Derbyshire County Council

Equality Impact Analysis Record Form

Department	Policy & Community Safety (joint analysis with PCT)
Service Area	Public Health
Title of policy/ practice/ service of function	Health and Wellbeing Strategy
Chair of Analysis Team	Alison Pritchard – Consultant in Public Health

Stage 1. Prioritising what is being analysed

a. Why has the policy, practice, service or function been chosen?
b. What if any proposals have been made to alter the policy, service or function?

The Health and Wellbeing Strategy will set out priorities to meet the local health needs identified across Derbyshire through the Joint Strategic Needs Assessment, key plans, strategies and stakeholder engagement. This will provide the basis for commissioning plans within the reformed health and social care system.
Derbyshire's priorities are to:

- Improve health and wellbeing in early years
- Promote healthy lifestyles
- Improve emotional and mental health
- Promote the independence of people living with long-term conditions and their carers
- Improve health and wellbeing of older people

The overarching aim of the strategy is to reduce health inequalities, therefore it is essential that the strategy is fair and does not discriminate against any protected groups of people.

c. What is the purpose of the policy, practice, service or function?

To set out the priorities of the Health and Wellbeing Board to meet the health needs of local people and provide the basis for commissioning public health services in Derbyshire.

Stage 2. The team carrying out the analysis

Name Health & Wellbeing Strategy Task and Finish Group	***Area of expertise/ role***
(Chair) Alison Pritchard	PCT - Public Health
Jayne Needham	PCT - Public Health
Jane Cox	DCC - Policy
John Cowings	DCC - Policy
Sabina Enback	DCC - Policy
Melanie Turvey	DCC - Research & Information

Stage 3. The scope of the analysis

The Health and Wellbeing Strategy will provide the foundations upon which Health and Wellbeing Boards exercise their shared leadership across the wider determinants that influence health and wellbeing. This will also enable commissioners to plan and commission integrated services that meet the needs of the local community, in particular, for the most vulnerable individuals and groups with the worst health outcomes.

The Equality Analysis will identify whether the priorities identified in the strategy are sufficiently evidenced-based and take into account the needs of the protected groups and the general population of Derbyshire.

Stage 4. Data and consultation feedback

a. Sources of data and consultation used

Source	***Reason for using***
Alcohol Concern (2010) The impact of alcohol on health	Provides information on alcohol use and its health impacts.
APHO (2011) Derbyshire Health Profile	Provides a picture of health for the area to help local government and health services understand their community's needs to improve health and reduce health inequalities.
Bird L, Faulkner A (2000) Suicide and self-harm	Provides information on suicide and self-harm.
Blank L, Ellis L, Goyder E, Peters J (2004) Tackling inequalities in mental health – the experience of New Deal for communities	Provides information on deprivation and mental health.
Brooker C, Fox C, Barrett P, Syson-Nibbs L (2008) A health needs assessment of offenders on probation caseloads in Nottinghamshire and Derbyshire	Provides information on the health needs of Derbyshire offenders.
Census 2001	Provides demographic information.
Census 2011	Provides demographic information.
Consultation response on the high level priorities of the Health and Wellbeing Strategy (2012)	Quantitative and qualitative responses from public consultation and stakeholder event in regards to the proposed strategy and its priorities.
Deaville J A (2003) Health-care challenges in rural areas: physical and sociocultural barriers	Provides information on the health needs of rural communities.
Department of Health (2007) Bisexual people's health	Provides information on the health needs of bisexual people.
Department of Health (2007) Gay men's health	Provides information on the health needs of gay men.
Department of Health (2012) Health Profiles 2012	Provides health information on district level.
Department of Health (2004) The National Service Framework For Mental Health: Five	Provides information on mental health issues amongst offenders.

Source	***Reason for using***
Years On	
Department of Health (2007) Reducing health inequalities for lesbian, gay, bisexual and trans people	Provides information on LGBT people's experiences of health care.
Department of Health (2009) Religion or belief: a practical guide for the NHS	Provides information on the health implications of belonging to various religious groups.
Derbyshire Friend	Provides information on LGBT groups in Derbyshire.
Derbyshire Sustainable Community Strategy (2009-14)	Sets out the overarching priorities for the Derbyshire Partnership Forum (the County-wide LSP), based on consultation and evidence.
District-based LSP Sustainable Community Strategy	Sets out priorities for the area covered by the LSP, based on consultation and evidence.
Fear N T, Jones M, Murphy D et al (2010) What are the consequences of deployment to Iraq and Afghanistan on the mental health of the UK armed forces? A cohort study	Provides information about the health care needs of army personnel.
Fish J (2007) Reducing health inequalities for lesbian, gay, bisexual and trans people - briefings for health and social care staff	Provides information on the health care needs of LGBT groups.
House of Commons, Obesity, 2004	Provides information on the health implications of obesity.
Herritty H, Hudson M, Letts M (2001) Health, welfare and the social needs of the Armed Forces community: a qualitative study	Provides information about the health care needs of army personnel.
http://www.alzheimers.org.uk/site/scripts/download_info.php?fileID=1057	Provides Alzheimer prevalence rate.
http://observatory.derbyshire.gov.uk/IAS/	Provides population and health indicators.
http://www.nhs.uk/Conditions/Stroke/Pages/Introduction.aspx	Provides information on stroke and race.
http://www.diabetes.org.uk/Guide-to-diabetes/Complications/	Provides information on diabetes and comorbidity.
Institute of Alcohol Studies (2010) Binge drinking – nature, prevalence and causes	Provides information about alcohol use and harm amongst young people.
Itzin C (2006) Tackling the health and mental health effects of domestic and sexual violence and abuse	Provides information about the health impacts of domestic abuse and sexual violence.
Joint Strategic Needs Assessment (JSNA)	Provides a profile of the county and its population, communities and projections of need.
Kroner Z (2009) The relationship between Alzheimer's Disease and Diabetes: Type 3	Provides information on the link between Alzheimer's Disease and Diabetes.

