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.

Final approval of a proposal, can only happen after the completion of an equality impact assessment. It is unlawful to adopt a proposal contingent on an equality impact assessment

Central Bedfordshire Equality Impact Assessment

Title of the Assessment:		**Residential and Nursing Home Care for Older People Contract Retender**	**Date of Assessment:**	14/11/17
Responsible Officer	**Name:**	Ann Knought		
	Title:	Head of Contracts, Business & Service Development	**Extension Number:**	75832
	Email:	ann.knought@centralbedfordshire.gov.uk		

Stage 1 - Setting out the nature of the proposal and potential outcomes.

Stage 1 – Aims and Objectives

1.1 What are the objectives of the proposal under consideration?

To put in place a new contract with Residential and Nursing Providers in Central Bedfordshire. The contract will set out the specification for care services, monitoring arrangements, fee rates and detailed terms and conditions.

The Council has a strong record in working with care home providers and has the following overall objectives in doing so:

- To manage overall care home capacity.
- To manage costs – both council costs and customer costs
- To maintain and improve choice for customers
- To improve the quality of both care and accommodation in care and nursing homes
- To improve transparency and information available to customers and their relatives including information about costs
- To encourage diversity and innovation in the sector

1.2 Why is this being done?

The current contract was let in January 2014 for a period of four years and will expire in January 2018. A new contract will therefore need to be put into place to ensure continuity of service for existing customers and the availability of service for future customers.

1.3 What will be the impact on staff or customers?

There will be no impact on Council staff.

The Council's approach to the retender is one which intends to minimise the risk of immediate impact on existing customers as a result of the new contract and which generally has a beneficial impact on future customers. It is intended that the beneficial impact on customers will be in the following areas:

- Continued improvement in the quality of care and accommodation in residential and nursing homes for older people,
- Maintenance and improvement in the amount of choice that customers have about which home they go to,
- Greater transparency of information about the costs that customers will face when choosing a care home.

The principal changes to the existing contractual arrangements are set out below:

1. The new contract uses the ADASS Regional Contract as its basis. This has been developed in conjunction with neighbouring authorities and has the benefit of being 'tried and tested' and subject to continuous improvement. It also serves to deliver consistency across the region and enable accurate comparison in relation to costs.

2. The tender process has been open to providers who have homes in Central Bedfordshire or located within three miles of the Central Bedfordshire border.

3. The new arrangements will have provision for new providers to join during its currency (at the discretion of the Council) as the market expends and new and replacement homes are constructed. If the Council reopens the framework in this way any new provider(s) will need to meet the original award criteria specified by the Council.

4. The Contract period will be 15 years to 2033. This is to demonstrate the Council's commitment to the market and to avoid the need to retender the contract sooner than necessary. There are Contract Variation provisions and a 'break' clause in the Contract that allows the Council to retender the Services prior to the end of the Contract by giving not less than six months notice.

5. The Contract will support the development of innovative additional and enhanced services – especially short term services and those which have specific outcomes. Such services will be specified and offered to Service Providers within the general Contract terms.

6. The Contract will align arrangements with Bedfordshire Clinical Commissioning Group (BCCG) and allow for the Council and the CCG to jointly develop new services and enhancements to existing services. The provisions of the Contract also clarify that where a customer becomes entitled to CHC funding then the terms and conditions of the Bedfordshire CCG contract shall apply.

7. The Contract will support Service Providers by moving to paying Service Providers the full contracted rate and the Council taking responsibility for collecting the Service User's contribution to the cost of their care (also know as 'paying gross' rather that 'paying net'). The Council will link this change of practice to the regularisation of the position in relation to any 3rd Party Top Ups, where the Council will also take responsibility for the arrangements and collection of 3rd Party Top Ups and paying these across to the Service Provider.

8. The Contract will simplify the current payment rates whilst retaining the incentives Service Providers have to achieve good quality services. Following a transition period from January 2018 to April 2018, the Contract rates will be revised to contain only two quality-based rates – one for homes that achieve 'Good' or 'Excellent' and a lower rate for other homes. This change will coincide with the annual pricing amendments in April 2018.

9. The Council will continue to support and value the achievement of Dementia Quality Mark (DQM) by homes but will phase out the fee premium in the current contract and recycle savings into basic fee rates and/or other initiatives within care homes.

10. The Council intends to build on existing good practice in terms of engagement and partnership working with Service Providers and to share supply, demand and commissioning information with Service Providers on a regular basis to enable Service Providers to plan their operations and to contribute to the Council's duty to shape the care market. It intends to do this through both direct engagement activity with Service Providers and by providing support for the establishment and/or development of trade association(s) representing Service Providers.

11. The approach to annual fee setting may include elements of independent data collection and analysis. Service Providers will be expected to cooperate with such processes and the Council will keep commercial data confidential.

12. The Council will collect occupancy data from the Service Providers on a regular basis to inform the placement process and to monitor the market.

13. The Council will work with Service Providers to enable the online publication of care home vacancy and fee information to allow potential customers to be able to more effectively choose a care home.

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

This proposal relates to Council initiatives in relation to:

- Improving the range and quality of accommodation for older people.
- Working more closely and seamlessly with the NHS in Central Bedfordshire and beyond.

1.5 In which ways does the proposal support Central Bedfordshire's legal duty 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

The retender will advance equality of opportunity for people who have a protected characteristic (primarily older people, carers and disabled people, but also including people who have one or more of the other protected characteristics) in the following ways:

- The ability to use the contractual framework to commission innovative services to meet the needs of customers and carers. This could include innovative services to meet the needs of groups who have a protected characteristic.
- The contract requires all providers to have appropriate policies, training and arrangements in place to support equality and diversity and ensure that customers remain at the centre of their care and that their views are always taken into account.
- The terms of the contract give the Council the ability to take action against any provider which is behaving in a way that is not in accordance with the equality duty.

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 members 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?

There are no aspects of the proposal that the Council considers could lead to any damage to relations.

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

Stage 2 - Consideration of Relevant Data and Consultation

In completing this section it will be helpful to consider:

- **Publicity** – Do people know that the service exists?
- **Access** – Who is using the service? / Who should be using the service? Why aren't they?
- **Appropriateness** – Does the service meet people's needs and improve outcomes?
- **Service support needs** – Is further training and development required for employees?
- **Partnership working** – Are partners aware of and implementing equality requirements?
- **Contracts & monitoring** – Is equality built into the contract and are outcomes monitored?

2.1. Examples of relevant evidence sources are listed below. Please tick which evidence sources are being used in this assessment and provide a summary for each protected characteristic in sections 2.2 and 2.3.

Internal desktop research			
	Place survey / Customer satisfaction data	✓	Demographic Profiles – Census & ONS
✓	Local Needs Analysis	✓	Service Monitoring / Performance Information
	Other local research		
Third party guidance and examples			
	National / Regional Research		Analysis of service outcomes for different groups
✓	Best Practice / Guidance		Benchmarking with other organisations
✓	Inspection Reports		
Public consultation related activities			
	Consultation with Service Users		Consultation with Community / Voluntary Sector
	Consultation with Staff	✓	Customer Feedback / Complaints
	Data about the physical environment e.g. housing market, employment, education and training provision, transport, spatial planning and public spaces		
Consulting Members, stakeholders and specialists			
	Elected Members		Expert views of stakeholders representing diverse groups
	Specialist staff / service expertise		

Please bear in mind that whilst sections of the community will have common interests and concerns, views and issues vary within groups. E.g. women have differing needs and concerns depending on age, ethnic origin, disability etc

Lack of local knowledge or data is not a justification for assuming there is not a negative impact on some groups of people. Further research may be required.

2.2. Summary of Existing Data and Consultation Findings: - Service Delivery Considering the impact on Customers/Residents

- Age: *e.g. Under 16 yrs / 16-19 yrs / 20-29 yrs / 30-44 yrs / 45-59 yrs / 60-64 yrs / 65-74 yrs / 75+*

Local data

Age of Central Bedfordshire Council (CBC) 65+ nursing and care home clients (November 2017)

Age	Nursing home clients	Residential home clients	Total
65-74	30	52	82
75-84	62	123	185
85-94	59	222	281
95+	13	47	60
Grand Total	164	444	608

Potential population growth of older people in Central Bedfordshire - Information from POPPI

	2010 current figure	2015 figures and % increase	2020 figures and % increase	2025 figures and % increase	2030 figures and % increase
All people aged 65+	39,300	47,000 20%	53,200 35%	60,100 53%	68,900 75%
People aged 85+	10,000	11,800 18%	14,500 45%	17,700 77%	22,700 127%

National research

Ageing population

Key factors that may influence potential changes in demand for health and social care in people aged 65 and over – Information available from POPPI and is available for the following health issues

- Limiting long term conditions
- Depression
- Severe depression
- Dementia
- Heart attack
- Stroke
- Bronchitis/emphysema
- Falls
- Falls – hospital admissions
- Continence
- Visual impairment
- Hearing impairment

- Mobility
- Obesity
- Diabetes

The significant increase expected in the older population is likely to lead to more people needing care and support. On average older people are more likely to report lifestyle limiting illness (circa 17,000 in 2010), live alone (circa 14,000), live in poverty and rely on public services and informal carers for support.

Dementia is most common in older people, with prevalence rising sharply amongst people over 85 years. It is also one of the main causes of disability in later life. The number of people over 65 years of age with dementia is forecast to increase by circa 46% between 2010 and 2020 rising from 2,500 to 3,700.

Behaviours and attitudes

- The importance of training Behaviours and attitudes were identified as crucial issues in determining not only whether people felt they were treated fairly but also whether the outcome was non-discriminatory. People gave numerous examples of discriminatory attitudes based on age, summarised in the phrase "what can you expect at your age?" The high incidence of untreated depression in older people and examples of situations when staff "talked over" older people were also quoted as examples of discrimination. (Department of Health - DoH)
- Assumptions are sometimes made that it's natural for older people to have lower expectations, reduced choice and control and less account taken of their views (DOH).

Strategic commissioning

Good information on health, care and wellbeing needs was seen as an essential first step in ensuring that service planning and delivery are fair and proportionate. People who can experience multiple discrimination such as older prisoners and older people from minority ethnic groups can be overlooked. Commissioning must be informed by data that is broken down and analysed by age and other factors. Public involvement in commissioning decisions is crucial. Representatives of patient, service user and public groups observed that their role needed to cover planning and design stages and also the delivery and evaluation and review stages. [CCGs] and LAs needed to use age appropriate means of engaging different groups, especially different communities of older people. (DoH).

Personalisation in assessment, referral and care planning

People's individual needs and situation must be taken into account rather than basing decisions on a series of assumptions about the person's chronological age. Information must be consistent and linked between agencies.

- Older people stressed a frustration at being constantly referred to the internet – other forms of information should be used as well.
- Decision making processes for an individual's care and organisations' plans and priorities need to be clearer.
- Too many assumptions are made about which services older people can and cannot access.
- People needed to be regarded as partners and able to agree mutual expectations and to be supported to make informed choices.

- Service users of all ages should always be offered different approaches to personalisation and staff should not assume whether people of a certain age may or may not want a specific approach. Services should be accessible and easy to navigate, in practice this is often not the case.
- Advocacy was seen as very important, particularly at times of personal stress as its availability was seen as critical to the system working well. (DoH).

Dual and multiple discrimination

The interaction of age with other characteristics e.g. race, belief and sexual orientation, can lead to discrimination. (DoH).

Mental health and older people

- Scores of three or more depressive symptoms were more likely among older respondents (of both genders) and higher scores were more prevalent in those reporting LLTI and mobility problems. Around 25% of those over 65 had significant depressive symptoms in 2005. The comparable figure in the general population is around 10%.

Dignity and older people

Age UK, *Improving later life: Services for older people – what works*, 2014[1]:

- The potential for a loss of personal dignity increases with age, especially in the context of declining health. Falls, continence problems and loss of mobility, for example, affect self-respect in profound ways.
- Evidence shows consistently that personal dignity is undermined by the loss of independence associated with declining health and that anxiety over the prospect of further deterioration in the future exacerbates this.
- What might appear insignificant to a care provider might be deeply significant to the service user and their family and personal dignity is affected profoundly by the ways in which members of staff behave towards older people.

Safeguarding and older people

Health and Social Care Information Centre, Abuse of Vulnerable Adults in England 2012-13, Final Report, 2014[2]

- Physical abuse and neglect were the most common types of abuse reported in referrals, accounting for 28 per cent and 27 per cent respectively of all allegations. Alleged abuse was more likely to occur in the vulnerable adults own home (39 per cent of all locations) or a care home (36 per cent). The source of harm was most commonly reported as a social care worker (32 per cent of all perpetrators) or a family member (a combination of the Partner and Other Family Member categories, 23 per cent).
- For care homes and hospital settings, the majority of allegations were for older adults (aged 65 and over).
- For care homes with nursing the alleged victims tend to be slightly older than those in care homes without nursing.

- Disability: *e.g. Physical impairment / Sensory impairment / Mental health condition / Learning disability or difficulty / Long-standing illness or health condition / Severe disfigurement*

[1] https://www.ageuk.org.uk/Documents/EN-GB/For-professionals/Research/Services-what_works_spreads.pdf?dtrk=true, accessed Nov 2017

[2] https://digital.nhs.uk/catalogue/PUB13499, accessed Nov 2017

Local data

Disability of 65+ nursing and care home clients (November 2017)

Disability	Nursing home clients	Residential home clients	Total
Learning Disability Support	0	13	13
Memory & Cognition Support	33	92	125
Mental Health Support	18	42	60
Physical - Access & Mobility Support	8	26	34
Physical - Personal Care Support	100	248	348
Sensory - Dual Impairment Support	1	1	2
Sensory - Visual Impairment Support	1	8	9
Social - Social Isolation/Other Support	3	14	17
No disability	22	156	178
Grand Total	164	444	608

Residents with a health problem or disability that limits their day to day activities.
Central Bedfordshire residents were less likely to state that they had a health problem or disability that limited their day to day activities

	Central Bedfordshire		**England**
Day to day activities limited a lot	15,500	6.1%	8.3%
Day to day activities limited a little	21,100	8.3%	9.3%
Day to day activities not limited at all	217,800	85.6%	82.4%
Total	**254,400**	**100%**	**100%**

(ONS, 2011)

National findings

Using the widest definition there are more than 11 million disabled people in the UK, which is more than one in five of the adult population and one in 20 children. 80% of people experience a year of being disabled at some point in their lives. Disability also covers people who may not recognise themselves as having a disability, such as those with long-term conditions (e.g. diabetes or cancer) or older people.

An investigation into the health inequalities experienced by people with mental health problems or learning disabilities found that many people reported problems with gaining access to services, with staff attitudes, and with getting the necessary treatment and support. (Equality Review).

Social care services are vital in order to progress equality for disabled people. If these services are not part of the solution in actively removing the barriers to living independently that disabled people face, they can become part of the problem in creating barriers to equality.

- 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*

Local data

Carers of 65+ nursing and care home clients (November 2017)

Carer			
Row Labels	Nursing home clients	Residential home clients	Total
Has Carer	56	174	230
No Carer	130	426	556
Grand Total	186	600	786

National Findings

3 in 5 people will become a carer at some point in their lives. Over 2 million people become carers every year.

By 2026 more than 10% of the population will be over 75 and significant numbers of the workforce age 45+ will have caring responsibilities.

Carers' contribute an extra £1 billion a year in helping to set up and run services in the community helping disabled and older people and in advising organisations and public authorities. They did this on top of the care they already provided as carers. The basic saving to the NHS, social services and other statutory bodies resulting from the work of carers starts at something in excess of £34 billion a year.

- 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*

National Findings

- Trans people are a wide and very varied group of people: care should not be presumed but should be agreed with the individual
- People should be accommodated according to their presentation: the way they dress, and their current names and pronouns
- Views of family members may not accord with the trans person's wishes: the trans person's view takes priority
- Privacy, confidentiality, dignity and respect are of the utmost importance
- Records should protect the confidentiality of trans people's gender history while flagging for appropriate screening, diagnosis and treatment.

Older people: Dignity, compassion and respect are more important than ever for older people, particularly as their care needs increase or with the onset of dementia. Health staff should make every effort to assist older trans people to continue living as they wish, whether this is at home or in a residential care setting. Trans people may be encouraged to write instructions about how

they wish to be treated. These instructions should prevail even where relatives take a different view (Unison guide for health staff).

CQC, The State of Health Care And Adult Social Care In England 2016/17[3]:

- From our analysis of 10,000 adult social care provider information returns in 2016/17, although over 99% of adult social care services told us that they have equality and diversity policies and procedures, only 46% said that they had carried out any specific work on equality for people using their service in the past 12 months.
- Figures were even lower for promoting equality for specific groups of people. For example, only a fifth (20%) of residential adult social care services told us that they had done work to ensure equality for lesbian, gay and bisexual people and only 13% had worked on equality for transgender people.
- A body of evidence […] shows this work is necessary for LGBT people to feel safe and confident when using care services.
- In services with poorer ratings we sometimes find that consideration of meeting the needs of people with protected characteristics, such as LGBT people and people from BME groups, can be tokenistic. These services still have a way to go to demonstrate responsive care for people in these groups.

- Pregnancy and Maternity: *e.g. pregnant women / women who have given birth & women who are breastfeeding (26 week time limit then protected by sex discrimination provisions)*

- Race: *e.g. Asian or Asian British / Black or Black British / Chinese / Gypsies and Travellers / Mixed Heritage / White British / White Irish / White Other*

Local data

Race of 65+ nursing and care home clients (November 2017)

Race	Nursing home clients	Residential home clients	Total
Information Not Yet Obtained	3	7	10
Other Ethnic Group	2	9	11
White any other background	2	7	9
White British	152	412	564
White Irish	5	9	14
Grand Total	164	444	608

National Findings

Research published in 2014 indicates that White British people had a better understanding of the social care system than South Asian people, and that the language needs of South Asian people were not usually met in mainstream social care services (CQC 2014).

[3] http://www.cqc.org.uk/sites/default/files/20171017_stateofcare1617_report.pdf

People from Black and minority ethnic (BME) groups have reported lower levels of satisfaction with social care services than the White British population (NHS NIHR S Asian attitudes towards social care).

Language may be a barrier to understanding for staff and for people using services. This will be particularly important if the numbers of people with dementia increase across ethnic groups, as people can lose the ability to communicate in languages that they have acquired later in life as their dementia progresses.

CQC, The State of Health Care and Adult Social Care In England 2016/17[4]:

- From our analysis of 10,000 adult social care provider information returns in 2016/17, although over 99% of adult social care services told us that they have equality and diversity policies and procedures, only 46% said that they had carried out any specific work on equality for people using their service in the past 12 months.
- In services with poorer ratings we sometimes find that consideration of meeting the needs of people with protected characteristics, such as LGBT people and people from BME groups, can be tokenistic. These services still have a way to go to demonstrate responsive care for people in these groups.
- Getting information about services is a critical factor in equality of access. In the 2016 national adult social care survey, Asian or Asian British people were more likely to have difficulty finding information about services, closely followed by Black or Black British people.

- Religion or Belief: *e.g. Buddhist / Christian / Hindu / Jewish / Muslim / Sikh / No religion / Other*

National findings

Research evidence has demonstrated that some religious groups have lower levels of awareness and take-up of services e.g. the Muslim community.

A lack of awareness about a person's religious or other beliefs can lead to discrimination. This is because religion can play a very important part in the daily lives of people. Discrimination can occur if specific requirements are not taken into account for example Diet / fasting Religious observance / prayer and festivals and specific customs and practices.

The then Commission for Social Care Inspections (now CQC) published *Putting people first: Equality and Diversity Matters 2 Providing appropriate services for black and minority ethnic people* in 2008. Research found that there were a number of misconceptions about black and minority ethnic communities that may contribute to a lack of action on the part of service providers:

- Assumptions that the needs of black and minority ethnic people can be wholly met by responding to cultural needs as they arise and that more general work on race equality is not required.
- Assumptions that there are no black and minority ethnic people in the area, so race equality is not an issue for the service.
- Assumptions may still persist that black and minority ethnic communities 'look after their own'

[4] http://www.cqc.org.uk/sites/default/files/20171017_stateofcare1617_report.pdf

- Assumptions that the service is not equipped to work with people from a particular minority ethnic community.
- Assumptions that black and minority ethnic people do not want to use the service as they do not enquire about it.

- Sex: *e.g. Women / Girls / Men / Boys*

Local data

Sex of 65+ nursing and care home clients (November 2017)

Gender	Nursing home clients	Residential home clients	Total
Female	108	373	481
Male	78	227	305
Grand Total	186	600	786

National data

Women currently live longer than men, but elderly women tend to have worse health than elderly males of the same age: fewer elderly men survive, but those who do tend to be fitter than their female counterparts. This means that elderly women have proportionally greater need for social care services than men. (Information source: Why women live longer than men, David Goldspink, Liverpool's John Moores University). The average life expectancy at birth of females born in 2007-2009 in England was 82.3 years compared with 78.3 years for males.

Age Concern estimates that at least 1.7 million single older men could be living in isolation in the UK. Nearly 400,000 of these are single older men aged 75 and over. Furthermore, it is estimated that 289,000 single older men are living in poverty.

There is some evidence that men may not be as good at accessing services as women, which we perhaps need to consider. Differences in service take up between men and women, therefore, appear to be related to differences in need and are not evidence of unequal treatment.

The Equality Act 2010 states that sex discrimination does not apply where the service (which is proportionate and achieving a legitimate aim) is likely to involve physical contact between the service user and another person and that other person might reasonably object, (Equality Act 2010, sc3, para 27). The Health and Social Care Act 2008 regulation 10(1) guidance also supports this: When providing intimate or personal care, provider must make every reasonable effort to make sure that they respect people's preferences about who delivers their care and treatment, such as requesting staff of a specified gender.

- Sexual Orientation: *e.g. Lesbians / Gay men / Bisexuals / Heterosexuals*

National findings

While there is a lack of recent evidence, in a large-scale survey in 2010, 60% of lesbian, gay and bisexual people were not confident that social care services could meet their needs (CQC 2014).

From police stations to family courts and from housing to health services, gay people remain uncertain of fair treatment, an uncertainty which is often derived from personal experience. Contact with any LGB people needs to be carried out with sensitivity, they must feel assured that their privacy will not be breached and that their confidentiality will be guaranteed.

Older LGB people grew up at a time when homosexual acts were 'against the law' until 1967. This can impact upon older LGB people's sense of well-being and upon their feelings about their sexual orientation making them reluctant to discuss their private lives with strangers.

Of the UK population over State Pension Age, it is estimated that between 500,000 to 800,000 people are lesbian, gay or bisexual. (Age Concern)

Older LGB people are 2 ½ times more likely to live alone and 4 ½ times less likely to have no children to call upon in times of need be without informal care and support networks, making their need for appropriate social care services even more acute. (Stonewall)

Within social care there is generally a low level of awareness of lesbian, gay and bisexual disabled people. Although there is no firm data on the number of Gay, Lesbian and Bisexual people, the Government estimates that it is between 5% and 7% of the UK population. Stonewall, www.stonewall.org.uk, confirms the accuracy of this estimate. Although there is very little research on the health of gay and lesbian and transgender people, there is research that suggests the LGB communities experience high rates of mental health problems than in general population.

Stonewall published *Building Safe Choices* in June 2016 which examined the current provision of housing and related care and support for the older LGBT population. It found that 'at the moment there is no answer for older LGBT people as to where they can access the best LGBT care and support. It is a great source of worry as no-one can predict what levels of help they may need in future, given people are living longer, but often with long term health conditions to deal with. Their fears and concerns are about access to good quality care that takes account of the life you have lived and who you are. There are numerous examples of older people who have been out all their adult lives, going back into the closet and hiding their sexuality once they are either living in a care home or receiving care in their own home'.

'What tends to happen is that people end up choosing a care home, or domiciliary care provider because of a specific crisis. This might be following a fall or illness or hospital admission. Their primary concern in choosing a provider might not at that moment in time be around their LGBT needs. What's then necessary is for some sort of quality assurance that can give prospective customers the confidence that the care providers they are choosing are aware and well trained to meet their LGBT needs'. (Building Safe Choices in 2016).

CQC, The State of Health Care And Adult Social Care In England 2016/17[5]:

- From our analysis of 10,000 adult social care provider information returns in 2016/17, although over 99% of adult social care services told us that they have equality and diversity policies and procedures, only 46% said that they had carried out any specific work on equality for people using their service in the past 12 months.
- Figures were even lower for promoting equality for specific groups of people. For example, only a fifth (20%) of residential adult social care services told us that they had done work

[5] http://www.cqc.org.uk/sites/default/files/20171017_stateofcare1617_report.pdf

to ensure equality for lesbian, gay and bisexual people and only 13% had worked on equality for transgender people.

- A body of evidence […] shows this work is necessary for LGBT people to feel safe and confident when using care services.
- In services with poorer ratings we sometimes find that consideration of meeting the needs of people with protected characteristics, such as LGBT people and people from BME groups, can be tokenistic. These services still have a way to go to demonstrate responsive care for people in these groups.

If an LGBT person with dementia has had or still has difficult experiences in the past these could negatively impact their experiences of dementia. For example, if they have encountered prejudice or discrimination from professionals or services they may not want to access services, or they may feel uncomfortable being open about their sexual orientation or gender identity around professionals. It is important to be sensitive to the person's needs, history and experiences in order to support them to live well. (Alzheimer's Society)[6]

Dementia Action Alliance, *Dementia and the lesbian, gay, bisexual and trans (LGBT) population, 2016*[7]

Older LGBT people will have grown up in a society that pathologised homosexuality and for a time lived in fear of criminality

LGBT older people experience stigmatisation, firstly because of their sexual and/or gender identity and secondly because of stigma associated with old age. This experience of double stigma leads to a cumulative health inequality. However LGBT older people with dementia form a specific minority that experience disadvantage, discrimination and prejudice that impacts their health and social care experience, leading to health inequalities and unmet needs. Their age, their gender/sexual identity and their cognitive impairment bring a triple marginalisation to this group.

Older LGBT people are more likely to be isolated – they may be estranged from their families and they are less likely to have had children – thus they lack the (family) support that heterosexual people with dementia may have greater access to. This increases LGBT people's need for dementia care services.

People with dementia experience invisibility and a lack of recognition within dementia services. What is already difficult is made worse as health and social care professionals frequently reinforce this by assuming everyone in care is heterosexual. In fact, many care providers and carers report never encountering anyone with dementia who is LGBT. This risks further silencing LGBT people and makes it more difficult for them to feel able to come out.

Someone who is LGBT with dementia may have lost their capacity to assess when and where it is safe to disclose their sexual/gender identity. And dementia can be exposing - increasing cognitive impairment and confusion can lead to inadvertent disclosure. Or they may decide to not disclose at all. By not disclosing, by remaining silent, LGBT people with dementia are more likely to have unmet long term care needs – moreover they may choose to not use services at all.

6 https://www.alzheimers.org.uk/info/20046/help_with_dementia_care/38/supporting_gay_lesbian_and_bisexual_people_with_dementia/4 Accessed November 2017

7 http://www.dementiaaction.org.uk/news/19643_dementia_and_the_lesbian_gay_bisexual_and_trans_lgbt_population

Knowing there are others there or knowing that the care services are LGBT friendly will provide a safe environment for LGBT people to seek care and help when needed and feel safe to come out and stay out.

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

The Human Right – right to a private and family life is especially relevant with the commissioning and delivery of Nursing and Residential Homes. Some problems that couples or families may face are:

- The lack of double rooms
- Lack of privacy for couples
- Couples being placed in different care homes because of their differing needs
- A client being placed in a care home far away so that they are separated from their family.

2.3. Summary of Existing Data and Consultation Findings – Employment Considering the impact on Employees

- Age: *e.g. 16-19 / 20-29 / 30-39 / 40-49 / 50-59 / 60+*

- Disability: *e.g. Physical impairment / Sensory impairment / Mental health condition / Learning disability or difficulty / Long-standing illness or health condition / Severe disfigurement*

- Carers: *e.g. 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*

- 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*

- Pregnancy and Maternity: *e.g. Pregnancy / Compulsory maternity leave / Ordinary maternity leave / Additional maternity leave*

- Race: *e.g. Asian or Asian British / Black or Black British / Chinese / Gypsies and Travellers / Mixed Heritage / White British / White Irish / White Other*

- Religion or Belief: *e.g. Buddhist / Christian / Hindu / Jewish / Muslim / Sikh / No religion / Other*

- Sex: *Women / Men*

- Sexual Orientation: *e.g. Lesbians / Gay men / Bisexuals / Heterosexuals*

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

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

Older people and disabled people will be more affected by this proposal because those living in care homes are typically 65+ and may have a disability or frailty.

This client group will benefit from the proposals because the conditions of the contract and contract monitoring arrangements will lead to:

- Continued improvement in the quality of care and accommodation in residential and nursing homes for older people through contract monitoring including regular feedback from clients and families,
- Maintenance and improvement in the amount of choice that customers have about which home they go to,
- Greater transparency of information about the costs that customers will face when choosing a care home,
- Flexibility to meet future demand for services which will help address the care needs of the ageing population,
- Flexibility to increase fees to a care home where a client's challenging behaviour or needs leads to difficulty finding a place under the standard rate,
- Flexibility to develop innovative additional and enhanced services in the future to meet individual's bespoke needs,
- Clarity around the setting and collection of third party top ups to ensure the system is fair and transparent,
- Continued financial incentives for good quality services,
- Continued support for the Dementia Quality Mark (DQM),
- Setting dementia services as an expectation, not an additional incentivised service. The fee premium for achieving the DQM will be phased out and the savings recycled into basic fee rates and/or other initiatives within care homes,
- Improved market shaping activity to future proof services that meets changing or increasing needs,
- Improved information and advice offer for families and clients when choosing a suitable care home – this will include a new post that will be able to oversee and broker third party top ups and the online publication of vacancy and fee information.
- Continued fair fee setting through discussion with care home providers at annual review meetings to ensure that the full impact of fee changes on the clients are understood.

The potential adverse effects of a new third party top up approach could be that a standard approach may unintentionally encourage care home providers to establish third party top ups as the norm rather than the exception.

The Council would become the gatekeeper for clients choosing a care home. The Council's approach should therefore be proportionate, reasonable, fair and transparent so as not to hinder choice and control unless there is legitimate and justifiable reason.

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

As set out above the proposed contract carries forward some existing good practice which takes account of client's needs. Also, the care and support planning process ensures that the client's views, wishes, feelings and beliefs are taken into account through a person-centred approach.

The terms of the contract and contract monitoring promotes the importance of clients' wellbeing. Current practice includes:

- Improvement in the quality of care and accommodation in residential and nursing homes for older people through contract monitoring including regular feedback from clients and families,
- Continued financial incentives for good quality services that promote wellbeing and continued support for the Dementia Quality Mark (DQM),
- Maintenance and improvement in the amount of choice that customers have about which home they go to including flexibility to increase fees to a care home where a client's behaviour or needs are challenging,
- Flexibility to develop innovative additional and enhanced services in the future to meet individual's bespoke needs,
- Improved market shaping activity to future proof services that meets changing or increasing needs, and flexibility to meet future demand for services which will help address the care needs of the ageing population,
- Improved information and advice offer for families and clients when choosing a suitable care home.

2.6. Are there any gaps in data or consultation findings

Contract monitoring provides a good understanding of the quality of care and support delivered by care homes under the contract. However, there is not an overall understanding of how well clients' needs, as defined by their protected characteristics, are met.

2.7. What action will be taken to obtain this information?

Research needs to be carried out to understand how clients' experiences of care home or choice of care home is effected by their protected characteristic. For example, how well are LGBT clients' needs being met, are there any barriers to choosing a care home and what good practice is evident in the care homes. This review will be used to inform future contract monitoring and discussions in annual reviews with the care homes.

Stage 3 - Providing an overview of impacts and potential discrimination.

Stage 3 – Assessing Positive & Negative Impacts					
Analysis of Impacts	**Impact?**		**Discrimination?**		**Summary of impacts and reasons**
	(+ve)	(- ve)	YES	NO	
3.1 Age	✓			✓	Older people will be more affected by this proposal because those living in care homes are typically 65+. Improvement in the quality of care and accommodation will be achieved through continued contract monitoring. The needs of an ageing

					population will be better met through improved market shaping to meet future demand.
3.2	**Disability**	✓		✓	Disabled people will be more affected by this proposal because those living in care homes may have a disability or frailty. Improvement in the quality of care and accommodation will be achieved through continued contract monitoring. The needs of an ageing population (hence more people with a long-term life limiting condition) will be better met through improved market shaping to meet future demand. Continued support for the Dementia Quality Mark (DQM)
3.3	**Carers**	✓		✓	Clarity on third party top ups will ensure that future top ups are applied fairly and the process is easier for the third party.
3.4	**Gender Reassignment**	✓		✓	Improvement in the quality of care and accommodation will be achieved through continued contract monitoring.
3.5	**Pregnancy & Maternity**	N/A		N/A	
3.6	**Race**	✓		✓	Improvement in the quality of care and accommodation will be achieved through continued contract monitoring.
3.7	**Religion / Belief**	✓		✓	Improvement in the quality of care and accommodation will be achieved through continued contract monitoring.
3.8	**Sex**	✓		✓	Improvement in the quality of care and accommodation will be achieved through continued contract monitoring.
3.9	**Sexual Orientation**	✓		✓	Improvement in the quality of care and accommodation will be achieved through continued contract monitoring.
3.10	**Other** *e.g. Human Rights, Poverty / Social Class / Deprivation, Looked After Children,*	✓		✓	Improvement in the quality of care and accommodation will be achieved through continued contract monitoring.

Offenders, Cohesion Marriage and Civil Partnership					

Stage 4 - Identifying mitigating actions that can be taken to address adverse impacts.

Stage 4 – Conclusions, Recommendations and Action Planning
4.1 What are the main conclusions and recommendations from the assessment? Older people and disabled people will be more affected by this proposal because those living in care homes are typically 65+ and may have a disability or frailty. This client group will benefit from the proposals because the conditions of the contract and contract monitoring arrangements will lead to improved services, flexible services that will meet the needs of an ageing population and a consistent approach to third party top ups. The third party top up approach still needs to be established. Once a specific proposal has been formed, this EIA will be updated to check that the approach is reasonable and fair. In depth research (equality review) will be carried out to understand how clients' experiences of care home or choice of care home is effected by their protected characteristic. This review will be used to inform future contract monitoring and discussions in annual reviews with the care homes.
4.2 What changes will be made to address or mitigate any adverse impacts that have been identified? Once the equality review has been concluded, good practice will be shared and contract monitoring arrangements updated where necessary.
4.3 Are there any budgetary implications?
4.4 Actions to be taken to mitigate against any adverse impacts:

Action	Lead Officer	Date	Priority
Agree consistent approach to top ups.	Tim Hoyle	February 2018	H
Research in to whether potential care home clients can have their individual needs met in current provision – placing outside area.	Tim Hoyle	2018/19	M

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

Stage 5 – 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: Engagement events have been held with providers on the proposals. An officer responsible for contract monitoring with awareness of good and instances of poor practice in care homes has also been included in the development of the EIA.	
Has the Corporate Policy Advisor (Equality & Diversity) reviewed this assessment and provided feedback? *Yes/No*	
Summary of CPA's comments:	
Step 2:	*Th* *Po* *ac* *th* *ne*
5.2 Feedback from Central Bedfordshire Equality Forum	

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

Stage 6 – Monitoring Future Impact
6.1 How will implementation of the actions be monitored? The project group to develop the proposal will monitor the development of the third party top up approach. The Head of Contracts, Business & Service Development will monitor delivery of the equality review.
6.2 What sort of data will be collected and how often will it be analysed? Data on protected characteristics will continue to be collated and analysed for providers' annual review meetings.
6.3 How often will the proposal be reviewed? The contract will be reviewed in 2033 but contract performance is reviewed annually.
6.4 Who will be responsible for this? The Head of Contracts, Business & Service Development.
6.5 How have the actions from this assessment been incorporated into the proposal? Actions have been added to the project plan.

Stage 7 - Finalising the assessment.

Stage 7 – Accountability / Signing Off
7.1 Has the lead Assistant Director/Head of Service been notified of the outcome of the assessment **Name: _____Tim Hoyle_____ Date: _____16/11/17_____**
7.2 Has the Corporate Policy Adviser Equality & Diversity provided confirmation that the Assessment is complete? **Date: _____16/11/17_____**

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