

## Equality Impact Assessment Template (EqIA)

### Section 1: About the proposal, policy or project

**Name of proposal, policy, or project:**

Recommissioning of the following three contracts:

Lot 1: Universal and Targeted Services for Children (0-5) and their Parents

Lot 2: Best Start Service (0-5)

Lot 3: Healthy Child Programme (0-19)

**Name of lead officer and contact details:****Lot 1**

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**Name of service and directorate for this proposal, policy, or project:**

Public Health, Adults and Quality Assurance

Early Help, Children's Services

**Strategic Director responsible for this proposal, policy, or project:**

Marc Gadsby (Lots 2 & 3) & Nicky Crouch (Lot 1)

**Date the EqIA was started:**

01/11/2025

**What kind of proposal, policy or project is this assessment for?**

Tick all that apply.

- Change in service delivery or new service
- Change in policy or new policy
- Grants and commissioning
- Budget change or service cut
- Other  - if ticked, please give more detail: Click or tap here to enter text.

### Section 2: Proposal, policy, or project summary

**Please give a summary of this proposal, policy, or project**

Give brief details of:

- What the proposed decision or change is.
- The reasons for this decision or change.
- The outcomes you are hoping to achieve.

The proposed decision is to undertake a competitive procurement process under the Provider Selection Regime (PSR) to re-procure the Healthy Child Programme (0–19) and its associated contracts.

The current contracts are due to expire on 30 June 2027. A decision has therefore been taken to undertake a competitive tendering process to ensure that children and young people in the borough continue to receive high-quality, effective services that represent best value. The recommissioning process has supported a deeper understanding of the needs of children, young people and families, and has informed future commissioning priorities.

Based on a framework of proportionate universalism, the intention is for services to maintain a strong universal offer, while strengthening targeted support for families with the greatest level of need. It is anticipated that the recommissioned services will operate in a more integrated and accessible way, ensuring equitable access for all families and focused intervention where it is most required.

#### **Who will be affected by this proposal, policy, or project?**

For example: staff, service users, or the wider community

All Children and Young People aged 0-19 (0-25 for those with Special Educational Needs and/or a Disability) in the borough and their families.

Staff currently employed by the three organisations commissioned to deliver these services.

Partners across health and social care, schools and early years settings.

### **Section 3: Equality analysis**

This section asks you to consider the potential impact (both positive and negative) of the proposed proposal, policy or project on the protected characteristics and the mitigations that will be taken to avoid or counteract any negative impact identified. If no negative impact(s) has been identified for that group, briefly explain why this is not applicable.

**Please consider how the proposed change will affect staff, service users or members of the wider community who share one or more of the following protected characteristics. Think about what action(s) you can take to address their specific needs. In addition, you may wish to consider the short-, medium- and longer-term implications, intersectionality between the different characteristics, as well as mitigations that may be required.**

#### **Age**

This can refer to people who have, for example, a specific age, or who are in a specific age range.

**Will the proposed change have a differential impact [negative] on people of a specific age or age group (e.g. older or younger people)? If so, explain why this group may be affected and what mitigating actions will be taken.**

This contract is focused on services for 0-19 years (0-25 for children and young people with SEND), including support for parents and families in Waltham Forest. While continued services support positive outcomes for children and families, there are several considerations to note:

**i. Reduction in funding:** Funding has reduced for all three lots in real terms and in actual terms for Lot 1. Reductions in Lot 1 funding have resulted in a reduction of staff by the Lot 1 provider. This has led to the reduction of play sessions for children aged 0-5 years from 9am-6pm, from 9 sessions per week per hub to 6 sessions per week, meaning a reduction in footfall across our 4 family hubs.

**-Mitigating actions:**

- Family Hubs is now a national initiative, and we have been awarded funding for the next 3 years to deliver a 5% increase in 'Good Learning Development' for our 5-year-olds. This will result in the creation of targeted sessions and support for our families.

ii. **Resource allocation for 0-5 years versus 5 years+:** As per national guidance, most of the resource allocation focuses on the Health Visiting service. At present in Waltham Forest, we have approximately 1 school nurse per 5,500 children compared to the recommended ratio of 1 per 1,200 children (Royal College of Nursing guidance). Health visitor ratios are currently 1 WTE per 750 children (also significantly higher than the recommended 250). Noncompliance with recommended ratios has been noted as a risk for service quality in both cases, but particularly in the case of school nursing there is a question mark around the ability to deliver meaningful intervention at existing service provision ratios. Research has shown parents and children often don't know what the school nursing service offers (e.g., mental health support, healthy weight, immunisations). Historically, expectations on school nurses to attend all safeguarding meetings constrained their capacity to offer preventative health and wellbeing support before issues escalate. There is a risk of imbalance between early years and school aged provision and a need to consider how we bring parity to supporting school-aged children in the borough.

**- Mitigating actions**

- Method statement question seeks to ensure providers demonstrate expertise in working with school-aged children, i.e. not only focused on health visiting.

iii. **Gap between age 2 and school entry provision:** Although less pronounced than the gap between 0-5 and school aged children, some parents noted a 'cliff edge' after the 2-year health check, with limited support until school nursing begins at age 5. In addition, many parents stop attending after their first child, suggesting a need for ongoing engagement strategies.

