South Tyneside Urgent and Emergency Care Equity Audit
Executive Summary

This audit has been carried out following the response to the relocation of the Jarrow Walk in Centre services to an integrated GP/urgent care hub based at the Emergency Department at South Tyneside Hospital.

Subsequent to formal consultation and a decision by South Tyneside CCG to implement revised arrangements, a referral was made to the Secretary of State for Health by South Tyneside Council Overview and Scrutiny Call-in Committee in 2014.

This referral was considered by the Independent Review Panel (IRP) on behalf of the Secretary of State and a response was received in February 2015. The response did not consider the matter to be suitable for full review because it considered that ‘further local action by the NHS with the Council can address the issues raised.’

In direct response, the Health and Wellbeing Board (HWBB) established a multi-agency assurance group to consider the issues which had been raised in the referral, which focused on six areas.

The group reported back to the HWBB in June 2015 on progress against the six areas and gave assurance to board members that the necessary measures were being put in place to support the transition to new urgent care arrangements in South Tyneside, however, it was recommended that Healthwatch carry out a full equity audit of access to the new Urgent Care hub within six months of opening.

Members of the assurance group, supplemented by new membership from South Tyneside CCG, North East Commissioning Support, and South Tyneside Council Public Health have continued to meet to carry out the audit, resulting in this report.

Findings

In summary this report has identified that on the whole, and using information available, there appears to be equity of access to urgent and emergency care services for the residents of South Tyneside. The provision of urgent and emergency care for the South Tyneside population is comprehensive, accessible and timely for the varying needs apparent across the borough. Given South Tyneside’s geographical position in the region, there is comprehensive access to services provided in neighboring boroughs and cities, as well as services provided locally in communities, centres of expertise, and people’s homes. These are available both in and out of hours and they are provided relative to need and urgency.

Ambulance Response Times

On ambulance response times for the highest level of emergency (categorised as Red), South Tyneside performs better than the North East average, with some of the quickest
response times. Against the 8 minute response target, the slowest median response time in South Tyneside was 6 minutes and 2 seconds for the SR6 postcode (Whitburn and Marsden and Cleadon and East Boldon) in the south east of the borough and the quickest median response time was 4 minutes 45 seconds in the NE32 postcode (Jarrow and Fellgate regions). In SR6, 79% of Red calls were responded to in less than 8 minutes and in NE32, 97% of calls were responded to in less than 8 minutes.

From our analysis there appears to be no association between the level of deprivation and a faster or slower response time in South Tyneside. As deprivation goes up, response times do not get better or worse in a way that would lead us to suspect any inequalities.

A&E Attendance

There were 79,000 attendances at Accident and Emergency in 2015/16 by South Tyneside residents, a number that has been steadily increasing in South Tyneside and across England. A&E attendance rates (the average number of visits to A&E per person) in South Tyneside are significantly higher than the North East aggregate across all ages with the exception of females aged 85 years and older. Twenty percent of these attendances are at A&E units outside of South Tyneside, particularly at Gateshead, Sunderland and Newcastle. South Tyneside is ranked 4th highest out of 10 commissioning areas in the North East for A&E attendance rates.

As is the case for most healthcare utilisation, those residents living in areas that are more deprived are more likely to attend A&E. In 15/16, residents in the 10% most deprived areas were twice as likely to attend A&E as those living in the 10% least deprived areas.

Nationally, the target is for a minimum of 95% of patients attending A&E to meet the 4-hour standard (the length of time from first presentation through to discharge). There is very little variation between electoral wards in the borough, with 93% meeting the standard on the lower end in Hebburn South and 95.2% meeting the standard from West Park on the high end. There is therefore a high level of equity across South Tyneside geographically. This equity remains when we analysed 4-hour performance by deprivation, gender and ethnicity. Age is the one characteristic analysed that did have some significant variation between groups. Of the 26,000 attendances amongst 0-4 year olds, 99.5% met the 4-hour standard – compared to just 83% of the 13,300 attendances amongst those 85 and older. There is national evidence available that illustrates that this is not just a problem for South Tyneside. In England, on average, older people spend longer in A&E departments when they visit. Using the national evidence as an explanation for this inequality, it is likely that finding is confounded by the complexity of care required by older people; potentially waiting for social care to be organised, and/or older people being referred through A&E for urgent diagnostics or admission to a ward. The high levels of younger patients meeting the 4-hour standards.
may be due to the specialist A&E department at South Tyneside Hospital for paediatrics. It is likely that the true cause is a combination of these factors, however it does warrant further review.

GP In-Hours Services
In general, patients are more satisfied locally than the national average with GP surgery hours and access to appointments. In both these domains however, reports show a decline in satisfaction over the past 4 years both locally and nationally.

Unfortunately without individual-level data we have not been able to analyse any relationship between deprivation (or other measure of need) and access. However, when we analysed these measures by GP practice deprivation score we found no correlation between performance and deprivation score. This means at a practice-level there appears to be equity in relation to deprivation.

Out of Hours Services
GP Survey respondents answered several questions related to Out-of-Hours services:
1. “How do you feel about how quickly you received care or advice on that occasion?”
2. “Considering all of the people you saw or spoke to on that occasion, did you have confidence and trust in them?”
3. “Overall, how would you describe your last experience of NHS services when you wanted to see a GP but your GP surgery was closed?”
For all three questions, patients rated South Tyneside services higher than national averages.

NHS 111 and 999 Services
NHS 111 and 999 medical telephone services have roughly 66,000 contacts between them every year from South Tyneside. These services are virtually universally available and accessible via a telephone. Use of these services in South Tyneside generally increases in line with deprivation. Though the service does not screen NHS 111 calls by any identifying feature of the caller, we have identified variations in quality of access to 111 between groups in South Tyneside by gender, deprivation, and geography. This is possibly due to capacity in the service at different hours in the day, though further investigation is required.

Other services
The report also highlights that there are other key initiatives underway in South Tyneside that are part of the urgent and emergency care system, for example:
- The Better U self-care programme,
- Think Pharmacy First programme – provided through the comprehensive
network of pharmacies in South Tyneside (as evidenced by the Pharmaceutical Needs Assessment),

Future Analysis
The key areas of further analysis and potential improvement identified by this analysis are:
1. Ambulance Red response times, which whilst within the national response standard of 8 minutes, illustrate some variance between wards.
2. The age inequality in the 4 hour wait standard for Accident and Emergency.
3. The response times for 111 calls in South Tyneside – exploring why performance varies across the region and why there is significant variation in response times within South Tyneside.

It is recommended that these three areas are explored further though existing governance and assurance routes for urgent and emergency care delivery.
South Tyneside Urgent and Emergency Care Equity Audit

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1 Introduction
The NHS provides a large range of services to meet the health needs of the population. These needs take many different forms and therefore require very different responses from healthcare providers; ranging from those services that can be planned – for example, when managing a person’s diabetes – through to services that react to an immediate and unplanned need – for example, an injury or sudden illness. The NHS’s often commonly perceived response to unplanned needs is through 999 Emergency Calls, Ambulance Blue Light Response and Accident and Emergency Services. These services are the high-profile and commonly understood response to urgent or emergency needs, but in reality these needs can be met by a range of services that are available in communities, depending on severity of the need.

Millions of people in England have non-life threatening short-term illnesses or health problems for which they need prompt and convenient treatment or advice. Others have pre-existing health problems which fluctuate or deteriorate. A much smaller number suffer from serious illness or have a major injury which requires swift access to highly-skilled, specialist care to give them the best chance of survival and recovery. To meet these needs an improvement in information and advice and access to timely and appropriate urgent and emergency care, across the 24-hour period within the NHS, is required.

Nationally, it is suggested that the current system of urgent and emergency care is unaffordable and unsustainable and consuming NHS resources at a greater rate every year. Urgent or unplanned care – when there is a need to access care quickly – leads to at least 100 million NHS calls or visits each year, which represents about one third of overall NHS activity and more than half of the costs. Growing numbers of frail elderly patients, increasing morbidities, more treatable illnesses and an increased public expectation of healthcare have all contributed to ever greater pressure on health and social care services. In urgent and emergency care, this has led to more people:

- using GP services
- using urgent care, walk-in centres and minor injury units;
- accessing the most expensive types of urgent and emergency care; and
- being admitted to hospital through emergency services.

South Tyneside has a range of urgent and emergency care services available to its population, and this is supplemented by services provided across the regional network which helps to support patients with specific acute needs, such as major trauma, stroke and cardiac centres.

Recent changes in the structure of urgent and emergency care in South Tyneside has led to some questions about the fairness of local provision and if it’s truly accessible to all in South Tyneside. This analysis seeks to explore whether access to the urgent and emergency care system is fair across the South Tyneside population, and how it compares to other areas and national performance.
2 Definitions
Specifically defining urgent/emergency needs and urgent/emergency services is complex, and it is difficult to clearly delineate between the terms “urgent” and “emergency”.

**Urgent needs** are often defined as illnesses that are not life threatening and injuries that are not serious. NHS England’s vision is that adults and children with urgent care needs should have access to a highly responsive service that delivers care as close to home as possible, minimising disruption and inconvenience for patients, carers and families.

**Emergency needs** are therefore services that require “time-critical” care i.e. care that if not provided within a specified timeframe could lead to a loss of life or a permanent disability. NHS England’s vision for those people with more serious or life-threatening emergency care needs is that we should ensure they are treated in centres with the right expertise, processes and facilities to maximise the prospects of survival and a good recovery.

The NHS England framework for transforming urgent and emergency care services in England (August 2015) define urgent and emergency services as follows.

**Urgent care services** deliver ambulatory care\(^1\) in a facility dedicated to the delivery of medical care outside of the hospital emergency department. These services are provided by a range of practitioners in a range of settings, but commonly include general practice, pharmacies, urgent care centres (also technically called type 3 units) etc.

**Emergency services** include a range of services to meet serious and life-threatening needs. Emergency Departments are specifically defined by virtue of what they provide. These include:

- **Type 1 A&E department** – Major A&E, providing a consultant-led 24 hour service with full resuscitation facilities
- **Type 2 A&E department** – Single Specialty A&E service (eg ophthalmology, dentistry)
- **Type 3 A&E department** – Other A&E / Minor Injury Unit / Walk In Centre, treating minor injuries and illnesses. Type 3 Units however are commonly for urgent needs rather than emergency needs.

The Ambulance Service also provides an acute response service to ensure that life-threatening cases receive the quickest response. The immediate life threatening categories are as follows:

- **Red 1**: 75% of Category A Red 1 calls (the most time critical, where patients are not breathing or do not have a pulse) to be responded to within 8 minutes
- **Red 2**: 75% of Category A Red 2 calls (still serious, but less immediately time critical, like strokes or fits) to be responded to within 8 minutes. The clock starts ticking up to 60 seconds after the clock for Red 1.

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\(^1\) Care provided without the need for an overnight stay/admission
• **R19**: 95% of calls to receive a patient carrying resource within 19 minutes.

There are also non-emergency ambulance response categories:

• **Green**: these are responses for non-life threatening conditions.
• **Urgent**: assigned to calls made by a GP or other health care professional.

The table below gives examples of the various needs and services.
<table>
<thead>
<tr>
<th>Needs</th>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Urgent</strong></td>
<td><strong>NHS Choices website</strong></td>
</tr>
<tr>
<td>sprains and strains</td>
<td>111 Telephone Advice</td>
</tr>
<tr>
<td>broken bones</td>
<td>General Practice</td>
</tr>
<tr>
<td>wound infections</td>
<td>Dental Services</td>
</tr>
<tr>
<td>minor burns and scalds</td>
<td>Community Services e.g. Integrated Community Teams</td>
</tr>
<tr>
<td>minor head injuries</td>
<td>Pharmacy</td>
</tr>
<tr>
<td>insect and animal bites</td>
<td>Out of Hours GP and Dental Services</td>
</tr>
<tr>
<td>minor eye injuries</td>
<td>Mental Health Crisis Response</td>
</tr>
<tr>
<td>injuries to the back, shoulder and chest</td>
<td>Care Home Liaison</td>
</tr>
<tr>
<td><strong>Emergency</strong></td>
<td><strong>999 Emergency Calls</strong></td>
</tr>
<tr>
<td>chest pain</td>
<td>Ambulance Response – blue light emergency for immediate life threatening cases</td>
</tr>
<tr>
<td>breathing difficulties</td>
<td>Mental Health Crisis Response</td>
</tr>
<tr>
<td>major injuries</td>
<td>Mental Health Liaison Service</td>
</tr>
<tr>
<td>stomach pains</td>
<td>Emergency Department</td>
</tr>
<tr>
<td>gynaecological problems</td>
<td>Paediatric Emergency Department</td>
</tr>
<tr>
<td>pregnancy problems</td>
<td></td>
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<tr>
<td>allergic reactions</td>
<td></td>
</tr>
<tr>
<td>overdoses</td>
<td></td>
</tr>
<tr>
<td>alcohol related problems</td>
<td></td>
</tr>
<tr>
<td>mental health problems</td>
<td></td>
</tr>
</tbody>
</table>
NHS England proposes a model for delivering safer, faster and better urgent and emergency care that illustrates the definitions and services above. NHS England’s vision is that this is provided through urgent and emergency care networks (UECNs) in the future to deliver best practice.

Given the complexity in delineating the two groups of services, this equity audit has therefore taken both into account. One of the key challenges is that people with an urgent care need can present at an emergency care service – this is not always appropriate and can block emergency care services. Patients do not distinguish between urgent and emergency healthcare needs, and therefore the two terms can be used interchangeably. As an overall guide, urgent and emergency care is the range of responses that health and care services provide to people who require – or who perceive the need for – same day advice, assessment, transport, care or treatment. Same-day responsiveness is an expectation of the modern healthcare system. Note that the judgement of urgent and emergency is made by the patient and not by a clinician retrospectively: this is because the true urgency of a problem cannot be determined until it has been assessed. Clinicians may choose to distinguish between emergency (time-critical) and urgent (not time-critical) care.
The NHS England review proposes that five key changes need to take place in order to significantly improve current service arrangements and improve better outcomes for people. These are:

- Providing better support for people and their families to self-care or care for their dependants.
- Helping people who need urgent care to get the right advice in the right place, first time.
- Providing responsive, urgent physical and mental health services outside of hospital every day of the week, so people no longer choose to queue in hospital emergency departments.
- Ensuring that adults and children with more serious or life threatening emergency needs receive treatment in centres with the right facilities, processes and expertise in order to maximise their chances of survival and a good recovery.
- Connecting all urgent and emergency care services together so the overall physical and mental health and social care system becomes more than just the sum of its parts.

### 3 National and local strategy

There are a number of national strategies that are driving the developments in urgent and emergency care. These are as follows:

- **Safer, faster, better: good practice in delivery urgent and emergency care**
- **Commissioning Standards Integrated Urgent Care**
- **Urgent and Emergency Care Route map (as set out in the NHS Five Year Forward View)**
- **General Practice Forward View April 2016**

Locally South Tyneside is part of the Regional Urgent and Emergency Care Vanguard with is taking a more prominent role in steering the provision of local services. This regional approach recognises that urgent and emergency care must act as a network to ensure that the highest standards of care are provided and that people in the North East have access to centres of excellence for their care.

### 4 Aims and exclusions

This paper seeks a high level analysis of access to urgent and emergency care services in South Tyneside, addressing the question:

“After the relocation of the Jarrow Walk-in Centre to the new Urgent Care Centre, can the South Tyneside population equitably access urgent and emergency care services now in place?”
This question will be addressed in the context of urgent and emergency care service provision to South Tyneside residents as a whole, including the urgent care centre, general practice, pharmacy services, 111 and self-care amongst others (see Table 1 for details of local services). The review will assess whether South Tyneside residents are able to access the right service at the right time in proportion to their need and, where appropriate, how this compares regionally and nationally.

5 Understanding health equity

5.1 Health Equity Audit Definition

A Health Equity Audit (HEA) is a comparison of the people that are in need of a service and the people that are accessing that service. It confirms that services affecting health and wellbeing are reaching the groups of people that would benefit most. Groups are often identified according to:

1. age
2. gender
3. ethnicity
4. deprivation level, and
5. geography

At its most basic level, an HEA looks like this:


**Figure 1 Balanced Need vs Service Provision**

In Figure 1, need is perfectly balanced against service provision. Those with more need receive a proportionally higher amount of service.

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2 Health Equity Audit: A guide for the NHS
Figure 2 shows those with the most need getting the lowest level of service, an example of the “inverse care law” and an unbalanced, inequitable system that requires intervention.

HEA’s are produced because inequalities in the provision of services lead to inequalities in health outcomes. The South Tyneside Clinical Commissioning Group’s constitution makes specific reference to addressing needs and inequalities: “The values that lie at the heart of the group’s work are...responding to local health needs” and “striving to ensure equality and reduce inequalities.”

5.2 Supply, access, demand, and need
Service provision is a combination of supply of and access to a service. A&E is only useful to people that can physically get to it. When service provision is balanced with true need and demand for the service across all population groups, the system is said to be equitable. This means that regardless of where people live in South Tyneside, their age, gender, social class or other characteristic - their urgent and emergency care needs are appropriately met.

Ideally, we can distinguish between the true need for a service and demand for that service. People might arrive at A&E when a call to NHS 111 would have sufficed – an example of demand for a service without a true need. Conversely, people may need emergency medical care, but not seek it out – an example of true need without demand.

Due to the difficulties in delineating between true need and demand using information that is available, the analysis in this paper will assume the two are the same. That is, the population in South Tyneside will largely seek out urgent and emergency services when they need them. We do not always expect, however, that people will seek the most appropriate service for their need. They may call 999 when they could have visited a pharmacy. We would consider this to be accessing the Urgent and Emergency system, even if they accessed a less effective part of the system for their specific need. Individual services are responsible for triaging users to the appropriate level of care.

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Any problems that are identified in this step are a service performance issue, rather than a system failure related to access and are thus outside the scope of this report\textsuperscript{4}.

If equity audits are about comparing supply with true need, and we are assuming true need is equivalent to demand, we can assess equity by comparing supply against demand. We will do this by analysing how well groups of people are able to access services in South Tyneside.

### 6 Population and health in South Tyneside

#### 6.1 Population

Figure 3 South Tyneside Population Overview

\textsuperscript{4} Although not the focus of this paper, a highly-functioning urgent and emergency care system also routinely ensures that the population is well educated on the most appropriate point of access for services.
South Tyneside is a metropolitan borough in the North East of England. It has close to 150,000 residents and slightly more females than males. The population is aging at a faster rate than the English average. 19% or 29,000 residents are over 65 compared to 17% nationally. In 2035, there will be an estimated 43,000 people over aged 65.

South Tyneside is the 3rd most deprived local authority in the North East and the 26th most deprived nationally.

6.2 Health
South Tyneside has generally worse health than average in England. High deprivation and associated poor behaviours contribute to lower life expectancies and greater utilisation of healthcare services. The area does perform better than most in several health domains however. The immunisation and vaccination coverage for South Tyneside is one of the most comprehensive in the country.

While indicators related to health and wellbeing are largely below average compared to England, many are improving. Preventable mortality from cardiovascular disease has almost halved in 10 years, from 250 early deaths in 2003 to 140 in 2013. Men and women are living longer on average. Life expectancy has increased by 2-3 years over the last decade.

For an overview of health and wellbeing indicators for South Tyneside, see several highlights in Figure 4 and a comprehensive, up-to-date report from the Public Health Outcomes Framework5.

5 http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000049
Our health and wellbeing

**BIRTH**
- Every year around 4,500 children are born in South Tyneside.
- 25.2% of mothers smoke during pregnancy.
- 61% of mothers breastfeed for 4 weeks or more.
- 61% of mothers breastfeed for 4 weeks or more.
- 61% of mothers breastfeed for 4 weeks or more.
- 61% of mothers breastfeed for 4 weeks or more.

**FEEDING**
- Half of mothers indicate breast feeding within 48 hours of delivery.
- Just a quarter of babies are breastfed by their 6 months.
- 37.0% of babies are breastfed by their 6 months.
- 37.0% of babies are breastfed by their 6 months.
- 37.0% of babies are breastfed by their 6 months.

