Experiences and actions of inclusivity & cultural competence in community based social care for older LGBTQ+ adults: A Qualitative Study

Elizabeth Kirsty Wands-Murray

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Abstract

Background:
Social care is often required by older people, and those with marginalised identities may be at risk of inequitable or discriminatory experiences. Older LGBTQ+ people have commonly faced historic discrimination over their lifetimes, which may include experiences that influence decision making and engagement with social care. Inclusivity, particularly in more informal community-based social care, is a complex area. Understanding what may need to change and how to achieve inclusive services has been little explored in community-based provision.

Method:
A scoping review of current literature was undertaken. Subsequently, interviews and focus groups with 23 older LGBTQ+ people and staff/volunteers were used to understand their perspectives of using and delivering inclusive community based social care. Thematic and narrative analysis of findings was undertaken.

Findings:
There were differences in the importance and relevance given to sexual identity by older LGBTQ+ people and staff. A range of methods for demonstrating inclusivity were identified across both groups. Providers were motivated to consider actions but identified complexities and a lack of external drivers and guidance for taking action.

Collection of sexual identity data was felt to be important, but complex to implement. Older LGBTQ+ people did not want to be treated differently but wanted validation and recognition of their LGBTQ+ identity. Staff training was felt to be key, although ways of delivering impactful training often relied on retelling lived experiences without frameworks of support. Clear signals of LGBTQ+ inclusion and tangible links with wider LGBTQ+ networks and services were felt to be key to inclusive support.

Conclusions:
A range of actions by providers may improve experiences of inclusivity, but support is required to ensure adjustments are effective and meaningful. Mechanisms and support for inclusive conversations, although complex to navigate, are likely to have the most impact on uptake and engagement with informal social care.

I declare that this thesis is a presentation of original work, and I am the sole author. This work has not previously been presented for a degree or other qualification at this University or elsewhere. All sources are acknowledged as references.

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Table of Tables

Definitions of key terminology

Ageing/older - for the purposes of the study, people aged 50 and over were classified as ageing/older. This is not indicative of any judgement of the researcher as to what constitutes old age but is linked to the classifications commonly used in wider society, especially in care settings and within research.

Cisgender - This term refers to those who identify with the binary gender assigned at birth.

CQC - This acronym refers to the Care Quality Commission.

LGBTQ+ - To reflect contemporary terminology and inclusivity, the umbrella acronym LGBTQ+ is used throughout this thesis for people who identify as lesbian, gay, bisexual, transgender, queer, questioning, asexual, non-binary and other non-conforming genders or sexualities. It is recognised that current acronyms incorporate other members of the community more explicitly (for example LGBTQIA+), but for ease the LGBTQ+ acronym has been used.

Non-binary - This term refers to individuals who do not identify with either binary genders (eg male and female) or do not consistently identify with one binary gender at any given time.

Person-centred care - This term is used to denote an approach to providing care which is holistic, meets individual needs and is led or directed by the person receiving support through meeting personal preferences and wishes for care and support.

Service Users - This term refers to anyone who receives, is allocated, or requires support from formal or informal social care organisations and services. Although this is acknowledged to be a contentious term, it is used on occasion to identify which group is being referred to, in order to ensure the group remains distinct from service providers.

Service Providers - This term refers to any person or persons who are delivering any type of social care support, intervention, guidance or activities. Although not all participants were employed staff (as some were volunteers), it is used here to identify which group is being referred to throughout the thesis in order to be able to be distinct from service users.

Social care - This broad term is used to describe care and support with activities of daily living, wellbeing support, support for mental health conditions, tackling of loneliness and isolation, support with conditions which are not holistically supported within healthcare and any other support required in order for people to have levels of quality of life and be able to fulfil activities of daily living.

SCIE - This acronym refers to the Social Care Institute for Excellence.

Trans/Transgender - This term refers to those who present differently in their gender identity from the biological gender assigned at birth. This can include women who were born male at birth and vice versa. It makes no assumptions in relation to surgical procedures, physical health treatments or any other activity related to identifying as an alternative gender from that assigned at birth.

WHO - This acronym refers to the World Health Organisation.

1. Introduction

This chapter begins with an overview of the context, background, rationale and significance framing this study. It includes an introduction to relevant topics including ageing and sexuality, person-centred care, cultural competence and adult social care and LGBTQ+ people. Following this, the statement of purpose and accompanying research questions are introduced.

1.1 Rationale & Significance

The rationale for this study comes from a need to promote and understand inclusivity in relation to older LGBTQ+ people's experiences of community based social care. Increased understanding of why actions of inclusivity are important, how and whether they can be implemented and what further barriers there may be, are intended to contribute to wider evidence debates.

The significance of this research includes adding to the limited research in this area, where little is known or understood about community based and informal social care provision and the experiences of inclusivity for older LGBTQ+ individuals within these settings. Few studies have incorporated the perspectives of both older LGBTQ+ people and staff or volunteers working in the community.

1.2 Background & context

Effective health and social care support systems are fundamental to quality of life. In the United Kingdom (UK), there are structured frameworks for development and delivery of care and support. Care and support to live independent and fulfilling lives are considered a human right, valued by society, and subject to internal and external scrutiny. Much of the focus of social care systems within the UK is around promoting independence and avoiding the requirement for more intensive, personalised support (Willis et al 2022). By nature, these systems often deal with those that are classified as 'vulnerable', although this is a contested term (Burghardt 2013).

When any person develops a health or social care need, whether it be attributable to a physical or mental health problem, they are more likely to struggle with day-to-day life and in many cases will seek help and support. However, it is now well established that marginalised groups experience worse outcomes than the general population within the health and social care sector (Women & Equalities 2019, Mackenbach & Kunst 1997, Marmot 2001, Braveman 2006). Such inequalities are a strong focus of policy making.

Possible factors influencing these inequalities include: difficulty accessing support (Malzer 2013, Sandhu et al 2022); beliefs about how and when to seek help (Campbell & Long 2014, Shefer et al 2013, Lawrence et al 2006); expectations about the ways in which people will be treated (Bécares & Das-Munshi 2013); stereotypes and discrimination impacting on the perceived credibility of someone's symptoms or experiences (Shavers et al 2010); low levels of cultural competency, or adapting approaches to cultural differences (Troung et al 2014, Henderson et al 2018, Dauvrin & Lorant 2017); a dearth of relevant and applied research examining affected groups; decision making influenced by previous experiences or anxieties unrelated to the social care need itself; lack of available training and support for staff to understand different variables and identities and the relevance of those (Henderson et al 2018); the heterogeneous nature of marginalised groups (Hutchinson 2000); and a range of other factors.

For service providers attempting to deliver high quality care within a constrained system, this complexity poses some difficulties. It is challenging to ensure that local policy, service design and delivery is able to incorporate a wide population with diverse needs within often constrained funding, lack of preventative and advocacy-based support and growing numbers of older people requiring support (Humphries et al 2016). These challenges can be exacerbated for marginalised groups, where broader research and policy exploration show there are more likely to be poorer outcomes (Serrano-Amaya & González 2019). This is demonstrated in relation to LGBTQ+ communities in the Women & Equalities Committee report in 2019 which highlighted unequal access and negative experiences resulting in LGBTQ+ people with similar health and social care needs to the general population often being less healthy and not receiving the same levels of care (Women & Equalities Committee 2019).

Social care in the UK is effectively a quasi-market, with the majority being provided by organisations independent of Local Authorities, primarily within the private and voluntary sectors (Baxter et al 2019, Glasby 2017). For those services working within a context of systems trying to do more with less (Humphries et al 2016), there is pressure to prioritise what can be delivered in the most efficient ways to maximise capacity to meet increasing levels of need. This can result in inequalities and barriers within the system which, for some services, may be difficult to recognise or address.

Where these gaps exist, there may be a greater impact on marginalised communities relative to the general population. Where this then results in disengagement of populations or individuals, and the creation of unmet need, it can drive political and social action for change in working towards achieving more inclusive and effective services. It is complex to build a comprehensive understanding of the needs of all marginalised groups, and the fact that these groups are rarely homogenous further complicates efforts to address gaps effectively (Hutchinson 2000).

AgeUK (2022) estimates that 12% of people aged 50+ (2.6 million people) have at least one unmet care need and that nearly 40,000 older people died before receiving the care they had requested in 2020/2021. ADASS (Association of Directors of Adult Social Services) reported that 6 in 10 Local Authorities are currently only able to assess serious safeguarding and hospital discharge, demonstrating the enormous strain on health and social care systems within the UK (AgeUK 2022). Problems with access and availability of healthcare and residential care for both older people and marginalised groups are reasonably well understood (Goins et al 2005, AgeUK 2022, Jo, Kruger & Tennant 2021, Osborn et al 2014, Westwood et al 2020, Westwood 2016) although this is less true for domiciliary care, community based, and informal provision.

Evidence demonstrates that if people do not access social care support when needed, this can lead to loss of independence (Curry 2006, Bimou et al 2021), greater risk of hospital admission (Mortimer & Green 2015, The Kings Fund 2010, SCIE 2022, Thorlby et al 2018) and greater use of primary care services (Mortimer & Green 2015, The Kings Fund 2010, Thorlby et al 2018). These outcomes represent an economic burden for families, individuals and services such as primary and secondary care, providing a policy imperative to ensure that access to early, preventative, informal types of support is facilitated, available and accessible (Caiels et al 2010). The avoidance of seeking care and exacerbation of already existing problems can be seen particularly for the LGBTQ+ population (Lick et al 2013, Facione & Facione 2007, Li et al 2015). It is known that LGBTQ+ people are more likely to be economically disadvantaged (Uhrig 2015). Poor quality services and difficulty in securing access to appropriate services and support can also disproportionately affect those in lower socio-economic groups, potentially resulting in multiple external disadvantages (Kings Fund 2021, Marmot 2018).

The challenges around accessing community-based care are not well explored or understood from either the provider or service user perspective (Hughes et al 2011, Tinker et al 2014). Much research in this area is focused on specific services, interventions, or groups, rather than considering the wider arena of community-based care and support or how these need to be navigated (Funk 2019). International differences in the systems and structures of social care delivery also further complicates identifying generalisable findings. However, within the UK and even specifically within England, research on barriers can remain localised and specific. It can be challenging to apply findings in different contexts.

Quality of social care provision and support, access to services and the impact on outcomes is an area of wide and constantly evolving research. A rapidly ageing population, with the number of people over the age of 85 in the UK predicted to double over the next 25 years, will have a range of effects (The Health Foundation 2021). The likely increasing demand on health and social care systems, increasing legal, social and political pressure to provide equitable and inclusive services and acknowledged financial challenges in services are outlined in substantial evidence in the UK and internationally (Kings Fund 2016, Smalley et al 2018). A concerted effort has been made in more recent policy and strategy research to understand the changing needs and pressures of the health and care system to ensure funding, workforce and patterns of service delivery match the requirements of the changing demographics in the UK (Raymond et al 2021).

There has been increasing interest in understanding equality and inclusivity for marginalised groups, including LGBTQ+ issues in both UK based and international research and policy development (Serrano-Amaya & González 2019), much of it with a focus on the social elements of being part of this group. There have been concerted efforts internationally to design and implement policies and strategies that serve to bolster or improve the rights and equal treatment of LGBTQ+ populations (Serrano-Amaya & González 2019, European Commission 2015, UN 2013, Women & Equalities Committee 2019). These programmes and strategic efforts to raise the standards and access/uptake of care for people who are part of the LGBTQ+ community have come alongside historic developments for the rights of LGBTQ+ people more broadly.

1.2.1 Ageing & Sexuality

Identity associated with ageing and the crossover with sexuality and sexual identity, are relevant considerations for services. However, individual identities are by their nature complex, and the ways in which older people perceive and centre their own ageing identity will be multiple. Variables, such as the way a person perceives where old age starts, their own position in that timeline and the types and severity of their health conditions will influence how they feel about ageing (Demakakos et al 2007, Bowling et al 2005). Age-identity can be viewed as a dimension of self-concept (George, Mutran & Pennybacker 1980). This means that approaches to support require broad consideration beyond assumptions that a specific age denotes a requirement for specific support. In a similar way, assumptions around approaches preferred by the multiple individuals and constituencies within the LGBTQ+ population complicate this further.

A range of aspects of experience may impact on perceived quality of life for older people (Kelley-Gillespie 2009, Borglin et al 2005, Netuveli & Blane 2008, Walker 2005(1)). These can include social, physical, psychological, cognitive, spiritual, and environmental wellbeing, which are multi-dimensional. A range of both objective and subjective factors such as social contact, levels of dependency, health status, material circumstances and social comparisons can all be used by older people as measures of quality of life (Netuveli & Blane 2008). Service providers must engage effectively with each individual person and the above factors to accurately understand how they view themselves, which parts of their identity they view as relevant and the ways in which support can be provided to maintain their identity. At best, this may be meeting a person’s needs effectively while validating who they feel they are, and at minimum, meeting their needs without causing additional harm.

An inability to express sexual identity can impact on self-worth, social relationships and mental health (Hodson & Skeen 1994, Hajjar & Kamel 2003). For many older people, sexuality, sexual expression and sexual identity form part of their self-image and social lives, contributing to quality of life more broadly. Attitudes towards ageing and sexuality have been subject to extensive research over the last two decades, with stereotypes around the ‘asexuality’ of older people considered pervasive (Dominguez & Barbagallo 2016, Gott 2005, Bauer et al 2007, Bouman et al 2007). Mulley (2007) notes that in almost all portrayals of older people from media, literature and art to birthday cards and road traffic signs, there is a pervading reinforcement of negative stereotypes linked to older people. However, evidence suggests older people are just as likely to express sexual identity (Nay, 2004, Gott 2005) demonstrating the inaccuracy of these stereotypes.

As seen in Foucault (1979) & Weeks (1985), the ways in which we define sexuality and sexual identity result in beliefs about good and bad, or in the case of older people, appropriate or inappropriate behaviours. The impact of ageist attitudes towards older people being sexual beings is felt to encourage the belief that them expressing sexuality is abnormal (Hafford-Letchfield 2008, Willis et al 2016, Simpson et al 2015). Gott (2005) notes that although sexuality has become more visible, it is assumed only the privilege of the young and physically fit (Minichiello et al 2005) to the extent that even at a research and policy level, sexuality is not seen as relevant in older age, subsequently becoming a naturalised fact (Gott 2005). This belief can be seen to be influencing policy through the exclusion of sexuality from older people's policy, and the exclusion of older people from sexuality policy (Taylor & Gosney 2011, Bouman et al 2007).

A potential impact of the stereotypes around older people and sexual expression is how this may then influence beliefs around the importance of sexual identity for older people. Despite the relative asexualisation of older people, there continues to be evidence that being able to express one's sexual identity, regardless of age, is important to feelings of wellbeing (Bouman et al 2007). It is important to consider how the presence or absence of opportunities for expression of sexual identity may impact on individual people's experiences within support services, but particularly for those who are both older and LGBTQ+.

1.2.2 Social Care & LGBTQ+ People

LGBTQ+ rights in the UK have changed substantially and significantly in the last 20-30 years (Gray 2023). Understanding and acceptance have become more commonplace, and legal rights and protections have improved in support of the LGBTQ+ community. However, this progression could be considered unstable when considering current complexities around the validity and acceptance of transgender communities (University of Law 2023). A move towards better equality and inclusion has become a 'workstream' for many organisations, including health and social care, although many inequalities still exist.

The LGBTQ+ population are more likely to need formal and informal services, and there is a higher likelihood of poorer health and mental health outcomes (Fredriksen-Goldsen et al 2013, Fredriksen-Goldsen et al 2017, Henderson & Almack 2016, Wallace et al 2011). A Parliamentary Report 'Health, Social Care & LGBT communities' (Women & Equalities Committee, 2019), identified a misaligned professional focus and unhelpful conflation between LGBTQ+ affirming and appropriate care and sexual health. Practitioners were found to assume that LGBTQ+ affirming care was being demonstrated through access and referral to sexual health, but LGBTQ+ identity was not necessarily being considered in the delivery of any other kind of care. The report concluded that LGBTQ+ people need to be treated equally but not identically to others, with a recognition that this may include specialised or focused approaches beyond sexual health.

Discrimination and its impact on those who have protected characteristics is well documented within LGBTQ+ research. 'Minority Stress', the theory that members of marginalised groups face additional stress because of the discrimination they face over time, is generally recognised as having both a physical and mental impact (Abbruzzese and Simon 2018, Correro & Neilson 2019, Fish and Weis 2019, Anderson-Carpenter et al 2019, Donisi et al 2019, Mankowski et al 2019). Factors such as lack of social support (or lack of social capital), experience of negative treatment such as prejudice, and low socioeconomic status are argued to affect these groups, resulting in stress responses for individuals which accumulate over time.

There are potential links between minority stress, depression, self-harm, drug and alcohol misuse, obesity and a range of other mental and physical conditions and diseases (Witten & Eyler 2012, Williams 2013). In line with these findings, demographic data shows that in general, LGBTQ+ people are more likely to live alone, less likely to have children and are less likely to see family members on a regular basis or have family support networks to call on (Stonewall 2011). Although this will not be true for all members of the LGBTQ+ community, it is important to consider how these factors may put them at greater risk of social isolation, and in turn have a greater need to access support.

A Stonewall (2011) survey found gay and bisexual men over the age of 55 were three times more likely to be single than their heterosexual counterparts. The higher likelihood of being single becomes more relevant when considering the problematic reliance within the social care system in the UK on unpaid/family carers. The most recent census data demonstrates that 72.5% of those identifying as LGBTQ+ have never been married/in a civil partnership (ONS 2022[2]). Many older LGBTQ+ people are caring for a partner without additional support because care cannot be shared with wider family, which potentially results in higher levels of reliance on formal and informal social care (Stonewall 2011).

While not all those without children will be LGBTQ+, AWOC (Ageing without Children) found that 90% of older LGBTQ+ people do not have children and those ageing without children are more likely to use formal care services. Higher likelihood of using residential care at an earlier age and with lower levels of dependence, and challenges relating to navigation of care, often done by adult children, were also features of ageing without children (AWOC, 2019). Single people ageing without children, especially single men, are at a higher level of disadvantage in accessing unpaid care and informal support compared to those with a partner. They are more likely to live in institutional care, be caring for elderly parents and in general have worse health and health behaviours and higher mortality rates than those with children (AWOC, 2019).

Being LGBTQ+ and single in later life is also linked to lower levels of social support and financial security, with negative outcomes such as elevated social isolation, poorer mental health, cognitive impairment, and even premature death (Czaja et al 2016, Sagie 2015, Fredriksen-Goldsen et al 2011). There is a recognised correlation between social isolation and lower quality of life, adverse health outcomes, cognitive decline and mortality (Aylaz et al 2012, Ellis & Hickie 2001, Fratilioni et al 2000, Shankar et al 2013, Steptoe et al 2013). Thus LGBTQ+ older individuals may be more likely to require early social support to avoid losing independence and social isolation.

There are specific nuances for the LGBTQ+ community in interacting with support, including the ability to control disclosure according to the context of the situation (Simpson et al 2018, Malterud & Bjorkman 2016). Sharing or withholding information about sexual identity has impacts on both the individual and the service. Research has demonstrated that if LGBTQ+ people feel unable to disclose their sexual identity it can impact on them in negative ways, damaging confidence and self-esteem (Langley 2001, Boule et al 2020, Brennan 2021, Pachankis et al 2020, van der Star et al 2019, Walch et al 2016, Williams et al 2017, Zuckerman 1998).

Visibility of the LGBTQ+ population within services can impact on the level of importance placed on sexual identity, which can result in failure to recognise the distinct needs of the LGBTQ+ individuals (Fish 2009, Simpson et al 2018). The need to understand factors which influence decision making about accessing services and how services can respond to instigate changes to perceptions and experiences seems pressing.

1.2.3 Person-Centred Care

A key feature of social care delivery in the UK over the last two decades, there has been a drive to move towards person-centred care. The term ‘person-centred care’ originated as a concept within psychological therapies in the United States of America in the 1950s through the work of Carl Rogers and was further developed by George Engel in the 1970s as part of the development of the biopsychosocial model of health (Latimer et al 2017). In 2000 the NHS in the UK added it as a core principle (DH 2000) and in 2010 it was a key principle in ‘A vision for adult social care’ (DH 2010). It has subsequently been a feature of a range of policies and approaches to working with people who require some element of care (Latimer et al 2017, Needham & Glasby 2014) and is a key principle of the Care Act (2014) (SCIE 2023).

Within social care, person-centred care originally focused on specific groups such as people with learning disabilities, to consider how these groups could be supported in a way that worked for them as individuals. The adoption of person-centred approaches has led to the development of policies and frameworks such as self-directed support, where the allocation and spending of money on support is based on the hopes and needs of the individual rather than a formula for support facilitated through block contracting to service providers for generic support packages (Latimer et al 2017).

The term person-centred care is complex with no definitive description or common model in use, partly because there is unlikely to be a common model which fits every population (Wilberforce et al 2017). Ways of thinking and doing things where people are considered equal partners in planning, developing and monitoring care to ensure it meets needs are considered to be the main features of good person-centred care (Latimer et al 2017). There are a range of attributes which are potentially required to deliver person-centred care, including ways to understand the person, to engage them in decision making, and through promoting the care relationship (Wilberforce et al 2017). Assumptions can be made that person-centred care indicates high quality, responsive and flexible support (Wilberforce et al 2017) and it is associated with improved outcomes (Robinsom et al 2008, Stewart et al 2000). It is also often recognised as lacking, when things go wrong (Francis 2013).

A significant challenge for services in having no concrete or widely accepted definition of person-centred care is that it remains open to interpretation for both those delivering and receiving care. For some, simple adaptations to approaches can result in care being experienced in a more person-centred way. For example, a person who has set routines, or preferences around what they eat and when, may feel that changes to a standard care package to meet these requirements/wishes results in a more effective level of support. For those with religious needs, the ability for care and support to be amended to meet those specific needs may be vital in them accepting care in the first place and feeling valued within that.

There are a range of best practice guidelines which include principles of promoting identity, inclusion, attachment, comfort and occupation (Wade & House 2022, Kitwood 1997, Clissett et al 2013). The National Institute for Health and Care Excellence [NICE] and the Social Care Institute for Excellence [SCIE] have guidelines which support the idea that spiritual needs may be just as important as meeting physical/clinical needs, demonstrating the holistic approach needed to truly feel supported (Wade & House 2021). This recognition of the wider elements and factors that may influence a person’s individual experience, behaviours and the effectiveness of care, show that in some areas of treatment and support, a holistic approach is felt to offer the best outcomes.

Many barriers to delivering person-centred care are identified by health and care workers including: capacity; training; systems which actively discourage these approaches; the context of the service; beliefs and cultural practices; and a lack of understanding of the value of considering other facets of a person’s life when planning social care support (Needham & Glasby 2014, McCormack 2004, McCance et al 2009, Bolster & Manias 2010). Although there are examples of innovative frontline work in health and social care, this can be hindered by structural obstacles such as bureaucracy and a lack of service-user led initiatives (Innes et al 2006). A lack of information related to access and lack of cultural understanding, often inherent within services, can lead to barriers for minoritised groups (Innes et al 2006).

Although staff may be focused on providing affirming care to the LGBTQ+ population, sparse understanding of specific concerns and lack of connections to specialist support or resources impact on the ability to do so (Donaldson & Vacha-Haase 2016). Meeting needs effectively requires health and care delivery systems which are inclusive at all points of contact (Roe & Galvin 2021). Moving from a biomedical to biopsychosocial holistic assessment, considering the context of lived experience, developing clear markers of inclusivity and training staff to utilise communication more effectively may be more achievable (Hewa & Hetherington 1995, Roe & Galvin 2021, MacDonnell & Daley 2015).

One of the unknown or little understood elements of this type of care is whether services and staff consider the context of a person’s life story, and how this then impacts on how people are treated, and experiences within that. There is a burgeoning field of research and guidance related to, for example, how social workers implement and embed person-centred approaches into the work they do (Willis et al 2022), but much less is known or understood about what community social practitioners do.

Further consideration should also be given to the ways in which person-centred approaches are understood and implemented. Because of the lack of a universal understanding of the principles and implementation of person-centred models of care, this can mean that the ways it is conceptualised is varied across contexts and settings (Waters & Buchanan 2017). Additionally, it may lead to organisations assuming that where methods of care delivery have worked effectively for a member of a particular group eg LGBTQ+, that this will be replicable across that group, resulting in a move away from a personalised approach because of an assumption that commonalities in identity result in commonalities of solution or approach. It may also discourage flexibility in service delivery through following a process of assessment which is time specific and therefore becomes unsuitable when needs change.

Additionally, it should be considered that there are a range of challenges associated with understanding and applying person-centred principles in social care settings. For example; giving a person choice and control relies to an extent on cognitive capacity; empowering self-determination and making choices may be dependent on a provider’s capacity to implement decisions which they may perceive as negative or indeed actually be unsafe;

relationships between a provider and person require shared responsibility for nurturing them; social inclusion and citizenship may not be a primary requirement for all individuals although generally accepted as a key component of person-centred care; and focusing on strength based approaches within person-centred care approaches requires staff to retain positivity and act in sustainable person-centred ways (Waters & Buchanan 2017).

1.2.4 Cultural Competence

Similar to the foundations of person-centred care, in that it is usually formulated through an approach to the individual, cultural competence focuses on adaptation of care according to the culture of the person (Purnell 2002). Culture, in this context, includes attention to marginalised groups such as LGBTQ+ communities. The importance of culturally compassionate care was bolstered by the Francis Report (Francis 2013, Papadopoulos et al 2016). Models focus on cultural identity and the ways in which this might impact on how care is delivered, how it is experienced and how it can avoid causing undue distress, which may be more likely for marginalised communities where culture is less well understood.

As with definitions of person-centred care, ways to define and operationalise cultural competence also vary and often benefit from greater situational context. There are three key elements which feature in many cultural competence models: cultural skills, awareness and knowledge (Alizadeh & Chavan 2016). For services who are working to promote cultural competence, the limited clarity of definition and ways to measure and evaluate can be challenging (Papadopoulos et al 2008). Contexts such as society, community, family and the individual can all impact on the reach of a culturally competent model of care (Purnell 2002).

Broad focus is required on areas including communication, heritage, spirituality, nutrition, workforce, healthcare, family, high risk behaviours, and death rituals, which can all impact on how care should be delivered (Purnell 2002). Domains such as nutrition become relevant, when considered contextually, as the rituals/behaviours/impact of these can have fundamental effects on both how support is delivered and received or experienced (Purnell 2002). Particularly for ageing LGBTQ+ populations, communication, heritage, family, high risk behaviours and even death rituals are likely to be highly relevant when considered alongside identity, lifestyle, and the impact of historic mistreatment or discrimination.

Studies have found a link between cultural competence and service user satisfaction (Alizadeh & Chavan 2016, Govere & Govere 2016), and reductions in health disparities (Kirmayer 2012), although this a relatively sparsely researched area at the current time. There are also studies which link lack of culturally competent care to poor patient outcomes and health disparities (Lehman et al 2012). There are a range of challenges in implementing cultural competence because of the lack of both definition and measurement frameworks currently in place.

An overall strategy that reduces disparities and inequalities through attempts to address discrimination is often required to embed cultural competence (Brach & Fraser 2000). Many services are structured to cater for the normative expectations of the majority e.g., those who are heterosexual, white, non-disabled, with access to familial support, in the case of social care for older people. Building understanding, acceptance, and recognition of difference can lead to cultural competence (Brach & Fraser 2000). However, current research shows that many organisations and staff have not had training or support focused on the skills required to deliver culturally competent care (Nowaskie et al 2018, Bell et al 2010, Greene et al 2018).

The ability of services to deliver culturally competent care will be impacted by a multitude of factors including the importance an individual might place on different aspects of their identity and how this impacts on their preferences for support (Tieu et al 2022, Smith et al 2022, Schilder et al 2001). Levels of staff understanding and attitudes, the practicalities of meeting individual needs in a broader service setting, levels of disclosure about identity, and guidance available to services locally will all influence providers' efforts to deliver culturally competent care (Renzaho et al 2013). Further complexities exist when considering the intersections between different identities, and what this may mean for services and staff’s ability to manage different beliefs and identities within a single service.

Cultural competency models are not universally accepted as being effective for a range of reasons. Beagen (2018) argues that the model has notable conceptual limitations including that culture becomes reduced to race and ethnicity, is considered as unchanging, and it places professionals/staff as the conduits of power without considering that these professionals may also be marginalised despite their relative power. There are questions around cultural competency frameworks' ability to address structural problems (Danso 2018), and a risk that interpretations can result in tokenistic approaches to addressing diversity (Furlong & Wight 2011).

Lekas et al (2020) argue that cultural humility, where care is oriented more towards self-reflexivity, continuous openness to learning and appreciation of lived experience, addresses some of the shortcomings of cultural competency models. They conclude that the model is cognisant of changing systems of beliefs and values, more resistant to stereotyping of groups or individuals, and mindful of intersectionality (Lekas et al 2020). Other explorations of cultural humility conclude it focuses more on accountability, critical reflection and lifelong learning, with both intrapersonal and interpersonal components (Hook 2014, Fisher-Borne et al 2015). Ortega & Faller (2011) state that a strength of cultural humility is its ability to allow practitioners to develop better understanding of individuals without needing a detailed knowledge of other cultures, which may be stereotyped or bounded.

However, Danso (2018) argues that although perhaps more politically correct and semantically appealing, attempts to move to a cultural humility model do not necessarily offer practice advantages. There is a lack of conceptual clarity, which can make it difficult for practitioners to know whether they are being effectively culturally humble, and practising cultural humility can be challenging when core values or worldviews conflict (Foronda et al 2016, Hook 2014). It is sometimes unclear how the concept can be operationalised and there is an assumption that cultural humility translates to respect for diversity without acknowledging that this may need to be intentionally developed (Ridley et al 2001, Hester 2012). Additionally, cultural humility models tend to focus on micro-level practices, which might mean macro-structural issues are not addressed (Danso 2018). These challenges demonstrate the variable understanding and application of both cultural competence and cultural humility models.

1.3 Summary

The current generation of older LGBTQ+ people have had their identity questioned in law and society and may have experienced significant discrimination across their lives. As ageing often results in greater need for support, the willingness and ability to access appropriate support is impacted by previous experiences and associated expectations of discrimination. This anxiety about accessing support and feeling safe within that may lead to less engagement with services, or greater use of other kinds of services, which may or may not be appropriate or effective in meeting particular needs. It may also result in unmet needs and possible exacerbation of other social and mental health needs.

It is likely that older LGBTQ+ people are more likely to have social care needs and need social care support in older age. There are various factors contributing to experiences within service provision and despite many providers being engaged with the idea of providing inclusive support, a lack of understanding of the relevance of sexual identity has been found in a range of studies.

Formal service provision often has systemic frameworks which function within normative constructs, making it complex to consider person-centred approaches. The evidence suggests the values and benefits of person-centred care can sometimes be easier to articulate than to deliver and the frameworks necessary to encourage this kind of approach are seen as complex to change. However, the drive to make these changes is generally recognised as positive, regardless of the complexity of barriers.

The importance of sexual identity and expression can often be negated in research, particularly for older people and this can also be true for service provision itself. Although many practical reasons for this exist, the impact on those using services can be detrimental to health and wellbeing. It is vital to build understanding of both the reasons as well as the solutions. Where services and groups are less formal in structure and lack recognised training programmes, the problems associated with trying to address inclusivity may be even greater, although this has not been fully explored. The potential lack of drivers to meet the needs of a minority population and minimise unintentional discrimination becomes more relevant for informal, community based services.

There is limited evidence about what needs to change, why and how within community based social care, particularly those settings which could be classified as preventative, low level, and informal, such as social clubs or interest groups. This research aims to consider more informal settings from both a service user and service provider perspective, in order to understand the importance, impact and actions that may serve to make experiences within this type of support inclusive and person-centred for older LGBTQ+ people.

1.4 Statement of Purpose & Research Questions

The purpose of this study is to explore the experiences and preferences of older LGBTQ+ people who use community based social care (or may use them in the future) with regard to the inclusivity of these services. It will also explore the experiences and perspectives of service providers in the context of what older LGBTQ+ people say about their experiences to better understand and address the barriers service providers face in implementing change.

To provide this understanding the following research questions are addressed:

1. What are the experiences and factors which affect choosing and accessing community based social care for older LGBTQ+ people, to meet assessed or self-identified social care needs?
2. What are the service characteristics that influence the perception of older LGBTQ+ people in their assessment of cultural competence and inclusivity in community social care settings?
3. What are the perceptions of service providers of the views of the LGBTQ+ community and how do they currently try to address diversity?
4. In what ways might services be able to further address concerns raised within the research, how can these be more effectively implemented and what barriers exist?

1.5 Theoretical Frameworks & key concepts

A range of theoretical frameworks and key concepts are considered throughout the thesis. These are discussed in more detail in Chapter 3, but a brief overview is provided here for context. Consideration of theoretical frameworks contributes to recognising underlying assumptions and contextualising findings and conclusions. Several factors will influence drawing conclusions from the data in the thesis, including identity, both personal and more widely, discrimination and its effects, and social structures. This is likely to include both LGBTQ+ and ageing identity, the identity and conduct of services and staff and the systems they work within.

Critical Theory provides a potential basis for considering how data is collected, analysed, and conclusions drawn advocating for reform for both individuals and broader social structures, empowering those who are marginalised by centralising their voices. It assumes that research is focused on the reform needed to change social structures, based on fairness, freedom and equality (Denzin & Lincoln 2000). Within the context of this research, Critical Theory assumes there are inequalities in the system delivering social care for marginalised groups, mirroring those found in wider society. It argues that through utilising those marginalised voices as a central guiding principle for change, it will be more meaningful and effective.

Social Identity Theory seeks to explain how individuals come to describe themselves, and how they come to be described by others through their membership of social groups. This theory states that to be able to build an understanding of individuals and their responses, it is crucial to consider what factors influence how they might feel about themselves. It provides a framework for considering factors which may influence analysis and conclusions from both a personal and structural perspective. Each individual participant will have both personal and structural influences on their experiences, and where Critical Theory may offer a broad basis for understanding and influencing change, Social Identity Theory helps to capture that on a more individual level.

Chapter 3 also provides further discussion around other relevant theories which seek to describe the structural pressures which may impact on older LGBTQ+ people. These include Minority Stress Theory, which argues that members of marginalised groups face additional stress because of the discrimination they face over time (Abbruzzese & Simon 2018, Correro & Neilson 2019, Fish & Weis 2019). The impact of these stressors may subsequently impact on identity construction and is therefore relevant within this research.

2. Literature Scoping Review

2.1 Introduction

In order to appropriately formulate research questions for the intended area of study, it was necessary to explore what is already known and understood about the relevant participant groups more widely and in the context of community services. This helps to ascertain gaps in research, as well as giving context and focus to the conduct of the research.

A scoping review was conducted, a type of literature review suited to looking at qualitative research (Arksey & O’Malley 2005). It was felt this would provide a systematic approach to identifying and analysing relevant literature. Scoping reviews allow for a comprehensive view of the field of research, as well as helping to identify gaps in understanding. They can also help when considering research conduct in studies of interest and can clarify concepts identified within other research to contribute to the design of this study (Munn et al 2018). The scoping review facilitated analytical interpretation of the literature without the need to assess the quality of the studies or limit the study design methodology included in the scoping review which otherwise met the inclusion criteria (Levac et al 2010).

This scoping review focused on research looking at the provision and experiences of social care services for older LGBTQ+ people, including research that sought to explore or review key themes, factors and experiences, identified by older LGBTQ+ people themselves or those who provided services. Literature included empirical research in relation to the considerations, experiences and challenges for this wider group in using and accessing social care and particularly within community-based services.

2.2 Questions leading the review

Three main research questions led the review:

- What is known about the factors influencing older LGBTQ+ people’s experiences of inclusivity in community based social care?
- What is known about the cultural competence of community based social care services in meeting older LGBTQ+ people’s needs?
- What research gaps are identified?

2.3 Methods

A scoping review was undertaken to allow consideration of a wide range of topics, rather than being limited to narrowly defined research (Arksey & O’Malley 2005, Manthorpe et al 2010). This allowed for studies to be selected focused on their relevance as opposed to design or quality, resulting in a broader overview of the literature in the area (Abendstern et al 2017). This is pertinent when considering the nature of the topic being looked at, as it allowed for consideration of qualitative studies which may not have utilised systematic methodology but still included relevant findings.

The six stage methodological framework (Arksey & O'Malley 2005) of identifying a research question, selecting relevant studies, collating and summarising these and reporting results suited the diverse nature of studies in the field and allowed for wide research questions, ultimately leading to a broader overview of the field of study. This was appropriate as LGBTQ+ and social care studies is an emerging rather than established field, where systematic methodologies may be less common (Colquhoun et al 2014). The ability to rapidly identify key concepts and sources of evidence in an area of study not fully reviewed previously was felt to be helpful in designing and finalising research questions.

2.3.1 Identification of relevant studies

Search Strategy

The search involved computerised searching of the databases Web of Science, Proquest* (*multiple database search) and ASSIA during May 2020, with secondary checks of newly published research in October 2020, December 2021 and November 2023.

The search strategy comprised of three dimensions:

- LGBT - the search terms included Lesbian, Gay, Bisexual, Homosexual, Queer, LGBT* & Transgender
- Older people - the search terms included Older, elderly, ageing*, geriatric & senior
- Community support - the search terms included "Social Care", domiciliary* care, day services. homecare, day care, "Social capital", peer support, voluntary, "community care", "community services", "community based" & charity.

These three broad terms were combined using Boolean operators into a final search. An example of this can be found below in *Table 2.C*. An overview of search results can be viewed at *Appendix 1*.

Search engine	**Row 1**	**Row 2**	**Row 3**	**Row 4**	**Number of results**
Web of Science	Lesbian OR Gay OR Bisexual OR Homosexual OR Queer OR LGBT* OR Transgender	Older OR elderly OR ageing* OR geriatric OR senior	(Community NEAR/3 services) OR (Community NEAR/3 provision)	NOT HIV OR AIDS	18

Table 2.1: Example of search term construction

Study selection

Following the completed searches, selection of studies was undertaken by title, then abstract, followed by consideration of full text, applying the inclusion/exclusion criteria at each stage, shown in *Table 2.2.*

	Inclusion criteria	***Exclusion criteria***
Study design	Qualitative Quantitative Mixed methods	Non-empirical Intervention based studies Healthcare services or interventions

Study participants	Older (50+) LGBTQ+ people Staff or carers of older LGBTQ+ people	Younger people Children Non-LGBTQ+ people
Study focus	Older LGBTQ+ people's experiences in relation to accessing and using community-based services and/or social care and support services. Staff experiences working in community-based services in relation to supporting LGBTQ+ older people	HIV/AIDS/Sexual health specific services Healthcare specific services Intersectionality People with learning difficulties
Date	Any up to 30th November 2023	None
Publication type	Peer reviewed journals Conference proceedings if article not available	Narrative articles Discussion/opinion pieces Books & chapters
Language	Any language if English version available	Any articles not translated into English

Table 2.2: Inclusion & Exclusion criteria

2.4 Results

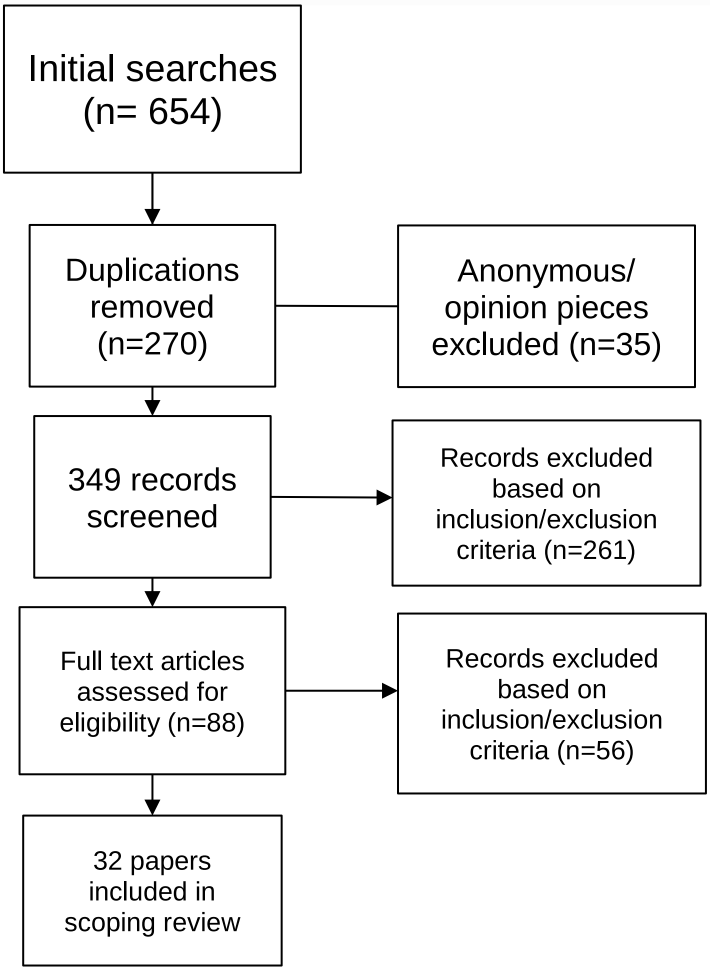

Table 2.3: Flow diagram of searches

Stage 1

Stage one involved undertaking database searches of Web of Science, Proquest* (*multiple database search) and ASSIA. A total of 654 results were identified from the search strategy. De-duplication resulted in 384 unique papers. Anonymous or opinion pieces from magazines/blogs/websites were removed at this stage as per the inclusion/exclusion criteria. This resulted in 133 (Web of Science) and 216 (Proquest/ASSIA) outputs being taken through to Stage 2.

Further articles identified through hand searching using Google Scholar as opposed to individual databases were also included where they met the inclusion criteria. This generated one further reference. Where studies had included secondary data analysis or interpretation/theorisation of sections of other research, the original source of the data was also considered for inclusion. This did not result in any additions to the final studies analysed. See *Appendix 1* for an overview of database search results, *Appendix 2* for full search results and *Appendix 3* for database searches with 0 results.

Stage 2

In stage two all 349 titles and abstracts were reviewed utilising the inclusion/exclusion criteria (see *Table 2.2* for further detail). Reviews of books or chapters were removed as these did not offer direct feedback from LGBTQ+ people or staff, but rather focused on second hand interpretations and critical review of studies which may or may not have been within the remit of the review. Studies pertaining to housing, healthcare or condition-specific (e.g. HIV or cancer) and healthcare interventions were excluded as these did not generally focus on the everyday lived experiences of community based social care or the factors that might make a service feel more or less inclusive, but tended to focus on the outcome of a specific action. Additionally, intervention based studies more generally were excluded for similar reasons. Studies focused on specific topics such as Transgender women of colour, autistic traits of Transgender people, racial and socioeconomic inequities etc were excluded because these were outside the remit of the review. Where the empirical research was new analysis of secondary qualitative data, these were included where the original data collection met the inclusion criteria. Those that did not include empirical research, or where the empirical research was based on the outcomes of interventions such as drug trials or experimental approaches, or were not relevant to the topic, were not included in the final analysis.

Where studies included reference to potentially relevant areas (e.g. community based services or social care services) within the introduction but did not explore these further, these were considered and in some cases referenced within the introduction or discussion, but not included in the final scoping review results.

This resulted in 88 studies being considered for inclusion, and following final exclusions according to the inclusion/exclusion criteria, the SPIDER tool was employed to standardise the search strategy (Cooke, Smith & Booth, 2012). The SPIDER tool was utilised as; it is better suited to focusing on qualitative and mixed methods studies; a direct comparison of findings was not required; much of the qualitative research did not include outcomes which would be classified as observable; and the research questions were broad.

This meant the search would be better managed using SPIDER than other alternatives. The more widely used PICO, a model based on Population, Intervention, Comparator and Outcome, is more likely to retrieve references to quantitative research, and the comparison component is not usually part of qualitative research (Cooke, Smith & Booth, 2012). Although the review was carried out using the principles of a systematic review, it followed scoping review methodology more closely and therefore utilisation of the SPIDER tool was felt to be more appropriate to be used as part of the search strategy. A description of the SPIDER tool can be found below in *Table 2.4*. A copy of the SPIDER analysis of papers can be found at *Appendix 4*.

Sample	Can account for a range of sample sizes, more suited to qualitative research which may have low numbers of participants or not be generalisable to larger populations
Phenomenon of Interest	Qualitative research aims to understand the how and why of certain behaviours, decisions of individuals. A phenomenon of interest therefore explores the reasons for behaviour or decisions rather than focussing on interventions.
Design	Design or methodology of the research e.g. interviews, surveys or focus groups. As inferential statistics are absent in qualitative research, details of the study design may assist in making decisions about the robustness of the study or analysis.
Evaluation	The outcome measures being used within the research. Qualitative research, like quantitative research methods, is concerned with outcome measures. These will differ depending on the research question and may include more unobservable and subjective constructs when compared to quantitative research (e.g. attitudes and views).
Research type	Whether the research is qualitative, quantitative and/or mixed methods

Table 2.4: Description of SPIDER analysis tool used (Cooke, Smith & Booth, 2012)

The SPIDER tool was used to capture the Sample, Phenomenon of Interest, Design, Evaluation & Research type which allowed for categorising and a description of the sample to be collated. 32 papers were taken forward for inclusion in the scoping review. A copy of the SPIDER analysis for included papers can be found at *Appendix 4*.

Following this, a thematic analysis (Braun & Clark, 2006) was undertaken with all 32 papers, leading to themes and subthemes discussed in the Findings section below, A copy of the coding applied to included papers can be found at *Appendix 5*. *Table 2.5* gives a summary overview of the papers included in the final review.

Reference	**Research paradigm**	**Sample size & type**	**Method of data collection**	**(Country of Origin) Focus**
Smith & Wright (2021)	Systematic Review	7 studies involving 169 participants, 106 lesbian women, 58 gay men, 5 bisexual, median age 60+	Systematic review	(UK) Experiences & perceptions of home care services
Alba et al (2020)	Quantitative	230 lesbians, 503 gay men 60+yrs	Survey	(Australia) LGBTI caregiving
Boule et al (2020)	Qualitative	21 gay, lesbian, trans & queer adults 60-79 yrs	Semi-structured focus groups	(Canada) Identifying perceived care & support needs
Grant & Walker (2020)	Qualitative	13 lesbians 55+yrs	Interviews	(Tasmania) Barriers/enablers for healthy ageing
Lof & Olaison (2020)	Qualitative	5 bi/lesbian women, 5 bi/gay men, 5 trans 70-81 yrs	Interviews	(Sweden) Important aspects of inclusion in elder care
Lottmann (2020)	Qualitative	3 lesbians, 3 gay men, 1 trans, 1 intersex 59-92 yrs	Secondary data analysis of interviews	(Germany) How sexuality can be respected in elderly care
Lottmann & King (2020)	Mixed methods	175 self-identified LGBT people 50+yrs	Survey & Focus groups	(UK) Social capital & networks
Hoekstra-Pijpers (2020)	Mixed methods	115 LGBT people 65+yrs, in receipt of social care	Survey & interviews	(Netherlands) Understanding experiences of care & links to history/identity
Siverskog & Bromseth (2019)	Qualitative	33 self-identified LGBTQ adults 59-94yrs	Interviews	(Sweden) Meaning of community, belonging

Reference	**Research paradigm**	**Sample size & type**	**Method of data collection**	**(Country of Origin)** **Focus**
Waling et al (2019)	Qualitative	19 lesbians, 14 gay men 60-70yrs	Interviews	(Australia) Perceptions & experiences of social care
Butler (2018)	Qualitative	20 lesbians 65+yrs using social care	Interviews	(United States) Experiences of in-home social care
Jones et al (2018)	Qualitative	12 bisexual people 50+yrs	Interviews	(UK) Ageing, bisexuality & social care
Simpson et al (2018)	Quantitative	187 care staff & managers	Survey	(UK) Attitudes & knowledge of care home staff
Willis et al (2018)(1)	Qualitative	29 LGB identifying adults 50-76 yrs	Interviews	(UK) Exploring meaning attached to home/place
Yang et al (2018)	Quantitative	113 gay people, 100 lesbians, 17 bisexual/trans/not identified	Needs assessment survey	(United States) Impact of welcoming service providers on isolation
Boggs et al (2017)	Qualitative	73 gay/lesbians 50-69 yrs	Focus groups, interviews & meeting	(United States) Identifying barriers and supports to ageing in place
Proctor & Krusen (2017)	Qualitative	6 male, 1 gender neutral gay/bisexuals 50+yrs	Interviews, site visits & observations	(United States) Determining community-based needs for veterans
Czaja et al (2016)	Mixed methods	124 gay men & lesbian women 50-85+yrs	Survey & Focus groups & survey	(United States) Concerns about ageing & caregiving

Reference	**Research paradigm**	**Sample size & type**	**Method of data collection**	**(Country of Origin) Focus**
Jones & Willis (2016)	Qualitative	9 trans people	Interviews	(UK, United States, Canada) Trans positive care delivery
McGovern et al (2016)	Qualitative	7 women, 2 men	Focus group & interviews	(United States) Exploring impact of senior centre
Spatenkova & Olecka (2016)	Qualitative	6 managers, 10 care employees, 9 health & social care students	Focus groups & interviews	(Czech Republic) Provider preparedness with LGBT+ clients
Westwood (2016)	Qualitative	60 self-identified LGB people, mean age 64	Interviews	(UK) Concerns related to housing & social care
Willis et al (2016)	Mixed methods	41 care staff & managers, 19 lesbians, 9 gay men, 1 bisexual person	Survey & Focus groups	(UK) Comparison of staff and LGB people's expectations for future care provision
Wilkens (2016)	Qualitative	35 lesbian / bisexual / did not identify women	Interviews	(UK) Looking at impact of same-sex social groups
Sagie (2015)	Quantitative	209 gay men and lesbian women 55+yrs	Survey	(Israel) Predictors of well-being
Brennan-Ing et al (2014)	Mixed methods	210 LGBT adults mean age 60	Survey collecting (qual & quant)	(United States) Social support networks & service utilisation
McCann et al (2013)	Mixed methods	Survey - 143 LGBT people 55+yrs Interviews - 36 LGBT people 55+yrs	Survey & interviews	(UK) Experiences of using care services
Price (2012)	Qualitative	21 gay men & lesbian women carers	Interviews	(UK)

Reference	**Research paradigm**	**Sample size & type**	**Method of data collection**	**(Country of Origin) Focus**
		20-67 yrs		Experiences of LGBT carers
Hughes et al (2011)	Quantitative	87 members of staff	Survey	(United States) Ageing providers awareness of LGBT needs
Fannin (2006)	Mixed methods	130 participants	Survey & interviews	(UK) Social inclusion & community inclusion
Brotman & Cormier (2003)	Qualitative	32 older people or staff/managers (21 LGBT)	Focus groups	(Canada) Experiences of accessing social care in community
Langley (2001)	Mixed methods	19 lesbians & gay men 51-68 yrs	Survey & interviews	(UK) Perceptions of needs and attitudes to services

Table 2.5: Overview of studies included in scoping review

The studies identified employed a range of methodologies, as demonstrated in *Table 2.5*. Eighteen used qualitative research methods, with twelve using interviews, two using focus groups, three using both interviews and focus groups and one using focus groups and observations/site visits. Five used a survey/questionnaire. Eight employed mixed methods with four of these using both a survey and interviews, three using both a survey and focus groups and one using a survey to gather both qualitative and quantitative data.

Twenty five studies included participants who were older LGBTQ+ people, three included staff and managers in various types of social care and community based services, two included a combination of LGBTQ+ people and staff from services. It was not possible to ascertain in two studies whether participants were all LGBTQ+ people (one noted some were and some were heterosexual and one noted 130 participants but did not give any further information). Although the studies spanned a 22-year period, 24 of the 32 included had been published in the last 7 years (2016-2023) demonstrating an emerging area of research, with just three published before 2011.

Although some studies were specific in the groups they were looking at e.g. lesbian women, transgender people, bisexual people, most spoke about the LGB/LGBT/LGBTQ+ communities in both their methodology and findings/discussion and reference to participants primarily as a homogenous community. Within a total of approximately 2552 LGBTQ+ participants across all studies, only a very small proportion were clearly identified as bisexual (approx. 71 or 2.8%) or transgender (approx. 59 or 2.3%). Several studies provided information about gender makeup but did not further expand in terms of sexuality. There is a possibility some participants were accounted for twice in relation to statistical data as, for example, those who are transgender may also identify as male or female, gay, bisexual or heterosexual and most studies did not give detailed information about overlaps.

There appeared to be distinct differences between gay men and lesbian women in terms of wishes, expectations and perceptions in relation to a wide range of areas and some evidence that gender as well as sexual identity has an impact on perceptions and choices, particularly for lesbian women. Several studies did not note gender, however, of those where it was possible to determine gender (26 studies) it appears that around 60% of participants were male, 38% female and 2% transgender (without further expanding on gender identity of choice). These distinctions are relevant when considering the overarching themes noted across numerous studies as it is possible gender identity has impacted on these.

Within the studies whose participants were staff working in services, a total of approximately 383 people took part. Of these, 136 were classified as managers or professionally registered staff, 117 were care staff delivering direct support, 9 were students and 102 were either not classified or were classified as ‘other’. In two studies, data was collected in relation to staff sexual identities.

Some studies included consideration, either as part of methodology or within the discussion of findings, of whether participants lived alone where this was relevant. In some cases the data were compared with those who did not live alone. This is a factor frequently raised in relation to LGBTQ+ populations. None of the studies provided information about whether participants had formally assessed care needs, although a small number implicitly indicated that some form of assessment had been carried out. A small number included reflection on changes that may be needed to the formal assessment process.

2.5 Findings

Thematic analysis identified three main discussion areas, LGBTQ+ identity and community, the impact of ageing and cultural competence in service delivery. Although many of these were cross cutting or interdependent, they are separated out for ease of discussion here, but it is important to note these themes and subthemes inevitably intersect and influence one another.

Each of the studies had different cohorts of participants, and referred to them in various ways. The following discussion primarily uses the term LGBTQ+ to encapsulate all parts of the community. Where it is relevant or significant to do so, it is indicated which part of the LGBTQ+ community particular study participants belonged to, but overall the wider term is used in the discussion for ease. Please refer to *Table 2.5* for details of participants in individual studies.

2.5.1 LGBTQ+ identity and community

The importance and influence of LGBTQ+ identity was highlighted in all studies. A focus on the impact of structural influences present within both local and LGBTQ+ communities was also present in many studies, highlighting the ways in which these might affect experiences, choice and perceptions of inclusivity.

There was evidence across studies that a history of discrimination over the lifespan had a significant impact on current lives and views. Many study participants recalled examples of discrimination, citing accounts of marginalisation, oppression and discrimination, which they felt impacted on their expectations for social care going forward (Boule et al 2020, Boggs et al 2017, Brotman 2003, Waling et al 2019, Smith & Wright 2021). There were overarching assumptions that use of social care would result in discrimination, regardless of setting, age, or level of planning for future care, and that poor quality care, lack of inclusivity, and lack of recognition of rights and identities and histories were expected (Boule et al 2020, Waling et al 2019, Smith & Wright 2021).

There were specific examples given of discriminatory treatment from caregivers (Hoekstra-Pijpers 2020). McCann et al (2013) reported high proportions of participants describing verbal insults, actual or threats of physical violence and people threatening to 'out' them on the basis of their LGBTQ+ identity. Links were made in several studies between previous negative experiences and current concerns in relation to levels of trust and perceptions of health & social care support, as well as confidence or ability to defend oneself in threatening situations (Lottmann 2020, Willis et al 2016, Brotman 2003). Participants reported perceptions of ongoing social stigma leading to them expressing reservations as to whether wider attitudes had truly changed. There was recognition of the importance of being able to share experiences with others in the LGBTQ+ community (Waling et al 2019).

The levels of openness around, or disclosure of self-identity, particularly within services or with care staff, was felt to be relevant within multiple studies. Being open about sexual identity featured in some studies, with participants keen to be open and able to talk about their lives (Löf and Olaison 2020). This was inextricably linked in many cases to historic discrimination, and the resulting ‘living invisibly’ (Boule et al 2020). Some participants reported hiding their sexual identity to avoid expected segregation or anticipated discrimination (Langley 2001, Willis et al 2016, Smith & Wright 2021). Transgender people noted they felt they had less control over sharing their identity as it could be more physically obvious (Löf and Olaison 2020).

The ongoing need to disclose was viewed as a constant and exhausting process by some (Langley 2001, Boule et al 2020). There were references to internalising in a way that caused anxiety about self-identity (Langley 2001). There were a range of feelings about the importance of talking about sexual identity in relation to expectations of discrimination, the positive impact of owning sexual identity and ways in which this might contribute to changing opinions of those who might have discriminatory views (Langley 2001). The impact of not being able to comfortably disclose sexual identity included descriptions of people changing appearance or behaviours in order to align with what they identified as socio-normative expectations, despite expressing this to be a form of repression (Boule et al 2020).

Being an active part of the LGBTQ+ community was generally considered to be positive, and participants recognised the importance of belonging, sharing common experiences, culture, beliefs, politics, identity, as well as being part of a ‘collective resistance’ to build resilience and access to appropriate resources (McGovern et al 2016, Hoekstra-Pijpers 2020, Siverskog & Bromseth 2019, Westwood 2016, Willis et al 2018(1), Boggs et al 2017). There was also felt to be value, for those who were not out in the wider community, to have safe spaces to access (Wilkens 2016). Some people expressed the importance of being in LGBTQ+ spaces, which meant they felt part of a majority rather than a minority (Price 2012).

Prejudice within the LGBTQ+ community was also noted, highlighting the non-homogenous nature of the group. Sometimes focused on particular groups within the wider community such as the transgender or bisexual population, there was a general recognition across studies that the community itself is not cohesive (Jones et al 2018, Boule et al 2020). A historic separation in the categories of sexual identity, traditionally excluding transgender people, was felt to have an enduring impact on the ways in which LGBTQ+ spaces were viewed (Siverskog and Bromseth 2019).

Some lesbian participants noted that exclusively lesbian spaces had historically been fought for and felt these were potentially compromised through the inclusion of transgender women (Wilkens 2016). Bisexual people felt there was often a lack of understanding of bisexual identity within LGBTQ+ communities and being in a relationship often resulted in being misidentified (Jones et al 2018). There were examples given of prejudice within the LGBTQ+ community pertaining to other protected characteristics. This included ageing, ableism, racism and classism (Boule et al 2020, Lottmann 2020). Experiences of using community-based provision, particularly those in specific service settings, were often influenced by the levels of diversity within the local community (McGovern et al 2016).

Staying connected to LGBTQ+ communities as people aged was felt to be important, but some reported feeling stigmatised or unable to join existing groups because of their age (Boggs et al 2017, Hoekstra-Pijpers 2020). There was a perception that communities responded better to younger members and for some this was classified as age discrimination (Brotman et al 2003, Boule et al 2020, Czaja et al 2016, Brennan-Ing et al 2014, Langley 2001). Issues raised included a lack of age appropriate activities, a focus on the bar scene, and stereotypical ideas of what constituted enjoyable activities for LGBTQ+ people (Hoekstra-Pijpers 2020, Price 2012).

Many studies focused on weaknesses, deficits or the negative consequences of being in minority groups, particularly as people aged. Participants noted less ability to defend themselves against discrimination in older age, less self-determination, less resilience, less energy for activism, loss of privacy, autonomy and independence and general loss of power (Lottmann 2020, Siverskog & Bromseth 2019, Waling et al 2019, Boule et al 2020). However, many studies highlighted the perceived or recognisable power people felt came from those experiences. Participants felt they were able to continue to influence the social and political position of the LGBTQ+ community and many maintained their desire to continue activism in their older age, to benefit from social changes to come (Jones & Willis 2016).

There were examples given of how older people utilised this power through less tolerance of negative or discriminatory treatment and using their experiences, confidence, abilities and networks to challenge exclusion through both social and legal action. Teaching and supporting younger members of the community was seen as a key part of this and was felt to add to social capital (Siverskog & Bromseth 2019, Boggs et al 2017).

