Title of the Assessment:	Healthier Communities Strategy	**Date of Assessment**	28.07.10
Responsible Officer: **Email:**	Craig Lister - Public Health Manager NHS Bedfordshire	**Extension Number**	

Stage One – Aims and Objectives

1.1) What are the objectives of the strategy, policy or service being assesse

Central Bedfordshire's vision identifies a prosperous and ambitious environment for the benefit of all. To enable this all sections of the community must be afforded the opportunity to thrive and prosper. There is a wealth of evidence that links the economic development and success of a community to the underlying health. The strategy sets out the strategic direction we will take throughout Central Bedfordshire and directs readers to other strategic plans that have links to developing a healthier community.

1.2) What needs is it designed to meet?

The key priorities of the Healthier Communities Strategy are to:

- Ensure a healthy start to life;
- Reduce health inequalities and increase healthy life expectancy;
- Support people to have healthier lifestyles;
- Promote choice and access to high quality services based on needs and preference; and
- Support and care for an ageing population and those who are most vulnerable.

1.3) What outcomes will be delivered?

To reduce the prevalence and impact of the major conditions which are associated to a greater or lesser extent with today's lifestyle choices: Cancer, Smoking, Cardiovascular Disease and Obesity

1.4) Which other strategies or policies support this?

Most of the determinants of health sit outside the direct remit of the NHS. Place shaping, planning, housing, education, transport and access to services, together with projected population growth will all impact on population health.

1.5) In which ways does this support Central Bedfordshire's intention to tackle inequalities and deliver services to vulnerable people?

It is important that everyone within Central Bedfordshire is afforded the best opportunity to develop and that existing inequalities in health and economic status are reduced. While there is a need to focus on large scale improvements to the health of our population, the Healthier Communities Strategy will set out how we will improve the health of people in areas and communities with the poorest health to further reduce the inequalities gap. As the health of a

community continues to improve there is an expectation that healthcare costs for some of the more common lifestyle related conditions will reduce. This enables additional focus on specific health inequalities, reducing the gap between differing geographical and demographic groups to provide a more equitable society.

1.6) Is it possible that this could damage relations amongst different communities or contribute to inequality by treating some members of the community less favourably such as people from black and minority ethnic communities, disabled people, women, or lesbian, gay, bisexual and transgender communities?

It is important that the needs of all vulnerable groups are identified and reflected in the action plans.

2) What sources of evidence and key facts will be used to inform the assessment?

2.1) Existing Data and Consultation Findings:

Age National Research:

Demographics

In 2007, for the first time in the UK there were more people over state pension age than children under 16 (Department for Work and Pensions DWP).

Health

In 2006, 63% of people aged 65 to 74 reported having a longstanding illness and 38% said longstanding illness limited their ability to carry out daily activities (ONS). 70% of people aged 75 and over reported having a longstanding illness and 50% said longstanding illness limited their ability to carry out daily activities (Office for National Statistics (ONS)). In 2006/07 an estimated 2.5 million older people had some need for care and support (Kings Fund / Commission for Social Care Inspection). Older people can experience limiting health and social care options (Department of Health (DOH)). Around 25% of people over 65 years living in the community have symptoms of depression which warrant intervention. (Age Concern)

Poverty

Seven million people are estimated to be under-saving for retirement which means they may find themselves living in poverty in retirement (DWP). Around 33% of women reaching State Pension Age in 2005 were entitled to a full basic pension, compared to 85% of men (Department for Work and Pensions DWP). 2.1 million Pensioners live in poverty after housing costs are taken into account, while the figure rises to 2.5 million before housing costs (DWP).

Isolation

Over 65s are estimated to spend 80% of their time in the home (90% for over 85 year olds) (Help the Aged). One million people over 65 report feeling trapped in their homes (DWP). 21% of men and 31% of women aged 65 to 74 lived alone in 2006 and 32% of men and 61%

of women aged 75 and over lived alone (Office for National Statistics (ONS)). 180,000 people over 65 report having gone for a whole week without speaking to friends, neighbours or family (DWP).

Discrimination

Ageism is the most commonly experienced form of discrimination, with 23% of adults reporting experiences of this type of prejudice. (Age Concern) 33% of people aged 65 to 74 and 35% of people aged 75 and over feel able to influence decisions affecting their local area, compared to 38% of all adults in England and Wales. (Department for Communities and Local Government (DCLG)). Assumptions are sometimes made that it's natural for older people to have lower expectations, reduced choice and control and less account taken of their views (DOH).

Research undertaken for the Department of Health looking at **age equality in Health and Social Care highlighted the following issues:**

- **Behaviours and attitudes – the importance of training** Behaviours and attitudes were identified as crucial issues in determining not only whether people felt they were treated fairly but also whether the outcome was non-discriminatory. People gave numerous examples of discriminatory attitudes based on age, summarised in the phrase **"what can you expect at your age?"** The high incidence of **untreated depression** in older people and examples of situations when staff "talked over" older people were also quoted as examples of discrimination.

- **Strategic commissioning** Good information on health, care and wellbeing needs was seen as an essential first step in ensuring that service planning and delivery are fair and proportionate. People who can experience **multiple discrimination** such as older prisoners and older people from minority ethnic groups can be overlooked. **Commissioning must be informed by data that is broken down and analysed by age and other factors**. Public involvement in commissioning decisions is crucial. Representatives of patient, service user and public groups observed that their role needed to cover planning and design stages and also the delivery and evaluation and review stages. PCTs and LAs needed to **use age appropriate means of engaging different groups,** especially different communities of older people.

- **Personalisation in assessment, referral and care planning:** People's individual needs and situation must be taken into account rather than basing decisions on a series of assumptions about the person's chronological age. Information must be consistent and linked between agencies.

    - Older people stressed a **frustration at being constantly referred to the internet** other forms of information should be used as well;

    - Decision making processes for an individual's care and organisations' plans and priorities need to be clearer;

    - **Too many assumptions** are made about which services older people can and

cannot access.;

- People needed to be regarded as partners and able to agree mutual expectations and to be supported to make informed choices; and

- Service users of all ages should always be offered **different approaches to personalisation** and staff should not assume whether people of a certain age may or may not want a specific approach**.** Services should be accessible and easy to navigate, in practice this is often not the case; and

- **Advocacy** was seen as very important, particularly at times of personal stress as its availability was seen as critical to the system working well.

- **Health Promotion and Prevention is an important means of maintaining people's health and social inclusion** and a way of stressing a positive role for older people and other marginalised groups by acting as volunteers, advocates and enablers for others. These activities could be supported by the third sector and through intergenerational working to address ageist attitudes and assumptions. There were concerns that services such as foot care that had an important role in prevention were often regarded as lower priorities.

