Office of the
Trust Special Administrator
of MSFT

Mid Staffordshire NHS
NHS Foundation Trust

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

Trust Special Administrators' Final Report

Volume Four

The Health and Equality Impact Assessment report

December 2013

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The Health and Equality Impact Assessment report

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Health and Equality Impact Assessment Report

From: Health and Equality Impact Assessment Steering Group

To: the Office of the Trust Special Administrator for Mid Staffordshire NHS Foundation Trust

November 2013

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Glossary

Abbreviation	Meaning
A&E	Accident and Emergency
AHP	Allied Health Professionals
AMRC	Academy of Medical Royal Colleges
APHO	Association of Public Health Observatories
BADS	British Association of Day Surgery
BAME	Black, Asian & Minority Ethnic
BGHS	British General Household Survey
BGS	British Geriatrics Society
BHT/BHFT	Burton Hospital NHS Foundation Trust
BSG	British Society of Geriatricians
CAG	Clinical Advisory Group
CB	Commissioning Board
CCG	Clinical Commissioning Groups
CCN	Community Children's Nursing
CHS	Community Health Service
COPD	Chronic Obstructive Pulmonary Disease
CPT	Contingency Planning Team
CQC	Care Quality Commission
CVD	Cardiovascular Disease
CRG	Clinical Reference Group
DfT	Department for Transport
DH	Department of Health
DGH	District General Hospital
DLA	Disability Living Allowance
DMS	Defence Medical Services
ECS	Engaging Communities Staffordshire
E&D	Equalities and Diversity
ED	Emergency Department
EDCM	Every Disabled Child Matters
ENT	Ear, Nose and Throat
EUCC	Emergency and Urgent Care Centre
EWTD	European Working Time Directive
EPAU	Early Pregnancy Assessment Unit
FEAU	Frail Elderly Assessment Unit
FT	Foundation Trust
GFR	General Fertility Rates

Abbreviation	Meaning
GI	Gastro-Intestinal
GMS	General Medical Services
HCC	Healthcare Commission
HCS	Healthcare Commissioning Services
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
HTCS	Healthcare Travel Costs Scheme
HWB	Health and Wellbeing Board
ICM	Intensive Care Medicine
ICS	Intensive Care Society
ICU	Intensive Care Unit
IMD	Index of Multiple Deprivation
IHT	Inter-Hospital Transfers
LAT	Local Area Team
LFS	Labour Force Survey
LGBT	Lesbian, Gay, Bisexual and Transgender
LHE	Local Health Economy
LSOA	Lower Layer Super Output Area
LSS	Location Specific Services
LTCs	Long-Term Conditions
LTLI	Long-Term Limiting Illness
MAU	Medical Assessment Unit
MIU	Minor Injuries Unit
MLU	Midwife-led Unit
MoD	Ministry of Defense
MoU	Memorandum of Understanding
MSFT / The Trust	Mid Staffordshire NHS Foundation Trust
MTC	Major Trauma Centre
NCAG	National Nursing and Midwifery Advisory Group
NCAT	National Clinical Advisory Team
NCT	National Childbirth Trust
NHS	National Health Service
NOMS	National Offender Management Service
NPPF	National Planning Policy Framework

Abbreviation	Meaning
ONS	Office of National Statistics
PCT	Primary Care Trust
PAU	Paediatric Assessment Unit
PHM	Public Health Medicine
PHS	Public Health Staffordshire
PIU	Paediatric assessment unit
PSED	Public Sector Equality Duty
QC	Queen's Counsel
QOF	Quality and Outcomes Framework
RCM	Royal College of Midwives
RCN	Royal College of Nurses
RCS	Royal College of Surgeons
RCOG	Royal College of Obstetricians and Gynaecologists
RCPCH	Royal College of Paediatric and Child Health
RWT	The Royal Wolverhampton NHS Trust
SaTH	Shrewsbury and Telford Hospitals NHS Trust
SAU	Surgical Assessment Unit
SCBU	Special Care Baby Unit
SME	Subject Matter Experts
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

1. Executive summary

1.1. Purpose, objectives and timing of the impact assessment

Monitor, the national regulator for foundation trusts, has appointed Trust Special Administrators to manage Mid Staffordshire NHS Foundation Trust (MSFT) and develop proposals for the future provision of services at its two hospital sites: Stafford Hospital and Cannock Chase Hospital. The proposals represent significant changes within the definition of the Equality Act 2010, which establishes a general equality duty on public authorities to have due regard to "understand the potential impact of their decisions on people with different protected characteristics" and "identify potential mitigating steps to reduce or remove adverse impacts"[1]. A Steering Group has been engaged to carry out an assessment of the impact of the TSAs' draft recommendations. The assessment has been carried out in two parts[2]:

(i) **The Scoping Report**: understanding the local population and its health status, including prioritising sub-groups within this local population; and

(ii) **The Impact Assessment Report (this document)**: describing (both qualitatively and quantitatively) the impacts of the TSAs' draft recommendations and providing proposals to potentially minimise negative and maximise positive impacts.

1.2. Governance and scope of the impact assessment

The TSAs wished to ensure an objective and independent assessment of Health and Equality Impact. They therefore appointed a chair who is independent both of themselves and of Monitor, and asked her to convene a Steering Group to oversee the impact assessment process. The chair selected members of the Steering Group to bring a balance of professional and technical expertise and stakeholder perspectives, including active participation by patient representatives and members of the public.

The Steering Group has the remit to assess the potential health and equality impact of the TSAs' draft recommendations for the local population of the hospitals, according to guidance set out by HM Government. After assessment (as set out in the Scoping Report), the Steering Group defined the population of impact as the 276,500 people who make up the registered population of the two local clinical commissioning groups of Stafford and Surrounds Clinical Commissioning Group (CCG) and Cannock Chase CCG.

1.3. The in-scope characteristics

The protected characteristics set out in the Equality Act 2010 are: age; disability; gender reassignment; race (this includes ethnic or national origins, colour or nationality); religion or belief (this includes lack of belief); sex (gender): and sexual orientation. The Act also applies

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

[2] *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.

to marriage/civil partnership and pregnancy/maternity but largely for the purposes of preventing discrimination in employment. Based on the nature of the TSAs' recommendations and the local population profile, the Steering Group agreed in the Scoping Report that the focus of the impact assessment for MSFT should be on **age, disability, sex (gender) and race**. The Steering Group also agreed to add two further areas of concern to the list of in-scope characteristics: **socioeconomic deprivation and rural isolation.**

1.4. Assessment of impacts

1.4.1. Overview of the impact assessment process

Monitor has established a strict timescale for the administration process. The health and equality impact assessment has therefore run parallel to the TSAs' development of their draft recommendations, as published in July 2013. Throughout this impact assessment, all mentions of the TSAs' plans for MSFT refer to these draft recommendations, which are subject to change following the public consultation. As not all of the TSAs' draft recommendations were specific, it has not been possible to carry out a detailed analysis of the recommendations relating to either elective and day case services, or to the impact on staff. Any further changes to services arising from the consultation or as otherwise set out in the TSAs' final recommendations to Monitor should also be considered according to the approach set out here.

The TSAs' draft recommendations have prompted concern both across the local community and amongst the MSFT workforce. The Steering Group understands the anxiety that such significant proposals for the local hospital are bound to cause. Based on the qualitative evidence gathered from focus groups, much of this concern has been driven by the perception that all access to hospital services will be affected, including outpatient and elective/day case surgery, which are the services most used by local people. In fact, the TSAs' draft recommendations are centred on the removal of **obstetric delivery (birth), inpatient paediatrics, emergency surgery and level 3 critical care** from Stafford Hospital, together with the establishment of a frail elderly assessment unit (FEAU) there. These are services which most people use only on an occasional basis. Services at Cannock Chase Hospital will broadly remain as they are now, with some potential to extend the range of activity, and there will therefore be a minimal or positive impact for users of that site.

The Steering Group's assessment has focused on the services that the TSAs have recommended removing from Stafford Hospital, and has considered both issues arising from analysis of the data and those voiced as concerns by local people. The Steering Group welcomes the public debate on the proposals, and recognises that the review of services at Stafford Hospital offers the opportunity to develop a blueprint for providing safe and sustainable services for a small district general hospital, which will be relevant to many communities across the country.

1.4.2. Framework for assessment

To fully consider the range of ways in which changes may impact on a community's experience of health care, the Steering Group has looked at the TSAs' draft recommendations in relation to five of the six criteria for quality in healthcare put forward by Maxwell[3] (Table 1.1).

Table 1.1: 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?
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?
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?
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?
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?

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

The first four criteria (effectiveness, acceptability, access and relevance) look at the impacts on the population as a whole. The fifth criterion (equity) is where the Steering Group has specifically considered the impact of the TSAs' draft recommendations in relation to the Equality Act 2010 and the impact on staff. The criterion of efficiency would require a detailed financial analysis, which is outside the scope for this impact assessment.

1.4.3. Effectiveness

The TSAs drew on the advice of a dedicated National Clinical Advisory Group (CAG) of experts to make a judgement on clinical safety and the recruitment/retention implications of any proposed clinical models. The Steering Group has thoroughly debated the question of effectiveness, and concluded that the National CAG is best placed to form this judgement; the Steering Group has therefore largely relied on their advice, focusing its comments on areas where information seemed to be missing or incomplete.

The Steering Group welcomes the proposals to build on MSFT's recent history of developing clinical networks and ensure that in future clinical teams are working as part of extended groups with ready access to wider expertise and infrastructure. The Steering Group would want to see any changes at MSFT supporting the readiness of proposed alternative providers

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

to meet these standards in future, particularly across the range of emergency and urgent services: obstetric delivery, emergency surgery and critical care, and inpatient paediatrics.

Specific concerns have been raised by local people about the safety of patient transport in emergencies where there are longer journeys involved. There will be some longer emergency journeys, following the same pattern as happens now between 10pm and 8am each day when Stafford Hospital's accident and emergency (A&E) department is closed. However, from the evidence it appears that these journeys will be safe and unlikely to lead to poorer outcomes. The Steering Group's analysis indicates that all the journeys are estimated to take less than 40 minutes; this longer travel time is currently experienced in other rural areas within the West Midlands. The West Midlands Ambulance Service (WMAS) has advised the Steering Group that it has the capability to stabilise and safely maintain patients during these journeys. The additional work will require adequate resources to ensure available capacity.

1.4.4. Acceptability

The proposal to retain all current services at Cannock Chase Hospital has been well-received and should have no negative health or equality impacts. However the draft recommendations for Stafford Hospital raise significant concerns about local acceptability. Much of this challenge arises from concerns about future access to services in relation to length and cost of journeys, and the safety of patient transport in emergencies; these issues are discussed in detail in a dedicated section of the impact assessment (Section 10), as well as under 'Access' below.

Other concerns include the risk of disruption to continuity of care, impact on visitors and carers and the status of the local hospital and, by association, the county town. There are specific issues about communication and responsiveness, particularly for people with disabilities. Several similar issues were raised by members of the South Asian community; however in this case there may also be benefits arising from treatment in hospitals with a significant proportion of patients from minority ethnic groups, and associated cultural competence and services.

1.4.5. Access

Extended journey times and the associated costs are the areas that have caused the most concern locally. Some 184,885 of the 276,500 residents of Stafford and Surrounds CCG and Cannock Chase CCG currently have Stafford as their nearest hospital and around 90% of them have access to the site within 20 minutes by private car or ambulance. Inevitably, the reduction in specific services will have a negative access impact particularly on those who live very close to Stafford Hospital, face socioeconomic deprivation, and/or have other barriers to travel.

Travel to access services that will no longer be provided in Stafford Hospital under the TSAs' draft recommendations (obstetric-led birth, inpatient paediatrics, emergency surgery and level 3 critical care) will mostly be by ambulance or car (private car or taxi). This is because

mothers giving birth, children ill enough to require an inpatient stay, or patients requiring emergency surgery or level 3 critical care are not likely to try and travel by public transport.

The TSAs state[4] that MSFT had 400,000 patient contacts ("spells") in 2012/13; this includes all outpatient, day case, Accident and Emergency (A&E), and inpatient spells. As the services affected are largely those for the very ill or for specific events (giving birth), the number of actual *users* impacted is relatively small. From the 184,885 residents who are impacted, it is estimated that approximately 7,000 will be users of services that will no longer be provided in Stafford Hospital under the TSAs' draft recommendations every year; this is about 20 people per day. These users will need to travel further to access alternative hospitals with journey times within 45 minutes by private car or 40 minutes by ambulance.

Approximately 1,830 of the 7,000 impacted users (about five people per day) will have journey times over 30 minutes (but still less than 40 minutes by ambulance and 45 minutes by car); the remaining ca. 5,170 will have journey times less than 30 minutes. Stafford Hospital users already experience these longer travel times when the A&E is closed at night (22:00 to 08:00). Furthermore, the impact on access is not disproportionate on individuals with the in-scope characteristics (i.e. average travel times for individuals with the in-scope characteristics are not longer than those for the general population).

However, the Steering Group recognises that, despite the relatively limited impact of the new travel times, there is public anxiety about travel to non-MSFT sites. This is especially the case where journeys are unfamiliar and/or irregular and involve women in labour, ill children, or older people who could find the journey more difficult. In addition to the anxiety surrounding an unfamiliar journey, there is substantial public concern around both the cost and capacity of car parking at local hospitals. The Steering Group noted that the national Healthcare Travel Costs Scheme (HTCS) and other local arrangements are in place to offset travel costs for those on low incomes, for example if a parent with no access to a car brings a sick child to A&E in a taxi after assessment by a GP. However, any alternative providers should seek to improve current arrangements to address these public concerns (see below).

The most significant impact is on visitors and carers without access to private transport, as this group of people would have to rely upon (often infrequent) bus services, expensive taxis or the help of family and neighbours. The Steering Group notes that, as the number of patients affected by the TSAs' draft recommendations is relatively low, the number of visitors and carers is commensurately small. However, this still means there could be ca. 24,000 visitor journeys associated with the estimated 7,000 patients admitted to more distant hospitals, or 66 journeys per day.

Although Staffordshire has high car ownership rates (82% in the county[5]) and public transport usage rates are low (only 3.3% of the population of Staffordshire commutes to

[4] The Office of the Trust Special Administrator of Mid Staffordshire NHS Foundation Trust, *Trust Special Administrators' Draft Report – Volume One (Main report)*, July 2013, p. 17, para 41.
[5] Office of National Statistics (2011 Census).

work by bus[6]), there will be a segment of the population that is reliant on public transport. The 17% of people who do not own cars are likely to be part of the older population and/or on a low income. Furthermore, there are some areas where relying on friends and family for access to a car is not an option as some communities do not have this level of car ownership. Even for those with access to a car, qualitative evidence highlighted that with older couples, often only one of them is able or confident to drive.

Nationally there is no NHS-funded support for *visitors* travelling to hospital to see patients. Locally there are limited schemes available for all travel (including to hospitals) for people meeting certain eligibility criteria (e.g. concessionary bus travel for older people).

Visitors and carers from some areas in Staffordshire currently have no access or limited access to public transport to visit loved ones in hospital; the TSAs' draft recommendations provide an opportunity to address this need. The impacts of increased travel will fall disproportionately on communities living in socioeconomic deprivation, communities living in rural isolation, and older people. Individuals with more than one of these characteristics will be at particular disadvantage. The Steering Group's proposals therefore seek to mitigate the impacts on the relatively small number of people affected, but for whom the impact is most significant (see Section 1.5).

1.4.6. Relevance

Acute care in England is developing towards the provision of services that is balanced between a concentration of specialist and emergency care into larger hospitals with a full range of facilities which can safely sustain 24/7 delivery[7], and delivery of assessment, rehabilitation and other on-going treatment as close to home as possible[8,9]. The TSAs' draft recommendation to move emergency surgery from MSFT largely reflects this trend. The Steering Group is disappointed that the limitation of the TSAs' focus to hospital services may represent a missed opportunity to do more to support care closer to home, particularly for older people and children, who may face particular anxiety and disruption from a hospital stay that takes them away from family and carers.

The public has expressed particular concern that the TSAs may have underestimated the need for local hospital services, by failing to take sufficient account of housing growth and an increase in military families stationed in the area. The Steering Group has considered all

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[6] Office of National Statistics (2011).

[7] For example: "The College is adamant that the obstetric delivery suite needs fully qualified specialists available at all times, 24 hours a day, 7 days a week – more than half of all births, after all, take place 'out of hours'. That requires the employment of more specialists, which raises the issue of affordability. This, in turn, may well mean fewer acute obstetric units, so that for the more specialised obstetric care, women may have to travel further as the service applies the logic that care should be 'localised where possible, centralised where necessary". Royal College of Obstetricians and Gynaecologists (2012) *Tomorrow's Specialist*.

[8] "Hospital-based centres for acute care services will be supported by the extension of hospital services into the community, developing alongside primary and social care services. These specialised services, currently largely hospital based, will be delivered in or close to the patient's home", *Future hospital: caring for medical patients.* A report from the Future Hospital Commission to the Royal College of Physicians. London: Royal College of Physicians, 2013, p. 58.

[9] "Firstly, for those people with urgent but non-life threatening needs we must provide highly responsive, effective and personalised services outside of hospital. These services should deliver care in or as close to people's homes as possible, minimising disruption and inconvenience for patients and their families". *High quality care for all, now and for future generations: Transforming urgent and emergency care services in England - Urgent and Emergency Care Review End of Phase 1 Report*, NHS England, November 2013, p. 5.

of the general population growth and demographic changes, and investigated the impacts of specific planned local housing growth and the increase in the local population as a result of Armed Forces personnel moving into the area. The Steering Group has concluded that although this growth may seem significant (some 3,000 additional new homes and 420 military families), the services proposed to move from Stafford Hospital are largely emergency and acute and most families will never or rarely use them. The exception to this is obstetrics delivery, where there will be growth in the population of women of child-bearing age, many of whom will have a baby in the next five years. Even in this case, the additional number of births due to these two factors is estimated to be on a range of ca. 80 to 140 per year[10], or less than an additional three per week. The population growth on all three factors is therefore well within the planning assumptions for the TSAs' draft recommendations and there should be adequate capacity to respond to all the service changes that have been proposed.

The Scoping Report's analysis of historic service use at MSFT compared to national benchmarks suggests that some patients have been escalated to a higher level of care, for a longer period of time, than may have been necessary. This is particularly true for decisions to admit relating to children. The TSAs' draft recommendations should mean that overall, local people receive a safer balance of assessment, intervention and advice on how to care at home than has previously been the case. There may be a small number of families who have become very reliant on the hospital-based paediatric service, and who should receive particular support in the transition to the new model of care.

The Steering Group considers that the TSAs' draft recommendations have the potential for a positive impact on the relevance of services by both addressing the over-utilisation of acute services (especially paediatrics) and introducing new services to meet the needs of a growing part of the population (the Frail Elderly Assessment Unit). In order to successfully implement the TSAs' draft recommendations, community services will need to respond to provide interventions and advice to support care at home. The effect on patients if community services are not able to respond is a potential negative impact of the TSAs' draft recommendations. The Steering Group recognises that community services are outside the scope of the TSAs' work (except where they are delivered by MSFT, e.g. community midwifery). Nevertheless, the interface with community services is in scope and properly managing this interface could mitigate the potential negative impacts.

1.4.7. Equity

As noted above, due to the emergency and specialist focus of the services affected by the TSAs' draft recommendations, the overall number of patients impacted is relatively small. This is particularly true at the level of specific protected characteristics (age, sex, disability, and race). However, within the protected characteristics, there are different levels of impact, and older people will be particularly vulnerable to any potential negative impact of the proposals.

[10] Public Health Staffordshire analysis for the Steering Group, based on data communicated by the Head of Armed Forces Health for NHS England.

With respect to age, there is a broadly positive impact on older people as they are majority users of emergency and acute services, and the proposals should improve the overall safety, effectiveness and sustainability of emergency treatment. In addition, the proposals for the Frail Elderly Assessment Unit (FEAU) will create a dedicated facility supporting continued access to local diagnosis and stabilisation. Further clarity is required on both the interface with community care and the model for local step down care to ensure that the (frail) elderly only have to be admitted to a hospital setting when this is clinically appropriate, and are able to return home with support for rehabilitation and convalescence at the earliest safe opportunity.

Also with respect to age, the Steering Group accepts that there is an opportunity to redesign paediatric services to decrease the very high rates of attendances and admissions at MSFT, and that becoming part of a wider clinical network should support this. Parents also need help in understanding where to turn for help in the event of a child being ill (e.g. the '111' service, or local out of hours GP services for assessment and advice), rather than assuming that they have to travel to A&E.

Centralisation of paediatric inpatient services for acutely ill children follows the direction of travel set out in national guidelines for safety and effectiveness[11]. However, there will always be a small group of chronically ill children who require contact with hospital services. As with the FEAU, the Steering Group welcomes the commitment to sustain a Paediatric Assessment Unit (PAU) parallel to A&E at Stafford Hospital, as a means of maintaining local access for a very vulnerable group. However, for those children requiring regular contact or admission at more remote units, providers will need to ensure they have the capacity and processes to respond more flexibly to families who live further away and may need additional help and support, including overnight accommodation.

In relation to sex (gender), the main impact is on maternity services. There is huge disappointment and concern amongst the local community at the proposed loss of obstetric delivery at Stafford Hospital. In future, women will continue to receive antenatal and postnatal care locally, but would have to travel to one of the other four delivery units in the wider area to give birth. Again, the Steering Group understands the logic of the argument about concentration and availability of limited medical expertise into a smaller number of units, with a full range of neonatal support. However, the TSAs' draft recommendations seem to neglect the potential of the Midwifery Led Unit (MLU) at Lichfield as a model or an option, and say little about the arrangements which will be necessary to ensure continuity of care and planning between community midwifery and a more remote delivery unit.

In relation to disability, the Steering Groups considers that the impacts will generally be the same as those experienced by the general population. However, there are specific concerns in relation to access. Qualitative evidence from focus group discussions drew attention to

[11] "Although it may appear desirable for every hospital to have an inpatient paediatric unit, given the finite number of trained paediatric doctors and nurses there is a limit to how many units can be staffed safely. Reconfiguring acute services represents part of the solution. These proposals are made to ensure that our service standards are met and high quality care is delivered for all our children and young people". *Facing the Future: A Review of Paediatric Services*, London: Royal College of Paediatrics and Child Health, April 2011, 0. 16.

the importance of continuity of care and to the availability and resilience of specialist communication services (e.g. for the hard of hearing or those with learning disabilities). There are also issues about availability, siting and cost of disabled parking, and movement around large and confusing hospital sites, to which providers should respond.

The Steering Group considers that, in general, the TSAs' draft recommendations do not have a disproportionate impact on minority ethnic groups. There may be some additional positive impacts. For example, where services are delivered in hospitals that care for a larger number of patients from minority ethnic groups, there is likely to be a broader range of support, greater awareness, and more capacity to respond to specific cultural practices or needs (e.g. interpretation services).

The impacts on the other in-scope characteristics (socioeconomic deprivation and rural isolation) are mostly similar to the impacts on the general population, with the exception of access by public transport for visitors or carers (see the above discussion on access). Although the numbers affected are relatively small, the impact could be significant and will fall on people in these groups who are already facing stressful circumstances.

1.5. Service-specific impact: maternity services

The TSAs' draft recommendations do not propose changes to antenatal and postnatal services at Cannock Chase or Stafford Hospitals. However, there is a recommendation to close the obstetric-led delivery unit at Stafford Hospital, which would mean all women seeking a medically supervised birth would have to go to one of five other units in the surrounding area (at Burton, Stoke, Telford[12], Walsall, or Wolverhampton) or could choose a midwife supported birth in the MLU at Lichfield. The TSAs' draft recommendations therefore have an impact on women of child-bearing age (15 to 44); this relates to two of the in-scope protected characteristics: age and sex.

The public has expressed particular concern at the loss of the choice of giving birth in their local hospital. Although about a quarter of women from Stafford Hospital's catchment area already choose to go elsewhere to give birth, there is significant concern about travelling to alternative hospitals during labour. WMAS is confident that safe transport arrangements will be put in place, although these may need to be reinforced to manage any additional volume arising if more women in labour have to rely on ambulance transport to a more distant hospital site. Midwives will need to ensure that women and their birthing partners consider travel to hospital as part of their birth plans, and women (or their partners) make themselves familiar with the hospital site and route if using private transport. The proposals do little to take forward *Changing Childbirth*[13] and other national policy, which emphasises choice in style and site of delivery. Commissioners should ensure that they explore wider opportunities arising from any changes to increase awareness of local alternatives, including

[12] The consultant-led unit in Telford will open in summer 2014 (source: http://www.sath.nhs.uk/Future/Womens_Services.aspx).

[13] Department of Health (1993) *Changing Childbirth*. Report of the Expert Maternity Group (Cumberlege Report). HMSO: London.

the Midwifery Led Unit at Lichfield and home birth, for the majority of healthy women who can give birth with a minimum of medical procedures[14].

The Steering Group recognises the financial limitations facing the TSAs and the importance of finding a sustainable solution for MSFT. The obstetric proposals place strong emphasis on the importance of national standards and guidelines to drive improvements in the safety and sustainability of maternity care. The Steering Group is concerned that these changes will only be valuable where alternative local providers are able to meet those national standards as a result of reconfiguring the current maternity workforce at Stafford Hospital. It is also essential that changes to obstetric activity are matched by investment in other associated services, including neonatal care and the ambulance service.

The Steering Group further believes that it is essential that alternative providers of obstetric-led care ensure the provision of a robust community midwifery service available through local sites. This service should support continuity of care, clear birth planning, and exercise of choice in style and site of birth; it will also need to have the capacity and skills to undertake assessment in labour, and provide active support.

Although local people have been concerned about capacity to support hospital births if the unit at Stafford Hospital closes, the Steering Group is satisfied that the TSAs' draft recommendations do adequately reflect local population growth and expected birth rates. However, commissioners should assure themselves of the capacity available across the range of alternative sites, particularly in neonatal support, including the provision of routine post-birth paediatric assessment.

1.6. Service-specific impact: paediatric services

There a range of positive health impacts which should arise from the draft recommendation to concentrate paediatric inpatient services within a wider clinical network and on sites with more specialist support. This is consistent with national trends[15] and should support effectiveness, safety and the right range of services being available to the small number of children requiring frequent or regular contact with paediatric services. The retention of a Paediatric Assessment Unit (PAU) on site at Stafford Hospital opening at the same hours as A&E, together with input from the paediatric team at the relevant Paediatric Inpatient Units (PIUs), will maintain local access to urgent specialist assessment between 08:00 and 22:00. The transition to a clinical network should encourage care as close to home as possible, and therefore minimise the number of children who experience the anxiety and disruption of 24 hour medical supervision due to requiring inpatient care.

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[14] *Maternity Care Working Party. Making normal birth a reality. Consensus statement from the Maternity Care Working Party: our shared views about the need to recognise, facilitate and audit normal birth*. National Childbirth Trust; Royal College of Midwives; Royal College of Obstetricians and Gynaecologists; 2007.

[15] "We recognise that effective networks involve clinicians working across individual primary care trust and hospital trust boundaries. These arrangements should be made explicit, and enabled further through discussions between service providers and relevant service commissioners. Centres providing specialised paediatric services must have a sufficient volume of specialised paediatric care to ensure that they can provide sustainable and comprehensive support services. Reconfiguration of specialised paediatric services should take into account the needs of children of all ages". *Commissioning Safe and Sustainable Specialised Paediatric Services-A Framework of Critical Inter-Dependencies*. London: Department of Health, August 2008, p. 16.

There has been a history of very high levels of admission and recall at the MSFT paediatric unit; 12.9% of MSFT admissions were for the age group 0-14, compared with 11.4% nationally[16]. There will be families, well known to the service, who may need extra support and advice during the transition to a new model. It is clear from the comments in focus groups and public meetings that current arrangements for urgent care and advice are confusing and that parents have been resorting to A&E as their default option when a child is sick, as they know when it is open and where it is. This has then increased concerns about access to paediatric care if inpatient services move out of Stafford Hospital. Commissioners and GPs should be more proactive in advising the public about the use of 111 for immediate advice over the telephone or primary care (in and out of hours) for medical assessment close to home. Where a parent is concerned that their child is seriously ill, 999 will result in a paramedic attending, who will be able to provide immediate assessment and stabilisation, and ensure safe transportation by ambulance to a fully equipped specialist unit. No seriously ill child will have to rely on public transport to access hospital care.

Although a significant proportion of paediatric admissions in England consists of children with minor illness or injury[17], there is a small group of children who do need regular contact with inpatient services. The Steering Group is concerned about the lack of emphasis on the interface between hospital and community services for chronically and seriously ill children, and the possible disruption to the care pathway between local primary/community services and a remote acute paediatric team. There is also an increased risk of missing signs of children at risk of neglect or abuse where a variety of teams are involved in the care of the child; the development of an effective clinical network across community and hospital services will be vital to minimise this safeguarding risk.

The Steering Group is concerned that the small number of families with a child requiring frequent or an extended admission, which do not have access to private transport, will need active support to maintain contact during a stay and minimise costs to the family. Providers should ensure adequate capacity for parents to stay with their child, and arrangements that are flexible enough to respond to families who may need to travel some distance to visit.

1.7. Service-specific impact: emergency, urgent and critical care services

The changes to emergency, urgent and critical care (EUCC) services will have an impact on the general population whose closest site is Stafford Hospital and could have an additional impact on individuals with protected characteristics (particularly the elderly and those with disabilities) or facing socioeconomic deprivation or rural isolation.

The TSAs' draft recommendations contain a commitment to retain Accident and Emergency (A&E) services at Stafford Hospital and the Minor Injuries Unit (MIU) at Cannock Chase Hospital. As with other proposals, the Steering Group welcomes the extension of a clinical network approach and the opportunity this offers of more sustainable and safer services.

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[16] The Office of the Trust Special Administrator of Mid Staffordshire NHS Foundation Trust, *Trust Special Administrators' Draft Report – Volume One (Main report)*, July 2013, p. 127, para 416.

[17] It is estimated that 20–25% of the UK child population receives treatment annually in A&E departments. A significant proportion of this workload consists of children with minor illness or injury. Phillips BM, Robson WJ. Paediatrics in the accident and emergency department. *Arch Dis Child* 1992; 67:560–4.

The service changes proposed all relate to emergency and other care of the critically ill, and patients will primarily be accessing these services by ambulance conveyance, either to or between hospitals. Whilst most patient transport will be arranged by the NHS, there could be a significant burden on visitors and carers of older people who are admitted to a more remote hospital and who may be dependent on friends, relatives or public transport to maintain contact with their loved ones.

The Steering Group welcomes the dedicated focus on care of the elderly offered by the proposal for a Frail Elderly Assessment Unit (FEAU) and the commitment to develop step down arrangements, which will support the transfer of older people back from more remote hospitals into Stafford as they become medically stable. The Steering Group is concerned that: (i) the model of care makes no comment on the interface with community services, which are vital to the experience and recovery of older people; and (ii) the focus on hospital care may encourage the tendency to rely on hospital beds when people (particularly if confused) may be better off at home with the appropriate support. In particular, the Steering Group would be concerned that multiple moves are associated with increased mortality in the elderly[18], and that commissioners should track the impact and outcomes of the new model of care if it is introduced.

In relation to emergency surgery and the level 3 critical care service at Stafford Hospital, the Steering Group notes that the National Clinical Advisory Group (CAG) views this service as unsustainable due to low volumes, previous concerns raised by the Royal College of Surgeons[19], and evidence that supports the drive towards centralisation of these services[20]. The potential safety benefits of concentrating critical care into a larger unit will rely on ensuring that there is the right capability at Stafford Hospital to intervene during a surgical or medical emergency (including intubation and respiratory support) and stabilise for transfer, and the right capacity at other sites to receive patients. Although there are public concerns about the risks of transferring critically ill patients, the evidence on transfer was reassuring. The most important time factor in critical care is to stabilise rapidly, and the patient can then be moved to the best site for on-going specialist care. The West Midlands Ambulance Service (WMAS) has confirmed that inter-hospital transfers for level 3 critical care are already common across the region and paramedics are trained for stabilisation and transfers.

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[18] For example, Mikhail ML. (1992) Psychological responses to relocation to a nursing home, *Journal Gerontol Nurs*; McKinney AA, Melby V (2002) Relocation stress in critical care: a review of the literature, *J Clin Nurs*; and Nicholas G. Castle, *Relocation of the Elderly*, Institute for Health, Health Care Policy and Aging Research.

[19] Although this review has not been published, it was reported to the public inquiry chaired by Robert Francis QC. http://www.midstaffsinquiry.com/assets/docs/Inquiry_Report-Vol1.pdf.

[20] For example, "Surgery has become much more specialised and …[m]any surgical specialties have already split away and now run their own rotas…This creates major problems for small and medium-sized acute Trusts where it is not possible to employ sufficient numbers of each type of surgeon to provide a viable rota, particularly if, as is desirable, a consultant-delivered service is to be organised. Mid-Staffordshire Foundation Trust is one such example". *Mid Staffordshire NHS Foundation Trust: A review of the procedures for emergency admissions and treatment, and progress against the recommendation of the March Healthcare Commission report*, 29 April 2009 (The "Alberti report").

1.8. Service-specific impact: elective and day case services

The TSAs have confirmed that the current range of elective and day case activity delivered at Cannock Chase Hospital will be maintained, and that there may be opportunities to extend the range and volume of local activity. Stafford Hospital will continue to offer a range of elective and day case work but the TSAs propose to reduce the range of specialties and activity. At the time of publication of their draft recommendations, the TSAs did not specify which specialities or procedures would be affected. It has therefore proved difficult for the Steering Group to assess the impact. The draft recommendation to maintain and, if possible, to enhance day cases (surgical and medical) is likely to have a positive impact on access. Again, to optimise the benefits, the Steering Group would have liked to see some reference to the interface with community services, particularly in relation to the potential for early supported discharge.

The Steering Group notes that the proposal to maintain activity at Cannock Chase Hospital has been positively received and will largely maintain the current situation. The Steering Group would like reassurance that there is a commitment to sustaining the historically more specialist outpatient and day case activity that has previously been available locally, possibly through other providers.

1.9. Impact of the draft recommendations on staff

It has not been possible to carry out a detailed analysis of the impact for staff. All the current staff at MSFT will be impacted by the TSAs' draft recommendations, through the dissolution of the Trust and/or by the changes in services provided at Stafford Hospital (the current services at Cannock Chase Hospital are not affected). It is likely that any negative impacts would affect those on low pay or with limited qualifications the most. Evidence from a focus group suggests that the three main concerns for staff are: pay and conditions; communications; and travel/access, including the impact of extended travel times on current child-care arrangements.

Pay and condition changes would primarily impact support services or administrative staff, were they to transfer under future arrangements to non-NHS employers. Any alternative provider would be bound by Transfer of Undertakings (Protection of Employment) Regulations 1981 (TUPE) and other employment legislation. The workforce at MSFT has been facing significant uncertainty and this will remain until the Secretary of State for Health makes a decision on the future of the organisation and/or the proposals for specific services. Staff would welcome early and frank communication from the TSAs about their future and emerging arrangements. They are particularly concerned about the future impact of working across multiple sites over greater distances, and the Steering Group highlights an early review of staff travel plans by provider organisations as a priority once future arrangements are confirmed. In particular these should consider multiple-site parking permits, car-pooling or other arrangements for travel between sites.

1.10. Mitigating proposals

The Steering Group has identified a range of proposals that could mitigate the risks associated with some elements of the TSAs' draft recommendations and/or reinforce the potential positive outcomes. More detailed proposals relevant to each service area (e.g. maternity and paediatrics) are given in the relevant sections.

1. Meeting national clinical standards and guidelines

The TSAs' draft recommendations are based on discussions with the National CAG, which have placed a high value on rationalising services at MSFT in order to promote compliance with a variety of national standards and guidelines. In particular, this consideration has had a significant impact on the draft recommendations to concentrate obstetric expertise outside of MSFT, move paediatric inpatients off-site, and stop emergency surgery and level 3 critical care. It is therefore essential that, if positive health impacts are to be realised, these changes facilitate alternative local providers in meeting the relevant national standards.

2. Enhancing the interface with community services

Further work needs to be done on the interface between hospital services and community services. The TSAs should be more explicit about how this interface will be developed to ensure that as much care as possible is delivered closer to (or at) home, especially for the elderly and children. The TSAs and local providers should consider how the development of clinical networks to support the future delivery of many of the services covered by the draft recommendations can include community clinicians. In particular, assertive management within the clinical network should seek to minimise disruption to the lives of children living with disabilities or chronic conditions, including optimising the development of community support as an alternative to hospital contact. Commissioners may wish to consider how they can adjust the balance of investment to support alternatives to hospital care where appropriate.

3. Capacity and capability in alternative provision

Many of the TSAs' draft recommendations entail a transfer of activity to alternative providers in order to deliver improved health outcomes and a more sustainable local health economy. If these benefits are to be realised, it will be essential that these alternative providers have both the capability and the capacity to cope with this additional activity. Particular concern has been expressed throughout this process about whether UHNS will be able to meet the scale of this challenge in a range of the specialities affected, including paediatrics and critical care.

The TSAs' draft recommendations are predicated on a model in which patients will be either taken to more remote units (involving longer ambulance journeys than at present), or stabilised and transferred between units (involving more ambulance journeys). WMAS has demonstrated elsewhere in the region that is has the skills to undertake this work safely. However, it will be essential that commissioners consider what level of investment is

required to ensure that the service also has the capacity to maintain current standards of response.

4. Aligning 'front door' activity

The public response to the proposals has revealed genuine confusion about first response services, and how to access advice and assessment for acute illness. Commissioners will want to work with primary care to ensure that GPs proactively support their patients in making best use of 'front door' services, particularly in educating those with a history of using A&E for minor and self-limiting conditions; A&E colleagues should reinforce these messages.

The paediatrics team will need to work closely with those families with a history of regular contact and admission to support them through the transition to any new model of service.

It will be essential that the hospital emergency and urgent care services are aligned with A&E. The Early Pregnancy Assessment Unit (EPAU) proposed for Stafford Hospital should operate at the same hours as A&E and with shared protocols (in a similar way to the draft recommendation for the Paediatric Assessment Unit (PAU)). There must be clear arrangements in place, visible to primary care and the ambulance service, for alternative arrangements for both the PAU and EPAU services between 22.00 and 8.00 each day.

5. Maintaining continuity of care

There is public concern about potential compromise to continuity of care given that the TSAs' draft recommendations introduce a division between specific outpatient and hospital inpatient services. This should be addressed through the clinical network process but requires additional attention to communications across sites, between different clinical teams, and at the interface with community services. This is true particularly for:

- Arrangements for community midwifery, choice of site and style of delivery, planning travel to hospital, and advice and assessment during onset of labour;
- Paediatric services relating to chronic care and the exacerbation of chronic conditions, and/or where there are safeguarding concerns;
- People in need of specialist communications support; and
- Those with multiple conditions.

6. Safety of patient transport over longer distances

The evidence from research and the experience of WMAS elsewhere in the region suggests that whilst journey times will be extended, they should be safe. What will be critical is having the capability, both with paramedics and on site in the local hospitals, to intervene (including intubation and respiratory support) and stabilise for transfer.

There will need to be increased capacity to support the transfer of patients, and this will potentially include additional activity for neonatal transfer.

7. Carer, staff and visitor journeys

The Steering Group considers that the greatest potential negative impact arising from the TSAs' draft recommendations is the effect on carers and visitors of extended journeys to more remote hospitals to visit inpatients. The Steering Group proposes that the TSAs work with alternative providers of services to actively review:

- Extended financial support to facilitate travel for the small number of visitors who are most in need. To ensure viability, this scheme should be by exception only and cover different modes of travel including taxi and private car; however, providers need to promote this scheme to ensure public awareness and design it for simplicity of use;
- The application and awareness of the national Healthcare Travel Costs Scheme;
- Capacity and availability of car parking and arrangements for charging, including multi-site permits and multi-day passes;
- The scale, siting (proximity to the hospital) and charging for disabled parking;
- Support for Voluntary Transport Schemes (VTS) to ensure their continued existence. Additionally, there may be new areas that could benefit from such schemes and communities in those areas should be offered assistance in setting them up if there is interest; and
- Signage and seating which would help with negotiating unfamiliar and larger sites.

The workforce has highlighted the arrangements for travel, both to and from work and across multiple sites, as a source of significant concern. All providers have staff transport policies, and as implementation proposals become clearer, the host employers should review and develop these. There are opportunities for initiatives which could limit the negative impact on staff including multi-site parking permits, car-pooling, designated 'in-transit' parking, or the extension of 'shuttle bus' schemes.

8. Infrastructure to support carers and families in more distant hospitals

Hospitals already make arrangements to support parents visiting young children, but their capacity should be reviewed to ensure that they are able to cope with greater numbers of families living at longer distances from the site. They may need to extend onsite family accommodation, or consider how to support parents to stay locally.

The Steering Group recognises the challenge of limiting local hospitals' visiting hours to optimise treatment time, and minimise tiring of patients and the risk of infection. However, the TSAs and alternative providers may want to consider how to respond flexibly to carers and parents living at a distance to support contact and recovery (particularly where they are dependent on infrequent public transport services).

9. Range of services

The Steering Group is concerned that limiting the scope of the TSAs' remit to the current hospital services has limited the extent to which they can explore appropriate alternatives to the current hospital provision. The discussion of obstetric care pays little attention to national policy on extending choice of site and style in childbirth. In particular, the TSAs should reconsider their analysis of a midwifery-led unit (MLU) at Stafford Hospital to take into account the experience of the MLU at Lichfield. For emergency surgery, the Steering Group proposes that the TSAs work with commissioners to develop the step down model and ensure that resources are targeted where they will deliver most benefit for older people.

The limits placed on the TSAs have driven relatively traditional proposals, during a period of significant change, where there is the opportunity to develop thinking of national significance on the future role of the district general hospital. This has no doubt supported constructive debate about service effectiveness, but potentially at the expense of access, relevance and responsiveness. Commissioners will have the opportunity to further consider how the spirit of these proposals could be reflected in implementation, with the aim of delivering more care closer to home.

10. Engagement with public and staff

The TSA process, coming after several years of high profile investigations into the failings in local services, has generated enormous local interest and debate. The Steering Group has experienced exceptionally generous participation by local people, and this has been reflected in its focus group discussions and participation in public meetings. There is real local energy and interest in being involved in shaping the future of health services; the Steering Group would urge commissioners and future providers to encourage this and actively engage with members of the public and particular interest groups as they move towards implementation.

The workforce has indicated that, once the Secretary of State for Health has made a decision about the future arrangements, this is clearly communicated and the local health system moves quickly to end uncertainty and take action in response. Where the process of implementation is itself experienced as engaging and empowering of staff and patients (of all ages), this will itself provide a positive health impact.

11. Monitoring the impact of the TSAs' recommendations

There is genuine public anxiety around safety and capacity issues arising from the TSAs' draft recommendations. The Steering Group suggests that commissioners should agree a set of metrics with all future providers, aligned with the TSAs' final recommendations to Monitor, which addresses the areas of public (and staff) concern. These metrics should be published and measured regularly to provide on-going reassurance that the proposals have realised their intended benefits and that potential risk has not translated into negative consequences.

2. Introduction and context

2.1. Purpose and objectives of the impact assessment

On 16th April 2013 Monitor appointed Joint Trust Special Administrators (TSAs) for Mid Staffordshire NHS Foundation Trust (MSFT) under the National Health Service (NHS) Act 2006, as amended by the Health and Social Care Act 2012. Monitor has engaged a Steering Group to carry out an impact assessment of the TSAs' draft recommendations. This impact assessment has looked at how the recommendations could have health and equality impacts for the local population, drawing on public health information, previous NHS activity and the perspectives of local people.

2.1.1. Purpose of the impact assessment

The purpose of impact assessments has been articulated by different levels of government (e.g. HM Government[21] (HMG) and the Department of Health[22] (DH); further details are given in the Scoping Report). For MSFT, the impact assessment is to support the TSAs in fulfilling Monitor's guidance that throughout its work, an Administrator 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) and the public sector duty. The equality assessment should apply to patients, public and staff"[23].

2.1.2. The Equality Act 2010 and the public sector equality duty

The Equality Act 2010 protects people on the basis of 'protected characteristics'. The equality duty covers the protected characteristics[24] that are set out in Table 2.1[25]:

Table 2.1: Definition of protected characteristics

Protected characteristic	Definition
Age	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, including children and young people.
Sex	Someone being a man or a woman.
Disability	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.
Race	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.

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

[22] *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.

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

[24] *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.

[25] 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.

Protected characteristic	Definition
Sexual orientation	This is whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes.
Pregnancy and maternity	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.
Gender reassignment	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	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).
Religion or belief	Religion means any religion, including a reference to a lack of religion. Belief includes religious and philosophical beliefs including lack of belief.

Source: Equality Act 2010 Technical Guidance on the Public Sector Equality Duty England

For marriage and civil partnership, the protection extends "in respect of the requirement to have due regard to the need to eliminate discrimination"[26].

2.1.3. Objectives of the impact assessment

Based on the relevant guidance, the objectives of the impact assessment are to:

- Understand the impact of the TSAs' draft recommendations on the health of the local population;
- Assess the impact 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 can pay 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 any negative impact and reinforce potential positive impacts.

The assessment is being carried out in two parts, based on the Department of Health's guide to carrying out an impact assessment[27]:

[26] Ibid.

[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.

(i) **The Scoping Report**: understanding the local population and its health status; understanding and prioritising sub-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 recommendations of the TSAs; and

(ii) **The Impact Assessment Report (this document)**: 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 Steering Group has only been able to consider the possible impacts of proposals where there is a level of detail which supports its analysis. Given that some draft recommendations are more detailed than others, there is correspondingly greater commentary on those in this Impact Assessment Report. As the future arrangements for management and hosting of services remain uncertain, it has been particularly difficult to provide a detailed analysis of the impact for staff. Many MSFT staff live locally and will therefore share a level of impact with the general population. The Steering Group has made some specific comments about the impact on staff as employees in Section 5.10.

2.1.4. Governance of the impact assessment

The TSAs wished to ensure an objective and independent assessment of the health and equality impact. They therefore appointed a chair who is independent both of themselves and of Monitor, and asked her to convene a Steering Group to oversee the impact assessment process.

The chair selected members of the Steering Group to bring a balance of professional and technical expertise and stakeholder perspectives, including active participation by patient representatives and members of the public. The full membership of the Steering Group is shown in the table below.

Table 2.2: Members of the HEIA Steering Group

Role	Name	Organisation	Position
Independent Chair	Sophia Christie	Independent Consultant	Director, UKPrime
Patient, Carer and Public representatives	Jan Sensier	Engaging Communities Staffordshire	Chief Executive
	[*]	CCG District PPG	Public and patient representative
	[*]	CCG District PPG	Public and patient representative
	[*]	N/A	Public and patient representative
	[*]	N/A	Public and patient representative

Role	Name	Organisation	Position
Public Health representatives	Prof Aliko Ahmed, represented by Lucy Heath (consultant in Public Health)	Staffordshire County Council	Director of Public Health
Adult and children's care	Martin Samuels	Staffordshire County Council	Commissioner for Care
Local CCGs	Andrew Donald (represented by Alexandra Bennett, head of commissioning at Stafford & Surrounds CCG Cannock Chase CCG)	Stafford & Surrounds CCG Cannock Chase CCG	CCG Chief Officer
	Jonathan Bletcher	Stafford & Surrounds CCG Cannock Chase CCG	Public Health Lead
Specialised commissioning	Stephen Washbourne	NHS England	Head of Specialised Commissioning (West Midlands)
Transportation	Clive Thomson	Staffordshire County Council	Commissioner for Transport and 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 Steering Group in their personal capacity rather than as professionals providing subject matter expertise. Of the five patient, carer and public representatives, four were able to attend the majority of meetings. The fifth representative was unable to attend all meetings; however the Steering Group drawn upon a range of knowledge and insights from a range of subject matter experts who attended meetings and reviewed papers.

2.2. Structure of the impact assessment report

The remainder of this Scoping Report is structured as follows:

- **Section 3 – Process and methodology for the impact assessment**: this section provides a brief description of the process and methodology used for the impact assessment.
- **Section 4 – Summary of the Scoping Report and approach**: this section summarises the key points from the Scoping Report and the approach to the in-scope characteristics.
- **Section 5 – Summary of the impacts on the in-scope characteristics and staff**: this section summarises the key impacts on people sharing the in-scope characteristics. It also provides a high-level summary for the impact on staff as a result of the TSAs' draft recommendations.
- **Section 6 – Impact of the TSAs' draft recommendations on maternity services**: this section describes the potential impacts as a result of the TSAs' draft recommendations relating to maternity services, and the mitigating proposals.

- **Section 7 – Impact of the TSAs' draft recommendations on paediatric services**: this section describes the potential impacts as a result of the TSAs' draft recommendations relating to paediatric services, and the mitigating proposals.
- **Section 8 – Impact of the TSAs' draft recommendations on emergency, urgent, and critical care services**: this section describes the potential impacts as a result of the TSAs' draft recommendations relating to emergency, urgent, and critical care services, and the mitigating proposals.
- **Section 9 – Impact of the TSAs' draft recommendations on elective services and day cases:** this section describes the potential impacts as a result of the TSAs' draft recommendations relating to day case and elective services, and the mitigating proposals.
- **Section 10 – Access and travel**: this section describes the travel and transport impacts in relation to patients, visitors and staff, and the potential costs of these impacts. The section then presents the mitigating proposals relating to travel.
- **Section 11 – Summary of proposals and next steps**: this section summarises the Steering Group's proposals and provides a brief overview of next steps.
- **Appendix A – Additional information on service impacts**: This appendix provides additional information on the impacted services (obstetrics, inpatient paediatrics, and emergency, urgent and critical care).
- **Appendix B – Travel times methodology**: This appendix summarises the travel times approach, methodology and assumptions used for the impact assessment.
- **Appendix C – Qualitative evidence summary**: This appendix presents the qualitative evidence collected by the Steering Group and is made up of: (a) the report summarising the qualitative evidence gathered from focus group and one-on-one interviews; and (b) a summary of the meetings and focus groups held with local subject matter experts.
- **Appendix D – Memoranda to the TSAs**: This appendix shows the memoranda sent by the Steering Group to the Office of the TSA during the course of its work.

3. Impact assessment process and methodology

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 has therefore been carried out in parallel with the process that the TSAs have undertaken to develop their recommendations, and the subsequent public consultation on these.

The Steering Group considers that the very tight timescale of the TSA process does not really allow for any "early" assessment of impact. The chair was appointed within 18 days of identifying the need for impact assessment, and the group met for the first time within eight days of the chair's appointment. The Steering Group has still had to work in parallel to the TSAs' process, such that the assessment process has been simultaneous to the public consultation. However, the Steering Group has provided feedback on the impact assessment to the TSAs via a series of memoranda that can be found in Appendix D.

3.1. Overview of the impact assessment process

The impact assessment process is based on DH's guidance for conducting health impact assessments (HIAs) and has incorporated the statutory equality impact requirements. This guidance recommends a five stage process:

Table 3.1: Summary of the DH's HIA process

Stage	Description
Stage 1: Screening	• Screening questions are used to decide whether to proceed to further stages
Stage 2: Identify health impacts	• 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	• 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	• 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

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

Stage	Description
Stage 5: Recommendations to achieve most health gains	• 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.*

The Scoping Report covered stages one and two (including a consideration of equality impact within the terms of the Equalities Act 2010), and parts of stage three; this Impact Assessment Report covers stages three to five. To undertake the stages covered in the Scoping Report, the following steps were undertaken:

- An initial analysis of the local population and its health status;
- Further analysis of the local population based on a variety of data sets 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 (i.e. this Impact Assessment Report), the following steps were undertaken:

- Further work on the above, in light of the specific TSA draft recommendations for consultation;
- Engagement with stakeholders to understand the implications on the identified impact areas arising from the TSAs' draft recommendations;
- Engagement with stakeholders to understand the implications of the TSAs' draft recommendations for people with protected and other 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;
- An extended literature review to provide additional evidence for the impact assessment; and

- Synthesising the above to identify the main areas of potential impact, and possible mitigating actions for negative impacts and areas which could strengthen positive impacts.

3.2. Overview of the methodology

The analysis for stages three to five used both quantitative and qualitative methods to assess the potential impacts of the TSAs' draft recommendations. Quantitative approaches drew on analysis of a wide range of demographic, epidemiological and hospital activity information. The public have expressed particular concern about the impact of the proposals on longer and more expensive journeys for patients and visitors and there is therefore a specific discussion of the methodology used in the quantitative analysis of travel time in that section of this report (Section 10), with further details provided in Appendix B. The Scoping Report set out a wide range of information that formed the basis of the approach used here.

For this Impact Assessment Report, the Steering Group also drew on:

1. A review of the literature for each area (maternity; paediatrics; emergency, urgent and critical care; and elective and day case services). This review discussed and adopted the safety and effectiveness assessments of the National Clinical Advisory Group (CAG) (see below);
2. Attendance at the TSAs' public meetings to understand the concerns and issues raised by members of the public;
3. Focus groups and interviews held with selected members of the public with the in-scope characteristics that are the focus of the equality impact assessment; and
4. Focus groups and interviews held with subject matter experts.

Various members of the Steering Group were present at almost all of the TSAs' public meetings and used this as an opportunity to listen to the concerns and issues expressed by members of the public. These members of the Steering Group also took this opportunity for more focused conversations with individual members of the public. The Steering Group gained important insights into the perceptions and concerns of local people through this process, which have informed its discussions and conclusions.

The Steering Group retained Engaging Communities Staffordshire (ECS) to carry out the workshops and analysis for the focus groups with members of the public. The focus groups used the standard methodology of a small group (usually not more than 12 people, to enable full participation and discussion by all[29]) responding to a core set of themes or questions. The focus groups and interviews sought to complement the perspectives of the general public, as expressed in the large public meetings and through the consultation responses, with the experience and perceptions of 'at risk' groups. The Steering Group

[29] The recommended number of people per group is usually six to ten (MacIntosh 1993), but some researchers have used up to fifteen people (Goss & Leinbach 1996) or as few as four (Kitzinger 1995). MacIntosh J. (1981) 'Focus groups in distance nursing education', Journal of Advanced Nursing 18: 1981-85. Goss J.D., Leinbach T.R. (1996) 'Focus groups as alternative research practice', Area 28 (2): 115-23. Kitzinger J. (1995) 'Introducing focus groups', British Medical Journal 311: 299-302. Taken from Social Research Update, Winter 1997, University of Surrey (http://sru.soc.surrey.ac.uk/SRU19.html, accessed 3rd June 2013).

concentrated on two of the main in-scope characteristics, age and disability, and also sought to understand the perspectives of women with recent experience of using maternity services, families living on low incomes, and people from local minority ethnic groups. More detailed information on the approach to the focus groups, including the meetings and interviews held, is given in Appendix C.

ECS is a not for profit community interest company set up to represent the people of Staffordshire particularly on health and social services in the county. It holds the contract to run Healthwatch Staffordshire and in that capacity, ECS had a place on the Health and Equality Impact Assessment Steering Group (HEIA SG or Steering Group) through which it worked to ensure that the public perspective is heard. It also supported public engagement through the work of its Insight Officer, who worked with Staffordshire County Council's Public Health team to provide intelligence and analysis to the Steering Group. In addition, as Healthwatch, ECS has also provided the independent chairmanship to the TSAs' own public meetings, and advised on their consultation processes.

Where there were specific areas of concern discussed within the Steering Group, or on which the HEIA SG felt the need for more detailed information, the group was grateful for the opportunity to meet with subject matter experts. The Steering Group also supplemented the focus group discussions with a series of in-depth interviews with individuals who represented a particular at-risk or in-scope group to seek further insight into their concerns and explore the possible impact of the TSAs' draft recommendations.

Where possible, the impacts were assessed at two levels: firstly at the level of the general population; and secondly at the level of the in-scope characteristics. In order to ensure a holistic approach, the impacts were considered under a number of dimensions (the "Maxwell criteria", described below). The potential impacts found through this analysis were used to inform the proposals to mitigate the potential negative impacts and enhance potential positive ones.

3.2.1. A holistic assessment of impact

The Steering Group was very concerned to ensure that it paid attention to the range of ways changes to local health services may have an impact on local people. As discussed in the Scoping Report, the Steering Group drew on the well-established framework devised by Maxwell[30] to understand the qualitative and quantitative evidence gathered. 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. They are each important markers in their own right, and are often in tension with each other; for example, improvements in effectiveness may reduce locality, or increasing access to a service may reduce relevance if people start to present with self-limiting or very minor illness.

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

Table 2.2: 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?
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?
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?
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?
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?

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

The Scoping Report describes each of these areas in more detail. The first four criteria (effectiveness, acceptability, access and relevance) look at the impacts on the population as a whole. The fifth criterion (equity) is where the Steering Group has specifically considered the impact of the TSAs' draft recommendations in relation to the Equality Act 2010 and the impact on staff. The criterion of efficiency is out of scope for the impact assessment as it is for the TSAs to evaluate financial sustainability.

The TSA process has been set in train by Monitor to respond to the financial situation at Mid Staffordshire NHS Foundation Trust (MSFT). The TSAs have focused most on two aspects of health care quality: effectiveness and efficiency. They sought to enhance the clinical assessment of their draft recommendations through a National Clinical Advisory Group (CAG), made up of senior doctors, which provided advice on the extent to which potential clinical models[31]:

- Can be delivered safely;
- Can move services to be more closely aligned with Royal College guidelines;
- Could potentially impact the local health economy; and
- Can support the recruitment and retention of key clinical staff.

A National Nursing and Midwifery Advisory Group extended the range and scope of relevant professional advice parallel to the NCAG. This group also comprised senior representatives from the professional bodies and Trusts nationally. A local Clinical Reference Group drawn from providers within the Mid Staffordshire health economy further supplemented this advice.

[31] Trust Special Administrators' Draft Report – Volume One (Main Report, The Office of the Trust Special Administrators of Mid-Staffordshire NHS Foundation Trust, July 2013, p.g. 67)

The Steering Group had wide ranging discussion about various aspects of safety and effectiveness arising from the TSAs' proposals, many of which are reflected here. However, the Steering Group has relied on the core assessments reached by these national groups as representing current professional consensus on best practice, and providing a level of technical insight the Steering Group cannot replicate. The Steering Group's challenges on safety and effectiveness are therefore more to do with what is missing from the proposals rather than the core assumptions on which they are based.

4. Summary of the Scoping Report and approach

This section summarises the main points from the Scoping Report and the approach to the in-scope characteristics.

4.1. Summary of the Scoping Report

4.1.1. 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. The Trust employs around 3,000 staff and provides a range of services including outpatients, elective surgery, non-elective admissions, and a partial Accident and Emergency (A&E) service.

The services provided by the Trust have changed significantly over the last five years, by concentrating serious illness and injury at other more specialist hospitals. MSFT has entered a series of partnerships with both Royal Wolverhampton NHS Trust (RWT) and University Hospital of North Staffordshire (UHNS) to meet these changing expectations of quality, sustainability and safety. These changes to the Trust's operating model over the past few years are part of a broader national 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 overall[32]. For example, the Secretary of State for Health announced[33] in April 2012 a network of 22 centres across England to provide treatment 24 hours a day, seven days a week for seriously injured patients, such as those who have head injuries, stab wounds or have been in a car accident. In the West Midlands, a major trauma centre (MTC) has been created at UHNS[34], with MSFT's A&E no longer providing this service. Similar changes have taken place to concentrate acute treatment outside of MSFT for e.g. stroke.

4.1.2. The local population

The Scoping Report identified that over 90% of people using MSFT services come from the registered population of the two local CCGs, with only limited use from outside that area. This represents 276,500 people who are the general population for whom impacts have been 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

[32] *Urgent and Emergency Care Review - Evidence Base Engagement Document*, NHS England, 17 June 2013, p. 70.
[33] *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.
[34] *Business Case and Options Appraisal for a West Midlands Trauma Care System*, Final Draft, West Midlands Strategic Commissioning Group, September 2011, p. i.

delivered in an acute setting. These general population projections exclude the impacts of specific local growth, which have generated concern and debate amongst local people during the consultation process:

- 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 estimated six hundred children[35] (these numbers are subject to change); and
- 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)[36].

The impact of all three areas of this growth has been closely considered in the impact assessment, as it is an issue of particular concern to local people. The Steering Group has not found that the additional growth is sufficient to change the TSAs' assumptions or have an impact upon health outcomes.

Overall Staffordshire is a relatively affluent area of the country. The Index of Multiple Deprivation 2010[37] (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 6% (5,600 people) of Cannock Chase's population as living 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. Five per cent (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.

Using the Rural and Urban Area Classification 2004[38], 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. 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. Around 14,500 people in Cannock Chase and 49,400 people in Stafford are disadvantaged in terms of geographical access (defined as living in the most geographically deprived quintile nationally.

[35] As communicated (June 2013) by the Head of Armed Forces Health, NHS England

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

[37] Department for Communities and Local Government, HM Governement

[38] 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"

4.1.3. Current issues with service provision and access

The Scoping Report noted some current issues in the way services provided by MSFT are currently used:

- **Accident and emergency (A&E)**: the Steering Group commented that activity figures suggest a low threshold for admission from A&E within the hospital. The Steering Group is concerned more generally by the limited visibility of community services and support, and the focus on hospital services at the expense of care closer to home;

- **Paediatrics:** the issues pertaining to A&E were also observed with the paediatric services currently offered by MSFT. The current paediatrics provision at MSFT features very high admission rates (12.9% of MSFTs admissions were for the 0-14 age group compared with 11.4% nationally[39]), which do not reflect either the disease patterns or the characteristics of the local population, and suggest a low threshold of admission. There is therefore the potential to risk encouraging dependency in families, and causing unnecessary distress and disruption for children and parents; there seems to be low awareness of GP and other services which would provide assessment at home and prevent difficult journeys to hospital;

- **Maternity services:** total deliveries for women in Stafford and Cannock Chase between 2007 and 2011 were consistently above 2,400, which meant that the maternity unit was operating at the lower end of size nationally. The downward trend over this period started to reverse for the latest year for which data are available, and deliveries at Stafford Hospital increased between 2011 and 2012. Nevertheless, the impacted population is surrounded by a choice of alternatives, including a midwifery led unit convenient to the otherwise isolated Rugeley area, which has spare capacity; and

- **Critical Care**: level 3 is a sophisticated level of critical care for the very sick, and requires high levels of technical competence and regular activity to maintain the expertise of staff. As large parts of very acute care has moved off-site to be concentrated in larger hospitals serving a wider population (e.g. major trauma), the focus of critical care on site at Stafford Hospital needs to be the ability to stabilise and transfer to full-service units; this will also create greater resilience and safety in the wider network.

[39] Trust Special Administrators' Draft Report – Volume One (Main Report, The Office of the Trust Special Administrators of Mid-Staffordshire NHS Foundation Trust, July 2013, p.g. 127)

4.2. Approach to in-scope characteristics

4.2.1. In-scope 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; 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/civil partnership and pregnancy/maternity but largely for the purposes of preventing discrimination in employment. In its Scoping Report, the Steering Group reviewed the demography of the local population and concluded that the focus of attention for the impact assessment should be on:

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

These are the characteristics that the Steering Group considers to be at the greatest risk of *differential* impact from that felt by the general population. The changes to maternity services have been considered in relation to the protected characteristic of "sex".

4.2.2. Additional in-scope characteristics

Given the local population profile described above, the Steering Group also concluded that particular attention needed to be paid to the potential impact of changes proposed by the TSAs on:

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

In addition to these characteristics, MSFT staff have also been included as a part of the impact assessment.

4.2.3. Approach to in-scope characteristics

The approach to each of the in-scope characteristics is described below:

- **Age**: the main focus is on the TSAs' draft recommendations for paediatric services and on those services where older people are the majority users. Additional focus

on this protected characteristics is provided within maternity services in considering the impact for older and teenage (younger) mothers;

- **Sex** (gender): this is the protected characteristic under which the TSAs' draft recommendations for maternity services are discussed. Due to the lack of sufficient detail in the TSAs' draft recommendations, this characteristic is not discussed for the elective and other surgical services where it may be relevant (e.g. if there were significant changes to breast surgery);

- **Disability**: this protected characteristic is relevant to all the service proposals, particularly in relation to access;

- **Race**: the Scoping Report noted that there is a very small proportion of the local population from minority ethnic groups. The proportion of people from a minority ethnic group in Cannock Chase is 3.5% (3,420 people) and in Stafford is 7.4% (9,709 people). 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). The proposals are not for services that could disproportionately impact upon particular ethnic groups (with the possible exception of maternity services). The Steering Group has therefore looked at this characteristic mainly through qualitative evidence (see Section 5.5) to understand whether there are any disproportionate impact;

- **Socioeconomic disadvantage and/or rural isolation**: the Steering Group has focused on the potential negative impact in a number of areas, but has concentrated on access. From the qualitative evidence gathered, the Steering Group concluded that access is the single most important area of concern for the local community, primarily in relation to the impact on carers and other visitors; and

- **Staff**: as noted in Section 1.10, since the future arrangements for management and hosting of services remain uncertain, it has been difficult to provide a detailed analysis of the impact for staff. Many staff of the hospitals live locally and will therefore share a level of impact with the general population. The Steering Group has made some specific comments about the impact on staff as employees.

5. Summary of the impacts on the in-scope characteristics and staff

This section summarises the impacts of the TSAs' draft recommendations in relation to the in-scope characteristics, including the impact on staff. Based on the nature of the TSAs' draft recommendations and the local population profile, the Steering Group agreed in the Scoping Report that the focus of the impact assessment should be on age, disability, sex (gender), and race. Based on the local population profile, the Steering Group also concluded in its Scoping Report that it should pay particular attention to the potential impact on those living with socioeconomic deprivation and/or rural isolation. The Steering Group has also considered the impact on staff in this section. Given the combination of in-scope characteristics and draft recommendations, this section provides a high-level summary of the likely impact on each characteristic. Where there is potential for specific impacts arising due to the nature of the service, this is covered in the relevant service-specific sections.

