Quality and Equality Impact Assessment (QEIA) template[1] (refer to guidance)[2]

Scheme/Policy Name: Children's Community Health Services QEIA v1.6 **(23 August 2023)**

Author (name): Sarah Rajendram **Job title:** Senior Commissioning Officer

Date commenced: 23/02/2023

1. Indicate below whether this scheme or policy will affect stakeholders at place (select which one) or system level:

East Surrey ☒ Guildford & Waverley ☒ North West Surrey ☒ Surrey Downs ☒ Surrey Heartlands ☒ Surrey ☒

North East Hampshire ☒ Farnham ☒ Surrey Heath ☒

2. Summarise the scheme or policy being assessed. Describe in plain English any changes that stakeholders would experience.

This overarching EQIA is to inform the recommissioning of Children's Community Health Services for a new contract to go live post April 2025. It considers the implications of the new service model on service users and families that fall within the protected equality characteristic groups, as well as other population groups where there may be existing inequities. This EQIA has also been informed by the Task and Finish Group discussions on the current contract, and the individual EQIAs that were carried out for each broad service area. It takes into account any potential impact that could be felt in the future contract on services, children, young people and their families.

The EQIA is an iterative document which has been in development from February 2023. It reflects the confirmed financial envelope and the services described in the service specifications.

[1] **Always download the latest template from the Intranet. Do not use a previous version.**

[2] **Please send final QEIA to:** syheartlandsicb.qeia@nhs.net

The baseline financial envelope for the new contract is at the same level as the current contract. This would mean that emerging needs and continued population demand remains unmet. Children and families will seek support from elsewhere including independent provision to fulfil statutory requirements within Education Health and Care Plans (EHCPs), and primary and secondary care services for a general health response. There will be a reduction or stop to earlier identification and support because the focus instead will be on clinical demand and need. There will be a move further towards only providing statutory assessment and care for children with additional (SEND) or complex needs. The knock-on effect would be more requests for EHCPs because this would be seen by children, families and schools as the only way to access services. Non delivery of these activities would result in further tribunals and distress for families.

Through transformation, the newly designed model will mitigate some of this through:

- Multi-disciplinary team working so that children, young people and their families receive more joined up care
- Co-location with other services for ease of access
- Working within localities and communities so that service users receive services where they live
- System collaboration to ensure as much as possible that there is prevention, early intervention and a strong system response to service delivery

Surrey County Council has agreed to provide additional funding for each year of the contract in line with Surrey's trajectory of EHCPs related to the need for Occupational therapy support in education. The indicative funding is £300K but the exact level of funding will be agreed on an annual basis and enacted through an annual contract variation.

Through further investment, improved experiences can be delivered for children, young people and families through:

- Improved digital infrastructure to enable text message reminders and appointment booking and choice
- Better data sharing to facilitate joined up care

3. Who has been or needs to be involved with developing this QEIA?

A key principle for completing impact assessments is that **they should not be done in isolation**. Consultation and engagement with affected groups and stakeholders is vital and needs to be built in from the start, to enrich the assessment and develop relevant mitigations/actions. Detail here who is supporting the completion of this QEIA.

Role / job title / forum *(No names)*	**Organisation**	**Internal or External?**

Project Support Officer	SCC	Internal
Associate Director – Children & Young People's Commissioning	Surrey Heartlands ICB / SCC	Internal
Recommissioning Programme Board members (for review and initial sign off)	Mixed across health and social care	Internal/external
Multi-professional reference group member	Family Voice Surrey	External
Surrey Heartlands QEIA Panel	Surrey Heartlands	Internal
Contracts Managers	NHS England	External
Service Manager	Surrey Heartlands ICB	Internal
Director of Patient Experience	Surrey Heartlands ICB	Internal
ICS Director of Multi-Professional Leadership and Chief Nurse	Surrey Heartlands	Internal

4. Equality Impact Assessment *(see Appendix 1 for notes on definitions)*

Note: Whilst the outcome may be similar, you need to tailor your response and rationale to each characteristic. Do not enter the same answer for every row.

4.1 Protected characteristics under the Equality Act 2010 must all be considered and information included for each characteristic.

Protected equality characteristic	Discuss & describe here the considerations and concerns in relation to the scheme/policy for each group.	Discuss & describe here suggested mitigations to inform the actions needed to reduce inequalities.
Age	There are 67,995 children aged 0-5, 183,093 children and young people aged 5-16 and 105,667 young people aged 17-24 in Surrey. In recent years births have declined from 13,542 births in 2015 to 11,880 in 2020. The Community Health services are for 0-19, and up to 25 for young people with an Education Health Care Plan (EHCP). There are some services where there are inequalities in age groups serviced, e.g. Audiology where it is 0-16 Surrey-wide but up to age 18 in Surrey Downs. There needs to be consideration that the services are for young people who are school/education aged rather than school based in order to include those not in education or home schooled.	Commissioners to ensure there is a consistent and equitable offer across the population. This work will need to be done through the transformation phase of mobilisation. Children and young people's needs will be triaged by clinical and statutory requirements.
Disability	At the end of July 2022, there were 3,303 children aged 0-17 on the disability register. Since July 2018, there has been a year-on-year increase. The three most common disabilities for all five years have been: Diagnosed with Autism Spectrum Conditions, Behaviour, and Speech and Language Communication Needs (SLCN). The Joint Service Investigation/Review (Dec 2022) indicated that demand on services for children and young people with disabilities and additional needs continues to rise: • 30% increase in Education Health and Care Plans (EHCPs)	The practicalities should be considered of attending appointments for children and young people with disabilities, including access, travel etc. The new model proposes multi-disciplinary team working, multi-therapist appointments so that where possible, a single appointment can be offered for children with complex health needs who touch multiple services, giving ease of access and joined up care. Digital/hybrid options should also be considered where safe and appropriate to do so. Children and young people's needs will need to be triaged by clinical and statutory requirements.

