NHS
Vale of York
Clinical Commissioning Group

Annex A

Equality Act
Public Sector Equality Duty Report
2016-17

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Executive Summary

NHS Vale of York Clinical Commissioning Group (the "CCG") has a duty to report annually on its equalities activities, and the 2016-17 report sets out the main areas of legislation and reporting requirements which affect clinical commissioning groups. These include:

- Equality Act 2010
- Equality Delivery System 2 (EDS2)
- Accessible Information Standard (AIS)
- Workforce Race Equality Standard (WRES),

as well as proposed new guidance on the Workforce Disability Equality Standard (WDES), and the Disability Confident employment standard, which replaces the former "Two Ticks" statement.

The report also outlines the main sources of data used for the nine equalities strands (as set out in the Equalities Act 2010) and for carers, an additional equalities strand identified locally during the development of the CCG's equalities strategy.

The main objectives for the CCG's equalities work are:

1. To provide accessible and appropriate information to meet a wide range of communication styles and needs.

2. To improve the reporting and use of equality data to inform equality analyses.

3. To strengthen stakeholder engagement and partnership working.

4. To be a great employer with a diverse, engaged and well supported workforce.

5. Ensure our leadership is inclusive and effective at promoting equality.

About us

NHS Vale of York Clinical Commissioning Group (CCG) is made up of 27 member GP practices. Our member practices are listed on the Vale of York CCG website, http://www.valeofyorkccg.nhs.uk/about-us/about-the-ccg/. We are an NHS organisation led by clinicians who understand the needs of the community and the impact that local services have on patients' health.

Our vision is

To achieve the best in health and wellbeing for everyone in our community

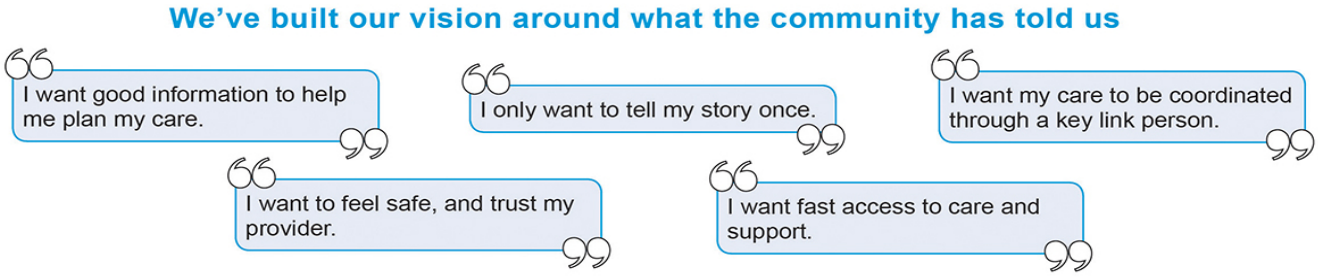
In order to do this we are committed to listening to and respecting the voices of our diverse communities in order to promote equality and diversity throughout the planning and development of service commissioning. We value and respect our staff and aspire to be an inclusive employer of choice. This commitment is supported by our Equality, Diversity and Human Rights Strategy and Implementation Plan 2013-2017, which can be found on the CCG website.

We serve a population of more than 351,000 living in York, Selby, Tadcaster, Easingwold, Pocklington and the surrounding villages and rural areas.

Our footprint covers an area of approximately 857 square miles that runs broadly north to south through North Yorkshire. It is mainly rural with a number of small market towns and the main urban centre of York. It covers three local authority boundaries - North Yorkshire County Council, City of York Council and East Riding of Yorkshire Council. The Vale of York is a comparatively affluent area but with pockets of significant deprivation in the York, Selby and Sherburn-in-Elmet areas. We have two local Universities with a significant, vibrant and diverse student population. Our Universities have built particularly strong links with China, attracting both students, staff and their families and this is reflected in our local population where people of Chinese heritage make up 1.2% people living in the city of York.

We are responsible for planning, designing and monitoring many health services. Our main areas of commissioning responsibility are:

- Planned hospital care
- Urgent and emergency care
- Rehabilitation care
- Community health services
- Mental health and learning disability services



Integrated Operational Plan

The 2017-19 Operational Plan is currently under development, but previous versions of the CCG's operational plan are available on the CCG website at: http://www.valeofyorkccg.nhs.uk/publications-plans-and-policies-1/ . For 2016-17 the priorities focused on sustainability in primary and secondary care through redesigning community-based pathways, and developing a wider partnership approach including the development of Sustainability and Transformation Plans across a wider footprint. The 2016-17 plan included a summary of population need to highlight areas of health inequalities.

Primary Care Commissioning

In April 2015, we took on the responsibility for commissioning the majority of local GP services. The potential benefits of co-commissioning for the public and patients include:

- Improved access to primary care and wider out-of-hospitals services, with more services available closer to home.
- High quality out-of-hospitals care.
- Improved health outcomes, equity of access, reduced inequalities.
- A better patient experience through more joined up services.

You can find out more about Primary Care Commissioning in the Vale of York on our website at http://www.valeofyorkccg.nhs.uk/about-us/about-the-ccg/

Purpose of the Public Sector Equality Duty Report

Equality Act 2010

As part of the Equality Act 2010 a 'public sector equality duty' was introduced which places an obligation on the CCG to proactively improve equality for people with one or more 'protected characteristics'. This is made up of a general duty and specific duties. The general duty is the main part of the legislation with the specific duties supporting public bodies to demonstrate performance and compliance.

The General Duty

The Equality Duty, which came into force in April 2011, aims to help public authorities avoid discriminatory practices and integrate equality into core business. The CCG has to pay due regard to the three aims of the general duty, in the exercise of their functions and need to

- Eliminate discrimination, harassment and victimisation
- Advance equality of opportunity
- Foster good relations

Specific Duties:

- **Equality objectives**

The Act requires public bodies like the CCG to prepare and publish one or more specific and measurable equality objectives, which they believe will support them to achieve the aims of the general duty. The purpose of the objectives is to help the CCG better perform the general equality duty, focusing on the outcomes achieved. You can find further information on our equality objectives later in this report.

- **Publication of information**

Annually the CCG will have to demonstrate the impact of its policies and practices on people with protected characteristics. This will be achieved by the publication of this report.

Protected Characteristics

Protected characteristics are defined as:

- Age
- Sex
- Disability
- Gender Reassignment (Transgender)

- Race (ethnicity)
- Religion or Belief
- Sexual Orientation
- Pregnancy and maternity
- Marriage and civil partnership (employment only)

We additionally pay due regard to the needs of carers when making commissioning decisions.

In publishing this report Vale of York CGG is demonstrating that we have consciously thought about the three aims of the Equality Duty as part of our decision-making process.

The Act also requires that employers with a workforce of over 150 employees publish information relating to employees who share protected characteristics. We currently have 86 employees and so will not publish this information as it has the potential to identify individual members of staff. We undertake an annual staff survey and analyse this to see if there are any differential experiences of staff from protected characteristic groups.