Source	***Reason for using***
Diabetes?	
North East Public Health Observatory (2011) Including migrant populations in JSNA	Provides information on the health needs of migrant populations.
North East Public Health Observatory (2012) Local alcohol profiles for England	Provides information on local alcohol related harm.
Knapp M, Prince M (2007) Dementia UK, 2007	Provides information on dementia.
Ministry of Justice (2010) Population in custody 2010	Provides information on prisoner numbers.
National Statistics (2012) Area of occurrence, type of ceremony and denomination	Provides information on marriage and civil ceremony prevalence.
National Statistics (2010) Cancer Registrations in England	Provides information on cancer prevalence.
National Statistics (2010) General lifestyle survey overview	Provides information on people, places, health and wellbeing.
National Statistics (2010) Integrated Household Survey 2010	Provides information on people, places, health and wellbeing.
National Statistics (2011) Statistics on drug misuse, England 2010	Provides information on drug use.
National Statistics (2010) Survey of carers in households 2009/10	Provides information on carers' health issues.
Naylor C, Parsonage M, McDaid D, Knapp M, Fossey M, Galea A (2012) Long term conditions and mental health: the cost of co-morbidities	Provides information on mental health comorbidities.
NEPHO (2012) Community mental health profile 2012	Provides data on local mental health information.
Opinion Research Services (2008) Derbyshire Gypsy and Traveller Accommodation Assessment 2008	Provides information on Gypsy and Traveller health needs.
Sainsbury Centre for Mental Health (2010) Mental health inequalities: measuring what counts	Provides information on mental health and comorbidity.
Sepho (2006) Excess winter mortality in the South East	Provides information on excess winter mortality.
Scarborough P, Bhatnagar P, Wickramasinghe K, Smolina K, Mitchell C, Rayner M (2010) Coronary heart disease statistics	Provides information on heart disease prevalence.
Spencer, N, Health consequences of poverty for children	Provides health and child poverty information.
Stakeholder Engagement Forum (2 events held)	Provides views and feedback on the priorities for the strategy.
Survey (on-line and paper) on priorities and strategy	Provides views and feedback on the priorities for the strategy.
The Mental Health Foundation (2007) The	Provides information on mental health

Source	***Reason for using***
fundamental facts	issues and race
The NHS Information Centre (2011)Statistics on Smoking, England 2011	Provides information on smoking prevalence.
Samaritans (2004) Samaritans Information Resource Pack	Provides information on offenders and mental health issues.
Warner J, McKeown E, Griffin M, Johnson K, Ramsay A, Cort C, King M (2004) Rates and predictors of mental illness in gay men, lesbians and bisexual men and women: results from a survey based in England and Wales	Provides information on LGB groups and mental health.
Whittle S, Turner L, Al-Alami M (2007) Engendered Penalties: Transgender and Transsexual people's experiences of inequality and discrimination	Provides information on transgender people's experiences of health care.
Wilson C M, Oswald A J (2005) How Does Marriage Affect Physical and Psychological Health? A Survey of the Longitudinal Evidence	Provides information on how marriage affects health and wellbeing.
Wood J (2004) Rural health and healthcare	Provides information on the health needs of rural communities.

Stage 5. Analysing the impact or effects

a. What does the data tell you?

Protected Group	***Findings***
Age	• According to the 2011 Census the number of people aged 65+ in the county has grown, representing 18.6% of Derbyshire's population. The average for England and Wales is 16.4%. • According to the 2011 Census, Derbyshire Dales has the highest number of those over the age of 65 at 22.2% followed by North East Derbyshire (21.2%), Chesterfield (18.7%) and Amber Valley (18.7%). South Derbyshire has the lowest number of those aged 65 and over at 15.4% followed by High Peak (17.3%) and Erewash (17.8%) and Bolsover (18.2%). • The highest number of young people (0-19 years) in the County live in South Derbyshire (24.6%) followed by High Peak (23.2%), Bolsover (22.9%), Erewash (22.8%), Chesterfield (22.5%), Amber Valley (22.3%), North East Derbyshire (21.3%) and Derbyshire Dales (21%). <u>Young people</u> • 31,169 people under the age of 20 in Derbyshire suffer a long-standing illness or disability. This equates to 4% of Derbyshire's population. • Chesterfield and Bolsover have significantly higher levels of obese children in year 6 compared to the England average. Bolsover also has significantly higher numbers of children living in poverty compared to the England average. Child poverty increases the risk of health problems such as respiratory problems, cerebral palsy, learning difficulties, anaemia, ADHA and teenage pregnancy. • North East Derbyshire, Bolsover, South Derbyshire, Chesterfield, Derbyshire Dales and Amber Valley all have higher than average levels of alcohol-specific hospital stays for those under the age of 18. • High Peak suffers from significantly higher numbers of alcohol-related hospital stays for those aged under 18. **How the findings align with the Strategy:** The strategy targets obesity, poverty and alcohol use amongst young people. <u>Older people</u> • Dementia is more prevalent amongst older age groups. Derbyshire has significantly higher levels of dementia sufferers and emergency hospital admissions for dementia compared to the England average. Derbyshire Dales has the highest predicted rate of Dementia followed by North East Derbyshire and High Peak. South Derbyshire, Bolsover and Erewash have the lowest predicted rate of dementia. • Amber Valley has significantly higher numbers of excess winter deaths compared to that of the England average. Most excess winter deaths involve older people and most of winter deaths can be attributed to either respiratory or cardiovascular conditions – primarily ischaemic heart disease and stroke. **How the findings align with the Strategy:** The strategy directly targets dementia and excess winter deaths are taken into account in the 'Older People' priority's underpinning actions relating to the Handy Van Scheme and housing support.
Disability	• Chesterfield, Amber Valley, Erewash and Bolsover have

