Appendix 1: EQIA

Equality Impact Assessment (EqIA) Template									
Type of Decision: Tick ✓		Cabinet ✓		Portfolio Holder		Other (explain)			
Date decision to be taken:	15 June 2017								
Value of savings to be made (if applicable):	£610k								
Title of Project:	**Reorganisation of the Public Health Service**								
Directorate / Service responsible:	Public Health								
Name and job title of Lead Officer:	Andrew Howe, Director of Public Health								
Name & contact details of the other persons involved in the assessment:	Carol Yarde, Business Manager Joint Public Health Service								
Date of assessment (including review dates):	04/4/2017								
Stage 1: Overview									
1. What are you trying to do? A reduction in the Public Health Service in Harrow via a reorganisation and restructure of the service. The reorganisation will produce a significant reduction in the number of staff currently employed within the Public Health Service who directly support Harrow Council. Currently there are approximately 17 full-time equivalent roles directly supporting Harrow Council number. The budget available for staffing the new service will fund approximately 5 full time equivalent posts.	Public Health mission is to keep people healthy throughout their lives and prevent or delay the need for expensive health and social care services. Public Health commissions services – sexual health, substance misuse, health checks, school nursing and health visiting (0-19 service) which have excellent evidence of effective impact and cost savings if they are universally accessible to a whole borough population. Public Health works to address health inequalities, such as differences in life expectancy between poorer and more affluent segments of the population (currently around 6.1 years for men and 5.6 years for women in Harrow and 7.6 and 5.6 respectively in Barnet), by ensuring all policy and programmes consider health impact and how to improve the health of those with the greatest need the fastest. In order to address these health inequalities, Public Health professionals are expert advisors on how the physical, social and economic conditions in which we are born, grow up and work shape our health directly and indirectly by influencing our lifestyles. interventions are not about directly controlling individual lifestyle behaviour, but providing the means for all people, regardless of their circumstances, to choose to live healthier lives. By investing in Public Health, Councils have the capacity to identify and mitigate any detrimental impacts to health and wellbeing as a result of a programme or policy e.g. construction programme and impact on air quality. Councils can also expect to enhance the positive impacts on their resident populations e.g. as a result of regeneration programmes because health, wellbeing and equality is embedded at the core. This underlines the importance of a model for Public Health which is embedded across the Council, not simply aligned with reactive front line service provision for vulnerable people. Public Health is currently a shared service with Barnet Council. The Director of Public Health post is a statutory obligation for all Councils across England. The Public Health team is divided into a specialist commissioning function, a Harrow focused team and a Barnet focused team. It								

	is well respected in London and a desirable training placement attracting 5-10 trainees per year. A significant proportion of the work the Harrow focused Public Health team undertakes is to serve as specialist advisors, supporting Harrow Council and partners, including Harrow CCG, to consider health, wellbeing and inequality in all it does. There is excellent evidence of return on investment from Public Health interventions and disinvestment is associated with long term increases in prevalence of mental and physical ill health and associated increased dependence on public sector funded services (Ref: Kings Fund/Local Government Association (2014), Making the case for public health interventions). **The Service has four key responsibilities:** 1. Leading health Improvement and reducing health inequalities 2. Health protection and ensuring appropriate plans are in place. 3. Public health support to health service commissioning and joint commissioning 4. Providing public health knowledge and intelligence These responsibilities are discharged through the following activity and services: Development, commissioning and evaluation of: Health and wellbeing initiatives & services: tobacco control, alcohol & substance misuse, physical activity, healthy eating, sexual health, oral health, breastfeeding, obesity, school nursing, Health Visiting, NHS health checks, community wellbeing and dental health. Health & wellbeing initiatives for vulnerable groups Building policy, programmes & strategic partnerships to promote the health agenda including through the Health & Wellbeing strategies and Health & Wellbeing Boards Leading local health information, education and communication by generic and targeted 'social marketing' Leading on health intelligence and knowledge management (Joint Strategic Needs Assessment) Commissioning, monitoring, and supporting secondary and tertiary prevention programmes Leading patient, public and community engagement Ensuring plans are in place for health protection, screening, infection control and immunisation.