**CHILD DEVELOPMENT**
- Around 4 out of 10 10-11 year olds are overweight or obese.
- Nationally it’s just over 19.0%.
- 16.0% of children aged 5-15 are overweight or obese.
- Nationally it’s just over 19.0%.
- 16.8% of children aged 5-15 are overweight or obese.
- Nationally it’s just over 19.0%.

**TEENAGE PREGNANCY**
- Around 3 conceptions in every 100 teenage girls.
- 29 per 1,000 teenage girls.
- 29 per 1,000 teenage girls.
- 29 per 1,000 teenage girls.

**ALCOHOLIC BEV. DAILY ACTIVITY**
- Over 85% of adults aged 20-44 consume moderate amounts of alcohol: 28.9% compared to 21.9% in England.
- Around 3 in 10 adults are physically inactive.
- Nationally it’s just over 22.9%.
- 12.5% of adults are physically inactive.
- Nationally it’s just over 22.9%.

**MENTAL HEALTH CANCER**
- Over 40% of cancer deaths in South Tyneside are in the 55-74 age group.
- 2.4% of adults have a long term illness: 2.4% compared to 3.1% in England.
- 12.9% of adults have a long term illness: 2.4% compared to 3.1% in England.
- 12.9% of adults have a long term illness: 2.4% compared to 3.1% in England.

**SOCIAL SERVICES**
- 5,860 people are in long term employment.
- 42% live in low income households.
- Nationally it’s just over 35%.
- 14.5% of South Tyneside residents have a long term illness.
- Nationally it’s just over 35%.

**NURSING CARE**
- 2.4% of hospital admissions are for influenza.
- Nationally it’s just over 2.4%.
- 2.4% of hospital admissions are for influenza.
- Nationally it’s just over 2.4%.
- 2.4% of hospital admissions are for influenza.
- Nationally it’s just over 2.4%.

**DEATH**
- Over 1,000 South Tyneside residents are registered as having dementia.
- 12% said that everyday activities cause them distress because of a health problem or disability.
- Nationally it’s just over 9.5%.
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- 12% said that everyday activities cause them distress because of a health problem or disability.
- Nationally it’s just over 9.5%.

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Figure 4 Overview of South Tyneside Health and Wellbeing
7 Current Urgent and Emergency Care Provision for the population of South Tyneside

NHS commissioning standards documentation\(^6\) outlines an ideal integrated urgent care system (Figure 5), with NHS 111 and 999 triaging patients to the appropriate service based on their needs. South Tyneside’s Urgent and Emergency Care system is largely similar, with the relevant organisations given in Table 1. A map of GP, pharmacy and hospital locations is given in the next section.

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**Figure 5 Integrated Urgent Care System**

**Table 1 Urgent and Emergency Care Services in South Tyneside**

<table>
<thead>
<tr>
<th>Service</th>
<th>Provider</th>
<th>Location</th>
<th>Access</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS 999</td>
<td>North East Ambulance Service</td>
<td>Russell House, Hebburn</td>
<td>Phone</td>
</tr>
<tr>
<td>NHS 111</td>
<td>North East Ambulance Services</td>
<td>Russell House, Hebburn</td>
<td>Phone</td>
</tr>
<tr>
<td>Urgent Care Hub &amp; A&amp;E</td>
<td>STFT</td>
<td>South Tyneside District Hospital, South Shields</td>
<td>Self-Transport, Ambulance</td>
</tr>
<tr>
<td>GP Out of Hours</td>
<td>Northern Doctors Urgent Care</td>
<td>South Tyneside District Hospital, South Shields</td>
<td>NHS 111 (phone)</td>
</tr>
<tr>
<td>GP In-Hours</td>
<td>28 practice surgeries</td>
<td><a href="http://www.southtynesideccg.nhs.uk/your-health/find-your-gp-practice/">http://www.southtynesideccg.nhs.uk/your-health/find-your-gp-practice/</a></td>
<td>Self-Transport</td>
</tr>
<tr>
<td>Dental Out of Hours</td>
<td>Dencall</td>
<td>Palmers Community Hospital, Jarrow</td>
<td>NHS 111 (phone)</td>
</tr>
<tr>
<td>Dental In-Hours</td>
<td>16 dental surgeries</td>
<td><a href="http://www.nhs.uk/Service-">http://www.nhs.uk/Service-</a></td>
<td>Self-</td>
</tr>
</tbody>
</table>

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## South Tyneside Urgent and Emergency Care Equity Audit

<table>
<thead>
<tr>
<th>Ambulance Services</th>
<th>North East Ambulance Service</th>
<th>Search/Dentist/LocationSearch/3</th>
<th>Transport</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Russell House, Hebburn &amp; Boldon Lane, South Shields</td>
<td>NHS 111, NHS 999</td>
<td></td>
</tr>
</tbody>
</table>

| Think Pharmacy First | 32 participating pharmacies | http://www.southtynesideccg.nhs.uk/your-health/thinkpharmacyfirst/ | Self-Transport |

<table>
<thead>
<tr>
<th>Mental Health</th>
<th>Northumberland, Tyne and Wear NHS Foundation Trust</th>
<th>Hospital Liaison Service</th>
<th>A&amp;E</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Initial Response Service</td>
<td>24/7 Phone Triage</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><a href="http://www.nhs.uk">www.nhs.uk</a></td>
<td></td>
</tr>
</tbody>
</table>

### Out of Area Services Commonly Accessed by South Tyneside Resident

<table>
<thead>
<tr>
<th>A&amp;E</th>
<th>City Hospitals Sunderland NHS Foundation Trust</th>
<th>Sunderland Royal Hospital, Sunderland</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Gateshead Health NHS Foundation Trust</td>
<td>Queen Elizabeth Hospital, Gateshead</td>
</tr>
<tr>
<td></td>
<td>Newcastle upon Tyne NHS Foundation Trust</td>
<td>Royal Victoria Infirmary, Newcastle</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Urgent Care Centre</th>
<th>Northern Doctors Urgent Care</th>
<th>Bunny Hill Urgent Care Centre, Sunderland</th>
</tr>
</thead>
</table>
7.1 GP, Hospital and Pharmacy Geographical Locations in South Tyneside

There are a range of access points available for urgent and emergency services. For example, patients are able to directly access a minor ailments consultation at the local community pharmacy.

7.2 Access to Urgent and Emergency Care in South Tyneside

There are a range of access points available for urgent and emergency services. For example, patients are able to directly access a minor ailments consultation at the local community pharmacy.
Other services, such as mental health liaison services, are accessible via A&E as they are designed to provide safe and effective discharge from A&E back into the community. GP and dental Out-of-Hours plus self-care advice services are reached through NHS 111 by phone. In total, there are 4 main points of access to the urgent and emergency care system that we will consider: self-transport to A&E, self-transport to GP services, by phone, and via ambulance. People in South Tyneside should have equitable access to each of these options in proportion to their needs.

The following sections are organised by the 4 points of access to urgent and emergency care. We will first describe the services and the level of activity they typically experience. Then, where data is available, we will assess the equity of access to the services using either national standards or patient feedback.

8 Ambulance Service

8.1 Introduction

In the context of equitable access to urgent and emergency care, universal access to care and transport by an ambulance service eliminates inequities of access due to self-transport. There are South Tyneside residents who can easily walk into A&E, and there are those who would need to take several buses after a walk to the closest stop, and even then may not be able to afford the bus fare. An ambulance service that is free of charge and accessible to everyone is ultimately the single factor that makes the urgent and emergency care system equitable (acknowledging that oftentimes many needs can be met by more local services; GP out of hours or urgent same day appointments for example).

It is therefore important that we assess how equitable residents in South Tyneside receive timely care to ambulance services, measured between the initial point of contact with dispatch services (NHS 999) and first contact with medical personal on scene.

8.2 Patterns of service uptake

There are about 22,000 calls per year in South Tyneside to 999 that result in an ambulance being dispatched. Overall, response times in the borough are quicker than average compared to England and the North East. This is primarily due to the high density population and close proximity to A&E for all South Tyneside residents.

Ambulance calls are categorised based on severity:

- Red 1: assigned to patients in cardiac arrest. Ambulance services are expected to reach 75% of Red 1 calls within 8 minutes.

---

7 Even though the initial point of contact for ambulance services are by phone through NHS 111 and 999, we will still consider it as a distinct access route due to its relevance to reaching critical services in A&E.
- Red 2: assigned to other types of potentially life-threatening incidents (including stroke, difficulty breathing, and major blood loss). Ambulance services are also required to reach 75% of these calls within 8 minutes of dispatch.
- Red 19: this is how quickly a patient carrying vehicle gets to the scene of a Red 1 or Red 2 call. Ambulance services are expected to reach the scene in 19 minutes 95% of the time.
- Green: these are responses for non-life threatening conditions.
- Urgent: assigned to calls made by a GP or other health care professional.

8.2.1 National Context

Figure 6 Red response times 2011-2014 UK (source: ambulanceresponsetimes.co.uk)

Figure 7 Red response times 2011-2014 North East (source: ambulanceresponsetimes.co.uk)

Figure 6 and Figure 7 show the North East performing better than average compared to national median response times for red calls. South Tyneside performs even better than the North East on
average, with some of the quickest response times. The slowest median response time in South Tyneside was 6 minutes and 2 seconds for the SR6 postcode in the south east of the borough (Whitburn and Marsden and Cleadon and East Boldon) and the quickest median response time was 4 minutes 45 seconds in the NE32 postcode (Jarrow and Fellgate regions). In SR6, 79% of Red calls were responded to in less than 8 minutes and in NE32, 97% of calls were responded to in less than 8 minutes (http://www.ambulanceresponsetimes.co.uk/).

8.2.2 Local Context

Figure 8 Electoral Ward Map of South Tyneside

Of the roughly 22,000 yearly ambulance responses, the majority are categorised as red, followed by green, then urgent. The figures in Table 2 and Table 3 show data collected from the North East Ambulance NHS Foundation Trust in 2014/25 and 2015/16. Calls have been grouped into red, green and urgent and show the location of the call (rather than the home residence of the patient accessing the service).

<table>
<thead>
<tr>
<th>Ward</th>
<th>Red</th>
<th>Green</th>
<th>Urgent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beacon and Bents</td>
<td>1,127</td>
<td>951</td>
<td>101</td>
</tr>
<tr>
<td>Bede</td>
<td>689</td>
<td>490</td>
<td>84</td>
</tr>
<tr>
<td>Biddick and All Saints</td>
<td>680</td>
<td>487</td>
<td>70</td>
</tr>
<tr>
<td>Boldon Colliery</td>
<td>581</td>
<td>404</td>
<td>100</td>
</tr>
</tbody>
</table>
Call volumes range from 123 red calls per 1,000 people in Beacon and Bents to 40 per 1,000 in Cleadon and East Boldon. Reporting ambulance data as a rate per population is slightly misleading, however, as call volumes will be skewed by where people are calling from rather than where they live. Beacon and Bents, for example, contains the sea front and South Shields, so we would expect a higher call volume due to non-residents in the area.

Table 3 Average yearly calls/1,000 population 2014/15-2015/16 (source: NECS)

<table>
<thead>
<tr>
<th>Ward</th>
<th>Red</th>
<th>Green</th>
<th>Urgent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beacon and Bents</td>
<td>123</td>
<td>104</td>
<td>11</td>
</tr>
<tr>
<td>Bede</td>
<td>90</td>
<td>64</td>
<td>11</td>
</tr>
<tr>
<td>Biddick and All Saints</td>
<td>77</td>
<td>55</td>
<td>8</td>
</tr>
<tr>
<td>Boldon Colliery</td>
<td>63</td>
<td>44</td>
<td>11</td>
</tr>
<tr>
<td>Cleadon and East Boldon</td>
<td>40</td>
<td>37</td>
<td>7</td>
</tr>
<tr>
<td>Cleadon Park</td>
<td>73</td>
<td>47</td>
<td>10</td>
</tr>
<tr>
<td>Fellgate and Hedworth</td>
<td>63</td>
<td>46</td>
<td>9</td>
</tr>
<tr>
<td>Harton</td>
<td>74</td>
<td>51</td>
<td>12</td>
</tr>
<tr>
<td>Hebburn North</td>
<td>73</td>
<td>67</td>
<td>12</td>
</tr>
<tr>
<td>Hebburn South</td>
<td>88</td>
<td>62</td>
<td>14</td>
</tr>
<tr>
<td>Horsley Hill</td>
<td>61</td>
<td>51</td>
<td>9</td>
</tr>
<tr>
<td>Monkton</td>
<td>78</td>
<td>60</td>
<td>13</td>
</tr>
<tr>
<td>Primrose</td>
<td>104</td>
<td>77</td>
<td>15</td>
</tr>
<tr>
<td>Simonside and Rekendyke</td>
<td>96</td>
<td>72</td>
<td>10</td>
</tr>
<tr>
<td>West Park</td>
<td>58</td>
<td>46</td>
<td>7</td>
</tr>
<tr>
<td>Westoe</td>
<td>75</td>
<td>62</td>
<td>13</td>
</tr>
<tr>
<td>Whitburn and Marsden</td>
<td>51</td>
<td>43</td>
<td>9</td>
</tr>
<tr>
<td>Whiteleas</td>
<td>117</td>
<td>82</td>
<td>61</td>
</tr>
<tr>
<td><strong>Average</strong></td>
<td>78</td>
<td>60</td>
<td>13</td>
</tr>
</tbody>
</table>

### 8.3 Equity of Access

To assess how equitably people in South Tyneside can access ambulance services, we analysed response times by call category, call location, and the deprivation level of the location. For each category, we looked at the distribution of response times and identified the 75th percentile mark to
create a standard of care. That is, the length of time where 75% of calls received a response in less time and 25% received a response in more time. The standards we created are given below:

Red: 8 minutes
Green: 73 minutes
Urgent: 165 minutes

This method of analysis means that 25% of ambulance calls will be over the standards described above. What we are assessing is, of all the calls with a response time over the standard, whether or not those calls are evenly distributed across geographies and deprivation deciles. The question is: if I live in Ward A, do I have an equal chance of receiving an ambulance response for a red/green/urgent call as someone living in Ward B within the standard?

8.3.1 Geography by Electoral Ward

Figure 9 Equity of Access to Ambulance Services, Red priority by ward (source: NECS)

Figure 9 shows that there is some significant variation in receiving ambulance care across the borough. The marker furthest to the right represents Beacon and Bents, where there were 2,253 calls over the two years and 61% of them (1,373) were responded to in less than 8 minutes. In Whiteleas, represented by the highest marker, there were 1,924 calls, 87% of which were responded to in less than 8 minutes.

South Tyneside Foundation Trust A&E is located in Whiteleas, which explains the quick response times. Ambulances completing a call after delivering a patient to A&E are then well positioned to respond to a Red call nearby. A high volume of quick responses from the hospital in Whiteleas will
pull the standard response time for the borough down, in effect making it more difficult for other wards that are further from the hospital to achieve the standard.

Several other wards in addition to Beacon and Bents are significantly below the South Tyneside Average, including: Horsley Hill, Hebburn North, and Whitburn and Marsden. The average response time from each of the locations was between 7 and 8 minutes and within the standard for Red calls.

![Equity of Access to Ambulance Services, Green priority by ward](source: NECS)

Figure 10 Equity of Access to Ambulance Services, Green priority by ward (source: NECS)
Figure 10 and Figure 11 show that there is no significant variation by geography related to access to ambulance services for Green and Urgent calls. This indicates that any variation in response times over or under the standard is evenly distributed amongst the electoral wards. Of note in Figure 11, Whiteleas has a far higher number of Urgent priority calls, with more than 4 times the number of calls compared to the next ward down (Monkton, with 220 calls over the two years). This is likely due to healthcare professionals transferring patients from care facilities within the hospital to other providers or to the patient’s home on discharge.
8.3.2 Deprivation

While we observed some geographical variation in access to ambulance services, it appears there is almost no significant variation in access to red, green, or urgent calls according to deprivation decile.

The one exception is for Red calls to deprivation decile 5, which received slightly slower access compared to other deprivation deciles. Decile 5 is the mid-point of deprivation, where 50% of areas in England are less deprived and 40% are more deprived (1 is most deprived and 10 is least). A map of deprivation deciles in South Tyneside in Figure 13 shows that geographically, the 5th deprivation decile is largely concentrated around the periphery of the borough. The slower response times here are then consistent with the slower times observed in Wards that were further from the hospital.

There is not association between the level of deprivation and a faster or slower response time. As deprivation goes up, response times do not get better or worse in a way that would lead us to suspect any inequalities.
Figure 13 Deprivation in South Tyneside by LSOA (source: 2015 IMD, DCLG)

Figure 14 and Figure 15 below show that access to Green and Urgent priority ambulance calls is very consistent across deprivation deciles in South Tyneside.

Figure 14 Equity of Access to Ambulance Services, Green priority by deprivation decile (source: NECS)
8.4 Summary
South Tyneside on average has very good access to ambulance services across the three different categories of need: red, green and urgent. Because of its compact nature and proximity to A&E services both in South Tyneside and in neighbouring authorities, ambulances are well positioned to respond to calls quickly.

Given that people in South Tyneside have access to a comparatively quick ambulance service, we do find that access to be somewhat inconsistent across the borough for Red priority calls only. Several wards and the 5th deprivation decile have a statistically significant number of ambulance responses that were slower than the standard in South Tyneside. This can largely be explained by both the high standard and the further than average proximity of the wards and deprivation decile to A&E services.

These results should be interpreted with caution, however, as we have judged equity of access by benchmarking against a South Tyneside standard. That is, does Ward X in South Tyneside have equal access to an ambulance as Ward Y in South Tyneside? We have not done this analysis benchmarking Ward X in South Tyneside against an England standard. However, based on national data showing average response times by postcode, we can infer that South Tyneside residents on the whole receive a better than average level of access to ambulance services, even in those areas receiving a slower than South Tyneside average response.

Figure 15 Equity of Access to Ambulance Services, Urgent priority by deprivation decile (source: NECS)
9 Self-transport and Ambulance Access to Accident and Emergency

9.1 Introduction
Timely access to Accident and Emergency is a core feature of a comprehensive urgent and emergency care system. South Tyneside residents have several provider options and available access routes. South Tyneside Foundation Trust, QE Hospital Gateshead, and Sunderland Royal Hospital all provide A&E services within a short walk, drive, metro, bus, taxi, or ambulance journey (depending on the nature of the need). All these sites now offer an urgent care hub arrangement which means that individuals who have an urgent need can be triaged at these sites, and seen by the most appropriate professional depending on their need (eg a GP, a nurse or for genuine emergencies, the Emergency Department team).

9.2 Patterns of service uptake
There were 79,000 attendances at Accident and Emergency in 2015/16 by South Tyneside residents, a number that has been steadily increasing in South Tyneside and across England. A&E attendance rates (the average number of visits to A&E per person) in South Tyneside are significantly higher than the North East aggregate across all ages with the exception of females aged 85 years and older. South Tyneside is ranked 4th highest out of 10 commissioning areas in the North East for A&E attendance rates.

When people present at the urgent care hub, they are triaged and either streamed into the emergency department (which is defined at a Type 1 A&E attendance) or into the GP service (a Type 3 attendance). It must also be noted that there is only one route into the hospital for unplanned GP admissions to the ward or for GP referrals for urgent diagnostic tests, so a good number of these A&E attendances will be made up of these GP referrals. It should not therefore be assumed that all A&E attendances are self-referred walk-ins.

9.2.1 Age and Gender
The figure below shows the differences in attendance by age and gender in more detail. Children and older people tend to visit A&E more frequently. Overall, males and females are roughly as likely to attend A&E, though there are some variations amongst age groups.
9.2.2 Geography

When we look at attendances by electoral ward, all have displayed growth in accident and emergency attendance rates over time, though some have higher rates than others. The electoral ward with significantly higher rates in 2015/16 compared to the South Tyneside average are Bede, Biddick and All Saints, Cleadon Park, Primrose, Simonside and Rekendyke and Whiteleas – areas with higher levels of deprivation. The map below shows the frequency of attendances to South Tyneside Foundation Trust.
9.2.3 Other Providers
About 19% or 1 in 5 attendances to A&E by South Tyneside patients are at providers other than South Tyneside Foundation Trust.
9.2.4 Deprivation

As is the case for most healthcare utilisation, those residents living in areas that are more deprived are more likely to attend A&E, shown in the figure below. In 15/16, residents in the 10% most deprived areas were twice as likely to attend A&E as those living in the 10% least deprived areas. It is outside the scope of this report to assess whether this is true need or just demand for a high level service that should be met elsewhere, though it is likely a combination of both.

Figure 19 Overall Attendance Rates to A&E linked to IMD Centile South Tyneside (2009/10-2015/16)

<table>
<thead>
<tr>
<th>IMD Centile</th>
<th>Population</th>
<th>09/10</th>
<th>10/11</th>
<th>11/12</th>
<th>12/13</th>
<th>13/14</th>
<th>14/15</th>
<th>15/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>10% Least Deprived</td>
<td>4,277</td>
<td>312</td>
<td>331</td>
<td>368</td>
<td>398</td>
<td>386</td>
<td>364</td>
<td>325</td>
</tr>
<tr>
<td>10-20% Least Deprived</td>
<td>11,213</td>
<td>323</td>
<td>365</td>
<td>394</td>
<td>414</td>
<td>420</td>
<td>388</td>
<td>363</td>
</tr>
<tr>
<td>20-30% Least Deprived</td>
<td>5,573</td>
<td>334</td>
<td>350</td>
<td>396</td>
<td>378</td>
<td>355</td>
<td>346</td>
<td>387</td>
</tr>
<tr>
<td>30-40% Least Deprived</td>
<td>6,885</td>
<td>324</td>
<td>375</td>
<td>409</td>
<td>419</td>
<td>399</td>
<td>363</td>
<td>390</td>
</tr>
<tr>
<td>40-50% Least Deprived</td>
<td>3,258</td>
<td>315</td>
<td>355</td>
<td>369</td>
<td>373</td>
<td>388</td>
<td>374</td>
<td>371</td>
</tr>
<tr>
<td>40-50% Most Deprived</td>
<td>14,736</td>
<td>364</td>
<td>403</td>
<td>442</td>
<td>470</td>
<td>452</td>
<td>432</td>
<td>442</td>
</tr>
<tr>
<td>30-40% Most Deprived</td>
<td>16,874</td>
<td>379</td>
<td>420</td>
<td>461</td>
<td>495</td>
<td>472</td>
<td>466</td>
<td>495</td>
</tr>
<tr>
<td>20-30% Most Deprived</td>
<td>17,192</td>
<td>398</td>
<td>443</td>
<td>472</td>
<td>477</td>
<td>486</td>
<td>479</td>
<td>515</td>
</tr>
<tr>
<td>10-20% Most Deprived</td>
<td>36,970</td>
<td>436</td>
<td>469</td>
<td>503</td>
<td>503</td>
<td>530</td>
<td>534</td>
<td>588</td>
</tr>
<tr>
<td>10% Most Deprived</td>
<td>31,450</td>
<td>487</td>
<td>535</td>
<td>579</td>
<td>594</td>
<td>581</td>
<td>594</td>
<td>636</td>
</tr>
</tbody>
</table>

9.3 Equity of Access

To assess how equitably patients were able to access A&E services, we used the national standard of 4-hours to be seen and treated, then admitted or discharged (applied to all types of A&E). This standard applies to both patients arriving by ambulance and those using self-transport. Nationally, the target is for a minimum of 95% of patients attending A&E to meet the 4-hour standard. We have assumed that patients choose their method of transport based on their own assessment of urgency or from guidance given by a health professional.

The 4-hour standard was chosen in the absence of information giving the time between first contact with the service and initial treatment. This would have been a more appropriate way to assess equity of access, as we are primarily interested in how equitably people can receive treatment for their urgent and emergency care needs (rather than how quickly that treatment progresses, which the 4-hour standard captures).

We analysed equity according to geographic location (using electoral wards), deprivation, gender, ethnicity and age. All findings are from a 3-year average between 2013/14 and 2015/16. During this time period, 94.1% of South Tyneside residents were treated and admitted or discharged at A&E within the 4-hour standard.

9.3.1 Geography by Electoral Ward

There is very little variation between wards, with 93% meeting the standard on the lower end in Hebburn South and 95.2% meeting the standard from West Park on the high end. All of the points in Figure 20 are close to the South Tyneside Average line, indicating a very high amount of equity.
9.3.2 Deprivation

There are no significant differences between deprivation deciles that would indicate inequitable access to the 4-hour standard within A&E.

<table>
<thead>
<tr>
<th>Ward Name</th>
<th>4-hour standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beacon and Bents</td>
<td>93.7%</td>
</tr>
<tr>
<td>Bede</td>
<td>94.2%</td>
</tr>
<tr>
<td>Biddick and All Saints</td>
<td>94.9%</td>
</tr>
<tr>
<td>Boldon Colliery</td>
<td>94.4%</td>
</tr>
<tr>
<td>Cleadon and East Boldon</td>
<td>94.5%</td>
</tr>
<tr>
<td>Cleadon Park</td>
<td>94.6%</td>
</tr>
<tr>
<td>Fellgate and Hedworth</td>
<td>94.2%</td>
</tr>
<tr>
<td>Harton</td>
<td>93.8%</td>
</tr>
<tr>
<td>Hebburn North</td>
<td>93.6%</td>
</tr>
<tr>
<td>Hebburn South</td>
<td>93.0%</td>
</tr>
<tr>
<td>Horsley Hill</td>
<td>94.1%</td>
</tr>
<tr>
<td>Monkton</td>
<td>93.3%</td>
</tr>
<tr>
<td>Primrose</td>
<td>93.7%</td>
</tr>
<tr>
<td>Simonside and Rekendyke</td>
<td>94.0%</td>
</tr>
<tr>
<td>West Park</td>
<td>95.2%</td>
</tr>
<tr>
<td>Westoe</td>
<td>93.2%</td>
</tr>
<tr>
<td>Whitburn and Marsden</td>
<td>93.9%</td>
</tr>
<tr>
<td>Whiteleas</td>
<td>94.4%</td>
</tr>
</tbody>
</table>
9.3.3 Gender

Male patients are slightly, though not statistically significantly, more likely to meet the 4-hour standard compared to female patients (93.6% vs 94.5%).

Figure 23 Equity of Access to the 4-hour standard in A&E by Gender, 2013/14 to 2014/16 (Source: NECS)

9.3.4 Ethnicity

Patients who identify as British are the largest majority of overall attendances (83%), with those who identify as African as the second highest group (5%). There are no significant differences between ethnicities meeting the 4-hour standard.
9.3.5 Age

Age is the one characteristic analysed that did have some significant variation between groups. Of the 26,000 attendances amongst 0-4 year olds, 99.5% met the 4-hour standard – compared to just 83% of the 13,300 attendances amongst those 85 and older. However, this is likely to be explained by differing need.

There is a near linear negative relationship between age and the likelihood that the 4-hour standard is met in A&E. As age goes up, the percentage meeting the target goes down. This age inequality in South Tyneside is consistent with that seen across England. The Health Foundation and Nuffield...
Trust report (2014) on A&E attendances illustrated that a similar pattern is apparent nationally. By analysing person-level A&E data, the report identified that older people spend longer in A&E departments. People over 75 spent an average of 213 minutes in A&E, compared with 149 for those aged under 75 in 2012/13. This difference applied regardless of whether they were ultimately admitted or discharged, and increased the likelihood of breaching the four hour target; older people were much more likely to breach the four-hour target, with those aged 65 and over being nearly three times as likely to breach the target as those under 65.

The most likely causes are higher complexity patients (and the associated increase in the presence of one or more long-term conditions) and a higher chance of delayed discharge due to bed availability, transport or social care for older people. The Health Foundation and Nuffield Trust report also supports this explanation by illustrating the distribution of long-term conditions by age of A&E attendees.

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**Figure 26 Average time spent in A&E by age and outcome in England 2012/13 (Source: The Health Foundation and Nuffield Trust)**

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8 Blunt, I. (2014) Quality Watch, Focus on: A&E Attendances – why are patients waiting longer? The Health Foundation and Nuffield Trust
In South Tyneside, as illustrated earlier, if a GP requires a patient be admitted to a ward, or requires urgent same day diagnostics, then they must refer these patients into A&E for this purpose. It is possible that a number of these individuals are older people with more complex needs, which may potentially explain the time involved in their review although this warrants further review and analysis using local data.
Table 4 Equity of Access to the 4-hour standard in A&E by Age Group, 2013/14 to 2014/16 (Source: NECS)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>4-hour standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 to 4</td>
<td>99.5%</td>
</tr>
<tr>
<td>5 to 9</td>
<td>99.6%</td>
</tr>
<tr>
<td>10 to 14</td>
<td>99.4%</td>
</tr>
<tr>
<td>15 to 19</td>
<td>97.3%</td>
</tr>
<tr>
<td>20 to 24</td>
<td>96.4%</td>
</tr>
<tr>
<td>25 to 29</td>
<td>96.3%</td>
</tr>
<tr>
<td>30 to 34</td>
<td>95.9%</td>
</tr>
<tr>
<td>35 to 39</td>
<td>95.5%</td>
</tr>
<tr>
<td>40 to 44</td>
<td>94.8%</td>
</tr>
<tr>
<td>45 to 49</td>
<td>94.5%</td>
</tr>
<tr>
<td>50 to 54</td>
<td>94.4%</td>
</tr>
<tr>
<td>55 to 59</td>
<td>92.9%</td>
</tr>
<tr>
<td>60 to 64</td>
<td>91.3%</td>
</tr>
<tr>
<td>65 to 69</td>
<td>89.9%</td>
</tr>
<tr>
<td>70 to 74</td>
<td>88.1%</td>
</tr>
<tr>
<td>75 to 79</td>
<td>87.5%</td>
</tr>
<tr>
<td>80 to 84</td>
<td>84.7%</td>
</tr>
<tr>
<td>85+</td>
<td>82.9%</td>
</tr>
</tbody>
</table>

Figure 28 Equity of Access to the 4-hour standard in A&E by Age Group, 2013/14 to 2014/16 (Source: NECS)

9.4 Summary

All of the analysed groups accessing A&E look to have equitable access to a 4-hour standard except for older people. This is likely due to the complexity of older people attending A&E rather than any issues with triage or waiting times, though further investigation is required.
10 Self-transport and telephone access to GP Services

10.1 Introduction
GP’s providing urgent same day appointments and out of hours services are a key access point for patients with urgent and emergency care needs. Each contact with a primary care provider is potentially avoiding an A&E attendance for those who have, or perceive that they have, more urgent needs, and comes with the added benefit of more holistic treatment – with full access to the patient record - that addresses both acute and long term care needs.

We have two sources of information available to assess the equity of access to GP services, NHS 111 data reported in a later section, and patient surveys summarised here. The surveys are limited to assessing how well residents in South Tyneside feel their access needs are being met. We can only make rough geographical comparisons by using GP practice as a proxy for location, though GP registered patient populations will come from across South Tyneside and the surrounding areas.

10.2 Healthwatch Report
Healthwatch South Tyneside produced a report that explored patient experiences of GP surgeries in South Tyneside. Data gathering was conducted over eight weeks in December 2014 and January 2015. This project received 725 completed surveys from GP surgery patients in the Borough.

Comparing data from the Healthwatch South Tyneside GP survey, with the national data (by CCG area) and NHS England averages, showed that South Tyneside patients who responded are:

MORE LIKELY than the average patient in England to be very or fairly satisfied with: the contact they have with their GP surgery by telephone, how much the GP involves them in decisions about their care, the opening hours of their GP surgery; and their GP surgery overall.

ALMOST AS LIKELY as the average patient in England to: have a written care plan and be involved in completing it. But people in South Tyneside who have a care plan are MORE LIKELY than the England average to use it to manage their day-to-day health. People in South Tyneside are also MORE LIKELY to have their written care plan reviewed regularly by a GP, nurse or health professional.

SLIGHTLY LESS LIKELY than the average patient in England to:

- be seen on time for their appointment (but are less likely to be kept waiting for more than 15 minutes beyond their appointment time),
- be confident managing their own self---care, be managing daily activities (people who experience severe pain and discomfort),
- be managing daily activities (people who are moderately or severely anxious or depressed),
- have the GP surgery opening hours after 6.30pm on weekdays, when they would like; and
- have trust, confidence and an overall excellent or good experience with out---of---hours clinicians.
SIGNIFICANTLY LESS LIKELY than the average patient in England to: use online booking systems for appointments; and recommend their practice to friends and family.

10.3 GP Patient Survey

The national, independent GP Patient Survey is run twice annually, once between July-September and again January-March. About 8,000 surveys are randomly distributed to South Tyneside residents a year. In 15/16, there were 3,000 responses (roughly equal to average response rate in England). Results from 2007 on are reported publicly for every GP practice in England and can be found at http://results.gp-patient.co.uk/report/explanation.aspx.

Questions in the survey that describe access to GP services are related to this urgent and emergency care equity audit and reported below. Overall, South Tyneside CCG performs well against national averages. Variations between practices are apparent in the figures, though interpreting results based on a low number of responses at individual practices should be done with caution.

10.3.1 GP In-hours services

In general, patients are more satisfied locally than the national average with GP surgery hours and access to appointments. In both these domains however, reports show a decline in satisfaction over the past 4 years both locally and nationally.

![Figure 29 South Tyneside CCG over Time: How satisfied are you with the hours that your GP surgery is open? (Source: Ipsos MORI)](source:ipsosmori.com)
Figure 30 South Tyneside Practices: How satisfied are you with the hours that your GP surgery is open? (Source: Ipsos MORI)

Figure 31 South Tyneside CCG over Time: Last time you wanted to see or speak to a GP or nurse from your GP surgery, were you able to get an appointment to see or speak to someone? (Source: Ipsos MORI)
Figure 32 South Tyneside Practices: Last time you wanted to see or speak to a GP or nurse from your GP surgery, were you able to get an appointment to see or speak to someone? (Source: Ipsos MORI)

Figure 32 shows that there is some variation locally in regards to the percentage of patients who were able to get an appointment the last time they tried to see or speak to a GP or nurse. The Glenn Medical Group and The Park Surgery are both on the lower end of the scale, though have recently merged and have been going through a period of settlement and as such are working closely with commissioners to make improvements to their services. Also on the lower end, Mayfield Medical Group has recently absorbed Jarrow GP Practice after the providers at the Jarrow GP practice decided not to renew their contract with NHS England and is similarly going through a period of settlement, working closely with commissioners.

A look at patients who were satisfied with opening hours and able to get an appointment across South Tyneside practices shows no correlation between those who answered yes and the practices deprivation score (Figure 33 & Figure 34).
When patients were unable to get an appointment that was convenient for them, they were most likely to either attend the appointment that was offered or request a different day. Only 4% went to A&E and 1% saw a pharmacist (Figure 35).
10.3.2 Out-of-Hours Service

GP Survey respondents answered several questions related to Out-of-Hours services:

1. “How do you feel about how quickly you received care or advice on that occasion?”
2. “Considering all of the people you saw or spoke to on that occasion, did you have confidence and trust in them?”
3. “Overall, how would you describe your last experience of NHS services when you wanted to see a GP but your GP surgery was closed?”

For all three questions, patients rated South Tyneside services higher than national averages (Figure 36 and Figure 37). These questions were only recently added for the 2015/16 survey, so trends will not be available until July 2017.
10.4 Summary

Satisfaction with GP services, both in and out-of-hours is mixed in South Tyneside, but on the whole higher than national averages. Because survey results are reported per practice and GP practices in South Tyneside are made of patients around the borough, conclusions on equitable access between groups of people are difficult to make. We cannot say, for example, that more deprived people in South Tyneside have access to GP services in proportion to their higher needs (though in general, practice deprivation scores showed satisfaction with access across all deprivations). We can broadly conclude, however, that access is equitable when compared to access across England. The declining satisfaction with GP services both locally and nationally is acknowledged in NHS planning documents such as the GP Forward View and the NHS Planning and Contracting Framework for 2017 -2019, which highlight the need for transformation and investment in general practice. This will be subject to further work involving NHS England, the CCG and local practices and plans for 2017-2019 are currently being developed.
11 NHS 111 and 999 Telephone Services

11.1 Introduction
NHS 111 and 999 medical telephone services have roughly 66,000 contacts between them every year from South Tyneside. With 93% of adults in the UK who personally own and use a mobile phone\(^{10}\), now more than ever South Tyneside residents can access urgent and emergency care advice from anywhere in the area.

We can largely assume that 999 and 111 services are accessible by residents if they have a phone. We will give a brief overview of how often people called these services, followed by an assessment of how equitably people were able to access NHS 111. This will be determined by a national quality standard that states that all calls must be answered within 60 seconds after being queued for an advisor. This type of data is not available for NHS 999, though equity of access to ambulance responses initiated by a 999 calls is covered in section 8.

11.2 Patterns of service uptake
NHS 111 calls have several outcomes, called service dispositions. The most common ones are given in the table below, with “contact your GP within 6 hours.” South Tyneside residents were advised to access emergency treatment within 1 hour slightly more often than the 111 advisor requested a non-emergency green ambulance on their behalf.

![Total Referrals](image)

*Figure 38 Top 5 service dispositions reached for South Tyneside contacts to NHS 111 (Source: NECS)*

Table 5 and Figure 39 both show that 999 and 111 access is generally higher amongst more deprived residents. This follows a trend observed in access to A&E in South Tyneside, but also most healthcare in general.

Table 5 111 Utilisation by Deprivation Decile in South Tyneside (Source: NECS)

<table>
<thead>
<tr>
<th>IMD Centile</th>
<th>Population</th>
<th>Number of Calls</th>
<th>Annual Call Rate per 1,000 Residents</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>2014/15</td>
<td>2015/16</td>
</tr>
<tr>
<td>10% Least Deprived</td>
<td>4,277</td>
<td>503</td>
<td>592</td>
</tr>
<tr>
<td>10-20% Least Deprived</td>
<td>11,213</td>
<td>1,415</td>
<td>1,655</td>
</tr>
<tr>
<td>20-30% Least Deprived</td>
<td>5,573</td>
<td>668</td>
<td>771</td>
</tr>
<tr>
<td>30-40% Least Deprived</td>
<td>6,885</td>
<td>740</td>
<td>969</td>
</tr>
<tr>
<td>40-50% Least Deprived</td>
<td>3,258</td>
<td>457</td>
<td>686</td>
</tr>
<tr>
<td>40-50% Most Deprived</td>
<td>14,736</td>
<td>2,323</td>
<td>2,804</td>
</tr>
<tr>
<td>50-60% Most Deprived</td>
<td>16,874</td>
<td>3,339</td>
<td>4,061</td>
</tr>
<tr>
<td>60-70% Most Deprived</td>
<td>17,192</td>
<td>3,173</td>
<td>3,657</td>
</tr>
<tr>
<td>70-80% Most Deprived</td>
<td>36,970</td>
<td>7,318</td>
<td>8,766</td>
</tr>
<tr>
<td>80-90% Most Deprived</td>
<td>31,450</td>
<td>7,689</td>
<td>9,428</td>
</tr>
<tr>
<td>South Tyneside</td>
<td>148,428</td>
<td>27,625</td>
<td>33,389</td>
</tr>
</tbody>
</table>

Figure 39 999 calls by deprivation decile and type per 1,000 population, 2014/15 - 2015/16 (source: NECS)

11.3 Equity of Access to 111
The length of time it took for NHS 111 calls to be answered by an advisor was assessed according to the national standard of less than 60 seconds. Comparisons were made between electoral wards, deprivation deciles and genders.

NHS England provides an aggregated minimum dataset from every 111 provider in the country. The North East Ambulance Service (NEAS) reports that, for 2015/16, 95.1% of answered calls reached an
advisor in 60 seconds. This meets the 95% national target and exceeds the national average of 87.8% over the same period.

The NEAS figure of 95.1% covers the North East of England, from the northern border of North Yorkshire up through Northumberland, but excluding Cumbria. Direct comparisons cannot be made from local data specific to South Tyneside requested through North of England Commissioning Support (NECS), which shows a far lower rate of calls answered within 60 seconds. The local data analyses the length of time between the phone call and contact with an operator and includes the length of time patients are listening to an automated message at the beginning of the call (national data excludes this). The local data shows that 74% of calls were answered within 60 seconds in 2014/15 and 43% in 2015/16. A one month snapshot from March 2016 using the local method (Figure 40) shows that there are large variations within the North East that require further investigation.

![Figure 40 NHS 111 Calls Answered within 60 seconds, local method, March 2016](source: NECS)

Phone calls to NHS 111 are not screened by location or any other identifying feature. Each call goes into a pool that is picked up by the next available advisor. Nevertheless, there appears to be an unexplained variation between South Tyneside, and the rest of the North East with regards to how quickly the call is answered by an advisor. We have also observed variation within South Tyneside between groups of people.

11.3.1 Geography

There are several geographies that have significantly lower rates of 60 second access to an advisor though NHS 111: Cleadon Park (53%), Whiburn and Marsden (53%), and Cleadon and East Bolden (50%). This was determined by comparison with the borough average over 2014/15 to 2015/16 (57%).
11.3.2 Gender

Females accessed NHS 111 roughly twice as often as males in South Tyneside over the two year period (36,000 calls vs 27,000), but also had a statistically significantly lower rate of 60 second access (56% vs 58%). The unknown category for gender made up a very small proportion of all calls (700 over two years).
Figure 43 % of calls to NHS 111 answered in less than 60 seconds in South Tyneside by Gender (Source: NECS)

11.3.3 Deprivation

Deprivation has a positive relationship with 60 second access to NHS 111 advisors. In general, as deprivation level increases, access improves. Calls to NHS 111 from the most deprived 10% of areas within the borough reached an advisor within 60 seconds 58% of the time and the least deprived 10% reached an advisor within 60 seconds 49% of the time.
Figure 44 Funnel plot of NHS 111 calls from South Tyneside answered in less than 60 seconds by deprivation decile, 3 standard deviations (source: NECS)

Figure 45 % of calls to NHS 111 answered in less than 60 seconds in South Tyneside by deprivation decile (1 is most deprived) (Source: NECS)
11.4 Summary
We can assume that equity of access to NHS 111 and 999 services is present by virtue of residents having access to a telephone. We also know that within the 111 and 999 services, calls are not prioritised or screened by any caller characteristics, as no prior information on the caller is available to the call handler. However, we have observed two types of variation in how quickly calls reach an NHS 111 advisor: variation between South Tyneside and the North East, and variation between groups within South Tyneside.

Both types of variation require further investigation outside the scope and timescales of this report. One possible explanation for the variation between groups within South Tyneside may be the availability of advisor capacity throughout the day linked to variation in the likelihood residents seek support at different times of the day. This might also explain the variation between South Tyneside and NEAS averages. Regardless, the variation we have observed is non-random and deserves attention.

12 Additional Services

12.1 Introduction
The following sections provide details on other Urgent and Emergency Care services where either there was not enough detail to assess the equity of access, or access was through some other means (NHS 111 or via A&E).

12.2 Self-Care and A Better U
Residents in South Tyneside with urgent and emergency care needs are of course able to provide themselves and others a certain amount of self-care advice and support. While the urgent and emergency care system does not expect a patient to address needs and their own, there are many resources out there to assist patients with self-care.

One resource is NHS Choices (www.nhs.uk). It is the UK’s biggest health website and accounts for a quarter of all health-related web traffic, receiving about 2 million visits a day. From their website:

“NHS Choices provides an award-winning, comprehensive health information service with thousands of articles, videos and tools, helping you to make the best choices about your health and lifestyle, but also about making the most of NHS and social care services in England.”

Another resource is A Better U, a programme aimed at developing South Tyneside’s residents’ skills, knowledge and confidence to improve outcomes through self-care.

South Tyneside was the original pioneer programme site with the aim to increase self-care and self-management of health conditions to increase the general health and wellbeing of our local population and reduce demand on statutory services. Rebranded a Better U the programme planned to develop peoples knowledge, skills and confidence to manage their conditions through changing
interactions between care givers and care receivers moving conversations from what support is available to what support can be given to help the person help themselves through increasing patients activation to self-care.

12.2.1 A Better U Activity
Following an initial pilot the programme is currently being scaled up borough wide and has identified priority areas that were deemed has high risk areas with likelihood to have interactions with the health and social care economy or already be highlighted as an area for improvement. Evidence suggests that these people tend to be less active self-carers and more passive about their own health and wellbeing.

As part of the development of the programme we have set out a number of key priority area including Carers and COPD and people with long term conditions. We selected COPD as a health condition to focus on for a self-management intervention due to our NHS Right Care data analysis and a review of the evidence for self-management in different conditions. South Tyneside has the highest prevalence of COPD in the region and the highest prescribing spend per head. Our COPD prevalence in 2014/15 was 3.7% compared with 1.8% nationally. Compared to comparative CCGs, South Tyneside also has significantly higher non-elective spend for COPD. The rate of COPD emergency admissions to hospital per 100,000 population is 485.45 in South Tyneside, compared to the national average of 269.03. A local Respiratory Strategy Group has reviewed the current pathway for COPD patients, and recognised a potential gap in support offered upon receipt of diagnosis, prior to an exacerbation which results in hospital admission.

We have also developed a small grants scheme that allows bids from community organisations around new scheme that encourage self-care as highlighted above for example funding for a Learning Disability Group to produce a video on diabetes and how it can be prevented and managed. Other small grants schemes include Women Health Group Activities, Taster Sessions for the visually impairment and swimming and healthy eating activities for female members of the BME community.

Self-care is being built into organisational strategies and plans as a key priority for all health and care partners in South Tyneside, such as the Primary Care Strategy, the Better Outcomes Scheme for general practices and Commissioning Strategies to ensure when support is received from any resident of South Tyneside there is a focus on self-care at every opportunity.

12.2.2 A Better U Evaluation
South Tyneside is one of only 7 Pioneer sites to have access to a validated tool to measure patient activation levels (PAM). Using PAM universally across the partnership supports the delivery of the overall programme by testing ways of changing the behaviours and increasing self-care not only in a specific group of people but also the wider community. Our approach to the use of PAM will allow us to actively engage with patients, residents and carers across the community to better understand the activation levels at a community and individual level so as to personalise responses and resources needed to engage with patients and carers thus increasing the likelihood of patients becoming actively engaged and starting to take control of the management of their conditions at every opportunity.
The tool will be utilised as a standard tool across the South Tyneside Partnership including 3rd sector and voluntary organisations, GP Practices and our Integrated Health and Social Care Community Teams.

We anticipate the use of the PAM Tool will better support our programmes development whilst being able to measure outcomes for individuals, priority areas and the overall programme through the emergence of healthy behaviours, less reliance on services, reduction in emergency and unplanned care all leading to better patient experience, improving outcomes and delivering financial benefits to the local health and social care economy.

12.3 Dental Services

12.3.1 Urgent Care Demand

Public Health England North East has analysed dental urgent care data from NHS 111 and dental contractor claims in an unpublished 2014 report: “Modelling Urgent and Unscheduled Care Demand: County Durham and Tees Valley & Cumbria, Northumberland and Tyne & Wear”.

The analysis from 2012/13 NHS dental data was broken into those that accessed urgent dental care only and those that accessed both urgent and routine dental care.

South Tyneside had rates between 23.2 and 37.2 per 1,000 people claiming urgent dental care across its wards. Regionally, rates varied from 0.4 per 1,000 in Redcar and Cleveland to 26.8 for South Tyneside.

For those that accessed both urgent and routine dental care, South Tyneside wards had rates between 4.2 per 1,000 population and 9.9, with an average of 6.3. Rates regionally varied from 0.5 per 1,000 population in Redcar and Cleveland to 7.0 in Hartlepool.

The analysis showed no association between deprivation and access to services. Females accessed urgent care services more often than males and access tended to be poorer in sparsely populated areas. Young adults were more likely to access urgent care than children and older adults.

12.3.2 Interpretation

It is clear that residents of South Tyneside are accessing urgent dental health services at rates that are consistent with or above other local authorities in the North East. This may in part be due to higher levels of need, though benchmarking data\(^\text{11}\) shows South Tyneside has relatively average levels of dental health compared to England (for children, which may not represent all age groups).

The large variation between South Tyneside wards is most likely due to variations in need related to age rather than deprivation. The primary routes of access will be NHS 111 and GP referral, covered elsewhere in this paper.

\(^{11}\) http://fingertips.phe.org.uk/search/dental#page/1/gid/1/pat/6/par/E12000001/ati/102/are/E08000023/iid/90359/age/34/sex/4
12.4 Think Pharmacy First
The following section details information and activity from the Pharmacy First Scheme. It details the uplift in activity since October 2015 to April 2016 compared to the levels from April 2015 to Sept 2015. It then details the presentation activity and provides evidence of the age range of patients using the service.

12.4.1 Patterns of service uptake
Total activity has risen from 7457 (April 2015-Sept 2016 inclusive) which averages at 1243 per month. This has risen by 45% to a monthly average of 1803 which has meant 12621 presentations to the scheme (October 2015-April 2016 inclusive). This is shown broken down by individual pharmacies below.

