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

Proposals to change and improve Obstetrics and Gynaecology 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 obstetrics and gynaecology services and neonatal care services across South Tyneside and Sunderland:

Option1 entails

- A consultant-led maternity unit and an alongside Midwife Led Delivery Unit (MLU) at Sunderland
- A free-standing MLU at South Tyneside for low risk births
- A single community midwifery team serving both areas

Option 2 entails

- A consultant-led midwifery unit and alongside MLU at Sunderland serving both South Tyneside and Sunderland populations
- A single community midwifery team serving both areas

Both options include identical plans for gynaecology services i.e.

- All inpatient gynaecology surgery will be provided at Sunderland (surgery requiring at least an overnight stay)
- Gynaecology day case and ambulatory care will remain provided from both sites
- Gynaecology outpatients will remain provided from both sites

This assessment was undertaken in parallel with a similar assessment of proposals to reconfigure acute urgent and emergency paediatrics services in the area. This review considers the impact that, proposals to reconfigure the special care baby unit in South Tyneside, will have on new mothers and their babies. Those proposals mean that babies needing specialist care from both South Tyneside and Sunderland will be treated at the special care baby unit at Sunderland Royal hospital where there is also a neonatal intensive care unit.

This IIA entailed a process that systematically considered the proposed changes to Obstetrics and Gynaecology services with the aim of identifying potentially positive or negative impacts on equality, health and health inequalities. It drew on relevant research and statistics to evaluate the impact which the two proposed models for acute Obstetrics and Gynaecology services could have with reference to 23 service specific attributes across four domains of health (Healthcare Outcomes; Access to High Quality Health Care; Environment; Economy).

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

- Socioeconomic deprivation
- Disability (physical, mental, learning)
- Race (BME communities)
- Age (older women, older and teenage mothers)
- Women who misuse alcohol or drugs
- Sensory impairment
- Women with co-morbid conditions

These groups may be more likely to need women's services and will therefore benefit from the proposed improvements in service quality. They might also be more vulnerable to some aspects of the changes.
The IIA impact scores gave a crude indication of the relative scale and direction of possible impacts. The total (net) IIA impact scores were overwhelmingly positive.

Total Integrated Impact Scores (all attributes)	
Option 1	**Option2**
152	**111**

The total IIA score was higher for Option 1 than Option 2 because the latter Option entails more far reaching changes which will affect more women. Its main feature is that it does not include either a consultant-led obstetrics delivery unit or a midwifery led unit in South Tyneside.

The IIA process entails a systematic attempt to identify possible drawbacks to the changes. The main findings are highlighted in the box below.

Health attributes for which total IIA impact scores were negative	
Option 1	**Option2**
Transport	Acceptable health care
Pollution	Transport
	Pollution

This report includes some suggestions regarding actions that could mitigate against any of the identified drawbacks. These suggestions could enable stakeholders to identify how they can contribute to the reconfiguration and further maximise the potential benefits. The suggestions relate to patient transport, organisational development, quality improvement, education and training, monitoring and evaluation

Overall, the IIA provided quantitative and qualitative evidence that the proposed changes could have major benefits for the resident populations including vulnerable groups. The key benefits relate to the ability of the changes to achieve:

- More sustainable and consistent high quality care, regardless of the day of the week or the time of day – for women, mothers and babies
- Safer Care due to sustained and improved levels of specialist staffing - especially in Obstetrics care and neonatal care - able to provide timely intervention and avoid clinical deterioration
- More cost-efficient and cost-effective Obstetrics and Gynaecology services

These service improvements could achieve enduring and significant benefits to child health, population health and inequalities across South Tyneside and Sunderland[1].

This IIA provides evidence based information to underpin the Path to Excellence rational planning and consultation process for the reconfiguration of Obstetrics and Gynaecology 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] Marmot (2010) Fair Society Health Lives

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1 Introduction

1.1 Path to Excellence: Obstetrics & Gynaecology Services

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 Obstetrics and Gynaecology 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 new options have been identified to change the way obstetrics and gynaecology services are delivered 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 obstetrics and gynaecology 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 constitution[2]:

- *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.*

In order to ensure these goals are met, all changes to NHS services are subject to a rigorous assurance process[3].

[2] The NHS constitution for England Department of Health 2015

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 services are provided in an integrated way where this might reduce health inequalities[4].

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

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

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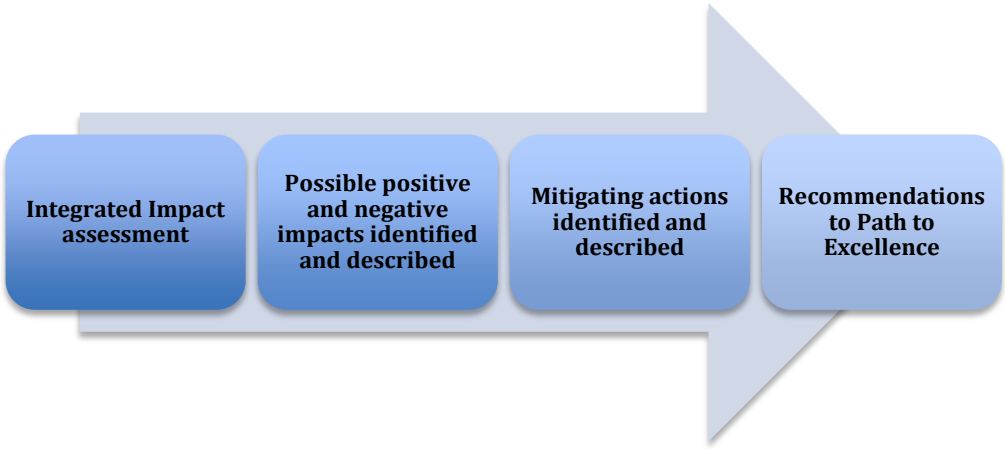
[3] NHS (2015) Planning, assuring and delivering service change for patients: a good practice guide for commissioners on the NHSE assurance process for major service changes and reconfigurations.

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



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 that were used in combination to generate a single integrated assessment of each proposed service model as indicated by this figure.

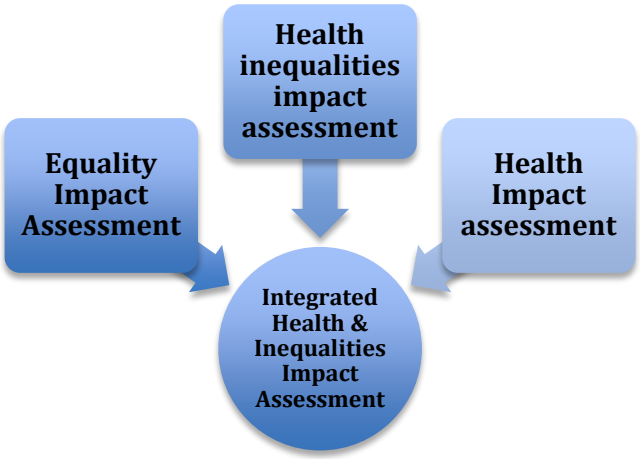


Figure 1: Overview of the methods used in the Integrated Impact Assessment

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.[7]"

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,*

[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.

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

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 debated[9].

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 health[10].

Health Inequalities **-** Health inequalities can be defined as differences in health status or in the distribution of health determinants between different population groups[11]. 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 occurs[12].

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 disability[13].

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/disadvantage[14]. Health impact assessment is usually underpinned by a focus on social justice in which equity plays a major role[10].

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].

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

Box 1: Concepts and definitions supporting the IIA

3.3 The Service Models addressed by the IIA.

The proposed reconfiguration of obstetrics and gynaecology services aims to enable service quality improvements in terms of sustainable, specialist staffing and cost-effectiveness across South Tyneside and Sunderland.

Two possible solutions have been identified, the IIA considered both options. They both propose the same changes for gynaecology services, but there are differences between the two options in terms of Obstetrics and Midwifery services. The changes can be summarised as follows:

Option 1:

- Obstetrics: Consultant-led obstetrics unit in Sunderland; Midwife-led units in South Tyneside and Sunderland. Merged community midwife service. Postnatal care provided in Sunderland and South Tyneside
- Gynaecology: Outpatient clinics at both sites; Complex inpatient care in Sunderland; Day case and ambulatory care at both South Tyneside and Sunderland sites
- Relocation of the Special Care Baby Unit in South Tyneside to Sunderland

Option 2:

- Obstetrics: Consultant-led obstetrics unit in Sunderland; Midwife-led unit in Sunderland. No deliveries at South Tyneside hospital site. Merged community midwife service. Postnatal care provided in Sunderland and South Tyneside
- Gynaecology: Outpatient clinics at both sites; Complex inpatient care in Sunderland; Day case and ambulatory care at both South Tyneside and Sunderland sites
- Relocation of the Special Care Baby Unit in South Tyneside to Sunderland

Further details of each, supported by comprehensive business cases and clinical service review reports, are provided in the Path to Excellence suite of documents.

3.4 Key Interdependencies

The proposed changes to obstetrics and gynaecology services coincide with proposals to reconfigure urgent and emergency paediatric services. Those proposals entail the relocation of the special care baby unit in South Tyneside to Sunderland with specific implications for maternity services and perinatal care across the two sites.

The impact of the changes to the way newborn babies will be cared for are fully considered within this IIA. Further details of the plans to reconfigure acute paediatric services 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.

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 women (51%). Approximately 37% of the South Tyneside population is aged between 15-44 years compared with 39% in Sunderland[20].

During the period 2013-15, the stillbirth rates for South Tyneside and Sunderland residents were 3.7 and 4.8 (per 1000 live and stillbirths) respectively[21]. Further statistics relating to maternal, perinatal and female sexual health are available in Appendix 3, especially, Table 19, Table 21, Table 22 with some key decriptors and comparators summarised below:

BOX 2: Key indicators relating to the population affected

Indicator	Time Period	South Tyneside	Sunderland	England
Percentage of babies born to mothers born in Middle East and Asia	2014	3.8 (61)	3.3 (94)	9.7
Caesarian section - percent (count)	2014/15	20.6 (307)	21.9 (620)	25.8
Percentage of deliveries to women aged 35 years or older (count)	2014/15	11.5 (171)	13.4 (379)	20.4

[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] Based on 2011 ONS Census data – see Appendix 3 for more details.
[21] Source PHE mortality profiles, see Appendix 3 for more details.

Under 18s birth rate/ 1,000 (count)	2014	7.7 (20)	11.1 (50)	6.7
Low birth weight of term babies - percent, (count)	2014	7.2 (119)	4.2 (111)	2.9
Smoking status at time of delivery - percent (count)	2015/16	21.8 (352)	18 (505)	10.6
Breastfeeding initiation – percent (count)	2014/15	53 (821)	57.5 (1,557)	74.3
Breastfeeding prevalence at 6-8 weeks after birth	2015/16	24 (395)	26.8 (757)	43.2
Pelvic inflammatory disease admissions rate / 100,000 (count)	2014/15	268.8 (73)	158.6 (84)	236.4
Ectopic pregnancy admissions rate /100,000 (count)	2014/15	110.5 (30)	58.5 (31)	89.6
Cervical cancer registrations rate / 100,000 (count)	2011-13	11.2 (26)	15.8 (65)	9.6

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.

As pregnancy is a normal physiological process with implications for mother and baby, the analysis included health and wellbeing outcomes and determinants specific to pregnancy and based around the outcomes and priorities identified by NICE and the Birthplace study**Error! Bookmark not defined.,Error! Bookmark not defined.,Error! Bookmark not defined.,Error! Bookmark not defined.**

These pregnancy and newborn specific health & wellbeing outcomes were:

1. Mortality – maternal deaths, stillbirths, or other infant deaths in the first month of life.
2. Spontaneous Vaginal Deliveries
3. Obstetrics interventions
4. Transfers of care during labour or immediately after the birth
5. Delivering a baby without serious medical problems
6. Infant feeding ideally breastfeeding
7. Maternal health – social, emotional and physical
8. Infant health - social, emotional and physical

In order to address the health impacts of gynaecology services, the assessment included additional outcomes for gynaecology patients. These were

9. Improved life expectancy (in relation to diagnosis and management of women's cancers, infections, and management of gynaecological emergencies eg ectopic pregnancies
10. Improved quality of life (including pain, continence, abnormal uterine bleeding, sexual and reproductive health)

The outcomes relating to each of the four domains are listed below. Impacts on health inequalities and access to equitable health care were considered throughout the HIIA rather than as separate entities.

Health care outcomes	**Access to high quality health care**	**Environment**	**Economy**
1. Mortality – maternal deaths, stillbirths, or other infant deaths in the first	1. Effective health care 2. Safe health care 3. Cost - Efficient health care	1. Transport 2. Natural and built environment 3. Pollution 4. Housing	1. Education, skills, learning 2. Employment 3. Business development and

month of life 2. Spontaneous vaginal deliveries. 3. Obstetrics interventions 4. Transfers of care during labour or immediately after the birth 5. Delivering a baby without serious medical problems 6. Infant feeding ideally breastfeeding 7. Maternal health – social, emotional and physical 8. Infant health - social, emotional and physical 9. `Improved life expectancy 10. Improved quality of life 11. (Health inequalities)	4. Sustainable health care relevant to population need 5. Acceptable health care (patient experience) 6. (Equitable health care)	investment 4. Financial inclusion

Box 3: Health & wellbeing outcomes relating to each of the four domains

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 obstetrics and gynaecology services in those localities.

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

- Women with gynaecological problems needing specialist advice, assessment, screening or care
- Women across the antenatal, perinatal and postnatal continuum
- Mothers with babies requiring special care
- Staff currently working in obstetrics & gynaecology and special care baby services across South Tyneside and Sunderland
- Partners, friends, relatives and carers of the women using gynaecology, obstetrics and special care baby 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 healthcare outcomes 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.

3.6.5 Impact scores

The scoring systems reflected those recommended in the NHS recommended toolkit[22], 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 would enable wider stakeholder consultation and more detailed subsequent assessment.

[22] NHS Centre for Equality and Human Rights. A toolkit for carrying out Equality impact assessment

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 & 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 Obstetrics and gynaecology services:

Option 1:

- Retain consultant-led maternity unit at Sunderland and an alongside MLU
- Develop free-standing MLU at South Tyneside for low risk births
- Development of a single community midwifery team serving both areas
- All inpatient gynaecology surgery will be provided at Sunderland (surgery requiring at least an overnight stay)
- Gynaecology day case and ambulatory care will remain provided from both sites
- Gynaecology outpatients will remain provided from both sites

Option 2:

- Develop a single consultant-led midwifery unit and alongside MLU at Sunderland serving both South Tyneside and Sunderland populations
- Develop a single community midwifery team serving both areas
- All inpatient gynaecology surgery will be provided at Sunderland (surgery requiring at least an overnight stay)
- Gynaecology day case and ambulatory care will remain provided from both sites
- Gynaecology outpatients will remain provided from both sites

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. Further details of the basis for the scores are described in the next section.

4.1.1 Positive EqIA and HIIA Impact Scores

Positive equality impact scores

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

	Positive equality impact scores	
Equality Group	**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 4: Positive EqIA scores for each option

These results show that both the proposed solutions have the potential to transform the provision of high quality acute Obstetrics and Gynaecology

services with all equality groups benefiting equally across Sunderland and South Tyneside.

The scale of the benefits was identical for both Options and relates to the proposed improvements in service quality to give children a better start in life right from the outset[23].

Positive health and inequalities impact scores

The positive HIIA impact scores across the four domains and the related 23 attributes of health status are summarised in the table below:

Impact Domains	Attributes	Total POSITIVE integrated health and health inequality impact score	
		Option 1	Option 2
Outcomes of Obstetrics and gynaecology care	Mortality	18	18
	Spontaneous vaginal delivery	15	9
	Obstetrics interventions	18	10
	Transfers of care	9	11
	Delivering a baby without serious medical problems	18	18
	Infant feeding	0	0
	Maternal health	18	12
	Infant health	18	18
	Life expectancy	12	12
	Quality of life	8	8
Access to high quality health care	Effective health care	18	18
	Safe health care	12	12
	Cost efficient health care	15	13
	Relevance to healthcare need	12	8
	Acceptable health care	10	8
Environmental determinants of health	Transport	0	0
	Natural and built environment	0	0

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

Impact Domains	Attributes	Total POSITIVE integrated health and health inequality impact score	
		Option 1	Option 2
	Pollution	0	0
	Housing	0	0
Economic determinants of health	Education, skills and learning	4	4
	Employment	4	4
	Business development	4	4
	Financial inclusion	0	0
TOTAL	ALL	**213**	**187**

Box 5: Positive HIIA Impact Scores

The HIIA indicated that both Options have the potential to result in large gains for health and health inequalities. These gains largely relate to the sustained improvements in service quality able to assure children from all groups to achieve a better start in life right from the outset**Error! Bookmark not defined.**.

Moreover, the total positive HIIA impact scores were very similar for both Options – 213 for Option 1 compared with 187 for Option 2.

The higher score for Option 1 relates to its potential to achieve more acceptable and sustainable care whilst minimising avoidable Obstetrics interventions.

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	Option 1	Option 2
Sex/ gender	-3	-6
Sexual orientation	0	0
Gender reassignment	0	0
Race	-6	-6
Marriage and civil partnership	0	0
Pregnancy / maternity	-3	-6

Religion or belief	0	0
Disability	-6	-6
Socioeconomic deprivation	-6	-6
Age	-6	-6

Box 6: Negative EqIA impact scores

Impacts on equality in relation to gender (women) and pregnancy/maternity groups were an inevitable finding relating to changes affecting Obstetrics and Gynaecology services which chiefly serve these groups. Possible negative impacts on women were also noted with respect to job losses but these figures were very small compared to the numbers affected by other issues. The difference in the impact on these groups reflects the fact that Option 2 requires more women from South Tyneside to travel outside the borough than Option 1.

Both Options were assessed as having the same scale of impact with potential drawbacks for four of the equality groups:

1. Socioeconomic deprivation
2. Disability
3. Race (BME communities)
4. Age (older and teenage women)

These groups are all at greater risk of needing obstetric led care and both proposed Options include significant changes to the availability of consultant led obstetric services in South Tyneside. This could have 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 are summarised in the table below:

Impact domains	Attributes	Option 1	Option 2
Health outcomes of O&G services	**Mortality**	-2	0
	Spontaneous vaginal delivery	0	-6
	Obstetrics interventions	0	-5
	Transfers of care	-8	-3
	Delivering a baby without serious medical problems	-4	0
	Infant feeding	0	0
	Maternal health	-4	-8
	Infant health	-4	-8

Impact domains	Attributes	Option 1	Option 2
	Life expectancy	-2	-2
	Quality of life	-4	-4
Access to high quality health care outcomes	Effective health care	0	0
	Safe health care	-4	0
	Cost efficient health care	-4	-6
	Relevance to healthcare need	-2	-6
	Acceptable health care	-5	-10
Environmental determinants of health	Transport	-4	-4
	Natural and built environment	0	0
	Pollution	-2	-2
	Housing	0	0
Economic determinants of health	Education, skills and learning	-4	-4
	Employment	-4	-4
	Business development	-4	-4
	Financial inclusion	0	0
TOTAL	ALL	**-61**	**-76**

Box 7: Negative HIIA Impact scores

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

There were some small negative HIIA scores associated with all four HIIA impact domains, although the scale of the impact was higher in relation to Option 2 than Option 1. These differences largely reflected the extent of the changes in Option 2 compared to Option 1. Option 2 requires more women from South Tyneside to deliver further from home with implications for emotional wellbeing, acceptable health care and travel costs. Option 2 may also be associated with more obstetric interventions and fewer "normal births". The key potential drawback associated with Option 1 relates to the possibility of more women requiring inter hospital transfer during or immediately after delivery as this might affect emotional wellbeing, maternal-infant bonding and generate some safety issues relating to handovers of care.

