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Recommissioning of Advocacy Services in Surrey

Did you use the EIA Screening Tool?

No

1. Explaining the matter being assessed

Is this a:

- A new service or function

Summarise the strategy, policy, service(s), or function(s) being assessed. Describe current status followed by any changes that stakeholders would experience.

Surrey County Council (SCC) is the lead commissioner (working in partnership with Surrey Heartlands on behalf of all Surrey CCGs, and Public Health Surrey) responsible for commissioning advocacy services for Surrey.

The commissioning environment is complex with accountabilities and responsibilities shared between SCC (ACS, Children's Services, Public Health) and NHS. Surrey County Council is contracting one or more providers to deliver:

- Adult non-instructed advocacy services
- Adult instructed advocacy services
- Children's non-instructed and instructed advocacy

Eligibility for advocacy includes statutory and discretionary elements arising from a raft of legislation and statutory guidance outlined in the section entitled "Who is affected by the proposals section of this EIA". However, broadly speaking, SCC is seeking to re-commission the following:

Non-Instructed Advocacy: Statutory Advocacy for people who lack mental capacity (Independent Mental Capacity Advocates - IMCAs) subject to the Mental Capacity Act, including Deprivation of Liberty Safeguards (DOLS) and non-instructed Care Act advocacy.

The statutory requirements from the MC Act 2005, SCC has a statutory duty to provide IMCA's in certain situations such as Accommodation moves, Serious Medical Treatment, Paid Representatives (for DOLS) and from Care Act 20214, where someone has substantial difficulty in engaging with the assessment or review process and does not have an appropriate person who is willing and able to support them.

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Instructed Advocacy: Statutory Advocacy for people who are detained under the Mental Health Act (Independent Mental Health Advocates – IMHAs) - in line with statutory legislation and will include those detained under Part 2 of the Mental Health Act such as those under section, guardianship, community treatment order (CTO) or Part 3 of the Mental Health Act such as those under section 37/41, 47 and 48, and additionally:

- People in Prison or approved premises (in line with statutory legislation and best practice guidance and includes Care Act advocacy)
- Young people aged 16 and 17 years detained under the Mental Health Act.
- People who have substantial difficulty understanding: (in line with statutory legislation and best practice guidance and will include Care Act advocacy, safeguarding support and young carer's assessment. It will apply equally to carers in accordance with the parity they are given in the Care Act.
- Care Act advocacy for young people (in line with statutory legislation and best practice) for young people moving from Children's to adult's services.

In addition, the instructed advocacy specification includes non- statutory/discretionary advocacy to people at risk and who require preventative support in line with best practice for those:

- accessing mental health services
- receiving substance misuse support
- living with a long-term condition or diagnosis, such as HIV
- with care and support needs who have difficulty understanding or retaining information and are at high risk of an escalation in care needs if preventative measures are not taken.

All other residents in Surrey, with or without care and support needs, can access the general information and advice services provided within Surrey under the Care Act duty, and the advocacy provider(s) have a duty to signpost individuals not eligible for advocacy support to other information and advice support options.

Advocacy for Children and Young People: Surrey County Council (SCC) has a statutory duty under Children Act 1989, Children Leaving Care Act 2000, Adoption and Children Act 2002, Children and Families Act 2014, Care Planning, Placement and Review Regulations 2010, to offer an independent advocacy service to Looked After Children (LAC). The main purpose is to empower and enable young people to have a voice through the delivery of independent information, advice, support and advocacy and provides a confidential opportunity for Children and Young People (C&YP) to share information and concerns about their care or treatment, awareness rights and access to independent representation. This duty is detailed in the Adoption and Children Act 2002 and Children Act 1989 and Article 12 of the UN Convention on the Rights of the Child which upholds children's rights to participation in decision-making about matters of concern to them.

SCC has a duty to provide advocacy services to care leavers making or intending to make representation under section 24D, and for children making or intending to make a representation under section 26 of the Children Act 1989.