Protected equality characteristic	Discuss & describe here the considerations and concerns in relation to the scheme/policy for each group.	Discuss & describe here suggested mitigations to inform the actions needed to reduce inequalities.
	and Special Education Needs and Disability (SEND) sufficiency planning impact; • Increase in cost of funding children's complex and continuing health care needs; including those post-surgery and with cancer; • Post covid impact on school readiness (continence; speech, language and communication needs; increased anxiety etc); If capacity in these services is not increased, waiting lists will increase further, and there will be a reduction or stop to universal support, training and provision. It may be that only children and young people in receipt of an EHCP will be able to access provision. This will perpetuate the myth that children and young people require an EHCP to access services and support, thereby driving higher demand for clinical services. The knock-on effect would be more requests for EHCPs because this would be seen by children and families, schools as the only way to access services. Non delivery of these activities would result in further tribunals and distress for families. Co-location of services is central to the service model to offer ease of access for families and reduce the need to travel long distances and to multiple locations. However, the financial envelope risks that with no investment put towards an estates strategy to support delivery of family hubs, wellbeing centres etc.	There will need to be system tolerance for longer waiting lists, and the risk of an increased need for medical intervention longer-term as a result. Communications and engagement with affected families and educational settings will be essential to manage expectations and signpost to alternative support whilst waiting or if not deemed to meet (possibly revised) criteria. Appointments may need to be delivered via digital/hybrid options, though this may disadvantage those families experiencing digital exclusion. Bringing leadership of Therapy services together will support using capacity (workforce and estates) more effectively. There will need to be additional funding to manage tribunals and rising complaints.

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Gender reassignment	Trans young people will be made to feel welcome with staff and in the services that they access. Equity of access will be assured for trans young people.	There will be training of key staff on inclusivity. Children and young people will be able to identify by their preferred gender (forms, questionnaires etc will need to reflect inclusive language), there will be inclusive language and imagery. There will be engagement with young people forums to continue to understand the needs of trans young people.
Marriage & civil partnership	N/a	N/a
Pregnancy & maternity	The 0-19 Healthy Child Programme includes an antenatal visit to ensure that families feel supported, with clearly stipulated expectations of the Health Visiting service. Young parents will receive a targeted offer from within universal service provision. Whilst some of the earliest new birth visits may be prioritised, this will be at the loss of other mandated checks that take place across a child's earliest years as the financial envelope does not support an increased workforce.	Joint planning with other related services such as Family Hubs and Place-based models for family support may help mitigate and ensure that across the system a consistent offer of support is provided to our more vulnerable families. Accessing direct support, information and advice online and through advice lines that may signpost to community support but not provide clinical overview will predominantly be the offer for children and young people requiring a lower level or universal help.
Race	Using 2011 Census estimates adjusted for the 2020 population, 115,118 (9.6%) of people in Surrey are from a minority ethnicity group that is not white. A further 6.9% of the population belong to other white ethnic groups; 'Irish', 'Gypsy or Irish Traveller' and 'other white'. A small proportion (0.2%) of the population (2,400 people) described themselves as Gypsy or Irish Traveller, making it the smallest reported ethnic category (with a tick box) in the 2011 census. However, it is widely believed that the Gypsy, Roma and Traveller (GRT) community is under reported in the Census. GRT	System translation services will need to be bolstered to support the provider and help them to reduce spend in this area. There will need to be easy-read materials available, possibly translated into multiple languages. Imagery use will be inclusive of different backgrounds and ethnicities. There will need to be ongoing consideration of the emerging physical and mental health needs of Asylum-seeking families

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	communities have the poorest health outcomes of any ethnic groups, not only in the UK but internationally. Language is very important in communicating health information, and may be a barrier to understanding, in populations where proficiency in English is not as high as others. The Surrey system is currently supporting the Home Office in provision of services to asylum seeking families and individuals and the Afghan refugee resettlement programme. There needs to be consideration of migrants and refugees with missing immunisations - need to ensure all immunisations are offered in order to avoid vaccine preventable diseases.	and individuals to ensure they are given additional support to equitably access universal services. From a wider system perspective, capacity in both primary care and the school-age Immunisation Service should be considered, to ensure the vaccination offer for 0-19s is robust.
Religion & beliefs	Religion and beliefs can influence attitudes towards medicine and health care there can also be concerns about discrimination that affect trust about how people of different religions and beliefs would be treated in different health care settings. For example, there is flu vaccine hesitancy within Muslim communities due to the ingredients of vaccines determining whether they are permissible or not. Known preference is for the cell-based vaccine, but this is often available later in the flu season than the egg-based vaccine (eg the eggs would need to be confirmed as being from a halal chicken – the egg-based vaccine also contains porcine gelatine). Similar considerations apply for the MMR vaccination.	The provider will need to be respectful of people's religions and beliefs e.g. dietary requirements, religious holidays, vaccine preference. There will need to be robust processes in place to ensure all children and young people are offered vaccines equitably; especially where certain vaccines are not available until later in the season (eg cell-based flu vaccine). Families are supported to make informed choices by accessing www.nhs.uk, where ingredients contained within vaccines are listed, together with alternative choices. Families need to inform GPs in advance if requesting an alternative form of the vaccine to enable ordering in advance if/as appropriate. Communications with families should clearly stipulate where there are alternative options and how to access them.
Sex	There is no known evidence that people of different sexes have different needs when accessing the services.	Language and imagery use will be inclusive; not supporting traditional gender stereotypes.

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Sexual orientation	There is no known evidence that people with different sexual orientations have different needs when accessing the services.	Language and imagery use will be inclusive.