- **Beyond health and social care - The importance of other services that impact on people's health, social care and wellbeing**. These include housing, employment, leisure and, crucially, the benefits system, where people observed that they wanted to understand the justification for age criteria in some existing benefits, such as Disability Living Allowance and Mobility Allowance.
- **Geographical variation in the availability of services –** People perceived the "postcode lottery" as being closely linked with age discrimination because of the different services that are available between and within the PCTs and LAs. Older people are less mobile, and feel particularly disadvantaged.

- **Dual and multiple discrimination –** the interaction of age with other characteristics e.g. race, belief and sexual orientation, can lead to discrimination. The impact of living in a rural community can also be seen as a form of disadvantage.

- **Exclusion from Technology:**

  - 47% of one adult households aged 60 or over had a mobile phone in 2006, compared to 83% of all households. (ONS)
  - In 2006, 45% of people aged 50 or over had used a computer in the previous three months compared to 87% of people aged 16 to 30. (ONS)

  - 41% of people aged 65 to 74 and 20% of people aged 75 and over used the internet in 2007, compared to 71% of the overall population. (ONS)

  - 42% of people aged 65 to 74 and 27% of people aged 75 and over had access to the internet at home, compared to 65% of the overall population. (Age Concern)

Housing:

- 2.1 million households with at least one person aged over 60 (28% of this age group) are living in a non-decent home. This includes 900,000 households with someone over 75 (31% of the age group). (DCLG)

- 73% of all non-decent dwellings lack effective insulation or efficient heating required to meet the thermal comfort criterion. (Age Concern)

- Around a quarter of a million people aged 65 and over need specially adapted accommodation because of a medical condition or disability and 130,000 of them report living in homes that do not meet their needs (DCLG).

Crime and Fear of Crime

- In 2006/07, 12% of men and 10% of women aged 65 to 74 perceived high levels of antisocial behaviour in their local areas.

- Older people are over-represented among the 5% of people who report that their life is greatly affected by fear of crime.

- There were 12,750 recorded distraction burglary crimes in 2006/07. The average age of a victim is 81 years

Access to Services:

- In 2001, 1.5 million people aged 60 to 74 and 0.8 million people aged 75 and over were living in rural areas. (Commission for Rural Communities (CRC))

- 29% of households in rural areas do not have access to a supermarket within 4 kilometres. (CRC)

- Older People who are reliant on public transport find it harder to visit their GP or hospital, see friends and go shopping. (Cabinet Office)

Disability National Research:

Demographics

Using the widest definition there are more than 11 million disabled people in the UK, that's more than one in five of the adult population and one in 20 children. 80% of people experience a year of being disabled at some point in their lives and 66% of disabled people develop impairments during working age.

Health Inequalities

An investigation into the health inequalities experienced by people with mental health problems or learning disabilities found that many people reported problems with gaining access to services, with staff attitudes, and with getting the necessary treatment and support (Equality Review).

Discrimination

Disabled people do not always have the same opportunities or choices as non-disabled people. They can experience discrimination, lack of respect and unreasonable barriers to participation in society on an equal basis.

Poverty

The income of disabled people is on average less than half that of non disabled people. (EFD).

Employment:

Disabled people are more than twice as likely to be out of work as non disabled people. (Family Resources Survey - 2006/07) Only one in two disabled people are likely to be in employment compared with four in five non disabled people. (Government Equalities Office) Disabled people make 2.5 times more job applications than non disabled people, yet receive fewer job offers. (Employers Forum on Disability (EFD))

Crime and Fear of Crime

Disabled people are at greater risk of experiencing violence than non-disabled people (Equality and Human Rights Commission (EHRC)). Disabled people face harassment. One in four has experienced hate crime. (EHRC). Disabled women are found to be twice as likely to experience domestic violence as non-disabled women (EHRC). 75% of people with mental health conditions and 66%of those with learning difficulties have experience of being victims of crime. (Greater London Assembly; Mind)

Experiences of Discrimination in Social Care Services

Social care services are vital in order to progress equality for disabled people. If these services are not part of the solution in actively removing the barriers to living independently that disabled people face, they can become part of the problem in creating barriers to equality (Commission for Social Care Inspection).

Disabled people said they experienced the following barriers to equality in social care services:

- **Physical barriers** were the most common barriers to disability equality addressed by sample of services (24% of 400 services). Environmental barriers, such as poor access to or within buildings, can be significant, but they were experienced by the lowest number of disabled people (17% of the 307 disabled people taking part in our survey and 37% of people with physical or sensory impairments).
- **Communication barriers** were experienced by a majority of disabled people responding to the survey, with only 38% agreeing that all staff communicated well. These barriers were not always related to the disabled person's impairment, for example providing information in accessible formats, but could be due to the communication skills of staff.

- **Social inclusion barriers** Only 29% of disabled people living in care homes felt that the service had helped them to challenge disabling barriers in the community, e.g. transport or inaccessible community facilities, compared to 43% of people using home care and 44% of people using Direct Payments.

- **Attitudinal barriers** were the most common barriers that people faced. 55% of all disabled people, and 65% of people living in care homes, had experiences of social care staff who did not respect their right to be treated equally with non-disabled adults; for example patronising attitudes or a lack of regard for the disabled person's rights to make choices about how care was delivered.

- A minority of disabled people report experiences where their human rights may have been compromised, e.g. a **lack of regard for basic privacy or dignity**.

- 94% of social care services reported that they were undertaking some general work on equality, such as policy development or staff training.

- Only 33% of social care services identified any focused action that they had taken on equality for disabled people

Housing:

Much of the social housing stock is unsuitable for disabled people. Sub standard housing can make some conditions worse (Department for Communities and Local Government). For many disabled people the main barrier they encounter is people's attitudes:

  - 1in 3 people believe wheelchair users to be less intelligent;

  - 1 in 2 people express a fear of disabled people;

  - 1 in 4 people feel resentment and anger towards disabled people (Employers Forum on Disability).

Travel: (Disability Rights Commission)

Disabled people travel one-third less than non disabled people and physical access to public transport can be difficult.

1.4. Gender National Research:

Health:

There are big differences in women's and men's health needs and behaviour. Biological and social factors influence the health risks they are exposed to, their health behaviour and their experience of health care. For example,

- Women are more susceptible to lung cancer, but more men die of the disease, because they seek medical help late. (Department of Health (DOH))

- Men are still less likely to go to their GP, and are therefore less likely to identify health problems early on. (DOH)

- Policies to shorten hospital stays can affect women differently from men, as women will often not have the appropriate support in place at home to enable full recovery, and will quickly resume household and work responsibilities. (DOH)

- It is possible that depression and anxiety are under-diagnosed in men. Suicide is more common in men. (DOH)

Cardiovascular disease

The mortality rate for coronary heart disease (CHD) is much higher in men, and men are more likely to die from CHD prematurely. Men are also more likely to die during a sudden cardiac event. Women's risk of cardiovascular disease in general increases later in life and women are more likely to die from stroke. Men and women often experience different symptoms for CHD, with the 'typical' symptoms being more often experienced by men. This may mean that women are less likely to recognise symptoms in themselves and tend to seek help at a later stage (although surprisingly little is known about the link between gender and help-seeking behaviour). Women are also less likely to be referred to specialists. Despite these differences, there is very little national policy that takes gender differences into account.

