HARINGEY COUNCIL

EQUALITY IMPACT ASSESSMENT FORM

Service: Carers

Directorate: Adult, Culture and Community Services

Title of Proposal: Revision of Haringey Carers Strategy

Lead Officer (author of the proposal): Barbara Nicholls

Names of other Officers involved: Jan Bryant
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Step 1 - Identify the aims of the policy, service or function

Haringey Carers Strategy was first developed in 2004-2005 as a multi-agency strategy for improving support to unpaid carers in Haringey. Its aim was to develop sustainable and appropriate services and support for known carers and to reach out and identify carers who were 'hidden' from services.

Its vision was that, by 2008, "carers in Haringey are empowered to care and live a better life".

The strategy was underpinned by an action plan which detailed the contribution of all the partners to delivering the goals of the Strategy. Key areas for improvement were identified:

- Information
- Assessment of carers' needs
- Carers' health and short breaks
- Carers' employment and financial security
- Voice of carers in service planning

It is now time to revise the existing strategy and update the action plan, assessing what has been achieved so far, what is still work in progress and what new objectives need to be set. These should take account of legislative changes, national and local policy developments and the needs and aspirations of Haringey carers.

Haringey Adult Carers Strategy 2009-2014 is a partnership strategy for the longer term. The strategy as a whole seeks to improve the support offered to carers in their caring roles whilst ensuring that they have the opportunities to lead a life outside caring e.g. through the provision of breaks from caring. It seeks to ensure that carers do not have their health compromised by their caring role and to mitigate the financial burden involved in caring. Carers should, through better information and improved service provision, be able to have the same choice and control in their lives as those without caring responsibilities.

A further intended effect is to strengthen partnership working and to secure

commitment and actions on the basis that *carers are everybody's business*. Carers' involvement and carers' views of what is important are the foundation of the strategy's development.

The revised strategy will benefit unpaid carers, aged over 18 years, caring for adults living in Haringey, aged over 18 years. *A carer is someone who looks after a partner, parent, brother or sister, son or daughter (including adult children) or a friend who is ill or disabled, and would not be able to live in the community without their help. They are unpaid. (*Haringey Carers Strategy 2005-8 definition)

Because most carers support a person with a disability, it can reasonably be assumed that a strategy for improving support to carers will also have some beneficial effect on the disabled population. What matters most to carers is the provision of quality services to the person they look after. Carers do not want to be supported to the detriment of the person they look after.

A number of legislative changes, policy initiatives and new strategies have impacted significantly on the status of carers and how they are supported. These are set out in full in the Strategy document. To select the most important:

- **Forthcoming Equalities Bill April 2009**
  will outlaw discrimination against carers. Employers and service providers must not treat carers differently to people who do not have caring responsibilities

- **A New Deal for Carers Feb. 2007**
  announced a review of the 1999 National Carers Strategy and 'key deliverables'

- **Personalisation: Putting People First Dec. 2007**
  sets out the vision for the transformation of adult social care with citizens empowered to shape their own lives and the services they receive

- **Darzi review of the NHS-High Quality Care For All 2008**
  calls for a health service that empowers staff and gives patients choice , providing health care that is personalised and fair

- **New National Carers Strategy June 2008**
  sub-titled *Carers at the heart of 21st-century families and communities "A caring system on your side. A life of your own"*

Step 2 - Consideration of available data, research and information

According to the 2001 census, 15,967 people in Haringey identify themselves as unpaid carers. This represents 7.4 % (1 in 13) of the *usual resident population* of the borough (216,507).

3,232 Haringey carers (20% of carers) provide care for 50 or more hours a week. 10,637 Haringey carers (67% of carers) provide care for 1-19 hours a week.

6 million people in the UK care, unpaid.

The 2001 census gives the total Haringey population *living in households* as 214,379 and this figure is the one used in the tables below:

Gender profile

Men make up 41% of carers and women 59% compared with a male to female ratio of 48:52 for all people in the borough. (Since 2001 the gender difference has reduced and by 2007 Mid Year estimates -224,700 people in total- there are roughly equal numbers of men and women resident in Haringey).

Gender difference is apparent in the *number of hours* men and women carers spend caring; women undertake a larger volume of caring:

Unpaid care by gender, Haringey, 2001

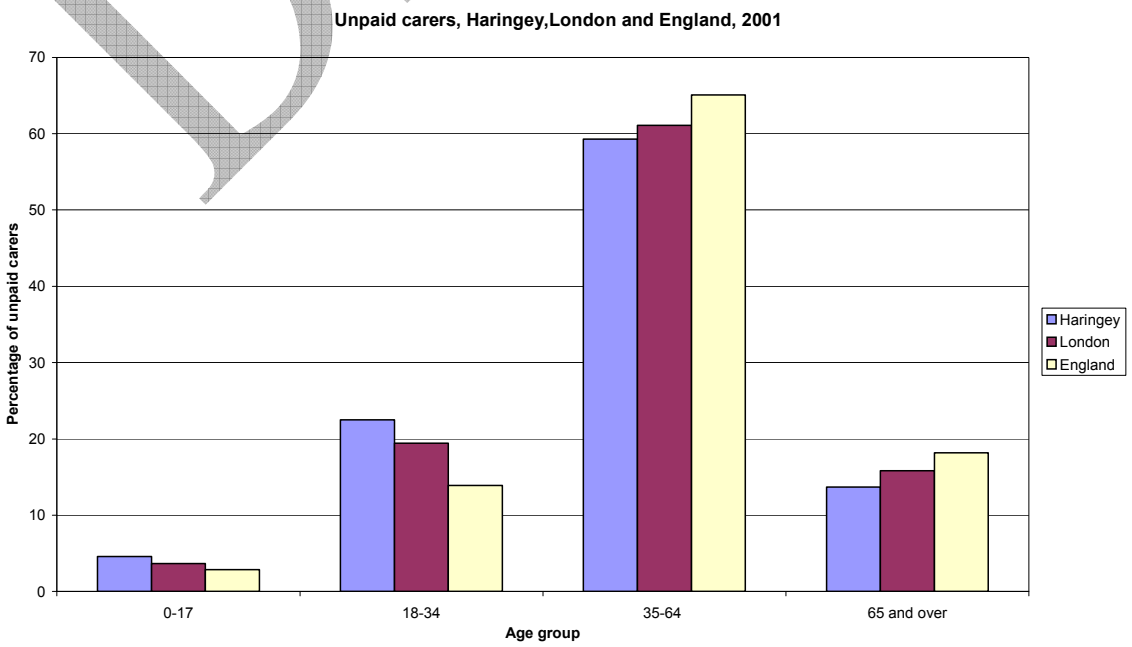
Table Population: All people in households

	Total	Provides no care		1 to 19 hours		20 to 49 hours		50 or more hours	
		No.	%	No.	%	No.	%	No.	%
All people	214,379	198,490	92.59	10,597	4.94	2,097	0.98	3,195	1.49
Male	102,644	96,189	93.71	4,534	4.42	837	0.82	1,084	1.06
Female	111,735	102,301	91.56	6,063	5.43	1,260	1.13	2,111	1.89

Of those who care 1-19 hours, 57% are women and 43% are men
Of those who care 20-49 hours, 60% are women and 40% are men
Of those who care 50 or more hours, 66% are women and 34% are men

Age profile

From census data, the peak age for caring in Haringey is between 35-49 years. The table below shows the age profile of Haringey carers compared with that of carers in London and in England:



Source: 2001 Census Standard Table ST025. Crown copyright 2005

In overall terms Haringey carers are younger and in comparison Haringey has the most young adult carers aged 18-34 years. In 2006 over half the general population of Haringey was less than 35 years of age (ONS Mid Year Estimate).

Ethnic profile

According to the 2001 census, 34.4% of the population of Haringey reported that they were of Black and Minority Ethnic origin (BME). In 2005 it was estimated that the largest ethnic groups in Haringey were White British (47.6%), White Other (14.1%)- includes white commonwealth, USA, European Union, eastern European and middle eastern origins- Black Caribbean (8.3%) and Black African (9.1%). Haringey is the 5th most diverse borough in London. Between 2001-2005, the largest growth in the Haringey population was seen in the Pakistani (38.1%), Chinese (36%) and mixed White and Asian (12.5%) communities (source: JSNA page 5).

From the 2001 census, the ethnic profile of the 'usual resident population' of Haringey is made up as follows:

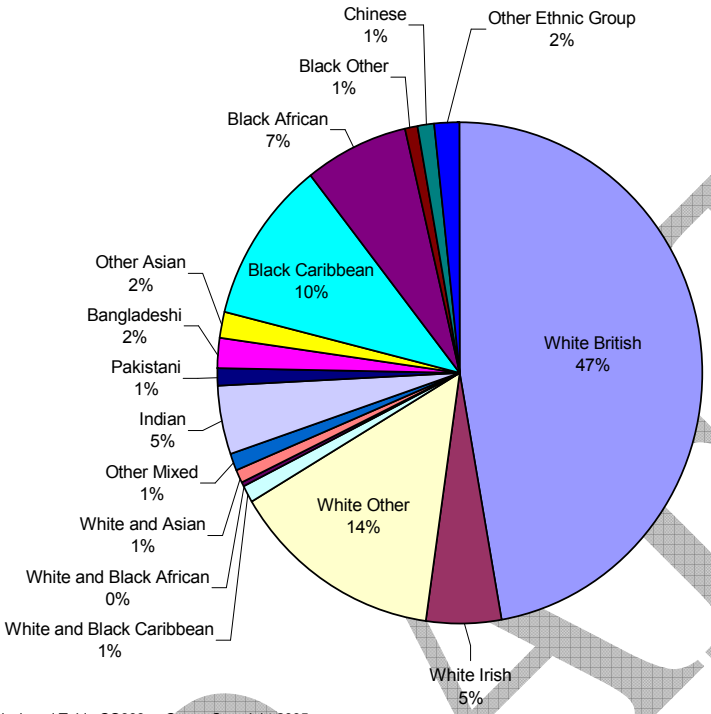
Ethnic origin of Haringey Residents 2001

Ethnic Group	Haringey		London
	Number	%	%
White - British	98,028	45.28	59.79
White - Irish	9,302	4.3	3.07
White Other	34,752	16.05	8.29
Sub Total White	*142,082*	*65.63*	*71.15*
White & Black Caribbean	3,205	1.48	0.99
White & Black African	1,551	0.72	0.48
White & Asian	2,329	1.08	0.84
Other mixed	2,761	1.28	0.85
Sub Total Mixed	*9,846*	*4.56*	*3.16*
Indian	6,171	2.85	6.09
Pakistani	2,046	0.95	1.99
Bangladeshi	2,961	1.37	2.15
Asian or Asian British - Other	3,348	1.55	1.86
Sub Total Asian & Asian British	*14,526*	*6.72*	*12.09*
Caribbean	20,570	9.50	4.79
African	19,879	9.18	5.28
Black or Black British - Other	2,928	1.35	0.84
Sub Total Black or Black British	*43,377*	*20.03*	*10.91*
Chinese	2,444	1.13	1.12
Other Ethnic Group	4,232	1.95	1.58
Sub Total Chinese or Other Ethnic Group	*6,676*	*3.08*	*2.7*
TOTAL	**216,507**	**100%**	**100%**
Source: ONS 2001 Census- Table KS06			

The 2001 census gives the most recent data on the ethnic make up of unpaid carers. The ethnicity of all residents who provide unpaid care is represented in the chart below:

Graphic A

Residents in Haringey who provide unpaid care, 2001



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Ethnic groups over-represented as carers (by more than 1%) compared with their profile in the local population:

Ethnic group	Ethnic profile all residents	Ethnic profile of carers
White British	45.3%	47%
Indian	2.9%	5%

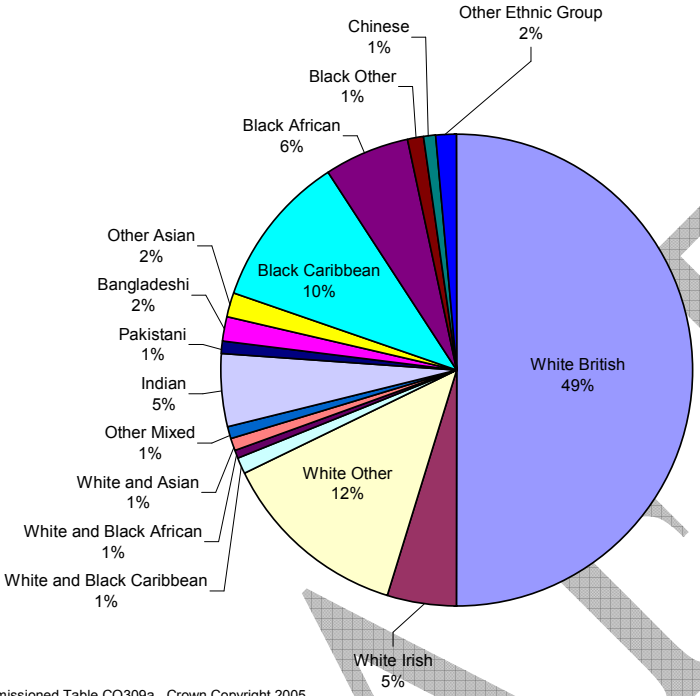
Ethnic groups under-represented as carers (by more than 1%) compared with their profile in the local population:

Ethnic group	Ethnic profile all residents	Ethnic profile of carers
White Other	16.1%	14%
Black African	9.2%	7%

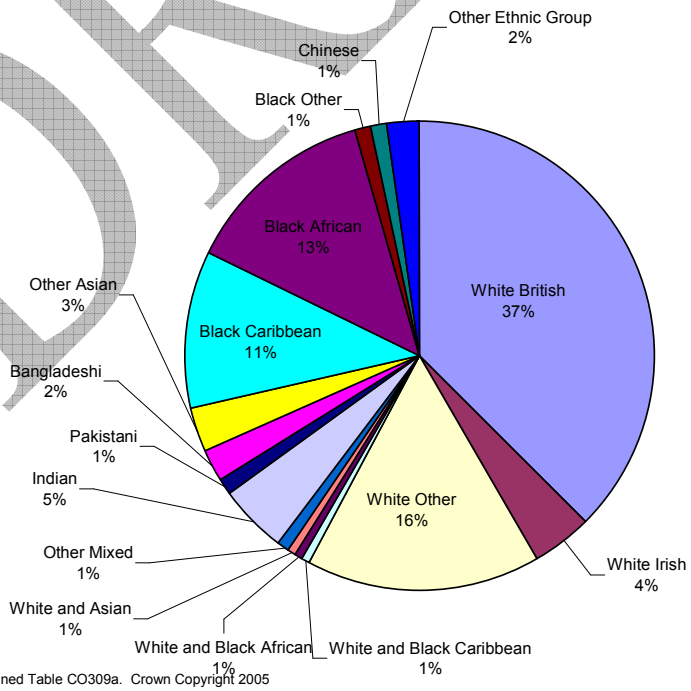
Differences of 1-2% are in the nature of the data slight, especially when decimal figures are rounded up. There was also a 17% non-response rate to the census in Haringey. Small differences, therefore, may be due to chance. However, the over-representation of people of Indian ethnic origin as carers, given their profile in the local population, merits attention.

If the variable of number of hours spent caring is introduced, the charts show differences in the pattern of unpaid care:

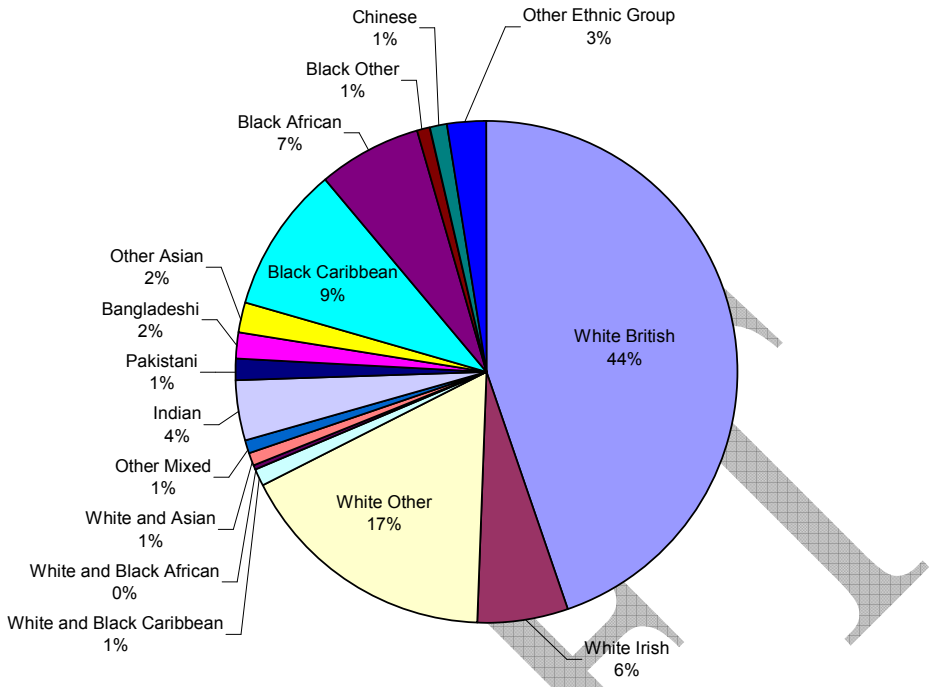
Residents in Haringey who provide 1-19 hours of unpaid care per week, 2001



Residents in Haringey who provide 20-49 hours of unpaid care per week, 2001



Residents who provide 50+ hours of unpaid care per week, 2001



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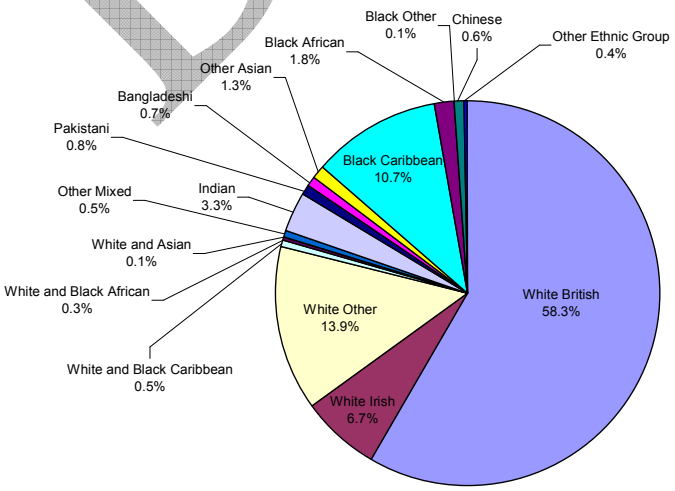
Of Haringey residents who provide 20-49 hours, there is a 10% drop in White British carers, a 6% increase in Black African carers and 2% increase in White Other carers compared with overall figures (Graphic A above). Speculatively, cared for people from these communities may either be exceeding the threshold for care, thence be receiving day care services (to account for the *reduction* in unpaid carers) or at a stage where they need more input from unpaid carers e.g. children with disabilities who are in school on weekdays (to account for the increase in unpaid carers).

When age intersects with ethnicity, the results for all carers of pensionable age (under 60 years for women, under 65 years for men) are reproduced below:

Residents of pensionable age who provide unpaid care, Haringey, 2001



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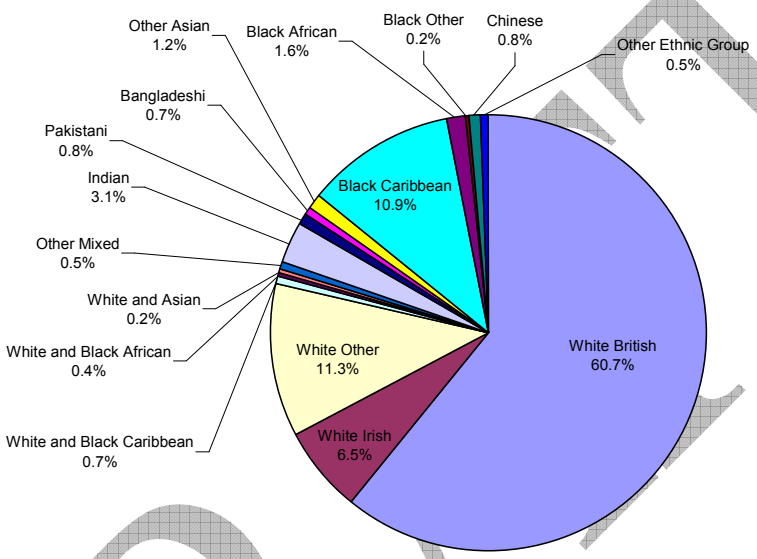
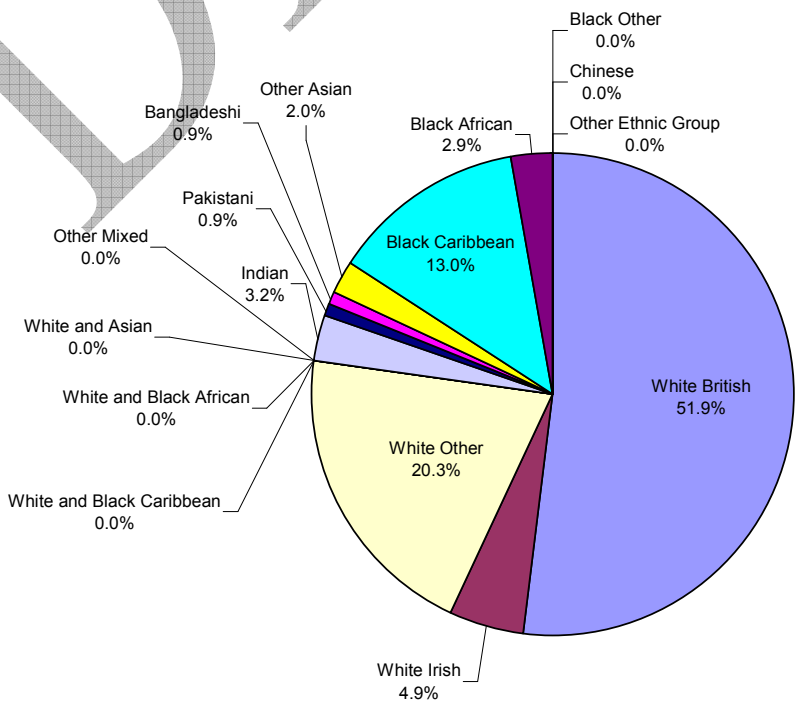
White British carers of pensionable age make up 58% of the total (up from 47%) and Black African carers of pensionable age make up 2% (down from 7%) compared with all carers (Graphic A). Differences in age structure between majority ethnic and minority ethnic groups are reflected here; generally black and minority ethnic carers are younger, which also means they are of working age.

If the variable of number of hours spent caring is again introduced, differences in patterns of caring again emerge:

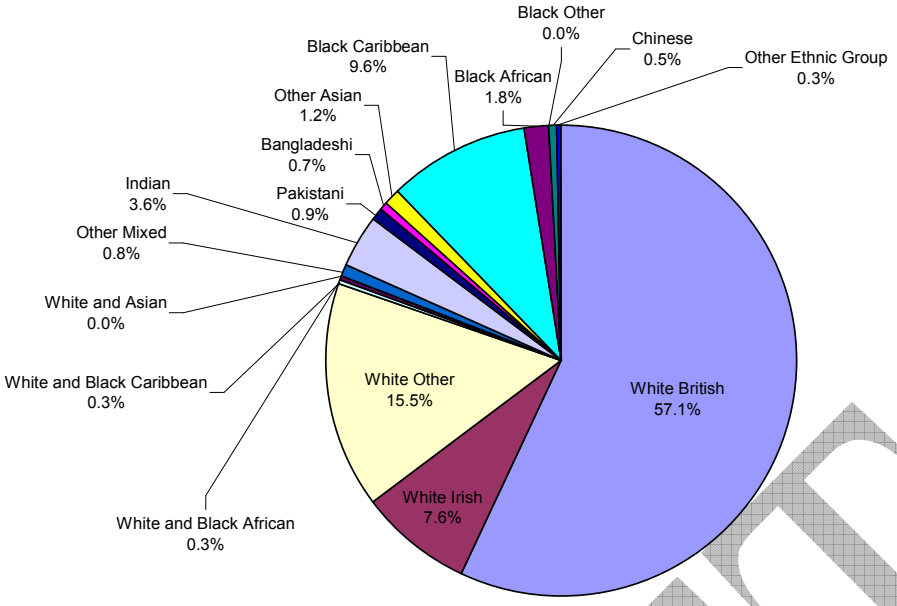
Residents of pensionable age who provide 1 to 19 hours of unpaid care, Haringey, 2001



Residents of pensionable age who provide 20 to 49 hours of unpaid care, Haringey, 2001



Residents of pensionable age who provide over 50 hours of unpaid care, Haringey, 2001



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Carers of pensionable age are overwhelmingly White British irrespective of the number of hours of care they provide. They make up 61% of carers of pensionable age providing 1-19 hours of unpaid care. Speculatively, these may be spouses beginning to care for spouses. They make up 57% of carers providing 'heavy end' care (50+ hours per week). However, there is again a variation in respect of carers of pensionable age providing 20 to 49 hours of care: a 9 % decrease in White British carers and a 9% increase in White Other carers. White Other is not broken down here; it includes Greek/Cypriot, Turkish/ Cypriot, Turkish, Kurdish as well as white Commonwealth, other European Union and Eastern European. In overall terms White Other make up 16% of the Haringey population and 14% of carers. As there is no reason to doubt the statistics, one may speculate that the increase reflects an ageing population in settled groups and, possibly, spouses caring for spouses. Co-incidentally 35+ hours of caring per week is one of the eligibility criteria for payment of Carers Allowance or being entitled to Carers Allowance even if it cannot be paid. An underlying entitlement may mean an extra amount is paid with some other social security benefits. The figure drops back to White Other groups making up 15.5% of carers of pensionable age providing 50+ hours.

Disability The 2001 census collected data on long-term illness and general health. *Limiting long-term illness* covers any long-term illness, health problem or disability which limits daily activities or work. *General health* refers to respondents' self-defined health over 12 months prior to the Census day (29.4.'01). In respect of unpaid carers, two questions of relevance are: how many carers in Haringey have an existing illness or disability as they take up caring and how many carers experience poorer health as a consequence of their caring role? The census data provides only indirect answers.Of the *usual resident population* of Haringey (216,507), 15.5% reported that they had a limiting long-term illness, 12.8% of whom were people of working age. 70.2% of the *usual resident population* reported good health, 20.9% reported fairly good health and 9% not good health (2001 Key Statistics Table KS08).

The following tables, adapted from Table KSO8 Health and provision of unpaid care, show the relationships between health, caring and the hours of care given.

Provision of unpaid care			
All people who provide unpaid care *(based on figure for 'usual resident population')*	Number and percentage of people who provide unpaid care		
	1 to 19 hours a week	20 to 49 hours a week	50 or more hours a week
15,967	10,637	2,098	3,232
100%	66.6%	13.1%	20.2%

All people who provide care *(based on figure for 'all people in households')*	Good Health					
	1 to 19 hours		20 to 49 hours		50 or more hours	
	No.	%	No.	%	No.	%
15,889	6,315	39.7	1,051	6.6%	1,285	8.1%
	Fairly Good Health					
	1 to 19 hours		20 to 49 hours		50 or more hours	
	No.	%	No.	%	No.	%
	3,164	19.9%	747	4.7%	1,238	7.8%
	Not Good Health					
	1 to 19 hours		20 to 49 hours		50 or more or hours	
	No.	%	No.	%	No.	%
	1,118	7%	299	1.9%	672	4.2%

(There is 0.48% difference between the baseline figures for unpaid carers in Haringey). Here is evidence that carers experience poorer health than those who do not provide care:

Self-reported Health	*Usual resident population*	Unpaid carers (*all people in*

		households)
Good Health	70.2%	54.4%
Fairly Good Health	20.9%	32.4%
Not Good Health	9%	13.1%

Self-reported health status worsens as the number of weekly hours of care increases. Sustained poor health may affect carers' ability to care and their eventual need for care services themselves. Global self-rated health is a strong and independent predictor of subsequent illness and premature death (Haringey JSNA Aug. 2008 Chap. 5).

The effects of caring upon health will not be experienced equally amongst Haringey carers. Local data correlating caring and health status with age, with disability and with ethnicity, for example, is not available. National studies e.g. *Diversity in Caring*: *towards equality for carers* S. Yeandle et al (2007) provide some evidence base for differential health outcomes. Carers can suffer physical strain associated with lifting or handling the disabled person, physical health problems associated with stress such as high blood pressure, and mental ill health. A representative study based on analysis of the British Household Panel Survey found that carers are more likely to report high levels of psychological distress, including anxiety, depression, loss of confidence and self-esteem, compared to non-carers (*Hearts and Minds: the health effects of caring* M. Hirst 2004). Women were also more likely than men to suffer from mental ill health if they were a carer.

As a snapshot of the incidence of disability amongst Haringey carers, 22% of respondents to a survey questionnaire in January-February 2009 considered themselves to be disabled.

Proposals in the Haringey Carers Strategy 2009-2014 should seek to mitigate the impact that caring has upon the health of the carer and so reduce the inequality that carers face.

Belief

Census data for religious belief is available for the *usual resident population* of Haringey but not specifically for unpaid carers.

Table KS07 Religion gives the breakdown set out below:

All people	Classification	Percentage of people stating religion as:
216,507	Christian	50.1%
	No religion	20.0%
	Religion not stated	12.1%
	Muslim	11.3%
	Jewish	2.6%
	Hindu	2.1%
	Buddhist	1.1%
	Other religions	0.5%
	Sikh	0.3%

Respondents to a survey questionnaire about carers' priorities for the revised Haringey Carers Strategy in January-February 2009 described their religion or belief as follows:

Classification	No of carers	%
Christian	68	53.1%
No religion	21	16.4%
Not stated	12	9.4%
Muslim	12	9.4%
Hindu	8	6.3%
Jewish	3	2.3%
Buddhist	2	1.6%
Greek Orthodox	1	0.8%
Sikh	1	0.8%
Rastafarian	0	0%
Total	128	100%

Nationally …."the 2001 census showed that people of Muslim religion have slightly higher rates of caring (possibly related to other linked factors)…" (DH Impact assessment of Health and Social Care proposals in the Carers' Strategy 2008). Given that the Pakistani community was one of the fastest growing in Haringey between 2001-2005, there is a need for further enquiry and possible targeted action to reach Muslim carers.

Distribution and socio-economic context

The 2001 census provides data at ward level about the number of households with one or more persons with a limiting long-term illness. More than one third of households in six Haringey wards have a family member with a limiting long-term illness; these are White Hart Lane, Northumberland Park, Noel Park, St Ann's, Tottenham Hale and Tottenham Green. These wards are all in the east of the borough.

More than 30% of households in another five wards -Bounds Green, Bruce Grove, Seven Sisters, West Green and Woodside-have someone with a limiting long-term illness. The wards with the highest incidence of limiting long-term illness are White Hart Lane (39.9% of households), Northumberland Park (36.3% of households) and Noel Park (35.7% of households).

"Many factors combine to affect the health and well-being of individuals and communities in Haringey. These include environmental and social factors such as the quality of homes people live in, unemployment and deprivation and access to services…….The Index of Multiple Deprivation 2007 (IMD 2007) is a measure of multiple deprivation at small area level; it draws together a number of socio-economic criteria such as education and income in such a way that we can compare areas across the country. The IMD 2007 shows that Haringey is the 18th most deprived borough in England and the 5th most deprived in London….areas in Haringey that have the highest deprivation scores are mainly in the north east of the Borough, particularly in White Hart Lane and Northumberland Park". (*Towards JSNA in Haringey* Aug. 2008).

The wards with the highest number of unpaid carers in absolute terms are ranked 1-6 in the table below. They correlate with the wards with the highest percentage of households with a family member who has a limiting long-term illness. They are located in the east of the borough, with the exception of Fortis Green:

Table KS08 Health and provision of unpaid care

Source: 2001 Key Statistics Tables

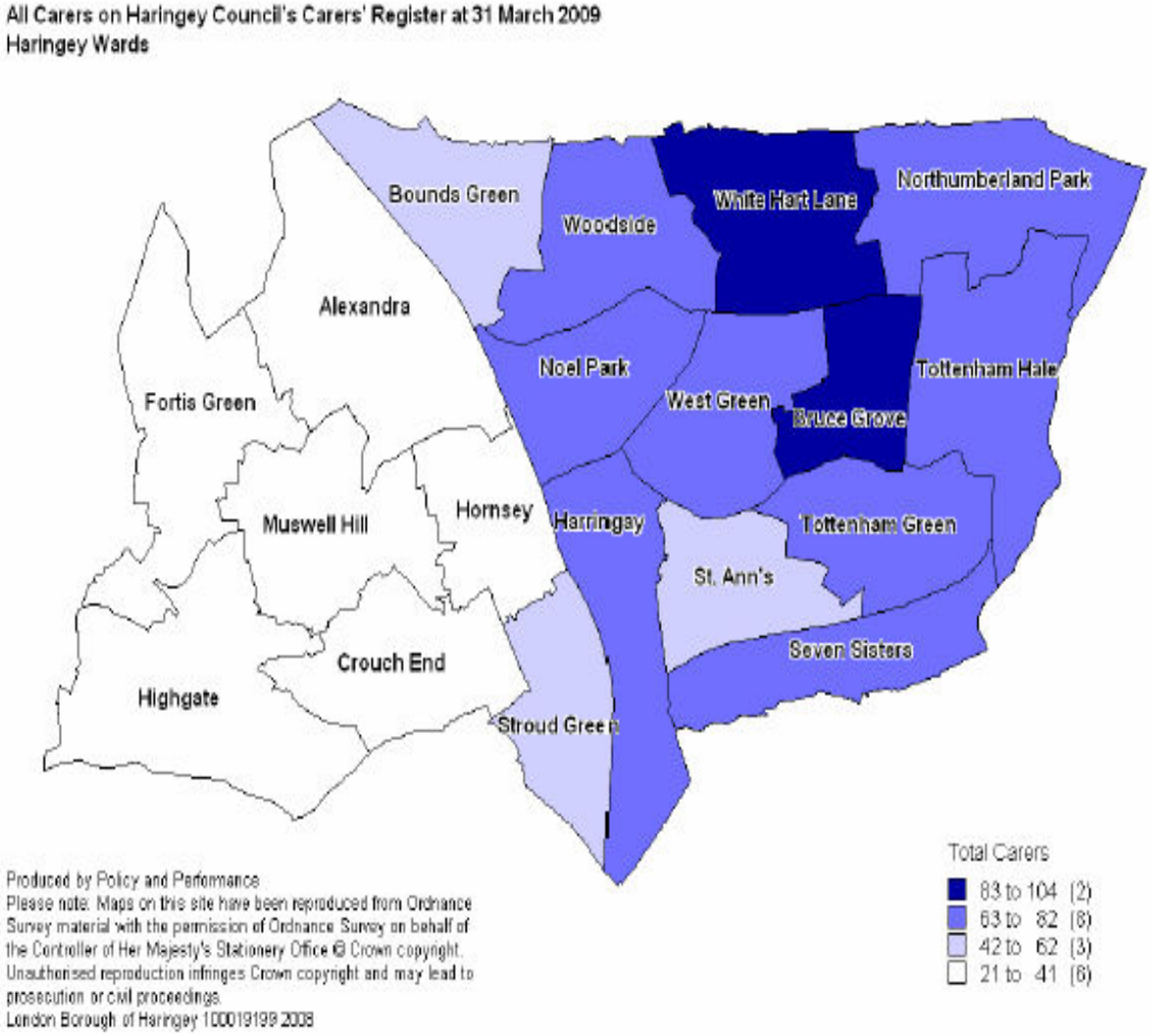
	All people	All people who provide unpaid care	Number of people who provide unpaid care		
		Rank	1 - 19 hours a week	20 - 49 hours a week	50 or more hours a week
Alexandra	10,475	828	658	71	99
Bounds Green	10,905	846	546	139	161
Bruce Grove	11,997	913 (6)	573	124	216
Crouch End	10,762	760	604	74	82
Fortis Green	11,235	919 (4)	686	79	154
Harringay	10,525	682	422	101	159
Highgate	10,310	699	568	60	71
Hornsey	10,075	779	554	103	122
Muswell Hill	9,975	828	641	64	123
Noel Park	11,472	859	519	123	217
Northumberland Park	12,606	979 (1)	582	158	239
Seven Sisters	13,179	879	542	134	203
St Ann's	12,603	915 (5)	565	109	241
Stroud Green	10,324	684	516	72	96
Tottenham Green	11,966	934 (3)	586	138	210
Tottenham Hale	12,728	828	490	145	193
West Green	11,884	814	486	145	183
White Hart Lane	11,985	951 (2)	545	136	270
Woodside	11,501	870	554	123	193
Haringey	216,507	15,967	10,637	2,098	3,232

The high ranking for Fortis Green is most likely explained by the high proportion of much older people who live in the ward. They may not define themselves as having a limiting long-term *illness* (older age isn't …) but they may define themselves as *carers* e.g. if a spouse is looking after a spouse.

'Heavy end' caring (50 or more hours a week) is most concentrated in White Hart Lane, St Ann's and Northumberland Park wards.

Unpaid carers may register on Haringey Council's Carers Register and thereby gain access to non-assessed carers' services provided by voluntary sector organisations and to advice and information. There were 1201 people on the Register as at 31.3.'09.

The distribution of all carers on Haringey Carers Register was mapped at 31st March 2009:



Carers as individuals change over time (one third move in to caring and one third cease caring in one year). If the incidence of long term illness and provision of unpaid care has remained fairly constant since 2001, this snapshot of the Carers Register is evidence for 'hidden' carers in St Ann's ward not accessing the Carers Register. It justifies some targeted action e.g. leafleting on Carers Rights Day to promote registration and carers' assessments.

Sexual Orientation

This is an area of sensitivity. Carers, in common with other Haringey residents, need to understand why the Council is asking for information about sexuality. Timing is all. A family carer took issue with the question being asked of his terminally ill mother in the last days of her life in her home surrounded by her children.

Questions on gender identity and sexual orientation have been incorporated into equalities monitoring on a routine basis only within the last 12 months. Over time they will become familiar and better understood.

Of the 128 respondents to the Carers' Survey 2009 on the revised Haringey Carers Strategy, 30 (23%) declined to answer the question “How would you describe your sexual orientation?” There were fewer non-responses to questions about religion or

belief (12 or 9%), age group (1 or 1%), disability (4 or 3%) and none to questions about ethnicity or gender.

2 a) Using data from equalities monitoring, recent surveys, research, consultation etc. are there group(s) in the community who:

- ***are significantly under/over represented in the use of the service, when compared to their population size?***
- ***have raised concerns about access to services or quality of services?***
- ***appear to be receiving differential outcomes in comparison to other groups?***

2 (a) Monitoring data for equalities performance indicators for three quarters of 2008-2009 is reproduced in the table below:

Improved Quality of Life and Freedom from Discrimination and Harassment

Receiving Carers Services from Carers Assessment

The percentage of carers receiving services by ethnicity and gender divided by the percentage of the population that are ethnic minority/male to produce a ratio.													
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Gender (Males) 18-64													
Ratio			**0.55**			**0.57**			**0.56**				**0.56**
Actuals			31			68			102				102
Ethnicity 18-64													
Ratio			**1.73**			**1.62**			**1.53**				**1.53**
Actuals			63			117			167				167
Gender (Males) 65+													
Ratio			**0.84**			**0.78**			**0.85**				**0.85**
Actuals			19			44			57				44
Ethnicity 65+													
Ratio			**2.15**			**2.00**			**2.14**				**2.14**
Actuals			24			51			67				67

Expressed as a ratio (calculated against population statistics), a figure of 1.0 is ideal representation, under 1.0 is under-representation and over 1.0 is over-representation. Drawing on RAP data, Black and Minority Ethnic carers aged 18-64 and 65+ are significantly represented as receiving services following a carer's assessment. Whilst male carers of all ages are under-represented in services, there is less of an imbalance aged 65+.

Overall men take on a caring role later than women: women have a 50-50 chance of having substantial caring responsibilities at least once before they are aged 59. Men, on the other hand, reach this point when they are 74 years old. (…..*It could be you* M.George Carers UK Report 2001). After age 75, the incidence of caring is higher among men than women (DH Impact Assessment of the Health and Social Care proposals in the (national) Carers' Strategy). Of male respondents to the Carers Survey 2009 38% were aged 65-74 years.

Unpaid carers may register on Haringey Council's Carers Register and thereby gain access to non-assessed carers' services provided by voluntary sector organisations and to advice and information. From a snapshot of carers on the Carers Register as at 11.6.'09, 48.4% were of Black and Minority Ethnic origin and 51.6% were White (excludes 4% not stated).

Concerns have been raised about access to culturally appropriate services for carers and

the people they care for on behalf of the Orthodox Jewish (Charedi) community based around Stamford Hill. This is a fast growing Jewish minority characterised by its own significant social and cultural mores. No reliable data is available about services currently provided to members of this group because of inconsistent recording of religious belief. The case for an allocation of funding for carers of young adults with learning disabilities has been persuasively made by the Interlink Foundation.

The Asian Carers Support Group has consistently lobbied for the provision of culturally appropriate domiciliary care for older people from the Asian community. This group are best served by paid care workers who speak their language. A recent survey of 71 carers on the Asian Carers Support Group's mailing list elicited a 53% response rate with ratings for the services provided overwhelmingly in the range good-very good- excellent. Respondents commented: "good opportunity to socialise; allows me to get out of the house; very essential support group for Asian carers".

In terms of differential outcomes, there is strong evidence for male carers being under-represented in policy development and consultation (a mere 27% of respondents to the Carers Survey 2009 were men). Muslim carers are hidden also. Hindu carers were significantly represented among 128 respondents to the Carers Survey 2009 (6% of total, albeit the sample was small).

No data is available on Haringey carers by sexual orientation; it is therefore impossible to take a view about differential outcomes.

It needs re-iterating that carers experience differential outcomes compared to the rest of the population *because they are carers.* Sources of inequity, drawn from national research, have been outlined in Step 2 above.

2 b) What factors (barriers) might account for this under/over representation?

The 2001 census provided important data about carers down to a sub-ward level. However, it is now 8 years old and less and less reliable given that carers are a diverse and changing population. It is estimated that one third of carers take on a caring role and one third of carers cease caring in the course of one year. Where carers fulfil a caring role for long periods, on average they care for around 8 years. There is a lack of basic up to date information on overall numbers of carers, the details of their caring role, and the numbers of them in work, for example, as well as characteristics such as age, gender, ethnicity, disability and health status. (DH Impact Assessment of Health and Social Care proposals in the Carers' Strategy 2008).

Factors that might account for under-representation are:

- people who are care givers may not identify themselves as *carers*
- cultural concepts of caring don't translate well into some BME community languages with the consequence that people do not always understand they might be entitled to support (National Black Carers and Carers Workers Network report 2007)
- confusion with term ‘carer’ (cf unpaid carer vv paid care worker)
- lack of information
- lack of targeted information in community languages
- gender roles e.g. historical assumptions that caring should be performed unpaid at home by women and men go out to work

- religious preferences and cultural expectations
- lack of appropriate/desired services to meet individual needs
- limits of current patterns of service delivery (inflexible)

Factors that might account for over-representation are:

- some health conditions and illnesses are more prevalent among people from certain BME groups
- socio-economic circumstances, financial disadvantage and breakdown in support
- effect of positive action through targeting of services since 2002

Step 3 - Assessment of Impact

3 a) How will your proposal affect existing barriers? (Please tick below as appropriate)

Increase barriers?	Reduce barriers? √	No change?

Comment

3 b) What specific actions are you proposing in order to respond to the existing barriers and imbalances you have identified in Step 2?

Barrier /Imbalance	Actions	Link to Haringey Carers Strategy
Carers 'hidden' as carers- all groups	Enable carers to self-identify as carers • Planned outreach to wards with high concentrations of carers e.g. St Ann's	Outcome 1 Promote recognition and respect for carers
'Hidden' carers in under-represented groups (in terms of age, ethnic origin, religious belief, sexual orientation)	Enable carers to self-identify as carers • Review support needs of Young Adult carers (previous group disbanded) • Plan outreach to Bangladeshi, Pakistani and Chinese community groups • Plan approach to faith community at Turnpike Lane mosque with Muslim members of Carers Partnership Board • Make links with West London Gay Men's Project (Caring with Confidence provider) and publicise through appropriate networks (local + London-wide)	Outcome 1 Promote recognition and respect for carers

Limited information for carers in community languages	Scope range of information needed e.g. about carers/caring, access to services, self-assessment - Information and Communication sub-group of Carers Partnership Board (CPB) to lead • material to be translated into top 6-8 languages, as advised	Outcome 1 Enable carers to access integrated and personalised services
Under-representation of male carers in services	Improve understanding and recognition of needs of men as carers: men of working age/men of pensionable age (e.g. hold focus groups, conduct survey)	Outcome 1 Promote recognition and respect for carers
Lack of presence and participation in service development -Charedi community	• Ongoing contact with Interlink at officer level • Involve groups in voluntary sector provider forum ahead of re-commissioning of carers' services	Outcome 1 Enable carers to access integrated and personalised services
Lack of individualised services (perception and reality)	Involve carers in *Transforming Social Care* agenda esp. service re-design and commissioning • Improve availability of information about non-assessed services, Direct Payments and charging	Outcome 2 Ensure access to to separate carer's assessment and flexible carer's service
Lack of data on carers and their diversity and their experience of services	Improve evidence base for carers commissioning • Continue to collect information on carers e.g. Carers Experience Survey (pilot site) • Ongoing collation and review of equalities data • Report findings to CPB and beyond social care • Provider services to monitor users by religious belief	Outcome 2 Ensure access to to separate carer's assessment and flexible carer's service
Lack of awareness of carers as disadvantaged group in own right and of barriers caring creates to more equal outcomes	Raise awareness of discrimination against carers and current/proposed legislative protection-through briefings and training (see training plan) • Paper to Equalities Board on carers as identified equalities strand, carers' rights and 'carer proofing' of local policies and procedures • Discussion with HR on implications of Coleman judgement ('discrimination by association') and measures to identify LBH employees who are carers	Outcome 1 Promote recognition and respect for carers

3 c) If there are barriers that cannot be removed, what groups will be most affected and what Positive Actions are you proposing in order to reduce the adverse impact on those groups?

Not applicable

Step 4 - Consult on the proposal

4 a) Who have you consulted on your proposal and what were the main issues and concerns from the consultation?

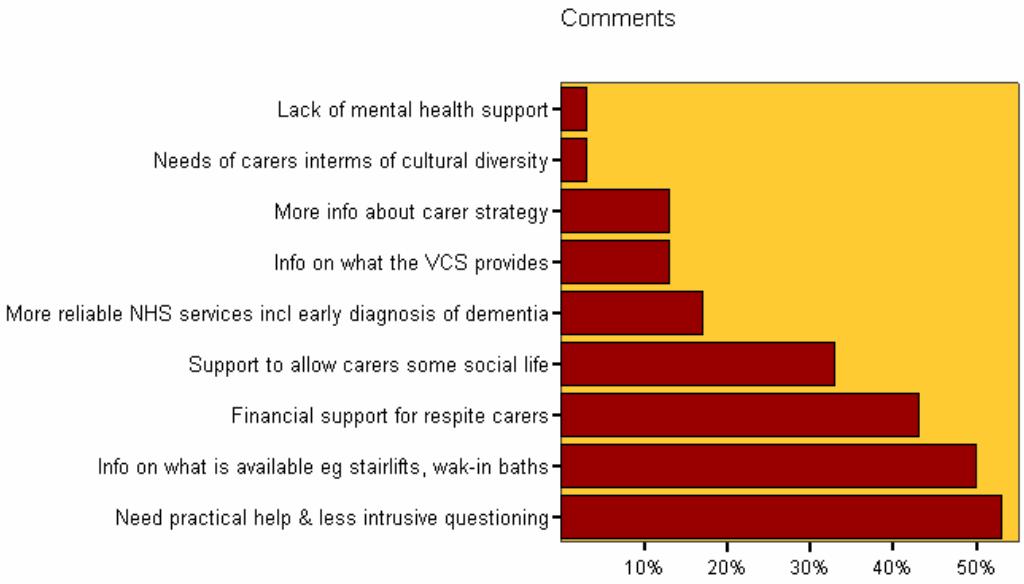
4 (a) The following groups of stakeholders were consulted during the formal consultation on the revised Haringey Adult Carers Strategy (January-April 2009):

- Unpaid adult carers of adults living in the borough of Haringey (via Carers Register)
- Voluntary sector and community organisations
- Health partners
- Council partners

The purpose of the consultations was to help set future priorities for supporting carers in line with the outcomes of the national Carers Strategy 2008-2018. This has its title: "Carers at the heart of 21st-century families and communities A caring system on your side A life of your own". The main methods of consultation were a questionnaire survey of carers' views and a carers' consultation event. A Carers Strategy sub-group, of eight carers, was involved from the outset in developing the Strategy including consultation.

For the **Carers Survey** (January-February 2009), a total of 4000 questionnaires were distributed via GP surgeries, community groups, libraries, and to all carers on the Council's Carers Register (1250 carers). There was also an online version. A total of 128 completed forms were returned by the closing date (13.2.'09). These were entered into SNAP software and data analysed using SPSS. 'Recognition and respect for you as a carer' and 'flexible support to help you carry on caring' emerged as carers' highest priorities. Being involved in planning services attracted *least* number of top priority scores. The characteristics of respondents have been referred to earlier in relation to gender, religious belief and sexual orientation. In terms of ethnic origin, 48% were White British and 52% were of Black and Minority Ethnic and mixed heritage.

A third of carers made suggestions about other goals for the Strategy besides the ones proposed. Of these 16 identified the need for practical help, including 5 carers who also commented that they would prefer less intrusive questioning when they ask for help. Another 15 asked specific questions about what practical help is available including stair lifts and walk in baths. One respondent raised the needs of carers in terms of cultural diversity. The suggestions are grouped into categories in the table below:



The following are verbatim comments about recognition and respect and equalities monitoring:

This makes no difference-carers are treated as third class by family and public.

There needs to be recognition of the sacrifices carers make due to lack of facilities.

I note that two thirds of your questionnaire is about equal opportunities and not about caring. What does one have to do with the other?

Around 90 carers took part in the **Carers Consultation event** on 23.3.'09 planned by the Carers Strategy sub-group of the Carers Partnership Board. Health, voluntary and community sector organisations working with carers were also invited. Consultation took the form of café-style table discussions organised around the four outcomes of the national Carers Strategy relating to adults. These are:

- Carers will be respected as expert care partners and will have access to the integrated and personalised services they need to support them in their caring role (Outcome 1)
- Carers will be able to have a life of their own alongside their caring role (Outcome 2)
- Carers will be supported so that they are not forced into financial hardship by their caring role (Outcome 3)
- Carers will be supported to stay mentally and physically well and treated with dignity (Outcome 4)

Each group was asked to identify practical suggestions for how carers' needs relevant to one of the outcomes could be met. For outcome 1, the role of carer should be respected and celebrated, but also normalised as part of the lottery of life. The profile of carers needs to be raised so carers recognise themselves and the public at large recognises carers and what they do. Services provided directly to carers e.g. Take a Break are important. For outcome 2, carers wanted assurance about the competence of the person taking over from them e.g. at hospital admission and for respite breaks to be more flexible and

personalised. Day centre hours are not suitable for carers who work full time. Carers need to have the opportunity of an ordinary life with other family members. For outcome 3, it was proposed that there is an annual review of carers' financial circumstances. Carers are penalised by not being able to work and need advice and support to claim what they are entitled to. There are limits in reality to the flexible working employers of carers can accommodate. For outcome 4, carers need access to different sorts of breaks- time out e.g. to look after their health and pampering, time away from home e.g. a holiday and time at home relieved of their caring responsibilities. The essence of breaks is that they are flexible and available when needed and care cover is personalised to the needs of the cared for person. Information was seen as a crucial component of all the outcomes; it too needs to be personalised and available at different times during the caring role.

In an **Ask the Audience** session at the consultation event, carers used computerised handsets to give their views anonymously about specific suggestions for carer support. A weekend away with other carers, face to face carer's assessment, payment to cover transport costs, and personal support in the form of counselling and support groups were given the highest ratings by carers.

In their feedback on the consultation event, carers commented:

Wonderful to see so many carers, it shows how important it is to us.

Good experience of meeting and interacting with people and sharing opinions

More events like this will be very good and supportive for everybody

Among additional comments were further thoughtful suggestions from carers:

An end to end plan for the carer starting with training, recognition, support, development, and post care counselling

More thought about how to reach carers without computers. Some also have difficulty reading so leaflets not always the answer. Picture packs, TV adverts, an advert in the local cinema, Indian restaurants.

Can there be an automatic date each year for a carer's assessment? It's stressful to try to get an assessment if there's not an automatic assessment. ….

Housing-unsatisfactory housing is so stressful for carers. Lots of issues around supported living for carers and cared for person. Services protecting their own resources instead of shared resource and responsibility.

More home visits. More support for carers (outings, beach, weekend break, picnic, London Eye). Some people have never been outside the house (especially Bangladeshi).

If everything said today is being considered or taken into account, carers will live longer and have their lives back.

In terms of internal partners, a presentation was given to policy officers from across the Council at the March 2009 meeting of the Policy Network to raise the profile of carers.

4 b) How, in your proposal have you responded to the issues and concerns from consultation?

All the responses to the consultation have been documented and analysed by the writers of the revised Haringey Adult Carers Strategy or by the Council's consultation team. Suggestions have been incorporated into successive drafts of the strategy. A comprehensive delivery plan to cover the first three years of the strategy's implementation has been developed and suggestions which are cost neutral are included in the plan. New services will be commissioned as funding becomes available.

4 c) How have you informed the public and the people you consulted about the results of the consultation and what actions you are proposing in order to address the concerns raised?

In line with the Council's corporate consultation policy, the results of the public consultation will be published on the Council's web site. The final version of the Haringey Adult Carers Strategy 2009-2014 and Delivery Plan 2009-2012 will also be available on the external web-site. A summary version of the Strategy will be produced to send to carers on the Carers' Register and will be available for professionals to download from the web-site. An easy read version will also be prepared which can be down loaded from the web-site.

The proposed actions to address the concerns raised are contained in the Delivery Plan 2009-2012.

Step 5 - Addressing Training

Do you envisage the need to train staff or raise awareness of the issues arising from any aspects of your proposal and as a result of the impact assessment, and if so, what plans have you made?

Envisioning a changed world for carers….

Training Plan for Staff

Objectives

- Front line staff are able to recognise an unpaid carer and signpost carers to support and services
- Staff understand, respect and work with carers as expert partners

Directorate	Job Role	Number of staff	Induction	Briefing (up to ½ hour)	Team training (up to 1 hour)	Carer Awareness (Half day)	Practitioner Group (monthly)
Adults							
ACCS	*Trainee social workers	8 x1 intake pa (Feb.)		√	√	√	√

ACCS	*Student social workers	20 x 1 intake pa (Oct)	√		√	√	√
ACCS	*New social care staff		√		√	√	√
ACCS	*Care managers/reviewing officers in assessment teams: LD inc. Transition, Older People inc. ICT, MH, Phys. Dis./Sensory impairment				√	√	√
ACCS	*Finance Assessment Team			√	√		
ACCS	*Community Care officers				√	√	√
ACCS	*Out of Hours Duty S/W Team			√	√		
ACCS	Community Alarm Service			√			
ACCS	HICES (Integrated Community Equipment Service)			√			
ACCS	*Phys. Dis. Floating Support Service				√	√	
ACCS	*Homecare/Re-ablement Service/ Rapid Response				√	√	√
ACCS/ Housing	Supported Housing Scheme managers			√			
MH	*Community Mental Health Teams**:** START, Support and Recovery, Early Intervention in Psychosis, Home Treatment, Assertive Outreach				√	√	√
ACCS	Providers- Day Services: LD/MH/OPS/Phys.Dis./ Sensory Impairment				√		
ACCS	Providers-Residential Services: Older People/LD/MH			√			
Independent sector	Supporting People Teams: 60+ in Haringey One Support HARTS for families				√		
Libraries / Adult Learning/ Leisure Centres							
ACCS	Customer facing staff on Reception/ at Information points in Libraries and HALS			√			
ACCS	Reception/desk staff in Leisure Centres (handling Carers Active Card applications)			√			
Housing							
Housing	Allocations/assessment officers Homeless Persons officers Special Needs Housing officers Housing Benefit officers et al			√			
Call Centre (x1)							
Corporate Resources	Customer Service officers			√			
Customer Service Centres (x4)							
Corporate Resources	Customer Service officers			√			

Note: * these staff groups have selected for them, or select from, the range of indicative training according to role, experience and interest

Equalities and diversity issues will be embedded in the training, which carers will co-produce and co-facilitate.

Step 6 - Monitoring Arrangements

The Haringey Carers Partnership Board (CPB), chaired by the Council's Carers Champion, Councillor Catherine Harris, will be responsible for monitoring the implementation of the Haringey Adult Carers Strategy. The Board will review progress quarterly. The CPB reports to the Well-Being Partnership Board, one of six thematic Boards which make up the Haringey Strategic Partnership (HSP). The Well-Being Partnership Board aims to promote a healthier Haringey by improving well-being and tackling inequalities. A Performance Management Group (PMG) oversees the overall performance of the Partnership.

The main indicator which will monitor progress with the strategy is NI 135-carers receiving needs assessment or review and a specific carer's service, or advice and information, as a percentage of people receiving a community-based service. This performance indicator is one of 35 improvement targets in Haringey's Local Area Agreement (LAA) which encompass key priority areas for the period 2008-2011. As a baseline, the target for 2008-2009 was 14.22% with a final outturn of 21%. Linked projects funded through Area Based Grant are monitored quarterly by the Council's Partnership and Governance team. Month by month performance is published on the web site in a corporate scorecard under 'Promote Independent Living'. The data for NI 135 is supplied by the Electronic Social Care Record and can be analysed by the equalities groups provided the information has been collected.

The Carer User Experience survey, when it is introduced, will also yield useful data for monitoring the equalities impact of the Strategy.

The equalities performance indicators reproduced in 2a above will continue to be monitored quarterly by the Adult, Culture and Community Services' (ACCS) Equalities Board. Progress with NI 135 is monitored monthly at ACCS performance call over.

There is to be a Scrutiny Review of support to carers in 2009-2010, the terms of which are under discussion. The Panel Report and Cabinet member response will be posted on the web site.

Step 7 - Summarise impacts identified

Age	Disability	Ethnicity	Gender	Religion or Belief	Sexual Orientation
Under-support of young adult carers aged18-34 years	Improved support for carers has potential to positively impact on disabled people, thence reduce inequalities between disabled and non-disabled people Improved support for carers as a whole population has potential to benefit carers with a disability	Under-representation of Pakistani, Bengali, and Chinese carers (growing populations) in provided services Evidence for people of Indian ethnic origin being over-represented as carers in 2001 census Lack of data about carers and caring among new migrant groups, esp. working age migrants from Eastern Europe	Under-representation of male carers in services and consultations	Lack of robust data on ESCR about religion or belief Available evidence points up under-representation of Muslim carers in services and consultations Carers from Charedi community not separately identified as faith group and not directly represented in service development	Lack of information about needs of lesbian, gay, bi-sexual and transgender carers to make an evidence-based assessment of impact

Step 8 - Summarise the actions to be implemented

NB This Equalities Action Plan only includes actions which are realistic and practical in terms of available resources, financial and human. There are significant budgetary pressures and spending constraints within Adult's division, the ACCS directorate and the Council as a whole. As opportunities for remodelling existing services and reinvesting in new services arise, they will be incorporated into the commissioning strategy for Adult, Culture and Community Services. The initiatives outlined here are to be funded from existing resources within each partner organisation.

Step 9 - Publication and sign off

When and where do you intend to publish the results of your assessment, and in what formats?

The results of the assessment will be published on the web-site in August 2009. They will be available in community languages upon request. Other formats are described in 4(c) above.

Assessed by (Author of the proposal):

Name: Barbara Nicholls

Designation: Head of Commissioning

Signature:

Date:

Quality checked by (Equality Team):

Name:

Designation:

Signature:

Date:

Sign off by Directorate Management Team:

Name:

Designation:

Signature:

Date: