Appendix 2

Equalities Impact Assessments for the Health and Wellbeing Board priority areas

What are Equality Impact Assessments (EIAs)?

Public sector bodies need to be able to evidence that they have given due regard to the impact and potential impact on all people with 'protected characteristics' in shaping policy, in delivering services and in relation to their own employees.

'Protected characteristics' are: age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, sexual orientation. They also include marriage and civil partnership but only in relation to eliminating discrimination.

The following principles, drawn from case law, explain what is essential in order for the Public Sector Equality Duty to be fulfilled.

Public bodies should ensure:

Knowledge – everyone who works for the council and other statutory bodies must be aware of our Equality Duties and apply them appropriately in their work

Real consideration – you must consider the aims of the Equality Duty as an integral part of your decision-making process. The Duty is not about box-ticking; it must be done properly, with rigour and an open mind so that it influences your final decision.

Sufficient Information- you must consider what information you have and what further information is needed to give proper consideration to the Equality Duty

Proper Record Keeping – we must keep records of the process of considering the Equality Duty and the impacts on protected groups. This encourages transparency and the proper completion of Equality Duties. If we don't keep records then it may be more difficult for us to evidence that we have fulfilled our equality duties.

Review – we must have regard to the aims of the Duty not only when a policy is developed and decided upon but also when it is implemented and reviewed. The Equality Duty is a continuing duty.

EIAs are about making services better for everyone and value for money; getting services right first time.

The Health and Wellbeing Board – Priority Areas

Through its Joint Health and Wellbeing Strategy (JHWS), the Health and Wellbeing Board has chosen five priority areas on which to focus the Board's work.

Detailed information on how the priority areas were chosen can be found in the introduction to the Joint Health and Wellbeing Strategy document. In terms of equality impacts, the themed data used in the prioritisation process was considered under a number of criteria including the impact on particular groups including protected characteristic groups, and on their impact on inequalities.

The Brighton and Hove Local Information Service (BHLIS) website has more detail about the Joint Strategic Needs Assessment which was used to inform the HWB in choosing their priorities (http://www.bhlis.org/jsna2012). This link includes a detailed impact matrix, showing the impacts on affected equalities groups where known.

The five priorities for the HWB are:

- cancer and access to cancer screening
- dementia
- emotional health and wellbeing (including mental health)
- healthy weight and good nutrition
- smoking

Each of these areas has its own Equalities Impact Assessment (EIA). This document's purpose is to pull the EIAs together into one place and to provide a link to each EIA.

The HWB has not been directly involved in any of the EIAs for the priority areas. However the expectation is that the HWB members will use the EIAs to review service delivery, policy and make recommendations for the next steps in service development. The EIAs should be reviewed annually as a matter of good practice.

The Equality Impact Assessments

This section links to each Equality Impact Assessment (attached at the end of the document), details which agency is responsible for the EIA and when it was completed.

- **cancer and access to cancer screening (Enclosure 1)**

to follow

- **dementia (Enclosure 2)**

  The Dementia Action Plan; written by the Clinical Commissioning Group, November 2011.

  Anticipated outcomes include:

- Initiation of a new Memory Assessment Service
- Recommissioning of Care Home In each Team
- Completion of EOL and dementia care pathway
- Dementia champion for the Royal Sussex County Hospital

  Service commences June 2013, with pathway to be completed by December 2013.

  The Plan is for 2 years and the CCG joint commissioner for Dementia in conjunction with the Dementia Implement Group will be responsible for its continued delivery.

- **emotional health and wellbeing (including mental health) (Enclosure 3)**

  The Emotional Health and Wellbeing EIA was written by Brighton & Hove City Council, August 2013

- Despite higher levels of self-reported wellbeing across the city, local prevalence of mental illness continues to be generally higher than the average for England for both common mental health problems, such as anxiety and depression and severe mental illness, such as schizophrenia or bipolar disorder.

- The chapter sets out an intention to develop an all age emotional health and wellbeing strategy; a further EIA will need completing when the strategy is completed, The aim of the strategy will be to promote improved emotional health and wellbeing for the whole population and to offer timely and appropriate mental health interventions for children and adults in a range of settings, taking account of all equalities issues.

- **healthy weight and good nutrition (Enclosure 4)**

  Strategy written by Public Health, Brighton and Hove City Council. Completed in July 2013

- In Brighton and Hove an estimated 43,632 adults are obese and 6,500 are morbidly obese. An estimated 14,000 children and young people

aged 2-19 years are overweight or obese. This is predicted to increase to 16,400 by 2020.
- Obesity is strongly correlated with inequalities and deprivation.
- The estimated annual cost to the NHS in the city related to overweight and obesity was £78.1 million in 2010. This is predicted to increase to £85 million by 2015.
- Excess weight is a major risk factor for diseases such as type 2 diabetes, cancer and heart disease.

The action plan and strategy aim to promote healthy weight and healthy lifestyles for the whole population and to offer weight management programmes and services to overweight and obese children and adults in a range of settings

- **smoking (Enclosure 5)**

  Reducing Health Inequalities through Tobacco Control and Joint Health & Wellbeing Strategy; written by Public Health, Brighton and Hove City Council, January 2013.

  The BHTCA acts to reduce health inequalities caused by smoking. Smoking is a local priority for the Brighton & Hove City Council Health & Wellbeing Strategy .

