Name of meeting: Cabinet
Date: 13 December 2016
Title of report: Transition to Kirklees Wellbeing Integrated Model and Redesign of Smoking Cessation services

Key Decision - Is it likely to result in spending or saving £250k or more, or to have a significant effect on two or more electoral wards?	Yes
Key Decision - Is it in the Council's Forward Plan (key decisions and private reports?)	Yes
The Decision - Is it eligible for call in by Scrutiny?	Yes
Date signed off by Director & name **Is it also signed off by the Director of Resources?** **Is it also signed off by the Assistant Director (Legal, Governance & Monitoring)?**	Richard Parry, Director for Commissioning, Public Health & Adult Social Care, 29 November 2016 Debbie Hogg, 25 November 2016 Julie Muscroft, 29 November 2016
Cabinet member portfolio	Adults, Health and Activity to Improve Health

Electoral wards affected: All

Ward councillors consulted: Cllr Viv Kendrick, Portfolio Holder

Public or private: Public

1. Purpose of report

1.1 To brief Cabinet on the transition towards the Integrated Wellbeing Model, primarily the necessity to redesign the approach to smoking cessation that is central to freeing up resources for the new model.

2. Summary

2.1 The Council and NHS have prioritised the development of an Integrated Wellbeing Model of health improvement. This involves integrating, either fully and formally, or virtually, a number of existing services and approaches. This includes smoking cessation, weight management, physical activity, diabetes prevention, NHS health checks and health trainers. This has been discussed with the Health and Wellbeing Board, Clinical Commissioning Groups and the leads for Early Intervention and Prevention and adult social care.

2.2 Smoking cessation services are currently delivered by South West Yorkshire Foundation Trust (Smoke Free Service - SFS) and by GPs. The SFS contract expires on 31.3.2017. All other contracts (weight management, etc) end on 31.3.2018 so the proposed start date of the new Wellness model is 1st April 2018.

Because the SFS does not fit this timescale, the two options are:

- A contract extension for SFS until 31.3.2018
- Issue notice to the current provider and begin a new approach from 31.3.2017

2.3 It is proposed that Cabinet support the second option because the current service uses a model that will not continue post-2018 and because stand-alone smoking cessation services across the country have been struggling to get the target number of referrals as smoking prevalence has reduced and e-cigarettes appear to be a more valid quit option for people.

3. Information required to take a decision

3.1 Health in Kirklees: A Reminder

- The average life expectancy in Kirklees is 79 for men and 83 for women, lower than the England average. Healthy life expectancy is also lower.
- In 2015 men living in the most deprived areas of Kirklees could expect to die 9 years before those living in the least deprived, the gap for women is 6.3 years.
- 70% of deaths before 70 years of age are considered preventable.
- Two thirds of the adult population are overweight and/or obese (66%, up from 62% in 2012) as well as one third of children aged 11.
- The number of adults who smoke has fallen to 16% (CLIK survey, 2016) though this remains higher in disadvantaged areas and smoking in pregnancy remains a concern, particularly in North Kirklees.
- Kirklees has more physically inactive people and fewer active people than the English and West Yorkshire averages.
- Diabetes mortality is significantly higher than the England average and increasing
- Emotional health and wellbeing remains a major concern across all age groups.
- 1 in 4 people have one or more long term condition and the number is rising

3.2 Integration of health improvement services

This section outlines why the Health and Wellbeing Board and Clinical Commissioning Groups are planning on commissioning an integrated Wellness Service as part of a wider wellbeing model that is better aligned with New Council and the Target Operating Model, Early Intervention and Prevention and the NHS Five Year Forward View/Sustainability and Transformation Plans. These outline the importance of system-wide change and this approach offers a genuine opportunity to deliver an improved collaborative offer across Kirklees. The Integrated Commissioning Executive will lead commissioning of the new approach.

