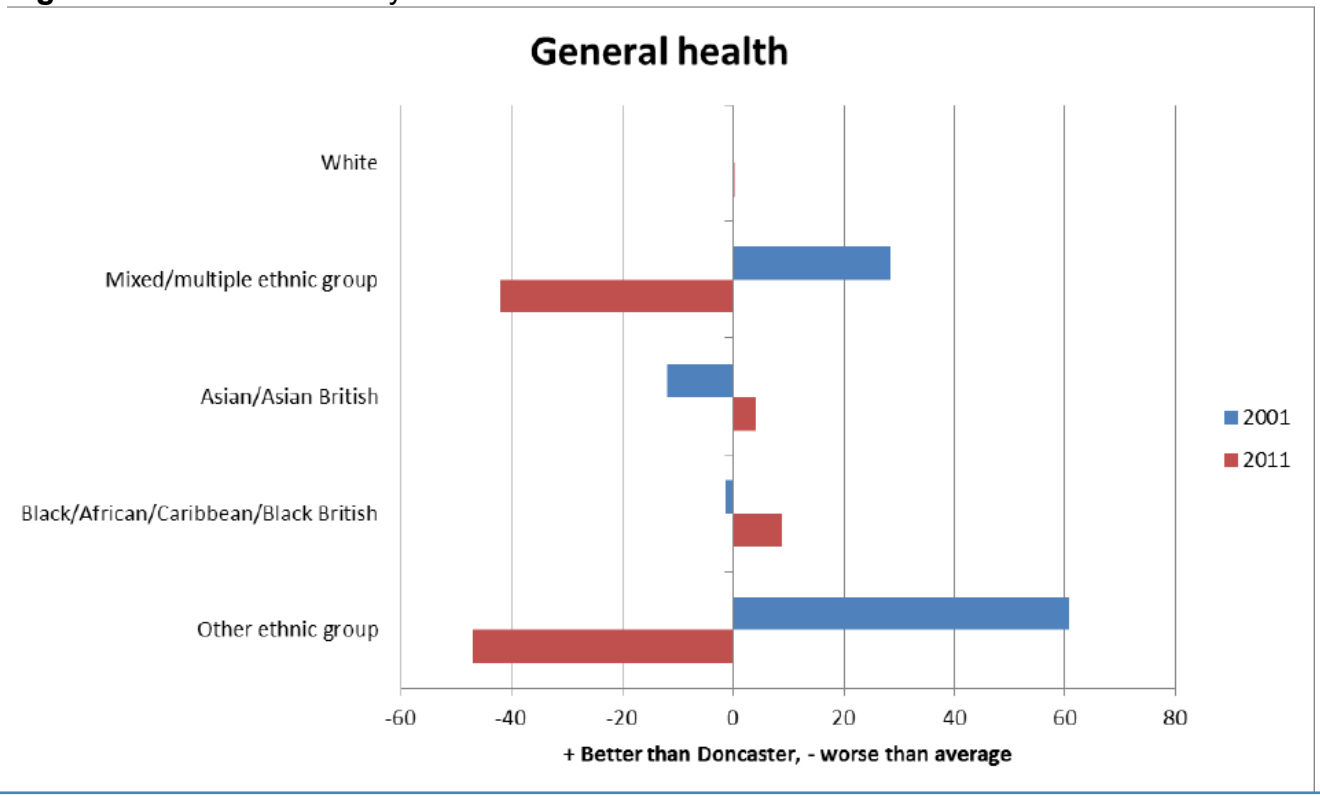
Appendix 2. Due Regard Statements on the proposed public health services covered in the commissioning strategy

1	**Name of the 'policy' and briefly describe the activity being considered including aims and expected outcomes. This will help to determine how relevant the 'policy' is to equality.**	**Public Health Commissioning Strategy.** The aim of this strategy is to contribute to improving and protecting health; and reducing health inequalities. The commissioning of the public health services is guided by the Public Health Outcomes Framework, the local joint strategic needs assessment and the joint health and wellbeing strategy, as well as individual service reviews. The general health of the people of Doncaster, according to different ethnicities, is shown in Figure 1, based on data from Census 2001 and 2011. **Figure 1:** General health by ethnicities in Doncaster at 2001 and 2011 national census 

