NHS Leeds Clinical Commissioning Groups Partnership

Public Sector Equality Duty

Report 2017/18
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An Overview NHS Leeds Clinical Commissioning Groups Partnership

The last year has been very challenging with significant change at a national, regional and local level for the NHS and health and social care. There have been increasing financial challenges across the health and care system, and we’ve seen unprecedented demand on services.

Locally, the three clinical commissioning groups (CCGs) in Leeds, NHS Leeds North CCG, NHS Leeds South and East CCG and NHS Leeds West CCG undertook a review called ‘One Voice’, to explore a single approach for commissioning health and care services in Leeds. Since 1 April 2017, the three CCGs have been working closely together as the NHS Leeds Clinical Commissioning Groups Partnership, with a shared leadership team and joint governance arrangements. This is because the way we commission (plan and fund) services locally and across West Yorkshire is changing, as well as the way we work with local authorities. This means we need to be preparing for a different way of commissioning services. Whilst working as a partnership, each CCG has remained a membership organisation made up of local GP practices. From April 2018, the three Leeds CCGs will become one organisation, known as NHS Leeds CCG.

The Leeds Clinical Commissioning Groups Partnership has remained committed to addressing health inequalities. We know that patients and carers use and experience of health services is often very different and this can result in differing health outcomes for many of our diverse communities. Health inequalities exist within geographical areas and across the city of Leeds and we continue to try to understand and tackle the causes of this.

The current 3 CCGs in Leeds cover different geographical areas with different populations and different health needs.

Leeds West CCG, has the largest population out of the three CCGs in Leeds, with over 40% of the population in Leeds living within the CCGs boundary. Areas of high deprivation have the lowest life expectancy in the city this means that a man living in one of the poorer wards will, on average, die 11 years earlier than a man living in one of the more affluent wards. This area also includes some communities with specific needs, for example offenders, gypsies and travellers and most of the university student population of Leeds (around 65,000 students).
There are significant health problems which are predominantly linked to levels of deprivation; for example in some areas all rates for smoking, obesity and alcohol admissions are above the Leeds average.

**Leeds North CCG** has the smallest population of the three Leeds CCGs with 23.9% of the Leeds population and has the largest geographical boundary. This area includes some of Leeds’ most deprived communities as well as affluent rural areas on the outskirts of the city. Over sixteen thousand people, around 8% of patients registered with Leeds North CCG are living within areas that are in the 3% most deprived in England.

The ethnic mix of the Leeds population is changing quite rapidly and Leeds North CCG practice population has a much larger proportion of ‘Pakistani or British Pakistani’; ‘Indian or British Indian’; and ‘Black Caribbean’ ethnic groups than the Leeds average.

**Leeds South and East CCG**, population faces significant morbidity and premature mortality compared with the rest of Leeds. Leeds South and East CCG also have a high proportion of patients living in deprived areas and the under 75 mortality rates in the most deprived areas are amongst the highest in Leeds.

The population is diverse and changing over time. A higher percentage of the Leeds South and East population are self-identifying as being Asian, Asian British and Black African which is recorded as being higher than the Leeds average. In addition, the population aged over 50 is increasing and a large rise is predicted in the number of people diagnosed with dementia.

It is important that as a partnership we understand these local differences and the three CCGs are working together to reduce the inequalities that exist within our population, 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. We also work with colleagues in public health and use the Joint Strategic Needs Assessment (JSNA) and local health profiles to better understand the health inequalities that exist within our communities and between different groups.

Further information on the Leeds JSNA, additional Leeds based Health Needs Assessments and local health profiles can be found on the [Leeds Observatory](#).
We value and respect our staff and aspire to be an inclusive employer of choice. This commitment is supported by the work we do in relation to the NHS Equality Delivery System 2, our equality objectives, the NHS Workforce Race Equality Standard and the partnership work we are proactively involved in across the NHS in Leeds, local authority and third sector organisations.

During this period of transition we have worked hard to develop joint ways of working whilst adhering to our responsibilities and obligations as individual CCGs.

The purpose of this report is to provide both evidence and assurance that the NHS Leeds Clinical Commissioning Group Partnership are adhering to the statutory obligations to deliver the Public Sector Equality Duty, (PSED).

This report is published, together with our evidence for 2017/18 for the NHS Equality Delivery System 2, our performance against our equality objectives and the NHS Workforce Race Equality Standard indicators to enable service users, staff our regulators and other interested parties to assess the equality performance of our partnership.
Background

Publishing equality information and setting equality objectives is part of CCGs compliance with the Equality Act 2010 and one of the ways the Leeds Clinical Commissioning Groups Partnership demonstrates it is meeting the Public Sector Equality Duty. The three CCGs agreed to sign up to the original city wide equality objectives in 2013 and worked collaboratively with other NHS organisations in Leeds to improve performance.

During 2017 all NHS organisations in Leeds reviewed and revised their equality objectives, using evidence collected for the NHS Equality Delivery System and agreed new equality objectives for 2017-2020.

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:
  • 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, seldom heard groups and vulnerable groups when making commissioning decisions.

Appendix One, provides demographic details for Leeds and health inequalities experienced in relation to the protected characteristics

In publishing this report, the Leeds Clinical Commissioning Groups Partnership is demonstrating that it has consciously thought about the three aims of the Equality Duty as part of its 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 Accessible Information Standard, introduced by NHS England in July 2015, required all organisations that provide NHS services (including GP practices) or adult social care to meet the standard by 31 July 2016. The aim of the standard is to make sure people who have a disability, impairment or sensory loss get information they can access and understand, and any communication support they might need. This includes making sure people get information in different formats, for example large print, Braille, easy read and support such as a British Sign Language interpreter, deafblind manual interpreter or an advocate.

