Equality Analysis
(Health Inequalities, Human Rights, Social Value)

Birmingham Mental Health Carer Support Service

Before completing this equality analysis, it is recommended that you:

- ✓ Contact your equality and diversity lead for advice and support
- ✓ Take time to read the accompanying policy and guidance document on how to complete an equality analysis

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1. Background

EA Title	Birmingham Mental Health Carer Support Service		
EA Author	Michelle Dunne	Team	Nursing
Date Started	24th May 2018	Date Completed	7th August 2018
EA Version	V0.2	Reviewed by E&D	7th August 2018

What are the intended outcomes of this work? Include outline of objectives and function aims

The objectives of the service are:

- To improve outcomes, independence and choices for mental health carers, and for Carer of individuals diagnose with Autism or ADHD including young mental health carers (aged 4 – 17 years).
- To engage mental health carers in the development and evaluation of the service and to manage and respond effectively to concerns or complaints raised by carers.
- To recognise and value the role and expertise of carers
- To proactively engage with underrepresented groups of carers (this may include but limited to
    - BAME groups, disabled carers, LGBT carers, those not registered with a Birmingham GP
- To develop effective referral process and signposting arrangements with key partner agencies in health and social care
    - Working from numerous locations across the Birmingham and Solihull CCG footprint, including with Early Help and Wellbeing Hubs and Crisis Cafés.
    - Developing a referral pathway and presence within CMHT's and GP practices
- To provide access to high quality information resources
- To provide a range of support to mental health carers based upon a holistic understanding of their needs
- To help carers to mitigate the financial impact of caring
- To support carers to enjoy a life outside caring and gain access to respite from their caring role
- To help protect children from inappropriate carer roles and to engage with agencies and
- organisations providing services to children across health, education and social care
- To help ensure that carers are recognised and supported as expert care partners
- To help ensure that carers stay mentally and physically well and are treated with dignity and respect.
- To provide a service that identifies, includes and gives due regard and consideration to mental health carers regardless of gender, ethnicity, age, sexuality, religion or belief and any other factors.
- To provide intelligence in respect of the needs to carers to information policy and practice amongst local mental health providers.

Who will be affected by this work? e.g. staff, patients, service users, partner organisations etc. Explain how they might be affected.
It is estimated that there are up to 1.5 million people in the UK care for someone with mental ill health, 50,000 of these are children and young people looking after someone with mental ill health in the UK. In Birmingham there are approximately 85,000 Carers for Individuals with some level of mental health illness. One in four carers is a mental health carer.
The service is provided to carers of adults with mental health needs or diagnosed with Autism or ADHD. (including those accessing mental health services in primary, secondary or tertiary care or those who have not yet accessed services or have disengaged from services). Carers can be of age including young carers (those aged 4 – 17 years old).
This service will be focused on the Birmingham area, as there is an existing service operating within Solihull.

2. Research

What evidence have you identified and considered? This can include national research, surveys, reports, NICE guidelines, focus groups, pilot activity evaluations, clinical experts or working groups, JSNA or other equality analyses.

Research/Publications	Working Groups	Clinical Experts
NHS Five Year Forward View 2014		
Census 2011 Extracts		
Carers Trust – Young adult carers at school – experiences and perceptions of caring and education		
Carers UK – Half a million voices: Improving support for BAME carers		
Carers UK – State of Caring 2014		
Carers UK – Making connections, get support – recognising ourselves and others as carers (2017)		
IRISS – Insights – Improving support for black and minority ethnic carers		
Carers Trust – Husband, Partner, Dad, Son, Carer? – A survey of the experiences and needs of male carers (2014)		
Carers Trust – Dads Care Too – a survey of the experiences of fathers who are carers (July 2015)		
Carers UK – State of Caring 2017		
Carers UK – Missing Out – the identification challenge (Nov. 2016)		

Centre for Mental Health, Supporting Carers – Mental Health Carers' Assessments in policy and practice (Kirsty Matthews)		
Carers Trust Scotland – young people caring OUT there: experiences of LGBT young adult carers in Scotland		
Carers UK – Research Briefing, October 2016		

3. Impact and Evidence:

In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should also include any identified health inequalities which exist in relation to this work.

Age: Describe age related impact and evidence. This can include safeguarding, consent and welfare issues:

Age Profile Birmingham

Birmingham has a relatively young population compared to other cities in England, with a larger proportion of children and young people, and a smaller proportion of people in older age groups. However, Birmingham's population is far from stable and the rate of growth for various age groups varies widely. 46% of the Birmingham population is under 30. 13% is over 65 years. There is also a sizeable 20-24 years' population due to the large student population.

Local population figures by age groups:

Age	Birmingham	BSol	England
Age 0 to 17	25.54%	24.94%	21.39%
Age 18 to 64	61.57%	61.17%	60.59%
Age 65+	12.88%	13.90%	16.33%
Total Popln	1073045	1279719	53012456

A carer is defined in the Carers (Recognition and Services) Act 1995 as a person who provides a "substantial amount of care on a regular basis". Given that many people do not recognise themselves as carers (according to research by Carers UK nearly a third of carers do not recognise themselves as such for over 5 years) and that the number of carers is increasing across the country (research by Carers UK estimates a 60% increase in the number of carers by 2037).

In Birmingham and Solihull 10.29% of the population are providing unpaid care each week; in Solihull alone 11.75% provide unpaid care and in Birmingham it is 10%.
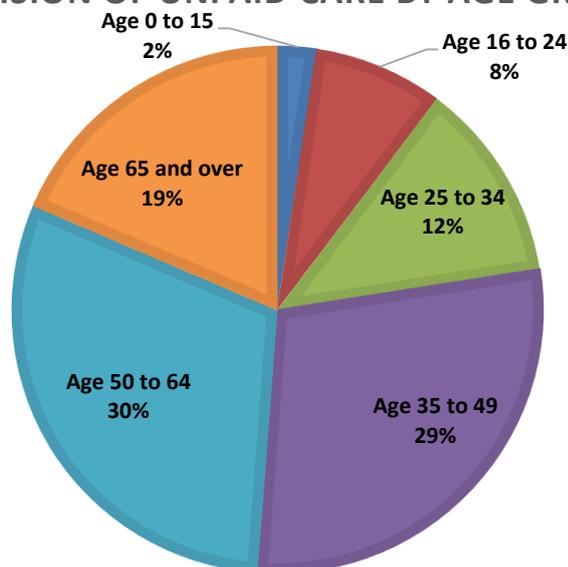
3. Impact and Evidence:

Provision of unpaid care per week	Bham & Solihull Count	Bham and Solihull %
Totals:	1,278,132	100%
Provides no unpaid care	1,146,648	89.71%
Provides 1 to 19 hours unpaid care	77,268	58.77%
Provides 20 to 49 hours unpaid care	20,537	15.62%
Provides 50 or more hours unpaid care	33,679	25.61%

Carers by Age Groups

- 10% of carers locally are young people, aged between 0 and 24
- 19% of local carers are aged 65+
- 59% of local carers are aged between 35 and 64
- 49% of carers are aged 50+

PROVISION OF UNPAID CARE BY AGE GROUP

Age 0 to 15 2%
Age 16 to 24 8%
Age 25 to 34 12%
Age 35 to 49 29%
Age 50 to 64 30%
Age 65 and over 19%

Hours of care provided

- The majority of care provision is for 1 to 19 hours per week;
- A significant proportion of care (25%) is provided for 50 or more hours per week.