		The public health services covered in this strategy are: (1) 0-5 services, (2) infection prevention and control service, (3) smoking, and (4) healthy living for BME women. **(a) 0-5 Services** Giving every child the best start in life is crucial to reducing health inequalities across the life course. The foundations for virtually every aspect of human development - physical, intellectual and emotional – are set in place during pregnancy and in early childhood. All families with a child aged 0-5 years and all pregnant women currently resident in the local authority area must be offered the Healthy Child Programme via 5 mandated universal checks and assessments (see paragraphs 11-13 for details). The Healthy Child Programme promotes child development and aims to improve child health outcomes Smoking remains the leading cause of preventable death and disease in England. Smoking in pregnancy is a major contributor to higher infant mortality in the routine and manual socio-economic group. Doncaster has chosen to incorporate smoking cessation services for pregnant and post natal women into the 0-5 Healthy Child pathway. This integrated model sees specialist stop smoking advisors sitting alongside and working with Health Visiting teams. **(b) Infection Prevention and Control Service** For the citizens of Doncaster, the Infection Prevention and Control Service means that the health of our residents in care homes are protected from infections by ensuring that there is appropriate service in place for preventing infections, and where there are any infections these are promptly controlled. The service will achieve the following key outcomes for the people of Doncaster: • Reduced incidence of bloodstream infections from bacteria called Methicillin Resistance Staphylococcus Aureus (MRSA); • Reduced incidence of Clostridium Difficile Infection (CDI); • Reduced number of outbreaks of infectious disease in health and social care settings in

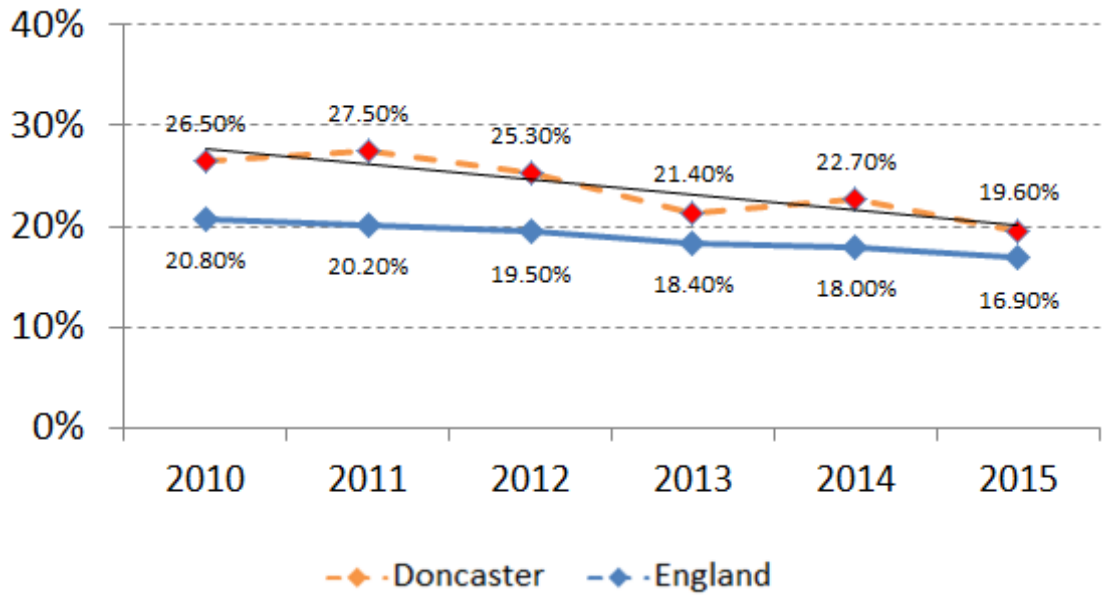
the community (care homes);

- Better training & education, audit, surveillance (e.g. CDI, MRSA) in the community including care homes.

(c) Doncaster Smoke-free services

Smoking prevalence has reduced steady in the past years in Doncaster, with the same pattern as seen in England (Figure 2). The average national prevalence of smoking is 16.9%, whereas Doncaster prevalence of smoking is 19.6%. Smoking related mortality is also higher in Doncaster than the national average. An effective Doncaster smoke free service will reduce smoking prevalence and decrease smoking related mortality.

