Salford Clinical Commissioning Group

# Annual Equality Data Publication
# 31 January 2014

## Executive Summary

NHS Salford CCG (Clinical Commissioning Group) know that different patients, carers and staff take up healthcare services, information and employment opportunities differently. Health inequalities exist within the vulnerable communities we serve. This publication sets out what data we are aware of for protected groups and highlights any significant gaps or trends with links to our Equality Objectives.

This is Salford CCG's first Annual Equality Data Publication, since forming on 1 April 2013. We are therefore at the early stages of responding to the need to provide transparent reporting on what equality data is held about local protected characteristic groups and with the option in place for patients to declare their demographic profiles. In this publication it is important for us to acknowledge that in relation to equality and diversity the CCG this year has focused on getting systems and processes in place.

Salford CCG knows that a robust equality, diversity and human rights approach makes sound ethical and business sense. We are required to show how we take 'due regard' of vulnerable protected groups and Inclusion Health groups in our decision making processes. We use various processes to help us to achieve and evidence good outcomes for those groups. How we consistently provide fair access to healthcare services for all vulnerable people under the Equality Act 2010 and the Health and Social Care Act 2012 is our key concern within this publicly available report.

Paula Vasco Knight (Equality Lead NHS England) said "Every person in England deserves to be treated to the same level of access, outcomes, experience, dignity and respect from our health and care system. However, we must develop a culture of learning and sharing from best practice wherever possible and always strive to ensure Everyone Counts " (July 2013). The NHS planning guidance for 2013-14 'Everyone Counts' outlined the incentives and levers that will be used to improve services from April 2013, the first year of the new NHS where improvement is driven by clinical commissioners. It also addresses health inequalities, so that those most in need gain the most from the support we provide.

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 also rely on our providers to report on a number of equality measures set out within the Equality Delivery System 2 (EDS2) equality performance framework (using an annual public grading), within the EDHR Schedule submission due 1 November annually, through website compliance and through accessibility for equality diversity and human rights information and services.

Salford CCG wants to be able to evidence that we can give our patients, carers and staff the following assurances:

- Our services provide fair access and are inclusive to vulnerable groups, including the services we commission from provider organisations

- Our recruitment, selection, training and promotion processes deliver fair outcomes, where the person with the best talents and skills is enabled to gain the skills to apply for appropriate vacancies arising. The person with the best talents and skills for the job role is the successful candidate. Trained staff support this fair and equitable process at every stage.
- Our workforce are well trained to respond to the priority healthcare needs of vulnerable protected group communities and Inclusion Health groups. They understand the different access and support needs of these vulnerable local groups. They listen and make fair and reasonable commissioning decisions based on sound information on needs and priorities.
- Commissioner focused staff are supported in an inclusive workplace environment where wellbeing is an important consideration within achieving a work-life balance.

Note: Inclusion Health groups include socially excluded and disadvantaged groups. Socially excluded groups experience a range of poor health outcomes. For example:

- Just 30% of Irish Travellers live beyond their 60th birthday
- People with learning disabilities are 58 times more likely to die prematurely than the general population
- Hepatitis B and C infection among female prisoners are 40 and 28 times higher than in the general population
- Socially excluded people often make chaotic and disproportionate use of health care services, and experience a range of barriers and issues relating to their access and quality of care. For example:
    - Homeless people each consume an estimated eight times more hospital inpatient services than an average person of similar age, and their secondary care costs around £85 million in total per year. Compared to the general public, they are 40 times more likely not to be registered with a GP and have about five times the utilisation of A&E. 81% of GPs interviewed by Crisis thought that it was more difficult for a homeless person to register than the average person.
    - Street sex workers, who have the most acute health needs of sex workers, are more likely to be in contact with health care services than the general population. They are over five times more likely to report visiting a GP in the past year: 58% reported seeing a GP; 29% had visited A&E; 24% had been to an STI clinic; 21% to inpatient clinics; and 17% to outpatient clinics in the previous year. They are also more likely than the general population to use acute care, but are less likely to have taken up routine screening, health checks and vaccinations.

## Introduction

**What does CCG commission for local vulnerable groups?**

Salford Clinical Commissioning Group (CCG) exists to improve the health care of the local population. The main focus is to use the local knowledge of our GPs and their practice teams to advance the way that health services are currently delivered, and help our patients to make full use of the services that are available.

