PURPOSE
Equality Analysis is a best practice method to demonstrate due regard to the general duty under the Equality Act 2010 to eliminate discrimination, advance equality of opportunity and foster good relations between people from different groups.

The purpose of an Equality Analysis (EA) is to examine the extent to which a proposed service change/policy/strategy may impact differently on different members of the community and, where appropriate, prompt the consideration of alternative measures to ensure an equal standard of service is accessible to all¹.

RESPONSIBILITY
Responsibility for compliance with the CCGs public sector equality duty rests with the author’s lead Director. Specialist guidance and support is, however, available from the Policy & Engagement Manager and the Director of Governance & Compliance.

Assessments must be carried out for all policies, strategies and service change proposals. New analysis should start early in the development process and must be carried out in the following circumstances²:

• Where a new policy or function is planned
• Where an existing policy or function is to be altered significantly
• Where a function has not been assessed for three years

CONSULTATION & ENGAGEMENT
Please note that early engagement is recommended and in many cases is necessary to develop policies, procedures, strategies or service changes. Completing the EA early in the project cycle i.e. at Project Charter stage will identify the groups that you need to engage with. Please ask the Communications & Engagement Team if you would like some help with finding and meeting particular groups.

¹ Note: Different impact does not necessarily mean adverse (or negative) impact
² Meeting the Equality Duty in Policy and Decision-Making England (and non-devolved public authorities in Scotland and Wales) 2014
### SUMMARY OF EQUALITY ANALYSIS for In-Scope Services for Surrey's Children's Community Health Services

<table>
<thead>
<tr>
<th>Equality Group</th>
<th>Negative Impact</th>
<th>Level of Negative Impact</th>
<th>Positive Impact</th>
<th>Level of Positive Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>YES / NO</td>
<td>HIGH / MEDIUM / LOW</td>
<td>YES / NO</td>
<td>HIGH / MEDIUM / LOW</td>
</tr>
<tr>
<td>Age</td>
<td>NO</td>
<td>LOW</td>
<td>YES</td>
<td>HIGH</td>
</tr>
<tr>
<td>Disability</td>
<td>NO</td>
<td>LOW</td>
<td>YES</td>
<td>HIGH</td>
</tr>
<tr>
<td>Ethnicity / Race / Ethnic Group</td>
<td>NO</td>
<td>LOW</td>
<td>YES</td>
<td>MEDIUM</td>
</tr>
<tr>
<td>Gender</td>
<td>NO</td>
<td>LOW</td>
<td>YES</td>
<td>HIGH</td>
</tr>
<tr>
<td>Gender Reassignment</td>
<td>NO</td>
<td>LOW</td>
<td>YES</td>
<td>MEDIUM</td>
</tr>
<tr>
<td>Religion &amp; Beliefs</td>
<td>NO</td>
<td>LOW</td>
<td>YES</td>
<td>MEDIUM</td>
</tr>
<tr>
<td>Marriage &amp; Civil Partnership</td>
<td>NO</td>
<td>LOW</td>
<td>YES</td>
<td>LOW</td>
</tr>
<tr>
<td>Pregnancy &amp; Maternity</td>
<td>NO</td>
<td>LOW</td>
<td>YES</td>
<td>HIGH</td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td>NO</td>
<td>LOW</td>
<td>YES</td>
<td>MEDIUM</td>
</tr>
<tr>
<td>Carers</td>
<td>NO</td>
<td>LOW</td>
<td>YES</td>
<td>HIGH</td>
</tr>
<tr>
<td>Areas of Deprivation/Geographical Location</td>
<td>NO</td>
<td>LOW</td>
<td>YES</td>
<td>HIGH</td>
</tr>
<tr>
<td>Vulnerable Groups</td>
<td>NO</td>
<td>LOW</td>
<td>YES</td>
<td>MEDIUM</td>
</tr>
</tbody>
</table>
**Who is this ‘activity’ aimed at? Please delete and explain further if relevant.**

Children, young people and their families

**What are the main aims and objectives of the ‘activity’?**

The six Clinical Commissioning Groups (CCG), Surrey County Council and NHS England in Surrey commission a range of community health services for children and young people across Surrey through three main contracts. In January 2016 it was agreed that NHS Guildford & Waverley CCG, on behalf of the eight commissioners, would carry out the procurement of the community health services delivered to children and young people in Surrey with the aim to deliver these services through one contract with one provider, commencing on 1st April 2017. The Contract once awarded, will be for a term of three years (36 months), with the possibility of extending the term for a period of up to two years (five year maximum contracting period) by agreement between the Contract Authorities and the Provider.

