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	Integrated Lifestyle Service (ILS)	**Person / people completing analysis**	Sarah Chaudhary
Service Area	Public Health Division	**Lead Officer**	Robin Bellamy
Who is the decision maker?	Derek Ward in conjunction with Executive Councillor for Adult Care, Health and Children's Services	**How was the Equality Impact Analysis undertaken?**	Desk Based – review of latest JSNA and national data. Review of most recent related service data
Date of meeting when decision will be made	01/01/2019	**Version control**	0.2
Is this proposed change to an existing policy/service/project or is it new?	New	**LCC directly delivered, commissioned, re-commissioned or de-commissioned?**	Commissioned
Describe the proposed change	The Integrated Lifestyle support (ILS) service will provide high quality and accessible information and support to adults in Lincolnshire to help them adopt and maintain healthier lifestyles. It will focus on the four lifestyle behaviours that have the greatest impact on health and wellbeing: • Smoking of tobacco • Physical inactivity • Excess alcohol consumption, and • Food, Nutrition and a healthy weight The ILS will support adults who have unhealthy behaviours with information and digital and face-to-face support to enable behaviour change.		

	The service will provide a referral pathway for adult service users, primarily aged 40-74, who are identified as having a status "at risk" and with one or more unhealthy behaviours (smoking, obese, inactive, excessive alcohol consumption) following an NHS Health Check, social care assessment or other clinical referral(s): The service will target; • People with long-term health conditions, whose condition is made worse (or likely to be made worse) by unhealthy behaviours, these conditions include diabetes, CVD risk, liver disease, musculoskeletal conditions and coronary heart disease • At-risk adults who have undertaken a NHS Health Check for CVD Prevention. • People who are engaged with the NHS's health optimisation policy regarding the future requirement for support for smoking cessation and/or weight management • Carers being supported by LCC who may be obese, a smoker or inactive. • People who smoke and seek help to stop smoking, particularly pregnant women who smoke tobacco. • The Lincolnshire County Council workforce with any of the above.

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:** The service will be targeted at people aged 40 – 74, which is also the age range to which NHS Health Checks are available. NHS Health Checks will provide one of the main referral routes for the ILS. NHS Health Check uptake is highest for females aged 60 – 69 and lowest for those aged 40 – 44. For males the highest uptake is at 65-69 years and lowest at 40 – 44 years Smoking: within existing stop smoking services, during 2016 – 17, the largest proportion of people setting a quit date was amongst the 45 – 59 age range (1443); with 1285 coming from the 18-34 year old range. Benefits from quitting smoking for different age groups are as follows; • At 30, 10 years of life expectancy gained • At 40, 9 years of life expectancy gained • At 50, 6 years of life expectancy gained • At 60, 3 years of life expectancy gained • There is rapid benefit after the onset of life threatening disease; people who quit after having a heart attack reduce their chances of having another heart attack by 50% Physical Activity and Weight: long term conditions are positively correlated with age; physical inactivity (especially after 75) and obesity (until age 75) are also related to ageing. In 2014 – 15 the commissioned Weight Watchers services received the following referrals; • 34% aged 50 – 64 • 21% aged 40 – 49 • 19% aged 25-39 • 22% aged 65+ • 4% aged <25 59% of all referrals achieved a weight loss of 5% or above In 2015 – 16 the commissioned Exercise Referral scheme received the following referrals; • *850 – aged 40 - 49 • *840 – aged 50 -59 • *780 – aged 60 – 69