	Support service and care pathway redesign and demand management programmes Support the development of health outcome measures and quality indicators for health services Ensuring effective and cost effective services Assessing need, utilisation, demand and outcomes **<u>The Service is made up of the following functions:</u>** • **Director of Public Health role** o Surveillance & assessment of populations' health and wellbeing o Assess the evidence of effectiveness of health and social care interventions, programmes and services o Policy and strategy development and implementation o Leadership and collaborative working for health • **Procurement & commissioning of health improvement services** o Review current services and pathways of care o Review/ develop service specifications based on evidence of effectiveness and cost effectiveness o Procurement and contract negotiation o Contract monitoring and performance assessment o Commission & performance managing health improvement programmes o Supporting commissioning activity within CCGs, NHS England and Public Health England o Supporting commissioning activity within the Councils • **Health improvement** o Interpretation and application of new policies o Coordinate health improvement projects and programmes and monitor and evaluate them o Involve the public in assessing their health and wellbeing needs and identify means to address such needs • **Public Health analysis** o Collection & analysis of data on defined populations o Support identification & evaluation of user strategic need for health data and intelligence and negotiation of solutions o Disseminate health data and intelligence from diverse sources to various

<table>
<tr><td></td><td colspan="6">audiences
o Inform and influence policy and priority setting and performance
o Assess relevance and usability of health data and intelligence, methods and systems

The proposals for change are to:
1. Disaggregate the service as per the inter-authority agreement that comes to an end on the 31.3.2018.

2. Restructure the Harrow Public Health Team and reduce staffing budget by £610k to be in place by 01.04.2018

The reorganisation will produce a significant reduction in the number of staff employed within the Public Health Service that directly support Harrow Council. Across the shared service there are currently 38 established posts. Of these posts there are approximately 17.0 full-time equivalent posts dedicated to Harrow. .

The budget for the new service (£380k) will fund approximately 5 full time equivalent posts</td></tr>
<tr><td rowspan="5">2. Who are the main people / Protected Characteristics that may be affected by your proposals? (✓ all that apply)</td><td>Residents / Service Users</td><td>x</td><td>Partners</td><td>x</td><td>Stakeholders</td><td>x</td></tr>
<tr><td>Staff</td><td>x</td><td>Age</td><td>x</td><td>Disability</td><td>x</td></tr>
<tr><td>Gender Reassignment</td><td>x</td><td>Marriage and Civil Partnership</td><td></td><td>Pregnancy and Maternity</td><td>x</td></tr>
<tr><td>Race</td><td>x</td><td>Religion or Belief</td><td>x</td><td>Sex</td><td>x</td></tr>
<tr><td>Sexual Orientation</td><td>x</td><td>Other</td><td></td><td></td><td></td></tr>
<tr><td>3. Is the responsibility shared with another directorate, authority or organisation? If so:
• Who are the partners?
• Who has the overall responsibility?
• How have they been involved in the assessment?</td><td colspan="6">Harrow Council has an Inter Authority Agreement with Barnet Council for the delivery of a Public Health Service in Barnet which ceases on 31 March 2018. The reorganization proposals relate solely to staff supporting Harrow. Partners have not been involved in the initial assessment.</td></tr>
<tr><td colspan="7">Stage 2: Evidence & Data Analysis</td></tr>
<tr><td colspan="7">4. What evidence is available to assess the potential impact of your proposals? This can include census data, borough profile, profile of service users, workforce profiles, results from consultations and the involvement tracker, customer satisfaction surveys, focus groups, research interviews, staff surveys, press reports, letters from residents and complaints etc. Where possible include data on the nine Protected</td></tr>
</table>

Characteristics. (Where you have gaps (data is not available/being collated for any Protected Characteristic), you may need to include this as an action to address in your Improvement Action Plan at Stage 6)

The main sections below cover impact on the population of Harrow; potential impact on staff is covered in a separate section at the end of the main table.

