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Report of the Director of Public Health

Report to Executive Board, Leeds City Council

Date: 9th March 2016

Subject: Leeds City Council Health Breakthrough Project "Early Intervention to Reduce Health Inequalities"

Are specific electoral wards affected? If relevant, name(s) of ward(s): The **Integrated Health Living Service (IHLS)** procurement is citywide The **Locality Community Health Development / Improvement (LCHD/I)** procurement affects: Armley, Alwoodley, Beeston and Holbeck, Bramley and Stanningley, Burmantofts and Richmond Hill, Chapel Allerton, City and Hunslet, Cross Gates and Whinmoor, Farnley and Wortley, Gipton and Harehills, Hyde Park and Woodhouse, Killingbeck and Seacroft, Kirkstall, Middleton Park, Moortown, Pudsey, Roundhay, Temple Newsom and Weetwood wards.	☒ Yes	☐ No
Are there implications for equality and diversity and cohesion and integration?	☒ Yes	☐ No
Is the decision eligible for call-In?	☒ Yes	☐ No
Does the report contain confidential or exempt information? If relevant, access to information procedure rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

1. The commissioning of an integrated health living service (IHLS) for Leeds and the re-commissioning of the Locality Community Health Development and Improvement (LCHD/I) services are part of the Leeds City Council Health Breakthrough Project "Early Intervention to Reduce Health Inequalities" under the leadership of the Executive Board Member Communities. The Health Breakthrough has three objectives:
   - To commission an integrated healthy living service for Leeds.
   - To ensure strategic alignment with healthy living services commissioned by partners.
   - To inspire communities and partners to work differently to reduce health inequalities.

2. Far too many people die too early in Leeds. There are around 2,200 deaths under the age of 75 years each year. Of these, around 1,520 can be considered avoidable. The largest contribution to premature death is lifestyles / behaviour (40%) such as smoking, poor nutrition, low levels of physical activity, poor sexual health and drug and alcohol

misuse. Early deaths are disproportionally experienced by people living in the most deprived areas of Leeds.

3. Twenty-seven Public Health contracts are expiring. Thirteen individual citywide Public Health healthy living contracts, which support individuals to adopt and maintain healthy lifestyles; and fourteen individual Public Health LCHD/I contracts.

4. Reviews of these services have been undertaken. The purpose of the reviews was to ensure services commissioned meet the needs of the population of Leeds in relation to healthy living (smoking, healthy eating and physical activity) and also the local level holistic support for people to address the wider issues that impact on their health and wellbeing.

5. The healthy living contracts are being considered as a package, which will enable Public Health to design and commission an integrated healthy living service (IHLS) which will support people engaging in multiple unhealthy lifestyles in a single service, respond to barriers including broader factors influencing health and support people to change behaviour.

6. The new Locality Community Health Development / Improvement (LCHD/I) services will be commissioned in three lots focusing on each of the city councils areas. The services will continue to contribute to reducing the difference in healthy life expectancy between communities, by working with individuals who live in the 10% of most deprived neighbourhoods nationally. The focus will primarily be on the drive to tackle the broader determinants of health and where appropriate supporting people to live healthy lifestyles. Both of these measures contribute towards reducing preventable disability and early deaths.

7. The government cuts to the Public Health Grant for 16/17 and future years will result in a parallel reduction in the funding available to re-commission the Healthy Living Services and the Leeds Locality Community Health Development / Improvement Services

Recommendations

7. The Executive Board is asked to note progress being made by the Health Breakthrough project.

8. The Executive Board to give permission to the Director of Public Health to procure an Integrated Healthy Living Service for Leeds and Locality Community Health Development / Improvement Services and for contracts to be awarded in April 2017 and September 2016 respectively.

1 Purpose of this report

1.1 To describe the need for an Integrated Healthy Living Service (IHLS) and Locality Community Health Development and Improvement (LCHD/I) services in Leeds. To describe how services currently work and how we plan to commission future services as part of the Health Breakthrough project and as a contribution to the Best Council Plan.

1.2 To outline the option appraisal approaches undertaken and the preferred service delivery option for the IHLS and the LCHD/I services.

1.3 To gain approval to procure an IHLS and LCHD/I services for Leeds.

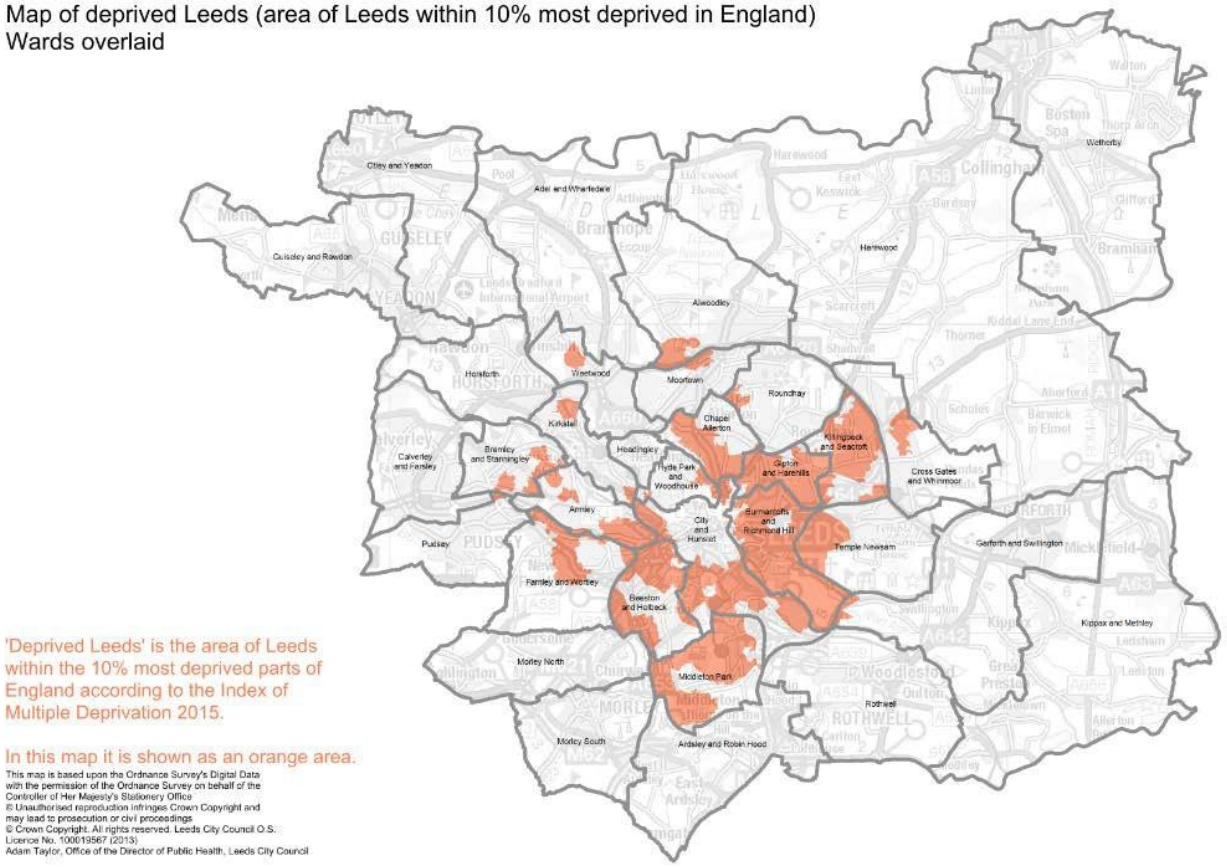
2 Background information

2.1 Nationally, the overall health of the population, as measured by life expectancy, continues to improve. However, in Leeds, life expectancy for men and women continues to be significantly lower than the national picture, with a recent worsening gap for women. Death rates from the “big killers” of cardiovascular disease, cancer and respiratory disease continue to be higher in Leeds than nationally.

2.2 Within Leeds, there are significant health inequality gaps – both between different geographies and different populations. For example there is a 10.2 year life expectancy gap between people living in the most and least deprived wards. For women the gap is even larger (11.6 years). There has been some progress with a recent greater rate of improvement in cardiovascular mortality in our most deprived areas. However this has to be set against the worrying picture presented to the Executive Board in February on the 2015 Index of Multiple Deprivation in Leeds. This shows an increasing concentration in our deprived and least deprived communities.

2.3 The map below illustrates the areas of Leeds which are amongst the 10% most deprived Super Output Areas nationally. Approximately 20% of people living in Leeds fall in the 10% most deprived areas.

Map of deprived Leeds (area of Leeds within 10% most deprived in England)
Wards overlaid



'Deprived Leeds' is the area of Leeds within the 10% most deprived parts of England according to the Index of Multiple Deprivation 2015.

In this map it is shown as an orange area.

2.4 Far too many people die too early in Leeds. There are around 2,200 deaths under the age of 75 years each year. Of these around 1,520 can be considered avoidable. The largest contribution to premature death is lifestyles/behaviour (40%) followed by genetic pre-disposition (30%), social circumstances (15%), health care (10%), environmental exposure (5%). Early deaths are disproportionally experienced by people living in the most deprived areas of Leeds.

2.5 Tackling unhealthy lifestyles has been an important component of the Joint Health and Well Being Strategy (2013 – 2015) to improve health and reduce health inequalities and will continue to be so in the developing Health & Well Being Strategy (2016 – 2021). Ensuring healthier lifestyles is also part of the ambitions set out in the Best Council Plan 2016 – 17 as well as contributing to the delivery of the NHS Five Year Forward View.

2.6 The major unhealthy lifestyles relate to smoking, low levels of physical activity, poor nutrition, poor sexual health and drug and alcohol misuse. These behaviours are modifiable, whether through national policy e.g. taxation, legislation or through individual action. However, as the World Health Organisation Europe stated in 2013, modern societies actively market unhealthy lifestyles. Two further challenges are to tie in people's abilities and skills to access, understand and use information to improve their health plus being able to navigate through an increasingly complex health and care system.

2.7 It is imperative to improve the health and wellbeing of individuals and groups who live in the most deprived neighbourhoods of Leeds. Individuals living in such disadvantaged circumstances often find it very hard to adopt healthier lifestyles unless assisted to overcome the impacts of the broader determinants of health,

such as poverty, low educational status, poor housing, poor mental health and financial exclusion.

2.8 Public Health responsibilities transferred from the NHS to Leeds City Council in April 2013. Along with this transfer came responsibility for a series of service contracts to support healthier lifestyles and wellbeing. These healthy living services and LCHD/I services have been commissioned over the years through various NHS re-organisations as city wide services and as local services involving the NHS and the third sector providers. Leeds City Council has already re-commissioned sexual health services as well as drug and alcohol services.

2.9 The re-commissioning of the remaining services is part of the Leeds City Council Health Breakthrough Project "Early Intervention to reduce Health Inequalities" under the leadership of the Executive Board Member for Communities. The Health Breakthrough has three objectives:

- To commission an IHLS for Leeds.
- To ensure strategic alignment with healthy living services commissioned by partners.
- To inspire communities and partners to work differently to reduce health inequalities

2.10 The work to re-commission the healthy living services and the LCHD/I services as set out below has been undertaken by two project groups. Both have been led by public health with input from PPPU.

2.11 We are actively seeking alignment with commissioners and providers of key services to ensure there is no duplication, and benefits and opportunities are identified and built upon. We are also ensuring links to the prevention element of the sustainable transformation plans being developed for Leeds by the Leeds Health and Care Partnership Executive under the Health and Wellbeing Board. Examples of key partnerships include links with CCG commissioned Social Prescribing projects, New Models of Care work, Community Mental Health Service Review and digital portal, Targeted Prevention work stream of the Transformation Board, the Diabetes Prevention Programme, Public Health England 'One You' campaign, Smart Cities, the self-management programme (including Tele X developments) and related Breakthrough projects.