3. Impact and Evidence:

ALL CATEGORIES: AGE

- Provides 1 to 19 hours unpaid care a week
- Provides 20 to 49 hours unpaid care a week
- Provides 50 or more hours unpaid care a week
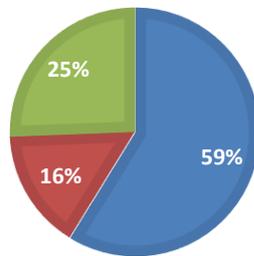
Hours of Care Provided by Different Age Groups

- Over 2,400 children aged between 9 and 15 provide 1 to 19 hours of unpaid care per week

- People aged 65 and over are the largest provider of 50 or more hours of care per week.

- People aged between 50 and 65 are the largest provider of 1 to 19 hours per week.

PROVISION OF UNPAID CARE BY AGE

- Provides 1 to 19 hours unpaid care a week
- Provides 20 to 49 hours unpaid care a week
- Provides 50 or more hours unpaid care a week
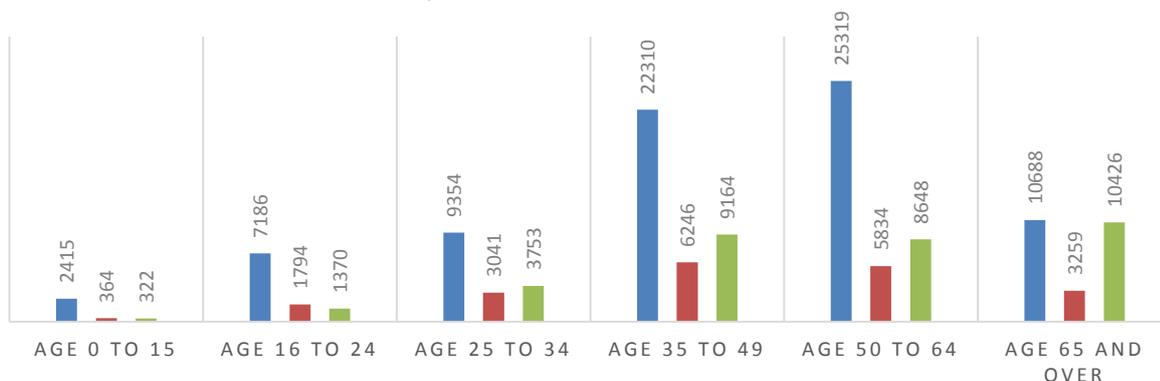
In a document produced by Carers Trust - **Young Adult Carers at School: Experiences and Perceptions of Caring and Education**; Dr Joe Sempik and Professor Saul Becker, Young Carers International, The University of Nottingham (2013) they identified the following:

- A survey of young adult carers (average age 15.5 years) who were still at school shows that two thirds were providing a high or very high level of care.
- Almost a third (29%) reported that their own physical health was 'just OK', and 38% reported having a mental health problem.

3. Impact and Evidence:

- Most (67%) young people informed school staff that they were a carer but the majority of those who did not felt that 'there was no point' in telling anyone.
- A quarter (26%) were bullied at school because of their caring role
- Few (15%) had received a formal review or assessment of their needs, and only half felt that their family received good support and services.
- The majority of respondents who attended a young carers project or a young adult's carers project (65%) felt that it had improved their confidence, and 54% thought that they had more friends as a result. 39% felt they had performed better at school because of the project.

There is now a large body of research which explores the issues facing children and young people who provide unpaid care, support or assistance to other members of their families. These young and young adult carers are at substantial risk of a variety of negative outcomes which include poorer physical health, emotional problems and educational difficulties (Aldridge and Becker, 1999; 2003). In three large surveys, Dearden and Becker (1995; 1998; 2004) have shown that around one third of young carers aged 5-15 experience educational difficulties, and that a greater proportion of older young carers experience such problems. Similarly, Cree (2003) has reported that approximately two thirds of young carers perceive problems with school and worry about it; and analysis of the 2001 Census data shows that young adults (aged 16-24) with caring responsibilities are less likely to be in further or higher education and less likely to be in full or part-time work (Yeandle and Buckner 2007, p.21). Hence, caring responsibilities can lead in many cases to reduced opportunities of participating and achieving in higher education and employment.

The most common disability or condition of those cared for by the young adult carers in this sample were physical disability (53%), long-term physical illness (40%), which included terminal illness, and mental health problems (38%). 28% cared for someone with a learning disability or autism and 19% for someone with a behavioural problem. None of the respondents in this sample cared for someone with drug or alcohol problems.

Recommendations from this report include:

Projects for young carers and young adult carers should seek ways to reduce the amount of care provided by children and young people. This may take the form of helping young people access

3. Impact and Evidence:

services and information, facilitating contacts with local authorities and service providers, and enabling young people to access relevant training to help them in their caring roles. It will also mean working with adult service providers to ensure that disabled and other parents receive adequate support so reducing the need for children and young people to provide care.

There is a need to examine the accessibility and usefulness of online support materials for young adult carers and update and improve these as appropriate in order to make them relevant to this group of young people.

Disability: Describe disability related impact and evidence. This can include attitudinal, physical, communication and social barriers as well as mental health/ learning disabilities, cognitive impairments:

Impact on health in provision of care

According to the Carers UK report – **State of Caring 2017**:

Caring can have a significant impact on health, with the pressures of providing care taking a toll on both carers' physical and mental wellbeing. Those providing round the clock care are more than twice as likely to be in bad health as non-carers.

The most recent GP patient survey found that 3 in 5 carers have a long term health condition, this compares with half of non-carers. This pattern is even more pronounced for younger adults providing care – 40% of carers aged 18-24 have a long term health condition compared with 29% of non-carers in the same age group. Carers' own experiences suggest that long term back and mobility problems are caused by long term physical stress from moving and handling without the right equipment or training. This impact is often exacerbated by carers being unable to find time for medical check-ups or treatment or being forced to put off treatment because of their caring responsibilities. Without proper support, carers are often pushed to breaking point and have to give up work, stop caring, or even to into hospital themselves.

The impact of caring on carers' health

3. Impact and Evidence:

6 out of 10 people (61%) said their physical health has worsened as a result of caring, while 7 out of 10 (70%) said they have suffered mental ill health. 13% said their health is no different as a result of caring.

People providing over 50 hours of care a week and older carers over the age of 65, were both more likely to say their physical health had worsened as a result of caring (67% and 65% respectively), while over three quarters (78%) of those providing care to a child with a disability said they have suffered mental ill health such as stress or depression as a result of caring.

Staying healthy as a carer

Carers reported a number of negative impacts of caring upon their wellbeing. 8 out of 10 people (78%) said they feel more stressed because of their caring role, and 7 out of 10 (72%) said caring has made them feel more anxious. 7 in 10 (69%) also said they find it difficult to get a good night's sleep because of their caring role.

Over half of people (54%) also reported that they have reduced the amount of exercise they take because of caring and 45% reported that they have found it difficult to maintain a balanced diet. Nearly half of respondents (46%) said they have suffered from depresson because of their caring role.

Mental Health Carer's

In a report from the **Centre for Mental Health**, Kirsty Matthews; **Supporting carers - Mental health carers' assessments in policy and practice** the following was identified:

Mental health carers face significant challenges to access carers' assessments and appropriate support. Barriers can include information sharing, stigma, terminology and the quality of delivery.

1.5 million people care for an individual with mental ill health within the UK (Carers Trust 2013). Mental health carers face particular challenges, for example confidentiality and sharing information with professionals, and the unpredictability and the stigma associated with mental health (healthtalk.org, 2013).

3. Impact and Evidence:

Gender reassignment (including transgender): Describe any impact and evidence on transgender people. This can include issues such as privacy of data and harassment:

Gender reassignment profile

There is a lack of good quality statistical data regarding trans people in the UK. Current estimates indicate that some 650,000 people are "likely to be gender incongruent to some degree" Research evidence indicates that trans people experience fear and discrimination when accessing health services.

Transgender people may be less likely to access the care and support they need, and may feel they are likely to experience discrimination. This can put the person and those supporting them under a lot of strain. It is important to be aware of the experiences that they may have had as an Transgender person in the past and how they may affect them today.

