



Office of the
Trust Special Administrator
of MSFT

Mid Staffordshire 
NHS Foundation Trust

**The Office of the Trust
Special Administrator of
Mid Staffordshire NHS
Foundation Trust**

**Trust Special Administrators'
Draft Report – Volume Three
(Independent Health and
Equality Impact Assessment
Scoping Report)**

July 2013

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Special Administrator of
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Steering Group

To: the Office of the Trust Special
Administrators for Mid Staffordshire NHS
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Glossary

Abbreviation	Meaning
A&E	Accident and Emergency
APHO	Association of Public Health Observatories
BGHS	British General Household Survey
BHT	Burton Hospital NHS Foundation Trust
CB	Commissioning Board
CCG	Clinical Commissioning Groups
CHS	Community Health Service
COPD	Chronic Obstructive Pulmonary Disease
CPT	Contingency Planning Team
CQC	Care Quality Commission
CVD	Cardiovascular Disease
DH	Department of Health
DLA	Disability Living Allowance
DMS	Defence Medical Services
E&D	Equalities and Diversity
ED	Emergency Department
ENT	Ear, Nose and Throat
FT	Foundation Trust
GFR	General Fertility Rates
GMS	General Medical Services
HCC	Healthcare Commission
HEFT	Heart of England NHS Foundation Trust
HEIA	Health and Equality Impact Assessment
HEIA SG	Health and Equality Impact Assessment Steering Group
HES	Hospital Episode Statistics
HIA	Health Impact Assessments
HMG	Her Majesty's Government
HWB	Health and Wellbeing Board
IMD	Index of Multiple Deprivation
LAT	Local Area Team
LFS	Labour Force Survey
LGBT	Lesbian, Gay, Bisexual and Transgender
LHE	Local Health Economy
LSOA	Lower Super Output Area
LTCs	Long-Term Conditions
MoD	Ministry of Defence

Abbreviation	Meaning
MoU	Memorandum of Understanding
MSFT / The Trust	Mid Staffordshire NHS Foundation Trust
MTC	Major Trauma Centre
NHS	National Health Service
NOMS	National Offender Management Service
NPPF	National Planning Policy Framework
ONS	Office of National Statistics
PCT	Primary Care Trust
PHM	Public Health Medicine
PHS	Public Health Staffordshire
PSED	Public Sector Equality Duty
QC	Queen's Counsel
QOF	Quality and Outcomes Framework
RWT	The Royal Wolverhampton NHS Trust
SaTH	Shrewsbury and Telford Hospitals NHS Trust
SSCCG	Stafford & Surrounding CCG
SSOTP	Staffordshire and Stoke-on-Trent Partnership NHS Trust
TSA	Trust Special Administrator (in general)
TSAs	Trust Special Administrators (specifically for Mid Staffordshire NHS Foundation Trust)
UHNS	University Hospital of North Staffordshire NHS Trust
WHO	World Health Organisation
WHT	Walsall Healthcare NHS Trust
WMAS	West Midlands Ambulance Service
WTE	Whole Time Equivalent

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1 Executive summary

1.1 The Trust Special Administrators for Mid Staffordshire NHS Foundation Trust

On 16th April 2013 Monitor, the NHS Foundation Trust regulatory body appointed Joint Trust Special Administrators (TSAs) to Mid Staffordshire NHS Foundation Trust (MSFT or the Trust). This is the first time that Monitor has appointed a TSA to take over the running of a foundation trust (FT) and follows the appointment in October 2012 of a Contingency Planning Team (CPT) to assess the viability of MSFT. The CPT's interim report¹ was published in January 2013 and concluded that, despite the Trust's success in improving its performance, its small scale means it is both clinically and financially unsustainable in its current form. In its second phase, the CPT suggested local hospital models in both Stafford and Cannock². The TSAs are now preparing proposals for the future configuration, range and site of services which are currently provided by MSFT.

1.2 Purpose, objectives and timing of the impact assessment

A TSA is required to "observe equality legislation and principles and demonstrate that due regard has been paid to the equality duty of the Equality Act (2010). The equality assessment should apply to patients, public and staff"³.

The TSAs have established an impact assessment process to:

- Understand the impacts of the TSAs' draft recommendations on the health of the local population;
- Assess the impacts of the TSAs' draft report and recommendations on specific groups within the local population and staff so that, in preparing their final report and recommendations, the TSAs have paid due regard to the aims of the public sector equality duty when exercising their functions;
- Quantify where possible the impact of the TSAs' draft report and recommendations and gather qualitative evidence where required; and
- Make recommendations to the TSAs on actions to potentially mitigate negative impacts and help develop positive impacts.

The assessment is being carried out in two parts, based on the Department of Health's guide to carrying out an impact assessment⁴:

¹ *Mid Staffordshire NHS Foundation Trust Sustainability Report*, London: Monitor, January 2013.

² *Recommendations of the CPT*, London: Monitor, March 2013.

³ *Statutory guidance for Trust Special Administrators appointed to NHS foundation trusts*, London: Monitor, 5 April 2013, p. 17.

- (i) **The scoping report (this document):** understanding the local population and its health status; understanding and prioritising specific groups within this local population using both the “protected characteristics” set out in the Equality Act (2010) and any other relevant characteristics; and identifying and prioritising for mitigation the potential impact areas of the draft recommendations of the TSAs; and
- (ii) **The impact assessment report:** describing (both qualitatively and quantitatively) the impacts on health and equality outcomes of the recommendations of the TSAs and providing proposals to potentially minimise negative and maximise positive health and equality impacts.

The HEIA process is being carried out in parallel to the overarching TSA process. This scoping report has been produced at the same time as the recommendations for consultation; it sets out the focus and approach that will be applied, during the consultation period, to the TSAs’ draft recommendations. It does not, therefore, include any commentary or analysis on the draft recommendations at this point. This is the purpose of the impact assessment report, which will be published after the public consultation is complete; the impact assessment report will consider the draft recommendations and their impacts for consideration by the TSAs.

1.3 Governance of the impact assessment

The TSAs wish to ensure that the impact assessment is carried out in an objective and independent manner. They have sought out an individual with relevant experience who is independent of both Monitor and themselves as TSAs, to act as an independent chair of a Health and Equality Impact Assessment Steering Group (HEIA SG). Members of the HEIA SG have been selected to ensure that a wide range of professional expertise and stakeholder perspectives is incorporated from the start, including representing the views and perspectives of patients and members of the public in the HEIA process. The impact assessment will be submitted to Monitor to inform the TSAs’ final report and recommendations.

1.4 Scope of the impact assessment

The Steering Group has agreed the following scope for the impact assessment:

⁴ *Health Impact Assessment of Government Policy: A guide to carrying out a Health Impact Assessment of new policy as part of the Impact Assessment process*, London: Department of Health, July 2010, p. 7.

- **Health:** consider the TSAs' recommendations for changing the pattern of services at MSFT and identify the potential health consequences for the local population, with particular attention to those at increased risk of negative impact because of either socioeconomic disadvantage, living in isolated villages or dwellings, or a combination of these with the prioritised "protected characteristics"; and
- **Equality:** consider the recommendations for change in the pattern of services at MSFT made by the TSAs and assess the potential impact for those groups covered by the public sector equality duty, with a primary focus on age, disability, sex, and race (these are the prioritised "protected characteristics").

Based on this scope, the impact assessment is referred to as a "Health and Equality Impact Assessment" (HEIA).

1.5 Approach to the impact assessment

The Steering Group will use a combination of quantitative and qualitative analysis to understand the health and equality impacts of the TSAs' draft recommendations. The impacts will be assessed to understand their scale and relative impact so that the Steering Group can develop proposals to mitigate negative impacts or enhance positive ones. These proposals will be presented to the TSAs for their consideration in formulating their final recommendations to Monitor.

To ensure an impartial assessment of the range of important considerations in health quality, the Steering Group is using a framework devised by Maxwell⁵ (Table 1). This framework is based on the assertion that quality in health care is multidimensional and covers six areas: effectiveness, acceptability, efficiency, access, equity and relevance.

⁵ RJ Maxwell 'Dimensions of Quality Re-visited' in *Quality in Health Care* 1992 1:171-177.

Table 1: Framework for assessing the impacts of the TSAs' draft recommendations

Questions that help to define and expand the label “quality”	
Effectiveness	Is the treatment given the best available in a technical sense, according to those best equipped to judge? What is their evidence? What is the overall result of the treatment?
Acceptability	How humanely and considerately is the treatment/ service delivered? What does the patient think of it? What would/ does an observant third party think of it (“How would I feel if it were my nearest and dearest?”) What is the setting like? Are privacy and confidentiality safeguarded?
Efficiency	Is the output maximised for a given input or (conversely) is the input minimised for a given level of output? How does the unit cost compare with the unit cost elsewhere for the same treatment/service?
Access	Can people get this treatment/service when they need it? Are there any identifiable barriers to services – for example distance, waiting times, opening times or straightforward breakdowns in supply?
Equity	Is this patient or group of patients being fairly treated relative to others? Are there any identifiable failings in equity – for example, are some people under-represented in service usages?
Relevance	Is the overall pattern and balance of services the best that could be achieved, taking account of the needs and wants of the population as a whole?

Source: RJ Maxwell 'Dimensions of Quality Re-visited' in *Quality in Health Care* 1992 1:171-177.

1.6 Overview of the Trust

MSFT is a 344-bed acute Trust located on two sites, Stafford Hospital (built in 1984) and Cannock Chase Hospital (built in 1992), with the majority of acute-based services located at the former. It provides services to the populations of Stafford, Rugeley, Cannock, and the surrounding areas, most of which are registered with the Stafford and Surrounds Clinical Commissioning Group (CCG) or the Cannock Chase CCG. The Trust has an annual turnover of ca. £155m and employs around three thousand staff. It provides a range of services in core specialties, including out-patients, elective surgery, non-elective admissions, and a partial Accident and Emergency (A&E) service. The Trust has entered a series of partnerships with both Royal Wolverhampton NHS Trust (RWT) and University Hospital of North Staffordshire (UHNS) to meet changing expectations of quality, sustainability and safety.

1.7 The local population

The scoping process has identified that over 90% of people using MSFT services comes from the registered population of the two local CCGs, with only limited use from outside the area. This represents 276,500 people who will be the general population for which impacts will be considered: the registered populations for Cannock Chase CCG and Stafford and Surrounds CCG were 131,900 and 144,600 respectively.

The Office for National Statistics (ONS) estimates that the overall population for Staffordshire will increase by 5% between 2011 and 2021. There will be significant increases in the older age groups (23%, compared with 19% for England), particularly for those aged 75 and over, which will have an impact on the provision of health services including those delivered in an acute setting. These population projections exclude the impacts of changes in the local Armed Forces population, with a potential increase of some 1,040 service personnel who would bring with them ca. 420 families with six hundred children (these numbers are subject to change). Stafford Borough Council has also given planning permission for some three thousand houses. The impact of this growth will be considered in the impact assessment as it is an issue of particular concern to local people.

Life expectancy at birth is often used as a high level indicator of the overall health status of the population. It measures the average number of years a baby born in a particular population can expect to live if it experienced the current age-specific mortality rates for that particular area throughout its life. Most of Staffordshire has a life expectancy similar to or better than the national average but within this overall positive picture, there are areas where life expectancy is below the national average, e.g. in Cannock Chase, men's life expectancy is five months less and women live three months less than the average.

Overall Staffordshire is a relatively affluent area of the country. The Index of Multiple Deprivation 2010 (IMD 2010) is a way of identifying deprived areas, by grouping 38 different indicators into several domains. Only nine of the 525 geographically-defined areas in Staffordshire are in the bottom 10% of most deprived areas in England. The IMD 2010 identifies eight geographically-defined areas in Cannock Chase that fall within the most deprived 20% of areas in England, making up 12% (5,700) of the population. In Stafford, four of these areas fall within the most deprived 20% of areas in England, making up 5% (6,900) of the population.

Using the Rural and Urban Area Classification 2004, 20% of Stafford & Surrounds CCG's population and 3% of Cannock Chase CCG's population lives in areas that are classified as "village, hamlet and isolated dwelling", compared with 10% nationally, 9% regionally and 12% for Staffordshire as a whole. In these areas individuals may have to travel to access services, and where they are dependent on public transport this may lead to long travel times, or periods of the day or week when it is very difficult to travel at all by public transport. In Cannock Chase, around 14,500 people are disadvantaged in terms of geographical access (defined as living in the most geographically deprived quintile nationally); and in Stafford, around 49,700 people are disadvantaged in terms of geographical access (defined as living in the most geographically deprived quintile nationally).

Given this local population profile, the Steering Group will be paying particular attention to the potential impact of changes proposed by the TSAs on:

- Those living with socioeconomic disadvantage; or
- Those living in isolated villages or dwellings; or
- A combination of these with the protected characteristics set out in the Equality Act (2010).

The Steering Group will also consider the potential impact for different groups of staff employed at MSFT.

1.8 Scoping of protected characteristics

The TSAs have a public sector equality duty that covers the “protected characteristics” set out in the Equality Act (2010). The protected characteristics are: age; disability; gender reassignment; pregnancy and maternity; race (this includes ethnic or national origins, colour or nationality); religion or belief (this includes lack of belief); sex (gender); and sexual orientation. It also applies to marriage and civil partnership but only in a narrowly defined way. At this stage of scoping, the focus of attention for the impact assessment will be on the protected characteristics of (Table 42 in Section 7.11 summarises the Steering Group’s reasoning):

- Age;
- Disability;
- Sex (gender); and
- Race.

During the impact assessment phase, the Steering Group will reach out to members of the lesbian, gay, bisexual and transgender (LGBT) community to better understand the extent to which they may be affected by any proposals for change at MSFT in ways that are different to the general population.

The protected characteristic of “Pregnancy and Maternity” relates largely to protection in employment. Consequently where there are changes to maternity services proposed, these will be considered in relation to the protected characteristic of “sex”, alongside other services which may have a differential impact for one sex, e.g. changes to urology outpatients for men. Given the potential wide impact for the working age population of any changes in maternity services, particular attention will be paid to the assessment of these if they form part of the TSAs’ recommendations.

1.9 Scoping of the impact of proposed service changes

The Steering Group will apply the approach set out in this report to assessing the impact for the general population, those with the prioritised protected characteristics and others of concern due to any changes proposed by the TSAs. These proposals could have a mix of positive and negative impacts; the impact assessment report will seek to identify the impacts and contain proposals to the TSAs to enhance the positive impacts and minimise the negative impacts.

1.10 Next steps

This scoping report has both identified the potential impact areas that may need to be considered, dependent on the nature of the TSAs' proposals, and identified particular groups of concern within both the general population and those with protected characteristics as defined in the Equality Act 2010. The next steps are to describe these identified impacts in both qualitative and quantitative terms. The qualitative analysis will include engaging with "seldom heard" groups to understand the potential impacts on particular groups of users (these groups will largely be aligned with the prioritisation of the nine protected characteristics, and also seek specific information in relation to economic disadvantage, rural isolation and those at risk of multiple negative impacts). This quantitative and qualitative analysis will be used as the basis on which to provide the mitigating proposals to the TSAs. It is expected that the TSAs will use these recommendations to modify their proposals.

2 Introduction and context

2.1 Background to the appointment of the TSAs

MSFT is a two site organisation (Stafford Hospital and Cannock Chase Hospital) with 344 beds and was authorised by Monitor as a foundation trust on 1st February 2008. In the following year, the Healthcare Commission (HCC) carried out a review into reportedly high levels of patient mortality and poor standards of care. Further reviews followed, of which the most significant were the two inquiries led by Robert Francis QC⁶; the second inquiry report sets out the events that led to the inquiries being established⁷.

The Trust has made significant improvements in the clinical care provided for patients and the Care Quality Commission (CQC) has stated⁸ that it no longer has outstanding concerns about the care delivered by the Trust. However, the Trust is losing money, and had to be given significant financial support from the Department of Health (DH) to maintain service provision. Monitor therefore appointed a Contingency Planning Team (CPT) whose terms of reference⁹ were published in October 2012. The CPT's work was carried out in two phases: Trust sustainability and forming recommendations. In its first phase, the CPT concluded¹⁰ that MSFT is neither financially nor clinically sustainable and there is not a credible plan to deliver sustainability over the next five years in the Trust's current form. In its second phase, the CPT recommended¹¹ the establishment of local hospitals in both Stafford and Cannock.

2.2 The TSA process

On 16th April 2013 Monitor appointed Joint Trust Special Administrators (TSAs) to MSFT under the National Health Service (NHS) Act 2006, as amended by the Health and Social Care Act 2012. This is the first time that Monitor has appointed a TSA to take over the running of a foundation trust (FT).

The TSAs are following a statutory timescale during which¹²:

⁶ The results of these inquiries can be found at <http://www.midstaffspublicinquiry.com/>.

⁷ *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*, February 2013, Executive summary, London: The Stationery Office, p. 11.

⁸ In its Inspection Report of March 2013, the CQC stated that the Trust is meeting the all standards (Respecting and involving people who use services, Care and welfare of people who use services, Safeguarding people who use services from abuse, Supporting workers, and Complaints).

⁹ The terms of reference are available on Monitor's website <http://www.monitor-nhsft.gov.uk/home/news-events-and-publications/latest-press-releases/terms-reference---contingency-planning-team->

¹⁰ The CPT's full report on sustainability is available at <http://www.monitor-nhsft.gov.uk/node/1953>

¹¹ The CPT's full recommendations are available at <http://www.monitor-nhsft.gov.uk/home/news-events-and-publications/our-publications/browse-category/reports-nhs-foundation-trusts/rep-1>

¹² *Statutory guidance for Trust Special Administrators appointed to NHS foundation trusts*, 5 April 2013, p. 7.

- Monitor must determine whether it is satisfied that the recommended action fulfils the objectives of special administration and that the TSAs have carried out their duties; and
- If Monitor is satisfied, the Secretary of State for Health must determine whether he intends to exercise his limited grounds for veto. This avoids prolonged periods of uncertainty and clinical and/or financial underperformance.

Based on these objectives and timescale, the TSAs have developed a high-level plan for delivering their recommendations to Monitor (Figure 1).

Figure 1: High-level timeline for the TSA process



*On 19 June 2013 Monitor granted an extension of 30 working days for the publication of the TSAs' draft recommendations and an extension of 10 working days to the public consultation period

A Steering Group was established to carry out an impact assessment of the recommendations of the TSAs. Specifically, this impact assessment is looking at how

these recommendations will influence health and health outcomes for the local population, integrated with consideration of the public sector equality duty.

2.2.1 Key definitions

Health is defined by the World Health Organisation (WHO) as a “state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity”¹³, which covers the factors that support health, and the determinants of health and ill health. It is this definition of health that is the focus of the impact assessment.

Health outcomes are defined as “Measurable changes in the health status of an individual, group or population...These may be intended or unintended, and may not become apparent for many years”¹⁴.

2.2.2 Purpose of the impact assessment

The purpose of impact assessments has been articulated by different levels of government. At the broadest level, HM Government (HMG) defines¹⁵ impact assessments as being both:

- A continuous process to help think through the reasons for government intervention, to weigh up various options for achieving an objective and to understand the consequences of a proposed intervention; and
- A tool to be used to help develop policy by assessing and presenting the likely costs and benefits and the associated risks of a proposal that might have an impact on the public, private or third sector, the environment and wider society over the long term.

The Department of Health’s (DH) guidance on impact assessments states that a good Health and Equalities Impact Assessment (HEIA) “will guide policymakers to consider the positive and negative impact of their proposed policy on health. It will identify any unintended health consequences that may either lend support to the policy or suggest improvements to it. It will also contain a clear analysis of whether the health

¹³ Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948. The Definition has not been amended since 1948 (note that this description is quoted from *Health Impact Assessment of Government Policy: A guide to carrying out a Health Impact Assessment of new policy as part of the Impact Assessment process*, London: Department of Health, July 2010, p. 4).

¹⁴ *Health Impact Assessment of Government Policy: A guide to carrying out a Health Impact Assessment of new policy as part of the Impact Assessment process*, London: Department of Health, July 2010, p. 4.

¹⁵ *Impact Assessment Overview*, London: Department for Business, Innovation and Skills, August 2011, p. 3.

of the whole population or just certain sections within the population will be affected”¹⁶.

The statutory guidance issued by Monitor advises that throughout its work, a TSA is required to “observe equality legislation and principles and demonstrate that due regard has been paid to the equality duty of the Equality Act (2010). The equality assessment should apply to patients, public and staff”¹⁷.

The purpose of the current impact assessment, including the scoping report and impact assessment report, is to ensure adherence to Monitor’s guidance through the use of both the DH and HMG descriptions.

2.2.3 The Equality Act (2010) and the public sector equality duty

The Equality Act (2010) (the Act) consolidates and replaces previous discrimination legislation for England, Scotland and Wales¹⁸. The Act covers discrimination (e.g. because of age or disability) and lists nine protected groups, which are known in the Act as *protected characteristics*. The public sector equality duty is made up of a general equality duty as set out in section 149 of the Act and supported by specific duties in the Equality Act 2010 (Statutory Duties) Regulations 2011¹⁹. Section 149 of the Act sets out a general equality duty on public authorities and other bodies when exercising public functions to have due regard to the need to²⁰:

- Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Act;
- Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; and
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

These are often referred to as the three aims of the general equality duty. To “have due regard” means that in making decisions and in their other day-to-day activities, the TSAs must have due regard to each of the three aims of the general equality duty. The duty is to meet “needs”, rather than any desires or preferences for a particular treatment or service; there is no requirement to take steps to offer

¹⁶ *Health Impact Assessment of Government Policy: A guide to carrying out a Health Impact Assessment of new policy as part of the Impact Assessment process*, London: Department of Health, July 2010, p. 2.

¹⁷ *Statutory guidance for Trust Special Administrators appointed to NHS foundation trusts*, London: Monitor, 5 April 2013, p. 17.

¹⁸ *Equality Act 2010 Technical Guidance on the Public Sector Equality Duty England*, Equality and Human Rights Commission, January 2013, ISBN 978 1 84206 475 7, p. 7.

¹⁹ The regulations can be found at: <http://www.legislation.gov.uk/ukdsi/2011/9780111512951>.

²⁰ EHRC, Op Cit, p.12.

separate services to different groups on demand²¹. To have “due regard”, the TSAs must “understand the potential impact of their decisions on people with different protected characteristics” and “identify potential mitigating steps to reduce or remove adverse impacts”²².

The public sector equality duty covers the protected characteristics of age, disability, gender reassignment, pregnancy and maternity, race (this includes ethnic or national origins, colour or nationality), religion or belief (this includes lack of belief), sex (gender), and sexual orientation. It also applies to marriage and civil partnership but only in respect to the requirement to have due regard to the need to eliminate discrimination.

Note that the second and third aims of the duty (advancing equality of opportunity and fostering good relations) only apply in relation to persons who share a “relevant protected characteristic” and that Section 149(7) sets out the list of these “relevant protected characteristics”. This list includes all the protected characteristics set out above, *with the exception of marriage and civil partnership status*. Therefore, in relation to the protected characteristic of marriage and civil partnership, a body subject to the duty only needs to comply with the first aim of the duty (to have due regard to the need to eliminate discrimination)²³. In addition, some aspects of the Act are more relevant for public bodies as employers: for example it is unlawful for an employer to subject a woman to unfavourable treatment during the ‘protected period’ as defined by the Act²⁴ (the protected period starts when a woman becomes pregnant and continues until the end of her maternity leave, or until she returns to work if that is earlier²⁵).

While there is no explicit legal requirement under the general equality duty to engage with people with the different protected characteristics, the general equality duty requires public authorities to have an adequate evidence base for their decision-making²⁶. The general equality duty does not set a particular process for assessing impacts that public bodies are expected to follow. The impact assessment should inform the TSAs’ final report and recommendations so that due regard can be given to the potential impacts of the TSAs’ draft recommendations on people with

²¹ EHRC, Op Cit, p.30.

²² The essential guide to the public sector equality duty is: *England (and non-devolved public authorities in Scotland and Wales) Equality and Human Rights Commission*, November 2012.

²³ *Equality Act 2010 Technical Guidance on the Public Sector Equality Duty England*, Equality and Human Rights Commission, January 2013, ISBN 978 1 84206 475 7, p. 13.

²⁴ *Equality Act 2010 Statutory Code of Practice – Employment*, Equality and Human Rights Commission, 2011, ISBN: 9780108509735, p. 36.

²⁵ *Ibid.*, p. 100.

²⁶ *Engagement and the equality duty: A guide for public authorities - England (and non-devolved public authorities in Scotland and Wales)*, Equality and Human Rights Commission, Revised (second) edition, 19 December 2011, p. 4.

different protected characteristics, and will help to identify potential mitigating steps to reduce or remove negative impacts and enhance positive impacts.

2.2.4 Objectives of the impact assessment

Based on the HMG and DH definitions given above and, more specifically, on Monitor's guidance and the equality duty of the Equality Act (2010), the impact assessment's objectives are to:

- Understand the impacts of the TSAs' draft recommendations on the health of the local population;
- Assess the impacts of the TSAs' draft report and recommendations on specific groups within the local population and staff so that, in preparing their final report and recommendations, the TSAs have paid due regard to the aims of the public sector equality duty when exercising their functions;
- Quantify where possible the impact of the TSAs' draft report and recommendations and gather qualitative evidence where required; and
- Make recommendations to the TSAs on actions to potentially mitigate negative impacts and help develop positive impacts.

The assessment is being carried out in two parts, based on the Department of Health's guide to carrying out an impact assessment²⁷:

- (i) **The scoping report (this document)**: understanding the local population and its health status; understanding and prioritising specific groups within this local population using both the "protected characteristics" set out in the Equality Act (2010) and any other relevant characteristics; and identifying and prioritising the potential impact areas of the draft recommendations of the TSAs; and
- (ii) **The impact assessment report**: describing (both qualitatively and quantitatively) the impacts on health and equality outcomes of the recommendations of the TSAs and providing proposals to potentially minimise negative and maximise positive health and equality impacts.

The HEIA process is being carried out in parallel to the overarching TSA process.

This scoping report has been produced at the same time as the recommendations for consultation; it sets out the focus and approach that will be applied, during the consultation period, to the TSAs' draft recommendations. It does not, therefore,

²⁷ *Health Impact Assessment of Government Policy: A guide to carrying out a Health Impact Assessment of new policy as part of the Impact Assessment process*, London: Department of Health, July 2010, p. 7.

include any commentary or analysis on the draft recommendations at this point. This is the purpose of the impact assessment report, which will be published after the public consultation is complete; the impact assessment report will consider the draft recommendations and their impacts for consideration by the TSAs.

2.2.5 Governance of the impact assessment

To ensure that the impact assessment of the recommendations of the TSAs is carried out in an objective and independent manner, a Health and Equality Impact Assessment Steering Group (HEIA SG or Steering Group) has been convened to oversee the impact assessment process. The HEIA SG is headed by a chair that is independent of both Monitor and the TSAs; the HEIA SG will submit its impact assessment report to the TSAs as advice available to shape their final recommendations.

Members of the HEIA SG have been selected to ensure that a wide range of professional expertise and stakeholder perspectives is incorporated from the start, including representing the views and perspectives of patients and members of the public in the HEIA process; the full membership of the HEIA SG is shown in the table below.

Table 2: Members of the HEIA Steering Group

Role	Name	Organisation	Position
Independent Chair	Sophia Christie	UK Prime	Director
Patient, Carer and Public representatives	Jan Sensier	Engaging Communities Staffordshire	Chief Executive
	[*]	N/A	Public and patient representative
	[*]	N/A	Public and patient representative
	[*]	N/A	Public and patient representative
Public Health representatives	Prof Aliko Ahmed	Staffordshire County Council	Director of Public Health
Adult and children's care	Martin Samuels	Staffordshire County Council	Commissioner for Care
Local CCGs	Andrew Donald and Dr Jonathan Bletcher	Stafford & Surrounds CCG Cannock Chase CCG	CCG Chief Officer and Public Health lead
Specialised commissioning	Stephen Washbourne	NHS England	Head of Specialised Commissioning (West Midlands)
Transportation	Clive	Staffordshire	Commissioner for Transport and

Role	Name	Organisation	Position
	Thomson	County Council	the Connected County
Equality and diversity and local strategic partnerships	Norman Jones	Stafford Borough Council	Head of Policy and Improvement

[*] Note that the names of these four patient, carer and public representatives have been omitted as they are on the HEIA SG in their personal capacity rather than as professionals providing subject matter expertise.

2.3 Structure of the scoping report

The remainder of this scoping report is structured as follows:

- **Section 3 – Methodology for the impact assessment:** this section provides an overview of the methodology being used for the impact assessment.
- **Section 4 – Description of the Trust:** this section describes the services currently provided by the Trust and an overview of the Trust’s staff.
- **Section 5 – Overview of the local health economy:** this section describes the local health economy, including a description of local commissioners and providers, and the role of NHS England in providing specialised commissioning.
- **Section 6 – Overview of the population and its health status:** this section presents an overview of the population, including high-level descriptions of its socioeconomic and health status and communities that may be at higher risk of negative health impacts as a result of the TSAs’ recommendations.
- **Section 7 – Scoping of protected characteristics:** this section describes the scoping of the protected characteristics, and their prioritisation in the impact assessment.
- **Section 8 – Scoping of health impact areas:** this section described the framework and scoping for the health impact areas.
- **Section 9 – Consultation and engagement:** this section outlines the general consultation that the TSAs will be undertaking and the stakeholder engagement that will be required for the HEIA.
- **Section 10 – Work to be undertaken for stages three to five:** this section outlines the next steps for the HEIA.

3 Methodology for the impact assessment

Monitor's guidance states that it "is recommended that the [impact] assessment is undertaken early on in the failure regime to allow the Trust Special Administrator to identify, for example, groups with protected characteristics that may be affected and which their draft report can take into account"²⁸. The impact assessment analysis has therefore been carried out in parallel with the process that the TSAs have undertaken to both develop their recommendations and hold a public consultation on these.

