

Path to Excellence: An Independent, Integrated, Equality, Health and Health Inequalities, Impact Assessment.

Proposals to change and improve Urgent and Emergency Paediatric Services in South Tyneside and Sunderland

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Executive Summary

The Path to Excellence is a five-year transformation of healthcare provision across South Tyneside and Sunderland that has been set up to secure the future of local NHS services.

This report presents a desk top Integrated Impact Assessment (IIA) of the two options which have been proposed as part of the reconfiguration of acute paediatric services across South Tyneside and Sunderland. Option 1 entails providing a 12-hour day-time paediatric Emergency Department (ED) service at South Tyneside District Hospital (STDH) with 24/7 paediatric ED at Sunderland Royal Hospital (SRH). Option 2 entails the development of nurse-led paediatric minor injury/illness service between 8am-10pm at STDH with 24/7 acute paediatric services at SRH.

Both options include changes to the provision of the Special Care Baby Unit in South Tyneside. The IIA of obstetrics services examines the impact that changes to provision of special care for babies could have on new mothers and their babies.

The IIA comprises an Equality Impact Assessment, and a Health and Health Inequalities Impact Assessment. The assessments were based on research evidence and measures of population health, health care and health inequalities (see Appendix 3 for a summary of the evidence and statistics).

For each of the two possible reconfiguration options, the assessment generated Equality Impact Scores for each equality group, and Health and Health Inequalities Integrated Impact Scores relating to eighteen attributes across four domains of health (Health Outcomes; Access to High Quality Health Care; Environment; Economy) relating to acute paediatrics services.

The results of this IIA of acute paediatric services suggested that the changes could have a greater effect on communities in South Tyneside and on certain vulnerable groups, most notably:

- Children, carers and families affected by socio-economic deprivation,
- Children, carers and families affected by substance or alcohol misuse
- Children, carers and families affected by physical or mental illness, disability or sensory impairment
- Infants and Young people
- BME communities
- Children in need of safeguarding
- Pregnant and recently delivered mothers and their babies

The IIA impact scores gave a crude indication of the relative scale and direction of possible impacts. Positive impact scores were higher for Option 2 than Option 1 due to the greater cost-efficiency savings associated with that option. However, negative impact scores were also higher for Option 2 because the

changes associated with that option are more far reaching and affect greater numbers of children. The total (net) IIA impact scores were overwhelmingly positive and small scale negative scores were only identified for three attributes - acceptable healthcare, pollution and housing.

Total HIIA Impact scores		
	Option 1	Option2
Total positive integrated impact score	130	133
Total negative integrated impact score	-51	-88
Total Integrated Impact Scores	79	45

This report includes some suggestions around actions that could mitigate against the identified drawbacks. These suggestions could enable stakeholders to identify how they can contribute to the reconfiguration so that the benefits can be maximised. The suggestions largely relate to patient transport, organisational development, quality improvement, education and training, monitoring and evaluation.

The IIA provides strong evidence that the proposed changes could achieve overwhelmingly positive impacts on health and inequalities. These benefits related to the ability of the changes to result in:

- More sustainable and consistent high quality care, regardless of the day of the week or the time of day
- Safer Care due to improved levels of specialist staffing able to assess and treat children promptly
- Improved levels of specialist staff and resources able to deal with rising population needs in terms of scale and complexity
- Cost savings in the face of economic austerity

These achievements could have profound benefits for children in relation to

- More effective and timely treatment of acute illnesses
- Less risk of deterioration
- Less pain and distress due to delays in assessment and treatment
- Shorter hospital stays and less readmissions or readmissions
- Improved capacity to identify and safeguard children in need

Ultimately, because of their benefits for all service users as well as vulnerable and equality groups, the proposed service improvements could lead to significant benefits to child health and inequalities across South Tyneside and Sunderland, giving children 'a better start in life' and 'enabling all children,

young people and adults to maximize their capabilities and have control over their lives'¹.

This IIA provides evidence based information to underpin the Path to Excellence rational planning and consultation process for the proposed reconfiguration of Acute Paediatric Services. It enables all stakeholders to contribute to the consultation process with due regard to the public sector duties around equality and health inequalities.

¹ The Marmot Review. Fair Society, healthy lives. Strategic review of Health Inequalities in England post 2010

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1 Introduction

Path to Excellence is a five-year transformation of healthcare provision across South Tyneside and Sunderland.

The transformation has been set up to secure the future of local NHS services and to identify new and innovative ways of delivering high quality, joined up, sustainable care that will benefit the population of Sunderland and South Tyneside both now and in the future.

One of the first developments is a Clinical Services Review of Acute Paediatric Services across City Hospitals Sunderland and South Tyneside Foundation Trusts. The review aims to overcome current challenges relating to quality, sustainability and cost-effectiveness of the current service configuration. Two possible solutions have been identified to support the sustainability of urgent and emergency paediatrics services across the two districts.

In order to identify and plan for possible impacts on equality, health and health inequality, the Path to Excellence team commissioned an independent desk based Integrated Impact Assessment (IIA) of the proposed solutions.

This report describes the approach to, and the results and recommendations of, an independent Integrated Impact Assessment of the possible models considered as part of the proposed reconfiguration of acute paediatric services.

2 Integrated Impact Assessment (IIA)

2.1 Context

The NHS is committed to promoting equality and reducing health inequalities. These principles are embedded in the NHS constitution²:

- *a comprehensive service, available to all irrespective of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status.*
- *to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population.*

² The NHS constitution for England Department of Health 2015

In order to ensure these goals are met, all changes to NHS services are subject to a rigorous assurance process³.

This assurance process comprises two major aims:

1. Eliminating discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it;
2. Identifying and reducing any inequalities in access to, and outcomes from, health care services and ensuring service are provided in an integrated way where this might reduce health inequalities⁴.

Integrated impact assessments can provide information to inform this assurance process.

2.2 Approaches to Integrated Impact Assessment

Integrated Impact Assessment (IIA) is a method of estimating the possible implications, intended and unintended, of policies, plans, strategies, projects or initiatives. An IIA examines how any proposal could affect the communities served and how these effects may be distributed amongst different groups within the community. The aim of IIA is to make recommendations to enhance potential positive outcomes and minimise negative impacts of a proposal.

There is no one single definition of, or approach to, IIA. Integrated assessments can consider a wide range of topics but will consider them simultaneously where previously they would have been considered separately.

2.3 Commissioned Remit

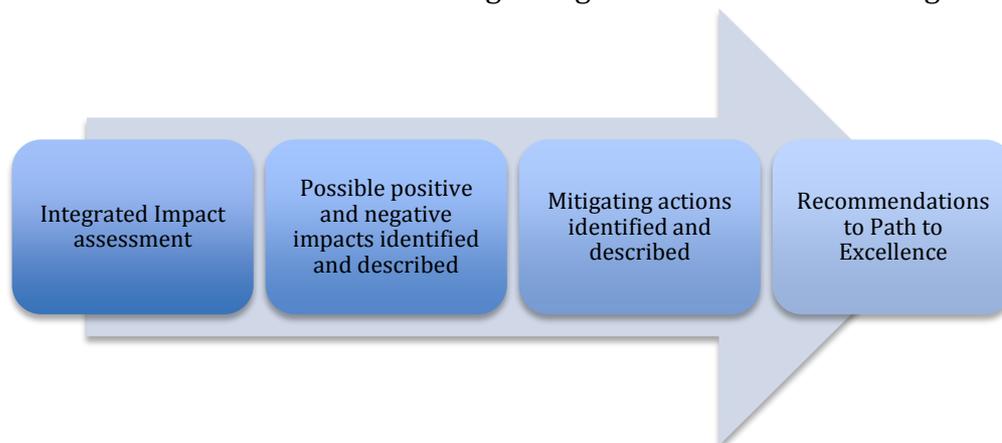
The remit was to undertake an integrated impact assessment that would consider the positive and negative impact that each possible service model could have on

- equality groups
- population health outcomes,
- population health inequalities

³ NHS (2015) Planning, assuring and delivering service change for patients: a good practice guide for commissioners on the NHSE assurance process for major service changes and reconfigurations.

⁴ NHS England (2015) Equality and Health Inequalities legal duties: Guidance for NHS Commissioners on Equality and Health Inequalities legal duties

If the assessment identified any potentially negative consequences, there was a remit to make recommendations regarding how these could be mitigated.



The commissioned aims were:

a) To explore the overall health impact (+ve, neutral, or -ve) and the impact on health inequalities (+ve, neutral, or -ve) in relation to:

- Service outcomes;
- Service activities;
- The safety of the service;
- The quality of the service;
- Sustainability and resilience of the service (including its ability to respond to projected demographic changes);
- Access to the service;
- Choice for patients, their families and carers;
- The mental, social and emotional wellbeing of patients, their families and carers.

AND

b) To explore the equalities impact (+ve, neutral, or -ve) in relation to:

- Age
- Disability
- Gender reassignment
- Marriage and Civil Partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation
- Deprivation or social economic status.

3 The Integrated Impact Assessment (IIA) Methods

3.1 Overall Approach

The approach combined three different methodologies and associated NHS guidance:

- Equality Impact Assessment (EqIA)⁵;
- Health Inequalities Impact Assessment (HIIA);
- Health Impact Assessment (HIA) ⁶

These methods were combined to develop assessment tools which were used in combination to generate a single integrated assessment of each proposed service model as indicated by Figure 1.

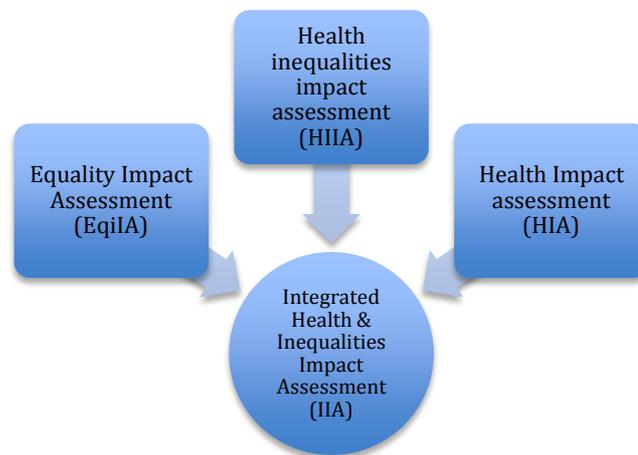


Figure 1: Overview of the methods used in the Integrated Impact Assessment

3.2 Concepts and definitions underpinning the IIA

The assessment tools were developed with relevance to key concepts and definitions summarised in Box 1.

Health - Health is a complex, multidimensional concept. The most commonly adopted definition is that formulated by the World Health Organisation in 1948 :
“a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”

⁵ The NHS Centre for Equality and Human Rights. A toolkit for carrying out Equality Impact Assessment

⁶ DH (2010) Health Impact Assessment Tools. Simple tools for recording the results of the Health Impact Assessment.

In 1986, in response to modern ideas around molecular, individual and societal influences on health, the European Regional Office of the WHO redefined health as “*a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities*”⁸.

Both definitions are frequently criticized as being idealistic or unattainable and alternative definitions continue to be debated⁹.

Health impact - A health impact can be positive or negative. A positive health impact is an effect which contributes to good health or to improving health. A negative health impact has the opposite effect, causing or contributing to ill health¹⁰.

Health Inequalities - Health inequalities can be defined as differences in health status or in the distribution of health determinants between different population groups¹¹. Health inequities are *avoidable* inequalities in health between groups of people. These inequities arise from inequalities within and between groups in society. Social and economic conditions and their effects on people’s lives determine their risk of illness and the actions taken to prevent them becoming ill or treat illness when it occurs¹².

Equality - Equality is about ensuring that every individual has an equal opportunity to make the most of their lives and talents, and believing that no one should have poorer life chances because of where, what or whom they were born, what they believe, or whether they have a disability.

Equality recognises that historically, certain groups of people with particular characteristics e.g. race, disability, sex and sexuality, have experienced discrimination.

The Equality Act 2010 brings together for the first time all the legal requirements for the private, public and voluntary sectors, making existing equality laws simpler, more effective and easier to understand.

To meet the needs of disabled people, the Equality Act 2010 states that reasonable adjustments can be made for disabled people, and that it is not unlawful discrimination to treat disabled people more favourably than non-disabled people because of their disability¹³.

Equity - Equity in health can be defined as the absence of systematic disparities in health (or in the major social determinants of health) between social groups who have different levels of underlying social advantage/disadvantage¹⁴.

⁷ World Health Organization. (2006). Constitution of the World Health Organization – Basic Documents, Forty-fifth edition, Supplement, October 2006.

⁸ WHO (1986) First International Conference on Health Promotion, Ottawa,

⁹ Huber M. How should we define health? *BMJ* 2011;343

¹⁰ WHO (accessed February 2017) Health Impact Assessment: glossary of terms used

¹¹ WHO (accessed February 2017) Health Impact Assessment: glossary of terms used

¹² WHO (accessed February 2017) Social determinants of health – key concepts)

¹³ Equality and human rights commission

<https://www.equalityhumanrights.com> last accessed February 2017

¹⁴ Braveman P, Gruskin S Defining equity in health *Journal of Epidemiology & Community Health* 2003;57:254-258.

Health impact assessment is usually underpinned by a focus on social justice in which equity plays a major role¹⁰.

Equitable access has been defined as “care that does not vary in quality because of personal characteristics, such as gender, ethnicity, geographical location and socio-economic status”¹⁵.

Box 1: Concepts and definitions supporting the Integrated Impact Assessment

3.3 The Service Models addressed by the IIA.

The proposed reconfiguration of urgent and emergency paediatric services aims to enable cost-effective, sustainable, service quality improvements and assurance across South Tyneside and Sunderland.

Two possible solutions which were assessed during the IIA are summarised below. Full details of each, supported by comprehensive business cases, are provided in the Path to Excellence suite of documents.

Option 1: provision of 12-hour day-time paediatric ED service at STDH with 24/7 paediatric ED at SRH. The service would operate at STDH from 8am to 10pm (doors closing at 8pm to allow children to be treated and discharged) The service would continue with full medical support.

Option 2: Development of nurse-led paediatric minor injury/illness service between 8am-10pm at STDH with 24/7 acute paediatric services at SRH.

Under both options outpatient and community based paediatric services would continue to be provided within South Tyneside and Sunderland.

3.4 Key Interdependencies

Both possible options entail the relocation of the Special Care Baby Unit (SCBU) at STDH to SRH. This has specific implications for maternity services and perinatal care. The impact of this closure was fully considered within the integrated impact assessment of proposed changes to obstetric services. Further details of this assessment are available in the Path to Excellence suite of documents.

As part of the Path to Excellence planning process, more detailed consideration and modelling is underway regarding implications for travel, transport and ambulance services. These assessments will provide vital information but were not available to inform this IIA .

¹⁵ Millman M, ed. *Access to health care in America*. Washington, DC: National Academy Press, 1993.

3.5 The local context

South Tyneside and Sunderland are both recognised to face significant health challenges relating to socioeconomic deprivation, health inequalities, long term unemployment and poor health outcomes^{16, 17,18,19}.

South Tyneside has slightly worse deprivation scores than Sunderland, with a higher proportion of the population living in the most deprived neighbourhoods in England. Long term unemployment rates are also higher in South Tyneside than Sunderland.

The life expectancy gap for females in South Tyneside is slightly higher than Sunderland (8 years compared with 7.6 years). The life expectancy gap for males is higher than that for women in both areas and is higher in Sunderland (9.9 years) than in South Tyneside (8.6 years).

The population of Sunderland is almost twice that of South Tyneside. Both areas have a similar proportion of children (20%)²⁰ with almost one quarter of them living in low income families and very small numbers with mothers born in the Middle East and Asia²¹.

	South Tyneside	Sunderland
Number and percentage of children living in low income families	6,565 (26%)	11,525 (24%)
Number and Percentage of babies born to mothers born in Middle East and Asia (%)	61 (4%)	94 (3%)

Box 2: Selected demographic details of deprivation and BME communities in the local population

Comparative statistics indicate that both localities experience high rates of rates health care utilisation which, for acute paediatric problems, are higher than the national average²⁰. Children’s A&E attendance rates are significantly greater than their admission rates as indicated in Box 3

South Tyneside	Sunderland

¹⁶ Sunderland Council: Annual report of the Director of Public Health 2015

¹⁷ South Tyneside Council : Annual report of the Director of Public Health 2015

¹⁸ South Tyneside Council : Joint Strategic Needs Assessment 2013-2014

¹⁹ Sunderland Council: JSNA suite of documents

²⁰ Source ONS - see Appendix 3 for more details

²¹ Source PHE - see Appendix 3 for more details

Number of A&E attendances 0-19 year old 2014/15	18,466	45,442
Number of emergency hospital admissions 2014/15	2,720	5,353

Box 3: Healthcare utilisation data

3.6 Assessment tools

3.6.1 Equality Impact Assessment

The EqIA was conducted with reference to the following groups:

- Sex /Gender
- Sexual orientation
- Gender reassignment
- Race
- Marriage / civil partnership
- Pregnancy and maternity
- Religion or belief
- Disability
- Emotional wellbeing
- Socio-economic deprivation
- Age

3.6.2 Health and Inequalities Impact Assessments

These assessments examined health and health inequalities impacts relating to four domains of health and wellbeing:

- Health care outcomes
- Access to high quality Health Care;
- Environmental determinants of health;
- Economic determinants of health.

Specific health attributes were identified for each of these domains. To meet the contract brief, there was a greater emphasis on health and wellbeing outcomes and access to health care.

Five, service specific, health & wellbeing attributes were developed with reference to expert consensus regarding acute paediatric service outcomes ²². These attributes were:

1. Timely and effective management of acute illness – to achieve resolution and avoid unnecessary suffering or worsening of the condition

²² RCPCH (accessed from website February 2017) Service Level Quality Improvement Measures (SLQMAPS)

2. Emotional wellbeing including pain management, anxiety and distress
3. Health promotion to address biological risks and lifestyle risks to future health eg obesity, contraception,
4. Safeguarding children from harm
5. Avoidable health care eg length of stay, readmissions,

The attributes adopted for each of the four domains are listed below:

Acute paediatric service outcomes	Access to high quality health care	Environment	Economy
1. Timely and effective management of acute illness	1. Effective health care	1. Transport	1. Education, skills, learning
2. Emotional wellbeing	2. Safe health care	2. Natural and built environment	2. Employment
3. Health promotion	3. Cost - Efficient health care	3. Pollution	3. Business development and investment
4. Safeguarding	4. Sustainable health care relevant to population need	4. Housing	4. Financial inclusion
5. Avoidable health care, (health inequalities)*	5. Acceptable health care (patient experience)		
6.	6. *(Equitable health care)		

Box 4: Health & Wellbeing Attributes in each of the four domains

* Impacts on equity, equitable access and health inequalities are embedded throughout the assessment rather than being assessed individually.

