Salford CCG

Annual Equality Data Publication

January 2015

Fair access to healthcare services for protected groups

1 Executive Summary

This is the Clinical Commissioning Group's (CCG) second annual equality data publication. It shows, to key stakeholders and monitoring organisations, the CCG's commitment to promoting equality, reducing health inequalities, and sets out the way in which the CCG fulfils its responsibilities arising from the Equality Act 2010. This Act requires public bodies to publish relevant, proportionate information showing compliance with the equality duty on and is best read in conjunction with the equivalent reports published by our providers, which also must be published by 31 January.

Monitoring who is accessing health care services and employment is one way of meeting our public sector equality duty. Listening and responding to feedback from protected groups is another important means of the vulnerable patient voice being enabled to shape healthcare services to be more inclusive with fair access across the varying and diverse needs of each of the 9 protected groups. We will use this information to continue to inform and shape services improvements and will enable us to review and update the CCG's Equality action plan (including equality objectives) and strategy in light of this information. This report has enabled us to identify any gaps or continued inequalities that may exist across the work streams of the organisation and develop a list of priority recommendations.

Priority recommendations and future actions;

- A comprehensive review of current EHDR information and action plans to ensure they support CCG strategic aims
- Undertake an audit to establish the quality of the equality analysis (EA) process within the CCG and work with Governing Body to ensure evidence of EA's is provided and scrutinised within Governing Body papers
- CCG equality lead to work with Governing Body to review mechanisms for improving accessibility of Governing Body meeting
- The CCG should ensure it clearly outlines its governance arrangements for EDHR, including reporting requirements (this is to be set out within EDHR Strategy), ensuring there are clear lines of accountability and assurance
- Through the NWCSU (North West Commissioning Support Unit) the CCG will ensure that the Equality, Diversity and Human Rights schedule is clear on achievable outcomes and ensures providers show evidence of making 'reasonable adjustments'
- Workforce (through the NWCSU); improve recording rates of equality monitoring data for all staff, seek assurance that HR policies embed equality standards (through audit of EA's of HR policies), explore if the CCG should invest in working towards an employer standards award linked to local health inequalities (e.g. Mindful Employer).

2 Introduction

2.1 Overview of the publication

This is the Clinical Commissioning Group's (CCG) second Annual Equality Data Publication. The report will set out how the CCG has been demonstrating 'due regard' to the Public Sector Equality Duty's three aims, will provide evidence for meeting the Specific Equality Duty further information regarding the Equality Act 2010 and the Public Sector Equality Duty can be found by following the link http://www.equalityhumanrights.com/private-and-public-sector-guidance, which requires all public sector organisations to publish their equality information annually and includes overviews of the CCG's aims to meet Salford's diverse population health challenges.

This report gives an overview of how we are meeting our legal duties. It also links to a range of background reports, giving more detail for local protected groups on (all available on CCG website – Equality & Diversity section):

- ✓ Equality Delivery System 2 (EDS2) current standards and beyond (Appendix 1)
- ✓ local and national health inequalities data and demographic profiling (Appendix 2)
- ✓ JSNA (Salford's Joint Strategic Needs Assessment
- ✓ patient satisfaction levels via complaints data analysis
- ✓ Annual Engagement Summary Report 2014
- ✓ Equality objectives and EDHR action plan

2.2 Who are the intended audiences of this publication?

- ✓ Salford CCG patients and carers
- ✓ Members of the public
- ✓ Interested stakeholders
- ✓ Salford CCG Governing Body and Executive team, as well as CCG staff
- ✓ Provider organisations

Salford CCG wants to make sure that this information is easily accessible to all sections of our local communities

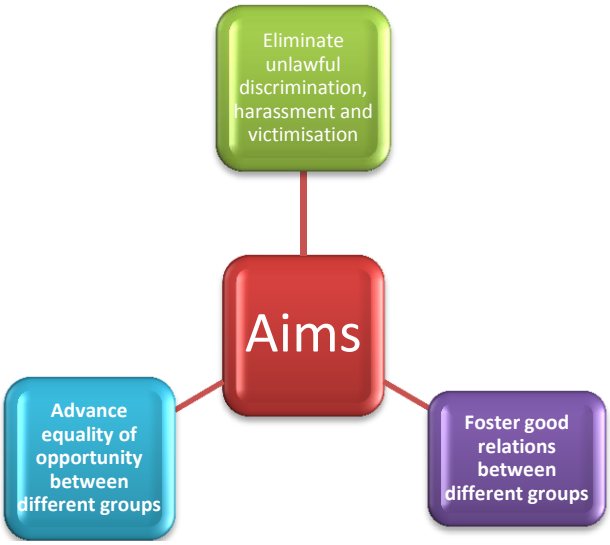
3 Demonstrating 'due regard'

3.1 What is 'due regard?'

Due regard means that the Clinical Commissioning Group has given advanced consideration to issues of equality and prohibited discrimination before making any strategy, programme,

policy or 'key healthcare change' decision that may potentially impact negatively on local protected groups. That is a valuable requirement that is seen as an integral and important part of the mechanisms for ensuring the fulfilment of the aims of anti-discrimination legislation set out in the Equality Act 2010. The CCG will use various mechanisms to demonstrate 'due regard' including; equality analysis, Equality Delivery System 2 (EDS2) and its implementation and development of its equality objectives.

The CCG continues to work to show due regard to the aims of the public sector general equality duty as set out in the Equality Act and as detailed below:



Through the adoption of the NHS Equality Delivery System the CCG aims to demonstrate to the people we serve and how we are meeting the three aims of the equality duty.

3.2 Equality Analysis (EA)

Equality analysis is a systematic process used by organisation's to enable them to demonstrate 'due regard' to the impact (both positive and negative) and outcomes of key decision making on the 9 protected groups. If completed in a timely manner, EA's also ensure that the CCG engages with any appropriate groups so that any anticipated negative outcomes can be reduced or eliminated or positive outcomes identified and developed.

Equality analysis are being carried out as part of the development of the 2014/15 commissioning intentions to ensure that equality is at the heart of the process. EA's require engagement with local protected groups to find out whether services under consideration require to be re-shaped to take account of fair access needs for information, services and premises. CCG want to provide opportunities for local vulnerable groups to work with CCG to re-shape services from the earliest stages.

The following are examples of the equality analysis undertaken in 2014.

3.3 Table 1: List of Equality Analysis

Integration of Health & Social Care – Older People
ISOP – Integrated Strategic Operating Plan
GP Development Plan
Bladder & Bowel Service Review SRFT
Communications & Engagement Strategy
Car Parking policy
Car Leasing policy
Macmillan Cancer Service
Maternity Unit Business Case
Safeguarding
Integrated Clinical Assessments and Treatment Service (ICATS)

The CCG acknowledges that the EA process requires continued improvement, one of the key ways this will be achieved is through having more streamlined information sharing processes across departments within the organisation. Work is currently underway with the engagement and service improvement teams to identify future areas of joint working which will enable us to ensure that the EA process is triggered at the start of the decision making process.

3.4 Robust Equality Analysis (data, data and more data)

Analysis of data is fundamental to achieving robust and quality assured EA's, by undertaking a comprehensive review of both quantitative and qualitative data available from national and local sources the EA will enable commissioners to identify and anticipate key health inequalities and areas of good practice that prevail within existing services.

By working to embed this work within the commissioning cycle, the CCG will clearly demonstrate its commitment to reduce health inequalities by placing key equality outcomes at the heart of its decision making and support a person centred approach to its work.

Recommendation

- The CCG should continue to improve the EA process by undertaking an audit of the current EA's completed, this will establish if they are robust, fit for purpose and identify any significant areas for improvement. This could be undertaken by another CCG's E&D department, through a critical friend approach.

- Improved ways to undertake data analysis needs to be incorporated into the EA template to ensure that relevant information is reviewed and is available is accessible formats to the relevant teams.

3.4 Equality Delivery System (EDS): (EDHR performance framework)

3.4.1 Aims of EDS

The Equality Delivery System (EDS) has been designed to be a tool for the NHS organisations (and their contracted provider partners), through involvement with stakeholders, to assess CCG's equality performance across 4 Goals and 18 required outcomes. This framework should enable the CCG to demonstrate its compliance with the Equality Act and subsequent duties and assists the CCG to identify, in partnership with the EDS Stakeholder group, future objectives and priorities.

3.4.2 Progress on EDS

The CCG carried out an annual public grading in June 2014, looking at Goal 4: Inclusive Leadership performance during 2013 to 2014. Key recommendations and actions were agreed as a result of this process. **See Appendix 1** for details**.** A recent audit undertaken on EDHR identified that the EDS process and reporting system would benefit from additional improvement plans including clearer links to the EDHR action plan and improving participation of protected groups within the EDS2 scoring mechanisms.

Recommendation

- Undertake a review of the CCG's EDS (2) current progress report and action plan to ensure that it is clear, transparent, incorporates any cross over recommendations made throughout this paper and look to embedded within the EDHR overarching action plan.
- Work with engagement manager and partner organisations to identify ways to improve inclusion and widening participation to EDS2 process.

3.5 Equality Objectives

3.5.1 Current Equality Objectives

Each public sector organisation is required to develop and publish four yearly equality objectives. CCG retained the objectives set by the former PCT (Primary Care Trust) initially in shadow form, in April 2012, then 5 equality objectives were identified to be delivered over the remaining 4 year period October 2013 to 2017:

1. Improve health and narrow the gaps in access, experience and outcomes
2. Improve collection and use of data/evidence for protected group;
3. Communicate and engage with all protected groups;
4. Develop equality and diversity competent and well supported staff; and
5. Develop leadership, corporate commitment and governance arrangements for Equality and diversity.

These equality objectives have been developed in partnership with Salford patients, staff and communities and in light of key data analysis including 'Key health inequalities by protected groups for Salford 2014 See Appendix 2.

Every four years the CCG will consult widely and agree new equality objectives with local communities of interest; including protected groups, patient and carer representatives. The CCG executive team will annually review these objectives, in light of this analysis data report, to ensure they are 'fit for purpose' against a backdrop of changing delivery of health and social care to all sections of our local communities.

Recommendation

- The CCG must ensure that it reviews its current agreed action plan, developed from its equality objectives, in light of any key recommendations and actions identified in this paper.

3.5.2 Equality Strategy

Later in 2015 we will publish our governing body approved equality and diversity strategy which will include:

- ✓ How we will deliver on our agreed equality objectives (2013-17) in terms of improved outcomes for protected groups
- ✓ How we will embed Equality Analysis (EA) into our standard processes, procedures and work streams.
- ✓ Ensure transparent and open consultation with local protected groups, on key changes
- ✓ Equality, diversity and human rights (EDHR) compliance and quality checks through provider partner contract arrangements;
- ✓ Consider reasonable adjustments in workforce and service delivery issues;
- ✓ Outline our EDHR governance approach (including management of EDHR risks);
- ✓ Identify our progress on Equality Delivery System (EDS2), including our approach to gathering evidence and carrying out an annual public grading with local interest groups
- ✓ Demonstrate how our annual equality data publication findings is used by CCG to identify any health inequalities and improve fair access to information, services, premises and any employment opportunities for protected groups.

3.5.3 Progress made on Equality Objectives

Equality Objective 1: **Improve health and narrow the gaps in access, experience and outcomes.**
Progress in 2014 • Sexual orientation: CCG funded embedding of *Pride in Practice* kite-mark for 55 GP Practices in Salford locality. This includes March 2014 to date: 13% (7) completed PIP self-assessments. Practices receiving regular condom lube distribution scheme (CLDS) 55% (30). LGF co-ordinator met in person onsite to discuss Pride in Practice 16% (9). This helps to address improving health and narrowing the gaps in patient experience. • Gender; Developed questionnaire for cancer survivors on how we can improve information and take up of information bespoke to males and females. Project start up from Sept 2014. Monitoring by age bands and gender.

- Targeted groups through JSNA; Working with Salford City Council Public Health colleagues on next steps for producing Joint Strategic Needs Assessment (JSNA) sub sections which include focus on health needs of local protected characteristic groups. Under consideration: safeguarding needs assessment specifically considers ethnic minorities; sexual orientation HNA; Gypsy Roma Traveller HNA; CCG to attend SCC JSNA Operational Working Group / Research & Intelligence

Equality Objective 2:
Improve collection and use of data/evidence for all protected groups.

Progress in 2014

- The EDHR Schedule is embedded into main provider contracts in March annually. In consultation with provider partners, NWCSU are developing an annually refreshed GM wide schedule of evidence.
- The Equality Analysis Toolkit has been improved to include, for example, a generic statement and simple checklist for commissioners when writing service specifications for providers.
- CCG have put into place Equality Analysis training and guidance, which will allow CCG to identify potential equality business risks to the organisation and to the outcomes of patients.
- Workforce data through the electronic staff records (ESR) system has been considerably improved through continued data cleansing exercise's where all staff were given the option to declare / update their equality monitoring data.
- Older people related priority care pathway service specifications to include monitoring of service take up by each of the protected groups where relevant (provider to provide the option to declare their demographics to all patients). (Age and Race – secondary care)
- Patient experience data (complaints, comments, compliments and concerns) will be monitored by protected groups and scrutinised for any element of prohibited discrimination. This process has begun in 2014 but requires more refinement to try to improve return rates from patients.

Equality Objective 3:
Communicate and engage with all protected groups
(For detailed information see Annual Engagement Publication 2014 available on CCG website)

Progress in 2014

- Linked with existing Salford City Council engagement work with young people. The group was successfully was launched during October 2014 and is in the process of establishing its key work streams.
- Commissioned a piece of research work re engagement with the wider Jewish community (to include Jewish Orthodox community). Working with young peoples' services to raise awareness of local support services re e.g. Domestic Violence or Abuse and monitoring demographics of people taking up that service. The research is being led by Jonny Weinberg, Chair of the Jewish Care Forum. Findings due early in 2015.
- Undertaken a review of the demographic profile of the CCG's E&D Sounding Governing Body Group which is another vehicle the CCG uses to engage with the local community. The 19 members are not currently representative of the local community and does not cover all of the 9 protected groups. CCG need to widen membership of the group and target patient and carer representative's where appropriate.
- Promoted the involvement of patients and their carers in decisions about provision of the health services to them enabling patients to make choices with respect to aspects of health services provided to them. Consultation and engagement work has

taken place with Virtual Panel members about key changes in healthcare such as the Engagement Strategy by the Head of Engagement. Vulnerable local groups have been asked to provide feedback on any adverse impacts arising, on any protected groups they represent. CCG's approach is to ask for feedback in terms of 'You said. We did.' with evidence from CCG of good outcomes for protected groups.

Equality Objective 4:
Develop equality and diversity competent and well supported staff

Progress in 2014

- Developed 'core briefing' information delivered to all CCG staff over 2014/15 every 2 years thereafter by NWCSU equality lead. Equality quiz also developed, at CCG's request, to assist managers to 'test' level of staff understanding. Delivery links to NLMS Equality E-learning module for all CCG staff every 3 years for compliance, and to EDS(2) *Goal 4:Inclusive Leadership 'required Outcome' 4.3: Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination.*
- Equality and Diversity training is part of the CCG's mandatory core training, compliance is carefully monitored by executive & governing body members.
- Raised staff awareness of what does discrimination look like? An All Staff Briefing: *Prohibited Discrimination* has been developed for CCG staff. This is one Briefing in a set of 5 core Briefings for all staff to sign off with line manager their awareness and understanding by 31/3/15.

