APPENDIX 2

Northumberland County Council

Equality Analysis Report

Name of Group:	Public Health Service within the Wellbeing & Community Health Group
Date of Analysis:	January 2017
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What is public health?

The UK Faculty of Public Health (2010) defines public health as '*The science and art of promoting and protecting health and wellbeing, preventing ill-health and prolonging life through the organised efforts of society*[i].

Health is influenced by many factors. Differences in health experience or health outcome arise because of differences in the conditions in which people are born, grow, live, work and age. The diagram below shows the relative influence these broad factors have on health outcomes.

To respond to this, public health practice falls into 3 broad domains:

- Health Improvement: describes the work to improve the health and wellbeing of individuals or communities and reduce inequalities through enabling and encouraging healthy lifestyle choices as well as addressing underlying issues such as poverty, lack of educational opportunities and other such areas. This domain also includes the surveillance and monitoring of specific diseases and their risk factors.

- Health Protection: ensuring the safety and quality of food, water, air and the general environment; preventing the transmission of communicable diseases (e.g. through immunisation); managing outbreaks and the other incidents which threaten the public health through robust emergency preparedness, resilience and response. It also includes programmes which aim to detect diseases early (e.g. screening programmes).

- Population Health Care Quality: consists of efforts to ensure that the health care needs of the population are being properly identified and that the clinical services being commissioned and provided to meet those needs are cost effective and of high quality. This includes processes such as Joint Strategic Needs Assessment, clinical pathway design, service specification development, clinical audit and service evaluation.

The Public Health Outcomes Framework Healthy Lives, Healthy People: Improving outcomes and supporting transparency (2013) sets out a vision for public health, desired outcomes and the indicators that will help the Department of Health understand how well public health is being improved and protected and is broken into four domains:

Domain 1: Improving the wider determinants of health, with the objective of improvements against wider factors that affect health and wellbeing, and health inequalities.

Domain 2: Health Improvement, with the objective that people are helped to live healthy lifestyles, make healthy choices and reduce health inequalities.

Domain 3: Health Protection, with the objective that the population's health is protected from major incidents and other threats, while reducing health inequalities.

Domain 4: Healthcare public health and preventing premature mortality, with the objective of reducing numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities.

Public health in Local Authorities are responsible for the following mandated functions:

- The provision of an open access sexual health service.
- Delivering the NHS Health Check Programme.
- Public health advice to Clinical Commissioning Groups (CCGs).
- Delivering the National Child Measurement Programme.
- Protecting the health of the local population.

Other commissioning responsibilities for non-prescribed services include:

- An accessible drug and alcohol treatment and recovery system
- Prevention activities to reduce drug and alcohol harm and improve resilience
- Lifestyle services to support healthy weight, healthy eating, increasing physical activity and stopping smoking.
- Wider tobacco control
- Children and young people (0-19 public health services)
- Health at work
- Public mental health

- Mandated functions for enabling dental surveys, promoting oral health and duties around fluoridation arrangements.
- Miscellaneous, which includes:
  - o Nutrition initiatives
  - o Accidents prevention
  - o General prevention
  - o Community safety, violence prevention & social exclusion
  - o Infectious disease surveillance and control
  - o Environmental hazards protection
  - o Seasonal death reduction initiatives
  - o Birth defect preventions
  - o Other public health services

Local authorities commission public health services on their populations' behalf, funded through a ring-fenced grant from the Department of Health and put improving health and wellbeing outcomes and reducing inequalities at the heart of all activity.

Public Health – Local Picture

Northumberland County Council (NCC) assumed responsibilities for improving and protecting public health in April 2013.

The key public health challenges facing Northumberland

- Health inequalities, within the county and between the county and the region/England.
- Morbidity and mortality from the main diseases affecting the population -
  - Cancers (breast, lung, bowel, prostate, skin, oral)
  - Cardiovascular disease - heart attacks, strokes, high blood pressure
  - Respiratory diseases - Chronic Obstructive Pulmonary Disease (COPD), chronic bronchitis, emphysema
  - Mental health - such as self-harm (inc dementia)
- Modifying behavioural risk factors –
  - Smoking
  - Alcohol
  - Drugs
  - Diet
  - Physical activity
  - Obesity
  - Sexual behaviour

    - ‘Appropriate use of services’ e.g. – screening, immunisation, seeking early diagnosis

- Addressing wider determinants of health –
    - Employment/income
    - Housing
    - Education
    - Physical environment
    - Productive relationships
    - Social cohesion, safety and security, including road injuries and deaths

A county-wide snapshot of the health status of the population of Northumberland produced annually by the Public Health England is presented in a health profile (Appendix A).

The Public Health Service works in tandem with the Health and Wellbeing Board (of which the DPH is a statutory member) to identify and put in place plans to improve the key priority areas which will make a fundamental difference to the health and wellbeing of those who live in Northumberland. These focus on:

- Children and families, who without some extra help and support early on, would be at risk of having poorer health, not doing as well at school, and not achieving their full potential in their lives
- Tackling some of the main causes of health problems in the County including obesity and diet, mental health and alcohol misuse
- Supporting people with long term conditions to be more independent and have full choice and control over their lives
- Making sure that all partners in Northumberland work well together and are clear about what they themselves need to do to help improve the health and wellbeing of local people
- Making sure that all public services support disabled people and those with long term health conditions to stay active for as long as possible.

The County Council employs around 11,000 staff (including school and casual staff). The Service has developed a robust programme of health initiatives to improve the health of the workforce. The concept behind this now well established programme is that as the largest employer in Northumberland, the Council, by improving the health of its workforce, will have a wider impact on the health of the rest of the community.

The Service has a Public Health Ring Fenced budget for 2016/17 of £17.075M. The Public health function, like many other services within the Council, is facing financial pressures. In 16/17, the reduction to the public health grant was £384,347 (a 2.2%

reduction). This is to be followed by a further 2.5% in 17/18, and 2.6% in 18/19 and 19/20, resulting in a reduction of £2.6m since 2015, a total reduction of 9.6%.

The majority of the budget is used to commission a range of public health services to fund the prescribed and non-prescribed services, ensuring spend is prioritised where need is greatest and tackling the key challenges for public health listed at page 5.

The services commissioned by the Public Health Service have a direct impact on equality for the people that use them.

Table 1 Key Equality Groups

Key equality impacts	Primary impact	Other key impact
Public Health	Sex, Age, Sexual Orientation, Pregnancy and Maternity	Race, Religion and Belief, Disability

Within NCC the service leads on driving health improvement locally and deploying resources to improve health and well-being in the community.

Public health has a cross-cutting agenda and the Service works across various departments within NCC to help deliver public health outcomes. Examples of collaborative work include working with:

- Children's services to improve breastfeeding rates, reducing teenage pregnancy and the development of an integrated multiagency model for 0-19 children's services;
- Adult services to improve services for people with a learning disability or mental health issues and drug and alcohol misuse;
- Public protection to promote a public health perspective in licensing and community safety activity.

Working collaboratively allows for robust needs assessments to be undertaken ensuring work is commissioned and delivered based on evidence of effectiveness and reaches those identified as being most likely to experience poor health and wellbeing.

Work is also carried out with Northumberland County Council Services on a provider and commissioner basis, such as:

- Schools team leading in the co-ordination and provision of health and wellbeing work in schools, providing universal advice and support to all schools across the county to encourage and support them to implement the standards outlined in the national healthy schools toolkit and as described in the Northumberland Healthy School Standard

guidelines.

- The Young People's Substance Misuse Service (Sorted) providing a comprehensive substance misuse service offering comprehensive assessment, individualised packages of care and interventions based on the needs of young people. The service works with young people under the age of 18 who misuse drugs and/or alcohol and who reside in Northumberland.

The Public Health Service also commissions a range of services from external providers - both large and small, based throughout Northumberland. These include relatively small providers based in the community, such as general practitioners and community pharmacists, to the larger providers, such as Northumberland Tyne and Wear NHS Foundation Trust.

Each of the commissioned services are required to provide regular monitoring reports. This allows the Public Health Service to gain an understanding of the health of our local population and to commission services where there is need, which in turn will hopefully improve the health of the local population, reduce health inequalities and allows the Service to monitor impact of commissioned services thus ensuring they are reaching the right target group and providing value for money.

Health and healthcare needs assessments led by public health consider equality and diversity within Northumberland and ensures that commissioned services are responsive to the needs of the population. The Service ensures that Equality Impact Assessments are completed when a change to any of its commissioned services is proposed. Services have been developed to meet the needs of specific groups, for example, women, drug and alcohol users, LGBT people, to encourage under-represented groups into services. All public health commissioned services provide appropriate assistance and make reasonable adjustments for service users, who do not speak, read or write English or who have communication difficulties.

The Public Health Service collects local data outlined in Table 2. Some data is collected for national reporting. This data is set at a national level it is not possible for Northumberland Public Service to influence what data is collected and therefore the data may not capture all protected characteristics.

- National Drug Treatment Monitoring System (NDTMS)
- NHS Health Check Programme
- Stop Smoking Data
- National Childhood Measurement Programme

The key Public Health functions and services, residing with the Local Authority, that are likely to be relevant to equality are outlined in Table 2.

Table 2 Key Functions & Services likely to be relevant to Equality

Integrated Drug and Alcohol Recovery Service	This service is for adults with drug and/or alcohol misuse issues in Northumberland. The service is available for all adults over the age of 18 who reside in Northumberland, or who are registered with a Northumberland GP. It also provides pharmacological interventions to young people in treatment with specialist young person's substance misuse treatment service within Northumberland. The services provided will include: open access to screening, assessment, harm minimisation, specialist treatment interventions, recovery support interventions and assessment and referral to other specialist services in line with service user need.
Exercise on Referral	To provide opportunities for people with underlying medical conditions or risk factors to become more active, in a safe and friendly environment under the guidance of qualified staff.
Local Public Health Services, which include Health Check Programme, Supervised Opioid Consumption, Needle Exchange Scheme, Long Acting Reversible Contraception, Stop Smoking Services	Health Check Programme - to identify patients at risk of developing cardiovascular disease (CVD) over the next ten years and then deliver a service for those patients. While achieving this overall aim, an underlying key objective is to ensure that NHS Health Checks are offered in such a way that the difference in uptake between GP practice populations and sub-populations within these is kept to a minimum and the gap in health inequalities is not widened. Supervised Opioid Consumption - to ensure that service users in structured community based drug treatment in Northumberland have access to supervised opioid substitute treatment from community pharmacies. Needle Exchange Scheme - to ensure that injecting drug users within Northumberland have access to needle exchange facilities.

	Long Acting Reversible Contraception (LARC) - provision of intrauterine devices/systems and implants, ensuring that women accessing contraceptive advice and treatment are given advice and access to the full range of contraceptive methods.
Other Commissioned Services, such as Health Improvement, Sexual Health Services, School Nursing, Health Visiting, Oral Health, Adult and Children Weight Management, Breastfeeding, Specialist Stop Smoking	Information relating to equality is currently not collected from other providers; however, performance will be monitored via a performance management framework. Stop Smoking Service - to ensure patients who are smokers have an accessible treatment service to help them to stop smoking. To contribute to local public health and tobacco control strategies, which have a commitment to reduce smoking and contribute to the Local Authority targets measured by the number of smokers who stop.

This analysis is part of a suite of action plans, strategies, needs assessment and other documents to improve the health and wellbeing of the population in Northumberland. It was compiled using a range of sources of data, information, intelligence and evidence including:

- Joint Strategic Needs Assessment 2013
- Public Health Service Plan 2016
- Health and Wellbeing Strategy 2014
- National Drug Treatment Misuse Service
- Public Health Outcomes Framework

PART 2 – Information Analysis

Whilst this analysis considers specific groups sharing each of the Equality Act 2010 protected characteristics in turn, it also acknowledges that people have multiple aspects to their identity and equality impacts are likely to span across different groups.

In the delivery of Public Health Services both prescribed and those that are non-prescribed and our response to local and national equalities requirements, it is important to acknowledge our aspiration to improve the health and well-being of all those who reside in Northumberland, not just those with the protected characteristics defined in the Equality Act 2010. We therefore seek to close the gap in health inequalities.

The analysis indicates which services are most significant – either because of their scale (number of users, total budget) or because of their specific focus on potentially disadvantaged groups, or their special relevance to equalities issues (for instance services specifically for one gender or because of sexual orientation); impact on particular groups (where known), what measures are in place to promote equality; what else needs to be done to promote equality or tackle any barriers; what the data gaps are and key equality issues.