Overweight and obesity

The proportion of men and women who are obese is roughly the same, although men are markedly more likely to be overweight than women, and present trends suggest that weight-related health problems will increase among men in particular. Women are more likely than men to become morbidly obese. Women are much more likely to take part in private sector weight loss programmes and more likely to be treated for overweight in primary care. There are important differences between men and women in how they view weight problems. It is probable that men and women take different approaches to weight management and they may find different approaches helpful. It is also possible that health professionals may take different attitudes to men and women in relation to weight, although research into this is limited. There are no gender-specific national targets in relation to overweight and obesity, and very little consideration of gender in the relevant national strategies.

Mental health

Women are more likely to report, consult for and be diagnosed with depression and anxiety. It is possible that depression and anxiety are under-diagnosed in men. Suicide is more common in men, as are all forms of substance abuse. There is a national strategy for women's mental health but no equivalent for men, although there is a focus on the prevention of young male suicide in the *National Suicide Prevention Strategy* (DH, 2002b). The shortage of knowledge in relation to barriers to service use for both men and women is acknowledged in the equality impact assessment of the Mental Health Act 2007.

Alcohol misuse

Alcohol disorders are twice as common in men, although binge drinking is increasing at a faster rate among young women. Among older people, the gap between men and women is less marked. Policy tends to see the consequences of unsafe drinking as different for men and women; men become violent or take unwise risks, women may become more vulnerable to abuse or attack. It is possible that women feel more stigmatised by alcohol-related problems and this may influence their response to services – at the same time, women are more likely to use some services than men, despite men's greater level of problems. National alcohol policy takes little account of the differences between men and women.

Cancer

Morbidity and mortality are consistently higher in men for virtually all cancers that are not sex-specific. At the same time, cancer morbidity and mortality rates are reducing more quickly for men than women. The most common avoidable cause of cancer – tobacco – may be used by men and women differently. Tobacco use may also affect men and women differently. Many of the early signs of cancer are easily confused with minor health problems and there is some evidence that men may be less likely to consult for these kinds of symptoms. There are variations between men and women in their experience of the cancer care 'journey'. The reasons for these differences are not well understood. Historically, there has been little consideration of the need for gender-sensitivity in cancer services but the *Cancer Reform Strategy* (DH, 2007a) has highlighted the need for a better understanding of the issue and suggests that research is needed.

Sexual health

Sexual health is unique in that patterns of male and female health status are directly linked. It is, however, difficult to make judgements about the use of services because detailed data about use of GUM (genito-urinary medicine) clinics are not currently available in gender-disaggregated form (although planned changes in data collection systems will eliminate this problem in the future). With the exception of gonorrhoea, incidence rates of all sexually transmitted infections are rising, with the increase being greater in women than men. HIV infection has always been much higher in men, although the rate of infection from heterosexual sex is increasing more rapidly than among men who have sex with men. It seems very probable that men and women view sexual health differently but there is little research in the field. Gender is considered frequently in sexual health policy in the sense that many services are for one sex or the other, but there is less consideration of the link between gender and help-seeking behaviour. The National Chlamydia Screening Programme has pioneered a strategy for increasing the take-up of services by men – currently the only strategy of its kind in any area of health provision.

Isolation and Access to Services

It is estimated that at least 1.7 million single older men could be living in isolation in the UK. Nearly 400,000 of these are single older men aged 75 and over. Furthermore, it is estimated

that 289,000 single older men are living in poverty. (Age Concern)

Low Income

- Occupation segregation is one of the main causes of the gender pay gap. Women's employment is highly concentrated in certain occupations and those occupations which are female-dominated are often the lowest paid. (GEO)

- Many women bear the majority of the responsibility for childcare with the result that 44% of women work part time compared to 10% of men. Part-time work can limit career progression; lead to lower pay and reduced pensions. (EOC)

- Although women generally live longer than men, since the early 1980s poorer women have been living less long than rich men

Crime and Fear of Crime

- 45% of women in England & Wales experience domestic violence, sexual assault or stalking during their lifetime. (British Crime Survey Home Office)

- For females, the majority of the violence experienced is in the home and the offender is known to them

Transport

- In general women have less access to private cars than men, and are the main users of public transport. (Planning Advisory Service (PAS))

1.5. Gender Reassignment National Research:

1 in 10,000 people suffer from the recognised medical condition known as gender dysphoria, generally referred to as being transgender or transsexual. Recent research estimates that 7% of the trans population are aged 61 or over (Equalities Review). Research undertaken in the areas of employment, health provision, social exclusion and hate crime indicates that Transgender people experience disproportionate levels of discrimination, harassment and violence. This includes bullying and discriminatory treatment in schools, harassment and physical/sexual assault and rejection from families, work colleagues and friends.

Department of Health Guidance - Social attitudes towards trans people

Although social attitudes have become more accepting towards trans people, there is a persistent assumption that there are only two genders (female and male) and that one's gender is assigned from birth and cannot be changed. Trans people still face prejudice. This continues to limit their employment opportunities (despite legislation prohibiting discrimination); their personal relationships; their access to goods, services and housing; their health status; their safety in both public and private spheres; and their access to health and social care. Trans activists have lobbied for a shift in social and health perspectives from gender pathology (a disease or abnormality) to gender nonconformity (trans people do not

conform to society's narrow view about gender)

What are trans people's health needs?

Like lesbian, gay and bisexual people, trans people often meet with discrimination and prejudice in their everyday lives. Many, regardless of social position or class, experience isolation and face limited understanding of their lives. These experiences place many trans people at risk of alcohol abuse, depression, suicide, self-harm, violence, substance abuse and HIV.

- **Victims of violence:** Because many (MTF) trans women are visibly trans for several years after starting living in their new gender role, (transphobic) violence is more often directed at them than (FTM) trans men.

- **HIV rates:** One US study found (MTF) trans women to have the highest incidence of HIV infection of any risk group; however, HIV infections are not a major risk factor in the UK, mainly because sex work or recreational drug use is not usual in UK trans cultures.

- **Self-harm and suicide rates:** The UK's largest survey of trans people (*N* = 872) found that 34% (more than one in three) of adult trans people have attempted suicide. Similar rates were reported in a US study.

- **Young people's concerns:** Young trans people report insecure housing, economic hardship, legal problems and difficulty in accessing appropriate healthcare. They have limited family support, high rates of substance abuse and high risk sexual behaviours.