There were accounts of the power and strength gained from a personal perspective in relation to ageing and LGBTQ+ identity. People reported being stronger, less dependent, more active, less vain, less out to impress others, more resilient, and less constrained by societal expectations than their heterosexual peers (Butler 2018, Boggs et al 2017, McCann et al 2013, Brotman et al 2003). This was attributed to previous experiences having built resilience. There were also examples of adaptability and ingenuity in positively navigating current systems such as care and support. Finding alternative ways to manage potential systemic issues such as correct recognition of next of kin, which can be challenging for LGBTQ+ people, were noted (Fannin 2006, Langley, 2001).

2.5.2 The impact of ageing

Levels of independence developed over the lifecourse featured in several studies, including where this had made transitions to dependence much harder (Boule et al 2020, Czaja et al 2016, Butler 2018, Hoekstra-Pijpers 2020). LGBTQ+ life experiences were felt to be framed by discrimination, invisibility of identity, and developing strategies to manage oppression, prejudice and inequitable treatment, which had contributed to building resilient characteristics. However, in a situation where frailty, loss of function, an increasing reliance on others in relation to daily living and avoidance of isolation were developing, levels of independence sometimes became problematic.

Acknowledgement of support needs and requesting formal or informal support was suggested to be more challenging for those who had developed considerable resilience and independence through years of managing discrimination (Brotman et al 2003). Fears related to loss of independence were felt to be more notable in relation to the delivery of care.

Carers coming into people's homes, loss of control over personal disclosure and receipt of personal care against a history of sometimes intense privacy were all raised as concerns (Lottmann & King 2020, Jones & Willis 2016, Waling et al 2019, Price 2012).

Fear of dependence was rooted in experienced rejection, inadequate recognition of life stories, loss of control over appearance and inability to express sexual identity in a care setting (Lottmann 2020, Willis et al 2016, Jones et al 2018). This included heteronormative assumptions about fitting into conventional roles and having conventionally gendered interests or attributes forced onto them, without any ability to consent or control this. There were also several examples of participants, usually women, being concerned about being sexually vulnerable, particularly within more residential based settings (Willis et al 2016).

Isolation was identified as a key social care need in many studies and causes and potential solutions were explored (Lottman & King 2020, Butler 2018). While some participants did not feel sexual identity was relevant to ageing experiences, it was identified as a cause for feelings of isolation, highlighting the link being made between isolation and self-identity (Butler 2018). Fear of being separated from partners, not having historical networks to call on, or a perception of less options being available to gay couples were all cited as potential causes of isolation (Siverskog & Bromseth 2019, Waling et al 2019). Isolation was perceived by some to be separate to ageing, but rather linked to historical and ongoing discrimination because of sexual identity (Butler 2018, Yang et al 2018). However, others felt that ageing had led to increased feelings of isolation (Boggs et al 2017, Czaja et al 2016).

Some studies noted that providers were missing opportunities to do more to tackle isolation. Policy and practice models limited the ability to link people who might benefit from social contact, or in developing creative mechanisms to bring people together (Waling et al 2019). Several studies concluded services could create opportunities for socialisation, build community based advocacy, and use online tools to combat isolation (Brennan-Ing et al 2014, Boggs et al 2017, Willis et al 2018(1)) although there was little evidence of effective use of technology to do this. The potential role for services in tackling isolation and the ability to provide opportunities to connect with people and build networks was seen as valuable, in some cases impacting on levels of isolation (Fannin 2006, Yang et al 2018). Services which fostered a sense of belonging were seen to reduce isolation and improve wellbeing (Wilkens 2016) and conversely, unsuitable placements increased feelings of loneliness and isolation (Langley 2001).

There appeared to be recognition that membership of LGBTQ+ communities as an older person was liberating but simultaneously required negotiation of narrow norms for identifying and expressing gender and sexual identity. The networks people formed, particularly those which had a functional purpose in terms of providing support in older age, were felt to be important. Sometimes referred to as 'families of choice', and defined as family support networks made up of partners, friends and neighbours, these networks commonly differed from the networks people might have through birth or marriage (families of origin). Former partners were more likely to make up part of social networks and they were sometimes geographically widespread (Jones et al 2018, Proctor & Krusen 2017, Butler 2018). Some studies focused on the formation and maintenance of these networks and others considered the support that came from these and how they either helped or hindered physical, emotional, and social lives. There were lower levels of functional support from families of origin than families of choice, with one study highlighting that 77% of respondents had a friend that could provide practical support, compared to just 26% who had families of origin that could (Brennan-Ing et al 2014).

These networks varied in terms of formation, composition and perceived benefits. Families of choice were felt to help people develop positive perceptions of themselves and strengthen connections to the wider LGBTQ+ community, and for some they were part of their self identity (Willis et al 2016, McGovern et al 2016, Langley 2001). Other benefits included increasing interaction and participation in wider society, and stimulation in relation to politics, social, academic, philosophical, emotional, and artistic worlds (Lottman 2020, Jones & Willis 2016). Decreased access to advocacy was observed where networks were not present (Waling 2019, Siverskog & Bromseth 2019). Common characteristics in the formation and membership of networks were found, including shared historic struggles and strong connections through early activism (Löf & Olaison 2020, Siverskog & Bromseth 2019).

For many people there was a strong focus on emotional support from friends or existing informal support systems with several making concrete plans for mutually beneficial arrangements with others. Moving to more accessible living environments or enjoying the advantages of polyamorous living arrangements were given as some examples (Lottmann & King 2020, Waling et al 2019, Jones et al 2018). However, this forethought and planning was not the norm, with examples of what could be viewed as unrealistic or worrying responses about future plans related to care or support. Whilst it was common for fears or concerns to be articulated, people were less able to describe what was in place to mitigate these risks (Boggs et al 2017, Grant & Walker 2020). Some spoke of fear in relation to having to enter residential care, especially if this was provided by organisations they perceived to be non-inclusive, such as religious organisations (Grant & Walker 2020).

Several studies noted the potential role of service and support structures in helping to build and maintain these networks, with some examples of forming or nurturing these networks within community based services (McGovern et al 2016). However, there were very few where this was felt to be being actively delivered. Drawing on more informal support systems included utilisation of functional, emotional, social, physical and financial support and this often outstripped reliance on statutory agencies (Jones et al 2018, Brennan-Ing et al 2014, Fannin 2006, Langley 2001). Even where families of origin were part of networks, or partners were providing intensive support, negating need for formal support, there continued to be reliance on families of choice (Hoekstra-Pijpers 2020, Butler 2018).

There were a range of factors that impacted on opportunities or enthusiasm for building these networks. These included fear of judgement from others, levels of accessibility, a continued desire for invisibility and the impact of socioeconomic status (Jones et al 2018, Fannin 2006, Wilkens 2016, Boule et al 2020). Established networks were used in a variety of ways, and for some, planning for their future included broadening these networks to provide practical support, although this was more focused on isolation and loneliness than meeting practical care needs (Boule et al 2020, Lottmann & King 2020).

As part of considering how care needs could be met effectively, the lack of planning for future care needs was a common theme across a number of studies. Many had experienced negative treatment within health and social care settings throughout their lives, but relatively few had made concrete plans for meeting their social care wishes and needs as they aged. Many participants felt health disparities and discrimination were likely and planning for end of life required a great expenditure of emotional energy which they did not feel they had (Westwood 2016, Czaja et al 2016, Lottmann & King 2020).

While many did not plan, a small proportion of individuals did give thought to future care needs, most noticeably in the group who were carers themselves (Price 2012). Experiences in their caring roles had led them to take actions to ensure their sexual identity was not lost, despite their relatively young age and the fact those they were caring for were not necessarily LGBTQ+. Examples included a ‘photo book’ of life stories, clear ideas on what care would look like, marriage/civil partnerships to legalise unions and writing wills. Because the carers felt providers were unable or unlikely to offer culturally competent services, their caring experiences had created expectations which resulted in them planning how their own care needs might be met in the future.

Although practical planning was lacking, some mental preparation was seen in a number of studies. Researching options, planning changes to suitable providers, and developing action plans with people at work were some examples (Boule et al 2020, Boggs et al 2017). There was evidence this planning was directly influenced by sexual identity. Developing active coping strategies for expected discrimination, mental preparation for unpleasant encounters, researching and joining community-based organisations (such as social groups that offered inclusive support) and moving to geographic locations perceived to have inclusive values were given as examples of consideration of future care needs.

A small number of reports highlighted the consequences of lifelong discrimination and restricted human rights, leading some to articulate that euthanasia was a viable choice and a way to maintain autonomy, dignity and freedom of choice, if and when care might be required (Grant & Walker 2020, Waling et al 2019, Westwood 2016). This varied in where it featured within long term planning, with some considering it an active option, and others considering it to be a last resort if the only other option was non-inclusive care. Some participants expressed they were unlikely to live long enough to require care, they would not become frail enough to need care, or they could not bring themselves to think about needing care, with primary focus being on the present rather than the future (Westwood 2016, Waling et al 2019, Grant & Walker 2020).

2.5.3 Cultural competence in service delivery

A key factor felt to result in LGBTQ+ people living with a hidden identity was levels of comfort, willingness or opportunities to disclose, linked to historical discrimination (Boule et al 2020). The reasons why lack of visibility occurred, the impact and the systems and approaches which exacerbated the problems were discussed. Lack of asking about sexual identity meant invisibility endured, with studies finding it was uncommon to be asked about sexual identity, civil partnerships or gender identity across a wide range of community based services and settings (Hughes et al 2011, Simpson et al 2018(1)). High numbers of staff stated they had no LGBTQ+ service users and it was felt systems and the staff within them perpetuated invisibility by overlooking possibilities (Brotman et al 2003). There were perceived generational differences in willingness to disclose sexual identity, which also potentially impacted on levels of visibility (Price 2012).

There were many reported benefits to sexual identity being visible, including improved understanding of needs, wider general awareness, improved take up of support and a potential contribution to stronger social shifts, decreasing the likelihood of discrimination (Löf & Olaison 2020). Hoekstra-Pijpers (2020) reported general openness about sexual identity almost always improved perceived quality of care contacts despite evidence of discrimination by some caregivers. 80% of respondents felt disclosing sexual or gender identity to caregivers was useful. Willis et al (2018) also suggested several participants felt disclosure at an early stage was a vital tool for exercising choice and control, facilitating screening out unsuitable carers.

However, other participants reported withholding information about sexual identity due to fear of receiving inadequate treatment, to avoid anticipated segregation or the repeated need for disclosure to staff which could be upsetting (Czaja et al 2016, Langley 2001, Waling et al 2019). People were often fearful of whether staff would be tolerant and inclusive and examples were given of methods people used to avoid discrimination beyond not disclosing, including removing items from within homes, or not talking about histories or sexual lives (Butler 2018, Willis et al 2018(1), Willis et al 2016).

Not disclosing sexual identity was also seen to have an impact on wellbeing. The ability to challenge discrimination in care settings was seen to be dependent on whether people were out or not within that setting, which caused some frustration (Westwood 2016). In some local communities, lack of acceptance meant people felt they had to continue hiding their identities, reported more so for those who were bisexual or polyamorous (Boule et al 2020, Jones et al 2018). Some specific settings were felt more likely to harbour invisibility, such as residential care, where heteronormative structures based on traditional views of opposite gender couples and gender conforming roles were more likely to be a feature (Grant & Walker 2020, Löf & Olaison 2020). Lack of acknowledgement or recognition of sexual identity and discrimination were reported to lead to distress or feelings of being devalued (Westwood 2016, Willis et al 2016).

Invisibility in relation to sexual identity in services appeared to be exacerbated by both rigid structures and lack of staff awareness, or willingness to see and recognise LGBTQ+ people. Staff failing to recognise clear signs such as identifying regular visitors as partners, an inability to readily identify any LGBTQ+ residents and no evidence of discussion of people’s LGBTQ+ lives were given as examples of lack of awareness (Waling et al 2019, Willis et al 2016). Barriers were seen in both physical and organisational arrangements with examples of poor practice including lack of adjoining rooms for LGBTQ+ couples, LGBTQ+ identities and histories not accounted for in activities for people themselves or in relation to staff development and a lack of inclusion of sexual identity in care plans (Willis et al 2016). In some studies, the presence of LGBTQ+ staff was more evident than LGBTQ+ residents. Although the presence of LGBTQ+ staff was felt to be positive, it exacerbated frustrations about older people not being as visible and acknowledged within provision (Willis et al 2016, Simpson et al 2018). Mainstream groups which included gender assumptive activities were felt to exacerbate feelings of isolation and loneliness. Conversation topics such as grandchildren and marriage often left people feeling excluded (Wilkens 2016).

A range of additional systemic issues perpetuated the challenge to identities. Managers felt open discussions about sexual identity were not appropriate, on the basis it may offend others (Willis et al 2016). Openness required trust, confidence and staff taking the lead to initiate ongoing discussions. Heteronormative structures within assessments and referral forms exacerbated invisibility, overlooking important aspects of people's lives (Langley 2001, Brotman et al 2003). One study noted that a person's wish not to disclose their sexual identity, combined with the discomfort of professionals to raise the topic, results in a lack of solutions being identified within services (Brotman et al 2003).

Despite shifts in social, political, and legal attitudes, many LGBTQ+ people were able to give examples of ongoing discrimination having a marked influence on their perceptions and expectations of providers, and social care systems. Although some low expectations of aged care for the general population were seen, actual and expected experiences of discrimination were highlighted as influencing perceptions (Jones & Willis 2016, Smith & Wright 2021).

Ongoing discrimination within social groups from neighbours and neighbourhood-based activities were not uncommon, with examples of homophobic views voiced and promoted in community groups and settings (Grant & Walker 2020, Hoekstra-Pijpers 2020). Homophobia from care workers, damage to property, refusal to do a particular haircut and people whispering in a local shop were all cited as recent experiences (Butler 2018, Willis et al 2018(1)). These negative experiences were exacerbated by several factors including an inability to fight back, concern that challenging discrimination would mean disclosing sexual identity and a perception that statutory agencies such as the Police would not recognise the discrimination or act in response (Boggs et al 2017, Czaja et al 2016).

Care delivered in the home included expectations of homophobia and breaches of privacy (Willis et al 2018(1), Smith & Wright 2021). More generally people felt services would not acknowledge, respect, or celebrate people's identities (Willis et al 2016, Price 2012). The expectation of discrimination impacted on likelihood of seeking services when needed, with some studies showing unwillingness to place trust in individuals and systems which may have historically persecuted people (Langley 2001, Brotman et al 2003, Smith & Wright 2021).

The perceived heteronormativity of the social care system was also seen to lead to low expectations, with a general belief that it permeated structures, organisations and society, particularly in social care (Boule et al 2020, Grant & Walker 2020, Waling et al 2019, Westwood 2016, Willis et al 2016, Wilkens 2016, Smith & Wright 2021). Participants noted invisibility, microaggressions and sometimes unintended discrimination, which all influenced experiences, and expectations. Some individuals worried that heteronormative structures and attitudes would result in them feeling they needed to hide their sexual identity (Grant & Walker 2020, Löf & Olaison 2020).

Heteronormative structures were felt to be pervasive across service types, and social care services with models of practice which excluded sexual orientation, gender identity and family context were less likely to be able to address specific needs (Boggs et al 2017, Willis et al 2016). Language and topics of conversation, levels of openness about sexual identity and perpetuating negative stereotypes were all felt to influence the perceived heteronormativity of settings (Westwood 2016, Löf & Olaison 2020, Boule et al 2020, Lottmann 2020). Recommendations included addressing the lack of policies, staff training and inclusivity markers in services (Simpson et al 2018(1), Smith & Wright 2021).

The lack of acknowledging difference was highlighted in several studies. Attitudes of staff included that LGBTQ+ people had similar needs to a heterosexual person and that a person's behaviour was more likely to alter approaches to care than sexual identity might (Spatenkova & Olecka 2016). One reason given for this approach was so as not to draw attention to an individual by treating them differently. Staff displayed a lack of understanding about the importance of sexual identity and because sexual identity was not discussed as part of planning to meet needs, it was judged not to be relevant (Willis et al 2016).

For many staff, equality equated to sameness - an approach taken whereby you treat everyone the same - which was felt to be in detriment to recognising individual differences in sexual identity and biography. A lack of knowledge about laws and rights specifically protecting or impacting LGBTQ+ people was also seen (Boule et al 2020). A potential conflation of tolerance with understanding was highlighted for staff, in that staff tolerated LGBTQ+ service users, which seemed to negate the need to understand specific characteristics and needs related to, or influenced by sexual identity.

Staff competence and challenges around training and awareness were a theme running through many studies, with those which included staff interviews focused on this to a greater extent. Studies which focused on informal and local groups identified the importance of raising awareness and building culturally sensitive systems to work within. There were concerns that stereotypes about LGBTQ+ lifestyles and characteristics would influence the way staff would treat people. One study found as many as 30% of staff felt uncomfortable providing care or support to older LGBTQ+ people, although this data is over 10 years old so may not reflect current attitudes (Hughes et al 2011).

Issues related to staff training were also highlighted. Rural services were less likely to have staff with LGBTQ+ awareness, and workforce skills and staff capability were cited as a cause for concern (Grant & Walker 2020, Waling et al 2019). Ways to facilitate learning, such as using markers within home environments to start conversations and readily answering questions were suggested by LGBTQ+ participants as ways to educate staff, although this was countered by other accounts of exhaustion at having to instruct people repeatedly (Hoekstra-Pijpers 2020, Löf & Olaison 2020, Smith & Wright 2021). Examples were given of what was considered to be good practice, which included staff being knowledgeable and welcoming of LGBTQ+ people, and staff receiving specific training (Lottmann 2020, Yang et al 2018, Smith & Wright 2021). Lack of training was felt to exacerbate poor care delivery (Simpson et al 2018, Jones & Willis 2016, Smith & Wright 2021).

Other actions identified as contributing to good practice included available resources, opportunities for socialisation with other LGBTQ+ people and knowledge of legal rights for LGBTQ+ people (Czaja et al 2016, Boggs et al 2017, McGovern et al 2016). It was felt that limited awareness of historical discrimination, social and legal rights impacted on staff attitudes (Willis et al 2016). There was recognition that resources and knowledge would need to be available discreetly, to enable those who were not open about their sexual identity to safely access specialist support and information when needed (Boggs et al 2017). Positive practice was noted in some studies around recognition of already existing networks, and nurturing these through proactive outreach and facilitation (Jones & Willis 2016). Environments which were not heteronormative, and where contact with partners and friends was facilitated resulted in people feeling safe and valued (Willis et al 2016).

Examples of actions highlighted as poor practice and the impact of these were given across multiple studies. Being treated with disgust, discrimination from caregivers, physical and verbal abuse, lack of response from staff to discrimination exhibited by other service users, separation from partners or important networks and restrictions placed on privacy were all reported (Lottmann 2020, Hoekstra-Pijpers 2020, Smith & Wright 2021, Willis et al 2016). Staff were not always familiar with markers of LGBTQ+ identity, with some instances where staff avoided using LGBTQ+ related terms and identity types entirely. Examples were given of people feeling staff did not always challenge discriminatory views expressed by others, but instead tried to prevent emotional distress through shielding them, rather than tackling the comments, with some staff supporting an individual's right to express discriminatory views (Willis et al 2016).

People using services felt that recognition and respect of individuality constituted person-centred practice more so than many different options for support being made available. Inadequate recognition of identity and life stories influenced levels of fear about accessing support (Lottmann 2020). Authenticity, respect for individuality and LGBTQ+ identity, being listened to by staff, feeling safe and avoiding repeated disclosure were used as measures for judging the quality of support favourably (Löf & Olaison 2020, Butler 2018, Jones & Willis 2016, Hoekstra-Pijpers 2020, Willis et al 2016).

Staff were more likely to view personalised care as a focus on activities such as maintaining daily routines and dietary preferences, without attention to sexual identity or life story. Opportunities to build knowledge and understanding in order to provide holistic support were often missed (Willis et al 2016). Sexual identity and life histories were often seen as separate or irrelevant, and although staff expressed wishes to be responsive to individual needs, accounts often showed that staff did not recognise the importance of sexual identity or life history in contributing to person centred care delivery. This was felt to be more challenging for those with a diagnosis of dementia, where expressing sexual identity could be viewed negatively and was often assumed to be a symptom of the condition (Price 2012).

There were challenges for service providers in the provision of both person-centred and culturally competent care. These included the need to identify individualised approaches focused on the specific needs of what is an extremely diverse, non-homogenous group. Recognition of relationships and networks, sensitivity to unique needs, creating opportunities to talk about life stories and the ability to have cultural visibility in their own homes were all felt to be key ways to deliver person-centred care to LGBTQ+ people (Boule et al 2020, Löf & Olaison 2020, Fannin 2006, Grant & Walker 2020, Price 2012). There were also examples of service providers feeling their provision was culturally competent despite not providing anything which specifically recognised sexual identity (Boule et al 2020). Some LGBTQ+ people highlighted anxieties related to the influence of stereotypes on the actions providers might take (Grant & Walker 2020, Price 2012).

Many studies highlighted that management, leadership, and policies were key influences on the ability to deliver culturally competent care. Organisations were felt to require strong leadership in order to implement and promote policies of inclusion (Boule et al 2020, Willis et al 2016). A commitment from management to building skills, knowledge, confidence and empathy of frontline staff was felt to be important, with a belief that management effectively set the culture, ethos and tone of an organisation (Jones & Willis 2016). There were some examples given of services managing equalities responsibilities through only meeting minimum requirements, which was not always felt to be a genuine commitment to diversity and equality, but rather a tolerance of difference (Simpson et al 2018).

Some studies highlighted what was felt to be a lack of strategic thinking about how providers delivered services, with a lack of creativity noted by some service users as impacting on meeting their needs effectively (Waling et al 2019). Leadership around responsibilities and opportunities to develop culturally competent care was felt to be needed to tackle wider social care needs and broadly people felt culturally competent practices were unlikely to develop in the wider organisation without this. Some studies concluded that if management did not openly demonstrate systematic opposition to homophobia and heteronormativity and include inclusivity as a prominent feature of their statement of purpose, it was unlikely to be culturally competent provision (Langley 2001, Willis et al 2016).

Management staff who took part in some of the studies considered their knowledge and understanding to be good, although there was a recognition that broader conversations about inclusivity were not necessarily happening within organisations at management level (Simpson et al 2018). As a collective group (managers and frontline staff), only a small number could give specific information about the laws affecting LGBTQ+ people and few knew if they were integrated into the policies within the services they worked in. Examples were given of discomfort and lack of willingness to include discussion of the needs of LGBTQ+ people in national meetings and conferences, or a belief that meeting needs specific to LGBTQ+ people was a low priority (Brotman et al 2003, Hughes et al 2011).

A range of physical, practical, and staff-based markers of inclusivity were identified across the studies. Physical items including LGBTQ+ symbols, LGBTQ+ friendly advertising & promotional materials and LGBTQ+ specific magazines and literature were felt to be positive indicators of inclusivity.

Other perceived positive markers of inclusion included:

- Inclusion of LGBTQ+ communities within mission statements or policies
- Sexual identity included in files or questions asked as part of assessments
- Staff using less heteronormative language
- Employing LGBTQ+ staff and volunteers
- Staff with common demographics such as sexuality, gender, or interests
- Effective ways of welcoming or recognising partners
- Upholding privacy
- Personalised treatment
- Respect for preferences
- Links to LGBTQ+ organisations
- Recognition of identity and life stories

(Boule et al 2020, Willis et al 2016, Price 2012, Brotman et al 2003, Löf & Olaison 2020, Hoekstra-Pijpers 2020, Simpson et al 2018, Boggs et al 2017, Jones & Willis 2016, Butler 2018, Westwood 2016, Smith & Wright 2021)

Table 2.6 Practical markers of inclusivity in services

There were few examples of these clear markers of inclusivity being in place and staff themselves identified lack of activities, information, and training as contributing to this (Hughes et al 2011). Many staff were open to working inclusively with LGBTQ+ people but struggled to identify strengths in their approach currently, or they felt there were positive practices to promote inclusion, but these were not always immediately obvious (Simpson et al 2018). Some felt that a simple way to indicate inclusiveness would be a kite mark system which measured cultural competency. Other ideas included changes to institutional policies, advertising the affirmative nature of the service, participation in community events, and collaborative work with community groups (Price 2012, Brotman et al 2003).

Approximately half of the studies (17 of the 32) had participants who expressed a preference for LGBTQ+ specific services. The ability to maintain links to the LGBTQ+ community was a key reason cited for this, as well as the safety and appropriateness of support that might be provided in specialist groups. Equally, others felt segregated services were not preferable to broader inclusive services although many felt it should be an option available to people (Jones et al 2018, Waling et al 2019). Some felt strongly that failure to provide specialist provision could be viewed as discriminatory under equalities legislation (Westwood 2016). Some participants noted they would prefer LGBTQ+ specific provision if needing to access residential care (Lottmann & King 2020).

Studies highlighted the importance of services with very specific functions or attributes to meet specialised needs related to LGBTQ+ identity such as specific types of personal care which might be required for transgender people (Boule et al 2020). There were also a range of additional challenges for service provision related to LGBTQ+ identity, such as the demand for women-only provision, and single people needing different support to those in relationships (Grant & Walker 2020, Butler 2018, Westwood 2016, Willis et al 2016, Wilkens 2016, Löf & Olaison 2020). Older lesbian and bisexual women, older gay men and bisexual men often had very little in common and inclusion of transgender women in lesbian settings was seen as a problem for some groups (Westwood 2016, Wilkens 2016, Smith & Wright 2021).

There were indications that some participants had accessed LGBTQ+ exclusive provision more than engaging with wider activities in their local neighbourhoods (Hoekstra-Pijpers 2020). The preference for LGBTQ+ specific provision was reported to be based on perceptions and beliefs around feeling settled, having more in common with others, people being able to be themselves without fear of discrimination, true recognition of the importance of sexual identity and higher likelihood of staff competence around the needs of LGBTQ+ people (Waling et al 2019, McGovern et al 2016, Westwood 2016, Fannin 2006, Price 2012).

Participants noted that accessing LGBTQ+ services enabled them to maintain links to the LGBTQ+ community and this was a factor in people choosing them (Westwood 2016, Czaja et al 2016, Lottmann & King 2020). There were examples of people using online tools to connect with LGBTQ+ groups, forums and to make one-to-one connections (Willis et al 2018(1)). Connecting with the LGBTQ+ community did not necessarily become less important as people aged and the benefit of forming new networks and maintaining long-standing connections from earlier years of activism was felt to be important (Siverskog & Bromseth 2019, Proctor & Krusen 2017).

Services which were LGBTQ+ specific were not felt to be helpful in fighting for equality and acceptance in wider society (Löf & Olaison 2020, Waling et al 2019, Fannin 2006). Mainstream provision was seen as the only way to avoid segregation (Westwood 2016). By separating out LGBTQ+ service users from broader community based provision, there were concerns that a potential 'ghetto' of LGBTQ+ provision could develop (Price 2012). Additionally, those who kept their identities private felt LGBTQ+ specific provision threatened their carefully constructed existence and internal prejudices within the LGBTQ+ community could or had impacted on the delivery, experiences and effectiveness of services (Price 2012, Jones et al 2018, Siverskog & Bromseth 2019).

2.6 Discussion

Overall, the papers included in this review highlighted that those receiving support rarely separate their sexual identity from the lives they are leading (Lottmann 2020, Löf & Olaison 2020, Butler 2018, Jones & Willis 2016, Hoekstra-Pijpers 2020, Willis et al 2016). The delivery of culturally competent care, which makes people feel safe, valued and supported, alongside recognising the importance of sexual identity would seem to be a key component of effective social care support (Lottmann 2020, Löf & Olaison 2020, Butler 2018, Jones & Willis 2016, Hoekstra-Pijpers 2020, Willis et al 2016). Lack of recognition of sexual identity appears to influence experiences, including where needs are not directly related to sexual identity (Willis et al 2016, Price 2012, Butler 2018). Many areas identified as important were aligned to areas identified by the wider older population. Achieving support which is culturally competent may be more difficult in settings where care delivery may be task based, such as within domiciliary care, in terms of what is practical to deliver within those interactions.

For many LGBTQ+ people, a belief that simple things need to change for them to feel they are valid and accepted should be considered in terms of actions that can be taken. These simple things include greater consideration about what questions are asked about topics like sexual identity and support networks, how these are framed, where assumptions can be avoided and how needs can be met in alternative ways (Boule et al 2020, Löf & Olaison 2020, Fannin 2006, Grant & Walker 2020, Price 2012). Such adaptations may result in more effective cultural competence, arguably impactful for all those using a service. The recognition of partners, significant relationships, and life stories were seen to be an indicator of an inclusive service (Jones & Willis 2016). Examples of support to maintain and develop these relationships was considered to be good practice, although across this review, few felt this was happening successfully.

Several studies included suggestions and reflections from older LGBTQ+ people themselves about ways services could adjust approaches to meet the needs of the population more effectively. Some were structural in relation to assessments, and the ways in which services were chosen or allocated. The ways in which these might be addressed by services perhaps belies the complex nature of service structures, funding restrictions and the rate of change that can be realistically implemented within the social care system and further consideration will be required in order to understand how structural changes can be implemented in ways that meet the needs of all populations, not just LGBTQ+ communities.

The importance of framing data collection and conversations in a way that does not make heteronormative assumptions may ensure an individual's sexual identity and their life story are not eliminated from their person-centred care plan. There appeared to be an overarching desire to remove heteronormativity from the assessment process, to recognise individual characteristics and avoid stereotyping within these formal processes, which may offer opportunities to utilise more accurate assessments in shaping service delivery (Price 2012).

It was common for staff to state that LGBTQ+ people were not present within their service (Brotman et al 2003), although most studies showed that this information was rarely collected. Sexual identity disclosure is complex and it was clear that services lacked confidence in addressing this. However, the result may be that general heteronormative assumptions being made throughout society persist in services, which serves to make LGBTQ+ identities less visible. Additional consideration needs to be given to the impact on those who do not wish to disclose their identity and how visibility in services may not be considered positive for every LGBTQ+ person. It may be possible to assume that the lack of visibility of LGBTQ+ people might have resulted in people feeling they have to make this part of their identity explicit so that it is recognised and responded to. By doing this, it may influence the ways in which people then construct their expectations about how services recognise and respond to sexual identity, how they feel about their own identity and what they centre as important in relation to meeting needs.

There were indicators within the studies that services were making some efforts to be inclusive, but also that missed opportunities were still common. Building wider cultural competence within staff groups was seen as crucial to improving the experiences of people using services (Grant & Walker 2020, Waling et al 2019). Service improvement could be implemented through development of staff understanding of LGBTQ+ identities and issues in order to build trust and confidence in the services (Brotman et al 2003). Conversely, it was viewed as problematic to introduce training that implied LGBTQ+ people had distinct needs from the general population, which potentially increased social division and overlooked diversity within and between the lives of the LGBTQ+ population. A wider approach to cultural competence training was felt to be much more appropriate, increasing interpersonal skills and being attentive to all sexual biographies (Lottmann 2020, Yang et al 2018, Smith & Wright 2021). For some, cultural competence was as much a mind-set as it was a possession of a set of skills including understanding information, being open-minded, non-judgemental and assumption free (Jones & Willis 2016).

The perceived barriers to positive experiences seemed largely dependent on the actions and attitudes of staff and the heteronormative structures services they work within (Willis et al 2016, Simpson et al 2018, Langley 2001, Brotman 2003, Grant & Walker 2020, Waling et al 2019, Westwood 2016, Wilkens 2016, Smith & Wright 2021). There may be difficulties for those who design, commission and deliver services in making an ongoing investment into cultural competence and inclusion when there are few drivers, incentives or perhaps perceived benefits in doing so.

There appear to be actions that services can perform to achieve more effective inclusion, and a general feeling that services can better understand the people they are working with through having conversations as part of a person-centred approach (Westwood 2016, Löf & Olaison 2020, Boule et al 2020, Lottmann 2020). The inclusion of conversations about what is important to people and how their needs might be met effectively would potentially highlight the value of actions such as making connections with other LGBTQ+ organisations, although the challenges of this for providers have not necessarily been fully explored. The benefits of sharing knowledge, resources and understanding between services in local communities through mutually beneficial partnerships are rarely realised in the current structure of provision. This identifies a potential opportunity going forward to consider how this might be done in a way that supports both LGBTQ+ and other marginalised groups through culturally competent practice.

Services are sometimes focused on rigid ways to meet needs and do not necessarily explore some of the actions that might further tackle emotional and social needs effectively. Providers bringing people together based on frailty, loneliness and older age but not then focusing on how to build confidence or levels of independence could be considered short sighted (Langley 2001). This may be particularly pertinent to older LGBTQ+ populations, where there are potentially different levels of independence and resilience and exploring ways to build on these characteristics offers an opportunity to have a positive impact. Services also have a potentially valuable role in facilitating access to information about rights and resources and building knowledge and awareness, but this appeared in the studies included in this review, to be primarily recognised by people and not services themselves (Boggs et al 2017, Czaja et al 2016, Willis et al 2016).

Links to the LGBTQ+ community were as important and examples of how this sometimes happened within local services and initiatives were a feature of some studies, indicating this may be within the gift of services to facilitate. Additionally, the value and positive outcomes related to geographically local services can be demonstrated from a practical and broad social point of view. Groups and activities which include and embrace LGBTQ+ people may be helpful in building local ‘community’, improving visibility, and ultimately contributing to the acceptance of LGBTQ+ people in the local area.

LGBTQ+ people highlighted they felt services and staff did not necessarily take opportunities to facilitate networks between people which they felt constituted a lack of oversight or creative solutions to tackling loneliness and isolation or helping people to build secure social networks (Boule et al 2020, Lottmann & King 2020). The importance of this for older LGBTQ+ people, where networks are seen to strengthen resilience and improve overall well being, were not necessarily being realised within service settings. The desire for services to undertake activities to link people to others or wider networks may show, to a certain degree, a level of potential misunderstanding about the key role of most social care services. Services are likely to be focused on helping an individual meet a social care need and in turn build those assets themselves. There may also be safeguarding limitations which will inevitably restrict some actions.

Examples of how services designed to meet one need might then have an effect on other needs, such as including positive elements of social interaction were seen. This engagement with services locally can potentially contribute to building wider social networks, especially those which are LGBTQ+ focused. However, it is important to recognise the challenge for locally based groups and services to meet a wide range of needs with limited resources. It is difficult to ensure volunteers and staff are trained and supported appropriately and complex to identify and implement inclusivity markers and solutions if services are individually run and/or are not part of wider networks or organisations that can offer them practical support in making relevant changes.

LGBTQ+ people themselves did not always wish to have separate services (Löf & Olaison 2020, Waling et al 2019, Fannin 2006, Westwood 2016, Price 2012), with a preference for more widely available culturally competent services. The desire to ensure that services are inclusive in relation to sexual identity could be partially met through the actions that services take. LGBTQ+ people wanted to be able to access similar things to their neighbours, friends, families and those in the wider communities in which they live. Taking into account people's life stories, not making assumptions about relationships and living arrangements, and recognising where heteronormative structures of assessment and activity occur, may facilitate more inclusive experiences for LGBTQ+ people.

There is likely to be a direct relationship between the enthusiasm of staff working in frontline services to make changes that might improve inclusivity, and senior management enabling systems or processes which facilitate this. It is often individual staff members rather than collectives that lead initiatives or make experiences positive. Without wider strategic efforts, this is likely to remain the case. The risk with this is that staff who are driving inclusivity agendas forward are not effectively supported by senior management, which makes ongoing change more difficult to embed.

One element of complexity is around services knowing and understanding what actions they can take that may lead to improved cultural competence. This is challenging in an environment where clear frameworks for cultural competence often seemed unavailable to guide organisations and staff. The studies demonstrated that the context of the support being delivered is likely to be highly relevant, and achieving convincing cultural competence with a heterogenous group may be extremely difficult. Although regulatory and legal drivers for meeting equality and discrimination legislation are in place, these are also not explicit, are not consistently monitored and may only focus on avoiding discrimination as opposed to proactive elements of work which contribute to an inclusive environment. Without drivers, incentives and clarity on expectations and what actions are needed, it may be challenging for individual services to move the inclusivity agenda forward in meaningful ways.

2.7 Gaps in research

As a burgeoning area of research, LGBTQ+ experiences of social care are still being explored. This population is diverse as are the settings being considered which makes transferability of findings challenging. It is difficult to ascertain whether the experiences and points of view of smaller groups are representative of the wider LGBTQ+ population. This is partly because we do not know and cannot access the population as a whole, which may result in an unrepresentative view of the positive and negative elements of accessing social care as a minority group. The influence of the 'activist voice' is an important consideration, with those who take part in research possibly more likely to be in better health, less frail, more articulate, passionate about their opinions and possessing a greater sense of self within the LGBTQ+ community. This impacts on confidence in what we already know as well as being able to robustly identify gaps in understanding. Further research capturing wider examples of experiences and feelings for older LGBTQ+ people will continue to contribute to this understanding, including within this research.

Research around community based social care specifically, particularly in the UK, is relatively sparse, more so than consideration of more formal settings such as residential care. Much of the research focuses on wider considerations such as people's abilities to build networks and families of choice and the implications of this, rather than their interface with statutory and non-statutory service provision. Although this is extremely relevant in terms of understanding what people's needs might be and how they may compensate for lack of services or wishes to engage with provision, it does not tell us much about experiences when they do access provision.

It is useful to be able to build an understanding of why older LGBTQ+ people do not engage with services, what influences experiences when they do, and how sexual identity is relevant to these experiences. Although there will clearly be a range of factors leading to decision making for this group, and some of these will not be related to sexual identity, evidently some are and building a better picture of that is much more likely to contribute to changing approaches through building understanding from a research and practice perspective.

The networks and connections people build are seen to be important, but little has been explored about the ways in which services and staff can or should contribute to the building and maintenance of these networks, particularly where this is linked to connection with the LGBTQ+ community. If further understanding of how locally embedded groups and services can facilitate these can be created, this has the potential to bolster the development of both effective and comprehensive support addressing social care needs and providing points of connection which improve overall quality of life for older LGBTQ+ people.

Services require reliable sources of information about what their strengths and weaknesses are in relation to supporting older LGBTQ+ people inclusively and direction and guidance in terms of the actions they can take. This can only be provided through research which highlights what is important, why and how it can be changed. Many services continue to believe that they do not have enough LGBTQ+ service users to justify specific approaches and that sexual identity is not relevant to care delivery. Further evidence of the need for consideration of this group can potentially contribute to embedding the values of inclusivity into service delivery.

There are a few examples of research which highlight what is felt to be good practice in terms of inclusivity for older LGBTQ+ people, and in the absence of legal and institutional drivers, further research on what good looks like and how it influences decision making is likely to contribute positively to services changing. The complexities for services in changing approaches have not been extensively explored. There are very small numbers of studies which consider older LGBTQ+ people’s experiences and feelings alongside service providers highlighting the challenges and complexities of making impactful changes to these experiences. Many services and organisations are keen to know what practical steps they can take to become more inclusive, to be culturally competent and beyond studies which consider education of staff through specific training, little other research addresses these issues concurrently.

There are also inherent challenges for community-based services, which are often run or facilitated through volunteers or charities/non-profit organisations. Those who are facilitating groups and services cannot necessarily fall back on policies and procedures, as these often are not in place within the structures of the organisation. This means that solutions may need to be simple, affordable, and palatable. Research in the area of LGBTQ+ people and social care often highlights what is ineffective or impactful on experiences, without necessarily considering the complexities and barriers that might exist for service providers within that. More pragmatic approaches, where there may be opportunities for compromise within solutions which result in better experiences for older LGBTQ+ people but do not cause further complexity for providers, have not been fully explored within the research to date.

Ways to be inclusive need to be manageable and not reliant on hierarchical mandates. Applied research, focusing on some of the smaller, more practical ways to increase inclusivity is currently lacking, and opportunities to consider how the preventative and informal nature of many community-based social care groups and organisations can contribute to meeting the wider needs of the population needs to be further explored. The role of identity, the value of linking with local communities including the LGBTQ+ community and the actions that are perceived as inclusive are reasonably well understood in the existing research. However, the complexities within some of that, particularly in terms of the implications for community based services is not currently as well understood. There are potentially benefits for all types of provision in these being explored in more detail.

In undertaking this scoping review, the aim was to find research about the role of community-based services and the experiences of accessing these for older LGBTQ+ people, particularly in the UK. However, this broader area has not been extensively explored, with virtually none of the research that met the inclusion criteria specifically focusing on the experiences of this group with these particular services. Therefore, one of the conclusions in relation to this research was that the research questions are sufficiently unique to justify this research being undertaken

3. Methods & Methodology

3.1 Introduction and Overview

In this thesis, qualitative methodology and methods have been used to explore the identified research aims and objectives. The term methodology describes the conceptual approach to the research process, while methods are the practical techniques utilised to generate and analyse data. The philosophical framework and relevant theories within which the thesis is situated, followed by the ways this was subsequently applied to the research, are further explored. The methods used, how these were implemented and the resulting sample are presented.

The purpose of this study is to understand the experiences and feelings of inclusivity within community based social care for older LGBTQ+ people and staff. The study utilises qualitative methods in order to capture the feelings and experiences of people who access services or work in them, on the basis that people are best placed to describe the things that influence their choices, experiences and behaviours. These methods assume variables are complex, interwoven and potentially difficult to measure and are not necessarily led by hypotheses, but by using words and narrative to derive meaning (Stuckey 2013).

Qualitative research is arguably the most effective way to capture lived experience. It can allow collection of richer, more complete descriptions and gives the researcher an opportunity to consider the meaning of both human phenomena and lived experiences. It contextualises the social, cultural and behavioural constraints by considering beliefs and attitudes, motives or obstacles. Rather than quantification of data, it emphasises the importance of words (Bryman 2016).

These approaches allow the situations, context and dynamics people are in to be explored at a deeper level through consideration of basic concepts and assumptions. Viewing the relationship between theory and research as inductive and allowing the researcher to draw conclusions and suggest actions based on analysis of experiences gathered as part of the study are helpful tools in building understanding. The nature of qualitative research allows experiences, behaviours and interactions to be utilised to question fundamental assumptions about the causes of those experiences (Pope & Mays 2006). It addresses the question of ‘what’ while conceptualising the question of ‘how’ in a way that allows consideration of the whole and all of the individual parts (Bloomberg & Volpe 2019).

It is important to consider how this research may have been influenced by theories both before and after fieldwork was carried out. Additionally, it should be considered that literature reviews can act as a type of proxy for theory (Bryman 2016). Due to the nature of the research topic, the ways in which the worldview taken by the researcher may shape the approach to research may also be relevant. Working with marginalised groups and considering how these groups may be empowered through research that includes their voices is likely to lead to a more informed outcome. The inclusion of focus groups with social care staff which utilises data collected from interviews may assist in filtering the researcher's interpretation, which in turn may decrease the influence of the researcher's worldview.

3.2 Philosophical framework & worldview

People have a unique capacity, and need, to assign meaning to events and actions and strive to make sense of experiences. There is an interaction between our inner selves and external environments (Loevinger 1976). Philosophical paradigms allow us to articulate our own beliefs about reality and, in the case of research, study the world. These philosophical concepts include: ontology - what exists and assumptions about how we understand and categorise what we believe to be real; epistemology - the philosophical approach to how we acquire that knowledge and use it to understand the world; methodology - the most appropriate philosophical frameworks we can apply to achieve the understanding we are looking for, and; methods - the practical ways we will collect the information we need to inform our understanding (Rehman & Alharthi 2016).

A 'paradigm', or a philosophical way of thinking, with Greek origins in understanding and observing patterns in data (Kuhn, 1962) is used to describe a researcher's worldview - or the basic beliefs which guide their actions (Guba 1990). This is likely to have a bearing on how data are both collected and interpreted (Bryman 2016, Brown & Opie 2019, Creswell & Creswell 2018). It is well understood that what we observe and conclude is shaped by what we already believe (Babbie 1995). However, there are complexities in studying the social world as opposed to the natural world (Bryman 2016). Each research paradigm has its own specific purpose and provides distinct means of producing unique knowledge (Taylor & Medina 2013). Ultimately, the impact of the researcher's own interpretations and worldview should be recognised and acknowledged.

The four most commonly identified philosophical worldviews are Pragmatism, Constructivism, Positivism/Post Positivism and Critical Theory. The researchers worldview will influence the research design, the process of inquiry and the methods used in data collection (Creswell and Creswell, 2018).

Pragmatism is a wide and flexible approach, not committed to a specific philosophy or paradigm (Bloomberg & Volpe 2019, Moon & Blackman 2014). A pragmatic approach considers the nature of inquiry as created through the occurrence of a problem in a past experience. It does not consider all possible influences although it does consider the problem from a range of angles. Constructivism is commonly reflected in qualitative research (Guba & Lincoln 1994), with meaning derived from interaction and interpretation, social and historical context (Bryman 2016). It acknowledges underlying realities, allowing each individual to construct their own reality based on their experiences (Scaife 2019). Positivism argues that a single reality exists which can be objectively measured and strives to confirm or predict adherence to patterns of behaviour (Bryman 2016). Post positivism challenges a model of absolute truth, acknowledging we cannot positively claim things about human behaviour and actions (Phillips & Burbules 2000). Participatory approaches to Critical Theory are discussed in further detail as the researcher's worldview.

Ontologies differ in their approaches to understanding human experience and for applied social research, realist and relativist ontologies are especially important orientations. Realist ontologies argue there are objectively measured single realities (such as Positivism). Relativist ontologies posit multiple constructed realities which require subjective interpretation. Relativism recognises a lack of objectivity in people's experiences and the actions that will impact on those experiences as they are related to perspective and context. This is subsequently applicable to both people's own point of view or experiences and the observations by others of someone's experience. A recognition of the lack of objectivity in relativism will be crucial in framing both the approach and findings within this thesis.

The philosophical frameworks around acquisition and use of knowledge (epistemologies) vary widely. Epistemologies are concerned with the validity, scope and methods of acquiring knowledge. They consider what constitutes knowledge, how that knowledge can be gathered and whether it is transferable (Moon & Blackman 2014). Subjectivism purports that our mental activity is the only factor of our own experience, therefore is unquestionable and is in fact, not objective truth. Interpretivism sees people as actors within the social world, instead of considering the ways they may be impacted by external factors or social structures. Constructivism and interpretivism standpoints include the belief that multiple realities can be constructed and therefore require interpretation as they are relative and subjective. Neither approach is without challenges.

In practical terms, a requirement to quantify the lack of external or objective truth through focussing on people's own experiences enables exploration of the challenges of addressing the impact of the actions of others, such as discrimination. Applying this type of evaluation involves making a judgement about what has been meaningful for individuals by considering how both individuals and groups have constructed that meaning (Patton 2015).

3.2.1 Critical Theory

Participatory frameworks, situated within critical theory, have a focus on social justice and advocating for actions which address injustice and inequality through the recognition of political and social reform. Its basis considers the perspectives of feminist, queer, transgender and disability discourse and theory without the structural theories imposed within postpositivism (Bloomberg & Volpe 2019). It assumes that research will focus on the reform needed to change the lives of those groups, and that of the social environments they live within (Brookfield 2005). Its goal is to bring change to social structures by allowing research design to be led by those who strive for changes and attempts to reflect the relationship between the researcher and those researched within its assumptions.

Central to this approach are factors such as equality, fairness, freedom and liberation (Denzin & Lincoln 2000). It is critical of the status quo, leading the theory to be frequently adopted by the most marginalised individuals and groups. Assumptions include that reality may be objective or subjective and the truth is continuously contested by opposing groups (Creswell & Creswell 2018). Due to its focus being on marginalised groups, its epistemological roots are in power (Bryman 2016). The power to determine what knowledge is important can often dominate worldview approaches to research, whereas this framework seeks to transcend the groups it looks to represent.

The ability to identify an issue which is the result of inequality, oppression or an imbalance of power, then seek to solve the problem may allow the researcher to empower the marginalised. This fundamentally moves marginalised voices into central focus. This will be important here because the group being researched are likely to be experts in their own lives and decision making. Seeking to understand how people experience something and make decisions is a crucial part of this research.

Therefore those voices must be the central focus, while the wider social context within which the research sits must feature as part of analysis. To be able to clearly delineate between what people want or hope for, and what might be possible within the systems of power and the social context of the current time will provide an opportunity to consider the theoretical implications of the study. The theoretical framework will also be applied to the research aims and research design in terms of centering the voices of those who have the most understanding (older LGBTQ+ people) and those who may have the ability to influence experience through taking action (service providers).

3.2.2 Identity theory & its impact on decision making

Identity provides us with the ability to assign meaning to our lives. It can give us a sense of belonging, which can be an important component of wellbeing and confidence (Tajfel & Turner 1979). Additionally, it helps us to categorise ourselves and others, and influences the ways in which we behave and the attitudes and values that we have (Tajfel & Turner 1986). There are a range of factors which contribute to our own identity, which can include personality, social relationships, life experiences, cultural norms, how we feel about ourselves, our own psychological well-being, cognitive biases and even the access we have to resources such as education, employment and healthcare (Cheek & Briggs 1982, Stryker 1997, Pennington et al 1999). It is important to consider the impact of identity on the choices, behaviour and responses of both older LGBTQ+ people using services, and staff working in these services. Understanding theoretical perspectives on the role of identity provides framing for the design and interpretation of findings within this study.

Decision making is influenced by identity (Blustein & Phillips 1990), and therefore it is relevant to consider the role of identity in a range of actions. Making choices about accessing services, deciding what makes them inclusive, and judgements formulated based on experiences and expectations about discrimination and unfair treatment all become relevant. Understanding what might be influencing staff to think in the ways they do about ageing and LGBTQ+ populations will contribute to understanding and drawing conclusions about how these groups are viewed.

Social Constructionist Identity Theory, an underlying philosophical view of identity, proposes that the meaning we extract from the world is co-created, rather than reflecting objective reality (Berger & Luckmann 1966). It theorises that key processes occur in formation of identity: self-categorisation and social comparison. A combination of self-reflection, feedback from others, and a process of comparing self to others and attributes of an identity, result in a formulation of self identity (Tajfel & Turner 1979, Abrams & Hogg 1988, Jenkins 2014).

Interpretation is framed using common social and cultural narratives which interact with our views of ourselves. This can result in us judging the behaviours we think are typical to an identity and using this to guide our behaviours, sometimes to support or refute the identity, depending on the advantages or disadvantages associated with it (McCall & Simmons 1978, Burke & Reitzes 1991). These processes are rarely static and can change over time (Stets & Burke 2000) with factors such as ageing, changes in wider social views, or personal experiences influencing how we relate to an identity and how prominent that identity is for us as individuals in each context. Most people will identify with a range of identities which may be more or less relevant over our life course and many of these identities will intersect.

As part of the process of asserting identity, we will identify things we think are similar or different to others with that identity and make judgements about who is in the inside and outside groups. As part of trying to align with the inside group, our views and perspectives can be influenced, including how we then categorise ourselves (Hogg & Hardie 1992, Stets & Burke 2000) and we may also act in specific ways according to the context of the situation (Flournoy, Holt & James 1917). This demonstrates the relevance of what others do or believe about particular identities in relation to how we then feel about ourselves and our experiences.

We will use attitudes, values, behavioural norms and other attributes common to the identity to judge whether we or others fit those parameters. It may include selectively accentuating or minimising behaviours associated with that identity (Stets & Burke 2000). This potentially influences the ways in which we behave. We all tend to act in the ways we feel are appropriate for our identities (Seidman 2011). We may downplay attributes we feel are incompatible with a particular identity (Goffman 1959). Most categories of identity are part of a social structure which exists on the basis of contrasting binary identities eg homosexual/heterosexual, disabled/able bodied. There are factors which can impact on these such as the power, prestige or status associated with particular identities (Hogg & Abrams 1988) as classifications are rarely neutral (Jenkins 2004).

Categorisation of identities is utilised within many social and economic systems and the ways in which these categories are viewed can impact on how we feel and judge ourselves and others. The range of categorisations used can be an important source of pride and self-esteem, giving us a sense of belonging in the wider social world (Tajfel & Turner 1979). However, there can be variations over time and culturally in the attitudes towards and treatment of particular identities. LGBTQ+ identity is a good example of this, where legally and socially there are huge differences in how this identity is viewed across the world and this continues to change over time.

Within social care provision, the importance of identity may become relevant to the ways in which people interact with services and anxieties they may have about accessing support. How we view ourselves and how others view us is likely to influence behaviour. One feature of categorising identities is the attributes assigned to that identity may then become stereotypes associated with it. This can be both positive and negative but can also become exaggerated or inaccurate over time. Negative stereotypes associated with an identity can potentially cause harm to individuals and groups as a whole. We can internalise these stereotypes and if they do not align with how we really feel or how we wish to express our identity, this can have a range of effects. Correlations between internally held negative beliefs or stereotypes about our identity and our physical bodies, cognitive performance and health outcomes show the importance of ensuring validation of identity (Levy 2009, Levy et al 2016, Vecci & Želinský 2019). If there are established stereotypes associated with an identity, this can discourage people from challenging these. This in turn may reduce the likelihood of a person, particularly an older person, contributing to society in positive ways because they do not wish to act counter to other’s expectations (Levy 2009, Swift et al 2017).

It is common for both ageing and LGBTQ+ identity discourse to focus on shortcomings, problems, decline and more negative aspects of these identities (Butler 1969, Nelson 2002, Palmore 1999, McInroy & Craig 2017, McDermott et al 2008). Traditionally, ageing research has focused on decline in cognition and on negative stereotypes (Cuddy et al 2005, Kite et al 2005, North & Fiske 2013). Decline can be viewed as inevitable and universal, leading to a belief that older people can no longer contribute productively to society (Victor 2005).

Much of the research of LGBTQ+ communities has focused on discrimination, mistreatment and the impact of inequalities. This potentially validates the view that the LGBTQ+ community are defined by negative aspects of their identity, which may in turn contribute to discriminatory attitudes. Negative stereotypes may result in the pursuit of coping measures such as negative behaviours, or subconsciously performing behaviours in order to bolster a sense of self or as an act of self protection (Jackson et al 2010, Akerlof & Kranton 2000, Pearson & Rose 2021, Kailey 2005, Levitt & Ippolito 2014). In the longer term, this can influence self-perception as well as potentially serving to revalidate stereotyped views of that identity, indicating a level of impact on an individual as a result of these stereotypes, regardless of whether they are accurate (Hull et al 2017).

Identity can also be influenced by societal norms, and where those identities fit within the current social order, which can impact on attitudes towards particular groups, and the ways that group behaves and is treated (Rubin 1984, Diefenbach 2013). This is particularly pertinent when considering older LGBTQ+ people using social care services. If a person is older and LGBTQ+ there is a potential for them to be viewed according to the associated stereotypes of these identities, which may be inaccurate and negative in nature. This may influence their behaviours, willingness to engage with services and expectations according to how their identities are validated, or negated within service provision.

Primary focus on negative elements of an identity can remove agency from a person, fails to validate that identity and may contribute to building wider negative views of that identity, decreasing focus and visibility on positive or valuable aspects (Quinn & Chaudoir 2009, van den Scott 2017). If a generally held view or attitude about a group is wholly negative, it is likely to mean those in that group make associations between their identity and the negative stereotypes, regardless of their own experiences (Abrams 2010). The attitudes of staff towards both older and LGBTQ+ people will likely be influenced by the stereotypes associated with these identities. This may mean the ways in which a service is designed or run is based on inaccurate stereotypes. There is also a possibility that the performance of these stereotypes decreases visibility and causes the individual distress if they feel there is a need to behave in particular ways. Conversely, older LGBTQ+ people may make assumptions about how services are going to treat them based on equally negative stereotypes about social care staff and services.

It is common for those who have a marginalised identity to expect mistreatment and discrimination and this can have a direct effect on how decisions are made (Fredriksen-Goldsen et al 2013, Jackson et al 2008, Butler 2017). The ways in which a person perceives themselves to fit stereotypes, and how they might be impacted by what judgements others make about them fitting a stereotype can impact on how they make decisions (Schneider & Dimito 2010, Smith & Turrell 2017). The intentional concealment of identity can have mental health consequences (Meyer 2003) and it can be common for LGBTQ+ people to mask their identity in anticipation of discrimination (Aksoy et al 2023). This can influence how decisions are made, especially if it is felt that being open about identity presents a risk of mistreatment (Aksoy et al 2023). The value of providing inclusive environments, where people feel confident that being open is unlikely to result in discrimination, may therefore have a direct effect on engagement, experiences and self-validation.

Decision making may also be impacted by ageing. Older people are more likely to retain or focus on positive elements of a situation (Mather & Cartensen 2005, Reed et al 2014) and manage emotional regulation more effectively (Charles 2010), allowing them to mediate decision making in a way that prioritises positive elements (Brassen et al 2012). There is generally more focus on pursuing goals and activities that support wellbeing as ageing progresses (Lim & Yu 2015). This shift in thinking towards positive mindsets may offset some more negative experiences which shape older people’s expectations.

Individuals will have multiple identities (e.g.ethnicity, geography, age, class, sexual identity) and multiple determinants of discrimination, such as sexual identity and racial minority may impact on the ways services are engaged with (Quinn & Dickson-Gomez 2016). People will make efforts to navigate their own simultaneous identities in a way that minimises negative impacts (Quinn & Dickson-Gomez 2016). Intersectionality, the theoretical framework that considers the interaction between identity categories and systems and structures of power, argues that lived experience cannot be reduced to singular characteristics, contexts or time periods (Etherington et al 2020). This presents a challenge for services and staff who may be navigating a range of identities within a social care system which may unintentionally discriminate against some of those identities.

As part of this study, it is important to understand the theoretical frameworks and existing research related to identity, decision making, and anticipation of discrimination. The ways in which these might influence engagement with services and how staff feel and behave within service settings towards those who have marginalised identities is relevant. It helps to enable confidence in the methods used and provides a foundation to better understand the data collected and its subsequent analysis.

3.3 Research design

Following a qualitative research design framework, the study was developed using an inductive and iterative approach. In line with the research aims and theoretical approach, understanding the topic requires the synthesis of individual experiences to form an overall view. This includes an indirect process within the research design of collecting data about something not to singularly scrutinise and interpret that, but to utilise it to predict what changes might be required. To have freedom to recognise the nuances of human behaviour and attitudes, interpretivism allows for the consideration of the meaning people attach to their actions and an ability to consider this within any conclusions. It is vital for a researcher to understand the participants perspective to allow a retained focus on emerging themes (Bogdan & Taylor 1975).

A qualitative design, employing a combination of semi-structured interviews and focus groups, aimed to capture experiences and ideas. Interviews with older LGBTQ+ people and staff/volunteers in community based social care services and groups formed the initial stages of the study. A topic guide was developed for both groups based on these aims. Interview data were coded to identify initial themes and key topics for further exploration in subsequent focus groups. Focus groups were held to discuss initial findings from the interviews, focusing on wider feelings and experiences in relation to supporting older LGBTQ+ people in inclusive ways within community based social care.

3.3.1 Research sample

In planning the research, the aim was to recruit participants according to the sampling framework noted in *Table 3.1*. This framework demonstrates the range of representation aimed for in the sample, with an intention of maximum variation, ensuring as much diversity as possible was achieved across age, gender identity, sexual identity, type of area, type of service provision (staff only), disability (older LGBTQ+ only) and whether or not a formal social care assessment was in place (older LGBTQ+ only). This allowed a broad view of feelings and experiences to be considered and contributed to identifying differences and similarities across groups.

Participant eligibility was identified prior to and during recruitment. For older LGBTQ+ people, inclusion criteria included age (over 50), self-identifying as LGBTQ+ and either using social care or anticipating use of social care in the future. For staff/volunteers eligibility included that they currently or had previously worked or volunteered in a community based social care group or service.

Purposive sampling was undertaken, defined as a non-probability form of sampling whereby the researcher defines the specific groups or categories of participants needed to achieve the research aims (Bryman 2016). The research sample was conditional on self selection of participants, as opposed to structured access to a broad and representative group.

Participants were asked to take part in a one-to-one interview. This was in person, online using a video communication platform such as Zoom or via telephone according to the preference of the person. Interviews were between 60-90 minutes and were informal, guided using the topic guide but allowing for the participant to raise any topics they felt relevant. Interviews were recorded and transcribed. All interview participants were asked to sign a consent form prior to the interview. An example of the consent forms can be found at *Appendix 6*. Topic guides can be found at *Appendix 11*.

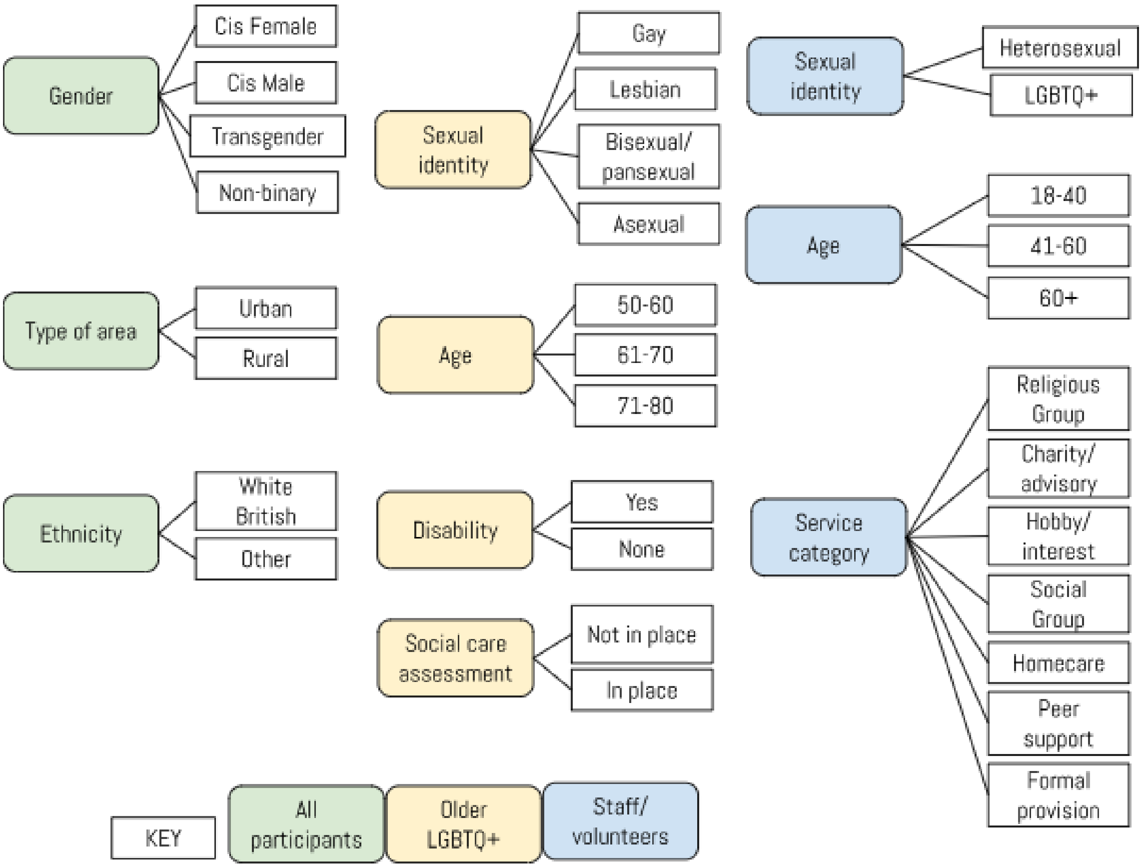

Table 3.1 Sampling framework for research design

All older LGBTQ+ interview participants were asked for characteristic data at the start of their interviews, including age, sexual identity, gender identity, ethnicity, type of location, disability and whether they had a formal social care assessment. Rather than a set list, for categories including sexual identity, gender identity, ethnicity, and disability, participants were able to self-identify. Where participants were indicating a disability, there was no requirement to be classified as disabled according to the Equality Act 2010, and no further questions were asked about the nature of the disability or its impact. Participants were not stopped from providing further information in regard to this if they wished, but this information was not purposefully gathered.

Focus groups were organised for a 90 minute slot. These were either online using a tool such as Zoom, or in person. Focus groups were recorded and transcribed. All participants were asked to sign a consent form prior to the focus group. An example of the consent forms can be found at *Appendix 6*.

All focus group participants were asked to complete a demographic information form prior to taking part in the session. This was to enable privacy and confidentiality between the focus group participants and the researcher. The form asked for age, sexual identity, gender identity, type of organisation, type of role, location and ethnicity based on UK government guidance for ethnicity categorisation: (https://www.ethnicity-facts-figures.service.gov.uk/style-guide/ethnic-groups). Sexual identity and gender identity was self-identification rather than a set list. A copy of the demographic information sheet can be found at *Appendix 7*. Following the completion of the interviews and focus groups, all data was transcribed.

3.3.2 Ethical approval and considerations

Ethics approval from the University of York's departmental Ethics Committee was sought prior to any data collection. This included an ethics application form, a data management plan, a risk assessment, examples of topic guides, consent forms, information sheets and any other associated documents. No fieldwork commenced until this had been granted. Copies of the relevant associated documents not already included in other appendices can be found at *Appendix 9*.

A number of ethical considerations were considered, some of which influenced the research design and data collection. As with any qualitative research where people are being spoken with, there was a risk that participants would reveal evidence of criminal activity. Examples include hate crimes or instances of prosecutable discrimination, as well as a risk of identifying moral or safeguarding issues. Additionally, using a snowball approach during recruitment could have presented issues of confidentiality, difficult power dynamics and the possibility of participants recognising other's contributions in any output (e.g. articles, thesis, focus group discussions).

The information sheet and consent form included a section regarding the sharing of information. If any participant revealed information that could lead to harm for themselves or others, this would need to be reported through appropriate channels. Participants gave written and verbal consent to this through the consent form and at the start of the interview or focus group.

Older LGBTQ+ people may be classified as having higher levels of vulnerability due to their levels of frailty or cognitive decline. This was monitored through discussion between the researcher and the participant to ensure understanding of what participating involved, with the option to withdraw at any time highlighted by the researcher at the start of the interview/focus group. Additionally, older LGBTQ+ interview participants may have been anxious due to their membership of a minority group, their older person status, or the requirement to identify their sexual identity in order to take part in the research. Anonymity and pseudonyms were used throughout to protect confidentiality, including in relation to sexual identity. Topic guides and questions asked remained mindful of the potential vulnerabilities of the participant group. Participants were able to refuse to answer questions, or have their data withdrawn until a specified date. The identity of participants remained confidential, and were only available to the researcher and supervisors.

Participants were self-selecting, and no undue pressure was put on participants by the researcher to take part in the research. Where people participated following recommendations or referrals from others, these connections were not discussed. Participants were assigned pseudonyms in all writing related to the data collection and subsequent reporting, with some participants selecting their own pseudonyms. The names and types of services were allocated to a generic category to ensure anonymity. In instances where data, particularly direct quotes were considered for use, this was measured against the likelihood of breaking confidentiality or potentially revealing connections between participants or between a participant and a service or group. Permission to use direct quotes in any outputs was included on the consent form, and all participants had the option to deny consent for this if they wished.

Older LGBTQ+ participants may have felt distress as a result of disclosing difficult experiences, or from revisiting previous frustrations with service provision they continue to rely on. Interviews were conducted sensitively to ensure any distress was minimised and acknowledged. The participant was told they could pause or cease the interview at any time and support was offered to allow them to express their feelings in any way that felt appropriate to them. Participants could choose to not answer a question or change the topic if they wished at any time. The researcher checked wellbeing and comfort throughout the interview and paused any line of questions which was causing distress. Participants may have also felt obliged or pressured to reveal intimate or sensitive information which may have caused them distress or presented ethical dilemmas. Appropriate responses from the researcher and offers to pause or stop the interview were offered to the participant in this situation.

Older LGBTQ+ participants and those who worked in services may have given accounts of poor practice which constituted abuse. A disclaimer regarding the sharing of data where potential harm may have occurred was included in the information sheet, and reiterated within the Data Information Sheet (Appendix 8). If any participants shared information which indicated that abuse had taken place, the safeguarding duties of the researcher would have been discussed with the participant and the supervision team. Following established escalation procedures within the University, where required, the abuse would have been reported to the appropriate authorities. If the issue had occurred within a registered service, a report would have been made to the Care Quality Commission, and/or the Local Authority or Safeguarding team. Where any person admitted to carrying out abuse, depending on the nature of the report, appropriate authorities such as the police would have been notified and where appropriate, an employer. If this had occurred, the interview or focus group would have been stopped, and all relevant records (e.g. recordings) would have been provided to the involved authorities.

For people who worked, volunteered in, or ran services, groups or organisations, it was recognised that they may have experienced distress or frustration when revisiting negative experiences or recounting observed behaviours from their employer or work colleagues. This was managed through allowing participants the opportunity to express this and discuss in further detail, if it was felt to be helpful. It was made clear to participants that revealing poor practice would not result in any risk to their employment status or reputational risk with any service provider. The anonymising of data as part of the data collection mitigated the risk, as did the assigning of generic service types (which the participant chose themselves). Service types were utilised via generic categories to allow for anonymity.

When carrying out the interviews and facilitating the focus groups, it was possible the researcher would be at risk of feeling distress due to the nature of stories being told by participants. This risk was mitigated largely due to the researchers extensive experience of interviewing individuals about distressing situations in previous roles. Discourse, or debrief could be sought with supervisors following any distressing or upsetting interviews.

It was important for participants to feel comfortable with the researcher's credentials. This was managed through measures including ensuring all communication happened through University systems (phone and email) to confirm identity. Ethical approval documents were provided upon request (one service provider requested sight of these). The researcher has previously held multiple full clear Disclosure and Barring Service (DBS) checks and full Home Office clearance and an updated DBS was sought prior to field work commencing.

During the focus groups there could have been anxiety for participants in relation to confidentiality and feeling judged by others. They may have experienced distress as a result of listening to others talking about their own experiences. The consent form and information sheet gave a clear overview of the expectations, potential topics and how the research was being conducted and reported. Participants were offered the opportunity to ask questions at several stages of the process including when sent the information sheet, on committing to take part, on arrival at the focus group, during the focus group session and after the focus group had taken place.

In order to ensure that focus group discussions remained respectful, appropriately focused and constructive, there was close management of facilitation by the researcher. Senior staff and managers could have a dominating influence on culture, and negative examples can create normalised behaviours. If any discussion became inappropriate, participants were being impacted by particular views or participants were unable to contribute their own opinions, the researcher intervened to de-escalate the conversation or move on to another topic (see section 6.6 for further reflections on the focus group sessions).

3.4 Recruitment methods

Recruitment for data collection started in early 2021, following receipt of the appropriate ethical approval from the University of York. All associated ethics approval documentation can be found at *Appendices 6, 7, 8 & 9.* Following this, recruitment was undertaken alongside data collection and initial analysis. Recruitment and data collection continued throughout 2021 with interviews carried out between April 2021 and November 2021. Initial data analysis was carried out prior to focus groups to allow for the development of a topic guide and stimulus material for use during the focus group discussions. Focus groups were held between August and October 2022. A copy of the topic guides is included in *Appendix 11*.

3.4.1 Recruitment approaches

Recruitment was approached in a range of ways. An information sheet was produced which was shared as part of the recruitment process. A copy of the information sheets can be found at *Appendix 8*. *Table 3.2* illustrates the contacts utilised in recruiting both older LGBTQ+ people and those who worked or volunteered in services. Organisations and groups were asked to advertise the research and request for participants using their usual communication methods. This included adverts in newsletters, direct contact with groups, and attendance at groups or meetings with individuals to talk about the research. A snowballing approach was used where participants were asked to promote the opportunity to take part in the research with friends, groups and networks. Prior to the pandemic, adverts were to be displayed and distributed to places such as community centres and community hubs to encourage further participation but this was not possible during the recruitment and data collection phase due to COVID-19 restrictions (see section 6.7.2 for further discussion about the impact of COVID-19).

Those participants who took part in interviews were asked if they would be interested in participating in a focus group with others. Records were retained for those who felt they would be happy to take part in a focus group in the future.

Type of organisation	**Method of contact**
Community based organisations such as community centres	Initially via email
Centres for voluntary services	Initially via email
Healthwatch & similar advisory organisations	Initially via email
LGBTQ+ support and advisory groups and organisations, charities and groups	Initially via email
Social Prescriber and Social Care networks	Initially via email
National LGBTQ+ networks	Initially via email
National Social Care Organisations who communicate with staff and volunteers eg Skills for Care	Initially via email
Local and national LGBTQ+ Facebook Groups	Facebook page created, joining groups & posting adverts
Private social care organisations who employ staff for frontline social care work	Initially via email
Any individual or organisation who may be interested in the research	Advertising via a social media platform

Table 3.2 Types of organisations to be contacted during recruitment

3.5 Data Collection

3.5.1 Original design

The original intention was to carry out interviews with older LGBTQ+ people and staff/volunteers, to analyse the data collected and utilise this to steer the content of subsequent focus groups which would include both older LGBTQ+ people and staff/volunteers. This design was kept under review during data collection and several amendments (see section 3.5.5 for further details) were made to the process following feedback from potential participants and consideration of the already collected data during and after the initial data collection.

3.5.2 Recruited participants

Overall, 23 participants were recruited for both the interviews and focus groups. Sixteen were interviewed (12 older people and 4 service providers) and the remaining 7 (service providers) took part in two focus groups. A breakdown of characteristics of older LGBTQ+ people interviewed is provided in *Table 3.3* and staff and volunteers who participated in either interviews or focus groups are provided in *Table 3.4.*

Demographic		**Number**
Gender	Cis Male	7
	Cis Female	4
	Transgender	1
Sexual identity	Heterosexual	1
	Gay	6
	Lesbian	2
	Bisexual	2
	Asexual	1
Age	50-60	3
	61-70	3
	71-80	6
Type of area	Urban	7
	Rural	5
Ethnicity	White British	10
	White American	1
	Chinese	1
Disability	Yes	4
	No	8
Social care assessment	Yes	3
	No	9

Table 3.3 Demographic breakdown of older LGBTQ+ people who participated

Demographic		**Number**

Gender	Cis Male	3
	Cis Female	7
	Non-binary	1
Sexual identity	Heterosexual	4
	Gay	2
	Lesbian	3
	Bisexual/Pansexual	2
Age	18-40	3
	41-60	4
	61+	4
Type of area	Urban	9
	Rural	2
Ethnicity	White British	10
	White European	1
Service Category	Charity/advisory	2
	Hobby/activity/interest	2
	Social group	1
	Homecare agency	4
	Other (community library)	2

Table 3.4 Demographic breakdown of staff & volunteers who participated

3.5.3 Interviews

Interviews were carried out with older people who identified as part of the LGBTQ+ community. This was adapted following the start of fieldwork to broaden both the language being used (change from LGB to LGBTQ+), the inclusion and exclusion criteria and the characteristics or experiences of the participants (expanded from ‘using social care’ to ‘using social care or might use in the future’). Further discussion relating to these changes can be found in section 3.5.5 below. An overview of the full participant demographics can be found at *Appendix 10*.

It was considered relevant to understand staff and volunteer attitudes towards the LGBTQ+ community, partly to gauge differences between LGBTQ+ and non-LGBTQ+ staff. After completion of initial interviews, it appeared there were clear differences in experiences which warranted a tailored topic guide for staff who were themselves part of the LGBTQ+ community. There were potentially different perspectives around areas such as starting points for levels of understanding, enthusiasm for change and understanding of challenges. This additional topic guide is included in *Appendix 11.*

Participants were identified in a range of ways. Contact with a large number of organisations was made via email, detailing an overview of the research and the information sheets with a call for participants. This was carried out methodically through identifying types of organisations that may include appropriate participants or have access to networks where participants might be present, and contacting these organisations.

Initially, community based organisations such as community centres, centres for voluntary services, community based groups and organisations were targeted through an email campaign. Following this, health and social care organisations, particularly Healthwatch organisations were contacted via email. The third tranche of organisations were those focused on the LGBTQ+ community, which included a range of organisations and groups both focused on social care and community connection as well as charities, Pride organisations and peer support groups. Social prescriber networks and social care services, groups and organisations as well as national networks were then contacted. A total of 800+ emails and contacts were sent during this part of the recruitment phase.

For both older LGBTQ+ people and staff/volunteers, advertising and direct contact with local services/charities/groups resulted in publication/promotion of the opportunity to take part in the research in more than 30 newsletters. It also led to the researcher attending multiple online focus groups, group meetings, presentations and sessions to talk about the research in a bid to find participants (around 12 in total). Contact was also made with large key organisations and charities such as the LGBT Foundation, Opening Doors and SAND (Safe Ageing No Discrimination). Entries were included on their websites in the research section, promoting the opportunity to take part in the research and individual meetings with key members of staff in these organisations were held to consider ways to promote participation opportunities.

Online meetings were conducted with charity trustee boards, local authorities and multiple healthwatch representatives to share more detailed information with them for subsequent promotion of the research to members and networks. Opportunities to be involved in the research were also advertised through local and national social care networks, local and national service provider networks, local and national LGBTQ+ networks and via local authority contacts including Local Area Coordinators and social prescribers.

Information sheets about the research were distributed to all these networks for wider distribution, to enable those interested in participating to contact the researcher. The information sheet included the contact details of the researcher and clear guidance on how to indicate interest in participating. The information sheets included the eligibility criteria.

A snowball approach was also employed and existing participants were able to share information with other eligible contacts/groups they may have had. This resulted in a small number of additional participants. Some direct approaches were made to services, groups or activities that were aimed at or suitable for people over the age of 50 where information about the group was widely available in the public domain. These included the information sheet and an offer of further information/presentation about the research.

Multiple appeals were made using social media (Twitter & Facebook) for people who may have been eligible to take part, making use of existing networks, groups and suitable hashtags. A Twitter account and Facebook page were created specifically for recruitment to the research and were linked to the researcher's university email address. This included links to the information sheets with an overview of the research, what participation involved, and the aims of the research as well as contact details for the researcher. The posts included limited information detailing the inclusion criteria (i.e. Are you a 50+ LGBTQ+ person who uses community based social care services, groups or activities? Would you be interested in sharing your experiences? Click the link for further information).

3.5.4 Focus groups

Following initial data analysis from the interviews, it was identified that the service providers who had taken part were low in number and limited to members of the LGBTQ+ community. It was decided that focus groups would include staff and volunteers only and would focus on some of the data from the interviews in order to explore these topics in more detail and from an alternative perspective. The perspective of service providers more broadly, in relation to implementation of actions to be more inclusive, was not well enough understood from interview data alone, so this was perceived to be a gap. Exploring these perspectives with a broader range of service providers, would potentially give a more transferable view of the topics being discussed. An overview of the participants can be found at *Appendix 10*. A copy of the slides used during the focus group sessions can be found at *Appendix 12*.

It was important to canvas opinion from non-LGBTQ+ service providers, who would arguably be less motivated to make changes or who may perceive the relative importance of sexual identity in social care delivery in different ways. This was identified as a gap in the data following the interviews and led to the revision of the content, recruitment and topic guide for the Focus Groups. It allowed for broader understanding of the challenges, issues and opportunities of changes to approaches and the implications for implementing these, which may have otherwise been more difficult to consider.

Limiting participants of focus groups to staff and volunteers allowed exploration of whether the levels of importance/relevance of sexual identity were mirrored in the service provider group. Additionally, how realistic, impactful or challenging it might be to implement some of the suggestions from interview participants about signs of inclusivity. The topics were based on interview data and included the importance/relevance of sexual identity in service delivery, collection of demographic information from service users, the challenges of collecting this data, the role of services in connecting people to other LGBTQ+ specific support, advocacy and activities, the markers of inclusion and how these might be perceived and implemented, signs of inclusiveness and use of language, staff understanding and awareness of LGBTQ+ people and their needs and staff training and development.

All interview participants were informed (if appropriate) about the focus groups both before and following their interview and asked if they may like to take part in this at a future time. Information about their wish to participate was retained by the researcher. However, as noted above in section 3.5.3, following the initial data analysis, a decision was taken to not invite participants to take part in the focus groups due to the more focused approach required to meet gaps in data and diversity of sample (all service providers who were interviewed were part of the LGBTQ+ community). A separate information sheet for recruitment to focus groups included the contact details of the researcher and eligibility criteria. A separate consent form was used for participation in the focus group.

Due to a range of factors including the external environment (COVID19, pressure on social care) it was extremely challenging to recruit staff to take part in the focus groups. Further reflections on this are included in section 6.6. Following some concerted effort to raise interest, mainly through social media, contact was made with a researcher who had direct links to a national homecare agency currently engaged in a range of research projects. An initial email was sent to around forty five managers, and the first focus group, carried out online, was made up of service providers from four different areas of the country, not known to each other.

A further attempt was made to recruit for an additional focus group and although this resulted in some interest, participants did not result from this. Following this, contact was made with a link in a Local Authority specialising in working with community based social care services and networks. Advertisements were sent to a range of groups and this resulted in three further participants who attended an in-person session in their local area.

The researcher maintained responsibility for writing, disseminating and advertising all relevant information throughout all the recruitment cycles, although this was supplemented with help promoting the research through colleagues and local networks.

3.5.5 Amendment to research design and approaches

The first tranche of recruitment was carried out in line with the original text submitted to the Ethics committee and included use of the acronym ‘LGB’ rather than ‘LGBTQ+’ in the promotional material used. Following feedback, it was decided that the absence of the word transgender or use of the ‘T’ in promotional material was problematic. Assumptions were made by others that this group was automatically excluded, because the use of the acronym LGB went against the ‘inclusive’ banner the research situated itself in. Initially individual responses were sent when the absence of transgender in the literature was queried (see *Appendix 13* for the response sent when this was raised).

Following reflection on the concerns raised, changes were made to language used in promotional material to provide clarity over the inclusion of transgender people and the focus on sexual identity rather than gender identity. A review was undertaken of participant recruitment to consider ways in which sampling could be more diverse and accessible. This included recognition of the invisibility/’hard-to-reach’ element of the participant group but also the relative specificity of seeking those who had previously or currently used community based social care. Within the remit of the overarching research it was felt that those who met the age and sexual identity eligibility but had not yet used community based social care could also be included, with a slightly altered focus within those interviews on factors that would influence choosing to engage with the type of provision being considered.

This meant the focus of the research was broadened but still allowed for focus on the applicability of the findings for older LGBTQ+ people. Ethical considerations remained broadly the same, with the risk related to current service provision removed. An additional ethical consideration included older LGBTQ+ participants who had not used social care feeling responsible for influencing the output without having had direct experiences of what using those services feels like or what might make that experience positive or negative. This posed a broader ethical risk for the researcher in terms of the inclusion of perceived or assumed predictions of how something *might* feel, but it was felt important to consider these perspectives.

3.6 Data Analysis & Synthesis

3.6.1 Data Analysis

A five stage approach to data analysis, following Pope et al's (2000) framework was utilised, which includes familiarisation, identifying a thematic framework, indexing, charting, mapping and interpretation. Data collected were transcribed and uploaded into analysis software (NVivo). Interview data were fully coded prior to focus groups and codes were further reviewed following the addition of the focus group data. This allowed the data to be explored inductively and assisted with the ability to allow ongoing data collection to be refined and for new avenues of inquiry to be explored (Pope et al 2000). Coding of data utilised a thematic analysis approach and a coding framework was developed iteratively. The coding framework and related data frequency can be found at *Appendix 14*.

Data analysed included:

- Transcripts from audio recorded interviews
- Transcripts from audio recorded focus groups

Familiarisation

Familiarisation with the data was undertaken by listening to the recorded data and reading and re-reading transcripts. Some initial codes were identified, such as markers of inclusion and historic discrimination, following a grounded theory framework approach. These were limited in order to avoid bias from the researcher (Pope et al 2000). The majority of codes were taken from the emerging themes within the data. A reflexive approach was followed to account for the potential influence of the personal attributes of the researcher. Consideration was also given to critical theory and identity theory, situating identity in social and cultural contexts and reflecting the focus on social change and nuances of the injustice that may have been felt by participants because of their marginalised identity.

Thematic framework

The coding framework was created following the interviews to contribute to the topics discussed within focus groups. This framework was then added to following focus groups. Any themes identified from focus group analysis were then revisited within interview data to contribute to the references to each of the identified topics. The analysis of interview data fed into the design of the focus group topic guide and slides to enable focus group participants to consider some of the data that had been collected from older LGBTQ+ people and other service providers.

Indexing

Content analysis was undertaken in order to populate the coding framework, although the frequency with which a topic was raised did not necessarily result in focus on that topic specifically. There were some areas of discussion which were crucial to building rapport with participants but were not necessarily pertinent to the research. For example, many older LGBTQ+ participants were keen to share their ‘coming out’ stories, but these were not necessarily relevant to the main topics.

3.6.2 Synthesis of data

Charting

Constant comparison was utilised, in order to establish analytical categories and to ensure the nuances of the data were reflected. NVivo allowed for cross indexing which ensured that multiple themes could be reflected. These topics were then further refined into higher level key themes.

Mapping & interpretation

Connections between areas and topics which appeared to be dominant were considered. Mapping of these was carried out to consider where there was crossover, interdependence or connections between themes, including what these connections were. A visual map can be found at *Appendix 15*.

Following coding, data were considered under each thematic heading. Data was rechecked during synthesis to ensure any nuanced but relevant data was considered. Focus on the differences between older LGBTQ+ people and service providers was used to highlight where there may have been different perspectives. Similarities in attitudes and feelings were also considered and both were utilised to reach conclusions about what the data implied.

All identified themes were initially written into a narrative synthesis which included both the data itself, and where appropriate, what else was already known on topics from existing research. This was then discussed with supervisors to identify which key themes would be carried through into discussion within the thesis. Data themes which were identified, but are not included in the key topics within this thesis, were retained to allow for future exploration regarding less prominent but equally interesting topics. The two main themes were identified as identity and disclosure, and the perceptions and actions of inclusivity. These are explored further in the subsequent chapters.

3.7 Summary

This chapter has explored the relevant theoretical frameworks, world views, theories and considerations undertaken as part of the methodology and methods for this research. It could be considered somewhat naive to assume a researcher can hold an exclusive and singular worldview, or that this worldview is the most appropriate to apply to the nature of the research being carried out. In this research, the research and the researcher are situated in the participatory/critical theory worldview. The premise of this worldview is that action to address social injustice is the focus and therefore the research and the researcher conduct activity against that aim. It does not require that research is carried out in specific ways in relation to methods, beyond prescribing that those who are the subject or affected by the research and associated actions should be front and centre of the research and the solutions.

The researcher selected a qualitative methodology as it is generally accepted to be the most effective way of collecting data about people's lived experiences. From an ontological and epistemological perspective, acknowledging individuals as social beings who construct and inhabit their own realities, based on their subjective experiences is key. This led to an ontological approach of relativism to be applied throughout, with an epistemology of subjectivism as the fundamental building block for the research methods, interpretation of results and subsequent conclusions.

This chapter also included an account of the research methods used, how these were undertaken, what real time amendments were required, how data was analysed and subsequently utilised for the development of themes within the thesis.

4. Identity & Disclosure

4.1 Introduction

Interviews highlighted a strong focus on identity for older LGBTQ+ people - the ways in which people’s own identity and external factors were or may be relevant in making choices about accessing social care. This chapter addresses the theme of identity and the disclosure of LGBTQ+ identity when considering which services to access. It includes the perspectives of older LGBTQ+ people and those who work or volunteer in social care services. The importance and relevance of identity in relation to choosing and using social care and the understanding and adjustment of service provision are explored. The impact of ageing and its role in influencing the drive to perform levels of activism (including generational activism) is presented, with analysis based on the idea that feelings and actions related to activism will directly or indirectly affect both choices and experiences. Other cultural identities and the way these influence perceptions and experiences within social care are further considered.

4.2 LGBTQ+ identity & networks

The importance and significance of a clear identity as LGBTQ+, how this influenced individuals, as well as the perceived value of links to the wider LGBTQ+ community were evident when talking to older LGBTQ+ people.

> *“It’s very hard, some people just find it difficult to understand…what difference would it make that you, as a gay man…if there’s something wrong with you and you need support, does it matter what your sexuality is? And the answer is of course it does matter” (Fifi, 60s, gay man, service user).*

People talked about personal feelings in relation to their LGBTQ+ identity, why the links they had to the community were important to them and the ways in which they continued to seek these out in older life.

4.2.1 Importance & relevance of identity

Older LGBTQ+ people felt their sexual identity was relevant in a range of ways which influenced choosing services, driven by whether they perceived the service to be specifically inclusive of LGBTQ+ identities. The ways in which older people expressed the importance of this differed. Some felt it was a key part of their decision-making process and others felt it was less important, but still relevant, with many feeling it was more relevant to social care delivery than other areas of their lives, particularly where this was more formal care (e.g. domiciliary care).

Older LGBTQ+ people valued shared experiences, including shared history, activism, politics, lifestyles, and interests. Shared experience was felt to strengthen connections and peer support within LGBTQ+ communities and many identified these links as valued.

> *“Well, there’s a big difference because people just get you straight away, you know, we have a lot of the same experiences and I feel that there’s probably a lot of differences between other people and they wouldn’t understand me” (Woodie, 60s, gay man, service user).*

> *“I think for me it’s about just not having to explain anything isn’t it? You don’t have to explain yourself; you don’t have to; people kind of get your experience” (Cynthia, 50s, lesbian woman, service user).*

Many talked about feeling accepted and understood when around other members of the LGBTQ+ community and for some, this would be something they were unsure could be achieved or created when among a mixed or purely heterosexual group.

Older people related the importance of foregrounding their LGBTQ+ identity to the impact of historical secrecy and shame on the ways they viewed and judged themselves, and identified how this affected their feelings towards services now. They made connections between their previous experiences and how they imagined they would make decisions about social care, with many focused on the possibility of negative experiences.

There was little difference between those who had only recently ‘come out’ and those who had always been openly part of the LGBTQ+ community. Examples were given, including one by Joseph who had only recently come out, about a formal social group to address social isolation (not LGBTQ+ specific). The provider had talked with him about his sexual identity in early interactions, which influenced how he felt in terms of comfort with his own LGBTQ+ identity.

> *Service User “I have escalated with the LGBT community and now I’ve come out it is important to be part of that community”.*
>
> *Interviewer “Do you think that made a difference in terms of how you feel about your sexual identity…that you had that positive introduction once you realised that you were bisexual?”*
>
> *Service User “Yeah, yeah. It has made me more…positive, it’s made me more understanding, and obviously I’m more comfortable with everything.”*
>
> *(Joseph, 70s bisexual man, service user).*

Providers gave examples of older LGBTQ+ people who had hidden their identity, or come out at an older age, and they felt this could be complex to manage. The examples did not necessarily focus on the impact for the person themselves. They were often more focused on the impact for families and how this was something they, as providers, would potentially need to deal with through engagement with family and friends who had been impacted by the person coming out.

> *“I know…two people…twenty-five years married with children and then finally came out…and obviously must have been very unhappy for those years, perhaps, maybe not but…you kind of think well if he wasn’t living in his true identity there must have been some conflict”* (*Persephone, 60+ heterosexual woman, service provider, FG2)*.

Some providers made an assumption that the person had been tortured by this secret, and did not necessarily consider, for example, that perhaps the person was bisexual or pansexual or might have been in an consensual open relationship. The impact of validating sexual identity by a provider taking an inclusive approach can be seen in Joseph's recounting of his experience. The potential role of services in validating identity was not always recognised by providers themselves. Often the focus appeared to be more on what was required of them, like liaising with families, than what power they might have to improve someone’s own individual experience both of the service and of their comfort with their sexual identity.

4.2.2 Person-centred service provision

Providers were unclear about how sexual identity might be relevant or make a difference to care, and expressed reliance on older people themselves to make it clear whether it was relevant or important.

> *“I guess it’s about how much information they want to give about their personal lives, cos actually it’s…not a lot to do with us; what we need to know about is the other stuff, it’s what…support they actually need” (Anna, 41-60, pansexual woman, service provider, FG1).*
>
> *“We don’t ask people’s sexuality, it’s…not required as relevant. Sometimes we get told it; so, I’ve got a couple of people who openly express their sexuality and they say that they’re gay or whatever…but it’s not something we ask, you know, I don’t regard it as being relevant unless somebody wants to make it relevant to them” (Brad, 60+, heterosexual male, service provider, FG1).*

There was a focus on the importance of person-centred support approaches and how these would ensure that where someone felt their sexual identity was relevant to their support this would be taken into account.

In reflecting on interview quotes from older people about the importance and relevance of sexual identity, providers felt that knowing and understanding was particular to each individual.

> *“In a way…it depends on how relevant it is to that person…for some people it’s a really big part of their conversation, it’s a part of their background, it’s something that very quickly crops up in conversation when we’re first meeting with them and it’s really part of like who they are, it’s a big part of their story, and then for other people it’s…not and it’s something that in later conversation with the caregiver…they find out and they know but it’s not something that has a big impact on their care, it’s just something that…is who they are.” (Lyla, 18-40, bisexual female, service provider, FG1).*

Some providers felt that where it was identified as relevant, it would influence the ways in which they supported people, but a decision to disclose needed to be controlled by the older person themselves.

For some older people, the relevance of their sexual identity was sometimes fluid, and some felt that ageing had impacted on the priority they gave it, or that they prioritised it less than they did their ageing identity in terms of the practical impact it had on choosing and accessing care. One older service provider who identified as LGBTQ+ talked about the process of coming out at a younger age, the ways in which their sexual identity was at the forefront of their lives at that stage and how this had changed over their life course. They were able to identify the benefits of being older in terms of having formed networks, being able to choose who to and when to disclose, and that in fact for them, their sexual identity had now become a secondary consideration.

> *"It's…there and it's not…hidden and it's not unimportant but it's not a driving force and actually now I…feel that the ageing thing…and speaking up about all of that is probably even more important to me than the sexuality thing"* (*Cara, 60s, lesbian woman, service provider)*.

This consideration of how, when and to what extent it was relevant differed, which supported providers assertions that individual approaches needed to be utilised. The principles of person-centred working, focussing on individuals and their needs, was felt to be extremely important for providers. Both older people and providers expressed that care and support could not be classified as person-centred if it did not respond to the relevance of someone's sexual identity. Providers talked about the importance of working with the whole person, not judging, and allowing people to feel authentic.

> *"I think it's incredibly important; I think you've got to support the whole person…they don't need to feel that they're gonna be judged, they need to be able to be who they are. So, I think to be able to support the whole person you need to know the whole person" (Aubrey, 41-60, heterosexual woman, service provider, FG2).*

Participants highlighted the importance of ensuring people felt comfortable and were treated with empathy as well as creating spaces for people to be open. It was felt that if this did not happen, then supporting them was more challenging. Providers discussed how the current generation of older LGBTQ+ people particularly would have lived through historical secrecy around sexual identity, were less likely to feel their LGBTQ+ identity was important, or openly discuss sexual identity or sex in general. They also described the importance of respecting and protecting people from being made to feel uncomfortable by being asked questions about their sexual identity.

Examples were given of adapting support where there were explicit indicators of the relevance e.g., a service user requesting support to attend Pride. These demonstrated provider's desires to deliver personalised care when the older person themselves identified the need and associated support required.

4.2.3 LGBTQ+ Networks & Families of Choice

Families of choice ('family' units made up of chosen connections) and historic issues with families of origin (biological/adoptive families from early life) were discussed by many of the older LGBTQ+ people. Most felt it was less likely to be an issue for younger people, as there was much better acceptance now than when they were young and first exploring their sexual identity. Older people felt that these networks brought commonality of experience and were based on a common language free from heteronormativity. In relation to social care support, they felt that recognition of these networks and relationships was important and influenced the perceived inclusivity of a service. Older people expressed a desire for services to recognise and routinely collect information about families of choice, Next of Kin and important relationships, feeling that if sexual identity was not considered, then these important connections might also be missed.

> *"I mean for me it was a very small part, a very important part but a very small part of my life…maybe five/ten percent…everything I do is not enthused by that, in fact very few things are. But…some of the key things are…my partner of course is a very important thing, the gender of my partner and stuff" (Fifi, 60s, gay man, service user)*.

As part of discussions about ageing, older LGBTQ+ people voiced concerns relating to death and dying, with this being primarily focused on the importance or control given (or not given) to long term partners. This included concerns about whether their partner would be listened to, given authority to make decisions, monitor adherence to wishes by healthcare professionals and funeral services as well as in relation to insurance and pensions. For some this also included the additional complications of having families of origin who either did not approve or were not aware of the person's significant relationships e.g., with their partner.

4.3 Intersecting impacts on identity

Older LGBTQ+ people discussed how parts of their identities and those of others, may have an impact on decision making, experiences and anxieties. In the most simplistic sense this was related to the ways in which people recognised their LGBTQ+ identity was only part of who they were, and for some (particularly those with other prominent identities) it was less pronounced.

> *"I like football, I like Mini Coopers, I have two cats…that's just part of who I am; being transgender is just one of my things, it's not everything, and this is what I try to break down to people" (Faith, 50s, transgender woman, service user).*

> *"Everyone, all members of the LGBT community have many other things about them that are nothing to do with being LGBT…but they bring those obviously (as you will)...to the rest of our lives" (Fifi, 60s, gay man, service user).*

Providers described the ways in which they tried to consider facets of people's identities and how these might impact on the support being offered.

> *"If you put LGBT people into a box of one group of people then not only…are you ignoring the very obvious kind of gender identity and sexuality…but…you're also dismissing ethnicity, class status, housing tenure, socioeconomic circumstances, geographic location, familial history, mental illness, physical health" (Zayn, 18-40, gay man, service provider).*

This was felt to be complex and the importance of all the different component parts of a person were not always practical to consider in the design and delivery of services and groups. However, some providers were cognisant of a responsibility to try.

4.3.1 LGBTQ+ and Ageing identity

The intersection between ageing and sexual identity was demonstrated in some discussions. Accounts included the unwanted or more general effects of ageing and the perceived inevitability of loss of independence. It also included the confidence and resilience felt to come from being older as well as the more robustly established social networks likely to be present in later life for some. This particular impact of ageing fed into feelings about LGBTQ+ identity and was a driver for being 'activist' in approach. Although some of these topics of discussion could be considered common across all older people, clear examples were given of specific fears and anxieties directly related to sexual identity.

> *"There's the practical loss of independence, there's the practical having to live somewhere else…but there's also the fear… it's the same as if someone comes into your own home, it's me going into another place to access something that I need…I don't want to be in a residential care setting where either staff or other residents are homophobic, transphobic, biphobic, and don't treat me as an individual… that would have a really negative impact on the quality of my life just from…having to live with other people, but also I'd be very apprehensive about having the care that I needed affected, based purely on someone's perception of me as an LGBT person….I don't want to go into that place to be back in a closet that I came out of a long time ago…that would be massively problematic" (Jason, 50s, gay man, service user).*

Some of the anxiety about needing care and support in older age was related to how older people's LGBTQ+ identity might be eroded in care and support settings. The combination of ageing and being LGBTQ+ was seen as a double threat to identity and status as an independent person. Jason demonstrates that a combination of ageing, losing his home, losing his independence, coping with staff and residents in his space, the potential loss of power over disclosure and judgement and discrimination were all linked to his fear about ageing and requiring social care as an LGBTQ+ person.

There appeared to be specific fears related to dementia and particularly displaying sexually disinhibited behaviours and how this might be viewed. Some participants gave anecdotal or actual accounts of negative reactions from staff in residential care (some participants had experienced partners using residential care). Some felt this influenced the anxieties they had about accessing social care now or in the future.

> *"So my feeling is we don't allow older people to have any kinda sexuality…regardless of whether you're LGBTQ or heterosexual…we don't allow people to have that….I always say the problem is sexual orientation has got the word sex in it; if it was knitting orientation or salsa orientation or something really stupid people wouldn't struggle with asking the question…I've talked to a lot of friends who are gay men in terms of they worry loads about…becoming disinhibited because of dementia and it's quite a concern about what if I do this…what's gonna happen, how are they…going to respond?" (Cynthia, 50s, lesbian woman, service user).*

Providers felt the main concern was how dementia might change people's behaviours in a way that negatively affected others (for example becoming disinhibited as a result of dementia and this being difficult for families and staff to support). Older LGBTQ+ people had similar fears but focused on the impact for themselves rather than others. They feared the ways in which it might affect both their memories and behaviours (particularly if that was sexually disinhibited). This was mainly in relation to disclosure and acceptance from others, being able to live authentically as themselves, but also how they themselves may be re-traumatised by past experiences. One older LGBTQ+ person whose long term partner had dementia and been in residential care prior to his death recounted some of his partner's fears.

> *"I think it's a bit scary for those with dementia because they've lost their short-term memory, they've gone back to their younger days, and they see these other male members of the home there and they just think oh he, he looks like somebody that bashed me a few years ago or called me a poof or called me a queer, and it can be a bit scary sometimes for, for the older gay people" (James, 70s, gay man, service user).*

Older people felt that services which were clearly inclusive, and ensured that people's identities were known and valued would be much better than those who did not work to retain the facets of identity that were relevant to the person.

4.3.2 Broader attitudes towards ageing

Older LGBTQ+ people and providers both expressed opinions indicating that they felt that generally, older people were more likely to be close-minded, less tolerant, more conservative, more likely to display discrimination and less likely to be adaptive and accepting in their thinking. This arguably stereotyped belief about older people being static in their opinions was applied in various topics of discussion during interviews and focus groups. This was primarily around the perception of the older generation not being accepting of LGBTQ+ people, not being willing to discuss sexual identity or being resistant to openly discussing such topics or changing their opinion. This was despite the fact that many older people are likely to be open to such differences and almost all the participants were classified as older people themselves.

Providers discussed the challenges of being an older LGBTQ+ person more generally. Problematic attitudes felt to be directed to all older people included a presumption of resilience towards the challenges of everyday life and in relation to any adversity (such as discrimination) gained through life experience. They felt that older LGBTQ+ people were likely to have been negatively affected over a long period of time and interactions should be mindful of that.

> *"We were talking about...how we dealt with things and…I think the attitude for the older person is to think, well you just have to get on with it…I think you've got to be brave enough to go and ask if you need it, which some people feel they can't".* (*Persephone, 60+ heterosexual woman, service provider, FG2).*

Older LGBTQ+ people made the assumption that other older people would be discriminatory towards them and in some cases, they were more concerned about other older people's negative attitudes than the treatment they might receive from services or staff members. Rose talked about her partner's experiences when accessing a local group, and her perception that it was not a very tolerant or inclusive space because of the age and attitude of other group members.

> *"It was very difficult because a lot of the people she was talking to were older and their idea of being sort of broadminded and tolerant was saying hello to someone of a different skin colour, you know" (Rose, 70s, bisexual woman, service user).*

This also extended to some well-established older people advocacy and advice organisations where older LGBTQ+ people felt these organisations had displayed more traditional attitudes.

> *"I think often organisations like* [name of organisation] *are very, you know, cos they're quite established and…they're somewhat rooted in an old-style attitude towards ageing and it's…a bit more paternalistic." (Alex, 70s, gay man, service provider).*

The expectations about how groups and individuals would respond or act were sometimes based on previous experiences, but for some older LGBTQ+ people appeared to be based on an assumption that spaces for older people would be less tolerant or accepting.

4.3.3 Ageing without families or children

Consideration of the impact of ageing without families or children was seen with both older LGBTQ+ people and providers. It was felt to be more likely that LGBTQ+ people would be in this group, as well as be estranged from their families. The impact was focused on the implications of ageing without children, and the need to seek out wider networks to provide the engagement or support families or children might otherwise offer.

There were emotive opinions and strongly held beliefs, as opposed to direct experiences, about the gaps left by lack of family. There were a range of thoughts about how and whether these should be met by formal support.

> *"This is an invisible group...we need to…make them visible…so you are ageing without the support of children…we are now worried about loneliness and isolation and the rising demographic of older people living…alone…it's estimated that ninety percent of the LGBT community is AWOC* [Ageing Without Children]*...Now they might also be ageing without family of any kind because….they're no longer then deemed to be part of the family…they're persona non grata in the family….then as you get older your friends start dying off…you're still alone…you haven't got any family and you haven't got any children and you… end up being totally alone, and that's when the services are not up to it… they just aren't adequate and they don't take into account the fact that you're alone, that you might be LGB and that you are, might as well be dead, you feel you might as well be dead; I mean what's the point of carrying on?" (Sally, 70s, asexual woman, service user).*

Examples were given of organisations specifically geared towards people ageing without children and although these were aimed at anyone fitting that category, (people who do not have children through choice, for medical reasons, whose children have died, are estranged or disabled, and will therefore be unlikely to offer any support) the primary group that accessed this peer led support were LGBTQ+ people.

> *"Ageing without children's probably got the most overlap with LGBT because of the…statistic of how many older lesbians and gay men are…have grown up not having family in the sense of…their own families, cos obviously a lot's changed in that arena in the last twenty years or so…..those people are often invisible because there's a huge amount of family carers going…they carry the burden really, family carers and informal carers" (Cara, 60s, lesbian woman, service user).*

Some older LGBTQ+ people felt those with adult children enjoyed advantages such as having someone to call on to provide some elements of support or to provide guidance with decision making about care. Some also noted that building more practical networks of support was challenging when families of choice were often of similar age, so less likely to be able to provide that kind of support.

The combination of not having children, perceived disadvantages of being LGBTQ+ more widely and the effects of ageing impacted how older LGBTQ+ people made judgements or created expectations about what services they wanted or expected. For some, there was a belief that services would be unlikely to compensate for any lack of support from family and friends. There was also recognition from some providers that services in local areas may be based on supportive families and children, and there was a need to think more broadly about how older LGBTQ+ people without those connections could still build and maintain networks.

> *"We're challenging the local connection thing but that's a totally different story; it's not very appropriate for our community cos it's often based on if you have children or family in the area which as a community, we're less likely to have, but that's a big policy question that we have to ask elsewhere and we're doing that" (Zayn, 18-40, gay man, service provider).*

The feelings of older LGBTQ+ people about this topic may have been very similar to other groups (i.e., non-LGBTQ+ people without children or families), but it was apparent from the interviews that this was a source of anxiety or an influence on choices made, despite the efforts of services to be inclusive. Providers indicated they would respond to the person's needs irrespective of their family status and the level of care would be based on the level of need rather than carving up caring responsibilities between themselves and available family members, unless this was a requested feature of care planning and delivery.

Examples were given of assumptions being made in relation to the support networks people would be able to access. One provider who oversaw a wide range of services discussed their frustrations with a perceived systematic problem of assuming people have someone to help with care and support. They felt this caused people to apologise for not having that support mechanism, as opposed to the service recognising the false assumption which had been made in the first place.

> *"I think there is always that assumption there's always AN-other to support or help or, or to accompany places… you always seem to be making apologies to other people when they make that assumption…It can be isolating, it can be very isolating…People seem to judge immediately…they've got the measure of you*

> *straight away…I notice it more, you know, there's always this assumption with social care, hospitals, all these services that an older person has somebody in their life, has a partner, has a child to support, and that often isn't the case and I don't think we've…set up that" (Aubrey, 41-60, heterosexual woman, service provider, FG2).*

Service Providers felt this assumption was particularly prevalent in health and social care and that systems were not adequately prepared to deal appropriately with this. The difficulties of navigating the care system were discussed, including the fact that those who did not have support networks may struggle to find people within the workforce they could have discussions with about what support might be right for them in a similar way to ones they may have with close family or friends.

> *"All these things, navigating care systems, again it's the ageing without children, which again would be relevant for…this community. A lot of research has shown that…it's really difficult…one person was saying they didn't…have children and if they had children, they wouldn't expect to care for them in their old age, but they would love to have a sounding board, somebody to say, should I think about going into care, should I do this? And they have nobody and it's…really difficult" (Aubrey, 41-60, heterosexual woman, service provider, FG2).*

Some participants felt that services should be offering a level of support around decision making and that groups should be created to allow those connections to be made.

4.4 Activism

Many older LGBTQ+ people and providers discussed the importance of knowledge about LGBTQ+ communities, and for older LGBTQ+ people, how they used activism directly and indirectly. This included a desire to improve services more widely, but also in the hope it would improve their own individual outcomes. Direct actions included working or volunteering in services (including those they already accessed or might access in the future). Indirect influence was felt to come from involvement in networks, research, or acting to make wider services more inclusive.

Some older LGBTQ+ people viewed the ability to be an activist as part of investing in their own futures, especially in relation to care and support. There were clear reasons for undertaking the activist role, so as to continue investing in inclusivity for the wider LGBTQ+ population, as well as the personal benefits in doing these activities.

> *"I think we need to share the experience and…try and help others…coz there's still lots of my age group that are still scared to pin their colours to the mast, if you like….it's trying to just make it as user friendly as possible. I do stuff for them…I do talks for them, and so…I suppose in a way I'm sort of just safeguarding my future by locking into all these organisations…so when the time comes I can just phone up and say, oi, you know me…..I'm trying to sort of feather me nest in a way". (James, 70s, gay man, service user).*

> *“Locally, I..support whatever project…seems to bring people together and improve people’s lives; and I support that by…letters or giving talks or whatever” (Roy, 70s, gay man, service user)*

Older LGBTQ+ people demonstrated a hope this would have a wider effect on how service provision was delivered overall. While many seemed to value activist roles, there were also frustrations, mostly in relation to the exhaustion of having had to continually fight for rights, recognition, and representation over a prolonged period of time. This ongoing need to advocate for rights and equality of treatment appeared to result in cumulative frustration, as documented within Minority Stress Theory. Most felt that awareness raising was needed and beneficial, but this was in part reliant on those within the community serving an educating role. One provider had asked an older service user to be an LGBTQ+ representative (which they had done previously), but they responded saying that while they still wanted to be part of the conversation they did not want to be leading it.

> *“She said ‘Well I was forty then and I’m sixty now and I don’t want to do it anymore, you know, I just want to…chill out and…I want to throw my kinda two cents in the ring every now and again but that’s all I want to do’.” (Zayn, 18-40, gay man, service provider).*

Older LGBTQ+ people wanted recognition of life stories, or significant relationships but accepted that these parts of their identity might need to be at the forefront of what/who they were presenting, so performing their own activism served the purpose of demonstrating these wishes. Sometimes that was focused on the benefits they were seeking within their own lives and was related to their own stories, lives and experiences. However, this was sometimes much more general, focused on fighting for inclusion of LGBTQ+ identities in the ways services and groups were run.

Many of those who identified as LGBTQ+ reported feelings of exhaustion from the perception that they needed to constantly educate people about LGBTQ+ communities.

> *“Not really afraid of their reaction, you know; what’s the word I’m looking for? More fed up about, OK, well here we go again, I’m gonna have to go…through the whole things about…people are different…but we’re all the same, you know…maybe have to explain myself in a way which…I wouldn’t have to in another organisation, in another group.” (Fifi, 60s, gay man, service user).*

> *“We are educators whether we like to be or not, we are the ones that educate everybody….do we have to rely on our community in order to do the educating, which is what we do all the time don’t we?” (Cynthia, 50s, lesbian woman, service user).*

This was spoken about as a drive to normalise LGBTQ+ identity whilst simultaneously demonstrating the unique characteristics, needs or wishes of this group. However, this was countered with a recognition of the importance and potential impact of doing this.

A similar assumption was made by older LGBTQ+ people that inclusivity within services and groups was reliant on their activism, with some feeling they had their own role to play through education and being clear of their expectations. This was echoed by providers who suggested they felt it was the individual responsibility of older LGBTQ+ people to share and educate, although this was less pronounced. This suggested the need for overt activism was felt to be more of an expectation for those using services than it was perhaps an expectation of providers. There were however some examples given by providers of the expectation that older LGBTQ+ people needed to advocate for what they wanted and that without this, it would be extremely challenging to deliver truly person-centred care.

Although potentially not exclusive to older LGBTQ+ people, activism and feelings related to the need to educate people appeared extremely relevant to the experiences of choosing and using groups and services. It demonstrated the importance of services understanding how older LGBTQ+ people felt about having to take on this role, and how they might counter it through actions themselves to create environments where activism was not needed because they were already inclusive.

There was some crossover with the topic of intergenerational expectations and actions, where older LGBTQ+ people felt that younger generations needed to be aware of LGBTQ+ history, be proactive in facilitating improvement for the whole LGBTQ+ community (not just young people) and be the activists many of them had been in their youth. For some this was positive, since they felt attitudes had changed. For others it was more focused on younger people recognising (or not recognising) changes had been fought for by the older generations and was key to ensuring long-lasting change and acceptance were embedded into wider society and were long lasting. There was a perception that older LGBTQ+ people had an active role to play in educating the younger generation about LGBTQ+ history but it would be important to build understanding and acceptance of ageing.

> *"There's the benefit of hindsight, experience, and challenge. Older people need to help younger people to accept challenges and to face the future with hope, younger people need to look at older people and respect their experience and maybe learn, and the two should be able to talk to one another sensibly" (Roy, 70s, gay man, service user).*

Although there was fatigue attached to activism, there was also resignation that it would need to continue to ensure that inclusivity within services was improved. There was a perception that this would continue to be required. However, this appeared to negate the possibility that younger people's lack of engagement with this history and context might signify less of a need for it, because of changes in social attitudes towards LGBTQ+ communities.

> *"Often young…people in their twenties just have no concept of the history… about things like the women's movement…….there are lots of young feminists and stuff and people have to discover these things for themselves, but there's a lot of assumptions made by young gay people…the older people…who are gay are just not visible to them either, which seems terrible….I mean, because one day… they will be older. So…I think…that's where that intergenerational stuff can help as well because there's a lot to learn…from older people, and…people get more reflective as they get older" (Cara, 60s, lesbian woman, service provider).*

The desire of older LGBTQ+ people to improve younger people's understanding of LGBTQ+ community history appeared partly linked to their belief that younger people would need to continue the equality fight, so that inclusivity within service delivery and inclusive staff (likely to be of younger generations) would become mainstream. It also demonstrated the desire of older LGBTQ+ people to be heard and seen within those intergenerational interactions.

4.5 Routine service data collection

The importance of routine collection of sexual identity data was raised by both older LGBTQ+ people and providers. Such discussion included whether the data should be collected, why this was felt to be important, how it was a possible indicator of inclusivity, what the data was or could be used for, and what challenges there might be in collecting data.

Older LGBTQ+ people felt strongly that their sexual identity was important and relevant to the delivery of care and support and providers expressed that this kind of information would usually be picked up as part of a person-centred assessment so did not necessarily require additional or specific questions.

> *“Some people don’t want to discuss that but at least I think you need to give people the opportunity” (Cara, 60s, lesbian woman, service provider).*

One provider stated they would not be offended by being asked those questions and, as long as there were opportunities to choose not to divulge information without pressure, this would be better than not asking in the first place. As it was not a standard part of routinely collected data for the providers, this meant it was usually reliant on the older LGBTQ+ person themselves deciding it was relevant information and raising it unprompted.

It seemed likely that person-centred assessments might cover factors like sexual identity within questions about significant relationships, lifestyle, preferences, and anxieties/fears. However, there was evidence that this was not always the case. One older LGBTQ+ person, who had previously been a carer for his long-term partner with dementia, spoke about the lengthy social care assessments undertaken before and during their illness including one with 11 sections, none of which had questions about sexual identity, significant relationships or alternative support networks.

Some of these examples were subsequently used in the provider discussions to highlight older LGBTQ+ people’s experiences and feelings about the collection of this data. Cynthia spoke about her experience within a service and felt that if those questions were not asked then it did not constitute person-centred care.

> *“There’s no monitoring around sexual orientation hardly and…gender identity for older people because it’s not seen as being significant…if you did real person-centred care then you would acknowledge people with sexual orientation and gender identity” (Cynthia, 50s, lesbian woman, service user).*

Jason talked about how not asking these questions as part of an initial contact or conversation ultimately resulted in a lack of recognition about him as a whole person.

> *“The assumptions that if somebody who identifies as a man is filling a form out he’s necessarily got a…partner of the opposite sex, and also not asking about gender or sexual identity because that would mean that actually I don’t think the assessment would fully cater for the needs that I would be looking for as an individual…if I had to go into some form of formal health care or residential setting, I would want to be clear that I’d been assessed…of the needs of who I am and that would include things like…not making assumptions about my pronouns, asking me, just respecting me and giving me the opportunity to tell you what I need without people making assumptions based on my physical appearance or assumptions about my sexuality or gender… it’s not recognising me for the whole person that I am” (Jason, 50s, gay man, service user).*

For providers there appeared to be general agreement about the benefits of discussing sexual identity and topics such as significant relationships, although there were mixed feelings about how and when that would be done. One provider felt it might be viewed as offensive to ask those kinds of questions at all, even for LGBTQ+ service users.

> *“A lot of elderly people do not like you to ask them about their sexuality” (Brad, 60+, heterosexual male, service provider, FG1).*

This demonstrated assumptions made by providers and highlighted the well documented challenge sexuality and sexual behaviour presents for providers, where it is assumed that people become asexual as they age (Steckinrider 2023). The concern about asking older people about their sexuality may have been based on stereotypes that all older people are adverse to discussing such matters, but also serves to minimise the importance of sexual identity, especially for LGBTQ+ people. Some providers felt allowing the individual to indicate if it was relevant was important, and one felt asking questions about sexual identity would validate the individual and help providers to understand how the person defined themselves, which in turn would improve the support being delivered. The group overall felt that by asking for this information, a more person-centred approach was possible. Anna showed the perceived benefit of creating a signal of acceptance through asking the questions, which might be validating in its own right and overall improve the experience of the individual.

> *“For us to be able to demonstrate that acceptance…that it is a safe place for them to be able to talk about sexuality, if it’s relevant to them…somebody to know that it’s OK because…it’s that generation…a lot of people had a hard time coming through that when they were younger; so giving them the safe space…it’s almost like having a little…flag waving…to say it’s fine, it’s, you can talk about this…we’re OK, we accept you for who you are, it doesn’t matter about your sexuality, but if you want to talk about it then you can and if…there’s…things you need support with…..that then we can do that too” (Anna, 41-60, pansexual woman, service provider, FG1).*

Many older LGBTQ+ people felt they were waiting to be asked about their sexual identity and were happy to provide this information, although they had rarely been asked. It was felt that by asking the question, it might provide an opportunity to talk about it more. There appeared to be a belief that providing this data would positively impact on the inclusivity of a service, indicating an expectation that answering demographic questions would lead to changes in approach.

> *"I got a text from my GP asking me questions about…sexuality and I decided to respond…properly and fully, so I put…that I'm gay. So that's on their records now. So the fact that they did ask as a sort of a survey, including questions about nationality…and sex and…transgender and…those sort of questions, I would have thought they would be more upfront when you actually go into the surgery, to show that they're welcoming" (Woodie, 60s, gay man, service user).*

Providers raised potential challenges including the damage that could be caused by an older person unexpectedly coming out in this scenario, and how important it was to know what difference knowing that information would make to care and support. This highlights a focus on the impact on providers rather than the context of the individual and/or their family. The impact of not gathering data was discussed by providers, and examples were given of how knowing information beforehand would help with making individual effective adjustments, intentionally inclusive service design and planning and providing information about other organisations a service might need to make links with, (such as LGBTQ+ advocacy) or signpost to. Service providers generally felt this would be useful, although acknowledged the relevance would be influenced by the setting and nature of support. For example, in residential care, where a person's partner or lifestyle might have more impact than it might in community-based services.

Most providers did not collect sexual identity information at the first point of contact, unless it was offered as relevant information by the person themselves and there were varying levels of knowledge around LGBTQ+ people currently or previously using the services. Most could give examples of people they had worked with at some point who were part of the LGBTQ+ community, but there appeared to be a lack of confidence about the ways in which you would work these kinds of topics into conversations, primarily designed to assist in writing a care plan or assessing needs.

4.5.1 Challenges

Providers felt there were challenges in collecting sexual identity information. They were presented with quotes from interview participants during the focus groups, which demonstrated how important older LGBTQ+ people felt it was to be asked those questions and have approaches adjusted accordingly. Providers focused on the experiences of staff when doing this, with less focus on older LGBTQ+ people's feelings about it happening. Other complexities raised included being British, inferring cultural influences on willingness to discuss, the possibility of additional stigma for the individual beyond that related to social isolation and how so much other information needed to be gathered during this first interaction, that it would not be practical to add more. Most felt it was the responsibility of the older LGBTQ+ person to choose to give the information where they felt it was relevant.

