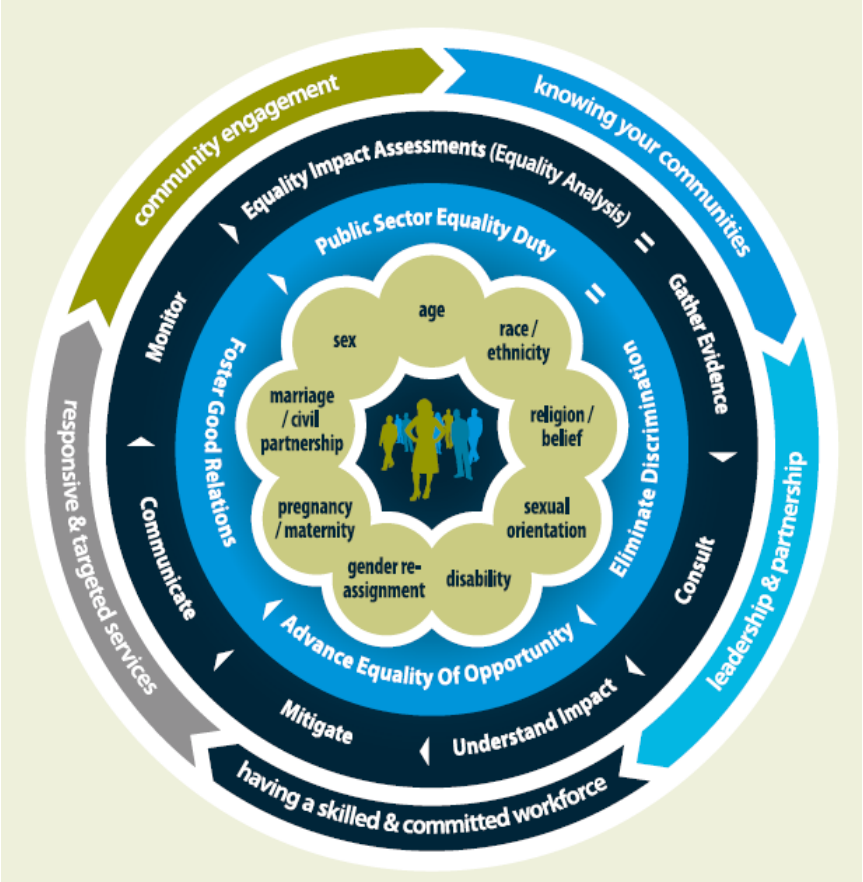
Equality Impact Assessment (EqIA) Template

APPENDIX 1

EqIAs make services better for everyone and support value for money by getting services right first time.

EqIAs enable us to consider all the information about a service, policy or strategy from an equalities perspective and then create an action plan to get the best outcomes for staff and service-users[1].They analyse how all our work as a council might impact differently on different groups protected from discrimination by the Equality Act 2010[2]. They help us make good decisions and evidence how we have reached them.[3]

An EqIA needs to be completed **as a project starts** to identify and consider possible differential impacts on people and their lives, inform project planning and, where appropriate, identify mitigating actions. It must be completed **before** any decisions are made or policy agreed so that the EqIA **informs that decision or policy**. It is also a live document; you should review and update it along with your project plan throughout.



Full guidance notes to help you are embedded in this form – see the End Notes or hover the mouse over the numbered notes.
If your project/proposal relates primarily to staff **– e.g. a restructure – there is a specific EqIA template for this here**

Please share your initial EqIA with the equalities team, equalities@hertfordshire.gov.uk and the final/updated version at the end of the project.
Key EqIAs should be reviewed by the relevant Head of Service. Examples of EqIAs can be seen in the **EqIA Library**.

