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Equality & Human Rights Impact Assessment (EHRIA)

This Equality and Human Rights Impact Assessment (EHRIA) will enable you to assess the **new, proposed or significantly changed** policy/ practice/ procedure/ function/ service** for equality and human rights implications.

Undertaking this assessment will help you to identify whether or not this policy/ practice/ procedure/ function/ service** may have an adverse impact on a particular community or group of people. It will ultimately ensure that, as an Authority, we do not discriminate and we are able to promote equality, diversity and human rights.

Please refer to the EHRIA guidance before completing this form. If you need any further information about undertaking and completing the assessment, contact your Departmental Equalities Group or equality@leics.gov.uk

***Please note: The term 'policy' will be used throughout this assessment as shorthand for policy, practice, procedure, function or service.*

Key Details	
Name of policy being assessed:	Development of an integrated lifestyle service for Leicestershire.
Department and section:	Public Health
Name of lead officer/ job title and others completing this assessment:	Mike Sandys, Director of Public Health Elizabeth Orton, Consultant in Public Health Thomas Dunn, Specialist Registrar in Public Health
Contact telephone numbers:	0116 30 55347
Name of officer/s responsible for implementing this policy:	Elizabeth Orton, Consultant in Public Health
Date EHRIA assessment started:	15/01/18
Date EHRIA assessment completed:	18/09/18

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Section 1: Defining the policy

Section 1: Defining the policy
You should begin this assessment by defining and outlining the scope of the policy. You should consider the impact or likely impact of the policy in relation to all areas of equality, diversity and human rights as outlined in Leicestershire County Council's Equality Strategy.

1	What is new or changed in the policy? *What has changed and why?* **The development of an integrated lifestyle service will bring together multiple separately-commissioned lifestyle services into a more integrated service offer in Leicestershire. The proposed model consulted upon outlined the move to more information being available online to support self-help and to an increase in telephone and digitally-based support for weight loss, with a retention of some face to face support.** **The new service will provide different levels of support:** • **Universal information and advice (tier 1)** • **Telephone-based health assessment and behaviour change planning** • **Telephone and digitally-based (internet/app-based) individualised health coaching for weight management (tier 2)** • **Targeted face to face support for certain groups at certain times (also at tier 2).** **Lifestyles that will form the integrated service offer include (but may not be limited to in the future) the existing stop smoking service, weight management and physical activity advice (with local delivery of programmes). Alignment with the current First Contact Plus service will mean access to support for broader determinants of health also.** **This change is driven in part by the council's Medium Term Financial Strategy (MTFS), with financial efficiencies being realised by bringing services together and potentially in-house, but also the need to have a more joined-up holistic approach to lifestyle behaviour change given that unhealthy lifestyle behaviours often cluster together in the same individuals.**
2	Does this relate to any other policy within your department, the Council or with other partner organisations? *If yes, please reference the relevant policy or EHRIA. If unknown, further investigation may be required.* **The development of this service relates to the Early Health and Prevention Review undertaken in 2016, the council's MTFS and the stop smoking service EHRIA undertaken in 2015.**
3	Who are the people/ groups (target groups) affected and what is the intended change or outcome for them? **The target group is people who have one or more unhealthy lifestyle behaviours i.e. are overweight/obese, inactive or smoke. Individuals will have also expressed a readiness to change these unhealthy lifestyle behaviours.**

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	Outcomes would be lifestyle changes leading to improved health and wellbeing (e.g. reduction in percentage bodyweight, meeting the Chief Medical Officer (CMO) guidelines for physical activity and consuming alcohol within the CMO guidelines for consumption. This in turn will lead to reduction in lifestyle-associated disease such as type 2 diabetes, cardiovascular disease etc.			
4	Will the policy meet the Equality Act 2010 requirements to have due regard to the need to meet any of the following aspects? **(Please tick and explain how)**			
		Yes	**No**	**How?**
	Eliminate unlawful discrimination, harassment and victimisation	✓		These requirements will be explicitly written into the service specification
	Advance equality of opportunity between different groups	✓		These requirements will be explicitly written into the service specification
	Foster good relations between different groups	✓		These requirements will be explicitly written into the service specification

Section 2: Equality and Human Rights Impact Assessment (EHRIA) Screening

Section 2: Equality and Human Rights Impact Assessment Screening
The purpose of this section of the assessment is to help you decide if a full EHRIA is required.

If you have already identified that a full EHRIA is needed for a policy/ practice/ procedure/ function/ service, either via service planning processes or other means, then please go straight to Section 3 on Page 7 of this document.

Section 2 **A: Research and Consultation**			
5.	Have the target groups been consulted about the following?	**Yes**	**No***
	a) their current needs and aspirations and what is important to them;	✓	
	b) any potential impact of this change on them (positive and negative, intended and unintended);	✓	
	c) potential barriers they may face	✓	

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6.	If the target groups have not been consulted directly, have representatives been consulted or research explored (e.g. Equality Mapping)?	**n/a**	
7.	Have other stakeholder groups/ secondary groups (e.g. carers of service users) been explored in terms of potential unintended impacts?	✓	
8.	*If you answered 'no' to the questions above, please use the space below to outline either what consultation you are planning to undertake or why you do not consider it to be necessary.		

Section 2 **B: Monitoring Impact**			
9.	Are there systems set up to:	**Yes**	**No**
	a) monitor impact (positive and negative, intended and unintended) for different groups;	✓	
	b) enable open feedback and suggestions from different communities	✓	
Note: If no to Question 9, you will need to ensure that monitoring systems are established to check for impact on the protected characteristics.			

Section 2 **C: Potential Impact**				
10.	Use the table below to specify if any individuals or community groups who identify with any of the 'protected characteristics' may ***potentially*** be affected by the policy and describe any positive and negative impacts, including any barriers.			
		Yes	**No**	**Comments**
	Age	✓		**This is an adult service. Children's weight management is being delivered through more child-friendly methods (e.g. FLiC and Energy Clubs). If the adult in the service is a parent of a child the food for the whole family will be included for weight management components.** **Older adults or others who do not use digital technology such as the internet could**

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				potentially be affected. Mitigation would be face to face support although capacity for this will be limited. Behaviour change advisors could consider advising people to seek out commercial weight management services or district-led lifestyle services as an alternative.
	Disability	✓		**People who have disabilities that mean that telephone-based communication is difficult could potentially be disadvantaged if the service was only telephone based. However text and internet options will be available and face to face group-based support will be included in the model. People with mobility disabilities may benefit from digital delivery.** **People with complex needs, chronic conditions and some disabilities will need specialist support (Tier 3) which is beyond the scope of Local Authority commissioning responsibilities (i.e. Tier 1 and 2 services) and will be excluded from the proposed model. The current service may be supporting people with these additional needs currently and changes will affect these people.**
	Gender Reassignment		✓	**Gender does not impact on the service delivery. People are supported regardless of their gender and there are no issues foreseen following reassignment.**
	Marriage and Civil Partnership		✓	**Relationship status does not impact on the service delivery.**

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	Pregnancy and Maternity		✓	**National Commissioning guidance states that Tier 2 services are not recommended for women who are pregnant. However general lifestyle advice can be provided and pre-conceptual advice will be included in the model.**
	Race		✓	**Dietary advice will include culture/ethnicity-specific diets. For example based on the current DAHL weight management service for people with a South Asian diet.**
	Religion or Belief		✓	**The service will be available to people regardless of their religion/belief. Any dietary recommendations will be sensitive to religious observations.**
	Sex		✓	**Sex does not impact on the service delivery. People are supported regardless of their sex and there are no issues foreseen in this regard.**
	Sexual Orientation		✓	**Sexual orientation does not impact on the service delivery. People are supported regardless of their sexual orientation and there are no issues foreseen.**
	Other groups e.g. rural isolation, deprivation, health inequality, carers, asylum seeker and refugee communities, looked after children, deprived or disadvantaged communities		✓	**People who are socially disadvantaged are at most risk of having unhealthy lifestyles so services will need to take this into account in terms of access (e.g. location and travel); there will be no cost to the users of the service. People living in rural and isolated locations may be better served as they will not have to travel to health centres/hospitals/other venues around the county. Delivery will be predominantly digital with some telephone- and face-to-face based**

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				support. Criteria for being offered face-to-face support would include not having access to technology (smart phones/internet). Interpreters need to be explored for people not able to speak English. Carers will be actively encouraged to participate in order to remain in good health themselves whilst in their caring role. There will be no exclusions based on asylum/refugee status.
	Community Cohesion		✓	**This is a service for individuals wanting to improve their lifestyle behaviours and so there is no anticipated impact on community cohesion.**

11.