The Accessible Information Standard means that organisations providing health or social care need to do 5 things:

1. Ask people if they have any information or communication support needs and identify how to meet them.

2. Record those needs in a set way on the patients’ records.

3. Highlight or flag the person’s file or notes so it is clear that they have information or communication support needs and details of how to meet those needs.

4. Share information about a person’s needs with other NHS and adult social care providers when they have consent to do so

5. Make sure that people get information in an accessible way and communication support if they need it.

Although the CCGs are exempt from meeting the requirements of the standard, we are required to pay due regard to it and therefore we will make sure that whenever we communicate with the public that we
consider the requirements of the standard. In addition, we will work closely with our member GP Practices to provide the necessary support to enable them to meet the requirements of the standard and we will continue to seek assurance from provider organisations in relation to their compliance with the standard, including evidence of how they are planning to meet the standard.

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
**Our commitment to equality and diversity**

We aim to commission health services that gives 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 Leeds City Council and others to address the needs of protected groups as shown in the Joint Strategic Needs Assessment (JNSA).

- 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.

**Equality and Diversity Steering Group**

The Equality and Diversity Steering Group has been meeting bi monthly and providing support to our diversity champions. The group has been a valuable forum for members to share their current knowledge of equality and diversity legislation and developments and to discuss ideas for sharing good practice; consider future development opportunities and potential challenges in relation to equality, diversity and inclusion. However, in light of the current transition taking place across teams within the CCG Partnership, it is recognised that the current membership of the equality and diversity steering group needs to be reviewed and revised. The proposal for the future equality and diversity steering group will be developed once the “People and Organisational Development Strategy” is finalised.

The final meeting of the equality and diversity steering group with the current membership was held in July 2017.
NHS Leeds Equality Leads Forum

As members of the Leeds NHS Equality Forum, we continue to work in partnership with all NHS organisations in Leeds to ensure that there is a joined up approach to addressing inequalities experienced by some of our diverse communities in relation to health outcomes and access to, and experience of healthcare.

During 2017, the Leeds NHS Equality Leads Forum has been taking forward the new city wide planning and facilitation of the Engagement and Assessment Workshops and looking at how to prepare for the NHS Workforce Disability Equality Standard.

Leeds Equality Network

Our Equality Lead continues to Chair and work with members of the Leeds Equality Network, which brings together public sector organisations across Leeds and third sector partners.

Leeds Equality Network members continue to organise attendance at the Leeds Migrant Community Network (MCN) meetings. Other key topics/areas of work included: staff networks; the lesbian, gay, bisexual and transgender (LGBT) mapping exercise that has taken place in Leeds; Stonewall’s “Unhealthy Attitudes Report” 2015; and co-ordinating and sharing key events and dates across all organisations.

Regional Equality Leads Network

The Leeds Clinical Commissioning Groups Partnership continues to be a member of the Yorkshire and Humber Regional Equality Leads Network, which has over eighty members. Key areas of work currently include: The NHS Workforce Disability Equality Standard and Gender Pay Gap.

Leadership and Governance

Since 1 April 2017, the three CCGs have been working closely together as the NHS Leeds Clinical Commissioning Groups Partnership, with a shared leadership team and joint governance arrangements.

We also have external governance arrangements. In 2011 all the NHS organisations in Leeds worked in partnership to identify third sector and statutory organisations with an interest in the NHS and equality. The Leeds NHS Equality Advisory Panel was subsequently established and provides a useful and constructive “community voice” to help with our assessment of grades for the EDS2.
The new Leeds proposal for the EDS2 was agreed in 2016 and during 2017/18 we have continued to take this forward. The EDS2 partnership approach provides an additional mechanism for engagement, external scrutiny and assurance.

**Equality Impact Assessments**

During 2017 we reviewed our Equality Impact Assessment and engagement plan and update report templates and agreed to integrate this into one template and process.

We finalised the equality and engagement templates during July and agreed the following three stage process:

1. **Planning: Completion of the equality analysis and engagement plan**

   The equality analysis is carried out, taking into consideration all protected characteristics. The intelligence should be used to understand who is using the service, who should be using services; prevalence of illness/condition within certain communities and highlight any gaps. This information will help inform who we need to engage with and how to plan the engagement.

2. **Reporting: Production of the assessment of equality impact and engagement report**

   Following an engagement the findings are written up and include; who we talked to and what they told us. Any identified themes and recommendations should be included and details of the impact the change or project will have on people with protected characteristics (these could be positive or negative). Recommendations should be included that could remove/reduce any negative impacts.

3. **Updating: Production of the Equality and Engagement Update Report**

   The report should outline how we have addressed the recommendations in the assessment of equality impact and engagement report, in addition we should be outlining why we have not taken action on recommendations.

   The inclusion of equality analysis is important to help assess the impact of our decisions and to carefully consider how they affect the local population, particularly in relation to people with protected characteristics.
This helps us to make sure we are meeting local need and addressing health inequalities.
The NHS Equality Delivery System 2

The NHS Equality Delivery System (EDS2) was designed by the NHS for the NHS. It is a performance framework that helps NHS organisations to improve the services they commission or provide for their local communities, consider health inequalities in their locality and provide better working environments, free of discrimination, for those who work in the NHS. NHS organisations are required to assess and grade their equality progress using the NHS EDS2. The involvement of key stakeholders, representing the interests of our diverse communities, is an essential element of this. Following initial self-assessment, the role of stakeholders is to agree, through constructive discussion, one of four grades for each outcome and to identify key areas for improvement.

The EDS2 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

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.


