Equality Analysis : Final Report
Report v7

Haemato-Oncology inpatient services reconfiguration and service integration

Liverpool University Hospitals NHS FT and The Clatterbridge Cancer Centre NHS FT

Start Date:	Scoping meeting Oct 2020 Pre-engagement EA December 2020 Post- engagement EA July 2021	
Equality and Inclusion Service Signature and Date:	Jo Roberts	8th January 2021 8th February 2021 11th February 2021 12th February 2021 15th July 2021 29th July 2021
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Sign off should be in line with the relevant NHS organisations' Operational Scheme of Delegation		
The Clatterbridge Cancer Centre Lead Officer Signature	Name: Tom Pharaoh, Director of Strategy	Date of review: 16/09/2021
The Clatterbridge Cancer Centre Committee	Committee Name: Internal H-O Integration Steering Group	Date considered: 16/09/2021
Liverpool University Hospitals NHS FT Lead Officer Signature	Name: Tom Pharaoh, Director of Strategy (pp the committee)	Date of review: 17/09/2021
Liverpool University Hospitals NHS FT Committee	Committee Name: Joint H-O Integration Steering Group – this group includes CCC, LUHFT, South Sefton CCG and Liverpool	Date considered: 17/09/2021 and formally approved on 01/10/2021
South Sefton CCG Lead Officer Signature	Name: Martin McDowell, CFO NHS South Sefton and Southport and Formby CCGs	31.8.21
South Sefton CCG Committee	Clinical Advisory Group Joint QIPP Delivery Group	3.8.21 31.8.21
Liverpool CCG Lead Officer Signature	Refer to box below.	Refer to box below.
Liverpool CCG Committee	Committee Name: Joint H-O Integration Steering Group – this group includes CCC, LUHFT, South Sefton CCG and Liverpool	Date considered: Date considered: 17/09/2021 and formally approved on 01/10/2021

Document control:

Version	Type of changes	Date
V1	Original doc	08.01.2021
V2	Text edits / answer questions	01.02.2021
V3	Update patient data	08.02.2021
V4	Update patient data	11.02.2021
V5	Narrative amended specific to travel questions. Risk section updated.	12.02.2021
V6	Final analysis	15.07.2021
V7	Final edits	29.07.2021

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.

The acute providers in North Mersey – which were the Royal Liverpool & Broadgreen University Hospitals NHS Trust (RLBUHT)[1], Aintree University Hospital NHS Foundation Trust (AUHFT) and Southport and Ormskirk Hospital NHS Trust (S&O) when this project began – have historically all provided comprehensive Haematology services, including both malignant (Haemato-Oncology) services, and non-malignant clinical haematology services. In addition, RLBUHT provided specialist services for Haemostasis and Thrombosis and also Haemoglobinopathies and Thrombotic Microangiopathy.

Following a proposal made by the haemato-oncology clinicians, the executive teams of the respective organisations agreed to explore the migration of Haemato-Oncology services from RLBUHT and AUH to The Clatterbridge Cancer Centre NHS Foundation Trust (CCC). The management integration of RLBUHT Haemato-Oncology services occurred in July 2017 and it had been originally proposed that the AUHT Haemato-Oncology services would integrate with CCC at a later date. Both trusts are now in a position to manage this move in 2021.

The clinical case for change sets out how Haemato-Oncology (H-O) services across Liverpool and North Mersey can achieve the best care and treatment through a reconfiguration in the way in which H-O services are delivered.

The proposals will significantly enhance care for people with H-O cancers by:

- Creating a single, resilient service by concentrating teams and resources to enable greater sub-specialisation for this increasingly complex group of cancers.
- Transferring management of the Aintree University Hospital (AUH) service from Liverpool University Hospitals NHS Foundation Trust (LUHFT) to the management of The Clatterbridge Cancer Centre NHS Foundation Trust (CCC),

[1] RLBUHT and AUHFT merged on 1st October 2019 to create Liverpool University Hospitals NHS Foundation Trust (LUHFT). AUH is used in this document to refer to the Aintree University Hospital site, not just the former trust.

which already provides the majority of H-O care in Liverpool.

- Relocating six inpatient Haemato-Oncology (H-O) beds worth of activity from the AUH to the new CCC–Liverpool, the specialist centre.
- Continuing to provide chemotherapy, day case treatments and outpatient appointments at the AUH site under the management of CCC.

This proposal involves changes to the way North Mersey H-O services are delivered.

Within North Mersey adult H-O services are provided by both CCC and AUH. These services provide emergency and non-emergency care that may:

- Diagnose blood cancer or disorders using a wide range of diagnostics such as scans and biopsies
- Treat blood cancers or disorders with chemotherapy, other medication or radiotherapy
- Provide long term follow-up

However, currently, the ways in which these services are delivered differ between both organisations and services. CCC is a specialist regional service and is the only provider for Teenage and Young Adult services and adult Bone Marrow Transplantation within Cheshire and Merseyside. The nearest other Level Four (i.e. transplant) units are Manchester University NHS Foundation Trust and The Christie NHS Foundation Trust.

The clinical service at CCC is spilt into four specialities which are delivered by a multi-disciplinary team that are aligned to the four H-O specialities. The haematology medical and nursing teams at AUH currently provide H-O care as well as care for a number of non-malignant conditions.

Due to the increasing number of speciality diagnoses and the availability of ever more complex therapies, it is widely recognised that H-O conditions should be managed by subspecialist H-O multidisciplinary teams, a model now mandated nationally and described in the various Improving Outcomes Guidance and NICE guidelines available.