Equality Delivery System 2 (EDS2)

The main purpose of the Equality Delivery System 2 (EDS2) is to help local NHS organisations, in discussion with local partners and people, to review and improve their performance for people with characteristics protected by the Equality Act 2010. By using EDS2, NHS organisations can also be helped to deliver on the public sector Equality Duty (PSED). You can find out more about EDS2 at https://www.england.nhs.uk/wp-content/uploads/2013/11/eds-nov131.pdf.

From April 2015, EDS2 implementation by NHS provider organisations was made mandatory in the NHS standard contract. EDS2 implementation is explicitly cited within the CCG Assurance Framework, and will be measured within the “well-led organisation” component and will continue to be a key requirement for CCGs.

In February this year we engaged with fellow CCGs in North Yorkshire and our Providers to review our EDS2 priorities. We agreed the following shared priorities:

1. **Directory of Services –** to provide better information on how to access services. We are working with partners particularly Healthwatch to progress this.

2. **Information sharing –** to generate and share information and knowledge across a wider area. The Trusts and the CCGs have agreed to work together and share information and this will lead to a better understanding of the needs of our communities across Acute hospital, Mental Health and Learning Disability Services. We are currently in the process of developing a list of information that we will share on a regular and on-going basis.

3. **Develop options for improved representation –** we need to gather information about the experiences of a range of local people and to share the purpose of EDS and how people can be more widely involved. We have identified that collectively we will attend and / or receive minutes from various stakeholder meetings that take place across the areas the organisations serve. We have agreed that we will work collaboratively to share and action any feedback as appropriate. We have also committed to raise awareness of the EDS process at relevant meetings that we each attend.

4. **Communication about the EDS process -**this is currently being addressed in line with action 3.

Our next meeting with our Partners to review EDS2 and our progress will be in June 2017 in Scarborough.

Accessible Information Standard (AIS)

The Accessible Information Standard has been introduced requiring all organisations that provide health services (including GP Practices) or adult social care to meet the standard by 31st July 2016.

The standard requires organisations to identify, record, share and meet the communication needs of patients who have a disability, impairment or sensory loss. This includes making sure that people get information in different formats if they need it and that they get any communication support they need, for example support from a British Sign Language (BSL) interpreter, or an advocate.

Although the CCG is exempt from delivering the standard, it is required to pay due regard and will make sure that when it communicates with the public it considers the requirements of the standard. The CCG is required to seek assurance from provider organisations of their compliance with the standard, including evidence of how they are planning to meet the standard. As Vale of York CCG is now co-commissioning Primary Care, this

will include GP practices. The CCG is currently working with the provider trust to agree how the standard will be implemented and monitored. Further information about the accessible information standard, including the Specification and Implementation Guidance can be found on the NHS England website at www.england.nhs.uk/accessibleinfo

Workforce Race Equality Standard (WRES)

The NHS Equality and Diversity Council announced in July 2014 that it had agreed action to ensure employees from Black and Minority Ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. The move follows recent reports that highlight disparities in the number of BME people in senior leadership positions across the NHS, as well as lower levels of wellbeing amongst BME NHS staff.

The WRES became mandatory in April 2015 and requires NHS organisations to demonstrate progress against nine indicators of workforce equality, including a specific indicator to address the low levels of BME Board representation. Further information can be found at the NHS England website at https://www.england.nhs.uk/about/gov/equality-hub/equality-standard/

As well as the CCG needing to give due regard to the WRES it also has a duty to ensure that it holds its providers to account in meeting their duties under the standard. Due to the small number of staff within the CCG and the risk of breaching confidentiality, the CCG is not required to publish statistical data for the WRES. However, the CCG is collecting and analysing this data to inform the ongoing development of its action plan.

Workforce Disability Equality Standard (WDES)

The NHS Equality and Diversity Council (EDC) has recommended that a Workforce Disability Equality Standard (WDES) should be mandated via the NHS Standard Contract in England from April 2018, with a preparatory year from 2017-18. NHS England has agreed to do so. The EDC has also agreed to support a programme of work to explain and support it.

The Equality Diversity Council considered the report published by Middlesex and Bedfordshire Universities on the 'Experience of Disabled Staff in the NHS', alongside findings from research carried out by Disability Rights UK and NHS Employers 'Different Choices, Different Voices', which found that disabled people had poorer experiences of working in the NHS in England than non-disabled colleagues.

Consultation on the proposed Workforce Disability Equality Standard has begun, alongside an extensive programme of communications and engagement to raise the profile of this initiative and to outline what support will be provided to organisations to deliver the change with disabled staff.

You can find further information on the WDES on the NHS England website at https://www.england.nhs.uk/about/gov/equality-hub/wdes/.

Disability Confident Employer

This year the Department of Work and Pensions (DWP) replaced the Two Ticks positive action scheme with the Disability Confident initiative.

Disability Confident encompasses a number of voluntary commitments to encourage employers to recruit, retain and develop disabled staff, such as offering work experience opportunities and implementing a flexible recruitment process. The scheme is intended to address the shortcomings of Two Ticks, which was criticised for not setting rigorous standards for employers displaying the TT logo.

The scheme is organised into three tiers of commitment. Tier one and two are self-assessment based and tier three requires external validation. We currently hold the Two Ticks and we are planning to transfer over to Disability Confident accreditation as further guidance and support becomes available.

Equality Objectives

The development of our equality objectives have been formulated through our self-assessment using EDS2 and the initial engagement work we have already undertaken to develop our commissioning priorities. Our equality objectives are:

6. To provide accessible and appropriate information to meet a wide range of communication styles and needs.

7. To improve the reporting and use of equality data to inform equality analyses.

8. To strengthen stakeholder engagement and partnership working.

9. To be a great employer with a diverse, engaged and well supported workforce.

10. Ensure our leadership is inclusive and effective at promoting equality.

You can view our progress against our equality objectives and implementation plan at http://www.valeofyorkccg.nhs.uk/data/uploads/about-us/equality/jan16-equality-performance-report-final.pdf

Our population and health inequalities

Some groups of people experience different access, experience and outcomes when they use NHS services. The impact of this can be inequalities that affect broad groups of patients, families and carers.

Health inequalities are not only apparent between people of different socio-economic groups (i.e. with different incomes). They exist, for example, between different genders, or different ethnic groups. Older people and people with mental health problems or learning disabilities also have worse health than the general population.