One provider referenced their own upbringing and the social attitudes that influenced their own feelings about disclosing this information, framed around the conflation between sex and sexual identity and the associated shame of being open about sexuality.

> *“I was brought up very firmly like…you hide your body…certainly normally I wouldn’t be talking openly about sex with someone, unless I trusted them…a close friend or whatever…certainly not my family. (Irene, 41-60, heterosexual woman, service provider, FG1).*

The assumption that any conversation about sexual identity would include discussion of sexual behaviour was evident in some provider discussions. The implication in some of these conversations was that physical sexuality, and talking about that element, was the reason people would want their sexual identity known, i.e. they would use the opportunity to talk about sexual behaviour. This did not match with the reality of why older LGBTQ+ people thought their sexual identity was relevant and important. Although all the older LGBTQ+ people in the interviews spent, in most cases, over an hour talking about their sexuality and the impact of this in relation to social care, few mentioned anything related to the physical aspects of their sexuality.

4.5.2 Inclusive conversations

In discussing collection of data, most participants expressed wanting to have open and honest, or ‘inclusive’ conversations that allowed for disclosure and talking about what was relevant and important to them about their lives, lifestyles, anxieties, and experiences. There was a hope that these inclusive conversations would include lifestyle, life history, significant relationships, and elements of anxiety related to sexual identity. Many participants felt that if services created opportunities for inclusive conversations (even if these were challenging) or gave opportunities to disclose sexual identity in a safe way, this would lead to a more inclusive experience.

Older LGBTQ+ people felt there were actions staff could take to create inclusive spaces through building personal connections, valuing and understanding life stories (a person’s individual history, significant events, relationships, and other defining experiences) and avoiding assumptions that may be experienced negatively.

> *“After I’d been once or twice, she said to me “Would you like to meet me for coffee and have a…chat about things so I can get the background about your situation?” So that’s what we did…I told her my story and my background. So, it was outside of the…group…there was just us two and she was very attentive and very supportive”. (Woodie, 60s, gay man, service user).*

The participants' positive experience was based on being provided with a space to talk about his life, and within that his sexual identity. Another older LGBTQ+ person also linked being asked questions about sexual identity with a positive and inclusive experience. Both examples demonstrate how a relatively small action still had a positive impact on the experience of accessing social care.

> *“I thought actually that they were extremely good in the way that they…made no assumptions about who I was, and you know, they…asked all the right questions and once they’ve realised that you are a member of the LGBT community then they…discuss it in the way you would… understand” (Fifi, 60s gay man, service user).*

Providers talked about the focus of care delivery being the person's needs rather than broader identity and that asking specific questions seemed complex if it did not appear relevant. This again highlighted how providers did not see the relevance of sexual identity as part of the wider view of a person. There were examples given by providers about only asking questions about sexual identity when there was a very specific project running. If projects included connecting with LGBTQ+ organisations or communities, were linked to specific funding, or where others (such as commissioners) had requested the information, sexual identity data might be collected. One provider used forms that included ethnicity and gender identity but not sexual identity, and they felt if it was to be added it was important to allow opting out of answering the question. Providers felt it was also important to ensure the context to questions and information collection clearly demonstrated why it was relevant to care delivery suggesting providers' views generally reflected sexual identity as only relevant to a specific element of care delivery, as opposed to a key part of who that person was.

Some older LGBTQ+ people reflected on generational differences in attitudes towards its relevance, which reiterated the fact that some challenges were viewed as generation specific, and would not be a concern in the future.

> *"I envy youngsters in some ways; I was talking to a younger relative of mine…this sixteen year old was talking about one of her cousins who is openly bisexual and she was saying that…she has had a girlfriend as well as a boyfriend and no big deal, you know…and I envy them that, I think life is much, much easier...there are kids who don't…have the hang-ups" (Rose, 70s, bisexual woman, service user).*

> *"I think the younger generation now, by the time they get to my age it will be totally different because they're much more open and much more kind of, almost more resilient as well, I think…and talk about stuff that needs to be talked about whereas for old people it's all a bit like; and I think again it's about…that matron in that nursing home felt really uncomfortable cos it was, oh my God, it's sex, we can't talk about it, and I think it's, it's about people being uncomfortable and not feeling able enough" (Cynthia, 50s, lesbian woman, service user).*

Service providers talked about the challenges of having inclusive conversations but also about the positive ways it could be approached and the importance of acceptance and creating safe spaces for people. They suggested it was important to build trust to be able to have conversations about more personal or 'private' issues, or to build a picture of people over time which would help to judge the relevance and importance of sexual identity to the person. The view that sexual identity was a private or personal matter indicated the heteronormative social influences on the ways in which sexual identity is viewed more broadly. Some service providers highlighted the importance of building trust to be able to judge whether asking sexual identity questions might help build or break down relationships.

Examples were given of occasions where asking these types of questions would have had a detrimental impact on the person and that clarification would have made little difference to the way care was delivered. However, within the example below, the information care staff had available to them about this person's sexual identity (through indirect sources) did ultimately tailor the care delivery, even if that was only through care staff accepting certain behaviours because of their understanding of the historical context. This could be considered an interesting contradiction between the belief from providers that knowing someone’s sexual identity will not have any impact on service delivery, and then demonstrating that even assuming someone’s sexual identity can alter care approaches, as seen in Lyla’s example. This gives weight to the argument that overall, the information, however it is collected, has the potential to affect service delivery.

> *“There’s a gentleman that we used to care for who we were told by the family members that…he was a very religious man who was very conflicted. He was a gay man who never really like properly came out; it was a very big part of his story but it was never something that…we discussed with him directly…when his dementia progressed, it became a really important part of his story because he actually started to use a lot of homophobic terms with the…caregivers; whenever he was feeling frustrated that was something that…we understood as something internal for him and it was a really big part of his conversation. But I think if we had gone to the initial consultation and asked him outrightly if that was something that he was part of it would have been a very closed conversation, he might have been quite offended by it” (Lyla, 18-40, bisexual woman, service provider, FG1).*

One provider highlighted the importance of how sexual identity questions were asked, the timing within the interaction and what knowledge would be required by the person asking the questions to ensure that appropriate signposting could be done. They felt that by asking the question early in the relationship this would potentially enable their needs to be met more appropriately, but that asking the question might also result in people putting barriers up. They also reflected on the fact that as a ‘local’ organisation they were not experienced in having those conversations so would not necessarily know which questions were appropriate to ask and whether it was right to ask. It suggested a lack of confidence in being able to respond appropriately and lack of knowledge about local support networks available.

Providers suggested gathering information using indirect questions or guided conversations at initial contact, where questions could be asked about lives, friends and family, previous occupations, holidays, or anything that might encourage disclosure in a safe way. There was felt to be power in allowing the person to disclose what information they deemed important, allowing some personal autonomy over what was discussed or considered. Providers felt there was value in the person leading the conversation and also in using earlier information to ask pertinent questions in later conversations when people might feel more comfortable.

Providers also focused on the skills and willingness of staff and what their perspectives might be about the need to have potentially ‘awkward’ conversations. One provider also raised the challenges of how respecting the wishes of staff and asking them to instigate these conversations, or indeed support people they may not ‘approve’ of, could be challenging. This indirect support of heteronormative attitudes without challenge suggested a lack of understanding about the relevance of sexual identity to care delivery and a lack of willing challenge of discriminatory views from an organisational perspective. The dilemma about whose rights and values should be respected was discussed as being a complex situation to navigate. The discussion included how issues with staff would either need to be handled carefully, or would be avoided through robust recruitment processes.

There was recognition of supporting staff, who had the right to feel and think the way they did, but this needed to be within the parameters of non-discriminatory behaviours. The discussion highlighted one of the more complex areas for providers, of striking a balance between respecting service users and respecting staff. The difficulty of forcing a staff member to support someone whose lifestyle is in direct opposition to their religious beliefs for example, was felt to be complicated. It was unclear from the discussion how services would draw the line in deciding whether one firmly held belief was privileged over another, and highlighted again the view that sexual identity was felt to be aligned to religious belief.

Staff training and support was felt to be key to making open conversations a possibility. Staff recruitment was also felt to be a way to identify staff who might be biassed or discriminatory in their values and attitudes. Providers felt they had a responsibility to support staff to be open-minded and avoid assumptions, to address situations where staff were acting in non-inclusive ways, to not employ people who demonstrated bias, and to educate and encourage understanding of the needs of particular groups. It was unclear if measures were already in place as part of recruitment to identify these kinds of attitudes and values, and some providers indicated they would use their own modes of judgement to coax out or identify prejudiced recruits. It was also unclear whether these personal modes of judgement were free from heteronormative biases and would therefore support more inclusive attitudes towards something like sexual identity.

4.6 Summary

LGBTQ+ identity was viewed as a variable but important part of who older LGBTQ+ people were, and there was sometimes a clear wish to share this information so that this identity could be considered within service delivery, more so than in other parts of people’s lives. There were external and historical factors that influenced how sexual identity was viewed by both older LGBTQ+ people themselves and providers and this impacted on how relevant and important disclosing sexual identity was felt to be.

Older LGBTQ+ people and providers had considered the value and importance of disclosure around sexual identity with some shared and differing perspectives. Older LGBTQ+ people largely wished to disclose, especially where it had direct relevance to the delivery of care. However, the ability or opportunity to disclose only contributed to a sense of feeling included rather than defining it. Providers offered practical ways in which this might be achieved and also articulated anxieties about how, when and why they would ask for information about sexual identity.

Older LGBTQ+ people expressed feelings of responsibility to educate others and build awareness, and despite feeling some fatigue around the need for this, it remained a perceived expectation. This expectation was not mirrored within provider discussions, beyond individual relevance to delivery of care.

5. Perceptions & actions of inclusivity

5.1 Introduction

This chapter presents findings linked to the ways in which markers of inclusivity were offered by providers and perceived by older LGBTQ+ people. Discussions covered tangible signals people used to indicate or gauge inclusivity and how these impacted on choices and experiences. LGBTQ+ representation, setting ground rules, language and heteronormativity were discussed in relation to the effects these might have on perceptions of inclusivity within services. The social care workforce, training, policies and frameworks were all perceived to be necessary considerations to enable an inclusive environment.

Some of the practical signals services used or might use to improve a sense of inclusivity and some of the additional barriers faced by both providers/groups and those in the LGBTQ+ community were also discussed.

5.2 Markers & actions of inclusion

5.2.1 Tangible Markers & perceptions of tokenism

Within the interviews, both older LGBTQ+ people and providers were asked about the things they looked for or did to demonstrate inclusivity. Discussions included what the markers or signs might be and how this influenced choice making, but also what older LGBTQ+ inferred about the service from these markers. Some older LGBTQ+ people referred to a dislike of signals which they labelled as tokenistic (such as badges, lanyards, use of pronouns). However, such signals were concurrently felt to be valuable and indicative of a welcoming service.

> *"I would probably look for those* [tangible signs of inclusivity] *and…I think every step in the right direction is a step in the right direction, even if they are, at the beginning, tokenistic because those things eventually work into an ethos which is more holistic and more…inclusive" (Fifi, 60s, gay man, service user).*

As this quote suggests, there was some optimism that signs perceived as tokenistic developed into broader levels of inclusivity. This general progression from what were described as tokenistic signs to embedded inclusivity and cultural shifts was suggested to be triggered by relatively small actions. Many actions mentioned were considered as being simple things, with older LGBTQ+ people being able to articulate the differences these kinds of signals made to their feelings of comfort about the inclusivity of a service more generally.

> *"It's a really clear signal by doing things like having it on your Zoom name, having it on your email signature, having it on your name badge, and it just demonstrates that that's an inclusive environment and people can feel safe and….it is those simple things that make the difference sometimes"* [referring to pronouns] *(Faith, 50s, transgender heterosexual woman, service user).*

Some older LGBTQ+ people spoke about how they actively sought out such signals in advertising materials and stated they would be unlikely to entertain an organisation that did not have these. It was felt to be disappointing when these signifiers were missing and older LGBTQ+ people considered this a missed opportunity by providers which might have given them the confidence to seek out more information.

> *"There's no rainbow flag around, there's no imagery that gives me confidence about…being gay...they've got, you know, I don't know, a thousand posters up there on the walls…I would expect them to have something which would help me to identify that this…is fine" (Woodie, 60s, gay man, service user).*
>
> *"You'd want to see stuff on their website, you know, it's about language…and recognition through publicity materials and…actively, you know, not just sort of everyone is welcome but…something that shows that people understand that people are coming from very diverse backgrounds and have different issues" (James, 70s, gay man, service user).*

Providers gave examples of how they signalled inclusivity such as flags hanging in the office, information on notice boards and an interview with an older LGBTQ+ person in a newsletter. Although it was noted that some of these signals would only be directly visible to staff, they were still felt to contribute to being an inclusive organisation, and could indirectly influence culture over time through serving as a reminder to staff. None of the providers could recall using same sex couples in advertising materials or having specific statements around inclusivity in any of their documentation but one provider was currently reviewing this and considering the ways in which this could be done appropriately.

There was also some discussion about who the inclusive advertising or use of tangible markers such as rainbows was for, and how this could conversely serve to alienate others (presumably non-LGBTQ+ people or people with particular religious or cultural beliefs). Providers were able to identify the benefits of tangible markers, and assumed these would facilitate open conversations and reduce fear of being 'found out'. However, there was an identified tension between an organisational need to achieve broad representation and inclusivity for a large and varied constituency of staff and service users (i.e. all minority or protected characteristics) and how specific groups of people who used the service would judge an organisation's inclusivity.

Some examples were given of specific displays that featured LGBTQ+ resources and reading materials during Pride week or month. The providers felt this sent a clear message of inclusion and reasoned these had the potential to encourage people to feel more comfortable in asking questions or initiating conversations around topics such as sexual identity. The providers noted it was a temporary resource and that to have real impact this would need to be more permanent, alongside similar displays for things like Black History Month. Challenges around this were discussed, including availability of space, ways to select different topics, and the temporary nature of some topics or celebrations.

Some felt that while many people may not notice a signal such as a rainbow on documentation, LGBTQ+ people would be seeking these out, so it was meaningful without being forced on to those for whom it was not relevant. The need for consistent, permanent efforts to signal inclusivity were suggested by some. There was also an indication that while some providers recognised their inclusive approaches might alienate others, they felt it important to continue to do so.

> *"We can't just be held to ransom by some people saying we don't like that…that's the world we are living in, and everybody should be represented" (Aubrey, 41-60, heterosexual woman, service provider).*

Older LGBTQ+ people were clear that they did not wish to make adjustments or 'hide' when receiving support. This was demonstrated across different service settings and examples were given of how for some, LGBTQ+ staff made this less anxiety inducing. Woodie talked about the anxiety he felt when people were coming into his home and the signs of his sexual identity being seen by others.

> *"I wouldn't want to have to live where I've got to hide photographs and take pictures down… I've left this leaflet about by mistake and then…this guy came in; I felt really embarrassed that he may have seen that" (Woodie, 60s, gay man, service user).*

This discomfort was something he did not want to experience again and demonstrated the fear related to signs of being LGBTQ+ being disclosed without him choosing to do so. For Roy, who talked about the comfort he took from staff being openly LGBTQ+, there was less concern about disclosing and overall, the impact was he felt it had been a more inclusive experience because of the feeling of safety an LGBTQ+ staff member afforded him.

> *"The fact that he happens to be gay means…I don't have to hide anything or explain anything and that makes life a lot easier, you know" (Roy, 70s, gay man, service user).*

Although there was recognition from providers that acceptance and normalisation of LGBTQ+ identities within teams had not necessarily filtered through into approaches and attitudes about supporting older LGBTQ+ people, the providers had a range of examples of how they made LGBTQ+ staff feel accepted and valued. This included training, resources, flags in the office and ability to express sexual identity with lanyards and pin badges. These were all seen as extremely positive but there was also recognition these things in and of themselves would not necessarily demonstrate inclusivity in service delivery more widely.

The idea of the potential value of social care kitemarks (awards that measure a specific activity/activities to give a form of guarantee about minimum standards being met) was raised in both interviews and focus groups.

> *"I think, yes, if that* [LGBT+ kitemark] *existed then I think that would be useful, because if it was in… common use then the fact that an organisation didn't have it would, that…would bother me"* [talking about the perceived value of a kitemark] *(Rose, 70s, bisexual woman, service user).*

Both service providers and older LGBTQ+ people felt that if something like this existed, which was specifically focused on LGBTQ+ inclusion, or broader inclusion of minority groups, this would be a useful way to indicate inclusivity and that the absence of this kitemark would also signal something about any organisation. However, few providers were aware of any framework they could use and there was a general feeling that unless these were widely recognised they would not have the intended impact. There was also no broader consideration of what types of organisations such a framework would be applicable to and how that might be structured in a universally applicable way. Many of the providers felt that without some kind of robust system of support and guidance in place, it would be challenging to make changes that were evidence based and effective in improving inclusivity.

5.2.2 Creating inclusive cultures

Discussions also raised other, less tangible actions, and responses within services to signal inclusivity for older LGBTQ+ people, including ways to create inclusive spaces and cultures. The area of discriminatory language or behaviours by other service users and how that might be complex to deal with were raised. Some older LGBTQ+ people felt that services that set and clearly indicated ground rules or a 'code of conduct' were taking a positive step, and that by setting an inclusive tone, it would make services feel more welcoming.

> *"I might speak to the leader and…ask her if she'll make ground rules at the beginning and see how…people react to that so that it's not sort of aimed at me specifically but just, yeah, that seems like a good way forward really" (Woodie, 60s, gay man, service user).*

Participants made the distinction between proactive steps such as codes of conduct, viewed as anticipatory, and more reactive steps taken when addressing incidences of discrimination or prejudice, which was mainly viewed as a separate issue. In relation to the reactive behaviour of organisations when incidents occur, some examples were given of how this had been addressed. Older LGBTQ+ people were clear about it being vital for staff to tackle prejudice and discrimination proactively and fully embrace opportunities to affirm and validate the presence and value of diversity within the group. However, some signalled a level of acceptance or resignation that it was unreasonable to expect staff to tackle incidences of prejudice in more direct ways such as confronting discriminatory behaviours in the moment with the individuals involved.

When talking about inclusive cultures and the role of services in creating what were referred to as safe spaces, there were additional factors raised by both older LGBTQ+ people and providers. One of these was gender, where viewpoints ranged from the importance of creating safe spaces, free from discrimination towards transgender people or bias toward specific genders, to the complexities of crossover between gender specific and LGBTQ+ specific provision, such as the example seen below in Sally's quote.

Discussion also included gendered approaches to activities, which were felt to be rooted in attitudes towards traditional male and female interests and gendered roles. Some participants had a perception that it was more challenging for gay men than lesbian women, although this observation did not primarily come from the gay men that participated but other participants. Some groups and services had tried to create broadly inclusive spaces through addressing gender imbalance, but had found this challenging, and more so when referring to LGBTQ+ specific groups and services. Attempts to be inclusive to all members of the LGBTQ+ community sometimes created division, with examples given of internal discrimination, with lesbian, gay, bisexual and transgender communities not necessarily being congruent.

> *"...we…have a problem as far as lesbians are concerned…because in fact…in the title of course…* [name of service]*…., it does sound as though we're…but that was in days when gay meant everything, if you see what I mean, it covered…all aspects. We have a few lesbian members but…the majority of the group are…male and that's not because we want it to be that way, it has been very difficult to get lesbians in… in the past" (Alex, 70s, gay man, service provider).*

The potential complexities of creating spaces for groups that were not necessarily homogeneous was recognised to be a barrier to creating inclusive spaces.

> *"We started it as a lesbian theatre company…I let in a non-lesbian…and it'd been open to trans women…it was an open door…and then the lesbians all had a fit and said, well not all of them, one or two of them had a fit and said, "You're supposed to be running a lesbian theatre." And I said, "Well I've gone off it, you know, because I…really think that if a woman wants to be part of this* [name of group] *who am I to keep them out?" (Sally, 70s, asexual woman, service user).*

Older LGBTQ+ people were more likely than providers to raise these kinds of concerns and issues, potentially indicating a greater awareness within the LGBTQ+ community of the diversity of feelings and opinions than was perhaps present for providers. However, this lack of understanding from providers was potentially contributing to the lack of actions being taken by them.

Older LGBTQ+ people gave examples of ways in which they might feel more comfortable within services, through what they viewed as validation of their LGBTQ+ identity. They suggested that actions such as use of gender neutral language, or them being overtly LGBTQ+ in the language they used when communicating might avoid heteronormative assumptions being made. They also felt consideration of the nature of topics of conversation and being able to have open discussions without judgement would help the experience feel more inclusive. Providers considered the use of inclusive language in relation to the examples provided from older LGBTQ+ people, and many thought it was complex to know how and when you might use specific terms pertinent to the LGBTQ+ population without risking offence. None talked about making efforts to understand inclusive language in order to build knowledge of what may or may not be appropriate in order to embrace less heteronormative approaches.

5.2.3 Meeting intersectional needs

One challenge identified by both groups concerned identifying 'hidden' communities, and being able to support them successfully. This was considered to be complex, as people rarely had binary identities, but more often identified with multiple communities and identities. Examples were given of providers being specifically funded to support a range of identities but needing to be mindful of the implications of this.

> *"Around barriers and protocols to engaging with diverse communities and particularly around everything from culture to gypsy Romany traveller, LGBTQ plus, substance misuse, mental health, because…whilst we have those communities identified as examples in our contract with our commissioner, how we work…is that they are very*

> *much fluid because none of us fit into…just one thing…you and I are both wearing glasses, well if we walk into a room no-one else is gonna know whether we're vegan or what faith we are or sexual orientation" (Ruth, 41-60, lesbian woman, service provider).*

When considering delivering specific staff guidance, training or resources, providers talked about their dependence on, firstly, knowing local populations and subsequently developing an understanding of the particular needs of those groups. One older LGBTQ+ person described the work done by an LGBTQ+ (healthcare) organisation they had worked for and how knowledge of the local population helped to ensure they were impactful.

> *"So if we have a service that is opening, for example,* [name of geographical area]*…, the chances are that we will meet the people that we're hoping to meet because we know that…from all the statistics from local communities and stuff, from the local authorities, that they are…probably the most disadvantaged in many different ways. And so that…is another… good reason why you want to have a locally based group, because they're gonna meet those people and you're gonna meet those people if you go to those groups" (Fifi, 60s, gay man, service user).*

There were indications that older LGBTQ+ people felt they may have to decide which parts of their identity would be at the forefront to enable the service to understand and meet their needs. However, they also expressed understanding the challenges for services in providing something that met all these potential needs, and accepted they might not always get things right.

> *"When you talk about inclusivity in community services it is very, very, very difficult. Now if I include some, I'm going to reject…not even ignore, deselect…leave behind another group of people" (Michael, 70s, gay man, service user).*

> *"I think it's political because you're being…handed a service which isn't good enough; so, it's political, how do you change, how do you adapt that service so that it actually meets your needs as a vegan, atheist, lesbian, whatever else you are?" (Sally, 70s, asexual woman).*

For many, the focus was more on the perceived effort those services had made than the actual measures taken. The ways in which a service or group worked with the individual was felt to be more important than providing specific activities or services for specific identities. There were concerns from some older LGBTQ+ people that if services only considered addressing the needs of one identity, other needs might be missed, such as links to the LGBTQ+ community. It was felt that services had a role to play in linking people through guidance and referral to other specific groups, advocacy and support.

> *"If we're only here just to…look after your…loneliness and isolation; and obviously that's very important but…it's so interconnected with so many other things and sometimes we find ourselves saying, well sorry I don't really know how to help you with that. And for…a service user I would imagine,...or a person, never mind a service user,...for a person, that…can be quite distressing" (Fifi, 60s, gay man, service user).*

Where older LGBTQ+ people had accessed a service and felt their needs had not been fully met, they recognised this might sometimes be the responsibility of the service but they also recognised that it may relate to a service's lack of links to relevant resources (e.g. being able to refer someone to LGBTQ+ specific groups, or advice and advocacy related to sexual identity). Where these links had been provided, this was felt to have had a positive impact and where they had been absent, older LGBTQ+ people perceived their needs had not been met.

Some providers expressed the challenges of working in ways which met individual needs and incorporated relevant characteristics, but they felt it was important to think of meaningful ways to meet a range of needs effectively.

> *"It takes a huge amount of resources to reach out to a massive subset of the community…to develop and kind of…look with a more intersectional approach on things, but I would always say just try, because a lot of organisations go as far as saying, we've reached out to some…black people during Black History Month, and you just think, that's…an ingenuine effort towards that aim" (Zayn, 18-40s, gay man, service provider).*

There were a range of opinions about how services could meet such a broad range of needs and affirm identity within that, with many returning to the importance of collecting information and understanding local populations.

5.2.4 Nature, appeal & accessibility of activities

Several older LGBTQ+ people raised concerns about the age appropriateness of activities offered under both LGBTQ+ and social care banners. These included activities being too young or too old in nature and being inaccessible/unsuitable for older people (both in terms of practical access and the nature of the activity). This could be considered a broader problem within social care more generally, as opposed to something specific to LGBTQ+ people.

Many of the informal groups and activities people engaged with, especially those that were longstanding, had been adapted to try and meet the needs of an ageing cohort. This included changing the time from evening to during the day and considering the location (where this was flexible). With more informal groups, such as the one Alex was involved in running, there was discussion about how these groups were run in terms of the types of activities, and how these were not always designed to be accessible, as issues such as mobility began to impact on people's ability to engage with the service.

> *"As people do get older….and become more house bound then even a group like* [name of group]*...is no use because they've got to come out to whatever events we are holding" (Alex, 70s, gay man, service provider).*

Some felt inaccessibility was increasingly connected to erosion of specific LGBTQ+ spaces, with reduced availability, perceived by some to have a negative impact.

> *"There's a big aspect that…there's been a kind of gutting of LGBT spaces in* [name of geographical area]*…I think it's something like sixty percent in the past ten years" (Zayn, 18-40, gay man, service provider).*

The perceived inaccessibility was more noticeable when activities or groups were part of wider projects, where this was seen as appended to the projects focussing on younger people, with less urgency and fewer resources allocated to work supporting older people. There was a perception that specific projects or activities for older people were less mainstream and that larger organisations, and LGBTQ+ organisations particularly, prioritised meeting the needs of younger people.

> *"My experience of…*[name of organisation]*.. was at the beginning less than satisfactory…because it…was a project funded by an outside source in a group that basically focused on younger people and…this…older people's project was, if you like, more of a tag on, do you know what I mean? It was a bit like…it wasn't really central at the beginning anyway as far as I could see, central to its main cause" (Fifi, 60s, gay man).*

Although likely a wider issue, not necessarily specific to LGBTQ+ communities, it was viewed as more problematic on the basis of the paucity of older LGBTQ+ specific opportunities. A provider made the point that activities and opportunities aimed at older LGBTQ+ people were sometimes viewed as secondary to mainstream services or were imagined to be the business of smaller, specialist organisations rather than larger or more formal service providers. Moving specifically focused activities from niche to mainstream provision was seen as challenging for providers and raised a question around providing services that were both mainstream provision but that maintained acknowledgement of LGBTQ+ identity in specialist ways.

> *"There is stuff going on and I think it's just that there are all those things but perhaps they're still seen as a bit fringe or, you know, it's how you get that into mainstream services and big organisations like* [name of organisation]*…nationally" (Cara, 60s, lesbian woman, service provider).*

Some providers felt that community building and outreach often focused on a broad range of people (e.g. families) which might be isolating for some older LGBTQ+ people. Providers suggested that changing approaches in broader service provision, or offering more specific services, such as those aimed solely at LGBTQ+ people would need to include work at a local level to ascertain need or demand and the nature of desired provision, and work with commissioners to broaden remits for funding and impose or build expectations about the inclusiveness of a service.

There were indications that older LGBTQ+ people and providers both viewed diversity within services as positive. It was suggested that mixed generations, consideration of social or economic barriers, and appealing to a diverse range of people all improved the experiences within those services, but this was felt to be challenging to achieve. Activities such as drama groups, choirs, and book clubs (usually initially accessed to address social isolation, or to seek links to particular communities) were spoken about as being exclusionary on the basis of the social and political attitudes of members. There were issues related to the accessibility of these types of activities both financially and socially. The impression groups sometimes gave was felt to be exclusionary.

> *"We encourage, as far as possible, mixed ethnicity, but the trouble is we give the impression of being white middle class so…sometimes that puts people off" (Rose, 70s, bisexual woman, service user).*

One provider suggested that although their core group had been intergenerational for a long period of time, this was starting to wane because younger generations used different mechanisms to connect with the LGBTQ+ community. The group had adapted to provide a range of routes for involvement which would appeal to different age groups, but this had not necessarily resulted in broadening membership.

> *"It has meant that in recent years, and indeed even still now, we do have a younger element in* [name of group]*... but in the main our core element is getting older and we are not getting young LGBT people joining* [name of group]*…, because there were all these various other facilities out there; they can go on the scene, it's not considered to be a problem, you don't have to have a sort of private, secret society that you belong to anymore. And so in time I suspect* [name of group]*…will completely fold because we will all die and, and there won't be anybody to take over (Alex, 70s, gay male, service provider).*

The intersection between ageing, frailty and being LGBTQ+ and additionally wishing to maintain strong links to the LGBTQ+ community demonstrated some of the challenges for providers and older LGBTQ+ people alike in being able to be flexible to changing needs. This was viewed by both groups as having a negative impact on the suitability and accessibility of LGBTQ+ specific groups, which were not necessarily designed or run with older people in mind.

Conversely, when considering the adaptations that might be needed by older people to accommodate younger generations, older LGBTQ+ people and providers appeared enthusiastic about adapting approaches. Those, like Zayn and Cara, who worked for LGBTQ+ organisations providing elements of care and support, felt making these links to younger generations and the local community were important in embedding both the service and the LGBTQ+ community in wider society.

> *"We're building up connections like that already; we're doing a piece of work on intergenerational activities…, to…more generally…explore…creative outlets so we can kind of bring generations together, or whether we can involve kind of an LGBT angle to that in terms of bringing younger LGBT people …to talk to older LGBT people about their experiences…So that's one kind of example of how we're really keen to make sure that* [name of service]*…isn't this kind of locked off area, that it's actually somewhere that…actively interacts with the community at large within the area; that's really important" (Zayn, 18-40, gay man, service provider).*

Some of the benefit was felt to come through building awareness of older people's previous and current experiences.

> *“Mixing people up a bit more…there are organisations…where they deliberately focused on…young professionals, people in their twenties and thirties, doing stuff with older people…and lots of different activities and; so I think things like that… an awareness of ageing…can actually really…benefit both parties really, in that sense” (Cara, 60s, lesbian woman, service provider)*.

Providers who were interviewed spoke positively about exploring these connections, but all were also part of the LGBTQ+ community themselves. The conversations mainly focused on the ways in which education, awareness and proximity between generations could play a part in solidifying LGBTQ+ identity, rather than on building broader acceptance with the wider population.

Some older LGBTQ+ people talked about the location of services and the importance of being able to access inclusive services locally. The benefits identified included ability to build or maintain social connections, contribution to a local community, being able to gauge other’s experiences and choose groups accordingly. For some, value came from being able to act as an advocate or representative for the LGBTQ+ community.

> *“Well, I think in the local community it is important to be part of the society or be part of the community. I think it’s quite important for a person’s wellbeing and a person’s mental health” (Joseph, 70s, bisexual man, service user).*
>
> *“It can be a bit off-putting, unless you know somebody who’s already involved in one of the more sort of statutory type things or the…charity” (Cara, 60s, lesbian woman, service provider).*

Conversely, there were negative connotations for some older LGBTQ+ people pertaining to services being locally based. References were made to not accessing something locally, or purposefully accessing specific LGBTQ+ groups further away due to concerns about others learning their sexual identity, perhaps indicating an ongoing expectation of discrimination.

> *“...in our younger days we would never go to a gay club or pub within our own town, we’d always go to the next town, because we just would live in fear of meeting the neighbours or meeting somebody from work, so we always went somewhere else; and I suppose in a way I’m still in that sorta mode sometimes” (James, 70s, gay man, service user).*
>
> *“I don’t mind people knowing I’m a member of this group, but I don’t want my picture in the newspaper in case my neighbours see it” (Fifi, 60s, gay man, service user).*

Many older people expressed that their ongoing fear of prejudice from the local community and neighbours was linked to being older, in the sense they perceived younger people were less likely to have these concerns. It was felt to be rooted in historic events rather than being linked to recent experiences.

5.2.5 Role of services in making links

Older LGBTQ+ people talked about the challenges of finding out about services, but felt this was additionally challenging if they wanted to find LGBTQ+ specific provision. Providers discussed their responsibility to link people to LGBTQ+ services. They felt this was difficult but also exponential in terms of other links they might need to make for other marginalised identities and groups. Examples were given by providers of signposting people where explicit requests were made, but this was related to specific activities rather than making links to other groups and services.

Older LGBTQ+ people focused on the importance of having links to local and LGBTQ+ communities, which they felt were relevant to the choices they made, especially since the pandemic. In multiple interviews, service users talked about wanting a specific group to access (eg LGBTQ+ specific, condition specific, activity specific) and that engaging with local services offered additional benefits, such as the opportunity to make connections with others who lived locally.

> *"My understanding was that it was a social care group that basically helped support older gay men, well actually older LGBT members to…get over any isolation and loneliness. And…we had moved, my partner and I had moved to* [name of geographical area]*…and thought actually that would be sort of good access as it were (1) to the LGBT community and (2) indeed, as we didn't literally know anybody in* [name of geographical area]*…when we arrived…to try and make…some connections there" (Fifi, 60s, gay man, service user).*

> *"Well I'd want to access it as close as possible to home so I didn't have to go to a lot of effort to go…elsewhere, just the practicality really, but also I want to access it there because…it's relatively near to where the rest of my family are and…in the same place as the…other support networks that I hopefully will…have at that… point in time" (Jason, 50s, gay man, service user).*

The multifaceted purposes of accessing local groups were linked to making connections more broadly in the area, which was felt to be valuable.

> *"I think because of not knowing anybody, because of all of a sudden you land, and it's very rural…where we live, so I think it's about wanting to kind of connect with people in the area…I think it's about connecting to…local…whatever's going on in your area, and kinda giving you something to do in the evenings as well, so actually kind of physically going and doing something" (Cynthia, 50s, lesbian woman, service user).*

Many providers suggested that being embedded in local communities and encouraging the building of those local networks were crucial to the success of the group. Benefits included encouraging people to contribute themselves to addressing social isolation and the opportunity to explore what else might be available through the local knowledge of other members of the group. Other providers felt the function of the service was more important than whether it was local or an exclusively LGBTQ+ space.

> *"Why do people join groups…is it mostly social…there's so much stuff around loneliness and social isolation now, and obviously Covid has heightened that as well hasn't it?...is it about someone sharing a particular issue or…characteristic or is it about I just need to get out of my house cos I don't see anyone and therefore…that's the most important thing, and as long as I can go to a group and we can have some*

> *chat…those other things aren't so important to me, or is it really that…it's this particular interest or characteristic" (Cara, 60s, lesbian woman, service provider).*

One provider, whose services focused on addressing social isolation, felt they had a role in connecting people to LGBTQ+ specific resources and opportunities as part of a holistic approach to support but saw challenges within that. These included ways of working with a group that may not be willing to disclose relevant information about themselves such as sexual identity. They felt one possible solution was to make information available in ways that did not rely on people having to ask for it specifically. However, this required the service knowing what else was available and being able to have, for example, display materials to promote those opportunities. A provider who was developing a support mechanism linked to ageing without children hoped this would provide support to the LGBTQ+ community but would not require sexual identity disclosure for membership.

Most providers seemed happy to facilitate links to LGBTQ+ specific resources but some felt constrained in the sense they lacked the knowledge they felt they required to do this. There appeared to be a limited base of knowledge about services that might be available and, where this knowledge was present, it was mainly focused on dealing with a specific problem, rather than links to the LGBTQ+ community. No providers gave examples of seeking out these wider links and finding that challenging to do, so it was seemingly based on the assumption that it would be difficult. Additional benefits were identified by some providers, such as being able to work collaboratively with these specific LGBTQ+ groups to gain advice and guidance about how to make their own organisation more inclusive but action was limited, despite providers being able to vocalise potential benefits.

Some providers within the voluntary sector had an instrumental role in key advocacy work, organising and facilitating opportunities for people to access information (about services, support, local opportunities as well as around issues such as legal rights) and they felt this was a valuable element of what they provided.

> *"One resident…called me up and said, "I'm really interested in…there being a will writing service and I really want a…service where…I don't have to be concerned about talking about my…male partner." The customer's a man and he didn't want to be concerned about talking about leaving his assets to…another man, because he'd done it before and there'd been questions asked and…he felt it was really difficult so he didn't call this…will writing organisation back" (Zayn, 18-40s, gay man, service provider).*

There were expectations around access to information about what was available, and as these expectations were not often met, some older LGBTQ+ people had found alternative methods to access information. Examples were given of older people utilising links with one group to try and investigate other opportunities and utilising broader community provision such as libraries. This also included expectations that Local Authorities would hold such information about the services available, but this was not always the case.

> *"I was hoping that there would be a sort of list of things that…all LGBT members do when I joined…and in fact that wasn't the case…I was hoping when I came to [*name of geographical area]*…as is the case in* [name of geographical area]*…that you could go to local town hall and go to the focal point…the LGBT focal point and say tell me*

> *all the things that are happening…tell me all of the organisations…what they do, give me the list and stuff when they meet and…as far as I'm aware, that isn't available…while I would say that* [name of local authority]*…does a lot more for the LGBT community through its projects and through its services than I did know, actually having that welcome desk as it were would have been quite helpful, because everything, all the doors are there, you then decide whether you want to go into them or not" (Fifi, 60s, gay man).*

This lack of central repositories of information, which is a more widely recognised issue with social care support, appeared to result in an expectation or hope that existing service providers would facilitate these links instead. This seemed pertinent in relation to LGBTQ+ specific resources, and although it was seen as complex, providers and older LGBTQ+ people were able to readily identify the benefits of knowing about and using such resources.

Older LGBTQ+ people and providers suggested that inclusive services would provide information on other local LGBTQ+ groups. Where services were affiliated with local LGBTQ+ networks such as Pride groups or advice, support and charities, this was considered a clear sign of an inclusive service by older LGBTQ+ people.

Some providers had a specific function to provide information (through specific commissioning from statutory authorities), but even those who did not, saw it as an important role in building connectedness.

> *"We are commissioned jointly by the local authority and the NHS CCG to provide guidance, support and advice and information in line with the 2014 Care Act; so therefore we're commissioned by the local authority whose responsibility it is to… provide those services, and we provide them to everybody" (Ruth, 41-60, lesbian woman, service provider).*

The expectation that a specific remit to provide information was in place for all services and that this indicated inclusivity was more prevalent within older LGBTQ+ participants, but providers also saw value in having this knowledge, despite the challenges of gathering and maintaining such information about local groups and services.

5.3 Heteronormativity & assumptive approaches

Older LGBTQ+ people indicated they anticipated negative treatment in services, and despite 10 out of the 12 older LGBTQ+ people having experience of formal or informal social care, this expectation endured regardless of previous positive experiences. Some felt that wider societal attitudes, which they perceived to be broadly negative towards the LGBTQ+ community, would filter through to services. It was challenging to identify whether this was because of previous experiences, or because people assumed social care providers would behave in negative ways because they held stereotyped beliefs about the LGBTQ+ community and the community themselves held negative beliefs about the workforce.

Part of the expectation, or direct experience, of services for older LGBTQ+ people was around the pervasive presence of heteronormativity. Links were made between these kinds of heteronormative assumptions and the quality of the experience. It was felt that heteronormative assumptions were easily made, had cumulative negative effects, but were simple to avoid. Many gave examples of how difficult it might be for them to manage an environment where heteronormative assumptions were made by staff and others.

> *"If that person annoys you every time…because, for example, they kept saying, 'why don't you just get married? If you got married, you wouldn't have all this, somebody would be able to look after you…I'm sure there's a woman out there for you'...if that constant…those sorts of comments, even if they were jokes…well I would expect that that service could be better and…that person to be sensitised into finding out as best as you can…what this person needs. Many people have explained to me when they've gone to the doctors and…the doctor will say…if it's a man…will your wife be waiting for you outside? Or if it's a woman…will your husband come and pick you up…those things can be made very gender neutral…who's coming to pick you up today or…do you have somebody that can look after you? Rather than assuming that …you have a partner and if they do, is from the opposite sex" (Fifi, 60s, gay man, service user)*.

Some older LGBTQ+ people felt that challenging heteronormativity was one of the ways that marginalised identities would be normalised, even where this might mean more specific LGBTQ+ tailored support was compromised. Broader acceptance and normalising marginalised identities was seen to be a longer term goal, which could be achieved through addressing approaches and systems of heteronormativity.

> *"I think that…it's like black power, you've got to raise the flag and you've got to say, here we are…LGB people and you've got to deal with us, and trans people, you've got to deal with us, deal with us. But then after that you're never going to move society on until society sees you as…a normal part of society. So…it's quite tricky" (Sally, 70s, asexual woman, service user).*

Providers were able to give their own examples of how heteronormative assumptions can be made easily and how this made them feel personally and professionally. They appeared to have a good level of understanding about the potential impact, although this sometimes appeared to be indicative of assumptive thinking which did not centre the person's own experiences.

> *"It's very difficult when you walk into somebody's house and the nephew says "Well Bernard's never been married…and he's ninety-two years old" and you…can't make an assumption that he's not had lots of girlfriends and just never been married, but it might be that he perhaps once was whatever but ninety-two year old perhaps hid their sexuality thirty years ago" (Brad, 60+, heterosexual male, service provider, FG1).*

It was felt that being aware of serving a diverse community and the attitudes, values and behaviours of staff impacted on whether the experience was inclusive and free from assumption for service users. This included assumptions in relation to sexual identity and was not an uncommon experience. It was felt to be difficult to constructively address this without causing embarrassment to others.

> *"I think some of the things that I've experienced personally is like when you have to correct someone, you just feel a bit bad, like you, they didn't mean any harm but also you, you're then telling them that they're wrong, and it's kind of awkward, like it makes you feel a bit uncomfortable" (Lyla, 18-40, bisexual woman, service provider, FG1).*

There was a focus on how these interactions were awkward for the individual, but that both the individual and the provider could potentially adapt their behaviour through giving opportunities for people to disclose that information on their own terms.

> *"I guess that's from personal experience;...it's not…I don't think, damaging that…but, you know, cos I've got a child people assume that I've had that child with a man and I didn't. So then you can get into awkward conversations and I would hate for somebody else to have to unpick that awkward conversation. So starting off in a, you know,..in a sorta generic way so people can offer you that information on their terms rather than making an assumption" (Anna, 41-60, pansexual woman, service provider, FG1).*

Asking about sexual and gender identity, and the use of neutral language, were seen as ways to avoid awkward interactions at a later time.

> *"How we ask questions at consultation, how we answer the telephone, what we're asking people, it's...using sort of neutral language and letting it be led by that person so we can find out as much information as they want to give, cos it can be quite damaging to have an assumption made" (Anna, 41-60, pansexual woman, service provider, FG1).*

Providers commented that staff sometimes said 'stupid or thoughtless' things, but that staff tried to be sensitive, open to learning and had no malicious intent. One provider was confident that assumptions did not occur when they had contact with people, partly because of the way they approached getting to know them as part of their initial care assessment, which they felt would avoid assumptions being made. However, it was unclear whether this was based on confident observations of staff not making assumptions, or a less evidenced belief by a manager that it was unlikely to be happening.

> *"I don't think we're doing anything that would be obvious like that; I wouldn't have thought so. I certainly know that we wouldn't do anything like that within an interview for a new member of staff…..so I wouldn't have thought we're doing that in the care interviews, when we…..go and see people who want care…I can't see that really happening" (Brad, 60+, heterosexual male, service provider, FG1).*

There was acceptance from both providers and older LGBTQ+ people that it was relatively usual for people to ask questions that might be classed as heteronormative around partners, families, or children. Some providers talked positively about how these kinds of questions often created talking points for further conversation, others raised the fact that people often used the opportunity to dig into further details and this could be intrusive. An example was given of asking about whether someone had children, which might then be followed by further (potentially intrusive) questioning about why they were childless.

One provider suggested that heteronormative assumptions should be challenged, but in ways that helped the person see the connections between themselves and the other person, to seek commonalities rather than focussing on the differences. They suggested that by challenging those assumptions and speaking openly about their impact, it would help to raise awareness of how to behave inclusively.

> *"I think one of the best ways to help people understand differences is to help them to relate to those differences by thinking about how that's similar to something in your life. So, you know, if you…have that experience of…being on your own and…people are always asking…is your partner coming?...is your wife coming?...some people…will have that sort of aversion to…even dealing with those topics but helping people to kind of relate to their…own sort of experiences and how they might feel if they were asked these questions and…it didn't apply to them and it made them feel quite isolated or like they're not being considered" (Quinn, 18-40, lesbian, non-binary, service provider, FG2).*

Older LGBTQ+ people had strong feelings about assumptions being made in homecare in particular, with many expressing heightened fears around this kind of support. There was anxiety about welcoming staff into their homes where indications about lifestyle and significant relationships might be more obvious. Use of heteronormative language, forced disclosure and the perceived need to hide elements of lives and lifestyles was felt to be more challenging when in one's own home. Homecare providers felt there was a responsibility to be mindful of the nature of care and saw value in considering whether the person wanted to, or had, disclosed their sexual identity as relevant to care planning and delivery. One provider highlighted the need for training for staff to include why homecare specifically might be difficult for older LGBTQ+ people.

> *"We've got another training coming up for staff just about the daily adaptations that LGBT people make to often hide themselves within…the public realm and what they do in their homes, for example, like…often hiding photos or queer literature, that, that's a big thing…that we found" (Zayn, 18-40, gay man, service provider).*

The fear of having to hide things when in receipt of this kind of care had been a finding of their organisation's work to understand people's feelings about being supported in their own homes.

Some providers reported that no LGBTQ+ populations existed within their service, despite being unable to evidence this through any systematic data collection. This provided further evidence of heteronormative assumptions being made by providers about presumptive calculations of the service user base they were supporting. There were some discussions about the role of collecting sexual identity data in determining whether as providers, there was a need to make specific adjustments or efforts to be inclusive on the basis of knowing precisely who comprised their client base. This knowledge was also felt to be useful in making decisions about delivery of specific training to staff. Examples were given of situations where it had been assumed there were not many (or any) LGBTQ+ Service Users in their local area who needed care.

> *"I do some of the core training...around awareness and we had...twelve new ambassadors…we went into their main big meeting…in there I reported…that we*

> *have got big areas that we are focusing on and one of those was, however people termed it, whether it was diverse communities, hidden carers, underrepresented carers…we've really got to reach these people; and one of these very middle-aged ladies sat there and she said "Well this is* [name of geographical area]*…, dear, we don't have people like that here" (Ruth, 41-60, lesbian woman, service provider).*

Ruth's example of taking a diverse group of older people, including older LGBTQ+ people, to a local community meeting where diversity was then denied indicated the difficulties faced in making those diverse populations truly visible. One provider felt if there were more LGBTQ+ people in their area, they would make efforts to appeal to them because it represented more income, but they felt it was not currently required because they assumed rather than knew about the presence of LGBTQ+ clients, so investments in staff training and inclusive advertising would be potentially less valued or impactful. Another felt there was little diversity in their local area, so training was helpful due to lack of exposure to the more diverse groups. A further provider felt their area was very diverse so staff would routinely encounter diversity and would already be aware of what they might need to know to support a particular community. This indicated an assumption that a diverse staff team substituted for attempts for building knowledge of those communities. However, most of these providers did not routinely collect sexual identity information and so may have been basing this on assumptions about their client base. This further demonstrated that knowing whether there was a relevant client base influenced providers' efforts to create inclusive support.

5.4 The Social Care workforce

Both older LGBTQ+ people and providers talked about the impact of staff attitudes and behaviours. This was primarily focused on staff training and awareness, and the ways in which this made a difference to people's experiences. Older LGBTQ+ people talked about the role they had in building staff knowledge to improve understanding, and the associated challenges. Providers spoke of the perceived value and complexities of providing appropriate training, and the difference this could make to the quality and appropriateness of support. Some recognised that by engaging with awareness raising and training, this would provide them with the skills to talk to, and about, the LGBTQ+ community and subsequently be part of bringing that community together.

> *"I think is really helpful in terms of if that was something that someone was discussing with me, I'd be able to talk about how we're part of different talks and things in the community that have allowed me to…kind of understand a bit better; also if ever they needed help I'd be able to…signpost, I'd be able to tell them a little bit more about what I know in terms of what's around, and if ever they were able to share something with me then it would mean that I could then allow that to be something to access for the rest of the community" (Lyla, 18-40, bisexual woman, service provider).*

There was general consensus across all groups that it would be good practice to deliver training around LGBTQ+ awareness, and even better practice if training included other aspects of equality and diversity, although some felt LGBTQ+ awareness was treated as less of a priority than other topics such as disability and race training. There was also recognition that other steps towards equitable services felt slow to happen and staff training was one effective way to develop more inclusive approaches.

> *"I personally would much rather…everybody working in care…have the best training ever that made sure it included LGBT not just…ethnicity or…disability…it's very often…"couldn't get round to do it" or "we haven't got time for that", or "we've done the disability and we've done the ethnicity cos they're important aren't they?"...we're on a continuum, aren't we…..it's a drop in the ocean…everything takes an awful long time doesn't it? So…I think the training of everybody…must be the…key thing, I think…that we're equal, that…our relationships are valid and equal to everybody else's relationship…we have an Equality Act and the care should be not prejudiced…That's why I come back to training all the time". (Delia, 61-70, lesbian woman, service user).*

Where training was being provided, it was felt to be important not to make assumptions about levels of understanding in staff teams. Examples were given including one where training had been delivered and an attendee in their 50s did not know what a lesbian was, indicating a potential need to ensure training was cognisant of audience knowledge levels.

> *"I would expect them not to have any LGBT sensitivity and I would try and introduce that straight away, because my experience has been that…we've given a few training sessions to community-based organisations as part of the work that I do now and what I've come to understand is…that there's an absolute lack of understanding, not necessarily any ill will, but just lack of understanding of what, why that would be different." (Fifi, 61-70, gay man, service user).*

Staff training was felt to reduce the risk of overt discrimination, or lack of understanding, which might result in inappropriate care. A range of examples were given of where training had resulted in positive impact, or where a lack of training had exposed shortcomings in support. Providers in the interviews appeared passionate and were actively delivering awareness training, and most continued to consider how they could train staff to meet older LGBTQ+ people's needs. However, this was arguably influenced by the fact all the providers interviewed were themselves part of the LGBTQ+ community and could have potentially been driven by personal values, experiences, and attitudes about the importance of doing this.

Providers talked about the approaches they might take to improving inclusivity (such as design and delivery of staff training) and how these approaches needed to be sensitive and shaped by those affected rather than designed based on assumptions about older LGBTQ+ people. One provider noted how developing specific groups, working with members of the community to develop services, and ensuring their approach included being able to signpost to other opportunities, were all ways to help older LGBTQ+ people feel included.

> *"I'd like to see and I know our CEO is keen…for us to…be really involved and maybe to…have our own group, but…sensitively and working again…with the community rather than telling them this is that group, come to us…it's something we really do want to explore that we could maybe provide that safe space…so…we could give advice on ageing well and…everything else but then have a group specifically for people who…have shared experiences together…and then as well…move out into*

> *other groups…it wouldn't just be…this is your little group, you stay here, but it would be a start where people could maybe start meeting and sharing their experiences." (Aubrey, 41-60, heterosexual woman, service provider, FG2).*

Other suggestions made about ways to broaden staff awareness are shown in *Table 5.1*

- Having literature accessible in staff rooms or offices
- Presentations from speakers with lived experiences
- Interactive and challenging training sessions
- Discussion groups on topics
- Using train the trainer model to empower non-LGBTQ+ staff to be 'champions' for inclusive support
- Delivering joint sessions which members of the public could join in with
- including LGBTQ+ topics within wider inclusivity training
- Working with commissioners to build expectations of staff in commissioned services having awareness and knowledge of specific topics
- Involving staff in updating or developing policies
- Having trained 'ambassadors' delivering training on behalf of LAs or large providers
- Dramatic plays or drama based performances
- Sharing LGBTQ+ history
- Training that assumes absolutely no prior knowledge and understanding
- Sessions which focus on behaviour and attitudes rather than differences
- Insisting training is mandatory for all staff regardless of role
- Using creative approaches to delivering training

Table 5.1 Suggestions for inclusivity building in staff teams

In the most simplistic of terms, the ways older LGBTQ+ people expressed their feelings about staff training reiterated their fundamental desire to be recognised and valued for who they were. There were relatively few references to specific elements of care delivery, with the main focus being about the hope of being treated respectfully. In some cases, there was resignation or acceptance that not everyone would approve of their life choices but the duty of staff to treat people respectfully and without prejudice remained.

5.4.1 Challenges & approaches to training

Both providers and older LGBTQ+ people themselves identified a range of challenges around the quality, frequency, content, and commitment needed to deliver impactful, meaningful and practical training for staff and volunteers. There was a feeling there were negative impacts from untrained staff and that it was important to provide opportunities to build understanding. Blame for this was generally apportioned to those in management. Providers mostly felt staff would be keen to complete training, and some had engaged with the community to ensure staff had, at a minimum, been exposed to accounts from older LGBTQ+ people. There were some concerns about making training mandatory and other views were expressed, such as one provider who was concerned about the appropriateness of asking their LGBTQ+ staff to complete training. The provider was concerned about the impact on themselves and their staff of introducing or completing training, rather than considering the potential positive impact of building awareness and knowledge across the staff team to improve delivery of inclusive care. This appeared to stem from a belief that staff would be offended at this request rather than objections being raised from the staff group.

> *"I don't know whether there's a huge amount of value in it for me, because…in ten years I've met one trans person who…needed care…it's a very small amount. Whether we put something onto the e-learning about diversity training…I would think that quite a number of my staff would say "Oh I'm openly gay…why do I want to be…what are you doing, you went to me wedding?"...And like fair enough…I'm not…quite sure whether they might take that as, you know…what are you doing…? I mean I'd be delighted to put it on the e-learning and perhaps have it as a module…to get it over and show how important it is to us, but whether…I'd want to actually sorta make it compulsory for every member of staff to…do it as…part of a…programme, I think I'd be uncomfortable with that…in fact I would be uncomfortable with that because I think I might insult some members of my staff who I really don't want to insult" (Brad, 60+, heterosexual man, service provider, FG1).*

Some providers noted that if they were supporting particular individuals or there was a surge in market demand from LGBTQ+ people, this would likely result in delivery of specific training. The benefits for specific older LGBTQ+ individuals were clearly vocalised, with much less focus on the benefits to staff over a career where they may come across a number of older LGBTQ+ people, even if that was not the case at the current time. There were no concerns voiced from either group about budget and time constraints in providing specialised training.

There were also some challenges raised by providers in getting staff to complete training, and/or knowing whether it was having the necessary impact intended in improving inclusivity. One provider talked about their experiences, as a volunteer, of online training. They felt it would be extremely helpful for them in their role and talked about the benefits of in-person training, but raised challenges around asking volunteers to complete optional training which took time and did not necessarily fit with other commitments. This was felt to be dependent on the individual person's interest in a topic and the volunteers themselves making the time to attend.

One provider who facilitated training for staff highlighted the need to start by introducing the broader picture, and wider implications of having a marginalised identity through relating it to people's own experiences. They felt this was a more effective way to train staff. This approach, which also included using real life examples to demonstrate how easy it is to make assumptions or ignore the historical context of someone's story, was felt to be impactful and relatable.

> *"...all of our training always starts with this kind of LGBTQ 101 awareness;...we unpick what it is to be LGBTQ, what does sexual orientation mean, what does gender identity mean?...I start by asking people "Is being LGBTQ a choice?"...then I say "Look, I…don't want to out anybody who's heterosexual cos that's really not fair, the outing process isn't a very good thing…and I'm not wanting anybody to kind of identify themselves as heterosexual because…it's OK to be heterosexual in this place." And then I say "But if you are heterosexual would you just answer these questions in your head;..."How do you know you're heterosexual? What did your*

> *friends and family say when you came out? Is it a phase you're going through? What do you think caused your heterosexuality?"...“When did you come out?"...and then I say to them. "So have you ever been asked those questions?" And they go "Well no." And I go "Well do you think I've been asked those questions?" And they go "Have you?" And I go "Yeah, incessantly, forever, lots of times."" (Cynthia, 50s, lesbian woman, service provider).*

Some providers felt that promoting clear LGBTQ+ representation and alternative styles of training delivery, such as live plays or drama productions, could have more impact and leave a lasting impression (as opposed to online training packages). These were felt to be more innovative ways of framing awareness raising through promotion of people who were already high profile but also happened to be part of the LGBTQ+ community, such as artists, writers, historians and pioneers. It was felt that by using these figures to stimulate exploration of the topic, there would be a stronger understanding.

Ensuring literature specifically relating to LGBTQ+ issues, history and needs was made available to staff and notice boards with LGBTQ+ specific activities or community opportunities were seen as an easy and non-invasive way to broaden staff knowledge. One provider who had a volunteer role felt there were other ways to build understanding of the community through materials such as reading resources written by or for the LGBTQ+ community, which they believed had helped them to broaden their approaches in the workplace.

LGBTQ+ people sharing lived experiences was felt to be the most impactful way of delivering awareness raising, mostly focused on those experiences which had been negative. Challenges were identified within that for both providers, in terms of finding or having access to people willing to deliver that, and for older LGBTQ+ people, who might be expected or required to relive potentially traumatic experiences for the benefit of others. There appeared to be a belief that training needed to include LGBTQ+ history and retelling of negative experiences rather than equipping staff with practical knowledge on how to avoid assumptions.

Some providers felt it was more likely that LGBTQ+ people talking about lived experiences would allow for discussions to arise organically and this would provide more effective training through staff being able to ask questions or find commonalities with their own experiences. Many felt that space for discussion and debate was a valuable part of building staff understanding. One provider commented that by listening to a person with lived experience it might make the challenges of being an older LGBTQ+ person seem more believable.

> *"I think it would…have more impact because it's…a person who knows…personally has experience as opposed to someone who's just in a…situation where they're…teaching it, if you like, and…I think it would…far more...believable in some respects"* (*Persephone, 60+ heterosexual woman, service provider, FG2).*

The use of the word 'believable' could infer that without this form of delivery, accounts of discrimination or prejudice might be viewed as somehow questionable or untrue. Questioning the validity of someone's experience could be argued to be a form of passive discrimination, even though the intention from this participant is potentially positive. Some providers also noted how bringing in older LGBTQ+ people to talk about their lived experience offered them an opportunity to build links with people in their local LGBTQ+ communities, offering the potential to subsequently involve them in other activities such as steering groups, focus groups, or service design and development groups.

Some older LGBTQ+ people gave examples of being asked to deliver talks, as well as the impact of this. They spoke about their role in speaking about their own experiences and how they felt this was a powerful way of helping people to understand other perspectives and experiences. James gave an example of delivering a talk about difficult past experiences for him personally and the wider LGBTQ+ community. This resulted in an individual, who was personally impacted, to develop understanding about why that might have happened.

> *"Quite a lot of them just sit there open-mouthed and don't realise what we've actually gone through…when I did the one for* [name of service and location]*…the lady came up to me afterwards, she said "Do you know what"..."I really enjoyed that"..."it really makes me understand things a lot better." So I said "Oh why's that?" She said "Well"..."my husband's gay and he's come out and so we've fallen apart now, but we had a family"..."and I'm pleased in a way for him"..."Now I can understand why he couldn't come out all those years ago and why…we actually got married"..."it wasn't an easy marriage but"..."I can understand why he did it."" (James, 71-80, gay man, service user).*

Providers also considered that although it was potentially powerful to hear about lived experiences, it might be difficult for people to hear or recount any traumatic experiences, particularly because it was felt important to showcase these specifically negative experiences.