4.2 For this section, not every group will be relevant to your scheme or policy. Complete for those that apply.

Other groups / existing inequity	Describe here the considerations and concerns in relation to the scheme/policy.	Describe here suggested mitigations to inform the actions needed to reduce inequalities.
Children with additional needs	12,467 children and young people in Surrey have an Education Health Care Plan (EHCP). The most prevalent primary needs from 2-5 years are Autism (ASC) and Speech Language Communication Need (SLCN). It should be noted that many children will be identified as SLCN and will then subsequently receive a diagnosis of Autism. ASC and SLCN equate to over 78% of new EHCPs for children under 5 years of age. The Joint Service Investigation/Review (Dec 2022) identified that there has been a 30% increase in Education Health and Care Plans (EHCPs) and that there has been considerable post covid impact on school readiness (continence; speech, language and communication needs; increased anxiety etc). The financial envelope for 2023/24 and the resulting impact on service provision is being reviewed and will ultimately be agreed at the Surrey Heartlands ICS Exec Board. For the	The services will need to focus and prioritise children and young people with EHCPs. There will need to be more funding to cover complaints and tribunals as a result of delays in meeting statutory timelines for EHCPs. There will need to be communication to partner agencies regarding the changes to service provision and increase in demand on their services. The new model proposes an integrated additional needs service and a single pathway for children accessing multiple services to meet their needs in the most flexible way and use resources more

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	Therapy services, this may result in prioritising those children and young people with an EHCP; only assessing and providing treatment to children and young people whose GP is within Surrey and who access a Surrey specialist school setting. The risks for the new contract will be that children who access a Surrey school but live in a neighbouring county will not receive a therapy service during 2023/24. Harm will include delays in accessing therapy, risks of school staff working to out-of-date therapy plans, increased health inequalities, long term delays and harm to a child's development, increased presentations at primary care and A&E, and increased need for medicalised solutions. There is a risk of school being unable to meet children's health needs if the outreach element from the Specialist Schools Nurses (SSN) to satellite units and MLD schools is ceased in 2023/24. There is a risk that by potentially stopping transport staff training in 2023/24 for children who attend Severe Learning Disabilities (SLD) schools that children will become unwell on their journey to school requiring emergency intervention, The risk will result in more children requiring hospital admission, an increase in 999 calls, families losing faith in the school's ability to manage their child's health needs, or children and young people unable to attend school.	creatively. This model may mitigate some of the risk but will not mitigate all without additional funding. Make additional resources available online to these settings. Maintain therapies advice line for settings and expand to include questions from these schools Nursing / Consultant support to dentistry and optometry clinic visits. Surrey County Council is currently reprocuring the transport to school service.

Other groups / existing inequity	Describe here the considerations and concerns in relation to the scheme/policy.	Describe here suggested mitigations to inform the actions needed to reduce inequalities.
Children with complex health needs	There is a risk that equipment adjustments made by the Therapies services will cease in 2023/24, impacting children and young people into the future contract. The change of service that both Occupational Therapists and Physiotherapists currently provide within specialist school settings will delay children and young people from having their equipment adapted when they grow and when their needs change. This could result in children and young people with complex needs finding it difficult to access school (unable to use a standing frame, unable to sit at a table to eat) as the school will not be able to meet the child's needs whilst waiting for the adaptations. If the decision to apply a cap to the Orthotic service is agreed in the service year 2023/24, this will have an impact on children with complex health needs that may develop pain from ill-fitting orthotic devices. Without correct fitting, long-term harm will occur; having a knock-on effect on waiting lists in the future contract. If there is a decision to stop the phlebotomy element of the CCN service in 2023/24, this will result in increased demand for primary and acute care, with children and young people possibly being required to attend hospital for routine blood tests.	Schools to be upskilled to recognise pressure damage and to advise families to see their GP for treatment, support and referral to the Children's Community Nursing team. Millbrook Wheelchair Service to be required to provide all equipment adjustments. Equipment services to regularly visit school settings. There would need to be communication to school settings for them to understand how to contact Millbrook Wheelchair Service. There would need to be communication to parents regarding how to access support for adjustments to their child's equipment. Orthotic referrals to be triaged and prioritised. Families to be signposted to self-help for orthotics once the cap has been reached. Sign post children, young people and families to other phlebotomy services

Other groups / existing inequity	Describe here the considerations and concerns in relation to the scheme/policy.	Describe here suggested mitigations to inform the actions needed to reduce inequalities.
	The new model initially included extended hours for the Community Nursing Service – moving from 5 days a week to 7, from 8am-8pm and 24/7 access for end-of-life care, life limiting and threatening conditions. Unfortunately, the financial envelope will not be able to fund this. The risk is that families will present at A&E and have long wait times in order to receive medical attention, risking that the children/young people become more unwell, and that more children/young people with complex and additional needs will experience delayed discharge from hospital. Future Proofing CCN services by the RCN (2020) recommends that there is flexibility in service provision to enable 24/7 care for children at the end of their lives. The service will not be able to provide this with the changes to service provision. NICE guidance – End of Life Care for Infants, Children and Young People with Life-Limiting Conditions: Planning and Management Guideline (2016) supports a flexible approach to care and a 24-hour service covering 7 days a week with adequate numbers of nurses to provide care. The new model also included the exploration of using virtual/hybrid wards. This initiative would need investment, which the financial envelope does not allow. This risks children/young people not being serviced as holistically and efficiently.	There is no mitigation for there not being extra hours for community nursing, although it is not a change from existing services. The extension to provision originally suggested reflected feedback from engagement with our population and wider system including primary care and acute provisions. Professionals and practitioners to work in a multi-disciplinary team approach. The proposed new model will not be able to mitigate fully against these risks.