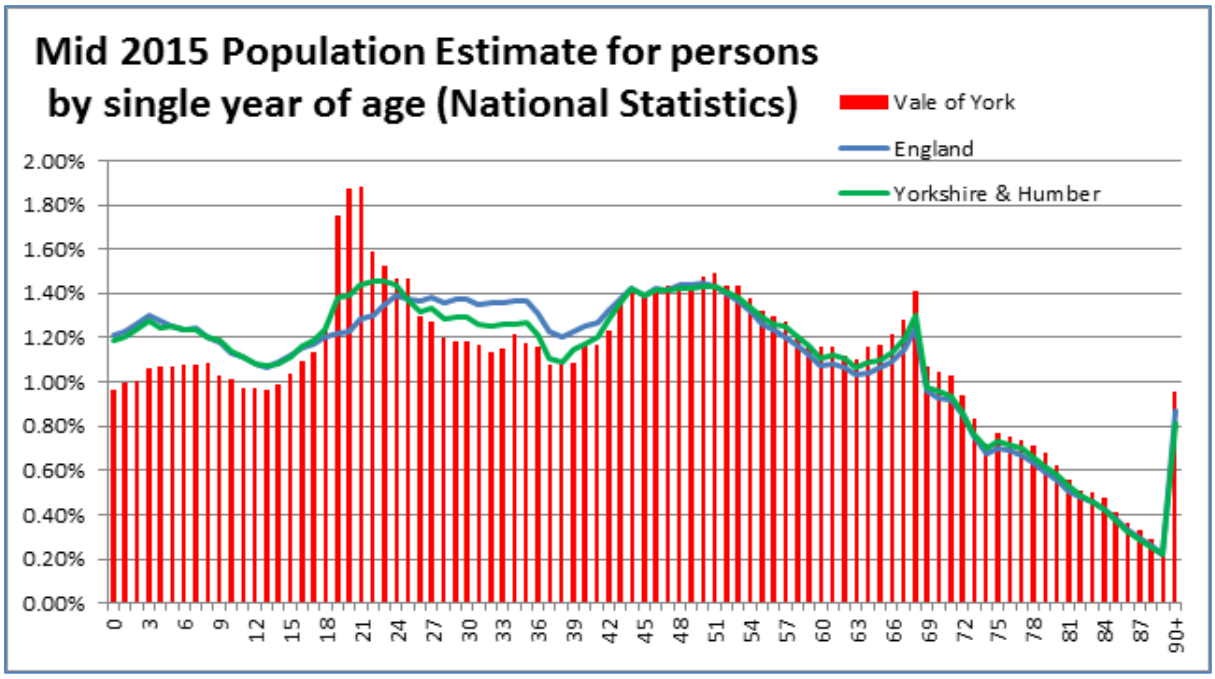
The causes of health inequalities are complex, and include lifestyle factors — smoking, nutrition, exercise to name only a few — and also wider determinants such as poverty, housing and education.

Access to healthcare may play a role, and there are particular concerns about 'institutional ageism', but this appears to be less significant than other determinants (House of Commons Health Committee 2009, p.5).

This report will consider some of the issues that may arise for the protected groups.

Age

Local picture



Please note: There is a sharp increase at 90+ because this is the number of all people aged 90 and over, not a single year as for all other ages

It can be seen from the chart that Vale of York has:

- A significantly higher proportion of younger people (aged 18-25) than the Yorkshire and Humber and England averages. This is likely be due to the university student population.

- There is a lower proportion of children (aged 0-15) and a slightly higher older population 50+ (particularly early 60's-70's) than both the Yorkshire and Humber and England averages.

- Isolation was regarded as one of the key concerns, based on engagement input into the JSNA, which particularly affects older people.

- Although child poverty is lower than the national and regional index, the North Yorkshire Child Poverty Needs Analysis, compiled in 2011, shows that child poverty is most prevalent around urban areas such as Scarborough, Northallerton, Thirsk, Skipton, **Selby**, the Harrogate/Knaresborough conurbation, and in Catterick Garrison. Child poverty is also found in some rural locations, most particularly in **Central Ryedale**, Wolds/Filey, and Whitby areas, but also in North Craven, the northernmost area of Swaledale, and the southernmost area of the **Selby** locality.

Health Inequalities experienced by older people (65+)

This is one of the most significant groups in terms of size of population and service need, compared to other groups who share protected characteristics.

- There is evidence to suggest that health services sometimes deal with some older people in ways that they find humiliating or distressing.[1]

- Our health needs change as we age. The incidence of disability rises with age and older people (65 and over) also have a higher rate of depression than younger people.

- Dementia affects 30% of the over 65s and this has a significant impact on their carers in terms of their health and wellbeing.[2]

- Reliance on public transport is significantly higher in this group.[3] This has an impact on accessibility of services for this group.

[1] Equality & Human Rights Commission, "How Fair is Britain?" (2010) http://www.equalityhumanrights.com/key-projects/triennial-review/online-summary/health/
[2] 1 in 3 people over 65 will die with a form of dementia: http://www.alzheimersresearchuk.org/siteFiles/resources/documents/ARUK_Dementia_statistics_2012.pdf
[3] http://www.positiveageing.co.uk/blog/2013/03/25/transport-troubles-for-older-people/

- Older people are frequent users of A&E departments; UK research suggests A&E attendances are high among those aged between 65 and 80 and highest amongst those over 80 years of age.[4]

- Falls are the most common cause of accidents and associated morbidity and mortality in older people. More than 600,000 fall-related A&E attendances occur each year in the UK for persons over the age of 60 (approximately 12 million people), of which 66% occur in those over the age of 75. Annually, these falls result in over 200,000 admissions to hospital, 78% of which account for those over the age of 75.[5]

- Studies have shown a marked increase in the number of A&E attendances by older patients in the winter months when there is a higher risk of both falls and respiratory illness.

- Cancer is primarily a disease which affects older people:
  - More than 63% of cancer diagnoses are in people aged 65 and over.[6] In particular, in the UK in 2010, 80% of all breast cancer diagnoses were in women aged over 50 and 45% of all diagnoses in women aged 65 and over.[7]

  - Cancer Research UK reported bowel cancer as one of the most common forms of cancer which is strongly linked to age. In the UK between 2007 and 2009, on average 72% of bowel cancer cases were diagnosed in people over the age of 65.[8]

  - Between 2006 and 2008, diagnoses rates for stomach cancer within the UK increased steeply from the age of 60, reaching 140 per 100,000 population in men aged 85 and over, and 67 per 100,000 in women aged 85 and over.[9]

Health Inequalities experienced by young people and children

- The NHS also needs to take into account young people's needs. The Department of Health "You're Welcome" quality criteria lay out principles that will help health services get it right and become more young people friendly.

- The emergency admission rate for children under the age of 15 in England has increased by 28% in the past decade, from 63 per

[4] Downing A and Wilson R (2005): 'Older people's use of Accident and Emergency services'. In Age and Ageing Vol 34. (1)
[5] http://www.bgs.org.uk/
[6] Cancer Research UK (2012): 'Cancer incidence by age'
[7] Cancer Research UK (2012): 'Breast cancer incidence statistics'
[8] Cancer Research UK (2012): 'Bowel cancer incidence statistics'
[9] Cancer Research UK (2012): 'Stomach cancer incidence statistics'

1000 population in 1999 to 81 per 1000 in 2010;[10] and in 2011/2012, 27% of all emergency attendances in England were aged 0-19.[11]

- Statistical analysis by the Kings Fund found that 14 per cent of all admissions were patients under 5 years old, with 10.4% of emergency admissions being attributable to acute conditions such as ear, nose and throat infections.[12]

- Statistics show that young people are amongst those more likely to attend A&E departments, specifically between the hours of 9am and 9pm. In England, 16.3% A&E attendances were patients aged 20-29 in 2011/2012.[13]

- Over recent years, binge drinking and alcohol related injuries have become some of the most common reasons for emergency admissions amongst young people; each year there are over 13,000 alcohol related hospital admissions amongst young people.[14]

- Those aged 16-24 are more likely to be a victim of violence (8.4%) than older age groups.[15]

- Teenage mothers and their babies are more likely to experience poor nutrition, being at a higher risk of low birth weight and lower rates of breast feeding. Young mothers are also more likely to smoke during pregnancy, as well as being at greater risk of infant mortality and poor mental health, therefore having more particular needs for maternity services.[16]

- 1 in 10 children and young people aged 5 - 16 suffer from a diagnosable mental health disorder - that is around three children in every class (nationally).

