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: Public Health	Service area: Health Improvement
Lead person: Chief Officer, Consultant – Public Health	Contact number 07712 214811
Date of the equality, diversity, cohesion and integration impact assessment: Version 1 November 2015 Version 2 (following review) October 2016 Version 3 (following review) January 2017	

1. Title: Leeds Integrated Healthy Living Service project

Is this a:

	Strategy /Policy	x	**Service / Function**		**Other**

If other, please specify

2. Current members of the assessment team:

Organisation	**Role on assessment team e.g. service user, manager of service, specialist**
LCC (Public Health)	Specialist
LCC (Public Health)	Specialist
LCC (Public Health)	Specialist Equality and Diversity Lead
LCC(Public Health)	Specialist
LCC(Public Health)	Specialist
LCC (PPPU)	Specialist
LCC (PPPU)	Specialist
LCC	Specialist Reviewer

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 citywide, in a way that maximises community assets and skills.

The current programme for adult healthy living activity is branded as 'One You Leeds' (from February 2016) and was previously 'Leeds Let's Change'. The Council is the responsible 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 currently provided by local third sector organisations and all are funded by Public Health. The integrated healthy living service will be due to go live in October 2017 and will consist of 2 contracts which will deliver a range of healthy living interventions and activities:

- 'One You Leeds' – focusing on adults
- 'The Family Healthy Living Programme' – focusing on family and children

In addition, work is ongoing to explore potential co-commissioning or alignment opportunities with Clinical Commissioning Groups (CCGs) in Leeds for related healthy living related activity which they fund or have plans to fund such as social prescribing services.

This project will consider the best way for healthy living services to be provided in the future, and through a robust commissioning process, determine 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	☐
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: Leeds Integrated Health Living Service is the working title for 2 contracts which will be live in October 2017. 'One You Leeds', which is a service predominantly catering for the adult population and The 'Family Healthy Living Programme', aimed at children and families. Both contracts aim to improve the health and wellbeing of the population through offering a range of interventions and activities, from self-help to more intensive one to one interventions, in order to support people change lifestyle behaviours and then to sustain that change.	

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

1. Early discussion of equality by the healthy living project team (includes representatives from Public Health and Procurement), identifying gaps in knowledge, actions to address these and periodic review of equality issues.
2. Carrying out an extensive Health Needs Assessment (HNA) 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 services 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) which helped us to broadly 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 has also identified gaps in data and areas where improvements can be made to data capture, to be able to monitor service activity in relation to access by groups with protected characteristics.
    - 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 the direction for ensuring services contribute to reducing 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.
    - The HNA can be found here http://observatory.leeds.gov.uk/resource/view?resourceId=4901
    - A summary of the HNA can be found here http://observatory.leeds.gov.uk/resource/view?resourceId=4902

3. We have been mindful of the interaction between the integrated healthy living service re-commission and the Leeds Community Health Development Review 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 and wellbeing.

4. A review was carried out of Integrated Healthy Living Service Models and Procurement Plans in the UK in order to identify a range of service and procurement models to be considered in an options appraisal. This enabled information and learning to be considered from a number of other Local Authorities and helped inform the rationale for a move from individual healthy living services to an integrated model. An integrated model would address equality through including robust wellness outcomes focussing on reducing inequalities through a demonstrable targeted approach to those greatest in need.

5. Consultation and Insight. In order to draw together the information from a range of consultation and insight, a comprehensive Consultation Report was produced. This report comprised a thematic review across all LIHLS-related consultations and insight, from which key issues to inform service redesign were extracted. 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.
   The Consultation Report can be found here
   http://observatory.leeds.gov.uk/resource/view?resourceId=4903

The consultation report drew information from the following sources (all full reports are available from Leeds City Council Public Health where web links are not provided):

- Internal two hour workshops for Leeds City Council public health staff, 2 April 2015 and 10 September 2015 (17 and 25 attendees). This generated ideas around effective approaches and areas for further consideration, and included issues linked to equality.
- Provider survey (summer 2015) – to gain current provider views into the strengths and gaps in current service provision compared with the need of their service users
- CCG meetings throughout May to September 2015 to a) discuss the model of delivery and consider opportunities to align with CCG commissioned services and b) consider the views of GPs as key referrers to the new IHLS.
- Current Provider Consultation Workshop, 25 August 2015 (25 attendees) Included discussion questions related to equality issues to develop our options for service delivery and to inform the content of the service specification. Feedback will help identify challenges and suggestions for mitigation to incorporate into service redesign.
- Children's physical activity provider workshop, August 2015 (5 attendees) – To determine what types of physical activities encourage children to be active, how to effectively engage with children to be physically active and involve them in service design
- Healthy Living OBA event 18 September 2015 (150 attendees) – To determine the priorities for Healthy Living in Leeds taking into account view from a wide range of

stakeholders from various organisations across the city. A separate report was produced and is available on request from public health.