Equality Objective 5:
Develop leadership, corporate commitment and governance arrangements for equality and diversity

Progress in 2014

- Continued to raise awareness at Governing Body level of the key links between protected groups and local health inequalities Focus on health inequalities for protected groups in Salford. First session delivered to Governing Body 30 October 2013. CCG is working on a second session to be delivered before 31/3/15.
- Reviewed Governing Body cover papers to ensure evidence of 'due regard' is being taken from service re-designs / decommissioning of services to pilot and small tests for change stages. Amend Governing Body / prime committee front sheets to include EDS2 Outcomes 4.3 - recognise and manage EDHR business risk.
- Delivered 3 Equality Analysis Briefings sessions (1.5 hours) to 23 senior nominated staff, quarterly refresher training/new starters agreed to be delivered on a rolling basis by EDHR lead.
- Continued to review the current EA process within the CCG, to identify areas of good practice and key areas for improvement. Close working with engagement team and service improvement teams has enabled us to develop an improvement plan which will be used to update the CCG's equality action plan.
- Influenced JSNA development by Salford City Council Public Health colleagues, to include sub sections at annual refresh for each of the local protected characteristic groups. CCG joining Operational Group November 2014 to work collaboratively on shared decision making and any agreed research. Sub section to be available at next JSNA refresh re: sexual orientation (lesbian, gay, bi-sexual people in Salford); Gypsy Roma Traveller community. Commissioners use the JSNA to inform which local services they buy for local people.

Recommendation

- As part of the this data publication report, the CCG should ensure that its agreed action plan has SMART outcomes, so that progress can be reported annually, to

clearly demonstrate outcomes and impact for the local population and staff (the 'so what' test) and clearly demonstrate how they support the strategic aims of the CCG.
- The CCG will ensure that it gathers evidence which clearly demonstrates how commissioning decisions have made a difference to the equality and inclusion agenda (you said, we did outcomes)

4 Service Users Data

4.1 Complaints, concerns and compliments

Understanding and acting to improve the patient's experience is fundamental to the core business of NHS Salford CCG. The Patient Services Team at GMCSU (Greater Manchester Commissioning Support Unit) supports NHS Salford CCG to achieve this, it is responsible for providing a comprehensive focal point for all public enquiries and the team will receive, investigate where necessary and resolve:

- Informal patient enquiries including providing advice, information and informal resolution of issues and concerns (PALS – Patient Advice and Liaison Service)
- Patient complaints in line with the statutory duty under the Local Authority Social Services and National Health Services Complaints (England) Regulations 2009; including referrals of complaints to the Parliamentary and Health Service Ombudsman
- Enquiries from local MPS
- Requests under the Freedom of Information Act 2000
- Claims made against NHS Salford CCG

4.2 Demographic data

When acknowledging receipt of complaints a patient demographic form is sent to complainants for them to complete and return to the Patient Services Team. A full explanation is given as to the reasons for collecting this data and complainants are assured that the information they provide will be treated in strictest confidence and not divulged to anyone involved in considering the complaint. Complainants are also assured that if they do not return a completed form it will not prejudice the outcome of their complaint in any way.
The same information is also requested when concluding a PALS enquiry, albeit that this information is requested verbally.

4.3 Analysis of this data

The CCG is provided with regular reports from the NWCSU (Patient Services and Patient Demographic Data Analysis Report here (insert link) and on an annual basis, this information is published in relation to reporting against key protected groups. While the report contains various tables reporting against protected groups, to date there are no firm conclusions drawn and a lack of actions to progress this work. This will be addressed during 2015.

4.4 Service Analysis Data from GP Practices

At present there is not a standardised system of data collection standards in relation to the collection and reporting of equality monitoring data across all protected groups from GP practices. This is an area of improvement that the CCG will review in light of any guidance from NHS England.

4.5 Other sources of service user and patient data

The CCG has made significant process in reviewing how EHDR agenda reports into its internal governance structure, through this process it is anticipated that the CCG will see a more joined up approach of using patient experience data reporting and equality outcomes. It will also ensure better use of other sources of data (i.e. Joint Strategic Needs Assessment (JSNA), which focus on health inequalities for particular groups, to influence the decision making process. This is an objective that will be monitored by the Experience and Engagement Management Group.

Recommendation

- An action plan will be developed in relation to patient complaints data to a) improve collection data rates b) improve analysis of the data
- Explore how GP member practices can begin to provide the option to all patients to declare their demographic profiles by protected groups onto the Electronic Patient Records (EPR) system at GP practices. CCG will then collate basic data.
- Develop improved ways of reviewing current data sources, in particular, the JSNA to inform and influence commissioning outcomes where health inequalities for particular groups have been identified.

5 Engagement in action with local people (for detailed report see Annual Engagement Report 2014)

5.1 Engagement Cycle

As residents of Salford, local people need to be involved in holding the CCG accountable for the way it is choosing to allocate its resources. Therefore, it is vital that we engage our stakeholders on how decisions are made, about their choices and about what services might be commissioned. It is essential that this is done in a meaningful way – not as a tick box exercise with no real commitment. We must continue to encourage the citizens of Salford to keep investing as much time and effort as possible into engaging with us and in return we must regularly demonstrate our commitment to listen and act on what they tell us. Salford CCG follows the principles as highlighted in the Engagement Cycle when commissioning services.

Engagement Cycle

Salford CCG strives to recognise and understand our populations':

- Health aspirations
- Perception of health service needs
- Feeling of gaps or barriers in fair access to the healthcare system
- Beliefs on what is working and not working in the local health service
- Suggestions of potential solutions

Salford CCG will always seek to involve the public in:

- Determining the principles that should underpin how priorities are set
- Ranking and priority setting
- Choosing a preferred strategic option
- Pathway design
- Designing service specifications
- Developing criteria for evaluating tenders
- Assessing potential providers.

See below for key mechanisms from CCG engaging with local protected groups in 2014.

- Citizen and Patient Panel - "Your Voice, Your Choice"
- Equality and Diversity Sounding Governing Body
- Health and Social Care Integrated Engagement Governing Body
- Salford Youth Health Ambassadors
- Drama Workshops for young people
- Voluntary Sector Communities of Interest (Disability, LGBT, Faith and BME)
- Health and Social Care Forums of Interest (Older people, learning difficulties, physical and sensory impairments, dementia and learning difficulties)
- Maternity Services User Group
- Jewish Community Engagement
- Salford Community Health Reporters
- Patient Participation Groups (PPGs)

Recommendations

- The CCG's Equality Manager has recently undertaken a review and analysis of engagement undertaken across the local population. The key outcomes of this engagement must be used when reviewing the EHDR actions plan and equality objectives to ensure that they are incorporating local views and demonstrate that 'local voices' are shaping 'local decisions on healthcare'.

- Continue to review membership of the above engagement groups to ensure that they are representative of local community groups/protected groups, where appropriate, and support the CCG's engagement work streams to ensure we meet the aims of the equality duty.

- Ensure that the integration of the User Development Workers into the CCG results in improved partnership working (to be monitored through the EEMG) and agreed actions are included within EDHR action plan and EDS2 progress reports

6 Monitoring our providers

6.1 Embedding equality outcomes within providers contracts

The CCG through its contracts with providers ensures that those provider organisations are compliant with equality legislation. All the NHS providers and private providers which the CCG contracts with undertake the annual equality performance review using the NHS Equality Delivery System (EDS). They are also required to annually submit evidence electronically to the CCG in support of their equality, diversity and human rights compliance via their EDHR Schedule within their contract. Face to face meetings are provided with providers to support them in meeting required EDHR evidence standards. Any variance in required performance is raised for discussion within cyclical Quality / Contract meetings to ensure year on year progress is evidenced throughout the year and assurances of compliance are provided to CCG.

