## 2017 Equality Analysis

**SUMMARY OF EQUALITY ANALYSIS** for Re-procurement of Adult Community Health Services in Guildford and Waverley 2017

<table>
<thead>
<tr>
<th>EQUALITY GROUP</th>
<th>Negative Impact YES / NO</th>
<th>Positive Impact YES / NO</th>
<th>ADJUSTMENTS PROPOSED YES/NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Disability</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Ethnicity / Race / Ethnic Group</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Gender</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Gender Reassignment</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Religion &amp; Beliefs</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Marriage &amp; Civil Partnership</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Pregnancy &amp; Maternity</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Carers</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Areas of Deprivation/Geographical Location</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Vulnerable Groups</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
</tr>
</tbody>
</table>
CONCLUSION: Summarise your findings.
Overall, the re-procurement of adult community health services for adults living in Guildford and Waverley will benefit all equality groups as long as reasonable adjustments are made to the manner in which all services are designed and provided, as recommended. Procurement offers the opportunity to review existing service models and reflect user experience in defining future service delivery. The analysis below provides current information about the population of Guildford and Waverley and makes proposals to ensure all equality groups benefit positively from the re-procurement.

Steps will need to be proactively taken to ensure that adult community services provide for the different equality groups within the community. Providers will need to:

- Improve involvement of patients and carers representing different equality groups when consulting on services.
- Be familiar with the changing demography of the local area to ensure service provision is tailored to the local community.
- Undertake further equality analyses and build in adjustments when developing and improving services.
- Provide a needs-based service.
- Communicate effectively to all relevant groups.
- Ensure that the health and social care workforce are appropriately trained so that they can cater for those who require reasonable adjustments to access services.
- Ensure that the needs of carers are understood and provided for.
- Ensure that the impact of deprivation in causing the early onset of frailty is understood and provided for.
- Ensure that reasonable adjustments are made so that majority and minority groups are offered fair access to the service.
- Understand that patients are individuals and care needs to be flexible. Community services need to adapt to changing circumstances.
- Make provisions for the local population aging and living longer.
- Promote and support self-care/self-management for appropriate patients and carers.
- Adopt an inclusive communications and engagement strategy that reflects and meets the demographics of the local population and ensures services are understood by and appeal to a broad range of people.

RECOMMENDATIONS: Summarise the amendments that need to be made to prevent any identified health inequalities from arising or continuing with this activity.
AGE

• The provider must consider the implications on the accessibility of the adults’ community health services. Consideration must be given to those who are disabled and/or considered as frail and elderly and have limited mobility.

• The provider must consider how it communicates with the population about services, especially if any services change as a result of a re-procurement exercise.

• A growing elderly population will have an impact on social and health services. Planning must account for this. Part of the challenge will be to ensure the right preventative and support services are in place so older people can remain independent for as long as possible.

• An ageing population will lead to an increase in people with long term conditions, for example diabetes, COPD, Parkinson’s disease and heart failure. Providers must consider future workforce planning to meet this need.

• 10% of the Guildford and Waverley population is made up of students at university, therefore services such as sexual health, prevention and managing minor illnesses should be thoughtfully and innovatively provided for this population as well as ensuring seamless care arrangements with other organisations in student’s usual place of residence for students with long term conditions.

DISABILITY

• The Provider must adhere to the Accessible Information Standard Information and Guidance

• The Provider must utilise all appropriate channels of communication for its services.

• Communications must be provided in an appropriate format and via an appropriate medium, such as Easy Read, Audio or Braille, to ensure that the most vulnerable groups of service users within Guildford and Waverley who access these services are fully informed.

• Providers must have robust access to high quality, responsive and comprehensive interpreter services for people who are deaf as well as those who speak different languages (see section on Ethnic Group). Consideration must be given to those patients who will require an access to an interpreter or advocate.

Telephone and online technology must be configured to be equally accessible to all disability groups e.g. SMS text messaging facilities; hearing loops.

• Ensure that training is in place for staff to equip them with the skills needed to provide a quality service to patients and carers with
disabilities including people with complex mental health needs and learning disabilities.

- Having a learning disability can increase anxiety and distress (adding to the patient’s vulnerability) as the individual may not understand why they are there or what to expect. Guildford and Waverley has a number of patients with disabilities, so we expect providers to make the situation as predictable as possible for the person – always letting them know what is happening. Consideration should be given to the appropriate reception and treatment for patients with a learning disability who arrive at an urgent care facility and to whether staff are sufficiently trained to safely discern the person’s needs; to communicate effectively with the patient and their carer(s); and to ensure the best possible patient experience.

- About 5% of the CCG population has a diagnosed long term mental illness, and there is likely to be a significant additional number who are undiagnosed. Reducing premature mortality in this section of the population will require a combination of increasing diagnosis and support while reducing the level of risky health behaviours and ensuring prompt treatment for physical health conditions. Exclusions for different care should not include the presence of mental illness; providers are expected to have a skilled workforce that can holistically meet a range of different needs.

- Providers must have robust arrangements in place that allow patient information to be routinely produced in an Easy Read format.

ETHNICITY/RACE/ETHNIC GROUP

While the population of the CCG overwhelmingly identifies as being White British, there are small but significant numbers of people who state they are a different ethnic group, specifically Gypsy Roma Traveller and Nepalese, as well as Indian and Black African Caribbean. The greatest concentrations of non-White British groups are in parts of North Guildford. It is essential to work closely with local voluntary groups and patient representatives to understand the specific needs of these groups e.g. advice regarding healthy lifestyle as part of treatment for diabetes should fit cultural practices.

It has been evidenced that mental illness within GRT communities is often though not always stigmatised and that overall health outcomes are significantly worse than the England average; this will impact on overall health outcomes from community services. Providers need to ensure staff are skilled in different cultural practices to enable identification and support for this group. The CCG is committed to narrowing the gap in life expectancy for the Gypsy and Roma communities it serves and expects its providers to actively pursue innovative means to reaching members of this ethnic group requiring community health care. To increase referral rates to a more appropriate level from black and ethnic minorities compared with white peers. The providers will work with voluntary, community and faith organisations to deliver and
respond to emotional and mental health needs.

Consideration by providers will need to be given to:

- The linguistic needs of different communities - the use of family members and friends to interpret for those that do not speak or understand English sufficiently well to take part in their own care. This introduces inequity and should be avoided. Providers must have robust access to interpreter services that are responsive at short notice to avoid this.

- The accessibility – in the broadest sense of the word - of community health services by people belonging to different communities.

- The need to provide appropriate levels of cultural awareness training to ensure staff are able to meet the needs of the different ethnic minority groups in the community in which they operate and equipped and motivated to make reasonable adjustments to their services.

GENDER

The Providers must utilise methodologies that ensure that men (who are typically least likely to access healthcare services) are aware of the services available and feel welcome to approach the services as part of any care that they may need.

It is important that services as a whole are able to meet the needs of men who may prefer to be cared for by a man (just as women can state a preference to be cared for by a woman). Service providers must ensure that their workforce strategy encourages the recruitment and retention of men to meet these possible gender needs and should ensure that satisfaction surveys probe this aspect of care.

GENDER REASSIGNMENT

- Staff awareness and training to reduce discriminatory behaviours that may have an impact on Transgender people accessing community health services within Guildford and Waverley.

- Patients who have stigmatizing conditions can end up in urgent and emergency departments partly because of limited access to other health care services. Therefore inclusive policies, awareness and training are key to all provider operations.

There are concerns in trans communities about recording gender reassignment status and the potential for identifying people where postcode information is also identified. Opportunity to engage further and for Providers to review policies for reception and treatment for
patients and carers; and training for staff.

RELIGION AND BELIEFS

• The Provider will need to consider ways of engaging faith forums in service design to ensure that any changes made meet the needs of these groups and do not have a negative impact in areas such as access e.g. a certain outpatient service only being available on a Friday would not be best practice.

• It is tempting to use family members or even friends to interpret for those that do not speak or understand English sufficiently well to take part in their own care. This places patients at risk of not being fully informed as it has been shown that family members can change information they interpret for different reasons. Providers must have robust access to interpreter services that are responsive at short notice to avoid this.

• Flexible appointment times should be offered to meet different cultural needs.

• Inpatient facilities must have appropriate faith facilities and be able to meet different dietary needs linked to religious beliefs.

• Providers should pursue gender balance in its workforce to meet preferences for same gender care, which can be linked to religious beliefs.

MARRIAGE AND CIVIL PARTNERSHIP

• Providers need to ensure that support for carers is built in to all of their service models.

• For people living alone requiring community services, providers should ensure links and signposting to organisations that can offer support and advice.

• Inclusive procedures must be in place that includes people living in same-sex partnerships and those that are in a civil partnership.

PREGNANCY AND MATERNITY

• Premises and facilities must accommodate the needs of pregnant and breastfeeding mothers and provide for parents to change babies.

• Services need to be responsive to changes in clinical need amongst women with long-term conditions who become pregnant in order to maximise health outcomes of mother and baby.

SEXUAL ORIENTATION

• Consideration must be given to those who belong to the LGBT community who may be at risk of developing specific health problems that will require easy access to these services.
• Consideration must be given to ways in which members of this protected group are engaged, should any services be redesigned. This will help to ensure that any changes meet their needs. Services must be accessible, inclusive and diverse.

• Providers need to ensure that information materials are inclusive to a variety of different minority groups including those who identify as Lesbian, Gay, Bisexual or Transgender.

CARERS
• Providers need to actively promote support services available to carers of all ages in order to improve awareness and uptake. This could potentially include displaying leaflets or posters or discussing support services with someone who has identified as a carer.

• Providers should ensure staff are fully equipped to engage young carers they encounter when providing care to the cared-for person in seeking support and linking with agencies such as Surrey Young Carers.

• Providers should encourage local people who identify as a carer to register with their GP so that they can access support via that channel.

• All community services should maintain links with carer support organisations across the CCG.

AREAS OF DEPRIVATION and GEOGRAPHICAL LOCATION (urban, rural, isolated)
• Access and response times for rural areas needs to be factored into decisions regarding place-based care. This relates to the ability of patients to get to services and to the ability of staff to allocate time and care for people requiring care in their own home.

• Mobile working needs to account for differences in access to the 3G/4G signal.

• Certain groups within the population will benefit from additional support to counteract loneliness and isolation. Providers must work in partnership with voluntary and community organisations to enhance overall health outcomes.