Some of the key relevant issues for Transgender people are:

- More likely to live on their own and be single, than heterosexual people
- Fear that mainstream care/support services will not be willing or are not able to understand how to meet their needs

Marriage and civil partnership: Describe any impact and evidence in relation to marriage and civil partnership. This can include working arrangements, part-time working, and caring responsibilities:

Caring responsibilities and impact has been described in the other protected characteristics.
No further equality impacts have been identified in relation to marriage and civil partnerships.

Pregnancy and maternity: Describe any impact and evidence on pregnancy and maternity. This can include working arrangements, part-time working, and caring responsibilities:

No specific equality impacts have been identified in relation to pregnancy and maternity.
Issues around caring and working arrangements are picked up in the Carers section.

Race: Describe race related impact and evidence. This can include information on different ethnic groups, Roma gypsies, Irish travellers, nationalities, cultures, and language barriers:

Race Profile Birmingham

The table below shows the percentage of the population in Birmingham, and BSol by race, taken from the 2011 census.

3. Impact and Evidence:

Race %	B'ham	BSol
White British	53.14%	58.40%
White Irish	2.05%	2.02%
Gypsy/Irish Traveller	0.04%	0.03%
White Other	2.70%	2.49%
White & Black Caribbean	2.30%	2.11%
White & Black African	0.30%	0.27%
White & Asian	1.04%	0.96%
Other Mixed	0.79%	0.70%
Asian Indian	6.02%	5.60%
Asian Pakistani	13.48%	11.56%
Asian Bangladeshi	3.03%	2.59%
Asian Chinese	1.18%	1.06%
Asian Other	2.90%	2.55%
Black African	2.79%	2.41%
Black Caribbean	4.44%	3.87%
Black Other	1.75%	1.49%
Arab	1.02%	0.88%
Other	1.02%	0.91%

- 58% of Birmingham's population is White British, but the White British share varies widely with age. 42% are from a Black and Minority Ethnic background (BAME). BAME groups are very unevenly distributed within Birmingham. The heart of the city has the majority of the 'non-white' ethnic groups. Over half of the 'non-white' population (51%) live in these areas with only 18% in south Birmingham. Birmingham is a growing city linked in part to migration (9.9% increase since 2004)

3. Impact and Evidence:

Language Profile for Birmingham

Proficiency in English (%) Census 2011 data

	Birmingham			BSol		
	Male	**Female**	**Total**	**Male**	**Female**	**Total**
Main language is English	85.13%	84.29%	**84.70%**	87.11%	86.36%	**86.73%**
Main Language is not English	14.87%	15.71%	**15.30%**	12.89%	13.64%	**13.27%**
Where English is not their main language:						
Can speak English very well	37.90%	31.04%	**34.31%**	38.54%	31.74%	**34.98%**
Can speak English well	39.92%	31.78%	**35.66%**	39.62%	31.78%	**35.51%**
Cannot speak English well	19.22%	28.29%	**23.97%**	18.93%	27.81%	**23.58%**
Cannot speak English	2.95%	8.89%	**6.06%**	2.90%	8.67%	**5.93%**

The table above details proficiency in English for Birmingham, extracted from the Census 2011 data. The data shows that 84.7% of the population had English as their main language, in Birmingham, and an overall figure of 86.73% for the area.

Where English was not their main language residents were asked to identify their proficiency in English. Just under 30% stated that they could either not speak English well or at all, in the Birmingham and Solihull area.

The top 10 languages (at the time of the 2011 Census; and other than English) were:

Top 10 Languages in Birmingham			
	Language	**No.**	**%**
1	**Urdu**	29960	**2.45%**
2	**Punjabi**	22014	**1.80%**
3	**Bengali**	14933	**1.22%**
4	**Pakistani Pahari**	10864	**0.89%**
5	**Polish**	9390	**0.77%**
6	**Somali**	8158	**0.67%**
7	**Arabic**	7153	**0.58%**
8	**Pashto**	6189	**0.51%**

3. Impact and Evidence:

9	All other Chinese	5983	0.49%	
10	Gujarati	5489	0.45%	

Carers in Birmingham and Solihull

At the time of the 2011 Census, there were 131,484 people providing unpaid care in Birmingham and Solihull (10.29% of the resident population).

All Resident Population providing care		
No.	%	Hours of unpaid care
77,268	58.77%	1 to 19 per week
20,537	15.62%	20 to 49 per week
33,679	25.61%	50+ per week

Race Profile of Carers, by number of hours provided each week:

White Resident Population Providing Care:	
%	Hours of unpaid care
60.24%	1 to 19 per week
13.71%	20 to 49 per week
26.05%	50+ per week

BAME Resident Population Providing Care:	
%	Hours of unpaid care
55.35%	1 to 19 per week
20.03%	20 to 49 per week
24.62%	50+ per week

3. Impact and Evidence:

Significantly more BAME residents provide 20 to 49 hour's unpaid care per week than White residents.

In terms of different races and provision of unpaid care, White Irish residents were the largest provider followed by White British, Asian and Black communities.

Race	Total No. Residents	% of that population group who provide unpaid care
White Irish	25,956	13.15%
White British	747,465	11.58%
Asian	299,201	8.98%
Black	99,599	8.34%
Other	23,030	6.90%
Mixed	52,009	5.68%
White Other	32,459	5.64%

Research into BAME Carer's Experiences

Carers UK report – **Half a million voices: Improving support for BAME carers** states that whilst BAME carers face the same challenges as all carers they also face additional barriers, for example:

- Stigma of caring for particular conditions, such as mental illness;
- Language and literacy barriers, combing with a lack of knowledge of entitlements;
- Cultural barriers which can hinder access to services;
- A lack of culturally appropriate practical services;
- The fact that BAME communities are seen as homogenous and yet are very diverse;
- Particular barriers faced by refugees;
- Misconception about extended family support that may not exist;
- Faith is not always explored in relation to BAME issues.

These cultural, stereotypes and language barriers can increase the chances of poorer health, poverty and social exclusion.

The research showed through interviews that it is an unfair assumption that all BAME carers would like to have a service that are from their own community. It recommends that "as with all

3. Impact and Evidence:

carers it is important to present them with a range of options. This is particularly the case when there is stigma attached to their caring responsibility. Mainstream carers' groups and centres need to focus on outreach, providing culturally appropriate services and a self-audit of their services and carers they are in contact with."

Furthermore "Carers' groups and centres need to meet needs for BAME carers, for instance providing appropriate food, accessing the right language, being religious aware and providing a friendly atmosphere. Outreach with faith and community organisations to identify BAME carers needs to be continuous because as we all know, the number of people becoming carers and stopping caring each year is the same. It is also important to conduct an audit to evaluate whether they are meeting the needs of all their carers; in particular, the needs of BAME carers in areas where there is a high percentage of BAME carers."

Much of the findings in the above report are supported in a document produced by IRISS (The Institute for Research and Innovation in Social Services) – Improving support for black and minority ethnic carers. Additional considerations or impacts identified are:

- While BME and white carers face similar difficulties in their caring role (namely high levels of stress and difficulties securing paid employment), BME carers are known to experience unique challenges in accessing support services. These challenges arise in the main from **a lack of self-identification among BME individuals** of their status as carers and hence an absence of policy recognition of their needs, compounded by stereotypical assumptions of how their needs are, or should be, met.
- Even when BME carers are identified, research indicates that they face numerous barriers in accessing and using services. These barriers relate to and include communication difficulties, a lack of culturally competent services, the increased isolation experienced by refugees and asylum seekers and **a lack of understanding by BME carers about how services can support them.**

3. Impact and Evidence:

- BME carers who have been assessed and are receiving support often value the support they receive. Many others, however, report that their **cultural needs relating to gender, religion** and diet are not being met by service providers.