Other groups / existing inequity	Describe here the considerations and concerns in relation to the scheme/policy.	Describe here suggested mitigations to inform the actions needed to reduce inequalities.
Children with continence needs	For the 2023/24 contract year, a decision may be taken to stop targeted early toileting advice and enuresis clinics for over 7s. There is a risk that this will have an impact on children's health and wellbeing and development (e.g. unable to attend sleepovers with friends, basic hygiene, potential for bullying) as more children will start school with early toileting issues and resulting in longer waiting lists into the new contract. There is a risk that by stopping continence support from Special School Nurses in 2023/24 in the form of toileting skills and support for families out of hours i.e. targeted workshops and school "open evenings / days that children will not develop the skills required in order for the child and family to manage their continence, an increase in continence product requirement, an increase in families feelings of isolation due to the perceived image of older children who are not continent. This will still be having an impact through to the life of the new contract.	Families will seek support from primary care and their child's school to manage nocturnal enuresis. Families to be directed to online support (eg ERIC UK – national charity dedicated to improving children's bladder and bowel health). Maintain the advice line and take queries through this route. Pick up wider continence support when seeing CYP otherwise. Upskill the wider workforce on the Best Start Strategy
Families with attachment difficulties including low mood, social isolation and health inequalities	There will be a risk of poor attachment impacting families in the new contract if a decision is made to reduce the baby massage offer in the service year 2023/24. Baby massage groups offer new parents (particularly those identified with low mood and poor attachment) an opportunity to interact with other new parents and build local support networks.	Triage and provide to most at risk families and those known to multiple organisations. Signpost to other voluntary sector support that is available and online help.

Other groups / existing inequity	Describe here the considerations and concerns in relation to the scheme/policy.	Describe here suggested mitigations to inform the actions needed to reduce inequalities.
	A reduction in offer will result in social isolation and the potential for increased mental health concerns for new parents. There is evidence linking the experience of poor attachment with poor outcomes in later life.	
Children with Asthma, Allergy and Epilepsy needs	If there is a decision to cease the core Asthma, Allergy and Epilepsy training for schools in 2023/24, this will reduce schools' confidence in managing health needs and may result in increased numbers of children and young people requiring support from ambulance services and acute providers. This reduction in training could also result in children and young people experiencing delayed discharge from hospital. There could be increased absences from school due to lack of parental confidence in the support that schools can offer to meet health needs, which has an interdependency for Surrey Healthy Schools. It also links with the Core 20 plus 5 which would not be met and is contrary to the wider system ambition of keeping children and young people well in their community setting. These impacts will be felt into the future contract.	Mainstream/routine training could be possible online. Face to face training needs would be less but necessary in some cases.
Armed forces	Service Families should not be disadvantaged because of their, or their family's lifestyle, choices and/or circumstances. However, the reach or ability to reach forces families may be more limited because of the financial envelope.	The new provider will need to take the new Armed Forces Covenant Duty 4 into consideration when supporting Service Families, along with opportunities to signpost to existing provisions. School-age Immunisation Service providers would need to include plans on how they would increase uptake and ensure records are maintained for forces children.

Other groups / existing inequity	Describe here the considerations and concerns in relation to the scheme/policy.	Describe here suggested mitigations to inform the actions needed to reduce inequalities.
		Any and all of the proposed service stoppages/reductions detailed within this EQIA will equally apply to service families. The proposed new model will not be able to mitigate all of these risks without additional funding.
Carers	Young carers will access community health services and will be supported through earlier identification. If services within schools and settings are reduced particularly within the universal offer, the identification of Young Carers will be more limited. This may result in Young Carers' needs to access services in a different way being missed.	The responsibility/duty of care to our Young Carers sits across the whole system; all are champions of Young Carers. As part of this, the Children's Community Health Services provider(s) will need to identify young carers and signpost to the relevant supporting services. Other initiatives such as Healthy Schools, Angel Award and more broadly schools and wider services in general will help to ensure that Young Carers are identified and supported to access services. Any and all of the proposed service stoppages/reductions detailed within this EQIA will equally apply to Young Carers. The proposed new model will not be able to mitigate all of these risks without additional funding.
Digital exclusion	Some parents/carers and families will have a range of digital exclusivity. As we move services to online support and remote appointments, for some children and young people there is likely to be an increase in inequity of access to services. Consideration also needs to be given to the learning from the pandemic; a 'blanket' increase in digital appointments may result in families needing additional (targeted) support being missed. This could result in for example an increased number of non-accidental injuries, particularly in non-mobile babies under the age of one.	Appointment letters will continue to be sent via the postal system. Digital reminders still to be explored. Face to face/phone appointments will need to be offered alongside any virtual appointments. Information needs to be available in print alongside digital/online access. Consent needs to be available by paper if digital consent cannot be taken.

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	Nationally, there is a strong push to move to digital notifications and it is believed that this will improve appointment attendance. Through engagement, young people and parents/carers expressed interest in appointment choice and the ability to amend appointment days/times. This will improve the patient experience; delivering more family-centric services; fitting around the needs of busy families and may help to reduce the current Did Not Attend/Was Not Brought rates. The financial envelope does not include additional funding to support the exploration/pump priming of this digital element, risking that families find it difficult to attend appointments.	Services will assess families for digital exclusivity during the triage process.
Domestic abuse within families and Non-Accidental Injuries to Children and Young People	There may unfortunately be cases of domestic abuse and suspected non-accidental injuries within families that access community health services. As we move to online support and remote appointments, this will decrease opportunities for observations and to ask safeguarding questions relating to children and young people and the family. Post Covid19, the National Domestic Abuse helpline saw a 25% increase in the number of contacts requesting support from what is categorised as woman and men who have not been identified previously with domestic abuse issues.	The provider will need to Make Every Contact Count (MECC) and ensure there is a robust system for identifying Domestic Abuse (DA) and suspected Non-Accidental Injuries to children and young people. Provider(s) will need to ensure that there is a robust referral pathway to Outreach services when DA is disclosed, and that safeguarding policies/processes are strictly adhered to. The increased need will impact on other provider services – social care, education, primary care and acute providers, Early Help.
Looked after children	Some of the Children Looked After Pathways (CLA) as part of the Developmental Paediatrics service may cease in 2023/24 due to the financial envelope. There is a statutory requirement for a whole partnership approach to completing initial health assessments for newly looked after children	Families will seek support from primary care, education, acute providers and the voluntary sector. Young people to be able to consent to vaccinations themselves under 'Gillick competence' particularly where there are barriers obtaining consent from parents.