  Smoking is the primary cause of premature death.
  The principal beneficiaries are-
    - Young people and others who are not recruited to smoking
    - City residents who quit.
    - Benefits for communities and families who live in areas of high smoking prevalence.
    -

  The Brighton & Hove Tobacco Control Alliance has been established with multiagency representation which will-
- Helping communities to stop smoking
- Maintaining & Promoting Smokefree environments
- Tackling cheap and illicit tobacco
- Stopping the inflow of young people as smokers.

Enclosure 2 – Dementia EIA/ Action Plan

Name of Function - Dementia Action Plan

Date of Equality Impact Analysis –November 2011

Name and position of person completing the EIA – Katie Hirst, Commissioning [Clinical Commissioning Group]

Sources of information used to complete EIA- Input from GP clinical leads and secondary care clinicians, contract monitoring data, information from Public Health .

Names of stakeholder groups or numbers of individuals involved and the protected characteristic communities they represent

- Sussex Partnership Foundation Trust
- Brighton and Hove City Council
- Sussex Community NHS Trust
- Brighton and Sussex University Hospital Trust
- Alzheimer's Society
- Age Concern
- MIND
- The Martlets Hospice
- People with dementia and carers via the Alzheimer's Society

Anticipated positive impact for each relevant group

- Initiation of a new Memory Assessment Service
- Recommissioning of Care Home Inreach Team team
- Completion of EOL and dementia care pathway
- Dementia champion for the Royal Sussex County Hospital

Evidence that this impact has been delivered

- Service commences 1st June 2013
- Redesigned service starts April 1203.
- Pathway to be completed by Dec 2013.
- Post holder operational

Anticipated negative impact for each relevant group – none identified

Evidence this impact has been mitigated – N/A

Where evidence of positive or negative impact has not been collected please indicate how this evidence will be collected – none identified

Outstanding actions from the EIA - including timescale for delivery and responsible individual -

The Plan is for 2 years and the CCG joint commissioner for Dementia in conjunction with the Dementia Implement Group will be responsible for continued delivery of the plan

Enclosure 3 – Emotional Health and Wellbeing EIA

Title of EIA	Emotional health and wellbeing Health and Wellbeing Strategy Priority. The strategy is currently in draft form.	**Ref No.**	
Delivery / Resource / Finance Unit or Intelligent Commissioning name	Joint strategy across CCG , BHCC children's commissioning and public health (delivery through range of local statutory and CVS organisations)		
Aim of policy or scope of service	Despite higher levels of self-reported wellbeing across the city, local prevalence of mental illness continues to be generally higher than the average for England for both common mental health problems, such as anxiety and depression and severe mental illness, such as schizophrenia or bipolar disorder. The chapter in the health and wellbeing strategy sets out an intention to develop an all age emotional health and wellbeing strategy and further EIA will need completing when the strategy is completed, The aim of the strategy will be to promote improved emotional health and wellbeing for the whole population and to offer timely and appropriate mental health interventions for children and adults in a range of settings The strategy will take due account of all equalities issues herewith		

2. Record of data/engagement; impacts identified; and potential actions to meet the Duties.

	Data[1] that you have	**Community engagement exercises or mechanisms[2]**	**Impacts identified from analysis (actual and potential)[3]**	**Potential actions to advance equality of opportunity, eliminate discrimination, and foster good relations** (You will prioritise these below)
Consider: • How 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). • How to 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 • How to foster good relations between people who share a protected characteristic and those who do not. This means: – Tackle prejudice – Promote understanding				
Community Cohesion (what must happen in all communities to enable different groups of people to get on well together.)	Focus on developing services in the community and via for example primary care, schools. . Developing greater focus on promotion of emotional wellbeing and raising awareness and reducing stigma.	The draft JHWS, including the Emotional health and wellbeing priority, was discussed with the CVSF, and consulted on via the council's portal in 2012 and at focus groups in 2013	Poor mental health retains a stigma and ongoing work needed to reduce this	We have information about self reported wellbeing from the national ONS survey for the whole city, but need further work on the Health Counts survey to understand the distribution of emotional wellbeing across

[1] 'Data' may be monitoring, customer feedback, equalities monitoring, survey responses…

[2] These may be ongoing links that you have with community and voluntary groups, service-user groups, staff forums; or one-off engagement sessions you have run.

[3] If data or engagements are missing and you can not define impacts then your action will be to take steps to collect the missing information.

	Participation in World mental health day. Social connectedness is in itself protective for mental wellbeing.			different neighbourhoods, communities of interest and demographic groups.
Age (people of all ages)	Taking the Brighton & Hove population of 5-16 year olds to be approximately 38,198[4] and using the mental health strategy data of one in 10 children experiencing mental health problems, this would equate to 3,819 children & young people in the city with mental ill-health. Most mental health problems start in childhood & adolescence & the majority of severe & enduring mental illnesses are diagnosed by the age of 18.Adolescence is a vulnerable time for the emergence of emotional ill	Service user groups in adult mental health services. Amaze is the parent participation organisation locally. Representation of parent carers and service users on key strategy groups and partnerships. CVSF have contributed to consultation on the HWS chapter. Safe and Well at schools survey asks specific mental health questions of school age children and has been extended to include students at 6th form colleges Mind is commissioned to deliver mental health	Lack of an all age mental health strategy increases likelihood of their being 'gaps' between areas of provision for different age ranges. Developing this strategy will help mitigate this	Teen to adult personal advisers support young people aged 14-25 who find it difficult to access services. Right Here (a partner with the local authority) supports young people aged 16-25 via resilience building activities and volunteering opportunities. Development of all age mental health strategy. Increased focus on improved transitions from child to adult services. Specific ongoing developments for young people eg online counselling