Protected Characteristic	Evidence	Analysis & Impact
Age (including carers of young/older people)	Key messages • Harrow has a larger and growing proportion of older people than the London average and a higher proportion of under 16s. As people age, the risk of ill health increases. For example, there are more than 16000 people living with Type 2 diabetes in Harrow (one of the highest rates in England), 84.1% of people with Type 2 diabetes in Harrow are over 40 (35.2% are over 65). • Life expectancy in Harrow is good but there is a gap between the deprived and affluent parts of the borough meaning that men die 6.1 years younger and women 5.6 years younger in the most deprived parts of the borough. • Not all of our lives are lived in good health. In Harrow, on average, the last 13 years of men's lives and the last 15 years of women's lives are lived with long term conditions and disability. The gap between rich and poor is magnified when we look at healthy life expectancy. So, not only do people in the deprived parts of the borough live shorter lives but they also live a greater proportion of those lives in poor health. Men in the most deprived areas live 8.5 more years of their life in poor health and women 9.8	<u>Impact of reduced PH service in Harrow</u> • Projected increases in obesity and physical inactivity (associated with more than 20 long term conditions including Type 2 diabetes) due to: o no staff to oversee research trial into effectiveness of commercial weight management programme on ethnically diverse Harrow population. o No staff to lead on work with Harrow fast food outlets impacting on salt, sugar and fat content particularly amongst children o No prospective work with regeneration to undertake Health Impact Assessments which could improve the health and wellbeing related environment in which people live e.g. age friendly communities. o No support for Harrow CCG around best practice for weight management pathways (they will be responsible for commissioning tier 3 and 4

Protected Characteristic	Evidence	Analysis & Impact
	more years. • Only 55% of Harrow adults people take the recommended daily amount of exercise – lower than London and England averages. Only 18% use outdoor space for exercise. Almost 30% of Harrow people are physically inactive. • Although people are living longer, loneliness and isolation are more common. Only 35% of adult social care users in Harrow have as much social interaction that they would like – 10% lower than the England average. • Almost 2000 older people are hospitalized due to falls in Harrow. Although the number has been falling in the past four years, this group is likely to have high need for social care. • Over 1,500 people aged over 65 are recorded as having dementia. Both the number and the proportion of people with dementia has been increasing year on year. Smoking, physical inactivity and overweight are all risk factors for dementia. Many of these people are dependent on social care but living independently in their own homes. • Last year there were almost 15,000 attendances at A&E by children under 5, putting Harrow in the highest 25% in the country. • One in five children in Harrow are obese by the age of 11. Overweight children are likely to become overweight adults. Nationally, cases of type II diabetes – thought of as an adult onset disease - have been occurring in younger ages including in children.	services from 2018/19) ○ No staff to oversee potential £13m Sport England programme focusing on addressing physical inactivity led by Public Health in partnership with Young Harrow Foundation and an alliance of 30 external organisations. Inability to deliver this programme will lead to significant reputational risk. • Projected increase in tooth decay as prevention due to cessation of programme to raise awareness of oral health amongst parents and child focused professionals • Projected increase in Type 2 diabetes (13% by 2020 mainly due to obesity and physical activity rates) due to: ○ no staff to support Harrow CCG implement Diabetes Strategy ○ no staff to lead on diabetes peer support programme (for which external funding has been provided) • Potential increase in suicides (national trend is of increased rates) due to: ○ Absence of any preventative interventions ○ No governance to oversee the Harrow Suicide Prevention plan – a collaboration between Public Health, Harrow CCG, CNWL, British Transport

Protected Characteristic	Evidence	Analysis & Impact
	• Harrow has some of the highest rates of poor oral health in 5 year olds in the country. One in three five year olds in Harrow have one or more obviously decayed, missing (due to decay) and filled teeth and the rate of admissions for treatment of dental caries is also very high. • 75% of adult mental ill health develops before age 14 • 16.24% of children in Harrow are living with families that are income deprived. The higher proportion of children living in poverty are in the Wealdstone corridor and in the south west of the borough.. • Harrow profile (2015 ONS Mid-Year Estimates): 20.6 per cent of Harrow's residents are aged under 16 (50,800), a slightly higher level compared to London overall (20.3%) and England, at 19 per cent. 64.5 per cent (159,400) of Harrow's population fall within the working age bracket (16 to 64), below the London level of 68.1 per cent, but just above England's level of 63.3 per cent. The number and proportion of older people in Harrow continues to increase. 15 per cent (36,950) are now aged 65 and over, compared to: 14.8 per cent in 2014; 14.6 per cent (35,500) in 2013 and 14.3 per cent (34,700) in 2012. This 2015 level compares to 11.5 per cent in London overall and 17.7 per cent nationally. The average (median) age in Harrow is approximately 37.1 years, below the average age of 39.8 for England overall and depicting a younger average than the majority of local authorities nationally. However, London's average age was lower at 34.6 giving Harrow a ranking of 26th out of the 33 London	Police and local voluntary sector partners such as Mind in Harrow and Samaritans. • Potential increase in mental ill health at work in Harrow Council (associated with increased absenteeism and reduction in productivity). Harrow's sickness absence rates are higher than London average and the staff survey results suggest employees typically rank their work experience at Harrow lower than their experience elsewhere which potentially will increase staff sickness absence rates. This is due to: o ceasing all work on mental health promotion for Council staff o No Public Health advisory support for Harrow Wellbeing Strategy implementation led by HR o No oversight of mental health peer support and training programme developed by Public Health for Harrow Council. Although the programme is designed to be self-sustaining and run by staff for staff, there will be no co-ordination or quality control element which has been provided by Public Health o No advice in relation to crisis care and signposting to immediate sources of support