- Research shows[17] that the transition to adult services for disabled young people and those with complex health needs is problematic mainly due to lack of co-ordination between different agencies and insufficient good information to young people and parents.

- Infant mortality rates are almost twice the national average for some BME groups, and 60% higher for mothers under 20.

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[10] http://academia.edu/2557082/Increase_in_emergency_admissions_to_hospital_for_children_aged_under_15_in_England_1999-2010_national_database_analysis
[11] HES (2013): Accident and Emergency Attendances in England (Experimental statistics),2011-12
[12] Kings Fund (2012): 'Emergency hospital admissions for ambulatory care-sensitive conditions: identifying the potential for reductions'
[13] HES (2013): Accident and Emergency Attendances in England (Experimental statistics),2011-12
[14] Department for Education (2012): 'Children and young people: Alcohol'
[15] ONS (2013) 'Focus on: Violent Crime and Sexual Offences', 2011/12
[16] Department of Health (2010) "Teenage Pregnancy Strategy: Using lessons learnt to go beyond"
[17] http://www.york.ac.uk/inst/spru/pubs/rworks/2011-02Jan.pdf

- Looked after children and young people are at greater risk of early pregnancy than those not in care.

Disability

Local picture

We understand disabled people experience health inequalities. We are committed to the principles of the social model of disability that recognises that a person's environment enables or disables them, rather than focusing on how a person's impairment disables them.

Data from the 2011 Census:

Long-term health problem or disability

All usual residents	336,330	%	England and Wales %
Day-to-day activities limited a lot	22,824	6.79	8.5
Day-to-day activities limited a little	30,386	9.03	9.4
Day-to day activities not limited	283,120	84.18	82.1

The number of people who feel that their long term health problem or disability is limiting their day-to-day activities a lot, is lower than for England and Wales.

Sensory Impairment

The table below indicates the number of people in North Yorkshire diagnosed as sight impaired or severely sight impaired and the prevalence by age group (data is not available at District level):

People diagnosed as sight impaired or severely sight impaired currently on the North Yorkshire Certificate of Visual Impairment (CVI) register							
	Total no. of people	Age 0-4	5-17	18-49	50-64	65-74	75+
Partially Sight Impaired	2040	5	40	170	160	145	1520
Severely Sight Impaired	1610	5	25	180	145	130	1125

Data source: www.ic.nhs.uk/pubs/blindpartiallysighted11

The GP population aged 18+ on the learning disability register is 476.9 per 100,000 people.

The incapacity claims rate for people with mental health or behaviour problems is 16.7 per 1000 working age adults. This is lower than the national average; however the JSNA also uncovers some other statistics relating to mental and emotional health:

- It is estimated that in North Yorkshire, 52,790 people aged 16-74 experience common mental health problems including phobias, depression, anxiety, obsessive-compulsive disorder and panic disorder.

- During 2010/11, there were 60,789 people on the GP depression disease register in North Yorkshire, equivalent to a prevalence of 13.3%, above the national average of 11.2%.

Health Inequalities experienced by disabled people

In 2008, the Government's Office for Disability Issues published "Experiences and Expectations of Disabled People". 1,860 disabled people were interviewed about all aspects of their lives:

- 59% described their life as a whole as good but disabled people were less happy with their lives than other people. Levels of dissatisfaction were highest amongst younger disabled people, disabled people living alone, people with mental health problems, disabled people from BME communities, disabled people in urban areas and disabled people on lower incomes.

- 92% of disabled people had used a health service in the past three months, which is significantly higher than the general population.

- Disabled people were satisfied with the staff in the health services used: 90% in terms of friendliness, helpfulness and understanding, 94% said they were treated with dignity and respect and 88% in terms of staff knowledge.

- 48% said there were barriers to using health services, in terms of transport difficulties, distance and needing someone to accompany them.[18]

- Around a quarter of Deaf or hearing impaired people miss health appointments and 19% miss more than 5 because of poor communication.[19]

Learning Disabilities and Mental Health

- An estimated 25-40% of people with learning disabilities also have mental health problems.[20] People with learning disabilities are more vulnerable to more of the risk factors associated with mental ill health, such as adverse life events and lack of social support, and are much less likely than the general population to be able easily to access psychiatric services.[21]

- In 2006, the Disability Rights Commission published "Equal Treatment: Closing the Gap", a formal investigation into physical health inequalities experienced by people with learning disabilities and /or mental health problems. This showed that people with learning disabilities and people with mental health problems are much more likely to have significant health risks and major health problems than other people. For people with learning disabilities, these particularly include obesity and respiratory disease and for people with mental health problems, obesity, smoking, heart disease, high blood pressure, respiratory disease, diabetes and stroke.[22]

- "Six Lives" was published in March 2009 following the investigation into the deaths in hospital of six people with learning disabilities and described "Significant and distressing failures in service across health and social care".[23]

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[18] Office for Disability Issues, Experiences and Expectations of Disabled People – Executive Summary (2008) .
[19] RNID data

[20] 2. Department of Health (1993). Services for people with learning disabilities, challenging behaviour or mental health needs. Project group report. London: Department of Health.)
[21] Bouras N, Holt G, Gravestock S (1995). Community care for people with learning disabilities: deficits and future plans. Psychiatric Bulletin 19: 134–137.)
[22] Disability Rights Commission, Equal Treatment: Closing the Gap (2006)
[23] Six Lives: the provision of public services to people with learning disabilities
http://www.ombudsman.org.uk/improving-public-service/reports-and-consultations/reports/health/six-lives-the-provision-of-public-services-to-people-with-learning-disabilities

- Just 3% of women aged 18 and over with learning disabilities /difficulties living within a family, and 17% of those in formal care have had [cervical] screening, compared to 85% for women aged 20-64 nationally.[24]

Mental Health and students

Mind found that:

• 2 out of 3 students feel down at some point during their studies.

• Over 50% of students don't feel comfortable admitting they're not coping to someone else.

• 1 in 8 students experience suicidal feelings at university.