3.1 The impact assessment process

The impact assessment process is based on DH's guidance for conducting health impact assessments (HIAs); this guidance recommends a five stage process (Table 3).

Table 3: Summary of the DH's HIA process

Stage	Description
Stage 1: Screening	<ul style="list-style-type: none"> Screening questions are used to decide whether to proceed to further stages
Stage 2: Identify health impacts	<ul style="list-style-type: none"> A long list of all the potential impacts on the health of the population is identified These impacts could be major or less serious, direct or indirect and occurring at any stage of the implementation of the policy
Stage 3: Identify impacts with important health outcomes	<ul style="list-style-type: none"> The most important health impacts These impacts may impact on the whole population or on specific groups (defined by age, ethnicity/race, religious belief, etc.) The impacts may be difficult to remedy or have an irreversible impact and/or cause a great deal of public concern The impacts may be medium to long term
Stage 4: Quantify or describe important Health Impacts	<ul style="list-style-type: none"> A qualitative or quantitative judgement is made about the important health impacts This could cover the potential costs and benefits, how health varies in different circumstances and why
Stage 5: Recommendations to achieve most health gains	<ul style="list-style-type: none"> Recommendations are given on how to amend the policy to deliver the greatest possible health gain for the population in relation to the overall costs of the policy

Source: Health Impact Assessment of Government Policy: A guide to carrying out a Health Impact Assessment of new policy as part of the Impact Assessment process, London: Department of Health, July 2010.

²⁸ *Statutory guidance for Trust Special Administrators appointed to NHS foundation trusts*, 5 April 2013, London: Monitor, p. 17.

Initial assessment by the TSAs found that it would be appropriate to undertake a health and equality impact assessment (stage one). This scoping report therefore covers stage two and parts of stage three; the impact assessment report will cover stages three to five. To undertake the stages covered in this report, the following steps were undertaken:

- An initial analysis of the local population and its health needs;
- Further analysis of the local population based on a variety of datasets to provide descriptions of this population by protected and other characteristics;
- Analysis of the available evidence to prioritise the protected and other characteristics for further analysis in stages three to five;
- Analysis of the available evidence to identify the potential impact areas for further analysis in stages three to five; and
- An initial review of the literature to inform stages one, two and three.

For stages three to five, it is expected that the following steps will be undertaken:

- Further analysis and engagement with stakeholders to understand the implications on the identified impact areas arising from the draft recommendations of the TSAs;
- Further analysis and engagement with stakeholders to understand the implications of the draft recommendations of the TSAs for people with protected and other characteristics;
- Further analysis to understand the impacts of the proposed changes to access to healthcare, including travel times;
- Analysis of potential impact for existing staff of MSFT who fall within the scope of the protected and other groups;
- An extended literature review to provide additional evidence for the impact assessment; and
- Synthesising the above to identify and clarify mitigating actions for negative impacts and developments to strengthen positive impacts.

The impact assessment report will be considered by the TSAs in formulating their final report and recommendations.

3.2 Scope of the impact assessment

The Steering Group agreed the following scope for the impact assessment:

- **Health:** consider the TSAs' recommendations for changing the pattern of services at MSFT and identify the potential health consequences for the local population, with particular attention to those at increased risk of negative impact because of either economic disadvantage or of living in isolated towns or villages, or a combination of these with the protected characteristics (see Section 6.7); and
- **Equality:** consider the recommendations for change in the pattern of services at MSFT made by the TSAs and assess the potential impact for those groups covered by the public sector equality duty, with a focus on age, sex, disability and race (see Section 7.11).

Based on this scope, the impact assessment is referred to as a "Health and Equality Impact Assessment" (HEIA). Note that an environmental assessment (e.g. looking at changes in carbon emissions due to changes required by the recommendations put forward by the TSAs) is not being carried out due to the limited time available.

3.3 Identifying in-scope characteristics

The Steering Group will consider:

- The TSAs' draft recommendations for changes to services currently provided by the Trust;
- The potential impact of these changes on the general population;
- The potential impact of these changes on those deemed to be at 'additional risk' of negative impact, including those with socioeconomic disadvantage, and those living in isolated towns or villages; and
- Consistent with Monitor's guidance, the potential impact for those communities within the nine protected characteristics²⁹, with a focus on age, sex, disability, race, and consideration given to sexual orientation (see Section 7).

At this stage of analysis, it does not appear that any proposed changes to the services currently delivered by the Trust would be likely to have differential impact from the general population for the protected characteristics of gender

²⁹ *Equality Act 2010 Technical Guidance on the Public Sector Equality Duty England*, Equality and Human Rights Commission, January 2013, ISBN 978 1 84206 475 7, p. 44.

reassignment, marriage or civil partnership, and religion/belief. The protected characteristic of pregnancy and maternity relates largely to employment status and this will be legally protected in any changes to employment arrangements. If changes are proposed to maternity services, their impact will be assessed with reference to the protected characteristic of sex (gender). A detailed analysis of each of the protected characteristics is given in Section 7.

As noted in Section 2.3, Monitor advises that throughout its work, a TSA is required to “observe equality legislation and principles and demonstrate that due regard has been paid to the equality duty of the Equality Act (2010). The equality assessment should apply to patients, public and staff”³⁰. The Steering Group concluded that, in order to have due regard to this guidance, three additional groups should be considered in the Health Impact and Equality assessment process:

- Socioeconomic deprivation has been included because poverty, poor education and inappropriate housing can all have an adverse effect on an individual’s health with people living in deprived communities often experiencing poorer health outcomes compared with those living in more affluent communities;
- A significant minority of people in the catchment area for existing services at the Trust live in isolated towns or villages, where issues of physical access may be magnified for those reliant on public transport; and
- The impact for people who fall into two or more of these groups, and/or have protected characteristics may have a “multiplier” effect.

3.4 Approach to analysis

The Steering Group has agreed that the evidence base will include both quantitative and qualitative³¹ data (Table 4).

³⁰ *Statutory guidance for Trust Special Administrators appointed to NHS foundation trusts*, London: Monitor, 5 April 2013, p. 17.

³¹ “The requirement to have sufficient evidence does not imply that a body subject to the duty needs, in every instance, to have hard statistical data. A relevant body can also use more qualitative sources such as service user feedback” – *Ibid.*, p. 46.

Table 4: Approach to identifying health and equality impacts

Analysis	Type	Comments
Quantitative	Numerical analysis	There is a wealth of published health and associated information and the HEIA will use this evidence, as well as commissioning bespoke analysis where required, to inform its conclusions
	Literature review	Review of the literature to understand potential quantified impacts (positive and negative) on health outcomes
Qualitative	Literature review	Review of the literature to understand non-quantifiable potential impacts (positive and negative) on health outcomes
	Interviews	Interviews with selected stakeholders to identify potential impacts on service users

In addition, whilst many proposals may have an impact, the HEIA Steering Group will be interested in assessing the likely scale or intensity of that impact to make recommendations on the priorities for amelioration or acceleration. An example matrix that may be used to achieve this is shown in Table 5.

Table 5: Potential risk assessment matrix

Severity of the impact	Mortality			
	Morbidity			
	Wellbeing			
	Size/proportion of the population affected	Low	Medium	High

3.5 Framework for assessing health impacts

3.5.1 Overview of the framework

Proposals for service change could have a differential impact for different populations. To address the complexity of assessment in health care quality, the HEIA Steering Group has adopted the well-established framework devised by Maxwell³². This framework is based on the assertion that quality in health care is multidimensional and covers six areas: effectiveness, acceptability, efficiency, access, equity and relevance (Table 6).

³² RJ Maxwell 'Dimensions of Quality Re-visited' in *Quality in Health Care* 1992 1:171-177.

Table 6: Overview of the Maxwell criteria

Questions that help to define and expand the label “quality”	
Effectiveness	Is the treatment given the best available in a technical sense, according to those best equipped to judge? What is their evidence? What is the overall result of the treatment?
Acceptability	How humanely and considerately is the treatment/ service delivered? What does the patient think of it? What would/ does an observant third party think of it (“How would I feel if it were my nearest and dearest?”) What is the setting like? Are privacy and confidentiality safeguarded?
Efficiency	Is the output maximised for a given input or (conversely) is the input minimised for a given level of output? How does the unit cost compare with the unit cost elsewhere for the same treatment/service?
Access	Can people get this treatment /service when they need it? Are there any identifiable barriers to services – for example distance, waiting times, opening times or straightforward breakdowns in supply?
Equity	Is this patient or group of patients being fairly treated relative to others? Are there any identifiable failings in equity – for example, are some people under-represented in service usage?
Relevance	Is the overall pattern and balance of services the best that could be achieved, taking account of the needs and wants of the population as a whole?

Source: RJ Maxwell ‘Dimensions of Quality Re-visited’ in *Quality in Health Care* 1992 1:171-177.

3.5.2 Description of the Maxwell criteria

The Maxwell criteria are useful for looking at the quality of healthcare, when strength in one dimension may have a more negative impact on another dimension³³. The framework highlights the balance that needs to be struck in delivering high quality healthcare; for example to maintain excellent standards in effectiveness of emergency care, the proximity of services may be changes, which will raise issues around access.

Effectiveness is the extent to which a service achieves the desired result(s) or outcome(s), at the client, population or organisational level³⁴. The Steering Group may draw on the national comparisons available through the NHS Outcomes Framework or other well-established measurement sources; for example the Royal Colleges provide professional insight and evidence for optimising safety and effectiveness in service provision.

In its broadest sense, acceptability can be described as the extent to which the planning and delivery of services: involves clients; provides them with information to support their decision-making; is positive, acceptable and responsive to their needs

³³ Ibid.

³⁴ Klassen et al. (2010) “Performance measurement and improvement frameworks in health, education and social services systems: a systematic review”, *International Journal for Quality in Health Care*, Volume 22, Number 1: pp. 44–69.

and expectations; and respectful of privacy, confidentiality and differences³⁵. The national patient surveys, and a range of other patient feedback mechanisms, provide information on levels of satisfaction with services across a range of indicators and across all NHS organisations, which enables direct comparisons.

The TSAs will actively consider efficiency as part of the process to form their recommendations, which need to be sustainable and affordable. The Steering Group will not focus on this as an issue, but may need to consider it in relation to its impact on other elements of quality.

Access refers to the extent to which services are available and accessible in a timely manner³⁶. Much of the public interest to date has focused on physical access for face-to-face services, but increasingly it is possible to communicate without requiring patients to travel, and the relative availability of services during the week may also be relevant.

Equity can be characterised as the provision of services that are of equal quality for a range of patients that are distributed fairly across populations, regardless of patient characteristics³⁷, and will be actively considered in the impact assessment through attention to the potential effect on those with protected characteristics. This will clearly be a critical element of the Impact Assessment report.

Relevance is a measure of the extent to which services represent a “best fit” with population profile and patient needs³⁸. It can be measured by the extent to which services used reflect the demography and disease profile of the local population. No local health community has an optimum fit of need and services. However for the population of MSFT the high rates of A&E contact, paediatric admissions, and emergency admissions more generally, suggest that there has been an over-emphasis on hospital-based services in the past; this may be at the expense of community support which could help people to do well in their own homes or with the support of primary care services.

³⁵ Ibid.

³⁶ Ibid.

³⁷ Ibid.

³⁸ Ibid.

4 Description of Mid Staffordshire NHS Foundation Trust

4.1 Introduction

MSFT is a 344-bed acute Trust located on two sites, Stafford Hospital (built in 1984) and Cannock Chase Hospital (built in 1992), with the majority of acute-based services located at the former. It provides services to the populations of Stafford, Rugeley, Cannock, and the surrounding areas and the lead commissioners are Stafford and Surrounds CCG and Cannock Chase CCG. The Trust has an annual turnover of ca. £155m and employs around three thousand staff.

4.2 Activity at the Trust

Table 7 summarises hospital activity at MSFT as a proportion of all hospital activity for all Staffordshire CCGs, and for Cannock Chase CCG and Stafford and Surrounds CCG in particular. The proportion of total activity at MSFT has declined in the period 2009/10 to 2012/13, and this is particularly apparent for the population of Cannock Chase and Stafford and Surrounds CCGs (Table 7).

Table 7: MSFT activity commissioned by Staffordshire CCGs (as a proportion of all activity)

	2009/10	2010/11	2011/12	2012/13
Staffordshire CCGs				
Non-elective patients	26,373 (27.7%)	27,256 (28.0%)	26,561 (26.6%)	23,784 (22.4%)
Elective patients	4,890 (21.4%)	4,215 (18.4%)	3,774 (16.4%)	3,825 (17.6%)
Day case procedures	26,432 (27.4%)	28,566 (29.4%)	28,407 (28.6%)	27,618 (27.4%)
New outpatients	62,597 (25.3%)	63,614 (25.2%)	66,456 (24.7%)	68,070 (25.0%)
Follow up patients	130,805 (23.6%)	147,770 (24.3%)	185,771 (26.8%)	190,351 (27.6%)
A&E attendances	48,190 (19.3%)	48,601 (18.7%)	45,498 (18.5%)	42,668 (16.3%)
Cannock Chase CCG				
Non-elective patients	11,333 (73.2%)	11,877 (71.8%)	11,283 (67.5%)	10,143 (60.5%)
Elective patients	2,265 (62.5%)	1,839 (54.8%)	1,672 (51.1%)	1,712 (51.9%)
Day case procedures	11,811 (73.0%)	12,887 (74.3%)	12,619 (71.9%)	12,467 (69.0%)
New outpatients	28,938 (67.5%)	29,893 (66.6%)	30,981 (65.9%)	30,922 (63.9%)
Follow up patients	59,001 (64.1%)	67,155 (63.6%)	84,325 (67.0%)	86,847 (66.2%)
A&E attendances	19,480 (40.4%)	19,480 (38.1%)	18,093 (40.4%)	16,438 (35.2%)
Stafford & Surrounds CCG				
Non-elective patients	14,011 (81.4%)	14,358 (79.8%)	14,321 (77.8%)	12,830 (68.5%)
Elective patients	2,216 (59.2%)	2,013 (55.0%)	1,850 (51.9%)	1,902 (50.6%)
Day case procedures	12,426 (71.2%)	13,273 (71.5%)	13,181 (67.6%)	13,253 (66.8%)
New outpatients	29,857 (72.2%)	29,905 (69.2%)	31,597 (67.0%)	34,139 (67.8%)
Follow up patients	64,186 (68.3%)	72,051 (67.4%)	88,946 (69.0%)	90,800 (69.7%)
A&E attendances	26,669 (79.5%)	27,040 (77.3%)	25,587 (73.9%)	24,670 (67.3%)

Source: Healthcare Commissioning Services (HCS)

4.3 Services provided by the Trust

MSFT provides the broad range of services typical of a small district general hospital, with the more specialised services being provided by the larger/tertiary hospitals in the region. The services currently provided by the Trust are divided into four directorates: planned care, acute care, emergency care and clinical support services.

Each of these directorates is described below; Table 8 provides a full list of services provided by each directorate.

Table 8: Summary of services currently provided by each directorate

Planned care		Acute care		Emergency care	Clinical support services
T&O	General surgery	Respiratory	Clinical haematology	Emergency medicine (A&E)	Radiology
Gynaecology	ENT	Pulmonary rehab	Elderly care	Acute medicine (AMU)	Pathology
Obstetrics	Urology	Gastro/endoscopy	Physiotherapy	Diabetes and endocrinology	Pharmacy
Midwifery	Maxiofacial	Cardiology	OT	Surgical assessment unit	Health records
DSU	Orthodontics	GUM	Dietics	Paediatrics & PAU	Psychology
HDSU	Ophthalmology	Neurology	Neuro-psychology	Special care baby unit	Cancer
Anaesthetics	GI	Cohort ward	Fairoak	Shugborough	Breast screening unit
Theatres	Colorectal	Acute coronary unit	Hollybank	Psychiatric liaison	Chemotherapy unit
CCU	Vascular	Acute stroke unit	Wards 1,2,10,12	Emergency planning	Nuclear medicine
Breast unit / plastics	Audiology	Flex (ward 11)			Bone densitometry
Rheumatology	Ultrasound				Infection prevention & control
Dermatology	Wards 3,6,7,8				

4.3.1 Planned Care Directorate

The Planned Care Directorate consists of five service areas including: general surgery (upper gastro-intestinal, colorectal, vascular, breast and urology); surgical specialities (orthodontics, oral and maxillofacial surgery, ophthalmology, ENT, dermatology and audiology); musculoskeletal (rheumatology, trauma and orthopaedics); theatres and anaesthetics (hospital sterilising and disinfection unit, theatres, anaesthetics and critical care); and obstetrics and gynaecology.

4.3.2 Acute Care Directorate

The Acute Care Directorate is primarily concerned with the on-going inpatient and outpatient care of unplanned patient activity. The Directorate includes: acute specialties, such as cardiology, thoracic medicine and neurology; therapy services (for example, physiotherapy, occupational therapy and dietetics); and elderly care services, which include stroke and rehabilitation services.

4.3.3 Emergency Care Directorate

The Emergency Care Directorate contains A&E (partial service), the acute medical unit, the surgical assessment unit, paediatrics and the paediatric assessment unit.

4.3.4 Clinical Support Services Directorate

The Clinical Support Services Directorate includes a wide range of departments providing diagnostic, therapeutic and support functions. Services provided include: imaging, pathology, pharmacy, therapies, cancer services as well as chaplains, endoscopy, audiology and breast screening.

4.4 Networking of services at the Trust

The Trust has entered a series of partnerships with other neighbouring Trusts to meet changing expectations of quality, sustainability and safety:

- Ophthalmology – services are provided on site by medical staff and nursing staff from Royal Wolverhampton NHS Trust (RWT) at Cannock Chase and by RWT medical staff with MSFT nurses at Stafford Hospital;
- Ear, Nose and Throat (ENT) – services provided on MSFT sites by five medical staff, of which three are MSFT staff and two are from University Hospital of North Staffordshire (UHNS);
- Vascular Surgery – outpatient appointments, preoperative assessments, investigations and simple treatments are provided on MSFT sites, from August 2013 by one MSFT member of staff who also has sessions at UHNS, and one UHNS member of staff. Vascular emergencies and surgical procedures are all managed at UHNS;
- Cancer services – patients are referred onwards for treatment at tertiary centres in accordance with guidance for improving outcomes for cancer patients³⁹;
- Renal – services are provided on site at MSFT by medical staff from both UHNS and RWT;
- Maxillo-facial (including orthodontics) – services are provided on-site by medical staff from UHNS, supported by MSFT staff;
- Plastics – services are mainly provided on site by medical staff from UHNS;
- Hyper-acute and urgent stroke – services are provided at both UHNS and RWT, intervention is provided on site in crisis by MSFT medical staff with support from UHNS;
- Urgent cardiology care (acute coronary syndrome, or ST elevated myocardial infarction) – services are provided on-site by staff from by UHNS and RWT; and
- Chiropody and Community Diabetes – services are provided on-site by staff from SSOTP.

³⁹ *Improving Outcomes: A Strategy for Cancer*, Department of Health, 12 January 2011.

Aligned with this move to greater networking across the local health economy, the Trust signed a Memorandum of Understanding (MoU) with UHNS, which was approved by the MSFT Board in July 2012. The MoU established a framework for a formal collaboration between UHNS and MSFT and set out the role of each organisation towards achieving common objectives⁴⁰; the terms of the MoU applied from 6th July 2012 to 31st March 2013.

These changes to the Trust's operating model over the past few years are part of a broader international trend in health care provision towards networks and centres of excellence, which can result in a safer experience for patients, as well as a more efficient system overall⁴¹. For example, the Secretary of State for Health announced⁴² in April 2012 a network of 22 centres across England specialising in treating patients who suffer from major trauma. These specialist major trauma centres (MTCs) provide 24 hours a day, seven days a week treatment for seriously injured patients, such as those who have head injuries, stab wounds or have been in a car accident. Locally, a West Midlands Trauma Care System has been designed to promote co-ordinated care through a network to ensure patients receive care in dedicated specialist MTCs⁴³. This has led to a major trauma centre being created at UHNS with MSFT A&E no longer providing a major trauma care service.

4.5 Overview of the Trust's staff

Tables 9 and 10 and Figure 2 give a breakdown of the Trust's staff as at June 2013 by gender and ethnicity, and salary band; the staff numbers are expressed as whole time equivalents (WTEs).

⁴⁰ Future Partnership Working (27 June 2012), presented to the Trust Board on 5 July 2012.

⁴¹ *Urgent and Emergency Care Review - Evidence Base Engagement Document*, NHS England, 17 June 2013, p. 70.

⁴² *New major trauma centres to save up to 600 lives every year* Press release, Department of Health, April 2012, <https://www.gov.uk/government/news/new-major-trauma-centres-to-save-up-to-600-lives-every-year>.

⁴³ *Business Case and Options Appraisal for a West Midlands Trauma Care System*, Final Draft, West Midlands Strategic Commissioning Group, September 2011, p. i.

Table 9: Number staff by broad staff group and gender as at June 2013

Broad staff group	Number and percentage of staff by gender		
	Female	Male	Total
Nursing and midwifery registered	783 (27%)	44 (1%)	827 (28%)
Administrative and clerical	544 (18%)	92 (3%)	636 (22%)
Additional clinical services	463 (16%)	63 (2%)	526 (18%)
Medical and dental	117 (4%)	201 (7%)	318 (11%)
Estates and ancillary	166 (6%)	135 (5%)	301 (10%)
Allied health professionals	137 (5%)	22 (1%)	159 (5%)
Healthcare scientists	57 (2%)	31 (1%)	88 (3%)
Additional professional scientific and technical	66 (2%)	19 (1%)	85 (3%)
Other	1 (0%)	0 (0%)	1 (0%)
Total	2,334 (79%)	607 (21%)	2,941 (100%)

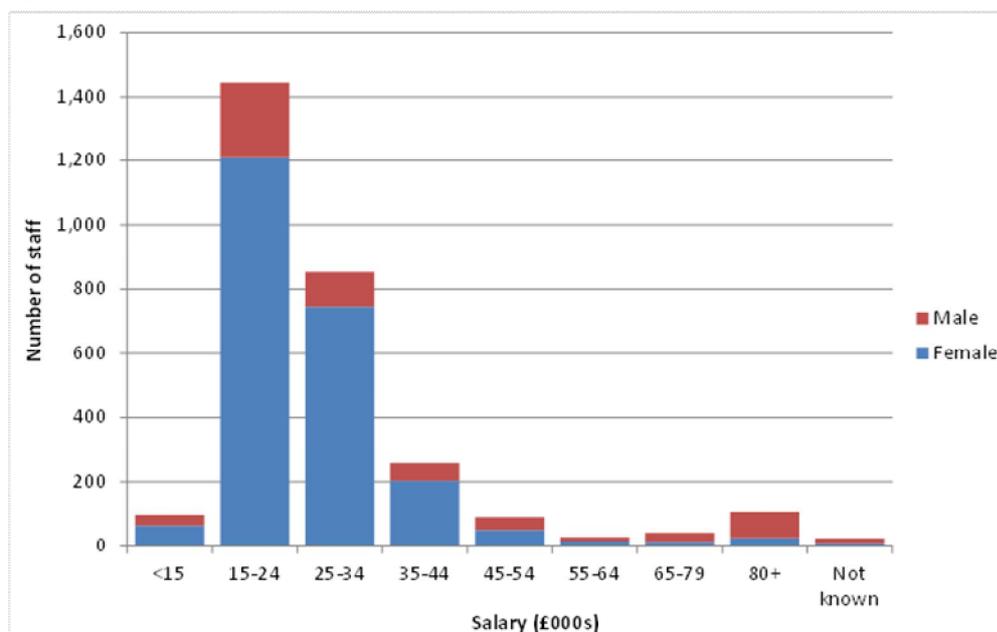
Source: Mid Staffordshire NHS Foundation Trust

There are approximately 2,900 staff working for MSFT and the majority are female (79%). Most of the staff are White British (82%), with the largest age groups in the 40-49 (28%) and 50-59 (27%) categories. There are 176 members of staff (6%) who are over sixty years old.

Table 10: Number staff by broad staff group and ethnicity as at June 2013

Broad Staff group	Number and percentage by ethnic group						Total
	White British	White other	Mixed / multiple ethnic group	Black or Asian	Other	Not known or not stated	
Additional professional scientific and technical	74 (3%)	3 (0%)	1 (0%)	3 (0%)	1 (0%)	3 (0%)	85 (3%)
Additional clinical services	484 (16%)	7 (0%)	9 (0%)	14 (0%)	2 (0%)	10 (0%)	526 (18%)
Administrative and clerical	589 (20%)	6 (0%)	6 (0%)	23 (1%)	2 (0%)	10 (0%)	636 (22%)
Allied health professionals	139 (5%)	5 (0%)	1 (0%)	6 (0%)	0 (0%)	8 (0%)	159 (5%)
Estates and ancillary	253 (9%)	9 (0%)	6 (0%)	21 (1%)	4 (0%)	8 (0%)	301 (10%)
Healthcare scientists	78 (3%)	2 (0%)	1 (0%)	6 (0%)	1 (0%)	0 (0%)	88 (3%)
Medical and dental	84 (3%)	37 (1%)	11 (0%)	148 (5%)	20 (1%)	18 (1%)	318 (11%)
Nursing and midwifery registered	722 (25%)	13 (0%)	4 (0%)	63 (2%)	6 (0%)	19 (1%)	827 (28%)
Other	1 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (0%)
Total	2,424 (82%)	82 (3%)	39 (1%)	284 (10%)	36 (1%)	76 (3%)	2,941 (100%)

Source: Mid Staffordshire NHS Foundation Trust

Figure 2: Number of staff by salary band as at June 2013

Source: Mid Staffordshire NHS Foundation Trust

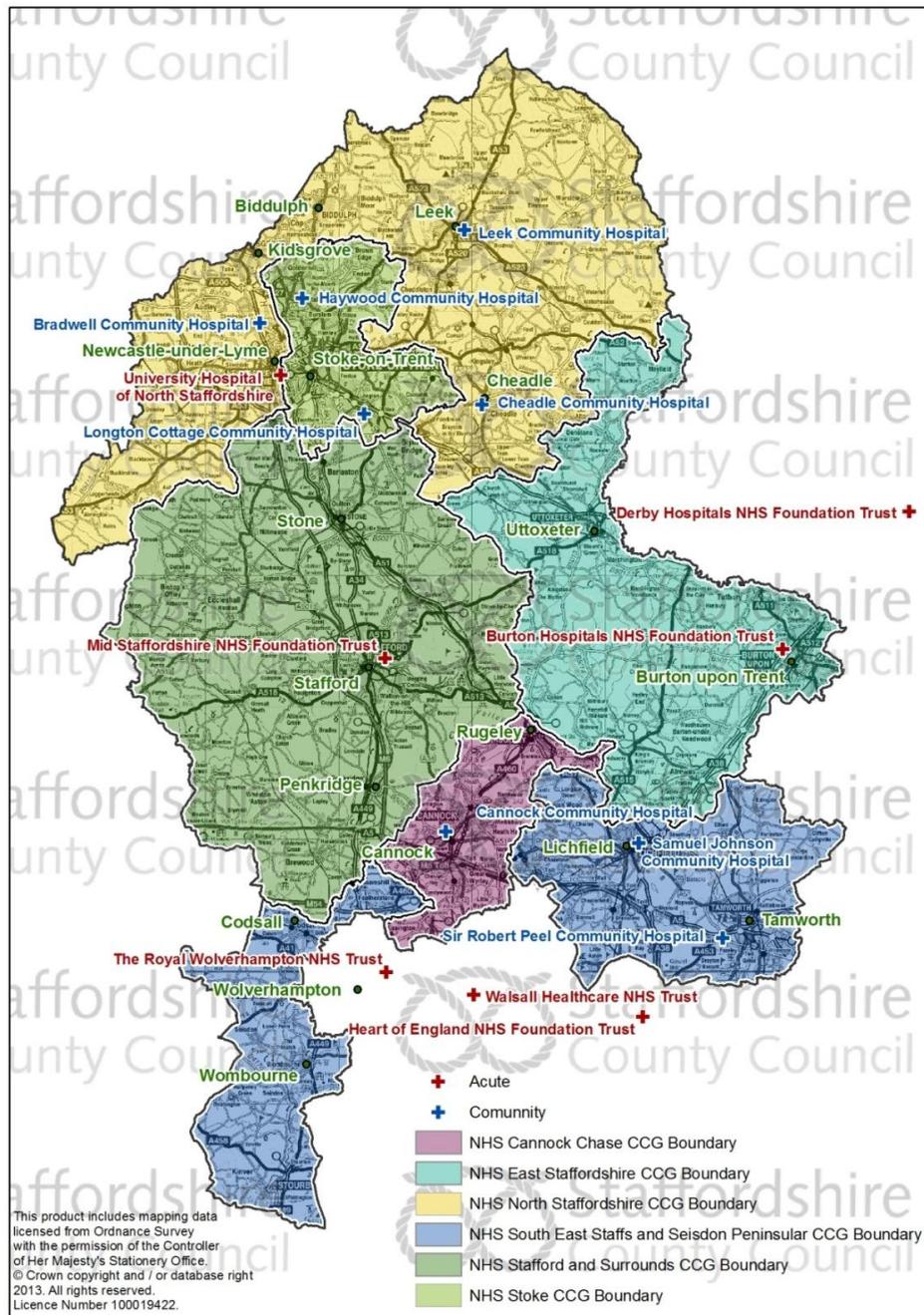
Just over half (57%) the staff work full time with more men (83%) than women working on a full time (50%) basis; just under three hundred staff (10%) work less than half time. About half of the staff (52%) earn less than £25,000 and most of

these are women (83%); around one hundred staff earn less than £15,000 (Figure 2). Given the profile of the staff, the focus for the impact assessment will be on those at the lower end of the pay scale, particularly women and those with less transferable skills as it is these groups that are most likely to have difficulty in finding alternative job opportunities.

5 Overview of the local health economy

The map below shows the commissioners and providers that comprise the local health economy in Staffordshire.

