Appendix 3 Equality Impact and Outcome Assessment (EIA) Template - 2015

EIAs make services better for everyone and support value for money by getting services right first time.

EIAs enable us to consider all the information about a service, policy or strategy from an equalities perspective and then action plan to get the best outcomes for staff and service-users[1].They analyse how all our work as a council might impact differently on different groups[2]. They help us make good decisions and evidence how we have reached these decisions[3].

See end notes for full guidance. Either hover the mouse over the end note link (eg: Age[13]) or use the hyperlinks ('Ctrl' key and left click).

For further support or advice please contact the Communities, Equality and Third Sector Team on ext 2301.

1. Equality Impact and Outcomes Assessment (EIA) Template

First, consider whether you need to complete an EIA, or if there is another way to evidence assessment of impacts, or that an EIA is not needed[4].

Title of EIA[5]	Remodel of supported accommodation and related services for single homeless people – implementation and procurement	**ID No.[6]**	AS52
Team/Department[7]	ASC – Commissioning		
Focus of EIA[8]	This is the first EIA and will be continuously reviewed until the model is fully embedded; and after that as part of the business and commissioning planning process each year. This EIA is intended to cover service users and council staff working in homeless services. We recognise that we have a duty to ensure that our services prevent discrimination and promote positive community relations and equality.		

2. Looking at the evidence

1. Please summarise the purpose of the proposal, project or policy and its desired outcomes:

National context

Homeless levels have been increasing in recent years. Health and wellbeing needs are high among the single homeless population which includes rough sleepers.

People who are homeless often have complex and tri-morbid care needs with a high prevalence of mental ill-health, physical ill health and drug and alcohol dependency.

The national average age of death for a homeless person is 47 years old compared to 77 for the general population, with death from drugs and alcohol being particularly common.

Local context

The JSNA highlights that Brighton & Hove has a younger than average population with high mental health and substance misuse needs, which can be risk factors for and are associated with homelessness.

Homeless levels have increased in recent years with the loss of private rented accommodation a significant factor.

The city has seen an increase in the official count for rough sleeping from 14 in 2010 to 50 in 2013 (3rd highest in England). Services estimate that over 80 people are rough sleeping in the city (November 2015). There is a flow currently of approximately 20 new rough sleepers into the city every week (June 2016).

In 2014/15 the rough sleeping outreach service worked with 1,129 people involving 775 different people (around a third of cases relate to people seen more than once).

There are also approximately 400 households in emergency and temporary accommodation of which approximately 30% are single people or couples.

The city has 272 hostel places for single homeless people, with a current waiting list of 162 people (July 2016).

Demands on our services have changed since the existing supported accommodation pathway was set up in 2007. We are experiencing increasing numbers of people sleep rough, longer accommodation waiting lists and higher complexity (of needs) from service users alongside reduced funding and service provision. People who enter the current supported accommodation pathway are finding it harder to move through the pathway and access independent private rented accommodation.

2. **Who should benefit from the proposal, project or policy and in what way?**

   This proposal is for remodelling the supported accommodation services for single homeless people and rough sleepers with support needs and other related support services.

   Following initial feedback from service users & stakeholders we have been developing a new model for accommodation and support services. This is also informed by other strategy developments e.g. Rough Sleeper Strategy 2016.

   Given the changing demand for services, and the increased complexity of need, it has now become essential to have a new model for accommodation for people who are homeless.

   Our aims with the remodelling of service are:

- To reduce rough sleeping and support individuals through personalised services which better meet their needs.
- Improving people's health, building their resilience and community links and supporting them to move on to independent living.

3. **Is there any evidence or reason to believe that in relation to this proposal, project or policy, there may be a difference between certain groups and communities in relation to:**

- **Levels of participation**
- **Uptake**
- **Needs or experiences**
- **Priorities**

Referrals into supported accommodation are currently received from Probation, Housing Options and the Rough Sleeper Outreach Team. Demand far outweighs the number of properties which become available.

The referral and assessment process will be reviewed to revise prioritisation of those on the waiting list. Following needs analysis and consultation with service users and stakeholders, we will be commissioning services to meet specific needs.