Protected Characteristic	Evidence	Analysis & Impact
	Authorities, where 1st is the youngest average age. Despite high abstinence levels, partly due to the ethnic and religious breakdown of the community it is estimated that 50,000 people in Harrow drinking at hazardous and harmful drinking levels. In Harrow it's estimated that of those that drink, about 6.5% of them are higher risk drinkers and it may be this group contributing to the increase in hospital admissions. Hospital admissions continue to rise most steeply among males, but also among females and data suggest those aged 55 to 64 are the group most likely to make an alcohol related ambulance call out. This suggests a growing level of need among older people and the call out data highlights how this group may be more likely to receive medical treatment for health problems related to alcohol rather than the dependency itself[1]. This data shows a picture of a growing problem of drinking that will over time harm Harrow residents health and will produce more long term conditions associated with alcohol, more hospital admissions and more people living with preventable ill health. Older people who live in poorly maintained physical environments are less likely to get out and about and are therefore more prone to social isolation and loneliness, depression, reduced fitness and increased mobility problems. **Primary prevention extends disease free life and supports the compression of morbidity (i.e. people**	• Significantly reduced ability to reduce the number of people drinking harmful and hazardous levels of alcohol and consequent increased demand for treatment and recovery services and reliance on health and social care as a result of alcohol dependence and related ill health. • Rise in consequences of fuel poverty due to no work on improving winter resilience to support vulnerable people which will result in the cessation of support to circa 300 vulnerable adults annually to help get out of fuel debt, secure new boilers and insulation. This will disproportionally effect those living in a cold home and as a result people may require more support from health and social care. • • • Reduction in benefits resulting from partnership working within and outside the Council: o Reduced commissioning support to Harrow Clinical Commissioning Group (statutory) o Reduced Public Health intelligence support for

[1] Harrow JSNA 2015-2020

Protected Characteristic	Evidence	Analysis & Impact
	will be supported to live healthy lives for longer) Life expectancy has increased significantly in recent years as has the prevalence of chronic degenerative disease. If life expectancy increases at a faster rate than increase to disability-free life expectancy (i.e. later onset of chronic disease), the period that people live with chronic disease and their demands on services will increase. To avoid this there needs to be substantial delays in the onset of disability in later life. This is achieved through primary prevention that promotes the widespread adoption of healthier lifestyles, coupled with social changes that support these lifestyles. Investment in secondary prevention, i.e. preventing illness becoming more severe, aims to prevent deteriorating health and escalating need for services but may lead to an expansion of morbidity (see below): The interventions that compress morbidity, that are supported most strongly by evidence, are (1) Education, (2) Employment, and (3) Physical activity. **Focusing spend on early years in the life course will deliver greatest returns** Returns on investment in early childhood (0-5 years) are higher than at any other time in the life-course. The positive cumulative effects of interventions in early years provide a strong argument for investing in 0-5 year olds. Spending is currently invested more heavily in later periods in the life course and should be redirected towards prenatal and pre-school services (see below):	input into needs assessments and health impact assessments which can identify inequalities in need, service provision or outcomes for any of the protected characteristics. o No public health support for: troubled families, children with special educational needs & children looked after, o No work with schools to facilitate them improving the health and wellbeing of pupils – e.g. Healthy Schools London o No work with partners inside and outside the Council on poverty reduction for families o No work on improving joined up working (pathway redesign) with partners for Female Genital Mutilation, Forced Marriage and Domestic Violence o Significantly reduced or no support to other Council directorate including economic development, regeneration, housing, environmental health and social care which will have an effect on all ages. The expertise that Public Health Consultants currently provide to the Adult Safeguarding Board, Children's Safeguarding Board and the Clinical Commissioning Board will cease. As will lead