Children's Advocacy for Children and young people living within and outside of Surrey applies if they are;

a) Looked after
b) Care leavers
c) going through child protection procedures

It also applies if Children and young people are living within and outside of Surrey, with Special Educational Needs and Disabilities who are;

a) over the age of 16, with an Education, Health & Care Plan (EHCP),

b) any age, with an EHCP and English as an Additional Language,

c) under 16, with an EHCP, with no parent capable of advocating on their behalf

SCC also has responsibilities to children detained under the MHA. At present the service is being delivered by a 3rd sector group however it is not fully understood how this is monitored and whether this satisfies need. The new tender requests that consideration is given to meeting this requirement, where required, by the successful bidder.

Why does this EIA need to be completed?

As per the Equality Act 2010, carrying out an EIA helps us understand the implications of policies and decisions on people with protected characteristics. The Advocacy contracts are being recommissioned.

Who is affected by the proposals outlined above?

Demands for advocacy (both statutory and discretionary) are placed on the Council and its partners and applies to a range of age groups, needs and people living or placed in a range of settings home, hospital, prison for example, including children, young people in transition to adult services, older people, adults with disabilities, including carers, those with sensory impairments, learning difficulties, autism, physically disabled and those with mental health issues and individuals with limited capacity (for example, with Dementia or an acquired head injury).

The service is available to any resident (that meets eligibility criteria) living in Surrey and to non-residents detained in Surrey mental health facilities under relevant sections of the Mental Health Act or committed to Surrey based prisons.

How does your service proposal support the outcomes in the Community Vision for Surrey 2030?

"By 2030 we want Surrey to be a uniquely special place where everyone has a great start to life, people live healthy and fulfilling lives, are enabled to achieve their full potential and contribute to their community, and no one is left behind." – Community Vision for Surrey 2030.

Advocacy services will be expected to help achieve the Community Vision through supporting the following ambitions:

- Everyone lives healthy, active and fulfilling lives, and makes good choices about their wellbeing.
- Everyone gets the health and social care support and information they need at the right time and place.

Tacking Inequality – the advocacy Provider (s) must be prepared to deliver the service(s) to Surrey residents from a wide range of backgrounds ensuring residents with protected characteristics[1] are provided with equal opportunities to receive high quality support when needed.

More joined up health and social care – Advocacy supports partnership with the wider health and social care structure within Surrey.

[1] Equality Human Rights Commission - Protected Characteristics

Creating a greener future – Surrey County Council has declared a climate emergency. The Provider will need to respond to this by delivering the Service in an environmentally sustainable way, through the appropriate use of transport, efficient accessibility practices and through the minimisation of waste.

Embracing Surrey's Diversity – Advocacy supports people of all backgrounds and cultures and providers are required to treat everyone with respect; SCC representatives will set an expectation for people to do the same for anyone supporting them.

Partnership working – advocacy is an adjunct to the social care and health integrated system in Surrey, and in delivering the Service advocates will be expected to work closely and collaboratively with social care and/or health professionals.

Digital revolution – providers must utilise appropriate digital systems to track the delivery of the service in line with this specification and be prepared to use appropriate technology to engage with the people they support and social care and health partners

Are there any specific geographies in Surrey where this will make an impact?

- County-wide

Assessment team

- Mark Rapley, Commissioning Manager ACS Commissioning Manager, Health, Wellbeing & Social Care.
- Jim Poyser Senior Manager for MCA and DOLS Health, Wellbeing & Social Care.
- Natasha Garthwaite, Senior Commissioning Officer (Corporate Parenting)

2. Service Users / Residents

Age

Describe here the considerations and concerns in relation to the programme/policy for the selected group.

The Office for National Statistics (ONS) estimated that the resident population of Surrey at Mid 2020 is 1,199,870. There are an estimated:

- 71,000 children aged under 5 in Surrey (6.0% of the population)
- 175,300 children aged 5-16 (14.8% of the population)
- 105,100 people aged 17-24 making up almost a tenth of the population (8.9%)
- 611,700 people aged 25-64 making up just over half of the population (51.6%)
- 222,200 older people aged 65+, making up just under one in five (18.7%) of the population

Positive Impacts

- **Older people benefit from a single point of access to advocacy which will help to reduce social isolation and loneliness. Advocate support enables residents to engage with services.** Supporting evidence - Older people are more likely than their younger counterparts to suffer from loneliness or social isolation, particularly if they live alone and reside in locations set away from communities. While this is widely researched as an issue, the NHS website states the following [NHS loneliness-in-older-people]

Negative Impacts

- **Children subject to Mental Health Acts.** There is no minimum or maximum age criterion applied to eligibility for advocacy. Advocacy for children subject to mental health legislation has yet to be fully commissioned and this anomaly will be corrected by these arrangements.