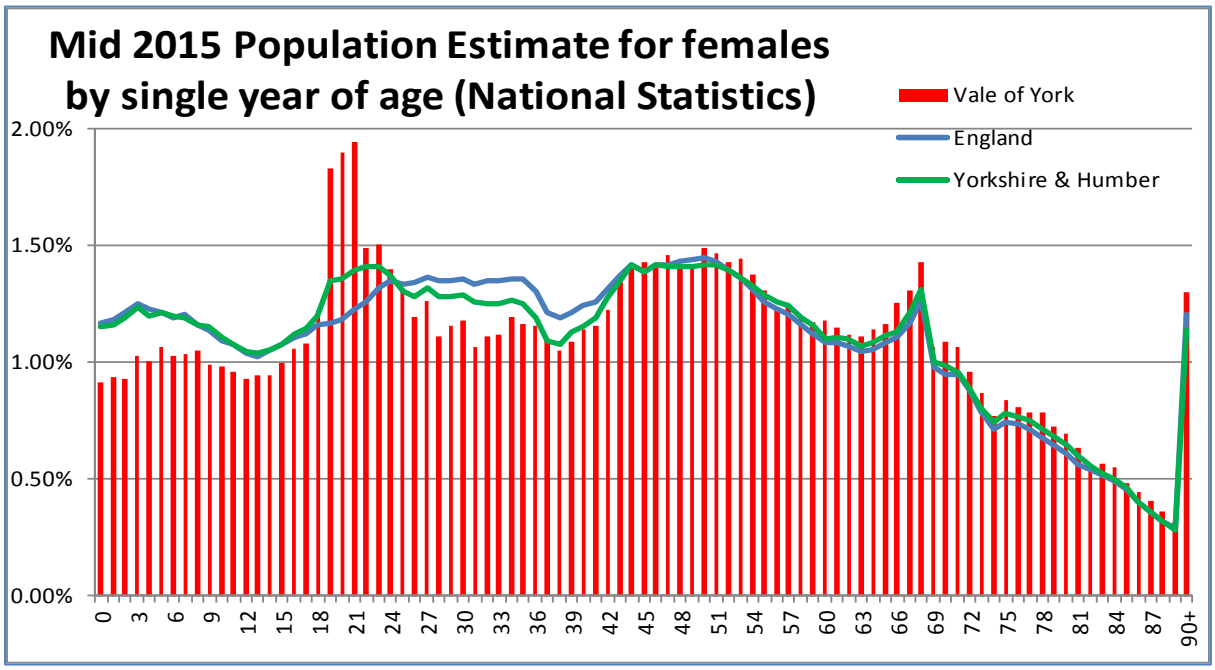
• 20% of higher education students consider themselves to have a mental health problem.

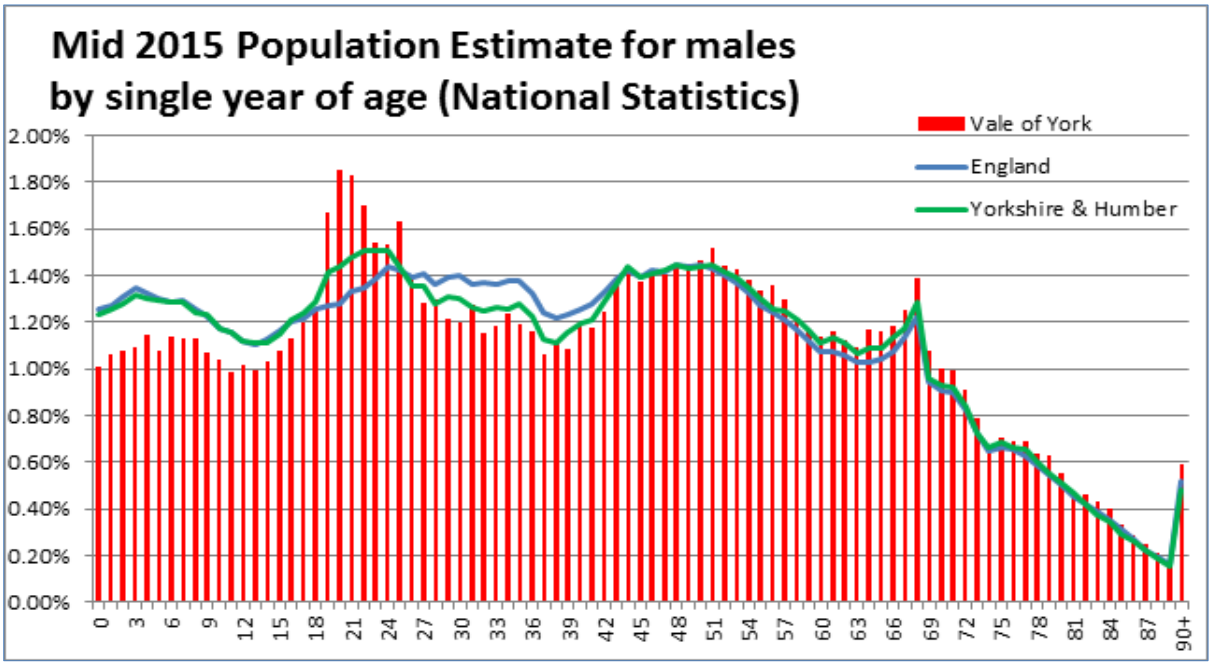
• The number of students who took their own lives increased by 50% between 2007 and 2011.
(http://mind.org.uk/get-involved/students/)

[24] The NHS – health for all? People with learning disabilities and health care, Mencap, 1998

Sex (Gender)

Local picture





Please note: There is a sharp increase at 90+ on both charts because this is the number of all people aged 90 and over, not a single year as for all other ages

It can be seen from the charts that for Vale of York:

- There is a greater variation to the Yorkshire and Humber and England averages for females then there is for males.

- There are approximately twice as many women as men aged 90+, although this is in line with Yorkshire and Humber and England averages.

Health Inequalities experienced by men

- Men are less likely to use their GP which can lead to late diagnosis.[25]
- Men are more likely to take exercise but less likely to eat the recommended amounts of fruit and vegetables.[26]
- Men die four years younger than women, and are twice as likely to get the 10 most common cancers affecting both sexes. They have higher rates of heart disease and obesity yet they are far less likely to access health services. Men aged between 15-45 see their GP half as often as women.

Health Inequalities experienced by women

- Women are more likely to eat the recommended amounts of fruit and vegetables but less likely to take exercise.[27]
- The 2010 National Audit of Cardiac Rehabilitation (NACR) demonstrated that women are under-represented in cardiac rehabilitation. If men and women were taking part in proportion to the case rates for heart attack, we would expect there to be 63% men and 37% women. In practice, women made up 32% of referrals but only 26% of participants. It is mainly older women who are under-represented in cardiac rehabilitation; women over the age of 80 are less likely to take part than men of the same age.[28]

Violence against women

The World Health Organisation states three reasons why violence against women should be a priority issue for health workers. These are:

- Violence causes extensive suffering and negative health consequences for a significant proportion of the female population (more than 20% in most countries)

[25] Equality and Human Rights Commission, "How fair is Britain?" (2010) http://www.equalityhumanrights.com/key-projects/how-fair-is-britain/online-summary/health
[26] Ibid
[27] Equality and Human Rights Commission, "How fair is Britain?" (2010)
[28] NACR Annual Report 2010

- It has a direct negative impact on several important health issues, including safe motherhood, family planning, the prevention of sexually transmitted diseases and HIV/AIDS

- For many women who have been abused, health workers are the main and often the only point of contact with public services which may be able to offer support and information.[29]

[29] Violence against women. Definition and scope of the problem, WHO

Gender Reassignment (Transgender)

Transgender people or Trans people is an umbrella term for people whose gender identity and/or gender expression differs from the sex they were assigned at birth.