Figure 3: Commissioners and providers in the local health economy



As discussed in Section 4.4, MSFT has increasingly provided its services in partnership with other well-established NHS providers. The significant majority of activity at MSFT is commissioned through the local CCGs: Cannock Chase CCG and Stafford and Surrounds CCG, and this section therefore focuses on those

organisations, as the other Staffordshire CCGs largely relate to other acute providers.

5.1 Providers in the local health economy

As noted above, along with MSFT there are two other acute providers within Staffordshire: University Hospital of North Staffordshire NHS Trust (UHNS) in Stoke-on-Trent and Burton Hospital NHS Foundation Trust (BHT); in addition a number of other acute providers from neighbouring areas also serve Staffordshire's population. All seven acute Trusts provide a range of services including maternity services and a variety of different specialties: elective surgery and unplanned admissions, out-patients and A&E. The Royal Wolverhampton NHS Trust (RWT) and UHNS both provide a range of more specialised services for the Staffordshire population.

Table 11: Summary of providers in the local health economy

Hospital	A&E	Out-patients	Maternity services	Routine elective	Non-elective
Mid Staffordshire NHS Foundation Trust (MSFT)	Partial	Yes	Yes	Yes	Yes
Burton Hospitals NHS Foundation Trust (BHT)	Yes	Yes	Yes	Yes	Yes
Derby Hospitals NHS Foundation Trust	Yes	Yes	Yes	Yes	Yes
Heart of England NHS Foundation Trust (HEFT)	Yes	Yes	Yes	Yes	Yes
The Royal Wolverhampton NHS Trust (RWT)	Yes	Yes	Yes	Yes	Yes
University Hospital of North Staffordshire NHS Trust (UHNS)	Yes	Yes	Yes	Yes	Yes
Walsall Healthcare NHS Trust (WHT)	Yes	Yes	Yes	Yes	Yes

Source: NHS Choices

The Staffordshire and Stoke-on-Trent Partnership NHS Trust (SSOTP) provides community health care and adult social care services in Staffordshire, and community health services in Stoke-on-Trent. The Trust operates five community hospitals in the north of the county with approximately three hundred community

beds and in April 2012 it took on responsibility for adult social care in South and North Staffordshire.

West Midlands Ambulance Service (WMAS) NHS Foundation Trust is the statutory NHS ambulance service that covers Staffordshire, Warwickshire, West Mercia and the Birmingham and Black Country conurbation, a population of 5.6 million people⁴⁴. The Trust employs over four thousand staff and responds to around 760,000 emergency calls every year. The main measure of ambulance service performance is the time taken to respond to patients who are assessed as potentially life-threatening during the 999 call. The targets are to reach 75% of these patients within eight minutes and 95% within 19 minutes; WMAS achieved these targets in Staffordshire at 77.7% and 96.8% respectively during 2012/13. Year-to-date performance against these targets was 76.9% and 97.2% for the first two months of 2013/14.

5.2 Local commissioning arrangements: Stafford & Surrounds and Cannock Chase CCGs

5.2.1 Overview of the CCGs

In England, Clinical Commissioning Groups (CCGs) are responsible for investing NHS budget in providers of a range of healthcare services to meet the general needs of their registered populations (i.e. principally those people registered with local general practitioners, but also anyone living locally without a GP). They are responsible for ensuring access to elective care, rehabilitation, urgent and emergency care (including out-of-hours and accident and emergency services), most community health services, maternity services, mental health and learning disability services⁴⁵. There are five CCGs covering a population largely coterminous with the County Council area of Staffordshire (Table 12).

Table 12: Commissioners in the Staffordshire health economy

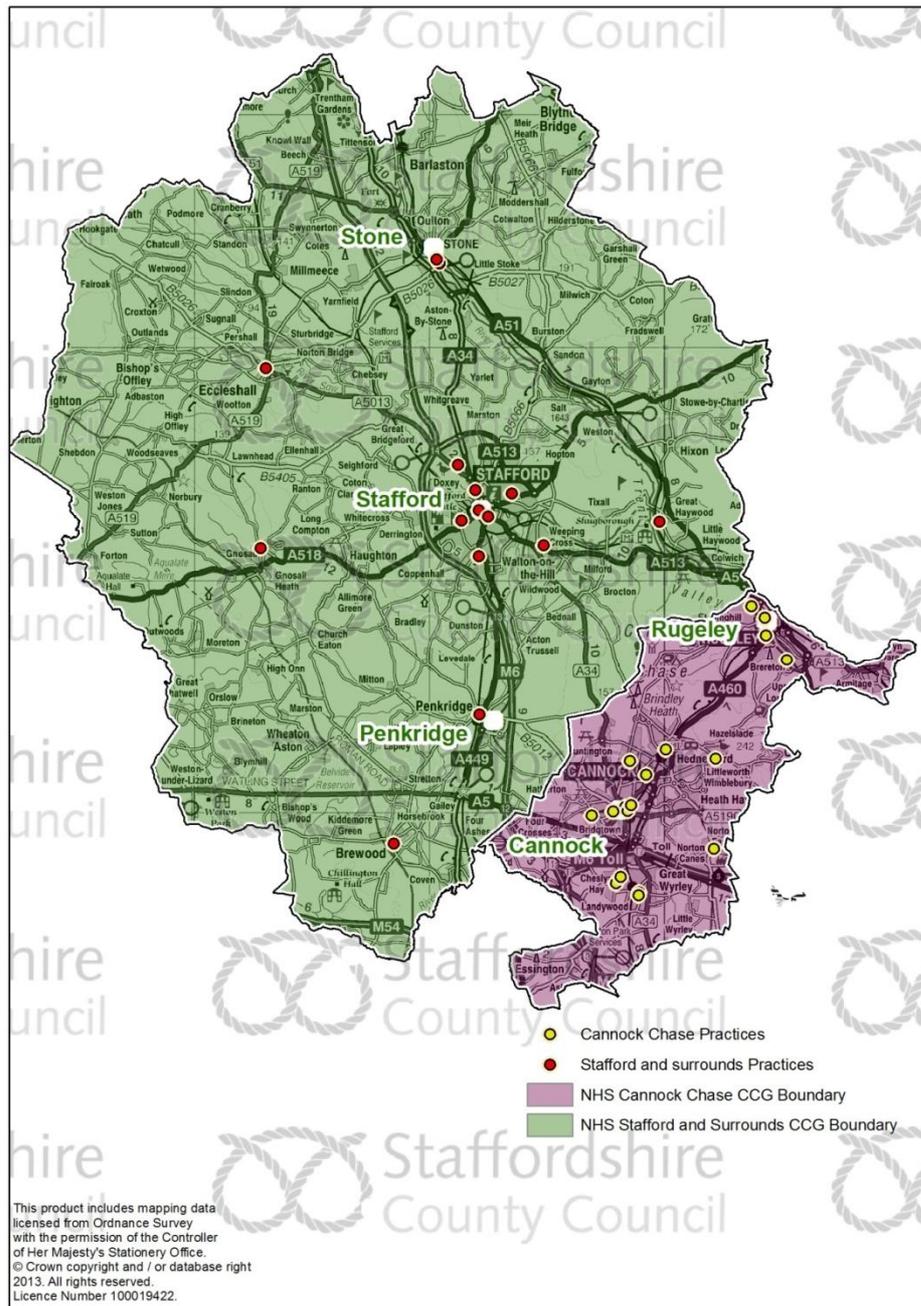
Commissioners
Cannock Chase CCG
Stafford and Surrounds CCG
East Staffordshire CCG
South East Staffordshire and Seison Peninsular CCG
North Staffordshire CCG

⁴⁴ Health Select Committee Inquiry into Emergency Services and Emergency Care, Submission from West Midlands Ambulance Service NHS Foundation Trust, WMAS, 2013.

⁴⁵ *Guide to the Healthcare System in England Including the Statement of NHS Accountability*, May 2013, London: Department of Health, p. 4.

Each of the CCGs typically relates to a particular acute provider. Stafford and Surrounds CCG and Cannock Chase CCG commission services for a combined population of 276,000 and their main acute provider is MSFT. The CCGs were formed in 2012 and authorised as statutory bodies (with a small number of conditions) from 1st April 2013; a map of the CCGs and their practices is shown in Figure 4. The significant majority of patients using services at MSFT are registered with these local GPs.

Figure 4: Stafford and Surrounds and Cannock Chase CCGs



5.2.2 Commissioning intentions

Both Cannock Chase and Stafford and Surrounds CCGs have described goals that set the “direction of travel” for future service provision and signal a significant shift in investment from hospital-based provision to support for people to self-care in primary and/or community care.

Historic activity across the two CCGs shows higher levels of hospital activity than most other CCGs across the country, which is unexpected given the profile of the local population. For example emergency admissions to hospital on an unplanned basis are double the national average when compared to other CCGs. There is particular concern where these are patients with ambulatory care sensitive conditions, as best evidence⁴⁶ suggests that patients with these conditions can and should be managed outside of acute hospitals. In 2013/14 commissioners are seeking reductions in hospital activity for: outpatients; elective admissions; accident and emergency (A&E) attendances; and non-elective admissions.

The CCGs hope that in the future many more people with chronic conditions will be supported in primary care and by community services, and admission to hospital for this group will become the exception rather than the rule. The commissioner aspirations are for a more integrated provider landscape that reduces fragmentation and handoffs, and ultimately reduces acute interventions as a consequence of a failing system of care. More specifically, commissioners wish to ensure that:

- Emergency and urgent care is adequate to meet population needs while being safe and affordable;
- Planned care pathways are robust enough to safely manage patients effectively in primary care for longer through the use of new interventions; and
- The provision of new services using technological advances in healthcare is maximised.

5.3 The local authority’s role as a commissioner

Public Health functions and responsibilities transferred from Primary Care Trusts (PCTs) to local authorities on 1st April 2013, including commissioning a range of public health services. The majority of these services are preventive or delivered outside of hospital; however MSFT is the current local provider of sexual health services. If the TSAs propose a change to this, then the Staffordshire County Council

⁴⁶ For example *Transforming our health care system: Ten priorities for commissioners*, London: The King’s Fund, revised edition April 2013, p. 6.

Public Health Team will be responsible for ensuring continuing availability of sexual health services in any new arrangements.

5.4 NHS England and direct commissioning

NHS England (known in legislation as the NHS Commissioning Board or NHS CB) holds overall responsibility for the NHS budget. Although it delegates money and responsibility to CCGs, it retains direct responsibility for the commissioning of a significant range of services. This includes for rarer and more specialised conditions, primary care (including GP services), offender health, and military health. It is responsible therefore for many services which people living in the catchment area of MSFT will need, although the majority of them would not be provided in a small district general hospital. Any changes to current provision at MSFT would have to support effective patient pathways out of primary care, into secondary care, and where necessary on into more specialised support.

5.4.1 Commissioning for the Armed Forces

Serving members of the Armed Forces, Reservists Veterans and all of their families form part of a larger “Armed Forces Community”⁴⁷:

- Serving Armed Forces – ca. 140,000 people are registered with Defence Medical Services (DMS) Medical Centres in England. Approximately half of the England DMS-registered population is concentrated in four areas (Devon, Hampshire, Wiltshire and North Yorkshire);
- Their families – i.e. spouses / partners and dependent children and adults; most are registered with NHS GP practices and approximately twenty thousand are registered with DMS Medical Centres in England;
- Veterans – defined as anyone who has been a member of the serving Armed Forces for a day or more; there are approximately four million in England, all of whom should be registered with NHS GP practices;
- Reservists – Civilians who are called in to the serving Armed Forces from time to time for particular tours of duty. Reservists are regarded as members of the Armed Forces while mobilised; when not mobilised, reservists are regarded as veterans when accessing NHS care. The number of reservists is planned to grow from approximately fifteen to thirty thousand;
- Overseas – In addition to the England-based population, there are 53,000 serving Armed Forces and dependants on overseas operations/postings. All

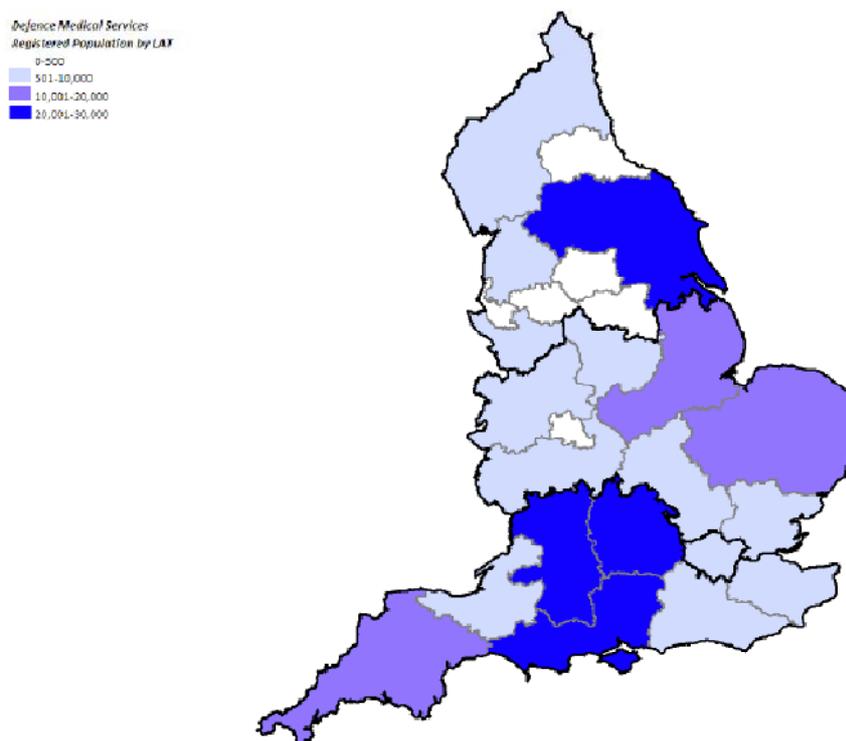
⁴⁷ *Securing excellence in commissioning for the Armed Forces and their families*, March 2013, NHS Commissioning Board, p. 6.

have a right of return to receive NHS secondary and community care in the UK; and

- Devolved Administrations – for Scotland, Wales and Northern Ireland, the normal rules of NHS commissioning responsibility apply. The NHS CB has responsibility only for commissioning health services for members of the Armed Forces and their families registered with DMS practices in England or, for those posted Overseas, who choose to return to use NHS services in England.

The figure below shows the distribution of the DMS-registered population in England⁴⁸.

Figure 5: The distribution of DMS-registered population by Area Team



Source: *Securing excellence in commissioning for the Armed Forces and their families*, March 2013, NHS Commissioning Board.

As noted above, the NHS CB is responsible for the direct commissioning of secondary and community health services for Armed Forces and families registered with DMS Medical Centres. It has also assumed responsibility for commissioning some public health services that the Armed Forces and their families can access⁴⁹. CCGs are responsible for commissioning health services for those veterans and families of members of the Armed Forces who are registered with NHS GP practices. CCGs are

⁴⁸ Ibid., p. 15.

⁴⁹ *Securing excellence in commissioning for the Armed Forces and their families*, March 2013, NHS Commissioning Board, p. 11.

also responsible for the commissioning of emergency care services for “every person present in its area”, which includes members of the Armed Forces and their families⁵⁰.

5.4.2 Commissioning for health and justice in Staffordshire

One of the NHS CB’s responsibilities is to directly commission health services for persons who are detained in prison or other secure accommodation. In addition to prisons and Young Offender Institutions, these facilities include: secure children’s homes; secure training centres; immigration removal centres; police custody suites; and courts⁵¹.

Adult Offenders and children and young people in secure settings typically have poorer health and health outcomes than the average population. Examples include:

- 81% of adult prisoners said they had used illicit drugs at some point prior to entering prison, including almost two-thirds (64%) within the month before entering prison⁵²;
- In a survey of prisoners released from custody, 12% of prisoners said they had a mental illness or depression as a long-standing illness and 20% reported needing help with an emotional or mental health problem. Around 17% of prisoners had been treated or counselled for an emotional or mental health problem in the year before custody⁵³; and
- Children and young people in the youth justice system are at least three times as likely to have mental health problems as their non-offending counterparts⁵⁴.

NHS England’s Shropshire and Staffordshire Area Team is responsible for commissioning health services for the offender population of Staffordshire which hosts nine prisons: Werrington, Drake Hall, Swinfen Hall, Brinsford, Dovegate, Featherstone, Stafford, Stoke Heath, and Oakwood⁵⁵. Of these nine, one is in Shropshire (Stoke Heath) and the remaining are in Staffordshire on the six sites shown in Figure 6 (note that Brinsford, Featherstone and Oakwood are all on the same site).

⁵⁰ Ibid., p. 12.

⁵¹ *Securing Excellence in Commissioning for Offender Health*, February 2013, NHS Commissioning Board, p. 4.

⁵² Surveying prisoner crime reductions in the 2010 compendium of reoffending statistics and analysis, MOJ statistical bulletin (www.justice.gov.uk/publications/compendium-reoffending).

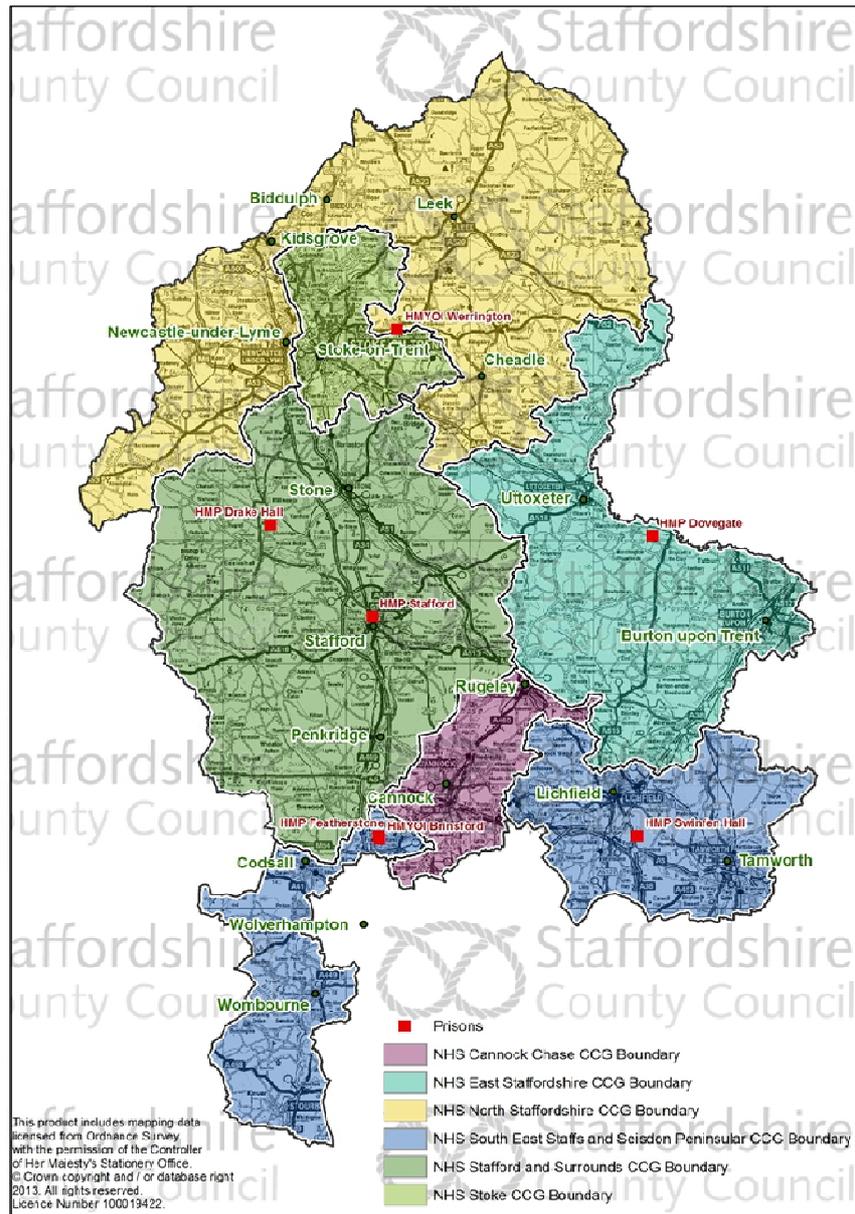
⁵³ Ibid..

⁵⁴ *Securing Excellence in Commissioning for Offender Health*, February 2013, NHS Commissioning Board, p. 8.

⁵⁵ *Securing Excellence in Commissioning for Offender Health*, February 2013, NHS Commissioning Board, p. 27.

Although any of the prisons in Staffordshire could potentially use MSFT, in practice, Stafford and Drake Hall prisons are the main regular users of MSFT’s services. Volumes are relatively low (for example, there were around three hundred outpatient appointments between April 2011 and March 2012 or 0.45% of new outpatient activity).

Figure 6: Prisons in Staffordshire



5.4.3 Specialised services commissioning in Staffordshire

For 2013/14, NHS England has a budget of £1.3bn to commission designated specialised services across the West Midlands health economy. Most NHS providers do some specialised work, but as is typical for a district general hospital, MSFT is limited to a small contract of £9m relating mainly to the provision of chemotherapy

and a neonatal service that supports the maternity unit. A wider range of specialised services is commissioned at Royal Wolverhampton Hospitals NHS Trust (ca. £78m) and University Hospitals North Staffordshire NHS Trust (£122m) and this is where the majority of Staffordshire residents (including those in the catchment of MSFT) access these services. For some rarer conditions or even more specialised work, pathways support access to University Hospital Birmingham NHS FT, Birmingham Children's Hospital NHS FT and Heart of England NHS FT.

6 Overview of the local population and its health status

6.1 Defining the catchment population of MSFT

The MSFT catchment *area* (the geographical area as a whole) is largely consistent with the registered population of Cannock Chase and Stafford and Surrounds CCGs. However, it has a smaller catchment *population*, which is the people who choose to use a particular hospital if they require treatment. Many factors affect the size of a hospital's catchment population including: the type and size of a hospital, its proximity to other hospitals, characteristics of the population, reputation and patient choice. These factors can change over time. Table 13 shows how the local catchment area compares with the catchment population.

Table 13: Mid Staffordshire NHS Foundation Trust catchment area and catchment population

Catchment area			Catchment population	
Resident [1] population of Cannock Chase and Stafford (2011)	Registered [2] population of Stafford and Surrounds CCG and Cannock Chase CCG (2012)	MSFT Website (2012)	Association of Public Health Observatories (APHO) (2006/07 to 2008/09)	Public Health Staffordshire (2010/11 to 2012/13)
228,300	277,400	276,500	226,300	204,400

Notes:

[1] Resident population: People who live within the geographical boundaries of Cannock Chase Borough and Stafford District

[2] Registered population: People who are registered with GPs who are part of the Stafford and Surrounds or Cannock Chase CCGs

Sources: *Population estimates - 2011 mid-year population estimates*, Office for National Statistics, Crown copyright, *2012 GP registered populations*, South Staffordshire PCT and North Staffordshire PCT, *Catchment populations - Association of Public Health Observatories*

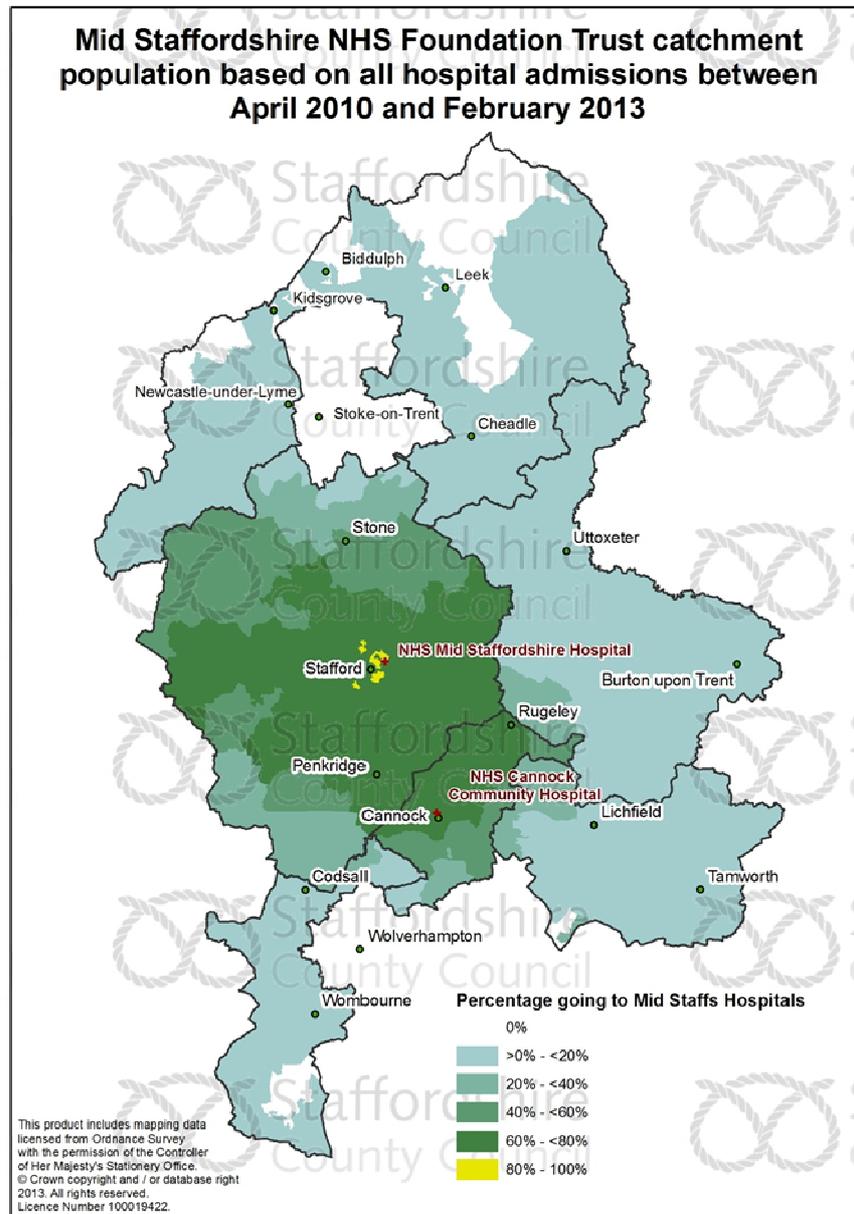
The catchment population for MSFT for all admissions was estimated to be 226,300 in 2009⁵⁶. Locally-derived information indicates a decline in the catchment population from 2009/10 onwards and Public Health Staffordshire's (PHS) estimate, based on all hospital admissions between 2010/11 and 2012/13, suggests that the catchment population has fallen by around 11% to 204,400 with a likely range between 192,000 and 217,000. Figure 7 shows a map of the MSFT catchment population based on all admissions between April 2010 and February 2013.

Around 95% of admissions to MSFT are for people who live in Staffordshire and ca. 75% of admissions are for people who live in Stafford or Cannock Chase. Figure 7 shows that the closer people live to the main acute hospital site in Stafford and the

⁵⁶ The Association of Public Health Observatories (APHO) produced hospital catchment population estimates for English trusts.

hospital in Cannock, the more likely they are to go to these hospitals for treatment. There are only a few geographical areas (shown in yellow) where over 80% of residents go to MSFT for treatment and these are all very close to the Stafford Hospital site. **For this reason, the impact assessment will focus on impact for people registered with the two local CCGs (277,400), as this represents the significant majority of people using services at MSFT.**

Figure 7: Mid Staffordshire NHS Foundation Trust catchment population based on all admissions between April 2010 and February 2013



6.2 Overview of the population

Staffordshire has a resident population of around 848,500 (2011 Census), a GP registered population of 837,900 (1st January 2013) and covers a large area of around 2,616 km² (1,010 square miles). Staffordshire includes a mixture of towns and villages that are covered by nine local government organisations:

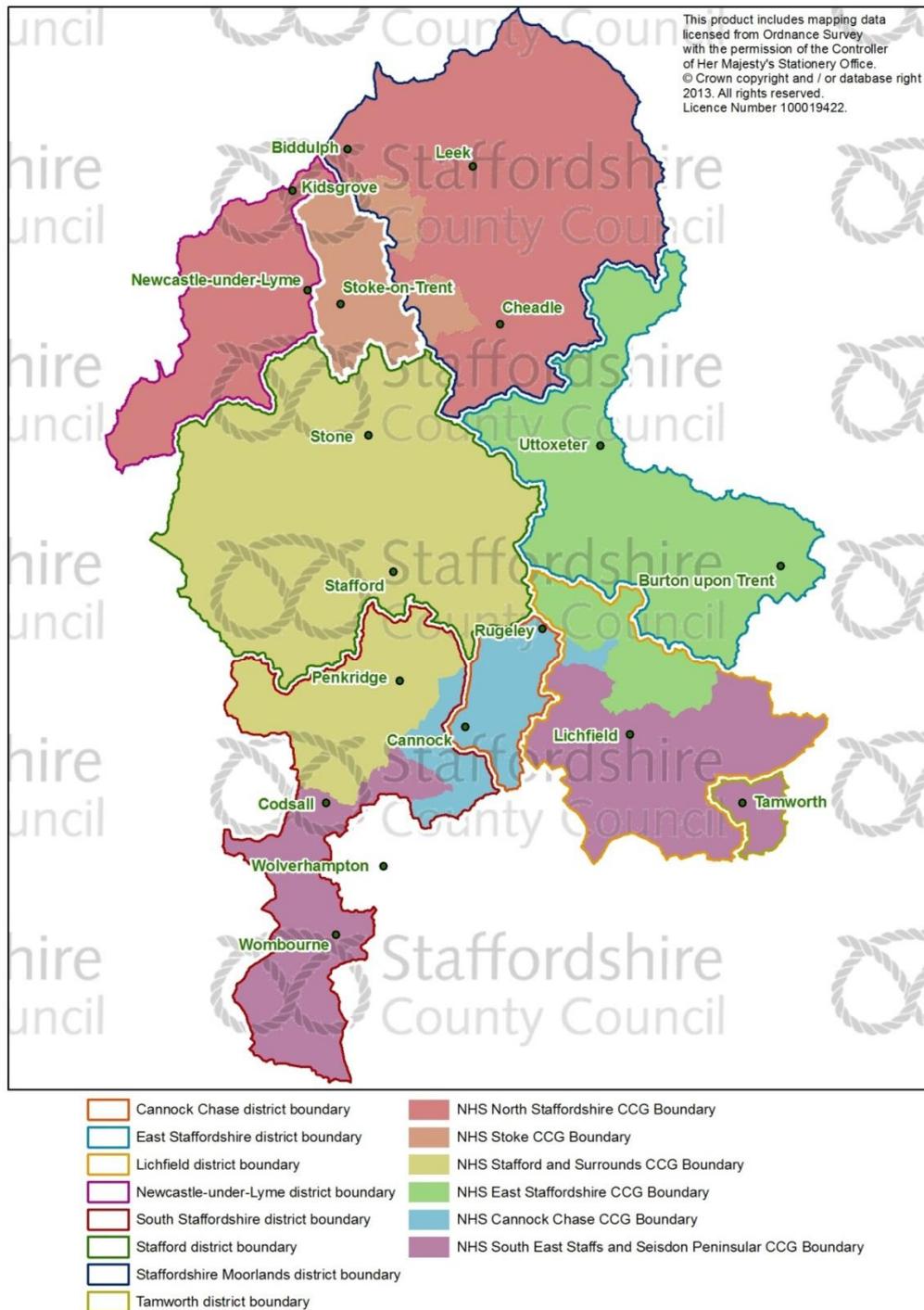
- Staffordshire County Council; and
- Eight district councils (Cannock Chase, East Staffordshire, Lichfield, Newcastle-under-Lyme, South Staffordshire, Stafford, Staffordshire Moorlands and Tamworth).

