

Developing inclusive residential care for older Lesbian, Gay, Bisexual and Trans (LGBT) people: An evaluation of the *Care Home Challenge* action research project.

ABSTRACT

There have been substantial achievements in legislative and human rights for Lesbian, gay, bisexual and transgender (LGBT) older people and their visibility in health and social care has equally increased. These appear to have surpassed the ability of care services to meet their needs given documented concerns about the accessibility, inclusiveness and safety of care services particularly institutionalised care. This requires systemic change not easy to operationalise. This paper describes an action research initiative where six care homes belonging to a national care provider, collaborated to assess and develop their services with the support of local LGBT ‘Community Advisors’ and academic partners. Framed within Rogers’ (2003) change management framework and combined with a participatory leadership approach, a programme of intervention was implemented comprising structured activities around seven key areas thought to promote LGBT inclusion. A formal evaluation was conducted involving 35 pre and post intervention qualitative interviews with 18 people (community advisors; care home managers and senior managers). The findings are presented across three key themes 1) starting points on the journey; 2) challenges encountered along the journey (organisational and interpersonal); and, 3) making change happen; opportunities, initiatives and gains. We make recommendations on the value of a programme approach for achieving tangible outcomes that demonstrate increased inclusion for older LGBT older people living in long-term care settings.

Keywords: LGBT; older people; care homes; inclusive environments; co-production; human rights.

What is known about this topic?

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- There is widespread discrimination and exclusion of older LGBT people in care services.
- There are few practical resources or guidance documents supporting inclusion in long-term care settings.

What this paper adds:

- An example of a holistic programme of structured activities promoting LGBT inclusion in care homes.
- Ideas for developing, piloting and evaluation of an evidence-based assessment and development tool to promote LGBT inclusion.
- Reinforces the value importance of working within a framework of change management theory underpinned by participative leadership from the LGBT community.

INTRODUCTION

Substantial political, legislative, policy and social changes impacting on Lesbian, Gay, Bisexual and Transgender (LGBT) people in the UK have softened attitudes and increased recognition. Within the estimated older LGBT population, there are one million lesbian, gay and bisexual people aged over 55 years (Age UK, 2016) and 300,000 transgender/non-binary people (GIRES, 2009). Research has documented concerns about the readiness, accessibility and quality of services needed to provide inclusive support (Simpson et al 2016; Fredrickson-Goldsen et al, 2014; Willis et al, 2016). Older LGBT people are an invisible and marginalised group whose life stories, relationships and culture can be overlooked by care providers (Price, 2010) or result in direct discrimination, hostility and violence (Bytheway et al, 2007; Wintrip, 2009). Stereotypes about sexuality and intimacy in later life may deem people sexless, aberrant or invisible (Hafford-Letchfield, 2008; Villar et al, 2014a; 2014b). Women,

transgender and intersex older people's experiences are especially overlooked and under-researched in education and practice (Witten, 2014; Silverskog, 2014).

This evidence provides a reliable base to inform change and inclusion. Surveys of knowledge, skills, attitudes and capabilities of those working in residential care suggest a need for radical change to ensure accessible, high-quality care and improved outcomes for LGBT older people (Willis et al, 2016; 2017;Almack et al, 2015). Empirical research from Australia and the USA has identified institutional and historical barriers that prevent older people 'coming out' or identifying as LGB to care providers (Barrett, 2008; Jackson et al, 2008; Knockel et al, 2010; Leyerazpf et al, 2016; Tolley and Ranzijn, 2006). In the UK, pioneering work by Polari (see Hubbard and Rossington, 1995) whose report 'as we grow older', was the first to survey older LGBT experiences of housing, health and social care. Further collaborations between Age UK and organisations in Northern Ireland (Rainbow Project and Age NI, 2011) and with Oxfordshire have highlighted the importance of proactive engagement with LGBT people in determining their future care needs.

Whilst practice guidelines exist (CSCI, 2008; Hafford-Letchfield, 2015) there is no coherent framework for auditing the outcomes or contexts in which guidelines are implemented. Developing LGBT 'cultural competence' (Gendron et al 2013) has no mandatory basis, nor is training prioritised or commissioned where resources are limited (King 2015). Training alone cannot support the organisational change needed to tackle deep-seated prejudice and exclusion within care organisations (Westwood and Knocker, 2016). Despite increasing service standards, improving provision concerning sexual difference and gender reassignment lags behind other equality work (Commission for Social Care, 2011). Initiatives should involve synthesis of organisational change frameworks which are evolutionary rather than revolutionary. Sudden change including those associated with new legal requirements often involves inadequate consultation with stakeholders alongside external constraints. Together

such factors reflect poor/inappropriate leadership leading to ineffective communication among staff and exert pressure on under-motivated/under-supported individuals and teams (Mitchell, 2012). This stands in contrast with an innovative USA-based project which identified ten core staff competencies (Fredriksen-Goldsen et al, 2014). These competencies were aligned with specific strategies to improve professional practice and service development in care settings aiming to promote the well-being of LGBT older adults and their significant others.

In sum, the emerging research agenda apropos of older LGBT inclusion lacks empirical evidence that would help translate its recommendations into practice. For residents, entering a care home demands significant adjustment alongside challenges in maintaining an authentic self, social connections and support structures in one's community (Hutchinson et al, 2011). This study contributed towards this gap in knowledge/practice using a holistic programme of activities designed to promote LGBT inclusion and to encourage staff to recognise their own learning needs. This action-learning project was based on Rogers (2003) organisational change framework comprising five phases of planned change: awareness, interest, evaluation, trial and adoption and was combined with a participative leadership model (see Hafford-Letchfield et al, 2014). We discuss the project with reference to the awareness, interest and evaluation phases and findings from the independent structured evaluation and make recommendations based on what we have learned from Rogers' approach.

PROJECT BACKGROUND

The *Care Home Challenge* (CHC), designed to improve care home service standards, was piloted with a major care home provider in England. It aimed to enable all care staff to increase awareness and skills in supporting older LGBT residents and their significant others in order to maximise benefits derived from service improvement plans. Collaboration

involved the organisation’s senior managers; six care home managers (CHMs) within one geographical location and eight volunteers from the LGBT community as Community Advisors (CAs). CAs’ motivations for being involved in the project commonly involved the desire to be part of positive change in enhancing the quality of *differentiated* service provision for vulnerable, seldom-heard individuals. Identification as older and/or LGBT or having experienced other forms of marginalization (on grounds of ethnicity or gender) reinforced motivation to help improve care for others and their future selves. An overview of the diversity characteristics of the CA’s is illustrated in Table 1.

Table 1: Profile of Community Advisors (CAs)

Age	Ethnic origin	Sexual /identity	Gender identity	Religion	Relationship Status
35-44	Asian British	Heterosexual	Cisgender	No religion	Prefer not to say
45-54	Asian British	Gay	Cisgender	Buddhist	Single
55-64	White British	Gay	Cisgender	No religion	Married/Civil partnership
55-64	White Irish	Lesbian	Transgender	No religion	Single
65+	White British	Lesbian	Cisgender	Christian	Married/Civil Partnership
65+	White British	Gay	Cisgender	Christian	Single
65+	Jewish	Lesbian	Cisgender	Jewish	Married/Civil Partnership
65+	White British	Lesbian	Cisgender	No religion	Single

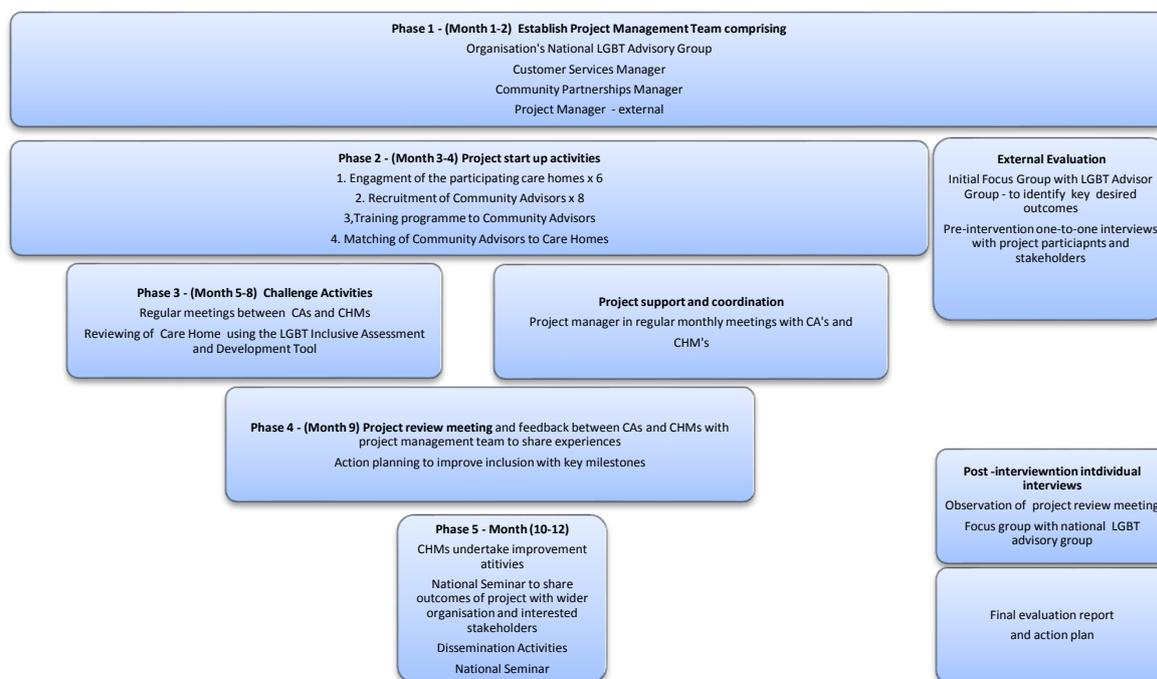
*No equivalent data was collected on the Care Home Managers

Characteristically, creative initiatives involve networks of varied expertise extending beyond the immediate workforce (Hafford-Letchfield et al, 2014). For example, community visitors (Tanner and Brett, 2014) can enhance communication between staff, residents and family members in care settings, especially if this occurs alongside participatory leadership. The project was steered by academic-practitioners with expertise in LGBT research and the care provider organisation’s national LGBT advisory group and management team. CAs worked closely with an allocated care home and led a programme of structured activities over four months. The awareness and interest phase of Rogers’ model (2005) was used to engage

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residents and staff concerning LGBT inclusion. Figure 1 provides an overview of the projects main activities and timeline.

Figure 1: Project activities overview of the Care Home Challenge



Following 4 months 'fieldwork,' CAs met with managers to discuss outcomes from their assessment where an action plan was developed and service improvement initiatives were identified and led by local 'LGBT champions' (trial phase). This knowledge was shared with strategic leaders to enable them to embed improvements in their equalities vision/policy (adoption phase).

Project intervention

An assessment tool was developed by academic partners from a review of research evidence to inform key areas of good practice in LGBT inclusion (Hafford-Letchfield et al, 2016). This provided a framework for structuring CAs interactions with care homes in relation to seven domains; policies and procedures; consultation; risk management; end-of-life support;

cultural safety; transgender specific issues; and workforce development. CAs used case studies to identify issues and strategies for action. These promoted discussions on assertiveness, knowledge of legislation, including LGBT rights and particular cultural references. To ensure legacy, in the three-month period after fieldwork CAs and CHMs co-developed action plans designed to effect change in conjunction with senior managers, within homes and cross-sector/nationally.

Combining community participation with workers and managers experiences helped collective exploration of and solutions to inclusion-related problems. Partnership work is often fraught with challenges, given vested interests, budgetary and value conflicts between stakeholders, which require careful management/negotiation (Hafford-Letchfield et al, 2014). The Rogers' model (2003) was useful as it places stress on assessing the impact of proposed organisational change before adoption of any changes.

Evaluation

The CHC evaluation drew on Pawson and Tilley's realist approach (2000) and sought to understand how the intervention effected change. This approach regards programmes as 'theories' that are 'embedded' yet 'active' within 'open systems' (p. 215) and acknowledges that such systems are constituted and informed by different layers of social reality. The complexity involved in challenging care homes to become more LGBT inclusive had to start with the process of staff own understanding, expectations and interpretation of LGBT ageing within this particular setting and set of relationships. Exploring and agreeing key concepts about what could or needed to happen gave rise to a more dynamic process during the intervention. This led to multiple 'measures' concerning attitudes, acceptance and 'doing', being designed into the evaluation whilst simultaneously revising and aligning these with the programme objectives and providing formative feedback. The evaluation methodology

therefore took cognisance of the participating members' position and context through the three stages posed by Rogers.

Semi-structured telephone interviews pre- and post-interventions with CHMs, CAs and senior managers (see Figure 1) revealed unanticipated themes and respondent perspectives (Maxwell, 1996). Although telephone interviews preclude insights into body language, participants can express themselves more freely without facing an unfamiliar academic interviewer (Berg, 2011). Thirty-five interviews were conducted with 18 respondents, (CAs (8), CHMs (6), senior managers (3) and a trainer (1). One focus group was conducted with the LGBT national advisory group and another focus group at the mid-term review comprising of CAs and CHMs. The interim feedback and evaluation findings were used to inform questions in the post-intervention stage through detailed note-taking by the evaluation team. All telephone interviews were audio-recorded and transcribed and findings were generated through thematic analysis. This involved identifying key themes (explicit and implicit) emerging across the dataset and how people draw on commonly available stories to understand and construct their experiences (Braun and Clarke, 2006).

Ethical requirements

Ethical approval was granted via the Nottingham University Ethics Committee. Participants gave informed consent. Data were anonymised and stored in accordance with data protection law. Our ethical approach involved foregrounding participant narratives and seeking feedback on the credibility (via a report to CAs and the partner organization) of our interpretations of their accounts. This strategy helps equalize asymmetries of 'representation, authority and voice' (Sherman Heyl, 2001, p. 378). Resident safety was paramount in CA interactions with staff and managers. CAs understood that safeguarding concerns should be reported immediately to the manager and thereafter, to the project leader.

FINDINGS

1. Starting the journey: Recognising LGBT issues within care homes.

Before the intervention, managers acknowledged low levels of awareness amongst staff and service users concerning the lived experience and support needs of LGBT people. Most reported having no experience of LGBT-identified residents in their homes:

I think the older generation don't talk to you about their sexuality. They won't tell you - and we don't have any awareness..... They might be gay or lesbian but they might never have spoken to anyone and we won't be able to probe. (CHM)

This account reflects an historic reluctance to ask (a 'don't ask, don't tell' policy) that reinforces invisibility and marginalization. It indicates a lack of confidence in enquiring sensitively about or signalling awareness of a person's sexual and/or gender difference. Further, the speaker invokes the stereotype that older LGBT residents will be closeted (i.e. not 'out' to others), which prioritizes individual responsibility to come out over collective responsibility of staff/the home to enable disclosure. CHMs' comments also reflected admirable candour, which owns the lack of awareness concerning LGBT issues, whilst acknowledging that residents could feel confident about disclosing and expressing their difference subject to the creation of a supportive, valuing environment.

All CHMs reported that the ethos in their care home was conducive to equal treatment of LGBT people but there was confusion about what this meant:

Someone's sexual orientation is a personal thing; it doesn't come first in looking at a person's needs on assessment. Anyone who is gay or lesbian, we would treat the same as anybody else. (CHM)

These well-intended statements concerning treating everyone the same can reinforce social inequalities, erase difference and fail to differentiate care services. As one CHM concluded, equality (of outcomes) entails attention to diversity and the different forms of provision required to achieve equality. The view that sexual identity should be ignored because it is a personal matter and that sexual/gender identity should be privatized is reminiscent of oppressive attitudes that oblige self-censorship and denial of difference.

2. Challenges encountered on the journey

Organisational demands

CAs' stories commonly reflected structural-organizational obstacles to fulfilling their role because of the high demands of running care homes on staff and managers' time. CAs described frustration at getting access to managers and staff to begin any dialogue and spoke of difficulties in ensuring attendance at meetings given shift patterns. Communication by telephone and email with managers was sometimes difficult or CAs felt 'fobbed off' by what they perceived as quietly reluctant managers. Managers encouraged staff to attend LGBT advisory sessions but did not always attend themselves, raising questions about leadership and modelling engagement. CAs' earlier frustrations were, however, counterbalanced by appreciation of the pressures on managers and staff concerning unanticipated demands on time and resources. The project timelines were also challenging given the need to engage with staff, plan, provide advisory sessions and initiate change.

Challenging staff views and beliefs

CAs identified interpersonal challenges encountered by CAs concerning prejudiced views from care staff. Some conversations were experienced as confrontational given that, by definition, their own sexual and/or gender identity was being problematized. Indeed, one staff

member declared to a CA that they ‘knew how to deal with that disease,’ though such views could be covert and contradictory:

One staff member stated she would ban her son from the house if he came out as gay but had worked quite happily with trans people. Some were supportive, other people less so because of their religion and culture. [CA].

The same CA observed that all staff appeared to be committed to person-centred care, but they needed to extend such thinking to LGBT individuals/concerns. This observation suggests, despite emphasis on person-centred care, persistence of ingrained homophobia and partial tolerance of LGBT individuals in a setting where care is provided for vulnerable, older individuals. Such anxieties were animated by tensions between religious beliefs and sexuality, which constrained some staff members’ awareness of LGBT lives:

We recognised early on that cultural issues were a potential barrier. Boy, oh boy, that proved to be the case. Negative beliefs of staff from other nationalities in which homosexuality are illegal or persecuted can be deeply entrenched. This education process is therefore a necessity. It was a brave thing to put the spotlight on the issue. [Senior manager].

It is unsurprising that staff from societies where sexual and gender difference are outlawed and/or attract severe moral condemnation should express hostility or unease but we believe, in principle and in the interests of good practice, that such attitudes require challenge:

Because of the cultural background of our staff... and because I know in some countries it is taboo... and we have staff from these countries... If you’re here and you’re saying you can’t provide care, then you can’t fulfil your role, really.

This principled stand taken by a CHM is a salutary reminder of the existence of equality legislation and the need for professional-ethical practice where the needs of vulnerable adults take precedence over religious or other anxieties about sexual and gender differences. CMHs also noted concern about the views of individual residents and the habitual constraints by virtue of age and having lived through a less forgiving era. This barrier could be compounded by loss of cognitive capacity:

It can be quite difficult talking to them [residents with a dementia] about different issues, so if it is not something they grew up with, they might not cope with it very well. (CHM)

While generational influences impact upon acceptance of LGBT individuals (Robinson, 2008), it is wrong to assume that all older LGBT people struggle with their difference. They may have developed confidence as well as emotional and political resources through the ageing process that could help them contest stereotyping, prejudice and discrimination (Rosenfeld, 2010). The testimony of ‘out’ LGBT residents, acting as peer educators could be used to help empower other residents and staff to question pathologising views. Their testimony could be used to communicate how heteronormative and cisgender discourses (the latter assuming compliance with ascribed gender) inform prejudice and discrimination (Ansara, 2015; Tolley and Ranzijn, 2006).

3. Making change happen: opportunities, initiatives and gains

Providing direction through lived experience

Having identified low levels of LGBT awareness, the CA group decided to co-facilitate advisory sessions in each home, which included information-sharing on LGBT history and equalities legislation. This innovation helped open up conversations with staff and managers

and served as a gentler introduction to the assessment process. Such preparatory conversations were important in enabling examination of entrenched beliefs in an emotionally safe, non-judgemental environment. They were pivotal in enabling staff to explore with LGBT individuals their assumptions and the role of social and biographical influences that had imperceptibly shaped their attitudes:

Most memorable moment?it was actually seeing a genuine shift from some of those workers and giving them the opportunity to say what they are struggling with. Getting people to think about people in terms of identity and about the fears of being marginalised..... It's about trying to appeal to people's compassion. [CA].

The advisory sessions were crucial in mobilising the compassion of those with religious (or other) reservations to see LGBT individuals as expressing a form of difference or 'identity' as a personal right. The sessions also enabled exploration of the consequences of exclusion, marginalization and being ostracised. Giving further cause for optimism, CAs were struck by the willingness of staff members to engage in difficult conversations and their honesty in naming their personal beliefs and views on sexual and gender diversity:

Having some difficult and important conversations... I knew we would encounter prejudices of some staff... But, there were huge benefits because there were some genuine conversations.... some light-bulb moments and, most encouraging of all, people who held some entrenched views, have said, 'I think differently now.' [CA].

Participatory leadership

CAs' testimonies highlight the value of open dialogue as a start-point for identifying the source of assumptions and stereotypes, itself a pre-requisite for change in attitudes and practice. They also underscore the value of opportunities for relationship-building, using a

participatory leadership model leading to small but important shifts in thinking about LGBT lives:

It was important to have the opportunity to build relationships over several months and to follow issues through... Genuine relationships were built that made a huge difference... [CA].

Developing mutual trust through the advisory sessions was identified as key to implementing changes pre-requisite for inclusion. CHMs remarked on the perceived value of these sessions described them as 'enlightening' and 'educational and informative' in specific ways:

I think we'll know better how to start conversations, not ask direct but be able to have more open conversations... build relationships to find out more and meet their needs.

Further, the advisory sessions enabled critical, sensitive discussions which involved challenging heteronormative thinking (the understanding of heterosexuality as the benchmark of human sexual expression). Such shifts in thinking augur well for care practice if staff feel better prepared to support residents' self-expression, listen for indications of difference and know how to signal positive recognition of difference

CAs observed that involvement in the project inspired managers to lead on more extensive changes, which included: initiating conversations on LGBT issues with residents; making available LGBT-related literature in the home; and reviewing the 'LGBT-friendliness' of the reception area. One home initiated an equality and diversity day where LGBT issues were central. Other changes were more gradual and became more evident in the latter stages of the project as the process moved into trial and adoption phases (Rogers, 2003). For example, CHMs initially agreed to display a poster about the project and publicize among staff teams and service users and wear a rainbow ribbon to initiate conversations about LGBT older

people. While managers reported having displayed LGBT-themed visual materials, how visible or well-noted these were, appeared piecemeal. Few responses were reported from staff, residents or others involved in the home. One CHM observed: ‘It is a gradual process, but I have seen people looking at them and reading them.’ Another CHM reported that the night staff especially were surprised to see the project poster but thought it was a good idea. Only one CHM mentioned wearing a rainbow ribbon badge stating: ‘I put it on as soon as I was given it and it has stayed on but only the CA had remarked on this.’

Promising practices emerging in care homes

Post-intervention interviews with CHMs seven months after initial interviews were important in identifying small but important shifts in attitudes and gains in awareness that could be capitalized on. These revealed a greater willingness by CHMs to own and subsequently address staff apprehension concerning such issues:

Before staff might have said ‘Why are we doing this?’ Now they know why it’s important. Culture and religion were big barriers but there was a real lack of knowledge. Some staff were very sceptical, very resistant to the project, initially. We were asking staff to really think about inclusive environments and it was very challenging. It took time to break down barriers but we’re getting there. (CHM)

Visual materials designed to make the project and its aims visible featured increasingly in interview responses too. In the initial interviews, CHMs tended to confirm that posters had been displayed. By the second (post-intervention) interviews, some referred to them unprompted. One reported moving a poster to a more prominent place (reception area) and another who had recognised the importance of wearing the rainbow ribbon after the review meeting between CHMs and CAs reported how it prompted conversations about its significance: ‘One resident got a bit upset with me. She said: “I don’t want to hear about

this”... but, I explained to her times had moved on.’ Whilst this exchange was problematic, the CHM appears to have developed the confidence to support LGBT rights to self-expression

Shifts in attitudes were visible in events and gestures that would not have been part of participants’ thinking beforehand. For example, one staff group requested observing a two-minute silence after the Orlando shootings (where 49 people were murdered in an LGBT nightclub, June 2016). What is particularly encouraging about the impact of the programme was the inculcation of a longer-term commitment to addressing equality and mirroring CAs’ desire that the project leave a positive legacy.

DISCUSSION

The experience and findings from the CHC project provides scope to pause and reflect on the implications of some of the issues raised by its evaluation. Both policy and academic framings of person-centred care and latterly relationship centred care where staff and service users are overwhelmingly assumed to have shared goals and interests was significantly challenged through the interactions between CAs and CHMs. Whilst the CHC was motivated by the lack of awareness of differences in sexual and gender identity in residential care settings and the desires of its care home participants to be more LGBT inclusive, it revealed that unquestioning adoption of policy themes around person-centred approaches also has the capacity to undermine personalised, holistic care and the identities of older LGBT residents. The personalisation of care should ensure respect for diversity and that individuals feel able to discuss their support needs with staff confident in working with individuals regardless of sexual identities and relational and life histories. Further, person-centred care is often cited without recognition of the need for choice of services that are supportive, safe and culturally appropriate (Westwood, 2016; Hafford-Letchfield, 2015).

Our findings illuminate the challenges, tensions and opportunities that can present when implementing research and practice guidance on sexuality and inclusion and the importance of situating this within theories of change and participatory leadership (Hafford-Letchfield et al, 2014; Rogers, 2003). We have also highlighted the value of well-supported, community volunteers whose innovations during the assessment process, motivations for change and capacities for empathy were pivotal in raising staff awareness. These three factors helped create rapport and a non-judgemental space where staff could question assumptions and stereotypes and thus develop the empathy that is pre-requisite for overcoming ignorance and hostility. Such factors also reflect a person-centred approach to support that avoids ‘treating everybody the same’, which only ignores difference (Leyerzapf et al., 2016) as well engaged with culturally competence from those providing it (Fredriksen-Goldsen et al, 2014).

