Monitoring should track waiting times and complaints and accessible communications.

### Ethnicity

Larger groups show patterns similar to overall geography impacts Smaller groups have limited data so interpretation requires caution The mechanism links to communication digital access and transport patterns Mitigations include clear information accessible formats and transport support Monitoring involves reviewing feedback and triangulating with other data

### Religion or belief

Negative patterns broadly mirror overall results with some variation in smaller groups The mechanism relates to cultural safety and communication Mitigations include inclusive messages and quiet spaces Monitoring involves tracking thematic complaints

### Sexual orientation

People selecting prefer not to say often show higher negative responses Larger groups mirror the overall pattern The mechanism relates to safety privacy and trust Mitigations include visible staff support and clear policies Monitoring includes feedback logs

### Gender reassignment

Small numbers limit detailed analysis Prefer not to say shows elevated negative scores The mechanism relates to privacy dignity and trust Mitigations include discreet spaces and trained staff Monitoring requires sensitive data use

### Marriage and civil partnership

Living with a partner shows higher negatives at Southport Widowed respondents show higher negatives at Ormskirk The mechanism links to caring roles and travel burden Mitigations include flexible visiting arrangements and accessible parking Monitoring includes periodic experience review

### Carer

- Closed questions show that unpaid carers are likely to be disproportionately affected by travel burden in Sefton if the site is Ormskirk, carers rated travel 77.7 percent negative for Ormskirk compared with 9.1 percent for Southport
- Carers also rated parking more negatively for Ormskirk than for Southport in Sefton, 48.8 percent negative for Ormskirk compared with 21.3 percent for Southport
- Open text adds emphasis on cost pressures, the practicalities of attending with dependants, and the need for predictable support at arrival and discharge
- Mitigation focus includes priority information and navigation, cost and parking concessions, carer support routes, and practical support for families and lone carers

### Armed forces

- Very small response base means no reliable conclusions can be drawn from consultation returns
- Mitigation focus includes respectful communication and signposting to veterans support routes where relevant
- Monitoring should be through thematic review of feedback rather than subgroup percentage analysis

Equality and health inequalities analysis of Survation polling, October 2025

Date 20 January 2026

## 16.1 Purpose and project context

This note provides an equality and health inequalities review of the Survation public polling undertaken as part of the wider Southport and Ormskirk urgent and emergency care programme. It is designed to support the programme evidence base alongside the formal consultation results, clinical case for change, and the developing Equality Impact Assessment.

The polling offers a structured snapshot of resident views across Sefton and West Lancashire. It does not replace the statutory duties to have due regard under the Public Sector Equality Duty, nor the requirement to consider health inequalities, but it provides useful contextual evidence for decision makers.

## 16.2 About the polling

- Fieldwork dates 29 September to 3 October 2025
- Sample size 507 residents aged 18 plus in Sefton and West Lancashire
- Data collection via telephone and online panel
- Weighting by age, sex and ward using ONS derived targets
- Margin of error reported as around 5.3 percentage points at 95 percent confidence for a 50 percent result

Weighting by age, sex and ward strengthens confidence in the overall headline results and reduces the risk that responses are driven by a single locality or demographic group. However, the poll is not weighted by all protected characteristics such as disability, religion, sexual orientation, pregnancy and maternity, or gender reassignment. Subgroup findings for characteristics with smaller bases should therefore be treated as indicative.

## 16.3 Headline results from the polling

### 3.1 Recent use of urgent or emergency care services

51 percent reported that they or someone in their household had used local urgent or emergency care services in the last 12 months. 48 percent reported they had not used services in the last 12 months.

### 3.2 Awareness of the proposals

54 percent said they already knew about the proposals to bring adult and children's A and E together on a single site. 46 percent did not know about the proposals before the survey.

### 3.3 Support for the two single site options

Option A, combining adult and children's A and E at Southport, was supported by 40 percent and opposed by 38 percent. The remainder were neutral, unsure or expressed no opinion (see Survation questionnaire categories).

