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	Public Health and Communities Hub
Title of the activity being assessed i.e. the strategy, plan, policy or service	Procure and Award a Contract to Deliver an Adults Healthy Lifestyles Service
Brief outline of the proposal(s)	The lifestyle behaviours known to have the biggest impact on healthy life expectancy and health inequalities are smoking, excess alcohol, poor diet and physical activity - linked to obesity. The Council currently commissions a Healthy Lifestyles Service (HLS) that supports adults 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 undertook a strategic review of the current Service and wider system offers, and conducted a consultation exercise on draft proposals and priorities for a new Healthy Lifestyles Service model from April 2024. Since the current HLS was commissioned in 2017 there has been an increase in the provision of weight management services for adults available within the NHS.

	At the same time the Council reviewed its strategic direction around the delivery of weight management services and has invested in Children and Young People's weight management support in line with the One Gloucestershire Integrated Care System priorities for 'the best start in life' and addressing health inequalities. This direction of travel is supported by the data, which demonstrates a significant increase in the numbers of children and young people that have obesity post Covid-19. In response to the increase in weight management support available for adults within the NHS, and the increased focus on health inequalities following the Covid-19 pandemic and cost of living increases, we are proposing to move away from the universal weight management on referral offer (e.g., Slimming World vouchers), which has tended not to be accessed by people with the greatest needs, to the provision of a range of targeted bespoke support for those groups of adults that our Equality Impact Assessment and service data suggest face the greatest challenges in accessing and benefiting from mainstream services. Commissioners have consulted on draft proposals for a new service. The consultation sought to gather views from general public, including current and potential service users on their experience of accessing Healthy Lifestyles service, on the proposed changes, and any other factors that should be considered when developing the service specification. It also sought feedback from public and voluntary and community sector stakeholders on the proposed changes, and any potential impact on people with protected characteristics and those at increased risk of ill-health. The specific focus was on gathering feedback from across the protected characteristics, and those groups experiencing the greatest health inequalities. Actions relating to consultation feedback provided by demographic groups are included within this Equality Impact Assessment, alongside further detail in the consultation report.

Who is affected by the proposals?	Service users [X] Workforce [ ] Other, please specify: [ ]
Decision to be taken and decision maker	To seek Cabinet approval to conduct a competitive procurement process for the delivery of an Adults Healthy Lifestyles Service from 1st April 2024. To delegate authority to award the contract to the preferred tenderer to the Director of Public Health in consultation with the Cabinet portfolio holder for Public Health and Communities.
Person(s) responsible for completing this assessment	Angelika Areington – Senior Public Health Officer; Tracy Marshall – Public Health Manager; Sue Weaver – Head of Commissioning (Health Improvement)
Date of this assessment	May 2023

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 was carried out to seek views on the proposals from current and potential service users, and wider system stakeholders. This was open to all but actively promoted to groups representing/working with people across the protected characteristics, and those most affected by health inequalities who have the greatest capacity to benefit from healthy lifestyles support. In addition to an online survey, commissioners conducted a range of focus groups and discussions with stakeholders, focusing on gathering feedback from groups experiencing inequalities This EIA document has informed who we sought to actively engage with as part of this process. It includes the findings relating to protected characteristics from the public consultation. Where available, data on the characteristics of service users has been drawn from existing activity data submitted by the current HLS as part of routine contract monitoring.

Workforce	Discussions with the senior team and wider staff from the current HLS were held as a part of the engagement and consultation process. This elicited 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	Partners had an opportunity to formally respond to the consultation. The survey comprised separate questionnaires for the general public; Voluntary, Community and Social Enterprise Organisations (VCSE); and for public sector stakeholders. In addition to the online survey, commissioners held discussions with stakeholders, focusing on gathering feedback from groups experiencing inequalities. Discussions have taken place with commissioners and senior managers from key stakeholders, such as the NHS, including primary care colleagues, and community representatives. The Local Medical Council (LMC) and Integrated Care Board Operational Executives recognised the greater need to focus on health inequalities via a more targeted offer, and to better utilise the other weight management offers available, such as the NHS Digital Weight Management programme. These discussions will continue as the project progresses.
Other	We engaged with other local authorities that 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.

Protected Characteristic	Service Users	Workforce
Age	**Any new service will be available to all adults regardless of age.** **Challenge:**	No identified significant impact

Weight management

The proportion of adults with excess weight (overweight or obesity) in Gloucestershire, in 2021/22, is 62.4%, which is statistically similar to the England average of 63.8%. The proportion with obesity is 25.7% for Gloucestershire, which is also similar to the England average of 25.9%.[1]

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

Area	Overweight or obese - %	Obese - %
Cheltenham	55.6	21.0
Cotswolds	51.6	18.3
Forest of Dean	62.3	24.0
Gloucester	70.6	31.9
Stroud	64.8	26.8
Tewkesbury	67.5	31.3
Gloucestershire	62.4	25.7
England	63.8	25.9

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 65 and 74 (81%), followed by men aged 75 and over (74%). Among women, the proportion was highest in middle-aged and older women, affecting between 66% and 69% of women aged 45 and over.[3]

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

Physical Activity

According to Office for Health Improvement and Disparities, the proportion of adults in Gloucestershire who are physically active (undertake 150 minutes or more of moderate intensity physical activity a week) is 71.1%, which is statistically better

[1] Obesity Profile - OHID (phe.org.uk)
[2] Obesity Profile - OHID (phe.org.uk)
[3] HSE 2019 Overweight and obesity in adult and child (digital.nhs.uk)

than England average of 67.3%.[4]

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

Area	Physically Active %
Cheltenham	69.6
Cotswolds	78.4
Forest of Dean	67.8
Gloucester	68.0
Stroud	71.9
Tewkesbury	71.8
Gloucestershire	71.1
England	67.3

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

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

physically active.

The survey also showed 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.
- Among all age groups between 16 and 54 years, White British people were more likely than average to be physically active. However, the numbers of people surveyed for the mixed ethnic group in these age groups were too small to make reliable generalisations.
- Among all age groups between 16 and 74 years, people from 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 13% of people smoke compared to 13% in England.[5] Smoking prevalence is highest among men; and among the 25-34 years age group for both men and women. Prevalence for both men and women are lowest among people aged 60 and over. Those in routine and manual occupations aged 18-64 have the highest smoking rates in Gloucestershire with 30.8% of this cohort being smokers compared to 24.6% in England.

Data from the ONS show the following smoking prevalence rates for England[6].

Age range	Men %	Women %
16-24	13.7	12.7
25-34	17.6	15.9
35-49	16.1	13.1
50-59	15.9	13.3

[5] Local Tobacco Control Profiles - Data - OHID (phe.org.uk)

[6] Adult smoking habits in the UK - Office for National Statistics (ons.gov.uk)

60+	8.3	6.8

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.

There is evidence that more children and young people are taking up vaping, including those who have never smoked. This is an emerging issue and will be kept under review.

Alcohol

Alcohol consumption

According to the Health Survey for England 2021, the proportion who drank alcohol in the last 12 months increased with age, from 62% of 16 to 24 year olds to 85% of 55 to 74 year olds, and was lower in the oldest age group (77% of those aged 75 and over). There was a similar pattern for drinking at least once a week. Those aged 16 to 24 were least likely to drink at least once a week (31%) and those aged between 55 and 64 years old were the most likely to do so (59%). Adults aged between 55 and 64 were the most likely to drink more than 14 units of alcohol per week whereas adults aged between 16 and 24 were the least likely. The proportion of all adults who drank more than the recommended daily limit on any day in the last week increased with age and was the highest for those aged between 55 and 64. [7]

Summary of weekly alcohol consumption, by age and sex

Health Survey for England 2021. 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

[7] Health Survey for E

	%	%	%	%	%	%	%	%
Men								
Non-drinker/did not drink in last 12 months	35	17	19	17	14	12	20	19
Up to 14 units (low risk)	46	59	53	55	50	52	57	54
More than 14, up to 50 units (increasing risk)	13	19	25	23	29	32	18	23
More than 50 units (higher risk)	7	4	3	4	7	4	4	5
More than 14 units (increasing or higher risk)	*20*	*23*	*28*	*27*	*36*	*36*	*22*	*28*
Women								
Non-drinker/did not drink in last 12 months	42	25	23	21	17	19	26	24
Up to 14 units (low risk)	47	64	64	58	62	64	63	61
More than 14, up to 35 units (increasing risk)	10	9	10	17	18	14	10	13
More than 35 units (higher risk)	1	2	3	4	4	3	1	2
More than 14 units (increasing or higher risk)	*10*	*11*	*13*	*21*	*21*	*17*	*11*	*15*
All adults								
Non-drinker/did not drink in last 12 months	38	21	21	19	15	15	23	21
Up to 14 units (low risk)	47	62	59	57	56	58	61	57
More than 14, up to 35/50 units (increasing risk)	11	14	18	20	23	23	13	18
More than 35/50 units (higher risk)	4	3	3	4	5	4	2	4
More than 14 units (increasing or higher risk)	*15*	*17*	*21*	*24*	*28*	*26*	*16*	*21*

Bases (unweighted)								
Men	*167*	*285*	*412*	*381*	*505*	*498*	*372*	*2620*
Women	*172*	*377*	*482*	*526*	*597*	*559*	*391*	*3104*
All adults	*339*	*662*	*894*	*907*	*1102*	*1057*	*763*	*5724*
Bases (weighted)								
Men	*337*	*493*	*452*	*465*	*432*	*345*	*260*	*2783*
Women	*342*	*479*	*459*	*482*	*453*	*368*	*320*	*2903*
All adults	*678*	*972*	*910*	*946*	*886*	*713*	*580*	*5686*

Source: Health Survey for England 2021

Alcohol related mortality

In 2021 276 people (39.9 per 100,000) died from alcohol related illness in Gloucestershire.

Alcohol related mortality by district 2021

Area	Persons number	Persons Rate per 100,000	Men Number	Men Rate per 100,000	Women Number	Women Rate per 100,000
Cheltenham	61	52.6	44	81.0	17	27.6
Cotswolds	36	31.9	26	49.4	10	
Forest of Dean	38	37.1	26	52.3	12	23.9
Gloucester	57	46.1	43	74.5	14	21.2

Stroud	44	32.4	30	46.8	14	20.0
Tewkesbury	40	38.5	24	49.7	16	28.8
Gloucestershire	276	39.9	193	59.3	82	23
England	20,970	38.5	14,854	58.3	6,115	21.3

Source: Office for Health Improvement & Disparities, Local Alcohol Profiles for England

In 2021 there were 93 alcohol specific deaths (14 per 100,000) in Gloucestershire, compared to 7,556 deaths (13.9 per 100,000) in England.

Alcohol related hospital admissions:
In Gloucestershire, in 2021/22 the admission episodes for alcohol-related conditions (narrow definitions) were highest among adults aged 40 - 64 years (1612 admissions, rate: 742 per 100,000).

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 identified.

Weight management
Younger adults are currently underrepresented within the HLS one-to-one weight management offer. Those in older age groups (41-50 years, 51-60 years and 61+years) accessing HLS weight management support, made up a higher proportion of clients.

However, of those who accessed the offer, people from the younger groups (age 20 years and under, and aged 21-30 years) were more likely to achieve significant weight loss (3% or more of initial weight)

HLS service user data for weight management 2022/23

Age	% of clients	3+% Weight

		loss
Age 20 and under	1%	100%
Age 21-30	9%	63%
Age 31-40	16%	45%
Age 41-50	23%	45%
Age 51-60	24%	48%
Age 61+	27%	50%
Not recorded/Declined	1%	67%
Total	**100%**	**49%**

Slimming World data for weight management 2022/23

Age	**% of clients**	**3+% Weight loss**
Age 20 and under	0.8%	36%
Age 21-30	9.7%	48%
Age 31-40	19.2%	55%
Age 41-50	18.3%	65%
Age 51-60	26.0%	71%
Age 61+	25.9%	76%
Not recorded	0.1%	50%
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 made up the smallest proportion, and the highest proportion were those aged 51 years and over. Service users aged over 61 were more likely to achieve a 3%+ weight loss; those aged under 20 – less likely.

Alcohol

Younger adults are less likely to access support from the HLS to reduce their alcohol intake. Service users aged 51 years and over accounted for more than half of all those accessing this support in each of the last three years – out of 629 people accessing the HLS alcohol support during last three years 56% (362 people) were aged over 51. In general, the proportion of service users accessing support to reduce alcohol increased with age. There were no clients aged 20 year and under who accessed this service during the last year. Those over 61 years were less likely to achieve a positive outcome than other age groups.

Physical activity

Younger adults are less likely to access support from the HLS to increase their physical activity levels. Clients aged over 61 years made up the highest proportion of all clients – out of 2756 accessing this support during the last three years, 28% were aged over 61; those aged 20 years and under – the smallest (1% of all service users); followed by those aged 21-30 years age group. In general, those accessing this support aged 31-40 years and 41-50 years were more likely to achieve positive outcomes than other age groups over the past three years.

Smoking

Those aged under 20 made up the smallest proportion of all service users accessing smoking support over the last three years (between 2% and 3%). Those aged 31-40 accounted for the highest proportion, with the exception of the last year, when those over 61 years old made up the highest proportion. There was no pattern among age groups in achieving a 4 week quit; the age groups achieving the highest and lowest number of 4 week quit were different for each of the last three years.

HLS service user data for stop smoking 2022/23

Age	% of clients	% of 4 weeks quits
Age 20 and under	2%	79%
Age 21-30	15%	73%
Age 31-40	22%	63%

Age 41-50	17%	69%
Age 51-60	21%	69%
Age 61+	23%	68%
Not recorded/Declined	0%	100%
Total	**100%**	**68%**

Public consultation – Healthy Lifestyles Service

The oldest (75 years or older) and youngest (18 – 24 years) age groups were underrepresented in the survey responses: equating to 4% and 3% of responses respectively.

Younger adults (age 20 years and under)

Survey responses suggested that all (100%) of young respondents might seek a support from a Healthy Lifestyles Service in the form of group or one-to-one support to lose weight, increase physical activity or stop smoking, as well as general information about healthy lifestyles. The majority of respondents either agreed or strongly agreed with the three proposals described in the survey: prioritising this resource on supporting individuals and communities facing the greatest challenges to living a healthy lifestyle; moving away from providing weight management support for anyone; and working with community organisations in areas of greatest need (100% agreed or strongly agreed). The most popular method to find out what support is available, was the internet/a search engine, followed by asking the GP. Lack of confidence was indicated as a key barrier preventing young adults from seeking support to make a lifestyle change, while support from family/friends was cited as an enabler.

Older adults (65 years and over)

Older adults indicated that they might seek group or one-to-one support to lose weight or increase physical activity; only a few mentioned a need for support to reduce alcohol, and none mentioned support to stop smoking. The majority of respondents either agreed or strongly agreed with the three proposals within the survey: prioritising this resource on supporting individuals and communities facing the greatest challenges to living a healthy lifestyle; moving away from providing weight management support for anyone; and working with community organisations in areas of greatest need.

Similarly to other age groups, the most popular method to find out what support is available was the internet/a search

	engine, followed by asking the GP. Older adult respondents mirrored the barriers and enablers they experience in accessing support and adopting a healthy lifestyle, raised by other age groups. Barriers included: lack of confidence, lack of time, accessibility issues, cost, and knowledge of what's available. Some participants added that it is hard for them to be active due to their age and mobility issues. Additionally, the stakeholders who support older people highlighted the impact of social isolation and lack of transport on accessing services. Enablers included: flexible timings and local venues; friend/ and family support; non-judgemental, friendly service; personalised support; skilled and competent provider staff, and awareness of available services. **Removal of the universal weight management on referral offer and its impact on age groups.** The proposed removal of the universal weight management on referral offer will potentially have the greatest impact on those in the post 50 age-group categories who currently make up the majority of service users (52%) and those aged between 31-40 years and 41-50 years (adding up to 38% of service users). The majority of respondents agreed or strongly agreed with the proposal to move away from the universal offer. When disaggregating responses by age groups, there was a small variation. Among those aged 45-54 years and 55-64 years a greater proportion (38% of each age group) disagreed or strongly disagreed with this proposal. The main reasons for disagreeing were that the support should be offered to everyone who needs it; that the group support is effective; and some referred to achieving good outcomes from attending Slimming World. **Eliminate discrimination** Greater numbers of people in the older age groups accessing the weight management services are in line with what would be expected given the increase in prevalence of obesity with age. Similarly, physical activity support is mostly accessed by clients in the older age categories, who are less active. Smoking and alcohol services are also accessed by age groups who are most likely to smoke or drink above recommended alcohol intakes. In general, the support is taken up by those age groups in greatest need. However, younger adults are clearly underrepresented within the current HLS. The new service will need to work closely with communities and services representing the younger adults to further understand key barriers and enablers in making healthier lifestyles choices, and what was important to them making these choices or seeking lifestyles support. 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. The service will be expected to have an awareness and understanding of issues that may be experienced by adults of different age ranges and operate in an unbiased way towards all age groups.	
Disability	**<u>The proposed new service will be open to all adults regardless of disability.</u>** **<u>Challenge:</u>** 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 current UK law obesity in not a disability. However, there is a strong two-way association between obesity and disability. Obesity puts people at greater risk of many health problems, including heart disease, high blood pressure, stroke, diabetes, and several types of cancer[8]. These health problems can limit a person's ability to carry out normal day-to-day activities. In addition, those living with a disability are more likely to have obesity. On a national level, in 2021/22 , among people with disabilities, excess weight was 10.5 percentage points higher than among those without disabilities (72.2% of people with disability were classified as overweight or obese versus 61.7% of not disabled).[9] People with learning disabilities, and those with poor mental health, are known to be at particular 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 3.5 times more common among people with a learning disability and the ratio for overweight is 2.6.[10] In addition, people with a learning disability experience a disproportionate range of social disadvantages, such as poverty, poor housing and social isolation, which are closely linked with a poor diet and excess body weight.[11] 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	No identified significant impact