Table 2: Provider perspective of service delivery

Our main providers are detailed below with equality related information submitted to Salford CCG. Data helps show whether services are being taken up by protected groups and by locality and includes applications for referrals, referrals to services, discharges.

Main provider partner organisations	Service delivery information to Lead commissioner i.e. CCG	Service Access detail provided	Equality Delivery System 2 (last public grading completed)	Workforce scrutiny report submitted to Lead commissioner	Website check by CCG for PSED compliance
Salford Royal Foundation Trust	EDHR Schedule submitted October 2014. Quality Assurance check completed. No significant issues identified.	Service Access and Patient Experience Report received Sept 2014. No issues of concern identified.	April 2014 and next submission due in 2015. Detailed case studies and a dashboard of scores displayed on their website.	Data covering Nov 2013 to July 2014 submitted in Sept 2014. Data largely representative of local population.	Sept 2014. Comprehensive, high quality information with a focus analysis of year improvements for protected groups. No issues of concern identified.
Greater Manchester West Mental Health Foundation Trust	EDHR Schedule submitted Nov 2014. Quality Assurance check completed but further analysis for good outcomes and year on year improvements for protected groups requested. 2015 Action Planning by provider to show progress.	Patients access monitoring report (access and discharges by protected groups) received Nov 2014. Further summary analysis and qualitative data requested.	System not previously used. First submission completed in June 2014.	Data as at Sept 2014 submitted Nov 2014. Data largely representative of local population but no year on year analysis for improvements in representation.	Sept 2014. Significant effort and progress shown with good Salford specific information. Going forward reports need to show summarised analysis of data, dates and reflect the up to date position with year on year comparisons and with service improvements shown for protected groups.
Oaklands Healthcare Private Hospital (orthopaedic care)	First EDHR Schedule of evidence submitted Nov 2014. The requirement for an EDHR Schedule was not included within 2013-14 contract	Patient access monitoring shown on website	First EDS public grading due before April 2015.	Organisation data as at Sept 2014 provided but required by locality of Salford.	Full compliance Nov 2014. No Annual Publication produced in 2014, however concise information already on website Nov 2014.

6.2 Examples of good practice/progress for each of the main providers (all reports mentioned are available on providers websites)

Salford Royal (Foundation Trust)

- Recruitment & Workforce Reports: Within this section you will find a comprehensive list of reports and workforce statistics published by the Trust.
- Comprehensive Salford Health Inequalities Data publication, including analysis of service users and local population data
- Equality Delivery System Annual Reports April 2014. This includes: EDS Scores April 2014; Presentations for both Workforce Event and Public Event March 2014.
- 2013/14 delivery of staff awareness and development sessions to improve and promote understanding of needs for key groups (men's health, disability, sexual orientation, gender reassignment & religion and belief).

Greater Manchester West MH (Foundation Trust)

- 2014 set equality objectives by localities of Salford, Bolton and Trafford, are available to view on GMW's EDHR webpage.
- Also GMW district network equality objectives re the 2014-15 business plan; and overarching Trust equality objectives 2013-14 are available on the EDHR webpage.
- Equality Delivery System (EDS 2) annual public grading by a trained stakeholder group from local communities of interest, was completed during June 2014, EDS summary report is available on their website.

Oaklands Healthcare

- Equality Diversity & Human Rights statement of commitment on their website including -
  In line with Ramsay's 'People Caring for People' mission statement, our aim is to provide a quality service where we aim to recognise and address barriers to ensure fair access to information, services, premises and any employment opportunities, and where people matter most.
- 4 equality objectives have been set by Oaklands in 2014, to evidence their commitment to embedding Equality Delivery System (EDS) the NHS equality performance framework into their day to day practice. (This applies to NHS commissioner organisations and their provider partner organisations.)
- Patient and workforce profiles for 2014 and by localities of Salford, Bolton and Oldham are available to view / download on Oaklands EDHR webpage.

Recommendation

- We will continue to ensure that we seek assurance that our providers are making progress in terms of publishing analysis of data on service delivery and workforce issues, for local protected groups. EDS requires evidence of how people from local protected groups *fare* compared to people in general re healthcare. The current EDHR schedule should be continually reviewed, based on feedback from both commissioners and providers to ensure that it is clear, transparent, achievable and fit for purpose.

7 Governance arrangements for equality diversity & human rights

7.1 Current workforce structure and reporting

EDHR service is provided by the North West Commissioning Support Unit (NWCSU) with an identified equality lead who works closely with the Head of OD and Engagement at the CCG. This work stream reports into the Engagement and Experience Management Group (EEMG), which is attended by the CCG's lay Governing Body member for engagement and the Governing Body's Nurse, and chaired by an Executive Team Member.

Recommendation

- A recent EDHR audit identified that the CCG should clearly define its current reporting and governance arrangements, this information will written into all relevant papers including the EDHR strategy

8 Workforce Profile

8.1 Requirements of workforce data publications

As part of the public sector duty, public service employers have to monitor key employment relations and workforce data including; recruitment, promotion, training, pay, grievances and disciplinary action by protected characteristics. This information enables organisations to review if there are any differences (positive or negative) in outcomes within its workforce.

We do not legally have to publish workforce data as we have fewer than a 150 staff, however an annual workforce report will be received and reviewed internally by the Executive Team and key recommendations will be developed.

Recommendations

- The CCG will work to improve staff to disclose recording of equality monitoring, in preference to 'do not wish to disclose'.
- Assurances given to CCG by People Services of EDHR being embedded within all People Services related strategy, policies and recruitment practices at CCG, to include timely staff training and equality analysis being implemented when policies are new or due for review.
- To support its role as a positive employer the CCG will investigate working towards achieving employment award in relation to a key local health inequality (e.g Mindful Employer).
- NHS Salford CCG will introduce measures to encourage men to apply to the CCG and more women to apply for Governing Body roles
- The CCG will carry out a gender pay audit.
- The governing body demographic profile will be routinely requested and maintained as confidential data for reporting purposes

9 Way forward

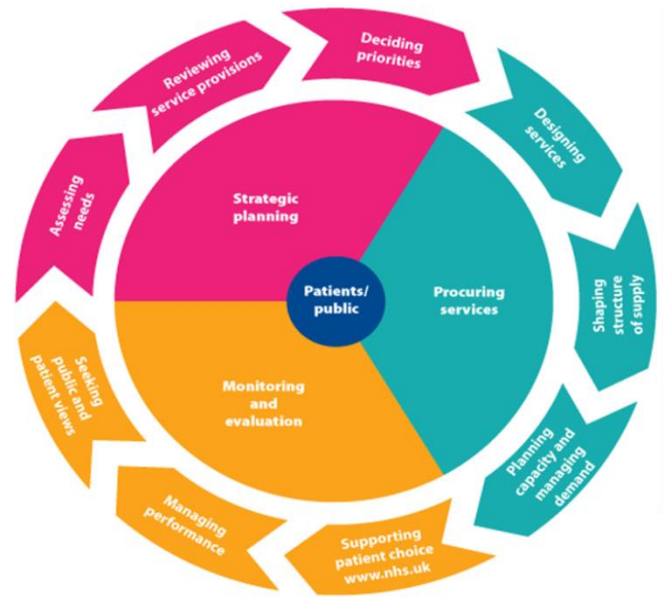
9.1 Embedding EDHR

The aim of the CCG is to place equality and inclusion at the heart of commissioning services, to ensure that the services we provide for the local population strive to improve access and outcomes for all our citizens, and in particular reduce health inequalities for our most vulnerable groups (by protected groups and local deprivation indicators). The CCG has started to make progress in embedding Equality Diversity and Human Rights into its planning and decision making processes and this is increasingly reflected in the closer working across the organisation between the equality lead, engagement and service improvement teams in the redesign of existing services.

9.2 EDHR at the heart of commissioning

- Patient centred performance management e.g. using the EDS equality performance framework and delivery system.
- Ensure all CCG staff and providers have received training in how to embed EDHR into day to day practices.
- Ensure providers monitor access to services by protected groups and differential satisfaction levels. Build equality returns into contract reviews.
- Build in EDHR criteria into all contracts e.g. EDHR Schedule of evidence, and EDS performance framework.
- Involve all protected groups in service design and re-design.
- Specify required equality outcomes within service specifications.

The diagram below illustrates the key components of mainstreaming equality and inclusion into the commissioning cycle:



10 Key Recommendations and future actions

In light of the progress made and through the analysis of this report, a number of key recommendations are presented, to be discussed with key stakeholders and agreed with Governing Body members. It is acknowledged that due to the number of recommendations throughout this paper the CCG equality lead has prioritised the key recommendations. Prioritised final recommendations will be incorporated into the EDHR action plan, with other recommendations being considered by the Engagement and Experience Group.

10.1 Priority Recommendations (service delivery)

The highlighted recommendations are identified as priority areas for consideration of the CCG. They are key to the assurance processes of the CCG in relation to this agenda and by ensuring these key recommendations are actioned, the CCG will be able to demonstrate clear, achievable and measureable outcomes.

- Given the theme of key recommendations throughout this paper and recent changes to the NWCSU equality staffing structure, it is recommended that a comprehensive review of current EHDR reporting mechanisms is undertaken.

  Action: Equality Lead to support NWCSU to undertake a review of current EHDR information and action plans to ensure they support CCG strategic aims.

- The CCG should continue to improve the commissioning cycle to ensure that the process clearly demonstrates 'due regard' and is undertaken at the very start of the process. The CCG should, therefore, review a) that the EA toolkit to ensure that it is fit for purpose b) embed this document within mainstream commissioning cycle and c) ensure that 'sign off' at Governing Body level scrutinises for clear evidence of the EA's being undertaken at the start of the process and this is evidenced in Governing Body papers (also links to EDS2 action plan).

  Action: NWCSU to agree with third party to undertake a 'critical friend' review of completed EA's, agree areas for improvement and work with the Governing Body to ensure evidence of EA's is provided and scrutinised within Governing Body papers.

- The CCG should provide evidence of Governing Body Papers routinely discussing protected groups and giving 'due regard'. Improve accessibility of Governing Body reporting to the general public and our most vulnerable local groups (e.g. easy read, filming & publishing on You Tube) This evidence should be taken to the next EDS public grading (public scrutiny of CCG's equality performance) for feedback from the EDS Stakeholder group on Goal 4: Inclusive Leadership performance.

  Action: CCG Equality Lead to work with Governing Body to review mechanisms for improving accessibility of Governing Body meeting.

- The CCG should ensure it clearly outlines its governance arrangements for EDHR, including reporting requirements (this is to be set out within EDHR Strategy), ensuring there are clear lines of accountability and assurance. This conclusion has also been drawn from a recent EDHR Internal Audit report.

Action: NWCSU to ensure governance arrangements are included in the EDHR strategy.

- The CCG should continue to influence the EDHR schedule of reporting for providers, working on the following key areas 1) commissioners ensure that reporting compliance on EDHR is clear, transparent, achievable and demonstrates year on year progress 2) patient experience data is collated and reported on by protected groups, where ever possible, including evidence on year on year improvement of engagement with these groups and that this information is being used to influence and shape service provision 3) assurance by providers of all staff awareness of the anticipatory duty to consider reasonable adjustments in service delivery and workforce issues.

Action: NWCSU to ensure that EHDR schedule meets the above requirements, seeking feedback from both commissioners and providers to ensure that standards are achievable and relevant.

10.2 Recommendations for consideration but not identified as priority (service delivery)

- The CCG should demonstrate that staff (including governing body members) have engaged with local groups to learn more about a particular community and understand their healthcare needs and how best to promote provision of fair access for that community. Local communities of interest will be invited to two governing body meetings in the coming year to present on healthcare needs for that local community.

- The CCG (Primary Care Development Lead) should look into online provision of access to signers / BSL interpreters (trained to at least Level 6) for emergency healthcare appointments.

- GP member practices to begin providing the option to all patients to declare their demographic profiles by protected groups onto the Electronic Patient Records (EPR) system at GP practices. CCG to provide a basic monitoring form to practices. Patient satisfaction by protected groups also to be captured by practices as appropriate.

- Where protected groups are not fully represented at e.g. Equality Delivery System (EDS) annual public grading meetings, or at special groups set up to canvas opinion of protected groups, CCG will continue to involve a more representative membership and attendance from local communities of interest and stakeholders.

- Develop improved ways of reviewing current data sources, in particular, the JSNA to inform and influence commissioning outcomes where health inequalities for particular groups have been identified.

- Develop a demographic profile of E&D Sounding Board Group to evidence reaching local protected groups for their feedback on key healthcare changes. Demographic profiles are available. The 19 members are not currently representative of all of the 9 protected groups. CCG needs to target patient and carer reps where additional protected group members required. In terms of the E & D sounding board, it currently includes information on what protected group(s) the member is representing.

10.3 Priority Recommendations (workforce - responsibility for these will sit with NWCSU but monitored by the CCG)

- The CCG to work to improve staff to disclose recording of equality monitoring, in preference to 'do not wish to disclose'; information to be sent to all staff to explain the importance of recording this information and giving assurance of confidentiality.

  Action: CCG Equality Lead to support NWCSU HR business partner to implement measures to improve recording of this data.

- Assurances are given to CCG by People Services of EDHR being embedded within all People Services related strategy, policies and recruitment practices at CCG, to include timely staff training and Equality Analysis being implemented when policies are new or due for review.

  Action: NWSCU HR business partner/equality advisor to arrange audit of HR policies through 'critical friend' approach, agree actions from review.

- To support its role as a positive employer the CCG should investigate working towards achieving employment award in relation to a key local health inequality (e.g Mindful Employer)

  Action: CCG Equality Lead to explore options and to outline options to staff forum and Execs.

10.4 Recommendations for consideration but not identified as priority (workforce)

- It is recommended that NHS Salford should introduce measures to encourage men to apply to the CCG and more women to apply for Governing Body roles.

- The CCG should carry out a gender pay audit.

- The Governing Body demographic profile should be routinely requested and maintained as confidential data for reporting purposes.

13 Conclusion

This report demonstrates that NHS Salford CCG has undertaken significant work in relation to equality and diversity. We believe this report demonstrates our commitment to commissioning for equal access to health care and improving health outcomes for vulnerable groups. It also demonstrates our compliance with the requirements of the Public Sector Equality general and specific duties, as well as providing data with respect to our commissioning and engagement activities. It shows how we have made our commissioning decisions, and what needs to be undertaken in 2015 to continue commissioning for diversity.

Appendix 1: Salford CCG EDS(2) Public Grading Report June 2014 – Goal 4 Inclusive Leadership

Equality Delivery System – the NHS equality performance Framework

The Equality Delivery System (EDS) has been designed to be a tool for NHS organisations and their contracted provider partners, through involvement of stakeholders, to assess how we are performing in respect of equality and diversity and to help identify future priorities and objectives. A refreshed EDS(2) framework was launched by NHS England to all NHS commissioner organisations (and their provider partners) on 4 November 2013.