Are the human rights of individuals ***potentially*** affected by this proposal? Could there be an impact on human rights for any of the protected characteristics? **(Please tick)**

Explain why you consider that any particular article in the Human Rights Act may apply to the policy/ practice/ function or procedure and how the human rights of individuals are likely to be affected below: [NB: include positive and negative impacts as well as barriers in benefiting from the above proposal]

	Yes	No	Comments
Part 1: The Convention- Rights and Freedoms			
Article 2: Right to life	✓		**People will be supported to be as healthy as possible and so improve their quality of life and reduce the likelihood or impact of long term health conditions.**
Article 3: Right not to be tortured or treated in an inhuman or degrading way		✓	
Article 4: Right not to be subjected to slavery/ forced labour		✓	
Article 5: Right to liberty and security		✓	

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	Article 6: Right to a fair trial		✓	
	Article 7: No punishment without law		✓	
	Article 8: Right to respect for private and family life		✓	
	Article 9: Right to freedom of thought, conscience and religion		✓	
	Article 10: Right to freedom of expression		✓	
	Article 11: Right to freedom of assembly and association		✓	
	Article 12: Right to marry		✓	
	Article 14: Right not to be discriminated against	✓		**As described above, people with protected characteristics will be treated equitably. Where there may be disadvantage this will be mitigated as described.**
	Part 2: The First Protocol			
	Article 1: Protection of property/ peaceful enjoyment		✓	
	Article 2: Right to education		✓	
	Article 3: Right to free elections		✓	

Section 2
D: Decision

13.	Is there evidence or any other reason to suggest that:	**Yes**	**No**	**Unknown**
	a) the policy could have a different affect or adverse impact on any section of the community;	✓		
	b) any section of the community may face barriers in benefiting from the proposal	✓		

13.	Based on the answers to the questions above, what is the likely impact of the policy			
	No Impact ☐	Positive Impact ☐	Neutral Impact ☐	Negative Impact or Impact Unknown ☑

Note: If the decision is 'Negative Impact' or 'Impact Not Known', an EHRIA Report is required.

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14.	Is an EHRIA report required?	Yes ✓	No

Section 2: Completion of EHRIA Screening

Upon completion of the screening section of this assessment, you should have identified whether an EHRIA Report is requried for further investigation of the impacts of this policy.

Option 1: If you identified that an EHRIA Report ***is required***, continue to Section 3 on Page 7 of this document.

Option 2: If there are no equality, diversity or human rights impacts identified and an EHRIA report ***is not required***, continue to Section 4 on Page 14 of this document.

Section 3: Equality and Human Rights Impact Assessment (EHRIA) Report

Section 3: Equality and Human Rights Impact Assessment Report

This part of the assessment will help you to think ***thoroughly*** about the impact of the policy and to critically examine whether it is ***likely*** to have a positive or negative impact on different groups within our diverse communities. It should also identify any barriers that may adversely affect under-represented communities or groups that may be disadvantaged by the way in which we carry out our business.

Using the information gathered either within the EHRIA Screening or independently of this process, this EHRIA Report should be used to consider the impact or likely impact of the policy in relation to all areas of equality, diversity and human rights as outlined in Leicestershire County Council's Equality Strategy.

Section 3 **A: Research and Consultation**	
When considering the target groups, it is important to think about whether new data needs to be collected or whether there is any existing research that can be utilised.	
15.	Based on the gaps identified either in the EHRIA Screening or independently of this process, ***how*** have you now explored the following and ***what*** does this information/ data tell you about each of the diverse groups? a) current needs and aspirations and what is important to individuals and community groups (including human rights);

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	b) likely impacts (positive and negative, intended and unintended) to individuals and community groups (including human rights); c) likely barriers that individuals and community groups may face (including human rights)

The new model proposes a shift to a more integrated method of delivery of lifestyle advice generally and weight management more specifically, with a shift from the current predominantly group-based, face-to-face delivery to a combination of internet/digital, telephone and face-to-face based delivery. An evidence summary was prepared that considered the following research questions, focusing in particular on weight management:

- What are the barriers to face-to-face weight management?
- What are the barriers to telephone-based weight management?
- What are the barriers to online (web, app, smartphone) weight management?