2.12 An Outcome Based Accountability (OBA) event was held to launch the Health Breakthrough in September 2015. The event was chaired by the Executive Board Member Health, Wellbeing and Adults and attended by 135 partners. Four key work streams emerged as priorities for the city:

- Increase physical activity and encourage active travel.
- Increase the contribution of local businesses in creating broader opportunities to reduce health inequalities in Leeds.
- Increase digital opportunities to reduce health inequalities.
- Increase capacity and capability amongst communities and the broader health workforce in Leeds to reduce health inequalities.

Further OBAs for each are being arranged, led by The Executive Board Member Committees.

3 Main issues

3.1 Services to be commissioned

3.2 Healthy Living Services

3.2.1 Currently there are thirteen individual lifestyle services, the majority of which focus on single aspects of healthy living e.g. smoking and weight management. The services in scope are listed below. These are: Healthy Lifestyle Service, Health Trainer Programme, Stop Smoking Service, NRT Pharmacy Access Scheme, Enhanced Service for Smoking Cessation in Primary Care, Weigh Ahead, Watch It, Change for Life, Ministry of Food, DAZL, Leeds United Foundation, ACE and The Works Skate Park. The value of contracts in scope is currently £2,187,221 per year; broken down as shown in the table below.

3.2.2 This equates to £3.03 per head of population, compared to the national spend which ranges from £3 to £7 per head. This reflects the historical underfunding of public health in the city.

3.2.3 Table listing currently commissioned healthy living services

Title	Service	Coverage	Supplier	Cost per annum
Healthy Lifestyle Service	single information source and non-specialist support for smoking cessation, weight management, alcohol reduction, relapse prevention	adults, citywide	Leeds Community Healthcare	£213,740
The Health Trainer Programme	motivational and coaching support for behaviour change for healthier lifestyles	adults 16+, most deprived 10-20% SOAs	Health for All	£187,100
Stop Smoking Service	specialist stop smoking services	all smokers 12+ citywide, most clinics in 10% most deprived SOAs, specialist support for key groups	Leeds Community Healthcare	£728,000
Nicotine Replacement Therapy (NRT) Pharmacy Access Scheme	dispensing NRT to help people stop smoking	participating pharmacies	Various Pharmacies	£130,000
Enhanced Service for Smoking Cessation in primary care	stop smoking services at GP practices	primary care patients that smoke	Various GPs and Pharmacies	£8,000
Weight Management Services (Weigh Ahead)	tier 2 lifestyle intervention services for weight management for obese adults	obese people 16+ registered with a Leeds GP	Leeds Community Healthcare	£432,381
Watch-It Children's weight management service	specialist services for weight management for children and young people	children 5-19, citywide, target most deprived SOAs and higher BMI	Leeds Community Healthcare	£125,000
Change4life service South Leeds		families with overweight children LS10 LS11	Health for All	£15,000

Ministry of Food	healthy eating and cooking skills services	Adults, citywide targeting deprived areas	Zest - Health For Life Ltd	£145,000
A community dance programme for children and young people	physical activity services for children	children and young people in disadvantaged areas	Dance Action Zone Leeds (DAZL)	£87,000
Active Clubs - physical activity programme for children at risk of being overweight or obese		children and young people in disadvantaged areas	ACE / Health for All	£77,000
Football activity for children in disadvantage communities		children and young people in disadvantaged areas	Leeds United Foundation	£21,000
To engage inactive children in physical activity		children and young people in disadvantaged areas	The Works Skatepark	£21,000
TOTAL				**£2,187,221**

3.3 Locality Community Health Development / Improvement Services

3.3.1 The LCHD/I contracts aim to improve the health and wellbeing of individuals and groups who live in the most deprived neighbourhoods of Leeds. Individuals living in such disadvantaged circumstances often find it very hard to adopt healthier lifestyles unless assisted to overcome the impacts of the broader determinants of health, such as poverty, low educational status, poor housing, poor mental health and financial exclusion. The LCHD/I contracts are currently delivered across Leeds by 11 Third sector organisations through 14 separate contracts. The contracts, which show provider and contract value below, are historical, originating from the five PCTs. The value of the current contracts in scope is £802,838 and shown broken down in the table below.

3.3.2 This currently equates to a spend of £4.05 per head of deprived population in East North East Leeds, £4.47 in South and East Leeds and £8.38 in West North West Leeds. This reflects differential funding through various NHS re-organisations.

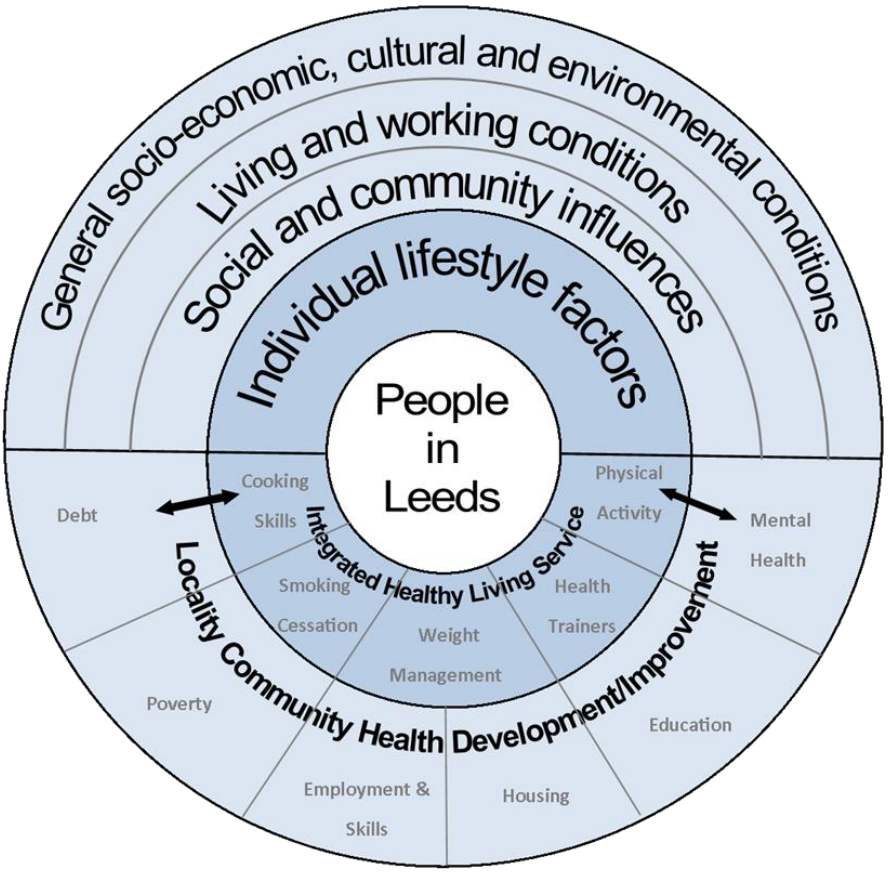
3.3.3 Table listing currently commissioned LCHD/I services

Provider	**Area**	**Contract Value**	**Geographical/Community of interest**
Space 2	ENE	£80,000	Gipton and Seacroft
Zest Health for Life	ENE	£80,000	Burmantofts, Richmond Hill, Meanwood and parts of Moor Allerton
Feel Good Factor	ENE	£60,000	Chapeltown and Harehills
East Leeds Health for All / Touchstone	ENE	£60,000	Burmantofts and Bayswater
Leeds Irish Health and Homes	ENE	£47,570	Irish population in mainly, but not exclusively ENE
Shantona	ENE	£30,600	Bangladeshi women mainly living in Harehills
Total	*ENE*	*£358,170*	
Hamara	S & SE	£70,000	BME communities in Beeston (IS and Harehills IE)
ASHA	S & SE	£20,750	BME women in Inner South Leeds
South Leeds Health	S & SE	£ 110,000	Holbeck, Hunslet, Beeston, Belle Isle,

for All			Middleton, Cottingley
South Leeds Health for All (Cupboard)	S &E	£42,000	Bell Isle, Hunslet, Middleton (LS 10) and Beeston, Beeston Hill, Cottingley and Holbeck (LS 11)
Total	*SE*	*£242,750*	
BARCA	WNW	£60,000	Bramley, Stanningley and Kirkstall
BARCA	WNW	£60,959	Healthy living activities (West Leeds)
BARCA	WNW	£60,959	Community Health Education
CALLS	WNW	£20,000	Little London Estate and surrounding areas
Total	*WNW*	*£201,918*	
Grand Total		**£802,838**	

3.4 Links between healthy living services and LCHD/I services

3.4.1 The model below shows how the healthy lifestyle services and LCHD/I services currently work together to respond to different influences on health. The healthy lifestyle services focus on supporting individuals to tackle unhealthy lifestyles such as smoking, lack of physical activity and poor nutrition. The LCHD/I services primarily support people to tackle broader determinants of health. This means that the LCHD/I services provide vulnerable users with the means to build strong foundations, upon which every other aspect of health can be built; including the benefits that healthy lifestyles can bring. This model will be built upon when the services are re-commissioned.



3.5 Service Reviews

3.5.1 As part of the Health Breakthrough project, service reviews have been undertaken both for the healthy living services and for the LCHD/I services. These reviews have included in depth consultation and a detailed Health Needs Assessment (HNA) work. The published HNA includes data around lifestyles and ill health; a review of evidence, a review of current services and consideration of new approaches in other parts of the country. The key findings from these service reviews have been used to develop the priorities for the future commissioning of these services.

3.5.2 In addition, account has been taken of the views of the Health & Well Being Adult Social Care Scrutiny Board meeting on 22nd December 2015 on the importance of the Third sector on the health; wellbeing and social care economy. This followed a discussion with the three Clinical Commissioning Groups, Adult Social Care and Public Health.

3.5.3 Account has also been taken of the many new activities and development in the city, including through an Outcomes Based Accountability workshop held on 18th September 2015. Efforts are being made to align with commissioners and providers of key services to ensure there is no duplication and that benefits and opportunities are identified and built upon.

3.5.4 A large consultation exercise was undertaken to inform the IHLS and LCHD/I plans. Full details are available in the supporting documents.

3.6 Key findings from the reviews

3.6.1 All stakeholders recognised that living a healthier lifestyle and changing behaviours is not easy. Everyone that was consulted recognised that there are a range of barriers and the importance of building confidence and motivation, as a prelude to change.

3.6.2 Services need to be planned around individuals and communities. There was a need to stop working in silos e.g. a focus on a single issue such as smoking, and rather respond to how people live their lives and who may engage in multiple unhealthy behaviours. Although building confidence and motivation is essential to enable an individual to consider adopting a healthier lifestyle, what is required to enable that change is: consistent information on healthy lifestyles; services that are accessible in local communities; working together to building social networks and peer support; considering the whole family and their influence on healthy behaviours; and ensuring healthy living services can reach out to those who find it hard to access services. To achieve this requires a skilled workforce and ensuring that we can measure successful achievement of healthy lifestyles in a way that is meaningful to providers and the people of Leeds.

3.6.3 Target groups emerged from the IHLS review. These are: people who live in the 10% most deprived communities in Leeds, people who smoke, people who are obese, people from black and minority ethnic communities, people with long term conditions, people with mild to moderate mental health problems and physically or mentally disabled people.

3.6.4 The LCHD/I review supported a future model that focuses primarily on tackling wider determinants.

3.6.5 The LCHD/I review confirmed a continued focus on improving the health of those who are living in neighbourhoods which are included in the 10% most deprived neighbourhoods in England. There was also support for a service model that provided flexibility within those neighbourhoods in each of the three Leeds City Council areas depending on particular communities of interest or geographies. The healthy living services were confirmed as universal services with a proportionate focus on providing services across Leeds based on need.

