Equality Analysis Report
Pre-Consultation

Integration and Reconfiguration Programme - Clinical Service Model Business Case – Urology Services NHS Cheshire and Merseyside

Start Date:	30 May 2022	
Equality and Inclusion Service Signature and Date:	AW/BSS	30/5/22
NHS Cheshire and Merseyside Officer	EH	21/7/22
Senior Manager Sign Off Signature and Date	CH	22/7/22
		

1. Details of service / function:

Overview of services

Urology is the largest surgical specialty after general surgery and orthopaedics and involves the treatment of conditions of the Urinary tract and male genital tract. The includes some very common cancers including prostate cancer (which is now as common as lung cancer and bowel cancer put together), bladder, kidney and testicular cancer and some very common but debilitating benign conditions such as kidney stones (which cause severe pain and affect 6-18% of the population as some point in their lives), lower urinary tract symptoms (affecting about 50% of the population over 50), urinary sepsis and number of other problems.

Urological services for the people of Liverpool have been provided by 2 separate units based in each of the legacy trusts. With the exception of complex cancer work referred through the cancer network and small numbers of other tertiary cases, the units have largely functioned as separate, duplicated services although a common leadership structure has been introduced in 2020.

What is the **legitimate aim** of the service change / redesign

- Demographic needs and changing patient needs are changing because of an ageing population.
- Value for Money-more efficient service
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2. Change to service

Proposed Clinical Model

The proposed clinical model is to configure all in-patient Urology work at the New Royal site with outpatients services to be split between the New Royal and Aintree sites. This will not only improve patient outcomes, access, and experience in addition to the benefits for staff, it also aligns and enables the Trust's wider strategy for the reconfiguration of services across sites working on the principle of centralised where necessary and closer to home where possible. The benefits are manifold and include providing a better patient service, improved working environment, increased support to, and from, interdependent services whilst reducing duplication and improving sustainability. This configuration produces a central high capacity hub to act as a focal point for high quality in-patient care which will achieve:

- ✓ Volume related improvement in clinical outcomes
- ✓ Urology patients more likely to be cared for by urology nurses
- ✓ Urology patients more likely to be cared for by condition-specific subspecialist teams
- ✓ Opportunity to streamline and improve pathways taking the best from each site and working together
- ✓ A more resilient service
- ✓ Better for staff training, career progression and staff retention
- ✓ Substantial reduction in duplication of expensive specialist equipment
- ✓ Much simpler to provide around the clock expert emergency cover
- ✓ Better for innovation, teaching and research
- ✓ Patients can still access the most commonly used services (outpatients) closer to home
- ✓ A balanced approach to proportionate deployment of out-of-hours resources to where most needed while providing a safe and accessible service to other specialties across site

This proposed model was informed by completing an options appraisal, analysing data from 2017 onwards as well as conducting external interviews with other Urology departments who have experienced an integration. Dedicated Urology in-patient beds will no longer be provided at the Aintree University Hospital site. All visitors of Urology in-patients will attend the New Royal Liverpool Hospital

Dedicated Urology in-patient beds will no longer be provided at the Aintree University Hospital site. All patients requiring Urology in-patient care will be admitted to the new Royal Liverpool Hospital. This will improve the quality of care that is delivered and ensure that all patients are able to access the same standardised and consistent care.

Urology outpatient services will be maintained across Aintree and the Royal Liverpool to ensure that patients can continue to access care closer to home where it is clinically appropriate.

Patients, their carers and families and the wider public will be given the opportunity to have their say on the proposed clinical model for the provision of acute Urology services as part of a wider consultation exercise planned for later in the year 2021.

The proposed clinical model set out in the business case will impact on medical and nursing staff groups. The main changes will be linked to the transfer of in-patient Urology care to the New Royal Liverpool Hospital.

Structured staff engagement plans will be developed to ensure that communication and

involvement of affected members of staff are a central part of the business case as it develops, enabling staff to play a meaningful role in shaping and influencing plans.

3. Barriers relevant to the protected characteristics

Guidance note: describe where there are potential disadvantages.

National Context

Patient safety should be important to any clinician, foremost for the wellbeing of the people under their care. General principles of safety can help ensure the best patient outcomes and benefit the clinician. However there are particular problems that need to be considered:

Fatigue – Doctors work long shifts, frequently with little rest. When fatigue sets in, it can be harder to think and concentrate, leading to mistakes.