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	
	Option1	Option 2
Sex/ gender	6	3
Sexual orientation	9	9
Gender reassignment	9	9
Race	3	3
Marriage and civil partnership	9	9
Pregnancy / maternity	6	3
Religion or belief	9	9
Disability	3	3
Socioeconomic deprivation	3	3
Age	3	3

Box 8: Total EqIA impact scores

This shows that, for either Option, the considerable benefits for all equality groups outweigh any of the drawbacks identified during the assessment.

As described above, the lower scores for Option 2 reflect losses to the South Tyneside community with respect to either consultant led or midwife led delivery options in South Tyneside.

Both Options affected the other vulnerable groups equally because these groups are more likely to need Consultant led Obstetric led care and the proposals for this type of care are the same in each Option.

Total Health and Inequality Impact scores

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

Impact domains	Attributes	Option 1	Option 2
Health outcomes of O&G services	Mortality	16	18
	Spontaneous vaginal delivery	15	3
	Obstetrics interventions	18	5
	Transfers of care	1	8

Impact domains	Attributes	Option 1	Option 2
	Delivering a baby without serious medical problems	14	18
	Infant feeding	0	0
	Maternal health	14	4
	Infant health	14	10
	Life expectancy	10	10
	Quality of life	4	4
Access to high quality health care outcomes	Effective health care	18	18
	Safe health care	8	12
	Cost efficient health care	11	7
	Relevance to healthcare need	10	2
	Acceptable health care	5	-2
Environmental determinants of health	Transport	-4	-4
	Natural and built environment	0	0
	Pollution	-2	-2
	Housing	0	0
Economic determinants of health	Education, skills and learning	0	0
	Employment	0	0
	Business development	0	0
	Financial inclusion	0	0
TOTAL	ALL	**152**	**111**

Box 9: Total integrated HIIA impact scores

The total HIIA integrated impact scores show that both options were assessed as having a strongly positive impact on health and health inequalities. Option 1 had a higher total impact score than Option 2.

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

Total HIIA impact scores	Option 1	Option2

Positive	Nine of ten of the attributes in the health care outcomes domain - all but infant feeding. All five attributes in the access to high quality care domain	Nine of ten of the attributes in the health care outcomes domain - all but infant feeding Four of five attributes in the access to high quality care domain – all but acceptable health care
Negative	Two of the four attributes in the Environment domain i.e. pollution and transport	One of the five attributes in the access to high quality care domain i.e.. acceptable health care Two of the four attributes in the Environment domain i.e. pollution and transport
Neutral	All four attributes in the Economic determinants of health domain Two of the four attributes in the Environment domain i.e. housing and natural/built environment One attribute in the health care outcomes domain - infant feeding	All four attributes in the Economic determinants of health domain Two of the four attributes in the Environment domain i.e. housing and natural/built environment One attribute in the health care outcomes domain - infant feeding

Box 10: Summary of differences between the two options in the total HIIA impact scores

These results illustrate that both Options could achieve significant positive impacts on health with minimal negative or neutral impacts. The main differences between the two options relates to acceptable care because more women will need to travel outside of South Tyneside for care.

The nature of all 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 the HIIA indicated that communities in South Tyneside and certain vulnerable might be more likely to be affected by the changes. The identified vulnerable groups were:

1. Socioeconomic deprivation
2. Disability (physical, mental, learning)
3. Race (BME communities)
4. Age (older women, older and teenage mothers)
5. Women who misuse alcohol or drugs
6. Sensory impairment
7. Women with co-morbid conditions

These groups are most affected because these groups have a higher risk of perinatal complications and will therefore benefit from the proposed improvements to service quality, but they may also be more vulnerable to any associated drawbacks such as increased travel costs.

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**
	Number of under 18s births 2014	**33**	**70**
	Number of births to women over 35 2014/15	**171**	**379**
Disability	Disability – day to day activities limited a little or a lot	**34,069 (23%)**	**63,366 (23%)**
Socio-economic deprivation	Socio-economic Deprivation – households with some level of deprivation	**42,315 (63%)**	**76,645 (64%)**

Box 11: Demographic details of key vulnerable groups

4.2.2 Pregnant and maternity women and their babies in South Tyneside

Service users living in South Tyneside are most likely to be affected by any changes to the obstetrics services because of the more significant changes relating to availability of consultant-led obstetrics care 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 of the time of day – for women, mothers and babies

- Safer Care due to sustained and improved levels of specialist staffing - especially in obstetrics care and special baby care - able to provide timely intervention and avoid clinical deterioration
- More cost-efficient Obstetrics and Gynaecology services
- More 'normal' birth experiences with less avoidable obstetrics interventions and associated complications (Option 1 more than Option2)

All of these advantages can ensure that mothers have a positive experience of pregnancy and birth so that their babies have the best start in life**Error! Bookmark not defined.**.

This good start in life could be fundamental to improving population health and reducing inequalities in health across South Tyneside and Sunderland.

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. Indeed, as illustrated in Box 10, very few attributes were assessed as having a negative total HIIA score.

The drawbacks which were identified, are described more fully below and related to (in no specific order):

1. Barriers to access
2. Challenges to continuity of care
3. Travel and transport costs
4. Understanding and adapting to the new changes
5. Traffic and pollution
6. Local economy
7. Sustainability
8. Cost-efficiencies
9. Transfers of care during labour or immediately after the birth
10. Acceptable health care
11. Obstetric interventions

1) Possible barriers to access - especially for vulnerable groups (common to both options)

Evidence shows that some key groups of the population who are at risk of poorer outcomes from pregnancy are also less likely to engage in prompt and comprehensive antenatal care and more likely to experience poorer outcomes and health inequalities[24].

[24] NICE (2010) CG110. Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors

For these groups familiar, accessible care is both valued and valuable along with continuity of integrated service provision[24]. Therefore, these groups are susceptible to any reconfiguration that creates additional barriers to access.

Both options might create additional barriers for women – Option 2 affects greater numbers than Option 1. These potential barriers are explored further below and include:

- Challenges to continuity of integrated care health services and from Local Authority Children and Adult and Lifestyle Services,
- Increased travel and transport costs – in personal, economic and emotional terms
- Understanding and adapting to the new changes.

2) Challenges to continuity of care (common to both options)

Continuity of care is valued by all women during their maternity care. It is especially important to vulnerable groups who may be involved with a range of other health services e.g. mental health, primary care as well as Local Authority social care and lifestyle services. Integrating this level of provision is easiest when all providers are co-terminous but it can be challenging to maintain continuity when service users cross boundaries for episodes of care.

Both options entail challenges for continuity due to organisational change and loss of 'co-terminosity' and these are most marked for Option 2.

Loss of, or challenges to, continuity might act as a further barrier to access and can compromise coordination and communication across services.

Gaps in coordination or communication increase risks relating to patient safety[25], emotional wellbeing[24] and safeguarding for women, families and children[26].

3) Travel and transport costs (personal, economic and emotional) for users (common to both options)

Both options generate a requirement for women, their carers, friends and families to travel outside their usual area. There is an increased burden for users who live in South Tyneside and need maternity services, inpatient gynaecology services and special baby care services. The burden is greater for Option 2 as it affects more maternity users.

Travelling further for care or to visit partners, relatives or newborn children could generate additional expense, time, inconvenience and emotional stress for everyone concerned. These multiple costs disproportionately affect vulnerable

[25] NPSA & BMA (2006) Safe Handover: safe patients.

[26] Department of Education (2011) Safeguarding children across services: messages from research on identifying and responding to child maltreatment.

groups and can undermine maternal wellbeing, infant wellbeing and economic wellbeing resulting in deeper health inequalities[27]. The impact will be greatest for residents of South Tyneside.

The detailed transport analysis could provide further information to ascertain whether this is a relevant health risk.

4) Understanding and adapting to the new changes (common to both options)

Service users will notice the changes most keenly when choosing where to deliver their baby, experiencing a transfer during labour or immediately after delivery, if a baby requires special care and if they need inpatient gynaecology services. Many of these situations require users to understand the changes and how they impact on them and their care.

Adapting to the changes is more challenging for vulnerable groups due to their increased risk of English language, communication or cognitive difficulties. These groups may find it harder to choose where to deliver or to access care in an emergency and may be less resilient in the face of unexpected transfers of care. These difficulties can manifest in barriers to access, poorer health outcomes and worse user experience.

5) Transport and Pollution (common to both options and resulting in a negative total HIIA score)

Both options might generate additional traffic commuting between South Tyneside and Sunderland. This traffic could increase risks associated with noise and air pollution, congestion, and road traffic accidents with implications for the health and health inequalities for those living close to commuter routes. The detailed transport analysis could provide further information to ascertain whether these are relevant health risks.

6) Local economy (common to both options)

Both options entail a loss of some specialist health services in South Tyneside and some investment in specialist health services in Sunderland. This could have an impact on the local economy with respect to skills, jobs and business development. The health of the local economy determines population health and health inequalities.

7) Sustainability (common to both options)

Both options place greater demands on services in Sunderland raising questions around sustainability in the face of population growth. Option 1 provides more local delivery options and greater capacity for any rise in demand.

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

8) Cost efficiencies (common to both Options)
Both options achieve significant Trust level cost efficiency savings by consolidating Obstetrics led care in one unit. In Option 2, these savings are only achieved by reducing other delivery options in South Tyneside.

For both Options, the wider economic impact which the changes could have on health inequalities, the public health and health care system is unclear. Option 1 could increase ambulance costs and Option 2 could increase costs relating to obstetric interventions and travel. The economic implications of any re-admissions is unknown.

9) Transfers of care during labour or immediately after the birth (greater for Option 1 than Option 2)
Evidence shows that transfers of care are a common occurrence[28] and that handovers are a risk to patient safety[25.] Rates from freestanding midwifery led units to consultant-led obstetrics units vary between 9% (multiparous women) and 36% (nulliparous women).

The service configuration described in option 1 will entail more women and babies travelling between South Tyneside and Sunderland.

The detailed transport analysis and the review of Ambulance Services capacity could provide further information on this issue.

10) Acceptable health care (greater for Option 2 than Option 1 generating an overall negative total IIA score)
The negative impacts associated with this outcome were much greater for Option 2 generating an overall negative integrated impact score. Evidence shows that user experience is of profound importance for maternal and infant health and health inequalities[29]. Surveys show that service users value access, choice and continuity[30]. Option 2 reduces levels of provision of care close to home which might affect access, choice and continuity of care.

11) Obstetric interventions (Greater for Option 2 than Option 1)
Midwife led units are associated with an increased likelihood of a 'normal birth' when compared to consultant led obstetric units. Freestanding midwifery units have the highest rates of "normal births". This means Option 2 could have more drawbacks than Option 1 relating to spontaneous vaginal deliveries and obstetric interventions such as intrapartum caesarean section, instrumental delivery, episiotomy.

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[28] National perinatal epidemiology unit: Birthplace in England Research programme (last accessed February 2017)
[29] National Audit Office (2013) Maternity services in England
[30] NHSE (2016) National review of maternity services: assessment of quality in maternity services

4.3 Summary of the IIA findings

The results provide detailed 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:

1. Socioeconomic deprivation
2. Disability (physical, mental, learning)
3. Race (BME communities)
4. Age (older women, older and teenage mothers)
5. Women who misuse alcohol or drugs
6. Sensory impairment
7. Women with co-morbid conditions

The key areas of concern are summarised below.

Attributes with negative total impact scores	
Option 1	**Option2**
Transport	Acceptable health care
Pollution	Transport
	Pollution

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

	Total HIIA scores	
	Option 1	**Option2**
Total positive integrated impact score	213	187
Total negative integrated impact score	-61	-76
Total Integrated Impact Scores	152	111

This IIA indicates that both proposed options can achieve significant gains for population health and inequalities in South Tyneside and Sunderland. These gains relate to sustainable improvements in service quality which can give

children a better start in life and thus improve health and reduce health inequalities across South Tyneside and Sunderland.

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.

The suggestions should 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 services for women and babies. 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.

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 acute paediatric services would be a key example. Where the findings are similar, there may be opportunities to identify actions which 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 i.e. :

1. Socioeconomic deprivation
2. Disability (physical, mental, learning)
3. Race (BME communities)
4. Age (older women, older and teenage mothers)
5. Women who misuse alcohol or drugs
6. Sensory impairment
7. Women with co-morbid conditions

5.1 Suggested mitigating actions relevant to both Options

5.1.1 Promoting continuity of care especially for vulnerable groups

- Introduce arrangements to monitor user satisfaction and critical incidents relating to service continuity and coordination for all users, especially vulnerable groups. These arrangements could ensure that intelligence is translated into service developments as appropriate and necessary.

- Integrated records and information systems could be developed to promote information sharing and communication across service and sector boundaries.
- Introduce arrangements to monitor equity of access audit data for each service and ensure that this information is translated into timely and appropriate service developments whenever necessary

5.1.2 Reducing 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 scrutinise user experience data and ensure that this information is translated into timely and appropriate service developments whenever necessary.

5.1.3 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 an elective or emergency situation
- A cross area 'women's services' user group could be supported to champion the needs of women, their carers, partners, friends and relatives with an emphasis on vulnerable groups.
- The new service specification could specify responsibilities for monitoring and evaluation of service outcomes including equity of access
- Oversight arrangements could scrutinise equity and satisfaction data and ensure that this information is translated into timely and appropriate service developments whenever necessary.

5.1.4 Minimising any implications arising from 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 advocating car share schemes
- The transport analysis currently underway could provide additional insights into this aspect of the reconfiguration

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5.1.5 Minimising any negative impact on the local economy

- Other Trust functions eg IT, quality assurance, R&D, could be provided in South Tyneside to develop skills, jobs and investment in the borough.

5.1.6 Promoting sustainability

- Oversight arrangements could monitor demand and supply linked with population projections and modelling to identify and plan for any future capacity issues.

5.1.7 Maximising cost-efficiency savings

- Commissioners could agree specifications which reflect NHS and public health advice to maximise opportunities to promote health and reduce health inequalities[31], [32] , [33]
- The promotion of home births (appropriately risk assessed) could deliver further cost efficiencies while mitigating against the reduced delivery options in South Tyneside
- Consideration of further local developments to enhance the local non-acute elements of maternity pathway, as per Better Births' recommendations, could ensure the best possible, locally delivered maternity care

5.2 Suggested mitigating actions most relevant to Option 1

5.2.1 Maximising outcomes of transfers of care during labour or immediately after the birth

- 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 with preliminary reports that the service has sufficient capacity to accommodate the small numbers
- The proposed health service specifications could include protocols which address how the risks associated with potential delays in transfer and handovers of care will be minimised
- The proposed health service specifications could include processes to promote and monitor patient safety relating to transfers and handovers of care
- Oversight arrangements could monitor patient safety, user satisfaction, and critical incidents relating to inter hospital transfers and handovers of care and ensure that this information is translated into service developments as appropriate and necessary.

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[31] Burton A. Giving every child the best start in life: a public health approach. PHE:2017

[32] PHE (2016) Making Every Contact Count: Concensus Statement

[33] PHE (2016) Health matters: giving every child the best start in life.

- Oversight arrangements could monitor ambulance performance data and ensure that this information is translated into service developments as appropriate and necessary

5.3 Suggested mitigating actions most relevant to Option 2

5.3.1 Acceptable health care

- The consideration of suggestions at sections 5.1.1, 5.1.2 and 5.1.3 could help to ensure a positive experience for women

5.3.2 Obstetric interventions

- The promotion of home births (appropriately risk assessed) could mitigate against unnecessary obstetric interventions
- Clinical audit, guidelines and protocols could be developed to minimise unnecessary obstetric interventions

6 Conclusions and Recommendations

6.1 Conclusions

This IIA entailed a process that systematically considered the proposed changes to Obstetrics and Gynaecology services with the aim of identifying potentially positive or negative impacts on equality, health and health inequalities. It drew on relevant research and statistics to evaluate the impact that the two proposed models for women's services could have with reference to 23 service specific attributes of health.

There are inter-dependencies between the proposed changes to obstetrics and gynaecology services and plans to reconfigure urgent and emergency paediatric service. Both sets of plans have been the subject of an IIA. This IIA also considered the impact that the changes to the provision of a special care baby unit in South Tyneside could have on newly delivered mothers and their babies.

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

- Socioeconomic deprivation
- Disability (physical, mental, learning)
- Race (BME communities)
- Age (older women, older and teenage mothers)
- Women who misuse alcohol or drugs
- Sensory impairment
- Women with co-morbid conditions

These groups may be more likely to need women's services and will therefore benefit from improvements in service quality. They might also be more vulnerable to some of the changes in the way services are provided.

The HIIA impact scores gave a crude indication of the relative scale and direction of possible impacts. The total (net) HIIA impact scores were overwhelmingly positive.

Total Integrated Impact Scores (all attributes)	
Option 1	**Option2**
152	**111**

The total IIA score was higher for Option 1 than Option 2 because the latter Option entails more far reaching changes which will affect more women. Its main drawback is that it provides fewer delivery options in South Tyneside and this may be received as less acceptable health care.

Health attributes for which total IIA impact scores were negative	
Option 1	**Option2**
Transport	Acceptable health care
Pollution	Transport
	Pollution

Both Options achieved negative IIA scores relating to the environmental impact the changes could have on transport and pollution. These issues will be explored in more detail by the transport impact analysis.

Although the overall IIA scores were usually positive, the IIA identified possible drawbacks associated with both Options. Therefore, the IIA included some suggested actions that could mitigate against these 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 related to patient transport, organisational development, quality improvement, education and training, monitoring and evaluation.

Overall, the IIA provided quantitative and qualitative evidence that the proposed changes could have major benefits for the resident populations including vulnerable groups. The key benefits relate to the ability of the changes to achieve:

- More sustainable and consistent high quality care, regardless of the day of the week of the time of day – for women, mothers and babies
- Safer Care due to sustained and improved levels of specialist staffing - especially in obstetrics care and neonatal care - able to provide timely intervention and avoid clinical deterioration
- More cost-efficient and cost-effective obstetrics and gynaecology services

These service improvements could achieve enduring and significant benefits to child health, population health and inequalities across South Tyneside and Sunderland.

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 may provide additional insights into the impact of 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.