The new suite of community health services for children and young people aims to focus on prevention of ill health, advising on child development and providing early intervention, targeted and specialist medical, nursing, therapy services and safeguarding. The Children’s community health services in scope of this procurement are as follows:

1. Community Paediatric Medical Services (Developmental Paediatricians)
2. Physiotherapy*
3. Speech and Language therapy – Early Years
4. Occupational Therapy*
5. Community Children's Nursing team
6. Children's Continuing healthcare Team
7. Audiology
8. Safeguarding children team
9. Looked after children health team
10. Tongue tie (over 10 days)
11. Specialist school nursing*
12. Enuresis & Continence Assessments*
13. Integrated Healthy Child Programme (0-19) including Family Nurse Partnership
14. Specialist Health Visiting – Emotional Wellbeing and Mental Health*
15. School Nursing – Emotional Wellbeing and Mental Health*
16. Children’s Community and School based Immunisation Service
17. Child Health Information Service
18. Children's Sexual Abuse Service – linked to Sexual Assault Referral Centre (SARC)
19. Dietetics (Surrey Downs CCG locality only)
   *jointly commissioned services (CCGs & SCC)

**Describe the current situation:**

Surrey’s Children’s Community Health Services are currently delivered by three community health providers Virgin Care Services Ltd (VCSL), First Community Health and Care Services (FCHC) and CSH Surrey. These contracts currently provide a range of community health services to all ages in the population.

- NHS North West Surrey CCG is the lead commissioner for the current community health services contract with VCSL.
- NHS East Surrey CCG is the lead commissioner for the current community health services contract with First Community Health and Care.
- NHS Surrey Downs CCG is the lead commissioner for the current community health services contract with CSH Surrey, which will expire in March 2018, one year after the commencement date for the new contract.

The Children’s Community Health Services procurement does not include adult community health services, child and adolescent mental health services, acute care or primary health care. However crucially interfaces with the wider health sector must been maintained to support seamless and accessible care.

**Please describe what ENGAGEMENT AND/OR CONSULTATION that has taken place to inform this equality analysis?**
Consider internal and external routes. If you would like assistance with identifying particular groups to consult with please liaise with the Communications & Engagement team.

The commissioners have carried out various forms of engagement with children, young people and their families/carers. In total 612 people responded to the engagement via online surveys and a number of public and stakeholder events and patient engagement forums. Stakeholders provided information about the current gaps in the service and areas for improvement. Through engagement the outcomes (below) have been developed to underpin delivery across all services by the new provider.

- Outcome 1: Person-centred services
- Outcome 2: Consistent provision with timely access
- Outcome 3: Intervening early
- Outcome 4: Delivery of good quality care that makes a difference to children, young people and their families
- Outcome 5: Good communication that facilitates access to best care and good outcomes
- Outcome 6: A skilled, competent empowered workforce
- Outcome 7: Effective partnership working

Additional needs assessments; surveys; annual reviews and national research have been used to inform this impact assessment which are as follows:

- Joint Strategic Needs Assessment – Surrey [www.surreyi.org.uk](http://www.surreyi.org.uk)
- Child health information available at: [http://www.chimat.org.uk/profiles](http://www.chimat.org.uk/profiles)
- Population Data – this is available on Surrey Release Edition Reference Tables - ONS

Complete the table below asking “how will this group be affected by this service change proposal/policy/strategy/guidance?”

Does the ‘activity’ have the potential to:

- Have a POSITIVE impact (benefit) on any of the equality or vulnerable groups? Answer YES or NO. If YES please explain (Reasons) and detail amendments.
If there is an impact is this HIGH (H), MEDIUM (M) OR LOW (L)? If no impact, insert N/A
- Have a NEGATIVE impact / exclude / discriminate against any of these groups? Answer YES or NO. If YES please explain (Reasons) and detail amendments.
  - If there is an impact is this HIGH (H), MEDIUM (M) OR LOW (L)? If no impact, insert N/A

You must be familiar with what your activity wants to achieve and/or what would result and the corresponding evidence base before being able to complete this assessment comprehensively.
For the different Equality Groups and Vulnerable Communities please make sure you are familiar with the Joint Strategic Needs Assessment and the Health Profile for this CCG.

<table>
<thead>
<tr>
<th>AGE</th>
<th>Negative Impact: NO Level: LOW</th>
<th>Positive Impact: YES Level: HIGH</th>
</tr>
</thead>
</table>

Reasons for positive / negative impact: Please reference evidence you have considered as part of your analysis

It is estimated that there are 278,248 children and young people aged 0-19 living in Surrey with 54% concentrated in the northern, more urban districts and boroughs of Elmbridge, Epsom and Ewell, Runnymede, Spelthorne, Surrey Heath and Woking. Estimates predict that the 0-19 population will increase by 12% by 2037, with the North East experiencing the lowest rate of growth (8%) and the highest in the North West (15%).