Protected Characteristic	Evidence	Analysis & Impact
	Supporting elderly people to improve their ability to look after themselves will improve their health and minimise their need for care outcomes, and allow funding to be re-invested in prevention rather than cure In both the NHS and Adult Social Care, the spending profile is skewed towards acute hospital and residential based care. Better care and support can be delivered in people's own homes avoiding admissions to hospital, promoting choice in end of life care through integrated working across health and social care, joining up services around the individual and providing good support to family carers to sustain them in their caring role."	responsibility for FGM. ○
Disability (including carers of disabled people)	**Harrow profile***: 14.1 per cent of Harrow's working age population (16-64) classified themselves as having a disability in 2015-16 (July to June), a total of 22,500 individuals. 10,500 (13.1%) are men and 12,000 (15.2%) are women. This signifies an increase of around 1,200 people (5.3%) compared to the previous year (2014-15). * Office for National Statistics • People with physical and/or mental disability are less likely to participate in physical activity. • People in Harrow with serious mental illness are 2.5 times more likely to die under the age of 75 than the	• We will have no staff resource to support and contract monitor the Mental and Employment programme which aims to get approximately 200 people with mental health problems into work (one of the biggest drivers of worklessness and demand for employment benefit) and improve their mental health. • Public Health have been acting in an advisory capacity which has resulted in mental health becoming a Equalities Board priority for 17/18 and the launch of a campaign to tackle stigma and discrimination, This support along with the commitments made as part of the Corporate Mental Health action plan will fail to be met. • It will not be possible to implement the Physical activity

Protected Characteristic	Evidence	Analysis & Impact
	Harrow average.39% of our council tenants, surveyed as part of Housing Satisfaction Survey commissioned by Housing in 2016, identify with having a disability. • Disability (physical and mental) is a significant barrier to physical activity • Disability is a significant barrier to employment	strategy implementation plan which specifically aims to support disabled people to get active and to overcome the barriers (e.g. related to the discrimination or physical access they may face in using sports facilities) Potential increase in suicides (national trend is of increased rates) due to: o Absence of any preventative interventions o No governance to oversee the Harrow Suicide Prevention plan – a collaboration between Public Health, Harrow CCG, CNWL, British Transport Police and local voluntary sector partners such as Mind in Harrow and Samaritans. •
Gender Reassignment	No evidence available	
Marriage / Civil Partnership	No evidence available	
Pregnancy and Maternity		We currently work across the whole obesity pathway to promote physical activity and maintaining of a healthy weight. This includes promoting access to physical activity options within the borough that are open access and free and therefore reduce any barriers experienced by vulnerable groups such as cost and childcare based on local insight. We will no longer be able to support physical activity in this group. Individuals often have concerns about exercising

Protected Characteristic	Evidence	Analysis & Impact
		as usual during pregnancy, which can limit their participation. Providing information and support about this can be helpful. This is particularly important because raised BMI and physical inactivity during pregnancy has consequences for both maternal and foetal health and wellbeing. Supporting physical activity in the post-natal period can help manage the risk and occurrence of post-natal mental health issues, and the relative isolation that often occurs at this time.
Race	**Harrow profile** (Census): Harrow is one of the most diverse areas in the country. At the time of 2001 Census 49.9 per cent of Harrow residents were classified as White British. 2011 figures reveal that the White British category now includes only 30.9 per cent of Harrow's population, 69.1 per cent of residents are therefore classified as belonging to a minority ethnic group. The most significant minority ethnic group, at 26.4 per cent is Asian/Asian British: Indian, ranking Harrow as second in England and Wales for its Indian population. Another significant group is classified as Asian/Asian British: Other Asian, making up 11.3 per cent of residents and ranking Harrow 1st within this classification; this group is largely comprised of Sri Lankan community. All Asian/Asian British groups have increased since 2001. White Other is another group which has grown considerably, from 4.5% in 2001 to 8.2% in 2011, an increase of 10,370. The 2011 Census showed that within this group there were 3,868 residents who were born in Poland and 4,784 residents born in Romania, the largest Romanian community within England and Wales, based on the proportion of Romanian born	