The CCG is made up of Salford GPs, who alongside other health colleagues are responsible for commissioning (planning and purchasing) health services across the area. This responsibility for GPs comes as a result of the Government's health reforms which pledged to make the NHS more accountable to patients, free-up front line staff from excessive bureaucracy, and focus on clinical outcomes rather than targets.

## What are Salford CCG's main priorities over the first few years?

The CCG's strategic direction can be found in the following documents which are all available of the CCG's website:

- Salford's Joint Health and Wellbeing Strategy to 2016
- Integrated Strategy and Operating Plan 2013-14 and 2015-16 and associated Public Prospectus

## Meeting our legal obligations

**What is an Equality Data Publication?**

We know that different groups take up and experience services differently. Some harder to reach, more marginalised groups may need support in accessing healthcare information, services and premises. Salford CCG is keen to understand from the experiences of patients, how services can be fair and accessible to all sections of our local communities. We are therefore pleased to present this annual publication containing an overview of the quantitative and qualitative equality data available to the CCG to help patients, carers and staff from each of the 9 protected groups to shape healthcare services for improvements.

This annual publication sets out Salford CCG's known equality data for each of the protected groups, for staff (including main provider organisations' workforce make up), and service delivery i.e. who is taking up healthcare services. It scrutinizes for any significant gaps in equality data and sets out what the CCG plans to do to address any such significant shortfalls over the four year cycle (2013-17). Any agreed actions will be linked to the CCGs Equality Objectives which are listed below. Our Equality Objectives for 2013-17 were first published in April 2012 and refreshed by the CCG in October 2013:

**Objective 1:** Improve health and narrow the gaps in access, experience and outcomes.

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

**Objective 3:** Communicate and engage with all protected groups.

**Objective 4**: Develop equality and diversity competent and well supported staff.

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

Agreed equality actions are available in Salford CCG's overarching EDHR Action Plan 2013-14.

## Why are CCG producing this document?

**Regardless of which *protected group local people align with they should have fair access to healthcare information, services, premises and any employment opportunities.**

The Specific Equality Duties require all public bodies to:

- publish information to show their compliance with the Equality Duty (PSED or Public Sector Equality Duty), at least annually; and
- set and publish equality objectives, at least every four years.

All information must be published in a way which makes it easy for people to access.

Public bodies subject to the specific duties (this includes CCGs and their main provider organisations) must publish information to show their compliance with the Equality Duty.

* The 9 protected characteristics covered by the Equality Duty and set out in the Equality Act 2010 are:

- age
- disability
- gender reassignment
- marriage and civil partnership (but only in respect of eliminating unlawful discrimination)
- pregnancy and maternity
- race – this includes ethnic or national origins, colour or nationality
- religion or belief – this includes lack of belief
- gender – male / female
- sexual orientation.

Marriage and civil partnership does not apply to the PSED, but organisations must be mindful of the other provisions of the Act that prohibit discrimination on the grounds of marriage and civil partnership.

Public bodies must publish information to show that they consciously thought about the three aims of the Equality Duty as part of the process of decision-making (see below 'What is the Public Sector Equality Duty?').

## Aims of Annual Equality Data Publication

The publication will look at our available equality data and consider whether that gives a reasonable picture of progress on equality issues affecting our employees and patients / service users and carers. However Salford CCG commission services from other provider organisations. We also have a responsibility to scrutinse the equality data information provided by our providers, for legal compliance with the Equality Act 2010 and the PSED.

Our publication should be easily accessible to protected groups on request. We have produced an Accessibility Statement summary which is displayed on our CCG website.

The focus of this annual report or publication is as follows:

- To provide information to the public and CCG governing body on our equality and human rights performance during 2013.

CCG are keen to use this performance information to make a real difference to vulnerable local groups, in terms of 'You said, We did'.

## What will this include?

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:

- the CCG's workforce and provider partners' workforce where over 150 staff
- who is accessing local health services
- patient satisfaction levels and complaints by community group and discrimination type.

