

---

**IMPACT**

**THE INTERNATIONAL HEALTH IMPACT ASSESSMENT CONSORTIUM**

---

**Screening of the Coventry and Warwickshire Acute Services  
Review Proposals**

**January 2007**



THE UNIVERSITY  
*of* LIVERPOOL



## **Acknowledgements**

We would like to thank Stephen Munday and Sarah Bannister of Warwickshire PCT for commissioning this work and providing much background data. In addition our thanks are extended to Amanda Lambert of West Midlands Strategic Health Authority for the public health data and analysis.

**Debbie Abrahams,**  
International Health Impact Assessment Consortium,  
University of Liverpool

**Richard Little,**  
Health Planning and Management,  
University of Keele

## **Contents**

<b>Acknowledgements .....</b>	<b>2</b>
<b>Contents .....</b>	<b>3</b>
<b>List of tables and figures .....</b>	<b>4</b>
<b>1. Introduction .....</b>	<b>5</b>
<b>2. Summary of Coventry and Warwickshire’s Acute Services Review proposals .....</b>	<b>6</b>
<b>3. Screening methodology .....</b>	<b>8</b>
<b>4. Screening findings.....</b>	<b>9</b>
Population and socio-environmental characteristics.....	9
Impacts on wider health determinants.....	12
Impacts on health care and health outcomes.....	13
<b>5. Conclusion and recommendations .....</b>	<b>17</b>
Conclusion.....	17
Recommendations .....	18
<b>Bibliography.....</b>	<b>19</b>

## List of tables and figures

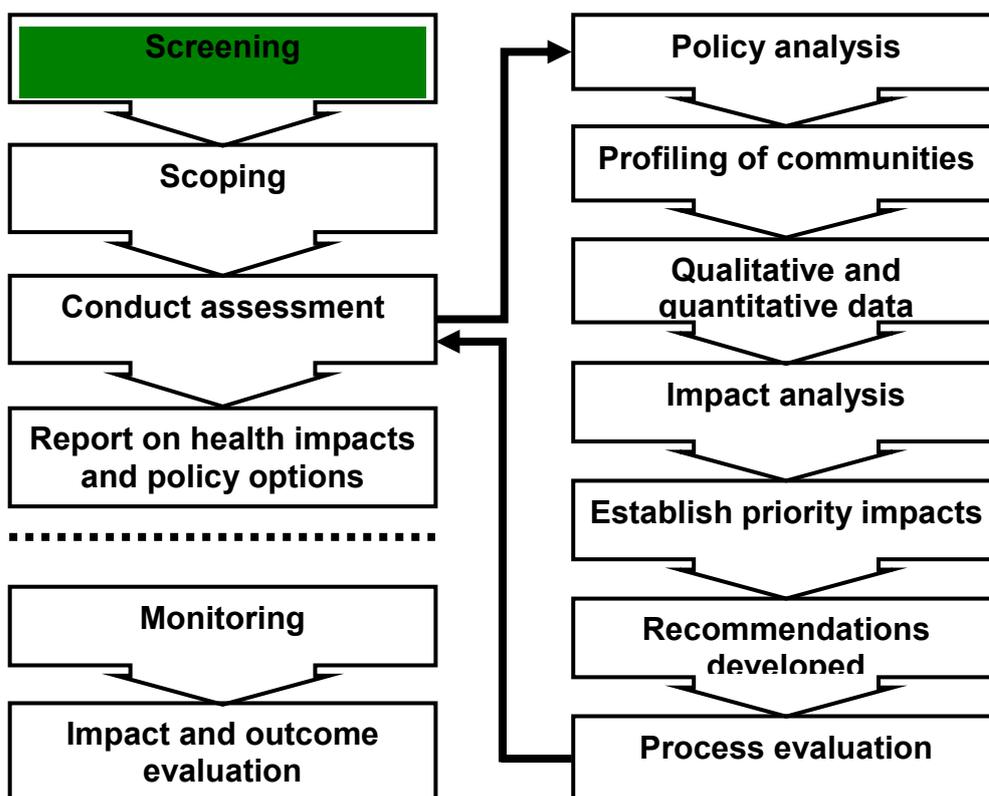
Table 2.1 Summary of Acute Services Review proposals and recommendations.....	7
Table 4.1 Number (Thousands) and percentage of Coventry & Warwickshire Population Aged 65 or more and 85 or more.....	9
Table 4.2 Income Deprivation & Unemployment.....	9
Table 4.3 Access to private transport.....	10
Table 4.4 Access to General Practitioners.....	10
Table 4.5 Current acute services relevant to Review.....	11
Table 4.6 Performance of Trusts in Review Area, 2005/06.....	11
Figure 1 A generic HIA methodology.....	5
Figure 2 Model of obstetric care.....	15