There are five local clinical commissioning groups, as set out in Section 5.2. The unitary authority of Stoke-on-Trent is within the geographical boundary of Staffordshire but does not form part of Staffordshire County and is host to its own major hospital; it is therefore not included in this impact assessment.

Based on the assessment of MSFT's catchment area and population in Section 6.1 above, for the purposes of the scoping report and the impact assessment, the local population is defined as the population of Stafford and Cannock (the registered population of the local CCGs, or local authority residents if CCG-level information is not present in a dataset)⁵⁷; see Figure 8 for the relevant boundaries. This is the population that has historically made up some 90% of the people using MSFT services (based on in-patient activity for 2010/11). For the purposes of comparison, these populations are presented alongside data for both Staffordshire and England. Note that if the TSAs' recommendations have a significant impact on populations outside the two local CCGs, the impact assessment will look at these additional populations where this is feasible.

⁵⁷ These descriptions of the local population have been used as the basis for the maps used in the Appendix.

Figure 8: Map of Staffordshire showing the CCG and district boundaries



On 1st January 2013, the registered population for Cannock Chase CCG was 132,500 and for Stafford and Surrounds CCG it was 144,900. A breakdown of these populations by age and gender is shown in Table 14; both CCGs have an older population compared to the average in England.

Table 14: Overall population profile for 2013

	0-4	5-15	16-24	25-49	50-64	65-74	75+	All ages
Males								
Cannock Chase	3,800 (2.8%)	8,200 (6.2%)	7,700 (5.8%)	22,500 (17.0%)	12,900 (9.7%)	6,800 (5.1%)	4,200 (3.1%)	65,900 (49.8%)
Stafford and Surrounds	3,600 (2.5%)	8,300 (5.7%)	8,200 (5.7%)	24,100 (16.7%)	14,700 (10.1%)	8,300 (5.7%)	5,600 (3.9%)	72,900 (50.3%)
Staffordshire	23,200 (2.8%)	50,800 (6.1%)	47,000 (5.6%)	139,600 (16.7%)	83,200 (9.9%)	44,400 (5.3%)	29,300 (3.5%)	417,500 (49.8%)
West Midlands (2013 projected)	3.3%	6.6%	6.2%	16.4%	8.8%	4.7%	3.4%	49.4%
England (2013 projected)	3.3%	6.4%	6.0%	17.1%	8.8%	4.5%	3.3%	49.3%
Females								
Cannock Chase	3,600 (2.7%)	7,800 (5.9%)	7,200 (5.4%)	22,300 (16.8%)	12,800 (9.6%)	7,100 (5.4%)	5,900 (4.4%)	66,600 (50.2%)
Stafford and Surrounds	3,500 (2.4%)	7,900 (5.5%)	6,900 (4.7%)	22,800 (15.7%)	14,600 (10.1%)	8,700 (6.0%)	7,600 (5.2%)	72,000 (49.7%)
Staffordshire	21,900 (2.6%)	48,200 (5.8%)	44,400 (5.3%)	135,400 (16.2%)	82,500 (9.9%)	46,800 (5.6%)	41,300 (4.9%)	420,500 (50.2%)
West Midlands (2013 projected)	3.2%	6.3%	5.9%	16.5%	9.0%	4.9%	4.8%	50.6%
England (2013 projected)	3.1%	6.1%	5.7%	17.2%	9.0%	4.8%	4.7%	50.7%
Persons								
Cannock Chase	7,400 (5.6%)	15,900 (12.0%)	14,800 (11.2%)	44,800 (33.8%)	25,700 (19.4%)	13,900 (10.5%)	10,000 (7.6%)	132,500 (100.0%)
Stafford and Surrounds	7,100 (4.9%)	16,200 (11.2%)	15,100 (10.4%)	47,000 (32.4%)	29,300 (20.2%)	17,000 (11.8%)	13,200 (9.1%)	144,900 (100.0%)
Staffordshire	45,000 (5.4%)	99,000 (11.8%)	91,400 (10.9%)	275,000 (32.8%)	165,700 (19.8%)	91,300 (10.9%)	70,600 (8.4%)	837,900 (100.0%)
West Midlands (2013 projected)	6.5%	13.0%	12.0%	32.9%	17.8%	9.6%	8.2%	100.0%
England (2013 projected)	6.4%	12.5%	11.7%	34.3%	17.8%	9.3%	8.0%	100.0%

Note: Numbers may not add up due to rounding

Source: GP registered populations 2012/13 Q3 and 2011-based interim population projections, Office for National Statistics, Crown copyright

The Rural and Urban Area Classification 2004 categorises areas as urban or rural simply on the basis of their geographic relationship to settlements with a population of ten thousand or more. When the majority of an area's population lives within settlements of more than ten thousand people, the area is treated as urban. All other areas are then classified as rural and are subdivided into two further categories based on the settlements in that area: "town and fringe" and "village,

hamlet and isolated dwellings”. Using these definitions, almost a third (32%) of Stafford’s population and a tenth (9%) of Cannock Chase’s population is classified as rural, compared with 19% nationally, 16% regionally and 24% for Staffordshire as a whole. Moreover, 20% of Stafford & Surrounds CCG’s population and 3% of Cannock Chase CCG’s population live in areas that are classified as “village, hamlet and isolated dwelling”, compared with 10% nationally, 9% regionally and 12% for Staffordshire as a whole.

6.3 Population projections

6.3.1 General Trends

The Office for National Statistics (ONS) estimates that the overall population for Staffordshire will increase by 5% between 2011 and 2021 and there will be significant increases in the older age groups (23%) compared with 19% for England. Projections for Cannock Chase and Stafford and Surrounds CCGs are shown in Table 15. In terms of the significant increase in older age groups, this will be particularly apparent in those aged 75 and over: by 2021, Cannock Chase is projected to see 3,500 more people aged 75 and over, whilst there will be an increase of 5,000 people in this age group in Stafford and Surrounds CCG.

Table 15: Population projections for Cannock Chase and Stafford & Surrounds CCGs, and Staffordshire CCGs and England 2012-2021

	Cannock Chase CCG			Stafford & Surrounds CCG		
	2012	2017	2021	2012	2017	2021
0-15	23,400	23,500 (0.8%)	24,000 (2.7%)	23,400	24,100 (3.0%)	25,000 (6.6%)
16-24	14,900	13,700 (-7.8%)	12,700 (-14.4%)	15,200	14,900 (-2.3%)	14,100 (-7.5%)
25-49	44,800	43,100 (-3.7%)	41,700 (-6.9%)	47,100	45,500 (-3.4%)	44,400 (-5.7%)
50-64	25,700	27,800 (8.4%)	29,600 (15.2%)	29,300	30,900 (5.5%)	32,600 (11.1%)
65-74	13,800	15,400 (11.8%)	15,400 (11.9%)	16,900	18,800 (11.2%)	18,500 (9.9%)
75+	9,900	11,500 (15.5%)	13,500 (35.7%)	13,100	15,400 (17.2%)	18,100 (38.2%)
0-15	23,400	23,500 (0.8%)	24,000 (2.7%)	23,400	24,100 (3.0%)	25,000 (6.6%)
16-64	85,300	84,600 (-0.8%)	84,000 (-1.6%)	91,600	91,200 (-0.4%)	91,000 (-0.6%)
65+	23,700	26,900 (13.3%)	28,900 (21.9%)	30,000	34,100 (13.8%)	36,600 (22.2%)
All ages	132,400	135,100 (2.0%)	136,900 (3.4%)	145,000	149,500 (3.1%)	152,700 (5.3%)

	Staffordshire CCGs			England		
	2012	2017	2021	2012	2017	2021
0-15	144,100	148,900 (3.3%)	153,800 (6.7%)	10,120,700	10,755,500 (6.3%)	11,294,300 (11.6%)
16-24	91,800	86,000 (-6.3%)	81,700 (-11.1%)	6,320,700	6,106,100 (-3.4%)	5,863,900 (-7.2%)
25-49	275,100	269,700 (-2.0%)	264,400 (-3.9%)	18,512,400	18,742,000 (1.2%)	18,934,200 (2.3%)
50-64	165,800	175,000 (5.5%)	183,800 (10.8%)	9,575,800	10,254,900 (7.1%)	10,808,300 (12.9%)
65-74	90,500	101,300 (12.0%)	101,200 (11.8%)	4,836,800	5,428,400 (12.2%)	5,523,200 (14.2%)
75+	70,100	81,900 (16.8%)	96,200 (37.2%)	4,219,100	4,651,300 (10.2%)	5,263,900 (24.8%)
0-15	144,100	148,900 (3.3%)	153,800 (6.7%)	10,120,700	10,755,500 (6.3%)	11,294,300 (11.6%)
16-64	532,800	530,800 (-0.4%)	529,900 (-0.5%)	34,408,900	35,103,000 (2.0%)	35,606,400 (3.5%)
65+	160,600	183,300 (14.1%)	197,400 (22.9%)	9,055,900	10,079,700 (11.3%)	10,787,100 (19.1%)
All ages	837,600	862,900 (3.0%)	881,100 (5.2%)	53,585,500	55,938,200 (4.4%)	57,687,800 (7.7%)

Note: Numbers may not add up due to rounding

Source: GP registered populations 2012/13 Q2 and 2011-based interim population projections, Office for National Statistics, Crown copyright

These projections are based on the 2011 Census, births, deaths and estimated migration flows, and do not reflect other local factors.

6.3.2 Growth in local military personnel

The Ministry of Defence (MoD) has suggested that it is its intention to relocate two Signals regiments from Germany to Stafford during the summer of 2015. The combined units will be formed of approximately 1,000 service personnel and will bring with them ca. 350 families with six hundred children. The registered military population for the whole Midlands and East region is recorded at 39,680, and most of that is based in the East given the concentration of facilities there. It is therefore unlikely that these additional personnel and their families will increase the concentration of DMS-registered population in Staffordshire from the current level.

From previous experience, commissioners do not expect these largely office-based staff and their families to have a significantly different pattern of service use to that of the civilian population. Members of the Armed Forces are typically younger and fitter than the general population and there is therefore a lower prevalence of long-

term conditions, but a higher incidence of musculo-skeletal injury⁵⁸. Serving personnel have access to a range of in-house rehabilitation services, which reduces their requirement to use the general NHS. With the exception of combat-related injuries, their healthcare needs can usually be met by standard NHS services. Similarly, the families and dependants of serving Armed Forces members have health needs typical of their age and gender. It is recommended that “[m]aternity services and children’s health services in particular must be planned and commissioned with the needs of military families in mind where they are present in large numbers in a community”⁵⁹. Usual planning assumptions would be for one additional GP per 1,500-2,000 people and there may be very limited impact on hospital utilisation at this scale, particularly given the younger profile of this group; however this will be explored and considered in the impact assessment as it is an issue of particular concern to local people.

6.3.3 Growth due to increases in the local housing stock

The National Planning Policy Framework (NPPF) sets the context for the provision of new development and requires local authorities to establish the appropriate scale of development for an area based on objectively assessed needs. The *Plan for Stafford Borough* establishes the level of housing across the area, taking into account past completion rates, existing commitments and information from the Strategic Housing Land Availability Assessment to show the potential scope for supply, population and household projections over the Plan period⁶⁰. The *Plan for Stafford Borough* also establishes a spatial principle that: “[t]hroughout the Borough, provision will be made for the development of 500 dwellings per year over the plan period, not including additional requirements for military housing, and provision for gypsies”⁶¹. The plan notes that the average figure of 454 completions per year fell to around two hundred per year in the period 2009-2011 due to the recession and difficulties in mortgage provision. However Stafford Borough Council had 425 housing completions in 2011/2012, and by 31st March 2012 had given planning permission for 2,911 new houses to be built which are yet to be completed, providing six years of supply (based on five hundred new homes per year)⁶².

6.4 Overall health status

Life expectancy at birth is often used as a high level indicator of the overall health status of the population. Life expectancy measures the average number of years a baby born in a particular population can expect to live if it experiences the current

⁵⁸ *Securing excellence in commissioning for the Armed Forces and their families*, March 2013, NHS Commissioning Board, p. 7.

⁵⁹ *Ibid.*, p. 7.

⁶⁰ *The Plan for Stafford Borough Publication [Pre-submission]*, Stafford Borough Council, 2013, p. 23.

⁶¹ *Ibid.*, p. 23.

⁶² *Ibid.*, p. 24.

age-specific mortality rates for that particular geography throughout its life. Most of Staffordshire (including Stafford) has a life expectancy similar to or better than the national average (see Table 16) but within this overall positive picture, there are a number of areas in the county where life expectancy is below the national average. In Cannock Chase, life expectancy is just slightly less than the national average: men have a life expectancy which is five months less than the national average and women live three months less than the average.

Table 16: Life expectancy in Staffordshire, 2009-2011

Location	Men		Women	
	Life expectancy at birth (years)	Difference to England (months)	Life expectancy at birth (years)	Difference to England (months)
Cannock Chase	78.5	-5	82.7	-3
Stafford	80.1	14	83.6	8
Staffordshire	79.0	2	82.9	0
West Midlands	78.4	-6	82.6	-3
England	78.9		82.9	

Key: **Statistically higher than England; statistically lower than England**

Source: Death extracts, Office for National Statistics, Revised mid-year population estimates, Office for National Statistics, Crown copyright and Vital statistics Table 3, Office for National Statistics, Crown copyright.

Cannock East, Cannock North, Cannock South, Hawks Green, Hednesford North, Rawnsley in Cannock Chase CCG and Forebridge in Stafford & Surrounds CCG have a shorter life expectancy than England for men. The following wards falling in Cannock Chase CCG also have shorter life expectancy than England for women: Hawks Green, Heath Hayes East and Wimblebury, Rawnsley, Armitage with Handsacre, Essington and Huntington and Hatherton. Maps showing the statistical difference (local vs. England) for female and male life expectancy for (a) Staffordshire and (b) Stafford and Cannock are given in the Appendix.

6.5 Socioeconomic deprivation

The World Health Organisation (WHO) Regional Office for Europe notes⁶³ that at the highest level of influence on health, there are major structural factors (socioeconomic, cultural and environmental) that have an impact. At the next level down, the material and social conditions in which people live and work; their economic status, also has a bearing on health and health outcomes.

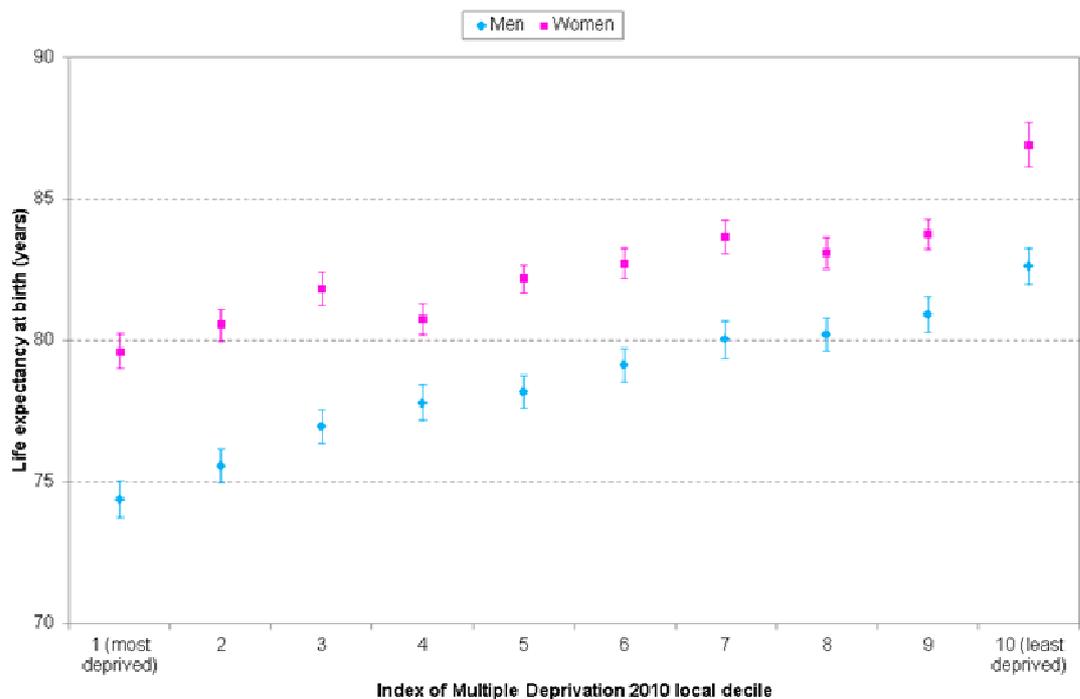
⁶³ G Dahlgren and M Whitehead (1991) "Policies and strategies to promote social equity in health: Background document to WHO – Strategy paper for Europe", Institute for Futures Studies, Stockholm (ISBN 978-91-85619-18-4), p. 11.

6.5.1 Levels of deprivation

The Index of Multiple Deprivation 2010 (IMD 2010) is a way of identifying deprived areas. It measures deprivation in its broadest sense (i.e. beyond the level of family income) by including 38 indicators which assess deprivation by combining them into seven areas (called domains)⁶⁴: income deprivation; employment deprivation; health deprivation and disability; education, skills and training deprivation; barriers to housing and services; crime; and living environment deprivation. These domains are measured at a “lower super output area” (LSOA) level; each LSOA is a geographical area with a population of around 1,500 people⁶⁵.

Figure 9 shows a clear link between multiple deprivation and life expectancy.

Figure 9: Life expectancy by deprivation decile, 2007-2011



Source: Death extracts, Office for National Statistics, Mid-year population estimates, Office for National Statistics, Crown copyright and Vital statistics Table 3, Office for National Statistics, Crown copyright

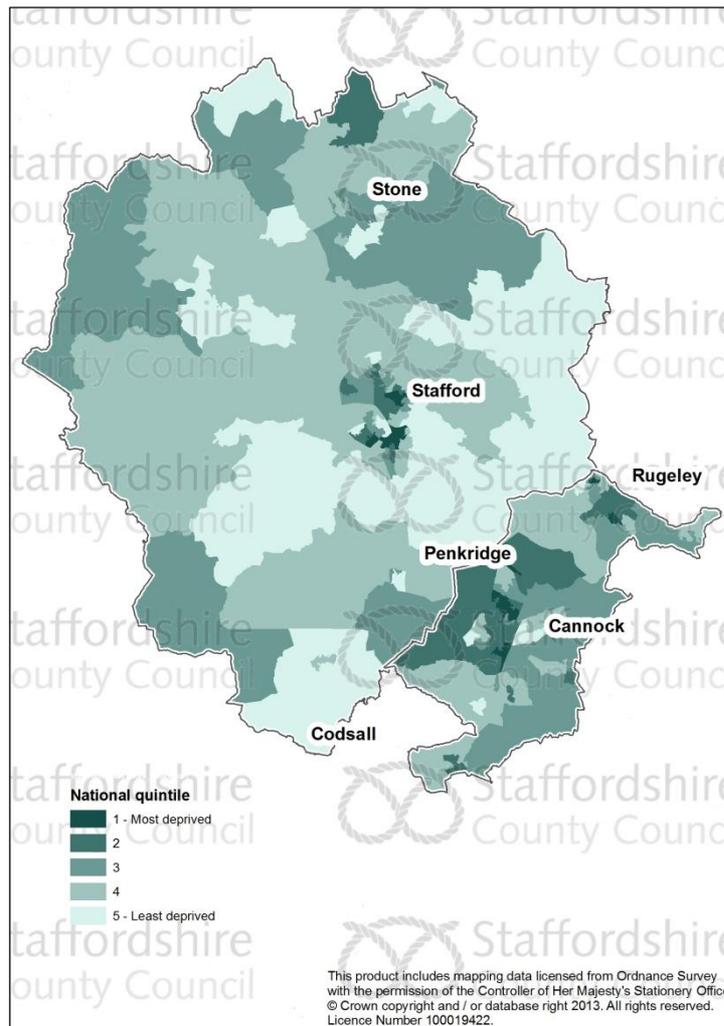
Only nine of the 525 lower layer super output areas in Staffordshire are in the lowest decile of most deprived areas in England. More specifically, there are eight LSOAs that fall within the most deprived quintile of areas in England, making up 12%

⁶⁴ *The English Indices of Deprivation 2010*, Department for Communities and Local Government, March 2011, p. 13.

⁶⁵ A Lower Layer Super Output Area (LSOA) is a geographic area and LSOAs are a geographic hierarchy designed to improve the reporting of small area statistics in England and Wales. LSOAs are built from groups of contiguous Output Areas and have been automatically generated to be as consistent in population size as possible, and typically contain from four to six Output Areas. The Minimum population is 1000 and the mean is 1500. There is a LSOA for each postcode in England and Wales (source: http://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/l/lower_layer_super_output_area_de.asp?shownav=1, accessed 4th May 2013).

(5,700) of the population of Cannock Chase. In Stafford, there are four LSOAs that fall within the most deprived quintile of areas in England making up 5% (6,900) of the population.

Figure 10: IMD (2010) map for Stafford and Cannock



Source: *Indices of Deprivation 2010, Communities and Local Government, Crown Copyright 2010*

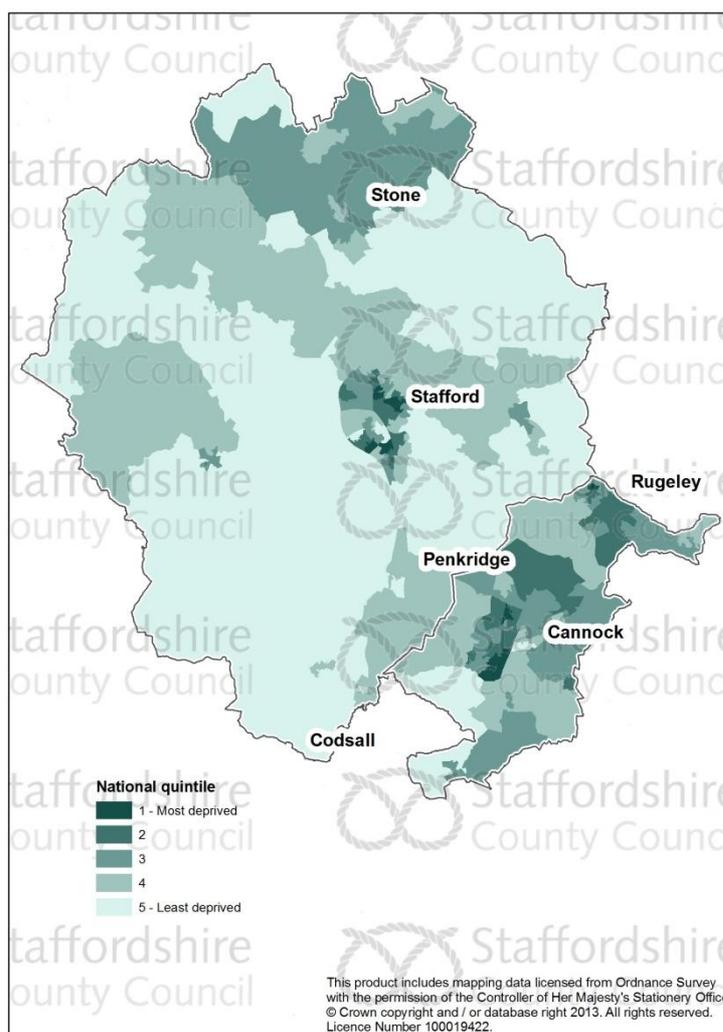
6.5.2 Health deprivation

The health deprivation and disability domain from the IMD 2010 identifies areas where there are higher rates of people dying prematurely or where their quality of life has been impaired by poor health or disability. The domain considers both physical and mental health indicators, which are standardised for age and gender.

Figure 11 illustrates the number of people who are disadvantaged in terms of health deprivation and disability across Staffordshire:

- Only 6% (5,600 people) of Cannock Chase's population live in areas in the most deprived quintile in England for health deprivation and disability, with a further 39% (31,400 people) living in the second most deprived quintile; and
- Only 5% (6,000 people) of Stafford's population live in areas in the most deprived quintile in England for health deprivation and disability. A further 10% (12,500 people) live in the second most deprived quintile.

Figure 11: Health deprivation and disability in Stafford and Cannock



Source: *Indices of Deprivation 2010, Communities and Local Government, Crown Copyright 2010*

6.5.3 Health inequalities

Table 17 below shows how deprivation inequalities can show up as health inequalities in old age as poor life chances lead to unhealthy lifestyles that result in early onset of disease, severe disease and premature death. The table illustrates the

differences in life experience and health outcomes amongst those living in the least and most deprived parts of Staffordshire.

Table 17: Inequalities in Staffordshire: comparison of babies born in the least deprived and most deprived areas in Staffordshire.

Area	Indicator	Least deprived	Most deprived
Health	Claim incapacity benefit	1%	3%
	Have a limiting long term illness	15%	22%
	Smoke	16%	34%
Education	Get a least five GCSEs A*-C	71%	40%
	16-18s not in education, employment or training	4%	15%
	Claim free school meals	3%	26%
Work	Become a professional or manager	40%	15%
	Are employment deprived	5%	19%
	Live on benefits	6%	24%
Home and family	Live in poverty as a child	5%	39%
	Live in income deprived households as an adult	4%	28%
	Go home to a council house	3%	41%
	Are part of a lone parent family	4%	11%
	Have no access to a car or van	8%	38%
Experience of crime	All crime	2%	10%
	Anti-social behaviour	1%	6%
	Burglary	0.2%	0.4%
	Deliberate fire	0.1%	0.5%
Other	Live alone as a pensioners	11%	12%
	Live in poverty when they are aged 60 and over	8%	32%
	Live to the age of (for men)	81	74
	Live to the age of (for women)	85	79

Data analysed and compiled by Health and Wellbeing Intelligence, Staffordshire Public Health

6.5.4 Socioeconomic deprivation and usage of acute services

Evidence from the UK, North America and Europe suggests that people living in areas of socioeconomic deprivation have higher rates of emergency admissions (after adjusting for other risk factors)⁶⁶. Socio-demographic variables explain around 45% of the variation in emergency admissions between GP practices, with deprivation more strongly linked to emergency than to elective admission^{67,68}. Indeed, an analysis of data from the 2004–05 British General Household Survey (BGHS)

⁶⁶ S Purdy *Avoiding hospital admissions: What does the research evidence say?*, London: The King's Fund, p. 3.

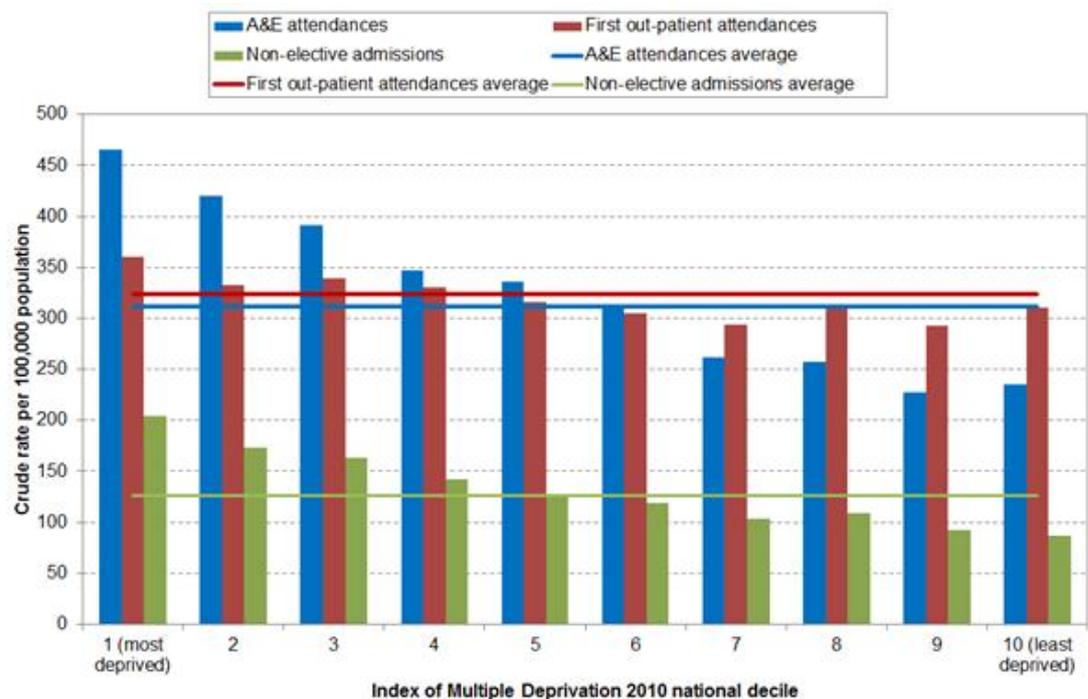
⁶⁷ Reid F, Cook D, Majeed A (1999). 'Explaining variation in hospital admission rates between general practices: cross sectional study'. *British Medical Journal*, **319**: 98–103.