What amendments can be/have been made to the activity in order to eliminate or reduce the adverse impact on different groups?

Within the service specifications there is a requirement to ensure:
- Children’s Community Health Services will be available to children and young people between the age range of 0-18. For children and young people in special schools 19, for some young people up to the age of 25 in line with the Children and Families Act 2014
- Adhere to the acceptance criteria for the child or young person’s age indicated in each of the individual service specifications for the in scope services outlined above
- Children’s Community Health services work closely with adult services to meet the needs young people undergoing their transition to adult care in line with the Children and Families Act 2014
- Information provided is in a format that best meets the needs of the child, young person, or their family

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3 Joint Strategic Needs Assessment, ‘Children’s Summary Analysis’ (March 2015) 3
• Use mobile technologies that improves communication, access, data collection, and delivery of community health services

**Recommendation: No change to remit and scope of these services**

<table>
<thead>
<tr>
<th>DISABILITY</th>
<th>Negative Impact: NO</th>
<th>Positive Impact: YES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Level: LOW</td>
<td>Level: HIGH</td>
</tr>
</tbody>
</table>

**Reasons for positive / negative impact:** Please reference evidence you have considered as part of your analysis

The number of children and young people in Surrey assessed as requiring a Statement of Special Educational Needs or Education, Health and Care Plan (EHCP) has increased since 2009 by 7.5% from 5,360 to 5,631 (in January 2015). The proportion of children and young people with statements or EHCPs in Surrey schools has increased from 2.9% to 3.1% of the overall school population, which compares to regional and national averages of 2.8%.4

In January 2014 of the 147,184 children and young people on roll in Surrey maintained schools, academies and free schools 17% were identified as having special educational needs (SEN). Of those identified with special educational needs (SEN) 19% had a statement, 48.5% received school action and 32.5% school action plus. In November 2014, 732 children and young people were receiving social care support from the Children with Disabilities Team, 358 in the east of the County and 374 in the west.

**What amendments can be/have been made to the policy or procedural guidance in order to eliminate or reduce the adverse impact on different community groups?**

*Within the service specifications there is a requirement to ensure:*

- Children’s Community Health Services are in line with the updated changes to the children continuing healthcare national guidance (2016)
- Children’s Community Health services work closely with adult services to meet the needs young people undergoing their transition to adult care in line with the Children and Families Act 2014
- Age range has been increased from 16 to 19 year old if child with a neurodisability requires physio and is in full time education
- Integration of health and education paediatric OT and physio services
- A focus on health related speech and language needs, including dysphagia for children 0-5 year olds
- There are no barriers to entry to the service on the grounds of any disability

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4 'The SEND Challenge: Growing Levels of Need' (16 March 2016) 25
There is a named SEND Medical Advisor who will work closely with Designated Clinical Officer for SEND to ensure health compliance with the legislation and spirit of the SEND Code of Practice leading to improved outcomes for children and young people with special educational needs and disability.

Recommendation: To ensure there is a stronger interface to delivery SEND within Surrey

<table>
<thead>
<tr>
<th>ETHNICITY / RACE / ETHNIC GROUP</th>
<th>Negative Impact: NO Level: LOW</th>
<th>Positive Impact: YES Level: MEDIUM</th>
</tr>
</thead>
</table>

Reasons for positive / negative impact: Please reference evidence you have considered as part of your analysis.

Surrey’s Joint Strategic Needs Assessment\(^5\) reports that the proportion of the population from black and minority ethnic groups is smaller in Surrey than in the country as a whole, this varies between local authorities and clinical commissioning groups. Of the 11 boroughs and districts in Surrey, Woking has the highest percentage of its population from non-white ethnic groups and Waverley the lowest. Indian and Pakistani are the largest single ethnic minority groups in Surrey, comparable to the South East but a smaller proportion than in England overall.

However there is now greater ethnic and cultural diversity with 20% of school children in Surrey from a minority ethnic group. There are 187 languages spoken in Surrey’s maintained schools and academies, with the most common after English being Polish, Spanish, Portuguese, French and Punjabi.

It is estimated 1,400 GRT children and young people on role in Surrey schools. Research into the health outcomes of GRT communities indicates these communities have the worst physical health outcomes of any ethnic group in the UK\(^6\).

Findings from ‘Surrey’s Strategy for GRT children and young people 2014-2017’\(^7\) highlighted:

- A number of barriers exist for the GRT community in accessing universal health provision.

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\(^5\) JSNA Chapter: Ethnicity (July 2015) 1

\(^6\) Surrey County Council, Needs analysis for Surrey’s Gypsy, Roma and Traveller children and young people (2013), 7

- Cultural beliefs around immunizations and vaccinations leave the GRT community vulnerable to illness
- The incidence of heart disease, asthma, bronchitis, diabetes and long-term illness is significantly higher than for the general population.
- Fear and a lack of knowledge about statutory services mean that they are often only accessed at a point of crisis

What amendments can be/have been made to the policy or procedural guidance in order to eliminate or reduce the adverse impact on different community groups?

Within the service specifications there is a requirement to ensure:
- Proactive engagement of children and young people, or their families that may not ordinarily engage with community health services are reached and supported.
- Children’s Community Health Services meet local need, shaped to meet individual child’s needs, and the needs of their locality
- Equity of access
- Ensure information is accessible and services using interpreting and translation services when required.
- Children’s Community Health Services are culturally sensitive

Recommendation: There are no barriers to entry to the service on the grounds of ethnicity and culture

<table>
<thead>
<tr>
<th>GENDER</th>
<th>Negative Impact: NO Level: LOW</th>
<th>Positive Impact: YES Level: HIGH</th>
</tr>
</thead>
</table>

Reasons for positive / negative impact: Please reference evidence you have considered as part of your analysis

The gender split in Surrey is almost equal with 51% of the Surrey population female and 49% male.\(^8\) When it comes to children’s community health services, there is little evidence of the uptake of the service due to gender.

What amendments can be/have been made to the policy or procedural guidance in order to eliminate or reduce the adverse impact on different community groups?

Within the service specifications there is a requirement to ensure:
- The provider engages in proactive identify any barriers and undertake actions to overcome any barriers identified.

Recommendation: There are no barriers to entry to the service on the grounds of gender

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**GENDER REASSIGNMENT**

<table>
<thead>
<tr>
<th>Negative Impact: NO</th>
<th>Positive Impact: YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level: LOW</td>
<td>Level: MEDIUM</td>
</tr>
</tbody>
</table>

**Reasons for positive / negative impact:** Please reference evidence you have considered as part of your analysis

An identified gap in Surrey’s JSNA\(^9\) indicates a shortfall in services to transgendered populations. The discrimination and prejudice faced by transgendered people can have a drastic affect upon physical and mental health.

Most gender variant children do not know where to seek specialist help, or are reluctant to, face discrimination and be vulnerable to bullying and hate crime, in school, their families and local communities. There is no local data for Surrey’s young people, there is some national data exists but predominately in relation to adults.

**What amendments can be/ have been made to the policy or procedural guidance in order to eliminate or reduce the adverse impact on different community groups?**

*Within the service specifications there is a requirement to ensure:*

- Accessible information is available via the telephone, email and a website
- Adopted the ‘No wrong door’ approach – no referral for a child or young person will be turned away from advice and direction to support will be given
- As a system leader for physical health will work closely with Surrey & Borders Partnership NHS Foundation Trust the system leader for mental health and emotional wellbeing ensuring parity of esteem.

**Recommendation:** Professionals will be offered training in this area of need. More data is also required to plan for local service to meet the needs of young people.

<table>
<thead>
<tr>
<th>RELIGION &amp; BELIEFS</th>
<th>Negative Impact: NO</th>
<th>Positive Impact: YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level: LOW</td>
<td>Level: MEDIUM</td>
<td></td>
</tr>
</tbody>
</table>

**Reasons for positive / negative impact:** Please reference evidence you have considered as part of your analysis

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\(^9\) JSNA Chapter: Lesbian, Gay, Bisexual and Transgender (April 2011)

The JSNA\textsuperscript{10} found that young people were more likely to state they had no religion in the 2011 Census compared to people in older age groups. For example, more than one third (36%) of people aged 16 to 24 stated they had no religion compared with 10% of people aged 65 and over.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Christian</th>
<th>Muslim</th>
<th>Hindu</th>
<th>All other religions</th>
<th>No religion</th>
<th>Religion not stated</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-15</td>
<td>59%</td>
<td>3.2%</td>
<td>1.4%</td>
<td>1.1%</td>
<td>27%</td>
<td>8%</td>
</tr>
<tr>
<td>16-24</td>
<td>51%</td>
<td>2.9%</td>
<td>1.3%</td>
<td>1.6%</td>
<td>36%</td>
<td>8%</td>
</tr>
</tbody>
</table>

What amendments can be/have been made to the policy or procedural guidance in order to eliminate or reduce the adverse impact on different community groups?

Within the service specifications there is a requirement to ensure:

- Children’s Community Health Services take account of children and young people and their families religion and beliefs in the planning and delivery of care
- There are no barriers to entry to the service on the grounds of religion offering flexibility of appointments on non-religious days
- Children & young people are able to access same gender professionals if requested
- Education and raise awareness of Female Genital Mutilation (FGM) and the impact on physical and mental health

Recommendation: Professionals will be offered training in this area.

<table>
<thead>
<tr>
<th>MARRIAGE &amp; CIVIL PARTNERSHIP</th>
<th>Negative Impact: NO Level: LOW</th>
<th>Positive Impact: YES Level: LOW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reasons for positive / negative impact:</td>
<td>Please reference evidence you have considered as part of your analysis</td>
<td></td>
</tr>
</tbody>
</table>

\textsuperscript{10} JSNA Chapter: Religion and Belief (October 2013)
Due to the age range of clients who access these services it is unlikely that there will be young people who are married or in civil partnerships.

What amendments can be/have been made to the policy or procedural guidance in order to eliminate or reduce the adverse impact on different community groups?

Within the service specifications there is a requirement to ensure:

- There are no barriers to entry to the service on the grounds of marriage and civil partnership through the adoption of a ‘No wrong door’ approach – no referral for a child or young person will be turned away from advice and direction to support will be given

Recommendation: No change to remit and scope of these services

<table>
<thead>
<tr>
<th>PREGNANCY &amp; MATERNITY</th>
<th>Negative Impact: NO Level: LOW</th>
<th>Positive Impact: YES Level: HIGH</th>
</tr>
</thead>
</table>

Reasons for positive / negative impact: Please reference evidence you have considered as part of your analysis

Children’s early health development provides the foundations for childhood and developing affectionate bonds. Research and consultations have highlighted this stage as being crucial in helping our children and families reach the best outcomes at later stages.¹¹

In 2013 there were:

- 13,569 live births recording the mother’s usual place of residence as Surrey. North East Surrey had the highest number with 4,084 live births and the lowest number was 2,775 in the South West.
- 1% of women giving birth in Surrey were under 18 years old. Although there is a lower percentage of births to teenage girls compared with England there is a higher than average termination rate in Surrey at 59%. Runnymede, Woking and Spelthorne have a higher rate of teenage conceptions than Surrey overall.
- 2% of all Early Help Assessments and Common Assessment Frameworks were started pre-birth. It is important that the early help offer is available during pregnancy to ensure services are co-ordinated and families are supported to prevent unmet needs escalating

The rate of live births in Surrey is expected to rise by around 1,000 over the next 15 years. Interventions promoting maternal mental health, targeting parents and pre-school children show a high level of effectiveness and cost effectiveness as early intervention can prevent many of

¹¹ Joint Strategic Needs Assessment, ‘Children’s Summary Analysis’ (March 2015) 5
the negative effects of perinatal mental illnesses on families. This means family planning and healthy relationships education is important across Surrey and there are areas where it may need to be targeted.

Lifestyle choices during pregnancy can have a significant impact on the health outcomes of babies, for instance the use of drugs and/or alcohol and smoking

- 7% of mothers in Surrey are smokers at the time of delivery
- 6% of babies born in Surrey have a low birth weight
- Surrey has a lower percentage than the national average for both of the above factors which can lead to the baby having complex needs
- The risk of domestic abuse is increased for women during pregnancy

Maternal mental health problems during pregnancy and the postnatal period (the perinatal period) can have far-reaching serious consequences for mothers and babies, their families and society as a whole. During pregnancy, depression affects 15% of women. The 2004 CEMACH report ‘Why mothers die’ highlighted that mental illness during pregnancy accounts for 12% of maternal deaths. 1.2% is due to suicides. For some groups of mothers, the rate is higher. For example, about 40% of teenage mothers suffer from postnatal depression and mothers living in deprived circumstances or who are subject to domestic violence also experience above average rates.

In Surrey, based on national data, it is estimated between 900 and 2,000 mothers to experience PNMH problems. In south east Surrey in 2007-8, health visitors identified 270 (15%) mothers with postnatal mental health problems and offered them support. Of these mothers, 150 (58% of those offered support, 8% of the total) accepted the offer.

<table>
<thead>
<tr>
<th>What amendments can be/have been made to the policy or procedural guidance in order to eliminate or reduce the adverse impact on different community groups?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within the service specifications there is a requirement to ensure:</td>
</tr>
<tr>
<td>- Every contact counts</td>
</tr>
<tr>
<td>- An Integrated Healthy Child Programme comprising of School Nursing, Health Visiting and Family Nurse Partnership</td>
</tr>
<tr>
<td>- The integrated specification dovetails and reads across to other relevant services within the CCHS, acute care and primary care; and as well as the involvement in Surrey’s multi-agency safeguarding hub (MASH)</td>
</tr>
<tr>
<td>- The Integrated Healthy Child Programme will provide leadership, experience and knowledge across teams, with a skills mix that ensures to the needs of Surrey’s children and young people are met</td>
</tr>
<tr>
<td>- Working across the four domains of the Healthy Child Programme the service will provide a number of discrete functions which broadly fit under the following areas:</td>
</tr>
</tbody>
</table>
1) Public Health prevention and early intervention
2) Developmental reviews and checks
3) Screening
4) Health protection function.
   - Emotional wellbeing and mental health needs of expectant mothers/mothers are met

Recommendation: No change to remit and scope of these services

<table>
<thead>
<tr>
<th>SEXUAL ORIENTATION</th>
<th>Negative Impact: NO Level: LOW</th>
<th>Positive Impact: YES Level: MEDIUM</th>
</tr>
</thead>
</table>

Reasons for positive / negative impact: Please reference evidence you have considered as part of your analysis

It is estimated that 7% of the population are lesbian, gay, bisexual, transgender or questioning (LGBTQ). Applying this to mid-2009 population estimates for Surrey, there may be around 5,700 people aged 11 to 16 in Surrey who are LGBTQ. LGBT young people in Surrey continue to feel unable to be open with others about their identity due to fear or personal experience of homophobia and transphobia.

Many young people discover that they are lesbian, gay or bisexual (may have feelings of being different) from the age of 11. However a number of young people do not 'come out' until the age of 16. The age range of 11 to 16 is a critical period for most young people who are LGBTQ. LGBTQ young people are likely to experience some degree of identity-related stigma which contributes to increased risk of:

- Bullying and social exclusion – 34% of LGBTQ young people are estimated to have experienced homophobia whilst in school. It should also be noted that homophobic bullying in school doesn’t just affect those who are gay, but also other pupils who are perceived as being different.
- Domestic abuse – a third of LGBTQ young people are estimated to have experienced bullying at home by a parent.
- Poor mental health – bullying, domestic abuse and social exclusion can result in the development of mental health disorders such as stress and psychotic behaviour.
- Self-harm and suicide – young people who aren’t able to access appropriate support often develop their own strategy of coping with the stigma. This can involve self-harm and suicide which are more common amongst LGBTQ young people than their peers.
- Smoking and substance abuse.
- LGBTQ children and young people from Asian and Afro-Caribbean minority ethnic backgrounds may be at particular risk of social

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12 JSNA Chapter: Lesbian, Gay, Bisexual and Transgender (April 2011)
13 As above, page 2
exclusion and experiencing homophobic behaviour from their respective communities, including being forced into arranged marriages

In addition, children and young people with same sex parents or guardians are at risk of bullying and social exclusion in schools

What amendments can be/have been made to the policy or procedural guidance in order to eliminate or reduce the adverse impact on different community groups?

*Within the service specifications there is a requirement to ensure:*

- There are no barriers to entry to the service on the grounds of sexual orientation through the adoption of a ‘No wrong door’ approach – no referral for a child or young person will be turned away from advice and direction to support will be given
- Services are accessible via the telephone, email and a website
- Improvements are made in the recording of data for this area

**Recommendation:** No change to remit and scope of these services

### Other categories relevant to CCG’s statutory duty to reduce health inequalities:

<table>
<thead>
<tr>
<th>CARERS</th>
<th>Negative Impact: NO</th>
<th>Positive Impact: YES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Level: LOW</td>
<td>Level: HIGH</td>
</tr>
</tbody>
</table>

**Reasons for positive / negative impact:** Please reference evidence you have considered as part of your analysis

The census (2011) identified there were 6021 children and young people age 0 – 24 years old providing unpaid care in Surrey. It is suspected that this is an underestimation of young carers as it is estimated that there are 14,030 young carer’s in Surrey with 1,500 young carers (just over 10%) accessing services.¹⁴

Surrey Carers undertook a Young Carer’s Survey (2012) which received 265 responses. Key findings of this survey were:

- 30% wanting to know more about ‘coping methods’ with approx.
- 18% concerned about bullying.
- GPs were highlighted as having a key role in identifying and registering young carers, monitoring their health and signposting them to advice, information and support including ensuring they know they are entitled to a carer’s assessment.

‘Making it Real for Young Carers in Surrey’¹⁵ is a strategy introduced by Surrey County Council for 2015 to 2018 to improve recognition and

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¹⁴ Nottingham University Young Carers Study carried out by Professor Saul Becker (2008)

¹⁵ Making it Real for Young Carers in Surrey 2015-2018, Surrey County Council
support for young carers. The strategy is based around the following priorities:
- Information and Advice – having the information I need, when I need it
- Active and supportive communities – help to keep in touch with friends, maintain family relationships and join in local activities
- Flexible and integrated support
- Workforce – my support staff
- Risk enablement – feeling in control and safe
- Personal budgets and self-funding – my money

The impact of caring can be detrimental to carers health. The ‘Healthy Lives Healthy People 2010’ report stated that carers who care for 50 hours or more per week are 80% more likely to have health impacts. The 2011 Surrey Carers Health Survey Report showed that 60% of respondent cared for more than 50 hours per week. From the survey almost 100% of respondents identified a health condition they suffered from as a result of caring.

