

Inner North West London Primary Care Trusts

Advancing Equality in Inner North West London

Report outlining how the three Inner West London Primary Care Trusts (NHS Hammersmith & Fulham, NHS Kensington & Chelsea and NHS Westminster) meet their duty to publish information demonstrating compliance with the equality duties under the Equality Act 2010

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<http://www.northwestlondon.nhs.uk/>

Foreword

The three Inner North West London PCTs (NHS Hammersmith & Fulham, NHS Kensington & Chelsea and NHS Westminster) are committed to ensuring that all people in the PCTs' area have access to high quality healthcare and to eliminating discrimination and advancing equality of opportunity for all. This document demonstrates that commitment and is part of the PCTs' work to meet the requirements of the Equality Act 2010.

The three PCTs have a long history of work to promote equalities, some of which is set out here. We are committed to building on this work in the future, in partnership with local people. We recognise the particular importance of working closely with groups whose needs are currently least well met and who are hardest to reach.

Following the publication of this statement, the PCTs will work with clinicians, local authorities, local groups and individuals to develop objectives for promoting equality for the PCTs and successor organisations.

SECTION 1 – BACKGROUND

1.1 This report

This report focuses on the actions being taken by NHS Hammersmith & Fulham, NHS Kensington & Chelsea and NHS Westminster to meet their duty to demonstrate compliance with the equality public duties, under the Equality Act 2010 and the Equality Act 2010 (Specific Duties) Regulations 2011.

NHS Hammersmith & Fulham, NHS Kensington & Chelsea and NHS Westminster are collectively known as the Inner North West London Primary Care Trusts or “INWL PCTs”. As the three Trusts work closely together and share a common management team, this statement has been produced on behalf of all three.

1.2 The Equality Act public duties

As a public body, the general duty set out in s149 (1) of the Equality Act 2010, requires Primary Care Trusts, in the exercise of their 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.

PCTs (along with other public bodies) must publish information to demonstrate compliance with the specific equality duties. This must include information relating to people who share a relevant protected characteristic who are either its employees, or people affected by its policies and practices. The report considers both PCT staff and the users of the services the PCTs commission.

Information must be published either in the statement itself, or within other documents accessible to the public. Therefore, where data has not been provided in this document, signposting to relevant documentation on freely accessible websites has been included.

Protected Characteristics

The protected characteristics under the Equality Act 2010 are:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion and belief
- Sex
- Sexual orientation

1.3 The PCTs' vision for equality

The PCTs are committed to equality of access and opportunity, both as a commissioner of services to local residents, and as an employer to staff, irrespective of whether or not they are covered by the provisions of the Equality Act. We are mindful that those protected by the Equality Act may experience disadvantage and discrimination which impacts on their health and wellbeing, because of their protected characteristic.

The PCTs are aiming to:

- ensure people in the PCT areas have access to higher quality, innovative healthcare and a higher quality of patient experience for all
- reduce inequalities in health that lead to differences in life expectancy between persons living in wealthier and deprived wards.

The PCTs will achieve these aims by engaging with partners and other stakeholders, local people and communities through Local Involvement Networks (LINKs). We will also work with the extensive network of community based organisations that we commission to gather insight from patients and communities currently not accessing services and in particular those with the protected characteristics.

1.4 Managing the process

The three PCTs are working closely with a number of local stakeholders to deliver the shared strategic objective of improving the health and well being of people in the area. This report outlines how, working with local stakeholders, the PCTs meet the public duties under the Act, including reducing health inequalities.

Stakeholders include the three local authorities (which are also under obligation to comply with the Act), the developing Clinical Commissioning Groups, third sector organisations and the Health and Wellbeing Boards.

The Government has stated its intention to abolish Primary Care Trusts from April 2013 and legislation to give effect to this is currently working its way through Parliament. After April 2013 it is intended that consortia of General Practitioners ('Clinical Commissioning Groups') will take responsibility for much of the commissioning of NHS services. The National Commissioning Board will assume responsibility for the remaining NHS commissioning, for example of GPs, dentists, community pharmacies and optometrists. Local authorities will have increased responsibilities for public health and will establish Health and Wellbeing Boards which bring together health and local care commissioners.

An important part of the PCTs' work is to effect a smooth transition to the new NHS structures. In particular the PCTs aim to maintain a focus on embedding equality and best practice on continuing to tackle the substantial health inequalities experienced locally into the work of its successors.

For further detail on what the three Inner North West London PCTs are doing please see the 2010/11 PCT Annual Reports:

Hammersmith & Fulham:

<http://www.northwestlondon.nhs.uk/hammersmith-fulham/publications/?category=2923&search=Annual+report>

Kensington & Chelsea:

<http://www.northwestlondon.nhs.uk/kensington-chelsea/publications/?category=2923&search=Annual+report+2010>

Westminster:

<http://www.northwestlondon.nhs.uk/westminster/publications/?category=1647-Annual+Reports-d&pct=93>

1.5 Timetable for action

Under the Act, the PCTs are required to prepare and publish one or more objectives to enable us to meet our specific equality duty by 6th April 2012. In February and March 2012, the PCTs will be working with stakeholders on objectives for equality, based on the information provided in this report and associated documentation.

To support work on equality, the PCTs are using the framework provided by the Equality Delivery System (EDS), which is being used across the National Health Service to drive up performance on equality, embed equality into the mainstream NHS business, and deliver on the requirements of the Equality Act.

SECTION 2 – THE PCTS AS EMPLOYERS

The PCTs' staff policies have a strong equality basis. The actions of the Human Resources team and its interactions with staff are founded upon the equality principles commonly used across the NHS. Each of the PCTs has an "Equality in Employment Policy" setting this out.

The common theme in these policies is that the Trust is "committed to eliminating unlawful discrimination [and] promoting equality...". This commitment is manifested in many different ways. For example, the standard contract that is used for staff includes a section on managing diversity and states that failure to adhere to the Trusts' equal opportunities policy will be treated as misconduct. Additionally managers are bound by the Code of Conduct for NHS Managers which has, as one of its six principles, the requirement for managers to treat staff and patients with dignity and respect. The Code requires that managers ensure no one is unlawfully discriminated against because of any of the protected characteristics as described in legislation.

The PCTs are committed to promoting equality and diversity amongst staff. Training has been offered to all staff and take-up of this has been good. The PCTs are committed to working with the Clinical Commissioning Groups and other successor organisations to ensure that the work that has been done continues after April 2013.

Recruitment follows NHS best practice including the focus on equality. The usual route to employment is via a job advertised on NHS Jobs website with the application coming via the same website. This method ensures that all applicants are treated fairly and the design of the system ensures that recruiting managers only see the parts of the application form that are required to shortlist candidates: information about ethnicity or age, for example is not available to managers. The system also captures equality monitoring data for applicants and allows us to monitor the success of different groups of staff in the recruitment journey.

The three Inner North West London PCTs employ a total of approximately 400 staff between them. Monitoring information about protected characteristics is captured for employees during recruitment, typically in the data from their application. Some information (eg. date of birth and sex) is required in order to pay staff through the payroll system. As a result this information is captured for all staff. Other information is less complete because either staff do not need to provide the information in order to get paid or because the process where this information has been requested began after the employee was recruited.

Further consideration is being given to what additional data should be collected, although due to the fact that it is the Government's intention to abolish PCTs in April 2013, it is not expected that there will be any large scale project to update the information held about staff.

Human Resource records show only two staff having been dismissed from across the PCTs because of conduct and it is therefore not possible to identify any patterns across the protected characteristics. There have been no Employment Tribunal cases relating to discrimination during the year.

The Inner North West London PCTs share an Human Resource team with the eight PCTs in North West London who work for NHS North West London. Recruitment and appointment systems have been aligned across the eight PCTs in North West London so that monitoring information will be captured for all new employees.

SECTION 3 – THE PCTS AS A COMMISSIONER OF HEALTH SERVICES

3.1 Equality and inequalities in health

Both national and local research has identified economic and social deprivation as associated with health inequalities between affluent and deprived regions.

There is a substantial difference in life expectancy between residents living in the most deprived areas and more affluent areas in each of the three boroughs. Those people with the protected characteristics covered by the Equality Act are also generally disproportionately represented amongst those living in the more deprived areas, in particular disabled people with physical or mental impairments, people from Black and Minority Ethnic (BME) groups and children & young people, many of whom live in poverty.

The PCTs work on improving health and healthcare access for all has at the same time taken a targeted approach, working directly with people with the protected characteristics. This is particularly true around service development and change where active engagement and the involvement of local people affected by change has been an important element. This ensures that the needs and concerns of local people, including those with the protected characteristics, are taken into account. This has helped the PCTs to meet the public duties to eliminate discrimination and advance equality of opportunity. Bringing local people together to shape their services also helps to foster good relations between local people, including those with the protected characteristics.

In many cases, the focus on tackling inequalities in health has primarily been on those living in wards experiencing poverty and deprivation. Work streams have generally centred on the major causes of poor health and disability, such as mental health, cancer, heart disease, as well as on the 'wider determinants' and lifestyle factors that have influence on health. This has indirectly impacted on outcomes for many of those with the protected characteristics.

3.2 Profiles of the Inner North West London boroughs

For more detail on the protected characteristics in Inner North West London, see Appendix A

All three boroughs are characterised by cultural diversity, a large working age population, and substantial inequalities in health predominantly between areas of affluence and deprivation.

Hammersmith & Fulham

Hammersmith & Fulham has a very high proportion of young working age residents, with fewer children and older people than elsewhere. Like other parts of Inner London, the area is characterised by both wealth and deprivation. The borough has a life expectancy of 79.4 years for men and 84.3 years for women, which are slightly higher than the London and England averages. Parts of the borough, particularly in the north (White City and Shepherd's Bush), Hammersmith, and Sands End in the south, have poor health, deprivation and associated chronic diseases.

Hammersmith & Fulham's population is culturally and ethnically diverse, with populations from Western Europe, Eastern Europe (particularly Poland), Australia and the Middle East. The northern wards of Wormholt & White City and College Park & Old Oak have the highest black and minority ethnic populations in the borough, at over 30%. The most common faith after Christianity was Islam, at 1 in 10 of the population in 2001.

Kensington & Chelsea

Kensington & Chelsea is one of the UK's wealthiest boroughs and is also the most densely populated. It currently has the highest life expectancy in the country, at 85.1 years for men and 89.8 for women. However, overall good health masks variations in life expectancy and parts of the north of the borough in particular have a much higher burden of disease and lower life expectancy. Around half the population in these areas live in social housing and these areas are more likely to be home to residents belonging to a number of the protected groups, such as those with a disability and those from black and minority ethnic groups.

The population is culturally very diverse, and the borough also has a significant daytime population, comprising workers, tourists and shoppers. Only 4 out of 10 residents were born in the UK, the lowest of any borough in the country. Communities range from the more affluent – Western European, American, and Australian – to more vulnerable – Middle Eastern and North African. The borough also has among the highest numbers of residents known to have HIV transmitted through sex between men.

Westminster

Westminster is one of the most prosperous boroughs in the UK in terms of average income, and residents enjoy the second highest life expectancy in the country after Kensington & Chelsea, at 83.8 years for men and 86.7 years for women. It is also unusual in that it is a huge daytime population, predominantly workers, tourists and those visiting entertainment in the borough. The borough is, like Kensington & Chelsea, culturally very diverse, with large numbers of residents from Western Europe and America, and the largest Arabic-speaking population in the country.

The borough has the largest difference in life expectancy of anywhere in the country, with an absolute difference between affluent and deprived areas of 17 years for men and 10 years for women. Areas such as Church Street and Queens Park in the north of the borough are among the most deprived in the country. Populations in these areas are characterised by ethnic diversity, poor health outcomes and worklessness. Like Kensington & Chelsea, the borough also has among the highest numbers of residents known to have HIV transmitted through sex between men, particularly in the Soho area.

For in-depth analysis of the health needs see the JSNA pages (link below) or the Association of Public Health Observatories (APHO) Health Profiles: <http://www.apho.org.uk/default.aspx?RID=49802>

3.2 Understanding the health gap for those with protected characteristics

Background

In instances where data is routinely collected, our local understanding of the health status of those with protected characteristics is good. This is particularly true in the case of the 2001 Census, which delivered a large enough number of responses to be able to understand the needs of vulnerable populations and to target resources, including information on older people in poor health, disabled people unable to work due to an impairment, older pensioners living alone and those from specific ethnic groups reporting poor health.

However, our understanding of the health status of protected groups is often informed primarily by national and international published evidence as, while local data may be able to identify trends, only rigorous research studies are generally able to adjust for other influencing factors to identify *true* causality.

Also, in some cases, no local data exists, usually because data is not routinely collected. In some cases this is for reasons of practicality or sensitivity; in other cases this is purely historical and is now being addressed.

As part of the Equality Delivery System process, the PCTs have undertaken a comprehensive mapping of the health profile of the groups with the protected characteristics. This highlighted that there was robust data covering most of the equality strands. However, for certain characteristics such as Marriage & Partnerships and Gender Reassignment, there is a gap in information.

Evidence of good practice

PCTs and councils have a duty to produce health needs information under the Joint Strategic Needs Assessment (JSNA) process. As part of this, we have produced a range of outputs, covering detailed breakdowns for many of the protected groups. Examples of good practice include a Children's Joint Strategic Needs Assessment for Hammersmith & Fulham, focused Assessments on a range of different topic areas in Westminster (e.g. mental health, older people) and a range of data fact sheets in Kensington & Chelsea. In Westminster, the survey carried out as part of the Major Health Campaign allowed unique insight into the health needs of some vulnerable groups.

H&F Children's JSNA:

http://www.lbhf.gov.uk/Images/Children's%20JSNA%202010_tcm21-164266.pdf

Kensington & Chelsea JSNA report and data fact sheets:

<http://www.rbkc.gov.uk/voluntaryandpartnerships/jsna.aspx>

Westminster JSNA pages (including Major Health Campaign report):

<http://westminstercitypartnership.org.uk/Partnerships/Health%20and%20Wellbeing/Pages/JSNA.aspx>

Gaps

- Little is known locally about the health needs of disabled people with particular impairments, and around sexual orientation.
- Little is known locally around mortality for ethnic groups, as ethnicity is not coded on death certificates.
- Population data on those with protected characteristics is not always known, making comparisons difficult, particularly between Censuses.

3.4 Routine monitoring and improvement of service quality, satisfaction and access for those with protected characteristics

Background

All PCT contracts require providers to collect data relating to the equality strands. Routine monitoring of issues around access and service quality/satisfaction is therefore carried out by organisations providing services on behalf of the PCTs, In some cases this is on a regular (e.g. monthly) basis, in the case of patient surveys, this tends to occur annually or bi-annually.

The PCTs welcome feedback, complaints as well as compliments, as part of the process for continuous service improvement. All complaints are followed up on a regular basis. Details on where to find information by provider have been given below.

There are methodological challenges to gathering comparator data on those with protected characteristics using surveys or routine quantitative data. In some cases, they may constitute too small a proportion statistically to allow accurate comparison, or else data on their protected characteristic either is not gathered or cannot be gathered, making it impossible to define the population. In these instances, qualitative style projects have often been found to be more appropriate, such as the user-focused monitoring within mental health services, or examination of complaints trends.

Gaps

Other than for age, gender and ethnic group, methodological challenges around identifying and measuring satisfaction of certain groups mean our understanding of many of those with protected characteristics is quite limited. In particular, experiences of disabled people are relatively poorly known, given they represent a significant proportion of the population

User focused monitoring

http://www.centreformentalhealth.org.uk/pdfs/uv_summ.pdf

Inpatient and mental health surveys (CQC website)

<http://www.cqc.org.uk/public/reports-surveys-and-reviews/surveys>

Service provider equality sites:

<http://www.chelwest.nhs.uk/about-us/equality-diversity>

<http://www.imperial.nhs.uk/equalityanddiversity>

<http://www.uclh.org/aboutus/wwd/SES/Pages/Home.aspx>

<http://www.clch.nhs.uk/about/SES/documents/CLCH%20Consulation%20Single%20Equalities%20Scheme.pdf>

http://www.cnwl.nhs.uk/equality_diversity.html

<http://www.wlmht.nhs.uk/about-the-trust/equality-and-diversity/>

3.5 Improving outcomes through regular engagement with service users with protected characteristics

Background

The PCTs have a dedicated Engagement Team covering all aspects of stakeholder engagement. The Engagement Team works closely with community groups. Equality is mainstreamed into the engagement work of the PCTs.

The PCTs have developed a joint Operating Plan for their engagement work which includes the specific priorities of:

- Developing process for the systematic collection and use of patient feedback to improve commissioning decisions and hold provider services to account for delivering high quality services
- Developing an engagement plan to ensure systems are in place to support patient and public engagement across all levels of decision making from strategic commissioning decisions through to individual involvement in treatment plans.

In 2011/12 engagement work is focused on the Quality, Innovation, Productivity and Prevention (QIPP) initiatives across the PCTs and the development of 2012/13 commissioning Intentions.

Engagement

Engagement is considered to be a mainstream part of the work of the PCTs. Care is taken to ensure that engagement initiatives are inclusive of all participants and that they are accessible. As well as ensuring that there is physical access to buildings where engagement are held or that on-line and paper based consultations are accessible, the team address any barriers that they find. For example:

- questionnaires are designed and circulated to target people with learning disabilities
- community researchers are used to elicit responses from the Arabic, Bengali and Chinese community
- carers, homeless people and children and young people were targeted by distributing questionnaires to various community centres and groups aimed at these service users.

It is important that the Engagement Team elicit the participation of, and responses from, as many stakeholders as possible and that participants reflect the diverse communities within the PCT areas in order that engagement:

- helps to ensure that commissioned services are fit for purpose, are high quality and will meet the needs of service users and any barriers to access are identified at an early stage
- assists in ensuring that policies and proposals for change or the introduction of new initiatives do not inadvertently discriminate against people with the protected characteristics, or that any adverse impacts are mitigated or removed
- can form an important part of the PCTs' equality analysis
- helps to foster good relations between different groups within the areas in which the PCTs operate by bringing stakeholders together to help shape policies and proposals
- brings transparency and accountability to all that the PCTs do
- gives the people whose lives are impacted by policies the opportunity to voice any concerns at an early stage
- builds trust and confidence of local people in the services they helped to shape
- enables patients to take control of their health and manage their long term conditions.

The Engagement Team is working with the developing Clinical Commissioning Groups in Inner North West London to develop effective patient and public engagement systems as they take over responsibility for commissioning health services for local residents. Mainstreaming equality into this work is a priority for the PCTs.

Involving people with protected characteristics in decisions about service changes

The PCTs consult and involve local people in our work to ensure that we meet the needs of local people. This also assists the PCTs in meeting the public duties to:

- eliminate discrimination, by ensuring that policies and practices do not inadvertently discriminate against people with the characteristics covered by the Equality Act, but that if they do, the effects can be mitigated or removed
- advance equality, by building up the capacity of local groups and people to engage with the PCTs and by making a contribution to proposals that advance equality
- foster good relations, by facilitating local people and organisations to work together on proposals and issues that affect them and their communities. Ensuring that all consultation and engagements are accessible and demonstrating that all views are welcome

encourages participation and results in better and more effective services for all service users.

The PCTs regularly engage with:

- local residents, including those with characteristics protected by the Act
- Patient Groups
- Local Involvement Networks (LINKs)
- Local authorities of Hammersmith & Fulham, Kensington & Chelsea and Westminster
- Community and third sector groups
- Local General Practitioners
- Local Pharmacies
- NHS trusts
- Neighbouring Primary Care Trusts
- Communities deemed to be 'hard to reach' through existing community networks – which can go where we cannot
- Staff.

Recent engagement initiatives have included:

- **Health White Paper 2010: 'Equity and Excellence: Liberating the NHS'**
 - Local residents were consulted about the White Paper
- **Pharmaceutical Needs Assessments**
- **Carers Forum**
 - Establishing a Forum in Kensington & Chelsea to gather views from local people with caring responsibilities.
- **Increasing access to NHS Kensington & Chelsea Dental Services**
 - To explore ease of access and the quality of dental services and premises within NHS Kensington & Chelsea.
- **Kensington & Chelsea Memory Assessment Service (Dementia Services)**
 - To gather views on the proposed dementia pathway and specification for the Memory Assessment Service and to ensure that the new arrangements help to improve early diagnosis and identification of dementia.
- **User involvement of people with just diagnosed dementia**
 - To engage in a range of different ways with people with dementia to support them to express their views about current dementia services.
- **Consultation on the Falls Prevention & Bone Health Framework**
 - To elicit views of stakeholders on the aims and objectives outlined in the Falls Prevention & Bone Health Delivery Framework.
- **Physical Disability and Sensory Needs Annual Consultation**

- To establish the issues for disabled people in accessing primary care services and their recommendations on how services could be improved to meet their needs.
- **Consultation on Mental Health Partnership Strategy 2010-2013**
 - To obtain users' feedback to inform a three year strategy for mental health and mental healthcare in Westminster. The Mental Health Partnership Strategy 2010 –2013 established the key priorities for mental health and mental healthcare in Westminster for the next three years.
- **Major Health Campaign 2010: Lifestyle Survey**
 - To gather information on residents' attitudes towards and behaviours in relation to smoking, alcohol, healthy eating and taking regular exercise.
- **Your Health Festival 2010 (A Festival of Health and Well Being)**
The aim was to:
 - Provide information to local residents about their own and their community's health
 - Signpost to local health services and provide tailored healthy lifestyle advice
 - Improve health literacy in local residents through engagement activities and opportunities for self-care
 - Gather feedback from residents/service users about their local services and needs
 - Gather feedback from residents/service users about health and wellbeing priorities for Hammersmith & Fulham and GP consortia
 - Provide opportunities for the public to engage with commissioners to influence how services are provided.

The following examples illustrate the way in which the involvement of and engagement with stakeholders was used to shape services and support the PCTs in meeting its public equality duties under the Equality Act.

St Charles Centre for Health and Wellbeing in Kensington & Chelsea

The engagement activities involved local residents in the development of the St Charles Health and Wellbeing Centre through the major refurbishment of a wing of a Grade II listed Victorian hospital. The engagement involved:

- *Local residents*
- *Local voluntary and community organisations*
- *NHS Kensington & Chelsea*
- *Central London Community Healthcare PCT.*

Two patient/public representatives from the Local Involvement Network (LINK) were involved in the procurement of the new pharmacy on the site. They were supported by the community.

In the autumn of 2010, the centre was opened as a state-of-the-art primary care Centre with excellent GP surgeries, the largest renal dialysis unit in Europe, rehabilitation suites and other primary care services. St Charles has become an integral part of the local community with activities that complement current health and social services, voluntary services and surrounding businesses.

A community arts festival was held to celebrate the opening of the new Centre and to raise awareness of services available on site for local residents. Over 200 people attended the celebrations. There was also opportunity for local people to voice their thoughts on how the centre can be used for community services.

The BME Health Forum

The Black and Minority Ethnic (BME) Health Forum is a collaborative partnership network between statutory, voluntary and BME community organisations that aims to improve health and reduce inequalities for BME communities in Kensington & Chelsea and Westminster. The Forum aims both to empower communities to engage effectively in debate with the health services and to provide a conduit for statutory services to hear, understand and respond adequately to the health needs of BME communities. The BME Health Forum focuses both on the strategic policy issues and initiatives within the health services and on the grassroots health concerns of the diverse BME communities in the area.

Following consultations with local residents and its members, the BME Health Forum has prioritised the following areas of its work

- **Mental Health**
Mental Health continues to be a top priority for BME communities and therefore the Forum decided to begin a new project around mental health. A first step will be to look at the 2005 report 'Caught between stigma and inequality' and evaluate what has happened since recommendations were made on this topic five years ago.
- **Older people's health and wellbeing**
A number of organisations said that they would like to see the BME Health Forum do more work around older people's health and wellbeing. The Forum is therefore holding a quarterly meeting on this topic.

- **Cancer Screening**
The BME Health Forum is working with NHS Westminster to improve screening uptake for Arabic women.
- **Late Diagnosis**
The BME Health Forum is planning to develop a project around the issue of late diagnosis of BME communities for a variety of disorders including diabetes, cancer, cardiovascular disease and mental illness.

Diabetes Service Redesign - Hammersmith & Fulham PCT

The aim of the engagement activity was to involve service users in the service redesign of the diabetes service. Engagement involved working with 25 service users selected with different types of diabetes, from different geographical areas and to reflect diversity of the local communities, including those with complex conditions. Five service user representatives were trained to participate in the service redesign. The engagement also involved the diabetes clinical network and the Diabetes Partnership Board.

Patients made the decision about the new model of care together with other members of the service redesign group. There was also agreement on a patient care charter between service users and clinicians’.

Funding was secured from Collaboration for Leadership in Applied Health Research and Care (CLAHRC) to develop a peer education, champion and mentor programme to develop a team of 20 volunteers to extend support and education.

The PCTs funding for equality initiatives

The PCTs fund a number of organisations and initiatives to support work on equality. Working through and with these organisations allows PCTs unique access to people with the protected characteristics

The PCTs also fund the Westminster Equality Partnership to act as a critical friend. The Partnership maintains a database of equalities experts, made up of organisational and individual experts on the protected characteristics who are available to the PCT for consultation and feedback.