- Locality Community Health Improvement and Development Service Review, September 2015
- Primary schools in the south of Leeds, September/October 2015 (38 consultees) – Questionnaires were completed by children to find out what children knew about being healthy, what activities they liked doing and what helped them to be healthy through physical activity, healthy eating, sitting less and healthy weight
- 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. We carried out a review of previously published Insight , relating to healthy living services in Leeds. This entailed a drawing together a number of reports of insight work with service users, service providers and the general public and a analysis the common themes across the reports. The report can be found here http://observatory.leeds.gov.uk/resource/view?resourceId=4904
- Health Living Services Consultation Public Research Report (October 2015) Additional consultation work was conducted by DIVA (an independent social marketing company) comprising focus groups with over 100 members of the public including BME respondents and people with long term physical and mild to moderate mental health conditions. Insight work into smoking and smoking cessation was conducted by Leeds Beckett University on behalf of Leeds South and East CCG (December 2015). This involved face to face interviews and surveys with a range of stakeholders including the public, users of the smoking service, smoking service staff and referrers to services including GPs.

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

1) We requested information from Providers on what equality considerations they've already made, including current data collection and whether their staff have 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 and 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 attending 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.

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

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

Please provide detail:

Please also see list of reports outlined in section 5 (fact finding)

1. To involve people who are most likely to be affected by this service, we commissioned Diva (insight provider) to carry out focus groups with members of the public. This enabled 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.

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 those which are discrete aspects specific to particular services. We will also be proactive in working with services around collecting data to evidence their effectiveness in addressing the needs of particular target groups whilst taking into account best practice in information governance. For example, our future service model will need to consider:

Targeting: As noted earlier, within the universal offer, the re-commissioning 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:

For Contract 1 (One You Leeds)

- People living in the most deprived communities in Leeds particularly:

  - People from Black or Minority Ethnic (BME) communities
  - New and emerging migrant communities
  - People with, or at risk of developing, long term health conditions (COPD, CVD, diabetes, cancer)
  - Pregnant women and their partners
  - People with mild to moderate mental health problems

For Contract 2 (Family Healthy Living Programme)

- Families with children aged 5-19 years old living in the most deprived communities who are overweight and/or inactive
- Children and families living in the wards with the consistently highest rates of child obesity (based on National Child Measurement Programme data)
- Children and families from BME communities

- Children in care and their carers
- Children and families with mild to moderate learning disabilities

Information: information both about services and about healthy lifestyle advice will be written in Plain English, will be easy to understand and where possible, available in a range of languages to reflect the diversity of local communities as noted in the HNA, as well as in a range of formats to ensure these are accessible to disabled people. The use of visual aids and images should be used to support understanding of messages as many people with English as a second language don't read their first language.
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.
The new service will be required to use Community Language Interpreters and Language Line or an equivalent interpreting service where needed.

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 vital 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 needs to be strengthened 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 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 – while it may not necessarily be essential to gain data on numbers but we need to ensure that the service is open and welcoming – requirements for equality related staff training, organisational policy, environmental factors etc. can be built into the service specification.

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. The requirement for staff to complete the necessary training will be included within the service specification workforce section.

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/physical activity), 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 re-commissioning 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.

Action required:

All the above aspects will require weaving considerations of equality throughout the whole re-commissioning process and specifically within the service specification. This is reflected in the action plan in section 12.

We will ensure the service model takes a person-centred approach and has strong connections to initiatives that support (such as buddying people to services), build confidence, raise self-esteem and community participation as well as to mental illness services

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.

Ensure the application process to become/ continue as a provider is able to accommodate smaller/specialist organisations and consortia to apply as well as larger organisations

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.

To encourage people to use the service there is the potential to promote stories, events and '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 and be an example of good practice for other services.

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.

There will also be a requirement for the new service to consider the use of community assets in supporting and sustaining behaviour change, both in terms of peer support, volunteering and facilities within communities.

To provide volunteering opportunities for clients to develop their personal skills in supporting and developing the programme and if appropriate to provide access to relevant quality training

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.