VULNERABLE GROUPS e.g. ex-military, homeless, looked-after children, those seeking asylum
• Communications will need to be provided in an appropriate format and via an appropriate medium to ensure that the most vulnerable groups of service users within Guildford and Waverley who access these services are fully informed and able to understand the information being provided.

• Providers must consider those patients who will require access to an interpreter or advocate.

• Providers should devise ways of working and staff skills to meet the needs of the homeless population, including rough sleepers, who have conditions requiring adult community health care services.

• The Social Care Institute for Excellence (2010) publication ‘Good Practice in social care for asylum seekers and refugees’ though targeted
at social care, has a useful set of principles from which community health care services could learn:

- A humane, person-centred, rights-based and solution-focused response to the [health] care needs of asylum seekers and refugees
- Respect for cultural identity and experiences of migration.
- Non-discrimination and promotion of equality
- Decision-making that is timely and transparent and involves people, or their advocates, as fully as possible, in the process.

- Providers must apply the Armed Forces Covenant Processes.
- The commissioning arrangements for the armed forces community are complex but the CCG has significant responsibilities, especially for veterans or ex-service personnel and military families. This needs to be considered while service planning. Specifically, the families of the armed forces personnel living in Guildford and Waverley are likely to be users of the local health service and to have experienced difficulties with continuity of care.
- Ex-service personnel are likely to require additional support for mental health problems, excess alcohol consumption and physiotherapy.
<table>
<thead>
<tr>
<th>NAME OF THE SERVICE/STRATEGY / POLICY / GUIDANCE/ SERVICE CHANGE PROPOSAL / PLAN ('ACTIVITY')</th>
<th>ADULT COMMUNITY HEALTH SERVICES RE-PROCUREMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who is this ‘activity’ aimed at? Please delete and explain further if relevant.</td>
<td>Patients/Public</td>
</tr>
<tr>
<td>What are the main aims and objectives of the ‘activity’?</td>
<td></td>
</tr>
<tr>
<td>This re-procurement seeks to commission an integrated adult community health service. NHS Guildford and Waverley CCG has a clear vision for the development of a comprehensive and fully integrated model of health and care provision to our local population. Central to this vision is the development of excellent integrated community services, wrapped around Primary Care to provide a holistic health and care response genuinely tailored to the needs of a specific individual. Our new model of care, which will continue to evolve from 2017 onwards, focusses on the creation of an organised, coordinated and effective Out of Hospital provider environment that is seen as the main conduit for meeting a person’s health and care needs.</td>
<td></td>
</tr>
<tr>
<td><strong>Overarching Aims</strong></td>
<td></td>
</tr>
<tr>
<td>The ultimate aim of the integrated community service is to provide and coordinate a high quality, holistic response to an individual’s care needs in a domiciliary or other community care setting.</td>
<td></td>
</tr>
<tr>
<td>• Promote recovery, rehabilitation and sustainability of health and functional status after an episode of ill health or injury, through rapid response, intermediate care and supported discharge.</td>
<td></td>
</tr>
<tr>
<td>• Support for patients (in particular those with long term conditions) in the community through early interventions and evidence-based care to maintain their health, wellbeing and independence.</td>
<td></td>
</tr>
<tr>
<td>• Optimise the experience of care of people approaching the end of their lives and their carers both in a domiciliary (home) or care home setting in Guildford and Waverley.</td>
<td></td>
</tr>
<tr>
<td><strong>Objectives</strong></td>
<td></td>
</tr>
<tr>
<td>• Reduction of emergency admissions and attendances at A&amp;E</td>
<td></td>
</tr>
<tr>
<td>• Improve access to 7 day services particularly rapid response and crisis intervention</td>
<td></td>
</tr>
<tr>
<td>• Ensure patients, their families and carers have a high quality experience of care</td>
<td></td>
</tr>
<tr>
<td>• Work seamlessly with the medical leadership of primary care professionals, implementing a Proactive Care Service Teams focused within localities responsible for jointly identifying and managing patients in conjunction with primary care</td>
<td></td>
</tr>
</tbody>
</table>
To minimise duplication, fragmentation and confusion by providing a single point of access for all referrals where clinical inputs can be coordinated around the needs of an individual patient

To work collaboratively with social care, mental health and voluntary sector agencies to ensure individuals can access a comprehensive health and social care support package

To provide a comprehensive care response at all stages of the patient pathway from proactive care through to end of life care; to improve the proportion of people who die in their preferred place of death

To reduce the need for long term care through effective preventative care and intervention

To manage resources efficiently to deliver an excellent standard of service within the financial envelope available

Services within scope

<table>
<thead>
<tr>
<th>1. Proactive Care</th>
<th>2. Intermediate Care</th>
<th>3. Place based Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Nursing</td>
<td>Rapid Response</td>
<td>Community Hospitals – Haslemere and Milford</td>
</tr>
<tr>
<td>Specialist Nursing</td>
<td>Community In-Reach</td>
<td>Haslemere Minor Injuries Unit</td>
</tr>
<tr>
<td>Podiatry</td>
<td>Community Rehabilitation</td>
<td>Diagnostic Assessment and Treatment Centre - Milford</td>
</tr>
<tr>
<td>Continence</td>
<td></td>
<td>GP Direct Access Physiotherapy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lymphoedema Service</td>
</tr>
</tbody>
</table>

Describe the current situation:

Currently, adult community health services are not fully integrated. The following outlines Guildford and Waverley CCG’s plans to address the situation. The local drivers underpinning the need to transform clinical services in Guildford and Waverley include:

- The residents of Guildford and Waverley have changing health needs, as people live longer and live with more chronic diseases – putting pressure on health care provision.
- We need to have more planned and integrated care, provided earlier to our population in settings outside of hospital. Patients do not always need to receive hospital based care and alternative community and primary care based services can often be delivered closer
to home and be more cost effective and centred around the patient

- Capacity within our acute hospital providers is constrained and this is adversely impacting referral to treatment waiting times for patients, indicating that services need to be provided differently to ensure the best clinical outcomes
- Variation in both quality and access and standards must improve ensuring that services are centred around the patient
- Providing a value for money service that achieves clinical and financial sustainability

Clarify what exactly is being analysed:
The needs of our local population in relation to the adult community health services that are in scope for this re-procurement and the new model being proposed; will encompass the following:

- Community services accountability to primary care
- Development of core, integrated teams focused around localities of GP practices
- Robust care coordination and the use of key workers to coordinate access
- The development of a much higher level of generalist skill across community nursing rather than specialised silos
- A single point of access for referral and telephone access
- A unified patient record that is streamlined, and provides efficient methods of referral and information sharing
- A service that responds to the needs or the patient with regards to response times, access and operating hours
- Accessibility of services;
- Communications;
- Service capacity;
- The care services provide for patients;
- Service location;
- Staff training;
- The impact of coordinated working.

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.

NHS Guildford and Waverley CCG carried out several Patient and Public Engagement Forums involving over 150 residents from May 2013, covering a range of commissioning issues.
April 2014
- Public and Patient Engagement Forum- focused on older people, integrating services and 7-day working.

July 2014
- Provider Engagement for the Integrated Care Organisation (later replaced by the Integrated Care Partnership; much of the feedback is still applicable as many of the features of the service change have remained the same through the transition)

October 2014
- Public and Patient Engagement Forum- focused on older people, integrating services and 7-day working

January 2015
- Practice Council
- Frailty Forum
- Executive Briefing- Guildford and Waverley Clinical Commissioning Group

March 2015
- Frailty Forum

May 2015
- Frailty Forum
- Patient and Public Engagement Group
- GP Practice Participation Group

June 2015
- Better Care Fund event

September 2015
- Talking about Commissioning Intentions 2016/17- Engagement Event
- Annual General Meeting- Engagement Event
- Care Home Forum

October 2015
- Patient and Public Engagement Forum- Godalming - 2016/17 Commissioning Intentions
January 2016 – Procurement stage

- Market Engagement event including PPE representative
- Survey Monkey results from public questionnaire

Events organised by North West Surrey CCG prior to the decision that Guildford and Waverley CCG would procure its own services:

Between September and November 2015, communications leads from all commissioners promoted the procurement process and encouraged people to provide feedback to help shape the development of community services. Activities included:

- four public / stakeholder meetings with about 50 attendees
- attendance at five health and wellbeing / patient and public / AGM events
- more than 1,000 visits to the procurement website
- more than 100 tweets released and placed on two Facebook pages and two other websites (reach more than 70,000)
- almost 300 people provided feedback via online or paper survey
- two press releases distributed to newspapers and radio
- articles in two newspapers and two schools bulletins
- letters, surveys and posters sent to more than 500 voluntary and community organisations and their branches including CAB and NCT
- visits to ten practices
- letters and updates for HOSC
- letters and meetings with MPs
- attendance at more than ten locality meetings, practice manager forums, practice nurse forums, practice commissioning committees and similar
- email sent to all pharmacies in Surrey
- email sent to more than 100 practices, including posters and text to place on display screens
- more than ten articles in CCG newsletters, hospital newsletters, adult social care newsletters and similar
- information sent to borough councils, mental health networks, social care partnerships coordinators, coordinators of youth projects, adult social care and other directorates for cascade

In addition, four market events were hosted by North West Surrey CCG to inform interested organisations about the process.

Following the decision of the CCG’s Governing body not to proceed with the preferred provider, in February 2017, re-procurement is taking place. No further patient and public engagement has been carried out since then as the aim is to repeat the procurement of the same
integrated community health care service.

June 2017
- Market Engagement event for re-procurement

Does the ‘activity’ described above already impact negatively or positively on different equality groups or would the activity:
- Have a POSITIVE impact (benefit) on any of the equality or vulnerable groups? Answer YES or NO
- Have a NEGATIVE impact / exclude / discriminate against any of these groups? Answer YES or NO

AGE

Analysis: Refer to national evidence and data and then think about the local population and how people of different ages may or may not benefit from the ‘activity’.

There are two main sources of information on the number of people living in Guildford and Waverley CCG area - resident and registered populations. The resident population is the number of people living within the CCG area mapped to administrative boundaries; these are estimated using the 2011 Census data as a baseline and taking into account subsequent births, deaths and movements into and out of the area. The registered population is a count of the number of people registered with GP practices which comprise the CCG on a given date. The two populations usually differ due to GP practices overlapping administrative boundaries and ghost patients on GP lists. Below we provide both populations, broken down by age and gender, and identify implications for the CCG.

The total Guildford and Waverley CCG population is 207,772 and consists of approximately 102,725 (49.4%) men and 105,047 (50.6%) women. Approximately one quarter (24%) are children and young people aged 0-19 years. Almost 60 per cent (58%) are adults of working age (20-64 years). Approximately a fifth (18%) are older adults, aged 65 years and over, with 3% of the population the very old, aged 85 years and over.

Table 1: Mid 2013 Estimate of Guildford and Waverley Population by broad age group and gender

<table>
<thead>
<tr>
<th>Age</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
<th>% Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-19</td>
<td>25,915</td>
<td>24,188</td>
<td>50,103</td>
<td>24</td>
</tr>
<tr>
<td>20-64</td>
<td>59,792</td>
<td>59,962</td>
<td>119,754</td>
<td>58</td>
</tr>
<tr>
<td>65 and over</td>
<td>17,018</td>
<td>20,897</td>
<td>37,915</td>
<td>18</td>
</tr>
</tbody>
</table>
Table 1 shows the resident population by gender and 5 year age bands (bars), compared to the population of England (outline). Guildford and Waverley CCG has a similar proportion of men and women compared to the English population, but the CCG age profile differs from the English one. The proportions for both men and women aged 25-34 are significantly lower than England while those for men and women aged 35 and over are higher in every age band, especially in adults aged 40-54.

**Figure 1: Mid 2013 Estimate of Guildford and Waverley Population by 5 year age group and gender**

![Population by age and gender](image)

**Source:** ONS

**Note:** ONS estimated resident population represents the number of people who live in that area at that time. Guildford and Waverley CCG had a GP registered population of 220,804 as of April 2015, of which approximately 49% were men and 51% women.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Male (ONS)</th>
<th>Female (ONS)</th>
<th>Male (CCG)</th>
<th>Female (CCG)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4 yrs</td>
<td>2,071</td>
<td>3,958</td>
<td>6,029</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>102,725</td>
<td>105,047</td>
<td>207,772</td>
<td>100</td>
</tr>
</tbody>
</table>

**Table 2: GP registered population (April 2015) and CCG resident population (Mid-2013 Estimate) by broad age group and gender**
<table>
<thead>
<tr>
<th>Age Range</th>
<th>GP registered population (April 2015)</th>
<th>CCG resident population (mid-2013 estimate)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>0-19</td>
<td>26,326</td>
<td>25,493</td>
</tr>
<tr>
<td>20-64</td>
<td>64,894</td>
<td>63,742</td>
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<tr>
<td>65 and over</td>
<td>18,015</td>
<td>22,334</td>
</tr>
<tr>
<td>85 and over</td>
<td>2,215</td>
<td>4,186</td>
</tr>
<tr>
<td>Total</td>
<td>109,235</td>
<td>111,569</td>
</tr>
</tbody>
</table>

Source: HSCIC and ONS  
Note: Registered population is the number of patients signed on with GPs at that time

Table 3: Projected Guildford and Waverley population from 2015 to 2025

<table>
<thead>
<tr>
<th>Age</th>
<th>2015</th>
<th>2017</th>
<th>2019</th>
<th>2021</th>
<th>2023</th>
<th>2025</th>
<th>2015 to 2025</th>
<th>% Change 2015-2025</th>
<th>% Change Surrey</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-14</td>
<td>37,500</td>
<td>38,800</td>
<td>39,700</td>
<td>40,300</td>
<td>40,600</td>
<td>40,800</td>
<td>3,300</td>
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<tr>
<td>15-29</td>
<td>41,400</td>
<td>41,900</td>
<td>42,200</td>
<td>42,200</td>
<td>42,600</td>
<td>43,100</td>
<td>1,700</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>30-44</td>
<td>39,800</td>
<td>39,200</td>
<td>39,100</td>
<td>39,500</td>
<td>40,000</td>
<td>40,200</td>
<td>400</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>45-64</td>
<td>53,200</td>
<td>54,500</td>
<td>55,500</td>
<td>55,900</td>
<td>56,200</td>
<td>56,500</td>
<td>3,300</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>65 and over</td>
<td>39,700</td>
<td>40,800</td>
<td>42,200</td>
<td>43,700</td>
<td>45,400</td>
<td>47,200</td>
<td>7,500</td>
<td>19</td>
<td>21</td>
</tr>
<tr>
<td>85 and over</td>
<td>6,500</td>
<td>6,900</td>
<td>7,500</td>
<td>8,000</td>
<td>8,700</td>
<td>9,300</td>
<td>2,800</td>
<td>43</td>
<td>43</td>
</tr>
<tr>
<td>All ages</td>
<td>211,600</td>
<td>215,200</td>
<td>218,700</td>
<td>221,600</td>
<td>224,800</td>
<td>227,800</td>
<td>16,200</td>
<td>8</td>
<td>8</td>
</tr>
</tbody>
</table>

Table 3 shows that Guildford and Waverley CCG population is expected to grow by 8% in the next 10 years which is consistent with the Surrey average (8%).
The 30-34 age cohort is projected to grow less than Surrey average whilst those aged 65 and over will increase (21%). Within this age cohort, the number aged 85 and over is projected to grow 43%. However, the absolute number of those aged 85 and over continues to be a small proportion of the overall population of the CCG. The proportion of the population in all age groups aged 55 and over projected to increase and the proportion of people in age group 15 to 29 set to decrease.

**Figure 2: Guildford and Waverley Population projection 2015 to 2025**

The CCG has substantially fewer young adults than the English population with higher numbers at older ages indicating that the CCG is likely to have a greater preponderance of patients with developing or developed long term conditions in the working adult population as well as greater proportion of frail elderly than the English norm. However, the CCG is home to the University of Surrey in Guildford which contributes a large number of young adults to the population at certain times of the year, all of whom are encouraged to register locally for healthcare.
The registered population for Guildford and Waverley CCG is appreciably higher than the resident population, possibly indicating an issue with list inflation.

These projections suggest an initial rise in demand for children’s services over the next 10 years with demand falling after 2025, but the demand for services for older people will continue to rise over the next 25 years. It is worth noting that most health and social care is accessed by the younger (0-14) and the older (65+) sections of the population which are projected to increase in Guildford and Waverley, but such care is usually delivered by those in the middle age bands (15-64) which are projected to decrease.

<table>
<thead>
<tr>
<th>Conclusion:</th>
<th>Positive? YES</th>
<th>Negative? NO</th>
</tr>
</thead>
</table>

What amendments are required to eliminate or reduce any adverse impact to this equality group identified by the analysis?

- The provider must consider the implications on the accessibility of the adults’ community health services. Consideration must be given to those who are disabled and/or considered as frail and elderly and have limited mobility.
- The provider must consider how it communicates with the population about services, especially if any services change as a result of a re-procurement exercise.
- A growing elderly population will have an impact on social and health services. Planning must account for this. Part of the challenge will be to ensure the right preventative and support services are in place so older people can remain independent for as long as possible.
- An ageing population will lead to an increase in people with long term conditions, for example diabetes, COPD, Parkinson’s disease and heart failure. Providers must consider future workforce planning to meet this need,
- 10% of the Guildford and Waverley population is made up of students at university, therefore services such as sexual health, prevention and managing minor illnesses should be thoughtfully and innovatively provided for this population as well as ensuring seamless care arrangements with other organisations in student’s usual place of residence for students with long term conditions.

Further information

Resident population data by 5 year age band available from ONS
Data for GP registered population available from Surrey-i
JSNA chapter - Population estimates and projections
JSNA data - Population estimates and projections (2015 update)
It is estimated that 10.8% of the adult population
would not benefit from the ‘activity’.

Analysis: Refer to national evidence and data and then think about the local population and how people with physical, mental and/or learning disabilities may or may not benefit from the ‘activity’.

Physical disability

People with physical disabilities are a very diverse group with a variety of causes and severity of disability. What they do have in common is that they are more likely than able-bodied people to suffer from falls, have poorer measured quality of life and health related quality of life, and be more likely to suffer from respiratory and urinary tract infections. Depending on the level and nature of their disability, they are more likely to live in poverty or to be economically inactive, less likely to have educational qualifications and more likely to experience problems with hate crime, harassment or sexual violence and transport.

The 2011 Census measured physical disability by asking if people had difficulty with activities of daily living due to a long-term illness or disability, i.e. one which lasted a year or longer. This information has been used to provide estimates at CCG level of the number of people with disabilities and to project what the future numbers are likely to be.

It is estimated that 10.8% of the adult population in Great Britain are disabled, which equates to 22,000 people in Guildford and Waverley CCG. The CCG was estimated to have 1078 people aged 18 – 64 with a serious personal care disability in 2015. This is projected to increase by 6% in the next ten years.

Table 4: Predicted numbers with a physical disability
### Mental Health

Data on the number of people living with mental health conditions is not routinely collected. The National Psychiatric Morbidity Study, which is undertaken every 7 years, has the most robust estimates of this particular population. Data were most recently collected in 2014; the results of the study are expected during the summer of 2015, but have not yet been published. When they become available, Public Health will summarise the results for the CCGs.

An estimated 211,949 people in Surrey meet the criteria/screened positive for one or more psychiatric conditions. Approximately 5% of people living in Guildford and Waverley i.e. 10,800 people have a long term mental health problem. 10,800 people therefore require long term support. Of these 10,800 people, 1,580 are registered with their GP practice as having schizophrenia, bipolar disorder or other psychoses. (National

<table>
<thead>
<tr>
<th>NHS Guildford and Waverley CCG</th>
<th>2015</th>
<th>2020</th>
<th>2025</th>
<th>Change from 2015 to 2025</th>
<th>% change</th>
</tr>
</thead>
<tbody>
<tr>
<td>People aged 18-64 predicted to have a serious personal care disability</td>
<td>1078</td>
<td>1119</td>
<td>1144</td>
<td>66</td>
<td>6</td>
</tr>
<tr>
<td>People aged 18-64 predicted to have a serious physical disability</td>
<td>2916</td>
<td>3056</td>
<td>3138</td>
<td>222</td>
<td>8</td>
</tr>
<tr>
<td>People aged 18-64 predicted to have a moderate personal care disability</td>
<td>4815</td>
<td>5036</td>
<td>5154</td>
<td>339</td>
<td>7</td>
</tr>
<tr>
<td>People aged 18-64 predicted to have a moderate physical disability</td>
<td>9855</td>
<td>10228</td>
<td>10431</td>
<td>576</td>
<td>6</td>
</tr>
</tbody>
</table>

**Source:** PANSI

**Note:** Figures by Clinical Commissioning Group (CCG) are derived from PANSI figures. District based figures have been split by percentage of 18-64 year population living in the CCG area (population source: Office of National Statistics (ONS) Mid 2010 Population estimates for LSOA aggregated up to CCG.
People with a mental health diagnosis are registered mainly with seven GP practices, most of them located in the north of the Guildford and Waverley CCG area.

Figure 3: The map on the next page illustrates where the greatest numbers of patients with schizophrenia, bipolar affective disorder and other psychoses as recorded on practice disease registers (18yrs and over) are registered (the bigger the green triangle, the more people there are in this area).

However these figures are underestimates as the Adult Psychiatric Morbidity Survey also demonstrates there is considerably higher prevalence of mental health problems among the general population, than those receiving treatment as indicated by data from primary and secondary health services.

A survey carried out by the Office for National Statistics (2000) found that 85% of those with a probable psychotic disorder were having treatment at the time of interview; in comparison, only 24% of those assessed as having one or more neurotic disorders (depressive episodes and disorders (mild, moderate and severe), phobias, panic disorders, generalised anxiety disorder, mixed anxiety and depressive disorder and obsessive compulsive disorder) were receiving treatment at the time of interview. Often the stigma surrounding mental health can make it harder for people to seek help from health services, hence the importance of widely available self-help information and anti-stigma interventions.

Indicator 1.5 of the NHS Outcome Framework requires the CCGs to reduce premature mortality in people with mental illness, specifically the excess under 75 mortality rate in adults with serious or common mental illness, as well as reducing suicide and mortality from injury of undetermined intent among people with recent contact from NHS services.

Learning Disability
The Confidential Enquiry into Premature Deaths of People with Learning Disabilities (2013) found that men with learning disabilities died, on average, 13 years earlier than the general population, while women with learning disabilities died 20 years earlier. While some of the causes of learning disabilities are associated with health problems leading to lower life expectancy, 42% of deaths investigated in the Confidential Enquiry were assessed as
potentially avoidable, due to inferior healthcare or lack of reasonable adjustments to enable people with learning disabilities to access healthcare appropriately. Additionally, virtually all those investigated had at least one long term health condition including epilepsy, cardiovascular disease, hypertension, dementia and osteoporosis.

The Valuing People report (2001) defined a learning disability as a significantly reduced ability to understand new or complex information and to learn new skills (impaired intelligence) combined with a reduced ability to cope independently (impaired social functioning), which started before adulthood, with a lasting effect on development.

Surrey had large numbers of long stay hospitals and the placement of large numbers of people into these during the last century and their subsequent closure has artificially increased the proportion of people with a learning disability in the general population. Those who remained are aging so that the population with learning disabilities in Surrey is believed to be older than those with learning disabilities in other areas. In the long term these numbers will gradually reduce returning the number of people in Surrey with a learning disability towards the national average for the indigenous population.

However, the only source of estimated numbers of people with learning disabilities locally uses national modelling, so the numbers presented here are believed to be an underestimation of local numbers, especially in the older age groups. Surrey County Council Public Health are undertaking a piece of work in 2015-16 to develop better local estimates of this particular population to support the commissioning of health and social care for this group of residents.

In Guildford and Waverley CCG, 3,091 adults (aged 16 -64) are estimated to have a learning disability, which is projected to increase to 3,196 by 2025. The number of adults aged 65 and over with learning disabilities is predicted to increase from 820 to 973 in the same period. In Surrey 21,239 adults are estimated to have a learning disability, which represents 2.37% of Surrey’s adult population.

<table>
<thead>
<tr>
<th>Table 5: People predicted to have a learning disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Group</td>
</tr>
<tr>
<td>-----------</td>
</tr>
<tr>
<td>Age Group</td>
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<td>-----------</td>
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</tr>
</tbody>
</table>

**Source:** Aged 65+ taken from Projecting Older People Population Information (POPPI) and 18 to 64 from Projecting Adult Needs and Service Information (PANSI)

**Note:** Figures by Clinical Commissioning Group (CCG) are derived from POPPI figures. District based figures have been split by per cent of 18 to 65+ population living in the CCG area - population source: Office of National Statistics (ONS) Mid 2010 Population estimates for LSOA aggregated up to CCG

Disability is a protected characteristic under the Equality Act (2010), so the CCG must have regard to this population in the services they commission. Additionally, Indicator 1.7 of the NHS Outcomes Framework monitors the CCGs progress in reducing the excess under-60 mortality in this particular group. It is worth noting that almost 40% of those with moderate or severe learning disabilities under 65 live with
their parents. As they and their parents age there is a risk that parents may no longer be able to support their children, requiring substantial additional input by health and social care services.

<table>
<thead>
<tr>
<th>Conclusion:</th>
<th>Positive? YES</th>
<th>Negative? NO</th>
</tr>
</thead>
</table>

What amendments should be made to eliminate or reduce any adverse impact to this equality group identified by the analysis?

- The Provider must utilise all appropriate channels of communication for its services.
- Communications must be provided in an appropriate format and via an appropriate medium, such as Easy Read, Audio or Braille, to ensure that the most vulnerable groups of service users within Guildford and Waverley who access these services are fully informed.
- Providers must have robust access to high quality, responsive and comprehensive interpreter services for people who are deaf as well as those who speak different languages (see section on Ethnic Group). Consideration must be given to those patients who will require an access to an interpreter or advocate as per the Accessible Information Standard Information and Guidance.
- Telephone and online technology must be configured to be equally accessible to all disability groups e.g. SMS text messaging facilities; hearing loops.
- Ensure that training and support is in place for staff to enable them to routinely provide a high quality service to patients and carers with disabilities including people with complex mental health needs and learning disabilities; there must be parity of care for all groups.
- Having a learning disability can increase anxiety and distress (adding to the patient’s vulnerability) as the individual may not understand why they are there or what to expect. Guildford and Waverley has a number of patients with disabilities, so we expect providers to make the situation as predictable as possible for the person – always letting them know what is happening. Consideration should be given to the appropriate reception and treatment for patients with a learning disability who arrive at an urgent care facility and to whether staff are sufficiently trained to safely discern the person’s needs; to communicate effectively with the patient and their carer(s); and to ensure the best possible patient experience.
- About 5% of the CCG population has a diagnosed long term mental illness, and there is likely to be a significant additional number who are undiagnosed. Reducing premature mortality in this section of the population will require a combination of increasing diagnosis and support while reducing the level of risky health behaviours and ensuring prompt treatment for physical health conditions. Exclusions for different care should not include the presence of mental illness; providers are expected to have a skilled workforce that can holistically meet a range of different needs.
- Care needs to be more person-centred where mental and physical wellbeing are routinely considered as being equally important. This is sometimes referred to as ‘parity of care’ and requires providers to establish systems and professionals fully equipped to manage
patients and carers mental wellbeing regardless of the reason for requiring the service.

- Providers must have robust arrangements in place that allow patient information to be routinely produced in an Easy Read format.

Further information
Data available from Surrey-i
JSNA chapter - Mobility
JSNA Chapter - Long Term Neurological Condition
JSNA Chapter - Visual Impairment
JSNA Chapter - Hearing Impairment
JSNA Chapter - Dual Sensory Loss
NICE guidance People with physical disability
Data available from Surrey-i
JSNA Chapter - People with learning disability
Confidential Enquiry into Premature Deaths of People with Learning Disabilities
NICE guidance People with learning disability
Estimates of people with mental health conditions available from Surrey-i
Long term mental health problem data available from GP practice survey
Adult Psychiatric Morbidity Study 2007
Adult Psychiatric Morbidity Study 2000
JSNA Chapter - Adult Mental Health PHE mental health profile
Risks of all-cause and suicide mortality in mental disorders: A meta-review Emotional Wellbeing and Mental Health Integrated Commissioning Strategy
NICE guidance Mental health and behavioural conditions
Domestic Abuse Strategy
Physical Activity Strategy
Surrey Substance Misuse Strategy - Alcohol Consultation
The Government ‘s Alcohol Strategy

ETHNICITY / RACE / ETHNIC GROUP

Analysis: Refer to national evidence and data and then think about the local population and how people belonging to different ethnic groups may or may not benefit from the ‘activity’.
Nationally, the Afiya Trust suggests that “many minority ethnic communities have poor access to health and social care services for a variety of reasons including language barriers, lack of awareness/information, social isolation, lack of culturally sensitive services and negative attitudes about communities”. (Afiya Trust 2010)

“There is evidence that groups about whom very little research has been conducted, notably Gypsies and Travellers, asylum seekers and refugees, have particularly low levels of health and wellbeing. Those without fixed addresses, such as Roma, gypsies and travellers, asylum seekers and refugees, have difficulty in accessing services and their needs are often different and unknown.” (EHRC 2010)

One specific ethnic group which is important locally but not necessarily well captured in routine information is the **Gypsy Roma and Traveller population (GRT)**. Gypsies and Travellers collectively are believed to comprise one of Surrey’s largest minority ethnic groups. GRT ethnic groups include Gypsies, Travellers of Irish Heritage, and European Roma. The first two groups comprise the majority of Travellers in Surrey and include both mobile and housed families. Surrey has one of the highest numbers of resident Travellers in England. Non-ethnic Travellers include Fairground and Circus families, and New Travellers. Gypsy Travellers have significantly poorer health than any other disadvantaged UK residents. Local research with this community identified high levels of smoking (48%), high blood pressure (52%) and anxiety/depression (48%). This poorer health could lead to a greater prevalence of the long term conditions that require the kind of support provided by the localities. The general poorer health of this community could lead to persons presenting with the long term conditions and the associated frailty at an earlier age.

The Gypsy, Roma and Traveller Community encounter a range of different barriers to accessing health and social care services. Much of the community continues to travel from place to place and so are less likely to register with a GP. This movement also makes it difficult for other health and social care services to identify the needs of the GRT Community and to provide the necessary support. Increasingly, however, the Gypsy, Roma and Traveller Community are living in settled locations. This helps health and social care services to provide the needed health and social care to this community. In spite of this, the community still encounters barriers to accessing the right support from health and social care. For example, literacy skills are worse within the community and so literacy-based registration to services can be a barrier to access. Many of the community also report poor experiences when presenting to GP practices for treatment.

Surrey has the 4th largest GRT community in the country. Pitches that are known to Surrey County Council are detailed below and show that Guildford and Waverley is home to the largest proportion of the GRT community across Surrey.
### Table 6: GRT community pitches known to Surrey County Council

<table>
<thead>
<tr>
<th>Local Boroughs</th>
<th>Pitches</th>
<th>Population (approx)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elmbridge</td>
<td>41</td>
<td>164</td>
</tr>
<tr>
<td>Epsom &amp; Ewell</td>
<td>33</td>
<td>132</td>
</tr>
<tr>
<td>Guildford</td>
<td>112</td>
<td>448</td>
</tr>
<tr>
<td>Mole Valley</td>
<td>75</td>
<td>100</td>
</tr>
<tr>
<td>Reigate &amp; Banstead</td>
<td>7</td>
<td>28</td>
</tr>
<tr>
<td>Runnymede</td>
<td>46</td>
<td>184</td>
</tr>
<tr>
<td>Spelthorne</td>
<td>28</td>
<td>112</td>
</tr>
<tr>
<td>Surrey Heath</td>
<td>38</td>
<td>152</td>
</tr>
<tr>
<td>Tandridge</td>
<td>68</td>
<td>777</td>
</tr>
<tr>
<td>Waverley</td>
<td>125</td>
<td>500</td>
</tr>
<tr>
<td>Working</td>
<td>57</td>
<td>228</td>
</tr>
</tbody>
</table>

(1) The average number of persons per pitch is four. This has been used to estimate the population numbers at local authority level.

(2) To meet IG requirements around small counts, the data has been colour coded on the map in terms of quintiles with the first quintile having the highest number of pitches and the fifth quintile the lowest (< 12 pitches) at Lower Super Output Area (LSOA).

* It should be noted that LSOAs have a population of around 1,500 people.
Another ethnic group which is more common in Surrey than other parts of the country is the Nepalese, who have settled locally because of links with the military and the Gurkhas. They usually describe themselves as Other Asian in the Census. They share the health profile of other South Asian communities such as Indian and Pakistani ethnic groups, with higher rates of diabetes and coronary heart disease than the general population.
The majority of the population in Guildford and Waverley CCG (86%) describe themselves as White British. A small but substantial number (7%) describe themselves as other white, likely to be either Eastern European or possibly Gypsy Roma Traveller. (See Figure 4).

There are around 403 Gypsy Roma Traveller. Almost 3% of the population describe themselves as other Asian and are likely to be Nepalese, while 1% of the local population describes themselves as Indian, and a further 1% as Black African Caribbean.

**Figure 5: Guildford and Waverley Population non-white ethnic group percentages**

**Source:** Census 2011 **Note:** figure excludes White-British

**Figure 6: Geographical distribution of non-white ethnic population by LSOA in Guildford and Waverley**

**Source:** Census, 2011

**Lower Super Output Areas (LSOAs)** are areas with a population between 1,000 and 3,000
What amendments are required to eliminate or reduce any adverse impact to this equality group identified by the analysis?

While the population of the CCG overwhelmingly identifies as being White British, there are small but significant numbers of people who state they are a different ethnic group, specifically Gypsy Roma Traveller and Nepalese, as well as Indian and Black African Caribbean. The greatest concentrations of non-White British groups are in parts of North Guildford. It is essential to work closely with local voluntary groups and patient representatives to understand the specific needs of these groups e.g. advice regarding healthy lifestyle as part of treatment for diabetes should fit cultural practices.

It has been evidenced that mental illness within GRT communities is often though not always stigmatised and that overall health outcomes are significantly worse than the England average; this will impact on overall health outcomes from community services. Providers need to ensure staff are skilled in different cultural practices to enable identification and support for this group. The CCG is committed to narrowing the gap in life expectancy for the Gypsy, Traveller and Roma communities it serves and expects its providers to actively pursue innovative means to reaching members of this ethnic group requiring community health care and to increase referral rates to a more appropriate level from black and ethnic minorities compared with white peers. The providers will work with voluntary, community and faith organisations to deliver and respond to emotional and mental health needs.

Consideration by providers will need to be given to:

- The linguistic needs of different communities - the use of family members and friends to interpret for those that do not speak or understand English sufficiently well to take part in their own care. This introduces inequity and should be avoided. Providers must have robust access to interpreter services that are responsive at short notice to avoid this.
- The accessibility – in the broadest sense of the word - of community health services by people belonging to different communities.
- The need to provide appropriate levels of cultural awareness training to ensure staff are able to meet the needs of the different ethnic minority groups in the community in which they operate and equipped and motivated to make reasonable adjustments to their services.

Further information
Ethnicity data available from Surrey-i
Gypsy and Traveller Caravan Count available from Surrey-i
JSNA chapter - Ethnicity
| JSNA chapter: Gypsies, Roma and Travellers  
NICE guidance Black ethnic minority |
|----------------------------------------------------------|

**GENDER**

**Analysis:** Refer to national evidence and data and then think about the local population and how men and women may or may not benefit from the ‘activity’.

**National Information**

National life expectancy statistics show women having a significantly higher life expectancy than men. These differences mean that it is likely that more women than men will receive support, as women will generally be living longer than men and require this kind of support.

There is also anecdotal evidence that men and women access health and social care services differently. It is known that men are less likely to visit their GP than women, even when feeling unwell. In a study reported in the BMJ in 2013, the crude consultation rate was 32% lower in men than women. The greatest gender gap in primary care consultations was seen among those aged between 16 and 60 years; these differences are only partially accounted for by consultations for reproductive reasons. Differences in consultation rates between men and women were largely eradicated when comparing men and women in receipt of medication for similar underlying morbidities.

Men are less likely to access services until their needs have escalated to the point where they need significant health and social care interventions. Women as a whole are generally more likely to approach health and social care at an earlier stage.

Research indicates that more women than men suffer with frailty nationally and in particular within elderly people who live in their own home. For example a UK study from 2010 using the phenotype approach to defining frailty found a prevalence of **8.5% in women** and **4.1% in men** aged 65 – 74 years (Fit for Frailty, BGS, 2014).

Due to gender-related prevalence of frailty, fewer men than women will be cared for by the integrated care model and being a minority can lead to needs being overlooked. For visual analysis charts and data tables, please see the ‘AGE’ section of this equality analysis.

For local information please see the ‘AGE’ section of this equality analysis.

| Conclusion: | Positive? YES | Negative? NO |
What amendments are required to eliminate or reduce any adverse impact to this equality group identified by the analysis?

The Providers must utilise methodologies that ensure that men (who are typically least likely to access healthcare services) are aware of the services available and feel welcome to approach the services as part of any care that they may need.

It is important that services as a whole are able to meet the needs of men who may prefer to be cared for by a man (just as women can state a preference to be cared for by a woman). Service providers must ensure that their workforce strategy encourages the recruitment and retention of men to meet these possible gender needs and should ensure that satisfaction surveys probe this aspect of care.

<table>
<thead>
<tr>
<th>GENDER REASSIGNMENT</th>
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</thead>
</table>

**Analysis:** Refer to national evidence and data and then think about the local population and how people who have undergone gender reassignment may or may not benefit from the ‘activity’.

The Department of Health’s 2007 briefing on trans people’s health notes that:

- female to male trans men are rarely included in breast screening programmes
- male to female trans women are rarely offered prostate screening
- trans people have experienced the refusal of care such as smear tests, breaches of confidentiality and the practice of placing trans women on male wards, and trans men on female wards.

Equally Well, the Scottish Government’s report of the Ministerial task force on health inequalities, notes in its introduction that transgender people experience lower self-esteem and higher rates of mental health problems and these have an impact on health behaviours, including higher reported rates of smoking, alcohol and drug use. These behaviours have their associated health risks such as cardiovascular disease and various cancers.

Hence it can be concluded that trans-gender people experience poorer health outcomes and barriers to accessing services that providers need to make adjustments for in their systems and processes.

There are no gender specific gender reassignment statistics for Guildford and Waverley. Those who have undergone gender reassignment have been found to have similar health outcomes to the Lesbian, Gay, Bisexual and Transgender (LGBT) community. For the impact on the LGBT community, see the sexual orientation section.
Conclusion: Positive? YES  Negative? NO

What amendments are required to eliminate or reduce any adverse impact to this equality group identified by the analysis?

- Staff awareness and training to reduce discriminatory behaviours that may have an impact on Transgender people accessing community health services within Guildford and Waverley.

- Patients who have stigmatizing conditions can end up in urgent and emergency departments partly because of limited access to other health care services. Therefore inclusive policies, awareness and training are key to all provider operations.

- There are concerns in trans communities about recording gender reassignment status and the potential for identifying people where postcode information is also identified. Opportunity to engage further and for Providers to review policies for reception and treatment for patients and carers; and training for staff.

RELIGION & BELIEFS

Analysis: Refer to national evidence and data and then think about the local population and how people of different religions or faiths or with different beliefs may or may not benefit from the ‘activity’.

The main source of information about what religion the local population practice is the 2011 Census. There was a significant increase in the number of people stating they had no religion in the 10 years between the last census and the 2011 Census.

Figure 7: Religion and belief in the population

About two-thirds of Guildford and Waverley CCG’s population said that their religion was Christian in the 2011 Census, while a substantial proportion said they had no religion or did not state their religion.

Source: Census 2011  Note: Figures excludes Christians

People who follow different religions may have beliefs which need to be taken into consideration in the commissioning of health services. For example, modesty in dress while receiving clinical care and being treated by a doctor of the same sex are important in some religions, while care plans and short breaks services for carers may need to take into account aspects of religion such as festivals and holidays. Different religions tend to have different rituals particularly around births and
deaths.

Religion is increasingly being recognised as an important signifier of customs and traditions which may have a bearing on health and prevalence of ill-health (for example dietary habits). It can also help, but not always, in consideration alongside data on race (ethnicity), to identify physical, cultural, or behavioural barriers to accessing health and social care services.

Conclusion: Positive? YES  Negative? NO

What amendments are required to eliminate or reduce any adverse impact to this equality group identified by the analysis?

- The Provider will need to consider ways of engaging faith forums in service design to ensure that any changes made meet the needs of these groups and do not have a negative impact in areas such as access e.g. a certain outpatient service only being available on a Friday would not be best practice.
- Flexible appointment times should be offered to meet different cultural needs.
- Inpatient facilities must have appropriate faith facilities and be able to meet different dietary needs linked to religious beliefs.
- Providers should pursue gender balance in its workforce to meet preferences for same gender care, which can be linked to religious beliefs.

Further information

Data available from Surrey-i
JSNA chapter - Religion and belief

MARRIAGE & CIVIL PARTNERSHIP

Analysis: Refer to national evidence and data and then think about the local population and how people who are married or in civil partnerships may or may not benefit from the ‘activity’.

Table 7: Breakdown of Marital Status- Health Profile 2015

<table>
<thead>
<tr>
<th></th>
<th>Single</th>
<th>Married</th>
<th>Same-sex civil partnership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guildford %</td>
<td>35.2</td>
<td>49.4</td>
<td>0.2</td>
</tr>
<tr>
<td>Guildford Number</td>
<td>39,639</td>
<td>55,650</td>
<td>174</td>
</tr>
</tbody>
</table>
The 2000 General Household Survey (GHS) showed that married or cohabiting adults are more likely to be carers than those who are single, or were previously married. However, there are gender differences with married women twice as likely to provide care as married men as women are more likely to juggle a range of caring roles (grandchildren and elderly parents).


**Table 8: % of all households with one person aged 65 and over**

<table>
<thead>
<tr>
<th>% all households: one person household aged 65 and over</th>
</tr>
</thead>
<tbody>
<tr>
<td>England Average</td>
</tr>
<tr>
<td>South East Average</td>
</tr>
<tr>
<td>Surrey Average</td>
</tr>
<tr>
<td>Guildford Average</td>
</tr>
<tr>
<td>Waverley Average</td>
</tr>
<tr>
<td>Guildford &amp; Waverley CCG Average</td>
</tr>
</tbody>
</table>

There is a higher proportion of people in Waverley compared to Guildford living in a one-person household. This has implications in terms of unpaid carer resource and mental health that providers need to account for when designing the services.

Spouses and civil partners have a higher likelihood of being carers. For how this service change impacts carers, see the carers section.

Issues have been identified nationally with same sex partners not having easy access to loved ones in emergency/urgent circumstances, or being included in consultations in the same way that heterosexual couples/married partners would.

**Conclusion:**  Positive? YES  Negative? NO

**What amendments are required to eliminate or reduce any adverse impact to this equality group identified by the analysis?**

- Providers need to ensure that support for carers is built in to all of their service models.
- For people living alone requiring community services, providers should ensure links and signposting to organisations that can offer support and advice.
- Inclusive procedures must be in place that include people living in same-sex partnerships and those that are in a civil partnership.

**PREGNANCY & MATERNITY**

**Analysis:** Refer to national evidence and data and then think about the local population and how women who are pregnant or who have recently had a baby may or may not benefit from the ‘activity’.

The birth rate in Surrey (62.9 per 1,000 women aged 15-49) is similar to the England birth rate (62.4), but varies considerably within Surrey. Births in Surrey are characterised by relatively low rates of teenage pregnancy but high rates of live births in older mothers (aged 35+) compared to the rest of the country. Risks and complications within pregnancy and birth increase with maternal age – as a consequence services need to cater for a more complex maternity population.

It is also important to note that domestic abuse has been identified as a prime cause of miscarriage and stillbirth and of maternal deaths during childbirth. Between 4 and 9 women in 100 are abused during and/or after birth and 30% of domestic violence starts in pregnancy.

GRT families tend to have more children compared to their age-sex matched counterparts, with high rates of infant and child deaths. 18% of GRT mothers experience the death of a child (not necessarily in infancy) compared to 1% in the wider population. Complications in pregnancy are more prevalent and breastfeeding rates are low due to lack of privacy and the belief it is dirty to breastfeed in front of a man. (Surrey Emotional Wellbeing and Mental Health Services for Children and Young People Needs Assessment Refresh, April 2014)

There were 2,200 births in Guildford and Waverley in 2013. The Guildford and Waverley CCG birth rate for women aged 15-44 years (56/1,000) is significantly lower than the England average (62/1,000).

**Table 9: Live births per 1,000 women aged 15-44 years (2013)**

<table>
<thead>
<tr>
<th>Area</th>
<th>Female population 15-44 years</th>
<th>Births</th>
<th>Rate per 1,000 Female population</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>10,653,480</td>
<td>664,517</td>
<td>62.4</td>
</tr>
<tr>
<td>Surrey</td>
<td>215,556</td>
<td>13,569</td>
<td>62.9</td>
</tr>
<tr>
<td>NHS Guildford and Waverley CCG</td>
<td>39,511</td>
<td>2,200</td>
<td>55.7</td>
</tr>
</tbody>
</table>
**Source:** ONS 2013

Health outcomes for mother and child are disproportionately worse for women who can be described as vulnerable, for example if they have learning disabilities.

A proportion of women who are pregnant will have existing long-term conditions that require additional monitoring during pregnancy or will develop conditions during pregnancy that may require care from community services. Services need to be responsive to this change in clinical need in order to maximise health outcomes of mother and baby.

<table>
<thead>
<tr>
<th>Conclusion</th>
<th>Positive? YES</th>
<th>Negative? NO</th>
</tr>
</thead>
</table>

**What amendments are required to eliminate or reduce any adverse impact to this equality group identified by the analysis?**

- Premises and facilities must accommodate the needs of pregnant and breastfeeding mothers and provide for parents to change babies.
- Services need to be responsive to changes in clinical need amongst women with long-term conditions who become pregnant in order to maximise health outcomes of mother and baby.

**Further information**

Births data available from Surrey-i by local authority
JSNA Chapter - Maternity

**SEXUAL ORIENTATION**

**Analysis:** Refer to national evidence and data and then think about the local population and how people who are gay, lesbian, bisexual or transexual may or may not benefit from the ‘activity’.

The health needs of people may vary depending on their sexual orientation.

Members of the lesbian, gay, bisexual and transgender communities (LGBT) have been found to have higher levels of certain health behaviours such as excess alcohol consumption, drug use and smoking, as well as lower uptake of screening programmes. This could contribute to disproportionately more members of the LGBT community developing long term conditions, which can exacerbate frailty and therefore require the coordinated support offered by the locality model.

They have also been found to have higher levels of anxiety and depression, attributed to experiences of homophobia, domestic abuse and...
bullying. There is also variation within the LGBT community with those from ethnic minority groups suffering greater health inequalities than those with White British ethnicity. There is little information on life expectancy by sexual orientation but recent evidence on self-reported health status suggests that lesbians and gay men may have better self-rated health than the general population while bisexual and trans people have worse health.

It is estimated that the LGBT population is 5-7% of the population (assumed to mean the adult population). For Guildford and Waverley CCG, this equates to between 8,430 and 11,800 people identifying as LGBT, in the absence of specific population data for this equality group in the CCG area.

Table 10: Estimated numbers of people who identify themselves as LGBT in Guildford & Waverley - Health Profile 2015

<table>
<thead>
<tr>
<th>Age</th>
<th>%</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-18yrs</td>
<td>16.6</td>
<td>1,679</td>
</tr>
<tr>
<td>19-49yrs</td>
<td>41.1</td>
<td>4,157</td>
</tr>
<tr>
<td>50-64yrs</td>
<td>18.7</td>
<td>1,892</td>
</tr>
<tr>
<td>65+</td>
<td>18.4</td>
<td>1,861</td>
</tr>
</tbody>
</table>

Although awareness is improving, research shows that older people are still the least likely age demographic to be open about their sexuality due to continuing stigma. This is likely to contribute to riskier health behaviours and higher rates of mental health issues within this group.

Conclusion: Positive? YES | Negative? NO

What amendments are required to eliminate or reduce any adverse impact to this equality group identified by the analysis?

- Consideration must be given to those who belong to the LGBT community who may be at risk of developing specific health problems that will require easy access to these services.
- Consideration must be given to ways in which members of this protected group are engaged, should any services be redesigned. This will help to ensure that any changes meet their needs. Services must be accessible, inclusive and diverse.
- Providers need to ensure that information materials are inclusive to a variety of different minority groups including those who identify as Lesbian, Gay, Bisexual or Transgender.
Carers provide unpaid care for family partners or friends in need of help because they are ill, frail or have a disability. They can be adults looking after other adults, parents looking after disabled children or young people under 18 looking after siblings, parents or other relatives. The physical and mental health of carers can suffer as a result of their caring. 40% of carers have been found to suffer from mental distress or depression, with levels of distress increasing with the amount of time spent in caring activities. There is evidence that carers have an increased risk of back injuries and may have higher blood pressure and increased risk of stroke. In addition to risk associated with the number of hours spent caring, carers reporting ‘strain’ appear to have worse health outcomes. Young carers may suffer particularly from the health effects of their caring responsibilities.

Carers play an important role in keeping the ill or frail out of hospital – one study found that problems with the carer contributed to hospital readmission in 62% of cases while another found that 20% of those requiring care were admitted to hospital after their carer could no longer cope. See also the People receiving Adult Social Care section in this profile for a snapshot of the number of carers receiving support from adult social care.

The 2011 Census shows that there are around 20,000 people in Guildford and Waverley CCG who provide unpaid care. Almost one in ten (9.4%) in Guildford and Waverley are providing unpaid care.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Number of Carers</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-18yrs</td>
<td>2400</td>
<td>12%</td>
</tr>
<tr>
<td>19yrs and over</td>
<td>16820</td>
<td>88%</td>
</tr>
<tr>
<td>Total</td>
<td>19220</td>
<td>100%</td>
</tr>
</tbody>
</table>
Source: Census 2011

Table 12: Carers receiving support from Surrey County Council

<table>
<thead>
<tr>
<th>CCG of Residence</th>
<th>&lt;18*</th>
<th>18 to 54</th>
<th>55 to 64</th>
<th>65 to 74</th>
<th>75 to 84</th>
<th>85 plus</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS East Surrey CCG</td>
<td>84</td>
<td>265</td>
<td>204</td>
<td>176</td>
<td>116</td>
<td>67</td>
<td>912</td>
</tr>
<tr>
<td>NHS Guildford and Waverley CCG</td>
<td>98</td>
<td>312</td>
<td>291</td>
<td>232</td>
<td>206</td>
<td>123</td>
<td>1,262</td>
</tr>
<tr>
<td>NHS North East Hampshire and</td>
<td>32</td>
<td>81</td>
<td>66</td>
<td>54</td>
<td>73</td>
<td>34</td>
<td>340</td>
</tr>
<tr>
<td>NHS North West Surrey CCG</td>
<td>110</td>
<td>691</td>
<td>561</td>
<td>447</td>
<td>387</td>
<td>194</td>
<td>2,390</td>
</tr>
<tr>
<td>NHS Surrey Downs CCG</td>
<td>119</td>
<td>344</td>
<td>357</td>
<td>253</td>
<td>235</td>
<td>157</td>
<td>1,465</td>
</tr>
<tr>
<td>NHS Surrey Heath CCG</td>
<td>50</td>
<td>154</td>
<td>131</td>
<td>135</td>
<td>105</td>
<td>61</td>
<td>636</td>
</tr>
<tr>
<td>NHS Windsor, Ascot and Maidenhead</td>
<td>4</td>
<td>14</td>
<td>13</td>
<td>11</td>
<td>10</td>
<td>7</td>
<td>59</td>
</tr>
<tr>
<td>Grand Total</td>
<td>497</td>
<td>1,861</td>
<td>1,623</td>
<td>1,308</td>
<td>1,132</td>
<td>643</td>
<td>7,064</td>
</tr>
</tbody>
</table>

Source: People List Report - AIS (1st May 2015). Notes: Some clients may be open to social care as both a carer and as an individual in receipt of social care.

Numbers for the CCGs have been identified by client postcode. The number of people open to the different area teams is likely to be different to those identified here. Some of the difference will be due to lack of current postcode; people open to area team but placed outside Surrey or elsewhere in Surrey; difference in CCG and LA boundary.

Table 13: Percentage of population receiving carer support from Surrey County Council

<table>
<thead>
<tr>
<th>CCG of residence</th>
<th>% of Population Age 65-74 that are Carers who are open to ASC</th>
<th>% of Population Aged 75-84 that are Carers who are open to ASC</th>
<th>% of Population 85+ that are Carers who are open to ASC</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS East Surrey CCG</td>
<td>1.10%</td>
<td>1.24%</td>
<td>1.43%</td>
</tr>
<tr>
<td>NHS Guildford and Waverley CCG</td>
<td>1.24%</td>
<td>1.69%</td>
<td>2.01%</td>
</tr>
<tr>
<td>CCG Area</td>
<td>2014-15</td>
<td>2015-16</td>
<td>2016-17</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>---------</td>
<td>---------</td>
<td>---------</td>
</tr>
<tr>
<td>NHS North West Surrey CCG</td>
<td>1.52%</td>
<td>1.94%</td>
<td>2.32%</td>
</tr>
<tr>
<td>Englefield Green (part of NHS Windsor, Ascot and Maidenhead CCG)</td>
<td>1.67%</td>
<td>2.32%</td>
<td>3.85%</td>
</tr>
<tr>
<td>NHS Surrey Downs CCG</td>
<td>0.91%</td>
<td>1.27%</td>
<td>1.78%</td>
</tr>
<tr>
<td>NHS Surrey Heath CCG</td>
<td>1.46%</td>
<td>1.86%</td>
<td>2.97%</td>
</tr>
<tr>
<td>Farnham (part of NHS North East Hampshire and Farnham CCG)</td>
<td>1.54%</td>
<td>2.60%</td>
<td>3.15%</td>
</tr>
</tbody>
</table>

**Source:** People List Report - AIS (1st June 2015). **Notes:** Some clients may be open to social care as both a carer and as an individual in receipt of social care. Numbers for the CCGs have been identified by client postcode. The number of people open to the different area teams is likely to be different to those identified here. Some of the difference will be due to lack of current postcode; people open to area teams but placed outside Surrey or elsewhere in Surrey; difference in CCG and LA boundary.

**Young carers**

Being a young carer can have a severe, significant and long-lasting impact on a young person’s health and wellbeing.

Conflicts between the young carer and the person being cared may arise, which may lead to feelings of guilt, anger, isolation or being trapped. Young carers are also more likely to suffer traumatic life events such as the death of a parent or sibling.

A 2012 Surrey Young Carers Survey received 265 responses and found that 56% wanted to know about opportunities for the future and nearly 30% wanting to know more about ‘coping methods’ with approximately 18% concerned about bullying.

GPs and other health professionals can refer the young carer to Surrey Children’s services for an assessment under the Common Assessment Framework. A young carer’s assessment should automatically trigger a community care assessment or review of the person being cared for. Some young carers and their families are reluctant to admit the child’s role as a carer and are fearful of seeking help from social care. There is a range of services available to Carers in Surrey. The support can be provided to the Carer directly, or to the person being cared for, to help the Carer have a better balance between their caring role and their life away from caring. See [www.surreynhhscarersprescription.org.uk](http://www.surreynhhscarersprescription.org.uk) for more details.
Carer Prescription Service
The Carers Prescription provides GP’s with an easy solution to support Carers they come into contact with. Across Surrey there are a number of organisations that GP’s can refer Carers to. The Carers Prescription is a secure mechanism for GP’s to make a referral. The team will then make arrangements for the referral to be processed quickly and efficiently.

<table>
<thead>
<tr>
<th>Conclusion:</th>
<th>Positive? YES</th>
<th>Negative? NO</th>
</tr>
</thead>
</table>

What amendments are required to eliminate or reduce any adverse impact to this equality group identified by the analysis?

Almost one in ten of Guildford and Waverley residents (20,000 people) provide unpaid care. The Provider should ensure that these carers are supported and specifically, that their own health needs are being met. About 10% of carers known to social services are under 18 and this group is known to have particularly significant health needs. About 10% of carers of all ages provide more than 50 hours unpaid care, again a group with significantly worse health needs than those without caring responsibilities.

- Providers need to actively promote support services available to carers of all ages in order to improve awareness and uptake. This could potentially include displaying leaflets or posters or discussing support services with someone who has identified as a carer.
- Providers should ensure staff are fully equipped to engage young carers they encounter when providing care to the cared-for person in seeking support and linking with agencies such as Surrey Young Carers.
- Providers should encourage local people who identify as a carer to register with their GP so that they can access support via that channel.
- All community services should maintain links with carer support organisations across the CCG.

**Further information**
Data available from Surrey-i
JSNA Chapter - Carers
JSNA Chapter - Young Carers and Young Adult Carers
RCGP Carers Action Guide
Open cases data available from Surrey-i
Adult Social Care Profiles
JSNA Chapter - Carers
JSNA Chapter - Young Carers and Young Adult Carers
RCGP Carers Action Guide
Surrey Carers Prescription

AREAS OF DEPRIVATION and GEOGRAPHICAL LOCATION (urban, rural, isolated)

Analysis: Refer to national evidence and data and then think about the local population and how people that live in different parts of the CCG, in more or less deprived wards, may or may not benefit from the ‘activity’.

National
The Marmot report, Fair Society, Health Lives: Strategic Review of Health Inequalities post 2010, laid out in great detail the variety of health impacts deprivation has across the life course of individuals. People living in deprived communities have more risky health behaviours and experience more long term conditions at earlier ages, with consequent impact on the individuals and the health service. The CCG will want to ensure that local service provision takes into account areas of deprivation where need for health services is likely to be greater.

In overall terms, Marmot estimated the potential years of life lost nationally due to health inequalities from 1.3 to 2.5 million years. More detail on the effect of deprivation on inequalities in life expectancy is given in the Life expectancy section of this report.

Deprivation is usually measured using the Index of Multiple Deprivation, which incorporates deprivation across 7 domains, including income, employment, health and disability, education training and skills, barriers to housing and services, crime, and living environment. A new deprivation index will be issued during the summer of 2015 but was not available in time for this year’s profile.

Local
Surrey as a whole 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 significant deprivation and variation across the county. Figure 7 shows the variation in deprivation in the CCG area, with small areas (lower super output areas (LSOAs)) ranked by index of multiple deprivation and divided into tenths. In the map, 1 is the least deprived and 10 is the most.

The most deprived area within Guildford and Waverley CCG is in the ward of Westborough but there are other small pockets including Shalford which sits within an area which is one of the least deprived. The five most deprived LSOAs within Guildford and Waverley CCG are in the wards of Westborough, Godalming Central, Ockford and Stoke.
Access
The Department for Transport estimate the travel time by several modes of travel (car, public transport, cycling and walking) to key local services, including health services, shops, offices and other services. This dataset provides a wealth of information showing how easily local people can access essential services. Here we have produced maps showing variation in access to health services using public transport, since those without access to a car (at risk users) may find accessing healthcare more difficult. Other data is available using the links given in further information.

Figure 8 shows that a significant proportion of LSOAs in rural areas may have as low 17.2% at risk users with access to a GP (practice or surgery) within a reasonable time by public transport and walking.

Figure 8: Overall deprivation by LSOA (decile 10 is most deprived)

Source: DCLG Index of Multiple Deprivation 2010

Note: Lower Super Output Areas (LSOAs) are areas with a population between 1,000 and 3,000. Decile is each of ten equal groups into which the LSOAs are divided after ordering by the rank of deprivation, 10 being the most deprived.
Figure 9: Percentage of at risk users with access to GPs within a reasonable time by public transport/walking by LSOA

**Source:** Department for Transport

**Notes:** ‘At risk’ users are particular social groups at risk of exclusion. In this instance considering access to GPs or hospitals, at risk users are defined as households without a car.

The measure of access to services within a reasonable time takes into account the sensitivity of users to the travel time for each service. Deterrence factors are applied which reflect the user’s willingness to travel and are derived from the National Travel Survey identifying the sensitivity of trip making to travel time. The longer it takes to get to the service, the fewer people will undertake the journey. Lower Super Output Areas (LSOAs) are areas with a population between 1,000 and 3,000.

Quintile is each of five equal groups into which the wards are divided after ordering by the percentage. The range of the percentage for each quintile is shown.

A lower percentage suggests key services are less accessible from a particular LSOA by public transport / walking. That population may find it more difficult to access GPs or hospitals if they do not have access to alternative forms of transport.
Rural Area

Action with Communities in Rural England (ACRE) commissioned Rural Health Profiles for CCGs, published in 2013, which bring together quantitative data for the rural areas in CCGs with comparisons to the CCG urban areas. The profiles include information on:

- Health and wellbeing
- Population
- Social place and wellbeing
- Lifestyles and health improvement
- Service use

With 34% of Guildford and Waverley CCG living in rural areas, this is a useful resource to consider the needs of people living in these areas. A third of the local population live in rural areas, with associated health issues including lower healthy life expectancy compared to those living in urban areas, greater proportion of the population over 65 and greater difficulty accessing services, especially for those with access to a car.

There is also reportedly poorer access to the 4G signal and high-speed internet in some rural parts of the CCG. This can increase isolation from online methods of information and support as well as being challenging in terms of the ability to provide an equally safe, high quality service using mobile working technology compared to areas that do not have these technological challenges.

The CCG is notable for its urban/rural mix with Guildford being the main town centre surrounded by a large number of smaller towns, villages and hamlets. Waverley is the more rural borough of the two. Our rural communities face particular challenges such as reduced public transport services which providers need to consider in their service delivery planning.