⁶⁸ Duffy R, Neville R, Staines H (2002). 'Variance in practice emergency medical admission rates: can it be explained?' *British Journal of General Practice*, vol. 52, no. 474, pp 14–17.

concluded that “[r]educed access to A&E services will disproportionately affect poorer individuals”⁶⁹ in relation to access.

A&E attendance and non-elective admission rates are particularly high in deprived areas (Figure 12); however A&E departments in deprived urban areas have the highest proportion of patients who do not require hospital treatment⁷⁰. Where change to this pattern of use encourages earlier and more systematic contact with primary care it may lead to earlier intervention, changes in health behaviour, better chronic disease management and health outcomes⁷¹. There is less of a relationship between first out-patient attendance and deprivation, as this happens as a result of GP- rather than self-referral.

Figure 12: Non-elective admission rates by deprivation decile in Staffordshire, 2012/13



Source: Hospital in-patient data extracts, Healthcare Commissioning Services (HCS), Indices of Deprivation 2010, Communities and Local Government, Crown Copyright 2010 and 2011 Census, Office for National Statistics, Crown copyright

However in relation to other acute services, a study found that: lower income individuals were less likely to have inpatient treatment than higher income ones; the unemployed were less likely to have outpatient treatment; and those with lower educational attainment were less likely to have outpatient, day case and inpatient

⁶⁹ SM Shah DG Cook (2008) “Socio-economic determinants of casualty and NHS Direct use”, *Journal of Public Health* Vol. 30, No. 1, pp. 75–81.

⁷⁰ A McLellan (2011) “Analysis: patients in poorer regions using A&E over GP”, *Health Service Journal*, 13th December 2011.

⁷¹ Investing in primary care “will improve health outcomes in these areas [areas with lowest life expectancy], with more targeted and preventive interventions that identify and tackle illness at an earlier stage”. Professor Lord Darzi, *NHS Next Stage Review Interim Report*, Department of Health, October 2007, p. 25.

treatment⁷². In fact, micro-studies of cardiac surgery, elective surgery, cancer care, preventive care and chronic care suggest that use of services was higher relative to need among higher socioeconomic groups⁷³; this is the inverse care law, where the well-educated and assertive are able to argue for greater access to services at the expense of the disadvantaged.

Given the socio-demographic profile of the Trust's catchment population, the group of people who may experience a disproportionate negative impact of any changes to service configuration is likely to be small. They are disproportionately likely to bear a dual burden of ill-health and limited economic or social capital. In addition, there is a strong correlation between disability and deprivation, which could have a negative multiplier effect arising from changes to site of service provision. The reduced access to private transport in these at-risk communities could magnify the potential negative impact of any proposals to change service site.

One of the other purposes of measuring deprivation is to highlight particular localities that are deprived, but where this deprivation may be masked by a generally more affluent population such as Staffordshire. As some of the data sources used to evaluate socioeconomic deprivation are provided at the electoral ward- or LSOA-level, the Steering Group has therefore acknowledged that there may be pockets or deprivation "hot spots" within more affluent areas that are masked by the averaging of data. In these cases, the Steering Group may use local intelligence and insight, together with qualitative data, to identify potential adverse impacts on these "hidden" areas due to the recommendations of the TSAs.

It is the role of the Steering Group to also consider the impact of changes on staff at the hospital. Staff in lower income groups and/or low skilled employment could be at greater risk of negative impact of change of service site, be less able to compete in the labour market⁷⁴ and/or experience greater barriers in travel for work. This is a group that may be more reliant on public transport in seeking to travel to other labour markets, and also more likely to be asked to work unsocial hours when public transport may not be as readily available.

Given the factors discussed in this section, socioeconomic deprivation will be a high priority area for consideration of impact of the TSAs' recommendations.

⁷² Sutton M, Gravelle H, Morris S, et al. *Allocation of Resources to English Areas: Individual and Small Area Determinants of Morbidity and Use of Health Care Resources Report to the Department of Health*. Edinburgh: Information and Services Division, 2002.

⁷³ A Dixon et al "Is the British National Health Service equitable? The evidence on socioeconomic differences in utilization", *Journal of Health Services Research & Policy* Vol 12 No 2, 2007: 104–109.

⁷⁴ There are ca. 520,000 residents in Staffordshire who are of working age, of which 79,000 live in Stafford and 61,000 in Cannock Chase; the proportion that are working age and hold no qualifications is 8% in Stafford and 13% in Cannock Chase. The data are taken from the Office of National Statistics via Nomis for the period January 2012 to December 2012; working age is defined as ages 16 to 64.

6.6 Access to healthcare services

6.6.1 Geographical access to services

There is some evidence to suggest that limited access to transport (whether private or public) can mean that some people living in rural areas may not make use of the services that they need⁷⁵. This is sometimes known as “distance decay” where uptake of services decreases with increasing geographical remoteness from the service (and correspondingly proximity to hospital services is strongly associated with higher intensity use). The 2012 Staffordshire Joint Strategic Needs Assessment noted that⁷⁶:

“[L]ack of physical access to transport can lead to social isolation, particularly for vulnerable groups, for example people with mental health problems, older people, those living in rural areas and without access to a car. Those without good access to transport can also lead to barriers in accessing services and accessing information. There may also be concerns about safety, all which can affect an individual’s quality of life.”

In the context of obstacles to using and providing rural social care, it has been noted that⁷⁷:

“Poor transport networks mean that service users and carers who do not have private transport are less able to access public services. However, while research shows that the rural poor are more likely to have a car than those in urban areas, they are also likely to spend a higher proportion of their income on transport. Moreover, women, especially those in households with only one car, older people, people with disabilities, young people, and carers, are all much more likely to suffer transport poverty. Even where community or public transport is available, the times and frequency of service may militate against its use. Journeys may take too long, or services may be too infrequent, perhaps requiring users to spend too long at their destination, or they may not be available at convenient times, or in the evening and at weekends. People with disabilities may have difficulty boarding, and may be reluctant to wait for long in exposed places or fear being stranded if services are delayed or cancelled.”

The “geographical barriers” sub-domain (part of the “barriers to housing and services” domain) from the IMD2010 measures geographical access to local services that are important for day-to-day life, e.g. supermarkets, post offices, GP surgeries

⁷⁵ R Pugh, T Scharf, C Williams and D Roberts, “Obstacles to using and providing rural social care”, Research Briefing 22, Social Care Institute for Excellence, September 2007.

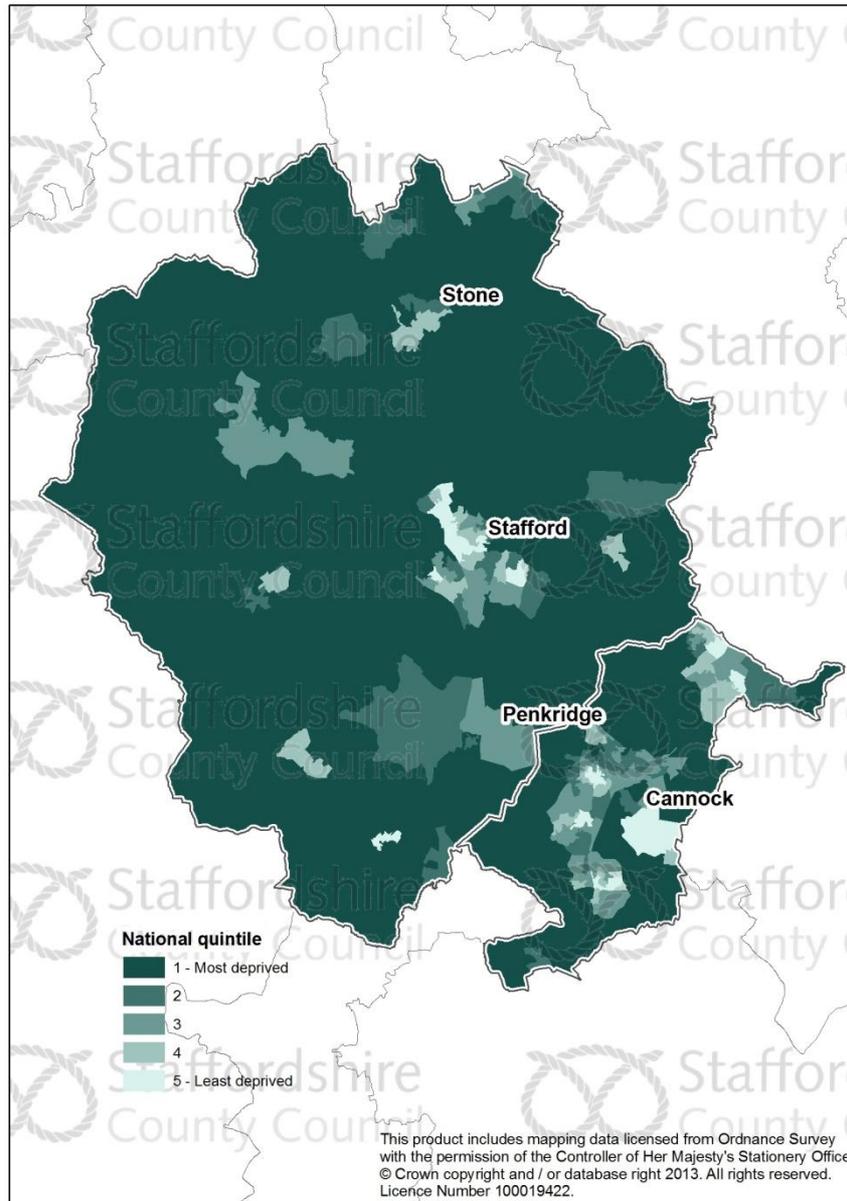
⁷⁶ Working Together for Better Health, op. cit., p.15.

⁷⁷ R Pugh, T Scharf, C Williams and D Roberts, Op Cit., p. 3.

and primary schools. The “geographical barriers” measure is particularly relevant for some of the more rural areas of Staffordshire where individuals have to travel long distances to key services and are therefore disadvantaged. Figure 13 illustrates the number of people who are disadvantaged in terms of geographical access across Staffordshire, which correlates with rurality:

- In Cannock Chase, around 14,500 people are disadvantaged in terms of geographical access (defined as living in the most deprived quintile nationally). These are located in Etching Hill and The Heath, Hawks Green, Hednesford Green Heath, Hednesford North, Hednesford South, Norton Canes and Rawnsley wards; and
- In Stafford, around 49,700 people are disadvantaged in terms of geographical access (defined as living in the most deprived quintile nationally). These are located in Barlaston and Oulton, Chartley, Church Eaton, Common, Eccleshall, Fulford, Gnosall and Woodseaves, Haywood and Hixon, Highfields and Western Downs, Littleworth, Milford, Milwich, Rowley, St. Michael's, Seighford, Stonefield and Christchurch, Swynnerton, Tillington, and Walton wards.

Figure 13: Geographical access to services domain



Source: *Indices of Deprivation 2010, Department for Communities and Local Government, Crown copyright 2011*

6.6.2 Private and public transport

Data from the 2011 Census found that 18% of Staffordshire’s households do not own a car or van in Staffordshire meaning that they are reliant on good public transport to access services (Table 18); this is lower than the average for England (26%).

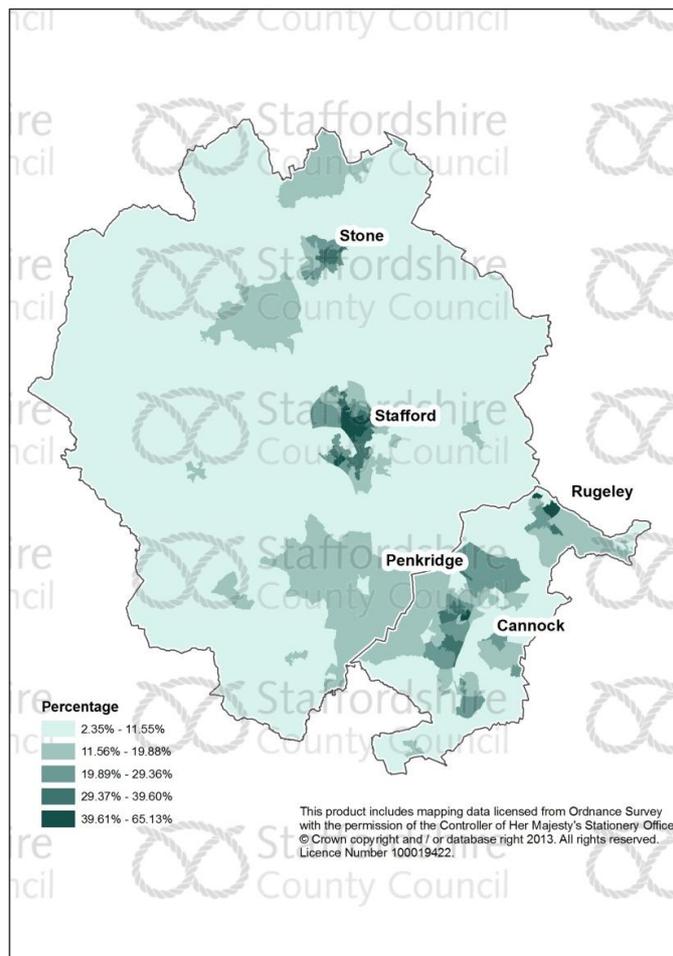
Table 18: Households who do not own at least one car or van, 2011

	Number of households	Percentage	Statistical difference to England
Cannock Chase	8,213	20.2%	Lower
Stafford	9,742	17.5%	Lower
Staffordshire	63,893	18.0%	Lower
West Midlands	566,621	24.7%	Lower
England	5,691,251	25.8%	N/A

Source: 2011 Census, Office for National Statistics, Crown copyright

Almost eighteen thousand households in Cannock Chase and Stafford do not own at least one car or van. At a ward level the proportion of households in these two districts who do not have at least one car or van ranges from 5% in Milwich ward in Stafford to 33% in Forebridge ward (Figure 14).

Figure 14: Proportion of households with no car or van, 2011



Source: 2011 Census, Office for National Statistics, Crown copyright

Wards with high levels of households without a car are shown in Table 19. These areas will be a particular focus for considering the impact of changes in site of care, and possible amelioration of that impact.

Table 19: Wards in Cannock Chase and Stafford with proportions of households without at least one car or van at a level higher than the average for England, 2011.

Ward name	Local authority	Proportion
Forebridge	Stafford	33%
Cannock North	Cannock Chase	32%
Coton	Stafford	31%
Cannock South	Cannock Chase	31%
Cannock East	Cannock Chase	30%
Common	Stafford	30%
Highfields and Western Downs	Stafford	29%
Manor	Stafford	28%

Source: 2011 Census, Office for National Statistics, Crown copyright

The majority of bus services in Staffordshire are provided on a commercial basis by public transport operators. The County Council has established fora to meet and discuss transport infrastructure with the bus operating companies, although influencing commercial routes can sometimes be difficult as the financial risk is borne by the operators. It is possible that bus routes may change in future to reflect new patient flows if health care services change; however operators will consider all transport movements before introducing new routes. There is a risk that the routes of some bus services would be limited by operators if significant changes to the site of healthcare are made. It may mean that the operators decide that there are no longer sufficient passenger numbers to sustain sections of routes which previously included the hospital sites at Stafford or Cannock Chase as destinations. It is already the case that some more isolated towns and villages have almost no access to public transport on Sundays and bank holidays.

Stafford is well-served on the national rail network, including regular fast services to both Stoke and Wolverhampton, where the two major hospitals offering more specialised services to the population of Staffordshire are based. However, a local bus connection would be necessary if significant volumes of Stafford-based users needed to travel to these locations for their healthcare as the hospitals are not located within an acceptable walking distance of the rail stations.

6.6.3 Digital Access

Access to digital information and services is increasingly critical, as ever greater numbers of people use digital services, often through smart phone or television technology. Increasingly the internet hosts the delivery of services, rather than just information, for example through email, posting diagnostics, or virtual face-to-face

calls. This may offer a significant advantage over traditional face-to-face activity for information exchange, particularly for rurally isolated individuals, those without access to a car or van, or people with disabilities⁷⁸.

The Office for National Statistics (ONS) publishes quarterly data about internet use by adults aged sixteen and over; the data are derived from the Labour Force Survey (LFS) and the latest dataset is for January to March 2013. Internet use is linked to various socioeconomic and demographic characteristics, such as age, sex (gender), disability, geographical location and weekly earnings. UK data suggest that only around 14% of the population have never used the internet but those who are less likely to have used the internet include older communities (around 66% of those aged 75 and over have never used the internet) and adults who are disabled (around 32% have never used the internet). However, it should be noted that some are digitally excluded by choice: of those who do not have the internet at home, 55% say they have no interest or see no use for it, and only 12% cite financial reasons. Some people are aware that services exist online but choose to access them by other means⁷⁹. At a local level, data are available for Staffordshire and indicate that just 13.9%⁸⁰ of Staffordshire residents aged sixteen and over have never used the internet (data for January to March 2013); this is similar to the UK average.

6.6.4 Potential impact of service changes on access to health care

The Steering Group recognises that the issue of access, and in particular of extended travel times, is of great importance to the local community. The Steering Group will therefore be commissioning analysis to assess the impact of travel time changes upon the population and patients of MSFT under the revised models of care contained in the TSAs' draft recommendations. This analysis will seek to use nationally recognised data sources to look at changes in private car, public transport and ambulance travel times for the general public and for some of the nine protected characteristics. Where feasible, the analysis will also seek to make judgements about the impact on travel times and modes of transport for visitors; this is because visitors' travel times themselves are important and because visitors can have a positive effect on patient outcomes^{81,82}. The analysis will also consider the potential impact on staff.

⁷⁸ NHS England notes that "A comparable model in health would offer online access to individual medical records, online test results and appointment booking, and email consultations with individual clinicians...This approach could extend to keeping people healthy and independent through at-home monitoring, for example. These innovations would not only give patients more control, they would also make the NHS more efficient and effective in the way that it serves the public". *The NHS belongs to the people*, NHS England, July 2013.

⁷⁹ *Equality Analysis - The power of information: Putting all of us in control of the health and care information we need*, Prepared by the Information Strategy Team, Department of Health, May 2012, p. 6.

⁸⁰ At the 95% confidence interval: range 11.3-16.4%.

⁸¹ S Fumagalli et al. (2006) "Reduced Cardiocirculatory Complications with Unrestrictive Visiting Policy in an Intensive Care Unit", *Circulation*, **113**: 946-952.

6.7 Communities at higher risk of negative impacts from changes to provision

From this scoping of the characteristics of the catchment population of MSFT, the Steering Group has agreed that there are three to whom particular attention will be paid to in assessing the potential impacts of the TSAs' draft recommendations, in addition to the consideration of impact for the general population:

- Those living with socioeconomic disadvantage;
- Those living in isolated villages or dwellings; and
- Those who experience a number of disadvantages together, e.g. disability, poverty and rural isolation, where there is a high risk of a “multiplier” effect meaning that a small number of people could be significantly disadvantaged even where the general population may experience only limited impact.

Table 20: Summary for additional in scope characteristics

Scope	Characteristic	Comments
First focus area	Socio-economic deprivation	<ul style="list-style-type: none"> • Socioeconomic deprivation is strongly correlated with health inequality, earlier mortality and additional years of chronic disease • There is a strong correlation between disability and deprivation, which could have a negative multiplier effect arising from changes to site of service provision • The Index of Multiple Deprivation (IMD) includes rates of car ownership as a factor; access to private transport will have an effect on the impact of any changes to service site • Staff in lower income groups and/or low skilled employment could be at greater risk of negative impact of change of service site, be less able to compete in the labour market and/or experience greater barriers in travel for work • There are eight lower super output areas (LSOAs) in Cannock Chase that fall within the most deprived quintile of areas in England making up 12% (5,700) of its population. There are four lower super output areas (LSOAs) in Stafford that fall within the most deprived quintile of areas in England making up 5% (6,900) of its population
	Isolated towns and villages	<ul style="list-style-type: none"> • Over 65,000 people in Cannock Chase and Stafford are in the most geographically deprived quintile nationally and already suffer disadvantage in accessing key services • Some in this group are already economically

⁸² CE Gonzalez et al. (2004) “Visiting preferences of patients in the intensive care unit and in a complex care medical unit”. *American Journal of Critical Care*, vol13, No.3.

Scope	Characteristic	Comments
		disadvantaged and/or with limited access to transport, so there is therefore an increased risk that service reconfigurations exacerbate unequal access to health services, especially if there is an adverse impact on travel times
	Multiple risk factors	<ul style="list-style-type: none"> • Groups where multiple risk factors co-exist (e.g. the rural and elderly; disability and socioeconomic deprivation) and who are likely to be higher users of health services • Although the absolute numbers of users with multiple risk factors may be small, they are more liable to be at risk of a disproportionate negative impact arising from a reconfiguration of services

7 Scoping of protected characteristics

This section provides an initial scoping of the protected characteristics defined by the Equality Act (2010), and the extent to which they should provide a focus for the ‘Equity’ element of the impact assessment.

7.1 Definition of protected characteristics

The Equality Act (2010) defines a range of “protected characteristics”⁸³ (Table 21).

Table 21: Definition of protected characteristics

Characteristic	Definition
Age	<ul style="list-style-type: none"> This refers to a person having a particular age (for example, 32 year olds) or being within an age group (for example, 18-30 year olds). This includes all ages, from birth to old age.
Disability	<ul style="list-style-type: none"> A person has a disability if s/he has a physical or mental impairment which has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities
Gender reassignment	<ul style="list-style-type: none"> This is the process of transitioning from one sex to another. People who are proposing to undergo, are undergoing or have undergone a process (or part of a process) to reassign their sex have the protected characteristic of gender reassignment under the Equality Act 2010
Marriage and civil partnership	<ul style="list-style-type: none"> A person has the protected characteristic of marriage and civil partnership if the person is married or is a civil partner (source: http://www.legislation.gov.uk/ukpga/2010/15/part/2/chapter/1)
Pregnancy and maternity	<ul style="list-style-type: none"> Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth, and is linked to maternity leave in the employment context. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth, and this includes treating a woman unfavourably because she is breastfeeding
Race	<ul style="list-style-type: none"> This is the protected characteristic of race. It refers to a group of people defined by their colour, nationality (including citizenship), ethnic or national origins
Religion or belief	<ul style="list-style-type: none"> Religion means any religion, including a reference to a lack of religion. Belief includes religious and philosophical beliefs including lack of belief
Sex	<ul style="list-style-type: none"> Someone being a man or a woman
Sexual orientation	<ul style="list-style-type: none"> This is whether a person’s sexual attraction is towards their own sex, the opposite sex or to both sexes

Source: Taken from the Glossary (except where noted) to Equality Act 2010 Technical Guidance on the Public Sector Equality Duty England, Equality and Human Rights Commission, January 2013, ISBN 978 1 84206 475 7, pp. 88-99.

⁸³ Equality Act 2010: Public Sector Equality Duty - What Do I Need To Know? A Quick Start Guide for Public Sector Organisations, Government Equalities Office, June 2011, p. 3.

For marriage and civil partnership, the protection extends “in respect of the requirement to have due regard to the need to eliminate discrimination”⁸⁴. For pregnancy and maternity, the focus of the legislation is employment law and protection in the ante-natal period. If there are proposals to make changes to the nature or site of maternity services delivered by MSFT, these would be considered as representing a risk of disproportionate impact to women, and would fall within the scope of ‘sex’ as a protected characteristic.

For the scoping exercise, the Steering Group carried out: (i) a review of these protected characteristics; (ii) an analysis of how they are distributed across the local area; and (iii) a prioritisation of the protected characteristics for this impact assessment report. In the sections below, each of these characteristics is described in terms of: an overall description of the characteristic and its prevalence in the local population; and key considerations for understanding the prioritisation that will be given to each characteristic for the impact assessment (including usage of hospital services where relevant data or research exist).

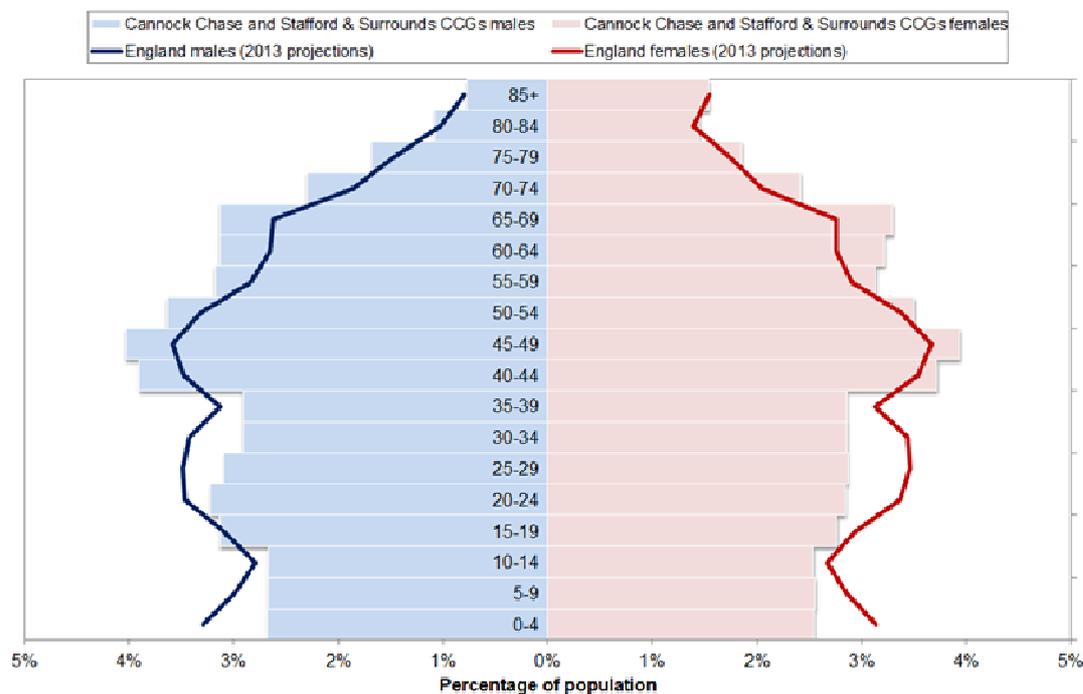
7.2 Age

7.2.1 Overall description

The protected characteristic of age means a person belonging to a particular age or age-group (for example, 32 years) or being within an age group (for example, 30-39 years). Children and the elderly are the two age groups which tend to make the greatest use of health services, and will therefore be the focus of this section.

Table 22 and Figure 15 give a breakdown of the age profile for Cannock Chase and Stafford districts, along with figures for Staffordshire, the West Midlands and England. In 2011, around 18% of Cannock and Stafford’s resident population was aged under 16 (compared to 19% for England) and 18% aged 65 and over (cf. 16% across England). The resident population of Cannock Chase and Stafford and Surrounds CCGs is older than the English average (Figure 15).

⁸⁴ Ibid.

Figure 15: Age-sex structure of Cannock Chase and Stafford & Surrounds CCGs compared with England, 2013.

Source: GP registered populations 2012/13 Q3 and 2011-based interim population projections, Office for National Statistics, Crown copyright

Table 22: Population by age group and district, 2011.

Location	0-4	5-15	16-24	25-49	50-64	65-74	75+	All ages
Cannock Chase	5,800 (6.0%)	12,500 (12.8%)	10,900 (11.2%)	34,200 (35.1%)	18,300 (18.8%)	9,000 (9.2%)	6,800 (7.0%)	97,600 (100.0%)
Stafford	7,000 (5.3%)	15,200 (11.6%)	14,400 (11.0%)	42,500 (32.5%)	26,300 (20.1%)	14,100 (10.8%)	11,400 (8.7%)	130,900 (100.0%)
Staffs	46,100 (5.4%)	103,900 (12.2%)	93,600 (11.0%)	276,600 (32.6%)	171,100 (20.1%)	88,600 (10.4%)	69,700 (8.2%)	849,500 (100.0%)
West Midlands	6.3%	13.2%	12.1%	33.4%	18.0%	9.1%	7.9%	5,608,700
England	6.3%	12.6%	11.8%	34.8%	18.1%	8.6%	7.8%	53,107,200

Note: Numbers may not add up due to rounding. Source: 2011 mid-year population estimates, Office for National Statistics, Crown copyright

The wards in Cannock Chase and Stafford that have particular high levels of children under sixteen are: Hawks Green (23%), Cannock North (21%) and Hagley (21%) in Cannock Chase district; and Penside (23%), St. Michael's (21%), Highfields and Western Downs (20%) and Tillington (20%) wards in Stafford (refer to the Appendix for the relevant maps).

As noted in Section 6.3, the overall population for Staffordshire is projected to increase by 5% between 2012 and 2021 and there will be significant increases in the

older age groups (23%, compared with 19% for England) and both Cannock and Stafford CCGs will see significant increases in the older age groups, which will be particularly apparent in those aged 75 and over. The Appendix presents maps showing the distribution of age groups (0 – 15, 16 – 64 and 65+) for Staffordshire and Stafford/Cannock.

Higher concentrations of older people are found in Staffordshire Moorlands (21%), South Staffordshire (20%), Lichfield (20%) and Stafford (19%) (refer to the Appendix for the relevant maps). At a ward level, communities of older people tend to live in more rural areas. Wards in Cannock Chase and Stafford districts that tend to have high proportions of older people are identified in the table below.

Table 23: Wards in Cannock Chase and Stafford with proportions of people aged 65 and over higher than England, 2011.

