Appendix B
KENT COUNTY COUNCIL
EQUALITY ANALYSIS / IMPACT ASSESSMENT (EqIA)

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Directorate:
Social Care, Health and Wellbeing

Name of policy, procedure, project or service
Health Improvement Service

What is being assessed?
The Integrated Health Improvement Service

Responsible Owner/Senior Officer
Dr. Faiza Khan, Consultant in Public Health

Date of Initial Screening
26th Oct 2015

Date of Full EqIA : during contracting

Update each revised version below and in the saved document name.

Version	Author	Date	Comment
V1	Rachel Coyle, Wikum Jayatunga	27/10/15	
V2	Wayne Gough	28/10/15	Action plan updated
V3	Rachel Coyle	30/10/15	Screening grid and action plan updated
V4	Rachel Coyle	30/10/15	Revisions to action plan
V5	Rachel Coyle	02/11/15	Revisions to action plan
V6	Rachel Coyle	02/11/15	Revisions to action plan

Screening Grid

Characteristic	Could this policy, procedure, project or service, or any proposed changes to it, affect this group less favourably than others in Kent? YES/NO If yes how?	Assessment of potential impact HIGH/MEDIUM LOW/NONE UNKNOWN		Provide details: a) Is internal action required? If yes what? b) Is further assessment required? If yes, why?	Could this policy, procedure, project or service promote equal opportunities for this group? YES/NO - Explain how good practice can promote equal opportunities
		Positive	Negative	Internal action must be included in Action Plan	If yes you must provide detail
Age	YES - The proposed Health Improvement Service (HIS) would be open to adults of all ages however we note some aspects of the model could be used preferentially by different age groups. Smoking prevalence is highest in young adults at (32%) in men aged 25-34 and women (29%) in the 20-24. It is noted that young people are low users of services such as smoking cessation. This discrepancy between service use and smoking prevalence indicates that the current stop smoking	HIGH	MED	**Internal Action** – not required **Further assessment** - Public consultation will be used to ensure services are delivered in a manner which is accessible and acceptable to a variety of age groups, e.g. medium of consultation, preferred location. Data on service use by age should be recorded and reported by providers, so that any underutilisation by age group can be recognised and acted on. With regards to underutilisation of stop smoking services by younger adults this will be addressed within the focus groups to shape the model.	YES – through shaping the proposed model through public consultation we have the opportunity to create a service which is more accessible. Therefore there should be a greater impact on the various health behaviours addressed in the model. For example we would explore using technology to promote novel ways of accessing the service, e.g. use of online services. Currently some services have a range of delivery methods, for example stop smoking services can be delivered through an online group, which improves accessibility for people unable to attend the services due to either time constraints or issues with mobility.

	service is underutilised by younger adults. Obesity – local data indicates that older people (>40years) are higher users of weight management services. However this group is at higher risk of obesity related illness, and therefore could benefit disproportionately. NHS Health Checks, carried out once every 5 years, are targeted at individuals aged 40-75. Between 2013-2018 there will be an estimated 455,591 individuals eligible for a Health. Of these individuals 8.7% have been offered a health check in 2015/16, of whom 1 in 5 have accepted. If this trend was to continue we would expect that over the 5 year period until 2018 52.7% of eligible Kent residents would be offered a Health Check and only 19.1% would have had			**Further action** - Health checks will be offered as part of the proposed model. Data should be collected to monitor uptake of health checks relative to current uptake.	Through the Health Improvement Service we would aim to increase online accessibility to include some aspects of healthy weight, physical activity and mental health services. The Health Improvement Service also acts as a hub for referral to associated health improvement programmes targeted to need. Where these services are targeted at older people access for users with mobility issues has been incorporated into the programme. For example, if appropriate transport can be arranged to the Postural Stability Service, a service aims to reduce falls in older people. Chronic disease, such as heart disease and stroke, is more common in older people. Increasing the uptake of Health Checks in this group would facilitate early health interventions and help to prevent more serious illness. Health Trainers would play a key role in delivering the Health Improvement Service. Health Trainers are skilled in assessing new clients and ensuring that advice is tailored to suit each individual, e.g. age appropriate

