PRE-CONSULTATION EQUALITY ANALYSIS
EASTERN SECTOR CANCER HUBS

Pre-Consultation Equality Analysis Report: Eastern Sector Cancer Hubs

Start Date: Nov 2018
Finish Date:

Signature:

Signed off (senior manager):

1. Purpose of this document:

Meeting the needs of the Equality Act 2010 is a statutory duty. Section 149 Public Sector Equality Duty is engaged, along with other sections of the act (see below), when a service provider is making changes to a service that may have an impact on service users.

Knowsley, Halton, St Helens & Warrington CCGs are making changes, these changes have to be tracked against different protected characteristics to see if there will be any negative impact on any particular people or groups covered by the Act.

Pre-consultation:

A 'pre-consultation' equality analysis report looks at 'potential' barriers and impacts and tries to identify which groups will need specific engagement as part of the consultation process. This is then fed in to the consultation and engagement activities.

Post consultation:

All responses and any other evidence is then reviewed, and a final Equality Analysis report is made. This reports on how well the change in service will meet the Equality Act 2010 and any negative impacts that need to be understood and mitigated before any final decision to change the service is made by the decision makers. The final report has to be presented to the decision makers.

The Equality Act 2010.

The parts of the acts that are 'engaged' (i.e. active in relation to this proposal) are:

Section 4 – protected characteristics

Section 13 - direct discrimination

Section19 – indirect discrimination

Section 20 – duty to make adjustments

Section 29 – provision of a service

Section 149 – Public Sector Equality Duty

In relation to Public Sector Equality Duty (PSED) there are three objectives.

Section 149 Public Sector Equality Duty states:

> A public authority must, in the exercise of its functions, ***have due regard*** to the need to—
>
> (A) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
>
> (B) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
>
> (C) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

In order to satisfy objective A, the following section have to be considered:

- Section 4 – protected characteristics,
- Section 13 - direct discrimination,
- Section19 – indirect discrimination,
- Section 20 – duty to make adjustments for people with disabilities, and
- Section 29 – provision of a service, are fundamentally relevant to this project.

In order to satisfy ‘objective B’ - ‘Advance equality of opportunity’ - section 3 of PSED, will have to be explored and met where relevant:

> 3 (a) remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic;
>
> 3(b) take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it;

3(c) encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low

Objective 'C' - 'foster good relations' is not engaged in this project as the project is not one of tackling hate crime, community cohesion and /or challenging prejudice or building relationships across community and cultural boundaries.

When all the evidence is collected, post consultation, all the sections of PSED will be commented on and a view will be taken on whether, in making the change Knowsley CCG and partners are doing so lawfully.

2. Details of service / function:

The Clatterbridge Cancer Centre is a specialist hospital providing radiotherapy, chemotherapy and supporting services for the non-surgical treatment of cancers. Currently the main base of the hospital is Clatterbridge Cancer Centre-Wirral, there is also a satellite radiotherapy treatment centre at Clatterbridge Cancer Centre-Aintree (which opened in 2011) and we provide outpatient and chemotherapy care in local hospitals right across Cheshire, Merseyside and the Isle of Man.

From July 2017 our services include the regional specialist services for patients with blood cancers (a service previously provided from The Royal Liverpool Hospital). This includes treatments such as bone marrow transplants.

Cancer survival rates have doubled over the last 40 years, with around half of patients now surviving the disease for more than ten years. This is a success story for the NHS. However, the rate of cancer and its diagnosis is rising, which means every year our services have to respond to growing demand. This means we are now supporting many more patients to live well with and beyond cancer; Public Health England have predicted that 1:2 people will be living with cancer from 2025, this will place continued pressure on our current services because 1:3 people live with cancer now.

More and more new therapies to treat cancer (e.g. immunotherapy) are becoming available, which means the number of treatments we can offer is increasing and it is no longer acceptable that patients should travel long distances for care that can be provided closer to home. 90% of chemotherapy and immuno-therapy for common cancers (breast, lung, colo-rectal and prostate) can now be safely and effectively provided closer to home and for some patients at home. There is no need to travel to the Cancer Centre.

These new treatment options also mean that our patients will require even more joined up care by specialist teams of staff who can work closely together to ensure we deliver high quality care and access to research, consistently throughout the year.

Like many hospital services, CCGs and Trusts need to think differently about how they can best deliver services in the future.