Access to healthcare (for people when transitioning) Gender reassignment services

The community's primary health needs are access to gender reassignment services, including assessment, counselling or psychotherapy, hormonal treatments, and gender reassignment surgeries (hair removal, vaginoplasty and breast enhancement for (MTF) trans women, and mastectomies, hysterectomies and genital surgery for (FTM) trans men). Evidence suggests that large numbers of trans people are refused NHS treatment:

  - 17% were refused (non-trans related) healthcare treatment by a doctor or a nurse because they did not approve of gender reassignment;

  - 29% said that being trans adversely affected the way they were treated by healthcare professionals; and

  - 21% of GPs did not appear to want to help or refused to help with treatment.

The survey also found that little improvement had been made in funding gender recognition treatments and in waiting times over the past 15 years.

Barriers to routine healthcare

Health professionals hold polarised views of transsexualism ranging from considerable empathy to strong moral disapproval. As a consequence, there are many examples of

inappropriate healthcare:

- (FTM) trans men are rarely included in breast screening programmes;
- (MTF) trans women are rarely offered prostate screening;
- Intersex women report being repeatedly asked about their last period and their contraceptive use, some are given smears (although they do not have a cervix).

Physical examinations and screening tests should be offered to patients on the basis of the organs present rather than their perceived gender. Health care discrimination against trans people has included the refusal of care such as smear tests.

Communicating and engaging with trans people.

More than 30% of trans people in one study had experienced discrimination from professionals who were insensitive to trans issues when they were trying to get information from their GP; obtaining funding for gender reassignment surgeries; accessing ordinary non-trans related healthcare. Trans people also complained of healthcare professionals persisting in using male pronouns rather than female, ie using 'he' rather than 'she' and vice versa; being critical about appearance, in particular about style of dress; and asking for their 'real' name. They also report being made to wait longer than other patients when accessing health services or surgery, and that doctors assume that any presenting health problem is related to their trans identity and often regarded as psychosomatic.

- Trans people may also be at greater risk of isolation, alcohol abuse, suicide, self-harm, substance abuse and HIV infection, although these issues require further investigation. (Equality and Human Rights Commission)
- Trans people are susceptible to depression and at risk of suicide. (Department of Health)
- 33% of Trans Adults in the UK attempt suicide at least once. (Press for Change)

Housing: (Equality and Human Rights Commission)

- Trans people may be particularly at risk of housing crisis and homelessness arising from transphobic reactions and harassment by family, neighbours and members of their local community.
- Trans people fear disclosing their identity to housing officers for fear that they will not be treated with dignity and respect. The result can be that they do not receive the housing services that they need or receive a service inappropriate to their needs.

Media, leisure and sport: (Equality and Human Rights Commission)

- There are particular problems for trans people in accessing changing facilities that are appropriate to their gender identity in sports and leisure facilities and in shops.

- Many trans people do not use these facilities in order to avoid discrimination, thereby restricting their leisure opportunities.

Crime: (Equality and Human Rights Commission)

- Trans people appear to experience high levels of hate crime and hate incidents
- 62% of respondents had experienced transphobic harassment from strangers in public places who perceived them to be trans: mostly this had taken the form of verbal abuse.
- 40% had experienced transphobic threatening behaviour.
- 17% had been physically assaulted and 4% had been sexually assaulted.

1.6 Race: National Research

People from black and minority ethnic communities can often experience multiple inequalities. 70% live in the 88 most deprived neighbour-hoods in the United Kingdom and they are more likely to be poor, with lower incomes spread across larger household sizes. They can also experience discrimination, stereotyping and racism. These overall patterns also vary between and within different ethnic groups. Gypsies and Irish Travellers can face acute discrimination and awareness of the needs of these communities can be low.

Health - Equality Review 200

"Where evidence exists it shows that the overall health experience of ethnic minority groups in Britain is worse than that of the White British population, and that the differences cannot be explained entirely by reference to class or poverty. There are important differences between (and within) ethnic minority groups. For example, Pakistani and Bangladeshi people report the highest levels of poor health, although Chinese people report the best overall levels of health (and have better outcomes on health determinants such as educational attainment than the White British group). As is the case for all groups, the likelihood of ethnic minorities reporting poor health is strongly associated with ageing and deprivation.

For ethnic minorities, we do know that for some conditions there is higher risk of disease. For example, people born in South Asia have the highest mortality rates from circulatory disease. This is due in part to their varied but substantially raised prevalence of diabetes as well as other factors such as, for example, rates of smoking and obesity. The Health Survey for England suggests that Pakistani men are also significantly more likely to suffer coronary heart disease or stroke than the general population. On the other hand, corresponding rates for Black African men and women are significantly lower than for the general population, and, cancer incidence and mortality is low in most ethnic minority groups.

The incidence of mental health remains significantly higher for some groups than for others. Disproportionately high rates of young men from some Black groups who are sectioned under the Mental Health Act have been evident for many years and show no sign of reducing. The Department of Health's innovative census of mental health patients undertaken in 2005 suggested that in-patients from the Black Caribbean, Black African, and Other Black groups were more likely (by 33 per cent to 44 per cent) to be detained under the Mental Health Act

1983 compared with the average for all in-patients. Patients from these groups were also detained for a longer period of time on average than other in-patients. Research suggests that Black groups have more than six times the rate of psychotic illness than the general population and are presenting direct to acute care via the criminal justice system."

Gypsies and Irish Travellers have the poorest life chances of any ethnic group today. Life expectancy for men and women is ten years lower than the national average (Commission for Race Equality (CRE)).

Experiences Using Social Care

Adults and older people from black and minority ethnic communities are less likely to be provided with social services following an assessment (Commission for Social Care Inspection (CSCI)). Only 33% of all social services users in England thought that matters of race culture and religion were noted by local authority social services staff (CSCI). The experience of black and minority ethnic people using social care services is still very variable.

- Whilst the majority of BME people say that they would recommend the service to another black or minority ethnic person and that staff were suitable.

- Only around 50% felt that their needs as a black and minority ethnic person were adequately considered at their last assessment

- 25% said that they had faced prejudice or discrimination when using services, with over half the people aged under 60 reporting this.

Examples included both direct discrimination such as verbal abuse and indirect discrimination such as the failure of services to provide information in the person's preferred language or assumptions being made on assessment.

Many, particularly older people, had low expectations of services, were uncertain whether discrimination had occurred or were reluctant to report concerns - so providers are not necessarily getting the feedback that they need to improve.

- Only 37% of providers said that they had taken specific action to address equality for black and minority ethnic people

Gypsy and Traveller Communities experience a lack of access to culturally appropriate support services for people in the most vulnerable situations, such as women experiencing domestic violence (EHRC).

Employment

- Overall black and minority ethnic people are more likely to be unemployed, irrespective of their qualifications, place of residence, sex or age. They are less likely to hold senior management positions. (Equality Review (ER))

Housing

- Black, Pakistani and Bangladeshi households are more likely to live in homes that fall below the Decent Homes Standard than white households. (Department for

Communities and Local Government)

- Although the majority of Gypsies and Irish Travellers are believed to live in conventional housing, no one is sure how many actually do, or what their particular needs might be. (Commission for Race Equality (CRE))

- Many sites are located in polluted environments, far away from local services. Pitches are often overcrowded and facilities are well below the standard expected in social housing. (CRE)

Crime and Fear of Crime

- The Police estimate that most racial hate crime is not reported because victims are too frightened or embarrassed. (HO)

Migrant Workers:

- There is anecdotal evidence from different local professionals of multiple occupancy in private rented accommodation, environmental health problems, destitution, exploitation and lack of knowledge about rights among migrants generally. These findings reflect conclusions found in research elsewhere. (Bedfordshire NHS Primary Care Trust)

1.7 Religion or Belief

Religion or Belief a Practical Guide for the NHS - Department of Health Research has highlighted differences in the health and wellbeing of different religious communities – a finding that provides an opportunity to target services. The British Muslim community, for example, has the poorest reported health, followed by the Sikh population. For both groups, as well as for Hindus, females are more likely to report ill health, whereas for Christians and Jews there is only minimal gender difference. It should be borne in mind that this is not necessarily a case of cause and effect, but more likely is compounded with other factors such as housing and economic and social status.

A lack of awareness about a person's religious or other beliefs can lead to discrimination. This is because religion can play a very important part in the daily lives of people. In addition there is often a perceived overlap between race and religion which needs to be taken into account. Discrimination can occur if specific requirements are not taken into account for example:

- Diet / fasting, e.g. some groups are vegetarian; others require animals for consumption to have been slaughtered in a particular way, e.g. Muslims and Jews.

- Dress / Jewellery

- Religious observance / prayer and festivals
- Customs and practices to be followed in the case of birth and bereavement

- Cultural stereotypes for maleness and femaleness.

For many people, belief is not merely external it is often based on a strong inward philosophy that has out workings in day to day life. For some religions (including atheism) there are not many outward signs of belief (i.e. festivals, dietary requirements etc.) Therefore there is danger of causing offence if organisations only focus on the outward, often more visible, aspects of religion and do not understand the moral constructs of the religion or belief. Such an approach can also result in an unbalanced bias towards more regimented, visible religions. Local authorities need to bear in mind that a significant proportion of the population (16% in Central Bedfordshire) may have humanist or non religious beliefs and their views should also be taken into account when addressing community cohesion, service delivery and employment.

Employment

- Only 61% of Muslim men have jobs compared to 80% of Christian men and 82% of Hindu men. (Government Equalities Office)

- There is emerging evidence that Indian and White Muslims experience employment disadvantage when compared to Indian and White Christians. (Equality Review)

Crime and Fear of Crime

- In 2006 there were 260,000 racially or religiously motivated offences (British Crime Survey)

1.8 Sexual Orientation

National research

It is estimated that 5 to 7% of the population in the UK is LGB (Stonewall). Of the UK population over State Pension Age, it is estimated that between 500,000 to 800,000 people are lesbian, gay or bisexual (Age Concern). Older LGB people are 2 ½ times more likely to live alone and 4 ½ times less likely to have no children to call upon in times of need be without informal care and support networks, making their need for appropriate social care services even more acute (Stonewall).

Research has identified that Lesbian, gay, bisexual and transgender people want:

- **To feel safe and be free from discrimination**, where services take seriously any discrimination, whether from people providing services, other people using services or from the wider community; and LGB people have choice in the way that this is handled.

- **To be valued for who they are**, where services provide an environment where LGB people know that they will be valued, have opportunities to 'come out' when they choose and receive a positive response from staff.
- **Support to live the lives that they choose**, where services enable people to have choice about their social life, leisure activities and relationships. For many people, this means support to have contact with other LGB people.

- **To live a variety of lifestyles**, where services recognise that not all LGB people are the

same and understand the aspirations and needs of each individual, ensuring they have choice and control over the support they use (Commission for Social Care Inspection).

Health - Introduction to the Department of Health briefings

Lesbian, gay, bisexual and trans (LGBT) people experience a number of health inequalities which are often unrecognised in health and social care settings. Research suggests that discrimination has a negative impact on the health of LGBT people in terms of lifestyles, mental health and other risks. Many people are reluctant to disclose their sexual orientation to their healthcare worker because they fear discrimination or poor treatment. Healthcare and other professionals commonly assume that LGBT people's health needs are the same as those of heterosexual people, unless their health needs are related to sexual health. The Briefings are intended to show that LGBT people can be younger, older, bisexual, lesbians, gay men, trans, from black and minority ethnic (BME) communities and disabled, and to dispel assumptions that they form a homogeneous group. These Briefings were commissioned as part of the work programme of the Department of Health's Sexual Orientation and Gender Identity Advisory Group. **Further Information can be found in Appendix 1 of the Equality Impact Assessment.**

1) Barriers to LGBT healthcare

1.1) Attitudes and behaviour of health and social care providers

Although homophobia and transphobia seem to have become less common, studies suggest that up to 25% of health service staff have expressed negative or homophobic attitudes. There is evidence to suggest that healthcare staff and organisations have been judgemental and unsupportive towards LGBT people who use services, and that such attitudes mean that LGBT people do not receive effective health and social care. In comparison, heterosexual people are much less likely to report adverse experiences of healthcare.

1.2) Obstacles to communication with healthcare providers

Many LGBT people fear that if they disclose their sexual orientation or gender identity status to a healthcare worker, they will receive discrimination and poorer treatment. Instead, many LGB people choose to stay 'in the closet' (ie they pretend to be heterosexual) and trans people may not access healthcare services. Research indicates that over half of gay men had not disclosed their sexual orientation to their GP even though GPs could deliver more appropriate healthcare if they knew. A number of factors influence whether or not LGB people will come out, including confidentiality of patient records, and how information is recorded and who will have access to patient records (including employers, mortgage providers and insurance companies). They also may fear lower standards of care or a negative or inappropriate response where a health problem may be attributed to their sexual orientation.

1.3) Staff knowledge and understanding of LGBT health issues

There is a lack of knowledge and awareness among NHS staff about LGBT health needs; the undergraduate medical curriculum, nursing education and the training of allied health professionals include little input about sexual orientation. GPs do not always know the questions to ask and their personal feelings may form a barrier to open discussion. Research

highlights the need for training and experiential learning opportunities (eg the use of role play).

1.4) Delayed attendance and reduced screening

The three issues identified above – attitudes, communication and knowledge – mean that LGB people delay seeking help for a health problem and are less likely to access routine health screening. This includes breast and cervical screening for women, and presenting with early signs of prostate or anal cancer for men. It also means that LGB people are less responsive to preventative healthcare messages because they think the health sector has little to offer them.

1.5) Delays in provision of care

For trans people, the biggest barriers include waiting times for surgery for gender reassignment and inappropriate general healthcare.