One of the greatest difficulties in measuring or estimating the size of the Trans population is that no systematic or reliable data has been collected through the Census or through other Government-sponsored surveys. One study suggested that the number of Trans people in the UK could be around 65,000 (Johnson, 2001, p. 7), while another notes that the number of gender variant people could be around 300,000 (GIRES, 2008b).[30] According to GIRES, organisations should assume 1% of their employees and service users may be experiencing some degree of gender variance.

Health Inequalities experienced by Trans people

In September 2012 a **Trans Mental Health Study**[31] was published. It is the largest survey of its kind in Europe – 889 people responded to the survey, providing rich data about Trans people's mental health and wellbeing. The report includes detailed information about Trans people's experiences of using NHS Gender Identity Clinic services and Mental Health services (pp.87-88). Some of the key findings are:

- 70% of the participants were more satisfied with their lives since transitioning and only 2% were less satisfied.
- 70% of respondents felt they had lost or missed out on something as result of being Trans, transitioning or expressing their gender identity.
- 81% of respondents felt they had gained something as result of being Trans, transitioning or expressing their gender identity.
- Rates of current and previously diagnosed mental ill health were high. 88% of respondents felt that they either were or had previously experienced depression, 80% stress and 75% anxiety.
- 8% of respondents felt they had been so distressed at some point that they needed to seek support urgently. 35% of those people had avoided seeking urgent help due to being Trans.
- 53% of participants had self-harmed at some point with 11% currently self–harming.

[30] http://www.equalityhumanrights.com/uploaded_files/trans_research_review_rep27.pdf
[31] http://www.scottishtrans.org/Uploads/Resources/trans_mh_study.pdf

- 84% of participants had thought about ending their lives at some point. 35% of participants overall had attempted suicide at least once and 25% had attempted suicide more than once.

- Hate crime is a key issue. Over 90% of participants had been told they were not normal and over 80% had experienced silent harassment. Over 37% of respondents had experienced physical threats or intimidation for being Trans and 19% had been hit or beaten up for being Trans.

- 52% of participants had experienced problems at work due to being Trans or having a Trans history.

- High rates of homelessness were evident with 19% reporting having been homeless at some point and 11% having been homeless more than once.

Race (Ethnicity)

This chart shows the high level ethnic breakdown of Vale of York CCG's population, and that of Yorkshire and the Humber and England as recorded in the 2011 census:

Ethnic Group	Vale of York	Vale of York	Yorks & Humber	England
All usual residents	343,109			
White: English/Welsh/Scottish/Northern Irish/British	317,589	92.56%	85.80%	79.80%
White: Irish	1,658	0.48%	0.50%	1.00%
White: Gypsy or Irish Traveller	464	0.14%	0.10%	0.10%
White: Other White	9,731	2.84%	2.50%	4.60%
Mixed/multiple ethnic groups: White and Black Caribbean	822	0.24%	0.60%	0.80%
Mixed/multiple ethnic groups: White and Black African	418	0.12%	0.20%	0.30%
Mixed/multiple ethnic groups: White and Asian	1,288	0.38%	0.50%	0.60%
Mixed/multiple ethnic groups: Other Mixed	914	0.27%	0.30%	0.50%
Asian/Asian British: Indian	1,787	0.52%	1.30%	2.60%
Asian/Asian British: Pakistani	473	0.14%	4.30%	2.10%
Asian/Asian British: Bangladeshi	395	0.12%	0.40%	0.80%
Asian/Asian British: Chinese	2,732	0.80%	0.50%	0.70%
Asian/Asian British: Other Asian	2,221	0.65%	0.80%	1.50%
Black/African/Caribbean/Black British: African	1,140	0.33%	0.90%	1.80%
Black/African/Caribbean/Black British: Caribbean	289	0.08%	0.40%	1.10%
Black/African/Caribbean/Black British: Other Black	115	0.03%	0.20%	0.50%
Other ethnic group: Arab	535	0.16%	0.40%	0.40%
Other ethnic group: Any other ethnic group	538	0.16%	0.40%	0.60%

There is a rapidly growing black and minority ethnic population in York, due in part to the continuing expansion of university and higher education facilities within the city. Another factor is seasonal work in York's tourism and agricultural industries. In addition, York has been one of the earlier cities to support the resettlement of Syrian refugee families.

Although the total number of BME people identified in the Census is lower than the UK average, the report *Mapping rapidly changing minority ethnic populations: a case study of York by the Joseph Rowntree Foundation*[32], reports that York has a very diverse BME population with 78 different first languages spoken by its residents. People from different nationalities may come to York as migrant workers (mainly from Central and Eastern

[32] http://www.jrf.org.uk/sites/files/jrf/ethnicity-population-change-york-full.pdf

European) or as asylum seekers. York also attracts a large number of overseas students making up 17% of their student population[33]. In the City of York the Chinese make up 1.2% of the population and are one of the most significant BME communities.

York's Gypsy, Roma and Traveller Strategy 2013-18 says: "There are approximately 350 Gypsy and Traveller families in York, living on traveller sites, houses and on the roadside (Gypsy and Traveller Area Assessment 2009). Data from the 2011 Census reports a figure of 269- White: Gypsy or Irish Travellers, although it is widely recognised that members of the community are very reluctant to self-identify due to perceptions that they will be discriminated against." The JSNA Topic Summary for Gypsy, Traveller and Show People estimates just over 1100 GRT people in York. In Selby, the figure is estimated at 478 living in 151 households. In Ryedale: 318 people living in 100 households[34].

Health Inequalities experienced by Black and Minority Ethnic people

- Type 2 diabetes is 3.5 times more prevalent in South Asians than Europeans.15 However, a Diabetes UK survey of South Asian members found that only 16% of those responding had attended a course to help manage their diabetes.[35]

- In the UK, men of Black African and Black Caribbean descent are three times more likely to develop prostate cancer than white men of the same age.[36]

- Men are more likely to be overweight than women; however, among Pakistani, Bangladeshi and Black African people, women are less likely to be of normal/healthy weight than men (data available for England only).[37]

- The most recent systematic review of prevalence of mental health disorders in adult minority ethnic populations, shows that Black or Black British people are more likely than white people to have used services and more than twice as likely to have spent time in hospital than White people. People from other ethnic groups are much more

[33] http://www.york.ac.uk/admin/po/equality-students.htm
[34] http://www.northyorks.gov.uk/CHttpHandler.ashx?id=18883&p=0
[35] Survey of South Asian people with diabetes 2006: Access to healthcare services at a glance, Diabetes UK
[36] Ben-Shlomo, Y., S. Evans, et al. (2008). "The risk of prostate cancer amongst black men in the United Kingdom: the PROCESS cohort study." European Urology 53(1): 99-105.
[37] Equality & Human Rights Commission, "How Fair is Britain?" (2010) http://www.equalityhumanrights.com/key-projects/triennial-review/online-summary/health/

likely to have used services but no more likely to have been hospital.[38]

- Immigrants to the UK are typically at two to eight times greater risk of psychoses than native- born groups. This higher risk extends into the second generations. Factors that explain raised rates in immigrants and their descendants include: stressful life events, discrimination, urban living and socio-economic deprivation.[39] Women refugees and asylum seekers have higher rates of post-traumatic stress disorder and other mental illness.[40]

Race for Health highlights the following inequalities:

- Some 35% of African Caribbean men smoke, compared with 39% of white Irish men, 44% of Bangladeshi men and 27% of the general population.

