Equality Analysis Report
Pre-Consultation

Integration and Reconfiguration Programme - Clinical Service Model Business Case – Nephrology Service 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:

The Trust faces a number of challenges in the provision of an optimal, multifaceted Nephrology Service.

The existing service model is characterised by unwarranted clinical variation across sites, with a lack of standardisation and consistency in the quality of, and access to, services provided.

The LUHFT patient population is ageing, with higher levels of deprivation and an increasing prevalence of co-morbidities compared to regional and national averages.

The proposed Nephrology Clinical Model, as set out in the business case, tackles the unwarranted variation that exists and enables a standardised and consistent Nephrology Service to be embedded, that is equitably accessible to all patients based on their individual level need, irrespective of where they live.

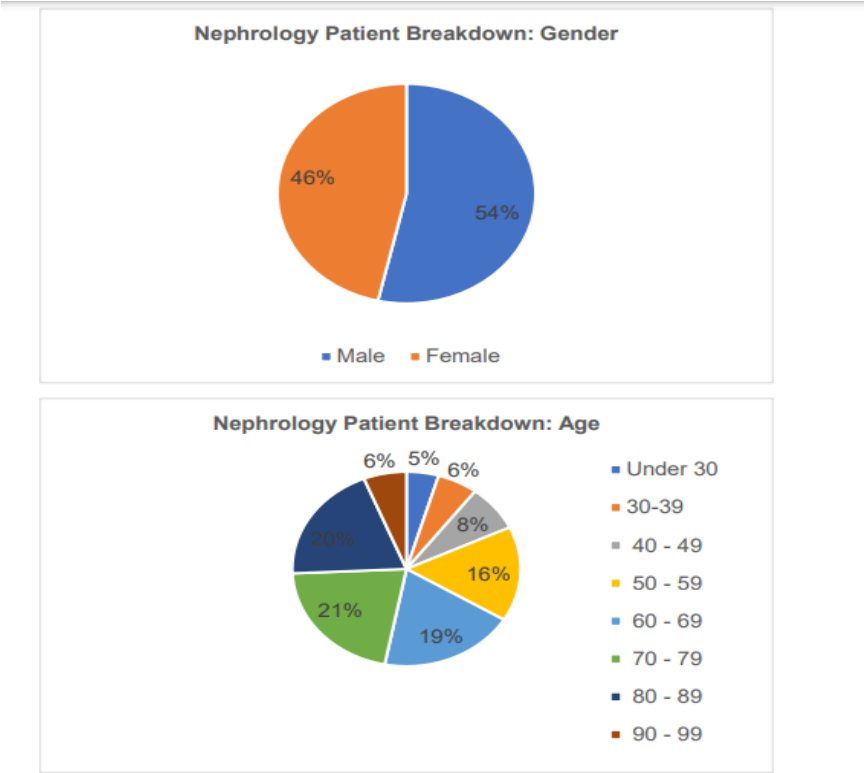
The proposed clinical model centralises Nephrology in-patient services onto the new Royal Liverpool Hospital site, with the provision of in-reach consultant cover at the Aintree University Hospital site to ensure appropriate care for patients with kidney disease as a co-morbidity.

The new Royal Liverpool Hospital features purpose-built wards, specifically designed to meet the complex care needs of Nephrology patients.

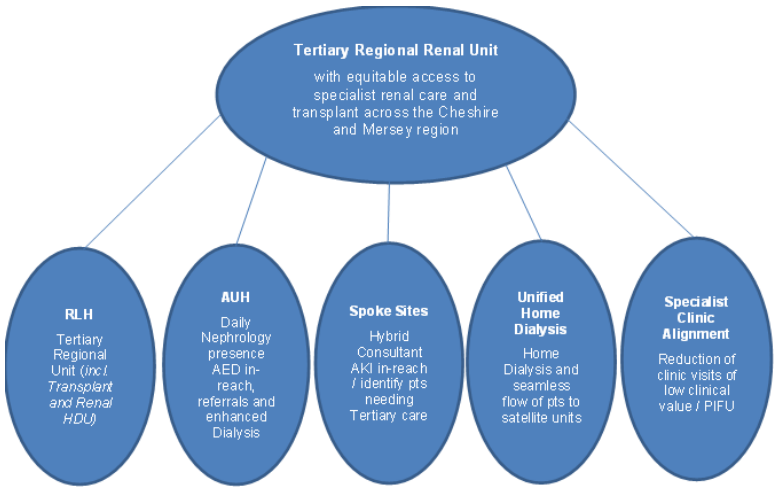
Under the proposed clinical model, the Aintree University Hospital site will retain a daily Nephrology Consultant presence, as well as utilising Advanced Nurse Practitioners to specifically cover in-house referrals.