The wellbeing approach goes beyond looking at single-issue, healthy lifestyle services with a focus on illness, and instead aims to take a whole-person and community approach to improving health. Many people who smoke are also overweight. Many who do not exercise have mental health issues. Behaviours and conditions are often connected, and a 'silo-based' approach where each service focuses on one issue is an increasingly outdated model. Integration is not just a necessity for financial reasons but also offers genuine opportunities to improve health and reduce inequalities across Kirklees.

Based on self- care and intervening as early as possible but as late as necessary, it is clear that individuals who manage their own lifestyles are healthier, more productive, have fewer absences from work, and make fewer demands for medical and social services. Early intervention and prevention, keeping people healthy and out of acute and expensive urgent services, has direct financial advantage to the Council and NHS and longer term health and wellbeing advantages for residents.

Since 2012 other areas have adopted this approach, in particular the North East of England (Sunderland, Gateshead, Tyneside, Durham have all integrated services to a greater or lesser extent). Research is ongoing in each area but initial findings are positive. Public Health England has launched a "community of practice" to develop wellness in West Yorkshire as Leeds and Calderdale are also developing this approach.

As well as offering health improvement benefits the wellbeing model also offers an 'integration divided' and initial estimates by Public Health and Finance outlined a saving of £270,000 on the existing models currently in place. As the model is further developed by the Integrated Commissioning system this estimate will become more precise.

3.3 Current smoking provision

This paper primarily concerns our approach to smoking because the SFS contract expires on 31.3.2017. The contract has been operational for two years and the service, in common with other similar services elsewhere, has struggled to get people through the door. Whilst 466 people quit last year (2015/16) this is short of the expected amount and fewer than primary care services deliver.

Reasons are as follows:

- Overall smoking prevalence continues to reduce and many remaining smokers are resistant to a specific smoking based intervention as they also have other issues such as obesity, heavy drinking or mental health issues.
- E-cigarettes have become the preferred aid by which people quit. Many people quitting via the SFS also use e-cigs despite the service not promoting them because of an absence of NICE guidance.
- An increasing number of people have been quitting via the GP and pharmacy programmes. These are also funded by Public Health but at a significantly lower cost.

2015/16 Primary Care Quit conversions

Service Provided	Quit Date Set	Quits
GP Practice	935	465
Pharmacy	104	49
Grand Total	1039	514

Clinical Commissioning Groups and NHS England are considering restricting access to surgery to people who smoke because evidence shows smokers have worse surgical outcomes and take longer to recover. It will be expected that smokers make attempts to quit before surgery. The mechanism for this will be via GPs and primary care. It is logical to place the Kirklees approach to smoking cessation firmly within primary care. This will enable shared priorities to be met and also enable integration into the Wellbeing Model at a later date.

3.4 Advantages of this approach

- Primary care based services already deliver outcomes at least as strong as the specialist service but at lower cost to the public health budget, which also pays for these. A change of approach to a fully primary care based model will save the Council c£400k each year (although some of this will need to be invested in the wellbeing model from 1.4.18). This is needed to help to cope with the Public Health grant cuts.
- The future model involves an integrated approach with a strong primary care component so there is strategic alignment in the proposal. Health Checks, Health Trainers and PALS (physical activity) work closely with GPs and pharmacists already.
- CCGs will require additional capacity as they adapt surgical thresholds and there will be an opportunity to embed stronger partnerships.
- Deprived areas will be easier to target via GP surgeries.

3.5 Risks

- The major risk concerns the ability to tackle smoking in pregnancy, which remains a concern across the district with 618 women recorded as smoking at the time of delivery in 2015/16. To ameliorate these concerns, and to ensure GPs are properly trained in smoking cessation, it is proposed that a post is added to the Health Trainers service to manage the transition to the primary care model and to work with the Healthy Child Programme and maternity services to tackle smoking in pregnancy.

4 Implications for the Council

The Wellness Model will support the aims of New Council to empower people to live their lives to the fullest possible potential by enabling people to increase control over their health through making changes to their lives. It will also support the NHS 5 Year Forward View and Sustainability and Transformation Plans by diverting people from secondary healthcare services towards self-care and prevention pathways, helping to contain rising health and social care costs.