**- Mitigating actions**

- Early Years are leading on a Starting School together booklet

- Planned integrated health reviews between Early Years and Health Visiting for children identified with developmental concerns at 2 years

iv. **Support for young parents:** With regard to universal services in family hubs settings, young parents have reported feeling judged or unwelcome in some settings, which can deter attendance. While FNP offers support for this group, if FNP capacity is limited or eligibility criteria are too narrow, some young parents may not be picked up early enough, increasing risk of isolation and missed support. Young parents group running at Queens road may provide insights for future engagement-

**- Mitigating actions**

- Explicit links with colleges and other settings could support early contact with young parents. Considerations should be given to how to promote hubs as welcoming spaces through inclusive messaging. Building on peer support models, use of Family Hub champions to provide friendly, non-judgmental first point of contact and improve parent engagement with whatsapp groups for ongoing communication

**Highlight any positive benefits the proposed decision will have on people of a specific age or age group.**

Waltham Forest has a younger than average population with 24.5 per cent of residents aged 0 to 19 compared to 23.7 per cent in London and 23 per cent nationally. A higher-than-average youth population underscores the importance of targeted early years and school-age services. Although the birth rate has decreased in Waltham Forest (in line with London and national trends), we still have one of highest number of births in London- and higher than England average. In addition, Waltham Forest has seen rising demand for services including an 83% increase in FNP referrals between 2018 and 2025.

Research has outlined clear benefits to 0-19 services for both children and families, particularly among 0-5 year olds in relation to: Improved child development and school readiness; early identification of health and development needs; infant feeding support and mental health and social connection for parents. Research consistently shows that the first two years of life are pivotal for brain development, attachment, and long-term health. The Best Start programme

aligns with this evidence by focusing on antenatal support, infant feeding, and early parenting advice. Insights have shown parents value these services in Waltham Forest, describing services as a “lifeline,” especially for first-time mums and those without local support. They valued social interaction, child development activities, and health advice. For school aged children, documented benefits include health promotion and safeguarding, and support for SEND and language development.

Further to this, continuation of the Family Nurse partnership will offer continued support for parents aged 24 years old or younger to promote healthy pregnancy, emotional wellbeing, child development, positive relationships and lifestyle goals (with resulting impact on both parents and babies). Parents supported by FNP have described the service as “amazing” and a “lifeline,” particularly for young mums navigating complex needs, with benefits including improved confidence, access to services and mental health support.

## Sex (gender)

Sex refers to whether you are a man or a woman.

### **Will the proposed change to service/policy have a differential impact [negative] on people of a specific sex (e.g. women, men)? If so, explain why this group may be affected and what mitigating actions will be taken.**

This contract covers universal and targeted services for children aged 0–19 and their families. While services are designed to be inclusive, there are several considerations relating to sex and gender:

#### **i. Maternal health and wellbeing**

Women are disproportionately affected by perinatal mental health challenges, breastfeeding difficulties, and recovery from childbirth. These issues often require timely, sensitive support. If workforce pressures (e.g., health visitor shortages) limit capacity for home visits or antenatal engagement, women may experience reduced access to early intervention.

##### **- Mitigating actions**

- Maintain focus on antenatal and postnatal support within Best Start and Family Nurse Partnership (FNP).
- Include KPIs for maternal mental health referrals and infant feeding support.
- Ensure specifications require providers to demonstrate cultural competence and trauma-informed practice.

#### **ii. Engagement of fathers and male caregivers**

Research and engagement feedback indicate that fathers often feel excluded from early years services, which are perceived as “mum-focused.” In addition, weekday daytime sessions can be difficult to attend for working parents. This can limit father involvement in child health and development. Strong involvement of both parents is associated with better outcomes for the child and mother. Evidence of cultural and structural barriers affecting some ethnic minority families (see further details under ethnicity and race below) may combine to create additional barriers for fathers from these communities.

##### **Mitigating actions:**

- Explicit requirement in tender specifications for providers to outline strategies for father engagement (e.g., dedicated sessions, flexible timings, evening/weekend options building on successful in library clinic on Saturday mornings).
- Promote inclusive messaging in Family Hub communications to normalise father participation.
- Explore partnerships with community groups to reach fathers who may not engage through traditional channels.
- Consideration should also be given to the use of inclusive visual imagery, language and communications across Family Hubs and commissioned services, to ensure spaces feel welcoming to all parents and carers, including fathers, partners and non-traditional family structures
- Consideration should be given to how to engage with fathers from diverse ethnic backgrounds. Opportunities to link in with the borough wide ‘Mental Health of Black Boys and Young Men’ project could support development of culturally competent services for young black fathers.

### iii. Provision of women-only spaces

While consideration must be given to engagement of fathers and male care givers (as outlined above), some women may wish to access women-only spaces, particularly in relation to infant feeding support or discussions of maternal health, mental health and wellbeing. This may be for a variety of reasons including religious belief, trauma and abuse. Women-only infant feeding support sessions have helped the current service to reach more women from Black, Asian and Mixed ethnic backgrounds, who are underrepresented in the service.

#### Mitigating actions:

- Supporting flexibility within service delivery models, including both women-only sessions and father inclusive sessions
- Ensuring such provision is offered transparently and as part of a wider inclusive offer, rather than as a separate or marginalised service.