# 1. Introduction

1.1 This report describes the findings from screening Coventry and Warwickshire’s Acute Services Review (ASR) proposals. Screening involves considering the health effects of policy, strategy, programme or project proposals against a screening tool or checklist. Screening also determines whether the proposals need a full Health Impact Assessment (HIA) (figure 1). The screening was undertaken during December 2006 and the first week of January 2007 on the final ASR report (version 14) which contained recommendations to the ASR Board following the consultation of proposed service developments. The findings from the screening process will be considered by the ASR Board in the middle of January together with the recommendations for service development.

1.2 IMPACT, the International Health Impact Assessment Consortium, based in Public Health at the University of Liverpool was commissioned by Warwickshire Primary Care Trust to undertake this work.

Figure 1 A generic HIA methodology (Abrahams et al, 2004)



## **2. Summary of Coventry and Warwickshire's Acute Services Review proposals**

2.1 Coventry Teaching Primary Care Trust (PCT), Warwickshire PCT, George Eliot NHS Hospital Trust, South Warwickshire General Hospitals NHS Trust and University Hospital Coventry and Warwickshire NHS Trust consulted on proposed changes to health services provided in Coventry and Warwickshire between June and September 2006. The principles underpinning the service developments are 'patient safety, quality of care and accessibility' (ASR Board, 2006). The Coventry and Warwickshire Acute Services Review (Coventry and Warwickshire Acute Services Review Board, 2006) described the national and local context for these changes and put forward seven formal consultation proposals (table 2.1 – dark blue) associated with:

- Emergency care;
- Children's and maternity services;
- Cancer services.

In addition plans for other service areas were also described but were not being formally consulted on (table 2.1 - light blue):

- Older people;
- Planned care;
- Clinical support services.

2.2 Although it is reported that these service changes are not driven by financial pressures, affordability is important and proposals should be either cost neutral or contribute to cost savings for the health economy. The rationalisation for change is the need to meet Government policy as well as the health needs of the people of Coventry and Warwickshire whilst securing the future of the existing acute hospitals. The argument is put forward that patterns of ill health and developments in health care are changing; for example, over a fifth of emergency medical admissions are due to flare ups of chronic diseases such as diabetes, heart disease or asthma, which can potentially be managed at home or in a community setting. In addition more planned care can be provided in hospital on a day case basis reducing the time patients are in hospital. The provision of specialist care within Coventry and Warwickshire is another challenge which is said to be only just viable; the proposals will strengthen their retention locally rather patients having to travel out of the area. Providing quality, local, 24 hour emergency care is also problematic under existing arrangements. Finally staffing issues such as the European Working Time Directive which will restrict working hours and current on-call practice also contribute to the need to reorganise how services are provided.

2.3 Responses to the consultation have been collated into a Final Report with recommendations for consideration and decision by the ASR Board.

**Table 2.1 Summary of Acute Services Review proposals and recommendations**

<b>Service Review Areas</b>	<b>Proposal plans</b>	<b>Recommendations</b>
Emergency care	Consolidate 24 hour emergency surgery at University Hospital (UH)	ENT and urology - Supported for immediate implementation. General surgery – develop appropriate models of care.
	Develop a new model of care for acute medicine (Medical Assessment Units)	Supported for immediate implementation.
Planned care	Shift non-surgical procedures and specialities out of hospital to 'office' or community clinic settings	
	Maintain ambulatory care at current 5 sites	
	Potentially develop ambulatory care at other sites	
	Increase specialist tertiary services provided at UH (subject to patient choice)	
Care for older people	Home-based re-ablement in Coventry, North & South Warwickshire and Rugby	
	Integrated health and social care system	
	Community hospitals in Coventry, North & South Warwickshire and Rugby	
Cancer services	Centralise complex cancer services at UH	Supported.
	Develop ambulatory cancer units at University and Warwick Hospitals (maintain at George Eliot)	Supported for immediate implementation.
Children's and maternity services	Set up Paediatric Assessment Units (PAUs) at Warwick (24 hour max.) and George Eliot (GE) (12 hour max.) Hospitals. Special Care Baby Unit (SCBU) at UH and WH. Neonatal Intensive Care Unit (NICU) at UH.	Supported 24 hour PAUs for WH and GE. SCBU to be retained at GE until further work on design of paediatric and maternity services undertaken over next 12 months.
	Specialist in-patient paediatric care at UH	Supported – especially if reduces out of area treatment.
	In-patient obstetric care at UH for high-risk births; enhanced midwife-led unit (MLU) at GE for low risk births.	Supported merger of UH and GE maternity units with consultant-led maternity service retained at GE, but not MLU.
Clinical support services	One managed pathology service across all Trusts	
	One managed prescribing service for all Trusts	

2.4 In addition to recommendations related to the formal consultation, there were also recommendations to reduce the overall acute bed numbers by 1798 and to undertake a transport scoping study.

### **3. Screening methodology**

- 3.1 The aim of screening Coventry and Warwickshire's Acute Services Review proposals is to quickly assess the potential health gains or losses of specific proposals against pre-defined criteria (screening tool) for a given population. In particular, screening should identify which population groups and what geographical areas may be affected by the proposals and whether these health effects are likely to be positive or negative; it should also assess the scale and severity of the possible effects.
- 3.2 Although a number of generic screening tools are available it was decided to identify criteria that were specific and relevant to the Review area. Using datasets from a combination of sources, e.g., public health and performance data, evidence from the literature, disadvantaged population groups and/or geographical areas were identified across the Review area and relative to England and Wales (or the United Kingdom). In particular, socioeconomic data (deprivation, employment, access to transport), access to and quality of health services and health/quality of life data were analysed. The impacts of the proposals on the same indicator set were then considered, identifying whether the proposals would potentially result in health gains for the health of the whole population affected but especially considering the groups currently disadvantaged.
- 3.3 There is a necessary compromise between brevity and rigour in any study. In this case, the urgency for this work prevented the screening tool being tested or validated; in addition there were limitations on the data and evidence-base accessed. It should also be noted that screening is not a health impact assessment (HIA), but identifies whether a HIA is needed or not.

## 4. Screening findings

### *Population and socio-environmental characteristics*

4.1 The population is projected to grow and age in all areas except Coventry. Those aged 85 and over are projected to increase by a greater proportion. Coventry's age profile is different from the rest of the Review area with a higher proportion of young people aged 15 to 29 years and fewer older people. South Warwickshire and Rugby have a higher proportion of people over 75 years compared with other parts of the Review area and England.

**Table 4.1 Number (Thousands) and percentage of Coventry & Warwickshire Population Aged 65 or more and 85 or more**

Year	65 and over		85 and over		Total All Ages
	%	No.	%	No.	No.
2004	15.9	131.7	1.8	15.3	829.7
2009	16.3	140.7	2.2	18.8	861.0
2019	18.6	170.8	2.6	23.5	919.2
2029	20.8	201.4	3.4	33.2	970.1

Source: 2004 based sub national population projections, ONS

4.2 Black, Asian and Minority Ethnic (BAME) population groups tend to reside in urban areas with the largest proportion of non-white population groups located in Coventry (16%), Warwick (7%), Rugby (6%) and Nuneaton and Bedworth (5%).

4.3 Income deprivation is focussed in the urban centres. Coventry and Nuneaton and Bedworth were the areas with the highest rate of income deprivation, which were also above the average for England and Wales. These areas were also amongst the 20% most deprived areas in the country. Unemployment appears low when compared with some other areas of the UK that have experienced industrial decline. The precise definition of how unemployment was calculated was not stated in the report. No data were available on incapacity benefit claimants for the area.

**Table 4.2 Income Deprivation & Unemployment**

Place	Income Deprivation (%)	Unemployment Rate (%)
Coventry	36.2	4.0
Nuneaton & Bedworth	27.2	2.9
Warwick	21.7	2.6
South Warwickshire is stated as "less deprived" with pockets of deprivation		

Source: Final Report V14 p.9

4.4 Access to private and public transport, and its impact on access to health services, is of concern in the Review area. Car ownership data (table 4.3) indicates nearly a third of the population in Coventry have no access to a private vehicle; this is slightly higher in Nuneaton and Bedworth. However data (WMSHA, 2005) suggests that these urban areas are well served by public transport. Conversely car ownership is higher in rural areas but public transport is not good with less than 50% of the population in Warwickshire being 30 minutes from an acute hospital by public transport.

**Table 4.3 Access to private transport**

Place	No Car/ Van (%)
Coventry	33.1
Nuneaton & Bedworth	24.1
Rugby	19.5
Warwick	19.4
North Warwickshire	17.9
Stratford-on-Avon	13.6
No data was presented for rural areas	

Source: Public health data analysis, p.17

4.5 The consultation responses also highlighted travel and transport issues, e.g., validity of the emergency transport times particularly in congested areas such as Coventry, the increase in travel distance, time and cost for relatives and friends and not just patients with centralisation of some services (it was not clear if the provision of care closer to people's homes might offset this).