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

[9] 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/tbm/1/page-options/ine-ao-1_ine-ct-27_ine-pt-0_ine-yo-1:2020:-1:-1

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

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

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.[12]

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.[13] Rates of obesity are higher among 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, people in the UK 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, compared to their non-disabled peers. Additionally, prevalence rate ratios in the US appear to be increasing over time due to a more rapid decrease in smoking among the non-disabled population. UK based research reached similar findings and concluded that adults with disabilities who 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 with disabilities, especially women.[14]

In Gloucestershire, in 2021/22 the likelihood of smoking among adults (18+) with a long-term mental health condition was 2.5 as compared to those without a long-term mental health condition, with Cheltenham having the highest ratio of 3.5. Smoking prevalence in adults with a long-term mental health condition was 22.1% in Gloucestershire, which is statistically similar to the England rate of 25.2%; Stroud and Cheltenham have highest rates (25.5%, 25.4% respectively). 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.[15] The smoking rate among people with mental health conditions is the largest contributor to their 10-to-20-year reduced life expectancy.[16] 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

[12] https://www.nice.org.uk/media/default/about/what-we-do/into-practice/measuring-uptake/niceimpact-mental-health.pdf
[13] obesity_in_mental_health_secure_units.pdf (publishing.service.gov.uk)
[14] Smoking_REVISED_SUBMIT.pdf (lancs.ac.uk)
[15] Local Tobacco Control Profiles, Small Area Tobacco Control Profiles - OHID (dhsc.gov.uk)
[16] Smoking and tobacco: applying All Our Health - GOV.UK (www.gov.uk)

marked decline in smoking prevalence in the general population.[17]

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 than non-disabled people, with inactivity (less than 30 minutes per week) at 35.4% among people with disabilities and 17.9% for non-disabled adults.[18] 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.[19]

Research indicates that people with mental illness are less physically active than the general population. Physical activity is beneficial to mental wellbeing in general, a preventative action in a number of mental health disorders, and a potential preventive or disease-modifying treatment for dementia and brain aging, as well as a possible treatment for symptoms in schizophrenia.[20]

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

Alcohol

There is little research about alcohol use among people with a disability. A small number of self-reported studies indicate that people with learning disabilities are less likely to misuse substances than the general population, though some subgroups 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 are at an increased risk of substance misuse if they: have borderline to mild learning disabilities; are young and male; or 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.[21]

Alcohol misuse is linked with a range of mental health difficulties, including depression and bipolar disorder. Many people

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

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

[19] 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)

[20] Frontiers | Thirty years of research on physical activity and mental health during 1991–2021 | Psychiatry (frontiersin.org)

[21] Substance misuse in people with learning disabilities: reasonable adjustments guidance - GOV.UK (www.gov.uk)

who misuse alcohol also have a mental health difficulty, and many people with mental health problems misuse alcohol. Having a 'dual diagnoses' of alcohol use- and a mental health disorder is common. 86% of people using alcohol treatment services have a mental health comorbidity.[22] Similarly, "an estimated 44% of community mental health patients have reported problem drug or l alcohol use in the previous year".[23]

Healthy Lifestyles Service level data

Weight management

The current service does not classify service users by the disability category as a whole; however, 'learning disabilities' and 'mental health' categories were used. Three years of service data - 2020/21, 2021/22 and 2022/23 - have some limitations, due to the impact of the pandemic and service adaptations, and therefore should be interpreted with caution.

People with self-reported mental health problems made up 21% to 23% of all service users who completed the Slimming World weight management support offer between 2020/21 and 2022/23. A greater proportion of people accessing HLS weight management support, self-reported a mental health problem - 27% in 2020/21, and 53% in 2022/23. Outcomes achieved by people with self-reported mental health problems were similar to those achieved by other service users, with the exception of HLS outcomes for 2022/23, when the proportion of people with self-reported mental health issues achieving an expected weight loss was below general service users (34% versus 49%).
One year of data indicated that 5% of people accessing Slimming World, had a learning disability. They were slightly less likely to achieve a positive outcome than other service users.

4%-6% of those who accessed the HLS weight management service had a learning disability, and with the exception of 2022/23, were more likely to achieve expected weight loss than other l 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 a 4 week quit, compared with overall service users.

[22] Better care for people with co-occurring mental health, and alcohol and drug use conditions (publishing.service.gov.uk)
[23] Health matters: harmful drinking and alcohol dependence - GOV.UK (www.gov.uk)

	The numbers of people with learning disability accessing the smoking cessation service for each year are relatively small, between 1% and 2% of all service users. The proportion of achieving a 4 week quit is lower than other service users. ***Alcohol*** The proportion of service users a with mental health problem being supported with to manage alcohol use was between 24% and 29% in the last three years; with positive outcomes achieved by a similar or slightly higher proportion than other service users. Fewer than 10 people with a learning disability accessed alcohol support during the three years reported. ***Physical activity*** The proportion of service users with self-reported mental health issues accessing physical activity support increased from 25% to 36% from 2022/21 to 2022/23. A similar or higher proportion of people with mental health issues achieved positive outcomes. Between 3% and 4% of people accessing physical activity support had a learning disability. A similar or higher proportion of this group achieved a positive outcome, compared to other service users. **<u>Public consultation – Healthy Lifestyles Service</u>** 94 (36%) respondents disclosed that they have a disability, long-term illness, or health condition. In addition, one focus group was held with people with learning disabilities, as well as a discussion with an organisation supporting people with learning disabilities. The most popular choice of type of support, which people with disabilities might seek was one-to-one support, for weight loss or to increase physical activity, followed by group support for these two behaviours. Similarly to the general public, the majority of respondents either agreed or strongly agreed with the three proposals described in the survey: prioritising this resource on supporting individuals and communities facing the greatest challenges to living a healthy lifestyle; moving away from providing weight management support for anyone; and working with community organisations in areas of greatest need.	

	The most popular method to find out what support is available, indicated by people with disabilities, was the internet/a search engine. People with disabilities mirrored the barriers and enablers they experience in accessing support and adopting a healthy lifestyle raised by other groups, with particular focus on accessibility. Lack of easy read materials and user-friendly website information, with additional problems accessing physical activity centres, discourage people with learning disabilities from taking the first steps towards making a lifestyle change. Respondents raised that services should be targeted and tailored to the needs of people with disabilities, with longer and interactive sessions. **Removal of the universal weight management on referral offer and its impact on people with disabilities**. Numbers of people with disabilities accessing the current universal weight management offer are low. The majority of consultation respondents with disabilities agree with the removal of the weight management on referral. Moreover, insight from the survey, focus groups, and stakeholder meetings highlighted the need for services that are more tailored, easily accessed, and experienced in supporting people with disabilities. However, some respondents valued the support they had received from the Sliming World offer and had achieved a positive outcome. **Eliminate discrimination** There is a lack of research to understand the four healthy lifestyle behaviours: weight management, smoking, alcohol and physical activity among people with physical disability. The new service will ensure people with physical disabilities have equal access and will be expected to improve recording of data regarding disabilities to enable monitoring of access, experience and outcomes, and take necessary action where avoidable disparities exist. People with poor mental health and learning disabilities are more likely to experience negative impacts of all four lifestyle behaviours. The proportion of people with mental health problems accessing the current HLS is increasing, but uptake by those with learning disabilities remains low. The new service will be open to all adults regardless of disability. The proposed changes should improve access and options for support for people with disabilities, and are not anticipated to have any negative will impacts. The new service will be expected to have a good understanding of how disability can impact people's life, the barriers they might experience in accessing, and how they can be supported to achieving healthier lifestyles. Additionally, the new provider will be required to consider the barriers and enablers identified via the consultation process, and making reasonable adjustments to address these factors.	