Other drivers for change include:

• patients wait no longer than 7 days for a first appointment following referral
• Their treatment begins within 24 days of that first appointment
• All patients get the same access to clinical trials, so that all patients can access the latest treatments and also be a vital part of developing new treatments
• 90% of patients with common cancers receive chemotherapy and immune-therapy closer to home; less travel to the Cancer Centre for common cancer care
• Patients get consistent access to supportive services (for example cancer information, dietary advice, benefits advice) at their first appointment

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

- Demographic need and changing patient need's because of cancer survival rates
- Value for Money-more efficient service

3. Change to service: what is the fundamental change to service?

The new clinical model will:

- Provide high quality, sustainable care
- Meet growing demand and expectations
- Integrate care and research
- Maximise accessibility

The model:

- 4 hubs will provide the majority of care for common cancers, and also some intermediate cancers which can be repatriated significantly increasing the range of treatments which provided closer to patients' homes
- New Hospital in Liverpool will physically integrate complex care, acute oncology services and research centres of excellence
- Linked and underpinned with digital transformation through 'connecting for the future# programme
- To help care in the most clinically appropriate place, the range of cancer needs are split in to three:-
    - **Rare** – less than 500 referrals per year : testicular, Penile, Brain, CNS, sarcoma and ocular caners (treatment delivered at the centre)

- **Intermediate**: between 500 -1400 referrals per year: Head, neck, HPB, Myeloma, MUO (treatment increasingly at hubs)
- **Common –** over 1400 referrals per year: Breast, Lung, Prostate and Lower GI (treatment mostly at hubs)

Sector Hubs

Sector Hubs will provide the majority of first Clatterbridge appointments for common (and some intermediate) cancers. They will provide more complex chemotherapy, as well as a co-located, dedicated ambulatory acute oncology service. Three of the hubs will provide radiotherapy.

Moving to 'four' sector hubs and the region will provide the optimum balance between local care for patients and ensuring that all patients can consistently see a tumour -site -specific consultant lead team of experts for their first appointment. This team will co-ordinate all aspects of their care and treatment. Sector Hubs will provide extended hours service seven days a week.

For patients:

The hub model will provide :-

- a wider multi-professional team
- co-ordinate and signpost to wider support/services – to access everything that is available in the community
- improve continuity and consistence of palliative enhanced supportive care.
- Cancer specific ambulatory care
- Entry into the service via telephone triage and referrals from other service points of the NHS e.g. 111, NWAS, UTC, A&E
- Co-locations with chemo services
- Extended opening ours
- Access to clinical trials

If the service is a 'new or redeveloped' service – has 'new money' been made available or have budgets been moved from one sector to another?

Its anticipated that no new money will be made available but a better use of existing resources.

4. Barriers relevant to the protected characteristics (where are the potential disadvantages)

A number of exploratory talks with selected parties (see report below for full details[1]) such as clinicians, cancer patients, cancer support services, took place to discuss the outline care model and to identify issues that the project developers need to be cognisant of as they develop the models towards a preferred option and public consultation.

There was overwhelming support for the idea of Hubs and making cancer care closer to communities. When asked about what the priority should be in selecting such centres- the top concern was clinical excellence. However, whilst this is understandable, it can skew thinking to locations. In effect, no matter where the hubs are placed, they will become clinically excellent. Once this issue is put to one side, by far the most concerning issues for attendees where:

- Location, Travel and parking
- Equitable service delivery for all
- Understanding the limits to hubs provision

When asked a number of searching questions, the following answer emerged:

Q1 – why is change needed
(Top answer) Patients currently have to travel too far

Q2b – why a cancer hub?
(Top joint answers)
The need to provide specialist treatment
Easy to access / local service

Q4 who will it affect?
(Top answers)
Patients living further away from the hub
Patients and relatives that rely on public transport
Elderly Patients
Patients and relatives who drive and need access

Some felt there should be equality amongst people who do and don't drive, many felt patient wellness should be considered more thoroughly in relation to fitness to travel distances for care/treatment.

ESCT
[1] Pre-Consultation En pre-consultation engagement report with selected parties

However, there was a juxtaposed view that was prevalent in that some people thought ‘patients would be happy to travel further for specialist care’. Though clarity needs to be sought on this point as to whom this refers to, especially if it’s tied into a question on any future questionnaire.