Leeds approach to the NHS Equality Delivery System 2

We continue to work in partnership across all NHS organisations in Leeds. We held a citywide EDS2 engagement and assessment workshop for Goal One “Better Health Outcomes for all” in June 2017; the second workshop for Goal Two “Improved Patient Access and Experience” was held in September 2017; with a third workshop for Goal Three “Empowered, engaged and well-supported staff” and Goal Four “Inclusive Leadership at all Levels” being held in February 2018.

All workshops were attended by representatives from each of the local NHS organisations, as well as representatives from Voluntary Action

At these workshops each of the NHS organisations showcases one or more examples of good practice and presents collated evidence of performance against each of the EDS2 outcomes along with self-assessed grades. The panel of trusted partners provides feedback and asks questions so that grades can be agreed and areas for improvement identified.

**Goal One “Better Health Outcomes for all” - June 2017**

The showcase projects for the Leeds CCGs included the Mindwell project; the mental health crisis service for Deaf people provided by Sign for Health; the patient empowerment project; bowel cancer screening and the bowel cancer champions project.

**Goal Two “Improved Patient Access and Experience” – September 2017**

The showcase projects for the Leeds CCG Partnership included:
- Improving access and experience of NHS services for the Gypsy and Traveller community living at Cottingley Springs;
- Chapeltown mental health pilot;
- Chapeltown project development worker;
- Improving access and experience of maternity services for women with learning difficulties/disabilities and autism;
- Patient insight working group;
- Work undertaken by the quality and complaints teams.

**Goal Three “Empowered, engaged and well-supported staff” and Goal Four “Inclusive Leadership at all Levels” - February 2018**

The good practice highlighted by the CCGs at this workshop is the People and Organisational Development Strategy for the new NHS Leeds Clinical Commissioning Group which will launch as one organisation on 1st April 2018. One of the strategy’s six delivery themes is Inclusion and an associated implementation plan will include specific outcomes / indicators linked to equality. These measures will be derived from EDS work and will make it easier to measure and report on progress and should ensure that improvements in workforce equality are better owned across the organisation.
Equality Objectives

Working jointly with our NHS provider trusts in Leeds we reviewed progress in implementing our equality objectives for 2013 to 2017 and agreed a new set of equality objectives for the period 2017-2020.

All NHS organisations in Leeds will continue to work in partnership on these objectives:

- To improve the collection, analysis and use of equality data and monitoring for protected groups;
- To improve access to NHS services for protected groups.

In addition, NHS Leeds CCG will work:

- To ensure implementation of the Accessible Information Standard across all commissioned healthcare providers.

Each year we will provide a performance update on our progress in relation to these objectives and identify priorities for the following year. This update report forms part of our Public Sector Equality Duty Report and is published on our website.
**Monitoring Provider Organisations**

As a commissioner of health care, we have a duty to ensure that all our local healthcare service providers are meeting their statutory duties under the Equality Act 2010 Public Sector Equality Duty. As well as regularly monitoring performance, patient experience and service access we work with them to consider their progress on their equality objectives, the NHS Equality Delivery System (EDS), the NHS Workforce Race Equality Standard (WRES) and the implementation of the Accessible Information Standard. Each provider organisation is subject to the specific duty and has published its own data.

We have included the requirement for provider trusts to evidence their compliance with the Public Sector Equality Duty, their performance in relation to the NHS EDS, the WRES and the implementation of the Accessible Information Standard within their contracts and we have developed and agreed systems to monitor their equality performance.

When procuring new services, we ensure that service specifications include the need to have robust policies in place to ensure that the needs of the 9 protected characteristics and other vulnerable groups are adopted. These policies are examined and approved by procurement teams and our Equality Lead prior to any contract award being made.
Commitment to our Workforce

Disability Confident Employer

In 2016 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 Two Ticks logo. The scheme is organised into three tiers of commitment. Tier one and two are self-assessment based and tier three requires external validation. The three Leeds CCGs transferred over to Disability Confident accreditation in 2016.

NHS Workforce Race Equality Standard

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 followed 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/

It is expected that year on year all NHS organisations will improve workforce race equality and that these improvements will be measured and demonstrated through the annual publication of data for each of the WRES indicators.

Our third WRES reports (2017) were produced during July and detail performance for 2016-2017 against each of the nine indicators, enabling us to identify specific areas for improvement. The reports and proposed actions were presented to the senior management team (SMT) on 26 July.
and published on our websites at the end of July. The CCG’s WRES reports can be found here:

Leeds West CCG WRES report 2017
Leeds North CCG WRES Report 2017
Leeds South and East CCG WRES report 2017

The key inequality identified in these reports is that Black and Minority Ethnic (BME) staff are under-represented at senior levels within the organisation. We will take action to reduce this inequality and use WRES data to measure progress on an annual basis. We have also produced a joint WRES action plan for 2017-18, which can be found here.

From 1 April 2018, we will be reporting on WRES as one organisation. As well as the CCG needing to give due regard to the WRES we also have a duty to ensure that we hold our providers of healthcare to account in meeting the requirements of the standard.

**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 develop the WDES.

The EDC, prior to the recommendation to develop the standard, considered the report published by Middlesex and Bedfordshire Universities on the “Experience of 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 nondisabled colleagues.

Consultation on the proposed WDES 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. During 2018, baseline data will need to be collected, and the first report published in August 2019 and will initially apply to NHS provider trusts.

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

2017 has been a period of significant change for the three Leeds CCGs. The NHS Leeds Clinical Commissioning Groups Partnership has continued to work hard during 2017 to improve in our equality performance both as commissioners and as employers. Furthermore, during this period of transition we have developed joint ways of working whilst adhering to our responsibilities and obligations as individual CCGs.