Figure 2: Smoking Prevalence among adults aged 18 years and older in Doncaster compared to England: 2010-2015



		Smoking prevalence among pregnant women in Doncaster is one of the highest in the nation. Earlier trends show a decline in the percentage of pregnant women who smoke. However, the decline has been very modest. Currently, the percentage of pregnant women who smoke in England is 11.4 while the percentage in Doncaster is 20.5. **(d) Healthy Living for BME Women in Doncaster** BME Women experience poor health inequalities and often excluded from services that seem alien and intimidating due to: unfamiliarity; cultural and religious reasons; language barriers; and little knowledge of the service provision available. This service aims to reduce language barriers and provide support to the women in accessing the appropriate health services; improving both health and well-being.
2	**Service area responsible for completing this statement.**	Public Health
3	**Summary of the information considered across the protected groups.** **Service users/residents**	The needs information was taken from the Equality analysis for Public Health England's Healthy Lives, Healthy People; transparency in Outcomes. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216164/dh_132374.pdf There is some evidence of public health areas where equality of outcome, access and experience needs attention. There is also evidence of demographic and cultural issues that can lead to a lack of equality if they are not addressed. These data underline the importance of the policy intention of reducing variability in quality and outcomes. The key evidence is set out below:

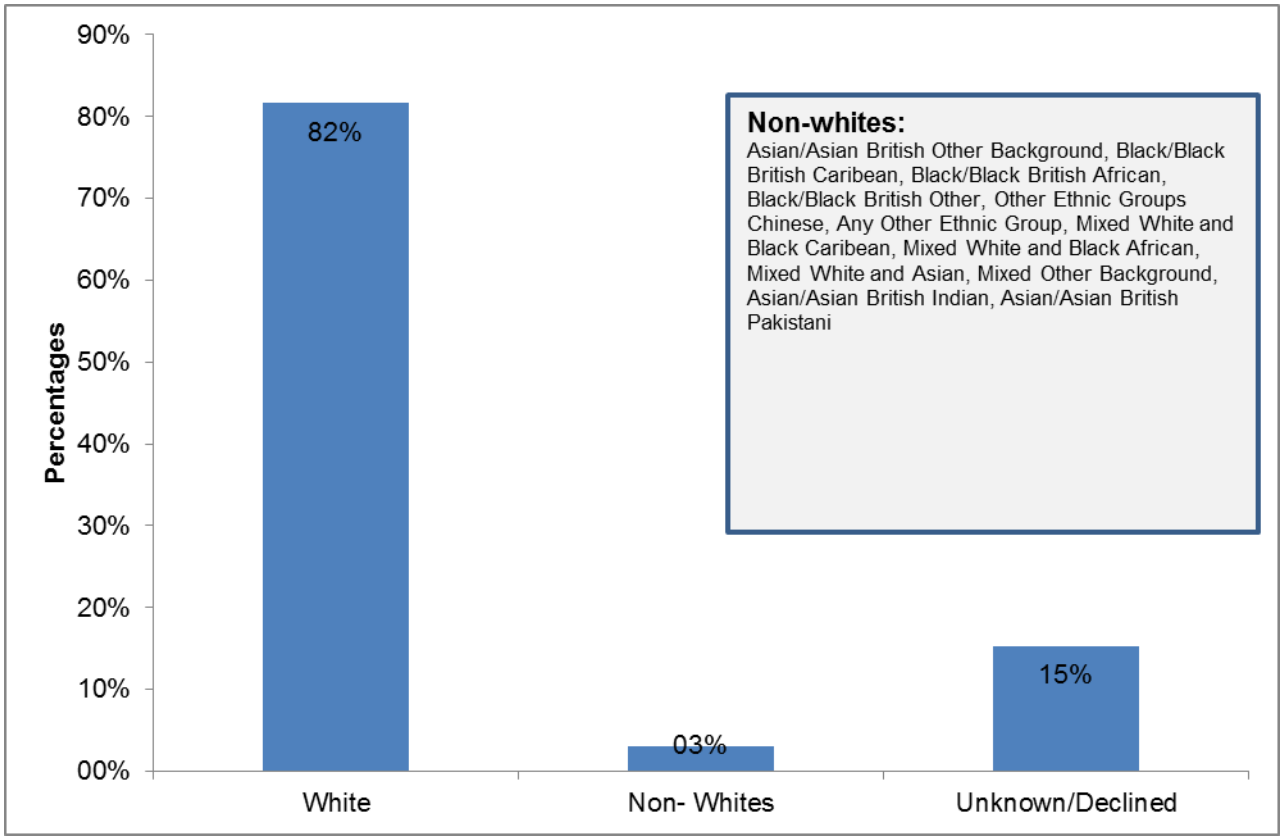
	Doncaster Workforce	**Ethnicity** Detailed amenable mortality data for England is not readily available by ethnic group. However there is evidence to show that mortality from some of its constituent causes is higher in certain ethnic groups: · South Asians, particularly Bangladeshis and Pakistanis, have significantly higher CHD prevalence and mortality than the general population Although people of Black and Black British origin have a low prevalence of CHD compared with the white population, they have much higher prevalence of and mortality from hypertension and stroke. While people from black and minority ethnic (BME) groups are at a lower risk overall from cancer than the white population, there is an increased risk of certain cancers in the Asian and Black ethnic groups. Asian and black women have lower survival than the white ethnic group for females diagnosed with breast cancer aged under 65 years. The lower number of cancer deaths overall among BME groups may partly be explained by the younger age profile of BME groups. The Care Quality Commission (CQC) Maternity Patient Survey in 2007 found that women of Asian and Black origin are less likely to have their first booking appointment with a midwife within 2 weeks of pregnancy and were less likely to have a scan at 20 weeks. These are key risk factors for Infant and Perinatal Mortality and maternal death. Infant mortality rates are higher among some ethnic groups than others, with Pakistani and Black and Black British -Caribbean babies being twice as likely to die in their first year compared to White British or Bangladeshi babies. A review by the Equality and Human Rights Commission in 2009 found that gypsies and travellers had an infant mortality rate that was three times higher than in the rest of the population. High rates of maternal death during pregnancy and shortly after childbirth have also been reported by Parry et al, 2004. The rate of stillbirth in babies born to women with a black ethnicity (African, Caribbean or other) was 2.3 times higher than the rate among babies born to women of white ethnicity. The neonatal death rate was twice as high for babies born to women of black ethnicity compared with babies born to women with white ethnicity. Similarly, the stillbirth rate and neonatal death rate for babies born to women of Asian ethnicity were 2.0 and 1.8 times higher, respectively, compared with those for babies born to women of white ethnicity.