	one. Increasing uptake in this group could have a positive impact on health.				physical activity recommendations.
Disability – long term illness	NO – the Health Improvement Service would be open to all adults, regardless of physical disability or learning difficulties. It is recognised that chronic illness is associated with a higher risk of mental health problems, and with a higher prevalence of risk factors for chronic illness such as smoking, overweight and physical inactivity. The integrated service would offer more opportunities to address a wide range of issues which are associated with ill health than separate services.	HIGH		<u>Long-term illness</u> – No internal action required. **Further action** – Focus groups will be carried out to ensure that the views of a wide range of service users are represented. This will include users with chronic illness, physical disability, sensory impairment and mental health conditions. In addition, focus groups will include the providers of the current services which we propose to integrate, for example the physical activities services and the mental health and well-being services. It is recognised that current providers, including NHS providers, and voluntary organisations, have extensive experience in issues relating to access of their services by particular populations and it is important that this be considered during the consultation.	Yes – the integrated model offers greater opportunities for health improvement in people with long-term illness. Venues for face-to-face consultations will be accessible to people with disabilities.
Disability – learning difficulties	YES – 6490 of adults registered at a GP in Kent and Medway were documented as having a learning disability, equivalent to 0.46% of		Unknown	<u>Learning disability –</u> **Internal action** – Monitoring of service use by adults with learning difficulties will be needed to ensure uptake is as expected.	All documentation regarding the service will be available in Easy Read format. All service information will be produced in accordance with KCC

	adults. However it is recognised that many adults with learning difficulties will not have been given this diagnosis, thus this figure is an underestimate. The evidence shows that eligible adults in Kent with learning difficulties are less likely to have an NHS Health Check than adults without learning difficulties – 33.2% compared to 40.2%, which is lower than the England average, 52.7%. This represents a missed opportunity for health promotion.			**Further action** - Public consultation should include getting input from people living with learning disabilities and carers to ensure that the service is appropriate and accessible. Focus groups may be used to ensure that representation of the views of adults living with learning disabilities are represented.	and UK government guidance on inclusive communication.
Gender	No – the Health Improvement Service would be open to all adults irrespective of gender. Practitioners within the services would assess each service user as an individual and tailor support and interventions to individual need. A key component of this is that practitioners have a broad range of knowledge	NONE	NONE	Internal action – monitoring of service uptake by gender will be necessary to evaluate the impact of the Health Improvement Service. This is necessary to detect any change in uptake, either positive or negative, from the current models of care delivery.	A key benefit of the Health Improvement Service would be that there is a central point of access to information about a range of health improvement services, and the potential to signpost appropriate resources to service users. Facilitating access may increase uptake, although this is likely to have an equal impact on men and women. Monitoring of uptake will be needed to evaluate this.

	regarding health improvement in adults including gender specific health issues.				
Gender identity	Unknown – There is very little national health data relating to people who identify as transgender, and experiences of healthcare. Data collection is compromised by the fact transgender people may be reluctant to discuss or disclose gender identify due to experience of stigma. In addition, staff may not feel comfortable or qualified to discuss gender, or be concerned that this may impinge on their relationship with the client.	UN-KNOWN	UN-KNOWN	Internal action - All staff providing care should have completed equality and diversity training This must include training the issues which may be faced by service users in relation to gender identity.	
Race	Yes – Approximately 6.3% of Kent residents identify as belonging to a black or minority ethnic (BME) group, equivalent to approximately 95,600 individuals living in Kent. It is recognised that certain illnesses and health issues occur more or less commonly in different ethnic groups. For example	HIGH	LOW	**Internal Action** - there should be monitoring of the characteristics to service users, to ensure by a particular group is not lower than expected. **Further action** - Services should be appropriately tailored to reflect different needs of service users. Public consultation will facilitate this. In Kent Health Trainers from a range of backgrounds, including from the GRT community, have been used to help	Public consultation and focus groups will be used to identify any issues which may make the service less accessible to different ethnic groups. Services referral criteria should be evidenced based, i.e. they must take account of the different needs of service users from different ethnic backgrounds. For example national guidance (NICE 46 2013)

