Shropshire Council
Equality, Social Inclusion and Health Impact Assessment (ESHIA)
Stage One Screening Record 2026

Please note that part A and part B of this document should be completed.

A. Summary Sheet on Accountability and Actions

Name of proposed service change
Shropshire Domestic Abuse Partnership Strategy

Name of the officer carrying out the screening
Wendy Bulman

Decision, review, and monitoring

Decision	**Yes**	**No**
Initial (Stage One) ESHIA Only?	X	
Proceed to Stage Two Full ESHIA or HIA (part two) Report?		X

If completion of a Stage One screening assessment is an appropriate and proportionate action at this stage, please use the boxes above, and complete both part A and part B of of this template. If a Full or Stage Two report is required, please move on to full report stage once you have completed this initial screening assessment as a record of the considerations which you have given to this matter.

Assessment of likely neutral, negative impact or positive impact of the service change in terms of equality and social inclusion considerations
The Shropshire Domestic Abuse Partnership Strategy was created by Shropshire Council, working alongside partners of the Shropshire Domestic Abuse Local Partnership Board. The Board will agree priorities and objectives over the next three years to reduce domestic abuse in Shropshire. This collaborative effort ensures that the Council meets its duties under the Domestic Abuse Act 2021. Central to the strategy is the provision of a clear and inclusive definition of domestic abuse. The Domestic Abuse Partnership Strategy proactively addresses the needs of individuals in statutory Protected Characteristic groupings, as defined in the Equality Act 2010, as well as local communities that may require additional support. There are nine Protected Characteristic groupings defined in the Equality Act 2010: Age; Disability; Gender Reassignment; Marriage and Civil Partnership; Pregnancy and Maternity; Race; Religion or Belief; Sex; and Sexual Orientation. It is important to note that there is intersectionality between these groupings.

In Shropshire, there is an additional focus on those at risk of social exclusion, as well as inclusion health groups. This group also encompasses people who are homeless or have experienced rough sleeping, especially over extended periods as well as those with other overlapping risk factors such as substance misuse, poverty or trauma among others. While not a statutory protected characteristic, social exclusion is considered a crucial category to ensure the strategy is inclusive of vulnerable individuals and households, particularly those experiencing or fleeing domestic abuse, where relocation from support networks is a potential risk. Furthermore, the strategy considers all residents of Shropshire which includes Young People Leaving Care, Carers (including young carers), and Veterans and Serving Members of the Armed Forces and their families as local groupings requiring support.

To mitigate any negative impacts and enhance positive outcomes, the strategy completed a comprehensive consultation process involving feedback from a wide range of individuals and stakeholder organisations. This approach was intended to evaluate and address any potential negative consequences of the strategy, as well as to identify opportunities to strengthen its positive impact on the wellbeing of Shropshire residents.

Initial screening before the consultation indicated that the strategy would likely have a low to moderate positive effect on individuals and households within protected and local groups. By focusing on improving accessibility, reducing inequalities, and achieving better outcomes for everyone, the strategy aims to tackle and reduce rates of domestic abuse throughout Shropshire. It identifies four main priorities—victims, perpetrators, community, and workforce—to address domestic abuse locally and provide support for all protected and vulnerable groups. The public consultation for the draft Shropshire Domestic Abuse Partnership Strategy took place online between February 2 and March 2, 2026, and collected 73 responses. Of the 69 participants who clarified their role, most (50) responded as individuals, with the remainder (19) representing organisations. Of these organisational respondents, 40% (10) were from public service providers, 20% (5) from ‘Other’ categories, and 12% (3) from strategic or cross-boundary organisations and local partnerships. Most respondents had a Shropshire (SY) postcode, though some organisational representatives may reside outside the county.

Demographic Profile of respondents

- Gender (69 respondents): 81% female (56), 13% male (9), 6% preferred not to specify (4)
- Age (68 respondents): largest group 45–54 years (32%, 22), followed by 55–64 years (29%, 20), then 35–44 years (16%, 11)
- Gender identity: 91% (62 of 68) reported gender remained unchanged since birth; 9% (6) preferred not to say; no respondents indicated a change
- Sexual orientation (67 respondents): 84% straight or heterosexual (56), 15% preferred not to specify (10), 2% bisexual (1)
- Pregnancy status (66 respondents): 86% not pregnant (57), 8% preferred not to say (5), 6% not applicable (4)
- Disability (67 respondents): 60% no (40), 24% yes (16), 16% preferred not to respond (11)

- Condition details (26 respondents): 62% preferred not to specify (16), mobility concerns 15% (4), mental health concerns 12% (3)
- Neurodiversity (64 respondents): 77% no (49), 13% preferred not to say (8), 11% yes (7)
- Care leaver status: no responses, aspect unanalysed
- Religion (66 respondents): 49% no religion (32), 32% Christian (21), 15% preferred not to disclose (10), Buddhist, Agnostic, Muslim each 2% (1)

The impact assessment in the draft ESHIA remains unchanged, as the majority of respondents expressed satisfaction with the strategy's vision and priorities. Most participants agreed that the strategy is accessible and meets statutory duties, and no substantial concerns were raised requiring revision of the initial positive impact assessment.

While responses were captured from a diverse range of sectors, including data on gender, age, disability, neurodiversity, and care leaver status, some notable gaps emerged. Specifically, there were no responses from individuals who identify as transgender, those from ethnic backgrounds other than white or white British, or members of faith communities. This lack of feedback limits our understanding of these groups' perspectives, highlighting a risk that the strategy may not fully address the unique challenges faced by vulnerable populations.

To address these gaps, the action plan will incorporate targeted measures to improve engagement and support for underrepresented groups, ensuring their voices inform service development and delivery. Although the overall impact assessment did not change after consultation, feedback identified areas for further engagement. The strategy will proactively seek to reach and support groups whose perspectives were not reflected in the initial consultation—strengthening equality, social inclusion, and the effectiveness of domestic abuse services throughout Shropshire.

Assessment of likely neutral, negative or positive impact of the service change in terms of health and wellbeing considerations

It is recognised that there will be challenges of disruption and social isolation, which the Council and partners seek to address within the strategy, along with emphasising the need for further exploration to identify effective ways of mitigating potential negative impacts. Priority actions will incorporate health, wellbeing, economic, and wider community considerations, aiming to maximise positive outcomes for those affected by domestic abuse. Given the profound consequences of domestic abuse—including murder, suicide, physical injuries, chronic health conditions, trauma, anxiety, depression, and long-term emotional harm for both adults and children—the strategy seeks to address these issues holistically and promote resilience and recovery.

For example, some safe accommodation offers a significant positive impact for all individuals fleeing domestic abuse. By providing a secure environment, it enables those affected to escape from their perpetrators and relocate to a space where their whereabouts are unknown and inaccessible to those posing a risk. This transition reduces stress and anxiety and allows individuals to receive essential

support in a protected setting, leading to improvements in both mental and physical health and overall wellbeing.

Nevertheless, it is important to acknowledge the potential negative consequences associated with such displacement. Leaving behind their original location, individuals may become isolated from family, friends, and established support networks, which can adversely affect mental wellbeing and contribute to feelings of loneliness. This concern is particularly pronounced for children and young people, who may have to move school or college, lose contact with friends, and be separated from familiar social activities. These changes can make it difficult for them to express their feelings or discuss their challenges, potentially resulting in negative health and wellbeing outcomes. It should be noted however that the improvements in safety, and access to effective support services provide far greater positive impacts than the negative impacts resulting from remaining in a potentially dangerous situation. Where possible, suitable mitigations would be put in place against these negative impacts.

Actions to review and monitor the impact of the service change in terms of equality, social inclusion, and health considerations

The development of the final strategy is shaped by the public consultation feedback and insights, as well as valuable insights from our Lived Experience Advisory Group. Recognising that domestic abuse impacts far more than just those directly involved, the strategy is designed with the broader community in mind. An action plan will underpin the strategy, with regular monitoring and annual reviews to ensure it remains effective. These reviews will incorporate feedback from individuals who have firsthand experience of domestic abuse, ensuring that lived experience continues to inform service development and commissioning.

