



Initial Equality Health Impact Assessment Form – Low level or Unknown Equality Impacts

Team/Directorate	Maternity	Senior Responsible Owner/Delegated Other	Heather Johnstone, Chief Nursing and therapies Officer (SSOT ICB)
Name and job role of person(s) completing this form:	Gina Gill, Transformation Programme Lead	Is this a new or existing policy, service or function	Existing Service
Title of policy, service or function being assessed:	Birthing Services at County Hospital, Stafford and Samuel Johnson Community Hospital, Lichfield	If not the Board, which delegated decision making body will be approving this proposal:	Integrated Care Board Meeting in Common
Summarise and list the overall aims and objectives of this proposal	The full EIA completed in 2024 provides the full background to this proposal including the evidence considered, the case for change and an overview of previous patient and public engagement. The purpose of updating this assessment is to provide additional information following a formal public consultation and targeted engagement that took place in 2026. An updated outline of the process has been included below.		

	Freestanding Midwifery Units are midwife-led units, separate from an acute hospital, where some women (considered low-risk) can choose to give birth. They do not provide immediate obstetric, neonatal, or anaesthetic care, so people may need to be transferred to an acute hospital if there are complications during or after birth. In March 2020, at the beginning of the Covid-19 pandemic and in line with national guidance, birthing services at both at County Hospital, Stafford and Samuel Johnson Community Hospital, Lichfield were temporarily suspended to consolidate the midwifery workforce at the main acute sites. Whilst the initial closures were directly related to COVID-19, significant staffing challenges in the maternity workforce have prevented both Trusts from being able to safely reopen these units. Following a robust options appraisal process, in September 2023 a maternity technical group agreed that the only viable proposal was to make permanent the service changes the Trust made in 2020. The ICB subsequently approved the pre-consultation business case (PCBC) that outlined the evidence and proposal and agreed to a twelve-week formal public consultation. A comprehensive stage 2 EHIA was completed and approved in 2024. The assessment considered the impacts of the viable proposal and any mitigating factors. This updated EHIA has been completed to include any new and additional information following the formal public consultation. As a result, information that is unchanged has not been repeated in this update and the original EHIA should be read in conjunction with this update. The consultation built on relationships already established with stakeholders and used a range of methods to obtain feedback. Full details are available in the Report of Findings. Feedback was received at a further maternity technical group in November 2025. During the public consultation it was highlighted that there were elements of antenatal care that were in place prior to COVID-19 at Samuel Johnson Community Hospital that have not been reinstated. The group therefore recommended a further four-weeks engagement targeted at UHDB antenatal services to gather the views of women and their families on this element of the pathway.
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	Feedback was received at a further maternity technical group in April 2026 where no new proposals were suggested, and it was agreed the ICB could proceed to a decision-making business case (DMBC). This EHIA is an update to the original and will support that decision-making. Key themes that have emerged throughout public involvement and consultation have been: • Travel and access • Patient Choice • Impact on other hospitals <u>Travel and Access</u> Travel emerged as an early key concern of patients, birthing partners and family members. It was also highlighted as a concern by the Staffordshire Health Overview and Scrutiny Committee. A detailed travel analysis was completed during the development of proposals to clarify the travel impacts of centralising birthing services at the acute Trust sites. The full analysis is available in the PCBC and was included within the quality impact assessment completed in 2024. Travel was also raised as a key concern during the additional engagement around antenatal services at Samuel Johnson Community Hospital. Up until 2020, there were 8 bookable slots per week for Glucose Tolerance Test(GTT)¹ and 8 bookable slots per week for Anti-D² immunoglobulin administration available at Samuel Johnson Community Hospital. The GTT appointment slots were regularly filled while the Anti-D immunoglobulin appointment slots were underutilised. Both of these clinics are now offered at Queen's Hospital, Burton.
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¹ GTT is a blood test used to diagnose gestational diabetes, which can occur during pregnancy. If a woman has one or more risk factor, they are invited to have a GTT test for diagnosis.