3.6.3 The population for assessment

This assessment explored the impacts on the current and future population resident or working in South Tyneside and Sunderland Local Authority areas with respect to changes to acute paediatric services in those localities.

Within these populations, specific attention was given to those groups most affected by the proposed reconfiguration:

- Children with acute paediatric illness living in South Tyneside and Sunderland
- Parents, carers, relatives and friends of the children with acute paediatric illness living in South Tyneside and Sunderland
- Staff currently working in acute paediatric services across South Tyneside and Sunderland
- The communities resident in South Tyneside and Sunderland.

3.6.4 Evidence and indicator reviews

Each assessment was preceded by a review of the evidence and indicators relating to relevant equality, inequality and care quality issues both nationally

and locally. The reviews highlight relevant priorities and concerns and details of the communities affected by the reconfiguration. Full details of the evidence sources and a summary of the findings, are provided in Appendix 3.

The findings of these reviews were used during the assessment to

- develop appropriate health attributes relating to the services being reconfigured
- identify possible impacts on the equality, health and inequalities of the communities affected by the service reconfiguration
- make judgements of impact severity and scale and assign appropriate scores

The main data sources were Office of National Statistics (ONS) Neighbourhood Statistics for Local Authority Areas and Public Health England (PHE) profiles. Evidence was generated by published medical research, professional audits, international reviews, and best practice guidelines.

This assessment process was underpinned by two, well documented, strands of evidence (see review in Appendix 3)

- vulnerable groups are more likely to need and use acute paediatric services and can therefore significantly benefit from improvements in the quality of services provided.
- high quality children's services can help to improve health outcomes and reduce health inequalities by giving children 'a better start in life' and 'enabling all children, young people and adults to maximize their capabilities and have control over their lives'²³.

3.6.5 Impact scores

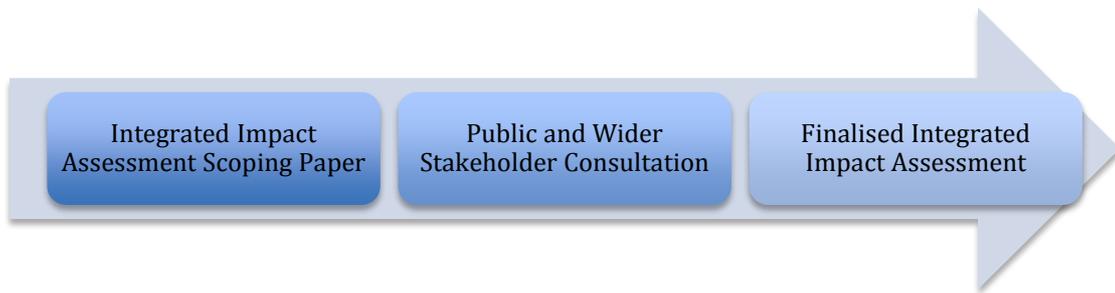
The scoring systems reflected those recommended in the NHS recommended toolkits, and were a product of the level of available evidence and an assessment of the scale of the impact in terms of severity and numbers affected. Full details are available in Appendix 1 and Appendix 2.

Following the assessment, scores were graded as falling into three categories of impact : Major – Moderate - Minor. These categories were colour coded to give an 'at a glance' overview of the impacts on the different health issues and equality groups.

3.7 Assumptions and Limitations

Stakeholder engagement is recognised as fundamental to high quality impact assessments. This review was commissioned as a desktop exercise to identify and outline key issues that could enable wider stakeholder consultation and more detailed subsequent assessment.

²³ The Marmot Review. Fair Society, healthy lives. Strategic review of Health Inequalities in England post 2010



The assessment was undertaken in parallel with a review of the travel and transport implications of the proposed reconfiguration and discussions of the impact on North East Ambulance Services. The results of those discussions and reviews were not available to inform this assessment.

The assessments use a population based methodology to consider scale and severity of impact with respect to groups of people who share similar characteristics.

3.8 Language

Wherever possible, this report has avoided specialist medical and healthcare language and terminology in order to widen accessibility and promote engagement.

4 Integrated Impact Assessment Findings

This section describes the results of the equality impact assessment and the health & inequalities impact assessment.

Further details of the Equality Impact Assessment (EqIA) findings are presented in Table 1 and the positive, negative and total impact scores are presented in Table 2.

The findings from the Integrated Health and Health Inequalities Impact Assessment (HIIA) are fully described in Table 3 and the scores are summarised in Table 4.

All of the findings were developed with reference to the data, indicators and evidence presented in Appendix 3 and the scoring systems described in Appendices 1 and 2.

Throughout this Section, the labels Option 1 and Option 2 are used to denote the following possible solutions arising from the Path to Excellence reconfiguration of acute paediatric services:

Option 1: provision of 12-hour day-time paediatric ED service at STDH with 24/7 paediatric ED at SRH. The service would operate at STDH from 8am to 10pm (doors closing at 8pm to allow children to be treated and discharged) The service would continue with full medical support.

Option 2: Development of nurse-led paediatric minor injury/illness service between 8am-10pm at STDH with 24/7 acute paediatric services at SRH.

4.1 Integrated Impact Scores

The absolute numeric scores should be considered with caution as the scoring system is blunt. The figures should be considered as crude indicators of the direction of impact rather than accurate measures.

4.1.1 Positive EqIA and HIA Impact Scores

Positive equality impact scores

The positive EqIA impact scores for each option and equality group are summarised in the Box below:

Equality group	Positive Equality Impact Scores	
	Option 1	Option 2
Sex/ gender	9	9
Sexual orientation	9	9
Gender reassignment	9	9
Race	9	9
Marriage and civil partnership	9	9
Pregnancy / maternity	9	9
Religion or belief	9	9
Disability	9	9
Socioeconomic deprivation	9	9
Age	9	9

Box 5: Positive EqIA impact scores

These results show that both the proposed solutions have the potential to transform the provision of high quality acute paediatric services with all equality groups benefiting equally across Sunderland and South Tyneside

The scale of the benefits was identical for both Options.

Positive health and inequalities impact scores

The positive HIIA impact scores across the four domains and the related 18 service-specific attributes of health status are summarised in the table below:

Impact Domains	Impact Domain Attributes	Total POSITIVE integrated health and health inequality impact score	
		Option 1	Option 2
Health status relating to use of acute paediatric services	Disease management	18	18
	Emotional Wellbeing	18	18
	Prevention	18	18
	Safeguarding	13	13
	Avoidable health care	11	11
Health status relating to access to high quality health care	Effective health care	18	18
	Safe health care	12	12
	Cost efficient health care	6	9
	Relevance to healthcare need	8	8
	Acceptable health care	2	2
Health status relating to Environmental determinants of health	Transport	0	0
	Natural and built environment	0	0
	Pollution	0	0
	Housing	0	0
Health status relating to Economic determinants of health	Education, skills and learning	2	2
	Employment	2	2
	Business development	2	2
	Financial inclusion	0	0
TOTAL	ALL	130	133

Box 6: Positive HIIA impact scores

The HIIA indicated that both Options have the potential to result in significant gains to population health and inequalities. These gains largely relate to use of, and access to, acute paediatric services rather than economic or environmental determinants.

Moreover, the total positive HIIA impact scores were very similar for both Options – 130 for Option 1 compared with 133 for Option 2.

The slightly higher score for Option 2 related to its potential to achieve greater cost efficiencies.

4.1.2 Negative EqIA and HIIA Impact Scores

Negative equality impact scores

The negative EqIA impact scores for each option and equality group are summarised in the table below:

Equality group	Negative Equality Impact Scores	
	Option 1	Option 2
Sex/ gender	-3	-3
Sexual orientation	0	0
Gender reassignment	0	0
Race	-3	-6
Marriage and civil partnership	0	0
Pregnancy / maternity	-2	-4
Religion or belief	0	0
Disability	-3	-6
Socioeconomic deprivation	-3	-6
Age	-3	-6

Box 7: Negative EqIA impact scores

These results show that both options were assessed as having a small but potentially negative impact on the following Equality groups:

- Sex - female
- Race (BME)
- Pregnancy and maternity
- Disability
- Socioeconomic Deprivation
- Age (children and young people)

The negative impacts on equality relating to age, pregnancy and gender were an inevitable finding relating to acute paediatric services which disproportionately serve children, new mothers and female carers. However, teenage children are a

specific sub group to consider in terms of their specific needs around accessing timely and convenient care²⁴.

Negative impacts on women were also noted with respect to job losses but the net numbers were in single figures and therefore minimal in comparison to the other issues affecting larger numbers of users.

The negative impacts associated with Option 2 were considered to affect more people than in Option1 and this resulted in higher negative impact scores

The equality groups living in South Tyneside were most likely to be affected because of the more significant changes relating to availability of services there. This has important implications for health inequalities within and across South Tyneside.

Negative health and inequalities impact scores

The negative HIIA impact scores for each option and health attribute are summarised in the table below:

Impact Domains	Attributes	Option 1	Option 2
Health status relating to use of acute paediatric services	Disease management	-5	-10
	Emotional Wellbeing	-6	-9
	Prevention	-6	-12
	Safeguarding	-4	-10
	Avoidable health care	-3	-3
Health status relating to access to high quality health care	Effective health care	-5	-8
	Safe health care	-6	-12
	Cost efficient health care	-2	-6
	Relevance to healthcare need	0	0
	Acceptable health care	-4	-8
Health status relating to Environmental determinants of health	Transport	-2	-2
	Natural and built environment	0	0
	Pollution	-2	-2
	Housing	0	0
Economic determinants	Education, skills and learning	-2	-2

²⁴ Department of Health (2011) Quality criteria for young people friendly health services

Impact Domains	Attributes	Option 1	Option 2
of health	Employment	-2	-2
	Business development	-2	-2
	Financial inclusion	0	0
TOTAL	ALL	-51	-88

Box 8: Negative HIIA Impact scores

The numeric results indicate that any negative impacts are on a much smaller scale than the positive impacts.

The scale of the negative impacts was considered to be higher for Option 2 than Option 1 because the associated changes are more far reaching and affect more people.

The small negative HIIA scores were associated with all four HIIA impact domains, although the scale of the impact was higher in relation to use of, and access to, acute paediatric services. Further details of these drawbacks are described below.

4.1.3 Total Integrated Impact Scores

Total equality impact scores

When summed together, the large positive and small negative impacts resulted in strongly positive impact scores for all equality groups as indicated by the summary below:

Equality group	Total Equality Impact Scores	
	Option 1	Option 2
Sex/ gender	6	6
Sexual orientation	9	9
Gender reassignment	9	9
Race	6	3
Marriage and civil partnership	9	9
Pregnancy / maternity	7	5
Religion or belief	9	9
Disability	6	3

Socioeconomic deprivation	6	3
Age	6	3

Box 9: Total EqIA impact scores

For both Options, the total EqIA impact scores were positive for all equality groups. This shows that, for either Option, the considerable benefits for equality groups outweigh any of the drawbacks identified during the assessment. The nature of these benefits is described below.

Total Health and Inequality Impact scores

When summed together, the majority of the total HIA impact scores were positive as indicated by the summary below:

Impact Domains	Impact Domain Attributes	Option 1	Option 2
Health status relating to use of acute paediatric services	Disease management	13	8
	Emotional Wellbeing	12	9
	Prevention	12	6
	Safeguarding	9	3
	Avoidable health care	8	8
Health status relating to access to high quality health care	Effective health care	13	10
	Safe health care	6	0
	Cost efficient health care	4	3
	Relevance to healthcare need	8	8
	Acceptable health care	-2	-6
Health status relating to Environmental determinants of health	Transport	-2	-2
	Natural and built environment	0	0
	Pollution	-2	-2
	Housing	0	0
Economic determinants of	Education, skills and learning	0	0

Impact Domains	Impact Domain Attributes	Option 1	Option 2
health	Employment	0	0
	Business development	0	0
	Financial inclusion	0	0
TOTAL	ALL	79	45

Box 10: Total HIIA scores

For both Options, the positive total HIIA impact scores related to use of, or access to high quality, acute paediatric services.

There were some differences between the two Options as summarised in the following table:

Total HIIA scores	Option 1	Option2
Positive	All five attributes relating to the Healthcare use Domain Four of the five attributes relating to the Health care access domain - not acceptable health care	All five attributes relating to the Healthcare use Domain Three of the five attributes relating to the Health care access domain - not safe care (scored neutral) or acceptable care Two of the four attributes in the Environment domain i.e. housing and natural/built environment
Negative	Acceptable healthcare Two of the four attributes in the Environment domain i.e. pollution and transport	Acceptable Healthcare Two of the four attributes in the Environment domain i.e. pollution and transport
Neutral	All four attributes in the Economic domain Two of the four attributes in the Environment domain i.e. housing and natural/built environment	Safe healthcare All four attributes in the Economic domain Two of the four attributes in the Environment domain i.e. housing and natural/built environment

Box 11: Summary of differences between the two options in the HIIA impact scores

Negative total impact scores related to acceptable healthcare, pollution and housing.

The nature of the benefits and drawbacks is described below.

4.2 Details of the rationale driving the IIA scores

4.2.1 Vulnerable groups

The EqIA and HIIA indicated that vulnerable groups, especially those living in South Tyneside, would be more likely to be affected by the changes. These groups were:

- Children and families affected by socio-economic deprivation,
- Children and families affected by substance or alcohol misuse
- Infants and Young people
- BME communities
- Children in need of safeguarding
- Children and families affected by physical or mental illness, disability or sensory impairment
- Pregnant and recently delivered mothers and their babies

Demographic information relating to those groups is summarised below (further details and sources provided in Appendix 3):

	Equality group	South Tyneside Count (%)	Sunderland Count (%)
Race	BME groups	7,259 (4.9)	14,326 (5.2)
	Babies born to mothers born in Middle East and Asia (2014)	61 (3.8)	94 (3.3)
Pregnancy & maternity	Women aged 15-44 years	28,024 (36.6)	54,215 (38.3)
	Number of live births (2015)	1,647	2,889
Disability	Disability – day to day activities limited a little or a lot	34,069 (23%)	63,366 (23%)
	Mean number of disabled children	831-1,496 (3-5)	1,552-2,794 (3-5)
Socio-economic deprivation	Socio-economic Deprivation – households with some level of deprivation	42,315 (63%)	76,645 (64%)
Age	Number of children aged	29,662 (20%)	54,945 (20%)

0-18 years		
Young people – 15-17 years	5,696 (3.8)	10,079 (3.7)

Box 12 Summary of demographic details for key vulnerable groups

These groups are disproportionately affected because they are more likely to need and use acute paediatric services. Positively, these groups are more likely to realise the benefits of any improvements arising from the changes, but they may also be more vulnerable to any associated drawbacks.

4.2.2 Service users in South Tyneside

Service users living in South Tyneside were most likely to be affected by any weaknesses because of the more significant changes relating to availability of acute paediatric services in the borough. This has important implications for health inequalities within and across South Tyneside.

4.2.3 Positive impacts on equality, population health and inequalities

The benefits identified by the HIIA were similar to those identified by the EqIA and related to improvements in the services provided i.e:

- More sustainable and consistent high quality care, regardless of the day of the week or the time of day
- Safer Care due to improved levels of specialist staffing able to assess and treat children promptly
- Improved levels of specialist staff and resources able to deal with rising population needs in terms of scale and complexity
- Cost savings in the face of economic austerity

These service improvements could have profound benefits for children, especially in relation to

- More effective and timely treatment of acute illnesses
- Less risk of deterioration
- Less pain and distress due to delays in assessment and treatment
- Shorter hospital stays and less readmissions or readmissions
- Improved capacity to identify and safeguard children in need

Ultimately, because of their benefits for all service users as well as vulnerable and equality groups, the service improvements could lead to significant benefits to child health and inequalities across South Tyneside and Sunderland, giving children ‘a better start in life’ and ‘enabling all children, young people and adults to maximize their capabilities and have control over their lives’²⁵.

²⁵ The Marmot Review. Fair Society, healthy lives. Strategic review of Health Inequalities in England post 2010

The changes will result in more specialist skills, services and jobs in Sunderland which could have a positive impact on health and health inequalities there but the associated losses in South Tyneside meant that the related total impact scores were neutral. .

4.2.4 Possible negative impacts on equality, health and health inequalities

It is essential to recognise that identified drawbacks were rarely significant enough to offset the strongly positive benefits that were identified.

The drawbacks of both Options related to (in no specific order)

1. the challenges of understanding and adapting to the proposed changes
2. vulnerable groups experiencing possible barriers to access
3. continuity of care during hand overs between hospitals and when crossing local authority and CCG boundaries
4. increased travel costs (personal, social and economic)
5. acutely ill children being transferred from South Tyneside to Sunderland
6. increases in demand for acute ambulance services and acute paediatric services in Sunderland
7. increases in traffic commuting between South Tyneside and Sunderland

The identified drawbacks were considered to pose a greater risk to the vulnerable groups identified above and also those living in South Tyneside with implications for health inequalities within and across South Tyneside.

The possible drawbacks are described more fully below:

1) Possible challenges, especially for vulnerable groups, to understanding and adapting to the proposed changes

Adapting to any change is more challenging for the identified equality groups due to their increased risk of English language, communication or cognitive difficulties.

For these reasons, these groups may find it harder to access health care in the face of acute illness and may be less resilient in the face of unexpected transfers of care. They may also be less likely to become involved in public consultations relating to the reconfiguration.

These difficulties can manifest in poorer health outcomes, delays in accessing timely care in an emergency, 'dropping out of the care system', coordinating care, and increased social exclusion.

2) Possible barriers, especially for vulnerable groups, to accessing acute paediatric health care

The equality groups identified are more likely to need access to acute paediatric care due to the increased incidence of acute childhood illnesses in these groups.

Evidence shows that BME groups, disabled groups, socio-economically deprived groups and young people experience multiple barriers to access. The changes introduce further barriers to access which in turn could lead to poorer health outcomes and health inequalities.

For these groups, timely, convenient, coordinated care is valued and can promote improved health outcomes and reduce health inequalities.

The key access barriers that were identified, relate to children, families and carers, in the face of existing challenges (social, economic, disability or impairment, emotional wellbeing, caring) and in need of timely specialist paediatric care

- understanding where to take an acutely ill child in South Tyneside at different times of the day and night and where they might be transferred
- travelling further from South Tyneside to Sunderland to seek assessment, treatment or advice or to accompany an acutely ill child
- accompanying acutely sick children requiring inter-hospital transfers transferred from South Tyneside to Sunderland
- navigating and coordinating care across CCG and LA boundaries

Option 1 is associated with minimal changes for the population and only during the night, whereas Option 2 is associated with more significant changes day and night.