2.1 Disability

2.1.1 What do we know?

Outlined below are the statistics of either the population of Northumberland or the UK of those who consider themselves to have a disability.

Baseline Information

Disability:
Physical Disability: Around 8% of adults have a moderate or severe physical disability
Wheelchair Users: Around 2% of the population are likely to be regular wheelchair users
Learning Disability: Estimated 2% of people in the population have a learning disability
Visual Impairment: around 0.5% of the Northumberland population are registered as severely sight impaired, blind, or partially sighted
Hearing Impairment: 14% of the adult UK population has hearing loss
Carers: Around 11% of the Northumberland population are carers providing unpaid support to people because of illness, disability or frailty
Employment: 48.4% of disabled people are in employment, compared with 77.5% of non-disabled people
Choice and Control: 23% of disabled people do not believe that they frequently have choice and control over their lives

Prior to commissioning a public health service a needs assessment is undertaken. The purpose of the needs assessment is to determine and address needs, or 'gaps' between current conditions and desired conditions or 'wants'.

Additionally, each year public health undertake a robust review of service specifications, which includes reviewing datasets. Disability data is not collected via these datasets, as public health services are not commissioned specifically for disabled people.

However, public health contracts state the need for providers to comply with the Equality Act 2010 and states 'Parties must not discriminate between or against Service Users, on the grounds of disability'. Therefore, it is an expectation that providers of commissioned services make adequate and reasonable adjustments, within service, to deliver an equitable service to all population groups.

To highlight an example of public health supporting health and wellbeing of those with a disability, the Public Health Service commissions a range of services for children from 0 to 19, and up to 25 years for those with special needs, living, learning, working or visiting Northumberland, regardless of disability.

The Programme (0-19) aims to:

- help parents develop and sustain a strong bond with children
- encourage care that keeps children healthy and safe
- protect children from serious disease, through screening and immunisation
- reduce childhood obesity by promoting healthy eating and physical activity
- identify health and wellbeing issues early, so support can be provided in a timely manner
- make sure children are prepared for and supported in all child care, early years and education settings and especially are supported to be 'ready for to learn at two and ready for school by five.

The provision, as outlined above, is extend to those up to 25 years for those with special educational needs and disabilities. The basic goals are to give families a greater involvement in decisions about their support and to encourage social care, education and health services to work together more closely in supporting those with special needs or disabilities.

The Equalities Act defines disability as having a physical or mental impairment which has a substantial and long-term adverse effect on a person's ability to carry out normal day-to-day activities.

In England, 2.2% of claimants in receipt of incapacity benefit in 2013 had a primary disabling condition of alcohol misuse; 1.4% of claimants had a primary disabling condition

of drug misuse. These equate to 107,760 claimants with alcohol misuse and 68,420 claimants with drug misuse. In Northumberland, 67% of people in structured drug treatment and 54% of people in structured alcohol treatment were on benefits at the end of 2011/12.

Smoking rates in the general population are at an all time low at 18% amongst women and 19% amongst men. This figure rises to 87% for smokers amongst the offender population. In January 2016, the National Offender Management Service (NOMS) supported by NHS England have engaged in a systematic roll out of a smoke free prison estate. As this roll out progresses around the country we will see that people who have been in prison, who are returning to live in Northumberland, will have been in a smoke free environment during their sentence and will have been able to avail themselves of Nicotine Replacement Therapy (NRT) and psycho-social interventions to help them manage their addiction to nicotine. This affords us an excellent opportunity to support this population in continuing to build on their efforts in addressing their nicotine dependency and enable them to continue to remain smoke free on their return to the community.

In 2016 the integrated substance misuse services were re-procured for a new contract to start in April 2017. The new service will build on the gains made by the integrated service developed between 2013-2016, particularly in relation to the developments of a dedicated alcohol service provision which has resulted in a significant increase in numbers of people accessing and being engaged in alcohol treatment with the associated improvements in treatment outcomes.

2.1.2 What are the key impacts on disabled people?

Disabled people face a range of barriers to accessing services including: physical and environmental barriers (such as poor access to buildings); communication barriers (such as poor access to BSL interpreting, accessible information, loop systems etc.); social inclusion barriers (such as poor access to public transport and community facilities); and attitudinal barriers. Disabled people have long recognised that equality will only be achieved if the focus is on the barriers that disabled people face in society, rather than on disabled people's impairments.

Disabled people have the same general health care needs as everyone else, and therefore need access to mainstream health care services. However, disabled people report seeking more health care than people without disabilities and have greater unmet needs. The World Health Organisation states, health promotion and prevention activities seldom target disabled people. For example disabled women receive less screening for breast and cervical cancer than women without disabilities. People with intellectual

impairments and diabetes are less likely to have their weight checked. Adolescents and disabled adults are more likely to be excluded from sex education programmes.

There is a need to ensure that public health commissioned services are available and accessible to everyone including those people with a range of disabilities. However, we do not hold information about whether a person has a disability; this may be held at provider level.

2.1.3 What do we have in place?

The Public Health topic leads supported by the Public Health Analytical Team, ensure that public health commissioned services are subject to a health needs assessment. This process highlights areas of need linked to specific population groups, including the nine protected characteristics. Where a need to reshape services is identified the Public Health team works with providers to address needs.

In the NCC contract with all providers, we state that 'the Parties must not discriminate between or against Service Users, on the grounds of age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion or belief, sex, sexual orientation or any other non-medical characteristics except as permitted by the Law'.

Through data collected in April 2014, via the Pharmaceutical Needs Assessment questionnaire, we know the pharmacies that have a consultation area, 86% are available with wheelchair user accessibility. As outlined in the General Pharmaceutical Committee's Standard of Conduct, Ethics and Performance (September 2010), pharmacists must not unfairly discriminate against people. They must ensure their views about a person's lifestyle, religion or belief, race, gender reassignment, identity, sex and sexual orientation, age, disability, marital status or any other factors, do not affect how they provide their professional services.

For General Practices, the Care Quality Commission (CQC) guidance should be followed, this advises that GPs should 'ensure the premises are accessible to people who need to enter the premises and meet the appropriate requirements of the Disability Discrimination Act 1995' This has since been replaced by the Equality Act 2010 The CQC carries out audits of premises.

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, states a GP should, 'take care to ensure that care and treatment is provided to service users with due regard to their age, sex, religious persuasion, sexual orientation, racial origin, cultural and linguistic background and any disability they may have'.

All specifications reference the need for providers to adhere to NCC's guidelines on Equality and Diversity. It is an expectation that providers of public health commissioned services make adequate and reasonable adjustments, within service, to deliver equity to

all population groups.

The Public Health Service also has in place:

- systems to provide appropriate BSL interpreting and information in other formats such as Braille and easy read;
- Within contracts for commissioned services, Northumberland County Council processes to report safeguarding issues are outlined;
- Performance management processes in place to monitor quality against key local and national indicators;
- Through the commissioning of sexual health services, bariatric equipment is available for use by those who require it;
- The Director of Public Health sits on the Health and Wellbeing Board and supports the key priority of preventing avoidable death and disability in adults with an emphasis on risk of heart disease and stroke;
- Public Health procured two anatomically correct life size dolls called Jack and Josephine. They were developed with help from people with learning disabilities to make sure they work with their needs, such as personal hygiene, friendships and feelings, relationships, health checks, sex rights and choices, sexual orientation and screening;
- Training for all staff on issues around disability inequality via the Council's statutory and mandatory training.
- Service changes are subject to equality impact assessment and are not anticipated to disproportionately impact on those with a disability.

2.1.4 What else do we need to do?

The Public Health Service will ensure EIAs are carried out when necessary and collated within the Public Health Service. The EIAs where possible will cover all nine protected characteristics. The Public Health Service will analyse this data to ensure needs are being met.

Public Health commissioned services will be subject to annual review, including site visits to ensure for example, compliance with policy and guidance, qualifications of staff, analysing patient and user feedback, including compliments and complaints.

We will also:

- Continue through the various groups within the Council, to engage with different groups of disabled people to ensure they continue to be involved in planning and development of services that meet their needs.
- Ensure the public health staff refresh their training on issues around disability inequality.

- Ensure all staff are aware of the systems in place to provide appropriate BSL interpreting and information in other formats such as Braille and easy read.

2.2 Sex

2.2.1 What do we know?

Sex equality means to be treated the same as others in society regardless of whether a man or woman, and to have the same opportunities. This means, the same access to services and to job opportunities at the same rate of pay (relative to experience and qualifications); to work within policies and guidelines which do not discriminate because a person is a carer or parent, man or women; and the same opportunities to develop careers and still have a family/home life.

Baseline Information (Corporate)

Gender:
Gender ratio: In Northumberland just over 51% of the population are female and just under 49% are male, which is similar to the national gender ratio.

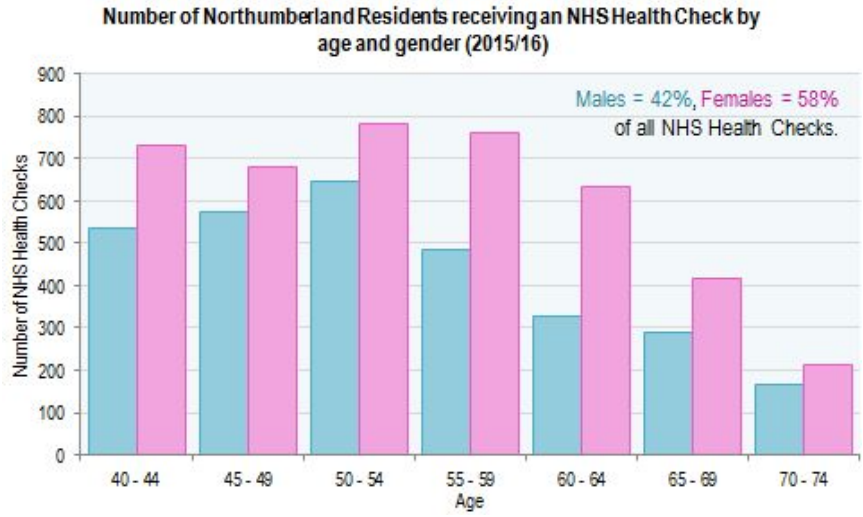
The Public Health team commissions a range of Public Health services for the population of Northumberland. A minimum data set for commissioned public health services has been established and each year a robust review of service specifications is undertaken, which includes reviewing datasets.

This includes for some of our commissioned services the collection of gender (although the majority of commissioned services are not specifically for people of a particular gender). We routinely collect gender from the following commissioned services: Health Checks, Needle Exchange Scheme, Supervised Opioid Substitute Consumption and Intermediate Stop Smoking Services. Some services, such as Long Acting Reversible Contraceptives (LARCs) and some elements of the Integrated Sexual Health Service are obviously provided for females. The Service can also access information, for example, drug prevalence in the county by gender.

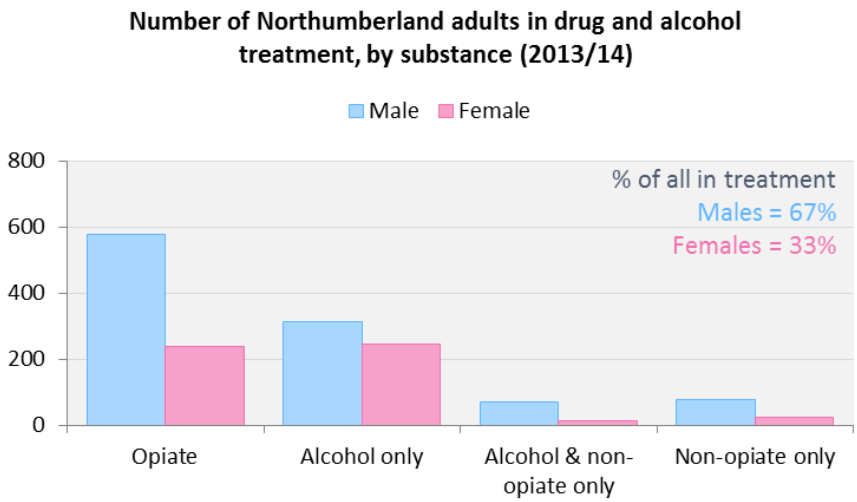
One purpose of this data collection is to gain an understanding of, for example drug prevalence in both males and females, or through a Health Check the prevalence of patients who have a high risk of developing cardiovascular disease (CVD) and whether prevalence is higher in males or females. This type of data may help support future commissioning intentions.