Ward name	Local authority	Proportion
Seighford *	Stafford	28.0%
Fulford	Stafford	25.8%
Barlaston and Oulton *	Stafford	25.4%
Chartley *	Stafford	24.4%
Baswich	Stafford	24.0%
Eccleshall *	Stafford	23.6%
Weeping Cross	Stafford	23.5%
Cannock West	Cannock Chase	23.4%
Milwich *	Stafford	23.0%
Walton	Stafford	23.0%
Church Eaton *	Stafford	22.1%
Swynnerton *	Stafford	21.8%
Gnosall and Woodseaves **	Stafford	21.0%
Haywood and Hixon **	Stafford	20.4%
Western Springs	Cannock Chase	20.1%
Holmcroft	Stafford	19.9%
Stonefield and Christchurch	Stafford	19.8%
Rowley	Stafford	19.5%
Tillington	Stafford	19.4%
Brereton and Ravenhill	Cannock Chase	18.9%
Manor	Stafford	18.9%
Cannock East	Cannock Chase	18.4%
Milford *	Stafford	18.2%

Source: 2011 mid-year population estimates, Office for National Statistics, Crown copyright

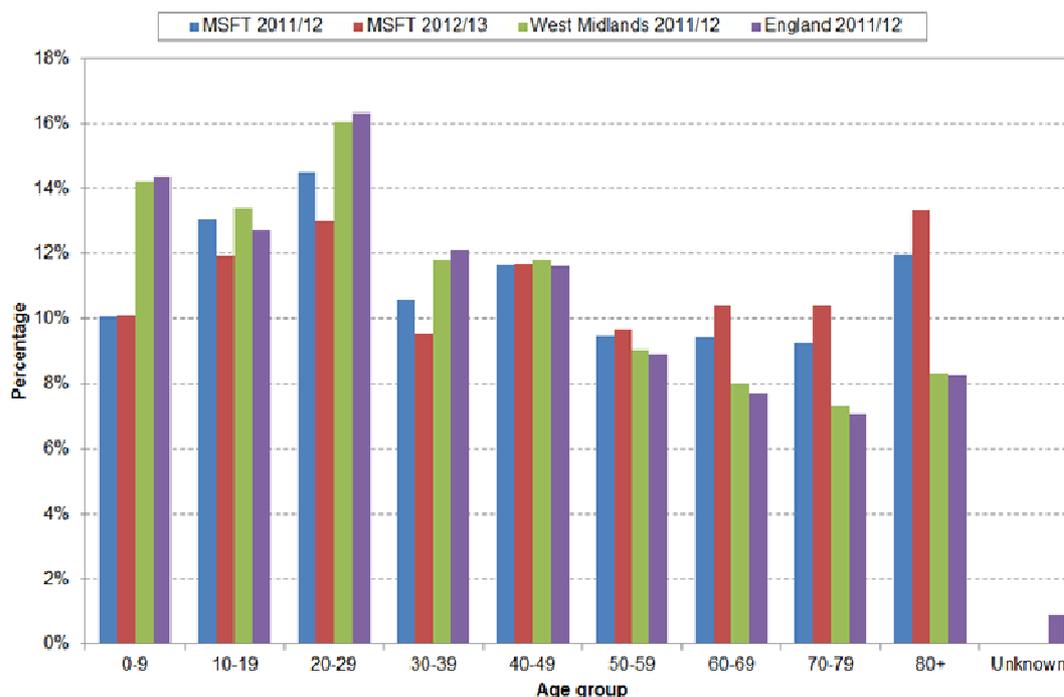
* Denotes wards falling into the “village, hamlet & isolated dwelling” category, as defined by the Rural and Urban Area Classification 2004

** Denotes wards falling into the “town and fringe” category, as defined by the Rural and Urban Area Classification 2004

7.2.2 Usage of services

Figure 16 shows A&E usage by age at MSFT. Although children and young people tend to have a relatively high usage of A&E services nationally, usage of MSFT services is relatively higher for people in the 60+ categories.

Figure 16: A&E attendances by age group, 2011/12 and 2012/13



Source: Hospital accident and emergency data extract, Healthcare Commissioning Services (HCS) and A&E attendances: Provider level analysis (experimental statistics), 2011-12, Copyright 2013, The Health and Social Care Information Centre. All Rights Reserved.

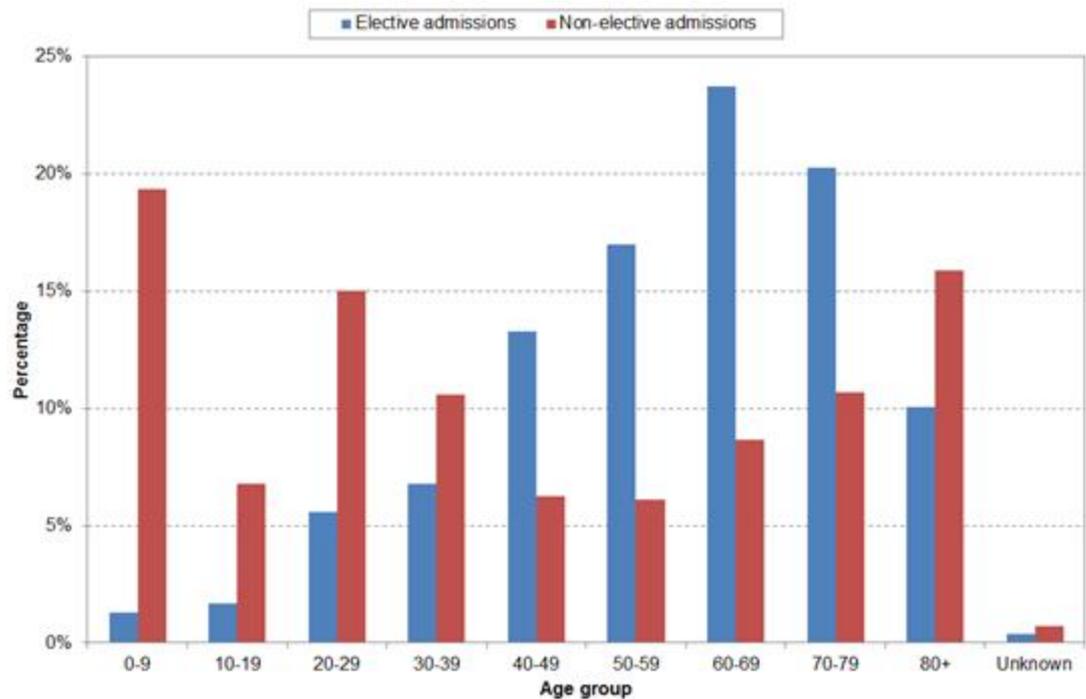
Although part of the increase in emergency admissions to hospitals observed across England has been due to a rise in the proportion of older adults within the national population⁸⁵, the rates are proportionately higher at MSFT. These high rates of A&E attendances at MSFT in the 60+ age group (and in particular the 80+ band) could be attributable to an acute bias in current clinical pathways for patients with long-term conditions and a relative underinvestment in community services. Another factor may be the increase in the use of end-of-life pathways over the past few years. Evidence suggests that, where these are poorly defined or supported, uncertainty at the end-of-life often results in A&E attendances or emergency admissions to hospital that are, in retrospect, deemed unnecessary⁸⁶, and may have increased distress and disruption in the last few months or weeks of a person's life.

⁸⁵ Urgent and Emergency Care Review - Evidence Base Engagement Document, NHS England, 17 June 2013, p. 21.

⁸⁶ R Addicott (2009) "Delivering better care at end of life: the next steps", Report from the Sir Roger Bannister Health Summit,

Figure 17 shows admissions for elective (planned) and non-elective admissions by age group. Higher rates for elective admissions are seen in older people (aged 60 and over) and non-elective admission rates (which include transfers and well-babies) are also high in older groups, particularly those aged 80 and over. However, rates are also high in younger populations.

Figure 17: Utilisation of hospital in-patient activity by age group at MSFT, 2012/13



Source: Hospital in-patient data extracts, Healthcare Commissioning Services (HCS)

Given that there is nothing in the profile of the population to explain the relatively high level of non-elective use, it is probable that this is a consequence of the current patterns of service provision and uncertainty, perhaps confounded by a relatively limited community infrastructure and/or low clinical thresholds for risk in an atmosphere of heightened scrutiny. For elective activity, further analysis on demography and disease prevalence is required to determine the cause of high volumes of activity in the 40+ age ranges, which appears unusual given the profile of the local population. During 2012/13 activity increased in certain specialities (such as gastroenterology, cardiology, and trauma and orthopaedics) as part of the drive to achieve the 18-week performance targets at MSFT.

Tables 24 and 25 summarise elective and non-elective admissions by age group and specialty. For elective admissions for older people (over 60), trauma and orthopaedics (T&O), gastroenterology (disorders of the stomach and intestines) and

clinical haematology (diseases of the blood and bone marrow) are all high use specialties. For non-elective admissions for the same age group, general medicine and general surgery are the highest use specialties. For elective admissions for younger people (under 18), paediatrics (including paediatric surgery), ENT and T&O are the high use specialties. Over 40% of all non-elective admissions are attributable to the two specialties of paediatrics and obstetrics.

Table 24: Elective admissions by speciality and age-group at MSFT, 2012/13

	0-9	10-19	20-29	30-39	40-49	50-59	60-69	70-79	80+	All ages
Trauma & Orthopaedics	8 (2.0%)	95 (18.0%)	203 (11.6%)	250 (11.7%)	594 (14.2%)	818 (15.3%)	955 (12.8%)	834 (13.1%)	325 (10.3%)	4,082 (13.0%)
General Surgery	16 (4.0%)	41 (7.8%)	195 (11.1%)	314 (14.7%)	735 (17.6%)	783 (14.7%)	874 (11.7%)	791 (12.4%)	319 (10.1%)	4,068 (13.0%)
Gastroenterology	X	47 (8.9%)	263 (15.0%)	260 (12.2%)	529 (12.7%)	624 (11.7%)	897 (12.0%)	715 (11.2%)	344 (10.9%)	3,679 (11.7%)
Clinical Haematology	X	X	68 (3.9%)	131 (6.1%)	316 (7.6%)	462 (8.7%)	990 (13.3%)	960 (15.1%)	539 (17.1%)	3,466 (11.1%)
Rheumatology	X	X	100 (5.7%)	219 (10.3%)	429 (10.3%)	675 (12.6%)	958 (12.8%)	620 (9.7%)	261 (8.3%)	3,282 (10.5%)
Clinical Oncology	X	X	X	41 (1.9%)	260 (6.2%)	781 (14.6%)	1,089 (14.6%)	703 (11.0%)	173 (5.5%)	3,047 (9.7%)
Urology	27 (6.7%)	58 (11.0%)	77 (4.4%)	109 (5.1%)	208 (5.0%)	284 (5.3%)	586 (7.9%)	657 (10.3%)	433 (13.7%)	2,439 (7.8%)
Gynaecology	X	X	522 (29.7%)	500 (23.4%)	628 (15.0%)	324 (6.1%)	187 (2.5%)	111 (1.7%)	42 (1.3%)	2,343 (7.5%)
ENT	289 (71.7%)	123 (23.3%)	73 (4.2%)	74 (3.5%)	107 (2.6%)	82 (1.5%)	89 (1.2%)	66 (1.0%)	14 (0.4%)	917 (2.9%)
Ophthalmology	X	X	X	X	X	X	172 (2.3%)	286 (4.5%)	310 (9.8%)	805 (2.6%)
Oral Surgery	8 (2.0%)	44 (8.3%)	168 (9.6%)	91 (4.3%)	63 (1.5%)	45 (0.8%)	29 (0.4%)	28 (0.4%)	11 (0.3%)	487 (1.6%)
Paediatrics	21 (5.2%)	35 (6.6%)	6 (0.3%)	X	X	X	X	X	X	62 (0.2%)
Paediatric Surgery	28 (6.9%)	11 (2.1%)	X	X	X	X	X	X	X	39 (0.1%)
Other specialties	X	X	82 (4.7%)	144 (6.8%)	X	X	637 (8.5%)	598 (9.4%)	384 (12.2%)	2,611 (8.3%)
All admissions	403 (100.0%)	528 (100.0%)	1,757 (100.0%)	2,133 (100.0%)	4,179 (100.0%)	5,340 (100.0%)	7,463 (100.0%)	6,369 (100.0%)	3,155 (100.0%)	31,327 (100.0%)

Notes: **Denotes top five specialties for age-group.** Numbers under five (including zero) and any secondary suppression are denoted with an X.

Source: Hospital in-patient data extract, Healthcare Commissioning Services (HCS)

Table 25: Non-elective admissions by speciality and age-group at MSFT, 2012/13

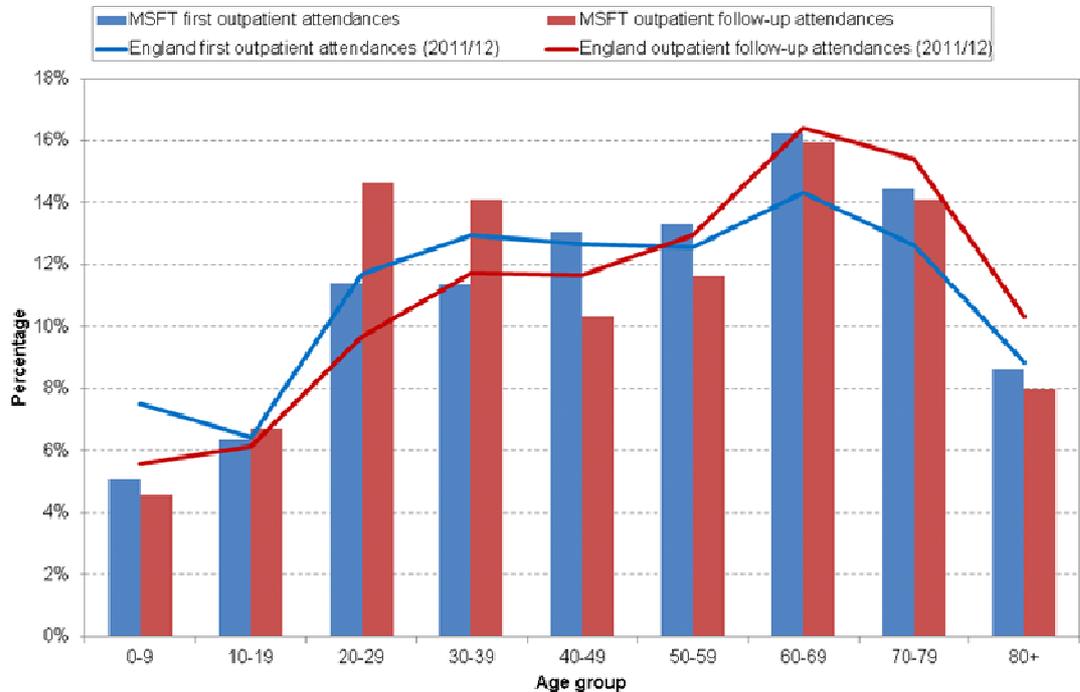
	0-9	10-19	20-29	30-39	40-49	50-59	60-69	70-79	80+	All ages
General Medicine	16 (0.3%)	49 (3.0%)	322 (9.0%)	321 (12.7%)	572 (38.5%)	649 (44.7%)	1,005 (48.8%)	1,311 (51.7%)	2,036 (53.9%)	6,281 (26.6%)
Paediatrics	4,472 (97.2%)	902 (55.9%)	17 (0.5%)	X	X	X	X	X	X	5,391 (22.8%)
Obstetrics	9 (0.2%)	335 (20.8%)	2,325 (65.1%)	1,529 (60.7%)	123 (8.3%)	X	X	X	X	4,323 (18.3%)
General Surgery	16 (0.3%)	156 (9.7%)	495 (13.9%)	386 (15.3%)	462 (31.1%)	431 (29.7%)	503 (24.4%)	497 (19.6%)	566 (15.0%)	3,512 (14.9%)
Trauma & Orthopaedics	78 (1.7%)	93 (5.8%)	79 (2.2%)	72 (2.9%)	126 (8.5%)	123 (8.5%)	166 (8.1%)	201 (7.9%)	435 (11.5%)	1,373 (5.8%)
Cardiology	X	X	X	27 (1.1%)	66 (4.4%)	111 (7.6%)	170 (8.3%)	186 (7.3%)	201 (5.3%)	781 (3.3%)
Gynaecology	X	53 (3.3%)	272 (7.6%)	128 (5.1%)	45 (3.0%)	X	14 (0.7%)	12 (0.5%)	X	546 (2.3%)
Geriatric Medicine	X	X	X	X	20 (1.3%)	26 (1.8%)	39 (1.9%)	108 (4.3%)	244 (6.5%)	448 (1.9%)
Respiratory/ Thoracic Medicine	X	X	X	22 (0.9%)	33 (2.2%)	38 (2.6%)	84 (4.1%)	96 (3.8%)	144 (3.8%)	439 (1.9%)
Gastroenterology	X	X	11 (0.3%)	12 (0.5%)	16 (1.1%)	32 (2.2%)	36 (1.7%)	75 (3.0%)	78 (2.1%)	266 (1.1%)
Other specialties	6 (0.1%)	17 (1.1%)	11 (0.3%)	14 (0.6%)	24 (1.6%)	25 (1.7%)	41 (2.0%)	52 (2.0%)	64 (1.7%)	254 (1.1%)
All admissions	4,601 (100.0%)	1,614 (100.0%)	3,572 (100.0%)	2,519 (100.0%)	1,487 (100.0%)	1,451 (100.0%)	2,058 (100.0%)	2,538 (100.0%)	3,774 (100.0%)	23,614 (100.0%)

Notes: **Denotes top five specialties for age-group.** Numbers under five (including zero) and any secondary suppression are denoted with an X.

Source: Hospital in-patient data extract, Healthcare Commissioning Services (HCS)

Figure 18 shows that the distribution of out-patient attendances at MSFT is skewed towards older communities (ages 50-79).

Figure 18: Utilisation of hospital out-patient activity by age group at MSFT, 2012/13



Source: Hospital outpatient data extract, Healthcare Commissioning Services (HCS) and Outpatient statistics, 2011-12, Hospital Episode Statistics for England. Copyright 2012, The Health and Social Care Information Centre. HES Analysis. All Rights Reserved.

There are also high proportions of people aged 20-39 having a follow-up attendance, which is primarily due to maternity episodes and in particular the high level of midwife episodes in the community; a new pathway is in place for 2013/14 that should address this issue (if it is a contributing factor). The overall increase in outpatient activity in the age 40+ bands could be attributed to waiting list initiatives and the delivery of the 18-week target during 2012/13. Further analysis is required to look at the disease prevalence and determine the influence of the high volume specialties. The high volume specialties for first and follow up attendances by age band are shown in Tables 26 and 27.

Table 26: First out-patient attendances by speciality and age-group at MSFT, 2012/13

	0-9	10-19	20-29	30-39	40-49	50-59	60-69	70-79	80+	All ages
Trauma & Orthopaedics	498 (14.4%)	1,227 (28.3%)	806 (10.4%)	675 (8.7%)	1,109 (12.5%)	1,159 (12.8%)	1,263 (11.4%)	1,055 (10.7%)	538 (9.1%)	8,330 (12.2%)
General Surgery	X	X	462 (5.9%)	687 (8.9%)	1,286 (14.5%)	1,114 (12.3%)	1,293 (11.7%)	1,136 (11.5%)	676 (11.5%)	6,764 (9.9%)
Allied Health Professional Episode	293 (8.4%)	454 (10.5%)	381 (4.9%)	425 (5.5%)	788 (8.9%)	927 (10.2%)	938 (8.5%)	701 (7.1%)	320 (5.4%)	5,227 (7.7%)
Gastroenterology	X	52 (1.2%)	209 (2.7%)	284 (3.7%)	609 (6.8%)	798 (8.8%)	1,001 (9.1%)	913 (9.3%)	474 (8.1%)	4,340 (6.4%)
Dermatology	111 (3.2%)	235 (5.4%)	331 (4.3%)	348 (4.5%)	464 (5.2%)	511 (5.6%)	710 (6.4%)	684 (6.9%)	493 (8.4%)	3,887 (5.7%)
Ophthalmology	554 (16.0%)	117 (2.7%)	111 (1.4%)	117 (1.5%)	289 (3.2%)	432 (4.8%)	736 (6.7%)	824 (8.4%)	673 (11.4%)	3,853 (5.7%)
Gynaecology	X	X	679 (8.7%)	751 (9.7%)	973 (10.9%)	587 (6.5%)	386 (3.5%)	223 (2.3%)	103 (1.8%)	3,791 (5.6%)
Nursing Episode	X	160 (3.7%)	1,260 (16.2%)	1,038 (13.4%)	437 (4.9%)	249 (2.7%)	170 (1.5%)	111 (1.1%)	66 (1.1%)	3,491 (5.1%)
Cardiology	X	44 (1.0%)	59 (0.8%)	112 (1.4%)	308 (3.5%)	591 (6.5%)	913 (8.3%)	806 (8.2%)	434 (7.4%)	3,267 (4.8%)
ENT	444 (12.8%)	224 (5.2%)	193 (2.5%)	220 (2.8%)	384 (4.3%)	401 (4.4%)	489 (4.4%)	399 (4.1%)	196 (3.3%)	2,950 (4.3%)
Midwife Episode	X	162 (3.7%)	1,256 (16.2%)	973 (12.6%)	89 (1.0%)	X	X	X	X	2,485 (3.7%)
Paediatrics	1,280 (36.9%)	433 (10.0%)	X	X	X	X	X	X	X	1,716 (2.5%)
Obstetrics	X	78 (1.8%)X	738 (9.5%)	620 (8.0%)	X	X	X	X	X	1,490 (2.2%)
Orthodontics	36 (1.0%)	398 (9.2%)	12 (0.2%)	X	X	X	X	X	X	457 (0.7%)
Other specialties	248 (7.1%)	555 (12.8%)	1,272 (16.4%)	1,486 (19.2%)	2,106 (23.7%)	2,296 (25.3%)	3,158 (28.6%)	2,993 (30.4%)	1,908 (32.4%)	16,022 (23.5%)
All attendances	3,470 (100.0%)	4,335 (100.0%)	7,769 (100.0%)	7,746 (100.0%)	8,897 (100.0%)	9,067 (100.0%)	11,058 (100.0%)	9,847 (100.0%)	5,881 (100.0%)	68,070 (100.0%)

Notes: **Denotes top five specialties for age-group.** Numbers under five (including zero) and any secondary suppression are denoted with an X. Source: Hospital outpatient data extract, Healthcare Commissioning Services (HCS)

Table 27: Follow-up out-patient attendances by speciality and age-group at MSFT, 2012/13

	0-9	10-19	20-29	30-39	40-49	50-59	60-69	70-79	80+	All ages
Midwife Episode	48 (0.6%)	1,513 (11.8%)	15,472 (55.5%)	13,077 (48.7%)	1,044 (5.3%)	8 (<0.1%)	X	X	X	31,168 (16.4%)
Allied Health Professional Episode	1,184 (13.7%)	1,878 (14.6%)	1,525 (5.5%)	2,010 (7.5%)	3,877 (19.8%)	4,530 (20.5%)	5,081 (16.7%)	3,073 (11.4%)	967 (6.4%)	24,125 (12.7%)
Trauma & Orthopaedics	616 (7.1%)	1,571 (12.3%)	1,394 (5.0%)	1,554 (5.8%)	3,061 (15.6%)	3,862 (17.4%)	4,777 (15.7%)	4,064 (15.1%)	1,879 (12.4%)	22,778 (12.0%)
Ophthalmology	2,558 (29.6%)	X	X	154 (0.6%)	466 (2.4%)	908 (4.1%)	2,195 (7.2%)	2,805 (10.4%)	2,423 (15.9%)	11,764 (6.2%)
Nursing Episode	X	X	3,362 (12.1%)	2,842 (10.6%)	1,170 (6.0%)	866 (3.9%)	947 (3.1%)	738 (2.7%)	X	10,750 (5.6%)
General Surgery	X	X	431 (1.5%)	643 (2.4%)	1,694 (8.6%)	1,826 (8.2%)	2,211 (7.3%)	2,040 (7.6%)	1,154 (7.6%)	10,108 (5.3%)
Rheumatology	X	X	293 (1.1%)	656 (2.4%)	1,301 (6.6%)	1,897 (8.6%)	2,502 (8.2%)	1,857 (6.9%)	788 (5.2%)	9,429 (5.0%)
Dermatology	116 (1.3%)	441 (3.4%)	594 (2.1%)	891 (3.3%)	1,258 (6.4%)	1,113 (5.0%)	1,601 (5.3%)	1,533 (5.7%)	1,180 (7.8%)	8,727 (4.6%)
Urology	X	X	162 (0.6%)	237 (0.9%)	496 (2.5%)	781 (3.5%)	1,593 (5.2%)	1,710 (6.4%)	1,097 (7.2%)	6,202 (3.3%)
ENT	945 (10.9%)	427 (3.3%)	278 (1.0%)	352 (1.3%)	637 (3.2%)	673 (3.0%)	1,049 (3.5%)	852 (3.2%)	507 (3.3%)	5,720 (3.0%)
Paediatrics	2,944 (34.0%)	1,815 (14.2%)	X	X	X	X	X	X	X	4,763 (2.5%)
Orthodontics	31 (0.4%)	3,460 (27.0%)	233 (0.8%)	52 (0.2%)	24 (0.1%)	12 (0.1%)	X	X	X	3,812 (2.0%)
Obstetrics	X	154 (1.2%)	1,345 (4.8%)	1,270 (4.7%)	128 (0.7%)	X	X	X	X	2,897 (1.5%)
Other specialties	146 (1.7%)	588 (4.6%)	2,694 (9.7%)	3,101 (11.6%)	4,465 (22.8%)	5,671 (25.6%)	8,389 (27.6%)	8,182 (30.5%)	4,872 (32.0%)	38,108 (20.0%)
All attendance	8,653 (100.0%)	12,822 (100.0%)	27,862 (100.0%)	26,839 (100.0%)	19,621 (100.0%)	22,147 (100.0%)	30,345 (100.0%)	26,859 (100.0%)	15,203 (100.0%)	190,351 (100.0%)

Notes: **Denotes top five specialties for age-group.** Numbers under five (including zero) and any secondary suppression are denoted with an X.

Source: Hospital outpatient data extract, Healthcare Commissioning Services (HCS)

In their commissioning intentions, Cannock Chase and Stafford and Surrounds CCGs have indicated a move of services to provide care closer to home, the development of community services and integrated clinical pathways. These service moves will have an impact on the volume of secondary care, with a net reduction in activity levels expected.

7.2.3 Key considerations

Children and young people

This group will be particularly considered in relation to any changes proposed in both paediatric services and, given the historic high levels of use, in A&E provision. National research indicates that many of these attendances are deemed as inappropriate⁸⁷. Lack of immediate access to A&E could therefore have a positive impact on effectiveness, encouraging the development of a relationship with the GP and increased continuity of care and confidence in the parent, at the same time as parents may express concern about a perceived negative impact on access.

Older people

Research suggests that older people attend A&E departments more frequently than younger people, although most assessments indicate that this higher level of use is appropriate⁸⁸. Indeed, since the elderly are more frequently ill and with greater severity, they require more tests and are hospitalised more often than the non-elderly⁸⁹. The main factors that have been reported to be associated with an increased use of A&E departments include old age (being over eighty)⁹⁰ and using social care (71% of old people using social care also used a hospital service)⁹¹. These high levels of usage and the presence of multiplier characteristics (car ownership, disability) suggests that any significant reconfiguration of the site of services is likely to have its greatest impact on those over 75.

⁸⁷ The Kennedy Review notes that "Around half of infants (under 12 months) and a quarter of older children will attend A&E in a typical year. Around 26% of all those attending A&E are children...Children and young people therefore attend A&E not only in emergencies, but also in cases that could be addressed outside hospital. Such use of A&E is unnecessary and inappropriate, given that A&E is designed and intended for accidents and emergencies". *Getting it right for children and young people: Overcoming cultural barriers in the NHS so as to meet their needs*, Professor Sir Ian Kennedy, September 2010, p. 20.

⁸⁸ E Burns (2001) "Older people in accident and emergency departments", *Age and Ageing* 30 S3: 3-6.

⁸⁹ A Sona et al. (2011) "Determinants of recourse to hospital treatment in the elderly", *European Journal of Public Health*, Vol. 22, No. 1, 76–80.

⁹⁰ A Downing, R Wilson "Older people's use of Accident and Emergency services", *Age and Ageing* 2005; 34: 24–30.

⁹¹ M Bardsley, T Georghiou, L Chassin, G Lewis, A Steventon and J Dixon (2012) "Overlap of hospital use and social care in older people in England", *J Health Serv Res Policy* 17: 133.

7.3 Disability

7.3.1 Overall description

A person has a disability if they have a physical or mental impairment, which has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities. Disabilities can have an impact on people of all ages and from all communities, and can be present from birth or acquired through accident, illness or as a consequence of ageing. Many people who are disabled may have more than one disability; for example around 47% of people in Staffordshire who are registered as blind or partially sighted had other disabilities (including physical disabilities, learning disabilities and/or a hearing impairment)⁹². Adults with learning disabilities or dementia are most likely to have repeat adult protection referrals, as are those in a permanent care home.

There is no complete dataset that contains the numbers of people with disabilities. Therefore three measures have been used to estimate levels of disability within Staffordshire and a fourth source of information has been included to give additional information.

1. **Census data** - the most recent census (2011) collected information on self-reported limiting long-term illness that can be used as a proxy for overall disease and disability. Based on these data just under one in five people in Staffordshire has a limiting long-term illness, which is about average for the West Midlands, although slightly higher than the average in England (as would be expected given the slightly higher age gradient). The proportion of people with self-reported limiting long-term illness is higher in both Cannock Chase (20.7%) and Stafford (18.2%) than in England, and in total there are 44,000 people with a self-reported limiting long-term illness in Cannock Chase and Stafford (Table 28). Of these, 1,680 are children under 16; the proportion of children in Cannock Chase (4.5%) is higher than England (3.7%), whereas the rate is similar to England for Stafford (3.8%).