Describe here suggested mitigations to inform the actions needed to reduce inequalities.

- Commissioning of specific children's advocacy service for children subject to MHA. Advocacy currently commissioned for adults is not appropriate for children by virtue of Childrens' different engagement and communication needs, their minority and competence of advocates trained to support adults.
- Use of KPI & performance data to identify usage by age profile and identify unmet need.

What other changes is the council planning/already in place that may affect the same groups of residents? Are there any dependencies decision makers need to be aware of?

The Older People's Commissioning programme – including the following areas of work:

- Review of the sourcing function for older people's care and support, including eligibility and referral processes.
- Recommissioning of Home-Based Care
- Recommissioning of Collaborative Reablement Services
- Discharge to assess and recovery planning

Surrey County Council operational practice amongst social care teams about the promotion of advocacy, will be crucial in supporting the usage of advocacy and is linked to the wider cultural shift of engaging with people through a strength-based approach to support them in their community.

Liberty Protection Safeguards (LPS).

- Government has passed the Mental Capacity (Amendment) Act 2019, and the Liberty Protection Safeguards are expected to be implemented at some point over the coming years. Implementation has been delayed several times already, and the latest planned date of 1st April 2022 has now been cancelled with no clear indication of a new date. This legislation places an onus on Local Authorities and NHS providers (when they are the Responsible Body for LPS either due to funding or their Hospital Status) to ensure that people who are subject to LPS but do not have an appropriate person to support them are allocated an IMCA to take on this role.

Any negative impacts that cannot be mitigated?

None known

Disability

Describe here the considerations and concerns in relation to the programme/policy for the selected group.

Disability is very broad conceptually and encompasses (frequently co-occurring with other conditions such as mental health for example) that impact on life experience and quality of life to some extent, such as:

- General learning disabilities
- Physical disabilities
- Communication and language needs
- Sensory difficulties
- Neurodevelopmental conditions (such as Autism)
- Specific learning difficulties (such as dyslexia and attention-deficit hyper-activity disorder)
- other conditions such as epilepsy

The 2001 Census asked people whether they suffered from a “limiting long-term illness, health problem or disability which limits daily activities or the work they can do, including problems that are due to old age.”
Wording in 2011 was slightly different:
“Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months, include problems related to old age” Respondents could choose “limited a little” or “limited a lot”

In 2011, 13.5% of residents reported a health problem, with 7.8% limited a little and 5.7% limited a lot. The overall proportion reporting a health problem was unchanged from 2001. The proportion of the population reporting a health problem is highest in Spelthorne (14.9%), Tandridge (14.8%) and Mole Valley (14.7%) and lowest in Elmbridge (12.1%).

Fewer Surrey residents reported a health problem than the national average. In England 17.6% reported a health problem with 9.3% limited a little and 8.3% limited a lot.

The likelihood of suffering from a long-term illness or disability increases with age. 78% of people over 85 reported a health problem compared with just 2.9% of children under 16.
All people with a disability should be eligible to receive advocacy services.

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Positive Impacts

- **Advocacy provides an approach to support people with a range of disabilities.** People with disabilities often find it difficult to make their voice heard and may experience barriers to accessing their human rights in areas such as health and wellbeing, housing, personal assistance, employment, finance and decision-making. Independent advocacy can promote choice, access, justice, and empowerment by helping people to have a stronger voice and address power imbalances. Source - Independent Advocacy Guide for Commissioners, Scottish Government (2013)

Negative Impacts

- None

Describe here suggested mitigations to inform the actions needed to reduce inequalities.

- Use of KPI & performance data to identify usage by disability profile and identify unmet need.

What other changes is the council planning/already in place that may affect the same groups of residents? Are there any dependencies decision makers need to be aware of?

As per those identified in the “Age” section.

Any negative impacts that cannot be mitigated?

None known

Gender Reassignment

Describe here the considerations and concerns in relation to the programme/policy for the selected group.

Population statistics on gender reassignment are very limited, particularly because the 2011 census did not collect information – the only question on gender was in relation to sex being male or female (source: [Office for National Statistics - Gender Identity]).

At present, there is no official estimate of the trans population. GIRES, in their Home Office funded study estimate the number of trans people in the UK to be between 300,000 – 500,000, defined as ‘a large reservoir of transgender people who experience some degree of gender variance’. Applying this percentage to the Surrey population would lead to an estimate of at least 7,000 trans people.

It is expected that this will change with the inclusion of a question on gender identity in the 2021 census, which will collect information on those whose gender is different from their sex assigned at birth. SCC Adult Social Care does not specifically record whether individuals are undergoing gender reassignment as a reportable aspect of their care records. There is therefore no current way to reliably calculate the number of people with this protected characteristic.

Positive Impacts

- **Gender fluid people will benefit from a single point of access to advocacy and help to reduce social isolation and improve access to services provided eligibility criteria are met.** Although not fully articulated currently, research data suggests that people with a diagnosis of autism are more likely to identify as transgender than in the general population, (the consultation responses for SCC All Age Autism strategy supports this) and researchers have suggested that autism may be under-diagnosed in gender-fluid people (UK Parliament Postnote #612, January 2020).

Negative Impacts

- **Risk of discrimination due to lack of awareness and training of people working with people seeking gender reassignment, reflecting what could be experienced elsewhere in society.** Ongoing stigma related to gender reassignment within society.

Describe here suggested mitigations to inform the actions needed to reduce inequalities.

- Collection of key performance (KPI) Management Information and demographic data will enhance support of gender fluid people.
- Advocacy providers will be expected to be responsive to the needs of people undergoing gender reassignment and support them without discrimination and ensure staff are appropriately trained/recruited under equal opportunities legislation.

What other changes is the council planning/already in place that may affect the same groups of residents? Are there any dependencies decision makers need to be aware of?

None known.

Any negative impacts that cannot be mitigated?

None known.

Pregnancy and Maternity

Describe here the considerations and concerns in relation to the programme/policy for the selected group.

Antenatal and postnatal mental health clinical management and service guidance (Nice 2015) suggests, ‘Pregnancy and the period from childbirth to the end of the first postnatal year comprises one of the most important times of a woman’s life, but for women with a mental health problem it can be difficult and distressing. In pregnancy and the postnatal period, women are vulnerable to having or developing the same range of mental health problems as other women, and the nature and course of majority of these problems are similar in women at other times of their lives. However, the nature and treatment of mental health problems in pregnancy and the postnatal period differ in several important respects not discussed here but clearly of importance in relation to impact of any mental health problem on the foetus/baby, the woman’s physical health and care, and her ability to function and care for her family.

In Surrey, Perinatal Mental Health has been recognised as a local issue for quite some time. As a result, the Adult Mental Health Strategy for Surrey and North East Hampshire 2014-2017 set out to prioritise the development of a Specialist Perinatal Mental Health service as one of its key outputs during the second and third year of implementation but this service has not been set up. It is also known that local specialist perinatal mental health services fall short of national standards and this is acknowledged in Surrey's Joint Emotional Wellbeing and Mental Health Commissioning Strategy for Children and Young People 2014-17. Currently mainstream services are providing all the care for women during the perinatal period and some roles and pathways have been developed specially to prioritise pregnant women or those with a baby. These include IAPT (Improving Access to Psychological Therapies) services, a parent and infant mental health service and recruitment of specialist mental health midwives in maternity services. Although there are many accounts where people have received good responsive care from these mainstream services, there are recorded incidents where general mental health services have not had the relevant specialist knowledge to manage medication, safeguarding assessments or timeliness of intervention for perinatal mental health issues and therefore the experience on these occasions have been poor.

Detention under the Mental Health Acts is a risk for some pregnant women, particularly those with pre-existing mental health conditions and it is therefore critical that advocacy services engage with this group. It is an anachronism that advocacy data does not reference this special characteristic and new contracts will specify this feature as part of management information requirements.