3.6.6 There are newly emerging communities that present a challenge to existing services. Current providers and stakeholders have reported a recent acceleration of un-met need in newly arrived migrant and Eastern European populations, which is challenging the current model. Issues include cultural differences, diversity of languages spoken, costs of translation services, insufficient English courses being run and the level of competency after courses is often too low to ensure integration and a level of health literacy that can support lifestyle change and appropriate use of services. The new populations are also settling in less deprived neighbourhoods, if housing is available. Many are still disadvantaged because of discrimination and prejudice, existing health conditions or traumatic experience, but will not be covered by activity in these contracts. Therefore this is considered as a gap in the context of whether there are other contracts which can cover their needs.

3.6.7 There are gaps in population groups who have particular health needs but are not evidenced as accessing the service as much as expected. These include Lesbian Gay, Bisexual and Transgender groups, disabled individuals, carers and those with learning difficulties.

3.6.8 National policies are having an adverse impact. Current providers report that many more users are turning to them in crisis, as a result of welfare reforms. Sanctions, lack of money for food, issues with refugee and asylum processes and mental health issues exacerbated by language difficulties are common. Strengthening links and referral processes with relevant LCC directorates, community learning, CCGs, Job Centre Plus and English language skills providers minimise the negative impacts as described.

3.7 Options appraisals for the IHLS and LCHD/I Services

3.8 Options appraisal for the IHLS

3.8.1 In November 2015, following the service review, the Breakthrough IHLS project team commenced work on identifying service delivery options. This involved considering a wide range of service delivery options.

3.8.2 Seven options were shortlisted:

- Continue with current individual services (“Business as usual”)
- An IHLS commissioned by CCG footprint (one integrated service for each of the three wedges) with healthy living activities as citywide lots
- An IHLS commissioned by city council footprint (one integrated service for each of the three council areas) with healthy living activities as citywide lots.
- Medical model (1 contract for specialist / medical services only. Other healthy living activities to be decommissioned)
- In-house integrated service

- An IHLS with healthy living activities delivered at a city wide level with one provider (1 contract)
- An Integrated healthy living interventions service delivered at a city wide level, with healthy living activities as citywide lots.

3.8.3 From the shortlist, the Breakthrough project team considered a range of evaluation criteria against which the options would be scored, these criteria were then weighted by perceived importance between one and five (one least important, five most important). The approach to the options appraisal was a consensus approach whereby evaluators scored individually and then came together for a group discussion to review their collective scores, agreed a collective score and the reasons why they had scored high or low. Projects, Programmes and Procurement Unit colleagues were in attendance at the consensus scoring meeting to record scores and rationale for each option.

3.8.4 The preferred option was to develop an integrated healthy living interventions service delivered at a city wide level, with healthy living activities as a citywide lot. The main advantages of this option are:

- Represents value for money – reduces the number of healthy living service contracts
- Can move resources around
- Can target services
- Can meet local need, community based
- Works to the strength of the service
- Allows for partnership working
- Third sector involvement and collaboration is possible
- It is thought to be politically acceptable
- Acceptable to the market place

3.9 Options appraisal for the LCHD/I services

3.9.1 In June 2015 the Breakthrough LCHD/I project team commenced work on identifying service delivery options. Five final options were shortlisted and evaluated:

- Multiple providers deliver specified services
- City wide service with one lead provider
- A lead provider for each of the 3 city council areas
- Funding disbursed via Community Committees
- A combined healthy living and community health development service.

3.9.2 An options appraisal evaluation team was established which consisted of the 3 locality leads (Health and Wellbeing Improvement Manager and 2X Advanced Health Improvement Specialists) on the project, a Public Health Contracts Officer, Consultant in Public Health and the Leadership Fellow, who is leading the Early Intervention and Reducing Health Inequalities breakthrough project. A consensus approach was taken with evaluators scoring individually and then coming together for a group discussion to review their collective scores, agree a collective score and the reasons why they had scored high or low. Project, Programmes and Procurement Unit colleagues were in attendance at the consensus meeting to record scores and rationale for each option.

3.9.3 From this, the preferred service delivery option is: A lead provider for each of the 3 city council areas (wedge). The main advantages of this option are:

- Value for money will be achieved with having three providers, through reduced management costs as opposed to the current 14.
- The model is medium sized and has the ability to integrate well at a system level with other services and work at a local community level with service users and locality structures.
- Performance management will be easier (with reduced internal resource requirements also) by having three providers.
- The model allows flexibility to meet the changing needs of communities
- It is thought there will be stakeholder acceptability for example-the Clinical Commissioning Groups having more local services on which to draw.
- It is thought politically acceptable as the model allows for local services for local people

3.10 How will the IHLS and LCHD/I services fit within the broader system?

3.10.1 The model shown in 3.11 below illustrates how it is proposed the IHLS and LCHD/I will interface and interact within the broader context of the health system in Leeds. The person can be seen at the centre of the model. Services in italics are directly commissioned services which form the Leeds IHLS. Services that are not in italics are services which are aligned and form part of the Leeds Integrated Healthy Living System but are not directly commissioned.

3.10.2 The red section of the model is where intention to change is built. The IHLS will ensure staff use an outreach approach and campaigns to work with people who may not be aware of their unhealthy behaviours. Activity may target people in a range of settings or following a range of life events. The service will also respond to referrals from NHS partners.

3.10.3 The green section of the model provides information, support and navigation to a service user. Service users could have a coaching conversation with a navigator to access the right support, or independently access the One You website which may provide enough information and support to make a behaviour change themselves.

3.10.4 The blue section of the model describes the range of services to choose from to facilitate and support change. These include self-help, accessing healthy living activities in the community, accessing a more traditional healthy living intervention, receiving holistic support to work to remove barriers to behaviour change or a peer support approach. People wishing to make a behaviour change can enter and exit the system at any single point. There is no set pathway.

3.10.5 Drawing on service reviews, the LCHD/I outcomes are increased social capital, increased community and individual resilience and reduced health inequalities with a focus on the wider determinants of health. The IHLS outcomes are increased confidence to change, increased level of motivation, increased physical activity, healthier weight, healthier nutrition, reduced problematic alcohol use, improved emotional health and reduced smoking.

3.11 Leeds Integrated Healthy Living System

4 Corporate considerations

4.1 Consultation and engagement

4.1.1 Formal consultation was undertaken in addition to reviewing previously commissioned local public health insight and needs assessment work. Views were sought from the public, existing service users, service providers, potential co-commissioners, public health colleagues and wider stakeholders. Results are described in full in the background documents.

4.2 Equality and diversity / cohesion and integration

4.2.1 Equality and diversity, cohesion and integration impact assessments on the review processes have been completed (attached as appendices) and equality

and future monitoring processes. Due regard was given to equality during the both options appraisal processes and the findings of the LCHD/I review have highlighted a number of equality related considerations to be built into the new services. This process will reduce health inequalities in Leeds.

4.3 Council policies and best council plan

4.3.1 The IHLS and LCHD/I services will help to deliver:

- Vision for Leeds 2011 to 2030
- Joint Health and Wellbeing Strategy 2013 – 15
- Best Council Plan 2015 – 20
- The NHS Five Year Forward View and NHS Planning Guidance

4.4 Resources and value for money

4.4.1 All costs for the IHLS and LCHD/I services are revenue funding. They are funded by the Public Health directorate. The level of public health funding for these services is low, reflecting the historic under funding in public health services in Leeds. This has been recognised by the Department of Health and Leeds is considered still to be around £6m below target. The government cuts to the Public Health grant in 16/17 and in future years rather than the expected increased, will result in a parallel reduction in funding for these services. In the light of the cuts to the Public Health grant there will be a 10% reduction in funding for the re-commissioned services. Discussions are ongoing with CCGs to explore co-commissioning and alignment opportunities e.g. making close links between the IHLS, LCHD/I services and the CCG commissioned social prescribing and community mental health services.

4.4.2 The proposed IHLS provides value for money in two ways. Firstly because work to reduce unhealthy lifestyles is highly cost effective and secondly delivering the IHLS as proposed in the draft model will use resources more efficiently and provide greater value for money.

4.4.3 ASH estimate that smoking costs the Leeds health and broader economy £209.5 million per year. The National Institute for Health and Care Excellence (NICE) have assessed the economic and health benefits of lifestyle services and conclude that most activities aimed at improving the public's health are extremely good value for money and generally offer more health benefits than the alternatives tested. Such activities include: stop smoking services, healthy eating initiatives, physical activity programmes and alcohol interventions. Some activities can be 'cost saving', that is, in the long run they reduce costs by more than the total spent on them.

4.4.4 Value for money for the IHLS will be created through the proposed service redesign through:

- Integrating a number of services (Smoking, Weight Management, Health Trainers and Healthy Lifestyle Service) into one
- Increasing the numbers of people who self-help through the use of digital resources (website and Apps)
- Improving retention of service users
- Improving the chances of maintaining a behaviour change by using a health coaching approach and facilitating peer support
- Using the breakthrough status to align and capitalise on other developments e.g.

CCG commissioned Social Prescribing projects and supporting service users to access other sources of support in the city e.g. leisure services and IAPT.

4.4.5 Value for money for the LCHD/I services will be achieved with having three providers through reduced management costs.

4.4.6 There is high 'social value' return on LCHD/I work, including the wellbeing of individuals and communities, social capital and the environment. The monetary value of volunteering, which is a key facet of the current LCHD/I contracts and is recommended to continue, is calculated to be £13,500 per person per year (Cabinet Office 2011).

4.4.7 A significant number of current LCHD/I providers have demonstrated that the public health funding they receive, is also used as a catalyst for securing match funding, creating a useful multiplier effect in impoverished communities.

4.4.8 There will be further work to finalise planned benefits of the IHLS and LCHD/I services and to create a benefits realisation plan.

4.4.9 The delivery approach, procurement plans and plans relating to performance management and payments will be completed during Stage 2 of the project. The value of the contracts post 10% reductions are approximately: IHLS service £1,968,500 per annum and LCHD/I services £722,554 per annum. Therefore EU Procurement rules will be applied. This will include a Prior Indicative Notice (PIN) and using the OJEU advertising requirements. Consultation will be undertaken with commercial and legal colleagues in PPPU for assurance that correct procurement procedures are adhered to.

4.4.10 Prior to the recent cuts in Public Health funding, the intention was to increase the spend per head of deprived population in the East North East and South and East areas to the same level as that available in West North West. Although this is no longer possible, the long term intention is to utilise other funding which may become available (from CCGs for example) to supplement this activity.

4.4.11 The current LCHD/I budget has been reduced from £802,838 by 10% to £722,554. The total budget available has been allocated equitably by head of deprived population. This is shown below along with the proposed distribution of the £80,000 reduction in funding.

Area	**No. of people living in most deprived decile (10% nationally)**	**Funding per deprived head of population (£)**	**Current allocation (£)**	**New allocation (£)**	**Difference (£)**
ENE	92,179	3.79	358,170	349,706	-8,464
S&E	60,555	3.79	242,750	229,732	-13,018
WNW	37,724	3.79	201,918	143,116	-58,802

4.5 Legal Implications, access to information and call In

4.5.1 The IHLS and LCHD/I services will be commissioned through a formal procurement process. The procurement process will adhere to council procedure and practice and European public procurement directives. PPPU is supporting project delivery to offer guidance and support on the procurement to ensure legal compliance and that a fair and transparent process is undertaken. Due to the value of the services this will be subject to call-in.

4.6 Risk management

4.6.1 A risk register for both projects has been compiled and is regularly assessed and updated when necessary to ensure risks are identified, managed or escalated if required. The risk register is presented to Public Health Programme Board on a monthly basis as an appendix to the highlight report for strategic review and consideration.

5 Conclusions

5.1 The Health Breakthrough project includes the existing healthy living services and LCHD/I contracts which are coming to an end.

5.2 Two formal service reviews, a health needs assessment and findings from a range of consultation events have provided information which has been used to develop future service models.

5.3 A formal options appraisal has been undertaken for each service.

5.4 The contract for an IHLS will be awarded in April 2017 and the service will go live in October 2017. The contract for the LCHD/I services will be awarded in September 2016 and the service will go live in April 2017.

5.5 The service specifications for the IHLS and LCHD/I services will clearly set out the connections between each of the services to ensure citizens of Leeds receive the support they need to be become and remain healthy. Both these services sit within a broader healthy living system. The Health Breakthrough is providing opportunities to align both these commissions within broader assets and opportunities within the system, for example opportunities from Smart Cities, CCG social prescribing projects and mental health open data.

5.6 The next step for both commissions is to finalise a business case and develop and consult on a detailed service specification.

5.7 The main focus of the IHLS will be to support people who are engaging in multiple risk factors in a single service, to change behaviour; with a secondary focus on supporting service users to access support to respond to barriers including broader factors influencing health. The main focus of the LCHD/I service is on addressing the wider determinants of health, with healthy living activities being delivered as a secondary focus, such as through healthy eating and physical activity groups. These will be used to meet expressed community needs or as a means of initial engagement.

5.8 The service review identified clear priority groups for the IHLS and LCHD/I service. Both services aim to reduce health inequalities in Leeds.

5.9 Whilst the IHLS will support individuals and families to build their confidence and motivation, it will not be able to reach everyone who needs help and the LCHD/I service can dedicate service time to meet this need. The benefit of the IHLS and LCHD/I services being closely aligned is that this will reduce the risk of targeted service users "slipping through the net", and will provide easier access, choice and different ways for getting support depending on levels of need and readiness to make a behaviour change. There should be "no wrong door" when a service user needs help and wishes to access health improvement services.

6 Recommendations

6.1 The Executive Board is asked to note progress being made by the Health Breakthrough project.

6.2 The Executive Board to give permission to the Director of Public Health to procure an IHLS for Leeds and Locality Community Health Development / Improvement Services and contracts to be awarded in April 2017 and September 2016 respectively.

7 Background documents[1]

7.1 Ingold, K; Thomson, H; Squire, C; Burkhardt, J and Lambert, P. (2015) Health Needs Assessment: Integrated Healthy Living Service.

7.2 Squire, C; Ingold, K; Thomson, H; Burkhardt, J; Munton, J and Fox, J. (2015) Consultation Findings: Integrated Healthy Living Service.

7.3 Jackson L, Bailey L, Brighton R, Hindley J and Daly K. (2015) Executive Summary Community Health Development and Improvement Services Review.

[1] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

As a public authority we need to ensure that all our strategies, policies, service and functions, both current and proposed have given proper consideration to equality, diversity, cohesion and integration. In all appropriate instances we will need to carry out an equality, diversity, cohesion and integration impact assessment.

This form:

- can be used to prompt discussion when carrying out your impact assessment
- should be completed either during the assessment process or following completion of the assessment
- should include a brief explanation where a section is not applicable

Directorate: Public Health	Service area: Health Improvement
Lead person: Consultant in Public Health (Healthy Living and Health Improvement)	Contact number 07712 214812
Date of the equality, diversity, cohesion and integration impact assessment: November 2015	

1. Title: Leeds Integrated Healthy Living Service project
Is this a: ☐ **Strategy /Policy** ☒ **Service / Function** ☐ **Other** **If other, please specify**

2. Members of the assessment team:

Role		**Role on assessment team e.g. service user, manager of service, specialist**
Health Improvement Manager	LCC	Specialist
Health Improvement Principle	LCC	Specialist
Advanced Health Improvement Specialist	LCC	Specialist
Head of Public Health Partnerships & Projects	LCC	Specialist
Advanced Health Improvement Specialist	LCC	Specialist
Public Health Leadership fellow	LCC	Specialist
HR Manager	LCC	Specialist
PPPU Senior Project Officer	LCC	Specialist
PPPU Project Support Officer	LCC	Specialist

3. Summary of strategy, policy, service or function that was assessed:

The aim of the project is to re-commission healthy living services to:

- be effective in tackling health inequalities,
- provide value for money, and
- align with other commissioning and service arrangements both locally and city wide in a way that maximises community assets and skills.

The current programme for healthy living activity is branded as 'Leeds Let's Change', and the Council is the commissioner for a number of healthy lifestyle services which support people of all ages to change and sustain their behaviour in terms of smoking, weight management, physical activity, healthy eating and alcohol use.

Thirteen different Council contracts have been identified as being in scope for replacement by a more integrated service, some of these are with local third sector organisations and all are funded by Public Health. In addition work is ongoing to explore potential co-commissioning with Clinical Commissioning Groups in Leeds for related service activity which they fund or have plans to fund.

The project will consider the best way for healthy living services to be provided in the future, and who should provide them.

The current services are predominantly either delivered citywide (such as stop smoking support) or focused on geographic areas (such as Health Trainers). They also can have other targeting, for example any smokers aged 12 or over can access the stop smoking support, overweight children and their parents are supported by the Watch-It children's weight management service, and inactive children and young people in disadvantaged areas are a focus for the four contracts providing physical activity services.

4. Scope of the equality, diversity, cohesion and integration impact assessment
(complete - 4a. if you are assessing a strategy, policy or plan and 4b. if you are assessing a service, function or event)

4a. Strategy, policy or plan
(please tick the appropriate box below)

The vision and themes, objectives or outcomes	x
The vision and themes, objectives or outcomes and the supporting guidance	
A specific section within the strategy, policy or plan	

Please provide detail: See section 3.

4b. Service, function, event please tick the appropriate box below	
The whole service (including service provision and employment)	☐
A specific part of the service (including service provision or employment or a specific section of the service)	☐
Procuring of a service (by contract or grant)	**x**
Please provide detail:	

5. Fact finding – what do we already know

Make a note here of all information you will be using to carry out this assessment. This could include: previous consultation, involvement, research, results from perception surveys, equality monitoring and customer/ staff feedback.

(priority should be given to equality, diversity, cohesion and integration related information)

We have scrutinised a wide variety of both epidemiological and service data in order to consider equality in the re-commissioning of healthy living services, and to inform the wider multi-agency and multi-faceted healthy living system within which this sits. The processes that have helped us look at this include:

- Obtaining advice from the Communities Team-Central (Equality) early in this project.
- Early discussion of equality by the healthy living project team, identifying gaps in knowledge, actions to address these and periodic review of equality issues.
- Carrying out an extensive Health Needs Assessment (HNA) (Ingold et al, 2015) and using this as an essential tool to inform commissioning and service planning. Detail in relation to groups experiencing inequality can be seen in the HNA Report
    - The HNA includes specific data from a large number of national and local data sets and evidence bases (including the Leeds Joint Strategic Needs Assessment) and notes how particular groups with protected characteristics and populations in areas of geographical inequality are impacted on in relation to key conditions, behaviours or lifestyle related ill health such as obesity, diabetes, mental illness, smoking, physical inactivity, diet. This evidence is used for building a picture of current population needs and for targeting of services, and will inform future provision.
    - The HNA looked at the existing healthy living service arrangements in Leeds

and includes an analysis of the access to current services by different sections of the population (e.g. gender; ethnic group; postcode and links to areas of deprivation), using records of people who accessed the services in 2014/15. This was then compared to the Leeds population profile (using data from the 2011 census). This helped us to see where we are currently achieving good coverage in relation to equality but also where the gaps are and where more understanding is required of the barriers to service access by specific groups and exploration of ways to address by service redesign.
    - The HNA includes an analysis of commissioner views on the strengths, weaknesses and gaps relating to current healthy living services, within which issues relating to equality are considered.
    - The HNA includes a review of national and local policy in relation to healthy living services, which set out direction for ensuring services reduce health inequalities for communities living in areas of deprivation and for vulnerable groups (appendix A of HNA).
    - The HNA sets out a summary of broad considerations in relation to protected characteristics. (Appendix B of HNA)

- We included discussion questions related to equality issues in a Provider Consultation Workshop to develop future options. We will use this feedback about challenges and suggestions for mitigation to incorporate into service redesign.
- We have been mindful of the synergy between the healthy living service recommission and the Leeds Community Health Development Review (Bailey, 2015) and have cross referenced with data for target communities within that, both from a geographical health inequalities perspective and in line with the Leeds Health Inequalities Model of Vulnerability described in the HNA**.** The Vulnerability Model notes the complex inter-relationship of "who you are" demographics such as ethnicity, disability, religion and faith beliefs, with where you live and with how people treat you (stigma, discrimination etc) in order to examine how the circumstances surrounding different population groups and equality groups affect their health.
- We carried out a review of previously published Insight (Munton, 2015) relating to healthy living services in Leeds. This entailed a synthesis of a number of reports of insight work with service users, service providers and the general public and a thematic analysis across the reports.
- A review was carried out of Integrated Healthy Living Service Models and Procurement Plans in the UK(Squire, 2015) in order to identify a range of possible procurement models to be considered in an options appraisal. This enabled information and learning to be considered from a large number of other Local Authorities. It helped inform the rationale for a move from individual healthy living services to an integrated model that would address equality through including robust wellness outcomes focussing on inequalities through a demonstrable targeted approach to those greatest in need.
- A consultation event took place with a wider group of Leeds City Council Public Health staff. This generated ideas around effective approaches and areas for further consideration, and included issues linked to equality.
- Additional consultation work took place in autumn 2015 by DIVA comprising focus groups with over 100 members of the public including BME respondents.
- Several of the the above were included in a larger and wider Consultation Report. (Squire, Burkhardt and Fox, 2015). This comprised a thematic review across all LIHLS-related consultations and insight, from which key issues to inform service redesign were extracted from a number of reports including:

1. Public Health internal two hour workshops for staff, 2 April 2015 and 10 September 2015 (17 and 25 attendees)
2. Provider survey
3. CCG meetings on the following days:

- 6th and 27th May 2015
- 15th , 16th and 27th July 2015
- 4th , 11th , 15th, 24th and 29th September 2015
- 15th October 2015

4. Provider event, 25 August 2015 (25 attendees)
5. Children's physical activity workshop, August 2015 (five attendees)
6. OBA event 18 September 2015 (150 attendees)
7. Locality Community Health Improvement and Development Service Review,
8. September 2015
9. Children's primary school in the south of Leeds, 8 October 2015 (30 attendees)
10. Review of previously published Insight reports of consultation work with service providers, service users, health and wider professionals, and the general public in deprived areas, August 2015.
11. Review of Integrated Healthy Living Service Models and Procurement Plans in the UK, April 2015
12. Health Living Services Consultation Public Research Report, DIVA, October 2015.

This thematic review enabled many cross-cutting considerations to be identified and the information used to inform this project. Amongst these were motivators, barriers, self-support, communications, use of a holistic person-centred approach, use of a health coaching approach, physical activity issues, food issues, the needs of vulnerable groups, and addressing inequalities.

Are there any gaps in equality and diversity information
Please provide detail:

1) We wanted further information from Providers on what equality considerations they've already made, including whether their staff have already undergone Equality training.
2) The thematic review of published Insight reports (above) highlighted gaps in previous consultations with service users and the general public regarding BME and other groups with protected characteristics.
3) We are uncertain of the extent to which Providers generally can be required contractually to ensure that their staff reflect the diversity of the population they serve.
4) We analysed the level of data collected from services (e.g. geographical spread, age, gender, ethnicity) and concluded that this level was acceptable. We acknowledged that where this was sensitive or difficult to obtain, proxy data provided good indications (for example, school ethnic breakdown is used rather than asking individual children for after-school physical activity clubs). It was felt that there were some information gaps around Gypsy and Traveller Communities, physical activity and learning disabilities, emerging migrant groups such as Eastern European groups, asylum seekers and refugees in relation to key issues and access to healthy living services. Services noted that providing for transient communities

was a challenge.