	• *520 - aged 30 – 39 • *490 – aged 18 – 29 • *400 – aged 70 – 79 • *50 – aged 80 – 89 There was a completion rate of 64% for all referrals. The highest completion rate was for those aged 60 – 69. Alcohol: the relationship between alcohol related harm and age is complex; the average age of people receiving alcohol treatment services is 42, the highest rate of hospital admission for alcohol related harm is amongst 35-44 year olds and people aged 55-64 are most likely to drink at a higher risk level; however, people under the age of 24 are more likely to binge drink. **Impact:** Smoking: the largest proportion of people setting quit dates within current stop smoking services is in the 45-59 age range. Successful quitters will gain an average of 3 – 9 years life expectancy; as this age group is within the population targeted by the ILS there is likely to be a positive impact. Weight and Physical Activity: positive impact in terms of weight loss and increased physical activity (and consequent reduction of risk for a number of long term conditions including type 2 diabetes, CVD and some cancers) for those within the targeted age range of the ILS, as the risk of inactivity and excess weight increases with age. Alcohol: there is likely to be a positive impact for people within the target age range of the ILS as they are more likely to drink at risky levels.
Disability	**Evidence:** In Lincolnshire, 10000 people aged 18 – 64 have a serious physical disability and 82 000 > 65 have a physical disability that limits their life to some extent (JSNA: physical disability and sensory impairment). There are 15 000 people in Lincolnshire with learning disability Smoking 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. Physical Activity and Obesity

	Both learning disabled and physically disabled people are less than half as likely as the population as a whole to be active (JSNA physical activity). Over 80 people recorded on referral forms as having learning disabilities participated in the commissioned Exercise Referral scheme in 2015 – 16. Although referrals were made for a range of physical health conditions, it is not clear whether these would come within the definition of physical disability used within the Physical Activity and Sensory Impairment JSNA Learning disabled people are more likely to be obese than the general population (PH Profiles). The previously commissioned Weight Watchers scheme did not collect data on disability status Obesity and physical inactivity are risk factors for a number of long term conditions including CVD and Type 2 diabetes which increase the risk of disability Alcohol: local data regarding alcohol consumption amongst people with disabilities is unavailable. **Impact:** Smoking: positive impact as people with LTCs (and therefore at an increased risk of disability) are a targeted population Weight management and physical activity: positive impact as people with LTCs (and therefore at an increased risk of disability) are a targeted population and people with disabilities are more likely to be overweight and inactive Alcohol: no positive impact based on available evidence
Gender reassignment	**Evidence:** **Smoking**: Gender transition surgery can often require individuals to give up smoking as 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).) Local data describing obesity, overweight, physical activity and drinking alcohol at risky levels are unavailable for this population **Impact:** Positive impact of quitting smoking on surgical outcomes No impact ascertainable from local data with respect to weight management, physical activity and alcohol

Marriage and civil partnership	No local data available regarding the behaviours included within the ILS and these population groups No positive impact ascertainable from available data
Pregnancy and maternity	**Evidence:** Smoking: 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". 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. Weight, Physical Activity and Alcohol: local data unavailable with respect to pregnant women **Impact:** Smoking: Positive impact as pregnant women are one of the targeted populations Weight management, physical activity and alcohol: potential positive impact if pregnant women who are targeted as smokers also engage in with weight, physical activity and alcohol services
Race	**Evidence:** Smoking: 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.

	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. Weight management and physical activity: no data is available within the Lincolnshire JSNAs or their supplementary data documents regarding the levels of obesity or physical inactivity by ethnic group. Similarly uptake data from previously commissioned weight management and physical activity services is not broken down by ethnicity. Nationally, black, and white British adults are most likely to be overweight or obese. And Asian, black and 'other' adults are most likely to be inactive (PH Profiles) People from Asian backgrounds are known to have an increased risk of type 2 diabetes at a lower BMI than the population as a whole. Consequently there will be a lower weight threshold for their eligibility into weight management services. services Alcohol: local data not broken down by ethnic group **Impact:** Smoking: positive impact on those ethnic groups whose smoking prevalence is higher than the population as a whole. Weight management: positive impact as eligibility thresholds for weight management support will be lower than for the population as a whole Alcohol: no positive impact based on available evidence
Religion or belief	**Evidence** Local data on those behaviours that come within the ILS are not broken down by religion **Impact** No positive impact based on available data
Sex	**Evidence:** Smoking: 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%. Physical activity: levels of inactivity are higher for women than for men (JSNA Physical Activity, PH Profiles)