Option B, combining adult and children's A and E at Ormskirk, was supported by 35 percent and opposed by 45 percent. The remainder were neutral, unsure or expressed no opinion (see Survation questionnaire categories).

3.4 Option choice in the poll

When asked to choose, 33 percent chose Option A at Southport, 29 percent chose Option B at Ormskirk, and 32 percent chose neither option. 6 percent were unsure.

The proportion preferring neither option is a key programme insight. It suggests that a substantial group anticipates trade offs whichever option is chosen, and will expect strong, credible mitigations to protect access, experience, and outcomes.

#### 3.5 Views on bringing adult and children's A and E onto one site

43 percent believe bringing adult and children's A and E onto a single site is a good idea where benefits outweigh drawbacks. 38 percent disagree, and 20 percent are unsure.

#### 3.6 What matters most to residents

Residents were asked to identify the single most important factor. The results show a clear prioritisation of clinical quality and 24 hour availability, ahead of travel time.

- Highest quality of care 38 percent
- 24 hour A and E for adults and children 34 percent
- Short travel time 18 percent
- Sustainable and cost effective for the NHS 10 percent

### 16.4 Equality and health inequalities interpretation

The polling provides supportive evidence that the public place greatest emphasis on quality of care and consistent 24 hour urgent and emergency cover. This aligns with the programme case for change focused on clinical safety, workforce resilience, and sustainable service delivery. However, travel time remains important for a material proportion of residents. This reinforces the need for the programme to clearly evidence and fund mitigations that prevent unequal access or delayed presentation for communities facing the greatest barriers.

The high proportion preferring neither option indicates that some communities may have low confidence that mitigations will work in practice. In equality terms, this should be treated as a prompt for stronger assurance on access, transport, navigation support, and the capacity of alternative pathways.

### 16.5 Signals by protected characteristics and inequality proxies

The detailed polling tables provide indicative differences across sex, age, ethnicity, employment, tenure, and place. These signals should be interpreted with caution where

subgroup bases are smaller. The key value is to identify where targeted engagement, mitigations, and monitoring are most likely to be required.

### Sex

Awareness was higher among women at 60 percent compared with men at 48 percent. Men were more likely to select travel time as the most important factor at 22 percent compared with women at 15 percent.

There is no evidence of a major divergence by sex in overall acceptability, but the difference in travel salience supports ongoing monitoring of access and navigation, particularly for households where travel is a practical barrier.

### Age

Awareness among respondents aged 18 to 24 was low at 20 percent, compared with 60 percent in the 65 plus group. Respondents aged 18 to 24 were also less likely to say a single site model is a good idea at 20 percent, compared with 48 percent in the 65 plus group.

The 18 to 24 group showed a stronger preference towards Option B at Ormskirk, with 45 percent selecting this option. This pattern supports the need to strengthen youth focused communications and to ensure that mitigations account for reliance on public transport, digital access to information, and confidence in local urgent care alternatives.

### Race and ethnicity

Ethnicity is presented within the detailed tables, but the poll is weighted by age, sex and ward rather than by ethnicity, and uses a combined minority ethnic category (labelled BAME in the poll). Awareness was lower in this combined minority ethnic group at 35 percent compared with 58 percent for White respondents. Support for Option A at Southport was lower in the combined minority ethnic group at 28 percent compared with 42 percent in the White group. Support for Option B at Ormskirk was higher in the combined minority ethnic group at 45 percent compared with 34 percent in the White group. Interpret these as indicative signals only, because the combined category base size is likely to be small.

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*Travel time was selected as the most important factor by 25 percent of the combined minority ethnic group (labelled BAME in the poll) compared with 17 percent in the White group. Taken together, these signals justify targeted engagement with communities where language, trust, and travel costs may shape access and experience. They also strengthen the case for monitoring impacts by geography and by ethnicity where data quality allows. This will happen post decision and during the implementation phase.*

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### Socioeconomic signals using employment and tenure

Awareness among social renters was low at 26 percent. Social renters were also less likely to say a single site model is a good idea at 32 percent. Travel time was selected as the most important factor by 24 percent of social renters.