5) The My Health, My School survey showed that Asian girls are the least active group amongst primary school children. We needed to find out more about the reasons for this**.**

Action required:

1) We devised a table for Providers to complete in order to collect this information and hence identify good practice and gaps.
2) External Insights providers DIVA were instructed to target more diverse groups in the consultation they were carrying out to inform the service model (see section 6 below).
3) Exploring the scope of leverage Public Health broadly may have in requiring providers to employ staff that reflect the diversity of the population they serve is being addressed across the Public Health Directorate, and the findings will be applied to this reprocurement.
4) We are exploring what other needs assessments have been conducted in Leeds that can be used to understand how to better support these communities to access services, and to inform the model e.g. Gypsy and Traveller Needs Assessment, studies on the needs of emerging migrants, asylum seekers and refugees.
5) We commissioned a focus group with primary school Asian girls. This identified family issues as a key constraint to being active, and that the girls themselves would welcome more opportunities for playing out in order to be more active.

6. Wider involvement – have you involved groups of people who are most likely to be affected or interested

[x] **Yes** [ ] **No**

Please provide detail:

1. We involved people who are most likely to be affected by commissioning the insight providers Diva in August-September 2015 to carry out focus groups with members of the public to enable us to gain a better understanding of:

   - What the public consider to constitute a healthy lifestyle and how they assess this
   - The motivators that help the public feel confident to change to a healthier lifestyle
   - The barriers that prevent the public from feeling confident to change to a healthier lifestyle
   - What the public think they need to be able to manage their lifestyle effectively (including testing a range of intervention ideas)
   - What the public would consider as an effective healthy lifestyle intervention

Fifteen focus groups were conducted with 100 members of the target audience, which included the following groups: Mixed ethnicity age13-16, Mixed ethnicity age over 65, Mother and toddler group, Parents with teenage children, White males and females age 18-65 from deprived areas, White males and females age 18-65 from non-deprived areas, Pakistani males age 18-65, Pakistani females age 18-65, Indian males age 18-65, Indian females age 18-65, African males and females age 18-65, People with mild to moderate mental health problems, People experiencing mental ill health or physical disability, People

with an existing health condition – Coeliac disease, People with a long-term health condition – COPD.

2. We invited representatives from a variety of equality groups to our Healthy Living Outcome-based Accountability Breakthrough event and targeted with follow-up invitations where necessary. This multi-agency event enabled a wide spectrum of stakeholders to contribute views on the development of the Leeds Integrated Healthy Living System within which these services will operate.

Action required:
We recognise that we need to involve people from diverse backgrounds in future consultations on the draft service specification, at all stages in the reprocurement process and in assessing customer access and satisfaction following the implementation of the awarded contract (see action plan, section 12)

7. Who may be affected by this activity?
please tick all relevant and significant equality characteristics, stakeholders and barriers that apply to your strategy, policy, service or function

Equality characteristics

[x] **Age**	[x] **Carers**	[x] **Disability**
[x] **Gender reassignment**	[x] **Race**	[x] **Religion or Belief**
[x] **Sex (male or female)**	[x] **Sexual orientation**	
[ ] **Other**		

(Other can include – marriage and civil partnership, pregnancy and maternity, and those areas that impact on or relate to equality: tackling poverty and improving health and well-being)
Please specify: pregnancy and maternity

Stakeholders

[x] **Services users**	[ ] **Employees**	[ ] **Trade Unions**
[x] **Partners**	[ ] **Members**	[x] **Suppliers**
[ ] **Other please specify**		

Potential barriers.

x	**Built environment**	x	**Location of premises and services**
x	**Information and communication**		**Customer care**
x	**Timing**	x	**Stereotypes and assumptions**
	Cost		**Consultation and involvement**
x	**Financial exclusion**		**Employment and training**

	specific barriers to the strategy, policy, services or function

Please specify

See section 8.

8. Positive and negative impact

Think about what you are assessing (scope), the fact finding information, the potential positive and negative impact on equality characteristics, stakeholders and the effect of the barriers

8a. Positive impact:

We are aware from service reviews, insight, and reviews of service arrangements in other areas of the UK, that whilst the Leeds healthy living services demonstrate many successes, we need to remodel future services if we are to reach those people that epidemiological data tells us are most in need, within an offer that serves the whole Leeds population (see Health Needs Assessment, Ingold et al, 2015). In this remodelling, we want to address particular aspects that are pertinent for equality groups in order to have a positive impact for these groups. We will need to consider what aspects regarding equality should run consistently across all healthy living services, and which are discrete aspects specific to particular services. For example, our future service model will need to consider:

Targeting: As noted earlier, within the universal offer, the recommissioning of the healthy living services will involve targeting and tailoring provision to reach those experiencing the greatest health inequalities, utilising information acquired from the Health Needs Assessment (HNA), service reviews and feedback, equality impact assessments previously carried out on existing services, user consultation and consultation with the general public. This will have a positive impact on equality characteristics by removing barriers and increasing access to lifestyle change. Our target groups are:

- People living in the 20% most deprived communities in Leeds
- People who smoke
- Adults with a BMI over 30 or children with a BMI on the 91st centile or over
- People from black or ethnic minority communities
- People with long term conditions (Serious Mental Illness, Coronary Obstructive Pulmonary Disease, Cardio Vascular Disease, Diabetes)
- People with mild to moderate mental health problems
- Physically or mentally disabled people

Information: information both about services and about healthy lifestyle advice will be designed to be easy to understand and consideration will be given to making them available in a range of languages which reflect the diversity of local communities as noted in the HNA, as well as in a range of formats to reduce difficulty for those with sight impairment. The use of visual aids may be increased to address difficulties in language support. Information will be regularly reviewed in order to be responsive to the needs of emerging migrant communities in Leeds. It will need both web-based accessibility and also non-digital information via places our target audience utilises or seeks information such as GP surgeries, libraries, Community Hubs, supermarkets, places of worship, nurseries etc. Innovative dissemination methods will be also explored such as further development and support of champions to spread information, particularly to enable a positive impact across new migrant or hard to reach communities.

Access:
Healthy living services should ideally operate from outreach facilities or service buildings that are easy for everyone to visit or work in. Consideration should be given to physical access re steps etc and provision such as disabled toilets. Lighting and location may also be key to enable access for those groups who may fear victimisation/harassment in public places. In some services, carers can already attend and take part in activities with the client at no cost if they are in a supporting role, and continuation of this should be ensured.

Approachability of staff: The welcoming attitude of staff at the first point of contact and approachability throughout the client's journey is key to a positive client experience and to success. This is a key feature of current healthy living services and an area that services have expressed they are keen to strengthen in future developments. Many clients may lack confidence in accessing services, either due to low self esteem linked to difficulties in their lives or due to difficulties understanding and and acknowledging their lifestyle related health concerns. In addition, it is essential that groups with protected characteristics are not stigmatised and are made to feel welcome. For example, regarding sexual orientation and gender reassignment – it may not necessarily be essential to gain data on numbers but we need to ensure that the service is open and welcoming – staff training organisational policy, environmental factors can be built into the service specification. Gender reassignment may be an issue with particular impact on weight management – this will be considered as part of a psychological assessment which will be built into the standard treatment procedure.

Staff language skills that enable access for the diversity of Leeds communities will be important, and the sharing of provision around community language skills across the integrated service may need to be explored. A review has been carried out of the level of equality and diversity training of staff in existing healthy living services, and this will inform future requirements of the service, resulting in continuous improvement in provision for equality groups.

Religion / Cultural beliefs: These can have a great impact on physical activity, healthy eating and weight management interventions. This will require an understanding by staff (e.g. the concept of "healthy weight" differs amongst cultures; there are different behavioural norms within different families and cultures; there are different cultural attitudes towards women engaging in sport), improved messaging (e.g. to break down myths and misperceptions within communities about services), and responsive service delivery, e.g. taking account of Ramadan when designing weight management and physical activity programmes; considering women-only exercise and appropriate changing room provision.

Cost: The overarching aim of the reprocurement of the healthy living services and the development of a Leeds Integrated Healthy Living System is to help deliver the vision of the Leeds Joint Health and Wellbeing Strategy (2013-15) so that: Leeds will be a healthy and caring city for all ages, where people who are the poorest will improve their health the fastest, with a particular focus on outcome one (People will live longer and healthier lives) and outcome five (people will live in healthier and sustainable communities).

It is important therefore that costs to the client are kept to the minimum in order to maximise uptake by individuals from the poorest communities, where we know there are the greatest inequalities in the city in relation to lifestyle related ill health. Community agencies report that this situation is currently being exacerbated by Welfare Reforms. Costs also include indirect costs such as transport costs to the venue and accessibility by public transport.

Whilst a model will be developed that will provide a universal offer across the whole Leeds population, this programme is about reducing health inequalities and so more focussed targeting and tailoring of services will aim to reach areas of deprivation, where the need is highest.(as described in the HNA).

Insight has shown the need to address motivational factors and also the impact of the determinants of health (housing, jobs, education) on people's ability to engage in lifestyle change, often hitting the poorest hardest. For example, services have reported that because of the multiple issues facing migrants, health is not always a priority. Therefore, in order for healthy living services to be effective, strong links and signposting to address these broader issues will be made. For example, the inclusion of a person-centred health coaching approach; alignment with CCG social prescribing programmes and the Locality Community Health Improvement and Development Service; the strengthening links and referral processes with relevant LCC directorates, community learning, Job Centre Plus, a range of third sector agencies and English language skills provision; healthy environment initiatives; and alignment with the current direction of travel promoted by system leaders such as the Department of Health, Public Health England and NHS England which advocates place-based, community asset-based and community engagement approaches

Co-production: In order for services to be acceptable to equality groups, continued engagement with local communities, communities of interest representing equality groups and community leaders for on-going service review (including input from non-users) will be needed (including evaluation tools in different languages), and opportunities for outreach work explored and implemented. This is more likely to lead to a more person centred and holistic service that is more responsive to equality needs. An engagement approach will also contribute towards empowerment for equality groups, which is health-promoting in itself.

Mental health: Poor mental health is a concern both in itself and as a barrier to accessing healthier lifestyles and services. This is a key issue for many groups with protected characteristics due to complex play between factors such as living in areas of deprivation, severe pressures around issues such as unemployment, domestic violence, housing etc, and issues such as stigmatisation, as outlined with reference to the Vulnerability Model noted in section 5 above. Our service model as well as taking a person-centred approach needs to have strong connections to initiatives to support (such as buddying people to services), build confidence, raise self esteem and community participation as well as to mental illness services

Action required:

All the above aspects
will require weaving considerations of equality throughout the whole recommissioning process. This is reflected in the action plan in section 12.

8b. Negative impact:

A key outcome of the project is to reduce health inequalities for groups with protected characteristics, and the considerations outlined above will have a positive impact. However, whilst the move towards an integrated service will improve the person-centred experience, there is a potential risk that smaller agencies that can actually best meet the needs of equality groups may not have the capacity to bid for the contract.
These small agencies have a track record of detailed experience in knowing the needs of the local communities and how best to meet them, which a larger or external to Leeds provider would need much time and development of local connections in order to build.

Action required:
The above risk will need to be considered at the appropriate stage and mitigating actions implemented to support such agencies.

9. Will this activity promote strong and positive relationships between the groups/communities identified?

[x] **Yes** [ ] **No**

Please provide detail:

Action required:
To include into the specification the need for group work and if the service provider is to encourage user-led clubs. Also, to encourage people to use the service there are positive stories/events/'celebrations' which would lead to positive relationships. This proactive community approach could potentially build relationships between groups rather than the service focus being solely on individuals. The current cooking courses involve people of all different ages, and it is intended this approach will continue. The potential training of people to provide a peer support approach is being explored, and this would include targeting people from equality groups to represent communities, plus enable the positive intermixing of different communities.

10. Does this activity bring groups/communities into increased contact with each other? (e.g. in schools, neighbourhood, workplace)

[x] **Yes** [ ] **No**

Please provide detail:
Services will be located out in communities, so there will potentially be greater contact between groups and communities.

Action required:

11. Could this activity be perceived as benefiting one group at the expense of another? (e.g. where your activity/decision is aimed at adults could it have an impact on children and young people)

[x] **Yes** [ ] **No**

Please provide detail:
This service will be benefiting those most in need, so the same level of service is not available to all-it will be a universal, but not an equal, service, operating under the principle of universal proportionalism. Because the purpose is to reduce health inequalities, there will be an offer, but a lesser offer, to wider, non-deprived areas who have greater capacity for self-efficacy than the deprived areas and those with protected characteristics who are our target groups. We will be putting more resource where the greatest health needs are and where the impact of the resource will be most effective. We will continue to monitor service data to ensure all groups who need the service have access (e.g. older people). Effectiveness will also continue to be monitored to analyse whether resource could be used differently or by a different group.

Action required:

There may be a need to provide support to help individuals (e.g. Elected Members) understand the approach being used here to address inequalities.

Equality, Diversity, Cohesion and Integration Impact Assessment

As a public authority we need to ensure that all our strategies, policies, service and functions, both current and proposed have given proper consideration to equality, diversity, cohesion and integration. In all appropriate instances we will need to carry out an equality, diversity, cohesion and integration impact assessment.

This form:

- can be used to prompt discussion when carrying out your impact assessment
- should be completed either during the assessment process or following completion of the assessment
- should include a brief explanation where a section is not applicable

Directorate: Office of the Director of Public Health	**Service area: Locality Public Health Teams**
Lead person: Health and Wellbeing Improvement Manager	**Contact number: 0113-3367641**
Date of the equality, diversity, cohesion and integration impact assessment: Updated for Stage 2December 2015	

1. Title: Re-commission of the 'Locality Community Health Development/Improvement Contracts
Is this a: ☐ **Strategy /Policy** ☑ **Service / Function** ☐ **Other** **If other, please specify**

2. Members of the assessment team:

Name		**Role on assessment team e.g. service user, manager of service, specialist**
Health & Wellbeing Improvement Manager	LCC	Project Team Lead (ENE Leeds)
Advanced Health Improvement Specialist	LCC	Project team member (WNW Leeds)
Advanced Health Improvement Specialist	LCC	Project team member (S & SE Leeds)
Public Health Contracts Officer	LCC	Project Team Public Health Contracts
Advanced Health Improvement Specialist	LCC	Equality and Diversity Support
PPPU Project Support Officer	LCC	Project Support Officer
Senior Policy and Support Officer	LCC	Senior E & D Officer, Policy &

3. Summary of strategy, policy, service or function that was assessed:

The LCC Public Health commissioned Locality Community Health Development/Improvement contracts have been operating in deprived communities of Leeds for a number of years. A review, which is informing the re-commissioning of this service, has been completed.

The overarching aim of the contracts is to: improve the health of the poorest fastest and thereby:

Reduce the difference in healthy life expectancy between communities through tackling the wider determinants of health and supporting people to live healthier lifestyles, focusing especially on those that are most vulnerable and / or live in the more deprived areas of the city.

The review provided information to help us to secure a future service that is based on:

- A fair process for existing and other organisations (all of whom to support equality groups) to bid to provide services, in line with the Council's rules;
- Learning from what has been going well and what works, both in Leeds and elsewhere, so that services can become more effective and efficient
- Making sure our services are focussed on supporting those people and communities most in need, taking into account any demographic or other changes, and considering how we can encourage greater local responsiveness to local needs during the duration of any new contracts
- A continuing focus on reducing the health inequality gap and ensuring that those who are the poorest improve their health the fastest
- Improved consistency of standards across the city
- Improved and embedded robust outcome measurement, monitoring and management process
- Incorporate value for money as defined by HM Treasury i.e. the optimum combination of whole-of-life costs and quality (or fitness for purpose) of the good or service to meet the users requirement. Value for money is not the choice of goods and services based on the lowest cost bid (HM Treasury 2006). The project team have agreed a split of 60% quality and 40% price.
- Making sure the new contracts are fit for purpose, linking well with and adding value to other commissioned services and programmes. For example the Clinical Commissioning Groups are funding Third sector grants and social prescribing activity and other parts of Public Health fund e.g. Community Health Educators or community cancer screening awareness. We want to make sure that all this work is complementary, eliminates risk of duplication in public health activity and sustains future community public health capacity.

The equality impact assessment has assessed current practice, taken into account access by equality groups, identified gaps in service, geographical reach and barriers to access and is using this to take steps to build remedial action into the service specification, in order to design a more inclusive future service model.

The full range of equality characteristics which were considered are detailed below:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation.
- Poverty and health and wellbeing

4. Scope of the equality, diversity, cohesion and integration impact assessment
(complete - 4a. if you are assessing a strategy, policy or plan and 4b. if you are assessing a service, function or event)

4a. Strategy, policy or plan (please tick the appropriate box below)	
The vision and themes, objectives or outcomes	☐
The vision and themes, objectives or outcomes and the supporting guidance	☐
A specific section within the strategy, policy or plan	☐
Please provide detail: N/A	

4b. Service, function, event please tick the appropriate box below	
The whole service (including service provision and employment)	√
A specific part of the service (including service provision or employment or a specific section of the service)	☐
Procuring of a service (by contract or grant)	√

Please provide detail:

A review of the current service, which consists of 14 contracts delivered by 11 different organisations, has helped us understand who currently accesses the services and some reasons why people do and don't. We are using this understanding together with comprehensive demographic data, provider, stakeholder and community consultation information to help us design and procure an inclusive service for the future.

As well as the positive impacts detailed above, the re-commissioning of the service could result in potential negative impacts, including:

- Future employment implications- some of the current third sector providers employ local people, and certainly recruit volunteers from the deprived area in which they work. Any cuts to funding, or different providers securing the contract, could affect training and development opportunities, employment and income for local people.
- There is a risk that a new service, by new providers is not familiar or acceptable to local people, which could result in low usage.
  Some of the current providers are small enough to respond well to community needs, but they may not be large enough to compete effectively in the LCC tendering process, potentially meaning

community needs remain unmet

5. Fact finding – what do we already know

Make a note here of all information you will be using to carry out this assessment. This could include: previous consultation, involvement, research, results from perception surveys, equality monitoring and customer/ staff feedback.

(priority should be given to equality, diversity, cohesion and integration related information)

During the review process, available data sets were used to build a picture of current population needs and levels of access to the current service by equality groups, in order to meet those needs. Provider monitoring information, annual reports, provider and stakeholder events, user and citizen questionnaires/ focus group information has been added. Also Census data and other national and local data sets have been analysed.

All current services are contracted to work in priority neighbourhoods that are within the 10% most deprived nationally and consequently target those on the lowest incomes. Some also focus on specific sub population groups, which historically have been in terms of the predominant BME groups, which research tells us have the poorest health. This, together with postal code referencing and equality monitoring, has provided evidence of access by individuals from deprived neighbourhoods, with all the diversity they contain.

We use the equality monitoring data which is returned by providers quarterly, to track access by different priority groups to all the activities, rather than providing targeted activities for e.g. disabled, those with learning difficulties or gay, lesbian and transgender individuals/ communities. We are aware that some of this data is missed by some organisations due to sensitivities/concerns around asking some questions. Gender reassignment, marriage and civil partnership and pregnancy and maternity, are not currently included . There is a separate city wide public health contract which covers Gypsy Travellers, (arguably the most disadvantaged group of all in terms of health inequalities), but the community health improvement contracts monitoring does provide evidence of access by this group as well.

The current service caters for a diverse set of sub communities, each with different histories, capacities and needs. Some live in a particular geography, side by side within a shared neighbourhood, whilst others are geographically dispersed, but may share a common bond through experience, ethnicity, disability, interest etc. Both in the current contracts and in the future, the intention is to reach the poorest and most inaccessible groups, in the most deprived communities so we can improve their health the fastest, close the health inequality gap and improve life expectancy.

The review has identified current and emerging health needs in terms of age, gender, and ethnicity as well as differences between deprived communities and non-deprived communities

Gender

We know that both nationally and locally women are more likely to access health activity, than men.
In 2012, the population of Leeds males was 367,900 and 383,600 females. Monitoring of users of the Community health development and improvement contracts during 2014-15 found they were overwhelmingly female (71%) to 29% male users, which doesn't adequately reflect the male female proportions in the general population. However, many of the providers are now responding to this imbalance and specifically targeting men in their activities. This has also been identified as a continuing need in the new contracts.

We are less informed about access to the Community health development and improvement services by transgender individuals and their experience of those services as it is most likely that individuals will identify with, and be recorded under their new gender.

Age
In the coming years, Leeds is expecting to see an increase in the numbers of children of primary school age, which also possibly means an increase in women of child bearing age, as well as increased numbers of those aged over 75 and over 85. Analysis of the Community health development and improvement contracts from 2014-15 showed most users were in the young to middle aged group (40% were 19-40yrs) and 33% were aged 41-65yrs. 18% were in the 65+ group and although no analysis beyond this is possible (i.e. breakdown between 65+ and 74yrs, 75-84yrs or 85+), monitoring returns do seem to suggest that the situation is acceptable, both to commissioner and users.

Older people, who access the services, do appear to be well catered for and according to monitoring data, access the service activities e.g. health walks, modern technology awareness, gardening groups, tea dances etc. These provide respite from loneliness, help functioning in the modern world and improve mental, as well as physical health. Whilst it is possible that older people who live in outer rural locations, may not be able to travel easily to these projects, the outer, more affluent areas are not included in our target audience. Although citizen questionnaires showed a perception amongst younger groups that older people are not well catered for and many respondents said that children's activities could be better, children who gave their views during the consultation were very positive about the range of activities that were on offer in their local areas.

Race
The most recent census (2011) indicates that the Leeds population has grown 5% since 2001 and is a diverse city, with over 140 ethnic groups including Black, Asian and other minority ethnic populations representing almost 19% of the total population.

Almost 93% of people across Leeds have English as their main language, but just over 51,000 (7.1%) reported a main language that was not English. Polish was the most popular (6,717) people, Urdu (4,989) and Panjabi (4,537) people. (Census 2011 Migration doc). In schools, 15 000 pupils in Leeds have a first language that is not English. This is equivalent to 18% of primary and 13% of secondary pupils.

The Leeds' non-UK born population is now 14%, higher than the Yorkshire and Humber average of 9% Non-UK born residents have settled particularly in Gipton and Harehills, City and Hunslet, and Hyde Park and Woodhouse wards. Gipton and Harehills ward is the first in the city where the BME population is in the majority (2011 Census).

In terms of access by BME groups, the majority of users of the CHIDS were White (62%), with 20% Asian or Asian British, 10% Black or Black British, 5% mixed/multiple ethnic group and the smallest number (2%) other ethnic groups.