As the strategy is implemented, the monitoring and review process will focus on identifying opportunities to increase positive outcomes for victims, perpetrators, staff, and the wider public. Ongoing engagement and evaluation will be central to this approach, enabling the strategy to adapt to emerging needs and insights.

Over the coming months and years, specific actions to review and monitor a range of impacts will be developed as the new strategy and commissioned service are rolled out. This process will remain responsive to any local changes arising from national developments, particularly the awaited publication of an updated Equality and Human Rights Commission (EHRC) Code of Practice. The draft Code, still with the Minister for Women and Equalities following national consultation—where Shropshire Council contributed—reflects the Supreme Court ruling that Sex as a Protected Characteristic refers to the biological sex recorded at birth.

Associated ESHIAs

ESHIA re Domestic Abuse Safe Accommodation Strategy 2025.

Given the importance of addressing homelessness, rough sleeping, temporary accommodation, independent living, and specialist accommodation within the

context of domestic abuse, it is crucial that our Housing ESHIAs remain closely aligned with this strategy. Ensuring that these ESHIA documents are interconnected will help support individuals affected by domestic abuse and those experiencing housing instability.

After the public consultation period for the draft Shropshire Domestic Abuse Partnership Strategy concluded, a second screening ESHIA was undertaken. This allowed us to incorporate feedback received during the consultation, ensuring our approach remains responsive and effective.

Assessment of likely neutral, negative or positive impact, and actions to review and monitor overall impacts, with regard to climate change impacts and with regard to economic and societal impacts

The Shropshire Domestic Abuse Partnership Strategy is designed not only to support those directly affected by domestic abuse, but also to address its wider impacts across the community. This includes careful consideration of environmental, economic, societal, and human rights factors to seek to ensure an holistic and effective approach.

Climate Change
While the strategy has a minimal direct effect on climate change, its implementation can influence environmental outcomes through the way services are delivered. Activities such as outreach travel and building use contribute to carbon emissions and resource consumption. To minimise environmental impact, the Domestic Abuse Partnership Board will promote the use of safe digital meetings, and regular reviews of travel, energy consumption, and procurement practices. These measures are intended to keep the service's climate footprint as low as possible, in line with local commitments.

Economic and Societal/Wider Community Impacts
The consequences of domestic abuse extend far beyond individual households. Economically, it leads to lost employment, decreased productivity, financial instability, housing disruption, and heightened demand for public services, including health, policing, social care, and housing support. At the societal level, domestic abuse undermines community cohesion, increases feelings of fear and isolation, puts strain on both voluntary and statutory services, and perpetuates intergenerational cycles of harm. These factors establish domestic abuse as not only a personal crisis but also a significant public health, economic, and community issue.

Human rights considerations are also central to the strategy. For example, the right to family life may be raised by perpetrators of domestic abuse, particularly when their children are provided with safe accommodation. The strategy will address such issues as partnership work develops further, with a focus on minimising any potential negative impacts.

Taken together, the Shropshire Domestic Abuse Partnership Strategy is integral to creating positive change, addressing not only immediate safety needs but also broader economic, social, and environmental challenges within the community.

Scrutiny at Stage One screening stage

People involved	Signatures	Date
Wendy Bulman Domestic Abuse Strategic Lead	W BULMAN	3 April 2026
Officer carrying out the screening (if different from the above)		
*External support** **Mrs Lois Dale** **Senior Insights and Research Specialist** **Phil Northfield** **Public Health Integration & Inequalities Officer**	Lois Dale I Northfield	31st January 2026 2nd April 2026

This refers to support external to the service and within the Council, e.g., the Senior Insights and Research EDI specialist, the Integration & Inequalities Officer – Public Health, other Insights and Research or Public Health colleagues, the Feedback and Insight Team, Climate Change specialists, etc.

