Equality Impact Analysis to enable informed decisions

The purpose of this document is to:-

I. help decision makers fulfil their duties under the Equality Act 2010 and
II. for you to evidence the positive and adverse impacts of the proposed change on people with protected characteristics and ways to mitigate or eliminate any adverse impacts.

Using this form

This form must be updated and reviewed as your evidence on a proposal for a project/service change/policy/commissioning of a service or decommissioning of a service evolves taking into account any consultation feedback, significant changes to the proposals and data to support impacts of proposed changes. The key findings of the most up to date version of the Equality Impact Analysis must be explained in the report to the decision maker and the Equality Impact Analysis must be attached to the decision making report.

****Please make sure you read the information below so that you understand what is required under the Equality Act 2010****

Equality Act 2010

The Equality Act 2010 applies to both our workforce and our customers. Under the Equality Act 2010, decision makers are under a personal duty, to have due (that is proportionate) regard to the need to protect and promote the interests of persons with protected characteristics.

Protected characteristics

The protected characteristics under the Act are: age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation.

Section 149 of the Equality Act 2010

Section 149 requires a public authority to have due regard to the need to:

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

The purpose of Section 149 is to get decision makers to consider the impact their decisions may or will have on those with protected characteristics and by evidencing the impacts on people with protected characteristics decision makers should be able to demonstrate 'due regard'.

Decision makers duty under the Act
Having had careful regard to the Equality Impact Analysis, and also the consultation responses, decision makers are under a personal duty to have due regard to the need to protect and promote the interests of persons with protected characteristics (see above) and to:-

(i) consider and analyse how the decision is likely to affect those with protected characteristics, in practical terms,
(ii) remove any unlawful discrimination, harassment, victimisation and other prohibited conduct,
(iii) consider whether practical steps should be taken to mitigate or avoid any adverse consequences that the decision is likely to have, for persons with protected characteristics and, indeed, to consider whether the decision should not be taken at all, in the interests of persons with protected characteristics,
(iv) consider whether steps should be taken to advance equality, foster good relations and generally promote the interests of persons with protected characteristics, either by varying the recommended decision or by taking some other decision.

Conducting an Impact Analysis

The Equality Impact Analysis is a process to identify the impact or likely impact a project, proposed service change, commissioning, decommissioning or policy will have on people with protected characteristics listed above. It should be considered at the beginning of the decision making process.

The Lead Officer responsibility
This is the person writing the report for the decision maker. It is the responsibility of the Lead Officer to make sure that the Equality Impact Analysis is robust and proportionate to the decision being taken.

Summary of findings
You must provide a clear and concise summary of the key findings of this Equality Impact Analysis in the decision making report and attach this Equality Impact Analysis to the report.

Impact – definition

An impact is an intentional or unintentional lasting consequence or significant change to people's lives brought about by an action or series of actions.

How much detail to include?
The Equality Impact Analysis should be proportionate to the impact of proposed change. In deciding this asking simple questions “Who might be affected by this decision?” "Which protected characteristics might be affected?" and “How might they be affected?” will help you consider the extent to which you already have evidence, information and data, and where there are gaps that you will need to explore. Ensure the source and date of any existing data is referenced.
You must consider both obvious and any less obvious impacts. Engaging with people with the protected characteristics will help you to identify less obvious impacts as these groups share their perspectives with you.

A given proposal may have a positive impact on one or more protected characteristics and have an adverse impact on others. You must capture these differences in this form to help decision makers to arrive at a view as to where the balance of advantage or disadvantage lies. If an adverse impact is unavoidable then it must be clearly justified and recorded as such, with an explanation as to why no steps can be taken to avoid the impact. Consequences must be included.

Proposals for more than one option If more than one option is being proposed you must ensure that the Equality Impact Analysis covers all options. Depending on the circumstances, it may be more appropriate to complete an Equality Impact Analysis for each option.

The information you provide in this form must be sufficient to allow the decision maker to fulfil their role as above. You must include the latest version of the Equality Impact Analysis with the report to the decision maker. Please be aware that the information in this form must be able to stand up to legal challenge.

