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:

Overview of Services

Liverpool Vascular and Endovascular Service (LiVES) has been an established single service for several years and provide vascular services for the Merseyside region and a tertiary service for North England, Isle of Man and North Wales. It is based on a hub and spoke model, with the main hub based at the Royal Liverpool Hospital site, and 'spoke' sites based at Aintree, Whiston and St. Helens and Liverpool Heart and Chest Hospitals (LHCH) under Service Level Agreements and Southport under a joint venture.

Current Challenges

The greatest challenges within the LiVES service currently is that of capacity, both theatres and beds, in addition to challenges on inter-hospital transfers and Interventional Radiology services. These challenges significantly impact on the Trust's ability to provide timely access to care and subsequently on patient outcomes and experience.

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
- Alignment with ICB

2. Change to service

Proposed Clinical Model

The proposed clinical model would see the relocation of LiVES services to the Aintree University Hospital site. This would be based on expanding to two hybrid theatres, an

open theatre, 33 vascular beds, 7 Intermediate Care Beds (Stoddard House) 4 critical care beds, comprehensive outpatient, vascular lab and office facilities, potential for research facilities, and access to CT scanner together with co-location of dependent services.

Vascular surgery and in-patient beds will transfer to the Aintree University Hospital site. All patients requiring vascular surgery and in-patient care will be admitted to Aintree, which will house increased theatre and bed capacity and will benefit from being co-located with dependent services. This will improve the quality of care that is delivered and ensure that all patients are able to access safe, timely and consistent care.

Vascular services delivered out of satellite sites, including outpatient clinics will remain in place, maintaining patient choice where it is clinically appropriate.

Detailed plans for public consultation, including timescales for communicating with the Local Authorities and other key stakeholders, are being developed over the coming months.

Change for staff

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 theatre and in-patient Vascular care to the Aintree University Hospital site.

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.

The proposed clinical model set out in the business case will impact visitors.

Vascular in-patient beds will be provided at Aintree. All visitors of Vascular in-patients will attend the Aintree University Hospital site

National Context

What is vascular disease?

The term vascular disease covers any condition that affects the arteries, blood vessels, veins, and tiny capillaries that carry blood. It also covers the lymphatic system—the small vessels through which a fluid called lymph, containing infection-fighting white blood cells, travels from the tissues into the blood. Vascular disease includes a long list of conditions, some of which can become life-threatening:

- Acute venous thrombosis
- Aortic aneurysm (abdominal, thoracic)
- Carotid artery disease
- Critical limb ischemia
- Diabetes vascular disease and limb salvage
- Diseases of the aorta
- Dialysis graft and fistula management
- Non-healing wounds caused by vascular disease

- Peripheral artery disease (PAD)
- Thoracic outlet syndrome
- Varicose veins
- Vascular malformations
- Visceral artery disease

Who is at risk for vascular problems?

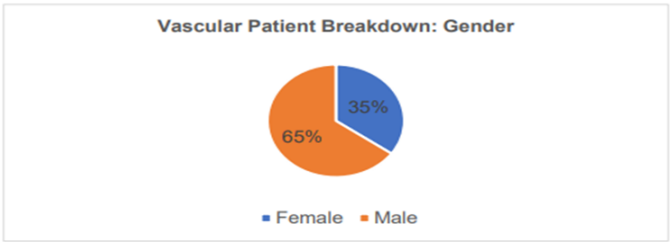
Vascular disease becomes more common with **age**, but people with a family history of vascular and heart disease are at higher risk, as well **as women who are pregnant**, or anyone who has a **cardiac-related condition such as high cholesterol or hypertension**.

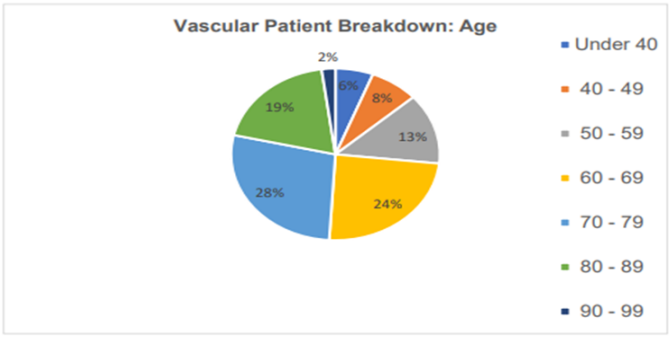
An unhealthy lifestyle also can lead to vascular problems, which are more prevalent among people who **smoke,** or are **obese or sedentary**, or who routinely **stand still or sit for long** periods of time.

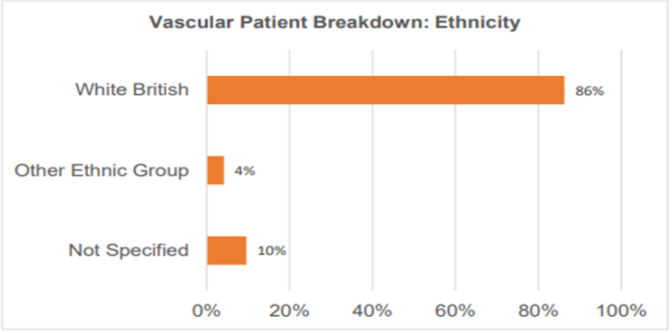
What are the risks of vascular surgery?

Like all surgeries, vascular surgery poses some risks of complications, which increase if the patient smokes, is obese, and has other serious conditions like chronic lung disease. There is additional risk when the surgeon operates on the chest or a major blood vessel. But for a serious vascular condition, **the benefits often outweigh the risks.**

Typical throughput of patients receiving vascular treatments.