[4] Office for National Statistics Mid year estimates 2010

	health issues. Self reported wellbeing in the Health Counts survey showed that respondents aged 65-74 years were most happy: 78% for men and 77% for women. However, respondents aged over 75 years were least likely to feel that things in their life were worthwhile (65%). An older people's needs assessment (2008) found the mental health problems affecting the greatest number of older people in the city are dementia and depression. Applying national prevalence to the local population suggests that there are around 3,100 with depression and 1,000 with severe depression.	advocacy and participation for children and young people		

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[5])	People with autism or Asperger syndrome are particularly vulnerable to mental health problems such as anxiety & depression, especially in late adolescence & early adult life.[6] This is an area of concern in the city and is a key aspect of the Special Educational Needs strategy. People with physical health problems, especially long term conditions, are more vulnerable to depression and anxiety. Analysis from the Compass database (the voluntary register for children & young people with disabilities in the city) shows that as of 1st June 2013	Currently there is no specific engagement with adults with a disability. AHA group for children and YAP.	Ensure that services are appropriately promoted and accessible to those with disability.	Increased data on those with disabilities and their mental wellbeing- including from Health counts data

[5] 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.

[6] Tantam D. Prestwood S. (A mind of one's own: a guide to the special difficulties and needs of the more able person with autism or Asperger syndrome. 3rd ed. London: National Autistic Society; 1999.

[7] Amaze analysis conducted for the JSNA in June 2013.

	26% of children & young people with an up-to-date record on the register are known to have received support from CAMHS over the past two years.[7] Long term ill health and in particular pain are contributors to being at risk of suicide			
Gender reassignment (a transsexual person is someone who proposes to, starts or has completed a process to change his or her gender. A person does <u>not</u> need to be under medical supervision to be protected)	An additional survey of a small number of trans young people[8] indicates that this cohort or particularly vulnerable to mental health issues	No specific mechanism in place due to lack of data. Awaiting information from trans needs assessment	No data.	Once available the data will be analysed and plans will be put in place accordingly.
Pregnancy and maternity (protection is during pregnancy and any statutory maternity leave to which the woman is entitled)	Women vulnerable to post natal depression or with other mental health problems before or after childbirth can access a specialist perinatal mental health service. All			

[8] Allsorts Youth Project (2013) Allsorts Trans* Survey Report, Quarter 4 Jan-March 2013

	mothers screened for mental health issues by midwives and health visitors . Family nurse partnership works intensively with first time mothers under 19 years. Young mothers are at greater risk of developing post natal depression.			
Race (this includes ethnic or national origins, colour or nationality, including refugees and migrants; and Gypsies and Travellers)	Across England, BME groups are more likely to be diagnosed with a mental illness than those who are White British, with new psychosis diagnoses up to seven times higher in Black Caribbean groups. [9] Local hospital admissions data do not reflect previous findings that rates were higher than expected among BME groups, however. In the Health Counts survey, there was no significant difference in	Service user groups in adult mental health services. Amaze is the parent participation organisation locally. Representation of parent carers and service users on key strategy groups and partnerships. CVSF have contributed to consultation on the HWS chapter. Safe and Well at schools survey asks specific mental health questions of school age children and has been extended to	The service specifications require providers to ensure that services are delivered in a culturally sensitive manner and are tailored accordingly.	

[9] Raleigh VS, Irons R, Hawe E, et al. Ethnic variations in the experience of mental health service users in England: results of a national patient survey programme. Br J Psychiatry. 2007;191:304-312.

	any of the self reported wellbeing measures for BME respondents. However, respondents with Mixed ethnicity showed significantly worse results for satisfaction (54%), happiness yesterday (57%) and for being less anxious (41% in the less anxious category).	include students at 6th form colleges Active engagement with community groups at the BMECP. Psychosocial support services for the BME community are currently being commissioned, following consultation.		
Religion or 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.)	In the Health Counts survey there were no significant differences by religion in self reported wellbeing. Buddhists were most likely to be satisfied with their lives (88%), feel that life was worthwhile (94%) and were most happy (82%). By contrast, Muslim residents reported lower levels of satisfaction with life (55%), were significantly less likely to feel that the things they did in life were worthwhile	No specific data collected.	Current approaches take into account faiths and cultures.	Further work is required to identify needs.