What amendments can be/have been made to the policy or procedural guidance in order to eliminate or reduce the adverse impact on different community groups?

*Within the service specifications there is a requirement to ensure:*
- Appropriate training for parents / carers so they feel better equipped with the knowledge and skills they need to play a greater role in their child's care.
- Parents/carers are sign posted to access support for themselves.
- Improve data collection of children identified as young carers

Recommendation: Professionals will be offered training in this area. More data is also required to plan for local service to meet the needs of children and young people.

<table>
<thead>
<tr>
<th>AREAS OF DEPRIVATION and GEOGRAPHICAL LOCATION (urban, rural, isolated)</th>
<th>Negative Impact: NO Level: LOW</th>
<th>Positive Impact: YES Level: HIGH</th>
</tr>
</thead>
</table>

http://carersworldradio.ihoststudio.com/carersnet/young%20carer%20strat.pdf


Reasons for positive / negative impact: Please reference evidence you have considered as part of your analysis

Surrey is the fifth least deprived county in England ranking 144th out of 149, with 60.9% of the population falling into the least deprived quintile. However there are pockets of deprivation, Maybury and Sheerwater (Woking) and Merstham (Redhill & Reigate) have Lower Super Output Areas (LSOA) in the most deprived quintile. The Local Authority (LA) with the highest number of LSOA in the most deprived areas is Spelthorne, with 10.3% of its population living in the top two most deprived quintiles, followed by Reigate & Banstead (7.7%), Runnymede (7.4%) and Guildford (7.3%).

Surrey’s Joint Strategic Needs Assessment highlighted:

- **Economic status**: Nearly 10% of 0 to 19 year olds live in poverty in Surrey. 8% of children qualify for Free School Meals.
- **Parental qualifications**: 7.8% of the Surrey working age population have no qualifications.
- **Young parents**: There are around 300 conceptions to girls under 18 in Surrey each year. About half of these result in a termination.
- **Education and employment**: Academic achievement for children eligible for Free School Meals is considerably lower than for other children. There are currently just over 500 young people, aged 16-19 years, classed as Not in Education, Employment or Training.
- **Housing**: The number of households in temporary accommodation has doubled since 2010.

What amendments can be/have been made to the policy or procedural guidance in order to eliminate or reduce the adverse impact on different community groups?

**Within the service specifications there is a requirement to ensure:**

- Ensure equity of access for children and young people wherever they live within the county, based on clinical health need not geography
- Consistent delivery of service so everyone can access the same services based on clinical need.
- Earlier Interventions so children and young people and their families are referred appropriately and helped sooner and do not have to wait for a diagnosis or worsen before they are eligible for help.
- Children’s Community Health Services are accessible, equitable, integrated, sustainable and flexible for all children and young people, regardless of diagnosis.

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18 JSNA Chapter: Index of Multiple Deprivation (2010)

19 JSNA Chapter: Children Living in Poverty (2011)
• Easy access to clear information and signposting provided in appropriate format so children, young people and families can be better informed and empowered to help themselves and be more active in their own care.
• Strong links are maintained with early years, education, services for young people, social care and adult services.

Recommendation: No change to remit and scope of these services

| VULNERABLE GROUPS e.g. ex-military, homeless, looked-after children | Negative Impact: NO Level: LOW | Positive Impact: YES Level: MEDIUM |

Reasons for positive / negative impact: Please reference evidence you have considered as part of your analysis

Looked After Children (LAC) - in Surrey, (2016) there were 780 looked after children and 100 unaccompanied asylum seeking children (3rd highest number in the UK).

Children often enter the care system with a poorer level of health than their non-looked after peers. Looked after children and care leavers are:
• More likely to have emotional and mental health disorders related to their experiences of trauma and/or lack of placement stability or permanency
• Between four and five times more likely to self-harm in adulthood
• More likely than their peers to experience problems including speech and language problems, bedwetting, co-ordination difficulties and eye or sight problems
• Be exposed to greater risk factors for teenage pregnancy due to social-economic deprivation, low education attainment, lack of consistent positive adult support, having a teenage mother, low self-esteem and experience of sexual abuse.
• Are almost twice as likely to have problems with drugs or alcohol (increased from 18% to 32%) and to report mental health problems (12% to 24%) and other health problems (28% to 44%) including asthma, weight loss, allergies, flu and illnesses related to drug or alcohol misuse and pregnancy in young people’s first year after leaving care, compared to measures taken within three months of leaving care
• Can experience health inequalities in terms of access to services if they move out of county.