This includes consideration of what equality data we know about for our workforce and for service delivery issues i.e. which patients are taking up which services. Also:

- customer satisfaction levels, informal feedback and results of consultations
- Equality Delivery System 2 (EDS2) intentions for 2013-14 and beyond
- Equality Analysis (EA) process which scrutinizes key changes such as service redesigns or strategy etc, for any potential adverse impacts on local protected groups
- Equality Diversity and Human Rights (EDHR) Strategy and Action Planning to deliver on the 5 Equality Objectives agreed by CCG in October 2013
- A summary of the current status of data provided by our main provider organisations via their websites, to the public and via an annual Equality Diversity and Human Rights Schedule (EDHR Schedule) which is submitted to the CCG annually in November.

**Caveat on equality data reporting by CCG before 1 April 2013**

Salford CCG is able to report on equality data (relating to workforce and service delivery) from 1 April 2013 and not on any data relating to before that time which would have been held by the Primary Care Trust for example. This includes any data from primary care (patients or staff from GP Practices, dental or optician services) or secondary care (hospitals or community healthcare services).

## 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.

## What is the public sector equality duty (PSED)?

The PSED (or general duty) has three aims. Organisations are asked in the exercise of their functions to have due regard or consideration to the need to:

- eliminate discrimination, harassment and victimisation and other conduct prohibited under the Act
- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it

- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

In other words pay particular attention in your decision making to:

- remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic
- take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it
- encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low
- it should be noted that the steps involved in meeting the needs of disabled persons that are different from the needs of persons who are not disabled include, in particular, steps to take account of the disabled person's disabilities.

Having 'due regard' to the need to foster good relations between persons who share a relevant protected characteristic and persons who do not share it, involves having due regard, in particular, to the need to:

- tackle prejudice
- promote understanding.

## 'Specific Duty' Requirements on CCG and provider partners

The Equality Act 2010 replaced previous anti-discrimination laws with a single Act. It simplified the law, removing inconsistencies and making it easier for people to understand and comply with. It also strengthened the law in important ways, to help tackle discrimination and inequality.

The Equality Duty is supported by **specific duties**, set out in regulations which came into force on 10 September 2011. The specific duties require public bodies to **publish relevant, proportionate information demonstrating their compliance with the Equality Duty**; and to set themselves specific, measurable **equality objectives**.

Publishing relevant equality information will make public bodies transparent about their decision-making processes, and accountable to their service users. It will give the public the information they need to hold public bodies to account for their performance on equality.

## Who does the PSED apply to?

The PSED applies to all NHS organisations including FTs (Foundation Trusts), listed in Schedule 19 to the Act. But the Act also states that a person who is not a public authority, but who exercises public functions, must in the exercise of their functions have due regard to the PSED.

## Transparent approach to taking decisions to fully include local vulnerable people from protected groups

Salford CCG has agreed to deliver on 5 Equality Objectives over a 4 year period (2013-17). This means agreeing an annual Action Plan with clear Milestones. Also the CCG is focusing on how we take consideration of or give 'due regard' to each of the 9 local protected groups in all our major decision making processes.

The CCG has set Equality Objective Milestones for 2013-14 which link closely with our commissioning priorities. Our Five Year Strategic Plan is going through stages of consultation with stakeholders and local communities of interest (including protected groups). This helps ensure that our plan's development also takes into account the needs of local vulnerable groups through feedback we receive at consultation events. This includes a summary of what equality data we know about for our workforce, and for service delivery issues i.e. which patients are taking up which services from protected characteristic groups.

Organisations with 150 staff or more are required to publish their staff equality data. Our workforce data at 30 September 2013 has been scrutinised by Salford CCG's Equality Lead. The numbers employed by the CCG are under 80 and there are no significant gaps or trends to include within this annual equality data publication. This 2013 data is therefore not included within this publication. However the CCG's Executive Team regularly review workforce reports to ensure no significant gaps or trends emerge.

## Listening… and Responding

The CCG undertakes a wide range of patient and public engagement to ensure that the views of local people are considered in our decision making.

Throughout the year we used a range of different engagement methods to reach as many local groups as possible and undertook targeted events to hear the views of people from protected groups.

Salford CCG works with the Virtual Patient Panel to help scrutinise key changes for any adverse impacts on local protected groups and Inclusion Health groups. A number of communities of local interest work with the CCG to highlight any perceived barriers in services for vulnerable local groups. The CCG is keen to understand which harder to reach more marginalised groups we are reaching in terms of receiving feedback on key changes, that help the CCG to shape services to take account of local needs.