	(57%), were less happy with their lives (54%), and were also significantly less likely to have low levels of anxiety (40%).			
Sex (both men and women are covered under the Act)	More men than women are admitted to hospital overall for mental illness: 64% of people admitted are men.[10] Females are significantly more likely to have to have medium to high satisfaction with life and to feel the things they do are worthwhile. Males however are significantly more likely to have had very low or low levels of anxiety on the previous day. There was little difference in how happy people felt on the previous day by gender (2012 Health Counts survey). Young females are more likely than males to	Service user groups in adult mental health services. Amaze is the parent participation organisation locally. Representation of parent carers and service users on key strategy groups and partnerships. CVSF have contributed to consultation on the HWS chapter. Safe and Well at schools survey asks specific mental health questions of school age children and has been extended to include students at 6th form colleges	Participation contract awarded to specifically target young men.	Suicide prevention group focuses on the most at risk groups

[10] Sussex Foundation Partnership NHS Trust data for Brighton and Hove residents (2012-13).

	present to A&E with serious self harm. Of the young people under 18 presenting to A&E with serious self harm in 2012, 88% were female. Men are three times more likely to die by suicide than women and men aged 35-49 are most at risk (local audit of Coroner's records). Safe and Well at school data (2012) indicates that girls are much more likely to experience feeling anxious / worried often or sometimes than boys (57% compared to 39% with boys). Girls are also more likely to feel very sad / depressed (32% compared to 21% with boys) or lonely / isolated (25% compared to 18% with boys). Boys are more likely to experience feeling very			

	angry often or sometimes (33% compared to 29% with girls) and marginally more likely to feel out of control (21% compared to 20% with girls).			
Sexual orientation (the Act protects bisexual, gay, heterosexual and lesbian people)	Brighton and Hove has a significant proportion of young people who would describe themselves as LGBT. Surveys undertaken by Allsorts, a local support project, reflect the increased vulnerability of this group to mental health issues. SAWSS : Across all categories of negative mood the trend with sexual orientation appears to be that LGB students are more likely to experience them than unsure respondents and unsure students are more likely to experience them then heterosexual students. The largest	Service user groups in adult mental health services. Amaze is the parent participation organisation locally. Representation of parent carers and service users on key strategy groups and partnerships. CVSF have contributed to consultation on the HWS chapter. Safe and Well at schools survey asks specific mental health questions of school age children and has been extended to include students at 6th form colleges Direct consultation via Allsorts	No data currently available.	Health Count analysis.

	differences between heterosexual and LGB students in SAWSS dats is on hurting or harming yourself (7% heterosexual and 46% LGB) followed by suicidal thoughts (7% heterosexual and 44% LGB) and spending time a lot of time alone (18% heterosexual and 49% LGB). The Count Me in Too survey found that 79% of the city's LGBT population reported some form of mental health difficulties. For the Health Counts survey, heterosexual respondents were more likely to be more satisfied with their life, feel the things the do are worthwhile, have higher levels of happiness and be less anxious than LGB and			

	unsure respondents. There were no significantly different results for any LGBU group.			
Marriage and civil partnership (only in relation to due regard to the need to eliminate discrimination)	The 2012 Brighton & Hove Health Counts survey showed that the risk of depression is significantly higher in people who area single, divorced or separated. This reflects national ONS survey data which shows higher levels of self reported wellbeing among those who are married, in a civil partnership or cohabiting.			
Other relevant groups eg: Carers, people experiencing domestic violence, substance misusers, homeless people, looked after children etc	Of the referrals to Tier 3 CAMHS in the period January-September 2012 102 were known to social services. The England average score for emotional and behavioural health (SDQ scores)of looked after children is 13.8	Service user groups in adult mental health services. Amaze is the parent participation organisation locally. Representation of parent carers and service users on key strategy groups and partnerships. CVSF have	The supported accommodation pathway has been redesigned – making more flexible use of resources and targeting resources more effectively to those with the most complex needs.	

	and the Brighton and Hove average is 14.8 (2012) with 0-13 being deemed normal, 14-16 being borderline for concern and 17+ being cause for concern Some groups within the population have a higher risk of developing mental ill-health: homeless people, offenders, certain BME groups, LGB people, veterans, looked after children, transgender people, gypsies and travellers, vulnerable migrants, victims of violence, people approaching the end of life, bereaved people, people with a dual diagnosis or complex needs, and people with learning	contributed to consultation on the HWS chapter. Safe and Well at schools survey asks specific mental health questions of school age children and has been extended to include students at 6th form colleges		

[11] HM Government. No health without mental health: implementation framework. London: July 2012.

	disabilities have all been identified as at higher risk[11]. Brighton and Hove has relatively high proportions of some of these groups including homeless, LGB and transgender people. The 2012 Health Counts survey showed that the risk of depression in significantly higher among more deprived groups. Respondents who own their own homes did significantly better across all measures, and those who are employed significantly higher for satisfaction with life and feeling the things they do are worthwhile. However, those who rent from a housing association or local authority or council fare significantly worse across all four measures. There was no significant			

	difference in levels of happiness and wellbeing for carers.			

Healthy Weight and Good Nutrition EIA

1. Front sheet

Title of EIA	Healthy Weight and Good Nutrition Action Plan and Joint Health and Wellbeing Strategy Priority. The strategy is currently in draft form.	**Ref No.**	
Delivery / Resource / Finance Unit or Intelligent Commissioning name	Public Health		
Aim of policy or scope of service	• In Brighton and Hove an estimated 43,632 adults are obese and 6,500 are morbidly obese. An estimated 14,000 children and young people aged 2-19 years are overweight or obese. This is predicted to increase to 16,400 by 2020. • Obesity is strongly correlated with inequalities and deprivation. • The estimated annual cost to the NHS in the city related to overweight and obesity was £78.1 million in 2010. This is predicted to increase to £85 million by 2015. • Excess weight is a major risk factor for diseases such as type 2 diabetes, cancer and heart disease. The action plan and strategy aim to promote healthy weight and healthy lifestyles for the whole population and to offer weight management programmes and services to overweight and obese children and adults in a range of settings.		

2. Record of data/engagement; impacts identified; and potential actions to meet the Duties.

	Data[12] that you have	**Community engagement exercises or mechanisms[13]**	**Impacts identified from analysis (actual and potential)[14]**	**Potential actions to advance equality of opportunity, eliminate discrimination, and foster good relations** (You will prioritise these below)
Consider: • How 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). • How to 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 • How to foster good relations between people who share a protected characteristic and those who do not. This means: – Tackle prejudice – Promote understanding				

[12] 'Data' may be monitoring, customer feedback, equalities monitoring, survey responses…
[13] These may be ongoing links that you have with community and voluntary groups, service-user groups, staff forums; or one-off engagement sessions you have run.
[14] If data or engagements are missing and you can not define impacts then your action will be to take steps to collect the missing information.

Community Cohesion (what must happen in all communities to enable different groups of people to get on well together.)	Programmes provided in community settings such as community centres, schools and local leisure facilities. Population level data are available from the 2012 Health Count Survey. This is self-reported height and weight for adults and is available by protected characteristic groups. Locally commissioned programmes have collected data on the protected characteristics of service users and since 2012 have been using the city council's equality monitoring framework. Information from the National Child Measurement	Citywide consultation and stakeholder interviews included within physical activity needs assessment. Focus groups with community weight management service users were completed in May 2013. The findings informed the service specification in particular providing more post programme support. Local Active Travel Forum brings together a wide range of community groups and service providers. The draft JHWS, including the Healthy Weight priority, was discussed with the CVSF, and consulted on via the council's portal in 2012.	The JSNA identified specific groups as needing further engagement to increase participation and access for a range of population groups. Older people, particularly the vulnerable, socially isolated and people at risk of falls. People with disabilities, both physical and learning; the consensus was that not enough is currently being done, particularly in university and youth settings. LGBT community, specific groups were people with disabilities, older more isolated people and young LGBT men.	The Healthy Weight Programme Board brings together a wide range of organisations from the voluntary, public and private sectors. The Board's Action Plan outlines four separate domains with a series of actions for each of the partners, the funding sources and key performance indicators. The key objective is to strengthen local action to prevent overweight and obesity through a life course approach and to address obesity through appropriate treatment and support. The Board will oversee the delivery of the JHWS priority for Healthy

	programme demonstrates that children from the more socio-economically deprived areas of the city are more likely to be overweight or obese. The contracts with providers stipulate the need for targeted work in areas of socio-economic inequality.			Weight and Good Nutrition. The JHWS Healthy Weight and Good Nutrition Priority was presented and discussed at the CVSF network in January 2013. the comments and suggestions from the CVSF network were integrated in the JHWS Healthy Weight and Good nutrition section.
Age (people of all ages)	The National Child Measurement Programme (NCMP) measures children aged 4-5 years and 10-11 years every year. 2011/2012 NCMP data shows that 19% of children in Reception	The parents of children with an unhealthy weight are contacted by a health professional before they receive the result by post and offered support and access to services.	Parents of very overweight children contacted directly by the School Nurse Team reported that they welcome the opportunity to discuss their child needs and receive advice accordingly.	Plans to increase participation of children and young people from the most socio-economically deprived parts of the city. Results from the Health Count Survey will inform further actions

	Year (4-5 years) were overweight or obese. 30% of children in Year 6 (10-11 years) were overweight or obese. There is no regular or reliable local data on the prevalence of adult obesity (a national issue). Data from the Health Survey 2011 estimates 22% of adults are obese. Data is collected on the age of service users attending local weight management services. Information is available from the Health Count Survey. Adults of all ages can be referred into local services by their GP or people can self-refer.	The Food Partnership is running focus groups for clients attending community and individual weight management programmes to improve access and participation. People who are overweight or obese can discuss their needs with primary care or other health care professionals.	Because of morbidity associated with obesity, people of all ages should receive advice and support from the health service.	for adults.

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[15])	National data shows that those with a disability or mobility issues are more likely to be overweight or obese. Locally ongoing work with children who have special and complex needs- e.g. work with individual children who are not suited to community group programmes such as MEND through the child weight management clinic at Seaside View. Adults are also able to attend a 1:1 clinic if they prefer this to group sessions. Some information on	Currently there is no specific engagement with adults with a disability, although some adults with mobility issues participated in the focus groups led by the Food Partnership.	Ensure that community services are appropriately promoted and accessible to those with disability.	Adults with disabilities can be referred to local weight management services. Data is now being provided which will indicate if further work is required.

[15] 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.

	adults is available through the Health Count Survey: Those with a limiting long-term illness or disability (39%) were significantly less likely than all respondents (53%) to be a healthy weight. The figure for those without a disability was 58% were a healthy weight.			
Gender reassignment (a transsexual 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)	The Health Count Survey shows that 9 of the 16 trans respondents giving self reported heights and weights were a healthy weight – a similar proportion to all respondents. As regard to service uptake, data is only starting to be collected.	No specific mechanism in place due to lack of data.	No data.	Once available the data will be analysed and plans will be put in place accordingly.