Food banks

Surrey County Council recently completed a Food Access Needs Assessment 2014 which maps the location of food banks in Surrey against deciles of deprivation. Five are located within Guildford and Waverley CCG. There are five food banks identified within the CCG area.
Cold homes and fuel poverty
In Guildford and Waverley CCG, there are 5,474 dwellings (6% of all dwellings) presenting an excess cold hazard due to poor insulation and energy efficiency. Figure 12 shows LSOAs where the proportion of dwellings with an excess cold hazard is highest, mainly rural areas of Guildford and Waverley CCG, as would be expected.

Figure 10: Percentage of households presenting an excess cold hazard by LSOA

Source: BRE Housing Stock Appraisal 2014.

Note: The Housing Health and Safety Rating System (HHSRS) scores excess cold as a category 1 hazard which is one of the highest and most prevalent hazards. Properties identified as presenting an excess cold hazard have a Standard Assessment Procedure (SAP) rating of less than 35. This is equivalent to the Energy Performance Certificate (EPC) rating G-F.

Lower Super Output Areas (LSOAs) are areas with a population between 1,000 and 3,000. Quintile is each of five equal groups into which the wards are divided after ordering by the percentage. The range of the percentage for each quintile is shown.

The areas of Guildford and Waverley with the highest proportion of households in fuel poverty are the rural areas of the CCG, although there are a few pockets in North Guildford. 8,174 households are in fuel poverty which is 9.3% of all dwellings.

Social Isolation and loneliness
There is good evidence that loneliness and social isolation are related to increased risk of ill-health and death, comparable in size to other more established physical risk factors such as smoking. In particular, loneliness appears to be linked with increased risk of overall mortality, cognitive decline, depression and high blood pressure, as well as increased use of health services.

A variety of factors contributes to social isolation such as bereavement, unemployment or retirement, physical disabilities or sensory loss
and can affect people of any age. However, these factors tend to converge in older age. Prevalence in the general population is about 6%, and greater in those under 25 (9%) and over 55 (9%). Amongst those in the older population, those most at risk are members of ethnic minorities, those with sensory loss and those over 80 years of age.

The areas with the highest concentration of people who are socially isolated include Stoke and Westborough, Clandon and Horsley, Friary and St. Nicholas, Cranleigh East, Onslow, Milford and parts of Haslemere and Godalming.

**Figure 11: Social isolation index by LSOA**

**Source:** Census; Mosaic; ONS. Data for West Sussex is incomplete

**Notes:** Lower Super Output Areas (LSOAs) are areas with a population between 1,000 and 3,000. Each LSOA is graded according to whether its index is in the top 25% (red), middle 50% (yellow) or bottom 25%. The index is a summary measure of a number of different indicators that may indicate social isolation.

<table>
<thead>
<tr>
<th>Conclusion:</th>
<th>Positive? YES</th>
<th>Negative? NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>What amendments are required to eliminate or reduce any adverse to this equality group impact identified by the analysis?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
• Access and response times for people living rural areas needs to be factored into decisions regarding place-based care. This relates to the ability of patients to get to services and to the ability of staff to allocate time and care for people requiring care in their own home.

• Mobile working needs to account for differences in access to the 3G/4G signal.

• Certain groups within the population will benefit from additional support to counteract loneliness and isolation. Providers must work in partnership with voluntary and community organisations to enhance overall health outcomes.

Further information
Data available from Department for Communities and Local Government
Fair Society Health Lives: The Marmot Review
JSNA chapter - Index of Multiple Deprivation
JNSA Chapter - Health Inequalities
Data available from Surrey-i
More information available from the Department for Transport
Guildford and Waverley Rural Health Profile
Data available from Surrey-i
JSNA chapter - Environment
NICE Guidance - Excess winter deaths and morbidity and the health risks associated with cold homes
Timebanking

VULNERABLE GROUPS e.g. ex-military, homeless, looked-after children, those seeking asylum

Analysis: Refer to national evidence and data and then think about the local population and how these various health inclusion groups may or may not benefit from the ‘activity’.

There are various markers of vulnerability in a community such as those listed below:

Homeless

The word ‘homeless’ is often referred to those sleeping rough. There are groups that are defined as statutorily homeless who are threatened with losing their home. Guildford and Waverley CCG has very low rates of statutory homelessness compared to London and the rest of England.

The provider must ensure that homeless people can access their services. Communication should be made with ‘Guildford Action’ who offer
support to homeless people. Homeless people attend A&E up to six times as often as the general population; are admitted four times as often and once admitted; tend to stay three times as long in hospital as they are invariably sicker. As a result, acute services are four times, and unscheduled hospital costs are eight times those of general patients. Nearly 90% of all ‘NFA – No Fixed Abode’ admissions are emergency admissions compared to around 40% for the general population. (Deloitte Centre; p5)

**Asylum Seekers**

The Faculty of Public Health briefing (2008) states that: “Asylum seekers are one of the most vulnerable groups within our society, with often complex health and social care needs. Within this group are individuals more vulnerable still, including pregnant women, unaccompanied children and people with significant mental ill-health”.

The number of people seeking asylum in the UK is increasing with the most recent arrivals coming from Eritrea, Pakistan and Syria (www.gov.uk/government/publications/immigration-statistics-april-to-june-2015/asylum ). There were 25,771 asylum applications from main applicants in the year ending June 2015, an increase of 10% compared with the previous year (23,515). Where those granted asylum settle is unknown but Providers need to have systems in place to manage people granted asylum requiring community services.

**Ex Armed Forces**

The Armed Forces Community is made up of serving members of the Armed Forces (regulars who are full time and reservists who are part time), veterans (or ex-service personnel) and their respective families. The responsibilities for commissioning health services for the armed forces community is complex, with NHS England retaining responsibility for serving members, but the CCG being responsible for healthcare for veterans, reservists not currently mobilised and armed forces families registered with NHS GPs. Surrey has three major Armed Forces training bases: The Royal Military Academy Sandhurst, The Army Training Centre Pirbright and Princess Royal Barracks Deepcut. The Defence Medical Services (DMS) medical centres (at the RMAS Sandhurst and the ATC Pirbright) are training centres and service families have the option of registering with a military GP.

The Defence Medical Rehabilitation Centre (Headley Court) which offers intensive rehabilitation for injured service personnel is located in Leatherhead. A new regiment has recently located to Pirbright. There are also three Army Reserve Centres in Surrey (Farnham, Reigate and Redhill).

The health needs of this group are broadly similar to the general population but with some specific differences:
• Armed forces families move every two to three years so may experience difficulty with continuity of care or variations in treatments which are funded between areas;

• Serving and ex-service personnel have a greater prevalence of excess alcohol consumption compared to the general population;

• Mental health is a significant health and wellbeing issue affecting military personnel, particularly combat personnel involved in challenging operations (predominantly depression and anxiety, but for a minority, more severe and enduring mental health issues such as Post Traumatic Stress Disorder).

  Engaging this population group with psychological support can be challenging; and

• A limited number of ex-service personnel return from conflicts with life changing injuries.

According to the 2011 Census there were around 2,500 members of the armed forces living in Surrey. Approximately 600 of these were living in communal establishments (Pirbright Barracks, very close to the Guildford border – 441 members). Guildford and Waverley has a further 659 members of the armed forces living in the community, possibly with families. There is no source of routine information of the number of ex-services men and women living locally but given the history of military presence there are likely to be greater numbers living locally than in other parts of the country.

**Table 14: Armed Forces in Surrey**

<table>
<thead>
<tr>
<th>Region</th>
<th>All Armed Forces</th>
<th>Armed Forces: Living in households</th>
<th>Armed Forces: Living in Communal Establishments</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>146,348</td>
<td>112,447</td>
<td>33,901</td>
</tr>
<tr>
<td>South East</td>
<td>33,483</td>
<td>24,506</td>
<td>8,977</td>
</tr>
<tr>
<td>Surrey</td>
<td>2,519</td>
<td>1,908</td>
<td>611</td>
</tr>
<tr>
<td>Guildford</td>
<td>920</td>
<td>479</td>
<td>441</td>
</tr>
<tr>
<td>Waverley</td>
<td>180</td>
<td>180</td>
<td>-</td>
</tr>
</tbody>
</table>

*Source: Census 2011*
What amendments are required to eliminate or reduce any adverse impact to this equality group identified by the analysis?

- Communications will need to be provided in an appropriate format and via an appropriate medium to ensure that the most vulnerable groups of service users within Guildford and Waverley who access these services are fully informed and able to understand the information being provided.
- Providers must consider those patients who will require access to an interpreter or advocate.
- Providers should devise ways of working and staff skills to meet the needs of the homeless population, including rough sleepers, who have conditions requiring adult community health care services.
- The Social Care Institute for Excellence (2010) publication ‘Good Practice in social care for asylum seekers and refugees’ though targeted at social care, has a useful set of principles from which community health care services could learn:
  - A humane, person-centred, rights-based and solution-focused response to the [health] care needs of asylum seekers and refugees
  - Respect for cultural identity and experiences of migration.
  - Non-discrimination and promotion of equality
  - Decision-making that is timely and transparent and involves people, or their advocates, as fully as possible, in the process.
- Providers must apply the Armed Forces Covenant Processes.
- The commissioning arrangements for the armed forces community are complex but the CCG has significant responsibilities, especially for veterans or ex-service personnel and military families. This needs to be considered while service planning. Specifically, the families of the armed forces personnel living in Guildford and Waverley are likely to be users of the local health service and to have experienced difficulties with continuity of care.
- Ex-service personnel are likely to require additional support for mental health problems, excess alcohol consumption and physiotherapy.

Further Information

Surrey Homelessness Health Needs Audit
Health Needs Assessment of the Armed Forces Community
Armed Forces Covenant
Dataset - Census Armed Forces
Priority treatment for veterans

<table>
<thead>
<tr>
<th>Name of person completing EA</th>
<th>Job Title</th>
</tr>
</thead>
</table>
There are many resources available regarding the local population of NHS Guildford & Waverley CCG. Some examples are given below. You are recommended to consult and use the following to inform your Equality Analysis:

- Local Practice Profiles: [http://fingertips.phe.org.uk/profile/general-practice](http://fingertips.phe.org.uk/profile/general-practice)
- Public Health England: Longer Lives; Outcomes Framework; Segment Tool; Local Health Tool; Data & Knowledge Gateway
- Reports of relevant Patient & Public Engagement forums and formal consultations
- Research (the evidence base e.g. National Institute for Health and Clinical Excellence (NICE), Scottish Intercollegiate Guidelines Network (SIGN)). Charities and the voluntary sector often produce guidance regarding inequalities e.g. SignHealth
- Complaints, public enquiries, audits & reviews