Meeting: Strategic Commissioning Board			
Meeting Date	04 October 2021	**Action**	Approve
Item No	9	**Confidential / Freedom of Information Status**	No
Title	Community Health Services contract extension and review		
Presented By	Will Blandamer, Executive Director of Strategic Commissioning Adrian Crook, Director of Adult Social Services and Community Commissioning		
Author	Hayley Ashall, Strategic Lead, Integrated Commissioning Carers, Physical Disabilities and Prevention		
Clinical Lead	Howard Hughes		

Executive Summary

In December 2020 the report 'Consideration of future arrangements for the provision of Community Health Care Services' was approved, granting a direct award to Northern Care Alliance for a period of 12 months (from 1 July 2021 to 20 June 2022) with a potential for a further 12 month extension. Since then and despite the challenges presented by the Covid Pandemic and the uncertainties of the development of the Integrated Delivery Collaborative and Integrated Care System. Considerable work has taken place to continue to build a strong local collaborative provider working across the sector, generate innovation and evolve both vertical and horizontal integration.

This paper sets out the work underway and planned, to maximize the potential and provide consistency at a time of uncertainty and recovery. The paper makes a recommendation to award an extension to the contract for a period of 12 months from 1 July 2022 to 30 June 2023. A further report will be brought back to SCB outlining options for future arrangements.

Recommendations

It is recommended that the Strategic Commissioning Board:

- Support the proposal to award an extension to the contract for a period of 12 months from 1 July 2022 to 30 June 2023.
- Agree to continue the scoping and review of the existing contract and services within to enable innovation and integration.

Links to Strategic Objectives/Corporate Plan	Yes
Does this report seek to address any of the risks included on the Governing Body / Council Assurance Framework? If yes, state which risk below:	No

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☒	N/A	☐
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☒	N/A	☐
Have any departments/organisations who will be affected been consulted?	Yes	☒	No	☐	N/A	☐
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☒	N/A	☐
Are there any financial implications?	Yes	☐	No	☒	N/A	☐
Are there any legal implications?	Yes	☐	No	☒	N/A	☐
Are there any health and safety issues?	Yes	☐	No	☒	N/A	☐
How do proposals align with Health & Wellbeing Strategy?	The scoping and review work will provide opportunity to innovate and integrate providing a better patient pathway and service. Putting people at the heart of what we do.					
How do proposals align with Locality Plan?	The scoping and review work will enable Bury's approach to population health being at the heart of our communities, with targeted, integrated, asset-based health and care provision at a neighbourhood level for those who need it. Working towards providing people joined up, quality care closer to home, as well as helping them stay out of hospital and manage their own wellbeing.					
How do proposals align with the Commissioning Strategy?	Enabling better value for the Bury Pound, creating innovative solutions to service delivery and a fully integrated service. Also, as the scoping/ review work is being done in collaboration changing the relationship of the commissioner and provider to more collaborative and outcome based, all fits with the commissioning strategy.					
Are there any Public, Patient and Service User Implications?	Yes	☐	No	☒	N/A	☐
How do the proposals help to reduce health inequalities?	Providing a better integrated service and pathway for all patients.					
Is there any scrutiny interest?	Yes	☒	No	☐	N/A	☐

Implications						
What are the Information Governance/ Access to Information implications?	None					
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☒	No	☐	N/A	☐
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☒	No	☐	N/A	☐
If yes, please give details below:						
An Equality Assessment was completed to accompany the first report in Dec 2020 and has been updated for this report.						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☒	N/A	☐
Are the risks on the CCG /Council/ Strategic Commissioning Board's Risk Register?	Yes	☐	No	☐	N/A	☐
Additional details	*None*					

Governance and Reporting		
Meeting	**Date**	**Outcome**
Finance Contracting & Procurement Committee	19/11/2020	The Committee supported the paper but requested that any further extension beyond June 2022 is re-presented to the Committee for sign off.
SCB	07/12/2020	SCB approved the award of the interim contract to the Northern Care Alliance. Requesting any further extension to the contract be re-presented to SCB.
Finance Contracting & Procurement Committee	16/09/2021	The Committee supported the paper to extend the Community Health Services contract with the Northern Care Alliance, and this should be until 30 June 2023.

Community Health Services contract extension and review

1. Purpose

1.1. This paper sets out the considerable work which has taken place to develop strong local collaborative provider working across the sector, generate innovation and evolve both vertical and horizontal integration.

1.2. The paper also describes the proposed next steps to continue the work in a time of recovery from the Covid pandemic and uncertainty around the emerging Integrated Care System and developing Integrated Delivery Collaborative.