4.6 The findings from a multiple regression analysis undertaken to determine what factors influenced access to hospital were examined although the model was not available for analysis. The findings suggested that deprivation and age determine access to hospital for both planned (65-74 and over 75 years) and emergency care (0-4, 15-44 and over 65 years) and not travel time. There are some issues in hospital admissions being used as a proxy measure for access: hospital admissions are determined by clinicians, access by someone seeking health care. Evidence from the literature shows a relationship between proximity to health care facilities and access to health care services. Evidence from the public health analysis suggests that people with poorer health tend to live in deprived urban areas, close to a NHS acute hospital. Currently the most deprived areas are served by University Hospital in Coventry and George Eliot Hospital in Nuneaton. It could be that populations living in deprived areas may take up emergency admissions because they live closer, and they have greater need; it could also be that they are less likely to present at an early stage of care need, as other evidence indicates.

4.7 The Coventry and Warwickshire is an 'under Doctored area' with lower levels of GPs than the rest of the West Midlands, but also compared to the rest of England. Coventry and North Warwickshire have particular GP shortages; the implications that this will have on the proposed plans for, e.g., effectively managing long term conditions in community settings and reducing emergency admissions from 'flare ups' from these conditions should be explored in more detail.

**Table 4.4 Access to General Practitioners**

Place	GPs per 10k population
Coventry	5.2
North Warwickshire	4.8
Rugby	5.7
South Warwickshire	5.8
Coventry & Warwickshire	5.4
<b>WMSHA</b>	<b>5.6</b>
<b>England &amp; Wales</b>	<b>5.8</b>

Source: Public health data analysis, p.17

4.8 Current patient flow data shows a clear relationship with local communities. Walsgrave Hospital (now University Hospital, Coventry) is predominantly attended by Coventry residents with a large inflow from Rugby; over a third of all planned and emergency treatment for Rugby residents is delivered by St Cross Hospital with some inflow from neighbouring Leicestershire. Warwick Hospital serves all of South Warwickshire (and to a much lesser extent Stratford Hospital) and George Eliot Hospital all of North Warwickshire. In addition over 10% of all elective activity in the Review area is currently provided by other providers, e.g., the three independent hospital units at Coventry, Nuneaton and Leamington Spa; it is estimated that this may increase to 15% of activity.

4.9 The current service configuration arrangements relevant to the proposals are as follows:

**Table 4.5 Current acute services relevant to Review**

	UCH	St Cross	GE	Warwick	Stratford
<b>Emergency Care</b>					
A&E	✓	✓	✓	✓	✗
24 hour surgery – ENT/Urology	✓	✓	✗	✓	✗
24 hour surgery – General	✓	✗	✓	✓	✗
Emergency Medical Admissions	✓	✓	✓	✓	✗
<b>Children</b>					
Paediatric - In-patient	✓	✗	✓	✓	✗
Paediatric - Out patient	✓	✓	✓	✓	✗
24 hour emergency admissions	✓	✗	✓	✓	✗
Minor injuries	✓	✓	✓	✓	✗
<b>Maternity/Neonatal</b>					
Obstetric – In patient	✓	✗	✓	✓	✗
Obstetric – Out patient	✓	✓	✓	✓	✗
SCBU	✓	✗	✓	✓	✗
NICU	✓	✗	✗	✗	✗
<b>Cancer services</b>					
Specialist ca centre	✓	✗	✗	✗	✗
Ambulatory ca care (inc. chemo)	✗	✗	✓	✗	✗
<b>Planned care</b>					
Ambulatory care (inc. diagnostics)	✓	✓	✓	✓	✓
Specialist care (inc. heart surgery)	✓	✗	✗	✗	✗

Source: Acute Services Review Board, Consultation document

4.11 The health economy had a variable performance record as follows:

**Table 4.6 Performance of Trusts in Review Area, 2005/06**

Trust	Quality of service	Use of resources
North Warwickshire PCT	Good	Fair
George Eliot NHS Trust	Fair	Weak
Coventry teaching PCT	Good	Weak
University Hospital, Coventry	Good	Fair
Rugby PCT	Good	Weak
South Warwickshire PCT	Fair	Fair
South Warwickshire General NHS Trust	Fair	Weak
Coventry & Warwicks. Ambulance Trust	Good	Fair

Source: Healthcare commission, NHS performance ratings

In addition evidence from the community indicates that community services in the north of the Review area are far from adequate.

4.12 The health and well being of populations across the Review area also show considerable inequalities. For example, the average life expectancy of men in Coventry is 75.6 years compared with 78 years in South Warwickshire and 76.2 in England. Similarly, women have an average life expectancy in North Warwickshire compared with 82 years in South Warwickshire and 80.7 in England. Coventry has consistently higher cancer mortality rates than England, Rugby and North Warwickshire sometimes. South Warwickshire is always below the England rate. Other indicators reveal a similar North/South pattern with Coventry and North Warwickshire having particularly high mortality rates for coronary heart disease and North Warwickshire also having high death rates from stroke. Self-reported ill health is also higher in Coventry (10%) and North Warwickshire (9.5%) compared with South Warwickshire (7.2%), Rugby (7.7%) and England (9.2%). Limiting long term illness shows a similar pattern.

### ***Impacts on wider health determinants***

#### **Transport**

4.13 The proposals will have an impact on travel times and distances; however it is unclear what the net effect would be and who this would disadvantage most. Where acute services such as emergency surgery are to be centralised there will be an increase; conversely services such as diagnostics and other ambulatory services will be provided more locally, potentially reducing travel times and distances. It will be important to undertake a detailed analysis of this with particular attention to the effects of additional travelling on disadvantaged communities in Coventry and North Warwickshire as well as people with mobility or communication difficulties and the potential impact on access to care. Impacts on air quality in urban areas should also be considered particularly if this affects air quality management areas. Similarly transport issues related to staff also need to be considered.

4.14 It is acknowledged that the Review Board has recommended that a transport scoping study be undertaken in response to the concerns raised. It is also recommended that the multiple regression analysis already undertaken is built on. An econometric analysis could be undertaken of those factors affecting admission, which could then be used to estimate the impact of the proposed NHS changes. Primary care is also important in patients' access to acute treatment; proposed changes here also need to be explored in conjunction with the acute sector reconfigurations to assess overall impacts on access and appropriate admissions.

#### **Economy and employment**

4.15 The overall approach to enhance services locally and help keep delivery local will contribute to and sustain not only the NHS but local employment and the economy too; much is already known about the association between employment and health. This is particularly important in the deprived areas of Coventry and North Warwickshire. As plans develop it will be valuable to consider the potential economic

impacts across the Review area and to engage with the Regional Development Agency as part of their economic development processes.

### ***Impacts on health care and health outcomes***

#### **Emergency care**

- 4.16 The proposals for emergency care include reducing the number of sites providing 24 hour surgery for ENT and Urology from three to one (UH); more detailed models of care need to be developed before a potential centralisation of emergency general surgery at UH takes place as well. These proposals could contribute to better health outcomes and quality of care by ensuring appropriately trained, senior clinicians, including anaesthetists are available out of hours for emergency surgery (NCEPOD, 2003). There will need to be consideration of appropriate transfer arrangements and protocols for patients presenting at A&E sites other UH as already identified.
- 4.17 In addition, the development of medical admissions units co-located with A&E facilities, acute out patient clinics staffed by senior clinicians have the potential to provide more appropriate and timely care for people with long term conditions contributing to reducing acute episodes and inappropriate emergency medical admissions (NCEPOD, 2005).
- 4.18 There is a comprehensive plan for the development of Emergency Care across primary and acute settings, managed by the Emergency Care Network, which has the potential to benefit all parts of the Review area. It will be useful to undertake a detailed analysis of specific proposals as they are developed. Governance arrangements for a non-statutory body also need to be considered. Similarly potential issues concerning the capacity of primary care practitioners to engage develop and integrate with secondary care needs to be assessed.

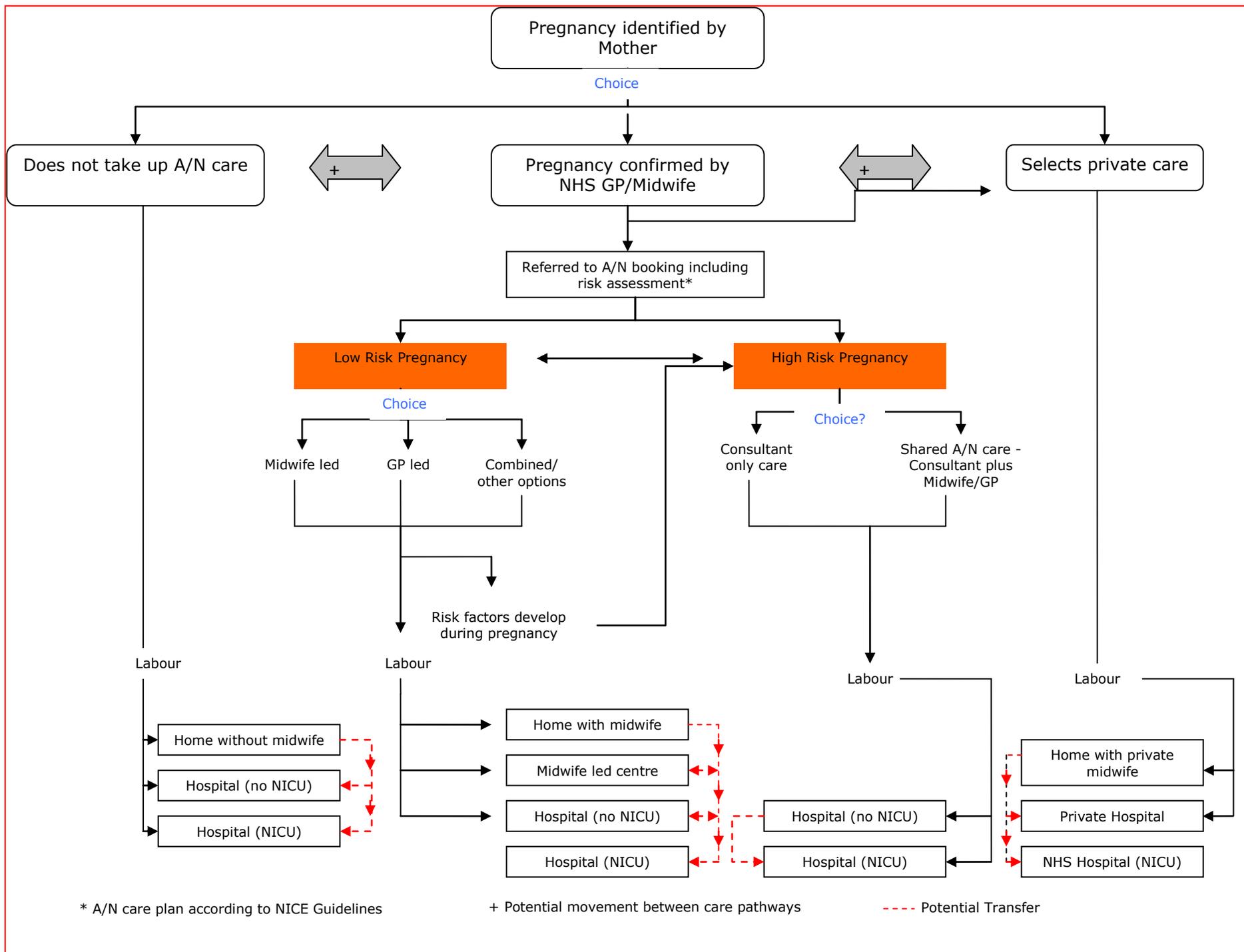
#### **Cancer services**

- 4.19 The proposals are to centralise complex cancer cases at University Hospital and to have ambulatory care also at Warwick hospital. There is the potential to improve both the quality of care and health outcomes through the implementation of these proposals; surgery for gastrointestinal cancers performed in high volume hospitals or by high volume surgeons has better survival rates. In addition by introducing more local cancer treatment this is increasing access to care for population groups at higher risk of the disease. The comments upon transport are relevant to the cancer proposals.
- 4.20 The main issue with cancer care is the statement in the Report V14 (p19) that palliative care is not part of the review. A recent review of anonymous data from English trusts noted that palliative care should always form a central part of cancer care (NCEPOD, 2001) and found that a number of key recommendations from the Calman-Hine report (1995) were patchily implemented. It is recommended that the review includes palliative care, together with the full patient cancer pathway.
- 4.21 If the objectives are for higher quality services, which are cost-effective, affordable and sustainable, the review of cancer services can be used as an opportunity to audit the current provision and identify areas for improvement against criteria which stem from the objectives.

## Children's and maternity services

- 4.22 The consultation document proposed a reduction in paediatric 24 hour emergency in-patient care from three to one site, however as a result of the consultation responses and pending the WMSHA women's and children's service review, this has been withdrawn for the time being. The 24 hour paediatric assessment units that will be established at GE and WH have the potential to provide a more appropriate care environment for children integrating out-patients, day case and short term care for ill-children; this is to be complemented by care in the community and at home, with the specialist tertiary centre at UH. Again transfer arrangements and protocols are needed in the event of a stay more than 24 hours. Accommodation needs for families should be considered in the plans for the specialist centre.
- 4.23 There were also proposals to reduce obstetric in-patient care from three to one site and establish an enhanced midwife-led unit at GE, however these proposals were rejected. Instead plans for a Maternity Network linking provision across the 3 Trusts are to be developed to pool resources and enhance safety and effectiveness. Proposals should seek to reduce risks of poor maternal outcomes especially for high-risk groups such as women from ethnic minorities and/or who are socially excluded; local, accessible care is central to this. Once again a model of care involving shared, integrated care between primary and secondary care at all stages of pregnancy would be important (DH, 2004). The issues upon transport are pertinent to maternity. If services are arranged such that one site addresses high risk cases, the issue of how to transport a case that only becomes manifestly high risk after the onset of labour to minimise adverse risks will be important. The other issue is how the choice agenda will interface with these plans.
- 4.24 Clearly the decisions upon care of neonates are bound up with the options appraisal for maternity. Although SCBU provision is to be retained at both WH and GE, timely transfer of premature (27 weeks plus) or low birth weight babies has been shown to be associated with increased survival rates (CEDSI, 2003) with standards/guidelines for in-utero and ex-utero transfers. There is a statement that the changes to maternity and paediatrics will save resources, but this is difficult to determine before the proposals have been clarified. There were no data presented in the report or appendices upon projected births. A further analysis would also need to know about geographic and sub population variations in births as well as attitudes to service take up. A model is presented below which incorporates the main factors that influence the demand for maternity care. This could be developed to analyse the options that are developed during the course of the review.

### Figure 2 Model of Obstetric Care



## Care for older people

- 4.25 Although there are no formal proposals for older people, the principles and plans for older people were very comprehensive, the implementation of which is underpinned by an integrated health and social care system. Fundamentally it sees care in the home as an entitlement and services to be delivered to meet this right.
- 4.26 A tiered approach is planned for when someone presents with a health need. This starts with a single point of access and assessment process communicated between relevant agencies; this should reduce the complexity of accessing the right service and the need for multiple assessments.
- 4.27 Home-based re-ablement provided by community services has been successful in Coventry and is to be rolled out more widely; this should help keep older people in their homes rather than admitting them to hospital, where their mental health may suffer (DH, 2005). Community hospitals are to be developed, particularly in North Warwickshire where they are less well developed, providing local out of hospital care such as physiotherapy or occupational therapy; diagnostics and day surgery will be soon added to the services provided in community hospitals. This will reduce the need to travel far from home.
- 4.28 Local acute hospitals such as WH will provide access to A&E and ambulatory cancer services, with UH as the specialist trauma and cancer centre. Transport issues are the key issue for older people outside Coventry.
- 4.29 There is an assumption in the report that a change would be resource saving. However this may not be the case, e.g. see Little (2005). The distribution of the elderly population, their access to transport, the distribution of health conditions among them would need to be better understood.

## Planned care

- 4.30 These plans were also not formally consulted on. However they describe how planned care will be organised in the future: out of hospital, local 'office-based' care for out patient services and non-surgical specialities, such as rheumatology and ophthalmology, ambulatory care providing diagnostics and day case surgery at the 5 hospital sites, and specialist care for, e.g., heart surgery, neurosurgery, renal transplants.
- 4.31 This could potentially increase access to services ranging from routine out patients appointments to complex and highly specialised surgery. It also provides more choice to patients locally and through the rationalisation of these services and resources, could enhance effectiveness. Although quality of health outcomes is not associated with volume of activity for all specialisms, e.g., orthopaedic procedures (hip or knee athroplasty) it is for others, e.g., transplant surgery (Teisberg et al, 2001). Financial data on the viability of smaller units will need to be assessed; in addition the potential travel times of clinical staff and impacts on activity will also need to be considered.

## 5. Conclusion and recommendations

### Conclusion

5.1 The NHS in Coventry and Warwickshire are under a number of pressures, including:

- Debt which appears to be growing;
- National and local drivers to move more resources and services to the community;
- The growth of the independent sector;
- Patient choice;
- The NHS tariff;
- The PFI scheme at University Hospital; and
- The need for different sections of the NHS to collaborate at a time of increased competition

The biggest pressure is to ensure the re-organisation of services achieves greater benefit to the population of Coventry and Warwickshire, particularly currently disadvantaged populations.

5.2 The results from the screening of the proposals to meet some of these challenges suggest they will have predominantly positive impacts across the Review area. It identified Coventry and North Warwickshire as areas of multiple deprivation and associated poor health. It also identified that a high proportion of older people reside in South Warwickshire, with specific health needs. Access to public and private transport is a problem which potentially impact on access to health care. The Review has not considered the health needs of BAME population groups, high-risk groups for a number of conditions, as well as at risk of poor maternal and neonatal outcomes; it is recommended that this is built into future planning. Similarly the needs of disabled people need to be addressed as plans develop, particularly in relation to access. There are concerns that the low levels of GPs may inhibit the Plans' implementation in an integrated way that is with simultaneous developments in primary, acute and tertiary settings; the implications for the clinical and non-clinical workforce are significant and it is recommended that this is considered at an early stage.