The review considered each protected characteristic in turn and considered 'who else' may be affected by the proposed shift from group based weight management to individualised services. This evidence base is summarised in this EHRIA.

There is good evidence of effectiveness for weight management interventions for weight loss and other health and wellbeing metrics. It is less clear who is likely to benefit more or less from the different intervention approaches. In general the research literature seems to be biased towards understand effectiveness of interventions for females and working and younger age adults. There are gaps related to how to support people with learning disabilities, engaging people in lower socio economic groups and the impact of stigma and mental health on weight management.

Based on a review of the research literature, there are some groups who may be affected by proposed changes to the service. These are:

- The 'digitally excluded' group. These are individuals who are more likely to be older or from lower socioeconomic backgrounds
- Men
- Black and minority ethnic (BAME) groups with specific evidence related to South Asians risk factors and food cultures
- Lower socioeconomic groups
- People with disabilities
- Older people

Section 19 aims to highlight what is known and what barriers different groups may face. The review was not fully systematic and there may be evidence that is not included.

16.	Is any further research, data collection or evidence required to fill any gaps in your understanding of the potential or known affects of the policy on target groups?

The demographic and reach of the current service (LEAP) will enable an assessment of if the service is engaging with groups who face barriers. The current providers have been asked for this information but have not yet responded.

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In the new service contract monitoring and evaluation will need to be put in place to allow the collection of demographic information, health outcomes and process measures (for example dropout rates) and will allow assessment of equity, effectiveness and appropriateness and highlight if there are adverse impacts.

When considering who is affected by this proposed policy, it is important to think about consulting with and involving a range of service users, staff or other stakeholders who may be affected as part of the proposal.

17.	Based on the gaps identified either in the EHRIA Screening or independently of this process, ***how*** have you further consulted with those affected on the likely impact and ***what*** does this consultation tell you about each of the diverse groups?

Two focus groups of current weight management service users were delivered with 49 attendees and a stakeholder and public consultation was held between 14th June and 5th August with 90 consultation responses submitted. A detailed analysis of the stakeholder and public consultation is summarised in a separate document found in Appendix A of the Cabinet report.

The main concerns raised in relation to potential discrimination were that any online aspects of service may not be suitable for older people who may not have digital skills and people in lower socioeconomic groups who may not have digital access.

An equalities challenge session was facilitated after the consultation on the 23rd August. This yielded some additional considerations for the development of the service and service design:

- People with low health literacy, this will include people who are not aware of the need to manage weight, or are aware of the risk of being overweight
- South Asian women as they are the gatekeepers for families
- Some women may want women only face to face sessions as mixed services may act as a barrier
- People who are in food poverty
- People may need translation services or family members to translate, this might be an issue in one to one or telephone based services
- Socially isolated people or lonely people, they can be referred by GPs to a weight management service
- People with mental health issues and those with eating disorders

The group suggested the following service design considerations to help mitigate inequity of access:

- Consideration given to training the local voluntary and community sector to deliver weight management. This could overcome some of the barriers and make the delivery culturally appropriate.
- Engage with the VCS
- GP working group to understand how GPs can refer into the services and identify lonely and socially isolated people
- Publicise the holistic nature of the integrated lifestyles service rather than solely as a weight loss programme
- Engage with older people groups

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	• Provide service mapping for signposting to other services, such as eating disorder clinics and Tier 3 services • Link to mindfulness services or consider how mindful eating can be included • Evaluate proposed services to consider other outcomes beyond simple weight loss • Consider how sustainable weight loss can be maintained, will long term behaviour changes be made and how can these be monitored? • Link to cookery courses for people who need additional skills or are in food poverty A separate statement has been written by the Leicestershire Equalities Challenge group and this can be found in Appendix B of the Cabinet report.
18.	Is any further consultation required to fill any gaps in your understanding of the potential or known effects of the policy on target groups?
	There would be value in understanding the views of people who are overweight or obese and who do not access weight management services to understand why/if there are local barrier to access.