	Weight: levels of overweight and obesity are higher in men than in women (PH Profiles); however, only 14% of referrals to previously commissioned weight management services were for men. Alcohol: Women are significantly less likely to be admitted to hospital for alcohol related liver disease than men and to drink at higher risk levels **Impact:** Smoking: potential positive impact for men as smoking prevalence is higher Weight: potential positive impact for men as prevalence of excess weight is higher Physical Activity: Potential positive impact for women as inactivity levels are higher Alcohol: potential positive impact for men as prevalence of risky drinking levels is higher
Sexual orientation	**Evidence** Smoking: 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). 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. Weight, Physical Activity and Alcohol: Local data are not broken down by sexual orientation. Previously commissioned services did not provide any data around sexual orientation **Impact:** Smoking: potential positive impact for non-heterosexual population as smoking prevalence is higher Weight, Physical Activity, Alcohol: no positive impact based on available data

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.
.As the target populations for the ILS include carers and Lincolnshire County Council staff, there is likely to be a positive impact for these groups. If the service is based on the principles of proportionate universalism there is potentially positive impact for economically disadvantaged populations, especially as these are more likely to be overweight and inactive, to smoke, and to suffer disproportionate harm from excessive alcohol consumption

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	**Evidence** Weight / Physical Activity: significant proportions of the adult population outside the target age-range of the service are overweight and inactive. At least 23% of participants in the previous commissioned weight management service were outside the target age group (in fact the figure is likely to be higher as the 65+ category was not broken down further). At least 27% of participants in the previously commissioned Exercise Referral service were outside the ILS target group (again the figure is likely to be higher as the 400 people aged 70-79 who accessed the scheme was not broken down further) Smoking: 1285 people aged 18-34 have set quit dates as part of the existing Stop Smoking Service. Younger people have the most to gain (in terms of increased life expectancy) from quitting smoking Alcohol: young people (16 – 24 years) are more likely to binge drink than those within the ILS target population, significantly more so than those aged over 65 **Impact** if the service reaches its capacity within the target age-group, younger people and very old people risk not having their needs adequately addressed **Mitigating factors**

	These negative impacts can be mitigated through effective communications about the availability of free electronic support sources such as One You and through comprehensive use of opportunistic, brief advice and system-wide adoption of the Making Every Contact Count (MECC) approach
Disability	**Evidence** Nationally, learning disabled people have far higher rates of premature mortality than the population as a whole (DH / CIPOLD 2013). People with learning disability are also more likely to be inactive and obese. **Impact** If the proposed ILS is not targeted effectively enough at, or if its services are not accessible to learning disabled people then these inequalities may be exacerbated. **Mitigating factors** One of the main referral routes for the ILS will be through NHS Health Checks; these are aligned with the delivery of personal health checks for people with learning disabilities; however, <30% of LD adults currently access their health check - better promotion and reach of health check services would potentially allay negative impacts
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	**Evidence** Weight: levels of overweight and obesity are higher in men than in women; however, only 14% of referrals to previously commissioned weight management services were for men. **Impact** If ILS weight management services are not accessible or attractive to men it is possible that this inequality increases **Mitigating factors** Effective promotion, design and delivery of weight management services to ensure their accessibility to men. Evidence may be available from other areas of the country where weight management services have successfully engaged men
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 ILS will have on the different populations who would benefit from accessing lifestyle support services. To gain further evidence throughout the lifespan of the service about how to mitigate any negative impacts and enhance positive effects with respect to protected populations

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.
Disability	This was a desk exercise and people from this protected characteristic have not been approached.
Gender reassignment	This was a desk exercise and people from this protected characteristic have not been approached.
Marriage and civil partnership	This was a desk exercise and people from this protected characteristic have not been approached.
Pregnancy and maternity	This was a desk exercise and people from this protected characteristic have not been approached.
Race	This was a desk exercise and people from this protected characteristic have not been approached.
Religion or belief	This was a desk exercise and people from this protected characteristic have not been approached.

Sex	This was a desk exercise and people from this protected characteristic have not been approached. .
Sexual orientation	This was a desk exercise and people from this protected characteristic have not been approached.
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.	Prior to commissioning the EIA will be based on professional assumptions derived from the available evidence; these assumptions will be tested with service users throughout the lifespan of the ILS
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 mitigate their effects

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**
	.Impacts will be monitored through the commissioning and contract management process, including an early piece of work by the provider to test this first version of the EIA and identify any mitigating factors	Alison Christie	Annual review by provider
Signed off by	Robin Bellamy	**Date**	30/07/2018