

EIA000847 Integration with Health partners ID224

About your EIA

Reference Number:	EIA000847
Subject of EIA:	Integration with Health partners ID224
Description:	<p>The purpose of this Equality Impact Assessment (EIA) is to assess the potential impacts of the implementation of the Universal Model on people while in the P1 pathway with protected characteristics, as defined under the Equality Act 2010. This EIA aims to identify any potential negative effects or inequalities resulting from the proposed changes and to recommend actions that can mitigate these impacts, ensuring that the service remains fair, inclusive, and accessible to all. The Universal Model operates within Adult Social Care's P1 Pathway, supporting individuals medically ready for hospital discharge who require short-term assistance to recover and adjust at home. Its primary aim is to reduce the need for long-term care by promoting independence through a person-centred, multidisciplinary approach. This model aligns with the Care Act 2014 and emphasizes prevention, early intervention, and integrated care to deliver tailored support across Birmingham. This Equality Impact Assessment (EIA) was initiated alongside the Universal Model's rollout to evaluate its effects on individuals with protected characteristics as defined by the Equality Act 2010, including age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation. Early findings show that the model generally promotes equitable access and improved outcomes by enabling individuals to remain independent in their communities and receive care suited to their unique needs. Positive impacts identified include enhanced support for older adults, people with disabilities, and those with long-term conditions through early intervention and integrated services, which reduce hospital readmissions and improve quality of life. The focus on home-based care also benefits individuals by reducing risks associated with hospital stays, such as delirium and infections. However, the assessment highlights potential challenges, such as ensuring timely access to support for diverse communities, including minority ethnic groups and those with sensory impairments or mental health needs. There may also be barriers related to communication, cultural appropriateness, and awareness of available services, which require ongoing monitoring and targeted mitigation. Overall, the Universal Model aims to provide an inclusive framework that reduces inequalities and fosters collaboration with voluntary and community organisations, supporting Birmingham's commitment to fairness, inclusion, and compliance with equality legislation.</p>
In support of:	["Amended service", "Amended/refreshed strategy "]
Reviewing Frequency:	Six monthly
First review date:	07/04/2025

Directorate, Division & Service Area

Directorates:	["Adults Social Care"]
Division:	EICT
Service Area:	EICT

Budget Savings

Related to budget savings?:	224
Budget proposal reference number:	224

Officers

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Data Sources

Data sources:	City Observatory Intelligence and Analysis Team, Birmingham City Council NHS England Professional guidelines Legislation Business Intelligence ACS - Adult Community Services
Data sources Details:	https://www.england.nhs.uk/publication/intermediate-care-data-collection/ . https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance/hospital-discharge-and-community-support-guidance .

Initial Assessment

Impact Age:	
Impact Disability:	Yes
Impact Sex:	Yes
Impact Gender Reassignment:	Don't Know
Impact Marriage and Civil Partnerships:	Yes
Impact Pregnancy and Maternity:	Don't Know
Impact Race:	Yes
Impact Religion or Beliefs:	Yes
Impact Sexual Orientation:	Maybe

Impact Care Experience:	
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Initial Assessment Summary

Initial Assessment Summary:	<p>The implementation of the Universal Model within Adult Social Care, specifically the P1 hospital discharge pathway, aims to support individuals transitioning from hospital to home with tailored, short-term assistance. This model prioritizes early intervention, prevention, and person-centred care, which are intended to improve outcomes and maintain independence for all service users. In line with the Equality Act 2010, this assessment focuses on identifying how the Universal Model may affect individuals across all nine protected characteristics—age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation. Preliminary analysis indicates that the model promotes equitable access by emphasizing community-based support, reducing reliance on long-term care, and addressing barriers to timely, appropriate assistance. Special attention is given to vulnerable groups who may face increased risk of discrimination or disadvantage, including older adults, disabled individuals, and minority ethnic populations. By fostering integration between social care and health services, the model seeks to mitigate inequalities related to care transitions, ensuring that no group is disproportionately impacted. This EIA will continue to monitor for any unintended negative consequences, such as potential barriers to accessing care or disparities in service outcomes. Recommendations will be made to address identified issues, supporting Birmingham’s commitment to equality, inclusion, and compliance with legal obligations. Overall, the Universal Model is expected to enhance fairness and improve the quality of care for diverse adult populations by promoting independence, choice, and control.</p>
Is a full EIA Required?:	Yes