For example, the graph below shows the gender split of Northumberland residents attending their general practice surgery for their NHS Health Check during 2015/16.

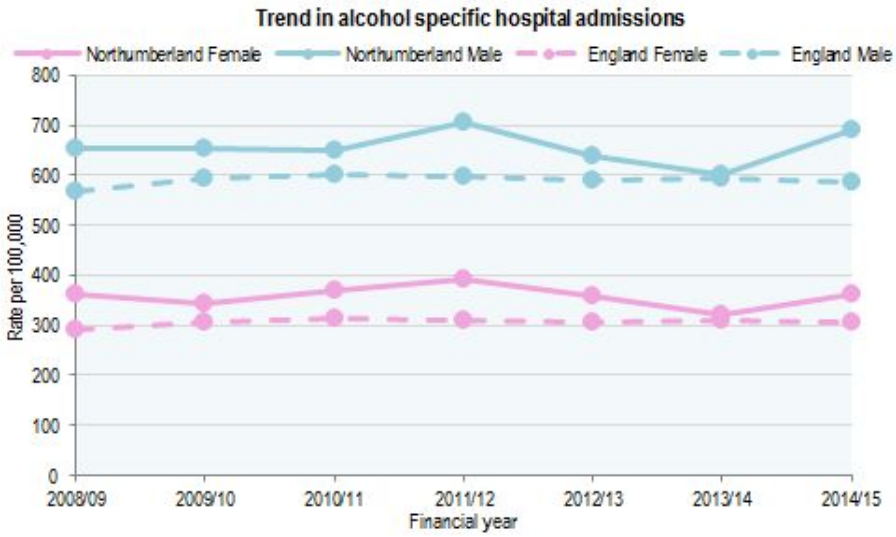
More women in Northumberland receive Health Checks than men, with women accounting for 58% of all Health Checks. This is consistent across all age groups but is particularly noticeable in those in the 55 to 64 age group: in 2015/16 nearly two-thirds of attendees were women whilst only just over a third were men. The smallest gap was in those aged 45-54 where 55% of attendees were women in 2014/15 and 45% were men.



Drug and alcohol services in Northumberland have always seen more males in treatment than females, and this is true across the country. This is reflective of the estimated prevalence of drug and alcohol misuse, with males being more likely to misuse substances than females.



There is more of a gender balance in alcohol only clients in treatment but this is not consistent with alcohol issues in the general population. Women generally drink less than men, and other data, such as the alcohol-specific hospital admission rate presented below, consistently indicate that alcohol is less of an issue in women than in men, and that the data for each gender tends to be mirrored in terms of changes up or down.



Similarly to adults, males made up 64% of the total young people's drug and alcohol treatment population in 2014/15. However, there was a different picture in those aged 13-14, where only 40% of clients were male. It is not known why this is and no further investigation has been made into this.

There is an underlying debate within the field around representation of women in drug and alcohol treatment and there are two main ideas as to why there are fewer females in treatment than males;

"…more men use drugs problematically than women, so the numbers seeking treatment are broadly proportional, or drug-using women are 'hidden' and are underrepresented in treatment, because of barriers that apply only to them[iii]*.*

In Northumberland, there are approximately 35,000 carers providing unpaid caring support (Census, 2011). Overall, carers are more likely to be women than men although amongst retired people, carers are slightly more likely to be men.

2.2.2 What are the key impacts on men and women?

There is a need to ensure that all public health commissioned services are available and accessible to everyone including those people of different sex, as both men and women benefit from most public health functions, however they may have different needs for some services, such as sexual health.

Whilst most of the public health services are equally available to both men and women, it is important to acknowledge that they may need to be promoted or provided differently to men and women in order to achieve the same outcomes. For example, there may be different motivators or drivers for a woman to stop smoking than a man. Therefore staff

within the commissioned services need to be able to be aware of this and have the skills to alter them when necessary.

2.2.3 What do we have in place?

The Public Health topic leads supported by the Public Health Analytical Team, ensure that public health commissioned services are subject to a public health needs assessment. This process highlights areas of need linked to specific population groups, including the 9 protected characteristics. Where need to reshape services is identified the Public Health Service works with providers to address needs.

In the NCC contract with all providers, we state that 'the Parties must not discriminate between or against Service Users, on the grounds of age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion or belief, sex, sexual orientation or any other non-medical characteristics except as permitted by the Law'.

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, states a GP should, 'take care to ensure that care and treatment is provided to service users with due regard to their age, sex, religious persuasion, sexual orientation, racial origin, cultural and linguistic background and any disability they may have'.

As outlined in the General Pharmaceutical Committee's Standard of Conduct, Ethics and Performance (September 2010), pharmacists must not unfairly discriminate against people. They must ensure their views about a person's lifestyle, religion or belief, race, gender reassignment, identity, sex and sexual orientation, age, disability, marital status or any other factors, do not affect how they provide their professional services.

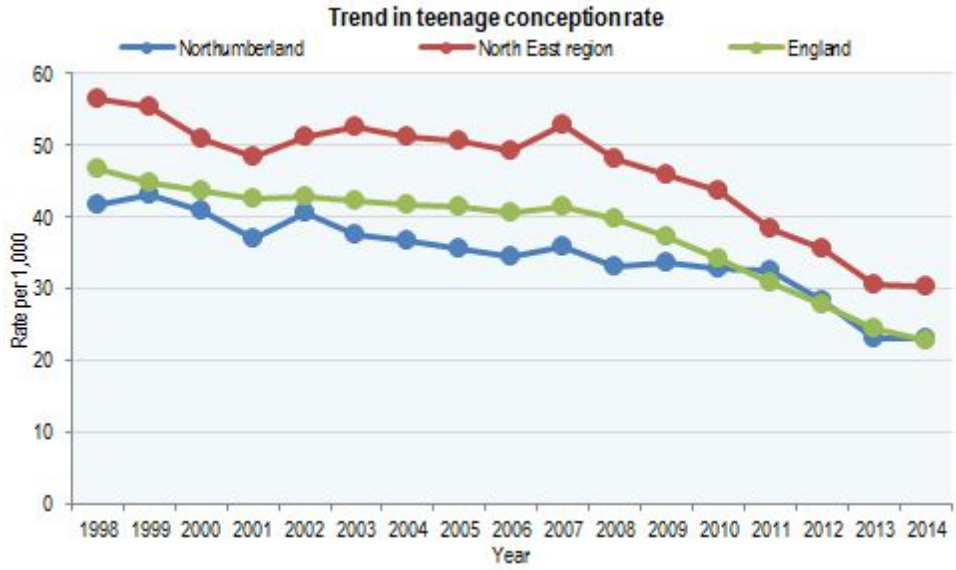
In terms of commissioning services:

All drug and alcohol services cater for both men and women with some having specific women's groups. In addition, all service users have an individually tailored care plan which will take into account any factors which may impact upon their treatment.

Long Acting Reversible Contraceptives (LARC) - It is estimated that about 30% of pregnancies are unplanned; the Public Health team commission services to increase uptake of LARC which is a more reliable contraception method. It is expected that increasing the uptake of LARC methods will reduce the numbers of unplanned pregnancies.

The under 18 conception rate in Northumberland was 23.0 per 1,000 in 2014. This shows a plateau after a number of years of continued decrease and mirrors the regional trend

(whilst the national trend continued to fall). The Northumberland rate is significantly lower than the regional average of 30.2 per 1,000 and similar to the national average.



Sexual Health Level 1 (Chlamydia Screening) via the Integrated Sexual Health Services - The purpose of this service is to ensure females within a certain age group are offered opportunistic Chlamydia and Gonorrhea screening as part of the national programme and to continue to ensure that women aged 13 years and over have equitable access to emergency hormonal contraception in a convenient location.

Breast feeding - Increasing the numbers of women who choose to initiate and sustain breastfeeding for their babies remains an important priority in improving health and reducing inequalities. It is recommended that infants are exclusively breastfed for the first six months of life. The importance of improving breastfeeding rates is recognised nationally and locally since it contributes to short and long term benefits to child and maternal health. At the end of 2015/16, 64% of new mums started breastfeeding after giving birth, but only 36% were breastfeeding 6-8 weeks after having given birth.

Others areas include:

- through a commissioned service support the work of the Health and Wellbeing team to work with schools to promote positive attitudes towards relationships which in turn generate community cohesion to reduce the likelihood of gender related harassment.
- training for all staff on equality issues, which includes gender equality.
- within the contracts of commissioned services, Northumberland County Council processes on how to report safeguarding issues are outlined.
- performance management processes in place to monitor quality against key local and national indicators.
- a range of sexual health services are commissioned for both males and females. Additionally, family support has been developed for families, with the focus on the whole family and not just the traditional focus of the new mum.

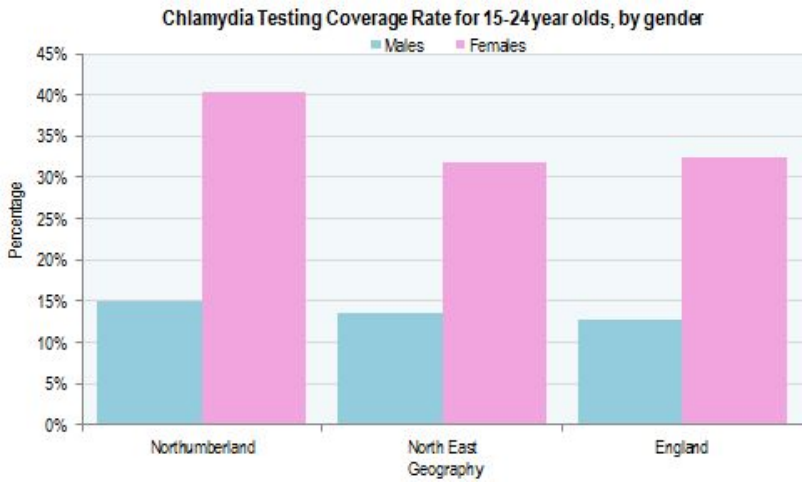
- Service changes are subject to equality impact assessment and are not anticipated to disproportionately impact on either men or women.

2.2.4 What else do we need to do?

Public Health commissioned services will be subject to annual review, including site visits to ensure for example, compliance with policy and guidance, qualifications of staff, analysing patient and user feedback, including compliments and complaints.

The Public Health Service will refresh the annual audit cycle, ensure Equality Impact Assessments (EIAs) are carried out when necessary and collated within the Public Health Service. The EIAs where possible will cover all nine protected characteristics. The Public Health Service will analyse this data to ensure needs are being met.

Chlamydia testing coverage rates in males aged 15-24 are less than half that in females of the same age. This pattern is mirrored across the country and is likely to be due to a lack of engagement with services that is common in this group. Therefore more targeted work to encourage more males for screening would be beneficial. This can be discussed with providers at regular performance meetings.



We will also ensure the public health staff refresh their training on equality issues, which includes gender equality.

We will continue to work on reducing the teenage pregnancy rates and consider working with our NHS Health Check providers to encourage more males to attend for their health check.

2.3 Race

2.3.1 What do we know?

Public Health need to take a systematic approach to removing barriers that may prevent black and minority ethnic (BME) people accessing services. These barriers include organisational processes or assumptions and the behaviour of individual staff, which may amount to either intentional or unwitting discrimination.

Baseline Information (Corporate)

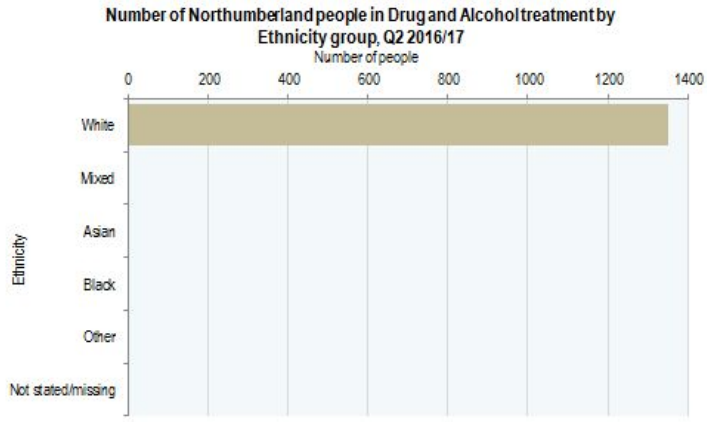
Race:
Profile: In Northumberland, 98.4% of the population described themselves as 'White'

The Public Health Service commissions a range of Public Health Services for the population of Northumberland. A minimum data set for commissioned public health services has been established and each year a robust review of service specifications is undertaken, which includes reviewing datasets.