	people from certain ethnic groups, including Black African/Caribbean/British and South Asian, have higher risk of developing Diabetes at a lower Body Mass Index (related to weight and height) than a person who is White European. The term gypsy, roma and traveller (GRT) encompasses a wide range of individuals with a diverse range of health issues. Utilisation of healthcare services is low in this group. There is a long tradition of GRT people living in Kent, in particular in East Kent. The prevalence of people who identify as GRT is 0.3%, or 4500 people. The health needs of this group should be a focus of any health improvement interventions.			increase access to and utilisation of healthcare by minority ethnic groups. This should continue in the proposed model.	recommends that service users from Black, Asian and minority ethnic groups should be referred to tier 2 weight management services using a lower Body Mass Index Criteria than White Europeans. This must be a criteria used when shaping the service to ensure that treatment is fair and appropriate.
Religion or belief	Yes – Healthy lifestyles may be influenced by religious beliefs and cultural practices. Initially, healthy lifestyle services or	MED-IUME	MED-IUM	Internal action – not required. Further action - Currently some healthy living services are delivered in faith centres, e.g. stop smoking and healthy weight services. We would anticipate this	Yes – location of some services within faith centres promotes access for clients using these centres, and would increase community engagement with the

	interventions may feel inappropriate.			will continue in the proposed model.	Health Improvement Service.
Sexual orientation	Yes – it is recognised that some individuals may have experienced stigma within the context of healthcare utilisation, which could act as a barrier to use of services.	LOW	LOW	Staff providing care within the model should have completed equality and diversity training to include issues in relation to sexual orientation, in addition to the wider range of protected characteristics.	
Pregnancy and maternity	No – certain healthy living interventions are offered in pregnancy, e.g. smoking cessation services. These will not be affected by the proposed Health Improvement Service. In addition, a relationship between providers within the HIS with specialists such as midwives could improve the uptake of services in pregnant women.	MED-IUM	LOW	Further action - There should be consultation with providers of Tier 3 and 4 services (e.g. stop smoking services for pregnant women) to promote help develop good working relationships between providers in the proposed HIS and Tier 3/4 providers.	Yes – through increasing access to healthy living services through referrals to and from Tier 3 and 4 services, which are often multidisciplinary services used for more complex health interventions.
Marriage and Civil Partnerships	No – the HIS would be a universal service open to all adults irrespective of marital status or civil partnership status.	NONE	NONE	No further action required.	
Carer's responsibilities	Yes – carers provide unpaid support to family members or friends. In 2011 10.4% of Kent residents provided unpaid	HIGH	HIGH	**Further action** – consultation should include seeking input from the Kent Carers Collaborative. Data should be collected on the use of services by carers, to establish if this group	Yes – flexible times and mediums of access (e.g. extended opening, online consultations) could increase accessibility for carers with limited free time.

	care, this is likely to have. Carers may not have sufficient time to look after their own health or access healthcare for concerns. In addition, the role of a carer can be a particularly stressful one. Furthermore, carers are more likely than non-carers to report fair, bad or very bad health. Nationally 6.1% of carers (compared to 4.8% of non-carers) report their health to be bad or very bad, this would be equivalent to around 1000 carers with bad or very bad health in Kent.			is adequately represented in service users.	A relationship between providers and the Kent Carers Collaboration would facilitate knowledge of the Health Improvement Service among carers and increase access.

Part 1: INITIAL SCREENING

Proportionality - Based on the answers in the above screening grid what RISK weighting would you ascribe to this function – see Risk Matrix

Low	Medium	High
Low relevance or Insufficient information/evidence to make a judgement.	Medium relevance or Insufficient information/evidence to make a Judgement.	High relevance to equality, /likely to have adverse impact on protected groups

State rating & reasons:

Medium – evidence of potential positive impacts, in particular in relation to individuals with chronic illness. There is a lot of potential to shape the proposed model through the consultation process, to ensure that it is relevant and appropriate to the groups described above.