Pregnancy and maternity (protection is during pregnancy and any statutory maternity leave to which the woman is entitled)	All pregnant women booking with BSUHT are weighed and offered dietetics advice to maintain a healthy weight during pregnancy. This is based on NICE guidance.	Discussed at the Maternity Service Liaison Group which is a user led forum.	Not all women to the Shape Up post pregnancy community programme chose to attend.	Further work is required to improve uptake of that Shape-Up post pregnancy service.
Race (this includes ethnic or national origins, colour or nationality, including refugees and migrants; and Gypsies and Travellers)	National data shows that children from black Caribbean background were more likely to be overweight and obese. Locally from the NCMP there is no significant difference between ethnic groups for children in Reception. However for children in Year 6, Asian, Asian British and Black or Black British children have an increase prevalence of obesity (but only the Asian	The Food Partnership actively engages with community groups at the BMECP, including parents.	The service specifications require providers to ensure that services are delivered in a culturally sensitive manner and are tailored accordingly. The JSNA Physical Activity shows that BME groups lack targeted sports and physical activity provision. In particular: Muslim women; those with a disability; those prone to clinical obesity and small clusters of	Continued communication of results with parents and service providers.

	category is statistically significant). For adults the Health Count Survey shows that there was some difference in being a health weight between BME respondents (59%) and White British respondents (52%) though neither group were significantly less likely to be of a healthy weight than all other survey respondents.		people where language is the key barrier to participation.	
Religion or 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.)	Further to the comment above related to ethnicity, no routine data collected. No data on children religion is collected through the NCMP but data is available for adults from the Health Count Survey. Respondents	No specific data collected.	Current approaches take into account faiths and cultures are regard diet and exercise.	Further work is required to identify needs. This will begin with the Health Count results.

	to the survey with no religion (58%) were significantly more likely to be a healthy weight. Christians were less likely (47%) though not significantly so and those with a religion other than Christian (54%) were similar to all respondents (53%).			
Sex (both men and women are covered under the Act)	National data shows prevalence by gender. Locally gender data is collected by providers. Population data from the Health Count Survey shows that adult male respondents (47%) are significant less likely to be a healthy weight than female respondents (59%) in Brighton and Hove.	As above (see age section).	JSNA physical activity identified the need to increase participation and access for girls and young women, students; adult women and parents. Men are more reluctant than women to attend mixed community groups and services and can be seen on a 1 to 1 basis or in men only groups.	Monitoring of prevalence and uptake of services.

	This is similar to the national picture. Adult males are less likely to be a healthy weight in all age groups.			
Sexual orientation (the Act protects bisexual, gay, heterosexual and lesbian people)	There is no national data available. Local data is available from Health Count Survey and indicates that heterosexual respondents (45%) and LGB, unsure and other respondents (47%) were as likely to be of healthy weight, the small difference was not statistically different. Data only recently being collected by providers locally.	If the Health Count identifies a need for further work with these groups then this will be pursued through existing engagement mechanisms.	No data currently available.	Health Count analysis.
Marriage and civil partnership (only in relation to due regard to the need to eliminate	There is no national data available. Local data from the Health Count Survey shows that are no statistically			

discrimination)	significant differences in healthy weight by marital status.			
Other relevant groups eg: Carers, people experiencing domestic violence, substance misusers, homeless people, looked after children etc	For Looked After children they are routinely included in the NCMP. Data on some of the groups is included in the Health Count Survey. Carers (42%) are significantly less likely to be a healthy weight than all respondents.			

3. Prioritised Actions:

NB: you should also highlight here if there is potential for <u>cumulative</u> impact across the service or for a specific group.

Action	Timeframe	Lead officer	Evidence of progress	Success measure
• Analysis and interpretation of Health Count Survey	**June 2013**	**Kate Gilchrist**	**Presentation at the Healthy Weight Programme Board in July 2013**	**Data used to inform equality monitoring and access to services.**
• Analysis and interpretation of service providers monitoring returns	**6 monthly evaluation reports**	**Lydie Lawrence**	**Evaluation inform service commissioning**	**Increased access to services, service effective and positive health outcomes.**
• Ensure the development of a comprehensive weight management service for children and adults from primary through to tertiary care.	**June-December 2013**	**Lydie Lawrence**	**Procurement service specification to P&R Committee on 11th July 2013**	**New contract in place by 1st April 2014.**
• Plans to increase participation of children and young people from the most socio-economically deprived parts of the city. • Results from the Health Count Survey will inform further actions for adults	**April 2013-April 2014**	**Lydie Lawrence**	**Support to GP practices to refer children to service (advice on how to deal with sensitive issue of weight with families and use of BMI charts for boys and for girls).**	**Increased referrals of children to Healthy Weight Referral Services.**

• To build on the work with the local community to identify and develop local venues for healthy weight and good nutrition linked programmes.	**April 2013- April 2014**	**David Brindley**	**Audit of existing prevention activities in the community.**	**Increased provision and access in local venues.**
• To further develop the partnership with local leisure centre providers to increase local community participation.	**April 2013- April 2014**	**David Brindley**	**Work with local leisure providers through exercise referrals and free swimming.**	**Increased local community participation**
• To promote healthy eating and active lifestyles to employees via the workplace.	**April 2013 -**	**David Brindley**	**Healthy choice awards in public sector catering and restaurants. Global Corporate Challenge in Local Authority**	**Healthy Eating promoted in Brighton and Hove City Council and NHS workplace**
• To improve the information for people, particularly vulnerable people, about healthy eating options available in their local area.	**April 2014**	**Lydie Lawrence**	**Embedded in the Community Weight Management service specification for procurement.**	**Increased access to service and advice for vulnerable people**
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Reducing Health Inequalities through Tobacco Control Equality Impact Assessment