Background Information

Title of the policy / project / service being considered	Re-procurement of the stop smoking service	**Person / people completing analysis**	Rosalind Watson
Service Area	Health Improvement, Public Health	**Lead Officer**	Philip Garner
Who is the decision maker?	Glen Garrod	**How was the Equality Impact Analysis undertaken?**	Desk Based – review of 2016/17 user data and National data.
Date of meeting when decision will be made	01/11/2017	**Version control**	0.3
Is this proposed change to an existing policy/service/project or is it new?	Existing policy/service/project	**LCC directly delivered, commissioned, re-commissioned or de-commissioned?**	Commissioned
Describe the proposed change	Re-procure Lincolnshire's stop smoking service – Contract length proposed 5 +2 years starting from 1st April 2018. The service will be available countywide to adults and young people 12+ with a particularly focus on Pregnant smokers, smokers with serious mental health issues (SMI's) and smokers with long term medical conditions or planned surgical procedures. The service will be enhanced to provide direct supply of nicotine replacement therapy (NRT); and have a Patient Group Directive (PGD) in place to enable the provision of Champix to clients.		

Evidencing the impacts

In this section you will explain the difference that proposed changes are likely to make on people with protected characteristics.
To help you do this first consider the impacts the proposed changes may have on people without protected characteristics before then considering the impacts the proposed changes may have on people with protected characteristics.

You must evidence here who will benefit and how they will benefit. If there are no benefits that you can identify please state 'No perceived benefit' under the relevant protected characteristic. You can add sub categories under the protected characteristics to make clear the impacts. For example under Age you may have considered the impact on 0-5 year olds or people aged 65 and over, under Race you may have considered Eastern European migrants, under Sex you may have considered specific impacts on men.

Data to support impacts of proposed changes

When considering the equality impact of a decision it is important to know who the people are that will be affected by any change.

Population data and the Joint Strategic Needs Assessment

The Lincolnshire Research Observatory (LRO) holds a range of population data by the protected characteristics. This can help put a decision into context. Visit the LRO website and its population theme page by following this link: http://www.research-lincs.org.uk If you cannot find what you are looking for, or need more information, please contact the LRO team. You will also find information about the Joint Strategic Needs Assessment on the LRO website.

Workforce profiles

You can obtain information by many of the protected characteristics for the Council's workforce and comparisons with the labour market on the Council's website. As of 1st April 2015, managers can obtain workforce profile data by the protected characteristics for their specific areas using Agresso.

Positive impacts
The proposed change may have the following positive impacts on persons with protected characteristics – If no positive impact, please state *'no positive impact'.*

Age

Evidence:

Smoking rates vary with age with over 80% of smokers beginning to smoke when they are under 18. The rate of smoking drops in the oldest age groups due to the impact of smoking related diseases and smokers die earlier than non-smokers on average.
Parents that smoke increase the likelihood of their children starting to smoke.

In 16/17 the Lincolnshire service had 4,788 people setting a quit date spread across the age ranges, the largest proportion 1,443 coming from the 45 – 59 age range, with 1,285 coming from 18 – 34 year olds.

The World Health Organisation report that people of all ages who have already developed smoking-related health problems can still benefit from quitting.

Benefits in comparison with those who continued to smoke:

- At about 30: gain almost 10 years of life expectancy.
- At about 40: gain 9 years of life expectancy.
- At about 50: gain 6 years of life expectancy.
- At about 60: gain 3 years of life expectancy.
- After the onset of life-threatening disease: rapid benefit, people who quit smoking after having a heart attack reduce their chances of having another heart attack by 50%.

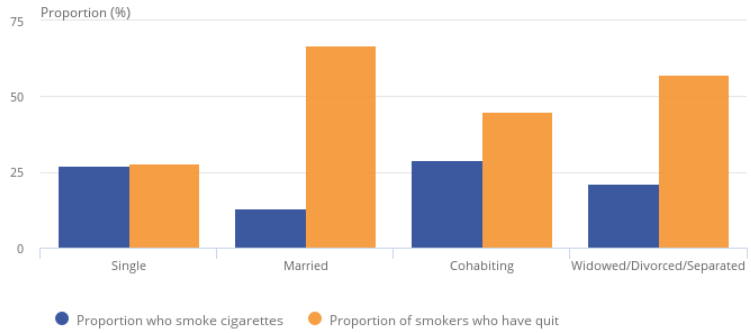
Lincolnshire Stop Smoking Service Data 2016/17 - Numbers setting a quit date and quit at 4 weeks by age and sex:

	Sex	All Ages	Under 18	18 - 34	35 - 44	45 - 59	60 and over
Number setting a quit date	Male	2,245	18	552	401	694	580
Number setting a quit date	Female	2,576	31	741	470	760	574
Total		**4,821**	**49**	**1,293**	**871**	**1,454**	**1,154**
Number quit at 4 weeks (self-report)	Male	1,113	4	205	185	381	338
Number quit at 4 weeks (self-report)	Female	1,199	8	302	201	390	298
Total		**2,312**	**12**	**507**	**386**	**771**	**636**