Section 3 **B: Recognised Impact**		
19.	Based on any evidence and findings, use the table below to specify if any individuals or community groups who identify with any 'protected characteristics' are ***likely*** to be affected by this policy. Describe any positive and negative impacts, including what barriers these individuals or groups may face. Full references are available in the source report: EHRIA Evidence	
		Comments
	Age	In general people over 35 experience higher rates of obesity than younger groups and are more likely to have a greater prevalence of risk factors or long term conditions such as such as type 2 diabetes or hypertension that raise the risk of obesity related ill health (ONS, 2017). It is unclear from the literature whether older people face specific barriers related to weight management. Telephone based weight management (TBWM) has been shown to be acceptable in older research trial participants (48 to 90 years, Median= 68 ± 8.6 years) (Hooker & al, 2005). A systematic review of mobile electronic device methods for weight loss reported effectiveness from trials for adults with mean ages that ranged from 38-53 (Khokar, 2014).

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		There is little evidence of the efficacy of online services for older people and digital literacy and access is often highlighted as a concern. In England there have been increases in digital use in older people, however there is a greater likelihood of some older adults being digitally excluded (Cabinet Office, 2012).
	Disability	There is a two way relationship between obesity and some disabilities, obesity can cause disability and disability can result in obesity (Public Health England, 2013) and in general people with disabilities have higher obesity than the general population (Kerr, 2004). There is limited research into the effectiveness of weight management for people with disabilities; however this should not be a justification for not providing services and is a reflection of the lack of quality research (Public Health England, 2013). Public Health England recommends the following reasonable adjustments to services to ensure equitable access: • Promotional health resources are likely to require literacy skills and often use abstract images so accessible information and resources are needed • People with learning disabilities benefit from a multi-disciplinary and multi-component approach that takes an individualised approach • People need support to understand the risks to their health to aid sustained motivation so training and appropriate information can help people to feel more positive about physical activity • The involvement of peers and/or partners without disabilities, who provide reciprocal support, has been shown to encourage participation in exercise in community settings. There are some additional barriers to consider: • Transport issues • Financial constraints • Immobility and illness • Risk assessment issues Taken from PHE Guidance Obesity and weight management (Public Health England, 2018) The NHS recommends that people with learning disabilities receive an annual health check through their GP which represents an additional opportunity to plan weight management taking into account individualised planning (NHS , 2017). NICE recommend that due to these additional needs there should be referral to Tier 3

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		weight management services (NICE, 2014) commissioned by clinical commissioning groups (CCGs). Deaf or hard of hearing may be at risk of access issues with the telephone based service. The Leicestershire Quit Ready smoking cessation service offers one to one support with the option of sign language services. There is limited research into telephone or online based services in people with visual impairment. There can be benefits and improvement to mental health from weight loss or engagement with services (Lasikiewicz, 2014). There are two weight related issues - stigma and eating disorders that should be considered in the design and delivery of online or offline services. *Weight stigma* Weight related stigma can be a real and perceived barrier with 88% percent of survey recipients reporting obesity related stigma in healthcare (RCPH, 2018). Supporting weight stigmatised individuals can include not focussing on solely individual factors and to include societal and environmental drivers. People from different ethnicities are more at risk of weight related stigma (National Obesity Observatory, 2011). Research has shown than 1/3 of people with obesity who completed a recent survey stated that they have not accessed any lifestyle or prevention services (RCPH, 2018). There was no available evidence on how stigma could be impacted by telephone or online services. *Eating disorders* Disordered eating may lead to underweight or overweight and includes a wide range of conditions such as anorexia nervosa, binge eating disorder and bulimia. These conditions are likely to require specialist support and should be referred to their GP for specific eating disorder support clinics or specialist services (NHS Choices, 2018).
	Gender Reassignment	The proposals are unlikely to provide barriers to access for transgender people, however stigma can be a barrier to access to health services in general and providers should ensure that the service is provided with an understanding of the needs of transgender persons (NHS England, 2015).
	Marriage and Civil Partnership	No specific evidence available.