Through funding of equality initiatives and organisations, the PCTs are able to demonstrate one way in which they meet the public duties to eliminate discrimination, advance equality and promote good relations. Funding also supports engagement with a range of organisations and people with the protected characteristics. This informs equality analysis of policies and proposals for initiatives and services

Organisations commissioned to provide services that are targeted on people with the protected characteristics include:

Age

- Hammersmith & Fulham Circle run a project targeted at people over the age of 50 with the aim of reducing isolation. The Community Champions Project includes a child oral health project promoting oral health in White City where there are a large number of BME residents and is gathering insight from families of children between the ages of 0 and 12
- Opportunity For All is an HIV and sexual health peer led programme with Champions working with BME young people to promote testing and raise awareness about sexual health
- Hammersmith & Fulham Caring for Carers is a project for older African and African Caribbean People to promote mental wellbeing and reduce isolation
- My Time Active Boost Programme promotes healthy eating amongst families with children under 5 in five Children's Centre across Hammersmith & Fulham
- Banooda Aid Foundation promotes sexual health and raise awareness about local sexual health services for young people from the Somali Community
- Hammersmith & Fulham Urban Studies Centre for young people in schools and sixth form colleges runs healthy living events and promotes access to local primary care and community services.

Disability

- British Sign Language interpreters are commissioned through the London Borough of Hammersmith & Fulham
- Refurbishment of existing non Disability Discrimination Act compliant premises in Hammersmith & Fulham
- Expert Patient Programme with Hammersmith & Fulham Action on Disability (HAFAD)
- Primary care programmes to improve GP data collection relating to learning disabilities and promoting uptake of screening and early diagnosis amongst people with learning disabilities.

Gender Reassignment

- There is a lack of information about projects that currently address this equality strand.

Pregnancy and Maternity

- Family Nurse Partnerships Programme is a preventive programme for young first time mothers. It offers intensive and structured home visiting, delivered by specially trained nurses (Family Nurses), from early pregnancy until the child is two.

Race

- St Mary's Female Genital Mutilation (FGM) and Chelsea & Westminster FGM clinics work to promote awareness around FGM and provides support and treatment for women and families affected by it
- BME Health Forum
- Interpreting services are commissioned from GRIP and CITAS
- CITAS Health and Social Care Forum for interpreters and non-english speakers to raise awareness about local issues about access to services

- Hairdressing Project to promote uptake of breast screening by BME women
- Good Access in practice scheme, a joint initiative between BME community organisations and local GP practices to improve access and signposting to local primary care services
- Refugee Inclusion Service which is a project which provides one to one support, group work on improving access to GP services by Refugee communities. The project also delivers a Skilled for Health Programme
- Migrant and Refugee Communities Forum supports health and well being programmes and improve access by migrant and refugee communities
- Interpreting Guide for healthcare professionals to promote and increase uptake of interpreting services.
- Community Champions Project in White City which has been commended by the NHS Futures Forum
- Expert Patient Programme targeted at BME Communities (Polish, African and African-Caribbean, Bangladeshi)
- Mother tongue Health Trainer Service
- Improving Access To Psychological Therapies (IAPT) services have targeted bilingual counsellors to provide support in mother tongues.

Religion

- The PCTs across Inner North West London have developed very close working relationships with Faith organisations and places of worship to enable the delivery of health promotion and prevention programmes.
- Interfaith HIV Health events and activities

Gender

- Westminster PCT and Chelsea Football Club's Men's Health Project (which is soon to have a sister project with Hammersmith and Fulham PCT) aims to deliver targeted promotion and prevention campaigns to men
- CALM suicide prevention work in Westminster target young men
- Queens Park Rangers and Chelsea Football Clubs Health Checks targeting men
- Queens Park Rangers in the Community works with young men aged 13-19
- SLAM DIY Happiness Course is targeted at women
- Standing Together Against Domestic Violence
- Women only physical activities sessions in White City Leisure Centres.

Connecting Communities - Bringing people together to improve their health and well being and foster good relations between people

The BME Health Forum supports the Open Age Hubs. A Hub is an expanding network of community based activities for older people. They are part of a new approach to living for people aged over 50. This initiative illustrates one of the ways that PCTs meet the equality duty to foster good relations between people, whatever their background.

The Hubs link closely with other services such as:

- Information & advice services from Age Concern

- Outreach service from Octavia
- Open Age telephone activity
- Service (free calls) activities in groups over the phone.

Hammersmith & Fulham Circle is a social enterprise that receives some funds from the PCT. It has over 450 members aged over 50 years who organise around 150 different social events, and also meet up to share hobbies, skills and interests. Members can volunteer to be Neighbourhood Helpers, who carry out more than 400 jobs for members each year in exchange of tokens, which they can use to receive services from other members. This can include cat sitting, DIY, or teaching a fellow member how to sew.

BME Health Forum: <http://www.bmehf.org.uk/#>

Hammersmith & Fulham Circle: <http://hfcircle.org.uk/>

SECTION 4 – CONCLUSION

The PCTs are committed to mainstreaming equality into all aspects of their work as commissioners of services and as employers. As interim organisations, a major focus of their work will be to ensure that best practice is embedded into the commissioning process when responsibility for commissioning passes to the Clinical Commissioning Groups, National Commissioning Board and local authorities in April 2013.

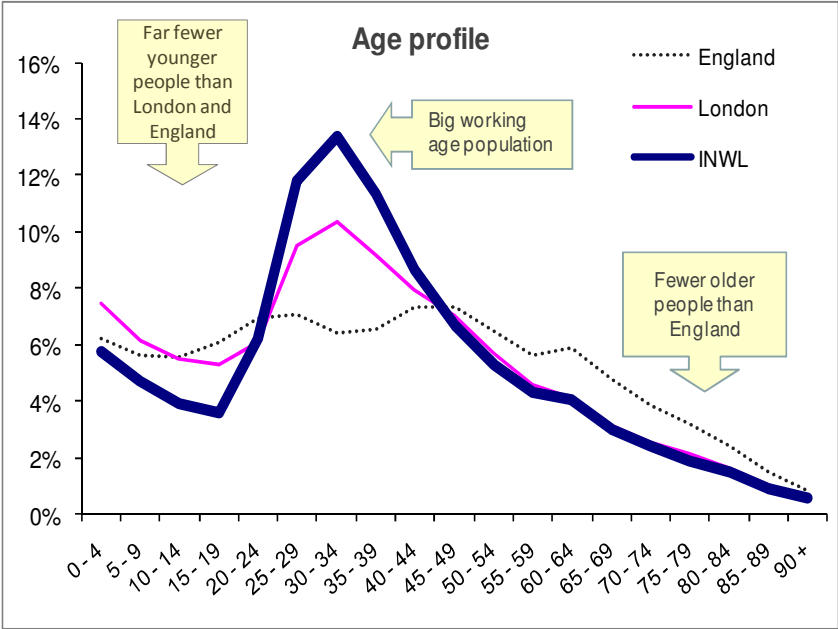
The PCTs will continue to participate in the development of their local Health and Wellbeing Boards that will become the forum where local commissioners across the NHS, public health and social care, elected representatives, and representatives of HealthWatch work together to deliver better the health and wellbeing outcomes for people in the area.