3. Review of information, equality analysis and potential actions

Protected characteristics groups from the Equality Act 2010	**What do you know[9]?** Summary of data about your service-users and/or staff	**What do people tell you[10]?** Summary of service-user and/or staff feedback	**What does this mean[11]?** Impacts identified from data and feedback (actual and potential)	**What can you do[12]?** All potential actions to: • advance equality of opportunity, • eliminate discrimination, and • foster good relations
Age[13]	*The average age of death for a homeless person nationally is estimated to be 47 years old compared to 77 for the general population.* *Nationally, it is estimated that the use of inpatient hospital care by people who are sleeping rough or living in insecure accommodation (such as hostels) is eight times higher than in the general population aged 16-64.* *The vast majority of rough sleepers are aged between 25 and 49 years old.* *Information from the rough sleeping outreach service July – August 2015:* *63 people were under 25 years old* *42 people were over 50 years old* Out of a total of 284 people *Children and young people under 18 years will not be the target group for the service (YoungPpeoples services are subject to a separate EIA)*	*Increasing numbers of people with multiple and complex needs both sleeping rough and in emergency accommodation and hostels.* *Homelessness increasing due to the lack of accommodation across all tenures, with younger people encountering more barriers to finding accommodation.* *Rising numbers of older people in hostel accommodation with physical health and substance misuse needs who are unable to move on to greater independence.*	*Benefit reforms are disproportionally affecting young people, leading to increasing numbers of young people becoming homeless and/or rough sleeping.* *Increased older residents with long term and complex health needs reduces throughput in accommodation.* *Older individuals are usually unable to access mainstream sheltered accommodation.*	*Ensure a robust multi-agency approach to commissioning and providing services.* *Commission services which can adapt and be flexible to meet changing needs, improve throughput and aim for sustainable outcomes for service users.* *Commission a service for older individuals with physical health needs and substance misuse in order to support them to greater*

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		Earlier interventions are more likely to prevent entrenched homelessness and patterns of behaviour to develop and become embedded.		*independence.* *Housing, health and social care are to work together to provide a holistic approach to improving people's health and wellbeing.*
Disability[14]	Significant numbers of people in non-specialist Mental Health Supported Accommodation have low to moderate mental health needs or multiple complex needs (e.g. Mental Health, Substance Misuse, Reoffending and Rough Sleeping). Within the Integrated Support Pathway in 2015, 48% of people were reporting mental health needs, this is an increase from 2011/12 which was 30%.	Potential increase in complex enduring health and social care needs in ageing homeless client group, including end of life care, Alcohol Related Dementia and Korsakoff's Syndrome, learning disabilities and physical disabilities related to or	Housing, health and social care are to work together to provide a holistic approach to improving people's health and wellbeing.	New service specifications to ensure accessible facilities as part of the tender process. Services to further develop and maintain excellent links with mental health, substance misuse services.

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	51% of people living in hostels reported that they were either disabled or long term sick in 2015/6, June 2016, there were 8 people waiting for level access accommodation. Vacancies tend to arise at one every 3 months. These are often people being discharged from hospital. There are currently 23 level access hostel rooms.	arising from long term alcohol and drug use. Increase in mental health needs. People with a learning disability find it more difficult to move out of hostel accommodation into independent accommodation and may not be accessing services appropriate for their needs. Significant and growing demand for level access	Longer waiting lists for those with physical health needs	Services to be aware of local support services (inc CVS) for disabled people. Services to ensure they deliver a Psychologically Informed service and that flexible and creative engagement models are explored so that a person centred approach does not exclude people with multiple and complex needs. Increase the numbers of level access properties through the re-procurement process.

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		accommodation.		
Gender reassignment[15]	The JSNA 2014 reported that 2% of people who were rough sleeping or single homeless identified as Trans*, an increase in the number reported in 2013. In 2015/6 there were 23 Trans people across all support services, an increase from 11 in 2012/3	The Brighton & Hove Trans* Needs Assessment 2015 reported that Trans* people experienced discrimination and/or abuse from other homeless people when rough sleeping and felt that hostels were unsafe.for trans* people particularly in respect of appropriate male/female sleeping arrangements and discrimination from other hostel users.	Trans* people find there are more barriers in accessing services and may feel their needs are not met by generic homeless services. Although the numbers are small it is important to engage with and support Trans* people at the earliest opportunity	Ensure service specifications embed the need for an inclusive approach. Ensure all commissioned providers implement recommendations of Stonewall Housing LGBT* report and encourage non commissioned services to also sign up Service to be aware of local CVS support services for trans people and mechanisms for

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				reporting hate incidents
Pregnancy and maternity[16]	There are low numbers of homeless people who are pregnant who rough sleep or live in hostels. This group are likely to be accommodated in emergency accommodation under a statutory homeless duty. The instances of pregnant females sleeping rough at the annual count was 8 in 2013/14. We do not have data on the number of women in supported accommodation services who are mothers however anecdotally trauma from having children taking into care or no longer having access to children is a significant support need among women.	No specific feedback received relating to this. Numbers of women becoming pregnant while living in a hostel is extremely low. They are expected to move out of the hostel before they are 6 months pregnant, usually through the statutory homeless route. That trauma related to lack of contact with children is a significant support need.	Pregnant women will be able to register with a GP of their choice or with the homeless practice.	Although the numbers are small it is important to engage with and support them at the earliest opportunity. Ensure that accommodation services are skilled in linking pregnant women in with appropriate support services to best ensure that they are able to establish themselves as effective parents. Tender a women only support service which meets the

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		.		support needs of women with complex needs. Monitor the numbers of service users who are parents (both male and female) and develop services and staff training accordingly. Ensure that floating support services workwith women leaving hostel/supported accommodation due to pregnancy and that they receive a robust tailored service to enable them to engage with specialist services and best meet the needs of their child.

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<td>Race[17]</td>
<td>A total of 296 people (98%) indicated their ethnicity during the Brighton & Hove Homeless Health Needs Audit 2014.

Out of these, 212 were White British (72%) and 84 were from Black and Minority Ethnic (BME) groups (28%) which includes all individuals who classified their ethnic group as something other than White British. These figures suggest that the homeless population is more ethnically diverse than the general population in Brighton & Hove.

Data from the rough sleepers outreach service Sept 2015-January 2016:

<table>
<tr><th colspan="2">Ethnicity</th></tr>
<tr><td>White British</td><td>225</td></tr>
<tr><td></td><td></td></tr>
<tr><td>White Other</td><td>54</td></tr>
<tr><td>Mixed</td><td>3</td></tr>
<tr><td>Arab</td><td>5</td></tr>
<tr><td>Asian or Asian British</td><td>7</td></tr>
<tr><td>Black or Black British</td><td>11</td></tr>
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</td>
<td>Increasing numbers of non white British people becoming homeless. Supported housing services have no choice but to evict foreign nationals when they cease to be eligible for public funds (for age or other reason)</td>
<td>Although no specific impacts identified from data and feedback for race, however, when looking at nationality, many rough sleepers are not British citizens and therefore will not have a local connection and will not be entitled to access some services provided in the city such as Housing and support.</td>
<td>Regarding nationality rather than race, ensure those with no recourse to public funds are signposted to agencies that can offer advice, advocacy and support (eg Doctors of the World, Brighton Voices in Exile)

Ensure links to local support groups are established to support individuals and the wider model.

Continue to monitor the ethnic background of services users and ensure</td>
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	Rough Sleeper Annual Report 2014-15 recorded 1,129 cases of rough sleeping (involving 775 people). Of these 19% (212 cases) were not from the UK with the largest group from central or eastern Europe (86 cases, a 50% increase from this region on 2013/14)			commissioned services are monitored around policies and practice around racial harassment, hate crime and inclusion. Services will be linked with the BHCC Community Safety Team for support and advice around dealing with hate incidents. Ensure collection of data on hate crime in homeless services
Religion or belief[18]	The Brighton & Hove JSNA 2011/12 data suggests that of the rough sleepers and single homeless people in Brighton & Hove - 52% had no religion with 20% self classifying as Christian, 3% Muslim, 2%	No specific feedback received relating to this	No detrimental discrimination is likely to be relevant with the new service model.	Ensure links to local faith groups from the range of faith communities are established to

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	Buddhist and less than 1% Jewish.			support individuals and the wider model. The commissioning of new services will be developed with a focus on supporting service users to develop community links which will include links to religious or belief groups. Services will be monitored on reported hate incidents. Services will be linked with the BHCC Community Safety Team for support and advice around dealing with hate incidents.

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				Monitor levels of hate crimes.
Sex/Gender[19]	Women are a minority amongst the single homeless population. The 2014/15 Rough Sleeper Annual Report recorded 1,129 cases of rough sleeping (involving 775 people). Of these 83% were male and 17% were female. Figures of female rough sleepers for July - August 2015 known to the street outreach team: Men 246 Women 38	Women rough sleepers feel more vulnerable and at risk. There is no specific or specialist homeless service for women, so they continue to be a minority in the generic male dominated homeless services. Homeless women are also more likely to have had children removed, sex worked and experienced DV and sex based violence.	Single males are less likely to be accepted as unintentionally homeless and in priority need and therefore at greater risk of becoming street homeless. There is a smaller number of women but they are more likely to feel isolated and vulnerable therefore at risk of becoming a victim of crime or becoming involved in inappropriate relationships to feel safer on the streets.	The delivery of services for women in certain settings requires careful planning to ensure privacy, confidentiality and to ensure that they have full access to the interventions relevant to their health and wellbeing. Ensure Safeguarding protocols include specific awareness of violence against women in new service contracts including financial and emotional

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				abuse and pimping. A women only service to be commissioned to meet the complex needs of vulnerable women who feel at risk in mixed sex services. Develop the current male only service to be a psychologically informed environment. Develop male only low support accommodation.
Sexual orientation[20]	The findings of the Stonewall Housing Finding Safe Spaces project identified that, for LGBT* individuals sleeping rough in the city, this often related to their sexual orientation or gender identity, having a detrimental and often irreversible effect on their support systems after coming out to	The findings of the Stonewall Housing Finding Safe Spaces project identified that, for LGBT* sleeping rough in the city, many did not feel safe in	Some people may feel their needs are not met by generic homeless services. Service users may feel discriminated against	Ensure all commissioned providers implement recommendations of Stonewall Housing LGBT* report and encourage non

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<td>friends or family.

