Equality Impact Assessment (EIA)

This document demonstrates how the council is meeting its duties under the Equality Act 2010, by giving due regard to the requirement to: eliminate discrimination; advance equality of opportunity; and promote good relations.

1. Background

Directorate	Prevention Wellbeing and Communities Hub
Service area	Commissioning
Title of the activity being assessed i.e. the strategy, plan, policy or service	Children and Young People's Healthier Lifestyles Programme n.b. This terminology replaces the 'Tier' framework previously used where Tier 1 would be universal prevention activities, Tier 2 was community weight management / healthier lifestyles interventions and Tier 3 was specialist weight management support. The change reflects the need for the offer to work more fluidly within the broad children's health and wellbeing system and design holistic, family centred support that responds to individual needs and strengths.
Brief outline of the proposal(s)	Childhood obesity is an inequalities issue. There is an increased obesity prevalence among children and young people who live in our most deprived communities and evidence suggests that the difference between the least and most deprived had continued to widen, particularly during the pandemic. Reducing health inequalities is a key Public Health and wider system priority and the provision of this service should help address obesity-related health inequalities among those children supported. There is also a clear relationship between obesity prevalence and children who have a long-term condition, mental health problem, or disability, including a learning disability. The current offer which commenced in January 2020 (with a pause due to Covid/move to virtual sessions) has been delivered through a series of pilots in Gloucester and Forest of Dean, in neighbourhood where the levels of childhood obesity are among the highest in the county. Learning from the pilots has highlighted the complexity of needs among local families affected by obesity e.g. a large proportion of families engaged are from within IMD quintile 1, and the cohort includes Children in Care, Children in Need, children on Child Protection plans, as well as children with disabilities and those with

	autism. We have learned that the key to sustainable health behaviour change is to support a family's 'structural' (or practical) and psychological readiness to change and for that family to be resilient and thriving. Our offer thus uses a strengths-based approach which seeks to address some of the practical and social enablers and barriers to behaviour change among families facing significant barriers to maintaining a 'healthy weight' . This thus aims to identify issues that impact a family's capacity to benefit and enable them to access existing support or work with them directly pre-programme to maximise outcomes. The proposed community-based delivery model builds on the pilot which was co-developed with local families. It aims to deliver a flexible 'system' of support for children with obesity and their families, where behavioural weight management support sits within a wider 'network' of support to address some of the practical barriers to sustained behaviour change. This might include support around welfare, housing, debt, and parenting as well as local support to develop cooking and meal planning skills and physical activity opportunities. The support will be family and community-centred innovative and age appropriate. Future development will continue to use a co-production approach and we will continue to monitor the service as it is rolled out across the county, to ensure it is meeting needs and is helping to address health inequalities.
Who is affected by the proposals?	Service users ✓ Workforce ✓ Other, please specify:
Decision to be taken and decision maker	Commissioning of a countywide community-based children and young people's healthy weight service Siobhan Farmer – Director of Public Health Councillor Nick Housden – Cabinet Lead for Public Health and Communities
Person(s) responsible for completing this assessment	Sam Howe - Commissioning Officer Beth Bennett-Britton - Public Health Consultant
Date of this assessment	August 2022

2. Information Gathering

Briefly outline your approach to consultation and engagement, together with details of any other information and data sources you have utilised:

Research, Consultation and Engagement	
Service users	In 2019 nine months of insight and engagement work was undertaken with children, families and communities in Gloucester and the Forest of Dean (FoD). This was used to develop the pilot service, which was tested in eight local neighbourhoods. It included, seven focus groups undertaken with 59 families. 75% were families from the two most deprived wards in pilot areas and 60% had concerns about their child's weight. Thematic analysis revealed key issues from parent/carer perspectives The City's key themes were: employment, community, culture, parenting respite, physical activity and mental health. Key themes in the FoD were: physical activity, money, food access, community, family relationships, parenting and technology was. In addition, an online survey was conducted to further explore themes arising from the focus groups. What emerged from this engagement process was that interindividual differences between districts (City and FoD), areas/towns within districts, and individual families were identified. Structural assets, barriers, demography and attitudes varied and presented a wide range of complexity. Alongside the development and testing of the pilot, we commissioned Teesside University to undertake an independent evaluation which commenced in 2021, after a delay due to the Covid-19 pandemic. The Teesside evaluation team conducted a series of interviews and small group sessions with service users, families accessing the pilot offer in Gloucester and the Forest of Dean. They did this to be as inclusive as possible and recognised some families would not be able to complete a survey for example. From the research already completed we recognised that there were still gaps in our understanding of the needs and preferences of ethnic minority communities and so over the summer of 2022 we engaged with representatives across a range of ethnic minorities to understand their perspectives, concerns and preferences around supporting their children to have a healthy weight.
Workforce	Senior Management teams across the Prevention, Wellbeing and Communities and Children and Families Hubs have been consulted, as have key individuals such as the Director of Public Health and local Councillors.

	As part of the research, consultation and engagement, Teesside University have independently evaluated the pilot with staff of the provider which include the CEO, the Service Manager as well as other health professionals working within the local system. Research methods included semi-structured interviews with staff and families.
Partners	The development of this offer began in 2017 with a portfolio of focused workshops, led by the Council, with support from NHS Gloucestershire Clinical Commissioning Group, for clinical and non-clinical stakeholders to work together to redesign and develop a proposal to meet the needs of children living with obesity in Gloucestershire. This informed the commissioning of the pilot service, which has in turn informed our proposed commissioning approach. To help refine our commissioning approach we are holding a minimum of six additional district level stakeholder and community engagement events over summer 2022. These will also help gain an initial understanding from communities of their appetite for being involved in the future delivery of a community led weight management offer. We will continue to engage with system partners from statutory services and voluntary and community organisations through partnership forums. As the new service is mobilised, delivered and refined we will continue to engage across the system, applying an 'integrated leadership model', which will aim to further develop the system, ensure collaboration and co-production, and drive continuous improvement. We have also collaborated with partners in statutory services such as school nurses, dietitians, early help, the social care workforce, GP's, Paediatricians and CCG. Clinical and non-clinical workshops have taken place; participants valued having the opportunity to network and share views, experiences and ideas with other professionals from a range of different organisations and services.
Other	The pilot has also engaged with various local community groups and conducted an asset mapping exercise, to support the research and consultation of this pilot.

3. Equality Assessment

Briefly explain your assessment of the impact of the proposed activity on the protected characteristics below. This section evidences how the council is giving due regard to the three aims of the general equality duty, which are to: eliminate discrimination; advance equality of opportunity; and promote good relations.

Protected Characteristic	Service Users	Workforce
Age	This service will have a **positive impact** on children and young people. The National Child Measurement Programme (NCMP) provides a robust data set of childhood weight for reception and Year 6 children. According to the NCMP Report, rates of obesity rise among all areas when children reach Year 6. Gloucestershire has the sixth highest rate of obesity when compared against its peers. Gloucester City has consistently had high obesity rates among reception age children when compared to the county, region and nation. Forest of Dean has also experienced similarly high rates for three out of the five years of the study. Rates of Year 6 children recorded as living with very overweight/obesity have risen each year nationally while regionally they have remained fairly constant until 2019/20 where the region experienced an increase. In the six districts of Gloucestershire, Gloucester City has the highest rate each year. Tewkesbury Borough has experienced the largest increases of obesity rates among year 6 pupils over the last three years. Forest of Dean District also has a consistently high rate each year with the exception of rates in 2018/19 and has the second highest rate in Gloucestershire. Exercise is a key component in maintaining a healthy weight. The Pupil Wellbeing Survey 2020 asked students why they did not exercise. A lack of affordable physical activities given as a main reason seems to increase with age – this may be due to less timetabled sports time in secondary schools leading to older young people needing to access sports through independent clubs and leisure centres. Younger students were more likely to give not exercising because of being 'too hot and sweaty' as a reason	**Neutral** We have considered this characteristic, and can find no particular disproportionate impact based on age.

	than older students. A provider will need to work with local community activity groups to support development of a range of affordable options for young people to be able to exercise. They will also need to be sensitive to young peoples' perceptions of themselves. Monitoring, through engagement and data collection will ensure that a provider is flexible in how it meets the needs of children and young people from different age groups. There will be a range of age-appropriate offers to meet the different needs of children, adolescents and older teenagers and these will be co-produced with them. This offer will be targeted at school age children and young people only, extended to those aged up to and including 24 years for young people with special educational needs or disability (SEND). There are already services in place to support adults with a healthy weight including by the Healthy Lifestyle Service. Younger children are supported through other means including via Health Visitors who work with families as children are weaned from milk to solid food and through our developing Family Hubs services.	
Disability	This service will have a **positive impact** on children and young people with disabilities **Challenge:** According to the 2021/22 JSNA update for Gloucestershire: Children and Young People with Special Educational Need or Disability (SEND), in January 2021 there were; 12,757 (13% of pupils) children and young people receiving SEN support packages in all Gloucestershire schools without an EHCP and 4,332 (2.46% of residents 0-24yrs) with an EHCP[1]. The number of children and young people with an EHCP has been increasing year on year for the previous 5 years. The rate of children and young people with EHCPs per 100 has also been rising, but is still slightly below our statistical neighbours (2.83%) and in line with England (2.56%).	**Neutral** We have considered this characteristic, and can find no particular disproportionate impact based on disability.

[1] https://www.gloucestershire.gov.uk/media/2114172/children-and-young-people-with-special-educational-needs-send-jsna-update-2021-22.pdf

	The disability and obesity: Children and Young People's paper published by PHE, mentions the energy and effort required to manage childhood disabilities means that children and their parents and carers may have to overcome significant barriers and complications in order to maintain a healthy lifestyle. Results from a systematic review suggest that a parent's socio-economic status, weight status and attitude towards their disabled children's weight and activity levels all play a part. https://webarchive.nationalarchives.gov.uk/20170110165944/https://www.noo.org.uk/NOO_pub/briefing_papers Learning through engagement it has been found that the key to successful and sustainable behavior change regarding 'weight' or 'health' is for a family to be resilient and thriving and what impacts a family's structural and psychological readiness to change. Learning from the pilot, the service will use a strengths-based approach which seeks to address some of the practical and social enablers and barriers to behaviour change among families facing significant barriers to maintaining a 'healthy weight'. This will aim to identify issues that impact a family's capacity to benefit and enable them to access support or work with them pre-programme to maximise outcomes and may include putting extra support in place, e.g. through that offered by a family support worker. This service will be targeted at school age children and young people (aged 4-17), but extended to those aged up to and including 24 years for young people with special educational needs and disability (SEND). The introduction of the service to families and young people will improve opportunities to share experiences, build friendships and support each other which could help more vulnerable people to strengthen their support network. A review of the client base for the current provider showed that, on average, around 25% of families on programmes have complex needs including children and adults on the autistic spectrum, additional physical and learning needs and families under social services etc. This was true of the findings by the focus groups delivered by the pilot and the findings of Teesside University in their independent evaluation. While weight loss was the trigger for referral, learning and physical disabilities, poor mental health,	

	disordered behaviour, socio economic challenges, social anxiety and body image issues were also present and needed attention. Engagement work undertaken during the pilot phase found that the level of complexity experienced provides evidence to the notion that traditional 'tier 2 weight management services' are not the answer' - providers will need to think creatively in how they can best meet the needs of diverse client groups. The focus groups run by the current provider in 2020 demonstrated the view that there weren't enough physical activities for CYP with disabilities or neuro diversity. A provider will need to work with local activity organisations to enhance the offer for a wider scope of people. Findings showed - 'It was evident from the volume and severity of additional needs within both groups that further specialisation and greater differentiation is required for future programmes or that bespoke programmes could be an option for development'. Engagement work also shows a need for support for families with behaviour management, specific to those families with a CYP with a disability or neurodiversity, According to a contract monitoring case studies, a number of CYP with autism are currently missing school. The Gloucestershire Pupil Wellbeing Survey shows that pupils from Special schools were significantly more likely to report drinking sugary drinks every day than every other statistical neighbour group. High consumption of energy drinks has been linked to an unhealthy weight[2], therefore a provider will need to use a range of coaching methods to best support healthy food and drink consumption. The new service will monitor levels of engagement, experience and outcomes of SEND children to ensure they continue to be overrepresented and that outcomes are in line with the overall cohort.	

[2] The Association of UK Dietitians (BDA) found

	The service will be flexible to adjust as appropriate if it is found that a particular group are unable to access the provision or there are any disparities in experience or outcomes. This will be informed by data collection and monitoring, and through engagement to explore the reasons for any disparities.	
Sex	This service will have a **positive impact** on both boys and girls **<u>Challenge:</u>** According to the NCMP data: **Reception obesity (2018/19) rates:** — **Reception obesity (2019/20) rates:** 9.5% of boys — 10.4% of boys 8.9% of girls — 10.3% of girls **Year 6 obesity (2018/19) rates:** — **Year 6 obesity (2019/20) rates:** 21.2% of boys — 21.3% of boys 16.1% of girls — 17.0% of girls In Reception Year there is no clear evidence to suggest that there is any gender inequality in those living with obesity. In Year 6, boys in Gloucestershire are more likely to be living with obesity than girls over the past 5 years. The gap between boys/girls living with obesity is evident in Year 6 and recorded NCMP data shows that this gap is widening slightly from 3.3% in 2016/17 to 4.3% in 2019/20. When looking at the confidence intervals in **Error! Reference source not found.** for gender this inequality is statistically significant over the five year period. The difference in obesity levels for year 6 pupils in 2018/19 and 2019/20 suggests that the pandemic has had an effect on increases in child weight.	**Neutral** We have considered this characteristic, and can find no particular disproportionate impact based on sex.

	Nationally, obesity rates are slightly lower than Gloucestershire for reception age children and the gap in gender inequality has been narrowing over the last 3 years of recording[3]. National rates for Year 6 obesity in males are similar and females are lower than local Gloucestershire rates each year and have a slightly wider inequality gap[4]. When looking at the most intensive form of support in the pilot phase, 63% of the CYP were male and 25% were female. A further 13% did not have their gender recorded. This suggests that the pilot has been responsive to recruiting boys who have a higher prevalence of living with obesity. Eating fresh fruit and vegetables each day is a sign of a healthy diet. There was little difference between the proportion of females reporting eating '5 portions of fruit and vegetables a day' than males (22% vs. 21% in 2012 and 25% vs. 24% in 2020) in the PWS. According to the PWS, Females were significantly more likely to want advice about *Losing weight* than males (24.9% vs. 17.1%). Girls and young women were twice as likely to say they didn't exercise because they were embarrassed (39%) than boys and young men (20.2%) in the PWS 2020. The service will be flexible and sensitive in its approach of how it supports male and female children. It will adjust its offer according to a child or young person's gender if it is found that a particular group are unable to access the provision or there are any disparities in experience or outcomes. This will be informed by data collection and monitoring, and through engagement to explore the reasons for any disparities.	

[3] Obesity Profile - Data - OHID (phe.org.uk) (Display "Trends" above chart and "Partition data by Sex" to the right of the chart, if no data is displayed select a different "Geography version" from the dropdown list)

[4] Obesity Profile - Data - OHID (phe.org.uk) (Display "Trends" above chart and "Partition data by Sex" to the right of the chart)

	Eliminate discrimination Very overweight school age children of both genders resident in the county will have access to a children and families weight management offer. Mothers and fathers and female and male carers of all children can access the service.	
Race	This service will have a **positive impact** on all races **Challenge:** **According to the NCMP Data:** **Reception obesity (2018/19) rates:** 9.9% Asian 19.5% Black 9.7% White **Year 6 obesity (2018/19) rates:** 25.2% Asian 27.6% Black 18% White **Reception obesity current (2019/20) rates:** 7.1% Asian 13.7% Black 11.7% White **Year 6 obesity current (2019/20) rates:** 23.4% Asian 26.4% Black 19.4% White NCMP results indicated that children of Black or Asian ethnicity are more likely to be living with obesity than classmates of White ethnicity. It is in Year 6 where this difference becomes more apparent. Obesity among reception aged Asian children have fluctuated above and below the obesity rate of White children. Over the last 5 years national data has reflected very similar obesity rates in Asian and Black children	**Neutral** We have considered this characteristic, and can find no particular disproportionate impact based on Race.

	and higher rates of obesity amongst White children than Gloucestershire[5] [6]. Care must be taken when considering the latest 2021 (10% sample) due to a lack of recording of Ethnicity which, over the years has improved, is still one of the lowest reported elements of the NCMP dataset on a national scale[7] This data demonstrates that there are key health inequalities between white children and ethnic minority children. This can include, but is not limited to practical barriers such as financial hardship which may be faced by some ethnic minority children and young people. Service level data suggests that 68.97% of those recruited to the pilot came from a white background, 18.96% came from an ethnic minority background and 12.07% did not have their ethnicity data recorded. The proportion of ethnic minorities within the population in Gloucestershire stands at 7.6% aged 0-19 (2011 Census). This therefore suggests that the pilot has targeted ethnic minority communities where there is an underlying health inequality when it comes to living with obesity/overweight. Eating a healthy diet is an important determinant on whether someone will have excess weight. In the Pupil Wellbeing Survey 2020, Asian and Asian British pupils were significantly less likely to report eating five portions of fruit and vegetables a day compared to their White British peers. All other ethnic groups were broadly in line. Exercise levels vary across different ethnic groups, broadly children and young people from Black, Asian, or minority ethnic groups **(**BAME) are significantly less likely to report doing the recommended amount of exercise and statistically more likely to report doing little or no exercise[8]. However, both these trends are driven by certain ethnic groups. Children and young people are significantly more likely to report doing little or no exercise if they are:	

[5] Obesity Profile - Data - OHID (phe.org.uk) (Display “Trends” above chart and “Partition data by Ethnic Group” to the right of the chart)

[6] Obesity Profile - Data - OHID (phe.org.uk) (Display “Trends” above chart and “Partition data by Ethnic Group” to the right of the chart)

[7] https://digital.nhs.uk/data-and-information/publications/statistical/national-child-measurement-programme/2020-21-school-year/data-quality

[8] Pupil Wellbeing Survey 2020

	White Eastern European, Other ethnic group, Other black background, Other Asian background South Asian (Pakistani, Bangladeshi, Indian), Gypsy/Roma, Black African. It is worth understanding that there may be cultural reasons for why pupils don't exercise or it could be a reason of cost/time. Cultural norms in specific communities such as modest female clothing in some religious communities may create or be perceived to create a barrier to exercise. Support will generally be targeted to those in greatest need regardless of race. However, some interventions could be targeted on the basis of cultural needs and preferences, when this is required. Feedback from focus groups suggest that not everyone from ethnic minority groups is aware of the offers to support with healthy lifestyles within communities. Therefore, a provider may need to make enhanced efforts to target communities with information about their offer. The new service will be expected to understand cultural norms around eating and doing exercise. Recent engagement with representatives from ethnic minority groups at a community venue in Gloucester suggested that the offer needed to have a level of cultural competency. The offer will actively work with the Council, ICB and community partners to develop local data and knowledge of children and their families within the county. Access may be more difficult for parents from a minority ethnic group because language and/or customs may present a barrier and we will explore actions to mitigate this impact. An example of this is the timings of sessions to enable families to attend madrasah and weight management sessions. A broad range of cultural foods will be used in nutritional session content. Service level data shows that in some instances an interpreter has been required for families to fully engage with a programme when English is not their first language. How a service utilises interpretation and demonstrates cultural competency is key to delivering an equitable offer. This will be an expectation of a successful provider. Different levels of English may also mean that a digital offer isn't appropriate in all instances as those engaging with the offer may not have the language to fully utilise an online platform.	

	Feedback from focus groups also demonstrated the need for the offer to hold sessions in local community venues which are already accessed by the community. This is an important expectation of the provider to use venues which are local and accessible. The programme of support may be adapted in content and delivery and resources may need to be produced in different languages. There may be opportunity to recruit peers to offer peer support and mentoring from local communities. A provider will be expected to undertake cultural humility training with all staff. . **Eliminate Discrimination:** In Gloucestershire there are correlations in living with very overweight in childhood and deprivation level and ethnicity in both Reception and Year 6. The prevalence of childhood obesity related to inequalities is higher in BAME groups. Co-production with people from BAME communities will be an important part of the service specification. The CYPWM offer is available to all eligible families regardless of their Race and adaptations will be made to ensure accessibility to all. **Promote good relations:** The service will be flexible and culturally sensitive in its approach of how it supports children from different ethnic minority groups. It will adjust its offer according to a child or young person's ethnicity and make reasonable adjustments if it is found that a particular group are unable to access the provision or there are any disparities in experience or outcomes. This will be informed by data collection and monitoring, and through engagement to explore the reasons for any disparities.	
Gender reassignment	As previously mentioned, following a healthy diet and doing regular exercise are important to keep a healthy weight. It is important to note, in the PWS, students who identified as Trans or non-binary were significantly less likely to report eating five portions of fruit and vegetables each day. Students who identified as transgender also reported the lowest physical activity levels, significantly lower not just than the average but than all other vulnerable groups.	**Neutral** We have considered this characteristic, and can find no particular disproportionate

	Support will also be delivered in a way that supports all types of families including parents who are trans/non-binary Evidence from Stonewall suggests that trans/non-binary people may not come forward to access service due to fear of discrimination[9]. The commissioned offer will be expected to have a level of socio-cultural competence to break down barriers and offer a programme of support which is as inclusive as possible. This means being adaptable and aware of the different needs of different groups of people. Access to services will be informed by data collection and monitoring, and through engagement to explore the reasons for any disparities.	impact based on gender reassignment.
Marriage & civil partnership	Engagement in 2020 shows that single parents often felt that they did not have time to do physical activities with their children. They also cited a lack of childcare for their other children to do physical activity with older children and the perceived costs. Living with both parents appears to be linked to likelihood of eating '5 portions of fruit and veg a day', pupils who said they lived with both parents were significantly more likely to report eating '5 a day' than those living with only one parent and those living with someone other than a parent. This may be linked to economic factors associated with different living situations. The provider will need to consider how it can best support a range of different family models so that parents feel best supported in engaging in a weight management service for their children. It will need to work with community organisations in order to keep costs down and provide activities that the whole family can enjoy. The service will aim to be flexible to adjust as appropriate if it is found that a particular group are unable to access the provision. This will be informed data collection and monitoring, and through engagement to explore the reasons for any disparities.	**Neutral** We have considered this characteristic, and can find no particular disproportionate impact based on marriage and civil partnerships

[9] Stonewall report reveals impact of discrimination on health of LGBT people

Pregnancy & maternity	Pregnancy falls out of scope for this service area unless the parent of a child accessing the service is pregnant. In Gloucestershire targeted support has already been developed (1001 days) for pregnant women with obesity (or women who have recently given birth) and their families. This programme focuses on how women can make positive changes to their lifestyles and support is provided up to the 2nd birthday of the child. In recognition of the fact that obesity tends to run in families, this service aims to support women to introduce good feeding, eating and activity habits from the start The programme was developed using insight information from women and continually seeks feedback from those on the programme regarding how improvements can be made. Additional efforts are being made to strengthen this offer post-Covid and to make it available to those women who are most vulnerable e.g. by working in partnership with family hubs. According to a recent study from the NHS – Having a poor diet before or during pregnancy may affect a child's risk of having overweight. Additionally, the children of women with frequent loss of control over their eating were more likely to be overweight at age 15 than children of mothers without loss of control. Source: https://www.nhs.uk/news/pregnancy-and-child/overeating-during-pregnancy-linked-maternal-weight-gain-and-child-obesity/ **Advance equality of opportunity:** The service aims to create more joined up support for children and families in need of the service. The service will ensure that the service delivery continues to focus on early intervention, and engaging with all parents when they access the programme and facilitating them to access appropriate support.	**Neutral** We have considered this characteristic, and can find no particular disproportionate impact based on pregnancy and maternity
Religion and/or belief	This service will have a **positive impact** on people of all religion and beliefs. **Challenge:** Evidence from the 2011 census shows that amongst people over 65, 26.4% of Muslims, 17.4% of Hindus, and 13.6% of Sikhs said their health was bad or very bad,	**Neutral** We have considered this characteristic, and can find no particular disproportionate

	compared with 11.7% of Christians, 10.9% of Jewish people, 8.9% of Buddhists and 11.0% of those who followed no religion. Research suggests that paying attention to the religious needs of patients and service users can contribute to their wellbeing and, for instance, reduce their length of stay in hospital; a person's value system, whether resulting from religious or other sources, has been linked to how they respond to illness and treatment. https://www.gloucestershire.gov.uk/media/1521542/ugjsna_2017-14.pdf The current pilot's 2020 Insights Report analyses the results from focus groups. For example, within a focus group with Muslim women living in Barton and Tredworth we learned that an after-school healthy weight intervention may not be accessible for families attending a Madrassa. The provider will need to work with the community develop and accessible alternative, for example, delivery aligned with the Madrassa directly, or potentially an online/digital offer. Support for children and young people will be provided according to their individual needs to ensure there will be no adverse or negative impact from the proposed service on any particular, religious or belief group or individual. **Promote good relations:** The service will be flexible and culturally sensitive in its approach and how it supports children from different religious of belief groups. It will make reasonable adjustments if it is found that a particular group are unable to access the provision, or there are any disparities in experience or outcomes. This will be informed by data collection and monitoring, and through engagement to explore the reasons for any disparities.	impact based on Religion and/or belief
Sexual orientation	We have considered this characteristic, and can find no particular, disproportionate impact based on sexual orientation Results from the Gloucestershire Pupil Wellbeing Service show that students who identified as non-heterosexual reported significantly lower physical activity levels than	**Neutral** We have considered this characteristic, and can find no particular. disproportionate

	their peers. The proportion of children and young people reporting they did not exercise because of feeling embarrassed was also significantly higher in those who identified as LGBTQ+ in the PWS 2020. The provider will look into any negative impact if raised based on the sexual orientation of a child or adult service user. They will need to be sensitive to the needs of a range of children and young people and different family units that access the service. Support for children and young people will be provided according to their individual need/s and therefore there will be no adverse or negative impact from the proposed programme on any particular individual or group who identifies as LGBT+. Support will also be delivered in a way that supports all types of families including parents who are LGBT+. There is some evidence to suggest that LGBT+ people may not come forward to access service due to fear of discrimination[10]. The commissioned offer will be expected to have a level of socio-cultural competence to break down barriers and offer a programme of support which is as inclusive as possible. This means being adaptable and aware of the different needs of different groups of people. Access to services will be informed by monitoring through engagement and data collection.	impact based on sexual orientation
Deprivation	According to the NCMP report, there is a strong correlation of areas in high deprivation and rates of obesity in Gloucester being considerably higher than the national average. Nineteen of Gloucester City's twenty-one most deprived neighbourhoods have recorded higher than national rates of obesity in year six children when pooling five years' data together. Service level data from the pilot project showed that 31% of families engaging with the support available from the project came from the most deprived areas (quintile one) of Gloucester and the Forest. There was then an even split of around 15% of families from the other quintiles of deprivation.	

[10] Stonewall report reveals impact of discrimination on health of LGBT people

	Insights from the current provider's engagement work in 2020 showed that financial worries were prevalent in areas of deprivation (46% of those engaged came from the most deprived quintile). This has likely only been exacerbated by the recent 'cost of living crisis'. The service provider must ensure participating families facing financial hardship are aware of / supported to access local advice and support including the household support fund (or equivalents). Options, for those engaged in the survey or in focus groups, to do physical activity were often impacted by cost. Activities therefore need to be affordable for families. In areas of deprivation there was a lot of conversations about the affordability and accessibility of fresh produce. 57% of non-drivers in Matson/Tuffley walk to get their food so good fresh produce in local stores is key. Creating tasty and nutritious meals often takes a lot of experimentation, this is impeded by the cost of multiple ingredients for a meal. The majority of respondents to an online survey in deprived areas said that their favoured form of support would be online/via email. However, this may be due to time pressures. If they experienced a face-to-face session, respondents may change their mind about how they wanted to access support around a healthy weight for their family. Reflections on the engagement work done by the current provider, suggests that there should continue to be a focus on access to affordable, healthy foods in deprived areas and the service provider will need to be aware of the work of Feeding Gloucestershire and the Holiday Activity and Food programme, as well as hyper-local sources of food related support, to ensure families are able to access the food they need to adopt a healthier diet. whilst also focusing on parenting and conflict styles and linking to existing organisations providing community services.	

	The PWS shows that pupils eligible for free school meals were significantly less likely to report eating five portions of fruit and vegetable each day compared to their counterparts. Nutrition advice and coaching needs to be tailored to the needs of families where affordability is a key component of any behaviour change. Affluence appears to be linked to likelihood of eating '5 a day'. Pupils from; mainstream schools with pupils living in the least deprived areas; Independent schools and Selective schools were significantly more likely to report eating '5 a day' than pupils at mainstream schools with pupils living in the most deprived areas. The PWS asked students about participating in exercise. The main reasons for non-participation do not appear to have changed much over time; however, the proportion citing expense and poor facilities has almost doubled between 2016 and 2020 (9.3% vs. 16.2% and 4.1% vs. 8%) respectively). To reiterate - a provider will need to work with community groups to ensure the affordability of any activities offered to families.	
Looked after Children and those on Child Protection Plans/Children in Need	Case studies from the current provider document a level of complexity within families including those open to social care. 25% have complex needs including being open to social care. Evidence gathered by the Teesside evaluation shows that many families referred to the programme were experiencing a wide range of issues e.g. child protection involvement, on the child protection register, family break up, conflict, social isolation and limited finances. The current pilot offer suggests that 71% of CYP attending its courses present complexity that could prevent them from making lifestyle changes without longer term, more intensive, flexible, and multiagency support. Case studies from the pilot service suggests that neglect, including neglect of obesity is a persistent concern. Parental mental health, drug use and lack of housing security among parents have been highlighted as additional concerns by the current provider. A weight management service provider will have to think beyond traditional weight management support, offering a holistic, tailored approach to supporting children and families to address barriers to making sustainable lifestyle changes. This will include	

	but not be limited to support around parenting techniques, family finances and so on. The provider must collaborate with a range of support organisations in both the statutory and VCSE sector – including social care, family support workers, mental health services, community-based activities and support, housing and at times, the courts.	
Access in Rural Areas	Access in rural areas has been a key issue for families where they do not have access to a vehicle and where bus services are restricted. On occasion the pilot provider has organised taxis for families. A provider will need to factor in how it can reach families in rural settings including through online delivery or by delivery of sessions in accessible locations/on a bus route or by organising taxis.	

4. Completed Actions

Set out how the proposed activity has already been amended following the equality assessment, to maximise the positive impact or minimise the negative impact:

Change	Reason for Change
Implement an approach to ensure meaningful ongoing engagement and co-production with children and families, communities, service users and professional stakeholders – to underpin the development, delivery and improvement of the children and families weight management offer	To ensure regular and genuine engagement with people who receive services is ongoing, learning and responding to feedback to continually adapt and improve the offer.

Introduce protected group reporting requirements into CYP WM pilot data collection, reporting and contract monitoring	To ensure that groups most likely to be affected by overweight are proportionately represented within the service.
Undertake an independent evaluation of the pilot to ascertain if the impact was positively received by service users, particularly those at higher risk of overweight such as children with SEND, Black and Asian ethnic groups and children being supported by social care.	To ensure the service is meeting the unique needs of individuals at higher risk of having overweight and is non-stigmatising.
Adapt programme content and delivery to respond to cultural diversity.	To ensure a broad range of cultural foods in a nutritional content are considered and spoken about with children and families. To ensure timings of sessions and venues are accessible to families of all religious belie
Develop and approach to ensure continued engagement with other services and agencies working with the family, as well as community stakeholders to improve impact and use of resources.	To ensure a coherent approach in supporting the family and maximise the impact of the interventions.

5. Planned Actions

Set out improvements that will be undertaken, following the equality assessment, to further maximise the positive impact or minimise the negative impact:

Potential impact (positive or negative)	Action	By when	Owner
Positive	Develop an integrated leadership model across the system to ensure continued community engagement and co-production through with stakeholders.	September 2023	Provider and Commissioners

Positive	Continue to ensure protected group and other groups at increased risk of obesity reporting requirements into CYPWM data collection and reporting (including SEND, gender, ethnicity and children being supported by social care).	June 2023	Commissioners
Positive	Ensure the service specification sets out clearly how GCC and ICB is required to work to promote equality and reduce health inequalities with due regard to the protected groups. Complying with the same standard as the Council regarding its due regard duties under the Equality Act	September 2022	Commissioners
Positive	Engage with service users to understand issues of access to CYPWM for pupils not in school such as Gypsy and traveller children, home schooled and excluded pupils.	August 2022	Commissioners
Positive	Ensure the offer works to improve the range of interventions and activities that are available to young people that respond to the unique needs of people with SEND, those living in rural areas, preferences due to gender, religion and sexual orientations etc.	March 2024	Provider
Positive	Ensure the offer uses local community venues that are accessible to local families.	June 2023	Provider

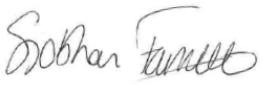
6. Monitoring and review

The following processes/actions will be put in place to keep this 'activity' under review:
This Equalities Impact Assessment Statement is a live document and will be reviewed and updated regularly (at least six monthly or as new information comes to light) during the commissioning and delivery of the weight management offer. Through continued engagement and monitoring, and the use of evidence-based methods (e.g. HEAT tool) we will assess whether we are appropriately considering and meeting the needs of all individuals within the service offer. The Equalities Impact Assessment Statement will form part of the routine contract monitoring and will be used to assess provider compliance with the equalities act, access, experience and outcomes across protected characteristics (as applicable and reasonable), and

service user satisfaction. This information will be used to drive continuous quality improvement and to inform future commissioning. Performance will be monitored, analysed, reported, scrutinised and acted upon via the usual Council arrangements.

7. Officer / Decision-maker Sign off

Officer: By signing this statement off as complete you are confirming that 'you' have examined sufficient information across all the protected characteristics and used that information to show due regard to the three aims of the general duty. This has informed the development of the activity

Signature of Senior Officer	
Name of Senior Officer	Siobhan Farmer
Date	16.08.22

Decision maker: I am in agreement that sufficient information and analysis has been used to inform the development of this 'activity' and that any proposed improvement actions are appropriate and I confirm that I, as the decision maker, have been able to show due regard to the needs set out in section 149 of the Equality Act 2010.

Signature of decision maker	

Name of decision maker	Cllr Nick Housden
Date	8.9.22

8. Publication

If this document accompanies a Cabinet report or an Individual Cabinet Member (ICM) decision report it will be published, as part of the report publication process, on the GCC website. If this statement is not to be submitted with a Cabinet report or an Individual Cabinet Member (ICM) decision report, please maintain a copy for your own records that can be retrieved for internal review and also in case of future challenge.

Appendix 1 – Service User Data

Details of service users affected by the proposed activity

N.b. The appendix below includes data from a number of sources. The 2021 Census data was only available for age and sex and general population profiles when this EIA was written.

Protected Characteristic	Service User Data and Information
Age *percentage/profile of service user ages*	**Gloucestershire County context** It is recommended that the children's community healthy weight management offer is available for children and young people aged 4-17 years old, extended to those aged up to and including 24 years for young people with special educational needs and disability (SEND).[11]

[11] https://www.nice.org.uk/guidance/ph47

	To understand the level of need of overweight and obese children in Gloucestershire we use information from the 2020 Mid-Year Population Estimates. According to Inform Gloucestershire Research and Intelligence, the population of Gloucestershire was estimated to be around 640,650 in 2016. Out of that 142,865 (22.3%) were children and young people aged 0-19. Gloucestershire has a slightly smaller proportion of people age 19 and under compared to England, 22.30% vs. 23.57%. However, the proportion of 0-19 years olds in Gloucestershire is higher than in the South West (21.85%) Gloucester has the highest proportion of 0-19-year olds with a share of 24.35% compared to Cotswold which has the lowest proportion of under 19s with 20.33%. According to the latest 2021 Census figures, there has been an increase in the numbers of 5-9 year olds (14.8%) and 10-14 year olds (8.5%). It is projected that the population of children and young people by 2039 will increase to 153,400. The highest rise in this age group over the twenty-five year period is expected in Tewkesbury (20%). (Source: GCC, Inform Gloucestershire, Population Estimates Overview Report Gloucestershire (Mid-2020)) **Service user context** Please note that overweight and obesity levels are defined at the clinical obesity thresholds (different thresholds than the levels defined in the "Gender" section): • overweight - BMI percentile 91st - 97.9th • obese - BMI percentile 98th – 99.5th • severely obese - BMI percentile => 99.6th The exact number of overweight and very overweight children across all age groups in Gloucestershire is unknown. Children within Primary School in Reception (aged 4 to 5) and Year 6 (aged 10 to 11) are weighed and measured to assess overweight and obesity levels, in line with the National Child Measurement Programme (NCMP). The recommended referral criteria for Tier 2 is children with a BMI>=91st centile[12] Based on 2019/20 figures (NOTE – number of children measured was less than usual due to school closures and so the figures should be interpreted with caution)

[12] PHE (2017) *A Guide to Delivering and Commissioning Tier 2 Management Services for Children and their Families*

	In Reception: 13.4% children were living with overweight, 10.3% were living with obesity or severeobesity and 2.5% were severely obese, In Year 6: 13.1% had overweight, 19.3% had obesity or had severe obesity and 4.6% were living with severe obesity. The 3 year average for Reception children who had obesity is 9.8% and for Reception children with excess weight is 23.1%. The 3 year average for Year 6 children who had obesity is 18.5% and for Year 6 children with excess weight is 32.1%. **(**Source: PHE Fingertips)
Disability *percentage/profile of service users who have a disability*	**National context** Based on Health Survey for England 2006- 2010, children aged 2–15 who have a limiting long-term illness or disability are approximately 35% more likely to haveobesity or overweight than those without; the difference increases with age.[13] Due to higher rates of obesity, children and young people with disabilities are at greater risk of serious obesity-related health conditions such as diabetes, asthma, musculoskeletal problems and cardiovascular risk factors. Obesity among children and young people with disabilities may also worsen the complications that arise from the health conditions or impairment associated with their disability and increase their likelihood of developing pain, mobility limitations, fatigue and depression **Gloucestershire County context** In January 2021 there were; 12,757 (13% of pupils) children and young people receiving SEN support packages in all Gloucestershire schools without an EHCP and 4,332 (2.46% of residents 0-24yrs) with an EHCP. The number of children and young people with an EHCP has been increasing year on year for the previous 5 years. The rate of children and young people with EHCPs per 100 has also been rising, but is still slightly below our statistical neighbours (2.83%) and in line with England (2.56%). Children and young people with special educational needs and disabilities (SEND), Gloucestershire County Council, 2021/22 JSNA update) Special educational needs appear to have some link with deprivation although it is not clear if the deprivation contributes to a special need or the special need contributes to the deprivation, it is most likely to be bidirectional. Forest of Dean district has a significantly higher rate of resident children with SEN than all the other districts. Gloucester also has a significantly higher rate than the remaining districts.

[13] PHE (2014) Obesity and disability. Children and young people

Children and young people in Gloucestershire with a long-term health problem which limits their day to day activities, by age group, 2011

	Age 0 to 4		Age 5 to 9		Age 10 to 19		Age 0 to 19	
	Number	%	Number	%	Number	%	Number	%
All children	33,407		31,437		67,926		132,770	
Day-to-day activities limited	579	1.7%	949	3.0%	2,895	3.3%	4,423	3.3%

(Source: ONS Census 2011)

Service user context

Local authorities should make reasonable adjustments in the way they commission and deliver public health services to children with physical disabilities and special educational needs and should work closely with schools to plan alternative provisions

The small number of children who are unable to take part in the programme due to their disability should be offered alternative arrangements., since their parents or carers can still benefit from receiving information and lifestyle advice, including specialist advice appropriate to the child's circumstances. PHE template letter can assist with this.

PHE, National Child Measurement Programme Operational Guidance 2017

Service level data from the pilot shows that 28% of those engaging with the most intense form of support in the pilot had some form of disability, 10% of those had autism.

Sex
percentage/profile of service users who are male and who are female

National context

Please note that overweight and obesity levels are defined at the different thresholds than the levels defined in the "Age" section:

- Overweight between ≥ 85th centile and <95th centile
- Obese - BMI ≥ 95th centile

According to Health Survey for England 2013-2015, boys aged 2-10 and 11-15 are more likely to be very overweight than girls. Looking at overweight status, boys are more likely to be overweight than girls for ages 2-10, however for ages 11-15 girls are more likely to be overweight.

Table 1 Health Survey for England, prevalence of obese and overweight children, England, 2013-15

HSE 2013-15	overweight	obese	overweight or obese
Boys aged 2-10	13.8%	14.6%	28.40%
Girls aged 2-10	13.0%	12.5%	25.50%
Boys aged 11-15	14.6%	20.0%	34.60%
Girls aged 11-15	16.7%	17.6%	34.20%

Regional context

Regional data indicates that boys in the Reception (aged 4-5) and Year 6 (aged 10-11) are more likely to have obesity and overweight or obesity than girls.

Table 2 NCP, prevalence of overweight and obese children in South West, 2016/17

NCMP 2016/17	South West overweight or obese	England overweight or obese
Boys aged 4-5	23.9%	23.2%
Girls aged 4-5	22.1%	22.1%
Boys aged 10-11	31.7%	36.0%
Girls aged 10-11	28.3%	32.4%

Table 3: NCMP, prevalence of obese children in South West, 2016/17

NCMP 2016/17	South West obese	England obese
Boys aged 4-5	9.5%	10.0%

	<table><tr><td>Girls aged 4-5</td><td>8.1%</td><td>9.2%</td></tr><tr><td>Boys aged 10-11</td><td>17.8%</td><td>21.8%</td></tr><tr><td>Girls aged 10-11</td><td>14.5%</td><td>18.1%</td></tr></table> (Source: PHE (2017) *Patterns and trends in child obesity*; PHE (2018) *Patterns and trends in child obesity in the South West)* **Gloucestershire County context** 71,003 0-19yr olds are male (51%) and 68,189 0-19yr olds are female (49%) (Source: From the ONS Population Estimates 2015) **Service User Context** In both Reception Year and Year 6, boys in Gloucestershire are more likely to be obese than girls over the past 5 years. The gap between boy/girl obesity is greater in Year 6 and recorded NCMP data shows that this gap is widening from 2.5% in 2014/15 to 4.3% in 2019/20. A higher proportion of girls are now living with obesity than before the pandemic – this means that the gap between boys and girls living with obesity has actually decreased since 2018/19 when compared to previous years. .
Race *percentage/profile of service users who are from black and minority ethnic backgrounds*	**National context** There is no straightforward relationship between obesity and ethnicity. Research suggests that for a given BMI, the average proportion of body fat differs between ethnic groups suggesting that ethnic specific thresholds may be needed. This complicity is deepened among children due to different rates of maturation up to and during adolescence. (Source: GCC and NHS Gloucestershire CCG (2016) *Gloucestershire Healthy Weight Needs Assessment*) Health and Social Care Information Centre states that based on the National Child Measurement Programme, obesity rates are higher in some ethnic minority groups of children (particularly Black African and Bangladeshi ethnicities.) (Source: PHE guidance (2015) *Childhood obesity: applying All Our Health)*

Gloucestershire County context

According to Census 2011 around 4.6% of Gloucestershire population is made up of Black and Ethnic Minorities, which is significantly lower than 14.6% reported for England as a whole. However, children and young people population is more diverse, with 7.6% of 0-19 year olds belonging to Black and Minority Ethnic groups - this proportion is still considerably lower than the national average of 21.1%. As presented in table 5, the proportion of BME groups is higher among younger children.

Table 4 Gloucestershire 0-19 population by White ethnic groups, Census 2011

	0-19
White Total	**92.4**
White British	89.4
White Irish	0.2
White Gypsy or Other	0.2
White Other	2.6

(Source: GCC (2020``) Population Profile)

Table 5 Gloucestershire 0-19 population by Black and Ethnic Minority groups, Census 2011

Ethnicity	Age 0 to 4	Age 5 to 7	Age 8 to 9	Age 10 to 14	Age 15	Age 16 to 17	Age 18 to 19	0 - 19 total
Asian/Asian British	3.0%	3.0%	2.9%	2.6%	2.2%	2.8%	2.3%	**2.8%**
Black/African/Caribbean/ Black British	1.1%	1.0%	1.1%	0.9%	0.8%	0.8%	1.1%	**1.0%**
Mixed/multiple	4.6%	4.2%	3.5%	3.3%	3.2%	2.7%	2.3%	**3.6%**
Other	0.2%	0.3%	0.2%	0.2%	0.1%	0.2%	0.2%	**0.2%**
White	91.1%	91.5%	92.3%	93.0%	93.6%	93.5%	94.1%	**92.4%**
Grand Total	100%	100%	100%	100%	100%	100%	100%	100%

	Source: GCC (2015) *Gloucestershire's Transformation Plan for Children & Young People's Mental Health & Wellbeing* **Service User Context** In Gloucestershire, the prevalence of obesity by ethnic group among children in Year 6 shows the highest proportion of Children who have very overweight to be in the black ethnic group. (Source: GCC and NHS Gloucestershire CCG (2016) *Gloucestershire Healthy Weight Needs Assessment*) Service level data suggests that 68.97% of those recruited to the pilot came from a white background, 18.96% came from an ethnic minority background and 12.07% did not have their ethnicity data recorded.
Gender reassignment *percentage/profile of service users who have indicated they are transgender*	**Gloucestershire County context** There is sparse evidence based research on the number of trans or non-binary people living in the UK with issues around self identification being a barrier to fully understanding the size of this community.1% of the population is estimated to have had some degree of gender reassignment. (Source: Gloucestershire Sexual Health Needs Assessment 2015) **Service User Context** Currently there is no estimate on the obesity levels amongst children with gender reassignment.
Marriage & civil partnership *percentage/profile of service users who are married or in a civil partnership*	**National Context** There are some wide-world studies suggesting that there is a relationship between family structure and obesity among children, suggesting that children from single parent household are more likely to become obese. However, this is relation is not confirmed and requires a further research. **Gloucestershire County context** According to Census 2011, in among residents of Gloucestershire: □ 30.5% are single and have never married or registered a same-sex civil partnership □ 50.2% are married □ 0.3% are in a registered same-sex civil partnership □ 2.3% are separated but still legally married or still legally in a same sex civil partnership

	□ 9.5% are divorced or formerly in a same sex civil partnership which is now legally dissolved □ 7.2% are widowed or a surviving partner from a same sex civil partnership (Source: GCC (2016) *Population Profile*) According to Census 2011, in Gloucestershire there are 13,130 lone parent households (5.2% of all households), which is below the national average of 7.1%. **Service User Context** Currently there is no estimate on the obesity levels amongst children by family structure.
Pregnancy & maternity *percentage/profile of service users who are female and who are pregnant or on a maternity leave*	**National Context** As indicated by Public Health England (PHE), in England approximately half of women of childbearing age (16 to 44 years) are either overweight or obese. Data on the prevalence of maternal obesity are not collected routinely in the UK. PHE estimates (based on benchmark rate from NICE), that 5.3% of obese women of childbearing age will become pregnant per year. There is strong evidence, that there is a significant relationship between maternal obesity and the birth of babies above a normal weight range, and the subsequent development of childhood and adult obesity, independent of genetic and environmental factors. (Source: PHE guidance (2015) *Childhood obesity: applying All Our Health* & PHE (2015) *Maternal Obesity)* **Gloucestershire County context** There were 6124 live births in Gloucestershire in 2019., Births to mothers aged 30-34 accounted for the largest number of all births in Gloucestershire (2,089 live births representing 34.1% of total births), followed by births to those aged 25-29 (1,821 births, 27.8%). (Source: Inform Gloucestershire *Population Profile, Birth Trends*)

<table>
<tr><td></td><td></td></tr>
<tr><td>Religion and/or belief
percentage/profile of service users religious beliefs</td><td>

Gloucestershire County context

According to the 2011 Census, 55.7% of children and young people aged 0-19 in Gloucestershire are Christian, making it the most common religion among children This is followed by no religion which accounts for 33.5% of the total population.

Religion	Age 0 to 4		Age 5 to 9		Age 10 to 19		Age 0 to 19	
	Number	%	Number	%	Number	%	Number	%
All categories: Religion	33,438		31,540		71,610		136,588	
Christian	16,264	48.6%	18,866	59.8%	41,004	57.3%	76,134	55.7%
Buddhist	40	0.1%	65	0.2%	176	0.2%	281	0.2%
Hindu	174	0.5%	135	0.4%	207	0.3%	516	0.4%
Jewish	22	0.1%	19	0.1%	49	0.1%	90	0.1%
Muslim	614	1.8%	551	1.7%	877	1.2%	2,042	1.5%
Sikh	33	0.1%	36	0.1%	55	0.1%	124	0.1%
Other religion	48	0.1%	78	0.2%	212	0.3%	338	0.2%
No religion	12,808	38.3%	9,348	29.6%	23,591	32.9%	45,747	33.5%
Religion not stated	3,435	10.3%	2,442	7.7%	5,439	7.6%	11,316	8.3%

(Source: ONS Census 2011)

Service User Context

NCMP participants are not asked about their faith beliefs and so the profile of service users is unknown.Similarly there is no data collected by the current pilot on religion.

</td></tr>
<tr><td>Sexual orientation
percentage/profile of service users who are lesbian, gay, bisexual, heterosexual</td><td>

There is no definitive data on sexual orientation at a local or national level. The most recent estimate from the ONS Integrated Household Survey suggests that nationally Lesbian, Gay and Bisexual people represent 1.5% of people aged 16 and over. If this figure applied to Gloucestershire it would mean there were around 7,400 Lesbian, Gay and Bisexual people in the county. (Source: GCC (2016) *Population Profile*)

</td></tr>
</table>

Appendix 2 – GCC Workforce Data

Details of Gloucestershire County Council staff affected by the proposed activity

Protected Characteristic	Total number of GCC staff affected:
Age	GCC staff are not affected
Disability	GCC staff are not affected
Sex	GCC staff are not affected
Race	GCC staff are not affected
Gender reassignment	GCC staff are not affected
Marriage & civil partnership	GCC staff are not affected
Pregnancy & maternity	GCC staff are not affected

Religion and/or belief	GCC staff are not affected
Sexual orientation	GCC staff are not affected