1. Who is completing the EqIA[4] and why is it being done?

Title of service / proposal / project / strategy / procurement you are assessing[5]	Public health prevention of risky behaviours among children and young people
Names of those involved in completing the EqIA	Sue Matthews, Sue Beck, Jen Beer
Head of Service or Business Manager	Sue Matthews (children and young people)
Team/Department	Public Health
Lead officer contact details	Sue Matthews
Focus of EqIA – what are you assessing?	Adolescence is a period during which risk-taking increases sharply, with potential long-term effects on health and wellbeing. This EQIA focusses on health risk taking behaviour - defined as behaviours which 'potentially expose people to harm, or significant risk of harm which will prevent them reaching their potential, or damage their health and wellbeing' and Public Health's approach to addressing these. Examples of health risk behaviours would include substance use (including smoking, alcohol consumption, and illicit drug use and sexual risky activity (including intimate sexual behaviour and underage sex, protected or otherwise).
Stakeholders Who will be affected? Which protected characteristics is it most relevant to? Consider the public, service users, partners, staff, Members, etc	Members of the public Public sector partners and community/voluntary groups Service users Elected Members

2. List of data sources used for this EqIA *(include relevant national/local data, research, monitoring information, service user feedback, complaints, audits, consultations, EqIAs from other projects or other local authorities, etc.)*

A range of useful local data on our communities can be found on Herts Insight and on the Equalities Hub

Title and brief description (of data, research or engagement – include hyperlinks if available)	**Date**	**Gaps in data** Consider any gaps you need to address and add any relevant actions to the action plan in Section 4.
Helping young people say 'no': the prevalence of risk-taking behaviour and what works to reduce it (CPRU, 2017) shows that adolescents are much more likely to be in that high-risk core group if they're from a deprived background, and multiple risk behaviours are more common in the white population. https://www.ucl.ac.uk/children-policy-research/documents/publications/case-studies/Adolescence_ThemeV6.1_WEB_FINAL.pdf *Determinants of risky behaviour in adolescence: Evidence from the UK (ESRC, 2018)* shows that risk factors for participation in risk taking behaviours include being male, living in a single headed household, parental substance use, and puberty. *Risky behaviours: prevalence in adolescence. Initial findings from the Millennium Cohort Study Age 14 Survey* *Hertfordshire Health Related Behaviour Questionnaire (HRBQ) 2016* https://www.hertshealthevidence.org/documents/thematic/hrbs-hertfordshire-briefing-2016.pdf	**2017** **2018** **2018** **2016**	The evidence highlights that people who are more deprived, male and those from a white population are much more likely to engage in multiple risky behaviours. For many risk behaviours, there appears to be an evidence gap; whilst we know that risk behaviours are in decline overall, we cannot be sure if the same can be said for vulnerable groups of young people. *The data points to the need ensure that more vulnerable groups are targeted effectively with a focus on deprived and white populations.*

3. Analysis and assessment: review of information, impact analysis and mitigating actions

Protected characteristic group	What do you know[6]? What do people tell you[7]? Summary of data and feedback about service users and the wider community/ public • **Who uses the service?** • **Who doesn't and why?** • **Feedback/complaints?** • **Any differences in outcomes? Why?**	What does this mean – what are the potential impacts of the proposal(s)[8]? - Consider positive and negative impacts - On service users / the public - *AND, where relevant,* ***staff**** **** if your proposals relate mainly to a staff restructure or reorganisation, you should use the template here***	What can you do[9]? What reasonable mitigations to reduce or avoid the impact can you propose? How will you communicate/engage or provide services differently to create a 'level playing field' – e.g. consultation materials in easy read or hold targeted engagement events ***If there is no current way of mitigating any negative impacts, clearly state that here and consider other actions you could take in the action plan in section 4.***
Age[10]	Determinants of risky behaviour in adolescence: Evidence from the UK (ESRC, 2018) reports: • the age of first participation in risky behaviours, for alcohol and smoking (no data available for other outcomes). Amongst those who ever tried alcohol, 17% did so before age 12, and the remainder since age 12. Males are more likely to have tried at a younger age than females, with just under 20% having tried before age 12, compared to around 13% of females. For smoking, just under 15% tried it before age 12, with the remainder since then. Although males are more likely than females to have tried at a younger age, at 16.7% versus 13%, this gender difference is not statistically significant. Finally, for those who had first tried smoking at age 11 or before, 25% said that they were regular smokers by age 14. This is compared to those who had tried their first cigarette age 12-14, of whom 15% reported being regular smokers at age 14. No evidence that young people are using electronic cigarettes are a gateway into smoking. • substance use (binge drinking, whether ever smoked) increased sharply between ages 11 and 14, from around 4% to 21%. • increases in risky substance use are driven by both risky (binge) drinking, from 0.6% at age 11 to around 11% at age 14, and smoking, from 3% to 17%. It also shows a substantial	Proposed prevention plans are influenced by these data and aim have a positive impact on young people based on this protected characteristic. Positive impact of reducing smoking in households with young children and promoting Smoke free environments where children play and learn.	We will monitor any changes in trends and take appropriate action. Ensure that there is a programme of work in primary schools to prevent health risk behaviours which continues into secondary schools