2) Specific healthy lifestyle issues for LGBT people

Lesbian, gay, bisexual and trans (LGBT) people are believed to lead less healthy lifestyles: they have higher levels of alcohol consumption, are more likely to smoke and more likely to misuse drugs than heterosexual people. Although there has been some controversy about these assumptions, researchers have pointed to the lack of social spaces for LGBT people apart from pubs and clubs. They suggest that LGBT people have been obliged to use the 'scene' and to fit in with a drinking culture. There is also an association between harassment in the workplace and alcohol problems for lesbian and bisexual women in comparison with heterosexual women. Some LGBT people may use alcohol and tobacco as coping mechanisms in dealing with homophobia. Homophobia may also lower self-esteem and undermine a person's ability to avoid pressures to drink or smoke.

2.1) Alcohol consumption

Lesbian and bisexual young women are at increased risk of a number of alcohol-related behaviours compared with heterosexual adolescent women. They are more likely to have used alcohol in the past month and more likely to have had episodes of binge drinking in the past year, and they report a higher average number of alcoholic drinks usually consumed when drinking. Among adult lesbian and bisexual women, abstention rates from alcohol were found to be lower, and they were more likely to report alcohol-related social consequences and alcohol dependence, and to have sought help in the past for an alcohol problem. The greatest difference in alcohol use patterns appears to be found among women in the 26–35-year-old age range. Lesbian and bisexual women were more likely to have higher levels of alcohol consumption, both in frequency and quantity. Although gay men spent more time in bars and at parties compared with other groups of men, the frequency of being in heavier drinking environments does not appear to be associated with heavier drinking. Among young gay and bisexual men, there were no differences in alcohol related behaviours in comparison with heterosexual young men

2.2) Smoking

Lesbian, gay and bisexual (LGB) people are significantly more likely to smoke than

heterosexuals. Being 35–44 years old and having lower educational attainment and low household income are associated with smoking in LGB people. Smoking increases the risk of lung cancer and other diseases, such as cervical cancer in women, and it accelerates the onset of AIDS among people living with HIV.

2.3)Substance misuse

Gay men and lesbians are more likely to have used a range of recreational drugs compared with heterosexuals. High levels of drug misuse may lead to risky sexual behaviour, including unprotected sex. Furthermore, there is evidence to suggest an increasing trend towards poly-drug use, for example poppers and Viagra, which may have significant side effects. Community surveys have found that bisexual men are as likely as gay men to use alcohol, poppers and gamma hydroxybutyrate (GHB). They are much more likely to have used all other drugs, including cannabis, acid, ecstasy, speed, cocaine and ketamine. Substance abuse is a concern among trans communities. Barriers to accessing treatment include a lack of sensitivity by service providers and gender segregation within programmes, which serves to exclude trans people.

2.4) Eating disorders (among gay men)

Gay men are more likely to engage in recurrent binge eating and purging compared with heterosexual men. Unlike heterosexual women with eating disorders (with whom they have often been compared), concern about their weight is not the biggest issue for gay men. Instead, eating disorders are more likely to be linked to aspirations to the ideal gay male body shape, which is both slim and muscular.

2.5) Obesity (among lesbians)

Lesbians are believed to be more likely to have a higher body mass index than heterosexual women. Studies have found that on average lesbians weigh more than heterosexual women and have a bigger waist circumference and waist to- hip ratio. There has been some research that suggests they may be more likely to be at risk of obesity. There is little research about lesbians' patterns of exercise or use of gyms.

2.6) Evidence and statistics

Smoking

- Young lesbian and bisexual women were almost 10 times more likely to smoke at least weekly compared with heterosexual women.
- 25% of lesbians are smokers, compared with 15% of heterosexual women.
- 33% of gay men are smokers, compared with 21% of heterosexual men.

Alcohol

- Lesbian and bisexual women aged 20–34 years reported higher weekly alcohol consumption and less abstinence compared with heterosexual women.

Substance misuse

In comparison with young heterosexual people, young LGB people are:

- three times more likely to use MDMA/ecstasy;
- eight times more likely to use ketamine; and
- 26 times more likely to use crystal methamphetamine.

2.7) Implications for service commissioners and providers

One of the core principles of the NHS Plan (published in 2002) is to challenge discrimination – including on the grounds of sexual orientation. This means that commissioners and providers should actively consider how services are delivered and how they are perceived by LGBT service users. There is evidence to suggest that tailored interventions are effective in enabling gay men to stop smoking. Steps should be taken to ensure representation of LGB people in smoking surveillance and to collect data in order to understand the high smoking rates in these groups. Alcohol and smoking prevention and cessation interventions should be targeted at LGB people. Services for gay men with eating disorders need to address their particular health concerns, rather than assuming gay men's needs are the same as those of heterosexual women. Further research is needed to identify lesbians' needs in relation to weight issues.

3) What are lesbian health needs?

Lesbian health is commonly assumed to be the same as that of heterosexual women, but recent research has suggested key differences in lesbians' health risks and health behaviours and in their experiences of healthcare. Lesbians are less likely to have children than heterosexual women and are more likely to be overweight. These factors may increase their risk of breast cancer and cardiovascular disease. Lesbians may also have less healthy lifestyles than heterosexual women. Limited opportunities for building social networks mean that some lesbians often socialise in bars and pubs. Coping mechanisms for dealing with discrimination have sometimes resulted in higher rates of alcohol use, smoking and drug misuse among lesbian and bisexual women.

4) What are gay men's health needs?

Research on gay men's health has often focused on sexual health and HIV prevention to the exclusion of their wider health needs. Gay men's health concerns include issues common to all men, such as cancers (testicular, anal and prostate) and erectile dysfunction. Gay men may have higher rates of drug, tobacco and alcohol use, which may increase their risk of lung and liver cancer. They may be more susceptible to eating disorders and have higher rates of mental health problems.

5) Bisexual People

Bisexual people's health may differ from that of lesbians and gay men and from heterosexual

people's health. Key differences have been identified in relation to mental health, sexual health and HIV, substance misuse, ease with their sexual orientation, access to healthcare and communicating with healthcare providers.

6) LGB and Ethnicity

There is a widespread assumption that being gay is a phenomenon of white people. Consequently, Black and minority ethnic (BME) lesbian, gay and bisexual (LGB) people's health needs have been almost completely overlooked in research conducted in the UK. It would be inappropriate to assume that BME LGB communities form a homogenous group; they are socially, culturally, politically, religiously and economically diverse. There are also wide-ranging differences in perceptions about what it means to be BME and LGB. However, experiences of being BME and LGB mean that one's health status and access to health services may differ from those of both BME heterosexuals and of white LGB people.

7) What are disabled LGB people's health needs?