1.3. The paper makes a recommendation to award an extension to the contract for a period of 12 months from 1 July 2022 to 30 June 2023, to enable the required scoping and review of community health services to take place and a new contract to be delivered.

2. Background

2.1. Back in 2011 the North East Sector (of Greater Manchester) PCTs, made up of Bury, HMR and Oldham, took the joint decision to transfer community health services as a stand-alone contract to Pennine Care NHS Foundation (PCFT). This followed a request to externalize community health services from the commissioning bodies, consider vertical integration with acute trusts, as well as horizontal integration with other NHS providers.

2.2. Community health services were subsequently hosted by PCFT until July 2019, at which point, they were transferred to the acute care provider in Bury, the Northern Care Alliance (NCA).

2.3. Following the landmark devolution agreement (February 2015) with the government to take charge of health and social care spending and decisions in Greater Manchester. The Local Care Organisation (LCO) was born in September 2017 and became the instrument for care delivery bringing together the NHS community health providers, mental health providers, primary care and social care.

2.4. The Bury Locality Plan Refresh (2019) described the importance of community health services delivered across a neighbourhood footprint, integrated with other community-based services to maximise benefits delivered to Bury people and the public purse.

2.5. The LCO has evolved into the Integrated Delivery Collaborative (IDC), despite evolution of the organisation key priorities remain the same. The IDC will continue to build on the success of establishing five neighbourhood teams, continue to transform and expand intermediate care focusing on more home-based care with a fully integrated health and care model, made up of teams with community health services and social care operational services. Also developing palliative and end of life care across the system.

2.6. The impacts of the Covid pandemic have slowed down progress to review and enable innovation and integration across community health services and national control is expected to remain in place until October 2021. Despite this the time has come to accelerate the scoping and review work to identify and build integration across the NHS (acute and community), social care and the voluntary sector, ensuring people remain at the heart of what we do, delivering the right care at the right time and in the right place for Bury residents.

3. Current position – value and scope of current services and impact of Covid pandemic

3.1 The services transferred continue to operate under the arrangements established in July 2019. The range of services currently within scope of this contract are listed in Appendix 1 of this report, they are very diverse and cover both children's and adult services.

3.2 The value of the current community health service contract is £19.73m (this is before contract variations for district nursing and former transformation funded schemes).

3.3 There is evidence of the NCA improving core quality of services, strengthening and reviewing its governance and working on their integrated clinical pathways. However, due to the Covid pandemic, since March 2020, services have been operating differently, with some services stood down in line with Covid-19 national guidance, others operating differently under NCA business continuity arrangements, with re-deployment of clinical staff to areas of pressure. These measures and national control are expected to remain in place until at least October 2021.

4 Current position drivers for integration and work to date

4.1 Community health services are central to plans for the future of the health and care system, this was reaffirmed by the NHS Long Term Plan (January 2019) and described through the Bury Locality plan and refresh (2019). Integration, neighborhood working and people being at the heart of what we do are all centric to the Bury 2030 strategy 'Let's Do It'.

4.2 The ambition to deliver more and better health services in the community is not new, and ensuring they are delivered in an integrated way means better services for patients with a number of real advantages:

- More possibilities for person-centred rather than condition focussed care.
- Genuine integration of primary care and community health care delivery.
- Reduced numbers of professionals going into someone's home.
- Care delivered closer to or within someone's home through the neighbourhood delivery model.

4.3 Despite the Covid pandemic and the pending development of the Integrated Care System putting pressure on the commissioning staff resource, work has already begun to review and scope the community health services:

- Building on the learning from the Covid Pandemic demonstrating genuine cross system working as part of the response for people in Bury.
- A senior stakeholder group established to oversee and review progress.
- Resource identified across the One Commissioning Organisation to drive a thorough programme of work in collaboration with health and social care.
- Mapping of Community Health Services.
- Mapping of acute services to help build potential for integration.
- Identified a set of key principles that will enable innovation and transformation of community health services.
- Created a service scoping template that will act as the foundation for future service specification.
- Established a Self-Assessment framework for service leads to review their services effectively.
- Initial testing of the scooping and review tools.

4.4 This work paves the way for vertical integration, streamlining pathways and innovation, which will be at the heart of the new contract.

5 Procurement Considerations and Contract Extension

5.1 In the report *'Consideration of future arrangements for the provision of Community Health Care Services'* agreed at SCB on 7 December 2020. A direct award to NCA for a period of 12 months (from 1 July 2021 to 20 June 2022) was granted along with the potential to extend the contract for a further 12 months (from 1 July 2022 to 30 June 2023). The appraisal, focus and plans of the previous report in December 2020 remain the same. This report requests the agreement of that further 12 months extension. It is understandable given the implications of the current Covid pandemic that progress to undertake the full scoping and review of the community health services has not moved at the pace anticipated.