Detailed results of the Equality Impact Assessment of both Options

Table 1: Equality Impact Assessment for the Proposed Obstetrics and Gynaecology 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

	Option 1: Maternity Retain consultant-led maternity unit at Sunderland and an alongside MLU Develop free-standing MLU at South Tyneside for low risk births Development of a single community midwifery team serving both areas Gynaecology All inpatient gynaecology surgery will be provided at Sunderland (surgery requiring at least an overnight stay) Gynaecology day case and ambulatory care will remain provided from both sites Gynaecology outpatients will remain provided from both sites		**Option 2** Maternity Develop a single consultant-led midwifery unit and alongside MLU at Sunderland serving both South Tyneside and Sunderland populations Development of a single community midwifery team serving both areas Gynaecology All inpatient gynaecology surgery will be provided at Sunderland (surgery requiring at least an overnight stay) Gynaecology day case and ambulatory care will remain provided from both sites Gynaecology outpatients will remain provided from both sites	
Protected characteristic	**Potentially Positive Impacts**	**Potentially Negative Impacts**	**Potentially Positive Impacts**	**Potentially Negative Impacts**
Sex / Gender	These are women's services and will, primarily, impact on women; the changes are designed to benefit all women by improving the quality of care available to residents of Sunderland and South Tyneside. Both options give women more choice regarding options for gynaecology day case and ambulatory care.	This option could have a negative impact on some women because they will have to travel further for care which was previously delivered closer to home. All women from South Tyneside needing / choosing to deliver in a consultant-led obstetrics unit will be required to travel outside of their borough. This could generate additional emotional, social and financial costs for these women and their partners, friends and families. Giving birth "away from home" can have enduring impacts on the health of mothers and babies There is a similar burden for those women and their partners/friends/families from	These are women's services and will, primarily, impact on women; the changes are designed to benefit all women by improving the quality of care available to residents of Sunderland and South Tyneside. Both options give women more choice regarding options for gynaecology day case and ambulatory care.	This option could have a negative impact on some women (more than Option 1) because they will have to travel further for care which was previously delivered closer to home. All women from South Tyneside needing or opting for delivery in a consultant-led obstetrics unit or midwife led unit will need to travel outside of their borough. This could generate additional emotional, social and financial costs for these women and their partners / friends and families. Giving birth "away from home" can have enduring impacts on the health of mothers and babies There is a similar burden for those women

	Option 1: Maternity Retain consultant-led maternity unit at Sunderland and an alongside MLU Develop free-standing MLU at South Tyneside for low risk births Development of a single community midwifery team serving both areas Gynaecology All inpatient gynaecology surgery will be provided at Sunderland (surgery requiring at least an overnight stay) Gynaecology day case and ambulatory care will remain provided from both sites Gynaecology outpatients will remain provided from both sites		**Option 2** Maternity Develop a single consultant-led midwifery unit and alongside MLU at Sunderland serving both South Tyneside and Sunderland populations Development of a single community midwifery team serving both areas Gynaecology All inpatient gynaecology surgery will be provided at Sunderland (surgery requiring at least an overnight stay) Gynaecology day case and ambulatory care will remain provided from both sites Gynaecology outpatients will remain provided from both sites	
Protected characteristic	**Potentially Positive Impacts**	**Potentially Negative Impacts**	**Potentially Positive Impacts**	**Potentially Negative Impacts**
		South Tyneside needing inpatient gynaecology care (elective or non –elective) as they will be treated further from home, outside of their borough generating additional emotional, social and financial costs. In the case of babies who require specialist inpatient care, mothers living in South Tyneside could experience additional travel costs (time, convenience, money) when visiting their babies in Sunderland. This could have a negative long term impact on infant bonding, and the emotional and physical health of the mothers and babies. Fathers and other relatives will also be affected but the impact on mothers will be greater.		and their partners/friends/families from S Tyneside needing inpatient gynaecology care (elective or non –elective) as they will be treated further from home, outside of their borough generating additional emotional, social and financial costs. In the case of babies who require specialist inpatient care, mothers living in South Tyneside could experience additional travel costs (time, convenience, money) when visiting their babies in Sunderland. This could have a negative long term impact on infant bonding, and the emotional and physical health of the mothers and babies. Fathers and other relatives will also be affected but the impact on mothers will be greater.
Gender 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**
Sexual orientation	These changes are designed to benefit all women, new families and their babies by improving the quality of obstetric, paediatric and gynaecology care available to residents of Sunderland and South Tyneside.	There is no indication that this group will be disproportionately negatively affected by the proposed changes	These changes are designed to benefit all women, new families and their babies by improving the quality of obstetri , paediatric and gynaecology care available to residents of Sunderland and South Tyneside.	There is no indication that this group will be disproportionately negatively affected by the proposed changes

	Option 1: Maternity Retain consultant-led maternity unit at Sunderland and an alongside MLU Develop free-standing MLU at South Tyneside for low risk births Development of a single community midwifery team serving both areas Gynaecology All inpatient gynaecology surgery will be provided at Sunderland (surgery requiring at least an overnight stay) Gynaecology day case and ambulatory care will remain provided from both sites Gynaecology outpatients will remain provided from both sites		**Option 2** Maternity Develop a single consultant-led midwifery unit and alongside MLU at Sunderland serving both South Tyneside and Sunderland populations Development of a single community midwifery team serving both areas Gynaecology All inpatient gynaecology surgery will be provided at Sunderland (surgery requiring at least an overnight stay) Gynaecology day case and ambulatory care will remain provided from both sites Gynaecology outpatients will remain provided from both sites	
Protected characteristic	**Potentially Positive Impacts**	**Potentially Negative Impacts**	**Potentially Positive Impacts**	**Potentially Negative Impacts**
Sexual orientation equality impact scores	**A=3 B=3 C=9**	**A=3 B=0 C=0**	**A=3 B=3 C=9**	**A=3 B=0 C=0**
Gender reassignment	These changes are designed to benefit all women, new families and their babies by improving the quality of obstetric, paediatric and gynaecology care available to residents of Sunderland and South Tyneside.	There is no indication that this group will be disproportionately negatively affected by the proposed changes	These changes are designed to benefit all women, new families and their babies by improving the quality of obstetric, paediatric and gynaecology care available to residents of Sunderland and South Tyneside.	There is no indication that this group will be disproportionately negatively affected by the proposed changes
Gender reassignment equality impact scores	**A=3 B=3 C=9**	**A=3 B=0 C=0**	**A=3 B=3 C=9**	**A=3 B=0 C=0**
Race	These changes are designed to benefit all women, new families and their babies by improving the quality of obstetric, paediatric and gynaecology care available to residents of Sunderland and South Tyneside.	Evidence shows that women from BME communities are at increased risk of Obstetrics complications and will therefore be more likely to need Consultant led care. Therefore, BME women and their families and friends living in South Tyneside will be	These changes are designed to benefit all women, new families and their babies by improving the quality of obstetric, paediatric and gynaecology care available to residents of Sunderland and South Tyneside.	Evidence shows that women from BME communities are at increased risk of Obstetrics complications and could therefore be more likely to need Consultant led care and specialist care for their babies. Therefore, BME women and their families

	Option 1: Maternity Retain consultant-led maternity unit at Sunderland and an alongside MLU Develop free-standing MLU at South Tyneside for low risk births Development of a single community midwifery team serving both areas Gynaecology All inpatient gynaecology surgery will be provided at Sunderland (surgery requiring at least an overnight stay) Gynaecology day case and ambulatory care will remain provided from both sites Gynaecology outpatients will remain provided from both sites		**Option 2** Maternity Develop a single consultant-led midwifery unit and alongside MLU at Sunderland serving both South Tyneside and Sunderland populations Development of a single community midwifery team serving both areas Gynaecology All inpatient gynaecology surgery will be provided at Sunderland (surgery requiring at least an overnight stay) Gynaecology day case and ambulatory care will remain provided from both sites Gynaecology outpatients will remain provided from both sites	
Protected characteristic	**Potentially Positive Impacts**	**Potentially Negative Impacts**	**Potentially Positive Impacts**	**Potentially Negative Impacts**
	Both options give women more choice regarding options for gynaecology day case and ambulatory care. BME women and their babies are at increased risk of perinatal complications and so they, their babies and families could experience more benefits from the proposed improvements.	disproportionately affected by the need to travel outside the borough for obstetric led care. Giving birth "away from home" can have enduring impacts on the health of mothers and babies. BME groups are at a higher risk of suffering economic deprivation, and English language difficulties. This means that they could be more disadvantaged by the additional transport costs for South Tyneside women (and their partners, friends and families) needing inpatient gynaecology services. The increased risk of obstetric complications in this group means that babies in this group may be at a higher risk of needing specialist care facilities. BME parents living in South Tyneside could therefore experience greater travel costs (time, convenience, money) when visiting their babies in Sunderland. Such costs could have a negative long term impact on infant bonding, and the emotional and physical health of babies and their families. BME groups in both areas may also be at a disadvantage if English is not their first language as this may generate challenges	Both options give women more choice regarding options for gynaecology day case and ambulatory care. BME women and their babies are at increased risk of perinatal complications and so they, their babies and families could experience more benefits from the proposed improvements.	and friends living in South Tyneside could be disproportionately affected by the need to travel outside the borough for obstetric led care and specialist care for their babies. Giving birth "away from home" can have enduring impacts on the health of mothers and babies and BME groups are at greater risk of perinatal problems. . Parents living in South Tyneside could experience additional travel costs (time, convenience, money) when visiting their babies in Sunderland and this could have a negative long term impact on infant bonding, and the emotional and physical health of the mothers and babies. BME women living in South Tyneside with low risk pregnancies, choosing to give birth in a midwife led unit will also need to travel outside of their borough as will BME women needing inpatient gynaecology services. Also, the increased travel burden could be greater for all women, partners, friends and families in BME groups living in South Tyneside because these groups are at a higher risk of economic deprivation and

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Protected characteristic	**Potentially Positive Impacts**	**Potentially Negative Impacts**	**Potentially Positive Impacts**	**Potentially Negative Impacts**
		around understanding and adapting to the new changes.		English language difficulties. Because, BME groups are at a higher risk of suffering economic deprivation, they could be further disadvantaged by the additional transport costs for South Tyneside women (and their partners, friends and families) needing inpatient gynaecology services. BME groups in both areas may also be at a disadvantage if English is not their first language as this may generate challenges around understanding and adapting to the new changes.
Race equality impact scores	**A=3 B=3 C=9**	**A=3 B=-2 C=-6**	**A=3 B=3 C=9**	**A=3 B=-2 C=-6**
Marriage and civil partnership	These changes are designed to benefit all women, new families and their babies by improving the quality of obstetric, paediatric and gynaecology care available to residents of Sunderland and South Tyneside.	There is no indication that this group will be disproportionately negatively affected by the proposed changes	These changes are designed to benefit all women, new families and their babies by improving the quality of obstetric, paediatric and gynaecology care available to residents of Sunderland and South Tyneside.	There is no indication that this group will be disproportionately negatively affected by the proposed changes

	Option 1: Maternity Retain consultant-led maternity unit at Sunderland and an alongside MLU Develop free-standing MLU at South Tyneside for low risk births Development of a single community midwifery team serving both areas Gynaecology All inpatient gynaecology surgery will be provided at Sunderland (surgery requiring at least an overnight stay) Gynaecology day case and ambulatory care will remain provided from both sites Gynaecology outpatients will remain provided from both sites		**Option 2** Maternity Develop a single consultant-led midwifery unit and alongside MLU at Sunderland serving both South Tyneside and Sunderland populations Development of a single community midwifery team serving both areas Gynaecology All inpatient gynaecology surgery will be provided at Sunderland (surgery requiring at least an overnight stay) Gynaecology day case and ambulatory care will remain provided from both sites Gynaecology outpatients will remain provided from both sites	
Protected characteristic	**Potentially Positive Impacts**	**Potentially Negative Impacts**	**Potentially Positive Impacts**	**Potentially Negative Impacts**
Marriage and civil partnership equality impact scores	**A=3 B=3 C=9**	**A=3 B=0 C=0**	**A=3 B=3 C=9**	**A=3 B=0 C=0**
Pregnancy and maternity	These changes are designed to benefit all pregnant and maternity groups by improving the quality of care available to mothers, new families and babies in Sunderland and South Tyneside. Both options give women more choice regarding options for gynaecology day case and ambulatory care.	This option could have a negative impact on some women because they will have to travel further for care which was previously delivered closer to home. This option could disadvantage pregnant and perinatal women from South Tyneside needing / choosing delivery in a Consultant led Obstetrics unit as they will need to travel outside the borough. This could generate additional emotional, social and financial costs for these women and their partners. Both Options could disadvantage women in this group from South Tyneside requiring inpatient gynaecology services as they will need to be cared for further away from home. Both Options could disadvantage parents, new families and their babies living in South Tyneside if the babies require specialist	These changes are designed to benefit all pregnant and maternity groups by improving the quality of care available to mothers, new families and babies in Sunderland and South Tyneside. Both options give women more choice regarding options for gynaecology day case and ambulatory care.	This option could have a negative impact on some women because they will have to travel further for care which was previously delivered closer to home. Compared with Option 1, this option could affect more pregnant and perinatal women from South Tyneside - those needing / choosing delivery in a Consultant led Obstetrics unit or a midwife led unit - because this care will no longer be provided in the borough. This travel could generate additional emotional, social and financial costs for women and their partners. Both Options could disadvantage women in this group from South Tyneside requiring inpatient gynaecology services as they will need to be cared for further away from home. Both Options could disadvantage parents,

	Option 1: Maternity Retain consultant-led maternity unit at Sunderland and an alongside MLU Develop free-standing MLU at South Tyneside for low risk births Development of a single community midwifery team serving both areas Gynaecology All inpatient gynaecology surgery will be provided at Sunderland (surgery requiring at least an overnight stay) Gynaecology day case and ambulatory care will remain provided from both sites Gynaecology outpatients will remain provided from both sites		**Option 2** Maternity Develop a single consultant-led midwifery unit and alongside MLU at Sunderland serving both South Tyneside and Sunderland populations Development of a single community midwifery team serving both areas Gynaecology All inpatient gynaecology surgery will be provided at Sunderland (surgery requiring at least an overnight stay) Gynaecology day case and ambulatory care will remain provided from both sites Gynaecology outpatients will remain provided from both sites	
Protected characteristic	**Potentially Positive Impacts**	**Potentially Negative Impacts**	**Potentially Positive Impacts**	**Potentially Negative Impacts**
		care. This care will be provided outside the borough, further away from home. This could have enduring impacts on the emotional and physical health of mothers and children.		new families and their babies living in South Tyneside if the babies require specialist care. This care will be provided outside the borough, further away from home. This could have enduring impacts on the emotional and physical health of mothers and children.
Pregnancy and maternity 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**
Religion or belief	These changes are designed to benefit all women, new families and their babies by improving the quality of obstetric, paediatric and gynaecology care available to residents of Sunderland and South Tyneside. Both options give women more choice regarding options for gynaecology day case and ambulatory care.	There is no indication that this group will be disproportionately negatively affected by the proposed changes	These changes are designed to benefit all women, new families and their babies by improving the quality of obstetric, paediatric and gynaecology care available to residents of Sunderland and South Tyneside. Both options give women more choice regarding options for gynaecology day case and ambulatory care.	There is no indication that this group will be disproportionately negatively affected by the proposed changes

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Protected characteristic	**Potentially Positive Impacts**	**Potentially Negative Impacts**	**Potentially Positive Impacts**	**Potentially Negative Impacts**
Religion/belief equality impact scores	**A=3 B=3 C=9**	**A=3 B=0 C=0**	**A=3 B=3 C=9**	**A=3 B=0 C=0**
Disability	These changes are designed to benefit all pregnant and maternity groups by improving the quality of care available to mothers, new families and babies in Sunderland and South Tyneside. Both options give women more choice regarding options for gynaecology day case and ambulatory care.	Disability may increase the likelihood of delivery in a consultant-led obstetrics unit and therefore disabled women and their families and friends living in South Tyneside will be disproportionately affected by the requirement to travel outside of the borough. Disabled partners, friends or relatives women from South Tyneside requiring a delivery in an Obstetrics unit, or undergoing inpatient gynaecology care will face greater personal, economic and emotional costs of travel outside the borough. Families from South Tyneside affected by disability and visiting babies in need of special care could experience more emotional difficulties arising from the increased travel burden. This could have enduring impacts on their and their babies' health. Any additional travel burden could generate	These changes are designed to benefit all pregnant and maternity groups by improving the quality of care available to mothers, new families and babies in Sunderland and South Tyneside. Both options give women more choice regarding options for gynaecology day case and ambulatory care.	This option requires more women from South Tyneside to travel outside the borough to deliver in either an obstetric led unit or a midwife led unit. Women, or their partners, relatives and families from South Tyneside and requiring inpatient gynaecology treatment will also suffer an additional travel burden. This additional travel burden could have a disproportionate impact on people in this group because they are more likely to be negatively impacted by the economic, emotional and practical burden of extra travel. Families from South Tyneside affected by disability and visiting babies in need of special care could experience more emotional difficulties arising from the increased travel burden. This could have enduring impacts on their and their babies' health.

	Option 1: Maternity Retain consultant-led maternity unit at Sunderland and an alongside MLU Develop free-standing MLU at South Tyneside for low risk births Development of a single community midwifery team serving both areas Gynaecology All inpatient gynaecology surgery will be provided at Sunderland (surgery requiring at least an overnight stay) Gynaecology day case and ambulatory care will remain provided from both sites Gynaecology outpatients will remain provided from both sites		Option 2 Maternity Develop a single consultant-led midwifery unit and alongside MLU at Sunderland serving both South Tyneside and Sunderland populations Development of a single community midwifery team serving both areas Gynaecology All inpatient gynaecology surgery will be provided at Sunderland (surgery requiring at least an overnight stay) Gynaecology day case and ambulatory care will remain provided from both sites Gynaecology outpatients will remain provided from both sites	
Protected characteristic	**Potentially Positive Impacts**	**Potentially Negative Impacts**	**Potentially Positive Impacts**	**Potentially Negative Impacts**
		a more significant burden on this group because of the greater risk of economic deprivation, emotional difficulties and practical physical challenges faced by this group. Some disabilities may be associated with increased difficulties around understanding and adapting to the new changes in service provision.		Any additional travel burden could generate a more significant burden on this group because of the greater risk of economic deprivation, emotional difficulties and practical physical challenges faced by this group. Some disabilities may be associated with increased difficulties around understanding and adapting to the new changes in service provision.
Disability equality impact scores	**A=3 B=3 C=9**	**A=3 B=-2 C=-6**	**A=3 B=3 C=9**	**A=3 B=-2 C=-6**
Socio - Economic deprivation	These changes are designed to benefit all pregnant and maternity groups by improving the quality of care available to mothers, new families and babies in Sunderland and South Tyneside. Both options give women more choice regarding options for gynaecology day case and ambulatory care.	Evidence shows that socio-economic deprivation is associated with increased risk of perinatal problems and may therefore increase the likelihood of delivery in a consultant-led obstetrics unit. Therefore economically disadvantaged women and their families and friends living in South Tyneside will be disproportionately affected by the additional travel outside the borough. Disadvantaged partners, relatives and friends of women from South Tyneside	These changes are designed to benefit all pregnant and maternity groups by improving the quality of care available to mothers, new families and babies in Sunderland and South Tyneside. Both options give women more choice regarding options for gynaecology day case and ambulatory care.	Evidence shows that socio-economic deprivation is associated with increased risk of perinatal problems and may therefore increase the likelihood of delivery in a consultant-led obstetrics unit. Therefore economically disadvantaged women and their families and friends living in South Tyneside will be disproportionately affected by the additional travel outside the borough. Disadvantaged partners of women from South Tyneside requiring / choosing to

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Protected characteristic	**Potentially Positive Impacts**	**Potentially Negative Impacts**	**Potentially Positive Impacts**	**Potentially Negative Impacts**
		requiring a delivery in a consultant-led obstetrics unit, or undergoing in patient gynaecology care, will face personal, economic and emotional costs of travel out of the borough. Families from South Tyneside visiting babies in need of special care could experience more challenges relating to the increased travel burden. This could have enduring impacts on their and their babies' health. The travel burden will be greater for this group because this group faces more significant economic challenges. Social isolation and educational disadvantage could create greater challenges for this group when seeking to understand and engage with the changes.		deliver in a consultant-led obstetrics unit, or midwife led unit or undergoing in patient gynaecology care, will face personal, economic and emotional costs of travel out of the borough. Families from South Tyneside visiting babies in need of special care could experience more challenges relating to the increased travel burden. This could have enduring impacts on their and their babies' health. The travel burden will be greater for this group because this group faces more significant economic challenges. Social isolation and educational disadvantage could create greater challenges for this group when seeking to understand and engage with the changes.
Deprivation equality impact scores	**A=3 B=3 C=9**	**A=3 B=-2 C=-6**	**A=3 B=3 C=9**	**A=3 B=-2 C=-6**

	Option 1: Maternity Retain consultant-led maternity unit at Sunderland and an alongside MLU Develop free-standing MLU at South Tyneside for low risk births Development of a single community midwifery team serving both areas Gynaecology All inpatient gynaecology surgery will be provided at Sunderland (surgery requiring at least an overnight stay) Gynaecology day case and ambulatory care will remain provided from both sites Gynaecology outpatients will remain provided from both sites		**Option 2** Maternity Develop a single consultant-led midwifery unit and alongside MLU at Sunderland serving both South Tyneside and Sunderland populations Development of a single community midwifery team serving both areas Gynaecology All inpatient gynaecology surgery will be provided at Sunderland (surgery requiring at least an overnight stay) Gynaecology day case and ambulatory care will remain provided from both sites Gynaecology outpatients will remain provided from both sites	
Protected characteristic	**Potentially Positive Impacts**	**Potentially Negative Impacts**	**Potentially Positive Impacts**	**Potentially Negative Impacts**
Age	These changes are designed to benefit all pregnant and maternity groups by improving the quality of care available to mothers, new families and babies in Sunderland and South Tyneside. Both options give women more choice regarding options for gynaecology day case and ambulatory care.	Evidence shows that older women and teenage women are at an increased risk of perinatal problems and more likely to need delivery in a consultant-led obstetrics unit. These women, their families and friends living in South Tyneside, will be disproportionately affected by the additional travel outside the borough. It is more likely that partners of teenage mothers will be younger and be disadvantaged by the personal, economic and emotional costs of travel out of the borough to be involved in the perinatal care of their partner and newborn(s). Evidence shows that teenage mothers experience many barriers to maternity care. These changes may represent additional challenges for this group and could have a long term impact on their health and the health of their baby. Newborn babies born to teenage mothers are more likely to need specialist neonatal care. This will entail an additional travel burden for teenage families from South Tyneside.	These changes are designed to benefit all pregnant and maternity groups by improving the quality of care available to mothers, new families and babies in Sunderland and South Tyneside. Both options give women more choice regarding options for gynaecology day case and ambulatory care.	Evidence shows that older women and teenage women are at an increased risk of perinatal problems and more likely to need delivery in a consultant-led obstetrics unit. These women, their families and friends living in South Tyneside, will be disproportionately affected by the additional travel outside the borough. This option also requires women from South Tyneside choosing delivery in a midwife led unit to travel outside the borough with associated travel costs for them, their partners, friends and family. Evidence shows that teenage mothers experience many barriers to maternity care. These changes may represent additional challenges for this group and may generate enduring effects on them and their baby. It is more likely that partners of teenage mothers will be younger and be disadvantaged by the personal, economic and emotional costs of travel out of the borough to be involved in the perinatal care of their partner and newborn(s). .

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Protected characteristic	**Potentially Positive Impacts**	**Potentially Negative Impacts**	**Potentially Positive Impacts**	**Potentially Negative Impacts**
		The partners, friends and families visiting women in South Tyneside who need inpatient gynaecology care will face an additional travel burden. This burden will be greater in relation to older and younger women due to the increased risk of economic hardship in both groups. Younger age groups may also face more emotional difficulties due to their relative immaturity, and older age groups will be more likely to suffer disabilities and longterm conditions generating additional difficulties.		Newborn babies born to teenage mothers are more likely to need specialist neonatal care. This will entail an additional travel burden for teenage families from South Tyneside. The partners, friends and families visiting women in South Tyneside who need inpatient gynaecology care will face an additional travel burden. This burden will be greater in relation to older and younger women due to the increased risk of economic hardship in both groups. Younger age groups may also face more emotional difficulties due to their relative immaturity, and older age groups will be more likely to suffer disabilities and longterm conditions generating additional difficulties.
Age equality impact scores	**A=3 B=3 C=9**	**A=3 B=-2 C=-6**	**A=3 B=3 C=9**	**A=3 B=-2 C=-6**

Table 2: Equality impact scores for protected groups

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

Protected group	Option 1: **Maternity** Retain consultant-led maternity unit at Sunderland and an alongside MLU Develop free-standing MLU at South Tyneside for low risk births Development of a single community midwifery team serving both areas **Gynaecology** All inpatient gynaecology surgery will be provided at Sunderland (surgery requiring at least an overnight stay) Gynaecology day case and ambulatory care will remain provided from both sites Gynaecology outpatients will remain provided from both sites			Option 2: **Maternity** Develop a single consultant-led midwifery unit and alongside MLU at Sunderland serving both South Tyneside and Sunderland populations Development of a single community midwifery team serving both areas **Gynaecology** All inpatient gynaecology surgery will be provided at Sunderland (surgery requiring at least an overnight stay) Gynaecology day case and ambulatory care will remain provided from both sites Gynaecology outpatients will remain provided from both sites		
	Positive impact score	**Negative impact score**	**Total Impact score**	**Positive impact score**	**Negative impact score**	**Total Impact score**
Sex/ gender	9	-3	6	9	-6	3
Sexual orientation	9	0	9	9	0	9
Gender reassignment	9	0	9	9	0	9
Race	9	-6	3	9	-6	3
Marriage and civil partnership	9	0	9	9	0	9
Pregnancy / maternity	9	-3	6	9	-6	3
Religion or belief	9	0	9	9	0	9
Disability	9	-6	3	9	-6	3
Socioeconomic deprivation	9	-6	3	9	-6	3
Age	9	-6	3	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

	Health Impact Comments and Scores			
	Option 1: **Maternity** Retain consultant-led maternity unit at Sunderland and an alongside MLU Develop free-standing MLU at South Tyneside for low risk births Development of a single community midwifery team serving both areas **Gynaecology** All inpatient gynaecology surgery will be provided at Sunderland (surgery requiring at least an overnight stay) Gynaecology day case and ambulatory care will remain provided from both sites Gynaecology outpatients will remain provided from both sites		**Option 2:** **Maternity** Develop a single consultant-led midwifery unit and alongside MLU at Sunderland serving both South Tyneside and Sunderland populations Development of a single community midwifery team serving both areas **Gynaecology** All inpatient gynaecology surgery will be provided at Sunderland (surgery requiring at least an overnight stay) Gynaecology day case and ambulatory care will remain provided from both sites Gynaecology outpatients will remain provided from both sites	
	Positive	**Negative**	**Positive**	**Negative**
Health outcomes				
Mortality – maternal deaths, stillbirths, or other infant deaths in the first month of life. **HEALTH IMPACT**	The changes are designed to improve the quality of care available in Sunderland and South Tyneside and further minimise the risk of maternal, perinatal or infant fatality. The changes will improve levels of staffing which are associated with fewer stillbirths.	Evidence shows that adverse events are rare and for low risk women, outcomes are the same for planned births in consultant-led obstetrics units and midwifery led units. Successful birth planning relates to effective risk assessment and is challenging. Studies vary in definitions of 'low risk' generating difficulties in comparing outcomes across settings.	The changes are designed to improve the quality of care available in Sunderland and South Tyneside and further minimise the risk of maternal, perinatal or infant fatality. The changes will improve levels of staffing which are associated with fewer stillbirths	Evidence shows that adverse events are rare and for low risk women, outcomes are the same for planned births in consultant-led obstetrics units and midwifery led units. Successful birth planning relates to effective risk assessment and is challenging. Studies vary in definitions of 'low risk' generating difficulties in comparing outcomes across settings.

	Health Impact Comments and Scores			
	Option 1: **Maternity** Retain consultant-led maternity unit at Sunderland and an alongside MLU Develop free-standing MLU at South Tyneside for low risk births Development of a single community midwifery team serving both areas **Gynaecology** All inpatient gynaecology surgery will be provided at Sunderland (surgery requiring at least an overnight stay) Gynaecology day case and ambulatory care will remain provided from both sites Gynaecology outpatients will remain provided from both sites		**Option 2:** **Maternity** Develop a single consultant-led midwifery unit and alongside MLU at Sunderland serving both South Tyneside and Sunderland populations Development of a single community midwifery team serving both areas **Gynaecology** All inpatient gynaecology surgery will be provided at Sunderland (surgery requiring at least an overnight stay) Gynaecology day case and ambulatory care will remain provided from both sites Gynaecology outpatients will remain provided from both sites	
	Positive	**Negative**	**Positive**	**Negative**
		Transfer times for women planning birth in South Tyneside will be longer than those in Sunderland. Unusually long – longer than those likely to be applied in this scenario - transfer times can adversely affect birth outcomes. Further evidence would be needed to ascertain whether emergency transfers have an impact.		Transfer times will have less impact in this option.
Mortality – maternal deaths, stillbirths, or other infant deaths in the first month of life. **HEALTH INEQUALITIES IMPACT**	Key 'inequalities groups' (BME communities, older and teenage mothers, disabled women, economically deprived women and hard to reach women) are at higher risk of perinatal complications including infant and maternal mortality. Giving every child a good start in life is a high impact intervention for reducing health inequalities. The improved quality of service could improve outcomes and could therefore reduce health inequalities.	Because of the evidence for inequalities groups being at higher risk, these women are more likely to give birth in a consultant-led obstetrics unit. This only option is outside of South Tyneside. There is no evidence that this lack of choice will increase mortality in inequalities groups.	Key 'inequalities groups' (BME communities, older and younger women, disabled women, economically deprived women and hard to reach women) are at higher risk of perinatal complications including infant and maternal mortality. Giving every child a good start in life is a high impact intervention for reducing health inequalities. The improved quality of service could improve outcomes and could therefore reduce health inequalities.	Because of the evidence for inequalities groups being at higher risk, these women are more likely to give birth in a consultant-led obstetrics unit. This only option is outside of South Tyneside. There is no evidence that this lack of choice will increase mortality in inequalities groups.
Mortality HEALTH Impact Score	**A=3 B=3 C=9**	**A=2 B=-1 C=-2**	**A=3 B=3 C=9**	**A=3 B=0 C=0**
Mortality HEALTH	**A=3 B=3 C=9**	**A=1 B=0 C=0**	**A=3 B=3 C=9**	**A=1 B=0 C=0**

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	Positive	**Negative**	**Positive**	**Negative**
INEQUALITIES Impact Score				
Spontaneous vaginal delivery **HEALTH IMPACT**	Evidence shows that low risk women who give birth in a midwifery unit have more 'normal' births than women who plan birth in a consultant-led obstetrics unit. This option gives women the option of birth in a midwifery led unit in both localities.	No negative consequences could be identified	Evidence shows that women who give birth in a midwifery unit have more 'normal' births than women who plan birth in a consultant-led obstetrics unit. This option gives women the option of birth in a midwifery unit. However, rates of spontaneous vaginal delivery are higher in freestanding midwifery units than in 'alongside' midwifery unit	However, rates of spontaneous vaginal delivery are higher in freestanding midwifery units than in 'alongside' midwifery unit Increased rates of intervention are associated with increased rates of complications e.g. infection, episiotomy which can have adverse health consequences
Spontaneous vaginal delivery **HEALTH INEQUALITIES IMPACT**	This option gives all women the option of birth in a midwifery led unit in both localities. Such units are associated with an increased likelihood of 'normal birth' – freestanding midwifery units have the highest rates. This proximity to home promotes continuity and consistency which is positive for women from many inequalities groups ((BME communities, older and younger women, disabled women, economically deprived women and hard to reach women).	Key health inequalities groups (BME communities, older and younger women, disabled women, economically deprived women and hard to reach women) are at greater risk of giving birth in a consultant-led obstetrics led unit with a higher risk of Obstetrics intervention – these risks are unrelated to the options proposed. There is no obvious negative impact for this option.	All women, including the key health inequalities groups (BME communities, older and younger women, disabled women, economically deprived women and hard to reach women) have fewer delivery options in South Tyneside. The available options have a lower rate of spontaneous vaginal delivery than in option 1. This is unlikely to have a significantly positive impact on health inequalities.	The available options have a lower rate of spontaneous vaginal delivery than in option 1 which could result in more adverse health consequences. Such consequences in the key health inequalities groups may result in poorer wellbeing which in turn may affect maternal baby bonding and a 'poorer start in life' which could deepen health inequalities. This will be compounded for these groups of women in South Tyneside.
Spontaneous vaginal delivery HEALTH	**A=3 B=3 C=9**	**A=3 B=0 C=O**	**A=3 B=2 C=6**	**A=2 B=-1 C=-2**

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	Positive	**Negative**	**Positive**	**Negative**
impact score				
Spontaneous vaginal delivery HEALTH INEQUALITIES impact score	**A=3 B=2 C=6**	**A=3 B=0 C=0**	**A=3 B=1 C=3**	**A=2 B=-2 C=-4**
Obstetrics interventions HEALTH IMPACTS	Evidence shows that low risk women who plan birth in a midwifery unit have substantially fewer intra-partum interventions than those who plan to give birth in a consultant-led obstetrics unit. This option gives women the option of birth in a midwifery led unit close to home	No negative consequences could be identified	Evidence shows that low risk women who plan birth in a midwifery unit have substantially fewer intra-partum interventions than those who plan to give birth in a consultant-led obstetrics unit. This option gives women the option of birth in a midwifery led unit but not in South Tyneside. It is unclear what impact this will have on intervention rate although evidence indicates that rates are higher in alongside midwifery units than freestanding units.	This option could be associated with higher rates of intervention than option 1 although further studies would be needed
Obstetrics interventions HEALTH INEQUALITIES impacts	This option gives all women the option of birth in a midwifery led unit in both localities. Such units are associated with a reduced risk of Obstetrics interventions – freestanding midwifery units have the lowest rates. This proximity to home promotes continuity and consistency which is positive for women from many inequalities groups ((BME communities, older and younger women, disabled women, economically	Key health inequalities groups (BME communities, older and younger women, disabled women, economically deprived women and hard to reach women) are at greater risk of giving birth in a consultant-led obstetrics unit with a higher risk of Obstetrics intervention – these risks are unrelated to the options proposed. There is no obvious negative impact for this option.	All women, including the key health inequalities groups (BME communities, older and younger women, disabled women, economically deprived women and hard to reach women) have fewer delivery options. The available options have a higher rate of intervention than in option 1. This option does ensure that those who need intervention get it in a timely manner 24/7 but is offset by a greater risk of interventions which could deepen	The available options have a higher rate of interventions than in option 1 which could result in more adverse health consequences. Such consequences in the key health inequalities groups may result in poorer wellbeing which in turn may affect maternal baby bonding and a 'poorer start in life' which could deepen health inequalities. This will be compounded for these groups of

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	Positive	**Negative**	**Positive**	**Negative**
	deprived women and hard to reach women).		inequalities.	women in South Tyneside.
Obstetrics intervention HEALTH impact score	**A=3 B=3 C=9**	**A=3 B=0 C=O**	**A=2 B=2 C=4**	**A=2 B=-1 C=-2**
Obstetrics intervention HEALTH INEQUALITIES impact score	**A=3 B=3 C=9**	**A=3 B=0 C=0**	**A=3 B=2 C=6**	**A=3 B=-1 C=-3**
Transfers of care during labour or immediately after the birth – HEALTH IMPACT	Transfers of care are a common occurrence and a significant consideration. Rates from midwifery led units to consultant-led obstetrics units vary between 9% (multiparous women) and 40% (nulliparous women). The changes promote the availability of medical staff to undertake timely interventions in the event of an unplanned transfer. (see appendix 3 for more detailed statistics about transfer rates)	Unplanned transfers to a consultant-led obstetrics unit may be required. The rate for low risk nulliparous women planning birth in a freestanding midwifery unit like the one planned for South Tyneside is 36% (9% for multiparous women). These statistics represent significant numbers of women requiring timely ambulance transfers between South Tyneside and Sunderland. Ambulance capacity will be key. NEAS performance data re capacity for timely transfers are presented in Appendix 3.	Transfers of care are a common occurrence and a significant consideration. Transfer rates from midwifery led units to consultant-led obstetrics units vary between 9% (multiparous women) and 40% (nulliparous women). This option minimises transfer times.	Unplanned transfers to a consultant-led obstetrics unit may be required. The rate for low risk nulliparous women planning birth in an alongside midwifery unit is 40% (13% for multiparous women). This option minimises transfer times.

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	Positive	**Negative**	**Positive**	**Negative**
Transfers of care during labour or immediately after the birth – HEALTH INEQUALITIES IMPACT	There is no evidence to indicate that health inequalities will be positively affected by this option in relation to transfers of care.	Transfers can have a negative impact on maternal wellbeing. Any negative impact might be greater when transferring outside of South Tyneside. This greater impact could compromise maternal infant bonding. Such an impact will have greater consequences for teenage women, and women in hard to reach or deprived communities. It could mean children do not have such a 'good start in life' thus deepening health inequalities	This option minimises the transfer time for babies requiring admission to a Neonatal care unit – this helps to give them a good start in life and could lessen health inequalities.	Transfers are likely to have a negative impact on maternal wellbeing but although the rates are higher for alongside units, the distances and pathways are less than in option 1 and so there is minimal negative impact on health inequalities.
Transfers of care during labour or immediately after the birth HEALTH impact score	**A= 3 B=3 C=9**	**A=3 B=-2 C=-6**	**A= 3 B=3 C=9**	**A=3 B=-1 C=-3**
Transfers of care during labour or immediately after the birth HEALTH INEQUALITIES IMPACT score	**A=1 B=0 C=0**	**A=2 B=-1 C=-2**	**A=2 B=1 C=2**	**A=2 B=0 C=0**
Delivering a baby without serious medical problems	Evidence shows that there are no significant differences in adverse perinatal outcomes between planned births in midwifery units and Obstetrics	Both options entail relocation of the Special Care Baby Unit at South Tyneside to Sunderland with out of hospital transfers to either a Special	Evidence shows that there are no significant differences in adverse perinatal outcomes between planned births in midwifery units and Obstetrics units.	Both options entail relocation of the Special Care Baby Unit at South Tyneside to Sunderland. This option reduces number of hospital transfers

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	Positive	**Negative**	**Positive**	**Negative**
HEALTH IMPACT	units. The changes will promote the quality of care and improve the chances of delivering a baby without serious medical problems.	Care Baby Unit or a Neonatal Intensive Care Unit in Sunderland. Theoretically, this additional transfer could carry additional risk for babies born in South Tyneside and requiring medical care, however, high risk births should be at Sunderland where medical care will be present. The level of risk relies on ambulance capacity for timely transfers. This risk must be balanced against the benefits of more prompt access to a neonatal care unit from the Sunderland SCBU.	The changes will promote the quality of care and improve the chances of delivering a baby without serious medical problems.	to a Neonatal Intensive Care Unit in Sunderland and provides more timely access to more specialised care.
Delivering a baby without serious medical problems HEALTH INEQUALITIES IMPACT	The changes will promote the quality of care and improve the chances of delivering a baby without serious medical problems. The changes also give babies with medical problems an increased chance of care in a neonatal intensive care unit. Both of these benefits will give children a good start in life and reduce health inequalities	Mothers and Babies from South Tyneside, requiring a hospital transfer to the special care or neonatal intensive care units may experience more complications and difficulties relating to bonding and a worse start in life with the possibility of worsening inequalities. However, this must be balanced against the benefits of improved access to a neonatal care unit from a Sunderland SCBU.	The changes will promote the quality of care and improve the chances of delivering a baby without serious medical problems. The changes also give babies with medical problems an increased chance of care in a neonatal intensive care unit. Both of these benefits will give children a good start in life and reduce health inequalities	This proposal will ensure that there are fewer inter-hospital transfers for mothers and babies thus minimising risks to the health of new families and newborn babies.
Delivering a baby without serious medical	**A= 3 B=3 C=9**	**A=2 B=-1 C=-2**	**A= 3 B=3 C=9**	**A=2 B=0 C=0**

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	Positive	**Negative**	**Positive**	**Negative**
problems HEALTH impact score				
Delivering a baby without serious medical problems 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=0 C=0**
Infant feeding (ideally breastfeeding) HEALTH impact	Infant feeding has a profound impact on health outcomes and health inequalities. The proposals do not provide evidence to suggest this outcome will be positively or adversely affected by the proposals.	Infant feeding has a profound impact on health outcomes and health inequalities The proposals do not provide evidence to suggest this outcome will be positively or adversely affected by the proposals.	Infant feeding has a profound impact on health outcomes and health inequalities The proposals do not provide evidence to suggest this outcome will be positively or adversely affected by the proposals.	Infant feeding has a profound impact on health outcomes and health inequalities The proposals do not provide evidence to suggest this outcome will be positively or adversely affected by the proposals.
Infant feeding (ideally breastfeeding) HEALTH INEQUALITIES impact	Infant feeding has a profound impact on health outcomes and health inequalities. The proposals do not provide evidence to suggest this outcome will be positively or adversely affected by the proposals. and will therefore not influence health inequalities .	Infant feeding has a profound impact on health outcomes and health inequalities. The proposals do not provide evidence to suggest this outcome will be positively or adversely affected by the proposals. and will therefore not influence health inequalities .	Infant feeding has a profound impact on health outcomes and health inequalities. The proposals do not provide evidence to suggest this outcome will be positively or adversely affected by the proposals. and will therefore not influence health inequalities .	Infant feeding has a profound impact on health outcomes and health inequalities. The proposals do not provide evidence to suggest this outcome will be positively or adversely affected by the proposals. and will therefore not influence health inequalities .
Infant feeding (ideally breastfeeding) 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**

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	Positive	**Negative**	**Positive**	**Negative**
Infant feeding (ideally breastfeeding) 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**
Maternal health – social, emotional and physical **HEALTH IMPACT**	Patient experience throughout the maternity period is vital for maternal wellbeing. Wellbeing relates to a wide variety of factors including choice, continuity of care, proximity to friends and family, delivery experience, post-operative complications. This option enhances women's choice to give birth closer to home and maximise the quality of care provided. Maternity care crosses sectors with children's and lifestyle services being provided by local authorities.	Patient experience throughout the maternity period is vital for maternal wellbeing. Wellbeing relates to a wide variety of factors including choice, continuity of care, proximity to friends and family, delivery experience, post-operative complications. Women from South Tyneside needing or choosing to give birth in a consultant-led obstetrics unit will have less proximity to home and less multi-sectoral continuity of care.	Patient experience throughout the maternity period is vital for maternal wellbeing. Wellbeing relates to a wide variety of factors including choice, continuity of care, proximity to friends and family, delivery experience, post-operative complications. This option does not offer the fullest array of delivery choices close to home especially for women from South Tyneside (other than home births). Maternity care crosses sectors with children's and lifestyle services being provided by local authorities.	This option does not offer the fullest array of delivery choices close to home, and women from South Tyneside (other than home births) will have to deliver further from home, family, friends etc. These women will also face more disruption to continuity of care by crossing Local Authority boundaries.
Maternal health – social, emotional and physical – HEALTH INEQUALITIES IMPACT	Improved choice, cross sectoral, continuity, and care quality combine to promote maternal health and give all children the 'best start in life' thus helping to reduce health inequalities.	Women from South Tyneside may need to travel outside the borough if they need or choose to give birth in a consultant-led Obstetrics unit, or if their baby needs admission to a special care or neonatal intensive care unit. Travel and care away from	The lack of delivery unit in South Tyneside limits woman's choice and cross sectoral continuity. However the improved service quality promotes maternal health and gives all children the 'best start in life' thus helping to reduce health inequalities	Women from South Tyneside will need to travel outside the borough if they need or choose to give birth in a midwifery or consultant-led Obstetrics unit, or if their baby needs admission to a special care or neonatal intensive care unit. Travel

	Health Impact Comments and Scores			
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	Positive	**Negative**	**Positive**	**Negative**
		family and friends could compromise wellbeing. Poorer wellbeing could compromise the maternal health, the maternal-infant bond and deepen health inequalities		and care away from family and friends could compromise wellbeing. Poorer wellbeing could compromise maternal health, maternal-infant bond and deepen health inequalities
Maternal health – social, emotional and physical – HEALTH impact score	**A=3 B=3 C=9**	**A=2 B=-1 C=-2**	**A=3 B=2 C=6**	**A=2 B=-2 C=-4**
Maternal health – social, emotional and physical – HEALTH INEQUALITIES impact score	**A=3 B=3 C=9**	**A=2 B=-1 C=-2**	**A=3 B=2 C=6**	**A=2 B=-2 C=-4**
Infant health- social, emotional and physical. HEALTH IMPACT	Evidence shows that are no significant differences in adverse perinatal outcomes between planned births in midwifery units and Obstetrics units. A strong maternal / infant bond is essential for positive infant and child health. Maternal wellbeing will determine this bond. Choice and fewer interventions can promote wellbeing. Infant wellbeing is also important. All	This option entails relocation of the Special Care Baby Unit at South Tyneside to Sunderland with out of hospital transfers to a Special Care or Neonatal Intensive Care Unit in Sunderland. This increased distance could undermine the maternal / baby bond and subsequent infant wellbeing for babies requiring medical care.	Evidence shows that there are no significant differences in adverse perinatal outcomes between planned births in midwifery units and consultant-led Obstetrics units. All babies with medical complications will be admitted directly to a neonatal intensive care unit.	This option provides less choice for mothers close to home especially for South Tyneside mothers who will need to give birth outside the borough with implications for maternal and infant wellbeing as explained above. This option will provide less cross sector continuity for children's services for South Tyneside families

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	Positive	**Negative**	**Positive**	**Negative**
	babies with medical complications will be admitted directly to a neonatal intensive care unit. Children's services are provided by local authorities and can be coterminous with the midwifery units. This option entails relocation of the Special Care Baby Unit in South Tyneside to Sunderland but the Special Care and Neonatal Intensive Care Unit sin Sunderland will continue. Babies delivered in Sunderland will have more timely access to more specialised care.	All of the maternal wellbeing issues identified above might also be relevant to bonding. Crossing boundaries for Children's services could have a detrimental impact on infant wellbeing.		delivering outside the borough. All babies with medical complications will be admitted directly to a special care or neonatal intensive care unit but this may distance mothers from South Tyneside .and compromise the maternal infant bond
Infant health - social, emotional and physical HEALTH INEQUALITIES IMPACT	Improved access to better quality maternity services and neonatal intensive care services will give children a 'better start in life' and reduce health inequalities	Babies born to key at risk groups (teenage mothers, deprived groups,) are more likely to be adversely affected by the maternal wellbeing and cross sector continuity issues. This might compromise their early health and maternal/infant bond which could deepen health inequalities.	Improved access to better quality maternity services and special care baby services will give children a 'better start in life' and reduce health inequalities	This option increases the likelihood of maternal wellbeing and cross sector continuity issues for women and babies from South Tyneside which could deepen health inequalities. However, this must be balanced against the benefits to mothers and their babies.
Infant health - social, emotional and physical 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**

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	Positive	**Negative**	**Positive**	**Negative**
Infant health - social, emotional and physical 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=-2 C=-4**
Improved life expectancy (gynae) **HEALTH IMPACT**	The reconfigured services should improve access and reduce waiting times for ambulatory care. This could theoretically improve life expectancy for key conditions such as gynaecological cancer due to earlier diagnosis. Further data would be needed to confirm this.	Women from South Tyneside requiring inpatient care will need to travel out of the borough but there is no evidence that this will affect access or related life expectancy. More pressure on inpatient beds and theatres on the Sunderland site could have an adverse impact on waiting times for life lengthening surgery although there is insufficient data to clarify this theoretical consideration.	The reconfigured services should improve access and reduce waiting times for ambulatory care. This could theoretically improve life expectancy for key conditions such as gynaecological cancers. Further data would be needed to confirm this.	Women from South Tyneside requiring inpatient care will need to travel out of the borough but there is no evidence that this will affect access or related life expectancy. More pressure on inpatient beds and theatres on the Sunderland site could have an adverse impact on waiting times for life lengthening surgery although there is insufficient data to clarify this theoretical consideration.
Improved life expectancy (gynae) **HEALTH INEQUALITIES IMPACT**	Improved access could improve timely diagnosis and treatment and reduce health inequalities from women's cancers causing premature mortality.	Women from South Tyneside requiring inpatient care will need to travel out of the borough but there is no evidence that this will affect access or related life expectancy and inequalities . More pressure on inpatient beds and theatres on the Sunderland site could have an adverse impact on waiting times for life lengthening surgery although there is insufficient data to clarify this theoretical consideration.	Improved access could improve timely diagnosis and treatment and reduce health inequalities from women's cancers causing premature mortality.	Women from South Tyneside requiring inpatient care will need to travel out of the borough but there is no evidence that this will affect access or related life expectancy and inequalities . More pressure on inpatient beds and theatres on the Sunderland site could have an adverse impact on waiting times for life lengthening surgery although there is insufficient data to clarify this theoretical consideration.

	Health Impact Comments and Scores			
	Option 1: **Maternity** Retain consultant-led maternity unit at Sunderland and an alongside MLU Develop free-standing MLU at South Tyneside for low risk births Development of a single community midwifery team serving both areas **Gynaecology** All inpatient gynaecology surgery will be provided at Sunderland (surgery requiring at least an overnight stay) Gynaecology day case and ambulatory care will remain provided from both sites Gynaecology outpatients will remain provided from both sites		**Option 2:** **Maternity** Develop a single consultant-led midwifery unit and alongside MLU at Sunderland serving both South Tyneside and Sunderland populations Development of a single community midwifery team serving both areas **Gynaecology** All inpatient gynaecology surgery will be provided at Sunderland (surgery requiring at least an overnight stay) Gynaecology day case and ambulatory care will remain provided from both sites Gynaecology outpatients will remain provided from both sites	
	Positive	**Negative**	**Positive**	**Negative**
Improved life expectancy HEALTH impact scores	**A=2 B=3 C=6**	**A=1 B=-1 C=-1**	**A=2 B=3 C=6**	**A=1 B=-1 C=-1**
Improved life expectancy HEALTH INEQUALITIES impact scores	**A=2 B=3 C=6**	**A=1 B=-1 C=-1**	**A=2 B=3 C=6**	**A=1 B=-1 C=-1**
Improved quality of life (gynae) HEALTH IMPACT	The reconfigured services should improve access and reduce waiting times for ambulatory care thus improving short term quality of life for women undergoing day case procedures and assessments for painful and unpleasant conditions such as pain, bleeding, prolapse. Further data would be needed to confirm this.	Women from South Tyneside will have to travel further for inpatient care. Additional travel could cause some dip in quality of life due to the added social, financial and emotional burden. More pressure on inpatient beds and theatres on the Sunderland site could have an adverse impact on waiting times for surgery. Any delays could undermine quality of life. However, there is insufficient data to clarify this theoretical consideration. .	The reconfigured services should improve access and reduce waiting times for ambulatory care thus improving short term quality of life for women undergoing procedures and assessments for painful and unpleasant conditions such as postmenopausal bleeding, prolapse, endometriosis. Further data would be needed to confirm this.	Women from South Tyneside will have to travel further for inpatient care. Additional travel could cause some dip in quality of life due to the added social, financial and emotional burden. More pressure on inpatient beds and theatres on the Sunderland site could have an adverse impact on waiting times for surgery Any delays could undermine quality of life. However, there is insufficient data to clarify this theoretical consideration.
Improved quality of life (gynae) HEALTH	Improved quality of life could improve wellbeing and occupational health with a positive impact on health inequalities.	The additional travel burden could have a disproportionate impact on key vulnerable groups – (as per equality impact assessment) with	Improved quality of life could improve wellbeing and occupational health with a positive impact on health inequalities	The additional travel burden could have a disproportionate impact on key vulnerable groups – (as per equality impact assessment) with

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	Positive	**Negative**	**Positive**	**Negative**
INEQUALITIES IMPACT		implications for subsequent inequalities.		implications for subsequent inequalities.
Improved quality of life HEALTH impact score	**A=2 B=2 C=4**	**A=2 B=-1 C=-2**	**A=2 B=2 C=4**	**A=2 B=-1 C=-2**
Improved quality of life 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=-1 C=-2**
Health inequalities	***not scored separately as addressed throughout***			
Access to high quality health care				
Effective health care – HEALTH CARE IMPACT	The changes will promote access to, and availability of, high quality EFFECTIVE services with associated benefits for all services users	There is no evidence of negative health impact in terms of access to effective health care	The changes will promote access and availability of high quality EFFECTIVE services with associated benefits for all services users	There is no evidence of negative health impact in terms of access to effective health care
Effective health care – HEALTH CARE INEQUALITIES IMPACT	The improved service effectiveness could have a significantly positive impact on health inequalities.	There is no evidence of any negative impact on health inequalities in terms of improved access to effective health care	The improved service effectiveness will have a significantly positive impact on health inequalities.	There is no evidence of any negative impact on health inequalities in terms of improved access to effective health care
Effective health care – HEALTH IMPACT SCORE	**A=3 B=3 C=9**	**A=1 B=0 C=0**	**A=3 B=3 C=9**	**A=1 B=0 C=0**
Effective health care –	**A=3 B=3 C=9**	**A=1 B=0 C=0**	**A=3 B=3 C=9**	**A=1 B=0 C=0**

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	Positive	**Negative**	**Positive**	**Negative**
HEALTH INEQUALITIES IMPACT SCORE				
Safe care - HEALTH CARE IMPACT	The proposals have been developed to promote safer maternity services with associated benefits for all services users	Transfers out of South Tyneside for Consultant led Obstetrics, special care or neonatal care may introduce more handovers of care with associated safety issues. These must be balanced against the safer staffing levels.	The changes will promote safer maternity services with associated benefits for all services users	More deliveries will be made closer to obstetric led care, special care or specialist neonatal care reducing transfer related risks of care.
Safe care - HEALTH CARE INEQUALITIES IMPACT	The improved safety will have a positive impact on health inequalities although this will be relatively small	Transfers between South Tyneside midwifery unit and consultant led Obstetrics care, special care or neonatal care outside the borough might introduce more handovers of care with associated safety issues. These must be balanced against the safer staffing levels. The impact on health care inequalities arising from patient safety issues is very small.	The improved safety will have a positive impact on health inequalities although this will be relatively small	Absence of a delivery unit in South Tyneside will reduce the safety issues relating to handovers of care during transfers to Obstetrics unit, special care or neonatal intensive care unit. The impact on health care inequalities arising from patient safety issues is minimal.
Safe care - HEALTH IMPACT SCORE	**A=3 B=3 C=9**	**A=2 B=-1 C=-2**	**A=3 B=3 C=9**	**A=2 B=0 C=0**
Safe care - HEALTH INEQUALITIES IMPACT SCORE	**A=3 B=1 C=3**	**A=2 B=-1 C=-2**	**A=3 B=1 C=3**	**A=2 B=0 C=0**
Cost - Efficient health	The business case for this option	The overall impact of cost efficiency	The business case for this option provides	The cost savings included in this

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	Positive	**Negative**	**Positive**	**Negative**
care HEALTH CARE IMPACT	provides evidence that the changes can achieve efficiency savings at acute Trust level. These savings could be made whilst improving the quality of care provided to local residents with subsequent benefits for the health of the local population. The cost savings included in this option improve quality and address user preferences to deliver in a unit close to home.	savings on the public health system health care service (eg ambulance services) cannot be fully quantified. Opportunities to promote the health impact of these proposals could be further developed thus maximising the cost efficiencies. Shifts in service provision outside of the borough along with loss of co-terminosity could have a negative impact on some vulnerable groups with implications for access to, and continuity of, care.	evidence that the changes can achieve efficiency savings at acute Trust level. These savings could be made whilst improving the quality of care provided to local residents with subsequent benefits for the health of the local population. At acute Trust level, this Option achieves higher savings than Option1 although these savings entail a shift of more services outside of the borough of South Tyneside.	option improve quality but with less choice especially for women from South Tyneside seeking delivery closer to home. The overall impact of cost efficiency savings on the public health system and other elements of the health service (eg ambulance services, increased obstetric interventions) have not been quantified. The drawbacks described elsewhere disproportionately affect South Tyneside residents.
Cost - Efficient health care HEALTH CARE INEQUALITIES IMPACT	Maternity care is a high impact intervention. Improved access to high quality maternity services could help to reduce health inequalities although this assessment highlights that the proposals may have different impacts on different groups.	The drawbacks described elsewhere disproportionately affect some South Tyneside residents at risk of health care inequalities and could affect health inequalities. Opportunities to "give every child the best start in life" could be further	Maternity care is a high impact intervention. Improved access to high quality maternity services could help to reduce health inequalities although the efficiencies may have different impacts on different groups and South Tyneside residents will experience less access to care closer to home.	The drawbacks described elsewhere disproportionately affect more South Tyneside residents at risk of health care inequalities. This option affects more women than option1 - leading to a greater scale of impact. Opportunities to "give every child the

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	Positive	**Negative**	**Positive**	**Negative**
		maximised to reduce health inequalities[34].		best start in life" could be further maximised to reduce health inequalities[35].
Cost - Efficient health care HEALTH CARE 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**
Cost - Efficient health care HEALTH INEQUALITIES CARE IMPACT score	**A=2 B=3 C=6**	**A=2 B=-1 C=-2**	**A=2 B=2 C=4**	**A=2 B=-2 C=-4**
Health care relevant to population need HEALTH IMPACT	Birth rates fluctuate although the general trend suggests an increasing birth rate. This option provides a sustainable service which can flex to meet the needs of the populations served	This option reflects population needs for choice, quality, and care closer to home with limited drawbacks other than increased travel and the possibility of increased pressures on inpatient gynaecology services in Sunderland.	Birth rates fluctuate although the general trend suggests an increasing birth rate. This option has less capacity to meet growing need.	This option reflects population needs for quality, but not choice of care especially close to home. It also creates a greater travel burden for a larger proportion of the population served. This option generates a possibility of increased pressures on inpatient gynaecology services in

[34] Burton A. Giving every child the best start in life: a public health approach. PHE:2017

[35] Burton A. Giving every child the best start in life: a public health approach. PHE:2017

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	Positive	**Negative**	**Positive**	**Negative**
				Sunderland.
Health care relevant to population need HEALTH INEQUALITIES IMPACT	Birth rates fluctuate although the general trend suggests an increasing birth rate. This option provides a sustainable service which can flex to meet the needs of the populations served and therefore positively impact on health care inequalities	There is no evidence indicating that this option will be unable to address population needs and reduce health inequalities.	This option has less capacity to meet growing need although the improved service quality will give children a good start in life and reduce healthcare inequalities.	Theoretically, the limited capacity could compromise future access and have a negative impact on health inequalities
Health care relevant to population need HEALTH IMPACT score	**A=2 B=3 C=6**	**A=2 B=-1 C=-2**	**A=2 B=2 C=4**	**A=2 B=-2 C=-4**
Health care relevant to population need HEALTH INEQUALITIES IMPACT score	**A=2 B=3 C=6**	**A=2 B=0 C=0**	**A=2 B=2 C=4**	**A=2 B=-1 C=-2**
Acceptable health care (patient and carer experience) HEALTH IMPACT	Evidence indicates that user experience is of profound importance for maternal and infant health. Improvements in Obstetrics and Gynaecology services in terms of safety, cost efficiency and clinical effectiveness must therefore be balanced against users' priorities around access, choice and continuity. This option provides choice and access	This proposal entails some challenges around continuity and travel for South Tyneside residents with respect to inpatient gynaecology care, obstetric led care and specialist neonatal care. There is no evidence to enable an assessment of the impact on user experience in relation to increased	Evidence indicates that user experience is of profound importance for maternal and infant health, Improvements in Obstetrics and Gynaecology services in terms of safety, cost efficiency and clinical effectiveness must be balanced against users' priorities around access, choice and continuity. Both options increase choice and access for	Compared with Option 1, this option provides less choice and less access close to home and more travel requirements especially for those women and families from South Tyneside needing inpatient gynaecology services, obstetric or midwife led maternity care or specialist baby care.

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	Positive	**Negative**	**Positive**	**Negative**
	close to home and can promote continuity. Both options increase choice and access for outpatient, day case and ambulatory gynaecology services. Both options improve access to high quality maternity and neonatal care.	pressures on inpatient gynaecology services in Sunderland,	outpatient, day case and ambulatory gynaecology services. Both options improve access to high quality maternity and neonatal care.	There is no evidence to enable an assessment of the impact on user experience in relation to increased pressures on inpatient gynaecology services in Sunderland,
Acceptable health care (patient and carer experience) HEALTH INEQUALITIES IMPACT	Maternity services and specialist baby care services have a key and enduring impact on the health of the population and can significantly reduce health inequalities. Improved access to high quality care for mothers, women and their babies could have a profound impact on health inequalities. Improved choice for and access to outpatient, day case and ambulatory gynaecology services could improve early diagnosis and reduce premature mortality from women's cancers. This could significantly reduce health inequalities. Improved access to treatment for symptoms which affect occupational health could also reduce	Barriers to acceptable care can lead to women booking late for, or disengaging with, maternity care. This has major implications for outcomes, safeguarding, and health inequalities. Any additional travel burden will have a greater negative impact on vulnerable groups and could compromise health inequalities. Effective integrated care is fundamental to tackling health inequalities therefore the changes affecting co-terminosity could have a negative impact. The need for consultant-led obstetrics care is greater in	Maternity services and specialist baby care services have a key and enduring impact on the health of the population and can significantly reduce health inequalities. Improved access to high quality care for mothers, women and their babies could have a profound positive impact on health inequalities. Improved choice for and access to outpatient, day case and ambulatory gynaecology services could improve early diagnosis and reduce premature mortality from women's cancers. This could significantly reduce health inequalities. Improved access to treatment for symptoms which affect occupational health could also reduce health inequalities.	This Option entails the drawbacks relating to Option 1, and also affects other South Tyneside residents needing to travel outside the borough for midwife led care. The additional travel burdens have a greater negative impact on more vulnerable groups and could further compromise health inequalities. Loss of co-terminosity could have an adverse impact on vulnerable groups in South Tyneside.

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	Positive	**Negative**	**Positive**	**Negative**
	health inequalities.	communities at risk of health inequalities therefore this proposal could deepen health inequalities in South Tyneside.		
Acceptable health care (patient and carer experience) HEALTH IMPACT SCORE	**A=2 B=3 C=6**	**A=2 B=-1 C=-2**	**A=2 B=2 C=4**	**A=2 B=-2 C=-4**
Acceptable health care (patient and carer experience)HEALTH INEQUALITIES IMPACT SCORE	**A=2 B=2 C=4**	**A=3 B=-1 C=-3**	**A=2 B=1 C=4**	**A=3 B=-2 C=-6**
Equitable health care – not scored as addressed throughout				
Environment				
Transport HEALTH IMPACT	A detailed transport analysis is underway. The proposals will increase commuting traffic between South 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 Noise pollution, air pollution and 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 South 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 Noise pollution, air pollution and Road Traffic Accidents especially affecting those commuting for health care and those living close to Sunderland and South Tyneside hospital sites.
Transport HEALTH	No clear health inequalities benefits	Socioeconomically deprived	No clear health inequalities benefits could	Socioeconomically deprived

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	Positive	**Negative**	**Positive**	**Negative**
INEQUALITIES IMPACT	could be identified	communities are more likely to be adversely affected by pollution accidents and traffic thus contributing to health inequalities for those populations	be identified	communities are more likely to be adversely affected by accidents and traffic thus contributing to health inequalities for those populations
Transport HEALTH IMPACT score	**A=1 B=0 C=0**	**A=2 B=-1 C=-2**	**A=1 B=0 C=0**	**A=2 B=-1 C=-2**
Transport 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=-1 C=-2**
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 increase noise and air pollution	No clear health benefits could be identified	The increased traffic could increase noise and air pollution

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	Positive	**Negative**	**Positive**	**Negative**
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 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**
Housing HEALTH impact	No evidence of health benefits could be identified	No evidence of health disadvantages could be identified	No evidence of health benefits could be identified	No evidence of health disadvantages could be identified
Housing HEALTH INEQUALITIES impact	No evidence of health benefits could be identified	No evidence of health disadvantages could be identified	No evidence of health benefits could be identified	No evidence of health 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**
Economy				
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	Both proposals entail staff losses albeit in very small numbers. The losses in this option are marginally lower than option 2.	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	Both proposals entail staff losses albeit in very small numbers. The losses in this option are marginally higher than option 1.

	Health Impact Comments and Scores			
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	Positive	**Negative**	**Positive**	**Negative**
	for Sunderland residents	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	Sunderland residents. The net effects are greater for this option.	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 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 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
Education, skills, learning HEALTH IMPACT score	**A=2 B=1 C=2**	**A=2 B=-1 C=-2**	**A=2 B=1 C=2**	**A=2 B=-1 C=-2**
Education, skills, learning HEALTH INEQUALITIES IMPACT score	**A=2 B=1 C=2**	**A=2 B=-1 C=-2**	**A=2 B=1 C=2**	**A=2 B=-1 C=-2**
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 effect 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 there

	Health Impact Comments and Scores			
	Option 1: **Maternity** Retain consultant-led maternity unit at Sunderland and an alongside MLU Develop free-standing MLU at South Tyneside for low risk births Development of a single community midwifery team serving both areas **Gynaecology** All inpatient gynaecology surgery will be provided at Sunderland (surgery requiring at least an overnight stay) Gynaecology day case and ambulatory care will remain provided from both sites Gynaecology outpatients will remain provided from both sites		**Option 2:** **Maternity** Develop a single consultant-led midwifery unit and alongside MLU at Sunderland serving both South Tyneside and Sunderland populations Development of a single community midwifery team serving both areas **Gynaecology** All inpatient gynaecology surgery will be provided at Sunderland (surgery requiring at least an overnight stay) Gynaecology day case and ambulatory care will remain provided from both sites Gynaecology outpatients will remain provided from both sites	
	Positive	**Negative**	**Positive**	**Negative**
Employment HEALTH INEQUALITIES IMPACT	The numbers are very small but increased jobs could have a positive impact on health inequalities in Sunderland,	The numbers are very small but could have a negative impact on health inequalities in South Tyneside	The numbers are very small but increased jobs could have a positive impact on health inequalities in Sunderland	The numbers are very small but could have a negative impact on health inequalities in South Tyneside
Employment HEALTH IMPACT SCORE	**A=2 B=1 C=2**	**A=2 B=-1 C=-2**	**A=2 B=1 C=2**	**A=2 B=-1 C=-2**
Employment HEALTH INEQUALITIES IMPACT SCORE	**A=2 B=1 C=2**	**A=2 B=-1 C=-2**	**A=2 B=1 C=2**	**A=2 B=-1 C=-2**
Business development and investment HEALTH IMPACT	Expansion of Consultant led Obstetrics and inpatient Gynaecology care in Sunderland could have a positive impact on health inequalities in Sunderland,	Losses to investment in Consultant led Obstetrics, specialist baby care services and inpatient gynaecology services are marked in South Tyneside and could have a negative impact on the health of the population there.	Expansion of specialist Obstetrics care in Sunderland and inpatient gynaecology in South Tyneside generates business opportunities for both areas with potentially positive impacts on health	Losses to investment in Consultant led Obstetrics, specialist baby care services, midwifery services and inpatient gynaecology services are marked in South Tyneside and could have a negative impact on the health of the population there.
Business development and investment HEALTH INEQUALITIES IMPACT	This expansion could have a positive impact on health inequalities in Sunderland.	These losses could have a negative impact on health inequalities in South Tyneside	This expansion could have a positive impact on health inequalities in Sunderland.	These losses could have a negative impact on health inequalities in South Tyneside
Business development and investment HEALTH IMPACT SCORE	**A=2 B=1 C=2**	**A=2 B=-1 C=-2**	**A=2 B=1 C=2**	**A=2 B=-1 C=-2**
Business development and investment	**A=2 B=1 C=2**	**A=2 B=-1 C=-2**	**A=2 B=1 C=2**	**A=2 B=-1 C=-2**

	Health Impact Comments and Scores			
	Option 1: **Maternity** Retain consultant-led maternity unit at Sunderland and an alongside MLU Develop free-standing MLU at South Tyneside for low risk births Development of a single community midwifery team serving both areas **Gynaecology** All inpatient gynaecology surgery will be provided at Sunderland (surgery requiring at least an overnight stay) Gynaecology day case and ambulatory care will remain provided from both sites Gynaecology outpatients will remain provided from both sites		**Option 2:** **Maternity** Develop a single consultant-led midwifery unit and alongside MLU at Sunderland serving both South Tyneside and Sunderland populations Development of a single community midwifery team serving both areas **Gynaecology** All inpatient gynaecology surgery will be provided at Sunderland (surgery requiring at least an overnight stay) Gynaecology day case and ambulatory care will remain provided from both sites Gynaecology outpatients will remain provided from both sites	
	Positive	**Negative**	**Positive**	**Negative**
HEALTH INEQUALITIES IMPACT SCORE				
Financial inclusion HEALTH IMPACT	No evidence of health benefits could be identified	No evidence of health disadvantages could be identified	No evidence of health benefits could be identified	No evidence of health disadvantages could be identified
Financial inclusion HEALTH INEQUALITIES IMPACT	No evidence of health benefits could be identified	No evidence of health disadvantages could be identified	No evidence of health benefits could be identified	No evidence of health 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 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**

Table 4: Integrated Health & Health Inequalities Impact scores

Colour Key

Positive	Negative	Option 1:	Option 2:
Major impact 13-18	**Major impact 13-18**	**Maternity** Retain consultant-led maternity unit at Sunderland and an alongside MLU Develop free-standing MLU at South Tyneside for low risk births Development of a single community midwifery team serving both areas **Gynaecology** All inpatient gynaecology surgery will be provided at Sunderland (surgery requiring at least an overnight stay) Gynaecology day case and ambulatory care will remain provided from both sites Gynaecology outpatients will remain provided from both sites	**Maternity** Develop a single consultant-led midwifery unit and alongside MLU at Sunderland serving both South Tyneside and Sunderland populations Development of a single community midwifery team serving both areas **Gynaecology** All inpatient gynaecology surgery will be provided at Sunderland (surgery requiring at least an overnight stay) Gynaecology day case and ambulatory care will remain provided from both sites Gynaecology outpatients will remain provided from both sites
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 HEALTH and HEALTH INEQUALITY IMPACT SCORE	
	Health and Health care outcomes	**Option 1**	**Option 2**	**Option 1**	**Option 2**	**Option 1**	**Option 2**
Health outcomes	**Mortality**	18	18	-2	0	16	18
	Spontaneous vaginal delivery	15	9	0	-6	15	3
	Obstetrics interventions	18	10	0	-5	18	5
	Transfers of care	9	11	-8	-3	1	8
	Delivering a baby without serious medical problems	18	18	-4	0	14	18
	Infant feeding	0	0	0	0	0	0
	Maternal health	18	12	-4	-8	14	4
	Infant health	18	18	-4	-8	14	10
	Life expectancy	12	12	-2	-2	10	10
	Quality of life	8	8	-4	-4	4	4
Access to high quality health	**Effective health care**	18	18	0	0	18	18

		Total POSITIVE integrated health and health inequality impact score		Total NEGATIVE integrated health and health inequality impact score		TOTAL INTEGRATED HEALTH and HEALTH INEQUALITY IMPACT SCORE	
	Health and Health care outcomes	**Option 1**	**Option 2**	**Option 1**	**Option 2**	**Option 1**	**Option 2**
care outcomes	**Safe health care**	12	12	-4	0	8	12
	Cost efficient health care	15	13	-4	-6	11	7
	Relevance to healthcare need	12	8	-2	-6	10	2
	Acceptable health care	10	8	-5	-10	5	-2
Environmental determinants of health	**Transport**	0	0	-4	-4	-4	-4
	Natural and built environment	0	0	0	0	0	0
	Pollution	0	0	-2	-2	-2	-2
	Housing	0	0	0	0	0	0
Economic determinants of health	**Education, skills and learning**	4	4	-4	-4	0	0
	Employment	4	4	-4	-4	0	0
	Business development	4	4	-4	-4	0	0
	Financial inclusion	0	0	0	0	0	0
TOTAL	ALL	**213**	**187**	**-61**	**-76**	**152**	**111**

Appendix 1: Details of the scoring system used for the Equality Impact Assessment[36]

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 positive	Evidence indicates: the proposal supports the organisation in meeting its	**+2**

[36] NHS Centre for Equality and Human Rights. A toolkit for carrying out Equality impact assessment.

	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

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.

Health Inequalities and Maternity Services: evidence summary

Key issues - The World health Organisation (WHO) describes maternity services as a continuum of care for mothers and children starting pre-pregnancy and continuing through pregnancy and childbirth, to the early days and years of life (1).

The Marmot review (2) emphasised the fundamental importance of high quality maternity services as a means of reducing health inequalities and giving every child the best start in life. The review explained how socio-economic circumstances affect maternal health, which in turn, affects their babies' health.

A positive attachment between a young child and their primary care-giver (usually but not necessarily the mother) is vital for healthy early development (2). Maternal attachment can be compromised by social isolation and depression.

Access to high quality maternity services can promote maternal and child health, avoid unnecessary intervention and ensure that women who do, or may, need intervention are signposted at an early stage to specialist care[2,3].

Antenatal risk factors – a full list is provided by NICE [3] and includes co-morbid diseases such as heart disease and diabetes, smoking, obesity, extremes of age, vulnerability and substance or alcohol misuse (see Table 18 for details).

Age (older women) - Adverse pregnancy outcomes rise with age and women over 40 have a higher risk of complications[6].

Age (under 20 years) – babies born to teenage mothers are at an increased risk of prematurity, congenital abnormality, low birth weight and being born into poverty[4]. Teenage women are less likely to breastfeed and are more likely to have experienced poverty, poor housing and educational under achievement[4,6]

There are many barriers to care for this group or women[8]. They may feel uncomfortable using antenatal care services in which the majority of service users are in older age groups; be reluctant to recognise their pregnancy; be inhibited by embarrassment and fear of parental reaction. They may also have practical problems such as difficulty getting to and from antenatal appointments[4,8].

Teenage mothers have threefold increased risk of postnatal depression and a higher risk of poor mental health for three years after the birth (4).

Socio-economic deprivation – associated with increased risk of low birth weight babies, neonatal mortality and stillbirths (5). The risk of perinatal mortality is 57% higher for mothers living in poverty (19). Low birth weight is associated with poorer longterm health and educational outcomes[6].

Socioeconomic deprivation is associated with higher rates of teenage pregnancy, maternal obesity, diabetes, alcohol or drug misuse during pregnancy and smoking whilst pregnant[5].

Smoking in pregnancy has detrimental effects for the growth and development of the baby and health of the mother. Smokers have more complications during pregnancy and labour, including bleeding during pregnancy, placental abruption and premature rupture of membranes[5].

Obese women are at greater risk of complications relating to pregnancy and birth[6].

Diabetes in pregnancy is associated with risks to the woman and the developing fetus. Miscarriage, perinatal mortality, birth injuries, congenital malformations, pre-eclampsia and preterm labour are more common in women with pre-existing diabetes[6,7]

Although continuity of care is important to pregnant women who use drugs or alcohol, they experience a number of barriers to access. Barriers include anxiety about the attitudes of healthcare staff and the potential [8] role of social services; or feeling overwhelmed by the involvement of multiple agencies. These women need supportive and coordinated care during pregnancy[8].

The risk of post operative complications (post caesarean) is increased with obesity, smoking, co-morbidities (often diabetes) and socioeconomic deprivation[12].

BME Women

Women from BME communities in the UK experience persistent inequalities in receipt of maternity services and in reproductive outcomes compared to the majority White British population[9]

Mothers from non-white ethnic groups are at increased risk of perinatal mortality, and maternal mortality[9] and have a 62% increased risk of having a low birth weight baby when compared with white mothers.

BME mothers experience less favourable maternity care than white mothers[9]. They are significantly more likely to book late**Error! Bookmark not defined.**, report shortfalls in choice and continuity of care[10], and are less likely to see a midwife as often as they wanted after birth[9,10]. Often this experience is compounded by language or cultural barriers combined with socio-deprivation**Error! Bookmark not defined.**.

Mental health and Emotional wellbeing - For many women, even those who have given birth before, anticipation of labour and birth can give rise to anxiety, uncertainty and, on occasion, outright fear[12].

Around 1 in 5 women report not being asked about their emotional and mental health state at the time of booking, or about past mental health problems and family history[11].

Perinatal mental illnesses are very common, affecting 1 in 5 women at some point during the perinatal period[11,19].
Depression and anxiety affects 15-20% of women in the first year after childbirth. About half of all cases of perinatal depression and anxiety go undetected, with many of those which are detected failing to receive evidence-based forms of treatment[19]. Effective integrated multi-agency care is vital for emotional wellbeing[21].

A woman who is experiencing domestic abuse may have particular difficulties using antenatal care services: for example, the perpetrator of the abuse may try to prevent her from attending appointments; the woman may be afraid that disclosure of the abuse to a healthcare professional will worsen her situation, or she may be anxious about the reaction of the healthcare professional[8].

Health Care Quality and Maternity Services: evidence summary

Maternity care in England - Having a baby is the most common reason for admission to hospital in England[12]**.** The total cost represents around 2.8 per cent of health spending[12]. Maternity is a unique area of the NHS as the services support predominantly healthy people through a natural, but very important, life event that does not always require doctor-led intervention[11].

NICE recognizes pregnancy as a normal physiological process and therefore any interventions should have known benefits and be acceptable to pregnant women[3].

For women in the United Kingdom, giving birth remains safer than ever – less than 9 in very 100,000 women die in pregnancy and around childbirth[12].

Population needs for maternity care have been changing over the last decade– birth rates are fluctuating but have been increasing, the mean age of mothers at childbirth is rising, the numbers of women giving birth over the age of 35 rising steeply[13]. This increase is associated with an increase in the proportion of 'complex' births, such as multiple births (for example twins) or women with obesity or pre-existing medical conditions. These complexities increase the risks of childbirth, meaning care often requires greater clinical involvement[14].

Effectiveness
Antenatal care seeks to optimise the health of the mother and baby throughout pregnancy and minimise the risk of any perinatal or postnatal complications. The first appointment should be within 10 weeks of conception to maximise the health benefits and identify risk factors as soon as possible[3] (see Table 18). Continuity is a priority for antenatal care[3].

Intra-partum care seeks to minimise interventions and transfers whilst

delivering a baby without serious medical problems[17]. Safety is of paramount importance[19]. Babies with problems require neonatal care[17].

Greater levels of consultant staffing are associated with improved outcomes, including fewer stillbirths and fewer readmissions[14].

Postnatal care seeks to promote maternal and infant health and infant feeding (ideally successful breast feeding)[15].

A study of French births found that distance to an Obstetrics unit did not increase neonatal mortality risk except for distances greater than 45km[14].

One Dutch study found that women who changed risk status from 'low' to 'high' during labour had worse outcomes; it also found that a transfer time from home to hospital of more than 20 minutes by car was associated with increased risk of mortality and adverse outcomes[14].

One-to-one midwife care for women during childbirth reduces the chance of intervention without compromising outcomes and reduces the length of labour[14].

NICE[3,7,16] recommends that women at low risk of complications during labour are given the choice of all 4 birth settings and information about local birth outcomes. The 4 settings where a woman at low risk of complications may choose to have her baby are:

- at home,
- in a freestanding midwifery unit,
- in an alongside midwifery unit
- in an Obstetrics unit.

Outcomes for women for each planned place of birth include[16,17]

- rates of spontaneous vaginal birth,
- transfer to Obstetrics unit,
- Obstetrics intervention
- delivering a baby with or without serious medical problems.

Patient experience

Patient experience for maternity care can affect the long term health outcomes for mother, baby and family. The experience of birth often remains with a woman for decades and can influence the manner in which they relate to and bond with their baby, maternal psychological well-being, relationships within the family, subsequent levels of engagement in healthcare[22].

Choice and continuity in care are key determinants of satisfaction in maternity services[11,12].

Women's experiences relating to continuity of care are mixed[10,11,12]. The

availability of sufficient midwives is a key factor in providing continuity of care[19] and one to one midwife care during childbirth improves women's reported birth experience[14].

Risks and benefits of different birth settings - there are no significant differences in outcome for the baby associated with planning birth in any setting[3,14,17]. The birthplace national cohort study[18] examined these questions (See Table 13 - Table 17 for data on rates of interventions, outcomes for babies and indications for transfer) with a focus on healthy women with straightforward pregnancies who are at low risk of complications. The study evaluated over 64,000 births and showed that:

- Adverse events are rare - 4.3 per 1000 births
- Midwifery units are safe for the baby and offer benefits for the mother
- For planned births in freestanding midwifery and alongside midwifery units there were no significant differences in adverse perinatal outcomes compared with planned birth in an Obstetrics unit
- Women who planned birth in a midwifery unit (freestanding or alongside) had significantly fewer interventions including caesarean sections and more 'normal births' than women who planned birth in an Obstetrics unit
- For multiparous women, there were no significant differences in adverse perinatal outcomes between planned home births or midwifery units and planned births in Obstetrics units
- For multiparous women, birth in a non Obstetrics unit setting significantly and substantially reduced the risk of having an intrapartum caesarean section, instrumental delivery, episiotomy
- For women having a first baby, there is a fairly high probability of transferring to an Obstetrics unit during labour or immediately after the birth - 36% for planned freestanding midwifery unit births and 40% for planned alongside midwifery unit births.
- For women having a second or subsequent baby, the transfer rate is around 10% (9%for planned FMU births and 13% for planned AMU births).

Patient Safety - Outcomes in maternity care are good for the vast majority of women and babies but, when things go wrong, the consequences can be very serious. Maternity care accounted for a third of the clinical negligence bill in 2012-13[12.]

Almost half of CQC inspections of maternity units result in assessments either inadequate (7%) or requires improvement (41%)[19].

There is evidence demonstrating poorer outcomes for mother and child out of hours[12]. Rates of maternal infection, infection to the baby and injury to the baby are all higher at the weekend[19].

Most clinical negligence compensation claims are based on mistakes in the management of labour, mistakes relating to caesarean sections and errors

resulting in cerebral palsy[12].

Less-experienced operators have been associated with adverse outcomes for instrumental births and failure to recognise the severity of a woman's condition[10].

Around 10% of all deliveries are carried out by elective caesarean section and 15% as an emergency caesarean section[19]. As with any other operation, it carries risks of post surgical complications eg infection, pain, thrombo-embolism. Complications can affect the family relationships, maternal bonding and lead to a hospital readmission.

NICE recommend that a Class 1 Emergency Caesarian Section should be performed within 30 minutes of the decision to deliver[20].

Risk assessment is essential to effective and safe care planning in pregnancy. It is estimated that[18]:

- 1 in 3 women can be assessed as at low risk
- 1 in 6 women can be assessed as at high risk
- 1 in 2 women cannot be assessed for risk level

Readmissions have emotional and social consequences relating to the length of time for which a new family is apart from one another[6]. Common reasons include surgical complications post caesarean section and feeding problems in babies with associated jaundice and dehydration[6].

Cost –efficiency - Nearly a fifth of spending on maternity services is for clinical negligence cover[12]. There are significant variations in the provision and costs of maternity services across England[11].

The birthplace cost-effectiveness study[18] examined costs associated with different birth settings. The costs related to avoided adverse perinatal and maternal outcomes and normal births. The study showed that costs were highest for Obstetrics units and lowest for planned home births. Average costs were as follows:

- £1361 for a planned birth in an Obstetrics unit
- £1461 for a planned birth in an alongside midwifery unit
- £1435 for a planned birth in a freestanding midwifery unit
- £1067 for a planned home birth

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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

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; English/Welsh/Scottish/Northern Irish/British	140821	95.1	261209	94.8
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

Religion

Table 8: Religion profile (Source ONS census data 2011: KS209EW)

	S Tyne		Sunderland	
	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 9: Marital and Civil partnership profile (Source ONS census data 2011: KS103EW)

	S Tyneside		Sunderland	
	Count	**%**	**Count**	**%**
All Usual Residents Aged 16 and	122200	100	227314	100

Over				
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 10: 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

Pregnancy and Maternity

Table 11: Total Number of Live births in each area: (source ONS Data 2015)

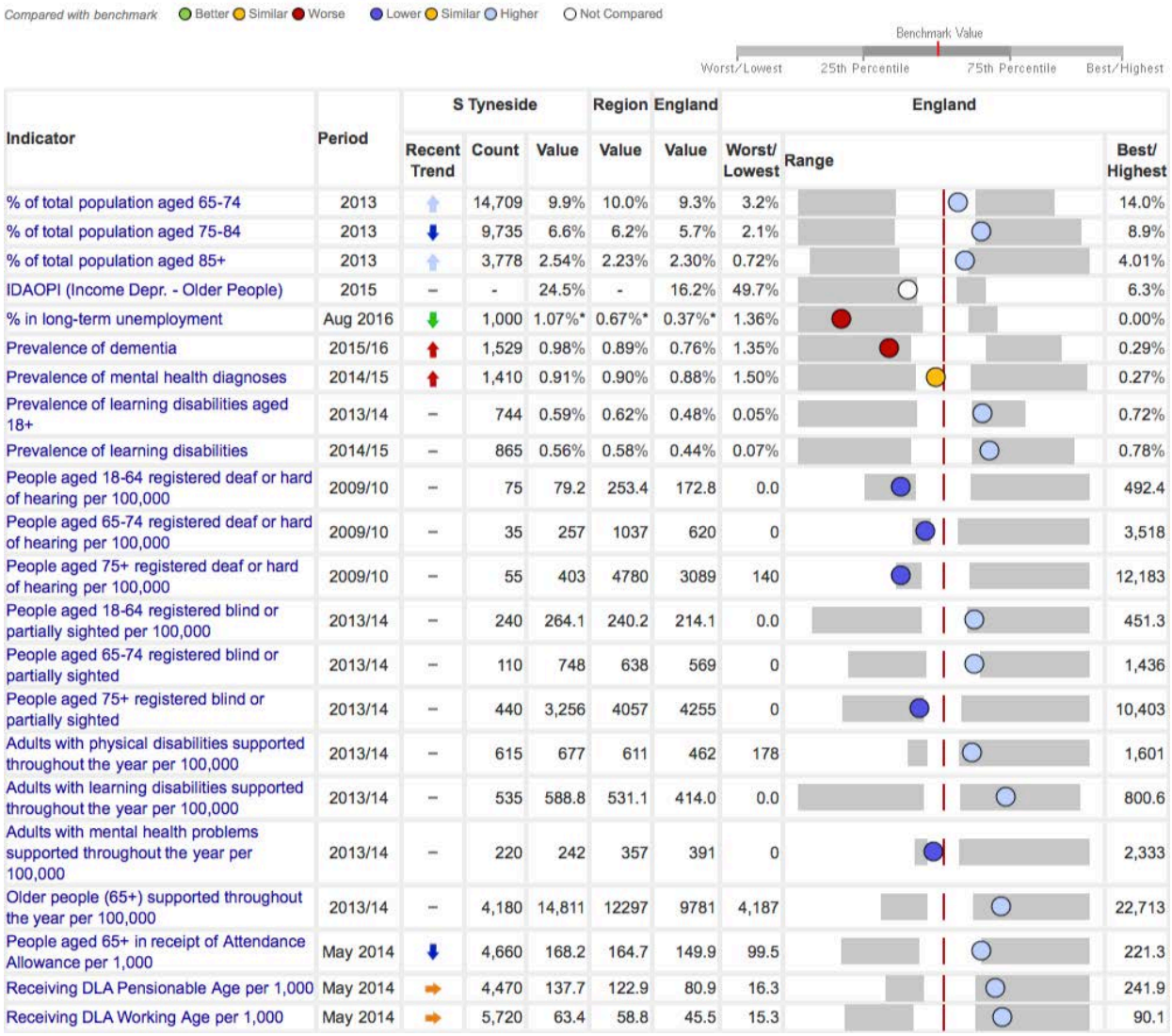
	Total number of live births (2015)
South Tyneside	1,647
Sunderland	2,889

Socioeconomic Deprivation

Table 12: Socio-economic deprivation of households (source ONS Census data 2011: QS119EW)

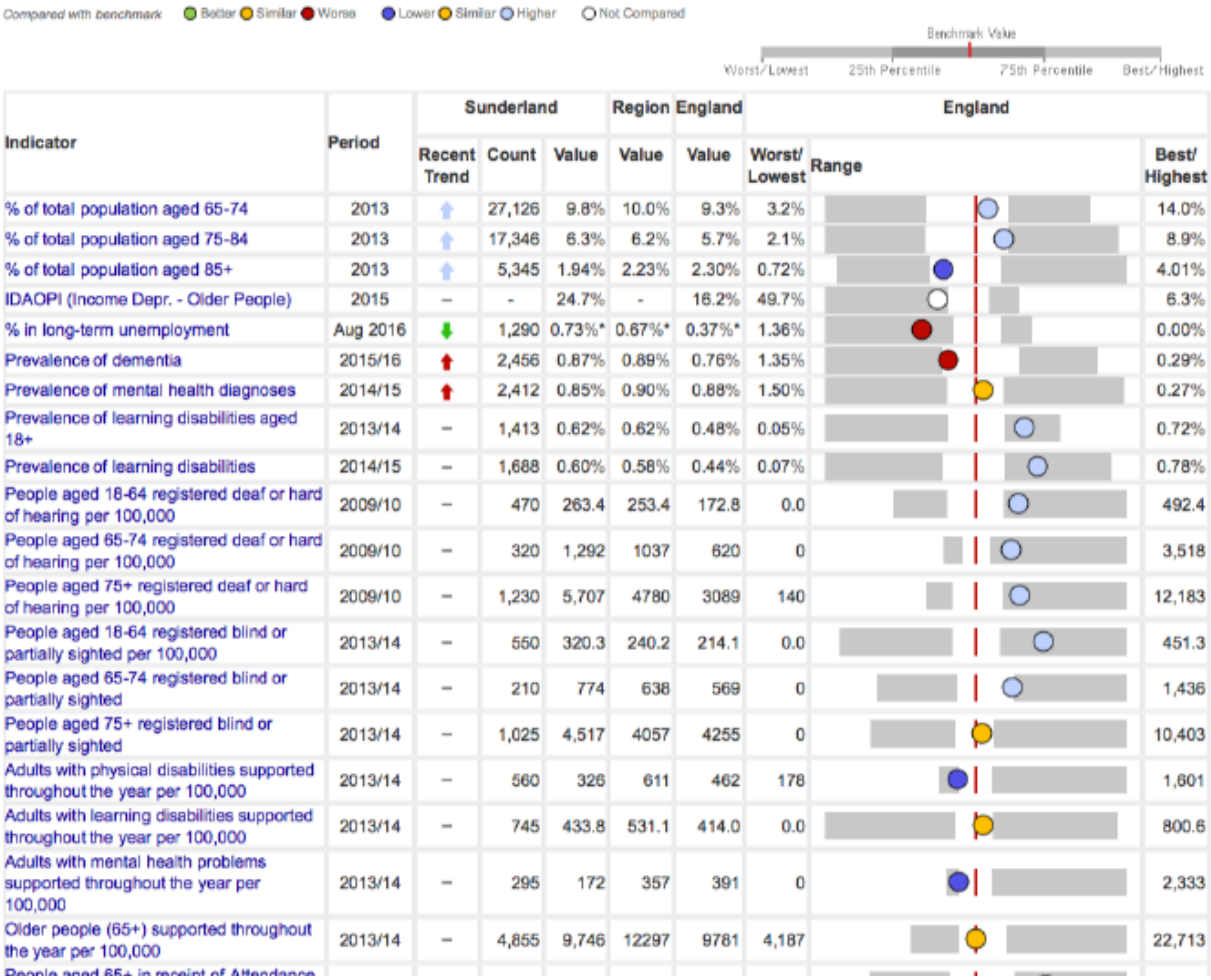
	S Tyneside		Sunderland	
	Count	**%**	**Count**	**%**
All Households	67167	100	119758	100
Household is Not Deprived in Any Dimension	24531	37	42790	36
Household is Deprived in 1 Dimension	21705	32	38223	32
Household is Deprived in 2 Dimensions	15947	24	29259	24
Household is Deprived in 3 Dimensions	4679	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).



Indicator	Period	S Tyneside			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
% of total population aged 65-74	2013	↑	14,709	9.9%	10.0%	9.3%	3.2%		14.0%
% of total population aged 75-84	2013	↓	9,735	6.6%	6.2%	5.7%	2.1%		8.9%
% of total population aged 85+	2013	↑	3,778	2.54%	2.23%	2.30%	0.72%		4.01%
IDAOPI (Income Depr. - Older People)	2015	–	-	24.5%	-	16.2%	49.7%		6.3%
% in long-term unemployment	Aug 2016	↓	1,000	1.07%*	0.67%*	0.37%*	1.36%		0.00%
Prevalence of dementia	2015/16	↑	1,529	0.98%	0.89%	0.76%	1.35%		0.29%
Prevalence of mental health diagnoses	2014/15	↑	1,410	0.91%	0.90%	0.88%	1.50%		0.27%
Prevalence of learning disabilities aged 18+	2013/14	–	744	0.59%	0.62%	0.48%	0.05%		0.72%
Prevalence of learning disabilities	2014/15	–	865	0.56%	0.58%	0.44%	0.07%		0.78%
People aged 18-64 registered deaf or hard of hearing per 100,000	2009/10	–	75	79.2	253.4	172.8	0.0		492.4
People aged 65-74 registered deaf or hard of hearing per 100,000	2009/10	–	35	257	1037	620	0		3,518
People aged 75+ registered deaf or hard of hearing per 100,000	2009/10	–	55	403	4780	3089	140		12,183
People aged 18-64 registered blind or partially sighted per 100,000	2013/14	–	240	264.1	240.2	214.1	0.0		451.3
People aged 65-74 registered blind or partially sighted	2013/14	–	110	748	638	569	0		1,436
People aged 75+ registered blind or partially sighted	2013/14	–	440	3,256	4057	4255	0		10,403
Adults with physical disabilities supported throughout the year per 100,000	2013/14	–	615	677	611	462	178		1,601
Adults with learning disabilities supported throughout the year per 100,000	2013/14	–	535	588.8	531.1	414.0	0.0		800.6
Adults with mental health problems supported throughout the year per 100,000	2013/14	–	220	242	357	391	0		2,333
Older people (65+) supported throughout the year per 100,000	2013/14	–	4,180	14,811	12297	9781	4,187		22,713
People aged 65+ in receipt of Attendance Allowance per 1,000	May 2014	↓	4,660	168.2	164.7	149.9	99.5		221.3
Receiving DLA Pensionable Age per 1,000	May 2014	→	4,470	137.7	122.9	80.9	16.3		241.9
Receiving DLA Working Age per 1,000	May 2014	→	5,720	63.4	58.8	45.5	15.3		90.1

Figure 2: Excerpt from PHE adult social care profiles 2015 – People with care and support needs – S Tyneside



Compared with benchmark: Better / Similar / Worse — Lower / Similar / Higher — Not Compared

Benchmark Value: Worst/Lowest | 25th Percentile | 75th Percentile | Best/Highest

Indicator	Period	Sunderland			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
% of total population aged 65-74	2013	↑	27,126	9.8%	10.0%	9.3%	3.2%		14.0%
% of total population aged 75-84	2013	↑	17,346	6.3%	6.2%	5.7%	2.1%		8.9%
% of total population aged 85+	2013	↑	5,345	1.94%	2.23%	2.30%	0.72%		4.01%
IDAOPI (Income Depr. - Older People)	2015	–	-	24.7%	-	16.2%	49.7%		6.3%
% in long-term unemployment	Aug 2016	↓	1,290	0.73%*	0.67%*	0.37%*	1.36%		0.00%
Prevalence of dementia	2015/16	↑	2,456	0.87%	0.89%	0.76%	1.35%		0.29%
Prevalence of mental health diagnoses	2014/15	↑	2,412	0.85%	0.90%	0.88%	1.50%		0.27%
Prevalence of learning disabilities aged 18+	2013/14	–	1,413	0.62%	0.62%	0.48%	0.05%		0.72%
Prevalence of learning disabilities	2014/15	–	1,688	0.60%	0.58%	0.44%	0.07%		0.78%
People aged 18-64 registered deaf or hard of hearing per 100,000	2009/10	–	470	263.4	253.4	172.8	0.0		492.4
People aged 65-74 registered deaf or hard of hearing per 100,000	2009/10	–	320	1,292	1037	620	0		3,518
People aged 75+ registered deaf or hard of hearing per 100,000	2009/10	–	1,230	5,707	4780	3089	140		12,183
People aged 18-64 registered blind or partially sighted per 100,000	2013/14	–	550	320.3	240.2	214.1	0.0		451.3
People aged 65-74 registered blind or partially sighted	2013/14	–	210	774	638	569	0		1,436
People aged 75+ registered blind or partially sighted	2013/14	–	1,025	4,517	4057	4255	0		10,403
Adults with physical disabilities supported throughout the year per 100,000	2013/14	–	560	326	611	462	178		1,601
Adults with learning disabilities supported throughout the year per 100,000	2013/14	–	745	433.8	531.1	414.0	0.0		800.6
Adults with mental health problems supported throughout the year per 100,000	2013/14	–	295	172	357	391	0		2,333
Older people (65+) supported throughout the year per 100,000	2013/14	–	4,655	9,746	12297	9781	4,187		22,713

Figure 3: Excerpt from PHE adult social care profiles 2015 – People with care and support needs – Sunderland

Maternity and Sexual Health Indicators

Delivery and Birth Outcomes in different birth settings

Table 13 Rates of spontaneous vaginal birth, transfer to an Obstetrics unit and Obstetrics interventions for each planned place of birth (Source NICE Table 1 and 3[Error! Bookmark not defined.]**)**

A = low risk multiparous women B= low risk nulliparous women

Intervention	Mother	Number of incidences per 1000 multiparous women giving birth			
		Home	Freestanding midwife unit	Alongside midwife unit	Obstetrics unit
Spontaneous vaginal birth	A (multi)	984	980	967	927
	B (nullip)	794	813	765	688
Transfer to an Obstetrics unit	A (multi)	115	94	125	10*
	B (nullip)	450	363	402	10*
Regional anesthesia	A (multi)	28	40	60	121
	B (nullip)	218	200	240	349
Episiotomy	A (multi)	15	23	35	56
	B (nullip)	165	165	216	242
Caesarian birth	A (multi)	7	8	10	35
	B (nullip)	80	69	76	121
Instrumental birth (forceps, ventouse)	A (multi)	9	12	23	38
	B (nullip)	126	118	159	191
Blood transfusion	A (multi)	4	4	5	8
	B (nullip)	12	8	11	16

estimated transfer rate from an Obstetrics unit owing to lack of capacity or expertise

Table 14: Outcomes for the baby for each planned place of birth (Source NICE Table 2 and 4[Error! Bookmark not defined.])