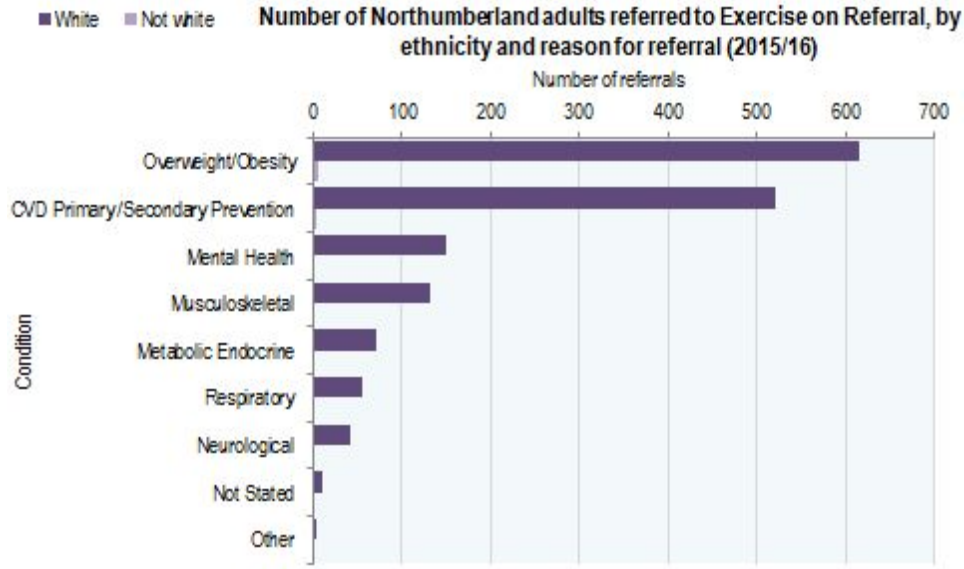
Northumberland has one of the smallest BME populations in England with only 1.6% of the population classifying themselves as not white. In contrast, 14.6% of the total population in England classify themselves as not white. Unsurprisingly, this is reflected in all the services that Public Health commissions.

Northumberland is in general a place with good community cohesion: 62% of residents say that their local area is a place where people from different ethnic backgrounds get on well together (Know Northumberland Research Summary – Northumberland Residents' Survey 2015).

The collection of ethnicity for Local Public Health Services (LPHS) occurs, although these are not commissioned specifically for people of a particular ethnicity. We routinely collect ethnicity from the following LPHS': NHS Health Check Programme, Needle Exchange Scheme, Supervised Opioid Substitute Consumption and Intermediate Stop Smoking Services and Long Acting Reversible Contraceptives (LARCs). The purpose of this data collection is to gain an understanding of, for example, the demography of service users, which may help support future commissioning intentions. For example, 99% of those in drug and alcohol treatment in 2016/17 classify themselves as white.



99% of those referred to Exercise on Referral in 2015/16 classify themselves as white (of those who agreed to provide an ethnicity).



We do not collect ethnicity data from our other providers.

We know from previous data analysis and national studies that poor sexual health amongst ethnic minorities is more prevalent than for White British people. When we commission sexual health services for the residents of Northumberland this information needs to be taken into account.

Gypsies and travellers form a minority ethnic group in Northumberland and for the first time were identified separately in the 2011 Census, 156 people identified themselves as gypsies and travellers living in the County. We know that life expectancy for Gypsy and Traveller men and women is 10 years lower than the national average and that there are inequalities in access to and experience of the healthcare system[iv].

We know that:

- Black British people are 30% more likely to rate their health as fair, poor or very poor.
- Pakistani and Bangladeshi people have the worst health of all the ethnic groups and are 50% more likely than white people to report fair, poor or very poor health [v].
- South Asian people who live in the UK are up to six times more likely to have diabetes than the white population. With the prevalence predicted to increase by 47% by 2025 (in England), the condition will continue to have a considerable impact on South Asian communities across the UK[vi].
- The premature mortality rate for stroke in England is higher for those born outside the UK than for those born within. Furthermore, stroke mortality rates are falling more slowly in minority ethnic groups than the rest of the population, widening inequalities[vii].
- Smoking rates are higher in Bangladeshi men (40%) and Pakistani men (29%) than in the general population (21%). Indian men and south Asian women are less likely to smoke. Some chew tobacco which can cause cancer and can be as addictive as smoking. If this was a particular issue for Northumberland, the Public Health Service would ensure relevant commissioned services were altered and campaigns would be promoted around the County.[viii]

2.3.2 What are the key impacts on people from different racial groups?

There is a need to ensure that commissioned services are available and accessible to everyone regardless of race. Whilst services are equally available to individuals from all ethnic groups, it is important to acknowledge that they may need to be promoted or provided differently to certain ethnic minority groups in order to achieve the same outcomes.

There may be a need to arrange access to an interpreter or to have information translated into other languages in order for BME people to make informed choices about services and support.

Certain ethnic groups, particularly Gypsies and Travellers, can face prejudice in the community. In addition, because they can move from place to place, Gypsies and Travellers' ability to access services can be limited.

Some services may need to be delivered in an alternative way, as there may be some cultural issues to take account of in relation to personal care for example.

However, it should also be acknowledged that given the race profile of Northumberland, there is likely to be a shortage of culturally appropriate services and workers available locally.

2.3.3 What do we have in place?

The Public Health topic leads supported by the Public Health Analytical Team, ensure public health commissioned services are subject to a public health needs assessment. This process highlights areas of need linked to specific population groups, including the nine protected characteristics. Where need to reshape services is identified the Public Health Service works with providers to address needs.

The NHS Health Check Programme aims to help prevent heart disease, stroke, diabetes, kidney disease and certain types of dementia. Everyone between the ages of 40 and 74, who has not already been diagnosed with one of these conditions or have certain risk factors, will be invited (once every five years) to have a check to assess their risk of heart disease, stroke, kidney disease and diabetes and will be given support and advice to help them reduce or manage that risk. Although the majority of Northumberland's population is white, the NHS Health Check Prorgramme (along with all our commissioned services) is inclusive to all residents in Northumberland and from the data outlined above, it is important those in a BME group attend for the Health Check.

In the NCC contract with all providers, we state that 'the Parties must not discriminate between or against Service Users, on the grounds of age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion or belief, sex, sexual orientation or any other non-medical characteristics except as permitted by the Law'.

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, states a GP should, 'take care to ensure that care and treatment is provided to service users with due regard to their age, sex, religious persuasion, sexual orientation, racial origin, cultural and linguistic background and any disability they may have'.

As outlined in the General Pharmaceutical Committee's Standard of Conduct, Ethics and Performance (September 2010), pharmacists must not unfairly discriminate against people. They must ensure their views about a person's lifestyle, religion or belief, race, gender reassignment, identity, sex and sexual orientation, age, disability, marital status or any other factors, do not affect how they provide their professional services.

Mechanisms are in place to provide members of the public with information translated into other languages, in line with the Council's Accessible Information Policy.

All members of staff undertake annual training on equality and diversity, which covers race equality.

A diversity of images are used in public documents to reflect different racial groups.

2.3.4 What else do we need to do?

The Public Health team will ensure EIAs are carried out when necessary and collated within the Public Health Service. The EIAs where possible will cover all nine protected characteristics. The Public Health Service will analyse this data to ensure needs are being met.

We will also ensure the public health staff refresh their training on equality issues, which includes race equality.

2.4. Sexual Orientation

2.4.1 What do we know?

HIV is associated with significant mortality, serious morbidity and high costs of treatment and care; 101,200 people were living with HIV infection (diagnosed and undiagnosed) in the UK at the end of 2015 [ix]. The infection is still frequently regarded as stigmatising and has a prolonged 'silent' period during which it often remains undiagnosed.

Anti-retroviral therapy (ART) has resulted in substantial reductions in acquired immunodeficiency syndrome (AIDS) and deaths in the UK. People diagnosed promptly with HIV who start ART early can expect near normal life expectancy. Challenges remain, with high rates of late HIV diagnosis and an ageing population.

Gay, bisexual men and other men who have sex with men (MSM)

HIV incidence (the number of new infections) among gay, bisexual and other men who have sex with men, remains consistently high; in England an estimated 2,800, gay/bisexual men acquired HIV in 2015 with the vast majority acquiring the virus within the UK. Overall in 2015, 47,000 gay/bisexual men were estimated to be living with HIV, of whom 5,800, or 12% remained undiagnosed.

Chemsex is also on the rise. The term 'Chemsex' is used in the UK to describe intentional sex under the influence of psychoactive drugs, mostly among men who have sex with men.

STIs

In England in 2015, among male Sexual Health Clinic attendees, 84% of syphilis diagnoses, 70% of gonorrhoea diagnoses, 21% of chlamydia diagnoses, 12% of genital herpes diagnoses and 9% of genital warts diagnoses were in MSM.

Baseline Information (Corporate)

Sexual Orientation:
Profile: Estimated that around 6% of the population are gay, lesbian or bi-sexual

The Public Health team commissions a range of Public Health Services for the population of Northumberland. A minimum data set for commissioned public health services has been established and each year a robust review of service specifications is undertaken, which includes reviewing datasets. However, this dataset does not specifically collect data on sexual orientation.

Research undertaken by Stonewall, found that many lesbian, gay and bisexual employees find it difficult to fully be themselves in the workplace which then impacts on their efficiency, relationships with colleagues and their confidence and motivation, which may lead to stressful situations. The stress that comes from daily battles with discrimination and stigma is a principle driver of higher rates of substance misuse, as some gay and transgender people are statistically more likely use tobacco, alcohol, and other substances as a way to cope with these challenges.

We know from research conducted by Stonewall[x] that in bisexual women :

- A quarter currently smoke
- More than three quarters (77 per cent) had a drink in the last week and over a third (37 per cent) drink three or more days a week compared to a quarter of women in general
- Two in five (41 per cent) had taken drugs in the last year, six times more likely than women in general
- More than two in five (43 per cent) had never been screened for sexually transmitted infections
- One in fourteen (seven per cent) had attempted to take their own life in the last year

There are also some significant differences among lesbians and bisexual women:

- Almost three in five (57 per cent) bisexual women have been tested for sexually transmitted infections compared to 44 per cent of lesbians

- Three in ten (29 per cent) bisexual women have deliberately harmed themselves in the last year compared to 18 per cent of lesbians

We know from research conducted by Stonewall[xi] that in bisexual men:

- Over a quarter (27 per cent) currently smoke compared to 22 per cent of men in general
- More than seven in ten (74 per cent) had a drink in the last week and four in ten drink on three or more days per week compared to 35 per cent of men in general
- Half have taken drugs in the last year compared to just 12 per cent of men in general
- More than a quarter (28 per cent) report being in 'fair' or 'bad' health compared to one in six men in general
- Five per cent have attempted to take their own life in the last year. Just 0.4 per cent of men in general attempted to take their own life in the same period
- More than one in ten (11 per cent) have harmed themselves in the last year compared to just 1 in 33 men in general who have ever harmed themselves
- Almost two in five (38 per cent) have never been tested for any sexually transmitted infection
- Half (49 per cent) have never had an HIV test
- One in three who have accessed healthcare services in the past year have had a negative experience related to their sexual orientation.
- One in four gay and bisexual men report being in fair or bad health compared to one in six men in general.
- Despite being more likely to have a normal BMI, just a quarter (25 per cent) of gay and bisexual men meet recommendations for 30 minutes or more of exercise five times or more per week compared to 39 per cent of men in general.

The drug and alcohol services which came into effect on 1 April 2013 enable the Public Health Service access to data which is collected by the services on the sexuality of clients as stated on admission, but not accessible to Public Health. This will enable the Service to assess if Northumberland services are being used fully by LGBT people.

2.4.2 What are the key impacts on people of different sexual orientations?

There is a need to ensure that public health commissioned services are available to everyone regardless of sexual orientation. However, due to the statistics outlined above, particularly attention should be paid to the following services:

- sexual health services
- mental health promotion
- stop smoking services
- drug and alcohol services

2.4.3 What do we have in place?

The Public Health topic leads supported by the Public Health Analytical Team, ensure that the public health commissioned services are subject to a health needs assessment. This process highlights areas of need linked to specific population groups, including the nine protected characteristics. Where need to reshape services is identified the Public Health Service works with providers to address needs.

In the NCC contract with all our providers, we state that 'the Parties must not discriminate between or against Service Users, on the grounds of age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion or belief, sex, sexual orientation or any other non-medical characteristics except as permitted by the Law'.

All of the public health commissioned services are subject to annual review, including site visits to ensure for example, compliance with policy and guidance, qualifications of staff, analysing patient and user feedback, including compliments and complaints.

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, states a GP should, 'take care to ensure that care and treatment is provided to service users with due regard to their age, sex, religious persuasion, sexual orientation, racial origin, cultural and linguistic background and any disability they may have'.
As outlined in the General Pharmaceutical Committee's Standard of Conduct, Ethics and Performance (September 2010), pharmacists must not unfairly discriminate against people. They must ensure their views about a person's lifestyle, religion or belief, race, gender reassignment, identity, sex and sexual orientation, age, disability, marital status or any other factors, do not affect how they provide their professional services.

There are a number of organisations which work in Northumberland to provide support to LGBT communities. In addition, all drug and alcohol service users have an individually tailored care plan which will take into account any factors which may impact upon their treatment.

A sexual health needs assessment has been undertaken, which reviewed need, mapped services in order to plan service delivery more effectively, capacity to meet current and future demands were assessed by identifying potential gaps between demand and supply of service provision. This has led to the procurement of an Integrated Sexual Health Service which will be awarded in 2016.

Men who have sex with men continue to experience high rates of STIs and remain a priority for targeted HIV and STI prevention and health promotion work. Evidence suggests that gay and bisexual men who use particular illegal drugs (as well as alcohol) are more likely to engage in risky sex. Lesbian, gay, bisexual and trans people experience a number of health inequalities that are often unrecognised in health and social care

settings. Research conducted by Stonewall indicates that a high proportion of lesbian and bisexual women, and gay and bisexual men, have never been tested for STIs. When the Public Health Service commissioned the new Integrated Sexual Health Service for the residents of Northumberland this information was taken into account.

The NCC Public Health team commissions HIV home-sampling test kits, which people can order online. The benefits of testing go beyond early treatment, having a wider public health benefit by reducing the risk of passing the virus on to other people. The team also commissions an Integrated Sexual Health Service, which includes specialist sexual health promotion targeted at men who have sex with men. The Adult Drug and Alcohol Treatment Service will offer support to those who are engaged in chemsex.

All staff undertake annual equality training which includes sexual orientation.

2.4.4 What else do we need to do?

The Public Health Service will ensure EIAs are carried out when necessary and collated within the Public Health Service. The EIAs where possible will cover all nine protected characteristics. The Public Health Service will analyse this data to ensure needs are being met.

Through commissioning arrangements with providers, we need to continue to encourage MSM, in particular, to be tested for STIs, for their own and future partner's health. We will continue to work with our Integrated Sexual Health Service provider to ensure LGBT people receive the relevant advice, treatment and service.

The exact number of LGBT people in Northumberland is unknown , however, given the statistics outlined earlier regarding higher rates of drug and alcohol use, it be could beneficial to consider promoting the maximum level of provision for needle exchange and supervised consumption of opioid substitutes.

Due to national data set constraints from the NDTMS it is not presently possible to collect information on sexual orientation of drug and alcohol users.

To continue to provide annual awareness training of staff around sexual orientation equality.

2.5. Age

2.5.1 What do we know?

Age equality is concerned with responding to differences between people that are linked to age, and with avoiding preventable inequalities between people of different age groups. Ageism, the attitudes of others, and the assumptions they make, can have a dramatic effect on people – on their quality of life, access to services and choices, employment, and other opportunities.

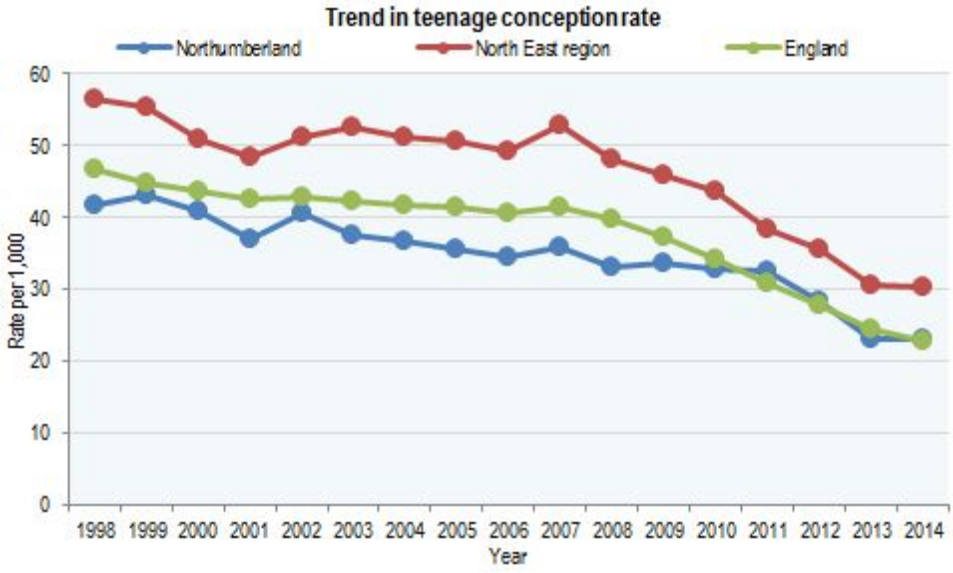
Baseline Information (Corporate)

Age:
Profile: In Northumberland, 17% are aged 0-15; 9% are aged 16-24, 46% are aged 50 or above, 23% are aged 65 or above and 3% are aged 85 or above.

The Public Health Service commissions a range of Public Health Services for the population of Northumberland. A minimum data set for commissioned public health services has been established and each year a robust review of service specifications is undertaken, which includes reviewing datasets. Age is collected for LPHS (although the commissioned services are not specifically for people of a particular age, except the NHS Health Check Programme). We routinely collect age data from the following commissioned services: Needle Exchange, Supervised Opioid Substitute Consumption and Intermediate Stop Smoking Services and Long Acting Reversible Contraceptives (LARCs).

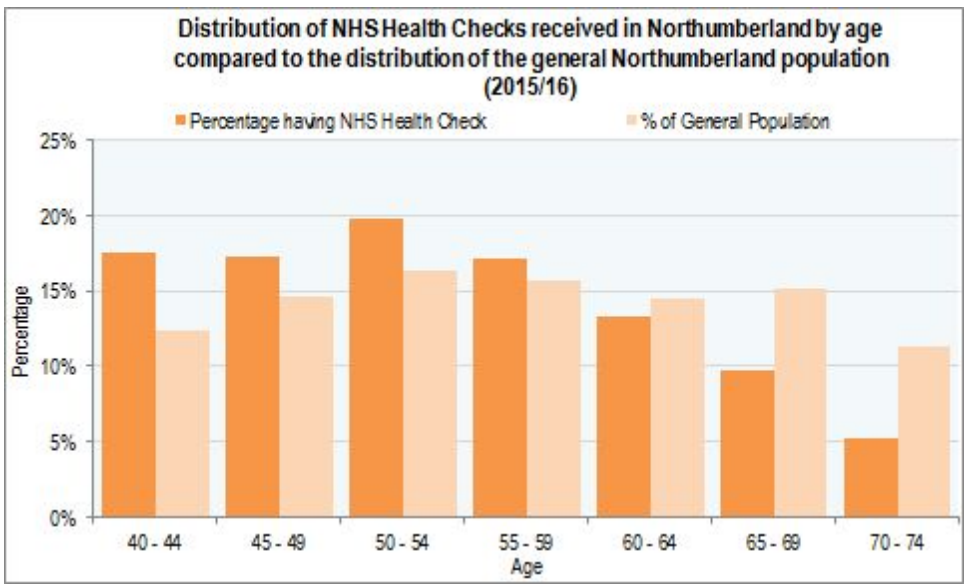
Age is not collected on all of our commissioned services due to the fact that some commissioned services are not specifically aimed at particular age groups. However, we know, over the next 20 years life expectancy will increase. The number of people in England aged 65-84 will increase by more than a third, and the number aged 85 and above will more than double.

We do targeted work with under 18-females in order to reduce the rate of teenage pregnancies. The under 18 conception rate in Northumberland was 23.0 per 1,000 in 2014. This shows a plateau after a number of years of continued decrease and mirrors the regional trend (whilst the national trend continued to fall). The Northumberland rate is significantly lower than the regional average of 30.2 per 1,000 and similar to the national average.



Health Checks are a national programme offered to people aged 40-74. The reason for this is that the programme is not deemed to be cost-effective for any other age group. The aim is to invite 20% of the target group to a Health Check every year.

The graph below compares the age of people receiving a Health Check to the age of people in the general population. From this we can see that far fewer people aged 60+ receive a Health Check, compared to those who are younger. People aged 40-74 are offered a Health Check by their GP and, as such, it may be that these offers are not distributed evenly across the age groups. However, it is also possible that uptake is poor in this older group.



The team also commissions the 0-19 Public Health Programme which supports all young people from birth to 19 years (25 years for those with a special need or disability) through

the work of the 0-19 public health workforce which includes health visitors and school nurses.

2.5.2 What are the key impacts on people of different ages?

There is a need to ensure that public health commissioned services are available and accessible to everyone including those people with different ages. From April 2013 a number of specific mandated services were transferred to Local Authorities, which are commissioned for particular age groups, such as the National Childhood Measurement Programme (NCMP) and the NHS Health Check Programme. We have access to data for NCMP from 2006, which allows us to track trends and prevalence of children who are a healthy weight, overweight or obese, which in turn helps with commissioning intentions.

The NHS Health Check Programme aims to help prevent heart disease, stroke, diabetes, kidney disease and certain types of dementia. These conditions are more likely to be present as age increases. We receive regular data on Health Checks that have been completed. This data allows us to analyse the prevalence of patients who have a high risk of developing cardiovascular disease (CVD) and whether this is due to age or other risk factors, such as alcohol intake. This type of data will help support future commissioning intentions.

In addition, the Public Health Service supports:

- A schools team leading in the co-ordination and provision of health and wellbeing work in schools, providing universal advice and support to all schools across the county to encourage and support them to implement the standards outlined in the national healthy schools toolkit and as described in the Northumberland Healthy School Standard guidelines.
- The Young People's Substance Misuse Service which provides a comprehensive substance misuse service offering assessment, individualised packages of care and interventions based on the needs of young people. The service works with young people under the age of 18 who misuse substances and who reside in Northumberland.
- Whilst the Specialist Stop Smoking Service stop smoking model is not tailored for young people, as evidence demonstrates that this is not an effective model, if young people present for support, there is a referral pathway. However, support is given to new legislation such as Smoke Free legislation, Smoke Free cars etc.

2.5.3 What do we have in place?

The Public Health topic leads supported by the Public Health Analytical Team, ensure that

public health commissioned services are subject to a health needs assessment. This process highlights areas of need linked to specific population groups, including the nine protected characteristics. Where need to reshape services is identified the Public Health Service works with providers to address needs.

In the NCC contract with all our providers, we state that 'the Parties must not discriminate between or against Service Users, on the grounds of age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion or belief, sex, sexual orientation or any other non-medical characteristics except as permitted by the Law'.

All of the public health commissioned services are subject to annual review, including site visits to ensure for example, compliance with policy and guidance, qualifications of staff, analysing patient and user feedback, including compliments and complaints.

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, states a GP should, 'take care to ensure that care and treatment is provided to service users with due regard to their age, sex, religious persuasion, sexual orientation, racial origin, cultural and linguistic background and any disability they may have'.

As outlined in the General Pharmaceutical's Committee's Standard of Conduct, Ethics and Performance (September 2010), pharmacists must not unfairly discriminate against people. They must ensure their views about a person's lifestyle, religion or belief, race, gender reassignment, identity, sex and sexual orientation, age, disability, marital status or any other factors, do not affect how they provide their professional services.

To ensure young people receive the same health services as adults do, Northumberland supports the Department of Health's You're Welcome initiative. This initiative has a set of criteria for health services – both in the community and in hospitals, must achieve to receive accreditation.
There are treatment services in place across Northumberland to cater for all age groups. There is a dedicated young people's service which is designed specifically for the under 18 population. This service operates on an outreach basis, able therefore to see the young person at a venue which suits them.

All members of staff undertake annual training on equality and diversity, which covers age equality.

2.5.4 What else do we need to do?

The Public Health Service will ensure EIAs are carried out when necessary and collated within the Public Health Service. The EIAs where possible will cover all nine protected characteristics. The Public Health Service will analyse this data to ensure needs are being

met.

The Marmot Review (2010)[xii] looked at the differences in health and well-being between social groups and described how the social gradient in health inequalities was reflected in the social gradient in for example, educational attainment, employment, income and quality of neighbourhood. A key message in the Marmot Review related to the importance of reducing health inequalities, recommending action in the following policy objectives:

- Give every child the best start in life
- Enable all children young people and adults to maximise their capabilities and have control over their lives.

With this is mind, the 0-19 Public Health Programme has the following aims:

- help parents develop and sustain a strong bond with children
- encourage care that keeps children healthy and safe
- protect children from serious disease, through screening and immunisation
- reduce childhood obesity by promoting healthy eating and physical activity
- identify health issues early, so support can be provided in a timely manner
- make sure children are prepared for and supported in all child care, early years and education settings and especially are supported to be 'ready for to learn at two and ready for school by five

The provision, as outlined above, is extend to those up to 25 years for those with special needs. The basic goals are to give families a greater involvement in decisions about their support and to encourage social care, education and health services to work together more closely in supporting those with special needs or disabilities.

We also know from analysis of historical data, that the younger population have the highest rate of poor sexual health, therefore interventions need to be sustained for this population group.
Ensure all members of staff refresh their annual training on equality and diversity, which covers age equality.

2.6 Religion and Belief

2.6.1 What do we know?

Religion means any religion and a reference to religion includes a reference to a lack of religion. Belief means any religious or philosophical belief and a reference to belief includes a reference to a lack of belief. In relation to the protected characteristic of religion or belief:

- A reference to a person who has a particular protected characteristic is a reference to a person of a particular religion or belief;
- A reference to persons who share a protected characteristic is a reference to persons who are of the same religion or belief.

Baseline Information (Corporate)

Religion and Belief:
Profile: In Northumberland, 69% of the population were classed as 'Christian'. The next highest group was 24% of people were classed as having no religion.

The Public Health Service commissions a range of Public Health Services for the population of Northumberland. A minimum data set for commissioned public health services has been established and each year a robust review of service specifications is undertaken, which includes reviewing datasets. However, this dataset does not specifically collect data on religion and belief, as the public health services are not commissioned specifically for people with particular religions or beliefs.

All specifications reference the need for providers to adhere to NCC's guidelines on Equality and Diversity. It is an expectation that providers of commissioned services make adequate and reasonable adjustments, within service, to deliver equity to all population groups.

2.6.2 What are the key impacts on people with different religions and beliefs?

There is a need to ensure that public health commissioned services are available to everyone regardless of religion and belief and that services take account of any particular factors relating to this.

For people of certain religions, specific days/times are considered to be sacred; therefore services may need to take account of timing of services offered to ensure they do not conflict with any religious requirements. However, it is considered the impact of the services commissioned with respect to this population is not significant.

There are different views towards sex and sexual health depending upon religion and belief, our providers of sexual health services understand these views and will give consideration to these views when consulting with a patient.

2.6.3 What do we have in place?

The Public Health topic leads supported by the Public Health Analytical Team, ensure that the public health commissioned services are subject to a health needs assessment. This

process highlights areas of need linked to specific population groups, including the nine protected characteristics. Where need to reshape services is identified the Public Health Service works with providers to address needs.

In the NCC contract with all our providers, we state that 'the Parties must not discriminate between or against Service Users, on the grounds of age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion or belief, sex, sexual orientation or any other non-medical characteristics except as permitted by the Law'.

All of the public health commissioned services are subject to annual review, including site visits to ensure for example, compliance with policy and guidance, qualifications of staff, analysing patient and user feedback, including compliments and complaints.

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, states a GP should, 'take care to ensure that care and treatment is provided to service users with due regard to their age, sex, religious persuasion, sexual orientation, racial origin, cultural and linguistic background and any disability they may have'.

As outlined in the General Pharmaceutical's Committee's Standard of Conduct, Ethics and Performance (September 2010), pharmacists must not unfairly discriminate against people. They must ensure their views about a person's lifestyle, religion or belief, race, gender reassignment, identity, sex and sexual orientation, age, disability, marital status or any other factors, do not affect how they provide their professional services.

Furthermore, via the Integrated Sexual Health Service, all pharmacists within Northumberland know who provides Emergency Hormone Contraception (EHC) to females, should a pharmacist because of their religion or belief, not wish to dispense EHC, they understand the need to signpost the female to another pharmacist.

There are no specific treatment groups for different religions or beliefs within the Northumberland drug and alcohol treatment system. However, all service users have an individually tailored care plan which will take into account any factors which may impact upon their treatment including religion and belief.

All members of staff undertake annual training on equality and diversity, which covers religion and belief.

2.6.4 What else do we need to do?

The Public Health Service will ensure EIAs are carried out when necessary and collated within the Public Health Service. The EIAs where possible will cover all nine protected

characteristics. The Public Health Service will analyse this data to ensure needs are being met.

Ensure all members of staff refresh their annual training on equality and diversity, which covers religion and belief.

2.7 Transgender

2.7.1 What do we know?

A person has the protected characteristic of gender reassignment if the person is proposing to undergo, is undergoing or has undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attributes of sex.

Baseline Information (Corporate)

Gender Re-assignment:
Profile: Estimated 0.009% of the population could be transgender

There is a continuing and rapid growth in the number of transgender people in the UK. Despite the introduction of supportive equalities legislation, transgender people continue to experience widespread discrimination.

People who experience severe gender variance require medical care to deal with their condition. Transition is a complex process that requires trans people to undergo many non-medical changes in the way they live and work, as well as their relationships.

The Public Health Service commissions a range of Public Health Services for the population of Northumberland. A minimum data set for commissioned public health services has been established and each year a robust review of service specifications is undertaken, which includes reviewing datasets. However, this dataset does not specifically collect data on transgender.
However all specifications reference the need for providers to adhere to NCC's guidelines on Equality and Diversity. It is an expectation that providers of commissioned services make adequate and reasonable adjustments, within service, to deliver equity to all population groups.

2.7.2 What are the key impacts on transpeople?

Gender reassignment can have major implications for mental health, with trans people more likely to experience depression and attempt suicide. Confidentiality around

someone's transgender status is important. Transgender people are often the victims of transphobic bullying and crime. Bullying that is not dealt with promptly and effectively can escalate into criminality.

There is a need to ensure that public health commissioned services are available and accessible to everyone.

The stress that comes from daily battles with discrimination and stigma is a principle driver of higher rates of substance use, as some transgender people are statistically more likely use tobacco, alcohol, and other substances as a way to cope with these challenges.

2.7.3 What do we have in place?

The Public Health topic leads supported by the Public Health Analytical Team, ensure that the public health commissioned services are subject to a health needs assessment. This process highlights areas of need linked to specific population groups, including the nine protected characteristics. Where need to reshape services is identified the Public Health Service works with providers to address needs.

In the NCC contract with all our providers, we state that 'the Parties must not discriminate between or against Service Users, on the grounds of age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion or belief, sex, sexual orientation or any other non-medical characteristics except as permitted by the Law'.

All of the public health commissioned services are subject to annual review, including site visits to ensure for example, compliance with policy and guidance, qualifications of staff, analysing patient and user feedback, including compliments and complaints.

There is no specific provision for transgender service users within Public Health Service provision. However, there are a number of organisations which work into Northumberland to provide support to transgender and LGBT communities. Drug and alcohol service users have an individually tailored care plan which will take into account any factors which may impact upon their treatment.

Training for staff which includes trans equality.

There is an LGBT Champion and LGBT Staff Network for the Council that act as a source of advice and guidance for staff and service users.

Trans and gender variant young people attend schools throughout Northumberland, and those schools recognise the need to be inclusive and to respond to the needs of every pupil. A toolkit of guidance to inform schools and colleges has been developed, so that they can support, inform, protect and enable pupils and students questioning their gender identity to achieve their full potential whilst in education. The ambition is that a consistent approach to Trans matters can be adopted throughout all Northumberland schools and colleges by increasing knowledge and confidence.

2.7.4 What else do we need to do?

The Public Health Service will ensure EIAs are carried out when necessary and collated within the Public Health Service. The EIAs where possible will cover all nine protected characteristics. The Public Health Service will analyse this data to ensure needs are being met.

The Public Health topic leads supported by the Public Health Analytical Team, ensures the public health commissioned services are subject to a public health needs assessment. This process highlights areas of need linked to specific population groups, including the nine protected characteristics. Where need to reshape services is identified the Public Health Service works with providers to address needs.

Ensure all members of staff refresh their annual training on equality and diversity, which covers transgender issues.

2.8. Pregnancy and Maternity

2.8.1 What do we know?

A woman is protected against discrimination on the grounds of pregnancy and maternity during the period of her pregnancy and any statutory maternity leave to which she is entitled. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth, and this includes treating a woman unfavourably because she is breastfeeding.

Baseline Information (Corporate)

Pregnancy and Maternity:
Profile: Estimated that around 1.3% of the population in Northumberland will be pregnant (leading to a live birth) at any one time

The Public Health Service commissions a range of Public Health Services for the population of Northumberland. A minimum data set for commissioned public health services has been established and each year a robust review of service specifications is undertaken, which includes reviewing datasets. However, the majority of datasets do not specifically collect data on pregnancy and maternity. The services that do record this data would be the Specialist Stop Smoking Services, Integrated Sexual Health Service, Drug and Alcohol Treatment Service and 0-19 public health programme. The Treatment Service ensure that each client will have an individually tailored care plan reviewed frequently throughput the time of their treatment.

All specifications reference the need for providers to adhere to NCC's guidelines on Equality and Diversity. It is an expectation that providers of public health commissioned services make adequate and reasonable adjustments, within service, to deliver equity to all population groups.

A local study of LGBT people in Northumberland (NCDN, 2012) suggested that the same sex couple may need more support around pregnancy and maternity.

2.8.2 What are the key impacts around pregnancy and maternity?

There is a need to ensure that public health commissioned services are available to expectant mothers. It is particularly relevant for Stop Smoking Services and Drug and Alcohol Service because smoking and substance misuse during pregnancy will impact on both the mothers and baby's health.

Pregnant disabled women and their partners may have particular anxieties about pregnancy, childbirth and being parents and may need extra time and support. Women with a learning disability, for example, may need information about pregnancy and parenting in other formats that explains information in a more accessible way.

Pregnant disabled women with progressive conditions such as MS or rheumatoid arthritis may fear exacerbation of their condition following birth, and women with existing mental health problems may be more prone to postnatal depression.

Disabled parents and 'teenage' parents may face particular prejudice from others in society, and assumptions are made by some about their ability to be parents.

Parents with a learning disability may face barriers to the provision of appropriate support due to negative, or stereotypical, attitudes about parents with learning difficulties on the part of staff in some services.

2.8.3 What do we have in place?

Commissioned services are subject to a process where a health needs assessment of the topic area is undertaken. This process highlights areas of need linked to specific population groups, including the nine protected characteristics. Where need to reshape services is identified the Public Health Service works with providers to address needs.

In the NCC contract with all our providers, we state that 'the Parties must not discriminate between or against Service Users, on the grounds of age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion or belief, sex, sexual orientation or any other non-medical characteristics except as permitted by the Law'.

The newly commissioned integrated drug and alcohol treatment service has included pregnant women as a priority service user group. The service specification clearly outlines the requirements for interdependencies between maternity services and treatment services.

We commission a range of services to support teenage mothers, such as supporting education, employment, housing health issues and support for breastfeeding as it appears teenage mothers are less likely to breastfeed than older mothers. This could be due to many young mothers lacking access to key sources of information and advice on breastfeeding such as antenatal classes, peer support programmes, friends, family and other social support networks, due to lack of assertiveness to access these support mechanisms. The Public Health Service commissions services to support an increase in the prevalence of breastfeeding.

There is much documented evidence that shows smoking in pregnancy is associated with increased risk of serious adverse pregnancy outcomes (such as miscarriage), and further short- and long-term health consequences for children born to smoking mothers. The North East has the highest rates of smoking in pregnancy in England. The Public Health Service commission a Specialist Stop Smoking Service, with a specific workstream to support pregnant women to stop smoking. This workstream is called BabyClear which aims to reduce exposure to the effects of smoking for unborn babies during pregnancy and work with midwives and hospital Foundation Trusts across the North East to ensure pregnant women who smoke get the best help to quit. Latest data demonstrates a 7.7% decline in smoking in pregnancy rates since the introduction of the BabyClear programme.

The young people's substance misuse service works closely with the Teenage Pregnancy Team, with young people being co-worked if appropriate.

Public Health participates in a range of awareness raising activities in support of Foetal Alcohol Spectrum Disorder (FASD) Awareness Day across the County and has recently commissioned training for front line staff in FASD.

There is a specialist midwife who works across the county, who links closely with children's services, drug and alcohol services and with obstetrics. There is a monthly meeting where all agencies attend, with sharing of information and concerns, and clarity of birth plans and referrals. Cases are all those who are using drugs and alcohol during pregnancy with immediate access to services.

Maternal obesity increases health risk for both the mother and child during and after pregnancy. Statistics on the prevalence is not routinely collected in the UK, but trend data from 1997-2010 shows an increase. To that end public health commissions the delivery of brief intervention training sessions to professionals supporting adults who are overweight or obese, which includes information on maternal obesity.

Ensure all members of staff undertake their annual training on equality and diversity, which covers pregnancy and maternity.

2.8.4 What else do we need to do?

The Public Health Service will ensure EIAs are carried out when necessary and collated within the Public Health Service. The EIAs where possible will cover all nine protected characteristics. The Public Health Service will analyse this data to ensure needs are being met.

The Public Health topic leads supported by the Public Health Analytical Team, ensure that public health commissioned services are subject to a public health needs assessment. This process highlights areas of need linked to specific population groups, including the 9 protected characteristics. Where need to reshape services is identified the Public Health Service works with providers to address needs.

Ensure all members of staff refresh their annual training on equality and diversity, which covers pregnancy and maternity.

A local approach to improve wellbeing through increased reliance for 0-19s is being led by public health.

2.9 Addressing the data gaps

Some datasets, outlined below, are reported nationally, which the Public Health Service either reports or can access; however, it is not possible to influence what data is collected.

- National Drug Treatment Monitoring System (NDTMS)
- Health Checks
- Stop Smoking Data
- National Childhood Measurement Programme

Data on specific protected characteristics is collected through some of the public health commissioned services. The minimum dataset was agreed in October 2012 and is reviewed on an annual basis. However we do collect data on all nine of the protected characteristics. The main gaps are around disability, sexual orientation, religion and belief and transgender.

2.10 Key equality issues

Priority equality objectives for Public Health

It is clear from this equality analysis that the Public Health Service has a number of potential impacts, both positive and negative, on all of the protected equality groups both specifically and collectively. It is very important, that when assessing the likely and actual impact of our services that we recognise that the protected groups are disproportionately characterised by socio-economic disadvantage, which then impacts on health inequalities.

The Public Health Service will through commissioned services and providing expert public health advice, work to reduce health inequalities in Northumberland. To support this they will:

- continue to monitor equality and diversity issues
- continue to review Public Health data to inform group analysis
- continue to undertake health needs assessment
- refresh the annual audit cycle
- ensure EIAs are carried out when necessary
- ensure our commissioned services are accessible by all the county's residents

PART 3 – Equality Objectives

Objective	How?	By Who?	By When?	Measure of Success?	Protected Characteristic							
					Human Rights							
					Disability	Sex	Race	Sexual orientation	Age	Religion/ or belief	Trans-gender	Pregnancy & Maternity
Ensure all commissioned services consider equality and diversity issues	Continue to undertake robust commissioning processes, including conducting public health needs assessments. Identify gaps in equality monitoring data. Ensure equality impact assessments are undertaken to support all procurement activities. Monitor information received via the various performance management frameworks for all public health commissioned services, incorporating	Public Health	Ongoing	Annual public health needs assessment completed. Updated performance management framework(s) Equality Impact Assessments completed. Performance management framework adhered to.								

	equality and diversity issues. Review information received via audits			Review of information received.								
Review Public Health data for commissioned services to inform group analysis for 2017	To review the group analysis and implement actions to address gaps.	Public Health	Summer 2017	Action plan developed and nominated leads identified								
Ensure that EIA's are carried out for all budget decisions	EIA to accompany budget report	Public Health	When required	Completed EIA for budget changes								

Appendix A

Public Health England

Protecting and improving the nation's health

Northumberland

Unitary Authority

This profile was published on 6 September 2016

Health Profile 2016

Health in summary
The health of people in Northumberland is varied compared with the England average. About 18% (9,300) of children live in low income families. Life expectancy for women is lower than the England average.

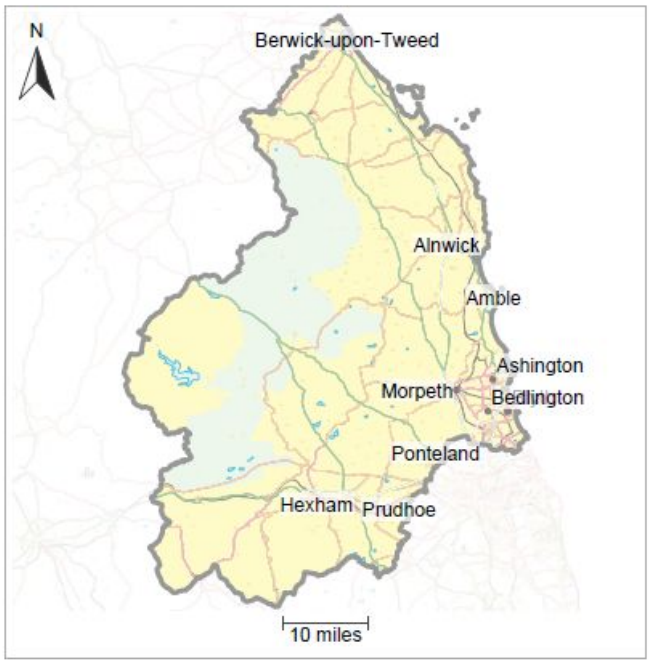
Health inequalities
Life expectancy is 9.3 years lower for men and 7.3 years lower for women in the most deprived areas of Northumberland than in the least deprived areas.

Child health
In Year 6, 19.8% (607) of children are classified as obese. The rate of alcohol-specific hospital stays among those under 18 was 56.8*, worse than the average for England. This represents 34 stays per year. Levels of breastfeeding initiation and smoking at time of delivery are worse than the England average.

Adult health
The rate of alcohol-related harm hospital stays is 822*, worse than the average for England. This represents 2,695 stays per year. The rate of self-harm hospital stays is 264.3*, worse than the average for England. This represents 762 stays per year. The rate of smoking related deaths is 300*, worse than the average for England. This represents 627 deaths per year. Estimated levels of adult excess weight are worse than the England average. The rate of people killed and seriously injured on roads is worse than average. Rates of sexually transmitted infections and TB are better than average. The rate of long term unemployment is worse than average. Rates of statutory homelessness, violent crime, excess winter deaths and early deaths from cardiovascular diseases are better than average.

Local priorities
In Northumberland the aim is to achieve resilient, flourishing communities who have high levels of wellbeing, across the county. Priorities include giving every child the best start in life, developing community wellbeing and resilience, addressing the social determinants of health, and facilitating healthy lifestyles. For more information see www.northumberland.gov.uk

* rate per 100,000 population



Population: 316,000
Mid-2014 population estimate. Source: Office for National Statistics.

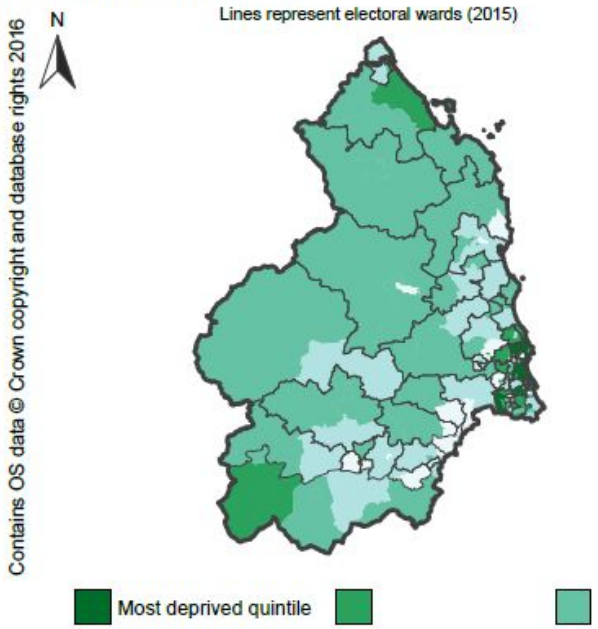
This profile gives a picture of people's health in Northumberland. It is designed to help local government and health services understand their community's needs, so that they can work together to improve people's health and reduce health inequalities.

Visit www.healthprofiles.info for more profiles, more information and interactive maps and tools.

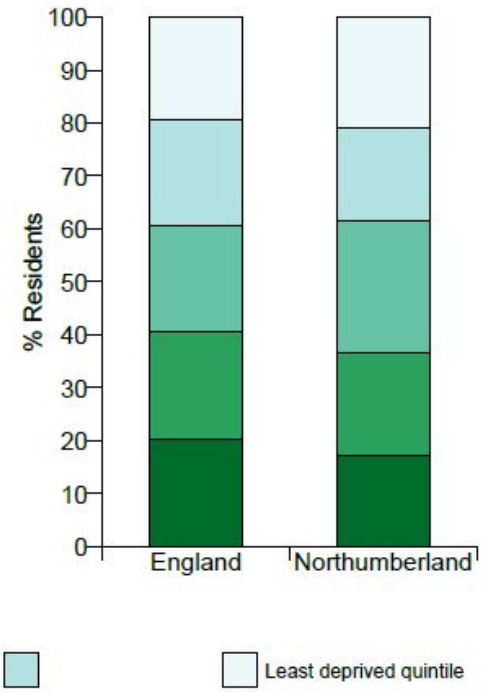
Follow @PHE_uk on Twitter

Deprivation: a national view

The map shows differences in deprivation in this area based on national comparisons, using quintiles (fifths) of the Index of Multiple Deprivation 2015 (IMD2015), shown by lower super output area. The darkest coloured areas are some of the most deprived neighbourhoods in England.



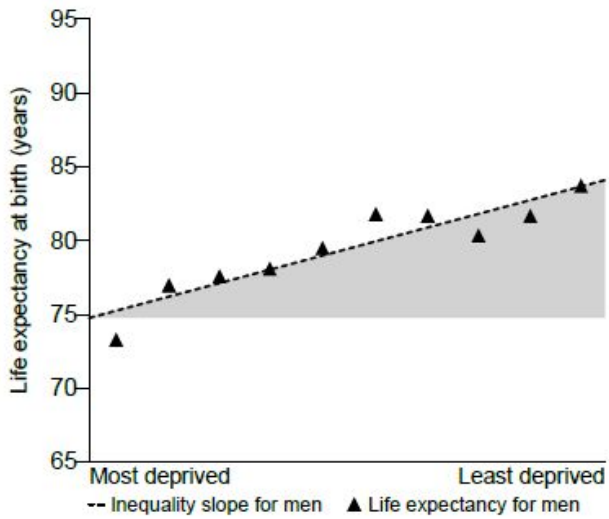
This chart shows the percentage of the population who live in areas at each level of deprivation.



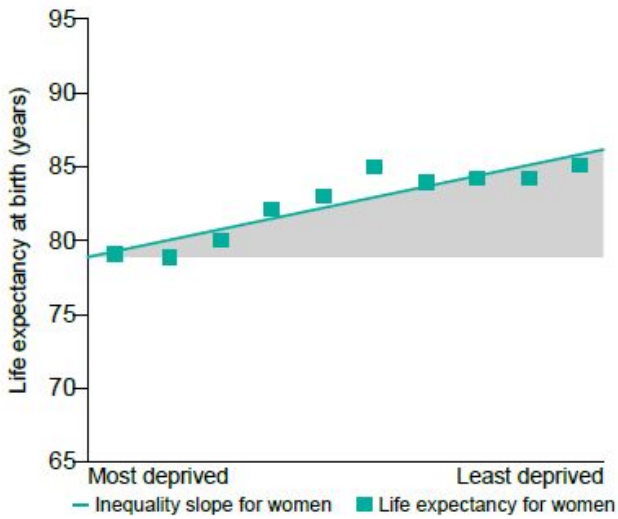
Life expectancy: inequalities in this local authority

The charts below show life expectancy for men and women in this local authority for 2012-2014. Each chart is divided into deciles (tenths) by deprivation (IMD2010), from the most deprived decile on the left of the chart to the least deprived decile on the right. The steepness of the slope represents the inequality in life expectancy that is related to deprivation in this local area. If there was no inequality in life expectancy as a result of deprivation, the line would be horizontal.

Life expectancy gap for men: 9.3 years



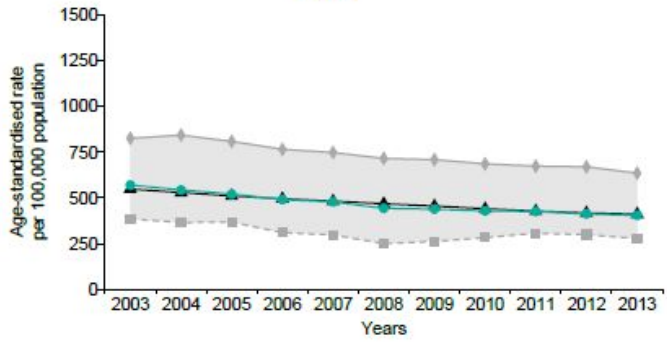
Life expectancy gap for women: 7.3 years



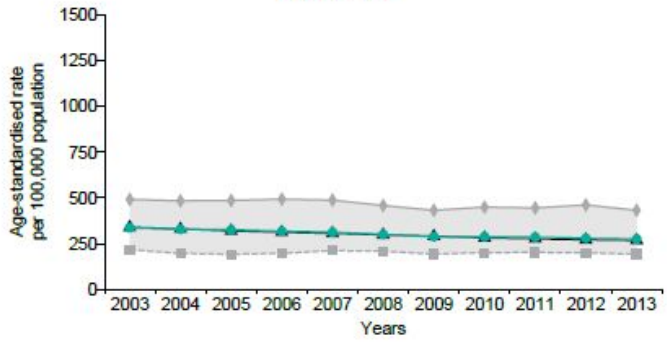
Health inequalities: changes over time

These charts provide a comparison of the changes in early death rates (in people under 75) between this area and all of England. Early deaths from all causes also show the differences between the most and least deprived quintile (IMD2010) in this area. (Data points are the midpoints of 3 year averages of annual rates, for example 2005 represents the period 2004 to 2006).

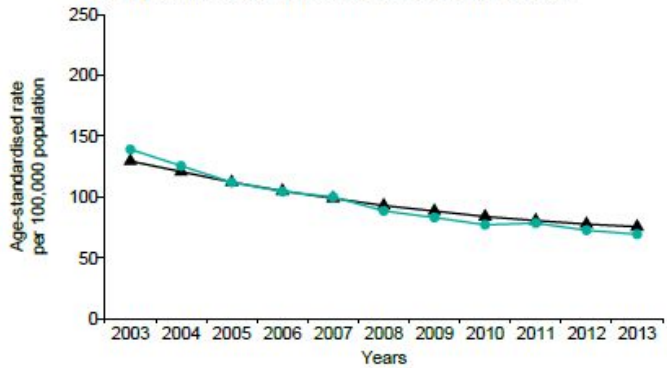
Early deaths from all causes: MEN



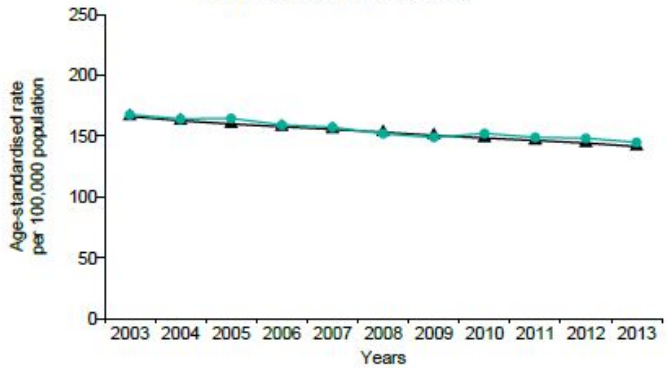
Early deaths from all causes: WOMEN

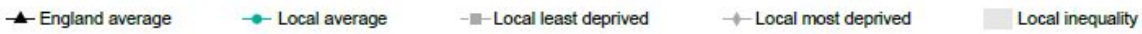


Early deaths from heart disease and stroke



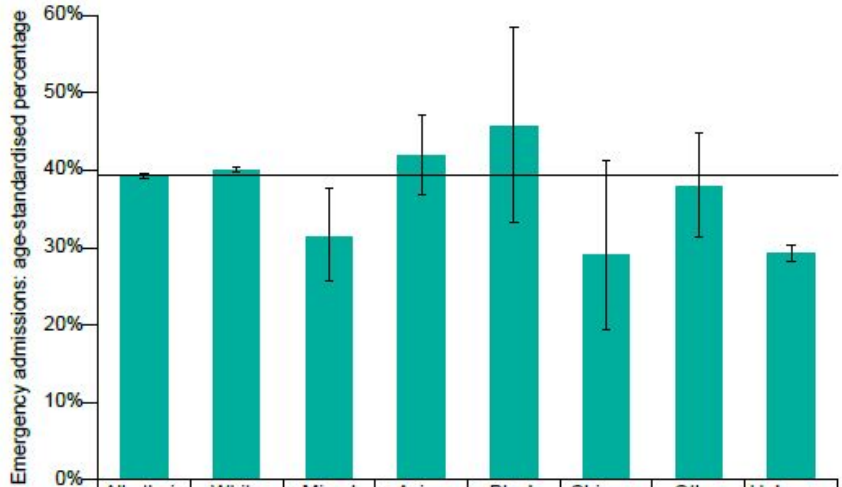
Early deaths from cancer





Health inequalities: ethnicity

Percentage of hospital admissions that were emergencies, by ethnic group, 2014/15



This chart shows the percentage of hospital admissions for each ethnic group that were emergencies, rather than planned. A higher percentage of emergency admissions may be caused by higher levels of urgent need for hospital services or lower use of services in the community. Comparing percentages for each ethnic group may help identify inequalities.

Northumberland

95% confidence interval

England average (all ethnic groups)

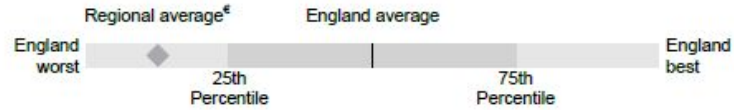
Figures based on small numbers of admissions have been suppressed to avoid any potential disclosure of information about individuals.

All ethnic groups	White	Mixed	Asian	Black	Chinese	Other	Unknown	
38,991	36,582	80	150	24	18	75	2,062	Local number of emergency admissions
39.2	40.0	31.5	41.9	45.6	29.4	37.8	29.2	Local value %
39.4	39.9	38.8	44.0	43.1	35.9	44.9	30.9	England value %

Health summary for Northumberland

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average
- Not compared



Domain		Indicator	Period	Local No total count	Local value	Eng value	Eng worst	England Range	Eng best
Our communities	1	Deprivation score (IMD 2015) #	2015	n/a	20.5	21.8	42.0		5.0
	2	Children in low income families (under 16s)	2013	9,265	17.7	18.6	34.4		5.9
	3	Statutory homelessness†	2014/15	70	0.5	0.9	7.5		0.1
	4	GCSEs achieved†	2014/15	1,909	56.8	57.3	41.5		76.4
	5	Violent crime (violence offences)	2014/15	1,897	6.0	13.5	31.7		3.4
	6	Long term unemployment	2015	1,378	7.2	4.6	15.7		0.5
Children's and young people's health	7	Smoking status at time of delivery	2014/15	381	14.2	11.4	27.2		2.1
	8	Breastfeeding initiation	2014/15	1,798	67.2	74.3	47.2		92.9
	9	Obese children (Year 6)	2014/15	607	19.8	19.1	27.8		9.2
	10	Alcohol-specific hospital stays (under 18)	2012/13 - 14/15	103	56.8	36.6	104.4		10.2
	11	Under 18 conceptions	2014	121	23.0	22.8	43.0		5.2
Adults' health and lifestyle	12	Smoking prevalence in adults†	2015	n/a	16.6	16.9	32.3		7.5
	13	Percentage of physically active adults	2015	n/a	55.2	57.0	44.8		69.8
	14	Excess weight in adults	2012 - 14	n/a	69.5	64.6	74.8		46.0
Disease and poor health	15	Cancer diagnosed at early stage #	2014	912	55.5	50.7	36.3		67.2
	16	Hospital stays for self-harm	2014/15	762	264.3	191.4	629.9		58.9
	17	Hospital stays for alcohol-related harm	2014/15	2,695	822	641	1223		374
	18	Recorded diabetes	2014/15	19,392	7.3	6.4	9.2		3.3
	19	Incidence of TB	2012 - 14	27	2.8	13.5	100.0		0.0
	20	New sexually transmitted infections (STI)	2015	1,031	526	815	3263		191
	21	Hip fractures in people aged 65 and over	2014/15	394	539	571	745		361
Life expectancy and causes of death	22	Life expectancy at birth (Male)	2012 - 14	n/a	79.4	79.5	74.7		83.3
	23	Life expectancy at birth (Female)	2012 - 14	n/a	82.5	83.2	79.8		86.7
	24	Infant mortality†	2012 - 14	27	3.1	4.0	7.2		0.6
	25	Killed and seriously injured on roads	2012 - 14	462	48.8	39.3	119.4		9.9
	26	Suicide rate†	2012 - 14	111	13.3	10.0			
	27	Deaths from drug misuse #	2012 - 14	35	4.0	3.4			
	28	Smoking related deaths	2012 - 14	1,881	300.3	274.8	458.1		152.9
	29	Under 75 mortality rate: cardiovascular	2012 - 14	669	69.5	75.7	135.0		39.3
	30	Under 75 mortality rate: cancer	2012 - 14	1,407	144.9	141.5	195.6		102.9
	31	Excess winter deaths	Aug 2011 - Jul 2014	226	6.9	15.6	31.0		2.3

Indicator notes

1 Index of Multiple Deprivation (IMD) 2015 2 % children (under 16) in low income families 3 Eligible homeless people not in priority need, crude rate per 1,000 households 4 5 A*-C including English & Maths, % pupils at end of key stage 4 resident in local authority 5 Recorded violence against the person crimes, crude rate per 1,000 population 6 Crude rate per 1,000 population aged 16-64 7 % of women who smoke at time of delivery 8 % of all mothers who breastfeed their babies in the first 48hrs after delivery 9 % school children in Year 6 (age 10-11) 10 Persons under 18 admitted to hospital due to alcohol-specific conditions, crude rate per 100,000 population 11 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 12 Current smokers, Annual Population Survey (APS) 13 % adults achieving at least 150 mins physical activity per week 14 % adults classified as overweight or obese, Active People Survey 15 Experimental statistics - % of cancers diagnosed at stage 1 or 2 16 Directly age sex standardised rate per 100,000 population 17 The number of admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause (narrow definition), directly age standardised rate per 100,000 population 18 % people on GP registers with a recorded diagnosis of diabetes 19 Crude rate per 100,000 population 20 All new diagnoses (excluding Chlamydia under age 25), crude rate per 100,000 population 21 Directly age and sex standardised rate of emergency admissions, per 100,000 population aged 65 and over 22, 23 The average number of years a person would expect to live based on contemporary mortality rates 24 Rate of deaths in infants aged <1 year per 1,000 live births 25 Rate per 100,000 population 26 Directly age standardised mortality rate from suicide and injury of undetermined intent per 100,000 population (aged 10+) 27 Directly age standardised rate per 100,000 population 28 Directly age standardised rate per 100,000 population aged 35 and over 29 Directly age standardised rate per 100,000 population aged under 75 30 Directly age standardised rate per 100,000 population aged under 75 31 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths (three years)

† Indicator has had methodological changes so is not directly comparable with previously released values. € "Regional" refers to the former government regions.
# New indicator for Health Profiles 2016.

More information is available at www.healthprofiles.info and http://fingertips.phe.org.uk/profile/health-profiles Please send any enquiries to healthprofiles@phe.gov.uk

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