5.4.2 Representation in the workforce

Many older LGBTQ+ people felt that representation of the LGBTQ+ community within the workforce through having LGBTQ+ staff, LGBTQ+ champions, or LGBTQ+ board/committee members was a sign of inclusivity. The presence of LGBTQ+ staff had a marked impact for some older LGBTQ+ people in their feelings of comfort about choices being made, potentially highlighting the impact of a diverse workforce. Some felt that LGBTQ+ staff were more likely to use inclusive language, less likely to make heteronormative assumptions and that their presence would mean not having to explain yourself or disclose anything for fear of discrimination. For others there were felt to be more fundamental impacts of a diverse staff team in relation to structure, ethos and culture within organisations being impacted through policy, attitude and expectations. Generally, across both older LGBTQ+ people and providers, it was acknowledged that people in any position of influence should be raising awareness to ensure there were cultural shifts within organisations.

Providers appeared to recognise the benefits of having a diverse workforce and how having staff wear badges or talk about their lives could help to raise awareness of the inclusive nature of the organisation. However, there were also a range of concerns, including from providers who were themselves part of the LGBTQ+ community, about the implications of doing this. Some were keen to embrace their staff being open with service users about their sexual identity. However, it was felt that it would be up to each individual staff member to choose whether they felt comfortable sharing their sexual identity openly.

There was recognition from some that seeking diverse representation in staff teams could be considered tokenistic and would not necessarily indicate the organisation was inclusive.

> *"Interviewer: what is tokenism to you? What do you mean by that?*
>
> *Participant: Well, that…there ought to be an LGBT person within the staff or in the management committee or whatever so that the LGBT voices is…heard" (Alex, 70s, gay man, service provider).*

Others felt that even if it were tokenistic, it often embedded cultures and practices over time, and this had a cumulative effect on the levels of inclusivity throughout the organisation.

> *"If tokenism extends to ensuring that at least one or a percentage of your staff are also from the LGBT community then that's definitely a step in the right direction, because that has an internal influence…an internal dynamic…which will, I hope anyway, would allow discussion to make things even better over time and moving… in the right direction over time, because, sadly, every step forward has to be won and every step forward has to be nurtured, because a step back is much quicker than the step forward" (Fifi, 60s, gay man, service user).*

There appeared to be a belief amongst older LGBTQ+ people that LGBTQ+ staff would equate to a more inclusive experience and for some it appeared to influence decision making. Examples were given of making care and support decisions based on the presence of LGBTQ+ staff.

> *"The activities coordinator was definitely one of us and I thought yeah…because I just knew that there was one or two members of staff that were of the LGBT community. Let's face it, the old gaydar soon clicks in and I just thought no…that makes me feel a bit more comfortable" (James, 70s, gay man, service user).*

This focus on LGBTQ+ staff indicating a level of safety or inclusiveness was demonstrated by more than one older LGBTQ+ person.

> *"If some of the staff are from the LGBT community, I do definitely feel it would help; I think it would help me….to be more comfortable." (Joseph, 70s, bisexual man, service user).*

There was a feeling from both older LGBTQ+ people and providers that ensuring LGBTQ+ representation within staff teams could be challenging, especially when/if trying to promote diversity of all cultural backgrounds. The importance of seeing intersectional approaches to inclusivity, rather than just towards the LGBTQ+ community in isolation, was expressed by some, although meaningfully including such diversity was recognised to be challenging.

> *"You need to show that you've got BAME, disabled, you need to get them in, you need to have them on your board, you need to have them in your meetings, you need to have deaf people in, blind people in…wheelchairs and everything, you just need to demonstrate that you are inclusive…You've got to start somewhere and you've got to say, right…we're all white, that's not good enough, or we're all, you know straight, that's not good enough, we're not being inclusive; so then how do you set*

> *about…you've got to then go..to little enclaves…like the LGBT…or BAMEs or whatever, or your Hindus…you've got to go to all these places" (Sally, 70s, asexual woman, service user).*

Many of the older LGBTQ+ people who talked about staff representation in the workforce focused on the benefits it brought for them in terms of offering a perceived level of safety and inclusiveness. Few considered within this either the practicalities of ensuring a diverse workforce, or the responsibility this may represent for staff members who are those representatives of a wider diverse group.

5.5 LGBTQ+ specific services & resources

Participants expressed mixed feelings about LGBTQ+ specific services. Some felt they were required and should be available, but that broader provision should also be inclusive for all, and others felt they were not necessarily positive.

> *"It's very important really…I feel a lot better and a lot happier, it's actually a lifeline for a lot of people, so in my opinion it is very important. A lot of older people don't know where to turn to...a lot of people that are LGBT may find it difficult mixing in different types of groups. In my life I've always acted straight, and it is difficult sometimes to be yourself; so, going to these groups you can be yourself, you can be comfortable, you can be yourself, you know nobody's watching you or you know nobody's assessing yer, and you can just be comfortable with being yourself" (Joseph, 70s, bisexual man, service user).*

Some older LGBTQ+ people perceived that LGBTQ+ exclusive spaces would allow them to feel at ease with expressing their LGBTQ+ identity. It was felt that the type of language used, the topics of discussion, the lower likelihood of heteronormative assumptions and awkward interactions would make these groups preferable to non-specific service settings.

> *"I would be able to be one hundred percent myself, it would be holistic care as far as I'm concerned and…all the things that we get from…being in a group where we can identify with others…it's very, very, very powerful" (Delia, 60s, lesbian woman, service user, referring to the benefit of an LGBT+ specific service provision).*

The historic discrimination older LGBTQ+ people had experienced appeared to impact on their decision making about accessing services and which kinds of services they might approach. Although there were some general feelings that integration and opportunities to mix were positive there appeared to be a link between previous negative experiences and the confidence to access new services. For some this was a defiance, in terms of being vocal and demanding fair treatment, where people saw themselves as activists. For others who were less confident, fear appeared to result in either not accessing opportunities, or remaining hidden within groups and services.

There were also some older LGBTQ+ people who felt not having to share spaces with people of other genders and of a similar sexual identity to them would lessen the risk of being exposed to discrimination and inappropriate sexual advances from others. It was unclear how LGBTQ+ exclusive spaces would minimise the risk or why they felt LGBTQ+

people would be less likely to display such behaviours in a specifically LGBTQ+ space than heterosexual people might in a broader service setting. There appeared to be some stereotyped thinking present for some around the higher likelihood of sexually disinhibited behaviours in those broader settings, especially in relation to heterosexual cis men.

Some talked about how older people were more likely to have had negative experiences in relation to their sexual identity and this was one of the reasons LGBTQ+ spaces needed to be created and protected. Balanced with a general feeling this was a generational, time-specific issue, older LGBTQ+ people felt what was needed now might be different from what was needed longer term.

> *"I mean maybe we need to go through a…stage of providing more niche services until they're not necessary. Like I look forward to a day when Black Lives Matter doesn't need to exist, when Gay Pride doesn't need to exist, you know, I think that would be, I would like to see that happen. Until then, yes, we need them" (Rose, 70s, bisexual woman, service user).*

Some older LGBTQ+ people gave examples of situations where the experience might have been different if the group had been LGBTQ+ specific and in some cases, how they had felt they needed to adjust their approach because of being in a non-LGBTQ+ space.

> *"Well there's a big difference because people just get you straight away… we have a lot of the same experiences…I don't know if I'd want, would want to go into detail with people who are strangers…who are not friends, who…you just meet casually in the group because I might not be accepted....we had a meeting about loss and I didn't talk about some of the things that I would have talked about had it been an LGBT group" (Woodie, 60s, gay man, service user).*

Having an LGBTQ+ specific service was seen as potentially exclusionary by some, with these only serving to increase feelings of difference, leading to slower acceptance of the LGBTQ+ community. Although many participants talked about broader services being inclusive as the better outcome, there continued to be an assertion that this would not necessarily be right for those who had experienced discrimination in the past.

> *"For myself I'm…very much actually for integration and that having a separate group isolates us and is probably not, in the long run, a good idea, and it's certainly not what I would want in an ideal world…my feeling is that people feel more comfortable, particularly if they are of my sort of age group and older, because they really have been in a situation where people hated them and thought they were disgusting and awful and shouldn't be allowed. So you've still got that mindset from all those many years ago; it may be OK for you now but you still remember those times back and, and you haven't quite got out of that" (Alex, 70s, gay man, service provider).*

> *"I wouldn't rule them out but I wouldn't automatically…put them top of my list…I think on the whole, rather than having specific LGBT+ homes, I would much rather have any place just providing…without even noticing…I think I'm all for as broad as possible inclusivity rather than niche providers for any group, Christians, whatever…I'd rather everyone were colour blind and gender blind and religion blind" (Rose, 70s, bisexual woman, service user).*

Many older LGBTQ+ people expressed initially that they would prefer it if broader services were inclusive rather than there being more niche LGBTQ+ specific provision, but some went on to state that given the choice, they would choose an LGBTQ+ specific service over a broader one in most contexts. Many identified this would be more likely to be the case if they were choosing residential or home care, but also applied to community-based services, including those that were extremely informal.

> *"If ever that happens, I needed care, I really think I'd prefer it to be LGBT, to be honest, cos everybody would be the same. So if ever I needed care in a big…way, yeah, I think I would prefer it to be LGBT because everybody would be the same" (Joseph, 70s, bisexual man, service user).*

> *"I belong to groups…they're very mixed on the whole…whether you're gay or…don't have children…that's not really particularly important in that context to me, but if I was trying to access care services I think it might be more important" (Cara, 60s, lesbian woman, service provider).*

There was a tension seen in many interviews around providing a service that was simultaneously inclusive and exclusive to people and their sexual identity. One of the ways older LGBTQ+ people felt this could be addressed was by attending a combination of broader inclusive services and LGBTQ+ specific provision alongside that. One participant demonstrated well the complexity of wanting something inclusive and exclusive at the same time.

> *"I definitely want to sort of try and seek out some form of LGBT…support groups, possibly if I needed that, whether that was just friendship…socialising, or whether that was some sort of more LGBTQ sort of support….if I decided that I was gonna move to* [name of geographical area]*…for the rest of my life but actually felt isolated as the only gay in the village…I would probably look for some sort of…LGBT sort of…third sector organisation to see what services they provide for friendship, socialising or advising me…on routes to other support that would be LGBT focused and supportive…I'd want to be sure that the services that I was accessing were inclusive and catered for my needs as a person rather than what somebody else thought I needed…I think…all organisations, no matter how large or small, need to be inclusive, but actually there needs to be safe spaces as well for people who perceive themselves to be different to share their experiences…for me to speak to other gay people in a safe environment, but there should also be environments where I can share my experiences with non-gay… in an inclusive environment" (Jason, 50s, gay man, service user).*

The desire for inclusive and exclusive services and groups, coupled with the challenges already present for services in meeting the needs of a wide range of groups and identities was recognised by some older LGBTQ+ people as complex for providers.

> *"I would like to see retirement homes dedicated to people generally; I like to assimilate…there is a…movement going on of trying to force local authorities to have say retirement homes dedicated to LGBT people. Now let me ask you one thing. So who are you going to exclude and are those people who are excluded not going to take umbrage? Because inclusivity includes everyone, right. How are you going to*

> *run a…retirement home or how are you going to run a community service…inclusive community service?" (Michael, 70s, gay man, service user).*

Because some older LGBTQ+ people felt they would be more comfortable in LGBTQ+ specific groups and settings, they equated this to more appropriate and effective care and support. It was unclear how the person themselves feeling comfortable might improve the quality of care delivery, so this seemed to be based on the ways in which people categorised their experiences rather than what was physically being provided to them in terms of social care support. This may have been primarily related to the importance of recognising and validating identity, as discussed in earlier examples. As discussed within Chapter 3, Social Identity Theory argues that identity is partly formed and maintained through others validating that identity. LGBTQ+ specific services were felt to be affirming and for some this was deemed just as, or more important than having needs met..

> *"It does allow a degree of freedom to talk, I mean not dirty sex matters…to feel completely free that the sort of relationships, etc, that you're talking about are not going to be treated by the other person as being peculiar and slightly odd, that in fact as far as the group are concerned it is complete normality…and it therefore gives them that amount of freedom to talk about things that they might not necessarily want to talk about with their heterosexual friends" (Alex, 70s, gay man, service provider).*

For some older LGBTQ+ people there seemed to be a perception that if groups or services were run exclusively for LGBTQ+ people then that would bring with it an innate suitability to meet LGBTQ+ specific needs. The majority of older LGBTQ+ people had identified that they considered their LGBTQ+ specific needs to be around recognition, validation and celebration of their lives and, within that, their sexual identity. It was unclear why these needs would be less likely to be met in broader services which were inclusive than they might in LGBTQ+ specific provision. Some providers felt that taking a broader approach to delivery of care would result in more holistic support, and there was a responsibility to create protected spaces and provide something for everyone.

> *"We want to be able to include anyone who…who comes to* [name of service]*…to be able to say there…is something for yourself…whole organisation-wise people do need to be very inclusive…we've…got to go internally cos…again a lot of our…services might be free but some are paid for services and if we know they can get that support…it's nice to be able to have an offer if someone comes to you to be able to say, OK, we're not the right fit, these people are, and we can do that introduction...we work that closely with organisations so that we have really friendly relationships with them, so we actually go along and say this is such-and-such or…if our project's not the right fit anymore they can move on"* (*Aubrey, 41-60, heterosexual woman, service provider, FG2).*

This ability to take a more holistic approach was felt to be flexible, in the sense that what was being provided might simply be signposting or referring to a different service. Providers felt that clear knowledge of their own strengths and abilities as a provider and being willing to signpost and advocate for people was indicative of an inclusive approach.

5.6 Summary

Older LGBTQ+ people were keen to see a range of approaches being utilised by providers to indicate their levels of inclusivity for the LGBTQ+ community. Tangible markers, actions such as setting ground rules, and staff avoiding stereotyping and heteronormativity were all seen as ways to make services feel more inclusive. Ways to promote understanding and awareness and smaller actions that might contribute to shifting attitudes and culture were seen as important parts of an inclusive approach.

Providers talked about some of the challenges within that, but were generally enthusiastic about the actions they might take to improve outward signs of inclusivity. There were some complexities and challenges to making changes to approaches but both older LGBTQ+ people and providers were able to make suggestions and advocate for the value of undertaking actions such as delivering accounts of lived experiences, acknowledging what this might mean for those involved.

Both older LGBTQ+ people and providers felt that meeting needs and identities in a person-centred way was complex but important. Older LGBTQ+ people felt that LGBTQ+ specific services and groups were important, but there was also a need to utilise broader services to build inclusion. LGBTQ+ specific services were felt to offer the benefits of comfort and safety as well helping to build LGBTQ+ networks. There was a general consensus that specialist services were not always helpful in terms of normalising and embedding LGBTQ+ communities into wider society. However, many older LGBTQ+ people felt they would be more likely to seek LGBTQ+ specific support when searching for providers of services such as residential care. Providers were not averse to implementing specific LGBTQ+ groups or activities but were much more focused on taking person-centred approaches to improve general inclusivity.

There were felt to be positive and negative implications from service being locally based or embedded in a local community, and as with many other areas, fear of discrimination often resulted in older LGBTQ+ people making choices based on the perception of how likely potential discrimination was to occur. Providers expressed enthusiasm about exploring better links to local groups and communities as part of their approach to improving inclusion, although there were many factors that influenced their ability to access information about services. Few were currently doing this explicitly but many stated their intention to improve their knowledge of other services and support in the future, with recognition this had a range of benefits for them and people that accessed their services.

6. Discussion & Conclusions

This thesis has provided insights into the thoughts and feelings of older LGBTQ+ people in the context of choosing and using community based social care services, specifically related to the ways in which these services feel, or do not feel, inclusive. It has also included an account of the complexities faced by service providers in understanding why and how efforts to make services inclusive for older LGBTQ+ people might be undertaken.

The following chapter will summarise the key findings of this thesis and engage in more detail with the empirical and theoretical contribution the research makes. Local and national implications of improving inclusivity for both older LGBTQ+ people and service providers will be discussed. Although many interesting topics arose from the data, it has not been possible to include all these areas in the discussion that follows. Key findings in this chapter include: the relevance, importance and influence of identity; data collection and disclosure regarding sexual identity; provider approaches to inclusivity including staff training and training methods; and the drivers for providers and mechanisms and signals of inclusivity felt to be meaningful within services.

As seen in section 4.2, the older LGBTQ+ people who participated in this research demonstrated a range of anxieties about accessing social care services, often, but not always, based on previous experiences of discrimination in a range of settings including formal and informal groups. Feelings were reported to be stronger about social care provision than might be present in other areas of people’s lives. The context of historic discrimination, how this potentially leads to anxiety and shapes decisions and behaviours around using support, will be considered in discussion of the complexities of person-centred care and recognition of identity. The implications of this for service provision are further explored.

The data explored in Chapter 4 of this thesis establishes the importance of identity for participants, both as an older person, and a member of the LGBTQ+ community. The theme of identity and its importance was also a key theme found in the literature review. Identity was a key factor in the ways situations were judged, experienced and responded to. As discussed in section 3.2.2, identity is a key component of well being and decision making. The ways in which identity is reflected back to us as individuals is often partially reliant on how others respond to and treat us. The ways in which we prioritise our identity directly affects our behaviours and evidence of this could be seen in the data collected as part of this research. There was a desire for active recognition of LGBTQ+ identity, through both asking about sexual identity and/or implementation of actions which supported comfortable disclosure. Collection of data, or the creation of opportunities to safely disclose, and the imagined impact of knowing that on subsequent service delivery, were a focus for many who took part, and will be considered in more detail in section 6.2.

From the perspective of service providers, the findings outlined in section 4.5 suggest that for those who worked or volunteered in services, there was not always an understanding of why sexual identity was relevant to the provision of social care. Nevertheless, there was clear evidence of a desire to be more inclusive and to build understanding of that importance. The lack of recognition of the relevance of sexual identity within services is not novel to this research (Benison 2020, Löf & Olaison 2020, Simpson et al 2018). As discussed in section 3.2.2, negating or denying opportunities to express identity can have a detrimental effect on people and negative stereotypes can dominate discourse about specific groups. This means that providers require ways to build understanding of the importance of sexual identity. Providers were anxious about how they might embed understanding of the importance of recognising sexual identity with staff teams. There were also concerns about the expectations there might be around their responses to knowing a person's sexual identity. The practicalities and implications for providers and wider communities in making efforts to be more inclusive will be discussed.

A range of possible actions that could be taken by services to build inclusivity were identified. As reported in section 4.5, many felt that active data collection was an important step as it increased visibility and would be a driver for providers to seek ways to improve inclusivity. Beyond this, staff training and building levels of knowledge were felt to be key by all participants. A range of beliefs around the ways in which this could be done most effectively, and what this might then signal or imply, were highlighted by both groups. The practicalities and implications of some of those methods are discussed in further detail in section 6.3 and 6.4 below.

Older LGBTQ+ people and those who provided services were keen to ensure that services felt inclusive for them, but a range of challenges were raised around how that could be done effectively. The expectations of older LGBTQ+ people were not always cognisant of the realities of social care delivery or delivering support which is culturally competent beyond a single protected characteristic. However, older LGBTQ+ participants identified how such actions would likely influence both their decision to access support and their experiences within that provision, demonstrating a potentially strong driver for providers to consider inclusivity.

As highlighted in Chapter 5, there were suggestions from older LGBTQ+ people about the value of measures to indicate inclusivity for LGBTQ+ people, including quality assurance frameworks and kitemarks. The benefits, challenges and implications of this are explored further in section 6.4.2. Other actions services can take to build inclusive services are also discussed. Lastly this chapter will suggest areas that went beyond the scope of the thesis but would benefit from further academic attention, address implications for services and policy, and summarise strengths, limitations and some final reflections on this research project.

6.1 Summary of the Research: Focus, Aims and Key Findings

As a reminder, this PhD addressed four main research questions:

- What are the experiences and factors which affect choosing and accessing community based social care for older LGBTQ+ people, to meet assessed or self-identified social care needs?
- What are the service characteristics that influence the perception of older LGBTQ+ people in their assessment of cultural competence and inclusivity in community social care settings?
- What are the perceptions of service providers of the views of the LGBTQ+ community and how do they currently try to address diversity?

- In what ways might services be able to further address concerns raised within the research, how can these be more effectively implemented and what barriers exist?

A key aim of the work was to explore what actions and signals older LGBTQ+ people used to determine whether a service would be inclusive to them. It was also important to understand what service providers thought, believed and understood about older LGBTQ+ people's needs. Whether they felt they should make efforts to demonstrate inclusivity and why that might be important was key. What actions they had already taken, as well as the challenges and complexities of taking different approaches were also explored.

A qualitative approach, including a literature review (Chapter 2), interviews with older LGBTQ+ people and staff/volunteers, and focus groups with staff/volunteers, allowed for better understanding of how people understood experiences. This led to both simple and more complex suggestions about how inclusivity could be addressed and improved.

The literature review engaged with empirical studies around LGBTQ+ people’s experiences and feelings about a range of social care including formal community based services such as day centres, residential care, homecare, and social and informal groups. There were three main themes identified as part of the review which included LGBTQ+ identity and community, the impact of ageing and cultural competence in service delivery. These themes have many commonalities to the findings of this research, where it could be seen that LGBTQ+ identity was felt to be important and relevant to delivering care. People wanted their important relationships and life stories recognised by services (Boule et al. 2020, Waling et al. 2019, Smith & Wright 2021).

In both the literature review and this research it could be seen that staff had differing views on the importance and relevance of sexual identity. Within the literature review there were several examples of discounting this importance, and similarly, there were some providers in this research who did not feel it was necessarily relevant to the delivery of care. The collection of sexual identity data, or knowing that LGBTQ+ people were using a service, was found to be variable in both the literature review and this research. Most providers felt confident they knew which of their clients might be LGBTQ+, but none included any questions as part of any assessment which might confirm this. Additionally, the challenges of asking sexual identity questions and having open conversations were felt to be complex, despite much broader research indicating that most people are happy to be asked (Rullo et al 2018, Bjarnadottir et al 2017, Cahill & Makadon 2014). There were indications that being asked was seen as a sign of inclusivity.

Research included in the literature review showed that LGBTQ+ people had a desire for specific inclusivity aimed at them as a community. As part of this research, older LGBTQ+ people, and some providers felt strongly that there should be specific actions aimed at improving inclusivity for them as a group. However, in both this research and the literature review there were indications that the broader nature of social care provision and the challenges that might exist in exploring a specific agenda around LGBTQ+ inclusivity were not always fully acknowledged. There were indications that LGBTQ+ people feel their needs could be met more effectively through inclusive support. Many felt that service providers could take actions that would make them more inclusive (Boule et al 2020, Waling et al 2019, Smith & Wright 2021, Willis et al 2018(1), Willis et al 2016, Price 2012).

Many LGBTQ+ people did not want to have separate services, and would rather have access to broader, inclusive services. The literature review highlighted the range of feelings about specialist provision and the importance of being able to build and maintain links to the LGBTQ+ community (Jones et al 2018, Waling et al 2019, Löf & Olaison 2020, Fannin 2006, Westwood 2016, Price 2012). Similarly, within this research, there were a range of feelings but overall, most wanted broader provision which felt inclusive. Some felt that it was a crucial part of embedding diversity within wider social care provision. However, the importance of having links to the LGBTQ+ community was also felt to be important and many felt that specialist groups helped to maintain those connections.

There were a range of factors felt to impact on efforts to improve inclusivity. Within the literature review it was seen that efforts to make a service inclusive were reliant on internal and external drivers such as management, culture, laws and regulation, funding and funding models (Boule et al 2020, Willis et al 2016, Simpson et al 2018, Waling et al 2019, Langley 2001). Within this research there was some discussion about the factors that impacted on service's ability to take actions, mainly connected to the confidence and guidance required to be able to do this effectively. Recognition of the role of management, drivers and barriers were all highlighted and continue to be an area for consideration. Efforts to improve inclusivity were being driven by individuals rather than more global drivers of an EDI agenda (Hughes et al 2011, Grant & Walker 2020, Waling et al 2019, Lottmann 2020, Yang et al 2018, Smith & Wright 2021). Within this research, there were signs that older LGBTQ+ people felt they had a role to play in building this inclusivity within services.

The literature review demonstrated that service providers, on the whole, were not cognisant of the importance of, and methods that could be used, to make social care environments more inclusive for older LGBTQ+ people (Brotman et al 2003, Waling et al 2019, Willis et al 2016, Langley 2001, Czaja et al 2016). This was framed by providers within this research as a lack of confidence in knowing which were the most impactful actions, rather than a lack of understanding the importance of taking actions. There was felt to be a lack of holistic approaches to delivering care and support, where opportunities to build levels of self-respect and independence were often missed because of external pressures to deliver something focused on only one area of need (Löf & Olaison 2020, Butler 2018, Jones & Willis 2016, Hoekstra-Pijpers 2020, Willis et al 2016, Price 2012). Within this research, providers appeared to have a good understanding of how knowing and responding to sexual identity could be an important element of delivering good person-centred care.

Unintentional discrimination, and heteronormative structures around assessment and care planning impacted on the experiences of LGBTQ+ people using social care services, which had an additional effect on how people viewed themselves and the importance of their sexual identity (Lottmann 2020, Willis et al 2016, Boule et al 2020, Boggs et al 2017, Brotman 2003, Smith & Wright 2021). Simple actions services could take to address wider inclusivity were identified such as measured approaches to language, assessment, activities and improving levels of understanding within staff teams (Boule et al. 2020, Willis et al. 2016, Price 2012, Brotman et al 2003, Löf and Olaison 2020, Hoekstra-Pijpers 2020, Simpson et al 2018, Boggs et al 2017, Jones & Willis 2016, Butler 2018, Westwood 2016, Smith & Wright 2021, Hughes et al 2011). Similarly, within this research there were a range of simple actions older LGBTQ+ people felt services could take, many the same as highlighted in the literature review. This brings some credence to these suggestions, as they are broadly similar across studies, so it can be assumed that these actions would be meaningful to many older LGBTQ+ people.

The literature review identified gaps in existing research which were utilised in the planning and design of this research. This included a dearth of studies focused on community based social care, with it being more common in the UK studies for these to be focused on more formal settings such as residential care. Some US studies, such as McGovern et al (2016), where funding is allocated differently, were more representative of informal community based services. There was a lack of detailed understanding as to why people do not access services in the first place, which although potentially harder to quantify through research, is extremely relevant to understanding the impact of inclusivity based actions services might take. Within this research it was expressed that the absence of signals of inclusivity and the enduring effect of historic discrimination impacted on engagement with social care.

The role of community based services in building connections to wider LGBTQ+ services, groups and organisations had also not been fully explored in the literature. There are challenges for small and informal services without infrastructure. Access to training, policies and drivers to change, ways to build confidence around taking actions to improve inclusivity, and the implications and outcomes of using specific tools such as storytelling around lived experience have not been fully explored within existing research. These guided the research and analysis undertaken as part of this thesis.

6.2 Recognising identity, history and fear

The design of this study, guided by existing gaps in the research, required foundational understanding of how older LGBTQ+ people's identity might be relevant to direct care delivery, both through consideration of the theory around identity and the feedback gathered and analysed as part of this research. Existing studies have mainly focused on levels of engagement, the differences in outcomes for this group in comparison to other populations (Women & Equalities Committee 2019), and primarily have considered either people using the service and their experiences, or separately, those running services. Less studies have brought those groups together to consider the other's point of view, and how sexual identity and previous experiences may impact on what service delivery looks and feels like. Building understanding with providers through direct sharing of perspectives of older LGBTQ+ people during focus groups encouraged discussion about how identity was relevant and important and what the implications of this might be for them as providers. Social identity theory, as discussed in 3.2.2, purports that identity is formed and maintained partly through interactions with others (people or organisations) and therefore it is arguably critical for providers to consider the impact of their behaviours on people's sense of identity.

There are many factors which influence service choices. However, the benefits of providing signals of inclusion towards marginalised identities to avoid people behaving in ways that misrepresent or conceal who they are, may result in improved engagement but also mental wellbeing for the individual, who might otherwise fear discrimination. As demonstrated within Chapter 4, this research found that older LGBTQ+ people held anxieties about how they would be treated in social care services. Moreover, this seemed to be a defining factor in how they made choices or interpreted experiences within social care services and groups.

There was a belief across the older LGBTQ+ group that underlying prejudice would prevent services and staff from being aware of, or enacting actions of inclusivity towards older LGBTQ+ people. Although there were few direct examples given of discrimination experienced within social care, the concerns of some older LGBTQ+ people about the likelihood of staff being prejudiced were based on perceptions of a constantly shifting landscape of attitudes towards LGBTQ+ populations more broadly. This may reflect the ever changing legal landscape within which parts of LGBTQ+ lives are legitimised or invalidated (Kuyper et al 2013, Roberts 2019, Hooghe & Meeusen 2013, Ayoub & Garretson 2017).

Recent decades have seen rapid changes in public discourse around equality and diversity, with the advent and proliferation of social media (Adamcyzk & Liao 2019). Whilst this can be viewed as a positive progression of social justice, the interviews highlighted that fears can linger, or become even more entrenched. The speed of cultural change raised concerns that reforms can be easily undone, or that organisations might superficially abide by current norms but revert to former unequal practices should the social tide turn. This presents a challenge for services in terms of how they might take actions that demonstrate inclusivity in such a way that it results in dispelling long held fears of older LGBTQ+ people.

The interview findings contribute to theories of intersectional anxieties brought about by ongoing discrimination, and ageing more broadly. Minority Stress Theory suggests there are potential cumulative impacts of discrimination over time (Abbruzzese & Simon 2018, Correro & Neilson 2019, Fish & Weis 2019, Anderson-Carpenter et al 2019, Donisi et al 2019, Mankowski et al 2019) and it could be reasonable to assume that this will result, for some, in those long held fears impacting on decisions and actions now. It could be seen that this was the case for some older LGBTQ+ people, and that additionally, ageing contributed to feelings of anxiety and vulnerability.

One such fear, highlighted by older LGBTQ+ people in this research, reported in section 4.3.1, and commonly found across other research, is that of losing independence, and becoming socially isolated, which can become consuming in later life (Brunton & Scott 2015, Goll et al 2015, Greenblatt-Kimron et al 2021). Attitudes towards older people within society can impact on levels of confidence, openness to help and support, engagement with ‘early intervention’ type activities and services, and ability to advocate for oneself (Abrams et al 2011, Gething et al 2002, Macnicol 2006, Minichiello et al 2000, Nelson 2005, Nelson 2002). There was evidence these attitudes towards older people were pervasive across the participant group despite most being older people themselves, usually manifesting as a belief that other older people were likely to be discriminatory.

It is widely evidenced that experiences linked to ageism are compounded by experiences of homophobia and heteronormativity (Heaphy et al 2004, Johnson et al 2005). The impact of minority stress and challenges associated with ageing may result in fearful responses, leading to a belief that future experiences are likely to be negative. The perception that services, staff and other service users would be ignorant at best and discriminatory at worst was particularly evident within this research, discussed in section 5.3. Although many only had minimal contact with formal social care up to this point, this was clearly expressed by older LGBTQ+ people. Negative perceptions formed through previous life experiences, or hearing about bad experiences from contemporaries, led to anxiety around accessing and trusting services (Almack et al 2015, Almack 2019, Almack 2020).

Within a broader research context it is generally understood that people may overestimate the likelihood of fearful events happening (Rachman & Bichard 1988). Fear heightens sensitivity, which in turn leads to higher likelihood of experiencing such events, because individuals are acutely monitoring for, and expecting them to happen; more widely known as the self-fulfilling prophecy (Merton 1948). Sevdalis & Harvey (2006) note that the emotions people anticipate in the future define their predicted preferences and are often inaccurate. Although it may be that fears are unfounded, older LGBTQ+ people in this research demonstrated that these anxieties affected both their choices and their perceptions of their experiences. This was primarily centred around not being recognised as an individual with an identity and a history. Testimonies around historic experiences were often followed up by acknowledgement that even though things have changed, mindset and expectations have not necessarily changed and the expectation of discrimination is still reasonably acute.

The presence of fear related to lack of validation of identity is not specific to LGBTQ+ populations. Older people, or those in need of support, have similar anxieties about being recognised as an individual within delivery of care (Henderson et al 2021, Glendinning et al 2006). Where personalised approaches are lacking, or communication is ineffective, this leads to people feeling powerless (Boudioni et al 2015). Powerlessness threatens social and personal identity, and discounting experiential knowledge is a key factor in those feelings (Aujolat et al 2007). Social care provider’s role in validating and strengthening identity may present a wider debate around what elements of personhood they ought to be responsible for, in terms of care and support being delivered.

Factors such as the perceived loss of independence experienced from needing social care in the first place, and historic discrimination, may have an influence on the ways identity is framed and incorporated into future decision making for older LGBTQ+ people. Despite participants' apparent understanding of the complexities of running a service in the current context of funding and staff shortages, there were some generally held beliefs. These included that although staff who worked in care were considered caring, the overall expectation remained that services would not treat people in the ways they wanted to be treated.

Mirroring wider research (Fenge & Hicks 2011, Todres et al 2009), a key theme for the older LGBTQ+ people in this research, discussed in 4.2.2, was the desire to engage with truly person-centred care, or at the very least, support which humanises care. This was viewed as one way to deliver support that fitted with how older LGBTQ+ people in this research wanted to be treated. It was sometimes challenging to identify exactly how care delivery itself needed to be different, but being treated as an individual was defined as including confirmation, validation and adjustment in approaches according to sexual identity.

One challenge for most informal services is the ability to demonstrate inclusivity in a way that provides this validation of identity. Research looking at culturally competent levels of support for LGBTQ+ communities often focuses on social work, a very specific type of contact with social care (Boyle & Springer 2001, Pezzella et al 2020). The lack of explicit guidance about how to build understanding of identity and its importance could mean that even the best efforts of a provider to deliver culturally competent care are missed. Although enthusiasm for improving inclusivity is often present within provider organisations and was clearly present within this research, there are a range of other factors that may also impact on the actions proposed or taken. This includes anxiety in relation to access to training and opportunities to build knowledge, capacity, and confidence to deliver something which is inclusive for a particular group, whilst ensuring they do not alienate any others (Fredricksen-Goldsen et al 2013, Smith et al 2019, Fredricksen-Goldsen et al 2011, Logie et al 2007). This point was raised by several staff/volunteer participants in this research as a genuine concern, as seen in sections 4.2 & 4.3. This in itself demonstrates some level of understanding of the importance of identity, as it recognises there may be a range of identities which require consideration.

Providers in wider research have reported that staff training and working collaboratively with LGBTQ+ organisations are key to a more inclusive culture within an organisation (Benison 2020, Ross 2016). Achieving person-centred care for a non-homogenous group requires a range of strength and asset-based approaches and ideally needs to involve people and professionals working together to build this inclusivity (Ross 2016). There can be a lack of confidence within staff teams and organisations about what actions are most appropriate, rather than an inability to take action, which several staff/volunteers in this research demonstrated. This further strengthens the potential benefits of working with ‘experts’ ie those from LGBTQ+ focused groups and organisations, who are more likely to have knowledge and expertise, especially around the importance of identity. However, it is also important to acknowledge that those who wish to do this awareness raising may not necessarily be experts in delivering training.

Making these connections to older LGBTQ+ people may provide some useful outcomes for services. Broader research around social care and older people has shown people do not expect to be passive in their support, but instead wish to be actively engaged in it (Andersson et al 2007). Outcomes are seen to be positively impacted by opportunities to contribute to support (as part of a focus on building or maintaining independence), services facilitating social contact and networks, and having links to other sources of support (Glendinning et al 2006, Francis & Netten 2004, Petch et al 2013, Boudioni et al 2015, Henderson et al 2021). Although there may be a difference between working with experts on specific initiatives and enabling input into an individual's care, it is possible both of these approaches would strengthen the feeling of being actively engaged for the individual.

This would need to account for the enthusiasm of the individual, but for most it would seem likely that the opportunity to contribute to their own care would be embraced in order to shape it for their needs. It is important to consider the impact of this on older LGBTQ+ people, who, as shown in the data collected as part of this research (section 4.4) and evidenced in other research, may feel fatigue in relation to acting in activist ways or advocating for themselves. Ways to build connections between individuals and services may be identified, and if these result in enhanced trust in an organisation, this may start to provide the validation of identity shown in this research to be so important to an inclusive experience.

There may also be other ways for providers to demonstrate validation of identity. As seen in 3.2.2, identity can be supported through feelings of similarity to others. We often seek out those with similar identities to ourselves as part of our desire to be in the ‘in’ group, and staff representation offers the opportunity to provide that environment (Hogg & Hardie 1992, Stets & Burke 2000). In 5.4.2, older LGBTQ+ people were able to give examples of how this representation within staff teams influenced decision making and it may be that this representation bolsters feelings of self confidence and safety. However, the ability and willingness of providers to affirmatively recruit to specific identities is complex. A more practical approach may be for those LGBTQ+ staff who are already part of staff teams to be supported to be as visible as they feel comfortable with, as part of a broader effort to demonstrate how LGBTQ+ people are respected and valued.

It is suggested that building trust is crucial to the effectiveness of a service (Henderson et al 2021, Baumann et al 2007) and the way in which individuals are treated by staff is at least as important as what else might be achieved in relation to quality of life measures (Petch et al 2013). The act of involving someone as the expert in the planning and delivery of their own and wider care is potentially a constructive way to build the trust which contributes to a positive experience and feelings of being recognised as an individual. All of these areas, pertinent to the general population of older people, are not dissimilar to the desires of the older LGBTQ+ population.

The ways in which services would meet those needs, despite them being common to all older people, might need to look different for older LGBTQ+ populations. Services first need to recognise the need for alternative approaches through understanding their client base, but then also need to consider how to build levels of trust and recognition of the importance of the identities a person has. This is likely to be challenging, as it may be difficult to produce a robust framework which is applicable in all contexts and settings, but this does not mean it is not possible to do.

6.3 Knowing LGBTQ+ people are there

One of the key findings from this research was the gap between older LGBTQ+ people’s desire to share their sexual identity with providers, and providers' general failure to collect this information routinely. As discussed in 4.5, some providers were keen to collect sexual identity information, while others were more reticent about whether it was needed. Most of the providers who were not part of the LGBTQ+ community themselves focused on the potential implications for staff and non-LGBTQ+ people of asking about sexual identity.

This research echoes what existing studies have found about both the relative invisibility of older LGBTQ+ people within services and strong feelings around disclosing sexual identity (Willis et al 2016, Lof & Olaison 2020, Fenge & Hicks 2011, Almack 2019, Ross 2016, Carr 2014, Hughes 2003). A lack of standard data collection in services (or more generally) on sexual identity has arguably reduced opportunities to research this population. Research about other marginalised groups, particularly in health settings, has shown the wider benefits of understanding the relevant attributes of who is using a service, and responding to this information in approaches to support (Henderson et al 2018). Levels of knowledge and understanding of staff teams impacts on levels of disclosure, as well as confidence to respond appropriately (Brooks et al 2018). However, there is a lack of relevant research for LGBTQ+ populations about what difference disclosure makes to individuals and to service delivery, particularly in social care settings.

Situations where disclosure is avoided means providers may not have the information they need to deliver appropriate care in a personalised manner, and there can be associated risks for LGBTQ+ people themselves in not disclosing. The ability to conceal and choose when to disclose can have a range of implications including individuals failing to engage with social care services and support because they do not feel all aspects of their identity will be acknowledged or respected (Boule et al 2020), damage to self-esteem and confidence (Langley 2001, Boule et al 2020, Brennan 2021, Pachankis et al 2020, van der Star et al 2019, Walch et al 2016, Williams et al 2017, Zuckerman 1998), and feelings of forced assimilation, which can cause mental distress (Ghosh 2018). The fear associated with disclosing sexual identity can impact on health and wellbeing (Jackson et al 2008) and can lead to low morale, particularly in later life (Friend 1990).

Systematic collection of data about sexual and gender identity in healthcare has been found to contribute to quality assurance, developing understanding of disparities, delivery of affirmative and inclusive care and facilitating open communication about LGBTQ+ specific issues (Bjarnadottir et al 2017, Cahill & Makadon 2014). Many studies have shown that the majority of people welcome being asked directly and that it can be viewed as a facilitator to open communication (Koh et al 2014, Roller et al 2016, Bjorkman & Malterud 2009, Law et al 2015, Daley 2012), although it is not necessarily welcomed by all (Venetis et al 2017, Roller et al 2016, Daley 2012, Guasp 2011). It may be that some, if not all those benefits would also be present in social care, where identity, networks and relationships and facets of lives and lifestyles are relevant to delivering support.

Creating an environment where people feel able and comfortable to disclose can also offer benefits for staff who will likely better understand, through these conversations, what else can be done to provide open and affirming environments (Sullivan 2014). For many providers, including those in this research, part of the anxiety around collecting this information is in the responsibility to subsequently respond to the information they now hold. Because there is a lack of research about the difference that disclosure can make in social care it is difficult to predict how this might impact on actions and experiences. However, when considering some of the known benefits in other contexts, it may be assumed that encouraging comfortable disclosure would be helpful for both individuals and organisations.

Much of the research around asking sexual and gender identity questions is based on healthcare and clinical settings (Rullo et al 2018, Bjarnadottir et al 2017, Bradford et al 2012, Cahill & Makadon 2014). A potential factor to be considered in making a comparison is that collecting healthcare based demographic information has been standard for some time. It could be assumed that anyone, regardless of sexual identity, is accustomed to being asked a range of questions which may or may not be relevant when in this setting. However, the differences in the settings and function do not necessarily mean that familiarity with and acceptance of this kind of data collection would not develop over time in social care, especially where more formal assessments of need are routinely undertaken. This potentially indicates a gap in the research currently published, specifically relating to personal comfort with answering these types of questions in social care settings.

There were a range of concerns raised by providers in this research about collecting sexual identity information as standard practice (see section 4.5). For some it was framed around their anxiety about asking the question at all, for others it was related to the potential consequences, or lack of consequences, of asking the question. Some providers were concerned that asking might implicitly signal it was seen as relevant, or would change their approach. Most felt that creating opportunities for people to disclose the information on their own terms, rather than ask the question as standard, was preferable. They felt it would give the person choice about disclosure and would not create any expectation about adjustments to the support provided on the basis that asking the question indicates it is seen as relevant.

The alternative approach of sexual identity being included as one of several demographic questions at the start of an interaction (for example as part of an initial assessment) was felt by some participants in this research to have the potential unintended consequence of upsetting or offending those for whom the question may be less relevant. Some participants felt that heterosexual older people may be offended by being asked about something they deem to be personal or intrusive.

Little evidence was identified that might support this view. In a randomised multisite trial looking at intake forms at outpatient clinics, it was found that only 3% of the 491 heterosexual, cisgender, older (>50 years age) participants were distressed, upset, or offended by sexual and gender identity questions (Rullo et al 2018). Moreover, Maragh-Bass et al (2017) surveyed more than 1500 people (patients and providers) in healthcare settings about routine documentation of sexual orientation and found that while only 11% of patients would be offended, 80% of providers felt it would offend patients.

This suggests that the concerns of providers are not necessarily in line with the reality for people using a service. Although some providers within this research were concerned about how they asked questions, most saw some purpose to this despite current anxieties and lack of confidence posing a barrier for providers. The potential benefits for older LGBTQ+ people of having this element of their identities recognised appears to offer more advantages than disadvantages to considering this as part of a standard approach to getting to know individuals within services.

Generally studies show that the majority of people are happy to disclose and feel it is important to be asked, regardless of their own sexual identity, although some do demonstrate that this is not always wanted by LGBTQ+ people themselves (Bjarnadottir et al 2017). A fear of negative consequences and homophobia can hinder disclosure of the information, which may be overcome by these kinds of questions being incorporated into routine assessment (Bjarnadottir et al 2017, Brooks et al 2018). It is important to consider if, how and when the question is asked is relevant, as understanding this may help to guide services around the ways in which this can be done in the most constructive way.

There are a range of factors which impact on individuals choosing to disclose their sexual identity. The relevance of sexual identity can be variable across individuals and contexts, as can levels of confidence. Stage of life, relationship status, and even a lack of cultural scripts related to how older LGBTQ+ people should behave, all potentially impact on comfort levels with disclosure (Geffros 2019, Guasp 2011). This research demonstrated that those who were confident in their LGBTQ+ identity felt it should be asked and accounted for in most situations. However, others felt less confident or able to disclose, or felt this was variable according to context. The ability to have a level of control over disclosure of sexual identity, albeit a potentially helpful tool for some LGBTQ+ people, also presents a complexity for providers.

Participants in this research often indicated they were happy to share their sexual identity but sometimes felt a pressure to do so unprompted, so that it was taken into account (Boule et al 2020, Hughes et al 2011, Simpson et al 2018, Smith & Wright 2021, Brotman et al 2003, Löf & Olaison 2020, Lyons et al 2021). Although this was a source of anxiety for some older LGBTQ+ people, as they did not always feel confident about how the information would be received or responded to if it was being provided unprompted, the importance of sharing this information remained. This potentially indicates that being asked the question rather than having to disclose unprompted is seen as a positive signal of inclusivity, which improves overall confidence. There are a range of reasons why LGBTQ+ people do not disclose in health and care settings, including fear of discrimination, negative responses, poor care, embarrassment, concern that sexual identity will be revealed to family members or that it will be captured within official records (Brooks et al 2018, Mitchell et al 2009, Burton et al 2020, Putney et al 2018). Providers are likely to require some cognisance of these concerns in planning approaches to collecting sexual identity information.

Other literature considering the willingness and impact of disclosure (primarily in healthcare) shows a range of responses and feelings for LGBTQ+ people. For example, one study involving lesbian women found 7 in 10 of those who disclosed to health workers were met with what they deemed inappropriate questions or comments and 1 in 10 were ignored (Hunt & Fish 2008). Studies considering whether people have disclosed their sexual identity to their GP often find between 20% and 50% have not done so, primarily due to fear of the response they will receive (Keogh et al 2004, Dodds et al 2005, Fredricksen-Goldsen et al 2011, Hughes 2017, Hunt & Fish 2008). Such accounts of how the information is responded to is likely to directly impact on people’s willingness to disclose, especially if this is in line with previous experiences. It indicates that in order to be an act of inclusivity, asking the question needs to be followed by a response which will not make the person feel discriminated against.

For social care the number who disclose or are asked about sexual identity can be even lower (Hubbard & Rossington 2005, Allen et al 1998). This is clearly replicated within this research, where all participants stated they had not been asked about sexual identity by any providers or they had only shared because they had deemed it relevant themselves. Some studies indicate that the individual’s judgement of the relevance of their own sexual identity impacts on whether they disclose or not in these interactions (Brooks et al 2018). This may mean that even if sexual identity questions are asked, they may not be responded to accurately, which is complex for providers to respond to appropriately. Building mechanisms which encourage people to feel comfortable disclosing is likely to be key. Communication using inclusive language, and welcoming body language are noted as being indicators that encourage disclosure, with the lack of these features being perceived as a barrier to disclosing sexual identity (Venetis et al 2017, Law et al 2015).

Services without formal structures such as community based groups may not have or require data collection, so a focus on creating opportunities for disclosure may be more appropriate. Creating conversations which provide a choice about disclosure for the individual, avoid heteronormative assumptions and are perhaps bolstered by other signals of an inclusive environment for the individual, may be more fitting for community social care. Research around disclosure has found that other cues such as leaflets, posters or rainbow signs may actually facilitate comfort with disclosure (Koh et al 2014, Daley 2012, Quinn et al 2015, Brooks et al 2018). These other signs do not negate the benefits and importance of knowing who is using a service by collecting formal data, or asking questions because they have other signals of inclusion available. However they may create ways to have more comfortable opportunities for disclosure.

One of the anxieties for providers in this research was around creating opportunities to disclose sexual identity through having inclusive conversations which covered the topic of sexual identity and used the right kind of language i.e. free from heteronormative assumptions and phrases. Effective communication is considered to be a key part of meeting person-centred outcomes, leading to feelings of being respected, listened to, and valued (Henderson et al 2021, Boudioni et al 2015, Petch et al 2013, Glendinning et al 2006). The use of nuanced language has been shown to support individuality and communicate respect (Johnston 2016). Furthermore, the ability to use LGBTQ+ terminology or inclusive language is seen as an important part of providing inclusive experiences and can have specific elements related to older LGBTQ+ people (Gendron et al 2013, Fredricksen-Goldsen et al 2013, Dentato et al 2014).

Common to older people more generally, good communication increases feelings of an effective person-centred approach (Willis et al 2022, Sharma et al 2015). Across research areas linked to social care more broadly, the desire to be assessed and supported in ways that promote aforementioned values are seen in learning disabilities (Wigham et al 2008, Leoncio & Martin 2022), mental health (WHO, 2021) as well as with older people, demonstrating a benefit across settings and groups.

There are broader debates within social care around the use of conversations and conversational assessment which move away from current more rigid and sometimes tick-box assessments. Traditional assessments can be transactional, and talking points are often centred on problems or deficits (Jefferson 2015). Multiple factors have been identified as affecting how these conversations play out. These include staff utilisation of professional judgement (Symonds et al 2018), the requirements of the information collecting body (Hayano 2012), the unspoken expectations, the ability to orient people to particular answers (Antaki et al 2000), the level of knowledge of the assessor (Bolger 2014) and the ability of assessors to move from one topic to another (Williams & Symonds 2022).

Conversational assessments can help build an understanding of what is important to a person, their strengths and talents, what is and is not working, what the person would like to achieve and how they would like to be supported. Ultimately these assessments are aiming to lead to support that reflects people's wishes and needs. Additionally, this form of assessment allows a judgement to be made about what is most important, provides opportunities for people to explore imaginative ways to meet their needs and as a result ensures what is delivered meets needs most effectively (Skills for Care 2018).

The time investment and levels of trust and openness needed, the whole life focus, joint decision making and shifting of power to recognise people as experts in their own lives, all differ greatly from traditional types of assessment. Where traditional social care assessment processes may encourage focus on a single need in isolation, conversational assessment can avoid ignoring relevant context or compartmentalising need (Martinell Barfoed 2018). This is likely to include relevant identity, and for LGBTQ+ older people, this type of approach may provide opportunities both to disclose and subsequently talk about how and why their sexual identity is relevant to their care. As participants in this research demonstrated, there are many reasons why sexual identity is felt to be relevant and ways to express this are greatly valued.

Encouraging or creating safe ways to disclose through more skilled and inclusive conversations, which would be characterised as open and free from heteronormativity, requires staff to have the right skills to be able to question openly, and respond in ways that validate the person in response. Having confidence to ask and respond to these questions can be challenging and potentially requires a different skillset to that of a standard conversational exchange between staff and service user, because of the complexity of the topic (Winters 2020). This was expressed by participants as being an area for development for them. While they were experienced at talking with a wide range of people, they articulated less confidence in relation to sexual identity where they perceived it may be intrusive and potentially awkward or upsetting. One possible approach is to structure those conversations in such a way that demonstrates the importance of the question, but also provides an option to choose whether to respond.

Benefits are possible for both the provider and the person by removal of the responsibility to disclose unprompted and providing a signal that the person/organisation is inclusive of all sexual identities. Because having to disclose unprompted was felt to be challenging in both this and other research, it is important to consider the actions that avoid this need, and subsequently the negative associations made when unprompted disclosure is felt to be needed. The information can be used to shape approaches and to lead to other questions about the relevance and impact, such as context around family/support networks. Staff will also be more informed and prepared for how to proceed within subsequent conversations in terms of language and avoiding heteronormative assumptions.

In terms of upskilling staff and building confidence around having these conversations, Skills for Care developed and released a LGBTQ+ evidence based learning framework for knowledge, skills and values for working affirmatively with LGBTQ+ people in later life (Hafford-Letchfield 2023). This framework notes that people who are asking questions about sexual identity need to gain or earn trust, demonstrate awareness of the history of discrimination and provide a welcoming and safe environment focused on improving outcomes. It suggests that asking questions and having inclusive conversations should be a baseline for anyone in the social care workforce. This was considered by older LGBTQ+ participants in this research as being a clear indicator of inclusivity and something which was very much hoped for in engaging with services.

The assertion that collecting this information is a fundamental part of creating an inclusive environment further strengthens the argument for adopting these kinds of approaches, even where this might then instigate a training need for staff. The ability to have an inclusive conversation is likely to provide benefits more widely than for just the LGBTQ+ community, with other marginalised groups potentially feeling more included through signals that diversity is valued and responded to appropriately. Although there is some evidence of an inclusive approach having positive outcomes in other research, especially in relation to ethnic identity, further understanding of the benefits of an intersectional approach to marginalised identities is needed. There are also benefits to providers, as discussed above, providing positive drivers for them to consider the ways in which they collect data or create opportunities for people to disclose their sexual identity in the future.

There are also other ways for providers to demonstrate they see LGBTQ+ identity as important. This includes the ways in which LGBTQ+ staff are supported and respected, and the ways in which they are visible within the organisation. Older LGBTQ+ people, as shown in section 5.4.2, were influenced by the presence of LGBTQ+ staff. Although there are some complexities present in asking LGBTQ+ staff to be visible, if providers create a culture where this is recognised and even celebrated, it may mean that staff feel more able to represent themselves and their community more openly. If people who are using services can see that LGBTQ+ staff are represented and well supported in expressing their identity, this potentially creates feelings of safety and inclusiveness which encourages them to also express their identity openly. As discussed in sections 3.2.2 & 6.2, being able to express identity can be extremely important for overall well being.

6.4 Provider approaches

6.4.1 Staff training

Throughout this research, discussed particularly in section 5.4, staff training and building awareness of LGBTQ+ communities and histories was believed to be a way to improve overall inclusivity within a service. Older LGBTQ+ people felt that effective staff training was key to making a difference to their experiences and that they had a role in ensuring staff had opportunities to develop understanding of the LGBTQ+ community more broadly. This was also reflected in service providers feelings about ways to ensure services felt inclusive. Research around LGBTQ+ people in health and social care continues to evidence poor experiences which are often attributed to levels of staff skills and knowledge (GEO 2018, Hudson-Sharp & Metcalf 2016, Somerville 2015). Some argue the progression of rights and visibility of the LGBTQ+ population now surpasses the ability of social care services to meet needs inclusively (Hafford-Letchfield et al 2017).

Under a Critical Theory lens, care providers may be predicted to follow heteronormative assumptions about their client base and resist introspection as to how they may be a conduit for both discrimination and to effect change. However, research looking at the impact of specific LGBTQ+ training identifies that educational interventions have positive effects on knowledge, awareness and attitudes, in turn reducing heteronormative and cisgendered communication, positively impacting on attitudes, confidence, self-efficacy, comfort, affirming behaviours, stigma, and discrimination (Sekoni et al 2017, Yu et al 2023, Jurček et al 2020). Furthermore, there is thought to be a connection between staff levels of cultural competence and their ability to meet needs, improve engagement with services and build levels of trust, although the longer term benefits of this are yet to be understood (Yu et al 2023). The impact of this type of training was presumed by all those who took part in this research to be far reaching and a belief that these advantages would be realised through delivery of training was present regardless of whether the participants had any experiences which confirmed or refuted this.

Although other suggestions were made for actions that might broaden staff awareness (see *Table 5.1*) specific training which included elements of lived experience was felt to be the most effective. Accounts included specific examples of where training had been delivered which had seemingly resonated with staff, although there was less evidence presented about whether the training had resulted in changes to experiences for those using those services. Those who participated in this research and were involved in delivering training or awareness raising identified a range of other factors which they felt impacted positively on the efficacy of LGBTQ+ training (see 5.4.1). Supported by broader research, these include the length and frequency, whether it is delivered at all levels of an organisation and how much focus is put on attitudes (Yu et al 2023). Acknowledging wider historical context, recognising a lack of homogeneity, ensuring different perspectives are considered and interactive strategies are seen to be key features of effective teaching (Higgins et al 2019), with these features all being common to the examples given by participants in this research.

However, there is also evidence that not all training impacts on experiences for people using a service, especially where behaviour change techniques are not a feature (Hunt et al 2019). Negative outcomes have sometimes been seen, where training has decreased levels of comfort and confidence in staff to meet the needs of specific populations. For example, training about supporting transgender people inclusively highlighted gaps in knowledge and as a result of exploring the complexities of this support, confidence in ability to effectively support was reduced for staff (Porter & Krinsky 2014). The willingness, openness and enthusiasm from staff to learn and adapt approaches following training is also potentially relevant. Thought needs to be given to how training is delivered, how it is followed up and what it includes. As participants in this research highlighted, some training does not make a difference to how care is delivered, and feelings about the hierarchy with broader EDI training resulting in less focus on LGBTQ+ topics lessened faith in how this might impact. The fact that training does not necessarily automatically lead to more inclusive experiences needs to be fully understood in order for training to be focused on the most impactful ways of changing attitudes and behaviours of staff.

There is currently no national agenda to tackle this potential training need. Developments such as core training standards for sexual orientation in NHS settings (Cree & O'Corra 2006), and the Equality Act (2010) provide legal protection in both workplaces and more widely, but have not globally progressed to systematic delivery of EDI training, much less LGBTQ+ specific training (Hunt et al 2019). The Equality Act's (2010) duties to "eliminate discrimination, harassment and victimisation, promote equality of opportunity and foster good relations between people from different groups" offers protections in relation to protected characteristics (e.g. disability, sexual orientation etc) but does not explicitly mandate EDI training as part of this. This lack of training potentially results in inconsistent levels of knowledge and impacts on the cultural competence of these services through a lack of onus on services to consider ways to improve inclusivity, as opposed to just avoiding discriminatory practices. When considering this through the lens of Critical Theory, it is possible to hypothesise that failure to connect with and promote diversity may be part of a lack of recognition of the power for change held both by organisations themselves and by the societally driven marginalisation of minority groups.

Publicly funded bodies often utilise delivery of training to demonstrate meeting statutory duties. Organisations such as the NHS have standards which require progress reports against a number of indicators of workforce quality or metrics (NHS Employers 2023). NHS Guidance for EDI training covers a wide range of content, but has no specific elements related to sexual identity beyond a link to a 'Sexual Orientation Monitoring Information Standard'. This standard clearly states it does not mandate collection of sexual identity information (NHS England 2023(1)). The lack of drivers for collecting sexual identity data and delivery of LGBTQ+ (or EDI) training means there is likely an inconsistency in both knowledge and practice across the country. This could be seen as part of this research, where geographical differences existed in relation to access to training and visibility of older LGBTQ+ people and LGBTQ+ resources more generally.

The NHS has released an NHS Equality, Diversity & Inclusion Improvement Plan (NHS England 2023(2)) which features LGBTQ+ specific references more prominently and states training and raising awareness, alongside other potentially impactful actions, are key components of improving EDI within healthcare settings. This shows a level of understanding about the need for improved knowledge in healthcare settings. For those organisations who are regulated, the CQC states as part of their monitoring, groups with specific needs such as the LGBTQ+ community should be considered, although there is, at the time of writing, no confirmation of how this can or should be done (CQC 2022). There are yet to be any equivalent plans or standards applicable to social care more generally or for unregulated services. This has meant that up until recently there has been a lack of coherent frameworks for providers to use (Hafford-Letchfield et al 2017). Participants in this research highlighted the inconsistencies and lack of drivers for training but also the challenges of accessing something like training as a small, often informal organisation.

As an example of potential progression, an evidence based learning framework for working affirmatively with LGBTQ+ people in later life has recently been developed through a collaboration between Skills for Care, the LGBT Foundation and the University of Strathclyde (Skills for Care 2023). This demonstrates that work is now underway to address training needs of social care staff around LGBTQ+ needs, rights and inclusive support, although this remains an optional training framework which providers would need to seek out. However, recognition that attention to this population is required can be considered a step forward and a feature of the changing social tides which seek to reduce marginalisation through the direct actions of providers.

The aforementioned framework suggests using the voices of older LGBTQ+ people via storytelling to enhance experiential, work-based and reflective learning. As part of this research, participants expressed a belief that retelling of lived experience was the most impactful way to change attitudes and behaviours of social care staff. This was primarily centred around retelling of negative experiences, both recent and social care based, and historic in terms of the experiences of being LGBTQ+ in less tolerant periods of time. The importance of understanding background and history has also been highlighted in the literature, as it is thought to be a key part of building staff skills around working inclusively with LGBTQ+ people (Hafford-Leitchfield et al 2021).