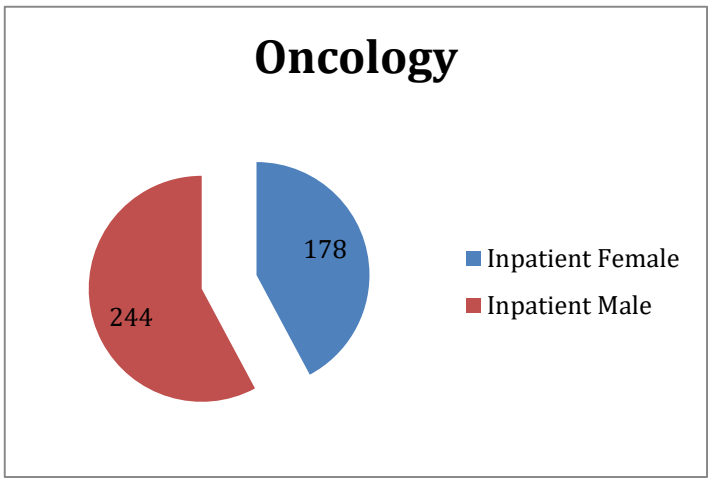
Without integration of the AUH service into CCC, H-O services at AUH would become an even greater standalone sub-specialty, with H-O clinicians becoming increasingly isolated. Moreover H-O patients will not receive equitable access to dedicated cancer services, novel therapies, clinical trials, home chemotherapy and the hub-and-spoke model of care.

Table and chart below describes 2019 activity information for the H-O service including: outpatients, day cases and inpatient services. These figures are derived from commissioned modelling work undertaken with AUH and CCC Business Intelligence.

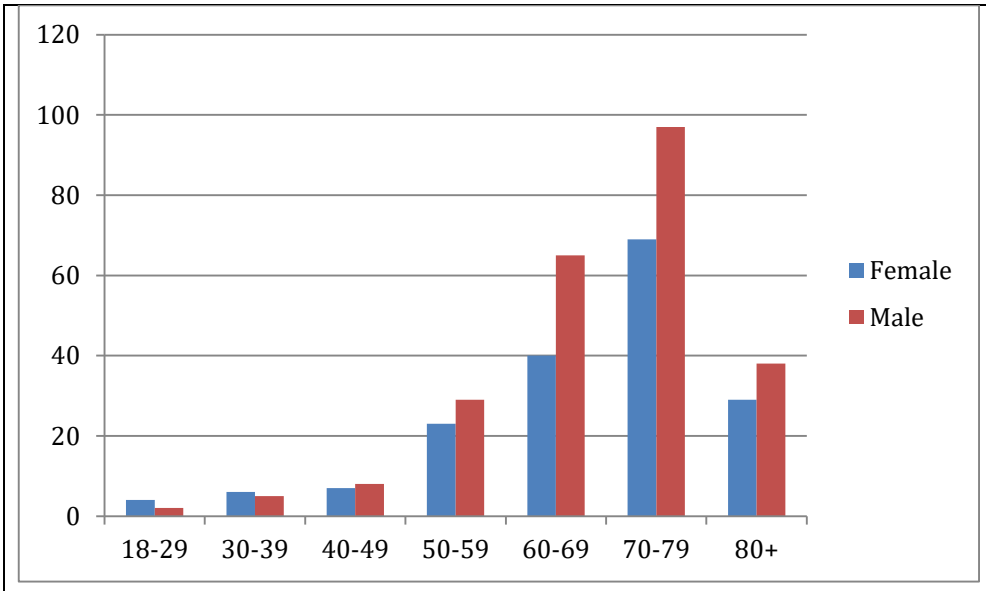
	CCC	AUH
New Outpatient Appointments	1,312	878

Follow-Up Outpatient Appointment	16,869	5,551
Inpatient admission	700	422
All patients treatment and chemotherapy	5,066	2,273

The figure below shows activity during January 2019 to December 2019 by male and female inpatient admissions at Aintree University Hospitals NHS FT. Total 422.



The chart below shows January 2019 to December 2019 inpatient admissions to Aintree University Hospital count by sex and age group.



Review of data indicates that the majority of patients are in the older age ranges starting from 50's. Many patients are anticipated to be retired and may already be frail with age.

Service Reconfiguration Proposal

The proposed reconfiguration of services would affect the way H-O services are delivered and the access/location of services for patients living in the North of the area. The proposal has two strands: firstly, it involves unifying both CCC and AUH clinical teams in sub-specialist teams to deliver care across the two sites and, secondly, changes to patient pathways and points of access.

Unification of sub-specialist teams

The CCC clinical service is split into four overarching specialties and is delivered by a multi-disciplinary team aligned to the four H-O specialties. If the proposals are approved, the LUHFT Aintree clinicians will align to this model of care within the CCC Acute Care Division and will be split as demonstrated in Figures 1 and 2.

Figure One: CCC and AUH as it is currently structured

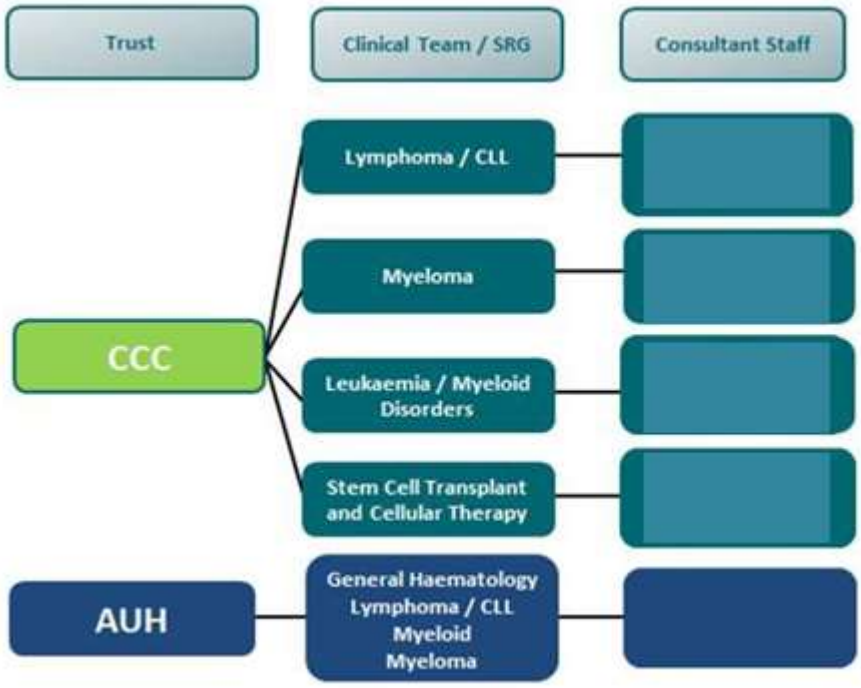
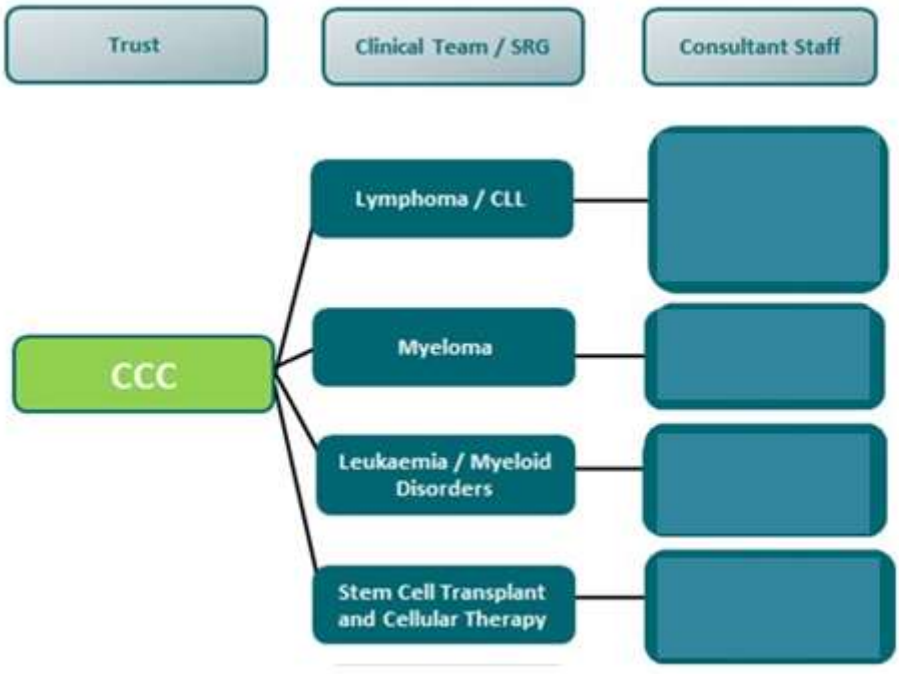


Figure Two: CCC Proposed structure



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

The case for change is to develop a more cohesive unit with significant benefits for the patients and staff of H-O services. These include:

- Improved clinical outcomes

- Enhanced safety and quality for patients
- Enhanced patient experience
- Improved access to specialist care for all patients with blood cancer
- Enhanced community provision and patient choice (as part of the CCC Future Clinical Model Project)
- Enhanced cancer service brand and reputation
- Addressing growth by increasing capacity and capability

2. Change to service

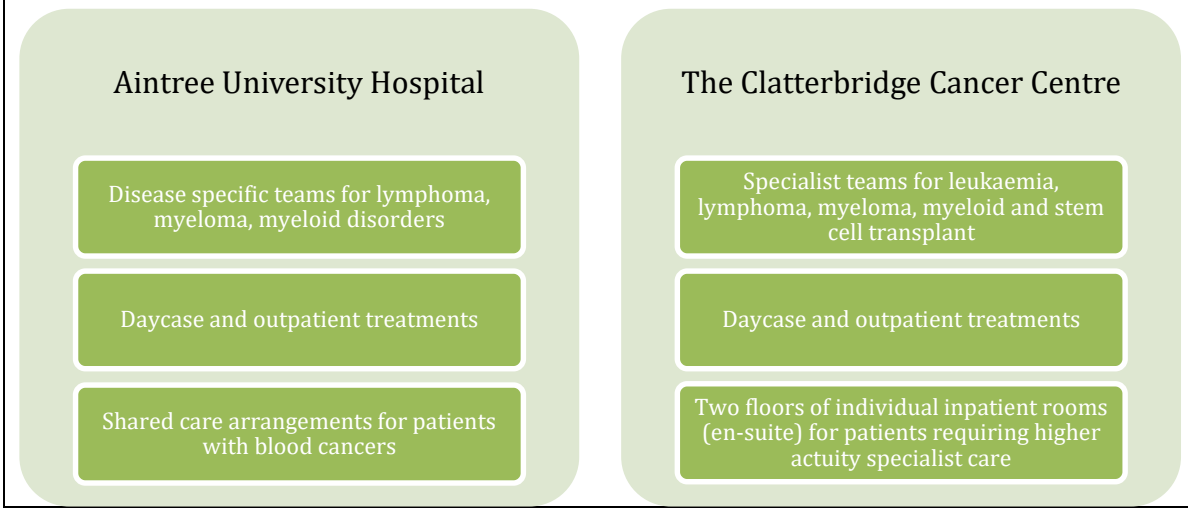
The proposed transformation would see a change in the ***patient pathway*** and ***patient access points*** as it is proposed that a hub and spoke model of care will be used, with the aim of delivering local care where possible, and centralised care where necessary. This is across both elective and non-elective model of care as described in Figures 1 and 2.

This proposal will mean that:

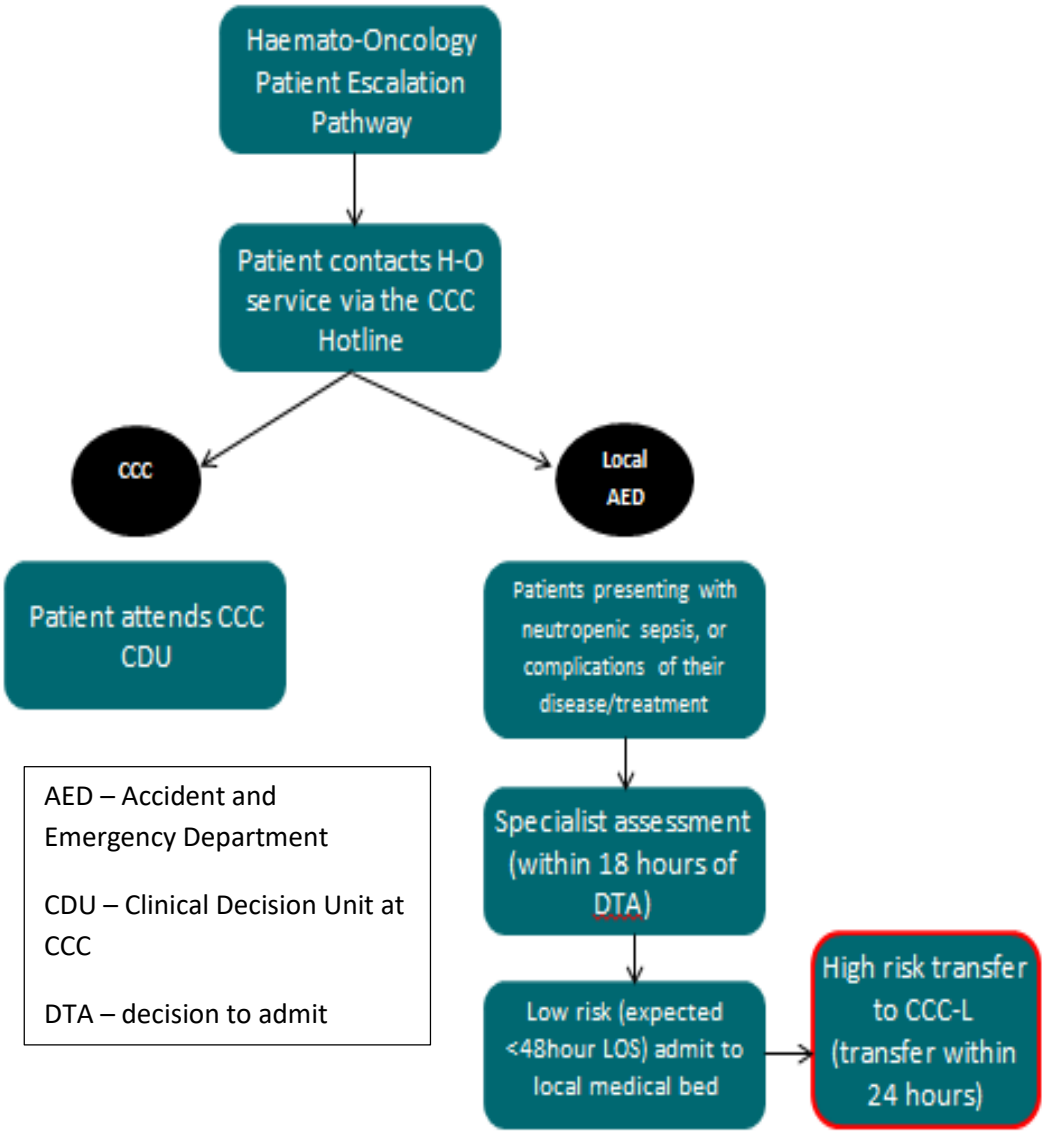
1. Higher acuity inpatient pathways of care will be delivered in CCC-L. This equates to six inpatient beds worth of activity to be transferred from AUH to CCC-L
2. Complex pathways of care such as acute leukaemia and stem cell transplants will remain within CCC-L
3. Outpatient and day care will be delivered across both sites, CCC-L and AUH
4. Emergency Pathways of care will be supported by CCC's 24/7 hotline service and rapid access to CCC-L
5. Shared care pathways for patients whose primary condition is not H-O, such as frailty, will continue to be clinically managed by AUH in line with the CCC/LUHFT model of care.

Whilst the 'behind the scenes' management of the service will shift to CCC-L, from a patient perspective only points 1 and 4 above will mean a visible shift in current service supply. As such, the restructuring presents a minimal shift in service provision from a patient perspective. The biggest change, from a patient perspective, will be the transfer of beds from AUH to CCC-L and case management from CCC-L.

Proposed Elective Inpatient and Outpatient Model of Care



Proposed Emergency Pathway Model of Care



The creation of a single H-O service with a hub-and-spoke model of care connected to a dedicated centre (CCC-L) will instigate fundamental improvements in the quality of service provision.

Faster diagnosis and treatment: The future goal for H-O is a 'one stop shop' for diagnosis and staging of haematological malignancies, with the intention being that such a service has the potential to dramatically cut waiting times and improve survivorship. CCC is working with the Cheshire and Merseyside Cancer Alliance to support Rapid Diagnostic Centres. An integrated service would benefit from CCC's involvement in this project.

Reduced Length of Stay: Reviews of the current H-O patient pathways highlights the potential scope to reduce length of stay and improve patient experience, through transforming the current fragmented service into a more operationally efficient, all-encompassing single clinical model.

Improved mortality rates: There is clinical evidence (such as via NICE) which

demonstrates that H-O outcomes can be improved through treatment in large specialist cancer centres, which is a compelling argument for centralisation of the care of complex inpatients from AUH. Wider team working will enhance knowledge and skills in all team members.

Access to CCC Clinical Decisions Unit/Helpline: The current H-O service lacks a streamlined admissions process which may cause delays in delivering specialist care to patients. Many patients present directly to A&E at both AUH and Southport and Ormskirk Hospitals (S&O) which can result in a delay to accessing a specialist oncology assessment. S&O has no H-O inpatient beds and those patients are currently admitted to AUH. CCC has a dedicated 24/7 helpline and access to a Clinical Decisions Unit (CDU) for patients under the care of the centre. AUH patients would benefit from this specialist access, reducing attendance at local A&E. The helpline is staffed by specialist cancer nurses who provide urgent care advice on a 24 hour basis to patients and other health professionals.

COVID-19 and hospital acquired infection: H-O patients are in the highest risk category as regards infection. The pandemic has led to organisations across the network working together in the spirit of mutual aid to protect patients as far as possible. CCC-L has allowed H-O patients to be transferred from high risk 'hot' centres such as AUH, to a 'cold' centre, with enhanced COVID-19 measures. Strict infection control policies and protocols and the single ensuite patient accommodation in the new cancer centre greatly improves effective infection control.

Research: The inclusion of AUH H-O within CCC will drive the research agenda forward, facilitating a centre of cancer research excellence and a focused research team. A significant amount of H-O research is already undertaken across the city of Liverpool but more could be done with access to a greater pool of patients. This would also provide AUH patients with equitable access to clinical trials to that of CCC H-O patients.

AUH is the superregional centre for primary CNS lymphoma patients, and has an established pathway with the Walton Centre for Neurology and Neurosurgery (WCNN), and regularly receives patients from Wales and the Isle of Man. It is one of only four UK centres recruiting to national and international phase three trials in this rare condition. Closer relationships between AUH, CCC and WCNN will improve patient access to specialist transplant services and reduce delays to pathway.

Dedicated beds: The CDU in CCC-L will ensure all patients are admitted into a dedicated H-O bed. This cannot be guaranteed at AUH, due to the acute admissions pathway in place which results in H-O patients often passing through multiple acute medical areas before reaching a specialist H-O bed. Thus patients admitted to CCC-L will benefit immediately from specialist input.

Improved pathways: There is currently fragmentation across the stem cell transplant pathways, MDT, and access to clinical trials. Unification will reduce any risk associated with patients being managed/referred across to separate organisations. This will additionally make the system robust and further comply with NICE guidance (2016).

Community care: CCC provides a Clatterbridge in the Community service where patients can receive their treatment at home or at work. As this expands to include more H-O treatments AUH patients could benefit from this service.

Addressing capacity constraints and releasing beds to the healthcare economy: The proposed H-O facility at CCC does not increase the current H-O bed base

substantially but offers the flexibility for growth and the ability to flex between solid tumour and H-O beds. CCC has the added feature of 15 High-efficiency particulate air (HEPA) filtered rooms. This capacity, coupled with a dedicated clinical decision unit, would free up capacity across the health economy, and help support a busy acute trust, in particular when COVID-19 is a challenge.

Workforce: The British Society for Haematology published a paper in 2019 that identified a number of issues affecting the H-O workforce. This included the number of vacancies at a time when there is an increase in incidence of this cancer type, and also an increase in the complexity of treatment required. This is further impacted by the reduced number of trainees being recruited to, with numbers having fallen over 36% in the last two years. This then impacts on the current workforce with increases in stress and sickness. This redesign helps to mitigate some of these issues to ensure that patients do not face barriers to diagnostics, and novel treatments.

3. Potential barriers relevant to the protected characteristics.

H-O services, albeit over two sites, has been delivering its services already in light of statutory demands of the Public Sector Equality Duty (PSED).

Part of the engagement with patients will be to identify any negative impact that they may have experienced linked to their protected characteristics (see section 5 below)

One of the concerns that automatically stands out is the issue of (public) travel and the fact that the formation of the new service means that inpatient admissions will be to CCC-L and not AUH. In logistical terms this means that people from the north of the city (AUH area) may incur additional travel times and when using public transport may have to travel across the city centre. However, patients who require admission will be supported to attend CCC-L via the local ambulance service or taxi firms (via contract). Most public transport is designed to pull people into the centre and not necessarily carry them across the centre. This may mean family and friends who wish to visit an inpatient may have to make multiple 'bus trips' as part of one journey. The impact of this will be on those that rely on public transport as their only means of travel, which includes (in more cases than not) women, older women and older men, low income families, and people with disabilities who cannot drive (e.g., partially sighted).

Families without cars or access to cars may be paying for taxis which are an unanticipated cost for families on small budgets. As such the impact of travel needs to be evaluated and mitigated as far as possible. However, it's worth noting that CCC-L is the only level 4 cancer service in the Merseyside and Cheshire regions. The next other level 4 cancer services are in Manchester. Compared to the difficulty of travelling to Manchester, travelling across the city is less daunting. CCC also has a dedicated team who work with patients and relatives to help them access benefits and charitable funds to support low income families who are experiencing additional cost due to illness.

Travel: Review of the 157 patients who could move from AUH to CCC-L for inpatient care has been undertaken. There is a physical distance of 5.5 miles (by road) between the two sites.

Patients who were admitted to CCC-L after attending AUH would not be disadvantaged by this distance as they would be transferred using patient transport.

Patients from the North Mersey area who were asked to attend directly to CCC-L (thus avoiding A&E at AUH or S&O) will potentially be affected. It's assumed in most cases patients will be brought to hospital by a friend/relative or taxi as they will be too unwell for public transport or to drive themselves. There may be some who meet the criteria for NWAS transport.

An initial travel assessment has been carried out of the impact on journey times from the four CCG areas that most of the 157 patients in 2019 came from. The following table shows average increased journey times by private vehicle or public transport of between zero and 16 minutes, depending on the starting point. It is believed the clinical benefits of providing inpatient care in the specialist cancer centre at CCC-L outweigh the impact on journey times for patients' families and friends, but patients' views will be sought on this as part of the engagement process.

CCC-L has dedicated drop off zones for both ambulance transfer or for family/carer drop off. These are adjacent to the main entrance and porters are available to provide wheelchair support if required. Patients can access parking in a dedicated car park (This is currently at Mount Pleasant but will be at Paddington Village from autumn/September 2021.) There is a shuttle bus that operates from the car park to the CCC-L main entrance.

Visitors to CCC-L have access to a number of nearby car parks. The hospital's new car park in Paddington Village will open in 2021. The University of Liverpool has reduced parking rates after 17.30 (£3.00 max per visit) for evening visits. There is a Q Park multi storey car park adjacent to the Royal Hospital, and some smaller, privately run, car parks in the area. Parking is also available at reasonable rates in Mount Pleasant.

There are a number of public transport options for patients' family and friends. CCC-L is readily accessible by public transport as it is located next to the Royal Liverpool University Hospital and the University of Liverpool. There is a bus from AUH to the Royal, operating every 8 minutes and taking 20 minutes. CCC-L is also close to Lime Street station for train access. There are links to the Merseytravel journey planner from CCC's website and there will be further liaison with Merseytravel as part of this process so patients have information about the best routes for the main journeys.

Table to show average times (minutes) for travel

	Journey time to AUH by car (mins)	Journey time to AUH by public transport (mins)	Journey time to CCC-L by car (mins)	Journey time to CCC-L by public transport (mins)	Average difference by car (mins)	Average difference by public transport (mins)
Knowsley	14	38	29	45	16 mins more	7 mins more
Liverpool	14	25	17	26	3 mins more	1 min less
Southport & Formby	34	74	51	67	16 mins more	7 mins less
South Sefton	18	37	27	46	9 mins more	9 mins more
West Lancs	29	72	42	86	13 mins more	14 mins more

The chart shows that public transport travel time is usually twice that of private car, and the switch from AUH to CCC-L is adding around at worst 16 minutes of travel time. This was based on total journey times in Google Maps which includes waiting/transfer times in the journey.

Potential discriminatory barriers in providing the service.

The table below looks at issues highlighted by patient engagement and if they present particular discriminatory barriers and if so how can these be mitigated.

Protected Characteristic	Issue	Remedy/Mitigation
Age: Majority of service users over 50 and of this cohort the 70 year old plus make up the biggest group.	The overall consensus was that the service is warmly received. Transport/ travel were highlighted as an issue, but it was generally felt that the additional travel to get to a better service was acceptable.	Continue to put patients at the centre of the service Help with travel costs is available for patients: https://www.nhs.uk/nhs-services/help-with-health-costs/healthcare-travel-costs-scheme-htcs/ The Trust signpost to https://www.macmillan.org.uk/cancer-information-and-support/impacts-of-cancer/benefits-and-financial-support Free parking will be available in Paddington Village, a newly-constructed car park opening in September 2021 and therefore fully compliant with the latest accessibility standards. The car park is just a few minutes from the hospital and we will run a frequent shuttle bus, providing a door-to-door service for patients and visitors. Drop-off facilities are also available right outside Clatterbridge Cancer Centre – Liverpool to assist people with reduced mobility or other additional needs. The Trust advertises links to Merseytravel and the Cancer Information & Support Centre team in CCC-L can help anyone who may not have internet access to determine the best travel tickets for them. Consider individual patient/ family needs in the event of further COVID-19 waves/ variants and travel impacts.
Disability. Cancer is described as a disability under	Concerns were raised by some patients in relation to: - support with mental health issues.	CCC has an SLA with Mersey Care NHS FT to ensure that specialist mental health support is available to assist where

the Equality Act 2010.	- access to psychological support - changes to consultation types e.g. virtual (which were part of the organisation's response to COVID-19) presented difficulties for patients who for example were Deaf and/ or preferred face to face appointments. Transport/ travel – **refer to Age.**	patients have mental health conditions. CCC to continue to promote the psychological support available to patients. Ensure staff are aware of how to support patients with sensory impairments including access to BSL interpreter provision and providing reasonable adjustments.
Gender reassignment	No issues identified, but a trans person may need specific support, especially about keeping their trans status private on the ward.	Ensure that protocols are in place to support trans patients.
Marriage and Civil Partnership	Family expressed concern over lack of visitation due to COVID-19.	Consider methods by which family could participate more in the patients care and continually review COVID-19 restrictions on ward visitation.
Pregnancy and maternity	Protocols and policy in pace as to the affect chemo may have on a foetus.	Consider wellbeing of mother and child in relation to treatment plan. Research shows that **chemotherapy** is generally safe for both the mother and the baby during the second and third trimesters, after the baby's organs have fully developed. However, radiation therapy and hormone therapy should be delayed until after a **pregnant** woman has given birth.
Race	There were no responses from other ethnic minorities.	Ensure that services are culturally sensitive. Ensure there is access to interpreter provision for people whose first language isn't English. Ongoing monitoring of patient experience/ feedback. Ongoing monitoring of care/outcomes across all protected characteristics.

Religion and belief	No comments were made in relation to religion from the consultation group.	Ensure patients can practice their religion as long as it is safe for them to do so.
Sex (Male /Female) Patient numbers are almost a 50% split between male/female.	Both males and females expressed how good the service was. Any criticism appeared to be non-gender specific and revolved around the general practicalities of hospital life. Transport/ travel – **refer to Age.**	Continue to provide high quality services and pick up concerns highlighted in section 5 below.
Sexual orientation	No concerns were raised on this issue.	Continue to provide quality services to all patients.
Health inequalities	H-O local outcomes historically differed significantly from the national average, and whilst joint working has improved this, a further consolidation of the teams would continue to support these improvements. It is acknowledged that there are improved survival rates in large specialist centres. **Lower socio economic** groups have a history of late presentation of illness and low compliance with treatment, which means improving mortality rates in Merseyside is even more challenging given the **high levels of deprivation** across the region. This notion is supported through analysis of National Cancer Intelligence Network (NCIN) data of outcomes for primary illnesses in Merseyside and Cheshire in terms of incidence, mortality and survival rates. Local outcomes can differ significantly from the national average. For example, whilst outcomes for non-Hodgkin's lymphoma are generally in line with the national average, leukaemia outcomes are significantly inferior in Merseyside and Cheshire, with the AML 5 year survival rate being 34.6% compared to a national average of 50.8%. Compare this to Leeds: In 2007 the Leeds Cancer Centre opened which saw the integration of the two separate H-O units with the solid tumour service into the new build	Continue to develop inclusive services. The Trust has advisors in CCC-L who can help identify what a person and their carers may be able to claim in terms of benefits etc. Help with travel costs is available for patients: https://www.nhs.uk/nhs-services/help-with-health-costs/healthcare-travel-costs-scheme-htcs/

	dedicated centre, which today is internationally recognised and one of the largest providers of cancer care in the UK. Subsequent to this integration, outcomes in H-O are now amongst the best nationally with 5 year survival rates for AML at 62.6%. Whilst there may be numerous facets that explain the inferior outcomes in the region, the current confederated model of service delivery is certainly a contributory feature, particularly given the presence of data indicating better and vastly improved survival rates in large specialist centres. Such regional service inequalities are also likely to be a factor in referral direction and patient choice.	

4. Does this service go the heart of enabling a protected characteristic to access health and wellbeing services?
Cancer treatment is essential to modern NHS service provision
5. Consultation
Targeted engagement was carried out with patients/carers during 2020 and 2021 to seek their views on the proposals and their experience of using local blood cancer services. A range of methods were used to offer patients/carers the opportunity to be involved, and to gain qualitative and quantitative feedback. The project team also engaged with GP groups in the Sefton area as half of the patients admitted to AUH in 2019/20 were from the borough. Due to the specialist nature of the service, engagement was very targeted and focused on people with direct experience of blood cancer as a patient or relative/carer. The Trust took steps to try and hear from a broad and representative group. The semi-structured phone interviews were with patients from a variety of ages and backgrounds, note that these were drawn from a small cohort of patients who had been inpatients in the last year and were clinically well enough to be interviewed. The online engagement was publicised across the hospital sites, via blood cancer patient groups, with patient appointment letters, and on social media. Online survey responses: • 15 were from people who currently or previously had a blood cancer • 4 were from relatives/carers of people who currently or previously had a blood cancer • Responses came from: Sefton (42%); West Lancashire (26%); Liverpool (21%); St Helens (5%); Wirral (5%). Although West Lancashire was over-represented in the responses, compared with the percentage of patients from the borough, this was not felt to be problematic, given the importance of hearing from people who may be adversely impacted by increased travel times.

Phone Interviews:
All of the nine inpatients interviewed were positive about the care they had received, whether at AUH or CCC-L. They were particularly complimentary about the staff.

Five of the patients were male; four were female. They ranged in age from their early thirties to their late seventies / early eighties and were mainly from Sefton and Liverpool, with a smaller number from West Lancashire and one person from Wirral. Their experience of inpatient care was:

- Seven had been inpatients in CCC-L.
- Four had been inpatients in AUH for blood cancer; two other patients had been admitted to AUH for other conditions.
- Three had been blood cancer inpatients both in AUH and CCC-L; a fourth had received inpatient blood cancer care in CCC-L and inpatient care for another reason in AUH.

Eight of the nine inpatients said that, if they needed to be readmitted in future, they would prefer to be treated in CCC-L than AUH. This wasn't because they were unhappy with the care they received at AUH – the reasons included preferring a single room, preferring to be in a hospital that only treated cancer, and preferring to be in the specialist cancer centre. COVID was cited by several patients who said their reduced immunity meant infection was a key concern and they would prefer to be in a single room in a hospital that did not treat people with other conditions, rather than a shared ward in an acute hospital.

Some extracts of the in-depth patient interviews are provided below:

People appreciating the service and the quality of nursing:
The treatment there was fantastic. You couldn't fault that at Clatterbridge, the nurses and everything

Clatterbridge was fantastic. I couldn't fault it. The young nurses in there are fantastic. They deserve a medal. You really get looked after in there. It's not the sort of place you want to be in but if you've got to go in that's the place to be. Even the girls when I go in for my chemo, they're good in there as well. I can't fault them at all. (At the Phoenix). I just get on with it. I can't complain about anything.

You couldn't improve on the service or the quality or the nursing or anything. It would take something to do that. The single room was great. When I first read about it when they were building the new hospital, I thought 'that would never work – how would they keep an eye on you'. But it does work. It's private, it's nice.

…the nurses were brilliant. They were so personable. Everything was explained really well. They made sure mum was all right – cups of tea, drinks, everything ['mum' is a wheelchair user and staff catered for 'mum's needs as a patient]

I had chemotherapy in Aintree. I was a day visitor every 2 weeks …. the chemotherapy care was fantastic.

The nurses are brilliant.

The facilities in room were brilliant. You've got the TV and everything. That's all you really need, isn't it? Like the shower, the bathroom is brilliant.

The nursing staff were absolutely spectacular, every single person that dealt with me. The doctors were spectacular and I appreciate at the time

[they] *made sure I was really aware of what was going to happen, so I felt informed when I was admitted*

I'm in a situation where I don't want to be in but I've always been treated courteously and everyone's always treated me with the ultimate respect

that new hospital – it was just amazing. Amazing

Patients expressing concerns: (items marked in bold have direct equality implications)

[Post treatment]…*I think they've lacked a bit in the care since. She's in remission. They told her she was in remission but that was a phone call and she got a letter but it's still not very personable.*

Traffic was our biggest problem. Aintree is 20 minutes and although the Royal is only 5 miles further, honestly, it took me nearly an hour to get there because it's city centre. That's the issue

Aintree, where the nurses were fantastic – they didn't really - nobody offered me along the way any assistance in terms of to get, you know, like counselling or psychological support or help with benefits

The meals aren't that bad but I had scouse 3 nights on the bounce and in the end on my 4th night I just said I don't want any dinner.. I got a Burger King delivered but the thing is they left it downstairs for half an hour before they brought it up. I couldn't eat it cold and it's a bit risky warming it up when you're having chemotherapy so I wasted about £16 on a Whopper, bacon double cheeseburger and everything. Then I got it and it had gone cold so I just had the Fanta.

[obtaining medication from the pharmacy] *there doesn't seem to be a lot of communication between the nurses and the staff. Even the nurses would say 'it takes you ages getting this stuff' – because of switching from the Royal, I think, because in the Royal you used to get it straight away. In Clatterbridge it's a struggle to get the medications. It's not their fault – there's something wrong in terms of the logistics of getting stuff from the Royal into Clatterbridge or vice versa. I don't know but they said in the Royal they've got no problems like they've got here, getting stuff.*

[on calling for help] *the auxiliaries come first and sometimes they could take 20 minutes or 25 minutes and you're like 'hmph, where are they' but they're busy.*

[multi-bed ward] *the first time I was in Aintree was October and I was in a multi-bed ward and it was horrendous because I was in a lot of pain and you've got other people around you and you don't want to speak to them. You just want to draw your curtains round and just – I mean, that's the way I am – so I did find it difficult being on a multi-bed ward ……. Clatterbridge is lovely and quiet because you've got your own individual room*

with Aintree, the staff need to keep their voices down at night.

communication – I feel like I've had a lot of letters which have been kind of pointless. Which is fine – you know, it doesn't do me any harm – but in terms of trying to move to a more sort of paperless and more environmentally-friendly.

Not so good, really, Aintree. I don't know how to say anything negative about it, really, because the staff were so good. Just being in an open ward and noisy and people shouting.

[patient was] ***diagnosed with bipolar …. when he went in for his first chemo, he was having a bit of a hyper moment, which I did discuss – because of how he would be, you know, on the ward. And the only thing that I kind of wish would have happened is that they could have got maybe a mental health nurse to actually come and speak to him at the time. Because obviously with his mental health as well, and having to go through the chemo, and obviously your imagination runs riot at that point, which was his first time going in. If there was any kind of little niggle, it was that. I was just a bit – and I know they're busy – but I wish – because I did bring it up and mention it, because he was extremely hyper when he was in.***

The patient is deaf in one ear so he doesn't always hear what's being said to him – I know they had masks on so it was difficult this time. Sometimes [staff] didn't really take that on board and make sure that he's understood what they've said.

The full engagement report is available here:

DRAFT Engagement report.docx

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

Patient feedback generally thought the service was very good – the only equality concerns that were flagged was the need for mental health support and also noting that there were no responses from people who are from ethnic minority.

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)

Access to the service was not a concern from the engagement group – many spoke of how fast doctors and specialist got to them and how quickly they flowed into the service.

The service is designed for all people and can cater for disabilities.

PSED Objective 2: Advance Equality of opportunity

Refer to sub-sections.

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.

The service is designed around the needs of the patient and in principle can meet all protected characteristic requirement.

Patient feedback shows that high quality care was given.

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

Some patients need mental health support, whilst this was available there was a criticism that there 'wasn't enough' at the right time. A number of the patients interviewed by phone spoke about the impact of the COVID-19 pandemic, including safety measures in hospitals such as visiting restrictions and phone/video consultations. People with blood cancer can be particularly at risk of infection and patients appreciated measures being put in place to reduce infection but also spoke honestly about some of the challenges. For example, hearing-impaired patients found it harder to understand what staff were saying while wearing facemasks or during phone consultations than in a traditional face-to-face setting. A patient who had wanted cancer advice and information (including benefits advice and psychological wellbeing) would have preferred to speak to someone in person rather than over the phone. At the time, drop-in services and face-to-face appointments for these services had been paused/reduced due to COVID-19. CCC-L to ensure that patients are offered access to psychological support/ signposted to other services and to continue to increase staff awareness of the barriers for people with sensory impairments to ensure reasonable adjustments can be implemented.
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.
The service is a 'needs lead' service based on A&E, GP referral or referral from other specialities. Patients without a GP can attend via A&E, however a continuous watch has to be keep to any health inequities in play which are acting as a barrier to either entering the service or carrying out the full treatment.
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)
Objective not engaged.
Health Inequalities: Have regard to the need to reduce inequalities between patients in access to health services and the outcomes achieved (s.14T);
Access to the service is via GP referral or A&E. the difficulty will be people who may be 'homeless' or marginalised' recognising that they are sick and need help.
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)
Not engaged at this point.
8. Recommendation to Board
Guidance Note: will PSED be met?
PSED is met, but issues around mental health support needs to be addressed to avoid it becoming an indirect discriminatory position. The service is highly thought of by patients and the issue of 'additional travel' is low down in their concerns especially when it comes to receiving better care. Mitigation that has been put in place, regarding parking and shuttle bus that will help patients to over come any barriers here.
9. Actions that need to be taken
Refer to section 3.