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	increase in young people who have ever tried alcohol, from 13% at age 11 to 48% at age 14.		
Disability[11]	There is no known data or feedback for of likely differential impact or need based on gender reassignment.	As far as we are aware this protected characteristic in of itself does not have an impact on health risk behaviours	Ensure children with disabilities are included in available training. Will continue to keep under review
Gender reassignment[12]	There is no known data or feedback for of likely differential impact or need based on gender reassignment.	As far as we are aware this protected characteristic in of itself does not have an impact on health risk behaviours	Promote availability of services via local LGBT networks. Will continue to keep under review
Pregnancy and maternity[13]	The Teenage Pregnancy Independent Advisory Group reported that: • babies of teenage mothers have worse health outcomes than older mothers; they are 60% more likely to die in the first year of life than babies of mothers aged 20 to 39 and twice as likely to be admitted to hospital because of an accident or gastroenteritis	Proposed prevention plans should have a positive impact on health outcomes for babies and children from low rates of teenage pregnancy	Continue with the work to prevent health risk behaviours among school age children. Work on the vulnerable parent's

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	• teenage mothers are:
	  ○ 3 times more likely to get postnatal depression than older mothers
	  ○ more at risk of poor mental health for 3 years after the birth
	  ○ 3 times more likely to smoke during pregnancy than mothers over 35 and less able to quit smoking than older mothers
	  ○ Are more likely to have partners who smoke
	  ○ less likely to breastfeed
	  ○ likely to struggle to complete their education and gain employment
			pathway underway jointly with children's services
			
			Ensure that pathways are in place to identify women of childbearing age who participate in risk-behaviours and provide behaviour change support
			
			Focus on identifying all mothers who smoke and drink alcohol provide support at the earliest opportunity in pregnancy.
			
			Will continue to keep under review

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Race[14]	Evidence from Risky behaviours: prevalence in adolescence. Initial findings from the Millennium Cohort Study Age 14 Survey shows that overall, risk-taking activities of all types were less common among teens from ethnic minority groups. For example, 94% of Bangladeshi 14-year-olds said they had never tried smoking, drinking or drugs, compared to 44% of white British 14-year-olds (note This might be selective reporting/gender specific as smoking in Bangladeshi and Pakistani men is high, whereas low in females). Black African teenagers had had less contact with the police than white teenagers, and Black African and Black Caribbean teenagers were less likely to have ever been a gang member, though they were more likely to say they had physically assaulted (shoved, hit, slapped or punched) someone.	Smoking prevalence is generally lower in ethnic minority groups, but can higher in specific ethnic minority communities, namely: Black Caribbean and Bangladeshi men, and Black Caribbean and Irish women and eastern European communities.	Work with community groups to identify and reduce risky behaviours in these groups Ensure effective targeting of more vulnerable groups for health risk behaviours (namely young white males) Will continue to keep under review
Religion or belief[15]	There is no known data or feedback for of likely differential impact or need based on religion or belief.	Reducing risk behaviours will impact positively on all communities	Notwithstanding that it is believed that this plan will not have a negative impact on this characteristic its impact will be monitored and action will be taken to