		Key Doncaster Data from the 2017 BME Health Needs Assessment · Overall Asian and Black groups had higher self reported health status (95.8% and 95.4%) than White British groups (91.3%), although both Asian and Black groups are less active than the general population. · White British groups show twice the level of alcohol dependency than other groups, however both White and Black groups show the same level of drug dependence. The Asian group has the lowest levels of alcohol and drug dependency. · National data shows that the Black population suffer from at least double the amount of Post-Traumatic Stress Disorder than other populations and as much as 10 times the levels of severe mental illness (including psychosis). · Other health conditions are more common in some ethnic groups, so heart disease is more common in the Asian population, stroke and hypertension more common in the Black population and both Asian and Black populations have high levels of infant mortality. · The census also shows that the level of educational qualification varies across the ethnic groups with White Irish, Asian and Black groups having higher numbers of people with level 4 (degree level) qualifications than the general population. Asian and Black groups are also more likely to be students and as a result of being younger populations are more likely to be unemployed and less likely to be retired than the general population. · The fertility rate in Doncaster has been in decline since 2009, and is now on par with the regional average. Births to mothers who were born outside the UK are lower than average but increasing over time; totalling 15% of all new births in 2014 compared to 20% across the Yorkshire and Humber. · English is spoken in 96% of Doncaster homes, the most common language after English is Polish and the 5 most common translations requested are Polish, Slovak, Kurdish, Czech and Russian. *Healthy Living for BME Women in Doncaster service*

		The Healthy Living for BME Women in Doncaster service, delivered by Changing Lives, provides an opportunity for women to access health and other advice and guidance relating to the wider determinants of health which they may not otherwise be able to get. Over the year 2016/17, the service has supported 471 women, of which 123 were new to the service. Over 20 different ethnicities are represented. Due to cultural reasons the provision of ESOL training is key to ensuring many of the women are able to access the Centre; during the year 97 women enrolled and so far 51 have received their accreditation. Sessions to support women that are not at the entry level for ESOL are held to help them become ESOL ready. Whilst the women are in the Centre there are opportunities for them to access other health promotion activities, this includes topics such as substance misuse, nutrition as well as more sensitive topics such as sexual health and screening. The women have also been able to access the Health Checks service at the Centre. They are also informed how to register with a GP, understand the appointment systems and learn which service they require when (Choose Well). The confidence the women gain from accessing the service has helped some become champions within their communities, acting as the messenger and being able to support others; for example 4 of the champions have been trained by SY Fire to deliver top 10 tips on how to keep your home safe from fire which has resulted in fire alarms being fitted in homes and two are supporting women to access the Respect Yourself website. The service also provides a crèche facility which is important in the development of the children. As well as accessing health information there have been 114 referrals over the year to other services including computer classes, domestic violence services and housing issues. Externally to the service provided at the Centre, the staff are delivering outreach sessions in Hexthorpe to engage the Roma community. *Smoking* An equity audit of Doncaster Stop Smoking Service (April 2017) found that the demographics of Doncaster (Census 2011), indicates that 95.2% of the population are white ethnicity (British 91.8%,

while others 3.4%) and 4.8% are non-white ethnicity. In line with the higher portion of whites in the population, more whites (White British, white Irish and white others) were referred to the stop smoking services (82%) while there was a very low percentage of non-white ethnicity referred to the stop smoking services (3%).– Figure 3.