	significantly higher levels of people diagnosed with diabetes. Those suffering from diabetes type 1 and 2 are more likely to suffer from foot ulcers, Alzheimer 's disease, diminished sight, kidney problems, Mastopathy, Polycystic Ovary Syndrome, Coeliac Disease, dental problems, musculoskeletal conditions and cardiovascular disease. People living with diabetes are also two to three times more likely to suffer from depression than the general population. Locally, Chesterfield followed by Bolsover and North East Derbyshire have significantly worse access to screening programmes for diabetic retinopathy. • High Peak has significantly higher incidents of malignant melanoma compared to the England average. • Amber Valley followed by Bolsover and Chesterfield had the highest proportion of hospital admissions for circulatory diseases between 2003 and 2007. • In 2009/10, significantly higher than Derbyshire average levels of hospital admissions for stroke were reported in Bolsover and South Derbyshire. Stroke sufferers are more likely to suffer other health problems such as loss of vision, epilepsy, depression and continence problems. • Between 2006 and 2009 the number of hospital admissions for myocardial infarction (heart attack) where highest in Bolsover, Amber Valley and Erewash. All Derbyshire districts had higher levels of admissions compared to the England average. • In 2010, Chesterfield held the highest prevalence of people diagnosed with HIV (83 people) followed by Bolsover and High Peak. • In 2010, Bolsover followed by South Derbyshire and Chesterfield held the highest mortality rate from chronic obstructive pulmonary disease (lung disease). The rates of these districts were also higher than the England average. Mental health problems are around three times more prevalent among people with respiratory disease than in the general population. **How the findings align with the Strategy:** Long-term conditions and preventative approaches to these are covered in the Strategy. Preventative approaches to sexual ill health such as HIV have not specifically been covered in the strategy but form a key part of the work undertaken by the Sexual Health Commissioning Group. The above average rate of malignant melanoma in High Peak will be taken account of during health promotion planning in regards to sun safety. **<u>Mental health</u>** • Derbyshire has significantly higher levels of people aged 18 and above on the learning disabilities register compared to the England average. • Derbyshire has significantly higher levels of residents above the age of 18 suffering depression compared to the England average. Individuals with depressive disorders are about twice as likely to develop coronary artery disease, twice as likely to have a stroke and four times as likely to have a myocardial infarction as people who are not depressed, even when other risk factors like smoking are controlled for. • Overall, Derbyshire has significantly higher levels of emergency hospital admissions for self-harm compared to the England

	average. On a district level both Chesterfield and Bolsover have significantly higher levels of emergency hospital admissions for self-harm. There is a high correlation between self-harming behaviour and mental health problems. Most of those who attend an emergency department after self-harming would meet the criteria for one or more psychiatric diagnoses. More than two thirds would meet the criteria for depression. People who have self-harmed are at significant risk of suicide. • Prevalence rates for other mental health disorders are currently unavailable however it is worth noting that 30% of those suffering a long-term physical health condition also experience mental health problems. There is particularly strong evidence for a close association with cardiovascular diseases, diabetes, chronic obstructive pulmonary disease (COPD) and musculoskeletal disorders. There is also evidence for higher than usual levels of mental health problems among people with other conditions, including asthma, arthritis, cancer and HIV/AIDS. **How the findings align with the Strategy:** The "Mental health and wellbeing" priority covers a range of mental health conditions and recognises that some groups may experience poorer access to support and that focus needs to be placed on these groups. The Strategy states that improved access to mental health support is needed and that awareness of mental health conditions needs to be raised with all partners. It also recognises that people with mental health problems might have to access other support services such as employment advice to increase their mental wellbeing.
Gender (Sex)	• 44.7% of women under the age of 20 and 55.3% of men in the same age group suffer from a long-standing illness or disability in Derbyshire. • Young men between the ages of 0 and 19 in Derbyshire are more likely to suffer a severe disability (68%) than women in the same age group are (32%). • Chesterfield, North East Derbyshire and Bolsover have significantly higher than average numbers of hospital stays for self-harm; nationally women are three to four times more likely to self-harm than men. Additionally, men are over 3 times as likely to commit suicide compared to women. Those aged 25-34 are four times as likely to commit suicide as women in this age group. • Life expectancy for men in Chesterfield is significantly lower than the England average. • Men are more likely than women to die from smoking related diseases**.** Adult smoking and smoking related deaths in Chesterfield and Bolsover are significantly higher than the average for England. • Nationally, more men than women die from coronary heart disease. Chesterfield, Bolsover and Amber Valley have significantly higher than average numbers of early deaths related to heart disease and stroke. • Chesterfield has significantly higher levels of drug misuse than the England average; it is believed that men are more likely to figure in this category as nationally, men are twice as likely as women to use illicit drugs. • Chesterfield and Bolsover have significantly higher levels than

	average of alcohol related harm and High Peak has significantly higher than average levels of alcohol-specific hospital stays for under-18s. Nationally, men (6%) are more likely than women (3%) to be heavy drinkers (heavy drinking for men is drinking 50 or more units per week, for women it is 35 units per week). Men are less likely than women to seek medical help which poses a problem as heavy drinkers are more likely to suffer health problems such as cancer, liver disease and heart problems. Bolsover has significantly higher than average numbers of women with alcohol specific hospital admissions. The same measure for men in Bolsover is not above average. • Men are more likely than women to suffer from cancer; Bolsover experiences significantly higher number of early deaths from cancer than the national average. • Derbyshire has significantly higher levels of residents above the age of 18 suffering depression compared to the England average. Depression is more common in women than in men. 1 in 4 women will require treatment for depression at some time, compared with 1 in 10 men. The reasons for this are unclear, but are thought to be due to both social and biological factors. • For men in Derbyshire between 2007 and 2009, the most common form of cancer was skin cancer. Chesterfield during this period held the highest overall male cancer rate as well as the highest rate for colorectal cancer. Bolsover suffered the highest rate of lung and stomach cancer whilst North East Derbyshire held the highest rate of prostrate and skin cancer other than malignant melanoma. For women, breast cancer had the highest incidence rate of all cancers. Erewash had the highest overall cancer incidence amongst women as well as the highest rates of breast cancer. Lung cancer was most common in Bolsover, colorectal cancer levels were highest in High Peak and the largest proportion of skin cancer other than malignant melanoma was found in North East Derbyshire. For all cancers, Chesterfield had the highest rate followed by Bolsover and North East Derbyshire; all districts apart from Derbyshire Dale and South Derbyshire had higher incident rates than the England average. **How the findings align with the Strategy:** Whilst the Strategy does not directly address gender differences in various health problems, the Strategy does set out to improve services in regards to the mental and physical conditions outlined above. Gender differences will be considered during the service planning stage.
Gender reassignment	• Estimated figures for Derbyshire indicate that there are between 150-200 people who have undergone gender reassignment in the county (including Derby City) but there may be many more that experience gender dysphoria. Nearest clinics are in Nottingham and Sheffield. • National data states that 1/5 of transgender people find their GP unhelpful in regards to gender reassignment issues. Barriers to accessing general GP treatment included a lack of sensitivity by service providers, which served to exclude transgender people. • 22% of transgendered people feel that being transgendered affect the way they can access routine treatment that is not related to being transgendered.

	• 35% of transgender people report having attempted suicide or self-harm. • Nationally, drug misuse is a concern among transgender communities. **How the findings align with the Strategy:** The Strategy sets out to develop healthy lifestyle initiatives especially designed to suit the needs of particular groups and to raise awareness across partners to reduce discrimination in terms of mental and emotional wellbeing. Service planning will need to be sensitive to the needs of transgender people.
Marriage and civil partnership	• Marriages in Derbyshire between 2008 (3583) and 2009 (3427) decreased by 4% however the number of civil partnerships has increased from 52 in 2010 to 66 in 2011. Married people's physical and mental health tends to be better than that of single people's. Single people's health is however better than widowed, separated and divorced individuals' health. **How the findings align with the Strategy:** The Strategy recognises that isolation, particularly amongst older residents needs to be addressed.
Pregnancy and maternity	• Amber Valley and High Peak have significantly higher than average levels of residents smoking during pregnancy. • Chesterfield has higher levels of teenage pregnancies (under 18) than the England average. All other districts have below average levels. • Mortality in infancy (under 1 year of age) between 2008 and 2010 was highest in Amber Valley and South Derbyshire - these levels were higher than the England average. • Currently there is no local data available in regards to post-natal depression but it is believed to affect between 8 and 15% of women nationally. • Chesterfield has significantly higher than Derbyshire average levels of children in need, children with a child protection plan, school absences due to illness, A&E admissions for gastroenteritis for children under 1, children living in workless households and obesity amongst 10-11 year olds. Chesterfield also has low vaccination levels of children age 2 and 5. **How the findings align with the Strategy:** The Strategy recognises that smoking levels during pregnancy as well as teenage pregnancies need to be reduced. A variety of targeted family support, especially to vulnerable people, will continue to be provided.
Race	• According to the 2001 Census, 2.8% of residents in Derbyshire describe themselves as coming from a black or ethnic minority background. South Derbyshire has the highest numbers of residents from these groups (4.1%) followed by South Derbyshire (4.1%) and Erewash (3.4%). Bolsover has the fewest numbers of residents with a black or ethnic minority background at 1.7%. • Chesterfield and Derbyshire Dales have higher than England average levels of hospital emergency admissions by ethnic groups (particularly Asian and Black) which might be a reflection of some of these patients not accessing or receiving the care most suited to managing their health. Amber Valley, North East Derbyshire, High Peak, South Derbyshire and Bolsover have similar issues for patients of mixed ethnicity.

	• In general, rates of mental health problems are thought to be higher in minority ethnic groups in the UK than in the white population, but they are less likely to have their mental health problems detected by a GP. Depression in ethnic minority groups has been found to be up to 60% higher than in the white population. • Black people are more likely than white people to be given physical treatments, such as medication and ECT, and are likely to be prescribed higher doses of medication. They are less likely to be offered psychotherapy, counselling and other non-medical interventions. • South Asian, African or Caribbean people's risk of stroke is higher than that of the general population. This is partly because of a predisposition to developing diabetes and heart disease, which are two conditions that can cause strokes. • 71% of respondents interviewed in a Derbyshire Gypsy and Traveller Accommodation Assessment reported that their household contained at least one member with a long-term health problem. The major problems reported were with stress or depression, walking and other mobility problems and diabetes. Of those households which contained someone with a health problem, 61% reported that the person with the health problem can support themselves. This implies that 39% require some form of care or support. Stress was identified as being a serious problem with the issue of temporary planning permission and security of tenure being raised. However, all of this group were at the time, receiving the care or support they required. • Data on the number of refugees, asylum seekers and migrants who reside in Derbyshire is not available at the time of writing. Recent figures suggest a fivefold increase in the number of UK residents born in Poland since the 2001 Census. It is difficult to estimate the size of the Eastern European migrant population as it tends to shrink, expand and move quite quickly however by looking at the number of National Insurance Number registrations from the Department for Work and Pensions one can get an overview of which district in the county hosts the largest migrant populations. Bolsover (240), Chesterfield (210) and Erewash (190) have the highest concentration of National Insurance Number registrations by overseas residents (2010/11). North East Derbyshire and Derbyshire Dales have the lowest number of registrations at 100. A quarter of these migrants were of Polish origin. These registrations however do not recognise migrants in the region who have not applied for a National Insurance Number such as students, unemployed or those working illegally. Nor do these figures cover migrants who obtained National Insurance Numbers previous to 2010. A study commissioned by DCC found that the majority of respondents were in low-paid employment, 40% had children living with them and 80% had registered with a GP. Nationally it has been found that the smoking prevalence amongst this group is higher to that of the general population (32%) and this group also tend to misuse alcohol to a greater extent than the general public. **How the findings align with the Strategy:** The Strategy sets out to promote a more co-ordinated approach to the provision of healthy lifestyle support by strengthening links between different settings and services