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			address identified issues. Will continue to keep under review
Sex/Gender[16]	*Risky behaviours: prevalence in adolescence. Initial findings from the Millennium Cohort Study Age 14 Survey* shows: • Boys tended to have first tried alcohol at a younger age than girls: 1 in 5 boys had drunk alcohol by age 11, compared to 1 in 7 girls. • overall, risk-taking activities of all types were more common among teenage boys than teenage girls (except for smoking) Evidence from the Hertfordshire Health Related Behaviour Questionnaire shows: • 81% of pupils said they have never self-harmed. 10% said they had and 8% didn't want to say. 17% Year 10 girl's self harmed and 10% did not have any support. If they told someone, most would talk to a friend (Year 8 and Year 10 ages 12 - 15)	Reducing risk behaviours generally in young people will impact positively on both genders	Given that data shows that boys engage more with risk behaviours, boys are being supported to develop resilience and healthy coping strategies, using the Just Talk campaign'. Will continue to keep under review
Sexual orientation[17]	Evidence from the Health Related Behaviour Questionnaire (2016) for Lesbian, Gay and Bisexual (LGB) shows higher rates of drug use and more likely to keep issues to themselves (including less feel listened to at schools and lower levels of self-esteem).	LGB may be more likely to engage in health risk behaviours	Promote availability of services via local LGBT networks.

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Marriage and civil partnership[18]	As far as we are aware this protected characteristic in of itself does not have an impact on health risk behaviours	As far as we are aware this protected characteristic in of itself does not have an impact on health risk behaviours	Will continue to keep under review
Carers[19]	There is no known data or feedback available of likely differential impact or need amongst carers.	Young people who are carers may have less opportunity to engage in health promoting activities.	Work closely with Young Carers Service and Commissioners to ensure that young carers have access to relevant support and training available to young people and that staff are skilled in this area.
Other relevant groups[20] Consider if there is a potential impact (positive or negative) on areas such as health and wellbeing, crime and disorder, Armed Forces	Deprivation is a significant risk factor for health risk behaviours The Teenage Pregnancy Independent Advisory Group reported that: • half of all under 18 conceptions occur in the 20% most deprived wards • over one third of teenage mothers have no qualifications and 70% are not in education, training or employment	Targeting of resources to more deprived areas and targeted groups using staff in existing services (such as YC Hertfordshire and the Youth Justice Team)	Support teams working with vulnerable groups (including CLA) to deliver one to one support and interventions to individuals that will not access mainstream services. Health

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community.	Children in care / Children Looked After (CLA) are more likely to smoke (HRBQ, 2016)		Behaviour Training – training is being developed for staff from services which support vulnerable young people including Targeted Youth Support, Children Looked After, Foster Carers, Families First staff and third sector organisations. The training will look at risky behaviours such as sexual behaviours, and substance use. It will encompass an online training resource open to all, and a series of face to face training sessions.

Opportunity to advance equality of opportunity and/or foster good relations[21]
A reduction in health risk behaviours may also have a positive impact on other risk behaviours and relevant communities e.g. crime.

Conclusion of your analysis and assessment - select one of the outcomes below[22] and summarise why you have selected i, ii, iii or iv; what you think the **most important** impacts are; and the key actions you will take.

OUTCOME AND NEXT STEPS	SUMMARY
i. No equality impacts identified - No major change required to proposal	
ii. Minimal equality impacts identified - Adverse impacts have been identified, but have been objectively justified (provided you do not unlawfully discriminate) - Ensure decision makers consider the cumulative effect of how a number of decisions impact on equality - No major change required to proposal	
iii. Potential equality impacts identified - Take 'mitigating action' to change the original policy/proposal, remove barriers or better advance equality - Set out clear actions in the action plan in section 4.	The following potential equality impacts have been identified: • deprived and vulnerable populations are more at risk and may not access mainstream prevention services • children from the age of 11 but younger in some circumstances Mitigating actions are included in the plan below
iv. Major equality impacts identified - The adverse effects are not justified, cannot be mitigated or show unlawful discrimination - You must stop and remove the policy **[you should consult with Legal Services]** - Ensure decision makers understand the equality impact	

YOU SHOULD INCLUDE THE SUMMARY ANALYSIS ABOVE IN THE 'Equalities Implications' SECTION OF ANY REPORT(S) THAT GO TO DEPT. MANAGEMENT BOARDS / MEMBER PANELS / CABINET, AS WELL AS APPENDING A COPY OF THE EqIA

4. Prioritised Action Plan[23]

Impact identified and group(s) affected	Action planned Include actions relating to: • mitigation measures • getting further research • getting further data/consultation	Expected outcome	Measure of success	Lead officer and timeframe
NB: These actions must now be transferred to service or business plans and monitored/reviewed to ensure they achieve the outcomes identified.				
Some young people with protected characteristics are at greater risk of participating in health risk behaviours and may face additional challenges in accessing services as they may also be marginalised for a variety of reasons.	Work closely with organisations who support vulnerable client groups to address health risk behaviours as part of their day to day work. Partnership working to ensure that services that work closely with vulnerable groups have the skills to address health risk behaviours through the provision of training or funding (see above). Public health is a member of the Youth Justice Board Ensure commissioned services include provision that is accessible and attractive for men.	Those with a high risk of multiple health risk behaviours are supported using existing services for young people (e.g. YC Hertfordshire and Youth Justice teams) Increase number of young white males who receive advice and support for health risk behaviours	Successful targeting and interventions delivered Less young white males engage in multiple health risk behaviours	Health Improvement lead (CYP) Health Improvement Lead (Sexual health) Ongoing
Young people and their families need different levels of interventions to reduce the risk of health risk behaviours.	Public health work closely in schools to ensure that evidence based tools are adopted. Ensure that there is a programme of work in primary schools to prevent health risk behaviours which continues into secondary schools, through a) the promotion	Parents have access to useful information and support Children receive information and support to reduce risk of participating in risky behaviours	Children, young people and their families receive advice and support that they need Young people can access advice and interventions tailored to	Head of Service (Children and Young People) Health Improvement Lead (Children & Young People)

	of the evidence based five ways to wellbeing, and b) improving communications, joint planning, and early identification of issues through the establishment of primary school pastoral leads networks (secondary school networks already in place). Public health nursing service provides clear role to advise and support e.g. Chat health, one to one support and dedicated websites for parents and young people on health risk related behaviours Provision of one to one support and more intensive delivery for vulnerable groups using services for young people (e.g. YC Hertfordshire and Youth Justice teams).	Children can access confidential advice and support where required Young people that are more vulnerable of multiple risk behaviours receive more intensive advice and support through trusted services and staff trained to work with young people.	their needs both in and out of education settings Reduction in health risk behaviours	Ongoing
Monitor and review	Progress against actions as outlined above will be monitored and reviewed by the Children and Young People Public Health Implementation Group.	Improved access to those groups with protected characteristics	High quality service delivery. Agreed actions are implemented within timescales agreed	Head of Service (Children and Young People) 6 monthly

This EqIA has been signed off by:

Lead Equality Impact Assessment officer: **Date:**

Head of Service or Business Manager: **Date:**

Review date: **October 2019**

Please now send the completed EqIA to equalities@hertfordshire.gov.uk

Please also ensure that the EqIA is referenced in and included as an appendix to reports to Management Boards Cabinet Panels and Cabinet so that decision makers can consider equality impacts before making decisions.

Guidance end-notes

[1] The following principles explain what we must do to fulfil our duties under the Equality Act when considering the effect of existing and new policies/ practices/services on equality. They must all be met or the EqIA (and any decision based on it) may be open to challenge:

- **Knowledge:** everyone working for the council must be aware of our equality duties and apply them appropriately
- **Timeliness:** the duty applies at the time of considering proposals and **before** a final decision is taken
- **Real Consideration:** the duty must be an integral and rigorous part of your decision-making and influence the process.
- **Sufficient Information:** you must assess what information you have and what is needed to give proper consideration.
- **No delegation:** the council is responsible for ensuring that anyone who provides services on our behalf can comply with the duty, are required in contracts to comply with it, and do comply in practice. It is a duty that cannot be delegated.
- **Review:** the equality duty is a continuing duty – it continues after proposals are implemented/reviewed.
- **Proper Record Keeping:** we must keep records of the process and the impacts identified.