Whilst many current service providers are well geared to meeting the needs of long established groups such as South Asian and African Caribbean, they have recently reported challenges around the language and cultural needs of some of the newly emerging communities. Interpretation and translation services are expensive (£40 per hour) and whilst many providers report that ESOL classes are very effective in helping people understand, they feel there are insufficient classes to meet increasing need and it takes considerable time to learn a new language well enough to improve health understanding, adapt to appropriate service use and integrate fully into their community. Other language and cultural impacts being reported include sanctions being applied for non-compliance around job seeking, inappropriate use of primary and secondary care and poor understanding around mental health/mental health services.

Religion
In terms of religion, the majority of people accessing the CHIDS during 2014-15 were Christian (42%) and the next largest group Muslim (41%). 14% of people did not state their religion and 1% Hindu and 1% Sikh users were recorded. This category will be continued to be monitored in the new contracts.

Poverty and Health and Wellbeing

In England, people living in the poorest neighbourhoods, will, on average, die seven years earlier than people living in the richest neighbourhoods. The average difference in disability free life expectancy is 17 years. So, people in poorer areas not only die sooner, but they will also spend more of their shorter lives living with impairments. This finding is reflected in Leeds statistics and although overall life expectancy has been increasing for all Leeds residents, the life expectancy for a man living in a deprived Leeds neighbourhood is 12 years lower than a man living in an affluent part of Leeds (Leeds Joint Health and Wellbeing Strategy 2013-15).

Current providers have historically tailored activities to meet the needs of those on very low incomes, the whole rationale behind this work, but many are reporting that the welfare reforms have resulted in an increase in families who are so impoverished, that focus often has to switch from health promotion, to crisis intervention work.

All providers are required to record postcode data, which shows they are providing an accessible service to neighbourhoods within the 10% most deprived nationally. As deprivation is still a huge challenge, particularly in inner city neighbourhoods, this needs to continue as a requirement into the new contract.

Sexual Orientation

We are less informed about access to the Community Health Improvement services by individuals who are Lesbian Gay or Bisexual and although sexual orientation is included in current provider monitoring returns, most people have identified as heterosexual (99%), or prefer not to say.

It is difficult to determine if this is a free choice, because they prefer the tightly knit and specialised support of other Lesbian, Gay or Bisexual people and the anonymity of services outside their neighbourhood, or a perception (imagined or real) that local services are not accessible to them. Local intelligence suggests that individuals from some newly emerging communities, where non heterosexual orientation is rejected, may choose not to answer this question, for fear of reprisal within their own community.

In Leeds generally, there is evidence of more mental health support available for Lesbian, Gay, Bisexual and Transgender people than in the past, and mainstream services are becoming more welcoming and accessible.

Evidence suggests that although the majority of Lesbian, Gay and Bisexual people do not experience poor mental health, some are at higher risk of mental disorder, suicidal behaviour and substance misuse. It also indicates that the increased risk of mental disorder in Lesbian, Gay and Bisexual people is linked to experiences of discrimination. Lesbian, Gay and Bisexual people are more likely to report both daily and lifetime discrimination than heterosexual people and higher rates of anxiety and depression than heterosexuals.

Gay men and Bisexual people are significantly more likely to say that they have been fi red unfairly from their job because of discrimination and discrimination has been shown to be linked to an increase in deliberate self-harm in Lesbian Gay and Bisexual people.

Lesbians are more likely to have experienced verbal and physical intimidation than heterosexual women and together, Lesbians and Bisexual women may be at more risk of substance dependency than other women. Lesbian, Gay and Bisexual people have also been shown to be at greater risk of deliberate self-harm.

One-third of Gay men, a quarter of Bisexual men and over 40% of Lesbians reported negative or mixed reactions from mental health professionals, when they disclosed their sexual orientation and one in five Lesbians and Gay men and a third of Bisexual men stated that a mental health professional made a causal link between their sexual orientation and their mental health problem.
(DOH Briefing No 9, 2007).

Monitoring is a key tool, in order to be able to respond to the needs of Lesbian, Gay and Bisexual individuals in the city, but providers often fail to use it, due to lack of understanding of its importance, or reluctance on the part of staff to ask what they feel are inappropriate questions (Volition 2014).

One current Community development and health improvement service provider has tried to rectify this by providing staff training and have recently reported that staff are now more confident to ask and users to provide this information. This good practice will be considered and to aid consistency across the wedges reflected in the service specification of the new service.

Disabled groups

26% of users were recorded as disabled and this seems to suggest that the service is accessible to this group, although this may not apply to all disabled groups. The majority of providers are showing a proportion of people with mental health impairments and physical impairments accessing the service.

Carers

Only 2% of users who accessed the Community health development and improvement service in the 12 months up to the review were described on monitoring returns as carers, so this may suggest limited access by this group, which needs to be addressed. However, this equated to 200 people and Carers Leeds do provide a substantial dedicated service for this group of people (including male carers). Very recently a Carers group, facilitated by Leeds North CCG has been set up and advertised. This is welcomed, as it is possible that some carers may have little support in their local neighbourhood. More research around this will need to be done around this, utilising other data such as the internal complements and complaints system, citizen surveys and consulting with other commissioners around specification design.

Currently the service does not ask for information around marital or civil partner status. This may need to be considered in the new contracts.

Are there any gaps in equality and diversity information Please provide detail:

Because we have low figures in terms of responses to the sexual orientation monitoring questions in our returns, our local knowledge as to reasons is limited. It is difficult to assess if this is a true reflection of the numbers of that particular group locally, if they prefer to access services elsewhere, or if some are accessing the activities, without disclosing status.

However, it does not appear that the questions are not being asked as during the 2014/15 period, 3,480 heterosexual individuals were recorded, 10 Gay, 11 Lesbian and 6 Bisexual individuals. Rather, it could be the low numbers of this equality group using the service, or disclosing, as in the same period 200 carers were identified and 2051 disabled individuals accessed the service.

There may be a gap in terms of newly arrived communities. This could be because of language barriers, lack of confidence, poor understanding or perhaps in some cases a wish to preserve anonymity.

As commissioners, we do not currently ask for data on gender reassignment, civil partnership arrangements, or pregnancy and maternity, but from monitoring information we do know that pregnant women are frequently targeted and supported in terms of e.g. parentcraft sessions, walking groups and healthy eating groups/activities. As long as they are aware of the service activities, access by this group does not appear to be a problem.

In terms of the new contracts, it will be imperative that the providers can demonstrate how they will continually monitor access by the relevant equality groups and also how they are responsive to continually changing demographics and the subsequent needs of new communities.

Action required:

1. Review Process

The review has considered issues arising from the evidence reviewed, examined the accessibility of projects to equality groups, and the consultation has included diversity considerations in terms of monitoring data, annual report examination, provider questions, stakeholder views and sampling of community respondents.

2. Service specification

This assessment, including the findings in the literature review, Health Needs Assessment and review process has highlighted a number of considerations, which will now be used to ensure that the new service specification and on-going monitoring arrangements in the new contracts are showing due regard to equality.

3. Ensure training provided.

One of the current provider organisations has reported that recent staff training has led to staff members being more confident around asking for information and a noticeable increase in the number of users willing to provide information around sexuality. This provider is the only one which has recorded bi-sexual users (6) accessing the service and recorded the second highest number of lesbian users (3). We will require the new providers to undergo this, or similar training, approved by Leeds City Council to ensure we can better track and address usage of the health improvement and development service by different sexual orientation groups.

There is likely to be an underestimation of access by transgender individuals as although some may identify themselves as such, perhaps in the change process it is expected that once through the process, they will state their new gender.

As a minimum, all providers will be required to adhere to the Leeds City Council equality and diversity policy and adopt its good practice.

4. On-going consultation by providers

We will ensure that the new contracts build in on-going consultation by the providers to ensure that they regularly test, assess, investigate and respond to apparent low usage of the service by any equality groups and that they strive to ensure staff teams, as far as possible are reflective of the communities they serve.

6. Wider involvement – have you involved groups of people who are most likely to be affected or interested

[x] **Yes** [ ] **No**

Please provide detail:

We have run a number of stakeholder consultation events, including, public health colleagues, other council colleagues, current providers, user groups and also done some street consultation with the local community, to gain their perceptions of the current service, identify gaps and ask views around what a good service would look like. However, in the interests of expediency, cost and lack of privacy in the street, whilst efforts were made to obtain a balance in terms of age, gender, ethnicity and disability, the community consultation was not set up to systematically seek out every equality group, it being assumed that individuals could provide an objective view, based on their personal experience, regardless of this.

Out of 20 people opportunistically questioned in Chapeltown and Harehills, the diversity of the local community and hence the need for the new contracts to be able to meet the needs of this population was well demonstrated. 1 person declined to participate because a non-English speaker and 1 declined to answer the ethnic grouping question. A mix of English (2), British (1), Any other white (Czech) 1, Pakistani (1), Indian (2) Bangladeshi (1) White and Black African (3) African (2) Black or Black British Carribean (3) White and Black Carribean (3).

In West Leeds, 16 people (12 females and 4 males) were consulted. Of those providing ethnicity data there were 7 White 2 African 2 Asian: 2 Polish and 1 mixed/multiple ethnic group.

Action required:

1. Findings from the review and consultations are being fed into developing the model and specification design.
2. To ensure that core equality characteristics and any other relevant characteristics for this service are built into the specification and that future monitoring arrangements capture this equality data.
3. Appropriate training to be put in place to enable delivery partners to build confidence around asking for potentially sensitive information.
3. All providers will be required to adhere to the Leeds City Council Equality and Diversity policy

7. Who may be affected by this activity?
please tick all relevant and significant equality characteristics, stakeholders and barriers that apply to your strategy, policy, service or function

Equality characteristics

[X] **Age**	[X] **Carers**	[X] **Disability**
[X] **Gender reassignment**	[X] **Race**	[X] **Religion or Belief**
[X] **Sex (male or female)**	[X] **Sexual orientation**	
[X] **Other**		

(Other can include – marriage and civil partnership, pregnancy and maternity, and those areas that impact on or relate to equality: tackling poverty and improving health and well-being)
Please specify: tackling poverty and improving health and well-being) pregnancy and maternity

Stakeholders

[X] **Services users**	[X] **Employees**	[ ] **Trade Unions**
[X] **Partners**	[X] **Members**	[ ] **Suppliers**
[X]		

Other please specify

Other potential providers (Third Sector or other public/private) who could potentially provide the service

Potential barriers.

[X] [X]

	Built environment		**Location of premises and services**
	Information and communication	X	**Customer care**
X	**Timing**	X	**Stereotypes and assumptions**
X	**Cost**	X	**Consultation and involvement**
X	**Financial exclusion**	X	**Employment and training**

X **specific barriers to the strategy, policy, services or function**

Please specify

Built Environment
The service needs to be delivered where it is accessible to all, including wheelchair users, parents with prams/buggies. Citizen questionnaires also cited the safety aspects (both traffic safety and street safety) issues when designing new services. Dangerous pavements and traffic were considered as important issues to consider.

Information and communication
There is a challenge in terms of information dissemination and communication, particularly with those, whose first language is not English. Translation skills are expensive and using other family members/friends may not be appropriate in some cases e.g. domestic violence issues. This could result in fewer people, who could benefit, accessing the service.

Citizen questionnaires revealed low awareness of current services although it was evident that the closer the service was to the sampling site, the more likely the respondent would recall the service. This shows that the new service needs to advertise widely, frequently, in a suitable channel for the target audience and in a very obvious way.

Timing
Timing of the service to ensure access for working age individuals, parents with school aged children and to enable more vulnerable individuals including impairment groups, learning disabilities and elderly people to travel safely.

Citizen surveys show that timing to accommodate working people and older people is important when the council is developing new service. Also dependent on activity/target audience/community needs, timing should consider school/nursery times to enable families and single parents to participate.