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	(including unaccompanied asylum-seeking children). In the absence of paediatric delivery, the timeliness of those assessments of unidentified health needs being completed is likely to be compromised. Given the requirement for medically trained staff to deliver this function, it is likely to result in increased demand on GP time or acute paediatricians. Families and partners across the system may also look to Primary Care where there are unmet health needs emerging. The statutory responsibilities for the local authority are therefore likely to be compromised and will have an impact into the future contract. The newly designed model initially included Specialist Nurses for Looked After Children. However, the financial envelope will not support the additional workforce for these roles. The statutory guidance: 'Promoting the Health of Looked after Children' (March 2015) states that CCG's, now ICB's, have a role in commissioning health provision considering the specific requirements for children and young people identified as Care Leavers in the Leaving Care Act (2000). They are required to ensure that plans are in place to enable children and young people leaving care to continue to obtain the healthcare they need and that arrangements are in place to ensure a smooth transition for Looked-After Children and Care Leavers moving from child to adult health services. Reducing health inequalities for this cohort is set out in Surrey Heartlands ICB Joint Forward Plan and the draft	If these proposed stoppages/reductions are agreed, the new model will be very limited in the level of possible mitigation of risk.

Other groups / existing inequity	Describe here the considerations and concerns in relation to the scheme/policy.	Describe here suggested mitigations to inform the actions needed to reduce inequalities.
	Looked After Children and Care Leavers Health Partnership Strategy. There is currently no service provision for the physical or emotional health needs of Care Leavers post 18 years. Current capacity and demand, with anticipated growth in the looked after child population leaves no room for developing a role such as this within the current workforce.	
Rural/urban geographies	Co-location of services is central to the service model to offer ease of access for families and reduce the needs to travel long distances and to multiple locations. However, the financial envelope risks that with no investment put towards an estates strategy to support delivery in Place locations of family hubs, wellbeing centres etc, this will not be delivered.	The provider will need to consider the practicalities of making appointments and delivering services within people's communities and neighbourhoods. Where possible, they will be co-located with other services and people won't need to travel long distances for appointments. There will be the opportunity for virtual appointments to be made available where clinically appropriate. The proposed new model will mitigate some of these risks, but not all.
Socioeconomic disadvantage	There is considerable variation in deprivation in Surrey, with over 23,000 children living in poverty, which is linked to poor health and wellbeing outcomes for them and their families. Surrey's Health & Wellbeing Strategy has identified priority populations and 21 priority areas. The NHS's Core20Plus also needs to be met. There are long waiting lists for services with children, young people and their families having to wait a long time to access services and receive support. Some families may choose to access private supervision and support in place of the	Limited mitigation possible due to workforce already holding higher than expected caseloads. Universal offer and free resources to be delivered where possible. The provider(s) will ensure that there is a regular check-in with families on waiting lists, to assess if their needs have changed, carry out harm reviews and ensure families are linked with any available voluntary/community sector support (as appropriate) in the interim.

Other groups / existing inequity	Describe here the considerations and concerns in relation to the scheme/policy.	Describe here suggested mitigations to inform the actions needed to reduce inequalities.
	community health services but children and young people who are disadvantaged socioeconomically won't have the same opportunities, resulting in poorer outcomes. There is often poorer attendance at schools for those from communities of socioeconomic disadvantage and this has an impact upon accessing immunisations sessions in schools. With the current financial climate, many families will be experiencing challenges with debt; this can have far reaching impacts for children, young people and the family unit including food deprivation, housing issues, etc. This will also increase the risk of children and young people experiencing one or more of the adverse childhood experiences (ACEs) such as substance misuse, domestic violence, child abuse/neglect, etc.	
Secondary school students	If a decision is made to cease directly delivered PHSE support in 2023/24 then there is a risk of an increase in STI's, teenage pregnancy, risk of grooming and sexual exploitation, understanding healthy relationships, vulnerability to County Lines and poor decision making, where the impact will be felt into the new contract.	Education settings could lead on PHSE for pupils and refer to Surrey Healthy Schools guidance. Share lesson plans to support delivery of these sessions in school.
Youth Offenders	If there is a reduction to the youth offending service in 2023/24, there is the risk of health inequalities widening for youth offenders, impacting the new contract as well.	Links to be made with the voluntary and community sector.

Other groups / existing inequity	Describe here the considerations and concerns in relation to the scheme/policy.	Describe here suggested mitigations to inform the actions needed to reduce inequalities.
	The new model proposed additional supporting roles in the service, but the financial envelope will not fund this. Engagement will lower and Young People Not in Education, Employment or Training (NEET) outcomes will reduce.	
Children with safeguarding concerns	Risk of not picking up on children's and families' vulnerabilities due to the 0-19 service providing more virtual appointments. This includes domestic abuse, mental health concerns and child safeguarding concerns. Stopping the universal "transfer-in" approach for over 1's will increase families' levels of vulnerability and families have the potential to "slip through the net." The transfer-in review is a chance for the Health Visiting service to identify unmet need and vulnerabilities to a child and family within a new area. If safeguarding support is stopped for independent schools in 2023/24, there is a risk that there will further safeguarding concerns that aren't picked up and problems are further exacerbated by lack of/reduced support. This will have a knock-on impact on families into the new contract.	Any family identified at the new birth visit as requiring to be part of the more targeted Universal Plus and Universal Plus Plus caseloads will continue to receive face to face mandated visits where staffing allows. All new birth visits to be face to face. Children and families will continue to move between caseloads dependant on need. Families to be directed to the local offer of support – voluntary agencies, on-line support, website, advice line etc. Over 1's will be directed to online resources for the area, voluntary agencies etc.
Paediatric Nutrition and Dietetics Service	A decision may be made to cease the Surrey Downs-only commissioned Dietetics service for community clinic and Home Enteral Feeding (HEF) in 2023/24.	Primary care to support regarding allergy in the interim. Communication to be shared with partners – schools, social care of the changed offer to services, including how to escalate concerns.

Other groups / existing inequity	Describe here the considerations and concerns in relation to the scheme/policy.	Describe here suggested mitigations to inform the actions needed to reduce inequalities.
	It is currently not in scope for the new contract and alternative provision is being found. There will be the following impact on children and young people if there is a gap in service delivery: There is a risk of children not receiving adequate nutritional requirements, food intake and growth if the dietetic service is stopped. There is a risk that children will be waiting longer for appointments, with increasing numbers of children waiting over 18 weeks. There is a risk that children who are waiting for allergy testing will be further delayed which impacts on a child and families' quality of life eg difficulty with mealtimes at nursery/school, food avoidance, social isolation etc. There is a risk of children with a suspected cow's milk allergy not receiving the correct treatment as per NICE guidance. The guided elimination diet and slow re-introduction diet is guided by a dietician and paediatrician and would not happen if their service is unavailable. There is a risk that children who are enterally fed will no longer have a dietician to monitor their feeding regime, prescribe new feeding regimes dependant on each child's requirements.	Acute care to provide support with enteral feeding in the interim as is the practice within all other areas of Surrey. Surrey Downs are currently exploring options for alternative service provision after the first 12 months of the new contract. Group appointments to be offered to manage the waiting list.

Other groups / existing inequity	Describe here the considerations and concerns in relation to the scheme/policy.	Describe here suggested mitigations to inform the actions needed to reduce inequalities.
	The number of children and young people waiting over 18 weeks will increase. This is due to the following issues: ○ The service is insufficiently funded, resulting in a cost pressure for the provider. ○ Workforce recruitment/retention challenges have led to the service being staffed predominantly by temporary staff. This leaves the service vulnerable to staff leaving without the requirement for notice periods, etc.	
Musculo skeletal service	There may be a decision to stop the MSK pathway in East Surrey in 2023/24. It is currently not in scope for the new contract and alternative provision is being found. The East Surrey service will need to be commissioned and delivered elsewhere otherwise there is a significant risk that these children will be left without a service for their MSK needs. Children and young people across Surrey receive MSK services from Acute Hospital Trusts. The impact on children and young people from this model of delivery is that the MSK pathways are delivered by an all-age team rather than by paediatric specialists. Currently, MSK children and young people are often deprioritised within the wider physiotherapy wait list. The MSK caseload has remained static but is alongside an ever-increasing list of complex needs children. This means that	The service will need to be commissioned and delivered elsewhere from 1 April 2025 with no gap in service delivery otherwise there is a risk that these children will be left without this service. Commissioners are working with colleagues in East Surrey Place to support this. Virtual appointments/support to be offered whilst waiting.

Other groups / existing inequity	Describe here the considerations and concerns in relation to the scheme/policy.	Describe here suggested mitigations to inform the actions needed to reduce inequalities.
	children will be waiting increasingly longer times for routine-type appointments.	
Children's continuing care service	Currently, children and young people are having to wait longer and there is not sufficient staffing, making it difficult to meet the levels of care required.	This would be mitigated through the preferred following option: Core block contract with a single provider for physical health services minimum 600 hours with incentivisation mechanism for the provider to expand the service (delivering more hours). With the ICB developing a brokerage function to manage additional care hours. This would hopefully mean that there is a core level of delivery from the provider but more flexibility around the edges.

5. Quality Impact Assessment *(see Appendix 2 for notes on definitions and Appendix 3 for how to calculate Risk Score)*

Note: Whilst the outcome may be similar, you need to tailor your response and rationale to each section. Do not enter the same answer for every row.

Area	Positive Impacts: Describe the positive impacts your scheme could have on each area.	Negative Impacts: Describe the negative impacts your scheme could have on each area (base this on if you have no mitigations/plans in place).	Risk Score *Appendix 3* (for negative impacts)	Suggested mitigations:
Patient Safety:	The service currently experiences a positive degree of patient safety. Increased capability to understand and navigate this service and the totality of Children's Services as a result of closer working with the Surrey Children's EWMH pathway, SEND pathway and the Early Help programme. The EWMH Service includes the appointment of a senior System Steward role, working across all Children's services	The financial envelope available for the services means that there could be unmanageable caseloads and complexity resulting in a risk of increased serious incidents.	12	The required standards will be stipulated in the service specifications, and bidders will be required to share their policies as appropriate (eg safeguarding). TUPE may be applicable and bidders will be evaluated on their mobilisation, transition and operational plans, infrastructure etc. Escalation to Exec Level may be required to review any estate rationalisation across the ICS.

	pathways to eliminate repetition and support providers in maximising common and consistent approaches.			
Staff Safety:	Staff training, as well as access to employee support services as appropriate will be championed by the provider(s) to help keep staff safe and supported. The provision of a Freedom to Speak Up Guardian within the provider will also continue. These will continue to be measured via our regular contract review monitoring cycles, along with attrition rates, reasons for sickness, reasons for leaving, etc.	Financial envelope may result in less capacity in terms of workforce, resulting in higher caseloads for staff. Recruitment may be frozen. Higher caseloads, longer waiting times and services being provided in a different way e.g. digitally may result in families feeling frustrated; this may present as anger and/or aggressive behaviour towards staff. These negative impacts will adversely affect team morale and there may be an increase in staff sickness, burnout, moral injury, increased vacancy and loss of skill due to the reduced service and increased complexity of children who are not being identified early. Staff may be concerned that their professional	12	Provider policies (which will be robustly reviewed as part of the recommissioning process) will be utilised by the provider to ensure staff remain safe e.g. lone worker policy, reducing violence policy, quality and safety monitoring, health and wellbeing offer and training. Incident reporting to be upkept and zero tolerance to abuse directed at staff. Communication to families to be directed by communication teams giving clear guidance for families regarding how to complain.

		registrations will be compromised due to the changes in service provision and fear of not providing the level of service provision that they have been used to. Staff may be concerned that the lack of service provision will mean that they are performance managed. There may also be a reputational risk to the Provider(s) as a result; this may then be reflected in further recruitment challenges.		
Clinical Effectiveness:	The service model will seek to offer a personalised agenda with services offered around the child and family appropriate to their age and life stage. A fluid pathway with a simplified referral, step up and step down process is being sought. The service will be developed in direct response to user and other	Longitudinal outcomes for children (increase in complexity and levels of need for both children and families) and young people within Surrey will lower due in part to increased waits, not meeting criteria and therefore not eligible for some services, virtual appointments, not being seen or heard.	12	Support from enabling services to formulate, deliver and monitor actions required to achieve compliance. Support from enabling services to take a QI approach to audits and improvement. Clear support and communication re the changes in service provision and why

	stakeholder insight and engagement; all services will focus on reducing health inequalities for children and young people.	Reduction in compliance with NICE guidance and quality standards and development of care pathways. Reduction in audit activity due to the limited capacity of clinicians to undertake and implement audit actions. Risk to partner agencies/services from reduced capacity and service offer – schools being required to cover school readiness, increase in demand to GP practices for support and advice, increase in hospital attendance, complexity of safeguarding referrals due to late identification of need.		
Patient Experience:	The service model will seek to offer a personalised agenda with services offered around the child and family	Children, young people and families may receive services in a different way eg digital, experience longer waiting times and frustration as a result.	12	The new model may mitigate some of these areas but may not be able to mitigate all due to funding/capacity.

	appropriate to their age and life stage. A fluid pathway with a simplified referral, step up and step-down process is being sought. Commissioners will investigate the adoption of a Single Point of Access; this may be incorporated into existing provision from alternate Surrey children's services such as the C-SPA or the EWMH SPA (plans to join these are underway). The service will be developed in direct response to user and other stakeholder insight and engagement; all services will focus on reducing health inequalities for children and young people.	Some families may experience digital and/or travel exclusion; this could impact on how they are able to access services. The impact of the funding on workforce capacity may mean that some services cannot be provided face to face locally in some areas. For children and young people with complex needs, this may negatively impact on travel time required and result in increased time away from education.		
Staff Experience:	Providing services in a more joined up way, aligning across the system, applying the principles of Making Every Contact Count and wrapping around children and young people in the community will bring	Financial envelope may result in less capacity in terms of workforce, resulting in higher caseloads for staff. Higher caseloads, longer waiting times and services being provided in a different way eg digitally may result in	12	The new model may mitigate some of these negative impacts. Staff who are at least partly colocated and/or working as part of a wider multi-disciplinary team will feel more connected and supported to their peers, their team and the wider system. Provider policies (which will be robustly reviewed as part of the recommissioning process) will be utilised by the provider to ensure staff remain safe eg lone worker policy, reducing violence policy, quality and safety monitoring, and training.

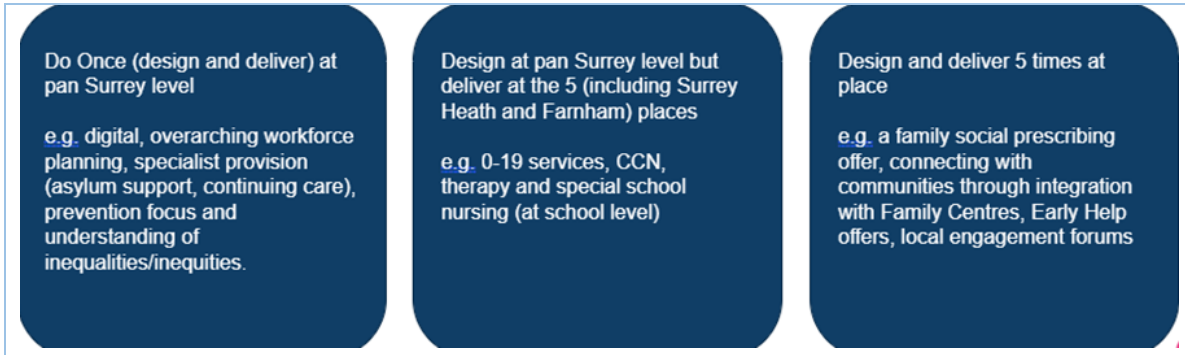
	greater job satisfaction to staff. This may reduce levels of staff sickness and increase recruitment and retention. Staff training, as well as access to employee support services as appropriate will be championed by the provider(s) to help keep staff safe and supported. The provision of a Freedom to Speak Up Guardian within the provider will also continue. These will continue to be measured via our regular contract review monitoring cycles, along with attrition rates, reasons for sickness, reasons for leaving, etc.	families feeling frustrated; this may present as anger and/or aggressive behaviour towards staff. These negative impacts may lead to increased levels of sickness, burnout and attrition. There may also be a reputational risk to the Provider(s) as a result; this may then be reflected in further recruitment challenges.		
Organisation Experience:	The Provider(s) will be an integral part of the wider system provision to meet the needs of children and young people. This will ensure closer networks and relationships across the system, sharing learning, support, etc and ultimately improving the experience for staff and our population. This will	The funding envelope for the new model may result in less capacity eg workforce to provide services. This could have a negative impact on the wider system, as the unmet need would impact on other areas eg acute services, primary care, etc. This may result in tensions between provider organisations, with the risk of	12	The new model reflects the funding envelope; this may be able to mitigate some of these challenges but not all. Provider(s) will need to ensure they have positive networks and relationships to enable collaborative system working. Provider(s) will need to ensure that service provision and access is clearly articulated to families, carers, referrers (including 111) and the wider system eg via communications, website, Directory of Services, etc.

	also lead to improved outcomes and life chances for our children and young people.	the needs of children and young people not being met appropriately. There may also be a negative reputational risk to the provider(s) as a result.		

6. Detailed Quality Impact Assessment *(Delete if not required)*

This additional more detailed quality impact assessment **should only be completed** if the initial quality impact assessment indicates a high risk (15 or above) in one or more areas. This detailed assessment along with the QEIA and business case should be submitted to the next available Quality and Performance Assurance Committee, to ensure scrutiny from a quality perspective.

1. Summary of strategy, policy, service(s) or function(s) being assessed:
Recommissioning of Children's Community Health Services, with the new contract to go live on 1 April 2025.
2. What are the benefits of approving this scheme?
The current contract is due to finish on 31 March 2025 and a new contract needs to be mobilised so that there is no gap in service delivery. The proposed model provides a framework against which services can be delivered and alignment with system ambitions for integration to be achieved, and will be delivered at scale, home, community and place where possible:



3. What are the high risks that have been identified in relation to this scheme?

1. Emerging needs and continued population demand remains unmet. Children and families will seek support from elsewhere including independent provision to fulfil statutory requirements within Education Health and Care Plan, primary and secondary care services for general health response.
2. Reduction or stop to earlier identification and support because focus will be on clinical demand and need.
3. Statutory responsibility - Risks to vulnerable groups of children (as detailed in previous sections)
4. Move further toward only providing statutory assessment and care for children with additional (SEND) or complex needs. Knock on effect would be more requests for EHCPs because this would be seen by children and families, schools as the only way to access services. Non delivery of these activities resulting in further tribunals and distress for families.
5. Financial envelope not attractive to current and any new providers.
6. Will not alleviate cost pressures from continuing care even if new model delivered (preferred option agreed)
7. Morale of the existing workforce is impacted, and retention becomes an increased challenge.
8. Reputational risk and quality of care.
9. Quality of care and caseload increase to levels that are deemed unsafe.

4. What can be put in place to mitigate these high risks?

1. Planning and understanding service delivery at different geographies (as per the proposed model) will help oversight of impact of the changes in different places and to different communities.
2. Limited mitigation possible due to workforce already holding higher than expected caseloads. The Inclusion Service that has previously supported unmet needs of emerging populations including asylum seeking families and Gypsy Roma travellers will no longer be directly

funded. Support will be offered through the Targeted aspect of the health visiting and school nursing services. The provider will need to manage balancing support to the wider population with delivery to these children and families.

3. Web based information, maintenance of Advice Lines.
4. System tolerates longer waiting lists and not being in statutory timeframes. System tolerates out of contract funding requirements for children's whose needs and provision are described within a statutory plan.
5. Test at market and through potential dialogue approach to contract award. Detail what is deliverable / prioritised – commissioners and provider together.
6. Go out as separate LOT for children's continuing care. Separate some of the financial risk from the provider by resourcing separately under a framework or other arrangement.
7. Clarity on priorities for delivery, support provider in stopping activity and build 'Thrive' type approach for wider support from the system (primary care, schools, social care).
8. Ensure potential gaps in service are identified and mitigated against where possible

5. After mitigation, what risks would remain?

- High caseloads
- Longer waiting lists and not being seen within statutory timeframes
- Not being able to deliver provision described within a statutory plan and the system tolerating out of contract funding
- Possible and potential harm due to delay in service to children and young people and also caseload for the provider workforce.

6. What are the risks if this scheme is not approved?

The procurement will breach contractual limits and system may need to enact emergency powers to maintain current service delivery.

7. Action plan and monitoring arrangements

Mitigations need to be taken forward for action. Include these in your overall programme or policy management and development procedures, you do not need to detail them here.

These are included within our risks.

8. Recommendation

Based on your assessment, please indicate which course of action you are recommending to decision makers. **You should explain your recommendation in the blank box below.**

Outcome No.	Description	Tick
Outcome One (NB this outcome is rare)	**No major change to the service/function/policy required.** This QEIA has not identified **any** potential for discrimination or negative impact, and all opportunities to promote equality have been undertaken. Proceed and review QEIA periodically.	☐
Outcome Two	**Adjust the service/function/policy** to remove barriers identified by the QEIA or better advance equality. Are you satisfied that the proposed adjustments would remove the barriers you identified? Proceed with adjustments, amend and review QEIA periodically.	☐
Outcome Three	**Continue with the service/function/policy** despite potential for negative impact or missed opportunities to advance equality identified. You will need to make sure the QEIA clearly sets out the justifications for continuing with it. You need to consider whether there are: • Sufficient plans to stop or minimise the negative impact • Mitigating actions for any remaining negative impacts and plans to monitor the actual impact. Proceed, monitor, and evaluate. Discuss with SRO.	☒
Outcome Four	**Stop and rethink** the service change/proposal/policy when the QEIA shows actual or potential unlawful discrimination. Review with the SRO for this area of work within 28 days of completion of QEIA.	☐
Rationale	The re-procurement is expected to deliver a safe, high quality and cost-effective Children's Community Service to the Children, Young People, parents and carers in Surrey and areas of Frimley that are included in the contract. It needs to go ahead due to the current contract coming to an end on 31 March 2024. The service is aiming to enhance the experience of users, staff and other stakeholders and where necessary/required and will enable improved transition to other children's services and adult services as appropriate. The holistic approach of the new model places it in a key position to effectively meet the needs of children and young people as part of our wider system.	

Signed (director / senior responsible officer)	**Signature**:	**Date:** 08/08/2023
	Job title: **Recommissioning Programme Board**	**Organisation: Other**