At 2013 consultation and engagement events, our Communications and Engagement team have introduced optional and anonymous monitoring for attendees to declare their protected group profiles. This data collection will help the CCG to analyse disaggregated data for local vulnerable groups, where demographic information is declared.

## Customer satisfaction levels and informal feedback from service users with different protected characteristics and results of consultations from people with different protected characteristics

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 by 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

**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.

As more anonymous equality data is returned to GMCSU, reporting will become more meaningful on which protected groups are taking up the complaints service and their differential satisfaction levels i.e. are our disabled customers are just as satisfied with the service as our non disabled customers?

## Equality Delivery System 2 (EDS2) intentions

Salford CCG is currently agreeing which EDS2 Outcomes it will focus on, following the NHS England refresh of the Equality Delivery System in November 2013. An overarching EDHR Action Plan 2013-14 (Equality Diversity and Human Rights) includes milestones for each of our agreed Equality Objectives 2013-17. This Action Plan also includes agreed EDS2 Outcomes where the CCG are gathering evidence of compliance for local people from the protected groups.

An annual public grading of evidence is planned to take place on 10 April 2014 with stakeholders and volunteer representatives from local communities of interest (including protected group patient representatives).

## Equality Analysis (EA)

Equality Analysis (EA) is the process which scrutinizes changes such as service redesigns or strategy, for any potential negative impacts on people from local protected groups.

Equality Analysis needs to be completed for key changes under consideration by CCG, involving consultation on any potential adverse impacts on local vulnerable groups, including patient and carer representatives from protected groups. This provides the CCG with evidence of taking 'due regard' of vulnerable people in their decision making processes.

The CCG has a number of nominated staff who lead in this area of scrutiny and assurance with training provided. Any key changes are considered for adverse impacts on protected groups. Where feedback is received the CCG will consider and may mitigate or re-shape services where appropriate to take into account specific needs which help vulnerable patients to access services fairly.

A list of completed Equality Analysis each year will be displayed on the CCG website.

## Provider organisation performance

The CCG's main provider organisations provide the CCG with a range of equality and diversity information . This is via their website to the public and via an annual Equality Diversity and Human Rights Schedule (EDHR Schedule) which is submitted to CCG annually on 1 November. Appendix 1 provides a summary of this as an equality performance dashboard.

A rich source of equality data is currently requested from our main provider organisations via the annual EDHR Schedule evidence submission. This includes for example: what Hate Crime Awareness training do your staff receive; confirmation of Access Audit report of premises, with supporting action plan to address any significant gaps; examples of how reasonable adjustments are successfully put into place for workforce and service delivery settings. A quality assurance check of evidence is carried out by the CCG's EDHR Lead.

Similarly to the CCG, provider organisations are required to support an annual public grading of their Equality Delivery System 2 evidence.

The CCG is looking to continuously improve this EDHR Schedule and for example plans in 2014/15 onwards to ask our main provider partners to monitor DNAs (patients who 'did not arrive') at healthcare appointments, by protected groups. This should then support further understanding of why patients may not be attending for appointments or why they are attending and may not have in place reasonable adjustments to enable the appointments to be completed.

These activities are part of the compliance check of providers, giving assurances on equality performance to the CCG.

## Conclusions

Equality diversity and human rights data reporting and scrutiny begin to tell the CCG a story about the experiences of its most vulnerable and more marginalised patients, carers and staff. Through quantitative and qualitative data gathering and review, the CCG can gain assurances about the quality and safety of its services for local protected groups and Inclusion Health groups.

It is a key challenge across all CCGs is to identify and address health inequalities specifically for local protected groups and Inclusion Health groups as illustrated in appendix 2.

The CCG recognises that this report outlines our early work and gives a commitment to build on our work in this area in future years.