CCG carried out an annual public grading event and training event for EDS Stakeholder group during June 2014. Evidence in year one of the four year delivery cycle (2013 to 2017 equality performance) focused on Goal 4: Inclusive Leadership. A detailed report and scoring dashboard can be found on CCG website EDS(2) page.

EDS(2) equality performance framework asks for evidence of: how do people from local protected groups *fare* compared to people in general re healthcare?

Table 4.1: EDS(2) Grading explanation

Score	Number of protected groups affected	Explanation
● **Underdeveloped**	0-2 care pathways/groups	Insufficient data available
● **Developing**	3-5 care pathways/groups	Improved outcomes.
● **Achieving** Level 1	6-8 care pathways/groups	Improved outcomes. Have significantly improved on developing but still have actions to complete, clear future achievable plans in place
● **Achieving** Level 2	6-8 care pathways/groups	Improved outcomes. Can demonstrate they have achieved significant actions & clear future achievable plans in place
● **Excelling**	9 care pathways/groups	Improved outcomes.

Table 4.2: Goal 4: Inclusive Leadership at all levels – Summary of public grading June 2014

EDS(2) required Outcome	Public grading equality performance score	Action plan for Goal 4 grading uplift by May 2015
4.1 Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations.	● **Developing**	

4.2 Papers that come before the Board and other major Committees identify equality related impacts including risks, and say how these are being managed.	● **Developing**	
4.3 Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination.	● **Achieving** (Level 2)	

The NHS Equality and Diversity Council decided on 30 October 2014 to support mandating the Equality Delivery System (EDS2) from April 2015 and to support a programme of work to support these proposals. Consultation is still underway at this time (November 2014). This decision is likely to make a significant difference to improving equality in the NHS. Each of Salford CCG's provider partners are currently on target to deliver EDS during 2014 to 2015, looking at 2013 to2014 equality performance across 18 required Outcomes over a 4 year delivery cycle of 2013 to 2017. CCG proactively encourage patient and carer representatives from each of the local protected groups to become part of the EDS Stakeholder Group who carry out an annual public grading of CCG's equality performance.

During 2014 to 2015 CCG's annual public grading focused on goal 4: Inclusive Leadership at all levels, only. A plan has been agreed to gather evidence for the remaining 3 EDS goals by 2017 (4 year delivery cycle 2013 to 2017 set by NHS England).

Follow the link to CCG Equality Delivery System (EDS) webpage for details.

Appendix 2: Key Health Inequalities and Demographic Profiles by Protected Groups for Salford

Inequality can be found in:

- The social and economic environment - factors such as jobs, housing, education and transport, sometimes called "wider determinants of health" (The Marmot Review – *Fair Society Healthy Lives*) (xxvii)
- Lifestyle and health behaviours - including diet, smoking and social networks
- Access to effective services - that result in health benefits

These factors combine to create inequalities in health outcomes - disease, disability or death. Genetic factors may also make some contribution to ethnic health inequalities, for specific conditions such as diabetes and stroke. For some groups there may be very little or no differences in the incidences of certain diseases and yet they may face a poorer experience of health services.

Equality Analysis measures the extent of any unintended consequences and adverse impacts for diverse groups. The national and local health inequality data shown here may provide some service specific evidence to support the process.
There are various other sources of data on local health inequalities as follows:

a. Health profiles for Salford provide a snapshot of health in the area. They are designed to help local authorities and NHS organisations improve the health of the

local population and tackle health inequalities. They contain issues such as demographics, life expectancy and disease prevalence

b. Salford Health Profile (Public Health Observatory): http://www.apho.org.uk
c. Salford Children's Heath Profile (Child and Maternal Health Observatory): http://www.chimat.org.

Acknowledgement to Salford Royal FT original Health Inequalities report listed http://www.srft.nhs.uk/about-us/diversity-equality/meeting-psed/ health inequalities research information developed by the Equality & Inclusion team.

<table>
<tr><th>Protected groups</th><th>Key Local Population Data (Salford)</th><th>Key National Health Inequalities</th></tr>
<tr><td>Age</td><td>
<table>
<tr><th>Age</th><th>Percentage</th></tr>
<tr><td>0 - 14</td><td>18.05%</td></tr>
<tr><td>15 - 74</td><td>75.25%</td></tr>
<tr><td>75 and over</td><td>6.77%</td></tr>
</table>
Salford's population is multi-cultural and predominantly young with 63% of the population under 45 years old. According to the 2011 census data, the largest age band for Salford is 25-29 followed by 20-24 (male and female). 67% of Salford's population is in the working age group, whilst 19% are classed as children and 14% are of a pensionable age (now classed as 65 and above for both men and women) as of 2011.

The number of people suffering with dementia is the same as the national average however the ratio of recorded to expected prevalence of dementia (i.e. those who are undiagnosed) is significantly worse than the national average (i).

Salford has a significantly higher proportion of Income deprived older people compared with the average across England (ii).

Numbers of Salford people using adult and elderly NHS secondary mental health services is significantly higher than the national average.

Hospital admissions caused by unintentional and deliberate injuries in under 18 year olds are significantly higher than the national average.</td><td>Depression is the most common mental health problem in later life. Of the third of older people with depression who discuss it with their GP, only half are diagnosed and receive treatment (i)

Young men continue to be the group with the highest risk of suicide.

More than 1m people aged over 50 feel they are "severely excluded" from society (Age Concern, 2008).</td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td>Gender</td><td>
<table>
<tr><th>Gender</th><th>Salford population</th><th>Percentage</th></tr>
<tr><td>Male</td><td>116,782</td><td>49.9 %</td></tr>
<tr><td>Female</td><td>117,151</td><td>50.1%</td></tr>
</table>
In 2011 Salford had an almost even split of men and women residing in the area.

Boys are more likely to have ADHD, conduct disorders, and autistic spectrum disorders.</td><td>Men are more likely than women to die from bowel cancer but less likely to be screened (iv).

Suicide is currently the biggest killer of men under 35 in the UK (v).

2.7 million men in England currently have a mental health problem like</td></tr>
</table>

	Girls are more likely to suffer from eating disorders and self-harm. More young women (age 16-19) smoke and so are at risk of lung cancer, than young men.	depression, anxiety or stress (2009). 7.7% of children aged 5-10 years have a mental disorder but boys are twice as likely to experience these problems as girls. Around 50 per cent of women who use mental health services have experienced violence and abuse. One in three women die from cardiovascular disease (similar to men), yet they are less likely to think they are at risk, call for help or attend a cardio rehabilitation programme (vi). Women are more at risk of stroke than men and tend to be more seriously affected, needing long-term care (vii). More men than women suffer from diabetes in England, but women are at relatively greater risk of dying from it than men.
Disability	Disabled people make up over 8% of Salford's population. The highest groups within Salford to claim Disability Living Allowance are 25-49 year olds (24.9%) and 60-69 year olds (25%) (2010) (viii). Little Hulton has the highest rate of people within this ward claiming Disability Living Allowance 12.2%. Children with severe learning difficulties known to schools is slightly higher in Salford compared with the average across England. Adults with Learning Disabilities in Salford have a median age at death of 48 years which, in comparison to the average of 55 years across England, is significantly worse. Local population statistics predict that 13,262 people in Salford between the ages 18-64 have a moderate or serious physical disability and that this will rise to 14,378 by 2025. Approximately one in 10 (9%) currently contact their GP surgery by email, while around three in	There are over eleven million people with a limiting long term illness, impairment or disability in Great Britain (x). Around 6 per cent of children are disabled, compared to 15 per cent of working age adults and 45 per cent of adults over State Pension age in Great Britain (xi). A substantially higher proportion of individuals who live in families with disabled members live in poverty, compared to individuals who live in families where no one is disabled. 22 per cent of children in families with at least one disabled member are in poverty, a significantly higher proportion than the

<table>
<tr>
<td></td>
<td>10 (31%) would be their preferred method of contact, suggesting that there is unmet demand for alternative communication methods such as email (ix).