- Infant mortality in England and Wales for children born to mothers from Pakistan is double the average.

- Young Asian women are more than twice as likely to commit suicide as young white women.

- Young black men are six times more likely than young white men to be sectioned for compulsory treatment under the Mental Health Act.

- South Asian people are 50% more likely to die prematurely from coronary heart disease than the general population.

- Asian women aged 65 and over have the highest rate of limiting, long-term illness (64.5% compared to 53% for all women aged 65 and over).

- The prevalence of stroke among African Caribbean and South Asian men is 40% to 70% higher than for the general population.

- 90% of children in the UK have visited a dentist. This compares with approximately 40% of Bangladeshi and 60% of Pakistani children.[41]

[38] Prevalence of mental health disorders in adult minority ethnic populations in England: a systematic review
Rees R, Stokes G, Stansfield C, Oliver E, Kneale D, Thomas J 2016)
[39] Foresight Mental Capital and Wellbeing Project (2008). Final project report. London: The Government Office for Science.
[40] Department of Health (2002). Women's mental health: into the mainstream. London: Department of Health.)
[41] Driving Forward Race Equality in the NHS (Race for Health)

Gypsies and Travellers

Gypsies and Travellers have a lower life expectancy than the rest of the population. Department of Health research indicates the average life expectancy for a gypsy or traveller man is 50. This is associated with access to services, lack of trust, attitudes and other social factors. Gypsies and Travellers experience poorer health than the average population: bronchitis (40% prevalence compared to 10%), anxiety (38% prevalence compared to 13%) with women twice as likely to be anxious as men and asthma (65% prevalence compared to 40%).[42]

[42] Parry G., Van Cleemput C. et al, *The Health Status of Gypsies and Travellers in England*, The University of Sheffield, October 2004.

Religion or Belief

Local picture

The table below shows the religion of Vale of York CCG's population compared to that of Yorkshire and Humber and of England as recorded in the 2011 census:

All usual residents	336.330	Vale of York %
Christian	216,306	64.3
Buddhist	1,285	0.4
Hindu	1,101	0.3
Jewish	284	0.1
Muslim	2,231	0.7
Sikh	191	0.1
Other religion	1.118	0.3
No religion	88,849	26.4
Religion not stated	24,965	7.4

The Vale of York has a higher proportion of its population identifying as Christian (64.3%) than England and Wales which is 59%.

For England and Wales 5% of the population identify as Muslim this is significantly less for Vale of York at 0.7%. Figures for No religion or not stated are in line with England and Wales figures.

Health Inequalities experienced by Muslim people

- Among groups defined by religion, Muslim people tend to report worse health than average.[43]

- Ghazala Mir and Aziz Sheikh of the Institute of Health Sciences, University of Leeds have recently published research into the factors, including stereotyping, that affect the psychosocial well-being of Pakistani Muslims and on their ability to manage long-term conditions.[44]

[43] Census data
[44] Fasting and Prayer don't concern the doctors….they don't even know what it is': communication, decision making and perceived social relations of Pakistani Muslim patients with long-term illness, by Ghazala Mir and Aziz Sheikh. Ethnicity and Health 2010 Vol 15

Sexual Orientation

Local picture

There is a lack of local data available about lesbian, gay, bisexual and transgender populations in York. Many services do not routinely record information about sexual orientation.

One service which does record sexual orientation information is the local substance misuse treatment service where 4.9% of clients (out of 716 people currently in treatment) accessing treatment identify themselves as either lesbian, gay, bisexual or confused. A further 8.8% of clients had no sexual orientation information recorded about them.

Information about tenants housed in council housing tells us that of 3,399 residential tenants, 2.3% (77 people) identify as lesbian, gay or bisexual. Sexual orientation of the remaining 4,408 residential tenants is unknown.

Employer level data about number of staff who identify as lesbian, gay or bisexual can help to identify the needs of staff more effectively. Out of 2,847 City of York Council staff, 48 identify as lesbian, gay or bisexual (1.69%). However, no information on sexual orientation is recorded about 304 of these employees.

Hate crime in York is not easy to directly measure. The Crime Survey for England and Wales 2012 shows that across North Yorkshire in 2011/12 there were 174 recorded hate crimes, two of which were recorded as being related to sexual orientation.

Recorded crime is not necessarily an indication of the actual amount of crime as some crime will go unreported. In their Homophobic Hate Crime survey, Stonewall identified that as much as 75% of hate crime based on sexual orientation went unreported.

This is taken from: http://www.healthyork.org/the-population-of-york/specific-population-profiles/lesbian,-gay,-bisexual-and-transgender-(lgbt)-population.aspx

There is a lack of local analysis about the specific health needs of the lesbian, gay, bisexual or transgender populations in York.

Health Inequalities experienced by Lesbian, Gay and Bisexual People

The Stonewall Gay and Bisexual Men's Health Survey 2012 shows no York specific data as only 19 men from York were surveyed and this was too small a sample for data from York to be included in the survey.

The Stonewall Lesbian and bisexual women's health check 2008 report highlights findings based on a national survey but provides no localised analysis. Key findings from this report are that lesbian and bisexual women:

- Have lower uptake of cervical screening than women in general.
- Are more likely to smoke than women in general.
- Have a higher risk of self-harming and attempted suicide than women in general.
- Half have had negative healthcare experiences and half are not out to their own general practitioner.

Although the majority of LGB people do not experience poor mental health, research suggests that some LGB people are at higher risk of mental disorder, suicidal behaviour and substance misuse.

Evidence indicates that the increased risk of mental disorder in LGB people is linked to experiences of discrimination.[45] LGB people are more likely to report both daily and lifetime discrimination than heterosexual people.

Gay men and bisexual people are significantly more likely to say that they have been fired unfairly from their job because of discrimination. Lesbians are more likely to have experienced verbal and physical intimidation than heterosexual women.[46] Discrimination has been shown to be linked to an increase in deliberate self-harm in LGB people.[47] LGB people demonstrate higher rates of anxiety and depression than heterosexuals[48]; lesbians and bisexual women may be at more risk of substance dependency than other women.[49]

[45] Mays, VM and Cochran, SD (2001) Mental health correlates of perceived discrimination among lesbian, gay, and bisexual adults in the United States, *American Journal of Public Health*, 91(11): 1869–76.