Positive Impacts

- **Pregnant women, particularly those subject to detention under the MHAs will benefit from a single point of access to advocacy which will help to reduce social isolation and improve access to services they are entitled to provided eligibility criteria are met.** NICE Antenatal and postnatal mental health clinical management and service guidance (2015).

Negative Impacts

- None

Describe here suggested mitigations to inform the actions needed to reduce inequalities.

- Collection of this demographic data will enhance support of pregnant women and maternity.

What other changes is the council planning/already in place that may affect the same groups of residents? Are there any dependencies decision makers need to be aware of?

Development of a Specialist Perinatal Mental Health services.

Any negative impacts that cannot be mitigated?

None known.

Race and Ethnicity

Describe here the considerations and concerns in relation to the programme/policy for the selected group.

In the 2011 census, 1,023,682 people (90.4 per cent of the population), reported their ethnic group as White in the 2011 Census. Within this ethnic group, White British was the largest, with 945,673 people (83.5 per cent), followed by those categorised as "Any Other White" with 62,736 people (5.5 per cent). Indian was the next largest single ethnic group with 20,232 people (1.8 per cent) followed by Pakistani (1.0 per cent). However, those categorised as "Other Asian" accounted for 1.7% of the population in total. There were two new tick boxes in the 2011 Census: Gypsy or Irish Traveller and Arab. Arab accounted for 4,101 usual residents (0.4 per cent of the population). Gypsy or Irish Traveller accounted for 2,261 usual residents (0.2 per cent of the population), making it the smallest ethnic category (with a tick box) in 2011.

In theory, all this population might access advocacy services provided they meet eligibility criteria, however, a better metric to use is eligible persons which in turn is derived from QPM/Annual reports -in 20-21 a total of 3915 people were supported during the year with the ethnic profile as illustrated below. (It should also be noted that this is not a complete picture, because some users of advocacy either refuse, or do not disclose their race and cannot be compelled to do so, therefore the table below is indicative rather than an absolute reflection of the racial characteristics in the snapshot)**.**

Ethnicity	Number
White (British/Irish/Other)	1,984
Black or Black British	76
Asian or Asian British	77
Chinese or other	64
Mixed (White/Asian, White/Black)	36
White Gypsy/Roma/Traveller	9
Ethnicity Refused	204
Ethnicity Not Yet Obtained	739

Positive Impacts

- **People from ethnic minorities will benefit from a single point of access to advocacy which will help to reduce social isolation and improve access to services they are entitled to provided eligibility criteria are met.** Rethink Mental Health (2019) states that "If you are from a Black, Asian or Minority Ethnic background, you may experience different rates of mental illness than the white population. Things like fear, stigma and lack of culturally sensitive treatment can act as barriers to accessing mental health care for people from BAME backgrounds. Further, rates of mental illness for people from Black, Asian and Minority Ethnic (BAME) backgrounds are sometimes greater than for white people, but more white people receive treatment for mental health issues than people from BAME backgrounds and they have better outcomes".

Negative Impacts

- **Risk of discrimination based on race/ethnicity due to lack of awareness and training of advocates, reflecting what could be experienced elsewhere in society.** Ongoing challenge in combating racism and discrimination within society, including in the delivery of care and support.

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Describe here suggested mitigations to inform the actions needed to reduce inequalities.

- Advocacy providers will be expected to be responsive to the needs of people regardless of race and support them without discrimination and ensure staff are appropriately trained/recruited under equal opportunities legislation.

What other changes is the council planning/already in place that may affect the same groups of residents? Are there any dependencies decision makers need to be aware of?

None known.

Any negative impacts that cannot be mitigated?

While racism will be challenged and investigated, less direct examples of discrimination would be very difficult to police through existing policies and procedures.

Religion or Belief (including lack of belief)

Describe here the considerations and concerns in relation to the programme/policy for the selected group.

As with the "Race" section above, while the Office for National Statistics Annual Population Survey has produced national statistics more recently, for a picture of religion or belief in Surrey the census figures for 2011 are regarded the only reliable source of information.