For tangible shifts in culture within organisations it is likely to require a wide range of elements to be considered and amended, but this and other research demonstrates that training and awareness raising for staff is a key way, or a step in the right direction to making those more cultural shifts (Sekoni et al 2017, Yu et al 2023, Jurček et al 2020). Coupled with other strategic and practical changes, and further introspection relating to the impact of heteronormative structures, there can be meaningful advances in improving inclusivity underscored by a staff team who value and understand the nuances of working with older LGBTQ+ people and frameworks to support those who are part of delivering such learning.

Several studies have considered the efficacy of interventions for educating social care practitioners on the experiences and needs of older LGBTQ+ adults and note storytelling as a common pedagogical approach. Systematic reviews of training interventions demonstrate that many utilise sharing lived experiences. Yu et al (2023) found 13 training interventions included sharing lived experiences, and 7 of the 9 interventions in Jurček et al (2020) also included these elements. Of particular interest is the variation of methods employed to share these experiences including panel presentations, theatrical performances, videos or documentaries, telling of personal narratives and fictional case studies based on real life examples. (Hanssmann et al 2008, Hanssmann et al 2010, Barrett et al 2021, Henry 2017, Gendron et al 2013, Long et al 2022, Leyva et al 2014, Pepping et al 2018, Pratt-Chapman 2021, Russell & Corbitt 2022, Schweiger-Whalen et al 2019, Pelts & Galambos 2017, Rogers et al 2013, Donaldson & Vacha-Haase 2016).

One element to be considered is encouraging the retelling of negative lived experiences, particularly from those who are older, may risk perpetuating negative stereotypes around both LGBTQ+ and older people. If staff are primarily exposed to older LGBTQ+ people telling negative stories over any kind of positive reinforcement or focus on the wishes and hopes they have in relation to social care provision, it could have the opposite effect to its intentions. Although retelling of negative experiences may help staff to understand an older LGBTQ+ person’s perspective, it does not necessarily provide any direction for how to support someone inclusively. It should also be taken into account that one individual's story is only representative of that one set of experiences, may not be common to other individuals' experiences, and may end up being the sole basis on which staff are building knowledge. When considering what the desired outcome of training staff might be, and the wide range of signals of inclusivity that are potentially impactful from an older LGBTQ+ person’s perspective, it is plausible to consider that staff training may only be one of multiple approaches needed to make a service truly inclusive.

There are a range of studies which consider the experience of storytelling more generally, in this context, the retelling of lived experiences. However, many of these studies focus on utilising storytelling to process trauma as part of a therapeutic approach (Divinyi 1995, Rosenthal 2003). Participants in this research, as discussed in 5.4.1, felt storytelling was powerful. For some it was deemed more believable than someone else delivering training, whatever format that might take. The accounts older LGBTQ+ people gave during this research often centred on the importance of staff understanding their individual histories and broader experiences of discrimination. Although data collection and inclusive conversations (further discussed within this chapter) were felt to aid this on an individual basis, sharing stories more widely with staff and other people who use a service was viewed as a constructive way to raise awareness.

Storytelling is felt to be a key communication strategy which is persuasive and easily understood and can be used as a way to motivate and engage learners, promoting discussion and critical reflection (Jarrett 2019). It is often a central component of training and research suggests that real life accounts can enhance engagement, increase empathy and raise awareness of LGBTQ+ specific issues (Jurček et al 2020, Gendron et al 2013, Leyva et al 2014, Pelts & Galambos 2017, Rogers et al 2013). However, there is less research considering the longer term effects of training on staff behaviours and whether these types of training impacts on experiences over a longer period (Yu et al 2023).

One of the areas missing from much research around storytelling or recounting lived experience is the impact on those telling their stories or sharing their lived experiences as part of a training offer. Older LGBTQ+ people within this research talked about fatigue related to their activism and providers gave anecdotal examples of trying to engage with older LGBTQ+ people who felt exhausted by requests for involvement in these kinds of activities. It is complex to know how the perceived importance of retelling lived experiences within training can be effectively balanced with the desire and energy of older people to undertake this kind of activity.

Reviews of the delivery of LGBTQ+ training demonstrated that many providers had involved LGBTQ+ people in design and delivery of training, regardless of the overarching delivery method (Yu et al 2023, Jurček et al 2020). Although service user involvement is believed to counter power imbalance (Harrison & Mort 1998) and improve accountability (Abelson et al 2003), it is not without its complexities. El Enany et al (2013) highlight the intricacies of involving people who use services as representatives of a population or group, where self-selection and professionals actively selecting, educating and socialising those involved, can result in unrepresentative involvement and tokenism. This presents a set of challenges for providers in relying on older LGBTQ+ people to build awareness, which ultimately may or may not be effective at changing staff attitudes and beliefs and potentially relies on people who may not wish to carry such a responsibility. Critical Theory argues that centering marginalised voices to guide positive action is likely to be most impactful, although doing this in isolation, without considering the wider picture may be less effective. Factors such as the infallible nature of individual perspectives, and the ability and willingness of organisations to objectively consider their own position within a heteronormative system should also be considered. It is therefore challenging to rely on older LGBTQ+ voices alone to improve cultural competence more widely.

Hope & Ali (2019) note that the concept of retelling of lived experience is likely to be influenced by a range of factors and does not account for different types of lived experience, such as other types of marginalisation or discrimination and how these intersect. Oppression, stigma, barriers, ability to access safe services and community integration will all potentially influence that lived experience. This was somewhat demonstrated with participants in this research who had other prominent identities and often or equally focused on these when answering questions. When returning to the idea that older LGBTQ+ people want to protect their identity as separate and distinct while simultaneously wanting to be mainstreamed, the pressure for a person retelling a lived experience as part of training in a way that incorporates both how they are different and the same is complex for the most experienced of trainers. It may be extremely difficult for these accounts to be measured, or solution focused, which arguably necessitates an approach that incorporates storytelling with other forms of education and awareness raising.

There are some recognised potential benefits for individuals in sharing their stories. Within a study looking at peer-led support in mental health (Faulkner & Kalathil 2012), there were a range of personal benefits identified including empowerment, increases in confidence and self-esteem, and dignity, respect and acceptance. However, these and the other benefits described were focused on the relationships formed in this ongoing role as a peer-supporter. Although participants were sharing their lived experiences, this was done over time, and other benefits listed, including hope, companionship and reduced isolation, being part of a group with mutual understanding, shared identity and a sense of belonging, were all based on the benefits brought about by the links made rather than the initial sharing of lived experience. This raises the question of whether these benefits would only be realised through a range of other engagement beyond the initial sharing of experiences.

The older LGBTQ+ people in this research felt they had a role to play in educating staff, and generally did not refer to any direct benefits for them in sharing their stories, but rather framed it as an altruistic act to benefit others (staff and other people who would be supported by those staff), indicating personal benefit was not usually their sole driver. However, some did note they viewed it as a way to 'feather their own nest', clearly expecting some longer term benefit of sharing their lived experience both directly and indirectly. Gray (2009) notes that the process of sharing an experience serves to help the individual make sense of those experiences, so it is plausible to conclude there may be some direct benefit for some in taking on the storytelling role, even if there are no other perceived benefits.

The absence of support frameworks for people sharing lived experiences as part of a training offer could be a stark driver for those people to feel taken advantage of, or for them to feel part of a tokenistic effort by services to demonstrate their inclusivity through an invitation for a single event. None of the providers who participated in this research noted the potential implications of asking people to relive negative experiences, and although there was evidence they felt this would be powerful for staff, it was unclear if they had considered what the negative consequences of this might be. It was also not considered that asking people to storytell did not necessarily guarantee that storytellers would be able to identify what needs to change in a particular setting to lead to improved inclusivity, in order to frame storytelling appropriately.

The implications of asking or expecting people to relive negative experiences without support frameworks, in addition to sourcing and facilitating this kind of input in the first place may simply be outside of the remit or ability of many providers. When considering what the desired outcome of training staff might be, and the wide range of signals of inclusivity that are potentially impactful from an older LGBTQ+ person's perspective, it is plausible to consider that staff training which includes storytelling may only be one of multiple approaches needed to make a service truly inclusive.

In the absence of a clear theoretical framework for why storytelling is impactful and appropriate within social care workforce training, the ability to justify the approach over others is challenging and the further development of frameworks to support storytellers is less likely. There are few research studies which look at different methods comparatively and justifying this approach over others would require clarity on the expected investment and outcomes for both older LGBTQ+ people telling their stories and the providers utilising this as part of their approach to building inclusivity.

6.4.2 Other activities of inclusion

As reported in Chapter 5, participants identified a range of signals and activities they felt indicated an inclusive service. Many of these could be classified as straightforward, although few were commonly adopted by providers or had been experienced by older LGBTQ+ people. Many of the lower level (i.e. easier to implement) signals were around clear signalling of acceptance and valuing of LGBTQ+ people without a requirement to state this specifically.

Visual cues such as rainbows within advertising materials and documentation, staff wearing badges and lanyards, recognition of LGBTQ+ focused significant events such as Pride or LGBTQ+ History Month, the presence of LGBTQ+ identified staff and regular use of inclusive language were all considered low cost, low effort signals within this research. Collaborating with LGBTQ+ organisations was viewed as both a signal of inclusivity and a tool for building awareness and understanding.

Similar studies considering the signals of inclusivity have also found that aside staff training, these key factors are utilised by older LGBTQ+ adults to signal inclusivity (Croghan et al 2015, Steele et al 2006, Boule et al 2020, Willis et al 2016, Price 2012, Brotman et al 2003, Löf & Olaison 2020, Hoekstra-Pijpers 2020, Simpson et al 2018, Boggs et al 2017, Jones & Willis 2016, Butler 2018, Westwood 2016, Smith & Wright 2021). It is also shown that the absence of these kinds of signals can lead to negative assumptions about the inclusivity of a service (Simpson et al 2018).

There is a dearth of research about signals of inclusion in social care specifically, with much more related to healthcare settings. The nature of healthcare means it is generally accessed and experienced as transactional, with focus on singular conditions, and often not linked to broader lifestyles or wider sociocultural factors (Krull et al 2023, Molodynski et al 2019, Anderson et al 2013). Although healthcare systems strive to be person-centred, they often work in silos according to the immediate and pressing conditions that require treatment (Krull et al 2023, Molodynski et al 2019, Danaher & Gallan 2016).

Similar to social care, there are many challenges present within the current healthcare system around better joint working and cross communication within healthcare (Glasby 2017). Often, primary focus on the ‘journey’ a person takes in relation to a single or set of specific conditions will be narrow (Danaher & Gallan 2016). Because social care is primarily related to activities of daily living, maintaining independence and social interaction, and can include housing, leisure, welfare as well as health (Kings Fund 2023), this can result in stronger links to lifestyle, identities and other factors which strengthen or impact on personhood than is seen in healthcare. As Social Identity Theory argues, validation and positively recognising identity, both through direct feedback and embedding of social norms, is likely to impact on the experiences of those receiving support.

Healthcare systems may have inherent expectations attributed to them by the patient which may differ from social care, including the legitimacy of collection of personal information, the methods of treatments and approaches utilised within treatment, and the autonomy of the patient to impact on their own condition (El-Hadded et al 2020, Bauman et al 2003, Mohammed et al 2016). Within social care, there may be more blurring of the lines between need and lifestyle, identity and other elements of personhood, especially where care is being delivered in a person’s home or alongside peers and neighbours. Participants in this research felt they had different expectations about social care, compared to other non-care related settings, in relation to recognition of their identity.

The expectations around what social care will look like, how it will be delivered and which needs it will address are further blurred for older LGBTQ+ people. As Minority Stress Theory hypothesises, this group may have compounded fear and anxiety related to expectations of discrimination (Abbruzzese & Simon, 2018, Correro & Neilson 2019, Fish & Weis 2019, Anderson-Carpenter et al 2019, Donisi et al 2019, Mankowski et al 2019). Indeed, participants in this research demonstrated the link they made between previous experiences of discrimination and how they made choices or perceived experiences now. Sexual identity being felt to be more relevant in seeking social care than in other parts of their lives demonstrates the direct link people make between their own identity, wider lives and social care.

For those who seek out less formal support, particularly where there is no official assessment of needs in place, there is potential to be more flexible in choosing what to engage with. However, this level of apparent choice may be impacted by what is available locally, the nature of the need, factors such as cost, as well as whether the service is inclusive for them as an older LGBTQ+ person. Within this research, providers gave examples of the barriers individuals faced in selecting which services or groups to engage with. This sometimes included the nature of the group, but was also impacted by practical considerations and expectations about whether it would be an inclusive environment. Focusing on options which are the most effective for meeting a need(s) rather than primarily basing decisions on the existence of signals of inclusivity, may mean older LGBTQ+ people more confidently engage with the most appropriate support (Croghan et al 2015), especially if they feel that all support would be inclusive in relation to their sexual identity.

Additionally, an ability to meet particular needs often results in other aspects of a person’s life being positively impacted indirectly (Levasseur et al 2010, Turcotte et al 2020). Social participation can be an important determinant of health equity, bringing benefits such as feelings of belonging, developing a sense of community and strengthening ability to take activist approaches (Levasseur et al 2010). These indirect impacts should also be considered from a theoretical perspective. Social Identity Theory argues that individual identity is partly formed and maintained through validation from others. The ability to be part of a community or a shared identity or group can help to strengthen individual identity but also provide the confidence to advocate for fair and equal treatment more broadly. Critical Theory argues that through activist approaches and the centralising of voices of the marginalised, change is likely to be more impactful. The value of belonging, and feeling part of a community which has a voice may heighten the possibilities for more structural and cultural changes over time, which then have the potential to improve both individual and group experiences. These kinds of benefits, which are less likely to be identified as social care needs than something like social isolation, potentially provide better overall outcomes for the individual. Older people need effective ways to foster social participation, and community-based services are in a unique position to support these additional benefits (Turcotte et al 2020).

As participants in this research and other literature notes, there are a range of benefits to come from, for example, being in the company of others who are felt to have similarities or commonalities (McGovern et al 2016, Hoekstra-Pijpers 2020, Siverskog and Bromseth 2019, Westwood 2016, Willis et al 2018(1), Boggs et al 2017). The creation and maintenance of networks are seen to be a valuable component of wellbeing overall, as are elements of recognition and acceptance. Therefore, It is feasible that inclusive services which help to bolster a sense of identity and pride in self will have wider positive influences on immediate experiences and in meeting a range of needs.

If there are opportunities to impact on multiple needs and minimise additional stressors it is likely to be viewed positively. When considering research shows higher risk to LGBTQ+

people in relation to mental health, health inequities, comorbidities, drug and alcohol misuse and a range of other risk factors, ensuring a service is inclusive may strengthen both the service and individual positive outcomes (Fredriksen-Goldsen et al 2013; Fredriksen-Goldsen et al 2017, Henderson & Almack 2016, Wallace et al 2011, Simpson et al 2018).

Concerns shared by providers as part of this research, seen in section 5.2, included lack of confidence around which signals they could or should adopt, whether there was a requirement for them if they were not currently supporting any LGBTQ+ people, and the potential impact these signals may have on non-LGBTQ+ people. Informal services may not have infrastructures, funding, staffing models or access to support and guidance around building inclusivity, presenting a range of challenges for implementing approaches, and the risk of efforts being judged as tokenistic remains for providers. There may be a lack of drivers for reflection on the role services play in non-inclusive experiences. Critical Theory idealistically positions providers, in this scenario, as holding power, and recognition and subsequent relinquishing of this power is required in order to make impactful change. However, it is important to consider the structural constraints providers face, which may mean that even straightforward and palatable changes may not be recognised or within the gift of individual providers to change, even if based on the marginalised voices highlighting these issues.

The lack of visibility of LGBTQ+ people is well understood within research and beliefs around equality being interpreted as treating everybody the same can be seen in several studies (Cowdell 2013, Simpson et al 2018, Spatenkova & Olecka 2016, Willis et al 2016). It is challenging to implore providers to undertake activities of inclusivity when data collection is not undertaken and providers knowledge of the presence of LGBTQ+ people is lacking, as they may not view it as required or worthwhile. The providers who took part in this research sometimes asserted that there were not any, or enough LGBTQ+ service users to warrant taking any action, or that there were risks associated with making LGBTQ+ inclusivity more prominent.

Around 1.7% of the over 50 population in the UK identified as LGBTQ+ in the 2022 census (ONS 2022). It is relevant to consider that this may mean the number of older LGBTQ+ people in a community group is low, with providers potentially making assumptions that smaller groups are less likely to have diversity within them. Although this assumption may be correct in some instances, it may also mean that where there are older LGBTQ+ people, this is discounted on the basis of assuming there are none present.

The impact on non-LGBTQ+ service users of using these signals of inclusivity is not something which has been fully explored within research on social care and future research is required. However, as previously discussed, other research looking at whether non-LGBTQ+ people are offended by being asked about their sexual identity shows that offence is unlikely to be noteable (Maragh-Bass et al 2017, Rullo et al 2018). Broader studies around the use of LGBTQ+ imagery have shown its use within advertising materials can foster confidence in the broader diversity and inclusive nature of something and can be more appealing, regardless of a person’s sexual identity, because a wider message of inclusivity is effectively conveyed (Cunningham & Melton 2014, Borgerson et al 2006).

Building networks between providers

In considering the range of signals a service might employ to demonstrate inclusivity, a further area highlighted in this research was around services forming networks or relationships with other LGBTQ+ specific groups and organisations and the potential impact of this. Although older LGBTQ+ people highlighted the importance of resources designed to educate or build awareness of broader EDI, services which were embedded in the local community and had active links to LGBTQ+ organisations, were felt to be demonstrating best practice.

Most of those who took part in this research felt they would prefer to access broader, but inclusive services rather than LGBTQ+ specific services in isolation. This is supported by other research studies finding similar attitudes towards specialist and broader inclusive services (Price 2012, Westwood 2016), where clear connections to LGBTQ+ organisations are felt to be a key way to create those broader inclusive services. This presents some challenges for service providers in terms of how they source and forge those links and what they use those links to do. It also provides opportunities to improve the quality and inclusiveness of support through taking a more holistic approach and becoming more embedded in a local community.

Having links to LGBTQ+ organisations, networks and resources can be a key component of maintaining wellbeing for older LGBTQ+ people (Willis et al 2016, McGovern et al 2016). Specialist services which are embedded in local communities benefit from these links, and are more likely to survive (Vermeulen et al 2016). The acquisition of legitimacy with both local populations and institutions, as well as an improved ability to represent local interests are shown to be positive factors for community based organisations (Vermeulen et al 2016). Arguably, these links also contribute to shifting social attitudes in a way which centres marginalised voices. Social Identity Theory positions recognition of identity as a key factor in how people feel about themselves and others, and forging these links to other organisations could be judged as an action to embrace or validate these marginalised identities. Critical Theory argues that centralising marginalised voices can contribute to shifting wider attitudes and clear actions to forge and promote links to specialist organisations may overtly demonstrate the importance and validity of these voices.

One key challenge is monitoring, sharing information, and making robust connections to and about services in a local area. The nature of the social care market means that, particularly for more informal services and groups not supported by centralised or secure funding, what is available can be variable and change rapidly. Older people are often discouraged by the need to navigate, access and co-ordinate what can be fragmented services, and this can be more profound for those who do not have family and friends to assist, with an argument that navigation of services should be moved from a private struggle to a public responsibility (Funk 2019). LGBTQ+ populations are less likely to have these support mechanisms in place (Stonewall 2011) which may mean that navigating care is more difficult for this group. This was raised by older LGBTQ+ people and providers in this research when talking about how they might find out themselves what LGBTQ+ specific resources and groups are in existence. Even if an individual has the capacity to seek out information, the disjointed nature of overall provision means this information may be extremely challenging to find. This further highlights the importance of services knowing they have LGBTQ+ people present, driving them to seek out links where possible.

Undertaking navigation can also have negative influences on wellbeing and quality of life for older people because these systems are often designed to manage single conditions. This can lead to unmet needs, unmet expectations and even inappropriate or ineffective use of social care systems (Vos et al 2018). Services making links to local LGBTQ+ organisations, support and advocacy may provide several layers of benefit. Through undertaking navigation of the local market, the service may: help individuals avoid the need to do this alone; foster relationships with LGBTQ+ organisations which may be able to guide them around inclusivity for older LGBTQ+ people; be potentially viewed as more inclusive because of those links; and be contributing to an overall shift in normalisation of LGBTQ+ identities.

Through making these links, it could be argued that broader services will be able to integrate their approaches to meeting needs more holistically. Work to understand and implement more integrated care has been an area of focus in the UK and many other countries for some time (Warwick-Giles & Checkland 2018). Although it is not possible to explore all the nuances of this area of work and research here, it is important to note some of the well understood challenges.

There are a range of structural barriers to services working cohesively together. These include: models of funding; administration; service delivery models; maintaining individual identity and function; navigating cultural and social contexts; strategy moving successfully to reality; facilitating communication; and maintaining flexibility (Warwick-Giles & Checkland 2018, Vos et al 2018, Funk 2019, Cumming 2011, Xie et al 2023, Glasby & Dickinson 2014). Different parts of the social care market have evolved independently of integration and there are legal, financial, practical and cultural barriers to providing joined up services (Glasby & Dickinson 2014). However, this does not mean it is not possible to achieve, at least to some extent, and further understanding of the value of more holistic care systems may, by proxy, result in better insight into how services can be inclusive.

Motivation and capacity to make these links, particularly for smaller, informal providers may be a further complexity. It is unlikely a provider will act to seek these links if they are not aware of any LGBTQ+ people using their service (Fish 2009, Kneale et al 2021). It may be unusual for a service to reflect on its role in validating personal identity or perpetuating marginalisation without a prompt to do so. If data collection is not undertaken, it is less likely a service will have the driver to seek out these kinds of connections. A lack of understanding of the particular needs of the LGBTQ+ community may lead to services believing they are acting inclusively because of a focus on equality mistakenly manifesting as treating everyone the same (Simpson et al 2018). All of these serve to reduce the likelihood of services actively seeking out connections.

Motivation of services to make these links is also influenced by potential overwhelm in considering protected characteristics. If a service aims to seek out links to LGBTQ+ resources and organisations, it may feel motivated or obliged to seek out links to resources aimed at people with other marginalised identities such as disabilities, broad cultural and ethnic backgrounds and so on. This may be difficult within less diverse populations where those other organisations may not be as visible or even present, and it also presents a potentially never ending task for a provider. It may not be possible to accommodate all diversities and respond accordingly (Gallagher 2006). A strategic approach may be required to either tackle this broadly, covering all areas of diversity, or more narrowly through focusing on areas pertinent to the particular service user group, which is dependent on knowing they are there.

If specialist services, resources and groups are keen themselves to make links in their local communities, this may be one way of tackling the complexities. Drivers to encourage those specialist groups and services to actively seek out links with social care groups and organisations, which includes benefits to themselves, may be a more effective way to manage the potential overwhelm of social care providers. Arguably this puts the burden on groups which only exist to support and advocate for those who are marginalised by wider society. Considering this through a Critical Theory lens would place the specialist groups as having less power than providers, but ensuring the perspectives of specialist providers are incorporated into changes may reduce the impact of heteronormative structures and other structural barriers.

This in itself would require awareness raising with specialist organisations and providers about social care and local groups and services delivering support. In larger cities such as London (e.g., Equality, Diversity & Inclusion Advisory Group), and York (e.g., York Together), there are ‘EDI Collectives’, (groups of individuals or organisations that come together to look at work across the EDI spectrum), who may be able to drive this level of understanding, but there is currently a lack of drivers and evidence base for them to do so. However, this may be one of the conduits for building knowledge of the local social care market to be able to identify and forge links. To fully understand effective ways to do this, research is required to identify the challenges and benefits within that. However, without external pressures to do so, from Local Authorities, Adult Social Care teams and social care services themselves, it is likely to remain the remit of individuals to drive such an agenda.

Minimum standards frameworks

The value of a kitemark or minimum standard framework looking at inclusivity for LGBTQ+ people was discussed by participants in this research as seen in section 5.2.1, and has featured in other similar research (Westwood 2016, Wathern 2013). Although some quality frameworks exist in varying formats such as quality improvement or competency frameworks within healthcare and healthcare education, they are much less common in social care. There are no common LGBTQ+ national standards currently in use (Hunt et al 2019). As well as measuring minimum standards, there are additional benefits for organisations of these kinds of schemes, such as improved understanding of gaps in provision (Berwick et al 2003).

The main nationally recognised measure of equality specifically related to sexual identity in the UK is the Stonewall Diversity Champions Programme (Stonewall 2023). This is designed for employers, and focuses primarily on the ways in which an employer can improve the experiences of LGBTQ+ staff, although for NHS settings work has been undertaken to include elements of patient experience (Equality & Diversity Council 2017). There is evidence that the existence of these kinds of signals serve to make employees feel safe to be visible in the workplace (Lee 2023), but currently these do not extend to people using a social care service. More recently this programme has come under scrutiny politically, with many high profile organisations, including the BBC, Equality & Human Rights Commission, Social Work England and several government offices, leaving the scheme. This is in part believed to be due to Stonewall’s perceived interpretation of the Equality Act 2010 in relation to transgender policies and rights and concerns around free speech (Waterson 2021, Martin 2023, Koutsounia 2022, McManus 2021).

Although schemes like Stonewall Diversity Champions may exist, it is also important to recognise that measures of cultural competence or quality do not necessarily translate into good care for an individual (Raleigh & Foot 2010, Shahzad 2020). The ways in which effectiveness is conceptualised and measured are not always clear within these types of frameworks, they are subject to interpretation of what constitutes cultural competence and local context is likely to impact on the ways improvements or changes might need to be applied (Arah et al 2003, Curtis et al 2019, Colgan 2011). Frameworks such as CQC standards focus on elements such as safety, effectiveness, person-centred approaches, timeliness, and efficiency (Raleigh & Foot 2010). These rarely include measures of, or strategies to address inequality, inequity or building cultural competence, and coupled with lack of robust data collection, there may be scepticism about whether these are required or effective (Shahzad 2020, Raleigh & Foot 2010).

Until more recently, the inspection framework used by CQC has not required any measurement of addressing inequality or data collection (CQC 2023), although the monitoring of specific actions in relation to being inclusive to particular marginalised groups is to be a part of their upcoming framework (CQC 2022). Some services who are not registered with CQC may still have contractual obligations to meet minimum standards as part of contracting with a Local Authority. Many of the more informal groups and services will not have any of these drivers in place, and currently, the funding accessed by many smaller groups will not usually mandate specific actions in relation to inclusivity. Additionally, it is important to consider that introducing an obligation to meet particular standards may become overly burdensome for some micro providers.

Broader research around organisations working on EDI approaches finds that public sector organisations are more likely to take an innovative approach to EDI than the private sector (Colgan et al 2009). As most social care is delivered within the private sector (Glasby 2017, Kings Fund 2021) this potentially leads to an absence of consistent drivers and innovative approaches for organisations to make improvements according to a framework of best practice. It also means that there are few incentives for organisations to reflect on their cultural competence or inclusivity without being prompted to do so.

Drivers for organisations to demonstrate their inclusivity through these kinds of standards frameworks might include legislation, social justice, social responsibility and financial gain (Colgan 2011). The available and active choices of people using a service may also drive providers to seek improvements (Raleigh & Foot 2010). However, the desire to have a positive reputation and secure further income does not necessarily translate into increased use, as it is reliant on people using measures to inform decisions about using the service (Hibbard 2008).

Uptake from providers of localised schemes such as Pride in Care (Opening Doors 2023) and the Covenant (SAND 2023) demonstrate an appetite for such standards, but the low levels of drivers, support and resources available to providers more widely to undertake such evaluations and action planning continues to limit the reach of these schemes. These kinds of initiatives can be reliant on services taking the initiative to sign up, and ultimately, people who use services need to recognise and be looking for these signs of commitment in the first place to make them meaningful.

Key features of the local schemes in place include: a focus on understanding what people's experiences are and have been; making links and supporting LGBTQ+ organisations; identifying ways to improve inclusivity on a continuous basis; and robust training. While this arguably embodies many of the attributes that older LGBTQ+ people in this and other research feel contribute to the inclusivity of a service, it does not necessarily contribute to clear guidance for services on exactly what actions might result in these outcomes.

One complexity for providers is that guidelines are often appropriately vague to allow for context and capacity to be considered, but therefore require providers themselves to identify what actions they need to take to meet the broader guidelines. This brings into question how variances in the LGBTQ+ population itself, and the range of expectations within that, can be effectively met through a standard set of guidelines, especially where some areas are influenced by things outside of the providers control. It echoes the providers within this research who did not necessarily have confidence about what they needed to do and how. External regulation, such as that imposed by CQC, has been seen to limit creativity and innovation within service design and delivery (Davis & Hobbs 2022) and there remains a risk that meeting set standards would have the same impact.

Additionally, as was seen with the differences in levels of importance and relevance of sexual identity within the older LGBTQ+ participant group in this research, which actions would make a difference to how the service is experienced would be variable between individuals. There were beliefs expressed by some participants around small steps leading to wholesale changes to culture, so it can be assumed that both the actual changes and the efforts made by providers towards these changes may have a positive impact for people using the service. However, this is also influenced by how important or tokenistic these changes are viewed to be by each individual using the service.

The reality of compromise required from both provider and service user means that limitations and complexities linked to making changes for a single marginalised group would need to be well understood. Conversations remain about what constitutes 'good enough' and which key actions are fundamental to inclusivity in order to allow providers to prioritise accordingly and also address the fears they might have about what to do and how. Understanding there is a relevant population is also likely to be an important driving factor for many organisations, and as can be seen here and in other research, this mechanism is rarely in place.

6.5 Reflections

6.5.1 Recruitment challenges

The process of recruiting participants for the research included some challenging and interesting points where flexibility and adaptation were required. The recruitment cycle was relatively unpredictable throughout the process. Following some initial efforts to recruit participants and an initial set of interviews (5), the recruitment slowed down considerably but making links with key individuals within networks and organisations helped. People were more likely to respond to an email or promotion from a connection they already had than via the ‘cold calling’ nature of the initial attempts to recruit.

Challenges were also raised by others during conversations about recruiting to the study. For example, one network raised that those who were of particular religions may not feel able or comfortable to take part in research of this nature because they often kept their sexual identity private. LGBTQ+ people, particularly older members of the community do not necessarily seek out or feel comfortable being associated with LGBTQ+ specific organisations. Those with a more activist voice are much more likely to volunteer to participate, meaning the voices of the most invisible are likely missing from discourse. The dominance of the white, gay man, recognised in other research as a problem, was partially seen within this research, where 58% of older LGBTQ+ participants identified as male. No specific recruitment was carried out with men’s groups. This may, to an extent, be due to the relative familiarity of participating in LGBTQ+ research for this group. It is challenging to reach those less visible people without the assistance of statutory services to identify participants. Multiple organisations raised with the researcher how many requests they received for participants to take part in research, with one organisation stating they received daily requests. This leads to ‘research exhaustion’ where people feel over-researched. Balancing this with ensuring the diverse voices of this group were heard is complex.

Insight gained from initial recruitment led to a more targeted approach in latter stages where underrepresented groups were sought in order to broaden the diversity of the participant group. Many efforts were made to reach out and connect with organisations and networks where people from, for example, different ethnic minority groups might be part of the membership. This did result in a small number of potential and actual participants but required substantial time investment in building those connections. This would need to be considered within any continuation or expansion of the research in the future.

6.5.2 Impact of discrimination & current attitudes towards LGBTQ+

Following concerted efforts to utilise different mediums to promote the research, two LGBTQ+ organisations suggested setting up a Facebook page with information about the research and using this profile to join community groups on the platform in order to promote the research but this led to a number of abusive comments which required moderating on a regular basis. This was unexpected although served to demonstrate that discrimination is still extremely common in the broader population. There were also supportive comments and the post was shared often but these were less frequent than derogatory ones.

At the start of the research, it appeared from the literature review particularly, that although a growing area, LGBTQ+ issues were still relatively under researched. However, throughout the period, particularly in the later years, discrimination and within that LGBTQ+ communities became a higher agenda item globally, there were a range of situations which brought discrimination into focus on an international stage. An American citizen was killed by police, sparking protests and profile raising across the world of ‘Black Lives Matter’ and associated actions needed throughout society to tackle racism discrimination. Campaigns to decolonise curriculums in Universities, the murder of a young woman by a police officer and the murder of a 16 year old transgender woman in the UK all received high profile coverage within the media. Increased activism was seen across media and in public settings. At one UK University a long established professor who voiced views about the debate in relation to gender identity was protested against, resulting in them standing down from their post and accusing the media of being silenced from free speech or ‘cancelled’, despite being given a broad media platform in which to voice these opinions. Where organisations made judgements about areas such as use of toilets by transgender people, or transgender participants in sports, public outcry on both sides of the argument have been given space in popular media.

As discussed in section 3.5.5, there were additional amendments needed in relation to the language used in recruitment materials, particularly around the inclusion of transgender participants and use of the acronym LGBTQ+ rather than LGB (which was on the original documentation). During the period of recruitment a complex political backdrop of considerable controversy around the rights and visibility of transgender people existed. This included the opening of a consultation on the Gender Recognition Act and the introduction of divisive voter registration laws that would disproportionately affect transgender and non-binary people. The government asked for input but failed to take action as promised in relation to gay conversion therapy, a review of gender-neutral public toilet facilities with a view to returning these to gendered spaces was undertaken and legal threats in relation to access to healthcare and public spaces were present. Several legal challenges and regulatory input related to transgender rights and frameworks of support for children were in the public eye. This context meant that the use of language, and ways of promoting and speaking with people within the LGBTQ+ community needed to be carefully managed.

Increased positive visibility of LGBTQ+ people was also seen within popular media. A long running American drag competition started running a series based in the UK, a very popular Saturday night family dancing show introduced its first gay couple and adverts increasingly depicted broader families and couples. This did potentially impact on the research and recruitment particularly. The over saturation of LGBTQ+ as a topic in general media meant that the promotion was often lost in a sea of LGBTQ+ related discourse and research recruitment. However, the raised profile of LGBTQ+ communities and the discrimination faced by many can only serve to raise awareness and hopefully ignite change and better awareness of the impact of discrimination and the legitimacy of LGBTQ+ lives.

6.5.3 Nuances of data collection

There are a range of positive or relevant reflections on the process of data collection. Within interviews, although participants were sometimes recounting distressing experiences, there was a distinct lack of distress in sharing these experiences. This appeared mainly due to the fact that participants saw purpose in sharing these experiences and that by doing so, it may lead to positive change which would help build inclusion. This driving factor in people’s agreement to take part seemingly mitigated the distress of sharing negative and discriminatory experiences. A similar situation also occurred in relation to sharing sensitive information. Although not asked about directly, many participants were happy to share personal information. Some expressed happiness at the opportunity to share experiences, often for the first time, in a way that felt constructive.

For staff and volunteers, none of the participants demonstrated any distress when talking about the poor practice they had experienced or witnessed. The focus of sharing these experiences was grounded within a desire to ensure poor practice was not allowed to continue and would not be experienced by others. Many were part of the LGBTQ+ community themselves and this is likely to have impacted on the experiences they had and the work they had done themselves to further raise awareness and understanding of meeting the needs of the LGBTQ+ community.

There were different dynamics to manage within each of the focus groups and this resulted in slightly different approaches taken across the two sessions. As part of the first Focus Group, one particularly outspoken participant was frequently managed by other members of the group when voicing more controversial views. Other members of the group constructively challenged, changed the focus of the conversation or expanded upon points being made in order to ensure the conversation remained inclusive. The second Focus Group discussion included management of one participant who was extremely talkative but did not necessarily have the focus of the research at the centre of their discussion. They were frequently interrupting other participants with only loosely linked examples to the subject being discussed. This was managed through facilitating the discussion to ensure straying too far from the subject was avoided, as well as ensuring that other participants were given the space and time to contribute to the discussion.

This development of the group's self-managing also demonstrated the challenges present within service delivery, where senior staff and managers can often have a dominating influence on the culture. The attitudes and behaviour of an individual person can often lead to others following suit, subsequently creating a culture of normalised behaviours (that may otherwise be viewed as inappropriate or discriminatory). For those who feel the inclusion agenda is important, it will be common to come up against individuals with different views or priorities which will potentially impact on the outcomes of these efforts.

6.6 Strengths & Limitations

Social research design characteristics include reflection and acknowledging of successes and limitations. This is felt to clarify the contribution research makes to knowledge (Harding 2019). The strengths and limitations of this research are presented, alongside brief discussion of the implications of each of these.

6.6.1 Transferability

Findings from this research effectively contribute to and support existing research around the complexities of providing inclusive care and support to older LGBTQ+ people. The findings, particularly those from older LGBTQ+ people themselves, have been in line with what is known from other research. Areas such what is important to people who access support, the fear and anxiety attached to accessing social care and the importance of sexual identity were all seen to have similar characteristics to that of other studies where these elements have been looked at (Hafford-Letchfield et al 2017, Butler 2018, Willis et al 2020, Waling et al 2019, Willis et al 2016, Smith & Wright 2021).

Similarly, the general feelings of providers that sexual identity is not necessarily relevant, that person-centred care approaches eliminate the need for specialist approaches and the confidence and know-how (or lack of) of providers to make changes are all in line with other studies (Boule et al 2020, Brotman et al 2003, Westwood 2016, Willis et al 2016). This offers some credibility to the research and further strengthens what is known and understood about this particular population.

6.6.2 Covid-19

The global pandemic, which occurred throughout this study, had a number of impacts, most notably many people being generally exhausted and emotionally drained, potentially impacting people’s enthusiasm and ability to take part. This was particularly pertinent for invitations to online activities, where participants' lives had been saturated by online engagement and activities over the first year of the pandemic.

Service providers, older LGBTQ+ people and the design of the research were all affected. Many service providers needed to close or move to online support and were required to creatively provide support in ways they may not have done before. Many groups and networks who may have engaged with in person activities were not running or running online which made presence and visibility more challenging. The barriers to personally connecting with people and having informal conversations about the research impacted on the ability as a researcher to attend groups and make personal connections with people through physical presence and opportunities to talk about the research. Talking to groups, using this as a guide for further framing of research questions and being able to create ongoing dialogue may have resulted in different outcomes, higher recruitment levels and a better understanding of the cultures within these informal groups.

Providers were distracted providing support during a pandemic, moving focus away from other areas of work, likely including EDI and cultural competency. It was important to recognise that providers will have been working to other priorities during the period when data collection was being carried out, and this may have affected levels of immersion in this wider agenda. Conversely, many providers talked about the ways in which the pandemic had crystallised the importance of local networks and strong connections, further encouraging them to think about alternative ways in which they could engage with individuals and marginalised groups.

Many of the services being closed also offered other opportunities. Being able to discuss with participants the importance of social care, or informal groups such as social groups and how they were affected by these closures, gave some insight into the levels of dependence and the role services play in older LGBTQ+ people’s lives. The value people felt about these services may have been less pronounced had those services not been either absent or greatly changed (moved to online in most cases). It is possible that older LGBTQ+ people were able to vocalise their reliance on and the positive aspects of using social care in ways they may not have done had those services been open.

During the COVID19 pandemic, guidelines were in place for a large proportion of the data collection period. Interviews were carried out online or via the telephone so arrangements had to be made to ensure participants could access and use the appropriate technology.

During Focus Group recruitment, restrictions were less relevant and therefore both online and in-person options were considered. For the first focus group, participants were based across the country and an online session was felt to be the most appropriate. As well as minimising physical risks, this also allowed participants who were geographically spread to take part as a group. The second Focus Group was carried out in person in a local library, as all attendees were local to the area. The opportunity to physically come and take part in the discussion was felt to be important for participants. It also allowed the researcher to observe interactions, body language and other useful information in order to help guide the conversation around each of the topics. It is possible the physical presence of a researcher may have had both negative and positive impacts on the discussions. This cannot be known so therefore is not considered here further in relation to the differences in data collected in person versus online.

6.6.3 Diversity & size of sample

While an ideal scenario for research may be a representative sample of the population (Bhandari 2022), this is often not realistic or achievable within the constraints of time, access, the pandemic and resulting barriers to making meaningful connections. The sample recruited were self-selecting and controls were not put in place for diversity due to the challenges of recruiting during a pandemic and with the population being researched often considered as hidden or harder to reach (Price 2011). The number of participants in the research was lower than had originally been intended and although conclusions have been drawn, the (lack of) diversity of voices included could undermine the robustness of the research.

Despite efforts, diversification within the sample has been a challenge- several groups were either not represented at all or represented in very small numbers. In terms of ethnicity and disability, there was not an extensive range of cultural and ethnic diversity. There were no participants who identified as disabled, and only two non-white/non-British heritage people, meaning these were not broadly representative of the population. In terms of sexual and gender identity, there was reasonable diversity but not all the most commonly used labels for people in the LGBTQ+ community were represented. This included: gay (n=8), lesbian (n=5), bisexual (n=3), asexual (n=1), pansexual (n=1) and heterosexual (n=5) participants. In relation to gender identity, cisgender male (n=10) and cisgender female (n=11) participants outnumbered non-binary (n=1) and transgender (n=1), and there was no representation of intersex people across the participant groups.

Social diversity within the participant group may have resulted in very specific viewpoints being centred within the research. For example, one person who was not White British talked in detail about their cultural identity and the discrimination they felt was related to their race. Similarly, a transgender participant talked about their gender identity and the subsequent discrimination they had faced because of this. This made it challenging to have confidence that all feelings being shared were in relation to sexual identity, although this also potentially is a more realistic expression of how complex people, and their intertwined identities, are.

Many of those who took part were articulate, accustomed to taking part in research or talking about their experiences and some had frequently participated in activism over their lifecourse. Although some participants were much less engaged with these kinds of activities, those voices were the minority within the wider group. This may have skewed the nature of the findings and also the interpretation of the data through a focus on what a louder set of voices believe to be important and reasonable, which may not fit with the wider LGBTQ+ community members beliefs and experiences.

Providers who were interviewed were all part of the LGBTQ+ community themselves and it can therefore be hypothesised they might feel differently from those who were not. They were much more likely to have already been involved in improving equality and inclusivity within the services they ran or worked in and this may have been less pronounced if those personal drivers had not been in place. They were able to give some useful insights into the efforts they had made and whether these had been successful or well received.

However, this potentially resulted in less discourse around the challenges and considerations of delivering changes because this group may have been motivated by both being situated within the LGBTQ+ community and their experiences of trying to build inclusive practice in their own services. This meant there was less data collected around the challenges for providers, with this being specific to the focus groups only, where discourse was likely to have been different from that of a one-on-one interview.

Because the numbers were therefore lower than intended, it potentially makes it more challenging to draw confident conclusions. This is also impacted by the lack of homogeneity within the LGBTQ+ population. Trying to ensure that a range of voices are heard within this kind of research is crucial in order to build confidence in the findings, and also to be able to confidently compare and contrast findings with other research.

6.6.4 Methodologies

A strength of this research was the opportunity to utilise data from older LGBTQ+ people in the interviews with those providers who participated in the focus groups. This allowed for discussion based on real feedback and instigated meaningful conversations about older LGBTQ+ people's actual feelings. Much of the discussion within focus groups centred on either individuals existing experience with older LGBTQ+ people they had supported, or the quotes presented during the discussion. This potentially avoided saturation of bias or stereotyped beliefs about older LGBTQ+ people which may have been present if relying on fictional testimonies, which are shown to have both theoretical and methodological issues (Barter & Renold 2000).

Utilising fictional testimonies is reasonably common in qualitative research that seeks to give some understanding of values and beliefs (Jenkins et al 2010). Research has shown that using fictional accounts can impact on both the researcher and the participant (Sampson & Johannessen 2020, O'Dell et al 2012). It can make it more challenging for the researcher to interpret responses and for participants, can result in separation between fiction and reality, as well as resulting in idealised answers (Sampson & Johannessen 2020).

Research methodologies can be positively impacted by utilising real life experiences as a trigger for discourse, as opposed to fictional testimonies. It can provide a focal point which triggers engagement and an increased willingness to discuss sensitive areas more quickly as well as reducing the tendency for idealised answers. They may also help to build rapport, credibility and trust, in turn impacting on the level of disclosure a participant feels comfortable with (Sampson & Johannessen 2020). Although the data from interview participants in this research was not used in the form of a vignette or full account, but was focused on specific statements, the advantages of utilising this method of discourse trigger appeared to stimulate open and honest discussion about the real life impacts on older LGBTQ+ people, which potentially enhanced the conversation.

One unexpected focus of the data collected was around the power of storytelling and the feelings from both older LGBTQ+ people and providers about the importance of this as a feature of training. Although other research has demonstrated the perceived importance and potential impact of training staff around the needs of older LGBTQ+ people, the belief that sharing narratives is the best way to do this and the implications of that have been less explored. This allowed specific highlighting of some of the considerations required if including this element of training from both an older LGBTQ+ person and providers perspectives. This is currently an under researched and under considered area of training approaches.

Much of the research undertaken within the area of LGBTQ+ health and social care inequity and discrimination focuses on the needs of older LGBTQ+ people and the changes that providers need to make in order for services to feel more inclusive. However, many of these do not consider the challenges for providers in great detail and few consider these alongside the data collected from older people. The research highlighted that providers are not averse to exploring ways to improve inclusivity but often do not consider why this might be needed, or how they can do that.

Although there are systematic considerations around areas such as data collection and some actions are outside of the control of individual providers, this research was able to explore some of the actions which might be impactful and would be potentially easier to implement. Understanding providers' challenges in undertaking actions to improve inclusivity helps to build a picture of what additional support mechanisms might need to be in place for them to be empowered to make evidence-based changes to approaches according to the needs of older LGBTQ+ people specifically.

Research can sometimes be very focused on the needs of the target group but recommendations are then made without fully exploring what this might mean for providers. Although this research highlighted that some actions are complex and require contextual consideration of the systems services function within, other actions were more straightforward or flexible enough that context of services will not preclude providers from implementing a form of these actions. The ability to utilise the evidence base to provide a list of some more implementable actions for providers may contribute to confidence of providers to take some of these more simple actions, consider the impact of those, and start to build a foundation for some of the more complex actions to be taken in the longer term.

Many of the older LGBTQ+ people who took part in the interviews were only utilising informal, community-based support and groups, and for some, these were not necessarily direct social care provision. Although this was the focus of the research in the sense that it was considering community based social care, it was not always clear whether the groups and organisations being accessed were utilised to meet a social care need or for another reason. This was felt to be an issue by those overseeing the research process as it was believed that much of the data collected was older LGBTQ+ people talking about imagined interactions as opposed to direct experiences. However, there were many that had engaged with things that could be considered social care, and the fact that some of the data reflected people's fears going forward, so their ongoing expectations, reflects the reality for many LGBTQ+ people in navigating society on a day to day basis. It could therefore be argued that this was not necessarily a limitation from the researchers perspective, but could be judged as so by other researchers.

The pragmatic classification of LGBTQ+ as a community throughout the data collection and the writing of this thesis potentially discounts some of the complexities within this broad categorisation. The history of the LGBTQ+ community has often been one of internal division despite outward efforts to appear as a cohesive group (Formby 2017). More recently this has been somewhat exposed by some women's rights groups who ascertain that transgender women should not be able to access women only spaces. There has been a media focus on the lesbian community in particular, and some of the more strongly opinionated groups such as the LGB Alliance.

There may possibly be good levels of cohesion within LGBTQ+ communities when considering the varied range of attributes likely to be present in its membership such as gender, sexual preferences, socially acceptable ways to act, areas of interest, social, political and economic variance, history and background. It is widely thought that this comes from a shared experience in relation to fighting for rights and acceptance to love who you want to love - a common thread for all those in the LGBTQ+ community (Easterbrook et al 2014).

As Social Identity Theory demonstrates, people will naturally seek out those who have similar viewpoints, values and experiences to themselves (Stets & Burke 2000, van den Scott 2017, Tajfel & Turner 1979, Abrams & Hogg 1988, Jenkins 2014), which again is potentially a feature of wider LGBTQ+ communities. The perceived reduction in fear related to LGBTQ+ spaces over mixed spaces may purely be based on basic beliefs about commonalities. Being unable to focus on this debate around the LGBTQ+ community as a community within the research results in an assumption of cohesion, which may have been further dismantled if the topic had been explored further.

Interview process

As demonstrated in the topic guides and codebook (see *Appendix 11 & Appendix 14)* there were a range of topics discussed within the interviews. Although topic guides were used to frame and lead questions, discourse was led by the participant. In many instances, questions were answered before they were asked according to the structure of the topic guide because of the nature of narrative accounts, which are often based on recall of the most emotive or significant parts of experience. Although challenging in terms of ensuring the 'right' questions had been asked and answered, taking this more informal approach to allow a more natural flow of conversation led to discussions and topics not initially considered in the design of the topic guides, and provided useful insights into the ways in which participants navigated their experiences and how these experiences went on to influence their decision making around accessing services.

When gathering demographic information, further clarity was provided in some instances. Some older LGBTQ+ people had received social care assessments in very particular circumstances (for example when a partner was diagnosed with dementia and the overarching assessment included the participant). For some participants, they were unclear on whether assessments they had taken part in were for social care support, so further clarification was required to ensure they felt able to answer the question confidently. No further information was collected regarding the nature of the assessment, which organisation carried the assessment out or whether the assessment had led directly to social care support provision (although in some instances, these experiences were shared in relation to other questions being asked).

Many participants referred to experiences within healthcare settings when giving examples - demonstrating the link people make between social care and healthcare in terms of experiences of delivery of support and care. Asking questions about access and knowledge of services allowed for consideration of whether there are additional areas of work to be done within social care more widely to promote opportunities. It also helped contextualise people's experiences and gave clarity about their understanding of what 'social care' can actually consist of.

It was important to allow people to talk about their experiences of discrimination because it was likely to have framed their decision making going forward about services they might engage with in the future. Understanding the context of people's attitudes by having an understanding of what had happened to them previously allowed for consideration of two things - how this was impacting on their willingness and enthusiasm to engage with social care support in the first place, and also which negative and positive experiences left lasting impact on them.

Discussing sexual identity in terms of the extent to which this was integral to people's self identity allowed context to be given to the other answers they had given. Those who felt their sexual identity was a large part of their self identity would potentially frame answers differently from those who did not feel it was necessarily relevant to their access and experiences of social care, or discrimination more broadly. Subsequent discussions around how people felt their sexual identity impacted on their experiences (or might in the future), when accessing community based social care, meant the data could be considered in terms of the relevance people attributed to this element of their identity as well as contextualising the discrimination they had previously experienced. It also gave the ability to determine or interpret the importance of other identity factors.

By gauging which factors people considered to be 'signs of inclusivity', separate from those linked to specific experiences, it was possible for statements early in the interview (about negativity linked to signs of inclusivity) to be considered by participants at later points in the discussion when subsequently identifying what they would look for. There were several instances within the interview process of people stating they disliked or were frustrated by some actions. However, these were subsequently noted as actions they would seek out to signify inclusiveness, giving participants the ability to reconsider their own perceptions of what inclusivity actually looks like. This process of reconsideration during interviews potentially demonstrated the gaps between what people think they want and what influences their decisions in reality.

Discussion related to what people wished and hoped for from staff and services and what was achievable and replicable within small, sometimes unstructured community groups gave insight into the lack of understanding of social care more broadly. It also indicated the ways in which services are held to account in ways that might be unrealistic or unachievable in the reality of service delivery.

Questions were included to gauge staff/volunteer knowledge of older LGBTQ+ service users' existence, needs as separate or different to non-LGBTQ+ service users, and the ways in which they anticipated LGBTQ+ people might feel more or less included. This was crucial in building an understanding of the potential differences and similarities between the assumptions and beliefs of staff and LGBTQ+ people themselves. Discourse around perceived and actual barriers to inclusion also provided data to allow comparison between staff and LGBTQ+ people themselves in relation to the potential impact of actions versus the effort required to implement these things.

Focus group process

Using quotations from older LGBTQ+ people (gathered at the interview stage) allowed for group dynamics and social ‘challenge’ to influence the direction of the conversation. This in turn instigated participants asking questions of others themselves, as well as comparisons of good and poor practice, thereby giving further insight into the challenges of implementing some of the suggestions from older LGBTQ+ people themselves.

Of the seven participants across the two focus groups, two were known to each other and the rest had not met before. Focus Group One included participants who did not know each other, but all worked for the same national organisation, which operates a franchise model. Within the group discussions, one participant had reasonably strong views that did not align with the rest of the group’s feelings and experiences. This was well managed within the group without the need for input from the researcher and further reflections can be found within section 6.6.3.

Focus Group Two included two participants who were known to each other. This potentially affected the dynamic of the group in the sense that the more vocal of the two dominated the conversation to a degree and the other participant was clearly less able to express their feelings. The participant may not necessarily have been as open as they might have been otherwise, due to not wishing to disclose in front of a colleague.

It is important to consider how some of these dynamics may have been relevant from both a theoretical and practical perspective. There are a range of factors that may have had an influence on the data collected and the ways in which this has subsequently been interpreted. Considering these within the conclusions section has been crucial to ensuring a broad and open approach has been taken to the research overall, both in terms of research design and any actions which are suggested to feed into an inclusive approach for services.

6.6.3 Reflexivity

This research was inspired, guided and influenced by my lived experience as a member of the LGBTQ+ community, my role as a director of an LGBTQ+ focused arts and creative community interest company (CIC), my experiences designing, judging the quality of, and running social care services and my imminent entrance into the ‘over-50’s’ population. Reflexivity and positionality within this thesis was therefore an important part of the work. This included both within data collection and data analysis and in any conclusions drawn from the work. As noted in Grace et al (2006), researchers who embark on self-reflection acknowledge the impact of subjectivity and positionality. This includes considering how heterosexism and homophobia may have been internalised, how to engage with research which is in opposition to heteronormativity and how insider status does not result in exemption from the impact of heterosexualising cultures. My own identity as someone who is both queer, and imminently in the over-50s category means my own reactions and position are important considerations.

Coughlan (2007) argues that ‘insider’ status can act as an indicator of trust and credibility for participants, leading to possible generation of more in-depth data. This trust may have implicitly indicated to LGBTQ+ participants that interviews or focus groups would be a ‘safe space’, free from discrimination because of my own position as a member of the LGBTQ+ community. Whether this is an accurate assumption on behalf of participants or not, the possibility that participants felt more comfortable talking to a person they perceived as an insider would presumably only lead to more honest descriptions of their experiences. Brannick & Coghlan (2007) note that thick description and narrative descriptions offer better insights than research driven by theory and political implications, and my ability to build levels of trust through my position as an insider could have contributed to richer descriptions of experiences from participants.

From a personal perspective, listening to stories of participants' experiences of discrimination presented some shared elements to my own experiences. Although sometimes confronting and upsetting, these connections provided further drivers for me as a researcher to find ways to highlight, problematise and seek possible solutions for the issues being discussed. Without this personal connection, ongoing enthusiasm may have been less present.

Additionally, my acquired understanding of being LGBTQ+ and involvement of running and inspecting services ensured that my at-hand knowledge and expertise was not neglected but became woven into the conclusions drawn in the research, arguably offering a more realistic and informed set of suggested actions (Riemer 1977). The insights and experiences I had allowed me to utilise internal language (jargon) in an informed way, and may have allowed me to draw on my own experiences to guide questioning and responses, although it was equally important to ensure this did not also lead to me making assumptions about how something felt or impacted on an individual (Brannick & Coghlan 2007).

Although I sought to consider the data and the findings in a way that focused on all elements of the picture, my own unconscious bias, particularly where expressions were made about the relative importance of sexual identity, may have influenced how I responded with follow up questions, how I interpreted findings within the evaluation process, and how I have subsequently presented these within this thesis. As Brannick & Coghlan (2007) identify, it is common for researchers to utilise familiar settings in their own research. Without knowledge of sexual identity and discrimination on that basis, as well as the intricacies of social care support structures, it is unlikely that I would have identified or been passionate about the research questions included in this research.

Additionally, my extensive working experience of social care, service design and delivery and regulation gave me unique insights into the practicalities and methods for making changes. However, this may also have influenced my interpretation of the findings from the data. Dobson (2009) argues that practitioner experiences may lead to truth seeking, through checking participant accounts against our own experiences and this may lead to a tendency to empathise with participants, familiar structures and processes, compromising criticality. Examples of this could have included; excusing providers from taking affirmative action because of my awareness of pressures within the social care system; over-identifying actions as discrimination because of my own experiences; blaming providers for lack of actions which I judged as easily implementable; excusing poor attitudes because of my own awareness of the levels of relative ignorance around the importance of sexual identity; and sympathising with providers who are trying to fight non-inclusive management directives, therefore holding them to a lower bar than other researchers might. I will inevitably have been influenced by my knowledge of services, commissioning and vulnerable service user groups, through assumed knowledge of whether something is realistic or possible to implement. However, this could have both negative and positive implications including an ability to apply a realistic view to the conclusions drawn and suggested actions to be taken by service providers.

I will inevitably have made assumptions about how impactful actions might actually be for a person from the LGBTQ+ community based on my own experiences, but this was tempered throughout by considering not just my own feelings, but those expressed by LGBTQ+ participants during data collection. This may have altered the way in which findings were both interpreted and presented. Grace et al (2006) note that LGBTQ+ researchers are cultural workers who enhance research through efforts to transgress heteronormativity, where being vocal and visible within the research process introduces a politics of hope and revelation which exposes LGBTQ+ voices to others. Throughout the research, my primary focus remained finding ways to make experiences better and my own positionality provided a driver for continuing to seek solutions that work for all those involved, through implicit knowledge of both being LGBTQ+ and working in structured environments to deliver and judge the effectiveness of social care support.

6.6.4 Final reflections

This research set out to build understanding of the experiences of inclusivity for older LGBTQ+ people in community based social care. Many findings reflect other similar research, where the ultimate hope of most older LGBTQ+ people is to have their sexual identity recognised, to be respected and be treated with cultural humility in social care. Although many complexities exist in providing inclusive services, the intentions of most providers are to support people in ways which enrich and enable. Changes are required, but many are achievable in some form, and all will ultimately contribute to moving towards more inclusive environments for those who require support.

6.7 Conclusions & Recommendations

6.7.1 Conclusions

This research study set out to understand older LGBTQ+ people's experiences of and feelings towards community based social care and simultaneously providers' actions and feelings towards inclusivity. The transaction between people using services and people running them is often based on elements of trust and assumed levels of understanding of meeting needs effectively. However, it has been shown that this is a complex transaction, affected by personal preferences and identities, structural and organisational enthusiasm and most fundamentally, a difference in the levels of importance attributed to sexual identity.

There are elements of time sensitivity for the current generation of older LGBTQ+ people in the UK, who have uniquely experienced extreme discrimination and criminalisation in their younger lives, but are now living in a different social context from that of their youth. These past experiences, both direct and indirect, can greatly influence how older LGBTQ+ people feel about their identity, their right to be valued and acknowledged and what they seek out to ensure they are able to protect themselves from further mistreatment (Brennan 2021, Pachankis et al 2020, van der Star et al 2019, Walch et al 2016, Williams et al 2017, Zuckerman 1998).

Within an era of mixed opinions about the legitimacy of LGBTQ+ identity and lifestyles, alongside local, national and international efforts to move the equality, diversity and inclusion (EDI) agenda forward (Kattel et al 2023, GOV.UK 2023, NHS England 2023(2), McIntosh 2023), the historic contexts used by older LGBTQ+ people to make decisions about care and support have been shown in this and other research to be extremely relevant. The findings of this research demonstrate the link made between historical discrimination, lack of visibility and decision making or framing of experiences. This indicates the importance of considering these elements, which shape decision making about accessing care for older LGBTQ+ people.

Service providers also find themselves in a unique and complex position. On the most fundamental level, most social care providers and staff/volunteers provide the services they do because they wish to help people and improve people's lives (England 2005). There are continuing efforts within service delivery and design, commissioning, social care research and regulation (where applicable) to meet a wide range of needs in ways that are free from discrimination and prejudice (Skills for Care & Skills for Health 2013) and this was clearly demonstrated by providers who were part of this research in terms of willingness to consider their approaches. Many organisations and individuals have made concerted efforts over the last 10 years to improve their EDI attributes, to act in ways that recognise, validate and value intersectionality, ranges of identities and associated needs, and ways to embrace diversity in all its forms (NHS England 2023(2), Women & Equalities Committee 2019).