Protected Characteristic	Evidence	Analysis & Impact
	residents to the overall population. There are no other data sources which give more up-to-date information on Harrow's population by nationality. However, the Department of Work & Pensions (DWP) releases statistics on National Insurance Registration (NINo) for overseas nationals every year. This data shows that from 2011/12 to 2015/16 there were 18,840 NINos issued to Romanian workers living in Harrow. This data gives an indication of how Harrow's Romanian population may be growing. Similarly 2,390 NINos have been issued to Polish workers from 2011/12 to 2015/16. Harrow still has a high Irish born population, ranked 7th in 2011. Whilst Black/African/Caribbean/Black British is not particularly dominant, Harrow has the highest number of Kenyan born residents (this can be attributed to a number of migrants from Kenya who are of Asian descent). • Harrow has a relatively large BME population. The South Asian population in particular has an inherent increased risk of diabetes and cardiovascular disease. Type 2 diabetes is six times more common in people of South Asian origin, thus relevant to the areas chosen. It is estimated that around 14.2% of the new Type 2 diabetes cases in Harrow could be prevented if adults were 100% active, and 5.6% prevented if adults were 50% active[i]. We know that BME groups are more likely to be inactive or do less than the CMO recommended amount of physical activity. APS (14-15) shows	

Protected Characteristic	Evidence	Analysis & Impact
	that in Harrow, 35.4% of Asians are inactive compared to 31.3% of our white British population. Research indicates the inequality is particularly true of some South Asian women whose physical activity is made up of a much smaller amount of formal activity including sport and predominantly entails walking and housework[ii]. UK South Asians in particular have an increased risk of cardiovascular disease and diabetes which are both of particular concern in Harrow given Type 2 diabetes rates are amongst the highest in the country and CVD is the biggest driver of health inequality in the borough. Physical activity can reduce this risk.	
Religion and Belief	**Harrow profile**: The 2011 Census showed that Harrow had the third highest level of religious diversity of any local authority in England and Wales, after Leicester and Redbridge, compared to Harrow's top ranking in 2001 (GLA's Religious Diversity Indices). Typically diversity indices account for the number of different/distinct religious groups present in the population and the sizes of these distinct religious groups relative to each other. The 2011 Census ranked Harrow 1st for persons of Hindu religion, Jain and Unification Church, 2nd for Zoroastrian and 6th for Jewish. Out of 348 areas in England and Wales Harrow has the 2nd lowest ranking of residents with no religion and 5th lowest for Christians (37.3%). Harrow is ranked 24th for Muslim faith residents, who account for 12.5 per cent of the population. Harrow's Muslim population doubled in size between the last two Censuses, increasing from 14,920	All work to engage with faith based groups to promote physical and mental health will cease. This may result in missed opportunities to engage people who would not otherwise become aware of opportunities to self-care and prevent ill health

Protected Characteristic	Evidence	Analysis & Impact
	to 29,880 in 2011. It should be noted that the question on religion is a voluntary census question and 6.8 per cent (14,780) residents chose not to answer this Question The ability to provide services to people in line with religious / cultural requirements such as single sex facilities is key to engagement with certain population groups.	
Sex / Gender	**Harrow profile:** The 2015 Mid-Year Estimates (ONS) showed that of Harrow's total population (247,130), 123,100 (49.8%) are male and 124,000 (50.2%) are Female	• Potential increase in suicides (national trend is of increased rates) due to: o Absence of any preventative interventions o No governance to oversee the Harrow Suicide Prevention plan – a collaboration between Public Health, Harrow CCG, CNWL, British Transport Police and local voluntary sector partners such as Mind in Harrow and Samaritans.
Sexual Orientation	**Harrow profile:** The 2011 census did not have a question on sexual orientation; however 306 persons declared living in a same sex couple. It is estimated that 6% of the UK population are lesbian, gay and bisexual (LGB), which would equate to approximately 14,430 of our residents belonging to the LGB community	
Other	Income People in lower socio-economic groups are more likely	Health Inequalities such as difference in life expectancy between the most and least deprived in Harrow are

