## The Public Sector Equality Duty

The Equality Duty requires public bodies to have ***due regard*** to the need to:

- Eliminate unlawful discrimination harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and people who do not share it
- Foster good relations between people who share a protected characteristic and people who do not share it

**Protected Characteristics:**
- Age
- Disability
- Gender Reassignment
- Pregnancy and Maternity
- Marriage and Civil Partnership (elimination of discrimination only)
- Race
- Religion or Belief
- Sex
- Sexual Orientation

**Due Regard** means consciously thinking about the three aims of the Duty as part of the process of decision-making. For example:

- How they act as employers
- How they develop, evaluate and review policy
- How they design, deliver and evaluate services
- How they commission and procure from others

**Advancing equality of opportunity** involves considering the need to:

- Remove or minimise disadvantages suffered by people because of their protected characteristics
- Meet the needs of people with protected characteristics
- Encourage people with protected characteristics to participate in public life or in other activities where their participation is low

**Fostering good relations** involves tackling prejudice and promoting understanding between people who share a protected characteristic and others.

**Complying with the Equality Duty may involve treating some people better** than others, as far as this is allowed in discrimination law. This could mean making use of an exception or positive action provisions in order to provide a service in a way that is appropriate for people who share a protected characteristic.

**Officers should:**
**Keep an adequate record showing** that the equality duties and relevant questions have been actively considered.
**Be rigorous in both inquiring and** reporting to members the outcome of the assessment and the legal duties.

<table>
<tr><td colspan="2">Title of the Assessment:</td><td>Proposals for the Future of Caddington Hall Older Persons Home<br>(Version 15)</td><td rowspan="2">Date of Assessment:</td><td rowspan="2">25th June 2015</td></tr>
<tr><td rowspan="3">Responsible Officer</td><td>Name:</td><td>Tim Hoyle</td></tr>
<tr><td>Title:</td><td>MANOP Head of Service</td><td rowspan="2">Extension Number:</td><td rowspan="2">76065</td></tr>
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</table>

## Brief Background

In common with other council areas and the nation as a whole, Central Bedfordshire's population of older people is set to grow much more rapidly than the overall population. This is particularly true of the group of people aged 85 and over.

When asked older people consistently say that their preference is to remain living independently in their own home for as long as possible and the Council aims to support this as much as it can.

The vast majority of people will continue to live in ordinary housing throughout their lives, supported by informal carers (such as relatives and friends) and 'paid for' carers sourced privately or commissioned by the Council. Additionally, in recent years the Council has developed extra care housing schemes that are able to deliver a high level of flexible care options to support residents as and when they need it.

However, even with the provision of extra care housing, for a small proportion of older people the best place in which their needs can be met is in a care home setting. In recent years increased expectations of the facilities in care homes have lead to changes in the physical and environmental standards which new care homes need to meet.

The Council's response to these twin challenges of an increase in population of older people and rising expectations is necessarily set within the financial constraints within which the public sector operates.

In response to the challenges set out above the Council has undertaken the following:

- Increased the availability of home care services in response to increasing demand and the desire by older people to remain in their own homes for as long as possible.
- Developed both domiciliary and residential reablement services that assist older people to regain independent living skills which allow them to remain living at home even after a spell in hospital.
- Commenced the development of extra care housing schemes for independent living in Dunstable (Priory View) and Leighton Buzzard (Greenfields) and is planning deliver a further four schemes of this type over the next six years.

The final challenge in this programme is the reconfiguration of care home provision for older people to deliver higher standards. This is the most challenging as such changes inevitably mean a degree of disruption to the lives of residents of the homes affected.

In November 2012 the Executive considered a report and approved an overall approach in relation to the Council's homes as part of a wider strategy for managing and contracting with the care home market. This set out the principles of a phased transition away from the homes whilst maintaining existing capacity in the market as a whole. It also set out the approach to stimulate the independent sector market to provide this capacity rather than the Council delivering it directly.

Following this the Director of Social Care, Health and Housing held meetings with residents, relatives and staff at the homes setting out the overall approach and indicating the possibility that the homes could be reprovided. This intention was reiterated to residents, relatives and staff when a further round of meetings was held prior to the ending of the contract with BUPA in 2014.

Within this context the Executive has approved the commencement of consultation on the future of one of the seven homes – Caddington Hall. The rationale for this is set out in detail in the Executive Report and Appendices (Improving Care Homes for Older People in Central Bedfordshire – 10th February 2015).

The proposals are also set out in detail in the report but can be summarised as follows:

- The Council is proposing to close the home and find suitable alternative accommodation for the existing residents.
- Residents will be given a choice of homes to move to within a reasonable distance. These choices would be of homes which offer a good quality of care, modern physical and environmental standards and fee rates that are in line with the Council's fee structure or the host Local Authority rates.
- One of the options available to all residents would be to move to Dukeminster Court so any of them wishing to stay as a group could do so.
- Any resident who wished to move further away (for example to be closer to a relative) would be assisted to do so.

It is important to differentiate the two phases of the process which is under way. 'Phase 1' relates to the consultation process and the period leading up to meeting of the Council's Executive that will determine the future of the home. 'Phase 2' relates to activities after that. It is envisaged that this document will be updated during the process, both prior to the meeting of the Executive and, if necessary after the decision (to reflect its outcome). Although a closure decision would not be made prior to the Executive meeting, this is the preferred option in the consultation so in this version of the document 'Phase 2' activities relate to the work that would need to be undertaken residents and others should the decision be for the home to close.

**Stage 1: Setting out the nature of the proposal and potential outcomes**

## 1. Aims and Objectives

*1.1 What are the objectives of the proposal under consideration?*

The objectives are:

- To improve the quality of physical environment and facilities of care home places for older people in the Chiltern Vale area.

- To minimise the impact of any decision to close Caddington Hall on its residents

1.2 *Why is this being done?*

This is being done to better align the quality of physical environment and facilities within care home provision for older people with the expectations of customers and regulators.

The approach being taken is one which seeks to achieve the desired change whilst minimising the impact on existing residents.

1.3 *What will be the impact on customers or staff?*

The change being proposed would have the following impacts on current and future customers:

a) *Positive:*

- An improved standard of physical environment in care home provision for older people – both current and future customers
- Older people able to have greater dignity and independence when living in a care home – both current and future customers
- Improved facilities for people who have dementia

b) *Negative:*

- Potential disruption for existing customers

The change being proposed would have the following impacts on current and future staff:

c) *Positive:*

- None

d) *Negative:*

- The disruption and stress of potential job loss or change of employer

1.4 *How does this proposal contribute or relate to other Council initiatives?*

The proposal is underpinned by, and supports the Council's priorities to *"promote health and well being and protect the vulnerable"*. It also contributes, and relates to other initiatives and strategies that promote service improvement:

- Extra Care supported living scheme developments
- Strategic Safeguarding Interventions
- Adult Social Care Strategies and Policies (i.e. Older People & Physical Disabilities, Learning Disabilities & Mental Health).

1.5 *In which way does the proposal support Central Bedfordshire's legal duty?*

By seeking to improve the quality of care home places in Chiltern Vale, in the way that is being proposed, the Council is meeting the powers and duties placed on it by the Care Act 2014 and associated guidance in respect of managing the care market.

In taking forward these proposals the Council needs to be mindful of legal duties in the following areas:

- The ‘duty to consult’ with people most affected by proposals
- The ‘duty of care’ to residents, relatives, staff members and others
- The ‘equality duty’.
- Employment-related duties to staff

1.6 *Is it possible that this proposal could damage relations amongst groups of people with different protected characteristics or contribute to inequality by treating some member of the community less favourably such as people of different ages, men or women, people from black and minority ethnic communities, disabled people, Carers, people with different religions or beliefs, new and expectant mothers, lesbian, gay, bisexual and transgender communities?*

Every effort is being made throughout this process to ensure that residents, their families and staff members do not experience less favourable treatment. The consultation process provides an opportunity to explore any concerns and identify mitigating action.

**Stage 2: Consideration of national and local research, data and consultation findings in order to understand the potential impacts of the proposal**

## 2. Research Findings and Data

### 2.1 *Consideration of Relevant Data and Consultation*

**Internal desktop research**

| | | | |
|---|---|---|---|
| Place survey / Customer satisfaction data | | Service Monitoring / Performance Information | ✓ |
| Demographic Profiles – Census & ONS | ✓ | Other local research | ✓ |
| Local Needs Analysis | ✓ | | |

**Third party guidance and examples**

| | | | |
|---|---|---|---|
| National / Regional Research | ✓ | Benchmarking with other organisations | |
| Analysis of service outcomes for different groups | | Inspection Reports | |
| Best Practice / Guidance | ✓ | | |

**Public consultation related activities**

| | | | |
|---|---|---|---|
| Consultation with Service Users | ✓ | Customer Feedback/Complaints | ✓ |
| Consultation with Community/Voluntary Sector | ✓ | Inspection Reports | ✓ |
| Consultation with Staff | ✓ | Data about the physical environment e.g. adult social care market, training provision, transport, spatial planning and public spaces | ✓ |

**Consulting Members, stakeholders and specialists**

| | | | |
|---|---|---|---|
| Elected Members | ✓ | Specialist staff / service expertise | ✓ |
| Expert views of stakeholders representing diverse groups | ✓ | | |

2.2 *Summary of Existing Data and Consultation Findings: Service Delivery Considering the impact on Customer/Residents*

### ***2.2.1) AGE: 65 years and Over***

A) *National & International Research:*

- Around a quarter of a million people aged 65 and over need specially adapted accommodation because of a medical condition or disability and 130,000 of them report living in homes that do not meet their needs. (DCLG)
- One million people over 65yrs report feeling trapped in their homes. (DWP)
- Some key points that emerged from a study by the Centre for Policy on Ageing and Age Discrimination (2009) showed that services for over 65s were worse, in respect of :
    - Assumption made about needs and capabilities of older people older people
    - The interpretation of concepts of independence and social care are often different and more restrictive for older people than other adult client groups e.g. independent living as basis for access to family and social life only recently extended to older people
    - Adoption of this independent living philosophy has been very slow amongst providers of services for older people.
    - Clear evidence of varying standards and expectations in the provision and delivery of services for older people and younger adults – with the former receiving a poorer level of service, and their social needs and wellbeing often neglected
    - Voices of older people with high support needs are so quiet as to be practically silent or indistinguishable from the other people who speak on their behalf
    - The focus and quality of assessments are different for older people. The pressure on resources and professional assessment of risk can inhibit the development of person centred assessments for older people.
    - Social care for older people tends to give more emphasis to the care and maintenance (i.e. task based activities of washing, dressing, eating), than the social aspect of enabling them to participate in social and community life.
    - Cost per capita spending on older people's services, is historically lower than other adult client groups.
    - Institutionalised inequalities in the resources allocated between different groups of people who use social care services i.e. differential funding of care packages is explicit.
    - Some key concerns with residential care include:- loss of control, identity, and personal possessions; not being valued; cultural and/or religious needs not met, lack of privacy; lack of activity; insufficient staff and inadequate training; care not provided at appropriate pace.

