



**Bristol  
North Somerset  
South Gloucestershire**

## **Re-commissioning of Children's Community Health Services for Bristol, North Somerset and South Gloucestershire**

### **Cumulative Equality Impact Assessment**

# Cumulative Equality Impact Assessment – updated November 2016

This is a cumulative Equality Impact Assessment (EIA) which has been undertaken by Bristol CCG's Equalities Lead. It was started in March 2015 and has been updated during the recommissioning of Children's' Community Health Services. It provides information covering the process undertaken at various stages throughout the process as well as detailing future plans for the advancement of equality of opportunity for all.

Step 1 – May 2014 (assessment of requirement for EIA)

Step 2 – May 2014 – April 2015 (scoping of EIA and involvement and engagement phases)

Step 3 – December 2015 – November 2016 (consultation phase and procurement phase)

Step 4 – April 2017 (new contract monitoring)

## Step 1: Equality Impact Assessment Screening May 2014

### 1. Context:

This Equality Impact Assessment screening is undertaken to ensure that the Recommissioning of Children's Community Health Services across Bristol, North Somerset, South Gloucestershire (BNSSG), meets statutory obligations under the Public Sector Equality Duty 2011.

### 2. Relevance to the Public sector Equality Duty:

#### **December 2013:**

In December 2013, a paper was presented to the adult's and children's community services recommissioning steering group (prior to the group becoming Programme Board), outlining what compliance with the Public Sector Equality Duty would look like for the project and making the following recommendations:

- 1) Ensure that up to date equality information is available at each key decision making milestone.
- 2) Commence documenting all EIA activity.
- 3) Ensure that the demography of the Bristol, North Somerset and South Gloucestershire is reflected in its decision making processes.
- 4) Ensure that relevant training for steering group members on the application of the PSED is arranged accordingly.
- 5) Actively encourage those that share relevant protected characteristics to participate in the involvement and consultation process. This shall offer valuable insights into potential impacts that might have been otherwise overlooked.
- 6) Build on the lessons learnt from re-commissioning programmes undertaken by other CCG's and ensure that these lessons are incorporated accordingly.

These recommendations have all be met as evidenced via this EIA and the consultation

reports (available at: <https://www.bristolccg.nhs.uk/get-involved/cchs/childrens-community-health-services-overview/>). Training was specifically delivered at the outset for the Programme Group members by Bristol CCG's Equalities Lead.

Due to the nature of the project and its focus on 3 geographical areas, it was critical that a cumulative Equality Impact Assessment approach was undertaken to ensure that the Recommissioning of Children's Community Health Services Programme Board:

- 1) Had oversight over the development of the Equality Impact Assessment activity and that decisions could be made in compliance with the Public Sector Equality Duty.
- 2) Was able to assess the impact of any of its changes across all 3 geographical areas.
- 3) Identified any interdependencies between the various elements of the project.

**May 2014:**

A further paper was presented to the children's community services recommissioning steering group in May 2014. Assessment was commenced by Bristol CCGs Equalities Lead and would continue to be developed as work progressed through the project and a service model identified.

In order to ensure that the project was meeting Public Sector Equality Duty compliance, the focus of the first phase (phase 1) of the project was to be on ensuring that all our engagement/ involvement activity was inclusive and that protected groups (identified in the Equality Act 2010) were actively involved in this phase.

It was therefore vital that demographic data was sourced for each of the geographical areas of BNSSG to ensure that involvement activities mirrored local demographics and assisted the Programme Board in identifying any gaps in its involvement activity with protected groups.

**3. Impact on Protected Groups:**

Has the above identified that the project has any relevance to any of the following protected characteristics?

Age	Yes	Disability	Yes	Sexual Orientation	Yes
Race	Yes	Sex.	Yes	Religion or Belief	Yes
Gender Reassignment	Yes	Pregnancy & Maternity	Yes	Marriage or Civil Partnership Status	No

The way in which the selected healthcare provider(s) deliver the services will be largely influenced by the way the services are designed, specified and procured. This includes the way equality and diversity issues are considered within each element of the re-commissioning process and this EIA document provides evidence of the achievement of this.

**4. Health Inequalities:**

Does it relate to an area with known Health Inequalities? Yes. It is envisaged that this recommissioning project shall take into consideration any concerns raised about current services in scope and incorporate improvements into the model/ pathway going forward. This has clearly been achieved and is evidenced via the Consultation Report and the Contract Particulars which are specific about addressing health inequalities and the feedback received via consultation and involvement.

**5. Where it is considered that the paper has no relevance to the General Duty or Protected Groups, this should be recorded here with reasons along with any advice received:**

N/A
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**6. Conclusion:**

Proceed to full EIA: <b>Yes</b>
Quality Assured by: Programme Team.
Date: 19th December 2013, April 2014, October 2014 and February 2015.

## Step 2 Scoping of the Equality Impact Assessment

### **What are the main aims, purpose and outcomes of the project? What do you hope to achieve by it? Who will benefit?**

A single integrated Community Children's Health Service for Bristol and South Gloucestershire was agreed in 2008 and a formal procurement exercise undertaken. South Gloucestershire Health Visiting was added in 2011. This service covers the majority of children's community services including Health Visiting, School Nursing, Community Paediatrics, Therapies, Child and Adolescent Mental Health Services (CAMHS) and some specialist services - the full list of services is shown in Appendix A. Some specialist services are jointly commissioned with Local Authorities.

The contract was awarded to North Bristol NHS Trust (NBT) in partnership with Barnardo's the Children's Charity from 1<sup>st</sup> April 2009. The contract award was for five years, with the option to extend for a further two, which was recently agreed. The timescale was to enable the commissioners to review and redesign the community health services to ensure they support the commissioner's strategic aims to provide more care closer to home, and to support innovative models of delivery and commissioning. This may be done through making changes to the core services, pathways and model of delivery.

Following the NHS reconfiguration in 2013 the commissioning responsibility was divided and now sits with the following commissioners:

- Bristol CCG (Community Paediatrics, Therapies and CAMHS)
- South Gloucestershire CCG (Community Paediatrics, Therapies and CAMHS)
- Bristol City Council (Public Health) (School Nursing – Health Visiting from 2015)
- South Gloucestershire Council (Public Health) (School Nursing – Health visiting from 2015)
- NHS England (Health Visiting to 2015)

In May 2014 North Somerset CCG confirmed that they wished to commission their children's community services as part of this procurement.

The timescale for this procurement for a new service, to commence from the end of April 2017, enabled the commissioners to engage widely and gather all required information to help scope the new service model. It allowed for the commissioners to meet their legislative requirements for consultation. The main purpose of phase 1 was to engage with the public and a wide range of stakeholders to ascertain their views on community services and gather this feedback to help us design the future service model.

## What aspects of the project are particularly relevant to equality?

The nature of the project means that it will have a far reaching impact on communities across Bristol, North Somerset and South Gloucestershire. The service commissioners recognise that all children and young people are entitled to receive appropriate health care wherever they access it.

For one section of this group (young people aged under 20), the Department of Health “quality criteria for young people friendly health services” lay out principles that will help health services to ‘get it right’ and become young people friendly. These quality criteria cover ten topic areas, including accessibility, confidentiality and consent, and young people’s involvement in monitoring and evaluation of patient experience.

Whilst it was hoped that such criteria will influence service delivery as a whole, the diversity amongst the children and young people of BNSSG was also recognised. Therefore, the focus of activity from an equality perspective will be to ensure that:

1. the engagement / involvement activity reflects the diversity of the population
2. the resultant services are accessible, inclusive and universally appropriate

As we progress through the different phases the project will, aim to identify the communities that we have not yet engaged or engaged effectively with. We will use this information to plan active engagement with them in the future phases.

The key objectives of this inclusive approach to engagement, involvement and consultation are to ensure that, regardless of people’s protected characteristics: the services we procure are equally accessible; patient experiences are equitable and the services are contributing to reducing health inequalities across BNSSG. Health inequalities are identified in the Joint Strategic Needs Assessments for Bristol, South Gloucestershire and North Somerset

There was an acknowledgement from the outset that Bristol has the majority of Black and Minority Ethnic (BME) and Lesbian, Gay, Bisexual and Trans (LGB&T) communities, as well as relevant support organisations. Although there are some representative groups in the rest of the BNSSG, people from these protected characteristic groups tend to affiliate with Bristol based groups. As such, there is a commitment, throughout the duration of the project, to ensure that intelligence and data collated from these groups will be shared between the different areas and taken into account collectively.

Feedback from phase 1 of the involvement phase has been made available to the relevant specification sub groups to enable them to incorporate this feedback into the specifications going forward. This feedback is available via the Consultation Report and the specific equalities issues have been raised within this EIA (see further on in this document).

## What evidence is already available that will help in the development of both the project and the EIA?

For phase 1 of the project, demographic data was critical to act as a guide to inform the way in which the project ascertained information from our communities about current services, gauge their thoughts on how the new model to be commissioned could be developed and address any concerns with the current model.

The biggest challenge to the involvement of protected groups is the fact that across BNSSG, an approach for sustainable engagement with our minority communities has not yet been developed to an effective level.

Bristol CCG is currently developing this capability within its own processes.

South Gloucestershire CCG is committed to patient and public involvement throughout all stages of the commissioning cycle. Work is on-going to further strengthen our approach to stakeholder analysis to ensure that communication with our stakeholders is undertaken via appropriate methodologies and at a frequency which meets stakeholders' identified needs.

Demographic data collated:

### **Black and Minority Ethnic (BME)**

#### **Bristol:**

The child population in Bristol has seen a consistent rise and is now at its highest level since the mid 1980's. There are more children aged 0-15 living in Bristol than people aged 65 and over.

The majority of this rise in child population has been concentrated in the Inner City and East area which has the highest percentage of BME population in Bristol (31% compared with a 16% Bristol average).

The child population (see table 1) figures in Bristol has an increasing ethnic diversity, with:

- a) 28% (22,596 based on 2012 figures) of children (0-15) are from BME communities, a higher percentage than average for Bristol total BME population at 16%.
- b) Rising number of children using English as an alternative language. In 2013, 9400 of Bristol school pupils had English as a second alternative language.

<b>Age Group</b>	<b>2012</b>	<b>2017</b>
0-15	80,700	86,700
16-24	66,800	67,900

Table 1: Population Projections by broad age band 2012-2017

Source: 2012-based Sub-national Population Projections, ONS

### **South Gloucestershire:**

The child population for South Gloucestershire is 19%. The area has a relatively small BME population representing 8.1% of the total population. A reasonable proportion of the BME population gravitate or affiliate to Bristol based groups.

### **North Somerset:**

It is estimated that one in five of residents are under 18. In 2011 the BME population (all ethnic groups other than white) accounted for 2.7% (5,490 people), compared to 4.6% in the South West and 14.6% in England as a whole.

The annual North Somerset Council school census collects details on the ethnic origin of all children. Results from the January 2012 Census showed that a higher percentage of children were from a BME population than the 2011 Census suggests the general population of North Somerset (4.8% compared to 2.7%) were BME.

The main challenge to involving BME communities in North Somerset (also true for South Gloucestershire) is the dispersal of these communities which could be attributed to the small numbers of this population.

### **Lesbian, Gay, Bisexual and Transgender:**

There is no hard data on the number of lesbians, gay men, bisexuals and transgendered people in the UK. However, the Government is using the figure of 5 to 7% of the population and Stonewall agree that this is a reasonable estimate, although local support group estimation is that this figure is closer to 10 - 15%.

There are no official Bristol records for the transgender community

There are no official figures to demonstrate the number of LGB&T young people in Bristol; this is also applicable for South Gloucestershire and North Somerset.

### **Children living with disabilities and complex needs:**

For **Bristol** 16.7% of the total population declared they have a form of disability which limits their day to day activities to some extent.

March 2015 figures (Source Bristol City Council) show that:

- 1) 7196 children in Primary Education were registered as having a Statement of Educational Need.
- 2) 1662 children in Secondary Education were registered as having a Statement of Educational Need.

For **South Gloucestershire**, 15.6% of the total population declared they have a form of disability which limits their day-to-day activities to some extent.

Of children and young people with a Statement of Educational Need (SEN), 9% are of BME background [1.105], 74% are boys and 26% are girls.

For **North Somerset**, 19.2% of the total population declared they have a form of disability which limits their day-to-day activities to some extent. The precise number of children with disabilities in North Somerset is unknown.

### **Other protected characteristics**

#### **Sex**

In terms of the SEND population, there is a greater prevalence of boys to girls and care must be taken to ensure equal access to both.

#### **Religion/belief**

No specific involvement activity with children and young people from religious groups was undertaken in phase 1. In order to mitigate this, specific engagement activity has been developed and was undertaken in the next involvement phase.

There is DH guidance to indicate that religious festivals or observances where a sensitive approach needs to be taken e.g. not offering appointments at times when people are unable to attend for religious reasons

#### **Pregnancy and maternity**

Female service users could be young mums and this will need to be planned for.

### **Do you require further information to gauge the probability and / or extent of any adverse impact on protected groups?**

No This information was detailed in the involvement plan.

### **Which communities and groups were consulted or involved in the development of the project?**

#### **April 2015**

Our involvement activity aimed at protected groups has focused on 2 approaches:

#### **1) Engagement events:**

##### **BME:**

A specific consultation event was organised to involve BME people in phase 1, and the forum of choice was the annual BREHP (Bristol Race Equality Health Partnership) conference on the 19th June, along with targeted media interviews with local radio stations (Ujima radio, BBC radio Bristol) in the build up to the event.

The findings from this event are equally applicable to South Gloucestershire and North Somerset.

Gypsy and Traveller groups have been identified as communities we have yet to involve and for a variety of reasons we were unable to do so. Summer is also traditionally the time when the community tend to travel making contact a bit more difficult.

Much greater forward planning and working with other agencies and trusted staff will be necessary ahead of and during the consultation phase to engage this community more effectively.

### **Lesbian, Gay, Bisexual and Transgender:**

A focus group was organised with the LGBT Bristol Youth Forum to ascertain feedback from LGB&T young people on their experiences accessing community health services to date. The findings from this event are equally applicable to South Gloucestershire and North Somerset.

### **Children with disabilities and complex needs:**

Involvement activity in Bristol targeted the following groups to ensure views were ascertained on both current services and suggestions for services going forward:

- Parents and carers of children with complex needs
- Parents and carers of children with learning difficulties
- Parents and carers of children who use mental health services
- Parents of children who use universal services (school nurses and health visitors)
- Young people with complex needs
- Young people with learning difficulties
- Young people who use mental health services
- Young people who use universal service (school nursing)
- Parents, carers and young people who may use community health services in the future

South Gloucestershire engaged with South Glos Parents and Carers a representative group who have children and young people with a disability or additional needs who also organised a number of engagement events on our behalf. Additionally a number of disabled children were engaged directly through events such as the Youth Board

The CCG promoted opportunities for engagement through the South Gloucestershire Disability Equality Network, South Gloucestershire Equality Forum, South Gloucestershire Deaf Association.

## **2) Surveys:**

Three surveys were designed, one for the parent and carers, one for the professional and one for children and young people and were used across BNSSG.

The online surveys across BNSSG were designed to capitalise on the fact that access to IT is more prominent today than ever, however hard copies were available and 36 were posted in response to email requests. Whilst online communication is acceptable for the engagement with

professionals, not all of our communities have access to an electronic device (phone, tablet, laptop, and computer) and the CCG and local authority websites.

It is also noted that the survey was developed in English only which may have restricted access to it to those that:

- a) have access to a device, internet, are IT literate; and
- b) read English - no easy read version was produced nor versions in alternative languages.

The online survey did however provide a useful tool to access a wide range of communities, this was evident from analysing the equality monitoring questionnaire which was attached to the survey.

The online survey analysis facility did not allow for corroboration between the equalities monitoring data and responses to the main questionnaire. This limits the validity of the data, and this has formed part of our learning going forward. However, all equalities related feedback has been captured and analysed as part of the formulation of the service specifications.

In addition, Bristol also used paper surveys to target BME communities through recruiting a community activist and ensuring that this was part of their wider approach to ensuring that we involved a wide cross section of our communities.

The analysis of the equality monitoring data produced inconsistent trends due to discrepancies in the completion of the equality monitoring section of the survey by respondents.

This needs to be addressed for future engagement, and shall be discussed with the communication team to determine the best way forward. As children and young people are likely to have high level of access to IT, it is critical that we can plan meaningful IT solutions to capturing the equality monitoring data in the future.

The professional engagement survey equality monitoring data did highlight a point of interest which is the under representation of BME staff. This is a pertinent point as the involvement with children and young people from BME backgrounds highlighted the importance of having people they can identify with within the mental health service. They said they find it easier to be open and honest with people who can understand their culture and/ or religion. They said that people who are from a minority group understand what that feels like and the impact that it can have on your life.

Highlights from the professional online survey are:

- There were no Hindu, Jewish, Muslim, or Sikh respondents.
- None of the respondents were from a BME background.
- 50% of the professionals surveyed were in the 45-54 age category.
- 84% of respondents were women.
- None identified as being Lesbian, Gay or bisexual with 3.7% identified as being a gender other than the one that they were assigned at birth.
- 3.75% stated that they are disabled.

## **State the key outcomes of the involvement and engagement**

- 1) Young BME males indicated that the ability to access online content anonymously was something that they felt was needed. With this in mind, future online engagement mechanisms need to be reflective of this requirement. The professional engagement survey equality monitoring data did highlight a point of interest which is the under representation of BME staff.
- 2) The professional engagement survey key highlights are outlined above including the link with children and young people from BME backgrounds. This indicates that the current workforce delivering the services are not representative of the communities they serve, and in light of the above feedback, this may need to be considered as a potential barrier to providing an effective service in accordance with need to children and young people.
- 3) Accessible communication: This relates to how communities receive communication from both commissioning organisations and service providers. Alternatives to standard IT/ electronic communication should be considered to address issues like IT illiteracy, lack of language appropriate content (spoken and sign language) on most websites make this way of communication inaccessible to some communities. In addition the lack of language support and interpretation services for spoken languages and also sign language could be a barrier to accessing services.
- 4) Access to services: The key words here are “isolation” and “points of access”. Suggestions to address these issues are:
  - a) to provide services in a community setting which may enable services to be accessed by “seldom heard communities”.
  - b) staff that are culturally sensitive and well trained to be aware of the specialist needs from a language or access perspective.
  - c) Tapping into voluntary and grass root organisations and utilise their knowledge and contacts in setting up the service.
  - d) Increasing the knowledge they have about the availability of services.

## **Which additional groups could usefully be engaged?**

It is evident that despite holding targeted involvement and engagement events for some protected groups, the numbers that we engaged with are low, and it is critical that we build on the links we have established to date and ensure that this interaction with protected groups continues now that we have built momentum.

It is also evident that we have not engaged with some groups such as

- 1) Religious groups and
- 2) Gypsy and Travellers

Further work was undertaken by the Children’s Public and Patient Involvement lead to address these gaps prior to the consultation starting in September 2015 and the report can be found at

[https://www.bristolccg.nhs.uk/media/medialibrary/2015/10/cchs\\_involvement\\_phase\\_report.pdf](https://www.bristolccg.nhs.uk/media/medialibrary/2015/10/cchs_involvement_phase_report.pdf)

Additional feedback can be found at

[https://www.bristolccg.nhs.uk/media/medialibrary/2015/12/cchs\\_patient\\_public\\_feedback\\_summary.pdf](https://www.bristolccg.nhs.uk/media/medialibrary/2015/12/cchs_patient_public_feedback_summary.pdf)

### Step 3 Equality Analysis

#### Assessing the impact for different groups

#### December 2015 following the consultation on the model, values and the outcomes of the new service

From the outset, the design of the consultation has into account the diverse needs of the populations it is aimed at. During the earlier involvement activity, we had ascertained that our communities access information (and therefore consultation) differently, and as a result we needed to design a consultation process that would accommodate these diverse needs and by doing so engaging as many people as possible in this process.



**Figure 1: Outline of consultation rationale.**

Our involvement process prior to the commencement of the consultation process, along with our understanding of our demographic data had placed us in good stead to anticipate the access needs of our communities.

Of the variety consultation methods/tools open to us, we selected the following approaches which we anticipate will accommodate as many needs as we have identified through our earlier involvement phase :

It is also anticipated that by using a variety of tools (outlined in table one), we would be able to address any gaps which might result in using a single consultation method/ tool.

**Method/ Tool****Comments****Web based consultation:  
Your Healthy Future.**

The “Your Healthy Future” website has been designed with the following features:

- Young person’s involvement in the development of the website through the Young People’s Reference Group, which has been expertly facilitated by the CCHS PPI lead.
- Built in accessibility and usability testing, with a specific focus on the accessibility of the consultation site by people who are visually impaired.
- A specifically commissioned sign language introduction to the consultation process.
- The use of google translate and browse aloud (whilst acknowledging their limitation, it can still assist in breaking down language barriers)
- A design that is compatible with a variety of screen readers to offer access for visually impaired users.
- Accessible design which is engaging and aims at presenting key concepts in a simplistic fashion to encourage more people to offer their views on the values, model and both the single & multiple needs pathways.

**Focus groups**

Focus groups have been set up to accommodate the needs of individuals and/or groups where a web based consultation is not suited.

**A facility to request  
alternative formats (easy  
read, paper based  
documents etc.).**

The Communications team have organised a range of publicity events (interviews, postcards and posters etc.) to ensure that our communities are aware of the consultation time frame, and whilst initially directing people to the “Your Healthy Future” website, a telephone number to receive and respond to queries for alternative formats.

Throughout the entire engagement and consultation process it has been important for Commissioners to ensure that we were hearing a diverse range of views from all sectors of the community. Importantly, the online survey allowed Commissioners to include equality monitoring questions. Whilst the completion of these questions was optional, this data where provided, was vital to help us ensure that we understood the needs of our communities and to check that we were reaching out to all sectors of the local population. There was a mid-point review during the consultation to evaluate the current number of responses and for a more in-depth look at the community members who were responding. This allowed us to identify any potential gaps in the reach of the consultation and to renew effort in reaching these groups.

From this mid-point analysis we identified that we had a lower response rate than we might wish from men and the lesbian, gay, bisexual and transgender communities

In order to attempt to address this South Gloucestershire contacted Barnardo's and asked them to publicise the consultation with Fathers' Groups which they engage with. We also contacted Off the Record to ask them to promote the consultation with the Freedom Project which works with LGBTQ young people, including those from South Gloucestershire. We also made contact with the Diversity Trust who posted the link to the consultation on their Twitter feed (1300 followers) and Facebook pages (500 reach) including two pages aimed at LGBTQ young people.

For Bristol this mid –point review identified that we had a lower response rate than we might wish from the black and ethnic minority communities (BME) and young people under the age of 15. Therefore the Bristol CCG contacted and identified further organisations, such as the BME forum and youth clubs that work with BME community members. The YPRG then had a second attempt in their schools and local areas targeting younger people and local youth groups.

For North Somerset and South Gloucestershire, from the mid-point review we identified that we needed to target Gypsy, Roma, Traveller (GRT) Communities and Lesbian, Gay, Bisexual and Trans (LGBT) young people. We developed our relationships with professionals and community groups including the South Gloucestershire Gypsy and Traveller Unit, the North Somerset Corporate GRT Group and the North Somerset LGBT Forum and HERO a voluntary organisation working within in Churchill Academy.

The full report from the consultation can be found at

[https://www.bristolccg.nhs.uk/media/medialibrary/2015/12/childrens\\_community\\_healthservices\\_consultation\\_report\\_1.pdf](https://www.bristolccg.nhs.uk/media/medialibrary/2015/12/childrens_community_healthservices_consultation_report_1.pdf)

### **Who did Commissioners hear from in the consultation?**

The approach to inclusive engagement has been a theme which we have built on from the earlier involvement process. We engaged with our diverse communities through focus groups, events and via the online survey.

### **Equality group representation at Bristol focus group discussions:**

A total of 440 participants took part in the focus group discussions. An analysis of the equality data available from these focus group discussions is as follows:

#### **Age:**

Of these 62% (274 participants) were young people, 9% (39 participants) were parents and 28% (127) were professionals.

#### **BME:**

Of the 274 young people that took part in the focus group discussions, only 4% (10 participants) identified as BME. In addition, 18% (7 participants) of the parents that took part in the focus group discussions identified as BME.

None of the professionals involved in the focus group discussions identified as BME. This was also highlighted during the earlier involvement stages.

**Gender:**

Of the young people that took part in the consultation, 30% (81) were male and 70% (124) were female. This was significantly higher than 8% (3 participants) male representation and 92% (36 participants) female representation in the focus groups. For professionals, males made up 16% (21 participants) of participants, with the remainder of participants.

**Transgender:**

Of all 440 participants, 0.5% (3 participants) identified as transgender. All of these were young people.

**Disability:**

Of the young people that participated in focus group discussions, 3% (10 participants) identified as disabled, 1% (3 participants) identified as Deaf and 5% (14 participants) identified as Autistic. In addition, 2% (1 participant) was a parent to a disabled child, and 10% (4 participants) were parents to Autistic children.

**Sexual Orientation:**

Of all the 440 participants, 1% (5 participants) identified as Gay. All of these were young people.

**Equality group representation at South Gloucestershire focus group discussions:**

A total of 10 participants took part in the focus group discussions. All of these were parents. An analysis of the equality data available from these focus group discussions is as follows:

**Age:**

40% (4 participants) were aged 25-49, 30% (3 participants) were aged 50-65.

**Ethnicity:**

70% (7 participants) identified as white.

**Gender:**

All of the focus group participants were women.

**Sexual orientation:**

70% (7 participants) identified as heterosexual.

**Religion and belief:**

50% (5 participants) identified as Christian, and 20% (2 participants) identified as not having a religion or belief.

**Disability:**

20% (2 participants) identified as disabled, and 50% (5 participants) identified as not having a disability.

**On line Survey Representation**

**Age:**

The age profile of the respondents suggests that the majority of the survey responses have been completed by parents, carers and professionals.

**Disability:**

Only 8% of the respondents were identified as disabled, however given that the majority of respondents are either parents, carers or professionals, it is highly likely some of these respondents would have completed the survey on behalf of a disabled child. In addition, a proportion of the respondents did not complete the equality monitoring questions which could account for the small numbers.

Other issues to consider are the preference some groups have for focus group discussions despite efforts such as the sign language video which was deployed to make the online consultation as inclusive as possible.

**Gender:**

The majority of the respondents are female (75%), with 21% of respondents being male, and 2.5% "preferred not to say".

**Transgender:**

None of the survey respondents identified as Transgender. It is important to note however that we did engage some people that identified as Transgender (0.5%) through focus group discussions.

This compares to the Gender Identity Research and Education Society and the Bristol LGBT Forum estimates which indicate that 1% of the population being on a "gender variant spectrum". This demographic is applicable across BNSSG.

**Sexual Orientation:**

93% (165 of respondents) identified as heterosexual, 3% (5 respondents) as Gay, 3% (6 respondents) as Bisexual and 0.5% (1 respondent) identified as Lesbian. All of the LGB respondents were Bristol based.

This compares to local demographic data of:

- **Bristol:**  
Stonewall estimate 6% of the local population being LGB, (The Bristol LGBT Forum estimate that this figure is closer to 10-15%)
- **South Gloucestershire:**  
There is no definitive figure for these groups in South Gloucestershire but estimates indicate that 5%-7% of the population are LGB.
- **North Somerset:**  
Government estimates that 5%-7% of the population are LGB.

**BME:**

Only 3% (6 respondents) identified as BME. This is exceptionally low given that 16.5% of Bristol's population is BME, along with 5% in South Gloucestershire and 2.7% in North Somerset.

A further analysis of the data supplied highlighted that 3 of these respondents is Bristol based, 1 is South Gloucestershire based, 1 is North Somerset based and one is unknown.

Whilst respondents identified as “other” make up 5% (9 respondents) of responses, and these could be from a BME background, it is possible therefore that the number of BME respondents could be higher. Further interrogation of the data supplied could not provide any further detail as to the ethnicity of these respondents. It must also be noted that 37% of all respondents did not provide the details of their ethnicity. In addition, we have undertaken to engage BME people through focus groups. The outcome of this was that an additional 4% (17 participants) across focus groups for parents, young people and professionals took part in the engagement process.

**Religion or Belief:**

The respondents reflected diverse religious and none religious backgrounds with 50% of all respondents declaring their religious identity (Table). Noticeably however were no responses from people that identified as Jewish (Census figures for Bristol: 0.2%, North Somerset 0.09% and South Gloucestershire 0.1%) , Hindu (Census figures for Bristol 0.6%, North Somerset 0.1% and South Gloucestershire 0.6%) or Buddhist (Census figures Bristol 0.6%, North Somerset 0.17 and South Gloucestershire 0.3%) compared to demographic data.

The largest single group of responses 38% were from people that identified as not having a religion, followed closely by respondents that identified as Christian 35%.

This compares with census data across BNSSG indicating that the largest religion represented is Christianity, followed by those that identify as not having a religion or belief.

**Table**

<b>Religion</b>	<b>Percentage response rate from the online survey. %</b>
Agnostic	4.5
Atheist	6
Christian	35
Muslim	3
No Religion	38
Roman Catholic	3
Sikh	0.5
Church of Jesus Christ Latter Day Saints.	0.5
Other	9

Overall the consultation has reached a diverse range of respondents. Our analysis of the equality monitoring data and any gaps in reaching some groups/communities must be considered in the context that equality monitoring data is not available for every participant. In addition, Commissioners have varied the methods they used in the consultation process to reach as many groups/communities as possible

A meeting of the Equality Leads across BNSSG to go through each of the specifications and cross reference this to the feedback received from equality groups to ensure that it has taken place and has been taken into account.

A specific requirement has been added to the overarching specification for the provider to provide data on outcomes by protected characteristics. This will be monitored as part of the contract management.

A paper was taken to Programme Board on the 5<sup>th</sup> January 2016 informing them of the high level changes that would be made to the specification from comments received during the consultation.

A meeting was held with the Director of Operations (Bristol) to strategise on how to ensure that feedback from equality groups have been incorporated.

The consultation document was prepared by the PPI lead and supported by the Equality Lead and signed off by Programme Board and published on commissioner's websites and was available for bidders to refer to. It was decided that since our approach to the EIA was to ensure that all of our engagement activity was inclusive that a joint report would be appropriate.

The Programme Director ensured that feedback from consultation was appropriately reflected in the procurement going forward. This included planning a procurement process that is designed to ensure that equality was embedded into the potential provider's core organisational systems.

There was ongoing dedicated equality support to the procurement team to ensure that all feedback from equality groups are incorporated and at the forefront of the procurement activity.

The equality leads from Bristol CCG, North Somerset CCG and South Gloucestershire CCG were invited to provide input to all stages of the procurement and the evaluation the bids received.

### **What can you do to maximise opportunities to further promote equality and ensure equitable outcomes for different communities and groups?**

Following contract award (December 2016) and during the mobilisation phase (December 2016 to 31<sup>st</sup> March 2017) discussions will take place to evaluate how national tools such as EDS2 (The Equality Delivery System 2), the Accessible Information Standard, and The Workforce Race Equality Standard can be utilised to develop an inclusion framework which will be monitored through performance management. This EIA will be shared with the Provider during this stage. Additionally, the following equalities issues, as put forward by consultees, have been addressed via the service specification **where proportionate and relevant**, and will also be specifically addressed with the chosen provider. This will result in action plan as part of the contract management to be taken forward by the chosen provider which will ensure the advancement of equality of opportunity within delivery of the contract: Please see the PPI report and Appendix B.

The above issues and overall equalities performance will continue to be monitored as part of the ongoing contract management.

<b>What is the outcome of the Equality Impact Assessment? (Choose ONE option)</b>	
No major change – the EIA demonstrates that the process followed to date is robust. The evidence shows no potential for discrimination as all comments received have been reviewed both by equalities leads and commissioners and amendments made to the values, model, outcomes and specifications have been made to reflect these and opportunities to promote equality have been identified and implemented, with clearly identified actions in place for performance management.	Yes
Adjust the project proposals / plan to remove barriers or to better promote equality.	No
Continue the project despite potential for adverse impact or missed opportunities to promote equality.	No
The EIA identified actual or potential unlawful discrimination. Changes have been made to the project to remove any unlawful discrimination. The proposals are deemed 'business critical'. Legal advice has been sought and objective justification for the proposals are attached.	No No No

#### **Step 4 Monitoring, Evaluation and Review**

<b>Monitoring and Review</b>	
The new contract will commence on 1 <sup>st</sup> April 2017. This contract will be monitored through the monthly Integrated Contract Quality and Performance meetings. The frequency of these meetings may change over the life of the contract	
<b>When will this EIA be reviewed?</b> (If not within a year please provide reasons)	Date: April 2017

#### **Step 5 Approval and Publication**

<b>Approved by Equality &amp; Diversity Lead</b>	Date: 29.11.2016 Name: Niema Burns
<b>Approved by Project Lead / RO</b>	Date: Name: Alison Moon

## Step 6 Monitoring and Reviewing the Action Plan

Review of EIA - Update / Observations / Changes	
<b>This EIA is scheduled for next update by Commissioners and Equalities leads from all the commissioning organisations in April 2017.</b>	
<b>Approved by Equality &amp; Diversity Lead</b>	Name: Niema Burns Date: 29.11.2016
<b>Approved by Project Lead</b>	Name: Fiona Butter Date:
<b>Date of Next Review</b> (If no further review required please provide reasons)	Date:

## Appendix A

Community Child Health Services are

- 0 – 19 service
- Community Nursing
- Community Therapies
- Designated Doctor and Looked after Children Specification
- Designated Doctor Safeguarding Service
- Family Nurse Partnership
- Paediatrics in the Community
- Speech and Language Therapy
- School Immunisation

Child and Adolescent Mental Health Services

- Child and Adolescent Mental Health Services
- Learning disabilities
- Substance misuse service

## Appendix B

**The Values** Ensure the values are applicable to meet the needs of all young people and children.

- Professionals to be more understanding and educated about all issues, e.g. gender identity – see page 22 of overarching specification
- Ensure that CYP, especially those with physical disabilities, can get to services – see page 22 of overarching specification
- Ensure communication with YP is in an understandable language see page - see page 22 and 31 of overarching specification
- A value around cultural sensitivity would be useful - see page 20 of overarching specification
- Include cultural competency and awareness training, so professionals can engage with families from varying cultures – see page 48 of overarching specification
- Should mention communication with those with learning difficulties & other specific communication needs e.g. BSL. –see page and 31 of overarching specification
- Staff to be diverse themselves not just culturally sensitive – see page 23 of overarching specification

### The Model

- A line to be added for extra support if needed, e.g. an interpreter - see page 22 and 31 of overarching specification
- The model needs to include outreach services.- see page 11 of CAMHS specification
- The model needs to reflect YP who require outreach, or who are in crisis - see page 19 of CAMHS specification
- Doesn't support the needs for deaf YP. The service needs to be in a language they understand. see page 31 of overarching specification
- Demonstrate clearer support for parents - see page 3 of overarching specification
- Ensure the model shows inter agency working with those who have multiple needs, not just clinical e.g. youth homelessness – see page 24 and 31 of overarching specification
- Reflects a health not an integrated social pathway for example with children centres or Gypsy Roma Traveller Drop ins & voluntary sector – see page 23 and 31 of overarching specification

### The Outcomes

- BME groups favoured the outcome about not being treated equally but thought it could say “treated differently” – see page 23 of overarching specification
- The definition of family for those where it is not straightforward. Definition of family shared with preferred bidder

*Our children's services have a family centred approach. This means our values, attitudes, and approaches to services for children and young people are set up with families in mind. Family-centred service recognises that families are unique and that they are the experts on the child's abilities and needs.*

*Our definition of family establishes a broad and encompassing concept of family. Family means any person(s) who plays a significant role in an individual's life. This may include a person(s) not legally related to the individual who act as a guardian of choice.*

*Members of 'family' include parent carers, spouses, domestic partners, and both different-sex and same-sex significant others, legal parents, foster parents, same-sex parent, stepparents, those serving in loco parentis, and other persons operating in caretaker roles.*

