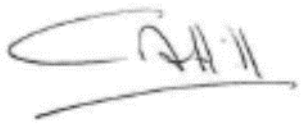
Equality Analysis Report
Pre-Consultation

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

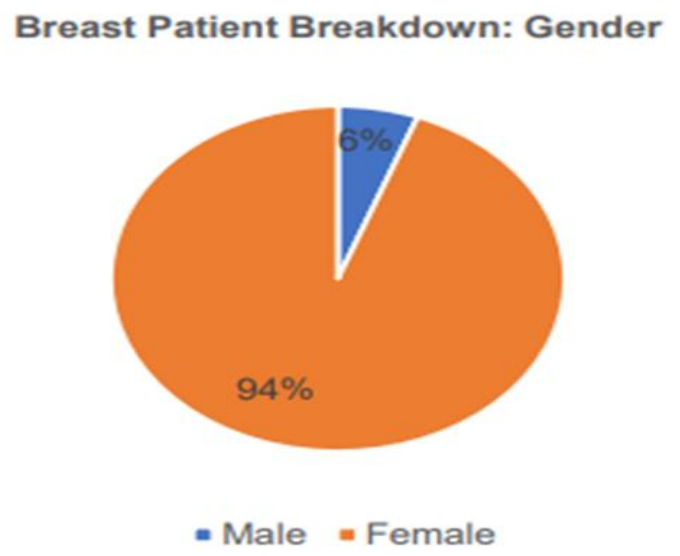
Start Date:	30 May 2022	
Equality and Inclusion Service Signature and Date:	AW/BSS	30/5/22
NHS Cheshire and Merseyside Officer	EH	21/7/22
Senior Manager Sign Off Signature and Date	CH	22/7/22
		

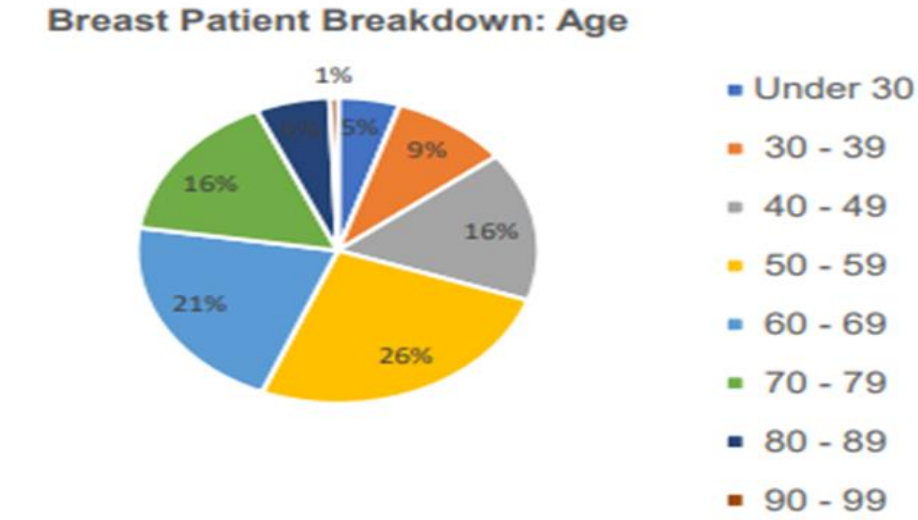
1. Details of service / function:

Overview of Services

The Breast service is a specialist unit for the diagnosis and treatment of benign breast disorders and breast cancer. The service aims to provide a world class individualised service to patients with breast concerns throughout the highly specialised multidisciplinary team that take pride in offering patients an efficient, high-quality service.

Breast services for the people of Liverpool are currently being provided by two separate units at Aintree University Hospital and the Royal Liverpool Hospital. The ground floor of the Elective Care Centre, located on the Aintree site, accommodates the Aintree Breast Unit and the Breast Unit at the Royal site is situated on the third floor of the Linda McCartney Centre. Both centres have worked closely pre merger, however in line with the Trust wide integration agenda the teams are working towards aligning clinical pathways as well as providing an equitable service for our patients across the geographic catchment area





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 and equitable service for patients

Case for Change – Current Challenges

The greatest challenges within the Breast service currently, is that of capacity, as well as the different care pathways that exist.

These challenges impact on the Trust's ability to provide timely access to care and subsequently on patient outcomes and experience.

This also affects the services ability to standardise care and operate as an integrated

and merged service.

2. Change to service

Proposed Clinical Model

Overview

The proposed model is for all surgery, both cancer and benign, to be consolidated at the New Royal Liverpool Hospital site. This model includes an allocation of 2 dedicated Breast inpatient beds, as well as 6 day case beds. Outpatients, diagnostic and surveillance services would remain at both sites, however Aintree Hospital patients who require cancer treatment or surgery would be referred to the Royal Site.

Changes for patients & visitors

Breast surgery and in-patient beds will all be accommodated on the New Royal Liverpool Hospital site. All patients requiring Breast surgery and in-patient care will be admitted to the Royal, which will house increased theatre and bed capacity and will benefit from being co-located with other cancer specialties. This will improve the quality of care that is delivered and ensure that all patients are able to access safe, timely and consistent care.

All outpatient diagnostic, and surveillance services will remain at the Royal Liverpool Hospital and Aintree Hospital Sites, maintaining patient choice where it is clinically appropriate. Furthermore, Breast Screening Services will remain at Broadgreen Hospital as part of the NHS Breast Screening Programme.

The proposed clinical model will impact visitors due to centralising location that may have an effect on travel and traveling. Breast in-patient and Day Case beds will be provided at the Royal Liverpool Hospital. All visitors of Breast in-patients will attend the Royal Liverpool Hospital Site.

3. Barriers relevant to the protected characteristics

Guidance note: describe where there are potential disadvantages or discrimination

National context

Breast cancer is now the most common cancer in the UK. It is by far the most common cancer in women.

1 in 7 women in the UK develop breast cancer during their lifetime.

In 2017 in the UK there were around 54,700 women and 390 men diagnosed with breast cancer.

Anything that increases the risk of getting a disease is called a risk factor.

Having one or more of the following risk factors doesn't mean that you will definitely get breast cancer. Many people who have these factors never get it and some people with no risk factors develop it.

- Being overweight or obese
- Alcohol
- Contraceptive pill

- Hormone replacement therapy (HRT)
- Being inactive

Risks that you can't change

- Getting older
- Family history and inherited genes
- X–rays and radiotherapy (ionising radiation)
- Diabetes
- Dense breast tissue
- Benign breast disease
- DCIS or LCIS
- Age when periods started and stopped
- Sex hormones and other hormones
- Ethnicity
- Previous cancer
- Height
- Not having children or having them later in life

Where there isn't clear evidence, some factors might increase the risk of breast cancer but there is not enough evidence to be sure.

- Diet and breast cancer risk
- Smoking

Source: Cancer Research UK (link below for further contextual information)

Risk factors for breast cancer | Breast Cancer | Cancer Research UK

The proposal

The proposed changes tackles capacity issues and variations in care that currently impact on the Breast service, which often lead to delays in care, duplicate tasks and appointments with patients which is impacting on the experience of care and the health outcomes for patients.

Through the proposed model, access to Breast services will be improved and the capacity of the service increased, which will benefit all patients.

Protected Characteristic	**Issue**	**Remedy/Mitigation**
Age	The data shows that the largest age group requiring treatment are women who are 50+ in age. Under 30's are the smallest cohort of patients. Breast cancer in women under 30 is rare.	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. Where patients meet the criteria, the Trust policy for non-urgent patient transport would support this patient cohort. Out-patient and diagnostic services remain on both sites, minimising the need to travel for clinic attendance. Consultation: Ensure adult women of all ages are included in the process.
Disability	Women with disabilities who develop early-stage breast cancer, for these women, cancer treatment decisions often must consider important factors beyond tumour characteristics. Patients must weigh the clinical implications of their underlying medical conditions for cancer treatments and side effects, as well as very practical questions, such as the potential effect on independent living, performance of daily activities, and use of mobility aids requiring upper body and arm strength and agility. Cancer could complicate patients' perceptions of their physical and emotional well-being that are already tied, in complex ways Severely physically disabled women report difficulty obtaining mammograms, primarily because of inaccessible equipment, positioning problems, and difficulties with uncontrollable movements. Severely physically disabled women often	Clinicians must consider women's disability and mobility functioning in making therapeutic recommendations to women with impairments or mobility difficulties who develop breast cancer. People with disabilities need to be encouraged to undergo all available treatment appropriate to them. The Trust is under a legal duty to ensure that all reasonable adjustments are made for disabled people. This includes types of treatment and use of