This model enables care to be provided to Aintree in-patients who are diagnosed with AKI, as a co-morbidity, but remain under the care of another department, allowing those patients to continue to receive timely, specialist renal care without compromising the care they need for their primary diagnosis.

Referrals from Aintree to the new Royal Liverpool Hospital site will be made when clinically necessary. A 'treat and transfer' model will be embedded for all urgent and emergency patients.



The proposed Nephrology Clinical Model:



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

- Demographic needs and changing patient needs are changing because of an ageing population.
- To increase choice of patients
- Value for Money-more efficient and equitable service for patients

2. Change to service

Dedicated Nephrology in-patient beds will no longer be provided at the Aintree University Hospital site.

All patients requiring dedicated Nephrology in-patient care will be admitted to the new Royal Liverpool Hospital, which houses purpose-built Nephrology in-patient beds. 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.

Nephrology Consultant and ANP cover will be maintained at the Aintree University Hospital site to ensure that patients with co-morbidities can continue to receive standardised and consistent renal services whilst accessing the care they need for their primary diagnosis.

The model will deliver better access to transplantation, better access to dialysis vascular access services and more opportunity for home dialysis.

Satellite dialysis units will continue to facilitate treatment near to home. The reconfiguration set out in the clinical model will ensure that older people who require Nephrology services will have equity of access based on their need, regardless of where they live, and will provide a standardised quality of care that is delivered by a skilled and experienced workforce.

Out-patient and diagnostic services remain on both sites, minimising the need to travel for clinic attendance

3. Potential barriers relevant to the protected characteristics

Guidance note: describe where there are potential disadvantages.

National context

Kidney disease can develop at any time, but those over the age of 60 are more likely than not to develop kidney disease. As people age, so do their kidneys.

According to recent estimates from researchers at Johns Hopkins University, more than 50 percent of seniors over the age of 75 are believed to have kidney disease. Kidney disease has also been found to be more prevalent in those over the age of 60 when compared to the rest of the general population

- Kidney disease kills more people each year than breast or prostate cancer.
- Risk factors for kidney disease include high blood pressure, diabetes, kidney stones, a family history of kidney failure, prolonged use of over-the-counter pain medications, and being over the age of 60

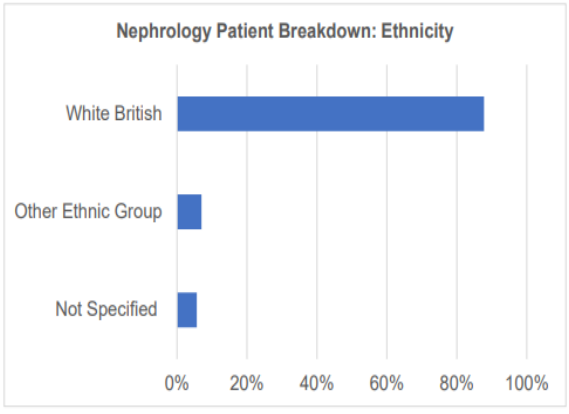
- Kidney failure is up to five times more common in people from minority ethnic groups.
- Many spouses talk about how living with a sick partner weighs down on them, causing severe fatigue. Some aspects of the illness can also become traumatic. The disease regularly disrupts the daily life of the couple and the family. This can lead to a breakdown / reworking of family relations