Many LGBT* people sleeping rough do not have a local connection and therefore are not entitled to some statutory services provided in the city.

Data from the rough sleepers outreach service Sept 2015-January 2016:
<table>
<tr><th colspan="2">Sexual Identity
The number of Service Users who describe themselves as</th></tr>
<tr><td>Heterosexual</td><td>199</td></tr>
<tr><td>Lesbian/ Gay</td><td>9</td></tr>
<tr><td></td><td></td></tr>
<tr><td>Bisexual</td><td>12</td></tr>
<tr><td>Unsure</td><td></td></tr>
<tr><td>Do not wish to disclose</td><td>8</td></tr>
<tr><td>Not asked / recorded</td><td>119</td></tr>
<tr><td>Total not known</td><td>127</td></tr>
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<td>hostels or on the streets. Drugs, alcohol, sex work or sex in exchange for accommodation was used as a way to secure a place to sleep, despite the great risk to safety as well as to their mental, physical and sexual health.</td>
<td>or isolated because of their sexuality.</td>
<td>commissioned services
to also sign up

Ensure services are monitored on support provided to LGBT clients and on the tackling of hate incidents.

Monitor hate crimes.</td>
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Marriage and civil partnership[21]	The number of couples sleeping rough on the streets is relatively low but is a factor is couples sleeping out if one is accommodated and the other not accommodated.	Relationship breakdown is a known reason for people ending up sleeping rough. Some individuals choose to sleep rough to stay with a partner who has not been offered accommodation.	Lack of supported accommodation for couples detrimentally affects some couples who are sleeping rough to be together.	Although the numbers are small it is important to engage with and support them at the earliest opportunity. Hostels and the Allocations Team to continue to accommodate couples within the same service where possible. Accommodation for couples will be requested in new service specifications.
Community Cohesion[22]	There is lack of understanding of the difference between the street community and rough sleeper groups. Those sleeping rough are more likely to be	Anecdotally, there are high numbers of ambulance call outs for street community people due to	People accommodated in hostels and emergency accommodation that spend time on the	Multiagency approach for those on the streets who have complex needs is part of

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	the victim of crime than the general population. Whilst the street population is often associated with crime and anti-social behaviour, it is estimated that only half of those on the streets are sleeping rough, with the other half housed. The street population is a diverse collection of groups and can be defined as people having one or more of the following attributes: rough sleeping; street drinking / begging; antisocial behaviour; insecurely housed (e.g. hostel or temporary accommodation) and spending a high level of time in street based activities, which may have a negative impact on other members of the public.	intoxication, perceived risk and concerns from members of the public.	streets will not be excluded from this service model. Street outreach is an important element of the new model and has links with the drug and alcohol outreach team. This is now part of priorities identified in the Rough Sleeping Strategy.	existing service outcomes. Commissioning of new services will include the engagement of the BHCC Community Safety Team and their support in the evaluation of tenders. Newly commissioned services will have a focus on supporting service users to access the local community and create networks and interests outside of the street community. Newly commissioned

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				services will increase activities and support offered during the day to relieve boredom and reduce the numbers of individuals on the streets.
Other relevant groups[23]	**Ex Offenders** and prison leavers. 10% of hostel residents in 2015/6 had left prison or were ex offenders. **Military Veterans-** 1% of hostel residents had previously been in the armed forces from 2015-6 data. **People have experienced DV**. 5% of hostel residents reported that they were at risk of DV in 2015/6. **Gypsies and Travellers** 2015-6 there were 117 unauthorised encampments in the city. 1% of hostel residents identified themselves as Gypsies or Travellers in 2015-6. **People with an Substance Misuse issue.** 73% in hostels have an SM issue from	People with Multiple & Complex needs need an MDT(multi disciplinary team) joint working approach to address their needs. There remains a lack of reliable information about the hidden homeless. e.g. whose living in squat, sleeping on sofas, staying with friends and family. A flexible approach from services on engagement models is	Other groups will not be excluded from the new service model.	New service specifications will ensure that services can be delivered to people with communication barriers, and have access to accredited and independent interpreters. MDT working to continue to be developed and embedded. Data will be collated on a wide range of groups who access

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	2015-6 data. This is an increase from 60% in 2012-3 **People with a learning disability.** 9% of people living in hostels in 2015-6 had a learning disability. This is an increase from 4% in 2012-3. **People with multiple and complex needs.** There is no accurate data for this group. However there were 90 people who had been living in a hostel for more than 2 years in 2015-6. This has doubled from the previous year. **People with language or communication barriers.** No accurate data. **Refugees and asylum seekers.** This group are more likely to be rough sleeping. Negligible numbers access hostels. **People with literacy issues**. 20% of hostel residents reported literacy issues in 2015/6. **People with caring responsibilities.** There is no accurate data for this group.	required to deliver a personalised service offer.		the support services. Develop integrated joint assessments and support planning across housing, care and health and the third sector. Services to develop approaches to ensuring they are meeting the needs of different vulnerable groups, including assessment, data collection/monitoring and pathways to statutory sector and CVS partners. A newly developed IT system will map service user