Context – What we do now and what we are planning to do

In April 2015, KCC Public Health began a process of transforming the way Health Improvement services are commissioned and delivered throughout the county. The NHS Five Year Forward View, published in 2014, highlighted the need to radically increase the role of prevention to achieve improvements in health outcomes for the public, reduce health inequalities and promote healthier lifestyles. Similarly, the Care Act of 2015 also emphasises the importance of prevention in addition to outlining key responsibilities for local authorities in addressing this. Delivering better prevention is the responsibility of local authority Public Health teams through the Health Improvement services commissioned.

Currently, KCC Public Health commissions services that focus on individual health and lifestyle behaviours. Some are open for all members of the public to 'self-refer' while others require referral from health professionals. The services will be:

- Stop smoking services
- Healthy Weight Services
- Physical activity programmes
- Mental Health services
- Health Checks

Currently, these services operate independently. This is in contrast to the fact that many users of these services suffer from multiple health problems, particularly those from lower socio-economic backgrounds. Navigating these multiple different services in a disjointed way is difficult for service users who would potentially benefit from a more integrated approach. As demonstrated in the model below, the Health Improvement Service would act as a central hub through which services users could access advice on a range of health

behaviours which are relevant to them, (smoking, healthy weight, mental well-being), in one location.

Kent is not alone in considering a more integrated approach to health improvement; many other Local Authorities, such as Dorset and Suffolk, are undertaking similar transformation programmes. Integration is also a key aspect of the NHS Five Year Forward View, which encourages integrated care as a means of facilitating coordinated patient care along the entire patient journey and collaborative working of service providers. Currently, examples of integration are in their early stages therefore there is limited evidence regarding their impact. Ongoing evaluation of the proposed models will be essential and would be built in to implementation.

Aims and Objectives

KCC are proposing a new integrated model for Health Improvement Services, based around a patient-centred approach to addressing the needs of the individual. It looks beyond individual unhealthy behaviours to consider the range of factors in their lives that contribute to these behaviours, with the aim being to improve their overall health and wellbeing. This would occur through a single point of access in to a 'Healthy Lifestyle Service' (either by self-referral via a website/phone or referral from health professionals). Once in the system, they can be assessed in a holistic way, and the most appropriate steps can be identified to address the range of factors affecting their health. This may involve referral to specialist services, but could simply involve brief advice and signposting to self-help apps or existing community groups, or advice about housing and employment, for example.

Beneficiaries

<u>Benefits to service users:</u>

- Single point of access, therefore the system is easier to navigate. This means that service users can access the full range of service needed by the individual at one point of access rather than, for example, attending separate smoking cessation, health weight and mental health and well-being services concurrently. This improves access across a range of protected characteristics including age, physical and learning disability and carer's responsibilities.
- Signposting can lead to a wider appreciation of the different forms of support that might be more appropriate than specialist services
- Being treated as an individual with multiple factors that can be supported; addressing the wider determinants of their health behaviour.

<u>Benefits to KCC:</u>

- More targeted and efficient use of specialist health improvement services via initial triaging process
- Better harnessing of existing community assets (community groups, voluntary sector and private sector) in realising population health improvement

- Addressing health inequalities by providing more targeted and holistic support to those in need with multiple health problems

Benefits to Health and Social care providers

- Easier system for health and social care professionals to understand and refer patients in to
- More effective preventative health

Benefits to Community Partners

- Increased utilisation of community groups and services

Information and Data

The data has been pulled from existing KCC Joint Strategic Needs Assessments across the range of areas studied – e.g.