These efforts, although not always impactful in the way they are intended, are often driven by activist individuals or groups who perceive they are fighting for those rights (Jones & Willis 2016, Nayak & Robbins 2018). Service providers continue to function in a severely underfunded and undervalued system which suffers from staff shortages, low pay, lack of career development, pressures from regulators and Local Authorities to deliver services in specific ways, as well as the potential complexity of service user groups demands and wishes (Kings Fund 2016, Smalley et al 2018). Providers as part of this research talked about these and other challenges inhibiting their efforts to make progress, but this was often framed around fundamental beliefs that they would be ‘nice to have’ rather than being necessary or required. There must be frameworks and drivers in place to ensure that efforts are evidence based, flexible and considered and ultimately, providers need to understand why and how they can adjust their approaches. This research adds to the discourse around the challenges for providers in delivering these kinds of inclusive services.

Part of the complexity within this research was around people's desire to be recognised as different while simultaneously being recognised as equal. Many older LGBTQ+ people who took part in the research talked about not necessarily wanting exclusive spaces, but broader inclusive ones, while at the same time wanting to be treated in different ways linked to their sexual identity. Many vocalised the benefits of being in exclusively LGBTQ+ spaces and the feelings of safety and ability to be themselves that these spaces brought.

The benefits were mostly related to being around other LGBTQ+ people, where it was perceived those interactions would be easier, less likely to be discriminatory or ignorant to the importance of LGBTQ+ identity and for some, less risky for a range of other reasons. The desire to be in spaces predominantly occupied by those in the same marginalised group is replicated in research relating to ethnic minority groups, where there has been shown to be better outcomes when staff are from similar backgrounds, and there are others with similar backgrounds using the service (Glendinning et al 2006, Mold et al 2005).

All these benefits can be linked back to elements of fear around the ways in which people would be understood and treated. Although it is plausible to assume that there is no reduction in risk of inappropriate sexual advances in LGBTQ+ exclusive settings versus mixed social care settings, the nature of the risk appears to have been processed differently by the older LGBTQ+ people who took part in this research.

This and other research in the area has shown that there are various ways that inequality of access and negative experiences can be tackled. Although most require person(s) or organisations to drive these, many are implementable in most types of service. Social care staff understanding why these actions are needed and important and subsequently implementing these in whichever ways they can is likely to improve the experiences of older LGBTQ+ in services, and potentially those with other protected characteristics where broader inclusivity would be welcomed.

While there are a range of actions providers and organisations could take, providers in this research had a fear around understanding which actions to take and this influenced their behaviours, in some cases resulting in no actions at all, or actions may have been limited in impact. For older LGBTQ+ people, their fear of how they might be treated and how their sexual identity might be minimised or ignored within services resulted in less enthusiasm about engaging with services. Many had created criteria for what they might look for in a provider or service, and there were a range of contradictions around broad and specific services, expectations about adjustments and how people wanted their sexual identity recognised. This also applied to what tokenism looked like and how this influenced their decision making.

There are many potential actions which can dispel myths about LGBTQ+ service users, and there are clear ways to grow awareness about LGBTQ+ older people within services, which would potentially alter experiences. However, it is more complex to know how to address the issue of fear with older LGBTQ+ people themselves. Ways to lessen or eliminate those fears require both global and local changes in approaches. Because part of the issue appeared to be the likelihood of discrimination, wider societal attitudes would likely need to shift towards anti-discrimination for these groups to feel more comfortable generally. Locally services would need to demonstrate in clear and tangible ways how they were avoiding or eliminating the possibility of any discrimination being present within their services, whether that be staff, other service users, links to relevant groups, physical signals of inclusivity or clear approaches to equality.

It is also important to consider whether mental shifts are needed within the older LGBTQ+ population itself around how they prioritise actions, what is reasonable to expect, what the minimum expectations are for them to feel able and happy about the social care they are seeking out and accepting, and how that is subsequently experienced. Although this may step away from an idealised model of care, there must be consideration of the current circumstances within which services are being delivered in the UK particularly. As previously discussed, service delivery is impacted by austerity, by current social attitudes and by demands on the support available within social care more generally. Realistic expectations, particularly with smaller, more informal services may need to be applied. This should not include the basic principles of respect, embracing identity and meeting needs. However, it may need to include acceptance that simple actions of inclusivity are more likely at this stage than wholesale shifts in approaches or attitudes which eliminate any possible discrimination or bias within service delivery.

Although this thesis has consistently returned to the nature of inclusive experiences, and the reasons why these are needed, this must be considered under the lens of the reality of service delivery, particularly those more informal and unregulated services. As part of the legislation and the regulatory framework in the UK, it is the responsibility of social care services, and the social care system more widely to ensure that services are inclusive. As discussed in the thesis, it may be that LGBTQ+ people want to and should be engaged in shaping that, but ultimately it must remain the responsibility of providers to make necessary changes. However, doing that in a meaningful way takes time, investment both mentally and financially and will need to be flexible as needs change over time. Through prioritising what people want and need in a way that is mindful of the input needed from all stakeholders (people using the services and people running them), especially older LGBTQ+ people who readily vocalise their fatigue in influencing change, this means that changes can be small, incremental or specific to a person or group but still impactful.

Commonly, services are not resourced or structured to be able to deliver more holistic approaches to support and the limitations of the wider market often result in piecemeal access to different types of service (Sharma et al 2015). Although person-centred approaches can be taken with individuals in terms of the way they are treated and interacted with, the effectiveness overall is often impacted by the availability of personalised services which are able to cater to a range of needs in individualised ways.

Because there is a lack of regulatory and policy drivers for providers, especially those who are more informal or limited in terms of approaches and initiatives available, it will likely remain the responsibility of individual service providers to drive changes. Without guidance or frameworks for providers to use to confidently put effort where it can be most impactful, it leaves uncertainty and potentially great variation in how something as relatively vague as inclusivity is approached. The development of a clearer framework, potentially linked to the relevant legislation, may provide a driver for organisations to be more proactive in creating inclusive services.

Many providers will not have the luxury of being able to widely consult, or research how they can adjust their approaches. Some will be unable to implement something like robust staff training, especially where groups are run by volunteers, some will be greatly restrained by funding, resources and capacity and some will be effectively paralysed by lack of knowledge or confidence. Being able to provide a framework for taking impactful actions according to the findings of research involving the affected group is much more likely to be effective than either no action at all, or action taken based on assumptions about what may be impactful.

Many services, including within this research, believe that either sexual identity is not relevant, or is not relevant for them because they have no LGBTQ+ service users, and this continues to be pervasive. This and other research shows that it is relevant for people and can be extremely relevant to the way some elements of care and support are delivered or experienced. Without the additional evidence robust data collection might bring, there continues to be a need to ensure that the presence and visibility of older LGBTQ+ people is highlighted and considered within service provision.

Knowing (or assuming) that LGBTQ+ people are in the population using a service appears to be the best driver for considering inclusivity, and data collection remains the key way of evidencing this need. Consideration needs to be given to what older LGBTQ+ people are expected to do in terms of advocating for themselves as individuals and as a group and services should be cognisant of that. There also needs to be mindfulness applied to how those older LGBTQ+ people are utilised and supported in raising awareness as part of staff training and other events.

Additionally, making robust links to LGBTQ+ organisations and being actively involved in the creation and maintenance of networks can bring a range of benefits, but it still very much the purview of a limited number of organisations. Without visibility driving demand there remains a burden on activist voices to champion the actions that can be taken to improve inclusivity. Until this becomes a wider approach to service design and delivery, it is likely to remain in the minority, limiting impact on the wider older LGBTQ+ populations accessing social care.

Some signals of inclusivity identified in this and other research are relatively easy to implement or adjust within the context of the service. This growing evidence base and developments such as LGBTQ+ learning frameworks must be further explored and promoted to ensure that they become standard across the provision. Although this requires support and guidance for providers, it demonstrates that not all of the actions need to be large and far reaching. It is possible to assume that if both drivers to make changes and guidance on how to do so are in place, many more providers would engage with them.

Theoretical underpinnings of conclusions

As well as being considered throughout the research, the theoretical underpinnings of the work are pertinent to drawing conclusions from the data. Additionally, it is important to consider the structural and individual pressures from a theoretical perspective in order to be able to fully consider the efficacy of recommendations being made. As introduced in Chapters 1 and 3, a range of guiding theories were considered in the design and conduct of the research. These included Social Identity Theory, Critical Theory, and Minority Stress Theory, as well as considering what is known and understood about ageing discrimination, heteronormativity and the structural impacts of homophobia more widely.

Minority Stress Theory posits that members of marginalised groups face additional and cumulative stress as a result of the discrimination suffered over time (Abbruzzese and Simon 2018, Correro & Neilson 2019, Fish and Weis 2019, Anderson-Carpenter et al 2019, Donisi et al 2019, Mankowski et al 2019). The impact of cumulative discrimination is likely to be individually experienced and will manifest in different ways for each person. Throughout this research, older LGBTQ+ participants gave examples of how they adjusted their behaviour, made decisions, and had particular perceptions about how they would be treated. They also gave accounts of how they might act in ways which they perceived would minimise discrimination such as sharing their lived experiences as part of a training offer. There appeared to be confirmation from these accounts that impact continued to be experienced over time, even if the experiences were historical. They continued to shape how people engaged with social care now and how they perceived they might engage with it in the future.

Following the principles of Critical Theory methodology to shape the methods used within the research, the voices of older LGBTQ+ people were used to steer topics of discussions with providers. This provided an opportunity to explore how marginalised voices might contribute to changing structural approaches to inclusivity and cultural competence. The recognition that change is needed to address non-inclusive experiences was described by both older LGBTQ+ people and providers. Although there were a range of challenges identified within those descriptions, almost all participants recognised the need for change and where they felt the power to make those changes was situated. Recognising that people with lived experience are best placed to share what impacts on their experiences, this was utilised with both groups of participants to encourage honest and realistic accounts of those experiences and in identifying possible solutions.

For older LGBTQ+ people this included using semi-structured interviews which allowed for off-topic discussion, open questions that encouraged reflection and freedom to vocalise not just decisions made, but thought processes behind those decisions. For providers this included creating a space in both interviews and focus groups to consider the statements made by older LGBTQ+ people, giving insight into experiences and understanding. In line with Critical Theory assumptions, there appeared to be a level of recognition about the need for change and where the responsibility to lead change might lie from all parties. However, what the resulting actions might be and how they would occur, differed between the groups. This highlighted the potential lack of congruence with a more purist take on how Critical Theory can be applied in real life situations where people and services will be functioning within variable contexts and agendas.

Older LGBTQ+ people understood the structural pressures for providers to a degree, some sympathised with them, many stated they felt obliged to contribute to changes but most felt it was primarily providers who held the power to make changes. Some felt that highlighting their stories gave them, as individuals, a form of power to instigate change. Providers seemingly understood the impact of negative experiences for older LGBTQ+ people and the importance of them taking action, but raised structural reasons for not taking action and laid some responsibility for instigating change at the door of older LGBTQ+ people. Critical Theory assumes this is because one group holds power over another, in this case providers having more power than older LGBTQ+ people might, and therefore responsibility to lead change is reliant on recognition of this power by all parties. This binary approach of powerful and powerless does not necessarily fit with the reality of social care delivery or wider societal cultural competence.

Although it can be argued that providers have some power, they are also subject to powers held elsewhere such as management directives, external regulation, political and financial circumstances, staffing and recruitment restrictions and challenges and even societal attitudes. This complexity and nuance means it is challenging to confidently identify solutions only led by those ‘in power’ but purely shaped by marginalised voices, without considering the perspectives and experiences providers may bring in relation to delivery of social care. It is possible that both groups can influence or lead changes to the current status quo. There is, however, a danger of developing a model of reliance on those who steer change (the marginalised) for those who can make changes (the provider) which potentially leads to less integration and collaborative working between services and those who use them. There is also a risk that minimising the centralising of those marginalised voices leads to ineffective change.

Where heteronormativity impacted on experiences, older LGBTQ+ people were able to identify what they felt the problems and potential solutions were. There was recognition that this was a broader societal problem rather than being specific to social care settings, but the impact was undeniable in some cases and frustratingly for some, easily avoided. Providers often justified heteronormative practice as catering to the majority and where there were economic considerations, this was communicated as a commercial decision, albeit unconsciously i.e. they were not purposefully trying to take heteronormative approaches but that those were the ‘normal’ ways of doing things. As seen with the scoping review (Chapter 2), perceptions of the wider social care system as being heteronormative led to low expectations and even fear of having to hide sexual identity (Boule et al 2020, Grant & Walker 2020, Waling et al 2019, Westwood 2016, Willis et al 2016, Wilkens 2016, Smith & Wright 2021, Löf & Olaison 2020).

Providers often stated that they would like to make changes but did not know how, or that they personally were driven to change approaches but there was a lack of management buy-in to do so. This demonstrates the challenges for providers in navigating both what needs to change and how that is driven. It also highlights how structural belief systems and approaches can impact on wider action being taken. However, without systemic and systematic responses to heteronormativity or discrimination, shifts to more culturally competent or inclusive services is less likely (Langley 2001, Willis et al 2016). Where providers are making statements about not knowing how to tackle heteronormative approaches, or how to demonstrate inclusivity, they essentially redirect the burden back onto the marginalised groups to shape and lead these changes. Although this arguably provides a centralising of marginalised voices, it also presents a potentially insurmountable challenge to those voices to both identify the problems and shape the solutions in a way that considers all the structural factors influencing those experiences.

The ways in which identity is formed, maintained and validated, as discussed in Chapter 3, is reliant on a range of factors, including the value people place on their own experiences and the ways in which their identities are reflected back to them by others. If individuals or groups feel that actions are being taken based on their own voices and feedback, it may contribute positively to individual comfort with identity through validation. If actions are perceived not to originate from those voices directly affected, it could be assumed this might weaken the impact or appropriateness of those actions. It may also contribute negatively to people's perceptions of their own value and position within broader society. Because older LGBTQ+ people are likely to be impacted by both their LGBTQ+ and ageing identity, both should be taken into account when considering any change services need to make. The data clearly demonstrated these intersecting identities, and the overlap in terms of how the identities themselves were experienced and the subsequent impact of those identities on people's perceptions and experiences.

It is well documented that perceived quality of life for older people is impacted by a range of factors including social and environmental wellbeing (Kelley-Gillespie 2009, Borglin et al 2005, Netuveli & Blane 2008, Walker 2005(1)). The social challenges of expressing sexual identity as an ageing person are further complicated by heteronormative assumptions and judgements of appropriateness (Foucault 1979, Weeks 1985, Gott 2005). The resulting normalisation of minimising expressions of sexuality and sexual identity may lead to acceptance of discriminatory views which may not be applied in the same way for younger people. This potentially creates an environment where older LGBTQ+ people are not just seeking inclusion, representation and acceptance of their LGBTQ+ identity, but are also doing so in a broader social context which routinely minimises or avoids expression of sexuality in later life.

Understanding the range of complexities faced by those who vocalise problems may involve acknowledging and accepting where power and responsibility might lie. By embracing and seeking to fully understand the structural oppression that may be faced by older, LGBTQ+ social care users, providers and the wider social care market may be able to identify actions which can reduce the impact of these. Normalising sexual identity as a key part of an individual may be a first step, and centering the lived experience voice is also likely to be useful. However, there are more structural changes which need to be embraced. Attitudes which are heteronormative or ageist, for example, would need to change from a wider societal perspective in order to fundamentally shift how older LGBTQ+ people are viewed and treated.

6.7.2 Recommendations

There are a range of areas for consideration, which include: improved data collection and improved skills to have inclusive conversations which provide opportunities to safely disclose; robust and ongoing training around the needs of older LGBTQ+ populations; a framework for providers to use which details evidence based expected standards for meeting older LGBTQ+ people's needs; consideration of whether storytelling is the most impactful style of training delivery, and if so, what frameworks of support are needed for those telling their stories; and effective ways for organisations to build connections and networks with LGBTQ+ organisations, groups and wider experts. Consideration of how these might be actioned, and where appropriate, understood in more detail through further research, are discussed below.

Actions and implementation

Many of the findings of this research suggest actions that providers could take to provide a more inclusive experience. Although many could be judged as simple or palatable, the knowledge, understanding and confidence of providers can be seen to have a direct effect on actions taken. Individual providers, particularly those who are run or staffed by people within the LGBTQ+ community were more likely to be taking actions which were aligned with what older LGBTQ+ people identified as relevant. However, this was not the case for other providers, or for those who felt unable to be proactive without the accompanying policy, leadership and organisational culture in place.

Organisational change can be complex for a range of reasons and capacity and enthusiasm for these changes can be dependent on perceptions of why the changes are needed or what they will achieve (Mosadeghrad & Ansarian 2014). Even where changes are relatively small, members of organisations will frequently focus on the implications for them as individuals and their roles, rather than considering the bigger picture or strategy driving the change. This can be further complicated when considering the potentially controversial nature of LGBTQ+ identity within wider society and particularly within health and social care, where a diverse workforce can be seen to have both negative and positive impacts (Cho et al 2017, Kumar & Suresh 2018, Gilliss et al 2010).

The ways in which an organisation approaches changes can have a direct effect on the outcomes achieved and often, this is dependent on the time, attention to detail and clarity of concept. Within social care in the UK, the additional pressures of delivering services as discussed in Chapter One, mean that service delivery may comply with regulatory minimum standards but changes and adaptations which require thinking, planning and facilitating are unlikely to be prioritised and creativity and innovation can be minimised. How these changes are highlighted, prioritised and facilitated in the current context is an important consideration.

When considering the wider attributes of social care services and the people using them, it is important to consider what factors contribute to the quality of these services, and indeed to reliably identify what might need to change. It can be particularly challenging to assess or account for the nuances of social care because specific aspects of delivery are mostly or wholly dependent on the co-produced nature of care (Malley & Fernández 2010). There are often few tangible measures, and the experience of care will be personal to all those involved. Studies show that the ways in which individuals process and use information is variable, including the use of guidelines, competencies and expected behaviours or tasks (LoPorto 2020).

One of the frameworks which may be helpful to consider is Donabedian's 'Quality of Care' (QoC) model (Donabedian 1980). The framework identifies three areas which are relevant to the delivery of good quality care; structure, process and outcomes (LoPorto 2020, Malley & Fernández 2010). Donabedian (1980) argues that high quality outcomes require effective processes, which in turn require established structures.

Structure

Structural factors are often stable characteristics of providers and can include the tools, resources, physical and organisational settings in place. Processes account for the activities that occur within and between those delivering and receiving services, and outcomes are the desired or undesired results of the care delivered. When applying this to social care specifically, accounting for the fact that care is effectively co-produced between a person and a service is relevant (Malley & Fernández 2010). This is complex, partly because every person (staff or person using a service) will attach different meanings to actions and interactions and ways of judging quality. These are likely to be impacted by a range of things including a person's own material, social, psychological and cultural circumstances (Wolff 2000, Benzeval & Judge 2001).

The structural factors at play when considering impact on outcomes and experience can include leadership behaviours & attitudes, as well as more static elements such as policies or expected competency frameworks. Organisational culture and leadership behaviours play a key role in the satisfaction, morale and commitment of employees and require specific skills in order to be effective, for example, the ability to influence others behaviours (Godshalk & Sosik 2000, Cameron 2011, Tuckey et al 2012). Additionally, although structural factors are often used as a measure of quality (such as staff ratios or physical attributes like buildings and accessibility), these indirect measures are generally poor predictors of overall satisfaction (Malley & Fernández 2010). They usually focus on stable elements of provision, which can mean that changes over time and the relevance of the relationship between person and carer are not taken into account. However, the role of structural factors should still be a consideration.

Policies and management directives which are conflicting, not in place or of poor quality can result in a range of negative outcomes. Poor or infrequent communication of directives, lack of support and guidance for implementation frameworks and leadership ability to empower employees will all form part of the structural factors influencing the quality of a service (LoPorto 2020). This influence, or lack of influence can be seen in this research, where both staff and older LGBTQ+ people felt that cultural competence needed to be driven by an organisational culture and supporting policies. Arguably, what needs to be a 'top level' commitment to equality and inclusion can be reasonably broad if it allows and empowers staff to implement in practical and impactful ways.

The ways in which service delivery might align with culturally competent approaches are subject to individual interpretation, but robust structural foundations are likely to positively support those developments. Even small or more informal services can identify key approaches to equality, inclusion and cultural competency, which serves to provide an overall guideline, expectation and ultimately, ethos of a service. It also potentially provides impetus for individual staff members, and indeed those using a service, to feel empowered to contribute to this overall aim, however that is done on the ground.

Clear examples of actions that would impact from an LGBTQ+ perspective have been captured throughout this research. Taking simple steps to ensure that policies, management directives, focus and importance displayed at higher levels of an organisation and even marketing and welcome/induction processes may all serve to provide a structural impetus to improve the inclusivity of services for this specific service user group.

Processes

Because care is simultaneously delivered and received, it can be complex to identify whether and to what degree a provider or staff member is influencing the experience of the service (Malley & Fernández 2010). Despite this, the nature of relationships, the amount to which the individual feels integrated into their own care planning and delivery, and how they perceive their treatment as an individual are all important processes used to measure quality (Qureshi & Nicholas 2001, Sangl et al 2005).

When taking into account the factors that are felt to contribute to quality of care and quality of life more broadly, many of these relate to the process element of the QoC model. These include attitudes and behaviours of staff, effective communication of changes, flexibility to meet changing needs, privacy and dignity, safety and security, access to social contact, maximum control, choice and autonomy (Reed 2007, Osborne 1992). When these are compared with the data collected as part of this research, alignment can be seen with the wishes of older LGBTQ+ participants and the elements with which they made judgements about whether their experiences had been inclusive.

Outcomes

Although it would be difficult to follow a prescriptive framework for implementing such changes because of the heterogeneity of service provision, where the structures discussed above are in place, these process areas are all ones which can potentially be explored by services and service users in the context of each setting. This may be complex to understand because experience is not straightforward to measure or verify (Malley & Fernández 2010) but this does not mean it is impossible. Additionally, implementation of processes which support something like inclusivity have the potential to act as impetus for managerial interventions, which may help to strengthen the structural elements (Steel et al 2004).

To be able to implement processes which encapsulate the examples given above, there are a range of actions services can consider. With areas such as attitudes of staff and effective communication, training and ongoing conversations about these areas both with staff and involving people using a service can act as a valuable tool. The notion that awareness training on LGBTQ+ specific needs and more generally around cultural competence is crucial can be seen in this and other research to be extremely prevalent. Within the QoC model, provision of these kinds of activities may serve to build confidence and abilities, and the visibility of this offers both tangible and discreet indications to service users.

The elements encapsulating privacy and dignity, choice, control and autonomy may all be influenced by the processes a person using a service is party to. This might include the initial assessment or introductory processes they experience when having first contact with a service. The older LGBTQ+ participants in this research, and other similar research are clear that being asked about their sexual identity is important, and to not be asked or feel like it is deemed irrelevant impacts on the dignity of the experience. As discussed in the earlier parts of this chapter, there is some evidence to show that sexual identity information being collected is not as problematic in reality as it is thought to be by staff. Although this is an area for further exploration, it could be assumed that implementing something like routine sexual identity information as a normal process might contribute to favourable judgement by all those who use services, regardless of sexual identity.

Throughout this thesis, the theoretical frameworks related to identity have demonstrated the ways in which treatment by others impacts on both sense of identity and comfort of identity. This can be seen throughout the data collected from older LGBTQ+ participants who were very clear in their assertions that negating their identity was harmful in a range of ways. It can be assumed that this might apply regardless of the nature of the identity. From a service perspective, considering the processes used and how these validate identity but also encourage choice, control and autonomy appears to be important.

As previously discussed, most people wish to have input into their own care and systems have been implemented more widely, such as self-directed support to encourage this. However, services may need to consider how this is done over and above funding and statutory care planning so that those who use services feel truly embedded in their own care. This could be as simple as allowing individuals to choose what elements of care they wish to engage with (and perhaps is more pertinent to residential settings) or asking individuals to contribute to planning activities or approaches. It could also include changing processes or approaches following purposeful gathering of feedback about how these processes are experienced.

Exploring these elements may provide a good starting point for organisations. It is hard to suggest specific actions because of the variety of factors that may influence what is delivered, how and to who. By looking at ways to further understanding, testing out simple actions and considering both macro and micro approaches to inclusivity, it is possible to imagine that regardless of type of service, improvements are possible.

Trauma Informed Approaches

Older LGBTQ+ people may have experienced trauma throughout their lives, often directly related to their sexual identity, as discussed in Chapter 1. Although there is no universal definition of trauma, it is generally accepted that exposure to trauma, which can include systemic discrimination, has a range of impacts including lack of engagement with support structures (Menschner & Maul 2016, Dolezal & Gibson 2022). It is generally acknowledged that trauma can result in adverse outcomes across all areas of life and persist across the lifecourse (Dolezal & Gibson 2022). They can include social, psychological, behavioural, psychiatric and physical problems, elevating the risk of chronic health, mental health and substance misuse issues (Knight 2019, Banaj & Pellicano 2020).

Research addressing trauma and trauma informed approaches to delivering care suggests there can be profound negative impacts on emotional wellbeing and social outcomes, sometimes resulting in lack of engagement with services (Barrett 2019, Poole & Greaves 2012). As a result, work has been ongoing over the last 30 years to consider the ways in which trauma is understood and subsequently responded to by services. Trauma informed approaches seek to understand trauma, its consequences and the conditions which can enhance healing within service delivery settings (Harris & Fallot 2001, Fallot & Harris 2008).

Trauma informed approaches to the delivery of care focus on five principles; safety; choice; trustworthiness, empowerment; and collaboration (Fallot & Harris 2008). With some features arguably consistent with person-centred approaches, trauma informed approaches include changes at all levels of an organisation including shifting culture, attitudes, policies and procedures as well as considering the physical attributes of accessing a service (Fallot & Harris 2008, Menschner & Maul 2016). Refocusing on how those with lived experience of trauma may be impacted, and considering the ways in which a service can create environments that offer safety, provide consistent information, prioritise choice and control, maximise collaboration and encourage empowerment can potentially reduce the effects of trauma and importantly, avoid re-traumatising a person in the future (Fallot & Harris 2008).

Within this study, the focus was on community based services. These are often informal, have no or pared back structures (such as staff training frameworks or extensive policies) and often cater for a broad range of people, which may make it challenging to adopt a trauma informed approach in its purest form, although some elements of these approaches may still be useful. If a service is seeking to adopt a trauma informed approach, this would usually require a full review of the ways in which processes such as assessment, first contact, the physical environment, policies, staff training and culture and attitudes in the organisation might impact trauma survivors. Where services are more informal, these areas may not be relevant to service delivery in the ways they may be in more formal settings. However, understanding the impact of trauma may provide insight into simple adaptations to approaches which could align with a trauma informed approach.

Further consideration should also be given to moving beyond a trauma informed model, to recognising the impact of shame and associated shame-sensitivity (Dolezal & Gibson 2022). Shame is commonly linked to identity, self-perception, social capital, social control & power (Dolezal 2015). This may be particularly pertinent to older LGBTQ+ people, and indeed is raised within this research by older LGBTQ+ people as something which has an enduring impact on daily lives. Several participants talked about how decisions they make now are shaped by the experiences of shame they felt to be themselves in their younger lives. This was mainly related to the legal and social standing of LGBTQ+ people in past decades resulting in them feeling negatively about themselves and those perpetuating negative attitudes towards them.

Through building awareness with staff and reviewing processes, it is possible to consider where there are opportunities to minimise negative and maximise positive experiences for those who may be affected by trauma. Ensuring initial experiences are mindful and cognisant of potential trauma through a lens of understanding personal experiences and ensuring that any subsequent contact does not exacerbate existing trauma may lead to improved outcomes. On a practical level, beyond gathering information about sexual identity, there are a range of actions which may contribute to a more trauma informed approach.

Building staff knowledge, as discussed elsewhere in this thesis, is felt to be a key driver for improved approaches, and this can occur in a range of ways. This may include taking time to listen to lived experience, where people or groups can reflect on what actions might make a positive difference to them, and staff subsequently utilising this knowledge to adjust approaches where possible. It could also include considering the ways in which individuals are empowered to make choices and have some control over what and how they engage, through critically exploring the systems used within those services. Finding meaningful ways to maximise collaboration through individual and collective efforts to share power, including through connections to people and organisations that specialise in supporting a particular group, in this case, older LGBTQ+ people, may offer opportunities for organisations to redress imbalances, reducing the ongoing impact of the trauma or shame.

Implementation of service user led advisory groups, reviews of processes to consider where there may be the possibility of reinforcing identity and value (in opposition to shame or ongoing discrimination) and focusing on person-centredness within individual approaches may all contribute to a reduction in the impact of trauma and indeed, lead to a more inclusive experience overall. The features of trauma informed approaches, cultural competency and person-centred approaches all share a focus on understanding and responding to the individual, the context in which they have historically and presently live, and the ways in which their experiences shape their decisions and actions. This supports an approach to service design and delivery which is cognisant of the experiences of older LGBTQ+ people, and utilises this knowledge to shape the support offered.

Further research

Most of the areas highlighted above also represent potential gaps in the research. In relation to data collection about sexual identity, little is known about how this might be perceived within social care settings and how this might be done more effectively, as well as the impact of better knowledge of who is using a service. Older LGBTQ+ people’s interactions with more informal community based social care and reasons why these may not be accessed by those in need, is still under researched, resulting in fewer drivers for providers to make changes. The links that can be made by social care services to specialist LGBTQ+ organisations may have a range of benefits for both individuals and organisations but the methods, outcomes and impact of this are not yet fully understood.

The efficacy of different types of training, guidance for providers about what minimum standards might look like, understanding of the actual and perceived barriers for providers in taking actions of inclusivity and what best practice looks like have not yet been fully explored within a research or policy context. These areas may have variable impact on individual older LGBTQ+ people’s experiences, but it is likely that most would result in more positive experiences for the group as a whole. The effort taken to consider these actions may be enough to make a person feel recognised and validated and so, more general efforts to make groups feel welcome, based on the feedback of older LGBTQ+ people themselves, are required.

As highlighted in section 6.4, one of the challenges remains there being a lack of drivers for providers to invest time and resources in making changes. This requires focus from a policy perspective to ensure that providers are incentivised to consider inclusivity and are able to access the right support and guidance to do this. Despite the Women and Equalities Committee report in 2019 and subsequent action plan, there has been little action to help providers understand the importance and have the tools to be able to make meaningful changes to improve cultural competency (Women & Equalities Committee 2019). Further evidence of the value and importance of delivering culturally competent care, regardless of the marginalised identity or protected characteristic, is required, as is clear, evidence based guidance and support. Ultimately, this must reflect the experiences of older LGBTQ+ people, who need to be central to shaping these resources, to ensure that actual experience is forefronted as opposed to assumptions about what might make something inclusive for this group.

6.7.3 Key Outcomes

In carrying out this research, findings and conclusions can be seen to further strengthen what is already understood about the experiences of older LGBTQ+ people and social care. In relation to the invisibility of LGBTQ+ people within service structures, this research shows, in line with other similar research, that lack of information gathering by services perpetuates these voices not being heard or considered in service design or delivery. Furthermore, this research demonstrates there are simple actions that can be taken to ensure the presence of LGBTQ+ people is seen, understood and responded to. Although there are measures to be taken to facilitate safe and meaningful disclosure through training and development of staff skills to have inclusive conversations, these are possible and realistic goals. True person-centred approaches would incorporate creating spaces for people to talk about what is important to them, and this should always include sexual identity, but especially so for LGBTQ+ people.

The impact of not taking key parts of a person’s identity into consideration in the planning and delivery of care can be seen throughout this research to be contributing to ongoing discrimination, shame and frustration from older LGBTQ+ people’s perspectives. This is likely to have a direct effect on not just experiences, but engagement more generally. To be able to inclusively support a person, staff and volunteers may require additional support, but this ought to be a fundamental part of delivering person-centred care.

Providers who took part in this research felt that having inclusive conversations and acting in inclusive ways more generally relied on the delivery of appropriate training of staff around cultural competence and LGBTQ+ experiences. This is similar to other research in the area which consistently demonstrates the importance of training. Uniquely, this research showed that assumptions were commonly made by both older LGBTQ+ people and providers that the retelling of lived experience was the most impactful way to facilitate this learning. However, it was also highlighted that there are rarely systems of support around those telling their stories, and broader literature confirms that actually, the efficacy and longevity of this type of training, particularly in social care is not well understood.

This research also highlights the importance of signs and markers of inclusion beyond data collection. There are a range of ways this can be implemented, and participants identified that even the smallest signals provide a sense of inclusion, despite sometimes being simultaneously considered as tokenistic. There is little research looking at signs and markers of inclusivity within social care settings, with most focused on healthcare settings or as part of marketing and advertising. The data collected demonstrates that older LGBTQ+ people use these markers to make and refine choices. Providers demonstrated that there are palatable and non-threatening ways to use these markers and although they were not currently utilising these, they predominantly felt that these were realistic considerations for them going forward.

Older LGBTQ+ people within this research also highlighted the value and importance of links to LGBTQ+ specialist organisations and groups. Some providers also recognised or were able to vocalise how this was helpful in building knowledge, encouraging connections and demonstrating inclusivity more broadly. This is an area of research more widely where it has been shown that community links to specialist organisations (regardless of the type of protected characteristics being focused on) are useful for a number of reasons, and this research highlighted the potential advantages of making those connections for older LGBTQ+ people. Although providers sometimes felt they were unclear about how to make those connections or utilise them in a constructive way for both parties, the enthusiasm and willingness to explore this was clearly present.

When considering all the findings of this research, but particularly the call to action for providers specifically, the importance of policy and management drivers was seen to be crucial to moving to a more inclusive model of service delivery. Although in line with other research in the area, this research demonstrates the reliance put on these drivers for all elements of inclusive action. All the actions identified in this research to improve experiences of inclusivity require input and engagement from providers who are often led by policy, legislation and current social pressures. This highlights the need to tackle inclusivity both ‘on the ground’ and in terms of wider policy and practice directions.

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Appendices

Overview of Appendices

Appendix 1 - Overview of Search results

Black indicates number in earlier searches, red indicates where additional papers were found in later searches

Database	**Search terms (1)**	**Search terms (2)**	**Search terms (3)**	**Search terms (4)**	**Total results**
Web of Science	Lesbian, Gay, Bisexual, Homosexual, Queer, LGBT* & Transgender	Older, elderly, ageing*, geriatric & senior	"Community Provision" OR "Community service"	"Social Care"	2 +1
Web of Science	Lesbian, Gay, Bisexual, Homosexual, Queer, LGBT* & Transgender	Older, elderly, ageing*, geriatric & senior	Asset based & "Asset based" (2 searches)	"Social Care"	0 x 1 1 x 1
Web of Science	Lesbian, Gay, Bisexual, Homosexual, Queer, LGBT* & Transgender	Older, elderly, ageing*, geriatric & senior	"Asset based"	NOT HIV OR AIDS	0
Web of Science	Lesbian, Gay, Bisexual, Homosexual, Queer, LGBT* & Transgender	Older, elderly, ageing*, geriatric & senior	Voluntary services	"Social Care"	0 +2
Web of Science	Lesbian, Gay, Bisexual, Homosexual, Queer, LGBT* & Transgender	Older, elderly, ageing*, geriatric & senior	Voluntary OR Community OR Charity	"Social Care"	13 +6
Web of Science	Lesbian, Gay, Bisexual, Homosexual, Queer, LGBT* & Transgender	Older, elderly, ageing*, geriatric & senior	Service provision	"Social Care"	12
Web of Science	Lesbian, Gay, Bisexual, Homosexual, Queer, LGBT* & Transgender	Older, elderly, ageing*, geriatric & senior	Peer Support	"Social Care"	3

Database	Search terms (1)	Search terms (2)	Search terms (3)	Search terms (4)	Total results
Web of Science	Lesbian, Gay, Bisexual, Homosexual, Queer, LGBT* & Transgender	Older, elderly, ageing*, geriatric & senior	"Community Provision"	“Social Care”	0
Web of Science	Lesbian, Gay, Bisexual, Homosexual, Queer, LGBT* & Transgender	Older, elderly, ageing*, geriatric & senior	Social care services	“Social Care”	26 +1
Web of Science	Lesbian, Gay, Bisexual, Homosexual, Queer, LGBT* & Transgender	Older, elderly, ageing*, geriatric & senior	"Voluntary Provision"	“Social Care”	1
Web of Science	Lesbian, Gay, Bisexual, Homosexual, Queer, LGBT* & Transgender	Older, elderly, ageing*, geriatric & senior	Day services*	“Social Care”	1
Web of Science	Lesbian, Gay, Bisexual, Homosexual, Queer, LGBT* & Transgender	Older, elderly, ageing*, geriatric & senior	(Community NEAR/3 services) OR (Community NEAR/3 provision)	NOT HIV OR AIDS	13 +4
Assia	Lesbian, Gay, Bisexual, Homosexual, Queer, LGBT* & Transgender	Older, elderly, ageing*, geriatric & senior	Row 1 as TITLE + "Social Care"	NOT HIV OR AIDS	21 +2
Assia	Lesbian, Gay, Bisexual, Homosexual, Queer, LGBT* & Transgender	Older, elderly, ageing*, geriatric & senior	(Community adj3 services) OR (Community adj3 based)	“Social Care” NOT HIV OR AIDS	46
Assia	Lesbian, Gay, Bisexual, Homosexual, Queer, LGBT* & Transgender	Older, elderly, ageing*, geriatric & senior	"Social Capital"	“Social Care” NOT HIV OR AIDS	5

Database	**Search terms (1)**	**Search terms (2)**	**Search terms (3)**	**Search terms (4)**	**Total results**
Web of Science	Lesbian, Gay, Bisexual, Homosexual, Queer, LGBT* & Transgender	Older, elderly, ageing*, geriatric & senior	Row 1 as TITLE + "Social Capital"	“Social Care” NOT HIV OR AIDS	40
Web of Science	Lesbian, Gay, Bisexual, Homosexual, Queer, LGBT* & Transgender	Older, elderly, ageing*, geriatric & senior	Row 1 as TITLE + "Social Capital"	NOT HIV OR AIDS	5
Assia	Lesbian, Gay, Bisexual, Homosexual, Queer, LGBT* & Transgender	Older, elderly, ageing*, geriatric & senior	Row 1 as TOPIC + "Social Care"	NOT HIV OR AIDS	204
Web of Science	Lesbian, Gay, Bisexual, Homosexual, Queer, LGBT* & Transgender	Older, elderly, ageing*, geriatric & senior	Row 1 as TITLE + ("Social Care" OR domiciliary* care OR day services OR homecare OR daycare OR peer support OR voluntary OR "community care" OR "community services" OR "community based")	NOT HIV OR AIDS	97
Assia	Lesbian, Gay, Bisexual, Homosexual, Queer, LGBT* & Transgender	Older, elderly, ageing*, geriatric & senior	Row 1 as TITLE + ("Social Care" OR domiciliary* care OR day services OR homecare OR daycare OR peer support OR voluntary OR "community care" OR "community services" OR "community based")	NOT HIV OR AIDS	2585

Appendix 2 - Full search results

⬛	Duplication	🟩	Outside inclusion criteria
🟥	No Author/traceable source eg magazine/narrative	🟨	Included in scoping review
🟦	Not relevant	🟪	Added in updated search

Source	Search no	Authors	Pub Year	Article Title	Source title
Web of Science	1.1	Manthorpe, J; Moriarty, J	2014	Examining day centre provision for older people in the UK using the Equality Act 2010: findings of a scoping review	H & S in the Community
	*	Spatenkova, N; Olecka, I	2016	THE EXPERIENCE OF PROVIDERS OF CARE FOR THE ELDERLY WITH LGBT plus CLIENTS	Starnuti 2016
Web of Science	1.2	Boule, Jess; Wilson, Kimberley; Kortes-Miller, Kathy; Stinchcombe, Arne	2020	We Live in a Wonderful Country, Canada, but horizontal ellipsis : Perspectives From Older LGBTQ Ontarians on Visibility, Connection, and Power in Care and Community	Int J Of Aging & Human Development
		Pijpers, Roos	2020	Experiences of older LGBT people ageing in place with care and support: A window on ordinary ageing environments, home-making practices and meeting activities	Sexualities
	*	Grant, Ruby; Walker, Briohny	2020	Older Lesbians' experiences of ageing in place in rural Tasmania, Australia: An exploratory qualitative investigation	H & S In The Community
		Lof, Jenny; Olaison, Anna	2020	'I don't want to go back into the closet just because I need care': recognition of older LGBTQ adults in relation to future care needs	European Journal Of Social Work
	*	Willis, Paul; Raithby, Michele; Maegusuku-Hewett, Tracey	2018	It's a nice country but it's not mine: Exploring the meanings attached to home, rurality and place for older lesbian, gay and bisexual adults	H & S In The Community
	*	Boggs, J. et al .	2017	Perspectives of LGBTQ Older Adults on Aging in Place: A Qualitative Investigation	Journal Of Homosexuality
		Hafford-Letchfield, Trish; Simpson, Paul; Willis, Paul B.; Almack, Kathryn	2018	Developing inclusive residential care for older lesbian, gay, bisexual and trans (LGBT) people: An evaluation of the Care Home Challenge action research project	H & S In The Community
		Putney, J M. et al	2020	The Housing Needs of Sexual and Gender Minority Older Adults: Implications for Policy and Practice	Journal Of Homosexuality
		Crossland, John	2016	Exploring the Care Act's potential for anti-discriminatory practice with lesbian, gay, bisexual and trans older people	Quality In Ageing And Older Adults
		Fenge, Lee-Ann; Jones, Kip; Gibson, Camilla	2018	Meaningful dissemination produces the long tail that engenders community impact	Qualitative Research Journal

		McParland, James; Camic, Paul M.	2016	Psychosocial factors and ageing in older lesbian, gay and bisexual people: a systematic review of the literature	Journal Of Clinical Nursing
		Green, Marcus	2016	Do the companionship and community networks of older LGBT adults compensate for weaker kinship networks?	Quality In Ageing And Older Adults
		Needham, Catherine; Carr, Sarah	2015	Micro-provision of Social Care Support for Marginalized Communities - Filling the Gap or Building Bridges to the Mainstream?	Social Policy & Administration
		Manthorpe, Jill; Moriarty, Jo	2014	Duplication	H & S In The Community
		Spatenkova, Nadezda; Olecka, Ivana	2016	Duplication	Starnuti 2016
Web of Science	1.3				
	*	Simpson, P; Almack, K; Walthery, P	2018	'We treat them all the same': the attitudes, knowledge and practices of staff concerning old/er lesbian, gay, bisexual and trans residents in care homes	Ageing & Society
	*	Jones, SM; Willis, P	2016	Are you delivering trans positive care?	Quality In Ageing And Older Adults
	*	Price, E	2012	Gay and lesbian carers: ageing in the shadow of dementia	Ageing & Society
		Fenge, LA; Jones, K; Gibson, C	2018	Duplication	Qualitative Research Journal
		Willis, P et al	2018	Duplication	H & S In The Community
		Needham, C; Carr, S	2015	Duplication	Social Policy & Administration
		Manthorpe, J; Moriarty, J	2014	Duplication	H & S In The Community
		Westwood, S	2016	LGBT* ageing in the UK: spatial inequalities in older age housing/care provision	Journal Of Poverty And Social Justice
		Ross, PDS	2016	Learning from international experiences - developing older LGBT affirmative housing and care options in England	Quality In Ageing And Older Adults
		Addis, S; Davies, M; Greene, G; MacBride-Stewart, S; Shepherd, M	2009	The health, social care and housing needs of lesbian, gay, bisexual and transgender older people: a review of the literature	H & S In The Community
		Concannon, L	2009	Developing Inclusive Health and Social Care Policies for Older LGBT Citizens	British Journal Of Social Work
Web of Science	1.4	Jurcek, A. et al	2020	Educating health and social care practitioners on the experiences and needs of older LGBT plus adults: Findings from a systematic review	Journal Of Nursing Management
		Dune, T et al	2020	Are Services Inclusive? A Review of the Experiences of Older GSD Women in Accessing Health, Social and Aged Care Services	Int J Of Environmental Research And Public Health

		Higgins, A. et al	2019	Pedagogical principles and methods underpinning education of health and social care practitioners on experiences and needs of older LGBT plus people: Findings from a systematic review	Nurse Education In Practice
		McParland, J; Camic, PM	2016	Duplication	Journal Of Clinical Nursing
		Needham, C; Carr, S	2015	Duplication	Social Policy & Administration
Web of Science	1.5	Beselt et al	2023	Experiences with social support among older adult women participating in gay square dancing	Psychology Of Sport & Exercise
		Lipinski, Stinchcombe & Wilson	2023	Are Age-Friendly Communities 'Friendly' for All? Perspectives from LGBTQ2S+ Communities	Journal Of Aging & Social Policy
		Dixon, Bunting et al	2022	Older lesbian, gay, bisexual, transgender and queer adults experiences with discrimination and impacts on expectations for long term care: results of a survey in southern United States	Journal Of Applied Gerontology
		Benbow & Kingston	2022	Older trans individuals' experiences of health and social care and the views of healthcare and social care practioners: 'They hadn't a clue".	Educational Gerontology
		Skeldon & Jenkins	2022	Experiences and attitudes of the LGBTQ+ Community on care/nursing home	Journal Of Homosexuality
		Smith, R & Wright, T	2021	Older lesbian, gay, transgender, queer & intersex people's experiences and perceptions of receiving homecare services in the community: A systematic review.	International Hournal Of Nursing Studies
		Fasullo, McIntosh et al	2021	LGBTQ Older Adults in Long-Term Care Settings: An integrative review to inform best practices	Clinical Gerontologist
		Cummings et al	2021	As we age:Listening to the voice of LGBTQ older adults	Social Work In Public Health
		Willis, P; Dobbs, C; Evans, E; Raithby, M; Bishop, JA	2020	Reluctant educators and self-advocates: Older trans adults' experiences of health-care services and practitioners in seeking gender-affirming services	Health Expectations
		McParland, J; Camic, PM	2018	How do lesbian and gay people experience dementia?	Dementia-Int J Of Social Research And Practice
		Cloyes, KG	2016	The Silence of Our Science Nursing Research on LGBT Older Adult Health	Research In Gerontological Nursing
		McPhail, R; Fulop, L	2016	Champions' perspectives on implementing the National Lesbian, Gay, Bisexual, Transgender and Intersex Ageing and Aged Care Strategy in Queensland	Australian Health Review
		Fenge, LA	2010	Striving towards Inclusive Research: An Example of Participatory Action Research with Older Lesbians and Gay Men	British Journal Of Social Work
		Holman, EG; Landry-Meyer, L; Fish, JN	2020	Creating Supportive Environments for LGBT Older Adults: An Efficacy Evaluation of Staff Training in a Senior Living Facility	Journal Of Gerontological Social Work
		Cronin, A; Ward, R; Pugh, S; King, A; Price, E	2011	Categories and their consequences: Understanding and supporting the caring relationships of older lesbian, gay and bisexual people	International Social Work

	*	Lottmann, R	2020	Sexual and gender diversity and care for older people-intersectional perspectives and the relevance of situations and contexts	Zeitschrift Fur Gerontologie Und Geriatrie
	*	Brennan-Ing, M; Seidel, L; Larson, B; Karpiak, SE	2014	Social Care Networks and Older LGBT Adults: Challenges for the Future	Journal Of Homosexuality
		Boule, J. et al	2020	Duplication	Int J Of Aging & Human Development
		Putney, JM et al	2020	Duplication	Journal Of Homosexuality
		Pijpers, R	2020	Duplication	Sexualities
		Dune, T et al	2020	Duplication	Int J Of Environmental Research And Public Health
		Grant, R; Walker, B	2020	Duplication	H & S In The Community
		Lof, J; Olaison, A	2020	Duplication	European Journal Of Social Work
		Higgins, A et al	2019	Duplication	Nurse Education In Practice
		Willis, P et al	2018	Duplication	H & S In The Community
		Simpson, P; Almack, K; Walthery, P	2018	Duplication	Ageing & Society
		Hafford-Letchfield, T et al	2018	Duplication	H & S In The Community
		Fenge, LA; Jones, K; Gibson, C	2018	Duplication	Qualitative Research Journal
		Boggs, JM et al	2017	Duplication	Journal Of Homosexuality
		McParland, J; Camic, PM	2016	Duplication	Journal Of Clinical Nursing
		Westwood, S	2016	Duplication	Journal Of Poverty And Social Justice
		Spatenkova, N; Olecka, I	2016	Duplication	Starnuti 2016
		Jones, SM; Willis, P	2016	Duplication	Quality In Ageing And Older Adults
		Ross, PDS	2016	Duplication	Quality In Ageing And Older Adults
		Needham, C; Carr, S	2015	Duplication	Social Policy & Administration
		Manthorpe, J; Moriarty, J	2014	Duplication	H & S In The Community
		Price, E	2012	Duplication	Ageing & Society

		Addis, S et al	2009	Duplication	H & S In The Community
		Concannon, L	2009	Duplication	British Journal Of Social Work
Web of Science	1.6	Manthorpe, J; Moriarty, J	2014	Duplication	H & S In The Community
Web of Science	1.7	Putney, JM et al	2020	Duplication	Journal Of Homosexuality
		Lof, J; Olaison, A	2020	Duplication	European Journal Of Social Work
		Willis, P; Raithby, M; Maegusuku-Hewett, T	2018	Duplication	H & S In The Community
		McParland, J; Camic, PM	2016	Duplication	Journal Of Clinical Nursing
		Spatenkova, N; Olecka, I	2016	Duplication	Starnuti 2016
		Manthorpe, J; Moriarty, J	2014	Duplication	H & S In The Community
		LeBron, AMW; Cowan, K; Lopez, WD; Novak, NL; Ibarra-Frayre, M; Delva, J	2019	The Washtenaw ID Project: A Government-Issued ID Coalition Working Toward Social, Economic, and Racial Justice and Health Equity	Health Education & Behavior
		Warren, AR; Steffen, AM	2020	Reactions and Preferences for Training Among Area Agency on Aging Providers Working With Transgender and Gender Nonconforming Older Adults	Journal Of Applied Gerontology
		Muftic, LR; Deljkic, I; Fansher, AK	2019	A Nationwide Evaluation of Services Provided to Domestic Violence Survivors at Shelters in Bosnia-Herzegovina	Journal Of Interpersonal Violence
		Kilbourn, S	2016	Perseverance, Patience, and Partnerships Build Elder LGBT Housing in San Francisco	Generations-Journal Of The American Society On Aging
	*	Waling, A. et al	2019	Experiences and perceptions of residential and home care services among older lesbian women and gay men in Australia	H & S In The Community
	*	Proctor, AR; Krusen, NE	2017	Time to ask and tell: Voices of older gay and bisexual male veterans regarding community services	Journal Of Gay & Lesbian Social Services
	*	Czaja, SJ et al	2016	Concerns about aging and caregiving among middle-aged and older lesbian and gay adults	Aging & Mental Health
	*	Sagie, O	2015	Predictors of Well-being Among Older Gays and Lesbians	Social Indicators Research
		Wright, LA; King, DK; Retrum, JH; Helander, K; Wilkins, S; Boggs, JM; Portz, JD; Nearing, K; Gozansky, WS	2017	Lessons learned from community-based participatory research: establishing a partnership to support lesbian, gay, bisexual and transgender ageing in place	Family Practice
		Kim, HJ; Acey, K; Guess, A; Jen, S; Fredriksen-Goldsen, KI	2016	A Collaboration for Health and Wellness: GRIOT Circle and Caring and Aging with Pride	Generations-Journal Of The American Society On Aging

		Sagie, O	2016	Well-Being in Older Gays and Lesbians: A Comparison of Predictors	Social Indicators Research
		Robinson, SR; Ravi, K; Schrag, RJV	2020	A Systematic Review of Barriers to Formal Help Seeking for Adult Survivors of IPV in the United States, 2005-2019	Trauma Violence & Abuse
Web of Science	1.8	Boule, J et al	2020	Duplication	Int J Of Aging & Human Development
		Jurcek, A et al	2020	Duplication	Journal Of Nursing Management
		Putney, JM et al	2020	Duplication	Journal Of Homosexuality
		Willis, P et al	2020	Duplication	Health Expectations
		Pijpers, R	2020	Duplication	Sexualities
		Dune, T et al	2020	Duplication	Int J Of Environmental Research And Public Health
		Holman, EG; Landry-Meyer, L; Fish, JN	2020	Duplication	Journal Of Gerontological Social Work
		Grant, R; Walker, B	2020	Duplication	H & S In The Community
		Lof, J; Olaison, A	2020	Duplication	European Journal Of Social Work
		Lottmann, R	2020	Duplication	Zeitschrift Fur Gerontologie Und Geriatrie
		Higgins, A. et al	2019	Duplication	Nurse Education In Practice
		Willis, P et al	2018	Duplication	H & S In The Community
		Simpson, P; Almack, K; Walthery, P	2018	Duplication	Ageing & Society
		McParland, J; Camic, PM	2018	Duplication	Dementia-Int J Of Social Research And Practice
		Hafford-Letchfield, T et al	2018	Duplication	H & S In The Community
		Fenge, LA; Jones, K; Gibson, C	2018	Duplication	Qualitative Research Journal
		Boggs, JM, et al	2017	Duplication	Journal Of Homosexuality
		McParland, J; Camic, PM	2016	Duplication	Journal Of Clinical Nursing
		Cloyes, KG	2016	Duplication	Research In Gerontological Nursing
		Westwood, S	2016	Duplication	Journal Of Poverty And Social Justice

		Spatenkova, N; Olecka, I	2016	Duplication	Starnuti 2016
		McPhail, R; Fulop, L	2016	Duplication	Australian Health Review
		Jones, SM; Willis, P	2016	Duplication	Quality In Ageing And Older Adults
		Crossland, J	2016	Duplication	Quality In Ageing And Older Adults
		Needham, C; Carr, S	2015	Duplication	Social Policy & Administration
		Manthorpe, J; Moriarty, J	2014	Duplication	H & S In The Community
		Price, E	2012	Duplication	Ageing & Society
		Cronin, A et al	2011	Duplication	International Social Work
		Fenge, LA	2010	Duplication	British Journal Of Social Work
		Concannon, L	2009	Duplication	British Journal Of Social Work
		Westwood, S	2016	'We see it as being heterosexualised, being put into a care home': gender, sexuality and housing/care preferences among older LGB individuals in the UK	H & S In The Community
	*	McCann, E; Sharek, D; Higgins, A; Sheerin, F; Glacken, M	2013	Lesbian, gay, bisexual and transgender older people in Ireland: Mental health issues	Aging & Mental Health
		Radicioni, S; Weicht, B	2018	A place to transform: creating caring spaces by challenging normativity and identity	Gender Place And Culture
		Willis, P	2017	Queer, visible, present: the visibility of older LGB adults in long-term care environments	Housing Care And Support
		Westwood, S	2017	Religion, sexuality, and (in)equality in the lives of older lesbian, gay, and bisexual people in the United Kingdom	Journal Of Religion Spirituality & Aging
		Ettner, R; Wylie, K	2013	Psychological and social adjustment in older transsexual people	Maturitas
		Benbow, SM; Beeston, D	2012	Sexuality, aging, and dementia	International Psychogeriatrics
Web of Science	1.9	Lottmann, R; King, A	2020	Who can I turn to? Social networks and the housing, care and support preferences of older lesbian and gay people in the UK	Sexualities
	*	Siverskog, A; Bromseth, J	2019	Subcultural Spaces: LGBTQ Aging in a Swedish Context	Int J Of Aging & Human Development
		King, A; Stoneman, P	2017	Understanding SAFE Housing - putting older LGBT people's concerns, preferences and experiences of housing in England in a sociological context	Housing Care And Support

		King, A; Cronin, A	2016	Bonds, bridges and ties: applying social capital theory to LGBT people's housing concerns later in life	Quality In Ageing And Older Adults
		Erosheva, EA; Kim, HJ; Emlet, C; Fredriksen-Goldsen, KI	2016	Social Networks of Lesbian, Gay, Bisexual, and Transgender Older Adults	Research On Aging
		Cronin, A; King, A	2014	Only connect? Older lesbian, gay and bisexual (LGB) adults and social capital	Ageing & Society
Web of Science	1.10	Boule, J. et al	2020	Duplication	Int J Of Aging & Human Development
		Jurcek, A. et al	2020	Duplication	Journal Of Nursing Management
		Lottmann, R; King, A	2020	Duplication	Sexualities
		Pijpers, R	2020	Duplication	Sexualities
		Holman, EG; Landry-Meyer, L; Fish, JN	2020	Duplication	Journal Of Gerontological Social Work
		Grant, R; Walker, B	2020	Duplication	H & S In The Community
		Lof, J; Olaison, A	2020	Duplication	European Journal Of Social Work
		Higgins, A et al	2019	Duplication	Nurse Education In Practice
		Waling, A et al	2019	Duplication	H & S In The Community
		Warren, AR; Steffen, AM	2020	Duplication	Journal Of Applied Gerontology
		Willis, P et al	2018	Duplication	H & S In The Community
		Simpson, P; Almack, K; Walthery, P	2018	Duplication	Ageing & Society
		McParland, J; Camic, PM	2018	Duplication	Dementia-Int J Of Social Research And Practice
		Hafford-Letchfield, T et al	2018	Duplication	H & S In The Community
		Wright, LA et al	2017	Duplication	Family Practice
		Proctor, AR; Krusen, NE	2017	Duplication	Journal Of Gay & Lesbian Social Services
		Willis, P	2017	Duplication	Housing Care And Support
		Boggs, JM et al	2017	Duplication	Journal Of Homosexuality

		Westwood, S	2017	Duplication	Journal Of Religion Spirituality & Aging
		McParland, J; Camic, PM	2016	Duplication	Journal Of Clinical Nursing
		Cloyes, KG	2016	Duplication	Research In Gerontological Nursing
		Sagie, O	2016	Duplication	Social Indicators Research
		Westwood, S	2016	Duplication	Journal Of Poverty And Social Justice
		Spatenkova, N; Olecka, I	2016	Duplication	Starnuti 2016
		McPhail, R; Fulop, L	2016	Duplication	Australian Health Review
		Crossland, J	2016	Duplication	Quality In Ageing And Older Adults
		Erosheva, E.A. et al	2016	Duplication	Research On Aging
		Sagie, O	2015	Duplication	Social Indicators Research
		McCann, E. et al	2013	Duplication	Aging & Mental Health
		Price, E	2012	Duplication	Ageing & Society
		Cronin, A. et al	2011	Duplication	International Social Work
		Fenge, LA	2010	Duplication	British Journal Of Social Work
		Concannon, L	2009	Duplication	British Journal Of Social Work
		Perone, AK; Ingersoll-Dayton, B; Watkins-Dukhie, K	2020	Social Isolation Loneliness Among LGBT Older Adults: Lessons Learned from a Pilot Friendly Caller Program	Clinical Social Work Journal
		Gato, J; Leal, D; Moleiro, C; Fernandes, T; Nunes, D; Marinho, I; Pizmony-Levy, O; Freeman, C	2020	The Worst Part Was Coming Back Home and Feeling Like Crying: Experiences of Lesbian, Gay, Bisexual and Trans Students in Portuguese Schools	Frontiers In Psychology
		Goffnett, J; Paceley, MS	2020	Challenges, pride, and connection: A qualitative exploration of advice transgender youth have for other transgender youth	Journal Of Gay & Lesbian Social Services
		Lewis, RJ; Ehlke, SJ; Shappie, AT; Braitman, AL; Heron, KE	2019	Health Disparities Among Exclusively Lesbian, Mostly Lesbian, and Bisexual Young Women	Lgbt Health
		Li, DJ; Chen, SL; Yen, CF	2019	Multi-Dimensional Factors Associated with Illegal Substance Use Among Gay and Bisexual Men in Taiwan	Int J Of Environmental Research And Public Health
		Jones, BE; Ferguson, A	2020	Black and gay: A historical perspective of black gay men	Journal Of Gay & Lesbian Mental Health