The rights of people who are disabled to engage in everyday activities that the rest of society take for granted (for example, taking part in leisure activities, getting a job and falling in love) are severely curtailed. Their rights to sexual relationships are not widely accepted; moreover, the fact that some may wish to have a same-sex relationship is largely unconsidered. Same-sex relationships are more likely to be seen as a potential danger and rarely as a source of pleasure or fulfilment. Current practice in work with people with learning disabilities is more likely to restrict opportunities for sexual relationships rather than support people to have relationships that are satisfying. As with heterosexual relationships, there are issues about consent, mental capacity and risk. But while parents, carers and professionals are concerned about protecting disabled people from exploitation, this often means that disabled people are not empowered to lead the lives they would choose. One LGB research participant remarked that they were unable to explore their sexual orientation and were kept under parental control until they were in their fifties when their parents died. Many disabled LGB people have not received relevant sex education in schools; as adults they lack appropriate information about sexual health and do not have access to information about fertility issues. They may also encounter difficulties in accessing mental health services.

8) Mental disorder

Although the majority of LGB people do not experience poor mental health, research suggests that some LGB people are at higher risk of mental disorder, suicidal behaviour and substance misuse. Evidence indicates that the increased risk of mental disorder in LGB people is linked to experiences of discrimination.1 LGB people are more likely to report both daily and lifetime discrimination than heterosexual people. • Gay men and bisexual people are significantly more likely to say that they have been fired unfairly from their job because of discrimination.

- Lesbians are more likely to have experienced verbal and physical intimidation than heterosexual women.

- Discrimination has been shown to be linked to an increase in deliberate self-harm in LGB people.

LGB people demonstrate higher rates of anxiety and depression than heterosexuals; lesbians and bisexual women may be at more risk of substance dependency than other women.

9) Specific issues for young LGB people

Young lesbian, gay and bisexual (LGB) people can be vulnerable to a number of health risks because of people's reactions to their identity. They may also feel stigmatised; there are very few role models for young LGB people, and many conclude that society will not approve of them. Many young people know they are lesbian, gay or bisexual by the age of 11 or 12, or have feelings of being different.1 However, some do not come out to someone else until they are 15 or 16. This period (11–16 years old) has been described as the **isolation years** and is the most crucial for targeting support and information. Homophobic bullying is an increasing problem in schools; the word 'gay' is the most frequent term of abuse in playgrounds. Evidence suggests that LGB young people, and those perceived to be LGB, may be more at risk of bullying. Between 30% and 50% of young people in secondary schools attracted to people of the same sex will have directly experienced homophobic bullying, compared with 10–20% of young people who have experienced general bullying. ChildLine estimates that around 2,700 young people access their services each year to talk about sexual orientation, homophobia and homophobic bullying. The most common problems talked about were homophobic bullying and fear of telling their parents about their sexual orientation. Furthermore, young people with LGB parents sometimes experience bullying. These problems are exacerbated if an adult dismisses their sexual orientation. Some young people report that adults, including health and social care workers, try and 'solve the problem' by claiming that the young person is too young to know whether or not they are LGB.

10) What are older LGB people's health needs?

Older people are overwhelmingly perceived to be heterosexual; consequently, older lesbian, gay and bisexual (LGB) people have often been invisible in service provision for older people. Older LGB people's needs may be, in some respects, no different from those of other older people: for example, their safety and physiological needs may be addressed by physical adaptations to their home. However, other needs are often overlooked in planning care, such as opportunities for maintaining social networks. Older LGB people may have a greater need for health and social care services because, compared with their heterosexual contemporaries, they are:

- two-and-a -half times as likely to live alone;
- twice as likely to be single; and
- four-and-a-half times as likely to have no children to call upon in times of need.

One of the biggest concerns for all older people is the possibility of needing residential care. But for older LGB people, there is no dedicated accommodation in the UK. Some care staff and other residents may hold discriminatory attitudes2 towards older LGB people, which are particularly problematic when they live in close proximity. In smaller accommodation or extra care housing, an older LGB person may be the only non-heterosexual person living in the home, which may mean that they become isolated and hide their sexual orientation. The

introduction of the Civil Partnership Act 2005 gave same-sex couples similar rights to those enjoyed by heterosexual married couples; this means that same-sex couples are eligible to occupy accommodation together in extra care sheltered accommodation and in residential care homes.

11) Sexual Health

While the number of HIV diagnoses is increasing among gay men, there has not been a corresponding increase in resources dedicated to them. Despite medical advances, there is no vaccine for HIV and no cure. The development of antiretroviral drugs has increased the period without symptoms of AIDS, improved quality of life and afforded longer survival. Because HIV suppresses the immune system, the disease may increase gay men's risk of other infections, including anal cancer. Human papilloma virus was twice as common among HIV-positive men as among HIV-negative men.

12) Crime

- Police estimate that 90% of homophobic crime goes unreported because victims are too frightened or embarrassed to report the crime. (Equality Review)

- One in five lesbian and gay people have experienced a homophobic hate crime or incident in the last three years. One in eight has been a victim in the last year. (Stonewall)

- Three in four of those experiencing hate crimes or incidents did not report them to the police. Only 6% reported them to third parties. (Stonewall)

- 8% of all black and minority ethnic lesbian and gay people have experienced a physical assault as a homophobic hate incident, compared to four per cent of all lesbian and gay people. (Stonewall)

- Overall, three in five lesbian and gay people have been a victim of any crime or incident in the last three years. (Stonewall)

1.9 Other Issues

Over 2 million people become carers every year (Carers UK). Every day, another six thousand people take on a caring responsibility. 3 in 5 people will become a carer at some point in their lives. By 2026 more than 10% of the population will be over 75 and significant numbers of the workforce age 45+ will have caring responsibilities. Over 65's account for around a third of those carers providing more that 50 hours of care a week, including many who provide informal care for grandchildren. Many also look after older relatives as well (Department for Work and Pensions). Carers' contribute an extra £1 billion a year in helping to set up and run services in the community helping disabled and older people and in advising organizations and public authorities. They did this on top of the care they already provided as carers. The basic saving to the NHS, social services and other statutory bodies resulting from the work of carers starts at something in excess of £34 billion a year.

Over 1 million people experience ill health, poverty and discrimination at work and in society

because they are carers (Carers UK). 18% of carers have left a job or been unable to take one due to caring responsibilities. Among those of working age, 36% of carers were 'struggling to make ends meet'. 38% said they were 'managing on the money coming in', while 26% were 'reasonably comfortable financially'. Carers who are struggling financially are more likely to be: in poor health (34%); unqualified (21%); caring for 20+ hours per week (88%).

Health: (Carers UK)

- One in five carers report that their health suffers as a direct result of caring.
- Without proper training carers are especially prone to back problems.
- Many of the most serious health problems carers suffer from, such as heart disease or mental breakdown, are a direct result of stress.
- Caring without a break, proper sleep or support is extremely stressful.

40% of carers new to caring are not getting the right information and support to help them manage their lives (Carers UK).

Carers (local findings):

There are approximately 25,210 carers in Central Bedfordshire

- 6,302 (1 in 4) are likely to be caring for someone with a mental health problem
- 2,801 (1 in 9) are looking after someone with dementia
- 17,647 (70%) care for someone 65 or over.
- 60% of people with learning disabilities will be looked after by a family carer – 3,025 carer
- 1,797 in Central Bedfordshire currently report that they are not in good health.