### iv. Workforce representation and gender balance

The workforce delivering these services is predominantly female, which may influence perceptions of accessibility for male caregivers. While this is common in health visiting and early years roles, it is important to ensure that recruitment strategies encourage diversity and that staff are trained to engage all caregivers equitably.

#### Mitigating actions:

- Consider renaming the service and job titles for some roles (e.g. potential rebrand of school nurse). To be explored through the commissioning questions
- Provide training on unconscious bias and inclusive engagement for all staff.
- Deliver clinics and sessions at times and venues convenient to working parents including fathers

### Highlight any positive benefits the proposal decision will have on people of a same or different sex (gender).

The proposed commissioning approach is expected to have positive benefits for people of all sexes by supporting more inclusive, family-centred early years and perinatal services.

Specifically, the proposal will:

- Improve access to timely support for women during pregnancy and the postnatal period, including infant feeding support, emotional wellbeing and recovery following childbirth.
- Support greater engagement of fathers, partners and male caregivers by encouraging inclusive service design, flexible delivery models and communications that recognise diverse parenting roles.
- Promote Family Hubs and community settings as welcoming spaces for all families through the use of inclusive language, imagery and messaging, helping to reduce perceptions that services are solely “mother-focused”.
- Strengthen whole-family wellbeing by recognising the role of both parents in supporting child development, parental mental health and positive relationships.

### Ethnicity and race

This refers to a group of people defined by their race, colour, and nationality (including citizenship), ethnic or national origins.

### Will the proposed change to service/policy have a differential impact [negative] on people of a certain race? If so, explain why this group may be affected and what mitigating actions will be taken.

Waltham Forest is a highly diverse borough, with just over half of all births (52%) to mothers born outside the UK. This highlights the importance of early years, health visiting, school nursing and perinatal mental health services being culturally sensitive and accessible to families from a wide range of ethnic backgrounds. Despite the universal nature of services, evidence indicates ongoing disparities in access and experience for some communities.

### **i. Persisting disparities in access**

Local research and engagement highlight under-representation amongst certain racialised communities in some aspects of early years and perinatal provision. Significant barriers to engagement exist. Often comms are not translated into all languages and translation services are limited; UK systems are complicated and there are less resources for system navigators. In addition, we know that people from minoritised communities receive worse, and often harmful, care (particularly women in maternity services). Given this, trust in services is an understandable barrier.

#### **Mitigating actions:**

- Commissioning specifications to emphasise actively anti racist services that challenge systemic barriers.
- Providers will be expected to demonstrate proactive outreach approaches, rather than relying solely on self-referral.

### **ii. Stigma around accessing support outside the family**

Evidence relating to some South Asian communities suggests reluctance to seek support outside the family structure, potentially driven by stigma or families from minoritised communities feeling unsafe or that services are not for them. This can result in delayed engagement until needs have escalated, particularly in relation to parenting, infant feeding and mental health.

#### **Mitigating actions:**

- Embedding support within universal and community-based provision to normalise access and reduce stigma.
- Ensuring messaging frames support as preventative and routine rather than problem-focused.

### **iii. Multigenerational households and extended family roles**

Many families live in multigenerational households, where grandparents and extended family members play a significant role in caregiving and decision-making. Services that focus engagement solely on parents may miss opportunities to influence family health behaviours and support.

#### **Mitigating actions:**

- Encouraging providers to consider how services can appropriately engage and communicate with extended family members, where appropriate.
- Designing group-based and community sessions that are inclusive of wider family support networks.

### **iv. Workforce representation and communications**

A workforce that does not reflect the diversity of the local population, alongside unclear or English-only communications, may reinforce existing barriers to access. Insights from school nursing, for example, have found that children and young people from Black backgrounds often say they prefer working with people from similar background.

#### **Mitigating actions:**

- Encouraging providers to build and support a workforce that reflects local communities.
- Requiring clear, accessible and multilingual promotion of services via GP surgeries, Family Hubs, community settings and digital channels (including social media).

### **Highlight any positive benefits the proposed change will have on people of a certain race.**

The proposed commissioning approach is expected to have a positive impact on people from racialised communities by addressing known disparities and strengthening inclusive practice.

Specifically, the proposal will:

- Support earlier engagement with early years, school nursing and perinatal mental health services in a borough where the majority of births are to mothers born outside the UK.
- Promote culturally sensitive and actively inclusive services that help reduce stigma associated with accessing support outside the family.
- Better reflect the needs of families living in multigenerational households by recognising the role of extended family networks.
- Improve awareness and uptake of services through clearer, multilingual communications and outreach pathways.

- Support recruitment of a diverse workforce across services, including school nursing, to encourage access
- Overall, the proposal advances equality of opportunity by actively addressing racial and ethnic differences in access and experience, ensuring services are better aligned with the diverse communities they serve.

## Religion or belief

Religion refers to a person's faith (e.g. Buddhism, Islam, Christianity, Judaism, Sikhism, Hinduism) and includes lack of belief (e.g. Atheism). Belief includes any religious and philosophical belief including lack of belief (e.g. Atheism).