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	Pregnancy and Maternity	Weight management in pregnancy is recommended by NICE as a Tier 3 service (NICE, 2010). This is beyond the scope of the planned Tier 1 and 2 service components. Tier 3 services are the commissioning responsibility of CCGs. NICE recommends that standard care lifestyle and weight management support is suitable and for women with a BMI over 30 there should be a specialist referral. Health services are recommended by NICE to incorporate access to childcare, be accessible and affordable and be suitable for women with other children (NICE, 2010).
	Race	There is limited evidence of the barriers and enablers for weight management services for BAME populations. There is evidence that there in an increased risk of type 2 diabetes and cardiovascular disease in South Asian populations (Diabetes UK, 2009) (November, L, 2014).This increased risk of obesity related disease is accounted for in the lower BMI thresholds of 23 and 27 for overweight and obesity for access to services. Due to small numbers, people of different ethnicities are underrepresented in research and there is limited available evidence into barrier to weight management, telephone or online services. There is some evidence that tailoring of weight management messages is potentially important for services serving South Asians, as a group with higher risk of morbidity from CVD and diabetes weight management services this should be mitigated by design of materials and messaging this could include greater emphasis on collective health, i.e. the family, rather than a sole focus on the individual (Lucas A, 2012).
	Religion or Belief	There is little evidence currently available on different religions and beliefs and how these may provide barriers or facilitators to weight management. There are specific dietary practices in many religions and this should be addressed in the design of materials (November, L, 2014). Mitigation will need to be considered in the design and delivery of services, this will need to include culturally appropriate messaging and education materials that incorporate different foods and eating patterns.
	Sex	Lower income women have higher rates of obesity compared to higher income women. This relationship is different from that of men who have less clear division by income status. There are differences between how men and women access weight management services with women more

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		likely to enrol in weight management programs (Ahern AL, 2016) and 10% of primary care weight management service user are male. Men have been found to not favour commercial weight management services (Men's Health Forum, 2014). There is some evidence that for some men there is a preference for men-only groups and this may increase the effectiveness of the program. The setting of the service seems to be important with social settings like sports clubs and workplaces may be more acceptable for men than NHS settings (Men's Health Forum, 2014). Women have greater representation in trials of using mobile technology at around 64–80% range (Bacigalupo R, 2013), there is no specific evidence for male trials and any specific barriers. Mitigation will need to be considered in the design of the proposed services to reduce barriers and risk of group based and digital exclusion.
	Sexual Orientation	No specific evidence available.
	Other groups e.g. rural isolation, deprivation, health inequality, carers, asylum seeker and refugee communities, looked after children, deprived or disadvantaged communities	Offering web or telephone based services has the potential to exclude some groups. In general in England there are high levels of access to landline telephones (84%) mobile telephones (92%) (OFCOM, 2017), smartphones (72%) (OFCOM, 2017) and internet (90%) (ONS, 2018). There are some groups who may experience issues such as digital exclusion; this is a broad term that takes into account many aspects of usage of digital channels and devices. The characteristics of people who are more likely to be digitally excluded are: • Over 65's, 51% of digitally excluded are older • Lower income groups, 45% of digitally excluded earn less than £11.5k a year • The unemployed, 19% of digitally excluded are not working • Social housing tenure, 37% of digitally excluded are social housing tenants • People with disabilities – 56% of digitally excluded have a disability or long-term condition • Lower educational attainment - 78% of digitally excluded left school before 16 • Rural living • Homeless people. The main digital barriers have been summarised as

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		access, skills, confidence, motivation (Cabinet Office, 2012). Rural living is a factor related to digital exclusion so potentially could be a barrier. Rural properties have the highest rates of landline ownership in England at 90% (OFCOM, 2017) so telephone based services could potentially mitigate this. Mitigation against digital inclusion can be by offering face to face or telephone based services and here is a program of Leicestershire wide broadband improvements to improve on line connectivity which will benefit rural areas. - Socioeconomic status People from deprived areas are likely to be at greater risk of obesity and clustering of health behaviours and may have lower take up with services (Ahern AL, 2016). Lower socio economic groups are more likely to be at risk of digital exclusion (Cabinet Office, 2012). Mitigation will need to be considered in the design of the proposed services to reduce barriers and risk of digital exclusion.
	Community Cohesion	No specific evidence available.

20.	Based on any evidence and findings, use the table below to specify if any particular Articles in the Human Rights Act are ***likely*** to apply to the policy. Are the human rights of any individuals or community groups affected by this proposal? Is there an impact on human rights for any of the protected characteristics?	
		Comments
	Part 1: The Convention- Rights and Freedoms	
	Article 2: Right to life	**None**
	Article 3: Right not to be tortured or treated in an inhuman or degrading way	**None**
	Article 4: Right not to be subjected to slavery/ forced labour	**None**
	Article 5: Right to liberty and	**None**

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	security	
	Article 6: Right to a fair trial	**None**
	Article 7: No punishment without law	**None**
	Article 8: Right to respect for private and family life	**None**
	Article 9: Right to freedom of thought, conscience and religion	**None**
	Article 10: Right to freedom of expression	**None**
	Article 11: Right to freedom of assembly and association	**None**
	Article 12: Right to marry	**None**
	Article 14: Right not to be discriminated against	**Section 19. details who and how may be at risk of discrimination and how mitigation can reduce this**
	Part 2: The First Protocol	
	Article 1: Protection of property/ peaceful enjoyment	**None**
	Article 2: Right to education	**None**
	Article 3: Right to free elections	**None**

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Section 3 **C: Mitigating and Assessing the Impact**	
Taking into account the research, data, consultation and information you have reviewed and/ or carried out as part of this EHRIA, it is now essential to assess the impact of the policy.	
21.	If you consider there to be actual or potential adverse impact or discrimination, please outline this below. State whether it is justifiable or legitimate and give reasons.

The proposed service offers a degree of mitigation by design in that there would be a range of delivery options from face to face, online and telephone based support. For each protected characteristic there are some groups that are highlighted in the research evidence who may face potential discrimination in weight management services. These groups were similar to those identified as concerns by consultation responses.

The characteristics of those who are more likely to be excluded from face to face (group or one to one) weight management services are:

- Men
- Lower socioeconomic status
- People who have experienced stigma.

The characteristics of people who are potentially disadvantaged by online services are:

- Older people
- Lower socioeconomic status (including income, housing tenure, level of education)
- People with some disabilities
- Rural living.

The potential for adverse impact to these groups is not justifiable and mitigation can be during design, recruitment and delivery of services.

There are some groups where legitimate discrimination is likely. This will be in those whose health needs are beyond the scope of the proposed service and signposting and referral routes will need to be in place. These health needs may require specialist services (Tier 3, eating disorder clinics). It is likely that the service will not meet the needs of the following

- People with eating disorders
- People with learning disabilities
- People who are pregnant
- People who are higher need and require clinical supervision.

Tier 3 services are the commissioning responsibility of NHS Clinical Commissioning Groups. Partners in CCGs have been contacted to enable discussions about the obesity/weight management pathway and how to ensure these groups have access to Tier 3 services.

NB:

i) If you have identified adverse impact or discrimination that is ***illegal***, you are required

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to take action to remedy this immediately.

ii) If you have identified adverse impact or discrimination that is ***justifiable or legitimate***, you will need to consider what actions can be taken to mitigate its effect on those groups of people.

22.	Where there are potential barriers, negative impacts identified and/ or barriers or impacts are unknown, please outline how you propose to minimise all negative impact or discrimination. a) include any relevant research and consultation findings which highlight the best way in which to minimise negative impact or discrimination b) consider what barriers you can remove, whether reasonable adjustments may be necessary and how any unmet needs that you have identified can be addressed c) if you are not addressing any negative impacts (including human rights) or potential barriers identified for a particular group, please explain why

The research evidence based for who may be discriminated against in weight management is small, and it is difficult to make generalisations to the local population. There are groups as highlighted in section 21 that are less likely to be supported by existing and proposed approaches.

In essence the different delivery models can offer a degree of tailoring to reduce barriers for most groups. Understanding individual barriers and enablers will be required, this should include an assessment of demographic information, digital literacy and protected characteristics and any reasonable adjustments that are required. This can be completed as part of the triage stage.

The Tier 1 and Tier 2 services will not be able to meet all needs for those who will need specific specialist support and criteria for referral to Tier 3 services will need to be agreed with CCG partners.