Protected Characteristic	Evidence	Analysis & Impact
	to experience chronic ill-health and die earlier than those who are more advantaged. Addressing health inequalities must address the wider determinants such as employment, low income, the physical environment and education. The cycle of inequality is apparent with children of people in the most deprived populations having poorer life chances and fewer choices than their affluent counterparts. Early years interventions play an important role in building the foundations of good health and breaking inter-generational cycles of health inequalities. The average for 2012-14 for men showed that men in the most deprived parts of Harrow live, on average, 6 years less than men in the most affluent. In women the inequalities gap closed (decreased) between 2002-4 and 2006-8 but after a period of stability, it has increased and women in the most deprived parts of Harrow live, on average, 5.6 years less than women in the most affluent. In Harrow men the biggest contributor to the inequalities gap is circulatory disease followed by respiratory disease and cancer. In women, the gap is being driven by cancer, circulatory disease respiratory disease and digestive system disease (including chronic liver disease) All these factors will benefit from preventative action focusing on reduction in smoking, increasing physical activity and improving diet and maintaining a healthy weight.	projected to rise since the changes proposed will have a disproportionate impact on people living in deprived circumstances who already suffer poorer health.

Protected Characteristic	Evidence	Analysis & Impact
	20% of residents are employed on low pay (approximately 21,000 over 16s in Harrow earn under £20,000, with a further 14,000 earning between £20-29,000). Wages paid in Harrow are considerably lower than London's average. Last year there were 19000 Council tax and housing support claims. The value of Council tax support claims was approximately £13m. The local branch of the Citizens Advice Bureau is receiving around 470 financial/debt enquiries a month. Harrow is also ranked the second-worst in London for fuel poverty (at 11.7%). We know that low income is a risk factor for physical inactivity and from the latest Active Lives Report we can see those in more routine occupations (NS SEC 6-7) are less active, with 32% inactive compared to 17% for NS SEC 1-2. In the 2015 APS survey, 33.3% of NS SEC 5-8 in Harrow were inactive.	

Impact on staff:

Given that a new staff structure is still to be developed and in turn that structure populated it is difficult to identify whether there will be any significant disproportionate impact on any staff protected characteristics.

Stage 3: Assessing Potential Disproportionate Impact

5. Based on the evidence you have considered so far, is there a risk that your proposals could potentially have a disproportionate adverse impact on any of the Protected Characteristics?

	Age (including carers)	Disability (including carers)	Gender Reassignment	Marriage and Civil Partnership	Pregnancy and Maternity	Race	Religion and Belief	Sex	Sexual Orientation
Yes	x	x	X		x	x			x
No				x			x	x	

YES - If there is a risk of disproportionate adverse Impact on any **ONE** of the Protected Characteristics, continue with the rest of the template.

- **Best Practice:** You may want to consider setting up a Working Group (including colleagues, partners, stakeholders, voluntary community sector organisations, service users and Unions) to develop the rest of the EqIA
- It will be useful to also collate further evidence (additional data, consultation with the relevant communities, stakeholder groups and service users directly affected by your proposals) to further assess the potential disproportionate impact identified and how this can be mitigated.

NO - If you have ticked 'No' to all of the above, then go to **Stage 6**

- Although the assessment may not have identified potential disproportionate impact, you may have identified actions which can be taken to advance equality of opportunity to make your proposals more inclusive. These actions should form your Improvement Action Plan at Stage 6

Stage 4: Further Consultation / Additional Evidence

6. What further consultation have you undertaken on your proposals as a result of your analysis at **Stage 3**?

Who was consulted? What consultation methods were used?	What do the results show about the impact on different groups / Protected Characteristics?	What actions have you taken to address the findings of the consultation? E.g. revising your proposals

Stage 5: Assessing Impact
7. What does your evidence tell you about the impact on the different Protected Characteristics? Consider whether the evidence shows potential for differential impact, if so state whether this is a positive or an adverse impact? If adverse, is it a minor or major impact?