Figure 3: Ethnicity of smokers referred to stop smoking services in Doncaster (2015-16)



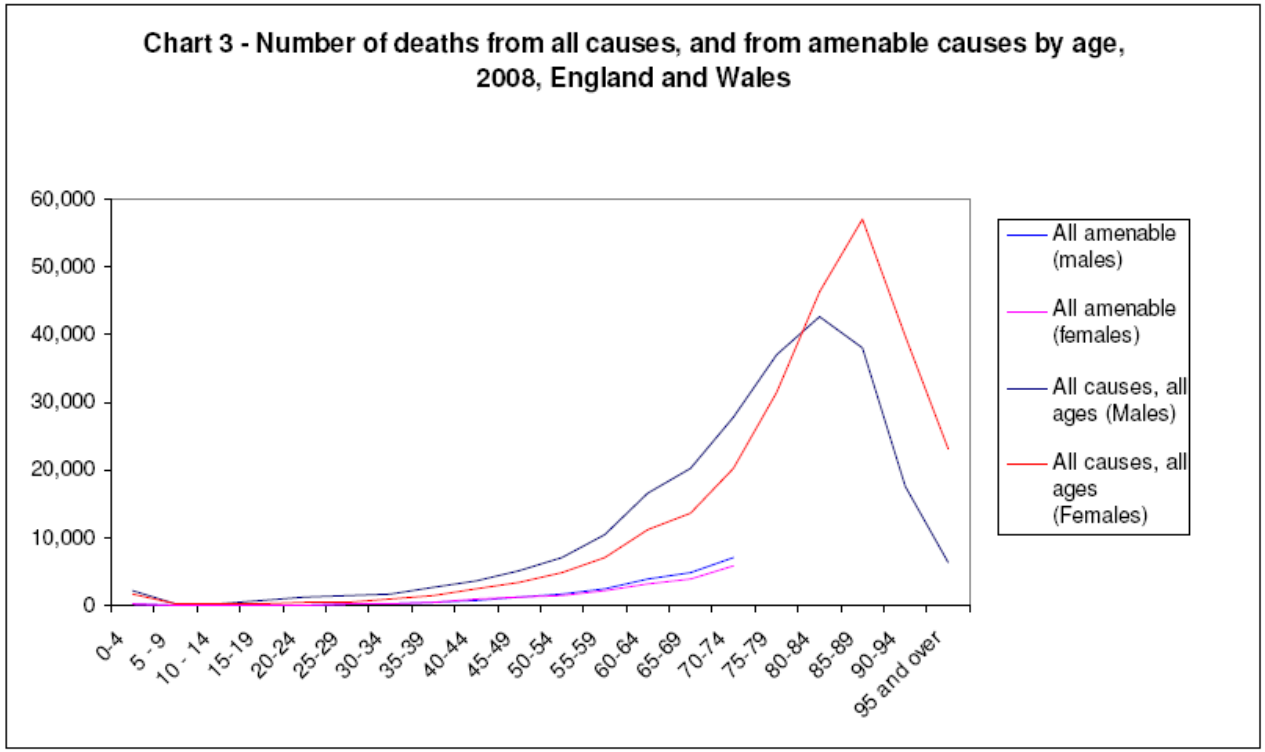
Source: SWYT (Doncaster) dated: 27/04/2016

A total of 1155 smokers quit smoking after four weeks of which eighty two percent of smokers who quit were of white ethnic origin while three percent of quitters were of non-white origin. 15% of quitter did not provide information about their ethnicity.