Gender	**Challenge:** **Weight management** In Gloucestershire, in 2021/22, 25.7% of adults (18+) were classified as living with obesity and 62.4% as having excess weight (overweight or obesity); both values were similar to England averages (respectively 25.9% and 63.8%). At a national level, in 2021/22, excess weight was nearly 11 percentage points higher for males than for females - 69.1% of men and 58.4% of women were classed as having an excess weight (overweight or obesity).[24] However, obesity levels were slightly higher for women than men (26.1% versus 25.8%). This means that being overweight but not having obesity is more common among men than women. **Smoking** Data for 2021 indicates that smoking prevalence in adults 18+ in Gloucestershire was 13% in line with the England average of 13%; the prevalence among males was higher than among females (15.3% versus 10.8% respectively). The proportion of all deaths attributable to smoking among adults aged 35 years and over in England, was higher for males than females (for example, cancers which can be caused by smoking: 59% - male, 43% - female)[25] **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).[26] According to the Health Survey for England 2021: [27] • A greater proportion of men than women drank alcohol in 2021 (82% and 76% respectively), with 57% of men and 43% of women drinking alcohol at least once a week. • 19% of men do not drink alcohol compared to 24% of women. • 54% of men and 61% of women drank at levels that put them at lower risk of alcohol-related harm. • A greater proportion of men (28%) than women (15%) drank at increasing or higher risk levels (over 14 units in the last week). • 5% of men and 2% of women drank at higher risk levels (usually over 50 units a week for men and 35 units for women). Males are more likely to be admitted to hospital for alcohol related conditions than females. In Gloucestershire, in 2021-22, hospital admissions for alcohol related and alcohol-specific condition were:[28]	No identified significant impact

[24] Obesity Profile, OHID Obesity Profile- Data - OHID (phe.org.uk),
[25] Smoking Statistics, May 2021, ASH https://ash.org.uk/resources/view/smoking-statistics
[26] Alcohol-specific deaths in the UK: registered in 2020, ONS, Alcohol-specific deaths in the UK - Office for National Statistics (ons.gov.uk)
[27] Health Survey for England 2021, Part 3: Drinking alcohol - NDRS (digital.nhs.uk)
[28] Local Alcohol Profiles for England. Local Alcohol Profiles for England - OHID (phe.org.uk)

- Admission episodes for alcohol-related conditions (narrow) rate was 575 per 100,000 for males and 325 for females; male's rate was better than, and female's rate similar to, England averages,
- Admission episodes for alcohol-related conditions (broad) rate was 2,081 per 100,000 for males and 759 for females; both rates were statistically better than England averages.
- Admission episodes for alcohol-specific conditions was 728 per 100,000 for males and 375 for females; male's rate was better than, and female's rate was similar to, England averages.

Alcohol-related mortality rates are higher among males than females. In Gloucestershire in 2021, alcohol-related mortality for males was: 59.3 per 100,000 population, and 23.0 per 100,000 for females.

Physical Activity
Men are more likely to be physically active than women. Nationally, in 2021/22, 69.9% of men and 64.9% of women undertook the recommended amount of physical activity per week (aged 19+). A greater proportion of women (23.7%) reported being inactive (doing less than 30 minutes physical activity per week) than men (20.6%)[29]

The gap in physical activity levels between genders is more prominent among younger people. In Gloucestershire, 51% of boys and 41% of girls reported doing the recommended amount of exercise in 2020.[30] Since 2012 the gap between the sexes has decreased from 15.7 percentage points in 2012 to 10 percentage points in 2020. This is due to an increase in physical activity levels among girls and young women, and a significant drop among boys and young men during that period. Although levels of physical activity increases at a similar rate for both sexes during primary school, girls' activity levels decline steadily during secondary school, whereas boys continue to become more active into the early years at secondary school, and as they get older the decline is much less pronounced.[31]

Healthy Lifestyles Service level data:
The three years of service data – 2020/21, 2021/22 and 2022/23 - 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 weight management service offers. Across both HLS and Slimming World weight management support, females made up the overwhelming majority of service users: 85%-87% of Slimming World were females, 61%-62% for HLS weight management. Specified weight loss outcomes were achieved by a lower proportion of females than males accessing Slimming World, and a slightly higher proportion of females than males accessing HLS weight management.

[29] Physical Activity - Data - OHID (phe.org.uk)
[30] Gloucestershire Pupil Wellbeing Survey 2020, pupil-wellbeing-survey-2020-headline-report.pdf (gloucestershire.gov.uk)
[31] Exercise Children & young people, Gloucestershire County Council, 2021, exercise-children-young-people-2021.pdf (gloucestershire.gov.uk)

Smoking
Over the past three years there were more females than males accessing the smoking cessation service, between 61% and 63% of all service users. Lower numbers of females achieved a 4 week quit, compared with males.

Alcohol
More males than females were supported for alcohol use problems (52-55% of those accessing this support over the last three years were males). The proportion of service users who achieved positive outcomes ranged between 69% to 82% for males, and 78% to 83% for females.

Physical activity
Females were more likely to access physical activity support than males; only 37-39% of service users in the last three years were male. The proportion of service users achieving a positive outcome was similar for both genders, ranging between 73% and 78% for females and 72% and 77% for males.

Public consultation – Healthy Lifestyles Service
196 (73%) of respondents were female and 63 (23%) were males.

The majority of male and female respondents either agreed or strongly agreed with the three proposals described in the survey: prioritising this resource on supporting individuals and communities facing the greatest challenges to living a healthy lifestyle; moving away from providing weight management support for anyone; and working with community organisations in areas of greatest need. There was a small variation in response from females and males in regard to the proposal of moving away from universal weight management support. The majority of responses still agreed or strongly agreed with this question (59% of females and 69% of males), however 29% of females strongly disagreed or disagreed with the proposal, compared to 13% of males. Feedback from females who did not agree with the proposal included comments that the support should be offered to everyone who needs it; that the group support is effective; and a small number reported achieving good outcomes from attending Slimming World.

The majority of barriers and enablers experienced in accessing support or adopting a healthy lifestyle were similar for males and females. Responses specific to females included accessibility – lack of women-only sessions/ activities.

Removal of the universal weight management on referral offer and its impact on gender groups.

The proposed removal of the universal weight management on referral offer will potentially have a greater impact on

	women who currently make up the overwhelming majority of service users. However, the public consultation indicated that the majority of women respondents agree with the removal of this offer. Commissioners and the new service provider will work together with stakeholders to promote the NHS weight management offers, and to understand and mitigate 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 the genders accessing alcohol and physical activity support. However, weight management and smoking support are accessed by a higher proportion of females, which is disproportionate to the prevalence of these behaviours. The service will be required to actively seek out and take into consideration the views and specific needs relating to service access and provision for both genders. The service will ensure equal access, and will offer non-judgemental support, to both sexes as well as understanding how the needs of men and women differ. Further work is needed to identify and mitigate the barriers to access for men, especially for stop smoking and healthy weight services. The service will be required to maintain accurate records to enable monitoring of access, experience and outcomes and take necessary action where avoidable disparities exist. Additionally, commissioners, the service provider and stakeholders will work towards promoting and monitoring the uptake of the other weight management offers (such as NHS weight management) to ensure that the numbers currently accessing the universal weight management on referral offer are adequately supported.	
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 national data, from the Active Lives Adult Survey (2021/22):[32] • Black adults were the most likely of all ethnic groups to have excess weight (overweight or obesity) (70.8%) and most likely to have obesity (33.7%) • White British adults were more likely than the national average to have excess weight (overweight or obesity) (64.2%), and obesity (27.3%) • Adults from the Chinese ethnic group were the least likely of all ethnic groups to have overweight or obesity	No identified significant impact

[32] Obesity profile, Obesity Profile - Data - OHID (phe.org.uk)

(33.1%); only 7.6% had obesity.

- The proportion of adults in Asian, White Other, Mixed and Other ethnic groups with overweight or obesity were lower than the national average; similarly obesity levels for these groups were lower than the national average, with the exception of the Mixed group – similar to the national average.
- Since 2015/16 the proportion of White British adults with excess weight (overweight or obesity) and obesity has been increasing year-on-year, while other ethnicities experienced fluctuation. 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 national data, from the Active Lives Adult Survey (2021/22):[33]

- People from the Mixed ethnic group were most likely of all ethnic groups to be physically active (72.4%), followed by people from the White British (69.3%) and White 'other' ethnic groups (68.8%) – this has remained consistent for the last six years.
- People from Black, Asian, Oher and Chinese ethnic groups were less likely than the national average to be physically active – this has remained consistent for the last six years.
- No ethnic minority group is showing a reportable difference compared to 2015-16, which suggests that inequalities continue to widen as White British adults have seen activity levels increase over the same period (up 1.6%).