Title of EIA	Brighton & Hove Tobacco Alliance (BHTCA) Reducing Health Inequalities through Tobacco Control and Joint Health & Wellbeing Strategy	**Ref No.**	
Delivery / Resource / Finance Unit or Intelligent Commissioning name	Planning & Public Protection : Regulatory Services		
Aim of policy or scope of service	The BHTCA acts to reduce health inequalities caused by smoking. Smoking is a local priority for the Brighton & Hove City Council Health & Wellbeing Strategy . Smoking is the primary cause of premature death. The principal beneficiaries are- • Young people and others who are not recruited to smoking • City residents who quit. • Benefits for communities and families who live in areas of high smoking prevalence. The Brighton & Hove Tobacco Control Alliance has been established with multiagency representation which will- • Helping communities to stop smoking • Maintaining & Promoting Smokefree environments • Tackling cheap and illicit tobacco • Stopping the inflow of young people as smokers.		

2. Record of data/engagement; impacts identified; and potential actions to meet the Duties.

	Data[16] that you have	**Community engagement exercises or mechanisms[17]**	**Impacts identified from analysis (actual and potential)[18]**	**Potential actions to advance equality of opportunity, eliminate discrimination, and foster good relations** (You will prioritise these below)
Consider: • How 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). • How to 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 • How to foster good relations between people who share a protected characteristic and those who do not. This means: – Tackle prejudice – Promote understanding				

[16] 'Data' may be monitoring, customer feedback, equalities monitoring, survey responses…
[17] These may be ongoing links that you have with community and voluntary groups, service-user groups, staff forums; or one-off engagement sessions you have run.
[18] If data or engagement are missing and you can not define impacts then your action will be to take steps to collect the missing information.

Community Cohesion (what must happen in all communities to enable different groups of people to get on well together.)	National smoking prevalence : 20% The Health Counts 2012 shows Brighton & Hove prevalence : 23.1% in some areas in the City eg Moulsecomb and Bevendean the smoking prevalence is 30-34% and in Withdean and Hove Park the prevalence is low 11-16% According to the Integrated Household Survey in all areas in England the smoking prevalence in Brighton & Hove is 22.9% for 2011/12. The stop smoking service works with anybody who wants to quit smoking	Neighbourhood Forums/LATS/NR Stop Smoking service. Health Trainers, Health Check Nurses, Health Service. GMB. Coptic Church. Taxi Forum. Target R & M groups. Local Community assets. BMECP	Smoke free homes. Smoke free vehicles. Smoke free leisure areas. 4 week quitters	Comparison of referrals to quitters – socio economic groups, ethnic groups. Public Health Outcomes Framework Tobacco Control Profiles(Public Health Observatories) Health Counts 2012 Integrated Survey

Age (people of all ages)	Health Counts Survey 2012 shows that there is no significant difference in smoking prevalence between males and females (males 25%),(females 22%). In Brighton & Hove prevalence in men increases between 18-24 years and 25-34 years which reaches 35%.At the age of 75 years or over for males and females smoking prevalence is at its lowest point 5% for males and 10% for females Nationally 21% of adult men and 19% of adult women are smokers Two thirds of smokers start smoking before age 18 years The 2012 SAWSS shows	Schools/Youth Centres/Community Centres/Local community assets /	Reduce under 16s trying smoking for the first time. Reduced smoking prevalence in Adults Tackling cheap & illicit tobacco	Test purchase operations. UAS training. Healthy Schools – PSHE. Quarterly data from Stop Smoking Service Health Counts Survey SAWS Survey

	that KS3 84% responded that they had never smoked not even a puff compared to 9.4% tried smoking once or twice. Also 25.5% of respondents had smoked more than 40 cigarettes in the last 7 days. KS4- 49.6% never smoked 7.4% have smoked more than 40 cigarettes KS2 96.9% have never tried a cigarette			
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	Causes of disability : cancer, COPD, CVD. Sussex Partnership Foundation Trust is developing 2013/14 a Physical Health	Retirement groups Day Centres Older People's Council Workers Forums Alzheimer's Society Amaze Fed Centre for	Reduce smoking prevalence and health inequalities	Introduction of new monitoring form will capture this information April 2013- Specialist Stop Smoking Service

normal day-to-day activities[19])	CQUIN and stop smoking is part of this. Staff will be trained to deliver stop smoking interventions to their clients	Independent Living Sussex Partnership Foundation Trust BSUH		Monitoring forms from Sussex Partnership Foundation Trust
Gender reassignment (a transsexual 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)	No data ?	LGBT Workers Forum Spectrum THT	Reduce smoking prevalence	Introduction of new monitoring form April 2013-Specialist Stop Smoking Service
Pregnancy and maternity (protection is during pregnancy and any statutory maternity leave to which the woman is entitled)	Reduce smoking during pregnancy to 11 % by 2015 measured at time of giving birth. Smoking at time of delivery 2011/12 in Brighton & Hove is	Maternal Health Steering Group Midwives Health visitors Children Centres	Reduced number of pregnant women smoking Reduce the risk of secondhand smoke Reduce the number of women smoking at time of delivery	Data collection from the monitoring forms Routine screening of pregnant women Tobacco control profiles Public Health Outcomes Framework

[19] 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.