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	National research shows that 48% of homeless males reported experiencing a **traumatic head injury.** **Sex workers.** Applying national estimates of the percentage of sex workers proportionately to the local resident population produces an estimate of 350 sex workers in total. However, there are factors associated with Brighton & Hove to suggest that actual numbers are somewhat higher in the city. Public Health are producing a rapid needs assessment which has highlighted the link between sex work and homelessness and the recommendations should be considered by commissioners and providers when published later in 2016. **Worklessness.** 2% of people living in hostels in 2015-6 were in paid employment. 3% in training and 8% volunteering. The majority, 60% were not seeking work or disabled. **Care Leavers**. Many adult service users			journeys and identify needs in order to allow for services to change and develop with the changing demographics and needs of this population.. Work and learning services will be remodelled to ensure they meet local needs. Monitor sex workers in homeless services. Expand work and learning and life skills services.

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	are care leavers,			
Cumulative impact[24]	Robust monitoring systems will be in place with the IT system tracking referrals and service user journey. Service user involvement is part of the remodelling process.	Feedback from service users will inform service delivery for all groups. Data from the new IT system will inform future commissioning priorities.	Robust equality data monitoring to be embedded in new service contracts. . Feedback from the service users will inform the service delivery for all groups.	Ensure alignment of data collection with third sector and statutory providers. Collate and respond to complaints, reflect and learn as an on-going PIE way of working for the integrated services.
Assessment of overall impacts and any further recommendations[25]				

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Key risks identified with the project (based on protected characteristics):

Processes and procedures

- *The new model may not have sufficient resources to address the diverse needs of single homeless people.*

Service Delivery

- *Homeless service users are from diverse backgrounds and the new service providers may not have operational resource to provide impartial treatment regardless of the patient's race, gender, sexuality, religion etc.*
- *Levels of support and care needs will be potentially high and increasing amongst an aging population of service users over 50 e.g. increased mobility issues, multiple and complex needs and increasing levels of homelessness. Plus lack of access to Sheltered accommodation and Extra Care services.*

Other risks:

Moving of service users during remodelling / loss of bed spaces / potential changes to HB eligibility / increasingly unaffordable private rented accommodation market with rising prices in neighbouring areas / staff TUPE and disruption leading to unmotivated and unsupported workforce (mitigation to be tested through tender evaluation for staff support, training etc) / reducing resources in other services i.e. substance misuse

- *Potential language barriers (amongst a growing non UK national population) when delivering services*

Staffing - managing change for in-house hostel staff

Mitigations

- *Recording methods to be agreed during the procurement phase and routinely reviewed during contract management meetings.*
- *Demand for services will be mitigated by improving the transition of service users between services.*
- *Pilot projects have identified approximate levels of health care needs.*
- *Service specification of the primary care service requires the service to ensure language is not a barrier to access the service.*

Protected characteristics groups from the Equality Act 2010	**What do you know[9]?** Summary of data about your service-users and/or staff	**What do people tell you[10]?** Summary of service-user and/or staff feedback	**What does this mean[11]?** Impacts identified from data and feedback (actual and potential)	**What can you do[12]?** All potential actions to: • advance equality of opportunity, • eliminate discrimination, and • foster good relations
• *the findings of this EIA can be built into the commission and are assessed as part of the process of deciding the provider, then you can ensure that all potential bidders consider these needs and how they will meet them. If it's a statutory duty, then we must ensure that they can do this.* • *Close liaison with Unions regarding staffing matters.* • *Setting up an interim support service to provide bespoke support to managers of services affected by the remodelling.*				

4. List detailed data and/or community feedback which informed your EIA

Title (of data, research or engagement)	**Date**	**Gaps in data**	**Actions to fill these gaps: who else do you need to engage with?** (add these to the Action Plan below, with a timeframe)
Annual Update on the Scrutiny Panel on Homelessness	**September 2015**	**None**	
Brighton & Hove Homeless Health Needs Audit	**February 2014**	**Current data required to update report from 2014**	**Schedule a homeless health audit in 2017/8**

Brighton & Hove Homelessness Review 2013	**2008-2013**	**None**	
Brighton & Hove Homeless Integrated Health and Care Workshop	**July 2014**	**None**	
Finding safe spaces – Understanding the experiences of lesbian, gay, bisexual and trans* rough sleepers	**2014**	**None**	
Head Injury and Mortality in the Homeless Population	**2014**	**No local data**	
Healthy Hostels Crisis Report	**2001**	**None**	
Homelessness Strategy 2014 – 2019	**June 2014**	**None**	
Hostels and Housing Report- R Cook	**2014**	**None**	
Hostels Nursing Team Evaluation Report	**2015**	**None**	
Joint Strategic Needs Assessment: Rough Sleeping and Single Homeless	**2014**	**None**	