3) Possible challenges to continuity of care, especially for vulnerable groups, when transferring across hospital sites and Local Authority and CCG boundaries

The identified equality groups may be more likely to benefit from a range of health and social care services. Integrated care across these providers can achieve better outcomes for children and families but this may be more difficult in the light of the change because

- Acutely ill children from South Tyneside, treated in Sunderland may need to cross CCG and LA boundaries
- Crossing boundaries may lead to gaps in coordination or communication increase risks relating to patient safety, emotional wellbeing and safeguarding for children and families
- Organisational changes and loss of 'co-terminosity' may undermine joint working and exacerbate fragmentation due to loss of organisational memory, and changes to working relationships e.g. links between Sunderland paediatricians and GPs or lifestyle services in South Tyneside
- Changes in care provision associated with inter hospital transfers requires more team handovers which are known to be a risk to patient safety

- Loss of, or challenges to, continuity might act as a further barrier to access because families may be reluctant to engage with unfamiliar service providers.
- Access to good quality information about children is essential for effective clinical management and such information may be lost during handovers or its availability may be affected by the loss of co-terminosity

Option 2 is associated with more significant changes to services in South Tyneside than Option 1 and will require higher numbers of children to cross CCG and LA boundaries.

4) Possible increased travel costs (personal, social and economic) for vulnerable groups travelling between South Tyneside and Sunderland.

These proposals will require more sick children to travel between South Tyneside and Sunderland. The numbers affected by Option 2 are greater than those affected by Option 1.

Travelling further for care or to visit sick children and/or newborns generates additional expense, time, inconvenience and emotional stress for everyone concerned.

These difficulties are magnified when caring for an acutely sick child who may be in pain or distressed and even more when caring for other siblings or children simultaneously.

The challenges are even greater for those from affected vulnerable groups because of related socio-economic difficulties; disabilities and impairments; cognitive and mental or emotional problems; language difficulties; difficulties navigating an unfamiliar environment or service; being pregnant or breastfeeding.

Such challenges can undermine health and wellbeing resulting in deeper health inequalities.

The detailed transport analysis could provide further information regarding the extent of this risk.

5) Possible risks associated with acutely ill children being transferred from South Tyneside to Sunderland

Both proposed solutions, will lead to acutely ill children being transferred between South Tyneside and Sunderland. These will largely be children who self present to the South Tyneside site and the numbers should reduce over time as users become more familiar with the service models.

The consequences for these children relate to the extra steps in their patient pathway which arise from assessment in South Tyneside and subsequent inter-hospital transfer.

This extra step has implications for timeliness and cost-efficiency of care. It could result in some children experiencing delays in effective treatment increasing the risk of clinical deterioration and delays in relief for their pain and distress. Avoiding delays will rely on the timely assessment of children in need of inter hospital transfer in South Tyneside, the availability of emergency ambulances to provide the transfer, and the efficiency of the clinical response in Sunderland when receiving and treating the transferred children.

Extra steps in a pathway increase the number of team handovers which, according to the research literature, are associated with increased risks to patient safety. Such risks might disproportionately affect key groups with language or communication difficulties in South Tyneside i.e. BME communities, disabled groups, older patients and those with socioeconomic deprivation.

Extra steps can generate increased anxiety for children, parents and carers and less satisfaction as, in the face of concerns about their acutely ill child, they repeatedly convey their concerns to changing medical teams.

6) Possible pressures on the service arising from increases in demand for acute ambulance services and acute paediatric services in Sunderland

Both Options, Option 2 more than Option1, generate additional demands on Sunderland hospitals and the ambulance services. The business case demonstrates that there will be adequate clinical capacity to accommodate the children.

The ambulance service capacity to respond is currently under consideration as part of the Path to Excellence plans. Relevant North East Ambulance Service performance data are presented in Appendix 3.

There will be additional pressures in Sunderland due to the additional demands for amenities such as refreshments and parking. This might affect user satisfaction.

7) Possible environmental impacts arising from increased traffic commuting between South Tyneside and Sunderland

The small increases in traffic flow were identified as having a potentially small negative impact on health risks associated with noise and air pollution and road traffic accidents. These negative impacts will have a greater impact on residents in South Tyneside and Sunderland living close to commuter routes and the hospitals. The detailed transport analysis could provide further information to ascertain whether this is a relevant health risk.

4.3 Summary of the IIA findings

The results provide detailed and systematic evidence based insights into the possible impacts of the proposals on population equality, health and inequalities.

South Tyneside communities and vulnerable groups could be more likely to be affected by the changes. These groups are:

- Children and families affected by socio-economic deprivation,
- Children and families affected by substance or alcohol misuse
- Infants and Young people
- BME communities
- Children in need of safeguarding
- Children and families affected by physical or mental illness, disability or sensory impairment
- Pregnant and recently delivered mothers and their babies

Importantly, the results indicate that both Options can achieve significant gains for population health and inequalities in South Tyneside and Sunderland.

The HIIA assessment identified the following key areas of concern for each Option

Negative total HIIA Impact scores - Health Attributes	
Option 1	Option2
Acceptable Healthcare	Acceptable Healthcare
Pollution	Pollution
Transport	Transport

The impacts relating to transport and pollution are currently being examined by a detailed study.

Although possible drawbacks have been described in detail, they should be viewed in context because, as the HIIA scores indicate below, there is strong evidence that the significant benefits associated with the proposed changes outweigh the drawbacks.

Total HIIA Impact Scores		
	Option 1	Option2
Total positive integrated impact score	130	133
Total negative integrated impact score	-51	-88
Total Integrated Impact Scores	79	45

The drawbacks associated with Option 2 are on a larger scale than those associated with Option 1 because the changes are more far reaching and affect a larger number of people. However, this must be balanced against the benefits Option 2 has in terms of greater cost efficiency savings compared to Option 1.

In summary, the IIA indicated that both Options could achieve considerable net gains with significant benefits for equality, children's health and inequalities.

5 Mitigating Action Planning

Undertaking an integrated impact assessment enables services to be developed in an integrated way to reduce potential health inequalities.

This section outlines actions that could mitigate against the potentially negative impacts identified by the integrated assessment and described more fully in Section 4.

These actions are merely suggestions, they are **not** intended to be either instructions or recommendations. They provide an opportunity for stakeholders – across all sectors including the voluntary and 3rd sector - to consider how they can contribute to maximise the impact of the changes on equality, health or inequalities.

The suggestions should also be considered with realistic reference to what can be achieved in the face of overstretched resources and the economic pressures on the NHS, hospitals and acute paediatric services.

There may also be advantages to considering these suggestions alongside those identified in other service re-configurations as there may be interdependencies. The IIA relating to Path to Excellence plans for obstetric and gynaecology services would be a key example. Where the findings are similar, there may be opportunities to achieve economies of scale.

In general, the suggestions should be considered with reference to the identified at risk groups which are most likely to be affected by the proposals

- Children and families affected by socio-economic deprivation,
- Children and families affected by substance or alcohol misuse
- Infants and Young people
- BME communities
- Children in need of safeguarding
- Children and families affected by physical or mental illness, disability or sensory impairment
- Pregnant and recently delivered mothers and their babies

5.1 Suggested mitigating actions

5.1.1 *Helping everyone to understand and adapt to the new changes, especially vulnerable groups.*

- Patient and public information campaigns could be developed and targeted to promote understanding and enable service users to adapt to the changes in the face of a child with an acute illness and ensure care can be given in the right place at the right time.
- A cross-area young people's user group could be supported to champion the views and needs of young people.
- The new service specification could specify responsibilities for monitoring and evaluation of service outcomes including equity of access
- Introducing oversight arrangements could ensure scrutiny of equity and user experience data and ensure that this information is translated into timely and appropriate service developments whenever necessary
- Community engagement and development schemes could be implemented to build the capability and confidence of children and their parents and carers to self-care and use health services appropriately, for example, the provision of education interventions in schools and the community.

5.1.2 *Promoting continuity of care especially for vulnerable groups*

- New oversight arrangements could monitor user satisfaction and critical incidents relating to service continuity and coordination for all users, especially vulnerable groups and ensure that this information is translated into service developments as appropriate and necessary.
- New oversight arrangements could monitor equity of access audit data for each service and ensure that this information is translated into timely and appropriate service developments whenever necessary
- Protected learning events for relevant professional groups, could help to build relationships and improve skills and knowledge especially with reference to adoption and development of key care pathways²⁶
- NHS patient safety initiatives could focus on quality assuring handovers between different teams
- Whole system learning collaboratives could help to build strategic connections across the system and to drive through system-wide improvements.
- System-wide collaboratives could champion the development of integrated records and information systems to promote information sharing and communication across service and sector boundaries

²⁶ RCPCH and RCGP (2015) Facing the future: together for child health

5.1.3 Addressing travel and transport costs especially for vulnerable groups

- A range of opportunities to minimise the additional travel costs could be explored. Possibilities include provision of shuttle buses between hospital sites or less costly alternatives such as volunteer drivers or subsidised parking at hospital sites
- Additional disabled and maternity parking bays could be provided at both hospital sites
- Patient and public information campaigns could maximise the benefits of any new transport services
- Future service user experience surveys could monitor and evaluate travel needs and experiences with reference to differences between equality groups in South Tyneside and Sunderland.
- Oversight arrangements could be introduced to scrutinise user experience data and ensure that this information is translated into timely and appropriate service developments whenever necessary.

5.1.4 Transfers of acutely ill children

- The capacity of the North East Ambulance Service to respond to the increased demand for timely and emergency transfers could be clarified using data modelling – this is already underway and the preliminary results suggest the service has sufficient capacity to accommodate the small numbers
- The proposed health service specifications could include protocols which seek to avoid delays in transfer and handovers eg application of early warning systems and provision for patient safety
- Oversight arrangements could be introduced to monitor patient safety, user satisfaction, and critical incidents relating to inter hospital transfers and handovers of care and to ensure that this information is translated into service developments as appropriate and necessary.
- Oversight arrangements could monitor ambulance performance data and ensure that this information is translated into service developments as appropriate and necessary

5.1.5 Demand for ambulance services and hospital services in Sunderland

- Ambulance capacity is already under review and early results indicate few difficulties in accommodating the additional numbers
- The impact on other aspects of the Sunderland hospital services can be monitored and addressed
- Commissioners will inevitably monitor and evaluate the ongoing performance of these providers and ensure service improvements as necessary.

5.1.6 Exploring the implications of traffic commuting between South Tyneside and Sunderland

- Wherever possible, any new transport initiatives could seek to minimise air and noise pollution, avoid congestion and promote road safety. Possible solutions include park and ride facilities with free hospital shuttle buses and less costly options such as advocating car share schemes
- The transport analysis currently underway will provide additional insights into this aspect of the reconfiguration

6 Conclusions and Recommendations

6.1 Conclusions

This IIA entailed a process which systematically assessed positive and negative impacts on equality, health and health inequalities. It drew on relevant research and statistics to evaluate the impact which two proposed models for acute paediatric services could have on 18 service specific attributes of health.

There are inter-dependencies between the proposed changes to acute paediatric services and plans to reconfigure obstetrics and gynaecology services. Both sets of plans have been the subject of an IIA. The IIA of obstetrics services examines the impact that changes to provision of special care for babies could have on new mothers and their babies.

The results of this IIA of acute paediatric services suggested that the changes could be more likely to affect communities in South Tyneside and certain vulnerable groups, most notably:

- Children, carers and families affected by socio-economic deprivation,
- Children, carers and families affected by substance or alcohol misuse
- Children, carers and families affected by physical or mental illness, disability or sensory impairment
- Infants and Young people
- BME communities
- Children in need of safeguarding
- Pregnant and recently delivered mothers and their babies

The IIA impact scores gave a crude indication of the relative scale and direction of possible impacts. Positive impact scores were higher for Option 2 than Option 1 due to the greater cost-efficiency savings associated with that option. However, negative impact scores were also higher for Option 2 because the changes associated with that option are more far reaching and affect greater numbers of children. The total (net) IIA impact scores were overwhelmingly positive and small scale negative scores were only identified for three attributes - acceptable healthcare, pollution and housing.

Total HIIA Impact scores		
	Option 1	Option2
Total positive integrated impact score	130	133
Total negative integrated impact score	-51	-88
Total Integrated Impact Scores	79	45

The IIA process identified and described the nature of the benefits and drawbacks associated with the proposed changes. It also included some suggested actions that could mitigate against the identified drawbacks. These suggestions could enable stakeholders to identify how they can contribute to the reconfiguration so that the benefits can be maximised. The suggestions largely relate to patient transport, organisational development, quality improvement, education and training, monitoring and evaluation.

The IIA provides strong evidence that the proposed changes could achieve overwhelmingly positive impacts on health and inequalities. These benefits related to the ability of the changes to result in:

- More sustainable and consistent high quality care, regardless of the day of the week or the time of day
- Safer Care due to improved levels of specialist staffing able to assess and treat children promptly
- Improved levels of specialist staff and resources able to deal with rising population needs in terms of scale and complexity
- Cost savings in the face of economic austerity

These outcomes could have profound benefits for children, especially in relation to

- More effective and timely treatment of acute illnesses
- Less risk of deterioration
- Less pain and distress due to delays in assessment and treatment
- Shorter hospital stays and less readmissions or readmissions
- Improved capacity to identify and safeguard children in need

Ultimately, because of their benefits for all service users as well as vulnerable and equality groups, the proposed service improvements could lead to significant benefits to child health and inequalities across South Tyneside and Sunderland, giving children 'a better start in life' and 'enabling all children,

young people and adults to maximize their capabilities and have control over their lives'²⁷.

The results of this integrated impact assessment can be used, alongside the other evidence developed by the Path to Excellence Board, to:

- empower stakeholders to contribute to the consultation process by enabling them to understand the potential positive and negative impacts of each option
- enable Commissioners to demonstrate compliance with their Public Sector duties around equality and health inequalities
- enable all decision makers to rigorously consider, and give due regard, to the equality, health and health inequality impacts of each Option
- identify possible ways in which services can be integrated to promote equality and reduce health inequalities
- re-configure local services which promote equality, promote health, and reduce health inequalities.

The consultation process might generate additional insights into other impacts arising from the proposals.

6.2 Recommendations to all stakeholders

All stakeholders are invited to:

1. Consider and give due regard to the nature, scale, and scope of the benefits and challenges identified by this integrated impact assessment
2. Consider and highlight any other positive or negative impacts which should be incorporate into the assessment
3. Consider the suggested mitigating actions and identify whether there are other opportunities to maximise the benefits arising from the proposed reconfiguration
4. Identify mitigating actions which should be implemented and consider contributing to the development of relevant mitigating action plans.

²⁷ The Marmot Review. Fair Society, healthy lives. Strategic review of Health Inequalities in England post 2010

Detailed results of the Equality Impact Assessment of both Options for Acute Paediatrics

Table 1: Equality Impact Assessment for the Proposed Acute (Urgent and Emergency) Paediatric Service Reconfiguration (for further details regarding sources and statistics, please refer to the evidence base summarised in Appendix 3)

KEY				
A score = level of evidence		B score = scale of impact		C score = AXB = Impact score
Total impact score = sum of C scores				
ED = emergency department		CSSAU= children's short stay assessment unit		SCBU = Special Care Baby Unit

	Option 1: Provision of 12-hour day-time paediatric ED service at STDH with 24/7 paediatric ED at SRH.		Option 2 Development of nurse-led paediatric minor injury/illness service between 8am-10pm at STDH with 24/7 acute paediatric services at SRH.	
Protected characteristic	Potentially Positive Impacts	Potentially Negative Impacts	Potentially Positive Impacts	Potentially Negative Impacts
Sex / Gender	The business plan demonstrates that this solution will achieve more sustainable, high quality cost effective care which will benefit all regardless of gender. High quality children's services play a vital role in population health and health inequalities	No evidence that any children will suffer any negative impacts due to gender Evidence that women take a disproportionate share of caring roles as well as breastfeeding newborns suggests that they might be more inconvenienced by the changes than their male counterparts. Staff changes might disadvantage more women due to losses of nurses and the relative prevalence of females in these roles – net numbers are in single figures	The business plan demonstrates that this solution will achieve more sustainable, high quality cost effective care which will benefit all regardless of gender. High quality children's services play a vital role in population health and health inequalities	No evidence that any children will suffer any negative impacts due to gender Evidence that women take a disproportionate share of caring roles as well as breastfeeding newborns suggests that they might be more inconvenienced by the changes than their male counterparts. Staff changes might disadvantage more women due to losses of nurses and the relative prevalence of females in these roles – net numbers are in single figures
Impact Scores	A=3 B=3 C= 9	A=3 B=-1 C=-3	A=3 B=3 C= 9	A=3 B=-1 C=-3
Sexual orientation	The business plan demonstrates that this solution will achieve more sustainable, high quality cost effective care which will benefit all regardless of	There is no indication that this option will have a disproportionate impact on groups in relation to sexual orientation	The business plan demonstrates that this solution will achieve more sustainable, high quality cost effective care which will benefit all regardless of sexual	There is no indication that this option will have a disproportionate impact on groups in relation to sexual orientation

	Option 1: Provision of 12-hour day-time paediatric ED service at STDH with 24/7 paediatric ED at SRH.		Option 2 Development of nurse-led paediatric minor injury/illness service between 8am-10pm at STDH with 24/7 acute paediatric services at SRH.	
Protected characteristic	Potentially Positive Impacts	Potentially Negative Impacts	Potentially Positive Impacts	Potentially Negative Impacts
	sexual orientation. High quality children's services play a vital role in population health and health inequalities		orientation. High quality children's services play a vital role in population health and health inequalities	
Impact scores	A=3 B=3 C=9	A=1 B=0 C=0	A=3 B=3 C=9	A=1 B=0 C=0
Gender reassignment	The business plan demonstrates that this solution will achieve more sustainable, high quality cost effective care which will benefit all regardless of gender assignment. High quality children's services play a vital role in population health and health inequalities	There is no indication that this group will be disproportionately negatively affected by the proposed changes	The business plan demonstrates that this solution will achieve more sustainable, high quality cost effective care which will benefit all regardless of gender assignment. High quality children's services play a vital role in population health and health inequalities	There is no indication that this group will be disproportionately negatively affected by the proposed changes
Impact scores	A=3 B=3 C=9	A=1 B=0 C=0	A=3 B=3 C=9	A=1 B=0 C=0
Race	Evidence shows that BME groups generally have worse health than the overall population - the business plan demonstrates that this solution will achieve more sustainable, high quality cost effective care better able to meet their needs and so they may experience a disproportionately positive benefit	Evidence shows that BME groups suffer worse health, are more likely to have perinatal problems, and experience many barriers to accessing health care. These changes could disproportionately affect them by creating further barriers to access - relating to their ability to understand and adapt to the changes. This solution entails the minimal changes for BME groups in South Tyneside compared with option 2.	Evidence shows that BME groups generally have worse health than the overall population - the business plan demonstrates that this solution will achieve more sustainable, high quality cost effective care better able to meet their needs and so they may experience a disproportionately positive benefit	Evidence shows that BME groups suffer worse health, are more likely to have perinatal problems, and experience many barriers to accessing health care. These changes could disproportionately affect them by creating further barriers to access - relating to their ability to understand and adapt to the changes. This solution entails greater changes for BME groups in South Tyneside compared with option 1