	Impact: Positive impact on number of life years saved by those people who maintain their quit attempt long term.
Disability	**Evidence:** Smoking causes a wide range of diseases. Some of these long term conditions lead to disability e.g. loss of limbs due to peripheral vascular disease; diminished lung capacity due to COPD. Low birth weight due to smoking is linked to both learning disability and physical disability. People with mild to moderate learning disability and low risk perception who smoke are less likely to quit without support, leading to a shorter life expectancy. People with mental health problems especially those with drug and alcohol problems are more likely to smoke than the general population and need more support to help them quit. Smokers with a serious mental health issue (SMI) are likely to die between 10 – 20 years earlier than a smoker without a mental health issues. Smoking rates are higher in people with HIV and smoking further depresses their immune system. **Figures for Lincolnshire in 2016/17 358 sick/disabled and unable to return to work smokers set a quit date, with 161 of these reaching a 4 week quit outcome.** **Impact:** Positive impact on the quality of life for those people who maintain their quit attempt. In addition people with SMI's on psychotropic medication such as Schizophrenia could see their medication dosage reduced once they come off tobacco, as drugs are no longer being suppressed.
Gender reassignment	**Evidence:** Evidence suggests that smoking rates are higher among lesbian, gay, bisexual and trans (LGB&T) people than among other communities. The reasons why LGB&T people smoke may be different from the reasons why other people smoke and so the necessary motivations for stopping smoking may also be different. Some LGB&T people will feel less comfortable accessing generic smoking cessation services. **Gender identity related surgeries**: Gender transition surgery can often require individuals to give up smoking being that smoking is a significant risk factor during and after any surgery. Smokers are 38% more likely to die after surgery (Turan et al**,** 2011) and more likely to experience wound infection (Sørenson, 2012).)

	Whilst evidence on the efficacy of specialist outreach services for the LGBT communities is sparse, there is no reason not to believe that generic stop smoking services are less effective. However there is some rational in ensuring that stop smoking services offer support from specialist advisors who understand particularly the needs of this community; and that services should be delivered by organisations serving LGB&T communities to ensure that LGB&T people receive effective smoking cessation services in the community settings. **Impact:** Positive impact, whilst the current service will support clients from this community there is no evidence that any specialism is offered from the generic service and clinics.
Marriage and civil partnership	**Evidence:** The Office for National Statistics report that "*single people are more likely to be younger, with married people, cohabiters and those who are widowed, divorced or separated are more likely to be older. However when age was controlled for, unmarried people were almost twice as likely to be cigarette smokers as married people.* *Married smokers were more likely than other smokers to have quit, but it is not clear whether those who had quit had done so before or after marriage".*

Figure 7: Proportion who smoke cigarettes and proportion of smokers who have quit, by marital status, Great Britain, 2013



Source: Opinions and Lifestyle Survey - Office for National Statistics

Notes:

1. The group 'married' includes those in same-sex civil partnerships
2. The proportion of smokers who have quit is the proportion of all those who said that they have smoked cigarettes regularly, who do not currently smoke

There is no locally gathered information available to confirm if this pattern is replicated in Lincolnshire.

Impact:
Positive impact, the service will continue to support clients regardless of their marital status.