## Appendix 1: 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 taken up appropriately 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 before Oct 2013.<br><br>Quality Assurance check completed. No significant issues identified. | Service Access and Patient Experience Report received Sept 2013.<br><br>No issues of concern identified. | March 2012 and next submission due in 2014.<br><br>Detailed case studies and a dashboard of scores displayed on their website. | Data covering Nov 2012 to July 2013 submitted in Oct 2013.<br><br>Data largely representative of local population. | Oct 2013.<br><br>Comprehensive, high quality information. No issues of concern identified. |
| Greater Manchester West Mental Health Foundation Trust | EDHR Schedule submitted Nov 2013.<br><br>Quality Assurance check completed. No significant issues identified but further qualitative data requested. | Patients access monitoring report (access and discharges by protected groups) received Nov 2013.<br><br>No issues of concern identified but further qualitative data requested. | System not previously used. First submission due in 2014. | Data as at Sept 2013 submitted Nov 2013.<br><br>Data largely representative of local population. | Dec 2013.<br><br>Significant effort and progress shown with good Salford specific information. Further up to date information expected in January 2014. Going forward reports need to show dates. |
| Oaklands Private Hospital (orthopaedic care) | The requirement for an EDHR Schedule was not included within 2013-14 contract. Discussions with Oaklands and contract changes mean this will be submitted in 2014. Ongoing dialogue with Oaklands is ensuring progress in this area with staff equality training planned for Feb 2014. | | | | |

## Appendix 2: Key Health Inequalities by Protected Groups

Inequality can be found in:

- The social and economic environment - factors such as jobs, housing, education and transport, sometimes called “wider determinants of health”
- 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.

<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.
</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 1<br><br>Young men continue to be the group with the highest risk of suicide.<br><br>More than 1m people aged over 50 feel they are "severely excluded" from society (Age Concern, 2008).</td></tr>
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<table>
<tr><td></td><td>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).<br><br>Salford has a significantly higher proportion of Income deprived older people compared with the average across England (ii).<br><br>Numbers of Salford people using adult & elderly NHS secondary mental health services is significantly higher than the national average.<br><br>Hospital admissions caused by unintentional and deliberate injuries in under 18 year olds are significantly higher than the national average.</td><td></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><br>In 2011 Salford had an almost even split of men and women residing in the area.<br><br>Boys are more likely to have ADHD, conduct disorders, and autistic spectrum disorders.<br><br>Girls are more likely to suffer from eating disorders and self-harm.<br><br>More young women (age 16-19) smoke and so are at risk of lung cancer, than young men.</td><td>Men are more likely than women to die from bowel cancer but less likely to be screened (iv).<br><br>Suicide is currently the biggest killer of men under 35 in the UK (v).<br><br>2.7 million men in England currently have a mental health problem like depression, anxiety or stress (2009).<br><br>7.7% of children aged 5-10 years have a mental disorder but boys are twice as likely to experience these problems as girls.<br><br>Around 50 per cent of women who use mental health services have experienced violence and abuse.<br><br>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).</td></tr>
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| | | |
|---|---|---|
| | | Women are more at risk of stroke than men and tend to be more seriously affected, needing long-term care (vii).<br><br>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.<br><br>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).<br><br>Little Hulton has the highest rate of people within this ward claiming Disability Living Allowance 12.2%.<br><br>Children with severe learning difficulties known to schools is slightly higher in Salford compared with the average across England.<br><br>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.<br><br>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.<br><br>Approximately one in 10 (9%) currently contact their GP surgery by email, while around three in 10 (31%) would be their preferred method of contact, suggesting that there is unmet demand for alternative communication methods such as email (ix).<br><br>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. | There are over eleven million people with a limiting long term illness, impairment or disability in Great Britain (x).<br><br>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).<br><br>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.<br><br>22 per cent of children in families with at least one disabled member are in poverty, a significantly higher proportion than the 16 per cent of children in families with no disabled member (xii).<br><br>Over a quarter of disabled people say that they do not frequently have choice and control over their daily lives.<br><br>• 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). |
| | | |

**Race**

| Ethnicity | Percentage |
|---|---|
| White British | 84.4% |
| White Irish | 1.2% |
| White Other | 4.4% |
| White Gypsy Traveller | 0.1% |
| Mixed | 2.0% |
| Asian/Asian British | 3.0% |
| Black/Black British | 2.8% |
| Other – Chinese | 1.1% |
| Other – Arab | 0.6% |
| Other any other ethnic group | 0.5% |

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

| Ward | Percentage |
|---|---|
| Broughton | 9.3% |
| Blackfriars | 8.5% |
| Pendleton | 7.9% |
| Ordshall | 6.9% |
| Eccles | 6.5% |
| Kersal | 5.6% |
| 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

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 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

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<td>Other and Black ethnic group populations which may reflect some patients not accessing or receiving care most suited to managing their conditions.</td>
<td>women, were more likely than the general population to have raised waist to hip ratio and raised waist circumference.<br><br>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).<br>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.<br><br>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.<br><br>Irish and Black Caribbean women are much more likely to have high blood pressure than women in the general population.<br><br>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.</td>
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<td></td>
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<tr>
<td>Religion or Belief</td>
<td>
<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>
</table>
</td>
<td>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.<br><br>Of all faiths, limiting long term illness or disability rates are highest amongst Muslims 24% females 21% males.</td>
</tr>
</table>

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|---|---|---|---|
| Buddhist | 0.4% | 0.5% |
| Sikh | 0.1% | 0.8% |
| Other | 0.3% | 0.4% |

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 to psychological interventions as well as neighbourhood health improvement services (xxi).