	Option 1: Provision of 12-hour day-time paediatric ED service at STDH with 24/7 paediatric ED at SRH.		Option 2 Development of nurse-led paediatric minor injury/illness service between 8am-10pm at STDH with 24/7 acute paediatric services at SRH.	
Protected characteristic	Potentially Positive Impacts	Potentially Negative Impacts	Potentially Positive Impacts	Potentially Negative Impacts
impact scores	A=3 B=3 C=9	A=3 B=-1 C=-3	A=3 B=3 C=9	A=3 B=-2 C=-6
Marriage and civil partnership	The business plan demonstrates that this solution will achieve more sustainable, high quality cost effective care which will benefit all regardless of marital status. High quality children's services play a vital role in population health and health inequalities	There is no indication that this group will be disproportionately negatively affected by the proposed changes	The business plan demonstrates that this solution will achieve more sustainable, high quality cost effective care which will benefit all regardless of marital status. High quality children's services play a vital role in population health and health inequalities	There is no indication that this group will be disproportionately negatively affected by the proposed changes
Impact scores	A=3 B=3 C=9	A=1 B=0 C=0	A=3 B=3 C=9	A=1 B=0 C=0
Pregnancy and maternity	The impact on this group arising from the shift of SCBU from South Tyneside has been explored in detail in the Obstetric service EqIA This group are more likely to have children with acute paediatric illness and will therefore benefit significantly from the quality improvements associated with this option as described in the business case	The impact on this group arising from the shift of SCBU from South Tyneside has been explored in detail in the Obstetrics service EqIA This group is less likely to be working and will suffer from the increased costs of travel This group, as users, may be more likely to have other children needing childcare or having to accompany them to seek help for a sibling. The requirement to travel from South Tyneside to Sunderland during the night could be inconvenient.	The impact on this group arising from the shift of SCBU from S Tyneside has been explored in detail in the Obstetric service EqIA This group are more likely to have children with acute paediatric illness and will therefore benefit significantly from the quality improvements associated with this option as described in the business case	The impact on this group arising from the shift of SCBU from South Tyneside has been explored in detail in the Obstetric service EqIA This group, as users, may be more likely to have other children needing childcare or having to accompany them to seek help for a sibling. The requirement to travel from South Tyneside to Sunderland during the day and night could be inconvenient and challenging.
Pregnancy and maternity	A=3 B=3 C= 9	A=2 B=-1 C= -2	A=3 B=3 C= 9	A=2 B=-2 C= -4

	Option 1: Provision of 12-hour day-time paediatric ED service at STDH with 24/7 paediatric ED at SRH.		Option 2 Development of nurse-led paediatric minor injury/illness service between 8am-10pm at STDH with 24/7 acute paediatric services at SRH.	
Protected characteristic	Potentially Positive Impacts	Potentially Negative Impacts	Potentially Positive Impacts	Potentially Negative Impacts
equality impact scores				
Religion or belief	The business plan demonstrates that this solution will achieve more sustainable, high quality cost effective care which will benefit all regardless of religion or belief. High quality children's services play a vital role in population health and health inequalities	There is no indication that this group will be disproportionately negatively affected by the proposed changes	The business plan demonstrates that this solution will achieve more sustainable, high quality cost effective care which will benefit all regardless of religion or belief. High quality children's services play a vital role in population health and health inequalities	There is no indication that this group will be disproportionately negatively affected by the proposed changes
Impact scores	A=3 B=3 C=9	A=1 B=0 C=0	A=3 B=3 C=9	A=1 B=0 C=0
Disability	Children with disabilities may be more in need of acute paediatric services. The business plan demonstrates that this solution will achieve more sustainable, high quality cost effective care which will benefit all. High quality children's services play a vital role in population health and health inequalities	Disability (affecting parents or carers or children) is associated with increased risk of financial difficulties, communication, problems, transport and travel difficulties, and complex medical problems. This group may experience increased challenges due to: <ul style="list-style-type: none"> the increased costs (personal, social, economic) of travel from South Tyneside to Sunderland especially during the night. difficulties around understanding and adapting to the new changes in service provision 	Children with disabilities may be more in need of acute paediatric services. The business plan demonstrates that this solution will achieve more sustainable, high quality cost effective care which will benefit all. High quality children's services play a vital role in population health and health inequalities	Disability (affecting parents or carers or children) is associated with increased risk of financial difficulties, communication, problems, transport and travel difficulties, and complex medical problems. This group may increase increased challenges due to: <ul style="list-style-type: none"> the increased costs (personal, social, economic) of travel from South Tyneside to Sunderland day and night difficulties around understanding and adapting to the new changes in service provision
Impact scores	A=3 B=3 C=9	A=3 B=-1 C=-3	A=3 B=3 C=9	A=3 B=-2 C=-6
Socio	Socio-economic deprivation is proven to affect children's health and	There is strong evidence that lower economic status is associated with greater	Socio-economic deprivation is proven to affect children's health and healthcare	There is strong evidence that lower economic status is associated with greater

	Option 1: Provision of 12-hour day-time paediatric ED service at STDH with 24/7 paediatric ED at SRH.		Option 2 Development of nurse-led paediatric minor injury/illness service between 8am-10pm at STDH with 24/7 acute paediatric services at SRH.	
Protected characteristic	Potentially Positive Impacts	Potentially Negative Impacts	Potentially Positive Impacts	Potentially Negative Impacts
Economic deprivation	healthcare outcomes. This group may have greater needs for access to acute paediatric services. The business plan demonstrates that this solution will achieve more sustainable, high quality cost effective care which will benefit all. High quality children's services play a vital role in population health and health inequalities	difficulty in accessing information about care options, funding for travel and child care costs, and involvement with other services This group may experience increased challenges due to: <ul style="list-style-type: none"> the increased costs (personal, social, economic) of travel from South Tyneside to Sunderland especially during the night. difficulties around understanding and adapting to the new changes in service provision fragmentation of care across boundaries 	outcomes. This group may have greater needs for access to acute paediatric services. The business plan demonstrates that this solution will achieve more sustainable, high quality cost effective care which will benefit all. High quality children's services play a vital role in population health and health inequalities	difficulty in accessing information about care options, funding for travel and child care costs, and involvement with other services This group may experience increased challenges due to: <ul style="list-style-type: none"> the increased costs (personal, social, economic) of travel from South Tyneside to Sunderland day and night. difficulties around understanding and adapting to the new changes in service provision fragmentation of care across boundaries
Impact scores	A=3 B=3 C=9	A=3 B=-1 C=-3	A=3 B=3 C=9	A=3 B=-2 C=-6
Age	Acute paediatric service changes disproportionately affect younger age groups. The business plan demonstrates that this solution will achieve more sustainable, high quality cost effective care which will benefit all. High quality children's services play a vital role in population health and health inequalities	Acute paediatric service changes disproportionately affect younger age groups. Evidence based best practice in provision of care for teenage children advocates convenience in terms of time, place, transport, location. These changes do not meet those requirements by night. This group might also find increased difficulties relating to <ul style="list-style-type: none"> understanding and adapting to the new changes in service provision 	Acute paediatric service changes disproportionately affect younger age groups. The business plan demonstrates that this solution will achieve more sustainable, high quality cost effective care which will benefit all. High quality children's services play a vital role in population health and health inequalities	Acute paediatric service changes disproportionately affect younger age groups. Evidence based best practice in provision of care for teenage children advocates convenience in terms of time, place, transport, location. These changes do not meet those requirements by day or night. This group might also find increased difficulties relating to <ul style="list-style-type: none"> understanding and adapting to the new changes in service provision

	Option 1: Provision of 12-hour day-time paediatric ED service at STDH with 24/7 paediatric ED at SRH.		Option 2 Development of nurse-led paediatric minor injury/illness service between 8am-10pm at STDH with 24/7 acute paediatric services at SRH.	
Protected characteristic	Potentially Positive Impacts	Potentially Negative Impacts	Potentially Positive Impacts	Potentially Negative Impacts
		<ul style="list-style-type: none"> the increased costs (personal, social, economic) of travel from South Tyneside to Sunderland especially during the night. 		<ul style="list-style-type: none"> the increased costs (personal, social, economic) of travel from South Tyneside to Sunderland day and night.
Age equality impact scores	A=3 B=3 C=9	A=3 B=-1 C=-3	A=3 B=3 C=9	A=3 B=-2 C=-6

Table 2: Equality impact scores for vulnerable groups

Key to categories and colour codes	Total Impact (C) Score	Positive	Negative
Major impact	+/- 7 - 9		
Moderate impact	+/- 4 - 6		
Minor impact	+/- 0 - 3		

Equality group	Option 1: Rationalising acute paediatric services in Sunderland overnight, with continued provision of services in both localities by day			Option 2 Option 2 entails rationalising acute paediatric services in Sunderland day and night with the provision of nurse led minor injury and minor illness services in South Tyneside by day.		
	Positive impact score	Negative impact score	Total Impact score	Positive impact score	Negative impact score	Total Impact score
Sex/ gender	9	-3	6	9	-3	6
Sexual orientation	9	0	9	9	0	9
Gender reassignment	9	0	9	9	0	9
Race	9	-3	6	9	-6	3
Marriage and civil partnership	9	0	9	9	0	9
Pregnancy / maternity	9	-2	7	9	-4	5
Religion or belief	9	0	9	9	0	9
Disability	9	-3	6	9	-6	3
Socioeconomic deprivation	9	-3	6	9	-6	3
Age	9	-3	6	9	-6	3

Detailed results of the Health and Health Inequalities Impact Assessment of both options

Table 3: Details of the health and health inequalities assessment of both options (for further details regarding sources and statistics, please refer to the evidence base summarised in Appendix 3)

A score = level of evidence B score = scale of impact C score = AXB

	Option 1: Provision of 12-hour day-time paediatric ED service at STDH with 24/7 paediatric ED at SRH.		Option 2 Development of nurse-led paediatric minor injury/illness service between 8am-10pm at STDH with 24/7 acute paediatric services at SRH	
	Health and Health Inequalities Impacts and Scores		Health and Health Inequalities Impacts and Scores	
	Positive	Negative	Positive	Negative
Health outcomes of acute paediatric services				
Disease management HEALTH IMPACT	The changes enable more children to benefit from high quality safe health care organised around their needs, 24 hours per day, 7 days per week.	<p>This option will require some children in need in South Tyneside, during the night, to travel to Sunderland.</p> <p>A number of factors – albeit only overnight – could lead to children suffering delays in assessment and treatment and subsequent deterioration. These factors include:</p> <ul style="list-style-type: none"> • Greater demands on services in Sunderland with an impact on triage efficiency • Increased travel times and 	The changes enable more children to benefit from high quality safe health care organised around their needs, 24 hours per day, 7 days per week.	<p>This option will require some children in need in South Tyneside to travel to Sunderland day and night. All of the negative impacts identified for Option 1 are magnified because of the greater number of children affected.</p> <p>Another magnifier is the potential for delays by day arising from the additional step of triage and assessment in the nurse led unit when a transfer to Sunderland is required.</p>

	Option 1: Provision of 12-hour day-time paediatric ED service at STDH with 24/7 paediatric ED at SRH.		Option 2 Development of nurse-led paediatric minor injury/illness service between 8am-10pm at STDH with 24/7 acute paediatric services at SRH	
	Health and Health Inequalities Impacts and Scores		Health and Health Inequalities Impacts and Scores	
	Positive	Negative	Positive	Negative
		ambulance transfers <ul style="list-style-type: none"> Delays in the pathway due to children presenting to South Tyneside due to poor understanding of the new service 		
Disease management HEALTH INEQUALITIES IMPACT	Consistent access to high quality children's services is key to reducing health inequalities	As vulnerable children are more likely to need acute paediatric services and more likely to be disadvantaged by the changes this option could have a negative impact on inequalities within and across South Tyneside	Consistent access to high quality children's services is key to reducing health inequalities	All of the negative impacts identified for Option 1 are higher in this option due to the greater numbers of children affected. As vulnerable children are more likely to need acute paediatric services and more likely to be disadvantaged by the changes this option could have a negative impact on inequalities within and across South Tyneside
Disease management HEALTH Impact Score	A=3 B=3 C=9	A=2 B=-1 C=-2	A=3 B=3 C=9	A=2 B=-2 C=-4
Disease management HEALTH INEQUALITIES Impact Score	A=3 B=3 C=9	A=3 B=-1 C=-3	A=3 B=3 C=9	A=3 B=-2 C=-6
Emotional wellbeing HEALTH IMPACT	An acutely ill child is often distressed. Caring for such a child is also distressing for parents and carers - timely expert assessment and advice can reduce the child's suffering and reduce parental anxiety.	Delays in access to care; transfers of care; confusion over pathways; travel to visit, care away from home; challenges around continuity with wider children's services (e.g. social workers) can all have a detrimental	An acutely ill child is often distressed. Caring for such a child is also distressing for parents and carers - timely expert assessment and advice can reduce the child's suffering and reduce parental anxiety.	Delays in access to care; transfers of care; confusion over pathways; travel to visit, care away from home; challenges around continuity with wider children's services (e.g. social workers) can all have a detrimental

	Option 1: Provision of 12-hour day-time paediatric ED service at STDH with 24/7 paediatric ED at SRH.		Option 2 Development of nurse-led paediatric minor injury/illness service between 8am-10pm at STDH with 24/7 acute paediatric services at SRH	
	Health and Health Inequalities Impacts and Scores		Health and Health Inequalities Impacts and Scores	
	Positive	Negative	Positive	Negative
	The changes will enable more children to benefit from high quality safe health care organised around their needs, 24 hours per day, 7 days per week	effect on the emotional wellbeing of children, their parents, carers, friends and families. This option introduces these factors for the small number of children in South Tyneside needing acute paediatric services overnight	The changes will enable more children to benefit from high quality safe health care organised around their needs, 24 hours per day, 7 days per week	effect on the emotional wellbeing of children, their parents, carers, friends and families. This option introduces these factors for more children in South Tyneside needing acute paediatric services day and night
Emotional Wellbeing HEALTH INEQUALITIES IMPACT	Consistent access to high quality children's services is key to reducing health inequalities and could minimise unnecessary emotional suffering for carers/parents and children arising from avoidable mortality and morbidity.	Vulnerable groups are at higher risk of needing acute paediatric services overnight and of suffering the negative impacts on emotional well being which are described above. However, health inequalities arise from more enduring and significant health impacts and so, although these groups may experience greater suffering, the impact on health inequalities is likely to be small.	Consistent access to high quality children's services is key to reducing health inequalities and could minimise unnecessary emotional suffering for carers/parents and children	Vulnerable groups are at higher risk of needing acute paediatric services overnight and of suffering the negative impacts on emotional well being which are described above. Again, this option magnifies the negative impacts noted in Option 1. But, since health inequalities arise from more enduring and significant health impacts the impact on health inequalities is likely to be small.
Emotional wellbeing HEALTH impact score	A=3 B=3 C=9	A=3 B=-1 C=-3	A=3 B=3 C=9	A=3 B=-2 C=-6
Emotional wellbeing HEALTH INEQUALITIES impact score	A=3 B=3 C=9	A=3 B=-1 C=-3	A=3 B=3 C=9	A=3 B=-1 C=-3
Prevention	Any presentation in the unscheduled care system should be seen as an	Challenges to effective prevention can arise when care is fragmented, and	The same benefits identified for Option 1 can be achieved by Option 2.	The challenges identified for Option 1 are magnified for this option due to

	Option 1: Provision of 12-hour day-time paediatric ED service at STDH with 24/7 paediatric ED at SRH.		Option 2 Development of nurse-led paediatric minor injury/illness service between 8am-10pm at STDH with 24/7 acute paediatric services at SRH	
	Health and Health Inequalities Impacts and Scores		Health and Health Inequalities Impacts and Scores	
	Positive	Negative	Positive	Negative
HEALTH IMPACTS	opportunity for health promotion and education on childhood illness and safety practices. Rationalised, high quality acute paediatric services which are cost-effective have the potential to provide consistent advice and develop strong links with related services and stakeholders leading to enduring positive health benefits for children and their families and carers.	when adequate information about children is not available. This option entails some risks to continuity and information sharing across boundaries as more children from South Tyneside will be crossing CCG and local authority boundaries over night. Overall, the numbers and impact is likely to be small.		the greater numbers of children affected and the extent of the reduction in services available in South Tyneside.
Prevention HEALTH INEQUALITIES impacts	Effective system wide health promotion and prevention is essential to reducing children's health inequalities and the reconfiguration provides an opportunity to implement enduring and far reaching changes to transform child health across south Tyneside and Sunderland.	The small impacts described above will be of more relevance to vulnerable groups with a negative impact on health inequalities but, the numbers are likely to be small.	The same benefits identified for Option 1 can be achieved by Option 2.	The negative impacts described above are more significant for vulnerable groups and could have an adverse impact on health inequalities.
Prevention HEALTH impact score	A=3 B=3 C=9	A=3 B=-1 C=-3	A=3 B=3 C=9	A=3 B=-2 C=-6
Prevention HEALTH INEQUALITIES impact score	A=3 B=3 C=9	A=3 B=-1 C=-3	A=3 B=3 C=9	A=3 B=-2 C=-6

	Option 1: Provision of 12-hour day-time paediatric ED service at STDH with 24/7 paediatric ED at SRH.		Option 2 Development of nurse-led paediatric minor injury/illness service between 8am-10pm at STDH with 24/7 acute paediatric services at SRH	
	Health and Health Inequalities Impacts and Scores		Health and Health Inequalities Impacts and Scores	
	Positive	Negative	Positive	Negative
Safeguarding- HEALTH IMPACT	Safeguarding is of paramount importance to child health. The changes provide an opportunity to ensure access to specialist assessment and treatment 24/7.	Effective safeguarding relies on good information, communication, and cross working at a system level. This option requires children in South Tyneside presenting in need overnight to cross LA and CCG boundaries and this may have a small negative impact on safeguarding effectiveness and subsequent health	Safeguarding is of paramount importance to child health. The changes provide an opportunity to ensure access to specialist assessment and treatment 24/7.	The challenges to effective safeguarding are considerably greater for this option because more children and families from South Tyneside will be affected
Safeguarding - HEALTH INEQUALITIES IMPACT	Effective safeguarding can have a positive impact on health inequalities.	The challenges to safeguarding are especially pertinent to vulnerable groups and health inequalities they suffer	The same benefits are available in this option	The challenges are especially relevant to vulnerable groups and the impact could have a larger effect on health inequalities.
Safeguarding HEALTH impact score	A= 3 B=3 C=9	A=2 B=-1 C=-2	A= 3 B=3 C=9	A=3 B=-2 C=-6
Safeguarding HEALTH INEQUALITIES IMPACT score	A=2 B=2 C=4	A=2 B=-1 C=-2	A=2 B=2 C=4	A=2 B=-2 C=-4
Avoidable healthcare HEALTH IMPACT	Effective and timely management, communication, information, safety netting and discharge advice can promote self care, reduce lengths of stay and avoid readmissions or returns to A&E . The changes offer an opportunity to improve care quality and rationalise and improve communication with families and carers to promote self care	This option introduced some barriers to access for users from south Tyneside. Such barriers to expert assessment could lead to children being transferred to Sunderland unnecessarily but the numbers are likely to be small. This should be balanced against the much greater gains achieved by improved quality of care.	This option can achieve the same potential positive health impacts as Option1.	Evidence indicates that outcomes for patients seen by paediatric nurse practitioners compared to those seen by doctors are similar with no significant differences in discharge or re-attendance rates. Therefore, any negative impacts relating to this item will be similar to Option1