The PCTs have worked hard through the dedicated Engagement Team to ensure that they engage with and involve stakeholders, especially the end service users, in the development and implementation of important services. Engagement with stakeholders assists the PCTs in meeting the public duties by ensuring that policies and proposals at the design, development and implementation phases do not inadvertently discriminate against service users or staff, whether or not they are protected by the Equality Act. Engagement helps to advance equality and foster good relations by bringing stakeholders and all sections of the local communities together to improve the health of local people.

Work has, however, highlighted the need to engage better with transgender people and organisations to better obtain their input into the design, development, and implementation of services.

Although the PCTs have made good progress, areas have been identified for attention. This includes better data collection, both in terms of workforce monitoring, but also of commissioning and the uptake of commissioned services. Work is underway at local and national levels to improve monitoring systems. Work is being done at a national level to make changes to the appropriate data sets to ensure that information/data related the protected characteristics is able to be captured and used to facilitate the analysis of service provision. This work will also include reviewing the capturing and monitoring of data related to the workforce, patient and staff surveys.

Appendix A: Profile of Protected Characteristic groups

	Age
<p>Background</p>	<p>Like the rest of Inner London, the area covered by the three PCTs is dominated by a large working age population (particularly people in their late twenties to early forties). All three PCTs have a smaller proportion of children and young people, and Hammersmith & Fulham in particular has a smaller proportion of older people. The area has an unusually high proportion of older people living alone, many in private rented or social housing.</p>  <p>Age profile</p> <p>The graph displays the percentage of the population in various age groups for three regions: England (dotted line), London (pink line), and INWL (dark blue line). The x-axis represents age groups from 0-4 to 90+, and the y-axis represents the percentage from 0% to 16%. Key observations include:</p> <ul style="list-style-type: none"> Far fewer younger people than London and England: INWL and London have a lower percentage of children and young people (0-24) compared to England. Big working age population: INWL and London show a significant peak in the 35-39 age group, reaching approximately 13.5%. Fewer older people than England: INWL and London have a lower percentage of people aged 65 and over compared to England.
<p>Health status</p>	<p>Locally and nationally, age is associated with poorer health and chronic disease, as well as greater levels of disability. Depression is relatively common but sometimes undiagnosed among older people, and the high proportion of older people living alone locally may impact on social isolation. The nature of some of the local housing stock also creates challenges of access for disabled older people, as adaptations to properties may be difficult because of planning restrictions.</p>
<p>Healthcare access and quality</p>	<p>Nationally and locally, older people are less likely to be accessing psychological therapies services for mental health problems. Nationally, they are also less likely to experience dignity and respect in hospital settings. Nationally, six out of 10 older people are at risk of becoming malnourished, or of their situation getting worse, while they are in hospital. Younger people both nationally and locally are more likely to use A&E</p>

rather than go to their GP, and younger women are less likely to attend cervical screening than older women. Locally, Kensington & Chelsea smoking cessation services have a poorer uptake among young groups than older groups, whereas Westminster has poorer uptake among older groups.

Disability																													
Background	<p>The number of disabled people, whilst generally lower in Inner North West London as a whole compared to national averages, still represents a substantial proportion of the population. The number of older disabled people is also likely to rise dramatically in the future due to improved life expectancy and the ageing of the post war baby boom generation.</p> <p>The 2001 Census also identifies working age disabled people as being much more common in areas of social housing and deprivation. Improved life expectancy at birth and better hospital care for disabled children means there is likely to be an increase in the numbers of disabled people with complex needs living into adulthood.</p> <table border="1"> <thead> <tr> <th></th> <th>H&F</th> <th>K&C</th> <th>Westminster</th> </tr> </thead> <tbody> <tr> <td>Limiting long-term illness (LLTI) (2001 Census)</td> <td>23,500</td> <td>21,000</td> <td>26,000</td> </tr> <tr> <td>Working age disability (couldn't work) (2001 Census)</td> <td>6,100</td> <td>5,000</td> <td>6,900</td> </tr> <tr> <td>Mobility impairment (estimate)</td> <td>2,500</td> <td>3,400</td> <td>4,000</td> </tr> <tr> <td>Registered for hearing impairment</td> <td>350</td> <td>295</td> <td>610</td> </tr> <tr> <td>Registered for visual impairment</td> <td>850</td> <td>940</td> <td>1,350</td> </tr> <tr> <td>Learning disability (GP registers)</td> <td>322</td> <td>304</td> <td>485</td> </tr> </tbody> </table>		H&F	K&C	Westminster	Limiting long-term illness (LLTI) (2001 Census)	23,500	21,000	26,000	Working age disability (couldn't work) (2001 Census)	6,100	5,000	6,900	Mobility impairment (estimate)	2,500	3,400	4,000	Registered for hearing impairment	350	295	610	Registered for visual impairment	850	940	1,350	Learning disability (GP registers)	322	304	485
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Health status	<p>Nationally, mental health has been identified as one of the primary causes of disability. Those with chronic physical diseases are also likely to have a common mental illness. Locally, there are very high rates of working-age incapacity benefit for mental health reasons in some wards in the boroughs, primarily in areas of deprivation (as well as much higher prevalence of severe and enduring mental illness). Nationally, learning disability is associated with low life expectancy and high rates of obesity and heart conditions.</p>																												

	<p>Young people with learning difficulties and disabilities nationally are also twice as likely to be unemployed or not in education or training than young people in general, which has a significant impact on health and well-being of these groups.</p>
<p>Healthcare access and quality</p>	<p>There are limitations in the understanding of health and service outcomes for disabled people, as data is not collected routinely across all services. There are challenges generally around providing accessibility for those with a physical impairment in the local primary care estate, given restrictions on adapting premises due to planning rules. These also impact on feasibility of adaptations and home care for those with a physical impairment.</p> <p>Locally analysis has identified lower rates of screening and health checks for the people with learning disabilities, in line with findings nationally. There are low numbers locally on hearing and sight registers, compared to their likely number in the population.</p> <p>Locally, groups who are sick/ disabled or unable to work are less likely to successfully quit with smoking cessation services than those who work.</p>

	<p>Gender Re-assignment</p>
<p>Background</p>	<p>The numbers for transgender and gender reassignment are not known locally. Nationally, around 1,500 people aged over 15 years present for treatment for gender dysphoria per year. There is also rapid growth (15% per year) in the number of people, of all ages, who are seeking medical treatment for profound and persistent gender dysphoria.</p>
<p>Health status</p>	<p>The national Engendered Penalties report found transgender people experience high levels of bullying and hate crime including physical and sexual abuse. 34% of transgender adults reporting at least one suicide attempt (Gender Identity Research and Education Society 2009).</p>
<p>Healthcare access and quality</p>	<p>Nationally, there is a lack of availability of counselling for transgender people – only 10% of transgender people seeking professional medical help obtain counselling outside the typical pathways via their GP. Counselling for family members of transgender people is not provided by the gender identity clinics. Treatment to suspend puberty is not available in the UK.</p>

Marriage and Civil Partnership	
Background	In 2001, 40 per cent of all households in Inner North West London were populated by married or cohabiting couples, which is lower than average. In many cases (e.g. mental health), married men have a more favourable health status than men who are not married. Since November 2005 when the Civil Partnership Act 2004 was implemented, there have been civil partnerships.

Pregnancy and maternity	
Background	Inner North West London has a higher proportion of older mothers and fewer young mothers. Private births are very common. NHS contact with expectant and new mothers is generally through health visiting services, and hospital abortion and maternity services.

Race, ethnicity and nationality																																				
Background	<p>Inner North West London is both ethnically and culturally diverse. The 'White other' ethnic group is a large group in all three boroughs. In Kensington & Chelsea and Westminster, there are large proportions of residents from the 'Other ethnic' or 'Mixed' groups.</p> <table border="1"> <thead> <tr> <th></th> <th>H&F</th> <th>K&C</th> <th>West</th> <th>London</th> </tr> </thead> <tbody> <tr> <td>White British</td> <td>58%</td> <td>50%</td> <td>49%</td> <td>60%</td> </tr> <tr> <td>White Other</td> <td>20%</td> <td>29%</td> <td>25%</td> <td>11%</td> </tr> <tr> <td>Black</td> <td>11%</td> <td>7%</td> <td>7%</td> <td>11%</td> </tr> <tr> <td>Asian</td> <td>4%</td> <td>5%</td> <td>9%</td> <td>12%</td> </tr> <tr> <td>Other/ Mixed</td> <td>7%</td> <td>10%</td> <td>10%</td> <td>6%</td> </tr> <tr> <td>BME</td> <td>22%</td> <td>21%</td> <td>26%</td> <td>29%</td> </tr> </tbody> </table> <p>These categories generally mask a range of different nationalities, some generally affluent (e.g. North Americans, Australians, and Western Europeans) and some more vulnerable. These include:</p> <p>Hammersmith & Fulham - Poland, Somalia, Caribbean countries, Philippines, Iran, Iraq</p> <p>Kensington & Chelsea - Middle East and North Africa (e.g. Morocco), Philippines, Travellers</p> <p>Westminster: Middle East (e.g. Iraq) and N Africa, Bangladesh.</p>		H&F	K&C	West	London	White British	58%	50%	49%	60%	White Other	20%	29%	25%	11%	Black	11%	7%	7%	11%	Asian	4%	5%	9%	12%	Other/ Mixed	7%	10%	10%	6%	BME	22%	21%	26%	29%
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<p>Health status</p>	<p>National findings identify poorer health and life expectancy for some groups such as those from Pakistani or Bangladeshi backgrounds. Those from Asian or Black ethnic groups tend to have a greater susceptibility to diabetes and CHD in particular. Infant mortality nationally is poorer for black and Asian groups. Nationally, those from some Asian background also have lower levels of physical activity. Higher rates of smoking (among men), as has been evidenced locally among some other groups such as Eastern Europeans.</p> <p>Local intelligence via the 2001 Census allows a relatively detailed understanding of health status by ethnic group and has identified a strong association between ethnicity, deprivation, and poorer levels of self-reported health.</p>
<p>Healthcare access and quality</p>	<p>National data has consistently shown that BME groups disproportionately use emergency services over routine/ GP services and some experience of challenges communicating with health professionals. Gypsies & travellers have also been found to be more likely to use emergency services over routine services. Local analysis has identified high 'Did not attend' rates among some ethnic groups for hospital services. Nationally, Black groups have been found to be more likely to be detained under mental health act and those from the black ethnic group are over over-represented among inpatient psychiatric admissions in all three boroughs. There are also differences in the incidence of cancer and cancer survival rates between different ethnic groups, although deprivation may be a causal factor in this.</p>

Religion and Belief																									
Background	<p>In the 2001 Census, six out of 10 people in Inner North West London classified themselves as Christian, compared to seven out of 10 nationally. Around one in 10 were Muslim, similar to London and three times higher than nationally (local data suggests the number of Muslims may have risen over the decade since the Census). 16% stated they had 'no religion' and a further 9% did not state a religion. The breakdown of religion across the three PCTs is relatively similar.</p> <div style="text-align: center;"> <table border="1" style="margin: 10px auto;"> <caption>Religion Breakdown Data</caption> <thead> <tr> <th>Religion</th> <th>Count</th> <th>Percentage</th> </tr> </thead> <tbody> <tr> <td>Christian</td> <td>303,000</td> <td>60%</td> </tr> <tr> <td>No religion/Not stated</td> <td>127,400</td> <td>25%</td> </tr> <tr> <td>Muslim</td> <td>46,000</td> <td>9%</td> </tr> <tr> <td>Jewish</td> <td>12,600</td> <td>3%</td> </tr> <tr> <td>Hindu</td> <td>6,900</td> <td>1%</td> </tr> <tr> <td>Buddhist</td> <td>5,500</td> <td>1%</td> </tr> <tr> <td>Other</td> <td>3,600</td> <td>1%</td> </tr> </tbody> </table> </div>	Religion	Count	Percentage	Christian	303,000	60%	No religion/Not stated	127,400	25%	Muslim	46,000	9%	Jewish	12,600	3%	Hindu	6,900	1%	Buddhist	5,500	1%	Other	3,600	1%
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Health status	<p>Understanding of health by religion has been shaped locally by the 2001 Census, although religion is 'confounded' by other factors which also influence health, primarily poverty and deprivation. Data identifies Muslim groups as having worse health than average.</p>																								
Healthcare access and quality	<p>Both nationally and locally, services aim to offer culturally appropriate services to local patients. Understanding of access by religion and faith is sometimes hindered by a lack of service data and is therefore limited to one-off surveys for instance. In some faith schools issues have arisen around sex and relationship education and around provision of HPV vaccine (which protects against cervical cancer).</p>																								