Protected Characteristic	Positive Impact ✓	Adverse Impact		Explain what this impact is, how likely it is to happen and the extent of impact if it was to occur. Note – Positive impact can also be used to demonstrate how your proposals meet the aims of the PSED Stage 7	What measures can you take to mitigate the impact or advance equality of opportunity? E.g. further consultation, research, implement equality monitoring etc (Also Include these in the Improvement Action Plan at Stage 6)
		Minor ✓	Major ✓		
Age (including carers of young/older people)				This section will be completed following staff and stakeholder consultation	
Disability (including carers of disabled people)					
Gender Reassignment					
Marriage and Civil Partnership					
Pregnancy and Maternity					

Protected Characteristic	Positive Impact	Adverse Impact		Explain what this impact is, how likely it is to happen and the extent of impact if it was to occur.	What measures can you take to mitigate the impact or advance equality of opportunity? E.g.
Race					Please see above
Religion or Belief					
Sex					
Sexual orientation					

8. Cumulative Impact – Considering what else is happening within the Council and Harrow as a whole, could your proposals have a cumulative impact on a particular Protected Characteristic? If yes, which Protected Characteristics could be affected and what is the potential impact?	Yes	x	No	
9. Any Other Impact – Considering what else is happening within the Council and Harrow as a whole (for example national/local policy,	Yes		No	
	Please see stage 2			

austerity, welfare reform, unemployment levels, community tensions, levels of crime) could your proposals have an impact on individuals/service users socio economic, health or an impact on community cohesion? If yes, what is the potential impact and how likely is it to happen?	

Stage 6 – Improvement Action Plan				
List below any actions you plan to take as a result of this Impact Assessment. These should include: • Proposals to mitigate any adverse impact identified • Positive action to advance equality of opportunity • Monitoring the impact of the proposals/changes once they have been implemented • Any monitoring measures which need to be introduced to ensure effective monitoring of your proposals? How often will you do this?				
Area of potential adverse impact e.g. Race, Disability	Proposal to mitigate adverse impact	How will you know this has been achieved? E.g. Performance Measure / Target	Lead Officer/Team	Target Date
Age, Disability, Pregnancy and Maternity, Race and Sexual Ordination				
Stage 7: Public Sector Equality Duty				
10. How do your proposals meet the Public Sector Equality Duty (PSED) which requires the Council to: 1. Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010 2. Advance equality of opportunity between people from different groups 3. Foster good relations between people from different groups				
Stage 8: Recommendation				
11. Please indicate which of the following statements best describes the outcome of your EqIA (✓ tick one box only)				
Outcome 1 – No change required: the EqIA has not identified any potential for unlawful conduct or disproportionate impact and all opportunities to advance equality of opportunity are being addressed.				
Outcome 2 – Minor Impact: Minor adjustments to remove / mitigate adverse impact or advance equality of opportunity have been identified by the EqIA and these are listed in the Action Plan above.				
Outcome 3 – Major Impact: Continue with proposals despite having identified potential for adverse impact or missed opportunities to advance equality of opportunity. In this case, the justification needs to be included in the EqIA and should be in line with the PSED to have 'due regard'. In some cases, compelling reasons will be needed. You should also consider whether there are				

sufficient plans to reduce the adverse impact and/or plans to monitor the impact. **(Explain this in Q12 below)**	
12. If your EqIA is assessed as **outcome 3** explain your justification with full reasoning to continue with your proposals.	The Public Health Services has to meet its MTFS target and therefore has no alternative other than to offer these suggested savings.

Stage 9 - Organisational sign Off			
13. Which group or committee considered, reviewed and agreed the EqIA and the Improvement Action Plan?			
Signed: (Lead officer completing EqIA)	Carol Yarde	Signed: (Chair of DETG)	Johanna Morgan
Date:	4.4.2017	Date:	9 May 2017
Date EqIA presented at the EqIA Quality Assurance Group (if required)	9 May 2017	Signature of DETG Chair	

[i] Harrow Diabetes Strategy 2017

[ii] Williams ED, Stamatakis E, Chandola T, Hamer M. J Epidemiol Community Health. 2011 Jun; 65(6):517-21. Assessment of physical activity levels in South Asians in the UK: findings from the Health Survey for England..