The Census asks people to state their religion. The question is voluntary and "no religion" is one of the options available. Christianity is the largest religion in Surrey with 711,110 people (62.8% of the population). 5% of the population (56,390) reported a Non-Christian religion. Within the Non-Christian religions, Muslim was the largest group with 24,378 people (2.2%) followed by Hindu with 15,018 people (1.3%). 24.8% of the population reported to have "no religion" and 7.4% did not answer the religion question.

All denominations might access advocacy services provided they meet eligibility criteria. An Illustrative summary of data relevant to Non- instructed advocacy is supplied in the appendix for information.

Positive Impacts

- **People who follow a specific religion or none will benefit from a single point of access to advocacy which will help to reduce social isolation and improve access to services they are entitled to provided eligibility criteria are met.** ECHR Article 9: Freedom of thought, conscience and religion states that everyone has the right to freedom of thought, conscience and religion and this freedom is subject only to such limitations as are prescribed by law and are necessary in a democratic society in the interests of public safety, for the protection of public order, health or morals, or for the protection of the rights and freedoms of others.

Negative Impacts

- **Risk of discrimination due to lack of awareness and training of people working with people of different religions or beliefs**. Ongoing challenge in combating racism and discrimination within society, including in the delivery of care and support

Describe here suggested mitigations to inform the actions needed to reduce inequalities.

- Providers are expected to be responsive to the needs of people regardless of religion or belief (including lack of belief) and support them without discrimination and ensure staff are appropriately trained under equal opportunities legislation.

What other changes is the council planning/already in place that may affect the same groups of residents? Are there any dependencies decision makers need to be aware of?

None known.

Any negative impacts that cannot be mitigated?

While abuse will of course be challenged and investigated, less direct examples of discrimination would be very difficult to police through existing policies and procedures.

Sex / Gender

Describe here the considerations and concerns in relation to the programme/policy for the selected group.

The Office for National Statistics subnational population projections, published in May 2018, indicates that of 1,189,934 people in Surrey, 584,230 are males and 605,704 females (49.1% or 50.9% respectively. In theory, all this population might access advocacy services provided they meet eligibility criteria.

Positive Impacts

- **Advocacy provision is managed in line with all Equalities legislation ensuring that all residents receive services and support appropriately and regardless of sex/gender.** Individuals' rights generally and regarding gender are protected under the Equality Act 2010.

Negative Impacts

- None known

Describe here suggested mitigations to inform the actions needed to reduce inequalities.

- Providers will be expected to deliver services in compliance with equalities legislation, including equal access to quality services for all, regardless of gender. Contracts will be regularly monitored to ensure compliance.

What other changes is the council planning/already in place that may affect the same groups of residents? Are there any dependencies decision makers need to be aware of?

None known.

Any negative impacts that cannot be mitigated?

While abuse will of course be challenged and investigated, less direct examples of discrimination would be very difficult to police through existing policies and procedures.

Sexual Orientation

Describe here the considerations and concerns in relation to the programme/policy for the selected group.

Office for National Statistics Annual Population Survey presents the following estimates for sexual orientation in the UK at 2019:

- The proportion of the UK population aged 16 years and over identifying as heterosexual or straight decreased from 94.6% in 2018 to 93.7% in 2019.
- An estimated 2.7% of the UK population aged 16 years and over identified as lesbian, gay or bisexual (LGB) in 2019, an increase from 2.2% in 2018.
- Between 2018 and 2019, the number of men identifying as LGB increased from 2.5% to 2.9% and women identifying as LGB increased from 2.0% to 2.5%.
- Younger people (aged 16 to 24 years) were most likely to identify as LGB in 2019 (6.6% of all 16 to 24-year olds, an increase from 4.4% in 2018); older people (aged 65 years and over) also showed an increase in those identifying as LGB, from 0.7% to 1.0% of this age category.
- Between 2018 and 2019, the proportion of people who identified as LGB increased for England (2.7%, up from 2.3%) and Scotland (2.7%, up from 2.0%), however Wales (2.9%) and Northern Ireland (1.3%) remained stable; among English regions, people in London were most likely to identify as LGB (3.8%, an increase from 2.8%).