5.2 It is hoped the national control of NHS services will conclude in October 2021, given the 'recovery' phase of the pandemic and return to some normality should provide the breathing space to pick up the intended work at pace.

5.3 Given the agreement was to award a contract to the NCA for 12-month period with the ability to extend the contract for a further 12 months this agreement should fit within procurement guidelines and requirements. It is however recommended to make the decision at the earliest opportunity to enable NCA to provide staff and service consistency, support the pandemic recovery and provide the wider market and alternative providers the information on the Bury position and intention.

5.4 Following the detailed scoping and review exercise of community health services a further report will come back to SCB outlining:

- Overview of community health services function and detail, showing alignment to the relevant documentation including the Locality plan, NHS Long Terms plan and Bury 2030 'Let's Do It' strategy.
- Clearly show vertical and horizontal integration of community health services

with acute, social care and voluntary sector.

- All community Health services will have a revised service specification in line with current legislation, regulation, embedding the principles designed and ensuring Bury people are at the heart of service delivery.
- Highlight any system or service efficiencies.
- Set out transformation and innovation of services delivery and partnership working.
- A plan and timeline for a procurement process in the unlikely event it will be required following hoped for changes in the health and care bill currently progressing through the house.

6 Proposed next steps and timeframe

6.1 The below table sets out the proposed next steps and timeline.

Table 1 proposed next steps and timeline

Date	Activity
October 2021	SCB report requesting extension of the community health services contract
September 2021 – December 2021	OCO Team to undertake collaborative scoping and review of existing Community Health Services, supporting leads to undertake self-assessment
September 2021 – June 2022	Identify horizontal and vertical integration, ways to transform/ innovative services and build strong collaboration
January 2022 – June 2022	Use the scoping/ service review detail to draft the revised service specs to underpin future contract
July 2022	Revised Community Health Contract drafted
August 2022	SCB report with review outcomes, next steps and tender detail
July 2023	New Community Health Services contract in place

6.2 Please note the above timeline is built following the recovery of the Covid pandemic, any further pandemic impacts which have not been foreseen may have an effect on the work planned. It should also be considered it may not be the One Commissioning Organisation but the developing Integrated Care System taking any future tendering or contract work forward.

7 Financial Considerations

7.1 The financial arrangements in respect of the current contract have been revised in line with national requirements put in place as a result of the Covid pandemic, which are block funded arrangements for 2020/21 and run until October 2021 when it is anticipated national control will end.

7.2 Withdrawal of services from the NCA may also cause financial uncertainly for the Trust as an organisation.

8 Workforce Considerations

8.1 Staff within all health and care services have worked tirelessly, all going the extra mile in supporting Bury residents with Covid for the past 18 months. This is set to continue until at least the October time then traditional winter pressures will begin. The pandemic has created significant system pressures which undoubtedly have impacted on staff.

8.2 This same staff group within Community Health Services, are those who transferred into the NCA from PCFT at the same time as working through the Covid pandemic. Therefore, they will benefit from a continuation of the existing service provision whilst the work to further scope and review the services is undertaken.

8.3 It is important that the staff and service leads in the NCA feed into the review and undertake the self-assessment framework as they are best placed to help shape and invigorate services and future integration.

9 Conclusion and proposal

9.1 As outlined in the previous SCB paper in December 2020 and this report, the delivery of services on a neighbourhood footprint is fundamental to transforming health and care services to become sustainable for the future.

9.2 Uncertainty remains of future operational and financial requirements in respect of community health services, due to Covid and future planning requirements of the NHS.

9.3 There is clear benefit from maintaining continuity of current services within the structure of the NCA at this time: to ensure continuity for staff and patients, to avoid uncertainty, to minimise risk of ineffective or unsafe delivery of care and to ensure leadership of the ongoing development of the Integrated Delivery Collaborative and the Integrated Care System.

9.4 The ability to successfully innovate and integrate community health services with the acute, social and voluntary sector is key.

9.5 Given the issues described above it is considered the most appropriate way to progress is to extend the current contractual arrangements by 12 months to allow sufficient time to explore and document these future requirements and create the blueprint for future community health service in Bury.

10 Recommendations

It is recommended that the Strategic Commissioning Board:

- Support the proposal to award an extension to the community health services contract for a period of 12 months from 1 July 2022 to 30 June 2023 to the Northern Care Alliance.

- Agree to continue the scoping and review of the existing contract and services within to enable innovation and integration.

Hayley Ashall
Strategic Lead, Integrated Commissioning, Carers, Physical Disabilities and Prevention
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4 October 2021

Appendix 1 – List of Services commissioned within the block contract for Community Health Services

Anti-Coagulation
Adult Speech & Language Therapy
Adults occupational therapy
Assess and treat nursing
Audiology
Children's community nursing team
Children's occupational therapy
Children's speech and language
Community equipment store
Community eye service
Community nursing
Continence and stoma
Community cardiac
Community IV therapy
Dietetics
Discharge liaison
Early discharge team/neuro rehab/stroke team
Falls team
Integrated diabetes team
Neuro rehab
Out of hours nursing
Paediatric physiotherapy service
Physiotherapy
Podiatry
Posture and mobility
Prestwich walk-in centre
Rapid response/crisis response
Resettlement
Respiratory team / COPD
Safeguarding/LAC
Special school nursing
Specialist palliative care
Special school
Trial without catheter
Wound care and lymphedema
VAC therapy

EQUALITY ANALYSIS

This Equality Analysis considers the effect of Bury Council/ Bury CCG activity on different groups protected from discrimination under the Equality Act 2010. This is to consider if there are any unintended consequences for some groups from key changes made by a public body and their contractor partners organisations and to consider if the activity will be fully effective for all protected groups. It involves using equality information and the results of engagement with protected groups and others, to manage risk and to understand the actual or potential effect of activity, including any adverse impacts on those affected by the change under consideration.

SECTION 1 – RESPONSIBILITY AND ACCOUNTABILITY *Refer to Equality Analysis guidance page 4*	
1.1 Name of policy/ project/ decision	**Community Health Services contract extension and review**
1. 2 Lead for policy/ project/ decision	Adrian Crook, Director of Community Commissioning, OCO Nina Parekh, INT Lead
1.3 Committee/Board signing off policy/ project/ decision	Strategic Commissioning Board
1.4 Author of Equality Analysis	Name: Hayley Ashall Role: Strategic Lead, Integrated Commissioning, Carers, Physical Disability and Prevention Contact details: h.ashall@bury.gov.uk
1.5 Date EA completed	10.09.21

SECTION 2 – AIMS AND OUTCOMES OF POLICY / PROJECT *Refer to Equality Analysis guidance page 5*	
2.1 Detail of policy/ decision being sought	Following agreement of the report in December 2020 'Consideration of future arrangements for the provision of Community Health Care Services', granting a direct award to Northern Care Alliance for a period of 12 months (from 1 July 2021 to 20 June 2022) with a potential for a further 12 month extension. Since then and despite the challenges presented by the Covid Pandemic and the uncertainties of the development of the Integrated Delivery Collaborative and Integrated Care System. Considerable work has taken place to continue to build a strong local collaborative provider working across the sector, generate innovation and evolve both vertical and horizontal integration. Work underway and planned aims to maximize the potential and provide consistency at a time of uncertainty and recovery. The recommendation is to award an extension to the contract for a period of 12 months from 1 July 2022 to 20 June 2023.
2.2 What are the intended outcomes of this?	If agreed: • Northern Care Alliance contract would be for a period of 12 months from 1 July 2022 to 20 June 2023, providing opportunity to maximise potential whilst provide consistency at a time of uncertainty and recovery

	• There will be a review of community health services function and detail, showing alignment to the relevant documentation including the Locality plan, NHS Long Terms plan and Bury 2030 'Let's Do It' strategy. • Understand and enable opportunity for vertical and horizontal integration of community health services with acute, social care and voluntary sector. • All community Health services will have a revised service specification in line with current legislation, regulation, embedding the principles designed and ensuring Bury people are at the heart of service delivery. • Highlight any system or service efficiencies. • Set out transformation and innovation of services delivery and partnership working. • A plan and timeline for a procurement process in the unlikely event it will be required following hoped for changes in the health and care bill currently progressing through the house.