² Anti-D is offered at 28 weeks gestation to pregnant people with a RD- negative blood group. This is a preventative safety measure, that protects against small, unpredictable fetal blood exposure that could otherwise cause the mother to develop antibodies and affect her current pregnancy

	During the maternity technical meeting, the group recognised the additional travel impact as a result of the proposals but noted that the majority of appointments and support during the pregnancy continue to be provided closer to home, in the local community which reduces the impact on travel. The group also referenced the changes to the Anti-D immunoglobulin pathway with the NICE Evidence-based recommendations on high-throughput non-invasive prenatal testing (NIPT) for fetal RHD genotype. NIPT is recommended to determine the fetal genotype from a maternal blood sample. This offers a more personalised approach because Anti-D immunoglobulin is therefore only administered if the foetus is rhesus positive which therefore reduces the number of women who require Anti-D immunoglobulin. Prior to the introduction of this guidance, all women with a rhesus negative blood group would have been offered Anti-D immunoglobulin. Evidence included within the NICE guidance highlights that up to 37.1% of women avoided unnecessary anti D immunoglobulin following the introduction of a NIPT programme. The travel analysis also demonstrated that choice of place of birth can be a factor over travel time as 25% of the cohort analysed chose to travel further to an FMBU rather than to their nearest maternity unit. The consultation and engagement further highlighted people's preferences to attend clinics outside of our local area with positive feedback on people's experiences when attending such clinics. During the consultation, concerns were raised over the safety of the mother and baby when travelling long distances to access care. As described within the 2024 Quality Impact Assessment, a safety sense check was completed during 2020 to assess the impact of COVID-19. This covered a number of key indicators and neither Trust reported any impact on safety at that time. Both Trusts continue to monitor incidents in line with local incident management policies and there has been no increase in the number of incidents as a result of the temporary closure. Prior to the pandemic a proportion of those who gave birth within County Hospital and Samuel Johnson Community Hospital subsequently needed to be transferred to an acute site for additional support. Centralising birthing services improves responsiveness to any intervention required due to the
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proximity of interdependent services at the acute sites compared to within a stand-alone unit where an ambulance transfer would be required with potential risks of delay.

Choice

Patient choice emerged as a key concern during the public consultation and additional engagement, with participants expressing their desire to choose midwife-led services and concerns that care may become medicalised without the option of a standalone birthing unit.

The Better Births Five Year Forward View for Maternity Care states that women must be offered the choice of home birth, midwife-led births and obstetric-led births, however it does not state whether midwife-led births should be within a freestanding unit. An alongside midwife-led unit provides the same service as a freestanding unit and therefore satisfies the choice requirements outlined within national strategies. Both Trusts continue to offer the choice of a consultant-led or midwife-led birth at Royal Stoke University Hospital and Queen's Hospital, Burton alongside the choice of a home birth.

All women are asked about their preferred choice of delivery during an assessment with the midwife. The midwife will take a number of factors into consideration including a woman's weight, age, overall health and any history of previous deliveries. All women who are considered to be in a safe range for these factors and having just one baby will be given the choice of where to deliver. Women continue to be assessed throughout their pregnancy to check for any developing risk factors or complications, which may require a change of recommended delivery options. Both Trusts stated that alongside units maintain the same philosophy of care as standalone units and confirmed that the alongside centres offered excellent midwife-led care, stressing that ethos and delivery of care were priorities for midwifery team, regardless of location

Some women also choose to give birth within hospitals outside of Staffordshire such as Good Hope, Walsall Manor in Walsall, New Cross in Wolverhampton, Royal Derby Hospital or Shrewsbury and Telford NHS Trust, for convenience to their place of residence. Women will continue to have the choice of delivery at alternative providers.