- In adopting differentiation in service provision and delivery this could inadvertently result in negative discrimination.

i) *UN Principles for Older Persons includes:*

- Older persons should be able to live in environments that are safe and adaptable
- Consideration of personal preferences and changing capacities.
- Older persons should be able to reside at home for as long as possible

ii) *Age UK:*

- Care Home provision varies around the UK but the shortage of places is acute in some areas, particularly for people who have dementia.
- Recruitment and retention of care home staff is a major issue, particularly acute in some areas, and there are calls for skill-mix guidance to be reviewed
- There are 394,000 older people in residential care.
- An estimated 244,185 people with late onset dementia live in care homes, or 36.5% of people with dementia.
- The proportion of people with dementia who live in care homes rises with age: while 26.6% of people with dementia aged 65-74 live in care homes, the figure is 60.8% for those aged 90 and over.

iii) *Health and Wellbeing*

- Around 40% of care home residents have clinical depression and more than 50% of care home residents have urinary incontinence.
- One study found that 20% of care home have no regular visit from a GP and research suggests that "almost 50% of residents' time is spent asleep, socially withdrawn or inactive, with only 3% spent on constructive activity".
- Only 29% of persons over the age of 65 who are cared for report attending any outside activity (such as a day centre or club).

iv) *Provision & Costs:*

- Private organisations are supplying a greater proportion of care home places in the UK. Since 1996, private supply of residential care has increased from 172,700 to 184,000 places, while local authority supply has more than halved from 77,200 to 35,400.

- Of residents in care homes operated by private or voluntary organisations approximately 39% pay all their own care costs, 55% have fees wholly or partially funded by local authorities and 6% by the NHS.

- On average for 2014, weekly fees for residents in private homes for older people are £485 for residential care, and £664 for nursing care. For single rooms, they are £471 for residential care, and £675 for nursing care. Average fees and fee increases vary by region. (Dec. 2014).

- On this basis, the average annual fee for a single room in a private residential home is £24,492; a private nursing home, £35,100.

There is some evidence that care homes charge different rates for council placements and for self-funding residents, with the higher rate for self-funders subsidising the rate the council will pay. However, the actual care provided does not differ.

v) *Perceptions of Care & Support:*

- 25% of adults in England said they worry about having to sell their home to pay for social care in old age, 28% worried about having to spend their children's inheritance to pay for care in their old age, and 38% worried about being a burden when they got older;
- 64% of adults in the UK said they had no plans to put any money aside to fund their social care in older age.

vi) *CQC:*

- Behaviours and attitudes of staff were identified as crucial issues in determining not only whether people felt they were treated fairly but also whether the outcome was non-discriminatory. Numerous examples demonstrated discriminatory attitudes based on age – highlighting the importance of effective staff training.
- Other forms of discrimination included incidences of staff "talking over" older people, particularly those with untreated depression.

B) *Local Research & Data:*

The total population of Central Bedfordshire is set to increase, and in line with national trends, the biggest increase will be in the 65 year old, and over with the most increase being of those people aged 85 and over. Members of this latter group are most likely to need the care and support.

The Council's approach to accommodation to accommodation for older people, the demand for care home places, the demand forecasting model and the underlying population trends are set out in the document 'Older Persons Care and Housing Demand Forecast' the latest version of which is dated February 2015. The local data will be updated monthly.

**Table 1: AGE: 65 years and Over (Central Bedfordshire)**

| CATEGORY | POPULATION AGED 65 & OVER | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | **2014** | ***% Change*** | **2015** | ***% Change*** | **2020** | ***% Change*** | **2025** | ***% Change*** | **2030** | ***% Change*** |
| People aged 65-69 | 15,200 | *0* | 15,600 | *3%* | 14,800 | *-3%* | 16,700 | *10%* | 19,800 | *30%* |
| People aged 70-74 | 10,700 | *0* | 11,400 | *7%* | 14,800 | *38%* | 14,100 | *32%* | 16,000 | *50%* |
| People aged 75-79 | 8,500 | *0* | 8,600 | *1%* | 10,300 | *21%* | 13,600 | *60%* | 13,000 | *53%* |
| People aged 80-84 | 5,900 | *0* | 6,200 | *5%* | 7,200 | *22%* | 8,800 | *49%* | 11,600 | *97%* |
| People aged 85-89 | 3,400 | *0* | 3,600 | *6%* | 4,400 | *29%* | 5,300 | *56%* | 6,600 | *94%* |
| People aged 90+ | 1,800 | *0* | 1,900 | *6%* | 2,400 | *33%* | 3,200 | *78%* | 4,300 | *139%* |
| **Total population 65+** | **45,500** | *0* | **47,300** | *4%* | **53,900** | *18%* | **61,700** | *36%* | **71,300** | *57%* |

*Source: POPPI 2014*

**Table 2: AGE Profile of Residents at Caddington Hall**

| CATEGORY | 2014 |
|---|---|
| People aged 65-69 | 0 |
| People aged 70-74 | 2 |
| People aged 75-79 | 2 |
| People aged 80-84 | 6 |
| People aged 85-89 | 6 |
| People aged 90+ | 6 |
| **Total residents 65+** | **22** |

**Age of respondents to consultation:**

| | | |
|---|---|---|
| 20-29 | 1 | 3.6% |
| 45-59 | 8 | 28.6% |
| 60-64 | 3 | 10.7% |
| 65-74 | 5 | 17.9% |
| 75+ | 8 | 28.6% |
| Preferred not to say or did not answer | 3 | 10.7% |

### *2.2.2) SEX: 65 years and Over*

*Local Data:* **Table 3: SEX 65 years and Over (Central Bedfordshire)**

| CATEGORY | 65 YRS & OVER (Central Bedfordshire) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | MALES | | | | | FEMALES | | | | |
| | 2014 | 2015 | 2020 | 2025 | 2030 | 2014 | 2015 | 2020 | 2025 | 2030 |
| Aged 65-69 | 7,500 | 7,700 | 7,100 | 8,200 | 9,600 | 7,700 | 7,900 | 7,700 | 8,500 | 10,200 |
| Aged 70-74 | 5,200 | 5,500 | 7,200 | 6,700 | 7,800 | 5,600 | 5,900 | 7,600 | 7,400 | 8,300 |
| Aged 75-79 | 4,100 | 4,100 | 4,900 | 6,500 | 6,100 | 4,500 | 4,500 | 5,500 | 7,100 | 6,900 |
| Aged 80-84 | 2,600 | 2,700 | 3,300 | 4,000 | 5,400 | 3,300 | 3,400 | 3,900 | 4,800 | 6,200 |
| Aged 85-89 | 1,400 | 1,500 | 1,900 | 2,300 | 2,900 | 2,100 | 2,100 | 2,500 | 2,900 | 3,700 |
| Aged 90 & over | 500 | 600 | 800 | 1,200 | 1,700 | 1,300 | 1,300 | 1,600 | 2,000 | 2,600 |
| **Total 65 & over** | **21,300** | **22,100** | **25,200** | **28,900** | **33,500** | **24,500** | **25,100** | **28,800** | **32,700** | **37,900** |

*Source: POPPI 2014*

**Table 4: SEX Profile of Residents at Caddington Hall**

| CATEGORY | 65 YRS & OVER (Central Bedfordshire) | |
|---|---|---|
| | MALES | FEMALES |
| | 2015 | 2015 |
| Aged 65-69 | 0 | 0 |
| Aged 70-74 | 1 | 1 |
| Aged 75-79 | 1 | 1 |
| Aged 80-84 | 2 | 4 |
| Aged 85-89 | 3 | 3 |
| Aged 90 & over | 1 | 5 |
| **Total 65 & over** | **8** | **14** |

*Source: POPPI 2014*

**Sex of respondents to consultation**

32% (9) of respondents were male, 57% (16) were female and 11% (3) preferred not to say or did not answer

***2.2.3) RACE:** (Asian or Asian British / Black or Black British / Chinese / Gypsies and Travellers / Mixed Heritage / White British / White Irish / White Other)*

*A) <u>National Research:</u>*

*i) Race Equality Foundation:*

Research carried out to date has been remarkably consistent in its findings (see, for example, Age Concern and Help the Aged Housing Trust, 1984; Jeffery and Seager, 1993; Jones, 1994; Bright, 1996; Mkandla, 2003; Patel et al., forthcoming). Key issues that have emerged include:

- Lack of awareness or understanding among BME elders of housing options;
- Lack of appropriate promotional material;
- Lack of understanding among service providers of specific religious and/or cultural needs;
- Lack of staff with appropriate language skills and/or cultural knowledge;
- Inconsistent allocation policies between service providers;
- Care home location (e.g. the importance of being near community facilities such as shops selling appropriate foodstuffs, and places of worship);
- Non evidence-based assumptions made by service providers regarding what individual preferences will be;
- The need to involve BME elders in the service-development process.

From the research carried out to date, certain key (and very basic) actions uniformly emerge as essential for service providers. These include:

- Assessing what need is out there: improving monitoring systems, carrying out research;
- Raising awareness of services available (thereby potentially boosting service take-up): outreach, promotion, translation and use of various media;
- Employing staff from diverse ethnic groups;
- Involving BME communities either directly as service providers or as part of the service-development process;
- Involving potential service users (e.g. working with BME elders groups), so that services are tailor-made to meet their aspirations and needs;
- Training staff: for example, in legislation, cultural awareness, equal opportunities, and anti-discrimination practice;
- Incorporating cultural and/or religious requirements into service design and delivery;
- Implementing clear policies and codes of practice.

*ii) Age UK:*

- Statistics show that BME people aged 55 and over are more likely to report their own general health as being bad or very bad. While figures are at 12% for both men and women for the whole population, levels for Black Caribbean and Indian men and women and Black African women are generally about 20%. For Pakistani people aged 55 and over, 34% of men reported bad or very bad health, and 45% of women; the figures are 53% and 44% respectively for Bangladeshi people.
- Pakistani and Bangladeshi older people again are more likely to report suffering from longstanding illness, especially a limiting one. While 40% of all men aged 55 and over reported suffering from limiting longstanding illness, the figures were 62% of Bangladeshi men, 54% for Pakistani, and 50% for Indian. Amongst women, the most significant figure is that 70% of Pakistani women reported suffering from a limiting longstanding illness, against 43% for the population as a whole. Pakistani men aged 55+ also were found to have a much higher rate of cardiovascular disease (42% against 29% for all men aged 55+) and of IHD or stroke (41.1% against 21.6%).
- Only around 50% of BME social care service users felt that their needs as a black and minority ethnic person were adequately considered at their last assessment.
- 25% said that they had faced prejudice or discrimination when using services, with over half the people under the age of 60yrs reporting this.

*iii) CQC:*
Black and Minority Ethnic People want:

- Accessible information about services leading to options about which services they use
- Control over decisions about their future
- Services that recognise differences in people's cultures, without making assumptions
- Support from staff with positive and respectful attitudes towards them
- Services that enable them to have contact with people that are important to them and to be connected to communities
- To feel safe and be free from discrimination
- Opportunities to give feedback and to improve services.

B) *Local Data* Table 5: RACE / ETHNICITY 65 and Over (Central Bedfordshire)

| CATEGORY | ETHINC GROUP: 65 YRS & OVER (2011) | | | | |
|---|---|---|---|---|---|
| | **White** | **Mixed / Multiple Ethnic Group** | **Asian / Asian British** | **Black/ African / Caribbean / Black British** | **Other Ethnic Group** |
| People aged 65-74 | 21,504 | 85 | 238 | 99 | 19 |
| People aged 75-84 | 12,991 | 67 | 126 | 39 | 9 |
| People aged 85 and over | 4,661 | 17 | 22 | 11 | 1 |
| **Total population aged 65 & over** | **39,156** | **169** | **386** | **149** | **29** |

*Source: POPPI 2014*

**Table 6: RACE / ETHNICITY 65 and Over – (Caddington Hall)**

| CATEGORY | ETHINC GROUP: 65 YRS & OVER (2015) | | | | |
|---|---|---|---|---|---|
| | White | Mixed / Multiple Ethnic Group | Asian / Asian British | Black/ African / Caribbean / Black British | Other Ethnic Group |
| People aged 65-74 | 2 | 0 | 0 | 0 | 0 |
| People aged 75-84 | 9 | 0 | 0 | 0 | 0 |
| People aged 85 and over | 13 | 0 | 0 | 0 | 0 |
| **Total residents aged 65 & over** | **24** | **0** | **0** | **0** | **0** |

## Race of respondents to consultation

75% (21) respondents were White: British, 14% (4) Respondents stated "Other" and 11% (3) respondents preferred not to state or did not answer

### *2.2.4) RELIGION OR BELIEF: (Christian, Jewish, Muslim, Hindu, Buddhist, Sikh, Other, No Religion)*

**Table 7: RELIGION (Central Bedfordshire)**

| RELIGION | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Category | Christian (all) | Buddhist | Hindu | Jewish | Muslim | Sikh | Any other religion | Prefer not to say | No religion | Total |
| Nos. | 668 | 4 | 0 | 1 | 2 | 0 | 21 | 144 | 203 | **1043** |
| % | 64% | 0.40% | | 0.10% | 0.20% | | 2% | 13.80% | 19.40% | |

*Source: Star Survey 2012*

**Table 8: RELIGION (Caddington Hall)**

| RELIGION | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Category | Christian (all) | Buddhist | Hindu | Jewish | Muslim | Sikh | Any other religion | Prefer not to say | No religion | Total |
| Nos. | 14 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | **16** |
| % | 88 | 0 | 0 | 0 | 0 | 0 | 6 | 0 | 6 | |

### *2.2.5) DISABILITY (Physical Impairment. Sensory Impairment, Mental Health Condition, Learning Disability or difficulty, Long-standing Illness or Health Condition, Severe Disfigurement)*

A) <u>National Data:</u>

Disability covers a wide variety of impairments such as learning disabilities, mental health conditions, mobility impairments, blindness and partial sight, deafness and hearing impairment and progressive long term health conditions. It also covers those who may not recognise themselves as having a disability, such as those with long term conditions like diabetes. Disabled people are not a homogenous group, and issues will vary when considering standards relating to access and adaptability.

*i) Age UK:*

Care home residents are normally aged 80 and over and have multiple and complex healthcare needs linked to conditions like dementia, arthritis, cardiovascular disease, stroke, or a combination of these.

ii) *CQC:*

Disabled people experienced barriers to equality in social care services as follows:-

- Physical barriers - the most common barriers
- Environmental barriers – e.g. poor access to or within buildings
- Communication barriers - experienced by a majority of disabled people and not always related to the disabled person's impairment, e.g. providing information in accessible formats, but could be due to the communication skills of staff.
- Social inclusion barriers – with the community e.g. transport or inaccessible community facilities.
- Attitudinal barriers – another very common barrier e.g. social care staff not respecting their right to be treated equally, manifested in patronising attitudes or a lack of regard for the disabled person's rights to make choices about how care is delivered.
- Lack of regard for basic privacy or dignity – in some cases where their human rights may have been compromised.
- Disabled people are at greater risk of experiencing violence than non-disabled people. (Equality & Human Rights Commission (EHRC)
- Disabled people restructure their lives to minimise real and perceived risk to themselves even if they have not experienced targeted violence personally. (EHRC)

B) *Local Data:*

NB: Physical Disability data on people aged 65 and over is not readily available locally (and nationally). *The closest indicator is the Domestic Task measure which measures 'People aged 65 and over unable to manage at least one domestic task on their own. Tasks include: household shopping, wash and dry dishes, clean windows inside, jobs involving climbing, use a vacuum cleaner to clean floors, wash clothing by hand, open screw tops, deal with personal affairs, do practical activities'.*

**Table 9: DOMESTIC TASKS (65 years & Over Unable to Undertake Domestic Tasks (Central Bedfordshire)**

| People aged 65 and Over | 2014 | 2015 | 2020 | 2025 | 2030 |
|---|---|---|---|---|---|
| Males aged 65-69 unable to manage at least one domestic task on their own | 1,200 | 1,232 | 1,136 | 1,312 | 1,536 |
| Males aged 70-74 unable to manage at least one domestic task on their own | 1,092 | 1,155 | 1,512 | 1,407 | 1,638 |
| Males aged 75-79 unable to manage at least one domestic task on their own | 1,476 | 1,476 | 1,764 | 2,340 | 2,196 |
| Males aged 80-84 unable to manage at least one domestic task on their own | 1,066 | 1,107 | 1,353 | 1,640 | 2,214 |
| Males aged 85 and over unable to manage at least one domestic task on their own | 1,292 | 1,360 | 1,836 | 2,448 | 3,128 |
| Females aged 65-69 unable to manage at least one domestic task on their own | 2,156 | 2,212 | 2,156 | 2,380 | 2,856 |
| Females aged 70-74 unable to manage at least one domestic task on their own | 2,240 | 2,360 | 3,040 | 2,960 | 3,320 |
| Females aged 75-79 unable to manage at least one domestic task on their own | 2,340 | 2,340 | 2,860 | 3,692 | 3,588 |
| Females aged 80-84 unable to manage at least one domestic task on their own | 2,211 | 2,278 | 2,613 | 3,216 | 4,154 |
| Females aged 85 and over unable to manage at least one domestic task on their own | 2,706 | 2,788 | 3,362 | 4,100 | 5,084 |
| **Total population aged 65 and over unable to manage at least one domestic task on their own** | **17,779** | **18,308** | **21,632** | **25,495** | **29,714** |

*Source: POPPI 2014*

**Table 10: LEARNING DISABILITY – MODERATE OR SEVERE 65 and Over (Central Bedfordshire)**

| LEARNING DISABILITY (LD) - MODERATE OR SEVERE | | | | | |
|---|---|---|---|---|---|
| **Category** | **2014** | **2015** | **2020** | **2025** | **2030** |
| People aged 65-74 predicted to have a moderate or severe learning disability | 91 | 95 | 104 | 108 | 126 |
| People aged 75-84 predicted to have a moderate or severe learning disability | 30 | 31 | 37 | 47 | 51 |
| People aged 85 and over predicted to have a moderate or severe learning disability | 9 | 10 | 12 | 15 | 20 |
| **Total population aged 65 and over predicted to have a moderate or severe learning disability** | **131** | **136** | **152** | **170** | **196** |

*Source: POPPI 2014*

**Table 11: LEARNING DISABILITY – MODERATE OR SEVERE 65 and Over (Caddington Hall)**

| LEARNING DISABILITY (LD) - MODERATE OR SEVERE | |
|---|---|
| **Category** | **2015** |
| People aged 65-74 with a moderate or severe learning disability | 0 |
| People aged 75-84 with a moderate or severe learning disability | 0 |
| People aged 85 with a moderate or severe learning disability | 0 |
| **Total residents aged 65 with a have a moderate or severe learning disability** | **0** |

Issues in relation to age and disability are also examined in the section below on legal duties and case law.

**Proportion of respondents to consultation who had a disability**

32% (9) of respondents stated that they had a disability, 50% (14) of respondents stated they did not have a disability and 18% (5) preferred not to say or did not answer

### *2.2.6) CARERS* ***(A person of any age who provides unpaid support to family or friends who could not manage without this help due to illness, disability, mental ill health or a substance misuse problem)***

A) *National Data:*

*Age UK:*

- Older Carers may experience increased stress and depression as a consequence of their work: it is estimated that between a third and a half (33-52%) of spousal Carers of people with dementia suffer from depression.
- Furthermore, long hours and intensity of work, frequently without the possibility of breaks, may well result in isolation from social networks and activity.
- 38% of Carers aged 65+ report that their caring duties have affected their personal relationships, social life, and/or leisure.

- Of those reporting such effects, 67% say they have less time for leisure activities, 29% say they are too tired to go out, 31% say they cannot go on holiday, and 21% say their own health has been affected. 20% report less time for friends, 16% less time for a hobby or pastime, and 13% less time for other family members. 18% say they have no social or leisure activities at all.
- Additionally, 18% report being more aware of the needs of the disabled because of their caring duties.

*B) Local Data:*

**Table 11: UNPAID CARE 65 and Over (Central Bedfordshire)**

| PROVISION OF UNPAID CARE | | | | | |
|---|---|---|---|---|---|
| **CATEGORY** | **2014** | **2015** | **2020** | **2025** | **2030** |
| People aged 65-69 providing 1-19 hours of unpaid care | 1,862 | 1,911 | 1,813 | 2,046 | 2,426 |
| People aged 70-74 providing 1-19 hours of unpaid care | 910 | 969 | 1,258 | 1,199 | 1,360 |
| People aged 75-79 providing 1-19 hours of unpaid care | 484 | 489 | 586 | 774 | 740 |
| People aged 80-84 providing 1-19 hours of unpaid care | 259 | 272 | 316 | 387 | 510 |
| People aged 85 and over providing 1-19 hours of unpaid care | 139 | 148 | 182 | 228 | 292 |
| People aged 65-69 providing 20-49 hours of unpaid care | 254 | 261 | 247 | 279 | 331 |
| People aged 70-74 providing 20-49 hours of unpaid care | 156 | 167 | 216 | 206 | 234 |
| People aged 75-79 providing 20-49 hours of unpaid care | 144 | 145 | 174 | 230 | 220 |
| People aged 80-84 providing 20-49 hours of unpaid care | 91 | 96 | 111 | 136 | 179 |
| People aged 85 and over providing 20-49 hours of unpaid care | 40 | 42 | 52 | 65 | 84 |
| People aged 65-69 providing 50+ hours of unpaid care | 574 | 589 | 559 | 631 | 748 |
| People aged 70-74 providing 50+ hours of unpaid care | 520 | 554 | 719 | 685 | 777 |
| People aged 75-79 providing 50+ hours of unpaid care | 469 | 475 | 569 | 751 | 718 |
| People aged 80-84 providing 50+ hours of unpaid care | 344 | 361 | 419 | 513 | 676 |
| People aged 85 and over providing 50+ hours of unpaid care | 228 | 241 | 298 | 372 | 478 |
| **Total population aged 65 and over providing unpaid care** | **6,474** | **6,720** | **7,521** | **8,501** | **9,771** |

*Source: POPPI 2014*

29% (8) of respondents are family members of residents of Caddington Hall

### *2.2.7) GENDER REASSIGNMENT (People who are proposing to undergo, are undergoing or have undergone a process (or part of a process) to reassign their sex by changing physiological or other attributes of sex).*

*A) National Research & Data:*

- 1 in 10,000 people suffer from the recognised medical condition known as gender dysphoria, generally referred to as being transgender or transsexual.
- Recent research estimates that 7% of the transgender population are aged 61 or over.
- Ensure policies, procedures & publicity include transgender people, including the need to address transphobia from staff or other people using services.
- Ensure staff training on equality includes issues for transgender people and that staff and managers have access to resources on transgender issues.

- Use the name and title (e.g. Mr, Ms, Mrs, Miss) that the person prefers.
- Allow transgender people access to appropriate single-sex facilities, which are in line with their gender identity.
- Be aware that some transgender people may have specific personal care needs and handle these sensitively

*B) Local Data:*

Given the small size of the cohort, and in respect of privacy, it would be inappropriate to provide local data on transgender people as their identity may be compromised.

**2.2.8) PREGNANCY & MATERNITY:** ***(Pregnant women, women who have given birth and women who are breastfeeding (26 week time limit then protected by sex discrimination provisions)).***

Not Applicable

**2.2.9) SEXUAL ORIENTATION** ***(Lesbians, Gay Men, Bisexuals, Heterosexuals)***

*A) National Research Data:*

Research undertaken by Stonewall indicates that older Lesbian, Gay and Bisexual (LGB) people are much more likely than heterosexual people to face the prospect of living alone with limited personal help from their families and therefore are more likely to rely on formal services for support in later life. Many older LGB people express considerable worries about the future – about having to hide their sexual orientation, about having to move into an environment that is designed for heterosexual people and about a lack of opportunity to socialise with other older gay people. These concerns will need to be considered as the standards are developed. Transgender people could also share similar concerns.

- It is estimated that 5 to 7% of the population in the UK is LGB.
- Older LGB people receiving services at home can feel unsure about the treatment they will receive.
- Three in five are not confident that social care and support services, like paid carers, or housing services would be able to understand and meet their needs.
- The possibility of needing to live in a residential care home is of particular concern to LGB people. While they share many concerns about care homes with their heterosexual peers, they do have an increased level of anxiety.
- 70 per cent of lesbian, gay and bisexual people don’t feel they would be able to be themselves if living in a care home

*B) Local Data:*

Given the small size of the cohort, and in respect of privacy, it would be inappropriate to provide local data on LGB people as their identity may be compromised.

### 2.2.10) *OTHER* ***(Human rights, Poverty, Social class, Deprivation, Look After Children, Offenders, Cohesion, Marriage and Civil Partnership, Care Homes)***

**Table 12: LIMITING LONG TERM ILLNESS 65 and Over (Central Bedfordshire)**

| CATEGORY | LIMITED LONG TERM ILLNESS: 65 YRS & OVER (Central Bedfordshire) | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | LIMITED A LITTLE | | | | | | LIMITED A LOT | | | | |
| | 2014 | 2015 | 2020 | 2025 | 2030 | | 2014 | 2015 | 2020 | 2025 | 2030 |
| People aged 65-74 whose day-to-day activities are:- | 5,284 | 5,508 | 6,039 | 6,283 | 7,304 | | 2,944 | 3,069 | 3,364 | 3,500 | 4,069 |
| People aged 75-84 whose day-to-day activities are:- | 4,501 | 4,626 | 5,470 | 7,001 | 7,689 | | 3,482 | 3,579 | 4,232 | 5,416 | 5,948 |
| People aged 85 and over whose day-to-day activities are:- | 1,379 | 1,459 | 1,803 | 2,254 | 2,891 | | 2,350 | 2,485 | 3,073 | 3,841 | 4,925 |
| **Total population aged 65 and over with a limiting long term illness whose day-to-day activities are:-** | **11,164** | **11,593** | **13,312** | **15,539** | **17,883** | | **8,775** | **9,133** | **10,668** | **12,758** | **14,942** |

A) *National Research:*

*Quality of Life in Care Homes (Help the Aged)*

a) *Quality of Life:*

- Quality of life is notoriously difficult to define as it pervades a range of aspects of everyday life in significant and complex ways. It encompasses many dimensions and can be viewed from a range of perspectives.
- Comfort is important for care home residents, who need to feel that their environment is attractive, supportive and safe.
- Care home residents may need to continue past activities or to begin new ones. This support needs to be carefully planned and discussed with residents.
- Maintaining existing friendships as well as developing supportive friendships with other residents is important for residents and should be encouraged.
- What constitutes quality of life is distinct for every person. In order to support and enhance quality of life we must seek to understand the priorities of each individual person.

b) *Quality of Care:*

- Promoting high-quality care within care homes requires consideration of the views and experiences of all major stakeholders: residents, families and staff.

The most recent publication on the subject of care home closures is: "Making Choices Good Practice Guide – Reconfiguration of Statutory Residential Homes" – Health and Social care Board for Northern Ireland

The abstract to this document states: The relocation of older people from one care setting to another can be particularly stressful, and there is a perception that the closure of residential homes can have an adverse effect on residents' health and wellbeing. However, research carried out by AGE NI has found that the effects a home closure has on resident's health and psychological well-being is influenced by the way in which a home is closed and how the relocation is managed.

This document outlines how best practice should be adopted pre- relocation, during relocation and post relocation. For the purpose of this document, pre-relocation refers to the time period from when the resident begins to consider moving to another residence until the actual move. Relocation refers to the actual day of transition from one residence to another; and post relocation refers to the time after the individual has moved from one residence to a new residence. This document draws on previously published papers which outline lessons learnt in the reconfiguration of care homes in the past, both within the Health and Social Care system in Northern Ireland and in the wider UK. It also draws on examples of best practice for planned, phased or emergency reconfiguration; and on the experience of the community and voluntary sector (AGE NI and the Alzheimer's Society) who have acted as advocates in the closure of care homes in the past.

The guidance states that: "Particular care and attention needs to be shown to those residents who have been identified as most vulnerable. A risk assessment tool should be used to identify those residents who may need more support during the relocation process.

**"**In understanding how older people cope with moving from one institution to another various factors need to be taken into account. A risk analysis exercise can help determine those who may be most at risk... It can:

- Identify those most at risk of negative experiences arising from proposed action
- Identify those who could be harmed
- Assess level of risk
- Consider measures you can take to mitigate the risks
- Assess the level of risk remaining after mitigation measures have been taken
- Decide if the benefits outweigh the risks"

## *2.2 <u>Summary of Existing Data and Consultation Findings:- Employment Considering the impact on Employees</u>*

### ***2.3.1) AGE: (16-19 / 20-29 / 30-39 / 40-49 / 50-59 / 60+)***

*<u>National & International Research:</u>*

- Younger people often make assumptions that they don't have relevant skills or experience for. (Employers Forum on Age)
- 62% of over fifty year-olds feel they have been turned down for a job because they are considered too old, compared with 5% of people in their thirties. (GEO)

- People over 50yrs who have lost their jobs remain out of work for longer than average: however, older people's employment rates rose faster than any other rates in the past decade, and so far have fallen by less in the recession. Older people have increasingly been using flexible patterns of work, and this could be helping to protect the overall proportion of them employed in the present downturn.

- Overall, 9% of people who reported experiencing unfair treatment at work believed it was because of their age. Younger workers were more likely to report unfair treatment and discrimination at work than their older colleagues, whilst older people were slightly more likely to report bullying or harassment.

- Research has found discrimination against older Black, White and Asian women who reported facing fewer promotion opportunities, limited access to training and were allocated less rewarding and challenging work

*<Any relevant feedback from the staff consultation process will be added here>*

### 2.3.2) RACE: *(Asian or Asian British / Black or Black British / Chinese / Gypsies and Travellers / Mixed Heritage / White British / White Irish / White Other)*

National Research:

- Overall, it seems that employment gaps for ethnic groups are narrowing over time, although differences remain considerable for the Bangladeshi and Pakistani populations

- People from ethnic minority groups are more likely to report experiencing discrimination in relation to promotion than White men
- 7% of White British people reporting discrimination compared to 12% of people from ethnic minorities

- Compared to 1% of White people, 7% of ethnic minority people in 2009/10 felt they had experienced labour market discrimination by being turned down for a job because of their race. Black Caribbean people are most likely to report experiencing this form of discrimination (10%) compared to 4% of Indians and 4% of Chinese/Others.

- In terms of promotion, 1% of White people felt they had experienced discrimination due to their race when seeking promotion. A higher percentage of people from ethnic minority backgrounds overall felt that they had experienced this form of discrimination (5%). In particular Black African (9%), Black Caribbean (8%), Indian (5%), Chinese/Other (4%) and Pakistani (3%) people were more likely to feel they had experienced discrimination on the grounds of their race than White people.

- Evidence suggests that ethnic minority groups are more likely to encounter racial discrimination in the private sector (35%) than the public sector (4%).

*<Any relevant feedback from the staff consultation process will be added here>*

### 2.3.3) RELIGION OR BELIEF: *(Christian, Jewish, Muslim, Hindu, Buddhist, Sikh, Other, No Religion)*

*National Research:*

- While there is some variation in employment rates among different religious groups, the most significant gap is for Muslim people who have the lowest rates of employment in the UK
- The 2009/10 ***Citizenship Survey*** shows that less than 0.5% of people overall felt they had experienced labour market discrimination by being turned down for a job because of their religion or beliefs; this is unchanged since 2008-09.

*<Any relevant feedback from the staff consultation process will be added here>*

### 2.3.4) DISABILITY *(Physical Impairment. Sensory Impairment, Mental Health Condition, Learning Disability or difficulty, Long-standing Illness or Health Condition, Severe Disfigurement)*

*National Research:*

- Across Britain, the employment rates of disabled adults are very low with only around 50% employed compared to 79% of non-disabled adults (a difference of nearly 30% in employment rates).
  Overall, disability affects work status more than gender or lone parenthood.
- When disabled people are employed, they are significantly more likely than nondisabled people to work part-time. In 2009, 33% of disabled people were in full-time employment, compared to 60% of non-disabled people. The reasons for this (personal choice or discrimination) are not clear.
- Those with some forms of impairment such as diabetes and skin conditions are almost as likely to be employed as the average. At the other extreme, people with depression or 'bad nerves' have employment rates of around 23%.
- More severe overall impairments are associated with poorer job prospects.
- Disabled employees are over twice as likely as other employees to report experiencing discrimination, bullying or harassment in the workplace, while disabled women are four times more likely to report being bullied than other employees
- People with a disability or long-term illness were more likely than those without to report experiencing unfair treatment (19% compared to 13%).
- People with a disability or long-term illness were almost twice as likely to report experiencing discrimination as those without a disability or long-term illness (12% compared to 7%) and were over twice as likely to report experiencing bullying or harassment in the workplace (14% compared to 6%).
- Disabled women were found to be four times more likely to be bullied than other employees.
- Those with a long-term illness or disability are significantly more likely to report feeling that they have been discriminated against in relation to recruitment or promotion than the average.

Caddington Hall has a kitchen worker with a learning disability. This matter will need to be taken into account when considering the options for the future of the home and the worker may require additional support during the staff consultation period.

*<Any relevant feedback from the staff consultation process will be added here>*

### 2.3.5) CARERS *(Parent, Guardian, Foster Carer, Person caring for an adult who is a Spouse, Partner, Civil Partner, Relative, or Person who Lives at the Same Address)*

National Research:

- There are currently over 3 million working Carers in the UK. Work is important for well-being, income and to keep social contacts.
- Between 46% and 62% of Carers are not getting adequate services to help them work
- Only just over half (56%) felt their employer was Carer-friendly and supportive

*<Any relevant feedback from the staff consultation process will be added here>*

### 2.3.6) GENDER REASSIGNMENT *(People who are proposing to undergo, are undergoing or have undergone a process (or a prat of a process) to ressign their sex by changing physiological or other attributes of sex).*

National Research:

- Small-scale studies point towards evidence of harassment and other forms of discrimination in the workplace.
- Transgender people are more likely than others to experience difficulty in finding work or retaining it if their background becomes known to others. High numbers report feeling obliged to change jobs because of workplace harassment and abuse. They have been found to be in jobs that are below their skills and educational capacity and appear more likely to work in lower-paid and insecure employment in the public sector, or to be self-employed.
- The employment sphere is the space in which transgender people face the most significant and pervasive levels of discrimination 42% of people not living permanently in their preferred gender cited the workplace, and a fear that their employment status might be threatened, as a reason for not transitioning.

*<Any relevant feedback from the staff consultation process will be added here>*

### 2.3.7) PREGNANCY & MATERNITY *(Pregnancy, Compulsory Maternity Leave, Ordinary Maternity Leave, Additional Maternity Leave)*

National Research:

- Evidence indicates that women are vulnerable to discrimination at particular points in their life, specifically when they are pregnant.
- An Equal Opportunities Commission (EOC) formal investigation into the employment experiences of pregnant women carried out in 2005 found that almost half of the 440,000 pregnant women in Britain experienced some form

of disadvantage at work, simply for being pregnant or taking maternity leave. Around 30,000 women were sacked, made redundant or treated so badly that they felt they had to leave their jobs.

- A survey of 122 recruitment agencies revealed that more than 70% had been asked by clients to avoid hiring pregnant women or those of childbearing age. (Women and Work Commission).

- The EOC's formal investigation into ethnic minority groups, found that just under a sixth of White women in the sample had often/sometimes been asked about their plans for marriage /children at interview compared to between a fifth and a quarter of ethnic minority women.

*<Any relevant feedback from the staff consultation process will be added here>*

### *2.3.8) SEX (Women, Men)*

National Research:

- Women of all ages are significantly more likely to be in part-time employment than men and less likely to be self-employed
- Women are much less likely than men to be employed full-time or self-employed in their early 30s (due to caring responsibilities), and if they return to work are more likely to take and remain in part-time employment.
- Mothers of children under the age of 16 are four times more likely than fathers to be economically inactive: being a parent exacerbates the gender gap.
- Women are more likely to report experiencing discrimination in relation to promotion than White men
- 38% of mothers and 11% of fathers have left a job or been unable to take one due to caring responsibilities
- The Equality Review highlighted that one of the most significant issues to address to resolve this inequality is the development of policies to help mothers and fathers to balance paid work and caring between them, at the same time as fulfilling their obligations to their employers
- The vast majority of people employed in local government are women (70%) but most are concentrated in lower paid and part-time jobs. (EOC)
- Women are still under-represented in the higher paid jobs within occupations – the "glass ceiling" effect. (GEO)

*<Any relevant feedback from the staff consultation process will be added here>*

### *2.3.9) Sexual Orientation: (Lesbians, Gay men, Bisexuals, Heterosexuals)*

National Research:

- There are no available data on employment or NEET status by sexual orientation

- LGB adults are around twice as likely to report experiencing unfair treatment, discrimination, bullying or harassment at work as other employees.

- LGB adults are far more likely than heterosexual people to report experiencing discrimination on the grounds of their sexual orientation in terms of recruitment (8% compared to less than 0.5% of all people

*<Any relevant feedback from the staff consultation process will be added here>*

2.3.10) Other: e.g. Human Rights, Poverty / Social Class / Deprivation, Looked After Children, Offenders, Cohesion, Marriage and Civil Partnership

*National Research:*

The Fair Treatment at Work Survey 2008 found that 13% of British employees had personally experienced unfair treatment in the workplace in the last 2 years, and 7% reported experiencing bullying, harassment or discrimination. Overall, respondents to the survey were far more likely to cite an individualistic reason for unfair treatment such as 'the attitude or personality of others' (41%), 'people's relationships at work' (35%) 'it's just the way it is' (23%) or 'your position in the organisation' (21%) than a reason directly associated with a protected equality characteristic.

*<Any relevant feedback from the staff consultation process will be added here>*

## 2.4 *To what extent are vulnerable groups more affected by this proposal compared to the population or workforce as a whole?*

***Service Related***

The focus of this work is on residential care provisions for older people, over the age 65 years. This includes people with a range of needs including dementia care, physical and sensory disability, other vulnerability, frailty and temporary illness.

National research indicates that people wish to be supported in their own home as long as possible and that if they need to move to a care home comfort and quality of life criteria are important considerations. Residents need to feel that their environment is attractive, supportive and safe.

The relocation of older people from one care setting to another can be particularly stressful and there is a perception that the closure of residential homes can have an adverse effect on resident's health and wellbeing. However, research has found that the effects a home closure has on resident's health and psychological well-being is influenced by the way in which a home is closed and how the relocation is managed.

Particular care and attention needs to be shown to those residents who have been identified as most vulnerable. Professional assessment should be used to identify those residents who may need more support during the relocation process.

***Employment related***

Furthermore, the Council undertakes regular ***Staff Opinion Surveys***, the key equality related findings (from the 2012 and 2014 surveys) of which are summarised below.

**Table 13: STAFF OPINION SURVEYS (Central Bedfordshire Council)**

| Key Findings – Equality Perspective | | | |
|---|---|---|---|
| **No.** | **Question** | **2012** | **2014** |
| 1 | Satisfaction with Opportunities for Flexible Working | 70 | 69 |
| 2 | Achieve Correct Balance between Work and Home Life | 56 | 63 |
| 3 | Believe CBC does not Discriminate on any Grounds | 72 | 79 |
| 4 | Confident CBC would deal effectively with bullying / harassment if issue was raised | 57 | 63 |
| 5 | Good Working Atmosphere in my Team, people get along & I enjoy being part of it | 78 | 79 |
| 6 | Good Working Atmosphere in my Team, people get along & I enjoy being part of it | 78 | 79 |
| 7 | My Line Manager is Approachable | 91 | 90 |
| 8 | My Line Manager is Supportive | 81 | 87 |
| 9 | PDR completed in the last 12 months | 72 | 61 |

**Table 14: WORKFORCE COMPOSITION (Central Bedfordshire Council)**

| WORKFORCE COMPOSITION | | | |
|---|---|---|---|
| **Characteristics** | **2012** | **2014** | **Comments** |
| Male | | | |
| Female | | | |
| Age – 18 - 24 | | | |
| Age – 25 – 34 | | | |
| Age – 35 – 44 | | | |
| Age – 45 – 54 | | | |
| Age – 55 - 64 | | | |
| Age – 65 + | | | |
| Race | | | |
| Disability | | | |
| Religion/Belief | | | |

### 2.5 *To what extent do current procedures and working practices address the above issues and help to promote equality of opportunity?*

#### A) *Commissioning for Outcomes: Approach to Standards and Quality of Dementia Care, Fee Levels for Care Homes*

The Council has identified a need to address issues relating to quality and access to appropriate care services across Central Bedfordshire and to ensure that the social care market is able to meet current care needs and the growing demands of the future. The Council needs to address the care needs of the whole care population and not just those who are publicly funded.

A strategic approach is being developed to raising the standards and quality of dementia care and linking quality to fee levels for care homes. This will be achieved through the linking of quality accreditation systems and fee levels paid for local authority funded customers.  This will allow greater choice for people who require this high level of care.

The focus will be on raising the standards of support and care offered to all older people who live in residential and nursing care homes.  This is achieved

by the introduction of two quality systems, the first introduced in January 2013 for provision of specialist dementia care, and the second introduced in 2013/14 covering all other care home services.

These two quality systems are the basis for how residential and nursing care homes receive payment for local-authority funded customers across Central Bedfordshire. This is achieved by linking quality ratings to the fee tariff paid

The fee tariff is part of new contracting arrangements with care home providers. The Council introduced a Framework Agreement with any qualifying provider that commits them to achieving quality standards in return for a designated tariff. Local authority funded customers will therefore have a much wider choice of care home, meeting the commitment to shift the balance of care to more personal, flexible arrangements.

The Council's seven homes offer consistently good levels of care but are now 30-50 years old and do not meet the environmental standards introduced by the Care Quality Commission (CQC) in 2010.

The Dementia Quality Mark has been developed and will help the Council achieve the medium term plan that by 2014, a minimum 60% of dementia care is rated as good or excellent. It will be the basis of a continuous improvement programme that drives excellence in care home provision across Central Bedfordshire. Once accredited, Council officers will monitor to ensure quality is maintained and in return the provider will receive an additional incentive payment. The outcome is that residents and their families can be assured of appropriate high quality care. In recognition of the added costs of supporting people with advanced signs of dementia, there is an incentive payment for providers who qualify for the dementia accreditation scheme. This additional payment supports on-going high quality care, allowing, for example, improvements to staffing/resident ratios, specialist staff training, and regular maintenance or replacement of high wear and tear items.

Following establishment of the Dementia Quality Mark Scheme, the principles are being expanded across all residential and nursing care home provision in Central Bedfordshire. This ensures transparency of the Council's expectations for delivering high quality care and person-centred outcomes for all people living in care homes. This quality system is clearly linked to level of remuneration for local authority funded care home customers. Implementation commenced in 2013/14.

Central Bedfordshire Council introduced outcome based commissioning; actively moving the focus of commissioning, to what the individual person wants to achieve to improve their quality of life and supporting them to make informed choices about their care and how it is provided. This shifts the balance of care towards more personal, flexible arrangements in turn moving away from traditional institutional approaches.

*B) Fee Level Setting for Care Home Placements*

The approach to fee levels has been developed into a four-band structure based on annual quality monitoring ratings of 'excellent', 'good', 'adequate'

and ‘poor’. This system rewards high quality provision and incentivises all providers to strive towards and then maintain high quality.

*C) Service Specification*

The service specification for accommodation-based services in care homes that has been drawn up is based on the regional standard for adult social care and housing support services in the East of England.

In providing the Services the Provider is required to be registered with the Care Quality Commission (CQC), be inspected as required by the CQC and to maintain that registration throughout the Agreement Period. The Provider must meet standards set down in the relevant statutes and regulations.

In addition to meeting the requirements of the Essential Standards of Quality and Safety the Provider is also required to meet the specific contract standards contained in the East of England Service Outcomes and Standards of Care.

The specification requires the Provider to provide the Services so that they meet the needs of the individual and are provided by competent staff in a way that supports the safety and security of the customer. The Services must be responsive, reliable and maintain a person’s dignity and respect at all times. The Services must be accessible and delivered with understanding and without discrimination.

The Services must always be provided in a person-centred way that enables customers to maximise their independence, health and well-being and supports their social, spiritual, emotional and healthcare needs. This will include:

- Orientation within and outside the care home;
- Companionship;
- Games and intellectual stimulation;
- Socialising with friends and family;
- Access to, and attendance at doctors, dentists, and out patient appointments, including providing a free escort service.
- Fitness activities.

In the provision of the Services the determining factor will always be the outcomes to be achieved which are recorded in the customer’s Care and Support Plan. The customer and, wherever possible and in accordance with the customer’s wishes, their Carers should always be central to discussions as to how those outcomes will be achieved.

The Services should also achieve the outcomes for customers in accordance with the White Paper ‘Our Health, Our Care, Our Say’, namely:

- Exercising Choice and Control;
- Improved Health and Emotional Well-being;
- Personal Dignity and Respect;
- Quality of Life;
- Freedom from Discrimination and Harassment;
- Making a Positive Contribution; and
- Economic Well-being

The Provider shall ensure that its staff have regard for its customers equality and diversity, uphold people's human rights (in line with the guidance outlined in the Equality and Human Rights Commission Home Care inquiry) and do not discriminate against people for any reason. Its policies will incorporate respect for both staff and customers.

The Provider shall ensure that all staff work in an enabling way that allows customers to increase or maintain their level of independence and develop self-caring and, where appropriate, leads to a reduction in the level of care and support they require.

The Provider will:

- Support the customer with self care when this is difficult because of their frailty or disability
- Enable the customer to retain their self respect and dignity when they meet, see, or are seen by others within the Care Home, including the staff of the Provider
- Assist the customer in such a way that any distress or discomfort is avoided or minimised, paying due regard to their health and safety and encouraging the exercise of personal choice and control
- Provide an agreed programme of rehabilitation designed to assist the customer to regain skills or develop new skills in personal care. This may include enabling the customer to assist with tasks around the Care Home or the local community.
- As well as carrying out personal care tasks the Provider should make it a clear and expected aspect of the work of their staff that part of their role is to spend time talking to, relating with, and understanding the lives of their customers, supporting them with appropriate activities and signposting them, as appropriate, to local services to improve their health and well-being.
- Safeguarding of vulnerable adults will be a core principle of the Provider and will be at the heart of their service delivery.
- Throughout the period of the Framework Agreement the Provider will be assessed against the Quality Monitoring Framework and their quality ranking on the Framework Agreement adjusted accordingly. This will be based on performance data collected from a number of sources, including quantitative and qualitative elements
- The Provider will work with the Council to develop customer satisfaction and quality assurance tools to effectively obtain and analyse feedback from customers in order to inform future service delivery. The Provider will give the Council access to the results of this process
- The needs of each customer will be identified through an assessment completed by the Council in conjunction with the customer.

Assessment will include (but not be limited to) the following:

- Feedback from customers and their Carers on the standards of the Services;
- Feedback from Council officers reviewing whether or not the Services are meeting customers' assessed needs and their outcomes in the best possible way;

- Systematic monitoring of the Provider in order to evaluate and record the Services against the Specification;
- Consulting with customers and their representatives;
- The investigation of complaints and safeguarding instances;
- Evaluation of Provider Performance Monitoring Forms;
- Reviewing the Provider's written procedures and individual records for both customers and staff;
- Assessment of the Provider's annual report detailing the outcome of quality assurance processes, including its service improvement plans;
- Consideration of external compliance reports from CQC

The Provider will provide the following additional information on an annual basis:

- Business Continuity Plan. The Council will review this to ensure that the risk of the Services being disrupted or discontinued has been minimised;
- Accounts for the most recent completed financial year (audited if required by law). These will be examined to ensure that the Provider remains financially viable;
- Insurance Schedules and Certificates. These will be examined to ensure that the Provider has maintained appropriate insurance cover as specified in the terms and conditions of the Framework Agreement;
- A Copy of the Provider Compliance Assessment tool (PCA) or equivalent. The Council will examine the PCA or equivalent to identify good practice and areas for improvement. It will also review the latest CQC Inspection Report;
- Results of the Provider's annual Customer Satisfaction Survey. The Council will use these to assess the quality and performance of the Services;
- A copy of the Provider's annual report including their service improvement plan; and
- A copy of their training matrix for all staff.

*D)* Service Outcomes And Standards Of Care For Accommodation-Based Services In Care Homes:

The specification includes five overall standards which are broken down into detailed requirements;

*Standard 1* - Involvement & Information:
Respecting & Involving Customers and Consent

*Outcome Customers understand the care and support choices available to them. They are encouraged to express their views and are always involved in making decisions about the way their care and support is delivered. Their privacy, dignity and independence are respected and their (or their Carer's) views and experiences are taken into account in the way in which the Services are provided*

Providers will ensure that its staff do not discriminate against people because of their age, disability, gender reassignment, race, religion or belief, sex,

sexual orientation, marriage and civil partnership, pregnancy and maternity. It will have policies that incorporate respect for both its staff and customers recognising their diversity, values and human rights.

*Standard 2* – Personalised Care and Support:
Care and welfare of customers, Meeting nutritional needs, Co-operating with other providers.

*Standard 3* – Safeguarding and Safety:
Safeguarding people who use the service from abuse, Cleanliness and Infection control, management of medicines, Safety and suitability of premises, safety, availability, and suitability of equipment.

*Standard 4* – Suitability of Staffing:
Requirements relating to staff recruitment, staffing and staff deployment, supporting staff.

*Standard 5* – Quality of Management:
Assessing and monitoring the quality of services, Complaints, Records.

*E)* Risk Assessment

The council has adopted and carried out a number of measures to assess the current providers, these include:

- Carrying out financial checks on current providers to ascertain financial viability using councils in house financial risk management framework
- A performance management and quality monitoring framework1 has been used to set a benchmark around quality levels
- A check of parent holding companies so far as is possible has been carried out to identify company risks
- Procure a training programme to help build in house capacity within the council to be prepared if an event such as the collapse of Southern Cross were to occur locally.

## 2.6 *Research and good practice relating to the impact of care home closures*

There are a number of good practice guides which have been developed in response to care home closures. All of these seek to mitigate the impact on residents of closures and transfers.

The Council is developing its own good practice guide based on published guidance and research and this will be available prior to any decision being made about the future of the home.

'Making Choices Good Practice Guide' – Reconfiguration of Statutory Residential Homes – Health and Social Care Board for Northern Ireland. This document was

[1] ADASS Regional Quality Workbook – East of England

published in 2013 as guidance for practitioners and managers in Northern Ireland in relation to the closure of homes there. Although there are some historical, governance and legislative differences between the UK and NI the majority of the recommendations in the guide are useful and relevant.

Achieving Closure – Good Practice in supporting older people during residential care closures – University of Birmingham / ADASS. This document was published in 2011 and draws on previously published studies and guidance as well as drawing on the experience of authorities that had undertaken care home closures.

The key points from these documents will be incorporated into the Council's own guidance, as it relates to processes that would take place after a closure decision has been made. This guidance will be available to decision-makers prior to them determining the future of the home.

Detailed practice guidance for the process to be undertaken prior to a decision being made will also be developed based on our experiences and on good practice guidance and this will be used to inform similar situations in the future. A review of current activities in this regard has revealed that activities currently under way are following or exceeding best practice recommendations.

This document is not the place to detail this guidance but key points are set out below:

*Phase 1*

- The importance of clear, open and honest communication with residents, relatives and staff is emphasised.
- Communication should be regular and be both proactive and reactive as the situation demands.
- The consultation documents must set out clearly the options being considered
- The outcome of the consultation must be considered by decision-makers before making a decision on the future of the home.
- Residents will be sensitively encouraged and facilitated to take part in the consultation process in ways that are compatible with their needs and abilities. Professional assessment of their ability to participate and the potential harmful effects of participation would be made.
- Residents would have access to advocacy.
- Although full assessments of residents would not be made during Phase 1, an initial assessment would be made of them to ascertain those who would be most at risk if they were to move homes, the actions that can be taken to mitigate those risks and the degree to which those actions would be able to reduce the risk. This information would be made available to decision-makers.
- Staff will be appropriately involved and supported.

*Phase 2*

If a decision is made to close the home then the following key points will be followed:
- All residents will have comprehensive assessments undertaken by appropriate professional(s) and the recommendation of these assessments will be taken into account in the choice of accommodation offered and in planning their move.
- A clear offer of alternative accommodation (which acknowledges the rights and choices that residents have) will be made.
- Residents and their relatives will be offered the opportunity to visit other homes and given time to make an informed decision.
- Residents would have access to advocacy.

- In planning moves particular attention would be paid to those residents identified as most vulnerable or at risk.
- Residents will be given practical help and support to move.
- Residents will not be moved if there is medical advice that to do so would put them at imminent risk. Moves would be postponed until this risk had been mitigated.
- There is some evidence that negative effects of a move may manifest themselves during the period after transfer so appropriate methods will be put into place to monitor the people who have transferred.
- Staff will be appropriately consulted, involved and supported.

### 2.7 *Consultation Plan and Timetable*

*A) Consultation with Residents and Relatives*

The consultation period was from 18th February to 13th May 2015. A detailed consultation timetable and process was developed and implemented. This will be further developed and refined during the process in response to any issues that emerge. Key activities are set out in the table below:

| Date | Activity |
|---|---|
| 28th & 29th January | Pre-consultation meeting with residents, relatives and staff members |
| 10th February | Individual letters sent out to relatives and stakeholders of the executive decision to consult |
| 17th February | Discussion with senior staff in the home about the ability of residents to participate in consultation |
| 18th & 19th February | Individual contact with relatives to explain about the consultation process and advising that the consultation process was starting |
| 19th February | Consultation documents published and sent to residents, relatives and o stakeholders |
| 19th February | Consultation documents published on CBC website |
| 3rd March | Individual contact with relatives about the consultation process – offering individual meetings |
| 9th & 13th March | Individual meetings with relatives and residents |
| 17th & 23rd March | Informal ‘drop in’ sessions with staff |
| 13th April | Mid-point communication and engagement with relatives, relatives and staff members |
| 13th April onwards | Individual assessment of residents who have not yet participated in consultation |
| 20th April onwards | Engagement with residents who have not yet participated in consultation where appropriate. |
| 27th April onwards | Further activity prior to the end of the consultation period if required |

*B) Consultation with Staff*

Staff will be involved in the consultation about the future of the home and can contribute (see timetable and plan above).

In relation to their employment, the formal Consultation period with employees and Trade Unions for these proposals will commence following the decision of the Executive in relation to the future of the home.

Staff will be encouraged to discuss any concerns they may have with their line manager in the first instance. Those employees who wish to request to have a one to one meeting will have a named contact in HR.

The Council is keen to avoid the need for compulsory redundancies, and a range of measures will be put in place to mitigate this. These are detailed in the Managing Change policy. Included is the provision of a voluntary severance scheme.

The Employee Support Service is available to support all Central Bedfordshire employees.

*C) Consultation with other stakeholders*

Stakeholders have been advised of the consultation and are kept up to date with progress via the Council's normal communication processes. In addition direct contact is being made with some key organisations/groups such as Healthwatch and OPRG and members of the team will attend meetings or briefing sessions with any organisation that requests it.

*2.8 Are there any gaps in data or consultation findings?*

Workforce composition data to be added.

GP's and staff in the home will be consulted to identify those most at risk.

*2.9 What action will be taken to obtain this information?*

Workforce composition data will be gathered during Phase 2 consultation

32.1% (9) of respondents are residents, 28.6% (8) are members of the public and 28.6% (8) are family members of residents of Caddington Hall, 3.6% (1) Older Peoples reference Group and 7.1% (2) are 'other' people

Some residents and family members state the preferred option has been well thought through and will provide good quality accommodation. They also stated that although they agree with the preferred option, they have been happy with the quality of care provided at Caddington Hall.

Comments included:

- The historic nature of the Hertfordshire site should be considered in any future planning.
- Family members expressed concern by the increasing traffic issues getting in/out of Dunstable.
- It has run its course - The homes need to be in an area easy access to shops and main services for customers and families
- Clarification over re-development and sale of the site.
- Quality care and decreasing staffing levels.

- Some respondents feel what they say will not make a difference to the outcome.
- Preference for Caddington Hall to remain a care home.
- Investigation of working with other Local Authorities to redevelop and improve the Caddington Hall.
- A request for ongoing communication between the Council and effected stakeholders
- A request clarification and reassurance over possible cost implications.
- Residents being "the key and how you manage them will dictate whether or not it is successful. Key to make it as stress-free as possible for them and that staff stay the same."
- The CBC consultation has been a positive experience. I think the Council has shown care for the people it looks after.

The majority of the 28 respondents support the preferred option to close the Home and re-locate current residents

**Stage 3: Providing an overview of impacts and potential discrimination.**

| Assessing Positive & Negative Impacts | | | | | |
|---|---|---|---|---|---|
| **Analysis of Impacts** | **Impact** | | **Discrimination** | | **Summary of impacts and reasons** |
| | **(+ve)** | **(- ve)** | **Yes** | **No** | |
| Age | ✓ | ✓ | | ✓ | The proposal aims to better meet the needs of older people, in particular those of 80 years and above – the group most likely to need a care home setting. The risk of adverse impacts relating to relocation increases with age |
| Gender | | ✓ | ✓ | | Care home residents need to feel that they are being treated equitably. Men are more likely to experience adverse impacts relating to relocation. |
| Race | | | | ✓ | Care home residents need to feel that their environment is, supportive and safe from any form of race-related, or any other form, of harassment. Intentional strategies may need to be considered to reach and engage people from BME communities in accessing care home provisions. |
| Disability | ✓ | ✓ | | ✓ | Most older people living in a care home are likely to have a disability, so a consistent provision of disability access in both private and communal rooms needs to be available. This is more likely in homes with modern standards of accommodation.<br>The relocation of older people from one care setting to another can be particularly stressful and there is a perception that the closure of residential homes can have an adverse effect on resident's health and wellbeing. However, the effects a home closure has on resident's health and psychological well-being is influenced by the way in which a home is closed and how the relocation is managed.<br>The risk of adverse impacts relating to relocation increases with the level and type of impairment. Particular care and attention needs to be shown to those |

| Assessing Positive & Negative Impacts | | | | | |
|---|---|---|---|---|---|
| Analysis of Impacts | Impact | | Discrimination | | Summary of impacts and reasons |
| | (+ve) | (- ve) | Yes | No | |
| | | | | | residents who have been identified as most vulnerable. |
| Religion / Belief | | | | ✓ | Care home residents need to feel that their environment is supportive and safe to exercise their faith and belief is so desired. |
| Carers | ✓ | | | ✓ | Provision of care homes can help to relieve pressure on carers. |
| Gender Reassignment | | | | ✓ | Care home residents need to feel that their environment is attractive, supportive and safe and is addressing their needs |
| Pregnancy & Maternity | | | | ✓ | Not Applicable |
| Sexual Orientation | | | | ✓ | Care home residents need to feel that their environment is attractive, supportive and safe and is addressing their needs |
| Other | | | | | |

**Stage 4: Identifying mitigating actions to be taken to address adverse impacts.**

*4.1* *What are the main conclusions and recommendations from the assessment?*

- There is a need to balance the potentially conflicting duties in relation to consultation with residents who may be distressed (or be at risk of harm for other reasons) by the consultation process itself.
- There is a need to ensure that decision-makers are given accurate information about the risks to individual residents and the degree to which these can be mitigated when coming to a decision about the future of the home.
- There is a need to ensure that the requirements of the PSED are taken into account and reflected in the information presented to decision-makers.
- A good understanding of the needs and preferences of each resident, along with detailed transition plans that reflect these needs are important in reducing the risk to residents.
- A high level of communication and engagement with residents, relatives and staff is important in helping to deal with issues as they arise and manage people's anxieties.

*4.2* *What changes will be made to address or mitigate any adverse impacts that have been identified?*

- Strenuous efforts were made to ensure that the views of residents about the future of the home were obtained. Each resident's ability to participate in the consultation was assessed by a social worker who had been briefed about the process and the key issues. Where a resident

had some degree of capacity to participate then the social worker explained the options, recorded their responses and fed these into the consultation. Where a resident was assessed as not having the capacity to participate then the social worker investigated further to establish if there was a friend or relative who was acting in their best interests and who could respond on their behalf. If a resident did not have anyone willing and able to act in this capacity then an advocate would have been sought.

The outcome of this process was that nine residents had capacity to take part in the consultation and were assisted to do so. A further seven residents were assessed not to have capacity to participate but all of those people had a relative or friend who was able to represent their best interests. No resident required an advocate.

- The risks to individual residents and the potential mitigation actions will be assessed and this information will be available to decision-makers in a way that preserves residents' confidentiality.
- Information provided to decision-makers will include an analysis of the PSED in relation to the options considered and the recommendations.
- The good practice guide will be updated and its content made available to decision-makers before them making a decision on the future of the home.
- Each resident will have assessments undertaken by both medical and social work professionals as part of the transition process, should the decision be made to close the home.
- Throughout the process a high level of communication and engagement with residents, relatives and staff will be maintained.

4.3 *Are there any budgetary implications?*

The above actions do not have any budgetary implications over an above resources already required.

4.4 *Actions to be taken to mitigate against any adverse impacts:*

| Actions | Lead Officer | Date | Priority |
|---|---|---|---|
| Update and finalise 'Good Practice Guidance' to reflect latest research | Tim Hoyle | June 2015 | High |
| Ensure that they GP's are aware of the proposals and their role in assessing and referring residents. | Tim Hoyle | March 2015 | Completed |
| Arrange for social work assessment of residents who have not been able to participate in the process. | Tim Hoyle | March 2015 | Completed |
| Undertake thorough analysis of PSED issues in relation to the proposal and options for inclusion in the Executive Report | Tim Hoyle | May 2015 | Completed |

| Actions | Lead Officer | Date | Priority |
|---|---|---|---|
| Arrange for the risks of a move to individual residents and the potential mitigation actions to be assessed | Tim Hoyle | June 2015 | High |
| Ensure the risks to individual residents and the potential mitigation actions will be will be made available to decision-makers in a way that preserves residents' confidentiality. | Tim Hoyle | June 2015 | High |

**Stage 5: Checking that all the relevant issues and mitigating actions have been identified**

Quality Assurance & Scrutiny - Checking that all the relevant issues have been identified.

*5.1* *What methods have been used to gain feedback on the main issues raised in the assessment?*

**STEP 1:**

a) *Has the Corporate Policy Advisor (CPA), Equality & Diversity) reviewed this assessment and provided feedback?*

- Yes

b) *Summary of CPA's comments:*

- The CPA (E&D) has fully supported the development of the EIA.
- Whilst recognising the importance of approaching the consultation process when the proposals are still at a formative stage there is also a need in relation to the public sector equality duty "to assess the risk and extent of any adverse impact and means of elimination before adopting the policy and not as a rear-guard action"
- It is therefore recommended that serious consideration is given to how the potential medical impact on residents can be assessed and possible mitigating steps identified as this will need to be clearly reported to members before a final decision relating to possible closure is taken.
- The Social Care Institute for Excellence website Social Care Online includes details of the guidance developed by the Health and Social Care Board for Northern Ireland. This guidance indicates that Relocation Stress Syndrome:

  "can occur in some cases and can have a negative impact on the health and well-being of elderly residents. It is defined as "physiologic and/or psychosocial disturbances as a result of transfer from one environment to another."

  Cognitive reactions

  The cognitive reactions that indicate relocation stress syndrome are:

  - Feelings of loneliness and sadness
  - Feeling of being misunderstood

- Lowered moods, Irritability, Confusion, Depression, Anger
- Anxiety and apprehension, Feelings of helplessness
- Feelings of insecurity
- Loss of interest in previously enjoyed activities
- Diminished ability to think or concentrate , Indecisiveness
- Suicidal thoughts

Physical reactions

The physical reactions that indicate physical reactions which indicate relocation stress are:

- Upset Stomach
- Increased heart rate
- Symptoms of influenza
- Disrupted eating habits
- Sleep disturbance
- Back pain
- Muscle spasms
- Low physical functioning
- Change in weight "

*Source:*
*Making Choices Good Practice Guide – Reconfiguration of Statutory Residential Homes – Health and Social Care Board for Northern Ireland*.

Officers have agreed that the risks to individual residents and the potential mitigation actions will be assessed and this information will be available to decision-makers in a way that preserves residents' confidentiality

**STEP 2**

*Feedback from Central Bedfordshire Equality Forum*

Members of the Forum made the following comments:

- The Council's proposed approach seems sensible if appropriate placement costs can be achieved at the Dukeminster site.
- It is possible that if carefully handled there can be positive outcomes for all parties
- The impact of a potential move on residents should not be under-estimated. If the proposal goes ahead, there needs to be a clear focus on considering risks and a range of mitigating actions being put in place
- It was agreed that advocates will be needed to work with those residents who lack capacity and/or representation by a friend or relative.
- The Caddington site is a quiet, rural location but it is remote and it is difficult to access via public transport which means that staff recruitment can be problematic
- Whilst this appears to be a move in the right direction, if the council is proposing to look at the future of other establishments it must ensure that mechanisms are in place to ensure that lessons learnt during the review of Caddington Hall are captured and applied to future reviews

The Forum requested that the Head of Service come back to a future meeting to report on the outcome of the process and what lessons were learnt from it.

**Stage 6: Ensuring that the actual impact of proposals are monitored over time.**

*6.1 Monitoring Future Impact*

*6.1) How will implementation of the actions be monitored?*

- By Head of Service and through the project governance structures for the reprovision process.

*6.2) What sort of data will be collected and how often will it be analysed?*

- If the decision is to close the home then it would be helpful to monitor the impact on residents who move in order to inform future reprovision plans.

*6.3) How often will the proposal be reviewed?*

- The proposals will be subject to review by members at Overview and Scrutiny Committee and at the Executive.

*6.4) Who will be responsible for this?*

- The Head of Service will prepare the necessary reports and recommendations.

*6.5) How have the actions from this assessment been incorporated into the Proposal?*

- The Head of Service has updated plans and proposals.

**Stage 7: Finalising the assessment**

*7.1 Accountability / Signing Off*

*7.1) Has the lead Assistant Director/Head of Service been notified of the outcome of the assessment?*

Name: …………………………………… Date: ……………………

*7.1) Has the Corporate Policy Adviser Equality & Diversity provided confirmation that the Assessment is complete?*

Name: …………………………………… Date: ……………………