According to the Gloucestershire Pupil Wellbeing Survey 2020, exercise levels varied across different ethnic groups. Children and young people from Black, Asian, or minority ethnic groups (BAME) were significantly less likely to report doing the recommended amount of exercise, and were statistically more likely to report doing little or no exercise.[34]

Smoking:

According to national data, from the Annual Population Survey (2021):[35]

- The proportion of adults who smoked was higher than average in Mixed (16%) and White (13.7%) ethnic groups.
- It was lower than average in Chinese (5.1%), Asian (7.7%) and Black (8.1%) ethnic groups.
- From 2011 to 2021, the proportion of White adults who smoked decreased from 20.6% to 13.7%
- The proportion of Black adults who smoked decreased from 26.3% to 16%
- When looking at country of birth, the proportion of adults who smoke was greatest for people born in Poland (21.1%); for people born in England this proportion was 13.4%; for other countries this proportion was similar or lower than the national average.

Alcohol:

[33] Physical Activity p

[34] Exercise Children

[35] Local Tobacco Control Profiles, Local Tobacco Control Profiles - OHID (phe.org.uk)

Nationally, 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.

Service level data

Due to small numbers of people from ethnic minority groups accessing the HLS s, the analysis below is based on the three years of pooled data.

Weight management

Of those who accessed the Slimming World offer, 'White British' made up the highest proportion (93%), followed by 'White Other' (2%). 'Mixed White and Black Caribbean', 'White Irish' and 'Asian - Indian' accounted for 1% of all service users each. Of those accessing this offer, White British participants where most likely to achieve the specified weight loss, and those from 'Any other Asian background' least likely.

Those accessing the HLS weight management service were marginally more diverse, with 'White British' accounting for 89% of service users. 'Asian/ Asian British', 'Mixed/Multiple Ethnic Group' accounted for 3% of all service users each and 'White Other' for 2%. 'White Irish', 'Black African/Caribbean/Black British' and 'Other Ethnic Group' accounted for 1% each. There were no service users of 'White Traveller' ethnicity. Noting that the numbers were small, of those accessing this offer 'Mixed/Multiple' and 'White Irish' ethnic groups were most likely to achieve positive outcomes and the 'White Other' group least likely.

A bespoke weight management offer has recently been coproduced with women from the South Asian community and has achieved positive outcomes. Scope to extend this approach to other ethnic minority groups will be explored.

Physical activity

The physical activity support offer was accessed by a greater proportion of ethnic minority groups than the other support offers, with White British accounting for 87% of service users, followed by 'Asian/ Asian British', 'Mixed/Multiple' and 'White Other' groups. Noting that the numbers were small, of those accessing this offer the 'Asian/ Asian British' ethnic groups was most likely to achieve positive outcomes and the 'Other Ethnic Group' least likely

Smoking

[36]Health Survey England Additional Analyses, Ethnicity and Health, 2011-2019 Experimental statistics, 2022, Drinking alcohol - NHS Digital

	The majority of smoking cessation service users were 'White British' (90%), followed by 'White Other' and 'Mixed/Multiple Ethnic Group' (2% each). The remaining ethnic groups accounted for 1% of service users each, with the exception of White Travellers, who made up the lowest numbers. The proportion of those who achieved a 4 week quit was similar across all ethnicities. ***Alcohol*** The alcohol support offer was accessed by the smallest proportion of people from ethnic minority groups of all the support offers. White British people accounted for 94% of service users, followed by the 'Mixed/Multiple Ethnic Group' representing 2% of service users (or 12 people over the past three years), which is in line with national (limited) research. **Public consultation – Healthy Lifestyles Service** 27 (10%) respondents were from ethnic minority groups. In addition, one focus group was held with women from various ethnic minority groups. The majority of ethnic minority respondents either agreed or strongly agreed with the three proposals described in the survey: prioritising this resource on supporting individuals and communities facing the greatest challenges to living a healthy lifestyle; moving away from providing weight management support for anyone; and working with community organisations in areas of greatest need. Responses that were specific to ethnic minority respondents are summarised as below: • Language barriers preventing some ethnic minority groups from seeking and accessing support. • Lack of opportunities for women-only activities. • Cultural values relating to meaning of health, healthy food, gender inequalities impact on lifestyle. • Importance of service being developed, delivered and promoted with support from people from different cultures. **Removal of the universal weight management on referral offer and its impact on ethnic minority groups.** The proposed removal of the universal weight management on referral offer 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. The public consultation highlighted that the majority of ethnic minority respondents agree with the removal of this offer. Offering more targeted bespoke support should be beneficial for ethnic minority groups. **Eliminate discrimination** Health disparities between ethnicities vary by healthy behaviours. In general, Black, and White British adults are more likely	

	to be affected by excess weight, with White British being the only ethnic group experiencing an increase in overweight, or obesity. Asian, Black, 'other' and Chinese adults are less physically active. 'Mixed' and White ethnic groups are most likely to smoke, and 'White British' most likely to misuse alcohol. 'White British' account for the highest proportion of all service users. Whilst this is expected given Gloucestershire's ethnic structure (87.7% of White British - based on the 2021 Census) and the prevalence of unhealthy behaviours in this population, only 1-2% of people from non-white ethnicities have used the service, which is not reflective of the ethnicity structure based on 2021 data. The new service will be available to all adults regardless of ethnicity. It will include a requirement for the provider to ensure cultural and racial competency in their provision to address the barriers identified during consultation and engagement. The provider will be required to seek further views and experiences from different ethnic groups to better understand the barriers and enablers to accessing lifestyle support, and to undertake the adequate service adaptations. Scope to extend the approach taken with South Asian women to coproduce bespoke weight managements offers with other ethnic minority groups will be explored. The service will explore opportunities for support through translation.	
Gender reassignment	**<u>Challenge:</u>** **Weight management, physical activity and smoking** There is no national or local data on these behaviours among transgender and non-binary people and has been little research on these subjects. **Alcohol** UK-based research is lacks accurate information on alcohol use by trans and non-binary people. Some studies show a greater prevalence of substance misuse among transgender compared with cisgender people, but there is insufficient evidence to estimate prevalence or quantify the risk for substance use.[37] Non-binary people face discrimination, stigma, and escalating hate crimes - these experiences, alongside a perceived or actual need to conceal their identity, can lead to excessive alcohol use. **<u>Service level data is not available for this group.</u>** **<u>Public consultation – Healthy Lifestyles Service</u>** There were four responses from people who identify with a different gender than that registered at birth. Acknowledging the small number of people, three respondents either agreed, did not mind or strongly agreed with the	No identified significant impact

[37] Prevalence and correlates of substance use among transgender adults: A systematic review - ScienceDirect

	three proposals described in the survey: prioritising this resource on supporting individuals and communities facing the greatest challenges to living a healthy lifestyle; moving away from providing weight management support for anyone; and working with community organisations in areas of greatest need; one person disagreed with the proposal of removing the universal offer, citing the reason that group support is efficient. **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] Any new service will be available to adults that have undergone gender reassignment. The new service will be required to continue to collect data on people's gender identity, where individuals are happy to provide this, to help with understanding service accessibility and reach. Commissioners will ensure that the new provider has a workforce, which is aware and appropriately trained to talk to people about their gender identity to ensure that the new service is inclusive.	
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 little research on these subjects. **Service level data is not available for this group.** **Public consultation – Healthy Lifestyles Service** Respondents to the survey were not asked about their relationship status. **Eliminate discrimination** All services are available regardless of marital status. No significant negative impacts on the basis of marriage or civil partnership have been identified. The proposed new service will support individuals of any martial or relationship status.	No identified significant impact

[38] lgbt_in_britain_health.pdf (stonewall.org.uk)

Pregnancy & maternity	**Any new service will be available to all adults including pregnant women.** **Challenge:** **Weight management** In Gloucestershire the prevalence of obesity in early pregnancy in 2018/19 was 16%, which is lower than the national prevalence of 22.1%. Pregnant women with obesity are at greater risk of a variety of pregnancy-related complications, including pre-eclampsia and gestational diabetes. They are also at increased risk of caesarean birth. Obesity is associated with lower 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** According to 2021/22 Active Lives Adult data, pregnant women or women with a child under the age of one are less likely to be active (150+ minutes a week) than the general females (57% versus 67%).[40] 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) include a reduction in depression; improved emotional wellbeing; improved physical conditioning; and reduction in postpartum weight gain and a faster return to pre-pregnancy weight.[41] **Smoking** Gloucestershire's prevalence of smoking status at the time of delivery (2021/122) was 10.3%, which is significantly worse than the national prevalence of 9.1%. Although the England rate has been decreasing, the local rate has remained relatively static over recent years.[42] Smoking during pregnancy can cause serious pregnancy-related health problems. These include complications during labour and an increased risk of miscarriage, premature birth, low birthweight, and sudden unexpected death in infancy.[43] **Alcohol** There are no national or local data on alcohol misuse among pregnant women. The Chief Medical Officers' guideline for pregnant women or women thinking about becoming pregnant recommends these women do not drink alcohol at all to minimise the risk for the baby. Alcohol can have a range of impacts on the foetus including lifelong conditions, known under the umbrella term of 'foetal alcohol spectrum disorders' (FASD). The severity and	No identified significant impact

[39] Royal College of Obstetricians & Gynaecologists, 2018, Care of Women with Obesity in Pregnancy (wiley.com)
[40] Active Lives Adult Nov 21-22 Tables 1-3 Levels of activity.xlsx
[41] UK Chief Medical Officers' Physical Activity Guidelines (publishing.service.gov.uk)
[42] Local Tobacco Control Profiles - OHID (phe.org.uk)
[43] Statistics on Women's Smoking Status at Time of Delivery: England 2022 Introduction - NHS Digital

nature of this are linked to the amount drunk and the developmental stage of the foetus. 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 increase in mothers drinking above 1-2 units/day during pregnancy.[44]

Service level data

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

Weight management

Across Slimming World and HLS Weight Management offer pregnant women accounted for 1% of service users. Since it is not recommended that pregnant women lose weight, the support provided is to help pregnant women maintain their weight (until the 3rd trimester) and eat a balanced diet.

Physical activity

1% of service users accessing physical activity support were pregnant. A much smaller proportion of pregnant women achieved a positive outcome, compared with other service users.

Smoking

Smoking cessation services saw the highest proportion of pregnant women access support compared with other behaviours, with 15% of clients accessing support for smoking being pregnant in 2022/23. A higher proportion of pregnant women achieved a 4-week quit, compared to other smokers. In 2022/23, 221 pregnant women were supported to stop smoking with 81% achieving a 4 week quit.

Alcohol

According to the service data, no pregnant women accessed the service for support with alcohol use.

Public consultation – Healthy Lifestyles Service

The survey did not ask a direct question about pregnancy or maternity, but five respondents had accessed the 'Lifestyle Support for Women During Pregnancy' service. In addition, there was also a focus group with a 'Baby and Toddler' group, and some comments of other survey respondents deserve reflection on, in relation to childcare.

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

	With the exception of one person, all respondents who had accessed the ' Lifestyle Support for Women During Pregnancy' service or who participated in the 'Baby and Toddler' focus group either agreed, did not mind or strongly agreed with the three proposals described in the survey: prioritising this resource on supporting individuals and communities facing the greatest challenges to living a healthy lifestyle; moving away from providing weight management support for anyone; and working with community organisations in areas of greatest need. One person strongly disagreed with all three proposals, praising the Slimming World offer for providing group and individual support. Responses relating to pregnancy and maternity can be summarised as below: • Services should be inclusive to the whole family, with flexible working hours and consideration of support with childcare arrangements, such as bringing children to the session. • Support should be offered in local communities. • Peer support from people experiencing similar problems (e.g., smoking mothers) is valuable. • Support should consider the stresses of family life, such as lack of time. **Removal of the universal weight management on referral offer and its impact on pregnancy and maternity groups.** The proposed removal of the universal weight management on referral offer is unlikely to have a disproportionate negative impact on pregnant women given the extremely low numbers accessing the service. Furthermore, the remodelled healthy lifestyles service will continue to provide targeted lifestyles support to pregnant women. **Eliminate discrimination** Pregnant women are well represented in the smoking cessation support service and achieve better outcomes than other service users. However, national data indicate that Gloucestershire should work to reduce 'smoking status at the time of delivery' rates. Although support to increase physical activity has been accessed by pregnant women, positive outcomes are much lower than expected. The new service will be open to individuals who are pregnant or in the post-natal period, and partners of those individuals. The service will be cognisant of issues and difficulties commonly experienced by pregnant women and mothers. It will also be expected to engage and work in partnership with community groups/stakeholders that represent or work with pregnant women.	
Religion and/or belief	**Any new service will be available to all adults regardless of religion or belief.** **Challenge**	No identified significant

	Weight management There is no national or local data on the weight status among different religions and there has been little research on this subject. **Physical activity** According to 2021/22 Active Lives Adult data, people identifying as 'No religion' were the most likely to be active (150+ minutes a week) (69%), followed by Jewish and Buddhist (64% each - however the confidence intervals were wide, due to small numbers), Sikh (63%, wide confidence intervals) and Christians (62%). The least likely groups to report being physically active were Muslim (48%), and Hindu (58%, with wide confidence intervals).[45] **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%).[46] **Alcohol** There are no national or local data on alcohol misuse among different religions and there has been little research on that subject. **<u>Religion data has not been collected by the service.</u>** **<u>Public consultation – Healthy Lifestyles Service</u>** 98 (37%) respondents reported having a religion. The main reported religion was Christianity (47%). There were no variations in responses when disaggregating data by religion in relation to the three proposals described in the survey: prioritising this resource on supporting individuals and communities facing the greatest challenges to living a healthy lifestyle; moving away from providing weight management support for anyone; and working with community organisations in areas of greatest need . The majority agreed, or strongly agreed with these proposals. Responses relating to religion can be summarised as below: • Lack of opportunities for women only activities. • Beliefs/attitudes about health and healthy lifestyle differ between religions.	impact

[45] Active Lives Adult Nov 21-22 Tables 1-5 Levels of activity.xlsx

[46] 2020 Religion and health in England and Wales - Office for National Statistics (ons.gov.uk)

	• Importance of having a workforce that understands and reflects community. **<u>Removal of the universal weight management on referral offer and its impact on religious groups.</u>** The proposed removal of the universal weight management on referral offer is unlikely to have a disproportionate impact on people of various religions/ no religion. **<u>Eliminate discrimination</u>** 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. The service will be required to ensure it is sensitive to these issues, and can provide, or work towards providing, culturally appropriate services on the basis of religion. The service will also be expected to be non-judgemental, have a good understanding of cultural competency and engage and work in partnership with community groups/stakeholders that represent or work with people different religious groups in the county.	
Sexual orientation	**<u>Any new service will be available to all adults regardless of sexual orientation.</u>** **<u>Challenge</u>** **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 had excess weight (overweight or obesity) (51%) than heterosexual adults (63%). When further stratified by sex, heterosexual men were more likely to have excess weight (either overweight or obese) (67%) than gay or bisexual men (49%), while the proportions among women were 58% of heterosexual women with excess weight compared with 53% of LGB women.[47] **Physical activity** According to the national Active Adult Survey 2021-22, Gay or Lesbians were most likely to be physically active (150+ minutes a week) (76%), followed by Bisexual people (70%), and 'Heterosexual or Straight' people (63%), with the lowest proportion among 'Other sexual orientation (57%) [48] 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, those known to social care, young carers, and people with SEN/EHCP).[49]	No identified significant impact

[47] Health and health-related behaviours of Lesbian, Gay and Bisexual adults (digital.nhs.uk)
[48] Active Lives Adult Nov 21-22 Tables 1-5 Levels of activity.xlsx
[49] Exercise Children & young people, Gloucestershire County Council, 2021, exercise-children-young-people-2021.pdf (gloucestershire.gov.uk)

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%, compared to 16% of heterosexual women, 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. [50]

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).[51]

Sexual orientation data has not been collected by the service.

Public consultation – Healthy Lifestyles Service
31 (12%) of respondents identified as non-heterosexual (e.g., lesbian, gay, bisexual, asexual etc – LGBT+). Also 31 (12%) preferred not to disclose their sexual orientation. Additionally, one focus group was held with the LGBT+ community.

The majority of LGBT+ respondents either agreed or strongly agreed with the three proposals described in the survey: prioritising this resource on supporting individuals and communities facing the greatest challenges to living a healthy lifestyle; moving away from providing weight management support for anyone; and working with community organisations in areas of greatest need. Those who disagreed with the removal of the universal weight management offer referred to a positive experience while accessing Slimming World, and some stated that this support should be offered to everyone.

Responses from LGBT+, which were specific to this group can be summarised as below:

- Social isolation, and fear of being judged, is preventing this group from accessing services.
- Importance of understanding the issues faced by the LGBT+ community and the specifics challenges for those undergoing the gender change.

[50] Health and health-related behaviours of Lesbian, Gay and Bisexual adults (digital.nhs.uk)
[51] Health and health-related behaviours of Lesbian, Gay and Bisexual adults (digital.nhs.uk)

	<u>Removal of the universal weight management on referral offer and its impact on age groups.</u> The proposed removal of the universal weight management on referral offer is unlikely to have a disproportionate impact on LGBT+ population. **<u>Eliminate discrimination</u>** Consideration will be given to how the service can be promoted to LGBT+ people. The Provider will be required 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. The new service will ensure that the staff is non-judgemental, and this will be a core foundation of the support that is offered. 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 LGBT+ community.	

4. Summary of analysis

This EqIA has highlighted that some groups with protected characteristics are not accessing the current Healthy Lifestyles Service offer and therefore current provision may be disadvantaging certain groups. Particularly, men, those with a learning disability, young people and those from particular ethnic backgrounds are underrepresented.

These findings, together with the consultation responses, have informed the proposed future service model whereby there will be a move away from a standard universal approach to weight management to a range of more targeted bespoke offers for those currently underserved.

The proposed model also includes a specific training and enabling function whereby the Provider will be required to collaborate and integrate more with communities and organisations working with underrepresented groups, to enable healthy lifestyles support to be delivered by community organisations and groups.

The Provider will work closely with communities and organisations representing them, to further understand key barriers and enablers in making healthier lifestyle choices, and to build on these insights to improve the service offer.

Using the learning from the consultation and engagement exercises we will require the Provider to be culturally competent, and consider how they can best promote the service to reduce stigma and barriers to seeking support with a particular focus on protected characteristics and inclusion groups. This will include a requirement to address language barriers.

5. 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
Commissioners have engaged with some groups/ communities facing the greatest challenges to living a healthy lifestyle in preparation for commissioning this service, as well as engaging stakeholder who support these communities. We will continue engaging with these groups to ensure their experiences are fully understood.	To ensure more regular engagement with people at higher risks of experiencing unhealthy behaviour to inform future service model

The consultation provided 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

6. 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	Ensure any future service specification sets out clearly how the Provider will be required to promote equality and reduce health inequalities with due regard to the protected groups.	June 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.	June 2023	Tracy Marshall
Positive	Working alongside communities to understand how the promotion, of and access to the service, can be adapted to be appropriate for those with protected characteristics and facing health inequalities.	From April 2024	Tracy Marshall

Positive	The future service provider will be required to consider accessibility and flexibility of its provision to all protected characteristic groups.	From April 2024	Tracy Marshall

7. 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. 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 new service 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.

8. 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	07.06.23

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
Date	07.06.23

9. 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 website: Inform Gloucestershire Census 2021[52] In 2021, the resident population of Gloucestershire was estimated to be 645,076 people of which: • 17.5% were aged 0-15; • 60.8% were aged 16-64; • 21.7% were aged 65 and over. Gloucestershire has a lower proportion of 0–115-year-olds and 16-64 year olds and a higher proportion of people aged 65+ when compared to England. There is some variation at district level: • Gloucester had the highest proportion of 0-15 year olds and 16- 64 year olds (19.2% and 64.1% respectively). • Cotswold and Forest of Dean had the lowest proportion of 0-15 year olds (16.0%) • Cotswold also had the lowest proportion of 16-64 year olds (58.0%). • Inversely, Gloucester had the lowest proportion of 65+ year olds (16.7%) and Cotswold the highest (26.1%). The population of Gloucestershire has increased by 48,092 people (8.1%) compared with Census Day 2011. The rate of growth in Gloucestershire was higher than nationally - Gloucestershire's 65+ population increased by 25.6% (England and Wales increased by 20%). Gloucestershire's 16-64 population increased by 3.6%, this is a slightly bigger increase than England and Wales (3.4%). The 0-15 population group also increased - Gloucestershire had the greatest growth with a 5.7% increase, this compares to a 4.3% increase in England and Wales overall. There is considerable variation at district level:

[52] Census 2021 - Inform (gloucestershire.gov.uk)

<table>
<tr><td></td><td>• Tewkesbury had the biggest increase in the 16-64 population (10.6%) however, Cheltenham (-1.5%) had a decrease in the working age population.
• Tewkesbury experienced the biggest growth of 0-15 population with an increase of 20.2% whilst Forest of Dean experienced a decrease by 0.4%
• All districts saw an increase in the 65+ age group. Growth was highest in Cotswold (26.1%), and all districts saw a larger percentage increase than England (18.4%), apart from Gloucester where the rate was lower (16.7%).</td></tr>
<tr><td>Sex
percentage/profile of service users who are male and who are female</td><td><u>All information below has been taken from the Gloucestershire County Council website: Inform Gloucestershire Census 2021</u>[53]

Overall, there were 329,832 women and 315,244 men living in Gloucestershire on Census Day 2021, equivalent to a 51.1% to 48.9% split. This is in-line with the South West and marginally different to the 51.0% female, 49.0% male split in England and Wales.

Population by sex, Gloucestershire 2021:
<table>
<tr><th>Area name</th><th>Females</th><th>Males</th><th>Net Difference</th><th>Female Proportion</th><th>Male Proportion</th></tr>
<tr><td>Cheltenham</td><td>60,751</td><td>58,085</td><td>2,666</td><td>51.1%</td><td>48.9%</td></tr>
<tr><td>Cotswold</td><td>47,060</td><td>43,772</td><td>3,288</td><td>51.8%</td><td>48.2%</td></tr>
<tr><td>Forest of Dean</td><td>44,441</td><td>42,563</td><td>1,878</td><td>51.1%</td><td>48.9%</td></tr>
<tr><td>Gloucester</td><td>66,916</td><td>65,500</td><td>1,416</td><td>50.5%</td><td>49.5%</td></tr>
<tr><td>Stroud</td><td>61,869</td><td>59,235</td><td>2,634</td><td>51.1%</td><td>48.9%</td></tr>
<tr><td>Tewkesbury</td><td>48,795</td><td>46,089</td><td>2,706</td><td>51.4%</td><td>48.6%</td></tr>
<tr><td>Gloucestershire</td><td>329,832</td><td>315,244</td><td>14,588</td><td>51.1%</td><td>48.9%</td></tr>
<tr><td>South West</td><td>2,911,551</td><td>2,789,635</td><td>121,916</td><td>51.1%</td><td>48.9%</td></tr>
<tr><td>England</td><td>28,833,712</td><td>27,656,336</td><td>1,177,376</td><td>51.0%</td><td>49.0%</td></tr>
<tr><td>England and Wales</td><td>30,420,202</td><td>29,177,340</td><td>1,242,862</td><td>51.0%</td><td>49.0%</td></tr>
</table>
All districts have a higher proportion of females than males. Cotswold has the highest proportion of females accounting for 51.8% of its population, whereas Gloucester has the lowest, accounting for 50.5% of its population.</td></tr>
</table>

[53] Census 2021 - Inform (gloucestershire.gov.uk)

	Gloucestershire has a smaller proportion of people in the age groups between 0- 4 and 40-44 and a higher proportion of people in all age groups over 50-54 for males and females combined, compared to England and Wales. There is more of a mixed picture when comparing to the South West, generally there is a bigger proportion of people in the 0-4 to 10-14 age groups and 35-39 to 60-64 age groups. In contrast, there is a smaller proportion of the population in the 15-19 to 25-29 and 65-69 plus age groups compared to the South West.
Disability *percentage/profile of service users who have a disability*	All information below has been taken from the Gloucestershire County Council website: Inform Gloucestershire Census 2021[54], Gloucestershire County Council Population Profile 2022 and from Office for Health Improvement and Disparities (OHID) Public health data. According to the 2021 Census: • 16.8% of Gloucestershire's population (108,379 people) were classed as disabled under the Equality Act (2010), of which 6.4% (41,202 people) said their daily activities are limited a lot and 10.4% (67,177 people) limited a little. There was a higher proportion of the population in both the South West (18.6%) and England and Wales (17.5%) classed as disabled • There was a slightly higher proportion of the Gloucestershire's population who have a long-term physical or mental health condition(s) but their daily activities are not limited, 8.0% of the population in Gloucestershire (51,411 people) vs. 7.7% in the South West and 6.8% in England and Wales overall. • Forest of Dean has a significantly higher proportion of people who are disabled under the Equality Act (2010); accounting for 19.2% of the population. • Cotswold has the significantly lowest proportion of disabled people with 15.4% of the population. • In Gloucestershire, 69.7% of households did not contain anyone classed as disabled. However, just under a quarter of households contained one disabled person and 5.8% of households had two or more disabled people living in them. The Gloucestershire proportions were similar to the regional and national proportions. 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.[55]

[54] Census 2021 - Inform (gloucestershire.gov.uk)

[55] 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 (2017). For those aged 65+ the figures are 9.1% and 110.2% respectively. In 2021/22, the recorded prevalence for depression (18+) was 11.9% in Gloucestershire compared to 12.7% in England.[56] 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*	All information below has been taken from the Gloucestershire County Council website: Inform Gloucestershire Census 2021[57] In 2021 93.1% (600,314 people) of Gloucestershire's population identified as "White". Gloucestershire was less diverse than the national average, with 81.7% of residents across England and Wales identifying as "White", however it was in line with the regional average where 93.1% of residents identified as "White". All districts in Gloucestershire had a higher proportion of residents identifying as "White" than nationally. The urban districts of Gloucester and Cheltenham (84.9% and 91.4%) had the lowest proportion of "White" residents, while the Forest of Dean had the highest (97.5%). "Asian, Asian British or Asian Welsh" accounted for the second largest proportion of Gloucestershire's population at 2.9%. This group was also the second largest group at a national and regional level, although it accounted for a larger proportion nationally (9.3%) than in Gloucestershire. This ethnic group also saw the largest percentage point increase from 2011, up from 2.1% . The third largest ethnic group in Gloucestershire was "Mixed or Multiple ethnic groups", this differs from the picture seen at a national level where "Black, Black British, Black Welsh, Caribbean or African" accounted for the third largest proportion of the population. As part of the "White" ethnic group, 87.7% of the total population in Gloucestershire identified their ethnic group as "English, Welsh, Scottish, Northern Irish or British", this is a decrease from 91.6% in 2011.

[56] Mental Health and Wellbeing JSNA - OHID (phe.org.uk)
[57] Census 2021 - Inform (gloucestershire.gov.uk)

	Across the 19 ethnic groups, the largest percentage point increase was seen in the number of people identifying through the "White: Other White" category (4.5% in 2021, up from 3.1%, in 2011). At ward level, Barton and Tredworth ward in Gloucester was the most ethnically diverse ward with three LSOAs in this area having less than half their population identifying as “White”. Given that the overall population has become more diverse since 2011 it is unsurprising the proportion of multi ethnic households increased during the same period. In 2011 6.1% of households in Gloucestershire were made up of different ethnic groups, this increased to 7.8% in 2021. The growth was primarily driven by an increase in households classed as “Ethnic groups differ within partnerships” with the proportion of households in Gloucestershire falling into this group increasing from 3.8% in 2011 to 5.1% in 2021. Since 2011 the proportion of Gloucestershire residents reporting a non-UK identity has increased from 4.4% in 2011 to 5.7% in 2021. Out of the 27,000 people living in Gloucestershire (4.3% of the population) whose main language was not English, 0.7% (4,294 people) could not speak English well or at all. Polish, Romanian and Portuguese were the most widely spoken languages in Gloucestershire other than English.
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 website: Inform Gloucestershire Census 2021[58] In 2021, among residents of Gloucestershire: • 48.0% of Gloucestershire residents aged 16+ were married or in a civil partnership, meaning this group accounts for the largest proportion of total residents. • Of the 48.0% of people in Gloucestershire who were married or in a registered civil partnership, 47.8% of individuals were married and 0.2% were in a registered civil partnership, • Of those people that are married 99.5% were in opposite-sex couples, • Same sex couples account for the largest proportion of civil partnerships at 70.6%, • 33.6% never been married and never registered a civil partnership, • 2.0% are separated but still legally married or still legally in a same sex civil partnership,

[58] Census 2021 - Inform (gloucestershire.gov.uk)

	• 9.9% are divorced or formerly in civil partnership which is now legally dissolved. • 6.5% are widowed or a surviving partner from 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.
Religion and/or belief *percentage/profile of service users religious beliefs*	All information below has been taken from the Gloucestershire County Council website: Inform Gloucestershire Census 2021[59] According to the 2021 Census, out of Gloucestershire's population, 266,959 people said they had no religion (equivalent to 41.4% of the population). This is a higher proportion than in 2011 when 26.7% of the population answered that they had no religion. The biggest change in proportion out of the categories given was the Christian category which decreased from a 63.5% share of the population in 2011 to a 49.2% share of the population in 2021 (equivalent to 61,534 fewer people. At district level: • Cheltenham had the smallest proportion of people identifying with Christianity at 45.5% whereas, Cotswold has the highest at 55.7%, • Cheltenham had the highest proportion of people stating they had no religion. • 30.1% of multi-person households stated that all members identify with the same religion, 22.2% stated that no members in the household were religious and 14.8% of households contained members who have the same religion and no religion.
Gender reassignment *percentage/profile of service users who have indicated they are transgender*	All information below has been taken from the Gloucestershire County Council website: Inform Gloucestershire Census 2021[60] In Gloucestershire, 94.39% of the population (502,440 people) over the age of 16 years have the same gender identity as their sex registered at birth, this is a higher proportion than both the South West (93.99%) and England and Wales (93.46%). 0.41% of the population (2,163 people) answered that their gender identity is different to the sex they were assigned at birth. This is similar to the proportion in the South West and England and Wales.

[59] Census 2021 - Inform (gloucestershire.gov.uk)
[60] Census 2021 - Inform (gloucestershire.gov.uk)

	In more detail, 0.08% of the population of Gloucestershire (423 people) identify as a trans woman, 0.07% of the population (380 people) as a trans man, 0.07% of the population (355 people) as non-binary and 0.04% of the population (229 people) specified other gender identities. These proportions are in-line with the regional and national proportions. At district level: • The district with the highest proportion of people whose gender identity is the same as their assigned sex at birth is Cotswold with 95.07% (72,549 people) whereas Gloucester has the lowest proportion with 93.75% of the population (100,259 people) • Gloucester has the highest proportion of the population whose gender identity is not the same as their assigned sex at birth (0.56%, 600 people) and Cotswold the lowest proportion with a 0.28% proportion (213 people). • Trans woman: Gloucester has the highest proportion with 0.11%, 114 people, whereas Forest of Dean has the lowest with 0.05% of the population, 38 people. • Trans man: Gloucester has the highest proportion with 0.10%, 107 people, and Forest of Dean the lowest with 0.04% of the population, 30 people. • Non-binary: Cheltenham has the highest proportion of the population with 0.12%, equivalent to 123 people, whereas Cotswold, Forest of Dean and Tewkesbury have the lowest with a 0.04% share, equivalent to 33, 30 and 29 people respectively.
Pregnancy & maternity *percentage/profile of service users who are female and who are pregnant or on a maternity leave*	All information below has been taken from the Gloucestershire County Council Population Profile 2022[61] There were 5,800 live births in Gloucestershire in 2020, which accounts for 1% of over 19 population. 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. 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

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

Sexual orientation *percentage/profile of service users who are lesbian, gay, bisexual, heterosexual*	All information below has been taken from the Gloucestershire County Council website: Inform Gloucestershire Census 2021[62] According to Census 2021, in Gloucestershire, 90.40% of residents (481,191 people) over the age of 16 stated that they are straight or heterosexual, 1.28% (6,814) said they are gay or lesbian, 1.21% (6,432) answered they are bisexual and 0.31% (1,660 people) of the population is classified as all other sexual orientations. In comparison, there was a similar proportion of the population in each of the sexual orientation categories in the South West and England and Wales. At district level: • Tewkesbury had the highest proportion of its population answering that they are straight or heterosexual with 91.58% (70,842 people) whilst the lowest proportion was in Cheltenham with 89.18% (87,790 people) • Cheltenham had the highest proportion of the population answering they were gay or lesbian (1.61%,1,581 people), bisexual (1.84%, 1,812 people) and all other sexual orientations (0.45%, 443 people). • The lowest proportion for the gay or lesbian category was Forest of Dean (1.02%, 747 people). • Cotswold accounted for the lowest proportion of people stating they are bisexual or stated a different sexual orientation, accounting for 0.85% (649 people) and 0.19% (144 people) respectively.

[62] Census 2021 - Inform (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