The Integrated Household Survey asks a question on self-perceived sexual identity of adults in the UK. The 2014 survey showed 1.1% of the population nationally reporting as gay or lesbian (1.5% of men and 0.7% of women), 0.5% reporting as bisexual (0.3% of men and 0.7% of women) and 0.3% reporting an “other” option. However, 5.3% of the sample refused to answer the question or answered “don’t know” or no response was received.

The 2011 Census did not collect information on sexual orientation so there is little reliable data on the number of people in these groups in Surrey. The UK Government estimates that 6% of the population are lesbian, gay or bisexual. Applying this to mid-2015 population estimates for Surrey means that there may be 56,500 people aged 16+ and around 4,000 people aged 11 to 15 in Surrey who are lesbian, gay or bisexual. Data from the Census shows 0.7% of Surrey residents aged 16+ living in a same sex couple (in a registered civil partnership or cohabiting) compared with 0.9% nationally.

Source: Office for National Statistics - Sexual Identity

All people, irrespective of sexual orientation might access advocacy services provided they meet eligibility criteria. An illustrative summary of data relevant to Non- instructed advocacy is supplied in the appendix for information.

Positive Impacts

- **Advocacy provision is managed in line with all Equalities legislation ensuring that all residents receive services and support appropriately and regardless of sexual orientation**. Individuals’ rights in relation to sexual orientation are protected under the Equality Act 2010.

Negative Impacts

- None known

Describe here suggested mitigations to inform the actions needed to reduce inequalities.

- Providers will be expected to deliver services in compliance with equalities legislation, including equal access to quality services for all, regardless of sexual orientation. Contracts will be regularly monitored to ensure compliance.

What other changes is the council planning/already in place that may affect the same groups of residents? Are there any dependencies decision makers need to be aware of?

None known.

Any negative impacts that cannot be mitigated?

None known**.**

Carers

Describe here the considerations and concerns in relation to the programme/policy for the selected group.

Surrey -I (2020) identifies that 108,400 (9.6%) Surrey residents are providing unpaid care to a friend or relative. In addition, Surrey County Council's Joint Strategic Needs assessment on Adult Carers provides significant amounts of information on Adult Carers: Surreyi - Adult Carers

It states that the number of carers aged 65 and over living in Surrey is expected to increase by 17.6% from 2016 to 2025, while the number of carers aged 85 and over is expected to increase by 31.2% over the same period.

It is widely recognised that the census undercounted young carers. The 'Kids who Care' survey of over 4,000 school children, conducted for the BBC by the University of Nottingham in 2010, showed that one in twelve (8%) had caring responsibilities, equating to some 700,000 young carers in the UK – four times the number identified in the 2001 Census (175,000). Based on the projected population of young people aged 5-17 years, this suggests that in 2016 there may be approximately 14,750 young carers aged 5-17 living in Surrey and approximately 15,790 in 2025.

Locally, the proportion of carers who require an advocate is relatively low- this is in part because young carer data is not captured by adult advocacy providers and because adult carers are only eligible under the Care Act and not other provision such as MHA etc. This manifestation is represented below and compared with other eligible cohorts as an example.

Positive Impacts

- **Advocacy provision can enable people to continue to care for the person in need of care and support.** Carers' rights in relation to Advocacy are protected under the Care Act 2014 and Adult Social Care Strategy for Carers.
- **People will benefit from advocacy which will help to reduce social isolation and loneliness amongst people with caring responsibilities.** People with caring responsibilities are risk of suffering from loneliness or social isolation, and the availability of advocacy will help to mitigate this.

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Negative Impacts

- None known

Describe here suggested mitigations to inform the actions needed to reduce inequalities.

- Providers will be expected to deliver services in compliance with equalities legislation, including equal access to quality services for all, regardless of sexual orientation. Contracts will be regularly monitored to ensure compliance.

What other changes is the council planning/already in place that may affect the same groups of residents? Are there any dependencies decision makers need to be aware of?

The Adult Social Care Strategy for Carers, and development of carer friendly communities and the encouragement of carer aware health and social care provider services able to identify carers and refer them to sources of preventative support, including support for their psychological and social wellbeing.

Any negative impacts that cannot be mitigated?

None known.

3. Staff

This is a commissioned service, so there are no impacts for Surrey County Council staff with protected characteristics.

4. Recommendation

Based your assessment, please indicate which course of action you are recommending to decision makers. You should explain your recommendation below.

- **Outcome One: No major change to the policy/service/function required.** This EIA has not identified any potential for discrimination or negative impact, and all opportunities to promote equality have been undertaken
- **Outcome Two: Adjust the policy/service/function** to remove barriers identified by the EIA or better advance equality. Are you satisfied that the proposed adjustments will remove the barriers you identified?
- **Outcome Three: Continue the policy/service/function** despite potential for negative impact or missed opportunities to advance equality identified. You will need to make sure the EIA 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 plans to monitor the actual impact.
- **Outcome Four: Stop and rethink the policy** when the EIA shows actual or potential unlawful discrimination. (For guidance on what is unlawful discrimination, refer to the Equality and Human Rights Commission's guidance and Codes of Practice on the Equality Act concerning employment, goods and services and equal pay).

Recommended outcome:

Outcome One: No major change to the policy/service/function required.

Explanation:

Engagement will be needed with potential future residents of extra care, regarding:

- Cultural and faith needs
- Communication needs
- Maintaining dignity and respect
- Dietary requirements
- Accessibility requirements (e.g. the number of wheelchair accessible units required in various locations)
- How best to maintain an inclusive environment that maximises independence
- Referral routes for people interested in becoming an extra care resident

While this engagement will help to identify actions to respond to impacts identified in this EIA, it will allow the Extra Care Strategy Team to:

- Better understand current expectations for extra care in general
- Set clear guidance and objectives for housing managers and care providers delivering services at newly opened sites, and

Inform future approaches to promoting extra care settings to people with care and support needs living in Surrey

5. Action plan and monitoring arrangements

Item	Initiation Date	Action/Item	Person Actioning	Target Completion Date	Update/ Notes	Open/ Closed
1	2021	Commissioning of specific children's advocacy service for children subject to MHA. Advocacy currently commissioned for adults is not appropriate for children by virtue of Childrens' different engagement and communication needs, their minority and competence of advocates trained to support adults.	Children's Services	April 2022		
2	April 2022	Use of KPI & performance data to identify usage by age/disability/pregnancy and maternity/gender reassignment and identify unmet need.	Commissioning, Adult Social Care	Ongoing via quarterly information and performance data on-going during the lifespan of Advocacy contracts.		
3	April 2022	Advocacy providers will be expected to be responsive to the needs of people with protected characteristics to support them without discrimination and ensure staff are appropriately trained/recruited under equal opportunities legislation.	Commissioning, Adult Social Care	On-going during the lifespan of Advocacy contracts.		
4	April 2022	Providers will be expected to deliver services in compliance with equalities legislation, including equal access to quality services for all. Contracts will be regularly monitored to ensure compliance.	Commissioning, Adult Social Care	On-going during the lifespan of Advocacy contracts.		

6a. Version control

Version Number	Purpose/Change	Author	Date
V0.1	Initial draft	Mark Rapley	10/12/2021
V0.2	Amended from initial feedback	Mark Rapley & Jim Poyser	05/01/22
V0.3	Added Children's commissioning	Natasha Gathwaite	07/01/22
V0.4	Commissioning Manager Review	Dan Stoneman	18/01/22
V0.5	Review by Kathryn Pyper, on behalf ASC Directorate Equalities Group	Kathryn Pyper	23/02/2022

The above provides historical data about each update made to the Equality Impact Assessment.

Please include the name of the author, date and notes about changes made – so that you can refer to what changes have been made throughout this iterative process.

For further information, please see the EIA Guidance document on version control.

6b. Approval

Secure approval from the appropriate level of management based on nature of issue and scale of change being assessed.

Approved by	Date approved
Head of Service	
Executive Director	
Cabinet Member	
Directorate Equality Group	23 February 2022

6c. EIA Team

Name	Job Title	Organisation	Team Role
Mark Rapley	Commissioning Manager	SCC	Subject Matter Expert, ASC
Jim Poyser	Senior Manager	SCC	Subject Matter Expert, ASC
Natasha Gathwaite	Commissioning Officer	SCC	Subject Matter Expert, Children's
Dan Stoneman	Head of Commissioning	SCC	Review

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