Gender																					
Background	<p>Inner North West London has a similar gender split to elsewhere. However, because women live longer than men, there are a greater proportion of older women than older men.</p> <table border="1"> <thead> <tr> <th></th> <th>H&F</th> <th>K&C</th> <th>West</th> </tr> </thead> <tbody> <tr> <td>Men all ages</td> <td>48%</td> <td>48%</td> <td>48%</td> </tr> <tr> <td>Women all ages</td> <td>52%</td> <td>52%</td> <td>52%</td> </tr> </tbody> </table> <table border="1"> <tbody> <tr> <td>Men over 75</td> <td>39%</td> <td>41%</td> <td>43%</td> </tr> <tr> <td>Women over 75</td> <td>61%</td> <td>59%</td> <td>57%</td> </tr> </tbody> </table>		H&F	K&C	West	Men all ages	48%	48%	48%	Women all ages	52%	52%	52%	Men over 75	39%	41%	43%	Women over 75	61%	59%	57%
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Health status	<p>Both nationally and locally, men are associated with a shorter life expectancy, higher levels of smoking, lower levels of fruit and vegetable consumption, a higher suicide rate, and higher levels of alcohol and substance misuse. Boys have higher levels of Autism and Attention Deficit Hyperactivity Disorder.</p> <p>Women are almost twice as likely as men to develop arthritis and rheumatism and are associated with higher levels of common mental illness, lower levels of physical activity and are more likely to be the subject of domestic violence than men.</p>																				
Healthcare access and quality	<p>Nationally, there tends to be lower use of GP services by men, as well as late presentation and diagnosis of cancer.</p>																				

Sexual Orientation	
Background	Little data is gathered around sexual orientation in the three PCTs. According to Stonewall, the size of the lesbian and gay population in the country may be in the region of 5-7% of the population. The Inner North West London area has among the highest rates in the country for HIV transmitted through sex between men, with very high rates in Soho and Earl's Court in particular, suggesting the gay population may be larger in these areas than elsewhere.
Health status	Nationally, lesbian, gay, bisexual and transgender (LGBT) groups are more likely to experience mental health problems and self-harm, as well as being more likely to engage in lifestyles harmful to health, such as drinking, smoking, and drug use. Locally, the area is noted for a higher than average level of sexually transmitted diseases and a very high level of HIV transmission via sex between men.
Healthcare access and quality	Nationally, issues have been highlighted around a lack of trust and/or understanding between LGBT groups and health professionals. National research has shown that four out of 10 gay men have not disclosed their sexuality to their GP. Local knowledge is restricted as data is not routinely collected around sexual orientation

Appendix B: Employment Data

Ethnic Origin	Hammersmith & Fulham	Kensington & Chelsea	Westminster
A White - British	29	66	114
B White - Irish	*	9	6
C White - Any other White background	*	16	19
D Mixed - White & Black Caribbean	*	*	*
E Mixed - White & Black African	*	*	*
F Mixed - White & Asian	*	*	*
G Mixed - Any other mixed background	*	*	*
H Asian or Asian British - Indian	7	12	11
J Asian or Asian British - Pakistani	*	5	8
K Asian or Asian British - Bangladeshi	*	*	*
L Asian or Asian British - Any other Asian background	*	6	7
M Black or Black British - Caribbean	*	26	9
N Black or Black British - African	*	16	10
P Black or Black British - Any other Black background	*	4	*
R Chinese	*	*	6
S Any Other Ethnic Group	*	4	*
Undefined	4	35	*
Z Not Stated	*	14	*
Grand Total	57	223	208
<i>%age Undefined</i>	<i>7%</i>	<i>16%</i>	<i>1%</i>

Status	H&F	K&C	Westminster
Civil Partnership	*	*	5
Divorced	*	4	7
Legally Separated	*	*	*
Married	28	39	76
Single	19	58	77
Unknown	9	119	41
Widowed	*	*	*
Grand Total	57	223	208
<i>%age Undefined</i>	<i>16%</i>	<i>53%</i>	<i>20%</i>

Age Band	H&F	K&C	Westminster
16-24	*	13.0	*
25-29	5.0	23.0	29.0
30-34	9.0	28.0	35.0
35-39	9.0	28.0	34.0
40-44	8.0	28.0	32.0
45-49	13.0	40.0	33.0
50-54	8.0	26.0	20.0
55-59	*	21.0	10.0
60-64	*	12.0	8.0
>65	*	4.0	5.0
Grand Total	57.0	223.0	208.0

Disability	H&F	K&C	Westminster
No	45.0	76.0	40.0
Undefined	11.0	147.0	166.0
Yes	*	*	*
Grand Total	57.0	223.0	208.0
%age Undefined	19%	66%	80%

Sexuality	H&F	K&C	Westminster
Bisexual	*	*	*
Gay	*	*	*
Heterosexual	34.0	87.0	77.0
I do not wish to disclose my sexual orientation	13.0	15.0	22.0
Lesbian	*	*	*
Undefined	10.0	117.0	105.0
Grand Total	57.0	223.0	208.0
%age Undefined	18%	52%	50%

Religious Belief	H&F	K&C	Westminster
Atheism	4	6	11
Buddhism	*	*	*
Christianity	14	61	55
Hinduism	*	7	5
I do not wish to disclose my religion/belief	16	12	25
Islam	5	9	8
Jainism	*	*	*
Judaism	*	*	4
Other	5	4	9
Sikhism	*	*	*
Undefined	10	116	89
Grand Total	57	223	208
%age Undefined	18%	52%	43%

Gender	H&F	K&C	Westminster
Female	34.0	115.0	127.0
Male	23.0	108.0	81.0
Grand Total	57.0	223.0	208.0

Maternity Leave	H&F	K&C	Westminster
FALSE	54.0	222.0	206.0
TRUE	3.0	1.0	2.0
Grand Total	57.0	223.0	208.0

Small numbers have been replaced by * to avoid the identification of individuals.