Joint Strategic Needs Assessment: Gender Identity and Trans People	2014	None	
Nurse Led Street Medicine Pilot Evaluation	June 2016	None	
Repeat Homelessness in Brighton, Homeless Link, 2015	2015	None	
Rough Sleeping Strategy: Position Paper	Autumn 2015	None	
Rough Sleeping Strategy	June 2016	None	
Rough Sleepers Street Services and Relocation Team: Annual Report 1st April 2014 to 31st March 2015	2015	None	
The Unhealthy State of Homelessness- Homeless Link	2014	None	
Update on Better Care Homeless Programme	March 2015	None	
The Hidden Truth about Homelessness – Experiences of Single Homelessness in England,	May 2011	None	

Hard Edges – Lankelly Chase	2015	Numbers of people with multiple and complex needs is not quantified locally	

5. Prioritised Action Plan[26]

Impact identified and group(s) affected	Action planned	Expected outcome	Measure of success	Timeframe
NB: These actions must now be transferred to service or business plans and monitored to ensure they achieve the outcomes identified.				
Disability/other relevant groups	Ensure services are flexible and accessible and do not exclude people with any special requirements	No inaccessible services to service users based on disability or multiple and complex needs	Feedback from service user consultation confirms responsive services are in place.	Start from May 2017
Disability	Ensure an increase in level access supported accommodation properties	No service users waiting longer for services than others due to mobility issues Increase in number of level access properties available as supported accommodation	Reduced waiting list and waiting time for level access properties	May 2016
Sexual orientation	Implement recommendations of Stonewall Housing LGBT* report	Recommendations are part of integrated working	Recommendation of Stonewall Housing LGBT* implemented Feedback from service users Monitoring data	March 2017
Sex/gender	Consultation with homeless women and other groups regarding service delivery models which best meet their needs	Responsive and tailored services. Some women only specialist provision of services	Feedback from service user consultation confirms responsive services are in place	May 2017
Sex/gender	Awareness in all services of Safeguarding protocols relating to violence against women	Responsive and tailored services.	Feedback from stakeholder and service user consultation	May 2017

Gender reassignment	Implement the recommendations of the Trans* Needs Assessment	Multi agency needs assessments are in place	Positive feedback from service users and the LGBT Health and Inclusion Project Monitoring data	On-going quarterly monitoring data reports March 2017
Age	Develop consultation with young people regarding service delivery models which best meet their needs when they are placed in adult services	Responsive services based on consultation findings	Feedback from service user consultation confirms responsive services are in place	October 2017
Age	Ensure recommissioned services meet the needs of older service users and can access appropriate services	Bespoke services for older people	New services in place	June 2017
Community cohesion	Joint outreach and assessment work with the street community and rough sleepers	Multi agency needs assessments are in place	Positive feedback from stakeholders and service users Logged on the new IT system	June 2017
All	Ensure that no one is excluded from services due to a language or other communication barrier	No services are inaccessible to people with a language or communication barrier	Recording is in place to monitor this in new contract and to ensure equality of access	May 2017
All	Monitor hate crimes	Track level of issue in services	Once we have a baseline, work to reduce incidents	April 2017
All	Monitor numbers of sex workers	Ensure we have the services in place to support this group	recording is in place and feedback from stakeholders is positive	April 2017
All	Develop integrated joint assessments and support planning across housing, care and health services	All service users to have an identified lead care coordinator	Integrated support for people with a clear lead as reported from monitoring data and stakeholder feedback	May 2017

All	Robust MDT approach to commissioning and providing services	Alignment of service contracts across sectors to support integrated working	Services working in an integrated way	Developed and embedded through interrelated commissioning plans throughout 2017
All	Complete a homeless heath audit, updating the 2014 data	Update of health needs	Data collated from all supported accommodation service with a high % of respondents	2017/8

EIA sign-off: (for the EIA to be final an email must sent from the relevant people agreeing it or this section must be signed)

Lead for the Equality Impact Assessment: **Date: 27 July 2016**

Head of Service: **Anne Hagan** **Date: 27 July 2016**

Guidance end-notes

[1] The following principles, drawn from case law, explain what we must do to fulfil our duties under the Equality Act:

- **Knowledge:** everyone working for the council must be aware of our equality duties and apply them appropriately in their work.
- **Timeliness:** the duty applies at the time of considering policy options and/or before a final decision is taken – not afterwards.
- **Real Consideration:** the duty must be an integral and rigorous part of your decision-making and influence the process.
- **Sufficient Information:** you must assess what information you have and what is needed to give proper consideration.
- **No delegation:** the council is responsible for ensuring that any contracted services which provide services on our behalf can comply with the duty, are required in contracts to comply with it, and do comply in practice. It is a duty that cannot be delegated.
- **Review:** the equality duty is a continuing duty. It applies when a policy is developed/agreed, and when it is implemented/reviewed.
- **Proper Record Keeping:** to show that we have fulfilled our duties we must keep records of the process and the impacts identified.

NB: Filling out this EIA in itself does not meet the requirements of the equality duty. All the requirements above must be fulfilled or the EIA (and any decision based on it) may be open to challenge. Properly used, an EIA can be a tool to help us comply with our equality duty and as a record that to demonstrate that we have done so.

[2] **Our duties in the Equality Act 2010**

As a council, we have a legal duty (under the Equality Act 2010) to show that we have identified and considered the impact and potential impact of our activities on all people with 'protected characteristics' (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, sexual orientation, and marriage and civil partnership).

This applies to policies, services (including commissioned services), and our employees. The level of detail of this consideration will depend on what you are assessing, who it might affect, those groups' vulnerability, and how serious any potential impacts might be. We use this EIA template to complete this process and evidence our consideration.

The following are the duties in the Act. You must give 'due regard' (pay conscious attention) to the need to:

- **avoid, reduce or minimise negative impact** (if you identify unlawful discrimination, including victimisation and harassment, you must stop the action and take advice immediately).
- **promote equality of opportunity**. This means the need to:
  - Remove or minimise disadvantages suffered by equality groups
  - Take steps to meet the needs of equality groups
  - Encourage equality groups to participate in public life or any other activity where participation is disproportionately low
  - Consider if there is a need to treat disabled people differently, including more favourable treatment where necessary
- **foster good relations between people who share a protected characteristic and those who do not**. This means:
  - Tackle prejudice
  - Promote understanding

[3] EIAs are always proportionate to:

- The size of the service or scope of the policy/strategy
- The resources involved
- The numbers of people affected
- The size of the likely impact
- The vulnerability of the people affected

The greater the potential adverse impact of the proposed policy on a protected group (e.g. disabled people), the more vulnerable the group in the context being considered, the more thorough and demanding the process required by the Act will be.

[4] **When to complete an EIA**:

- When planning or developing a new service, policy or strategy
- When reviewing an existing service, policy or strategy
- When ending or substantially changing a service, policy or strategy
- When there is an important change in the service, policy or strategy, or in the city (eg: a change in population), or at a national level (eg: a change of legislation)

Assessment of equality impact can be evidenced as part of the process of reviewing or needs assessment or strategy development or consultation or planning. It does not have to be on this template, but must be documented. Wherever possible, build the EIA into your usual planning/review processes.

Do you need to complete an EIA? Consider:

- Is the policy, decision or service likely to be relevant to any people because of their protected characteristics?
- How many people is it likely to affect?
- How significant are its impacts?
- Does it relate to an area where there are known inequalities?
- How vulnerable are the people (potentially) affected?

If there are potential impacts on people but you decide not to complete an EIA it is usually sensible to document why.

[5] **Title of EIA:** This should clearly explain what service / policy / strategy / change you are assessing

[6] **ID no:** The unique reference for this EIA. If in doubt contact Clair ext: 1343

[7] **Team/Department:** Main team responsible for the policy, practice, service or function being assessed

[8] **Focus of EIA:** A member of the public should have a good understanding of the policy or service and any proposals after reading this section. Please use plain English and write any acronyms in full first time - eg: ‘Equality Impact Assessment (EIA)’

This section should explain what you are assessing:

- What are the main aims or purpose of the policy, practice, service or function?
- Who implements, carries out or delivers the policy, practice, service or function? Please state where this is more than one person/team/body and where other organisations deliver under procurement or partnership arrangements.
- How does it fit with other services?
- Who is affected by the policy, practice, service or function, or by how it is delivered? Who are the external and internal service-users, groups, or communities?
- What outcomes do you want to achieve, why and for whom? Eg: what do you want to provide, what changes or improvements, and what should the benefits be?
- What do existing or previous inspections of the policy, practice, service or function tell you?
- What is the reason for the proposal or change (financial, service, legal etc)? The Act requires us to make these clear.

[9] **Data:** Make sure you have enough data to inform your EIA.

- What data relevant to the impact on protected groups of the policy/decision/service is available?[9]
- What further evidence is needed and how can you get it? (Eg: further research or engagement with the affected groups).
- What do you already know about needs, access and outcomes? Focus on each of the protected characteristics in turn. Eg: who uses the service? Who doesn't and why? Are there differences in outcomes? Why?
- Have there been any important demographic changes or trends locally? What might they mean for the service or function?
- Does data/monitoring show that any policies or practices create particular problems or difficulties for any groups?
- Do any equality objectives already exist? What is current performance like against them?
- Is the service having a positive or negative effect on particular people in the community, or particular groups or communities?
- Use local sources of data (eg: JSNA: http://www.bhconnected.org.uk/content/needs-assessments and Community Insight: http://brighton-hove.communityinsight.org/#) and national ones where they are relevant.