	<u>Impact on other hospitals</u> Feedback was received during the public consultation about the potential impact of the proposal on other hospitals with participants raising concerns about the increased demand on other services and the capacity of midwife-led care. Capacity and demand modelling for maternity, including inductions of labour, is based on staffing capacity rather than physical bed capacity. Modelling has been completed using the nationally recognised Birthrate Plus® assessment tool. This is completed every three years to ensure there is sufficient staffing and takes into account both the local birth rate and the complexity of the caseload. Both Trusts have confirmed there is sufficient low risk capacity within Royal Stoke and Queen's Hospital to meet current demand with ongoing recruitment programmes to maintain staffing levels in line with Birthrate Plus®. With regard to physical capacity, there are designated rooms for low-risk births within Royal Stoke and Queen's Hospital. This is ring-fenced capacity for low-risk births meaning that an increase in demand within other areas of maternity will not impact on the Trusts ability to offer low-risk, maternity-led care. Both sites have the ability to flex other delivery rooms to provide low-risk care as required. If additional capacity were required, women would be supported to have a midwife-led birth within the consultant-led units Both Trusts are committed to retaining midwifery led birthing options for women on a low-risk pathway and confirm that there have been no adverse impacts on capacity since the temporary closure of birthing services at the FMBUs. Inequalities in maternity care It is recognised that inequalities in maternity outcomes persist at both a national and system level, in line with national evidence highlighted within the NHS Long Term Plan and the Three Year Delivery
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	Plan for Maternity and Neonatal Services. Women from Black, Asian and minority ethnic backgrounds, those living in areas of deprivation, and women with multiple or complex social factors continue to experience disproportionately poorer outcomes. Addressing these inequalities is a key national priority, reflected in the CORE20PLUS5 approach for maternity, which focuses on reducing inequalities in maternal and neonatal outcomes. In developing this proposal, consideration has been given to how these inequalities may be impacted, particularly in relation to travel, access and continuity of care. While the centralisation of birthing services may increase travel time for some women, the majority of antenatal and postnatal care continues to be delivered within community settings to minimise disruption and support equitable access, consistent with the Better Births ambition to provide care closer to home. Support planning, prevention and early identification of risk in line with Saving Babies' Lives Care Bundle, and strengthened community outreach aims to reduce unwarranted variation in outcomes and ensure women receive safe, equitable and culturally competent care.
	Accessible and inclusive information All women receive an individualised risk assessment and personalised care plan, which includes options around place of birth, as part of their holistic needs. This also includes assessing any access requirements and communication needs. In line with the NHS Accessible Information Standard and health inequalities priorities, information is provided in a range of formats to support accessibility. This includes access to translation and interpretation services, easy read materials, and culturally appropriate communication. Women are supported to understand their care and make informed decisions through personalised discussions, with reasonable adjustments made for those with additional needs such as sensory impairment, learning disability or limited English proficiency.

	Engagement activities undertaken as part of the consultation process reflect national best practice in inclusive engagement, with targeted work to reach underserved communities and inclusion health groups to ensure that a broad range of experiences and perspectives have informed the proposal.			
	Support for women and families Women are supported throughout their maternity journey in line with the Better Births vision for personalised, safe and woman-centred care. This includes personalised care and support planning, regular review of needs, and access to multidisciplinary services to ensure safe and responsive care. Additional support is available for women with identified vulnerabilities or additional needs, including safeguarding, perinatal mental health services, and referral to specialist pathways in line with national guidance. Consideration of wider determinants of health, including transport and access, forms part of care planning to minimise barriers to care. Women continue to be supported to make informed choices about their care, including options for home birth, midwife-led care within alongside units, and consultant-led care. This reflects national policy requirements to maintain choice and ensure that care is delivered safely, with access to appropriate clinical support when needed			
Will patients, carers, the public, staff or other stakeholders e.g. providers or the voluntary sector be affected by this policy, service, function proposal? Insert cross as appropriate.		Yes	No	If yes, provide a brief explanation Women and their families may be affected by this proposal. The proposal is covered in detail within the original EHIA including consideration as to how different groups may be disproportionately affected by this proposal. The key impacts identified through the public consultation were identified as travel, choice and impact on other hospitals. Mitigating factors for these impacts has been described above. The report of findings includes an assessment of
	Patients	☒	☐	
	Carers	☐	☐	
	Public	☐	☐	
	Staff	☐	☐	
	Other	☐	☐	