Using the primary care model described will save the Council £400-450,000 in 2017/18 (this will be offset against the Public Health grant reduction, this is not new savings to the Councils bottom line). We are not expecting any reduction in the number of quits generated so the unit cost per quit will be significantly reduced.

The new service will also enable the council to work more closely with the CCGs and primary care services, which will support the groundwork required for the design of the Wellbeing Model.

5 Consultees and their opinions

The model has been outlined to Public Health England. They are supportive of the move towards an integrated wellness service.

The Integrated Commissioning Executive and Clinical Strategy Groups have had the new approach described and are supportive. Sue Richards, EIP lead, has agreed that Health Trainers would be the correct place to manage the transition to primary care in close partnership with Public Health. GPs and CCGs are supportive of a move towards a primary care based model.

6 Next steps

- Recruit a post to manage the transition to the primary care model
- Issues notice to the current SFS provider
- Draft plan outlining time line for new approach and integration into new Wellbeing Model by 31.3.2018

7 Officer recommendations and reasons

7.1 To support the paper and the transition towards a wellbeing model, including not renewing the current contract for the Kirklees Smoke-free service and designing a primary care based approach that will start on 1.4.2017. This will require that notice be served (three months is required) to the current provider.

8 Cabinet portfolio holder's recommendations

8.1 To support the paper and the transition towards a wellbeing model, including not renewing the current contract for the Kirklees Smoke-free service and designing a primary care based approach that will start on 1.4.2017. This will require that notice be served (three months is required) to the current provider.

9 Contact officer

Tony Cooke, Head of Health Improvement, tony.cooke@kirklees.gov.uk.

10 Background Papers and History of Decisions

Health and Wellbeing Board/CCG Clinical Strategy Group papers outlining the Wellbeing Model.

Public Health England review of wellbeing services

11 Assistant Director responsible

Rachel Spencer-Henshall, Director of Public Health

REPORT TO THE INTEGRATED COMMISSIONING GROUP ON

TITLE

1. PURPOSE OF REPORT

The Wellness Model has been agreed by the Health and Wellbeing Board and both CCGs, and a report is coming to the ICG to provide an update on progress as well as a reminder about the overall context for the proposed model and likely benefits and challenges.

2. BACKGROUND

See attached paper.

3. PROPOSAL

See attached paper.

4. IMPACT

4.1 **Impact of implementing the proposal**

- *Service users will benefit from an integrated service via elimination/reduction of waiting times, a broader offer, better skills mix and earlier intervention.*
- *Integration will provide system wide savings over time and minimise health inequalities.*
- *It is intended that the model can be expanded to deliver an improved prevention based approach to health improvement and self-care.*
- *Partnerships will be enhanced, particularly between IAPT, health trainers, physical activity and obesity services.*
- *The health improvement offer to adult social care, primary care and the acute sector will be targeted and more effective at responding to system-wide issues.*

4.2 **Impact of not implementing the proposal**

- *Higher system-wide costs as more people age in poorer health with multiple long-term conditions.*
- *Inability to integrate and work in partnership will result in an inconsistent and increasingly un-evidenced approach, widening health inequalities and entrenching silos.*
- *Failure to tackle obesity, improve activity and further reduce smoking will create increasing problems related to health, illness, social problems and mental distress.*

5. CONSULTATIONS

Providers, residents and potential service users will be consulted with over the next 6 months.

6. NEXT STEPS

Both CCGs and HWB have received a version of the full report, plus a presentation. A strategy and commissioning board has been set up to lead development of the new approach.

7. SIGN-OFF

Tony Cooke, Head of Health Improvement

8. RECOMMENDATIONS

Set out your recommendations clearly and concisely. You should not introduce new information in this section - the reasoning behind your recommendations should be set out in Section 3 above.

9. CONTACT OFFICER

Operational: Simone Arratoonian, simone.arratoonian@kirklees.gov.uk

Strategic: Tony Cooke, tony.cooke@kirklees.gov.uk

If you need any guidance regarding this template please contact helen.pearson@kirklees.gov.uk or phil.longworth@kirklees.gov.uk on Council switchboard 01484 221000

Your report must be sent to Helen and Phil no later than 11 days before the date of the meeting at which it is to be considered.

