NHS
Calderdale
Clinical Commissioning Group

Public Sector Equality Report

January 2015

Contents

Executive summary

NHS Calderdale CCG know that different patients and carers use and experience health services differently, health inequalities exist within our communities.

To make the difference and improve the health of our local population we have to reduce the inequalities that exist within health services, whether this is in access, experience or outcomes.

To help us understand the issues for our population we work closely with our communities to listen to their needs and to understand how best to commission services to meet those needs. Monitoring who is using, and not using services and employment is one of the ways to understand whether there are any significant issues.

This report sets out what data we have available for the protected groups locally and their use of the services we commission. We will also consider the under representation of protected groups in our data.

We will include comment on our workforce as we recognise that while this is not a legal obligation it forms part of our robust approach to delivering better outcomes for the people of Calderdale.

Where gaps exist in the data, these will be acknowledged and we will work with our providers to address these.

This data is published to enable service users, staff our regulators and other interested parties to assess the equality performance of our organisation. The data has been used to support our decision making through the past year.

The report is a work in progress, rather than an end result. As advised there are gaps in the data and it is not always simple to draw out themes from the mass of hard data. This is our second year of publishing the information. This report will be updated annually and the link will continue to be made with our Equality objectives and the outcomes of the Equality Delivery System.

Penny Woodhead
Head of Quality

Background

Publishing equality information and setting equality objectives is part of our CCGs compliance with the Equality Act (2010) and one of the ways we demonstrate meeting the Public Sector Equality Duty.

The public sector equality duty is made up of a general equality duty which is supported by specific duties. The 'specific duties' are intended to drive performance on the general equality duty.

The general equality duty requires the CCG, in the exercise of our functions, to have due regard to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct that is prohibited by or under the Act.
- Advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it.
- Foster good relations between people who share a relevant protected characteristic and those who do not share it.

Protected characteristics are defined as:

- Age
- Sex

- Disability
- Gender Reassignment (Transgender)
- Race
- Religion or Belief
- Sexual Orientation
- Pregnancy and maternity
- Marriage and civil partnership

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

In publishing this report Calderdale CGG is demonstrating that we have consciously thought about the three aims of the Equality Duty as part of our decision-making process. The specific duty requires us to publish information relating to people who are affected by our policies and practices who share protected characteristics.

The Act also requires that employers with a workforce of over 150 employees publish information relating to employees who share protected characteristics. Our CCG has had 44-47 employees (headcount) through the period of this report, however we will consider our employee profile as part of this report.

Introduction

As a CCG we aim to commission health services that give our protected groups the same access, experiences and outcomes as the general population, we recognise that there are many things that influence this which we may not have control over, but we will work to;

- Reduce inequalities in health outcomes and experience between patients. We will do this by planning our strategic aims and working

in partnership with Calderdale Council and others to address the needs of protected groups as shown in the JSNA

- Remove any barriers or inequalities faced by protected community groups in accessing healthcare, including making reasonable adjustments.
- Remove or minimise disadvantages suffered by people due to their protected characteristics.
- Promote the involvement of patients and their carers in decisions about the way their health care is provided and the way we commission our services
- Raise awareness of our services and their benefits with groups who are under-represented in services use.

To ensure progress on the equality agenda we have the following governance arrangements, the Head of Quality provides the lead for equality, there is a lay governing body member and a clinical lead with a responsibility for equality and the Quality Committee oversees progress.

The data included and referenced here is used by commissioners across the organisation to make informed plans when they are reviewing, designing or monitoring services. The data supports the development of appropriate services to meet the needs of the local community and strengthens the equality assessments that are undertaken to assure that relevant decisions are given due regard. Consideration of the data and understanding our community better means we are able to commission services which are more likely to address individual health needs and that are relevant and appropriate to the people we serve.

Local context

Calderdale is one of the smallest metropolitan districts in terms of population, but one of the largest in terms of area. According to the 2011 Census, Calderdale has a population density of just 5.6 people per

hectare, compared to 14.3 in Bradford, 10.3 in Kirklees, 13.6 in Leeds and 9.6 in Wakefield. Despite being a metropolitan district, Calderdale has very strong rural elements; most of the area is classified as rural and while definitions vary, up to a quarter of its population lives in rural areas

Largest population growth is expected to occur in the older age groups with a 28% increase in those aged 65 plus, combined with a significant increase in children. Data from the Census and national insurance number registrations indicates that the growth may not be uniform across all ethnic groups.

There has been an increase of around 4300 non-UK born residents between the 2001 and 2011 Censuses. The largest increase has been in those born in Poland, which has increased by around five times since 2001. There has also been a large increase in those born in Pakistan, which has increased by 1200 since 2001.

From the Census the majority of the population are White 90% with 1% being Irish heritage and 2% being other White. The Asian/Asian British population stands at 8% with the majority being of Pakistani heritage 7%.

In terms of age:

- The proportion in the 0 to 4 age group has decreased slightly from 1991 and then remained static
- The proportion of children aged 5 to 14 is currently 12.1%
- The proportion aged 25 to 34 has decreased over time as have the numbers
- There have been large increases in the proportion and the numbers aged 45 to 54 and 55 to 64 since 1991, which may have implications for the 65 plus population within the next ten years

- The 85 plus aged population has increased steadily from 3200 in 1991 to 4300 in 2011

The gender spilt is mostly even until the older age groups where women outnumber men due to the higher life expectancy.

The majority of residents identify as Christian, 60% though this is a 15% reduction since 2001, 8% are Muslim and 30% have no religion.

The Census of 2011, found that there were 491 people in a registered same-sex civil partnership across Calderdale (0.3% of the population). Ward level data shows that there is a significantly higher proportion that is in a registered same-sex civil partnership in Calder (1.13%), Luddendenfoot (0.67%) and Todmorden (0.45%).

Nationally it has been estimated that 6 to 7% of the population is lesbian, gay or bisexual (LGBT) and if this figure was applied to Calderdale this would equate to approximately 12,096 to 14,112 LGBT people. The Upper Valley hosts an above average number of lesbians, especially in Hebden Bridge so local figures are likely to be higher than the national estimates with possibly up to 19,800 LGBT people in Calderdale.

The 2011 Census detailed people who identified that their day to day activities have been limited a lot 8% and those limited a little 10%.

Incapacity benefit is paid to those who are unable to work due to illness or disability, so it provides an indication of the numbers with severe ill-health/disability. In December 2012, 3.1% (4020) of Calderdale residents claimed incapacity benefit.

Disability living allowance is a non-means-tested benefit provided to those who become disabled before the age of 65 and need help with personal care or have walking difficulties. in December 2012 5.2% (10545) Calderdale residents claimed disability living allowance.

Attendance allowance is a non-means-tested benefit paid to people aged over-65 and provides an indication of the numbers who are severely disabled. In Calderdale, 4575 (14.1%) of people aged over-65 claimed attendance allowance in December 2012.

Strategic Plan

In 2014 the CCG engaged the public on and developed its 5 year strategic plan which identified clinical priorities and refreshed their outcomes.

The equality objectives that the CCG developed align with both; drawing from the clinical priority of diabetes and the outcomes; 'improved patient experience and perception – both within and outside hospital care' and 'Improved quality of life of patients with a long-term condition or illness'

Equality Delivery System

The Equality Delivery System (EDS) was designed by the Department of Health to help NHS organisations measure their equality performance, and understand how driving equality improvements can strengthen the accountability of services to patients and the public. It aimed to support the NHS identify local needs and priorities, particularly any unmet needs of populations, and allow them to assist in the commissioning of services to deliver better health outcomes.

At the heart of the EDS is a set of 18 outcomes grouped into four goals;

1. Better health outcomes for all

2. Improved patient access and experience
3. Empowered, engaged and well-supported staff
4. Inclusive leadership at all levels

The CCG undertook the EDS in 2013 and as a result of public engagement and feedback identified a set of equality objectives which aimed to drive improvement in critical areas. An implementation plan has been developed to achieve the objectives within four years; progress will be monitored and reported on through our governance processes.

The objectives are;

- Improve the access, experience and outcomes for South Asian patients with diabetes
- Improve patient experience equality monitoring measures

A set of measure has been developed to track progress on the objectives; some are yet to be determined as there is no base line data available, but will be reviewed annually and updated accordingly.

Objective 1 measures:

- Views and experiences of practitioners and South Asian patients with diabetes collected and analysed
- Recommendations made for improved diabetes care for this population group
- Improved ethnicity monitoring in diabetes care
- Establish patient experience measures that monitor equality
- Reduction in DNA's for South Asian diabetic patients by x% over the next four years (tbc)
- Improve HBA1c results for South Asian diabetic patients by x% over the next four years (tbc)
- Improve patient experience outcomes for South Asian patients with diabetes by x% over the next four years (tbc)

Objective 2 measures:

- Equality monitoring tool identified
- Accurate equality monitoring data available in specific services
- Measures of patient experience disaggregated and reported by protected group in specific services
- If required, actions taken to improve experience for specific groups
- Measurable improvement in patient experience outcomes for equality groups where action is undertaken

The equality objectives in full can be found on this webpage.

The equality objectives were developed in line with the strategic priorities of the CCG aligned with the outcome of the EDS.

For each objective a steering group has been established with a patient/lay representative on each. The steering groups meet regularly to monitor progress on the activities. The action plan will be implemented over 4 years as the CCG want to demonstrate real progress and improvement in patient access, experience and outcomes.

The Diabetes work is part of a broader programme of activity, with the focus for the objective purely on the South Asian community as South Asian people of Indian, Pakistani and Bangladeshi heritage who live in the UK are up to six times more likely to have Type 2 diabetes than White British people and 8.1% of Calderdale CCG's population are of South Asian heritage and will possibly develop diabetes at an earlier age, with a higher risk of developing diabetes related complications.

The CCG has worked in partnership with Greater Huddersfield CCG to develop a Diabetes Strategy which outlines the scale of the issues and approaches to solutions. The focus on the South Asian population is

delivered by the steering group which will consider best practice models and a community based approach using surveys.

The second objective aims to improve the CCGs access to accurate equality monitoring data to enable them to make the best commissioning decisions. This will be enhanced by increasing the introduction of equality monitoring within the patient experience and satisfaction measures so that acceptability of services can be understood by equality characteristic and any differentials addressed.

Equality Impact Assessment

To demonstrate that we are paying due regard to the needs of protected characteristic groups we ensure that every decision we make, that would have an impact on the public or our staff, is analysed for its impact on the access, experience and outcomes for protected characteristic groups. This assessment is then used to support our decision making.

In the past year we have undertaken a number of assessments. For more information visit, here.

In the past year we have undertaken a number of assessments, some examples include:

- Wheelchair Services
- Care Closer to Home
- HR Policies
- 5 Year Strategic Plan
- Rebate Policy
- Interim Walk in Centre

For more information visit, here.

There are a number of activities the CCG has undertaken to ensure Equality and Diversity is embedded in the organisation. The following are a few examples:

- Mandatory Equality and Diversity training, including specific Governing Body training
- All engagement activity supported to ensure community representation – including Diabetes, RCTP, Care Closer to Home, health forum, equality forum
- Training delivered for engagement champions
- Equality and patient experience matrix developed

Engagement

The CCG is very committed to engaging the public in the work it does. It has invested in Voluntary Action Calderdale (VAC) to create Health Connections which connects the voluntary and community sector (VCS) with the NHS, supporting groups to become sustainable and business ready so that they can deliver NHS services on behalf of the CCG.

One of the significant parts of the programme is the Engagement Champions programme. The Engagement Champions act as a link between the voluntary and community sector groups and NHS Calderdale CCG to ensure that the views of a wide range of local people are available to support CCG decision making. The CCG work with over 40 groups in varying localities representing some of the most seldom heard residents in our area. By investing in local people and asking them to talk with their residents or clients, we are able to really understand those that we seldom hear from. This provides the CCG and other health partners with a rich picture of local needs, enabling us to provide better services in our communities.

The Champions were mobilised to support the Right Care, Right Time, Right Place programme, and with other engagement staff reached over

2000 people across Calderdale and Huddersfield, reaching a good representative sample of the Calderdale population.

Engagement is an on-going commitment we report every year on the work we have undertaken, the report for 13/14 is here.

Census 2011

The 2011 Census included a question on how people perceived their general health, ranging from very good to very bad. Some highlights from our results in respect of this perceived health status and protected characteristics are as follows:

- Irish heritage people described the worst relative health with 14 % reporting bad or very bad health compared to the average (6%). The group reporting the best health, 88% very good or good, was Black/Black British, although there is a very small population (899). Asian/Asian British people reported better health than White British at 83%/80% very good or good. This could be explained by the relative age demographics.

- The best reported general health was by Hindus, 91%, but this was a small sample (616), people with no religion reported above average very good/good health 87%. The worst, very bad or bad health was reported by those of other religions, Jewish and Buddhist people, though again these were small sample groups (total 1554)

- There was very limited difference between the sexes on general health, as expected there was a reduction in general health as age progressed with older people (65+) reporting very bad or bad health at 15% compared to 9% for 50-64 and 3% for 16-49.

Proficiency in English compared to general health;

- People whose main language is not English demonstrate that as proficiency in English declines health worsens although with the limited numbers involved it is hard to validate. If people cannot speak English well they were twice as likely to have poorer health with the same pattern followed with those unable to speak English.

Long term health problems

Disability is defined by the Census as a long-term health problem or disability that limits a person's day-to-day activities, and has lasted, or is expected to last, at least 12 months. This is close to the Equality Act 2010 definition of disability. People were asked to assess whether their daily activities were limited a lot or a little by such a health problem or disability, or whether their daily activities were not limited at all.

- As could be expected disability increases with age, with an even spread of people aged over 65 having activity limited a little and limited a lot. (26/27%) with 47% not limited at all. This was in contrast to the 50-64's at 76%. Men and women were more evenly spread with women slightly worse off, but this could be explained by their longevity.
- In line with their poor reported general health the Irish heritage population of Calderdale also report their activities being the most limited, with 16% limited a little and 18% limited a lot. This compares to 10% and 8% for the whole population in Calderdale

Carers

- The group aged 50-64 provide care most 20% at 13% the over 65's, are providing care, and significantly provide the most hours of care at 5% providing 50 or more hours a week.
- The health of carers is often impacted by their provision of care. those who provide 50 or more hours a week reporting bad or very

bad health 5% compared to 2% who have very good or good health.

The census data is provided in detail in Appendix 1

Other protected groups

Unfortunately there is limited or no Census, local data or other available current information on some of the protected characteristics: sexual orientation and gender reassignment in particular. However a brief examination of national reports on these issues has highlighted a number of implications for health inequalities.

Transgender/gender reassignment

Transgender 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.

The CCG is a member of the West Yorkshire Trans Equality Multi Agency Partnership Group which began meeting in July 2012 with the aim of improving trans peoples experiences and reducing health inequalities.

The group has members from the public sector across West Yorkshire, including; NHS organisations, local authorities, housing providers, universities and Police.

In 2013 the group commissioned research into trans experience of public services in West Yorkshire. The report will be on our website once published.

When participants were asked how they would rate their experiences as trans people, or people with a trans history, of using the NHS in West Yorkshire in general, many were very positive.

Of the 22 participants who responded to this question, most scored NHS services in West Yorkshire as at least average, with more tending to score positively than negatively overall.

55% of those participants felt that being trans had influenced how they were treated in NHS services, with only one of those people feeling that it had improved their experience. Positive experiences centred around being seen as a person with a trans history being incidental, with these seeming to centre around being treated with empathy and understanding, having the persons gender identity validated and respected, and staff who were not only willing to learn, but made efforts to self-educate rather than relying on their patient's for information.

Negative experiences often related to having to follow a treatment pathway that was rigid and inflexible, a lack of knowledge or understanding from NHS staff, and overt discrimination. These were largely related to incidents where their gender identities were not respected or valued, where blocks or delays were placed upon their treatment, having to follow rigid treatment pathways, engaging with services which were strongly gendered and ill-equipped to work with trans patients, or where they were dehumanised and their physical or mental health issues were conflated with their gender identity.

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 rated 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.

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

Patient experience

Understanding and acting to improve the patient's experience is fundamental to the core business of Calderdale CCG we consider any intelligence we receive in relation to complaints, concerns and issues, however we do not have consistent equality monitoring data to identify any trends in reporting.

The national GP Patient Survey is undertaken twice annually. The latest report covering last year's survey was published in July 2014 and collected during July-September 2013 and January-March 2014 by IPSO-MORI on behalf of NHS England.

The survey is designed to give patients the opportunity to comment on their experience of their GP practice and includes questions about their general health and some equality information.

The survey collects information from respondents in respect of the following equality protected characteristics: gender, age, ethnicity, religion/belief, sexual orientation and disability (defined for the purposes of this report in two ways: "deaf/sign language users" and "limiting long-standing health condition"). This will be used to consider differentials in patient satisfaction that may reveal new information.

This report will highlight some key issues in the GP patient survey comparing the West Yorkshire wide results with the CCG results on;

- GP involving you in decisions about your care
- Overall experience
- Confidence in managing own health

The emerging trends from the most recent publication are;
GP involving you in decisions about your care

- Compared to West Yorkshire respondents in Calderdale felt less negatively about being involved in their care, WY poor/very poor 3%/1%, Calderdale 2%/1%. There were no significant gender issues in involving you in decisions about your care.
- The white British group were more positive than the Pakistani heritage groups about being involved in decisions about their care (very good 43%/33%). There was limited negative feedback for all groups.
- There was a general trend in people feeling that they were involved in their care with increasing age; 33% at 18-24 to 45% at 85+. The only age groups to feel very negatively about their involvement in decisions were 25-34 and 35 – 44 both at 2%.

Overall experience of the GP surgery;

- Women were more likely to rate the surgery very good and men fairly good.
- Pakistani heritage people were less likely than White British to give the highest rating 30%/46%, but White British people were more likely to rate at the lowest fairly poor (3%) and very poor (1%).
- Experience had an upwards trend in line with age, 'very good': 18-24 year olds (27%); 85+ year olds (56%); but the most satisfied were the 75-84 year olds with 65% reporting their experience as 'very good'. The youngest group (18-24s) was the most dissatisfied with 9% reporting as fairly poor, although 2% of 25-34s reported their experience as very poor.

Confidence in managing own health;

- White British people were the most confident about managing their own health (46%), the least confident were Pakistani heritage people with only 31% reporting they were very confident.
- Those with a long term condition were less confident about managing their own health with 9% reporting they were not very confident and 2% not at all confident.

Data is available in Appendix 2

Workforce

The workforce data referred to in this report has been taken from the electronic staff record (ESR). ESR is an Oracle based database which securely holds all of the data regarding employees. All records are populated but it should be noted that not all staff want to make declarations. These fields have been marked appropriately. The ESR system is not able to capture information on transgender.

There is a statutory requirement to publish staff details if an employer has 150 or more staff. So while this does not apply the CCG is aware of the need to consider the impact their workforce may have on equality and so is publishing broad information. Due to the small numbers of staff employed in the CCG any reporting of data has to be done carefully, to avoid publishing person identifiable information; allowing staff with different characteristics identifying staff against their protected

The workforce data is summarised below;

- There are 45 employees
- The majority are women
- About half are aged 50-59
- Most are Christian
- Over 70% are full time, with more women than men in part time roles.

Consideration was given to whether data relating to the following would give any significant or valid data;

- recruitment and promotion
- numbers of part-time and full-time staff
- return to work of women on maternity leave
- grievances (including about harassment)
- disciplinary action (including for harassment)
- dismissals and other reasons for leaving.

However the very small numbers involved would not have been sufficient to identify any trends.

Equality impact assessments have been used to screen all relevant policies, and over the next year we will continue to monitor the impact of the implementation of our workforce policies on all our staff, including

their usage. This will ensure that we proactively identify and address any potential inequalities against equality characteristics.

The CCG also recognises that in order to remove the barriers experienced by disabled people, reasonable adjustments are necessary for our disabled employees, and for those people who would like to secure employment with the CCG. This will be achieved in a personalised way, involving occupational health services as appropriate. The CCG is a Two Ticks employer.

Staff survey

Annually employees are asked to complete a staff survey to report on their experiences as employees. The most recent report covers 2013-14. Equality questions are part of the survey, however the survey has not been commissioned to report on the disaggregation of answers by equality group.

Where data is available the highlights are presented below;

- There was a 73% response rate
- Staff were asked if they had a long-standing illness, health problem or disability/issue (defined as something that has lasted or will last at least 12 months). 13% of the staff said they had such a problem. Of the number of staff who needed adjustments, 100% said that they had been made (this compares to 4% on ESR)
- 78% of staff who thought that equality and diversity training was applicable to them said they had received such training in the last 12 months; a further 22% said they had received training on equality and diversity, but more than 12 months ago.
- 86% of staff said that they or a colleague reported when they last experienced harassment, bullying or abuse at work. 14% said that they did not report it.

- 81% of staff felt that their organisation acted fairly with regard to career progression/promotion regardless of ethnicity, gender, religion, sexual orientation, disability or age
- No staff said they had experienced discrimination

Data

The CCG is very aware that they are unable to report as comprehensively as we would like, as there are broad gaps in data. From the census on there are gaps in the data requested from people which have an impact on our ability to report against all 9 protected characteristics.

There are numerous reasons for this, some of our providers have systems in place which so not allow for recording of all characteristics, there is sensitivity in what data is appropriate to request and store, some people are reluctant to ask for data and some to provide the data.

The NHS will standardly collect age and sex data, in addition ethnicity is often requested. Beyond this data is not always routinely requested. Where collection is in place the data is not always collated and reported to the CCG.

The CCG is actively building in a requirement to equality monitor in new service specifications and contracts and has chosen this area to focus on as one of its equality objectives.

The CCG is actively building in a requirement to equality monitor in new service specifications and contracts and has chosen this area to focus on as one of its equality objectives. This year a new assurance process has been developed to ensure that equality and engagement are actively considered as part of any service developments.

Provider organisations

CCGs can commission a variety of service providers, NHS hospitals, social enterprises, charities, or private sector providers as long as they meet NHS standards and quality.

Our main NHS provider organisations are:

- Calderdale and Huddersfield Foundation Trust
- South West Yorkshire Partnership Foundation Trust

As a commissioner of health care, we have a duty to ensure that all of our local healthcare service providers are meeting their statutory duties under the PSED. As well as regular monitoring of performance, patient experience and service access we will work with them to consider their progress on their equality objectives and the Equality Delivery System. Each provider organisation is subject to the specific duty and has published its own data that they have used. These are available here; SWYPFT equality objectives; CHFT.

We have published the data related to our patient's use of A&E, elective, emergency, outpatients (first appointment), outpatients (follow up) and those who do not attend their outpatient's appointments, by age, sex and ethnicity in Appendix 3.

Most of the trends, when compared to the local population profile, that emerge are expected;

- The youngest and oldest groups are over represented at &E attendances and emergency admission
- The oldest groups are over represented in elective admissions
- There is a similar gender split in A&E attendance
- Women are over represented in elective and outpatients

Some issues warrant more consideration;

- White patients are underrepresented at A&E, but over at elective

- Asian people are over represented at A&E and emergency admissions and under on elective
- When considering 'did not attends' the most significant issue is for Asian/Asian British
- The small groups of people from mixed ethnic backgrounds are underrepresented in all areas.

Conclusion

Equality, diversity and human rights data reporting and scrutiny begin to tell the CCG a story about the experiences of its local population including the most vulnerable and 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.

This report demonstrates that we have undertaken significant work in relation to equality and diversity. The information in this report demonstrates our commitment to commissioning for equal access to health care. It also demonstrates our compliance with the requirements of the Public Sector Equality general and specific duties as well as providing data with respect to our commissioning and engagement activities.

It is a key challenge for the CCG to identify and address health inequalities, this report outlines our early work and gives a commitment to build on our work in this area in future years.

We are aware, however, that there is still more to do to make improvements in our support to this agenda. There are areas where; we need to better understand the access, experience and outcomes of patients from protected groups and support our providers to share these insights the CCG could use the insights on the experiences of protected

groups more effectively there is a need to improve quality and consistency of equality monitoring across our providers.

The CCG has identified a number of priority equality objectives which will support them to address some of the issues outlined in this report. There is a particular focus on considering South Asian populations in relation to diabetes; work which will hopefully developed to address other communities with differential health outcomes. We will also be researching and promoting equality monitoring in patient experience so we can understand more about whether membership of a protected group has an impact on experience, and if so, what actions can we take to address the differentials.

It is only through consideration of the data that we can begin to understand how health inequalities are produced and reproduced in Calderdale and inform evidence-based initiatives to tackle them.

Data

Appendix 1 Census 2011

General Health	All categories: Ethnic group	White: Total	White: English/ Welsh/ Scottish/ Northern Irish heritage/British	White: Irish heritage	White: Other White	Mixed/ multiple ethnic group	Asian/ Asian British	Black/African/ Caribbean/ Black British	Other ethnic group
Very good or good health	81%	80%	80%	62%	84%	87%	83%	88%	83%
Fair health	14%	14%	14%	24%	11%	8%	12%	9%	12%
Bad or very bad health	6%	6%	6%	14%	5%	4%	5%	3%	4%

	Sex		
General Health	**All persons**	**Males**	**Females**
All categories: General health	203,826	99,627	104,199
Very good or good health	81%	82%	80%
Fair health	14%	13%	15%
Bad or very bad health	6%	5%	6%

	Age				
General Health	**All categories: Age**	**Age 0 to 15**	**Age 16 to 49**	**Age 50 to 64**	**Age 65 and over**
All categories: General health	203,826	40,181	91,233	39,940	32,472
Very good or good health	81%	97%	89%	72%	49%
Fair health	14%	2%	8%	19%	37%
Bad or very bad health	6%	1%	3%	9%	15%

General Health	All categories: Religion	Christian	Buddhist	Hindu	Jewish	Muslim	Sikh	Other religion	No religion	Religion not stated
All categories: General health	203,826	114,667	593	616	153	14,802	355	808	57,193	14,639
Very good or good health	81%	78%	79%	91%	82%	82%	88%	72%	87%	78%
Fair health	14%	16%	14%	7%	8%	12%	8%	17%	10%	15%
Bad or very bad health	6%	6%	8%	2%	10%	6%	4%	12%	4%	7%

	Sex		
Disability	**All persons**	**Males**	**Females**
All categories: Long-term health problem or disability	203,826	99,627	104,199
Day-to-day activities limited a lot	8%	8%	9%
Day-to-day activities limited a little	10%	9%	10%
Day-to-day activities not limited	82%	83%	81%

Disability	All categories: Religion	Christian	Buddhist	Hindu	Jewish	Muslim	Sikh	Other religion	No religion	Religion not stated
All categories: Long-term health problem or disability	203,826	114,667	593	616	153	14,802	355	808	57,193	14,639
Day-to-day activities limited a lot	8%	10%	8%	3%	14%	7%	3%	12%	5%	10%
Day-to-day activities limited a little	10%	12%	9%	4%	3%	8%	6%	16%	7%	10%
Day-to-day activities not limited	82%	79%	83%	93%	82%	85%	90%	72%	89%	80%

Disability	All categories: Age	Age 0 to 15	Age 16 to 49	Age 50 to 64	Age 65 and over
All categories: Long-term health problem or disability	203,826	40,181	91,233	39,940	32,472
Day-to-day activities limited a lot		2%	4%	11%	26%
Day-to-day activities limited a little	10%	2%	5%	13%	27%

Disability	**All categories: Ethnic group**	**White: Total**	**White: English/Welsh/ Scottish/ Northern Irish heritage/British**	**White: Irish heritage**	**White: Other White**	**Mixed/multiple ethnic group**	**Asian/Asian British**	**Black/African/ Caribbean/ Black British**	**Other ethnic group**
All categories: Long-term health problem or disability	203,826	182,787	176,732	1,795	4,260	2,797	16,875	899	468
Day-to-day activities limited a lot	8%	8%	8%	18%	6%	6%	7%	5%	5%
Day-to-day activities limited a little	10%	10%	10%	16%	7%	6%	8%	5%	8%
Day-to-day activities not limited	82%	82%	82%	65%	87%	88%	86%	91%	87%

Carer	All categories: Age	Age 0 to 15	Age 16 to 24	Age 25 to 34	Age 35 to 49	Age 50 to 64	Age 65 and over
All categories: Provision of unpaid care	203,826	40,181	21,320	24,464	45,449	39,940	32,472
Provides no unpaid care	90%	99%	95%	92%	87%	80%	87%
Provides unpaid care: Total	10%	1%	5%	8%	13%	20%	13%
Provides 1 to 19 hours unpaid care a week	7%	1%	4%	5%	9%	14%	6%
Provides 20 to 49 hours unpaid care a week	1%	0%	1%	1%	2%	2%	2%
Provides 50 or more hours unpaid care a week	2%	0%	1%	2%	2%	3%	5%

	General Health			
Carer	All categories: General health	Very good or good health	Fair health	Bad or very bad health
All categories: Provision of unpaid care	202,376	164,036	27,473	10,867
Provides no unpaid care	89%	90%	85%	88%
Provides unpaid care: Total	11%	10%	15%	12%
Provides 1 to 19 hours unpaid care a week	7%	7%	8%	5%
Provides 20 to 49 hours unpaid care a week	1%	1%	2%	2%
Provides 50 or more hours unpaid care a week	2%	2%	5%	5%

	General Health		
Proficiency in English	**All categories: General health**	**Good health**	**Not good health**
All categories: Proficiency in English	196,024	156,867	39,157
Main language is English (English or Welsh in Wales)	95%	95%	94%
Main language is not English (English or Welsh in Wales): Can speak English very well	2%	2%	1%
Main language is not English (English or Welsh in Wales): Can speak English well	2%	2%	2%
Main language is not English (English or Welsh in Wales): Cannot speak English well	1%	1%	2%
Main language is not English (English or Welsh in Wales): Cannot speak English	0%	0%	1%

Appendix 2 GP Patient Survey

Q21d. Rating of GP involving you in decisions about your care/gender

	Male		Female	
Very good	40%	640	43%	721
Good	35%	566	33%	556
Neither good nor poor	14%	224	11%	183
Poor	2%	32	2%	41
Very	1%	14	1%	22

poor				
Doesn't apply	8%	129	9%	144
Total		1,606		1,668

	English / Welsh / Scottish / Northern Irish heritage / British		Irish heritage		Gypsy or Irish heritage Traveller		Any other White background		Pakistani heritage		Any other ethnic group	
Very good	43%	1,241	50%	11	*	*	24%	20	33%	51	33%	19
Good	34%	978	*	*	*	*	46%	38	37%	57	41%	24
Neither good nor poor	12%	335	*	*	*	*	19%	16	18%	28	*	*
Poor	2%	57	*	*	*	*	*	*	*	*	*	*
Very poor	1%	18	*	*	*	*	*	*	*	*	*	*
Doesn't apply	9%	261	*	*	*	*	*	*	*	*	*	*
Total		2,890		22		0		84		152		59

Q21d. Rating of GP involving you in decisions about your care/Age

	18 to 24		25 to 34		35 to 44		45 to 54		55 to 64		65 to 74		75 to 84		85 or over	
Very good	33%	88	39%	216	34%	197	46%	298	45%	235	49%	196	46%	100	45%	36
Good	30%	82	32%	180	35%	205	33%	216	36%	186	35%	141	38%	83	41%	33
Neither good nor poor	16%	42	14%	81	16%	94	13%	82	11%	56	8%	34	7%	16	*	*
Poor	7%	19	*	*	3%	15	2%	11	3%	13	*	*	*	*	*	*
Very poor	*	*	2%	12	2%	11	*	*	*	*	*	*	*	*	*	*
Doesn't apply	12%	31	11%	64	11%	62	5%	34	6%	30	6%	26	9%	20	*	*
Total		269		559		584		646		520		405		220		80

Q28. Overall experience of GP surgery/Gender				
	Male		Female	
Very good	42%	689	46%	782
Fairly good	44%	717	42%	728
Neither good nor poor	9%	147	8%	132
Fairly poor	3%	54	3%	56
Very poor	1%	18	1%	18
Total		1,624		1,715

Q28. Overall experience of GP surgery/Ethnicity										
	English / Welsh / Scottish / Northern Irish heritage / British		Irish heritage		Any other White background		Pakistani heritage		Any other ethnic group	
Very good	46%	1,337	51%	13	27%	24	30%	48	40%	24
Fairly good	43%	1,261	*	*	55%	49	46%	73	43%	26
Neither good nor poor	8%	223	*	*	16%	15	17%	27	*	*
Fairly poor	3%	91	*	*	*	*	*	*	*	*
Very poor	1%	25	*	*	*	*	*	*	*	*
Total		2,938		25		90		159		61

Q28. Overall experience of GP surgery/Age

	18 to 24		25 to 34		35 to 44		45 to 54		55 to 64		65 to 74		75 to 84		85 or over	
Very good	27%	76	32%	182	37%	216	48%	317	48%	252	58%	242	65%	149	56%	47
Fairly good	49%	137	52%	298	46%	270	40%	265	42%	221	35%	147	33%	75	35%	30

Neither good nor poor	12%	32	11%	61	13%	74	8%	51	6%	34	4%	17	*	*	*	*
Fairly poor	9%	24	3%	19	5%	28	3%	18	3%	15	*	*	*	*	*	*
Very poor	*	*	2%	12	*	*	*	*	*	*	*	*	*	*	*	*
Total		278		573		588		657		524		416		228		85

Q33. Confidence in managing own health/Ethnicity												
	English / Welsh / Scottish / Northern Irish heritage / British		Irish heritage		Gypsy or Irish heritage Traveller		Any other White background		Pakistani heritage		Any other ethnic group	
Very confident	46%	1,330	*	*	*	*	34%	30	31%	49	45%	27
Fairly confident	47%	1,364	54%	13	*	*	62%	55	62%	99	42%	25
Not very confident	5%	155	*	*	*	*	*	*	7%	11	*	*
Not at all confident	1%	39	*	*	*	*	*	*	*	*	*	*
Total		2,888		24		0		88		160		61

Q33. Confidence in managing own health/LTC						
	Yes		No		Don't know / can't say	
Very confident	41%	763	51%	705	21%	12

Fairly confident	48%	877	48%	668	65%	36
Not very confident	9%	159	1%	20	*	*
Not at all confident	2%	40	*	*	*	*
Total		1,840		1,394		56

Appendix 3 SUS data

Age Band	Population	A and E	Elective	Emergency	Outpatient First Attendances	Outpatient Follow Up	Did Not attend
0-14	18.3%	20.1%	3.6%	24.2%	9.4%	9.0%	15.0%
15-24	11.9%	15.1%	4.1%	5.9%	8.4%	5.7%	11.8%
25-64	53.8%	45.4%	51.6%	32.4%	55.4%	49.6%	55.4%
65-84	13.9%	14.2%	36.1%	26.1%	23.1%	30.4%	14.6%
85+	2.1%	5.3%	4.6%	11.4%	3.7%	5.3%	3.3%
Grand Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

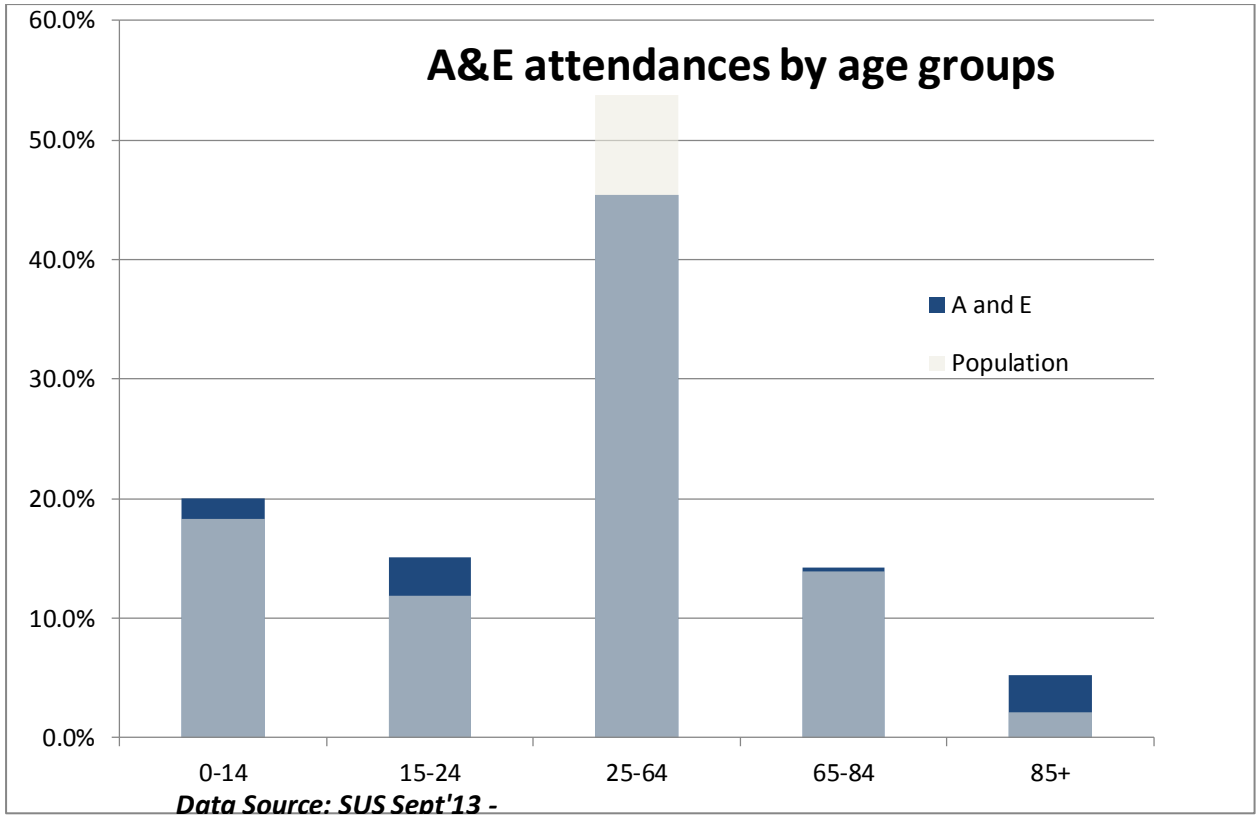
Gender

Gender	Population	A and E	Elective	Emergency	Outpatient First Attendances	Outpatient Follow Up	Did Not attend
Male	51.1%	52.0%	45.1%	49.0%	41.0%	44.8%	47.4%

Female	48.9%	48.0%	54.9%	51.0%	59.0%	55.2%	52.6%
Grand Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Ethnicity

Ethnicity	Population	A and E	Elective	Emergency	Outpatient First Attendances	Outpatient Follow Up	Did Not attend
White	89.7%	86.9%	94.4%	89.4%	90.4%	90.4%	85.4%
Mixed	1.4%	0.7%	0.4%	0.7%	0.6%	0.5%	0.9%
Asian/Asian British	8.1%	11.1%	4.5%	8.9%	7.9%	8.2%	12.3%
Black/Black British	0.4%	0.7%	0.3%	0.5%	0.6%	0.4%	0.8%
Chinese/Other Ethnic Groups	0.5%	0.6%	0.4%	0.5%	0.5%	0.4%	0.6%
Grand Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%



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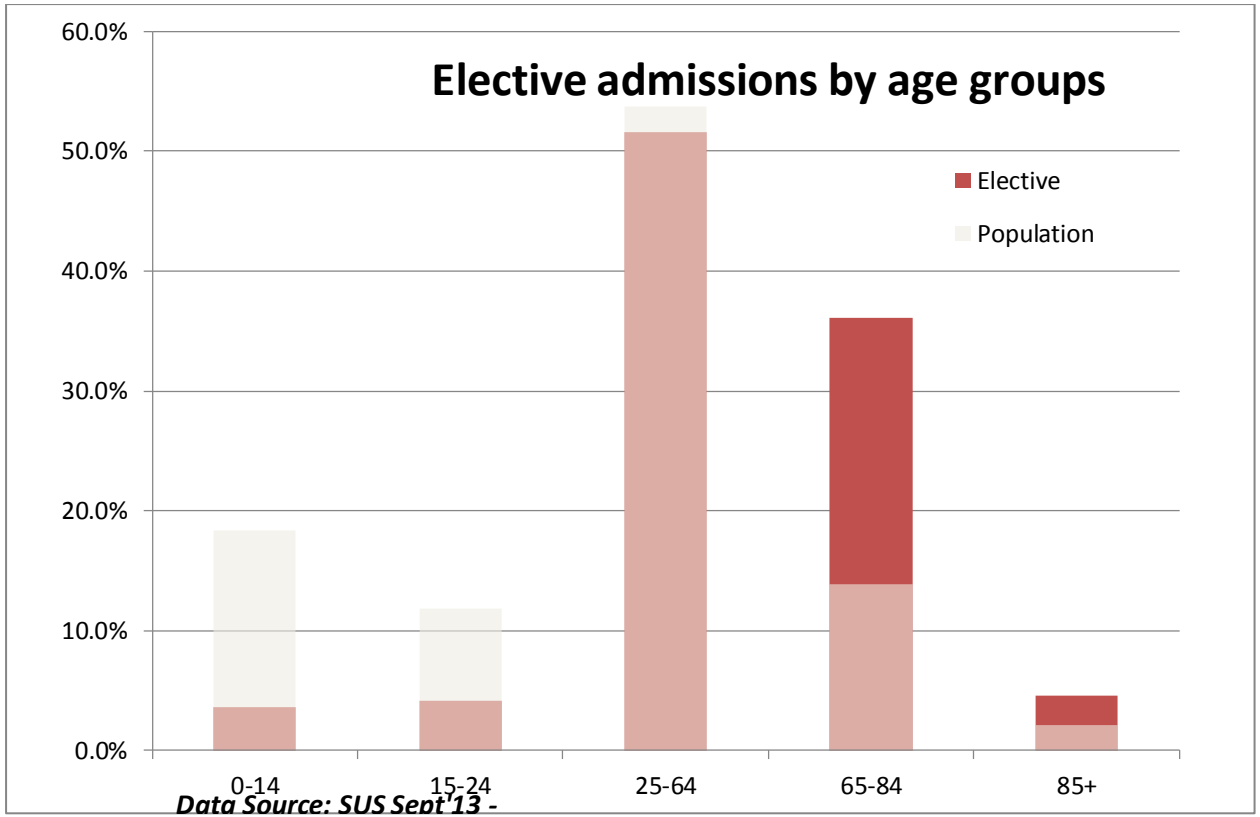

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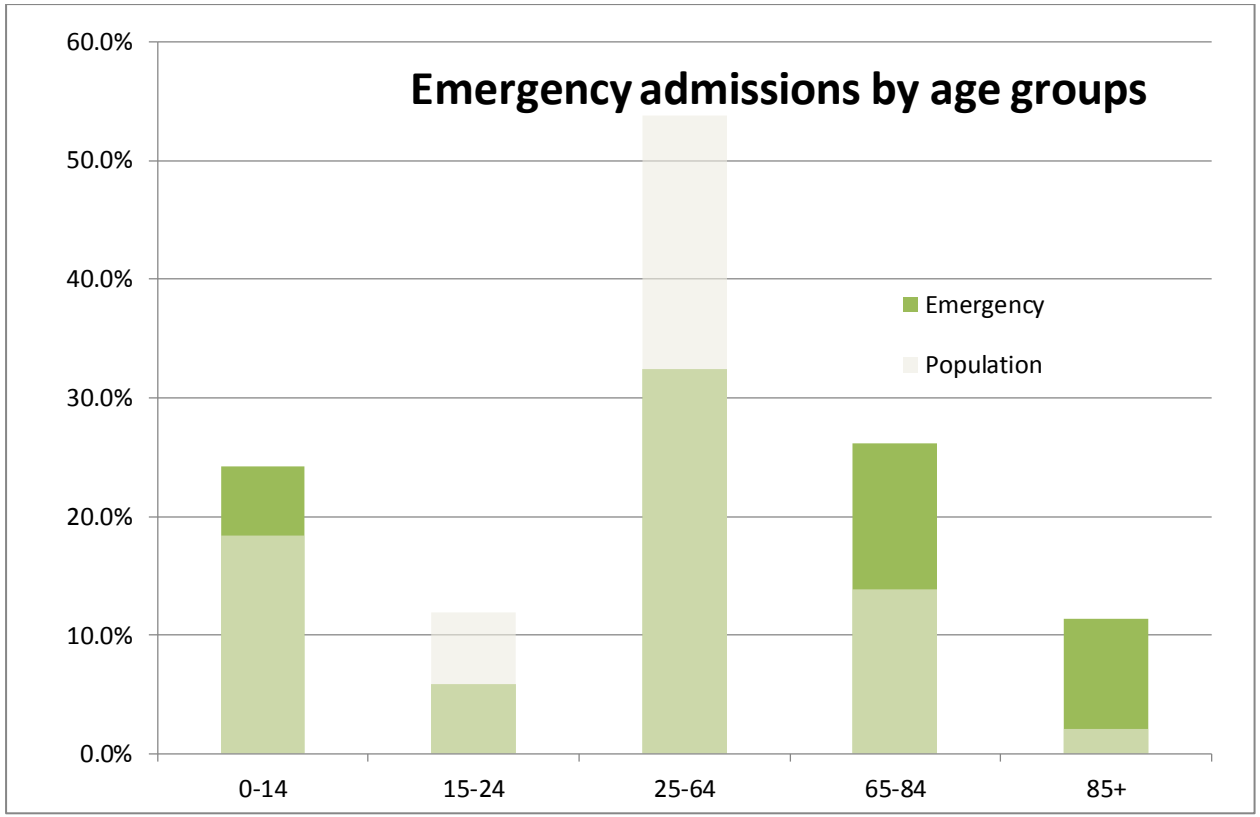
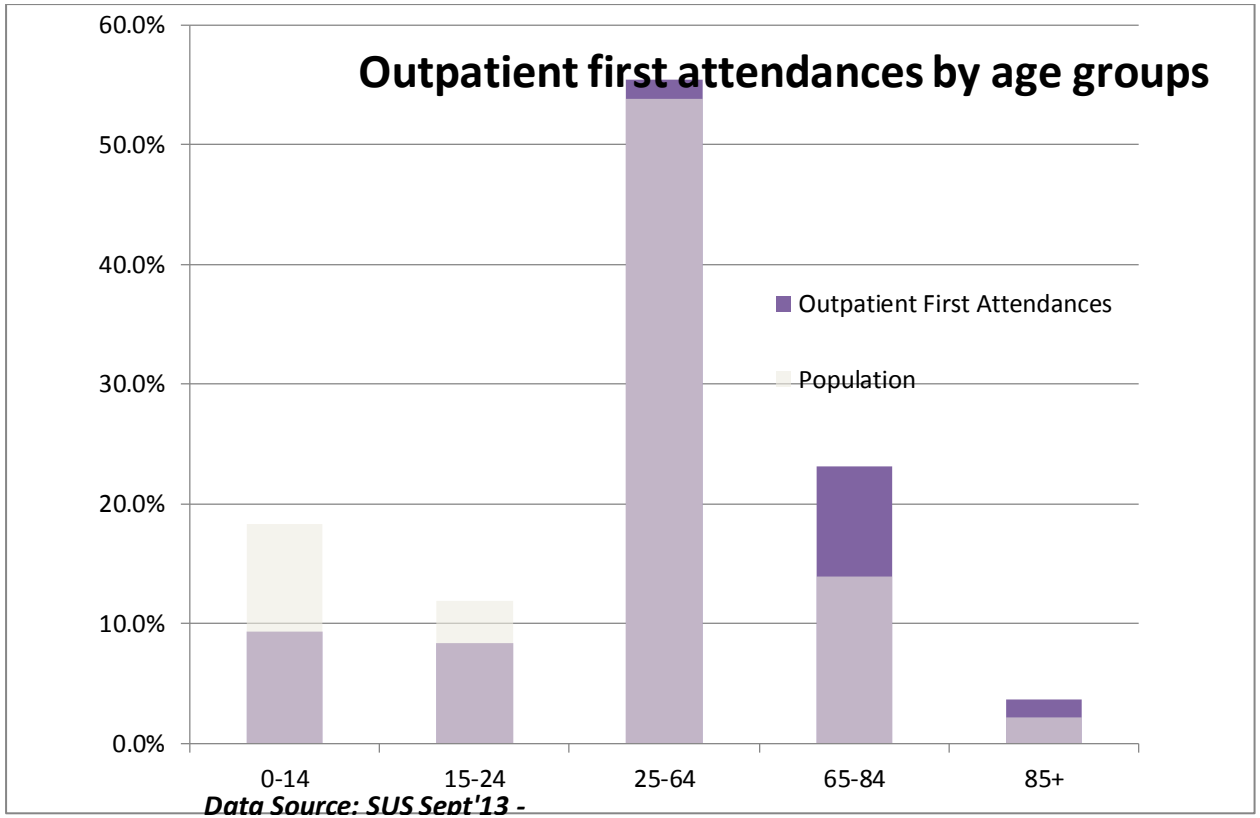

Emergency admissions by age groups
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
Emergency
Population
0-14
15-24
25-64
65-84
85+



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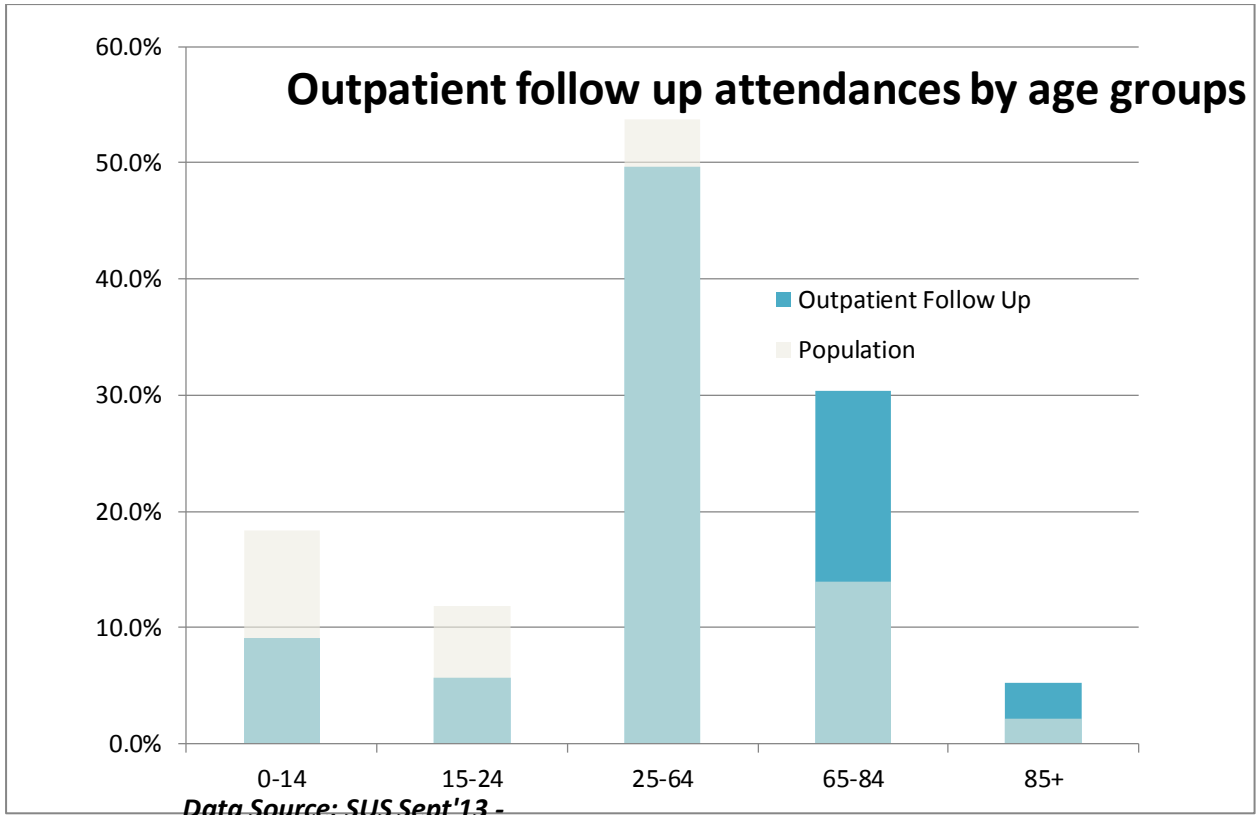
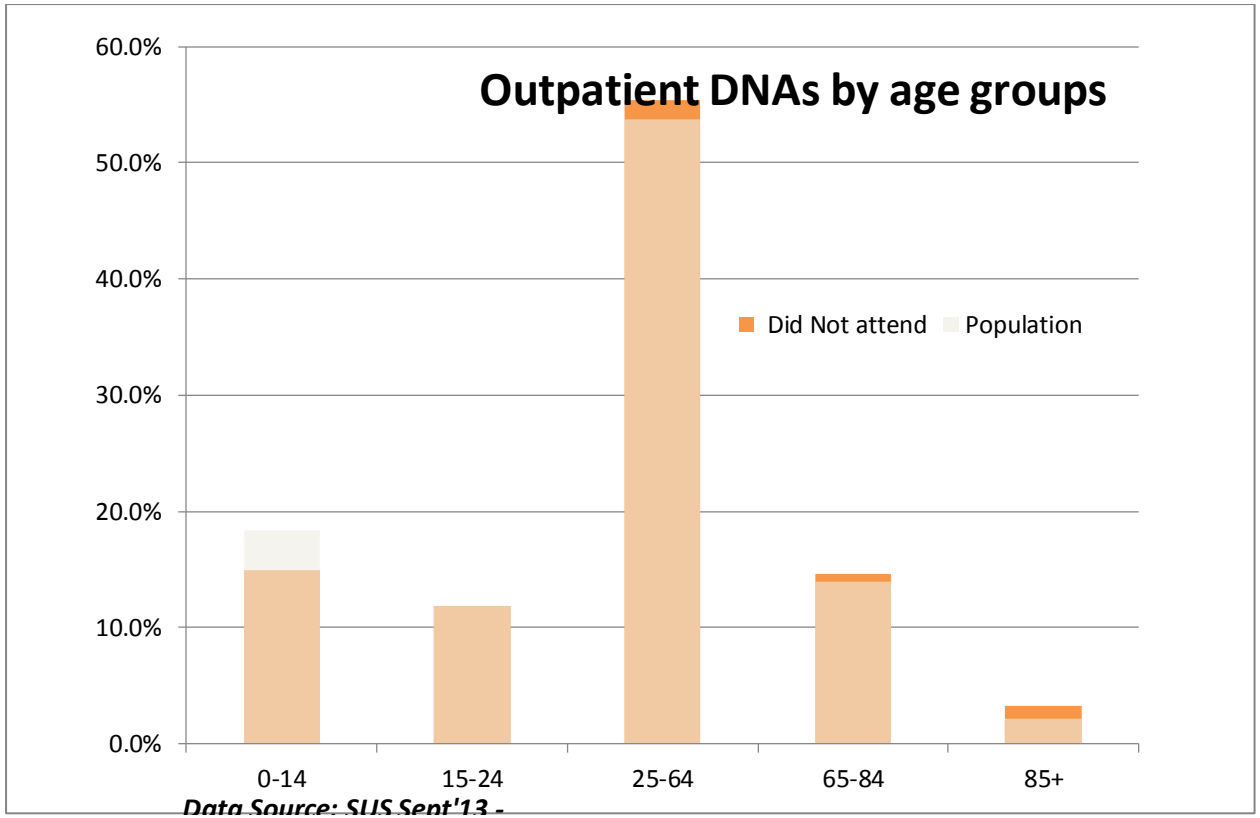
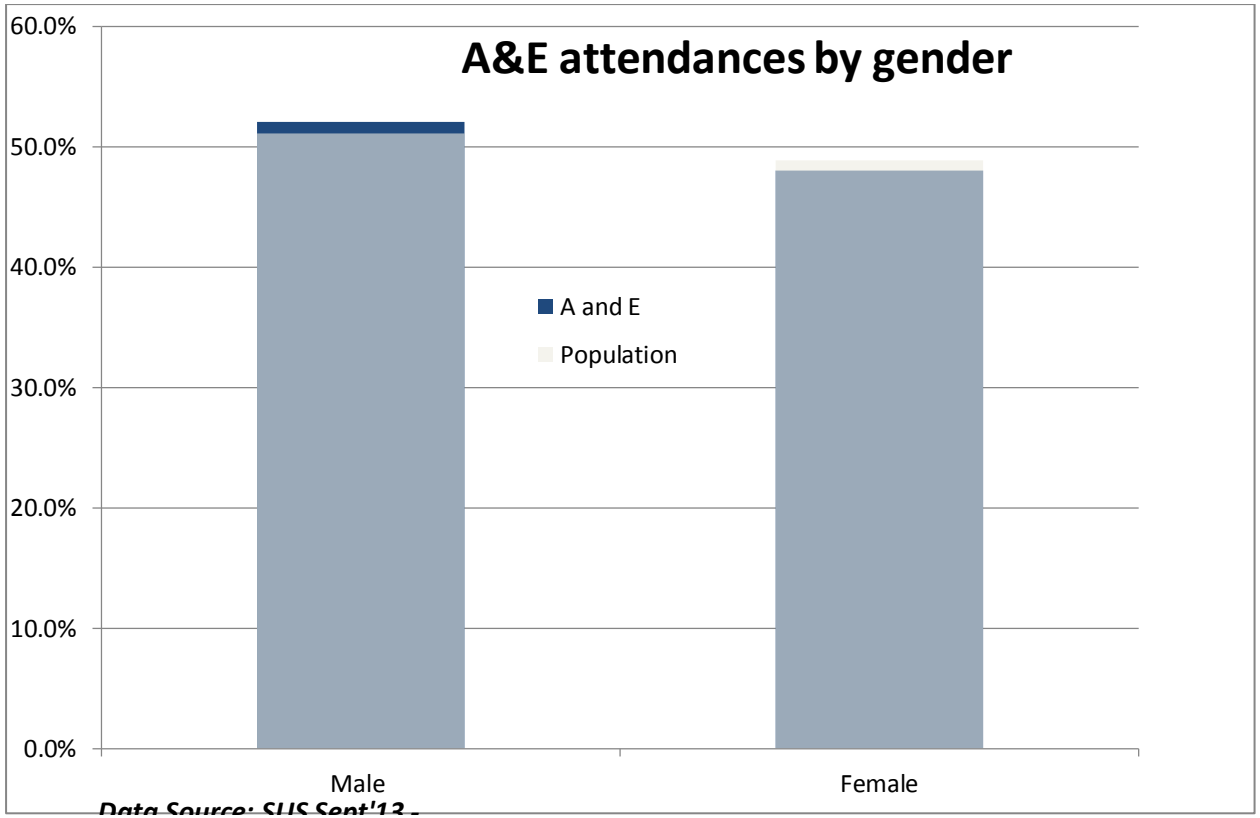

Outpatient follow up attendances by age groups
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
Outpatient Follow Up
Population
0-14
15-24
25-64
65-84
85+
Data Source: SUS Sept'13 -


Outpatient DNAs by age groups
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
Did Not attend
Population
0-14
15-24
25-64
65-84
85+
Data Source: SUS Sept'13 -



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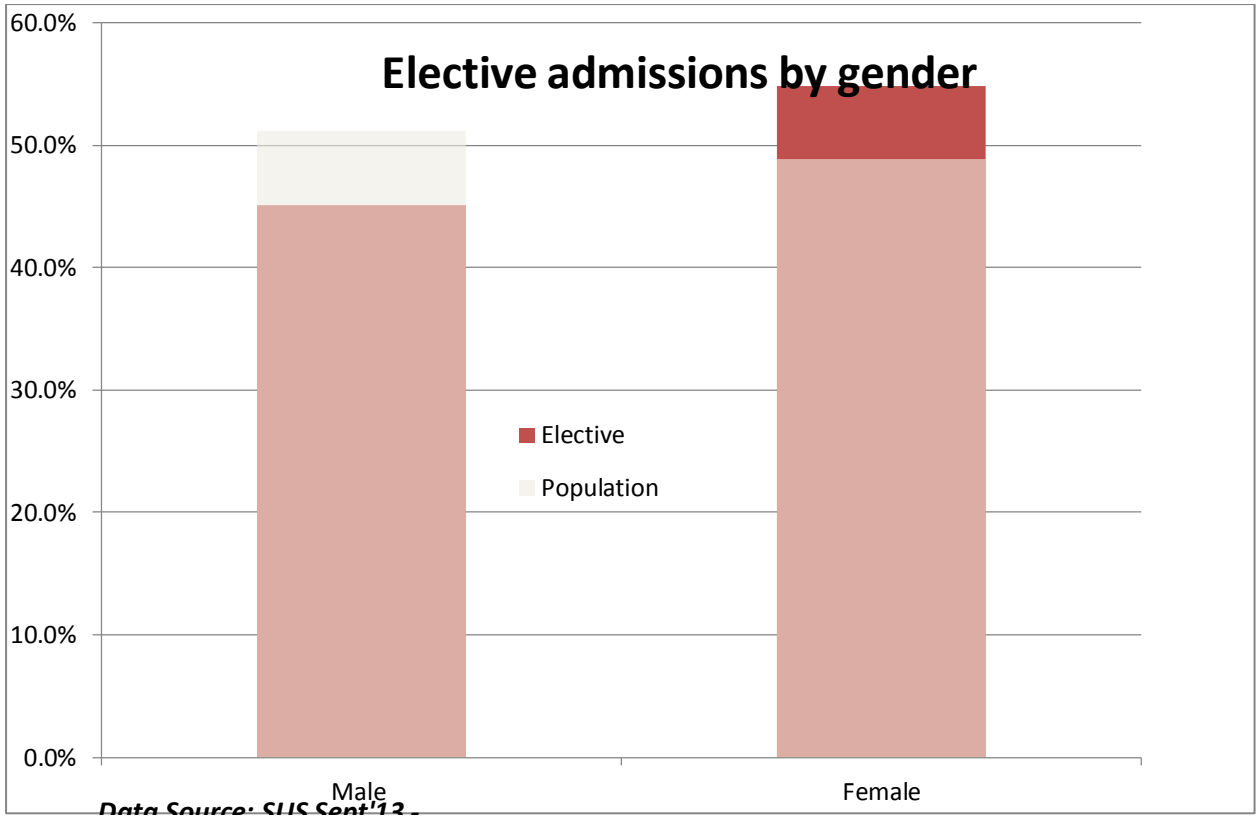

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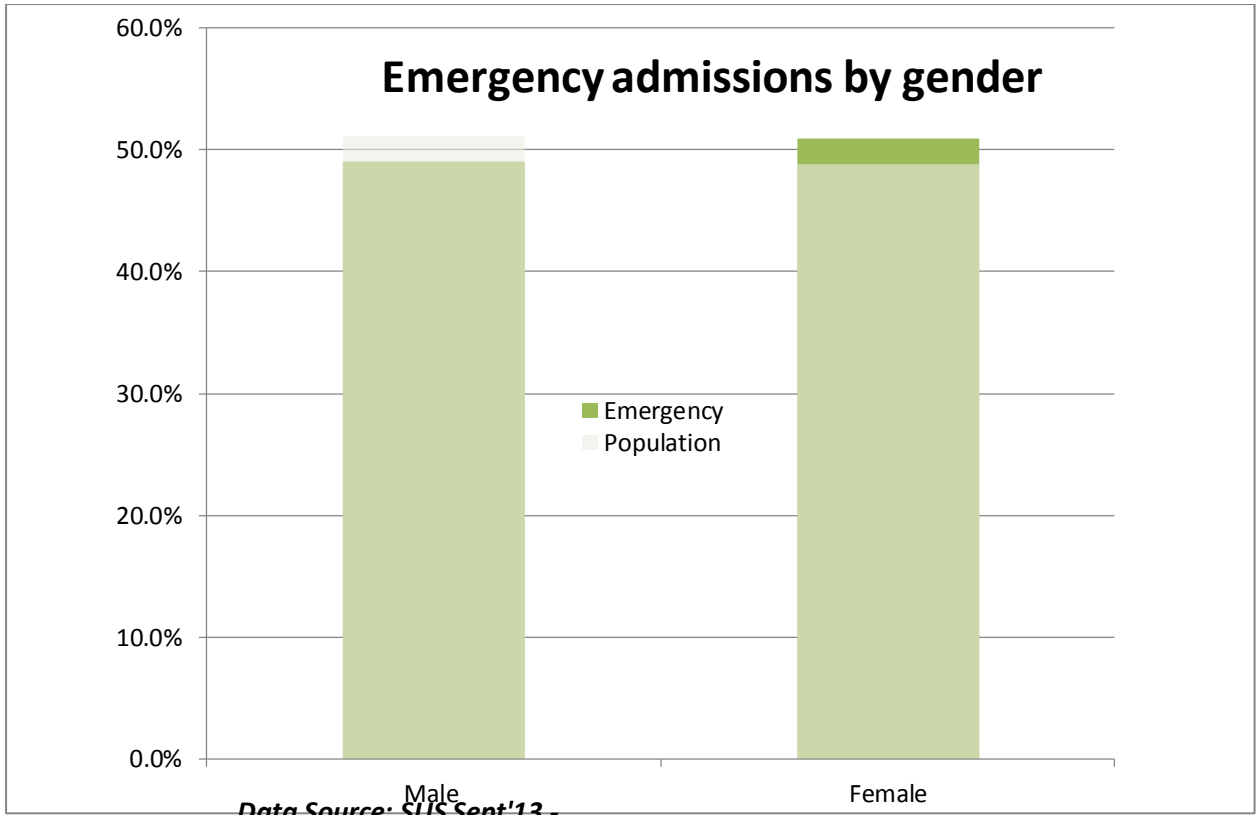

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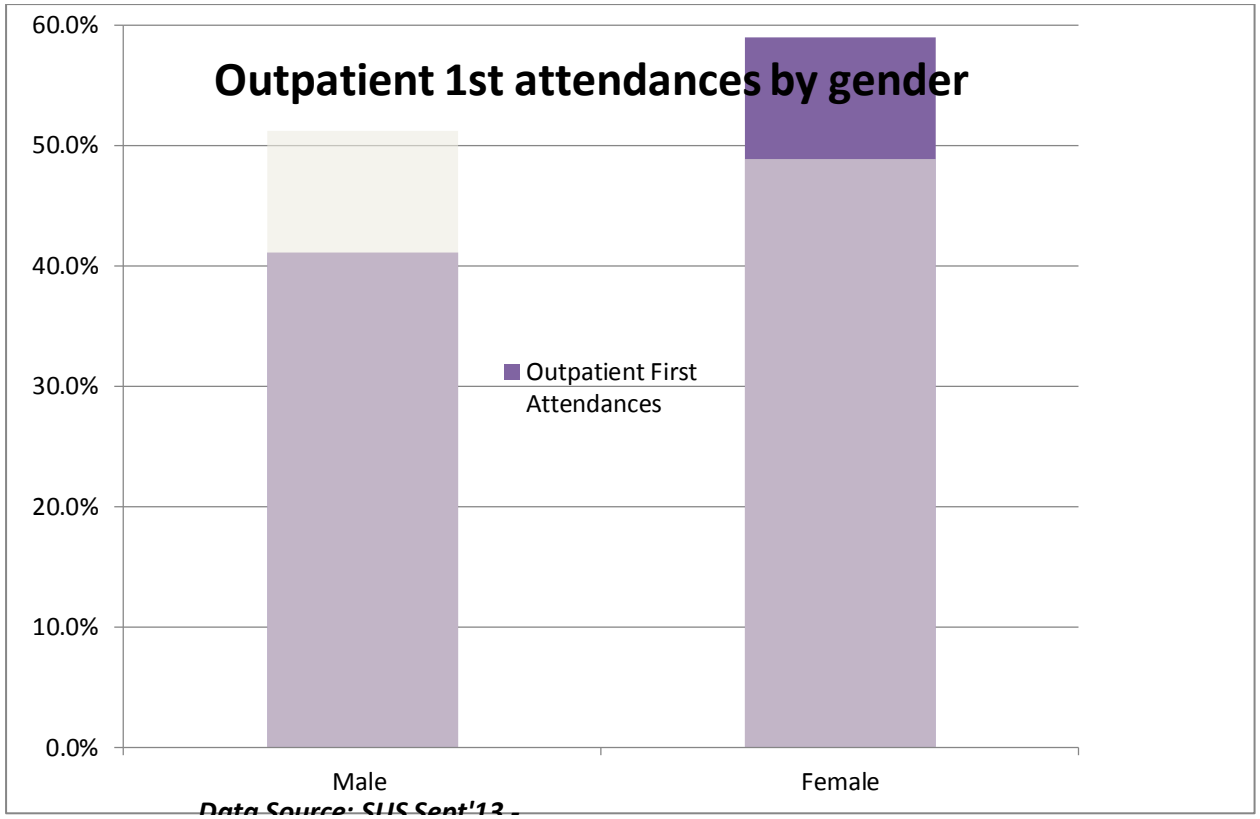
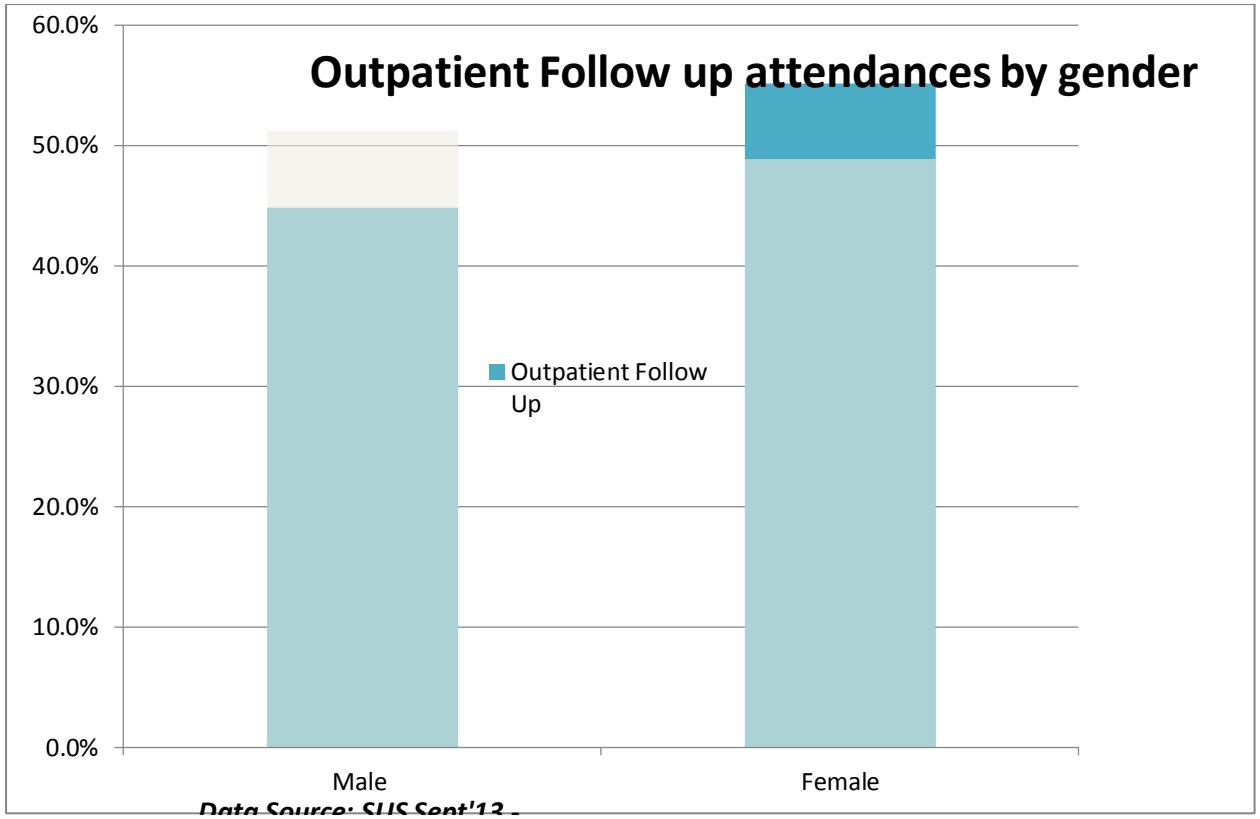
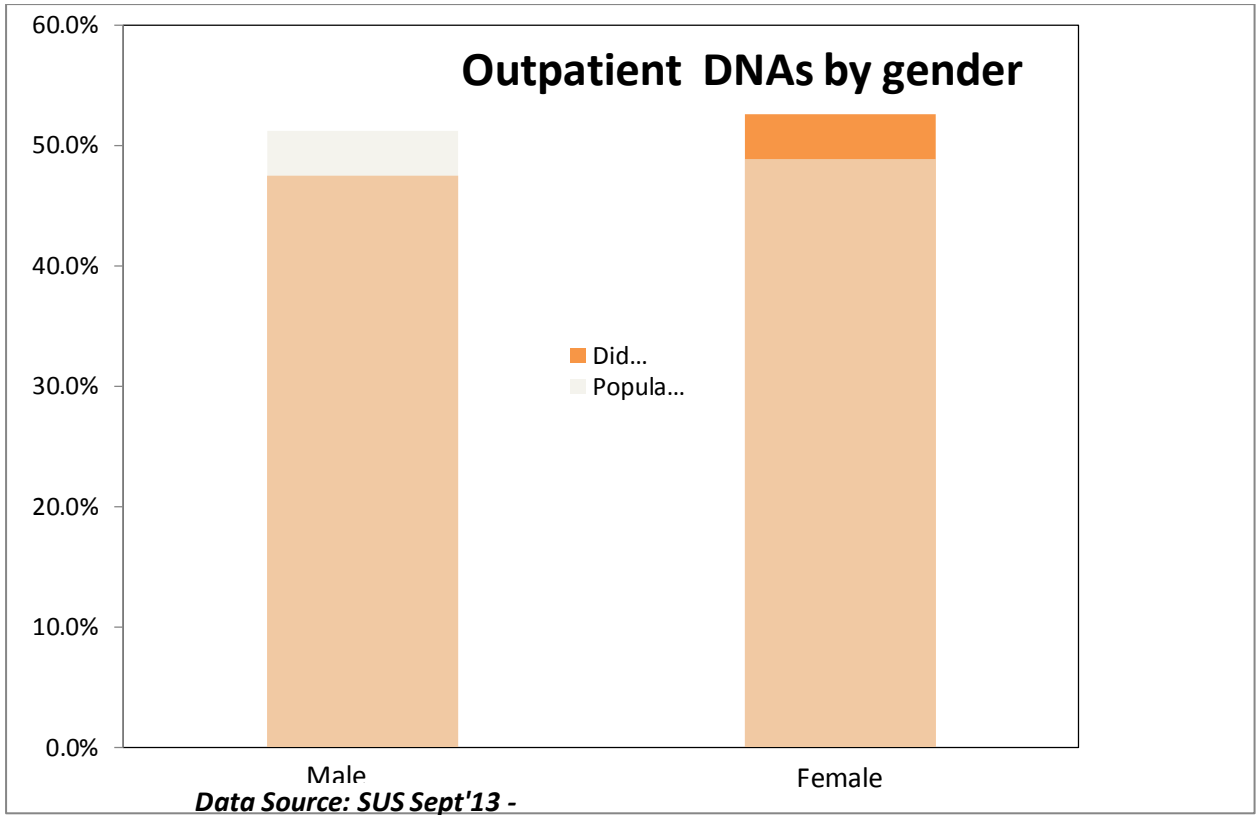

Outpatient 1st attendances by gender
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
Outpatient First Attendances
Male
Female
Data Source: SUS Sept'13 -


Outpatient Follow up attendances by gender
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
Outpatient Follow Up
Male
Female
Data Source: SUS Sept'13 -



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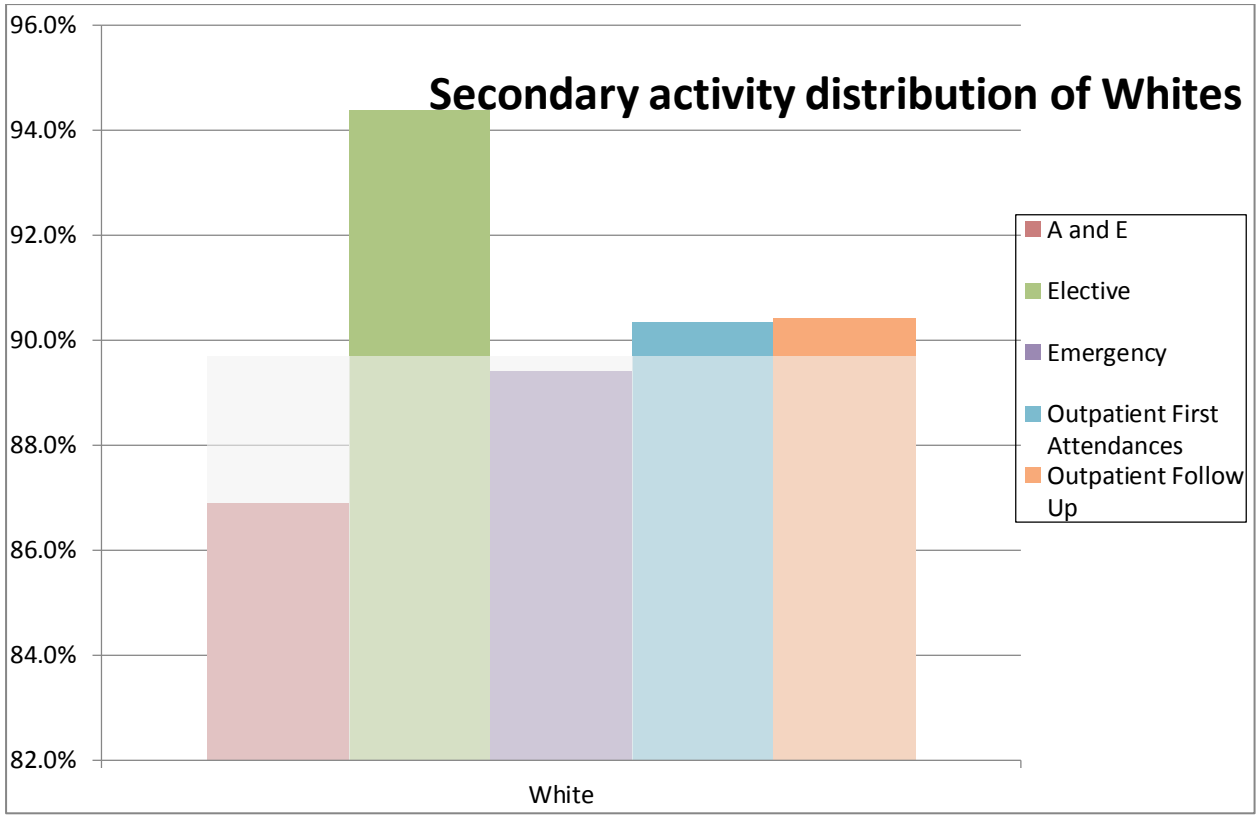
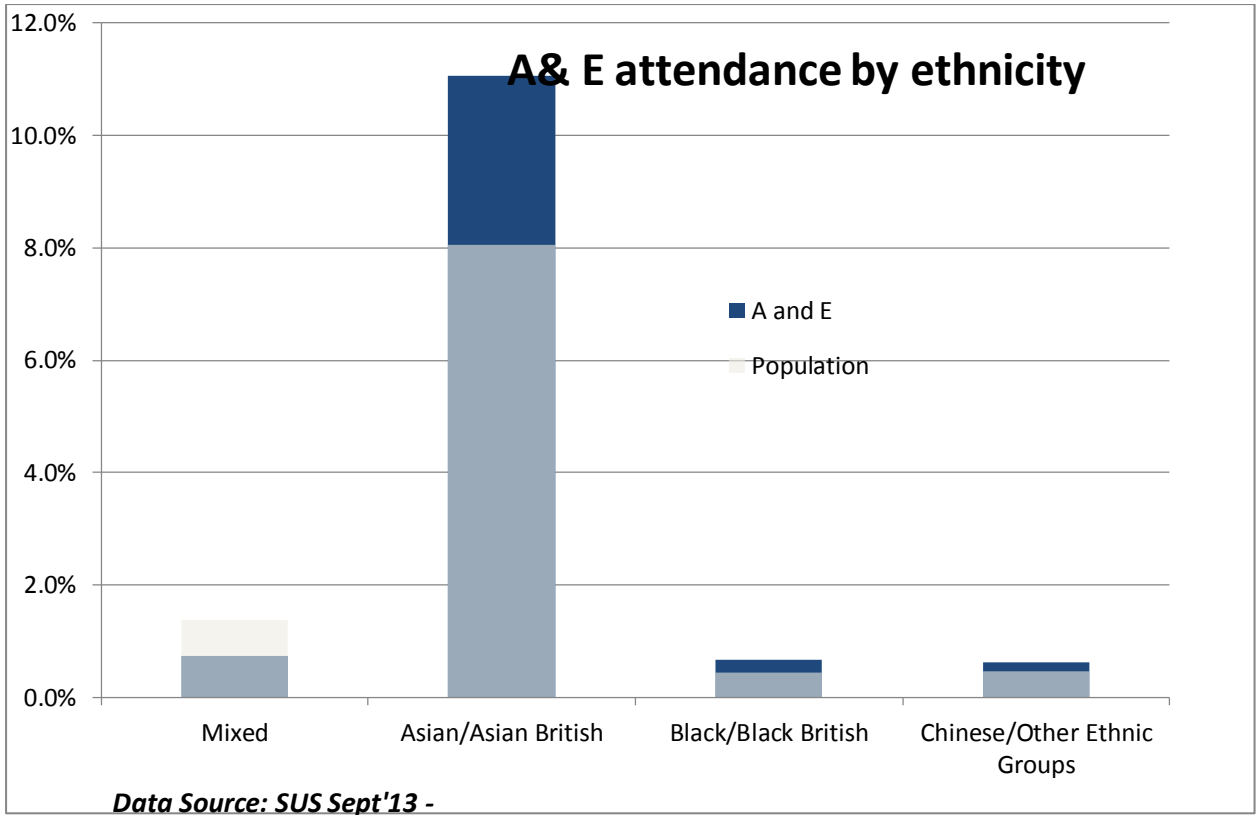
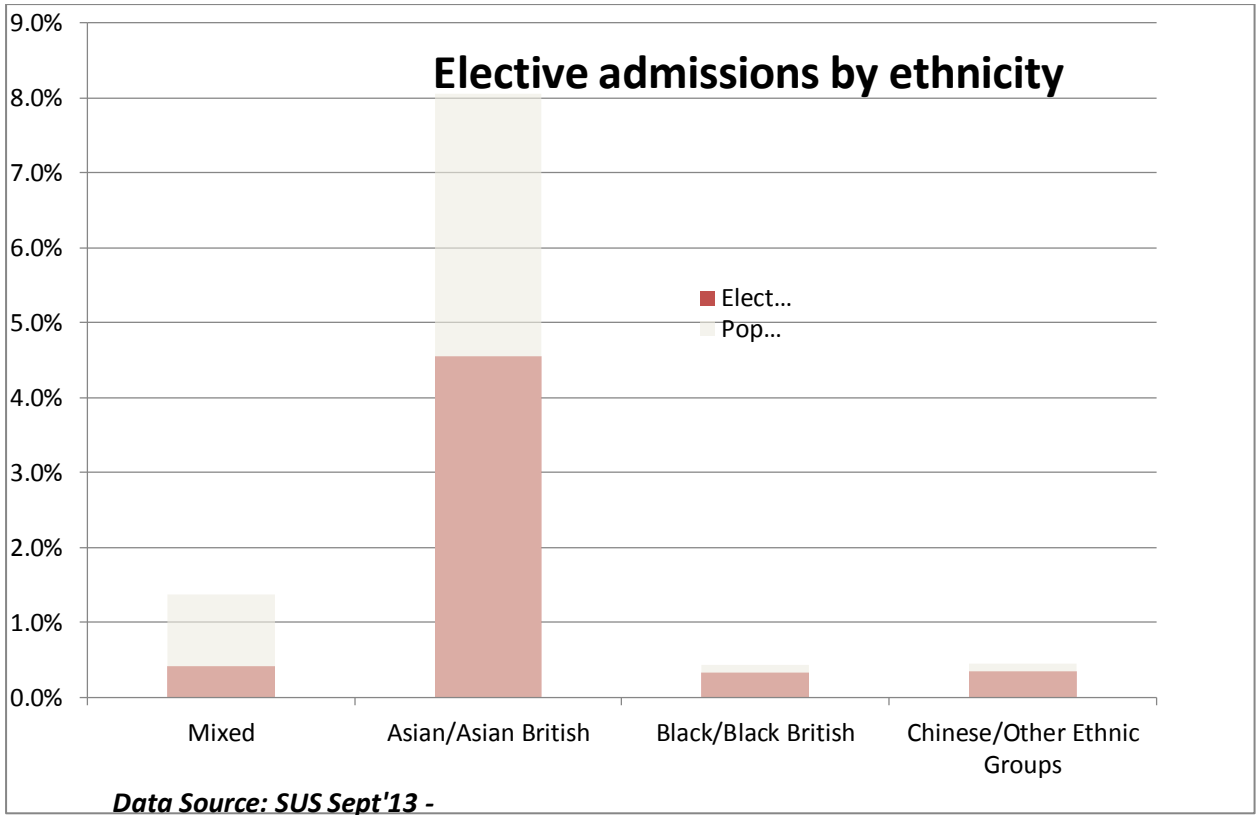
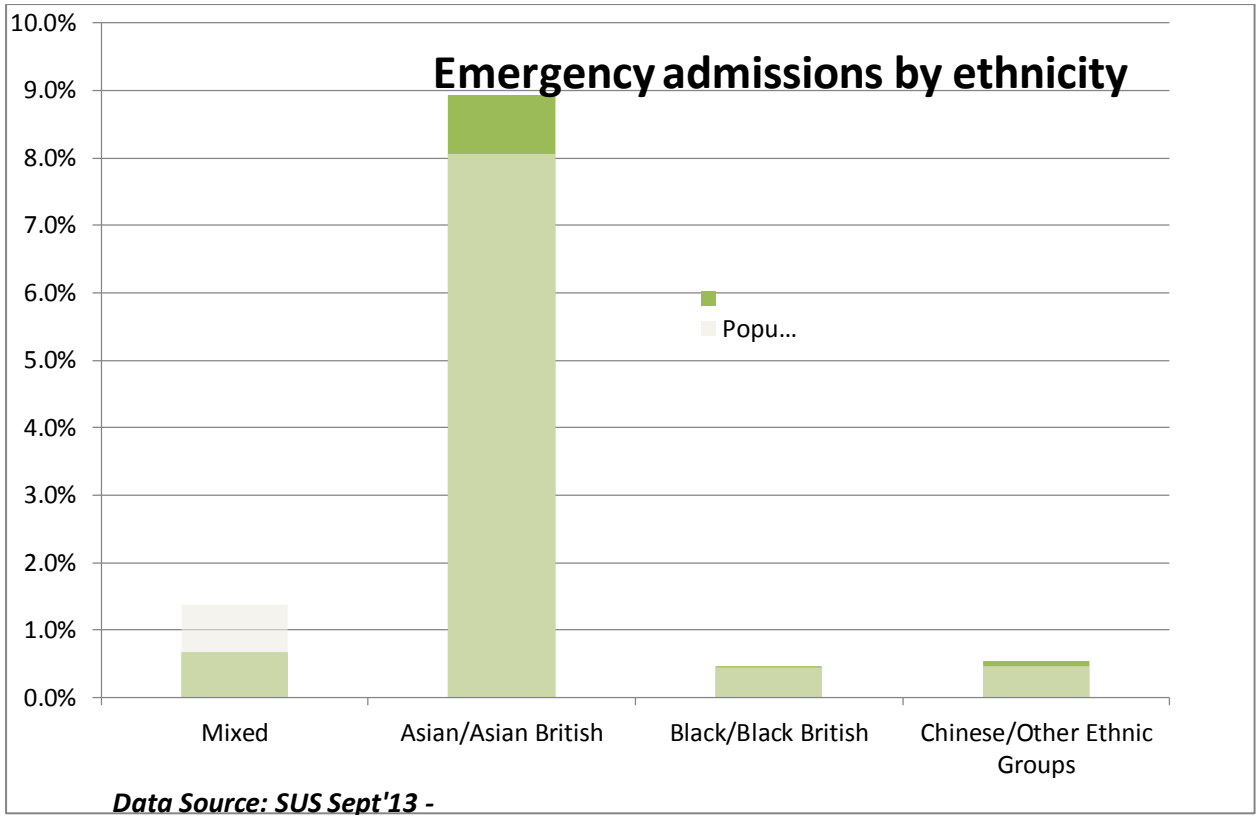
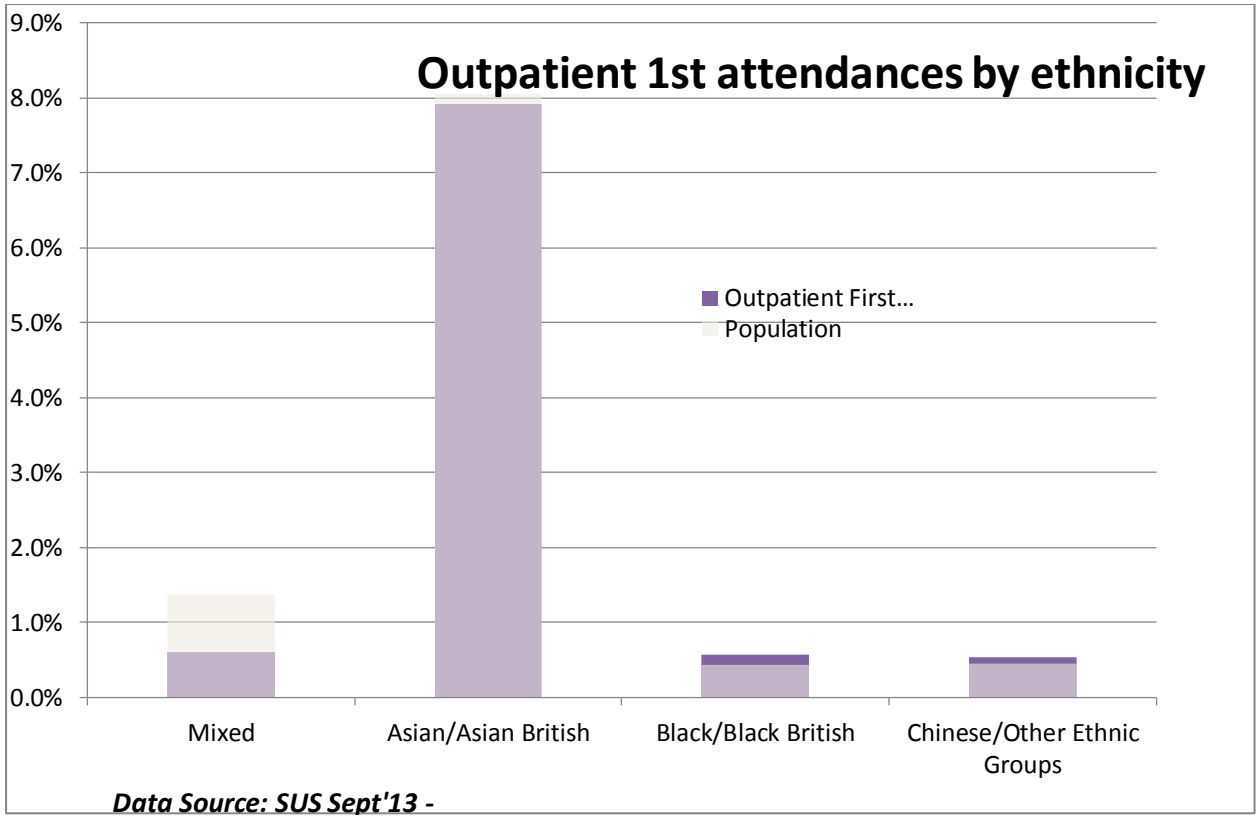
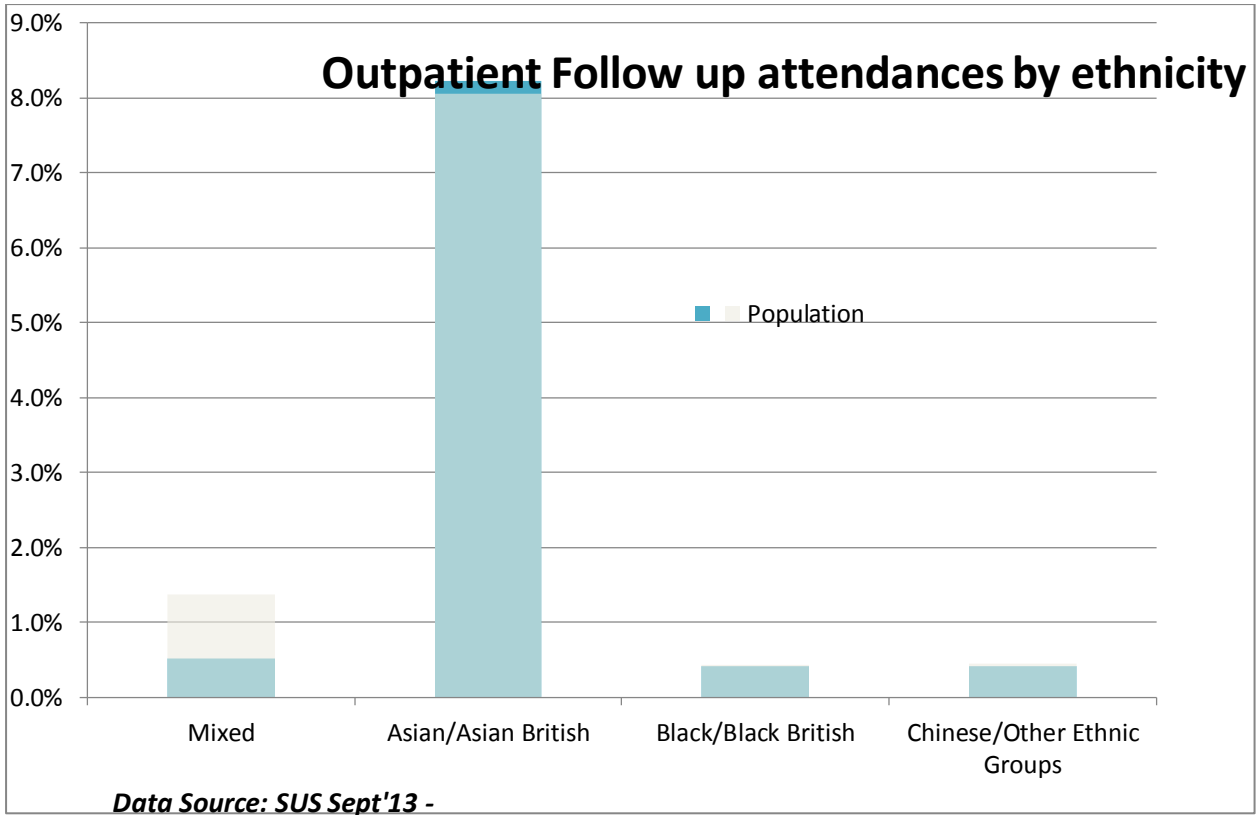

Secondary activity distribution of Whites
96.0%
94.0%
92.0%
90.0%
88.0%
86.0%
84.0%
82.0%
White
A and E
Elective
Emergency
Outpatient First Attendances
Outpatient Follow Up

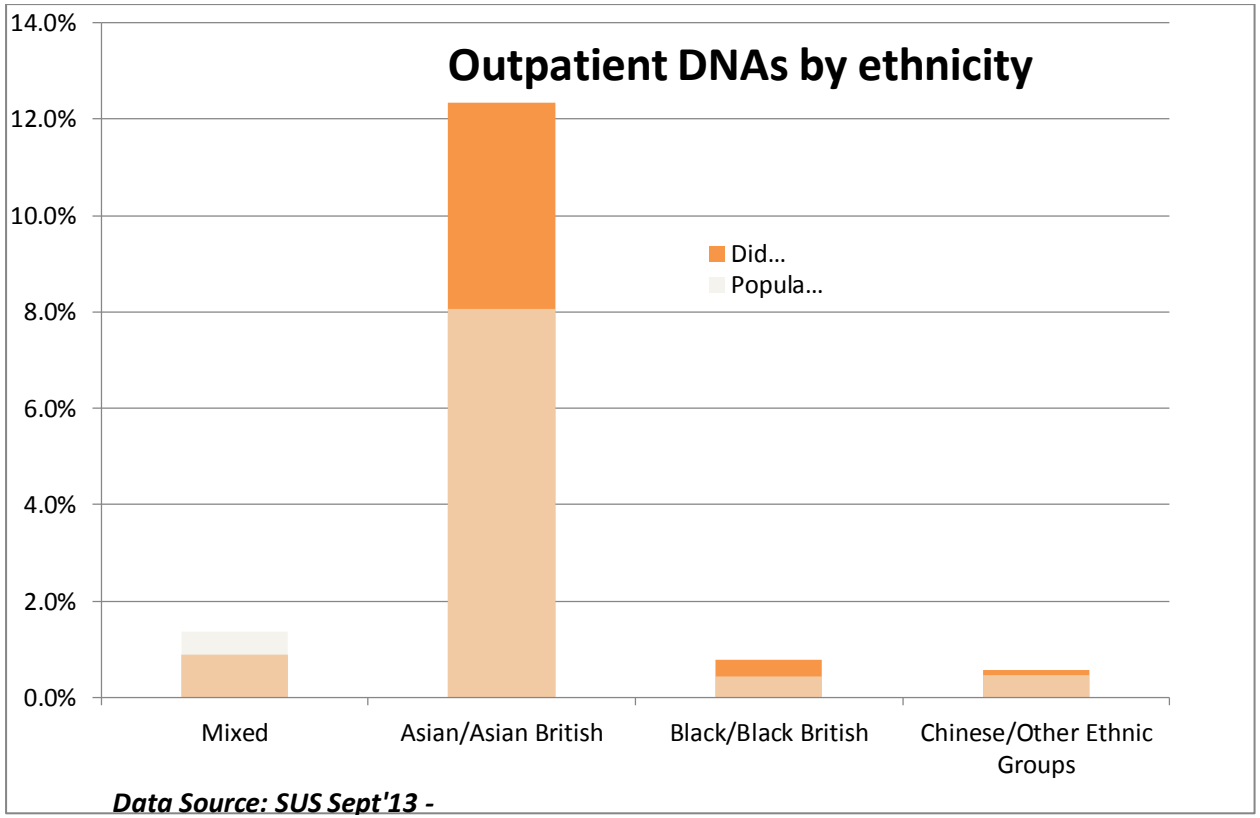

A& E attendance by ethnicity
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
A and E
Population
Mixed
Asian/Asian British
Black/Black British
Chinese/Other Ethnic Groups
Data Source: SUS Sept'13 -


Elective admissions by ethnicity
9.0%
8.0%
7.0%
6.0%
5.0%
4.0%
3.0%
2.0%
1.0%
0.0%
Elect…
Pop…
Mixed
Asian/Asian British
Black/Black British
Chinese/Other Ethnic Groups
Data Source: SUS Sept'13 -


Emergency admissions by ethnicity
10.0%
9.0%
8.0%
7.0%
6.0%
5.0%
4.0%
3.0%
2.0%
1.0%
0.0%
Popu…
Mixed
Asian/Asian British
Black/Black British
Chinese/Other Ethnic Groups
Data Source: SUS Sept'13 -


Outpatient 1st attendances by ethnicity
9.0%
8.0%
7.0%
6.0%
5.0%
4.0%
3.0%
2.0%
1.0%
0.0%
Outpatient First...
Population
Mixed
Asian/Asian British
Black/Black British
Chinese/Other Ethnic Groups
Data Source: SUS Sept'13 -


Outpatient Follow up attendances by ethnicity
9.0%
8.0%
7.0%
6.0%
5.0%
4.0%
3.0%
2.0%
1.0%
0.0%
Population
Mixed
Asian/Asian British
Black/Black British
Chinese/Other Ethnic Groups
Data Source: SUS Sept'13 -


Outpatient DNAs by ethnicity
14.0%
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
Did...
Popula...
Mixed
Asian/Asian British
Black/Black British
Chinese/Other Ethnic Groups
Data Source: SUS Sept'13 -