Cost
Recent and future budget reductions could mean that services that are preventive by nature, are not prioritised, current Third Sector providers do not survive and the most vulnerable groups in marginalised communities (both in terms of poverty and community of interest i.e. equality group, that have the poorest health) are not supported to maintain good levels of health and wellbeing.

Financial Exclusion
Local people in deprived areas have little or no disposable income and services need to be free or very low

cost. They also need to be locally available as affordability of childcare is an issue for families and single parents. Crèche considerations are important to enable those who are most in need to participate

Location of premises and services
People living in deprived communities are often reliant on having services nearby as travelling can be costly both financially and in terms of time. However, it is important to have services situated so they can be accessed by public transport. Cultural preference also needs to be considered as some e.g. Bangladeshi women prefer activity away from their own community.

Stereo types and assumptions
Within the contract, the providers will be required to treat all people with dignity and respect and not make any stereo typical assumptions that could upset anyone who wishes to access the service.

Consultation and engagement
The review process has comprehensively consulted with a wide cross section of people-those providing current services, service users, potential service users, stakeholders, Public Health and other relevant Leeds City Council colleagues, Elected Members and university colleagues. A snap shot street consultation, which includes a wide range of different ages and ethnicities as well as taking male and female views on board. The new specification will state a requirement for providers to consult regularly with users/potential users to ensure that quality of customer care, and location and timing is acceptable to users of all equality groups, if they wish to use the service.

Addressing financially excluded groups is core business, both now and in the future, so cost of activities, employment and training of staff and volunteers, location of premises and services, will be considered in detail through the service specification.

Employment and training
The review has highlighted potential impacts on local jobs when the service goes out to procurement. If the contract is secured by new provider/s, then staff jobs (who may be local) could be at risk. A need for training staff around collecting equality groups data has also been highlighted.

8. Positive and negative impact

Think about what you are assessing (scope), the fact finding information, the potential positive and negative impact on equality characteristics, stakeholders and the effect of the barriers

8a. Positive impact:

The service review and data analysis of the population needs in our priority neighbourhoods, as well as provider and customer feedback has helped us to identify 'what works' and current gaps in service. It has also helped us to assess demographic trends and the variation in usage by equality groups. This has helped us consider what needs to happen to ensure the future service is able to address currently unmet needs.

For instance, providers have already identified a need to better meet the needs of newly emerging Eastern European communities and others such as African and refugee asylum seeker populations, which have specific cultural needs. Knowing the barriers and learning from those who have adapted practice to help overcome some of the barriers will help us develop a more inclusive and efficient service for the future.

Action required:

1. Use the review findings to build adaptations and flexibility of service to ensure active monitoring/appropriate response to apparent low use by any equality groups into the new specification.
2. Conduct more research to find out why some groups do not appear to be accessing current service
3. Ensure potential providers can demonstrate, how they will deliver an inclusive service in a non-burdensome way

8b. Negative impact:

1. The increasing number of languages and variation in dialect in local communities makes it a challenge to ensure that services are well geared to meeting the needs of all equality groups and this could take efforts away from those groups that have traditionally found the service to meet their needs.

2. Translation costs are expensive and although some family members/friends have in the past been asked be asked to translate, it is not always appropriate when dealing with sensitive issues e.g. domestic violence, mental health, post- traumatic stress syndrome, lasting effects of torture or financial issues. These are issues that are routinely presented to our Third sector partners.

3. Fact finding has identified low recorded usage of the current service by carers and by a number of sexual orientation groups

4. If we were to add further categories of equality data, providers may find it burdensome and feel it inappropriate for their target groups. The service needs to see the tangible benefits of the additional activity, rather than it being a purely contractual function.

Action required:

1. Handle sensitively and source training that can help providers collect accurate equality and diversity information about their users
2. More investigative work to be done to find out why some groups are not recorded as accessing current services and what can be put in place to rectify this situation in the new service.

9. Will this activity promote strong and positive relationships between the groups/communities identified?

[X] **Yes** [ ] **No**

Please provide detail:

If groups are more visibly mixed, there is greater potential for community cohesion to increase and social isolation to decrease, positive mental health will be supported and barriers due to lack of understanding of others is likely to decrease.

Action required:

Identify good practice models where diverse groups have worked together. Design specification to ensure different providers can work together, rather than providers focusing only on their separate target group e.g Asian women, or older people

10. Does this activity bring groups/communities into increased contact with each other? (e.g. in schools, neighbourhood, workplace)

X	**Yes**		**No**

Please provide detail:

The new services will be open to all community members, with the intention that it will encourage strong community relations. This could be further enhanced by increased activity to engage and support other individuals/groups that are more reticent about joining in. The current providers have reported increased joint working and this can benefit both organisation and users, as linkages are made between projects and different users of projects. Mechanisms to encourage this will be by built into the new service specification.

Action required:

Now building into specification

11. Could this activity be perceived as benefiting one group at the expense of another? (e.g. where your activity/decision is aimed at adults could it have an impact on children and young people)

	Yes	X	**No**

Please provide detail:

The service will predominantly targets adults, but as activity is often family focused it will be open to all. As, Cupboard (a young people's project) has been included in South and East Leeds previously, the opportunity to provide activity for young people across all three areas will be included in the new contracts. Providing these services do not mean resource is diverted away from other groups, but thought needs to be given as how to increase and record access by all groups, particularly those that are from newly emerging communities.

Cupboard is currently working only in the South of the city and many community respondents felt that there was a dearth of activities locally for young people (not necessarily borne out by the young people we surveyed). However the opportunity to provide this activity, should it be a need in a particular area is being built into the new specification.

Action required:

Address in specification

12. Equality, diversity, cohesion and integration action plan
(insert all your actions from your assessment here, set timescales, measures and identify a lead person for each action)

Action	Timescale	Measure	Lead person
Ensure any gaps identified in current service review are systematically addressed in the new service specification	Review findings at beginning of September 2015	Use evidence collected during review to inform specification development. Support and challenge sessions will test out ideas to help modify and develop final version	LB
Ensure on-going consultation processes in new service include views from equality groups as to whether service meets their needs, unless these are being met elsewhere e.g. by other services, charities or city wide contracts	Consultation process for review findings began Sept 2015 Specialised services e.g. LIP, MESMAC, Volition and Carers Leeds invited to support and challenge event to gain insight into equality groups not yet consulted	Specification contains appropriate wording to ensure providers are clear about the requirements to ensure that any barriers to access for people with the relevant equality characteristics are removed	LB
Work up detailed plans to address language barriers to help facilitate added value workstreams e.g.JC+, community learning, health protection, appropriate use of public services etc	Nov 2015	Relevant individuals invited to support and challenge event in January, to help work up appropriate clauses in specification Providers to ensure that workforce adequately reflects the demographic make-up of	LB (in specification)

Action	Timescale	Measure	Lead person
		the local community, including access to appropriate community languages	
Ensure new service model is flexible to ensure the needs of communities of interest, especially those of newly arriving individuals can be met more effectively	November 2015	Service specification being developed. Incorporating detailed measures which need to be in place Monitoring arrangements to ensure that providers adhering to service specification and regularly assessed	LB
Provider to achieve the Domestic Violence Quality mark by the end of the first year of the contract.	To be included in the specification by January 2016.	Specification to include this and other relevant quality marks Contract officers to monitor providers to ensure compliance	LB, RB & JH
Provider to recruit staff that is in line with Equalities Act. All recruitment opportunities to be advertised locally as well as nationally including local newspapers.and websites that will encourage diversity.	To be included in the specification by January 2016.	Provider to submit information on where opportunities are advertised Provider to ensure that workforce adequately reflects the composition of the local neighbourhoods	LB, RB & JH
Ensure the collection of data pertinent to equality monitoring by the provider is written into the specification. To be specific on what data is to be	To be included in the specification by January 2016. Equality data to be submitted on a quarterly basis.to enable	Number of individuals taking up the service	LB, RB & JH

Action	Timescale	Measure	Lead person
collected, when it is to be collected, when it will be submitted and the reason for collection. To particularly respond to those categories e.g. carers, Lesbian Gay and Bisexual. and showing low participation in current activity Transgender monitoring issues still being clarified and this project will be guided by LCC Equality Team once policy is clear.	monitoring and responsive action.		
To ensure the venues for service delivery are compliant with the Equalities Act 2010 and venues are accessible to deprived communities e.g. well serviced bus routes,	Throughout the contract period	To monitor where services are delivered from	LB, RB & JH
Patient and Public Involvement (PPI) section to be included in the service specification. An opportunity for service users and non-service users to feedback. Detailing the kind of PPI that is expected including focus groups with equality groups but not exclusively.	To be included in the specification by January 2016. PPI to be submitted on an annual basis.	PPI Report.	LB, RB & JH
Marketing / Communication	To be included in the	A Service leaflet and	LB, RB & JH

Action	Timescale	Measure	Lead person
section to be included into the service specification clearly outlining the need for service information leaflet in line with The Information Standard. Must have communication in different languages.	specification by January 2016.	communication and branding strategy.	
Service Specification to include a section on engagement and access. Key groups to be identified in the specification.	To be included in the specification by January 2016.		LB, RB & JH
Method statement question on communication and engagement in the tender documentation. Tenderers to submit communication plan for the service.	March & July 2016	Evaluated using set criteria.	Project Team
All complaints to be captured and forwarded to the commissioner for review within five days. This will improve service provision and the nature of the complaint will help identify any issues that are impacting on equality. To be included in the specification	Provider to submit all complaints to the commissioner within five days. To be included in the specification by January 2016.	Number of complaints received	LB, RB & JH
All compliments to be captured	Provider to submit all	Number of compliments	LB, RB & JH

Action	Timescale	Measure	Lead person
and forwarded to the commissioner for review within five days. This will improve service provision and the nature of the compliment will help identify any issues that are impacting on equality. To be included in the specification	compliments to the commissioner within five days. To be included in the specification by January 2016.	received	
Ensure the collection of data pertinent to equality monitoring by the provider is written into the specification. To be specific on what data is to be collected, when it is to be collected, when it will be submitted and the reason for collection.	To be included in the specification by January 2016. Equality data to be submitted on a quarterly basis.to enable monitoring and responsive action.	Number of individuals taking up the service.	LB, RB & JH
Customer service requirements to be built into the specification.	To be included in the specification by January 2016	Complaints and compliments.	LB, RB & JH

13. Governance, ownership and approval State here who has approved the actions and outcomes from the equality, diversity, cohesion and integration impact assessment		
Name	Job Title	Date
Lucy Jackson	Consultant in Public Health	28/1/16
Date impact assessment completed 2nd December 2015		

14. Monitoring progress for equality, diversity, cohesion and integration actions (please tick)

x	As part of Service Planning performance monitoring
x	As part of Project monitoring
x	Update report will be agreed and provided to the appropriate board Please specify which board

(Public Health Programme Board)

	Other (please specify)

15. Publishing

Though **all** key decisions are required to give due regard to equality the council **only** publishes those related to **Executive Board**, **Full Council, Key Delegated Decisions** or a **Significant Operational Decision.**

A copy of this equality impact assessment should be attached as an appendix to the decision making report:

- Governance Services will publish those relating to Executive Board and Full Council.
- The appropriate directorate will publish those relating to Delegated Decisions and Significant Operational Decisions.
- A copy of all other equality impact assessments that are not to be published should be sent to equalityteam@leeds.gov.uk for record.

Complete the appropriate section below with the date the report and attached assessment was sent:

For Executive Board or Full Council – sent to **Governance Services**	Date sent:
For Delegated Decisions or Significant Operational Decisions – sent to appropriate **Directorate**	Date sent:
All other decisions – sent to equalityteam@leeds.gov.uk	Date sent:
