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

1. Name of Strategy, Policy or Plan

Fair Allocation of Community Care (Adult Services) Policy, incorporating updated Eligibility Criteria

This is a : New Policy

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

East Dunbartonshire Health and Social Care Partnership (HSCP) provides a range of Community Care support services to individuals with varying levels of support needs. Access to this support is determined by agreed Eligibility Criteria, with funding being made available where an individual has been assessed as having critical or substantial needs. The HSCP has a responsibility to provide or secure suitable and adequate services to a standard satisfactory to meet eligible needs and also to ensure there is fair and equitable allocation of the available resources. Where an individual has complex needs there can be significant variation in the costs of supporting the individual depending upon the model of care used to provide the support. This policy aims to ensure there is a fair and financially sustainable allocation of resources to individuals who require support and the models of care that will be considered, particularly when an individual requires a significant amount of support in their daily living. The policy applies to all service users over the age of 16 but excludes young people over the age of 16 where a designated children's service continues to be provided. The policy applies to planning for children and young people who are leaving school and will subsequently be subject to the adult community care policy environment.

3. Lead Reviewer

Cairns, Alan

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

Cairns, Alan (Service Redesign Officer); Sinclair, Caroline (Head of Community Mental Health, LD & Addictions)

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 Equality

Yes – throughout the policy, the objective is to establish fair, equitable and consistent approaches to resource allocation between and across all of the adults that we support. Extract Section 4.4 – 4.7: The Equalities Act 2010 was passed on 8 April 2010. The Act protects the following characteristics (referred to in the Act as "protected characteristics"): age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation. The Act prohibits discrimination (whether direct or indirect) against people who possess one of the protected characteristics. Direct discrimination takes place where a person treats another person who has a protected characteristic less favourably than he or she treats or would treat others not possessing the protected characteristic. Indirect discrimination occurs where a provision, criterion or practice is applied which would put a person possessing a protected characteristic at a particular disadvantage. Individuals who are assessed as needing Community Care supports often do so due to disability. While assessment of need is individualised and person-centred (and eligible services so provided), the HSCP has an obligation to ensure that it treats people fairly and equitably in terms of levels of support with which they are provided. The HSCP is accordingly required to perform its statutory duties under the terms of the 1968 and 2013 Acts, while exercising its discretion in performing these duties. It must also ensure that policy and practice is fair and equitable in line with the Equality Act 2010. The HSCP must ensure that an assessed eligible need is being met, but they do not have to fund the support requested by an individual or their guardian, attorney or carer if the assessed need can be met in a more cost effective manner. The HSCP is not required to fund more expensive models of care where support can be provided effectively by alternative models of care.

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	United Nations Convention on the Rights of Persons with Disabilities and Optional Protocol website: http://www.un.org/disabilities/documents/convention/convoptprot-e.pdf requires all service provision to be concerned about the difficult conditions faced by persons with disabilities who are subject to multiple or aggravated forms of discrimination on the basis of race, colour, sex, language, religion, political or other opinion, national, ethnic, indigenous or social origin, property, birth, age or other status. Equality and diversity and Older people with High Support Needs, (Blood and Bamford, Int Longevity Centre - UK, 2010) states that initiatives and policy decisions which impact on older people with high support needs cannot be 'equality neutral' since we know that this group contains: • by definition, those who are older and disabled (whether or not they would define themselves as such); • a higher proportion of women than men; • a smaller proportion of black people and those from ethnic minority groups than in the general population (but likely to expand rapidly), these groups being disproportionately affected by poor health and many long-term conditions and having support needs that are more likely to be 'hidden' from service providers, given barriers to accessing services; • a larger proportion of people who have religious beliefs than among the general population, beliefs that in many cases will affect the type of care these individuals wish to receive; • a higher proportion of people from poorer backgrounds, as a result of the association between poverty and ill-health and the greater visibility of their needs to public services; • a significant minority of lesbian, gay and bisexual people, a group that may be over-represented in the group needing support (as less care may be available from family and some health needs are likely to be greater), but which is more likely to be 'hidden' (as people often avoid accessing services or, when they do, do not reveal their sexual orientation for fear of discrimination); and • a small but increasing group of transgender people, who face particular discrimination. The World Health Organisation (WHO) estimates that learning disability prevalence is about 3% overall in industrialised countries (Mental Retardation 1989). In England, the Department of Health estimates that there are approximately 210,000 people with a severe/profound learning disability, around 3.5 per 1,000, and 1.2 million people with a mild/moderate one, around 25 per 1,000 ('Valuing People' 2001). The then-Scottish Executive's report 'The same as you?' (2000) estimates in Scotland that approximately 20 per 1,000 of the population has a mild/moderate learning disability and 3-4 per 1,000 has a severe/profound one It is estimated that around 2,500 people with a learning disability live in East Dunbartonshire, using traditional prevalence rates (Dept of Health, 1995). Many of these individuals will not be in regular contact with specialist health or social care services, but live largely independently or are supported by family. From our own figures we know that 460 adults with a learning disability do receive formal support, ranging from low-level advice and support to extremely intensive round-the-clock care and support with specialist health input. Autism spectrum disorder (ASD) is a lifelong, complex developmental disability that affects how a person communicates, relates, and interacts with/to other people. It also affects how a person makes sense of the world around themselves. ASD broadly refers to a group of disorders. It includes the classical form of autism, as well as closely related disabilities that share many of its core characteristics (for example, Asperger syndrome and Rett's syndrome). All people with ASD have the 'triad of impairments': social interaction difficulties, language impairment, and reduced imagination and restricted activities. It is widely acknowledged that there is a group of people with learning disabilities who have a complex range of difficulties which may include: • profound learning disabilities • physical disabilities that limit them in undertaking everyday tasks and often restrict mobility • sensory impairment • complex health needs, i.e. epilepsy or respiratory problems, eating & drinking problems • challenging behaviour • restricted communication, i.e. pre-verbal though a small number have some spoken or signed language. People with these characteristics are described as having profound and multiple learning disabilities (PMLD) or profound intellectual and multiple disabilities (PIMD). All, however, have the capacity to benefit from good health care and are able in various ways to communicate their satisfaction or otherwise with their quality of life. The causes of PMLD are many and varied. They include genetic disorders, acquired brain injury or brain damage as a result of infection. Causation may be ante-, peri- or post- natal. For many there is no known causation. It is estimated that the prevalence of PMLD in the general population is 0.05 per 1,000. This figure is derived from a survey undertaken in Scotland and would lead to a figure of 2,600 people with PMLD in the country. This is possibly an underestimate and a useful working figure would be 3,000. These numbers will increase with better survival rates, not only in the neonatal period but into childhood and adulthood, due to advances in medical care.	Sources cited in narrative
	Although carers are more likely to be female, there is growing evidence of a greater role played by men in care giving. 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) Equality and diversity and Older People with High Support Needs (Blood and Bamford, Int Longevity Centre - UK, 2010) explains that we also know that	Sources cited in narrative

Sex	there are significant patterns of inequality amongst those caring for older people with high support needs, in both a paid and an unpaid capacity. Younger family carers are more likely to be women and/or black or from ethnic minority communities; many of those caring for this group are themselves older people with support needs of their own; the paid workforce is predominantly female with an increasing number of migrant workers; and poverty can be both a cause and an effect of caring. Between 2015 -17 there was an estimated 11% rise on the number of people with dementia in East Dunbartonshire (2086 to 2314 people). This number will continue to rise with the growing older population and is one of the key development areas for services. Of the 2314 people with dementia that Alzheimer Scotland estimates (825 males and 1,488 females) in East Dunbartonshire 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 – we will ensure that this group of service users does not receive a lesser service due to their protected characteristics. In East Dunbartonshire, 61% of the adults known to the HSCP with a Learning Disability are male. This is almost exactly consistent with the Scottish average, which is 60%. The distribution of sex by age in East Dunbartonshire is also consistent with the national distribution, for example adults over 65 constitute 13% and 8% of all adults with learning disabilities for females and males respectively. The national ratio of males to females is 51% to 49%. The prevalence of learning disability affecting disproportionately more males than females is not fully understood, but has been variously associated with theories including biological vulnerabilities, referral bias and test/diagnosis bias.	
Gender Reassignment	Many of the health issues that can arise in later life are similar whether an individual is heterosexual, lesbian, gay, bisexual or transgender, but some matters may need special consideration. There are older people and people with disabilities who had successfully transitioned and are living part time or permanently in their preferred gender role. It is less well understood by the HSCP the extent to which people with complex, profound or multiple disabilities and/or with associated cognitive capacity issues perceive or feel free to express or pursue gender association or transition. There is no reliable information on the number of transgender people in Scotland. GIRES estimates that in the UK, the number of people aged over 15 presenting for treatment for gender dysphoria is thought to be 3 in 100,000. There has been no significant research into the care of older trans-people in sheltered or residential accommodation. (Age UKIG factsheet 02 (2015) The National LGB&T Partnership's roundtable has discussed the fact that LGBT older people are rarely acknowledged by service providers and commissioners (The national LGB&T Partnership (2014); The dementia challenge for LGBT Communities: a paper based on a round table discussion) This is an area where we have no local data (East Dunbartonshire) on service users and/or carers and requires development. The NHS GG&C offer guidance on health needs of transgender people and how to address discrimination against trans people in their Briefing Paper on Gender Reassignment and Transgender people, as well as offering training for NHS staff on the subject of transgender people. The Strategic Plan is fully inclusive to all. Partnership working, inclusive of the Third Sector, is highlighted in various themes within the Plan, and should also impact positively upon transgender people as major research and policy direction around trans people are as yet largely shaped by the Third Sector organisations.	Sources cited in narrative
	Ethnicity, Identity, Language and Religion in Scotland from the 2011 Census stated East Dunbartonshire has a population of 105,026; this is a reduction of 3% based on the 2001 census. In the 2011 census, 96% of the East Dunbartonshire population stated they are white Scottish, white British, and white Irish or white other. East Dunbartonshire 2011 census stated the BME pop to be around 4.2%, made up of mixed or multiple ethnic groups which stated they are from a, Asian, Asian Scottish or Asian British, African, Caribbean or Black and other ethnic groups. In the report by Trotter R. (2012); 'Over-looked Communities, Over-due Change' published by the Equalities National Council and Scope found many Black and Minority Ethnic (BME) people with disabilities reported that access to services can be compromised by poor translation, inconsistent quality of care and weak links between services and communities. People with disabilities are more likely to live in poverty but BME people with disabilities are disproportionately affected with nearly half living in household poverty. And like all people with disabilities, many of those from black and minority ethnic backgrounds find themselves socially excluded and pushed to the fringes of society. Learning Disability Alliance Scotland (2017) in their report: BME People Lose Out Across Scotland suggested that people from Black and Minority Ethnic (BME) communities are less likely to get a service than people from a White Scottish background. While the census shows that that BME people make up 5.2% of the Scottish population, the national database on learning disability, ESAY show only 1.24% of people with learning disabilities are from a BME background. There are some wide regional variations. Many BME communities are well established in Scotland and are likely to have a similar incidence of learning disability in the population. The Learning Disability Statistics Scotland 2017 release reported that of adults known to HSCPs with a learning disability, 88% were recorded as white; 1% as Asian, Asian Scottish or Asian British; 0.01% as Black, Black Scottish or Black British, 0.03% as	Sources cited in narrative

Race	mixed ethnicity and 10% not recorded or disclosed. Black and Minority Ethnic Older People's Views on Research Findings, Butt J. and O'Neil A (2004); JRF) reported that 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. Ethnic minority care giving: 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 responsibilities, 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. The lack of 'culturally appropriate' care options has been identified as a key barrier for older people from minority ethnic and/or faith groups. Key issues can include the proximity of care homes or housing with care schemes relative to the geographical 'hub' of a minority community; the lack of culturally and/or religiously appropriate catering arrangements; the mix of staff and residents; the types of activities on offer; and language barriers. Ironically, not all care homes are fully accessible, especially when we consider the role which physical design can play in helping people with dementia, learning disabilities or sensory impairments to move around safely and independently. The number of BME people with dementia in Scotland is increasing in line with the general trend of people living longer, so services need to pay attention to the cultural wishes of this group of people and their Carers, Family and Friends. There also needs to be an understanding that there is not one homogenous BME community but many different 'communities.' Issues Specific to the BME Community in East Dunbartonshire: • Lower levels of awareness about dementia as a disease, there is no word for dementia in any of the main five South Asian languages • Stigma and pride (feeling ashamed to ask for help outside the family and close-knit community) • Some older people live alone and may be socially and financially isolated • Carers may be reluctant to ask for help and their needs may go unrecognised • Some dementias in younger people (under 65) are more frequent among BME communities e.g. Irish and Gypsy-Traveller communities • Older people may not speak English or their ability to speak English as a second language can decrease or become confused • There may be limited cultural sensitivity amongst professionals e.g. medication could be taken intravenously during fasting for Ramadan • There may be a lack of written information on dementia in diverse languages and at times information may need to be delivered verbally due to an inability to read information in English	
Disability	Many of the causes of complex disabilities may also lead to physical or mental ill health. This means that people with complex disabilities may be more likely to be prescribed multiple drugs due to complex and multiple health needs which, in turn, can sometimes adversely affect health through side effects and drug interactions. In terms of prevention, people with complex disabilities are also less likely to exercise and eat healthily than the general public because they may not always have the knowledge or understanding to make healthy choices, and are reliant on others for support and communication. These issues are often added to by problems accessing the health services they need. Many people with complex disabilities experience limited verbal communication skills which impacts on others' ability to understand health needs. Both paid and family carers play an important role in identifying health needs. Many people with more severe learning disabilities rely completely on others to communicate what their health needs are. Adults with complex and learning disabilities experience very high rates of obesity. The increased rates of obesity in children with learning disabilities, compared to children who do not have learning disabilities, are already present by the age of three years old. Adults with learning disabilities aged 16-24 experience higher rates of obesity than adults over 50 who do not have learning disabilities. Many children and adults with complex disabilities do not have much opportunity to participate in physical activity. Instead, people with learning disabilities often have sedentary lifestyles. For example, children with learning disabilities spend 85% of each day sitting or lying down and a study in Glasgow found that, on average, adults with learning disabilities walk for around 15 minutes a week. These levels of inactivity cause health problems, such as heart problems or diabetes. One in three people with learning disabilities has unhealthy teeth and gums. This increases to four out of five for adults with Down's syndrome. This may be due to poor diet, poor dental hygiene, co-occurring health conditions and because oral health promotion may not	Sources cited in narrative

	always be accessible to people with learning disabilities. They may also fear dental treatment and, in some cases, will require general anaesthetic in a hospital setting to resolve matters. People with complex disabilities are more likely to have a hearing loss and are 10 times more likely to have a sight loss. This can have a profound impact on how they are understood and are able to interact with others. Someone with communication difficulties associated with their disabilities might demonstrate challenging behaviours if they are unable to communicate a hidden and undiagnosed sensory loss. Between 25 and 40% of people with learning disabilities also experience mental health problems, with higher prevalence than found in those without learning disabilities. The prevalence of dementia is much higher amongst older adults with learning disabilities compared to the general population (Source: Cooper, 1997a), particularly for people with Down's Syndrome (Source: Holland et al., 1998). Prevalence rates for schizophrenia in people with learning disabilities are approximately three times greater than for the general population (Source: Doody et al., 1998). It is widely acknowledged that there is a group of people with learning disabilities who have a complex range of difficulties which may include: • profound learning disabilities • physical disabilities that limit them in undertaking everyday tasks and often restrict mobility • sensory impairment • complex health needs, i.e. epilepsy or respiratory problems, eating & drinking problems • challenging behaviour • restricted communication, i.e. pre-verbal though a small number have some spoken or signed language. People with these characteristics are described as having profound and multiple learning disabilities (PMLD) or profound intellectual and multiple disabilities (PIMD). All, however, have the capacity to benefit from good health care and are able in various ways to communicate their satisfaction or otherwise with their quality of life.	
Sexual Orientation	The Lesbian, Gay, Bisexual and Transgender (LGBT) Health and Inclusion Project LGBT Identities and Learning Disabilities (2015) project found that participants reported that there is a lack of support for people with learning disabilities to access support around sex and relationships in general. This can includes misconceptions that all people with learning disabilites disabilities are asexual and that sexual urges generally are 'inappropriate'. Furthermore, participants discussed how people with complex disabilities can be infantilised which feeds into the notion that they would not need support around sex and relationships. Participants emphasised that this can be said for people with learning disabilities in general, and that LGBT people then face additional barriers. Participants identified risk of 'mate crime' and sexual or financial exploitation for people with learning disabilities in night-time venues, including the commercial gay scene. The stigma around disabilities can make it hard for people to disclose to LGBT support services that they have additional needs and stigma around LGBT identities can make it difficult to 'come out' to support workers. Participants identified stigma and shame as reasons why LGBT people with learning disabilities may not come out to workers. Participants noted that the first time that people might be asked to consider or disclose their sexual orientation or gender identity may be when completing a monitoring form. This was identified as problematic as there is often not enough time to properly explore what this means. A publication released in 2007, sampling Edinburgh and the Lothian's, by the Lesbian, Gay, Bisexual Transgender and Intersex (LGBTI) Centre for Health and Wellbeing reported that 0.8% of respondents were in a full-time caring role. The LGBT Youth Scotland written response to the consultation provided further evidence of issues affecting LGBT people. Many LGBT carers or the LGBT people they are caring for may have reduced social networks, due to a lack of acceptance by family and friends of their sexual orientation or gender identity. If LGBT carers experience these reduced social networks, they may have less support than other carers and rely more heavily on support from agencies. Many LGBT people fear potentially experiencing homophobia, biphobia and transphobia from services or have previous experience of discrimination from a service. There is often a lack of visibility of LGBT identities within services (such as staff knowledge of the issues affecting LGBT people, promotion of inclusive posters or websites, and explicitly stating that the service is LGBT-inclusive), which are necessary to counter LGBT people's expectations of discrimination or a lack of confidence that service services are able to meet their needs.	Sources cited in narrative
Religion and Belief	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. Scotland Census shows specific proportions of people's religion by local authority are as stated in the 2011 census. In East Dunbartonshire In East Dunbartonshire 62.5% of the population stated they belonged to a Christian denomination. In terms of the Christian denominations 35.6% of the population in East Dunbartonshire belonged to the Church of Scotland and 22.3% stated they were Roman Catholic. The 'Other Christian' group accounted for 4.6% of the population. A large percentage of residents reported they had no religion (28.2%) lower than the Scottish average of 36.7%. This can be seen across all Wards with Milngavie showing the highest percentage of residents stating they had no religion (31.5%). 2.43% of the population in Bearsden South reported that	Sources cited in narrative

	they were Muslim, 2.18% reported they were Sikh and 1% reported that they were Hindu. The Strategy does not make any reference to religion and belief. Adults with complex disabilities in receipt of services generally do so after assessment of risk using approved Eligibility Criteria. The threshold for service receipt is current limited to people who are assessed as presenting substantial or critical risk. In many circumstances, intellectual capacity is significantly affected, thereby often reducing ability to conceptualise religious or spiritual beliefs. In general, the adults supported by the HSCP may attend or practice aspects of religious ceremony as part of wider family convention, rather than through exercising informed and considered personal preference. Consequently, personal information is generally not gathered on religious association for adults with profound and complex disabilities, as it may not properly or accurately reflect capacity or choice.	
Age	The life expectancy of people with profound, complex and multiple disabilities has increased over the course of the last 70 years. This is despite the fact that people with learning disabilities are 58 times more likely to die before the age of 50 than the rest of the population (Emerson and Baines 2010). People with complex disabilities face many disadvantages in relation to health (Emerson and Baines 2010, Department of Health 2001). However, better social conditions and access to medicines like antibiotics have meant that more people are surviving beyond childhood and adulthood into older age. For example, people with Down's syndrome have seen a dramatic rise in their life expectancy from seven years in the 1930's to their late 50's today (Holland et al 1998). The number of people with complex disabilities aged over 60, in the UK, is predicted to increase by over a third between 2001 and 2021 (Emerson and Hatton 2008). Recent evidence suggests that older people are one of the fastest growing groups of the disabled population (Emerson and Hatton 2011). The most recent predictions suggest that by 2030 the number of adults aged over 70 using services for people with complex disabilities will more than double. Survival rates into older age vary with sex, with national and local statistics demonstrating that adults with complex disabilities age 65+ constitute 13% and 9% of all adults with learning disabilities for females and males respectively (LDSS, 2017). Notwithstanding the increasing longevity of adults with a complex disability, the distribution of age-breakdown still demonstrates a comparatively shorter lifespan. 48% of adults with a learning disability are aged between 18-34, compared to 22% within the general population. Adults with a learning disability aged 65+ comprise 10% of the population of all adults with a learning disability, compared to 27% of the general population (LDSS, 2017).	Sources cited in narrative
Pregnancy and Maternity	Whilst policy documents such as the National Parenting Strategy, Getting It Right For Every Child and the Scottish Good Practice Guidelines for Supporting Parents with Learning Disabilities state that early intervention and the right sort of ongoing support should be available to families where there are parents with complex disabilities, we know that often the reality for these families is very different. Disproportionate numbers of parents with learning disabilities, for example, have their children removed. Anecdotal evidence indicates that implementation of the Scottish Good Practice Guidelines is at best patchy. Evidence has also shown that human rights to respect for private and family life (article 8 European Convention on Human Rights82) and the right of a child not to be separated from its parents on the basis of disability of either the child or one of the parents (article 23, para 4 UN Convention on the Rights of Persons with Disabilities) are sometimes not upheld. Steps are therefore needed to improve the support available to these families. The Children (Scotland) Act 1995 establishes that the needs of the child must come first, and so far as is consistent with promoting the child's welfare the local authority should provide services to promote the upbringing of children in need by their families. Research evidence shows that in many cases children's needs can be met well by parents with learning disabilities with support. Support provided needs to be tailored to the needs of the individual parents and might include training, ongoing support and some supplementation of care as needed.	Sources cited in narrative
Marriage and Civil Partnership	The policy does not make any specific reference to marriage and civil partnership. People with disabilities have the same rights in law as anyone else to marry, enter into a civil partnership or live together. Providing the person is over 16 years and has capacity to understanding of what it means to get married, he or she has the legal right to consent to marriage. It is important to state that for many of the people we support who may be affected by this policy, their intellectual capacity is significantly affected, thereby often reducing ability to conceptualise marriage and may not legally have capacity to enter into such an arrangement. Reference to the Adults with Incapacity Act should help to inform the appropriate role for statutory services in relation to these matters, with additional advice available from the Mental Welfare Commission. The forced marriage of people with disabilities is a largely hidden problem. Little data has been collected on prevalence and there is a widespread lack of awareness of the particular features of such forced marriages. People with disabilities therefore need to be safeguarded from forced marriages. Staff members need to discuss any concerns with their line manager and refer to the HSCP's Multi-Agency Adult Protection Guidance. The law relating to divorce is the same for a couple with disabilities as for others, notwithstanding any potential issues with cognitive capacity, outlined above. Staff members should be aware of the support services on offer e.g. counselling with	Sources cited in narrative

	Couple Counselling Scotland. Again, the professional's role would be to offer guidance on the implications of any action.	
Social and Economic Status	In 2013/14, 27 per cent of people in families where someone is disabled were in poverty, compared with 19 per cent of those in families where no one is disabled, using the standard after housing costs measure. On the standard measure, one in three people in poverty live in a household with a disabled person. (source: Joseph Rowntree Foundation). 9% of the East Dunbartonshire population are income deprived (Scotland 16%), but there are wide variations across different areas, for instance in the Hillhead area of Kirkintilloch the population was 30% income deprived, yet just over a mile away in Lenzie South, it is 3%. In 2014-15, over 49% of enquiries to East Dunbartonshire Citizen's Advice Bureau were regarding support and advice to maximise income. Employment Support Allowance is the key contributory benefit for people who are incapable of work because of illness or disability and provides a proxy measure for income deprivation.	Sources cited in narrative
Other marginalised groups (homeless, addictions, asylum seekers/refugees, travellers, ex-offenders	The East Dunbartonshire Local Housing Strategy (2017-22) shows there has been an overall reduction in demand for homelessness services since 2011-12 in East Dunbartonshire, from a peak of approximately 700 applications in 2010-11 to approximately 500 in 2015-16. Unfortunately there is no available breakdown of demographic information to identify the age ranges of homeless applications.	Sources cited in narrative

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

	Highly Likely	**Probable**	**Possible**
General	Yes – the focus on establishing fairness and consistency of application across people with protected characteristics will have a positive impact on people if the plan recognises the interconnectedness of all protected characteristics and their specific needs. Yes – the focus on establishing fairness and consistency of application across people with protected characteristics will have a positive impact on people if the plan recognises the interconnectedness of all protected characteristics and their specific needs.		
Sex	Yes – the focus on establishing fairness and consistency of application across people with protected characteristics will have a positive impact on people if the plan recognises the interconnectedness of all protected characteristics and their specific needs. Yes – the focus on establishing fairness and consistency of application across people with protected characteristics will have a positive impact on people if the plan recognises the interconnectedness of all protected characteristics and their specific needs.		
Gender Reassignment	Yes – the focus on establishing fairness and consistency of application across people with protected characteristics will have a positive impact on people if the plan recognises the interconnectedness of all protected characteristics and their specific needs. Yes – the focus on establishing fairness and consistency of application across people with protected characteristics will have a positive impact on people if the plan recognises the interconnectedness of all protected characteristics and their specific needs.		

Race	Yes, the policy will apply to all racial groups and where information is required to be translated or provided in alternative formats it will be provided upon request as is the current Council and NHS Policy.		
Disability	Yes, the policy is designed to improve equity, fairness, and consistency associated with supporting people with disabilities to meet their personal outcomes, in line with statute, national and local policy.		
Sexual Orientation	Yes – the focus on establishing fairness and consistency of application across people with protected characteristics will have a positive impact on people if the plan recognises the interconnectedness of all protected characteristics and their specific needs. Yes – the focus on establishing fairness and consistency of application across people with protected characteristics will have a positive impact on people if the plan recognises the interconnectedness of all protected characteristics and their specific needs.		
Religion and Belief	Yes – the focus on establishing fairness and consistency of application across people with protected characteristics will have a positive impact on people if the plan recognises the interconnectedness of all protected characteristics and their specific needs. Yes – the focus on establishing fairness and consistency of application across people with protected characteristics will have a positive impact on people if the plan recognises the interconnectedness of all protected characteristics and their specific needs.		
Age	Yes – the focus on establishing fairness and consistency of application across people with protected characteristics will have a positive impact on people if the plan recognises the interconnectedness of all protected characteristics and their specific needs. Yes – the focus on establishing fairness and consistency of application across people with protected characteristics will have a positive impact on people if the plan recognises the interconnectedness of all protected characteristics and their specific needs.		
Marriage and Civil Partnership	Yes – the focus on establishing fairness and consistency of application across people with protected characteristics will have a positive impact on people if the plan recognises the interconnectedness of all protected characteristics and their specific needs. Yes – the focus on establishing fairness and consistency of application across people with protected characteristics will have a positive impact on people if the plan recognises the interconnectedness of all protected characteristics and their specific needs.		

Pregnancy and Maternity	Yes – the focus on establishing fairness and consistency of application across people with protected characteristics will have a positive impact on people if the plan recognises the interconnectedness of all protected characteristics and their specific needs. Yes – the focus on establishing fairness and consistency of application across people with protected characteristics will have a positive impact on people if the plan recognises the interconnectedness of all protected characteristics and their specific needs.		
Social and Economic Status	Yes – the focus on establishing fairness and consistency of application across people with protected characteristics will have a positive impact on people if the plan recognises the interconnectedness of all protected characteristics and their specific needs. Yes – the focus on establishing fairness and consistency of application across people with protected characteristics will have a positive impact on people if the plan recognises the interconnectedness of all protected characteristics and their specific needs.		
Other marginalised groups (homeless, addictions, asylum seekers/refugees, travellers, ex-offenders	Yes – the focus on establishing fairness and consistency of application across people with protected characteristics will have a positive impact on people if the plan recognises the interconnectedness of all protected characteristics and their specific needs. Yes – the focus on establishing fairness and consistency of application across people with protected characteristics will have a positive impact on people if the plan recognises the interconnectedness of all protected characteristics and their specific needs.		

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

	Highly Likely	**Probable**	**Possible**
General			The policy may mean that some existing service users with disabilities will require adjustment to service delivery arrangements, to establish consistency and fairness, but this would operate within established eligibility criteria and policy arrangements, to ensure that overall resources are shared out equitably based upon assessed need, with due

			regard for the particular impact of any protected characteristics and associated risks.
Sex			The policy may mean that some existing service users with disabilities will require adjustment to service delivery arrangements, to establish consistency and fairness, but this would operate within established eligibility criteria and policy arrangements, to ensure that overall resources are shared out equitably based upon assessed need, with due regard for the particular impact of any protected characteristics and associated risks.
Gender Reassignment			The policy may mean that some existing service users with disabilities will require adjustment to service delivery arrangements, to establish consistency and fairness, but this would operate within established eligibility criteria and policy arrangements, to ensure that overall resources are shared out equitably based upon assessed need, with due regard for the particular impact of any protected characteristics and associated risks.
			The policy may

Race			mean that some existing service users with disabilities will require adjustment to service delivery arrangements, to establish consistency and fairness, but this would operate within established eligibility criteria and policy arrangements, to ensure that overall resources are shared out equitably based upon assessed need, with due regard for the particular impact of any protected characteristics and associated risks.
Disability			The policy may mean that some existing service users with disabilities will require adjustment to service delivery arrangements, to establish consistency and fairness, but this would operate within established eligibility criteria and policy arrangements, to ensure that overall resources are shared out equitably based upon assessed need, with due regard for the particular impact of any protected characteristics and associated risks.
			The policy may mean that some existing service users with disabilities will require adjustment to service delivery arrangements, to establish

Sexual Orientation			consistency and fairness, but this would operate within established eligibility criteria and policy arrangements, to ensure that overall resources are shared out equitably based upon assessed need, with due regard for the particular impact of any protected characteristics and associated risks.
Religion and Belief			The policy may mean that some existing service users with disabilities will require adjustment to service delivery arrangements, to establish consistency and fairness, but this would operate within established eligibility criteria and policy arrangements, to ensure that overall resources are shared out equitably based upon assessed need, with due regard for the particular impact of any protected characteristics and associated risks.
Age			The policy may mean that some existing service users with disabilities will require adjustment to service delivery arrangements, to establish consistency and fairness, but this would operate within established eligibility criteria and policy arrangements, to ensure that

			overall resources are shared out equitably based upon assessed need, with due regard for the particular impact of any protected characteristics and associated risks.
Marriage and Civil Partnership			The policy may mean that some existing service users with disabilities will require adjustment to service delivery arrangements, to establish consistency and fairness, but this would operate within established eligibility criteria and policy arrangements, to ensure that overall resources are shared out equitably based upon assessed need, with due regard for the particular impact of any protected characteristics and associated risks.
Pregnancy and Maternity			The policy may mean that some existing service users with disabilities will require adjustment to service delivery arrangements, to establish consistency and fairness, but this would operate within established eligibility criteria and policy arrangements, to ensure that overall resources are shared out equitably based upon assessed need, with due regard for the particular impact of any

			protected characteristics and associated risks.
Social and Economic Status			The policy may mean that some existing service users with disabilities will require adjustment to service delivery arrangements, to establish consistency and fairness, but this would operate within established eligibility criteria and policy arrangements, to ensure that overall resources are shared out equitably based upon assessed need, with due regard for the particular impact of any protected characteristics and associated risks.
Other marginalised groups (homeless, addictions, asylum seekers/refugees, travellers, ex-offenders			The policy may mean that some existing service users with disabilities will require adjustment to service delivery arrangements, to establish consistency and fairness, but this would operate within established eligibility criteria and policy arrangements, to ensure that overall resources are shared out equitably based upon assessed need, with due regard for the particular impact of any protected characteristics and associated risks.