The promotion of community assets to support initial and sustained behaviour change will be a feature of the Healthy Living System in Leeds.

Action required:
Ensure that the Integrated Healthy Living Service specification includes a requirement to develop exit plans with clients which will actively identify and encourage the use of community assets to support health and wellbeing and monitor through the performance review process.

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 where the population is more likely to have greater capacity for self-help 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 in terms of addressing health inequalities. 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:

1) Develop and implement an appropriate communication plan to include additional support/ briefings that may be needed to provide support to help individuals (e.g. Elected Members) understand the approach being used here to address inequalities.

2) Include within the service specification a requirement to market all aspects of the universal service to ensure the available interventions are particularly promoted to the appropriate audience.

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)

This action plan represents the actions required throughout the whole re-commissioning process, actions that have been completed are shaded out.

Action	Timescale	Measure	Lead person
Throughout the project			
Ensure equality is considered at relevant stages of the re-procurement by flagging at the start of each stage.	Ongoing, review plan for beginning of each stage	ECDI reviewed at the start of each stage	Project Manager PH Project Lead
Stage 0- Identifying the need for change			
Review service and epidemiological data – identify the gaps in terms of data and information for each of the protected characteristics?	End July 2015	Completed summary	PH Project Lead PH – Advanced Health Improvement Officer
Ensure key equality groups are considered and represented in consultation to inform the service model.	30 November 2015		PH – Health Improvement Officer PH – Advanced Health Improvement Officer
Stage 1 – Feasibility and Options appraisal			

Action	Timescale	Measure	Lead person
Ensure the preferred option for service delivery does not exclude consortia of smaller organisations	December 2015	Options appraisal completed	PH Project Lead
Stage 2 Detailed business case and planning of preferred option			
Stage 3 - Designing the change			
The provider uses local facilities e.g. hire of sports centre, usage of parks to sustain long term change and to increase access to interventions.	To be included in the specification by 8th July 2016	Draft published	PH Project Lead
The provider of the FHLP to work towards increasing participation of young women/girls in physical activity.	To be included in the specification by 8th July 2016	Quarterly monitoring	PH – Advanced Health Improvement Officer
Ensure key equality groups are given the opportunity to comment on the draft specification and that key issues pertinent to equality are included e.g. ensure that organisations demonstrate and act in accordance with LCC	To be included in the specification by 8th July 2016.	Provider to submit information on where opportunities are advertised	Project team

Action	Timescale	Measure	Lead person
Equality and Diversity policy.			
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 8th July 2016.	Monitor provider – following review, consideration given and the requirement to achieve the DV quality mark in the specification taken out.	PH Project Lead
Ensure the following workforce requirements are included into the specification • Child Sex Exploitation training	Included in the safeguarding section of the service specification by 8th July 2016	Monitor provider	PH Health Improvement Officer
Ensure the specification is clear as to the religious, cultural and dietary needs of the communities of Leeds e.g. food contracts cater for vegetarian and halal options, opening hours take into account Ramadan etc.	To be included in the specification by 8th July 2016.	Monitor provider	PH Project Lead
Ensure the collection and reporting of data pertinent to equality monitoring by the provider is written into the specification.	To be included in the specification by 8th July 2016.	Included requirement to produce reports evidencing equality monitoring and responsive action.	PH Project Lead PH Health Improvement Officer

Action	Timescale	Measure	Lead person
Include within the specification a requirement to monitor the number of DNA (Did not attend). Service provider to contact service users that miss appointments. In order to inform service improvement and provide an insight into any equality issues e.g. access.	To be included in the specification by 8th July 2016. .	Included requirement to produce reports evidencing equality monitoring and responsive action.	PH Project Lead PH Health Improvement Officer
To ensure the venues for service delivery are compliant with the Equalities Act 2010 and are accessible to deprived communities and target groups e.g. well serviced bus routes, good disabled access	To be included in the specification by 8th July 2016	To include statement in the service specification	PH Project Lead PH Health Improvement Officer
To ensure the workforce delivering the service attend equality and diversity training	To be included in the specification by 8th July 2016.	To be included in the service specification.	PH Project Lead
Marketing / Communication section to be included into the service specification clearly outlining the need for service literature and information to meet 'The Information Standard'.	To be included in the specification by 8th July 2016.	To be included in the service specification.	PH Project Lead PH Health Improvement Officer
All compliments and	To be included in the	In the service specification,	PH Health Improvement