	such as stop smoking referrals. The Strategy also sets out to develop healthy lifestyle initiatives especially designed to suit the needs of particular groups.
Religion and belief including non-belief	• Overall, Derbyshire has relatively low numbers of residents adhering to faith groups other than Christianity and non-belief (0.88%). After Christianity and those of no religion, "other religions" is the biggest religious group in Derbyshire subsequented by Islam. Chesterfield followed by High Peak and South Derbyshire have higher numbers of Muslim residents than the Derbyshire average. High Peak and Derbyshire Dales have relatively high numbers of Buddhist residents. Erewash has higher than average numbers of residents of the Hindu and Sikh faiths. South Derbyshire has higher than average number of residents of the Sikh faith. • The British Muslim community has nationally, the poorest reported health, followed by the Sikh population. For both groups, as well as for Hindus, women are more likely to report ill health, whereas for Christians and Jews there is only minimal gender difference. This is not necessarily because of religion but more likely an effect of socio-economic factors. However religious and cultural views can influence attitudes towards reproductive medicine, abortion, contraception and neonatal care. Views on dying and the afterlife can influence attitudes towards pain relief for terminally ill people, means of determining the moment of death, brain death, organ donations and care for the corpse. Religious beliefs can also impact on the types of treatment and drugs used: for instance, the prohibition of eating pork in Judaism and Islam means that porcine-or alcohol-based drugs might be forbidden in these communities. **How the findings align with the Strategy:** The Strategy sets out to develop healthy lifestyle initiatives especially designed to suit the needs of particular groups. Various religious and non-belief requirements need to be taken into account during service planning and provision.
Sexual orientation	• The Department for Trade and Industry estimate that 5-7% of the population belongs to LBG groups. Derbyshire Library Service monitoring shows 1-2% so the actual figure may be somewhere between these two figures. • Results from a national survey reported that 42% of gay men, 43% of lesbians and 49% of bisexual men and women have planned or committed acts of self-harm. • Gay men are more susceptible to eating disorders and have higher rates of mental health problems. Anal cancer is 20 times more common in gay men than in the general population. • 80% of all domestically acquired HIV infections occur as a consequence of sex between men. Because HIV suppresses the immune system the disease can increase gay men's risk of other diseases such as anal cancer. 50% of gay men have never had a HIV test. Gay men are also at higher risk of contracting sexually transmitted infection. Compared to white gay men, African-Caribbean gay men are twice as likely to be diagnosed with HIV. • Bisexual men are less educated about STIs and how to prevent these compared to exclusively gay men. • Many LGBT people socialise in venues where alcohol and drugs

	are commonly consumed. Therefore, their opportunities for choosing healthier options are compromised in comparison with their heterosexual peers. In comparison with young heterosexual people, young LGB people are three times more likely to have used MDMA/ecstasy, 8 times more likely to have used ketamine and 26 times more likely to use crystal methamphetamine. In comparison with lesbian and heterosexual women, bisexual women are two-and-a-half times more likely to misuse alcohol; bisexual men and women are approximately two-and-a-half times more likely to be smokers and bisexual men are more likely to have recently used recreational drugs • BME lesbian and gay women are more likely than heterosexual women to be overweight. • Lesbian women have a slightly increased risk of developing breast cancer as they are more likely to delay childbirth, less likely to have children, less likely to seek regular gynaecological care, more likely to be overweight and more likely to drink alcohol than heterosexual women. Lesbian women also tend to be neglected in breast cancer awareness campaigns. • Older LGB people may have greater need for health and social care services as compared with heterosexual counterparts they are 2.5 times more likely to live on their own, twice as likely to be single and 4.5 times as likely to have no children to rely upon in times of crisis. 14% of older LGB people are open about their sexuality to health care providers and only 25% believe health care professionals were positive towards older LGB people. • Lesbian and bi-sexual women are less likely to attend mammograms and cervical smears, making them less likely to benefit from early detection of cancers. A national survey found that a third of gay men, a quarter of bisexual men and over 40% of lesbians reported negative or mixed reactions from mental health professionals when they disclosed their sexual orientation which might be a reason for why these women are less likely to attend such screenings. **How the findings align with the Strategy:** The Strategy sets out to develop healthy lifestyle initiatives especially designed to suit the needs of particular groups and to raise awareness across partners to reduce discrimination in terms of mental and emotional wellbeing. Future service planning needs to be sensitive to the needs of LGBT groups.

Non-statutory

Socio-economic	• Earning a low wage, being unemployed, living in poor housing, having low levels of education and membership of social classes IV (partly skilled people) and V (individuals with no skills) are all associated with a greater risk of experiencing physical and mental health problems. The Index of Multiple Deprivation combines a number of indicators, chosen to cover a range of economic, social and housing issues, into a single deprivation score for each district. Bolsover has the highest level of deprivation of all districts in Derbyshire (27.24) followed by Chesterfield (24.30), Erewash (19.19), Amber Valley (17.89), NE Derbyshire (16.94), High Peak (15.81), South Derbyshire (13.64) and Derbyshire Dales (12.56). • Chesterfield and Erewash have significantly higher rates than

	average of long-term unemployed people; nationally it has been found that 1 in 4 unemployed people suffer a common mental health problem. • Chesterfield has significantly higher levels than average of violent crime. Bolsover has also considerable higher than average levels of child poverty and low levels of GCSE attainment making its residents more susceptible to suffering ill mental health. • Areas with high deprivation are also more likely to have high numbers of obese residents; both Chesterfield and Bolsover have significantly higher levels than Derbyshire average of adults with excessive weight and obese children between the ages of 10 and 11. Erewash also has significantly high levels of adults with excess weight. This is a worry as obesity can lead to a range of health problems such as diabetes type 2, cancer, respiratory problems and heart conditions. Obesity can also reduce life expectancy by an average of 9 years and may lead to mental health problems such as depression and suicide. • Children of single-parent families are twice as likely to have a mental health problem as children of two-parent families (16%, compared with 8%). Also at higher risk are children in large families, children of poor and poorly-educated parents and those living in social sector housing. **How the findings align with the Strategy:** The Strategy recognises that socio-economic factors can have a detrimental effect on wellbeing and it sets out to reduce poverty and health inequalities, particularly amongst vulnerable people.
Rural	• Compared to the national picture, more people in Derbyshire live in rural areas or on the edge of towns with less people residing in urban areas. Derbyshire Dales has the highest concentration of residents living in rural areas followed by High Peak and North East Derbyshire whilst a large proportion of residents in Erewash and Chesterfield live in urban areas. • Health deprivation tends to be higher in rural areas and there is a concern that some patients will have to travel far in order to obtain specialist services, especially if these patients will have to rely on public transport. Practitioners themselves might have to travel greater distances in rural areas meaning that they are not able to treat as many patients as their urban counterparts. • In farming areas like High Peak there are certain conditions that might be more common as farmers have an increased incidence of osteoarthritis and may suffer from dust diseases such as farmer's lung, organophosphate poisoning and psittacosis. **How the findings align with the Strategy:** The Strategy recognises that the varied communities in Derbyshire might require different approaches to health and wellbeing depending on local health requirements. During the service planning stage these need to be evidenced and taken into account.
People addicted to drugs and alcohol	• Significantly higher than average numbers of those under the age of 18 in High Peak have experienced alcohol-related hospital stays. • Drug misuse in Chesterfield is significantly above average to that of England and both Chesterfield and Bolsover suffer from

	significantly higher than average levels of hospital stays for alcohol-related harm. • 30% of people who are dependent on alcohol and 45% of people dependent on drugs also have another psychiatric disorder. This dual diagnosis is associated with increased use of institutional services, poor medication adherence, homelessness, increased risk of HIV infection and contact with the criminal justice system. This group can be hard to reach in regards to treatment with approximately 40% of drug users with a psychiatric disorder receive no treatment for their mental health problem. **How the findings align with the Strategy:** Alcohol misuse forms part of the Strategy whilst drug misuse issues are continuing to be dealt with by the DAAT (drug and alcohol action team).
Offenders and ex-offenders	• Little data exists in regards to numbers of Derbyshire prisoners and offenders; there are 2 prisons in Derbyshire; Foston Hall which holds 310 prisoners and Sudbury Prison whose population is 581. In 2007, Derbyshire Probation Service supervised 2,764 offenders in the community. • Findings from a study of Nottinghamshire and Derbyshire offenders on probation suggest that offenders' health is significantly worse compared to the general population. Female offenders' health is worse than their male counterparts'. For many offenders, the use of cigarettes, alcohol and drugs were deemed a priority which meant that a good diet and a healthy lifestyle were often over-looked. • 81.6% of Derbyshire offenders reported to be smokers. This group reported more ill health than the non-smoking offending group. • 32.3% of Derbyshire offenders have had formal contact with mental health services. The most common disorder reported was depression. • 49% of Derbyshire offenders have been assessed as being at risk of misusing alcohol. 35% were assessed as being at risk of drug misuse. • 39% of Derbyshire offenders have used A&E/Walk in Centres in the last 12 months however quite a large amount (83%) had accessed a GP during the same period suggesting that Derbyshire offenders do have adequate GP access. • The physical health problems that cause most difficulties amongst Derbyshire offenders are skin problems and respiratory disorders. • Another study found that 90% of prisoners have at least one mental health disorder. Male prisoners are 14 times more likely to have two or more mental health disorders than men in general, and female prisoners are 35 times more likely to suffer such disorders than women in general. • The suicide rate in prisons is almost 15 times higher than in the general population: in 2002 the rate was 143 per 100,000 compared to 9 per 100,000 in the general population. • Male offenders on probation are 4 times more likely to die than the general population with almost half of all offender deaths occurring within 12 months of release. **How the findings align with the Strategy:** The Strategy sets out to reduce alcohol misuse as well as mental and physical health issues whilst drug misuse issues are continuing to be dealt with by the DAAT (Drug and Alcohol Action Team). During the service planning stage the needs of

	offenders and ex-offenders will have to be taken into consideration.
Veterans and army personnel	• The number of veterans and army personnel residing in Derbyshire is unknown however Chetwynd Barracks in Nottinghamshire is in close proximity of Derbyshire. The most common health problems among veterans and army personnel are depression, anxiety, stress, cognitive impairments, physical limitations and pain. Various social problems such as isolation and difficulties adjusting to civilian life can also be common. Additionally, those injured during their service often display more traumatic causes of injury/illness related to combat/explosion activity to that of the general population. • Alcohol misuse is common amongst army veterans and personnel with one study reporting 13% of such groups misusing alcohol. 19.7% of the sample reported common mental health issues. Another study found that 10.5% of UK veterans had attempted suicide or had self-harmed. **How the findings align with the Strategy:** The Strategy sets out to prioritise problems common in this group, such as, mental health issues and alcohol misuse. Further understanding of the specific needs of this group would be beneficial to help with service planning.
Homeless people	• Chesterfield and South Derbyshire followed by Bolsover host the largest proportions of homeless people in the county. • 1 in 4 homeless people will die by suicide. • 30-50% of homeless rough sleepers experience mental health problems. Around 70% misuse drugs. • Less than a third of homeless people with mental health problems receive treatment. • Behavioural problems have been found to be higher among homeless children living in temporary accommodation, and mental health problems are significantly higher among homeless mothers and children. • People with mental health issues are more likely to experience accommodation problems (48%) compared to those without such disorders (33%) **How the findings align with the Strategy:** The Strategy sets out to reduce alcohol misuse as well as mental and physical health issues, whilst drug misuse issues are continuing to be dealt with by the DAAT. Future service planning needs to be sensitive to the requirements of homeless people.
Carers	• Both Bolsover (1.8%) and Chesterfield (1.5%) have higher levels than the Derbyshire average (1.2%) of people claiming carers' allowance. There are of course informal carers and one national study found that around 12% of those over the age of 16 in England act as a carer. 11% of all carers reported receiving Carer's Allowance and 27% received Disability Living Allowance/Attendance Allowance. Almost half of all carers provide care for 20 or more hours per week. • Carers are less likely than the general population to describe their health as good. To a certain extent this can be because the majority of carers belong to the older age groups. 52% of carers stated that their health had suffered as a consequence of their caring responsibilities. • The most common effects on carers' health were feeling tired or stressed, having disturbed sleep and feeling irritable. Almost 1/5

	reported feeling depressed. **How the findings align with the Strategy:** The Strategy sets out to ensure that carers' needs are met.
Other groups	• Erewash, Chesterfield and Bolsover have higher than average numbers of children in care. Children in care are 4 to 5 times as likely to suffer a mental health problem as other children. • Chesterfield has significantly higher levels of domestic abuse compared to the Derbyshire average whilst Bolsover has significantly higher levels of violent crime, including sexual violence, compared to the Derbyshire average. The impact on victims of such assaults will not just be the physical injuries they sustained during the attacks but survivors of domestic and sexual abuse are more likely to self-harm, attempt suicide, experience depression, suffer eating disorders, smoke, misuse drugs and alcohol. There is also an increased risk for the prevalence of STIs, poor pregnancy outcomes and chronic gynecological problems. **How the findings align with the Strategy:** The Strategy prioritises vulnerable children and adults and will work to improve access to Child and Adolescent Mental Health Services. Victims of crime, such as, domestic abuse and sexual violence are supported through Safer Communities and partners using resources like the Sexual Assault Referral Centre.

b. What does customer feedback, complaints or discussions with stakeholder groups tell you about the impact of the policy, practice, service or function on the protected characteristic groups?
Note: Findings are summarised responses from members of the public obtained during various public consultation exercises.

Protected Group	***Findings***
Age	• Young carers need to be a focus in terms of health and wellbeing in early years. • Resources available within the community such as Children's Centres could be utilised as an outlet for children's primary health care. • Loneliness amongst older people is common in Derbyshire and efforts should be taken to reduce this. The older person should have one person responsible for them to ensure they are visited daily and to co-ordinate health and wellbeing for them. • Increased community cohesion (between older and younger groups) could increase wellbeing such as by encouraging younger people to help older people with transport. • It must be recognised that older people might not have the IT skills to access information and support online so this must be provided through other forms of communication. Flu jab clinics could provide an opportunity to inform patients about other services. • Promotion and strengthening of the First Contact signposting system to older people is needed. • Many older people misuse alcohol and this can negatively impact the medications they take. Alcohol use can contribute to more falls, poor diet and low nutritional uptake; alcohol

	also has a detrimental impact on dementia. • Young people should be educated further in regards to eating disorders, sexual health and self-harm. • There needs to be a specific child and adolescent mental health unit. • Past provision of mental health support for young people has been flawed and there is a worry that this area will not be given enough attention. • There is a lack of adequate housing for the elderly. • Increased health screenings for those over the age of 50 could work as a preventative mechanism. • There is a worry that Telecare will replace face to face contact with health care professionals resulting in increased isolation amongst older people. **How the findings align with the Strategy:** Although the Strategy does not specifically mention young carers, one of the strategy aims is to help carers take greater control of their own health; additionally, improved access to Child and Adolescent Mental Health Services are being developed. The Strategy recognises that appropriate housing for older people can be an issue and Derbyshire County Council is leading the development of Extra Care housing. Patients' housing situations will also be taken into account when care and support is being planned. The Strategy sets out to explore more integrated models of working and commits to strengthening joint commissioning of services. The Strategy aims to both increase the health and wellbeing of older people as well as reduce alcohol misuse. The service planning stage will need to consider the health requirements of older drug and alcohol misusers. Mental health issues such as eating disorders, sexual health and self-harm are prioritised by the Strategy with further action plan initiatives requiring consideration. Telecare and Telehealth will need to be implemented to best suit the user.
Disability	• Communications need to appeal and be appropriate to different audiences such as those with low literacy levels, mental health issues and learning difficulties. • Dying well across all stages of life needs to be addressed. • Health and Wellbeing initiatives must not lose focus on drug misuse and smoking problems. • Focus needs to be on prevention, and community support services should be in place to promote self-management of long-term conditions. • There is a lack of access to mental health services and a mental health accident & emergency service is needed. Mental health interventions should be long-term and preventative measures should be put in place. GPs need further training in regards to mental health issues. • Must ensure good transition between hospital and community, especially for patients with long-term conditions. • Accommodation and support needs of patients with long-term conditions must be considered and planned ahead for. • The impact of raising social care access criteria for services and incapacity benefit changes on long-term condition

	patients and their carers can result in those needing support might now fall below the threshold. • Social isolation affects long-term condition patients and their carers disproportionally so community support capacity needs to be ensured. • Long-term condition patients need emotional and practical support as well as benefit advice. • Services need to work in partnership as for instance there is strong links between alcohol misuse, smoking and a poor diet. • Some patients are unable to use phones and therefore lack access to particular health services. • Diabetes is becoming an increasing problem in Derbyshire and therefore special provisions need to be made. **How the findings align with the Strategy:** A targeted communications approach need to be developed during the service planning stage. End of life care will be further developed an individual and holistic service. A smoking cessation strategy for Derbyshire is being developed and the Strategy sets out to improve access to advice and support for young people with substance misuse problems whilst adult substance misuse issues are continuing to be dealt with by the DAAT. Community- based support and self-management form part of the Strategy priorities. The Strategy states that improved access to mental health support is needed and that awareness of mental health conditions need to be raised with all partners. The specific issue of mental health accident and emergency provision is not addressed but will be considered as part of the action planning process as will the transition between hospital and community needs to be developed. The Strategy recognises the risk of isolation amongst older age groups and there is a need to develop initiatives to prevent and reduce isolation. Local strategies and programmes will be developed to reduce barriers, such as poverty, to promote healthy lifestyles. Links to partners who can provide benefit advice and other services will be strengthened.
Gender (Sex)	• Focus needs to be placed on how to engage fathers in improving outcomes for children. **How the findings align with the Strategy:** The Strategy refers to “parents”, meaning mothers and fathers and does not distinguish a specific parent type.
Gender reassignment	
Marriage and civil partnership	
Pregnancy and maternity	• Effective sex education in secondary schools is important in order to reduce teenage pregnancies. • Family centred approach is needed to instil healthy lifestyles throughout a person’s life course. • Accommodation advice needs to be provided as inadequate housing can lead to a range of health issues. **How the findings align with the Strategy:** The Strategy outlines the need to ensure that accommodation issues are taken into

	account when assessing social and health care needs and strengthened links with partners should ensure that accommodation issues can be dealt with in the most effective way. The Strategy also states that families will be supported to improve the health and wellbeing of children.
Race	• Cultural barriers/requirements need to be taken into account (e.g. gypsies and travellers, homeless people, ethnic groups). **How the findings align with the Strategy:** The Strategy sets out to develop healthy lifestyle initiatives, especially designed to suit the needs of particular groups and to remove any barriers to healthy lifestyles.
Religion and belief, including non-belief	
Sexual orientation	• LGBT people are more likely to live on their own and can feel isolated and fearful when accessing services. Care homes are not designed to meet the needs of LGBT people. • Young LGBT people are more likely to smoke and use alcohol/drugs so a targeted prevention strategy needs to be in place. **How the findings align with the Strategy:** The Strategy recognises the need for making a range of housing available for older people in order to suit individual needs. The needs of protected groups will be furthered considered during service planning.

Non-statutory

Socio-economic	• It is important to engage people for other reasons (where health is secondary) such as economic motivation (saving money by eating healthier) or entertainment (sports and games). • Middle class drinkers having several units of alcohol per night might not consider having a drinking problem. • Socio-economic factors such as financial exclusion can increase or bring on physical or mental health problems so wider issues such as unemployment and poverty need to be considered. Likewise the provision of affordable leisure activities. **How the findings align with the Strategy:** A broader approach to engagement as the one outlined above need to be incorporated in service planning. Reducing alcohol misuse is part of the Strategy however; during the service planning stage needs to consider how different groups of users will be engaged through targeted approaches. Socio-economic factors as instigators to ill health are considered by the Strategy and it recognises the need for a targeted approach to poor health in deprived areas.
Rural	• People must have appropriate transport to access services and alternatives to ambulances, especially if living in rural areas. • A community based approach needs to be taken in order to find out about why particular health problems exist in certain communities.

	• Support services for parents in a rural setting need to be provided. **How the findings align with the Strategy:** Improved access to services for those living in rural locations need to be taken into consideration during the development of services. The varying health needs across the different districts of Derbyshire will be considered during the action planning stage.

c. Gaps in data

What are your main gaps in information and understanding of the impact of your policy and services? Please indicate whether you have identified ways of filling these gaps.

Gaps in data	Action to deal with this
The availability and quality of service user data needs to be reviewed to ensure that it reflects the needs and experiences of protected groups such as that of transgendered people and veterans.	Further plans for data sharing between partners are being developed.

Stage 6. Ways of mitigating unlawful prohibited conduct or unwanted adverse impact, or to promote improved equality of opportunity or good relations

Long-term plans need to be in place for information sharing of service user and non-user information between all partners in order to continually improve services and meet local need.

Carrying out a health needs assessment in order to determine the local prevalence of protected groups and related health issues would support effective and efficient service planning.

Consultation feedback should be forwarded to service delivery planners and providers to ensure that views of service users and communities are taken into consideration.

The local variations of Derbyshire will need to be taken into account when devising actions plans.

Telecare and Telehealth will need to be implemented as to best suit the user.

Stage 7. Do stakeholders agree with your findings and proposed response?

Overall, data and consultation feedback support the Strategy. The majority of feedback received concerned service delivery issues which need to be taken into account during the action planning stage, service planning and implementation.

Stage 8 and 9. Objectives setting/ implementation

Objective	***Planned action***	***Who***	***When***	***How will this be monitored?***
Information Sharing Agreements will be developed to ensure that there are clear processes in place to share information between agencies to support effective planning both at an individual and service level.	Development of Information Sharing Agreements.	Strategic Director, Policy and Community Safety	In progress	Reports to the HWB
Gaps in data regarding the local prevalence and experiences of protected groups need to be filled as much as possible.	To be incorporated into the HWB Strategy Action Plan.	Director of Public Health	March 2013	Reports to the HWB
The Strategy needs to be monitored through the delivery of programmes and experiences of service users.	An annual review will be produced and made publicly available.	Strategic Director, Policy and Community Safety	Sept 2013	Reports to the HWB and Annual Review Report.
Consultation feedback needs to be forwarded to service delivery planners and providers.	A summary report will be presented to the HWB and subsequently published online.	Alison Pritchard	In progress	Reports to the HWB

Stage 10. Monitoring and review/ mainstreaming into business plans

Please indicate whether any of your objectives have been added to service or business plans and your arrangements for monitoring and reviewing progress/ future impact?

The objectives will be incorporated into the service/action planning stage and a robust monitoring and review process will be implemented by the Health and Wellbeing Board.