				Through the public consultation, an additional travel impact for women who would have attended Samuel Johnson Community Hospital for their Glucose Tolerance Test (GTT) or Anti-D immunoglobulin administration. The nature of the coding of these appointments (i.e. antenatal appointments) means the demographics of those who would have attended these clinics cannot be disaggregated. Additional engagement was conducted to identify the impact to women and this did not identify any specific or disproportionate or impact for people with a protected characteristic. A key impact identified through this targeted engagement was travel and the mitigating factors have been described above.
Have you engaged or consulted with patients, carers, the public, staff or other stakeholders e.g. providers or voluntary sector in the development of this policy, service or function proposal? Insert cross as appropriate.	Patients	☒	☐	If yes, please provide brief details: • Patient, public and stakeholder involvement took place across 2019–20 as maternity services in Staffordshire and Stoke-on-Trent were considered as part of a wider transformation programme (Together We're Better Programme). • Further targeted maternity engagement via six focus groups was held in 2020 also as part of the Together We're Better Programme • Following a pause in engagement during 2020 as a result of the pandemic, further engagement was undertaken in 2021 to understand whether there were any additional considerations about the future of maternity services, or any further proposals which had not been considered.
	Carers	☒	☐	
	Public	☒	☐	
	Staff	☒	☐	
	Other	☒	☐	

[illegible]

Will this policy/service/function require reasonable adjustments or mitigating actions to be taken to address poor access, experience or outcome differences for people with protected characteristics or people from inclusion health groups? All women receive an individualised risk assessment and personalised care plan, which includes options around place of birth, as part of their holistic needs. This is regularly reviewed at every contact during the pregnancy		☐	☒	☐	☐
a) If your response is <u>Yes</u> to the above question can these reasonable adjustments or actions be easily implemented prior to the proposal being activated?		☐	☐	☐	☐
b) If your response to the above question is <u>No</u>, could you (if required) evidence or justify this?		☐	☐	☐	☐
Have you considered accessible and inclusive information and is this reflected in any policy, service or function agreements and communications? All women receive an individualised risk assessment and personalised care plan, which includes options around place of birth, as part of their holistic needs. This also includes assessing any access requirements and communication needs.		☒	☐	☐	☐
Assessment Decision – Approve and finish at Initial Stage					
Approve: ☒ Yes ☐ No			Full Assessment Required ☐ Yes ☒ No		
State the full name and title/s of the responsible person approving the assessment at the Initial Stage					
Name/s: Granville Thelwell		Job Title: ICB Equality Diversity Inclusion Business Partner		Date: 15.06.2026	
EDI Business Partner Comments:					

Thank you for completing the Initial Equality Health Impact Assessment and providing comprehensive additional information following the formal public consultation and targeted engagement undertaken in 2026.

On review of the documentation, and alongside any one-to-one discussions where applicable, I am satisfied that the level and quality of evidence provided is proportionate and sufficient to demonstrate due regard to the Public Sector Equality Duty under the Equality Act 2010. The decision to complete an Initial Assessment, rather than an Amendment/Update template, is appropriate given the extent of new and enhanced information arising from the consultation and engagement activity.

I can therefore approve and close this assessment at this point.

Should there be any further changes to the proposal, please ensure that an Amendment to the Equality Health Impact Assessment is completed and submitted to the EDI Business Partner at: granville.thelwell@staffstoke.icb.nhs.uk