5.2 The centralisation of some services such as emergency surgery, specialist cancer care will potentially contribute to improved health outcomes. In addition to centralisation clinical networks e.g., Emergency Care Network, will contribute to increasing effectiveness and also efficiency. The governance arrangements associated with these new bodies needs to be considered. Other aspects of the proposals indicate that they in line with national guidelines or good practice with the potential for improvements in the quality of care and health outcomes. However cancer services need to integrate palliative care into their plans. It is important to look at the impact of the review upon whole the cancer patient pathway. The opportunity could be taken to audit cancer services against the national criteria and local objectives. Developments in local women's and children's services are currently in abeyance as WMSHA undertake an SHA-wide review. However, the new Maternity Network will contribute to this; it will be important to assess the detailed proposals when they are produced. The plans for older people also seem well grounded with potential improvements in access and more effective care approaches. Plans for elective care are also acceptable although the financial status of smaller units will need to be assessed.

5.3 Although the screening results are generally favourable it cannot be emphasised strongly enough that this is not an exhaustive analysis; for a robust analysis it is recommended that a staged-comprehensive HIA is undertaken assessing the more detailed plans as they are developed, e.g., maternity and paediatrics.

### **Recommendations**

1. Transport  
Ensure the transport study considers the effects of increased travelling distances, time, cost, mobility and communication issues on disadvantaged groups;  
Build on multiple regression analysis and undertake an econometric analysis;
2. Data  
Develop a comprehensive dataset to inform planning, implementation and monitoring;
3. Plan development  
Cancer – integrate palliative care;  
Women’s and children’s – consider needs of high risk groups;
4. Equity  
Incorporate ‘equity’ as a principle for the Review and a criterion for planning services;
5. Governance  
Develop governance protocols for Network Boards that define the relationship with the host Trust;
6. Workforce  
Consider the implications for clinical and non-clinical staff across the health economy;  
Engage staff in the developments at an early stage;
7. HIA  
Undertake a phased, comprehensive HIA on different plan proposals.

## **Bibliography**

Abrahams, D, den Broeder, L, Doyle, D, Fehr, R, Haigh, F, Mekel, O, Metcalfe, O, Pennington, A, Scott-Samuel, A, (2004), European Policy Health Impact Assessment: A Guide. Liverpool: IMPACT, University of Liverpool.

Calman K and Hine D (1995), A Policy Framework for Commissioning Cancer Services, London: Department of Health

Coventry and Warwickshire Acute Services Review Board (2006) Final Report.

Coventry and Warwickshire Acute Services Review Board (2006) Consultation Document.

Royal College Of Psychiatrists (2005), Who cares wins. London: Royal College of Psychiatrists

Department of Health (2004), Maternity Standard, National Service Framework for Children, Young People and Maternity Services, London: DH Publications.

Department of Health (2004), Ill Child Standard, National Service Framework for Children, Young People and Maternity Services, London: DH Publications.

Healthcare Commission (2006), NHS Trust Annual Health Check Ratings, 2005/06  
<http://www.healthcarecommission.org.uk/yourlocalhealthservices.cfm>

Lambert, A., (2005), Coventry and Warwickshire Acute Services Review: Public Health Analysis. West Midlands Strategic Health Authority.

Little R (2005), Economic Evaluation of Intermediate Care, Chapter 9 in Roe B & Beech R, Intermediate & Continuing Care. London: Blackwell

NCEPOD (2005), An Acute Problem? London: NCEPOD

NCEPOD (2003), Who Operates When? II. [www.ncepod.org.uk/](http://www.ncepod.org.uk/)

NCEPOD (2001), Management of Malignancy [www.ncepod.org.uk/pdf/2001/01509.pdf](http://www.ncepod.org.uk/pdf/2001/01509.pdf)  
[accessed 3-1-2007](#)

NCEPOD (2001), Changing the way we operate. London: NCEPOD

Teamwork (2006) Impact of Clinical Redesign and Efficiency on Acute Capacity: Technical Analysis – Final Report. Bolton: Teamwork Management Services.

Quality Health (2006), Analysis of the Outputs on the Coventry and Warwickshire Acute Services Review Board.

Teisberg, P., Hansen, F., Hotvedt, R., Ingebrigtsen, T., Kvalvik, A., Lund, E., Myhre, H., Skjeldestad, F., Vatten, L., Norderhaug, I., (2001), Hospital volume and quality of health outcome. Oslo: NOKC