- Smoking and Tobacco JSNA
- Healthy weight JSNA
- Mental Health JSNA
- Adults with learning disabilities JSNA

Data from the JSNAs which is specific to each element of the Health Improvement Service includes:

Stop smoking services:

The prevalence of smoking in Kent is similar to England overall, however Dover and Thanet have a significantly higher prevalence of smoking than the national average, as demonstrated below. In Thanet this remains true when smoking is stratified by occupation. This is demonstrated in the table below.

	Smoking Prevalence 2013 (↑ increase ↓decrease from 2012)	
	Smoking prevalence Whole Population 2013	Smoking prevalence among routine and manual workers
England	**18.4 ↓**	**28.6 ↓**
Kent	**19.0 ↓**	**28.4 ↓**
Ashford	**21.1↑**	**34.7 ↑**
Canterbury	**19.0 ↓**	**31.8 ↓**
Dartford	**17.0 ↓**	**24.5 ↓**
Dover	**24.3 ↑**	**40.2 ↓**
Gravesham	**21.4 ↑**	**27.9 ↓**
Maidstone	**14.5 ↓**	**21.1 ↓**
Sevenoaks	**15.9 ↓**	**26.3 ↑**
Shepway	**22.0 ↓**	**17.2 ↓**
Swale	**20.4 ↓**	**21.4 ↓**
Thanet	**24.8 ↑**	**32.8 ↑**
Tonbridge & Malling	**13.5 ↓**	**27.6 ↓**
Tunbridge Wells	**15.6 ↓**	**36.9 ↑**

Source: Public Health Outcomes Framework 2014

As discussed above there is variation in smoking prevalence by age, with younger people being more likely to smoke than older people. In Kent the highest prevalence of smoking is in young men aged 25-29 (32%) and young women aged 20-24 (29%).

Smoking cessation services are only used by approximately 5% of people who smoke in Kent, and this figure is even lower in younger people. Therefore younger people represent an important target group for smoking cessation. The integrated Health Improvement Service would aim improve awareness and accessibility of the service through offering greater opportunities for novel access, such as online.

Healthy Weight Services

The prevalence of obesity in Kent is similar to that seen in England. The mean age of service users in Kent is around 50 years. Although this means that younger individuals are less likely to access the service, it is recognised that older individuals have a higher rate of complications of obesity, (e.g. diabetes mellitus and hypertension), and so it could be that they benefit disproportionately from accessing Health Weight Services.

Obesity by Local Authority area

Local Authority:	2011 Children Year 6	2012 Children Year 6	2013 Children Year 6	Latest Available Adult Obesity Data 2006-2008
Ashford	20.5	18.6	18.7	27.0
Canterbury	16.4	14.5	15.2	23.4
Dartford	22.7	21.9	19.8	28.2
Dover	17.3	21.1	20.5	26.8
Gravesham	19.9	19.1	20.0	28.5
Maidstone	17.3	19.5	19.0	26.3
Sevenoaks	15.5	16.1	16.7	23.9
Shepway	20.4	19.5	19.1	25.9
Swale	18.1	18.0	18.0	30.2
Thanet	19.8	19.5	19.4	27.7
Tonbridge & Malling	15.2	16.8	16.6	26.1
Tunbridge Wells	16.3	16.0	15.0	22.9
Kent	18.2	18.4	18.3	26.3
England	18.7	19.0	19.2	24.2

Source: Health Profiles 2013 APHO and Department of Health

People from ethnic groups, particularly women from a black and Pakistani origin and those with disabilities, including learning disabilities, who are at greater risk of obesity, are not accessing services in proportion to need. There is evidence that providers take services to local sub-groups for example the Nepalese and Sikh populations, groups of people with learning disabilities and men in prisons but this needs to be more closely monitored. Most programmes provide services in urban and rural areas and areas of high deprivation. Providers of services have recently used the Health and Wellbeing Impact Assessment Tool (HIWIA) and this has identified to a

number of providers that programmes should be more targeted to address health inequalities within their healthy weight services. Applying the HIWIA to all aspects of the service should be a requirement for any Kent provider. A quota of participants from specific subgroups in performance indicators is suggested in recent commissioning guidance for Tier 2 Weight Management services.

Physical Activity Programmes

Physical activity levels in England were formally reviewed as part of the Health Survey for England 2012. The survey found that in 2012 67% of men and 55% of women aged 16 and over met current guidelines for recommended physical activity. In addition, physical activity levels are associated with deprivation, with the proportion of physically active men and women decreasing to 55% and 47% respectively in the lowest quintiles of deprivation.

The proportion of participants classed as inactive generally increased with age in both sexes; from 8% of men and 22% of women aged 16-24 to 74% and 76% respectively in those aged 85 and over.

There is limited data on physical activity in people from BME groups, the last formal survey of physical activity in BME groups was carried out in 2004, the there are limitations in the usefulness of this data. In 2004 it was reported that regular participation in physical activity was similar to the general population level in individuals who are Black/Black British/Black African and Black Caribbean, while reported physical activity was lower in individuals of Asian ethnicity.

Locally there is very little information on physical activity in people with protected characteristics in Kent.

A key potential of the Health Improvement Service is the patient centred approach taken to tailoring behaviour change support. So, for example, a Health Improvement Service practitioner will have the skills to advise (or refer) an older adult to postural stability training to prevent falls, or a middle aged individual about suitable community resources for physical activity.

Mental Health Services

Older age is the single most important predictor for cognitive decline and dementia. Older adults are also particularly at risk of social isolation, as they withdraw from the labour market and become more susceptible to chronic disease. Since chronic physical illness is also a risk factor for depression, the higher prevalence of physical health conditions amongst older people further contributes to elevated rates of depression.

In addition, there are a number of groups which have a higher than average risk of developing a mental health problem. It is noted nationally that obtaining accurately information on mental health need in individuals from BME groups is difficult due to the broadness of the term which encompasses a wide variety of individuals from a variety of cultural and socio-economic backgrounds. The table below demonstrates the prevalence of mental health problems in various groups which have a protected characteristic.

	Proportion at risk of mental health problems	Estimated number of individuals effected in Kent
Gypsy, Roma, Traveller	35%	3500
People who are lesbian, gay, bisexual	39.40%	9450
People with a learning disability	25%	1125
Those with profound hearing loss	33.30%	3000
Marital Status - separated	23.3	7643
Marital Status - divorced	17.20%	30,600
Adult survivors of sexual abuse	12.40%	13290
Released prisoner	90%	4387
Carers	18%	25,000

The Kent Mental Health Strategy, Live It Well, sought the views of service users to shape its content. One recommendation from the strategy was that a mental health check be incorporated in to the Health Check for adults aged 40-75. This is an example of the sort of integration that would be possible under the Health Improvement Service.
Additionally, the Live It Well strategy recommended the use of health trainers to increase access to individuals from minority ethnic groups and individuals living in economically deprived areas. This is likely to be a key feature of the Health Improvement Service which will improve access.

Health Checks

As discussed above health checks are offered every three years to individuals aged 40-75 years. Uptake in Kent is around 52%. It is noted that number of eligible adults with a learning disability having a GP health check in Kent is

33.19%; performing significantly lower than the England average of 52.7% and lower than the regional average of 40.2%. This is particularly important because people with learning difficulties have a higher rate of chronic physical illness than the general population. Therefore increasing uptake of health checks in people with learning disabilities should be a target of the Health Improvement Service.

There is little available information on the uptake of Health Checks by other protected characteristics. Currently commissioning arrangements includes extra funding for out-reach programmes to target hard to reach groups including migrant workers, BME groups, travellers, individuals within the criminal justice system and people who are homeless and insecurely housed.

Data was also taken from any existing equality impact assessments (EIA) on previously prepared for the topics above. These include the Smoking Cessation Service EIA, the Obesity Needs Assessment EIA and the Health and Inequalities Wellbeing Impact Assessment.

Who have you involved and engaged with

The new model for Health Improvement services in Kent is currently going out for public consultation, and consultation with service providers. This is following a number of internal KCC workshops which were open to everyone in the public health team to discuss and help shape the new model.