These patterns are consistent with wider health inequalities evidence that deprivation, lower car access, and constrained household finances increase the risk of delayed presentation and poorer outcomes. The programme should therefore treat affordability and practical travel barriers as central to its mitigation strategy.

#### Place based signals

Awareness and preferences vary significantly by area. Awareness in the Southport area was 69 percent, compared with 27 percent in Bootle and Litherland. Bootle and Litherland also had a high proportion selecting neither option at 58 percent.

This strengthens the programme health inequalities case for a robust place based mitigation approach, focusing on communities with high neither option responses, limited awareness, and a higher likelihood of relying on public transport or being financially constrained.

### 16.6 Implications for programme decision making and due regard

- The polling supports a clear public priority for clinical quality and 24 hour availability, which aligns with the programme safety and sustainability rationale
- *Travel remains a key concern for a significant minority, and is more salient for some groups such as social renters and the combined minority ethnic group (labelled BAME in the poll)*

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- The high neither option preference indicates a requirement for visible, measurable mitigations and strong reassurance on access
- Awareness gaps are an equality risk and require targeted accessible communications and community based engagement

For Public Sector Equality Duty assurance, the poll can be used as supportive contextual evidence, but it should not be treated as a primary equality evidence source for all protected characteristics. The programme should triangulate these findings with the full consultation dataset, clinical evidence, workforce modelling, and targeted insight from seldom heard communities.

### 16.7 Actions, mitigations, and monitoring required

#### 7.1 Communications and engagement actions

- Targeted awareness raising in localities with low awareness, and among social renters and younger adults
- *Accessible information offer, Plain English, Easy Read, British Sign Language, translations on request, and multiple channels including offline options*

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- Community based engagement through VCSE networks, carers groups, youth services, and faith and community organisations
- Clear patient navigation messages, when to use A and E, urgent treatment centres, GP out of hours, NHS 111, and same day emergency care

### 7.2 Access and travel mitigations

- Transport mitigation package with clear eligibility criteria, focusing on low income households, carers, and those without car access
- 16.8 Travel cost support options
- Public transport mapping and journey planning materials, including step by step travel information and time of day options
- Capacity assurance for local urgent care alternatives in areas with high neither option responses, including additional UTC and SDEC capacity where needed

### 7.3 Mitigations for protected characteristic impacts

- Disability and neurodiversity, ensure reasonable adjustments are built into redesigned pathways, including communication support and flagging systems
- Children and young people, ensure clear paediatric streaming and assessment pathways with safe escalation and safeguarding assurance
- Older people and frailty, ensure access to rapid assessment, falls pathways, and transport support for carers
- Race and ethnicity, strengthen engagement routes and ensure information is culturally appropriate, with translation support where required

### 7.4 Monitoring dashboard and escalation

Monitoring must demonstrate that mitigations are working and that impacts are identified early. The following measures are recommended as a minimum set, reported monthly with quarterly deep dives.

- Emergency attendances and admissions by postcode deprivation quintile and by locality
- Arrival mode, ambulance and walk in, by locality, and by time of day
- Four hour performance and breach reasons, with locality and pathway analysis
- Paediatric urgent care outcomes and escalation events
- Did not wait and left without being seen rates by locality
- Patient experience, complaints and PALS themes linked to access barriers and reasonable adjustment issues

- Equality monitoring where data allows, including ethnicity and disability where recorded in local systems

Escalation routes should be clearly defined through programme governance, with agreed triggers for corrective action, for example sustained deterioration in access metrics for a locality or group, or increasing safety incident themes linked to delayed presentation.

### 16.9 Limitations and next steps

- Subgroup results are indicative and should be triangulated with the consultation dataset and wider intelligence
- The poll does not provide full coverage for all protected characteristics, and should not be used as sole assurance for disability, religion, sexual orientation, pregnancy and maternity, or gender reassignment
- Next steps should include targeted follow up engagement in the next phase of the programme to ensure they are at the heart of future inclusive design, where the signals suggest lower awareness or higher access risk.