User Error – In the shift to digital administration, medical errors can occur when a practitioner is unfamiliar with a system or fails to double-check the information put in. A slight misclick on a drop-down menu could lead to a mistake.

Inexperience – Everyone has to start somewhere, but when a new doctor fails to take into account diagnostic tools or symptoms outside their experience, it can lead to a preventable error that could have been avoided.

Human Error – Medical protocols and standards of care are established to ensure that providers perform to a high standard, and when those guidelines and regulations aren't met, it can lead to suffering, sickness, or death

Misdiagnosis

The wrong diagnosis can prove catastrophic to a patient in serious need of medical intervention. The best-case scenario is that the proper treatment is merely delayed, however, it could also turn out far worse. The wrong treatment can leave a condition rapidly worsening into increasingly severe symptoms, and some treatments can be harmful if they aren't being performed for the appropriate reasons.

Delayed Diagnosis

A refusal to believe there is an underlying medical condition can be just as dangerous as a misdiagnosis. Studies have shown that women and minorities experience difficulty in their pain and clinical symptoms being taken seriously by medical practitioners. This can lead to extended periods of suffering and a worsening of the condition before proper medical intervention is offered.

Medication Error

One of the most common medical errors occurs when a patient gets the wrong medication. This can be an error by the doctor, who may select the wrong dosage or enter it into an electronic prescription system incorrectly, or by the pharmacy that's responsible for reading, interpreting, and filling your prescription with the right medication at the right strength and with the correct dosing instructions. A simple preventable medical error like a misplaced decimal can lead to you receiving medication ten times stronger or weaker than what is

needed.

Infection

Medical providers are supposed to operate under protocols that limit the risk of infection. From sterile tools in surgery to frequent cleaning and sanitation, but some infections are resilient. In a hospital setting, MRSA takes constant vigilance, as its resistance to antibiotics makes it both dangerous and hard to treat. Respiratory infections, like Legionnaire's Disease, can spread quickly through care units. With more and more hospitals now rushing to contain the COVID-19 virus, diligence is needed to ensure proper quarantine so that infection can't spread through contaminated surfaces or shared air systems.

Improper Medical Device Placement

Medical devices don't just need to be safe and functional, they also need to be precisely positioned to alleviate a medical concern. Improperly placed stints can cut off the blood supply to areas of the body. Implantable devices can fail to function properly, leading to either a lack of therapeutic effect or life-threatening malfunction.

Men are far more likely to have urological problems. ***Women*** have urological problems too, but less frequently. The statistics on male/female patient shows this relationship.

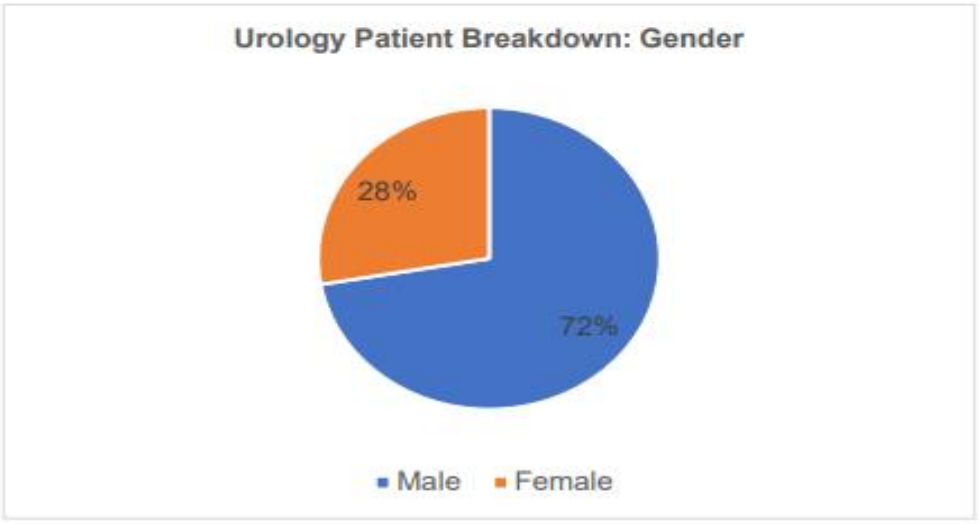
Whilst a person of any ***age*** could need urological advice and treatment it tends to be older men and women post pregnancy that need support and treatment.