Protected Characteristic	Issue	Remedy/Mitigation
Age	There is increasing incidence of most vascular conditions with age, including aneurysms, symptomatic carotid disease, critically ischaemic limbs and varicose veins. In addition. the risk of intervention also increases for older people. The transfer of in-patient services from the RLH to AUH site could disproportionately impact older people, particularly those living in the South Liverpool area, who will need to travel further to access the care they require.	The clinical model set out in the business case tackles the capacity issues that currently impact on the LiVES service, which often lead to delays in care, potentially impacting on the experience of care and the health outcomes for patients. 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. Transport Impact assessment needs to be undertaken
Disability	Accessing healthcare services can often present a challenge for people living with a disability. Disabled people can often be sedentary, obese and at risk. The transfer of in-patient services from the RLH to AUH site could disproportionately impact people living with a disability, particularly those living in the South Liverpool area, who will need to travel further to access the care they require.	The reconfiguration case sets out a clinical model for Vascular services that maintains equitable care, delivered closer to home where it is clinically appropriate to do so, and supported by accessible specialist inpatient services that are centralised in order to provide optimal care for all. Where patients meet the criteria, the Trust policy for non-urgent patient transport would support this patient cohort. Vascular out-patients will continue to be available at the Royal Liverpool site Clinic activity will still take place at RLH site as well as Aintree, with consultant and vascular nurse specialist clinics held. Also, AAA screening and vascular lab

		facilities will continue to have a presence at the new Royal Notes for consultation: Ensure disabled people and groups can input in to the design of the service and air their views on how the service does not meet needs. Ensure the consultation methodology is accessible to people with sensory and learning difficulties.
Gender reassignment	People who gender re-assign report difficulties with NHS service provision. Often discriminated against by staff. Ensure staff are trained and know how to treat and respond to trans patients.	Even though the change programme is focused on 'capacity' non the less as part of service delivery it must ensure it is not discriminating in any way against a trans person. Transgender people have very specific protection against discrimination within the current Gender Recognition Act 2014. This protects a trans person who intends to undergo, is undergoing or has undergone gender reassignment. In addition, good NHS practice dictates clinical responses be patient-centred, respectful and flexible towards all trans people including those who do not meet these criteria but who live continuously or temporarily in their confirmed gender role. General key points are that: • Trans people should be accommodated according to the pronouns that they currently use • This presentation may not always accord with the physical sex appearance of the chest or genitalia • Allocation of accommodation does not depend upon their having a gender recognition

		certificate (GRC) or legal name change • Allocation of accommodation will apply to toilet and bathing facilities (except, for instance, that pre-operative trans people should not share open shower facilities) • The views of the trans person should take precedence over those of family members Consultation: Ensure that a transgender people are invited to give views on the proposed changes.
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 baring on being able to visit.	Ensure that any covid restrictions are necessary and 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 women are at high risk of developing varicose veins due to several factors including an increase in blood volume, a decrease in blood flow rate, pressure on the vena cava from the uterus, and hormonal changes that dilate the vessels. All of these factors come together to promote the development of bulging, deformed veins, called varicose veins. Pregnant woman experiencing new symptoms of venous insufficiency, common signs include raised, swollen, or disfigured veins and skin changes in the legs, while symptoms include fatigue in the lower legs, leg pain, heaviness, numbness, and tingling. In most cases, surgery is not recommended for patients who are pregnant for one primary reason: venous	As part of consultation gather feedback on experiences of pregnant women undergoing surgical treatments. The model addresses capacity and demand issues impacting all patients. The clinical model does not propose any changes to provision across the satellite sites, meaning that services provided at the Liverpool Women's Hospital for maternity patients will be maintained.

	insufficiency often resolves on it's own following pregnancy. However, doctors can assist pregnant women in reducing the signs and symptoms of venous insufficiency and preventing complications during their pregnancy. Routine data[1] 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. 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** [2] Results	As part of consultation gather feedback on experiences of black and ethnic minority undergoing surgical treatments.

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

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

	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 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 of the planning and design process.
Sex	Typically, more males that females go through vascular treatments. Overall, when considering general surgery female patients have a 16% greater risk of complications and an 11% greater risk of readmission and were 20% more likely to have to stay in hospital	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.

	longer compared to men undergoing similar surgery[3].	Consider staff and surgical profile to create a more diverse and experienced work group.
Sexual orientation	Healthcare services have a legal duty under the Equality Act 2010 to treat LGB people fairly and without discrimination. However, this research[4] shows that **LGB people continue to face barriers in accessing healthcare treatment today** LGB community are known to be high risk smokers and high risk alcohol intake.	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 - vital service.
5. Consultation
Consultation planned for July 2022 on reconfiguration – both public and staff to be included.
6. Have you identified any key gaps in service or potential risks that need to be mitigated
Transportation and changes to travel arrangements need to be understood and the impact it may have on patients from different geographic regions. In addition, not all people have access to private cars – car ownership of older people is in decline and less lily to own a car.

Risk	**Required Action**	**By Who/ When**
Transport for public to new site from different geographic locations	Transport Analysis	Trust/CCG
Health inequalities report.	Health inequalities report	Trust/CCG

[3] https://www.theguardian.com/society/2022/jan/04/women-more-likely-die-operation-male-surgeon-study#:~:text=Overall%2C%20female%20patients%20also%20had,21%20types%20of%20surgery%20analysed.
[4] https://www.stonewall.org.uk/system/files/lgbt_in_britain_health.pdf

Give an understanding of the different needs of communities		

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