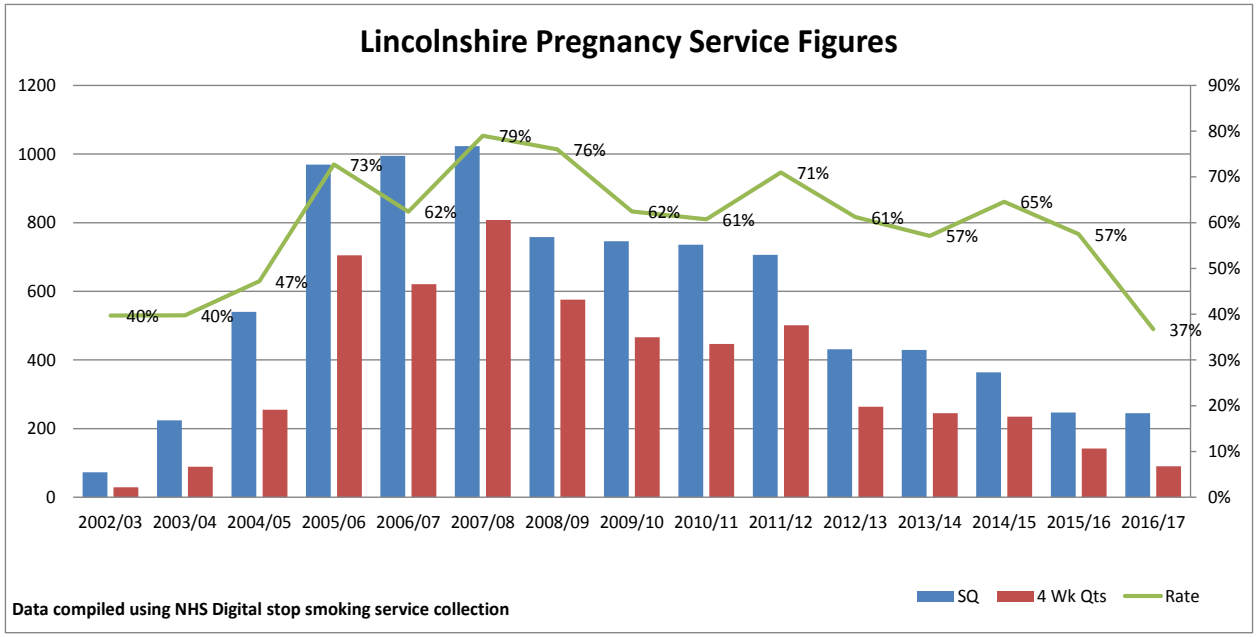
Pregnancy and maternity	**Evidence:** The Tobacco Advisory Group (TAG) of the Royal College of Physicians (RCP) reviewed the evidence available on the adverse effects of active and passive smoking amongst pregnant women. It states: 'Active maternal smoking causes up to 5,000 miscarriages, 300 perinatal deaths, 2,200 premature singleton births and 19,000 babies to be born with low birth weight in the UK each year these adverse effects are entirely avoidable. Tackling the issue of smoking in pregnancy is regarded as extremely important within Lincolnshire, so much so that it has been an area of focus in previous contracts and will continue to be a focus within the newly procured service.

Data collected in 2013/14 by United Lincolnshire Hospital Trust (ULHT) suggests that the smoking prevalence in pregnancy at booking is 18%, equating to approximately 1,300 women reducing to 15%, 1,080 at delivery, significantly higher than the England average of 11.4% and East Midlands average of 13.7%. However data collection issues have meant that the national reporting of smoking at time of delivery (SATOD), (the national indicator) for Lincolnshire is currently unreliable and has been estimated for the past two years.

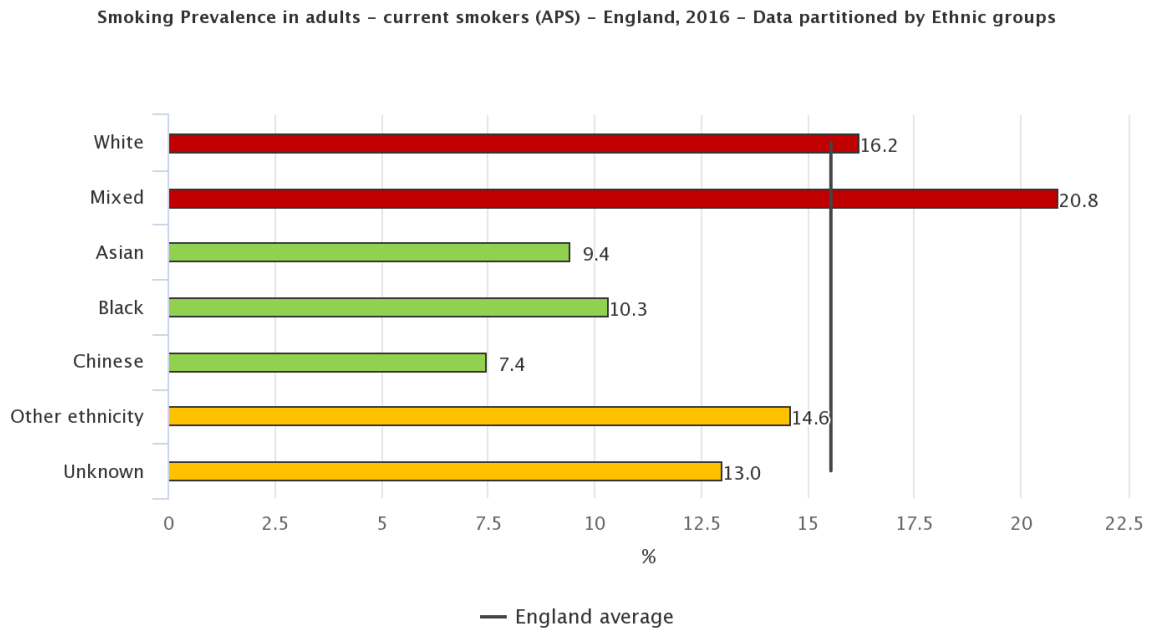
The Governments recently published (July 2017) Tobacco Control Plan – A Smokefree Generation, has a national ambition to reduce rates of smoking during pregnancy from 10.7% to 6% or less by 2022.