### **Will the proposed change to service/policy have a differential impact [negative] on people who follow a religion or belief, including lack of belief? If so, explain why this group may be affected and what mitigating action will be taken.**

Waltham Forest is a borough with a wide range of religious beliefs and practices. For some families, faith plays an important role in daily life, family structures, parenting practices and health-related decision making. If services are not designed and delivered sensitively, there is a risk of reduced access or engagement among families whose religious beliefs shape how and where they seek support.

#### **i. Experiences of stigma and discrimination**

For some families, particularly those from Muslim communities, experiences or fears of Islamophobia or being misunderstood can act as a barrier to engagement with statutory or community services. This may be compounded for women accessing support around infant feeding or perinatal mental health.

##### **Mitigating actions:**

- Ensuring services adopt inclusive, respectful and non-judgemental approaches that explicitly recognise and challenge discrimination.
- Embedding cultural humility and faith awareness within staff training and service delivery models
- Joint work with faith groups, including ensuring available services are promoted through faith networks and in places of worship

#### **ii. Cultural and faith-related considerations around food and healthy lifestyle**

Advice on nutrition, infant feeding and healthy eating that does not reflect cultural or faith-based dietary practices (including halal diets or maintaining health during periods of fasting) may reduce trust and engagement.

##### **Mitigating actions:**

- Ensuring infant feeding and healthy lifestyle guidance is culturally sensitive and adaptable to faith-based dietary practices.

#### **iii. Faith practices, spaces and staff needs**

Both staff delivering services and families accessing them may have religious practices that need to be accommodated, such as prayer.

##### **Mitigating actions:**

- Giving reasonable consideration to the provision of appropriate, inclusive spaces for prayer where feasible, which can be used by staff and service users.
- Ensuring flexibility in service environments to support dignity and inclusion.

### **Highlight any positive benefits the proposed change will have on people with different religions or beliefs (including a lack of belief).**

Promoting inclusive, respectful and flexible service delivery that reduces faith-related barriers to access will:

- Support greater trust and engagement by recognising and valuing the role of religion and belief in families' lives.

- Enhance the relevance of healthy eating and lifestyle advice by reflecting diverse cultural and faith-based dietary practices.
- Foster stronger relationships between services and communities through meaningful partnership working with faith groups.

## Disability

A person has a disability if they have a physical or mental impairment which has a substantial and long-term adverse effect on the person's ability to carry out normal day-day activities.

This could include physical impairment, hearing impairment, visual impairment, learning difficulties, long-term illness or health condition, mental illness, or other impairments.

**Will the proposed change to service/policy have a differential impact [negative] on people with disabilities? If so, explain why this group may be affected and what mitigating action will be taken.**

For the purposes of this assessment, we consider both parents/carers alongside babies and young children with disabilities. Evidence indicates that families affected by disability are experiencing increasing levels of demand and complexity, which may heighten inequality risk if services are not sufficiently accessible, integrated and responsive.

### **i. Rising levels of need among babies and children with SEND**

There has been a significant increase in the number of children and young people with Education, Health and Care (EHC) plans, reflecting rising levels of identified need. Families may require earlier identification, clearer pathways and coordinated support to navigate assessments, referrals and ongoing provision.

#### **Mitigating actions:**

- Maintaining a strong focus within health visiting, Best Start and school nursing services on early identification and monitoring of developmental needs.
- Using tools such as ASQ and other developmental checks to support timely identification, referral and escalation of concerns.
- Ensuring effective integration with specialist services, including NELFT provision, to support continuity and reduce duplication.
- Planned integrated health reviews between Early Years and Health Visiting for children who have been identified with developmental concerns at 2 years to support family and ensure holistic approach.

### **ii. Pressure on mental health services and reduced lower-tier support**

There have been significant increases in CAMHS waiting lists, alongside reductions in some lower-tier or preventative emotional wellbeing support. This increases the importance of universal early years and school-age services in identifying emerging needs, providing early intervention, and supporting families while specialist services are accessed. In this context, school nursing services play an important role in supporting children with emerging mental health needs, neurodevelopmental concerns and SEND, especially where families are waiting for CAMHS assessment or do not meet thresholds for specialist intervention. Without sufficient capacity or integration, there is a risk that children with additional needs and their families may experience unmet need, delayed support or escalation to crisis.

#### **Mitigating actions:**

- Strengthening the role of health visiting and school nursing in early identification, prevention and support for children with emerging mental health or developmental needs (including the use of tools such as ASQ and other developmental checks to support timely identification, referral and escalation of concerns.)
- Supporting clear referral pathways including between early years services and perinatal mental health provision (PBEW) and school nursing and specialist services including CAMHS.
- Ensuring school nursing services are supported to hold and manage need appropriately (or are able to support schools to do so) while awaiting CAMHS or other specialist support.

### iii. Parental mental health and impact on child outcomes

There is a well evidenced relationship between perinatal parental mental health and child outcomes, particularly for children with additional needs. Parents caring for babies or children with disabilities may experience higher levels of stress, fatigue and emotional strain.

#### Mitigating actions:

- Ensuring strong links between early years services and perinatal mental health support (including PBEW)
- Ensuring parental mental health needs are recognised as part of supporting child development and wellbeing.

### iv. Parents with learning disabilities

Parents with learning disabilities may experience barriers to engagement where communication is not accessible, information is complex, or services rely heavily on self-navigation and advocacy.

#### Mitigating actions:

- Promoting accessible communication, clear information and consistent, relationship-based support.
- Supporting workforce confidence and training in working with parents with learning disabilities.