The following recommendations are made by IRISS: "In terms of good practice, the evidence suggests the following:

- Training on conducting culturally competent assessments should be provided to staff for undertaking community care/carer assessments.
- Training on cultural diversity is recommended to increase staff confidence and to avoid racial stereotyping.
- Staff should not assume that a family network is providing support.
- Advocates should be encouraged to attend assessments, especially when assessing young BME carers.
- Staff should ensure that BME carers are aware of the complaints procedure and are supported to use it (National Assembly for Wales, 2003c)."

Religion or belief: Describe any religion, belief or no belief impact and evidence. This can include dietary needs, consent and end of life issues:

**Religion and Belief in Birmingham and Solihull**

Data from the 2011 Census in the table below, shows that for the Birmingham and Solihull area, the % of people who stated that they have a religion is higher than the figure for England (73.88% and 68.09% respectively):

	England	Birmingham	Solihull	BSol
Has religion	68.09%	74.19%	72.27%	73.88%
No religion	24.74%	19.27%	21.38%	19.61%
Not stated	7.18%	6.53%	6.35%	6.50%

Christianity is the largest religion in Birmingham however at 46.1% this is lower than that of England as a whole which is 59.4%. Birmingham has more Muslims (21.8%), Sikhs (3%) and Hindus (2.1%) than England (5%, 0.8% and 1.5% respectively).

3. Impact and Evidence:

Christianity is the largest religion in the area accounting for 63% (of those who stated that they had a religion), the next largest is Islam with 24%.

BSol Population with a Religion
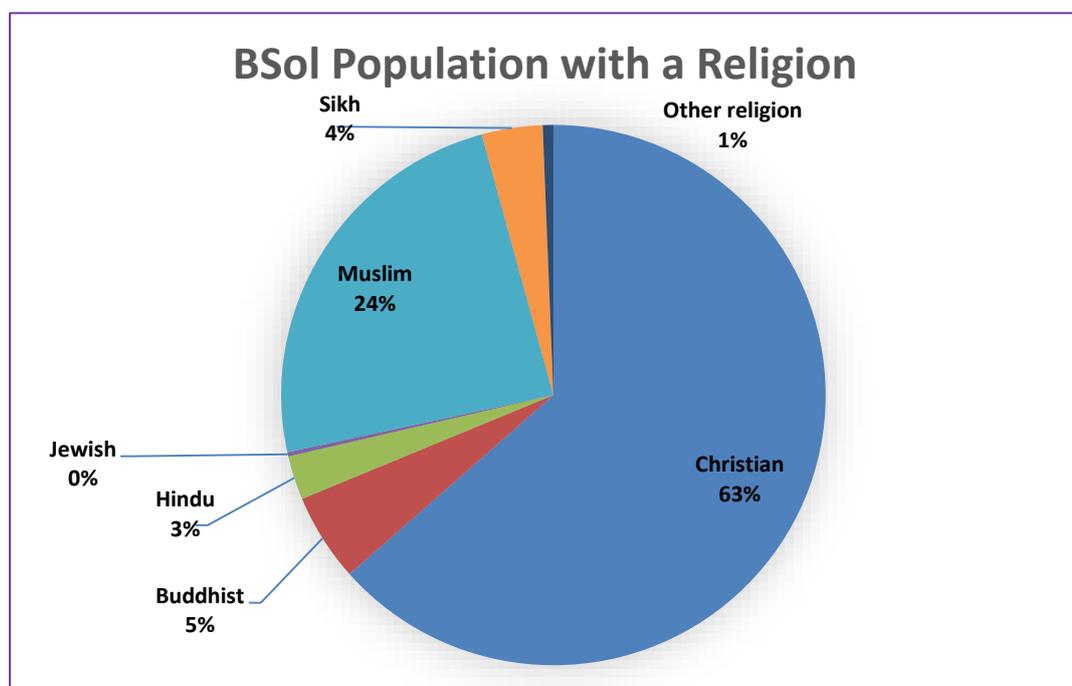
There is evidence that minority ethnic carers are more likely to be isolated from mainstream services. Some may view using a service as a source of shame. In Islam, Hinduism and Sikhism the duty of care is apparent or is regarded as a 'test from God'. *(Source: Social Care Institute for Excellence (https://www.scie.org.uk/dementia/living-with-dementia/bme/) - Black and minority ethnic (BME) communities and dementia).*

Sex: Describe any impact and evidence on men and women. This could include access to services and employment:

Birmingham has a slightly higher number of women 545,239 (50.8%) than men 527,806 (49.2%) this reflects the picture for England as a whole. Life expectancy for men is 77.6 years compared to a national average of 79.4 years, for women it is 82.2 years compared to a national average of 83.1 years. Birmingham has a gap in life expectancy between the most deprived and least deprived areas of 7.4 years for men and 4.9 years for women.

The hours of care provision were captured as part of the 2011 Census; the table below shows the split in terms of gender for the number of unpaid care hours provided:

Care provided for each week	Males	Females
1 to 19 hours	44.12%	55.88%
20 to 49 hours	42.21%	57.79%
50+ hours	38.29%	61.71%

3. Impact and Evidence:

More females than males are providing care for each time period. Overall the proportion of carers in Birmingham and Solihull is the same as the national picture in England and Wales (Census 2011), 42.3% males and 56.7% females providing unpaid care.

When you look at the females/males as individual groups, the majority of care provided by both genders is for 1 to 19 hours per week; females provide significantly more care than men for 50+ hours per week.

	Male	Female
Total No. of Carers	**55,458**	**75,564**
Providing care 1-19 hours	61.18%	56.86%
Providing care 20-49 hours	15.59%	15.67%
Providing 50+ care hours	23.22%	27.47%
	100%	100%

The Carers Trust conducted a survey of Dads who had caring responsibility (**Dads Care Too** - A survey of the experiences of fathers who are carers, July 2015, Authors: Moira Fraser, Rachel Harris). Caring is often seen as a 'female' issue but it is something that affects a large number of men too. The 2011 Census found that in England and Wales more than 4 in 10 carers are male (42.3%) – amounting to 2.44 million men providing care, unpaid, for a friend or family member due to illness, disability, a mental health problem or an addiction.
Findings from the survey include:

"These fathers were all supporting friends or family members with a range of care needs. **Of the dads caring for only one person by far the largest group were dads caring for a son or daughter with a learning disability or autism (72%)**. Many people had multiple conditions or kinds of support needs including 38% of sons or daughters who had physical disabilities or mobility needs and 30% who had communication problems.
44% of the dads who responded to the survey had sole responsibility for providing care for their child or children. There is a common stereotype that men are not the main providers of care and tend to take a more peripheral approach to caring in the home – evidently this is not the case and this perception must be challenged."

"**20% of fathers who were carers in the survey had been caring for 21 years or more**. This perhaps shows that for many dads, caring for a child is a lifelong responsibility that may be less transient than other caring roles."

"Whilst 30% of fathers in this survey had retired, 3**5% continue in employment alongside their caring role.** Just under half of them (49%) felt their responsibilities as a carer were supported by their employers, for example the provision of flexible working arrangements. This leaves 51% who did not feel fully supported at work.
43% indicated that they experience long term health problems or disability themselves. This means that as many as 4 in 10 of the fathers in the survey were having to manage their own condition as well as the challenges of being a carer."

3. Impact and Evidence:

Dad's participating in the survey were asked if they thought that dads have specific needs as carers, the responses included:

> "55% of this group of male carers felt the needs of male carers are different to those of female carers in a range of ways, for example in the social networks that are available. This seemed to be particularly the case for single dads. There were also perceptions of male roles in society, or the kinds of roles they may have had earlier in life which may mean they feel unprepared to take on a caring role.

> This means that for many dads, there is a need to recognise their role which can sometimes feel invisible and unsupported. Those providing support for carers need to recognise dads who care as a group with particular needs, who may need support designed for them to enable them to access this and for them to feel it is inclusive and relevant. This will help to ensure these dads can play the role they want to within their families, and also improve their own health and wellbeing."

The report included the following recommendations:

Carers Trust and the Men's Health Foundation therefore call for:

- Fathers who care to be fully recognised and involved in the care of and decision making about their son or daughter to the extent that they and their families wish.
- Health and care professionals to recognise dads who care as a group likely to experience poor physical or mental health.
- Children and family support services to recognise dads who care, in particular those who are single dads, and promote inclusion and involvement in networks and activities.
- Support services including carers services and commissioners to consult dads who care to ensure services are built to meet their needs.
- Communities and families to recognise the role played by dads who care and offer support.

An earlier survey also carried out by the Carers Trust (Carers Trust, Husband, Partner, Dad, Son, Carer? - A survey of the experiences and needs of male carers (2014)) had the following key findings which support the findings of the survey undertaken in 2015:

- **Over a quarter of male carers in employment said they do not describe or acknowledge themselves as a carer to others.** Employers and health and social care professionals need to be aware that male carers in employment are less likely to identify or describe themselves as a carer to others. Their need for support may not therefore be immediately obvious and might result in them missing out on vital help. Awareness raising is needed of the caring role many employed men undertake and the support available to them. Employers need to have, and make sure all staff are aware of, policies to support carers at work.

3. Impact and Evidence:

- **53% of male carers felt the needs of male carers are different to the needs of female carers.** Challenges for male carers which emerged included a lack of recognition by society, professionals and services; and men being less likely to seek support for their caring role. Male carers also reported that providing intimate care to women that they care for presents a challenge and that taking on domestic tasks previously undertaken by the person they care for can be difficult. Balancing work and care was also a cause of difficulty. Support needs to be developed in a practical, supportive and non-stigmatising way for men taking on caring roles, particularly later on in life, who may find aspects of domestic work difficult if they have previously been done by the person they now care for and for men providing intimate or personal care for women.

- **Over 100 male carers aged 18-64 told us they were not working due to their caring role.** However, many other men balance work with caring responsibilities, with over a quarter of those caring for over 60 hours a week also working.

- **56% of male carers aged 18-64 said being a carer had a negative impact on their mental health.** Health and social care professionals need to identify male carers and address their health needs. Caring has a considerable impact on the mental health of male carers, particularly those aged 18-64 and this group is in need of specific support from a range of NHS and other support services. Commissioners should look to develop services to support this group.

- **Four out of ten male carers never get a break from their caring role and nearly half have not had a carer's assessment. Male carers aged 18-64 are even less likely to have had a carer's assessment than those over 65**. Large numbers of male carers are not being referred for assessment and support. However, we know from this research that these men are in regular contact with health professionals. GPs in particular need to identify male carers and ensure they are referred for assessment and support.

- **Over half of male carers said they did not currently receive help and support from a local carers organisation. Over a quarter of these male carers said this was because they were not aware of the support that may be available to them in their local area.** Commissioners should consider developing services to specifically meet the needs of male carers of all age groups. Health, care and carers organisations should ensure male cares are made aware of existing support available in their local area.

The research also identified:

The research also found that **older male carers are less forthcoming in asking for help and support than older female carers**; meaning they tend to reach crisis point before asking for support from care services. Older male carers are primarily interested in practical support and are less likely to get involved with carers support groups and other group activity that is female dominated with deepens their social isolation.

3. Impact and Evidence:

A key finding from the research is that a quarter of respondents said they didn't get help and support as **they didn't know what help was available to them locally**. This means there is a clear need to raise awareness of men's caring roles and support available to male carers.

A need to ensure what is on offer to male carers is responsive to their needs was also demonstrated – **a third of men said they felt what was currently on offer did not meet their needs**. This may be because traditionally more women have proactively used these services and therefor they have evolved in a way which men feel less drawn to use. This is a useful point for service development, and reflects the informal feedback obtained from local carers organisation.

There were age differences in the findings. Male carers aged 18-64 were more likely than older age groups to not access support from a local carers organisation as they did not know what help was available locally.

However, men over the age of 65 were twice as likely to say that they didn't get help and support from a local carers organisation as they felt what was on offer didn't meet their needs (43% compared with 21%). These two findings reflect the **need to ensure younger male carers receive information on what is available locally, and for older male carers that what is offered meets their needs**.

Sexual orientation: Describe any impact and evidence on heterosexual people as well as lesbian, gay and bisexual people. This could include access to services and employment, attitudinal and social barriers:

Sexual Orientation Profile Birmingham/National

Office for National Statistics:

https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/sexuality/bulletins/sexualidentityuk/2016

- In 2016, just over 1 million (2.0%) of the UK population aged 16 and over identified themselves as lesbian, gay or bisexual (LGB).

- The population aged 16 to 24 were the age group most likely to identify as LGB in 2016 (4.1%).

- More males (2.3%) than females (1.6%) identified themselves as LGB in 2016.

- The population who identified as LGB in 2016 were most likely to be single, never married or civil partnered, at 70.7%.

- In 2016, around 2% of the population identified themselves as lesbian, gay or bisexual (LGB). This has increased from 1.7% in 2015 (a statistically significant increase)

3. Impact and Evidence:

- Around 1.7% of males identified themselves as gay or lesbian in 2016 compared with 0.7% of females. Conversely, 0.9% of females identified themselves as bisexual compared with just 0.6% of males. Overall, a larger proportion of males (2.3%) identified as lesbian, gay or bisexual (LGB) than females (1.6%)

- In 2016 in the UK, 4.1% of the population aged 16 to 24 identified as lesbian, gay or bisexual (LGB). This comprised of 1.7% identifying as gay or lesbian and 2.4% identifying as bisexual. The 16 to 24 age group was the only age group to have a larger proportion identifying as bisexual compared with lesbian or gay.

- The proportion of those aged 16 to 24 who identified as LGB increased from 3.3% in 2015 to 4.1% in 2016. This was not a statistically significant increase.

- The proportion of the population who identified as LGB declined with each consecutive age group (Figure 3). Older age groups were more likely to identify as heterosexual or straight in 2016. Only 0.7% of the population aged 65 and over identified as LGB, whereas for 25 to 34 year olds this was 2.9%.

- One reason for this pattern may be that younger people could be more likely to explore their sexuality, combined with more social acceptability of sexual identities today and the ability to express these.

- In 2016, around 2.7% of the population in London identified themselves as lesbian, gay or bisexual (LGB), the highest proportion of any English region. For the West Midlands the figure is 1.6%

- In 2016, the population identifying as lesbian, gay or bisexual (LGB) were most likely to be single, never married or never civil partnered (70.7%). This could be associated with:

  o the young age structure of the population that identify themselves as LGB

  o legal unions available to same-sex couples are relatively new

  o Those who had a legal marital status of single may be in same-sex cohabiting couples. In the UK, 0.5% of families were same-sex cohabiting couple families in 2016.

- Of the remaining LGB population, 12.6% were in opposite-sex marriages, consisting mainly of those who identified as bisexual, 11.5% were in same-sex marriages or civil partnerships, 4.5% were divorced or had a dissolved civil partnership and 0.7% were widowed or a surviving civil partner.

- In 2016, the Annual Population Survey found that 4.3% of the population who described their ethnicity as "Mixed or multiple ethnic groups" identified themselves as LGB. More than half of them (2.4%) identified themselves as bisexual compared with those who identified as gay or lesbian (1.9%). This was the highest percentage seen among the different ethnic groups.

3. Impact and Evidence:

- The proportion of the "Mixed or multiple ethnic group" population who identified as LGB increased from 2.5% in 2015 to 4.3% in 2016, which was not a statistically significant increase.

Figure 4: English region by gay or lesbian and bisexual population, 2016
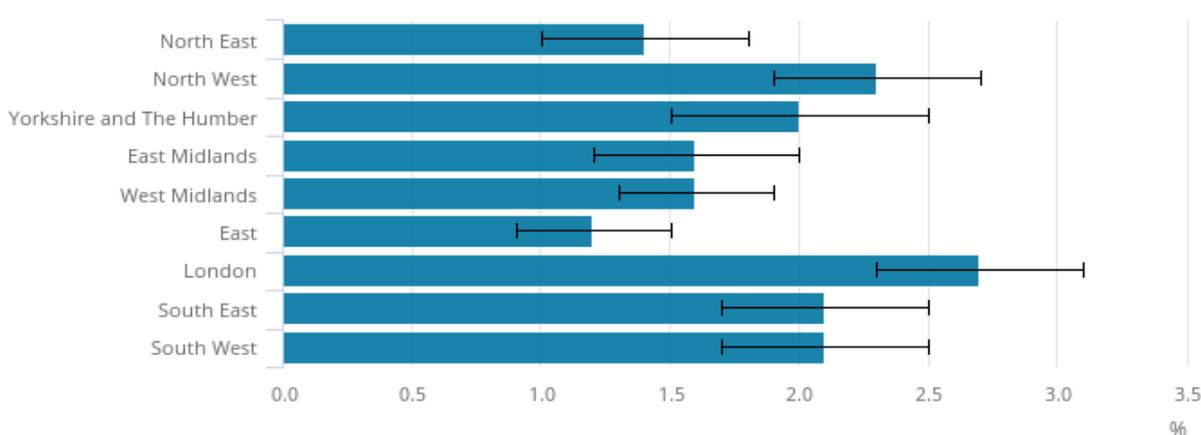
Source: Office for National Statistics

LGBT Carers

Little research has been found on the experience of LGBT carers in England, though the Carers Trust Scotland has undertaken research to explore the experiences of lesbian, gay, bisexual and transgender young adult carers aged 16 to 25 in Scotland. Relevant information has been taken from their report (**Carers Trust Scotland - Young People Caring OUT There: Experiences of LGBT Young Adult Carers in Scotland**).

Key findings:

- LGBT young adult carers feel they are assumed to be either a carer or a LGBT young person, not both, and their needs as LGBT young adult carers are not being fully met.

3. Impact and Evidence:

- LGBT young adult carers are more open to disclosing their LGBT status to their friends rather than their caring role. However, when they do disclose, they are more likely to receive negative reactions because of their LGBT identity rather than their caring role.

- LGBT young adult carers are three times more likely to experience bullying than young adult carers overall. They are also significantly more likely to experience bullying compared to LGBT young people generally. Bullying can have a detrimental and negative long-term impact on a person's mental health and wellbeing.

Getting it Right for Young Carers: The Young Carers Strategy for Scotland 2010-2015 (Scottish Government, 2010) highlighted the need to develop further information, advice and support for LGBT young carers. The strategy recognised that: "LGBT carers have to deal with issues around identity and sexuality at the same time as having to undertake caring responsibilities. These demands can affect their ability to form friendships, to access services and to source the necessary support to overcome these challenges. They may fear discrimination and stigma, as a result of both their sexuality and their caring responsibility, which may be to the detriment of their mental wellbeing."

The Carer's Trust Scotland made a number of recommendations, including:

- **Awareness in education and health**: better awareness of LGBT young adult carers and the difficulties they can experience. Embed intersectional identities across the education curriculum and in promotional health resources.

- **Greater identification in health**: health and social care professionals must be aware of issues related to health and wellbeing faced by many LGBT young adult carers. There must be better identification by professionals and robust policies across all health boards that enable them to refer on to relevant services or to provide support directly as appropriate.

- **Intersectional identify training for support services**: carer support services and LGBT youth services should help and signpost young people to access relevant information and support as required; they should receive intersectional training to raise awareness and further develop skills.

3. Impact and Evidence:

Carers: Describe any impact and evidence on part-time working, shift-patterns, general caring responsibilities:

Identification as a Carer

According to Carers UK report - **Making Connections, Get Support - Recognising ourselves and others as carers** (2017) "Getting the right information and advice to support you to care without putting your life on hold is a challenge and is made more difficult by the complexity and disjointed nature of our health, care and welfare systems. However, **the biggest challenge of all can be identifying yourself as someone entitled to the support on offer**."

This builds on the findings of their 2016 research - **Missing out - The identification challenge**, (Nov 2016) which stated "

> "For many people, looking after an ill, older or disabled loved one doesn't have a name, it is 'just something you do'. However, not recognising you are caring out a caring role can be a real barrier to accessing vital support.
>
> If you do not see yourself as a carer, then you are unlikely to consider asking for a carer's assessment, applying for Carer's Allowance, or seeking advice from others who find themselves in similar circumstances. Not recognising you are caring means missing out on help, advice and information, with serious personal and financial implications.
>
> The findings are stark. They demonstrate that the majority of carers take years to recognise their role, missing out on crucial financial, practical and emotional support in the meantime. This research demonstrates that, by not receiving support at an early stage, the negative impacts of caring are intensified with many carers missing out on benefits and entitlements and others forced to give up work altogether. On a personal level, a lack of practical help can have a huge impact on health and wellbeing, from long-term physical health such as back pain, to mental ill health and social isolation and as a result of caring without a supportive network.
>
> The longer it takes to identify as a carer the more likely it is that carers will struggle without the support and advice they need".

3. Impact and Evidence:

The majority of carers take years to recognise their caring role:

- Over half of carers (54%) took over a year to recognise their caring role.
- Almost one in four carers (24%) took over 5 years to identify as a carer, and nearly one in ten (9%) took over 10 years.

Some groups of carers, such as parent carers, mental health carers and distance carers, take longer than average to identify their role.

Not recognising a caring role is a significant barrier to accessing support:

- 91% of carers said they missed out on financial or practical support (or both) as a result of not identifying as a carer.

The impact of missing out on support due to not identifying as a carer is significant:

- Half of carers (50%) said that missing out on support had an impact on their physical health.
- Three quarters of carers (78%) suffered from stress and anxiety as a result of missing out on support.
- 3 in 5 carers (61%) said missing out on support put a strain on their relationships with friends and family.
- For half of carers (52%) missing out on support impacted negatively on their finances

Mental Health Carers

Those caring for someone with a mental health condition took significantly longer than average to identify as a carer.

- 28% of mental health carers took 5+ years to identify themselves.

For many, caring is perceived as being a physical role – helping life and dress someone, or helping the person receiving care use the toilet, for example. In contrast, mental health carers are more likely to be co-ordinating support, helping with paperwork and finances and providing emotional support, and this can act as a barrier to recognition.

Carers and Employment

In the '**State of Caring 2017'** by Carers UK, the impact of caring on employment is highlighted:

- Three million people, 1 in 9 of the workforce, combine caring for a loved one with paid work. However, the significant demands of caring mean that many are forced to give up work altogether, due to a lack of rights, flexibility and high quality care services at home.

3. Impact and Evidence:

Carers need to be supported so that they are able to juggle work and care and to enable them to return to work if they wish.

- A third (37%) of carers responding to the survey reported currently being in paid work. As many as a quarter (25%) of those providing care for over 50 hours a week reported being in paid work.

- Responses illustrate how caring takes a toll on people's employment opportunities, including career development, promotions and pay rises, as well as impacting upon carers' ability to work at all. And as many as 4 out of 10 carers (43%) said they had given up work completely to care, with 13% reporting that they had retired early to care.

- 1 in 5 of all carers (21%) said they had reduced their working hours to care. Nearly half of working carers (46%) said that they work the same hours but that their job is negatively affected by caring through tiredness, lateness and stress. 14% of all carers reported having had to take a less qualified job or having to turn down promotion to fit around their caring responsibilities.

- Having to work at the same time as providing care has a significant effect on people's health. Carers in paid work were more likely to have suffered mental ill health as a result of caring than some other groups, including stress and anxiety, with over 7 in 10 carers in paid employment (72%) reporting this.

- (55%) said their physical health has worsened as a result of caring. Two thirds (67%) said they found it difficult to get a good night's sleep, and half said they have reduced the amount of exercise they take (56%) and found it difficult to maintain a balanced diet (47%).

- Carers in paid work are also the group for whom it is least likely that their GP knows they are a carer, with a quarter (25%) of those in paid work reporting this. This suggest opportunities for them to be better supported in their caring role and to help them look after their own health and wellbeing are being missed.

Other disadvantaged groups: Describe any impact and evidence on groups experiencing disadvantage and barriers to access and outcomes. This can include lower socio-economic status, resident status (migrants, asylum seekers), homeless, looked after children, single parent households, victims of domestic abuse, victims of drugs / alcohol abuse: (This list is not exhaustive)

Barriers to access and the disadvantages experienced by carers are detailed in the previous sections.

4. Health Inequalities	Yes/No	Evidence
Could health inequalities be created or persist by the proposals?	No	This service aims to improve outcomes, independence and choices for mental health carers, and for carers of individuals diagnosed with Autism or ADHD including young mental health carers (aged 4 – 17 years). The focus shouldn't lead to health inequalities.
Is there any impact for groups or communities living in particular geographical areas?	Yes	The service will be available across Birmingham; Solihull has a pre-existing service.
Is there any impact for groups or communities affected by unemployment, lower educational attainment, low income, or poor access to green spaces?	Yes	The service supports carers and therefore will inevitably support carers who are unable to work due to caring commitments.
How will you ensure the proposals reduce health inequalities? The service will proactively engage with under-represented groups and will develop effect referral processes and signposting arrangements; it will provide access to high quality information resources and a range of support to mental health carers based on a holistic understanding of their needs.		

5. FREDA Principles/ Human Rights	Question	Response
Fairness – Fair and equal access to services	How will this respect a person's entitlement to access this service?	The service will be available across Birmingham; Solihull has a pre-existing service.
Respect – right to have private and family life respected	How will the person's right to respect for private and family life, confidentiality and consent be upheld?	Service will respect private and family life and also improve access to information to support informed decision making and future planning, 'capacity' advocacy and safeguarding as appropriate.
Equality – right not to be discriminated against based on your protected characteristics	How will this process ensure that people are not discriminated against and have their needs met and identified?	Principles around equality will be embedded in contract and monitored through the contract review structure.
	How will this affect a person's right to freedom of thought, conscience and religion?	Service will respect people's right to choose.

Dignity – the right not to be treated in a degrading way	How will you ensure that individuals are not being treated in an inhuman or degrading way?	Quality standards will be embedded in contract and monitored through the contract review structure.
Autonomy – right to respect for private & family life; being able to make informed decisions and choices	How will individuals have the opportunity to be involved in discussions and decisions about their own healthcare?	The service is designed to inform and support people to make decisions that impact on them.
Right to Life	Will or could it affect someone's right to life? How?	No
Right to Liberty	Will or could someone be deprived of their liberty? How?	No

6. Social Value

Consider how you might use the opportunity to improve health and reduce health inequalities and so achieve wider public benefits, through action on the social determinants of health.

Marmot Policy Objective	What actions are you able to build into the procurement activity and/or contract to achieve wider public benefits?
Enable all people to have control over their lives and maximise their capabilities	The service seeks to inform and support people who care for people with a mental health illness or a diagnosis of Autism or ADHD.
Create fair employment and good work for all	The service may not create employment, but is expected to have a positive impact on carers who are also in employment or would like to seek employment.
Create and develop health and sustainable places and communities	The service will work with others to create and develop sustainable places and communities.
Strengthen the role and impact of ill-health prevention	This service will promote ill-health prevention and support early access to information.

7. Engagement, Involvement and Consultation

If relevant, please state what engagement activity has been undertaken and the date and with which protected groups:

Engagement Activity	Protected Characteristic/ Group/ Community	Date

For each engagement activity, please state the key feedback and how this will shape policy / service decisions (E.g. patient told us …. So we will …..):

No engagement work has been undertaken.

8. Summary of Analysis

Considering the evidence and engagement activity you listed above, please summarise the impact of your work:

Age
- 10.29% of the local population are providing unpaid care each week (11.75% in Solihull and 10% in Birmingham).
- 10% of carers are young people (aged up to 24)
- 19% of carers are aged 65+
- 25% of carers provide care for more than 50 hours per week.
- Young adult cares are at substantial risk of a variety of negative outcomes, including poorer physical health, emotional problems and educational difficulties.

Race
- The Birmingham and Solihull has a diverse population; 58.4% of residents being White British, 11.56% Asian Pakistani, 5.6% Asian Indian and 3.87% Black Caribbean.
- English is not the main language for 13.27% of BSol residents (15.3% Birmingham and 2.9% Solihull).
- Of those for whom English is not their first language, 5.93% of residents cannot speak English at all.
- 20.03% of BAME carers provide between 20 and 49 hours' unpaid care per week.
- Irish carers are proportionately the largest provider of care of the different ethnic groups, with 13.15% of Irish residents providing care, compared to 11.58% of white British residents, 8.9% of Asian residents and 8.34% of Black residents.
- Barriers experienced by BAME carers include – stigma (particularly those caring for people with a mental health illness), language and literacy, lack of knowledge of entitlement and cultural barriers.

Disability/Health
- Caring can have a significant impact on health, with the pressures of providing care taking a toll on both carers physical and mental wellbeing. Those providing round the clock care are more than twice as likely to be in bad health than non-carers.
- Mental health carers face significant challenges to accessing carer assessments and appropriate support. Barriers include information sharing, stigma, terminology and quality.

Gender
- Women are more likely to be providing care than men (56.7% and 42.3% respectively); though the numbers of men providing care is significant.
- Caring is often seen as a female issue – common stereotype that men are not the main providers of care, yet 55,458 BSol male residents provide unpaid care.
- In the Carers Trust survey of Dad's who care – they found that the dads caring for one person by far the largest group were dads caring for a son or daughter with a learning disability or autism (72%).
- Over a quarter of male carers in employment said they do not describe or acknowledge themselves as a carer.

Dad's participating in the survey were asked if they thought that dads have specific needs as carers, the responses included:

"55% of this group of male carers felt the needs of male carers are different to those of female carers in a range of ways, for example in the social networks that are available. This seemed to be particularly the case for single dads. There were also perceptions of male roles in society, or the kinds of roles they may have had earlier in life which may mean they feel unprepared to take on a caring role.

This means that for many dads, there is a need to recognise their role which can sometimes feel invisible and unsupported. Those providing support for carers need to recognise dads who care as a group with particular needs, who may need support designed for them to enable them to access this and for them to feel it is inclusive and relevant. This will help to ensure these dads can play the role they want to within their families, and also improve their own health and wellbeing."

- Over half of male carers said they did not currently receive help and support from a local carers organisation. Over a quarter of these male carers said this was because they were not aware of the support that may be available to them in their local area.
- Older male carers are less forthcoming in asking for help and support than older female carers.
- Older male carers are primarily interested in practical support and are less likely to get involved with carers support groups and activities that is female dominated, which deepens their social isolation.
- Many (males) are not aware of what support is available locally and where there is some awareness, some age groups felt that the groups did not meet their needs.

Sexual Orientation
- Little research into the impact and experience of LGBT carers, particularly adults.
- LGBT young carers report that they 'feel they are assumed to be either a carer or a LGBT young person, not both and their needs as LGBT young adult carer are not being fully met.'
- LGBT young adult carers are 3 times more likely to experience bullying than young adult carers overall. They are also significantly more likely to experience bullying compared to LGBT young people generally. Bullying can be detrimental and have a negative long-term impact on a person's mental health and wellbeing.

Carers – General
- The biggest challenge of all can be identifying yourself as a carer and therefore as someone entitled to the support on offer.
- Majority of carers take years to recognise their role, missing out on crucial financial, practical and emotional support.
- Over half of carers (54%) took over a year to recognise their caring role.
- Some groups of carers such as parent carers, mental health carers and distance carers take longer than average to identify their role.
- 28% of mental health carers took 5+ years to identify themselves.
- For many, caring is perceived as being a physical role – helping life and dress someone, or helping the person receiving care use the toilet, for example. In contrast, mental

health carers are more likely to be co-ordinating support, helping with paperwork and finances and providing emotional support, and this can act as a barrier to recognition.

Carers – Employment
- Having to work at the same time as providing care has a significant effect on people's health. Carers in paid work were more likely to have suffered mental ill health as a result of caring than some other groups, including stress and anxiety, with over 7 in 10 carers in paid employment (72%) reporting this.
- (55%) said their physical health has worsened as a result of caring. Two thirds (67%) said they found it difficult to get a good night's sleep, and half said they have reduced the amount of exercise they take (56%) and found it difficult to maintain a balanced diet (47%).
- Carers in paid work are also the group for whom it is least likely that their GP knows they are a carer, with a quarter (25%) of those in paid work reporting this.

9. Mitigations and Changes :

Please give an outline of what you are going to do, based on the gaps, challenges and opportunities you have identified in the summary of analysis section. This might include action(s) to mitigate against any actual or potential adverse impacts, reduce health inequalities, or promote social value. Identify the **recommendations** and any **changes** to the proposal arising from the equality analysis.

Recommendations:

1. Projects for young carers and young adult carers should seek ways to reduce the amount of care provided by children and young people. This may take the form of helping young people access services and information, facilitating contacts with local authorities and service providers, and enabling young people to access relevant training to help them in their caring roles. It will also mean working with adult service providers to ensure that disabled and other parents receive adequate support so reducing the need for children and young people to provide care.
2. There is a need to examine the accessibility and usefulness of online support materials for young adult carers and update and improve these as appropriate in order to make them relevant to this group of young people.
3. Service providers should identify how they will address the barriers experienced by mental health carers around information sharing, stigma, terminology and accessing carers assessments.
4. Mainstream carer's groups need to focus on outreach, providing culturally appropriate services and evaluate how they are meeting the needs of BAME carers.
5. Training on conducting culturally competent assessments should be provided to staff for undertaking community care/carer assessments.
6. Training on cultural diversity is recommended to increase staff confidence and to avoid racial stereotyping.
7. Staff should not assume that a family network is providing support.

8. Advocates should be encouraged to attend assessments, especially when assessing young BME carers.

9. Fathers who care to be fully recognised and involved in the care of and decision making about their son or daughter to the extent that they and their families wish.

10. Recognise dads who care as a group likely to experience poor physical or mental health.

11. Support services to promote inclusion and involvement for dads who care and design services to meet their needs.

12. Ensure that younger male carers receive information on what is available locally, and for older male carers that what is offered meets their needs.

13. **Awareness in education and health**: better awareness of LGBT young adult carers and the difficulties they can experience. Embed intersectional identities across the education curriculum and in promotional health resources.

14. **Greater identification in health**: health and social care professionals must be aware of issues related to health and wellbeing faced by many LGBT young adult carers. There must be better identification by professionals and robust policies across all health boards that enable them to refer on to relevant services or to provide support directly as appropriate.

15. **Intersectional identify training for support services**: carer support services and LGBT youth services should help and signpost young people to access relevant information and support as required; they should receive intersectional training to raise awareness and further develop skills.

16. Services to consider how they can overcome the challenge of enabling carers to identify themselves as a carer entitled to support, advice and information.

17. Equality monitoring (age, disability, race, sexual orientation, gender reassignment, religion, caring status, sex) Provider to ensure that this data is captured and reported upon to the Commissioner. This will enable a better understanding of who is using the service and to identify any gaps in terms of reach and representation.

18. Targeted work (LGBT, BAME, Men, Younger People) – the Provider will need to have a plan of action to demonstrate how they will tailor the service to meet the needs of specific target groups.

19. Staff Training (Culture, Equality, LGBT) – Provider will need to demonstrate that staff involved in delivering the service have received training on understanding diverse communities, their needs and barriers to access.

20. Promotional Material (including Terminology) – information used to promote the service will be inclusive, relevant to the local diverse communities and accessible

New Recommendation
The original equality analysis referred to both Birmingham and Solihull; it has since been identified that this service already exists in Solihull and so this revised EA focuses solely on Birmingham.

It is unclear what equality analysis was undertaken to inform the service design in Solihull – it is recommended that the service is reviewed taking into account the analysis and findings of this and the previsions EA to ensure that needs of the local community are being met.

10. Contract Monitoring and Key Performance Indicators

Detail how and when the service will be monitored and what key equality performance indicators or reporting requirements will be included within the contract (refer to NHS Standard Contract SC12 and 13):

- Equality Profile – carers – detailed anonymous equality monitoring of service users.
- Improving Access (CQUIN) – payment for understanding barriers to access, having a plan for improving access with under-represented groups and for improving GP's knowledge of the service as well as demonstrable and evidenced improvement's achieved over the period of the contract.
- Accessible Information Standard – provider will need to demonstrate an understanding of the standard and be able to provide examples of reasonable adjustments made to meet the information and communication needs of service users and their carers.
- Translation/Interpreting Service provision – provider will need to demonstrate how they will meet the language needs of service users and their carers.
- Service User and Carer feedback – monitoring of feedback on experience of the service.
- Staff equality/cultural competency training.

11. Procurement

Detail the key equality, health inequalities, human rights, and social value criteria that will be included as part of the procurement activity (to evaluate the providers ability to deliver the service in line with these areas):

- **Translation/Interpreting Service provision** – provider will need to demonstrate how they will meet the language needs of service users and their carers
- **Accessible Information Standard** – provider will need to demonstrate an understanding of the standard and be able to provide examples of reasonable adjustments made to meet the information and communication needs of service users and their carers.
- **Equality Monitoring** – provider will need to demonstrate how they will use equality monitoring to improve access to the service for a diverse population; including men, younger people, LGBT, and BAME communities.
- **Staff Training** (Cultural Competencies, LGBT) – Provider will need to demonstrate that staff involved in delivering the Dementia Navigator service will/have received training on understanding diverse communities, their needs and barriers to access

- **Equality Policy** in place which covers both employees and service users
- **Provider to demonstrate how they will adapt service provision to meet the needs of different groups, in particular men, younger people, LGBT and ethnic minority groups.**

12. Publication

How will you share the findings of the Equality Analysis?

This can include: reports into committee or Governing Body, feedback to stakeholders including patients and the public, publication on the web pages.

The completed equality analysis will be published on NHS Birmingham and Solihull CCG webpages

13. Sign Off

The Equality Analysis will need to go through a process of **quality assurance** by the Senior Manager for Equality and Diversity or Manager for Equality and Diversity **and** signed-off by a delegated committee

	Name	Date
Quality Assured By:	Michelle Dunne, Equality & Diversity Manager	7th August 2018
Which Committee will be considering the findings and signing off the EA?	BSol SBP – SWBCCG – SCR –	3/8/18 24/8/18
Minute number (to be inserted following presentation to committee)		