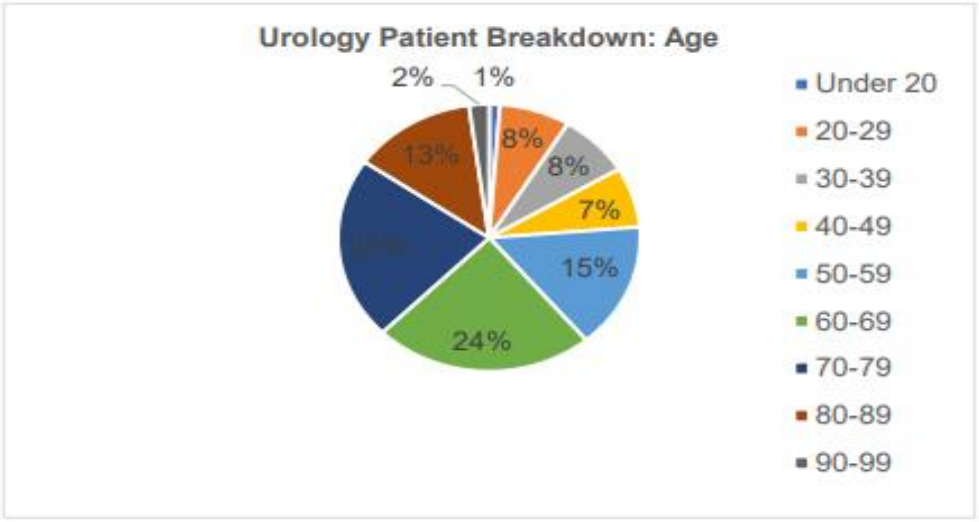
Race:[1] Men of African ancestry have demonstrated markedly higher rates of prostate cancer mortality than men of other races.

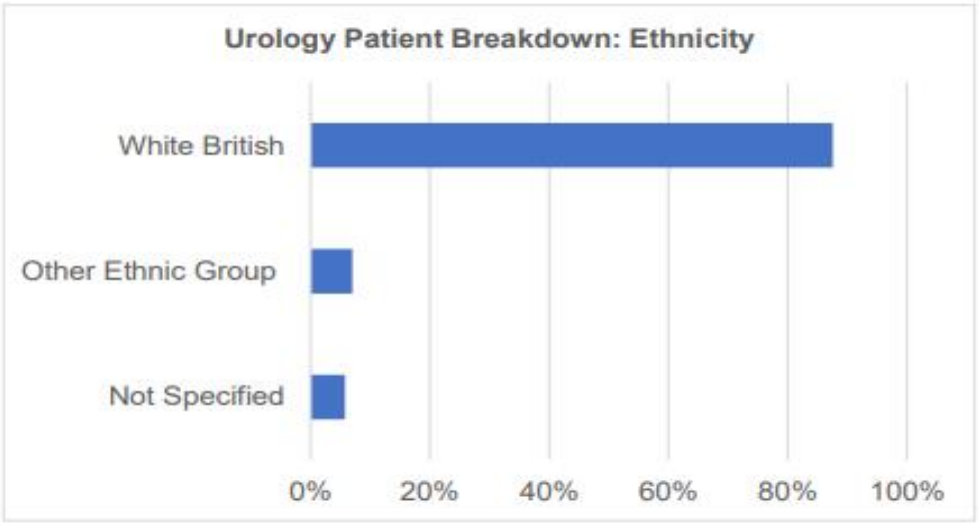
LGBT primary care physicians who will see LGBT persons with urologic issues and to urologists who may not be familiar with issues germane to the LGBT community. Need to focus on urologic issues for which there is evidence of significant differences between LGBT and non-LGBT patients. Specific areas include symptoms and medical/surgical management of lower urinary tract symptoms, sexual function and dysfunction in LGBT patients, the impact of HIV on the genitourinary (GU) tract, as well as unique considerations for screening and counselling LGBT patients regarding GU malignancy. There are unique urologic needs of LGBT patients that link to improving quality of care for this patient demographic.

Disability: The need to address the health needs and provide equity of access to health care for people with intellectual disabilities has been highlighted nationally within the UK. Despite a similar likelihood (if not an increased likelihood) of urological problems among people with intellectual disabilities, there are challenges that may be encountered in seeking to provide care and support a person with intellectual disabilities who may require the support of a urology nurse and provides some suggestions for practical actions to respond effectively.