	Option 1: Provision of 12-hour day-time paediatric ED service at STDH with 24/7 paediatric ED at SRH. Health and Health Inequalities Impacts and Scores		Option 2 Development of nurse-led paediatric minor injury/illness service between 8am-10pm at STDH with 24/7 acute paediatric services at SRH Health and Health Inequalities Impacts and Scores	
	Positive	Negative	Positive	Negative
	and avoid complications or problems leading to further contact.			
Avoidable healthcare HEALTH INEQUALITIES IMPACT	Improved care quality, user experience and communication could reduce the impact of avoidable care for vulnerable groups although this will have a limited impact on health inequalities.	Although vulnerable groups may be affected in greater numbers, the impact on health inequalities remains small.	This option has similar impacts on health inequalities as Option 1.	Any negative impacts relating to this item will be similar to Option1
Avoidable healthcare HEALTH impact score	A= 3 B=3 C=9	A=2 B=-1 C=-2	A= 3 B=3 C=9	A=2 B=-1 C=-2
Avoidable healthcare HEALTH INEQUALITIES impact score	A=2 B=1 C=2	A=2 B=-1 C=-1	A=2 B=1 C=2	A=2 B=-1 C=-1
Health outcomes of Access to high quality health care				
Effective health care – HEALTH CARE IMPACT	These changes have been developed to enable more children to benefit from high quality effective health care organised around their needs, 24 hours per day, 7 days per week. The changes are consistent with national expert guidance.	Timeliness is key to effectiveness. These changes might generate some small delays for the small numbers of children presenting to South Tyneside overnight and requiring inter-hospital transfers.	These changes have been developed to enable more children to benefit from high quality effective health care organised around their needs, 24 hours per day, 7 days per week. The changes are consistent with national expert guidance	The timeliness of care may be affected more in this option whereby higher numbers of self presenting 'sick children' will require inter hospital transfer
Effective health care – HEALTH CARE INEQUALITIES IMPACT	High quality children's services can have a major impact on health inequalities	The numbers are small but vulnerable groups may be disproportionately affected resulting in a small negative impact on health inequalities.	High quality children's services can have a major impact on health inequalities	The numbers are small but vulnerable groups may be disproportionately affected resulting in a small negative impact on health inequalities.
Effective health care –	A=3 B=3 C=9	A=3 B=-1 C=-3	A=3 B=3 C=9	A=3 B=-2 C=-6

	Option 1: Provision of 12-hour day-time paediatric ED service at STDH with 24/7 paediatric ED at SRH.		Option 2 Development of nurse-led paediatric minor injury/illness service between 8am-10pm at STDH with 24/7 acute paediatric services at SRH	
	Health and Health Inequalities Impacts and Scores		Health and Health Inequalities Impacts and Scores	
	Positive	Negative	Positive	Negative
HEALTH IMPACT SCORE				
Effective health care - HEALTH INEQUALITIES IMPACT SCORE	A=3 B=3 C=9	A=2 B=-1 C=-2	A=3 B=3 C=9	A=2 B=-1 C=-2
Safe care - HEALTH CARE IMPACT	The changes address safety concerns arising from inconsistent levels of specialist staffing. This will improve safety with a positive impact on child health outcomes	Safety can be affected by delays in care, during transfers and handovers of care and when adequate information about children is unavailable. These risks will be greater for children in South Tyneside - if they self refer and require transfer.	The changes address safety concerns arising from inconsistent levels of specialist staffing. This will improve safety with a positive impact on child health outcomes	Safety can be compromised during transfers and handovers of care and when adequate information about children is unavailable. This option carries greater risks to safety because it requires greater numbers of children to cross LA and CCG boundaries and to undergo inter hospital transfer
Safe care - HEALTH CARE INEQUALITIES IMPACT	The improved safety could have a small but positive impact on health inequalities with fewer significant events affecting children	The numbers involved are small but could affect health inequalities due to the significance of the health risks	The improved safety could have a small but positive impact on health inequalities with fewer significant events affecting children	The significance of the health risks arising from safety concerns could have a negative impact on health inequalities
Safe care - HEALTH IMPACT SCORE	A=3 B=3 C=9	A=3 B=-1 C=-3	A=3 B=3 C=9	A=3 B=-2 C=-6
Safe care - HEALTH INEQUALITIES IMPACT SCORE	A=3 B=1 C=3	A=3 B=-1 C=-3	A=3 B=1 C=3	A=3 B=-2 C=-6
Cost - Efficient health care HEALTH CARE IMPACT	This option achieves some cost savings whilst maintaining services close to home for all users and also overall higher quality services	The savings associated with this option may also be associated with some delays in care due to higher demands on services in Sunderland and also additional needs for inter	This option achieves higher cost savings than option 2 and overall higher quality services	The savings associated with this option may also be associated with some inefficiencies relating to higher demands on services in Sunderland and also additional needs for inter

	Option 1: Provision of 12-hour day-time paediatric ED service at STDH with 24/7 paediatric ED at SRH.		Option 2 Development of nurse-led paediatric minor injury/illness service between 8am-10pm at STDH with 24/7 acute paediatric services at SRH	
	Health and Health Inequalities Impacts and Scores		Health and Health Inequalities Impacts and Scores	
	Positive	Negative	Positive	Negative
		hospital transfer.		hospital transfer.
Cost - Efficient health care HEALTH CARE INEQUALITIES IMPACT	There is insufficient evidence to assess the impact on health inequalities	There is insufficient evidence to assess the impact on health inequalities	There is insufficient evidence to assess the impact on health inequalities	There is insufficient evidence to assess the impact on health inequalities
Cost - Efficient health care HEALTH CARE IMPACT score	A=3 B=2 C=6	A=2 B=-1 C=-2	A=3 B=3 C=9	A=2 B=-2 C=-6
Cost - Efficient health care HEALTH INEQUALITIES CARE IMPACT score	A=1 B=0 C=0	A=1 B=0 C=0	A=1 B=0 C=0	A=1 B=0 C=0
Health care relevant to population need HEALTH IMPACT	The planned changes meet the requirements for change in the face of changing population needs – the business plan indicates adequate capacity to deal with the additional demands on services in Sunderland. There is no available modelling to explore the impact of the changes in relation to future demographic changes	No negative impacts could be determined	The planned changes meet the requirements for change in the face of changing population needs – the business plan indicates adequate capacity to deal with the additional demands on services in Sunderland. There is no available modelling to explore the impact of the changes in relation future demographic changes	No negative impacts could be determined
Health care relevant to population need HEALTH INEQUALITIES IMPACT	The current plans indicate that the changes will meet the needs of the population and, because of their significance, could reduce health	There is no suggestion of any negative impacts on health inequalities.	The current plans indicate that the changes will meet the needs of the population and, because of their significance, could reduce health inequalities	There is no suggestion of any negative impacts on health inequalities.

	Option 1: Provision of 12-hour day-time paediatric ED service at STDH with 24/7 paediatric ED at SRH.		Option 2 Development of nurse-led paediatric minor injury/illness service between 8am-10pm at STDH with 24/7 acute paediatric services at SRH	
	Health and Health Inequalities Impacts and Scores		Health and Health Inequalities Impacts and Scores	
	Positive	Negative	Positive	Negative
	inequalities			
Health care relevant to population need HEALTH IMPACT score	A=2 B=3 C=6	A=1 B=0 C=0	A=2 B=3 C=6	A=1 B=0 C=0
Health care relevant to population need HEALTH INEQUALITIES IMPACT score	A=2 B=1 C=2	A=1 B=0 C=0	A=2 B=1 C=2	A=1 B=0 C=0
Acceptable health care (patient and carer experience) HEALTH IMPACT	<p>There is evidence that users value compassion, care closer to home, timeliness, communication, integration, accessibility, smooth transitions.</p> <p>The service improvements could address users needs for improved timeliness and communication within a 24/7 frame but the evidence is limited.</p>	<p>Given user preferences and priorities, these plans may not be wholly acceptable to users due to the loss of some overnight care close to home in South Tyneside.</p>	<p>The service improvements could address users needs for improved timeliness and communication within a 24/7 frame but the evidence is limited.</p>	<p>Given user preferences and priorities, these plans may not be wholly acceptable to users due to the loss of so overnight and day care close to home in South Tyneside.</p> <p>The access to nurse led care will offset some of these concerns.</p> <p>The additional barrier to acceptable access may lead to missed opportunities for health improvement though there is a lack of concrete evidence to quantify this impact</p>
Acceptable health care (patient and carer experience) HEALTH INEQUALITIES IMPACT	<p>There was no evidence to determine how the user experience could manifest positively in relation to health inequalities</p>	<p>Although vulnerable groups may benefit from higher quality care, the changes may be unpopular and perceived as barriers to care.</p> <p>This could have a small negative</p>	<p>There was no evidence to determine how the user experience could manifest positively in relation to health inequalities</p>	<p>Any negative impacts arising from barriers to access will have a disproportionate impact on vulnerable groups and in this option, significantly greater numbers are involved.</p>

	Option 1: Provision of 12-hour day-time paediatric ED service at STDH with 24/7 paediatric ED at SRH.		Option 2 Development of nurse-led paediatric minor injury/illness service between 8am-10pm at STDH with 24/7 acute paediatric services at SRH	
	Health and Health Inequalities Impacts and Scores		Health and Health Inequalities Impacts and Scores	
	Positive	Negative	Positive	Negative
		impact on healthcare inequalities		This could have a small negative impact on healthcare inequalities
Acceptable health care (patient and carer experience) HEALTH IMPACT SCORE	A=2 B=1 C=2	A=2 B=-1 C=-2	A=2 B=1 C=2	A=2 B=-2 C=-4
Acceptable health care (patient and carer experience)HEALTH INEQUALITIES IMPACT SCORE	A=1 B=0 C=0	A=2 B=-1 C=-2	A=1 B=0 C=0	A=2 B=-2 C=-4
<i>Equitable health care – not scored as addressed throughout</i>				
Health outcomes relating to Environmental Determinants of Health				
Transport HEALTH IMPACT	A detailed transport analysis is underway. The proposals will increase commuting traffic between S Tyneside and Sunderland and carry travel implications for service users, carers family and friends. No clear health benefits could be identified	Increased travel and traffic could generate an increased risk of Road Traffic accidents especially affecting those commuting for health care and those living close to Sunderland and South Tyneside hospital sites	A detailed transport analysis is underway. The proposals will increase commuting traffic between S Tyneside and Sunderland and carry travel implications for service users, carers family and friends. No clear health benefits could be identified	Increased travel and traffic could generate an increased risk of Road Traffic accidents especially affecting those commuting for health care and those living close to Sunderland and South Tyneside hospital sites
Transport HEALTH INEQUALITIES IMPACT	No clear health inequalities benefits could be identified	Socioeconomically deprived communities are more likely to be affected by accidents and traffic pollution thus contributing to health inequalities for those populations	No clear health inequalities benefits could be identified	Socioeconomically deprived communities are more likely to be affected by accidents and traffic pollution thus contributing to health inequalities for those populations
Transport HEALTH	A=1 B=0 C=0	A=1 B=-1 C=-1	A=1 B=0 C=0	A=1 B=-1 C=-1

	Option 1: Provision of 12-hour day-time paediatric ED service at STDH with 24/7 paediatric ED at SRH.		Option 2 Development of nurse-led paediatric minor injury/illness service between 8am-10pm at STDH with 24/7 acute paediatric services at SRH	
	Health and Health Inequalities Impacts and Scores		Health and Health Inequalities Impacts and Scores	
	Positive	Negative	Positive	Negative
IMPACT score				
Transport HEALTH INEQUALITIES IMPACT score	A=1 B=0 C=0	A=1 B=-1 C=-1	A=1 B=0 C=0	A=1 B=-1 C=-1
Natural and built environment HEALTH IMPACT	No clear health benefits / disadvantages could be identified	No clear health benefits / disadvantages could be identified	No clear health benefits / disadvantages could be identified	No clear health benefits / disadvantages could be identified
Natural and built environment HEALTH INEQUALITIES IMPACT	No clear health benefits / disadvantages could be identified	No clear health benefits / disadvantages could be identified	No clear health benefits / disadvantages could be identified	No clear health benefits / disadvantages could be identified
Natural and built environment HEALTH IMPACT SCORE	A=1 B=0 C=0	A=1 B=0 C=0	A=1 B=0 C=0	A=1 B=0 C=0
Natural and built environment HEALTH INEQUALITIES IMPACT SCORE	A=1 B=0 C=0	A=1 B=0 C=0	A=1 B=0 C=0	A=1 B=0 C=0
Pollution HEALTH IMPACT	No clear health benefits could be identified	The increased traffic could marginally increase noise and air pollution	No clear health benefits could be identified	The increased traffic could marginally increase noise and air pollution
Pollution HEALTH INEQUALITIES IMPACT	No clear health inequalities benefits could be identified	Socioeconomically deprived communities are more likely to be affected by pollution thus contributing to health inequalities for those populations	No clear health inequalities benefits could be identified	Socioeconomically deprived communities are more likely to be affected by pollution thus contributing to health inequalities for those populations
Pollution HEALTH IMPACT SCORE	A=1 B=0 C=0	A=1 B=-1 C=-1	A=1 B=0 C=0	A=1 B=-1 C=-1
Pollution HEALTH	A=1 B=0 C=0	A=1 B=-1 C=-1	A=1 B=0 C=0	A=1 B=-1 C=-1

	Option 1: Provision of 12-hour day-time paediatric ED service at STDH with 24/7 paediatric ED at SRH. Health and Health Inequalities Impacts and Scores		Option 2 Development of nurse-led paediatric minor injury/illness service between 8am-10pm at STDH with 24/7 acute paediatric services at SRH Health and Health Inequalities Impacts and Scores	
	Positive	Negative	Positive	Negative
INEQUALITIES IMPACT SCORE				
Housing HEALTH impact	No clear health benefits / disadvantages could be identified	No clear health benefits / disadvantages could be identified	No clear health benefits / disadvantages could be identified	No clear health benefits / disadvantages could be identified
Housing HEALTH INEQUALITIES impact	No clear health benefits / disadvantages could be identified	No clear health benefits / disadvantages could be identified	No clear health benefits / disadvantages could be identified	No clear health benefits / disadvantages could be identified
Housing HEALTH impact score	A=1 B=0 C=0	A=1 B=0 C=0	A=1 B=0 C=0	A=1 B=0 C=0
Housing HEALTH INEQUALITIES impact score	A=1 B=0 C=0	A=1 B=0 C=0	A=1 B=0 C=0	A=1 B=0 C=0
Health outcomes relating to Economic determinants of health				
Education, skills, learning HEALTH IMPACT	Both proposals entail staff losses albeit in very small numbers. There is an overall net shift of specialist skills out of South Tyneside and into Sunderland with an associated small health benefit for Sunderland residents	Both proposals entail staff losses albeit in very small numbers. The losses in this option are marginally lower than option 2. There is an overall net shift of specialist skills out of South Tyneside and into Sunderland with an associated small negative health impact for South Tyneside residents	Both proposals entail staff losses albeit in very small numbers. There is an overall net shift of specialist skills out of South Tyneside and into Sunderland with an associated small health benefit for Sunderland residents. The net impact is greater for this option.	Both proposals entail staff losses albeit in very small numbers. The losses in this option are marginally higher than option 1. There is an overall net shift of specialist skills out of South Tyneside and into Sunderland with an associated small negative health impact for South Tyneside residents. The net negative impact is greater for this option than option 1
Education, skills, learning HEALTH INEQUALITIES IMPACT	The numbers are very small but could have a marginal positive impact on health inequalities in Sunderland,	The numbers are very small but could have a marginal negative impact on health inequalities in South Tyneside	The numbers are very small but could have a marginal positive impact on health inequalities in Sunderland	The numbers are very small but could have a marginal negative impact on health inequalities in South Tyneside

	Option 1: Provision of 12-hour day-time paediatric ED service at STDH with 24/7 paediatric ED at SRH.		Option 2 Development of nurse-led paediatric minor injury/illness service between 8am-10pm at STDH with 24/7 acute paediatric services at SRH	
	Health and Health Inequalities Impacts and Scores		Health and Health Inequalities Impacts and Scores	
	Positive	Negative	Positive	Negative
Education, skills, learning HEALTH IMPACT score	A=1 B=1 C=1	A=1 B=-1 C=-1	A=1 B=1 C=1	A=1 B=-1 C=-1
Education, skills, learning HEALTH INEQUALITIES IMPACT score	A=1 B=1 C=1	A=1 B=-1 C=-1	A=1 B=1 C=1	A=1 B=-1 C=-1
Employment HEALTH IMPACT	Both proposals entail staff losses albeit in very small numbers. There is an overall net shift of specialist skills out of South Tyneside and into Sunderland with an associated small health benefit for Sunderland residents	Both proposals entail staff losses albeit in very small numbers. The losses in this option are marginally lower than option 2. Fewer jobs in South Tyneside could have a negative impact on health there	Both proposals entail staff losses albeit in very small numbers – less jobs in South Tyneside and more in Sunderland. The net impact is marginally greater for this option with a potentially positive impact on health in Sunderland..	Both proposals entail staff losses albeit in very small numbers. The losses in this option are marginally higher than option 1. Fewer jobs in South Tyneside could have a negative impact on health i there
Employment HEALTH INEQUALITIES IMPACT	The numbers are very small but increased jobs could have a marginal positive impact on health inequalities in Sunderland,	The numbers are very small but could have a marginal negative impact on health inequalities in South Tyneside	The numbers are very small but increased jobs could have a marginal positive impact on health inequalities in Sunderland	The numbers are very small but could have a marginal negative impact on health inequalities in South Tyneside
Employment HEALTH IMPACT SCORE	A=1 B=1 C=1	A=1 B=-1 C=-1	A=1 B=1 C=1	A=1 B=-1 C=-1
Employment HEALTH INEQUALITIES IMPACT SCORE	A=1 B=1 C=1	A=1 B=-1 C=-1	A=1 B=1 C=1	A=1 B=-1 C=-1
Business development and investment HEALTH IMPACT	Expansion of specialist paediatric care in Sunderland could generates business opportunities for this area with	Losses to investment in specialist paediatric services in South Tyneside could have a marginal negative impact	Expansion of specialist paediatric care in Sunderland could generates business opportunities for this area with potentially	Losses to investment in specialist paediatric services in South Tyneside could have a marginal negative impact