In relation to the use of public transport the following problems/issues were identified

- Bus not always a direct route
- Out of borough passes don’t work
- Time of use of pass, cannot use before 9.30am
- Bus passes only give free travel from 9.30am
- Cost is high
- Over 45 mins by bus
- Multiple bus journeys
- Length of time and any change overs
- Waiting time for buses in non-urban areas
- Some bus routes are less frequent or stop after 6pm
- Extra cost if carer comes
- Merseyside bus pass can only be used in the border
- Possibly patients who are frightened or have mobility issues using the bus
- Need to be clear on public transport and clear on every circumstance
- Often you will need more than one of the two buses to get to your destination

And when considering the issue of Patient Access the following points where raised

- Is this a fair target only counting car journeys? [45 minutes to get from home to site]
- Are you saying its acceptable for some areas to have worse access?
- Complicated bus journeys, cost of transport and finding a car park space is just as important.
- Delays at clinic can be a lot longer, prompt appointments need to be considered
- Must consider Toll Bridge, Tunnels etc
- Patient vulnerability

  o Effect upon patient mobility and access to transport

  o What facilities and functions would need to be put in place to enable vulnerable individuals to access services given the 45-minute travel time estimate?

- Time of day for appointments versus travel time will this be taken in to consideration or included in 45-minute travel time?
- How will travel be for a patient who has just been for their treatment

In addition to the above, ***there has to be clarity over just what the Hubs will provide*** as conversations reveal high expectations and a variety of service suggestions were made to be included in the hub: (items in italic are not typical and may not be considered or be made available at every hub – clarity on what is available will have to be given as part of the consultation documentation)

- Signposting to local support services
- *Holistic needs assessments*
- An information point for advice and guidance
- *Pharmacy on site*
- *24-hour urgent care*
- Therapies
- Lymphedema services
- Rehabilitation
- *Counselling for patients and families*
- Radiotherapy
- *Peer support*
- *Pampering*
- *Benefits advice*
- *Wig specialists*
- *Pain advice*
- Appropriate seating (covering different disabilities and mobility issues)
- Good signage to find your way around the building
- *Refreshments*
- IT support
- *Virtual consultations*
- *Creche*
- Disabled access
- *Generally avoiding a hospital type feeling.*

Any future Consultation should consider the following:

Protected Characteristic	Issue	Remedy/Mitigation
Age Young people[2] Older/retirees	○ What is the relations between young cancer patients and link to new hubs? ○ Older people – need to understand how they travel to appointments	Ensure young people are part of the consultation process Ensure older people are part of consultation exercise. Ensure all adult age groups are included in the consultation/engagement

[2] https://smhs.gwu.edu/cancercontroltap/sites/cancercontroltap/files/AYA%20Social%20Media%20Toolkit%20FINAL.pdf

	and relationship with hubs and whether they will be more likely to be disadvantage	process
Disability: Physical Learning difficulties Mental health Sensory impairment Atypical neuroprocessing	Clear concern was shown around disability in terms of access and equality of treatment. Anecdotal evidence of discriminatory practices in local services where disclosed in workshops.	Ensure disability groups are part of consultation covering main areas of disability. Consider focused groups as well as general questionnaire Ensure disability groups and people are included in the consultation processes. Consider special 'focus groups' to cover different disabilities (e.g. deaf, blind) Consider reasonable adjustments to venues/ questionnaires/ support to get views of disabled people. (e.g. easy read document/ braille/ induction loops at events Ask questions about: • Barriers/ difficulty in travel. • Barriers/difficulty in using equipment (e.g. screening) • Level of support they may need in accessing and going to appointments. Ensure any publicity material that uses imagery has inclusive imagery Post consultation consider further work on acceptable service level

		performance for disabled patients
Gender reassignment	No immediate issue identified by work groups – however, there were little to no 'trans' voices in the groups.	Consider focus group with trans community as part of general consultation.
Marriage and civil partnership	No Immediate issues identified- however, many patients rely on partners to support them and take the to and from appointments.	Include how 'partners' will be better supported in Hub model as part of consultation process.
Pregnancy & maternity	No Immediate issue identified out of work shops	Ensure consultation links with parents
Race	No immediate issues were identified from the workshops – however there are specific cancers which have a greater impact on certain BAME groups – e.g. prostate cancer and Afro-Caribbean men.	Ensure that BAME groups are identified and have clear links to the consultation process. Consider BAME focus groups • Identify barriers to travel • Identify barriers to screening/early attendance with symptoms Ensure any publicity material that has imagery has inclusive imagery
Religion and belief	The charity group 'Cancer Black Care' organisation draws attention to the fact that in some communities a diagnosis of cancer was seen as "the will of God" and in others the knowledge that a person had cancer could affect the marriage prospects of their children.	Ensure religious and different cultural groups are included in consultation process.
Sex (m/f)	Both male and females are affected by cancers.	Ensure both groups are well represented as part of consultation process.