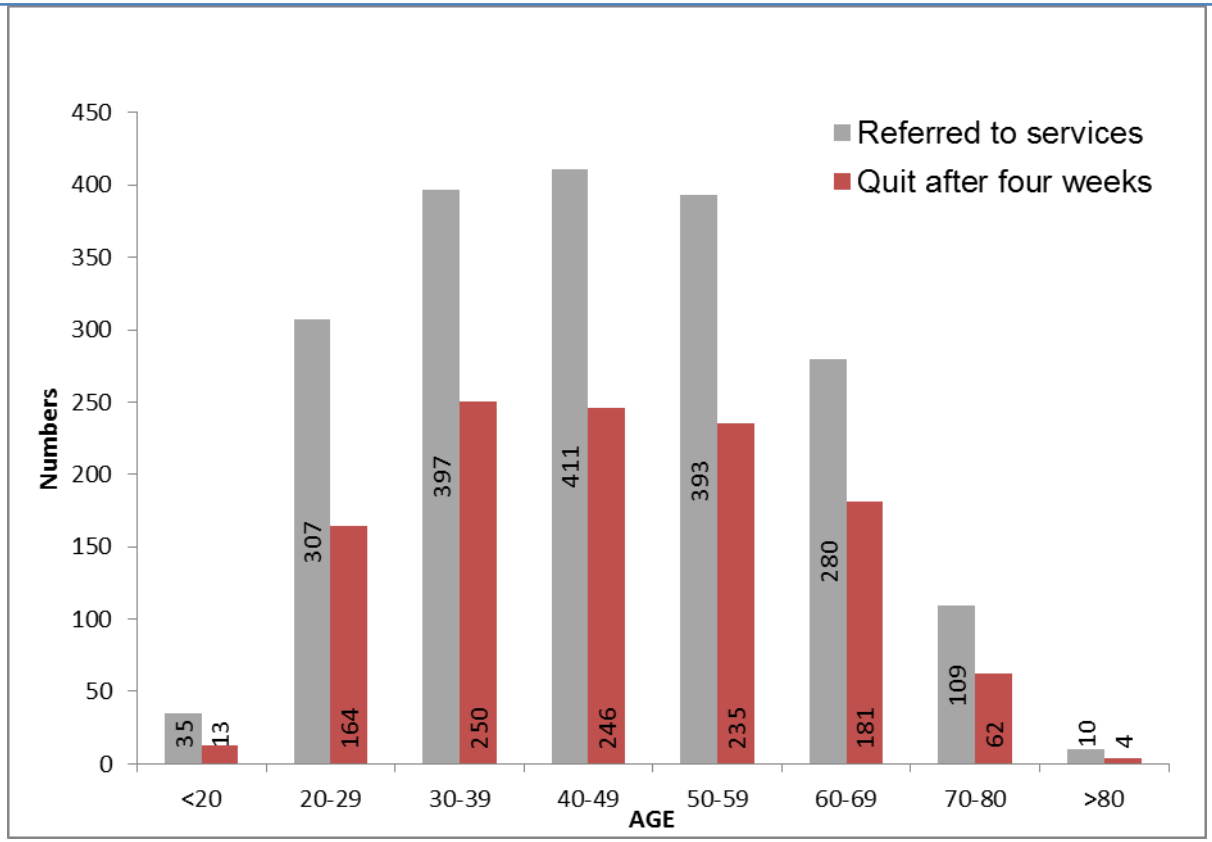
Age

Amenable mortality is by definition capped at age 75. Deaths under 75 are chosen largely because of the difficulty of ascribing cause of death in 75+ age groups where there are often multiple morbidities (Figure 4).

Figure 4: Death from all causes and from amendable causes by age groups



		Relative survival rates for the major cancers decrease with increasing age at diagnosis, even when the higher mortality from other causes in older people is allowed for. The proposed public health services are targeted according to evidence of health needs. For example, the 0-5 service aims to give the best start in life for children under the age of 5 years old; while the service for infection prevention and control predominantly aims to protect older people in care homes. Most of the smokers referred to Doncaster Stop Smoking Service were between 40 and 49 years of age (n=411). 62% of the smokers referred for the quit smoking service in Doncaster were between 30 and 60 years. The number of smokers referred for quit smoking services below the age of 20 were low, which is similar to the national average (Figure 5). **Figure 5:** Age groups of smokers referred to quit smoking services (2015-16)



Infection Prevention and control service

There Infection Prevention and Control services target people who are vulnerable: those in care homes, especially the elderly, and those with learning disabilities.

The service will be concerned with predominantly the Care Home infection prevention and control and methicillin resistance staphylococcus aureus (MRSA) bloodstream infection and Clostridium

difficile (CDI) cases in the wider community, for the target population. A main focus of the service will be the prevention and control of healthcare acquired infections including C.difficile and MRSA. Table 1 below details the reported incidence of CDI and MRSA in Doncaster over time.