	Option 1: Provision of 12-hour day-time paediatric ED service at STDH with 24/7 paediatric ED at SRH.		Option 2: Development of nurse-led paediatric minor injury/illness service between 8am-10pm at STDH with 24/7 acute paediatric services at SRH	
	Health and Health Inequalities Impacts and Scores		Health and Health Inequalities Impacts and Scores	
	Positive	Negative	Positive	Negative
	potentially positive impacts on health	on the health of the population there	positive impacts on health	on the health of the population there
Business development and investment HEALTH INEQUALITIES IMPACT	This expansion could have a small positive impact on health inequalities in Sunderland	These losses could have a small negative impact on health inequalities in South Tyneside	This expansion could have a small positive impact on health inequalities in Sunderland	These losses could have a small negative impact on health inequalities in South Tyneside
Business development and investment HEALTH IMPACT SCORE	A=1 B=1 C=1	A=1 B=-1 C=-1	A=1 B=1 C=1	A=1 B=-1 C=-1
Business development and investment HEALTH INEQUALITIES IMPACT SCORE	A=1 B=1 C=1	A=1 B=-1 C=-1	A=1 B=1 C=1	A=1 B=-1 C=-1
Financial inclusion HEALTH IMPACT	No clear health benefits / disadvantages could be identified	No clear health benefits / disadvantages could be identified	No clear health benefits / disadvantages could be identified	No clear health benefits / disadvantages could be identified
Financial inclusion HEALTH INEQUALITIES IMPACT	No clear health benefits / disadvantages could be identified	No clear health benefits / disadvantages could be identified	No clear health benefits / disadvantages could be identified	No clear health benefits / disadvantages could be identified
Financial inclusion HEALTH IMPACT SCORE	A=1 B=0 C=0	A=1 B=0 C=0	A=1 B=0 C=0	A=1 B=0 C=0
Financial inclusion HEALTH INEQUALITIES	A=1 B=0 C=0	A=1 B=0 C=0	A=1 B=0 C=0	A=1 B=0 C=0

	Option 1: Provision of 12-hour day-time paediatric ED service at STDH with 24/7 paediatric ED at SRH.		Option 2 Development of nurse-led paediatric minor injury/illness service between 8am-10pm at STDH with 24/7 acute paediatric services at SRH	
	Health and Health Inequalities Impacts and Scores		Health and Health Inequalities Impacts and Scores	
	Positive	Negative	Positive	Negative
IMPACT SCORE				

Table 4: Integrated Health & Health Inequalities Impact scores for both Options

Colour Key

Positive	Negative	Option 1	Option 2
Major impact 13-18	Major impact _13-18	Provision of 12-hour day-time paediatric ED service at STDH with 24/7 paediatric ED at SRH.	Development of nurse-led paediatric minor injury/illness service between 8am-10pm at STDH with 24/7 acute paediatric services at SRH.
Moderate impact 7-12	Moderate impact -(7- 12)		
Minor impact 0-6	Minor impact -(0—6)		

		Total POSITIVE integrated health and health inequality impact score		Total NEGATIVE integrated health and health inequality impact score		TOTAL INTEGRATED IMPACT SCORE	
Impact Domains	Impact Domain Attributes	Option 1	Option 2	Option 1	Option 2	Option 1	Option 2
Health &	Disease management	18	18	-5	-10	13	8

		Total POSITIVE integrated health and health inequality impact score		Total NEGATIVE integrated health and health inequality impact score		TOTAL INTEGRATED IMPACT SCORE	
Impact Domains	Impact Domain Attributes	Option 1	Option 2	Option 1	Option 2	Option 1	Option 2
wellbeing relating to use of acute paediatric services	Emotional Wellbeing	18	18	-6	-9	12	9
	Prevention	18	18	-6	-12	12	6
	Safeguarding	13	13	-4	-10	9	3
	Avoidable health care	11	11	-3	-3	8	8
Health & wellbeing status relating to access to high quality health care	Effective health care	18	18	-5	-8	13	10
	Safe health care	12	12	-6	-12	6	0
	Cost efficient health care	6	9	-2	-6	4	3
	Relevance to healthcare need	8	8	0	0	8	8
	Acceptable health care	2	2	-4	-8	-2	-6
Health & wellbeing status relating to Environmental determinants of health	Transport	0	0	-2	-2	-2	-2
	Natural and built environment	0	0	0	0	0	0
	Pollution	0	0	-2	-2	-2	-2
	Housing	0	0	0	0	0	0
Health & wellbeing	Education, skills and learning	2	2	-2	-2	0	0

		Total POSITIVE integrated health and health inequality impact score		Total NEGATIVE integrated health and health inequality impact score		TOTAL INTEGRATED IMPACT SCORE	
Impact Domains	Impact Domain Attributes	Option 1	Option 2	Option 1	Option 2	Option 1	Option 2
status relating to Economic determinants of health	Employment	2	2	-2	-2	0	0
	Business development	2	2	-2	-2	0	0
	Financial inclusion	0	0	0	0	0	0
TOTAL	ALL	130	133	-51	-88	79	45

Appendix 1: Details of the scoring system used for the Equality Impact Assessment²⁸

Impact decision = Score A x Score B

Level of available evidence scoring system (A)

Level of available evidence	Score A
Existing data/research	3
Anecdotal / awareness data only	2
No evidence or suggestion	1

Potential Impact scoring system (B)

Potential Scale of Impact	Definitions	Score B
High negative	Evidence indicates: the organisation will/may not meet its statutory requirements under equality and human rights legislation there is/may be disproportionate and/or unjustifiable adverse impact on staff, service users and/or the community.	-3
Medium negative	Evidence indicates: the proposal may adversely impact on some elements of the equality legislative requirements, but the impact will not affect compliance there is potential for some adverse impact which may affect groups differently.	-2
Low negative	Evidence indicates: there is little or no relevance regarding the equality legislative requirements there may be some differential impact, but this does not have disproportionate or inequitable outcome and can be reasonably justified	-1
No impact		0
Low positive	Evidence indicates: there is little or no relevance regarding the equality legislative requirements there is a positive and/or proportionate impact on staff, service users and/or the community	+1
Medium	Evidence indicates:	+2

²⁸ NHS Centre for Equality and Human Rights. A toolkit for carrying out Equality impact assessment.

positive	the proposal supports the organisation in meeting its statutory duties under equality and human rights legislation there is a positive and/or proportionate impact on staff, service users and/or the community	
High positive	Evidence indicates: the proposal supports the organisation in meeting its statutory duties under equality and human rights legislation there is a positive and/or proportionate impact on staff, service users and/or the community	+3

Appendix 2: Scoring system used for the Health Impact Assessment

Impact decision = Score A x Score B
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Level of available evidence scoring system (A)

Level of available evidence	Score A
Existing data/research	3
Anecdotal / awareness data only	2
No evidence or suggestion	1

Potential Impact scoring system (B)

Potential Scale of Impact	Definitions	Score B
High negative	Evidence indicates: A high risk to the health of the community, patients or staff	-3
Medium negative	Evidence indicates: A medium risk to the health of the community, patients or staff	-2
Low negative	Evidence indicates: A low risk to the health of the community, patients or staff	-1
No impact		0
Low positive	Evidence indicates: A small benefit to the health of the community, patients or staff	+1
Medium positive	Evidence indicates: A medium benefit to the health of the community, patients or staff	+2
High positive	Evidence indicates: A significantly positive benefit to the health of the community, patients or staff	+3

Appendix 3: Evidence to support the Integrated Impact Assessment.

Key Equality and Health Inequalities issues concerning children: evidence summary

Socio-economic deprivation - Marmot highlighted how poor health is strongly linked to socio-economic status, and how 'giving children a good start in life' and 'enabling all children, young people and adults to maximize their capabilities and have control over their lives' is key to reducing health inequalities (Marmot 2010).

It is widely accepted that adverse factors relating to a young child's family and environment cause poorer outcomes for the child, both to their safety, and to their development and behaviour. Parental mental health issues, substance misuse, domestic violence, financial stress and teenage motherhood are themes which are frequently identified as indicating poorer outcomes for children (ChiMat a). Social exclusion for children is more common in households where adults experience a range of social exclusions (Main 2014).

Child poverty is about children living in households suffering from a lack of material resources including money, access to healthcare, a decent home and a high- quality free education. Children are much more likely to live in low-income households than the population as a whole: 27% compared to 21% (Children's Society 2013).

Certain groups of children are more likely to suffer poverty (Children's Society 2013).

- Children in households affected by disabilities - Children living in poverty are more likely to live with adults with fair or bad health, and to live with adults with a limiting illness (Main 2014)
- Lone parent families
- BME groups
- Workless households
- Asylum seeking families
- Households affected by alcohol or substance misuse - National Statistics indicate that 30% of children aged under 16 years in the UK lived with one binge drinking parent and 8% lived with an adult who had recently used illicit drugs (ChiMat a)

Children born to poor families are more likely to be born premature, have low birth weights, and die in the first year of life (Main 2012) more likely to be hospitalised, report a long-standing illness, suffer a serious accident and be socially isolated (ChiMat a; The Children's Society 2013; Main 2014).

Evidence suggests that lower socio-economic status is associated with increased difficulty in accessing information about care options (NICE 2015) and poorer reported experiences of care (Kings Fund 2014).

Young people who are homeless, or in foster care, or who have difficult relationships with their family or carers, experience poorer health (AYPH 2014), significant inequalities (Barnardos 2000) and are less likely to make successful transitions into adult services (NICE 2016, NICE 2015).

Emotional wellbeing - Systematic reviews indicate that in the non-elderly adult population, 9-10% of women and 5-6% of men will be parents with a mental health

problem. Most suffer common mental disorders such as depression or anxiety, a very small suffer from psychotic disorders such as schizophrenia. Research studies estimate that as many as 25% of children aged 5-15 years have mothers who would be classified as at risk for common mental health problems (ChiMat a).

National statistics indicate that 1.8% of children in England live in households where there is a known high risk case of domestic abuse and violence (ChiMat a).

Mental health problems, in particular depression, are the largest contributor to the global burden of disease among young people. It is estimated that almost one in ten children aged 11-15 years suffer mental health problems including anxiety and depression (PHE 2015a)

Young people engage in risk taking behaviours that can significantly contribute to health problems later in life eg alcohol use contributes to road traffic accidents ; unsafe sex can lead to sexually-transmitted infections (STIs), including HIV, and unintended pregnancy (PHE 2015b).

Disability and sensory impairment - The prevalence rates of children and adolescents with mild disabilities are higher for those from semi-skilled manual and unskilled manual family backgrounds. Estimated rates vary between 3-5.4% (ChiMat b).

Health care priorities for children with disabilities, include 'joined up care'; communication; participation; care quality (CQC 2012).

Reports of patient experience are poorer for children with physical disabilities, a learning disability, a sensory impairment or a mental health condition. Children with these long term conditions are more likely to report their experience of health care as stressful (CQC 2012) because they have to 'fight for services'; and be negative about the information provided by staff and the quality of their communications with staff (CQC 2015) . Many families are concerned that staff do not know about their child's medical condition when treating them, but this is more common with respect to children with a physical disability or mental health condition (CQC 2015).

There are additional costs associated with raising a disabled child or supporting a disabled adult (Children's Society 2013). Families with disabled children incur additional health care costs relating to spending on aids, transport and accommodation (Kings Fund 2014).

Ethnicity - Black and minority ethnic (BME) groups generally have worse health than the overall population, although some BME groups fare much worse than others, and patterns vary from one health condition to the next. Evidence suggests that the poorer socio-economic position of BME groups is the main factor driving ethnic health inequalities (POST 2007). There is also evidence indicating that BME communities experience poorer access to healthcare because of personal and organisational factors (Stevenson 2004). The main personal factors include cultural differences, language and literacy challenges, and newness" or user ignorance concerning familiarity with the NHS and available services (Szczepura A).

Organisational factors which act as barriers to access for BME groups include provision for 'minority' problems which aren't required by the majority population eg thalassaemia, locations which aren't geographically accessible or do not provide adequate levels of interpreters (a common problem in A&E services in surveys), and staff skills and awareness of diversity issues (Szczepura A).

There is an association between BME status and lower subjective wellbeing resulting in

poorer physical and mental health outcomes (Stevenson 2004)

Young people of ethnic minority background, recent migrants and those who do not speak English as their first language are likely to have less access to information and advice, reduced access to health and social care services and may be more likely to drop out from services during transition (NICE 2015).

Ethnic minority carers are sometimes expected to provide informal care more often than their white counterparts (NICE 2015)

Gender - women carers are sometimes expected to provide informal care more often than their male counterparts (NICE 2015)

Key health care quality issues concerning provision and reconfiguration of Acute Paediatric Services: evidence summary

Reconfiguring paediatric services - There is consistent and considerable expert support for reconfiguring acute paediatric services but little research to guide an optimal configuration (Kings Fund 2014 b).

The chief drivers for reconfiguration include the current economic climate, increasing population needs in terms of numbers, expectations, technological advances and complexity, and achieving adequate levels of specialist paediatric medical staff to assure clinical quality in the face of recruitment difficulties, working time regulations and the shift towards seven day working (RCPCH 2015a)

A major consideration is access to timely assessment and consultant paediatric advice - consultants 'make better decisions more quickly and are critical to reducing the costs of patient care while maintaining quality (RCPCH 2015a; Kings Fund 2014 b; RCPCH 2012a).

Reconfiguration offers a means of achieving high quality, safe care, organised around the child's need, 24 hours a day, seven days a week (RCPCH 2015a)

Experts, with reference to available research and audit evidence, agree that successful reconfiguration must address the following principles (RCPCH 2015 a)

1. Reduce the number of inpatient sites
2. Increase the number of consultants
3. Expand significantly the number of registered children's nurses
4. Expand the number of GPs trained in paediatrics
5. Decrease the number of paediatric trainees

Achieving adequate levels of skilled staff is the priority so that children are seen by suitably qualified staff at the right time (RCPCH 2015 a; NCEPOD 2007)

A small prospective study compared outcomes for patients seen by paediatric nurse practitioners compared to those seen by doctors and found there were no statistically significant differences in discharge or re-attendance rates (Kings Fund 2014 b)

There is little and conflicting evidence on timeliness of access (Kings Fund 2014 b). One study found that asthma mortality increased with travel time to hospital, with a relative risk of 1.07 for each 10-minute increase in journey time and yet, a small review

of the literature about telemedicine and unscheduled paediatric care found studies reporting improvements in care quality indicators, better staff-reported measures of quality and reduced transfer rates (Kings Fund 201 b).

Experts recommend that an initial clinical assessment should be made within 15 minutes of arrival and provision should be made for high volume surges to reduce the risk of children waiting more than 15 minutes for assessment (RCPCH 2012b). This should include a senior decision maker undertaking rapid overviews of any children waiting (NHSE 2015).

Good practice entails involving children in developing and evaluating services (RCPCH 2010). Participation has the potential to reduce health inequalities; however this requires an understanding of existing power imbalances, barriers affecting the involvement of children and young people from diverse backgrounds and a range of experience, and an invested commitment to address the inequalities (RCPCH 2010).

Service quality standards - Numerous quality standards have been developed to guide delivery of paediatric services (RCPCH and RCGP 2015; RCPCH 2015 a; NHSE 2015; RCPCH 2012b; RCS 2015; RCPCH 2014a; NICE 2010; PICS 2015). These guidelines emphasise staffing mix and levels, paediatric skills, education and training, 'joined up working' and information sharing. Summaries of the most recent standards are presented below (RCPCH and RCGP 2015; RCPCH 2015).

Effectiveness & Safety- various audits have highlighted the main challenge in acute paediatrics - most children's illnesses are minor and it is difficult for healthcare professionals to identify the very few children with serious illnesses (RCPCH and RCHP 2015).

Failure to spot the severity of a child's illness because of lack of paediatric expertise and training is a key cause of avoidable child death (Kings Fund 2014 b; RCPCH 2014b)

Admissions can result in additional morbidity such as hospital-acquired infections, distress, disruption and costs to children and their families (separation, school absence, travel time and travel cost) as well as being costly for the NHS (RCPCH 2015). There is good evidence that regular consultant review can decrease length of stay for patients and improve quality of care (RCPCH 2015)

Transitions of care are central to clinical effectiveness (RCPCH 2015; PICS 2015; RCPCH and RCGP; Kings Fund 2014 b; NICE 2016; RCPCH 2014a)

- Effective handovers between paediatric teams are essential to ensure adequate continuity of care - There is a growing body of evidence that clinically significant information can be lost during the handover process, and that this can lead to adverse outcomes for patients
- Detailed discharge information on self-care enables children and their parents / carers to effectively manage care at home
- Safety netting information also provides advice on when and where to seek further help if needed, helps to reduce demands on health services including reducing re-attendances by decreasing parental anxiety, improving confidence to self-care and encouraging appropriate follow-up care with primary care
- Effective transitions between children's and adults services can avoid children being lost to follow up
- A life-course approach, coherently addressing the different stages in life and the key transitions, is more effective than tackling individual risk factors in isolation (CYPH 2012)

The various guidelines and standards cited above emphasise that special provision is

required for specific groups, for example

- Neonates
- Children with safeguarding concerns
- Young people
- Young people in transition
- Children with life-limiting conditions
- Children with physical, learning or emotional difficulties
- Families with socio-economic pressures eg homelessness, with social workers
- Families from BME communities without English as a first language
- Critically ill children - assessment, staffing, care pathways, transfers and transport

Any presentation in the unscheduled care system should be seen as an opportunity for health promotion and education on childhood illness and safety practices (RCPCH 2012b; RCPCH and RCGP 2015).