Table 28: Limiting long-term illness, 2011.

Ward	Number	Crude percentage	Statistical difference to England
Cannock Chase	20,204	20.7%	Higher
Stafford	23,834	18.2%	Higher
Staffordshire	162,647	19.2%	Higher
West Midlands	1,062,064	19.0%	Higher
England	9,352,586	17.6%	N/A

Source: 2011 Census, Office for National Statistics, Crown copyright

⁹² Registered blind and partially sighted people in England for year ending 31 March 2011, Copyright © 2011, The Health and Social Care Information Centre. All Rights Reserved.

2. **Disability benefit statistics** - these provide a proxy for numbers of people who are disabled. Disability Living Allowance (DLA) was payable to people who are disabled and who have personal care needs, mobility needs or both, although it was not available for children under three⁹³ (Personal Independence Payments replaced the DLA from 10th June 2013). In the Staffordshire area 44,225 people claim DLA, which represents 5.2% of the population (August 2012) and is consistent with the England average of 5.1%. The proportion of people claiming DLA in Cannock Chase is 6.8%, which is slightly higher than the national average; in contrast the proportion for Stafford is 4.4%, which is marginally lower than the national average (Table 29). DLA is a discretionary payment and claimants will typically experience significant barriers to full participation in local life⁹⁴. This is a high-risk group for the negative impact of changes to service site.

Table 29: Disability Living Allowance claimants, August 2012.

Ward	Number	Crude percentage	Statistical difference to England
Cannock Chase	6,600	6.8%	Higher
Stafford	5,750	4.4%	Lower
Staffordshire	44,225	5.2%	Higher
West Midlands	317,030	5.7%	Higher
England	2,698,055	5.1%	

Source: Department of Work and Pensions and 2011 mid-year population estimates, Office for National Statistics, Crown copyright

Table 30 shows DLA claimants for wards in Cannock Chase and Stafford where the level of claimants is above the national average of 5.1%. The Appendix presents maps showing the distribution of the population claiming DLA for Staffordshire and Stafford/Cannock.

⁹³ The eligibility criteria for DLA include the requirement to need help with personal care or have walking difficulties. The needs must have been present for at least three months and be expected to last for at least six months. Note that Personal Independence Payments have replaced the DLA from 10th June 2013. (Source: <https://www.gov.uk/dla-disability-living-allowance-benefit/overview>, accessed 15th June 2013).

⁹⁴ "Hospital admission rates were significantly correlated with many of the measures of chronic illness and deprivation. The strongest correlations were with disability living allowance". A Majeed et al (2000) "Cross sectional study of primary care groups in London: association of measures of socioeconomic and health status with hospital admission rates", *BMJ* 321:1057.

Table 30: Wards in Cannock Chase and Stafford with proportions of people claiming Disability Living Allowance higher than England, 2011.

Ward	Local authority	Proportion
Cannock North	Cannock Chase	9.7%
Cannock South	Cannock Chase	8.8%
Hednesford North	Cannock Chase	8.8%
Cannock East	Cannock Chase	8.8%
Brereton and Ravenhill	Cannock Chase	7.9%
Hagley	Cannock Chase	7.1%
Manor	Stafford	6.9%
Norton Canes	Cannock Chase	6.8%
Highfields and Western Downs	Stafford	6.7%
Penkside	Stafford	6.3%
Western Springs	Cannock Chase	6.1%
Etching Hill and The Heath	Cannock Chase	6.1%
Heath Hayes East and Wimblebury	Cannock Chase	5.8%
Cannock West	Cannock Chase	5.8%
Fulford	Stafford	5.7%
Rawnsley	Cannock Chase	5.7%

Source: Department of Work and Pensions and 2011 mid-year population estimates, Office for National Statistics, Crown copyright

- GP disease registers** – these provide the number of patients on clinical registers in general practice, which can then be used to calculate disease prevalence. The data are captured as part of the Quality and Outcomes Framework (QOF), which was introduced as part of the General Medical Services (GMS); in most cases GPs are only required to capture 80% of the population to achieve payment with some practices seeking to identify all patients who will benefit, and others stopping once the target level is achieved. Based on 2011/12 data, around 860 people were on learning disability registers in Cannock Chase and Stafford and Surrounds CCGs making up 0.5% and 0.3% (respectively) of the population aged 18 and over. This is lower than the national average and also significantly less than expected (2,230 and 2,490 respectively), suggesting under-reporting in primary care. In addition, around 5,030 people were on mental health registers (schizophrenia, bipolar disorder and other psychoses) which is 0.5% of Cannock Chase's population and 0.6% of Stafford and Surrounds' population; again both are lower than the average for England.

Table 31: Actual and expected number on GP disease registers for dementia, learning disabilities and mental health, 2011/12

Disease	Clinical commissioning group	Actual - number and percentage	Statistical difference to England	Expected - number and percentage	Statistical difference to England
Dementia	Cannock Chase	680 (0.5%)	Similar	1,510 (1.1%)	Similar
	Stafford and Surrounds	720 (0.5%)	Similar	1,990 (1.4%)	Higher
	Staffordshire CCGs	4,350 (0.5%)	Similar	10,570 (1.3%)	Higher
Learning disabilities (ages 18+)	Cannock Chase	510 (0.5%)	Similar	2,230 (2.2%)	Similar
	Stafford and Surrounds	350 (0.3%)	Lower	2,490 (2.1%)	Similar
	Staffordshire CCGs	2,810 (0.4%)	Lower	14,160 (2.1%)	Similar
Mental health	Cannock Chase	710 (0.5%)	Lower	530 (0.4%)	Similar
	Stafford and Surrounds	850 (0.6%)	Lower	590 (0.4%)	Similar
	Staffordshire CCGs	5,030 (0.6%)	Lower	3,370 (0.4%)	Similar

Source: NHS Comparators, NHS Doncaster QOF Benchmarking Tool, Quality and Outcomes Framework (QOF) for April 2011 to March 2012, Quality Management and Analysis System (QMAS) database - 2011/12 data as at end of July 2012, Copyright 2013, The Health and Social Care Information Centre, Prescribing and Primary Care Services. All rights reserved, GP registered populations.

4. **Adult social care service data** – a number of people who have a disability will use adult social care services. The extent to which people with disabilities use services could give further insight into the level of need of a particularly vulnerable group. The data reflect a sub-set of people who have a disability, but the definitions used to describe different conditions and to allocate records to CCGs may be different to the other sources discussed above.

Table 32: The number of adults in Cannock Chase or Stafford and Surrounds CCGs who used social care services as at 31st March 2013

Primary need	Age band			Aged 18 or over
	18-64	65-74	75+	
Learning disability	490	30	10	520
Mental health: dementia	10	20	170	200
Mental health: non-dementia	340	80	70	490
Physical disability	830	620	2,310	3,760
Total	1,670	740	2,560	4,960

Note: numbers may not add up due to rounding. Source: Based on Table P2S, 2012/13 RAP return as at 31/03/13

Data on the number of people who have a sensory impairment at a local level are limited, although information is available from local registers held by social care.

Registration of sensory impairment is voluntary and therefore these figures do not provide a complete picture of the numbers of people in Staffordshire who have a visual or hearing impairment:

- There were 2,360 people on the blind register in Staffordshire and a further 2,160 on the partially sighted register (as at 30th July 2012). Around 1,380 people were on the deaf register and a further 2,500 on the hard of hearing register (as at 30th July 2012). For Cannock Chase and Stafford there were 320 on the deaf register and 870 on the hard of hearing register;
- Based on national prevalence surveys it is estimated that in 2012, for the populations of Cannock Chase and Stafford, there were: around 90 adults aged 18-64 with a serious visual impairment; 3,670 adults aged 65 and over with a moderate or severe visual impairment; and 1,200 adults aged 75 and over with registerable eye conditions;
- Based on national estimates, there are around 510 Cannock Chase and Stafford adults with profound hearing loss and a further 23,200 adults with moderate or severe hearing loss. In addition findings from the 2011/12 GP survey suggest that ca. 450 people in Cannock Chase and Stafford and Surrounds CCGs may be deaf and use sign language; and
- People with hearing and vision impairment are more likely to be older (aged 75 and over).

7.3.2 Key considerations

Evidence suggests that disabled people experience increased levels of disadvantage and health inequalities in comparison to non-disabled people⁹⁵. For example, long-term users of mental health services have worse physical health and die earlier⁹⁶ and people with learning disabilities are a key population at risk of multiplying factors⁹⁷. Changes to service configuration and site of delivery are likely to have a greater

⁹⁵ The Marmot Review notes that “For instance, people with physical and learning disabilities are more likely to suffer discrimination, poor access to some health services and worse employment prospects as a result of their disabilities, all of which impact negatively on their health”. *Fair Society, Healthy Lives: The Marmot Review*, UCL Institute of Health Equity, 2010, p. 39.

⁹⁶ “Improved mental health and wellbeing is associated with a range of better outcomes for people of all ages and backgrounds. These include improved physical health and life expectancy, better educational achievement, increased skills, reduced health risk behaviours such as smoking and alcohol misuse, reduced risk of mental health problems and suicide, improved employment rates and productivity, reduced anti-social behaviour and criminality, and higher levels of social interaction and participation”. *No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages*, Department of Health, 2February 2011, p. 7.

⁹⁷ “[T]he social exclusion Task Force identified people with moderate and severe learning disabilities as one of the most excluded groups in our society”. *Valuing People Now: a new three-year strategy for learning disabilities*, Department of Health, 19 January 2009, p. 22.

negative impact on access for people with disabilities than the general population⁹⁸. Some forms of disability may also drive increased need for service contact.

The extent to which these groups use specific local services is not routinely available. The impact assessment will therefore need to further understand through qualitative analysis how, and to what extent, specific disability groups could be impacted by changes in the site or nature of services. In addition, the population with disabilities will be a key group for understanding the impact of the TSAs' recommendations across people with multiple protected and other characteristics. This is therefore a high-risk group for the Steering Group to consider.

7.4 Gender reassignment

7.4.1 Overall description

Gender dysphoria is a condition in which an individual's psychological experience of themselves as a man or woman is not congruent with their physical sexual characteristics. The individual's physical sex is not aligned to their gender identity. Sometimes, the distress/discomfort is sufficiently intense that an individual undergoes transition from one point on a notional gender continuum to another. This typically involves changes to social role and presentation and may necessitate treatment with cross-sex hormones and/or having gender-related surgery. Patients may be referred to a Gender Identity Clinic for initial assessment and treatment before potentially being referred for sex reassignment surgery. There are a very small number of these services available nationally on the NHS, and there is no specialist centre in the West Midlands providing them; people therefore already travel to national centres to access these services.

Protection under the Equality Act is provided where someone has proposed, started or completed a process to change their sex and this is referred to as gender reassignment in the legislation. It is estimated nationally that one in four thousand people is receiving medical help for gender dysphoria⁹⁹, which equates to around 215 people in Staffordshire or about 50 in the catchment population of MSFT. Other reports suggest that the prevalence may be 20 per 100,000 and that there has been a growth in the number of people who have presented for treatment in the UK¹⁰⁰, although the West Midlands appears to have a low prevalence¹⁰¹.

⁹⁸ "[H]ouseholds with ...people with disabilities...are all much more likely to suffer transport poverty", R Pugh, T Scharf, C Williams and D Roberts, "Obstacles to using and providing rural social care", Research Briefing 22, Social Care Institute for Excellence, September 2007, p. 3.

⁹⁹ P Blunden and J Dale (2009) "Gender dysphoria: Time for positive thinking", *Mental Health Practice*, Vol 12, No. 7.

¹⁰⁰ *Gender Variance in the UK: Prevalence, Incidence, Growth and Geographic Distribution*, Gender Identity Research and Education Society, 2009, p. 4.

¹⁰¹ Gender Identity Research and Education Society, Op. Cit., p. 5.

7.4.2 Key considerations

As MSFT does not provide gender identity services, it does not appear that this group would experience the impact of changes to local acute health services more or less than the general population. This group will not be considered further, unless specific evidence arises during the impact assessment that would warrant further analysis.

7.5 Marriage and civil partnership

7.5.1 Overall description

Marriage is the legal union between a man and a woman, whilst civil partnership is the legal recognition of a same-sex couple's relationship. Civil partners must be treated the same as married couples on a range of legal matters. **Protection from discrimination for being married or in a civil partnership is provided in employment and vocational training only.**

Data from the 2011 Census provide information on marital and civil partnership status at a local level. Table 33 shows marital status for Cannock Chase and Stafford districts; the proportions that are married or in registered same-sex civil partnerships are similar for both districts and to the national average.

Table 33: Population by marital and civil partnership status for Cannock and Stafford, 2011.

	Cannock Chase		Stafford	
	Number	Percentage	Number	Percentage
Single (never married or never registered a same-sex civil partnership)	24,686	31.2%	31,752	29.2%
Married	39,036	49.4%	56,389	51.9%
In a registered same-sex civil partnership	121	0.2%	166	0.2%
Separated (but still legally married or still legally in a same-sex civil partnership)	1,930	2.4%	2,527	2.3%
Divorced or formerly in a same-sex civil partnership which is now legally dissolved	7,562	9.6%	9,926	9.1%
Widowed or surviving partner from a same-sex civil partnership	5,692	7.2%	7,866	7.2%
All residents aged 16 and over	79,027	100.0%	108,626	100.0%

Source: 2011 Census, Office for National Statistics, Crown copyright

7.5.2 Key considerations

Although there is some evidence of different health outcomes for married and unmarried men and women respectively¹⁰², there is nothing to suggest that marital status would impact upon the experience (negatively or positively) of changes to local service configuration. As protection from discrimination for being married or in a civil partnership is provided in employment and vocational training only, this group will not be considered further, unless specific evidence arises during the impact assessment that would warrant further analysis.

7.6 Pregnancy and maternity

7.6.1 Overall description

Maternity is defined as the period after giving birth and **is linked to maternity leave in the context of employment**; in the non-work context, protection against maternity discrimination is for 26 weeks after giving birth (including as a result of breastfeeding). For all areas covered by the Act, a woman is protected from unfavourable treatment because of pregnancy or because she has given birth. The protected status primarily applies to staff currently employed at MSFT.

7.6.2 Key considerations

Given their use by a working age population, and the nature of the service, any proposals for change to maternity services at MSFT are likely to attract interest amongst local people. From a protected characteristic perspective, the impact will be considered (as for other gender-specific services) in relation to “sex” as a protected characteristic (see below). The Steering Group will also consider the potential for multiple disadvantages within the (relatively small) Pakistani and “White: Other populations” ethnicities in the catchment population for MSFT.

7.7 Race and ethnicity

7.7.1 Overall description

Race refers to a group of people defined by their colour, nationality, ethnic or national origins; a racial group can also be made up of two or more distinct racial groups. According to the 2011 Census, around 6% of the population was from a minority ethnic background (defined as non-White British) in Staffordshire and the presence of any minority ethnic groups is below the average for England.

¹⁰² Joung IM, van der Meer JB, Mackenbach JP, “Marital status and health care utilization”, *Int J Epidemiol.* 1995 Jun;24(3):569-75.

Data from the 2011 Census suggest that the local ethnic minority population is concentrated mainly within East Staffordshire, with the single largest minority group in these areas being Pakistani (0.8% of the population of Staffordshire overall). The proportion of people from a minority ethnic group in Cannock Chase (3.5%, 3,420 people) and Stafford (7.4%, 9,709 people) is relatively small, although this may mean more concerted effort need to be made to consider the health impact on these groups (Table 34). The main minority ethnic groups in Cannock Chase and Stafford are “White: Other White” (largely Eastern European¹⁰³), Indian, White and Black Caribbean, Other Asian, and White Irish (each with over one thousand individuals).

Table 34: Breakdown of population by ethnic group for Cannock Chase and Stafford, 2011

Ethnicity	Cannock Chase		Stafford	
	Number	Percentage	Number	Percentage
White: British	94,042	96.5%	121,160	92.6%
White: Irish	350	0.4%	770	0.6%
White: Gypsy or Irish Traveller	8	0.0%	119	0.1%
White: Other White	856	0.9%	2,259	1.7%
Mixed/multiple ethnic group: White and Black Caribbean	458	0.5%	819	0.6%
Mixed/multiple ethnic group: White and Black African	51	0.1%	126	0.1%
Mixed/multiple ethnic group: White and Asian	214	0.2%	439	0.3%
Mixed/multiple ethnic group: Other Mixed	144	0.1%	310	0.2%
Asian/Asian British: Indian	406	0.4%	1,359	1.0%
Asian/Asian British: Pakistani	110	0.1%	369	0.3%
Asian/Asian British: Bangladeshi	48	0.0%	128	0.1%
Asian/Asian British: Chinese	227	0.2%	503	0.4%
Asian/Asian British: Other Asian	191	0.2%	929	0.7%
Black/African/Caribbean/Black British: African	98	0.1%	391	0.3%
Black/African/Caribbean/Black British: Caribbean	147	0.2%	582	0.4%
Black/African/Caribbean/Black British: Other Black	35	0.0%	134	0.1%
Other ethnic group: Arab	10	0.0%	229	0.2%
Other ethnic group: Any other	67	0.1%	243	0.2%
Any minority ethnic group	3,420	3.5%	9,709	7.4%
Total population	97,462	100.0%	130,869	100.0%

Source: 2011 Census, Office for National Statistics, Crown copyright

The Appendix presents maps showing the distribution of ethnic minority groups in Staffordshire and Stafford/Cannock. For Cannock Chase and Stafford districts

¹⁰³ “The largest numbers of migrants registering with GPs in Stafford in the year ending November 2011 came from the European Union accession countries, particularly Poland, Bulgaria and Romania”. *Health needs assessment: Recent migration in Stafford Borough*, Staffordshire Public Health, p. 5.

specifically, the proportion of people from minority groups is over 10% in the following wards: Coton (25%), Forebridge (16%), Littleworth (13%), and Common (12%).

Table 35: Wards with high proportions of people from minority ethnic groups, 2011

Ward name	Local authority	All minority ethnic groups
Coton	Stafford	1,172 (25%)
Forebridge	Stafford	846 (16%)
Littleworth	Stafford	963 (13%)
Common	Stafford	543 (12%)

Source: 2011 Census, Office for National Statistics, Crown copyright

7.7.2 Key considerations

The absolute number of people from minority ethnic groups in Stafford and Cannock Chase is low. However, people from these groups often experience poorer health outcomes in the UK than the general population¹⁰⁴. This may be as a result of different factors according to specific ethnic origin, including predisposition to certain diseases in the South Asian population (e.g. diabetes, coronary heart disease¹⁰⁵), prevalence of smoking (e.g. in some White British¹⁰⁶, White Irish^{107,108} and White Other^{109,110} communities), poor access to services¹¹¹, language barriers

¹⁰⁴ The Marmot Review noted that “While worse health outcomes for some ethnic groups are associated with their socioeconomic status, for others outcomes are worse than would be expected from their economic status”. *Fair Society, Healthy Lives: The Marmot Review*, UCL Institute of Health Equity, 2010, p. 39.

¹⁰⁵ P Aspinall and B Jacobson, *Ethnic Disparities in Health and Health Care: A focused review of the evidence and selected examples of good practice*, London Health Observatory, July 2004.

¹⁰⁶ The Integrated Household Survey for April 2010 - March 2011 estimates that 21.5% of White respondents currently smoke, cf. 13% for Asian/Asian British, 15.2% for Black/Black British, 14.6% for Chinese and 18.2% for other ethnic groups. Source: *Integrated Household Survey April 2010 to March 2011: Experimental Statistics*, Statistical Bulletin, Office of National Statistics, 28 September 2011, p. 10.

¹⁰⁷ “Irish men in both age groups [35–44 and 45–54 years] smoked more than men in the general population”. J Abbotts, S Harding, K Cruickshank “Cardiovascular risk profiles in UK-born Caribbeans and Irish living in England and Wales”, *Atherosclerosis* Volume 175, Issue 2, August 2004, Pages 295–303.

¹⁰⁸ “The highest prevalence of current smokers was in the Irish...group, [at] 26%...31% of male smokers in the general population smoked 20 or more cigarettes per day, and were heavier smokers than those in all of the other groups, with the exception of Irish men (33% of whom smoked at least 20 cigarettes per day)”. *Health Survey for England 2004: The Health of Minority Ethnic Groups—headline tables*, NHS Health and Social Care Information Centre, 2005, p. 15.

¹⁰⁹ Based on a survey of 120 respondents from Eastern Europe, “Forty eight percent of respondents smoked”. *Health and Social Care Needs Assessment of Eastern European (including Roma) individuals living in Barking and Dagenham - Final Report*, Institute for Health and Human Development, University of East London, September 2010, p. 31.

¹¹⁰ A review of the health needs of around ten thousand Polish migrants noted that “In the younger urban population, particularly young single men, there are much higher rates of smoking, [and] excessive drinking”. P Coakley, *Health Needs Assessment of Polish Migrants in Hertfordshire*, April 2011, p.2 .

¹¹¹ “A substantial research base now exists to show disparities in access to healthcare services for ethnic minority populations”. A Szczepura “Access to health care for ethnic minority populations”, *Postgrad Med J* 2005;81:141–147.

and cultural differences¹¹². In terms of service usage, HEIAs have also identified the importance of considering the impact of service changes on populations from minority ethnic groups given their disproportionately higher level of A&E attendance¹¹³. Encouragement to use primary healthcare is likely to have a positive impact on health outcomes in populations where chronic disease and lifestyle are drivers for service use. However, evidence suggests that (after controlling for need variables such as age, sex, health and for the supply of health care¹¹⁴) ethnic minorities actually have lower usage rates for secondary care usage overall despite having higher use of primary care (and higher A&E attendances); this is borne out by local data. Table 36 shows that MSFT does not show higher utilisation of in-patient activity for minority ethnic groups, although this should be used with caution given that 8% of non-elective admissions do not have their ethnic status recorded (rising to 22% for obstetric/midwife episodes). A change in provider to one used to working with minority ethnic communities or onto a site where such communities are regular users may have a positive impact on service acceptability for these service users, although additional distance to travel could be perceived as a negative impact.

Table 36: Utilisation of hospital in-patient activity by ethnic group at MSFT, 2012/13

Ethnicity	Elective admissions	Non-elective admissions	Obstetrics / midwife episode	Percentage in population (2011)
White British	27,609 (87.8%)	20,978 (87.1%)	3,229 (72.8%)	93.5%
White Other	437 (1.4%)	427 (1.8%)	67 (1.5%)	2.1%
Asian	284 (0.9%)	304 (1.3%)	91 (2.1%)	2.5%
Black	98 (0.3%)	121 (0.5%)	20 (0.5%)	0.6%
Mixed	58 (0.2%)	181 (0.8%)	26 (0.6%)	1.1%
Any other ethnic group	32 (0.1%)	132 (0.5%)	19 (0.4%)	0.2%
Not known	2,925 (9.3%)	1,949 (8.1%)	986 (22.2%)	n/a
All admissions	31,443 (100.0%)	24,092 (100.0%)	4,438 (100.0%)	100.0%

Note: Obstetrics are also included in the total elective and non-elective admissions. Source: *Hospital in-patient data extract, Healthcare Commissioning Services (HCS) and 2011 Census, Office for National Statistics, Crown copyright*

¹¹² “In countries and regions that have experience of population diversity (especially the USA, Australia, Canada, and also the United Kingdom) consideration is now being given to developing linguistic and cultural competence in healthcare organisations. In particular, it is acknowledged that, in a range of clinical areas where access is shown to be poor, healthcare services now need to develop policies and structures to begin to tackle such disparities”. A Szczepura Op Cit.

¹¹³ Bottle A, Aylin P, Majeed A (2006) “Identifying patients at high risk of emergency hospital admissions: a logistic regression analysis”, *Journal of the Royal Society of Medicine*, vol 99, no 8, pp 406–14.

¹¹⁴ S Morris, M Sutton and H Gravelle (2003) *Inequity and inequality in the use of health care in England: an empirical investigation*, CHE Technical Paper Series 27, Centre for Health Economics, University of York, p. 3.

As noted above, different groups with the minority ethnic population in Stafford and Cannock Chase are likely to have differing needs. For example, migrant usage of health services is often characterised by ad hoc use of health services including reliance on A&E rather than primary care¹¹⁵. Eastern European usage of healthcare is sometimes characterised by later presentation of serious illness¹¹⁶ and premature mortality, and lifestyle behaviours of poor diet¹¹⁷ or alcohol can be drivers¹¹⁸. There is also a visible Asian population of which those of Indian descent tend to have health outcomes similar to general population, whilst those of Pakistani descent have poorer outcomes than the general population¹¹⁹, a higher burden of ill health¹²⁰ and higher fertility rates¹²¹. These communities are typically younger than the general population¹²² and therefore less likely to make use of hospital services at this point. This is with the exception of maternity services, where Pakistani communities have high general fertility rates (GFRs)¹²³ and higher infant mortality rates¹²⁴, and “White: Other” groups, which are also likely to include working age families¹²⁵.

Although only a small number of people in Stafford and Cannock Chase come from minority ethnic backgrounds, they may have a different burden of disease, or pattern

¹¹⁵ “The results [demonstrate] that migrants frequently use A&E services. This does not tell us anything about the reason for using these emergency services. However, a concern is that some migrants use such walk-in services because they are not registered with a GP and/or do not understand their entitlement to care within the NHS. They will therefore use more accessible services, even if this is not the most appropriate way to manage their health needs”. *Understanding the Health Needs of Migrants in the South East Region*, Health Protection Agency and partners, October 2010, p. 76.

¹¹⁶ “New migrants may not register with GPs unless a health emergency occurs. This could be due to lack of time due to work patterns, lack of English fluency, no expectation of ill health (especially if intending to stay only a short period of time) or lack of awareness of migrants’ entitlement to primary care”. *Health needs assessment: Recent migration in Cannock Chase*, Staffordshire Public Health, p. 6 and *Health needs assessment: Recent migration in Stafford Borough*, Staffordshire Public Health, p. 7.

¹¹⁷ Based on a survey of 120 respondents from Eastern Europe, “Many people expressed a desire to eat more healthily but cited cost, lack of time and not liking the taste as their main reasons for not doing so”. Institute for Health and Human Development, Op. Cit., p. 31.

¹¹⁸ A review of the health needs of around ten thousand Polish migrants noted that “In the younger urban population, particularly young single men, there are much higher rates of smoking, [and] excessive drinking”. P Coakley, *Health Needs Assessment of Polish Migrants in Hertfordshire*, April 2011, p.2 .

¹¹⁹ “Figure 4...shows changes in the relative risk of reporting fair or poor health for Pakistanis and Bangladeshis (the groups with the poorest health) compared with whites once the data had been standardised for a variety of socio-economic factors”. JY Nazroo (1998) “Genetic, cultural or socio-economic vulnerability? Explaining ethnic inequalities in health”, *Sociology of Health & Illness* Vol. 20 No.5, pp. 710–730.

¹²⁰ “Pakistani and Bangladeshi men and women in England and Wales reported the highest rates of both poor health and limiting long-term illness”. Health Inequalities Third Report of Session 2008–09: Volume I Report, together with formal minutes, House of Commons Health Committee, 26 February 2009, p. 17.

¹²¹ “Pakistani and Bangladeshi families also have more children than families in the majority white population”. *Independent Inquiry into Inequalities in Health Report*, Sir Donald Acheson, 1998 (available at <http://www.archive.official-documents.co.uk/document/doh/ih/part2h.htm>).

¹²² “Recent migrants are predominantly between the ages of 18 and 34”. *Health needs assessment: Recent migration in Stafford Borough*, Staffordshire Public Health, p. 3.

¹²³ “Only among Pakistani and Bangladeshi women does total fertility remain substantially above the national average despite a continuous decrease over the last 20 years”. DA Coleman and S Dubuc (2010) “The fertility of ethnic minorities in the UK, 1960s–2006”, *Population Studies: A Journal of Demography*, Volume 64, Issue 1.

¹²⁴ “A prospective study of 4934 babies of different ethnic groups has confirmed the high perinatal mortality rate for Pakistanis [i.e. UK-born Pakistani babies]”. S Bunday et al (1991) Why do UK-born Pakistani babies have high perinatal and neonatal mortality rates? *Paediatric and Perinatal Epidemiology*, Volume 5, Issue 1, pages 101–114.

¹²⁵ A review of the health needs of around ten thousand Polish migrants noted that “The major health needs currently in the population are obstetric and paediatric”. P Coakley, *Health Needs Assessment of Polish Migrants in Hertfordshire*, April 2011, p.2 .

of service use, which could mean they experience the impact of any proposed changes differently from the majority population. The Steering Group will seek to gain greater insight into the likely scale and nature of impact for the main minority ethnic groups living in Cannock Chase and Stafford as part of the impact assessment.

7.8 Religion or belief

7.8.1 Overall description

This area includes any religious or philosophical belief and includes a lack of belief, for example Humanism and Atheism; a belief need not include faith or worship of a god or gods, but must affect how a person lives their life or perceives the world. The 2011 Census found Christianity to be the majority religious affiliation in Staffordshire (68.2%), although over the last decade this proportion has dropped with significant increases in people stating they had no religious affiliation (22.8%). Muslims are the next biggest religious group (1.3%), with the data showing a similar pattern for both Cannock Chase and Stafford districts (Table 37) as for Staffordshire as a whole.

Table 37: Population by religion for Cannock and Stafford districts, 2011.