Sexual orientation	At present there is little information relating to cancer by sexual orientation. Anecdotal evidence of discriminatory practices in local services where disclosed in workshops.	Ensure any publicity material that has imagery has inclusive imagery. Ensure that LGBTQ+ are part of consultation process.

5. Does this service go to the heart of enabling a protected characteristic to access health and wellbeing services?

YES: Cancer is a main health concern and service to help better treat and support patients would be highly desirable.

6. Consultation:

The proposal of 'hubs' is a new way of working for the area, this in essence is a restructuring of cancer services. As such, it is highly likely, that local people will have a legitimate expectation on service provision and will need to be consulted on such a move, in particular:

- How services will be delivered and the case for change – and do people agree the need for change
- Cost to such an endeavour and whether it is a 'money saving exercise', as part of the information given to support consultation
- Performance standards that will be delivered with such a change, as part of information given to support the consultation
- Travel implication and impact of travel, as currently perceived linked to final proposal
- Equality of service – how the Hubs will meet and support people with different needs.
- What types of services will be delivered from hubs
- Comments

To this end, the consultation process needs to consider 'focus groups' from specific protected characteristics (BAME/ LGBTQ+/ Trans/ Disability) as well as a 'general questionnaire' targeted at the general population.

Questions around travel need to include issues on 'difficulty' and 'means of travel'

e.g. (a) will travelling to the new hub be: More difficult, As difficult, less difficult, about the same as before.
(b) how do you usually travel to hospital appointments (list methods)
(c) Do you think it will take you longer to travel to your nearest hub (by how much?)

Whilst there is evidence that many/ most people travel to treatment appointments by car, there needs to be clarity on patient methods of movement in relation to hubs.

In order to understand potential concerns/ impacts, the questionnaire needs to also collect equality data to aid disaggregation of answers and analysis.

Section 7 , 8and 9 for completion after final consultation.

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

Ensure you have action for who will monitor progress.
Ensure smart action plan embeds recommendations and actions in Consultation, review, specification, inform provider, procurement activity, future consultation activity, inform other relevant organisations(NHS England, Local Authority

8. 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 section 1- Objective A: Eliminate discrimination, victimisation, harassment and any unlawful conduct that is prohibited under this act:

PSED 1, Objective B; Advance Equality of opportunity

PSED objective B, sub section (3)(a): 'remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic';

PSED section 1, Objective B, sub section (3)(b): 'take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it';

PSED section 1, objective B, subsection (3)(c): 'encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low'.

PSED section 1, objective C: 'foster good relations between persons who share a relevant protected characteristic and persons who do not share it.'

PSED section 2: – 'A person who is not a public authority but who exercises public functions must, in the exercise of those functions, have due regard to the matters mentioned in subsection (1)[the 3 objectives]'.

PSED section 4 – 'The steps involved in meeting the needs of disabled persons that are different from the needs of persons who are not disabled include, in particular, steps to take account of disabled persons disabilities.'

PSED section 5 – 'Due regard to the need to foster good relations by tackling prejudice and promote understanding' Not engaged

PSED section 6 – Compliance with the duties in this section may involve treating some persons more favourably than others; but that is not to be taken as permitting conduct that would otherwise be prohibited by or under this Act.

9. Recommendation to Board

PSED will be met / unmet

Actions that need to be taken

Notes:
Piggybacking questions; There is an opportunity to ask questions about 'screening and early detection' in the form of 'how likely is it that if you suspect you have cancer you would see a GP ' 'immediately, put off for a few weeks, wait until symptoms worsened, very reluctant to pursue' etc - whilst not linked to the question of Hubs, it would allow us to capture information that could shape Public Health/Information giving to the population encouraging early detection.