Protected Characteristic – Age

Impact Age:	Yes
Age Group Impacted:	Ages 17 and over who are eligible for P1 pathway.
Age Impact Details:	<p>Birmingham remains a young city, but it is still ageing with the rest of the country and will become older relative to the working-age population. The number of people aged 50 to 64 years increased by 20% in recent times. The average age of Birmingham increased by 2 years from 32 to 34 in 2021 with a lower average age than England (40 years). The EICT service is for citizens aged 17+ and this will remain the same, the Universal Centralised Taskforce (UCT) has no impact or alteration to the referral criteria according to age. Data shows that it is population of elderly citizens who are the highest group discharged via the P1 pathway. The age ranges of the referrals are: 17-20 years: 14 21-29 years: 32 30-39 years: 56 40-49 years: 108 50-59 years: 255 60-69 years: 493 70-79 years: 993 80-89 years: 1480 90-99 years: 561 100 years+: 27 A “one-size-fits-all” approach may not account for the different needs of younger versus older individuals. Older people, especially those with dementia or frailty, may find it difficult to navigate the system if it is not designed with their needs in mind. According to recent statistics, women in Birmingham have a higher life expectancy than men, though the exact numbers can vary slightly based on factors like socio-economic status, health behaviours, and access to healthcare. As of recent data, the average life expectancy in Birmingham for women is around 81-82 years, while for men it's approximately 77-78 years. These figures are consistent with the national trend, where women typically live longer than men by several years.</p>
Age Impact Mitigation:	<p>A universal model could provide more integrated care, improving outcomes for older people, including those with complex, long-term conditions. The age of the citizen is clear at the point of referral and throughout the citizen's journey and remains a consideration when planning any contact, intervention and discharge from the service. The UCT has the same access to</p>

	<p>the citizen information on both BCC and BCHC data systems and there will be no change. Each person has a tailored discharge plan and then a comprehensive assessment by a healthcare professional, access to support services at home and support with daily living activities if necessary. The Universal Model advocates supporting by making links with many local charities and voluntary organisations which offer services that can help people post-discharge. Adult Social Care and Health workers collaborate together and with these organisations to ensure a comprehensive service network. Integrated systems ensure that medical, social, and psychological support are coordinated and delivered effectively, helping individuals to transition smoothly from hospital back into the community. Multi-Disciplinary Teams can collaborate to design a unified care plan that addresses all aspects of recovery and well-being, including Mental Health Support: Many older adults experience anxiety, depression, or loneliness after being discharged from hospital. Ensuring equitable access to mental health support is crucial, including services like counselling, therapy, or support groups. Social Support and Community Engagement: Social isolation is a significant issue for older adults. Encouraging participation in local community groups, day centres, or social clubs can help improve emotional well-being and reduce isolation. It's important to ensure that these options are accessible and inclusive. Ensuring that citizens aged 50 and over have equitable access to post-hospital discharge services in Birmingham, or any community, requires a comprehensive, integrated approach that addresses the diverse needs of this group. Clear, easy-to-understand information: People aged 50 and over should receive clear, accessible information about their discharge process, available services, and how to access help. This includes providing information in multiple formats (written, online, phone) and using language that is straightforward and easy to understand. Digital Access Support: Many older people may not be digitally literate. Ensuring they have support to access digital health services, such as online appointment booking or accessing advice and guidance, can be vital. The Universal Model has encouraged the adoption of assistive technologies and digital tools to support adults in maintaining their independence. This includes things like telecare (monitoring technology that helps manage health conditions remotely), smart home devices, and digital apps that provide access to information or services. In Birmingham, efforts have been made to expand access to such technologies, ensuring that adults, particularly those with physical disabilities, long-term health conditions, or elderly individuals, can benefit from technological support to stay independent at home. Transport Services: Many older adults may face difficulties with mobility or transport post-discharge, particularly if they are not fully recovered. Ensuring access to transport services or community-based transport schemes can help with follow-up appointments and access to services. Mobility Aids: Ensuring timely access to mobility aids, such as walkers or wheelchairs, as needed, is essential for older adults to regain their independence and prevent falls or further injuries. Technology Enabled Care (TEC) and Remote Monitoring: For individuals who have difficulty accessing care in person, TEC services can provide ongoing monitoring of health conditions, medication adherence, and offer advice and support without the need for physical appointments. Development for the future could consider age-specific care pathways, including tailored services for older adults and young people. The workforce will ensure that information is accessible and delivered in ways that suit different age groups (e.g., large print, audio formats for older people; digital tools for younger people). Development of the workforce could include providing age-appropriate training for staff, ensuring they are equipped to meet the needs of people from all age groups.</p>
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Protected Characteristic – Disability

Impact Disability:	The aim of a universal model is typically to provide services to everyone, but if it's not thoughtfully adapted to meet the specific needs of people with disabilities, it could unintentionally disadvantage them.
Disability Impact Details:	The Census 2021 data on disability within households show that in Birmingham: – In 65.5% (277,497) of households, no people are disabled. – In 26.5% (112,069) of households include one disabled member. – In the remaining 8.0% (33,890) of households, two or more people are disabled within the household. There is incomplete data available on the disability status of the referrals through the service. A universal model that is designed inclusively may improve the accessibility and coordination of health and social care services for people with disabilities, ensuring a holistic approach. However, people with disabilities may face barriers if the model does not account for different types of disabilities, including sensory impairments, learning disabilities, physical disabilities, or mental health conditions. Information might not be accessible for people with visual or hearing impairments. Individuals

	<p>with physical, sensory, or learning disabilities may find it harder to access services if those services are not designed with accessibility in mind. They may also be left out of communications if materials are not provided in accessible formats like large print, braille, or audio. People with complex or higher needs may not receive the personalised care required to manage their condition, leading to worse health outcomes or unmet needs. People with disabilities may face economic challenges such as unemployment or low income, which could affect their ability to access services under a universal model, especially if those services require out-of-pocket costs, transport, or other resources. If the universal model doesn't prioritise people with disabilities, they may experience delays in accessing care, poorer quality of care, or may not have their unique health needs recognised and addressed appropriately. People with disabilities may face barriers in understanding, using, and benefiting from services if the model does not ensure accessible communication. If the universal model doesn't actively combat stigma or educate service providers about the lived experiences of people with disabilities, individuals may be treated unfairly or overlooked. If the universal model does not incorporate mental health services or support, it may fail to address the mental health needs of people with disabilities, leading to worsening mental health outcomes.</p>
<p>Disability Impact Mitigation:</p>	<p>Mitigating against inequality for citizens with a disability involves taking proactive steps to ensure that they have equal opportunities, access, and support to live fulfilling lives. ensuring that communication materials are available in accessible formats. Offering reasonable adjustments such as sign language interpreters or accessible websites can help mitigate these barriers. Make sure that public services are fully accessible, whether that means providing sign language interpreters, assistive technology, or modifications to how services are delivered. During the design phase of the Universal Model, consultation will be undertaken with disability organisations and individuals with disabilities to ensure that services are accessible, inclusive, and tailored to a broad range of needs. This engagement will help identify any specific barriers or gaps in provision and inform ongoing service development. Regarding monitoring, while a formal, detailed monitoring framework has not yet been established, the Early Intervention Community Team (EICT) maintains close working relationships with disability-focused community organisations and charities. These partners provide ongoing feedback and insights, enabling the service to adapt responsively and organically to emerging needs or issues faced by people with disabilities. As the Universal Model is implemented, the EICT will continue to collaborate with these stakeholders to identify any inequalities or barriers in real-time, with plans to develop a more structured monitoring process based on this feedback. Responsibility for coordinating this ongoing engagement and informal monitoring currently rests with the EICT management team, who will ensure that relevant information is captured and used to shape improvements. This flexible approach allows for continuous refinement to better meet the diverse needs of disabled service users. Once consultation data is collected and clearer monitoring mechanisms are defined, the EIA will be updated to reflect these developments and to fill any current data gaps. Ensure the physical environment (e.g., buildings, transport) and digital services are fully accessible, including the use of assistive technologies. Train staff on disability awareness and provide specific services for individuals with disabilities, including personal assistance and adjusted care plans. Ensure the universal model has built-in personalisation and flexibility, allowing people with disabilities to receive care that is tailored to their specific needs. This could include providing access to specialist care teams, individual care plans, and a variety of support options. Ensure that financial assistance or subsidies are available to people with disabilities for accessing services, especially if additional costs (e.g., transport, personal assistants, or assistive devices) are involved. It's important to also consider employment support and inclusive education to address the broader economic challenges faced by people with disabilities. The universal model should include disability-specific health interventions and ensure targeted support for people with disabilities, such as preventative care, early intervention, and accessible healthcare services. Monitoring should be in place to assess the impact of services on people with disabilities and ensure that health inequalities are being reduced rather than perpetuated. Services should be provided with information that is accessible to people with various disabilities, such as easy-read materials, audio versions, or sign language interpreters. A universal model should actively include disability awareness training for all staff, to reduce stigma and improve understanding of the needs of people with disabilities. It should also include inclusive policies that ensure people with disabilities are treated with dignity and respect. Ensure that mental health services are embedded within the universal model and are accessible to people with disabilities. Mental health services should be designed to recognise and address the unique challenges faced by individuals with disabilities, and integrated with physical healthcare to provide holistic support. The universal model has the potential to positively impact people</p>

	with disabilities by promoting accessibility and equality in service delivery. However, without careful consideration and adaptation, it may unintentionally disadvantage people with disabilities, particularly if it does not account for the specific barriers they face. To mitigate these risks, it is crucial that the universal model includes flexible, accessible, and inclusive policies and practices that meet the diverse needs of people with disabilities. By addressing issues such as accessibility, personalised care, and targeted support, the universal model can be a tool for advancing equity and social inclusion for individuals with disabilities.
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Protected Characteristic – Sex

Impact Sex:	a universal model is designed to provide services to everyone, if it does not actively consider gender differences, it could unintentionally perpetuate existing gender inequalities or fail to address gender-specific needs.
Sex Groups Impacted:	All
Sex Impact Details:	The implementation of the Universal model can potentially impact individuals differently based on their gender, and there is a risk that it could inadvertently perpetuate existing gender inequalities if gender-specific needs and circumstances are not adequately addressed. There have been 37% more females discharged home via the P1 pathway in the last 12 months than males. The highest number of females were those in the age range 80-89, it was the same age range that was the highest for males also. Positive: A universal model could help ensure that both men and women have equal access to health services that address their gender-specific needs (e.g., maternal health for women, prostate screening for men). Negative: Without gender-sensitive care pathways, women may experience barriers to accessing services such as reproductive health, while men may not receive adequate care for conditions that disproportionately affect them. If caregiving responsibilities are not equally recognised, women may be disproportionately burdened with emotional, physical, and financial stress, which could affect their access to services or their health. Conversely, men who take on caregiving roles might feel overlooked if the model assumes caregiving is a female-dominated responsibility. A universal model that does not take into account gendered mental health needs may fail to provide the right kind of support, especially if services are not designed with both men's and women's mental health issues in mind. Bias and Stereotypes: Gender biases or stereotypes could impact how services are delivered to individuals based on their gender. For instance, women may be assumed to be primarily caregivers, while men may not be encouraged to seek help for mental health issues or domestic violence. Impact: This could lead to unequal service provision or reinforce gender stereotypes, potentially resulting in discrimination or suboptimal care. The economic disparities between men and women could affect their ability to access or benefit from services under a universal model.
Sex Impact Mitigation:	Ensure that the model in development includes gender-sensitive health pathways, such as those addressing reproductive health, sexual health, and gender-specific cancer screenings. Monitor gendered health outcomes to ensure that services are effectively meeting the needs of both men and women. Provide gender equality training for health and social care professionals to challenge stereotypes and ensure equitable care. The Universal Model should provide flexible support for caregivers, irrespective of their gender. This could include respite care, financial support, or access to caregiving resources. It should also encourage shared caregiving responsibilities and ensure that both men and women have access to services that support them in caregiving roles. Ensure that mental health services are gender-responsive and provide targeted support for the mental health challenges faced by both men and women. This could include raising awareness of mental health issues in men, addressing stigma around seeking help, and offering gender-specific counselling or therapeutic services. Implement training for all staff to recognise and address unconscious bias and gender stereotypes. The service should be designed to be inclusive and non-discriminatory, ensuring that all individuals have equal access to support regardless of their gender. The model should ensure that services are financially accessible to all genders, considering the economic inequality that women, in particular, may face. Providing financial support, such as subsidies or targeted resources for economically disadvantaged groups, would help address these disparities. To ensure that the universal model promotes gender equality, it is crucial to: Recognise and address gendered health needs and risks, ensuring both men and women receive appropriate care and support. Provide targeted support for caregivers, recognising the

	<p>gendered nature of caregiving responsibilities. Combat stigma and discrimination related to gender-based violence and mental health issues. Ensure financial accessibility and economic support for all genders, especially women, who are more likely to face economic challenges. By considering gender differences in both the design and delivery of services, the Universal Model can be inclusive and promote gender equality, ensuring that everyone, regardless of gender, has fair access to the support and services they need.</p>
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Protected Characteristic – Gender Reassignment

Impact Gender Reassignment:	
Gender Reassignment Impact Details:	<p>Gender reassignment data is not collected on EICT referrals and so was not available. For the Birmingham population aged 16 or over: – 807,422 (90.8%) indicated that their gender identity was the same as their sex registered at birth. – 7,826 people (0.9%) indicated that their gender identity was different to their sex registered at birth.</p> <p>Mitigating inadvertent discrimination against individuals who have undergone gender reassignment when it is not immediately apparent requires a thoughtful, inclusive, and proactive approach. While it may be difficult to identify whether someone has undergone gender reassignment based solely on external appearances or personal disclosure, there are several strategies that can be employed to ensure that discrimination is avoided: The model could offer inclusive and accessible healthcare services to transgender individuals, ensuring they are treated with respect and dignity. However, without proper sensitivity, transgender people may experience discrimination or feel that their specific healthcare needs (such as hormone treatment or mental health support) are overlooked.</p>
Gender Reassignment Impact Mitigation:	<p>Following the Equality Act 2010: In the UK, individuals who have undergone gender reassignment are legally protected from discrimination under the Equality Act 2010. Ensure all staff are familiar with these legal protections and know how to apply them in practice. This includes not discriminating against someone because of gender reassignment, whether or not their history is known. Ensure that healthcare providers are trained in transgender sensitivity and that services are inclusive of gender reassignment needs. Provide clear pathways for gender-affirming care and mental health support, and ensure these are integrated into the model. Implement a clear anti-discrimination policy and ensure that services are safe and welcoming for transgender individuals. Collect Demographic Information: In a sensitive and voluntary manner, collect data on gender identity as part of equality monitoring. This could include gender identity categories beyond male/female, ensuring that individuals who have undergone gender reassignment are included. Anonymous Feedback: Provide anonymous ways for people to offer feedback on whether they feel the environment or services are inclusive. This can help identify potential issues of inadvertent discrimination before they escalate. Create Safe Spaces for Disclosure: While individuals who have undergone gender reassignment may not wish to disclose their gender history, offering confidential spaces for people to voluntarily share information if they feel comfortable doing so can help. For instance, in healthcare or employment settings, ensure people know they can share their gender identity without fear of discrimination. Confidentiality Protocols: Ensure that any disclosed information about a person’s gender history is handled with the utmost confidentiality and in accordance with data protection laws (such as GDPR). Regularly evaluate the effectiveness of your policies and practices in preventing discrimination. This can be done through audits, surveys, and direct feedback from those affected by the changes. The feedback will help identify any inadvertent discrimination and correct it.</p>

Protected Characteristic – Marriage and Civil Partnership

Impact Marriage and Civil Partnership:	The universal model could potentially impact individuals differently based on their marital or civil partnership status.
Marriage and Civil Partnership Groups Impacted:	The Equality Act 2010 protects individuals from discrimination based on their marital or civil partnership status, but the design and application of services need to account for any potential disparities in how this protected characteristic is treated.
Marriage and Civil Partnership Impact Details:	<p>The implementation of the Universal model can potentially impact individuals differently based on their marital status. In some cases, married or civil partnered individuals may receive specific benefits, such as joint health insurance or tax advantages, that are not available to those who are single or in non-civil-partnered relationships. If the new model doesn't account for the different needs of individuals in various relationship statuses, it could unintentionally disadvantage those who are single or not in a civil partnership. The model could recognise the importance of family support and caregiving, ensuring that partners in civil partnerships or marriages have access to services. If the model doesn't acknowledge the role of partners as carers, married individuals or those in civil partnerships may face challenges accessing support services or respite care. Access to Services: Married individuals might receive different levels of care or support compared to unmarried individuals. This could happen if a care provider assumes that a spouse will always take responsibility for care needs, leaving the unmarried individual without adequate support. Financial or Housing Assistance: In some instances, married individuals might be treated differently in terms of financial assessments or housing eligibility. For example, there may be assumptions that a married couple's combined income should cover all care costs, whereas a single person might not have the same financial expectations imposed upon them. Recognition of Caregivers: Married partners may be excluded from certain caregiving support services if the person receiving care is not formally recognised as the caregiver. This could occur in cases where someone doesn't register their spouse as a primary caregiver, even though they provide a significant portion of care, leading to inadequate support for the caregiver. If the universal model does not consider financial differences resulting from marital status (e.g., dual incomes or shared financial responsibilities), it could result in unequal service provision. Single people or those who are divorced or widowed might not receive the same level of support or consideration in healthcare planning if services are structured with couples in mind. Those who are single or widowed may feel socially isolated and could be at a higher risk of mental health challenges if their needs for social engagement or emotional support are not recognised. Stigma or assumptions about an individual's relationship status could lead to discrimination or a lack of understanding in the delivery of services.</p>
Marriage and Civil Partnership Impact Mitigation:	<p>Ensure that partners and carers are considered in the care planning process, with appropriate support and recognition of their role in the individual's care. Provide carer support services and respite care, making sure that family members in partnerships have access to these. Carers who are married or in civil partnerships may experience additional pressures due to caregiving responsibilities, which could affect their health and access to services. We must ensure that we are flexible enough to accommodate the specific needs of people in different marital or partnership situations. This may include considering single individuals for benefits or services that could otherwise be seen as reserved for couples, like family support or joint care plans. We must also recognise the impact of caregiving responsibilities on both partners in a marriage or civil partnership. Additionally, flexible caregiving support could be offered to both single and partnered carers to ensure equality in support. Ensure the model takes into account financial needs across different relationship statuses. It should provide equal access to resources, regardless of whether individuals are married, in a civil partnership, or single. Ensure that individual needs are central to care planning, and that single individuals are given the same level of support as those in a partnership, especially when it comes to emotional or practical support in healthcare settings. The model should ensure that there is equitable access to social support, recognising that people in all relationship statuses may need different kinds of emotional or social services. Single or divorced individuals should have equal access to group services, mental health support, and community activities that might otherwise be more readily available to married or partnered individuals. Ensure that the model promotes inclusive language and practices, avoiding assumptions about individuals' relationship statuses. To mitigate any negative impacts, it's crucial to: Ensure equitable access to benefits and support for single, married, divorced, or widowed individuals. Recognise the specific needs of</p>

	carers and those with family responsibilities, whether they are single or in a partnership. Avoid assumptions or biases based on marital status and ensure inclusive and accessible services for all. By considering these factors in the design and implementation of the universal model, it is possible to minimise disparities and ensure that individuals are treated fairly, regardless of their marital or civil partnership status.
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Protected Characteristic – Pregnancy and Maternity

Impact Pregnancy and Maternity:	
Pregnancy and Maternity Impact Details:	The data is not collected within EICT for this characteristic and so is not available. The implementation of the Universal model can potentially impact individuals differently based on their pregnancy status. The model may improve access to maternity and post-natal care services, providing more integrated support for pregnant women and new mothers. Pregnant women or those on maternity leave may experience discrimination or be overlooked when accessing healthcare services.
Pregnancy and Maternity Impact Mitigation:	Ensure the model includes specific maternity care pathways, including services for mental health support during pregnancy and post-natal care. Ensure there is knowledge within teams of accessible pregnancy-related services, such as antenatal care, and that they are available for people from different cultural or socio-economic backgrounds.

Protected Characteristic – Ethnicity and Race

Impact Ethnicity and Race:	Using a universal model in the delivery of services could impact people differently based on their ethnicity or race, it may not always address the specific needs of different ethnic or racial groups in the most effective way.
Ethnicity and Race Groups Impacted:	
Ethnicity and Race Impact Details:	Birmingham has changed significantly in previous decades and, in 2021, became a super-diverse city, meaning citizens from ethnic minorities make up more than half the population. The Birmingham population is split 51.4% (588,314) "Black, Asian, Minority Ethnic (overall)" and 48.6% (556,608) "White (overall)" in 2021, compared to 42.1% (451,409) "Black, Asian, Minority Ethnic (overall)" and 57.9% (621,636) "White (overall)" in 2011. Birmingham has a higher proportion of "Black, Asian, Minority Ethnic (overall)" compared to all other Core Cities in England & Wales and compared to the other Local Authorities in the West Midlands. Race and ethnicity data is collected from referrals however this data is not compulsory to give, circa 10% of referrals have the description not known, 12% not stated and a small number blank and so is only a representation of the referrals. This data shows that the highest number of referrals is for white British, 86% less referrals were recorded as Asian or Asian British than white and 93% less referrals were recorded as Black or Black British than white British. This data does not reflect the diverse Birmingham population, so is inaccurate. The Universal Model could have both positive and negative impacts on people from different ethnic or racial backgrounds, the approach may inadvertently overlook the specific needs of minority ethnic groups, perpetuate existing health inequalities, or fail to provide culturally competent care. The Universal Model could improve service accessibility for people from diverse racial and ethnic backgrounds, providing culturally competent care that meets their needs. Racial minorities may face systemic barriers or experience discrimination in health and social care settings. The model may not consider the cultural needs of diverse racial groups, leading to unequal outcomes. Potential impacts are: Language barriers - Ethnic or racial minority groups, particularly immigrants or non-English speakers, may face challenges in accessing services if language barriers are not adequately addressed. For example, information and communication about services may not be available in different languages or formats. Cultural Sensitivity: A universal

	<p>model may not always take cultural differences into account, potentially leading to a lack of trust in the services or a mismatch between service delivery and the needs of individuals from different ethnic groups. Geographic Barriers: Certain ethnic or racial groups may be concentrated in specific geographic areas, and a universal model may not take these geographical patterns into account, potentially creating barriers for access to services. If the universal model does not take ethnic or racial differences into account, individuals from minority groups might not receive the same quality of care as others. For instance, health conditions more prevalent in certain ethnic groups may be insufficiently addressed. There may be a risk that unconscious bias or discrimination affects the quality of services for people from particular racial or ethnic backgrounds, leading to less effective treatment or support. Ethnic minorities may face economic barriers such as lower income, unemployment, or underemployment, which can impact their ability to access services. If the universal model does not consider these factors, it may inadvertently disadvantage these groups. The service may not engage sufficiently with ethnic or cultural communities. Without proper consultation and involvement, the model might overlook unique needs or cultural preferences, there is also a risk that ethnic minority groups might feel excluded from the process or that the services are not tailored to their cultural practices or beliefs.</p>
<p>Ethnicity and Race Impact Mitigation:</p>	<p>The service needs to ensure that it is culturally sensitive and tailored to the diverse needs of Birmingham's population. This includes providing interpreters for non-English speakers, offering culturally appropriate care, and addressing any particular needs that might arise due to cultural practices or beliefs. The service needs to provide citizens and their families with advocacy services ensures they can have their voices heard, especially if they face barriers to accessing services. Advocates can also help individuals navigate the often complex healthcare system. Regular training for staff on unconscious bias and ensuring that all ethnic groups receive equal quality care. The service must ensure that staff receive cultural competence training and that services are tailored to the needs of diverse racial groups. The service should collect and monitor ethnic data to identify disparities and take proactive steps to address them. The service should engage with community organisations and racial minority groups to ensure that services are culturally appropriate and sensitive. The universal model should be adapted to tackle the root causes of health inequalities and be flexible enough to target those groups who may need extra support. Tailored services or initiatives that address the specific needs of disadvantaged ethnic groups, such as preventative care or awareness campaigns focusing on common health issues within these communities. Ongoing monitoring and evaluation of the Model needs to take place to assess whether the Universal Model is successfully reducing or exacerbating health inequalities across ethnic groups. Consultation and involvement of ethnic minority groups would help to mitigate, this can include focus groups, community meetings, or partnerships with local ethnic organisations. Champions or culturally representative staff members could also be appointed to help bridge the gap between the service providers and ethnic communities.</p>

Protected Characteristic – Religion

<p>Impact Religion:</p>	
<p>Religion Groups Impacted:</p>	
<p>Religion Impact Details:</p>	<p>The religion question is voluntary in the census. In the census data, religion refers to a person's religious affiliation. In Birmingham, 6.0% of the population declined to answer the question in 2021, and 7.0% declined to answer in 2011). • 69.8% (798,734) of the Birmingham population have a religious affiliation in 2021, compared to 74.2% (796,138) in 2011. • "Christianity" was the most common response, with 34.0% (389,406) of the population describing themselves as "Christian" in 2021, compared to 46.1% (494,358) in 2011, a decrease of 12.1% by percentage points. This is similar to national trends, where the proportion of "Christians" has declined by 13.0 percentage points. • "Muslim" was the second most common response, increasing by 8.1 percentage points, from 21.8% (234,411) in 2011, to 29.9% (341,811) who described themselves as "Muslim" in 2021. • 24.1% (276,327) state they have "No religion" in 2021 compared to 19.3% (206,821) in 2011. For both Core Cities</p>

	and the wider West Midlands, Birmingham has the lowest proportion of those with “No religion”. In the EICT data, this was not collected in totality for all of the citizens and so does not reflect the population of Birmingham. The implementation of the Universal model can potentially impact individuals differently based on their religion. The model could include services that are sensitive to the religious and spiritual needs of individuals, improving overall well-being, however without proper consideration, people may face challenges in accessing services that align with their religious practices (e.g., dietary requirements, prayer facilities, or religious holidays).
Religion Impact Mitigation:	Ensure that services are flexible to accommodate religious practices, such as dietary needs, prayer times, and observance of religious holidays. Provide access to spiritual care or chaplaincy services where appropriate, ensuring individuals’ religious and spiritual needs are met. Consult religious groups to understand the specific needs of different faith communities in relation to health and social care.

Protected Characteristic – Sexual Orientation

Impact Sexual Orientation:	
Sexual Orientation Groups Impacted:	
Sexual Orientation Impact Details:	For the Birmingham population aged 16 or over: – 779,054 (87.6%) of the population identified as straight or heterosexual. – 11,968 (1.3%) described themselves as gay or lesbian. – 11,258 (1.3%) described themselves as bisexual. – 3,578 (0.4%) wrote in another sexual orientation, including pansexual, asexual, and other orientations Sexual orientation is not a statistic that is gathered in the EICT referral data and so was not available. The implementation of the Universal model can potentially impact individuals differently based on their sexual orientation. The model could provide more inclusive and accessible services for people who identify as lesbian, gay, bisexual, or other sexual orientations, ensuring they are treated with respect and receive appropriate care, however people who are LGBTQ+ may experience discrimination or feel excluded from the model if it doesn’t actively consider their needs, particularly in terms of mental health, sexual health, or support for family dynamics.
Sexual Orientation Impact Mitigation:	Provide LGBTQ+ inclusive care, ensuring that services are tailored to the needs of individuals based on sexual orientation. Offer training for staff on LGBTQ+ issues to ensure that care is non-judgmental and respectful of diverse sexual orientations. Ensure that mental health support is available for LGBTQ+ individuals, particularly those who may experience stigma or discrimination.

Protected Characteristic – Care Experience

Impact Care Experience:	This section focuses on individuals who have previously been, or are currently, in the care of the local authority, including children in care, care leavers, and adults with a history of being looked after. These groups often face distinct challenges, inc
Care Experience Impact Details:	
Care Experience Impact Mitigation:	Training for Service Providers - Equip all professionals delivering services within the Universal Model with training that builds understanding of the complex needs and experiences of individuals receiving care, explore including condition-specific training and having an expert in the team or access to one, to enable the support of those with

	<p>histories of trauma or prolonged support. - Foster cultural competence to ensure awareness of the diverse backgrounds of care recipients, promoting inclusive, respectful, and person-centred service delivery. Clear identification and tailored support pathways - Use community resources, assets and knowledge to provide personalised, coordinated care pathways that address the ongoing and changing needs of these individuals across health, social care, housing, education, and employment. - Ensure flexibility in support provision to adapt to varying needs over time. - Enhance and further develop partnerships with Specialist and Advocacy Organisations - Collaborate closely with specialist agencies and advocacy groups experienced in working with care-experienced adults to provide mentoring, advocacy, and additional community supports. - Engage individuals receiving care in ongoing consultation to inform service design and improvement. Accessible and Flexible Service Delivery - Ensure services are accessible in terms of location, timing, and delivery format—including in-person, remote, and outreach options—to reduce barriers to engagement. - Work towards targeted outreach to individuals at risk of disengagement or social isolation. Empowerment and Involvement - Promote the active involvement of individuals receiving care in decisions regarding their support, fostering autonomy and personalisation. - Support initiatives that build life skills, independence, and self-advocacy. Robust Monitoring and Evaluation - Establish monitoring frameworks to track service use, outcomes, and satisfaction among individuals currently or previously receiving care, including attention to intersecting protected characteristics such as disability, ethnicity, and mental health. - Use this data to identify service gaps and drive continuous improvements.</p>
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Other

<p>Any other risks or impacts:</p>	<p>Workforce resistance to change, training and skill gaps, lack of workforce engagement, inconsistent implementation, organisational culture, monitoring and evaluation difficulties. Ensure that carers are recognised as key partners in care delivery and that the universal model provides resources, support, and respite services to help them in their role. Offer training and information for carers, helping them navigate the new system and access the support they need. Engage with carer organisations to get input on how the model can best support family carers and reduce the risk of burnout. Cultural Competence: Ensure that the model incorporates culturally competent services that take into account the diverse needs of carers from different backgrounds. This includes understanding cultural norms, beliefs about caregiving, and specific challenges faced by carers from diverse communities. Language Support: Offer translation and interpretation services to ensure that carers who do not speak English as their first language can access the information and support they need. Community Engagement: Engage with community organisations that represent carers from diverse cultural or ethnic groups to ensure that the model meets their specific needs. Flexible Work Arrangements: Encourage employers to offer flexible working hours or remote work options for caregivers to help them balance work and caregiving. Financial Support: Ensure that there are financial allowances or benefits (e.g., carer’s allowance, tax relief) available to informal caregivers. This could help alleviate the financial pressures they face. Paid Carer Leave: Explore policies that provide paid leave for formal and informal caregivers, particularly when the person they care for is unwell or in crisis. Clear Information and Signposting: Ensure that caregivers are given clear, accessible information about the services available to them. This could include dedicated carer support webpages, helplines, or written materials in plain language. Carer Navigators: Introduce carer navigators—staff members who are trained to guide caregivers through the care system, helping them understand their rights, the services available, and how to access them. Tailored Communication: Provide tailored communication that takes into account caregivers’ needs, including translations for non-English speakers or alternative formats for those with disabilities (e.g., braille, audio). Peer Support Groups: Provide opportunities for caregivers to connect with others in similar situations through peer support groups or online forums, helping them share experiences and coping strategies. Community Engagement: Encourage caregivers to engage in community-based activities and social services to combat isolation, such as carer’s day out events or educational workshops. Social Care Outreach: Introduce outreach services where community workers regularly check in with caregivers to offer social support and encourage participation in community services. Involve Caregivers in Decision-Making: Ensure that caregivers are included in care planning and decision-making processes, as their input is often crucial to understanding the person’s needs and preferences. Recognition Programs: Develop programs that recognise caregivers for their vital role, such as awards, appreciation events, or public campaigns that highlight their contributions. Training and Education: Provide training and resources for caregivers to enhance their skills in managing care, advocating for their loved ones, and understanding</p>
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	<p>complex medical or care needs. Cultural Competence: Ensure the model includes culturally competent services, such as caregivers from ethnic minorities being provided with culturally relevant information and support. This may involve incorporating cultural sensitivity training for staff. Language Access: Offer translation and interpretation services to ensure that caregivers who do not speak English fluently can understand the information provided to them and access support effectively. Community Engagement: Engage with community leaders and organisations representing carers from different cultural groups to ensure the model is responsive to their specific needs. Person-Centred Care: Ensure that the model incorporates person-centred care, allowing caregivers to remain actively involved in the decision-making process regarding care and support for their loved ones. Flexibility in Care Plans: Provide flexible care plans that are tailored to the specific circumstances of the caregiver and the person they are caring for, allowing for adjustments as needs change. Empower Caregivers: Provide caregivers with the tools, information, and confidence to make informed decisions and advocate for the care needs of those they care for.</p>
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Full Assessment Summary

<p>Full Assessment Summary:</p>	<p>Improving health outcomes, experiences and access for all Increasing Capacity of our workforce Integrating our services Driving improvements Valuing Diversity Addressing the social determinants of health</p>
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Monitoring

<p>Monitoring Details:</p>	
<p>Monitoring Officer Email:</p>	