In addition to the public consultation focus groups will be held. A ‘broad’ focus group will be held in all the districts of Kent to include participants of a range of ages. In addition, more specific focus groups will be held to solicit the views of individuals with the following protected characteristics – learning disabilities, carers and members of the gypsy, roma and traveller community.

The consultation process is planned to run for 6 weeks, starting from 2/11/15.

Potential Impact

The transformative changes to how health Improvement services are organised may have impacts on how different types of people (age/sex/gender/ethnicity etc.) access and utilise the service.

Adverse Impact and how can these adverse impacts be mitigated, (capture this in the action plan)

An integrated model will need to be flexible to accommodate the needs and wants of a variety of service users and across various health behaviours. An integrated model would need to understand that as the reasons and factors of

eating, exercise and smoking behaviours (for example) are each different and not generic. One size does not fit all.

The new model utilises a website and phone number to allow members of the public to self-refer in to the system. It is important that web-based elements of the service are fully accessible to disabled service users. The Health Improvement Service should offer a range of mediums of access to accommodate a range of needs and abilities of service users. The range of media has not been finalised at this stage, as this should be informed by the public consultation. Clearly it is essential that the views solicited during the consultation are representative of the population of Kent who have protected characteristics.

The public consultation document asks members of the public how they would like a service to be delivered, including which channels they are likely to use to access health services, so therefore appropriate steps can be taken to include a range of different 'routes' into the service.

Positive Impact:

The new Health Improvement model may increase utilisation of health improvement services amongst those with the multiple health problems, by providing a simpler, single point of access and better coordinated care around their needs. It is recognised that increasing access can be extremely challenging. Particular aspects of the proposed model which address this include the use of health trainers, who often also possess protected characteristics, to increase relevance and appropriateness of the service for particular groups. In addition, the consultation process will create the opportunity to take on the views of service users, in particular those with protected characteristics, to shape the proposed model.

JUDGEMENT

Set out below the implications you have found from your assessment for the relevant diversity groups. If any negative impacts can be justified please clearly explain why.

Option 1 – Screening Sufficient NO

Justification:

Option 2 – Internal Action Required YES
There is potential for adverse impact on particular groups and we have found scope to improve the proposal

Option 3 – Full Impact Assessment **YES**

Monitoring and Review

The next stage in planning the Health Improvement Service is to solicit the views of service users through a public consultation, supplemented by focus groups to elicit the opinions of particular target groups. Monitoring of service use, including by users with protected characteristics, will be built into contract agreements to evaluate services use and identify and positive or negative changes in the pattern of service use overall and by protected characteristics.

Sign Off

I have noted the content of the equality impact assessment and agree the actions to mitigate the adverse impact(s) that have been identified.

Senior Officer

Signed: Faiza Khan Name: Dr Faiza Khan

Job Title: Interim Deputy Director of Public Health

Date: 02/11/2015

DMT Member

Signed: Andrew Scott-Clarke Name: Andrew Scott-Clarke

Job Title: Director Public Health Date: 02/11/2015

Equality Impact Assessment Action Plan

Protected Characteristic	Issues identified	Action to be taken	Expected outcomes	Owner	Timescale	Cost implications
All protected characteristics	Communication - some users with protected characteristics may have specific needs in terms of the forms of communication they can use and access.	All communication produced for the Health Improvement Service must be in line with KCC guidance on inclusive communication and accessible through a range of channels (e.g. online, telephone, written information etc.).	Increased accessibility of the service through the use of multiple communication channels as appropriate for various service users.	Karen Sharp	During contracting	Covered as part of contract
All protected characteristics	Some service users may have experienced stigma in relation to protected characteristics, or have felt unable to access healthcare services due to	Staff should have completed equality and diversity training to include the each protected characteristics discussed in this document.	Comprehensive equality and diversity training will help ensure a greater understanding from staff of the issues which may be	Karen Sharp	During contracting	Covered as part of contract