5.1. Overall health impacts

The overall health impacts of the TSAs' draft recommendations for the general population will be limited:

- A National Clinical Advisory Group (CAG) has reviewed the recommendations; they considered that the recommendations are based on sound clinical principles and should deliver a clinically safe and sustainable solution for local people[40]. (Note that further information on the role of the National CAG is given in Section 3.2.1);
- The development of a series of formal clinical networks should reinforce the sustainability and effectiveness of services offered through the two local hospital sites and provide improved access to more specialist services as required;
- The draft recommendations reinforce the role of Cannock Chase Hospital as a local provider, and suggest opportunities to further expand the range and scale of service provision there;
- However, the draft recommendations have been poorly received by many local people who are concerned about the range and scale of services available at Stafford Hospital and its subsequent status, and about the inconvenience of travel to more distant sites. Concerns have also been raised about the safety and responsiveness of services;
- Nevertheless, due to the emergency and specialist focus of the services impacted by the TSAs' draft recommendations (obstetrics, inpatient paediatrics, emergency surgery, and level 3 critical care and day case/elective services), the overall number of patients affected is relatively small. Most people will not need to use emergency care, have a surgery or a baby, or an in-patient admission most years. There will be an impact for that small number of families and patients who experience regular acute and serious illness and are in frequent need of admission;

[40] Letter to the TSAs from the National Clinical Advisory Group, p. 2 (see *Trust Special Administrators' Draft Report – Volume One (Main report)*, The Office of the Trust Special Administrator of Mid Staffordshire NHS Foundation Trust, p. 168.

- Access for these services will, in many cases, be through emergency transport and should not therefore have a direct impact on the ability of most patients to reach timely, appropriate care;
- Where access is by private car, most people in the two CCGs have access to private transport and although there is some increase in travel times, all residents will still be able to reach a hospital providing the services that will no longer be provided at Stafford Hospital under the TSAs' draft recommendations within 40 minutes of home[41]; and
- Moving inpatient services will have an impact for visitors and the greatest negative impact will fall on parents and carers who do not have access to their own car and/or are on low incomes.

The impacts on people within the in-scope protected characteristics, and this is discussed below.

5.2. Impacts on the characteristic of age

The elderly are the majority users of inpatient services[42]. There is a broadly positive impact for older people, particularly with respect to services that (i) will be part of a wider clinical network; and (ii) will be based on the advice of the National CAG, which should reinforce safety and effectiveness. The Steering Group particularly welcomed the proposal to develop a Frail Elderly Assessment Unit (FEAU), where it provides the right level of care as close to home as possible. However, the Steering Group had significant concerns about the lack of attention given to the interface of hospital services with community support and rehabilitation. There was no discussion in the TSAs' draft recommendations about the development of services beyond the hospital that could offer an alternative to admission. Further clarity is required on both the interface with community care and the model for local step down care to ensure that the (frail) elderly are seen in an acute setting only when this is essential, and that a series of moves within or between hospital sites does not have a negative impact on the health of already frail people[43].

The very young (i.e. children aged 0-5 years) are also major users of hospital services[44]. The maintenance of a dedicated Paediatric Assessment Unit (PAU), running parallel to A&E, supports continuing access to assessment and intervention for the acutely ill child at Stafford Hospital. Centralising inpatient services at other local hospitals provides an opportunity to bring local patterns of admission closer to the national average, and ensures that very ill children have access to the full range of services and skills which no district general hospital

[41] Based on current WMAS protocols, some residents of Coton are conveyed to Burton when Stafford's A&E is closed from 22:00 to 08:00. Should residents of Coton choose to travel to Burton rather than UHNS, travel times for some of them would be between 40 to 45 minutes.

[42] "Older people (aged 65+) comprise… 60–70% of overall hospital inpatients" *Acute care toolkit 3: Acute medical care for frail older people.* London: Royal College of Physicians (2012).

[43] "It is not uncommon for patients, particularly older patients, to be moved four or five times during a hospital stay, often with incomplete notes and no formal handover. Every ward move puts at least one day on a length of stay and has a detrimental impact on patient experience". *Hospitals on the edge? The time for action*, A report by the Royal College of Physicians, September 2012.

[44] Hospital Episode Statistics (2012). *Hospital Episode Statistics: Admitted Patient Care 2011-12 Summary Report*.

(DGH) could provide. However, this move has created significant public concern about access to medical assessment when a child is ill, and revealed a reliance on family attendance at A&E, where a GP (in or out of hours), 111 advice over the phone (including arranging transport to hospital where indicated), or receiving paramedic assessment and transport where necessary would be more appropriate options. Greater use of these first contact services would also minimise the challenge of getting to a more distant hospital for low-income families, single parents and those without access to private transport.

As the TSAs' draft recommendations for maternity services relate specifically to the site of delivery (antenatal and postnatal care are unaffected by the draft recommendations), they have an impact upon women of child-bearing age; however, this is discussed below in relation to the protected characteristic of sex.

5.3. Impacts on the characteristic of sex (gender)

In relation to the protected characteristic of sex, the main impact is on maternity services, where changes clearly have a disproportionate impact on women. The TSAs' draft recommendations maintain a range of antenatal and postnatal services at Cannock Chase and Stafford Hospitals, but change where women will be able to give birth, and they will therefore have an impact on women of child-bearing age (15 to 44). This relates to two of the in-scope protected characteristics: age and sex.

MSFT currently manages a full range of maternity patients, and it is only in cases where there are complications (e.g. relating to foetal surgery or newborn intensive care) that a woman is referred to a more specialised unit for management of her pregnancy. The TSAs' draft recommendations will therefore have an impact across the population of pregnant women (including older mothers, teenage mothers and mothers with disabilities). The relevant recommendations are largely driven by financial concerns and the sustainability. There are real challenges to maintaining a medically-led maternity unit 24 hours a day, seven days a week that is compliant with national safety guidelines and which allows staff to keep up their skills, but that only serves a small population. These proposals have raised real concern for the public about the management of labour, decisions about when and how to travel, and access to hospital over extended distances. They also pay little attention to national guidance about choice in childbirth for more natural deliveries and home births, and the existing availability of a midwifery-led option at Lichfield. Continuity of care will be a critical issue for implementation. There is a detailed discussion in Section 6.

5.4. Impacts on the characteristic of disability

In the Scoping Report, the Steering Group considered that the impact for people with disability would be largely similar to that for older people. This is an area where comments from the public and, in particular, the focus group discussions have revealed some distinct risks of negative impact arising from the draft recommendations. These are concentrated in a range of issues associated with acceptability and access: (i) the impact for those reliant on public transport travelling to support patients; (ii) the difficulties of moving around a large or unfamiliar hospital site; and (iii) the maintenance of communications for those requiring

specialist support (e.g. for the hard of hearing, or those with significant learning disabilities). The current MSFT communications service is largely well regarded but other local providers use different contractors. The Steering Group considers that other local providers could, in discussion with disability advocacy groups, audit their services against the quality and range of services provided by MSFT and identify ways to bridge any gaps and develop good practice.

5.5. Impacts on the characteristic of race

The Steering Group considers that, in general, the TSAs' draft recommendations do not have a disproportionate impact on minority ethnic groups (i.e. the impacts are generally those likely to be felt by the general population). In some cases, there may be positive impacts, especially where services can be delivered in hospitals that care for a relatively large number of patients from minority ethnic groups, and are more familiar with specific cultural practices or religious requirements and can offer a broader range of support services. The focus group discussion largely reflected the views of a South Asian community; however there are also populations of Eastern European and Irish origin locally who share even more of the characteristics of the general Staffordshire population.

5.6. Impacts on the characteristic of socioeconomic deprivation

The impacts on people living with socioeconomic deprivation are broadly the same as the impacts on the general population. The main disproportionate impact is in terms of access. For patients of affected services at Stafford Hospital, travel will be by ambulance or car (private car or taxi). The Steering Group believes that planning assumptions must be that public transport will not be used by mothers giving birth, children ill enough to require an inpatient stay, or patients requiring emergency surgery or level 3 critical care. This means that the disproportionate impact is for parents and carers of inpatients who are dependent on public transport to visit. Although the numbers affected are relatively small, the impact falls primarily on people who may already be living in stressful circumstances. In particular, visitors/carers who are on low incomes, are elderly and/or have no access to public transport are those most likely to be worse off. The Steering Group strongly urges the TSAs and others to take actions to mitigate this impact (see Section 11.1 for details of these proposals).

5.7. Impacts on the characteristic of rural isolation

The impacts on the service users living in rural isolation are broadly the same as the impacts on the general population. Users living in rural isolation already face difficulties in accessing services. The Scoping Report noted that the "geographical barriers" sub-domain (part of the "barriers to housing and services" domain) from the Index of Multiple Deprivation 2010 (IMD 2010) measures geographical access to local services that are important for day-to-day life, e.g. supermarkets, post offices, GP surgeries and primary schools[45]. The "geographical barriers" measure is particularly relevant for some of the more rural areas of Staffordshire

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

where individuals have to travel long distances to access key services. Across the two CCGs, some 64,500 people are disadvantaged in terms of geographical access[46].

People living in rural areas tend to use health services differently from the more urban population[47] and there are already mitigating actions in place to deal with potential differential access to services[48]. The emergency infrastructure has been developed to minimise disparities in access to healthcare. The ambulance service operates a dynamic system status plan, which designates the location of ambulances based on projected demand, and keeps ambulances as local as possible to a dispersed population. Paramedic teams are stationed in rural areas in order to ensure adequate response times. First response initiatives are voluntary, but supported by training delivered by the West Midlands Ambulance Service (WMAS). The ambulance service already takes people from across the two CCGs to the other hospitals, e.g. after a major accident or for a suspected acute stroke, or when the A&E at Stafford is closed every night after 22:00.

In relation to travel by car, the travel times analysis (see Section 10) indicates that the TSAs' draft recommendations do not have a significant impact upon these more isolated populations, as they have always been more distant from the MSFT services. The public transport availability from these more rural wards has always been poor, particularly at weekends, and people already have to largely rely on private transport, including voluntary schemes. They are not therefore disproportionately impacted by the TSAs' draft recommendations. The greatest impact on access will be for those communities who are very close to Stafford Hospital and will now have to use alternative sites for the relevant services affected by the TSAs' draft recommendations, e.g. in emergency surgery or delivery of a baby.

5.8. Impacts on users with other characteristics

The Steering Group gathered qualitative evidence to understand the impact of the TSAs' draft recommendations on the lesbian, gay, bisexual and transgender (LGBT) community. The qualitative evidence indicated that mental health and sexual health services[49,50,51] can be

[46] 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"

[47] For example: "The most important "socio-cultural factor" that differentiated rural and urban areas was a more intense relationship with general practitioners expressed in rural areas, associated with increased visibility of general practitioners in the local community…Differences in "access to services" were noted, with rural participants dependent largely on their general practitioner and urban participants more readily accessing hospitals and ambulances. Finally, and perhaps paradoxically, the lack of choice in rural areas seemed to lead to more "complex decision making" in emergencies compared to urban residents; the latter would more readily call an ambulance or attend Accident and Emergency Departments". Farmer J, Iversen L, Campbell NC, Guest C, Chesson R, Deans G, MacDonald J: Rural/urban differences in accounts of patients' initial decisions to consult primary care. *Health Place* 2006, 12:210-221.

[48] For example mitigating actions, see Action with Communities in Rural England (ACRE) policy position paper on healthcare. See http://www.acre.org.uk/Resources/policy-position-papers.

[49] For example: "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.

important to this community; these services are not affected by the TSAs' draft recommendations. Furthermore, there are no specific services for people within this community that are affected by the TSAs' draft proposals. The Steering Group concluded that there is therefore no disproportionate impact and that the impact on the LGBT community would be the same as that for the general population.

5.9. Impacts on users with multiple characteristics

The Steering Group found that there were relatively few groups with multiple in-scope characteristics. With one group sharing the multiple in-scope characteristics of age and sex (i.e. older and teenage mothers), the impacts are broadly the same as for the general female population of child-bearing age and are not therefore disproportionate. In terms of the other relevant multiple in-scope characteristics (e.g. disability and socioeconomic deprivation), the impact is largely about access for visitors/carers, rather than the direct impact for the patient. However, maintenance of relationships and availability of insights about the person from carers can be very important in treatment and recovery, particularly for older people, young children or those who might otherwise find it difficult to communicate with staff[52]. As noted in the discussion of disability above, this is an important area for the TSAs and commissioners to address.

5.10. Impacts on staff

All the current staff at MSFT will be impacted by the TSAs' draft recommendations, through the dissolution of the Trust and/or by the changes in services provided at Stafford Hospital (the current services at Cannock Chase Hospital are not affected). It has not been possible to carry out a detailed analysis of the impact on staff as the TSAs' draft recommendations remain at a high level. Clearly all staff employed within any of the services covered by the proposals may be affected, and many of them will also live locally so will also be covered by the assessment for local people. This impact assessment has concentrated on those staff groups who have in-scope characteristics, rather than looking at the impacts across all staff.

In terms of the in protected characteristics, any new organisation taking over either Cannock Chase or Stafford Hospitals will have to abide by the provisions of the Equality Act 2010 (and other relevant legislation). In particular, the protection that applies to pregnant women, those on maternity leave, and to marital status will apply during any changes. The Steering Group considered the impact on staff in two ways: (i) through a focus group with lower paid members of staff; and (ii) through the travel times analysis presented in Section 10. Both of these are summarised below.

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[50] 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.

[51] *Gay health: the issues*. Accessed from http://www.nhs.uk/Livewell/LGBhealth/Pages/Gayhealththeissues.aspx.

[52] *"Results demonstrated that paid carers have an important role in supporting the adult with disability, providing information, delivering basic care, and facilitating communication".* Hemsley B, Balandin S, Worrall L. Nursing the patient with developmental disability in hospital: roles of paid carers. Qual Health Res. 2011 Dec;21(12):1632-42.

5.10.1. Issues of concern

The focus group discussion and analysis of MSFT's employment information confirmed that some staff are at risk of being disproportionately affected by the changes, in particular lower paid women. A summary of the main points is given below:

- The Scoping Report observed that about half of MSFT's staff (52%) earns less than £25,000 and that most of these are women (83%); furthermore, around one hundred staff earn less than £15,000 per year. Given this profile, there remains a risk that it will be lower-paid staff and women who are disproportionately negatively affected by any changes;
- Many of the lower paid staff will probably remain employed within MSFT on NHS terms and conditions; however in other hospitals, some of these roles are undertaken by commercial contractors on lower pay rates and without the same range of NHS benefits. There are also concerns that increasingly administrative and management support functions will be contracted out and that whilst Transfer of Undertaking Protection in Employment (TUPE) is likely to apply initially, this will have an impact over time on the range and quality of employment and remuneration in the area;
- Many staff currently live locally and are able to travel to work without relying on cars; there are significant concerns that in future they will have to travel to sites which will require private transport or new dedicated travel services;
- Many staff have young children and by working locally can use nursery and other childcare arrangements; this may be difficult to maintain if they have longer distances to travel or move to different times of working;
- Some staff at a range of grades already work across the two sites of Stafford and Cannock Chase Hospitals, but the focus group believed it would be difficult to extend this flexibility to more distant hospitals; and
- Staff understand the uncertainty about the future but would have welcomed greater communication; in particular some staff have requested that once the Secretary of State for Health reaches a decision, the TSAs develop and share as soon as possible the high-level plan for the next three years, setting out the implications for staff.

The Steering Group notes that the legal framework for the Transfer of Undertakings (Protection of Employment) Regulations 1981 (TUPE) is likely to apply. The purpose of TUPE is to protect employment rights where there is a transfer of employees between organisations, but the Steering Group recognises the risks identified by staff in the focus groups. The Steering Group also notes that staff will have a valuable contribution to make to the redesign of services to better meet the needs of the local community, and will form the core of future clinical networks. The Steering Group strongly urges the TSAs and future employers to draw on the knowledge and skills of existing staff in developing the new arrangements.

5.10.2. Travel and access

The TSAs believe that the establishment of clinical networks for Stafford and Cannock Chase Hospitals will address the sustainability, recruitment and retention issues of specific services. This means that some clinical staff will need to operate across multiple sites. The TSAs have also identified the reduction of management and back office functions to NHS averages as a potential area where there could be savings[53]. This may result in some management and back office staff being redeployed to different sites or being made redundant. However, it is not possible to estimate the volume of staff that will be impacted as there are no further details available on the clinical networks and corporate/back office savings, including the definition of the term "back office" staff. As both sites will remain in operation (and there are no reductions to the services provided at Cannock Chase Hospital), the impact on the activity of lower paid staff such as catering, porters and cleaners may be limited. However, as noted by the focus group, there is uncertainty around future employment arrangements and whether facilities and support staff will remain with an NHS employer or potentially be transferred to a commercial contractor.

Although any new employer will be obliged (depending on the employee's contract) to meet additional travel costs for a period, cross-site working will be most difficult for lower-paid employees and/or those with young children. Any new organisation should take steps to ensure that these negative impacts are minimised. A reasonable proportion of current employees does not use a car to travel to work and the transition to a new organisational from has the potential to reduce this; future providers should therefore take the opportunity to update their staff transport policies to maintain this sustainable approach and encourage active and sustainable travel alternatives (e.g. through carpooling). One possible mitigating action for any future provider would be to offer staff car parking permits that are transferable across sites.

[53] The Office of the Trust Special Administrator of Mid Staffordshire NHS Foundation Trust, *Trust Special Administrators' Draft Report – Volume One (Main report)*, July 2013, p. 97, para 327.

6. Impact of the TSAs' draft recommendations on maternity services

This Section describes the TSAs' draft recommendations for maternity services and their associated impact. The appendix for the changes to maternity services is contained in Appendix A.

6.1. Summary of the Scoping Report

The Scoping Report noted that:

- 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;
- 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 women in that period choosing to give birth at MSFT;
- However, this downward trend has started to reverse for the latest year for which data are available and deliveries at MSFT increased between 2011 and 2012; nevertheless, 2,400 remains a low number of deliveries on which to base an obstetric-led service; and
- Fertility rates across Stafford and Cannock Chase are lower than the national average. There are two wards in Stafford district (Coton and Penkside) that have rates which are slightly higher than the average for England, and there will be some small increase in births associated with housing growth and an influx of military families.

6.2. Summary of the TSAs' draft recommendations for maternity services

The TSAs have recommended that the **obstetric service** in Stafford is decommissioned as soon as there is sufficient capacity established across the local health economy.

In their draft recommendations, the TSAs **rejected the option of a Midwifery Led Unit (MLU).** The National CAG is of the opinion that a Midwife Led Unit (MLU) could be provided safely although it is likely to see only ca. 200 births per year (of the ca. 2400 expected deliveries in the local population). It will need to be staffed on a networked basis to ensure that midwives maintain their skills. The TSAs note[54] that despite it being a safe option, they did not expect it to be financially viable. This was based on the assumption that, although 50-60% (900 – 1,000) of births in Stafford could be suitable for a MLU, only 10-12% of mothers would be likely to choose to use an MLU over an obstetrics unit. The TSAs therefore concluded that the cost of operating an MLU with a low number of births would significantly exceed the income from the unit.

[54] *Trust Special Administrators' Draft Report – Volume One Main Report*, The Office of the Trust Special Administrators of Mid-Staffordshire NHS Foundation Trust, July 2013, pg. 127.

Antenatal and postnatal care will continue to be provided from Stafford and Cannock Chase Hospitals once the obstetric service is decommissioned, delivered as part of a wider clinical network.

Where there are complications post-23 weeks, the TSAs' recommendations on labour and paediatric services mean that women will need to be seen at an alternative obstetric unit and not in Stafford Hospital. In 2012/13, 150 women would have had to go to an alternative unit (about 8% of deliveries). Women who have complications pre-23 weeks will be seen in an **Early Pregnancy Assessment Unit** (EPAU) in Stafford, which will operate during the day, Monday to Friday. Any high risk patients at the point of referral will be directed to other suitable local providers.

6.3. Effectiveness considerations of the TSAs' draft recommendations for maternity services

6.3.1. Capacity and capability

The National Clinical Advisory Group (CAG) notes that the obstetrics unit at Stafford Hospital delivers a low volume of births which makes it one the smallest units nationally (135 out of 148 based on number of births). The National CAG stated that in order to provide a safe obstetrics service, other services would also need to be available on a sustainable basis, including a paediatrics inpatient unit (PIU), a special care baby unit (SCBU), general surgery and anaesthetics. The National CAG therefore concluded that women would have access to a safer more effective service over time if obstetric services were concentrated into alternative sites. This change would be consistent with the national trend towards larger, units with enhanced capacity to manage risk[55].

The Steering Group notes this clinical advice and is concerned that the benefits of the TSAs' draft recommendations will only be realised where:

- The diversion of activity to alternative sites is matched by an increase in capacity in both obstetric and associated services;
- The alternative providers are able to meet the standards referenced by the National CAG and applied to Stafford Hospital;
- Attention is also given to the acceptability and responsiveness of services, which may be compromised by larger or more interventionist units; and
- The ambulance service has the capacity to handle longer journeys and a greater volume of traffic.

The Steering Group welcomes the commitment to introduce an Early Pregnancy Assessment Unit (EPAU) on site at Stafford Hospital to provide local assessment where a woman experiences difficulties in her pregnancy before 23 weeks. The Steering Group considers that

[55] "A radical re-think of the current organisation and configuration of women's health care is required to ensure that the required efficiency savings can be achieved without compromising quality … Risk assessment and stratification will be crucial at every interface; pathway algorithms should be adopted to ensure better direction of care". *High Quality Women's Health Care: A proposal for change*, Expert Advisory Group Report, Royal College of Obstetricians and Gynaecologists, July 2011.

the opening hours of this unit should be aligned to those of the Accident and Emergency department (A&E) to minimise confusion and maintain a consistent approach to urgent care across specialties at the hospital.

The Steering Group notes that there is significant public concern regarding existing capacity at other local obstetric-led units, in particular UHNS. Anecdotal evidence, confirmed by commissioners, suggests that routine paediatric assessment pre-discharge is already not undertaken in some cases, and the diversion of maternity activity to other units will place additional pressure on paediatric support at the remaining units. Commissioners are aware of this and the Steering Group urges them to review any emerging plans for transfer against the range of national obstetric and neonatal standards to realise the potential benefits of concentrating obstetric expertise at fewer sites.

MSFT currently provides community midwifery, which supports its obstetric services. In future, delivery of antenatal and postnatal services by community midwifery could come from a range of providers providing deliveries. The Steering Group considers that it is essential that alternative providers of obstetric-led care invest in the local provision of community midwifery to ensure: continuity of care; familiarity with the relevant obstetric service; and, in particular, the local capacity and skills to undertake assessment in labour and provide active support and advice to enable women to make safe and timely decisions about when to travel to hospital. This should also be an opportunity to develop capacity to increase the profile and availability of the home birth option for the circa 8-10% of women[56] for whom this could be a safe choice (although the Normal Birth Consensus Statement states[57] that "[w]ith appropriate care and support the majority of healthy women can give birth with a minimum of medical procedures").

Where enhanced midwifery-led services are developed (as a MLU, or with more women from the CCGs choosing Lichfield, or an increase in the choice of home birth), there will need to be consideration of the impact for in-labour (intrapartum) or postpartum transfer where there have been complications for either mother or baby. There will always be a proportion of births where, despite the mother having experienced a normal pregnancy and being low risk, complications arise during labour. Staff at an MLU or in the community must be able to provide short-term management of obstetrics and neonatal emergencies while awaiting transfer, and the receiving unit must be able to provide obstetric anaesthetic cover and a neonatal service. One member of the maternity focus group had experience of having a baby transferred to a specialist unit at another hospital; she acknowledged the benefits of giving birth in a hospital where the care of the baby and mother can be managed in the same place.

Whilst the TSAs' draft recommendations concentrate the delivery into more remote units, they also provide an opportunity to network with primary and community services, and

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[56] *Home Births*, Royal College of Obstetricians and Gynaecologists/Royal College of Midwives, Joint statement No.2, April 2007, p. 1.

[57] *Maternity Care Working Party. Making normal birth a reality. Consensus statement from the Maternity Care Working Party: our shared views about the need to recognise, facilitate and audit normal birth*. National Childbirth Trust; Royal College of Midwives; Royal College of Obstetricians and Gynaecologists; 2007.

provide enhanced antenatal and postnatal care closer to home. A lack of assertive community support carries risk in relation to unnecessary hospital visits early in labour or very late presentation with pressure on ambulances or deliveries in transit[58]. This will be essential to maintain continuity of care in the transitions from antenatal contact in Stafford or Cannock, to birth from a different team and back into local postnatal care. A review of staffing in maternity units for the King's Fund found that continuity of care, both obstetric- or midwife-led, has been shown to deliver favourable outcomes[59]. A review[60] of trials found that women who had continuity of care by a team of midwives were more likely to discuss antenatal and postnatal concerns, attend prenatal classes, give birth without painkillers, feel well prepared and supported during labour, and feel prepared for child care. Resuscitation was also less frequently required for their babies. A review of maternity services for the London Health Programmes noted that shift patterns of doctors do not always link with midwifery shift changes leading to multiple handovers and increasing the risk of miscommunication[61]. A comparison of continuity of carers (access to the same two midwives) during their antenatal care from some West Midlands maternity providers is given in Appendix A. A qualitative review of selected birthplaces across England found that effective and safe transfer is contingent on good communication systems, trusting and respectable relationships between staff groups and the confidence and competence of professionals[62]. This review has also showed that women are particularly concerned about the loss of continuity of care[63]. Women expressed concern about the effects of a loss of continuity and midwives also felt that continuity of care improved the quality of care received, as well as their capacity to detect clinical abnormality and changes in social circumstance.

6.3.2. Impact of increased journey times during labour

The local population and participants in the focus groups expressed particular concern about the safety of the TSAs' draft recommendations, and the risks to women of travelling to a more distant hospital whilst in labour. This was a subject that was actively debated by the Steering Group.

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[58] For example "evidence suggests that a sizeable proportion of women present at the labour ward before labour is established (leading to 'Category X' admissions)... it is hypothesised that a home visit by a midwife to assess labour progress and offer support might delay admission to the maternity unit and thus reduce unnecessary interventions...It may be that some women stayed at home to avoid arriving at the hospital too early and in the home group, the availability of support helped them to do so appropriately and prevented late admission. The importance of providing women with education about the service and signs of early labour were also identified". Improving care at the primary/secondary interface: a trial of community-based support in early labour. *The ELSA trial Report for the National Co-ordinating Centre for NHS Service Delivery and Organisation R&D* (NCCSDO) November 2008.

[59] *Staffing in Maternity Units: Getting the right people in the right place at the right* time. Sandall, J et al. The Kings Fund, 2011.

[60] Cochrane Pregnancy and Childbirth Group (2008) Continuity of caregivers for care during pregnancy and childbirth.

[61] *Quality and Safety Programme: Maternity services Case for change*, Final Draft, October 2012, p. 18, London Health Programmes.

[62] Birthplace in England research programme, *Final report part 6 - Birthplace qualitative organisational case studies: how maternity care systems may affect the provision of care in different birth settings*, National Institute for Health Research, November 2011.

[63] Birthplace in England research programme, *Final report part 6 - Birthplace qualitative organisational case studies: how maternity care systems may affect the provision of care in different birth settings*, National Institute for Health Research, November 2011, p. 42.

> *To be honest, the thought of having another child scares me. I stayed at home for so long; I would be so scared to get to Stoke if I went into labour in future'*

This is an issue that has been explored in several international studies. A study of infant deaths (new-born to one year old) within the cohort of all births in the rural county of Cumbria between 1950 and 1993 found no evidence of an increased risk of infant death with greater travel time to hospitals[64]. Although the study concluded that there was no evidence to suggest that living further from hospitals, in terms of road travel time, increased the risk of infant death or stillbirth in Cumbria, the authors stressed that a limitation of the study was lack of data after 1993. Another long-term study carried out in Finland did find "a temporal correlation between closing of small hospitals and an increase in accidental out of hospital birth rates was detected"[65]. A more recent study was carried out in France between 2007 and 2009 and identified travel time as a risk factor for accidental out of hospital delivery[66]. In this study a journey of over 45 minutes was considered a significant risk factor. The authors also found that accidental out of hospital delivery was not "significantly associated with prematurity or low birth weight". Although these studies are reassuring in terms of safety, they emphasise the importance of paramedic skill in managing labour, and ambulance service decision-making in transport to facilities with neonatal support.

There is evidence that there is an increase in probability of adverse outcomes for high risk births where extended journeys are required. Evidence from the Netherlands suggests that travel times to a maternity unit over 20 minutes after the onset of labour increases the risk of mortality and adverse outcomes[67] in women already considered as high risk prior to labour. Effective prenatal screening is essential to identify these women to ensure that they are admitted to a labour suite prior to the onset of labour.

The Steering Group was particularly concerned that it is difficult to plan labours, and even women with very 'normal' or low-risk pregnancies can get into difficulty during labour. A study[68] on emergency caesarean sections found no differences in outcomes for babies delivered within 15 minutes of a decision to carry out an emergency caesarean section compared to those delivered with an interval between 16 and 75 minutes. However, if it takes longer than 75 minutes from decision to intervene to caesarean delivery, there is an association with poorer maternal and baby outcomes and this sort of time delay should therefore be avoided. Under the TSAs' draft recommendations, no pregnant woman is expected to need to travel for more than 75 minutes to access an obstetrics unit; however

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[64] Hospital accessibility and infant death risk, T J B Dummer, L Parker, Arch Dis Child 2004; 89:232–234.

[65] Accidental out-of-hospital births in Finland, incidence and geographical distribution 1963-1995, *Acta Obstetricia et Gynecologica Scandinavica*, Volume 78, Issue 5, May 1999, Pages: 372–378, Kirsi Viisainen, Mika Gissler, Anna-Liisa Hartikainen and Elina Hemminki.

[66] Accidental out-of-hospital deliveries: a case–control study, *Acta Paediatrica*, Volume 102, Issue 4, April 2013, Pages: e174–e177, L Renesme, R Garlantézec, F Anouilh, F Bertschy, M Carpentier and J Sizun.

[67] Ravelli A, Jager K, de Groot M, Erwich J, Rijninks-van Driel G, Tromp M, Eskes M, Abu-Hanna A, Mol B. Travel time from home to hospital and adverse perinatal outcomes in women at term in the Netherlands. *BJOG* 2011;118:457–465.

[68] Thomas J, Paranjothy S, James D. National cross sectional survey to determine whether the decision to delivery interval is critical in emergency caesarean section. *British Medical Journal Online First*, bmj.38031.775845.7C, p. 1.

measures need to be put in place to ensure that women in labour who present in difficulty can be safely and quickly transferred to an obstetrics unit.

The Steering Group discussed the impact of these proposals with the West Midlands Ambulance Service (WMAS). WMAS noted that under the current arrangements, there are well-established obstetric protocols in place, and women know (and note in their birthing plans) to contact their assigned midwife when they go into labour, including where this is an early labour. Many women who live in the vicinity of Stafford have already been choosing to deliver at one of the alternative hospitals, without any apparent indications of poorer outcomes or problems. There are occasions across the region where women in labour self-present at A&E, and the WMAS workforce is already trained to deal with this type of situation. WMAS will require additional resources, which will mean working with the TSAs to analyse: (i) the increase in the numbers of women who might call the ambulance service because they have no other means of reaching an obstetric unit; and (ii) the impact of an increase in conveyance time. Participants in a focus group at an antenatal clinic commented that they felt it likely there would be an increase in the use of the 999 service by women in labour fearful of not reaching the maternity unit on time.

6.4. Impact on acceptability

Two principal issues of concern have emerged in relation to acceptability: continuity of care and method of delivery. Both of these are discussed below. There is significant and understandable disappointment amongst local people that if there is no longer a delivery unit at Stafford Hospital, the majority of local babies will no longer be born in the county town.

In reviewing the impacts of the TSAs' draft recommendations for maternity services, the Steering Group recognises the commitment to retain antenatal and postnatal services on both MSFT sites. However, the change in the location of care for the birthing event may cause some mothers to be in a new, unfamiliar environment. Mothers and partners will have to travel further in labour, potentially increasing stress and anxiety, and may struggle to assess the right time to travel during labour. This will therefore require building into the antenatal care pathway visits to a location (or locations) where women and their partners may be interested in giving birth, as well as additional support for women to understand the best time to travel to the delivery ward.

6.4.1. Continuity of care

The Operating Framework for the NHS in England 2012/13 (paragraph 2.39) states[69] that continuity in all aspects of maternity care is vital, from antenatal care through to support at home. Mothers and their families should feel supported and experience well co-ordinated and integrated care. However, the TSAs' draft recommendations entail an increased risk of dislocation of care between the obstetric unit and antenatal and postnatal care where

[69] *The NHS Outcomes Framework 2013-14*, Department of Health, 13 November 2012.

national evidence suggests women place a high value on continuity and familiarity in maternity services[70].

The focus groups and interviews confirmed the importance of continuity of care for a positive birth experience, and this was an area where feedback from recent users of Stafford Hospital was very positive. There is both public concern that valued and good quality services are being lost, and a lack of confidence in the capacity of other hospitals to meet the extra demand posed by the TSAs' draft recommendations.

> *"With my first child I saw the same people, they delivered my baby, I was in hospital for 6 weeks after I had her and it was all the same team who looked after me. With my third child, I saw a different consultant every time I went, I saw all different midwives and he was born early at 36 weeks. He was taken up to Stoke and I never saw the same person twice."*

There were particular concerns raised regarding the continuity of care where a woman has an underlying medical condition which would require on-going collaboration between obstetric and other medical services, and where the delivery would need to take place with full neonatal support available. The anxiety of additional travel and complex communications was seen as unfavourable. The TSAs could explore the potential for obstetric-led antenatal clinics for higher risk women to be hosted at Stafford and Cannock Chase Hospitals for this particular group of women.

In contrast, women using the Lichfield MLU particularly noted the advantages of being able to stay in contact with the delivery unit.

> *'I like coming here to the breastfeeding drop in as it's reassuring and I've made friends. It's nice to see the staff and other new mums'.*

6.4.2. Method of delivery

Evidence from intervention rates at local hospitals suggests that the method of delivery is very different across local units. Women at the Lichfield MLU commented on the soothing and calm atmosphere, and the prevalence of water births (over 50%), contrasting the experience with earlier births (e.g. "I wish I'd known about it when I had my first children"). Table 6.1 below suggests that intervention rates differ across the local health economy, although the hospitals with enhanced neonatal facilities will be handling more high risk births. None of the local providers appears to actively promote home birth as a positive choice at the moment, although the Lichfield MLU would have the skills and experience of independent delivery to be able to develop this.

[70] The fewer the number of caregivers the woman had during childbirth, the more likely she was to be satisfied with the care received" van Teijlingen, E. R., Hundley, V., Rennie, A.-M., Graham, W. and Fitzmaurice, A. (2003), Maternity Satisfaction Studies and Their Limitations: "What Is, Must Still Be Best". Birth, 30: 75–82.

Table 6.1: Number and proportion of deliveries by onset method of delivery, 2011-12

Provider	Number (proportion of deliveries where onset method of delivery known)					All deliveries where onset method known	All deliveries where onset method not known	All deliveries
	Spontaneous	Caesarean	Surgical induction	Medical induction	Surgical and medical induction			
Mid Staffordshire NHS Foundation Trust	1,246 (68.4%)	174 (9.5%)	122 (6.7%)	204 (11.2%)	76 (4.2%)	1,822 (96.4%)	69 (3.6%)	1,891
The Royal Wolverhampton NHS Trust	2,413 (60.3%)	539 (13.5%)	129 (3.2%)	735 (18.4%)	186 (4.6%)	4,002 (98.4%)	67 (1.6%)	4,069
University Hospital of North Staffordshire	3,284 (58.8%)	665 (11.9%)	436 (7.8%)	755 (13.5%)	445 (8.0%)	5,585 (93.6%)	383 (6.4%)	5,968
Walsall Healthcare NHS Trust	2,757 (70.8%)	34 (0.9%)	*	1,101 (28.3%)	*	3,892 (87.3%)	516 (11.6%)	4,460
West Midlands	**63.1%**	**13.5%**	**4.2%**	**15.1%**	**4.2%**	**96.0%**	**4.0%**	**73,433**
England	**65.8%**	**12.1%**	**4.7%**	**12.0%**	**5.4%**	**89.6%**	**10.4%**	**668,936**

- Spontaneous onset accounted for the greatest proportion of deliveries at MSFT during 2011/12 (68% where the method of onset is known). Note: the method of onset was unknown for 69 (4%) deliveries.
- Around one in five deliveries were induced (surgically or medical) whilst 10% of deliveries were due to a Caesarean section.

Source: Hospital Episode Statistics (HES), Health and Social Care Information Centre

6.5. Access to maternity services

This section focuses on access in the sense of availability, timeliness and travel times. The maintenance of antenatal and postnatal services at both Stafford and Cannock Chase Hospitals limits the scale of impact on access to maternity services. However, proposals to close the delivery unit at Stafford Hospital have caused widespread concern about choice and availability of place of birth and in particular timely access to care in labour.

6.5.1. Availability of choice in place of birth

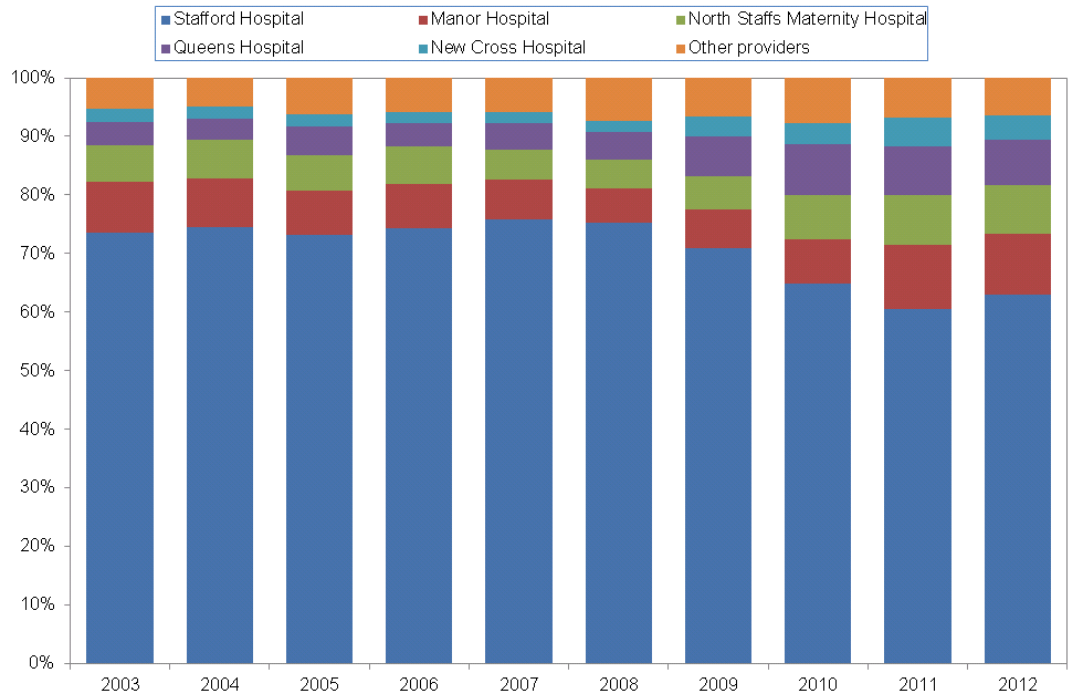
There are four national choice guarantees for women and their partners[71]. By having these guarantees, women and their partners are given the opportunity to make informed choices throughout pregnancy, birth and during the postnatal period. These choices relate to:

- Choice of how to access maternity care;
- Choice of type of antenatal care;
- Choice of place of birth; and
- Choice of postnatal care.

The choice of place of birth refers to women and their partners being "able to choose where they wish to give birth. In making their decision, women will need to understand that their choice of place of birth will affect the choice of pain relief available to them. For example, epidural anaesthesia will only be available in hospitals where there is a 24 hour obstetric anaesthetic service". The changes in activity at MSFT over the last five years suggest that some 25% of women from the local CCGs have already been actively exercising choice in place of birth and travelling to other units.

[71] *Maternity Matters: Choice, access and continuity of care in a safe service*, Department of Health/Partnerships for Children, Families and Maternity, April 2007.

Figure 6.1: Trends for births by provider



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

The geographical basis for patient choice has been observed in a study[72] which found that, following changes in the provision of maternity care in France, about one-third of women chose their maternity units based on proximity. The RCOG notes that "Choice needs to be aligned to the level of complexity and risk…There is also a need to ensure that the choices offered to women allow an appropriate use of resource [and it] is essential to balance choice against adequate service provision"[73]. The closure of the delivery unit at Stafford Hospital would reduce the choice of maternity units within 45 minutes access from six to five[74], which appears to offer a reasonable continuing range of choice. The National Childbirth Trust (NCT) analysed choice[75] by combining nationally collated home birth rates with the known locations of obstetric units and birth centres to determine how many women had reasonable access to a home birth service and a choice of types of maternity units. The study showed that 11.2% of the population of childbearing women live in an area with a home birth rate of 5% or more, and on average 57.4% live within an estimated 30 minute journey time of both a birth centre and obstetric unit. Across England, only 4.7% of women have reasonable access to all three settings to give birth, using these proxy measures of choice.

[72] Pilkington et al.: Choice in maternity care: associations with unit supply, geographic accessibility and user characteristics. *International Journal of Health Geographics* 2012 11:35.

[73] *High Quality Women's Health Care: A proposal for .change*, Expert Advisory Group Report, Royal College of Obstetricians and Gynaecologists, July 2011, p. 15.

[74] The consultant-led unit in Telford will open in summer 2014 (source: http://www.sath.nhs.uk/Future/Womens_Services.aspx).

[75] *An Investigation into Choice of Place of Birth*, Miranda Dodwell & Rod Gibson, London: NCT, 2009.

6.5.2. Access in relation to travel time

Access in relation to travel times is a key consideration in understanding the impacts of the TSAs' draft recommendations. The detailed discussion on overall travel times impacts is given in Section 10.4. This section highlights issues of particular significance to maternity services that are not covered elsewhere. A major concern for the public and participants in focus groups has been an assumption that the TSA's draft recommendations will affect people who are reliant on public transport, which will compromise their ability to access services during emergencies. The Steering Group does not expect that women in labour will resort to bus services; those women who do not have a friend, partner or relative able to take them, or pay for a taxi, will be most likely to call an ambulance. There have been particular concerns expressed about the safety of travelling longer distances in labour, and these are discussed in Section 6.3.2 above.

Interviewees felt that new mothers discharged with their newborn babies could be adversely affected by the recommendations if they do not have access to a car. Concerns were also raised regarding the additional distance to travel for maternity services and inpatient paediatrics and the impact this would have on the ability of families to visit.

> "*I had a caesarean at Stafford, and [we were] taken up to Stoke, my husband was having to work, coming to visit me, going to Stoke to visit my son. He would then go back and visit me again, go home to my daughter. By the time he had finished work, and working shifts doesn't help. When he actually gets to the hospital he would have literally 20 minutes to stay. Then the 3-4 hours to get back and he wasn't getting back until midnight. Sometimes he would have to pay for a taxi and then get up at 4:00am to go to work. That then had an impact on his health.* "

As noted above, an investigation[76] into the choice of place of birth by the National Childbirth Trust (NCT) established that on average 57.4% of women live within an estimated 30 minute journey time of both a birth centre and obstetric unit. Members of the NCT's Campaigns Advisory Groups for each of the four countries of the UK and NCT antenatal teachers were asked how far they thought that women would be prepared to travel to access a maternity unit. In general it was thought that a journey time of up to 30 minutes while in active labour to reach a maternity unit was the upper threshold of reasonable access. This threshold however cannot be directly applied to the Steering Group's analysis, as the NCT analysis was carried out on the basis of a very different travel times assessment based on straight line distances and average travel speed assumptions, rather than detailed travel data.

The majority of expectant mothers (77%) will need to travel further to give birth. Although analysis indicates that the new travel times for giving birth will be within the current range experienced across England, both local travel times work carried out and evidence from the focus groups and interviews indicates that the new journeys to give birth could add further anxiety to what is already a stressful time. The Steering Group recognises that planning will therefore be needed so that women and their partners have a better understanding of all

[76] Miranda Dodwell and Rod Gibson (2009) An Investigation Into Choice of Place of Birth, National Childbirth Trust.

aspects of travel (e.g. testing the route and car parking), and that this will need to be built into the antenatal care pathway.

In cases where there is no access to a private car, the most probable recourse will be to use the ambulance service. It is likely that more women may make the journey to hospital when in active labour due to the increase in travel times. This will be an issue particularly for:

- First time (nulliparous) mothers who may not be able to judge how far labour has progressed;
- Women where transition and established labour happens quickly and/or progresses rapidly who may require additional ambulance (or midwife) support; and
- Women who begin to experience difficulty during an otherwise straightforward pregnancy.

The Steering Group understands that the West Midland Ambulance Service (WMAS) is analysing the resources that will be required as a result of the additional transfers, even where the total number of births is the same.

Visitors and carers (including family) will also need to travel further to attend the birthing event and visits after this (most women only stay one day in hospital after a birth[77]). The impact will be greatest for those whose baby is sick or premature and requires a longer stay (e.g. admission into a SCBU) and where parents will therefore need to travel a greater number of times. This additional travel could have a disproportionate impact on those dependent on public transport, single parents, those with other young children and those living in isolated areas. This issue is discussed Section 10.5.

There is no change in travel times for antenatal and postnatal care as women currently accessing these services in Stafford Hospital and Cannock Chase Hospital will continue to do so. This also applies to women who have complications pre-23 weeks, as they will be seen in an Early Pregnancy Assessment Unit (EPAU) at Stafford Hospital. However, for women who experience complications post 23-weeks, there will be a need to travel further as they will be seen at the most appropriate obstetric unit, and not at Stafford Hospital. The TSAs estimate that this will affect 8% of pregnant women.

6.5.3. Access in relation to timeliness of care

The Steering Group recognises that timeliness of access to appropriate services is an important factor in maternity services. Women travelling to the wrong location or having limited availability of services, which do not meet their needs, would experience a negative impact on access.

The first issue regarding timeliness is the decision in labour about when to go to hospital. The Steering Group is concerned about the lack of information about the availability of midwife support and advice to help women make the best decisions in relation to not going

[77] The average length of stay (ALOS) at MSFT is 1.1 days. Whilst this is the ALOS for all obstetric spells, this figure provides a good indicator for a woman's length of stay after giving birth.

into hospital too early (and then having to undertake multiple trips) versus leaving a decision too late and having an anxious journey whilst in the advanced stages of labour. Effective communication is required to ensure that women know where they need to go to give birth and (for the very few who may have opted out of antenatal care and did not receive this information) safe transfer to a delivery unit.

The second issue regarding timeliness relates to the proposed Early Pregnancy Assessment Unit (EPAU). The TSAs' draft recommendations are that women who have complications pre-23 weeks should be seen in an EPAU at Stafford Hospital. The EPAU will operate during the day, Monday to Friday. The Steering Group recognises the benefits to the provision of an EPAU. However, given that the EPAU's stated aim is to see expectant women who have complications pre-23 weeks, the Steering Group proposes opening hours should be consistent with those of the A&E department, with clear protocols for transfer to alternatives when the EPAU is closed.

6.6. Impact on relevance of services for the local population

The Steering Group have looked at relevance in relation to the expected numbers of births due to both the underlying current population and fertility rate, and the increase that could be expected given the relocation of Armed Forces personnel and the expansion of the local housing stock.

The national increase in births is reflected in Staffordshire, with total births locally growing by 5% between 2008 and 2012 (15,600 to 16,400). However, births at Stafford Hospital have decreased by over a fifth within the same period and it is the only local provider to see a decrease over the last five years. Birth trends for the last five years for the two CCGs show an overall increase in births of 1% (further information is given in Appendix A).

The Office for National Statistics (ONS) estimates that the overall population for Staffordshire will increase by 5% between 2011 and 2021, excluding the additional growth described below.

6.6.1. Relocation of Armed Forces personnel

From 2015 there will be an additional 1,040 army personnel who would bring with them ca. 420 families[78] (although the precise number is subject to change). To estimate the number of babies that may be born to army personnel or their spouses, Public Health Staffordshire assumed that there could be one woman aged between 15 and 44 (child-bearing age) living in *each* of the 420 households. Clearly this is likely to be an overestimate for the number of births, but this assumption produces the highest estimate. The incoming population does not necessarily have the same demographic profile or characteristics of the existing Stafford population so the General Fertility Rate[79] for England was used to estimate the number of

[78] Data communicated (June 2013) by the Head of Armed Forces Health, NHS England.

[79] The General Fertility Rate is the number of births divided by the number of women of child-bearing age (15-44) multiplied by one thousand and is used to measure fertility within a population.

annual births. The estimated annual number of births using this methodology was 27, ranging from 17 to 37 (see Table 6.3).

6.6.2. Increase in the local housing stock

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)[80]. To estimate the number of babies that may be born to women who live in these new houses the household occupancy rate for Staffordshire[81] of 2.4 was applied to the 2,911 to give an overall estimated population of around 7,000. The number of women of child-bearing age (15-44) was estimated using the Staffordshire average to give 1,255 women. Applying the England General Fertility Rate suggests 81 babies each year (on a range from 64 to 99) when all 2,911 houses are lived in (see Table 6.3), based on a six year horizon.

6.6.3. Impact of future birth projections

Projections for births for the two CCGs and those at MSFT, including the impact of locally known changes as described above are shown in Table 6.2 (based on maternity services at Stafford Hospital remaining as they are).

Table 6.2: Projections in number of births at Cannock and Stafford CCGs and MSFT

	2012 (provisional)	2015	2020	2025	2030
Cannock and Stafford CCGs	2,968	3,040	2,980	2,850	2,630
Estimated number of births at MSFT	1,869	2,050	2,030	1,940	1,790
Proportion at MSFT	63%	67%	68%	68%	68%

Source: Public Health Staffordshire analysis based on birth extracts, Office for National Statistics, Public Health Birth Files, Office for National Statistics and 2010 and 2011-based subnational population projections natural change and migration summaries, Office for National Statistics

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

[81] Based on 2011 census

Table 6.3: Using England General Fertility Rate (GFR) to estimate the number of additional babies to new army personnel and new houses in Stafford

Stafford army personnel and families							
Model based on	Number of households (Stafford)	Estimated population	Female population aged 15-44 (Estimated 1 per household)	General Fertility Rate (GFR) for England	Estimated number of births per year	Minimum number of births [Lower confidence limit (95%)]	Maximum number of births [Upper confidence limit (95%)]
Single year (from 2015)	420	1,040 including family members	420	65	27	17	37
Housing developments in Stafford							
Model based on	Number of households (Stafford)	Estimated population (Based on Staffordshire average household occupancy)	Female population aged 15-44 (Based on Staffordshire average)	General Fertility Rate (GFR) for England	Estimated number of births per year	Minimum number of births [Lower confidence limit (95%)]	Maximum number of births [Upper confidence limit (95%)]
Single year	500	1,200	216	65	14	7	21
6 years (2018)	2,911	6,986	1,255	65	81	64	99
Army personnel and housing developments					**109**	**82**	**136**

Source: Army personnel numbers; Ministry of Defence (approximate), Housing developments: Stafford Borough Council, Household numbers and population: 2011 Census, Office for National Statistics, Crown copyright, Birth extracts, Office for National Statistics and Compendium of Population Health Indicators (www.indicators.ic.nhs.uk or nww.indicators.ic.nhs.uk), The NHS Information Centre for health and social care. Crown copyright

The impact of future birth projections has been analysed by looking at the underlying local birth rate, the increase in births due to the relocation of Armed Forces personnel, and the planned increase in the local housing stock. The analysis indicates that, even with the additional population growth over the next 20 years, the additional up to ca. 140 births would still mean that an obstetrics unit at Stafford Hospital would be a relatively small unit nationally. The Steering Group understands that some consultation responses may have come to a different conclusion based on the statement in the TSAs' draft report that[82] "additional births related to the population increases at MoD Stafford are unlikely to exceed 100 per annum". The detailed impact assessment has estimated this number to be ca. 27 per year and the Steering Group is satisfied that its estimates are robust.

6.7. Impact on equity

This section describes the specific impact of the changes on user groups with the in-scope characteristics agreed by the Steering Group.

6.7.1. Impact on the characteristic of sex

The changes to maternity services will predominantly affect expectant mothers, although partners and visitors (regardless of sex) will also be impacted. All the sections above (6.3 to 6.6) describe the impact on the general female population, but two points are noted here:

- Mothers in Cannock are already likely to use obstetric services in Walsall and Wolverhampton. Therefore the TSAs' draft recommendations will have a relatively greater negative impact on the population of Stafford, for whom the existing obstetric unit is the most local choice; and
- There are some circumstances related to complications in any potential pregnancy which may affect the safety of the foetus or newborn baby where the patient is currently referred to a more specialised unit and the TSAs' draft recommendations will make the same choices available to all expectant women.

6.7.2. Impact on the characteristic of age

There is significant evidence demonstrating that teenage (aged 13 to 19) and older (35 and above) women are at greater risk of facing complicated pregnancies[83]. Teenage women have a higher rate of delivering an infant prematurely and of low birth weight[84,85]. Older women on the other hand are more at risk of perinatal mortality, intrauterine foetal death, and

[82] The Office of the Trust Special Administrator of Mid Staffordshire NHS Foundation Trust, *Trust Special Administrators' Draft Report – Volume One (Main report)*, July 2013, p. 35.

[83] "All teenage groups were associated with increased risks for pre-term delivery, low birth weight and neonatal mortality… Teenage pregnancy increases the risk of adverse birth outcomes that is independent of important known confounders". Chen X, Wen S, Fleming N, Demissie K, Rhoads G, Walker M: Teenage pregnancy and adverse birth outcomes: a large population based retrospective cohort study. *Int J Epidemiol* 2007, **36**:368-73.

[84] Andrew J. Satin, et al. (1994) Maternal youth and pregnancy outcomes: Middle school versus high school age groups compared with women beyond the teen years, *American Journal of Obstetrics and Gynaecology*, Volume 171, Issue 1, July 1994, Pages 184–187.

[85] Alison M. Fraser et al. (1995) Association of Young Maternal Age with Adverse Reproductive Outcomes, *N Engl J Med* 1995; 332:1113-1118.

neonatal death[86,87]. A profile of births by mother's age group is shown in Table 6.4. MSFT has a higher proportion of older mothers: 18% aged 35 and over, compared with 15% at RWH and UHNS and only 12% at WHNT (however, these providers have a higher proportion of teenage births).

Table 6.4: Age profile of mothers by Provider, 2011/12

	Under 19	19-24	25-34	35-39	40+	All ages
Number of births						
Mid Staffordshire NHS Foundation Trust	71	433	1,032	267	70	**1,873**
The Royal Wolverhampton NHS Trust	170	1,113	2,169	505	118	**4,075**
University Hospital of North Staffordshire	232	1,636	3,245	705	165	**5,983**
Walsall Healthcare NHS Trust	217	1,290	2,381	443	84	**4,415**
West Midlands	2,504	17,848	40,837	9,612	2,364	**73,165**
England	18,990	140,724	381,823	104,768	26,102	**672,407**
Proportion of all births						
Mid Staffordshire NHS Foundation Trust	3.8%	23.1%	55.1%	14.3%	3.7%	100.0%
The Royal Wolverhampton NHS Trust	4.2%	27.3%	53.2%	12.4%	2.9%	100.0%
University Hospital of North Staffordshire	3.9%	27.3%	54.2%	11.8%	2.8%	100.0%
Walsall Healthcare NHS Trust	4.9%	29.2%	53.9%	10.0%	1.9%	100.0%
West Midlands	**3.4%**	**24.4%**	**55.8%**	**13.1%**	**3.2%**	**100.0%**
England	**2.8%**	**20.9%**	**56.8%**	**15.6%**	**3.9%**	**100.0%**

Source: NHS Comparators

Older mothers are more likely to experience complications[88], however the alternative providers are all well set up to respond to these, and at RWT and UHNS have a higher level of specialist support available (e.g. paediatric inpatient care units).

The available literature and qualitative evidence from the focus groups suggest that the travel time to access maternity clinics is an issue for particular ages. Guidance[89] suggests that transport to a hospital or clinic may be unaffordable or unavailable for young people, especially in rural areas. Qualitative research[90] suggests that logistics and travel is particularly a problem for women in their teens, who can find it difficult to travel to and

[86] Cleary-Goldman J et al. (2005) Impact of Maternal Age on Obstetric Outcome, *Obstetrics and Gynaecology*, May 2005 - Volume 105 - Issue 5, Part 1 – pp. 983-990.

[87] Jacobsson, Bo et al. (2004) Advanced Maternal Age and Adverse Perinatal Outcome, *Obstetrics and Gynecology*, October 2004 - Volume 104 - Issue 4 – pp. 727-733.

[88] "Older women were more likely to deliver preterm and more likely to deliver at <32 weeks gestation when there is a greater risk of perinatal morbidity and mortality… The risk of stillbirth was significantly higher in the older women". M. Jolly, N. Sebire, J. Harris, S. Robinson and L. Regan, "The risks associated with pregnancy in women aged 35 years or older", *Hum. Reprod.* (2000) 15 (11): 2433-2437.

[89] *Teenage Parents: who cares? A guide to commissioning and delivering maternity services for young parents*, Second edition – July 2008, Department for Children, Schools and Families and Department of Health.

[90] *Access to Maternity Services*, Research Report Prepared for: COI Communications on behalf of Department of Health, 16th November 2005, p. 28.

from appointments because they could not afford it or did not have the means to travel (particularly for those out of their area). These will be issues at the moment and the maintenance of clinics at Stafford and Cannock Chase will not affect this situation.

6.7.3. Impact on the characteristic of disability

Expectant mothers who face disabilities are more likely to face complications throughout and after pregnancy. Although pregnancy outcomes are favourable for most women with physical disabilities, increased rates of certain adverse outcomes, such as low birth weight (related to preterm birth or growth restriction) and caesarean delivery have been reported in women with spinal cord injuries, rheumatoid arthritis, multiple sclerosis, or other conditions[91]. Common symptoms of pregnancy[92] may be more severe than among women without disabilities; in addition, pregnancy may alter the course of the disability, temporarily or even permanently[93].

The Royal College of Midwives (RCM) recommends[94] that heads of midwifery should include individualised maternity services in the commissioning process for women with disabilities, for example continuity of carer/small team of midwives and increased midwifery and social support in the antenatal and postnatal period. The RCM also recommends that the same options and choices available for antenatal care, place of birth and analgesia should be made available to disabled women unless contraindicated by an existing medical condition. This aspect of continuity of care will require particular attention to ensure that it is not compromised by the separation of responsibility of antenatal and postnatal care from delivery.

MSFT currently deals with all women who choose to be treated at the hospital, regardless of factors such as disability. The commitment to continue to offer antenatal and postnatal care at Stafford and Cannock Chase Hospitals provides an opportunity to consider whether an obstetrics outreach clinic could be developed to support those women with higher risk pregnancies, who will deliver at an alternative site.

6.7.4. Impact on the characteristic of race

The number of women from minority ethnic groups is relatively low in the catchment area for MSFT; two of the largest minority populations are Eastern European and Irish.

There are relatively very low numbers of women from communities which are at higher risk of poor birth outcomes. An enquiry into maternal and child health in 2005 suggested that the mortality rate for Black African women and, to a lesser extent Black Caribbean and

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[91] Signore, Caroline MD et al. (2011) Pregnancy in Women With Physical Disabilities, *Obstetrics & Gynecology*, April 2011 - Volume 117 - Issue 4 - pp 935-947.

[92] E.g. Decreased mobility, fluid retention, bladder dysfunction, and increased incidence of vaginal and urinary tract infections.

[93] Smeltzer , S. C. , & Sharts-Hopko , N. C. (2005). *A Provider's Guide for the Care of Women with Physical Disabilities and Chronic Health Conditions*. Chapel Hill, NC: North Carolina Office on Disability and Health; Villanova University College of Nursing, p. 14.

[94] *Maternity Care for Disabled Women*, Guidance Paper, Royal College of Midwives, June 2008.

Middle Eastern women, is significantly higher than that for White women[95]. Another study attributed this disproportionate maternal death rate to the fact that severe maternal morbidity is significantly more common among non-White women than among White women in the UK, particularly in black African and Caribbean ethnic groups[96]. Additionally, there is evidence[97] showing that women in Asian Muslim communities may have onerous domestic responsibilities and may not be able to prioritise antenatal or postnatal clinics. Where their family insists on them being accompanied by another person for appointments, this can also prevent or delay attendance[98].

The focus group for minority ethnic groups noted that women in the Pakistani community, may prefer to give birth naturally, and are traditionally supported by their extended families. The Steering Group has noted that continued investment is required in the community midwifery service, including greater use of the option to give birth at home. Additionally, the population served by other hospitals in the local health economy has a higher number and proportion of women of child bearing age from South Asian backgrounds and may be better placed to understand and meet their needs.

Table 6.5: Number of women from an ethnic minority group

Local authority	Women of childbearing age (15-44)	Women from an ethnic group	Percentage
Cannock Chase	19,263	835	4.3%
Stafford	23,046	2,246	9.7%
Stoke-on-Trent	50,677	8,414	16.6%
Walsall	52,715	15,045	28.5%
Wolverhampton	51,312	21,361	41.6%

Source: 2011 Census, Office for National Statistics

Given the user-specific services that some women from this group may require (e.g. support and information in languages other than English), and the ability of the larger local maternity units to deliver these services, some of this cohort may experience a better level of care than is the case at present.

6.7.5. Impact on the characteristic of socioeconomic deprivation

Women living with socioeconomic deprivation have poorer maternity outcomes[99,100]. There is a causal relationship between poverty and ill-health, driven by a number of factors

[95] Lewis G, ed. The Confidential Enquiry into Maternal and Child Health (CEMACH). Saving mothers' lives: reviewing maternal deaths to make childhood safer—2003-2005 London: CEMACH, 2007, p. 30.

[96] Marian Knight, Jennifer J Kurinczuk, Patsy Spark and Peter Brocklehurst (2009) Inequalities in maternal health: national cohort study of ethnic variation in severe maternal morbidities, BMJ. 2009; 338: b542.

[97] Dartnall L, Ganguly N, Baatterham J. Access to Maternity Services: Research Report. Department of Health; 2005 Jan.

[98] Raleigh et al. (2010) *Ethnic and social inequalities in women's experience of maternity care in England: results of a national survey*, London: King's Fund.

[99] "Perinatal mortality and social deprivation are closely linked, and the West Midlands has high rates of both". *Perinatal Mortality, Social Deprivation and Community Midwifery 2008-9*, West Midlands Perinatal Institute, February 2011, p. 4.

[100] See, for example: (1) Melve KK, Skjaerven R. Birthweight and perinatal mortality: paradoxes, social class, and sibling dependencies. International Journal of Epidemiology. 2003; 32(4): 625-32; (2) Wilcox AJ. On the importance - and the unimportance - of birthweight. International Journal of Epidemiology. 2001; 30(6): 1233-41; (3) Kramer MS, Seguin L, Lydon J,

including differences in living conditions[101]. In England, women from poorer households or lower social classes are more likely to smoke, be obese or use drugs[102]; these factors all increase the risk of pregnancy complications. An analysis[103] of a 2007 national survey of over 26,000 women (16 years or over) about their experience of maternity care concluded that women living with socioeconomic deprivation were less likely to access timely care, attend antenatal classes, initiate breastfeeding, and have a postnatal check-up. They were also more likely to experience negative outcomes such as a hospital stay during pregnancy and having their baby cared for in a neonatal unit. These factors mean that it will be essential that more distant units offer community midwifery through the existing sites. It is also more likely that women at risk of having babies requiring active neonatal support will be giving birth in units where this support is available on site[104].

Responsive and proactive community midwifery is especially important for women facing socioeconomic deprivation. The Marmot Review of the social determinants of health inequalities in England noted that ensuring that parents have access to support during pregnancy is particularly important. Guidelines highlight the need for a strong midwifery workforce which provides the infrastructure to support women and their partners during pregnancy, birth and early parenthood, for delivery of services that avoid unnecessary intervention, and for ensuring that those women who do, or may, require intervention are signposted at an early stage to specialist care[105].

A study[106] based on experience in France has found that the preference for proximity was related to demographic and social characteristics: women from households in the manual worker class chose a maternity unit based on its proximity more often and also went to the nearest unit when compared with women from professional and managerial households. An assessment of maternity reconfiguration in the north of England concluded that additional visitor transport time, costs and distances to an obstetric-led unit had a disproportionate impact on those from disadvantaged areas, which could potentially worsen inequalities across socioeconomic groups but that could be mitigated by innovative transport schemes.

Based on the scale of the issues that could be encountered by mothers living with socioeconomic deprivation, and the TSAs' draft recommendations to maintain antenatal and postnatal care at Stafford and Cannock Chase Hospitals, the Steering Group anticipates that

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Goulet L. Socio-economic disparities in pregnancy outcome: why do the poor fare so poorly? Paediatric and Perinatal Epidemiology. 2000; 14(3): 194-210; (4) Stephansson O, Dickman PW, Johansson AL, Cnattingius S. The influence of socioeconomic status on stillbirth risk in Sweden. International Journal of Epidemiology. 2001; 30(6): 1296-301.

[101] *Fair Society, Healthy Lives: Strategic Review of Health Inequalities In England post-2010*, Department of Health, London: 2010.

[102] Ibid. pp.57 - 59

[103] VS Raleigh, D Hussey, I Seccombe, K Hallt "Ethnic and social inequalities in women's experience of maternity care in England: results of a national survey", *J R Soc Med* 2010: **103:** 188–198.

[104] For example, "the reorganisation of neonatal services into networks has led to greater transfer and survival of babies born at 27–28 weeks of gestation". Gale C, Nagarajan S, Santhakumaran S, Statnikov Y, Modi M. Changes in postnatal transfers and place of delivery following introduction of managed neonatal networks in England. *Arch Dis Child* 2011;96 Suppl 1:A36–A37.

[105] *Fair Society, Healthy Lives: The Marmot Review*, 2010, p. 97.

[106] Pilkington et al., Choice in maternity care: associations with unit supply, geographic accessibility and user characteristics. *International Journal of Health Geographics* 2012 11:35.

the TSAs will work with commissioners to ensure that there is targeted investment in those areas of highest need.

6.7.6. Impact on the characteristic of rural isolation

The National Childbirth Trust (NCT) has noted that there is relatively little information available on women's perceptions of rural maternity care[107]. However the review noted that, although women living in rural areas often expect to have to travel to access services and accept it as the norm, this should not induce complacency. Indeed many women and families are on low incomes without access to a car or the means to travel frequently, and poor public transport can limit access to routine antenatal care, antenatal classes, breastfeeding workshops and clinics. The NCT review also noted that providing care for women with high-risk pregnancies presents several challenges, including the fact that when women or babies have to be admitted to a regional centre providing higher-level care, they may be many hours' journey from home and isolated from their support network and families. The Steering Group expects that the TSAs will work with future acute providers of maternity services to manage the community midwifery service so that it continues to identify high risk pregnancies through prenatal screening, especially for women living in rural areas who are more likely to travel further upon the onset of labour.

Three Royal Colleges (General Practitioners, Midwives, and Obstetricians and Gynaecologists) have issued a joint statement on the role of GPs in maternity care[108]. This statement noted that in remote and rural areas, the GP's role in maternity care may be enhanced to ensure appropriate medical input, through GPs retaining a range of obstetric skills, which facilitate safe provision of antenatal, intrapartum and postnatal care for women. Whilst the role of primary care is beyond the remit of the TSAs, the Steering Group anticipates that the TSAs will work with primary care during the implementation of their final recommendations to review the role of General Practice in the most remote communities.

Section 6.3.2 discussed impact of long travel times on maternity health outcomes especially for high risk pregnancies. However analysis indicates that women living in rural isolation will not be disproportionately affected in terms of the change in travel times, which will not be significantly different by ambulance or private car than they are now.

6.8. Proposals to mitigate the impacts of the TSAs' draft maternity recommendations

Based on the impacts summarised above, the Steering Group has put forward the following proposals to mitigate the potential negative impacts and enhance the positive impacts of the TSAs' draft recommendations:

[107] Maggie Redshaw, Karen Hamilton, Rachel Rowe, Julie Jomeen and Mary Newburn "Maternity care in rural areas: key issues", *Perspective - NCT's journal on preparing parents for birth and early parenthood*, June 2012, p. 12.
[108] Consensus statement by RCGP, RCM, RCOG: The role of the General Practitioner in Maternity Care, 2011.

- The Steering Group welcomes the evidence-based approach taken by the TSAs as informed by their national medical and nursing advice, and notes the importance of applying these standards consistently to alternative provision of obstetric services. In particular, it will be important to reassure the public of medical and nursing workforce and bed capacity at alternative sites for maternity and associated paediatric and other services. The Steering Group recommends that the TSAs work with commissioners to define "sufficient capacity" and the metrics to monitor it and then publish this information on a regular basis;
- There is considerable and legitimate public concern about potential compromise to continuity of care given the division of antenatal care, delivery and postnatal follow up; it will be particularly important to understand the role of community midwifery in risk assessment, advice on style and site of delivery, support to visit and learn about the delivery suite and hospital lay-out and parking, and active availability for assessment and support in labour to get women into hospital in a timely and calm manner;
- The Steering Group understands the reasoning behind rejection of a MLU option at Stafford Hospital given the relatively low take up of midwifery led services (ca. 4.9% in 2007) across England[109]. However, the Steering Group is concerned that more analysis has not been carried out to understand availability and capacity at the local standalone midwife-led unit (MLU) at Lichfield, and to promote this as part of the choice available, particularly for the community around Rugeley who do not currently have good access to the delivery unit at Stafford Hospital, but is relatively close to Lichfield. This TSAs should reconsider their analysis of an MLU at Stafford Hospital in light of more local information from Lichfield;
- The Steering Group is concerned at the relative lack of attention given to the recommendations of *Changing Childbirth*[110] and other guidance associated with improving the acceptability and responsiveness of maternity services, in particular the opportunity to reinforce the role of community midwifery and the choice of home birth;
- The Steering Group welcomes the recommendation to create an Early Pregnancy Assessment Unit (EPAU) at Stafford Hospital as part of the core urgent care service, and would expect it to be available at the same times as A&E (including at weekends) to minimise confusion about where and when to go. Clear protocols and local communications need to be in place regarding alternatives when the EPAU is closed; and
- The Steering Group is assured that the range of obstetric and other birthing units available to the population does not mean that future journey times are so long as to put women or babies at risk; however the public is very concerned about this. It will be essential that commissioners work with the West Midlands Ambulance

[109] The Birthplace in England Research Programme reported that for the year ending 31st March 2007, there were 11,261 births in a freestanding MLU; 19,192 births in an alongside MLU; and 590,859 births in an obstetric-led unit. *Mapping maternity care: the configuration of maternity care in England Birthplace in England research programme*. Final report part 3, Birthplace in England Collaborative Group, November 2011, p. 22.

[110] Department of Health (1993) *Changing Childbirth*. Report of the Expert Maternity Group (Cumberlege Report). HMSO: London.

Service (WMAS) to ensure sufficient capacity for additional and extended journeys, capability in support for labour and care of the neonate, and active management of protocols to ensure that women in labour end up in the right place as quickly and safely as possible.

7. Impact of the TSAs' draft recommendations on paediatric services

This Section describes the TSAs' draft recommendations for paediatric services and their associated impact; the appendix for the changes to paediatric services is contained in Appendix A.

7.1. Summary of the Scoping Report

In Section 7 of the Scoping Report, the Steering Group noted that:

- Young families are concentrated in the Stafford and Surrounds CCG area, with Cannock Chase CCG serving a generally older population;
- There is population growth expected in Stafford and Surrounds. This is driven by housing planning and an expansion in military personnel, and will include young families;
- The current paediatrics provision at MSFT features very high admission rates (12.9% of MSFTs admissions were for the 0-14 age group compared with 11.4% nationally[111]), which do not reflect disease patterns or the characteristics of the local population, and indicates a low threshold of admission. This suggests a risk of encouraging dependency in families, and causing needless distress and disruption for children and parents through unnecessary attendances and admissions; and
- In 2012/13, there were 2,362 admissions into the Paediatric Inpatient Unit (PIU), of which 328 were direct from a GP. The average length of stay for non-elective admissions at MSFT for 2012/13 was 1.8 days[112].

7.2. Summary of the TSAs' draft recommendations for paediatric services

The TSAs have recommended that the **paediatric inpatient unit** (PIU) in Stafford is decommissioned as soon as there is sufficient capacity established across the local health economy. A **paediatric assessment unit** (PAU) will continue to be provided at Stafford Hospital once the PIU is decommissioned. This will provide a team of health professionals with additional training in care of the sick child and will run parallel to Accident and Emergency (A&E) department, 14 hours per day. The existing Paediatric service operates 24 hours a day, 7 days a week.

[111] Trust Special Administrators' Draft Report – Volume One (Main Report, The Office of the Trust Special Administrators of Mid-Staffordshire NHS Foundation Trust, July 2013, p.g. 127)
[112] Note that this is new analysis that was not presented in the Scoping Report.

7.3. Effectiveness impact of the TSAs' draft proposals for paediatrics

7.3.1. Effectiveness and safety

The Steering Group recognises the TSAs' draft proposals to concentrate the care of acutely ill children in specialist units with experienced teams that carry out a high volume of paediatrics work. Research shows that specialist teams are particularly important for paediatric services[113]. Similarly, there are benefits surrounding admission to a unit with a full range of paediatric services, including the ability to offer more complex or specialised care in serious illness, and an enhanced range of age-specific on-going educational and other support for those with chronic or long-term illness[114]. These benefits form part of a national and international[115] trend towards greater centralisation of paediatric services and are increasingly the norm across England. The Steering Group notes that the Royal College of Paediatric and Child Health (RCPCH) has been a strong advocate of centralising paediatric inpatient care[116].

This centralisation of services for acutely ill and very sick children is balanced by the proposal to maintain a local Paediatric Assessment Unit (PAU) aligned with the Accident and Emergency (A&E) department. This should support continuing access to appropriate local diagnosis and treatment, which ought to be strengthened by both incorporating the current team within a wider clinical network and establishing more common patterns of admission and advice. This will be most beneficial and safest where there are clear protocols for assessment, admission and transfer, and close working relationships established with community services and the GPs of families and children who are regular PAU attenders. This will help to address the RCPH's continuing concern that "too many children and young people being admitted to hospital, particularly for a day or less, when some could avoid being admitted"[117].

The RCPH report[118] noted that there are some areas of national concern about smaller paediatric services. It will be important for the TSAs to take the opportunity to address these in the design of the new clinical network, in particular in relation to ensuring that:

- The standards for medical cover are maintained as regularly at weekends and evenings as they are between the hours of 09:00 and 17:00, and that senior staff are available at times of peak activity; and
- The establishment of an audit programme and regular measurement and reporting of outcomes and experience of treatment.

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[113] *Commissioning Safe and Sustainable Specialised Paediatric Services-A Framework of Critical Inter-Dependencies*. DH, August 2008.
[114] Ibid.
[115]. M McKee and J Healey. *Hospitals in a changing Europe*. Open University Press, 2002.
[116] *Modelling the Future III: Safe and sustainable integrated health services for infants, children and young people*, December 2009, London: Royal College of Paediatrics and Child Health, p. 4.
[117] *Modelling the Future III: Safe and sustainable integrated health services for infants, children and young people*, December 2009, London: Royal College of Paediatrics and Child Health.
[118] *Modelling the Future III: Safe and sustainable integrated health services for infants, children and young people*, December 2009, London: Royal College of Paediatrics and Child Health – The report outlined various concerns e.g. lack of training and experience etc. that are used to highlight the need for reconfiguration.

Similarly, successive reports[119,120] from the Royal College of Nursing (RCN) have raised concern about the capacity and skills mix of nursing teams, which should be addressed in the re-provision of inpatient paediatric services and in the staffing of the PAU.

The emphasis of the TSAs' draft recommendations is on the response to acute illness. As elsewhere, the Steering Group is concerned that there is a relative lack of attention to the interface of acute services with those for chronic disease and disability, and particularly services focused on supporting children at home and in the community. Clearer understanding of those families living with chronic illness and their circumstances, and a co-ordinated response across children's services would be particularly beneficial for these vulnerable families, who may be living with multiple disadvantages.

There must be onsite capacity to intervene and stabilise in the event of a child with serious illness arriving at Stafford A&E. To mitigate the risk of confusion for parents or first contact services about where to take a sick child, there should be clear protocols for primary and first contact health professionals. The protocols should identify the critically ill child and arrange direct access to the site with the inpatient service, and differentiate this from the sick child who may be managed at home with advice or seen in primary care.

The model of a PAU operating in support of a local A&E with back-up from dedicated paediatric services and inpatient beds at another site depends on excellent triage, stabilisation and transfer services, particularly as this will create additional activity for the ambulance service, which will required robust planning to ensure a safe network. Anaesthetics guidelines[121] state that hospitals should ensure the ability to provide airway and respiratory support in a timely fashion until the transfer has been arranged. Intercollegiate guidelines[122] recommend that the emergency department (i.e. Stafford PAU/A&E) operates within clear transfer protocols for contacting the PIU or retrieval service. Contact should be made early in these situations, in order to reduce time to transfer and to optimise clinical outcomes.

There is also an increased likelihood of missing signs of safeguarding risk where a variety of teams are involved in the care of the child, and the development of an effective clinical network across community and hospital services will be vital to minimise this risk. The RCPCH has stated[123] that out-of-hours urgent care, emergency departments and acute assessment services in hospitals, together with paediatric intensive care units and surgical

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[119] There have been numerous public inquiries that have highlighted key issues related to the impact of inadequate nurse staffing levels or an inappropriate mix of skills. The RCN has repeatedly called for improved staffing levels across all service areas. 'Defining staffing levels for children and young people's services' http://www.rcn.org.uk/__data/assets/pdf_file/0004/78592/002172.pdf (Accessed 17 October 2013).

[120] J Ball. Guidance on safe nurse staffing levels in the UK. Royal College of Nurses (2010) http://www.rcn.org.uk/__data/assets/pdf_file/0008/78551/001934.pdf (Accessed 17 October 2013).

[121] Guidelines for the provision of Anaesthetic Services, 2013, Royal College of Anaesthetists.

[122] *Standards for Children and Young People in Emergency Care Settings Developed by the Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings*, British Association of Paediatric Surgeons, College of Emergency Medicine, Joint Royal Colleges Ambulance Liaison Committee, Royal College of Anaesthetists, Royal College of General Practitioners, Royal College of Nursing, Royal College of Paediatrics and Child Health, London: RCPCH, 2012, p. 18.

[123] *Modelling the Future III: Safe and sustainable integrated health services for infants, children and young people*, December 2009, London: Royal College of Paediatrics and Child Health, p. 44.

specialties, should all be commissioned as an integrated network, which could mitigate these safeguarding risks.

As with other services, the TSAs' draft paediatric recommendations do not cover the interface of hospital services with community support. According to the Intercollegiate Committee for Standards for Children, a whole-systems approach to the provision of urgent care for children should be taken to ensure a safe "patient journey". This includes[124]:

- Shared protocols, shared training, staff rotations, and quality improvement programmes which should operate across the whole geographical area covered by the network;
- Clinical guidelines and referral pathways which should be consistent;
- Establishment of link posts across the network (for example through staff rotation) that enable the development of consistent skills and appropriate referral patterns; and
- Integration of patient information systems or ability to rapidly transfer and share clinical information.

The Steering Group has additional concerns about possible disruption to the care pathway for children with chronic illnesses where local primary and community services need to work with a remote acute paediatric team. Community paediatric services are outside the remit of the TSAs, however effective working at the interface between specialist/acute and community paediatrics is critical in relation to the safety and positive experience of the child and family.

7.4. Impact on acceptability

There has been a history of high rates of use of inpatient services by the local population, and there is great attachment to these services and concern about their loss. It will be important that the new paediatric clinical network offers active support to the families of those children who have previously had very regular or frequent admissions into the Stafford Hospital unit, especially through the transition to the new model of service.

> *"When my son was younger he was in and out of Stafford hospital, he had numerous stays. If I had to travel to Stoke or somewhere else he probably would not be here today, I didn't drive at the time. He was 3 days old when he was first poorly, and I came out of hospital on day 3 and had to go back in on day 4. He was asthmatic and we stayed in there for 2 weeks with him, but if it had been any other hospital, bearing in mind I wasn't a driver back then, he wouldn't have made it anywhere else"*

The existing hospital services and primary care can both support more appropriate care and reduced parental anxiety by signposting families to the existing range of advice and assessment for the acutely sick child, including:

[124] *Standards for Children and Young People in Emergency Care Settings Developed by the Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings*, British Association of Paediatric Surgeons, College of Emergency Medicine, Joint Royal Colleges Ambulance Liaison Committee, Royal College of Anaesthetists, Royal College of General Practitioners, Royal College of Nursing, Royal College of Paediatrics and Child Health, London: RCPCH, 2012.

- 111 for advice on management of minor and self-limiting illness and when to seek further help;
- GP-booked appointments for local medical assessment, and out of hours contact for the onset of sudden acute illness or potentially serious deterioration; and
- 999 in cases of serious concern requiring urgent assessment or intervention.

In all of these cases, parents are able to access local or at home professional assessment. Where a child is assessed as requiring immediate attention at hospital, the relevant professional can arrange for ambulance transport. There seems to be considerable confusion amongst the local public about what urgent care is available when. Whenever services are provided at facilities on a part-time basis, the public must be fully informed of the opening hours and know how to access alternative care in a safe and timely way[125]. This also applies to GPs: research[126] has shown that (in relation to a newly-opened PAU) concerns exist amongst GPs and their teams with confusion around which children to refer (and when) to such units.

There is significant public concern about access to hospital for acute care, with parents and others expressing concern about travel to distant units when they may not have access to private transport or may have other children at home for whom they have to care. However, if they first access advice close to home, there may not be a need to travel at all; if the child is assessed as requiring specialist assessment, s/he can be transported in safety. It is important that parents can readily access advice and reassurance that will in most cases then enable them to care for the child safely at home.

When an inpatient admission is required, it is a time of great anxiety and disruption for a family. The TSAs will want to ensure that there is an appropriate infrastructure to support parents and siblings at alternative units, including provision for a parent to stay over as a more dispersed population is served. This could include through the expansion of onsite parent and family accommodation and building on the current service delivery model to understand what technology is available to support consultant-led delivery whilst ensuring minimal disruption to the lives of patients.

Based on the qualitative evidence gathered (including Steering Group members' attendance at public consultation events), there is particular concern in the local community around ensuring the continuing safety of acutely ill children where they may need to be transferred between an assessment and an inpatient unit on another site.

The NHS Institute for Innovation and Improvement has noted[127] the importance of clear and visible arrangements for the safe transfer of children in building the confidence of the local

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[125] *Standards for Children and Young People in Emergency Care Settings Developed by the Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings*, British Association of Paediatric Surgeons, College of Emergency Medicine, Joint Royal Colleges Ambulance Liaison Committee, Royal College of Anaesthetists, Royal College of General Practitioners, Royal College of Nursing, Royal College of Paediatrics and Child Health, London: RCPCH, 2012, p. 11.

[126] Lisa Williams et al, Setting up a Paediatric Rapid Access Outpatient Unit: Views of general practice teams, *BMC Family Practice* 2008, 9:54.

[127] *Focus on: Children and Young People Emergency and Urgent Care Pathway*, NHS Institute for Innovation and Improvement, 26 June 2008, p. 33.

community. In their case study, the Institute describes how a NHS Trust contracted with the St. John Paramedic Ambulance Service to provide dedicated transfer between the two units, and work as part of the core clinical team when they are not involved in the transfer of children. The West Midlands Ambulance Service (WMAS) has stated that it is actively reviewing the proposals for paediatric services and is confident that it could build on existing arrangements across the region to ensure the right skills will be available.

7.5. Access to services

The impact of travel times and costs is discussed in detail in Section 10.4; this section highlights only those issues most pertinent to paediatric services. The major concern here, as for the other draft recommendations, relates to the public perception of the scale of the change and arrangements for patient transport.

Most children, most of the time, will not need a hospital admission when ill. However, it is essential that the right services are available in a timely manner when a child does need them. In the two CCGs, there has been a history of some 45 children a week being admitted to hospital; if this reflected what might be expected nationally, it would still be ca. 40 children per week.

One of the main concerns voiced locally has been the increase in travel times for children who either have to travel further directly for admission or who have to be transferred from the PAU at Stafford Hospital. The travel time analysis presented in Section 10 demonstrates that the new travel times are within the norms associated with hospital travel in England. The Steering Group has also engaged with the West Midlands Ambulance Service (WMAS) and understands that: (i) paramedics are trained in advanced airway management (intubation and stabilisation); and (ii) WMAS already operates in rural areas (e.g. around Hereford) where there are relatively longer journey times and would apply their learning from this to Staffordshire. The Steering Group understands that additional resources are required for WMAS to appropriately operate the new service delivery model required under the TSAs' draft recommendations.

The maintenance of outpatients and the development of the PAU will minimise the numbers of families affected by the changes to paediatrics. The shift of inpatient services means that children would almost exclusively be travelling by ambulance, or perhaps private car for some minor operations. It seems very unlikely, and unreasonable, that parents would bring their acutely sick child to hospital by public transport for a possible admission.

For the majority of children and their families, the recommendations of the TSAs will make no difference to access. Existing outpatient services will continue to be offered at Stafford and Cannock Chase Hospitals, and the PAU at the former will operate from 08:00 to 22:00, consistent with A&E opening times. The inclusion of the Stafford Hospital services in a wider clinical network with access to specialist advice should reduce the rate of admission and call-back meaning less disruption and travel for many families of children with self-limiting acute illness or other ambulatory care sensitive conditions. There will be a significant impact on families who require regular admissions for exacerbations in chronic conditions or with a

child who has an acute episode of serious illness and who do not have access to a car; for the latter cases, the Steering Group expects access to be via the ambulance service.

Locally, parents have drawn attention to the wider impact of the changes on those families who have children requiring regular or extended hospital admission. They are at risk of negative impact and proposals to limit the impact of this are discussed in Section 10 on travel times:

- The difficulties of regular visiting when dependent on public transport;

> *"I have to walk 2 miles to the bus stop. I think it is going to lead to greater isolation of the patient because people will not be able to visit them frequently"*

- The challenge of making arrangements for looking after other children; and

> *"If you have got more than one child you don't want to drag the other children along. Who will have them after school if the buses are late? Or if it is in the middle of the night? What an earth will happen then? There is definitely a financial impact if only one of you drives and your partner has to have the day off work. They will either have to lose the money or take a holiday which will be impacting further down the line"*

- The cost of travel (particularly the opportunity costs with other household expenses for those on low incomes, and the difficulty of making 'upfront' payments, e.g. for taxis).

> *"One of the biggest problems is when people are at Stafford hospital and they are discharged under normal opening hours and are then tipped out at 1am in the morning and then have to get a taxi home which for a 3 mile journey is £15 pounds. That is obviously really bad. But if we have to go all the way to Stoke and they are tipped out early hours in the morning that is going to be really expensive, and for elderly people that is going to be a major financial disadvantage".*

There is scope to enhance accessibility at the interface with community services where:

- A wider range of assessments and clinics are provided through the enhanced paediatric network and hosted as part of the paediatrics outpatients service;
- Cannock Chase Hospital develops into an elective care centre, which could be an opportunity to host paediatric day case surgical cases, opening access for its local population (which is more deprived than the Staffordshire average); and
- A 'virtual ward' approach developed, enhancing early return to home for children who may require an extended period of treatment or rehabilitation.

7.6. Impact on relevance of services for the local population

7.6.1. Thresholds for attendance and admission

The Scoping Report noted that the current level of paediatric admissions to Stafford Hospital is above the national average (12.9% vs. 11.4% for 0-14 years). Qualitative evidence from the focus groups reinforces the implication that these high rates reflect a low threshold for admission at Stafford Hospital compared to that found elsewhere in England, which has been expensive for commissioners and potentially highly disruptive for children and families.

The development of a dedicated paediatric team working in parallel with Stafford Hospital's A&E as part of a wider paediatric network should both give timely access to specialist advice, and support active observation and assessment closer to home without admission. The concentration of inpatient paediatric beds on a more remote site is consistent with RCPCH guidelines and reflects a national shift to specialisation for serious illness[128,129]. It will be essential, particularly given the legacy of an inpatient bias in service provision, to offset the move of inpatient beds with greater investment in community support and the development of a 'whole system' approach to working with children and families which keeps the child as close to home as possible, and minimises the requirements to travel.

Even experienced medical professionals may need a period of observation to thoroughly assess a sick child, as the child may either stabilise or deteriorate quite quickly. The model proposed by the TSAs is consistent with RCPCH advice that paediatric networks should increasingly include tiered services where a few major hospitals offer 24/7 inpatient care, supported by a number of smaller hospitals that may offer less than 24/7 inpatient care without dedicated inpatient beds[130]. The short-stay PAU, close to the A&E department, allows for the observation of children when their clinical course is uncertain, without having to resort to immediate hospital admission, and should allow more children to return home on the same day with advice after assessment[131].

The current relatively high rates of admission for chronic disease in children suggest that there is also scope for more assertive advice and support to parents in home management and observation, and a review of availability and responsiveness of primary care to acute illness in children and young people.

7.6.2. Future activity based on local population growth

As with maternity services, there is real concern in the local population that expansion of housing and the increase in Armed Forces personnel has not been considered in the TSAs'

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[128] R Goudie, M Goddard (2011) Review of Evidence on What Drives Economies of Scope and Scale in the Provision of NHS Services, Focusing on A&E and Associated Hospital Services- A report for the OHE Commission on Competition in the NHS. Centre for Health Economics, University of York. 30 June 2011. Pg. 23

[129] *Commissioning Safe and Sustainable Specialised Paediatric Services-A Framework of Critical Inter-Dependencies*. DH, August 2008.

[130] *Modelling the Future III: Safe and sustainable integrated health services for infants, children and young people*, December 2009, London: Royal College of Paediatrics and Child Health, p. 45.

[131] Ibid., p. 32.

draft recommendations. The Office for National Statistics (ONS) estimates that the overall population for the two CCGs will increase by 4% between 2012 and 2021. The proportion of children and young people aged under 20 will remain fairly steady (increasing by 0.5%). In addition, growth in the local Armed Forces population[132], would bring ca. 420 families including ca. six hundred children (these numbers are subject to change). Stafford Borough Council has also given planning permission for some 3,000 new houses. It is estimated that the population growth from the Armed Forces and housing development will lead to an additional 1,670 children under 20 from 2018 onwards.

Table 7.1 shows the population projection and changes in hospital admissions, including the impact of the Armed Forces and additional housing. This indicates that, even with the additional population growth over the next several years, and assuming the proportion admitted to MSFT remains at its current rate there would be no significant change in the number of admissions required into paediatrics across the local health economy.

Table 7.1: Estimated population projections and hospital admissions for children and young people under 20 for Cannock Chase and Stafford & Surrounds CCGs

	2012/13	2015	2020	2025	2030
Cannock and Stafford CCGs population	60,000	61,300	62,400	64,000	63,800
Estimated number of admissions	8,700	8,600	8,600	8,600	8,500
Estimated number of admissions at MSFT	6,200	6,200	6,100	6,100	6,100
Estimated number of admissions that may be impacted by TSA recommendation (based on the assumption that 60% will continue to attend PAU)	2,500	2,500	2,500	2,400	2,400

Source: Hospital in-patient data extracts, Central Midlands Commissioning Support Unit (CSU)

The number of finished consultant episodes (FCEs) for children aged under 15 for MSFT, UHNS, Wolverhampton and Walsall has grown by around 6% between 2009/10 and 2011/12, compared to 3% nationally from 48,652 to 51,482. Almost half of that activity has previously been seen at Stoke (21,049 FECs in 2011/12), with local hospitals being the minority providers. Any potential concentration of inpatient activity at UHNS would be in line with the historic focus of paediatric capacity.

7.7. Impact on equity

7.7.1. Impact on the characteristic of age

It is axiomatic that paediatric services are targeted at children and young adults and their families. The impact in relation to age as a protected characteristic is therefore one that applies to the whole population of children and there is no specific inequality impact. This general impact is relevant under the characteristic of age and is discussed throughout.

[132] Data as communicated (June 2013) by the Head of Armed Forces Health, NHS England

7.7.2. Impact on the characteristic of disability

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. In Cannock Chase there are 836 children with a limiting long-term illness (4.5% of children) and 870 (3.9%) in Stafford, against a national average of 3.7%. Six hundred and eighty five families in Cannock Chase claim disability living allowance for a child under 16 (3.8%) and 660 in Stafford (3%) against a national average of 3%[133]. These families are likely to make regular use of health services (although not necessarily of inpatient care) and will be a high priority for active support and access to transport. The main impact will be felt by parents visiting those children requiring frequent admission, many of whom will be children with a disability.

Research[134] into admission patterns for children with special needs to a single Paediatric Assessment Unit (PAU) over five years concluded that 60% of the patients referred to the assessment unit as an emergency were admitted to hospital and that children with severe neuro-disability, learning difficulties, and dependent on technology were more likely to be referred. Moreover, this research showed that a small group of children with severe neurological disability and learning difficulties used emergency services very frequently. Although the cases considered (3.06%) represent only a tiny proportion of referrals to the assessment unit over the same period, the data provide important background information about the utilisation of the unit by this group of patients. Many referrals were for acute illnesses, but other episodes were as a result of complications to procedures performed on these children.

This research concluded that children with special needs tend to have a predictable pattern of conditions requiring inpatient care. In the study, one third of the inpatients episodes did not need a prolonged stay in hospital and this group of children could be managed at home with the support of community nurses. Integrated care pathways need to be developed to minimise disruption to their lives. Resources required include a dedicated team of outreach nurses who should have training in recognition of seriously ill children. In addition to core nursing skills, they should be able to manage gastrostomy[135], management of seizures, respiratory disease, and intravenous access including portage[136]. A comprehensive community nursing service should be the bedrock of wider out of hospital services for ill and disabled children[137] and the new clinical network will need to ensure the development of effective pathways for children with chronic conditions and long-term nursing needs.

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[133] Source: Department of Work and Pension, mid-year population estimates, Office for National Statistics, Crown copyright and 2011 Census, Office for National Statistics.

[134] M Mahon, M S Kibirige, Patterns of admissions for children with special needs to the paediatric assessment unit, *Arch Dis Child* 2004;89:165–169.

[135] Creation of an artificial external opening into the stomach for nutritional support or gastrointestinal compression

[136] An intravenous access port is a device used to give treatments and to take blood

[137] *NHS at home: Children's Community Nursing Services*, London: Department of Health - Partnerships for Children, Families and Maternity, March 2011, p. 7.

A 2013 report[138] from the British Medical Association (BMA) provides evidence of a large number of children with a relatively 'mild' disability requiring on-going local help, and a much smaller group of children with profound disability requiring more intensive and/or specialist intervention. The research therefore suggests that children with disabilities are potentially higher users of both PAU and inpatient services. However, with the right community infrastructure much of the contact should be deliverable at (or close to) the child's home. Of those who do need regular inpatient stays, this may well be of a specialised nature which have always have been seen at (for example) UHNS or Birmingham Children's Hospital rather than by the local team at Stafford Hospital.

7.7.3. Impact on the characteristic of race

The proportion of children under twenty from a minority ethnic group in Cannock Chase (8.4%) and Stafford (15.6%) is relatively small compared to the figure for England (46.3%) (see Table 7.2 below). The Scoping Report noted that the main minority ethnic groups in Cannock Chase and Stafford are "White: Other White" (largely Eastern European), Indian, White and Black Caribbean, Other Asian, and White Irish (each with over one thousand individuals).

In relation to the health needs of children from minority ethnic groups, a review[139] of ethnic differentials in health and healthcare noted that there are marked differences in obesity, with Afro-Caribbean and Pakistani girls and Indian and Pakistani boys more likely to be overweight. In addition, respiratory illness was more prevalent in Afro-Caribbean and White Irish groups. A review[140] of access to health care for minority ethnic groups concluded that evidence is emerging on the need for cultural competence, as well as linguistic competence, in healthcare organisations. However, although this national evidence suggests that children from certain minority ethnic groups can have greater health needs, this does not appear to be the case for Stafford as their admission rates are lower than that of the general population[141]. In addition, specific conditions related to ethnicity are more likely to be managed in specialised services outside of MSFT, and would not be affected by the TSAs' draft recommendations. These will be very small numbers locally but it would be a population likely to require more frequent inpatient admission.

There are much higher proportions of minority ethnic group populations in each of the Stoke, Walsall and Wolverhampton populations (see Table 7.2 below). Each of the hospitals in these areas is more likely to have the infrastructure and familiarity to deliver greater cultural competence in interactions with minority communities. In particular, during an inpatient stay, facilities may be more appropriate for children from minority ethnic groups at one of these alternative hospitals than at MSFT. It is not likely that children from minority ethnic groups will be particularly disadvantaged by the TSAs' draft recommendations, and

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[138] *Growing Up in the UK: Ensuring a Healthy Future For Our Children*, London: BMA Board of Science, May 2013, p. 109.

[139] *Ethnic disparities in health and health care: A focused review of the evidence and selected examples of good practice*, P Aspinall and B Jacobson, London Health Observatory, July 2004.

[140] A Szczepura (2005), Access to health care for ethnic minority populations, *Postgrad Med J* 2005; **81**:141–147.

[141] MSFT Health and Equalities Impact Assessment: Scoping Report

some South Asian communities may benefit from access to services which have developed a greater level of cultural competence and insight.

Table 7.2: Estimated ethnic minority group population for children and young people under 20 by local authorities, 2011

Local authority	Children aged under 20	Children from an ethnic group	Percentage
Cannock Chase	23,381	1,066	4.6%
Stafford	28,643	2,448	8.5%
Stoke-on-Trent	61,576	12,211	19.8%
Walsall	70,277	22,583	32.1%
Wolverhampton	62,952	27,552	43.8%
West Midlands	**1,391,931**	**396,026**	**28.5%**
England	**12,712,275**	**3,197,034**	**25.1%**

Source: 2011 Census, Office for National Statistics

7.7.4. Impact on the characteristic of socioeconomic deprivation

For families living in poverty, there are three main potential impacts of the TSAs' draft recommendations: (i) an improvement in the relevance of services if there is more effective and appropriate response to self-management; and/or (ii) access to specialist expertise where necessary through the development of a clinical network; and/or (iii) the risk of parents and carers being disadvantaged by longer travel times and higher costs, where they lack access to private transport.

Poverty and social inequalities are some of the most significant stressors on family life and are crucial determinants of children's health and wellbeing[142]. A 2010 review[143] of the research on emergency admissions noted that people from lower socioeconomic groups are at higher risk of avoidable emergency admission. For admission to A&E/PIU, research suggests that higher rates of admission to hospital in poorer areas may be due to the increased prevalence of certain disorders combined with a lowered threshold for admission[144] and that children living with deprivation are more likely to use A&E departments as a source of health care[145]. The difference in admission rates has been estimated: in one report[146], 7.2% of the most deprived children were admitted to hospital each year for surgical or paediatric care compared with 5.5% of the most advantaged. The majority of children in the catchment area for MSFT live in areas that are average or less deprived than others in England. The development of a clinical network should limit the risk of unnecessary disruption and anxiety for that group.

[142] *Growing Up in the UK: Ensuring a Healthy Future For Our Children*, London: BMA Board of Science, May 2013, p. 26.

[143] *Avoiding hospital admissions What does the research evidence say?*, London: The King's Fund, December 2010.

[144] Y Thakker, T A Sheldon, R Long, R MacFaul, Paediatric inpatient utilisation in a district general hospital, *Archives of Disease in Childhood* 1994; **70**: 488-492.

[145] M Stewart, U Werneke, R MacFaul, J Taylor-Meek, H E Smith, I J Smith , Medical and social factors associated with the admission and discharge of acutely ill children, *Arch Dis Child* 1998;**79**:219–224.

[146] R MacFaul, U Werneke, Recent trends in hospital use by children in England (2001), *Arch Dis Child* 2001 **85**: 203-207, p. 206.

This group is at risk of particular disadvantage in access, where the excess travel times and costs for visitors will have greatest negative impact for their parents. A report[147] on equity in the NHS concluded that although the direct costs of transportation should not act as a barrier to access to hospital for those on lowest incomes, there will be significant numbers still in the lower income groups who do not qualify for the scheme and may find direct costs a barrier to access. However, the Steering Group is particularly concerned that the group most likely to face additional challenges in access as result of the move of inpatient services is parents living in poverty. Some patients are eligible for the Healthcare Travel Costs Scheme (HTCS), which is for those that cannot meet the cost of travelling to hospital, and cannot get a friend or relative to assist[148]. The HTCS applies if a patient is receiving one of the qualifying benefits or allowances, or meets the eligibility criteria of the NHS Low Income Scheme. Travel costs for children can be claimed if the parent/carer receives one of the qualifying benefits or allowances. However visitors cannot claim help with travel costs, although visitors in receipt of one of the qualifying benefits may be able to receive assistance in the form of a Discretionary Care Grant from their local council. Further information on the impact of travel times and the associated mitigating actions is given in Section 10.

In the qualitative research commissioned by the Steering Group, an interview with a single mother on low income indicated that people facing socioeconomic deprivation tend not to travel far outside their local area. Journeys to other hospitals may be daunting and unfamiliar for both car owners and public transport users. The interviewee felt that the impact on families on low incomes has not been thoroughly considered in the development of the draft recommendations as the additional cost of travel to hospitals other than Stafford may have a disproportionate impact on them.

> *"...taxi firms are quoting daytime rates for UHNS of £28 - £33 one way, after midnight this rises to £42 - £50. New Cross is £26 - £30 day rate and after midnight £32 - £45. £50 is the food budget for the week for her family – how will families that rely on their entire income to run their homes and feed their children have the ability to pay for a taxi?"*

7.7.5. Impact on the characteristic of rural isolation

There are 16,200 children and young people aged under twenty living in areas across Cannock Chase and Stafford and Surrounds CCGs that are categorised as rural by the Office of National Statistics (ONS). Rates of admissions for children from these areas are lower than those living in more urban areas[149]. Current travel times for Stafford Hospital from these wards are higher than for users from other areas; however, the increase in travel times for rural areas due to the TSAs' draft recommendations is not significantly different from that of other areas (see Section 10 for a full description of travel times and related mitigating

[147] Anna Dixon, Julian Le Grand, John Henderson, Richard Murray and Emmi Poteliakhoff, *Is the NHS equitable? A review of the evidence*, London: LSE, 2003, p. 24.
[148] NHS Choices at http://www.nhs.uk/chq/Pages/1079.aspx?CategoryID=68&SubCategoryID=154 (accessed 21st August 2013).
[149] Public Health Staffordshire analysis.

actions). However, the limited availability of public transport to support visiting is a real issue for parents and the families of children requiring frequent or extended admission.

Access to services for children in rural areas is a challenge, particularly for those on low incomes or dependent on public transport. However, a review[150] of users and providers of children's centres in rural communities found that 62% of people surveyed believed that health services were available at the times and places where they were needed. Among those without access to private transport, less than a third felt that they could easily and conveniently access health appointments; among workless families, only 41% of families believed this to be true. This survey was based on access to all health-care (including primary care, outpatients and community services).

[150] *Peace and quiet disadvantage: insights from users and providers of children's centres in rural communities*, London: Capacity, 2009.

7.8. Proposals to mitigate the impacts of the TSAs' draft recommendations

Based on the impacts summarised above, the Steering Group has put forward the following proposals to mitigate the negative impacts and enhance the positive impacts of the TSAs' draft recommendations:

- As with maternity services, the TSAs should ensure that the aspiration to meet national standards is fulfilled by ensuring sufficient capacity in alternative inpatient paediatric services to provide effective medical and skilled nursing cover out of hours, at weekends and at times of peak activity. This should also address areas of associated concern (for example, anecdotal evidence around the availability of routine neonatal checks at UHNS);
- The Academy of Medical Royal Colleges (AMRC) notes[151] that the drive towards seven day consultant-delivered care must be complemented by support services available in the community seven days a week. This will be especially important in the TSAs' model of care because inpatient services will not be located at Stafford Hospital. For long-term conditions (LTCs), the RCPCH notes[152] that the model of service delivery should be largely community-based, meaning delivery at home, in schools, or in other local settings, with hospital-based reviews or interventions only when necessary;
- The RCPCH further recommends[153] that better urgent care should be provided in community settings, and parents need clearer information on how and where to access advice and treatment (see below);
- Clear protocols are required for first contact services (including primary care and 111) regarding where to take sick children, and availability of information for parents on signs of serious illness and management of acute but self-limiting illness (including fever, diarrhoea, sickness, headache etc.);
- Work with WMAS to ensure the service has the capacity and capability to sustain the new model of inpatient care;
- Where a child does require an admission or specialist assessment, active consideration and support for families living in rural isolation and/or on low income and/or dependent on public transport. The impacts could be ameliorated by the TSAs planning for: (i) financial and other transport support for vulnerable families (including ensuring availability of child seats in voluntary or commercial transport arrangements); and (ii) improved availability of family accommodation in proposed extended paediatric inpatient units;
- Given the substantial redesign of paediatric services that will be required, the Steering Group recommends taking the opportunity to address Recommendation 33 of the Kennedy Review[154]: "NHS services for children and young people should be designed, organised and delivered from the perspective of the child, young person and parent or

[151] *Seven Day Consultant Present Care*, London: Academy of Medical Royal Colleges, December 2012, p. 3.

[152] *Modelling the Future III: Safe and sustainable integrated health services for infants, children and young people*, December 2009, London: Royal College of Paediatrics and Child Health, p. 7.

[153] *Modelling the Future III: Safe and sustainable integrated health services for infants, children and young people*, December 2009, London: Royal College of Paediatrics and Child Health, p. 45.

[154] *Getting it right for children and young people: Overcoming cultural barriers in the NHS so as to meet their needs*, A review by Professor Sir Ian Kennedy, September 2010, p. 94.

carer. Relevant NHS services should regularly assess the expectations and views of children and young people using the services, and should take action in the light of the findings, which should be made public"; and

- Assertive management within the clinical network should seek to minimise disruption to the lives of children living with disabilities, including optimising the development of community support as an alternative to hospital contact. Outreach nurses should have training in recognition of seriously ill children. In addition to core nursing skills, they should be able to manage gastrostomy, management of seizures, respiratory disease, and intravenous access including portage. A comprehensive community nursing service should be the bedrock of wider out of hospital services for ill and disabled children[155].

[155] *NHS at home: Children's Community Nursing Services*, London: Department of Health - Partnerships for Children, Families and Maternity, March 2011, p. 7.

8. Impact of the TSAs' draft recommendations on emergency, urgent and critical care

This section describes the TSAs' draft recommendations for emergency, urgent and critical care (EUCC) services and their associated impact. The appendix for the changes to EUCC services is contained in Appendix A.

8.1. Summary of the Scoping Report

The Scoping Report did not explicitly comment on the elements of EUCC that are affected by the TSAs' draft recommendations but noted that:

- There is a low threshold for admission from the Accident and Emergency (A&E) department in MSFT, and that there is therefore a higher than average utilisation of these services given the profile of the local population; and
- There is an apparent lack of impact of, and perhaps capacity in, community services to support people closer to home as an alternative to hospital admission and for step-down and rehabilitation services.

8.2. Summary of the TSAs' draft recommendations for EUCC services

8.2.1. Overview of the recommendations

The TSAs have recommended that the **A&E at Stafford Hospital** remains open over the same hours as currently (14 hours a day, seven days a week).

A nurse-led **Minor Injuries Unit (MIU)** is currently provided at Cannock Hospital by Staffordshire and Stoke-on-Trent Partnership NHS Trust (SSoTP). The service operates 16 hours a day (08:00 to 24:00), seven days a week. As the MIU is not provided by MSFT, it cannot be included in the development of location specific services (LSS) for Cannock Chase. However, it is a stated commissioning intention of Cannock Chase CCG that there remains a MIU in Cannock.

In the TSAs' draft recommendations, non-elective/**emergency general surgery** and trauma surgery is no longer undertaken at Stafford Hospital.

Additionally, the TSAs' have also recommended that the critical care unit at Stafford Hospital to longer have a dedicated **level 3** area.

The TSAs have recommended that the **Medical Assessment Unit (MAU)** is enhanced to include a specialist focus on assessing the frail and elderly, in order to support more medical admissions closer to home. This **Frail Elderly Assessment Unit (FEAU)** would operate, between 08:00 and 22:00, seven days a week (in line with the recommended A&E opening times), but the beds in the unit will be operated 24 hours a day. Patients can be admitted into the MAU by the A&E at Stafford and directly referred to the MAU by community care and primary care providers.

8.3. Impact on effectiveness

The Steering Group considered effectiveness in relation to the impact on the West Midlands Ambulance Service (WMAS) and on the availability of critical care services in the local health economy.

8.3.1. A&E services

The A&E at Stafford has been operating between 08:00 and 22:00 some 18 months and has been supported by increased activity in the ambulance service, ensuring that outside of these hours, patients are safely transferred to the next nearest; available and appropriate unit.

8.3.2. Medical assessment unit / frail elderly assessment unit

The Steering Group recognises the commitment to maintain general medical services on site as part of a formal clinical network. A significant proportion of hyper-acute and serious illness is now managed in other more specialised units, and this initiative will support more local care for common and chronic conditions. It will be important to develop protocols within the network for the transfer of patients between specialised units and the local service, either in the case of deterioration or as part of a step-down service closer to home. This may require clarification of arrangements for inter-hospital transfers (IHT) and ensuring that sufficient capacity exists to support these, whether provided by WMAS or another organisation. Medical inpatient services may have an important role to play in minimising multiple moves for older people. There is considerable evidence that multiple moves are associated with raised mortality in older people[156,157,158] and there is concern that a model which concentrates specialist services on remote sites could increase multiple transitions and therefore risks for older people.

Members of the Steering Group anticipate that the impact of the development the frail elderly assessment unit (FEAU), which could provide diagnosis, stabilisation and treatment on-site in Stafford Hospital, and minimise the need to admit to a more remote unit, to be positive. WMAS has indicated that the anticipated impacts and clinical risks of the FEAU include the need to understand the FEAU care pathway, the expected number of patients, and therefore the resource impact. The British Geriatrics Society (BGS) has highlighted the importance of discharge planning as frail old people may require complex support networks, both formal and informal, to support them in their own homes[159]. The RCP notes[160] that lack of continuity of care is a principal concern and is a particular problem for older patients who are more likely to be hospital inpatients. Although services not provided by MSFT are

[156] Mikhail ML. (1992) Psychological responses to relocation to a nursing home, *Journal Gerontol Nurs.*

[157] McKinney AA, Melby V (2002) Relocation stress in critical care: a review of the literature, *J Clin Nurs*.

[158] Nicholas G. Castle, *Relocation of the Elderly*, Institute for Health, Health Care Policy and Aging Research.

[159] Ibid., page 5.

[160] Future Hospital Commission. *Future hospital: caring for medical patients*. A report from the Future Hospital Commission to the Royal College of Physicians. London: Royal College of Physicians, 2013, p. 64.

outside of the remit of the TSAs, the Steering Group considers that this issue is a priority that should be addressed during implementation.

8.3.3. Emergency Surgery

In relation to emergency surgery at Stafford Hospital, the Steering Group notes that the National Clinical Advisory Group (CAG) views emergency service as unsustainable due to low volumes, previous concerns raised by the Royal College of Surgeons, and evidence that supports the drive towards centralisation of these services. The Steering Group values an approach that both concentrates the very sick into specialist units and maximises care close to home, with arrangements to support an active elective and centralised emergency surgery programme with level 2 critical care at Stafford Hospital. This includes the ability to intervene (including intubation and respiratory support), and stabilise for transfer. Although there are concerns about the increase in travel times and transfer of patients (especially since the users of emergency surgery and level 3 critical services are very ill), there is a range of proposals (refer to Section 10) to mitigate these concerns. The Steering Group has engaged with the West Midlands Ambulance Service (WMAS), and understands that inter-hospital transfers for level 3 critical care are already common and paramedics are trained for stabilisation and transfers.

Centralisation of emergency surgery services is in line with national trends. The Royal College of Surgeons (RCS) recommends[161] that where possible, major emergencies are centralised but patient assessment and lower risk surgery is delivered closer to patients' homes. The RCS notes that medium-sized hospitals can deliver safe and proficient care where they meet all professional workforce and capacity standards and there are adequate transfer protocols in place for necessary cases and the receiving hospitals have adequate capacity. It is not clear that Stafford Hospital can meet these criteria, or that neighbouring hospitals would have the capacity to respond to ad hoc emergency transfers outside of a full transfer of service. There is a substantial amount of research that indicates a positive relationship between volumes and outcomes for both surgical procedures and critical care and is summarised in Appendix A.

8.3.4. Level 3 critical care

A range of services within Stafford Hospital need to be co-located with a critical care unit in order to operate a safe service. The services requiring a degree of critical care include acute medicine and the care of the elderly inpatient service. However, the TSAs have stated that the reduction in the volume of surgical activity of an emergency nature (following Recommendation 8) will reduce the demand at Stafford Hospital for all critical care, and especially for level 3 critical care. Level 3 critical care is a highly specialist service for very sick patients and requires significant throughput for staff to maintain their skills and a high staff to patient ratio, making it very expensive if patients do not require that level of intervention. Intensivists will form part of the new clinical network arrangements and this may make best

[161] Emergency General Surgery, Royal College of Surgeons and Association of Surgeons of Great Britain and Ireland.

use of their skills across a network of sites and potentially expose staff to a range of different levels of intervention, developing competency and resilience.

Under the TSAs' draft recommendations, patients in Stafford Hospital who require level 3 critical care will need to be stabilised and then transferred to the nearest suitable facility. Ambulance transfers from Stafford Hospital to UHNS and RWT are estimated to take between 20 and 30 minutes. Members of the public have expressed significant concern about patient safety where people need to be transferred out of Stafford to receive level 3 critical care.

The Steering Group did not find any relevant evidence on the impact of short distance transfers (30 minutes or less). However, there are five studies[162,163,164,165,166] covering a total of 245 critically ill patients who were intubated and ventilated prior to long distance transfers (above 100 minutes or 100 miles). Very few adverse events or significant therapeutic interventions during transport were reported. One study[167] reported a 19% incidence of respiratory alkalosis[168] on arrival and another study[169] documented a 30% overall intensive care unit mortality, while no adverse events or outcomes were reported after arrival in the three other studies. A separate study on patients with chest pain complaints found that transferring high-risk patients had no adverse impact on clinical outcomes or resource use as long as there were conservative patient selection criteria, pre-transfer stabilisation and the use of appropriate equipment and medical personnel[170].

8.4. Impact on acceptability

Patient choice is guaranteed under the NHS Constitution[171]: "You have the right to make choices about the services commissioned by NHS bodies and to information to support these choices. The options available to you will develop over time and depend on your individual needs". However, some services are excluded from this concept of choice where speed of access to diagnosis and treatment is particularly important, for example:

- Emergency attendances/admissions;

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[162] Barillo DJ, Dickerson EE, Cioffi WG, Mozingo DW, Pruit BA Jr: Pressure-controlled ventilation for the long-range aeromedical transport of patients with burns. *J Burn Care Rehabil* 1997, 18:200-205.

[163] Remond C, Jimeno MT, Dubouloz F: Mesures du CO_2 expire en transport extrahospitalier: Interets et limites, Jeur 1998, 4:179-186.

[164] Orf J, Thomas SH, Wedel SK: Ventilation rates in intubated head injury patients undergoing helicopter EMS (HEMS) transport
Crit Care Med 2000.

[165] Uusaro A, Parviainen I, Takula J, Ruokonen E: Safe long-distance interhospital ground transfer of critically ill patients with acute severe unstable respiratory and circulatory failure. *Intensive Care Med 2002*, 28:1122-1125.

[166] Veldman A, Diefenbach M, Fischer D, Benton A, Bloch R: Long-distance transport of ventilated patients: advantages and limitations of air medical repatriation on commercial airlines. *Air Med J 2004*, 23:24-28.

[167] Barillo DJ, Harvey KD, Hobbs CL, Mozingo DW, Cioff WG, Pruitt BA: Prospective Outcome Analysis of a Protocol for the Surgical and Rehabilitative Management of Burns to the Hand. *Plast Reconstr Surg* 100 (6): 1442-51, November 1997.

[168] Elevated blood pH due to hyperventilation.

[169] Uusaro A et al. Intensive Care Med. 2002 Aug;28(8):1122-5. *Epub 2002* Jun 15.

[170] Selevan JS et al (1999) Critical Care Transport: Outcome Evaluation After Interfacility Transfer and Hospitalization, Ann *Emerg Med January 1999*; 33:33-43.

[171] *The NHS Constitution for England*, Department of Health, 26th March 2013, p. 9.

- Attendances at a Rapid Access Chest Pain Clinic under the two-week maximum waiting time;
- Attendance at cancer services under the two-week maximum waiting time;
- Mental health services; and
- Public health services commissioned by local authorities.

The TSAs' draft recommendations clinical model for EUCC will have an impact on patient choice for the location of care for emergency and high risk elective surgery. Such surgeries can no longer take place in Stafford Hospital as there will not be a co-located level 3 critical care service.

The qualitative evidence from individuals living in rural communities suggested that there can be longer waiting times for emergency services due to difficulties in locating rural homes.

> *"Just last week we had someone go into an anaphylactic shock in the village, and I had to walk quite away to get out onto the road to wave the ambulance in because they didn't know where we were".*

Qualitative evidence from minority ethnic groups indicated a strong feeling that the A&E in Stafford Hospital should be open 24/7. They also had concerns on the quality of care and expertise of the retained staff in Stafford Hospital's A&E should paediatric and level 3 critical care services be transferred. Some of the South Asian community suggested that the transfer of level 3 critical care may make it more difficult for families to meet their cultural and religious requirement for urgent burial, although others reported that funeral arrangements at Stafford Hospital may already come through providers based in Wolverhampton or Stoke-on-Trent, where there is a larger Muslim population.

8.5. Impact on access to services

The greatest impact on access will fall on those who live closest to Stafford Hospital. These users may now have to be treated at a more distant hospital should they become seriously ill. Given the nature of all the proposed changes and the subsequent complexity in the impact on travel times, this analysis is presented in full in a separate section of the report (Section 10.4).

Under the TSAs' draft recommendations, access to the A&E at Stafford Hospital will be retained. The majority of A&E patients do not require emergency surgery and level 3 critical care, and will therefore be able to access Stafford Hospital as they do now. Additionally, the 16/7 MIU in Cannock Chase Hospital will remain.

The FEAU will offer a single point of access for frail elderly patients and should reduce the need for multiple hospital appointments. In addition, although providing care closer to home will have a positive impact on often vulnerable carers, particular attention will be required for support for carers and visiting arrangements (especially for those dependent on public transport). The maintenance of medical inpatients will support the 'step down' of

patients from more specialist units back to Stafford, limiting the length of stay at greater distance from home. The arrangements will not change the fact that for those living in rural isolation, it will remain difficult to visit the alternative hospital sites.

There is limited evidence on the impact of travel times that specifically relate to either emergency surgery or level 3 critical care. Instead, most studies are on the impact of travel times on emergency and urgent care outcomes as a whole. An observational cohort study[172] of 10,315 cases transported with a potentially life-threatening condition (excluding cardiac arrests) by four English ambulance services to acute hospitals suggested that a 10km increase in straight-line distance is associated with around a 1% absolute increase in mortality. A separate study[173] on the impact of travel on outcomes of emergency surgery also suggested a negative correlation between the two measures. The mean travel distance (68km) in this study is, however, much higher than the average for Stafford & Surrounds CCG and Cannock Chase CCG. As discussed in Section 8.2 emergency surgery and level 3 critical care patients will no longer be treated in Stafford Hospital. The study cited above suggests that this increase in travel times will increase mortality rates for such patients. However, it is not possible to conclude whether this cohort of patients will be worse off as there is a trade-off between the negative impact of longer travel and the positive impact of being treated at larger, more specialised hospitals. The impacts proposed by WMAS are described in Section 8.3 above.

8.6. Impact on relevance of services for the local population

Accident and emergency (A&E) attendances declined between 2009/10 and 2012/13 from 48,190 to 42,668 (for all Staffordshire CCGs)[174]; note that Appendix A provides additional details on local demand trends. However the Steering Group considers that there appears to have been a history of higher than average use of the A&E at Stafford Hospital for minor and self-limiting illness, which would be better self-managed or seen through general practice. There is nothing in the recommendations which seeks to address this, and the Steering Group considers that, in common with A&Es across England, patient education is required to change the current perception of A&E as the default option[175]. Not only do patients need to be informed on the best place to receive the type of care they require, but consistency between out of hospital and out of hours urgent care services is required to simplify access.

The number of admissions for emergency surgery from the population of Cannock Chase CCG and Stafford & Surrounds CCG rose from ca. 3,700 to ca. 4,600 (25% increase) between 2009/10 and 2012/13. The impact from the increase in demand from the CCG population

[172] The relationship between distance to hospital and patient mortality in emergencies: an observational study, J Nicholl, J West, S Goodacre, J Turner - *Emerg Med J,* 2007.

[173] Diaz JJ Jr et al (2006) Triaging to a regional acute care surgery centre: distance is critical, *J Trauma.* 2011 Jan;70(1):116-9.

[174] Public Health Staffordshire analysis.

[175] Sir David Nicholson, the chief executive of NHS England notes that "We also know that some people who present at A&E, and who we treat there, would have more appropriate care and a better patient experience if they were seen in a primary or community care setting. These may be people with long term conditions that need careful management, or people who are having problems getting an appointment at their local GP surgery." *Urgent and Emergency Care Review - Evidence Base Engagement Document*, NHS England, 17 June 2013.

varied across local providers. UHNS saw the largest increase (98%) in this period whilst MSFT saw a comparatively small increase of 9%[176].

In relation to level 3 critical care for Stafford & Surrounds and Cannock Chase CCG patients, critical care episodes having one or more day of level 3 care remained static between 2010/11 and 2012/13. However, there were changes at the trust level: MSFT saw a fall in the number of episodes, whilst UHNS, RWT and Walsall experienced a rise in episodes.

For activity at the proposed FEAU, the demand for acute medicine and care of the elderly services in Stafford Hospital is expected to increase in the future due to the forecast demographic changes in the local population. Whilst this increase is a national challenge, the projected rate of growth in the catchment area for the over-65 age group is higher than the national average (22% versus 19%). The creation of a FEAU should help meet and alleviate this demand.

The Steering Group recognises the benefits of the 'step down' model of care, where it reduces journey time and cost for often vulnerable carers. However most models of intermediate care are typically about active rehabilitation and the Social Care Institute for Excellence (SCIE) notes[177] that the focus of re-ablement is on restoring independent functioning rather than resolving health care issues with the of objective of helping people relearn how to do things for themselves. These modern models allow for support at home or in nurse- or Allied Health Professional-led units (e.g. with individual rooms, gyms, cooking facilities, en-suite rooms) rather than hospital wards[178].

8.7. Impact on equity

8.7.1. Impact on users in specific age groups

Clearly, the FEAU will benefit the elderly. There is also significant evidence[179,180,181] showing that the elderly face higher mortality rates following emergency or urgent care treatments. This is true for both low and high risk surgeries. The higher mortality rates can be attributed to increased disease severity and incidence of postoperative complications.

Over 65s have a higher demand for critical care and emergency surgery services. At MSFT, 79 of the 141 (56%) level 3 critical care episodes were for patients aged 65 and over. From 2012/13 patient level data, an A&E attendance by a patient aged 65 and above has a 14% chance of requiring emergency surgery (the probability for the general population is 10%). Their demand for EUCC services is therefore higher than that of the general population. In

[176] Public Health Staffordshire analysis.

[177] Reablement: a guide for families and carers, SCIE, March 2012.

[178] Examples of such facilities in hospitals include Berrywood Hospital and Homerton University Hospital Regional Neurological Rehabilitation Unit.

[179] Mary Beth Hamel et al (2005) Surgical Outcomes for Patients Aged 80 and Older: Morbidity and Mortality from Major Noncardiac Surgery, Journal of the American Geriatrics Society, Volume 53, Issue 3, pages 424–429, March 2005.

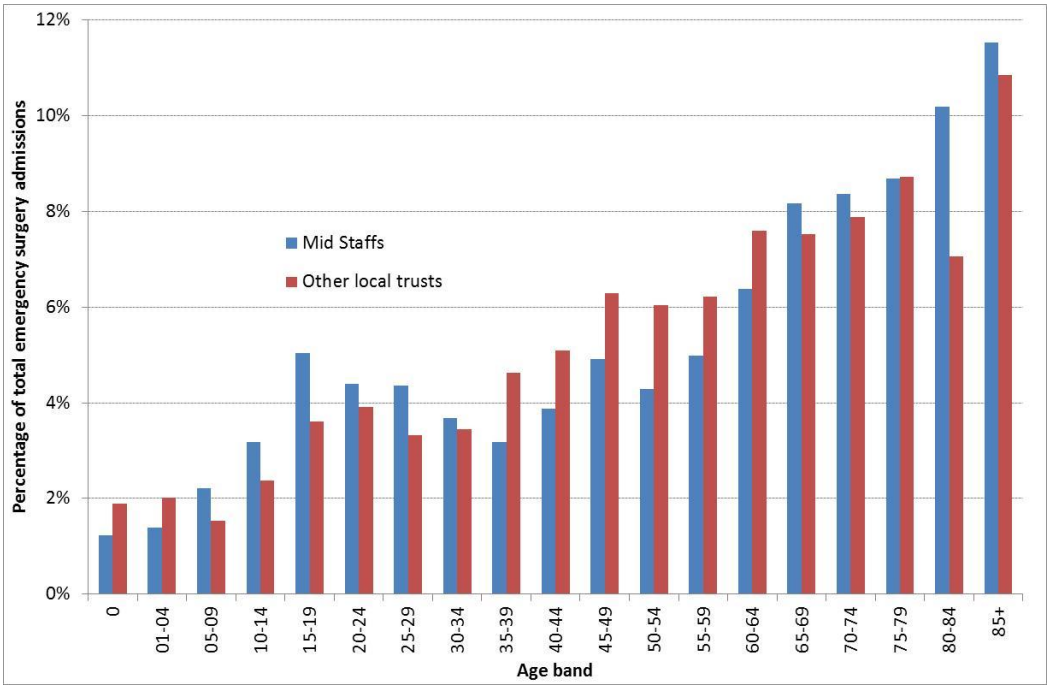
[180] Karen P Alexander et al (2000) Outcomes of cardiac surgery in patients age ≥80 years: results from the National Cardiovascular Network, J Am Coll Cardiol. 2000;35(3):731-738.

[181] Paola Primatesta and Michael Goldacre, Inguinal Hernia Repair: Incidence of Elective and Emergency Surgery, Readmission and Mortality, Int. J. Epidemiol. (1996) 25 (4): 835-839.

this context, the elderly may particularly benefit from a concentration of expertise and experience, although they are also more likely to end up at a more remote unit.

When comparing MSFT to other local trusts, a greater proportion of emergency surgery admissions were seen at MSFT in elderly patients (age 65 to 74 and age 80 and above) and in patients aged between 5 and 34 years, when compared with other local trusts.

Figure 8.1: Emergency surgery admissions for Cannock and Stafford CCG patients by age band and trust 2012/13



Source: Hospital In-patient Data Extract, NHS Healthcare Commissioning Services (HCS), South Staffordshire Health Informatics Service (HIS) data warehouse

8.7.2. Impact of the changes on users with disabilities

The Steering Group has been unable to find any data related to the usage rates and outcomes of emergency surgery and level 3 critical care services by individuals with disabilities. However, it is reasonable to assume that individuals with certain types of disabilities or long-term limiting illnesses such as epilepsy and chronic renal failure are more likely to use EUCC services than the general population. Individuals with certain long-term conditions may be more likely to require level 3 critical care but they are more likely to receive better care once admitted due to the higher volumes of patients seen at larger units (see below).

Additionally, some disabilities may present as a comorbidity and therefore increase the risk factors of medical and/or surgical interventions. This means that an intervention that is considered to be low risk for the general population may instead be considered as high risk for a patient with disabilities. Based on this assumption, individuals with disabilities will have a higher demand for post-operative level 3 critical care.

Given the complex needs of individuals with disabilities, they may be better served at larger, more specialised hospitals[182].

There was particular concern expressed in the focus groups about the difficulties that people with disabilities would experience in visiting partners or friends in more distant hospitals. There was a strong perception that a disproportionate number of people with disabilities will have limited access to affordable transport and will be reliant on family and friends or expensive private transport options in order to access services or visit patients. Qualitative evidence suggests that the ability of family and friends to provide transport could also be impacted by the transfer of services to other hospitals, due to a reluctance to drive longer distances or an inability to commit to a longer journey time whilst managing their own work and home life commitments.

[182] Rich E, Lipson D, Libersky J, Parchman M. Coordinating Care for Adults With Complex Care Needs in the Patient-Centered Medical Home: Challenges and Solutions. White Paper (Prepared by Mathematica Policy Research, MD: Agency for Healthcare Research and Quality. January 2012)

8.7.3. Impact on minority ethnic groups

Nationally, individuals from minority ethnic groups tend to have poorer health outcomes although this does not appear to be true for Stafford. The burden of disease for some health conditions including cardiovascular disease and diabetes falls particularly heavily on certain ethnic groups[183]. Based on the evidence that certain ethnicities are more prone to suffer from some types of poor health, it can be inferred that certain ethnicities to may be more likely to be users of EUCC services. However, research[184] suggests that ethnic minorities have lower use of secondary care despite having higher use of primary care. This statement appears to be true for users of MSFT as the A&E attendance rates for ethnic minorities is lower than that of the general population[185]. It does not appear that there will be a disproportionate impact for this group. However, South Asian participants in a focus group expressed concern that the concentration of inpatient services on more distant sites may hinder them in meeting their religious requirements to visit the sick in the wider community should hospital journeys become longer and more complex. Furthermore, they drew attention to cultural practices which meant that women were less likely to drive or go out by themselves and noted that this could also mean they were disproportionately impacted by changes to hospital site.

As for maternity and paediatric services, the fact that neighbouring hospitals tend to serve populations with larger numbers of patients from minority ethnic groups also means that the changes may bring them into contact with hospitals with greater cultural competence and a more developed infrastructure to serve diversity than in Stafford, where the numbers of individuals from minority ethnic groups have historically been very low.

8.7.4. Impact on the characteristic of socioeconomic deprivation

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)[186]. 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[187,188]. Indeed, an analysis of data from the 2004–05 British General Household Survey (BGHS) concluded that "[r]educed access to A&E services will disproportionately affect poorer individuals"[189] in relation to access.