Work within ULHT midwifery department and the SSS has been reviewing existing validation and referral processes and developing systematic approaches to pathways between the services. It is planned that this work will continue over the remainder of the contract with Q51 and be part of the transition when the new provider is in place.

The table below tracks the pattern of engagement by pregnant women into the SSS over time, measured by set quit and 4 week quits. The table highlights how numbers coming into the service have diminished over the years and how the percentage quit rate has also fallen considerably.



	Impact: Positive impact on both the mother and child if stops smoking before conception or early in pregnancy. The longer the woman smokes during pregnancy the greater the risks for a healthy and normal weight baby.)
Race	**Evidence:** The ethnic profile of the smoking population has changed considerably in recent years as a consequence of migration from a number of countries with high smoking prevalence as well as continued increases in the 'mixed' ethnicity population which has traditionally had high smoking rates. Analysis of data from the Integrated Household Survey (2009-10 and 2011-12) and the GP Patient Survey (2012) indicated that among UK born groups, smoking prevalence is highest among 'White and Black African' men (36%) and 'White and Black Caribbean' women (37.5%). Among non-UK born men, prevalence is highest in the 'White and Black African' (31.9%) and Bangladeshi (31.5%) groups while for non-UK born women, rates are highest in the 'Other White' group (20.9%). Smoking prevalence is substantially higher among migrants from East European countries, Turkey and Greece, compared with most other non-UK born groups. Smoking rates are highest in the Gypsy or Irish Traveller group, 49% (of 162) and 46% (of 155) for males and females respectively. Lincolnshire is a rural county with much of its employment aligned to agriculture. Over the past several years migrant workers from across Europe have moved and later settled within the county with higher penetration in areas such as Boston, Spalding and South Holland. Smoking rates have remained high in these areas compared with other areas of the county but it is difficult to say with any confidence whether this is purely down to ethnicity. The table below shows the 2016 Public Health Profiles:

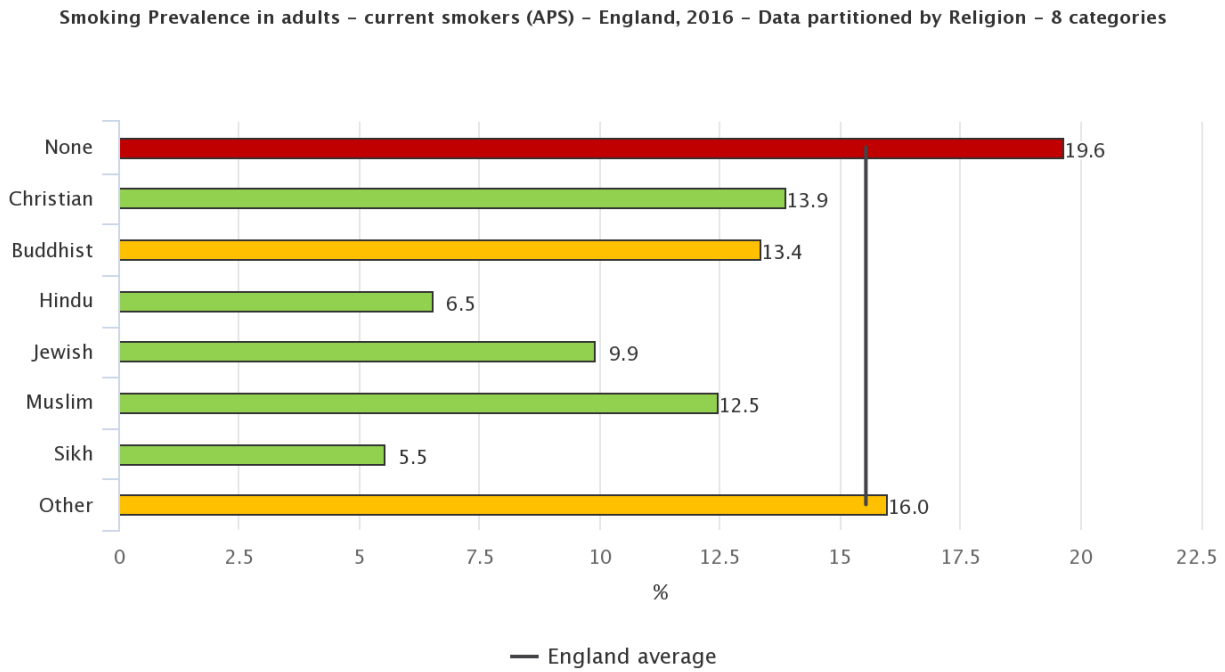


Across ethnic groups, rates are almost always higher in the UK born than non-UK born population with the notable exception of the 'Other White' group. In 2016/17, the majority (86%) of people setting a quit date with NHS Stop Smoking Services were 'White' (265,628). Among the ethnic minority groups, the 'Asian or Asian British' ethnic group had the largest number of people setting a quit date (13,038) and successfully quitting (self-reported) (7,268). The success rate of those giving up smoking was highest among the 'Asian or Asian British' group (56%) which is higher than the 'White' group (51%). The lowest quit rate amongst the ethnic minority groups was 'Mixed' at 46%.

Overall more women set a quit date through the services than men however, among most of the ethnic minority groups, the opposite was reported.

In 2016/17 the Lincolnshire stop smoking service had 2,312 people go through the service and set a quit date, the biggest proportion of these were 'White British' (88%) followed by 'Other White' at (0.07%). Other ethnicities were very small numbers (below 10). More work needs to be done to engage with ethnic smokers to help them quit smoking.

Impact:
Positive impact as the service will continue to support clients regardless of their race. Although the offer may need to be more focused towards identifying the barriers experienced for ethnic groups accessing the service.

Religion or belief	**Evidence:** Local evidence is not available at time of writing however nationally Lincolnshire smoking prevalence by religion is reported through the Public Health Profiles and shown in the table below:  **Impact:** Positive impact as the service supports all smokers that seek help to quit regardless of their religion or belief.
Sex	**Evidence:** Results of the Annual Population Survey (APS) for England 2016 show that the prevalence of cigarette smoking is higher for men (17.7%) than women (14.1%) however a higher proportion of women 61.4% quit smoking in 2016 than men 60.7%. **Stop Smoking Service Data 2016/17 - Numbers setting a quit date and quit at 4 weeks by age and sex:**

	Sex	All Ages	Under 18	18 - 34	35 - 44	45 - 59	60 and over
Number setting a quit date	Male	2,245	18	552	401	694	580
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Number quit at 4 weeks (self-report)	Male	1,113	4	205	185	381	338
Number quit at 4 weeks (self-report)	Female	1,199	8	302	201	390	298
Total		**2,312**	**12**	**507**	**386**	**771**	**636**

Impact:

Positive impact with numbers in Lincolnshire following a similar pattern to national figures: 52% of females quit at 4 weeks compared to 48% of males.

Sexual orientation

Evidence

National data taken from the Integrated Household Survey for 2014 shows that lesbian and gay people are much more likely to smoke than the general population (Gay /Lesbian smoking prevalence 25.3% v Heterosexual 18.4%).

Whilst there is a lack of research on smoking among bisexual and trans people, surveys do show both bisexual and trans people are more likely to smoke (Stonewall, 2012; Rooney, 2012).

Young LGB people are also more likely to smoke, to start smoking at a younger age and smoke more heavily (Corlissetal, 2013).

Mental Health: LGBT people are more likely to suffer from mental ill health. Smoking cessation is associated with reduced depression and improved quality of life (Taylor et al, 2014).

HIV: Men who have sex with men (MSM) are most at risk of acquiring HIV in the UK (PHE, 2014). As many as 47% of HIV positive men smoke. (Hickson et al, 2005).
HIV positive smokers are more likely to develop cancers of the lung, anus, mouth and throat. (Tirreli et al, 2000) and are more likely to suffer from respiratory disease (Diaz et al, 2000).