[2] **Our duties in the Equality Act 2010**
HCC has a legal duty under this Act to show that we have identified and considered the impact and potential impact of our activities on all people with 'protected characteristics' (see end notes 11-20 for details of the nine-protected characteristics). This applies to policies, services (including commissioned services), and our employees. **If you are creating an 'arms-length' company,** seek advice from the Equality Team or Legal.

We use this template to do this and evidence our consideration. **You must give 'due regard' (pay conscious attention) to the need to:**

- **Avoid, reduce or minimise negative impact**: if you identify unlawful discrimination, including victimisation and harassment, you must stop the action and take advice immediately.
- **Promote equality of opportunity**: by
  - Removing or minimising disadvantages suffered by equality groups
  - Taking steps to meet the needs of equality groups
  - Encouraging equality groups to participate in public life or any other activity where participation is disproportionately low
  - Consider if there is a need to treat disabled people differently, including more favourable treatment where necessary
- **Foster good relations between people who share a protected characteristic and those who don't**: e.g. by promoting understanding.

[3] EqIAs **should always be proportionate** to:
- The size of the service or scope of the policy/strategy
- The resources involved
- The size of the likely impact – e.g. the numbers of people affected and their vulnerability

The greater the potential adverse impact of the proposal(s) on a protected group (e.g. disabled people) and the more vulnerable the group is, the more thorough and demanding the process required by the Act will be. Unless they contain sensitive personal/employee data – EqIAs are public documents. They are published with Cabinet and Panel papers and public consultations and are available on request.

[4] **Who completes the EqIA:** The person who is making the decision or advising the decision-maker about a policy. It is better to do this as a team, with people involved who understand the implementation of the policy.

[5] **Title of EqIA:** This should clearly explain what service / policy / strategy / change you are assessing.

[6] **Data & Information:** Your EqIA needs to be informed by data. You should consider the following:

- What data relevant to the impact on protected groups is available?
  (is there an existing EqIA?, local service data, national data, community data, similar proposal in another local authority).
- What further evidence is needed and how can you get it? (e.g. further research or engagement with the affected groups).
- What do you know from service/local data about needs, access and outcomes? Focus on each characteristic in turn.
- What might any local demographic changes or trends mean for the service or function? Also consider national data if appropriate
- Does data/monitoring show that any policies or practices create particular problems or difficulties for any group(s)?
- Is the service having a positive or negative effect on particular people or groups in the community?

[7] **What have people told you about the service, function, area?**

- Use service user feedback, complaints, audits, and/or the results of specific consultation/engagement
- Are there patterns or differences in what people from different groups tell you?
- Remember, you must engage/consult appropriately and in an inclusive way with those likely to be affected to fulfil the equality duty.
- You can read HCC's Consultation and Engagement toolkits for full advice on this
- For practical tips and advice on consulting with people from protected groups, see this 'How-to' guide

[8] **Impact:** Your EqIA must consider fully and properly **actual and potential impacts** against each protected characteristic:

- The equality duty does not stop changes, but means we must fully consider and address the anticipated impacts on people.
- Be accurate and transparent, but also realistic: don't exaggerate speculative risks and negative impacts.
- Be detailed and specific where you can so decision-makers have a concrete sense of potential effects.
- Questions to ask when assessing whether and how the proposals impact on service users, staff and the wider community:
  - Are one or more protected groups affected differently and/or disadvantaged? How, and to what extent?
  - Is there evidence of higher/lower uptake among different groups? Which, and to what extent?
  - Does the project relate to an area with known inequalities (where national evidence or previous research is available)?
  - If there are likely to be different impacts on different groups, is that consistent with the overall objective?
  - If there is negative differential impact, how can you minimise that while taking into account your overall aims?
  - Do the effects amount to unlawful discrimination? If so the plan **must** be modified.
  - Does it relate to an area where equality objectives have been set by HCC in our Equality Strategy?