- Being treated equally outcome to include health condition and mental health – see page 20 of overarching specification
- Add an outcome about making sure YP understand what's been said – reaffirming – see page 23 of overarching specification

### **Lots and Specifications**

- Therapeutic programmes should be available for victims of sexual abuse. – this is not part of the CCHS contract
- Have a more adolescent and outreach focus
- Work with ... the most vulnerable – see page 31 of overarching specification
- Needs to include a disability section – see page 20 and 49 of overarching specification
- Definition of family to be included; current services excluded those who have parental split – see above
- Concerns that HV provision remains equal across the wider area – see page 22 of overarching specification
- Specialist services for therapeutic work for victims of sexual abuse should be included on the specification of the CCHS plan -. – this is not part of the CCHS contract
- 

### **School Health Nursing**

- It is important to know how to work with young people so you are approachable – see page 21 of overarching specification
- That different young people have different needs – we want you to understand our cultural or religious backgrounds – see page 19 and 20 of overarching specification
- It is important that school nurses understand the challenges young carers face – see page 22 of overarching specification
- Raise awareness of LGBT in schools (posters).
- Most young people wanted there to be a male or female nurse – young men commonly fed back that a barrier to accessing a school nurse would be there being no choice to see a man.
- Young people want their school nurse to be knowledgeable...school nurses need to have more training in mental health issues and be culturally aware - see page 19 and 23 overarching specification
- School nurses should be proactive and reactive and make themselves known better. Schools (with particular mention to their inclusion/student support teams) should be promoting the service of the school nurse and directing students there – see page 2 of the overarching specification
- A school nurse needs to be a preventative service, not just a fast fix. They need to understand emotional wellbeing and how to support or signpost students with particular needs. They need to be well trained in mental health, (there was particular mention to issues such as eating disorders and self-harm, cultural/religious needs) – see page 19 overarching specification

### **Health Visiting**

- Should have more specialist knowledge of children with complex needs – see page 22 of overarching specification
- Health visitors to have more specialist knowledge to identify disabilities and offer support – see page 22 of overarching specification

- Most parents of children asked to be communicated with in a way they understand. Often parents where English wasn't a first language, would receive letters in the post they couldn't read. This would be the same for those in settled travelling communities who are - see page 31 of overarching specification
- Gypsy, Roma and Travelling families believe this to be the most important health service they receive. The families that were involved in this project believed community health visiting to be vital to their health. Health visitors come and visit them on site and are a service that allows them to access health the most as they are flexible and proactive in their communities - see page 5 of 0 – 19 service specification
- Polish, Somali and Roma families believed health visiting to be a positive service. Overall the feedback from seldom heard parents was that health visiting was a very useful and successful service. It was mentioned that it "used to be better years ago" but recognised that with funding and population growth the service is more stretched.

### **Community Paediatrics and Therapies – Occupational Therapies**

- Understanding and advice around sensory issues – see page 5 of Community Therapies specification

### **Speech and Language Therapy (SALT)**

- SALT for those with English as an additional language – see page 31 of the overarching specification

### **Continence Service**

- Access to clinical waste collection – this is a local authority commissioned service and not part of this contract
- Information about alternative services/products – see page 19 of overarching specification

### **Child and Adolescence Mental Health Services (CAMHS)**

- More support for young people with autism and ADHD – see page 37 of overarching specification
- As boys we would prefer an online completely anonymous service – have commissioned as a pilot on line counselling
- Knowledge around YP with disabilities –see page 19 of overarching specification
- Diversity in workforce – see page 23 of overarching specification
- Better integration with schools/school nurse is needed. Young people felt that mental health was becoming an increasing problem especially in schools – see page 30 overarching specification
- Come to us! They felt that this services should be more flexible and come to see them in their communities where they feel most comfortable – see page 19 of overarching specification
- Break the Taboo! Mental health is commonly a taboo subject in the Gypsy, Roma, Somali communities (and similarly but less commonly in black minority and ethnic). Young people wanted a way for this to be challenged and changed.
- Key or link workers. Young people believed there could be key mental health workers in schools or the community working closer with school nurses and other health professionals. Link workers could help mental health become less of a taboo for seldom heard / religious groups. Young people also wanted professionals to come to them. They mentioned that

adults have mental health workers and they should too – [see page 19 of overarching specification](#)

- Appointments. Flexible in neutral community spaces – [see page 19 of overarching specification](#)
- Decorate. Waiting rooms need to be more young people friendly, private and calmer. Not so clinical or corporate – [see page 67 of overarching specification](#)
- Change the name. The culture of mental health services for young people needs to totally change. CAMHS have a bad reputation and lots of young people do not trust the service. Young people often discussed if there was even a need for separate ages at all in mental health services.
- Get rid of the age bracket- young people argued peoples mental health should be treated as individuals not by age bracket. They questioned whether there was even a need for separate age mental health services

### **General Involvement Feedback**

- “Understand us as individuals not a problem or diagnosis - ask us what we want” [see page 23 of overarching specification](#)
- Services should be responsible for being able to communicate directly with all their patients, however they needed to be communicated with – [see page 31 of overarching specification](#)
- Get online! – [see page 23 and IM&T part of overarching specification](#)
- Having more staff that reflect the community – [see page 23 of overarching specification](#)