We are aware, however, that as we become one organisation on 1 April 2018, that there is still more we can do to make further improvements to support our progress. For example; the access, experience and outcomes of patients from all protected groups is not sufficiently understood and equality monitoring data is often incomplete, with not all protected groups consistently being monitored, with some services monitoring but not others and the data provided is often not disaggregated.

We will support the CCG’s Equality and Diversity Champions to continue being members of the Leeds CCGs Equality and Diversity Steering Group. We will also continue to be an active member of the Leeds NHS Equality Forum, the Leeds Equality Network and the Regional Equality Network throughout 2018 in our aim to reduce health inequalities and improve the equality agenda across the NHS and the city of Leeds.

We will remain committed to listening to and understanding the needs of our diverse communities and to tackling with our partners, the health inequalities that exist within our different geographical areas, across Leeds and between different groups. We will use this knowledge to ensure that new ways of working and commissioning continues to meet the needs of our local communities, protected groups and other vulnerable groups.
Appendix One

Demographic and Health Inequalities Information for Leeds city wide and Leeds West CCG, Leeds North CCG and Leeds South and East CCG Geographical Areas

When considering our decisions we always take account of locally available data, this includes the Joint Strategic Needs Assessment, local census, GP patient surveys, patient experience and engagement feedback. The next section of this report provides demographic information for Leeds city wide and the three Leeds CCG’s; Leeds West CCG, Leeds North CCG and Leeds South and East CCG. In addition it provides health inequalities for each of the protected characteristics.

Age - Demographic Information

Leeds citywide

- The 2011 Census shows that there are 751,485 people living in Leeds, of which 51% are female and 49% are male

- The population of Leeds grew by just over 36,000 between 2001 and 2011, an increase of 5.0% (this is less than the 7.1% increase recorded for England and Wales, and the 6.4% increase for Yorkshire and the Humber)

- The age structure of Leeds is broadly similar to that for England and Wales with the notable exception in the 20-29 age band which in Leeds accounts for 17.5% of the population compared to 13.6% in England & Wales

- Children (aged 15 and under) account for 18.3% of the population of Leeds, while people aged 65+ accounts for 14.6%

West Leeds CCG

The age profile in West Leeds, using information from the Census 2011, shows that there is a greater proportion of 20-29 year olds than the Leeds average population; this is focused within localities with high student populations. The population age under 14 is slowly increasing as is the older age population.
North Leeds CCG

The age profile in Leeds North CCG in 2011 shows that there are fewer 20-34 year olds than the Leeds average, which is likely to be due to a higher proportion of students and graduates living in concentrated areas of the other two Leeds CCGs.

The remaining population is fairly evenly distributed across all the age bands in line with the Leeds average.
Leeds South & East CCG
The age profile in Leeds South and East geographical area indicates that the percentage of the population over 50 years of age is increasing, with the majority of older people now living more independently within their own homes. Leeds South and East have a higher population of children registered with GPs and a rising birth rate.
There is evidence to suggest that the health service sometimes deals with older people in ways that they find humiliating or distressing. (Equality and Human Rights Commission “How Fair is Britain” (2010))

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.

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 become more young people friendly.

Disability - Demographic Information

In this report 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.

Leeds city wide- Disability Demographic Information

In 2011, reported responses to long-term health problem or disability that limited day-to-day activities and expected to last, at least 12 months, included whether their daily activities were limited a lot, a little or not at all.
In 2001 responses were just “yes” or “no”. To compare 2001 and 2011, the 2011 results for "yes, limited a lot" and "yes, limited a little" have been combined into a single “yes” response.

- Over 125,000 people in Leeds (16.8% of the total population) feel that they have a long-term illness, slightly less than the England and Wales rate of 17.9%

- Of these, just over 59,000 (7.9% of the total population) feel that their day-to-day activities are limited a lot and just over 66,500 (8.9% of the total population) feel their day-to-day activities are limited a little

- Almost 61,000 people of working age (16-64 years) have a limiting long term illness

- 24.8% of all households in Leeds contain one or more people with a limiting long-term illness

- The number of people reporting limiting long-term illness in Leeds has fallen from just over 128,000 in 2001 (18%) to just over 125,000 in 2011 (16.8%)

**Leeds CCGs**

The table below shows that Leeds West CCG area has the lowest percentage of its population where day to day activities are limited a lot or a little. Leeds South and East CCG have the highest percentage of its population where day to day activities are limited a lot.

<table>
<thead>
<tr>
<th>Population where day to day activities are limited lot</th>
<th>Population where day to day activities are limited little</th>
<th>Population where day to day activities are not limited</th>
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<tr>
<td><strong>City wide area</strong></td>
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<td>59,155 (7.9%)</td>
<td>66,523 (8.9%)</td>
<td>625,807 (83.3%)</td>
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<tr>
<td><strong>Leeds West CCG area</strong></td>
<td></td>
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<tr>
<td>22,411(7.1%)</td>
<td>26,119 (8.2%)</td>
<td>268,412 (84.7%)</td>
</tr>
<tr>
<td><strong>Leeds North CCG area</strong></td>
<td></td>
<td></td>
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<tr>
<td>15,655 (7.9%)</td>
<td>18830 (9.5%)</td>
<td>164,380 (82.6%)</td>
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</table>
Learning Disabilities and Mental Health

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.

“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” 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.

Mental Health Demographic:

The table below shows that Leeds North CCG has the highest percentage of patients on the mental health register and Leeds South and East has the highest percentage on the learning disability register.