[1] Deconstructing, Addressing, and Eliminating Racial and Ethnic Inequities in Prostate Cancer Care 2022 https://www.sciencedirect.com/science/article/abs/pii/S0302283822016773?via%3Dihub


Urology Patient Breakdown: Gender
28%
72%
Male
Female


Urology Patient Breakdown: Age
2%
1%
8%
8%
7%
15%
24%
13%
Under 20
20-29
30-39
40-49
50-59
60-69
70-79
80-89
90-99


Urology Patient Breakdown: Ethnicity
White British
Other Ethnic Group
Not Specified
0%
20%
40%
60%
80%
100%

Protected Characteristic	Issue	Remedy/Mitigation
Age	Older people For a number of patients requiring in-patient urological, the transfer to the RLH sites will be required. This could disproportionately impact older people who will need to travel further to access the care they require.	Where patients meet the criteria, the Trust policy for non-urgent patient transport would support this patient cohort. Notes for Consultation: Ensure questions asked about transport and extra travel. Older people are less likely to own cars and rely on public transport or friends/family with cars Transport Impact assessment needs to be undertaken
Disability	Accessing healthcare services can often present a challenge for people living with a disability. The need to address the health needs and provide equity of access to health care for people with intellectual disabilities has been highlighted nationally within the UK. Despite a similar likelihood (if not an increased likelihood) of urological problems among people with intellectual disabilities, there are challenges that may be encountered in seeking to provide care and support a person with intellectual disabilities who may require the support of a urology nurse and provides some suggestions for practical actions to respond effectively.	The reconfiguration case sets out a clinical model for Urology services with simplified and equitable access for all. Notes for Consultation: Ensure people with disabilities & organisations representing people with disabilities are included in the consultation programme and can report on their experiences of using NHS services. Ensure questions asked about transport and extra travel ,for themselves and carers Transport Impact assessment needs to be undertaken For Trusts: Performance data need to be presented

		on how people with disabilities(and their carers) are supported and what reasonable adjustment have been made to accommodate particular need. As part of the transforming of service and service design ensure disabled people are part of the planning and design process.
Gender reassignment	Primary care physicians who will see LGBT persons with urologic issues and to urologists who may not be familiar with issues germane to the LGBT community. Need to focus on urologic issues for which there is evidence of significant differences between LGBT and non-LGBT patients. Specific areas include symptoms and medical/surgical management of lower urinary tract symptoms, sexual function and dysfunction in LGBT patients, the impact of HIV on the genitourinary (GU) tract, as well as unique considerations for screening and counselling LGBT patients regarding GU malignancy. There are unique urologic needs of LGBT patients that link to improving quality of care for this patient demographic.	Ensure trans people & organisations representing trans people are included in the consultation programme and can report on their experiences of using NHS services. Trusts: ensure staff are trained and understand the needs of the LGBT community and how they differ from non LGBT
Marriage and Civil Partnership	Having visitors and being supported by loved ones are important aspects to recovery. Wherever possible spouses and partner should be welcomed in to see the patient. Distance to hospital may have a bearing on being able to visit.	Ensure that any covid restrictions are necessary and wards work towards allowing close visitors to see patients. Consultation: Ask questions about visitation and the impact it might have on visiting due to relocation. Ask question about 'how people travel to the hospital' car/bus etc
Pregnancy and maternity	Pregnant patients may present with urological problems that necessitate management. Concerns over maternofoetal	Consultation: Where possible include pregnant women as

	safety are paramount and add a layer of complexity in the urologist's approach to treatment. It is important to understand the physiological changes associated with pregnancy and to familiarize oneself with the risks and benefits of management strategies in order to provide the highest level of care to this population. A multidisciplinary approach is advised, ensuring the patient's obstetrician is informed of urological interventions planned[2]	part of the consultation process. Trust: Issue data on how pregnant women have been treated and the outcomes.
Race	Race: Men of African ancestry have demonstrated markedly higher rates of prostate cancer mortality than men of other races. This can be linked to late entry into the medical system and how they are treated by the medical profession	Ensure black and ethnic minorities & organisations representing Black and ethnic minorities are included in the consultation programme and can report on their experiences of using urology / NHS services. Trust: Data showing ethnic minority doesn't reflect the demographic of the community . more work must be done to capture race protected characteristic and to show results of their treatment against white counterparts. Ensure staff are not discriminating As part of the transforming of service and service design ensure people of different races are part of the planning and design process.
Religion and belief	Healthcare services have a legal duty under the Equality Act 2010 to treat people of different faiths and beliefs fairly and without discrimination. However, people	As part of consultation gather feedback on experiences of from different faith groups