	7.6% 2011/12- 73 pregnant women recorded as stopping smoking at 4 weeks during pregnancy.			BSUH
Race (this includes ethnic or national origins, colour or nationality, including refugees and migrants; and Gypsies and Travellers)	Brighton & Hove 4 week quit data 2011/12 shows 7 mixed race 12 Asian/ Asian British 15 black/black British 12 other ethnic group attended stop smoking services Health Counts 2012 survey shows that there is no difference in smoking prevalence between BME respondents (23%) and white respondents (23%).Smoking prevalence in Brighton & Hove in	BME Workers Forums BME Community Partnership (www.bmecp.org.uk) CIMB Taxi Forum Coptic Church	Reduce smoking prevalence. Joint Health & Wellbeing Strategy	Introduction of new monitoring form April 2013-Specialist Stop Smoking Service Health Counts Survey Domain1 Tobacco Control action plan

	mixed ethnic groups is (32%) though this difference is not significant.			
Religion or 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.)	The Health Counts Survey states that there is no significant difference in smoking prevalence by religion, though it is higher in those with no religion (27%)	Church, Mosque and Temple groups BMECP	Reduce smoking prevalence	Introduction of new monitoring form April 2013-Specialist Stop Smoking Service Health Counts Survey
Sex (both men and women are covered under the Act)	This is described in section Ages above.	Same as section ages	Reduce smoking prevalence Tackle cheap and illicit tobacco	Brighton & Hove Stop Smoking Service currently collect this data
Sexual orientation (the Act protects bisexual, gay, heterosexual and lesbian people)	Health Counts survey 2012 shows LGB and unsure respondents (30%) more likely to say they smoke than heterosexuals (22%) Highest smoking	Stonewall Spectrum LGB Workers Forum	Reduce smoking prevalence	Introduction of new monitoring form April 2013-Specialist Stop Smoking Service Health counts survey

	prevalence is seen amongst bisexuals (40%) significantly higher than for all respondents			
Marriage and civil partnership (only in relation to due regard to the need to eliminate discrimination)	Health Counts Survey 2012 shows that single people are more likely to smoke (33%) Those in a civil partnership or living as a couple significantly less likely (18%) No significant difference in those who are widowed as a couple (16%) and those who are separated or divorced (25%)	LGB Worker s Forum Stonewall	Reduce smoking prevalence	This data is captured on the Health Counts Survey

Other relevant groups eg: Carers, people experiencing domestic violence, substance misusers, homeless people, looked after children etc	The Health Counts Survey 2012 shows no significant difference in smoking prevalence between carers (24%) and all respondents	Carers' Forum Carers' Centre	Reduce smoking prevalence	Introduction of new monitoring form April 2013-Specialist Stop Smoking Service Health counts survey

3. Prioritised Actions:

NB: you should also highlight here if there is potential for <u>cumulative</u> impact across the service or for a specific group.

Action	Timeframe	Lead officer	Evidence of progress	Success measure
Develop SDG action plans	2013/14	Sue Venables	Stop Smoking Service	Reduce smoking prevalence Reduce health inequalities
SDG1) Helping communities to stop smoking. SDG2) Maintaining and promoting smoke SDG3) free environments. SDG4) Tackling cheap and illicit tobacco. Stopping the inflow of young people Recruited.		Sue Venables		(Reduced prevalence ((young people). (4 week or 1 year (quitters. (Smoking status of (pregnant women at (time of delivery.
Based on Health count results				
Data from Gold Standard monitoring form				

Signing of EIA:-

Lead Equality Impact Assessment Officer:	**Sue Venables** **Tim Nichols**	**Date: 15.01.13**
Head of Service Delivery Unit	**Martin Randall**	**Date:**
Lead Commissioner (if required):	**Peter Wilkinson**	**Date:**

Equalities Impact Assessment Publication Template

Name of review:	Brighton & Hove Tobacco Alliance (BHTCA) Reducing Health Inequalities through Tobacco Control
Period of review:	Continuous – from setting up Tobacco Alliance in December 2010 and ongoing
Date review signed off by Head of Unit / Lead Commissioner:	15.01.13
Scope of the review:	Reducing Health Inequalities through Tobacco Control
Review team:	Susan Venables/Jean Cranford/Tim Nichols
Relevant data and research:	Discussion with South East Region colleagues from other Las and TCA's, published data (Association of Public Health Observatories, Department of Health, Action on Smoking & Health (ASH), Primary Care Trust, Stop Smoking service)

Consultation: indicate who was consulted and how they were consulted	Tobacco Alliance and Strategic Domain Group members, citizens of Brighton & Hove via Stop Smoking Services and via various campaigns e.g Stoptober, National stop smoking day events, BHCC & PCT staff via face to face contact, taxi drivers in B&H via the taxi forum
Assessment of impact, outcomes and key follow-up actions:	No negative impacts identified.
Name and contact details of lead officer responsible for follow-up action:	Susan Venables, Tobacco Control Co-ordinator susan.venables@brighton-hove.gov.uk 01273 293927
For further information on the assessment contact:	Susan Venables, Tobacco Control Co-ordinator susan.venables@brighton-hove.gov.uk 01273 293927