Equality Analysis Report
Pre-Consultation

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

Guidance Notes: Clearly identify the function & give details of relevant service provision and or commissioning milestones (review, specification change, consultation, procurement) and timescales.

Currently, the general surgery service is provided on a spilt site basis. Both Royal Liverpool Hospital and Aintree University Hospital provide emergency surgical care where Broadgreen Hospital provides elective activity only. Each site provides different models of service. Both sites provide a 7-day Consultant led service for emergency surgery.

Case for Change – Current Challenges

General surgical emergency admissions are the largest group of all surgical admissions to UK hospitals and account for a large percentage of all surgical deaths. Complications occur in as many as 50% of patients undergoing some common procedures, and these result in dramatic increases in length of stay.

The current clinical models across sites experience constrains and limitations to service provision and are unaligned; having two different service models also increases inequity amongst the population of Liverpool.

Key challenges for the emergency and elective subspecialty across sites include:

Emergency General Surgery

- **Clinical Outcomes** - Trust performance on clinical /patient outcomes and quality of care are mixed across sites, prompting concerns around the success of operations. These areas include - *Consultant present in theatre for high risk patients (when risk of death ≥ 5%); Length of Stay following Emergency Laparotomy Procedures; and Patient to be reviewed by Consultant within 14 hours of admission.*
- **Clinical Sustainability** - at the RL site, emergency surgery is provided by sub-specialist surgeons who deliver both emergency and elective care. This model is not consistent with recommendations or clinical evidence on best practice. Care should be

provided by consultants trained in emergency surgery and that support for complex patients should be provided by surgeons fully trained and experienced within a sub-specialty.

- **Recruitment** - There have been difficulties in recruitment of consultants without them already having subspecialty interests.
- **Operational Challenges** - There is a lack of rapid access service (Ambulatory Care 'Hot Clinic') leading to multiple procedures and operations (like uncomplicated hernia, appendicitis, abscess) being performed as inpatient rather than day case. This increases burden on NCEPOD theatre and emergency surgical and anaesthetic teams.
- **Estates** - There is no ring fenced assessment space within New Royal dedicated specifically for Emergency General Surgery, so change is needed in order to locate services within an appropriate estate footprint. Furthermore, the current estate in AUH does not provide sufficient capacity to provide safe and quality rapid assessment and efficient patient flow

Elective subspecialty services

- **Limited procedure volumes at each site due to fragmentation of services -** Volumes of elective colorectal and Upper GI patients are lower at both sites than the national average. **The Royal Colleges, Improving Outcomes Guidance, Clinical Networks and NHS national guidelines increasingly** relate patient outcomes to catchment population size and emphasise the importance of sufficient clinical volume. It follows that the current provision of services for the Trust's hospital sites will suffer when minimum surgeon volumes are not attained.
- **Clinical sustainability-** The fragmentation of services and different clinical models result in variation in patient outcomes and quality of care which also provide operational challenges including length of stay and timely access to care.

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 services

2. Change to service

Proposed Clinical Model

The key proposal underpinning the integrated model for general surgery is to consolidate similar services and patients onto the same site, establishing a 'hot' (non-elective) site at the AUH site where dedicated teams are in place to carry out emergency surgery, and a 'cold' (elective) site at RLH site specialising in carrying out planned surgery, with limited disruption to waiting lists caused by emergency cases.

The separation of elective and non-elective general surgical care will allow both aspects of the service to be managed efficiently, improve availability of staff for pre and post-operative reviews, allow for patients to be seen in a timely manner and treated by appropriate

3. Barriers relevant to the protected characteristics

Guidance note: describe where there are potential disadvantages.

National context

Sometimes, complications can occur following surgery. The following are the most common complications[1]. However, individuals may experience complications and discomforts differently. Specific treatment for any post-surgical complication(s) will be based on:

Your age, overall health, weight, gender, ethnicity, disability and medical history

Extent of the disease

Type of surgery performed

Your tolerance for specific medications, procedures, or therapies

Your opinion or preference

Complications may include:

Shock

Shock is the dangerous reduction of blood flow throughout the body. Shock is most often caused by reduced blood pressure. Treatment may include any/all of the following:

Stopping any blood loss

Maintaining an open airway

Keeping the patient flat

Reducing heat loss with blankets

Intravenous infusion of fluid or blood

Oxygen therapy

Medication

Haemorrhage

Haemorrhage means bleeding. Rapid blood loss from the site of surgery, for example, can lead to shock. Treatment of rapid blood loss may include:

Infusions of saline solution and plasma preparation to help replace fluids

Blood transfusion

Wound infection

When bacteria enter the site of surgery, an infection can result. Infections can delay healing. Wound infections can spread to adjacent organs or tissue, or to distant areas through the blood stream.

Treatment of wound infections may include:

Antibiotics

Draining of any abscess

[1] https://stanfordhealthcare.org/medical-treatments/g/general-surgery/complications.html

Deep vein thrombosis

Sometimes blood clotting occurs within deep-lying veins. Large blood clots can break free and clog an artery to the heart, leading to heart failure. Treatment depends on the location and the extent of the blood clot, and may include:

Anticoagulant medications (to prevent clotting)

Thrombolytic medications (to dissolve clots)

Surgery

Pulmonary complications

Sometimes, pulmonary complications arise due to lack of deep breathing within 48 hours of surgery. This may also result from inhaling food, water, or blood, or pneumonia. Symptoms may include wheezing, chest pain, fever, and cough (among others).

Urinary retention

Temporary urine retention, or the inability to empty the bladder, may occur after surgery. Caused by the anaesthetic, urinary retention is usually treated by the insertion of a catheter to drain the bladder until the patient regains bladder control.

Reaction to anaesthesia

Although rare, allergies to anaesthetics do occur. Symptoms can range from light-headedness to liver toxicity.

Protected Characteristic	**Issue**	**Remedy/Mitigation**
Age Older patients	**Age of patients undergoing surgery**[2] Results Some 68 205 695 surgical patient episodes (31 220 341 men, 45·8 per cent) were identified. The mean duration of hospital stay was 5·3 days. The surgical population was older than the general population of England; this gap increased over time (1999: 47·5 *versus* 38·3 years; 2015: 54·2 *versus* 39·7 years). The number of people aged 75 years or more undergoing surgery increased from 544 998 (14·9 per cent of that age group) in 1999 to 1 012 517 (22·9 per cent) in 2015. By 2030, it is estimated that one-fifth of the 75 years and older age category will undergo surgery each year (1·49 (95 per cent c.i. 1·43 to	As part of consultation gather feedback on experiences of different ages going through general surgical treatments. As part of the transforming of service and service design, consider how key performance indicators can be used to measure outcomes for older patients and consider proactively seeking feedback to measure patient experience. For older people (who may have given up

[2] https://bjssjournals.onlinelibrary.wiley.com/doi/abs/10.1002/bjs.11148

	1·55) million people), at a cost of €3·2 (3·1 to 3·5) billion. **Conclusion** The population having surgery in England is ageing at a faster rate than the general population. Healthcare policies must adapt to ensure that provision of surgical treatments remains safe and sustainable	driving) public transport may be an issue - ensure that an analysis of public transport and how patients and family/friends will travel to the new service provision is understood.
Disability	**Barriers to healthcare** There are several potential barriers to access to healthcare. • Clinical problems may be attributed to the learning disability rather than illness - diagnostic overshadowing • Communication problems. • Behavioural problems resulting in difficulty attending the surgery. • Lack of participation in decision making for patients and their carers. • Pressure on resources leading to reduced consulting time. • Equipment and reasonable adjustment being made to support the person. Clinicians have a duty to ensure that all patients with learning disability receive good medical care.	As part of consultation gather feedback on experiences of different disabilities going through general surgical treatments. Consider different methodologies for the public consultation (e.g. easy read / group discussion/ BSL etc.) as reasonable adjustments (Equality Act 2010 and Accessible Information standard.) As part of transforming service consider how people with different disabilities are treated and supported.
Gender reassignment	Based on the experiences of more than 800 trans and non-binary people, **a 2018 study by Stonewall** looked at the discrimination trans people face on a daily basis in the UK. The report examined discrimination in their home life and in access to medical support for transition, which can significantly increase mortality rates. The Stonewall report revealed the discrimination that transgender individuals experienced in the healthcare environment through a number of striking statistics: • When accessing general healthcare services in the last year, two in five	As part of consultation gather feedback on experiences trans people going through general surgical treatments. As part of the transforming of service and service design, consider how key performance indicators can be used to measure outcomes for

	trans people (45%) said healthcare staff lacked understanding of trans health needs. • 7% of trans people were refused access to healthcare because they were LGBT • 24% fear discrimination from a healthcare provider • 24% don't know how to access transition relation healthcare • 24% of trans people who are currently undergoing medical intervention are unsatisfied with the support given by their GP	transgender patients and consider proactively seeking feedback to measure patient experience of the services.
Marriage and Civil Partnership	Its vital that partners /wives/husbands have access to the patient in order to aid recovery – wherever possible (considering covid concerns) families should be allowed to see the patients.	As part of service development consider how partners/wives/husband can see the patients and play an active role in their rehabilitation.
Pregnancy and maternity	Routine data[3] from English hospitals show that general surgery during pregnancy, such as removing the appendix or gallbladder, **does not commonly harm mother or baby**. This suggests that surgery in pregnant women is generally safe, but that mothers could be provided with more specific estimates of the risks Women who had surgery during pregnancy for a condition unrelated to pregnancy were slightly more likely to experience miscarriage, preterm or caesarean delivery or a long stay in hospital. Babies were more also slightly more likely to be low birthweight or stillborn. However, the actual risks of negative outcomes were small. For example, 287 pregnant women would need to have surgery for one to experience a stillbirth and it was not possible to balance the benefits of their surgery against this as procedures were so varied.	As part of consultation gather feedback on experiences of pregnant women undergoing surgical treatments.

[3] https://evidence.nihr.ac.uk/alert/general-surgery-is-mostly-safe-during-pregnancy/#:~:text=Routine%20data%20from%20English%20hospitals,specific%20estimates%20of%20the%20risks.

	There isn't any guidance on surgery in pregnancy in the UK, so these findings may be useful when discussing surgery and the associated risks with pregnant women.	
Race	**The safety of health care for ethnic minority patients: a systematic review**[4] Results Forty-five studies were included in this review. Findings indicate that: (1) those from ethnic minority backgrounds were conceptualised variably; (2) people from ethnic minority backgrounds had higher rates of hospital acquired infections, complications, adverse drug events and dosing errors when compared to the wider population; and (3) factors including language proficiency, beliefs about illness and treatment, formal and informal interpreter use, consumer engagement, and interactions with health professionals contributed to increased risk of safety events amongst these populations. **Conclusion** Ethnic minority consumers may experience inequity in the safety of care and be at higher risk of patient safety events. Health services and systems must consider the individual, inter- and intra-ethnic variations in the nature of safety events to understand the where and how to invest resource to enhance equity in the safety of care.	As part of consultation gather feedback on experiences of black and ethnic minority undergoing surgical treatments. As part of the transforming of service and service design to monitor performance for Black or ethnic minority patients both in outcomes and experience of the services.
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 continue to face barriers and discrimination in accessing healthcare and how they are treated by staff today	As part of consultation gather feedback on experiences of from different faith groups who have undergoing surgical treatments for comparison. As part of the transforming of service and service design ensure people of different faiths are part

[4] https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-020-01223-2

		of the planning and design process.
Sex (M/F)		As part of consultation gather feedback on experiences of both men and women undergoing surgical treatments for comparison. As part of the transforming of service and service design, consider how men and women are treated and difference in outcomes between the sexes.
Sexual orientation (LGB)	Healthcare services have a legal duty under the Equality Act 2010 to treat LGB people fairly and without discrimination. However, this research[5] shows that **LGBT people continue to face barriers in accessing healthcare treatment today**	As part of consultation gather feedback on experiences of LGB undergoing surgical treatments. As part of the transforming of service and service design, consider how LGB people are treated and difference in outcomes.

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 carried out June 2022. Will consist of focus group and questionnaire. Methodology to be inclusive and include easy read / BSL

[5] https://www.stonewall.org.uk/system/files/lgbt_in_britain_health.pdf

Staff and public will be part of the consultation – it is important to be able to separate staff views (which will have more insight and may bias the outcome) from the public view.

The final EA will only be concerned with the public/patient opinion.

Analysing staff view will be a function of HR.

6. Have you identified any key gaps in service or potential risks that need to be mitigated

Lack of data on performance and outcomes of surgery by protected characteristics.

Lack of transport analysis.

Risk	Required Action	By Who/ When
Service outputs and outcomes data by protected characteristics	Trust to report methodology on performance	Trust /CCG ASAP
Transport and geographic area	Trust to develop transport analysis and health inequalities/ geographic breakdown of patients	Trust /CCG overview ASAP

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