There will be approximately 7,913 new carers each year in Central Bedfordshire, a total of 28,960 by 2021.

1.9.2)Health outcomes of socially excluded groups Department of Health

While significant progress has been made in delivering improvements in health outcomes across the population, meeting the needs of the small population of people with the most complex health needs remains a considerable challenge. A world-class health service needs to deliver high quality and affordable care to all, and the ambition of driving services 'from good to great' must be an ambition for all our citizens. New analysis by the Social Exclusion Task Force in the Cabinet Office and the Department of Health (DH) into the primary health care needs of socially excluded groups, highlights that these groups experience poor health

outcomes across a range of indicators including self-reported health, life expectancy and morbidity.

Socially excluded groups experience a range of poor health outcomes. For example:

- Just 30% of Irish Travellers live beyond their 60th birthday
- 85% of street sex workers report using heroin and 87% using crack cocaine
- People with learning disabilities are 58 times more likely to die prematurely than the general population
- Hepatitis B and C infection among female prisoners are 40 and 28 times higher than in the general population

Socially excluded people often make chaotic and disproportionate use of health care services, and experience a range of barriers and issues relating to their access and quality of care. For example:

- **Homeless people** each consume an estimated eight times more hospital inpatient services than an average person of similar age, and their secondary care costs around £85 million in total per year. Compared to the general public, they are 40 times more likely not to be registered with a GP and have about five times the utilisation of A&E. 81% of GPs interviewed by Crisis thought that it was more difficult for a homeless person to register than the average person.
- **Street sex workers**, who have the most acute health needs of sex workers, are more likely to be in contact with health care services than the general population. They are over five times more likely to report visiting a GP in the past year: 58% reported seeing a GP; 29% had visited A&E; 24% had been to an STI clinic; 21% to inpatient clinics; and 17% to outpatient clinics in the previous year. They are also more likely than the general population to use acute care, but are less likely to have taken up routine screening, health checks and vaccinations.

The health needs of socially excluded groups are often complex and require a sophisticated, coordinated and flexible response from services. The costs of failure are great not only to the individual life chances of socially excluded clients, but also to the taxpayer, services and the communities who pick up the pieces.

Action on health inequalities requires action across all the social determinants of health – Fair Society Health Lives The Marmot Review 2010

The Commission on Social Determinants of Health concluded that social inequalities in health arise because of inequalities in the conditions of daily life and the fundamental drivers that give rise to them: inequities in power, money and resources. These social and economic inequalities underpin the determinants of health: the range of interacting factors that shape health and well-being. These include: material circumstances, the social environment, psychosocial factors, behaviours, and biological factors. In turn, these factors are influenced by social position, itself shaped by education, occupation, income, gender, ethnicity and race.

All these influences are affected by the socio-political and cultural and social context in which they sit.

When we consider these social determinants of health, it is no mystery why there should continue to be health inequalities. Persisting inequalities across key domains provide ample explanation: inequalities in early child development and education, employment and working conditions, housing and neighbourhood conditions, standards of living, and, more generally, the freedom to participate equally in the benefits of society. A central message of this Review, therefore, is that action is required across all these social determinants of health and needs to involve all central and local government departments as well as the third and private sectors. Action taken by the Department of Health and the NHS alone will not reduce health inequalities. The unfair distribution of health and length of life provides compelling enough reason for action across all social determinants. However, there are other important reasons for taking action too. Addressing continued inequalities in early child development, in young people's educational achievement and acquisition of skills, in sustainable and healthy communities, in social and health services, and in employment and working conditions will have multiple benefits that extend beyond reductions in health inequalities.

2.2) To what extent are vulnerable groups experiencing poorer outcomes compared to the population or workforce as a whole?

2.3) Are there areas where more information may be needed?

2.4) Are there are any gaps in data or consultation findings?

2.5) What action will be taken to obtain this information?

2.6) To what extent do current procedures and working practices address the above issues and help to promote equality of opportunity?

Stage 3 – Assessing Positive & Negative Impacts	**Refer to Equality Checklist**	
	Awareness	**Accessibility**
	Take Up levels	**Staff Training Needs**
	Appropriateness	**Partnership - working**
	Adverse Outcomes	**Contracts & monitoring**

Analysis of Impacts	**Impact Yes**	**Impact No**	**Summary of impacts and reasons for this**
3.1) Age			
3.2) Disability			
3.3) Gender			
3.4)Transgender			
3.5) Race			
3.6) Religion / Belief			
3.7) Sexual Orientation			

3.8) Other e.g. *Poverty / Social Class/Deprivation, Looked After Children, Offenders, Cohesion*			

Stage 4 – Conclusions , Recommendations and Action Planning
4.1) What are the main conclusions from the assessment?
4.2) What are the priority recommendations and actions?
4.3) What changes will be made to address any adverse impacts that have been identified? **4.4) Are there any budgetary implications?**

4.5) Actions to be Taken		
Action	**Date**	**Priority (high / medium low)**
Strategy needs to highlight how the experience of discrimination and inequality can impact on access to services, well being, housing, transport, leisure, community safety and public health		
Awareness raising of issues is needed amongst staff and the voluntary sector		
Local Context of Strategy needs to highlight BME, LGBT communities		
Identify how to effectively monitor the impact of the strategy		

Stage 5 Quality Assurance & Scrutiny: Checking that all the relevant issues have been identified
5.1) What methods have been used to gain feedback on the main issues raised in the assessment? Checks have been made with:
Step 1: The Corporate Policy Advisor (Equality and Diversity) for comment and decision re further scrutiny ✓
Step 2: The Equalities Working Group
Step 3: The Equalities Forum
Other Please give details e.g. LGBT Network
5.2) Were any additional actions / amendments identified? *Please give details:* **Comments from the Equalities Forum 30/09/10:** The following issues were highlighted by Forum members:
1) The Forum queried the relevance of some of the national targets e.g. breast feeding (6 months & annual) and welcomed a move towards the adoption of more locally relevant and

flexible targets
2) Concern was expressed about whether alcohol related issues had been highlighted sufficiently
3) The Forum welcomed the extensive range of statistics included in the EIA and highlighted the need to understand and address individuals' complex needs. The value of the NHS operating framework was highlighted and it's focus on respect and dignity. There was agreement that it was hard to identify the priority issues and what activities could be ceased.
4) The need to look at LGB and transgender issues separately was highlighted.
5) The Forum expressed an interest in having further involvement in the consultation process and agreed that it would be helpful to assess the relevant action plans as part of this process
Stage 6 – Monitoring Future Impact
6.1) How will implementation of the actions be monitored?
6.2) What sort of data will be collected and how often will it be analysed?
6.3) How often will the policy be reviewed?
6.4) Who will be responsible for this?
6.5) Have the actions been incorporated in the service / business plan or team targets?