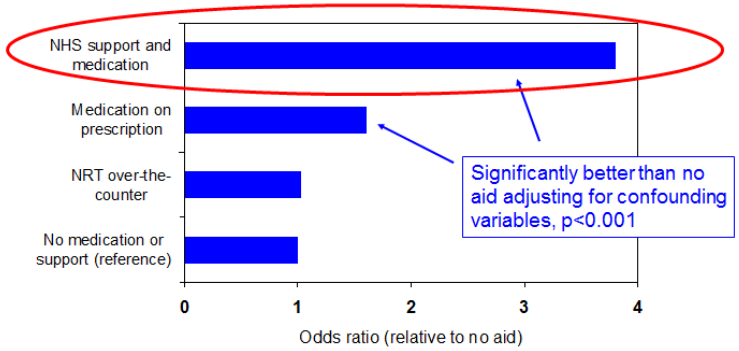
Whilst there is a lack of robust evidence to confirm the best approach to tackling the issue of smoking within the LGBT community, where studies have been undertaken the evidence suggests that current SS services are as effective within the LGBT community as with non-LGBT people. Therefore consideration should be focused on engagement of this community and offering support in settings that are already accessible and appropriate for LGBT communities.

	Impact: Positive impact as the service will continue to support clients regardless of their sexual orientation.

If you have identified positive impacts for other groups not specifically covered by the protected characteristics in the Equality Act 2010 you can include them here if it will help the decision maker to make an informed decision.

Socio economic status:

Smoking remains the biggest cause of premature mortality in England, accounting for around 80,000 deaths each year, approximately 1,200-1,300 in Lincolnshire. The evidence demonstrates the model of behavioural support with pharmacotherapy improves a smoker's chance of successfully quitting to 4 times greater than attempting to stop without additional support. See graph below:



Additional factors associated with higher smoking prevalence include living in a deprived area and lower socio economic status; smoking is a leading cause of health inequalities in England. There is an established and well-recognised socio economic gradient in smoking prevalence. For example in 2016 the APS reported that the proportion of people that smoke from routine and manual occupation was 24.9% compared to 10.9% among people in managerial and professional occupations.

Furthermore, unemployed people (35%) are almost twice as likely to smoke as those either in employment (19%) or economically inactive (16%) - for example, students or retired people. Data from the HSE 2013 indicate that the proportion of current smokers in the lowest two income quintiles was double the proportion in the highest income quintiles (36-40% for men in the lowest quintiles, 17-18% in the highest). Among women, prevalence was 22-30% in the lowest quintiles and 10-14% in the highest.

Geographical variation: There is also considerable variation in smoking prevalence between different regions in England (APS 2016-17) with an observable North/South

divide. Smoking prevalence in London (15.2%), the South East (14.6%) and the South West (13.9%) is significantly lower than the North East (17.2%), the North West (16.8%) and Yorkshire and The Humber (17.7%). The East Midlands (16.1%) and West Midlands (15.4%) sitting somewhere in between.

These geographical variations persist at local authority level with the most deprived areas having the highest proportion of current smokers. In 2016, Boston had the highest smoking prevalence rate in Lincolnshire (24.9%) whilst North Kesteven had the lowest at (11.1%). Regional prevalence rates range between 21.5% in Nottingham to 13.5% in Leicestershire. Lincolnshire prevalence is 17.7%.

Homeless people: The prevalence of smoking has been found to reach up to 96% among homeless people with smoking-related morbidity and mortality consequently very high in this population. Given the commonly poor engagement with general health services, access of free NHS Stop Smoking Services (SSS) is likely to be rare.

Refugees and asylum seekers: Asylum seekers and refugees are not a homogeneous group of people but it seems likely that smoking rates will be relatively high among certain national and/or ethnic groups. There are also likely to be barriers to refugees and asylum seekers accessing cessation support: these include inadequate information, particularly for new migrants unfamiliar with health care systems in England, insufficient support in interpreting and translating for people with limited English fluency, and confusion around entitlement to some types of services particularly among migrants with insecure immigration status.

Transient and travelling populations: Analysis of data from the Integrated Household Survey (2009-10 and 2011-12) and the GP Patient Survey (2012) indicated that smoking prevalence is substantially higher amongst migrants from East European countries, Turkey and Greece, compared with most other non-UK born groups. Smoking rates in the Gypsy or Irish Traveller group are very high, 49% (of 162) and 46% (of 155) for males and females respectively.

Adverse/negative impacts
You must evidence how people with protected characteristics will be adversely impacted and any proposed mitigation to reduce or eliminate adverse impacts. An adverse impact causes disadvantage or exclusion. If such an impact is identified please state how, as far as possible, it is justified; eliminated; minimised or counter balanced by other measures.
If there are no adverse impacts that you can identify please state 'No perceived adverse impact' under the relevant protected characteristic.

Negative impacts of the proposed change and practical steps to mitigate or avoid any adverse consequences on people with protected characteristics are detailed below. If you have not identified any mitigating action to reduce an adverse impact please state *'No mitigating action identified'*.

Age	No perceived adverse impact
Disability	No perceived adverse impact
Gender reassignment	No perceived adverse impact
Marriage and civil partnership	No perceived adverse impact
Pregnancy and maternity	No perceived adverse impact

Race	No perceived adverse impact
Religion or belief	No perceived adverse impact
Sex	No perceived adverse impact
Sexual orientation	No perceived adverse impact

If you have identified negative impacts for other groups not specifically covered by the protected characteristics under the Equality Act 2010 you can include them here if it will help the decision maker to make an informed decision.

Stakeholders

Stake holders are people or groups who may be directly affected (primary stakeholders) and indirectly affected (secondary stakeholders)

You must evidence here who you involved in gathering your evidence about benefits, adverse impacts and practical steps to mitigate or avoid any adverse consequences. You must be confident that any engagement was meaningful. The Community engagement team can help you to do this and you can contact them at consultation@lincolnshire.gov.uk

State clearly what (if any) consultation or engagement activity took place by stating who you involved when compiling this EIA under the protected characteristics. Include organisations you invited and organisations who attended, the date(s) they were involved and method of involvement i.e. Equality Impact Analysis workshop/email/telephone conversation/meeting/consultation. State clearly the objectives of the EIA consultation and findings from the EIA consultation under each of the protected characteristics. If you have not covered any of the protected characteristics please state the reasons why they were not consulted/engaged.

Objective(s) of the EIA consultation/engagement activity
To understand the impact that the Lincolnshire stop smoking service has on people who want to stop smoking.

Who was involved in the EIA consultation/engagement activity? Detail any findings identified by the protected characteristic

Age	This was a desk exercise and people from this protected characteristic have not been approached. It is our intention to test for impact within the first 6 to 12 months of new contract being in place.
Disability	This was a desk exercise and people from this protected characteristic have not been approached. It is our intention to test for impact within the first 6 to 12 months of new contract being in place.
Gender reassignment	This was a desk exercise and people from this protected characteristic have not been approached. It is our intention to test for impact within the first 6 to 12 months of new contract being in place.
Marriage and civil partnership	This was a desk exercise and people from this protected characteristic have not been approached. It is our intention to test for impact within the first 6 to 12 months of new contract being in place.
Pregnancy and maternity	This was a desk exercise and people from this protected characteristic have not been approached. It is our intention to test for impact within the first 6 to 12 months of new contract being in place.
Race	This was a desk exercise and people from this protected characteristic have not been approached. It is our intention to test for impact within the first 6 to 12 months of new contract being in place.
Religion or belief	This was a desk exercise and people from this protected characteristic have not been approached. It is our intention to test for impact within the first 6 to 12 months of new contract being in place.

Sex	This was a desk exercise and people from this protected characteristic have not been approached. It is our intention to test for impact within the first 6 to 12 months of new contract being in place.
Sexual orientation	This was a desk exercise and people from this protected characteristic have not been approached. It is our intention to test for impact within the first 6 to 12 months of new contract being in place.
Are you confident that everyone who should have been involved in producing this version of the Equality Impact Analysis has been involved in a meaningful way? The purpose is to make sure you have got the perspective of all the protected characteristics.	No as this was a desk exercise and people from this protected characteristic have not been approached. It is our intention to test for impact within the first 6 to 12 months of new contract being in place.
Once the changes have been implemented how will you undertake evaluation of the benefits and how effective the actions to reduce adverse impacts have been?	We will work with the Community Engagement team and the new provider to review the service and any impact on users. Any negative impacts will be identified and plans put in place to reverse this trend.

Further Details

Are you handling personal data?	No If yes, please give details.

Actions required Include any actions identified in this analysis for on-going monitoring of impacts.	**Action**	**Lead officer**	**Timescale**
	It is our intention to test for impact within the first 6 to 12 months of new contract being in place.	Ros Watson	By April 2019
Signed off by		**Date**	Click here to enter a date.