Protected Characteristic	Issue	Remedy/Mitigation
Age	Older people, particularly those with co-morbidities, are disproportionately affected by renal conditions compared to younger adults. The LUFT patient population is both ageing and characterised by multi-morbidities and higher levels of deprivation compared to national averages. However, the transfer of in-patient services from the AUH to RLH site could disproportionately impact older people who will need to travel further to access the care they require	The patient profile shows and overwhelming number of older service users. **Consultation:** Ensure that all age ranges take part in the process and ask about: 1 level of satisfaction with treatment 2.travel and difficulties with travel (older people tend to not own cars) 3 family support – where they draw support from at home (as many will be living alone)
Disability	People with learning disabilities are much more likely than the general population to have significant health risks and major health problems (Disability Rights Commission, 2006). It is often harder for them to access assessment and treatment (Michael, 2008). As a result, more have complex health needs and are at an increased risk of developing age-related health problems such as CKD (Barr, 2004). Adjustments are not always made to allow for communication problems, cognitive impairment or anxieties and preferences concerning treatment (Michael, 2008). This group will often need more support to	The reconfiguration case sets out a clinical model for Nephrology services with simplified and equitable access for all. Access to dialysis services at home, where it is clinically appropriate, will be improved, which may benefit patients and carers of people living with a disability.

	understand information and to communicate concerns[1]	Satellite dialysis units will continue to facilitate treatment near to home Show data on outcomes of disabled patients. **Consultation:** Ensure carers and disabled community are part of the process and their views are clearly expressed. Consider accessibility of consultation process and reasonable adjustment to ensure participation.
Gender reassignment	There are limited studies regarding the intersection of transgender persons and kidney disease and those that exist are mostly case reports[2]. Transgender persons are at an increased risk of adverse outcomes compared with the cisgender population. Individuals with CKD have a degree of hypogonadotropic hypogonadism and decreased levels of endogenous sex hormones; therefore, transgender persons with CKD may require reduced exogenous sex hormone dosing.	Ensure staff are aware and up to date n the needs of trans patients and how to work and support them. Check training records to ensure staff are appropriately trained. **Consultation:** Ensure trans community is part of the consultation process .
Marriage and Civil Partnership	Chronic kidney failure is a serious somatic disease. Addressing the issue of living with a chronic disease means fully considering the patients' entourage, their families, and those close to them, especially their children and spouses. Some couples show considerable resourcefulness. However, over the years, that capacity for adaptation and inventiveness can also be interrupted by the periods of greater suffering and even despair, especially when the somatic	The disease regularly disrupts the daily life of the couple and the family. As it emerges, it can disrupt the bonds of filiation, especially when the illness is hereditary. It's vital that support to the family is available to help them understand what is

[1] Jenkins, J.P. et al (2008) Explaining renal treatment to people with learning disabilities. Nursing Times; 104: 44, 28–29

[2] https://pubmed.ncbi.nlm.nih.gov/33552529/

	pathology becomes chronic. Many spouses talk about how living with a sick partner weighs down on them, causing severe fatigue. Some aspects of the illness can also become traumatic. The disease regularly disrupts the daily life of the couple and the family. This can lead to a breakdown / reworking of family relations[3].	happening and what the patient is going through. Making psychological care more accessible to partners is a real need. **Consultation:** Ensure that partners of patients are included Ask about what support hey have received/ or have identified as a need.
Pregnancy and maternity	Some changes in the female body make it hard to become pregnant. For example, most women on dialysis have anaemia (a low red blood cell count) and hormone changes. This may keep them from having regular menstrual periods. ***Women with kidney failure are usually advised against becoming pregnant***. The rate of complications is very high. Risks to both the mother and developing baby are high[4]. After having a kidney transplant, women are likely to have regular menstrual periods and good general health. Therefore, getting pregnant and having a child is possible.	Ensure younger women are part of the consultation process.
Race		Population by ethnicity Variable Liverpool White British 84.8% White Irish 1.4% White Other 2.6% Mixed ethnicity 2.5% Asian/Asian British 4.2% Black/African/Caribbean/Black British 2.6%

[3] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8121455/

[4] https://www.kidney.org/atoz/content/pregnancy#:~:text=Women%20with%20kidney%20failure%20are,talk%20to%20your%20healthcare%20provider.