[10] **Engagement:** You must engage appropriately with those likely to be affected to fulfil the equality duty.

- What do people tell you about the services?
- Are there patterns or differences in what people from different groups tell you?
- What information or data will you need from communities?
- How should people be consulted? Consider:
  - (a) consult when proposals are still at a formative stage;
  - (b) explain what is proposed and why, to allow intelligent consideration and response;
  - (c) allow enough time for consultation;
  - (d) make sure what people tell you is properly considered in the final decision.
- Try to consult in ways that ensure all perspectives can be considered.
- Identify any gaps in who has been consulted and identify ways to address this.

[11] Your EIA must get to grips fully and properly with actual and potential impacts.

- The equality duty does not stop decisions or changes, but means we must conscientiously and deliberately confront the anticipated impacts on people.
- Be realistic: don't exaggerate speculative risks and negative impacts.
- Be detailed and specific so decision-makers have a concrete sense of potential effects. Instead of "the policy is likely to disadvantage older women", say how many or what percentage are likely to be affected, how, and to what extent.
- Questions to ask when assessing impacts depend on the context. Examples:
    - Are one or more protected groups affected differently and/or disadvantaged? How, and to what extent?
    - Is there evidence of higher/lower uptake among different groups? Which, and to what extent?
    - If there are likely to be different impacts on different groups, is that consistent with the overall objective?
    - If there is negative differential impact, how can you minimise that while taking into account your overall aims
    - Do the effects amount to unlawful discrimination? If so the plan must be modified.
    - Does the proposal advance equality of opportunity and/or foster good relations? If not, could it?

[12] Consider all three aims of the Act: removing barriers, and also identifying positive actions we can take.

- Where you have identified impacts you must state what actions will be taken to remove, reduce or avoid any negative impacts and maximise any positive impacts or advance equality of opportunity.
- Be specific and detailed and explain how far these actions are expected to improve the negative impacts.
- If mitigating measures are contemplated, explain clearly what the measures are, and the extent to which they can be expected to reduce / remove the adverse effects identified.
- An EIA which has attempted to airbrush the facts is an EIA that is vulnerable to challenge.

[13] **Age**: People of all ages

[14] **Disability**: A person is disabled if they have a physical or mental impairment which has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities. The definition includes: sensory impairments, impairments with fluctuating or recurring effects, progressive, organ specific, developmental, learning difficulties, mental health conditions and mental illnesses, produced by injury to the body or brain. Persons with cancer, multiple sclerosis or HIV infection are all now deemed to be disabled persons from the point of diagnosis.

[15] **Gender Reassignment:** In the Act a transgender person is someone who proposes to, starts or has completed a process to change his or her gender. A person does not need to be under medical supervision to be protected

[16] **Pregnancy and Maternity:** Protection is during pregnancy and any statutory maternity leave to which the woman is entitled.

[17] **Race/Ethnicity:** This includes ethnic or national origins, colour or nationality, and includes refugees and migrants, and Gypsies and Travellers

[18] **Religion and Belief:** Religion includes any religion with a clear structure and belief system. Belief means any religious or philosophical belief. The Act also covers lack of religion or belief.

[19] **Sex/Gender:** Both men and women are covered under the Act.

[20] **Sexual Orientation:** The Act protects bisexual, gay, heterosexual and lesbian people

[21] **Marriage and Civil Partnership:** Only in relation to due regard to the need to eliminate discrimination.

[22] **Community Cohesion:** What must happen in all communities to enable different groups of people to get on well together.

[23] **Other relevant groups:** eg: Carers, people experiencing domestic and/or sexual violence, substance misusers, homeless people, looked after children, ex-armed forces personnel, people on the Autistic spectrum etc

[24] **Cumulative Impact:** This is an impact that appears when you consider services or activities together. A change or activity in one area may create an impact somewhere else

[25] **Assessment of overall impacts and any further recommendations**

- Make a frank and realistic assessment of the overall extent to which the negative impacts can be reduced or avoided by the mitigating measures. Explain what positive impacts will result from the actions and how you can make the most of these.
- Countervailing considerations: These may include the reasons behind the formulation of the policy, the benefits it is expected to deliver, budget reductions, the need to avert a graver crisis by introducing a policy now and not later, and so on. The weight of these factors in favour of implementing the policy must then be measured against the weight of any evidence as to the potential negative equality impacts of the policy,
- Are there any further recommendations? Is further engagement needed? Is more research or monitoring needed? Does there need to be a change in the proposal itself?

[26] **Action Planning:** The Equality Duty is an ongoing duty: policies must be kept under review, continuing to give ‘due regard’ to the duty. If an assessment of a broad proposal leads to more specific proposals, then further equality assessment and consultation are needed.