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[183] British Heart Foundation (2012) Coronary Heart Disease Statistics 2012. For example, the prevalence for Black Caribbean and Pakistani women was two and a half times that of the general population

[184] Stephen Morris, Matthew Sutton, Hugh Gravelle, *Inequity and inequality in the use of health care in England: an empirical investigation*, Centre for Health Economics, University of York, December 2003.

[185] An individuals of ethnic minority origins have a 14.7% chance of attending A&E in Stafford in a given year compared to 18.1% for the general population. Note that data on patient ethnicity is not as robust as data for other indicators.

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

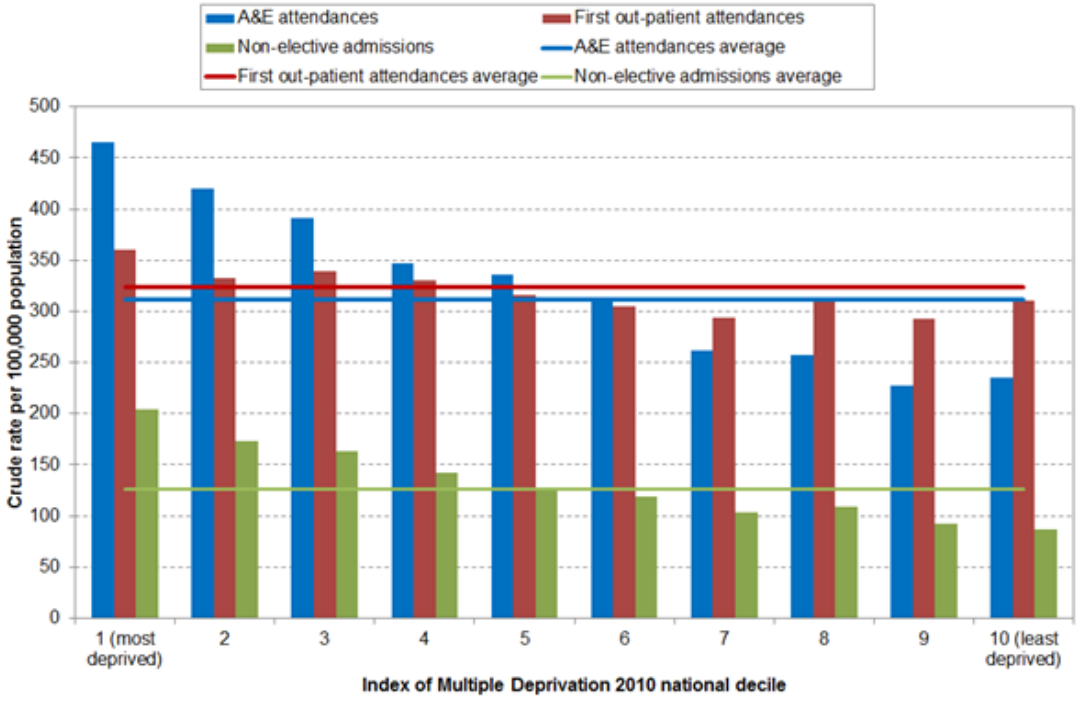
[187] Reid F, Cook D, Majeed A (1999). 'Explaining variation in hospital admission rates between general practices: cross sectional study'. *British Medical Journal*, **319**: 98–103.

[188] 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.

[189] 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.

A&E attendance and non-elective admission rates are particularly high in deprived areas; however A&E departments in deprived urban areas have the highest proportion of patients who do not require hospital treatment[190]. 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, and better chronic disease management and health outcomes[191].

Figure 8.2: 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

It is unlikely that individuals living in socioeconomic deprivation are more likely to use emergency surgery and level 3 critical care services as these are defined by medical need rather than patient choice. While socioeconomically deprived individuals tend to be more reliant on urgent care services due to poorer health and lack of interaction with primary care, the Steering Group was unable to find any evidence linking the usage of emergency surgery and level 3 critical care services to socioeconomic deprivation.

8.7.5. Impact on the characteristic of rural isolation

A large proportion of patients accesses emergency surgery or level 3 critical care through A&E. When performance is broken down to the level of individual primary care trusts (PCTs)

[190] A McLellan (2011) "Analysis: patients in poorer regions using A&E over GP", *Health Service Journal*, 13th December 2011.

[191] 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.

in England, it was found that in 2009/10, the category A eight minute response target[192] was met in only a quarter of the most rural quartile of PCTs. In comparison, the target was met in just under two-thirds of the most urban quartile[193]. Response times would not be affected by the proposed changes.

Twenty percent of Stafford & Surrounds CCG's population and 3% of Cannock Chase CCG's population lives in areas that are classified as rural by the Office of National Statistics[194]. As noted in the discussion on travel times in Section 10, the travel times from the areas classified as rural to the alternative hospital sites are not significantly different from other more urban areas.

8.8. Proposals to mitigate the impacts of the TSAs' draft EUCC recommendations

Based on the impacts summarised above, the Steering Group has put forward the following proposals to mitigate the possible negative impacts and enhance the positive impacts of the TSAs' draft recommendations:

- The Steering Group proposes that the TSAs work with local commissioners on a programme of patient education to reduce the level of attendances at the A&E;
- The Steering Group proposes that, within the scope of their remit, the TSAs work with commissioners to ensure that the FEAU is informed by close clinical collaboration with primary care and community health services, and forms the hub of a network of services developed to support people to stay as healthy as possible at home;
- The Steering Group proposes that the TSAs work with commissioners to develop the step down model and ensure that resources are targeted where they will deliver most benefit for older people; and
- Commissioners develop insight into current activity and capacity of level 3 critical care and actively monitor this, sharing the information with the public.

[192] Category A responses are for situations where a patient is in an immediately life threatening condition.For at least 75 per cent of Category A responses, an ambulance vehicle capable of transporting the patient should arrive at the scene within 8 minutes – Health and Social Care Information Centre.

[193] Department of Health (2011) Transforming NHS Ambulance Services.

[194] The Rural and Urban Area Classification 2004 classifies Output Areas and wards as either urban or rural depending on whether the bulk of their population falls in a settlement of greater than 10,000 residents.

9. Impact of the TSAs' draft recommendations on elective services and day cases

This chapter describes the TSAs' draft recommendations for elective surgery and day case services and their associated impact.

9.1. Summary of Scoping Report

The Scoping Report noted that:

- 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;
- "White British" and "Not known" ethnicities accounted for the vast majority of elective admissions (97.1%)[195]; and
- Children and younger adults tend to have a relatively high rate of elective activity, which does not seem to correlate to demography or epidemiology.

9.2. Summary of the TSAs' draft recommendations for elective surgery and day case services

9.2.1. Elective surgery and day cases at Stafford Hospital

MSFT splits elective surgery across the Stafford and Cannock sites, with a range of orthopaedic surgical procedures being carried out at Cannock Chase Hospital.

Elective inpatient surgery is currently carried out at Stafford Hospital across a range of surgical and medical specialties. The primary specialities are: urology, gynaecology, colorectal, gastroenterology, general surgery, ear nose and throat (ENT), gastro-intestinal (GI) surgery, and breast surgery. Elective day case procedures (surgical and medical) are also currently carried out at Stafford Hospital across a wider range of specialities than elective inpatient surgery (e.g. some specialist surgery areas such as oral surgery and day case medical procedures). For Stafford Hospital, the TSAs' draft recommendation is that elective surgery and day cases should remain, but with a reduced number of specialities.

The TSAs cannot recommend that other Trusts consolidate some of their elective surgery into Stafford. However, and dependent upon the provider operating services at Stafford Hospital, there may be an opportunity to repatriate Mid Staffordshire patients that currently have to travel to other hospitals for elective surgery. Surgical diagnostic procedures (such as endoscopy) and day case chemotherapy were part of the list of Location Specific Services (LSS) and as such will remain in Stafford Hospital.

9.2.2. Rehabilitation, elective surgery and day cases at Cannock Chase Hospital

The TSAs' minimum obligation is to secure the sustainable delivery of the LSS in Cannock over the next ten years. Currently one ward at Cannock Chase Hospital provides 27 GP-run

[195] Patient ethnicity tends to be poorly recorded

intermediate care beds (Littleton ward) which predominantly provide rehabilitation services[196]. Cannock Chase CCG wishes to retain this service in Cannock as it is aligned with their commissioning intentions to reduce patient admissions to acute hospital beds.

The current provision of elective inpatient surgery at Cannock Chase Hospital is mostly limited to orthopaedics. The hospital has a suite of laminar flow theatres that are necessary to minimise deep wound infections. The TSAs have recommended that elective inpatient surgery is retained at Cannock Chase Hospital, and the range of specialties could be expanded subject to the availability of overnight medical cover.

A range of day case procedures (surgical and medical) is currently provided at Cannock Chase Hospital; this includes the rheumatology services, which is used by both local patients and those from outside of the catchment area. The TSAs' draft recommendations are to maintain and potentially expand these services.

9.3. Impact for the in-scope characteristics

As noted above, the Steering Group has concerns about the lack of clarity around which operations in which specialties will in future be available at Stafford and Cannock Chase Hospitals, and what would no longer be provided at these sites. This makes it difficult to assess the possible impact on the protected characteristic of sex. For example, if elements of breast surgery are moved, whilst male uro-surgery remained available, there would clearly be a differential impact in access and acceptability for women and men.

The Steering Group would like to understand how actively the TSAs are seeking to bring an extended range of core surgery onto the two sites, recognising that some more complex or high risk activity will be concentrated where it can have the right level of support. The Steering Group is particularly keen to understand the scale of anticipated changes to higher risk orthopaedics work, as this may disproportionately impact on older people, and be associated with relatively longer lengths of stay, which would increase the disruption for older carers, and the vulnerability of the patient.

9.4. Impact on effectiveness

The TSAs have been refining the proposals for elective and day case services that will be provided at Stafford and Cannock Chase Hospitals at the same time that the Steering Group has been asked to carry out the impact assessment. It has therefore not been possible for the Steering Group to consider in detail the impacts of the TSAs' draft recommendations to the same level as the other service areas. Overall, the Steering Group welcomes the proposals to sustain or extend the range of services provided through Cannock Chase Hospital. The Steering Group understands the concerns about sustainability and safety of inpatient surgical services at Stafford, but notes that there will be a direct inverse relationship between reducing the range of services for reasons of safety and effectiveness, and the ease of access to services for patients.

[196] The Littleton Ward is provided by SSoTP and therefore does not form part of the set of location specific services.

As has been noted of the TSAs' draft recommendations overall, there is a lack of consideration of the relationship between hospital inpatient and wider community services. In elective surgery, the Steering Group suggests further consideration of the relationship with diagnostics, rehabilitation, convalescence and other support to deliver an effective service. In order to optimise the opportunities for care closer to home, the Steering Group proposes development of early supported discharge and optimisation of day case and minimally invasive procedures.

9.5. Impact on acceptability

Clarity is required on the types of elective orthopaedic surgery that will be carried out at Stafford Hospital (procedures, patient acuity, etc.) If patients with a higher acuity are seen at Stafford Hospital (due to the medical care it will provide), there is the potential for a mismatch in the provision of elective orthopaedic services between the Stafford and Cannock sites.

Although there were no specific comments made on elective and day case procedures in the focus group sessions, there were several general comments which reflect valid concerns in this area. The main apprehension cited by the focus groups was around travel times should there be a reduction in the range of elective services in Stafford Hospital. This concern was perceived to have major consequences on those facing socioeconomic deprivation and those who are vulnerable due to disability and/or frailty. Whilst patients would be unlikely to use public transport on the day of the operation, a change in site of surgery may also lead to changes in outpatient clinics which would begin to affect far greater numbers of people with greater frequency.

In regards to the impact of travel times on the frail, elderly and those suffering from disabilities the following observations were made by the focus groups:

- The extended travel times to hospital may be a very uncomfortable journey for the frail elderly;
- Those who are vulnerable may feel anxious about travelling and being treated in an unfamiliar place;
- People with disabilities may find it especially difficult to navigate in new surroundings as Stafford Hospital has been identified as a location of care with good facilitators for people with sensory problems;
- It may be harder for the frail and elderly to traverse larger hospitals; and
- These changes may mean that carers are less able to be involved due to the distance.

9.6. Impact on access to services

Access is a measure of availability, timeliness, communication and proximity. However, it has not been possible to carry out an analysis of the travel times impact as the elective and day

case clinical model described in the TSAs' draft recommendations for Stafford Hospital is insufficiently detailed. There are no travel times impacts for the services currently provided at Cannock Chase Hospital as there are no changes to these. The exception is the provision of elective orthopaedic services at Stafford Hospital, which will have a positive impact on access for patients local to that site.

The potential reduction in the number of specialties at Stafford Hospital could mean more travel for vulnerable people; the TSAs need to be clear about how the additional travel could be balanced against any increase in the quality and safety of services provided elsewhere. However, the Steering Group also considers that there may be scope to deliver a greater range of services locally and that the TSAs should actively consider this.

The travel time analysis in Section 10 sets out the impacts of travel to a range of alternative sites and this information can be drawn upon as it becomes clearer what range of specialties may no longer be available at Stafford Hospital.

9.7. Impact on relevance of services for the local population

9.7.1. Cannock Chase Hospital

The Steering Group believes that the TSAs' draft recommendations provide an opportunity to drive positive and sustainable change at Cannock Chase Hospital by establishing a local facility that provides a wide range of relevant services for the majority of people. In particular, the recommendations:

- Provide care in proximity to both the local and wider populations;
- Acknowledge the need to maximise the proportion of day case work to minimise disruption for both vulnerable individuals and families (visitors);
- Make better use of an under-used and expensive estate; and
- Build networks and access to a range of specialisms.

Indeed, the draft recommendations could provide the basis for development of an expert "cold" site that offers a wider range of high quality and safe services.

9.7.2. Stafford Hospital

As the TSAs' draft recommendations do not specify which elective inpatient and day case specialties will no longer be available at Stafford Hospital, it is not possible to make a judgement about their impact, other than to note that all the concerns expressed elsewhere about access, safety in transport, and relationship with visitors will be likely to apply if services are moved elsewhere.

9.8. Impact on equity

As noted above, in the absence of details about the changes in the range of surgical services offered at Stafford Hospital, the Steering Group cannot assess the possible impact on the protected characteristics. For example, if elements of breast surgery are moved, whilst male

uro-surgery remained available, there would be a differential impact in access and acceptability for women and men. However, in the majority of elective cases that are not carried out at Stafford Hospital, the decision on where to operate on the patient will be a result of clinical decision making based on factors such as the type of procedure and any patient co-morbidities.

The Steering Group would like to understand if the TSAs are seeking to bring an extended range of core surgery onto the two sites, recognising that some more complex or high risk activity will be concentrated where it can have the right level of support. The Steering Group is particularly keen to understand the scale of anticipated changes to higher risk orthopaedics work, as this may disproportionately impact on older people and be associated with relatively longer lengths of stay, which would increase the disruption for older carers, and vulnerability of the patient.

The full impact on equity, especially in relation to the in-scope protected characteristics, can only be assessed once the range of services and potential procedures are known. In order to assess the impact, the Steering Group proposes that the findings presented elsewhere in this document provide a sound basis to apply to any further proposals for changes to elective surgery.

9.9. Proposals to mitigate the impacts of the TSAs' draft recommendations on elective services and day cases

Based on the impact assessment summarised above, the Steering Group has put forward the following proposals:

- The TSAs should seek to optimise the opportunity for high quality care close to home, by maximising the use of day case and active pursuit of early supported discharge in inpatient care; both of these will be dependent on active development of the relationship with community services;
- The Steering Group seeks reassurance that there is a commitment to sustaining or developing the range of specialist outpatient and day case activity which has previously been available locally, possibly through other providers; and
- The TSAs and commissioners should consider applying the methodology set out in this document to any further proposed changes to elective surgery to minimise negative impacts.

10. Access and travel

This section describes the impact of the TSAs' draft recommendations on transport and travel. The impact on transport and travel is an element of the Maxwell criterion of Access.

10.1. Scope

10.1.1. Services considered

The majority of services currently being provided at Stafford Hospital and Cannock Chase Hospital will continue to be provided there under the TSAs' draft recommendations. These include the 14/7 A&E in Stafford, 16/7 Minor Injuries Unit (MIU) in Cannock, all outpatient clinics (including antenatal and postnatal care) and a range of elective and inpatient services on both sites. There will also be new services that will be introduced such as the Frail Elderly Assessment Unit (FEAU) in Stafford and step-down/rehabilitation beds on both sites.

The travel times analysis focuses on those services that will no longer be provided at Stafford Hospital based on the TSAs' draft recommendations. Note that this analysis has not been carried out for Cannock Chase Hospital as no services are being recommended for removal under the TSAs' draft recommendations[197] and there is therefore no impact from a travel times point of view.

There are several changes to services that are expected to only affect a very small volume of users and the travel times impact on these groups of patients cannot therefore be estimated with any degree of accuracy. The focus of this analysis is therefore the changes at Stafford Hospital for maternity services, inpatient paediatrics and emergency care of older people. Not only will these changes affect more users, but there are potentially some who will be affected on a regular basis. The in-scope services are shown in Table 10.1.

Table 10.1: In-scope services for travel times analysis

Service	Service element	In-scope/ out-of-scope
Maternity	Obsterics-led birth	In-scope
	Antenatal and postnatal care for high risk pregnancies post-23 weeks	Out-of-scope – likely to be very low volumes[1]
Emergency, urgent and critical care	Emergency surgery	In-scope
	Level 3 critical care	In-scope –very low volumes and therefore does not allow accurate estimation of the numbers of patients affected[2]
Paediatrics	Non-elective and elective paediatric inpatient admissions	In-scope
Elective and day case surgery	Elective and day case surgery	Out-of-scope – not possible to assess as the full range of services is not known

Notes:
[1] Not possible to estimate due to data limitations.
[2] Travel times and related issues will be the same as for adult non-elective/emergency surgery admissions, since patients will go to the same sites for level 3 critical care as well. There were ca. 120-140 level 3 critical episodes in 2012/13, including surgical patients who required level 3 critical care as well.

[197] The Office of the Trust Special Administrator of Mid Staffordshire NHS Foundation Trust, *Trust Special Administrators' Draft Report – Volume One (Main report)*, July 2013, p. 144, para 484.

10.1.2. Population of interest

The MSFT catchment *area* (the geographical area as a whole) is largely consistent with the registered population of Stafford and Surrounds and Cannock Chase CCGs. However, it has a smaller catchment *population* (ca. 276,500), 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.

Based on the assessment of MSFT's catchment area and population, the Steering Group agreed that the population of interest in the impact assessment is the population of Stafford & Surrounds CCG and Cannock Chase CCG.

10.1.3. Transport modes considered and methodology

Travel times for three modes of transport at different times of the day are used in this analysis.

Private car travel times are produced using Tom Tom™ data, which are collected from vehicles across the country using satellite navigation equipment. The Department for Transport (DfT) uses a similar data source, Trafficmaster™, to produce congestion indicators and provides it free to local authorities to inform local transport planning decisions. The Geographical Positioning System (GPS) enables the journeys made by participating vehicles to be recorded. The location of a vehicle and the exact time of day are recorded every few seconds and this information is then mapped to the road network. The time and measured distance between readings along the road network enable accurate journey time and speed data to be calculated. This type of data collection provides the largest number and geographical spread of observations available to transport planners. Ambulance travel times are also produced using Tom Tom™ data but are overlaid with ambulance speed information from the West Midlands Ambulance Service (WMAS).

The resulting car and ambulance travel times are averages for each specified time period. It is acknowledged that road conditions can vary and local events such as road accidents and road works can significantly increase travel times on specific days. For example, the Steering Group recognises that the M6, if congested, will significantly increase journey times within Stafford and to Walsall. Traffic data show that M6 users would have benefited from diverting off the motorway and using Stafford's local road network on 11 occasions in 2010/11 (for both directions of travel). This indicates that periods of an extraordinary increase in congestion within Stafford are relatively few. Nevertheless, these periods are included as part of the dataset in calculating travel times in response to public perception that they can have a significant impact.

Public transport (bus and rail) travel times are calculated using Accession accessibility planning software. The Accession software was developed by the MVA consultancy for the DfT to enable local authorities to measure and monitor local accessibility as part of the

Accessibility Strategy in their Local Transport Plans[198]. Accession calculates journey times based upon public transport timetable data, road network information and a range of user-defined parameters.

Travel times by private car, ambulance and public transport have been calculated at the Lower Layer Super Output Area level (LSOA). LSOAs are a statistical geography created by the Office for National Statistics that are smaller than wards[199] (average population ca. 1,500). Each datum represents a point within each LSOA the location for which is population-weighted. For readability, the analysis outputs are predominantly presented at ward level but LSOA-based data are used to highlight the most impacted areas. To allow a comparison of travel times between the current service provision and the TSAs' draft recommendations, exact travel times estimates, rather than time bands, from each LSOA have been used. Note that these are based on historical data and may change in the future as they are subject to developments in travel patterns, land use and highway infrastructure.

Table 10.2 shows the modes of transport, periods considered and their respective data sources.

Table 10.2: Transport modes and time periods considered for travel times analysis

Mode of transport	Periods considered	Data source
Private car	Peak (08:00 to 09:00 and 17:00 to 18:00) Off-peak (10:00 to 16:00)	Tom Tom data extracted over a four year period from 2008 to 2012
Ambulance	Peak (08:00 to 09:00 and 17:00 to 18:00) Off-peak (10:00 to 16:00)	Drive time analysis by Tom Tom assessed through West Midlands Ambulance Service core transport data (January 2013 to May 2013)
Public transport	Peak Wednesday (07:30 to 09:30) Off-peak Wednesday (10:00 to 12:00) Saturday and Sunday (14:00 to 16:00)	Staffordshire County Council analysis (performed in May 2013) using Accession, TravelLine and in-house bus route information for the period October 2011 to June 2013

The TSAs' draft recommendations focus on obstetrics, inpatient paediatrics, emergency surgery and level 3 critical care. These are not services for which patients would usually

[198] Accessibility planning guidance: full guidance, DfT, p. 16.

[199] 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 1,000 and the mean is 1,500. 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).

travel to hospital by public transport. For example, the Steering Group does not expect that parents would use a bus to bring a sick child to hospital in the evening, and would instead use either a private car (including lifts, or taxi) or call an ambulance. Similarly, the Steering Group does not expect any woman in labour to walk or wait for a bus to reach the delivery unit.

Note that the travel times for blue light ambulances are largely similar to those for private cars over the same distance. Although they may be able to clear a route through traffic and congestion, they are heavy vehicles and in order to maintain stability when transporting patients, cannot travel at high speeds.

The focus of the analysis for patients is on peak time travel as travel during these hours is likely to take longer than during off-peak hours. The Steering Group believes that this represents a robust estimate as it focuses on travel during the busiest time of day, and thus what would usually be the longest travel time.

Public transport times are included in the assessment of the impact on parents, carers and visitors travelling to visit a patient in hospital. Weekday (peak and off-peak), Saturday and Sunday travel is considered for the public transport analysis as bus frequencies and availability differ between each of those periods.

The full travel times analysis methodology is shown in Appendix B.

10.2. Travel times and the impacted population

10.2.1. National and regional benchmarks

There is no national established database of journey times to hospital, or recognised standards for what length of journey should be regarded as either safe or reasonable. The Steering Group has looked at several studies which have investigated this issue. The authors of a study[200] on rural access to healthcare services in South West England stress that:

"…there is little consensus and no strong theoretical or empirical basis for these choices. Standard estimates of 'remoteness' from health services have not been established – there is no a priori definition of the distance regarded as 'remote from health services' and no consensus has been established in the literature on access to health services."

In the absence of a clear indication on thresholds, the study authors used threshold distances to specialist[201] hospital services of between 39km to 80km[202,203] to investigate poor access. The study on rural access found that the median distance to a District General Hospital (DGH) was just less than 12km, with a maximum of 50km, corresponding to an

[200] Hannah Jordan, Paul Roderick, David Martin and Sarah Barnett, Distance, Rurality and the need for care: access to health services in South West England, International Journal of Health Geographics 2004, 3:21.
[201] Authors refer to secondary care hospitals as specialist hospitals.
[202] Cassar K, Godden DJ, Duncan JL: Community mortality after ruptured abdominal aortic aneurysm is unrelated to the distance from the surgical centre. Br J Surgery 2001, 88:1341-1343.
[203] Campbell NC, Elliott AM, Sharp L, Ritchie LD, Cassidy J, Little J: Rural and urban differences in stage at diagnosis of colorectal and lung cancers. Br J Cancer 2001, 84:910-914.

estimated 13 and 48 minute drive-time respectively. Almost 65% of residents in South West England have a DGH within a 13 minute drive. The authors however note that the travel distances to healthcare services in this study area is low by international standards.

Table 10.3: Access to District General Hospitals in South West England

Drive time	25th percentile	Median	75th percentile	95th percentile	Maximum
	7.1 mins	13.4 mins	20.5 mins	31.6 mins	48.3 mins
Percentage of population	38.9	64.4	84.7	97.2	100

Source: Hannah Jordan, Paul Roderick, David Martin and Sarah Barnett, Distance, Rurality and the need for care: access to health services in South West England, International Journal of Health Geographics 2004*, 3:21.*

A separate study[204] on patient choice found that 25% of the population in England has one acute hospital within 15 minutes (private) drive time and 41% have up to two hospitals. Fifteen percent has no hospital within 30 minutes, but 98% had one hospital and 92% has two hospitals within 60 minutes. In three areas of England people have to travel relatively further to reach an acute NHS trust: the north of England close to the border with Scotland; East Anglia and parts of Lincolnshire; and parts of Devon and Cornwall in the South West. Staffordshire was not identified as being an outlier for access.

Based on DfT data[205], it was found that 99.4% of households in England have access to a hospital within 30 minutes of travel by car. The definition of hospital used is any facility with an A&E or an outpatient unit with 300 or more beds.

An investigation[206] into the choice of place of birth by the National Childbirth Trust (NCT) established that on average 57.4% of women live within an estimated 30 minute journey time of both a birth centre and an obstetric unit. Members of the NCT's Campaigns Advisory Groups for each of the four countries of the UK and NCT antenatal teachers were asked how far they thought that women would be prepared to travel to access a maternity unit. In general it was thought that a journey time of up to 30 minutes while in active labour to reach a maternity unit was the upper threshold of reasonable access. This threshold however cannot be directly applied to the Steering Group's analysis as it was established on a basis of a very different travel times assessment based on straight line distances and average travel speed assumptions rather than detailed travel data.

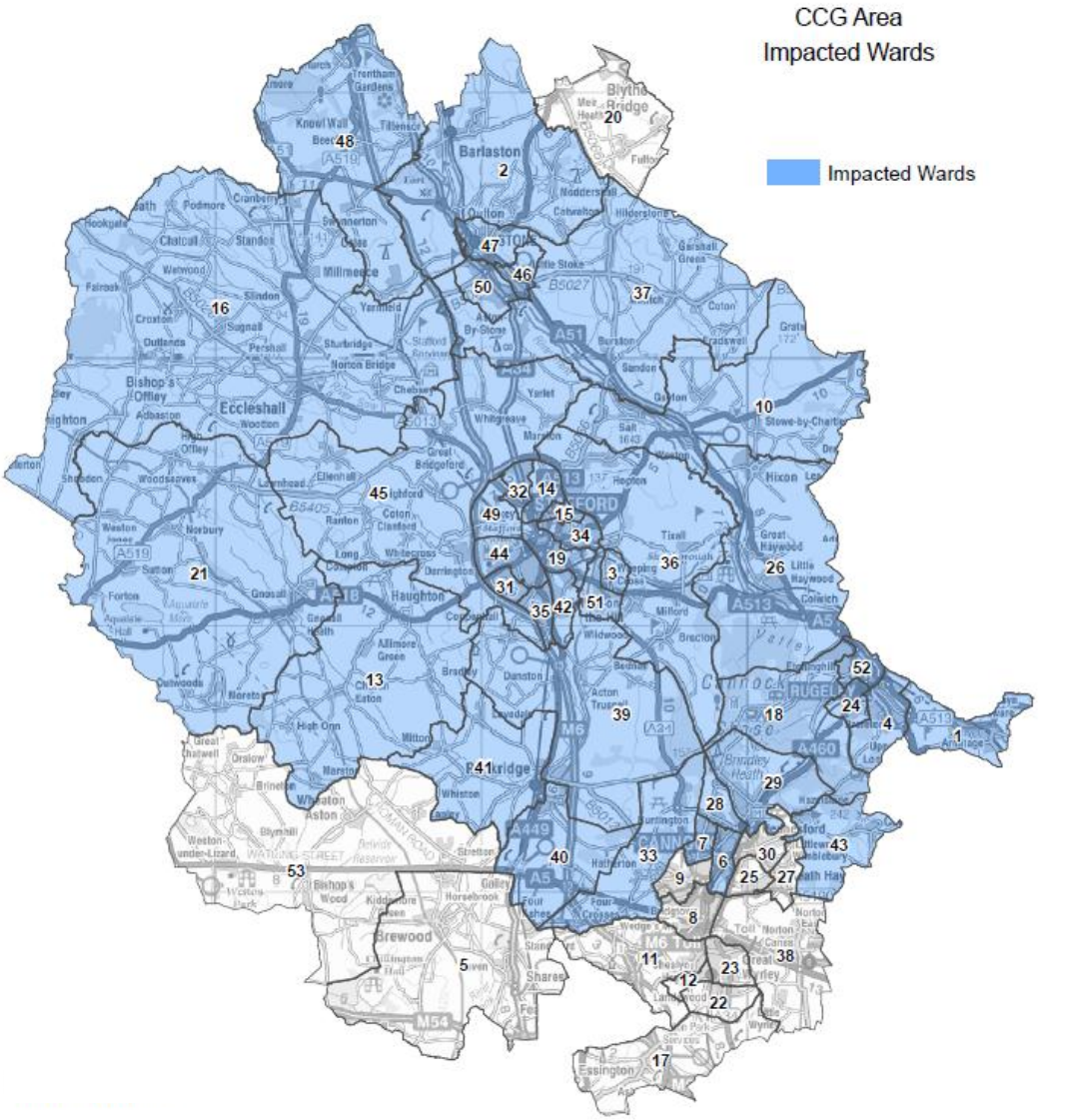
10.2.2. Impacted population

Not all of the population of Stafford & Surrounds CCG and Cannock Chase CCG will be affected by the TSAs' draft recommendations in terms of travel times as some do not currently have Stafford Hospital as their nearest hospital for acute surgery, obstetrics-led birth and inpatient paediatric services. For this group, there will be no change in access to services in terms of travel times. Figure 10.1 shows the wards where travel times by private car and ambulance will increase. The wards shown below have a combined population of

[204] Mike Damiani, Carol Propper, Jennifer Dixon (2004) Mapping choice in the NHS: cross sectional study of routinely collected data, *BMJ* 2005;330:284.
[205] 2011 Department for Transport accessibility statistics.
[206] Miranda Dodwell & Rod Gibson (2009) An Investigation Into Choice of Place of Birth, National Childbirth Trust

184,885 (67% of total CCG population of 276,500) and will henceforth be known as the **“impacted area”** (Section 10.4 discusses the impacted population in those wards).

Figure 10.1: Wards in Stafford and Surrounds CCG and Cannock Chase CCG and impacted wards



1 Armitage with Handsacre
2 Barlaston & Oulton
3 Baswich
4 Brereton & Ravenhill
5 Brewood & Coven
6 Cannock East
7 Cannock North
8 Cannock South
9 Cannock West
10 Chartley
11 Cheslyn Hay North & Saredon
12 Cheslyn Hay South
13 Church Eaton
14 Common
15 Coton
16 Eccleshall
17 Essington
18 Etching Hill & The Heath
19 Forebridge
20 Fulford
21 Gnosall & Woodseaves
22 Great Wyrley & Landywood
23 Great Wyrley Town
24 Hagley
25 Hawks Green
26 Haywood & Hixon
27 Heath Hayes East & Wimblebury
28 Hednesford Green Heath
29 Hednesford North
30 Hednesford South
31 Highfields & Western Downs
32 Holmcroft
33 Huntington & Hatherton
34 Littleworth
35 Manor
36 Milford
37 Milwich
38 Norton Canes
39 Penkridge North East & Acton Trussell
40 Penkridge South East
41 Penkridge West
42 Penkside
43 Rawnsley
44 Rowley
45 Seighford
46 St. Michael's
47 Stonefield & Christchurch
48 Swynnerton
49 Tillington
50 Walton
51 Weeping Cross
52 Western Springs
53 Wheaton Aston, Bishopswood & Lapley

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10.2.3. Current travel times to Stafford Hospital

Private car

The population of wards impacted by the TSAs' draft recommendations all have access to Stafford Hospital within 25 minutes by private car. Of the 184,885 residents of the impacted wards, almost 90% of them have access to Stafford Hospital within 20 minutes.

Table 10.4: Private car travel times to Stafford Hospital

Private car travel times to Stafford Hospital	Population		
0 to 5	12,523	7%	7%
5 to 10	55,884	30%	37%
10 to 15	27,823	15%	52%
15 to 20	67,580	37%	89%
20 to 25	21,075	11%	100%
Over 25	0	0%	100%
Total	**184,885**	**100%**	**100%**

Source: Steering Group analysis

Ambulance

Ambulance travel times are similar to private car times with almost 95% of residents having access to Stafford Hospital within 20 minutes. Note that not all existing ambulance transfers are automatically to Stafford Hospital. For example, patients may be transferred directly to a regional centre to access Major Trauma Centres (MTCs) or Hyper Acute Stroke Units (HASUs).

Table 10.5: Ambulance travel times to Stafford Hospital

Ambulance travel times to Stafford Hospital	Population		
0 to 5	14,074	8%	8%
5 to 10	57,646	31%	39%
10 to 15	33,597	18%	57%
15 to 20	67,877	37%	94%
20 to 25	11,691	6%	100%
Over 25	0	0%	100%
Total	**184,885**	**100%**	**100%**

Source: Steering Group analysis

10.2.4. Predicted future patient flows by private car or emergency ambulance

The TSAs' draft recommendations remove some services entirely from Stafford Hospital, and patients needing those services will have to travel to an alternative hospital within the wider area. Table 10.6 shows the most likely alternative sites for those travelling by private car. They are based on travel from each ward to hospitals where the travel times from that ward to the alternative sites are within five minutes of each other (e.g. a patient from Baswich may choose either Walsall or UHNS because the difference in travel times to these hospitals

is less than five minutes). Note that while a woman in labour or a sick child may be transported to hospital by private car, those in need of emergency surgery or critical care would be more likely to travel by ambulance.

Table 10.6: Alternative hospital sites by ward

Ward	Alternative hospital site(s)
Armitage with Handsacre	Burton, Good Hope
Barlaston and Oulton	UHNS
Baswich	Walsall, UHNS
Brereton and Ravenhill	Good Hope, Burton, Walsall
Cannock East	Walsall, Wolverhampton
Cannock North	Walsall, Wolverhampton
Chartley	UHNS
Church Eaton	Telford, Walsall
Common	UHNS
Coton	UHNS, Burton*
Eccleshall	UHNS, Telford
Etching Hill and The Heath	Walsall, Good Hope, Burton
Forebridge	UHNS, Walsall
Gnosall and Woodseaves	Telford, UHNS
Hagley	Walsall, Good Hope, Burton
Haywood and Hixon	UHNS, Walsall, Burton
Hednesford Green Heath	Walsall, Wolverhampton
Hednesford North	Walsall, Wolverhampton
Highfields and Western Downs	Walsall, UHNS
Holmcroft	UHNS
Huntington and Hatherton	Walsall, Wolverhampton, UHNS
Littleworth	UHNS, Walsall, Wolverhampton
Manor	Walsall, Wolverhampton, UHNS
Milford	Walsall, Wolverhampton, UHNS
Milwich	UHNS
Penkridge North East and Acton Trussell	Walsall, Wolverhampton
Penkridge South East	Walsall, Wolverhampton
Penkridge West	Walsall, Wolverhampton
Penkside	Walsall, Wolverhampton
Rawnsley	Walsall, Good Hope
Rowley	Walsall, UHNS
Seighford	UHNS, Telford
St. Michael's	UHNS
Stonefield and Christchurch	UHNS
Swynnerton	UHNS
Tillington	UHNS
Walton	UHNS
Weeping Cross	Walsall, UHNS, Wolverhampton
Western Springs	Good Hope, Walsall, Burton

** Burton is listed as an alternative site for the residents of Coton as WMAS currently conveys some patients from Coton there*
Source: Steering Group analysis, WMAS information

The A&E in Stafford Hospital has been operating between the hours of 08:00 to 22:00, seven days a week since December 2011. WMAS therefore already conveys patients to a range of sites other than Stafford when the A&E is closed. Ambulance protocols take into

consideration response and conveyance times, road conditions and patient presentation. WMAS operates a dynamic system status plan which designates the location of ambulances based on projected demand. Additionally, paramedic teams are also stationed in rural areas in order to ensure adequate response times.

The pattern of conveyances when Stafford Hospital's A&E is closed (refer to Appendix B for a list of ambulance destinations) gives a strong indication of potential default site by ward if the TSAs' draft recommendations are implemented, although other factors such as the final organisational form of Stafford Hospital and Cannock Chase Hospital may have an effect on conveyances to each site. Note that all travel times shown for ambulance travel are conveyance times. Response times relate to the ambulance's first attendance to a patient and should not be affected by the TSAs' draft recommendations, which relate to where the patient would be taken. The initial treatment and stabilisation of many conditions commences as soon as paramedics arrive.

10.2.5. Change in travel times and new travel times

Note that public transport access to hospital sites is discussed in Section 10.7.1.

Private car

The assessments in this section are based on travel times to the **furthest plausible alternative site** i.e. located not more than five minutes from the nearest alternative hospital site or is a WMAS destination.

In terms of an *increase* in travel times by private car, about 41% of residents in the impacted area will see an *increase* of ten minutes or less. Almost 85% of will see an *increase* in private car travel times of less than twenty minutes.

Table 10.7: Change in private car travel times – showing cumulative impact

Change in private car travel times	Population		
0 to 5	48,849	26%	26%
5 to 10	26,732	14%	41%
10 to 15	31,604	17%	58%
15 to 20	49,781	27%	85%
20 to 25	15,911	9%	94%
25 to 30	7,243	4%	97%
30 to 35	0	0%	100%
35 to 40*	4,765	3%	100%
Above 40 minutes	0	0%	100%
Total	**184,885**	**100%**	**100%**

** Only if residents of Coton chose to travel to Burton which is a WMAS destination instead of UHNS (which is the nearest hospital)*
Source: Steering Group analysis

The only ward that sees travel times *increase* by more than 30 minutes is Coton, which is next to Stafford Hospital. This is only if the private car journey is to Burton, which is the hospital where WMAS currently conveys patients from Coton in an emergency.

In terms of the *total* new travel times by private car, almost three quarters of residents in the impacted area will have *total* travel times of less than 30 minutes (see Table 10.8 below) and only residents of Coton see *total* travel times exceed 40 minutes (but below 45 minutes) if they travelled to Burton and not UHNS. UHNS is the nearest alternative site for Coton and the *total* travel time is within 25 minutes.

Table 10.8: New private car travel times – showing cumulative impact

New private car travel times	Population		
15 to 20	31,850	17%	17%
20 to 25	48,401	26%	43%
25 to 30	55,373	30%	73%
30 to 35	44,496	24%	97%
35 to 40*	1,706	1%	98%
40 to 45*	3,059	2%	100%
Above 45	0	0%	100%
Total	**184,885**	**100%**	**100%**

** Only if residents of Coton chose to travel to Burton which is a WMAS destination instead of UHNS*
Source: Steering Group analysis

Ambulance

Ambulance journeys have been estimated using hospitals to which patients are currently conveyed when Stafford's A&E is closed.

In terms of an *increase* in travel times by ambulance, while some 93% of residents will see an *increase* in travel times of less than 20 minutes, some 7% may have an ambulance journey up to 35 minutes longer than currently would be the case.

Table 10.9: Change in ambulance travel times – showing cumulative impact

Change in ambulance travel times	Population		
0 to 5	51,890	28%	28%
5 to 10	25,251	14%	42%
10 to 15	43,224	23%	65%
15 to 20	52,512	28%	93%
20 to 25	0	0%	93%
25 to 30	7,243	4%	97%
30 to 35	4,765	3%	100%
Above 35	0	0%	100%
Total	**184,885**	**100%**	**100%**

Source: Steering Group analysis

In terms of the *total* new travel times by ambulance, the majority (91%) of residents will continue to have access within 30 minutes by ambulance to a hospital providing services which are recommended to be removed from Stafford Hospital. All residents will have *total* new ambulance travel times of 40 minutes or less.

Table 10.10: New ambulance travel times – showing cumulative impact

New ambulance travel times	Population		
10 to 15	3,089	2%	2%
15 to 20	47,454	26%	28%
20 to 25	58,708	32%	60%
25 to 30	57,117	31%	91%
30 to 35	13,752	7%	98%
35 to 40	4,765	3%	100%
Above 40	0	0%	100%
Total	**184,885**	**100%**	**100%**

Source: Steering Group analysis

The Steering Group has been in contact with WMAS and understands that they have not expressed concerns about the impact on increased travel times, believing these to be safe and comparable to other areas they serve. WMAS has, however, expressed concerns regarding the additional resources required due to longer journeys and higher conveyance rates (including the need to separately commission any urgent transfer service).

Most Impacted Areas

There are some Lower Layer Super Output Areas (LSOAs) within the wards in Figure 10.1 where ambulance or private car journey times exceed 30 minutes (but remain below 40 minutes for ambulance journeys and 45 minutes for private car journeys). The total population of those areas is ca. 49,300 and is referred to as the "**most impacted areas"**.

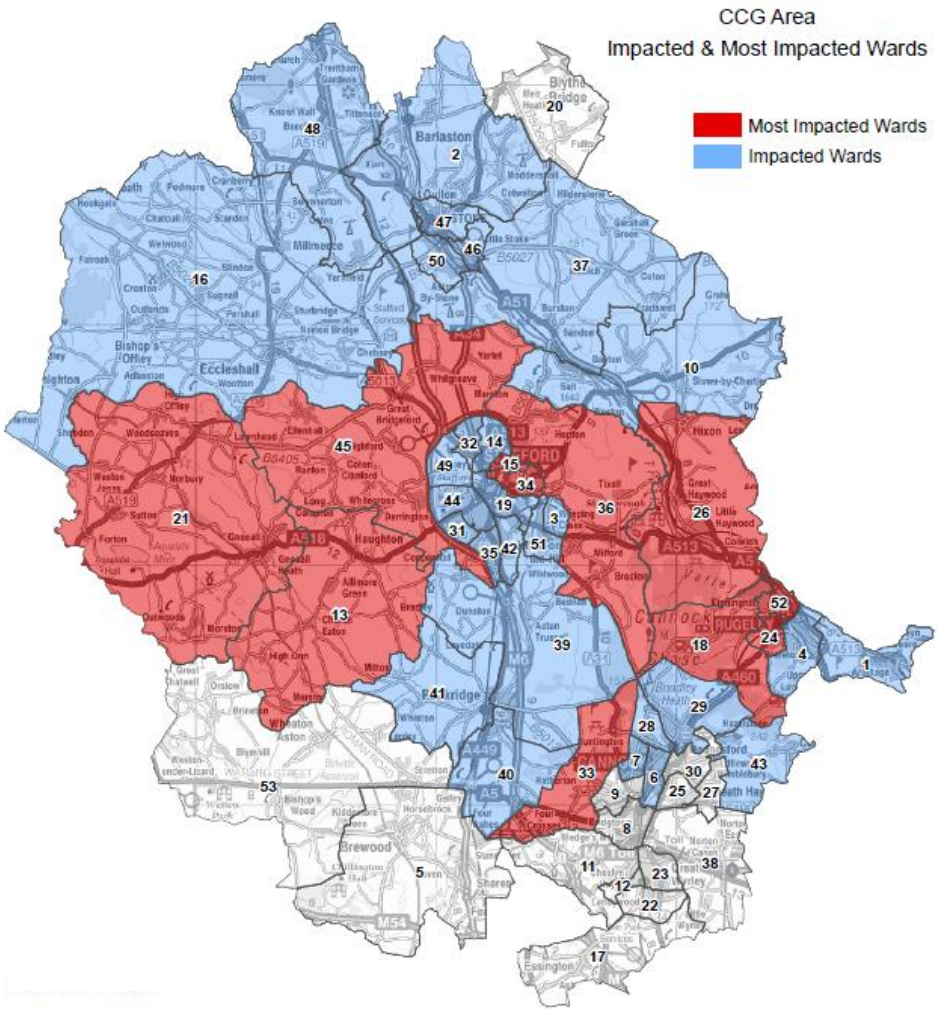
The most impacted areas cover a total population 49,300 (for each ward, the number of most impacted LSOAs and the total number of impacted LSOAs are shown):

- Church Eaton (1 out of 1 LSOA) – ca. 2,300 residents
- Coton (3 out of 3 LSOAs) – ca.4,800 residents
- Etching Hill and the Heath (5 out of 5 LSOAs) – ca. 6,800 residents
- Gnosall and Woodseaves (2 out of 4 LSOAs) – ca.3,000 residents
- Hagley (2 out of 2 LSOAs) – ca. 4,700 residents
- Haywood and Hixon (4 out of 4 LSOAs) – ca. 6,500 residents
- Huntington and Hatherton (2 out of 2 LSOAs) – ca.2,900 residents
- Littleworth (4 out of 4 LSOAs) – ca. 7,200 residents
- Milford (1 out of 3 LSOAs) – ca. 2,500 residents
- Seighford (1 out of 1 LSOA) – ca. 2,100 residents
- Western Springs (4 out of 4 LSOAs) – ca.6,600 residents

People in the most impacted areas already experience these travel times between 22:00 and 08:00 if conveyed by ambulance or travelling by private car. **Note that this analysis is based on users travelling to the furthest plausible alternative hospital to reflect a 'worst case' impact.** Should they choose to travel to the nearest alternative, only five LSOAs across Etching Hill & the Heath and Haywood & Hixon (ca. 7,300 residents) have travel times above 30 minutes.

In the absence of any comparable national or regional thresholds, the remainder of this section focuses on the 29 LSOAs which comprise of the most impacted areas as they would have the longest travel times. However, the number of impacted patients across the entire impacted area (total population 184,885) is also discussed.

Figure 10.2: Impacted and most impacted wards in the CCG area



1 Armitage with Handsacre
2 Barlaston & Oulton
3 Baswich
4 Brereton & Ravenhill
5 Brewood & Coven
6 Cannock East
7 Cannock North
8 Cannock South
9 Cannock West
10 Chartley
11 Cheslyn Hay North & Saredon
12 Cheslyn Hay South
13 Church Eaton
14 Common
15 Coton
16 Eccleshall
17 Essington
18 Etching Hill & The Heath
19 Forebridge
20 Fulford
21 Gnosall & Woodseaves
22 Great Wyrley & Landywood
23 Great Wyrley Town
24 Hagley
25 Hawks Green
26 Haywood & Hixon
27 Heath Hayes East & Wimblebury
28 Hednesford Green Heath
29 Hednesford North
30 Hednesford South
31 Highfields & Western Downs
32 Holmcroft
33 Huntington & Hatherton
34 Littleworth
35 Manor
36 Milford
37 Milwich
38 Norton Canes
39 Penkridge North East & Acton Trussell
40 Penkridge South East
41 Penkridge West
42 Penkside
43 Rawnsley
44 Rowley
45 Seighford
46 St. Michael's
47 Stonefield & Christchurch
48 Swynnerton
49 Tillington
50 Walton
51 Weeping Cross
52 Western Springs
53 Wheaton Aston, Bishopswood & Lapley

10.3. Summary of impact for groups with protected and other in-scope characteristics

No users with any of the in-scope characteristics are systematically impacted by the TSAs' draft recommendations in terms of travel times. Section 10.4 discusses the impact of service changes on both the general population of users, and users with each of the in-scope characteristics.

10.4. Impacted users by service area

10.4.1. Maternity services

The population of women of child-bearing age (15-44) in Stafford & Surrounds CCG and Cannock Chase CCG is ca. 51,600. Based on general fertility rates, the expected number of births from this CCG population is ca. 3,000 per year. Not all of these births will take place in Stafford Hospital as some women in the CCGs choose not to use Stafford Hospital although it is their closest site, and some will live closer to a different hospital. The expected number of births from the two CCGs in Stafford Hospital based on historical patterns is ca. 1,900.

Maternity (obstetrics –led birth) – *N.B. all figures shown are per annum*		
General	Total impacted births	1,460
	Wards with the most impacted areas (ambulance or car times between 30 to 45 minutes)	Church Eaton , Coton , Etching Hill and the Heath, Gnosall and Woodseaves , Hagley , Haywood and Hixon , Huntington and Hatherton , Littleworth , Milford, Seighford Western Springs
	Impacted births in most impacted areas	360
Age	All wards with a higher concentration of older mothers	No wards with a higher proportion of older mothers
	Impacted births by older mothers in all areas	270 of which 70 are from the most impacted areas
Race	All wards with a higher concentration of mothers of minority ethnic groups	Common, ***Coton***, Forebridge and ***Littleworth***
	Impacted births by mothers of minority ethnic groups in all areas	130 *(N.B. cannot attribute to wards due low volumes and data protection)*
Rural isolation	All wards with rural areas	Barlaston and Oulton, Chartley, Church Eaton, Eccleshall, ***Gnosall and Woodseaves***, ***Milford***, Milwich, Penkridge North East and Action Trussell, ***Seighford***, Swynnerton
	Impacted births in rural areas	80 of which 30 are from the most impacted areas
Disabilities	All wards with higher disability rates in women of childbearing age	Brereton and Ravenhill, Cannock East, Cannock North, Hednesford North
	Impacted births by mothers with disabilities in all areas	40 *(N.B. cannot attribute to wards due low volumes and data protection)*
Socio-economic deprivation	All wards with areas of deprivation	Brereton and Ravenhill, Cannock East, Cannock North, ***Etching Hill and the Heath***, Hednesford North, Highfields and Western Downs, ***Littleworth***, Manor, Penkside
	Impacted births in all deprived areas	220 of which 30 are from the most impacted areas

Wards highlighted indicate areas overlapping with the most impacted areas

Impact on the characteristic of sex

Based on peak private car and ambulance journey times, ca. 500 of the ca. 1,900 expected births per annum will either see a decrease or no change in travel time. Those who face a decrease in travel times are those who choose to go to Stafford Hospital but have an alternative maternity unit that is nearer. There are ca. 1,460 women per year that will face longer travel times by either car or ambulance. The total number of expected births from the most impacted areas is 360 (i.e. with new ambulance or private car journey times of 30 to 45 minutes).

Impact on the characteristic of age

As discussed in Section 6.7, there is evidence to show that older mothers are at higher risk of having more complicated pregnancies. The population of older women of child-bearing age (15 to 44) in the impacted area is ca. 13,000 and the number of births associated with this population is ca. 270 per annum[207]. The TSAs' draft recommendations propose continuing to offer antenatal and postnatal care at Stafford and Cannock Chase Hospitals. This should mean that even where a woman has had a higher risk pregnancy or birth, in the future she may be more likely to receive outpatient care locally, which may benefit older mothers. Note that a travel time analysis for teenage mothers has not been conducted as the relevant data cannot be released into the public domain due to data protection issues. The number of teenage pregnancies is expected to be very small and the impact on teenage mothers is discussed in Section 6.7.

No wards have a disproportionate number of older women of childbearing age[208] and there is no correlation between travel times and the proportion of older women of child bearing age. Approximately 70 of the births by older women of child-bearing age are in the most impacted areas.

Impact on the characteristic of disability

As discussed in Section 6.7, there is evidence to show that women with disabilities face more complications throughout the maternity pathway. Although MSFT does not currently routinely refer maternity patients to other providers on the basis of factors such as age and disability of the mother, there are some circumstances related to complications in any potential pregnancy (e.g. foetal surgery and neo-natal intensive care) where a woman is referred to a more specialised unit. There is a commitment to continue to offer antenatal and postnatal care at Stafford Hospital, which should mean that even where a woman has had a higher risk pregnancy or birth in the future, she may be more likely to be able to receive outpatient care at Stafford Hospital; this may benefit women with disabilities.

In estimating the population of births by mothers with disabilities in every year, it is assumed that the birth rate of women with disabilities is the same as the general birth rate. This is a

[207] In estimating the population of births by older mothers in every year, it is assumed that the birth rate of women above 35 is half of the general birth rate.
[208] Defined as average proportion plus two standard deviations.

generous estimate and the fertility rate of women with disabilities is likely to be lower than this. It is estimated that there are ca. 4,900 women with disabilities of child-bearing age in the impacted area and the associated number of births is expected to be small (ca. 80). Given the low number of these births, it is not possible to attribute them to wards with any reasonable degree of accuracy. Furthermore, there may also be data protection issues should births be shown at the ward level.

There are however areas in several wards with areas that have slightly higher disability rates i.e. Brereton and Ravenhill, Cannock East, Cannock North and Hednesford North. None of these are the most impacted areas. Moreover, there is no correlation between travel times (private car and ambulance) and disability rates and none of these wards has a travel time of over 30 minutes.

Impact on the characteristic of race

As noted in the Scoping Report and Section 5.5, the population of minority ethnic groups is small. On the whole, the distribution of births by women from minority ethnic groups is well dispersed. There are however areas within several wards which have areas with slightly higher numbers of ethnic minority women i.e. Common, Coton, Forebridge and Littleworth. The areas in Coton and Littleworth are also those that are most impacted in terms of travel times. The proportion of the population that is women of child-bearing age and is from a minority ethnic group is not correlated with travel times. The total number of births by the ca. 2,600 women of ethnic minority origins of child-bearing age that will see an increase in travel times is ca. 130. Given the dispersion of these births, it is not possible to attribute them to wards with any degree of accuracy.

Impact on the characteristic of socioeconomic deprivation

Nine wards in the impacted area have areas that fall in the national top quintile (i.e. 20% most deprived areas nationally) of the Index of Multiple Deprivation 2010[209].

Table 10.12: Wards in the impacted area facing socioeconomic deprivation

Wards facing socio-economic deprivation	
Brereton and Ravenhill	Highfields and Western Downs
Cannock East	Littleworth
Cannock North	Manor
Etching Hill and the Heath	Penkside
Hednesford North	

Source: Steering Group analysis, ONS data

Approximately 3,200 women of child bearing age live in these wards with ca. 220 births expected annually. None of the areas with high levels of socioeconomic deprivation, other than in Etching Hill and the Heath and Littleworth (ca. 30 births), are expected to have journey times of over 30 minutes. The travel times to alternative sites in deprived wards are not different to that of non-deprived wards. Additionally, the level of private car ownership

[209] Department for Communities and Local Government, HM Government.

even in these more disadvantaged wards is still 74% with a range from 68% (Cannock North) to 85% (Etching Hill and the Heath).

Impact on the characteristic of rural isolation

There are ten wards with areas that are classified as rural by the Office of National Statistics (ONS)[210].

Table 10.11: Wards with rural areas in the impacted area

Rural wards	
Barlaston and Oulton	Milford
Chartley	Milwich
Church Eaton	Penkridge North East and Acton Trussell
Eccleshall	Seighford
Gnosall and Woodseaves	Swynnerton

Source: Steering Group analysis, ONS data

Parts of Gnosall and Woodseaves, Milford and Milwich fall within the most impacted areas but on the whole, the travel times to alternative sites in rural wards is not different to that of non-rural wards.

Approximately 2,900 women of child bearing age live in rural wards with ca. 80 births expected annually (ca. 30 are from the most impacted areas).

10.4.2. Non-elective/emergency surgery

The number of unplanned admissions into surgical specialties expected from the population of the impacted area (184,885) is 3,200 per annum. While not all of these admissions will result in an emergency surgery[211], it is assumed that without a Surgical Assessment Unit (SAU) in Stafford Hospital, all patients suspected of requiring emergency surgery will need to be seen elsewhere. Most of these journeys will take place by ambulance and be governed by WMAS protocols. A proportion will arrive by car at Stafford A&E and the transfer will then be by ambulance. The ambulance journey time from Stafford hospital to UHNS (as next nearest site for emergency surgery) is 21 minutes.

[210] 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".

[211] Currently, Stafford Hospital performs ca. 1,200 emergency surgeries in a year. (Source: MSFT TSAs' Draft Recommendations Report).

Non-elective/emergency surgery – *N.B. all figures shown are per annum*		
General	Total impacted number of non-elective surgical admissions	3,200
	Wards with the most impacted areas (ambulance or car times between 30 to 45 minutes)	Church Eaton , Coton , Etching Hill and the Heath, Gnosall and Woodseaves , Hagley , Haywood and Hixon , Huntington and Hatherton , Littleworth , Milford, Seighford Western Springs
	Impacted surgical admissions in most impacted areas	850
Age	All wards with a higher concentration of the elderly (aged 65+)	Weeping Cross
	Impacted surgical admissions of the elderly in all areas	1,310 of which 330 are from the most impacted areas
Race	All wards with a higher concentration of minority ethnic groups	Common, ***Coton***, Forebridge and ***Littleworth***
	Impacted surgical admissions of patients of minority ethnic groups in all areas	160 *(n.b. cannot attribute to wards due low numbers and data protection)*
Rural isolation	All wards with rural areas	Barlaston and Oulton, Chartley, Church Eaton, Eccleshall, ***Gnosall and Woodseaves***, ***Milford***, Milwich, Penkridge North East and Action Trussell, ***Seighford***, Swynnerton
	Impacted surgical admissions from rural areas	340 of which 120 are from the most impacted areas
Disabilities	All wards with higher disability rates	Brereton and Ravenhill, Cannock East, Cannock North, Hednesford North
	Impacted surgical admissions of patients with disabilities in all areas	200 *(n.b. cannot attribute to wards due low numbers and data protection)*
Socio-economic deprivation	All wards with areas of deprivation	Brereton and Ravenhill, Cannock East, Cannock North, ***Etching Hill and the Heath***, Hednesford North, Highfields and Western Downs, ***Littleworth***, Manor, Penkside
	Impacted surgical admissions in all deprived areas	280 of which 60 are from the most impacted areas

Wards highlighted indicate areas overlapping with the most impacted areas

Impact on the general population

It is estimated that ca. 3,200 non-elective admissions will see an increase in travel times. Approximately 850 of them will be from areas where ambulance or private car travel times are between 30 to 45 minutes.

Impact on the characteristic of age

Section 8.7 presented evidence which indicate that older people are at greater risk of requiring emergency surgery. From 2012/13 patient level data, an A&E attendance by a patient aged 65 and above has a 14% chance of requiring a surgical non-elective admission. The probability for the general population is 10%.

The estimated number of surgical non-elective admissions for elderly patients that will see an increase in travel times is ca. 1,300. Of this, an estimated 330 admissions will be from the most impacted areas.

There is no correlation between travel times and the proportion of residents who are aged 65 or above. Only one ward, Weeping Cross, has a significantly higher proportion of elderly residents but the ambulance and private car travel times from that area would remain below 30 minutes.

Impact on the characteristic of disability

Although there is evidence to show that people with disabilities are more likely to use A&E services[212] , there is no indication that they are more likely to require emergency surgery. The number of estimated non-elective surgical admissions by individuals with disabilities is expected to be small (ca. 200) and is well dispersed across all wards. There are several wards with areas that have slightly higher disability rates i.e. Brereton and Ravenhill, Cannock East, Cannock North and Hednesford North. However, there is no correlation between travel times and disability rates and none of these wards have travel times of over 30 minutes.

Impact on the characteristic of race

As noted in the Scoping Report and Section 5.5, the population of residents from minority ethnic groups is small. The total number of non-elective surgical admissions by patients of minority ethnic groups in the impacted area is ca.160. On the whole, the distribution of non-elective surgical admission by patients of minority ethnic groups is well dispersed. There are however several wards which have areas with slightly higher number of ethnic minority residents i.e. Common, Coton, Forebridge and Littleworth. These areas in Coton and Littleworth are also the areas most impacted in terms of travel times. Given the low number of ethnic minority emergency surgery admissions, the figures are not shown at the ward level as they cannot be estimated to any reasonable degree of accuracy and there are possible data protection issues.

[212] Assumed to be 20% higher.

There is also no relationship between travel times from wards and the proportion of minority ethnic groups in each ward.

Impact on the characteristic of socioeconomic deprivation

The wards in the impacted area falling within the national top quintile of the socioeconomic deprivation index are as shown in Table 10.12. An estimated 280 non-elective surgical admissions per annum are attributable to residents of those wards. None of the areas with high levels of socioeconomic deprivation, other than in Etching Hill and the Heath and Littleworth (ca. 60 admissions), appears to have journey times of over 30 minutes. The travel times to alternative sites in deprived wards are not different to that of non-deprived wards.

Impact on the characteristic of rural isolation

The rural wards in the impacted area are listed in Table 10.11. An estimated 340 emergency surgery admissions (120 from most impacted areas) are attributable to residents from rural areas. As noted previously, the travel times to alternative sites in rural wards are not different to that of non-rural wards.

10.4.3. Paediatric services

The population of children and young people (0-19) in Stafford & Surrounds CCG and Cannock Chase CCG is ca. 64,000 and ca. 42,000 of them live in the impacted area. The TSAs' draft recommendation to no longer provide a Paediatric Inpatient Unit (PIU) at Stafford Hospital will have an impact on both elective and non-elective admissions. Under the proposals, Stafford Hospital would continue to host a Paediatric Assessment Unit (PAU), and it is estimated that 60% of non-elective paediatric cases will still be able to be seen there[213], without requiring onward transport to another hospital.

As noted in Section 7.1, the paediatric admission rate in Stafford Hospital is much higher than the national average. If admission rates remain as high as they have been, the estimated number of paediatric patients in the impacted area in any given year is ca. 1,780 for non-elective admissions and 560 for elective admissions. Additional parent and family accommodation would be required at the alternative PIUs to reduce the need for parents and families to make multiple extended journeys to more distant hospitals.

[213] In 2012/13, 4,575 of the 6,901 (66%) paediatric admissions were in the PAU. Therefore, a conservative estimate of patients who can continue to be seen in the PAU is 60% of all paediatric admissions.

Non-elective and elective paediatric inpatient admissions – *N.B. all figures shown are per annum*		
General	Total impacted number of paediatric admissions	1,780 non-elective admissions 560 elective admissions
	Wards with the most impacted areas (ambulance or car times between 30 to 45 minutes)	Church Eaton , Coton , Etching Hill and the Heath, Gnosall and Woodseaves , Hagley , Haywood and Hixon , Huntington and Hatherton , Littleworth , Milford, Seighford Western Springs
	Impacted paediatric admissions in most impacted areas	470 non-elective admissions 150 elective admissions
Age	All wards with a higher concentration of very young children (aged 0-5)	Brereton and Ravenhill, Cannock North, ***Coton,*** Holmcroft, Penkside, Tillington
	Impacted admissions of very young children in all areas	1,290 non-elective admissions of which 340 are from the most impacted areas 190 elective admissions of which 50 are from the most impacted areas
Race	All wards with a higher concentration children from minority ethnic groups	Baswich, Common, ***Coton, Littleworth***, Milford, Weeping Cross
	Impacted paediatric admissions of children from minority ethnic groups in all areas	160 non-elective admissions , 40 elective admissions *(n.b. cannot attribute to wards due low numbers and data protection)*
Rural isolation	All wards with rural areas	Barlaston and Oulton, Chartley, Church Eaton, Eccleshall, ***Gnosall and Woodseaves***, ***Milford***, Milwich, Penkridge North East and Action Trussell, ***Seighford***, Swynnerton
	Impacted paediatric admissions from rural areas	170 non-elective admissions of which 60 are from the most impacted areas 60 elective admissions of which 20 are from the most impacted areas
Disabilities	All wards with higher disability rates in children	Cannock North, ***Etching Hill and the Heath***, Highfields and Western Downs, Holmcroft, Tillington
	Impacted paediatric admissions of patients with disabilities in all areas	110 non-elective admissions, 30 elective admissions *(n.b. cannot attribute to wards due low numbers and data protection)*
Socio-economic deprivation	All wards with areas of deprivation	Brereton and Ravenhill, Cannock East, Cannock North, ***Etching Hill and the Heath,*** Hednesford North, Highfields and Western Downs, ***Littleworth***, Manor, Penkside
	Impacted paediatric admissions in all deprived areas	190 non-elective admissions of which 23 are from the most impacted areas 60 elective admissions of which 10 are from the most impacted areas

Wards highlighted indicate areas overlapping with the most impacted areas

Impact on the general population of children and young people (0-19)

There are ca. 1,780 non-elective paediatric admissions per year that will be impacted if the historic patterns of very high levels of admission were maintained. Around 470 of these admissions are from the most impacted areas. For elective paediatric admissions, ca. 560 admissions are affected per year (ca. 150 from the most impacted areas).

While the population of children and young people is well dispersed across wards, parts of Cannock North, Etching Hill and the Heath, Penkside and Tillington have slightly higher concentrations. Areas within Etching Hill and the Heath with a higher proportion of children and young people are also the most impacted ones in terms of journey times. There is however no correlation between the proportion of the population who is aged 0 to 19 and travel times.

Impact on the characteristic of age (0-5)

Very young children are at greater risk of requiring non-elective admissions. Based on 2012/13 MSFT data, a child aged between 0-5 had a ca. 27% chance of requiring a non-elective admission compared to ca. 11% for those aged 0-19. The estimated number of admissions for young children that will see an increase in travel times is ca. 1,290. Only ca. 340 of them are from the most impacted areas.

However, for elective admissions, very young children do not have higher elective admission rates. The estimated number of elective admissions by young children in the impacted areas is 190, of which ca. 50 are from the most impacted areas.

Additionally, there are also areas within several wards that have a slightly higher proportion of very young children:

- Brereton and Ravenhill;
- Cannock North;
- Coton – overlaps with most impacted areas;
- Holmcroft;
- Penkside; and
- Tillington.

There is however no correlation between the proportion of the population who are very young children and extended travel times.

Impact on the characteristic of disability

There is evidence to show that children with certain forms of disabilities have greater healthcare needs. In estimating the number of admissions by children with disabilities in every year, it is assumed that the admission rate for children with disabilities is 50% higher than the general admission rate.

The number of admissions by children with disabilities from the impacted area is expected to be small (non-elective ca. 110, elective ca. 30) and is dispersed across all wards. Similarly,

the number of elective admissions by children with disabilities in the impacted areas is expected to be very small (ca. 30).

The following wards have areas with higher disability rates (based on long-term limiting illness (LTLI) claimant rates for those aged 0 to 16):

- Cannock North;
- Etching Hill and The Heath – overlaps with most impacted areas;
- Highfields and Western Downs;
- Holmcroft; and
- Tillington.

There is no correlation between disability rates in the whole impacted area and extended travel times.

Impact on the characteristic of race

Children from minority ethnic groups in Stafford have a slightly higher chance of requiring a non-elective admission based on 2012/13 data (ca. 13% vs. ca. 11%). The total number of non-elective admissions by children from minority ethnic groups in the impacted area is ca. 160.

For elective admissions however, children from minority ethnic groups in Stafford have a similar chance of requiring an admission as the general population. The total number of elective admissions by children of ethnic minority origins in the impacted area is estimated to be ca. 40 in any given year.

On the whole, the distribution of children from minority ethnic groups is well dispersed. There are however several wards that see slightly higher numbers i.e. Baswich, Common, Coton, Littleworth, Milford and Weeping Cross. The distribution of children from minority ethnic groups is however uncorrelated with extended travel times.

Impact on the characteristic of socioeconomic deprivation

The wards in the impacted area falling within the national top quintile of the socioeconomic deprivation index are shown in Table 10.12. An estimated ca. 190 non-elective and ca. 60 elective admissions are attributable to children and young people from these areas. None of the areas with high levels of socio-economic deprivation, other than Etching Hill and the Heath and Littleworth (ca. 30 non-elective and 10 elective admissions), appear to have journey times of over 30 minutes. Across the area, the travel times to alternative sites from deprived wards are not more extended than from the more economically advantaged wards.

Impact on the characteristic of rural isolation

The rural wards in the impacted area are listed in Table 10.11. An estimated 170 non-elective and 60 elective admissions (ca. 60 and ca. 20 admissions respectively are from the most impacted areas) are attributable to children and young people from rural areas. Across the

area, the travel times to alternative sites from rural wards are not more extended than from the more urban areas.

10.5. Impact on visitors

Hospital visitors are likely to come from various parts of Staffordshire or further afield, but the most frequent visitors are likely to be those closely related to patients and living with (or near) to them. For the purpose of the impact assessment, it is assumed that these frequent visitors live in the same ward as the patients. Clearly, children or siblings of adults and older people may well live some distance from the catchment area, and would always have travelled to see the patient. The discussion on visitors is therefore focused on carers or those visitors who live close to the patient. The majority of patients will have Stoke, Wolverhampton, Walsall, Burton or Telford as their alternative hospital sites.

A total of ca. 7,000 patients annually who are currently treated in Stafford Hospital will be treated in a different hospital. Applying the current average length of stay[214] in Stafford Hospital for the relevant specialties and assuming that patients are visited once a day by their family and friends, there would be ca. 24,000 visitor journeys. This estimate does not take into account the TSAs' draft recommendation for step-down beds in Stafford Hospital and Cannock Chase Hospital to where stable patients who require a longer hospital stay can be repatriated. Furthermore many adult patients admitted for short periods may not receive any visitors (e.g. two days or less). Based on 2012/13 data, only 13% of obstetrics and 40% of emergency surgery patients have a length of stay of 3 or more days. Due to these two factors, the estimated number of visitors to hospitals other than Stafford is likely to be an overestimate.

Visitors are more likely to use public transport than the patients using services affected by the TSAs' draft recommendations, and they may also need to make frequent trips to hospital. The car ownership rate in the impacted area is high at 83% and it has been assumed that therefore ca. 4,400 of the visitor journeys may have to rely on public transport. The Steering Group is aware that car ownership does not necessarily translate to access to a car (for example, where the only person with a driving license in a household may be the one who has taken ill or the car may be required by another family member for work related travel), and that a proportion of people will not regularly use their car and be particularly nervous about driving outside of a local and familiar area. However, the estimate on the number of public transport journeys is likely to be a large overestimate as the 2011 census[215] shows that only 3.3% of the population of Staffordshire commute to work by bus. Additionally, the National Travel Survey 2012[216] show that only 6.4% of people across Great Britain travel by local bus for personal journeys. This suggests that even those who do not own or regularly use a car tend to make arrangements that do not require them to depend on public transport.

[214] Maternity – 1.1 days, non-elective surgical admissions – 5.6 days, non-elective paediatric admissions – 1.8 days, elective paediatric admissions – 2.1 days (Source: 2012/13 MSFT inpatient data).
[215] Office of National Statistics (2011).
[216] Refer to weblink for more information https://www.gov.uk/government/publications/national-travel-survey-2012.

For visitors travelling by private car, the impact on travel times for them will be comparable with that of patients and this has been discussed in the preceding sections. Existing public transport routes and travel times are discussed in Section 10.7.

Qualitative evidence indicates that some hospitals in the locality have more limited visiting hours compared to Stafford Hospital. The Steering Group understands that visiting hours are arranged such that the assessment and treatment of patients are not disrupted, infection risks are minimised and patients receive sufficient rest. However, visiting hours for close family members of children who have been admitted or patients who are critically ill are typically not restricted.

10.6. Impact on staff

The TSAs believe that the establishment of a clinical network for Stafford and Cannock Chase Hospitals will address the sustainability and recruitment and retention issues of some services. This means that some clinical staff will need to operate across multiple sites. The TSAs have also identified the reduction of management and back office functions to NHS averages as a potential area for savings. This may result in some management and back office staff being redeployed to different sites.

At present, it is not possible to estimate the volume of staff that will be impacted as there are no further details available on the clinical networks and corporate/back office savings. However, they are likely to be mainly highly-skilled staff who are not on low salaries (although staff across many grades currently rotate between the two MSFT sites). As both sites will remain in operation, the impact on low paid staff (such as catering, porters and cleaners) may be limited. Based on a staff survey in 2012/13, ca. 19% of staff walk to work and another ca. 3% cycle to work. Staff who use such modes of transport may no longer be able to do so should they be redeployed to a different site.

MSFT currently operates a shuttle bus service between Stafford Hospital and Cannock Chase Hospital. The bus service operates on weekdays between 06:00 and 18:00 and can accommodate 20 passengers on each journey. For insurance purposes, passengers are limited to staff but it is sometimes used to shuttle equipment at times. The service is free to staff members with the service fee charged back to the relevant department.

The implementation period of any changes will present an opportunity to refresh staff travel plans and consider alternative arrangements, e.g. facilitated car-pooling or shuttle buses to support inter-site working (where there is sufficient movement to justify the costs of a service).

10.7. Existing public transport access and transport schemes

10.7.1. Public transport access

Around 80% of residents in the impacted area have access to Stafford Hospital by public transport on weekdays at peak hours within 60 minutes (refer to Appendix B for public transport access information at off-peak hours, Saturdays and Sundays). There is however a

sizeable proportion (15%) of residents that currently has no public transport access, even at these times.

Table 10.15: Weekday peak hour public transport travel times to Stafford Hospital

Public transport times to Stafford Hospital	Population		
5 to 10	7,368	4%	4%
10 to 15	5,119	3%	7%
15 to 20	4,597	2%	9%
20 to 25	15,560	8%	17%
25 to 30	16,419	9%	26%
30 to 40	35,270	19%	45%
40 to 50	34,309	19%	64%
50 to 60	28,740	16%	80%
60 to 120	9,964	5%	85%
No access*	27,539	15%	100%
Total	**184,885**	**100%**	**100%**

*Journeys that cannot access a bus stop within 350m or that cannot complete the journey within the specified time period are classified as having no access

Source: Steering Group analysis

Table 10.16 compares current public transport access to Stafford Hospital to access to alternative sites from each ward. All wards that have public transport access to Stafford Hospital also have access to other sites. There are however wards with no access currently to either Stafford Hospital or any of the alternative sites. On the whole, public transport links to alternative sites are poorer than those to Stafford Hospital.

Table 10.16: Comparison of public transport access between Stafford Hospital and alternative sites by ward

Ward	Alternative site 1	Public transport	Alternative site 2	Public transport	Alternative site 3	Public transport
Armitage with Handsacre	Burton		Good Hope			
Barlaston and Oulton	UHNS					
Baswich	Walsall		UHNS			
Brereton and Ravenhill	Good Hope		Burton		Walsall	
Cannock East	Walsall		Wolves			
Cannock North	Walsall		Wolves			
Chartley	UHNS					
Church Eaton	Telford		Walsall			
Common	UHNS					
Coton	UHNS		Burton			
Eccleshall	UHNS		Telford			
Etching Hill and The Heath	Walsall		Good Hope		Burton	
Forebridge	UHNS		Walsall			
Gnosall and Woodseaves	Telford		UHNS			
Hagley	Walsall		Good Hope		Burton	
Haywood and Hixon	UHNS		Walsall		Burton	
Hednesford Green Heath	Walsall		Wolves			
Hednesford North	Walsall		Wolves			
Highfields & West. Downs	UHNS		Walsall			
Holmcroft	UHNS					
Huntington and Hatherton	Walsall		Wolves			
Littleworth	UHNS		Walsall		Wolves	
Manor	UHNS		Walsall		Wolves	
Milford	UHNS		Walsall		Wolves	
Milwich	UHNS					
Penk. NE & Act. Trussell	Walsall		Wolves			
Penkridge South East	Walsall		Wolves			
Penkridge West	Walsall		Wolves			
Penkside	Walsall		Wolves			
Rawnsley	Walsall		Good Hope			
Rowley	UHNS		Walsall			
Seighford	UHNS		Telford			
St. Michael's	UHNS					
Stonefield and Christchurch	UHNS					
Swynnerton	UHNS					
Tillington	UHNS					
Walton	UHNS					
Weeping Cross	Walsall		UHNS		Wolves	
Western Springs	Good Hope		Walsall		Burton	

Significantly poorer public transport access to alternative site compared to access to Stafford	Similar or better public transport access compared to access to Stafford
Poorer public transport access to alternative site compared to access to Stafford	No access to alternative site but does not have access to Stafford either

Source: Steering Group analysis

10.7.2. Voluntary Transport Schemes

There are several voluntary transport schemes (VTS) that operate in Staffordshire e.g. Gnosall, Brewood, Penkridge, Colwich & Haywoods and Landywood & District[217]. Although each scheme has different eligibility criteria, they generally cater to those who do not have access to private transport but are unable to take public transportation. The destinations serviced by the VTS are not limited to hospitals but also include local businesses. Some schemes will take visitors and patients, however this is not common. The number of volunteers active in the organisations range from five to 17 and serve approximately 50 to 80 clients a month. Clients are usually required to pay for fuel and administrative costs where applicable, although in some cases there are small subsidies from Staffordshire County Council.

Hospital visits are usually provided as an end-to-end service, where the volunteer picks up the client at their home, waits for the duration of the appointment and then drops them back home again. The qualitative evidence suggests that this method has been found to be very helpful for VTS clients, who are often frail and/or elderly and find travel to hospital stressful.

Discussions with VTS groups indicate concern about the lack of volunteers, despite an increased effort to recruit additional numbers. Current volunteers are mostly retirees, stay at home partners or job seekers who all have individual restrictions on when and where they prefer to travel. If extended journeys are required in future, not all volunteers would be able to participate. Additionally, some volunteers may not be comfortable with longer distance travel and already find the layout of some hospitals to be confusing. As many VTS schemes operate in rural areas, there is insufficient contact between schemes to allow a shared client pool and resources. It should however be noted that existing VTS schemes tend to be in wards that do not have good access to Stafford Hospital, and already cover travel to a variety of hospitals and will continue to do so in light of the recommended changes.

The Steering Group believes that the VTS schemes are a valuable resource for communities they serve, and proposes that other communities affected by the TSAs' draft recommendations should be encouraged and supported to develop their own local schemes. Additional funding for existing schemes should be considered to ensure their continued viability. Hospitals could also provide better signage within sites and improve parking facilities for VTS scheme volunteers.

[217] These are the VTS the Steering Group has engaged with.

10.7.3. Healthcare Travel Costs Scheme (HTCS)

The Healthcare Travel Costs Scheme (HTCS) is a national scheme which each hospital trust operates according to standards set by NHS England. Qualifying patients and accompanying carers can claim a refund under the HTCS of the cost of travelling to hospital or other NHS premises for NHS-funded treatment or diagnostic test arranged by a doctor or dentist[218]. To qualify for help with travel costs under the HTCS, a patient must meet three conditions:

- At the time of appointment, the patient or his/her partner (including civil partners) must be receiving one of the qualifying benefits or allowances, or meet the eligibility criteria of the NHS Low Income Scheme;
- The journey must be made to receive NHS-funded non-primary medical or non-primary dental care services, to which the patient has been referred to by a GP, dentist or hospital consultant (i.e. they do not cover self-referral to emergency services); and
- For referrals made by a primary practitioner such a GP or dentist, the service must be provided on a different day and in premises other than those occupied by the practitioner who made the referral.

MSFT, UHNS and RWT all run HTCS schemes to the standards set out by NHS England although there are variations in how they operate locally. All three trusts reimburse qualifying patients the cost of bus, train, taxi or private car travel.

MSFT requires patients who wish to be reimbursed for travel by taxi to have a recommendation from a GP. Qualifying patients who travel by private car receive free parking and are reimbursed at the rate of 10p/mile. The annual expenditure on this CCG-funded service is ca. £10,000 for ca. 650 unique clients. The service in UHNS is similar to MSFT's although patients can travel by taxi without a GP recommendation. Those who drive are reimbursed at a rate of 13p/mile with parking fees waived. UHNS serves ca. 3,500 unique clients annually at a cost of ca. £45,000. Unlike in MSFT where the service is CCG-funded, UHNS funds the service itself.

At RWT, patients who travel by taxi must demonstrate that they have no means of using private or public transport in order to qualify for reimbursement. As with the MSFT scheme, qualifying patients travelling by private car receive free parking and are reimbursed at a rate of 15p/mile. As Wolverhampton has outsourced the service to NSL Care Services Ltd, annual spend and annual client turnover have not been reported.

10.7.4. Concessionary travel

Free travel in the Staffordshire County Council area is available at any time to anyone with a council-issued free bus pass when they board a local bus service anywhere in Staffordshire. The bus pass also allows for free travel in the rest of England between 09:30 and 23:00 on Monday to Friday, and all day on Saturdays, Sundays and Bank Holidays. Those who are eligible for a pass but are unable to travel unassisted may also be eligible for a

[218] NHS England, http://www.nhs.uk/NHSEngland/Healthcosts/Pages/Travelcosts.aspx.

'companion pass' which allows free travel for their carers for journeys that commence within Staffordshire.

Older residents are entitled to a concessionary bus pass when they reach the state pensionable age and this is currently on a sliding scale to harmonise the pensionable ages of men and women. People are now no longer automatically entitled to an older person's bus pass when they reach the age of 60. Residents of Staffordshire aged between 11 and 19 can apply for a free 'Your Staffordshire Card', which allows travel for £1 on any single bus journey which starts or ends in Staffordshire. Children aged 11 and below do not require the 'Your Staffordshire Card' and can travel for £1.

Staffordshire County Council also provides free bus passes for individuals with disabilities covered by the following categories:

- Blind or partially sighted;
- Severely or profoundly deaf;
- Without speech;
- Walking disability;
- Loss of the use of both arms;
- Learning disability; and/or
- Refused a driving licence.

10.8. Impact of the TSAs' draft recommendations on the cost of travel

10.8.1. Private car

Based on the services impacted by the TSAs' draft recommendations, a proportion of users of obstetric services, inpatient paediatric services (elective and non-elective) and FEAU services will travel to hospital by private car. Given high car ownership rates, the majority of visitors are also likely to be travelling by private car.

The cost impact of the proposals was estimated using a DfT-recognised methodology (WebTAG unit 3.5.6) and includes two elements:

- **Vehicle operating costs**: includes fuel costs and non-fuel costs (e.g. tyre wear, maintenance and depreciation). Fuel consumption and fuel cost have been calculated for average vehicles based on the proportion of car kilometres travelled by petrol and diesel cars; and
- **Value of time**: people implicitly put a value on their own time which reflects the inconvenience of additional travel time in monetary terms. A value of £5.71[219] per hour was utilised which represents the value of time for journeys made for non-

[219] Default parameter in WebTag. The values for non-working time apply to all non-work journey purposes, including travel to and from work, by all modes. It is based on research conducted by the Institute for Transport Studies (ITS) for the Department for Transport, reported in 2003, and published as Values of Travel Time Saving in the UK. The value given in the ITS report was in end 1997 prices. These values were converted to 2010 values and prices by uplifting in proportion to changes in values of time growth and changes in prices (using the GDP deflator). TAG UNIT 3.5.6, *Values of Time and Vehicle Operating Costs*, October 2012, Department for Transport: Transport Analysis Guidance (TAG), p. 5

work purposes. A vehicle occupancy rate of two per car has been assumed providing a vehicle value of time of £11.42 per hour.

The average cost to travel for each one-way journey to Stafford Hospital in the impacted area is £4.02. This increases by £3.70 to £7.72 for journeys to alternative hospital sites. Based on the previous assumption that three return visitor journeys are made per patient, the cost impact on visitors per patient is a £22.22 increase to £46.34.

Table 10.17: Comparison of private car journey costs to Stafford Hospital and alternative sites

	To Stafford Hospital	To alternative sites	Increase in cost
Average vehicle operating cost (£)	1.40	3.14	1.74
Average value of time (£)	2.62	4.59	1.96
Average total cost (£)	4.02	7.72	3.70

Source: Staffordshire County Council analysis

The availability of parking spaces and costs across sites will also have an impact on those travelling to hospital by private car.

Table 10.18: Parking space capacity

Hospital	Number of parking spaces	Number of disabled spaces	Parking costs	Comments
Mid Staffordshire Hospital	243	23	1h: £2.50 1day: £6.00 1week: £8.00	
Cannock Chase Hospital	43	40	1h: £2.50 1day: £6.00 1week: £8.00	
Royal Wolverhampton Hospital (New Cross)	506	127	1h: £3.20 1day: £5.20 1week: £14.00	Multi-Storey Car Park Project at New Cross Hospital will deliver 175 additional car parking spaces. For visitors circa 70% occupancy with a turnover of spaces around 2.5 per space.
University Hospital of North Staffordshire	708	204	1h: £2.50 1day: £8.00 1week: £10.00	55,000 pay and display parking transactions on site each month. Expansion in 2014.
Princess Royal Hospital (Telford)	385	43	1h: £2.50 1day: £3.00 1week: £8.00	Car parks are all at capacity during normal operational weeks
Walsall Manor Hospital	548	43	1h: £2.00 1day: £6.00 1week: £10.00	

Source: Internal trust information

Taking into consideration the cost of parking (assumed to be £10 for a weekly pass), the total cost for visitors is £56.24. A study[220] on the cost of healthcare travel in the UK found

[220] Centre for Health Economics, University of York (2010) Hospital Car Parking: The Impact of Access Costs.

that the costs for an episode of care ranged from £60 (outpatient clinic for multiple sclerosis) to £380 (for a course of cancer treatment).

As staff may need to work across different hospital sites in the future, the organisations running the hospital sites should consider introducing multi-site parking permits so that they do not need to purchase an individual permit for each site. Additionally, there are concerns on the availability of parking spaces particularly in UHNS and efforts need to be made to ensure that there is sufficient capacity (including disabled parking) commensurate with the additional patient flows. In order to support VTS schemes, hospitals should offer free parking and designated parking spaces to make journeys easier for volunteers.

10.8.2. Public transport

For people who qualify for a concessionary travel pass, the proposed changes will not affect their ability to travel by bus for free.

Bus journeys to hospitals other than Stafford Hospital are more likely to be multi-operator. For example, buses within Stafford are predominantly operated by Arriva whereas the only service providing a connection to UHNS is operated by First. Bus tickets are not transferable between operators and the biggest cost increases for bus users are associated with multi-operator journeys. In contrast it is possible to travel to Wolverhampton using one operator and purchasing a one day ticket. Table 10.19 summarises the travel cost from each ward to relevant hospitals.

Table 10.19: Comparison of public transport costs to Stafford Hospital and alternative hospital sites

	To Stafford Hospital	To alternative sites	Increase in cost
Average bus fare cost (£)	5.84	8.06	2.22
Average value of time (£)	9.36	14.61	5.25
Average total cost (£)	15.20	22.67	7.47

Source: Staffordshire County Council analysis

Those who travel to hospital frequently may choose to purchase bus passes which are generally more cost effective. For example, a weekly Arriva Stafford or First area ticket costs £18 and £19 respectively. Family day tickets for two adults and up to three children are also available from bus operators in Stafford (e.g. Arriva - £12 and First - £10).

10.9. Comparison against other local travel times surveys and analysis

10.9.1. Travel times survey by the office of the Member of Parliament for Stafford

In response to the widespread concern about longer journey times expressed by local people, the office of Rt. Hon. Jeremy LeFroy, MP for Stafford, collated hospital travel information from its constituents. A total of 493 journeys were reported, although only 324 records provided sufficient information for a comparison to be drawn against the travel

times analysis conducted by the Steering Group. The travel times in the two datasets were not readily comparable as[221]:

- The HEIA SG's travel times are based on a systematic collection of data from Tom Tom™ devices from 2008 to 2012 while the information from the MP's office is self-reported. Self-reported information may suffer from inconsistencies in approach in recording information between respondents and a bias to remembering the 'worst case' experience;
- The sample from the constituents suffers from a self-selection bias where the majority (257 out of 324 complete records) of the respondents report live within 15 minutes from Stafford Hospital. This population is likely to face the largest increase in travel times and will show a disproportionately large increase in travel times. While their concern is understandable, the dominance of their data will overstate the impact for the wider population;
- Data from the constituents are imprecise where many data points are reported as bands rather than a single figure;
- The travel times recorded by the constituents may include drop-off and pick-up times while the dataset used by the HEIA SG is based on point to point travel times;
- The data are collected from a survey which may be subject to human error in recalling travel times for previous journeys made; and
- The constituents may currently go to hospitals other than Stafford Hospital infrequently at present and therefore be unfamiliar with the route. The travel times data used by the HEIA SG are based on the best possible route. Should Stafford Hospital users need to use an alternative site in the future, their familiarity with routes to other sites should improve over time thus reducing the journey lengths.

Despite these limitations, the information collected gives a strong sense of the anxiety which the changes are provoking and the extent to which local people perceive travel to other hospitals other than Stafford to be significantly more difficult. A comparison of the travel times reported in the survey against the Steering Group's analysis is provided in Appendix B.

10.9.2. Travel times by the Contingency Planning Team (CPT) for MSFT

There was a strong feeling locally that the Contingency Planning Team (CPT) estimates for the changes in travel times understated the negative impact on transport and travel. A

[221] The authors of a study to compare travel times to hospitals estimated by Geographic Information System (GIS) to self-recorded travel times were not confident that the recall of car travel time by respondents was accurate. One large source of variation was the almost universal practice (followed by 98% of respondents) of rounding journey times to the nearest five or ten minutes. In their survey, although respondents were requested not to include the time taken to park at the hospital in their journey time, it is possible that some patients did so. The mean reported parking time was 7.4 minutes, but was substantially more for some patients. Altogether, 34% said it had taken ten minutes or more to find a parking space at the hospital and 4% claimed parking had taken them at least 30 minutes. A probably much larger contributing factor was the variability of reported travel times for similar journey distances. For any given straight line distance, a range of actual travel times was reported. Even at very low distances of a few kilometres, respondents reported car journey times between 5 and 30 minutes. The average journey time is generally more useful for modelling purposes than the range of possible extremes. Robin Haynes, Andrew P Jones, Violet Sauerzapf and Hongxin Zhao (2006) Validation of travel times to hospital estimated by GIS, *International Journal of Health Geographics*.

comparison of the CPT estimates to the Steering Groups' travel times analysis, indicates that the reasons the CPT travel times appear to be low are:

- Instead of reporting a range of travel times, the CPT analysis reported an average travel time. The areas that are equidistant to Stafford Hospital and other hospitals mask the impact on the most affected areas. The Steering Group's analysis does not cite averages but instead focuses on those most impacted i.e. facing travel times of above 30 minutes; and
- The assumption used on the speed on ambulance travel in the CPT estimates is much higher than in the Steering Group's analysis. The CPT estimates assume that an ambulance is able to cover the same distance as a car in 65% of the time it takes by car. Based on WMAS data, the Steering Group's analysis assumes that an ambulance will only be slightly quicker, at 93% of the time taken by a car.

Comparing the averages from the Steering Group's analysis and the CPT estimates, private car travel times to the nearest alternative site are similar. As discussed above, the Steering Group does not cite averages as it does not capture the impact on those who are worst off. Additionally, the Steering Group's analysis also takes into account the possibility that patients may wish to go to an alternative which is not necessarily the nearest. Ambulance travel times in the HEIA analysis are substantially longer than those in the CPT estimates due to differences in assumptions made on the speed of ambulance travel.

Table 10.20: Comparison of Steering Group's travel times analysis and CPT estimates

			NHS Stafford and Surrounds CCG	NHS Cannock Chase CCG
HEIA	Private car	Average travel time to Stafford	11	19
		Average increase in travel time	12	6
		Average new travel time	23	25
	Ambulance	Average travel time to Stafford	10	18
		Average increase in travel time	11	5
		Average new travel time	21	23
CPT	Private car	Average travel time to Stafford	13	20
		Average increase in travel time	10	1
		Average new travel time	23	21
	Ambulance	Average travel time to Stafford	8	13
		Average increase in travel time	7	1
		Average new travel time	15	14

Source: Steering Group analysis, MSFT Contingency Planning Team Report (January 2013)

10.10. Overall implications on travel times and proposals

The relatively high rates of car ownership and low dependence on public transport, combined with the range of high volume services which are proposed to remain on the two MSFT sites mean that relatively small numbers of people will be affected by the changes. However, this reinforces the negative impact for these people as the low volumes mean it is

unlikely to be commercially viable for public transport providers to change their routes or provide new ones.

The ca. 7,000 users of the services impacted by the TSAs' draft recommendations are unlikely to travel to hospital by public transport, because of the serious nature of illness associated with those services. Those on low incomes using private transport are already being supported by the Healthcare Travel Cost Scheme, and other local schemes (refer to Section 10.7). There is however a need to ensure that hospital users are informed of the range of support offered to them.

There are ca. 24,000 visitor journeys associated with the 7,000 impacted users. While patients are supported for travel to hospital, similar schemes are not available to visitors. Although deprivation is limited and car ownership rates are high in Staffordshire, there will be visitors who will find travel to a hospital site other than Stafford Hospital to be significantly more difficult. These visitors are expected to be those who are frail elderly, living with disabilities and/or on low income. Given that they are likely to have a social network of individuals who are in similar circumstances, they may not be able to rely on informal assistance to travel. While it is not possible to estimate the number of such visitors, they are expected to be few and dispersed across Staffordshire and therefore a commercial bus service or inter-site shuttle buses are unlikely to be able to meet the needs of these individuals in a cost-effective manner. The Steering Group proposes that organisations which take on the provision of alternative services consider providing support to these individuals to ensure that patients continue to have contact with family and friends whilst in hospital.

10.11. Steering Group's proposals to mitigate impacts

Based on the impact assessment summarised above, the Steering Group has put forward the following proposals:

- The Steering Group proposes that hospitals extend financial support to facilitate travel for the small number of visitors who are most in need. To ensure viability, this scheme should be by exception only and cover different modes of travel including taxi and private car; however, providers need to promote this scheme to ensure public awareness and design it for simplicity of use;
- Providers of inpatient paediatric services should increase the range and availability of family accommodation as there is likely to be additional demand due to the increased burden of travel;
- The Healthcare Travel Costs Scheme (HTCS) and other local travel schemes should be promoted such that qualifying patients and/or visitors are aware of the financial assistance available;
- Voluntary Transport Schemes (VTS) should be supported to ensure their continued existence. Additionally, there may be new areas that could benefit from such schemes and communities in those areas should be offered assistance in setting them up if there is interest. Further subsidies for VTS schemes should be explored and hospitals could provide free designated parking spaces for volunteers;

- Parking is viewed as a major element of access and sufficient capacity needs to be established to match any growth in demand;
- There are concerns about current arrangements for disabled parking particularly on the variations by hospital site in terms of proximity of parking spaces to access points and costs. Hospitals should therefore work to reduce the variation across sites and improve accessibility; and
- In the future, some staff may need to work across different sites due to the clinical networks. Therefore, multi-site parking permits should be introduced to minimise the impact on parking costs, and other opportunities explored to support inter-site working, as part of revisions to staff travel plans.

11. Summary of proposals and next steps

11.1. Summary of proposals

11.1.1. Overall proposals

The Steering Group has identified a range of proposals that could mitigate the risks associated with some elements of the TSAs' draft recommendations and/or reinforce the potential positive outcomes. More detailed proposals relevant to each service area (e.g. maternity and paediatrics) are given in the relevant sections.

1. Meeting national clinical standards and guidelines

The TSAs' draft recommendations are based on discussions with the National CAG, which have placed a high value on rationalising services at MSFT in order to promote compliance with a variety of national standards and guidelines. In particular, this consideration has had a significant impact on the draft recommendations to concentrate obstetric expertise outside of MSFT, move paediatric inpatients off-site, and stop emergency surgery and level 3 critical care. It is therefore essential that, if positive health impacts are to be realised, these changes facilitate alternative local providers in meeting the relevant national standards.

2. Enhancing the interface with community services

Further work needs to be done on the interface between hospital services and community services. The TSAs should be more explicit about how this interface will be developed to ensure that as much care as possible is delivered closer to (or at) home, especially for the elderly and children. The TSAs and local providers should consider how the development of clinical networks to support the future delivery of many of the services covered by the draft recommendations can include community clinicians. In particular, assertive management within the clinical network should seek to minimise disruption to the lives of children living with disabilities or chronic conditions, including optimising the development of community support as an alternative to hospital contact. Commissioners may wish to consider how they can adjust the balance of investment to support alternatives to hospital care where appropriate.

3. Capacity and capability in alternative provision

Many of the TSAs' draft recommendations entail a transfer of activity to alternative providers in order to deliver improved health outcomes and a more sustainable local health economy. If these benefits are to be realised, it will be essential that these alternative providers have both the capability and the capacity to cope with this additional activity. Particular concern has been expressed throughout this process about whether UHNS will be able to meet the scale of this challenge in a range of the specialities affected, including paediatrics and critical care.

The TSAs' draft recommendations are predicated on a model in which patients will be either taken to more remote units (involving longer ambulance journeys than at present), or stabilised and transferred between units (involving more ambulance journeys). WMAS has demonstrated elsewhere in the region that is has the skills to undertake this work safely. However, it will be essential that commissioners consider what level of investment is required to ensure that the service also has the capacity to maintain current standards of response.

4. Aligning 'front door' activity

The public response to the proposals has revealed genuine confusion about first response services, and how to access advice and assessment for acute illness. Commissioners will want to work with primary care to ensure that GPs proactively support their patients in making best use of 'front door' services, particularly in educating those with a history of using A&E for minor and self-limiting conditions; A&E colleagues should reinforce these messages.

The paediatrics team will need to work closely with those families with a history of regular contact and admission to support them through the transition to any new model of service.

It will be essential that the hospital emergency and urgent care services are aligned with A&E. The Early Pregnancy Assessment Unit (EPAU) proposed for Stafford Hospital should operate at the same hours as A&E and with shared protocols (in a similar way to the draft recommendation for the Paediatric Assessment Unit (PAU)). There must be clear arrangements in place, visible to primary care and the ambulance service, for alternative arrangements for both the PAU and EPAU services between 22.00 and 8.00 each day.

5. Maintaining continuity of care

There is public concern about potential compromise to continuity of care given that the TSAs' draft recommendations introduce a division between specific outpatient and hospital inpatient services. This should be addressed through the clinical network process but requires additional attention to communications across sites, between different clinical teams, and at the interface with community services. This is true particularly for:

- Arrangements for community midwifery, choice of site and style of delivery, planning travel to hospital, and advice and assessment during onset of labour;
- Paediatric services relating to chronic care and the exacerbation of chronic conditions, and/or where there are safeguarding concerns;
- People in need of specialist communications support; and
- Those with multiple conditions.

6. Safety of patient transport over longer distances

The evidence from research and the experience of WMAS elsewhere in the region suggests that whilst journey times will be extended, they should be safe. What will be critical is having

the capability, both with paramedics and on site in the local hospitals, to intervene (including intubation and respiratory support) and stabilise for transfer.

There will need to be increased capacity to support the transfer of patients, and this will potentially include additional activity for neonatal transfer.

7. Carer, staff and visitor journeys

The Steering Group considers that the greatest potential negative impact arising from the TSAs' draft recommendations is the effect on carers and visitors of extended journeys to more remote hospitals to visit inpatients. The Steering Group proposes that the TSAs work with alternative providers of services to actively review:

- Extended financial support to facilitate travel for the small number of visitors who are most in need. To ensure viability, this scheme should be by exception only and cover different modes of travel including taxi and private car; however, providers need to promote this scheme to ensure public awareness and design it for simplicity of use;
- The application and awareness of the national Healthcare Travel Costs Scheme;
- Capacity and availability of car parking and arrangements for charging, including multi-site permits and multi-day passes;
- The scale, siting (proximity to the hospital) and charging for disabled parking;
- Support for Voluntary Transport Schemes (VTS) to ensure their continued existence. Additionally, there may be new areas that could benefit from such schemes and communities in those areas should be offered assistance in setting them up if there is interest; and
- Signage and seating which would help with negotiating unfamiliar and larger sites.

The workforce has highlighted the arrangements for travel, both to and from work and across multiple sites, as a source of significant concern. All providers have staff transport policies, and as implementation proposals become clearer, the host employers should review and develop these. There are opportunities for initiatives which could limit the negative impact on staff including multi-site parking permits, car-pooling, designated 'in-transit' parking, or the extension of 'shuttle bus' schemes.

8. Infrastructure to support carers and families in more distant hospitals

Hospitals already make arrangements to support parents visiting young children, but their capacity should be reviewed to ensure that they are able to cope with greater numbers of families living at longer distances from the site. They may need to extend onsite family accommodation, or consider how to support parents to stay locally.

The Steering Group recognises the challenge of limiting local hospitals' visiting hours to optimise treatment time, and minimise tiring of patients and the risk of infection. However, the TSAs and alternative providers may want to consider how to respond flexibly to carers

and parents living at a distance to support contact and recovery (particularly where they are dependent on infrequent public transport services).

9. Range of services

The Steering Group is concerned that limiting the scope of the TSAs' remit to the current hospital services has limited the extent to which they can explore appropriate alternatives to the current hospital provision. The discussion of obstetric care pays little attention to national policy on extending choice of site and style in childbirth. In particular, the TSAs should reconsider their analysis of a midwifery-led unit (MLU) at Stafford Hospital to take into account the experience of the MLU at Lichfield. For emergency surgery, the Steering Group proposes that the TSAs work with commissioners to develop the step down model and ensure that resources are targeted where they will deliver most benefit for older people.

The limits placed on the TSAs have driven relatively traditional proposals, during a period of significant change, where there is the opportunity to develop thinking of national significance on the future role of the district general hospital. This has no doubt supported constructive debate about service effectiveness, but potentially at the expense of access, relevance and responsiveness. Commissioners will have the opportunity to further consider how the spirit of these proposals could be reflected in implementation, with the aim of delivering more care closer to home.

10. Engagement with public and staff

The TSA process, coming after several years of high profile investigations into the failings in local services, has generated enormous local interest and debate. The Steering Group has experienced exceptionally generous participation by local people, and this has been reflected in its focus group discussions and participation in public meetings. There is real local energy and interest in being involved in shaping the future of health services; the Steering Group would urge commissioners and future providers to encourage this and actively engage with members of the public and particular interest groups as they move towards implementation.

The workforce has indicated that, once the Secretary of State for Health has made a decision about the future arrangements, this is clearly communicated and the local health system moves quickly to end uncertainty and take action in response. Where the process of implementation is itself experienced as engaging and empowering of staff and patients (of all ages), this will itself provide a positive health impact.

11. Monitoring the impact of the TSAs' recommendations

There is genuine public anxiety around safety and capacity issues arising from the TSAs' draft recommendations. The Steering Group suggests that commissioners should agree a set of metrics with all future providers, aligned with the TSAs' final recommendations to Monitor, which addresses the areas of public (and staff) concern. These metrics should be published

and measured regularly to provide on-going reassurance that the proposals have realised their intended benefits and that potential risk has not translated into negative consequences.

11.1.2. Service-specific proposals: maternity

Based on the implications for maternity services summarised in Section 6, the Steering Group has put forward the following proposals to mitigate the potential negative impacts and enhance the positive impacts of the TSAs' draft recommendations:

- The Steering Group welcomes the evidence-based approach taken by the TSAs as informed by their national medical and nursing advice, and notes the importance of applying these standards consistently to alternative provision of obstetric services. In particular, it will be important to reassure the public of medical and nursing workforce and bed capacity at alternative sites for maternity and associated paediatric and other services. The Steering Group recommends that the TSAs work with commissioners to define "sufficient capacity" and the metrics to monitor it and then publish this information on a regular basis;
- There is considerable and legitimate public concern about potential compromise to continuity of care given the division of antenatal care, delivery and postnatal follow up; it will be particularly important to understand the role of community midwifery in risk assessment, advice on style and site of delivery, support to visit and learn about the delivery suite and hospital lay-out and parking, and active availability for assessment and support in labour to get women into hospital in a timely and calm manner;
- The Steering Group understands the reasoning behind rejection of a MLU option at Stafford Hospital given the relatively low take up of midwifery led services (ca. 4.9% in 2007) across England[222]. However, the Steering Group is concerned that more analysis has not been carried out to understand availability and capacity at the local standalone midwife-led unit (MLU) at Lichfield, and to promote this as part of the choice available, particularly for the community around Rugeley who do not currently have good access to the delivery unit at Stafford Hospital, but is relatively close to Lichfield. This TSAs should reconsider their analysis of an MLU at Stafford Hospital in light of more local information from Lichfield;
- The Steering Group is concerned at the relative lack of attention given to the recommendations of *Changing Childbirth*[223] and other guidance associated with improving the acceptability and responsiveness of maternity services, in particular the opportunity to reinforce the role of community midwifery and the choice of home birth;

[222] The Birthplace in England Research Programme reported that for the year ending 31st March 2007, there were 11,261 births in a freestanding MLU; 19,192 births in an alongside MLU; and 590,859 births in an obstetric-led unit. *Mapping maternity care: the configuration of maternity care in England Birthplace in England research programme*. Final report part 3, Birthplace in England Collaborative Group, November 2011, p. 22.

[223] Department of Health (1993) *Changing Childbirth*. Report of the Expert Maternity Group (Cumberlege Report). HMSO: London.

- The Steering Group welcomes the recommendation to create an Early Pregnancy Assessment Unit (EPAU) at Stafford Hospital as part of the core urgent care service, and would expect it to be available at the same times as A&E (including at weekends) to minimise confusion about where and when to go. Clear protocols and local communications need to be in place regarding alternatives when the EPAU is closed; and
- The Steering Group is assured that the range of obstetric and other birthing units available to the population does not mean that future journey times are so long as to put women or babies at risk; however the public is very concerned about this. It will be essential that commissioners work with the West Midlands Ambulance Service (WMAS) to ensure sufficient capacity for additional and extended journeys, capability in support for labour and care of the neonate, and active management of protocols to ensure that women in labour end up in the right place as quickly and safely as possible.

11.1.3. Service-specific proposals: paediatrics

Based on the implications for paediatric services summarised in Section 7, the Steering Group has put forward the following proposals to mitigate the potential negative impacts and enhance the positive impacts of the TSAs' draft recommendations:

- As with maternity services, the TSAs should ensure that the aspiration to meet national standards is fulfilled by ensuring sufficient capacity in alternative inpatient paediatric services to provide effective medical and skilled nursing cover out of hours, at weekends and at times of peak activity. This should also address areas of associated concern (for example, anecdotal evidence around the availability of routine neonatal checks at UHNS);
- The Academy of Medical Royal Colleges (AMRC) notes[224] that the drive towards seven day consultant-delivered care must be complemented by support services available in the community seven days a week. This will be especially important in the TSAs' model of care because inpatient services will not be located at Stafford Hospital. For long-term conditions (LTCs), the RCPCH notes[225] that the model of service delivery should be largely community-based, meaning delivery at home, in schools, or in other local settings, with hospital-based reviews or interventions only when necessary;
- The RCPCH further recommends[226] that better urgent care should be provided in community settings, and parents need clearer information on how and where to access advice and treatment (see below);
- Clear protocols are required for first contact services (including primary care and 111) regarding where to take sick children, and availability of information for parents on signs

[224] *Seven Day Consultant Present Care*, London: Academy of Medical Royal Colleges, December 2012, p. 3.
[225] *Modelling the Future III: Safe and sustainable integrated health services for infants, children and young people*, December 2009, London: Royal College of Paediatrics and Child Health, p. 7.
[226] *Modelling the Future III: Safe and sustainable integrated health services for infants, children and young people*, December 2009, London: Royal College of Paediatrics and Child Health, p. 45.

of serious illness and management of acute but self-limiting illness (including fever, diarrhoea, sickness, headache etc.);

- Work with WMAS to ensure the service has the capacity and capability to sustain the new model of inpatient care;
- Where a child does require an admission or specialist assessment, active consideration and support for families living in rural isolation and/or on low income and/or dependent on public transport. The impacts could be ameliorated by the TSAs planning for: (i) financial and other transport support for vulnerable families (including ensuring availability of child seats in voluntary or commercial transport arrangements); and (ii) improved availability of family accommodation in proposed extended paediatric inpatient units;
- Given the substantial redesign of paediatric services that will be required, the Steering Group recommends taking the opportunity to address Recommendation 33 of the Kennedy Review[227]: "NHS services for children and young people should be designed, organised and delivered from the perspective of the child, young person and parent or carer. Relevant NHS services should regularly assess the expectations and views of children and young people using the services, and should take action in the light of the findings, which should be made public"; and
- Assertive management within the clinical network should seek to minimise disruption to the lives of children living with disabilities, including optimising the development of community support as an alternative to hospital contact. Outreach nurses should have training in recognition of seriously ill children. In addition to core nursing skills, they should be able to manage gastrostomy, management of seizures, respiratory disease, and intravenous access including portage. A comprehensive community nursing service should be the bedrock of wider out of hospital services for ill and disabled children[228].

11.1.4. Service-specific proposals: EUCC services

Based on the implications for emergency, urgent and critical care (EUCC) services summarised in Section 8, the Steering Group has put forward the following proposals to mitigate the potential negative impacts and enhance the positive impacts of the TSAs' draft recommendations:

- The Steering Group proposes that the TSAs work with local commissioners on a programme of patient education to reduce the level of attendances at the A&E;
- The Steering Group proposes that, within the scope of their remit, the TSAs work with commissioners to ensure that the FEAU is informed by close clinical collaboration with primary care and community health services, and forms the hub of a network of services developed to support people to stay as healthy as possible at home;

[227] *Getting it right for children and young people: Overcoming cultural barriers in the NHS so as to meet their needs*, A review by Professor Sir Ian Kennedy, September 2010, p. 94.

[228] *NHS at home: Children's Community Nursing Services*, London: Department of Health - Partnerships for Children, Families and Maternity, March 2011, p. 7.

- The Steering Group proposes that the TSAs work with commissioners to develop the step down model and ensure that resources are targeted where they will deliver most benefit for older people; and
- Commissioners develop insight into current activity and capacity of level 3 critical care and actively monitor this, sharing the information with the public.

11.1.5. Service-specific proposals: elective and day case services

Based on the implications for emergency, urgent and critical care (EUCC) services summarised in Section 9, the Steering Group has put forward the following proposals to mitigate the potential negative impacts and enhance the positive impacts of the TSAs' draft recommendations:

- The TSAs should seek to optimise the opportunity for high quality care close to home, by maximising the use of day case and active pursuit of early supported discharge in inpatient care; both of these will be dependent on active development of the relationship with community services; and
- The Steering Group would seek reassurance that there is a commitment to sustaining or developing the range of specialist outpatient and day case activity which has previously been available locally, possibly through other providers.

11.1.6. Proposals relating to transport and access

Based on the implications for transport and access summarised in Section 10, the Steering Group has put forward the following proposals to mitigate the potential negative impacts and enhance the positive impacts of the TSAs' draft recommendations:

- The Steering Group proposes that hospitals extend financial support to facilitate travel for the small number of visitors who are most in need. To ensure viability, this scheme should be by exception only and cover different modes of travel including taxi and private car; however, providers need to promote this scheme to ensure public awareness and design it for simplicity of use;
- Providers of inpatient paediatric services should increase the range and availability of family accommodation as there is likely to be additional demand due to the increased burden of travel;
- The Healthcare Travel Costs Scheme (HTCS) and other local travel schemes should be promoted such that qualifying patients and/or visitors are aware of the financial assistance available;
- Voluntary Transport Schemes (VTS) should be supported to ensure their continued existence. Additionally, there may be new areas that could benefit from such schemes and communities in those areas should be offered assistance in setting them up if there

is interest. Further subsidies for VTS schemes should be explored and hospitals could provide free designated parking spaces for volunteers;

- Parking is viewed as a major element of access and sufficient capacity needs to be established to match any growth in demand;
- There are concerns about current arrangements for disabled parking particularly on the variations by hospital site in terms of proximity of parking spaces to access points and costs. Hospitals should therefore work to reduce the variation across sites and improve accessibility; and
- In the future, some staff may need to work across different sites due to the clinical networks. Therefore, multi-site parking permits should be introduced to minimise the impact on parking costs, and other opportunities explored to support inter-site working, as part of revisions to staff travel plans.

11.2. Next steps

The Steering Group's draft proposals were shared with the TSAs through a formal memorandum to the Office of the TSAs on the 11th October 2013. This communication built on an earlier memorandum that outlined the emerging thinking from a workshop-style event held on 3rd September 2013 where the Steering Group discussed the TSAs' draft recommendations and explored, for each service area, the main messages, potential impact areas, and the possibilities for mitigating actions.

This Impact Assessment Report is being published at the same time as the TSAs' final recommendations to Monitor.

Figure 11.1: High-level timeline for the TSA process

Monitor has granted an extension of up to 40 days to the final report stage of the TSA process[229]. The Steering Group has been assured that the TSAs have considered the memoranda and mitigating proposals, in conjunction with the responses received from their consultation with the public, to arrive at their final report and recommendations to Monitor.

[229] http://www.monitor.gov.uk/home/news-events-publications/latest-press-releases/agreement-funding-services-key-delivering-patients-mid-staffs.

12. Appendix A: Additional information on services impacted

This appendix provides additional information on the impacted services (obstetrics, inpatient paediatrics, and emergency, urgent and critical care).

12.1. Impact of changes to maternity services

The national increase in birth rate is reflected in Staffordshire with the total births locally growing by 5% between 2008 and 2012 (15,600 to 16,400). However, births at Stafford Hospital have decreased by over a fifth within the same period and it is the only provider to see a decrease over the last five years.

Trends in number of births by provider

	2008/09	2009/10	2010/11	2011/12	Percentage change between 2011/12 and 2008/09
Mid Staffordshire NHS Foundation Trust	2,440	2,226	2,024	1,891	-23%
The Royal Wolverhampton NHS Trust	3,670	3,796	4,033	4,069	11%
University Hospital of North Staffordshire	5,829	5,999	5,692	5,968	2%
Walsall Healthcare NHS Trust	3,637	3,649	3,858	4,460	23%
Local providers	15,576	15,670	15,607	16,388	5%
West Midlands	**71,065**	**71,472**	**72,182**	**73,433**	**3%**
England	**652,638**	**652,377**	**668,195**	**668,936**	**2%**

Source: Hospital Episode Statistics (HES), Health and Social Care Information Centre

Birth trends for the last five years for the two CCGs show an overall increase in births by 1%.

Trends in number of births by CCG

	2008	2009	2010	2011	2012 (provisional)	Percentage change between 2008 and 2012
Cannock Chase CCG	1,468	1,460	1,510	1,520	1,570	7%
Stafford and Surrounds CCG	1,474	1,385	1,355	1,358	1,398	-5%
Cannock and Stafford CCGs	2,942	2,845	2,865	2,878	2,968	1%
West Midlands	**72,129**	**71,455**	**72,472**	**73,391**	**n/a**	**2%***
England	**676,236**	**674,545**	**690,513**	**691,739**	**n/a**	**2%***

Indicates percentage change between 2008 and 2011

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

The increase in the total number of births in the local health economy between 2008 and 2012 also resulted in increased in demand for antenatal and postnatal care.

12.2. Impact of changes to paediatric services

12.2.1. Deprivation scores by local authority

Local authority	Index of Multiple Deprivation 2010 weighted score	Rank of 326 districts (1 = most deprived and 326 is least deprived)	National decile (1 = most deprived and 10 is least deprived)
Cannock Chase	20.6	128	3
Stafford	13.1	232	7
Stoke-on-Trent	35.3	16	1
Walsall	31.2	30	1
Wolverhampton	34.4	21	1

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

12.3. Impact of changes to emergency, urgent and critical care (EUCC) services

12.3.1. Local demand trends

Accident and emergency

The table below 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.

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)

Emergency surgery

The number of admissions for emergency surgery from the population of Cannock Chase CCG and Stafford & Surrounds CCG rose from ca. 3,700 to ca. 4,600 (25% increase) between 2009/10 and 2012/13. The impact from the increase in demand from the CCG population varied across local providers. UHNS saw the largest increase (98%) in this period whilst MSFT saw a comparatively small increase of 9%. MSFT's share of total CCG emergency surgery admissions fell from 63% to 55% whilst the University Hospital of North Staffordshire share rose from 13% to 21%.

Emergency surgery admissions by provider for Cannock and Stafford CCG patients

	2009/10	2010/11	2011/12	2012/13	% change 2009/10 and 2012/13
Mid Staffordshire NHS Foundation Trust	2325	2343	2238	2524	9%
University Hospital of North Staffordshire	485	630	722	959	98%
The Royal Wolverhampton NHS Trust	288	309	376	411	43%
Walsall Healthcare NHS Trust	193	202	219	317	64%
Others	397	432	426	409	3%
Total emergency surgery admissions	**3688**	**3916**	**3981**	**4620**	**25%**

Source: Hospital In-patient Data Extract, NHS Healthcare Commissioning Services (HCS), South Staffordshire Health Informatics Service (HIS) data warehouse

Between 2009/10 and 2012/13, Stafford & Surrounds CCG experienced a 34% increase in emergency surgery admissions whilst Cannock Chase CCG experienced a more modest 17% increase. Much of the increase in Stafford & Surrounds CCG was accounted for by for by admissions to UHNS.

Emergency surgery admissions for Cannock and Stafford CCG patients

	2009/10	2010/11	2011/12	2012/13	% change 2009/10 and 2012/13
Cannock Chase CCG	1845	1884	1890	2156	17%
Stafford and Surrounds CCG	1843	2032	2091	2464	34%
Total emergency surgery admissions	**3688**	**3916**	**3981**	**4620**	**25%**

Source: Hospital In-patient Data Extract, NHS Healthcare Commissioning Services (HCS), South Staffordshire Health Informatics Service (HIS) data warehouse

Level 3 critical care

For Stafford & Surrounds and Cannock Chase CCG patients, critical care episodes having one or more day of level 3 care remained static between 2010/11 and 2012/13. There were however changes at the trust level. MSFT and University Hospitals Birmingham NHS Foundation Trust both saw a fall in the number of episodes, whilst UHNS, Royal Wolverhampton and Walsall Healthcare saw a rise in episodes.

Level 3 critical care episodes by provider for Cannock and Stafford CCG patients

	2010/11	2011/12	2012/13	% change 2009/10 and 2012/13
Mid Staffordshire NHS Foundation Trust	167	153	113	-32%
University Hospital of North Staffordshire	181	202	207	14%
The Royal Wolverhampton NHS Trust	94	74	104	11%
University Hospitals Birmingham NHS Foundation Trust	27	41	20	-26%
Walsall Healthcare NHS Trust	20	22	32	60%
Other	30	35	46	53%
Total episodes	**519**	**527**	**522**	**1%**

Source: Hospital In-patient Data Extract, NHS Healthcare Commissioning Services (HCS), South Staffordshire Health Informatics Service (HIS) data warehouse

The picture was different when looking at the numbers of level 3 support days. Both MSFT and Royal Wolverhampton saw a fall in support days whilst UHNS and University Hospitals Birmingham saw a rise in support days. Walsall Healthcare saw no change during this period although there was a dip in activity in 2011/12.

Level 3 critical care support days by provider for Cannock and Stafford CCG patients

	2010/11	2011/12	2012/13	% change 2009/10 and 2012/13
Mid Staffordshire NHS Foundation Trust	1243	1041	955	-23%
University Hospital of North Staffordshire	892	982	1315	47%
The Royal Wolverhampton NHS Trust	448	209	329	-27%
University Hospitals Birmingham NHS Foundation Trust	113	318	252	123%
Walsall Healthcare NHS Trust	108	54	108	0%
Other	144	133	191	33%
Total episodes	**2948**	**2737**	**3150**	**7%**

Source: Hospital In-patient Data Extract, NHS Healthcare Commissioning Services (HCS), South Staffordshire Health Informatics Service (HIS) data warehouse

FEAU

The demand for acute medicine and care of the elderly services in Stafford Hospital is expected to increase in the future due to the forecast demographic changes in the local population. Whilst this increase is a national challenge, the projected rate of growth in the catchment area for the over 65 age group is higher than the national average (22% versus 19%). The creation of a FEAU should help meet and alleviate this demand.

Population projections for local CCGs compared to national trends

Area	2011 population for age group 65+	Predicted 2021 population for age group 65+	% change
Stafford and Surrounds CCG	23,700	28.900	+21.9%
Cannock Chase CCG	30,000	36,600	+22.2%
All Staffordshire CCGs	160,600	197,400	+22.9%
England	9,055,900	10,787,100	+19.1%

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

13. Appendix B: Travel times methodology

This appendix summarises the travel times methodology and assumptions used for the impact assessment.

13.1. Limitations of the travel times analysis

The development of travel times used within the analysis was based on an aggregation of data points from average travel times, using the most accessible and detailed sources. However, the Steering Group recognised that travel times cannot be precise for every journey and are highly dependent on the time of day the journey is made, the route taken, driving style and traffic conditions. For public transport, the average speed of walking will vary between individuals (the assumption used within the analysis is a pace of 4.8km per hour). Despite these limitations, the sources used for the analysis were offered the most consistent and robust data, and enabled comparison against current routes and thus assessment of the impact of the TSAs' draft recommendations.

The analysis was developed by using a single central point for each Lower Layer Super Output Area (LSOA). A 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 1,000 and the mean is 1,500; there is a LSOA for each postcode in England and Wales[230]. The information to identify single central point was provided by the Office of National Statistics (ONS) and is selected on the basis of population density. For each LSOA, the analysis used this point to approximate a specific postal code from which all travel times from that LSOAs are defined. In a densely populated area, this approximation could have a slight impact when compared to actual specific postcode calculations because travel from any specific location to the centroid[231] point used for analysis will be a short distance. However, in a more rural/more sparsely populated area, the travel time assessment is likely to be less robust as the distance to the centroid point will be larger.

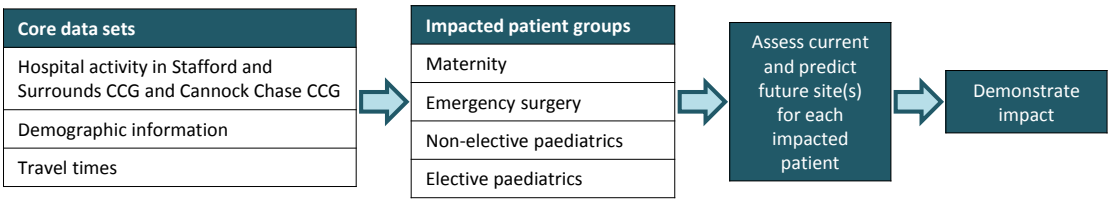
In addition, travel times analysis assumes that employees, patients and visitors use the shortest route to hospital. However, in reality there may be people who choose their route for other reasons such as cost and may choose to walk or cycle to the site.

[230] 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).

[231] The centroid is the population weighted central point of the lower layer super output area , or the 'central' point for that group of circa 1000 people.

13.2. Approach to the analysis

To assess the impact of changing travel times both on the general population and on individual patient groups, it is necessary to link a number of different information sources. The analysis used an approach set out below:



As shown in the diagram, the analysis uses the impacted population statistics and activity data for specific patient groups: maternity, emergency surgery, non-elective paediatrics and elective paediatrics.

The data are applied independently for each of these core patient groups within the impacted population. The reasoning behind this approach is to identify whether one or more of these groups may be at risk of significant negative impact following any changes and also to exclude where there are some in-scope groups which are less relevant for a specific change e.g. assessing the travel time impact of a change to maternity services on male patients or those over 65.

13.3. Calculation methodology

13.3.1. Travel times

The travel times from each LSOA to hospital sites are calculated using the following methodology:

1. The impacted area is defined by identifying LSOAs (within Stafford and Surrounds CCG or Cannock Chase CCGs) where Stafford Hospital is the nearest hospital or Cannock Chase Hospital is the nearest hospital with Stafford Hospital being the next nearest based on peak private car and ambulance travel times;
2. Alternative hospital sites are then identified for the LSOAs in the impacted area -
    a. Ambulance: The alternative site for each LSOA is based on the hospital to which WMAS conveys patients to at present when Stafford Hospital's A&E is closed overnight (22:00 to 08:00);
    b. Private car: The identification of alternative sites is based on patients travelling to the next nearest hospitals or to a hospital as defined by existing ambulance protocols. Where the difference in travel times to two or more sites is within 5 minutes, those sites are considered to be possible alternatives. However, for the purpose of the travel times analysis, the travel times to the site which is the furthest away is used to ensure that the worst case scenario is considered; and

3. Travel times to the Stafford Hospital and alternative hospital sites are then compared.

13.3.2. Impacted population

The impacted population is considered for each service area and the in-scope characteristics.

Maternity

General population

1. Identify LSOAs where Stafford Hospital is the nearest facility
2. Calculate the total number of births in the LSOAs and the number of these which took place in MSFT
3. Calculate the proportion of births which took place in MSFT as a proxy for patient choice
4. Calculate the population of women of child-bearing age (15-44) in the affected LSOAs from step 1and the general fertility rate
5. Impacted population = (pop of child bearing age) x (general fertility rate) x (patient choice)

Age i.e. older mothers (35-44)

1. Identify LSOAs where Stafford Hospital is the nearest facility
2. Calculate the total number of births in the LSOAs and the number of these which took place in MSFT
3. Calculate the proportion of births which took place in MSFT as a proxy for patient choice
4. Calculate the population of women of child-bearing age (35-44) in the affected LSOAs from step 1
5. Assume that the fertility rate for older mothers is half of the general population's
6. Impacted population = (pop of women aged 35-44) x (general fertility rate x 50%) x (patient choice)

Race

1. Identify LSOAs where Stafford Hospital is the nearest facility
2. Calculate the total number of births in the LSOAs and the number of these which took place in MSFT
3. Calculate the proportion of births which took place in MSFT as a proxy for patient choice
4. Calculate the population of ethnic minority women of child-bearing age (15-44) in the affected LSOAs from step 1
5. Assume that they have the same GFR as the general population

6. Impacted population = (population of ethnic minority women of child-bearing age) x (general fertility rate) x (patient choice)

Disability

1. Identify LSOAs where Stafford Hospital is the nearest facility
2. Calculate the total number of births in the LSOAs and the number of these which took place in MSFT
3. Calculate the proportion of births which took place in MSFT as a proxy for patient choice
4. Calculate the population of women of women of child bearing age with disabilities using LTLI/DLA rates as a proxy in the affected LSOAs from step 1
5. Assume that the fertility rate of women with disabilities is half of the general population's
6. Impacted population = (pop of women of child bearing age with disabilities) x (general fertility rate x 50%) x (patient choice)

Isolation

1. Identify LSOAs where Stafford Hospital is the nearest facility
2. Identify LSOAs classified as rural
3. Calculate the total number of births in rural LSOAs and the number of these which took place in MSFT
4. Calculate the proportion of births which took place in MSFT as a proxy for patient choice
5. Calculate the population of women of child-bearing age (15-44) in the rural LSOAs and the general fertility rate
6. Impacted population = (pop of child bearing age in rural areas) x (general fertility rate) x (patient choice)

Socio-economic deprivation

1. Identify LSOAs where Stafford Hospital is the nearest facility
2. Identify LSOAs that are deprived i.e. national top quintile
3. Calculate the total number of births in deprived LSOAs and the number of these which took place in MSFT
4. Calculate the proportion of births which took place in MSFT as a proxy for patient choice
5. Calculate the population of women of child-bearing age (15-44) in the deprived LSOAs and the general fertility rate
6. Impacted population = (pop of child bearing age in deprived areas) x (general fertility rate) x (patient choice)

Emergency surgery

General population

1. Identify LSOAs where Stafford Hospital is the nearest facility
2. Calculate total population in those LSOAs
3. Calculate total number of Stafford A&E attendances in those LSOAs
4. Probability of requiring A&E = (total A&E attendances across all LSOAs) / (total population across all LSOAs)
5. Probability of an A&E patient requiring acute surgery = (total acute surgeries/number of A&E attendances)
6. Impacted population = (total population) x (probability of A&E) x (probability of an A&E patient requiring acute surgery)

Age i.e. Elderly

1. Identify LSOAs where Stafford Hospital is the nearest facility
2. Calculate total population of over 65sin those LSOAs
3. Calculate total number of A&E attendances by over 65s in those LSOAs
4. Probability of requiring A&E = (total A&E attendances by over 65s across all LSOAs) / (total population of over 65s across all LSOAs)
5. Probability of an A&E patient requiring acute surgery = (total acute surgeries/number of A&E attendances)
6. Impacted population = (total over 65 population) x (probability of A&E) x (probability of an A&E patient requiring acute surgery)

Race

1. Identify LSOAs where Stafford Hospital is the nearest facility
2. Calculate total BAME population in those LSOAs
3. Probability of requiring A&E = use that of the general population with uplift based on attendance ratios by race
4. Probability of an A&E patient requiring acute surgery = (total acute surgeries/number of A&E attendances)
5. Impacted population = (ethnic minority population) x (probability of A&E with uplift) x (probability of an A&E patient requiring acute surgery)

Disability

1. Identify LSOAs where Stafford Hospital is the nearest facility
2. Calculate total population with disability in those LSOAs using DLA as a proxy
3. Probability of requiring A&E = use that of the general population with a 50% uplift
4. Probability of an A&E patient requiring acute surgery = (total acute surgeries/number of A&E attendances)
5. Impacted population = (disabled population) x (probability of A&E with uplift) x (probability of an A&E patient requiring acute surgery)

Isolation

1. Identify rural LSOAs where Stafford Hospital is the nearest facility
2. Calculate total population in those LSOAs
3. Probability of requiring A&E = use that of the general population
4. Probability of an A&E patient requiring acute surgery = (total acute surgeries/number of A&E attendances)
5. Impacted population = (rural population) x (probability of A&E) x (probability of an A&E patient requiring acute surgery)

Non-elective paediatric inpatient admission

General population of children and young people (0-19)

1. Identify LSOAs where Stafford Hospital is the nearest facility
2. Calculate number of children aged 0 – 19 in those LSOAs
3. Calculate number of non-elective admissions in the LSOAs
4. Probability of a child requiring a non-elective admission = (total non-elective paediatric admissions across all LSOAs)/(total children across all LSOAs)
5. Some children can continue to be seen in Stafford as a PAU will be established there. So, PAU factor = proportion of all paediatric admissions in 12/13 which took place in a PAU which is ca. 60%
6. Impacted population = (total children) x (admission probability) x (PAU factor)

Age i.e. The very young aged 0-5

1. Identify LSOAs where Stafford Hospital is the nearest facility
2. Calculate number of children aged 0 – 5
3. Probability of a young child requiring a non-elective admission = use that of general population with uplift based on attendance ratios by age
4. Some children can continue to be seen in Stafford as a PAU will be established there. So, PAU factor proportion of all paediatrics admissions in 12/13 which took place in a PAU
5. Impacted population = (total young children) x (admission probability with uplift) x (PAU factor for young children)

Race

1. Identify LSOAs where Stafford Hospital is the nearest facility
2. Calculate number of children from ethnic minority backgrounds
3. Probability of an ethnic minority child requiring a non-elective admission = use that of general population with uplift based on attendance ratios by race
4. Some children can continue to be seen in Stafford as a PAU will be established there. So, PAU factor = proportion of all paediatrics admissions in 12/13 which took place in a PAU

5. Impacted population = (total ethnic minority children) x (admission probability with uplift) x (PAU factor)

Disability

1. Identify LSOAs where Stafford Hospital is the nearest facility
2. Calculate number of children with disabilities using carer benefits as a proxy
3. Probability of a child with disabilities requiring a non-elective admission = use that of general population with 50% uplift
4. Some children can continue to be seen in Stafford as a PAU will be established there. So, PAU factor = proportion of all paediatrics admissions in 12/13 which took place in a PAU
5. Impacted population = (total number of children with disabilities) x (admission probability with uplift) x (PAU factor)

Isolation

1. Identify rural LSOAs where Stafford Hospital is the nearest facility
2. Calculate total population of children in those LSOAs
3. Probability of a child in rural LSOAs requiring an non-elective admission = use that of general population
4. Impacted population = (rural children population) x ((admission probability)
5. Socio-economic deprivation:
6. Identify LSOAs where Stafford is the nearest hospital
7. Identify LSOAs that are deprived i.e. national top quintile
8. Calculate total population of children (0-19) in those LSOAs
9. Probability of a child in deprived LSOAs requiring an non-elective admission = use that of general population
10. Some children can continue to be seen in Stafford as a PAU will be established there. So, PAU factor = proportion of all paediatrics admissions in 12/13 which took place in a PAU
11. Impacted population = (children population in deprived LSOAs) x (admission probability) x (PAU factor)

Elective paediatric inpatient admission

General population of children and young people (0-19)

1. Identify LSOAs where Stafford Hospital is the nearest facility
2. Calculate number of children aged 0 – 5
3. Calculate number of elective admissions in the LSOAs and identify those who went to Stafford
4. Patient choice factor = use that of the general population
5. Probability of a young child requiring an elective admission = use that of general population with uplift based on attendance ratios by age

6. Impacted population =(total children aged 0-5) x (admission probability with uplift) x (choice factor)

Race

1. Identify LSOAs where Stafford Hospital is the nearest facility
2. Calculate number of ethnic minority children aged 0 – 19
3. Patient choice factor = use that of the general population
4. Probability of an ethnic minority child requiring an elective admission = use that of general population with uplift based on attendance ratios by race
5. Impacted population =(total ethnic minority children) x (admission probability with uplift) x (choice factor)

Disability

1. Identify LSOAs where Stafford Hospital is the nearest facility
2. Calculate number of disabled children aged 0 – 19
3. Patient choice factor = use that of the general population
4. Probability of a disabled child requiring an elective admission = use that of general population with 50% uplift
5. Impacted population =(total disabled children)x (admission probability with uplift) x (choice factor)

Isolation

1. Identify rural LSOAs where Stafford Hospital is the nearest facility
2. Calculate total population of children in those LSOAs
3. Patient choice factor = use that of the general population
4. Probability of a child in rural LSOAs requiring an elective admission = use that of general population
5. Impacted population = (rural children population) x (admission probability) x (choice factor)

Socio-economic deprivation

1. Identify LSOAs where Stafford Hospital is the nearest facility
2. Identify LSOAs that are deprived i.e. national top quintile
3. Calculate total population of children (0-19) in those LSOAs
4. Patient choice factor = use that of the general population
5. Probability of a child in deprived LSOAs requiring an elective admission = use that of general population
6. Impacted population = (children population in deprived LSOAs) x (admission probability) x (choice factor)

13.4. Data sources

The data used within the analysis falls into three main categories:

1) Travel times data
2) Hospital activity data
3) Protected characteristics and other demographic data

13.4.1. Travel times data sources

The travel time analysis is based on private car, public transport and ambulance (blue light) travel times during peak and off-peak periods.

Travel times data sources

Mode of transport	Periods considered	Data source
Private car	Peak (08:00 to 09:00 and 17:00 to 18:00) Off-peak (10:00 to 16:00)	Tom Tom data extracted over a four year period from 2008 to 2012
Ambulance	Peak (08:00 to 09:00 and 17:00 to 18:00) Off-peak (10:00 to 16:00)	Drive time analysis by Tom Tom assessed through West Midlands Ambulance Service core transport data (January 2013 to May 2013)
Public transport	Peak Wednesday (07:30 to 09:30) Off-peak Wednesday (10:00 to 12:00) Saturday and Sunday (14:00 to 16:00)	Staffordshire County Council analysis (performed in May 2013) using Accession, TravelLine and in-house bus route information for the period October 2011 to June 2013

13.4.2. Hospital activity data sources

Data type	Data source
Patient level data	2012/13 data supplied by MSFT
Stafford and Surrounds CCG and Cannock Chase CCG activity data	Public Health Staffordshire data extracts

13.4.3. In-scope characteristics and other data sources

Data type	Source
Age	Super output area estimates for mid-year, Office of National Statistics 2011
Disability Living Allowance (DLA)	Number of DLA claimants by LSOA, Department for Work and Pensions Information, Governance and Security Directorate
Ethnicity	2001 Census uplifted to 2011 using population projections, Office of National Statistics
Economic Deprivation Index	Department for Communities and Local Government: English Indices of Deprivation 2010
General fertility rate	Public Health Staffordshire
Long term limiting illness claimant rates	2011 Census, Office for National Statistics
Rurality	Office of National Statistics

13.4.4. Application of data

Impacted LSOA list from Drive Time Model

1. There are 712 LSOAs in the dataset with travel times to nine hospital sites – Stafford Hospital, Cannock Chase Hospital, UHNS, Wolverhampton, Walsall, Good Hope, Telford, Burton and Sandwell.
2. Based on peak private car travel times, the number of LSOAs with Stafford Hospital as the nearest hospital is 80 unique LSOAs.
3. Based on peak private car travel times, the number of LSOAs with Cannock Chase Hospital as the nearest and Stafford Hospital as the next nearest is 42 unique LSOAs.

A&E data

1. 2012/13 A&E patient level data for Stafford Hospital are used for the travel times analysis. There are 46,174 A&E attendance records but 1,754 of them have an associated postcode which did not match with the LSOAs in the travel times analysis. This can result from incorrect recording of postcodes, the patient having no fixed address at the time of admission or the patient's postcode being outside the 712 LSOAs within the model (and therefore out of the Staffordshire locality)
2. Since the patient level data did not contain information on the demographics of patients, it was overlaid with an alternative source of A&E attendance information provided by Public Health Staffordshire.

Non-elective inpatient data and admission codes

1. 2012/13 inpatient level data for Stafford Hospital are used for the travel times analysis. An inpatient admission is considered to be non-elective if the admission code was 21, 22, 23, 24, 28, 31, 32 or 81.
2. From this classification, there are 24,263 non-elective inpatients but 484 of these did not match with the LSOAs in the travel times dataset.
3. Since the patient level data did not contain information on the demographics of patients, it was overlaid with an alternative source of inpatient information provided by Public Health Staffordshire.

Emergency/non-elective surgical admission and specialty codes

1. 2012/13 inpatient level data for Stafford Hospital are used for the travel times analysis. A non-elective inpatient admission is considered to be to a surgical specialty if the admission code was 100, 101, 110, 120, 171, 180 (no non-elective surgical activity was recorded for 130, 140, 141, 142, 143, 145, 146, 147, 148, 149, 150, 160 and 170).
2. From this assessment, there are 4,481 non-elective inpatients but four of them did not match with the LSOAs within the travel times model.

MSOA-LSOA scaling for ethnicity and Long Term Limiting Illness (LTLI) claimants

1. Data for ethnicity (by age) and disability numbers for paediatrics (LTLI) are at the Middle Super Output Area (MSOA) level rather than at the Lower Super Output area (LSOA) level. Since drive times within the travel times model are provided are at the LSOA level, MSOA data were scaled down to the LSOA level.
2. The percentage population split is calculated across the LSOAs within each MSOA
3. It is assumed that the distribution of ethnic minorities and LTLI claimants is uniform within each MSOA

Age scaling for LTLI claimants

1. LTLI claimant data are available for the 0-16 population while the paediatrics analysis is based on the 0-19 population.
2. The LTLI data are therefore scaled up by dividing the MSOA level LTLI data by the 0-16 population in the relevant MSOAs. This factor is then multiplied by the 0-19 MSOA population.

Variations in demographic information

1. As mentioned, neither the A&E data nor the inpatient data classified patients by ethnicity. A separate dataset is therefore used to estimate the number of ethnic minority users.
2. To approximate the probability of an individual of ethnic minority background requiring A&E (or being NEL inpatient) the following calculation was carried out:
   - Probability =Number of ethnic minority residents within impacted LSOAs in relevant CCGs attending A&E (or admitted as NEL inpatient) / Number of ethnic minority residents within impacted in relevant CCGs
3. For consistency, as both the numerator and denominator need to be from the same dataset, data are scaled as necessary.

Scaling for A&E attendances where ethnicity is classified as unknown attendances

1. A large number of patients' ethnicity was classified as "not known".
2. The split of ethnicity for the group of patients where the ethnicity in unknown is assumed to be the same as the ethnicity split of patients where the ethnicity is known. For example, if X% of the population is of an ethnic minority background, it is assumed that X% population where the ethnicity is unknown is also of an ethnic minority background.

Ambulance - Red 1 Times

1. The Red 1 ambulance travel speed is based on Red 1 WMAS data for journeys from various postcodes to Stafford (40), Walsall Manor (7) and New Cross (9). A total of 56 Red 1 journeys were provided.
2. Red 1 travel is for the most critical journeys and represents the worst case scenario. They are therefore assumed to represent the fastest times possible.

3. In order to obtain the average speed of Red 1 travel compared to private car travel, off-peak private car travel times and Red 1 journeys were compared.
4. The Drive Time Model has off-peak private car travel times by LSOA. Postcodes from the WMAS dataset were matched to their respective LSOAs to calculate the travel time from a particular postcode to hospital sites.
5. Anomalies from the dataset where Red 1 journey times differed from the off-peak private car journey time by greater than 100% were removed (one datapoint was lost as the result).
6. The average Red 1 travel time was 15.4 minutes while the average off-peak travel time from the same set of postcodes was 16.6 minutes. Therefore Red 1 travel times were, on average, 93% the duration of off-peak private car journeys.

Public transport travel times

All public transport data were accompanied by a guide outlining the data collection process.

Peak

Modelled journeys can use any combination of bus and rail services and the results include walk, wait and in vehicle time. Calculations are made for an average Wednesday between 07:30 and 09:30. The software makes a calculation every 10 minutes from the start time and returns to best result. Journeys have an initial connection distance from the origin point to the public transport network of 350m as the crow flies, if a public transport stop cannot be reached within this distance (which is Staffordshire County Council's transport policy) then a result of 'no access' is returned. Journeys that cannot be completed within the two hour specified time period return a result of 'no access'. As the journeys are modelled for an average Wednesday public transport services that do not operate on a Wednesday are not included.

Off-peak

Modelled journeys can use any combination of bus and rail services and the results include walk, wait and in-vehicle time. Calculations are made for an average Wednesday between 10:00 and 12:00. The software makes a calculation every 10 minutes from the start time and returns to best result. Journeys have an initial connection distance from the origin point to the public transport network of 350m as the crow flies, if a public transport stop cannot be reached within this distance (which is Staffordshire County Council's policy) then a result of 'no access' is returned. Journeys that cannot be completed within the two hour specified time period return a result of 'no access'. As the journeys are modelled for an average Wednesday public transport services that do not operate on a Wednesday are not included.

Saturday

Modelled journeys can use any combination of bus and rail services and the results include walk, wait and in vehicle time. Calculations are made for an average Saturday between 14:00 and16:30. The software makes a calculation every 10 minutes from the start time and returns to best result. Journeys have an initial connection distance from the origin point to

the public transport network of 350m as the crow flies, if a public transport stop cannot be reached within this distance then a result of 'no access' is returned. Journeys that cannot be completed within the two hour specified time period return a result of 'no access'. As the journeys are modelled for an average Saturday public transport services that do not operate on a Saturday are not included.

Sunday

Modelled journeys can use any combination of bus and rail services and the results include walk, wait and in vehicle time. Calculations are made for an average Sunday between 14:00 and 16:30. The software makes a calculation every 10 minutes from the start time and returns to best result. Journeys have an initial connection distance from the origin point to the public transport network of 350m as the crow flies, if a public transport stop cannot be reached within this distance then a result of 'no access' is returned. Journeys that cannot be completed within the two and a half hour specified time period return a result of 'no access'. As the journeys are modelled for an average Sunday public transport services that do not operate on a Sunday are not included.

A number of anomalous results have been identified in the Sunday public transport dataset. These had been investigated thoroughly and were found to be related to the algorithms within the software. On Sundays, it is likely that under certain circumstances accessibility to hospitals is only achieved through 'stop hopping'. The parameters in the model allow up to 350m initial access to a public transport stop and from then on up to 500m to make an interchange. It appears that the software calculation progresses from the LSOA centroid to the public transport stop within 350m but as there is no service in certain areas on Sundays, it immediately interchanges to another public transport stop up to 500m away. If there is no service it interchanges again and eventually locates a main road or bigger settlement with a bus service and interchanges with that and makes the remainder of the journey in an acceptable way. This can only happen in certain areas as consecutive bus stops would need to be no more than 500m apart which is unusual in rural areas. Also the maximum total travel time of 2 hours will stop this in some cases. Detailed quality checks of the data have identified where this is happening within Staffordshire although it cannot guarantee to have identified all occurrences.

Public transport network information outside Staffordshire is not available to the same level of detail and therefore does not allow the identification of results that are incorrect outside of Staffordshire. All anomalous results have been reclassified to show ‘no access’.

13.5. Quality assurance of analysis

Each travel time data source was reviewed in order to improve the validity and confidence in the analysis.

Transport mode	Validity checking
Private car	Using a sample of > 500 records consistency with GoogleMaps drive times, and also with Travelmaster data[232]
Public transport	Comparison to the National Public Transport Data Repository (NPTDR) database (last updated in 2011)
Blue light	West Midlands Ambulance Service data was used within analysis

A number of relevant stakeholders were engaged to ensure that all pertinent issues are captured. These stakeholders include:

Stakeholder group engaged	Role in the validation of sources and the approach
Public Health Staffordshire	Verification that the approach used met their expectations and creation of population mapping used within this report
Staffordshire County Council	Verification that the approach used met their expectations on other transport planning issues, assistance with local travel information and improving the accuracy of drive time sources and outputs. Note that Staffordshire County Council suggested more modest estimates for the number of visitors using public transport usage information but the Steering Group used car ownership rates as a proxy which gives a larger, more conservative estimate.

13.6. WMAS hospital destinations

The A&E in Stafford Hospital has been operating at reduced hours of 08:00 to 22:00, 7 days a week since December 2011. WMAS already conveys patients to a range of sites other than Stafford when Stafford's A&E is closed. WMAS conveyance destinations are as shown below.

WMAS destinations

Ward	Current WMAS destination
Armitage with Handsacre	Burton
Barlaston and Oulton	UHNS
Baswich	UHNS
Brereton and Ravenhill	Burton
Cannock East	Walsall
Cannock North	Walsall
Chartley	UHNS
Church Eaton	Telford
Common	UHNS
Coton	Burton
Eccleshall	UHNS
Etching Hill and The Heath	Burton
Forebridge	UHNS
Gnosall and Woodseaves	UHNS

[232] This data includes average impact of roadwork in the County over the collection year period. Additional information about current pattern of road-works will be available as an appendix

Ward	Current WMAS destination
Hagley	Burton
Haywood and Hixon	UHNS
Hednesford Green Heath	Wolverhampton
Hednesford North	Wolverhampton
Highfields and Western Downs	UHNS
Holmcroft	UHNS
Huntington and Hatherton	UHNS
Littleworth	Wolverhampton
Manor	UHNS
Milford	UHNS
Milwich	UHNS
Penkridge North East and Acton Trussell	Wolverhampton
Penkridge South East	Wolverhampton
Penkridge West	Wolverhampton
Penkside	Wolverhampton
Rawnsley	Wolverhampton
Rowley	UHNS
Seighford	UHNS
St. Michael's	UHNS
Stonefield and Christchurch	UHNS
Swynnerton	UHNS
Tillington	UHNS
Walton	UHNS
Weeping Cross	UHNS
Western Springs	Burton

Source: West Midlands Ambulance Service

13.7. Visitor journey estimates

A total of ca. 7,000 patients annually who are currently treated in Stafford Hospital will be treated in a different hospital. Applying the current average length of stay (ALOS) in Stafford Hospital for the relevant specialties and assuming that patients are visited once a day by their family and friends, there would be ca. 24,000 visitor journeys impacted.

Estimated visitor journeys by service area

Ward	Maternity users impacted	Maternity visitors (1.12 ALOS)	Non-elective surgical admissions impacted	Non-elective sur visitors (5.57 ALOS)	Non-elective paediatric inpatients impacted	Non-elective paediatrics visitors (1.80 ALOS)	Elective paediatric inpatients impacted	Elective paediatrics visitors (2.1 ALOS)	Total impacted patients	Total impacted visitor journeys
Armitage with Handsacre	2	3	92	513	50	90	16	33	160	639
Barlaston and Oulton	3	4	22	125	12	22	4	8	42	159
Baswich	32	35	77	429	44	80	14	29	167	574
Brereton and Ravenhill	44	50	113	628	67	121	21	44	245	843
Cannock East	25	28	48	269	26	47	8	17	108	361
Cannock North	65	73	98	547	66	119	21	44	250	783
Chartley	8	9	32	179	14	25	4	9	59	223
Church Eaton	8	9	39	218	21	38	7	14	75	279
Common	60	67	76	426	36	65	11	24	183	581
Coton	76	86	82	457	53	96	17	35	228	673
Eccleshall	19	22	87	483	41	73	13	27	159	604
Etching Hill and The Heath	36	40	117	649	68	123	22	45	242	858
Forebridge	68	76	89	497	40	72	13	26	210	671
Gnosall and Woodseaves	38	42	110	612	57	102	18	37	222	794
Hagley	33	37	80	447	53	96	17	35	184	616
Haywood and Hixon	48	54	111	618	58	105	18	38	236	815
Hednesford Green Heath	28	32	86	478	48	86	15	32	177	627
Hednesford North	62	69	122	677	70	126	22	46	275	919
Highfields and Western Dow	95	107	114	633	72	130	23	48	304	918

Ward	Maternity users impacted	Maternity visitors (1.12 ALOS)	Non-elective surgical admissions impacted	Non-elective sur visitors (5.57 ALOS)	Non-elective paediatric inpatients impacted	Non-elective paediatrics visitors (1.80 ALOS)	Elective paediatric inpatients impacted	Elective paediatrics visitors (2.1 ALOS)	Total impacted patients	Total impacted visitor journeys
Holmcroft	66	73	117	650	67	121	21	45	271	889
Huntington and Hatherton	31	34	51	281	31	55	10	20	121	391
Littleworth	61	68	125	694	57	102	18	37	260	901
Manor	75	84	108	604	61	110	19	40	264	839
Milford	26	30	90	499	55	99	17	36	188	664
Milwich	6	6	34	187	17	30	5	11	61	234
Penkridge North East and Ac	22	24	65	365	30	54	9	20	127	463
Penkridge South East	25	28	78	433	48	86	15	32	166	579
Penkridge West	16	18	35	197	17	31	5	11	74	257
Penkside	74	83	79	439	55	99	17	36	225	657
Rawnsley	26	29	57	315	35	63	11	23	128	430
Rowley	41	45	78	433	42	76	13	28	174	582
Seighford	7	8	36	198	15	27	5	10	63	244
St. Michael's	33	36	86	479	56	101	18	37	192	654
Stonefield and Christchurch	32	36	96	535	52	94	16	35	197	700
Swynnerton	7	8	53	296	28	50	9	18	96	372
Tillington	59	66	76	422	48	86	15	31	197	605
Walton	30	34	100	558	50	90	16	33	196	714
Weeping Cross	38	43	110	615	61	110	19	40	229	808
Western Springs	33	37	113	632	61	110	19	40	226	818
Total	**1,457**	**1,632**	**3,181**	**17,718**	**1,782**	**3,208**	**560**	**1,177**	**6,981**	**23,736**

Source: Steering Group analysis, internal MSFT data

13.8. Public transport visitor journey estimates

Ward-level car ownership data have been used to estimate the number of visitor journeys by public transport.

Estimated number of visitor journeys by public transport

Ward	Alternative site(s)	Impacted patients	Impacted visitor journeys	Car ownership rate	Journeys by public transport
Armitage with Handsacre	Burton, Good Hope	160	639	87%	85
Barlaston and Oulton	UHNS	42	159	88%	19
Baswich	Walsall, UHNS	167	574	88%	71
Brereton and Ravenhill	Good Hope, Burton, Walsall	245	843	77%	194
Cannock East	Walsall, Wolverhampton	108	361	70%	108
Cannock North	Walsall, Wolverhampton	250	783	68%	248
Chartley	UHNS	59	223	94%	13
Church Eaton	Telford, Walsall	75	279	94%	16
Common	UHNS	183	581	70%	172
Coton	UHNS, Burton	228	673	69%	211
Eccleshall	UHNS, Telford	159	604	90%	59
Etching Hill and The Heath	Walsall, Good Hope, Burton	242	858	85%	132
Forebridge	UHNS, Walsall	210	671	67%	224
Gnosall and Woodseaves	Telford, UHNS	222	794	90%	76
Hagley	Walsall, Good Hope, Burton	184	616	78%	137
Haywood and Hixon	UHNS, Walsall, Burton	236	815	92%	69
Hednesford Green Heath	Walsall, Wolverhampton	177	627	88%	76
Hednesford North	Walsall, Wolverhampton	275	919	76%	223
Highfields and Western Downs	Walsall, UHNS	304	918	71%	267
Holmcroft	UHNS	271	889	80%	177
Huntington and Hatherton	Walsall, Wolverhampton	121	391	83%	65
Littleworth	UHNS, Walsall, Wolverhampton	260	901	75%	228
Manor	Walsall, Wolverhampton, UHNS	264	839	72%	238
Milford	Walsall, Wolverhampton, UHNS	188	664	93%	45
Milwich	UHNS	61	234	95%	12
Penkridge North East and Acton Trussell	Walsall, Wolverhampton	127	463	87%	59
Penkridge South East	Walsall, Wolverhampton	166	579	91%	53
Penkridge West	Walsall, Wolverhampton	74	257	87%	35
Penkside	Walsall, Wolverhampton	225	657	74%	174
Rawnsley	Walsall, Good Hope	128	430	88%	52
Rowley	Walsall, UHNS	174	582	86%	79
Seighford	UHNS, Telford	63	244	93%	18
St. Michael's	UHNS	192	654	87%	84
Stonefield and Christchurch	UHNS	197	700	78%	151
Swynnerton	UHNS	96	372	93%	28
Tillington	UHNS	197	605	79%	127
Walton	UHNS	196	714	84%	118
Weeping Cross	Walsall, UHNS, Wolverhampton	229	808	90%	78
Western Springs	Good Hope, Walsall, Burton	226	818	76%	195
	Total	**6,981**	**23,736**	**83%**	**4,415**

Source: Steering Group analysis, ONS 2011 census data

13.9. Travel times by ward to Stafford Hospital and alternative site(s)

13.9.1. Private car travel times

This section shows the private car travel times to Stafford Hospital and alternative hospital sites (including WMAS destinations when Stafford Hospital's A&E is closed). As the travel times analysis is carried out at the LSOA level and some wards may cover a large geographical area, there are journey time variations within wards (e.g. for a particular ward, journey times to Stafford Hospital will differ depending on the location within the ward). For the same reasons, the nearest alternative site may also differ within a ward. Note that not all wards have more than one plausible alternative site. This is when the second nearest alternative site is much further away than the nearest alternative site.

Peak private car travel times to Stafford Hospital

	Peak private car travel times to Stafford Hospital				
Ward	**0 to 5**	**5 to 10**	**10 to 15**	**15 to 20**	**20 to 25**
Armitage with Handsacre					Y
Barlaston and Oulton				Y	
Baswich		Y			
Brereton and Ravenhill				Y	Y
Cannock East				Y	
Cannock North				Y	
Chartley		Y			
Church Eaton			Y		
Common		Y			
Coton	Y	Y			
Eccleshall				Y	Y
Etching Hill and The Heath				Y	
Forebridge	Y	Y			
Gnosall and Woodseaves				Y	Y
Hagley				Y	Y
Haywood and Hixon			Y		
Hednesford Green Heath				Y	Y
Hednesford North				Y	
Highfields and Western Downs		Y	Y		
Holmcroft		Y			
Huntington and Hatherton				Y	
Littleworth	Y				
Manor		Y	Y		
Milford		Y	Y		
Milwich				Y	
Penkridge North East and Acton Trussell			Y	Y	
Penkridge South East				Y	
Penkridge West				Y	
Penkside		Y			
Rawnsley					Y
Rowley		Y			
Seighford			Y		
St. Michael's			Y		
Stonefield and Christchurch				Y	
Swynnerton				Y	
Tillington		Y			
Walton			Y		
Weeping Cross		Y			
Western Springs				Y	

Source: Steering Group analysis

Peak private car change in travel times to nearest alternative site

		Change in travel times to nearest alternative				
Ward	**Nearest alternative site**	**0-5**	**5-10**	**10-15**	**15-20**	**20-25**
Armitage with Handsacre	Good Hope Hospital	Y				
	Queen's Hospital Burton	Y				
Barlaston and Oulton	North Staffordshire City General	Y				
Baswich	Manor Hospital				Y	Y
Brereton and Ravenhill	Good Hope Hospital		Y			
Cannock East	Manor Hospital	Y				
Cannock North	Manor Hospital	Y				
Chartley	North Staffordshire City General				Y	
Church Eaton	Princess Royal Hospital			Y		
Common	North Staffordshire City General			Y	Y	
Coton	North Staffordshire City General				Y	
Eccleshall	North Staffordshire City General	Y				
Etching Hill and The Heath	Good Hope Hospital			Y		
	Manor Hospital			Y		
Forebridge	Manor Hospital				Y	
	North Staffordshire City General				Y	
Gnosall and Woodseaves	Princess Royal Hospital	Y	Y			
Hagley	Manor Hospital		Y			
Haywood and Hixon	North Staffordshire City General				Y	
Hednesford Green Heath	Manor Hospital	Y	Y			
Hednesford North	Manor Hospital	Y	Y			
Highfields and Western Downs	Manor Hospital				Y	
Holmcroft	North Staffordshire City General			Y		
Huntington and Hatherton	Manor Hospital	Y				
Littleworth	North Staffordshire City General				Y	Y
Manor	Manor Hospital			Y		
Milford	Manor Hospital			Y	Y	
	North Staffordshire City General					Y
Milwich	North Staffordshire City General		Y			
Penkridge North East and Acton Trussell	Manor Hospital	Y	Y			
Penkridge South East	Manor Hospital	Y				
Penkridge West	Manor Hospital	Y				
Penkside	Manor Hospital			Y	Y	
Rawnsley	Good Hope Hospital	Y				
	Manor Hospital	Y				
Rowley	Manor Hospital				Y	
	North Staffordshire City General				Y	
Seighford	North Staffordshire City General				Y	
St. Michael's	North Staffordshire City General	Y	Y			
Stonefield and Christchurch	North Staffordshire City General	Y				
Swynnerton	North Staffordshire City General	Y	Y			
Tillington	North Staffordshire City General		Y		Y	
Walton	North Staffordshire City General	Y	Y			
Weeping Cross	Manor Hospital				Y	
Western Springs	Good Hope Hospital			Y		

Source: Steering Group analysis

Peak private car travel times to nearest alternative site

		Travel times to nearest alternative			
Ward	**Nearest alternative site**	**15-20**	**20-25**	**25-30**	**30-35**
Armitage with Handsacre	Good Hope Hospital		Y		
	Queen's Hospital Burton		Y	Y	
Barlaston and Oulton	North Staffordshire City General	Y			
Baswich	Manor Hospital			Y	
Brereton and Ravenhill	Good Hope Hospital			Y	
Cannock East	Manor Hospital		Y		
Cannock North	Manor Hospital		Y		
Chartley	North Staffordshire City General		Y		
Church Eaton	Princess Royal Hospital			Y	
Common	North Staffordshire City General	Y	Y		
Coton	North Staffordshire City General		Y		
Eccleshall	North Staffordshire City General		Y	Y	
Etching Hill and The Heath	Good Hope Hospital				Y
	Manor Hospital			Y	Y
Forebridge	Manor Hospital		Y		
	North Staffordshire City General		Y		
Gnosall and Woodseaves	Princess Royal Hospital		Y		
Hagley	Manor Hospital			Y	
Haywood and Hixon	North Staffordshire City General			Y	Y
Hednesford Green Heath	Manor Hospital		Y		
Hednesford North	Manor Hospital		Y		
Highfields and Western Downs	Manor Hospital		Y	Y	
Holmcroft	North Staffordshire City General	Y			
Huntington and Hatherton	Manor Hospital		Y		
Littleworth	North Staffordshire City General		Y	Y	
Manor	Manor Hospital		Y		
Milford	Manor Hospital			Y	
	North Staffordshire City General			Y	
Milwich	North Staffordshire City General		Y		
Penkridge North East and Acton Trussell	Manor Hospital		Y		
Penkridge South East	Manor Hospital	Y	Y		
Penkridge West	Manor Hospital		Y		
Penkside	Manor Hospital		Y		
Rawnsley	Good Hope Hospital		Y		
	Manor Hospital		Y		
Rowley	Manor Hospital		Y		
	North Staffordshire City General		Y	Y	
Seighford	North Staffordshire City General			Y	
St. Michael's	North Staffordshire City General	Y			
Stonefield and Christchurch	North Staffordshire City General	Y			
Swynnerton	North Staffordshire City General	Y		Y	
Tillington	North Staffordshire City General	Y	Y		
Walton	North Staffordshire City General	Y			
Weeping Cross	Manor Hospital			Y	
Western Springs	Good Hope Hospital			Y	

Source: Steering Group analysis

Peak private car change in travel times to second nearest alternative site *(note that not all wards have a plausible second nearest alternative site)*

		Change in travel times to second nearest alternative					
Ward	**Second nearest alternative site**	**0-5**	**5-10**	**10-15**	**15-20**	**20-25**	**25-30**
Armitage with Handsacre	Good Hope Hospital	Y					
	Queen's Hospital Burton	Y					
Baswich	North Staffordshire City General					Y	
Brereton and Ravenhill	Manor Hospital		Y				
	Queen's Hospital Burton		Y				
Cannock East	New Cross Hospital	Y					
Cannock North	New Cross Hospital	Y					
Church Eaton	Manor Hospital				Y		
Eccleshall	Princess Royal Hospital	Y					
Etching Hill and The Heath	Good Hope Hospital			Y			
	Manor Hospital			Y			
Forebridge	Manor Hospital					Y	
	North Staffordshire City General				Y		
Gnosall and Woodseaves	North Staffordshire City General		Y	Y			
Hagley	Good Hope Hospital		Y				
Haywood and Hixon	Manor Hospital				Y	Y	
	Queen's Hospital Burton				Y	Y	
Hednesford Green Heath	New Cross Hospital	Y	Y				
Hednesford North	New Cross Hospital	Y	Y				
Highfields and Western Downs	North Staffordshire City General				Y		
Huntington and Hatherton	New Cross Hospital		Y				
Littleworth	Manor Hospital					Y	Y
Manor	New Cross Hospital			Y	Y		
Milford	Manor Hospital					Y	
	New Cross Hospital				Y		
Penkridge North East and Acton Trussell	New Cross Hospital	Y		Y			
Penkridge South East	New Cross Hospital	Y					
Penkridge West	New Cross Hospital	Y					
Penkside	New Cross Hospital				Y		
Rawnsley	Good Hope Hospital	Y					
	Manor Hospital	Y					
Rowley	Manor Hospital				Y		
	North Staffordshire City General				Y		
Seighford	Princess Royal Hospital				Y		
Weeping Cross	New Cross Hospital				Y		
	North Staffordshire City General				Y	Y	
Western Springs	Manor Hospital			Y			

Source: Steering Group analysis

Peak private car travel times to second nearest alternative site *(note that not all wards have a plausible second nearest alternative site)*

		Travel times to second nearest alternative			
Ward	**Next nearest name**	**15-20**	**20-25**	**25-30**	**30-35**
Armitage with Handsacre	Good Hope Hospital		Y	Y	
	Queen's Hospital Burton		Y		
Baswich	North Staffordshire City General			Y	
Brereton and Ravenhill	Manor Hospital			Y	
	Queen's Hospital Burton			Y	
Cannock East	New Cross Hospital		Y		
Cannock North	New Cross Hospital		Y		
Church Eaton	Manor Hospital				Y
Eccleshall	Princess Royal Hospital			Y	
Etching Hill and The Heath	Good Hope Hospital				Y
	Manor Hospital				Y
Forebridge	Manor Hospital			Y	
	North Staffordshire City General			Y	
Gnosall and Woodseaves	North Staffordshire City General			Y	
Hagley	Good Hope Hospital			Y	Y
Haywood and Hixon	Manor Hospital				Y
	Queen's Hospital Burton				Y
Hednesford Green Heath	New Cross Hospital		Y	Y	
Hednesford North	New Cross Hospital		Y	Y	
Highfields and Western Downs	North Staffordshire City General			Y	
Huntington and Hatherton	New Cross Hospital		Y		
Littleworth	Manor Hospital			Y	
Manor	New Cross Hospital		Y	Y	
Milford	Manor Hospital				Y
	New Cross Hospital			Y	
Penkridge North East and Acton Trussell	New Cross Hospital		Y		
Penkridge South East	New Cross Hospital	Y	Y		
Penkridge West	New Cross Hospital		Y		
Penkside	New Cross Hospital			Y	
Rawnsley	Good Hope Hospital		Y		
	Manor Hospital		Y		
Rowley	Manor Hospital			Y	
	North Staffordshire City General		Y		
Seighford	Princess Royal Hospital				Y
Weeping Cross	New Cross Hospital			Y	
	North Staffordshire City General			Y	
Western Springs	Manor Hospital			Y	

Peak private car change in travel times to WMAS destination site *(note that many WMAS destinations are the nearest or next nearest alternative sites and therefore have the same travel times shown in preceding sections)*

		Change in travel times to WMAS destination							
Ward	**WMAS destination**	**0-5**	**5-10**	**10-15**	**15-20**	**20-25**	**25-30**	**30-35**	**35-40**
Armitage with Handsacre	Queen's Hospital Burton	Y							
Barlaston and Oulton	North Staffordshire City General	Y							
Baswich	North Staffordshire City General					Y			
Brereton and Ravenhill	Queen's Hospital Burton		Y						
Cannock East	Manor Hospital	Y							
Cannock North	Manor Hospital	Y							
Chartley	North Staffordshire City General				Y				
Church Eaton	Princess Royal Hospital			Y					
Common	North Staffordshire City General			Y	Y				
Coton	Queen's Hospital Burton								Y
Eccleshall	North Staffordshire City General	Y							
Etching Hill and The Heath	Queen's Hospital Burton			Y	Y				
Forebridge	North Staffordshire City General				Y				
Gnosall and Woodseaves	North Staffordshire City General		Y	Y					
Hagley	Queen's Hospital Burton			Y					
Haywood and Hixon	North Staffordshire City General				Y				
Hednesford Green Heath	New Cross Hospital	Y	Y						
Hednesford North	New Cross Hospital	Y	Y						
Highfields and Western Downs	North Staffordshire City General				Y				
Holmcroft	North Staffordshire City General			Y					
Huntington and Hatherton	North Staffordshire City General				Y				
Littleworth	New Cross Hospital						Y		
Manor	North Staffordshire City General			Y	Y				
Milford	North Staffordshire City General				Y	Y			
Milwich	North Staffordshire City General		Y						
Penkridge North East and Acton Trussell	New Cross Hospital	Y		Y					
Penkridge South East	New Cross Hospital	Y							
Penkridge West	New Cross Hospital	Y							
Penkside	New Cross Hospital				Y				
Rawnsley	New Cross Hospital	Y							
Rowley	North Staffordshire City General				Y				
Seighford	North Staffordshire City General				Y				
St. Michael's	North Staffordshire City General	Y	Y						
Stonefield and Christchurch	North Staffordshire City General	Y							
Swynnerton	North Staffordshire City General	Y	Y						
Tillington	North Staffordshire City General		Y		Y				
Walton	North Staffordshire City General	Y	Y						
Weeping Cross	North Staffordshire City General				Y	Y			
Western Springs	Queen's Hospital Burton			Y					

Source: Steering Group analysis

Peak private car travel times to WMAS destination site *(note that many WMAS destinations are the nearest or next nearest alternative sites and therefore have the same travel times shown in preceding sections)*

Ward	WMAS destination	15-20	20-25	25-30	30-35	35-40	40- 45
Armitage with Handsacre	Queen's Hospital Burton		Y	Y			
Barlaston and Oulton	North Staffordshire City General	Y					
Baswich	North Staffordshire City General			Y			
Brereton and Ravenhill	Queen's Hospital Burton			Y			
Cannock East	Manor Hospital		Y				
Cannock North	Manor Hospital		Y				
Chartley	North Staffordshire City General		Y				
Church Eaton	Princess Royal Hospital			Y			
Common	North Staffordshire City General	Y	Y				
Coton	Queen's Hospital Burton					Y	Y
Eccleshall	North Staffordshire City General		Y	Y			
Etching Hill and The Heath	Queen's Hospital Burton				Y		
Forebridge	North Staffordshire City General		Y	Y			
Gnosall and Woodseaves	North Staffordshire City General			Y	Y		
Hagley	Queen's Hospital Burton				Y		
Haywood and Hixon	North Staffordshire City General			Y	Y		
Hednesford Green Heath	New Cross Hospital		Y	Y			
Hednesford North	New Cross Hospital		Y	Y			
Highfields and Western Downs	North Staffordshire City General			Y			
Holmcroft	North Staffordshire City General	Y					
Huntington and Hatherton	North Staffordshire City General				Y		
Littleworth	New Cross Hospital				Y		
Manor	North Staffordshire City General		Y	Y			
Milford	North Staffordshire City General			Y			
Milwich	North Staffordshire City General		Y				
Penkridge North East and Acton Trussell	New Cross Hospital		Y				
Penkridge South East	New Cross Hospital	Y	Y				
Penkridge West	New Cross Hospital		Y				
Penkside	New Cross Hospital			Y			
Rawnsley	New Cross Hospital		Y	Y			
Rowley	North Staffordshire City General		Y	Y			
Seighford	North Staffordshire City General			Y			
St. Michael's	North Staffordshire City General	Y					
Stonefield and Christchurch	North Staffordshire City General	Y					
Swynnerton	North Staffordshire City General	Y		Y			
Tillington	North Staffordshire City General	Y	Y				
Walton	North Staffordshire City General	Y					
Weeping Cross	North Staffordshire City General			Y			
Western Springs	Queen's Hospital Burton				Y		

Source: Steering Group analysis

13.9.2. Ambulance travel times

This section shows the ambulance travel times to Stafford Hospital and WMAS destinations when Stafford Hospital's A&E is closed. As the travel times analysis is carried out at the LSOA level and some wards may cover a large geographical area, there are journey time variations within wards (e.g. for a particular ward, journey times to Stafford Hospital will differ depending on the location within the ward).

Peak ambulance times to Stafford Hospital

	Travel times to Stafford Hospital				
Ward	**0-5**	**5-10**	**10-15**	**15-20**	**20-25**
Armitage with Handsacre					Y
Barlaston and Oulton				Y	
Baswich		Y			
Brereton and Ravenhill				Y	
Cannock East				Y	
Cannock North				Y	
Chartley		Y			
Church Eaton			Y		
Common	Y	Y			
Coton	Y	Y			
Eccleshall			Y	Y	Y
Etching Hill and The Heath			Y	Y	
Forebridge	Y	Y			
Gnosall and Woodseaves				Y	Y
Hagley				Y	
Haywood and Hixon			Y		
Hednesford Green Heath				Y	
Hednesford North				Y	
Highfields and Western Downs		Y			
Holmcroft		Y			
Huntington and Hatherton				Y	
Littleworth	Y				
Manor		Y			
Milford		Y	Y		
Milwich			Y		
Penkridge North East and Acton Trussell			Y	Y	
Penkridge South East				Y	
Penkridge West				Y	
Penkside		Y			
Rawnsley					Y
Rowley		Y			
Seighford			Y		
St. Michael's			Y		
Stonefield and Christchurch			Y	Y	
Swynnerton				Y	
Tillington		Y			
Walton			Y		
Weeping Cross		Y			
Western Springs				Y	

Source: Steering Group analysis

Peak ambulance change in travel times to WMAS destination

	Change in travel times to WMAS destination						
Ward	**0-5**	**5- 10**	**10- 15**	**15 -20**	**20- 25**	**25-30**	**30-35**
Armitage with Handsacre	Y						
Barlaston and Oulton	Y						
Baswich				Y			
Brereton and Ravenhill		Y					
Cannock East	Y						
Cannock North	Y						
Chartley			Y				
Church Eaton			Y				
Common			Y	Y			
Coton							Y
Eccleshall	Y						
Etching Hill and The Heath			Y				
Forebridge				Y			
Gnosall and Woodseaves		Y	Y				
Hagley			Y				
Haywood and Hixon				Y			
Hednesford Green Heath	Y	Y					
Hednesford North	Y	Y					
Highfields and Western Downs				Y			
Holmcroft		Y	Y				
Huntington and Hatherton				Y			
Littleworth						Y	
Manor			Y	Y			
Milford				Y			
Milwich		Y					
Penkridge North East and Acton Trussell	Y		Y				
Penkridge South East	Y						
Penkridge West	Y						
Penkside				Y			
Rawnsley	Y						
Rowley				Y			
Seighford			Y				
St. Michael's	Y	Y					
Stonefield and Christchurch	Y						
Swynnerton	Y	Y					
Tillington		Y	Y				
Walton	Y						
Weeping Cross				Y			
Western Springs			Y				

Source: Steering Group analysis

Peak ambulance travel times to WMAS destination

	Travel times to WMAS destination					
Ward	**10-15**	**15-20**	**20-25**	**25-30**	**30-35**	**35-40**
Armitage with Handsacre			Y			
Barlaston and Oulton		Y				
Baswich				Y		
Brereton and Ravenhill				Y		
Cannock East		Y				
Cannock North		Y				
Chartley			Y			
Church Eaton				Y		
Common		Y				
Coton						Y
Eccleshall		Y	Y	Y		
Etching Hill and The Heath				Y	Y	
Forebridge			Y			
Gnosall and Woodseaves			Y	Y	Y	
Hagley				Y	Y	
Haywood and Hixon				Y	Y	
Hednesford Green Heath			Y			
Hednesford North			Y			
Highfields and Western Downs			Y	Y		
Holmcroft		Y				
Huntington and Hatherton					Y	
Littleworth				Y		
Manor			Y			
Milford				Y		
Milwich			Y			
Penkridge North East and Acton Trussell		Y	Y			
Penkridge South East		Y				
Penkridge West		Y				
Penkside			Y			
Rawnsley			Y			
Rowley			Y			
Seighford				Y		
St. Michael's		Y				
Stonefield and Christchurch		Y				
Swynnerton		Y		Y		
Tillington		Y	Y			
Walton	Y	Y				
Weeping Cross				Y		
Western Springs				Y		

Source: Steering Group analysis

13.9.3. Public transport travel times to Stafford Hospital and relevant alternative hospital sites

Note that “n/a” indicates that the site is not a plausible alternative site for the particular ward as there are other sites that are located substantially nearer.

	Stafford weekday (peak)	Stafford weekday (off-peak)	Stafford Sat	Stafford Sunday
Armitage with Handsacre	Within 50 to 60 minutes in some areas	Over 60 minutes in all areas	Over 60 minutes in all areas	Over 60 minutes in all areas
Barlaston and Oulton	Within 40 to 50 minutes for all areas	Within 40 to 50 minutes for all areas	Within 50 to 60 minutes for all areas	No access
Baswich	Within 30 to 40 minutes for all areas	Within 30 to 40 minutes for all areas	Within 30 to 40 minutes for all areas	Within 50 minutes for all areas
Brereton and Ravenhill	Within 60 minutes for all areas	Within 60 minutes for some areas and	Within 50 to 60 minutes for some areas	Exceeds 60 minutes for all areas
Cannock East	Within 60 minutes for all areas	Within 60 minutes for all areas	Within 50 to 60 minutes for all areas	Exceeds 60 minutes for all areas
Cannock North	Within 60 minutes for all areas	Within 60 minutes for all areas	Within 60 minutes for all areas	Within 60 minutes for some areas and exceeds 60 minutes for others
Chartley	No access	No access	No access	No access
Church Eaton	No access	No access	No access	No access
Common	Within 25 minutes for all areas	Within 25 minutes for all areas	Within 25 minutes for all areas	Within 30 to 40 minutes for all areas
Coton	Within 20 minutes for all areas	Within 25 minutes for all areas	Within 25 minutes for all areas	No data
Eccleshall	No access	No access	No access	No access
Etching Hill and The Heath	Most areas have travel times of 50 to 60 minutes while some exceed 60	Most areas have travel times of 50 to 60 minutes while some exceed 60	Most areas have travel times of 50 to 60 minutes while some exceed 60	Most areas have travel times of 50 to 60 minutes while some exceed 60
Forebridge	Within 25 minutes for all areas	Within 25 minutes for all areas	Within 25 minutes for all areas	Within 30 minutes for all areas
Gnosall and Woodseaves	Some areas have access within 30 to 40 minutes while others have no access	Some areas have access within 50 minutes while others have no access	Some areas have access within 50 minutes while others have no access	Some areas have access within 50 minutes while others have no access
Hagley	Within 60 minutes for all areas	Within 60 minutes for some areas and exceeds 60 minutes for others	Within 60 minutes for some areas and exceeds 60 minutes for others	Exceeds 60 minutes for all areas
Haywood and Hixon	Some areas have access within 40 minutes while others have no access	Some areas have access within 50 minutes while others have no access	Some areas have access within 50 minutes while others have no access	No access
Hednesford Green Heath	Within 60 minutes for all areas	Within 60 minutes for some areas and	Within 50 to 60 minutes for some areas	Exceeds 60 minutes for all areas
Hednesford North	Within 40 to 50 minutes for all areas	Over 60 minutes in all areas	Over 60 minutes in all areas	Exceeds 60 minutes for all areas
Highfields and Western Downs	Within 30 minutes for all areas	Within 30 minutes for all areas	Within 30 minutes for all areas	Within 40 minutes for all areas
Holmcroft	Within 40 minutes for all areas	Within 40 minutes for all areas	Within 40 minutes for all areas	Within 50 minutes for all areas
Huntington and Hatherton	Within 50 minutes for all areas	Within 40 minutes for all areas	Within 40 minutes for all areas	Within 50 minutes for all areas
Littleworth	Within 15 minutes for all areas	Within 15 minutes for all areas	Within 15 minutes for all areas	Within 15 minutes for all areas
Manor	Within 30 minutes for all areas	Within 25 minutes for all areas	Within 25 minutes for all areas	Within 50 minutes for all areas
Milford	Some areas have access within 30 to 40 minutes while others have no access	Some areas have access within 30 to 40 minutes while others have no access	Some areas have access within 30 to 40 minutes while others have no access	No access
Milwich	No access	No access	No access	No access
Penkridge North East and Acton Trussell	Within 40 to 50 minutes for all areas	Within 40 to 50 minutes for all areas	Within 40 to 50 minutes for all areas	Some areas have access within 50 to 60 minutes while others have no access
Penkridge South East	Within 50 minutes for all areas	Within 50 minutes for all areas	Within 50 minutes for all areas	Within 60 minutes for all areas
Penkridge West	Within 30 minutes for all areas	Within 30 minutes for all areas	Within 30 minutes for all areas	Within 40 to 50 minutes for all areas
Penkside	Within 30 to 40 minutes for all areas	Within 30 minutes for all areas	Within 30 minutes for all areas	Within 30 to 40 minutes for all areas
Rawnsley	Over 60 minutes for all areas	Over 60 minutes for all areas	Over 60 minutes for all areas	Over 60 minutes for all areas
Rowley	Within 30 minutes for all areas	Within 30 minutes for all areas	Within 30 minutes for all areas	Within 30 to 40 minutes for all areas
Seighford	No access	No access	No access	No access
St. Michael's	Within 30 to 40 minutes for all areas	Within 30 minutes for all areas	Within 30 to 40 minutes for all areas	No access
Stonefield and Christchurch	Within 50 minutes for all areas	Within 40 minutes for all areas	Within 50 minutes for all areas	Within 60 minutes for all areas
Swynnerton	Some areas have access within 50 to 60 minutes while others have no access	Some areas have access but travel times exceeds 60 minutes while others	Some areas have access but travel times exceeds 60 minutes while others	No access
Tillington	Within 40 minutes for all areas	Within 40 minutes for all areas	Within 40 minutes for all areas	Within 50 minutes for all areas
Walton	Some areas have access within 60 minutes while others have no access	All areas have access within 60 minutes	Some areas have access within 50 minutes while others have travel times	Some areas have access within 50 minutes while others have travel times
Weeping Cross	Within 30 to 40 minutes for all areas	Within 40 minutes for all areas	Within 40 minutes for all areas	Within 60 minutes for all areas
Western Springs	Some areas have access within 50 to 60 minutes while others exceed 60 minutes	Some areas have access within 50 to 60 minutes while others exceed 60 minutes	Some areas have access within 50 to 60 minutes while others exceed 60 minutes	Some areas have access within 50 to 60 minutes while others exceed 60 minutes

	UHNS weekday peak	UHNS weekday off-peak	UHNS Saturday	UHNS Sunday
Armitage with Handsacre	N/A	N/A	N/A	N/A
Barlaston and Oulton	Within 50 to 60 minutes for all areas	Within 50 to 60 minutes for all areas	Within 50 to 60 minutes for all areas	No access
Baswich	Over 60 minutes in all areas	Over 60 minutes in all areas	Over 60 minutes in all areas	Over 60 minutes in all areas
Brereton and Ravenhill	N/A	N/A	N/A	N/A
Cannock East	N/A	N/A	N/A	N/A
Cannock North	N/A	N/A	N/A	N/A
Chartley	No access	No access	No access	No access
Church Eaton	N/A	N/A	N/A	N/A
Common	Most areas have travel times of 50 to 60 minutes while some exceed 60	Most areas have travel times of 50 to 60 minutes while some exceed 60	Most areas have travel times of 50 to 60 minutes while some exceed 60	Exceeds 60 minutes in all areas
Coton	Exceeds 60 minutes in all areas	Exceeds 60 minutes in all areas	Exceeds 60 minutes in all areas	No data
Eccleshall	No access	No access	No access	No access
Etching Hill and The Heath	N/A	N/A	N/A	N/A
Forebridge	Within 50 to 60 minutes in some areas	Within 50 to 60 minutes in some areas	Within 50 to 60 minutes in some areas	Exceeds 60 minutes in all areas
Gnosall and Woodseaves	Some areas have access but exceeds 60 minutes while others have no access	Some areas have access but exceeds 60 minutes while others have no access	Some areas have access but exceeds 60 minutes while others have no access	Some areas have access but exceeds 60 minutes while others have no access
Hagley	N/A	N/A	N/A	N/A
Haywood and Hixon	Some areas have access but exceeds 60 minutes while others have no access	Some areas have access but exceeds 60 minutes while others have no access	Some areas have access but exceeds 60 minutes while others have no access	No access
Hednesford Green Heath	N/A	N/A	N/A	N/A
Hednesford North	N/A	N/A	N/A	N/A
Highfields and Western Downs	Within 50 to 60 minutes in some areas	Within 50 to 60 minutes in some areas	Within 50 to 60 minutes in some areas	Exceeds 60 minutes in all areas
Holmcroft	Within 50 to 60 minutes for all areas	Within 50 to 60 minutes for all areas	Exceeds 60 minutes for all areas	Within 50 to 60 minutes for all areas
Huntington and Hatherton	N/A	N/A	N/A	N/A
Littleworth	Most areas have travel times of 50 to 60 minutes while some exceed 60	Most areas have travel times of 50 to 60 minutes while some exceed 60	Most areas have travel times of 50 to 60 minutes while some exceed 60	Exceeds 60 minutes in all areas
Manor	Most areas have travel times of 50 to 60 minutes while some exceed 60	Exceeds 60 minutes in all areas	Exceeds 60 minutes in all areas	Exceeds 60 minutes in all areas
Milford	Some areas have access but exceeds 60 minutes while others have no access	Some areas have access but exceeds 60 minutes while others have no access	Some areas have access but exceeds 60 minutes while others have no access	No access
Milwich	No access	No access	No access	No access
Penkridge North East and Acton Trussell	N/A	N/A	N/A	N/A
Penkridge South East	N/A	N/A	N/A	N/A
Penkridge West	N/A	N/A	N/A	N/A
Penkside	N/A	N/A	N/A	N/A
Rawnsley	N/A	N/A	N/A	N/A
Rowley	Within 50 to 60 minutes in some areas	Exceeds 60 minutes for all areas	Exceeds 60 minutes for all areas	Exceeds 60 minutes for all areas
Seighford	No access	No access	No access	No access
St. Michael's	Within 50 minutes for all areas	Within 50 minutes for all areas	Within 50 to 60 minutes for all areas	No access
Stonefield and Christchurch	Within 50 minutes for all areas	Within 50 minutes for all areas	Within 50 minutes for all areas	Within 40 to 50 minutes for all areas
Swynnerton	Within 40 to 50 minutes in some areas and exceeds 60 minutes in others	Within 40 to 50 minutes in some areas and exceeds 60 minutes in others	Exceeds 60 minutes for some areas with other areas having no access	No access
Tillington	Exceeds 60 minutes in all areas	Exceeds 60 minutes in all areas	Exceeds 60 minutes in all areas	Exceeds 60 minutes in all areas
Walton	Some areas have access within 50 minutes while others no access	Within 60 minutes for all areas	Within 60 minutes for some areas while others exceed 60 minutes	Within 50 to 60 minutes for some areas while others exceed 60 minutes
Weeping Cross	Travel times exceeds 60 minutes	Travel times exceeds 60 minutes	Travel times exceeds 60 minutes	Travel times exceeds 60 minutes
Western Springs	N/A	N/A	N/A	N/A

	Wolverhampton weekday peak	Wolverhampton weekday off-peak	Wolverhampton Saturday	Wolverhampton Sunday
Armitage with Handsacre	N/A	N/A	N/A	N/A
Barlaston and Oulton	N/A	N/A	N/A	N/A
Baswich	N/A	N/A	N/A	N/A
Brereton and Ravenhill	N/A	N/A	N/A	N/A
Cannock East	Within 50 to 60 minutes for some areas	Within 50 to 60 minutes for all areas	Within 50 to 60 minutes for all areas	Exceeds 60 minutes in all areas
Cannock North	Within 50 to 60 minutes for all areas	Within 60 minutes for all areas	Within 60 minutes for most areas and other areas have access but with travel	Exceeds 60 minutes in all areas
Chartley	N/A	N/A	N/A	N/A
Church Eaton	N/A	N/A	N/A	N/A
Common	N/A	N/A	N/A	N/A
Coton	N/A	N/A	N/A	N/A
Eccleshall	N/A	N/A	N/A	N/A
Etching Hill and The Heath	N/A	N/A	N/A	N/A
Forebridge	N/A	N/A	N/A	N/A
Gnosall and Woodseaves	N/A	N/A	N/A	N/A
Hagley	N/A	N/A	N/A	N/A
Haywood and Hixon	N/A	N/A	N/A	N/A
Hednesford Green Heath	Within 50 to 60 minutes for some areas	Within 50 to 60 minutes for some areas	Within 50 to 60 minutes for some areas	Exceeds 60 minutes in all areas
Hednesford North	Within 50 to 60 minutes for some areas	Within 50 to 60 minutes for some areas	Exceeds 60 minutes in all areas	Exceeds 60 minutes in all areas
Highfields and Western Downs	N/A	N/A	N/A	N/A
Holmcroft	N/A	N/A	N/A	N/A
Huntington and Hatherton	Within 50 to 60 minutes for all areas	Within 50 to 60 minutes for all areas	Within 50 to 60 minutes for all areas	Exceeds 60 minutes in all areas
Littleworth	Within 60 minutes for all areas	Within 60 minutes for all areas	Within 60 minutes for all areas	Within 50 to 60 minutes for some areas while others exceed 60 minutes
Manor	Within 40 to 50 minutes for all areas	Within 50 minutes for all areas	Within 60 minutes for all areas	Within 60 minutes for all areas
Milford	Within 50 to 60 minutes for some areas while others exceed 60 minutes	Exceeds 60 minutes in some areas with others having no access	Exceeds 60 minutes in some areas with others having no access	No access
Milwich	N/A	N/A	N/A	N/A
Penkridge North East and Acton Trussell	Within 40 to 50 minutes for some areas while others exceed 60 minutes	Within 50 to 60 minutes for all areas	Within 50 to 60 minutes for some areas while others exceed 60 minutes	Within 40 to 50 minutes for some areas while others exceed 60 minutes
Penkridge South East	Within 40 to 50 minutes for all areas	Within 60 minutes for all areas	Within 60 minutes for all areas	Within 60 minutes for all areas
Penkridge West	Within 30 to 40 minutes for all areas	Within 30 to 40 minutes for all areas	Within 30 to 40 minutes for all areas	Within 30 to 40 minutes for all areas
Penkside	Within 50 to 60 minutes for all areas	Within 40 to 50 minutes for all areas	Within 50 to 60 minutes for all areas	Within 50 to 60 minutes for all areas
Rawnsley	N/A	N/A	N/A	N/A
Rowley	N/A	N/A	N/A	N/A
Seighford	N/A	N/A	N/A	N/A
St. Michael's	N/A	N/A	N/A	N/A
Stonefield and Christchurch	N/A	N/A	N/A	N/A
Swynnerton	N/A	N/A	N/A	N/A
Tillington	N/A	N/A	N/A	N/A
Walton	N/A	N/A	N/A	N/A
Weeping Cross	Within 50 to 60 minutes for some areas	Within 40 to 50 minutes for some areas	Within 50 to 60 minutes for some areas	Exceeds 60 minutes in all areas
Western Springs	N/A	N/A	N/A	N/A

	Walsall weekday peak	Walsall weekday off-peak	Walsall Sat	Walsall Sunday
Armitage with Handsacre	N/A	N/A	N/A	N/A
Barlaston and Oulton	N/A	N/A	N/A	N/A
Baswich	Exceeds 60 minutes in all areas	Exceeds 60 minutes in all areas	Exceeds 60 minutes in all areas	Exceeds 60 minutes in all areas
Brereton and Ravenhill	Within 50 to 60 minutes for some areas	Within 50 to 60 minutes for some areas	Within 50 to 60 minutes for some areas	Within 50 to 60 minutes for some areas
Cannock East	Within 60 minutes for all areas	Within 60 minutes for all areas	Within 60 minutes for all areas	Within 50 to 60 minutes for all areas
Cannock North	Within 60 minutes for all areas	Within 60 minutes for all areas	Within 60 minutes for most areas while others exceed 60 minutes	Within 50 to 60 minutes for all areas
Chartley	N/A	N/A	N/A	N/A
Church Eaton	No access	No access	No access	No access
Common	N/A	N/A	N/A	N/A
Coton	N/A	N/A	N/A	N/A
Eccleshall	N/A	N/A	N/A	N/A
Etching Hill and The Heath	Some areas have access but exceeds 60 minutes while others have no access	Some areas have access but exceeds 60 minutes while others have no access	Some areas have access but exceeds 60 minutes while others have no access	Some areas have access but exceeds 60 minutes while others have no access
Forebridge	Exceeds 60 minutes in all areas	Exceeds 60 minutes in all areas	Within 50 to 60 minutes for some areas	Exceeds 60 minutes in all areas
Gnosall and Woodseaves	N/A	N/A	N/A	N/A
Hagley	Within 50 to 60 minutes for all areas	Within 50 to 60 minutes for all areas	Within 60 minutes for all areas	Within 60 minutes for all areas
Haywood and Hixon	Some areas have access but exceeds 60 minutes while others have no access	Some areas have access but exceeds 60 minutes while others have no access	Some areas have access but exceeds 60 minutes while others have no access	Some areas have access but exceeds 60 minutes while others have no access
Hednesford Green Heath	Within 50 to 60 minutes for all areas	Within 50 to 60 minutes for all areas	Within 50 to 60 minutes for some areas	Within 50 to 60 minutes for some areas
Hednesford North	Within 60 minutes for all areas	Within 60 minutes for all areas	Within 60 minutes for all areas	Within 60 minutes for all areas
Highfields and Western Downs	Exceeds 60 minutes in all areas	Exceeds 60 minutes in all areas	Exceeds 60 minutes in all areas	Exceeds 60 minutes in all areas
Holmcroft	N/A	N/A	N/A	N/A
Huntington and Hatherton	Within 50 to 60 minutes for all areas	Within 50 to 60 minutes for all areas	Within 50 to 60 minutes for all areas	Within 50 to 60 minutes for some areas
Littleworth	Exceeds 60 minutes in all areas	Exceeds 60 minutes in all areas	Exceeds 60 minutes in all areas	Exceeds 60 minutes in all areas
Manor	Exceeds 60 minutes in all areas	Exceeds 60 minutes in all areas	Exceeds 60 minutes in all areas	Exceeds 60 minutes in all areas
Milford	Some areas have access but exceeds 60 minutes while others have no access	Some areas have access but exceeds 60 minutes while others have no access	Some areas have access but exceeds 60 minutes while others have no access	No access
Milwich	N/A	N/A	N/A	N/A
Penkridge North East and Acton Trussell	Exceeds 60 minutes in all areas	Exceeds 60 minutes in all areas	Exceeds 60 minutes in all areas	Some areas have access but exceeds 60 minutes while others have no access
Penkridge South East	Within 50 to 60 minutes for some areas	Within 50 to 60 minutes for some areas	Within 50 to 60 minutes for some areas	Exceeds 60 minutes in all areas
Penkridge West	Exceeds 60 minutes in all areas	Exceeds 60 minutes in all areas	Exceeds 60 minutes in all areas	Within 50 to 60 minutes for all areas
Penkside	Exceeds 60 minutes in all areas	Exceeds 60 minutes in all areas	Exceeds 60 minutes in all areas	Exceeds 60 minutes in all areas
Rawnsley	Exceeds 60 minutes in all areas	Exceeds 60 minutes in all areas	Within 50 to 60 minutes for all areas	Exceeds 60 minutes in all areas
Rowley	Exceeds 60 minutes in all areas	Exceeds 60 minutes in all areas	Exceeds 60 minutes in all areas	Exceeds 60 minutes in all areas
Seighford	N/A	N/A	N/A	N/A
St. Michael's	N/A	N/A	N/A	N/A
Stonefield and Christchurch	N/A	N/A	N/A	N/A
Swynnerton	N/A	N/A	N/A	N/A
Tillington	N/A	N/A	N/A	N/A
Walton	N/A	N/A	N/A	N/A
Weeping Cross	Exceeds 60 minutes in all areas	Exceeds 60 minutes in all areas	Exceeds 60 minutes in all areas	Exceeds 60 minutes in all areas
Western Springs	Exceeds 60 minutes in all areas	Exceeds 60 minutes in all areas	Within 50 to 60 minutes for some areas while others exceed 60 minutes	Within 50 to 60 minutes for some areas while others exceed 60 minutes

	Burton weekday peak	Burton weekday off-peak	Burton Saturday	Burton Sunday
Armitage with Handsacre	Exceeds 60 minutes in all areas	Exceeds 60 minutes in all areas	Exceeds 60 minutes in all areas	No access
Barlaston and Oulton	N/A	N/A	N/A	N/A
Baswich	N/A	N/A	N/A	N/A
Brereton and Ravenhill	Exceeds 60 minutes in all areas	Exceeds 60 minutes in all areas	Exceeds 60 minutes in all areas	No access
Cannock East	N/A	N/A	N/A	N/A
Cannock North	N/A	N/A	N/A	N/A
Chartley	N/A	N/A	N/A	N/A
Church Eaton	N/A	N/A	N/A	N/A
Common	N/A	N/A	N/A	N/A
Coton	Exceeds 60 minutes in all areas	No access	Exceeds 60 minutes in all areas	No access
Eccleshall	N/A	N/A	N/A	N/A
Etching Hill and The Heath	Some areas have access but exceeds 60 minutes while others have no access	No access	Some areas have access but exceeds 60 minutes while others have no access	No access
Forebridge	N/A	N/A	N/A	N/A
Gnosall and Woodseaves	N/A	N/A	N/A	N/A
Hagley	Exceeds 60 minutes in all areas	Some areas have access but exceeds 60 minutes while others have no access	Some areas have access but exceeds 60 minutes while others have no access	No access
Haywood and Hixon	No access	No access	No access	No access
Hednesford Green Heath	N/A	N/A	N/A	N/A
Hednesford North	N/A	N/A	N/A	N/A
Highfields and Western Downs	N/A	N/A	N/A	N/A
Holmcroft	N/A	N/A	N/A	N/A
Huntington and Hatherton	N/A	N/A	N/A	N/A
Littleworth	N/A	N/A	N/A	N/A
Manor	N/A	N/A	N/A	N/A
Milford	N/A	N/A	N/A	N/A
Milwich	N/A	N/A	N/A	N/A
Penkridge North East and Acton Trussell	N/A	N/A	N/A	N/A
Penkridge South East	N/A	N/A	N/A	N/A
Penkridge West	N/A	N/A	N/A	N/A
Penkside	N/A	N/A	N/A	N/A
Rawnsley	N/A	N/A	N/A	N/A
Rowley	N/A	N/A	N/A	N/A
Seighford	N/A	N/A	N/A	N/A
St. Michael's	N/A	N/A	N/A	N/A
Stonefield and Christchurch	N/A	N/A	N/A	N/A
Swynnerton	N/A	N/A	N/A	N/A
Tillington	N/A	N/A	N/A	N/A
Walton	N/A	N/A	N/A	N/A
Weeping Cross	N/A	N/A	N/A	N/A
Western Springs	Exceeds 60 minutes in all areas	Some areas have access but exceeds 60 minutes while others have no access	Exceeds 60 minutes in all areas	No access

	Good Hope weekday peak	Good Hope weekday off-peak	Good Hope Saturday	Good Hope Sun	Telford (all)
Armitage with Handsacre	Within 40 to 50 minutes in all areas	Within 50 to 60 minutes in all areas	Within 50 to 60 minutes in all areas	Within 50 to 60 minutes in all areas	N/A
Barlaston and Oulton	N/A	N/A	N/A	N/A	N/A
Baswich	N/A	N/A	N/A	N/A	N/A
Brereton and Ravenhill	Within 50 to 60 minutes for some areas	Exceeds 60 minutes in all areas	Exceeds 60 minutes in all areas	Exceeds 60 minutes in all areas	N/A
Cannock East	N/A	N/A	N/A	N/A	N/A
Cannock North	N/A	N/A	N/A	N/A	N/A
Chartley	N/A	N/A	N/A	N/A	N/A
Church Eaton	N/A	N/A	N/A	N/A	No access
Common	N/A	N/A	N/A	N/A	N/A
Coton	N/A	N/A	N/A	N/A	N/A
Eccleshall	N/A	N/A	N/A	N/A	No access
Etching Hill and The Heath	Some areas have access but exceeds 60 minutes while others have no access	Some areas have access but exceeds 60 minutes while others have no access	Some areas have access but exceeds 60 minutes while others have no access	Some areas have access but exceeds 60 minutes while others have no access	N/A
Forebridge	N/A	N/A	N/A	N/A	N/A
Gnosall and Woodseaves	N/A	N/A	N/A	N/A	Some areas have access but exceeds 60 minutes while others have no access
Hagley	Exceeds 60 minutes in all areas	Exceeds 60 minutes in all areas	Exceeds 60 minutes in all areas	Exceeds 60 minutes in all areas	N/A
Haywood and Hixon	N/A	N/A	N/A	N/A	N/A
Hednesford Green Heath	N/A	N/A	N/A	N/A	N/A
Hednesford North	N/A	N/A	N/A	N/A	N/A
Highfields and Western Downs	N/A	N/A	N/A	N/A	N/A
Holmcroft	N/A	N/A	N/A	N/A	N/A
Huntington and Hatherton	N/A	N/A	N/A	N/A	N/A
Littleworth	N/A	N/A	N/A	N/A	N/A
Manor	N/A	N/A	N/A	N/A	N/A
Milford	N/A	N/A	N/A	N/A	N/A
Milwich	N/A	N/A	N/A	N/A	N/A
Penkridge North East and Acton Trussell	N/A	N/A	N/A	N/A	N/A
Penkridge South East	N/A	N/A	N/A	N/A	N/A
Penkridge West	N/A	N/A	N/A	N/A	N/A
Penkside	N/A	N/A	N/A	N/A	N/A
Rawnsley	Exceeds 60 minutes in all areas	Exceeds 60 minutes in all areas	Exceeds 60 minutes in all areas	Exceeds 60 minutes in all areas	N/A
Rowley	N/A	N/A	N/A	N/A	N/A
Seighford	N/A	N/A	N/A	N/A	No access
St. Michael's	N/A	N/A	N/A	N/A	N/A
Stonefield and Christchurch	N/A	N/A	N/A	N/A	N/A
Swynnerton	N/A	N/A	N/A	N/A	N/A
Tillington	N/A	N/A	N/A	N/A	N/A
Walton	N/A	N/A	N/A	N/A	N/A
Weeping Cross	N/A	N/A	N/A	N/A	N/A
Western Springs	Exceeds 60 minutes in all areas	Exceeds 60 minutes in all areas	Exceeds 60 minutes in all areas	Exceeds 60 minutes in all areas	N/A

1.1. Cost of travel analysis

The cost of travel is estimated using the methodology described in Section 10.10. All calculations are based on a randomly selected postcode within each ward. Note that "n/a" indicates that data are not available.

Cost of private car travel

Ward	Stafford operating cost (£)	Stafford time cost (£)	Total Stafford cost (£)	Alternative site 1	Alt 1 operating cost	Alt 1 time cost (£)	Alt 1 total cost (£)	Alternative site 2	Alt 2 operating cost (£)	Alt 2 time cost (£)	Alt 2 total cost (£)	Alternative site 3	Alt 3 operating cost (£)	Alt 3 time cost (£)	Alt 3 total cost (£)	Impact £ (Alt 3 - Stafford)	Average operating cost to alt site	Average time cost to alt site	Average total cost to alt site
Armitage with	2.78	4.33	7.10	Burton	3.33	4.60	7.93	Good Hope	3.09	4.48	7.57						3.21	4.54	7.75
Barlaston and	1.89	3.70	5.59	UHNS	1.75	3.77	5.52										1.75	3.77	5.52
Baswich	0.56	1.52	2.07	Manor	3.99	5.19	9.18										3.99	5.19	9.18
Brereton and	2.18	3.83	6.01	Good Hope	3.48	5.00	8.48	Burton	4.28	5.51	9.79	Manor	N/A	N/A			3.88	5.26	9.13
Cannock East	1.95	3.76	5.71	Manor	2.26	3.89	6.15	Wolverhampt	N/A	N/A							2.26	3.89	6.15
Cannock Nort	1.95	3.64	5.59	Manor	2.24	3.92	6.16	Wolverhampt	N/A	N/A							2.24	3.92	6.16
Chartley	1.81	1.58	3.39	UHNS	4.01	4.62	8.63										4.01	4.62	8.63
Church Eaton	1.15	2.66	3.82	Princess Roya	3.68	5.39	9.07	Manor	N/A	N/A							3.68	5.39	9.07
Common	0.35	1.15	1.50	UHNS	3.17	3.96	7.13										3.17	3.96	7.13
Coton	0.35	0.99	1.34	UHNS	3.42	4.29	7.71	Burton	5.72	7.83	13.55						4.57	6.06	10.63
Eccleshall	1.95	3.76	5.72	UHNS	2.45	4.40	6.85	Princess Roya	N/A	N/A							2.45	4.40	6.85
Etching Hill a	1.98	3.33	5.31	Manor	3.52	5.68	9.20	Good Hope	3.79	5.80	9.59	Burton	4.09	6.23	10.32	5.02	3.80	5.90	9.70
Forebridge	0.19	1.06	1.24	UHNS	3.46	4.47	7.93	Manor	3.79	4.55	8.34						3.62	4.51	8.13
Gnosall and W	2.24	3.59	5.84	Princess Roya	2.65	4.44	7.09	UHNS	5.02	5.76	10.78						3.84	5.10	8.94
Hagley	2.20	3.74	5.94	Manor	3.25	5.23	8.48	Good Hope	N/A	N/A		Burton	3.89	6.00	9.89	3.95	3.57	5.62	9.18
Haywood and	1.34	2.42	3.76	UHNS	4.03	5.86	9.89	Manor	N/A	N/A		Burton	N/A	N/A			4.03	5.86	9.89
Hednesford G	1.71	3.51	5.21	Manor	2.55	4.29	6.84	Wolverhampt	2.24	4.72	6.96						2.40	4.51	6.90
Hednesford N	1.73	3.53	5.26	Manor	2.59	4.29	6.88	Wolverhampt	2.28	4.72	7.00						2.44	4.51	6.94
Highfields and	0.66	1.76	2.42	UHNS	3.70	5.04	8.74	Manor	3.68	4.77	8.45						3.69	4.91	8.60
Holmcroft	0.74	1.42	2.16	UHNS	3.07	3.65	6.72										3.07	3.65	6.72

Cost of private car travel (continued)

Ward	Stafford operating cost (£)	Stafford time cost (£)	Total Stafford cost (£)	Alternative site 1	Alt 1 operating cost	Alt 1 time cost (£)	Alt 1 total cost (£)	Alternative site 2	Alt 2 operating cost (£)	Alt 2 time cost (£)	Alt 2 total cost (£)	Alternative site 3	Alt 3 operating cost (£)	Alt 3 time cost (£)	Alt 3 total cost (£)	Impact £ (Alt 3 - Stafford)	Average operating cost to alt site	Average time cost to alt site	Average total cost to alt site
Huntington an	1.65	3.28	4.93	Manor	2.41	3.98	6.39	Wolverhampt	N/A	N/A							2.41	3.98	6.39
Littleworth	0.06	0.57	0.64	UHNS	3.42	4.55	7.97	Manor	N/A	N/A		Wolverhampt	3.52	5.89	9.41	8.77	3.47	5.22	8.69
Manor	0.60	1.65	2.24	UHNS	4.14	4.91	9.05	Manor	3.27	4.19	7.46	Wolverhampt	N/A	N/A			3.70	4.55	8.25
Milford	0.99	1.88	2.86	UHNS	4.69	5.55	10.24	Manor	3.81	4.88	8.69	Wolverhampt	N/A	N/A			4.25	5.22	9.46
Milwich	1.65	2.99	4.63	UHNS	2.47	4.55	7.02										2.47	4.55	7.02
Penkridge Nor	1.50	2.79	4.29	Manor	2.80	3.96	6.76	Wolverhampt	2.47	4.30	6.77						2.63	4.13	6.76
Penkridge Sou	1.60	3.37	4.97	Manor	2.67	3.69	6.36	Wolverhampt	2.35	3.79	6.14						2.51	3.74	6.25
Penkridge We	1.30	3.09	4.38	Manor	2.94	3.84	6.78	Wolverhampt	2.47	3.94	6.41						2.71	3.89	6.60
Penkside	0.41	1.58	1.99	Manor	3.54	4.41	7.95	Wolverhampt	2.59	4.98	7.57						3.07	4.70	7.76
Rawnsley	2.06	4.17	6.23	Manor	2.63	4.24	6.87	Good Hope	3.68	4.41	8.09						3.16	4.33	7.48
Rowley	0.45	1.39	1.85	UHNS	3.52	4.70	8.22	Manor	3.89	4.42	8.31						3.70	4.56	8.26
Seighford	1.81	2.31	4.12	UHNS	3.81	5.30	9.11	Princess Roya	N/A	N/A							3.81	5.30	9.11
St. Michael's	1.79	2.69	4.48	UHNS	2.04	3.58	5.62										2.04	3.58	5.62
Stonefield and	1.85	2.99	4.84	UHNS	1.71	3.28	4.99										1.71	3.28	4.99
Swynnerton	2.30	3.30	5.61	UHNS	2.10	4.20	6.30										2.10	4.20	6.30
Tillington	0.47	1.52	2.00	UHNS	3.42	4.17	7.59										3.42	4.17	7.59
Walton	1.79	2.59	4.38	UHNS	1.79	3.14	4.93										1.79	3.14	4.93
Weeping Cros	0.60	1.56	2.15	Manor	3.52	4.88	8.40	UHNS	4.53	5.39	9.92	Wolverhampt	N/A	N/A			4.02	5.14	9.16
Western Sprin	1.93	3.29	5.22	Good Hope	3.66	5.49	9.15	Manor	N/A	N/A		Burton	3.85	5.85	9.70	4.48	3.75	5.67	9.42

Source: Staffordshire County Council analysis

Cost of public transport travel

Ward	Stafford fare cost (£)	Stafford time cost (£)	Total Stafford cost (£)	Alternative site 1	Alt 1 fare Cost	Alt 1 time cost (£)	Alt 1 total cost (£)	Alternative site 2	Alt 2 fare Cost (£)	Alt 2 time cost (£)	Alt 2 total cost (£)	Alternative site 3	Alt 3 fare cost (£)	Alt 3 time cost (£)	Alt 3 total cost (£)	Average fare cost to alt site	Average time cost to alt site	Average total cost to alt site
Armitage with	6.00	16.82	22.82	Burton	10.40	20.21	30.61	Good Hope	6.00	11.20	17.20					8.20	15.71	23.91
Barlaston and	11.30	10.19	21.49	UHNS	7.90	13.51	21.41									7.90	13.51	21.41
Baswich	4.20	6.88	11.08	Manor	9.40	20.56	29.96									9.40	20.56	29.96
Brereton and I	6.00	17.57	23.57	Good Hope	6.00	13.67	19.67	Burton	10.40	22.68	33.08	Manor	N/A	15.37		8.20	18.18	26.38
Cannock East	6.00	11.49	17.49	Manor	9.40	13.05	22.45	Wolverhampt	N/A	11.86						9.40	13.05	22.45
Cannock Nortl	6.00	9.91	15.91	Manor	9.40	11.15	20.55	Wolverhampt	N/A	10.63						9.40	11.15	20.55
Chartley	6.00			UHNS	9.40	N/A										9.40	N/A	N/A
Church Eaton	6.00			Princess Roya	6.00	N/A		Manor	N/A	N/A						6.00	N/A	N/A
Common	4.20	5.77	9.97	UHNS	5.00	14.68	19.68									5.00	14.68	19.68
Coton	4.20	3.43	7.63	UHNS	9.20	14.51	23.71	Burton	10.40	N/A						9.20	14.51	23.71
Eccleshall	6.00			UHNS	10.20	N/A		Princess Roya	N/A	N/A						10.20	N/A	N/A
Etching Hill ar	6.00	12.59	18.59	Manor	9.40	16.41	25.81	Good Hope	6.00	15.99	21.99	Burton	10.40	N/A		7.70	16.20	23.90
Forebridge	3.40	4.06	7.46	UHNS	5.00	12.83	17.83	Manor	9.40	13.33	22.73					7.20	13.08	20.28
Gnosall and V	6.00	9.02	15.02	Princess Roya	6.00	18.47	24.47	UHNS	10.20	20.12	30.32					8.10	19.30	27.40
Hagley	6.00	17.05	23.05	Manor	9.40	14.04	23.44	Good Hope	N/A	14.45		Burton	10.40	23.19	33.59	9.90	18.62	28.52
Haywood and	6.00	7.66	13.66	UHNS	11.00	19.94	30.94	Manor	N/A	20.92		Burton	N/A	N/A		11.00	19.94	30.94
Hednesford G	6.00	12.23	18.23	Manor	9.40	13.67	23.07	Wolverhampt	6.00	11.76	17.76					7.70	12.72	20.42
Hednesford N	6.00	13.57	19.57	Manor	9.40	13.28	22.68	Wolverhampt	6.00	12.46	18.46					7.70	12.87	20.57
Highfields and	4.20	6.07	10.27	UHNS	9.20	13.84	23.04	Manor	9.40	14.58	23.98					9.30	14.21	23.51
Holmcroft	4.20	6.39	10.59	UHNS	5.00	12.03	17.03									5.00	12.03	17.03

Cost of public transport travel (continued)

Ward	Stafford fare cost (£)	Stafford time cost (£)	Total Stafford cost (£)	Alternative site 1	Alt 1 fare Cost	Alt 1 time cost (£)	Alt 1 total cost (£)	Alternative site 2	Alt 2 fare Cost (£)	Alt 2 time cost (£)	Alt 2 total cost (£)	Alternative site 3	Alt 3 fare cost (£)	Alt 3 time cost (£)	Alt 3 total cost (£)	Average fare cost to alt site	Average time cost to alt site	Average total cost to alt site
Huntington ar	6.00	7.81	13.81	Manor	9.40	11.36	20.76	Wolverhampt	N/A	10.85						9.40	11.36	20.76
Littleworth	2.40	2.02	4.42	UHNS	8.40	13.51	21.91	Manor	N/A	14.58		Wolverhampt	6.00	12.59	18.59	7.20	13.05	20.25
Manor	4.20	5.00	9.20	UHNS	9.20	14.12	23.32	Manor	9.40	13.92	23.32	Wolverhampt	N/A	7.90		9.30	14.02	23.32
Milford	4.20	7.64	11.84	UHNS	9.20	15.32	24.52	Manor	9.40	21.41	30.81	Wolverhampt	N/A	14.51		9.30	18.37	27.67
Milwich	8.40			UHNS	5.00	N/A										5.00	N/A	N/A
Penkridge Nor	6.00	10.56	16.56	Manor	9.40	16.27	25.67	Wolverhampt	6.00	13.33	19.33					7.70	14.80	22.50
Penkridge Sou	6.00	9.56	15.56	Manor	9.40	12.25	21.65	Wolverhampt	6.00	11.70	17.70					7.70	11.97	19.67
Penkridge We	6.00	6.69	12.69	Manor	9.40	13.59	22.99	Wolverhampt	6.00	10.26	16.26					7.70	11.93	19.63
Penkside	4.20	6.06	10.26	Manor	9.40	15.36	24.76	Wolverhampt	6.00	9.33	15.33					7.70	12.35	20.05
Rawnsley	6.00	16.00	22.00	Manor	9.40	25.40	34.80	Good Hope	6.00	15.78	21.78					7.70	20.59	28.29
Rowley	4.20	5.36	9.56	UHNS	8.40	13.63	22.03	Manor	9.40	14.44	23.84					8.90	14.03	22.93
Seighford	6.00			UHNS	9.20	N/A		Princess Roya	N/A	N/A						9.20	N/A	N/A
St. Michael's	11.00	5.20	16.20	UHNS	7.60	12.32	19.92									7.60	12.32	19.92
Stonefield and	8.40	6.01	14.41	UHNS	5.00	8.81	13.81									5.00	8.81	13.81
Swynnerton	8.10	21.83	29.93	UHNS	8.10	10.98	19.08									8.10	10.98	19.08
Tillington	4.20	7.56	11.76	UHNS	8.40	15.29	23.69									8.40	15.29	23.69
Walton	8.40	10.25	18.65	UHNS	5.00	10.81	15.81									5.00	10.81	15.81
Weeping Cros	4.20	6.14	10.34	Manor	9.40	16.53	25.93	UHNS	9.20	16.35	25.55	Wolverhampt	N/A	11.32		9.30	16.44	25.74
Western Sprin	6.00	13.98	19.98	Good Hope	6.00	15.42	21.42	Manor	N/A	15.98		Burton	10.40	23.23	33.63	8.20	19.32	27.52

Source: Staffordshire County Council analysis

13.10. Comparison against the travel times survey by the office of the Member of Parliament for Stafford

Noting all the caveats set out in Section 10.9, the following table shows the differences *(note that average times are based on travel from postcodes in the MP's office's dataset)* between the information collated by the MP's office and that used by the Steering Group.

Comparison of travel times – Office of the Member of Parliament for Stafford survey and Steering Group analysis

	Stafford	Walsall	Wolverhampton	UHNS	Telford	Burton
MP's office	15	60	58	54	65	65
HEIA SG	10	26	30	26	22	38
Difference	5	34	28	28	43	27
	53%	127%	95%	109%	190%	70%

Source: Steering Group analysis, Office of the Member of Parliament for Stafford

Travel times in the MP's office dataset are consistently higher than those calculated by through the Steering Group's analysis. This indicates that the collection of data by the MP's constituents may include drop-off and pick-up time rather than just point to point travel times. Journey times to hospitals other than Stafford are on average 118% higher than that recorded in the Steering Group's dataset. However, the difference for journeys to Stafford is only 53%.

14. Appendix C: Qualitative evidence summary

This appendix presents the qualitative evidence collected by the Steering Group and is made up of: (a) the report prepared by VAST summarising the qualitative evidence gathered from focus group and one-on-one interviews; and (b) a summary of the meetings and focus groups held with local subject matter experts.

14.1. The VAST Report

HEALTH AND EQUALITY IMPACT ASSESSMENT FOCUS GROUPS

Report for the Health and Equality Impact Assessment Steering Group on the Findings of the Focus Groups and Patient interviews as part of the Health and Equalities Impact Assessment of the Trust Special Administrators (TSAs) Draft Recommendations for Mid Staffordshire NHS Foundation Trust

Report Prepared by: VAST Services (1920) Ltd, in partnership with Engaging Communities Staffordshire
Date: September 2013

Contents

Introduction

The purpose of this report is to provide an overview of the findings of the focus groups and one-to-one patient experience interviews conducted as part of the Health and Equality Impact Assessment. This report provides an early indication of the positive and negative impacts identified through the focus groups with proposals to mitigate against those negative impacts and enhance the positive aspects.

In total nine focus groups took place as tabled below. The focus groups were extensively marketed with advertisements in the Express and Star, covering the Stafford and Cannock areas.500 flyers with details of each group were distributed at two public meetings. Posters and flyers were circulated to GP surgeries, and specialist partners were engaged to recruit patients from specific communities. Despite this recruitment to the focus groups was problematic and numbers taking part were lower than expected. One-to-one patient interviews were conducted with patients where interest was shown but insufficient numbers were available to run a full focus group.

For each focus group a presentation and a set of questions was provided by the Health and Equalities Impact Assessment Steering Group. The details of what took place are tabled below.

Focus Group	Location and Timing	Number of Attendees
People living in Rural locations	Friday 13 September, 11:30-1:30 – Community Council of Staffordshire, Stafford	11
Carers	Tuesday 17 September, 10:00-12:00pm, Age UK, Penkridge	Interview conducted with 1 attendee
Frail Elderly	Tuesday 17 September, 1:00-3:00pm, Age UK, Penkridge	Cancelled – poor recruitment
Individuals/Families on low incomes	Wednesday 18 September, 11:00-1:00, VAST, Stafford 1-2-1Interviews with residents of Highfields Estate	Interview conducted with 1 attendee 9 interviews
Disabilities	Wednesday 18 September, 2:00-4:00pm, Staffordshire Place 1, Stafford	7
Paediatrics	Thursday 19 September, 10:00-12:00pm, Chadsmoor Family Centre, Cannock	5
Maternity	Thursday 19 September, 1:00-3:00pm, Stafford Children's Centre, Stafford Interview with staff and users Lichfield Midwife led Maternity Unit 14th October, 2013	interview conducted with 1 attendee 2 staff 4 users
Race	Thursday 19 September, 6:00-8:00pm	6
Mid Staffs Foundation Trust Employees	Friday 20 September, 11:00-1:00pm, Post Graduate Medical Centre, Stafford	12

In addition to the focus groups tabled above, five one-to-one patient interviews were under taken. The patients interviewed represented 2 carers, 1 lady planning her first pregnancy, 1 family on a low income and 1 community representative.

Further meetings/ research took place with people from low incomes and with the Midwife led Unit at Lichfield. These are incorporated into the following findings.

People Living in Rural Communities

A focus group of 11 people was delivered in partnership with the Community Council for Staffordshire, a specialist organisation actively engaged in protecting and improving the quality of life for all those living or working in rural communities.

The standard presentation and questions, prepared by representatives of the Health and Equality Impact Assessment Steering Group, were used to open and facilitate the group discussion. These are enclosed as Appendix 1.

There was a mix of experience of amongst the participants. Overall the group mainly accessed diagnostic and outpatient services for long-term conditions. In addition to their own experiences, two members of the group represented voluntary patient transport schemes and regular visitors to Stafford and Cannock hospitals.

The findings of the focus group are below:

Transport – access to services

The Group agreed that it is more difficult to access hospital-based healthcare services if you live in a rural area, particularly for those in rural communities who do not have access to a car. Availability of public transport is inconsistent across rural communities, and the frequency and running times of local bus services are often incompatible with hospital appointment and visiting times.

There is a reliance on voluntary patient transport schemes to enable residents to access the local hospital. Providing reliable and accessible transport for local people to get to the hospital is one aspect of the service provided. These services are already in high demand; a voluntary car scheme in Penkridge was closed for short periods of time due to the effects of demand on its drivers.

One participant was a frequent user of cardiology care, and experienced difficulties in accessing hospital-based services due to a lack of accessible and timely public transport. The nearest bus stop is a two mile walk away and the service runs every hour ending at 5pm. It is often difficult to synchronise the availability of public transport with hospital appointment or visiting times.

Stafford was the hospital used most, with the group having experience of Cannock, Walsall, the University Hospital of North Staffordshire (UHNS), New Cross Hospital in Wolverhampton and the Queen Elizabeth Hospital in Birmingham.

Overall satisfaction of the current services was high, with the issue of parking being the only negative factor. There was a concern that in extending services out of Cannock, the problems experienced with parking would be made worse.

The availability of car parking was identified as being a weakness across all hospital sites, including Stafford and Cannock. Parking facilities and the cost of parking at UHNS was identified as being of concern, with availability and location of disabled parking spaces also highlighted as a significant issue.

Voluntary transport schemes are often used by elderly residents, who cannot access public transport, even when it is available, due to mobility or health issues. One group member referred to

an elderly gentleman who had a scheduled operation at 7am at UHNS and was quoted £50 for a taxi. Fortunately he was able to use the more cost effective voluntary transport scheme.

The voluntary transport schemes are concerned their services will be directly affected by the TSAs draft recommendations to transfer services to specialist hospitals further afield. Increased journey times will lead to a reduction in capacity to support people with fewer journeys throughout the day. This will lead to a less effective service which will particularly affect those who often have no alternative than to rely on their services.

Inaccessible public transport for people living in rural communities is a major cause for concern. Difficulties are experienced in accessing public transport; there is a lack of consistency across rural communities in terms of both availability and length of service of some routes. The additional complexity of travelling out of the borough renders access to hospitals such as UHNS or New Cross by public transport very difficult ,or for some impossible.

Transport - Cost

The cost of transport to hospital is a cause for concern. People living in rural communities are at a disadvantage as they often do not have the option of public transport, leaving only expensive private hire firms, putting rural communities at an even greater financial disadvantage than those living in urban areas who may have access to public transport.

Transport - Discharge

Transport relating to hospital discharge is also a cause for concern. Discharge during unsociable hours and at expensive times of the year increases the financial impact on rural communities. There is a fear that the cost of taxis from either UHNS or New Cross will impact on the ability for discharged patients to get home safely.

Private Transport

It was felt that the ability of family and friends to provide transport would also be impacted by the transfer of services to other hospitals, due to a reluctance to drive longer distances, or an inability to commit to a longer journey time whilst managing their own work and home life commitments.

There was a fear that the draft recommendations to transfer services to other hospitals would mean more missed appointments, as patients in rural communities struggle to make expensive and complex journeys.

The group identified a reluctance of some residents to drive to the major hospitals, due to their distance and location. Driving long distances, particularly on major highways, like dual carriageways and the motorway is outside the comfort zone for many drivers, in particular the elderly who primarily use their cars to get around the local area.

There were also concerns regarding the additional distance to travel for maternity services and in-patient paediatrics and the impact this would have on the ability of families to visit.

Transport - Patient Safety

Patient safety was a fundamental concern for the group with regard to the proposed transfer of critical care, in-patient paediatrics and out of hours accident and emergency. The group felt that journey time to UHNS or New Cross compromised patient safety and put lives at risk. There was recognition that this disproportionately impacted rural communities where longer waiting times for emergency services is commonplace, due to difficulties in locating rural homes. One participant gave the example of a villager who recently went into anaphylactic shock and a resident had to go out into the village to direct the attending ambulance to the address.

The group emphasised the importance of being able to access hospital based services quickly for certain patient groups; women in labour, seriously ill children and the frail elderly. They felt any additional travel time could impact on their safety and their wellbeing.

'What I have got an issue with is the safety of what they are proposing and as far as I'm concerned it is not providing sufficient safety for people in rural communities who need to access those services'.

Transport - Conclusion

For residents of rural communities access to affordable transport is the primary concern both for patients and visitors. A lack of suitable public transport, the cost of private hire and the complexity of the journey all impact on the ability of patients to keep appointments and for friends and family to visit. In-patients are likely to have a reduced number of visitors, risking increased isolation and having a negative impact on recovery.

Co-ordination between services

One participant feared that transferring to another hospital would lead to a duplication of assessments, which would further extend time from initial assessment to treatment. This could disproportionately impact on people living in rural communities who may have already have to wait longer to access services due to the location of their homes.

The group had worries about the capacity of other hospitals and the ambulance service to meet the additional demand with their already stretched resources. Patient safety during transfer was also a cause for concern. Additional responsibility moving ill people longer distance and the risks this poses.

Community services are inconsistent across rural communities; some villages have access to pharmacy delivery services, while others don't. There is reliance in rural communities on voluntary services, both for access to services and for meeting social care needs. Informal networks exist in rural communities which will be compromised by moving healthcare services further afield.

The group had concerns that the TSAs Draft Recommendations had not taken full consideration of the forecast increase in population for Stafford. An increased military presence and an additional 10,000 new homes will increase demand for hospital services, which the group felt cannot be met by the proposed re-configuration.

Proposals for mitigating actions

From the impacts identified the group were asked to put forward their ideas for mitigating actions for negative impacts and other actions to enhance positive impacts. The following ideas were proposed:

- There is no mitigation for increased journey times; however, resources need to be identified to ensure safe patient transfer between hospitals.
- Meet and greet schemes could be implemented at the larger hospitals to support patients to navigate large and unfamiliar hospital sites
- Sustainable and affordable patient transport for rural communities
- Recognition of Voluntary Car Schemes, this could include; providing schemes with up to date information regarding site or building changes, assigning reserved parking or drop off spaces and a waiver of parking fees for voluntary car schemes.
- Investment in Voluntary Car Schemes to enable them to cater for families with babies and children
- Free and regular shuttle bus between Stafford hospital and UHNS for visitors and patients to coincide with visiting times
- Improved signage at larger hospitals
- Reimbursement or a contribution towards the travel costs for people facing costs of transport to access services.
- Communication could be improved in advance, advising patients of the car parking arrangements, including how far you may have to walk and how much you will be expected to pay to park
- Provision of overnight services for families of children in hospital to enable parents to visit

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Paediatrics

The focus group of 5 participants was delivered at the West Chadsmoor Family Centre, which provides a range of activities for children and their families.

The standard presentation and set of questions, prepared by representatives of the Health and Equality Impact Assessment Steering Group, were used to open and facilitate the group discussion as at Appendix 1.

The focus group was made up of mothers and grandmothers, and one mother who is pregnant with a second child. The group have experience of Stafford and Cannock hospitals and one mother of a child with asthma has used the Paediatric Assessment Unit where they previously have been given 'open access'.

Another member of the group has a child who is in the process of being assessed for ADHD; she is concerned about the impact of the draft recommendations on services they may need to access in the future.

The group had experience of both Stafford and Cannock hospitals. One mother had been referred to the hospital in Lichfield, and due to difficulty in getting there had cancelled the appointment. Cannock Hospital was the most popular hospital accessed by the participants of the focus group.

The findings of the focus group are:

Travel

For those families who do not have access to a car, transport is the major issue that affects access to health services. There is a reliance on family and friends to supporting families to access services. Public transport is utilised where it is suitable. The cost of travelling to hospital can also be an issue for families on low incomes.

Accessing services can be problematic for families with multiple children, with some wards having restrictions on the number of siblings able to visit.

There would be a financial impact on families with children who are admitted to hospital with the higher costs of travelling and longer distance to travel. The additional time and cost associated with the longer journey impact on families and could prevent siblings and wider family members from being able to visit a poorly child.

The group agreed that visiting your child in a hospital outside your local area would pose challenges for most families, and would impact most on families on low incomes, challenged by the high costs of transport, and those with multiple children, who need to balance care for children at home with visiting a child in hospital.

The cost of travel and the additional time taken to travel to hospital are the major factors that impact on families with children. The cost of travel, for some families on low incomes, will restrict the number of times they are able to visit their child. The time taken to travel and the complexity of the journey if travelling y public transport are factors which are likely to impact most on siblings and other family members. Wider family members and friends are unlikely to be able to visit regularly, if

at all. Where journey times are significantly longer and complex families may have no choice but to take siblings out of school in order to be able to get to the hospital.

Capacity of other services

The group had generic concerns about the capacity of other hospitals and the ambulance service to meet the additional demand placed on them by the draft recommendations. Patient safety during transfer was a cause for concern as was the distance women would be expected to travel in labour.

The group were concerned about the impact of the closure of paediatric inpatient services on the level of expertise to be retained at the hospital, and the ability for children to be treated effectively if they require hospital admission from accident and emergency. Concerns were raised regarding the logistics of transferring children to other hospitals and how, for example a single parent with another child would be able to accompany their sick child in an ambulance.

There was overall agreement that joined up services currently work well, particularly between GP's and the assessment unit. There were concerns at how this would continue under the TSAs recommendations and how it would be possible for local GPs to integrate with services at the larger hospitals.

There were concerns over parents being given greater responsibility for poorly children when set against a backdrop of reduced out of hours services. Parents felt that having their child at home would be putting them at risk due to the additional time it would take to get the child hospital if needed.

Family Impact

The group felt that closing paediatric in-patient services in favour of services further afield would have a disproportionate impact on families of a child requiring a prolonged stay in hospital. Families would suffer a financial impact from additional costs of travel and potentially the cost of additional childcare for siblings. Siblings may also be impacted if families have to take them out of school in order manage visiting times. There will also be an emotional impact on children in hospital if parents cannot afford the cost of the time to visit every day.

Patient Safety

One mother who previously had 'open access' to the paediatric assessment unit at Stafford for her child with asthma had grave concerns about the distance she would need to travel to access services for her child under the TSAs Draft Recommendations. There were also concerns about the impact of the closure of the in-patient unit would have on the expertise of the staff retained in Stafford.

The group believed that the closure of paediatrics in-patient services combined with the reduced hours at the assessment unit will put sick children at risk. In addition the group felt that the recommendations put parents in a stressful position with regard to how they respond to their needs of their sick child, and may result in an increased use of ambulance services. Conversely, there was a fear that removing access to local services will lead to some parents not seeking medical attention for the children when they need to, putting children at risk.

Maternity

There were concerns raised regarding maternity services and the potential risk to mums travelling longer distances in labour. One member of the group had experience of having a baby transferred to a specialist unit at another hospital; she acknowledged the benefits of giving birth in a hospital where the care of the baby and mother could be managed in the same place.

There were concerns raised regarding the changing demographics in Stafford and the resulting increase in demand for hospital services over the coming years.

Experience of Stafford hospital amongst the group, particularly of maternity and paediatric services has been positive, and there is a concern that valued and good quality services are being lost combined with a lack of confidence in the capacity of other hospitals to meet the extra demand posed by the TSAs draft recommendations.

The group felt that the draft recommendations would result in more frequent use of 999 by worried parents and women in labour fearful of not reaching the maternity unit time.

Proposals for mitigating actions

From the impacts identified the group were asked to put forward their ideas for mitigating actions for negative impacts and other actions to enhance positive impacts. The following ideas were proposed:

- Relaxed visiting restrictions for paediatric inpatients, enabling flexible visiting times and making provisions for siblings.
- 24 hour free transport between hospitals synchronised with core visiting times.
- Free car parking for parent of paediatric inpatients, acknowledging that a parent visiting a child is likely to stay for long periods of time.
- Subsidised public transport for travelling to hospital.
- Facilities for siblings at larger hospitals, space to relax and do homework.
- Hospital discharge core hours to synchronise with patient transport.
- Clear communication to parents about any changes to reduce anxiety.

Maternity

Due to recruitment difficulties, there was not a focus group for maternity. However, one interview was conducted with a female planning her first pregnancy. She suffers from crohn's disease, for which she has regular appointments as an outpatient and has open contact with a specialist nurse at Stafford Hospital. She cannot drive, and although her husband is able to drive they do not have access to a car.

She wanted to participate in the impact assessment because she has serious concerns about not being able to give birth in her home town with her family and friends close by. Childbirth is a

daunting prospect and the thought of going through the process in unfamiliar surroundings exacerbates that fear.

From research she has done into her condition and the medication that she takes, she anticipates that if she were to fall pregnant she would need to be closely monitored and under the care of a consultant and would have to give birth at UHNS.

She is fearful for the safety of her and her unborn child if she had to make the journey to UHNS, which she feels is not only too far away, but also is prone to major congestion, further extending journey time. The added stress and anxiety that this would cause could lead to a 'flare up' in her underlying medical condition which may affect her pregnancy. The interviewee also has concerns regarding the impact that making the journey to UHNS whilst in labour would have on her partner.

Furthermore, she has concerns regarding continuity of care, all her care for her medical condition has been managed at Stafford and she is worried that her holistic care will suffer as a result of giving birth at UHNS.

Once in labour, she would be reliant on family and friends to transport her to hospital. She would not consider public transport or private taxi hire as a viable and safe option for travelling to hospital in labour. She feels pregnant women would be disproportionately affected by the draft proposals as their options for travel are reduced to a reliance on family members. She feels that her only other option if she did not have the support of family friends would be to call an ambulance.

The interviewee also feels that the journey from UHNS to Stafford is difficult and time consuming and that new mums being discharged with newborn babies will be adversely affected by the recommendations if they do not have access to a car.

The interviewee had a further concern regarding the impact the recommendations will have on existing services at Stafford in terms of a loss expertise and for the larger hospitals their capacity to respond to increased demand.

Proposals for mitigating actions

From the impacts identified the interviewee was asked to put forward their ideas for mitigating actions for negative impacts and other actions to enhance positive impacts. The following ideas were proposed:

- To combat unfamiliarity, ante-natal classes should include visits to or recordings of the maternity wards at UHNS, showing what to expect, where to go, which entrance to use, where to park and the cost of parking.
- A midwife unit at Stafford that would give low risk mums the opportunity to give birth closer to home.
- Support for travel expenses for people visiting inpatients
- Provision of transport between sites to support discharge and safe access to larger hospitals.

Owing to the lack of attendance at the Maternity Focus Group a visit was made to the Midwife led unit at Lichfield . These are the findings

Lichfield MLU: General

The unit has between 280 - 350 Births per annum and there exists stringent booking criteria – women are booked in by Community Midwives who are based in GP surgeries or Children's Centres. Some bookings don't materialise because the birth is likely to be more complicated e.g. diabetes.

A wide catchment area is covered which includes Birmingham, Derby, Sutton Coldfield and Stafford. Risk Assessments are undertaken and if necessary women are taken to Queen's Hospital, Burton - 14 miles away.

The unit could accommodate more births. Promotion of the service currently relies on word of mouth and referrals. 9 beds are available, with 5 specifically delivery suites. Mothers leave when ready (no time restrictions) and most feel confident to go home quickly.

There is a core staff of 11 midwives and 7 support staff. I midwife is on day duty, with 2 at night due to increased risk. The midwives in the team do not work in the Community teams but a recent project has bought the Community Midwives in to do a night shift alongside the team

The rooms were designed individually and people can choose, subject to availability which they want. There is also a dining room for the Mothers to eat together the staff remembered everyone's name. Mum, Dad and toddlers!

Services

Over 50% are water births. It has won numerous awards and is a centre of excellence for water births.

The Unit offers breast feeding drop-ins, antenatal and post natal clinics, hearing checks, parent education classes. The midwives have specialisms: Some midwives practice aromatherapy and reflexology for Mothers. Some midwives are trained on new born checks.

Feedback (3 new mums) and Visitors Book

Women are made aware of service, and who visit to look round do book to use the service, although around half then go elsewhere due to complications etc. Referrals/awareness from community midwives is patchy depending on individual knowledge and could be increased. Quotes from patients include:

"The staff are fantastic – everyone is so caring and helpful".

"Will definitely have more children here"

"Wish I'd known about it when I had my first children"

"Everyone is fantastic irrespective of their job"

"I like coming here to the breastfeeding drop in as it's reassuring and I've made friends. It's nice to see the staff and other new mums"

The Visitor Book is full of compliments from Mums, Dads, Grandparents and siblings.

Accessibility

It took our researcher 25 minutes to go from Stafford to the centre in Lichfield

The signposting to the Samuel Johnson Hospital could be better

Car parking is tight

The reception is welcoming, staffed by volunteers

The website is not very informative, and was acknowledged by staff to need improvement in order to be used more as a tool to attract women to the unit.

Race

The focus group of 5 participants was delivered in partnership with East Staffordshire Rights Equality Council, a voluntary organisation working towards the elimination of discrimination through the promotion of equal opportunities and good relations,

The presentation and set of questions, prepared by representatives of the Health and Equality Impact Assessment Steering Group, were used to open and facilitate the group discussion. Enclosed as Appendix 1.

The experience of the group was predominantly of Stafford and Cannock hospitals. The group had accessed maternity, accident and emergency, paediatrics and elderly inpatient services at Stafford and specialist orthopaedic services at Cannock. One participant with diabetes regularly attended the Diabetes Clinic at Stafford.

The findings of the focus group are:

Current Experience

The group agreed that the biggest strength of the current configuration of services is that they are local and accessible. The hospital is a familiar place and the Doctors that work there are a part of the local community. The reduced hours for accident and emergency was identified as being a weakness in the current service provision.

Use and experience of community based services following in-hospital care amongst the group was low, resulting in a lack of knowledge regarding community support services.

The group felt that access to services under the current configuration is good. The provision of translation and language support services is usually good.

Transport/Travel

The group had generic concerns regarding the distance and journey time to the larger hospitals identified in the TSAs Draft Recommendations. Participants felt strongly that accident and emergency should be open 24/7, and had concerns about the quality of care and expertise of the retained staff in accident and emergency with the transfer of paediatric and critical care services.

The group were concerned that women and children in BME communities would be disproportionately affected by the draft recommendations concerning maternity and paediatric services. Within the BME communities there are fewer females with access to a car which affects their ability to access those services which have been earmarked for transfer.

Members of the group were concerned that inpatients would feel anxious at being treated outside the local community and combined with fewer visitors due to the distance and location of the hospital could lead to isolation.

Some BME communities can be very small; with few networks outside the immediate family. For these people, where support from a wider family network is not available they will face multiple disadvantages, if services are no longer available locally. Transport will be an issue for those without access to access to a car, affecting the ability to visit, keep scheduled appointments and access services in an emergency.

Members felt that some people living within the communities they represent would have difficulty in travelling to UHNS, Wolverhampton or Walsall hospital. Some do not use public transport and would find it difficult to make the journey outside of their local community; equally families on low incomes would also be at disadvantage.

Low car usage by women in the Asian communities was again raised as an issue affecting the ability of some people to access health services or visit relatives that are hospital inpatients outside the local area. This is compounded by a reluctance to travel outside of the local community, and use public transport. Many people in BME communities will face an adverse financial impact by having reduced travel options.

Cultural Issues

Members of the group agreed that a fear of hate crime and racism is a barrier to accessing services outside of their local area for some people in BME communities.

There was a feeling that in addition to the impact on accessibility, the draft recommendations would have a deeper affect on the BME communities by impacting on the doctors that live in their communities. There was a fear that Doctors previously employed at Stafford Hospital may be driven to seek employment elsewhere to maintain their skill levels and gain experience no longer available at the local hospital.

One group member was concerned that draft recommendations for the removal of the maternity ward would disproportionately affect women in the Pakistani community, who culturally prefer to give birth naturally, and are traditionally are supported by their extended families.

Transfer of critical care also raised concerns around the ability of families to meet their cultural and religious requirement for urgent burial. Furthermore, the Muslim community expressed concerns that they would be hindered in meeting their religious requirement to visit the sick in the wider community where they were inpatients at the larger hospitals where the cost and complexity journey is an issue.

General

Generic concerns were raised regarding the changing demographics in Stafford and the resulting increase in demand for hospital services over the coming years.

Overall there is a worry that BME communities will find it more difficult to access services that are no longer delivered locally, which will lead to greater isolation of BME patients in hospitals, affecting emotional wellbeing and physical recovery.

Proposals for mitigating actions

From the impacts identified the group were asked to put forward their ideas for mitigating actions for negative impacts and other actions to enhance positive impacts. The following ideas were proposed:

- Larger hospitals must ensure that they make provisions for cultural and religious requirements; prayer rooms, special dietary requirements in cafes and restaurants and segregation of inpatients.
- Financial support for the cost of travel to make it possible for relatives and friends to visit inpatients.
- Provision of a shuttle bus between hospitals for patients and visitors.

People with Disabilities

The focus group of 7 participants was organised in partnership with East Staffordshire Rights Equality Council, a voluntary organisation working towards the elimination of discrimination through the promotion of equal opportunities and good relations, between people of different backgrounds.

The standard presentation and set of questions, prepared by representatives of the Health and Equality Impact Assessment Steering Group, were used to open and facilitate the group discussion. These are enclosed as Appendix 1.

The group accessed outpatient hospital-based health care services on a regular basis. There was some experience of In-patient hospital stays. Stafford and Cannock were the hospitals currently being used. The group represented people with sensory impairment, learning and physical disabilities.

The findings of the focus group are:

Current Experience

Current experience of Stafford and Cannock hospitals was good, particular strengths were highlighted in outpatient and maternity services.

Car Parking

The availability of disabled car parking was the key weakness identified with the current configuration of services. Access to support for people with sensory impairment was cited as both strength and a weakness. When available the quality and extent of communication services are very good, however, there is a lack of consistency of access to communication services across Stafford hospital, and there is a concern that this will get even worse under the draft recommendations.

Provision of car parking spaces reserved for people with disabilities is inconsistent across hospitals, with some providing free parking for blue badge holders and others charging. UHNS was identified as being particularly problematic in terms of the distance patients are required to walk from the car park to the pay and display meter to purchase a ticket and then from the car to the hospital entrance and onto the appropriate ward

The primary concern of the group was around the TSAs draft recommendations to transfer some services to non-local hospitals.

Continuity of Care

Continuity of care was a primary concern for all participants, and particularly for patients with a sensory impairment, where additional communication support is a necessity to ensuring the patient receives the best possible care and importantly that they understand about the care and treatment they are being given. A lack of consistency in the offer of support from one hospital to another and a lack of consistency in the provider of the communication support would both have a negative impact on the emotional and physical wellbeing of a patient with sensory impairment.

Travel - Accessibility

The draft recommendations for in-patient paediatrics, maternity and critical care, will all have a disproportionate impact on people with physical, sensory and/or learning disabilities. Accessibility is a key issue; each of the patient groups may have significant numbers of people who will experience difficulties with using public transport, either because it does not cater for their specific needs or because the complexity of the journey is a barrier to use. One participant with learning disabilities, who is not a current user of hospital services, had concerns about how he would access services or visit friends in hospital if they were not based locally. The impact of the issues concerning accessibility is that a disproportionate number of people with disabilities will have limited access affordable transport and will be reliant on family and friends or expensive private transport options in order to access service or visit inpatients.

There is a fear that the draft recommendations concerning the transfer of services to other hospitals outside the local area will impact on the ability of people with disabilities to remain independent. Concerns were also raised over the distance you can be required to walk to reach your appointment

in the larger hospitals (UHNS & Wolverhampton) and in turn the impact that has on a person's ability to be independent.

It was felt that the ability of family and friends to provide transport would also be impacted by the transfer of services to other hospitals, due to a reluctance to drive longer distances or an inability to commit to a longer journey time whilst managing their own work and home life commitments.

Patient Safety

The group had concerns regarding the length of the journey and the additional time it would take to travel to the larger hospitals and the impact this has on patient safety. There were also fears of the impact the proposed changes will have on existing services at the hospitals taking on additional patients and on the ambulance service.

Facilities at the larger hospitals to cater for people with disabilities who have a physical disability, but are not wheelchair bound, were highlighted as an issue. .

One participant with Crohn's disease was concerned about critical care moving from Stafford. If she were to require major surgery and it were to take place at UHNS she would feel additional anxiety at the difficulty her family would experience and the financial impact of travelling to UHNS to visit her. Continuity of care is also a major cause for concern, losing access to her specialist with whom she has a very good relationship at a critical point in healthcare.

Proposals for mitigating actions

From the impacts identified the group were asked to put forward their ideas for mitigating actions for negative impacts and other actions to enhance positive impacts. The following ideas were proposed:

- Subsidised and accessible door-to-door transport between hospitals should be provided
- Service level agreements should be put in place with providers of communication support to ensure that all patients that require it are offered communication support and that the support transfers with them if they are moved to another hospital
- Practical measures should be put in place at major hospitals where patients may have to walk further to reach their appointment, this includes simple solutions such as the provision of chairs in corridors, to allow patients to rest, thus enabling the patient to retain their independence.
- Disabled friendly shuttle bus between Stafford hospital and UHNS for visitors and patients to coincide with visiting times
- Improved signage at the larger hospitals
- Reimbursement or a contribution towards the travel costs for people facing costs of transport to access services.
- Improved communication ahead of hospital admission advising patients of the car parking arrangements, including how far you may have to walk and how much you will be expected to pay to park

Families/Individuals on Low Incomes

One interview was conducted with a single mum of two children living in Stafford with no immediate family support in her local area; her nearest family is in Alsager. At present she is not a frequent user of hospital based healthcare services, however, she fears the TSAs draft recommendations will put her and children at a significant disadvantage and in an emergency situation could even jeopardise their safety.

The interviewee was concerned that the transfer of paediatric inpatient services combined with the impact of reduced opening hours for accident and emergency will compromise the safety of her children in an emergency situation. People on low incomes with little family support around them will be disproportionately disadvantaged by the draft recommendations.

The interviewee is a car owner, but fears that she would struggle to drive to UHNS safely with a sick or injured child in the car. She feels that you cannot be a mum to sick or injured child and be a safe driver at the same time. Furthermore, she is concerned about the cost of travelling to UHNS or Wolverhampton – what if families cannot afford to put fuel in the car to get them to hospital? The impact she believes will have a knock on effect on the ambulance service, which will be called out more frequently because worried parents have no other choice.

The parent claims that people in her community that don't have a lot of money tend not to travel far outside their local area. The journey to Stoke on Trent for many families will be unfamiliar and daunting, for car owners and for people reliant on public transport.

The interviewee feels that the impact on families on low incomes has not been thoroughly considered in the development of the draft recommendations. For example, taxi firms are quoting daytime rates for UHNS of £28 - £33 one way, after midnight this rises to £42 - £50. New Cross is £26 - £30 day rate and after midnight £32 - £45. £50 is the food budget for the week for her family – how will families that rely on their entire income to run their homes and feed their children have the ability to pay for a taxi?

The cost of transport is likely to impact on a family's ability to visit their sick child regularly, which in turn will impact upon the child's health and wellbeing.

The mum of two identified one of the major strengths of Stafford Hospital is that it is locally based. The hospital can be easily accessed within 10-15 minutes from her home. She has visited accident and emergency and the experience was positive. She had her two children at Stafford hospital and the care she received was faultless.

In addition to the impact on her personally, she is also concerned about the quality of services at UHNS, with recent media coverage highlighting issues at the hospital, including rising debts, bed shortages and long waiting times.

Congestion on the main routes to the proposed hospitals is a further concern, distance, congestion and parking issues could add as much one hour to journey times. These concerns are as fitting for Wolverhampton as they are for Stoke.

The interviewee was very concerned to learn that no risk assessments have been carried out before drafting the recommendations, and that the risk of travelling the distance from Stafford to Stoke on Trent for patients in a critical condition, or for women in labour is high and compromises patient safety.

She was also concerned that difficulties in visiting paediatric inpatients could lead to siblings being affected, either by being separated from their parents or by being taken out of school to enable families to visit their sick child.

Proposals for mitigating actions

From the impacts identified the interviewee was asked to put forward their ideas for mitigating actions for negative impacts and other actions to enhance positive impacts. The following ideas were proposed:

- Free travel and exemption from paying for public transport for families on low incomes. Reimbursing is not sufficient as it is sometimes not possible to find the upfront travel costs
- Provision of family space at larger hospitals to cater for families visiting children with siblings who may stay for prolonged periods of time.
- Waive car parking fees for families with children who are admitted to hospital for long periods of time.

Visit to the Signpost Centre, Highfields

Highfields is a large estate that is home to some of the most deprived communities in Stafford. Nine individuals were interviewed on a 1:1 basis around the following questions;

What hospital based services, including those for any long term conditions are typically accessed and how frequently?

Several of the people interviewed had used hospital services in the last few months. One interviewee had received emergency treatment to have a appendix removed and has also undergone some reconstructive surgery earlier in the year, one who is physically disabled following a road traffic accident was a regular user of outpatient services having attended 4 appointments over the past couple of months, another is waiting for an operation that will be done at Rowley Hall Private Hospital Stafford although arranged through Stafford Hospital and who has attended two outpatient appointments within the last 6 months.

From which hospital were these services accessed?

One interviewee received reconstructive surgery in Stoke and one interviewee had a mother who received treatment in Stoke following a stroke. Both reported a good quality of care.

What are the strengths and weaknesses of the current services?

All those who had first-hand experience of services at Stafford Hospital were positive about their experience of the local service. One interviewee who had given birth at Stafford 12 months ago stated that the maternity unit had fully understood her pain as she suffered from Sciatica and had

treated her very well following an emergency 'C' section. The only issue she had was being cleaned up following the 'C' Section and being told when she could visit her baby.

Are there any other issues in accessing health services?

None were articulated

From the TSAs' recommendations, what are your thoughts in relation to yourself and your carers (if any)?

The main concerns articulated were around accessing services that would no longer be provided in Stafford. Several people said that they felt that loved ones and even some of the individuals would no longer be with us without quick access to local services.

What will be the impact on you if you had to go to UHNS, Wolverhampton or Walsall, whichever is the next nearest hospital?

The main issue that came out from virtually all attendees was the issue of transport. Only one of those questioned had access to their own transport with the remainder reliant on public transport. The manager of the centre confirmed that most families living on the estate did not have access to their own transport and could not rely on family or local social networks as they did not have their own transport either.

Most of the people were living on benefits and emphasised that they would find the cost of public transport, in particular taxis, prohibitive. There were no direct bus routes from Highfields to any of the hospitals named and journeys by bus would involve one change as a minimum.

One interviewee whose mother had attended Stoke following a stroke said that arranging child care for her younger brothers and sisters to enable her to visit her mother (who had wanted someone with her as often as possible) had been difficult. The stress of this also impacted on the mother. Another interviewee who suffered from mental health problems said that she would find it difficult to access services away from her local area and as a minimum she would need someone to accompany her. One man who is disabled is able to attend hospital by travelling on his mobility scooter. If services were moved away from Stafford he would have to use a taxi or travel with a friend which would mean that he would no longer be able to travel independently.

One lady said that she would either delay or not follow up health appointments rather than travel excessive distances.

What is the relative impact of different increase in travel times (e.g. <15 minutes, 15-30 minutes, 30-60 minutes)?

Several people said that they would be put off travelling the longer the journey time. This may be especially the case in rush hour periods. Comments were also made about needing to plan travel in advance particularly around connections.

What about those visiting you?

The main issues related to the cost of travel as most people will need to access public transport. It was felt that visitors would not make the journey and this could impact on patient's wellbeing. Travel to both Stoke and Wolverhampton can be heavily influenced by incidents on the motorway which can severely affect travel times.

What are community services currently being offered following in hospital care and how easy is it to access them?

Only one interviewee was in receipt of community physiotherapy and he had been referred to private gym through the hospital.

Do you have any other concerns regarding the recommendations?

No other comments were made.

Carers and Frail Elderly

An interview was conducted with a carer of a frail elderly relative, with considerable experience of inpatient services at Stafford hospital. The carer's experiences of hospital services are mixed and serve to demonstrate the critical role that carers play in the holistic care of inpatients. The carer's experience of enablement services was very good.

Following a fall the person she cares for was admitted to an orthopaedic ward from accident and emergency unit. It was her understanding of the person she cares for that led her to demand ward staff tested for a Uterine Tract Infection, the symptoms of which had been misdiagnosed as dementia. This illustrates that the in-depth knowledge that carers provide can support hospitals to give the best quality care.

The TSAs draft recommendations will impact upon the ability of carers to play a full role in the care and recovery of the people they care for, where patients are admitted to larger hospitals outside of the local area, which are more difficult and costly to get to. The impact of not having a regular carer visit during a stay in hospital would be felt on patient health and emotional wellbeing.

Carers continue to provide support to the people they care for even following hospital admission. The carer had continued to feed the person she cared for, who suffered from dementia, during a stay in hospital, although nursing staff tried to feed the patient she would only take food from her regular carer. There would have been a considerable impact on the patient's recovery and ability to fight off infection if her carer was unable to visit each day.

Travel times and the cost and complexity of the journey to larger hospitals will inevitably lead to carers being less involved in the patient care, which will negatively impact the recovery times of inpatients and will cause unnecessary worry and anxiety for the carer.

The carer had a further concern that the draft recommendations had not taken a long-term view, with 10,000 new homes planned and an increased military presence she felt that the recommended configuration of services would not be sufficient to meet changes in local demand.

The interviewee was concerned that the voice of carers must be listened to. Carers should be valued and they must be enabled to liaise with clinicians to ensure the right diagnosis is made at the right time and that patients are treated effectively and efficiently.

The carer had concerns about the wider impact of the recommendations not just on the frail elderly and their carers, but also the families of paediatric inpatients, particularly those on low incomes who cannot afford to make the journey to the larger hospitals. She also had concerns for single parents who have more than one child to care for. The current configuration of services is familiar, easily accessible and known by family and friends, who are likely to visit or just drop in.

The financial implication is a major barrier to visiting inpatients, but she also recognised that there is a psychological barrier to accessing services in areas like Stoke on Trent or Wolverhampton which would prevent friends and family 'dropping in'.

There would be greater impact on children with disabilities where the role of the carer is extremely important. It will be detrimental to the child's health and wellbeing if the parent or carer is prevented from being at the hospital due to financial or timing constraints.

The interviewee recognises the advantages of having specialist centres, which are well equipped with highly qualified and experienced staff.

Proposals for mitigating actions

From the impacts identified the interviewee was asked to put forward their ideas for mitigating actions for negative impacts and other actions to enhance positive impacts. The following ideas were proposed:

- Transport between hospitals for visitors at core visiting times should be provided to lessen the impact of the recommendations on carers
- Modernisation of visiting protocols to coincide with available hospital and public transport
- Financial support for carers of patients admitted UHNS or Wolverhampton hospital
- A GP led minor injuries unit or walk in centre be established at the hospital during the time when A&E is closed.
- Advocacy services be established to support the patients whose family and friends are unable to make the journey to visit them in hospital
- Advice on entitlements and community-based support to be accessed at the hospital - larger hospitals should work with local providers to enable them to provide information about services at a local level

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Employees of Mid Staffordshire NHS Foundation Trust

The focus group was delivered at the Postgraduate Centre at Stafford Hospital. A total of 12 participants took part.

The standard presentation and set of questions, prepared by representatives of the Health and Equality Impact Assessment Steering Group, were used to open and facilitate the group discussion. Enclosed as Appendix 2.

The findings of the focus group are catalogued below:

Maternity

The employees that participated in the focus group had a number of concerns, both as employees and as consumers of hospital services. One participant expressed serious concerns regarding the transfer of maternity services.

'To be honest, the thought of having another child scares me. I stayed at home for so long; I would be so scared to get to Stoke if I went into labour in future'

Usage of Stafford Hospital

Other members of the group were concerned that GPs are already starting to refer patients to other hospitals, reducing numbers being admitted to Stafford and skewing patient data.

'My concern is that I'm hearing over and over again that GP's are referring their patients elsewhere the last 6 plus months. Figures are going down in paediatrics. If the patients are referred elsewhere, we are not positioned to fight the argument. If that's what keeps happening how can we justify ourselves?'

Further concerns were raised with regard to the forecast rise in population over the coming years with a planned programme of new homes and an increased military presence and the impact this would have on the demand for local healthcare services.

Staff consultation

Staff were concerned that the TSA had not visited wards or sought sufficient input from staff in developing their draft recommendations, and the recommendations did not reflect the quality of the care being delivered across Stafford hospital.

Pay and Conditions

There were serious concerns across the group regarding the draft recommendation to dissolve Mid Staffordshire NHS Foundation Trust, the majority of the concerns related to uncertainty around employment security, terms and conditions, including pay and place of work.

Concerns regarding location of future employment were widespread, with some employees who depend on public transport to get work expressing fears that they would be unable to access UHNS or Wolverhampton hospitals in time to start their shift. Employees with children also felt that they would be adversely affected, by being unable to manage childcare arrangements within their existing working hours if they were required travel further to work. Further concerns regarding working specifically at UHNS were expressed around the availability and cost of car parking. There was uncertainty amongst the group of whether travel expenses between sites would be met for employees making journeys within the working day. Overall the additional cost of travelling further

to work, the cost of car parking and the cost of making journeys during the working day were a concern for most employees.

Employees occupying non-clinical posts felt they would be disproportionately impacted by the recommended change of employer. A number of 'back office' services including car parking and some occupational health service are outsourced to private organisations at UHNS. Affected employees were concerned at the impact this would have on the contractual terms and conditions, most notably, their pay and pension packages and flexible working practices.

Communications

The group agreed that there was an overall lack of clear information with regard to what the impact of dissolving the Foundation Trust would be on its employees. Significant concerns were voiced around job security and whether only posts within Stafford hospital would be at risk. A particular worry is around the services that are to transfer to other hospitals and what the impact on job security will be for existing staffs at Stafford hospital.

Employees are worried about differences in organisational culture between Stafford hospital and UHNS. Many employees of Stafford hospital feel that their professional reputations have been tarnished by the bad press afforded to Stafford hospital over the last 12 months, and that the perception of them held by employees at UHNS is poor, which may lead to difficulties in working together in future. Some clinical staff fear that as a result of the draft recommendations to transfer some critical care and inpatient services they risk losing specialist skills and valuable experience.

Employees currently working closely with UHNS do not feel accepted by their counterparts, and there is already an animosity between the two hospitals. There is discrepancy between the pay grades of some clinical and back office positions, with staff at UHNS being paid less than their equivalents in Stafford. Staff are further concerned that a potential drop in salary combined with rising transport costs and childcare costs to account of possible extended journey times will have a huge impact on their income.

Some participants felt that 'back office' staff had not been sufficiently defined. All non-clinical staff were concerned about the impact the draft recommendations would have on their jobs. The group agreed that Stafford hospital is significant local employer, providing secure and permanent employment opportunities for the local community. Back office staff represented at the focus group did not feel that similar job opportunities were available elsewhere locally. One participant who had already started to look at other opportunities found that most administration jobs advertised were temporary contracts.

Transport

Employees taking part travelled to work using public transport, their own car and two participants walked to work. For those staff using public transport, shuttle buses for staff between hospital sites during the working day are essential if they are required to work across multiple sites. Staff that utilise public transport have difficulties in accessing services to meet the requirements of out of hours shift patterns, personal safety is also a consideration for employees using public transport.

Proposals for mitigating actions

From the impacts identified the group were asked to put forward their ideas for mitigating actions for negative impacts and other actions to enhance positive impacts. The following ideas were proposed:

- **Employment terms and conditions**
  - Protection of pay and employment terms and conditions for all staff, including those whose employment may transfer to external organisations.
  - Flexible working patterns to mitigate longer journey times.
- **Travel**
  - Staff transport to be provided between hospital sites to reduce additional travel costs for employees.
  - Transferable parking permits that allow staff to pay for parking once
- **Communication**
  - All employees require clear, honest and regular communication regarding the impact of the draft recommendations, including a timeline for implementation as soon as it is available.
  - Initiatives need to be developed to support the integration of Mid Staffs NHS Foundation Trust employees with the staff from Hospitals taking responsibility for its services.

14.2. A summary of the meetings and focus groups held with local subject matter experts

HEIA Steering Group

Meeting Title: Subject Matter Expert (SME) Meeting

Date: 26/0/2013

Time: 13:00 – 15:00

Location: Mid Staffs Hospital

Attendees:
There were attendees from the following organisations:

- Community Council of Staffordshire
- Age UK Stafford & District
- SPAN
- Age UK South Staffordshire
- Staffordhire Neurological Alliance
- POhwer

Support officers to the HEIA Steering Group were also present

Minutes:

Item 1: Agenda and introductions

- Attendees were invited to introduce themselves
- The Chair of the group went through the agenda of the session:
  - Purpose of meeting
  - Review of the TSAs' draft recommendations
  - Discussion of the main areas of concern and/or impact
  - Ideas for mitigating actions
  - Wrap-up

Item 2: Purpose of the session:

- Before the session began, two of the SMEs wished to declare their participation in the Save Stafford Group and the Right Honourable Jeremy Lefroy's Hospital Group
- Another member wanted to make clear that having the consultations during school holidays and after 3pm made it difficult for parents with children to attend the sessions. Carers and those in day centres faced a similar problem.
- A member stated that although there was no particular mention of Neurological services, he would comment on how he thinks the changes would affect those with neurological ailments
- The meeting chair stated the purpose for the session was:
  - To discuss the impacts the TSAs' draft recommendations has on the health of the local population;
  - To look at the impact on travel times
  - To make recommendations to the TSAs on actions to potentially mitigate negative impacts and help develop positive impacts

Item 3: Review of the draft recommendations:

- The meeting chair gave a brief review of the draft recommendations and allowed time for members to read

- The SME group stated that they were aware of the draft recommendations and its implications to their stakeholders

Item 3: Discussion of the main areas of concern and/or impact:

- The SMEs were concerned that the draft recommendations would lengthen travel times, induce multiple handling and compound the pressures on families and volunteers

- In regards to transportation, there were concerns that:
  - The draft recommendations would make travel costs for low income families insurmountable.
    - One member noted that some disabled children are unable to take public transport because of their condition. To multiply that problem, she added that a high percentage of people living with disability are on low income.
  - The vulnerable inpatients that could be conveyed to an alternative hospital for emergency services would find it difficult to return home. If they were additionally disabled/rurally isolated and/or socio-economically deprived the situation would be even more problematic.
  - Use of public transportation to visit loved ones would be challenging as currently visiting times at hospitals are too short and often do not coincide with bus times
  - For people with a disability, the increase in distances and introduction to unknown and distant hospital would be a barrier to visiting. In addition, the number of designated disabled parking spots is often limited and often too far away from the ward they need.
  - Additional travel times would cause extra burden on the siblings of in patients

- In regards to multiple handling, there were concerns that:
  - As the NHS does not have a working national IT system, the recommended arrangement may not be able to cope with the number of patient movements suggested. There is particular apprehension with cases involving the elderly or disabled patients who may not be able to communicate their situation and/or needs
  - The TSA recommendations would increase the number of patient movements which has been shown in literature to be detrimental to recovery
  - Excessive movement would occur due to limited capacity in hospitals- there maybe movement to other hospitals just to find a bed

- In regards to the effect on volunteers, there were concerns that:
  - The current recommendations were putting additional pressures on already stretched families and volunteers.
    - One SME group member stated that the VTS struggling to meet the current demand for the service.
  - Not enough attention had been paid to the massive amount of help and relief volunteers currently bring to inpatients and staff

- Some other concerns were:
  - As there is no local plan for the building of neighbourhoods and parishes in Stafford (i.e. there is little sense of how many houses are being built over the next couple of years), there was a question around how the population forecasts was created. The example of school closure and seeing a rise in populations was used to illustrate the point.
  - By 2030 the number of elderly people will increase from 6600 to 15000 in the area and currently on any given day it was suggested that 2/3 of admissions to a hospital are 65+. These elderly people generally live in the country side. Has this increase been accounted for?
  - The services are moving to trusts with similar deficits who are doing cost cutting exercises, will this result in loss of employment for Mid Staffs employees?