	Kidney failure is up to five times more common in people from minority ethnic groups. It's not yet fully understood why minority ethnic groups are more at risk of kidney disease, but it could be due in part to high rates of diabetes and high blood pressure in these racial groups, as these are the most common causes of kidney failure. Asian people with diabetes are ten times more likely to suffer from kidney failure compared to white people with diabetes People from minority ethnic groups are more likely to need a kidney transplant, but less likely to receive one due to a shortage of donors. Tissue and blood types need to match for a successful transplant. And although many minority ethnic group patients are able to receive a transplant from a white donor, for many the best match will come from a donor from the same ethnic background. • A third of people (35 per cent) waiting for a kidney across the UK are from minority ethnic groups but in 2017/18, of those providing their ethnicity when registering on the NHS Organ Donor Register, only 3.3 per cent were Asian, 1 per cent were black and 2 per cent were mixed race. • Only 28 per cent of UK kidney transplants in 2017/18 were in minority ethnic groups. • There is a longer waiting time for kidney transplants for black and Asian patients compared to white patients (with and average wait of approx. 2.5 years compared to an average 2 year wait for a white patient)[5].	Other ethnicities 1.8% **Source: Census 2011 England and Wales Service users roughly coincide with actual demography of Liverpool. Although it's not clear which ethnic groups are attending. Data needs to include : • Protected characteristic of service user. • Outcome of treatment by protected characteristic. • Comparison of results by Protected characteristic **Consultation**: Ensure black and ethnic minority communities are part of the consultation process. As part of the consultation process it will be worth while to give information out on organ donation and to encourage this from Black and minority communities

[5] https://www.kidneyresearchuk.org/kidney-health-information/about-kidney-disease/am-i-at-risk/kidney-disease-in-minority-ethnic-groups/

Religion and belief	Culture and religion influence the way both health professionals and patients view treatments. It's important for carers to become aware of their own personal background and beliefs, to explore how these can play a role in the way they deliver care.	Dr/Nurses/Carers to become familiar with a number of other cultures and religions in order to relate better to all patients. Ensure appropriate training is available and staff access the training. **Consultation:** Ensure people from different faith and belief backgrounds are included in the process.
Sex (M/F)	The patient profile shows 46% female and 54% male service users. Sexual dysfunction is a common finding in both men and women with chronic kidney failure. Common disturbances include erectile dysfunction in men, menstrual abnormalities in women, and decreased libido and fertility in both sexes. These abnormalities are primarily organic in nature and are related to uraemia as well as the other comorbid conditions that frequently occur in the chronic kidney failure patient. Fatigue and psychosocial factors related to the presence of a chronic disease are also contributory factors.	Ensure that all aspects of quality of life are supported for both men and women - who may have different concerns. Data on outcomes by sex to identify any outcomes that may link to discrimination or difference in quality of service or need of patient **Consultation:** Ensure both men and women are part of the process and to ask participant questions linked to fair treatment.
Sexual orientation: LGBQ+	One study published in August 2020 called "Ensuring Gender-Affirming Care in Nephrology" recommended that "the nephrology workforce implement the following actions to enhance…care:" • Use affirming language when talking with patients. • Promote tools to improve care for LBGQT+ patients across all clinical environments. • Improve inclusive engagement of individuals in research and in the workforce.	Dr/Nurses/Carers to become familiar with LGBQ+ cultures and in order to relate better to all patients. Ensure appropriate training is available and staff access the training. **Consultation:**

	• Advocate for and implement non-discrimination policies that explicitly include gender identity, sex, and sexual orientation to protect all patients.	Ensure people from LGBQ+ groups are included in the process.

4. Does this service go the heart of enabling a protected characteristic to access health and wellbeing services?
It's a vital service with an ever growing demand as the population ages.
5. Consultation
LCCG is developing the consultation programme
6. Have you identified any key gaps in service or potential risks that need to be mitigated

Risk	**Required Action**	**By Who/ When**
Service Data is not presented showing numeric through put of patients at different sites and outcomes for patients categorised by protected characteristics .	1. Number of service users need to be shown as well as % 2. Outcome of treatment by protected characteristics. 3. Comparisons of outcomes by protected characteristic (e.g. differences in male and female outcomes)	LUHFT Before final Equality Assessment.
Show Evidence of Training / skills/ experience of supporting: • Trans patients • LGBQ+	Examine training records and/or develop initiatives that support workers to meet specific needs.	LUHFT - On going.

• Black and ethnic minority groups • Different religious and beliefs		

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);
Analysis post consultation
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?
response post consultation
9. Actions that need to be taken
RESPONSE post consultation