### v. Resource constraints and delivery of home visiting

Home visiting can be particularly important for families affected by disability, both to support access and to understand family circumstances in context. However, constrained resources may limit the availability or frequency of home visits, increasing the risk of unequal access for those with the greatest need.

#### Mitigating actions:

- Prioritising targeted home visiting where needs are highest.

### vi. Role of targeted programmes such as FNP

The Family Nurse Partnership (FNP) plays an important role in supporting vulnerable parents. Eligibility for the higher age threshold includes factors such as mental health concerns, substance misuse, domestic abuse, involvement with the criminal justice system or children's social care, low educational attainment, unemployment, unstable relationships and partner imprisonment. These factors may overlap with disability.

#### Mitigating actions:

- Maintaining clear referral and interface arrangements between FNP, universal services and specialist provision.
- Ensuring parents who do not meet FNP criteria are still supported through universal and targeted early years services.

### Highlight any positive benefits the proposed change will have on people with a disability.

The proposed commissioning approach is expected to have a positive impact on babies and children with disabilities or SEND, as well as parents and carers with disabilities, by strengthening early, joined-up and preventative support.

Specifically, the proposal will:

Improve early identification of developmental delay, disability and additional needs through health visiting and school nursing programmes, including use of ASQ and universal checks.

- Support earlier and more coordinated access to specialist services, reducing delays and duplication.
- Provide better support for parental mental health, recognising its impact on child outcomes, particularly for families affected by disability.
- Improve access for parents with learning disabilities and carers through accessible communication and flexible delivery models.
- Reduce reliance on crisis responses by investing in early intervention and preventative support at family and community level.
- Provide the best start for children of parents with additional needs, many of whom will likely take on young caring responsibilities in the future.

### Sexual orientation

This refers to whether a person is attracted to people of the same sex or a different sex to themselves. Please consider the impact on people who identify as heterosexual, bisexual, gay, lesbian, or asexual.

**Will the proposed change to service/policy have a differential impact [negative] on people with a particular sexual orientation? If so, explain why this group may be affected and what mitigating action will be taken.**

Early years, health visiting, school nursing and perinatal mental health services are accessed by families with diverse sexual orientations and family structures. While services are designed to be universal, there is a potential risk of differential impact if service design, language, imagery or assumptions are not sufficiently inclusive or reflective of different types of families.

**i. Visibility and representation in communications**

If communications, promotional materials or service environments predominantly reflect heterosexual or traditional family models, families who identify as LGBTQ+ may feel less visible or uncertain that services are intended for them. This may reduce confidence in accessing support, particularly for new or transitioning parents.

**Mitigating actions:**

- Ensuring commissioning specifications emphasise inclusive language and representation across all communications and promotional materials.
- Encouraging providers to review imagery, messaging and materials to reflect a range of family structures, relationships and caregiving arrangements.

**ii. Assumptions in service interactions and documentation**

Forms, assessments or conversations that assume heterosexual relationships or use gendered parental roles may inadvertently exclude or alienate families with different sexual orientations, particularly during antenatal, infant feeding or early parenting discussions.

**Mitigating actions:**

- Requiring providers to ensure practices, documentation and communications avoid heteronormative assumptions.
- Supporting staff training to build confidence in inclusive, respectful engagement with families of all sexual orientations.

**iii. Role of school nursing and sexual health provision**

School nursing services often play a key role in delivering sexual health education, advice and support to children and young people. If sexual health functions are not inclusive and equitable, there is a risk that LGBTQ+ young people may experience reduced access to information, support or appropriate referral pathways.

**Mitigating actions:**

- Ensuring school nursing services deliver sexual health support that is inclusive, age appropriate and reflective of diverse sexual orientations.
- Ensure school nurses are aware of and able to signpost / refer to LGBTQ+ specific services for support with sexual health, mental health etc. such as ELOP.
- Promoting equitable access to information and support through culturally competent and inclusive school nursing practice.

**Highlight any positive benefits the proposed change will have on people who identify as heterosexual, bisexual, lesbian or asexual.**

Reinforcing inclusive, consistent and equitable service delivery will:

- Improve confidence and access for families with diverse sexual orientations through inclusive representation, language and service design.
- Ensure school nursing sexual health provision is accessible and relevant to all children and young people, regardless of sexual orientation.
- Promote trust and engagement by creating welcoming environments where families feel recognised and respected.
- Support equitable access to early years, school nursing and perinatal mental health services for all family types.

## Pregnancy and maternity

Pregnancy refers to the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth and is linked to maternity leave in the employment context. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth, and this includes treating a woman unfavourably because she is breastfeeding.

**Will the proposed change to service/policy have a differential impact [negative] on pregnancy and maternity? If so, explain why this group may be affected and what mitigating action will be taken.**

Pregnancy and the postnatal period are critical life stages associated with heightened physical, emotional and social vulnerability. Evidence from local research and service insight highlights the importance of timely, accessible and compassionate support during this period to prevent escalation of need and support positive outcomes for parents and babies.

### **i. Workforce capacity and reduced provision during pregnancy and the postnatal period**

A reduction in Lot 1 funding may impact the capacity of universal services to deliver the same level of support through pregnancy and maternity. In the context of rising need, reduced capacity could disproportionately affect those who rely most on universal provision.