No matter where children are being cared for, their basic health information should be available, as needed, to those looking after them. Information should flow between systems while keeping confidential information safe and secure (RCPCH 2015; RCPCH and RCGP 2015; CYPH 2012)

Agreed and documented care pathways help to promote high-quality, evidence-based assessment and management of the acutely unwell child when accessing local unscheduled care services (RCPCH and RCGP 2015). Early warning and assessment scores can promote patient safety (NHSE 2017)

Regular whole system meetings can (RCPCH and RCGP 2015)

- help to build strategic connections across the system
- drive through system-wide improvements.
- provide the opportunity to work together to promote appropriate use of health services by building children's and their parent and carers' capability and confidence to self-care. (Especially for vulnerable and marginalised groups who repeatedly report poorer experiences of care)

The RCPCH work on outcomes measures identifies 5 domains and related priorities relevant to acute paediatric services for infants, children and young people aged 0 to 18 (RCPCH 2017):

a) Management of acute illness by inpatient general paediatric services

- Evidence based medical management of acute paediatric problems - with an emphasis on sepsis, asthma, epilepsy
- Timely clinical responses - with an emphasis on effective application of Paediatric Early Warning System and minimizing emergency transfers to paediatric intensive care .

b) Patient safety

- Medication and treatment errors
- Learning from significant events
- Clinical Handovers

c) Activity and patient flow

- Admissions rates
- Lengths of stay
- Unplanned readmissions within 24 and 48 hours and 7 days of discharge

d) Patient and parent/carer experience

- Pain management
- Anxiety and distress / emotional wellbeing

e) Staff experience

- Satisfaction,
- Health
- Capability

User experience - There is strong evidence that experience of care is linked to outcomes and safety (National Quality Board 2015). Priorities for all patients are patient-centred communication and compassion (National Quality Board 2015). In acute paediatrics, other priorities include (PEN 2013; CYPH 2012; NICE 2016; RCPCH and RCGP 2015)

- timely access to expert advice
- effective transitions between paediatric and adult care
- listening to and addressing the needs of young people
- integrating services and information

Communication issues of concern to children and their families relate to awareness of medical history, information on discharge and involvement of older children (12 years and over) in decisions about their care (CQC 2015). On discharge, families would like more information about the condition or treatment, and what to do if they are worried once home (CQC 2015). In a recent survey 41% of carers and parents did not feel that staff were definitely aware of their child's medical history when treating them (CQC 2015).

The provision of written in addition to verbal discharge information increases knowledge and satisfaction. There is also a growing demand for information to be provided in different formats, including video and internet-based information (RCPCH and RCGP 2015)

Children have different needs at different ages. Priorities for young people friendly health services address (DH 2011):

- Accessibility – public transport, convenient times for young people
- Publicity
- Confidentiality and consent
- Environment
- Staff training, skills, attitudes and values
- Joined-up working – co-location of services wherever possible
- Young people's involvement in monitoring and evaluation of patient experience
- Health issues for young people

Primary care for children – Around a quarter of patients seen by a GP are children, but many GPs lack the confidence to assess and treat children in their surgery, leading many to refer children to hospital for conditions that could be managed in general practice or other community settings (RCPCH and RCGP 2015)

Strong links between paediatricians and GPs are fundamental to providing more efficient and higher quality care for children in the community (RCPCH and RCGP 2015)

RCPCH (2015) Facing the Future: Standards for Acute General Paediatric Services (revised 2015)

1. A consultant paediatrician* is present and readily available in the hospital during times of peak activity, seven days a week.
2. Every child who is admitted to a paediatric department with an acute medical problem is seen by a healthcare professional with the appropriate competencies to work on the tier two (middle grade) paediatric rota within four hours of admission.
3. Every child who is admitted to a paediatric department with an acute medical problem is seen by a consultant paediatrician* within 14 hours of admission, with more immediate review as required according to illness severity or if a member staff is concerned.
4. At least two medical handovers every 24 hours are led by a consultant paediatrician*.
5. Every child with an acute medical problem who is referred for a paediatric opinion is seen by, or has their case discussed with, a clinician with the necessary skills and competencies before they are discharged. This could be: a paediatrician on the consultant rota, a paediatrician on the tier two (middle grade) rota, or a registered children's nurse who has completed a recognised advanced children's nurse practitioner programme and is an advanced children's nurse practitioner.
6. Throughout all the hours they are open, paediatric assessment units have access to the opinion of a consultant paediatrician* (*or equivalent staff, associate specialist or speciality doctor who is trained and assessed as competent to work on the paediatric consultant rota).
7. All general paediatric inpatient units adopt an attending consultant* system, most often in the form of the 'consultant of the week' system.
8. All general paediatric training rotas are made up of at least ten whole time equivalent posts, all of which are compliant with the UK Working Time Regulations and European Working Time Directive.
9. Specialist paediatricians are available for immediate telephone advice for acute problems for all specialties, and for all paediatricians.
10. All children, children's social care, police and health teams have access to a paediatrician with child protection experience and skills (of at least level 3 safeguarding competencies) who is available to provide immediate advice and subsequent assessment, if necessary, for children under 18 years of age where there are child protection concerns. The requirement is for advice, clinical assessment and the timely provision of an appropriate medical opinion, supported by a written report

RCPCH and RCGP (2015) Facing the future: together for child health: Summary List of Standards

1. GPs assessing or treating children with unscheduled care needs have access to immediate telephone advice from a consultant paediatrician.
2. Each acute general children's service provides a consultant paediatrician-led rapid-access service so that any child referred for this service can be seen within 24 hours of the referral being made.
3. There is a link consultant paediatrician for each local GP practice or group of GP practices.
4. Each acute general children's service provides, as a minimum, six-monthly education and knowledge exchange sessions with GPs and other healthcare professionals who work with children with unscheduled care needs.
5. Each acute general children's service is supported by a community children's nursing service which operates 24 hours a day, seven days a week, for advice and support, with visits as required depending on the needs of the children using the service.
6. There is a link community children's nurse for each local GP practice or group of GP practices.
7. When a child presents with unscheduled care needs the discharge summary is sent electronically to their GP and other relevant healthcare professionals within 24 hours and the information is given to the child and their parents and carers.
8. Children presenting with unscheduled care needs and their parents and carers are provided, at the time of their discharge, with both verbal and written safety netting information, in a form that is accessible and that they understand.
9. Healthcare professionals assessing or treating children with unscheduled care needs in any setting have access to the child's shared electronic healthcare record.
10. Acute general children's services work together with local primary care and community services to develop care pathways for common acute conditions.
11. There are documented, regular meetings attended by senior healthcare professionals from hospital, community and primary care services and representatives of children and their parents and carers to monitor, review and improve the effectiveness of local unscheduled care

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Equality Indicators

Gender

Table 5: Population gender profile (Source ONS Census Data 2011 KS101EW)

	S Tyneside		Sunderland	
	Count	%	Count	%
Total	148127	100	275506	100
Males	71560	48.3	133953	48.6
Females	76567	51.7	141553	51.4

Age

Table 6: Population age profile (Source ONS Census Data 2011 KS102EW)

	South Tyneside		Sunderland	
	Count	%	Count	%
All Usual Residents	148127		275506	
Age 0 to 4	8182	5.5	15378	5.6
Age 5 to 7	4619	3.1	8599	3.1
Age 8 to 9	2932	2	5534	2
Age 10 to 14	8233	5.6	15355	5.6
Age 15	1961	1.3	3326	1.2
Age 16 to 17	3735	2.5	6753	2.5

Age 18 to 19	3797	2.6	7708	2.8
Age 20 to 24	9447	6.4	19709	7.2
Age 25 to 29	8901	6	16945	6.2
Age 30 to 44	27436	18.5	52854	19.2
Age 45 to 59	32394	21.9	58541	21.2
Age 60 to 64	9637	6.5	18011	6.5
Age 65 to 74	13634	9.2	25031	9.1
Age 75 to 84	9632	6.5	16600	6
Age 85 to 89	2503	1.7	3576	1.3
Age 90 and Over	1084	0.7	1586	0.6
Population aged Total aged 15-44	55277	37.3	107295	39.1
Women aged 15-44 (2011) *		36.6		38.3
Children 0-18 years	29,662	20	54,945	20

* source ChiMat demography profiles

Ethnic Group

Table 7: Ethnic groups (Source ONS Census Data 2011 KS201EW)

Ethnic Group	South Tyneside		Sunderland	
	Count	%	Count	%
All Usual Residents	148127	100	275506	100
White;	140821	95.1	261209	94.8

English/Welsh/Scottish/Northern Irish/British				
White; Irish	305	0.2	608	0.2
White; Gypsy or Irish Traveller	9	0	70	0
White; Other White	964	0.7	2395	0.9
Mixed/Multiple Ethnic Groups; White and Black Caribbean	324	0.2	539	0.2
Mixed/Multiple Ethnic Groups; White and Black African	229	0.2	239	0.1
Mixed/Multiple Ethnic Groups; White and Asian	440	0.3	608	0.2
Mixed/Multiple Ethnic Groups; Other Mixed	332	0.2	392	0.1
Asian/Asian British; Indian	643	0.4	1736	0.6
Asian/Asian British; Pakistani	434	0.3	669	0.2
Asian/Asian British; Bangladeshi	1534	1	2075	0.8
Asian/Asian British; Chinese	235	0.2	1536	0.6
Asian/Asian British; Other Asian	465	0.3	1320	0.5
Black/African/Caribbean/Black British; African	316	0.2	1062	0.4
Black/African/Caribbean/Black British; Caribbean	61	0	111	0
Black/African/Caribbean/Black British; Other Black	43	0	100	0
Other Ethnic Group; Arab	566	0.4	292	0.1
Other Ethnic Group; Any Other Ethnic Group	406	0.3	545	0.2

Table 8: BME information about newborns (Source PHE Child Health profiles accessed February 2017)

	Period	South Tyneside		Sunderland	
		Count	value	Count	value
Percentage of babies born to mothers born in Middle East and Asia (%)	2014	61	3.8	94	3.3

Religion

Table 9: Religion profile (Source ONS census data 2011: KS209EW)

	S Tyne	Sunderland
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	Count	%	Count	%
All Usual Residents	148127	100	275506	100
Christian	104090	70.3	193642	70.3
Buddhist	223	0.2	550	0.2
Hindu	254	0.2	607	0.2
Jewish	57	0	76	0
Muslim	2854	1.9	3650	1.3
Sikh	424	0.3	814	0.3
Other Religion	362	0.2	511	0.2
No Religion	31247	21.1	60358	21.9
Religion Not Stated	8616	5.8	15298	5.6

Marital status

Table 10: Marital and Civil partnership profile (Source ONS census data 2011: KS103EW)

	S Tyneside		Sunderland	
	Count	%	Count	%
All Usual Residents Aged 16 and Over	122200	100	227314	100
Single (Never Married or Never Registered a Same-Sex Civil Partnership)	41841	34.2	80195	35.3
Married	53528	43.8	102531	45.1
In a Registered Same-Sex Civil Partnership	163	0.1	313	0.1
Separated (but Still Legally Married or Still Legally in a Same-Sex Civil Partnership)	3460	2.8	5530	2.4
Divorced or Formerly in a Same-Sex Civil Partnership which is Now Legally Dissolved	12546	10.3	20823	9.2
Widowed or Surviving Partner from a Same-Sex Civil Partnership	10662	8.7	17922	7.9

Disability

Table 11: Disability profile (Source ONS Census Data 2011: QS303EW)

	S Tyneside		Sunderland	
	Count	%	Count	%
All Usual Residents	148127	100	275506	100
Day-to-Day Activities Limited a Lot	18166	12	34206	12
Day-to-Day Activities Limited a Little	16315	11	30346	11
Day-to-Day Activities Not Limited	113646	77	210954	77

Table 12: Estimates of disability in children (Source: CHIMAT Service Snapshot - Disability profiles for South Tyneside and Sunderland - accessed February 2017)

	S Tyneside		Sunderland	
	Count	Value	Count	Value
Mean number (%) of disabled children - using national figures applied to the localities	831-1,496	3-5.4%	1,552-2,794	3-5.4%
Estimated number of visual impairment in 5-15 years olds - using national prevalence data of 20 children per 10,000	19-35		35-66	
Registered partially sighted 0-17 years (2011) - rate per 10,000 population		6.8		6.4
Hard of hearing children registered in 2010 aged 0-17 years - rate per 10,000	<1		2-3	
Deaf children registered in 2010 aged 0-17 years - rate per 10,000	<1		3-4	

* empty cells indicate lack of available data / indicators

Pregnancy and Maternity

Table 13: Total Number of Live births in each area: (source ONS Data 2015)

	Total number of live births (2015)
South Tyneside	1,647
Sunderland	2,889

Socioeconomic Deprivation

Table 14: Socio-economic deprivation of households (source ONS Census data 2011: QS119EW)

	S Tyneside		Sunderland	
	Count	%	Count	%
All Households	67167	100	119758	100
Household is Not Deprived in Any Dimension	24531	37	42790	36
Household is Deprived in 1 Dimension	21705	32	38223	32
Household is Deprived in 2 Dimensions	15947	24	29259	24
Household is Deprived in 3 Dimensions	4679	7	8920	7
Household is Deprived in 4 Dimensions	305	0	566	0

Description : All households in the area at the time of the 2011 Census with four of the selected deprivation dimensions. The dimensions of deprivation are indicators based on the four selected household characteristics - Employment (any member of a household not a full-time student is either unemployed or long-term sick); Education (no person in the household has at least level 2 education, and no person aged 16-18 is a full-time student); Health and disability (any person in the household has general health 'bad or very bad' or has a long term health problem.); and Housing (Household's accommodation is either overcrowded, with an occupancy rating -1 or less, or is in a shared dwelling, or has no central heating).

Children's Health and Health Inequalities Indicators

Vulnerable children

Table 15: Child Poverty Indicators (Source Public Health England: School Age Children Profile and Child Health Profiles accessed Feb 2017)

	Period	South Tyneside		Sunderland	
		Count	value	Count	value
Number and percentage of Children in low income families (under 16s) - percent		6,565	25.9	11,525	23.6
Children in Care - rate per 10,000	2015	300	102	570	105
Child protection cases – rate of children who were the subject of a child protection plan at the end of the year – rate per 10,000	2014/15	195	66.5	406	74.5
New child protection cases – rate of children who became the subject of a child protection plan during the year - per 10,000 aged under 18	2014/15	236	80.5	432	79.1
Family homelessness - percent	2014/15	166	2.4	55	0.5
Homeless young people aged 16-24 rate per 1000	2015/16	51	0.75	19	0.16
Pupils with social, emotional and mental health needs: % of pupils	2015	526	2.46	1,053	2.53

Mortality

Table 16 Child mortality indicators (Source: PHE Mortality profiles and child health profiles accessed February 2017)

Indicator	Time Period	South Tyneside	Sunderland	England
Child mortality rate 1-17 years (count)	2012-14	12.1 (10)	15.4 (24)	12
Infant mortality (count)	2012-14	2.7 (13)	3.6 (32)	4
Stillbirth rate	2013-15	3.7 (18)	4.8 (42)	4.6
Neonatal mortality	2013-15	1.23 (6)	2.96 (26)	2.71
Post-neonatal	2013-15	0.82 (4)	1.14 (10)	2.98

mortality				
Very low birth weight of all babies	2015	1.09 (18)	1.49 (43)	1.26
Life expectancy at birth (male)	2013-15	77.5	77	79.5
Life expectancy at birth (female)	2013-15	81.5	80.9	83.1

Children's Accidents

Table 17: Children's accidents (Source: Public Health England: School Children Profiles accessed Feb 2017)

	Period	South Tyneside		Sunderland	
		Count	Value	Count	Value
Children killed or seriously injured in road traffic accidents (rate per 100,000)	2012/14	14	18.1	44	30.5
Children aged 6-10 killed or seriously injured in road traffic accidents (rate per 100,000)	2012/14	2	8.5	11	25.1
Children aged 11-15 killed or seriously injured in road traffic accidents (rate per 100,000)	2012/14	7	29.4	28	63.3

Child health

Table 18: Indicators of child health (Source PHE child health profiles, accessed February 2017)

	Period	South Tyneside		Sunderland	
		Count	Value	Count	Value
Teenage mothers (%)	2014/15	23	1.5	44	30.5
Under 16s conceptions rate per 1000 females aged 13-15	2014	13	5.5	39	9.2
Under 18s conceptions rate per 1000 females aged 15-17	2014	80	30.9	163	34.9
Maternal smoking status at time of delivery (%)	2014/15	403	25.9	531	19.4
Breastfeeding initiation (%)	2014/15	821	53	1,558	57.5
Breastfeeding prevalence at 6-8 weeks after birth (%)	2014/15	394	24.9	725	26.2
School Reception - prevalence of overweight including obese*	2012/13-14/15	1,203	24.9%	2,144	23.4%

School Year 6 - prevalence of overweight including obese*	2012/13-14/15	1,596	38%	2,986	36.8%
Obese children 4-5 years*	2012/13-14/15	518	10.7%	979	10.7%
Obese children 10-11 years*	2012/13-14/15	980	23.3%	1,820	22.4%
MMR vaccination for one dose (2 years)	2014/15	1,651	98.2%	2,918	98.9
Dtap/IPV / Hib vaccination (2 years)	2014/15	1,672	99.4%	2,837	96.2

* modelled estimates

Table 19: Main causes of death by age group based on national figures 2012-2014 (source CHIMAT – Demography reports – accessed February 2017)

28 days to under 1 year	1-4 years	5-14 years	15-19 years	28 days – 24 years
Unclassified including sudden infant death (22.4%)	Neoplasms (16.3%)	Neoplasms (26.9%)	External causes (over 50% or total, a third of which are transport accidents)	external causes (35.1%)
congenital malformations, deformations and chromosomal abnormalities (22.4%)	External causes (strangulation, choking and deaths from fire) (15.7%)	External causes (19.2%)	Intentional self harm (17%)	neoplasms (12.3%)
Chronic respiratory disease and necrotising colitis (20.2%)	congenital malformations, deformations and chromosomal abnormalities (13.5%)		Neoplasms (12.5%)	diseases of the nervous system (9.3%)
	Diseases of the nervous system (12.3%)			congenital malformations, deformations and chromosomal abnormalities (9.1%)

South Tyneside Child Health Profile

March 2016

The chart below shows how children's health and wellbeing in this area compares with the rest of England. The local result for each indicator is shown as a circle, against the range of results for England which are shown as a grey bar. The red line indicates the England average. The key to the colour of the circles is shown below.

- Significantly worse than England average
- Not significantly different
- Significantly better than England average
- ◆ Regional average

25th percentile England average 75th percentile

	Indicator	Local no.	Local value	Eng. ave.	Eng. Worst		Eng. Best
Prevention of ill health	1 Infant mortality	4	2.7	4.0	7.2		1.6
	2 Child mortality rate (1-17 years)	3	12.1	12.0	19.3		5.0
Health protection	3 MMR vaccination for one dose (2 years) ● >=90% ● <90%	1,661	98.1	92.3	73.8		98.1
	4 Dtap / IPV / Hib vaccination (2 years) ● >=90% ● <90%	1,681	99.2	95.7	79.2		99.2
	5 Children in care immunisations	190	95.0	87.8	64.9		100.0
Wider determinants of ill health	6 Children achieving a good level of development at the end of reception	1,015	60.6	66.3	50.7		77.5
	7 GCSEs achieved (5 A-C inc. English and maths)	900	57.4	57.3	42.0		71.4
	8 GCSEs achieved (5 A-C inc. English and maths) for children in care	6	25.0	12.0	8.0		42.9
	9 16-18 year olds not in education, employment or training	320	6.0	4.7	9.0		1.5
	10 First time entrants to the youth justice system	78	597.4	409.1	808.6		132.9
	11 Children in poverty (under 16 years)	6,565	25.9	18.6	34.4		6.1
	12 Family homelessness	166	2.4	1.8	8.9		0.2
	13 Children in care	300	102	60	158		20
14 Children killed or seriously injured in road traffic accidents	4	16.8	17.9	51.5		5.5	
Health improvement	15 Low birthweight of term babies	34	2.3	2.9	5.8		1.6
	16 Obese children (4-5 years)	181	11.1	9.1	13.6		4.2
	17 Obese children (10-11 years)	340	23.0	19.1	27.8		10.5
	18 Children with one or more decayed, missing or filled teeth	-	27.7	27.9	53.2		12.5
	19 Hospital admissions for dental caries (1-4 years)	18	269.8	322.0	1,406.8		11.7
	20 Under 18 conceptions	76	28.9	24.3	43.9		9.2
	21 Teenage mothers	23	1.5	0.9	2.2		0.2
	22 Hospital admissions due to alcohol specific conditions	27	90.4	40.1	100.0		13.7
23 Hospital admissions due to substance misuse (15-24 years)	28	153.5	88.8	278.2		24.7	
Prevention of ill health	24 Smoking status at time of delivery	403	25.9	11.4	27.2		2.1
	25 Breastfeeding initiation	821	53.0	74.3	47.2		92.9
	26 Breastfeeding prevalence at 6-8 weeks after birth	376	24.4	43.8	19.1		81.5
	27 A&E attendances (0-4 years)	8,507	1,021.2	540.5	1,761.8		263.6
	28 Hospital admissions caused by injuries in children (0-14 years)	481	199.7	109.6	199.7		61.3
	29 Hospital admissions caused by injuries in young people (15-24 years)	310	172.6	131.7	287.1		67.1
	30 Hospital admissions for asthma (under 19 years)	87	278.9	216.1	553.2		73.4
	31 Hospital admissions for mental health conditions	25	85.3	87.4	226.5		28.5
	32 Hospital admissions as a result of self-harm (10-24 years)	134	512.8	398.8	1,388.4		105.2

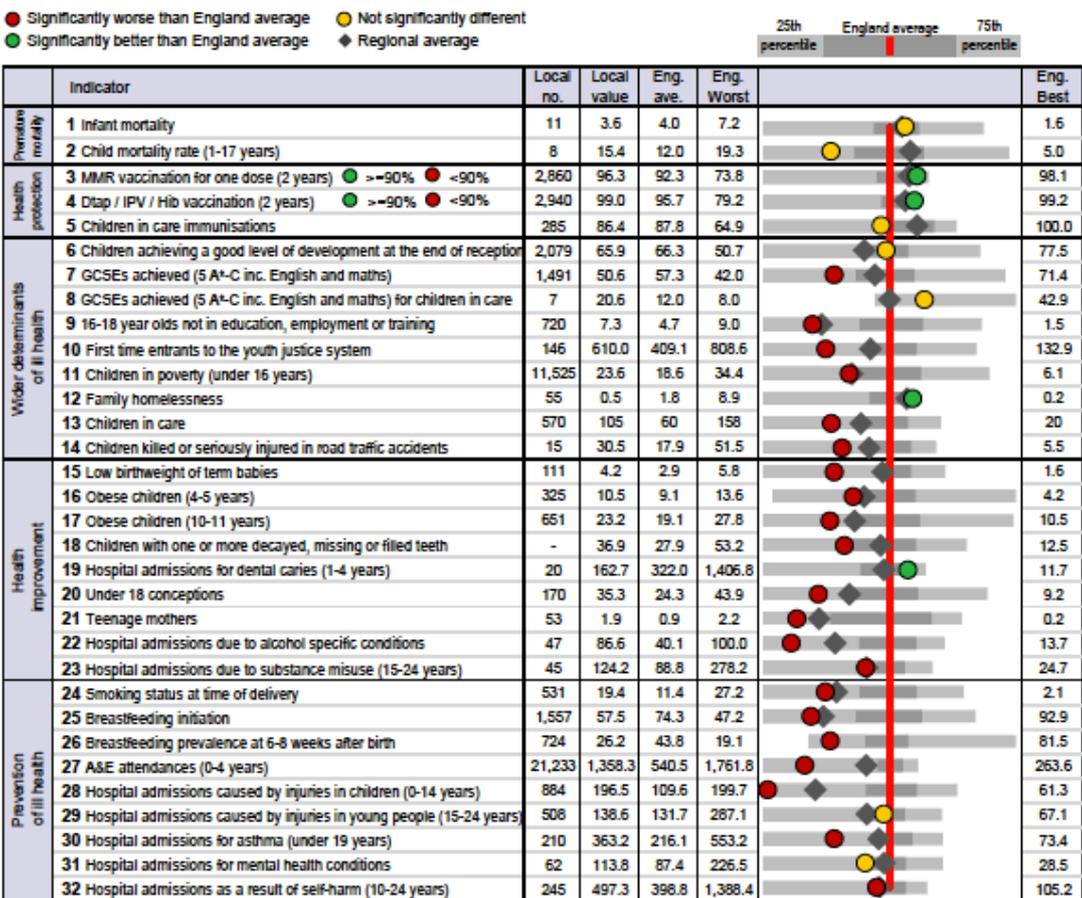
Notes and definitions - Where data is not available or figures have been suppressed, this is indicated by a dash in the appropriate box.

Figure 2: PHE (accessed February 2017) Child Health Profile for South Tyneside, March 2016

Sunderland Child Health Profile

March 2016

The chart below shows how children's health and wellbeing in this area compares with the rest of England. The local result for each indicator is shown as a circle, against the range of results for England which are shown as a grey bar. The red line indicates the England average. The key to the colour of the circles is shown below.



Notes and definitions - Where data is not available or figures have been suppressed, this is indicated by a dash in the appropriate box.

Figure 3: PHE (accessed February 2017) Child Health Profile for Sunderland, March 2016

Children's Use of Acute Hospital Services

Table 20: Common medical problems presenting to A&E for children (Source RCPC and RCGP (2015) Facing the future: together for child health)

Most common medical problems presenting to A&E for children under 15	Most common medical problems presenting to A&E for children 13-17 years old
<ul style="list-style-type: none"> • breathing difficulty (20%), • febrile illness (14%) • diarrhoea with or without vomiting (14%) 	<ul style="list-style-type: none"> • pain (16%), • self-harm (11%) • collapse (10%)

Table 21: A&E attendance rates for children (Source: Source Public Health England: Child Health and School Children Profiles accessed Feb 2017)

	Period	South Tyneside		Sunderland	
		Count	Value	Count	Value
A&E Attendances (under 18 years) rate per 1000 population	2014/15	18,466	628	45,442	834
A&E Attendances under 1 year rate per 1000 population	2014/15	2,530	1,535.8	5,646	1,896.4
A&E Attendances 0-4 years rate per 1000 population	2014/15	8,478	1,029.3	21,113	1,418.3
A&E Attendances (1-4) rate per 1000 population	2014/15	*	902.6	*	1,298.8
A&E Attendances (5-9 years) rate per 1000 population	2014/15	3,641	437	9,836	626.9
A&E Attendances (10-14 years) rate per 1000 population	2014/15	3,854	499	8,724	606.8
A&E Attendances (15-17 years) rate per 1000 population	2014/15	2,493	487.7	5,769	604.8
A&E Attendances (15-19 years) rate per 1000 population	2014/15	4,534	532.2	10,764	677.1

* values suppressed due to low numbers affecting disclosure control

Table 22: Emergency admission Rates by age - all causes (Source PHE Child Health Healthcare Use and School Children Profiles accessed Feb 2017)

	Period	South Tyneside		Sunderland	
		Count	Value	Count	Value
Admissions of babies under 14 days – per 1000	2014/15	77	51.7	90	31.8
Emergency admissions (0-19 years) rate per 1000 population	2014/15	2,720	82.9	5,353	88

Emergency admissions (under 1 year) rate per 1000 population	2014/15	597	364.7	1,138	381.5
Emergency admissions (1-4 years) rate per 1000 population	2014/15	797	120.9	1,629	136.8
Emergency admissions rate (per 1000 population) aged 5-9 years	2014/15	358	43	837	53.3
Emergency admissions rate (per 1000 population) aged 10-14 years	2014/15	372	48.2	787	54.7
Emergency admissions rate (per 1000 population) aged 15-19 years	2014/15	595	69.8	969	61
Emergency admissions rate (per 1000 population) aged 15-17 years	2014/15	376	73.6	583	61.1

Table 23: Admissions to hospital for children with specific conditions (Source PHE Child Health Healthcare Use and School Children Profiles accessed Feb 2017)

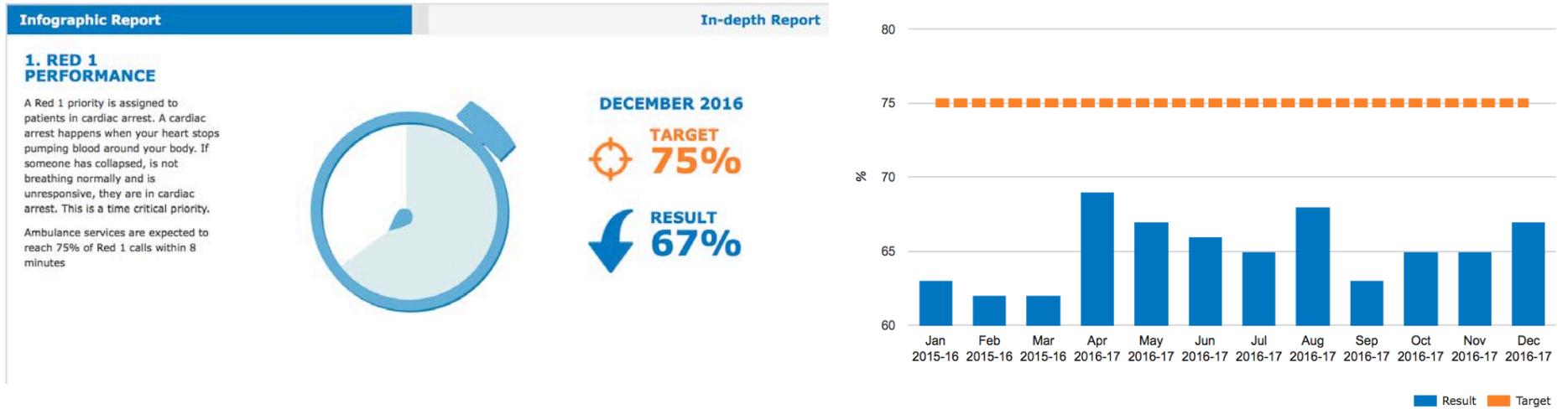
	Period	South Tyneside		Sunderland	
		Count	Value	Count	Value
Unplanned admissions for asthma, diabetes and epilepsy in under 19s (directly standardised rate)	2014/15	110	354	280	484
Admissions for asthma for children aged 0-9 (rate per 1000)	2014/15	50	301.7	145	474.2
Admissions for diabetes for children aged 0-9 (rate per 1000)	2014/15	*	*	11	35.9
Admissions for epilepsy for children aged 0-9 (rate per 1000)	2014/15	6	36.2	33	107.9
Admissions caused by unintentional deliberate injuries in children (0-14 years) rate per 10,000	2014/15	487	200.5	870	193.5
Admissions caused by unintentional deliberate injuries in children (15-24 years) rate per 10,000	2014/15	301	165.5	515	145.7
Admissions due to substance misuse (15-24 years) rate per 100,000	2012/13 – 14/15	83	149.4	138	129.4
Admissions due to alcohol specific conditions (under 18s) rate per 100,000	2012/13 – 14/15	75	85	152	92.9
Admissions for mental health conditions rates per 100,000	2014/15	25	85.3	62	113.8

Admissions for dental caries (1-4 years) rate per 100,000	2012/13 – 14/15	54	269.8	61	162.7
Admissions for gastroenteritis in infants aged under 1 years (per 10,000 population)	2014/15	40	244.3	106	355.3
Admissions for gastroenteritis in infants aged 1 year (per 10,000 population)	2014/15	14	85.1	61	200.3
Admissions for gastroenteritis in infants aged 2,3, and 4 years (per 10,000 population)	2014/15	21	41.6	46	47.9
Admissions for respiratory tract infections in infants aged under 1 years (per 10,000 population)	2014/15	108	659.7	213	714
Admissions for respiratory tract infections in infants aged 1 year (per 10,000 population)	2014/15	13	79	28	91.9
Admissions for respiratory tract infections in infants aged 2,3, and 4 years (per 10,000 population)	2014/15	7	13.9	22	22.9

* values suppressed due to low numbers affecting disclosure)

North East Ambulance Service Performance Indicators

Figure 4: Achievement of RED 1 Performance Target. (Source: NHS Ambulance Quality Indicators, North East Ambulance Service, Association of Ambulance Chief Executives accessed February 2017)



2. TIME CRITICAL RED 1 RESPONSE

Because Red 1 calls are a time critical priority, this indicator shows the time in which the ambulance arrived in 95% of all cases against the English national average.

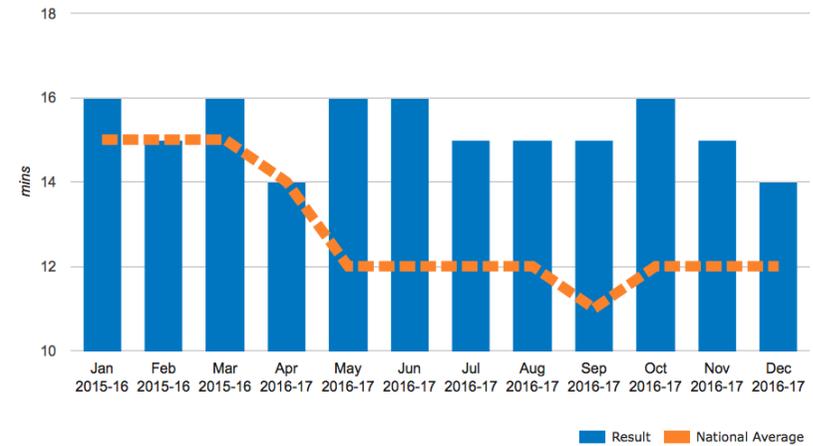


Figure 5: Achievement of RED 1 Response Time target (Source: NHS Ambulance Quality Indicators, North East Ambulance Service, Association of Ambulance Chief Executives accessed February 2017)

3. RED 2 PERFORMANCE

A Red 2 priority is assigned to other types of potentially life-threatening incidents. These include stroke, difficulty breathing, major loss of blood and heart attack.

A heart attack differs from cardiac arrest because the supply of blood to the heart is suddenly blocked, usually by a blood clot.

These cases are serious but less immediately time critical. Ambulance services are expected to reach 75% of Red 2 calls within 8 minutes.



DECEMBER 2016

TARGET
75%

RESULT
53%

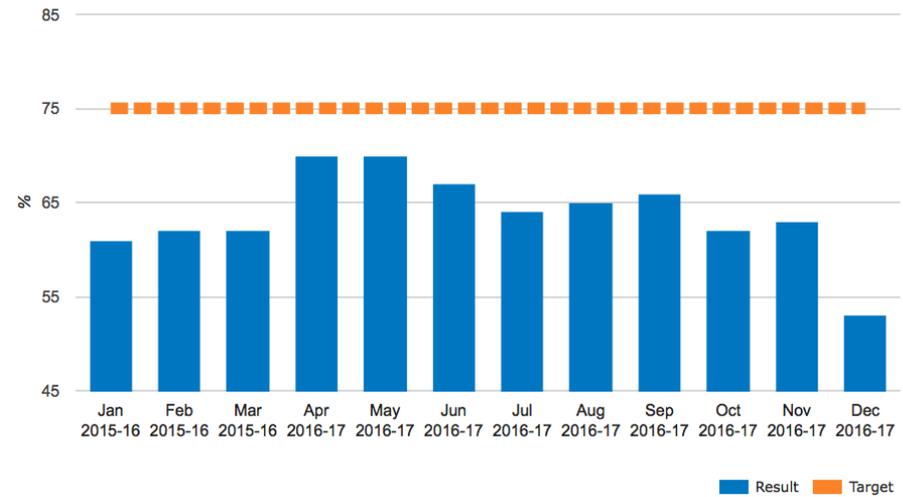


Figure 6: Figure 1: Achievement of RED 2 Performance Target (Source: NHS Ambulance Quality Indicators, North East Ambulance Service, Association of Ambulance Chief Executives accessed February 2017)

4. RED 19 PERFORMANCE

This target relates to how quickly ambulance services get a vehicle to the scene able to transport a patient. Trusts are expected to get a patient-carrying vehicle to Red 1 and Red 2 incidents within 19 minutes in 95% of the time.



DECEMBER 2016

TARGET
95%

RESULT
83%

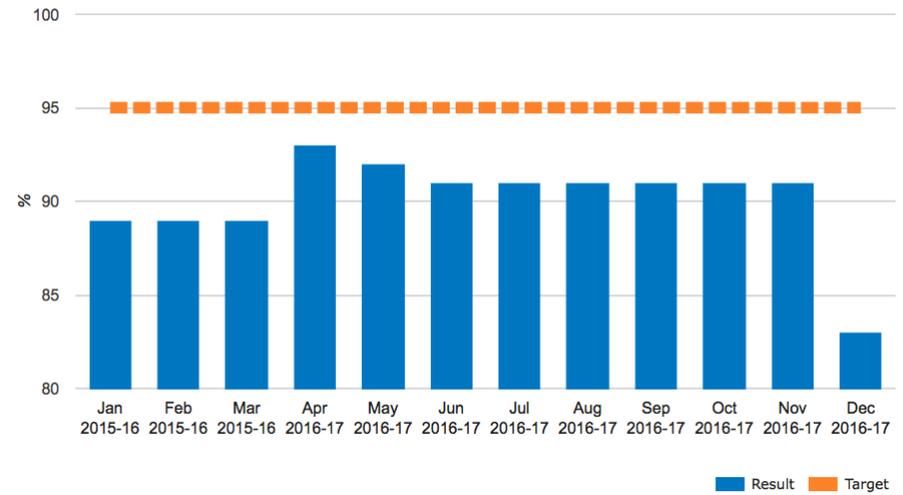


Figure 7: Achievement of RED 19 Performance Target (Source: NHS Ambulance Quality Indicators, North East Ambulance Service, Association of Ambulance Chief Executives accessed February 2017)