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 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.

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| | | 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.<br><br>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.<br><br>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). |
| | | |
| **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.<br><br>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.<br><br>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).<br><br>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).<br><br>For the Transgender community mental health problems are a serious concern as well as ignorance of their sexual health needs.<br><br>1 in 3 trans people face difficulties when trying to get information and obtaining funding for Gender Reassignment Surgery. |

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| | | 23% of the population suffer from long term illnesses, against the national average of 18%.<br><br>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.<br><br>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). |

Acknowledgement: Salford Royal Foundation Trust – health inequalities research information developed by the Equality & Inclusion team.

**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).

**Table 2: Sexual Orientation Salford**

| Data and quotes for Salford | Prevalence within the lesbian, gay and bisexual community |
|---|---|
| **236,597 people live in Salford. By 2015 this will be 246,400.**<br><br>**(Salford's Joint Health and Wellbeing Strategy: our vision for a healthier Salford by 2016)** | **'National and Greater Manchester data sources such as surveys designed to capture sexual orientation and behaviour show 5-7% of the population is LGB.'**<br><br>**11,830 – 16,561 2015 12,320-17,248 lesbian, gay and bisexual people** |
| **HIV and Sexual Health**<br>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.<br><br>Salford's acute STI rate remains high at 1038.3 per 100,000. This is the 4th highest rate in the North West.<br><br>(Salford City Partnership –Sexual Health http://www.partnersinsalford.org/2765.htm) | 8 out of 10 gay men contract HIV from a man who was unaware of his infection.<br><br>Direct and indirect measures of incidence show that the rate of HIV transmission in the MSM population remains high.<br><br>MSM experience 73% of male syphilis cases.<br>MSM experience 30% of male gonorrhoea infections.<br><br>Over 50% of lesbian and bisexual women have never had a sexual health check up[1]<br>• 75% of those who were not tested, did not get tested because they believed they were not at risk<br>• 4% of those who were not tested, because health care workers had advised them that there was no need to test. |
| **Mental health**<br><br>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.<br>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) | 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.<br><br>0.4% of men in general have attempted to take their own life compared to:<br>5% of bisexual men<br>3% of gay men |

[1] Hunt R & Fish J, *Prescription for Change*, Stonewall, 2008

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| **Alcohol**<br>Salford there are approximately:<br><br>□ 40,400 hazardous drinkers (23%)<br>□ 13,200 harmful drinkers (7.5%)<br>□ 4,200 dependent drinkers (4%)<br>□ This includes 44,000 (26.5%) binge drinkers (the cross-over between hazardous and harmful drinking).<br><br>'A Good Life with Alcohol in Salford: An Alcohol Harm Reduction Strategy For 2010–2020 | 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.<br><br>Drinking alcohol 3 or more times a week:<br>Women in general: 25% Lesbian and bisexual women: 40%<br>Men in general: 35% Gay and bisexual men: 42%<br><br>Indicative data:<br>10% of lesbian, gay and bisexual people reported binge drinking 4-5 times a week or almost daily. |
| **Cancer and smoking**<br>Early death rates from cancer and from heart disease and stroke have fallen but remain worse than the England average (2013)<br><br>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. | **Smoking**<br>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.<br><br>**Cervical cancer**<br>15% of lesbian and bisexual women have never been for a cervical screen compared to 7% of women in general.<br><br>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.<br><br>**Breast cancer**<br>1 in 12 lesbian and bisexual women aged between 50 and 79years old will be diagnosed with breast cancer.<br><br>**Anal cancer**<br>Accepted that the incidence for anal cancer is at least 20 times higher in gay men than the general population. |

**Source: Lesbian and Gay Foundation Manchester (2014)**

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