12.4.2 Casemix
The presentations with the highest rates are Fever and Head lice, they account for 41.7% of the total as shown in the chart below.
### All Ages

<table>
<thead>
<tr>
<th>Presentation</th>
<th>Number</th>
<th>Proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fever</td>
<td>4809</td>
<td>24.0%</td>
</tr>
<tr>
<td>Head Lice</td>
<td>3559</td>
<td>17.7%</td>
</tr>
<tr>
<td>Cough</td>
<td>1413</td>
<td>7.0%</td>
</tr>
<tr>
<td>Threadworm</td>
<td>1121</td>
<td>5.6%</td>
</tr>
<tr>
<td>Teething</td>
<td>902</td>
<td>4.5%</td>
</tr>
<tr>
<td>Bacterial Conjunctivitis</td>
<td>825</td>
<td>4.1%</td>
</tr>
<tr>
<td>Hay Fever</td>
<td>782</td>
<td>3.9%</td>
</tr>
<tr>
<td>Headache</td>
<td>683</td>
<td>3.4%</td>
</tr>
<tr>
<td>Vaginal Thrush</td>
<td>670</td>
<td>3.3%</td>
</tr>
<tr>
<td>Sore Throat</td>
<td>546</td>
<td>2.7%</td>
</tr>
<tr>
<td>Post Immunisation Pyrexia</td>
<td>523</td>
<td>2.6%</td>
</tr>
<tr>
<td>Skin Reaction</td>
<td>411</td>
<td>2.0%</td>
</tr>
<tr>
<td>Muscular Ache</td>
<td>372</td>
<td>1.9%</td>
</tr>
<tr>
<td>Toothache</td>
<td>328</td>
<td>1.6%</td>
</tr>
<tr>
<td>Chickenpox</td>
<td>263</td>
<td>1.3%</td>
</tr>
<tr>
<td>Cold Sores</td>
<td>208</td>
<td>1.0%</td>
</tr>
<tr>
<td>Nappy Rash</td>
<td>206</td>
<td>1.0%</td>
</tr>
<tr>
<td>Congestion</td>
<td>205</td>
<td>1.0%</td>
</tr>
<tr>
<td>Warts and Verrucae</td>
<td>182</td>
<td>0.9%</td>
</tr>
<tr>
<td>Indigestion</td>
<td>176</td>
<td>0.9%</td>
</tr>
<tr>
<td>Other</td>
<td>1895</td>
<td>9.4%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>20,079</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

If the presenting activity is broken down by age, 72% relates to the range 18 and under. This is compared to only 3% being aged over 75. The chart below breaks the age splits down further based on the total information from April 2015-April 2016 inclusive.
12.4.3 Pharmaceutical Needs Assessment

The public health team of South Tyneside Council, working alongside colleagues from Sunderland City Council, oversaw the development of the Pharmaceutical Needs Assessment (PNA) for South Tyneside April 2014 – March 2017 on behalf of the South Tyneside Health & Wellbeing Board.\(^\text{12}\)

In South Tyneside, there are currently 39 pharmacies made up of 35 Non-exempt category pharmacies (including 1 dispensing appliance contractor), 2 distance selling pharmacies and 2 hundred-hour pharmacies. There are no Essential Small Pharmacies Local Pharmaceutical Services (ESPLPS) and no dispensing doctors. There has been no change in the number of community pharmacies since the last pharmaceutical needs assessment was undertaken.

Community pharmacy contractors are required to open for a minimum of 40 core hours per week, however, in South Tyneside, 90% of pharmacies open for more than the core contract hours. The PNA found that South Tyneside is adequately served by community pharmacies and has 26.3 pharmacies per 100,000 population compared to 21.5 for England. The PNA also reported on a Healthwatch population survey that found respondents satisfied with the pharmaceutical services they received, and that mostly residents had no difficulty accessing their local pharmacy.

\(^{12}\) https://www.southtyneside.gov.uk/article/49433/Previous-JSNAs
12.5 Mental Health Initial Response Service

12.5.1 Patterns of service uptake
The referral route for all services with the exception of Older Persons Liaison Team is through the Initial Response Service single point of access which operates 24 hours/day. Referral route for the Liaison team is through the acute hospital. The operational hours for each service are:

1. Older People’s Service (referred to as PCP COG and FF below) predominantly Mon-Fri 9-5 but can be flexible to meet patients’ needs
2. Psychosis/Non Psychosis Team Mon-Fri 9-5 but can be flexible to meet patients’ needs,
3. Crisis Team 24/7 and
4. Older Persons Liaison Team 8am-9pm 7 days per week.

The following chart details the comparison from April-Sept 2015 compared to activity October 2015-March 2016. The % increase/decrease relating to each service is included within the chart.

<table>
<thead>
<tr>
<th>Referral Date</th>
<th>PCP Cog and FF South Tyneside Comm Team</th>
<th>PCP S Tyneside Psychosis/Non Psychosis</th>
<th>South Tyneside Crisis Team</th>
<th>ST Older Peoples Liaison Team</th>
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<td>589</td>
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% Increase:
- PCP Cog and FF South Tyneside Comm Team: -3%
- PCP S Tyneside Psychosis/Non Psychosis: 10%
- South Tyneside Crisis Team: 2%
- ST Older Peoples Liaison Team: 5%
- Total: 4%

12.5.2 Current issues for the service
As can be seen from information above the only team that has had a significant change in referrals is the Psychosis/Non Psychosis team which has had a 10% increase. It would be difficult to say if this is as result of the closure of Jarrow WIC as there are currently increased referral rates into Community Mental Health Teams from other areas of the North East which may suggest further factors that this could be attributable to.
13 Conclusions

Overall, this equity audit of urgent and emergency care for the South Tyneside population has illustrated that there is comprehensive provision of care, provided by a large range of services – some based very locally in communities, some provided in centres of expertise, and others that will respond to your needs at home.

The relocation of the Walk-in Centre was based on the following principles:

1. A lack of evidence that walk-in centres had a beneficial impact on workloads for A&E, GP, and out of hour’s services, plus local information demonstrating that A&E activity continued to rise despite the advent of the Jarrow Walk-in Centre. There is also national evidence that walk-in centres only increase access to care for those that need it least and local information illustrating that a vast majority of attendances were for minor ailments with most people arriving by car.

2. A belief that access to Urgent and Emergency Care in South Tyneside was equitable independently of any walk-in centre services.

This report has assessed and confirmed the second of these two principles. We will briefly recap the evidence for walk-in centres in 13.1 and conclude with a summary of our findings in 13.2.

13.1 The evidence for Walk-in Centres

The development of WiCs took place in the late 1990 in response to national policy to improve access to urgent care (particularly in populations with greater needs), respond more appropriately to patient needs, and reduce the increasing levels of activity in A&E/ Emergency Departments.

Findings from a review of international literature on WiCs found that users of WiCs tend to be a relatively affluent population of working age who choose to use the services on the basis of convenience. The evidence also highlighted that the main presenting problems at WiCs are minor illnesses and minor injuries.13

Key conclusions from the evidence are that NHS WiCs do improve access, but not necessarily for those with the greatest need, and also for needs that could be met by existing providers.14 There is some evidence to demonstrate that WiCs do not shorten waiting times for access to primary care.15 There is also inconclusive evidence on the impact of WiCs on the workload of A&Es, GP surgeries, and out-of-hours services.16 The overriding concern from published literature was whether WiCs are cost effective when compared with other forms of urgent and emergency care and whether the resources could be used on other priorities.

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The current NHS England urgent and emergency care transformation programme focuses heavily on issues relating to patient flow through the system, and evidence that getting patients access to the right care rapidly reduces mortality, patient harm and length of stay. This is supported by the need for patients to see a senior clinical decision-maker\(^\text{17}\) as soon as possible. In order to manage patient-flow there needs to be good “streaming” of patients (or demand) so that their needs are met appropriately. This includes ensuring that the services are well resourced to manage lower levels of need, without patients then having to “bypass” the system and attend inappropriately at A&E. NHS England actively supports co-location in order to ensure that patients use the service best suited to meet their needs rather than defaulting to A&E.

In addition to these pieces of evidence, a comprehensive review of local evidence was conducted by South Tyneside CCG in January 2015 as part of the Urgent Care Hub Business Case\(^\text{18}\). The case for change found that:

- We know that people are visiting WICs for conditions that could be treated by their GP or with over-the-counter medicines from a pharmacy. They are also continuing to attend A&E for minor ailments, rather than using the WIC service. Inappropriate use of services can increase waiting times for patients and is not a wise use of increasingly scarce NHS resources. It also means that people need to be referred from one service to another, for example from A&E to their GP practice.
- Overall, locally there has been an increase in the number of people attending Jarrow WIC without the anticipated decrease in the number of patients at A&E. There is a need to manage demand for services effectively to make sure that people can get the care they need, at the right time and in the right place.
- We know that the features of this patient group accessing the WIC are that they are primarily 30 and under, and tend to have access to their own transport.

Each of these points confirms the national evidence on the efficacy of Walk-in Centres.

### 13.2 Equity of Access to Urgent and Emergency Care

To truly understand whether access to Urgent and Emergency Care is fair in South Tyneside we would be required to know the precise levels of need in the area and how those needs have been met (or not). In this analysis we have had to assume that if someone has a need for urgent or emergency care then they will demand that their need is met by one of the available services e.g. ambulance, A&E, self-care etc. This equity audit attempts to determine if patients in South Tyneside are fairly provided access to urgent and emergency services when they demand them.

\(^{17}\) should be taken to mean a clinician with the skills and competencies to assess, determine a treatment plan and safely discharge patients under their care. Consultants and general practitioners typically fall within this definition. Doctors in their third year of specialist training (ST3) or above; experienced non-training grade doctors; and nurses, therapists and other clinicians with recognised advanced skills and training may also be considered to be ‘senior clinical decision makers’ within their spheres of competence.

We have been able to use key data sources to establish if these services have been fairly provided to different population groups; assessing by age, gender, ethnicity and deprivation where possible.

On the whole we have established that the urgent and emergency care system in South Tyneside is comprehensive and accessible. Key factors that confirm this are:

- 111 and 999 call services that are available to anyone who can access a telephone,
- Good primary care coverage and accessibility, particularly for GPs and Pharmacy,
- An ambulance service that responds (particularly quickly in South Tyneside) according to need and will convey people to and from care settings,
- Accident and Emergency services available in South Tyneside, Gateshead, Sunderland and Newcastle,
- An underlying health and care system that supports urgent needs through promoting self-care, pharmacy services, health and social care integration to support people in their own homes, urgent dental services, and a mental health initial response service.

The data we have analysed on all of the above seems to illustrate that the South Tyneside system provides access equitably. There were three key findings that warrant further investigation:

- Ambulance Red response times at the coastal wards of South Tyneside and in North Hebburn,
- The age inequality in the 4 hour wait standard for Accident and Emergency (although potentially explained by national evidence illustrating the correlation between age, complexity and therefore increased waiting times, this should be confirmed by local analysis), and
- The variation in 60 second responses to NHS 111 across groups of people within South Tyneside.

It is proposed that these three areas of further investigation are pursued through existing governance and assurance mechanisms for urgent and emergency care in South Tyneside.