SECTION 3 – ESTABLISHING RELEVANCE TO EQUALITY & HUMAN RIGHTS

Refer to Equality Analysis guidance pages 5-8 and 11

Please outline the relevance of the activity/ policy to the Public Sector Equality Duty

General Public Sector Equality Duties	Relevance (Yes/No)	Rationale behind relevance decision
3.1 To eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by Equality Act 2010	Yes	All patients would have equal access to services through referral mechanisms already agreed. Not subject to change through this piece of work, but possibly through transformation programmes, for which separate EIA would be undertaken.
3.2 To advance equality of opportunity between people who share a protected characteristic and those who do not.	Yes	All community practitioners should provide care of a consistent standard, based on clinical need of the individual. This in essence should allow equality of opportunity between people who share a protected characteristic and those who do not.
3.3 To foster good relations between people who share a protected characteristic and those who do not	Yes	Ensure where people are referred to services they are treated in agreed and safe time scales
3.4 Please outline the considerations taken, including any mitigations, to ensure activity is not detrimental to the Human Rights of any individual affected by the decision being sought.		
The list of Human Rights have been explored and this proposal does not have a detrimental impact on any area specified.		

<table>
<tr><th colspan="4">SECTION 4 – EQUALITIES DATA
Refer to Equality Analysis guidance page 8</th></tr>
<tr><th>Protected characteristic</th><th>Outcome sought</th><th>Base data</th><th>Data gaps (to include in Section 8 log)</th></tr>
<tr><td>4.1 Age</td><td>Yes</td><td>Patient record collates the client's data including age.

BURY CCG:
The Bury population can be split by the following categories (JSNA 2015):
<table><tr><td>Year</td><td>0-4</td><td>5-15</td><td>16-24</td><td>25-44</td><td>45-64</td><td>65+</td><td>85+</td></tr><tr><td>2015</td><td>12,430</td><td>25,630</td><td>18,910</td><td>48,100</td><td>49,420</td><td>33,410</td><td>3,950</td></tr></table>
JNSA for Bury CCG:
Bury has an estimated resident population of 182,600 (ONS 2009 mid year population estimates) but a registered (with a Bury general practice) population of 194,350 as at 31st March 2010. The resident population of Bury is expected to increase to 193,000 by 2022 (5.5% increase) mainly due to more births than deaths. By 2022, the number of people aged under 25 years old is expected to increase by only 2,600 so that their proportion of the population will decrease by 4%, whereas there will be 9,000 more people aged over 65 (29% higher proportion of the population) with 2,000 more people aged over 85 (54% higher proportion of the population).</td><td></td></tr>
<tr><td>4.2 Disability</td><td>Yes</td><td>Patient record includes data on any disability.
Over 21,224 people in Bury have a limiting long-term illness, health problem or disability equating to 11.24% of our resident population, compared to 18.8% of the population of England and Wales (Census 2011)

Data from Bury BC gives a comparator between residents who are disabled compared to their non-disabled neighbours:
<table><tr><th>Area:</th><th>All people in thousands</th><th>Disabled based on the DDA definition</th><th>work-limiting disabled</th></tr><tr><td>Bury</td><td>12.7%</td><td>4.8%</td><td>2.9%</td></tr></table>
Data from Rochdale Borough (HMR CCG) indicates:</td><td></td></tr>
</table>

		The number of Rochdale Borough residents reporting a long-term health condition or disability is 44,359 (21%). *Source: 2011 Census*	
4.3 Gender	Yes	Patient record includes client's data including gender. **Bury CCG:** In the 2011 census the population of Bury was 185,060 and is made up of approximately 51% females and 49% males. **HMR CCG:** According to the 2015 Mid-Year Estimates there are slightly more women than men in the Rochdale borough; with approximately 108,841 people identifying as female compared with 105,354 of the local population identifying as male.	
4.4 Pregnancy or Maternity	Yes	Patient record includes whether a client is pregnant/ has children. Public Health England March 16 Child Health Profile gives a live birth figure for Bury (2014) as 2,329. Children and young people under the age of 20 years make up 24.9% of the population of Bury. 23.6% of school children are from a minority ethnic group. The health and wellbeing of children in Bury is mixed compared with the England average. Infant and child mortality rates are similar to the England average. The level of child poverty is better than the England average with 17.1% of children aged under 16 years living in poverty. The rate of family homelessness is similar to the England average. Children in Bury have better than average levels of obesity: 7.8% of children aged 4-5 years and 17.2% of children aged 10-11 years are classified as obese. There were 295 children in care at 31 March 2015, which equates to a higher rate than the England average. A higher percentage of children in care are up-to-date with their immunisations compared with the England average for this group of children.	
4.5 Race	Yes	Patient record includes the client's data including race. BAME population 20,028 (Census 2011) Bury has a Black, Asian and Minority Ethnic (BAME) population of around 10.8% compared to 14.7% of the population of England and Wales (2011 Census). There is currently no data in relation to Race collected nationally for this service. **JSNA data for Bury CCG:** According to the 2001 Census, 93.9% of Bury's population is white with 'White British' representing 90.7% (compared to 87% nationally). The remaining 6.1% is made up of ethnic	Limited information on smaller and emerging communities in Bury

		communities with the largest group being Pakistani at 3% of the population. Indians are the second largest group representing 1.4% of the population. The largest concentration of non-white residents is in East Ward where ethnic groups make up over 20% of residents. The Census however was produced in 2001 recent estimates (2006) suggest that the white population has fallen to 87.9% (compared to 84% nationally), with the largest proportional increase being in the Bangladeshi community. This data shows a decreasing white population and a substantial increase in the Asian heritage community although it has to be considered that the Pakistani community is predominantly young (with 65% of the population aged under 30) and that many of the migrant workers settling in Bury may not be represented. Local Area Profile (Rochdale) 2011 for HMR CCG: Population Profile Rochdale (HMR CCG) 2011 vast majority of people in Rochdale Borough are from a White British ethnic background, equivalent to 83.5% of the total population. People of a Pakistani background make up the largest minority ethnic group, with 17,200 people (8.3%). A significant proportion of the Bangladeshi, Pakistani and Mixed ethnic groups are aged between 0-15 years old. In comparison to the White British ethnic group, the minority ethnic groups have a much younger age structure, with fewer older people (Irish and White Other are the exceptions). The 2011 Census revealed that in Rochdale Borough 166,481 people identify as White British which makes up 78.6% of the local population. The largest ethnic minority group is Pakistani which makes up 10.5% of the local population (22,265), and the second largest is Bangladeshi with 2.1% of the population (4,342). *Source: 2011 Census.*	
4.6 Religion and belief	Yes	Patient record collates the client's data including religion or belief. Census 2011 responses: Christian (62.7%, nationally 59.3%), Muslim (6.1%, nationally 4.8%) and Jewish (5.6%, nationally 0.5%). 18.6% identified as having no religion **Bury CCG**: 88.9% of people living in Bury were born in England. Other top answers for country of birth were 1.9% Pakistan, 1.2% Scotland, 1.0% Ireland, 0.6% Wales, 0.5% Northern Ireland, 0.4% India, 0.3% Iran, 0.2% Hong Kong , 0.2% South Africa. 95.1% of people living in Bury speak English. The other top languages spoken are 0.9% Urdu, 0.8% Polish,	

		0.7% Panjabi, 0.2% Persian/Farsi, 0.2% Pashto, 0.2% Arabic, 0.1% All other Chinese, 0.1% Italian, 0.1% French. Religion is given as The religious make up of Bury is 62.7% Christian, 18.2% No religion, 6.1% Muslim, 5.6% Jewish, 0.4% Hindu, 0.2% Buddhist, 0.2% Sikh. 11,069 people did not state a religion. 476 people identified as a Jedi Knight and 42 people said they believe in Heavy Metal.	
4.7 Sexual Orientation	No – Not applicable	There is currently no national or local data on sexual orientation. However, estimates provided by the LGBT Foundation and Stonewall that between 5% and 7% of the population identify as Lesbian, Gay or Bisexual nationally. In 2015, 1.7% of the UK population identified themselves as lesbian, gay or bisexual (LGB). More males (2.0%) than females (1.5%) identified themselves as LGB in 2015. Of the population aged 16 to 24, there were 3.3% identifying themselves as LGB, the largest percentage within any age group in 2015. The population who identified as LGB in 2015 were most likely to be single, never married or civil partnered, at 68.2%. In 2015, the majority (93.7%) of the UK population identified themselves as heterosexual or straight, with 1.7% identifying as LGB, the remainder either identifying as "other", "don't know" or refusing to respond. Young adults (16- to 24-year-olds) 3.3% are more likely to identify as LGB compared with older age groups, and a higher proportion of males identify as LGB than females. Of those they were most likely to be single, never married or civil partnered, at 68.2%. There are no accurate statistics available regarding the profile of the lesbian, gay and bisexual (LGB) population either in the UK as a whole. Sexuality is not incorporated into the census or other official statistics. It's acknowledged that approximately 6-10% of any given population will be LGB. Source: MYE 2015 and Stonewall	No – Not applicable
4.8 Marriage or Civil Partnership	Yes	Patient record collates the clients data including married/ spouse details etc. The Census 2011 showed those married as 70,088 and those in a registered same-sex civil partnership status as 253 in Bury **Bury CCG:** 46.6% of people are married, 11.5% cohabit with a member of the opposite sex, 0.8% live with a partner of the same sex, 24.3% are single and have never married or been in a registered same sex partnership, 9.4% are separated or divorced. There are 10,162 widowed people living in Bury.	

4.9 Gender Reassignment	No – we don't believe this is currently being collated.	There is currently no national or local data on gender identity. At present, there is no official estimate of the trans population. The England/Wales Census and Scottish Census have not asked if people identify as trans…" Equality and Human Rights Commission. The GIRES (2009) report on Gender Variance in the UK estimated that around 20 in every 100, 000 people had sought medical care for gender variance. Using 15+ ONBS data of current list size of 163,013 (ONS 2015-16) the Gender Reassignment figure for Bury would be approximately 33 Bury Residents and 34 Residents in HMR CCG.	To be reviewed – may differ dependent on specific service
4.10 Carers	Yes	Patient record collates the clients data including whether the person is a carer or supported by a carer Stats in Bury: 19,954 - Census 2011 300+ carers registered with the Bury Carers Hub The role of the carer is especially important when the person who receives care (the care recipient) is unable to live independently without the carer's help. A young carer is a child or young person under the age of 18, carrying out significant caring tasks and assuming a level of responsibility for another person that normally would be undertaken by an adult. Underpinning the caring role may be life-long love and friendship, together with an acceptance of the duty to provide care. Carers can derive satisfaction and a sense of well-being from their caring role, receive love and affection from the care recipient, gain a sense of achievement from developing personal attributes of patience and tolerance, and gain satisfaction from meeting cultural or religious expectations (Cassell et al, 2003). Caring responsibilities may arise at any time in life. Carers may have to adapt and change their daily routine for work and social life, perhaps incurring personal and financial costs. They may become isolated from other members of their family, friends and work colleagues. In an ageing population, family members are expected to undertake complex care tasks, often at great cost to their own well-being and health (Schulz & Matire, 2004). The role of carer can be demanding and difficult, irrespective of whether the care recipient has a mental disorder, learning disability or a physical disability, either separately or	

		combined. A survey of over 1000 carers in contact with carers' organisations found that just less than 50% believed that their health was adversely affected by their caring role (Cheffings, 2003). Mental health problems included stress and tension (38%), anxiety (27%) and depression (28%). Physical health problems included back injury (20%) and hypertension (10%). Back injury was associated with caring for individuals with physical disabilities. Similar figures were found in a survey by Carers UK (2002), in which the most frequently experienced negative emotions in carers were: feelings of being mentally and emotionally drained (70%), physically drained (61%), frustration (61%), sadness for the care recipient (56%), anger (41%), loneliness (46%), guilt (38%) and disturbedsleep (57%). Carers who are more vulnerable to health problems are women, elderly or very young people, those with pre-existing poor physical health, carers with arduous duties and those with few social contacts or support. Carers may attribute symptoms of an illness to their work as a carer and fail to recognise the onset of an illness. In Bury alone, we currently know of 3,320 adult carers but we acknowledge that there may be many more who do not receive any support to undertake their caring role .	
4.11 Looked After Children and Care Leavers	Yes	Patient record collates the clients data including whether the person is a Looked After Child or care leaver	
4.12 Armed Forces personnel including veterans	No – we don't believe this is currently being collated.	A veteran is someone who has served in the armed forces for at least one day. There are around 2.6 million veterans in the UK as a Regular or Reservist or Merchant Navy serving in an active theatre of war. Estimates for the Bury population by the British Legion are 12,000-14,000 Veterans currently resident within the Borough. This figure does not include the Spouses or close family members of those who have served who may have specific needs due to service life. Taken as a whole, the ex-Service population, which has been estimated at around 3.8 million for England, has comparable health to the general population. The current generation of UK military personnel (serving and ex-serving) have higher rates of heavy drinking than the general population. However, this difference may attenuate with age. The most common mental health problems for ex-Service personnel are alcohol problems, depression and anxiety disorders. In terms of the prevalence of mental disorders, ex-Service personnel are like their still-serving counterparts and broadly like the general population. Military personnel with mental health problems are more likely to leave over a given period than those without such problems and are at increased risk for adverse outcomes in post service life. The minority who leave the military with psychiatric	Specific question being asked in 2021 census To be reviewed

		problems are at increased risk of social exclusion and ongoing ill health. The British Legion 2012 gave estimates of the Military Veteran population of circa 12,000 (Bury) and 14,000 (HMR).	
4.13 Socio-economically vulnerable	No– we don't believe this is currently being collated.	15,700 Housing benefit / Council Tax support claimants NOMIS Claimant Count: 8,135 (October 2020) 356 people whom the council has a homeless duty Data is collected by BCSN and reported through to Bury Council and GM Humanitarian Aid Group regarding no. of people asking for financial support, advice and food parcels. C. 900 Food parcels distribute per week through Bury Community Support Network (Nov 2020-Feb 2021	To be reviewed

SECTION 5 – STAKEHOLDERS AND ENGAGEMENT *Refer to Equality Analysis guidance page 8 and 9*		
	Internal Stakeholders	External Stakeholders
5.1 Identify stakeholders	Patients using the services Carer and family of customer Workforce	Potential future users of the service Members of the public
5.2 Engagement undertaken	Community Health service staff engagement	N/A
5.3 Outcomes of engagement	The engagement is to be undertaken at the point of the services review and will help shape the next steps and outcomes.	
5.4 Outstanding actions following engagement (include in Section 8 log)	The engagement is to be undertaken at the point of the services review and will help shape the next steps and outcomes.	

SECTION 6 – CONCLUSION OF IMPACT *Refer to Equality Analysis guidance page 9* Please outline whether the activity/ policy has a positive or negative effect on any groups of people with protected inclusion characteristics		
Protected Characteristic	**Positive/ Neutral Negative/**	**Impact (include reference to data/ engagement)**
6.1 Age	Positive	All age groups will be accessing services based in the community
6.2 Disability	Positive	Ensure where people are referred to services they are treated within in agreed and safe time scales
6.3 Gender	Positive	Where people with any protected characteristic are referred into services, they should be treated in agreed and safe time scales. All

		patients should have services delivered in an accessible, compassionate, and safe way.
6.4 Pregnancy or Maternity	Positive	Where people with any protected characteristic are referred into services, they should be treated in agreed and safe time scales. All patients should have services delivered in an accessible, compassionate, and safe way.
6.5 Race	Positive	Where people with any protected characteristic are referred into services, they should be treated in agreed and safe time scales. All patients should have services delivered in an accessible, compassionate, and safe way.
6.6 Religion and belief	Positive	Where people with any protected characteristic are referred into services, they should be treated in agreed and safe time scales. All patients should have services delivered in an accessible, compassionate, and safe way.
6.7 Sexual Orientation	Positive	Where people with any protected characteristic are referred into services, they should be treated in agreed and safe time scales. All patients should have services delivered in an accessible, compassionate, and safe way.
6.8 Marriage or Civil Partnership	Positive	Where people with any protected characteristic are referred into services, they should be treated in agreed and safe time scales. All patients should have services delivered in an accessible, compassionate, and safe way.
6.9 Gender Reassignment	Positive	Where people with any protected characteristic are referred into services, they should be treated in agreed and safe time scales. All patients should have services delivered in an accessible, compassionate, and safe way.
6.10 Carers	Positive	Where people with any protected characteristic are referred into services, they should be treated in agreed and safe time scales. All patients should have services delivered in an accessible, compassionate, and safe way.
6.11 Looked After Children and Care Leavers	Positive	Where people with any protected characteristic are referred into services, they should be treated in agreed and safe time scales. All patients should have services delivered in an accessible, compassionate, and safe way.
6.12 Armed Forces personnel including veterans	Positive	Where people with any protected characteristic are referred into services, they should be treated in agreed and safe time scales. All patients should have services delivered in an accessible, compassionate, and safe way.
6.13 Socio-economically vulnerable	Positive	Where people with any protected characteristic are referred into services, they should be treated in agreed and safe time scales. All patients should have services delivered in an accessible, compassionate, and safe way.
6.14 Overall impact - What will the likely overall effect of your activity be on equality, including consideration on intersectionality?	Positive - Where people with any protected characteristic are referred into services, they should be treated in agreed and safe time scales. All patients should have services delivered in an accessible, compassionate, and safe way.	

SECTION 7 – ACTION LOG *Refer to Equality Analysis guidance page 10*			
Action Identified	Lead	Due Date	Comments and Sign off (when complete)
8.1 Actions to address gaps identified in section 4			
None that will have an impact on this proposal			
8.2 Actions to address gaps identified in section 5			
None			
8.3 Mitigations to address negative impacts identified in section 6			
None			
8.4 Opportunities to further inclusion (equality, diversity and human rights) including to advance opportunities and engagements across protected characteristics			
None			

SECTION 8 - REVIEW *Refer to Equality Analysis guidance page 10*			
Review Milestone	Lead	Due Date	Comments (and sign off when complete)
Ongoing			The proposed extension is for 12 months and it is anticipated that learning through service reviews, in order to shape the future service specification, would be in-depth, robust and outcomes focused. In the meantime, ongoing monitoring, in line with national requirements, will continue.