Equality Impact Assessment Tool: Policy, Strategy and Plans
(Please follow the EQIA guidance in completing this form)

1. Name of Strategy, Policy or Plan

Glasgow City Health and Social Care Partnership - Older Peoples Transformational Change Programme 2018-21

This is a : Current;#Current Policy

2. Brief Description - Purpose of the policy, Changes and outcomes, services or activities affected

Glasgow City HSCP Older People services will be undergoing a significant transformational programme across a 3 year period. The detail of the implementation programme has yet to be confirmed, however, associated changes to older people services may present risk of detrimental impact to individuals with protected characteristics. With this in mind, this Equality Impact Assessment was undertaken to formally capture contextual information relevant to different groups or individuals with protected characteristics and will be used to inform subsequent service proposals and implementation programme. Specific service proposals equality impact assessments will be undertaken to ensure any service change is compliant with the IJBs legal duties in respect of their Public Sector Duty: Eliminate unlawful discrimination, harassment and victimisation and other prohibited conduct, Advance equality of opportunity between people who share a relevant protected characteristic and those who do not and Foster good relations between people who share a protected characteristic and those who do not. Older People's Transformational Change Programme – Report to IJB from 08/11/17 In line with the guiding vision for older people set out in the IJB strategic plan and as a consequence of the programme of work described below, it is envisaged that by 2021 the HSCP's older people's service provision will be characterised by the following: • A continuing focus on delivering the best possible outcomes and quality of life to all older people in the city that require support from the HSCP. • A profound shift will have been achieved in whole system culture, with a clearly understood and enacted emphasis on supporting more and frailer older people to remain living in the community for as long as possible. • By extension, the profile of older people living in the community will have markedly changed. They will be older, frailer and with higher levels of support needs than at present and certainly the recent past. • Related to this, significantly more efficient use will be being made of the Acute system. Only those older people with genuinely acute medical needs will be occupying hospital beds. Where no such needs are present, older people will either be diverted from admission at the front door or discharged speedily when their acute medical needs have been attended to. Ideally the HSCP's anticipatory care activity will preclude the need for attendance at hospital in the first place. For some older people who are discharged from acute hospitals, they maybe discharge to intermitted care for recovery and rehabilitation and further assessment of their care needs. The length of stay in intermitted care will depend on the needs of the individual, their recovery from a stay in acute hospital and the appropriate care package being in place. • Where older people are being supported in the community they will experience a more joined up and co-ordinated input from HSCP staff, irrespective of their particular professional role, exemplified by the work being undertaken for the occupational therapy review outlined below. • Implementation of integrated operational older people teams across 10 local neighbourhoods in the city. • Significant change for the HSCP's own staff group, as integration begins to take full effect. • More effective co-ordination between HSCP and Acute staff and systems in three years. Focus on the front door of hospitals and the joint activity in relation to unscheduled care that is likely to bring significant changes in pathways, processes, staff and clinical roles and responsibilities and how resources are deployed across the whole system. • Ensuring that older people either present to the correct part of the health and care system or are directed there as efficiently as possible. Aim to have significantly fewer older people with non-medical needs such as loneliness presenting to GPs, due to more connection into community supports. • Making the best possible use of GP time and resource as clinical activity is shifted from the Acute system. • Greater emphasis on family and carer support than at present, building on the significant progress and the new Carers Act requirements, supporting families to maintain their caring role in the community for as long as possible, alleviating demand for paid support provided by the HSCP and wider health and social care system. • Greater and more effective application of technology to help sustain that carer role and community living in general. This will combine the use of technology enabled care for people with higher level care needs that require support from the HSCP, with generally available technology that individuals and their families may choose to purchase from the open market to provide reassurance and peace of mind at the early stages of frailty. • Closer and more effective partnership working with the housing sector in the city to help maintain their tenants in their homes for longer. This will build upon the work undertaken to date in the Accommodation Based Strategy and link into related activity around technology, aids and adaptations, community connectors etc. As increasing numbers of owner occupiers reach old age it is recognised that this activity must be effective across all housing tenures. • Likelihood of fewer care homes, with a frailer population. • Closer and improved partnership working with the third sector. The Scottish Government's draft budget announcement of December 2017 will have implications for the transformation programme's financial framework, previously considered by the IJB. The programme is within the context of an aging and fluid population and at this point there is no prediction of the uptake of services. This Equality Impact Assessment was circulated via IJB Finance and Audit Committee, Core Leadership Team and Older Peoples Strategic Planning Group. A specific meeting with Heads of Older People's Services was also held to review the content. The list includes everyone present at the groups as well as the people who collated the information and compiled the document.

3. Lead Reviewer

Stephen Fitzpatrick – Head of Strategy and Operations (Older People)

4. Please list all participants in carrying out this EQIA:

Hamish Battye (Head of Planning & Performance); Duncan Goldie (Performance Planning Manager); Levin, Katie (Senior Researcher); Wearing, Sharon (Chief Officer Finance and Resources); Sybil Canavan (Head of People amd Change (NHS)); Stuart Donald (Principle Officer); Stephen Fitzpatrick (Head of Older People's Services); Glanda Cook (Policy Perf & Srv Reform Manager); Amanda Ferguson (Senior Officer); Joanna Payne (Resource Worker); Fiona Brown (Head of Older People Services (NE)); Clare Hughes (Head of Residential & Day Care Services); Anne Mitchell - East CHCP (Head of Primary Care & Community Services South); George MCguinness (Resource Worker); Bridget CURRAN (Wheatley Group); Michael Gillespie (Principal Officer); Julie Young (SE Carers Centre); Sandra Stuart (Glasgow Disability Alliance); Una Munro (Mungo Foundation); Kelly, Alana (Secretary); Mike Burns (Assistant Chief Officer); Jillian Campbell (Audit Scotland); Peter Millar (Independent

Sector); Emma Keegans (Audit Scotland); Julie Kirkland (Senior Officer (Governance Support)); David McConnell (Audit Scotland); Susan Orr (Head of Childrens Services (Sth)); James Thomson (Commissioning and Performance Manager); Sheena Walker (Governance Support Officer); Cllr Jane Morgan (GCC); Bailie Ade Aibinu (GCC); Simon Carr (Health Board); Anne Marie Monaghan (Health Board); Steven McGowan (GCC); Will Hart (Audit Corprate); Ross Finnie (Health Board)

5. Impact Assessment

A. Does the policy explicitly promote equality of opportunity and anti-discrimination and refer to legislative and policy drivers in relation to Ec

The Glasgow City Health and Social Care Partnership(GCHSCP) Strategic Plan outlines 5 key priorities that apply to all GCHSCP services, including th support older people: - Early intervention, prevention and harm reduction. - Providing greater self-determination and choice. - Shifting the balance of car independent living for longer. - Public protection – including keeping vulnerable people safe from harm. Vision 2018-21 - A profound shift will have been whole system culture, with a clearly understood and enacted emphasis on supporting more and frailer older people to remain living in the community for possible. (Older People's Transformational Change Programme 2018-21 Report to IJB 08/11/17) Throughout implementation of this programme referen made to the General Duties (Equality Act (2010)) and will articulate how any proposed changes in service provision will meet the requirement • to elimin discrimination • advance equality of opportunity • and promote good relations

B. What is known about the issues for people with protected characteristics in relation to the services or activities affected by the policy?

		Source
All	Cross referral to sex, age, gender reassignment, race, disability, sexual orientation, marriage and civil partnership, social and economic status. Changes in older people services provision must ensure that this group of service users does not receive a lesser service due to their protected characteristics.	Sources in text
Sex	Gendered caregiving: Although caregiving is still predominantly a female occupation, there is growing evidence of a greater role played by men in caregiving. But, despite increasing care provision by sons and husbands, daughters and wives continue to provide more care. Likewise, grandfathers are increasingly involved in childcare provision but not to the same extent as grandmothers. (Government Office for Science, Current and future challenges of family care in the UK, 2015), web-link: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/454514/gs-15-18-future-ageing-family-care-er09.pdf "…analysis shows that hours spent doing unpaid care tends to balance out between genders as men and women retire."…"older males are more likely to be carers than older women, but due to population sizes there are more women than men providing care aged over 65" Growing Older in Scotland: health, housing and care, EHRC, 2015:https://www.equalityhumanrights.com/en/our-work-scotland/our-work-scotland/research-scotland Hochlaf, Dean and Franklin, Ben, 2017, When I'm 64: the ILC-UK fact pack on retirement transitions, Page 26 provides facts and figures on the experiences of those making the transition to retirement. Reports that life expectancy is growing among older people, but so too is poor health and inequalities. Finds that inequalities in life expectancy for older people by local authority have been rising, particularly for women, and notes that these inequalities are strongly related to local differences in health (relates to England & Wales) – cross references to age: http://ow.ly/NQTc30gN7va Alzheimer Scotland estimates 2,502 males and 5,615 females in Glasgow have dementia in 2017. The majority of dementia sufferers are aged 65 or over. Scotland wide rates of dementia increase with age from 1.8% of males and 1.4% at age 65-69 rising to 32.4% of males and 48.8% of males in the 95-99 and 100+ age ranges – cross references to disability:https://www.alzscot.org/assets/0002/5517/2017_Webpage_-_Update_Headline.pdf	Sources in text
Gender Reassignment	Cross referral to sex, age, disability, sexual orientation, marriage and civil partnership There are older people who had successfully transitioned and are living part time or permanently in their preferred gender role. There can be advantages as well as risks in taking this step. Many people who underwent treatment in the 1960s and 1970s are now facing all the ordinary issues that come with ageing, as well as some that are unique to middle and older trans-people. There has been no significant research into the care of older trans-people in sheltered or residential accommodation. (Age UK factsheets 16 (2015)):Web Links:http://www.ageuk.org.uk/Documents/EN-GB/Factsheets/FS16_Transgender_issues_and_later_life_fcs.pdf The National LGB&T Partnership's roundtable has discussed the fact that LGBT older people are rarely acknowledged by service providers and commissioners. It was hinted that services for trans-people who are likely to be invisible and the attitude is often 'we don't have lesbian and gay people in our care home' or you'll hear 'our manager's a gay man so we're probably ok [on equality]'. (The national LGB&T Partnership (2014); The dementia challenge for LGBT Communities: a paper based on a round table discussion):http://www.nationalcareforum.org.uk/spp-resources.asp It was suggested that some of the biggest challenges are, prejudice/ stigma in current or historic services. It was also argued that these remain powerful influences on how someone perceives experiences. While some lose their inhibitions due to dementia, others who have previously come out feel unable to be open about their sexuality or transgender status. Dementia causes anguish and confusion; this experience could be exacerbated as older people with the condition struggle to deal with negative perceptions of their sexuality or gender in residential care. Kelly alluded that LGBT older people with dementia are been "forced back into the closet". (Kelly D. (2015): The Guardian web link:https://www.theguardian.com/social-care-network/2015/mar/10/lgbt-older-people-dementia-social-care) Sage implied that due to higher levels of financial insecurity at present and a general lack of affordable housing, many LGBT middle and older people find that they cannot afford homes in the communities they may have lived in for years. Others may face harassment and intimidation in their homes and in long-term care settings from aging professionals, other residents, and even their own family members.	Sources in text

	(Sage (2015); Expanding Housing and Services for LGBT Older People). The report: Improving the lives of transgender older adults (2012) from SAGE and NCTE suggested that older transgender adults face profound challenges and experiences in accessing heath, social and housing services. Many Trans adults may have more incidents of mental health's issues that will remain a feature in older lives. Many transgendered people believe that there is a lack of culturally sensitive services to meet their needs today. In 2007 it was suggested that there were 885 Trans people in Scotland.	
Race	Ethnicity, Identity, Language and Religion in Scotland from the 2011 Census web Of the 7% (369,000) of people in Scotland on census day in 2011 who were not born in the UK, 89% had arrived in the UK aged under 35; this pattern was generally reflected across all ethnic groups: http://www.scotlandscensus.gov.uk/ethnicity-identity-language-and-religion 55,000 people were born in Poland (accounting for 15% of all those born outside the UK) making this the third most common country of birth after Scotland and England and ahead of Northern Ireland, the Republic of Ireland and Wales. This is an increase of 14 percentage points compared with 2001, when the number of people born outside the UK who reported their country of birth as Poland was 1% (2,500). The next most common country of birth outside the UK was India with 23,000 (6% of all those born outside the UK). Other countries outside the UK which were widely reported in 2011 were Germany, Pakistan, USA, China, South Africa, Nigeria, Canada and Australia. The proportion of the population aged 3 and over reported as not being able to speak English well or at all was 1.4% overall, and 11% for those born outside the UK. This proportion generally increased with age of arrival into the UK: for those who arrived aged under 16 it was 5% while for those who arrived aged 65 and over it was 31%. The highest proportions of people using languages other than English, Scots and Gaelic at home were found in councils with the larger cities:Aberdeen City, City of Edinburgh and Glasgow City (each with just over 12%): Scottish Government: Ethnic Group Demographics web link http://www.gov.scot/Topics/People/Equality/Equalities/DataGrid/Ethnicity/EthPopMig (Butt J. and O'Neil A (2004); Black and minority ethnic older people's views on research findings, JRF) Older people…wanted action that would bring about change and to be involved in decisions that affected their own lives - locally and nationally. • Black and minority ethnic older people are more likely to face a greater level of poverty, live in poorer quality housing, and have poorer access to benefits and pensions than 'white' older people. • Myths about minority ethnic communities need challenging: there is not necessarily an extended family which "looks after its own". • Older people from different communities may share experiences of ageism and racism, but the circumstances of Chinese, Afro-Caribbean or Asian older people may require different approaches and solutions:https://www.jrf.org.uk/report/black-and-minority-ethnic-older-peoples-views-research-findings Ethnic minority caregiving: There are about 130,000 family carers from ethnic minority backgrounds providing care for a minimum of 20 hours per week in England and Wales. Whereas intergenerational care is predominantly delivered by women, men are mainly involved in spousal care. Family carers from ethnic minorities are less likely to access health care or social services, which is a result of lack of awareness in combination with perceived 5 personal/family responsibility, experiences of stigmatisation and past negative experiences with health and social care services, particularly in the case of dementia. Another community, where there is a lack of data is the Gypsy and Travellers according to Age UK (Working with Older Gypsies and Travellers) believed that this community have significantly poorer health outcomes, in general, could experience even worse health than the general population of older adults. Their experiences of stigma, poverty and illiteracy have placed them in a disadvantaged position in seeking for support from services. They also felt that services, as a whole, are not sensitive to their culture. People over 65 from the Black and Asian communities are disproportionately affected by poor health quality health and higher rates of limiting long term illness. :https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/454514/gs-15-18-future-ageing-family-care-er09.pdf	Sources in text
	Chappell N. L. and Cooke H.A. (2010) Age Related Disabilities - Aging and Quality of Life; International Encyclopedia of rehabilitation suggested that with increasing age comes increased likelihood of disability. This is because as people live longer and do not encounter fatal diseases, their illnesses are chronic instead. The association between increasing age and increasing disability has led to a negative image of aging. Physical health does decline with age; this does not necessarily mean that older adults are incapacitated, or, in the language of some, handicapped. Disability is usually defined in terms of restrictions in the ability to perform Activities of Daily Living (ADL), or, the inability to function independently in terms of basic ADL or instrumental ADL (World Health Organization [WHO], 2003). The relationship between disability and poverty cannot be over-emphasized. Poverty can lead to malnutrition, poor health services and sanitation, unsafe living and working conditions etc. that are associated with disability; disability can also trap people in a life of poverty (Mont 2007). The number of people who are ageing with a disability is also increasing at different rates amongst men and women, and amongst different ethnic groups. Although the prevalence of some physical impairment is higher amongst males, many of the largest sub-groups of older disabled people contain more women than men. Many older people feel that their needs – and even their existence – have been overlooked. Many are anxious about the future and feel that their independence is being threatened by the lack of appropriate and acceptable supportive resources. There are many obstacles to older disabled people being able to articulate their needs and – most important of all – have their voices heard. These problems are often particularly acute for older women, and older black and ethnic minority disabled people – many of whom live in extreme isolation. Mental health was also an issue, in particular dementia and depression. Isolation sometimes led to high levels of depression and the need for more befriending services. While some participants said that depression and mental health could be a taboo subject in their communities. (Zarb G. and Oliver M. (1993); Ageing with a disability. What do they expect after all these years? University of Greenwich):http://disability-studies.leeds.ac.uk/files/library/Oliver-ageing-with-disability.pdf Worldwide more than 46 per cent of older persons – those aged 60 years and over—have disabilities and more than 250 million older people experience moderate to severe	Sources in text

Disability	disability. Looking ahead, the global trends in ageing populations and the higher risk of disability in older people are likely to lead to further increases in the population affected by disability. The number of older persons has increased substantially in recent years in most countries and regions. Between 2015 and 2030, the number of people in the world aged 60 years or over is projected to grow by 56 per cent, from 901 million to 1.4 billion, and by 2050, the global population of older persons is projected to reach nearly 2.1 billion. The accumulation of health risks across a lifespan of disease, injury, and chronic illness contribute to the higher disability rates among older people. Urges countries to review and further explore the complementarities between the discourses on ageing and on disability. Ageing & Disability – UN Division for Social Policy and Development: Disability:https://www.un.org/development/desa/disabilities/disability-and-ageing.html Older people born with disabilities: (Ward C. (2012); Older people with a learning disability; British Institute of Learning Disabilities). The life expectancy of people with learning disabilities has increased over the course of the last 70 years. Older people with learning disabilities are not exempt from experiencing age discrimination. There is substantial evidence that they experience a "double jeopardy" as they age. People with learning disabilities face many disadvantages in relation to health (Emerson and Baines 2010, Department of Health 2001). The profile of older people with learning disabilities in the future will be even more diverse than it is today. This is because the population profile of people with learning disabilities is changing. Not only are there more people with learning disabilities from black and minority ethnic communities, but many more people with complex health needs are living longer and will present a different set of challenges for services as they age. Cross reference with Age -Alzheimer Scotland Statistics:https://www.alzscot.org/assets/0002/5517/2017_Webpage_-_Update_Headline.pdf Lesbian ,Gay, Bisexual, Transgender, Queer and Intersex plus (LGBTQI+) disabled people and self-directed social care support NIHR School for Social Care Research (SSCR), London School of Economics and Political Science, Houghton Street, London, WC2A 2AE (Report available on the internet at: http://ow.ly/xC4t30gkJdS 2017 Pages: 6) Reviews the provision for LGBTQI+ disabled people who use self-directed social care support in England. Uses qualitative interviews with 20 LGBTQI+ Disabled People, a focus group of PAs and a survey of 56 LGBTQI+ Disabled adults who use self-directed social care. Finds that LGBTQI+ Disabled People who use self-directed support reported many positives from having more choice, control and power. Finds that concerns raised included: coming out to social care staff jeopardising support; difficulties in recruiting and retaining good PAs; difficulties in securing support for `social hours' leading to social isolation; and reactions of other people. Suggests assessments should emphasise the whole person, not ignore sexual orientation or gender identity and staff should draw on their professional training, ethical practice and legal obligations to raise equalities issues confidently and sensitively. Argues there is a need for more targeted support and information for LGBTQI+ Disabled People as well as more information for their Pas. Cross reference with section on Sexual Orientation	
Sexual Orientation	Unlike heterosexual older people, older Lesbian ,Gay and Bisexual (LGB) people are more likely to age as single people. Further, they are less likely to have children or to be out of touch with their children (particularly gay men) if they do have them, compared to heterosexual people. Notions of 'family' among LGB people are broad and go beyond the traditional 'biological families' that are familiar to most heterosexual people. Musingarimi P. (2008) Social Care Issues Affecting Older Gay, Lesbian and Bisexual People in the UK,International Longevity Centre (ILC-UK) Musingarimi P. (2008) Health Issues Affecting Older Gay, Lesbian and Bisexual People in the UK, ILC-UK, suggested that very little is known about the health outcomes and health care needs of older LGB people in the United Kingdom and how they compare to those of heterosexual individuals. Because gay men and lesbians have historically been socially defined within medical terms as being mentally ill, the healthcare system has been a primary arena through which control over their lives has been exerted. Among older LGB people, the current cohort in particular, may resist accessing healthcare services as these are the very establishments which tried to 'cure' them of their sexual orientation. The major health concern for gay men is still Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS). According to the Terence Higgins Trust, gay men are still the group at greatest risk of acquiring HIV in the UK. New HIV diagnoses amongst gay men are the highest ever and are continuing to rise, albeit slowly. There is very little that is known about the health outcomes and health care needs of older LGB people in the UK and how they differ from those of their heterosexual peers or younger LGB people. Most of the research that is done on health issues and LGB people does not distinguish between young and old. Stigma and discrimination that is experienced across the life course is likely to have a detrimental effect on health in later life, but there is no research evidence documenting this. According to Stonewall 'YouGov' survey 2010, (Lesbian, Gay & Bisexual people in later life), the older population of LGBT people are more likely to be socially isolated and with a history of mental health issues than the heterosexual population. With the possibility of reduced support/ families network, the need to access formal support services become more pivotal against a background of low confident in the services to meet their needs.	Sources in text
	Kaplan D.B. et al (2016) Religion and Spirituality in Older People) Summarises research findings regarding spirituality and religious belief and activity among "older people" in the US. States that the level of religious participation is greater among older people than among any other age group. Finds that generally, people who are "religious" have better physical and mental health, but it is not clear exactly why this is. Conversely, people who adhere to very strict religious rituals and practices may be disadvantaged in terms of medical treatment and mental wellbeing. Lists psychoses, Obsessive-compulsive disorder (OCD) behaviours, inflexibility, excessive guilt and anxiety as potential harmful effects. Other harmful effects may be replacing what are generally seen to be lifesaving medical treatments such as insulin injection and blood transfusions with prayer and chanting. Provides an explanation of the difference between "spirituality" and "religion". Lists the benefits to healthcare providers and caregivers of exploring a service user religion or spirituality. 'You do not have to alter your values and beliefs in order to receive a service. The principle of valuing diversity means that you are accepted and valued for who you	Obsessive-compulsive disorder

Religion and Belief	are. The legislation which outlaws discrimination has influenced care standards, and the standards in this section make it clear that you can continue to live your life in keeping with your own social, cultural or religious beliefs or faith when you are in the care home.' (Care Inspectorate, The National Care Standards 2007: Standard 12: Web Links to sources in text http://www.msdmanuals.com/home/older-people's-health-issues/social-issues-affecting-older-people/religion-and-spirituality-in-older-people 'You do not have to alter your values and beliefs in order to receive a service. The principle of valuing diversity means that you are accepted and valued for who you are. The legislation which outlaws discrimination has influenced care standards, and the standards in this section make it clear that you can continue to live your life in keeping with your own social, cultural or religious beliefs or faith when you are in the care home.' (Care Inspectorate, The National Care Standards 2007: Standard 12) 2011 Census data Males were more likely to state they had 'No religion' (39%) than females (34%). 32% of people identified with the Church of Scotland, which had fallen from 42% in 2001. 37% of people said they had no religion which had increased from 28% in 2001. 1.4% of people (77,000 people) reported that they were Muslim, an increase of 0.6 percentage points since 2001. The numbers of Buddhists, Hindus and Sikhs accounted for 0.7 % of the population, and all had increased between 2001 and 2011. The number of Jewish people has declined slightly to just under 6,000. In 2011 over half (54%) of the population of Scotland stated their religion as Christian - a decrease of 11 percentage points since 2001, whilst 37 per cent of people stated that they had no religion - an increase of nine percentage points. After Christianity, Islam was the most common faith with 77 thousand people in Scotland describing their religion as Muslim. This is followed by Hindus (16,000), people from Other religions (15,000), Buddhists (13,000), Sikhs (9,000) and Jews (6,000). Even with these groups added together they still accounted for less than 3% of the overall population.: http://www.gov.scot/Topics/People/Equality/Equalities/DataGrid/Religion/RelPopMig Scotland Census shows specific proportions of people's religion by local authority are as stated in the 2011 census: http://www.scotlandscensus.gov.uk/ods-visualiser/#view=religionChart&selectedWafers=0 "When thinking about activities and encouraging meaningful engagement, a person's religion, nationality or culture are likely to have a major influence on their preferred music, food, clothes and every day routines…. The danger of any label is that we then make assumptions…Stereotypes do exist for particular cultures and religions, however it is important to find out what a person's actual likes and dislikes are, rather than being led by our assumptions.":https://www.scie.org.uk/dementia/living-with-dementia/keeping-active/culture-religion.asp Religion and old age, Davie, G and Vincent, J, in Ageing and Society Vol .18 1998 pp 101-110 "Older people, it appears, have always been more religious than the young. Whether elderly people have regarded God as judgmental (the source of all their troubles) or as a father figure (a rock in the storm of life), they have always taken him more seriously than their sons and daughters. This kind of generational difference has been reflected in church membership studies for some time, and is, increasingly, supported by studies of religious belief. A Mori poll (Jacobs and Worcester 1990) illustrates this point clearly, revealing that 67% of those aged between 15 and 34 years believe in God as against 87% of those aged over 55 years. Similarly only 55% of the younger age group believe in heaven as opposed to 65% of the older. It seems that belief in God, and specifically belief in a personal God, declines with every step down the age scale, as indeed do practice, prayer and moral conservatism. In short, in Britain as in most of Western Europe, a religiously and morally conservative majority among the retired becomes a religiously conservative minority in the 18–24 age-groups. These findings are supported strongly in the two European Values Studies carried out in 1981 and 1990. In both surveys age, together with gender, is a strong and straightforward indicator of both religious practice and religious belief (cf Moberg 1990 for the USA)… Religion appears to be disproportionately attractive to elderly women in Britain…a section of the population that is growing rapidly."	
	Cross referral to marriage & civil partnership, sex, race, social & economic status National Care Forum (NCF) (2017) Dementia, Equity and rights explores key issues for people with dementia from groups that have higher prevalence rates and may experience greater disparities in the care they receive. Considers the issues for carers in these groups with regard to the support that is provided. Specifically outlines equalities issues for protected characteristics: http://ow.ly/ubnN3095XHN Growing older in Scotland: health, housing and care (2011 census data analysis: research briefing) Outlines demographic information relative to marital status and ethnic minority populations in Scotland before examining how older people spend their time, especially around employment; how they provide unpaid care, broken down by age and gender; what housing older people live in, including information about communal living, extra rooms and overcrowding; and long term and general health data. Notes that, although the older population is predominantly white, the ethnic minority population of Scotland aged over 65 has nearly doubled since 2001; there are increasing numbers of single people and people living alone in the older population; around 11% of people over 65 undertake unpaid care with those with the poorest health more likely to provide care for over 50 hours a week; there has been a rise in single people entering communal establishments, with women over 75 being much more likely than men to do so; and that health inequalities are becoming larger for older people living in Scotland with those in social rented accommodation reporting more health problems than home-owners over 65: http://ow.ly.HXmc309I7RC "Around 10% of people over 65 undertake unpaid care with around half of them contributing over 50 hours per week. This rate is double that of the 50-64 age group and only a quarter of those carers provide the most hours." "For Scotland, there has been no indication that the amount of unpaid care has decreased with the provision of free personal and nursing care." (p32). Future of ageing: attitudes to ageing: The barriers to and enablers of positive attitudes to ageing and older people, at the societal and individual level; Government Office for Science (January 2015) Reviews 25 years of research, some of it international, on ageism. Looks at: definitions of and perspectives on ageism; the prevalence of ageism in the workplace and health services; anti-age discrimination legislation; individual-level factors that influence attitudes towards age, including age itself, gender, education, ethnic background, employment status, residential location, subjective poverty, intergenerational contact; and macro-social factors that influence attitudes towards age, including national wealth, economic inequality, state pension age, unemployment, population age ration,	Sources in text

Age	urbanisation and cultural values. Discusses areas likely to be of concern for research, policy and practice. Available on the web. "Ageism is the most prevalent form of discrimination in the UK (Abrams et al., 2011a), estimated to cost the economy £31 billion per year (Citizens Advice, 2007). It restricts employment opportunities, and reduces workplace productivity and innovation (Swift et al., 2013). Ageism also results in inequality and social exclusion, reducing social cohesion and well-being (Abrams and Swift, 2012; Stuckelberger et al., 2012; Swift et al., 2012). Not only is ageism a barrier to the inclusion and full participation of older people in society, but it also affects everyone by obscuring our understanding of the ageing process. Moreover, by reinforcing negative stereotypes, ageism can even shape patterns of behaviour that are potentially detrimental to people's self-interest (Lamont et al., 2015)". "in the European Social Survey (ESS) and other national surveys, people on average tend to state that they feel more positive towards those aged 70 and over, than towards younger people in their 20s (Abrams et al., 2011a). This could lead to the erroneous conclusion that there is little age prejudice against older people. However, this positivity is entirely consistent with benevolent prejudice towards older people characterised by feelings of pity and sympathy rather than admiration and esteem. Such views can result in a common tendency to 'over-help' (Hagestad and Uhlenberg, 2005), but also ignore and exclude older adults from activities that are considered beyond their competencies (Cuddy et al., 2005). The beneficiaries of such efforts may easily feel disrespected, helpless and patronised (Avorn and Langer, 1982). This makes ageism a subtle form of prejudice that requires multiple modes of detection, and which may be more readily sensed by the target than the source of the prejudice…. Although both older men and women are viewed as less competent compared to younger people, older males are generally attributed with more competence than older women"(p15). "Bringing younger and older individuals together reduces explicit and implicit negative attitudes to age and age-based stereotypes (Knox et al., 1986; Harris and Fielder, 1988; Schwartz and Simmonds, 2001; Tam et al., 2006). It also has potential to increase the well-being of older adults and decrease: https://www.gov.uk/government/publications/future-of-ageing-attitudes-to-ageing Future of ageing: family care in the UK: Current and future challenges of family care in the UK; Government Office for Science (March 2015) (Relates to England & Wales only) Examines the ways in which the UK's changing demographic structure will pose challenges to the future care of elderly people within their own families. Considers the demographic trends causing the need for long-term care, as well as those reducing the availability of family carers. Focuses on changing family values and their implications for family formation and intergenerational family relations. Covers issues including; population ageing; the fastest growing age group; drivers of demographic change, including longevity,, fertility and immigration; increasing female employment; plural family forms; childlessness; changing intergenerational family relations; intergenerational family care; spousal care and grandparental childcare; gendered caregiving; carer health; ethnic minority caregiving; regional variations in caregiving; working carers; and dementia care. (Butt J. and O'Neil A (2004); Black and minority ethnic older people's views on research findings, Joseph Rowntree Foundation Research from 2004 found that groups of older people from black and minority ethnic communities felt they had been "researched to death". The study also drew on a literature review. The literature review shows that: • The numbers (and proportions) of older people from black and minority ethnic communities rose rapidly, from 60,000 in 1981 to over 350,000 in 2001. Although the numbers have grown from being quite small, this is not a new area of research. • The impact of ageing (in terms of health and support needs) happens at a comparatively younger age among many minority communities. • Black and minority ethnic older people are more likely to face a greater level of poverty, live in poorer quality housing, and have poorer access to benefits and pensions than 'white' older people. • Myths about minority ethnic communities need challenging: there is not necessarily an extended family which "looks after its own". • Older people from different communities may share experiences of ageism and racism, but the circumstances of Chinese, Afro-Caribbean or Asian older people may require different approaches and solutions. As well as endorsing many of these findings, the consultation groups raised the following issues: • Access to majority services for black and minority ethnic older people remains problematic. Barriers include language issues, knowledge of what is available, and the attitudes and practices of service providers. • Older people felt that community-based voluntary organisations were more likely to reflect their needs; such organisations are, however, the least financially secure. • Older people said that they had been over-researched, with researchers often asking the same questions (or producing the same findings) as had been evident 15 years ago. They did not want yet more research for its own sake. They wanted action that would bring about change and to be involved in decisions that affected their own lives - locally and nationally: https://www.gov.uk/government/publications/future-of-ageing-family-care-in-the-uk Life Fitness: Moving more, ageing well; UKActive, 2017, Page 31 Looks at opportunities to encourage more active lifestyles among older people in different environments - the home, the community and residential care - and in the broader health and social care system. Aims to identify where existing opportunities can be used more effectively to promote physical activity, promising programmes, and the additional infrastructure that would be required to deliver such a system. Discusses inactivity among people aged over 65, fitness problems associated with sedentary lifestyles and the health and social benefits of maintaining an active lifestyle. Looks at activities available in the community and the role of community-based organisations (physical activity facility operators, charities) in providing appropriate opportunities for older people. Discusses the benefits of social prescription, including physical activity behaviour intervention programmes. Includes case studies such as: Edinburgh Leisure - Steady Steps Programme, an exercise programme designed to support those who have had, or are at risk of having a fall; Let's Get Moving, an evidence-based intervention and behavioural change model; Oomph!, a social enterprise dedicated to transforming the mental, physical and emotional wellbeing of older adults; and Richmond Villages and Audley retirement living (onsite gyms). Recommends: embedding physical activity into all care pathways; creating a national centralised database of physical activity and exercise referral opportunities; and producing a national Physical Activity Strategy for older people living in care: http://disability-studies.leeds.ac.uk/files/library/Oliver-ageing-with-disability.pdf Cross reference with disability: Chappell N. L. and Cooke H.A. (2010) Age Related Disabilities (cross reference with disability) Zarb G. and Oliver M. (1993); Ageing with a disability

	According to the Scottish Government around 90,000 older people receive some kind of care, whether in their own home, a care home or long-term hospital care in Scotland. If we continue delivering care the way we do right now, an extra 23,000 people will need care by 2016. The Reshaping Care for Older People: A Programme for Change 2011-2021 sets out the government's vision – that 'Older people are valued as an asset, their voices are heard and they are supported to enjoy full and positive lives in their own home or in a homely setting'. The 2015 population for Glasgow City is 606,340; an increase of 1.1 per cent from 599,640 in 2014. The population of Glasgow City accounts for 11.3 per cent of the total population of Scotland. The make-up of older persons aged 60 and over is 18.5 per cent of Glasgow City. Retirement is one of many events in a person's life which can bring a change of routine, including routines and practices around alcohol. Processes and circumstances associated with ageing and retiring can present sudden broken routines that can be problematic in terms of periods of increased risk of social isolation and/or increased alcohol consumption, particularly for previous heavy drinkers. (F Edgar et al, 2016: 'Alcohol use across retirement: a qualitative study of drinking in later life'; Glasgow Centre for population health) Between 2004 and 2015, pensioner employment rose by 94%, whilst the employment rate increased from 5.2% to 8.2% over the same period. This rise in pensioner employment has highlighted a need to explore the social and economic risks and benefits of working beyond state pension age and to understand the reasons why more people are choosing to work into retirement. One of the main reasons for this is likely to be the introduction of the Employment Equality (Repeal of Retirement Age Provisions) Regulations 2011 that abolished the default retirement age in April 2011. This prevents employers from compulsorily retiring workers once they reach the age of 65. (Scottish Government, 2016: An Investigation of Pensioner Employment) Garstka T. et al (2004), Psychology and Aging: How Young and Older Adults Differ in Their Responses to Perceived Age Discrimination found older adults, however, must find ways to successfully counteract the negative consequences resulting from their permanent group membership. Age group identification appears to be a successful strategy that older adults can use to preserve well-being in the face of age discrimination. Older adults' experiences of age discrimination have been documented in a variety of everyday settings and situations, such as health care (Butler, 1975; Greene, Adelman, Charon, & Hoffman, 1986; Hillerbrand & Shaw, 1990) and the work environment. For older adults, perceived discrimination should have effects similar to those found in other low status groups whose group membership is permanent and for whom discrimination is difficult to avoid (e.g., African Americans, women), as outlined in the rejection–identification model. That is, perceptions of age discrimination should be harmful for older adults and be associated with greater identification with their age group. The Public Bodies (Joint Working) (Scotland) Act 2014 received Royal Assent, completing the process of legislation through Parliament, on 1 April 2014. The Act aims to support improvement in the quality and consistency of services through the integration of health and social care. Glasgow City Council and NHS Greater Glasgow and Clyde have integrated planning and delivery of all community health and social care services, including services for children, adults, older people, along with homelessness and criminal justice services. This work is directed by the Glasgow City Integration Joint Board, with the Council and Health Board delivering services under the banner of the 'Glasgow City Health and Social Care Partnership'. As part of this transformation process, services are been review to ensure that resources are effectively and efficiency allotted. Additional Info: Glasgow City Partnership Consultation Outcomes (2013): Report on the outcome of the consultation on the draft Joint Strategic Commissioning Plan 2013-16	
Pregnancy and Maternity	There is no research specific to Pregnancy and Maternity which would relate to any potential equality impacts of this policy.	
Marriage and Civil Partnership	The 'oldest old' are predominantly cared for by their children, whereas married older people predominantly receive spousal care…Spouses are the most important support source for married older people in need of care. Spouses are the fastest growing group of informal care providers. Despite growing numbers of older men providing spousal care it is still predominantly provided by women. In future, spousal care is likely to become more important than it is at present. (Hoff, A; Current and Future Challenges of Family Care in the UK, Government Office for Science, 2015)	https://www.gov.uk/government/publica of-ageing-family-care-in-the-uk
Social and Economic Status	In the context of homelessness older people are those over the age of fifty, some of whom continue to sleep rough others suffering from being trapped in poor, insecure and inappropriate accommodation. People also become homeless for the first time in later life often as a result of a combination of factors; such as bereavement, ill health, poverty, debt and substance misuse. Older people over 50 are the most adversely affected by homelessness in relation to both physical and mental health, yet paradoxically they often face the greatest difficulties in gaining access to vital services. The needs of older people are often ignored because their experience of homelessness is less visible than other groups and they lack the voice and representation required to highlight their specific interests and issues.	Sources in text
Other marginalised groups (homeless, addictions, asylum seekers/refugees, travellers, ex-offenders	Older refugees and asylum seekers may not have the same needs, requirements or aspirations as younger refugees and asylum seekers who have grown older in this country. They may have hidden traumas, fears and mental health issues which can cause distress but have become more pronounced in older people. There may be challenges like languages and culturally sensitive services.	Sources in text

C. Do you expect the policy to have any positive impact on people with protected characteristics?

	Highly Likely	Probable	Possible
General	None	Opportunity to promote and improve accessibility to services for individuals and communities	Changes provide opportunities to revie equality impact on local service provisi improve the service delivery to individu communities
Sex	None	Opportunity to promote and improve accessibility to services for men, women and non-binary individuals	Changes provide opportunities to revie equality impact on local service provisi improve the service delivery to men, w non-binary individuals
Gender Reassignment	None	Opportunity to promote and improve accessibility to services for Trans-men and Trans-women	Changes provide opportunities to revie equality impact on local service provisi improve the service delivery to Trans-r women and their communities
Race	None	Opportunity to promote and improve accessibility to services for black and ethnic minorities. community	Changes provide opportunities to revie equality impact on local service provisi improve the service delivery to black a minorities' community
Disability	None	Opportunity to promote and improve accessibility to services for individual with disabilities and their communities	Changes provide opportunities to revie equality impact on local service provisi improve the service delivery to individu disabilities and their communities
Sexual Orientation	None	Opportunity to promote and improve accessibility to services for Lesbian, Gay and Bisexual individuals and their communities	Changes provide opportunities to revie equality impact on local service provisi improve the service delivery to Lesbiar Bisexual individual and their communit
Religion and Belief	None	Opportunity to promote and improve accessibility to services for individuals religious, beliefs and non-belief	Changes provide opportunities to revie equality impact on local service provisi improve the service delivery to individu religious, beliefs and no-belief and thei communities
Age	None	Opportunity to promote and improve accessibility to services for individuals of all age groups and communities	Changes provide opportunities to revie equality impact on local service provisi improve the service delivery to individu groups and their communities
Marriage and Civil Partnership	None	Opportunity to promote and improve accessibility to services for individuals in marriage and civil partnership and their communities	Changes provide opportunities to revie equality impact on local service provisi improve the service delivery to individu marriage and civil partnership and thei communities
Pregnancy and Maternity	None	Opportunity to promote and improve accessibility to services for individuals who are pregnant and maternity leaves	Changes provide opportunities to revie equality impact on local service provisi improve the service delivery to individu communities
Social and Economic Status	None	Opportunity to promote and improve accessibility to services for individuals in social and economic status and their communities	Changes provide opportunities to revie equality impact on local service provisi improve the service delivery to individu regard to their social and economic sta communities
Other marginalised groups (homeless, addictions, asylum seekers/refugees, travellers, ex-offenders	None	Opportunity to promote and improve accessibility to services for individuals and communities from marginalised groups	Changes provide opportunities to revie equality impact on local service provisi improve the service delivery to individu communities from marginalised groups

D. Do you expect the policy to have any negative impact on people with protected characteristics?

	Highly Likely	Probable	Possible
General	In general people with protected characteristics can be negatively impacted due to changes in services. It is important that any discrimination is identified in early stages and actions taken to mitigate the worst of its impact as soon as possible.	Failure to examine and reflect on local service delivery can lead to negative impacts on individuals and communities.	None

Sex	In general men, women and non-binary people can be negatively impacted due to changes in services. It is important that any discrimination is identified in early stages and actions taken to mitigate the worst of its impact as soon as possible.	Failure to examine and reflect on local service delivery can lead to negative impacts on men, women and non binary individuals.	None
Gender Reassignment	In Trans-men and Trans-women can be negatively impacted due to changes in services. It is important that any discrimination is identified in early stages and actions taken to mitigate the worst of its impact as soon as possible.	Failure to examine and reflect on local service delivery can lead to negative impacts on trans-men and Trans-women and their communities.	None
Race	In general black and ethnic minorities community can be negatively impacted due to changes in services. It is important that any discrimination is identified in early stages and actions taken to mitigate the worst of its impact as soon as possible.	Failure to examine and reflect on local service delivery can lead to negative impacts on black and ethnic minorities' community.	None
Disability	In general people with disabilities can be negatively impacted due to changes in services. It is important that any discrimination is identified in early stages and actions taken to mitigate the worst of its impact as soon as possible.	Failure to examine and reflect on local service delivery can lead to negative impacts on individuals with disabilities and their communities.	None
Sexual Orientation	In general people from the Gay, Lesbian and Bisexual can be negatively impacted due to changes in services. It is important that any discrimination is identified in early stages and actions taken to mitigate the worst of its impact as soon as possible.	Failure to examine and reflect on local service delivery can lead to negative impacts on Lesbian, Gay and Bisexual individuals and their communities.	None
Religion and Belief	In general people with religious, beliefs and no belief can be negatively impacted due to changes in services. It is important that any discrimination is identified in early stages and actions taken to mitigate the worst of its impact as soon as possible.	Failure to examine and reflect on local service delivery can lead to negative impacts on individuals with religious, beliefs and no belief and their communities.	None
Age	In general people of all age groups can be negatively impacted due to changes in services. It is important that any discrimination is identified in early stages and actions taken to mitigate the worst of its impact as soon as possible.	Failure to examine and reflect on local service delivery can lead to negative impacts on individuals of all age groups and their communities.	None
Marriage and Civil Partnership	In general people in marriage and civil partnership can be negatively impacted due to changes in services. It is important that any discrimination is identified in early stages and actions taken to mitigate the worst of its impact as soon as possible.	Failure to examine and reflect on local service delivery can lead to negative impacts on individuals in marriage and civil partnership and their communities.	None
Pregnancy and Maternity	In general people who are pregnant and on maternity leave can be negatively impacted due to changes in services. It is important that any discrimination is identified in early stages and actions taken to mitigate the worst of its impact as soon as possible.	Failure to examine and reflect on local service delivery can lead to negative impacts on individuals who are pregnant and maternity leave.	None
Social and Economic Status	In general people from lower social and economic status can be negatively impacted due to changes in services. It is important that any discrimination is identified in early stages and actions taken to mitigate the worst of its impact as soon as possible.	Failure to examine and reflect on local service delivery can lead to negative impacts on individuals when considering their social and economic status and their communities.	None
Other marginalised	In general people in marginalised groups can be negatively impacted due	Failure to examine and reflect on local service delivery can lead to negative impacts on	

groups (homeless, addictions, asylum seekers/refugees, travellers, ex-offenders	to changes in services. It is important that any discrimination is identified in early stages and actions taken to mitigate the worst of its impact as soon as possible.	individuals and communities from marginalised groups.	None