#### **Mitigating actions:**

- Commissioning specifications prioritise maintaining support through pregnancy and the postnatal period, with a focus on highest-need families.

### **ii. Transition points and risk of fragmented support**

Local insight highlights that parents commonly experience vulnerability at key transition points, particularly between maternity services, health visiting and community-based provision. Where capacity is constrained or pathways are unclear, families may experience delayed engagement or inconsistent follow-up during the early postnatal period.

#### **Mitigating actions:**

- Strengthening referral pathways and information sharing between maternity services, health visiting, Best Start and specialist provision where appropriate
- Supporting integrated working to reduce reliance on parents navigating services independently.

### **iii. Perinatal mental health vulnerability**

Evidence from local perinatal mental health research highlights pregnancy and the postnatal period as a time of significantly increased risk of anxiety, depression and emotional distress. Parents consistently describe the importance of early validation and support, and the risks of escalation when needs are missed or minimised.

#### **Mitigating actions:**

- Retaining preventative and low-to-moderate perinatal mental health support embedded within early years pathways.
- Supporting trauma-informed, compassionate approaches that normalise help-seeking and reduce stigma.

### **iv. Infant feeding pressures and experiences**

Infant feeding is identified as a significant source of stress for parents during the postnatal period. Qualitative research highlights experiences of pressure, conflicting advice and fear of judgement, particularly where timely, face-to-face support is not available. These pressures are particularly acute in the early weeks following birth and are closely linked to parental mental wellbeing.

#### **Mitigating actions:**

- Ensuring infant feeding support remains non-judgemental, flexible and culturally sensitive.
- Integrating feeding support with wider emotional wellbeing and parenting support.

### **v. Physical recovery and accessibility of services**

Postnatal recovery, including recovery following caesarean sections or other medical complications, may limit parents' ability to attend services in standard formats or locations. This is commonly raised by parents as a practical barrier during the postnatal period.

**Mitigating actions:**

- Retaining flexibility in delivery models, including home visiting, telephone or digital contact where appropriate.

**Highlight any positive benefits the proposed change will have on people who are pregnant/expecting a baby.**

The proposed commissioning approach is expected to continue delivering positive outcomes for people who are pregnant or in the postnatal period by prioritising early, integrated and preventative support, despite wider system constraints.

**Gender reassignment**

This refers to people who are proposing to undergo, are undergoing, or have undergone a process (or part of a process) to reassign their sex by changing physiological or other attributes of sex.

According to a [2020 landmark Employment Tribunal ruling](#), people who identify as gender fluid and non-binary or transitioning are protected under this section of the Equality Act and should therefore be considered as part of your assessment.

**Will the proposed change to service/policy have a differential impact [negative] on transgender people? If so, explain why this group may be affected and what mitigating action will be taken.**

While the number of transgender parents or carers may be relatively small in Waltham Forest, there is a potential risk of differential impact (with a resulting rise in health inequalities) if services are not designed and delivered in a way that is inclusive and respectful.

**Population context and scale**

Census 2021 provides the first official data on gender identity. In Waltham Forest, 2,409 residents aged 16 and over (1.1%) reported that their gender identity was different from the sex assigned at birth. This proportion is higher than the England average (0.5%) and similar to the London average (0.9%). (<https://www.walthamforest.gov.uk/health-and-wellbeing/population/gender-identity-jsna> )

The Census data does not provide information on whether individuals have undergone medical gender reassignment, nor does it identify how many transgender residents are parents. It is therefore difficult to quantify service use amongst this population. This is an area where guidance is continually evolving, so the overarching approach will need to be ongoing dialogue between ourselves and providers to continue to evolve thinking and practice in the area, heeding guidance from national bodies where available. For now, consideration should be given to the following proposed mitigating actions:

**i. Language and assumptions in service design**

If services, communications or pathways rely heavily on gendered language such as “mothers” and “fathers”, there is a risk that transgender parents or carers feel excluded or unsure whether services are intended for them. This may particularly affect engagement during pregnancy, early parenthood and perinatal mental health support.

**Mitigating actions:**

- Commissioning specifications encourage use of inclusive language such as “parents”, “carers” or “birth parent”, alongside flexibility where individuals’ preferences are known.
- Providers are expected to review forms, communications and materials to avoid unnecessary gendered assumptions.

## ii. Staff confidence and inclusive practice

Transgender parents or carers may have previous experiences of misunderstanding or discrimination in health or public services. A lack of staff confidence in using correct names and pronouns may undermine trust and deter engagement.

### Mitigating actions:

- Supporting staff training in inclusive practice, including the use of correct pronouns and respectful communication.
- Emphasising non-judgemental, confidential and person-centred approaches across all commissioned services.

## iii. Role of school-age services and wellbeing support

School nursing services have a role in supporting children and young people's wellbeing. If services are not inclusive or sensitive to gender identity, transgender young people or children from gender-diverse families may experience reduced access to appropriate support.

### Mitigating actions:

- Ensuring school nursing services are delivered in a way that is inclusive, equitable and responsive to the needs of gender-diverse children and families.
- Promoting environments where families feel safe to access support without fear of stigma or exclusion.

### Highlight any positive benefits the proposed change will have on people who are proposing to undergo, are undergoing, or have undergone a process (or part of a process) to reassign their sex.