The design and delivery of the programme will need to consider the barriers to the groups highlighted in section 21.

Targeted outreach could mitigate against many of the barriers and create local evidence of unmet needs. The groups that may require targeted outreach would be:

- Digitally excluded people using an assessment tool
- Men
- People who have experienced stigma
- Older people
- Lower socioeconomic status (including income, housing tenure, level of education)
- People with some disabilities
- Rural living.

Section 3

APPENDIX C

D: Making a decision	
23.	Summarise your findings and give an overview as to whether the policy will meet Leicestershire County Council's responsibilities in relation to equality, diversity, community cohesion and human rights.
The proposed service has the potential to decrease inequalities in access by offering tailored, individualised options. There will be some groups where the proposed Tier 1 and 2 services will not meet their needs because they need Tier 3 services and these will need to be mapped to ensure sufficient referral pathways. Mitigation of any potential discrimination will be during the design phase and in the delivery of the service. There are some clear groups who are at risk of inequalities and targeted recruitment and referrals and evaluation of demographics and appropriateness can produce an assessment of if these groups' needs are being met.	

Section 3 **E: Monitoring, evaluation & review of the policy**	
24.	Are there processes in place to review the findings of this EHRIA and make appropriate changes? In particular, how will you monitor potential barriers and any positive/ negative impact?
	The proposed new service will need to undertake demographic monitoring of public engagement to ensure those at highest risk of obesity are represented. This should include, but not be limited to: age, sex, ethnicity, socio-economic group (e.g. Index of Multiple Deprivation or employment status), disability, and also include as assessment of digital inclusion and experience of stigma. A communications and marketing plan would be required to consider how to target to the groups most effectively.
25.	How will the recommendations of this assessment be built into wider planning and review processes? *e.g. policy reviews, annual plans and use of performance management systems*
	This EHRIA and the evidence review, consultation documents will form part of the design and delivery of the service. The potential for inequalities can be monitored as part of future evaluations. There are some groups whose needs will not be met by this Tier 1 and Tier 2 proposal and during the service mapping with CCGs there may be unmet needs and gaps highlighted. The EHRIA can provide evidence for the need of these services and define who require Tier 3 services. The evidence review can support public health planning; especially health needs assessments related to obesity and health inequalities in general.

APPENDIX C

Section 3:
F: Equality and human rights improvement plan

Please list all the equality objectives, actions and targets that result from the Equality and Human Rights Impact Assessment (EHRIA) (continue on separate sheets as necessary). These now need to be included in the relevant service plan for mainstreaming and performance management purposes.

Equality Objective	Action	Target	Officer Responsible	By when
Reduce the potential for inequalities in accessing services	Design and delivery should consider the needs of groups who have less engagement with weight management services	Plan process evaluation for any new services	Elizabeth Orton	September 2019
Signpost and refer to people with additional needs	Map services for groups whose needs are not met by the Tier 1 and 2 services	Have referral routes and plans in place	Elizabeth Orton	September 2019
Support individualisation and personalisation based on needs	Define who would benefit from different interventions (telephone, online, one to one)	Develop a triage, threshold and pathway for each intervention in the proposed model	Elizabeth Orton	September 2019

APPENDIX C

Section 4: Sign off and scrutiny

Upon completion, the Lead Officer completing this assessment is required to sign the document in the section below.

It is required that this Equality and Human Rights Impact Assessment (EHRIA) is scrutinised by your Departmental Equalities Group and signed off by the Chair of the Group.

Once scrutiny and sign off has taken place, a depersonalised version of this EHRIA should be published on Leicestershire County Council's website. Please send a copy of this form to the Digital Services Team via web@leics.gov.uk for publishing.

Section 4
A: Sign Off and Scrutiny

Confirm, as appropriate, which elements of the EHRIA have been completed and are required for sign off and scrutiny.

Equality and Human Rights Assessment Screening ✓

Equality and Human Rights Assessment Report ✓

1st Authorised Signature (EHRIA Lead Officer): …T J DUNN……

Date: 28th August 2018

2nd Authorised Signature (DEG Chair): Mike McHugh……

Date: ……24th September, 2018……

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