Table 1: Incidence of Clostridium difficile and MRSA in Doncaster, 2007/08 to 2016/17

Year	C. difficile	MRSA
2007/08	189	n/a
2008/09	172	10
2009/10	104	7
2010/11	82	5
2011/12	69	11
2012/13	97	3
2013/14	83	4
2014/15	81	1
2015/16	73	0
2016/17	84	0

0-5 services

The service profile relates to outcomes for children at various stages of their early lives and when they received health visits (Table 2)

Table 2: Health visiting in Doncaster 2016/17

Indicator	**Target**	**2016/17**			
		Q1	**Q2**	**Q3**	**Q4**
Number visited within 14 days		860	691	741	591
% visited within 14 days	80%	98%	88%	91%	86%
Number visited within 21 days		774	857	894	741

% visited within 21 days	95%	98%	97%	98%	94%
Number visited within 6-8 weeks		821	1003	1003	938
% visited within 6-8 weeks	95%	98%	95%	95%	97%
Number visited by 12 months		876	817	840	809
% visited by 12 months	80%	95%	91%	93%	95%
Number visited by 15 months		821	889	843	843
% visited by 15 months	95%	95%	95%	95%	94%
Number visited by 2.5 years		873	815	839	867
% visited by 2.5 years	90%	92%	91%	93%	95%

It is recognised the following protected characteristics may impact on the following groups:

- Age (children and young people)
- Sex (women)
- Pregnancy and maternity
- BME

Health Visiting services focus predominantly on children and families, however there are elements of service delivery that are specific to women, pregnancy and maternity, including ante natal visits, breastfeeding support, identification and support around post-natal depression and domestic abuse.

It is well documented that teenage conceptions occur more frequently in young women living in more deprived areas. In contrast with those who postponed parenthood to age 24 or above, teenage mothers are:

- 22% more likely to be in poverty at the age of 30;
- 20% more likely to have no qualifications;
- and much less likely to be employed.

		As a result of this; children born to teenage parents are more likely to experience poverty and poor housing, to encounter poor health, reduced educational attainment, and to have low economic activity as adults.
		
		Infant mortality rates are higher among some ethnic groups than others, with Pakistani and Black and Black British -Caribbean babies being twice as likely to die in their first year compared to White British or Bangladeshi babies. Babies born to a teenage parents experience a 60% higher infant mortality rate than those born to older women.
		
		Disability
		Detailed mortality data for England is not readily available by impairment group. However, there is evidence that disability impacts on the length and quality of life, and can adversely affect access to services:
		• Access to services can be difficult for people with a physical, cognitive or sensory impairment unless special measures are put in place
		• There is low uptake of both breast and cervical cancer screening amongst disabled people: Only 19% of women with a learning disability have cervical smears, compared to 77% in the general population. Access to mobile breast screening units is difficult for women with a physical impairment, but alternative arrangements are in place at static units.
		• The lack of inclusion of disability in routine recording makes it difficult to measure equity of access and treatment for disabled people, and presence of a disability is not recorded on death certificates so it is not possible to break down ONS mortality data by disability.
		• People with learning disabilities:
		  ○ are three times more likely to die from respiratory disease
		  ○ have a higher risk of ischemic heart disease than the general population and this is the second most common cause of death in people with learning disabilities are 58 times more likely to die before the age of 50 than the general population.
		• People with a diagnosis of Serious Mental Illness (SMI) are twice as likely to die from coronary heart disease and four times as likely to die from respiratory disease as the general population and people with schizophrenia are more than four times as likely to die from infectious diseases. Rates of diabetes and hypertension are also high. Clients with SMI sometimes find it difficult to engage with primary care services, which results in them not accessing routine health checks.

		This domain will include an indicator on amenable mortality in people with Serious Mental Illness to address this inequality directly. **Gender** There are particular issues around risk factors and mortality for both men and women: • Women can expect to live longer than men. • Although women live longer than men, they also spend more years in sub-optimal health on average, males in England spend 59.1 years in good health and 15.9 years in poor health; for women the corresponding figures are 61.4 years and 18.6 years. • For both males and females life expectancy at 75 has been increasing in recent decades, but the gap between males and females has decreased slightly over the last fifteen years. The gender difference in life expectancy is greatest in deprived areas. • Some cancers are gender specific. For most cancers which affect both men and women, such as lung cancer, age standardised survival rates are somewhat higher in women. However mortality from lung cancer in UK women is higher than the EU15 average, while for men it is lower. This may be related to UK women's relatively higher smoking levels. • Men are more vulnerable to cardiovascular disease than women, and at a younger age, and are also diagnosed with the majority of cancers. • Because the death rate from coronary heart disease (CHD) is very different for men and for women, the extent to which this condition is included in any definition of amenable mortality has a large impact on the difference in the amenable mortality rate between men and women. Evidence from local equity audit of Stop Smoking Service in Doncaster suggests that access for males and females was fair, with 50% access in each group (Philip A and Joseph V, 2017). **Religion or Belief** In general there is little available evidence on the links between specific religions or beliefs and amenable mortality beyond that relating to race. There are some issues around cancer screening and certain religions: • Uptake of routine invitations for breast screening is lower amongst Muslim women than among women in the general population possibly due to fear of a male carrying out the mammogram;

		and - In the first phase of the bowel screening programme overall population uptake was 62% but only 32% for Muslims. **Sexual orientation** There is currently limited data availability on sexual orientation issues. From the General Household survey, fewer people living in same sex couples had used hospital services in the past year than in the population as a whole, however this is likely to reflect the age profile of those in same sex couples. A study of mortality among over 8,000 Danish men and women in same-sex marriage concluded that despite recent marked reduction in mortality among gay men, Danish men and women in same-sex marriages still have mortality rates that exceed those of the general population. However the excess mortality is restricted to the first few years after a marriage, possibly reflecting pre-existing illness at the time of marriage. **Gender-reassignment** There is little evidence available to determine whether the mortality rate from amenable causes in the transgender population is different from the rate in the population as a whole. Available evidence shows: - 35% of the transgender population report having made at least one suicide attempt. However, the Gender Identity Research and Education Society (GIRES) are not aware of any data that indicate high mortality among severely gender dysphoric people from successful suicide attempts. - A report of the use of cross–sex hormones in the context of gender reassignment in a hospital in Netherlands from 1995 to 2006 in over 3000 (2236 male-to-female and 876 female-to-male transsexuals) reveals that the mortality rate from cancer and coronary heart disease was not higher than in a comparison group. **Marital status (marriage/civil partnership)** There is evidence to show that single men and to a lesser extent single women have higher mortality rates than married men and women and that single people have a greater risk of dying

		after surgery. Further study is needed to investigate the reasons for this. It is known that these outcomes are likely to be highly influenced by economic factors, and some studies have shown that stress associated with marital separation affects the body's immune system and its ability to fend off disease. Infant and perinatal rates are highest among sole registered births and births outside marriage registered jointly by both parents living at different addresses. **Missing Information** ▯ ethnic group ▯ social class ▯ religion or belief ▯ sexual orientation ▯ transgender; and ▯ marital status Data in relation to mortality rates for the protected characteristics listed above are not available routinely as it is not recorded on death certificates. Until this information is available an assessment of amenable mortality rates in these groups could be done through detailed investigation of a sample of deaths where the cause was considered 'amenable', if there were reliable estimates of numbers in the relevant populations. Mortality data are available by low level geographical area so deprivation of area where the death occurred can be used as a proxy for socio-economic group. Participation and experience data for protected groups will be collected by commissioned services and will be agreed through the commissioning process. Initially an equality profile will be sought from each provider. .
4	**Summary of the consultation/engagement activities**	The public health services currently in place have benefitted from service reviews and users experience / feedback. For each area of activity further consultations will be undertaken.

5	**Real Consideration:** **Summary of what the evidence shows and how has it been used**	Analysis of nationally available data suggests significant differences in health outcomes depending on protected characteristics. Local data, where available, shows differential access to smoking cessation services for BME citizens. The BME health needs assessment 2017 concluded a number of actions including: · Actions around building stronger engagement with BME communities and that this engagement needs to recognise the diversity within our BME population and that work should strengthen BME communities by seeking collaboration opportunities. · Ideas for engagement included community development approaches; single gender groups; use of pharmacies · Actions that ensure high quality and accessible interpretation and translation · Actions to develop community understanding (seek opportunities to bring people · together) challenge prejudice (from all sources offer training on cultural · competence; unintended bias) and celebrate and value diversity · Actions which focus on other determinants of health such as education (including · education around navigating the system and induction for new arrivals and access · to English courses) · Actions which focus on more intelligence gathering from our BME populations In light of this all commissioned services should produce an equity profile on who uses the service which should be mapped against population needs. In year actions to rectify significant gaps in services should be addressed. In addition all commissioned services should profile the outcomes of the service by protected groups and take any remedial action where outcomes are significantly different for protected groups. These should be made public.

6	**Decision Making**	The Public Health commissioning strategy should proceed but for each area of commissioning activity a separate due regard statement will be developed as part of the process. Equity profiles and remedial actions should be built into service specifications, contracts and contract review processes. If the strategy is implemented effectively then the strategy should reduce health inequalities.
7	**Monitoring and Review**	The Public Health Contracts and Finance Group will monitor progress.
8	**Sign off and approval for publication**	Dr Victor Joseph; June 2017 Consultant in Public Health