[9] **Consider actions relating to the following:**

- That specifically address the impacts you've identified and show how they will remove, reduce or avoid any negative impacts
- Explain clearly what any mitigating measures are, and the extent to which you think they will reduce / remove the adverse effect
- Will you need to communicate or provide services in different ways for different groups in order to create a "level playing field"?
- State how you can maximise any positive impacts or advance equality of opportunity.
- If you do not have sufficient equality information, state how you can fill the gaps.

[10] **Age**: People of all ages, but consider in particular children and young people, older people and carers, looked after children and young people leaving care. Also consider working age people.

[11] **Disability**: When looking at disability, consideration should be given to people with different types of impairments: physical (including mobility), learning, aural or sensory (including hearing and vision impairment), visible and non-visible impairment. Consideration should also be given to: people with HIV, people with mental health needs and people with drug and alcohol problems. People with conditions such as diabetes and cancer and some other health conditions also have protection under the Equality Act 2010.

[12] **Gender Reassignment:** In the Act a transgender person is someone who proposes to, starts or has completed a process to change his or her gender. A person does **not** need to be under medical supervision to be protected. Consider transgender people, transsexual people and transvestites.

[13] **Pregnancy and Maternity:** When looking at pregnancy and maternity, give consideration to pregnant women, breastfeeding mothers, part-time workers, women with caring responsibilities, women who are lone parents and parents on low incomes, women on maternity leave and Keeping in Touch days.

[14] **Race/Ethnicity:** Apart from the common ethnic groups, consideration should also be given to Gypsy, Roma and Irish Travellers communities, people of other nationalities outside Britain who reside here, refugees and asylum seekers and speakers of other languages.

[15] **Religion and Belief:** Religion includes any religion with a clear structure and belief system. As a minimum you should consider the most common religious groups (Christian, Muslim, Hindu, Jews, Sikh, Buddhist) and people with no religion or philosophical belief(s).

[16] **Sex/Gender:** Consider girls and women, boys and men, married people, civil partners, part-time workers, carers (both of children with disabilities and older cares), parents (mothers and fathers), in particular lone parents and parents on low incomes.

[17] **Sexual Orientation:** The Act protects bisexual, heterosexual, gay and lesbian people.

[18] **Marriage and Civil Partnership:** consider married people and civil partners – e.g. do same sex couple in a civil partnership have the same rights and benefits as married people?

[19] **Carers:** From April 2015, carers (people who provide unpaid care to a friend or relative) have been entitled to an assessment of their own needs in the same way as those they care for. Although not a 'protected characteristic' HCC Diversity Board has agreed that the impact of proposals on carers should also be considered.

[20] **Other relevant groups:** You should consider the impact on our service users in other related areas, such as health and wellbeing, crime and disorder (e.g. people experiencing domestic abuse), community relations and socio-economic status (e.g. homelessness or low incomes). If the proposal is likely to have an impact on service users in these areas, HCC Public Health and the County Community Safety Unit may be able to help. Also consider whether your policy or decision will impact current or former Armed Forces personnel living and working in Hertfordshire. The Council is committed to the Hertfordshire Community Covenant, a commitment from public and private organisations in the county to support the active and retired Armed Forces community.

[21] **Equality of opportunity and good relations:** summarise anything that will have a potential positive impact over and above the work of your project – e.g. engaging with the community may help raise awareness and community understanding of the needs of certain groups.

[22] **Conclusion**

- Make a frank and realistic assessment of the overall extent to which the negative impacts can be reduced or avoided by the mitigating measures. Also explain what positive impacts will result from the actions and how you can make the most of these.
- Make it clear if a change is needed to the proposal itself. Is further engagement, research or monitoring needed?
- Make it clear if, as a result of the analysis, the policy/proposal should be stopped.

[23] **Action Planning:** The Equality Duty is an ongoing duty: policies must be kept under review, continuing to give 'due regard' to the duty. If an assessment of a broad proposal leads to more specific proposals, then further equality assessment and consultation are needed.