Services based on dignity and respect also involves wider stakeholders such as those both commissioning and providing residential care. They need to use different sources of consultation so as to ensure that the unique needs of LGBT older people are genuinely shaped by community membership, their biography and narrative (Hafford-Letchfield, 2015). CA engagement with care staff and managers modelled challenging conversations and opportunities for dialogue across difference. Whilst ingrained prejudice (which requires ongoing education) persisted, there was an encouraging willingness by staff to address this. Commitment to a participatory, collaborative approach can better enable care-providing organisations to capitalize on such individual goodwill and turn this into a longer term collective, strategic resource to address LGBT inclusion.

There was clear evidence of gains in awareness and changes in attitudes by CHMs and staff during and post-intervention. Managers and staff became more enthusiastic in their implementation of awareness-raising and inclusion measures. However, concerns remain

about the invisibility of bisexual and transgender residents given the tendency to subsume them under the categories 'lesbian' and 'gay'. Concerns also remain about the implementation of equality measures, by treating residents 'all the same' based on heterosexual assumptions/stereotypes, which can compound inequality. As regards, equality of outcomes, LGBT individuals differ between and among themselves, something which requires differentiated provision. Sexual orientation and gender identity are aspects of LGBT identity but they cannot represent the whole of an individual's identity; these identities intersect and enmesh with other experiences such as class, ethnicity, age and belief system. These experiences should be considered when designing person-centred care and support in residential settings.

Implications for practice and policy

The CHC was an innovative collaboration between care home providers, members of the local LGBT community members, academics and practitioners who piloted a programme of activities designed aimed to promote more inclusive services for LGBT older people living in care home settings. Harnessing a systemic organisational change approach (Rogers, 2003) combined with a participative leadership model enabled a more sustainable model of influence by ensuring that those involved had the skills, knowledge and commitment to effectively monitor and review their own provision. As demonstrated in research we need to examine current levels of knowledge, skills, attitudes and capabilities of those working in residential care (Willis et al, 2016, 2017; Almack et al, 2015) and indeed other areas of the health and social care workforce. LGBT identity and sexuality issues are still not prioritised within their education and training. Where they are, this can appear tokenistic or lack integration with other equality training (Westwood and Knocker, 2015; King 2015). Standards and learning outcomes on LGBT equality and diversity could be embedded further

within the national care education curriculum and the related outcomes more closely examined within the relevant registration, regulation and inspection of care services currently mandated by the national bodies responsible. These objectives could be optimised when situated in a partnership like that developed by the CHC which both encourages and allows learning and development to inform good practice to develop, flourish and be shared in the spirit of co-produced holistic care. Further, leadership roles were distributed across the project by providing dedicated support to CHMs to lead alongside locally appointed LGBT champions, which suggests a more concerted, collective approach to promoting inclusion. These organisational practices need to be at the heart of policy imperatives towards co-production in older people's services (Hafford-Letchfield et al, 2016). At the strategic level, processes, procedures and organisational structures together with staff development measures and action planning encouraged resourcing of tangible change, which can be audited through the assessment and development tool. The tool has since been disseminated across the sub-sector of care where it can be tailored and improved further.

Consultation with LGBT older people has identified that wide diversity of care concerns and preferences among older LGB people about their future care needs which are driven by a range of intersectional identities (Jackson et al, 2014; Rainbow Project and Age Northern Ireland 2011; Westwood, 2016; Witten, 2014). There is a growing body of knowledge about heteronormativity in institutional care and lack of choice which if not purposefully addressed, then negates policy rhetoric around how well person-centred models grapple with equality and diversity issues for the LGBT population regardless of equality and human rights legislation (Westwood, 2016). Whilst this will take time to implement, ignoring LGBT inclusion is not an option. To do so perpetuates marginalization of LGBT residents at what is often experienced at the most vulnerable time of life. The time is ripe for a society-wide

conversation on how we ensure that care homes for older citizens operate as inclusive communities that are connected to the wider communities in which they are located.

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