Sign off at Stage One screening stage

Name	Signatures	Date
Wendy Bulman	W BULMAN	3 April 2026

This may either be the Head of Service or the lead officer

B. Detailed Screening Assessment

Aims of the service change and description
Part 4 of the Domestic Abuse Act 2021 ("the Act") sets out statutory duties for local authorities. In summary these are to: • appoint a multi-agency Domestic Abuse Local Partnership Board (DALPB) (in line with core membership set out in the Act and statutory guidance), which will carry out a governance and consultative role as it performs certain specified functions;

- assess the need for safe accommodation-based domestic abuse support for all victims in their area;
- in consultation with the partnership board, develop and publish a strategy for the provision of such support to cover their locality – which is based on the needs assessment, is implemented through commissioning decisions, and includes monitoring and evaluation

The most recent Domestic Abuse Strategy was published in 2018 following consideration by members. The strategy overarching goals were to stop domestic abuse and address prevention, provision of services and partnership working.

The production and publishing of a Domestic Abuse Strategy every 3 years is a statutory duty of the Local Authority and as such there could be consequences for failing to deliver Part 4 of the Act.

As per our statutory duty, in 2024 Shropshire Council conducted a Needs Assessment to inform commissioning of accommodation-based support to victims of domestic abuse and their children in all forms of safe accommodation as defined in the Act. In addition to supporting the Council in meeting our statutory duty we delivered a full review which has informed the development of this wider strategy and the development of a coordinated community response to domestic abuse.

The Shropshire Domestic Abuse Partnership Strategy overarching goal is to reduce domestic abuse within Shropshire. Developed in collaboration with the Domestic Abuse Local Partnership Board and individuals with lived experience, this strategy aims to address the needs of survivors and vulnerable populations across Shropshire. The framework is structured around four main priorities—victims, perpetrators, communities, and workforce—all aimed at reducing domestic abuse across Shropshire.

The Strategy outlines priority actions in the following areas:

- The '**Victims'** priority aims to ensure that victims and survivors, including children, promptly receive trauma-informed support and advocacy. Providing clear guidance to available information and services will facilitate access to further assistance, help mitigate long-term harm, and foster greater trust in local systems.
- The '**Workforce'** priority seeks to provide professionals with essential skills, knowledge, and confidence to respond effectively to domestic abuse. This approach will improve the identification of abuse, address gaps in service provision, and contribute to the reduction of domestic abuse incidents.
- The '**Perpetrators'** priority focuses on preventing harm through targeted interventions and holding individuals who engage in harmful behaviours accountable, thereby reinforcing a zero-tolerance approach and encouraging behavioural change.
- The '**Community'** priority is dedicated to equipping communities with the necessary skills, knowledge, and confidence to respond appropriately. By

promoting clear pathways to support, this objective aims to lower barriers to assistance, reduce stigma, raise awareness, and encourage early referrals for victims seeking help.

Intended audiences and target groups for the service change

- All those fleeing domestic abuse
- All those experiencing domestic abuse or at risk of domestic abuse
- Families and friends of those affected
- Support networks for those affected
- Agencies and providers involved
- Lived Experience Advisory Group
- Joint Commissioning Delivery Group.
- Domestic Abuse Local Partnership Board (DALPB)
- Community Safety Partnership
- Government departments
- Neighbouring local authorities

Evidence used for screening of the service change

- 2018 Strategy
- 2024 Needs Assessment
- 2025 Domestic Abuse Safe Accommodation Strategy
- Shropshire-wide Domestic Abuse Survey
- Statutory duties and guidance
- Safeguarding protocols and procedures

Specific consultation and engagement with intended audiences and target groups for the service change

Workshops with the DALPB and lived experience advisory groups to ensure the strategy was co-produced and meets the needs of individual people and organisations.

Initial equality impact assessment by grouping (Initial health impact assessment is included below this table)

Please rate the impact that you perceive the service change is likely to have for a grouping, through stating this in the relevant column, including if it is anticipated to be neutral (no impact).

Please also record in here your headline rationale for the ratings you have given.

Protected Characteristic groupings and other groupings locally identified in Shropshire	**High negative impact** *Stage Two ESHIA required*	**High positive impact** *Stage One ESHIA required*	**Medium positive or negative impact** *Stage One ESHIA required*	**Low positive, negative, or neutral impact (please specify)** *Stage One ESHIA required*
Age (please include children, young people, young carers, young people leaving care, people of working age, older people. Some people may belong to more than one group e.g., a child or young person for whom there are safeguarding concerns e.g., an older person with a disability)			Low to medium positive impact	
Disability (please include cancer; HIV/AIDS; learning disabilities; mental health conditions and syndromes; multiple sclerosis; neurodiverse conditions such as autism; hidden disabilities such as Crohn's disease; physical and/or sensory disabilities or impairments)			Low to medium positive impact	
Gender re-assignment (please include associated aspects: safety, caring responsibility, potential for bullying and harassment)			Low to medium positive impact	
Marriage and Civil Partnership (please include associated aspects: caring responsibility, potential for bullying and harassment)			Low to medium positive impact	
Pregnancy and Maternity (please include associated aspects: safety, caring responsibility, potential for bullying and harassment)			Low to medium positive impact	
Race (please include ethnicity, nationality, culture, language, Gypsy, Roma, Traveller)			Low to medium positive impact	
Religion or Belief (please include Buddhism, Christianity, Hinduism, Islam, Jainism, Judaism, Nonconformists; Rastafarianism; Shinto, Sikhism, Taoism, Veganism, Zoroastrianism, and any others)			Low to medium positive impact	

Sex (please include associated aspects: safety, caring responsibility, potential for bullying and harassment)			Low to medium positive impact	
Sexual Orientation (please include associated aspects: safety; caring responsibility; potential for bullying and harassment)			Low to medium positive impact	
Other: Social Inclusion (please include households in poverty or on low incomes; people for whom there are safeguarding concerns; people you consider to be vulnerable; people with health inequalities; refugees and asylum seekers; rough sleepers and those at risk of homelessness; and rural communities)			Low to medium positive impact	
Other: Carers (please include families and friends with caring responsibilities)			Low to medium positive impact	
Other: Veterans and serving members of the armed forces and their families (as per Armed Forces Act 2023)			Low to medium positive impact	
Other: Young people leaving care			Low to medium positive impact	

Initial health and wellbeing impact assessment by category

Please rate the impact that you perceive the service change is likely to have with regard to health and wellbeing, through stating this in the relevant column, including if it is anticipated to be neutral (no impact).
Please also record in here your headline rationale for the ratings you have given.

Health and wellbeing: individuals and communities in Shropshire	**High negative impact** *Part Two HIA required*	**High positive impact**	**Medium positive or negative impact**	**Low positive negative or neutral impact (please specify)**
Will the proposal have a *direct impact* on an individual's health, mental health and wellbeing?			Low to medium positive, balanced in favour of positive	

For example, would it cause ill health, affecting social inclusion, independence and participation? .			impacts, with low negative of potential disruptions to pre-existing support networks	
Will the proposal *indirectly impact* an individual's ability to improve their own health and wellbeing? For example, will it affect their ability to be physically active, choose healthy food, reduce drinking and smoking? .			Low to medium positive, balanced with low negative of potential disruptions to support networks	
Will the policy have a *direct impact* on the community - social, economic and environmental living conditions that would impact health? For example, would it affect housing, transport, child development, education, employment opportunities, availability of green space or climate change mitigation?			Low to medium positive, balanced with low negative of potential disruptions to support networks. Positive impact on wider communities that experience neighbour incidences of domestic abuse.	
Will there be a likely change in *demand* for or access to health and social care services? For example: Primary Care, Hospital Care, Community Services, Mental Health, Local Authority services including Social Services? .			Medium positive as there should be a reduction in demand for access to health and social care services	

Initial health equity assessment
For the following categories, please complete with the expected impacts of this service change on wider inequalities, not just those that are health-related (whether positive, negative, or neutral) – include any additional information you feel is pertinent or useful. **Consider and record which you can control, which you can influence, and which may be out of your control**.

Which population groups/demographics will face health impacts as a result of this change (if any)? • Socio-Economically Deprived • Geographic Deprivation (inc. Rurality) – *if so, where?* • Inclusion Health & Vulnerable Groups[1] • Other	*Positive impacts expected on socio-economically deprived, and inclusion health and vulnerable groups, however domestic abuse occurs in any home environment.*
What mitigations/enhancements are already in place, or what mitigations/enhancements do you plan to include for the foreseeable consequences of these changes?	*Overall, the Domestic Abuse Partnership Strategy is expected to have a **net positive impact on inclusion health groups**, particularly people experiencing homelessness, social exclusion, and multiple disadvantage. The strategy demonstrates strong alignment with health inequalities objectives through its focus on intersectionality, lived experience, safeguarding, and equitable access to support. Any potential negative impacts are recognised and actively mitigated through partnership working, consultation, and ongoing governance*

1- *Inclusion health is an umbrella term used to describe people who are socially excluded, who typically experience multiple overlapping risk factors for poor health, such as poverty, violence, and complex trauma. This includes people who experience homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system and victims of modern slavery. Health impacts for this wide grouping will therefore potentially be the same as those recorded under the Social Inclusion category in the equality impact table.*

Guidance Notes

1. Legal Context

It is a legal requirement for local authorities to assess the equality and human rights impact of changes proposed or made to services. It is up to us as an authority to decide what form our equality impact assessment may take. By way of illustration, some local authorities focus more overtly upon human rights; some include safeguarding. It is about what is considered to be needed in a local authority's area, in line with local factors such as demography and strategic objectives as well as with the national legislative imperatives.

Carrying out these impact assessments helps us as a public authority to ensure that, as far as possible, we are taking actions to meet the general equality duty placed on us by the Equality Act 2010, and to thus demonstrate that the three equality aims are integral to our decision-making processes. These are: eliminating discrimination, harassment and victimisation; advancing equality of opportunity; and fostering good relations.

These screening assessments for any proposed service change go to Cabinet as part of the committee report, or occasionally direct to Full Council, unless they are ones to do with Licensing, in which case they go to Strategic Licensing Committee.

Service areas would ordinarily carry out a screening assessment, or Stage One equality impact assessment. This enables energies to be focussed on review and monitoring and ongoing evidence collection about the positive or negative impacts of a service change upon groupings in the community, and for any adjustments to be considered and made accordingly.

These screening assessments are recommended to be undertaken at timely points in the development and implementation of the proposed service change. For example, a Stage One ESHIA would be a recommended course of action before a consultation. This would draw upon the evidence available at that time, and identify the target audiences, and assess at that initial stage what the likely impact of the service change could be across the national Protected Characteristic groupings and our additional local categories. This ESHIA would set out intended actions to engage with the groupings, particularly those who are historically less likely to engage in public consultation eg young people, as otherwise we would not know their specific needs.

A second Stage One ESHIA would then be carried out after the consultation, to say what the feedback was, to set out changes proposed as a result of the feedback, and to say where responses were low and what the plans are to engage with groupings who did not really respond. This ESHIA would also draw more upon actions to review impacts in order to mitigate the negative and accentuate the positive.

Meeting our Public Sector Equality Duty through carrying out these ESHIAs is very much about using them as an opportunity to demonstrate ongoing engagement across groupings and to thus visibly show we are taking what is called ‘due regard’ of the needs of people in Protected Characteristic groupings.

If the screening indicates that there are likely to be high negative impacts for groupings within the community, the service area would need to take advice on whether or not to carry out a full report, or Stage Two assessment. This is resource intensive but will enable more evidence to be collected that will help the service area to reach an informed opinion.

In practice, Stage Two or Full Screening Assessments have only been recommended twice since 2014, as the ongoing mitigation of negative equality impacts should serve to keep them below the threshold for triggering a Full Screening Assessment. The expectation is that Full Screening Assessments in regard to Health Impacts may occasionally need to be undertaken, but this would be very much the exception rather than the rule.

2. Council Wide and Service Area Policy and Practice on Equality, Social Inclusion and Health

This involves taking an equality and social inclusion approach in planning changes to services, policies, or procedures, including those that may be required by Government. The decisions that you make when you are planning a service change need to be recorded, to demonstrate that you have thought about the possible equality impacts on communities and to show openness and transparency in your decision-making processes.

This is where Equality, Social Inclusion and Health Impact Assessments (ESHIAs) come in. Where you carry out an ESHIA in your service area, this provides an opportunity to show:

- What evidence you have drawn upon to help you to recommend a strategy or policy or a course of action to Cabinet or to Strategic Licensing Committee.
- What target groups and audiences you have worked with to date.
- What actions will you take in order to mitigate any likely negative impact upon a group or groupings, and enhance any likely positive effects for a group or groupings; and
- What actions you are planning to monitor and review the impact of your planned service change.

The formal template is there not only to help the service area but also to act as a stand-alone for a member of the public to read. The approach helps to identify whether or not any new or significant changes to services, including policies, procedures, functions, or projects, may have an adverse impact on a particular group of people, and whether the human rights of individuals may be affected.

There are nine Protected Characteristic groupings defined in the Equality Act 2010. The full list of groupings is: Age; Disability; Gender Reassignment; Marriage and Civil Partnership; Pregnancy and Maternity; Race; Religion or Belief; Sex; and Sexual Orientation. There is also intersectionality between these. Eg a young person with a disability would be in the groupings of Age and Disability, and if they described themselves as having a faith they would then also be in the grouping of Religion or Belief. We demonstrate equal treatment to people who are in these groups and to people who are not, through having what is termed 'due regard' to their needs and views when developing and implementing policy and strategy and when commissioning, procuring, arranging, or delivering services.

For the individuals and groupings who may be affected, ask yourself what impact do you think is likely and what actions will you currently anticipate taking, to mitigate or enhance likely impact of the service change? If you are reducing a service, for example, there may be further use you could make of awareness raising through social media and other channels to reach more people who may be affected.

Social inclusion is then a wider additional local category we use in Shropshire, in order to help us to go beyond the equality legislation in also considering impacts for individuals and households with regard to the circumstances in which they may find themselves across their life stages. This could be households on low incomes, or households facing challenges in accessing services, such as households in rural areas, or people that we might consider to be vulnerable, such as refugee families or rough sleepers.

Please note that veterans and serving members of the armed forces and their families are a grouping to whom we are required to give due regard under Armed Forces legislation. In practice, we had been doing so for a number of years now.

We also identify two further distinct separate local groupings due to their circumstances: care leavers, as vulnerable individuals, and carers, due to the support they give and the support they need.

When you are not carrying out an ESHIA, you still need to demonstrate and record that you have considered equality in your decision-making processes. It is up to you what format you choose. You could use a checklist, an explanatory note, or a document setting out our expectations of standards of behaviour, for contractors to read and sign. It may well not be something that is in the public domain like an ESHIA, but you should still be ready for it to be made available.

Both the approaches sit with a manager, and the manager has to make the call, and record the decision made on behalf of the Council.

Carry out an ESHIA:

- If you are building or reconfiguring a building.
- If you are planning to reduce or remove or reconfigure a service.
- If you are consulting on a policy or a strategy.
- If you are bringing in a change to a process or procedure that involves other stakeholders and the wider community as well as particular groupings

Carry out and record your equality and social inclusion approach:

- If you are setting out how you expect a contractor to behave with regard to equality, where you are commissioning a service or product from them.
- If you are setting out the standards of behaviour that we expect from people who work with vulnerable groupings, such as taxi drivers that we license.
- If you are planning consultation and engagement activity, where we need to collect equality data in ways that will be proportionate and non-intrusive as well as meaningful for the purposes of the consultation itself.
- If you are looking at services provided by others that help the community, we need to demonstrate a community leadership approach

3. Council wide and service area policy and practice on health and wellbeing

This is an area to record within our overall assessments of impacts, for which we ask service area leads to consider health and wellbeing impacts, and to look at these in the context of direct and indirect impacts for individuals and for communities.

A better understanding across the Council of these impacts will also better enable the Public Health colleagues to prioritise activities to reduce health inequalities in ways that are evidence based and that link effectively with equality impact considerations and climate change mitigation.

Health in All Policies – Health Impact Assessment

Health in All Policies is an upstream approach for health and wellbeing promotion and prevention, and to reduce health inequalities. The Health Impact Assessment (HIA) is the supporting mechanism

- Health Impact Assessment (HIA) is the technical name for a process that considers the wider effects of local policies, strategies and initiatives and how they, in turn, may affect people's health and wellbeing.
- Health Impact Assessment is a means of assessing both the positive and negative health impacts of a policy. It is also a means of developing good evidence-based policy and strategy using a structured process to review the impact.
- A Health Impact Assessment seeks to determine how to maximise health benefits and reduce health inequalities. It identifies any unintended health consequences. These consequences may support policy and strategy or may lead to suggestions for improvements.
- An agreed framework will set out a clear pathway through which a policy or strategy can be assessed and impacts with outcomes identified. It also sets out the support mechanisms for maximising health benefits.

The embedding of a Health in All Policies approach will support Shropshire Council through evidence-based practice and a whole systems approach, in achieving our corporate and partnership strategic priorities. This will assist the Council and partners in promoting, enabling and sustaining the health and wellbeing of individuals and communities whilst reducing health inequalities.

Individuals

Will the proposal have a *direct impact* on health, mental health and wellbeing?

For example, would it cause ill health, affecting social inclusion, independence and participation?

Will the proposal directly affect an individual's ability to improve their own health and wellbeing?

This could include the following: their ability to be physically active e.g., being able to use a cycle route; to access food more easily; to change lifestyle in ways that are of positive impact for their health.

Provision or change to a service that allows greater reach to those most in need, this can involve relocation, pooling of resource/efficiency changes, or digitisation of some provision. It may also involve greater opportunities for employment, decreasing socio-economic inequality. Physical alternatives to be made available (where practical) to be offered wherever possible to avoid digital exclusion and reduce social isolation. These changes can be either positive or negative depending on the proposal.

An example of this could be that you may be involved in proposals for the establishment of safer walking and cycling routes (e.g., green highways), and

changes to public transport that could encourage people away from car usage. and increase the number of journeys that they make on public transport, by foot or on bicycle or scooter. This could improve lives. It could also involve virtual support sessions/appointments to avoid unnecessary travel and provide greater flexibility with individuals work schedules. It may involve greater internet connectivity, to improve remote working opportunities and air pollution concerns, or improved communications coverage through closer partnership working – targeting those most in need of specific information.

Will the proposal *indirectly impact* an individual's ability to improve their own health and wellbeing?

This could include the following: their ability to access local facilities e.g., to access food more easily, or to access a means of mobility to local services and amenities? (e.g. change to bus route)

Similarly to the above, an example of this could be that you may be involved in proposals for the establishment of safer walking and cycling routes (e.g. pedestrianisation of town centres), and changes to public transport that could encourage people away from car usage, and increase the number of journeys that they make on public transport, by foot or on bicycle or scooter. This could improve their health and wellbeing.

Communities

Will the proposal directly or indirectly affect the physical health, mental health, and wellbeing of the wider community**?**

A *direct impact* could include either the causing of ill health, affecting social inclusion, independence and participation, or the promotion of better health.

An example of this could be that safer walking and cycling routes could help the wider community, as more people across groupings may be encouraged to walk or engage in active travel. Increasing physical activity and minimising the time spent sitting down helps to maintain a healthy weight and reduces the risk of cardiovascular disease, type 2 diabetes, cancer, and depression. The UK Chief Medical Officers recommend that adults should do at least 150 minutes of moderate activity, or 75 minutes of vigorous activity, each week. At a wider level, reductions in vehicular emission lead to better air quality, and a reduction in NO_2 in the atmosphere.

An *indirect impact* could mean that a service change could indirectly affect living and working conditions and therefore the health and wellbeing of the wider community.

An example of this could be: an increase in the availability of warm homes would improve the quality of the housing offer in Shropshire and reduce the costs for households of having a warm home in Shropshire. This can reduce the risks of cold related health effects, as well as reduce the financial burden on the population, whose ability to shoulder these costs can vary. Often a health promoting approach

also supports our agenda to reduce the level of Carbon Dioxide emissions and to reduce the impact of climate change.

Demand

Will there be a change in demand for or access to health, local authority and social care services?

For example: Primary Care, Hospital Care, Community Services, Mental Health and Social Services?

An example of this could be: a new housing development in an area would affect demand for primary care and local authority facilities and services in that location and surrounding areas. If the housing development does not factor in consideration of availability of green space and safety within the public realm, further down the line there could be an increased demand upon health and social care services as a result of the lack of opportunities for physical recreation, and reluctance of some groupings to venture outside if they do not perceive it to be safe.

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