A COMMUNITY WELLNESS MODEL OF HEALTH IMPROVEMENT FOR KIRKLEES

CONTEXT, DESIGN PRINCIPLES AND OPTIONS

1. SUMMARY

This paper outlines initial thinking and emerging plans to move towards commissioning integrated wellness models of health improvement rather than narrower 'silo-based' based interventions. Reasons for this approach include:

- Integration will improve outcomes: Potential to deliver both health improvement and prevention and early intervention outcomes at different points in the life-course.
- Integration will promote strategic alignment across the health and social care system as outlined in the Joint Health and Wellbeing Strategy
- Integration is increasingly evidenced: A common skill-set focusing on behaviour change is applicable across health improvement interventions (with some tailoring to population groups and exceptions for the most vulnerable where elements of specialist provision may still be needed).
- People should tell their story once where possible: Ongoing health inequalities and people presenting with more than one issue necessitate a move towards a "one-stop shop" approach that minimises confusion and supports a system-wide approach.
- Integration will promote collaboration and innovation across providers and be rooted in community engagement and co-production.
- Integration will promote self-care, resilience and community connectedness.

Key considerations:

- The money required to establish the service is available from current budgets.
- The wider 'wellness model' architecture needs to be designed by all partners, including determining the approach to commissioning.
- The model needs to be integrated with, and is integral to, the council Early Intervention and Prevention Programme whilst also having broader aims than preventing people entering the social care system
- The current system is not financially sustainable as long term conditions are increasing and creating a larger burden on the health and social care system.
- People are living longer but many are living with extended periods of disability
- Two-thirds of people are overweight and/or obese but there are insufficient resources to offer medical treatment so a different and more effective approach is needed.
- We must prioritise reducing the impact of key risk factors at an avoidable earlier stage whilst promoting better self-management for people with more serious needs

2. CONTEXT

2.1 Widening the scope of Public Health interventions

A number of existing Public Health "lifestyle" service contracts end between March 2016 and March 2018. This paper sets out the case for recommissioning services as an integrated Wellness Service as part of a wider wellbeing model that is better aligned with New Council and the Target Operating Model, Early Intervention and Prevention and the NHS Five Year Forward View. The Joint Health and Wellbeing Strategy and Transformation and Sustainability Plans outline the importance of system-wide change and this approach offers a genuine opportunity to deliver an improved collaborative offer across Kirklees.

There are many definitions of wellness; broadly they all emphasise a proactive, preventive approach that focus on the whole person and which works to achieve optimum levels of physical, mental, social and emotional health. Good nutrition, healthy weight, exercise, increased resilience, emotional health and wellbeing and avoiding risk factors such as tobacco and alcohol misuse all play a role in wellness, as does a feeling of community connectedness and social capital.

The wellness approach goes beyond looking at single-issue, healthy lifestyle services with a focus on illness, and instead aims to take a whole-person and community approach to improving health. Based on self-care and intervening as early as possible but as late as necessary, it is clear that individuals who manage their own lifestyles are healthier, more productive, have fewer absences from work, and make fewer demands for medical and social services. Early intervention and prevention, keeping people healthy and out of acute and expensive urgent services, has direct financial advantage to the Council and NHS and longer term health and wellbeing advantages for residents.

2.2 From a top-down deficit model to a provider/community-led approach

The previous public health paradigm focused on using a combination of legislation, campaigns and direct intervention to generate top-down change. Successes included reduced smoking and drug use and control of major infectious diseases such as HIV. Whilst the recent Sugar Tax shows that legislation will remain a key lever, the emerging public health paradigm is centred on promoting health and wellbeing across the life-course but rooting this within an approach focused on building social capital and strong, resilient communities. Individual health behaviour is increasingly understood within the context of the social and economic influences on health and the multiple, diverse systems people inhabit (Marmot, 2010). Working across these systems to promote healthy lifestyles and so prevent and delay the onset of non-communicable disease, promote healthy ageing and tackle health inequality is therefore a key function of the New Public Health.

However, increased academic understanding about the importance of system-wide change is within the context of smaller public services, reduced budgets and devolution. This will require providers that are better able to innovate, are flexible enough to work across silos and inclusive enough to put the user/patient before organisational demands. Changing our local culture to one that promotes health improvement also means providers must challenge themselves and the system to generate new ideas about service improvement. Closer to the ground and more agile, providers should be effective collaborators across systems using partnership building and leadership to develop trusting and strong networks. New models also require a workforce that prioritises relationships over technical skills and are able to operate at the edges of their authority.

A distinctive Kirklees approach would also utilise an Assets and Strengths based approach to promote community connectedness and social capital and be rooted in a user-led approach with community builders, local champions and volunteers integral to delivery as a result of the need to promote culture change. Three of the most successful current public health interventions are PALS, Health Trainers and Auntie Pams. All are rooted in communities, use a network of volunteers, promote resilience and self-care and are essentially social learning interventions that increase the confidence of users to develop their whole being and think more widely than the issues that have initially motivated them to attend the services in question.

3. HEALTH IN KIRKLEES – A REMINDER

- The average life expectancy in Kirklees is 79 for men and 83 for women, lower than the England average. Healthy life expectancy is also lower.
- In 2015 men living in the most deprived areas of Kirklees could expect to die 9 years before those living in the least deprived, the gap for women is 6.3 years.
- 70% of deaths before 70 years of age are considered preventable.
- Two thirds of the adult population are overweight and/or obese (66%, up from 62% in 2012) as well as one third of children aged 11.
- Kirklees has more physically inactive people and fewer active people than the English and West Yorkshire averages.
- Diabetes mortality is significantly higher than the England average and increasing
- Emotional health and wellbeing remains a major concern across all age groups.
- 1 in 4 people have one or more long term condition and the number is rising

These are system-wide issues requiring a system-wide response. Tackling them has been compounded by the silo-based approach to the commissioning and provision of health prevention services based on single issues and by single organisations e.g. smoking, obesity. Currently services are provided by a range of organisations, in a variety of different locations, with individual contact numbers and different methods of access. Professionals and the public are often unaware of the full range of services on offer due to the complexity of navigating pathways through services. Whilst there are some people that might need single issue support, many service users present with more than one issue and skills for the promotion of behaviour change are common ones that can be applied generally to health improvement and self-care if the right training and support is provided.

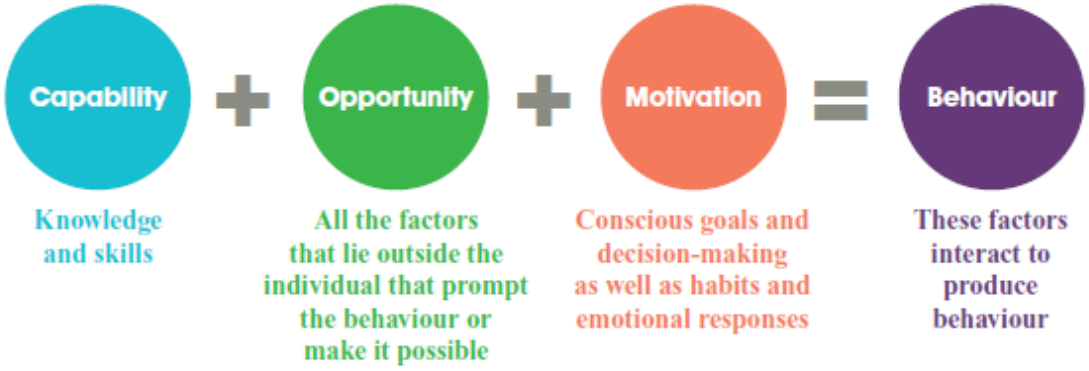
4. EVIDENCE BASE AND COST EFFECTIVENESS

Researchers have identified three main components that need to be present to influence behaviour (NESTA, 2016, see Figure 1 below). Whilst knowledge and skills are a key starting point, the great majority of, for example, obese people know that moving more often and eating a better diet is necessary. Opportunity, driven by wider factors, and motivation, influenced by culture and habits are at least as influential. The importance of wider factors and cultures that lie outside the immediate control of the individual demonstrate why a system-wide approach rooted in an integrated model is more likely to exert positive influences on individuals and populations than a silo-based approach to health improvement. With the wellness model, although a number of interventions are embedded, the same background awareness of the influences on behaviour are present and the staff work out which aspects of behaviour needs to be changed for each individual and a tailored programme developed.

The Liverpool Public Health Observatory review of wellness approaches concluded that they "*showed potential to give a return on investment and save future costs due to ill health. Some initiatives not only made savings in care costs, but improved quality of life, enabling individuals to live independently".* The report also found that wellness services could provide an effective longer term response to frequent attendees in primary care by tackling the underlying causes of their visits. Many of the services (such as social prescribing where patients are linked to the non-medical facilities and services available in their wider community) had low costs when compared to medical treatment (Public Health England/JMU 2012). Since 2012 other areas have adopted this approach, in particular the North East of England (Sunderland, Gateshead, Tyneside, Durham have all integrated services to a greater or lesser extent). Research is ongoing in each area but initial findings are positive. Public Health England has proposed the development of a community of practice approach

in West Yorkshire as Leeds and Calderdale are also considering this approach. Nonetheless, it is acknowledged by the Kings Fund (2015) "that because of the shortages of academic research evidence on the usefulness and cost-effectiveness of different approaches, commissioners will need to innovate and take risks". Because there is no national blue-print for this project, Kirklees commissioners and providers have an opportunity to develop a cutting edge approach that seeks to meet the requirements of a wide range of partners and improves outcomes across our diverse communities.

Figure 1: Influences on behaviour (Michie, Atkins and West, 2014)



5. AIMS, OBJECTIVES AND DESIGN PRINCIPLES

5.1 Aim

The proposed aim is *"to support people to live longer, healthier, happier lives through greater integration and by moving resources towards a life-course based approach rooted in prevention and early intervention and away from avoidable treatment and care".*

5.2 Design Principles underpinning the process

- Improved health and wellbeing
- Supporting independence, promoting resilience; helping people do more for themselves and each other
- Enabling healthy behaviours and reducing inequalities across the life-course
- Prevention and early intervention
- Self-care and better management of existing long term conditions, preventing these conditions worsening and utilising community focused approaches as well as preventative medicine
- Strengths and assets based approach to communities
- Collaboration and integration and clear pathways at all levels
- Intelligence and insight led
- Evidence based without hampering creative approaches and innovation
- Embedding behaviour change approaches that utilise the most effective behaviour change techniques tailored to each individual
- Long term thinking and planning horizons

5.3 Wellness Model Strategic Outcomes

The Wellness Model will support the aims of New Council to empower people to live their lives to the fullest possible potential by enabling people to increase control over their health through making changes to their lives. It will support the NHS 5 Year Forward View and Sustainability and Transformation Plans by diverting people from primary and secondary healthcare services towards prevention pathways, helping to contain rising healthcare costs. Pathways will be streamlined and consideration will be given to self-referral, drop-in and outreach approaches.

5.4 Integration

The primary objective of the Wellness Model is to provide a person centred, integrated, single point of access wellness service within a wider wellness network. The services that might, after partner discussion, be included are|:

- Diet and nutrition
- Physical activity and exercise on prescription
- Weight management and diabetes prevention
- Tobacco/smoking cessation
- Alcohol early intervention?
- Mental wellbeing and links to IAPT and personal resilience
- Self-care including Expert Patient Programme
- NHS Health Checks (based in primary care)
- Health trainers
- Volunteer Community Health Champions
- Health psychology and behavioural insights
- Promoting cancer prevention and engagement with screening
- Social marketing and community insight
- Digital health improvement

Other services integral to the wider model:

- Services for vulnerable adults (drugs, domestic abuse, offender health etc)
- Planned care e.g. pain services
- Proposed national diabetes prevention service
- Carers services and recovery services
- Social prescribing (Better in Kirklees etc)
- Schools as community hubs

Strong links to systems tackling wider factors influencing health within the model:

- Communities – including community development, sporting and third sector
- Healthy environments – leisure, parks/open spaces, active travel, food growing
- Housing advice and support – all tenures
- Employment advice and support
- Anti-poverty approaches including food banks, proposed credit union

6. DELIVERY OPTIONS

Whilst the overall design emphasises the importance of the broader partnership model consideration needs to be given to the approach to commissioning. Four possible service delivery models could be investigated for options appraisal:

- Maintain current service provision under several providers (no change option)
- Establish a virtual Wellness Service with several providers in a clearer collaboration based approach. Model and service would be 'emergent' and build on existing strengths/relationships
- Establish a fully integrated Wellness Service by bringing together existing lifestyle services under a lead provider model with sub-contracted specialist provision where necessary
- Establish a fully integrated service under a single provider

Other areas have opted for the second and third of these options. Some have instigated a "year zero" type approach and ended a series of contracts, others have taken an approach based on aligning contract end dates. Most existing Public Health contracts end in October 2017 and March 2018. A pragmatic approach would be to plan an approach in which different components of the service go live at different points in time, with the full approach going live on 1 April 2018.

7. NEXT STEPS

7.1 Determine Governance – A partnership project board has been set up with representation from CCGs, Council EIP Programme, Healthwatch, Public Health, Community Engagement, Third sector leaders group etc. The Wellness project board will report directly to the Integrated Commissioning Executive as well as via the Health and Wellbeing Board and CCG Governing Bodies. Procurement, legal, HR and finance support will be utilised as necessary.

7.2 Insight and engagement with public and providers - a public engagement exercise is being scoped to ensure that resident needs are defined and used to inform the design process for the Wellness Service. This will also obtain insight into community perceptions of potential approaches. Likewise, insight from existing and potential new providers will be important to generate mutual understanding about what may or may not be the best options for Kirklees.

7.3 Understand risks – initial conversations with other commissioners elsewhere in the country have outlined service related risks related to thresholds of intervention, attracting the worried well, a universal vs targeted approach. System issues appear to concern marketing, branding and ownership across the health and social care system, not losing added value inherent in (some) existing interventions and losing organisational memory.

7.4 Leadership and management – the Head of Health Improvement will act as strategic lead and will determine the resources needed to manage the process of designing the wellness model. A Project Initiation Document will be drafted with clear timelines between October 2016 and April 2018. Furthermore a logic model outlining the generation of long-term sustainable benefits from the new approach will be signed off in October 2016.

Tony Cooke, Head of Health Improvement, September 2016.

EQUALITY SCREENING TOOL

This screening tool has been developed to assist you to make an initial assessment on the priority you may give to a proposal about, or review of a service, function, or policy in your area. It acts to indicate the likely impact this proposal could have on groups of people. Multiple proposals, or alternate options, can be run individually through this tool. It should be completed by someone who has knowledge of both the issue and the employees who will be carrying out the work. **[If you feel that there is likely to be a high impact then you can go straight to Stage 2 Document (Ensuring Legal Compliance)]**

LEVEL OF IMPACT Is an indication of the likely impact your proposal could have upon communities &/or employees.
GREEN = low; YELLOW = medium rising to - AMBER = high medium; RED = High;

RISK This is an indication of the chance of not being able to mount a successful defence if challenged.
GREEN =low; YELLOW = medium; AMBER = high medium; RED = High;
NB **There is always a risk of challenge.** ***A lack of evidence leads to a high score.***

Directorate:	**Service**:
Public Health	Public Health
Lead Officer:	**Service Area:**
Tony Cooke	Tobacco
Officers responsible for Assessment:	**Date of Review:**
Tony Cooke	25-Oct-16

Impact Scores (max = 100)

30 and below - your proposal is likely to have little if any impact.
31 - 40 An **EIA could be considered**
41 - 54 your proposal is likely to have a **wide impact**. An **EIA is advised**
55 and above **An EIA is STRONGLY advised**

LEVEL OF IMPACT	RISK (%)
31	**18**

RISK (see above)
Irrespective of the impact score; **IF risk background is GREEN less than 30%** then there is **likely to be sufficient evidence** demonstrate that **DUE REGARD has been taken.**

QUESTION No.	WHAT IS YOUR PROPOSAL?	type y or n	Comments (please explain your answer)
1	To withdraw a service, activity or presence	N	
2	To reduce a a service, activity or presence	N	
3	To introduce or increase a charge for Service	N	
4	To change to a commissioned service	Y	We are planning on changing the current model of delivery for the Smokefree Service in Kirklees by moving away from a dedicated service and towards a model based in primary care. This will run from 1.4.2017-1.4.2018. After this, the Integrated Wellness Model will offer support for smokers seeking to quit.
5	To introduce, review or change a policy or procedure	N	
6	To introduce a new service or activity	N	
7	Is this about improving access to, or delivery of a service.	N	
8	Will you require supporting evidence on this issue	N	
	WHO WILL IT AFFECT?		People living in Kirklees/ smokers who want to quit / people who want to refer to existing service
9	Does this affect Employees? If YES please list	N	
10	Does this affect a Single Ward or Locality ONLY	N	
11	Does this affect most of Kirklees or its Residents	Y	The current service targets pregnant women. A primary care based service might find this harder as it requires work with maternity services, so the mitigation is a post based in health trainers for one year (1.4.2017-1.4.2018) until the wellness model starts on 1.4.2018. Support from a specialist worker will ensure the pregnant women who smoke still receive support.
12	Does this issue concern ANY Protected Characteristic Group.	N	
13	Can you foresee a negative impact on any Protected Characteristic Group(s)? If YES please state what these could be.	N	
14	If IMPACT at this stage is less than 15 answer Y to this question	n	IF YOU CAN ANSWER YES HERE THEN DO NOT ANSWER ANY FURTHER QUESTIONS

	TAKING DUE REGARD		
Where consultation was needed:			
15	**Have you got any general intelligence (research, consultation, etc.)?** If YES please list any related documents.	**Y**	There is a national problem with smoking cessation services, because as fewer people smoke, and those people increasingly use e-cigarettes to quit, there is less need for dedicated smoking cessation services. As stated, the current service model targets pregant women and it will harder to target these once the smokign cessation contract is not renewed. To mitigate this risk, a temporary post in the Health Trainers team will be responsible for managing this agenda and for working with primary care between 1.4.2017-1.4.2018. From 1.4.2018 this will then be integrated into the new Wellness Model as per the paper that was presented to the Health and Wellbeing Board.
16	**Have you got any specific intelligence (research, consultation, etc.)?** If YES please list any related documents.	**n**	
17	**Have you taken specialist advice? (Legal, E&D Team, etc).** If YES please state.	**n**	
18	**Have You considered your Public Sector Equality Duty?** Please provide a rationale	**Y**	
19	**Can the Public access a "Decision Report"?** If YES state where and how it can be accessed.	**n**	
20	**Can you mitigate any negative effect?** Please state how	**Y**	
21	**Do you have any supporting evidence?** If YES please list the documents	**Y**	
22	**Have you published your information?** If YES state where.	**n**	

ONLY IF your proposal is likely to have **little** or **no impact** upon groups and you are confident that you have evidence to support your proposal and this document. (RISK less than 30% [GREEN])
1) Save this scoresheet;
2) Complete and save a 'Front Sheet';
3) Make sure you have gathered any supporting evidence documents and they are listed above
4) SEND Electronic copies of this tool and a front sheet to equalityanddiversity@kirklees.gov.uk

IF your proposal is likely to have medium or above impact upon groups AND you are not confident that you have evidence to support your proposal and this document. (RISK greater than 30% [yellow, amber, red])
1) Save this scoresheet;
2) Proceed to Stage 2 document (Ensuring Legal Compliance)