Delivery of inclusive services which adhere to the above principles should support access and reduce inequalities for transgender residents and their families.

## Marriage and civil partnership

Marriage and civil partnerships are different ways of legally recognising relationships. The formation of a civil partnership must remain secular, where-as a marriage can be conducted through either religious or civil ceremonies. In the UK both marriages and civil partnerships can be same sex or mixed sex. Civil partners must be treated the same as married couples on a wide range of legal matters.

### Will the proposed change to service/policy have a differential impact [negative] on people in a marriage or civil partnership? If so, explain why this group may be affected and what mitigating action will be taken.

Early years, health visiting, school nursing and perinatal mental health services are accessed by families in a wide range of relationship arrangements, including those who are married, in civil partnerships, co-habiting, single parents, or no longer in a partnership. The proposed commissioning approach is family-centred rather than status-based, and services are not contingent on marital or partnership status.

As such, no specific negative differential impact on people who are married or in a civil partnership has been identified. Services are commissioned to recognise and support a range of family and relationship arrangements, and language and communications should be framed to be inclusive of different household structures and caregiving roles.

### Highlight any positive benefits the proposed change will have on people in a marriage or civil partnership.

The proposed commissioning approach ensures that services are accessible, supportive and relevant to families regardless of marital or partnership status.

## Care Leavers

### Will the proposed change to service/policy have a differential impact [negative] on people who are Care Leavers? If so, explain why this group may be affected and what mitigating action will be taken.

Care-experienced parents and young people may face additional vulnerabilities during pregnancy, early parenthood and while caring for children, including reduced informal support networks, earlier transitions to independence and higher prevalence of mental health need.

#### **i. Absence of family support networks**

Care Leavers are less likely to have access to extended family support during pregnancy and parenting. This increases reliance on early years, health visiting, school nursing and perinatal mental health services as primary sources of practical advice, reassurance and emotional support. Without sufficient engagement, there is a risk of isolation and missed early help.

##### **Mitigating actions:**

- Commissioning specifications emphasise proactive identification and engagement through health visiting, Family Hubs and perinatal mental health pathways.

#### **ii. Mental health impact of becoming a parent**

For Care Leavers, the transition to parenthood may trigger the processing of past experiences, including trauma associated with care histories. This can have a significant impact on mental health and emotional wellbeing, particularly during pregnancy and the postnatal period, increasing the risk of anxiety, depression or overwhelm.

##### **Mitigating actions:**

- Ensuring effective referral pathways for PBEW service through health visiting and early years services.
- Promoting trauma-informed, compassionate approaches that recognise the additional emotional impact of parenting for care-experienced individuals.

#### **iii. Role of targeted programmes such as Family Nurse Partnership (FNP)**

Care Leaver status is one of the eligibility thresholds for participation in the Family Nurse Partnership (FNP). In addition, the higher age threshold for FNP includes a range of vulnerability factors that may overlap with care experience, including mental health concerns, substance misuse, domestic abuse, involvement with the criminal justice system, children's social care involvement, low educational attainment, unemployment, unstable relationships, and partner imprisonment. However, not all Care Leavers will meet FNP eligibility criteria at all stages, and some may require support outside the programme.

##### **Mitigating actions:**

- Maintaining clear referral pathways into FNP for eligible Care Leavers.
- Ensuring Care Leavers who are not eligible for FNP are supported through universal and targeted early years services, with appropriate follow-up and navigation support

#### **iv. Challenges navigating complex systems**

Care Leavers may have lower confidence or reduced trust in statutory services due to previous experiences. Where services are fragmented or rely on self-advocacy, there is an increased risk of disengagement.

##### **Mitigating actions:**

- Promoting clear pathways, consistent points of contact and joined-up working across early years, perinatal mental health and wider support services.

#### **Highlight any positive benefits the proposal will have on people who are Care Leavers.**

Retention of the FNP programme, which includes care leaver as one of several eligibility criteria, will translate to additional support for this vulnerable group through the perinatal period.

#### **Other structurally disadvantaged groups**

The [State of the Borough report](#) identifies a number of groups that might suffer from structural disadvantage in Waltham Forest. These groups should also be taken in account when assessing proposal or policies and include:

- People experiencing socio-economic inequality or geographic deprivation
- People with caring responsibilities
- Survivors of domestic violence
- Migrants, including refugees and asylum seekers
- Homeless people and people at risk of homelessness
- People who are experiencing long-term unemployment

There might be other structurally disadvantaged groups that you know from your service data might experience a differential impact based on your proposal or policy. This may include how your work impacts on the social, economic, and environmental conditions in which people live, work and age that influence health outcomes. Please consider these groups in this section as part of your equalities impact assessment.

**Will the proposed change to service/policy have a differential impact [negative] on other structurally disadvantaged groups?**

Evidence from local insight and service experience highlights that families experiencing structural disadvantage often face multiple, compounding barriers to accessing early years and school nursing support, particularly where needs are complex or change over time.

**i. Increasing levels of deprivation and complexity among families**

Service intelligence and local insight indicate rising levels of complexity among families, including increased mental health needs and financial insecurity. Families experiencing deprivation may be less able to navigate complex systems or attend services delivered in fixed formats, increasing the risk of exclusion. In addition, the move towards charging for some sessions is also likely to increase the risk of exclusion for families experiencing deprivation.

**Mitigating actions:**

- Services are expected to prioritise early identification and proactive engagement with families facing multiple disadvantages.
- Providers will be required to collect detailed information on equity of access to services and provide regular reports to commissioners, with action taken when this identifies changes/reductions in equity of services

**ii. Relevance of Family Nurse Partnership (FNP) eligibility criteria**

The higher-age threshold criteria for Family Nurse Partnership (FNP) reflect many of the risk factors associated with structural disadvantage. These include: Mental health concerns, substance misuse, domestic abuse, involvement with the criminal justice system, children's social care involvement, low educational attainment or not being in education, employment or training, unstable relationships, partner or baby's father being in prison. However, not all families experiencing these challenges will meet FNP eligibility criteria, creating a risk that unmet need persists outside targeted programmes.

**Mitigating actions:**

- Maintaining clear pathways into FNP where eligibility criteria are met.
- Ensuring that families who do not meet FNP thresholds are supported through universal and targeted early years and school nursing provision.

**iii. Families moving in and out of borough**

Families experiencing housing insecurity or instability may move between local authority areas during pregnancy or early parenthood. Without robust handover processes, this can disrupt continuity of care and increase the risk of disengagement or unmet need.

**Mitigating actions:**

- Strengthening cross-borough communication and robust handover arrangements to support continuity when families move out of or into Waltham Forest.
- Encouraging providers to document and share relevant information appropriately to minimise disruption to support.

**Highlight any positive benefits the proposal will have on groups experiencing structural disadvantage.**

Provision of universal services, the majority of which are free at the point of access, should offer a multitude of benefits to families experiencing structural disadvantage providing services are delivered in a way that is accessible, non-judgemental and proactive in identifying risk. In addition, greater integration between services may benefit these groups.

## Section 4: Monitoring and reviewing

### Use this section to say:

- How you intend to monitor and review the effects of this proposal or policy
- Who will be responsible for assessing its effects
  - These services will be formally monitored on performance each quarter, with lot 1 reporting to Early Help and lots 2 and 3 to the Public Health team.
  - Outside of formal performance management meetings, regular monthly meetings organised by Early Help to bring together Lot 1, lot 2 and lot 3 providers will support shared learning to improve both access to, and integration of, 0-19 services. Providers will be required to collect detailed information on the demographic characteristics of service users, to ensure equity of access. Where feasible, this data will enable an exploration of intersectionality (i.e. exploring multiple characteristics given the potential for compounded disadvantage). Providers will provide regular reports to commissioners, with action taken when this identifies changes/reductions in equity of services. Reporting will also address how providers are making progress on tackling inequalities, drawing upon public health intelligence.
  - In addition to quantitative demographic data, providers will be expected to gather and use qualitative insights to tackle inequalities and improve access for groups underrepresented within their services. They will be encouraged to share insights with partners where appropriate.
  - Specific KPIs relating to mitigating actions will support this process. These may include KPIs around integration (e.g. maternal mental health referrals and delivery of training for the local workforce), actions to support access (e.g. sessions outside of working hours to support working parent attendance and provision of women only infant feeding sessions) and staff training access figures.

## Section 5: Conclusion

### Set out your conclusions from the analysis of the proposal or policy.

If there are negative equalities impacts, but you think that the proposal or policies should still proceed in the current or amended form, please provide evidence and an objective explanation as appropriate.

If it is helpful, refer to other documents e.g. a Cabinet report. You may find it helpful to identify one of the four outcomes below as being closest to your current proposal or policies. (Use your conclusions as a basis for the “Equalities Implications” in the Cabinet report.)

*This analysis has concluded that the decision has the potential to differentially impact individuals with protected characteristics but that this can be mitigated by ensuring appropriate and relevant actions are consistently implemented and monitored through the course of the contract. The proposed mitigating actions should not be considered an exhaustive list and may need to be revisited throughout the contract where monitoring suggests reduced access for identified groups, or in the case of issuing of new guidance on good practice. Given the potential for simultaneous, compounded disadvantages, this work will need to be situated within a framework of intersectionality. Consideration will need to be given on how we ensure we hear the voices of families when monitoring these services, particularly those who face the systemic inequalities outlined in this document.*

### Outcome of Equality Impact Assessment *check one that applies*

- **Outcome 1:** No major change required when the assessment has not identified any potential for discrimination or adverse impact and all opportunities to advance equality have been taken.
- **Outcome 2:** Adjustments to remove barriers identified by the assessment or to better advance equality. Are you satisfied that the proposed adjustments would remove the barriers identified?

- **Outcome 3:** Continue despite having identified some potential for adverse impacts or missed opportunities to advance equality. In this case, the justification should be included in the assessment and should be in line with the duty to have 'due regard'. For the most important relevant policies, compelling reasons will be needed. You should consider whether there are sufficient plans to reduce the negative impact and/or plans to monitor the actual impact.
- **Outcome 4:** Stop and rethink when an assessment shows actual or potential unlawful discrimination.

## Section 6: Signatures

Signed off by Corporate Director for the proposal or policy/project:

Name:

Joe McDonnell, Director of Public Health (Adults and Quality Assurance Directorate)

Date:

08.05.26