Action	Timescale	Measure	Lead person
complaints to be captured and forwarded to the commissioner for review within five days and reviewed quarterly. This will improve service provision and the nature of the complaint will help identify any issues that are impacting on equality.	specification by 8th July 2016.	terms and conditions and section 3. (general requirements)	Officer
Stage 4 – Making the change			
Assess organisations on communication and engagement to ensure appropriate methods are proposed for the target audience	June 2016	Include questions relating to communication and engagement in the method statement. Tenderers to submit communication plan for the service. Evaluated using set criteria.	Project Team
Ensure when going out to tender that the process is open and transparent to agencies working with groups with protected characteristics.	During procurement	Procurement opportunity advertised on YorTender, bids encouraged from consortia	Project Manager
Stage 5 – Mobilisation			

Action	Timescale	Measure	Lead person
Provider to recruit staff 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 reviewed during the mobilisation phase (between April –September 2017)	To monitor during mobilisation period Numbers of staff recruited from local areas	Contract manager PH Project Lead PH Health Improvement Officer
To ensure the venues for service delivery are compliant with the Equalities Act 2010 and are accessible to deprived communities and target groups e.g. well serviced bus routes, good disabled access	To be reviewed during the mobilisation phase (between April –September 2017)	Mapping of service delivery locations to be monitor during mobilisation period	Contract manager PH Project Lead PH Health Improvement Officer
All marketing and communications meet 'The Information Standard' and is provided in appropriate languages and formats to meet the needs of the population served and specifically target groups	To be reviewed during the mobilisation phase (between April –September 2017)	Information produced that meets the standard	Contract manager PH Project Lead PH Health Improvement Officer
Public Health to share best practice and new research with the provider.	Public Health to share information throughout mobilisation	Information provided	Contract manager PH Project Lead PH Health Improvement Officer

Action	Timescale	Measure	Lead person
Stage 6 – Steady state			
Ensure continued monitoring once the contract is awarded to ensure service take up by equality groups.	Include requirement to report back within activity monitoring /KPIs Commencing with Q3 (Oct-Dec 2017) data	End of year report	Contract Manager PH Project Lead PH Improvement Officer
Ensure key equality groups are considered and represented in the Service development and delivery	Monitor throughout the life of the contract	Information included in end of year report	Contract manager PH Project Lead PH Improvement Officer
To monitor the number of DNA (Did not attend). Service provider to contact service users that miss appointments. This will lead to service improvement and provide an insight into any equality issues e.g. access.	Monitor throughout the life of the contract	Provider to submit a quarterly report detailing number of missed appointments and reasons why. To also include what actions have been put in place where appropriate.	Contract manager PH Project Lead PH Improvement Officer
Provider to work towards increasing participation of young women/girls in physical activity.	Monitor throughout the life of the contract	Quarterly monitoring	PH Improvement Officer
To ensure the venues for service delivery are compliant with the Equalities Act 2010	Monitor throughout the life of the contract	Mapping of service delivery locations included in end of year report	Contract manager PH Project Lead

Action	Timescale	Measure	Lead person
and are accessible to deprived communities and target groups e.g. well serviced bus routes, good disabled access			PH Improvement Officer
Provider to recruit staff 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.	Monitor throughout the life of the contract	End of year report Numbers of staff recruited from local areas	Contract manager PH Project Lead PH Improvement Officer
All marketing and communications meet 'The Information Standard' and is provided in appropriate languages and formats to meet the needs of the population served and specifically target groups	Monitor throughout the life of the contract	Information produced that meets the standard	PH Project Lead PH Improvement Officer
All compliments and complaints to be captured and forwarded to the commissioner for review within five days and reviewed quarterly. This will improve service provision and the nature of the complaint will help identify any issues that are impacting on equality.	Provider to submit all complaints to the Public Health Contracts Manager within five days and complaints to be reviewed quarterly.	Number of complaints received	Contract manager PH Project Lead PH Improvement Officer

Action	Timescale	Measure	Lead person
Public Health to share best practice and new research with the provider relating to equality.	Public Health to share information throughout the length of the contract	Information provided	Contract manager PH Project Lead PH Improvement Officer

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
	Consultant in Public Health	11th December 2015
Date impact assessment completed		**11th December 2015**
Date impact assessment reviewed and amended		**18th January 2017**
Approved by:		
	Consultant in Public Health	

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
	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: 09/03/2017
All other decisions – sent to equalityteam@leeds.gov.uk	Date sent: