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	Adults
Service area	Prevention Wellbeing and Communities Hub
Title of the activity being assessed i.e. the strategy, plan, policy or service	Consultation on commissioning plans for a remodelled Integrated Healthy Lifestyles Service from April 2024
Brief outline of the proposal(s)	The lifestyle behaviours known to have the biggest impact on disability free life expectancy and health inequalities are smoking, excess alcohol, poor diet and physical activity - linked to obesity. The County Council currently commissions a Healthy Lifestyles Service (HLS) that supports people to make lifestyle behaviour changes (i.e. to stop smoking, reduce weight, increase physical activity and reduce alcohol). This Service is one of a range of Services and programmes that are delivered to support the Council's statutory duty to protect and improve the health and wellbeing of the population and reduce health inequalities. The contract for this Service expires in March 2024. In order to inform any future service provision, we are undertaking a strategic review of the current Service and wider system offers and are seeking authorisation to conduct a consultation exercise on draft proposals and priorities for a new Healthy Lifestyles Service model from April 2024.

	GCC is reviewing its strategic direction around the delivery of weight management services and has taken the decision to prioritise investment into Children and Young People's weight management support in line with the Integrated Care System priorities for 'the best start in life' and addressing health inequalities. This direction of travel is supported by the data, which shows that there has been a significant increase in the numbers of children and young people that have obesity post Covid-19. Since the universal weight management on referral offer (provided by Slimming World) was introduced in Gloucestershire, there has been an increase in what is offered in other parts of the local system to support people to live healthier lifestyles. Along with a new strategic direction in the NHS Long Term Plan, the NHS now provides range of weight management offers including an NHS digital offer; the National Diabetes Prevention Programme (NDPP); an Enhanced Weight Management Service offer and the provision of a free NHS 12-week Weight Loss Plan App. Offers of personalised care training and social prescribing have also expanded within the NHS alongside the on-going offer of exercise on referral. Similarly, capacity, capability, and opportunities to support heathy lifestyles either already exist, or could be enhanced within communities. e.g., peer support, cooking skills, parenting support, gardening skills. The universal weight management on referral offer (provided by Slimming World) is not targeted and evidence from the uptake data show that the offer is not consistently taken up by those with the greatest need. Given this, and the growth in weight management support across the local system, we are proposing to decommission the universal weight management on referral offer. However, our intention is to continue to provide targeted bespoke support for those groups of adults who have the greatest need. The proposed consultation process will explore stakeholder views on this proposed change and future Service offer, and how any potential impact on people with protected characteristics and those at increased risk of health inequalities can be mitigated.

	The new Service will continue to target behavioural support to make a lifestyle change for people that experience the greatest health inequalities and have the greatest capacity to benefit from lifestyles support. Commissioners will consult on draft proposals for a new service. The proposed consultation will be open to everyone but will specifically gather views from current and potential service users and wider system stakeholders, with specific focus on gathering feedback from across the protected characteristics and those groups experiencing the greatest health inequalities. Consultation responses will be used to inform the future service model and service specification. The consultation process and methods will be informed by our assessment of local needs and our pre-engagement conversations. The consultation will include the following mechanisms to further identify and explore areas of potential unmet need and how these might be addressed: • Online Questionnaire • Hardcopy Questionnaire (including in easy read format) • Focus groups with protected characteristics groups • Meetings and semi-structured interviews with specific stakeholder groups e.g. ICS system partners, community networks
Who is affected by the proposals?	Service users [X] Workforce [ ] Other, please specify: [ ]
Decision to be taken and decision maker	Individual Cabinet Member decision to be taken by Cllr. Mark Hawthorne, Leader of the Council; report title: 'Consultation on commissioning for Healthy Lifestyles. **Decision** That the Cabinet Member for Public Health and Communities grants authorisation to undertake a consultation on the proposed strategic direction, principles, and priorities for a

	remodelled service to encourage and enable individuals to adopt a healthier lifestyle in Gloucestershire from April 2024.
Person(s) responsible for completing this assessment	Angelika Areington – Commissioning Officer; Tracy Marshall – Senior Commissioning Manager; Sue Weaver – Head of Commissioning (Health Improvement)
Date of this assessment	November 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	A consultation plan is being developed to seek views on the proposals from current and potential service users as well as wider system stakeholders. This will be open to everyone but will be actively promoted to groups representing/working with people across the protected characteristics and those who experience the greatest health inequalities and have the most capacity to benefit from healthy lifestyles support. This EIA document will guide who we would seek to actively engage with as part of this process. This document will be updated using the findings from the consultation. Where available, data on the characteristics of service users has been drawn from existing activity data submitted by the current providers as part of routine contract monitoring. Between June and September 2022, we undertook an engagement exercise with people from a range of protected characteristics including older people; those with long-term conditions; those from different ethnic and religious groups and those from the LGBTQ+ community. This took the form of informal conversations with people to gather views on the key barriers and enablers in making healthier lifestyles choices, and accessing lifestyles support, and what was important to people in making these choices. **Key themes from engagement** - People did not always feel comfortable asking for help from services. Mental health issues and feelings of loneliness can make it challenging for those who want to improve lifestyles and reach out for support

	- Friends, family, and community were important in supporting people to look after their wellbeing and maintain 'good habits' as well as providing opportunities to meet socially. Sometimes a lack of support and 'issues' at home can be a barrier to getting out and 'doing things' - Some groups were not aware of the current service but would find it difficult to access it, or participate in other offers due to wider health conditions, which impact on their ability to make sustainable changes - Accessibility ca be an issue for people, particularly those living with a physical or learning disability. Service offers need to be tailored and targeted appropriately - Costs of services/opportunities to be physically active can be a barrier to participation and healthy food is too expensive to buy regularly - Transport is a barrier due to cost and availability - There needs to be a better understanding of cultural, religious, and differing health needs in order for people to feel that services are appropriate, welcoming, and 'feel safe' to them - Language barriers and lack of interpreters can make services inaccessible for some people Discussions also took place with community leaders, those working with people across the protected characteristics, and those representing these groups. **Comments from wider stakeholders** - Providers and commissioners need to have continuous engagement with communities (and those that work /represent them) and be proactive in ensuring services are reaching and serving those who need them most, and are gathering their views - Commissioners need to actively monitor contracts to ensure access to services is representative of the population - There are opportunities for better integration and or understanding across services and communities of what is 'out there' – services could be better at signposting to other providers to offer a more holistic approach to people's needs – 'how can we work better together' - There was enthusiasm for continued discussion and engagement to support the comments above
Workforce	Discussions with the senior team and wider staff from the current service provider will form part of the engagement and consultation process. This will elicit a greater understanding, from the provider's point of view, of any challenges faced by them in delivering the service and where opportunities could be acted on to make improvements to the current model of delivery / service specification.

Partners	Discussions have taken place with commissioners and senior managers from the One Gloucestershire Integrated Care Board (NHS) and GCC internal partners. These include those involved in services such as social prescribing, clinical weight management, community wellbeing services, and mental health and disabilities support. These discussions will continue as the project progresses and these partners will have the opportunity to respond formally to the consultation.
Other	We are engaging with other local authorities that currently offer comparable support for lifestyles behaviour change and/or are undertaking a similar procurement process. This is helping us to gather information on how services have been commissioned and what has been successful as well as gaining insight into their future service models.

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.

<table>
<tr><th>Protected Characteristic</th><th>Service Users</th><th>Workforce</th></tr>
<tr><td>Age</td><td><u>Challenge:</u>

<u>Weight management</u>

The proportion of adults with excess weight (overweight or obesity) in Gloucestershire, in 202/21, is 64.9%, which is statistically similar to the England average of 63.5%. The proportion with obesity is 25% for Gloucestershire, which is also similar to the England average of 25.3%.[1]

The percentage of people with overweight or obesity by district area is in the table below[2]

<table>
<tr><th>Area</th><th>Overweight or obese - %</th><th>Obese - %</th></tr>
<tr><td>Cheltenham</td><td>59</td><td>22.5</td></tr>
<tr><td>Cotswolds</td><td>60.7</td><td>22.4</td></tr>
</table>
</td><td>No identified significant impact</td></tr>
</table>

[1] Obesity Profile - OHID (phe.org.uk)
[2] Obesity Profile - OHID (phe.org.uk)

Forest of Dean	70.3	33.5
Gloucester	72.1	31.6
Stroud	62.2	19.1
Tewkesbury	67.6	25.0
Gloucestershire	64.9	25.0
England	63.5	25.3

The proportion of adults with overweight or obesity in England increases with age among both men and women. It is highest among men aged between 55 and 64 (82%), and women aged between 65 and 74 (70%). The proportion of adults with obesity also increases with age and is highest among men aged between 45 and 54 (36%), and among women aged between 55 and 64 (37%).[3]

Weight management in children and young people is out of scope for this Service; a separate children and young people healthier lifestyles service is currently being commissioned by the GCC, with an accompanying EIA.

Physical Activity

According to Office for Health Improvement and Disparities, the proportion of adults who are physically active (undertake 150 minutes or more of moderate intensity physical activity a week) in Gloucestershire is 70.2%, which is statistically better than England average of 65.9%.[4]

The percentage of people who are physically active by district area is in the table below

Area	Physically Active %
Cheltenham	71.6
Cotswolds	71.4
Forest of Dean	69.5
Gloucester	68.7

[3] Part 3: Adult overweight and obesity - NHS Digital

[4] Physical Activity - OHID (phe.org.uk)

Stroud	69.7
Tewkesbury	70.6
Gloucestershire	70.2
England	65.9

Percentage of people in England and Gloucestershire aged 16 years and over classed as 'physically active' by age group - November 2020 to November 2021 (Active Lives Survey)

Age range	England %	Gloucestershire - %
16-24	68.6	66.2
25-34	64.9	69.5
35-44	64.1	71.2
45-54	65.2	71.5
55-64	61.5	67.8
65-74	60.1	62.4
75-84	43.1	38.8
85+	21.6	No data

These data show that participation in physical activity declines from 65 year with those aged 75+ being less likely to be physically active.

The survey also shows that:

- White British people had the biggest reduction in physical activity levels with age – 72.4% of 16- to 24-year-olds were physically active, compared with 39.6% of people aged 75 and over
- in all age groups between 16 and 54 years old, White British people were more likely than average to be physically active – the number of people surveyed for the mixed ethnic group in these age groups was too

small to make reliable generalisations

- in all age groups between 16 and 74 years old, people from the Asian, Black and 'Other' ethnic groups were less likely than average to be physically active – the number of people aged 75 and over was too small to make reliable generalisations.

Smoking – Adults

In Gloucestershire 11.6% of people smoke compared to 12.1% in England. Smoking prevalence is highest in men and amongst the 25-34 age group for both men and women. Prevalence for both men and women is lowest among people aged 60 and over. Those in routine and manual occupations aged 18-64 have the highest smoking prevalence rates in Gloucestershire with 26% of this cohort being smokers compared to 21.4% in England.

Data from the ONS show the following smoking prevalence rates for England.

Age range	Men %	Women %
16-24	15.9	14.4
25-34	18.4	17.9
35-49	18.1	15.1
50-59	16.4	16.1
60+	9.8	9.1

Smoking - Children

According to the latest Gloucestershire Pupil Wellbeing Survey (2022), 90% of pupils said they had never smoked and 95% said they had never smoked/tried once or twice. This was an improvement on 2012 data when 89.7% of pupils said they had never smoked/tried once or twice. The current proportion of comparable-age pupils who do not smoke (never smoked/tried once or twice) in Gloucestershire is slightly lower than the 2021 national figure (95% in Gloucestershire versus 96.9% in England). The proportion of pupils smoking regularly (Quite Often (Weekly)/Most days) has also been declining, from 4.9% of pupils in 2012 to 2.2% in 2022.

Alcohol

Statistics on alcohol and drug misuse treatment for adults from the National Drug Treatment Monitoring System (NDTMS) estimate that in 2018/19:

- There were 5,509 adults in Gloucestershire with alcohol dependency
- Men are more likely to drink any alcohol than women and those aged 45-64 are the most likely to drink, while those aged 16-24 are the least likely to drink.
- Although 16–24-year-olds are less likely to have drunk alcohol in the past week, when they do drink, they are more likely to drink at high levels
- Since 2005, the overall amount of alcohol consumed in the UK, the proportion of people reporting drinking, and the amount drinkers report consuming have all fallen. This trend is especially pronounced among younger drinkers
- 30% of men drink more than 14 units of alcohol per week compared to 15% of women.
- 55- to 64-year-olds are the most likely to drink more than 14 units of alcohol per week whereas 16- to 24-year-olds are the least likely (31% vs 15%).
- The proportion of adults drinking more than 14 units of alcohol per week has remained stable since 2015.
- Adults aged 25 to 34 are the most likely to report binge drinking in the last week whereas those aged 75+ are the least likely (22% vs 3%).
- Adults aged between 45 and 64 are the most likely to be drinking above the low risk drinking guidelines whereas 18 to 24 year olds are the least likely (22% vs 12%).

Alcohol related mortality

In 2020 240 people (35 per 100,000) died from alcohol related illness in Gloucestershire.

Alcohol related mortality by district 2020

Area	Persons number	Persons Rate per 100,000	Men Number	Men Rate per 100,000	Women Number	Women Rate per 100,000
Cheltenham	43	37.2	26	48.8	16	
Cotswolds	32	28.3	22	43.1	9	

Forest of Dean	43	43.4	36	77.9	7	
Gloucester	50	41.6	35	61.1	15	
Stroud	46	33.2	31	49.2	15	
Tewkesbury	26	24.7	17	35.3	9	
Gloucestershire	240	35	168	52.8	72	19.9
England	20,468	37.8	14,536	57.3	5,932	20.9

Source: Calculated by OHID: Population Health Analysis (PHA) team from the Office for National Statistics (ONS) Annual Death Extract Public Health Mortality File and ONS Mid Year Population Estimates

In 2020 there were 70 alcohol specific deaths (10.6 per 100,000) by in Gloucestershire compared to 6,984 deaths (13.0 per 100,000) in England. Data split by districts and gender has not yet been released (ONS 2020)

According to the National Drug Treatment Monitoring System (NDTMS), in 2018/19 the proportion of men and women usually drinking over 14 units in a week varied across age groups and was most common among men and women aged 55 to 64 (39% and 19% respectively). Proportions drinking at these levels then declined among both sexes from the age of 65. Across all age groups, men were more likely than women to drink at increasing and higher risk levels.

Summary of weekly alcohol consumption, by age and sex

Health Survey for England 2019. Adults aged 16 and over

Estimated weekly alcohol consumption	**Age group**							
	16-24	**25-34**	**35-44**	**45-54**	**55-64**	**65-74**	**75+**	**Total**
	%	%	%	%	%	%	%	%
Men								

Non-drinker	26	15	18	17	13	13	19	17
Up to 14 units (low risk)	54	58	57	49	48	48	56	53
More than 14, up to 50 units (increasing risk)	15	25	21	29	32	32	22	25
More than 50 units (higher risk)	5	2	4	6	8	7	3	5
Women								
Non-drinker	31	24	23	19	18	18	31	23
Up to 14 units (low risk)	59	61	62	63	62	65	59	62
More than 14, up to 35 units (increasing risk)	9	12	12	14	16	13	9	12
More than 35 units (higher risk)	2	3	3	5	4	4	1	3
All adults								
Non-drinker	28	20	21	18	15	16	26	20
Up to 14 units (low risk)	56	60	59	56	55	57	58	57
More than 14, up to 35/50 units (increasing risk)	12	18	17	21	24	22	15	19
More than 35/50 units (higher risk)	3	2	3	5	6	5	2	4

According to the health Survey for England 2019, the proportion of participants drinking alcohol in the past year increased with age, from 74% of 16- to 24-year-olds to 85% of 55 to 74 year olds, and was lower in the oldest age group (75% of those aged 75 and over). There was a similar pattern for drinking 'at least once a week', with the youngest age group being the least likely to drink at least once a week (30%) and those aged between 55 and 74 years old being the most likely to do so (58%).[5]

Healthy Lifestyles Service level data

While the data for the Healthy Lifestyles Service are not corrected to be representative of the age profile of the Gloucestershire population there are still clear trends which can be drawn.

Weight management

Younger adults are currently underrepresented in the HLS one-to-one weight management offer. Those in an older age group category (age groups: 41-50, 51-60 and 61+) accessing the HLS weight management support, made up a higher proportion of all clients. The highest proportion of people accessing the offer who achieve at least 3%

[5] Health Survey for England 2019, Adult health related behaviours (digital.nhs.uk)

weight loss was the 21-30 and 61+ age categories with those aged under 20 least likely to achieve this figure.

HLS service user data for weight management 2021/22

Age	% of clients	3+% Weight loss
Age 20 and under	1%	33%
Age 21-30	9%	49%
Age 31-40	17%	43%
Age 41-50	22%	43%
Age 51-60	25%	41%
Age 61+	25%	49%
Not recorded/Declined	0%	100%
Total	**100%**	**45%**

Slimming World data for weight management 2021/22

Age	% of clients	3+% Weight loss
Age 20 and under	1%	36%
Age 21-30	10%	48%
Age 31-40	21%	55%
Age 41-50	21%	65%
Age 51-60	24%	71%
Age 61+	23%	76%
Total	**100%**	**65%**

Younger adults are also underrepresented within the 'weight management on referral' offer (Slimming World groups). Among all service users accessing Slimming World, those under 30 years old made up the smallest proportion; highest proportion were among those aged 41 and over. Service users aged over 51-60 were more likely to achieve a 3%+ weight loss; those aged under 30 – less likely.

Alcohol
Younger adults are less likely to access support from the Service to reduce their alcohol intake. Service users aged 51 and over accounted for more than half of all clients in each year over the last three years. In general, the proportion of service users increased with age. There were fewer than 10 clients aged 20 and under who accessed this service during the last three years. Those over 61 years old were less likely to achieve a positive outcome.

Physical activity
Younger adults are less likely to access support from this Service to increase their physical activity levels. Clients aged over 51 made up the highest proportion of all service user; those aged 20 and under – the smallest, followed by those in the 21-30 age group. In general, those in age groups 31-40 and 41-50 were more likely to achieve positive outcomes over the past three years.

Smoking
Service users aged between 31 and 40 made up the highest proportion of all clients. Those aged 21-40 achieved the greatest number of 4 week quits and those under 20 and aged 41-50 were less likely to achieve a 4 week quit.

Age	% of clients	% of 4 weeks quits
Age 20 and under	3%	67%
Age 21-30	20%	73%
Age 31-40	21%	73%
Age 41-50	17%	67%
Age 51-60	19%	72%
Age 61+	19%	70%
Not recorded/Declined	0%	50%
Total	**100%**	**71%**

Promoting good relations
The Provider will be expected to actively seek out and take into consideration the views and specific needs relating to Service access and provision for people of all ages. This will particularly focus on the needs of the age groups identified above that have the highest prevalence of unhealthy lifestyles behaviours or lifestyle-related health inequalities.

	The proposed removal of the universal weight management on referral offer will potentially have the greatest impact on those in the post 40 age-group categories (age groups: 41-50, 51-60 and 61+) who currently make up the majority of service users. The consultation will seek the views of representatives from these groups including how to best promote the NHS weight management offers to them, and to understand any remaining gaps. **Advance equality of opportunity** The Provider, throughout the contract, will be expected to engage and work in partnership with community groups/stakeholders that represent or work with people with age-related vulnerabilities and those who are under-represented within the Service **Eliminate discrimination** Higher numbers of people in older age group categories accessing the weight management services are in line with obesity and overweight prevalence, which increases with age. Similarly, physical activity support is mostly accessed by clients in the older age categories, who are less active. Smoking services and alcohol services are also accessed by age groups who are most likely to experience these behaviours. In general, the support is targeted to those age groups in greatest need. However, younger adults are clearly underrepresented within the Service. The planned consultation will aim to elicit further information from groups across the life course, including experiences and views on the possible impact of the proposals, and ways in which this impact could be mitigated. Any new service will be available to all adults regardless of age and additional efforts will be made to explore ways to engage and meet the needs of younger adults at greatest risk of lifestyle-related ill-health more effectively.	
Disability	**Challenge:** Evidence shows that people with a mental health condition; limiting long term health problem or disability have poorer health than the general population ***Weight management*** Under the current UK law obesity in not a disability. However, there is a strong two-way association between obesity and disability. Living with obesity puts people at much greater risk of many health problems, including heart disease, high blood pressure, stroke, diabetes, and several types of cancer[6]. These health problems can limit a person ability to carry out normal day-to-day activities. In addition, those living with a disability are more likely to	No identified significant impact

[6] Obesity and weight management for people with learning disabilities: guidance - GOV.UK (www.gov.uk)

have obesity. On a national level, in 2020/21, among people with disabilities, excess weight was 11.3 percentage points higher than among those without disabilities (72.6% of people with disability were classified as overweight or obese versus 61.3% of not disabled).[7] It's been recognised that people with a particular disability - learning disabilities or poor mental health - are at increased risk of excess weight (overweight or obesity) compared to the general population.

The most recent data, based on analysis from GPs across England, showed that in Gloucestershire obesity and overweight are approximately 3 times more common in people with a learning disability. Nationally, obesity is 3.7 times more common among people with a learning disability and the ratio for overweight is 2.8.[8] In addition, people with a learning disability experience a disproportionate range of broad social disadvantages, such as poverty, poor housing and social isolation, which are closely linked with a poor diet and excess body weight.[9] Some people with learning disabilities have particular problems with weight control as a result of conditions such as Prader Willi Syndrome or because of specific medications they take. Additionally, people with a learning disability have substantially higher rates of conditions associated with being overweight, such as diabetes, heart failure and strokes. Mental ill health, bullying and abuse are all more commonly experienced by people with learning disabilities than in the general population, but no estimates are available to show what contribution excess weight may make to these problems of health and wellbeing.

The largest single cause of disability in the UK is mental health. One in four adults experience a mental health condition in any given year.[10]

There is also a bidirectional association between obesity and mental health, with conditions such as depression often leading to weight gain and obesity leading to depression.[11] Rates of obesity are higher in people with severe mental health problems than in the general population, due to the effects of medication, poor diet, alcohol misuse and less active lifestyles. Further, in the UK community, people diagnosed with schizophrenia are reported to have a 2–3 times greater premature mortality rate than the general population, mainly due to cardiovascular disease associated with long-term lifestyle factors such as smoking and obesity. Obesity and overweight are more prevalent in the population detained within mental health secure units (with rates of up to 80% reported) than in the general population (around 60%) and patients appear to be at risk of weight gain when detained.

Smoking

The majority of population-based studies on smoking among people with disabilities have been undertaken in the U.S. These studies have consistently reported higher rates of smoking among US adults with disabilities when compared to their non-disabled peers. Additionally, the prevalence rate ratios in the US appear to be increasing

[7] Obesity Profile, OHID, https://fingertips.phe.org.uk/search/overweight#page/7/gid/1/pat/6/par/E12000009/ati/402/are/E10000013/iid/93088/age/168/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tom/1/page-options/ine-ao-1_ine-ct-27_ine-pt-0_ine-yo-1:2020:-1:-1

[8] Health and Care of People with Learning Disabilities, Experimental Statistics Microsoft Power BI

[9] Obesity and weight management for people with learning disabilities: guidance - GOV.UK (www.gov.uk)

[10] https://www.nice.org.uk/media/default/about/what-we-do/into-practice/measuring-uptake/niceimpact-mental-health.pdf

[11] obesity_in_mental_health_secure_units.pdf (publishing.service.gov.uk)

over time due to a more rapid decrease in smoking among the non-disabled population. A UK based research reached similar findings and also concluded that adults with disabilities who do smoke are significantly more likely to smoke heavily (20 or more cigarettes a day). The same source reported a higher rate of smoking among younger adults, especially women with disabilities.[12]

In Gloucestershire, in 2020/21 adults (18+) with a long-term mental health condition were nearly 2 times as likely to smoke as the general population: 23.9% v 12.6%; with Cotswold having highest rates (36.5%), followed by Gloucester (33%). The county rate for people with a long-term mental health condition is statistically similar to the England average of 26.3%. Smoking rates increase with the severity of mental illness. Among adults with a serious mental illness, 38.1% of adults (18+) in Gloucestershire smoked in 2014/15.[13] The smoking rate among people with mental health conditions is the largest contributor to their 10-to-20-year reduced life expectancy.[14] A third of all tobacco is smoked by people with a mental health condition. Smoking among those with a mental health condition has changed little over the past 20 years, in contrast to the marked decline in smoking prevalence in the general population.[15]

Physical activity

There are significant inequalities affecting people with disabilities in relation to physical activity. In England people with disabilities are twice as likely to be inactive when compared to non-disabled people, with inactivity (less than 30 minutes per week) at 43% among people with disabilities and 21% for non-disabled adults. It is also reported that just 18% of adults with disabilities engage in at least one physical activity session per week compared to 41% of non-disabled adults. Moreover, 'inactive' people with 3+ impairments are more likely to be sedentary compared to those with one or 2 physical, cognitive, sensory, and/or intellectual impairments.[16]

Research indicates that people with mental illness have lower physical activity compared with the general population. Physical activity is widely recognised as beneficial to mental wellbeing in general as well as a preventative action in a number of mental disorders and it is also seen as a potential preventive or disease-modifying treatment of dementia and brain aging or as a possible treatment for negative symptoms in schizophrenia.[17]

Alcohol

[12] Smoking_REVISED_CLEAN.pdf (lancs.ac.uk)

[13] Local Tobacco Control Profiles, http://fingertips.phe.org.uk/tobacco-control#gid/1938132885/ati/6

[14] Smoking and tobacco: applying All Our Health - GOV.UK (www.gov.uk)

[15] https://www.gov.uk/government/publications/better-mental-health-jsna-toolkit/3-understanding-people

[16] Physical activity for general health benefits in disabled adults, PHE, 2018, Physical activity for general health benefits in disabled adults: summary of a rapid evidence review for the UK CMO's update of guidelines (publishing.service.gov.uk)

According to the Active Lives Survey, (November 2020 to November 2021) 42.8% of those with a disability or long-term condition in Gloucestershire participated in at least 150 minutes of physical activity per week compared to 45.2% in England.

[17] Frontiers | Thirty years of research on physical activity, mental health, and wellbeing: A scientometric analysis of hotspots and trends (frontiersin.org)

There is little research about the alcohol use among people with a disability. A small amount of self-reported studies indicates that people with learning disabilities are less likely to misuse substances than the general population. Some groups of people with learning disabilities are more likely to misuse substances than others. People with profound and multiple learning disabilities are less likely to drink alcohol as they are unlikely to have the opportunity to do so.

People with learning disabilities have an increased risk of substance misuse if they: have borderline to mild learning disabilities; are young and male; have mental health problems. The main reasons for misusing alcohol and drugs have been described as 'self-medicating against life's negative experiences', such as psychological trauma, bereavement or abuse and isolation and loneliness[18]

Alcohol use disorders have been linked with a range of mental health difficulties, including depression and bipolar disorder. Many people who misuse alcohol also have a mental health difficulty, and many people with mental health problems also misuse alcohol. Having a 'dual diagnosis' of alcohol use- and mental disorders is common. Some 86% of people using alcohol treatment services have a co-occurring mental health difficulty.[19] Similarly, according to Public Health England (2016a), "an estimated 44% of community mental health patients have reported problem drug use or harmful alcohol use in the previous year".[20]

Healthy Lifestyles Service level data

Weight management

The current service does not classify the service users by the disability category as a whole; however, the 'learning disabilities' and 'mental health' categories were used. The three years of service data - 2019/20, 2020/21 and 2021/22 - have some limitations, due to the impact of the pandemic and due to service adaptations, and therefore should be interpreted with caution.

People with self-reported mental health problems made up between 21% and 24% of all service users who completed the Sliming World weight management support offer between 2019/20 and 2021/22. This proportion was slightly higher for people accessing HLS weight management support, between 26% and 32%. The outcomes achieved by people with self-reported mental health problems are similar to those achieved by the general population.

There is only one year of data including people with a learning disability accessing Slimming World, these made up

[18] Substance misuse in people with learning disabilities: reasonable adjustments guidance - GOV.UK (www.gov.uk)
[19] Better care for people with co-occurring mental health and alcohol and drug use conditions (publishing.service.gov.uk)
[20] Health matters: harmful drinking and alcohol dependence - GOV.UK (www.gov.uk)

	5% of all service users, with people achieving a positive outcome at a slightly lower rate compared with all service users. Those who accessed the HLS weight management service made up 4% service users and a higher proportion achieved the weight loss than all service users. ***Smoking*** Around 20% of people accessing the smoking cessation service during the past three years had self-reported mental health problems, with lower rates achieving the 4 week quit rate, as compared with overall service users. The numbers of people with learning disability accessing the smoking cessation service for each year are relatively small, between 1% and 3 % of all service users. The proportion of achieving a 4 week quit is lower than among all clients. ***Alcohol*** The proportion of service users a with mental health problem being supported with to manage alcohol use has been increasing, from 17% in 2019/20 to 29% in 2021/22; with positive outcomes achieved by similar or slightly higher proportion as compared with all service users. Fewer than 5 people with learning disability accessed alcohol support service during the three years of service. ***Physical activity*** The proportion of service users with self-reported mental health issues accessing physical activity support has been increasing from 22% to 32% in the recent year. Similar or higher proportion of people with mental health issues achieved the positive outcome. Between 3% and 4% of people with learning disability accessed the physical activity support and achieved higher than 'all service user' positive outcome. **<u>Promoting good relations</u>** The available data indicate that more needs to be done to explore and improve access, experience and outcomes regarding healthy lifestyles support for people with disabilities. The Provider will be expected to actively seek out and take into consideration the views and specific needs relating to service access and provision for people with disabilities. This will particularly focus on the needs of those groups identified above that have the highest prevalence of unhealthy lifestyles behaviours. The proposed removal of the universal weight management on referral offer will potentially have a negative impact on people with disabilities and / or mental health conditions who could have benefited from this service. The	

	consultation will seek the views of representatives from these groups including how to best promote the NHS weight management offers to them, and to understand any remaining gaps and how these might be addressed. **Advance equality of opportunity** The Provider, throughout the contract, will be held to account to engage and work in partnership with community groups/stakeholders that represent or work with people with disabilities in the county. **Eliminate discrimination** There is a lack of data understanding of the four healthy lifestyle behaviours: weight management, smoking, alcohol and physical activity among people with physical disability, and there is no information about their access to the services supporting these behaviours. Planned consultation will include the physical disability group and the provider will ensure this group has equal access and the future service will be expected to record physical disability to enable monitoring of access, experience and outcomes and take necessary action where avoidable disparities exist. The proportion of people with mental health problems accessing the healthy lifestyle services is increasing, however people with poor mental health are more likely to experience the negative impact for all four behaviours. The engagement exercise undertaken earlier in 2022 identified that mental health issues and feelings of loneliness can make it challenging for those who want to improve lifestyles or seek support to do so. In addition, accessibility to services can be an issue for those living with a physical or learning disability. The consultation will seek the views and experiences of people with poor mental health and physical disabilities to understand what action needs to be taken to ensure good access, experience and outcomes. Data indicate that people with a learning disability are more likely to engage in unhealthy lifestyle behaviours but access the current service in low numbers. The consultation will include this group to explore the reasons for any disparities and how these may be overcome. Any new service will be available to all adults regardless of disability and will be expected to maintain accurate records to enable monitoring of access, experience and outcomes and take necessary action where avoidable disparities exist.	
Gender	**Challenge:**	No

	Weight management In Gloucestershire, in 2020/21, 25% of adults (18+) were classified as living with obesity and 64.9% as having excess weight (overweight or obesity); both values were similar to England averages (respectively 25.3% and 63.5%). On a national level, in 2020/21, excess weight was nearly 10 percentage points higher for males than for females - 68.5% of men and 58.3% of women were classed as having an excess weight (overweight or obesity).[21] According to the 2019 national analysis, being overweight but not having obesity was more common among men than women. However, obesity (including morbid obesity) was more common in women than men.[22] **Smoking** Most recent data for 2020/21 indicates that the smoking prevalence in adults 15+ in Gloucestershire was 14.5% which is statistically better than the England average of 15.9% (QOF data). The smoking prevalence in adults 18+, in 2020/21 in Gloucestershire was 12.6%, which is also statistically better than the England average of 14.4%.[23] The split of smoking prevalence by gender is based on the 2019 data, which indicates that, more men (15.9%) smoked than women (12.5%), which is consistent with the previous years. The proportion of all deaths in England for adults 35 and over, which were estimated to be attributable to smoking was higher for male than female (e.g. cancers which can be caused by smoking: 59% - male, 43% - female)[24] **Alcohol** Consistent with previous years, the UK rate of alcohol-specific deaths for males in 2020 remained more than double the rate for females (19.0 and 9.2 deaths per 100,000 people respectively, registered in 2020).[25] According to the Health Survey for England 2019 [26] • A higher proportion of men than women drank alcohol in 2019 (83% and 78% respectively), with 55% of men and 41% of women drinking alcohol at least once a week • 17% of men do not drink alcohol compared to 22% of women • 53% of men and 62% of women drank at levels that put them at lower risk of alcohol-related harm • 30% of men drink more than 14 units of alcohol per week compared to 15% of women • 8% of men reported drinking alcohol almost every day compared to 5% of women • 19% of men report binge drinking in the last week compared to 12% of women. • 25% of males are drinking at increased or high risk levels compared to 12% of females • Among those adults that drank alcohol the average (mean) amount drunk was 15.7 units of alcohol for men and 8.7units for women, in a typical week	identified significant impact

[21] Obesity Profile, OHID, https://fingertips.phe.org.uk/national-child-measurement-programme#page/7/gid/1938133368/pat/159/par/K02000001/ati/15/are/E92000001/iid/93088/age/168/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1/page-options/ine-pt-1_ine-vo-0_ine-yo-1:2020.-1:-1_ine-ct-25

[22] Statistics on Obesity, Physical Activity and Diet, England, 2019, https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-obesity-physical-activity-and-diet/statistics-on-obesity-physical-activity-and-diet-england-2019/part-3-adult-obesity

[23] Local Tobacco Control Profiles, https://fingertips.phe.org.uk/profile/tobacco-control/data#page/1/gid/1938132696/pat/6/par/E12000004/ati/102/are/E10000013

[24] Smoking Statistics, May 2021, ASH, https://ash.org.uk/resources/view/smoking-statistics

[25] Alcohol-specific deaths in the UK registered in 2020, ONS, Alcohol-specific deaths in the UK - Office for National Statistics (ons.gov.uk)

[26] Health Survey for England 2019, Adult health related behaviours (digital.nhs.uk)

Gloucestershire hospital admissions for 2020/21:[27]

- Admission episodes for alcohol-related conditions (narrow) rate was 556 per 100,000 for male and 291 for female; both rates are statistically better than England average.
- Admission episodes for alcohol-related conditions (broad) rate was 1,917 per 100,000 for male and 683 for female; both rates are statistically better than England average.
- Admission episodes for alcohol-specific conditions was 713 per 100,000 for male and 366 for female; male's rate is better than England average and female's rate is similar to the England average.

Physical Activity

Men are more likely to be physically active than women. Nationally, in 2020/21, 63% of men and 60% of women undertook the recommended amount of physical activity per week (for 16+). Locally, these proportion were slightly higher, with 66% of men and 62% of women undertaking the recommended amount of physical activity.[28]

The gap in the levels of physical activity between genders is more prominent in younger population. In Gloucestershire, 51% of boys and 41% of girls reported doing the recommended amount of exercise in 2020.[29] Since 2012 the gap between the sexes has been reducing from 15.7 percentage points in 2012 to 10 percentage points in 2020. This is due to increase of the levels of exercise in girls and young women, and a significant drop in the level of exercise in boys and young men during that period. Although the levels of exercise increase at the similar rate for both sexes at the primary school, the females exercise level declines steadily during secondary school, whereas male exercise levels continue to increase into the early years at secondary school, and as they get older the decline is much less pronounced.[30]

<u>Healthy Lifestyles Service level data:</u>

The three years of service data - 2019/20, 2020/21 and 2021/22 - have some limitations, due to the impact of the pandemic and service adaptations, and therefore should be interpreted with caution.

Weight management

Men are underrepresented across the weight management service offers but those men accessing the Slimming World achieve better outcomes. Across both HLS and Slimming World weight management support, females made up the overwhelming majority of service users: 83%-87% of Slimming World were females, 61%-62% for HLS weight management. The specified weight loss outcomes were achieved by a lower proportion of females than males accessing Slimming World and higher proportion for females accessing HLS weight management.

[27] Local Alcohol Profiles for England, Gloucestershire - Local Alcohol Profiles for England - OHID (phe.org.uk)
[28] Active Lives Adult Survey 2020, Active Lives data tables | Sport England
[29] Gloucestershire Pupil Wellbeing Survey 2020, pupil-wellbeing-survey-2020-headline-report.pdf (gloucestershire.gov.uk)
[30] Exercise Children & young people, Gloucestershire County Council, 2021, exercise-children-young-people-2021.pdf (gloucestershire.gov.uk)

	Smoking Over the past three years the proportion of females accessing smoking cessation service increased from 58% to 63%; consequently, the males proportion decreased. Lower numbers of females achieved a 4 week quit rate, compared with males. ***Alcohol*** More males than females were supported with alcohol use problems (55% of males for the last two years). The achieved positive outcomes ranged between 69% to 80% for males, and 78% to 86% for females. ***Physical activity*** Females were more likely to access physical activity support than males; only 39% of service users were males. The proportion of achieving a positive outcome was similar for both genders, ranging between 73% and 78% for females and 72% and 80% for males. **Promoting good relations** The Provider will be expected to actively seek out and take into consideration the views and specific needs relating to service access and provision for both genders but particularly men. The proposed removal of the universal weight management on referral offer will potentially have the greatest impact on women who currently make up the overwhelming majority of service users. The consultation will seek the views of women from the age groups that are most likely to access this offer including how to best promote the NHS weight management offers to them, and to understand any remaining gaps. **Eliminate discrimination** There are prominent gender disparities across all healthy behaviours; with more males experiencing unhealthy behaviours in smoking, alcohol and weight status and females having lower levels of physical activity. This is reflected in the proportion of genders accessing the alcohol and physical activity support. However, the weight management and smoking support provided is disproportionate to the prevalence, accessed by a higher proportion of females. Planned consultation will include to seek views and experiences of both genders with a particular focus on men regarding weight management and smoking. Any new service will be available to all adults regardless of gender and will be expected to maintain accurate records to enable monitoring of access, experience and outcomes and take necessary action where avoidable disparities exist.	

Race	**Challenge:** There is no local data on adults' health behaviours by ethnicity, so the information below is based on the nationally available research. **Weight management**: According to the national data, based on Active Lives Adult Survey (2020/21):[31] • Black adults were the most likely out of all ethnic groups have overweight or obesity (72%) • White British adults were also more likely than average have overweight or obesity (64.5%) • Adults from the Chinese ethnic group were the least likely out of all ethnic groups to have overweight or obesity (37.5%) • The percentage of adults in the Asian, White Other, Mixed and Other ethnic groups who have overweight or obesity was lower than the national average • The percentage of adults who had overweight or obesity was similar to 2015/16 in every ethnic group except White British, which saw an increase from 62.0% to 64.5%, and Black adults, which decreased from 73.6% to 72% Adults from south Asian ethnic groups have a higher risk of obesity-related health issues (e.g. type 2 diabetes) at a lower Body mass Index than other groups leading to a recommended threshold for treatment of BMI 27 rather than BMI 30. **Physical Activity:** According to the national data, based on Active Lives Adult Survey (2020/21):[32] • People from a mixed ethnic background were most likely to be physically active out of all ethnic groups (68.0%), followed by people from the White 'other' ethnic group (65.0%) – this has remained consistent for the last 6 years • People from the Asian ethnic group were less likely than average to be physically active – this has remained consistent for the last 6 years • In the Asian and White British ethnic groups, men were more likely to be active than women • The percentages of physically active people in the Asian, black, 'other' and Chinese ethnic groups were lower than the national average (61.4%), ranging from 50.4% to 57.8%. According to the Gloucestershire Pupils Wellbeing Survey 2020, 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 identified significant impact

[31] Obesity profile, Ol

[32] Ethnicity facts and figures, Physical activity, Physical activity - GOV.UK Ethnicity facts and figures (ethnicity-facts-figures.service.gov.uk)

no exercise.[33]

Smoking:
According to the national data, based on Annual Population Survey (2020):[34]

- The percentage of adults who smoked was higher than average (12.1%) in the Mixed (17.1%) and White (12.6%) ethnic groups
- It was lower than average in the Chinese (4.3%), Asian (7.0%) and Black (7.8%) ethnic groups
- From 2012 to 2020, the percentage of White adults who smoked went down from 20.1% to 12.6%
- The percentage of Black adults who smoked went down from 13.0% to 7.8% and the percentage of Asian adults who smoked went down from 10.8% to 7.0%
- When looking at country of birth, the percentage of adults who smoke was highest for people born in Poland (20.1%); for other countries this proportion was similar or lower than the average[35].

Alcohol:
Nationally, the patterns of drinking alcohol differ markedly between ethnic groups.
According to the Health Survey for England 2011-2019 analysis:[36]

- Bangladeshi and Pakistani men and women were less likely to drink than those from other backgrounds
- Men and women from all white backgrounds were most likely to have drunk alcohol in the past 12 months
- Drinking at least once a week was most common among white British and white Irish men and women and least common among Pakistani and Bangladeshi men and women

<u>Service level data</u>
Due to small numbers of people from ethnic minority groups accessing the Healthy lifestyle support services, the analysis below is based on the three years of pooled data.

Weight management
Of those who accessed the Slimming World services, 'White British' made up the highest proportion (90%), followed by 'White Other' (2%). 'Black or Black British Caribbean', 'White Irish' and 'Mixed White and Black Caribbean' accounted for 1% of all service users each. Out of those, the highest proportion achieving the specified weight loss was among 'White British' and the lowest among 'Black or Black Caribbean'.

There was a similar proportion of 'White British' who accessed the HLS weight management (90%). 'White Other',

[33] Exercise Children & young people, Gloucestershire County Council, 2021, exercise-and-the-young-people-2021.pdf (gloucestershire.gov.uk)
[34] Local Tobacco Control Profiles, Local Tobacco Control Profiles - OHID (phe.org.uk)
[35] Local Tobacco Control Profiles - OHID (phe.org.uk)
[36] Health Survey England Additional Analyses, Ethnicity and Health, 2011-2019 Experimental statistics, 2022, Drinking alcohol - NHS Digital

	‘Asian/ Asian British’, ‘Black African/Caribbean/Black British’ accounted for 2% of all service users each. There were no service users from ‘White Traveller’ ethnicity. The highest proportion achieving the positive outcome was among ‘other Ethnic Group’ and ‘Asian/ Asian British’ and lowest among ‘Mixed/Multiple Ethnic Group’ and ‘White Other’. A bespoke weight management offer has recently been coproduced with women from the South Asian community and has received very positive feedback. Scope to extend this approach to other ethnic minority groups will be explored. ***Physical activity*** Physical activity saw the highest proportion of ethnic minority groups, as compared with the other support offers, with White British accounting for 88% of all service users. Second highest numbers accessing the physical activity were ‘Asian/ Asian British’, followed up by ‘White Other’ and ‘Black African/Caribbean/Black British’. The highest proportion of those who achieved the positive outcomes was among ‘Asian/ Asian British’ and the lowest among ‘Other Ethnic Group’ and ‘White Other’. ***Smoking*** The majority of smoking cessation service users were ‘White British’ (90%), followed by ‘White Other’ (3%). The remaining ethnic groups accounted for 1% of all service users each, with exception of White Travellers and White Irish, who made up the lowest numbers. The proportion of those who achieved a 4 week quit date was similar across all ethnicities, with exception of ‘Black African/Caribbean/Black British’ who had a smaller proportion achieving a positive outcome. ***Alcohol*** Alcohol support saw the smallest proportion of ethnic minorities accessing the service. White British accounted for 94% of all service suers, with White Other being second highest of 2% service users (or 10 people over the past three years), which is in line with national (limited) research. **Promoting good relations** The Provider will be expected to actively seek out and take into consideration the views and specific needs relating to service access and provision for people from all ethnicities. This will particularly focus on the needs of those groups identified above that have the highest prevalence of unhealthy lifestyles behaviours or where data is not available.	

	The proposed removal of the universal weight management on referral offer will is unlikely to have a disproportionate negative impact on people by virtue of their race given the underrepresentation of ethnic minority groups within this service. However, the consultation will seek the views of representatives from ethnic minority groups including how to best promote the NHS weight management offers to them, and to understand any remaining gaps. Scope to extend the approach taken with South Asian women to coproduce bespoke weight managements offers with other ethnic minority groups will be explored. **Advance equality of opportunity** The Provider, throughout the contract, will be expected to engage and work in partnership with community groups/stakeholders that represent or work with people from different ethnicities in the county. **Eliminate discrimination** Health disparities between ethnicities vary by healthy behaviours. In general, Black, and White British adults are more likely to be affected by weight status, with White British being the only ethnicity where the proportion of those that have overweight, or obesity is increasing. Asian, black, 'other' and Chinese adults are less active. 'Mixed' and White ethnicities are most likely to smoke and 'White British' most likely to misuse alcohol. 'White British' account for the highest proportion of all service users accessing support. Whilst this is expected given Gloucestershire's ethnic structure (91.6% of White British - based on the 2011 Census) and the prevalence of unhealthy behaviours in this population, there is only 1-2% of people from non-white ethnicities using the service which is not reflective of the ethnicity structure based on 2011 data. The consultation will seek views and experiences from different ethnic groups to better understand the barriers and enablers to accessing lifestyle support. The 2021 census is currently being analysed and the Ethnicity section will be revisited once the results are published to understand if those accessing the service is representative of the county's current ethnic composition. The engagement exercise undertaken earlier in 2022 identified the need for services to have a better understanding of cultural and religious health needs to ensure people feel that services are appropriate and welcoming to them. Feedback also cited that language barriers and a lack of interpreters can make services inaccessible to some people.	

	The consultation will seek the views of all ethnic minorities to understand what action needs to be taken to ensure good access, experience and outcomes. The new service will be available to all adults regardless of ethnicity.	
Gender reassignment	**Challenge:** **Weight management, physical activity and smoking** There is no national or local data on these behaviours among transgender and non-binary people and there has been very little research on these subjects. **Alcohol** The UK-based research is lacking in accurate information on alcohol use by trans and non-binary people. Some national studies show that there is high and excess prevalence of substance misuse among transgender compared with cisgender people, but insufficient evidence to estimate prevalence or quantify the risk for substance use.[37] Non-binary people often face discrimination, stigma, escalating hate crimes - these experiences, alongside a perceived or actual need to conceal their identity can sometimes lead to excessive alcohol use. **Service level data is not available for this group.** **Eliminate discrimination** There is a lack of robust research on healthy behaviours among transgender people. However, Stonewall data show that 40% face difficulties accessing healthcare because they are trans; 16% have been refused care and 37% avoided treatment for fear of discrimination.[38] The consultation will actively seek to engage with trans and non-binary communities and aim to elicit further information from this group, including previous experiences and views on any possible impact of the proposal and ways in which this impact could be mitigated. Any new service will be available to those adults that have undergone gender reassignment.	No identified significant impact
Marriage & civil partnership	**Challenge:** **Weight management, physical activity, smoking and alcohol use** There is no national or local data on these behaviours among those that are married or in a civil partnership and there has been a very little research on these subjects **Service level data is not available for this group.**	No identified significant impact

[37] Prevalence and correlates of substance use among transgender adults: A systematic review - ScienceDirect
[38] lgbt_in_britain_health.pdf (stonewall.org.uk)

	Eliminate discrimination All services are currently available regardless of marital status. It is not envisaged that targeted consultation based on marital status is needed. Any new service will be available to all adults including those that are married are in a civil partnership.	
Pregnancy & maternity	**Challenge:** **Weight management** Gloucestershire prevalence of obesity in early pregnancy in 2018/19 was 16%, which is better than the national prevalence of 22.1%. Pregnant women who live with obesity are at greater risk of a variety of pregnancy-related complications compared with women of normal BMI, including pre-eclampsia and gestational diabetes. They are also at increased risk of caesarean birth. Obesity is associated with low breastfeeding initiation and maintenance rates. The 2015 UK review into maternal deaths, reported that 30% of women who died were living with obesity and 22% with overweight.[39] **Physical activity** There is no national and local data on the levels of physical activity undertaken among pregnant women. Physical activity guidelines for pregnant women highlight the benefits of exercise during pregnancy, such as reduction in hypertensive disorders; improved cardiorespiratory fitness; lower gestational weight gain; and reduction in risk of gestational diabetes. The benefits of physical activity in the postpartum period (up to one year) were identified as a reduction in depression; improved emotional wellbeing; improved physical conditioning; and reduction in postpartum weight gain and a faster return to pre-pregnancy weight.[40] **Smoking** Gloucestershire's prevalence of smoking in early pregnancy (2018/19) was 11.4%, which is better than the national prevalence of 12.8%. However, the local smoking status at time of delivery data (2020/21), was worse than the England average (10.9% v 9.6%). Although the England rate has been decreasing, the local rate has remained relatively static over recent years.	No identified significant impact

[39] Royal College of Obstetricians & Gynaecologists, 2018, Care of Women with Obesity in Pregnancy (wiley.com)

[40] UK Chief Medical Officers' Physical Activity Guidelines (publishing.service.gov.uk)

Smoking during pregnancy can cause serious pregnancy-related health problems. These include complications during labour and an increased risk of miscarriage, premature birth, low birth-weight and sudden unexpected death in infancy.[41]

Alcohol
There is no national and local data on the alcohol misuse among pregnant women.

The Chief Medical Officers' guideline for pregnant women or women thinking about becoming pregnant highlights that the best approach is for these women to not drink alcohol at all, to minimise the risk for the baby. Alcohol can have a wide range of differing impacts on the foetus. These include a range of lifelong conditions, known under the umbrella term of 'foetal alcohol spectrum disorders' (FASD). The severity and nature of this are linked to the amount drunk and the developmental stage of the foetus at the time. Drinking heavily during pregnancy can cause a baby to develop foetal alcohol syndrome (FAS). FAS is a serious condition, in which children have: restricted growth; facial abnormalities; learning and behavioural disorders. Whilst FASD is less severe than FAS, it can result in physical, mental and behavioural problems including learning disabilities which can have lifelong effects. The risks of low birth weight, preterm birth, and being small for gestational age may all be increased in mothers drinking above 1-2 units/day during pregnancy.[42]

Service level data
Due to small numbers of pregnant women accessing the healthy lifestyle services, the below analysis is based on the three years of pooled data, with the exception of smoking services.

Weight management
Across Slimming World and HLS Weight Management pregnant women accounted for 2% of all service users. However, it is not recommended that pregnant women lose weight, therefore the support provided is to help pregnant women maintain their weight (until the 3rd trimester) and eat a balanced diet.

Physical activity
3% of all service users accessing physical activity support were pregnant women. A much smaller proportion of pregnant women achieved a positive outcome, compared with all service users.

Smoking
Smoking cessation services saw the highest proportion of pregnant women access support compared with other behaviours, with the highest proportion (18%) of all clients accessing support for smoking being pregnant in

[41] Statistics on Women's Smoking Status at Time of Delivery: England 2022 - Introduction - NHS Digital

[42] UK Chief Medical Officers' Low Risk Drinking Guidelines (publishing.service.gov.uk)

	2021/22. A higher proportion of pregnant women achieved a 4 week quit date, compared to all smokers. In 2021/22, 278 pregnant women were supported to stop smoking with 78% achieving a 4 week quit. ***Alcohol,*** According to the service data, no pregnant women accessed the service for support with their alcohol use. **Promoting good relations** The Provider will be expected to actively seek out and take into consideration the views and specific needs relating to service access and provision for pregnant women. The proposed removal of the universal weight management on referral offer is unlikely to have a disproportionate negative impact pregnant women given the extremely low numbers accessing the service. However, it is envisaged that the remodelled healthy lifestyles service will continue to provide targeted lifestyles support to pregnant women as part of the 'First 1001 Days' offer. **Advance equality of opportunity** The Provider, throughout the contract, will be expected to engage and work in partnership with community groups/stakeholders that represent or work with pregnant women. **Eliminate discrimination** Pregnant women are well represented in the smoking cessation support service and achieving better outcomes than all service users. However, the national data indicates that Gloucestershire needs to improve its smoking status at the time of delivery rate. Although support to increase physical activity has been accessed by pregnant women, the positive outcomes are much lower than expected. The consultation will include pregnant women and explore the barriers and enablers for them in undertaking lifestyle behaviour changes. Any new service will be available to all adults including pregnant women.	
Religion and/or belief	**Challenge** **Weight management** There is no national or local data on the weight status among different religions and there has been a very little research on this subject. **Physical activity** According to 2019/20 Active Life Adult data tables, people identifying as 'No religion' were the most likely to be	No identified significant impact

	active (150+ minutes a week) (66.6%), followed by Buddhists (64.3% - however the confidence intervals were wide, due to small numbers), and by Christians (61.5%). The lowest levels of being physically active were among Muslims (44.5%), Sikh (50.1%, with wide confidence intervals), and Hindu (54.2%, with wide confidence intervals).[43] **Smoking** According to the ONS, data from the UK Household Longitudinal Study for 2016 and 2018 show that smoking prevalence was significantly higher among those identifying as having no religion (18%) or Buddhist (17%) than those who identified as Muslim (11%), Christian (11%), Hindu (5%), Jewish (4%), Sikh (2%), or with "any other religion" (9%).[44] **Alcohol** There is no national or local data on the alcohol misuse among different religions and there has been a very little research on that subject **Religion data has not been collected by the service.** **Promoting good relations** The Provider will be expected to actively seek out and take into consideration the views and specific needs relating to service access and provision for people from all religions. This will particularly focus on the needs of those groups identified above that have the highest prevalence of unhealthy lifestyles behaviours or where data is not available. **Advance equality of opportunity** The Provider, throughout the contract, will be expected to engage and work in partnership with community groups/stakeholders that represent or work with people different religious groups in the county. **Eliminate discrimination** Any new service will be available to all adults regardless of religion or belief. The consultation will aim to elicit further information from this group, including previous experiences and views on any possible impact of the proposal and ways in which this impact could be mitigated.	
Sexual	**Challenge**	No

[43] Active Lives Adult Nov 20-21 Tables 1-5 Levels of activity.xlsx

[44] 2020 Religion and health in England and Wales - Office for National Statistics (ons.gov.uk)

orientation	**Weight management** The 2021 NHS digital report on health outcomes and behaviours of lesbian, gay and bisexual (LGB) adults, found that between 2011 and 2018 a lower proportion of LGBT adults were overweight or obese (51%) than heterosexual adults (63%). When further stratified by sex, heterosexual men were more likely to be either overweight or obese (67%) than gay or bisexual men (49%), while the proportions among women were 58% of heterosexual women being overweight or obese compared with 53% of LGB women.[45] **Physical activity** According to the national Active Adult Survey 2020-21, Gay or Lesbians were more likely to be physically active (150+ minutes a week) (67.9%), followed by Bisexual people (65.8%), with lowest proportion among 'Heterosexual or Straight' (62.1%).[46] According to the Gloucestershire Pupils Wellbeing Survey 2020, young people who identified as non-heterosexual or transgender reported the lowest activity levels, significantly lower than the average but also lower than all other vulnerable groups (such as those reporting a disability, known to social care, Young carer, SEN/EHCP).[47] **Smoking** According to the 2021 NHS digital report on health outcomes and behaviours of lesbian, gay and bisexual (LGB) adults, the proportion of current smokers between 2011 and 2018 was higher among LGB adults (27%) than among heterosexual adults (18%). There were different patterns of variation between sex and sexual orientation in cigarette smoking status. The proportion of LGB women who were current smokers was 31% and the proportion of heterosexual women who were current smokers was 16%, while the proportion of gay or bisexual men and heterosexual men who were current smokers was 24% and 20% respectively. The proportion of all adults who were heavy smokers (20 or more cigarettes per day) was higher among LGB adults compared to heterosexual adults, with 5% of LGB adults being heavy smokers compared with 3% of heterosexual adults. [48] **Alcohol** According to the 2021 NHS digital report on health outcomes and behaviours of lesbian, gay and bisexual (LGB) adults, the proportion of LGB adults who drank to a level of increased risk or higher risk (32%) was higher than the proportion of heterosexuals adults who did the same (24%). The mean number of units of alcohol consumed weekly by LGB adults was also higher compared to heterosexual adults (17.7 units and 12.7 units respectively).[49]	identified significant impact

[45] Health and health-related behaviours of Lesbian, Gay and Bisexual adults (digital.nhs.uk)
[46] Active Lives Adult NOV20-21 Tables 1-3 Levels of activity.xlsx
[47] Exercise Children & Young People, Gloucestershire County Council, 2021, exercise-children-young-people(2021.pdf (gloucestershire.gov.uk)
[48] Health and health-related behaviours of Lesbian, Gay and Bisexual adults (digital.nhs.uk)
[49] Health and health-related behaviours of Lesbian, Gay and Bisexual adults (digital.nhs.uk)

	Sexual orientation data has not been collected by the service. **Promoting good relations** The Provider will be expected to actively seek out and take into consideration the views and specific needs relating to service access and provision for people with different sexual orientations. This will particularly focus on the needs of those groups identified above that have the highest prevalence of unhealthy lifestyles behaviours or where data is not available. **Advance equality of opportunity** The Provider, throughout the contract, will be expected to engage and work in partnership with community groups/stakeholders that represent or work with people from the LGBTQ+ community. **Eliminate discrimination** The planned consultation will actively seek to engage with the LGBTQ+ community and aim to elicit further information from this group, including previous experiences of accessing services views on any possible impact of the proposal and ways in which this impact could be mitigated. Any new service will be available to all adults regardless of sexual orientation.	

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

Increased engagement with current service users	To ensure more regular engagement with people who receive the service is ongoing throughout the remainder of the current contract to inform future service model
Ensure that the consultation provides opportunities for those protected characteristics where the EIA has identified there is little or no data, or where access is low, to participate	To ensure that the opinions and concerns of these groups is actively sought enabling any new service to be more responsive and receptive to their needs

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	Communication Plan for Consultation with stakeholders, including service users and those working with or representing those with protected characteristics, will include approaches to understand the impact of proposed service changes and how these can be mitigated, and the challenges and opportunities associated with service uptake – including those issues identified by initial engagement feedback	January – March 2023	Tracy Marshall
Positive	Our market engagement will include information on protected characteristics and clearly set out the expectation that the provider will be required to work with these groups to increase access to support and improve outcomes.	Feb 2023	Tracy Marshall
Positive	Ensure any future service specification sets out clearly how GCC is required to work to promote equality and reduce health inequalities with due regard to the protected groups.	May 2023	Tracy Marshall

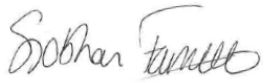
Positive	Throughout the contract term we will continue to engage with service users and wider stakeholders to understand if the service offer is meeting needs of those with protected characteristics	From April 2024	Tracy Marshall
Positive	Where appropriate include collection and reporting of protected characteristics for those accessing the new service	From April 2024	Tracy Marshall
Positive	Legal contracts to be developed flexibly so that provision can be adjusted in real time based on need.	May 2023	Tracy Marshall
Positive	Future service provider will be expected to consider accessibility and flexibility of its provision to all protected characteristic groups.	From April 2024	Tracy Marshall

6. Monitoring and review

The following processes/actions will be put in place to keep this 'activity' under review:
• This EIA will be reviewed and updated accordingly as the project moves forward. The project team will use this EIA to identify gaps in current service provision to ensure that the consultation includes representation from those groups where gaps have been identified. We will use the EIA as a tool to assess whether we are appropriately and accurately considering the needs and inequalities for all individuals within the service we provide. We will also use the EIA to understand which groups are most likely to be affected by proposed service changes and to ensure that the consultation exercise explores potential impacts and mitigations. • Following the procurement and implementation of our new service regular contract monitoring including service user satisfaction surveys will be used to monitor provider compliance, uptake and outcomes across protected characteristics (as applicable and practical), and service user satisfaction. This information will be used to inform continuous quality improvement and future commissioning. Performance will be monitored 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	24.11.22

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. Mark Hawthorne – Leader of the Council
Date	24.11.22

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

Protected Characteristic	Service User Data and Information
Age *percentage/profile of service user ages*	All information below has been taken from the Gloucestershire County Council ***Population Profile 2022***[50] In 2020, the resident population of Gloucestershire was estimated to be 640,650 people of which: • 22.3% were aged 0-19; • 55.9% were aged 20-64; • 21.8% were aged 65 and over. Gloucestershire has a lower proportion of 0–19-year-olds and 20-64 year olds and a higher proportion of people aged 65+ when compared to England. There is some variation at district level: At 24.5%, Gloucester has the highest proportion of children and young people (aged 0- 19) and exceeds the county and national figures. • Gloucester has the highest proportion of people aged 20-64 (58.4%), exceeding the county and national figures. • Cotswold, the Forest of Dean, Stroud and Tewkesbury all have a higher proportion of people aged 65+ when compared to the county and national figures. At 26.2% Cotswold has the largest proportion of people aged 65 and over. Gloucestershire's population has increased by approximately 46,553 people or 7.8% between 2010 and 2020. The percentage increase is higher than the increase experienced in both the South West (7.6%), and England (7.4%). During this period the number of children and young people in Gloucestershire increased by 5,802 people or 4.2%; this compares with an increase in England in this age group of 5.2%. Gloucestershire's working age population increased by 11,257 people or 3.2%; this was lower than the national increase of 4.3%. The greatest growth was in the 65+ age group which increased by 26.8% or 29,494 people; this growth was higher than the national percentage increase of 22.2%.

[50] equality-profile-2022-v2.pdf (gloucestershire.gov.uk)

<table>
<tr><td></td><td>There is considerable variation at district level:
• Tewkesbury had a faster growth rate in the children/young people age group (18.8%) compared with England, whilst the Forest of Dean experienced a decline in the number children/young people (-1.3%).
• Tewkesbury and Gloucester experienced a faster growth rate in the working age group (14.1% and 4.6% respectively) than in England, whilst Cheltenham experienced a decline in this age group (-4.5%).
• All districts saw an increase in the 65+ age group. Growth was highest in Tewkesbury (30.9%), and all districts saw a larger percentage increase than England (22.2%), apart from Cheltenham where the rate was lower (20.2%).

On current trends, the latest ONS 2018-based interim projections suggest that Gloucestershire's population will increase by 104,924 people or 16.6% to around 738,482 in 2043. This compares to a projected national increase of 10.3%.</td></tr>
<tr><td>Sex
percentage/profile of service users who are male and who are female</td><td>All information below has been taken from the Gloucestershire County Council Population Profile 2022[51]

The overall population split by sex in Gloucestershire is slightly skewed towards females, with males making up 49.0% of the population and females accounting for 51.0%. This situation is also reflected at district, regional and national level.

Population by sex, Gloucestershire 2020:
<table><tr><th></th><th colspan="2">% of population</th></tr><tr><th></th><th>male</th><th>female</th></tr><tr><td>Cheltenham</td><td>49.3</td><td>50.7</td></tr><tr><td>Cotswold</td><td>48.4</td><td>51.6</td></tr><tr><td>Forest of Dean</td><td>49.1</td><td>50.9</td></tr><tr><td>Gloucester</td><td>49.5</td><td>50.5</td></tr><tr><td>Stroud</td><td>49.1</td><td>50.9</td></tr><tr><td>Tewkesbury</td><td>48.7</td><td>51.3</td></tr><tr><td>Gloucestershire</td><td>49.0</td><td>51.0</td></tr><tr><td>England</td><td>49.5</td><td>50.5</td></tr></table></td></tr>
</table>

[51] equality-profile-2022-v2.pdf (gloucestershire.gov.uk)

	Although there are slightly more males than females in the 0-19 year old age band, as age increases, females outnumber males by an increasing margin. In Gloucestershire in 2020, 52.8% of people aged 65-84 were female, whilst for people aged 85+ the difference was more marked with females accounting for 63.4% of the total population; this difference is observed at district, regional and national level. As a result of this, 71% of single pensioner households are shown to be headed by a woman. However, the proportion of men in the older population is increasing as the life expectancy of men increases; thus amongst the population aged 85 and over in Gloucestershire, the proportion of men increased from 31.0% in 2010 to 36.6% in 2020.
Disability *percentage/profile of service users who have a disability*	All information below has been taken from the Gloucestershire County Council ***Population Profile 2022***[52] According to the 2022 Gloucestershire County Council Population Profile: • 16.7% of Gloucestershire residents reported having a long term limiting health problem, this was below the national figure. • 24.2% of households had at least one person with a long-term limiting health problem or disability; this was slightly lower than the national figure • the Forest of Dean had the highest proportion of residents reporting a long term limiting health problem at 19.6% of the total population, and was the only district that exceeded the national figure • As age increases the proportion of respondents reporting a limiting long term health problem increases. In Gloucestershire 18.3% of people aged 50-64 reported a limiting long term health problem, this increased to 49.0% of respondents for the 65+ age group. A similar picture is observed at district, regional and national level • Dementia is one of the major causes of disability in older people. Estimated projections suggest that in 2022 there will be approximately 10,320 people aged 65+ living with dementia in Gloucestershire. • Estimated projections suggest that in 2022 there will be approximately 12,194 people aged 18+ living with a learning disability in Gloucestershire equating to 2.3% of the adult population • In 2020/21 Gloucestershire GPs recorded that 0.6% of their registered patients were known to have a learning disability; this was higher than the England figure of 0.5%. In 2021, 1.4% of people aged 16+ who completed the GP patient survey in Gloucestershire, reported that they had a learning disability; this was lower than the England figure. This discrepancy may be due to under-reporting amongst GPs of people who have mild learning disabilities • In 2021 approximately 1.2% of the 16+ population in Gloucestershire reported blindness or partial sight. During the same period 5.9% of the population aged 16+ reported deafness or hearing loss.[53]

[52] equality-profile-2022-v2.pdf (gloucestershire.gov.uk)

[53] equality-profile-2022-v2.pdf (gloucestershire.gov.uk)

	The Office for Health Improvement and Disparities (OHID estimates that in Gloucestershire 14.6% of those aged 16+ have a common mental health disorder compared to 16.9% for England. For those aged 65+ the figures are 11.5% and 12.3% respectively. In 2020/21, the recorded prevalence for depression (18+) was 11.5% in Gloucestershire compared to 12.3% in England. Given the ageing population, the number of people with a limiting long term health problem is likely to increase in the future.
Race *percentage/profile of service users who are from black and minority ethnic backgrounds*	<u>All information below has been taken from the Gloucestershire County Council ***Population Profile 2022***[54]</u> The 2011 Census found that 7.7% of Gloucestershire residents (46,100 people) were born outside the UK compared with a national figure of 13.4%; of this group, 40.8% were born in another European country and 22.3% were born in the Middle East or Asia. More recent estimates suggest that in 2020/21, 7.6% of Gloucestershire residents were born in another country. With regards to ethnic origin, the 2011 Census found that 91.6% of Gloucestershire residents were White British, 2.1% were Asian/Asian British, 1.5% were from a Mixed/Multiple Ethnic group, 0.9% were Black/Black British, 0.6% were White Irish, 0.1% were of Gypsy or Irish Traveller origin, 3.1% were in an 'other White' category and 0.2% were in another ethnic group. Some 36% of the people who were not White British were born in the UK. The 2011 Census found that overall, 4.6% of the population in Gloucestershire was from Black and Minority Ethnic (BME) backgrounds; this figure increased to 8.4% when the Irish, Gypsy or Irish Traveller and 'other White' categories were included. The proportion of people from Black and Minority Ethnic backgrounds was considerably lower than the national figure of 14.6%. At district level: • Gloucester had the highest proportion of people from Black and Ethnic Minorities, at 10.9% of the total population. However, this is still considerably lower than the national figure. • Cheltenham also had a higher proportion of people from Black and Ethnic Minorities (5.7%) than the county-wide figure • Forest of Dean had the lowest proportion of people from a Black and Ethnic Minority, at 1.5% of the total population. • The proportion of people that were classified as 'other White' was higher in Cheltenham than Gloucestershire and England as a whole (5.0% compared with 3.1% for Gloucestershire and 4.6% for England).

[54] equality-profile-2022-v2.pdf (gloucestershire.gov.uk)

• 42% of people who were of Gypsy/Irish Traveller origin lived in Tewkesbury district.

At ward level: • Barton and Tredworth ward in Gloucester was the most ethnically diverse ward with 41.4% of its population from a Black and Minority Ethnic group and 10.3% from a white background other than White British.

Table: Population by ethnic group, Gloucestershire 2011 (% of population)

	Total Black and Ethnic Minority	Mixed/ Multiple Ethnic Group	Asian/ Asian British	Black/ African/ Caribbean / Black British	Other Ethnic Group	Total White	English/ Welsh/ Scottish/ Northern Irish/ British	Irish	Gypsy or Irish Traveller	Other White
Cheltenham	5.7	1.6	3.2	0.6	0.3	94.3	88.3	0.9	0.1	5.0
Cotswold	2.2	0.8	1.0	0.3	0.1	97.8	94.5	0.6	0.1	2.7
Forest of Dean	1.5	0.6	0.6	0.2	0.1	98.5	96.7	0.3	0.1	1.4
Gloucester	10.9	2.9	4.8	2.9	0.3	89.1	84.6	0.7	0.1	3.8
Stroud	2.1	1.1	0.7	0.2	0.1	97.9	94.9	0.5	0.1	2.4
Tewkesbury	2.5	0.9	1.1	0.3	0.1	97.5	94.0	0.6	0.4	2.6
Gloucestershire	**4.6**	**1.5**	**2.1**	**0.9**	**0.2**	**95.4**	**91.6**	**0.6**	**0.1**	**3.1**
England	14.6	2.3	7.8	3.5	1.0	85.4	79.8	1.0	0.1	4.6

Gloucestershire's 0-19 year old population is more diverse than other age groups. According to the 2011 Census around 7.6% of 0-19 year olds were from a Black and Minority Ethnic groups compared to 4.4% of 20-64 year olds and 1.4% of people aged 65+. This trend is reflected at a regional, national and district level.

According to the 2011 Census, 18,784 people in Gloucestershire (3.3% of the population) did not speak English as their main language. Amongst this group, Polish was the most common language (5,516 people), followed by Gujarati (1,065 people) and then a Chinese language (1,000 people). An EU language other than Polish was the main language of 5,993 people. At district level, Gloucester had the highest proportion of people who did not speak English as their main language (5.7%) followed by Cheltenham (5.3%). Some 82% of people, whose main language was not English, could speak English well or very well. Older people were less likely than younger people to be proficient in English; 29% of people aged 50 and over who did not speak English as a main language were not proficient in English compared with 17% of people aged under 50 who did not speak English as a main language

Marriage & civil partnership *percentage/profile of service users who are married or in a civil partnership*	All information below has been taken from the Gloucestershire County Council ***Population Profile 2022***[55] 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. Gloucestershire has a lower proportion of people who are single or separated when compared to the national figure. In contrast the proportion of people who are married, divorced or widowed exceeds the national figures. At district level: • Cheltenham has the highest proportion of single people (38.8%) and exceeds the county and national figures. In contrast 25.7% of people in Cotswold are single, which is below the county and national level. • Cotswold has the highest proportion of residents who are married at 54.9%, which is higher than the county and national figures. The lowest proportion was recorded in Cheltenham. The proportion of same-sex civil partnerships is fairly consistent across all districts. • Gloucester has the highest proportion of people who are separated and divorced. • Cotswold has the highest proportion of people who are widowed or a surviving partner of a same-sex civil partnership while Gloucester and Cheltenham have the lowest. This reflects the age structure of these districts. There is considerable variation in marital status between age groups. As you would expect, people aged 16-24 are the most likely to be single, while those aged 65+ are the most likely age group to be widowed or a surviving partner from a same sex civil partnership. Same sex civil partnerships are most common amongst 35-49 year olds, where they account for 0.4% of the total age group. The proportion of people that are married, separated or divorced increases with age, until 65+ when it begins to fall, to take into account the increasing proportion of people who have lost a partner. These trends are not unique to Gloucestershire, but are reflected at a regional, national and district level.
Religion and/or belief	All information below has been taken from the Gloucestershire County Council ***Population Profile 2022***[56]

[55] equality-profile-2022-v2.pdf (gloucestershire.gov.uk)
[56] equality-profile-2022-v2.pdf (gloucestershire.gov.uk)

percentage/profile of service users religious beliefs	According to the 2011 Census, 63.5% of residents in Gloucestershire were Christian, making it the most common religion. This was followed by no religion which accounts for 26.7% of the total population. Gloucestershire has a higher proportion of people who are Christian, follow an "Other Religion", have no religion or have not stated a religion than the national figures. In contrast it has a lower proportion of people who follow a religion other than Christianity, which reflects the ethnic composition of the county. At district level: • Cheltenham had the lowest proportion of people who are Christian at 58.7% of the total population, this was lower than the county and marginally lower than the national figure. • Cotswold had the highest proportion of people who follow Christianity. • Cheltenham had the highest proportion of Buddhists, Hindus and people who have no religion. • At 3.2% of the total population Gloucester had the highest proportion of Muslims. • Stroud had the highest proportion of people who follow an "Other Religion" and of people who did not state their religion. Christianity is the most common religion across all age groups, however it is less common amongst those aged 0-19, with 55.7% of 0-19 year olds reporting they are Christian compared to 82.3% of those aged 65+. Those aged 0-19 are more likely to report no religion than older age groups. This trend is reflected at a regional, national and district level.
Gender reassignment *percentage/profile of service users who have indicated they are transgender*	All information below has been taken from the Gloucestershire County Council ***Population Profile 2022***[57] There are no official estimates of gender reassignment at either national or local level. There are also no data available in Gloucestershire around numbers of people who consider themselves to be non-binary (including other gender identities such as gender-fluid). In the 2021 Census there was a new question around gender, asking "is your gender the same as the sex you were registered at birth?" It was directed only at people aged 16 and over, and answers were voluntary. A separate, individual form could also be requested and submitted by any household member, should confidentiality be a concern. The results from the 2021 Census are yet to be published, however it is hoped that more accurate data around gender will help equality monitoring in the future. Currently the best estimates on gender reassignment come from the Gender Identity Research and Education Society (GIRES). GIRES estimates that there are approximately 650,000, 1% of the population in the UK, who are experiencing some degree of gender diversity. By applying the same proportion to Gloucestershire's 16+ population, we can estimate that there may be approximately 5,250 adults in the county who are experiencing some degree of gender diversity.

[57] equality-profile-2022-v2.pdf (gloucestershire.gov.uk)

<table>
<tr>
<td></td>
<td>Table: Estimates of gender diversity, 2020
<table>
<tr><th></th><th>Number of people</th><th>% of 16+ population</th></tr>
<tr><td>Cheltenham</td><td>950</td><td>1.0</td></tr>
<tr><td>Cotswold</td><td>750</td><td>1.0</td></tr>
<tr><td>Forest of Dean</td><td>730</td><td>1.0</td></tr>
<tr><td>Gloucester</td><td>1,040</td><td>1.0</td></tr>
<tr><td>Stroud</td><td>990</td><td>1.0</td></tr>
<tr><td>Tewkesbury</td><td>790</td><td>1.0</td></tr>
<tr><td>Gloucestershire</td><td>5,250</td><td>1.0</td></tr>
<tr><td>England</td><td>456,980</td><td>1.0</td></tr>
</table>
Note: Figures may not sum due to rounding

Numbers of people identifying as transgender across the country appear to be increasing. According to the LGBT Foundation, “an increasing number of trans people are accessing Gender Identity Clinics; it is unclear if this represents an increase in the trans population or an increasing proportion of the trans population accessing Gender Identity Services”. Presentation amongst younger people has also been growing (pre-pandemic) and could accelerate if young people feel increasingly able to reveal their gender variation.</td>
</tr>
<tr>
<td>Pregnancy & maternity
percentage/profile of service users who are female and who are pregnant or on a maternity leave</td>
<td>All information below has been taken from the Gloucestershire County Council Population Profile 2022[58]

There were 5,800 live births in Gloucestershire in 2020, which accounts for 1% of over 19 population. Table below shows the age of mothers at the delivery of their baby (in five year age bands), the highest proportion of deliveries were to women aged 30 to 34 continuing the trend of later motherhood. Births to mothers in all age bands between the ages of 25 and 44 account for a slightly higher proportion of total births in Gloucestershire than they do nationally, whilst those to mothers aged under 25 account for a lower proportion.</td>
</tr>
</table>

[58] equality-profile-2022-v2.pdf (gloucestershire.gov.uk)

	At district level: • Gloucester has a higher proportion of births to mothers aged under 20 (3.6%) than Gloucestershire and England. • Cheltenham, Cotswold and Stroud have a higher proportion of births to mothers aged 35+ than Gloucestershire and England
Sexual orientation *percentage/profile of service users who are lesbian, gay, bisexual, heterosexual*	All information below has been taken from the Gloucestershire County Council ***Population Profile 2022***[59] There are currently no definitive data on sexual orientation at a local or national level. In the 2021 Census there was a new question around sexual orientation, asking "which of the following best describes your sexual orientation?", and providing a list of options. It was directed only at people aged 16 and over, and answers were voluntary. A separate, individual form could also be requested and submitted by any household member, should confidentiality have been a concern. When the results of the 2021 Census are published, it is hoped that more accurate data around sexual orientation will help future equality monitoring. Estimates on sexual orientation used by the Department of Trade and Industry in 2003, and quoted by Stonewall, suggest around 5-7% of the population aged 16 and over are lesbian, gay or bisexual. If this figure were applied to Gloucestershire it would mean somewhere between 26,300 and 36,800 people in the county are LGB. A more recent estimate from the 2019 ONS Annual Population Survey (APS) suggests that 2.7% of the England population aged 16 and over is LGB: if this figure were applied to Gloucestershire it would mean that there are approximately 14,200 LGB people in the county. The APS also found that, for the overall UK population, 2.9% of males compared with 2.5% of females identified as LGB in 2019, and that young adults were more likely to identify as LGB than older age groups (6.7% of people aged 16 to 24 compared with 1.0% of people aged 65 or over). The percentage of the population identifying as LGB in the APS is increasing, with overall England figures rising from 1.6% in 2014 to 2.7% in 2019. The APS also provides subnational estimates for Gloucestershire, but these are considered unreliable for practical purposes due to the small sample size.

[59] equality-profile-2022-v2.pdf (gloucestershire.gov.uk)

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	N/A
Disability	N/A
Sex	N/A
Race	N/A
Gender reassignment	N/A
Marriage & civil partnership	N/A
Pregnancy & maternity	N/A
Religion and/or belief	N/A
Sexual orientation	N/A