	experiencing a lack of understanding from providers. The literature suggests that this may be more common for, but not limited to, people from the LGBT community, transgender people and people with mental health conditions. This may impact on the likelihood of using a service.		encountered by service users with protected characteristics when accessing a health service, including stigmatisation.			
Age	Need to ensure mediums of access (online/phone/face-to-face) suitable for various age groups;	Public consultation – specific question included on this aspect, focus on extremes of ages within adult population. The underutilisation of stop smoking services by younger adults should be	Find out what method/s of access are preferred by service users of different ages.	Karen Sharp	6 weeks	n/a

		addressed in focus groups to shape the model. Monitoring of service use by protected characteristics should be built into contract arrangements to ensure uptake of services is as expected given known population needs.				
Disability - Communication	Communication may be more difficult for some service users with learning disabilities or sensory impairment. For example, we know that people with learning disabilities currently use less preventative health services than the general population,	All service information in line with KCC policy on information available to the public and should include, for example, easy-read, as well as braille and audio information for service users who additionally have a sensory	Increased accessibility of the service through using a range of channels of information suitable for different service users. This should improve uptake of and knowledge about the service.	Karen Sharp	6 weeks	Covered as part of contract

	this may represent issues with knowledge about the availability of services due to lack of service information, or with physical barriers to accessing services.	impairment.				
Disability - Access	There is limited data on the uptake of health improvement services in service users with a disability, particularly for people with a physical disability or sensory impairment. For this reason monitoring of service uptake with reference to protected characteristic should be undertaken.	Monitoring of service use by protected characteristics should be built into contract arrangements to ensure uptake of services is as expected given known population needs. Providers should be asked to report characteristics of service users both to inform on areas where information is limited and to evaluate any	Evaluation of service uptake by protected characteristics to assess whether uptake is as expected given what we know about the prevalence of preventable health problems in, e.g. smoking, in people with a disability.	Karen Sharp	During contracting	Focus group to be held, costs covered within project costs

		change in patterns of use				
Gender	Data on the use of an integrated by gender is not available, because such models in their early stages.	Monitoring of service protected characteristics should be built into contract arrangements to ensure uptake of services is as expected given known population needs.	Evaluation of service uptake by gender.	Karen Sharp	During contracting	Would be covered as part of contract
Race	The need for services differs between different ethnic groups. BME groups may be put off services if they appear to be irrelevant to their health needs. Information regarding services needs to be available in different languages.	Public consultation should include seeking views from service users from BME groups. The utilisation of resources such as health trainers to increase relevance and accessibility. Monitoring of service use by protected characteristics	Increased understanding of how the service could be more responsive to needs to BME groups.	Karen Sharp	6 weeks	Within contract

		should be built into contract arrangements to ensure uptake of services is as expected given known population needs. Action 4. All service information should be available in a range of languages.				
Religion or belief	Services and interventions to improve health behaviour should be culturally sensitive.	Public consultation to seek views of service users with religious or faith beliefs. Continued use of faith centres to host some services. Ensure providers have completed equality and diversity training to	In the first instance the consultation should aim to identify barriers to access of the Health Improvement Service due to religion or belief.	Karen Sharp	6 weeks	Within contract

		ensure sensitivity of staff to a range of equality issues in relation to protected characteristics. Monitoring of service use by protected characteristics should be built into contract arrangements to ensure uptake of services is as expected given known population needs.				
Pregnancy or maternity	Need for collaboration with existing Tier 3 and 4 services for pregnant women.	Consultation should include discussion with providers of Tier 3 and 4 services.	Improved working relationship with Tier 3 and 4 services which will improve outcomes for women and be mutually beneficial for the services.	Karen Sharp	During contract period	n/a

Carer's responsibility	On average carers have less good health than the general population. In addition they may struggle to access healthcare due to time constraints.	Focus groups will be necessary to ensure the views of carers are represented. Consult the Kent Carers Collaboration.	Understanding of how to increase accessibility of the proposed model to carers.	Karen Sharp	6 weeks	Accessibility will form part of the contract