<table>
<thead>
<tr>
<th>Practice Size list</th>
<th>Mental Health Register</th>
<th>CCG Prevalence %</th>
<th>National Prevalence %</th>
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<tbody>
<tr>
<td>Leeds South &amp; East CCG</td>
<td>2,452</td>
<td>0.93%</td>
<td>0.84%</td>
</tr>
<tr>
<td>Learning Disabilities Register (18+)</td>
<td>1,107</td>
<td>0.42%</td>
<td>0.37%</td>
</tr>
<tr>
<td>Practice Size list</td>
<td>Mental Health Register</td>
<td>CCG Prevalence %</td>
<td>National Prevalence %</td>
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<tr>
<td><strong>Leeds North CCG</strong></td>
<td></td>
<td></td>
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<tr>
<td>200,178</td>
<td>2,052</td>
<td>1.03%</td>
<td>0.84%</td>
</tr>
<tr>
<td>Learning Disabilities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Register (18+)</td>
<td>621</td>
<td>0.31%</td>
<td>0.37%</td>
</tr>
<tr>
<td><strong>Leeds West CCG</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>360,907</td>
<td>3,097</td>
<td>0.86%</td>
<td>0.84%</td>
</tr>
<tr>
<td>Learning Disabilities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Register (18+)</td>
<td>1,030</td>
<td>0.29%</td>
<td>0.37%</td>
</tr>
</tbody>
</table>

**Race - Demographic Information**

Based on GP recording in 2012 a large proportion of patients’ ethnicity was not recorded, not stated, or unknown: however of those recorded, 57.7% were ‘White British’, and compared to the Leeds average there is a smaller proportion of ‘other white background’, ‘Pakistani or British Pakistani’ and ‘Black African’ ethnic groups.

The GP practice population data breakdown is as follows (this varies from the 2011 census as patients living outside of the Leeds area can be registered with a Leeds practice)

<table>
<thead>
<tr>
<th>CCG area</th>
<th>Registered population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leeds South &amp; East CCG</td>
<td>263,271</td>
</tr>
<tr>
<td>Leeds North CCG</td>
<td>200,178</td>
</tr>
<tr>
<td>Leeds West CCG</td>
<td>360,907</td>
</tr>
<tr>
<td>Total GP registered population for Leeds CCG’s</td>
<td>824,256</td>
</tr>
</tbody>
</table>

**All Leeds CCG’s combined Ethnic Demographic data**

The table below shows the ethnic diversity of Leeds and variation between the different CCG areas. Leeds South and East and Leeds North CCGs are the most ethnically diverse.
<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Numbers</th>
<th>%</th>
<th>Ethnic Group</th>
<th>Numbers</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>White: British</td>
<td></td>
<td></td>
<td>Asian or Asian British: Indian</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LWCCG</td>
<td>271,940</td>
<td>85.7</td>
<td></td>
<td>6,232</td>
<td>2</td>
</tr>
<tr>
<td>LNCCG</td>
<td>156,164</td>
<td>78.5</td>
<td></td>
<td>6,393</td>
<td>3.2</td>
</tr>
<tr>
<td>LS&amp;ECCG</td>
<td>182,060</td>
<td>77.2</td>
<td></td>
<td>3,505</td>
<td>1.5</td>
</tr>
<tr>
<td>White: Irish</td>
<td></td>
<td></td>
<td>Asian or Asian British: Pakistani</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LWCCG</td>
<td>2,531</td>
<td>0.8</td>
<td></td>
<td>5,770</td>
<td>1.8</td>
</tr>
<tr>
<td>LNCCG</td>
<td>2,459</td>
<td>1.2</td>
<td></td>
<td>6,793</td>
<td>3.4</td>
</tr>
<tr>
<td>LS&amp;ECCG</td>
<td>2,041</td>
<td>0.9</td>
<td></td>
<td>9,929</td>
<td>4.2</td>
</tr>
<tr>
<td>White: Gypsy Traveller</td>
<td></td>
<td></td>
<td>Asian or Asian British: Bangladeshi</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LWCCG</td>
<td>311</td>
<td>0.1</td>
<td></td>
<td>294</td>
<td>0.1</td>
</tr>
<tr>
<td>LNCCG</td>
<td>126</td>
<td>0.1</td>
<td></td>
<td>899</td>
<td>0.5</td>
</tr>
<tr>
<td>LS&amp;ECCG</td>
<td>250</td>
<td>0.1</td>
<td></td>
<td>3,239</td>
<td>1.4</td>
</tr>
<tr>
<td>White: Other</td>
<td></td>
<td></td>
<td>Asian or Asian British: Chinese</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LWCCG</td>
<td>8,362</td>
<td>2.6</td>
<td></td>
<td>2,759</td>
<td>0.9</td>
</tr>
<tr>
<td>LNCCG</td>
<td>5,574</td>
<td>2.8</td>
<td></td>
<td>1,403</td>
<td>0.7</td>
</tr>
<tr>
<td>LS&amp;ECCG</td>
<td>8,119</td>
<td>3.4</td>
<td></td>
<td>1,771</td>
<td>0.8</td>
</tr>
<tr>
<td>Mixed Multiple Ethnic Groups:</td>
<td></td>
<td></td>
<td>Asian or Asian British: Other Asian</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White and Black</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LWCCG</td>
<td>2,920</td>
<td>0.9</td>
<td></td>
<td>2,927</td>
<td>0.9</td>
</tr>
<tr>
<td>LNCCG</td>
<td>2,805</td>
<td>1.4</td>
<td></td>
<td>2,641</td>
<td>1.3</td>
</tr>
<tr>
<td>LS&amp;ECCG</td>
<td>3,088</td>
<td>1.3</td>
<td></td>
<td>3,688</td>
<td>1.6</td>
</tr>
<tr>
<td>Mixed Multiple Ethnic Groups:</td>
<td></td>
<td></td>
<td>Black African/Black Caribbean/Black</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asian or Black Asian Caribbean</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ethnic Group</td>
<td>Numbers</td>
<td>%</td>
<td>Ethnic Group</td>
<td>Numbers</td>
<td>%</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>---------</td>
<td>----</td>
<td>-----------------------------------------</td>
<td>---------</td>
<td>----</td>
</tr>
<tr>
<td>White and Black African</td>
<td>LWCCG</td>
<td>862</td>
<td>British: African</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>LNCCG</td>
<td>650</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>LS&amp;ECCG</td>
<td>981</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mixed Multiple Ethnic Groups: White and Asian</td>
<td>LWCCG</td>
<td>2,134</td>
<td>Black African/Black Caribbean/Black British: Caribbean</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>LNCCG</td>
<td>1,363</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>LS&amp;ECCG</td>
<td>1,409</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mixed Multiple Ethnic Groups: Other Mixed</td>
<td>LWCCG</td>
<td>1,372</td>
<td>Black African/Black Caribbean/Black British: Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>LNCCG</td>
<td>1,036</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>LS&amp;ECCG</td>
<td>1,012</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Ethnic Group: Arab</td>
<td>LWCCG</td>
<td>1,749</td>
<td>Other Ethnic Group: Arab. Any other group</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>LNCCG</td>
<td>1,581</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>LS&amp;ECCG</td>
<td>1,144</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Taken from the 2011 census
National Health Inequalities

Type 2 diabetes is 3.5 times more prevalent in South Asians than Europeans.\(^1\) 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.\(^2\)

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.\(^3\) 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).\(^4\)

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

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.

\(^1\)Diabetes in the UK 2010, Diabetes UK
\(^2\)Survey of South Asian people with diabetes 2006: Access to healthcare services at a glance, Diabetes UK
Religion or Belief - Demographic Information

The table below gives a breakdown of Religion or Belief by CCG area (taken from the 2012 Census). This shows the Christianity is the most commonly stated religion across all three CCG areas. The secondly most common response is no religion, with this being highest in Leeds West and lowest in Leeds South and East. However, Leeds South and East also have the highest response of not choosing to declare a religion.

<table>
<thead>
<tr>
<th>Religion</th>
<th>Number Leeds West</th>
<th>Number Leeds North</th>
<th>Number Leeds South &amp; East</th>
<th>Number Leeds City Council</th>
</tr>
</thead>
<tbody>
<tr>
<td>All categories: Religion</td>
<td>316,942 (100%)</td>
<td>198,865 (100%)</td>
<td>257,700 (100%)</td>
<td>751,485 (100%)</td>
</tr>
<tr>
<td>Has a Religion</td>
<td>192,706 (96.8%)</td>
<td>137,241 (69%)</td>
<td>151,270 (58.7%)</td>
<td>488,841 (65.05%)</td>
</tr>
<tr>
<td>Christian</td>
<td>172,397 (54.4%)</td>
<td>112,593 (56.6%)</td>
<td>131,685 (51.1%)</td>
<td>419,790 (55.9%)</td>
</tr>
<tr>
<td>Buddhist</td>
<td>1,230 (0.4%)</td>
<td>763 (0.4%)</td>
<td>0 (0%)</td>
<td>2,772 (0.45%)</td>
</tr>
<tr>
<td>Hindu</td>
<td>2,922 (0.9%)</td>
<td>2,381 (1.2%)</td>
<td>4381 (1.7%)</td>
<td>7048 (0.9%)</td>
</tr>
<tr>
<td>Jewish</td>
<td>928 (0.3%)</td>
<td>5,573 (2.8%)</td>
<td>0 (0%)</td>
<td>6,847 (0.9%)</td>
</tr>
<tr>
<td>Muslim</td>
<td>11,069 (3.5%)</td>
<td>10,859 (5.5%)</td>
<td>4381 (1.7%)</td>
<td>40,772 (5.4%)</td>
</tr>
<tr>
<td>Sikh</td>
<td>3,023 (1.0%)</td>
<td>4,444 (2.2%)</td>
<td>206 (0.8%)</td>
<td>8,914 (1.2%)</td>
</tr>
<tr>
<td>Other Religion</td>
<td>1,137 (0.4%)</td>
<td>628 (0.3%)</td>
<td>8761 (3.4%)</td>
<td>2,396 (0.3%)</td>
</tr>
<tr>
<td>No religion</td>
<td>103,053 (32.5%)</td>
<td>47,798 (24%)</td>
<td>23708 (9.2%)</td>
<td>212,229 (28.2%)</td>
</tr>
<tr>
<td>Religion Not Stated</td>
<td>21,183 (6.7%)</td>
<td>13,826 (7%)</td>
<td>64940 (25.2%)</td>
<td>50,717 (6.7%)</td>
</tr>
</tbody>
</table>

National Health Inequalities

- Among groups defined by religion, Muslim people tend to report worse health than average.\(^5\)
- Ghazala Mir and Aziz Sheikh of the Institute of Health Sciences, University of Leeds have recently published research into the factors, including

\(^5\) Census data
stereotyping, that affect the psychosocial well-being of Pakistani Muslims and on their ability to manage long-term conditions. Spiritual interpretations of mental illness can play a crucial part in therapeutic success.