23% of the population has a long term condition which reflects the national data estimates of 1 in 5 of the adult population. Disabled people make up over 8% of Salford's population.</td>
<td>16 per cent of children in families with no disabled member (xii).

Over a quarter of disabled people say that they do not frequently have choice and control over their daily lives.

• People with learning disabilities are 58 times more likely to die before the age of 50 than the general population. A third of people with learning disabilities also have physical disabilities so have a higher risk of osteoporosis, hip displacement, chest infections, higher risk associated heart disease obesity, mental health and early onset dementia. A third of people with learning disabilities have epilepsy (some complex and sudden unexpected death from epilepsy).</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race</td>
<td>
<table>
<tr><th>Ethnicity</th><th>Percentage</th></tr>
<tr><td>White British</td><td>84.4%</td></tr>
<tr><td>White Irish</td><td>1.2%</td></tr>
<tr><td>White Other</td><td>4.4%</td></tr>
<tr><td>White Gypsy Traveller</td><td>0.1%</td></tr>
<tr><td>Mixed</td><td>2.0%</td></tr>
<tr><td>Asian/Asian British</td><td>3.0%</td></tr>
<tr><td>Black/Black British</td><td>2.8%</td></tr>
<tr><td>Other – Chinese</td><td>1.1%</td></tr>
<tr><td>Other – Arab</td><td>0.6%</td></tr>
<tr><td>Other any other ethnic group</td><td>0.5%</td></tr>
</table>

The majority of Salford residents are White British of which a significant amount of people have a poor socio-economic position, which is the main factor driving health inequalities (individual's place in the social hierarchies built around education, occupation and income).
Salford's BME resident population has grown to 14.5% (33,606 people in total) compared with 12.3% in 2007 and 3.87% in 2001.

Percentage of BME population at ward level
<table>
<tr><th>Ward</th><th>Percentage</th></tr>
<tr><td>Broughton</td><td>9.3%</td></tr>
<tr><td>Blackfriars</td><td>8.5%</td></tr>
<tr><td>Pendleton</td><td>7.9%</td></tr>
<tr><td>Ordshall</td><td>6.9%</td></tr>
<tr><td>Eccles</td><td>6.5%</td></tr>
<tr><td>Kersal</td><td>5.6%</td></tr>
</table>
</td>
<td>South Asian people are 50% more likely to die prematurely from coronary heart disease than the general population (xvi).

Type 2 diabetes is up to six times more common in people of South Asian descent and up to three times more common among people of African and African-Caribbean origin (xvii).

Asian women aged 65 or more have the highest rate of limiting, long-term illness at 64.5 per cent as compared to 53.1 per cent for all women aged 65 or over (xviii).

Bangladeshi and Pakistani men and women and Black Caribbean women were more likely than the general population to report bad or very bad health.

Pakistani women and</td>
</tr>
</table>

	Weaste & Seedley 4.3% An indication of Salford's diversity is further evidenced by the fact that the City Council provides information on its web site in six additional community languages and the NHS offers a locally-based interpreting service in ten languages (Arabic, Bangla, French, Farsi, Kurdish, Polish, Punjabi, Somali, Tigrinyan, and Urdu) (xv). The highest proportion of people admitted to A&E were from the Other and Black ethnic group populations which may reflect some patients not accessing or receiving care most suited to managing their conditions.	Bangladeshi men were more likely than those in the general population to report a limiting long-standing illness. Pakistani men and women were more likely than the general population to report acute sickness. Doctor-diagnosed diabetes was almost four times as prevalent in Bangladeshi men and almost three times as prevalent in Pakistani and Indian men, than in men in the general population (xix). Self-reported prevalence of cigarette smoking was greater among Bangladeshi and Irish men than in the general population. Use of chewing tobacco was most prevalent among the Bangladeshi group, with 9 per cent of men and 16 per cent of women reporting using chewing tobacco. Among Bangladeshi women, use of chewing tobacco was greatest among those aged thirty-five and over (26 per cent). Black Caribbean and Irish men had the highest prevalence of obesity; Pakistani and Bangladeshi men and women, and Black Caribbean and Black African women, were more likely than the general population to have raised waist to hip ratio and raised waist circumference. Indian, Pakistani and Bangladeshi men and women were less likely than the general population to meet the physical activity recommendations (of at least thirty minutes of moderate or vigorous exercise on at least five days a week). Black African boys were more likely to be obese than boys in the general population (31 per cent and 16 per cent respectively).

		Otherwise, the prevalence of obesity was similar among all groups. The prevalence of obesity among Black Caribbean and Bangladeshi boys increased between 1999 and 2004 from 16 per cent to 28 per cent, and 12 per cent to 22 per cent respectively. Irish and Black Caribbean women are much more likely to have high blood pressure than women in the general population. Gypsy and Travellers, on some sites, have life expectancies of 50 years and experience some of the worst health outcomes of any minority group. The Gypsy and Traveller community continue to experience in some areas significant barriers to accessing health care and public services.
Religion or Belief	<table><tr><th>Religion</th><th>Salford population</th><th>England & Wales %</th></tr><tr><td>Christian</td><td>64.2%</td><td>59.4%</td></tr><tr><td>Not religious</td><td>22.3%</td><td>24.7%</td></tr><tr><td>Not stated</td><td>6.2%</td><td>7.2%</td></tr><tr><td>Jewish</td><td>3.3%</td><td>0.5%</td></tr><tr><td>Islam</td><td>2.6%</td><td>5.0%</td></tr><tr><td>Hindu</td><td>0.6%</td><td>1.5%</td></tr><tr><td>Buddhist</td><td>0.4%</td><td>0.5%</td></tr><tr><td>Sikh</td><td>0.1%</td><td>0.8%</td></tr><tr><td>Other</td><td>0.3%</td><td>0.4%</td></tr></table> Compared to previous figures Christianity is down by 10%, No Religion is up by 10%. Salford has a much larger Jewish population compared with national data. Large pockets of Jewish communities can be found in Higher Broughton and Higher Kersal. Approximately 1 in 22 Salfordians are Jewish. It is a predominantly young community around 10% of all young people in Salford are Orthodox Jewish (xx). Jewish communities have a low uptake of cytological services and other screening, partly attributable to lack of appropriate female professionals for women to access; less access	Only half of people who are of South Asian heritage are likely to take up bowel cancer screenings, which drops to a quarter for Muslims. This is in comparison to two thirds of people who are not Muslim or not of South Asian heritage. Of all faiths, limiting long term illness or disability rates are highest amongst Muslims 24% females 21% males. Muslim, Sikh and Hindu females are more likely to report ill health than males from those religions. Some religions forbid certain types of treatment and drugs used: for instance, the prohibition of eating pork in Judaism and Islam means that porcine-or alcohol-based drugs might be

	to psychological interventions as well as neighbourhood health improvement services (xxi).	forbidden in these communities. Many religions believe in the 'supernatural' which implies that scientific explanations do not always apply. Religion and belief impacts on a variety of health matters such as blood transfusion, contraception and medication.
Sexual Orientation **Also see table 2 below**	National and Greater Manchester data sources such as surveys designed to capture sexual orientation and behaviour show 5-7% of the population is LGB. (Source: LGF 2013) 11,830 – 16,561 (2015: 12,320 - 17,248) lesbian, gay and bisexual people in Salford.	Lesbians may have a higher risk of breast cancer and gay men are at higher risk of HIV (xxiii). Almost 50% of the LGBT community smoke. Nine in ten lesbian and bisexual women drink and 40 per cent drink three times a week compared to a quarter of women in general, Lesbian and bisexual women are five times more likely to have taken drugs. In the last year, 3% of gay men and 5% of bisexual men have attempted to take their own life, compared to only 0.4% of men in general. Among the 16- to 24-year-old age group, 6% of gay and bisexual men have attempted to take their own life in the last year, compared to less than 1% of men in general in this age group. 7% of gay and bisexual men deliberately harmed themselves in the last year, compared to only 3% of men in general who have ever harmed themselves. Among the 16- to 24-year-old age group, 15% of gay and bisexual men have harmed themselves in the last year, compared to 7% of men in general in this age group who have ever deliberately harmed

		themselves. Lesbian young people are up to six times more likely to attempt suicide than heterosexual youth. Young gay men are 30 times more likely to attempt suicide than their heterosexual counterparts (xxiv).
	Data and quotes for Salford xxiv	**Prevalence within the lesbian, gay and bisexual community** xxiv
	HIV and Sexual Health HIV rate in Salford is 4.33 per thousand, the highest local authority rating outside of London according to 2012/13 Health Prevention England Data. Salford's acute STI rate remains high at 1038.3 per 100,000. This is the 4th highest rate in the North West. (Salford City Partnership –Sexual Health http://www.partnersinsalford.org/2765.htm) Source: xxiv Lesbian and Gay Foundation Manchester (2014)	8 out of 10 gay men contract HIV from a man who was unaware of his infection. Direct and indirect measures of incidence show that the rate of HIV transmission in the MSM population remains high. MSM experience 73% of male syphilis cases. MSM experience 30% of male gonorrhoea infections. Over 50% of lesbian and bisexual women have never had a sexual health check up • 75% of those who were not tested, did not get tested because they believed they were not at risk • 4% of those who were not tested, because health care workers had advised them that there was no need to test. Source: xxiv Lesbian and Gay Foundation Manchester (2014)
	Mental health In terms of depression, 40% of older people who consult their GP have some form of mental health problem and approximately 25% of older people living in the community have symptoms of depression that require intervention, 11% have minor depression and 2% major depression. Up to 40% of patients consulting their GP for any reason have a mental health problem and for 20-25% of patients, a mental health problem will be the sole reason for attending. (Salford Mental Wellbeing Strategy 2011 – 2015) Source: xxiv Lesbian and Gay Foundation Manchester (2014)	1 in 5 lesbian and bisexual women have deliberately self-harmed in the last year and they are 50 times more likely to do so than the general population. 0.4% of men in general have attempted to take their own life compared to: 5% of bisexual men 3% of gay men Source: xxiv Lesbian and Gay Foundation Manchester (2014)

	Alcohol Salford there are approximately: ▪ 40,400 hazardous drinkers (23%) ▪ 13,200 harmful drinkers (7.5%) ▪ 4,200 dependent drinkers (4%) This includes 44,000 (26.5%) binge drinkers (the cross-over between hazardous and harmful drinking). 'A Good Life with Alcohol in Salford: An Alcohol Harm Reduction Strategy For 2010–2020 Source: xxiv Lesbian and Gay Foundation Manchester (2014)	Alcohol dependency (over a 12 month period) was found to be 1.5 higher in the lesbian, gay and bisexual community compared to their heterosexual peers. Drinking alcohol 3 or more times a week: Women in general: 25% Lesbian and bisexual women: 40% Men in general: 35% Gay and bisexual men: 42% Indicative data: 10% of lesbian, gay and bisexual people reported binge drinking 4-5 times a week or almost daily. Source: xxiv Lesbian and Gay Foundation Manchester (2014)
	Cancer and smoking Early death rates from cancer and from heart disease and stroke have fallen but remain worse than the England average (2013) Cancer is a major cause of premature death in Salford. During 2006, 658 people in Salford were diagnosed with cancer and 327 people under the age of 75 died from cancer. For the 2008/9 Annual Health Check,1 Salford under-achieved the target for reducing cancer mortality. Salford is also currently failing to achieve the 80% target uptake for cervical cancer screening. Source: xxiv Lesbian and Gay Foundation Manchester (2014)	**Smoking** Young people who identify as lesbian or gay are more than twice as likely, and bisexual were almost twice as likely to have tried smoking as heterosexual people in the same age group. **Cervical cancer** 15% of lesbian and bisexual women have never been for a cervical screen compared to 7% of women in general. 40% of women who have sex with women have been previously told that they do not need a cervical smear either by a health professional or member of the community. **Breast cancer** 1 in 12 lesbian and bisexual women aged between 50 and 79years old will be diagnosed with breast cancer. **Anal cancer** Accepted that the incidence for anal cancer is at least 20 times higher in gay men than the general population.

		Source: xxiv Lesbian and Gay Foundation Manchester (2014)
Transgender	According to research carried out by the Gender Identity and Education Research Society (GIRES) the prevalence of people who had sought medical care for gender variance in 2007 was 20 per 100,000, i.e. 10,000 people nationally, of whom 6,000 had undergone transition. This equates to approximately 50 transgender people in Salford. 80% were assigned as boys at birth (now trans women) and 20% as girls (now trans men).	Tran's men (female to male) are rarely included in breast screening programmes. Tran's women (male to female) are rarely offered prostate screening but are often inappropriately invited for cervical screenings. Intersex women report being repeatedly asked about their last period and their contraceptive use, some are given smears (although they do not have a cervix). Transgender people are at a greater risk of depression, self-harm and suicide due to the social disapproval and discrimination that they encounter. 34% of people with gender identity issues report having attempted suicide or self-harm one or more times when they have not been able to access support and treatment in a timely way (xxv). For the Transgender community mental health problems are a serious concern as well as ignorance of their sexual health needs. 1 in 3 trans people face difficulties when trying to get

		information and obtaining funding for Gender Reassignment Surgery. 23% of the population suffer from long term illnesses, against the national average of 18%. Transgender people can face discrimination and harassment. Negative experiences have been reported e.g. being addressed incorrectly placed on the wrong ward for their acquired gender or staff allowing their personal feelings to be known by the patient. Young Trans people report insecure housing, economic hardship, legal problems and difficulty in accessing appropriate healthcare. They have limited family support, high rates of substance abuse and high risk sexual behaviours (xxvi).

Deprivation

In addition to the 9 protected groups, there are significant inequalities related to deprivation, a summary of which is provided here:

- Salford male residents have a life expectancy of 74.8 years, compared to the national average of 78.6 years and Salford female residents have a life expectancy of 79.9 years compared to the national average of 82.6 years.
- Women living in the most deprived areas have cervical cancer rates more than three times as high as those in the least deprived areas.
- Women living in deprived areas have a lower survival rate for breast cancer and inequalities in rates of breast cancer are increasing (iii).
- Men aged 25-64 from routine or manual backgrounds are twice as likely to die as those from managerial or professional backgrounds and there are also sizeable differences for women.
- Adults in the poorest fifth of the income distribution are much more likely to be at risk of developing a mental illness as those on average incomes.
- Teenage motherhood is eight times as common amongst those from manual social backgrounds as for those from professional backgrounds.
- Children from manual social backgrounds are 35% more likely to die as infants than children from non-manual social backgrounds.
- Deprivation in Salford is more than double 46.1% compared with the average in England 19.8% with higher rates of violent crime and unemployment (xiii).
- Early death rates from Heart Disease, stroke and Cancer are significantly higher than the average in England.
- Higher rates of White people are admitted to A&E compared to the average in England.
- There is a 12.1 year gap of life expectancy between men living in the most deprived parts of Salford compared to those men living in the least deprived, and this is consistent for women also with a gap of 8.2 years. Overall mortality from heart disease, cancer and lung disease are the major killers for Salford's residents, with lung cancer being the major contributor to deaths from cancer (xiv).

References

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