	make decisions[1] about surgical approach and chemotherapy by explicitly considering how various therapies would affect their arms, which are essential to their mobility (they use ambulation aids, self-propel manual wheelchairs, or otherwise rely on their arms for mobility or safety). Managing at home after surgery posed major mobility challenges, especially for women who lived alone. Physically disabled women reported feeling they suffered more chemotherapy side effects than do women without mobility problems. Weight gains with endocrine therapy can compromise the mobility of disabled women. Women with disabilities had higher breast cancer mortality rates and were less likely to undergo standard therapy after breast-conserving surgery than other women. Differences in treatment did not explain the differences in breast cancer mortality rates[2]	equipment and support packages post treatment. PSED is extremely clear on the issue that disabled people may need more resources in order for them to have comparable services and outcomes to non-disabled people. The Trust needs to provide (or develop) data which shows clinical performance linked to protected characteristics, in particular, that of disability in relation to patient outcomes and satisfaction levels of received treatment. Consultation: Ensure disabled people and disability groups are included in the consultation and can take part in discussions of how to develop and provide breast cancer ser vice to disabled people. Ensure that there are different method used to engage with disabled groups (sensory impairment and learning difficulties)
Gender reassignment	Transgender women (male sex assigned at birth, female gender identity) using hormone treatment show an increased risk	Trans patients often report the fact that they fell they are treated

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3052272/
[2] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2442165/

	of breast cancer compared with the general male population[3] Transgender men (female sex assigned at birth, male gender identity) had a lower risk compared with the general female population Although the risk in transgender women increased during a relatively short duration of hormone treatment, it is still lower than the general female population. As such, researchers say the absolute risk of breast cancer in transgender people remains lower that in the general female population, and therefore current breast cancer screening guidelines are sufficient for transgender people using hormone treatment. Previous studies have shown that hormone replacement therapy (HRT) increases the risk of breast cancer in postmenopausal women, which could suggest a similarly increased risk in trans women receiving hormone treatment. But information about the risk of breast cancer in transgender people is currently limited. Researchers conclude that "the absolute overall risk of breast cancer in transgender people remains low and therefore it seems sufficient for transgender people using hormone treatment to follow screening guidelines as for cisgender people."	poorly by NHS staff and services. Every effort must go in to educating staff and making sure that they are respectful and supportive of all patients. Training records may need to be reviewed to ensure that trans awareness and the treatment of trans patients are covered. Ensure services are delivered to trans patients and that information is given to the Trans community. Consultation: Ensure Trans community is included in consultation programmes.
Marriage and Civil Partnership	A study published in the journal Cancer found that married women diagnosed with a serious illness were six times more likely to be divorced or separated than a man with a similar diagnosis. In the study sample the divorce rate was 21% of women and only 3% of men.	Ensure that patients are linked/signposted (have leaflets) to services that support relationships and the breakup of relationship.
Pregnancy and maternity	Breast cancer during pregnancy is rare. Research[4] shows that breast cancer is	Ensure there are appropriately trained

[3] https://www.bmj.com/company/newsroom/study-shows-increased-risk-of-breast-cancer-in-transgender-women/

	reported in 1 in every 3,000 pregnancies. Most women are between 32 and 38 years old at diagnosis. Most are able to carry on with their pregnancy. Rarely, some women may need to think about whether to end the pregnancy (termination). Doctor will discuss your options but they may recommend it if you: • need chemotherapy • are less than 14 weeks pregnant Even then, it might be possible to delay your chemotherapy treatment until you are more than 14 weeks pregnant. Deciding to end your pregnancy is a very difficult decision and only you can make it.	cancer nurses available to discuss all the patients' options.
Race	A large prospective cohort study of middle aged women in the UK has shown that differences in breast cancer incidence by ethnicity are largely explained by differences in prevalence of known risk factors for the disease such as parity and breastfeeding, obesity, alcohol consumption and use of hormone replacement therapy[5] white women are far more prone to breast cancer due to the lifestyle choices and age compared to other black and minority women. For example many ethnic minority populations are significantly younger compared to the indigenous white population e.g. 80% of the black African population in England is under the age of 50 Outcomes from breast cancer for women in the UK have improved significantly over recent decades. These gains are largely attributable to a combination of earlier diagnosis and access to treatments delivered to patients by the National Health Service irrespective of cost. Ethnic minority	NHS England, NHS Improvement National cancer patient experience survey https://www.ncpes.co.uk/ (2019) (accessed March 2021 NHS is aware of treatment disparities between black and white patients. Trust to publish outcome figures and treatment of patient satisfaction levels between white and Black minority patients. Consultation: Ensure black and minority communities are included in consultation process. Liverpool is a

[4] https://www.cancerresearchuk.org/about-cancer/breast-cancer/living-with/breast-cancer-during-pregnancy

[5] https://www.sciencedirect.com/science/article/pii/S0748798321006971

	groups make up almost fifteen percent of the UK population and there is concern however that these groups may have poorer outcomes from the disease. Ethnic minority women, especially young black women, have been reported to have more aggressive tumour profiles compared to white women which may explain some of the observed survival differences[6]. Breast cancer tumour biology is related to age at diagnosis, with younger women in general presenting with more aggressive features. The National Cancer Patient Experience Survey audits experiences in a sample of cancer patients annually[7]. Poorer experience of cancer care is consistently reported in ethnic minority groups but the reasons for this are poorly understood and is this constitutes an important area of future research.	multicultural city and consultation needs to reflect that fact.
Religion and belief	The uncertainty about the influence of religion on cancer screening use is further increased by the diverging pathways[8]: On the one hand, the social and integrative aspect of religion may enhance screening rates among religious individuals, as a higher social support is associated with increased utilization of preventive health services. Furthermore, it is hypothesized that religious individuals score higher among personality traits such as conscientiousness, which are also related to an increased use of preventive cancer medicine.	Ensure that patients can practice their religion and have access to prayer/contemplation rooms. Ensure that staff are supportive of different religions and respectful. Ensure that training is available for all staff on understanding different needs linked to different religions and

[6] E. Copson, B. Eccles, T. Maishman, S. Gerty, L. Stanton, R.I. Cutress, et al.
Prospective observational study of breast cancer treatment outcomes for UK women aged 18-40 years at diagnosis: the POSH study
J Natl Cancer Inst (Bethesda), 105 (13) (2013), pp. 978-988

[7] NhS England, NHS Improvement
National cancer patient experience survey
https://www.ncpes.co.uk/ (2019)
(accessed March 2021

[8] https://www.dovepress.com/religious-denomination-religiosity-religious-attendance-and-cancer-pre-peer-reviewed-fulltext-article-RMHP

	On the other hand, highly religious individuals may have tendencies to mistrust academic medicine and therefore have decreased levels of preventive services utilization. Though, to the best of our knowledge, there is no review that systematically synthesized the evidence on the association between religion and the utilization of preventive cancer screenings.	types of support that may be needed.
Sex (M/F)	Studies have shown that hormone replacement therapy (HRT) increases the risk of breast cancer in postmenopausal women. Male patients Aged 50 years and older with a unilateral, firm subareolar mass with or without nipple distortion or associated skin changes	Through the proposed model, access to Breast services will be improved and the capacity of the service increased, which will benefit all patients Ensure needs of male patients are understood and catered for when providing services.
Sexual orientation	UK Government policy documents have stated that there may be higher rates of breast cancer in lesbians and bisexual women (LB women), but the evidence that this is based on is unclear. For example, in 2009 the Report by the UK All Party Parliamentary Group on Cancer's Inquiry into Inequalities in Cancer [1] stated that "Lesbians may be at a higher risk of breast cancer", and the USA Institute of Medicine's Report on the Health of Lesbian, Gay, Bisexual, and Transgender People 2011 states that: "While the relative risk of breast cancer for lesbians and heterosexual women is the topic of much discussion, a definitive answer is still unavailable. It is believed that lesbians may be at higher risk for breast cancer because there is some evidence that they have a higher prevalence of certain risk factors, including nulliparity, alcohol consumption, smoking, and obesity."[9]	The only realistic way to establish rates in LB women would be to collect sexual orientation within routine statistics, including cancer registry data, or from large cohort studies. Ensure data is collected. Consultation: Include LGB groups/individuals in consultation process.

[9] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3890640/#B1

4. Does this service go the heart of enabling a protected characteristic to access health and wellbeing services?
Yes – essential for women's health.
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)
LCCG communications team to develop and deliver on consultation.
6. Have you identified any key gaps in service or potential risks that need to be mitigated

Risk	**Required Action**	**By Who/ When**
No data available on performance and outcomes linked to protected characteristics.	Develop report on outcomes linked to protected characteristics in particular disability and Black minority patients	Trust/CCG – report be made available before final EIA
Training records	Ensure staff are appropriately trained in giving patient respect and support in relation to beliefs and lifestyles. The employer is vicariously liable for staff behaviour and only defence is to have trained staff and to record that training when it comes to discriminative behaviour linked to Tribunals or Judicial Review.	Trust to check staff records.

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?
Analysis post consultation
9. Actions that need to be taken
Analysis post consultation