[46] King, M and McKeown, E (2003) *Mental health and social wellbeing of gay men, lesbians and bisexuals in England and Wales: A summary of findings*, Mind, London.

[47] Meyer, IH (2003) Prejudice, social stress and mental health in lesbian, gay and bisexual populations: Conceptual issues and research evidence, *Psychological Bulletin*, 129: 674–97

[48] Sandfort, TG, de Graaf, R, Bijl, RV, Schnabel, P (2001) Same-sex sexual behavior and psychiatric disorders: Findings from the Netherlands Mental Health Survey and Incidence Study (NEMESIS), *Archives of General Psychiatry*, 58(1): 85–91.

[49] Cochran, SD and Mays, VM (2000) Relation between psychiatric syndromes and behaviorally defi ned sexual orientation in a sample of the US population, *American Journal of Epidemiology*, 151(5): 516–23.

Lesbian, gay and bisexual people may, for example, be reluctant to disclose their sexual orientation to their GP, because they anticipate discrimination, and then fail to receive appropriate health care.[50] A report by MIND found up to 36% of gay men, 26% of bisexual men, 42% of lesbians and 61% of bisexual women recounted negative or mixed reaction from mental health professionals when being open about their sexual orientation.[51]

Some health care professionals think that lesbians do not require cervical smear tests,[52] yet 10% of lesbians have abnormal smears – this includes 5% of lesbians who have never had penetrative sex with a man.[53] Lesbian and bisexual women were up to 10 times less likely to have had a test in the past three years but lesbians and bisexual women have often been invisible patients within health services and their needs are poorly understood.[54]

[50] Hunt R. and Minsky A., *Reducing health inequalities for Lesbian Gay and Bisexual people: Evidence of health care needs*, 2006, Stonewall and DH.
[51] King M. and McKeown E., *Mental health and social wellbeing of gay men, lesbians and bisexuals in England and Wales*, 2003, MIND.
[52] Hunt R. and Minsky A., *Reducing health inequalities for Lesbian Gay and Bisexual people: Evidence of health care needs*, 2006, Stonewall and DH.
[53] In the Pink Providing Excellent Care for Lesbian, Gay and Bisexual People: A practical guide for GPS and Other Health Practitioners, 2010 NHS Sheffield citing Stonewall/ Cancerbackup
[54] Fish J., Cervical screening in lesbian and bisexual women*: a review of the worldwide literature using systematic methods*, 2009, De Montford University.

Pregnancy and Maternity

Local picture

North Yorkshire has a lower than national average rate for infant mortality and low birth weight.

Health Inequalities linked to pregnancy and maternity

- Inequalities can begin before birth, can adversely impact health throughout adult life, and can persist across generations. Inequalities can impact on pregnancy, including maternal and perinatal death. Ethnicity and deprivation remain important associates of stillbirth and neonatal death.

- Poor and unequal access to antenatal healthcare contributes to inequalities in maternal and infant mortality and morbidity. We know that those women and babies who are at the greatest risk of poor health outcomes are the least likely to access and/or benefit from the antenatal healthcare that they need.

- Women aged less than 20 are at risk of higher rates of stillbirth (5.6 per 1000 total births), higher rates of perinatal deaths (8.9 per 1000 total births) and higher rates of neonatal deaths (4.4 per 1000 live births) than women aged 20-34.

- Children born to women from more vulnerable groups experience a higher risk of morbidity and face problems with pre-term labour, intrauterine growth restriction, low birth weight and higher levels of neonatal complications.

- 81% of women who died of direct or indirect causes and who were in abusive relationships found it difficult to access or maintain contact with maternity services. In over 50% of domestic abuse cases, children were also directly abused.

- Women from BME communities are 7 times more likely to die in childbirth than other groups.

- 20% of women who died either first booked for antenatal care after 2 weeks gestation, missed over four routine antenatal appointments, or did not seek care at all.[55]

Carers

Carers are not an Equality Act protected group but there is a lot of information nationally about the experiences of carers and the inequality they can face.

An Integrated Approach to Identifying and Assessing Carer Health and Wellbeing was published on 13th May 2016 by NHS England to strengthen the commitment to carers and provide clarity about the duties of cooperation in supporting carers. This builds on their commitment outlined in The Care Act 2014 which aimed to transform local health and social care services so that they work together to provide better, joined up, care. This includes requiring CCG's and local authorities to agree joint plans to outline the support made available to carers.

The central aim is to keep the carer at the centre, preserving their independence and their ability to undertake their caring role. In addition, carers have a right to request a formal carer's assessment of their own needs at any time.

Both the Care Act 2014 and the Children and Families Act 2014 address the needs of Young Carers, extending the right to an assessment of their support needs to all young carers under the age of 18 regardless of who they care for, what type of care they provide or how often they provide it.

There is a particular need for NHS bodies and the local authority to work closely when planning to support the discharge of patients from hospital.

Health Inequalities experienced by carers

- Carers often neglect their own health needs and are more likely to suffer financial hardship.

- Only small numbers of young carers are currently being identified or assessed for support. The reasons for this include blurred boundaries of responsibility between adults and children's services; a lack of awareness among many professional groups of young

[55] NICE Socially Complex Pregnancies - http://guidance.nice.org.uk/CG110/NICEGuidance/pdf/English

carers' needs and concerns; and young carers' own lack of awareness of their entitlements, and their reluctance to seek formal help. Research has found that young carers can experience substantial physical, emotional or social problems, and encounter difficulties in school and elsewhere. (See *www.scie.org.uk*)

Leadership and Governance

We understand that in order for equality and diversity to be part of our 'mainstream' business it must be embedded within all levels of the organisation with strong leadership. The Governing Body accountability for Equality and Diversity sits with the Chair of the CCG. The Accountable Officer is the Lead for Equality, with the Executive Director for Planning and Governance as the Corporate Lead and the Chief Nurse as the Clinical Lead. Our leadership approach will ensure that there is fairness in our commissioning decisions and that business is planned and conducted in to meet our equality duties.

We are in the process of reviewing our governance structures and it is anticipated that monitoring of our progress against our equality objectives will be undertaken by the Quality and Patient Experience Committee, with annual reporting to the Governing Body.

We use **Equality Impact Analyses (EIAs)** to measure the equality impact of our decisions and to carefully consider how they affect the local population, particularly in relation to people with protected characteristics. It also helps to identify any action we can take to reduce or remove any negative impacts. We use EIAs as a tool to analyse and consider a range information, including engagement to inform our decision making both as an employer and a commissioner.

You can find further information on our policies and EIAs on our website at http://www.valeofyorkccg.nhs.uk/publications/policies/.

All our policies and papers for Governing Body have to have given consideration to the need for an Equality Impact Analysis.

Get in touch

To request this document in a different language or in a different format, please contact the CCG via email: valeofyork.contactus@nhs.net or phone 01904 555870.