		Number of babies per 1000 births			
		Home	**Freestanding midwife unit**	**Alongside midwife unit**	**Obstetrics unit**
Low risk multiparous women	**Babies without serious medical problems**	997	997	998	997
	Babies with serious medical problems*	3	3	2	3
Low risk nulliparous women	**Babies without serious medical problems**	991	995	995	995
	Babies with serious medical problems*	9	5	5	5

*Serious medical problems – neonatal encephalopathy and meconium aspiration syndrome were the most common adverse events accounting for 75% of the total. Stillbirths after the start of labour and death of the baby in the first week of life accounted for 13% of the events. Fractured humerus and clavicle were uncommon (less than 4% of adverse events)

Birth and Delivery Complications

Table 15 Numbers and proportions of adverse outcomes recorded in the Birthplace UK (2011) study (Source NICE Appendix A1[Error! Bookmark not defined.])

Adverse Outcome	Incidence per 1000 births	Percentage of all adverse outcomes
Stillbirth after start of care in labour	0.22	5
Death of the baby in the first week after birth	0.28	7
Neonatal encephalopathy caused by oxygen deprivation before or during birth (clinical diagnosis)	1.6	40
Meconium aspiration syndrome	1.3	34
Brachial plexus injury	0.38	9
Bone fractures	0.17	4
TOTAL adverse outcomes	4	99*

*All categories are mutually exclusive and numbers do not add up to 100 due to rounding

Table 16 Common birth and delivery complications (Source: Compendium of NHS maternity statistics, England, April 2015)

	Complication	Number of births / deliveries (1000s)
Birth	Neonatal jaundice	51
	Disorders relating to short gestation and low birth weight	48
	Intrauterine hypoxia	38
	Disorders relating to long gestation and high birth weight	28
	Respiratory distress of newborn	26
Delivery	Perineal laceration during delivery	260
	Labour and delivery complicated by fetal distress	160
	Post partum haemorrhage	90
	Maternal care for known or suspected abnormality of pelvic organs	70
	Premature rupture of membranes	60

Table 17 Primary reason for transfer to an Obstetrics unit (Source NICE Table 5 Error! Bookmark not defined.**)**

	From home N=3529 % of N	From a freestanding midwifery unit N= 2457 % of N	From an alongside midwifery unit N= 4401 % of N
Delay during 1st or 2nd stage of labour	32.4	37.1	35.2
Abnormal fetal heart rate	7	10.5	10.8
Request for regional analgesia	5.1	6.6	13.3
Meconium staining	12.2	12.2	12.2
Retained placenta	7	7.3	4.6
Repair of perineal trauma	10.9	7.5	8.4
Neonatal concerns postpartum	5.1	2.6	0
Other	20.1	16.2	16.3

Higher risk pregnancies

Table 18 Equality and inequality factors indicating additional care requirements (Adapted from Source NICE Table 8 and 9[Error! Bookmark not defined.]**)**

- Medical conditions such as cardiac disease, diabetes and other conditions
- Substance misuse
- Alcohol dependency requiring assessment or treatment
- Onset of gestational diabetes
- BMI at booking greater than 35Kg /m^2 or BMI at booking of 30-35Kg /m^2
- Small for gestational age
- TB under treatment
- Previous CVA
- Psychiatric disorder requiring inpatient care – under current outpatient psychiatric care
- Age over 35 at booking
- Hypertensive disease
- Sickle cell trait
- Women who smoke
- HIV or HBV infection
- Vulnerable women eg teenagers, social isolation

Infant Mortality and Stillbirths

Table 19 Infant mortality and stillbirth indicators (Source: PHE Mortality profiles accessed February 2017)

Indicator	Time Period	South Tyneside	Sunderland	England
Infant mortality	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 mortality	2013-15	0.82 (4)	1.14 (10)	2.98
Very low birth weight of all babies	2015	1.09 (18)	1.49 (43)	1.26

Antenatal health, Sexual & Reproductive health

Table 20 Prevalence of recognised antenatal risk factors and co-morbidities (Source : PHE General Practice profiles accessed February 2017)

Indicator	Time Period	South Tyneside CCG	Sunderland CCG	England
Diabetes (%) – QoF prevalence – 17+	2015/16	7.1	6.8	6.5
Hypertension (%) - QoF prevalence – all ages	2015/16	16	16.5	13.8
Obesity (%)- QoF prevalence 18+	2015/16	13.8	12.3	9.5
Epilepsy (%)– QoF prevalence – 18+	2015/16	0.9	1.0	0.8
% reporting blindness or severe visual impairment	2015/16	1.4	1.0	1.0
% reporting deafness or severe hearing impairment	2015/16	5.7	5.3	3.8
Learning disability (%) – QoF prevalence	2015/16	0.6	0.6	0.5

Table 21 Indicators of sexual and reproductive health (Source PHE Sexual and Reproductive Health Profiles accessed February 2017)

	Indicator	Time period	South Tyneside	Sunderland	England
Reproductive health	**Pelvic inflammatory disease admissions rate / 100,000 (count)**	2014/15	268.8 (73)	158.6 (84)	236.4
	Ectopic pregnancy admissions rate /100,000 (count)	2014/15	110.5 (30)	58.5 (31)	89.6
	Cervical cancer registrations rate / 100,000 (count)	2011-13	11.2 (26)	15.8 (65)	9.6
Teenage pregnancy	**Under 16s conception rate/1000 (count)**	2014	5.5 (13)	9.2 (39)	4.4
	Under 18s conception rate / 1,000 (count)	2014	30.9 (80)	34.9 (163)	22.8
	Under 18s conceptions leading to abortion - percentage (count)	2014	41.3 (33)	42.9 (70)	51.1
	Under 18s birth rate/ 1,000 (count)	2014	7.7 (20)	11.1 (50)	6.7
HIV and STI	**Syphilis diagnostic rate / 100,000**	2015	7.4 (11)	4.7 (13)	9.3
	Gonorrhoea diagnostic rate / 100,000	2015	67.9 (101)	78.7 (218)	70.7
	Chlamydia detection rate /100,000 aged 15-24	2015	1,754 (315)	1,701 (624)	1887
	New HIV diagnosis rate / 100,000 aged 15+	2015	4 (5)	3.4 (15)	12.1
	HIV prevalence rate / 1,000 aged 15-59	2015	0.63 (54)	0.75 (123)	2.26
Wider determinants	**Percentage of people living in 20% most deprived areas in England**	2014	46.2	38.2	20.2

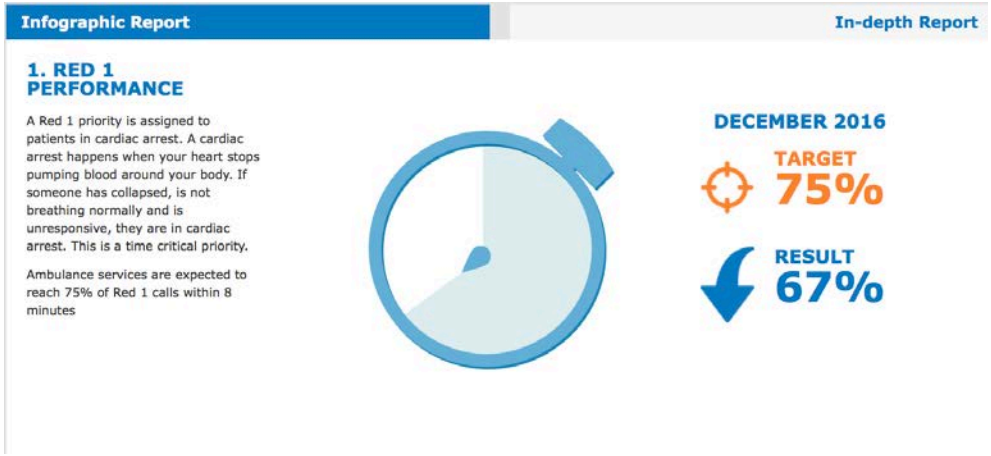
Pregnancy, Birth, and Child Health

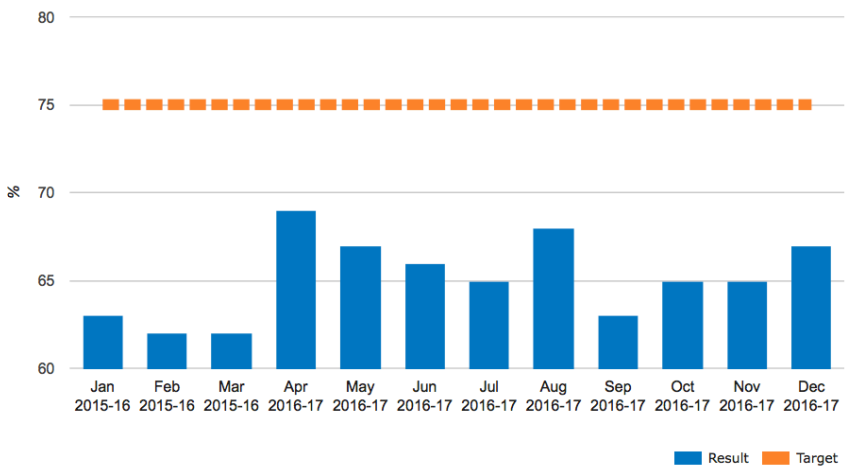
Table 22 Indicators of child health, pregnancy and birth (Source PHE child health profiles accessed February 2017)

Indicator	Time Period	South Tyneside	Sunderland	England
Percentage of babies born to mothers born in Middle East and Asia	2014	3.8 (61)	3.3 (94)	9.7
Caesarian section - percent (count)	2014/15	20.6 (307)	21.9 (620)	25.8
Percentage of deliveries to women aged 35 years or older (count)	2014/15	11.5 (171)	13.4 (379)	20.4
Low birth weight of term babies - percent, (count)	2014	7.2 (119)	4.2 (111)	2.9
Smoking status at time of delivery - percent (count)	2015/16	21.8 (352)	18 (505)	10.6
Breastfeeding initiation – percent (count)	2014/15	53 (821)	57.5 (1,557)	74.3
Breastfeeding prevalence at 6-8 weeks after birth	2015/16	24 (395)	26.8 (757)	43.2
Hospital admissions for mental health conditions (count)	2014/15	85.3 (25)	113.8 (62)	87.4
Family homelessness	2014/15	2.4 (166)	0.5 (55)	1.8
Hospital admissions due to substance misuse (15-24 years)	2012/13-2014/15	153.5	124.2	88.8
Hospital admissions due to alcohol specific conditions	2012/13-2014/15	85	92.9	36.6

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)





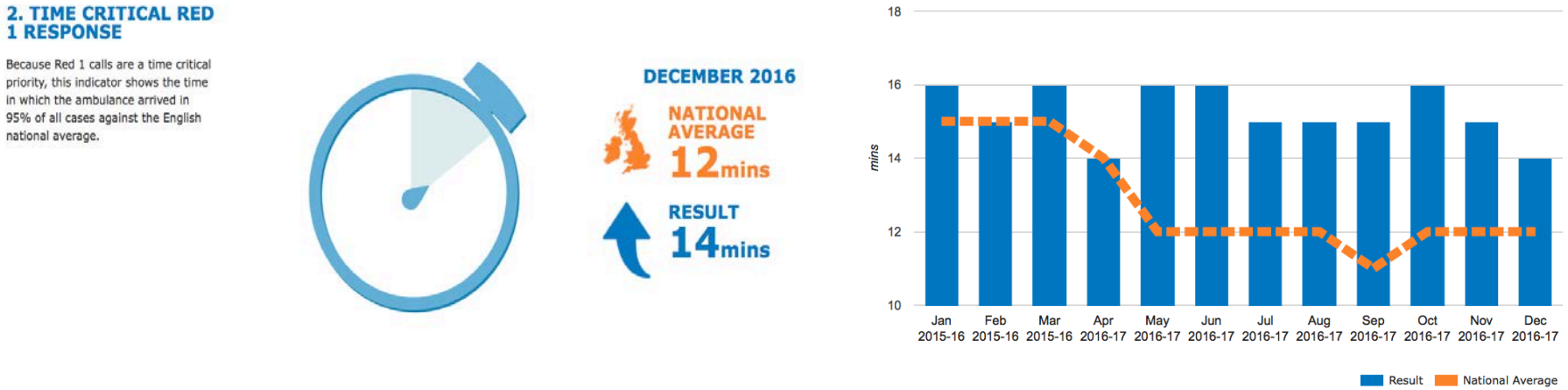


Figure 5: Achievement of RED 1 Response Time target (Source: NHS Ambulance Quality Indicators, North East Ambulance Service, Association of Ambulance Chief Executives accessed February 2017)

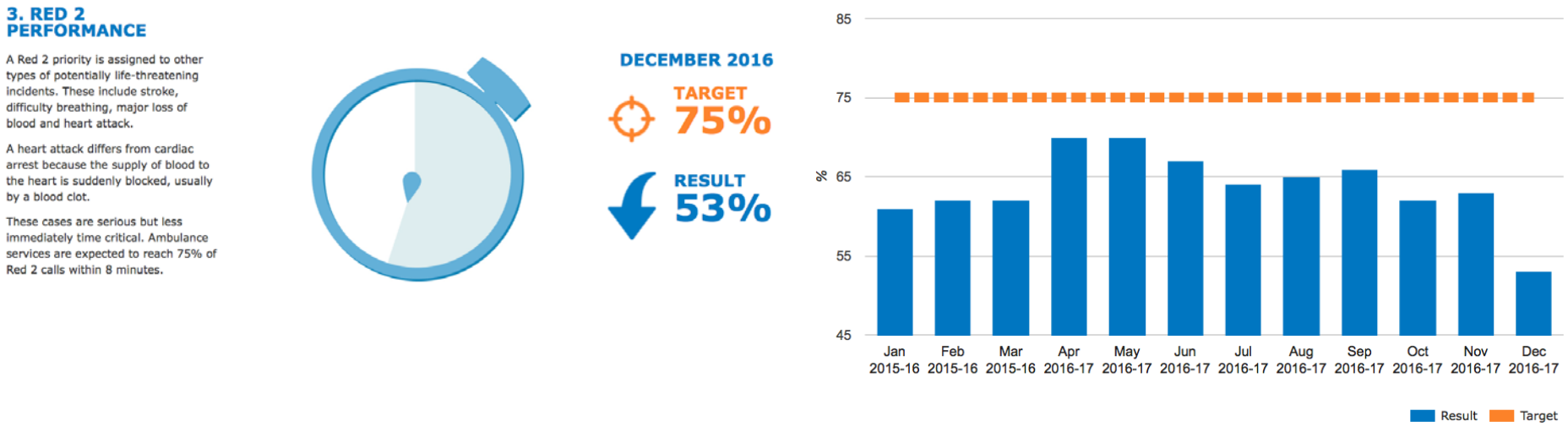


Figure 6: Figure 1: Achievement of RED 2 Performance Target (Source: NHS Ambulance Quality Indicators, North East Ambulance Service, Association of Ambulance Chief Executives accessed February 2017)

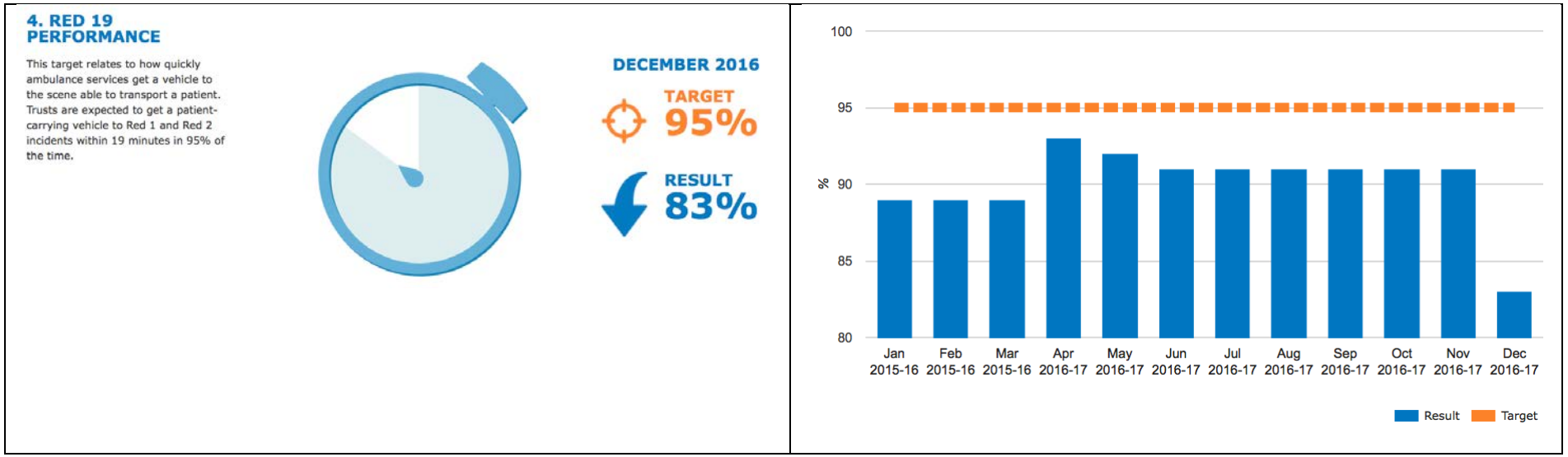


Figure 7: Achievement of RED 19 Performance Target (Source: NHS Ambulance Quality Indicators, North East Ambulance Service, Association of Ambulance Chief Executives accessed February 2017)