Belief system	Cannock Chase		Stafford	
	Number	Percentage	Number	Percentage
Christian	67,392	69.1%	88,799	67.9%
Buddhist	166	0.2%	457	0.3%
Hindu	128	0.1%	850	0.6%
Jewish	9	0.0%	64	0.0%
Muslim	219	0.2%	1,151	0.9%
Sikh	274	0.3%	495	0.4%
Other religion	283	0.3%	531	0.4%
No religion	23,066	23.7%	29,868	22.8%
Religion not stated	5,925	6.1%	8,654	6.6%
Total	97,462	100.0%	130,869	100.0%

Source: 2011 Census, Office for National Statistics, Crown copyright

7.8.2 Key considerations

There is little evidence that religion in Staffordshire has an effect on use of secondary healthcare. Given the pattern of services available in MSFT and the level of presence in the population it does not appear that particular religious groups would experience the impact of changes to services more or less than the general population. The factors influencing access to healthcare for ethnic minorities include cultural dimensions, of which religion “may affect compliance or access to services”¹²⁶ and where there is an impact it is likely to be picked up through analysing the impact on minority ethnic groups. This characteristic will not be

¹²⁶ A Szczepura Op Cit.

considered further, unless specific evidence arises during the impact assessment that would warrant further analysis.

7.9 Gender (sex)

7.9.1 Overall description

Gender is being male or female; the wider social roles and relationships that structure men's and women's lives change over time and vary between cultures. Across Cannock Chase and Stafford districts the population is split fairly evenly by sex: 113,700 males (49.8%) and 114,800 females (50.2%). Table 38 shows wards in Stafford that have higher proportions of either male or females compared to the England average.

Table 38: Wards in Cannock Chase and Stafford with higher proportions of either males or females compared with England, 2011.

Males	Females
<ul style="list-style-type: none"> ▪ Littleworth (58%) (possibly due to a high resident student population) ▪ Milford (56%) ▪ Coton (55%) ▪ Common (52%) ▪ Forebridge (51%) 	<ul style="list-style-type: none"> ▪ Barlaston and Oulton (53%) ▪ Eccleshall (52%)

Source: 2011 mid-year population estimates, Office for National Statistics, Crown copyright

7.9.2 Key considerations

Table 39 compares the health of men and women living in Staffordshire, Cannock Chase and Stafford and shows there are differences in health issues and outcomes by gender, which reflect those in the general population of England.

Table 39: Health issues for Staffordshire by gender.

Men	Women
Staffordshire	

<ul style="list-style-type: none"> ▪ Men have a life expectancy of 79.0 years which is similar to the England average ▪ Men in the most deprived areas in Staffordshire live eight years less than those in the least deprived areas ▪ 17% of men have a limiting long-term illness ▪ Higher rates of premature mortality, in particular from cardiovascular disease and cancer ▪ Higher suicide and accident mortality rates ▪ Higher rate of alcohol-related admissions 	<ul style="list-style-type: none"> ▪ Women have a life expectancy of 82.9 years which is similar to the England average ▪ Women in the most deprived areas in Staffordshire live seven years less than those in the least deprived areas ▪ 20% of women have a limiting long-term illness ▪ Prevalence rates of dementia higher amongst women ▪ Women are more likely to have been treated for a mental health problem than men
Cannock Chase	
<ul style="list-style-type: none"> ▪ Men have a life expectancy of 78.5 years which slightly less (five months) than the England average ▪ Men in the most deprived areas in Cannock Chase live seven years less than those in the least deprived areas ▪ 19% of men have a limiting long-term illness ▪ Higher rates of premature mortality, in particular from cardiovascular disease and cancer ▪ Higher suicide rates ▪ Higher rate of alcohol-related admissions 	<ul style="list-style-type: none"> ▪ Women have a life expectancy of 82.7 years which is slightly less (three months) than the England average ▪ Women in the most deprived areas in Cannock Chase live three years less than those in the least deprived areas ▪ 21% of women have a limiting long-term illness ▪ Prevalence rates of dementia higher amongst women ▪ Women are more likely to have been treated for a mental health problem than men
Stafford	
<ul style="list-style-type: none"> ▪ Men have a life expectancy of 80.1 years which is higher than the England average ▪ Men in the most deprived areas in Stafford live eight years less than those in the least deprived areas ▪ 16% of men have a limiting long-term illness ▪ Higher rates of premature mortality, in particular from cardiovascular disease ▪ Higher rate of alcohol-related admissions 	<ul style="list-style-type: none"> ▪ Women have a life expectancy of 83.6 years which is higher than the England average ▪ Women in the most deprived areas in Stafford live seven years less than those in the least deprived areas ▪ 19% of women have a limiting long-term illness ▪ Prevalence rates of dementia higher amongst women ▪ Women are more likely to have been treated for a mental health problem than men

Compiled by Health and Wellbeing Intelligence, Public Health Staffordshire

The most relevant aspect of the impact of any proposed changes is where the TSAs' recommendations affect sex-specific services: gynaecology, breast clinics and surgery, and maternity for women; and urology for men. However those men at greatest risk of premature mortality will be high risk for non-participation in cardiovascular disease (CVD), diabetes and cancer services, and this may also be

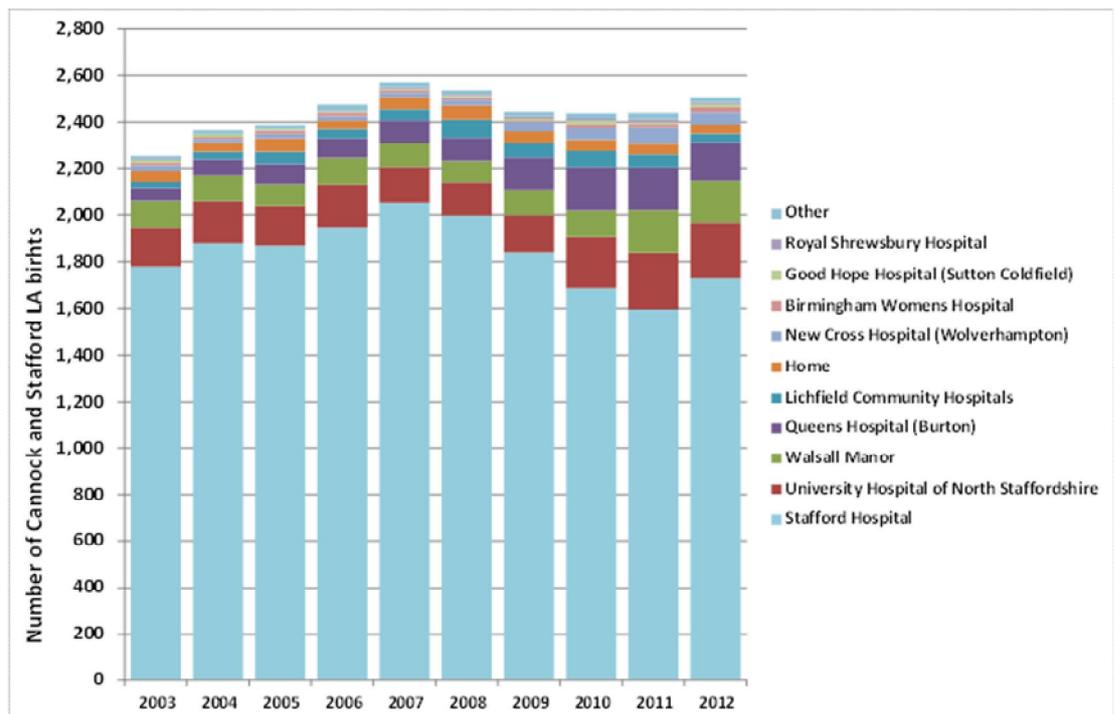
considered in assessing the potential impact of service changes. The support available for the acute management of dementia and co-morbidity with dementia will be a particular issue for women. Research suggests “that providers’ inability to respond to health problems in a sensitive manner can affect service use [by gender]”¹²⁷, e.g. privacy in an A&E department for women seeking help for domestic violence.

Maternity services

One of the areas of service change most likely to raise concern amongst local people are proposals that could affect the site or nature of maternity services. Any such proposals could be considered as potentially impacting upon the protected characteristic of sex (i.e. ‘being female’).

During 2011 there were almost nine thousand live births to women resident in Staffordshire, of which ca. 2,400 were to women in Stafford and Cannock (Figure 19).

Figure 19: Trends in births to women in Cannock Chase or Stafford by hospital, 2003-2012



Source: Public Health Births Files and Birth extracts, Office for National Statistics

Figure 19 shows that whilst total deliveries for women in Stafford and Cannock Chase between 2007 and 2011 have consistently been above 2,400, there have been four hundred fewer deliveries in the period at MSFT. However, this downward trend has started to reverse for the latest year for which data are available and deliveries at

¹²⁷ MK Goddard, *Quality in and Equality of Access to Healthcare Services in England CHE Research Paper 40*, Centre for Health Economics, University of York, August 2008, p. 10.

MSFT have increased between 2011 and 2012. Nevertheless, MSFT is still at the smaller end of maternity units¹²⁸ and smaller units may struggle to maintain adequate and suitably skilled staffing over a 24 hour period for both obstetrics and neo-natal services.

Key factors that affect the number of deliveries at a particular hospital include the birth rate; patient choice; and service changes (size, configuration, access, improvements etc.) The general fertility rates (GFRs) are a measure of the number of live births per thousand by women of child-bearing age (conventionally taken as those aged 15-44 years) and the number of live births is a useful indicator for the level of maternity and early years care required within an area. Fertility rates across Stafford and Cannock Chase are lower than the national average (Table 40), although two wards in Stafford district (Coton and Penside) have rates that are higher than the England average.

Table 40: General fertility rates in Staffordshire, 2011.

Area	Number of live births	Live births per 1,000 women aged 15-44	Statistical difference to England
Cannock Chase	1,132	58.8	Lower
Stafford	1,273	55.3	Lower
Staffordshire	8,986	58.1	Lower
West Midlands	73,023	66.1	Higher
England	688,120	64.2	

Source: *Compendium of Population Health Indicators* (www.indicators.ic.nhs.uk or www.indicators.ic.nhs.uk), *The NHS Information Centre for health and social care*. Crown copyright

Working age women are the majority users of maternity services, and they may otherwise make little use of the NHS. Local families may feel a particular attachment to a service where they or their children were born, which is typically different from the usual relationship with a hospital. For most women birth is a normal experience and they may reasonably expect a range of local services to be available. However, even normal pregnancies can quickly deteriorate during birth and then both woman and child need rapid access to a specialist infrastructure.

Trust staff

It is the role of the Steering Group to also consider the impact of proposed changes on staff at the hospital. Women tend to be over-represented in the workplace in

¹²⁸ Guidelines suggest that “obstetric units supporting relatively few births [are those with] less than 2500/year”. *Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour*, Royal College of Anaesthetists, Royal College of Midwives, Royal College of Obstetricians and Gynaecologists, Royal College of Paediatrics and Child Health, 2007, p. 33.

lower income groups and/or low skilled employment¹²⁹. Some 79% of the staff of MSFT are women; about half of all staff (52%) earn less than £25,000 and most of these are women (83%). Women could be at greatest risk of a negative impact of change of service site as they are: more likely to be reliant on public transport than other staff in seeking to travel to other labour markets¹³⁰; more likely to be asked to work unsocial hours when public transport may not be so available¹³¹; and more likely to have caring responsibilities for children or other adults which may limit their ability to travel far to work.

The Steering Group will actively review the TSAs' draft recommendations to assess relative impact for men and women, and consider whether there is a differential and significant impact for either sex.

7.10 Sexual orientation

7.10.1 Overall description

Sexual orientation is whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes. The 2010/11 Integrated Household Survey estimates that 1.5% of the UK population aged 18 and over is gay, lesbian or bisexual. The GP patient survey also asks about sexual orientation and based on respondents who replied to the question on sexual orientation, 1.4% of Staffordshire's population is gay, lesbian or bisexual compared with 1.9% across England (Table 41).

Table 41: Population by sexual orientation, 2011/12.

Sexual orientation	Cannock Chase CCG	Stafford and Surrounds CCG	Staffordshire	West Midlands	England
Heterosexual	95.8%	95.7%	95.4%	93.2%	92.9%
Gay / lesbian	0.7%	1.1%	1.0%	1.0%	1.3%
Bisexual	0.5%	0.3%	0.4%	0.5%	0.6%

¹²⁹ In 2012, of the 6.2m employees in the UK who earned £8.00 or less, more than 60% were women. Source: ONS (2012) Distribution of Low Paid Jobs by 10p Bands, 1998 to 2012.

¹³⁰ "Women are slightly more likely than men to travel by public transport, especially to work, with their greater use of buses outweighing men's slightly greater use of trains". Source: *Promoting gender equality in transport*, Kerry Hamilton and Linda Jenkins (University of East London) Frances Hodgson (University of Leeds) Jeff Turner (Jeff Jeff Transport and Social Development Consultancy Ltd) EOC Working Paper Series No. 34, Equal Opportunities Commission 2005, p. v.

¹³¹ "Women, especially those with a child under the age of five, are much more likely than men to work part-time. This is particularly difficult for those women working shift patterns if their shift means that they need to access public transport during the early mornings and evenings, rather than during peak hours" – Department for Transport Mobility Inclusion Unit, *Guideline no.2: Women, men and public transport*, p. 7.

Other	0.3%	0.3%	0.3%	0.6%	0.6%
Prefer not to say	2.7%	2.7%	2.9%	4.7%	4.6%
Total responses	2,372	2,729	15,289	103,034	987,390

Source: Ipsos MORI, NHS GP Patient Survey 2011/12, Copyright

7.10.2 Key considerations

Whilst there will be a visible community of lesbian, gay and bisexual people in Staffordshire, there will also be a significant invisible community which the impact assessment may need to consider. A systematic review of lesbian, gay, bisexual and transgender (LGBT) health in the West Midlands noted that for “general health, long term illnesses and prescribed medication use, there did not seem to be stark differences between the LGB[T] samples and the general population”¹³². The review’s main findings on delivery of health care did not mention usage of acute services. A Dutch analysis of homosexual versus heterosexual use of healthcare services found a higher rate of healthcare use among homosexual and bisexual people compared to heterosexuals, which could only be partly explained by differences in health status¹³³. However, both the West Midlands review and the Dutch study noted that there are large gaps in knowledge around LGBT health¹³⁴.

There is an established body of research that suggests higher levels of mental health problems, particularly anxiety and depression, across the LGBT community^{135,136}; however, given that mental health services are not provided by MSFT this is unlikely to be significant in terms of the potential impact of changes.

It does not appear at this stage of scoping that there would be significantly different impacts for the LGBT community of changes at MSFT, than would be the case for the general population. The potential impact of changes will be further explored through interviews in order to test this assumption, and inform the impact assessment report.

¹³² C Meads, M Pennant, J McManus and S Bayliss, *A systematic review of lesbian, gay, bisexual and transgender health in the West Midlands region of the UK compared to published UK research*, Department of Public Health and Epidemiology and West Midlands Health Technology Assessment Group, The University of Birmingham, March 2009, p. 85.

¹³³ Bakker FC, Sandfort TG, Vanwesenbeeck I, van Lindert H, Westert GP, “Do homosexual persons use health care services more frequently than heterosexual persons: findings from a Dutch population survey”, *Soc Sci Med*. 2006 Oct;63(8):2022-30.

¹³⁴ C Meads, M Pennant, J McManus and S Bayliss, *A systematic review of lesbian, gay, bisexual and transgender health in the West Midlands region of the UK compared to published UK research*, Department of Public Health and Epidemiology and West Midlands Health Technology Assessment Group, The University of Birmingham, March 2009, pp. v-vi.

¹³⁵ “LGB people are at higher risk of mental disorder, suicidal ideation, substance misuse, and deliberate self harm than heterosexual people”. M King et al (2008) “A systematic review of mental disorder, suicide, and deliberate self harm in lesbian, gay and bisexual people” *BMC Psychiatry*, 8:70.

¹³⁶ M King et al (2003) “Mental health and quality of life of gay men and lesbians in England and Wales”, *British Journal Of Psychiatry*, 183: 552-558.

7.11 Summary prioritisation of characteristics

7.11.1 Summary for protected characteristics

Based on prevalence in the local population and usage of hospital services, Table 42 summarises the scoping of the protected characteristics.

Table 42: Summary of scoping for the protected characteristics

Scope	Protected characteristic	Comments
First focus areas	Age	<ul style="list-style-type: none"> • The resident population of Staffordshire overall is slightly older than the English average • The number of older people (aged 75 or over) in Cannock Chase and Stafford is expected to increase by 41% between 2001 and 2021, compared with 27% for England • The rate of elective admissions and outpatient attendances tends to increase steadily with age whereas non-elective admissions are relatively high for young children as well as being high for older people • Older People are over-represented in in-patient services and their families and carers are at high risk of negative travel impact for any change of site • Older People may disproportionately benefit if service changes lead to different models of provision, including care closer to home • Children and younger adults tend to have a relatively high rate of emergency admissions and elective activity, which does not seem to correlate to demography or epidemiology
	Disability	<ul style="list-style-type: none"> • National evidence suggests that disabled people experience increased levels of disadvantage and health inequalities in comparison to non-disabled people • Based on census data for self-reported limiting long-term illness almost one in five people (19.2% or 162,647) in Staffordshire has a limiting long-term illness, which is more than the average in England (17.6%) • People with a disability are more likely to be regular users of hospital services and may disproportionately benefit if service changes lead to different models of provision (e.g. closer to home) or be particularly negatively impacted by a change to a more distant site

Scope	Protected characteristic	Comments
	Sex (gender)	<ul style="list-style-type: none"> • There appears to be little evidence that any changes to MSFT service delivery would have a specific impact for either men or women as patients beyond the impact for the general population or other protected characteristics • The exception to this is in relation to the impact of changes for gender-specific services, e.g. diseases of the prostate in men (urology) or gynaecological disorders in women, which will be considered as relating to the protected characteristic of sex • Where there are changes proposed for maternity services, these are likely to affect relatively large numbers of the general population. Particular attention will be paid to the relative benefits and risks of: (a) concentrating services for safety, resilience and effectiveness; and (b) making services more distant and harder to reach • Although small in number, there is likely to be a multiplier effect (positive or negative) of any changes to maternity services for certain protected groups, including communities with high GFRs and/or disadvantaged communities. • Women may be more prevalent amongst MSFT staff in lower income groups and/or low skilled employees and could be at greater risk of negative impact of change of service site, be less able to compete in the labour market and/or experience greater barriers in travel for work
Second focus areas	Race	<ul style="list-style-type: none"> • Representation for all minority ethnic groups in Staffordshire is below the average for England; the top three ethnic minority groups are “White Other” (1.6%), Pakistani (0.8%) and Indian (0.8%) • Qualitative evidence collection through interviews (where practical) may be needed to understand whether there is a disproportionate impact, particularly in specialties where members of the relevant community are over-represented e.g. diabetes and cardio-vascular outpatients
	Sexual orientation	<ul style="list-style-type: none"> • Based on responses to the GP patient survey, ca. 1.4% of Staffordshire’s population is gay, lesbian or bisexual (compared with 1.9% across England) • It is not clear at this point that there would be specific impacts for this group different or beyond that of the general population, but this will be tested in dedicated interviews during the consultation process • The Steering Group will seek advice on the perceived impact through discussions with LGBT community

Scope	Protected characteristic	Comments
Limited focus areas	Gender reassignments	<ul style="list-style-type: none"> • National rates for gender dysphoria are low (ca. one in 4,000 or 0.025%), equating to 215 people in Staffordshire • Dedicated services are specialist and not offered through MSFT and so not affected • There is little quantitative evidence to suggest that changes to MSFT will have specific either negative or positive impact for trans-gender individuals as opposed to those for the general population
	Pregnancy and maternity	<ul style="list-style-type: none"> • Protection from discrimination for being pregnant and in the post natal period is provided in employment and vocational training only and will be considered in relation to the current staff of MSFT • Changes to Maternity services would be considered as 'sex' specific and considered within that protected characteristic
	Religion or belief	<ul style="list-style-type: none"> • There appears to be little evidence that any changes to MSFT would have a specific impact for any particular religious community beyond the impact on the general population or on other protected characteristics • Where there is an impact it is likely to be covered by work within one of the other protected groups, e.g. ethnicity
	Marriage and civil partnership	<ul style="list-style-type: none"> • The public sector duty covers this protected characteristic only in respect of the requirement to have due regard to the need to eliminate discrimination and this group will not be considered further • It is not anticipated that this will prove an issue for staff affected by any service changes, but any alternative provider would have to meet all its legal duties

As well as the impact on the local population with the prioritised protected and socioeconomic characteristics, the impact assessment will carry out further work on the prevalence of these prioritised characteristics amongst the Trust's staff and the implications on them of the recommendations.

7.11.2 Summary of multiple protected and other characteristics

The Steering Group noted that, although there is a prioritisation of the protected characteristics for this scoping report, what is potentially more important for the impact assessment is to isolate particular groups that belong to multiple categories, and who may be most affected by any major service reconfiguration. An example of these groups is the elderly who are socioeconomically deprived or those with a disability and no access to private transport. Just under half of Cannock Chase people aged 75 or over (2,950) and a third of people in Stafford (3,470) have a long term health problem or disability and are 'limited a lot' in day-to-day activities.

The Steering Group further noted that the impact on Trust staff must be included in the impact assessment and that this is particularly important where multiple categories co-exist (for example, women on low wages).

8 Scoping of the impact of proposed service changes

8.1 Summary of timelines

Given the statutory timescale to which the HEIA is being produced, the process to scope the health impacts presents a significant challenge as the recommendations of the TSAs are being designed in parallel. However, it is possible that the recommendations of the TSAs are likely to include proposals that may lead to:

- Significant reconfiguration of services at MSFT; and/or
- An impact on provision of services and levels of usage at neighbouring providers; and/or
- Some services being supplied by providers that are not currently active locally.

Each of these could clearly be subject to public concern, and the HEIA will use a framework to understand the health impacts of the recommendations of the TSAs (see Section 3.5).

8.2 Services in Scope

As noted in Section 2.3, the statutory nature of the TSA timescale means that the recommendations of the TSAs have been developed in parallel and separate to this scoping report, and the Steering Group has had no information from the TSAs on the nature of their recommendations. The Steering Group will apply the approach set out in this report to assessing the impact for the general population, those with protected characteristics and others of concern due to any changes proposed by the TSAs, using the Maxwell criteria to understand the different aspects of quality.

Public discussion to date has highlighted significant concerns in the following areas, which will be considered where the TSAs' draft recommendations may change the current range, nature or site of provision. There is particular concern relating to possible change of site of delivery, which could aggravate existing issues of travel times.

Table 43: Summary of known areas of public concern

Area	Evidence	Source
Outpatient appointments	“During the last 12 months, 46% had also attended an NHS hospital as an outpatient”	Staffordshire People’s Panel, Summer 2012 Survey Report
	During 2012/13 the top three specialties for first out-patient attendances for Staffordshire residents were trauma and orthopaedics, general surgery and ophthalmology	Public Health Intelligence, Staffordshire Public Health
	It is estimated that around one in five people in Staffordshire have a limiting long term condition which increases significantly with age Data from a sample of practices revealed that at least one in four people have a registered disease with one tenth of the population having more than one condition. Almost a third of all patients with a specified registered disease are also obese, around 14% are smokers and 19% ex-smokers	Working Together for Better Health, The Staffordshire Joint Strategic Needs Assessment, April 2012, p. 26
Non-elective and A&E services	Some 22% of respondents had used A&E services in the last year; this was the fourth highest healthcare service used (after GPs, outpatients and pharmacies)	Staffordshire People’s Panel, Summer 2012 Survey Report
	During 2011/12, there were 79,300 emergency (unplanned) admissions for Staffordshire residents. Around 7% of the population were admitted at least once, and 2% were admitted more than once	Working Together for Better Health: Staffordshire Enhanced Joint Strategic Needs Assessment, April 2013 (Draft), p. 29
	Rural patients are less likely to attend an A&E department or an urgent care centre: this is likely to be due to reduced access to these services	Urgent and Emergency Care Review - Evidence Base Engagement Document, NHS England, 17 June 2013, p. 37

Area	Evidence	Source
Maternity	“Most participants had a limited knowledge of what services were currently being offered at either hospital so struggled to talk about specific departments or services. However, some services were discussed spontaneously....Stafford maternity”	Unpublished research report for Monitor
Paediatrics	“Most participants had a limited knowledge of what services were currently being offered at either hospital so struggled to talk about specific departments or services. However, some services were discussed spontaneously....Stafford paediatrics”	Unpublished research report for Monitor
Elective surgery	“Most participants had a limited knowledge of what services were currently being offered at either hospital so struggled to talk about specific departments or services. However, some services were discussed spontaneously....elective surgery”	Unpublished research report for Monitor

9 Consultation and engagement

9.1 Summary of the proposed consultation approach

The stakeholder engagement for the impact assessment will occur simultaneously with the wider statutory public consultation on the draft report and recommendations put forward by the TSAs. This consultation will be delivered in line with the legal and statutory requirements set out in the National Health Service Act 2006 (as amended by the Health Act 2009 and the Health and Social Care Act 2012) and Monitor's *Statutory guidance for Trust Special Administrators appointed to NHS foundation trusts*.

The purpose of the stakeholder engagement for the impact assessment is to provide additional, qualitative, data to inform the assessment of the impacts of these recommendations, and is therefore narrower in scope. Engagement is “a broad term intended to cover the whole range of ways in which bodies subject to the duty [of the Equality Act (2010)] interact with their service users and employees, over and above what they do in providing services or within a formal employment relationship”¹³⁷. However, public bodies “cannot engage with everyone, in every decision, all of the time. They should, therefore, take a proportionate approach to deciding whether to engage and with whom, and the extent of the exercise”¹³⁸. The stakeholder engagement for impact assessment will therefore be used to:

- Assess the impact of the recommendations of the TSAs on specific groups, especially for protected characteristics where quantitative data are lacking¹³⁹; and
- Identify ways to mitigate adverse impacts on certain groups¹⁴⁰.

This means that the stakeholder engagement will require input both from subject matter experts and from members of the public who have one or more of the in-scope prioritised protected and other characteristics. A stakeholder plan and engagement materials (e.g. structured survey questions) will be prepared to ensure that the limited time available for engagement is used effectively.

¹³⁷ *Equality Act 2010 Technical Guidance on the Public Sector Equality Duty England*, Equality and Human Rights Commission, January 2013, ISBN 978 1 84206 475 7, p. 50.

¹³⁸ *Ibid.*

¹³⁹ “Before deciding whether further engagement is necessary and the extent of the exercise, a body subject to the duty should establish what information is already available, such as research, or the results of earlier consultation and engagement exercises, and where the gaps are” – *Ibid.*, p. 51.

¹⁴⁰ *Engagement and the equality duty: A guide for public authorities - England (and non-devolved public authorities in Scotland and Wales)*, Equality and Human Rights Commission, Revised (second) edition, 19 December 2011, p. 6.

9.2 Consideration of seldom heard groups

The TSAs are required to demonstrate that they have observed equality legislation and principles and have operated in accordance with the requirements of the Equality Act 2010 and in particular, the general public sector quality duty (PSED) (section 149)¹⁴¹.

The Steering Group has considered which groups and networks to engage with for the impact assessment, in particular seeking to reach out to those 'seldom heard' groups who may struggle to participate in the general consultation process, or who have characteristics which mean they fall within the scope of the impact assessment process. Based on extensive engagement with local stakeholders and community advocates, the Steering Group has determined that a number of constituencies will be selected for particular engagement to ensure that the impact on them is understood.

Engagement with seldom heard groups will be grounded in the following principles¹⁴²:

- Engagement will be carried out in a way that is inclusive and non-judgemental, and will be positive about the potential of people who use services;
- There will be effective practical arrangements, ensuring access to information, services and debates. Service users will know what is expected of them, what they could expect from participation in a service or event, and what feedback they will receive about the outcomes; and
- Engagement will recognise the expertise of the people using services.

This engagement will be carried out in parallel to the TSAs' public consultation. At this stage, scoping work suggests that the Steering Group will need to ensure that further dialogue takes place with, at least, the following groups:

- Older people, particularly those with chronic disease and/or disability or in a caring role;
- People with a disability and groups which advocate on their behalf;
- People from the highest represented ethnic minority groups, and related community organisations;

¹⁴¹ *Equality Act 2010: Public sector equality duty what do I need to know? A quick start guide for public sector organisations*, Government Equalities Office, June 2011.

¹⁴² P Robson, A Sampson, N Dime, L Hernandez and R Litherland, Op. Cit.

- Members of the LGBT communities;
- Community groups active in areas of high disadvantage within the MSFT catchment area;
- Community groups in isolated towns and villages, particularly where there is a high reliance on public transport; and
- Staff of MSFT who may be affected by the changes and who fall into one of the protected groups, potentially with a dedicated approach to staff on low wages.

In addition to these groups with protected and other characteristics, it may be appropriate to meet with specific service-focused groups, depending on the nature of the recommendations.

10 Work to be undertaken for stages three to five

10.1 Summary of stages three to five

This scoping report has both identified the impact areas that the draft report and recommendations put forward by the TSAs are expected to have on the local population, and characterised this local population in terms of the nine protected characteristics defined in the Equality Act 2010. The next steps are to describe these identified impacts in both qualitative and quantitative terms (including the impact on health outcomes and access respectively) and provide recommendations to the TSAs on how the negative impacts can be minimised and the positive impacts enhanced. As stated in Section 3.1, the next steps cover stages three to five in the health impact assessment methodology:

- Stage 3: Identify impacts with important health outcomes;
- Stage 4: Quantify or describe important Health Impacts; and
- Stage 5: Recommendations to achieve most health gains.

The output from this will be a set of recommendations to the TSAs on how to mitigate the negative impacts, and enhance the positive ones, for the proposed reconfiguration.

10.2 Summary of analysis for the impact assessment

Based on the requirements for stages three to five, it is therefore expected that the following steps will be undertaken:

- Engagement with stakeholders to understand the implications on the identified impact areas arising from the recommendations of the TSAs;
- Engagement with stakeholders to understand the implications of the recommendations of the TSAs for people with protected characteristics;
- Analysis to understand the impacts of the proposed changes to access to healthcare, including travel times;
- Analysis of potential impact for existing staff of MSFT who fall within the scope of the protected groups;
- An extended literature review to provide additional evidence for the impact assessment; and

- Synthesising the above to identify and clarify mitigating actions for negative impacts and developments to strengthen positive impacts.

These steps will form the basis of the analysis that will be presented in the impact assessment report.