**Sex (Gender) - Demographic Information**

<table>
<thead>
<tr>
<th>Age bands</th>
<th>Leeds West</th>
<th>Leeds North</th>
<th>Leeds South &amp; East</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
</tr>
<tr>
<td>0 -4</td>
<td>9511</td>
<td>9043</td>
<td>6,155</td>
</tr>
<tr>
<td>5 - 9</td>
<td>7721</td>
<td>7444</td>
<td>5,757</td>
</tr>
<tr>
<td>10 - 14</td>
<td>7671</td>
<td>7218</td>
<td>5,863</td>
</tr>
<tr>
<td>15 - 19</td>
<td>10941</td>
<td>12006</td>
<td>6,355</td>
</tr>
<tr>
<td>20 - 24</td>
<td>21032</td>
<td>22135</td>
<td>5,332</td>
</tr>
<tr>
<td>25 - 29</td>
<td>13535</td>
<td>13266</td>
<td>6,083</td>
</tr>
<tr>
<td>30 - 34</td>
<td>11696</td>
<td>11342</td>
<td>6,354</td>
</tr>
<tr>
<td>35 - 39</td>
<td>10377</td>
<td>9998</td>
<td>6,604</td>
</tr>
<tr>
<td>40 - 44</td>
<td>10633</td>
<td>10386</td>
<td>7,140</td>
</tr>
<tr>
<td>45 - 49</td>
<td>10133</td>
<td>10022</td>
<td>7,101</td>
</tr>
<tr>
<td>50 - 54</td>
<td>8768</td>
<td>8805</td>
<td>6,367</td>
</tr>
<tr>
<td>55 - 59</td>
<td>7525</td>
<td>7640</td>
<td>5,744</td>
</tr>
<tr>
<td>60 - 64</td>
<td>7772</td>
<td>8071</td>
<td>5,889</td>
</tr>
<tr>
<td>65 - 69</td>
<td>5649</td>
<td>6044</td>
<td>4,649</td>
</tr>
<tr>
<td>70 - 74</td>
<td>4458</td>
<td>5241</td>
<td>3,574</td>
</tr>
<tr>
<td>75 - 79</td>
<td>3702</td>
<td>4827</td>
<td>3,146</td>
</tr>
<tr>
<td>80 - 84</td>
<td>2418</td>
<td>3824</td>
<td>2,231</td>
</tr>
<tr>
<td>85 +</td>
<td>1770</td>
<td>3795</td>
<td>1,766</td>
</tr>
<tr>
<td>Grand Total</td>
<td>155,312</td>
<td>161,107</td>
<td>96,110</td>
</tr>
</tbody>
</table>

**National Health Inequalities**

**Men’s health**

Men are **less likely to use their GP** which can lead to late diagnosis.  

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6 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

Men are more likely to take exercise but less likely to eat the recommended amounts of fruit and vegetables\(^8\).

“It is clear that there is an issue here. The NHS is just not designed around the needs of men. Men are more likely to work full-time, meaning most GPs are not available when they are. But it is also to do with how men are being brought up to manage their health. They are not socialised or exposed to it in the way women are through contraception, ante-natal care and screening. This means they feel less confident and familiar about it.”\(^9\)

Men are more likely to first access mental health services earlier in their lives between the ages of 18 and 35.\(^10\)

**Women’s health**

Women are more likely to eat the recommended amounts of fruit and vegetables but less likely to take exercise.\(^11\)

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.\(^12\)

Women are more likely to access mental health services later in life aged between 45 and 60.\(^13\)

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);
- 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; and
- 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.\(^14\)

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\(^8\) Ibid
\(^10\) BDCT Equality Analysis
\(^12\) NACR Annual Report 2010
\(^13\) BDCT Equality Analysis
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.

Sexual orientation
There is currently no reliable information on the size of the lesbian, gay or bisexual (LGB) population. Estimates range from 0.3% to 10% using different measures and sources. Additionally, none of these estimates correct for the possibility of higher than average rates of non-reporting and misreporting among LGB people.

The most up to date published information we have about sexual orientation is found through the Office of National Statistics (ONS), whose Integrated House Survey for April 2011 to March 2012 estimates that approximately 1.5% of the UK population are Gay/Lesbian or Bisexual. However, HM Treasury’s 2005 research estimated that there are 3.7 million LGB people in the UK, giving a higher percentage of 5.85% of the UK population.

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

Evidence indicates that the increased risk of mental disorder in LGB people is linked to experiences of discrimination. 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. Discrimination has been shown to be linked to an increase in deliberate self-harm in LGB people. LGB people demonstrate higher rates of

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14Violence against women. Definition and scope of the problem, WHO
anxiety and depression than heterosexuals\textsuperscript{18}; lesbians and bisexual women may be at more risk of substance dependency than other women\textsuperscript{19}.

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.\textsuperscript{20} 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.\textsuperscript{21}

Some health care professionals think that lesbians do not require cervical smear tests,\textsuperscript{22} yet 10\% of lesbians have abnormal smears – this includes 5\% of lesbians who have never had penetrative sex with a man.\textsuperscript{23} Lesbian and bisexual women were up to 10 times less likely to have had a test in the past three years.

The Stonewall 2015 Unhealthy Attitudes Survey which looked into the attitudes of health and social care workers towards LGBT service-users and colleagues. Stated that:

- 26\% of LGB staff say they have personally experienced bullying or poor treatment from colleagues in the last five years as a result of their sexual orientation
- 24\% of staff heard their colleagues make negative remarks about LGB people or use discriminatory language like ‘poof’ or ‘dyke’. 60\% of those who hear such remarks do not report it.
- 20\% have heard similar disparaging remarks about trans people.


\textsuperscript{21}King M. and McKeown E., \textit{Mental health and social wellbeing of gay men, lesbians and bisexuals in England and Wales}, 2003, MIND.


\textsuperscript{23}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
38% do not think senior management send out a strong message that bullying, harassment, or abuse due to someone’s sexual orientation is unacceptable.

72% patient-facing staff have not received any training on the health needs of LGBT people, the rights of same-sex partners and parents or the use of language and practices that are inclusive of LGBT community.

16% of staff say they would not feel confident challenging colleagues or patients who make negative remarks about LGB people or use discriminatory language.

57% of health and social care practitioners, say they don’t consider sexual orientation to be relevant to one’s health needs.

5% of staff witnessed colleagues discriminate against or provide poorer treatment because the patient is LGB.

15% of doctors and 6% of nurses say they are ‘not confident’ in their ability to understand and meet the specific care needs of LGBT patients.

10% of staff witnessed colleagues express the dangerous belief that someone can be ‘cured’ of being lesbian, gay or bisexual.

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.

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). The Equality Act 2010 protects transexual people from discrimination whether you are under medical supervision or not. At present there are over 4000 people receiving treatment for gender dysphoria in the UK. In 2011 the Charing Cross Gender Identity Clinic reported the number is multiplying by five every year.

In September 2012 a Trans Mental Health Study was published. It is the largest survey of its kind in Europe – 889 people responded to the survey.

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25The Equality Act states that “A person has the protected characteristic of gender reassignment if the person is proposing to undergo, is undergoing or has undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attributes of sex”
providing rich data about trans people’s mental health and wellbeing. Some of the key findings are:

- 70% of the participants were more satisfied with their lives since transitioning and only 2% were less satisfied
- 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.
- 58% 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.
- 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.

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

**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.

Public Health England’s analysis of national patient surveys involving West Yorkshire patients compared the reported experience of different protected groups and compared the West Yorkshire picture to the national picture. In
terms of the survey focusing on maternity services (which did not ask respondents about their religion or sexual orientation) this showed that:

- People aged 16-24 report a poorer experience compared to all respondents
- BME people report a poorer experience than White people, but compared to other hospital services and GP services the difference is not as marked
- Relative to the national picture, people of Asian heritage report a relatively positive experience

Stonewall ‘Unhealthy Attitudes Survey. The West Yorkshire sample size of disabled respondents was too small to report on, but nationally patients with a learning disability report a poorer experience compared to all respondents.

The **Leeds Maternity Needs Assessment**, which has subsequently informed the Maternity Strategy for Leeds 2015-2020 showed the following:

- While the rate of perinatal mortality (stillbirths and deaths within the first seven days after birth) dropped significantly between 2004 and 2012 the rate in deprived areas was strikingly higher than the Leeds average.
- Around 30% of births (3,000) take place to women in areas of the city considered to be among the ten per cent most deprived areas nationally.
- In Leeds the rate of babies born with a low birth rate was 7.4% compared with 7.3% nationally, but was 9.3% in deprived areas.
- Some women from BME communities in the city continue to have poorer birth outcomes and report less satisfaction with maternity services than white groups.
- There is no current way of identifying women with a learning disability who give birth
- There are about 500 people from gypsy, traveller and Roma communities in Leeds. These communities can find it hard to access healthcare; this could affect the health and wellbeing of pregnant women and infants from these communities.
- There were 748 births to young women under 19 and 166 to under-18s in 2012, which is higher than the national average. More women over 30 and 40 have given birth in recent years; this can carry a higher risk of complications in pregnancy and birth.
- We estimate that in Leeds 1,533 women will experience some form of pregnancy-related mental illness, 315 will experience pregnancy-related Obsessive Compulsive Disorder and 20 will experience more serious mental illness after the birth of their baby.
- We estimate around 470 women in the city will be misusing alcohol and/or illegal drugs during pregnancy.
Around 20% of women tell us they have or are experiencing domestic violence during their pregnancy.

White British women are least likely to start and continue breastfeeding.

Following extensive work with partner organisations across the city, the five-year Maternity Strategy for Leeds was published this year. It set out nine priorities with action plans to address the issues highlighted above. These are:

- Personalised care
- Integrated care
- Access
- Emotional health
- Preparation for parenthood
- Choice
- Targeted support
- Quality and safety
- Staffing

The Leeds Mental Health Needs Assessment - “Leeds in Mind” (2017) identified a number of recommendations for Leeds, these included the following:

- Ensure all commissioned service and programmes of work have an explicit focus on mental health.
- Mental health commissioners and service providers, LCC Public Health and The Third Sector to ensure further needs analysis and development work in the city addresses the needs of people with increased risk of poor mental health, particularly those groups who may not be easily identified in mental health data sources. These groups to include:
  - Homeless people, carers asylum seekers and refugees and LGBT+ communities (particularly trans and non-binary people)
  - People who have both mental health and substance use problems
- Commissioners/providers of mental health services to address inequity in identification and treatment of common mental health disorders. In particular:
  - IAPT to take steps to further address the following issues:
  - Improve access to the service from older people and increase the number of men finishing treatment
  - Improve the proportion of people from minority ethnic backgrounds who finish a course of treatment
  - Improve recovery rates in the most deprived parts of Leeds (particularly Inner South and Inner East Leeds)
Explore further the access rates and outcomes for people with long-term conditions

- Providers of physical healthcare pathways for long-term conditions and Primary Care, to pro-actively screen people with long term conditions for mental health problems as part of wider psychological informed conversations. Also, to ensure appropriate support and onward referral

- Mental health service providers, LCC Public Health and the Third Sector to review mental health provision for people from Black and Minority Ethnic communities across the whole (mental) healthcare system, in order to better meet needs and reduce identified mental health inequalities. In particular address the unmet needs of vulnerable migrants and disadvantaged groups.

- Leeds City Council and NHS Leeds CCGs to increase commissioned employment support services for people with mental health problems in order to build on existing good practice.

- LCC Public Health, mental health service providers and NHS Leeds CCGs to ensure that new models of care/population health management approaches are supported through regular provision of good quality mental health data at practice level. This to include information on: mental healthcare service usage, co-morbid long-term conditions and mental illnesses, and SMI annual physical health checks