[2] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7716830/

	continue to face barriers and discrimination in accessing healthcare and how they are treated by staff today	who have undergoing surgical treatments for comparison. As part of the transforming of service and service design ensure people of different faiths are part of the planning and design process.
Sex (M/F)	More men than women need urological intervention.	Ensure men are major part of the consultation process and play an active part in the redesign of services As part of consultation gather feedback on experiences of both men and women who have undergoing surgical treatments for comparison.
Sexual orientation	Primary care physicians who will see LGBT persons with urologic issues and to urologists who may not be familiar with issues germane to the LGBT community. Need to focus on urologic issues for which there is evidence of significant differences between LGBT and non-LGBT patients. Specific areas include symptoms and medical/surgical management of lower urinary tract symptoms, sexual function and dysfunction in LGBT patients, the impact of HIV on the genitourinary (GU) tract, as well as unique considerations for screening and counselling LGBT patients regarding GU malignancy. There are unique urologic needs of LGBT patients that link to improving quality of care for this patient demographic.	Ensure LGB people & organisations representing LGB people are included in the consultation programme and can report on their experiences of using NHS services.

4. Does this service go the heart of enabling a protected characteristic to access health and wellbeing services?
Yes
5. Consultation
Guidance note: How have the groups and individuals been consulted with? What level of engagement took place? (If you have a consultation plan insert link or cut/paste highlights)

Consultation to be planned for June/July BY LCCG's comms team.
6. Have you identified any key gaps in service or potential risks that need to be mitigated
There are a number of gaps in the information: **1. results of treatment by protected characters** **2. Transport assessment on the potential impact on change of location** **3 Health inequality report – identifying parts of the community that may be more prone to urological problems linked to lifestyle.** **4. data on reasonable adjustment for disabled people that have been made for patents in urology.** Urology, like all other services, make the claim that they are modernising and will be providing a better service to the patient. Base line data needs to be developed so this assertion can be assessed at a later date. How exactly will the changes benefit the patients and how can this extra performance be monitored?

Risk	**Required Action**	**By Who/ When**
Transport Impact assessment needs to be undertaken	Complete transport analysis	CCG/Trust. Before final decision is made and part of the decision makers contemplations.
For Trusts: Performance data need to be presented on how people with disabilities are supported and what reasonable adjustment have been made to accommodate particular need.	Produce performance data linked to all protected characteristics.	Trust
Data showing ethnic minority doesn't reflect the demographic of the community . More work must be done to capture race protected characteristics of patients and to show results of their treatment against white counterparts.	Produce performance data linked to all protected characteristics.	Trust

7. Is there evidence that the Public Sector Equality Duties will be met (give details) Section 149: Public Sector Equality Duty (review all objectives and relevant sub sections)
PSED Objective 1: Eliminate discrimination, victimisation, harassment and any unlawful conduct that is prohibited under this act: (check specifically sections 19, 20 and 29)
Analysis post consultation
PSED Objective 2: Advance Equality of opportunity. (check Objective 2 subsection 3 below and consider section 4)
Analysis post consultation
PSED Objective 2: Section 3. sub-section a) remove or minimise disadvantages suffered by people who share a relevant protected characteristic that are connected to that characteristic.
Analysis post consultation
PSED Objective 2: Section 3. sub-section b) take steps to meet the needs of people who share a relevant protected characteristic that are different from the needs of people who do not share it
Analysis post consultation
PSED Objective 2: Section 3. sub-section c) encourage people who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such people is disproportionately low.
Analysis post consultation
PSED Objective 3: Foster good relations between persons who share a relevant protected characteristic and persons who do not share it. (consider whether this is engaged. If engaged consider how the project tackles prejudice and promotes understanding -between the protected characteristics)
Analysis post consultation
Health Inequalities: Have regard to the need to reduce inequalities between patients in access to health services and the outcomes achieved (s.14T);
[ENTER RESPONSE HERE]
PSED Section 2: Consider and make recommendation regards implementing PSED in to the commissioning process and service specification to any potential bidder/service provider (private/ public/charity sector)
Analysis post consultation
8. Recommendation to Board
Guidance Note: will PSED be met?
Analysis post consultation
9. Actions that need to be taken
Analysis post consultation