Child sexual exploitation

In December 2015, Surrey County Council and Surrey Police identified a joint profile of children at Risk of Child Sexual Exploitation (CSE), which deemed 111 children to be at risk of CSE. Most identified CSE victims in Surrey (78.8%) are white females aged 14-17 years. The joint profile shows that in Surrey 94% of victims of CSE were female and 6% male. The risk of boys and young men becoming victims of sexual exploitation by both male and female offenders is underestimated and less well understood than those relating to girls.20

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Children from Armed-Forces Families

The health issues/social factors of serving military families are based on the frequent movement of families from one area to another and a tendency to be seen as itinerant patients. Surrey has a relatively small serving population, only about 5000 regular; the majority are here in the county for their training, with a smaller number, around 170, reservists.

Clinical Commissioning Groups (CCGs) have a responsibility for commissioning health services for veterans and families of members of the Armed Forces registered with NHS GP Practices. As part of the NHS Constitution entitlement to Choice of NHS providers, military families returning from postings or deployments must re-join waiting lists within the same time frame.

Homelessness

The demand on health services is directly affected by those in poor housing conditions. Rough sleepers are four times more likely to use acute health care services than the general population. 58% of those living in temporary housing accommodation experience a decline in their health. Nationally the levels of homelessness are rising; this is also the case in Surrey where the number of households in temporary accommodation has grown from 205 in 2010 to 748 in June 2015. Rough sleeping is also on the rise and estimates have tripled in the last 4 years.21

What amendments can be/have been made to the policy or procedural guidance in order to eliminate or reduce the adverse impact on different community groups?

Within the service specifications there is a requirement to ensure:

- Ensure equity of access for children and young people wherever they live within the county, based on clinical health need not geography
- Consistent delivery of service so everyone can access the same services based on clinical need.
- All staff must act in accordance with current child protection protocols (Surrey’s Safeguarding Children Board), regardless of the young person’s level of ability and adhere to as well as contributing to case conferences and serious case reviews as required.
- All professionals who work come into contact with children will have access to the named doctor and named nurse responsible for

21 JSNA Chapter: Housing (December 2015)
safeguarding children and young people.

- Effective public health, early identification and intervention for safeguarding, developmental health needs requiring comprehensive understanding of a wide range of services and agencies in Surrey
- By rota supply developmental paediatricians who will undertake the functions of Forensic Medical Advisors to the Paediatric sexual assault referral centre (SARC)
- Proactive engagement and implementation of joint working arrangements with children and young people’s services in Surrey including but not exclusive to the following:
  - SEND including Education, Health and Care Planning and maintaining the local offer
  - Early Help
  - Multi Agency Safeguarding Hubs (MASH)

Recommendation: No changes to the scope of these services

CONCLUSION: What is your overall assessment regarding the equality impact of this activity?

Overall, across all equality groups there will be a positive impact as a result of the procurement of Children’s Community Health Services, with age, disability, gender, pregnancy and maternity and areas of deprivation/geographical location experiencing a high positive impact. The commissioners have developed the service specifications and shaped overarching principles and outcomes around the needs of the child/young person and their family/carers responding to feedback from engagement.

The provider will be held to account for these principles and will be monitored through schedules 4 and 6 reporting requirements.

RECOMMENDATIONS: What steps, if any, should be taken to ensure the activity does not have an adverse impact?

The recommendations outlined above for each equality group should be implemented.

The recommendations above have Quality Standard requirements/reporting requirements written into the contract, which means the Provider has to ensure it meets the requirements. The Provider will also need to comply with Equal Opportunities legislations operating an equal opportunities policy observing Codes of Practice issued by the Commission for Equality and Human Rights and giving appropriate consideration to each customer’s race, nationality, cultural or ethnic background, marital status, age, gender, sexual orientation and disabilities.

Once implemented, how do you intend to monitor the actual equality impact of this activity?

The Provider will be monitored at monthly contract review meetings. There will be close monitoring of their abidance to the service specifications, quality standards and reporting requirements. All of these have been drafted in order to eliminate/reduce adverse impact on
different community groups.

<table>
<thead>
<tr>
<th>Name of person completing EA: Laura Bissell</th>
<th>Job Title: Commissioning Project Officer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of lead Manager / Director: Sarah Parker</td>
<td>Signature:</td>
</tr>
<tr>
<td></td>
<td>Date completed: 03.06.16</td>
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