- The Mid Staff maternity services are moving to hospitals that have capacity issues. There was a concern on what this means to the level of service one would expect to receive there and how detrimental these changes would be to those that are vulnerable

- In regards to perceived positive changes, the SME group commented that:
  - The recommendations for Cannock seemed acceptable
  - Centralisation of care in theory is a good idea and should lead to an improvement
  - An frail and elderly assessment unit is a useful thing to have

Item 4: Areas of mitigating actions:

- It was agreed that communication and more clarity around what these changes actually mean would help relieve some of the anxiety
- Direct buses between UHNS and Stafford was another option suggested
- The group also held that more investment in the third sector (e.g. VTS) would alleviate some of the issues
- It was agreed that ensuring a more seamless service between acute care and community would also be an acceptable mitigating action
- It was raised that suggesting mitigating action was difficult as the proposal of changes and providers are still not fully known

Meeting ended 15:00

Meeting Title: Subject Matter Expert (SME) Meeting

Date: 29/09/2013

Time: 13:00 – 14:00

Location: Over the phone

Attendees:
NCT Stafford Secretary
A support officer for the HEIA Steering Group chaired this meeting

Minutes:

Item 1: Agenda and introductions

- SB stated her involvement in the meeting between Trust Special Administrators and NCT Stafford, Chase and District and that she and two of her colleagues prepared NCT response to the TSA proposals.
- The chair of the meeting stated the purpose of the session and reiterated that it was different from the TSA consultations as it was chiefly concerned with impact.
- The HEIA support briefly went through the structure of the session:
  - Review of the TSAs' draft recommendations
  - Discussion of the main areas of concern and/or impact
  - Ideas for mitigating actions
  - Wrap-up

Item 3: Review of the draft recommendations:

- The HEIA support gave mention of the recommendations, highlighting the maternity point specifically

Item 3: Discussion of the main areas of concern and/or impact:

- The HEIA support took SB through the focus group questions for maternity
- SB stated that she had used the Mid Staffs facilities twice for the birth of her children and was very happy with the service she received- she found the in hospital and out of hospital care to be very joined up.
- SB stated that Mid Staffs maternity unit's major strength was the friendly and competent service. She felt that the major weakness was the staff seemed a bit overstretched. However, she noted that during her second birth, she was only one of two people in the postnatal ward and experienced more one on one care.
- SB's main concern was that option to give birth at Stafford had been completely removed without offering alternative options. She felt that this recommendation would:
  - Limit women's choice;
  - Entice an emotional response in the population over the loss of option to give birth in their county town;
  - Make women question whether they would want children as the extended travel times would cause anxiety;
  - Force the women of Stafford who currently have great maternity care to go to other hospitals with limited capacity and cope with inferior impersonalised services, and
  - Make it more difficult for loved ones to visit.

- In her opinion, the best option would be to have an MLU at Stafford similar to that at

Lichfield.

- SB additionally noted that the members of NCT were inclined towards more natural births.

Item 4: Areas of mitigating actions:

- SB suggested that the impact may be reduced by:
  - Liaising with the taxi companies and making late night taxis available at hospital sites
  - Introducing more bus routes to make travel to the new hospitals more accessible
  - Producing schemes for low-income families

Meeting ended 14:00

Meeting Title: Subject Matter Expert (SME) Meeting

Date: 17/10/2013

Time: 11:00 – 11:30

Location: Over the phone

Attendees:
Staff Buddies South Staffordshire HIV services case worker
A support officer for the HEIA Steering Group chaired this meeting

Minutes:

Item 1: Agenda and introductions

- The Chair of the meeting briefly introduced himself and the purpose of this meeting

Item 3: Review of the draft recommendations:

- The chair outlined the TSA recommendations and gave special mention to the fact that the outpatient services would remain at Stafford (AM had mentioned the movement of Genito-Urinary Medicine (GUM) clinic was a point of concern in previous communications)

Item 3: Discussion of the main areas of concern and/or impact:

- AM stated that in his opinion, based on the range of services that are likely to be moved, he did not feel there was a disproportionate impact on the LGBT community.
- His reasoning for this was due to the fact that:
  - The GUM clinic and mental health services were meant to remain;
  - HIV prevention work is currently carried out in South Staffordshire and isn't covered by Staffordshire hospital, and
  - The LGBT community has stronger links to Birmingham and Stoke than to Stafford due to lack of a community presence (e.g. lack of gay bars etc.)

Item 4: Areas of mitigating actions:

- As AM stated that there would not be a disproportionate impact, mitigating actions was not discussed

Meeting ended 14:00

Meeting Title: Subject Matter Expert (SME) Meeting

Date: 18/10/2013

Time: 11:00 – 11:30

Location: Over the phone

Attendees:
Commissioning Officer for Children's Care
A support officer for the HEIA Steering Group chaired this meeting

Minutes:

Item 1: Agenda and introductions

- The chair of the meeting stated the purpose of the session.

Item 3: Review of the draft recommendations:

- The chair gave a quick overview of the draft recommendations.

Item 3: Discussion of the main areas of concern and/or impact:

- VH stated her chief concerns centred around:
  - The added burden of cost for those who have minor injuries, for example, due to self-harm, who might want to present themselves at an A&E. She believed that those who are care leavers and are looking to live independently would not be able to afford the journey to North Staffs.
  - The emotional impact for those the loss of Stafford hospital for those with mental health issues. Some youth are

Item 4: Areas of mitigating actions:

- VH suggested mitigating actions could be:
  - Making the current pathways for out-of-hours crisis intervention well known.
  - Having a clear protocol for those who self-present out-of-hours.
  - Highlighting alternative transportation options for those who need to journey to alternative hospitals i.e. community transport

Meeting ended 14:00

Meeting Title: Subject Matter Expert (SME) Meeting

Date: 18/10/2013

Time: 11:00 – 11:30

Several queries were sent to WMAS and their response is as shown below.

Recommendation	Response	Key questions
Stafford Hospital should continue to have a consultant-led A&E department between 8am and 10pm daily. How far do you support or oppose the recommendation?	WMAS has worked with commissioners and the hospital to ensure patient safety on this basis for some time. Additional costs per annum as a result of the overnight closure are in the region of £1.2m. If the arrangement continues this value must be included in the baseline contract with Commissioners. We will support this recommendation if adequate funding is made available to ensure patient safety and on the understanding that appropriate medical cover is maintained. Maintaining an A&E function during the day in Stafford will ensure that patients are transported to A&E as quickly as possible and will not impact on the capacity of wither WMAS or surrounding A&E departments during the day time hours.	1. What are the protocols for a woman in labour turning up at A&E / when the A&E is closed? a. Women are unlikely to self-present in A&E out of hours as they should be in contact with their assigned midwife in their birthing plan should they go into early labour. The midwife will be able to provide necessary advice including the hospital to attend. However, in cases where women in labour self-present at A&E, this is already occasionally seen by in the West Midlands and the WMAS workforce is already trained to deal with this type of situation b. Where there is an obstetric emergency that increases the risk to mother and/or baby due to an increase in conveyance time, this will require more proactive management 2. What will the "adequate funding" be required for? a. Understanding the additional resources required will mean working with the TSAs to analyse: (i) the increase in the numbers of women who might call the ambulance service because they have no other means of reaching an obstetric unit; and (ii) the impact of an increase in conveyance time b. In the rare cases where a women delivers before reaching an obstetric unit, this would require 2 ambulances for the conveyance
An inpatient service for adults with medical problems will continue to be provided at Stafford Hospital. How far do you support or oppose the recommendation.	WMAS supports this recommendation on the understanding that appropriate support services and networks were available to ensure clinical safety.	1. Are any of the "appropriate support and networks" the responsibility of WMAS – or these related to services MSFT should be providing? a. Further clarity is needed on commissioner arrangements for inter-hospital transfers and whether these will be provided by WMAS or another organisation. Better understanding is needed of the pathways of care so that the resources implications can be

		modelled b. Clear criteria are required about the new model of care looks like. Specifically, this means knowing the specialties that will move and therefore the volume of patients for whom conveyance time will increase, and therefore the impact on resource. It is important that a network is built across sites (e.g. Stafford, Stoke and Wolverhampton) to provide an integrated approach and protocols that can be built into the resource planning assumptions
As well as retaining the present inpatient service a 14/7 Frail Elderly Assessment service is created to provide a one stop assessment for older people and to take referrals from a wide range of sources. The unit should be staffed by Geriatricians to ensure greater links with the community. The Frail Elderly Assessment Service should have clear referral systems in place so older people can get the most appropriate care.	WMAS would need to understand fully the inclusion and exclusion criteria for the service before being able to provide a full response.	1. What are the anticipated impacts and clinical risks of the FEAU on WMAS? a. There is a large frail elderly population that is growing. There is a need to understand the conditions that can be treated in the FEAU, expected number of patients and therefore the resource impact
Beds should be available at Stafford Hospital for recovering patients following a spell of inpatient treatment at a specialist hospital to rehabilitate nearer to home.	WMAS agrees with this in principle but will need to understand the numbers involved and the requirement for inter-hospital transfers to facilitate this arrangement. For example, WMAS would need to understand the clinical requirements of the patients requiring transport to this facility and whether the intention would be to commission for this through the current Emergency and Urgent contract or through existing arrangements with PTS providers.	1. What are the anticipated impacts and clinical risks of the step down on WMAS? a. One of the main issues that will affect WMAS resourcing is the fact that in winter, the threshold for discharge accelerates. This means that some of the step-down patients will deteriorate which will increase the usage of 999. This will have to be built into the resourcing model
No babies should be born at Stafford Hospital's consultant led delivery unit as soon as other hospitals have the capacity to deliver a service for more pregnant women. The TSAs' plan is designed to ensure that there is sufficient capacity at neighbouring hospitals so that mothers have a choice of where they have their baby. Consultant led pre and post natal care should be delivered in partnership with UHNS so that local patients can still attend appointments at Stafford.	WMAS agrees with this in principle and will need to understand the trajectory for increasing capacity at other units and therefore the expected changes in patient flow over the period of change to ensure sufficient resource is available. Without adequate resource at UHNS for maternity cases it is likely that cases will need to be taken to Cheshire which will have a significant effect of job cycle times and resource deployment in Staffordshire. It should be noted that WMAS would not support the creation of a midwifery led unit as this is considered to increase clinical risk.	1. What are the increased clinical risks associated with an MLU? b. The main criterion for the MLU is understanding where a woman needs to be transferred to receive the right level of care. Staff in the MLU must be able to provide short-term management of obstetrics and neonatal emergencies while awaiting transfer. The receiving unit must be able to provide obstetric anaesthetic cover and a neonatal service. 2. What non-financial resources are required to make this model work

		for WMAS? c. The main resourcing impact will be the fact that the MLU will have more transfers out where there are complications in what was a normal pregnancy.
Children should no longer be admitted as inpatients to Stafford Hospital and the service should stop as soon as other local hospitals have the capacity to accept them safely. Patients should be transferred to larger specialist hospitals for appropriate inpatient care	WMAS would need to discuss this further and understand the staffing levels and skills of the staff based in the A&E unit and the Paediatric Assessment Unit at Mid Staffs.	2. Does WMAS currently convey children to Stafford? If yes, at what level of acuity? a. Yes. Further work is needed to understand the level of acuity 3. What are the key clinical risks associated with transferring children from the PAU to a PIU? a. There are clinical risks associated with the risk of critically ill patients, particularly children. However, paramedics are trained in advance airway management (intubation and stabilisation) so this is not an issue. The key issue will be to ensure that the receiving PIU has the appropriate medical cover (paediatric anaesthetic cover) 4. What non-financial resources are required to make this model work for WMAS (especially in regard to children living in rural areas)? a. Training is already provided as part of the management of neonatal and paediatric patients. b. The key issue is whether this will be a transfer or retrieval service. If it is through a retrieval team, this will require paediatric anaesthetic cover at the PAU c. The length of time for conveyance is more than just the travel time, as the handling time needs to be factored in. This means that additional WMAS personnel will ne required 5. Is there any impact on attending to children living in rural areas (e.g. ensuring that ambulance crews attending patients in rural settings have advanced life support skills, and skills in the care of children) a. WMAS already operates in rural areas (e.g. around Hereford) where there are relatively longer journey times and would extend this model. All paramedics are already trained in advance life support for paediatrics and adults

Children will continue to be assessed at Stafford Hospital's existing Paediatric Assessment Unit during 8am and 10pm.	As above.	1. What are the key clinical risks associated with transferring children from the PAU to a PIU? a. See above 2. Will this require triage by WMAS? If so, are additional skills / training required? a. The role of paramedics is to assess the patient and make a decision on where to go for the best care. This may require a pre-alert to the admitting unit, but this already happens. b. However, to ensure a risk averse service, additional resource will be required to absorb the impact of the increase in the number of conveyances to PIUs on the basis of clinical risk management. If the criteria for transfer to the PAU vs. a PIU are complex, this will result in a default transfer to the PIU
Major emergency surgery should no longer be carried out at Stafford Hospital with the exception of minor surgical procedures which can be dealt with by A&E and scheduled to return to Stafford Hospital. Most major emergency surgery would instead be provided by a local larger hospital such as UHNS or RWHT. This means there will no longer be a surgical assessment unit on site. A&E consultants at Stafford Hospital will be able to consult surgeons remotely at larger hospitals about patients' surgical needs. Patients would then be transferred to another hospital for surgery when required.	Whilst WMAS agrees with this in principle it will be necessary for the anticipated patient flows to be carefully considered and additional resource appropriately commissioned from WMAS.	1. What are the key clinical risks? a. The conveyance times involved (e.g. Stafford to UHNS) are already encountered by WMAS in other parts of the West Midlands so there are no additional risks 2. What are the additional resources required for? a. The longer conveyance times will require additional resource b. New activity if WMAS is required to transfer these patients.
A small critical care area should be retained at Stafford Hospital so that very ill patients who come to A&E or inpatients who become unwell can be kept stable prior to urgent transfer to a larger specialist hospital. Current staff on the critical care unit should work as part of a clinical network established with a neighbouring hospital. An urgent transfer service should be established for very ill adults which is the same approach already used	The urgent transfer service should be established in conjuction with WMAS and commissioned separately – on a case by case basis? How does the Paediatric critical care work? Is it satisfactory? Do we get paid enough?	1. Are there other critical care units that stabilise a patient before transfer to a level 3 facility? a. WMAS is not aware of any other such units in the West Midlands. 2. What are the key clinical risks? a. If the patient is stabilised at Stafford Hospital (which would need suitable anaesthetic cover) then the length of conveyance would be similar to what already exists in other parts of the West Midlands 3. Are the additional resources required?

successfully across England to transfer sick children to regional centres.		a. The increase in conveyance time would require additional resources b. New activity from self-presenters and patients transported by Ambulance who subsequently deteriorate and require secondary transfer. 4. Will appropriate ambulance protocols need to be established to minimise the time it takes to convey critically ill patients to the nearest emergency surgery and/or level 3 critical care unit? Do response teams need to be trained to provide on-scene care? a. Appropriate protocols will be needed. However, WMAS already has similar experience in the networked MTC service in the West Midlands so no new training will be required
Elective care and day cases should remain in Stafford. This would include orthopaedic surgery	WMAS would support this on the understanding that appropriate support services are made available to avoid the need for any inter hospital transfers.	1. What are the key support services required? a. Patients will be to be properly risk-assessed; definitive discharge criteria will be required to avoid patients being transferred back; a list of support services will be needed to ensure that the right patients are transferred
Beds should be available at Cannock Chase Hospital for recovering patients, following a spell of inpatient treatment at a specialist hospital, to rehabilitate nearer to home.	WMAS would need to understand whether a WMAS resource is anticipated as being required for patients being transferred to this facility	1. Does WMAS think that a WMAS resource is required for patients being transferred to this facility? a. They key question is who will be commissioned to provide this service (WMAS or another provider). This situation needs to be avoided in which another provider is commissioned, but WMAS ends up carrying out some of the work as proper commissioning arrangements are not in place.
Elective Surgery is retained at Cannock hospital	WMAS does not anticipate any impact from this recommendation.	
How far do you support or oppose the recommendation for MSFT to be dissolved, with the services at Stafford and Cannock Chase hospitals being managed and delivered by another organisation or organisations in the future.	WMAS has no view on this.	

15. Appendix D: Memoranda to the TSAs

This appendix shows the memoranda sent by the Steering Group to the Office of the TSA during the course of their work.

TO: THE OFFICE OF THE TSA

FROM: THE CHAIR OF THE HEALTH AND EQUALITY IMPACT ASSESSMENT STEERING GROUP

SUBJECT: OUTCOMES OF THE FIRST STEERING GROUP MEETING

DATE: 22 MAY 2013

The Health and Equality Impact Assessment Steering Group (HEIA SG) held its first meeting on Wednesday 22nd May 2013. At this meeting, the HEIA SG agreed to keep the Office of the TSAs informed of the emerging thinking from the group, in order to provide as constructive a role as possible in developing and refining recommendations.

This first meeting was concerned primarily with reviewing the characteristics of the local population and, in particular, the protected characteristics and socio-economic deprivation present in Staffordshire. The HEIA SG's focus will include a "whole population" consideration for those who have used MSFT in the past and, as part of that discussion, will also look at the impact on staff as well as on service users. Where there are proposals to make significant shifts of service delivery to other locations, we may also need to consider the potential impact on those populations which have historically been majority users of those sites. The working evidence reviewed by the group indicated that the local population is largely white and with medium to wealthier income (compared to the national average). Many of the groups with protected characteristics (as set out in the Equality Act 2010) seem less prevalent in the local area, in comparison to other parts of the West Midlands.

However, the HEIA SG is concerned that there will be particular communities who may be at risk because of small scale, invisibility or an accumulation of disadvantage, and its focus will be on these groups. For example, one group that was referred to was that in which age, disability and deprivation coincide.

The HEIA SG is further concerned that the historic pattern of service utilisation at MSFT is not necessarily optimal and the SG will want to see the TSAs consider how to use Monitor's process as an opportunity for improvement. In particular this relates to areas with unexplained variation from national usage, for example high admissions in paediatrics and for the elderly, and the historic limitations in community support and infrastructure. Early mitigating possibilities include reducing the reliance on face-to-face meetings and using telephone or internet support where these channels could offer alternatives for basic transfer of information, or for follow up/intervention. This has the potential to significantly improve access to healthcare and information for some of the protected groups, for example people with a disability, the elderly, or those for whom English is not their first language.

TO: THE OFFICE OF THE TSA

FROM: THE CHAIR OF THE HEALTH AND EQUALITY IMPACT ASSESSMENT STEERING GROUP

SUBJECT: OUTPUTS OF THE STEERING GROUP MEETING HELD ON 3RD SEPTEMBER 2013

DATE: 20 SEPTEMBER 2013

The Health and Equality Impact Assessment Steering Group (HEIA SG) held its most recent meeting on Tuesday 3rd September 2013. This meeting was a workshop-style event for the HEIA SG to discuss the TSAs' draft recommendations and to explore, for each service area, the main messages, potential impact areas, and the possibilities for mitigating actions. As a high level summary, the potential impacts (negative or positive) are largely restricted to the protected characteristics of age and sex. Those services which require longer or more frequent journeys are also being reviewed for their potential disproportionate negative impact on those living in poverty and /or geographical isolation.

Based on the discussions at the meeting, there are several major themes emerging, which are set out below. For some of these, the concern relates initially to a lack of clarity about what is being proposed, making it difficult to assess whether or not there may be an impact for one of our protected groups. We would welcome an early conversation with Hugo Mascie-Taylor to clarify some of the detail here, which would then enable us to make a response.

1. The HEIA SG acknowledges the improved care and outcomes that many of the TSAs' draft recommendations may bring, if they are implemented properly. However, there is concern that in some areas the recommendations are too vague and/or not sufficiently thought through, and may require further work to minimise the risk of negative impact. Further details are set out below.

2. There is acknowledgement that more consideration needs to be given throughout to the interface between acute and community services in all of the services affected. The HEIA SG are aware that the provision of CHS sits outside the strict remit of the TSAs for MSFT, but believe that the management of the interface between the two does fall within your scope. A shift in focus to build capacity to support people as close to home as possible will be essential to balance the potential negative impact of some other services becoming more specialised and remote. The HEIA SG proposes that an acknowledgement of the very high importance of this interface, and an approach for delivering integration across it, is articulated in the TSA's final report, preferably with some concrete examples of areas where this could provide better care for the local community. This may require the more active involvement of the Staffordshire and Stoke on Trent Partnership NHS Trust in the discussions with the acute providers.

3. The models of service described appear to reproduce traditional assumptions about patients travelling to see clinicians at remote sites for face-to-face meetings. We would like to see more active exploration of how support could be made available remotely, including use of telephone and internet services, so that people only have to travel where they really need to. This could also create more efficient use of scarce clinical expertise by enabling remote clinician-to-clinician review and support.

4. Although the HEIA SG did not discuss the specific details relating to the on-going travel times analysis (as the work is still in progress), the group recognised the particular risk of negative impact

An additional concern is that transportation and travel times could become an overwhelming issue. Given the potential for this, the Steering Group has considered some early potential mitigating actions:

(i) The TSAs are strongly urged to consider how to sustain services requiring frequent contact, or involving large numbers of patients at local sites, regardless of the provider e.g. for outpatients (and to a lesser extent, diagnostics); and

(ii) Emergency admission is a much less frequent occurrence involving fewer people; however these patients may be more vulnerable people and the impact on access is largely likely to fall on families visiting these patients. If the TSAs are considering a shift in services to alternative sites than they are strongly urged to consider early dedicated transport arrangements or support for those without car access for carers and families.

The Steering Group also raised the issue of ensuring a proper provision of services in the light of local trends in the growth of young families. This includes the projected levels of housing growth and the expected relocation of Armed Forces personnel to the county:

(i) The *Plan for Stafford Borough* establishes a spatial principle that: "Throughout 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". The plan notes that in terms of past completion rates the average figure of 454 fell to around 200 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 500 new homes per year).

(ii) The MoD has suggested that it is their intention to relocate two Signals regiments from Germany to Stafford during the summer of 2015. The combined units will be formed of approximately 1,040 service personnel and will bring with them circa 420 families with 600 children (these numbers are subject to change). In terms of usage of services, the Local Area Team (LAT) expects this to be no different to the civilian population for serving personnel and their dependents, but would qualify that statement by adding that serving personnel have access to a range of in-house rehabilitation services which reduces their requirement to use the NHS.

Usual planning assumptions would be for one additional GP per 1500-2000 people and there may be very limited impact on hospital utilisation at this scale, particularly in younger people; however this should be explored and considered in the planning as it is an issue of particular concern to local people.

It is the aim of the HEIA SG to continue to provide the Office of the TSAs with on-going guidance on the themes emerging from its deliberations and analysis, and hopes that these will be used by the TSAs to inform their thinking on the development of recommendations.

for those dependent on public transport, and needing to travel to more remote services either as patients or more likely as visitors. For those with cars but on low incomes, there could also be a cost impact where frequent trips would need to be made. The group is sure that the TSAs are well aware of public concern in this area, and will have better intelligence of the specific changes which may be made and therefore the scale and nature of people affected. We would wish to see ideas in your final report which would ameliorate the negative impact, including enhanced advice about public transport, possible sources of support and early conversations with commercial providers about the possible impact on commercial routes and patient flow. We are particularly concerned that the downside of relatively few services moving off site is that this may not generate sufficient flow to create a parallel shift in public transport, disproportionately affecting those most isolated and/or economically disadvantaged.

5. The group notes that changes to maternity services differentially impact upon women, and are therefore within scope for Impact Assessment as relating to the protected characteristic of sex. We welcome the commitment to retain antenatal and postnatal services on both MSFT sites, and the proposed EPAU at Stafford to ensure continuing localised access to medical intervention in the early stages of pregnancy. We understand the clinical recommendations to concentrate obstetric expertise and support for the ca. 50% of births which require this level of intervention, however we are concerned at the apparent lack of serious consideration of midwifery led services for the significant proportion of women who do not require medical management. The use of national generic figures on MLUs, when there is a strong local example at Lichfield has caused particular concern that the potential of community midwifery services has been largely ignored. There are potential management issues, which arise in the current proposals:

- The division of sites for providing antenatal/postnatal care and labour care creates concern about continuity of care and effective communication, both in relation to safety and efficiency of services, and in terms of acceptability to women being handed from professional team to team at a very vulnerable point;
- It is unclear what arrangements will be made for access to midwife assessment in labour, and thus advice, as to when to travel to hospital. If this travel is too early, the family will face multiple trips and/or a higher risk of otherwise unnecessary intervention; if this is too late, there will be anxious journeys and potential for ambulance deliveries;
- There is a focus on obstetric services at the expense of the much wider implications of Changing Childbirth, in particular in giving women a choice of styles of birth, which impacts on women as a protected group (by virtue of their sex). Some of the clinical argument rests on the staffing level at Stafford Hospital; however there is relatively little reassurance in the draft recommendations that obstetric-led deliveries in the local health economy will be at units that do meet RCOG guidelines; and
- The current obstetric service is supported by limited SCBU capacity and this will need to be reproduced at any alternative units.

6. There are a range of other issues which particularly relate to access and acceptability in the proposals for Maternity Services:

The EPAU will operate during the day, Monday to Friday. However, given that the EPAU's stated aim is to see expectant women who have complications pre-23 weeks,

- the HEIA SG would prefer this to be a seven days a week facility and there should be clear protocols and extensive local communications regarding alternative provision of services when the EPAU is closed;
- Mothers and partners are likely to want to make at least one hospital visit ahead of labour to choose a unit and gain familiarity. This would have a disproportionate impact on those dependent on public transport, single parents, those with other young children and those living in isolated areas; and
- Visitors and carers (including extended family) will need to travel further to see women and babies who have to remain in hospital after first births, caesarean deliveries or complications. The impact will be greater for those whose baby requires a longer stay (e.g. admission into a SCBU). There will therefore be a need for additional on-site accommodation for families with babies that requires a longer length of stay.

7. We are conscious that we need to clarify current arrangements for higher risk births, particularly those which occur disproportionately in the protected groups of black and ethnic minorities, and/or teenage mothers (age), to understand whether these groups will be particularly impacted by the proposals to concentrate services at the more specialised units (although it appears likely that this will mean that all women in the catchment area will now face the same choices about site of birth).

8. The group notes that changes to paediatric services are within scope of the Impact Assessment by virtue of affecting those below the age of 18 years. We recognise that there are benefits regarding both access to specialist, experienced teams carrying out a high volume of specialised paediatrics work, and admission to a unit with a full range of paediatric services, including the ability to offer more complex or specialised care during serious illness. However there are concerns regarding the possible disruption to the care pathway between local primary and community services, and a remote acute paediatric team. These particularly relate to the safeguarding of children and the development of capacity to self manage and monitor in the context of a population which has relatively high rates of dependency on hospital intervention for conditions which would usually be managed at home or with primary care support. The general importance of a strong and effective partnership with community services is particularly important for this group, where the commitment should be to keep care as close to home as possible.

9. There are considerable issues for those families where a child does require an admission or specialist assessment. In particular, regular travel if dependent on public transport, arrangements for looking after other children, and the cost of travel (particularly the opportunity costs with other household expenses for those on low incomes) have been raised as issues. These could be ameliorated by TSAs planning for: (i) financial and other transport support for vulnerable families; and (ii) improved availability of 'family' accommodation in proposed extended paediatric inpatient units.

10. There are specific concerns about the proposals for a Paediatric Assessment Unit without the ability to admit

If the PAU is an acute paediatric team in A&E during opening hours, it may be able to 'turn around' patients who just need advice, but these should not be in A&E. If they identify serious illness requiring admission, the patient and family will have had an

- additional journey and delay in the pathway to treatment, as they will then need to travel on to either Stoke or Wolverhampton or Birmingham Children's Hospital; and
- Where the PAU is an assessment unit with a focus on the specialist review and intervention for child development and safety and/or chronic disease or disability, this could enhance the range of services available to families, who may need frequent contact with services, and limit travel costs and the disruption and anxiety of regular visits to a more remote site.

11. For the purposes of the impact assessment, the focus of concern in relation to elective and day case services is largely in relation to the potential impact for either men or women, depending on what range of elective work is planned at the two sites. However, we are not currently able to assess this impact as information about the range of operations and specialties proposed across each of the sites is not yet available.

12. In relation to emergency, urgent and critical care (EUCC), the group strongly welcomed a focus on the care of older people demonstrated by the commitment to develop a Frail Elderly Assessment Unit (FEAU) at Stafford Hospital. However, there are concerns that this requires an assertive focus on 'care closer to home' if it is to really contribute to the future safety and support of older people. Specific comments included:

- This unit should be informed by close clinical collaboration with primary care and community health services, and should form the hub of a network of services developed to support people to stay as healthy and well as possible at home. If set up on the traditional model it risks being a gateway to hospital admission;
- The 'step down' model is welcomed, where it reduces journey time and cost for often vulnerable carers; however modern models of intermediate care are typically about active rehabilitation and support at home or in nurse- or AHP-led units (with individual rooms, gyms, cooking facilities, en suite rooms) rather than hospital wards. Further work is required to develop the model and thinking and ensure that resources are targeted where they will deliver most benefit for older people;
- Where older people are treated in future in more specialist and remote units, particular attention will be required on support for carers and visiting arrangements (especially for those dependent on public transport). The availability of sufficient parking, and dedicated spaces for those with disability will be essential; and
- Where there is increasing traffic and transfers of older people from specialist units back to local services, there will be implications for community transport and ambulance provision.

13. There appears to have been a history of higher than average use of the A&E at Stafford Hospital for minor and self-limiting illness, which would be better self-managed or seen through general practice. There is nothing in the recommendations which seeks to address this, but it is a particular issue in paediatric services (with significant disruption for families). Conversely, we are concerned that with the concentration of surgical, medical and critical care expertise outside of Stafford, it will be essential to have clear ambulance protocols to ensure that vulnerable older people, or young children are taken straight to the place which can best meet their needs.

14. There are concerns about the arrangements for level 3 critical care, with different interpretations of the requirements for critical care cover in the more routine operations being undertaken at Stafford Hospital in future. The group is concerned to ensure that safe cover is in place, and that there will be sufficient capacity in the wider local economy when critical care at Stafford Hospital is downgraded. We are unconvinced of the value of 'an available anaesthetist'; this may not only add unnecessary cost but also offer a sense of false security which encourages surgeons to book cases which would more safely be undertaken in a site with full level 3 critical care support. In general, the group welcomed the concentration of higher risk activity into those hospitals with the right infrastructure to respond. However, there is concern that older people as the majority carers of users of these services could be disproportionately affected by additional journey time and cost. The relationship between these critical care changes and the 'step down' into stable but on-going medical supervision in local hospitals will have a significant role to play in ensuring both that older people get the best possible treatment and outcomes, and that they and their carers are not subject to additional cost, anxiety and trouble, at what would already be a difficult time.

15. The group strongly welcomes the proposal to focus activity at Cannock Chase Hospital on elective and day case work, and the associated diagnostic, outpatient and support services. As with other proposals, this will work best where there is formal collaboration with community services to maximise pre-hospital assessment, early supported discharge and active rehabilitation and recovery support at home. The benefits of this expansion of services at Cannock will be strongest where there is a commitment to maximise the benefits of a "cold" surgical site, with a focus on optimal proportion of day case work and high volume low risk services. From an equality perspective, we could see these developments being particularly interesting for older people as the majority users for whom services closer to home offer real value.

16. We do have concerns about the lack of clarity around what operations in which specialties will in future be available at Stafford and Cannock Chase Hospitals, and which would no longer be provided at these sites. This makes it difficult to assess the possible impact on the protected characteristic of sex. For example, if elements of gynaecology surgery are moved to align with obstetrics, whilst male uro-surgery remained available, there would clearly be a differential impact in access and acceptability for women and men. We would be interested to know how actively you seek to bring an extended range of core surgery onto the two sites, recognising that some more complex or high risk activity will be concentrated where it can have the right level of support. We are particularly keen to understand the scale of anticipated changes to higher risk orthopaedics work, as this may disproportionately impact on older people, and be associated with relatively longer lengths of stay, which would increase the disruption for older carers, and vulnerability of the patient.

17. We would like reassurance that there is a commitment to sustaining the historic more specialist outpatient and day case activity which has previously been available locally, possibly through other providers (e.g. dialysis).

18. At this stage, we could not identify areas where there may be a disproportionate impact on any other of the protected groups (including race, religion/belief, and sexual orientation); however we have commissioned focus groups which are now in progress which may raise issues of which we are currently unaware. In particular, we are conscious that there is a significant overlap between older

currently unaware. In particular, we are conscious that there is a significant overlap between older people and disability, but at this stage we may have missed particular risks of the impact for working age adults with disability, and will seek advice on this from local advocacy groups and charities.

TO: THE OFFICE OF THE TSA

FROM: THE CHAIR OF THE HEALTH AND EQUALITY IMPACT ASSESSMENT STEERING GROUP

SUBJECT: NOTES OF THE MEETING WITH HUGO MASCIE-TAYLOR HELD ON 20TH SEPTEMBER 2013

DATE: 23RD SEPTEMBER 2013

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1. Impact for ambulances - we are concerned that the proposals look like they could generate significant additional activity for the ambulance service and other patient transport e.g.(a) in transfers for 'step down' of older people; (b) for critical care transfer and back; (c) as acute intervention in surgical care; and {d) of women in labour. This looks like it could have a significant impact on ambulance workload.
   - The TSAs are in regular and detailed talks with West Midlands Ambulance Service (WMAS). WMAS have made new budget assumptions and are planning for this activity growth in both acute / emergency transport and in the movement of people who are medically stable. If we have detail we wish to pursue then Antony Marsh (CEO) is likely to be open to meeting with us.

2. Model in obstetrics – we are concerned that there is an over-focus on an obstetric led model and a lack of attention to the role of midwifery and the circa 50% births which do not require medical management or intervention
   - Royal College of Midwives have been involved in the clinical advisory work and these discussions continue, with them being invited to submit further comments on the potential for midwifery-led services
   - There is such variation in the activity and costs of standalone MLUs that the TSAs thought it best to go with the national information (irons out the variation) and therefore have not looked at the Lichfield unit specifically
   - It was the Obstetrician on the National Clinical Advisory Group who recommended a midwifery-led approach. The TSAs are convinced that such an approach would be safe; it does not appear to be affordable within current budget so commissioners would have to want to invest in higher cost payments for birth if this was to be made available
   - Hugo welcomed our comments about access to a midwife in early labour for assessment and advice, which could support women in making timely decisions about when to travel to hospital. He was not aware that this had been considered in the discussions so far.
   - I noted our concern that they propose weekday opening for the EPAU, which would be different from the 14 hour A&E and he welcomed our comments on this.

3. Model in Paediatrics: we have noted in our scoping report that the historic pattern of admissions and practice in Paediatrics appears high, and risks encouraging dependency in families, unnecessary distress and disruption for children. We were also concerned that moving all inpatient care off Stafford site could create real challenges in access, particularly for those living in poverty, and/or with children requiring regular admission.

- Hugo confirmed that the current acute Paediatric care in Stafford is the usual range to be expected in a DGH, so is largely acute onset illness; and that the historic model seems to have had (a) a low threshold for admission and (b) encouraged return and contact which does not seem to be clinically indicated. There are reports from parents of regular admissions "for observation", where no interventions are undertaken.
- The TSA proposals are intended to: (a) ensure that acutely ill children are seen by expert teams with the right infrastructure to support safe care and good outcomes; and (b) encourage care as close to home as possible with only those children who really need the anxiety and disruption of 24hour medical supervision being transferred for inpatient care. This would address our concerns about a model which supports parental responsibility and advice for observation rather than an assumption that hospital care is required.
- The Paediatric Assessment Unit would offer access to a "hot" team of consultant paediatric nurses, A&E consultants with paediatric training and a "hotline" to the paediatric consultants at Stoke for advice. It would be able to offer a period of observation by appropriately skilled staff to assess potential for stabilisation and return home with advice, or note deterioration, stabilisation and transfer to inpatient care where necessary. PAU hours should run parallel to and be consistent with A&E hours at Stafford and we should comment on this if it does not appear to be clear that this is the proposal.
- The principle of care as close to home as possible is very important in the care of children so there are not arrangements for step down beds as if the child is medically stable they should be at home with family, with community support if necessary, not in a hospital requiring visits and disruption to family and school.
- Hugo suggested that we if wanted more detail on the thinking here, then Robert Courtney Harris, the Stoke Medical Director, would be a good contact for us.

1. Arrangements for Critical Care at Stafford – we were concerned both that patients should have the right access to critical care to ensure safety, and that there should be no 'false sense of security' encouraging risk taking in surgery at what will be a site for largely routine activity, with higher risk patients or more complex procedures undertaken at sites with the right back up available.
   - Hugo confirmed that the historic user profile of level 3 critical care at Stafford has suggested a low threshold for admission, including patients who would usually be managed on a general ward.
   - It will be essential for the safety of surgical patients, and those in A&E, that the hospital has the capacity to intubate and ventilate and stabilise prior to transfer, or return to general ward. This can be achieved with the recommendations for level 2, and the proposal for additional anaesthetics capacity is to reinforce robust arrangements for this.
   - The level 2 critical care team will function as part of the wider surgical and anaesthetics network, and will be encouraged to play an active role in assertive peer review and audit and reporting.

1. Specialisation and range of elective surgical provision – we note the importance of ensuring that higher risk patients are given access to the right skills and infrastructure to optimise good outcomes from interventions. We are concerned that specialisation in some specialties or of some procedures could maximise the negative impact on access for older patients and their carers, and /or either men or women according to the detail of the proposals.
   - Hugo noted our concern that further information is required on the proposals for the range of surgical specialties and activity which will be undertaken at Stafford and Cannock, or move to more remote sites; and welcomed our thoughts on where this may be of particular risk for specific groups of people
   - The TSAs analysis is that as with paediatrics and critical care, there has been a history of bringing people back for hospital contact which is not clinically indicated and has unnecessarily increased contact (and therefore cost) in the system. The principle of care as close to home as possible will also apply in proposals for surgery; and it appears that our suggestions re early supported discharge and the interface with rehabilitation would be welcomed.
   - The TSAs are very conscious of the negative impact for older people and their carers of additional travel. The proposals are intended a) to concentrate specialist care where that is required and b) to develop an infrastructure for 'step-down' care which can return people to the most local hospital as soon as is optimal.
   - The proposals to strengthen anaesthetics particularly seek to support Stafford in offering surgery to a greater range of patients to keep care more local wherever safe to do so.

Sophia Christie
Chair, Health Equality and Impact Assessment Steering Group
20 September 2013

TO: THE OFFICE OF THE TSA

FROM: THE CHAIR OF THE HEALTH AND EQUALITY IMPACT ASSESSMENT STEERING GROUP

SUBJECT: MITIGATING PROPOSALS EMERGEING FROM THE STEERING GROUP MEETING HELD ON 9TH OCTOBER 2013

DATE: 11TH OCTOBER 2013

The Health and Equality Impact Assessment Steering Group (HEIA SG) held its penultimate meeting on 9th October 2013. This meeting was to finalise several aspects of the impact assessment, including the emerging possibilities for mitigating actions. Following from the memorandum to the Office of the TSAs sent on 20th September 2013, the HEIA SG would like to summarise the draft proposals for each of the areas under consideration: maternity services; paediatric services; emergency, urgent and critical care (EUCC) services; elective and day case services; and travel times. A summary of the impacts for each of these areas is given below, but note that the HEIA SG has its final meeting on 15th October to review these.

1.1. Impact on maternity services

The TSAs' draft recommendations will not have any impact with respect to antenatal and postnatal services at Cannock Chase and Stafford Hospitals. The draft recommendations affect where women will be able to give birth, and they will therefore have an impact on women of child-bearing age (15 to 44); this relates to two of the in-scope protected characteristics: age and sex. Although MSFT does not currently routinely refer maternity patients to other providers on the basis of factors such as age or disability of the mother, there are some circumstances related to complications in any potential pregnancy (e.g. foetal surgery and neo-natal intensive care) where a woman is referred to a more specialised unit. The draft recommendations would therefore have an impact across the population of pregnant women (including older mothers, teenage mothers and mothers with disabilities) and will therefore make the same choices available to all expectant women.

One of the main issues that arose in the focus groups was that of access. The Steering Group does not expect any woman to travel by public transport to give birth and analysis indicates that the new travel times for giving birth will be within the current range experienced across England. However, there is also recognition that, in cases where there is no access to a private car, the most probable recourse will be to use the ambulance service rather than a taxi. The Steering Group understands that the West Midland Ambulance Service (WMAS) is analysing the additional resources that will be required.

In relation to the interface with community services, MSFT itself currently provides the community midwifery which supports its obstetric services. The Steering Group considers that it is essential that alternative providers of obstetric-led care invest in this local service to provide the capacity and skills to undertake assessment in labour, and provide active support and advice. This is especially important given that the division of sites for providing antenatal/postnatal care and labour could create concerns about continuity of care and effective communication. This should also be an

opportunity to develop capacity to increase the profile and availability of the home birth option for the circa 8-10% of women[1] for whom this could be a safe choice.

There are ca. 38,500 women of childbearing age living in Stafford and Surrounds CCG and Cannock Chase CCG who have Stafford Hospital as their nearest maternity unit. Maternity services are not provided at Cannock Chase Hospital and women living near this site already travel to access maternity services (including Walsall and Wolverhampton). Therefore the TSAs' draft recommendations will have a relatively greater negative impact on the population of Stafford, for whom the existing obstetric unit is the most local choice.

Whilst there has been an increase in birth rates both nationally and in Staffordshire, the number of births at Stafford Hospital has decreased over the past five years. The increase in the number of births due to new house building and the arrival of Armed Forces personnel into the catchment area expected to lead to only a small increase in the number of births. Public Health Staffordshire estimates that this increase in the number of births will add only an additional ca. 130 births per year (this figure is subject to change). These additional births are too few to affect Stafford Hospital's status as one of the smallest in the county. However, the Steering Group recognises the significant concern of the residents of both the county of Staffordshire and Stafford Borough that the majority of babies will no longer be born in the county town.

1.1.1. Impact for the in-scope characteristics

Impact for those children and families with protected characteristics

The changes to maternity services will obviously affect the protected characteristic of sex and the impacts described above therefore apply to sex. In addition, the Steering Group has concluded that no woman would be expected to travel by public transport to give birth.

In relation to age, evidence suggests that teenage (aged 13 to 19) and older (35 and above) women are at greater risk of facing complicated pregnancies. Teenage women have a higher rate of delivering an infant prematurely and of low birth weight. Older women on the other hand are more at risk of perinatal mortality, intrauterine foetal death, and neonatal death. Postnatal care will continue to be delivered at Stafford and Cannock Chase Hospitals, which will benefit most mothers who have had a complex pregnancy, including most teenage and older mother. Centralisation of care for births may improve care; given the higher number of births at UHNS and RWT, the differential needs of older and teenage women are likely to be better met at these larger maternity units. The travel times analysis indicates that no wards have a disproportionate number of older women of childbearing age and there is no correlation between travel times and the proportion of older women of child bearing age.

The number of women from minority ethnic groups is relatively low in the catchment area for MSFT; however, the relationship between ethnicity and maternity outcomes is important as some women of ethnic minority backgrounds tend to have poorer maternity outcomes. The population served by other hospitals in the local health economy have a higher number and proportion of women of child bearing age from ethnic minority backgrounds and given the user-specific services that some women from this group may require (e.g. support and information in languages other than English), and the ability of the larger local maternity units to deliver these services, some of th

[1] *Home Births*, Royal College of Obstetricians and Gynaecologists/Royal College of Midwives, Joint statement No.2, April 2007, p. 1.

experience a better level of care than is the case at present. In relation to travel times, the proportion of the population that is women of child-bearing age and is of ethnic minority origins is not correlated with travel times.

Expectant mothers who face disabilities are more likely to face complications throughout and after pregnancy. MSFT currently deals with all women who choose to be treated at the hospital, regardless of factors such as disability. However, there are some circumstances related to complications in any potential pregnancy (e.g. foetal surgery and neo-natal intensive care). In future, there is a commitment to continue to offer antenatal and postnatal care at Stafford and Cannock Chase hospitals. This should mean that even where a woman has had a higher risk pregnancy or birth in future she may be more likely to be able to receive outpatient care locally, which may benefit women with disabilities. In relation to travel times, there is no correlation between travel times (private car and ambulance) and disability rates and none of the wards with higher disability rates.

Impact for other communities at heightened risk of additional disadvantage

Women living with socio-economic deprivation have poorer maternity outcomes. Strong midwifery support is especially important for women facing socio-economic deprivation. Based on the scale of the issues that could be encountered by mothers living with socioeconomic deprivation, and the TSAs' draft recommendations to maintain antenatal and postnatal care at Stafford and Cannock Chase Hospitals, the Steering Group anticipates that the TSAs work with commissioners to ensure that there is targeted investment in those areas of highest need. In relation to travel times, the analysis indicates that the travel times to alternative sites in deprived wards is not different to that of non-deprived wards.

For women living in rural isolation, the National Childbirth Trust (NCT) notes that providing care for rural women with high-risk pregnancies presents several challenges, including the fact that when women or babies have to be admitted to a regional centre providing higher-level care, they may be many hours' journey from home and isolated from their support network and families. Three Royal Colleges (General Practitioners, Midwives, and Obstetricians and Gynaecologists) have issued a joint statement on the role of GPs in maternity care which notes that in remote and rural areas, the GP's role in maternity care may be enhanced to ensure appropriate medical input. Whilst the role of primary care is beyond the remit of the TSAs, the HEIA SG strongly recommends that the TSAs work with primary care during the implementation of their final recommendations to ensure that the role of GPs is enhanced. The travel times analysis indicates that the travel times to alternative sites in rural wards is not different to that of non-rural wards.

1.1.2. Proposals to mitigate the impacts of the TSAs' draft maternity recommendations

Based on the impacts summarised above, the Steering Group has put forward the following proposals to mitigate the negative impacts and enhance the positive impacts of the TSAs' draft recommendations:

The Steering Group understands the reasoning behind rejection of a MLU option at Stafford given relatively low take up of midwifery led services (ca. 4.9% in 2007) across England [1].

[1] The Birthplace in England Research Programme reported that for the year ending 31 March 2007, there were 11,261 births in a freestanding MLU; 19,192 births in an alongside MLU; and 590,859 births in an obstetric unit. *Mapping maternity care: the*

- However, the Steering Group is concerned that more analysis has not been carried out to understand availability and capacity at the local standalone midwifeled unit (MLU) at Lichfield, to promote this as part of the choice available, and to use this as a better basis for the analysis of the viability of a MLU at Stafford Hospital. The Steering Group therefore proposes that the TSAs reconsider the analysis using more local assumptions.
- Given that women will now all have to travel during labour to a more distant site, the Steering Group strongly recommends review of the role and capacity of community midwifery to ensure active assessment and support is available to women during labour, and make the most of both the continuity with antenatal and postnatal services, and the potential to increase the profile and availability of the home birth option for the circa 8-10% of women[1] for whom this could be a safe choice.
- The division of sites for providing antenatal/postnatal care and labour could create concerns about continuity of care and effective communication, and the alternative providers will need to develop proposals which make best use of the outpatient options and sustain continuity of care. This should include ensuring that, through the antenatal service, women and their partners are familiar with the location and facilities at the remaining local obstetric-led units.
- Effective communication is required regarding obstetrics emergencies so the role of the Early Pregnancy Assessment Unit (EPAU) is understood by local women. The opening days of the EPAU should be reconsidered, with the aim of making this a seven days a week facility. Clear protocols and local communications need to be in place regarding alternatives when the EPAU is closed.
- Given the emphasis on safety and robust medical cover that has driven the recommendation to concentrate obstetrics services outside of Stafford, the Steering Group expects that alternative units will move towards meeting workforce guidelines and offer the capacity to respond to the proposed increase in activity. This covers all activity along the care pathway, including Special Care Baby Units (SCBUs). In addition, there will be a greater impact for women whose baby requires a longer stay (e.g. admission into a SCBU) and there will therefore be a need for additional capacity for on-site accommodation for families with babies that require a longer length of stay. The Steering Group proposes that the TSAs work with commissioners to define "sufficient capacity" and the metrics used to measure it, and then publish this information on a regular basis.
- The diversion of maternity activity to other units will also place additional pressure on paediatric support at those units. The new arrangements must also meet routine standards for the availability of a range of neonatal support, including access to SCBUs, and delivery of routine paediatric assessment before discharge.
- Even with the provision of comprehensive antenatal information and care plans, there will need to be protocols in place for responding to women in labour who arrive at Stafford Hospital in future, including for the safe transport of women in labour by the ambulance service. Commissioners will need to ensure the right capacity and skills mix is available to support the concentration of deliveries into a smaller number of units.

[1] *Home Births*, Royal College of Obstetricians and Gynaecologists/Royal College of Midwives, Joint statement No.2, April 2007, p. 1.

The Steering Group has concerns that the availability of paediatric assessment for limited periods of the day could cause some confusion, particularly for parents, about where to take very sick children and will require clear protocols for first contact services, ambulance staff and information to parents.

There is population growth expected in Stafford and Surrounds. Changes in the local Armed Forces population could see 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 3,000 houses. Public Health Staffordshire estimates that this population growth will lead to an additional 1,670 children under 20 from 2018 onwards. This population projection indicates that, even with the additional population growth over the next several years (and assuming the proportion admitted to MSFT remains at its current rate, ca. 72%), there is unlikely to be any change in MSFT's status as one of the smallest paediatric inpatient units in the country.

1.2.1. Impact for the in-scope characteristics

Impact for those children and families with protected characteristics

It is axiomatic that paediatric services are targeted to children and young adults and their families. The impact in relation to age as a protected characteristic is therefore one that applies to the whole population of children and there is no specific inequality impact. This general impact is relevant under the characteristic of age and is discussed throughout.

The Steering Group noted in its scoping report that certain ethnic groups may experience disproportionate rates of certain chronic diseases and that these groups are present in very small numbers in the local population. Specialist services related to ethnicity-specific disease have always been concentrated outside of the catchment area and the proposals will not affect these. There may be some benefit for children from ethnic minority populations in accessing services where there is a higher concentration of others from their community using services, and where service providers are more familiar with community norms and practices. No specific areas of concern emerged in relation to the changes proposed for paediatric services in analysis of the impact for race and ethnicity or in the dedicated focus group discussion.

There is concern that children with a disability may be disproportionately dependent on acute paediatric services and therefore disproportionately affected by changes to inpatient services. Up to 4% of children living in the catchment area of the two CCGs has a long-term limiting illness or is receiving disability living allowance (against a national picture of circa 3.8%). Research[1] has concluded that children with special needs tend to have a predictable pattern of conditions requiring inpatient care, where about one third of the admissions could have been managed at home with the support of community nurses. However, a small group of children (3% of activity) with severe neurological disability and learning difficulties used the emergency services very frequently; some of these requiring more specialised services than would be available in a local paediatric unit. Assertive management within the clinical network should seek to minimise disruption to the lives of children living with disabilities, including optimising the development of community support. The decision to

[1] M Mahon, M S Kibirige, Patterns of admissions for children with special needs to the paediatric assessment unit, *Arch Dis Child* 2004;89:165–169.

maintain day and assessment services locally will help to minimise this impact; however this is a group which may benefit from targeted support for transport and access.

Impact for other communities at heightened risk of additional disadvantage

Children and families living in rural isolation will experience much of the impact as for the general population. However, they are likely to be particularly disadvantaged by longer and more costly travel to access services. The greatest negative impact will fall on those families with one or more children with frequent exacerbations of chronic disease or disability, who live in an isolated area and have a low income and/or are dependent on public transport. These will be families who are already living in difficult circumstances. The new paediatric clinical network should assertively identify and consider opportunities for additional support to these families.

Families living in socioeconomic deprivation may disproportionately benefit from improved relevance and effectiveness of services, as they are more likely to use services regularly. However, they are at risk of additional negative impact of having to travel for inpatient services, given they are more likely to feel the impact of additional travel costs (potentially at the expense of the usual weekly family budget) and / or be dependent on inadequate public transport. They should be high priority for dedicated transport support and access to accommodation.

1.2.2. Proposals to mitigate the impacts on paediatric services

Based on the impacts summarised above, the Steering Group has put forward the following proposals to mitigate the negative impacts and enhance the positive impacts of the TSAs' draft recommendations:

- Ensure sufficient capacity in alternative in patient paediatric services to provide effective medical and skilled nursing cover out of hours, at weekends and at times of peak activity; including addressing areas of associated concern (for example, anecdotal evidence around the availability of routine neonatal check at UHNS);
- Clear protocols for first contact services (including primary care and 111) regarding where to take sick children, and availability of information for parents on signs of serious illness and management of acute but self-limiting illness (including fever, diarrhoea, sickness, headache etc.);
- Clear protocols for the ambulance service for assessment of serious illnesses and decisions about the site of treatment; this includes the capacity to stabilise and intervene during transit in cases of sudden deterioration or transfer;
- Formal contact and communications to be developed across the clinical network, including community services, to support those families and children with chronic disease and disability and for those where there is safeguarding risk or concern;
- Active consideration and support for families living in rural isolation and /or on low income / dependent on public transport where a child does require an admission or specialist assessment. These could be ameliorated by TSAs planning for: (i) financial and other transport support for vulnerable families (including ensuring availability of child seats in voluntary or commercial transport arrangements); and (ii) improved availability of family accommodation in proposed extended paediatric inpatient units;

- Older people being subject to multiple moves. There is considerable evidence that multiple moves are associated with raised mortality in older people [1,2,3] and there is concern that this model could introduce multiple transitions and therefore risks; and
- Ensuring that the model of step down care targets resources most appropriately.

Based on the key principle of providing care as close to home as possible, the interface with community care and the continuity of care between acute and primary care both require clarity. The Medical Assessment Unit (MAU) and FEAU will help patients to be treated and discharged more quickly, which encourages more care out of hospital. However, to enable the MAU and FEAU to operate efficiently, both community treatment and support services, and the role of GPs in delivering urgent care need to be improved. The Royal College of Physicians has noted [4] that the priority for hospital services and their partners in community settings must be to prevent health crises and manage exacerbations of chronic disease.

In addition, although providing care closer to home will have a positive impact on often vulnerable carers, particular attention will be required for support for carers and visiting arrangements (especially for those dependent on public transport).

Where there is increasing traffic and transfers of older people from specialist units back to local services, there will be implications for community transport and ambulance provision. The Steering Group has engaged with the West Midlands Ambulance Service (WMAS), and is satisfied that the TSAs are working with WMAS to understand the conditions that can be treated in the FEAU, the expected number of patients, and therefore the resource impact.

The 'step down' model is welcomed, where it reduces journey time and cost for often vulnerable carers; however modern models of intermediate care are typically about active rehabilitation and support at home or in nurse- or AHP-led units (with individual rooms, gyms, cooking facilities, en suite rooms) rather than hospital wards.

1.3.4. Level 3 critical care

In relation to emergency surgery and the level 3 critical care service at Stafford Hospital, the Steering Group notes that the National Clinical Advisory Group (CAG) views emergency these service as unsustainable due to low volumes, previous concerns raised by the Royal College of Surgeons, and evidence that supports the drive towards centralisation of these services. The Steering Group welcomes the approach to both concentrate the very sick into specialist units and maximise care close to home with arrangements to support an active elective and centralised emergency surgery programme with level 2 critical care in Stafford. This includes the ability to intervene (including intubation and respiratory support), and stabilise for transfer. However, there are concerns about the increase in travel times and transfer of patients especially since the users of emergency surgery and level 3 critical services are very ill. To mitigate these concerns, Steering Group has engaged with the West Midlands Ambulance Service (WMAS), and is satisfied that inter-hospital transfers for level 3 critical care are already common and paramedics are well trained for stabilisation and transfers.

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[1] Mikhail ML. (1992) Psychological responses to relocation to a nursing home, Journal Gerontol Nurs
[2] McKinney AA, Melby V (2002) Relocation stress in critical care: a review of the literature, J Clin Nurs
[3] Nicholas G. Castle, Relocation of the Elderly Institute for Health, Health Care Policy, and Aging Research
[4] Future Hospital Commission. *Future hospital: caring for medical patients* A report from the Future Hospital Commission to the Royal College of Physicians. London: Royal College of Physicians, 2013, p. 14.

However, there is also the question of level 3 capacity within the local health economy, and whether this is sufficient to cope with the volumes currently seen at MSFT. Unlike for other services, the TSAs have not stated that level 3 capacity will only be decommissioned when sufficient capacity is available elsewhere.

1.3.5. Impact for the in -scope characteristics

Impact for those with protected characteristics

The impact of changes to EUCC services has been considered for all in -scope protected characteristics other than sex. This is because the impact is unlikely to be different for individuals of a particular sex. In summary, the main impacts for the protected characteristics are:

- Age: the elderly have a higher demand for critical care and emergency services compared to the general population and national evidence suggests that they face higher mortality rates following emergency and urgent care treatments. How ever, centralisation may improve the quality of care;
- Race: the A&E attendance rates for ethnic minorities is lower than that of the general population but it has not been possible to establish emergency surgery and level 3 critical care usage by ethnicity in the local health economy due to data limitations; and
- Disability: individuals with disabilities are at greater risk of requiring EUCC services and may be better served at larger hospitals .

Impact for other communities at heightened risk of a dditional disadvantage

The two other characteristics that may face an additional impact are rural isolation and socioeconomic deprivation:

- Rural isolation: ambulance travel times from rural areas to the nearest alternative emergency surgery and level 3 cri tical care units are almost all within 30 minutes;
- Socioeconomic deprivation: although national evidence suggests that individuals facing socioeconomic deprivation are more likely to use A&Es, there is no clear link between socioeconomic deprivation and th e specific use of emergency surgery and level 3 critical care

1.3.6. Proposals to mitigate the impacts of the TSAs' draft EUCC recommendations

Based on the impact assessment summarised above, the Steering Group has put forward the following proposals:

- The Steeri ng Group proposes that the TSAs work with local commissioners on a programme of patient education to reduce the level of attendances at the A&E;
- The Steering Group proposes that, within the scope of their remit, the TSAs work with commissioners to ensure t hat this unit is informed by close clinical collaboration with primary care and community health services, and forms the hub of a network of services developed to support people to stay as healthy and well as possible at home;
- The Steering Group proposes t hat the TSAs work with providers to ensure the availability of sufficient parking and dedicated spaces for those with disabilities;

- The Steering Group proposes that the TSAs work with commissioners to develop the step down model and thinking and ensure tha t resources are targeted where they will deliver most benefit for older people; and
- The TSAs have not stated that level 3 capacity will only be decommissioned when sufficient capacity is available elsewhere. The Steering Group recommends that the TSAs make such a commitment.

1.4. Summary of the impact assessment for elective and day case services

1.4.1. Population focus

The TSAs have been refining the elective and day case services that will be provided at Stafford and Cannock Chase Hospitals at the same time that the Steering Group has been asked to carry out the impact assessment. It has therefore not been possible for the Steering Group to consider in detail the impacts of the TSAs' draft recommendations to the same level of analysis as for the other service areas.

This is especially true of the draft recommendation to reduce the number of specialties providing elective surgery and day case procedures at Stafford Hospital . Based on the current primary specialties provided, there may be an impact on the protected characteristics of sex / gender, if the relevant services are no longer offered (i.e. gynaecology, breast surgery and urology). However, it should be noted that th e CCGs have included some day case medical treatment as part of their location-specific services (LSS). On this basis, all will be retained in Stafford, including day case chemotherapy and endoscopy.

In contrast, the TSAs are recommending that elective ort hopaedic surgery for Stafford patients should form part of the clinical model for Stafford Hospital. This is likely to have positive impacts on effectiveness and access for groups of patients that are more likely to require elective orthopaedic surgery, in cluding age. There is a potential negative impact for elective inpatient surgery at Cannock Chase Hospital, as the draft recommendation to retain these services is dependent on the level of overnight medical cover. However, no further analysis has been car ried out on this area.

The draft recommendation to maintain and, if possible, to enhance day cases (surgical and medical) is likely to have a positive impact, especially on age (e.g. rheumatology). However, no further analysis has been carried out on this area.

1.4.2. Main areas of concern/reassurance

The Steering Group is unable to comment on specific impact given lack of detail, especially the further clarification for Stafford Hospital that is needed around the "reduced number of specialties" stated in the TSAs ' draft recommendation number ten.

However, the Steering Group strongly welcomes the proposal to focus activity at Cannock Chase Hospital on elective and day case work, and the associated diagnostic, outpatient and support services. As with other proposal s (and despite the TSAs' limited remit) this will work best where there is formal collaboration with community services to maximise pre -hospital assessment, early supported discharge and active rehabilitation and recovery support at home. The benefits of t his expansion of services at Cannock Chase Hospital will be strongest where there is a commitment to

maximise the benefits of a "cold" surgical site, with a focus on optimal proportion of day case work and high volume low risk services. From an equality perspective, we could see these developments being particularly interesting for older people as the majority users for whom services closer to home offers real value.

The Steering Group would like reassurance that there is a commitment to sustaining the historic more specialist outpatient and day case activity which has previously been available locally, possibly through other providers (e.g. dialysis).

1.4.3. Main points from protected characteristics

As noted above, the Steering Group have concerns about the lack of clarity around what operations in which specialties will in future be available at Stafford and Cannock Chase Hospitals, and which would no longer be provided at these sites. This makes it difficult to assess the possible impact on the protected characteristic of sex (gender). For example, if elements of gynaecology surgery are moved to align with obstetrics, whilst male urology-surgery remained available, there would clearly be a differential impact in access and acceptability for women and men.

The Steering Group would like to understand how actively the TSAs are seeking to bring an extended range of core surgery onto the two sites, recognising that some more complex or high risk activity will be concentrated where it can have the right level of support. The Steering Group is particularly keen to understand the scale of anticipated changes to higher risk orthopaedics work, as this may disproportionately impact on older people, and be associated with relatively longer lengths of stay, which would increase the disruption for older carers, and vulnerability of the patient.

Other factors related to the in scope protected characteristics that the Steering Group believes need to be considered once the TSAs' final plans are known are:

- Age/sex – Maintaining chemotherapy at local centres particularly benefits older people and sex (i.e. for breast cancer);
- Age- The elderly see more benefits from the local presence of catheterisation labs and cardiology services;
- Disability – The impact on individuals with disabilities will be positive if the provision of services remains local with day cases being maximised. However, there is a need to consider the interface with rehabilitation and community services to ensure the best quality of care.

1.5. Summary of impact on transport and travel

The TSAs' draft recommendations mean that obstetrics-led birth, emergency surgery, level 3 critical care and inpatient paediatric services will no longer be provided in Stafford Hospital. Inevitably, the reduction in services will have a negative access impact particularly on those who live in rural isolation, face socio-economic deprivation or have other barriers to travel. Therefore, continued access to these services is viewed as the main area of concern by the HEIA SG.

The HEIA SG does not anticipate that users of affected services will be travelling to hospital by public transport. For example, a woman in labour, an acutely ill child requiring hospital admission or a person requiring emergency surgery or critical care is unlikely to be in the position to use public transport. As a result of the TSAs' draft recommendations, it is estimated that 7,000 users will need

to travel further as a result of it. Of the 7,000 impacted users, 1,830 of them have ambulance journey times in excess of 30 minutes (but still less than 40 minutes by ambulance and 45 minutes by car). This is already currently being experienced by Stafford Hospital users when its A&E is closed at night (22:00 to 08:00). Furthermore, the impact on access is not disproportionate on individuals with protected and other in-scope characteristics.

The HEIA SG considered national benchmarks on patient access to acute services but was not able to find any established benchmarks. Nevertheless, based on Department for Transport data, it was found that 99.4% of households in England have access to a hospital1 within 30 minutes of travel by car.

The vast majority of users of Stafford Hospital can continue to be treated there. The small proportion that will need travel further will all have access to an alternative facility within 45 minutes by private car or 40 minutes by ambulance.

The main transport and travel impact will be on visitors rather than patients. Qualifying users of NHS funded services already receive travel support from the Healthcare Travel Cost Scheme and other local schemes. There is however less support for visitors and there are ca. 24,000 visitor journeys are associated with the ca. 7,000 impacted users. While Staffordshire is relative affluent and car ownership rates are high (83% in the impacted area), visitors who are on low incomes, are elderly or have no access to public transport are the ones who are likely to be worst off.

HEIA Steering Group's proposals to mitigate impacts

Based on the impact assessment summarised above, the Steering Group has put forward the following proposals:

- The Steering Group proposes that hospitals extend financial support to facilitate travel for the small number of visitors who are most in need. To ensure viability, this scheme should only be by exception and cover different modes of travel including taxi and private car
- Hospitals should increase family capacity accommodation as there is likely to be additional demand due to the increased burden of travel particularly for users of maternity and inpatient paediatric services
- Voluntary Transport Schemes should be supported to ensure their continued existence. Staffordshire County Council could explore further subsidies for existing schemes and hospitals could provide free designated parking spaces for volunteers
- Parking is viewed as a major element of access and sufficient capacity needs to be established to match demand. As users are more likely to be receiving treatment from more than one hospital site, multi-site parking permits should be introduced
- Some staff may need to work across different sites due to the clinical networks. At present, UHNS and Wolverhampton does not operate a shuttle bus service across hospital sites but this should be considered if the volume of inter-site working is sufficient to justify a service.