		Needham, J	2020	Sending Nudes: Intent and Risk Associated with 'Sexting' as Understood by Gay Adolescent Boys	Sexuality & Culture-An Interdisciplinary Journal
		Wheldon, CW; Roberts, MC; Boehmer, U	2019	Differences in Coping with Breast Cancer Between Lesbian and Heterosexual Women: A Life Course Perspective	Journal Of Womens Health
		Ingraham, N	2019	Perceptions of body size and health among older queer women of size following participation in a health programme	Culture Health & Sexuality
		de Vries, B. et al	2019	End-of-Life Preparations Among LGBT Older Canadian Adults: The Missing Conversations	Int J Of Aging & Human Development
		McCann, E; Brown, M	2019	Homelessness among youth who identify as LGBTQ plus : A systematic review	Journal Of Clinical Nursing
		Price-Feeney, M; Ybarra, ML; Mitchell, KJ	2019	Health Indicators of Lesbian, Gay, Bisexual, and Other Sexual Minority (LGB plus) Youth Living in Rural Communities	Journal Of Pediatrics
		Mountz, S; Capous-Desyllas, M; Perez, N	2019	Speaking Back to the System: Recommendations for Practice and Policy from the Perspectives of Youth Formerly in Foster Care who are LGBTQ	Child Welfare
		Stinchcombe, A. et al	2018	Physical and mental health inequalities among aging lesbian, gay, and bisexual Canadians: cross-sectional results from the Canadian Longitudinal Study on Aging (CLSA)	Canadian Journal Of Public Health-Revue Canadienne De Sante Publique
		McDermott, E; Hughes, E; Rawlings, V	2018	The social determinants of lesbian, gay, bisexual and transgender youth suicidality in England: a mixed methods study	Journal Of Public Health
		Lin, HC. et al	2018	Persistent and multisite homophobic harassment during childhood and adolescence and its association with school difficulties in gay and bisexual men in Taiwan	Archives Of Clinical Psychiatry
		Becerra-Culqui, TA. et al	2018	Mental Health of Transgender and Gender Nonconforming Youth Compared With Their Peers	Pediatrics
		McDermott, E; Hughes, E; Rawlings, V	2018	Norms and normalisation: understanding lesbian, gay, bisexual, transgender and queer youth, suicidality and help-seeking	Culture Health & Sexuality
		Chmielewski, JF	2017	A Listening Guide Analysis of Lesbian and Bisexual Young Women of Color's Experiences of Sexual Objectification	Sex Roles
		Bautista, AD. et al	2017	The Fizzling Effect: A Phenomenological Study on Suicidality Among Filipino Lesbian Women and Gay Men	Psychological Studies
		Bourne, A; Davey, C; Hickson, F; Reid, D; Weatherburn, P	2017	Physical health inequalities among gay and bisexual men in England: a large community-based cross-sectional survey	Journal Of Public Health
		Dessel, AB; Goodman, KD; Woodford, MR	2017	LGBT Discrimination on Campus and Heterosexual Bystanders: Understanding Intentions to Intervene	Journal Of Diversity In Higher Education
		Hoy-Ellis, CP; Fredriksen-Goldsen, KI	2017	Depression Among Transgender Older Adults: General and Minority Stress	American Journal Of Community Psychology
		Ingraham, N; Harbatkin, D; Lorvick, J; Plumb, M; Minnis, AM	2017	Women's Health and Mindfulness (WHAM): A Randomized Intervention Among Older Lesbian/Bisexual Women	Health Promotion Practice

		Sterzing, PR; Ratliff, GA; Gartner, RE; McGeough, BL; Johnson, KC	2017	Social Ecological Correlates of Polyvictimization among a National Sample of Transgender, Genderqueer, and Cisgender Sexual Minority Adolescents	Child Abuse & Neglect
		Hoy-Ellis, CP. et al	2017	Prior Military Service, Identity Stigma, and Mental Health Among Transgender Older Adults	Gerontologist
		Gahagan, J; Colpitts, E	2017	Understanding and Measuring LGBTQ Pathways to Health: A Scoping Review of Strengths-Based Health Promotion Approaches in LGBTQ Health Research	Journal Of Homosexuality
		Westwood, S	2016	Dementia, women and sexuality: How the intersection of ageing, gender and sexuality magnify dementia concerns among lesbian and bisexual women	Dementia-Int J Of Social Research And Practice
		Gonzales, G; Przedworski, J; Henning-Smith, C	2016	Comparison of Health and Health Risk Factors Between Lesbian, Gay, and Bisexual Adults and Heterosexual Adults in the United States Results From the National Health Interview Survey	Jama Internal Medicine
		Adams, MA; Poteat, T	2016	ZAMI NOBLA: Preserving History and Fostering Wellness in Black Lesbians	Generations-Journal Of The American Society On Aging
		Logie, CH et al	2016	Exploring Lived Experiences of Violence and Coping Among Lesbian, Gay, Bisexual and Transgender Youth in Kingston, Jamaica	Int J Of Sexual Health
		Hoy-Ellis, CP; Fredriksen-Goldsen, KI	2016	Lesbian, gay, & bisexual older adults: linking internal minority stressors, chronic health conditions, and depression	Aging & Mental Health
		Leon, SR et al	2016	High prevalence of Chlamydia trachomatis and Neisseria gonorrhoeae infections in anal and pharyngeal sites among a community-based sample of men who have sex with men and transgender women in Lima, Peru	Bmj Open
		Rizer, AM. et al	2015	Challenges in Intervention Research for Lesbian and Bisexual Women	Lgbt Health
		Hardacker, CT; Rubinstein, B; Hotton, A; Houlberg, M	2014	Adding silver to the rainbow: the development of the nurses' health education about LGBT elders (HEALE) cultural competency curriculum	Journal Of Nursing Management
		Grossman, AH et al	2014	Domestic Harm and Neglect Among Lesbian, Gay, and Bisexual Older Adults	Journal Of Homosexuality
		Bird, JDP; Kuhns, L; Garofalo, R	2012	The Impact of Role Models on Health Outcomes for Lesbian, Gay, Bisexual, and Transgender Youth	Journal Of Adolescent Health
		Barth, J; Overby, LM; Huffmon, SH	2009	Community Context, Personal Contact, and Support for an Anti-Gay Rights Referendum	Political Research Quarterly
		Bos, HMW; Van Balen, F	2008	Children in planned lesbian families: Stigmatisation, psychological adjustment and protective factors	Culture Health & Sexuality
		Aaron, DJ; Markovic, N; Danielson, ME; Honnold, JA; Janosky, JE; Schmidt, NJ	2001	Behavioral risk factors for disease and preventive health practices among lesbians	American Journal Of Public Health
		Mankowski, M; Brennan-Ing, M; Seidel, L; Larson, B; Karpiak, S	2019	Aging gay male veterans: a community-based study on their health and psychosocial needs	Social Work In Health Care

		Fish, J; Weis, C	2019	All the lonely people, where do they all belong? An interpretive synthesis of loneliness and social support in older lesbian, gay and bisexual communities	Quality In Ageing And Older Adults
		Pang, C; Gutman, G; de Vries, B	2019	Later Life Care Planning and Concerns of Transgender Older Adults in Canada	Int J Of Aging & Human Development
		Sussman, T. et al	2018	Supporting Lesbian, Gay, Bisexual, & Transgender Inclusivity in Long-Term Care Homes: A Canadian Perspective	Canadian Journal On Aging-Revue Canadienne Du Vieillissement
		Willis, P; Almack, K; Hafford-Letchfield, T; Simpson, P; Billings, B; Mall, N	2018	Turning the Co-Production Corner: Methodological Reflections from an Action Research Project to Promote LGBT Inclusion in Care Homes for Older People	Int J Of Environmental Research And Public Health
		Caceres, BA; Frank, MO	2016	Successful ageing in lesbian, gay and bisexual older people: a concept analysis	Int J Of Older People Nursing
		Simpson, P	2016	The resources of ageing? Middle-aged gay men's accounts of Manchester's gay voluntary organizations	Sociological Review
		Lyons, A	2016	Social Support and the Mental Health of Older Gay Men: Findings From a National Community-Based Survey	Research On Aging
		Eliason, MJ	2015	Doing It For Ourselves: Building Communities for Health Education and Support for Older Lesbian/Bisexual Women	Journal Of Gay & Lesbian Social Services
		Hughes, M	2010	Expectations of later life support among lesbian and gay Queenslanders	Australasian Journal On Ageing
		Brown, MT	2009	LGBT Aging and Rhetorical Silence	Sexuality Research And Social Policy
		Fokkema, T; Kuyper, L	2009	The Relation Between Social Embeddedness and Loneliness among Older Lesbian, Gay, and Bisexual Adults in the Netherlands	Archives Of Sexual Behavior
		Yang, J; Chu, Y; Salmon, MA	2018	Predicting Perceived Isolation Among Midlife and Older LGBT Adults: The Role of Welcoming Aging Service Providers	Gerontologist
		Butler, SS	2018	Older lesbians receiving home care: formal and informal dimensions of caregiving	Journal Of Women & Aging
		McGovern, J; Brown, D; Gasparro, V	2016	Lessons Learned from an LGBTQ Senior Center: A Bronx Tale	Journal Of Gerontological Social Work
					214 results
Proquest	2.1	Grant, Ruby;Walker, Briohny	2020	Duplication	H & S in the Community
		Westwood, S et al	2020	Duplication	Journal of Epidemiology and Community Health
		Perone, A. et al	2020	Duplication	Clinical Social Work Journal

		Higgins, A et al	2019	Duplication	Nurse Education in Practice
		Fish, Julie;Weis, Christina	2019	Duplication	Quality in Ageing and Older Adults
		Waling, A. et al	2019	Duplication	H & S in the Community
		Willis, P. et al	2018	Duplication	H & S in the Community
		Simpson, P. et al	2018	Duplication	Ageing and Society
		Hafford-Letchfield, T. et al	2018	Duplication	H & S in the Community
		Willis, Paul	2017	Duplication	Housing, Care and Support
		McParland, James;Camic, Paul M	2016	Duplication	Journal of Clinical Nursing
		McParland, James;Camic, Paul M	2016	Duplication	Journal of Clinical Nursing
		Crossland, John	2016	Duplication	Quality in Ageing and Older Adults
		Crossland, John	2016	Duplication	Quality in Ageing and Older Adults
		Cloyes, Kristin G	2016	Duplication	Research in Gerontological Nursing
		Green, Marcus	2016	Duplication	Quality in Ageing and Older Adults
		Ross, Paul D S	2016	Duplication	Quality in Ageing and Older Adults
		Westwood, Sue	2016	Duplication	The Journal of Poverty and Social Justice
		Cloyes, Kristin G	2015	Duplication	Research in Gerontological Nursing
		CRONIN, ANN;KING, ANDREW	2014	Duplication	Ageing and Society
		Brennan-Ing, M. et al	2014	Duplication	Journal of Homosexuality
		Brennan-Ing, M. et al	2014	Duplication	Journal of Homosexuality
		McCann, E. et al	2013	Duplication	Aging & Mental Health
		PRICE, ELIZABETH	2012	Duplication	Ageing and Society
		Price, Elizabeth	2012	Duplication	Ageing & Society
		Fenge, Lee-Ann	2010	Duplication	British Journal of Social Work

		Fenge, Lee-Ann	2010	Duplication	The British Journal of Social Work
		Addis, S;Davies, M;Greene, G	2009	Duplication	Health and Social Care in the Community (Print edition)
		Concannon, Liam	2009	Duplication	British Journal of Social Work
		Concannon, Liam	2009	Duplication	The British Journal of Social Work
		Kean, Reb	2006	Duplication	Nursing Older People (through 2013)
		Hawthorne, Oliver;Camic, Paul M;Rimes, Katharine A	2020	Understanding the structure, experiences and challenges of social support for older lesbian, gay and bisexual people: a systematic review	Ageing and Society
		Almack, Kathryn	2020	The experiences of older LGBT+ people in social care settings	Nursing & Residential Care : The Monthly Journal for Care Assistants, Nurses and Managers Working in Health and Social Care
		LEYERZAPF, H;Visse, M;de Beer, A;Abma, T A	2018	Gay-friendly elderly care: creating space for sexual diversity in residential care by challenging the hetero norm	Ageing and Society
		Westwood, Sue;Wathern, Tina	2017	Introduction to "housing, care and support for older lesbians, gay, bisexual and trans* people"	Housing, Care and Support
		King, Andrew	2015	Prepare for Impact? Reflecting on Knowledge Exchange Work to Improve Services for Older LGBT People in Times of Austerity	Social Policy and Society
	*	Alba, B. et al	2020	Health, well-being, and social support in older Australian lesbian and gay care-givers	H & S in the Community
	*	Jones, Rebecca L;Almack, Kathryn;Scicluna, Rachael	2018	Older bisexual people: Implications for social work from the 'Looking Both Ways' study	Journal of Gerontological Social Work
		Wilkens, Jill	2016	The significance of affinity groups and safe spaces for older lesbians and bisexual women: creating support networks and resisting heteronormativity in older age	Quality in Ageing and Older Adults
		WILLIS, P. et al	2016	Swimming upstream: the provision of inclusive care to older lesbian, gay and bisexual (LGB) adults in residential and nursing environments in Wales	Ageing and Society
	*	Fannin, Ann	2006	Gay and grey: lifting the lid on sexuality and ageing	Working With Older People
	*	Langley, Jackie	2001	Developing Anti-Oppressive Empowering Social Work Practice with Older Lesbian Women and Gay Men	British Journal of Social Work
			2019	How healthcare professionals can support older LGBTQ+ people living with dementia	Nursing Older People (2014+)
			2019	Breaking the mould: services that work for older LGBT people: How nurses can support those experiencing memory loss or isolation whose life experience differs so much from others their age	Nursing Standard (2014+)

			2017	Resource pack launched for older LGBT people	Nursing Older People (2014+)
			2004	VOICE FOR OLDER LESBIANS AND GAY MEN	Diva
		Kia, Hannah;Grace, Daniel;Strike, Carol;Ross, Lori E	2019	Across Serostatus: a Study of Subjugation and Resistance in Older Gay Men's Experiences Navigating Health Care	Sexuality Research & Social Policy
		Wathern, Tina;Green, Robert William	2017	Older LGB&amp;T housing in the UK: challenges and solutions	Housing, Care and Support
		Westwood, Sue	2017	Gender and older LGBT* housing discourse: the marginalised voices of older lesbians, gay and bisexual women	Housing, Care and Support
		King, Shawn D;Richardson, Virginia E	2017	Mental Health for Older LGBT Adults	Annual Review of Gerontology & Geriatrics
		McLaren, Suzanne	2016	The relationship between living alone and depressive symptoms among older gay men: the moderating role of sense of belonging with gay friends	International Psychogeriatrics
		Thomas, Ben	2016	Reducing health inequalities for older LGBTQ+ people	Nursing Standard (2014+)
		Cloyes, Kristen G	2016	Seeing Silver in the Spectrum: LGBT Older Adult Health, Aging, and Gerontological Nursing Research	Research in Gerontological Nursing
		Tinney, J. et al	2015	Mental health issues and discrimination among older LGBTI people	International Psychogeriatrics
		Kneale, D. et al	2014	Ageing and lesbian, gay and bisexual relationships	Working With Older People
		Webster, Jonathan	2013	Lesbian, Gay, Bisexual and Transgender Ageing	Nursing Older People (through 2013)
		Bancroft, Arthur	2008	Lack of Care for Older Gay People	Gay Times
		Kean, R	2006	Understanding the lives of older gay people.	Nursing Older People
		Barak, Yoram	2006	Whistling Women. A Study of the Lives of Older Lesbians By CHERYL CLAASSEN	International Psychogeriatrics
		WARD, RICHARD	2005	Gay Men Living with Chronic Illness and Disabilities: From Crisis to Crossroads / Whistling Women: A Study of the Lives of Older Lesbians	Ageing and Society
		Price, Elizabeth	2005	All but invisible: older gay men and lesbians	Nursing Older People (through 2013)
		Daley, A. et al	2017	Providing Health and Social Services to Older LGBT Adults	Annual Review of Gerontology & Geriatrics
Proquest	2.2	Grant, Ruby;Walker, Briohny	2020	Duplication	H & S in the Community
		Westwood, S. et al	2020	Duplication	Journal of Epidemiology and Community Health

		Perone, A. et al	2020	Duplication	Clinical Social Work Journal
		Hawthorne, O. et al	2020	Duplication	Ageing and Society
		Almack, Kathryn	2020	Duplication	Nursing & Residential Care : The Monthly Journal for Care Assistants, Nurses and Managers Working in Health and Social Care
		Alba, B. et al	2020	Duplication	H & S in the Community
		Higgins, A et al	2019	Duplication	Nurse Education in Practice
		Fish, Julie;Weis, Christina	2019	Duplication	Quality in Ageing and Older Adults
		Waling, A et al	2019	Duplication	H & S in the Community
		Kia, H. et al	2019	Duplication	Sexuality Research & Social Policy
		Willis, P. et al	2018	Duplication	H & S in the Community
		Simpson, P. et al	2018	Duplication	Ageing and Society
		Jones, R. et al	2018	Duplication	Journal of Gerontological Social Work
		Hafford-Letchfield, T. et al	2018	Duplication	H & S in the Community
		LEYERZAPF, H et al	2018	Duplication	Ageing and Society
		Wathern, Tina;Green, Robert William	2017	Duplication	Housing, Care and Support
		Willis, Paul	2017	Duplication	Housing, Care and Support
		Westwood, Sue;Wathern, Tina	2017	Duplication	Housing, Care and Support
		Westwood, Sue	2017	Duplication	Housing, Care and Support
		Daley, A. et al	2017	Duplication	Annual Review of Gerontology & Geriatrics
		King, Shawn D;Richardson, Virginia E	2017	Duplication	Annual Review of Gerontology & Geriatrics
		McParland, James;Camic, Paul M	2016	Duplication	Journal of Clinical Nursing
		McParland, James;Camic, Paul M	2016	Duplication	Journal of Clinical Nursing
		McLaren, Suzanne	2016	Duplication	International Psychogeriatrics

		Thomas, Ben	2016	Duplication	Nursing Standard (2014+)
		Crossland, John	2016	Duplication	Quality in Ageing and Older Adults
		Crossland, John	2016	Duplication	Quality in Ageing and Older Adults
		Cloyes, Kristin G	2016	Duplication	Research in Gerontological Nursing
		Cloyes, Kristen G	2016	Duplication	Research in Gerontological Nursing
		Wilkens, Jill	2016	Duplication	Quality in Ageing and Older Adults
		Green, Marcus	2016	Duplication	Quality in Ageing and Older Adults
		Ross, Paul D S	2016	Duplication	Quality in Ageing and Older Adults
		Westwood, Sue	2016	Duplication	The Journal of Poverty and Social Justice
		WILLIS, P. et al	2016	Duplication	Ageing and Society
		Cloyes, Kristin G	2015	Duplication	Research in Gerontological Nursing
		Tinney, J. et al	2015	Duplication	International Psychogeriatrics
		King, Andrew	2015	Duplication	Social Policy and Society
		Kneale, D. et al	2014	Duplication	Working With Older People
		CRONIN, ANN;KING, ANDREW	2014	Duplication	Ageing and Society
		Brennan-Ing, M. et al	2014	Duplication	Journal of Homosexuality
		Brennan-Ing, M. et al	2014	Duplication	Journal of Homosexuality
		Webster, Jonathan	2013	Duplication	Nursing Older People (through 2013)
		McCann, E. et al	2013	Duplication	Aging & Mental Health
		PRICE, ELIZABETH	2012	Duplication	Ageing and Society
		Price, Elizabeth	2012	Duplication	Ageing & Society
		Fenge, Lee-Ann	2010	Duplication	British Journal of Social Work
		Fenge, Lee-Ann	2010	Duplication	The British Journal of Social Work

		Addis, S;Davies, M;Greene, G	2009	Duplication	Health and Social Care in the Community (Print edition)
		Concannon, Liam	2009	Duplication	British Journal of Social Work
		Concannon, Liam	2009	Duplication	The British Journal of Social Work
		Bancroft, Arthur	2008	Duplication	Gay Times
		Fannin, Ann	2006	Duplication	Working With Older People
		Kean, R	2006	Duplication	Nursing Older People
		Kean, Reb	2006	Duplication	Nursing Older People (through 2013)
		Barak, Yoram	2006	Duplication	International Psychogeriatrics
		WARD, RICHARD	2005	Duplication	Ageing and Society
		Price, Elizabeth	2005	Duplication	Nursing Older People (through 2013)
		Langley, Jackie	2001	Duplication	British Journal of Social Work
			2019	How healthcare professionals can support older LGBTQ+ people living with dementia	Nursing Older People (2014+)
			2019	Breaking the mould: services that work for older LGBT people: How nurses can support those experiencing memory loss or isolation whose life experience differs so much from others their age	Nursing Standard (2014+)
			2017	Resource pack launched for older LGBT people	Nursing Older People (2014+)
			2004	VOICE FOR OLDER LESBIANS AND GAY MEN	Diva
ASSIA	2.3				
		Byrne, Peter;James, Adrian	2020	Placing poverty-inequality at the centre of psychiatry	BJPsych Bulletin
		Manthorpe, Jill;Samsi, Kritika	2020	Not forgetting gender: women and dementia	Working With Older People
		Waters, Jo	2020	PUSHED TO THE BRINK: THE JOURNAL OF THE HEALTH VISITORS' ASSOCIATION	Community Practitioner
		Willis, Paul;Vickery, Alex;Symonds, Jon	2020	“You have got to get off your backside; otherwise, you’ll never get out”: older male carers’ experiences of loneliness and social isolation	Int J of Care and Caring
		Hodgkin, Suzanne;Savy, Pauline;Clune, Samantha;Mahoney, Anne-Marie	2020	Navigating the marketisation of community aged care services in rural Australia	Int J of Care and Caring

		Silverman, Marjorie;Brotman, Shari;Molgat, Marc;Gagnon, Elizabeth	2020	“I’ve always been the one who drops everything”: the lived experiences and life-course impacts of young adult women carers	Int J of Care and Caring
		Woodall, James	2020	Health promotion co-existing in a high-security prison context: a documentary analysis	Int J of Prisoner Health
		Torres Stone R.. et al	2020	A Community Mental Health Needs Assessment of a Racially and Ethnically Diverse Population in New England: Narratives from Community Stakeholders	Community Mental Health Journal
		Herges, Katja	2020	Writing autohistoria-teoría: agency and illness in German life narratives by Evelyne Leandro and Mely Kiyak	Medical Humanities
		Coope, J. et al	2020	Resilience, mental health and urban migrants: a narrative review	Int J of Migration, Health, and Social Care
		Jones, Nev;Teague, Gregory B;Wolf, Jessica;Rosen, Cherise	2020	Organizational Climate and Support Among Peer Specialists Working in Peer-Run, Hybrid and Conventional Mental Health Settings	Administration and Policy in Mental Health and Mental Health Services Research
		Villar, F. et al	2019	Sexual Situations in Spanish Long-Term Care Facilities: Which Ones Cause the Most Discomfort to Staff?	Sexuality Research & Social Policy
		Scott, Anna	2019	WHAT DO YOU SEE?: THE JOURNAL OF THE HEALTH VISITORS' ASSOCIATION	Community Practitioner
		Baiocco, R. et al	2019	The Contributions of Self-Esteem, Loneliness, and Friendship to Children’s Happiness: The Roles of Gender and Age	Child Indicators Research
		Kerman, N. et al	2019	Perceptions of Service Use Among Currently and Formerly Homeless Adults with Mental Health Problems	Community Mental Health Journal
		Fox, Marie;Mo, Ray	2019	No pets allowed? Companion animals, older people and residential care	Medical Humanities
		Éidín Ní S. et al	2019	Clarifying the mechanisms and resources that enable the reciprocal involvement of seldom heard groups in health and social care research: A collaborative rapid realist review process	Health Expectations
		Meddings, S. et al	2019	To what extent does Sussex Recovery College reflect its community? An equalities and diversity audit	Mental Health and Social Inclusion
		Gillespie, Brian Joseph;Treas, Judith	2019	Perceived reliability of assistance among American older adults: a study of kin and non-kin help	Int J of Care and Caring
		Keating, N. et al	2019	Life course trajectories of family care	Int J of Care and Caring
		Moore, Steve	2019	The relativity of theory: applying theories of social psychology to illuminate the causes of the abuse of older people in care homes	The Journal of Adult Protection
		Moore, Steve	2019	Sharpening Occam’s razor: developing theory to explain the persistent abuse of older people living in care homes	Working With Older People
		Katz, Ruth;Lowenstein, Ariela	2019	Editorial introduction: Cross-cultural contexts of eldercare and caring: theory, research and policy. Guest edited by Ruth Katz and Ariela Lowenstein	Int J of Care and Caring

		Manthorpe, Jill;Martineau, Stephen	2019	Mental health law under review: messages from English safeguarding adults reviews	The Journal of Adult Protection
		Peacock, S. et al	2019	Older persons with dementia in prison: an integrative review	Int J of Prisoner Health
		Buccieri, K. et al	2019	Hospital discharge planning for Canadians experiencing homelessness	Housing, Care and Support
		Wright, Toni;Stephen O'Connor	2018	Reviewing challenges and gaps in European and global dementia policy	Journal of Public Mental Health
		Nygren, Lennart;White, Sue;Ellingsen, Ingunn T	2018	Investigating Welfare Regime Typologies: Paradoxes, Pitfalls and Potentialities in Comparative Social Work Research	Social Policy and Society
		Brannelly, Tula	2018	An ethics of care research manifesto	Int J of Care and Caring
		Saletti-Cuesta, Lorena;Aizenberg, Lila;Ricci-Cabello, Ignacio	2018	Opinions and Experiences of Primary Healthcare Providers Regarding Violence against Women: a Systematic Review of Qualitative Studies	Journal of Family Violence
		Preston-Shoot, Michael	2018	Learning from safeguarding adult reviews on self-neglect: addressing the challenge of change	The Journal of Adult Protection
		Brown, L. et al	2018	Openness, inclusion and transparency in the practice of public involvement in research: A reflective exercise to develop best practice recommendations	Health Expectations
		Buckner, Stefanie;Mattocks, Calum;Rimmer, Melanie;Lafortune, Louise	2018	An evaluation tool for Age-Friendly and Dementia Friendly Communities	Working With Older People
		Rutherford, M. et al	2018	Implementation of a Practice Development Model to Reduce the Wait for Autism Spectrum Diagnosis in Adults	Journal of Autism and Developmental Disorders
		Curry, Susanna R;Petering, Robin	2017	Resident Perspectives on Life in a Transitional Living Program for Homeless Young Adults: C & A	Child & Adolescent Social Work Journal
		Chachula, D. et al	2017	Layers of difference: a cancer center's approach to minimizing cancer health disparity	Int J of Human Rights in Healthcare
		Williams, John	2017	Adult safeguarding in Wales: one step in the right direction	The Journal of Adult Protection
		Li Ming Wen;Rissel, Chris;Cheng, Yan;Richters, Juliet;de Visser, Richard O	2017	Tobacco smoking and sexual difficulties among Australian adults: a cross-sectional study	Sexual Health (Online)
		Singh, Shipra;Schulz, Amy Jo;Neighbors, Harold W;Griffith, Derek M	2017	Interactive Effect of Immigration-Related Factors with Legal and Discrimination Acculturative Stress in Predicting Depression Among Asian American Immigrants	Community Mental Health Journal
		Hassiotis, A;Noor, M;Bebbington, P;Afia, A;Wieland, J;Qassem, T	2017	Borderline intellectual functioning and psychosis: Adult Psychiatric Morbidity Survey evidence	The British Journal of Psychiatry
		Kitchener, Martin;McDermott, Aoife M;Cooper, Simon	2017	Critical healthcare management studies: green shoots	Journal of Health Organization and Management
		Clough, Beverley	2017	Disability and Vulnerability: Challenging the Capacity/Incapacity Binary	Social Policy and Society

		Manthorpe, Jill;Moriarty, Jo	2017	Falls prevention: access and acceptability to all?	Working With Older People
		Moen, Phyllis;DePasquale, Nicole	2017	Family care work: a policy-relevant research agenda	Int J of Care and Caring
		Pritchard-jones, Laura	2017	Ageism and Autonomy in Health Care: Explorations Through a Relational Lens	Health Care Analysis : HCA
		Yoeli, Heather;Lonbay, Sarah P;Morey, Sarah;Pizycki, Lara	2016	Safeguarding adults: from realism to ritual	The Journal of Adult Protection
		Sweeney, Angela;Clement, Sarah;Filson, Beth;Kennedy, Angela	2016	Trauma-informed mental healthcare in the UK: what is it and how can we further its development?	The Mental Health Review
		Manthorpe, Jill;Harris, Jess;Mauger, Sam	2016	Older people's forums in the United Kingdom: civic engagement and activism reviewed	Working With Older People
		Young, T L et al	2016	Assessing the Helpfulness of One Parenting Assistance Helpline	Journal of Child and Family Studies
		de Macedo Bernardino, Í. Et al	2016	Profile of Men Who Are Victims of Physical Violence by an Intimate Partner	Journal of Family Violence
		Kneale, Dylan	2016	Connected communities? LGB older people and their risk of exclusion from decent housing and neighbourhoods	Quality in Ageing and Older Adults
		Villar, Feliciano;Serrat, Rodrigo;Celdrán, Montserrat;Fabà, Josep	2016	Attitudes Toward Masturbation Among Residents of Spanish Residential Aged Care Facilities	Sexuality Research & Social Policy
		Roberts, Jillian;Donkin, Angela;Marmot, Michael	2016	Opportunities for reducing socioeconomic inequalities in the mental health of children and young people – reducing adversity and increasing resilience	Journal of Public Mental Health
		Hafford-Letchfield, Trish;Lavender, Peter	2015	Quality improvement through the paradigm of learning	Quality in Ageing and Older Adults
		Godwin, Christopher;Mackay, Kathryn	2015	Neglecting justice? Exploring Scottish convictions for ill-treatment and wilful neglect	The Journal of Adult Protection
		Luke, Melissa;Goodrich, Kristopher M	2015	Working with Family, Friends, and Allies of LBGT Youth	Journal for Social Action in Counseling and Psychology
		Cooper, Adi;Lawson, Jane;Lewis, Sue;Williams, Cathie	2015	Making safeguarding personal: learning and messages from the 2013/14 programme	The Journal of Adult Protection
		Gregor, Claire;Hingley-jones, Helen;Davidson, Sarah	2015	Understanding the Experience of Parents of Pre-pubescent Children with Gender Identity Issues: C & A	Child & Adolescent Social Work Journal
		Bartik, W. et al	2015	Collaborative research for rural mental health makes minds matter	Advances in Mental Health
		Perkins, R. et al	2015	Real lives: promoting recovery through personalisation and peer support	Mental Health and Social Inclusion
		Vahabi, Mandana;Isaacs, Sandra;Koc, Mustafa;Damba, Cynthia	2015	Challenges in recruiting hard-to-reach populations focusing on Latin American recent immigrants	Int J of Human Rights in Healthcare
		Ford, Steve	2014	The Nursing Year 2014: NT	Nursing Times

		O'Driscoll, W. et al	2014	Patient experience of MDT care and decision-making	The Mental Health Review
		Andrew Landman, Roderick	2014	"A counterfeit friendship": mate crime and people with learning disabilities	The Journal of Adult Protection
		Tinker, A et al	2014	Why is it important to consider so-called "invisible" older people in UK healthcare?	Quality in Ageing and Older Adults
		Joly, Louise;Cornes, Michelle;Manthorpe, Jill	2014	Supporting the social networks of homeless people	Housing, Care and Support
		Teasdale, Gail	2014	Achieving success in reducing teenage pregnancy in Hull	Perspectives in Public Health
		Collier, Elizabeth;Foster, Celeste	2014	Teaching age and discrimination: A life course perspective	Nurse Education in Practice
		Byrkjeflot, Haldor;Kragh Jespersen, Peter	2014	Three conceptualizations of hybrid management in hospitals	The Int J of Public Sector Management
		Clery, Elizabeth;Tsang, Tiffany;Vizard, Polly	2014	The Children’s Measurement Framework: A new Indicator-Based Tool for Monitoring Children’s Equality and Human Rights	Child Indicators Research
		Cameron, Ailsa;Bostock, Lisa;Lart, Rachel	2014	Service user and carers perspectives of joint and integrated working between health and social care: Managing Community Care	Journal of Integrated Care
		George, P et al	2014	Reproductive health behaviour of Muslim immigrant women in Canada	Int J of Migration, Health, and Social Care
		Harvey, M E;Athi, R, M;Denny, E.	2014	Exploratory study on meeting the health and social care needs of mothers with twins: The Journal of the Health Visitors' Association	Community Practitioner
		Kidd, Sean;McKenzie, Kwame	2014	Social entrepreneurship and services for marginalized groups	Ethnicity and Inequalities in Health and Social Care
		Meddings, Sara;Byrne, Diana;Barnicoat, Su;Campbell, Emogen;Locks, Lucy	2014	Co-delivered and co-produced: creating a recovery college in partnership	The Journal of Mental Health Training, Education, and Practice
		Powell, Martin;Johns, Nick;Green, Alison	2013	Equal Opportunities and Diversity: Exploring the Relevance of Le Grand's Models of Service Provision	Social Policy and Society
		Mizrahi, Terry;Dodd, Sarah-Jane	2013	MSW Students' Perspectives on Social Work Goals and Social Activism Before and After Completing Graduate Education	Journal of Social Work Education
		Faulkner, Alison	2012	The right to take risks	The Journal of Adult Protection
		Henry, Claire	2012	"Ensure you meet the end-of-life needs of LGBT people": NT	Nursing Times
		Davie, Grace	2012	A European Perspective on Religion and Welfare: Contrasts and Commonalities	Social Policy and Society
		Minghella, Edana;Schneider, Kate	2012	Rethinking a framework for dementia 1: a journey	Working With Older People
		Willing, Indigo;Fronek, Patricia;Cuthbert, Denise	2012	Review of Sociological Literature on Intercountry Adoption	Social Policy and Society

		Mereish, Ethan H	2012	The intersectional invisibility of race and disability status: an exploratory study of health and discrimination facing Asian Americans with disabilities	Ethnicity and Inequalities in Health and Social Care
		Begley, Emer;O'Brien, Marita;Janet Carter Anand;Campbell Killick;Taylor, Brian	2012	Older people's views of support services in response to elder abuse in communities across Ireland	Quality in Ageing and Older Adults
		Gray, Ann Marie;Birrell, Derek	2012	Coalition Government in Northern Ireland: Social Policy and the Lowest Common Denominator Thesis	Social Policy and Society
		Scott, Daniel	2012	ESCAPING PURITY: LESSONS FOR CHILD AND YOUTH CARE FROM RELIGION	Int J of Child, Youth & Family Studies
		Williamson, Toby	2011	Grouchy Old Men? Promoting older men's mental health and emotional well being	Working With Older People
		Ward, Lizzie;Barnes, Marian;Gahagan, Beatrice	2011	Alcohol use in later life - older people's perspectives	Quality in Ageing and Older Adults
		Chambers, Stephanie A;Traill, W Bruce	2011	What the UK public believes causes obesity, and what they want to do about it: A cross-sectional study	Journal of Public Health Policy
		BROWNE, KATH;BAKSHI, LEELA;LIM, JASON	2011	'It's Something You Just Have to Ignore': Understanding and Addressing Contemporary Lesbian, Gay, Bisexual and Trans Safety Beyond Hate Crime Paradigms	Journal of Social Policy
		Clark, Suzannah;Jackson, Leila	2011	The Wellbeing Project: improving the psychological wellbeing of older adults	Working With Older People
		Gilbert, Peter;Parkes, Madeleine	2011	Faith in one city: exploring religion, spirituality and mental wellbeing in urban UK	Ethnicity and Inequalities in Health and Social Care
		Clarke, Liam	2010	An examination of the mental health of Irish migrants to England using a concept of Diaspora	Advances in Mental Health
		Battams, Samantha;Henderson, Julie	2010	The physical health of people with mental illness and 'the right to health'	Advances in Mental Health
		Samuel, Mithran	2010	Allowing user-led groups to flourish	Community Care
		Dawson, Alison	2010	Some Useful Sources on Harm, Abuse, Agency and Resilience Across the Lifespan	Social Policy and Society
		McGregor, Kirsty	2010	Social worker struck off for homophobic abuse	Community Care
		Ahmed, Maria	2009	Should I pray or should I go?	Community Care
		Cocker, Christine	2009	Costs and Consequences of Placing Children in Care, Harriet Ward, Lisa Holmes and Jean Soper, London, Jessica Kingsley, 2008, pp. 288,	British Journal of Social Work
		Johnston, Cynthia;Mohide, E. Ann	2009	Addressing diversity in clinical nursing education: Support for preceptors	Nurse Education in Practice
		Carpenter, Mick	2009	A Third Wave, Not a Third Way? New Labour, Human Rights and Mental Health in Historical Context	Social Policy and Society

		Trotter, Joy	2009	Editorial	British Journal of Social Work
		Gulland, Anne	2009	Wanted: one gay care worker	Community Care
		McDonald, Ruth;Checkland, Kath;Harrison, Steve	2009	The new GP contract in English primary health care: an ethnographic study	The Int J of Public Sector Management
		Gupta, Anna	2008	The effect of violence on children's lives	Community Care
		Cornes, Michelle;Peardon, John;Manthorpe, Jill	2008	Wise owls and professors: the role of older researchers in the review of the National Service Framework for Older People	Health Expectations
		Hussein, Shereen;Moriarty, Jo;Manthorpe, Jill;Huxley, Peter	2008	Diversity and Progression among Students Starting Social Work Qualifying Programmes in England between 1995 and 1998: A Quantitative Study	British Journal of Social Work
		Taylor, Amy	2008	Where are the same-sex adopters?	Community Care
		Christopherson, Jim	2008	Direct Work: Social Work with children and young people in care Barry Luckock and Michelle Lefevre (eds.),	British Journal of Social Work
		Vatnar, Solveig Karin; Bø;Bjørkly, Stål	2008	An Interactional Perspective of Intimate Partner Violence: An In-depth Semi-structured Interview of a Representative Sample of Help-seeking Women	Journal of Family Violence
		Allan, Ruth	2008	Racism and Racial Identity: Reflections on Urban Practice in Mental Health and Social Services, Lisa V. Blitz and Mary Pender Greene (eds), Binghamton, Haworth Press, 2006, pp. xv + 279, ISBN 7890-3109-4, US$36.00	British Journal of Social Work
		Leung	2008	Accountability to Welfare Service Users: Challenges and Responses of Service Providers	British Journal of Social Work
		Seddon, D. et al	2007	In their Own Right: Translating the Policy of Carer Assessment into Practice	British Journal of Social Work
		Madoc-Jones, Iolo;Bates, John;Facer, Barbara;Roscoe, Karen	2007	Students with Criminal Convictions: Policies and Practices in Social Work Education	British Journal of Social Work
		Wilson, Kate	2007	In Search of Belonging: Reflections by Transracially Adopted People, Perlita Harris (ed.)	British Journal of Social Work
		Anabel Unity Sale	2007	Secrets in the care sector	Community Care
		Strier, Roni	2007	Anti-Oppressive Research in Social Work: A Preliminary Definition	British Journal of Social Work
		Gillen, Sally;Anabel Unity Sale	2007	Too close and personal	Community Care
		Scourfield, Jonathan	2007	Social Work Practice and Men Who Have Sex with Men, Sherry Joseph,	British Journal of Social Work
		Gault, Alistair;Pugh, Stephen	2007	Lesbian, Gay, Bisexual and Transgender Aging: Research and Clinical Perspectives	Age and Ageing

		McMurdo, Marion E T	2007	The Futures of Old Age	Age and Ageing
		Lloyd, Paul	2007	The Psychology of Ageing: An Introduction, Ian Stuart-Hamilton, London, Jessica Kingsley Publishers,	British Journal of Social Work
		Slater, Phil	2007	Vulnerable Adults and Community Care, Keith Brown (ed.), Exeter, Learning Matters, 2006,	British Journal of Social Work
		Foster, Keith	2007	National Suicide Prevention Strategy for England	The Mental Health Review
		Scourfield, Peter	2007	Social Care and the Modern Citizen: Client, Consumer, Service User, Manager and Entrepreneur	British Journal of Social Work
		Handsley, Stephen	2006	Promoting public health: part 2	Nursing Management (through 2013)
		Blyth, Eric;Masson, Helen	2006	Editorial	British Journal of Social Work
		Johns, Nick;Jordan, Bill	2006	Social Work, Merit and Ethnic Diversity	British Journal of Social Work
		Sellick, Clive	2006	Opportunities and Risks: Models of Good Practice in Commissioning Foster-Care	British Journal of Social Work
		Trotter, Joy;Hafford-Letchfield, Trish	2006	LET'S TALK ABOUT SEXUALITY	Community Care
		Schuller, Nina	2006	Older people, crime and justice	Community Safety Journal
		Richards, Sally	2006	Group Work and Aging: Issues in Practice, Research and Education,Robert Salmon and Roberta Graziano (eds)	British Journal of Social Work
		MacFarlane, Neil	2006	Images of Idiocy: The Idiot Figure in Modern Fiction and Film	Journal of Intellectual Disability Research
		Valios, Natalie	2006	MATCHMAKERS	Community Care
		Schuller, Nina	2006	Implementing Section 17 of the Crime and Disorder Act: [1]	Community Safety Journal
		Featherstone, Brid	2006	Rethinking Family Support in the Current Policy Context	British Journal of Social Work
		Whittle, Stephen	2005	BORN IDENTITY	Community Care
		Anabel Unity Sale	2005	SERVICE WITH STIGMA?	Community Care
		Beresford, Peter	2005	The Changing Role of Professor: Including Everyone's Knowledge and Experience	The Mental Health Review
		Sakamoto, Izumi	2005	Use of Critical Consciousness in Anti-Oppressive Social Work Practice: Disentangling Power Dynamics at Personal and Structural Levels	British Journal of Social Work
		Hafford-Letchfield, Trish	2005	ON THE UP	Community Care

		Knight, Victoria;Goodman, Hannah	2005	Personal safety provisions, services and training for service providers and users in Leicester city	Community Safety Journal
		Garrett, Paul Michael	2004	LOST IN THE CROWD	Community Care
		Jeary, Katharine	2004	Sexual abuse of elderly people: would we rather not know the details?	The Journal of Adult Protection
		Perry, Joanna	2004	Hate crime against people with learning difficulties: the role of the Crime and Disorder Act and No Secrets in identification and prevention	The Journal of Adult Protection
		Lim, Jennifer N W	2003	Quality in Health Care: Strategic Issues in Health Care Management	Journal of Health Organization and Management
		Manthorpe, J;Price, E	2003	Out of the shadows	Family Journal
		Whittock, Margaret;Leonard, Laurence	2003	Stepping outside the stereotype. A pilot study of the motivations and experiences of males in the nursing profession	Journal of Nursing Management
		Myers, Jane E	2003	Coping with caregiving stress: A wellness-oriented, strenghts-based approach for family counselors	Family Journal
		Dwan, Kathryn;Boyce, Rosalie A	2003	Competition policy and intra-professional conflict: Re-regulating general practice	The Int J of Public Sector Management
		Miers, Margaret	2002	Developing an understanding of gender sensitive care: Exploring concepts and knowledge	Journal of Advanced Nursing
		Pinkerton, John;Campbell, Jim	2002	Social Work and Social Justice in Northern Ireland: Towards a New Occupational Space	British Journal of Social Work
		Thompson, Neil	2002	Social Movements, Social Justice and Social Work	British Journal of Social Work
		Beverley Prevatt Goldstein	2002	Catch 22--Black Workers' Role in Equal Opportunities for Black Service Users	British Journal of Social Work
		King, Michael;Coxell Adrian;Mezey, Gillian	2002	Sexual molestation of males: Associations with psychological disturbance	The British Journal of Psychiatry
		Oliver, Chris;Aggleton, Peter	2002	Mentoring for professional development in health promotion: A review of issues raised by recent research	Health Education
		Bagley, Christopher;Mallick, Kanka	2000	Prediction of sexual, emotional, and physical maltreatment and mental health outcomes in a longitudinal cohort of 290 adolescent women	Child Maltreatment
		Bowpitt, G	2000	Working with creative creatures: towards a Christian paradigm for social work theory, with some practical implications	British Journal of Social Work
		Popple, K	2000	Critical commentary. Community work	British Journal of Social Work
		Barker, Liz	2000	Theoretical papers: Effective leadership within hospice and Specialist Palliative Care Units	Journal of Management in Medicine

		McNeish, Diana	1999	Promoting participation for children and young people: Some key questions for health and social welfare organisations	Journal of Social Work Practice
		law, Elizabeth	1998	Women's health in Manchester	Nursing Management (through 2013)
		Hayden, Virginia	1993	How to increase market orientation	Journal of Management in Medicine
			2020	Diversity training evaluation for community aged care: Tool development	Nurse Education in Practice
			2020	Using Benner's model of clinical competency to promote nursing leadership	Nursing Management (2014+)
		Anonymous	2020	YOUNG PEOPLE ARE SAVING THE WORLD: THE JOURNAL OF THE HEALTH VISITORS' ASSOCIATION	Community Practitioner
		Anonymous	2012	Diary	Nursing Management (through 2013)
		Anonymous	2010	NEWS IN BRIEF	Community Care
		Anonymous	2009	Books Received	British Journal of Social Work
		Anonymous	2009	NEWS IN BRIEF	Community Care
		Anonymous	2009	NEWS IN BRIEF	Community Care
		Anonymous	2008	NEWS IN BRIEF	Community Care
		Anonymous	2008	word on the web	Community Care
		Anonymous	2008	CC LIVE IN QUOTES	Community Care
		Anonymous	2008	READERS' VIEWS	Community Care
		Anonymous	2008	Books Received	British Journal of Social Work
		Anonymous	2008	NEWS IN BRIEF	Community Care
		Anonymous	2007	word on the web	Community Care
		Anonymous	2007	word on the web	Community Care
		Anonymous	2007	Assessing the suitability of new adoptive parents	Community Care
		Anonymous	2007	NEWS IN BRIEF	Community Care
		Anonymous	2007	LETTERS	Community Care

		Anonymous	2006	NEWS IN BRIEF	Community Care
		Anonymous	2005	LETTERS	Community Care
		Anonymous	2005	Institute must work with range of users	Community Care
		Anonymous	2004	NEWS IN BRIEF	Community Care
		Anonymous	2004	NEWS IN BRIEF	Community Care
		Anonymous	2004	NEWS IN BRIEF	Community Care
		Various	2000	Book reviews	British Journal of Social Work
		Various	1999	Book reviews	British Journal of Social Work
		Wilson, Kimberley;Stinchcombe, Arne;Ismail, Mariam;Kortes-Miller, Katherine	2019	LGBTQ2+ aging in Canada: Building the evidence and informing action	The Canadian Journal of Human Sexuality
		Moriarty, Jo;Manthorpe, Jill	2017	The diversity of befriending by, and of, older people	Working With Older People
		Mikelyte, Rasa;Milne, Alisoun	2016	The role and influence of micro-cultures in long-term care on the mental health and wellbeing of older people: a scoping review of evidence	Quality in Ageing and Older Adults
		Moriarty, Jo;Manthorpe, Jill	2013	Handyperson schemes and the Equality Act 2010	Housing, Care and Support
		Brennan-Ing, Mark;Seidel, Liz;Larson, Britta;Karpiak, Stephen E	2013	'I'm Created in God's Image, and God Don't Create Junk': Religious Participation and Support Among Older GLBT Adults	Journal of Religion, Spirituality & Aging
		Grant, Ruby;Walker, Briohny	2020	Duplication	H & S in the Community
		Alba, B. et al	2020	Duplication	H & S in the Community
		LeBrón A M W. et al	2019	Duplication	Health Education and Behavior
		Waling, A. et al	2019	Duplication	H & S in the Community
		Willis, P. et al	2018	Duplication	H & S in the Community
		Laura J.E. Brown et al	2018	Duplication	Health Expectations
		Jones, R et al	2018	Duplication	Journal of Gerontological Social Work
		Hafford-Letchfield, T. et al	2018	Duplication	H & S in the Community
		Wathern, Tina;Green, Robert William	2017	Duplication	Housing, Care and Support

		Westwood, Sue;Wathern, Tina	2017	Duplication	Housing, Care and Support
		Westwood, Sue	2017	Duplication	Housing, Care and Support
		Westwood, Sue	2016	Duplication	H & S in the Community
		Wilkens, Jill	2016	Duplication	Quality in Ageing and Older Adults
		Joly, L. et al	2014	Duplication	Housing, Care and Support
		Kneale, D et al	2014	Duplication	Working With Older People
		Manthorpe, Jill;Moriarty, Jo	2014	Duplication	H & S in the Community
		Manthorpe, Jill;Moriarty, Jo	2014	Duplication	H & S in the Community
		Brennan-Ing, M. et al	2014	Duplication	Journal of Homosexuality
		McCann, E. et al	2013	Duplication	Aging & Mental Health
		Ward, L;Barnes, M;Gahagan, B	2011	Duplication	Quality in Ageing and Older Adults
		Fenge, Lee-Ann	2010	Duplication	British Journal of Social Work
		Fenge, Lee-Ann	2010	Duplication	The British Journal of Social Work
		Concannon, Liam	2009	Duplication	The British Journal of Social Work
		Fannin, Ann	2006	Duplication	Working With Older People
		Lavin, Nichola	2004	Duplication	Community Care
		Manthorpe, J;Price, E	2003	Duplication	Community Care
		Barker, Liz	2000	Duplication	Journal of Management in Medicine
		Lavin, Nichola	2004	Long-time companions	Community Care
		Boule et al	2020	"We live in a Wonderful Country, Canada, but horizontal ellipsis": Perspectives from Older LGBTQ Ontarians on visibility, connection and power in community	Journal of Ageing & Human Development
		Alba et al	2021	Older lesbian and gay adults perceptions of barriers and facilitators to accessing health and aged care services in Australia	H & S in the Community
ASSIA	2.4	Silverman, M. et al	2020	Duplication	Int J of Care and Caring

		Coope, J. et al	2020	Duplication	Inter J of Migration, Health, and Social Care
		Keating, N. et al	2019	Duplication	Int J of Care and Caring
		Wathern, Tina;Green, Robert William	2017	Duplication	Housing, Care and Support
		Westwood, Sue;Wathern, Tina	2017	Duplication	Housing, Care and Support
		Manthorpe, J;Harris, Jess;Mauger, S	2016	Duplication	Working With Older People
		Kneale, Dylan	2016	Duplication	Quality in Ageing and Older Adults
		Bartik, Warren;Barton, Rebecca	2015	Duplication	Advances in Mental Health
		Joly, L;Cornes, M;Manthorpe, J	2014	Duplication	Housing, Care and Support
		Joly, L;Cornes, M;Manthorpe, J	2014	Duplication	Housing, Care and Support
		Kidd, Sean;McKenzie, Kwame	2014	Duplication	Ethnicity and Inequalities in Health and Social Care
		Moriarty, Jo;Manthorpe, Jill	2013	Duplication	Housing, Care and Support
		Gilbert, Peter;Parkes, Madeleine	2011	Duplication	Ethnicity and Inequalities in Health and Social Care
		Samuel, Mithran	2010	Duplication	Community Care
		Johns, Nick;Jordan, Bill	2006	Duplication	British Journal of Social Work
		Schuller, Nina	2006	Duplication	Community Safety Journal
ASSIA	2.5	Bos Henny et al	2020	Meaning in Life as a Moderator between Homophobic Stigmatization and Coping Styles in Adult Offspring from Planned Lesbian-Parent Families	Sexuality Research & Social Policy
		O’Flynn Peta;White, Fiona A	2020	Harnessing Social Influence Theory to Improve Attitudes Towards Gay Parents	Sexuality Research & Social Policy
		Pistella Jessica;Caricato Victoria;Baiocco, Roberto	2020	Coming Out to Siblings and Parents in an Italian Sample of Lesbian Women and Gay Men	Journal of Child and Family Studies
		Geva, Shenkman;Kfir, Ifrah;Shmotkin Dov	2020	Interpersonal Vulnerability and Its Association with Depressive Symptoms Among Gay and Heterosexual Men	Sexuality Research & Social Policy
		Hull, Kathleen E;Ortyl, Timothy A	2019	Conventional and Cutting-Edge: Definitions of Family in LGBT Communities	Sexuality Research & Social Policy

		Lloren, Anouk;Parini, Lorena	2017	How LGBT-Supportive Workplace Policies Shape the Experience of Lesbian, Gay Men, and Bisexual Employees	Sexuality Research & Social Policy
		Badenes-ribera, L. et al	2017	Italian Validation of the Queer/Liberationist Scale (Short Version) in a Sample of University Students: Confirmatory Factor Analysis	Sexuality Research & Social Policy
		Sawning, S et al	2017	A first step in addressing medical education Curriculum gaps in lesbian-, gay-, bisexual-, and transgender-related content: The University of Louisville Lesbian, Gay, Bisexual, and Transgender Health Certificate Program	Education for Health
		Salvati, Marco;Ioverno, Salvatore;Giacomantonio, Mauro;Baiocco, Roberto	2016	Attitude Toward Gay Men in an Italian Sample: Masculinity and Sexual Orientation Make a Difference	Sexuality Research & Social Policy
		Baiocco, R et al	2015	Lesbian Mother Families and Gay Father Families in Italy: Family Functioning, Dyadic Satisfaction, and Child Well-Being	Sexuality Research & Social Policy
		Baiocco, R et al	2015	Negative Parental Responses to Coming Out and Family Functioning in a Sample of Lesbian and Gay Young Adults	Journal of Child and Family Studies
		Beckett, Clare	2015	Assessing the Cost of Cuts in Welfare Spending for Lesbian, Gay and Bisexual People	Social Policy and Society
		Hirsch, Oliver;Becker, Karina Löltgen; Annette	2014	Comparing health survey data from Internet- and paper-based convenience samples of lesbian women in Germany	Sexual Health (Online)
		Hubbard, R et al	2013	Themes in Heterosexuals' Responses When Challenging LGBT Prejudice	Sexuality Research & Social Policy
		Baiocco, Roberto;Nardelli, Nicola;Pezzuti, Lina;Lingiardi, Vittorio	2013	Attitudes of Italian Heterosexual Older Adults Towards Lesbian and Gay Parenting	Sexuality Research & Social Policy
		Lick, D J;Tornello, S L;Riskind, R G; Schmidt, K M;Patterson, C J	2012	Social Climate for Sexual Minorities Predicts Well-Being Among Heterosexual Offspring of Lesbian and Gay Parents	Sexuality Research & Social Policy
		Riggs, Damien W	2011	Australian Lesbian and Gay Foster Carers Negotiating the Child Protection System: Strengths and Challenges	Sexuality Research & Social Policy
		Jackson, Janna M	2009	"Teacher by day. Lesbian by night": Queer(y)ing identities and teaching	Sexuality Research & Social Policy
		Vanderburgh, Reid	2009	Appropriate Therapeutic Care for Families with Pre-Pubescent Transgender/Gender-Dissonant Children: C & A	Child & Adolescent Social Work Journal
		de Vries, Brian;Mason, Anne M;Quam, Jean;Acquaviva, Kimberly	2009	State recognition of same-sex relationships and preparations for end of life among lesbian and gay boomers	Sexuality Research & Social Policy
		Schindel, Jennifer E	2008	Gender 101-- beyond the binary: Gay-straight alliances and gender activism	Sexuality Research & Social Policy
		Davies, Michelle	2004	Correlates of Negative Attitudes Toward Gay Men: Sexism, Male Role Norms, and Male Sexuality	The Journal of Sex Research
		Elze, Diane E	2003	Gay, lesbian, and bisexual youths' perceptions of their high school environments and comfort in school	Children & Schools
		Elze, Diane E	2002	Risk factors for internalizing and externalizing problems among gay, lesbian, and bisexual adolescents	Social Work Research

		Bartlett, A;King, M;Phillips, P	2001	Straight talking: An investigation of the attitudes and practice of psychoanalysts and psychotherapists in relation to gays and lesbians	The British Journal of Psychiatry
		Hausman, Bernice L	2001	Recent transgender theory	Feminist Studies
		Burn, Shawn Meghan	2000	Heterosexuals' Use of "Fag" and "Queer" to Deride One Another: A Contributor to Heterosexism and Stigma	Journal of Homosexuality
		Grossman, Andrew	2000	"Beautiful Publicity": An Introduction to Queer Asian Film	Journal of Homosexuality
		Robert-Jay Green	2000	"Lesbians, gay men, and their parents": A critique of LaSala and the prevailing clinical "wisdom"	Family Process
		Rofes, Eric	2000	Young adult reflections on having an openly gay teacher during early adolescence	Education and Urban Society
		Weinberg, M S;Williams, C J;Calhan, C	1995	"If the shoe fits ...": Exploring male homosexual foot fetishism	The Journal of Sex Research
		Cohen, Martin Samuel	1990	The Biblical Prohibition of Homosexual Intercourse	Journal of Homosexuality
		Rothblum, Esther D	1990	Depression Among Lesbians: An Invisible and Unresearched Phenomenon	Journal of Gay & Lesbian Psychotherapy
		Silverman, M et al	2020	Duplication	Int J of Care and Caring
		Coope, J. et al	2020	Duplication	Inter J of Migration, Health, and Social Care
		Wilson, K. et al	2019	Duplication	The Canadian Journal of Human Sexuality
		Waling, A et al	2019	Duplication	H & S in the Community
		Keating, N. et al	2019	Duplication	Int J of Care and Caring
		Wathern, Tina;Green, Robert William	2017	Duplication	Housing, Care and Support
		Westwood, Sue;Wathern, Tina	2017	Duplication	Housing, Care and Support
		Ingraham, N. et al	2017	Duplication	Health Promotion Practice
		Boggs, J M. et al	2017	Duplication	Journal of Homosexuality
		Pistella, J. et al	2016	Duplication	Journal of Child and Family Studies
		Hoy-Ellis, C P;Fredriksen-Goldsen, K I	2016	Duplication	Aging & Mental Health
		Manthorpe, Jill;Harris, Jess;Mauger, Sam	2016	Duplication	Working With Older People

		Kneale, Dylan	2016	Duplication	Quality in Ageing and Older Adults
		Wilkens, Jill	2016	Duplication	Quality in Ageing and Older Adults
		Bartik, Warren;Barton, Rebecca	2015	Duplication	Advances in Mental Health
		Grossman, A H. et al	2014	Duplication	Journal of Homosexuality
		Joly, L;Cornes, M;Manthorpe, J	2014	Duplication	Housing, Care and Support
		Joly, L;Cornes, M;Manthorpe, J	2014	Duplication	Housing, Care and Support
		Hardacker, C T et al	2014	Duplication	Journal of Nursing Management
		Kidd, Sean;McKenzie, Kwame	2014	Duplication	Ethnicity and Inequalities in Health and Social Care
		Moriarty, Jo;Manthorpe, Jill	2013	Duplication	Housing, Care and Support
		Browne, Kath;Bakshi, Leela;Lim, Jason	2011	Duplication	Journal of Social Policy
		Hughes, A. K;Harold, R. D;Boyer, J. M	2011	Duplication	Journal of Gerontological Social Work
		Gilbert, Peter;Parkes, Madeleine	2011	Duplication	Ethnicity and Inequalities in Health and Social Care
		Samuel, Mithran	2010	Duplication	Community Care
		Gulland, Anne	2009	Duplication	Community Care
		Johns, Nick;Jordan, Bill	2006	Duplication	British Journal of Social Work
		Schuller, Nina	2006	Duplication	Community Safety Journal
		Jones, Teresa C;Nystrom, Nancy M	2003	Community building with aging and old lesbians	American Journal of Community Psychology
		Hughes, A K;Harold, R D;Boyer, J M	2011	Awareness of LGBT Aging Issues Among Aging Services Network Providers	Journal of Gerontological Social Work

Appendix 3 - Searches with 0 results

Database	Search terms (1)	Search terms (2)	Search terms (3)	Search terms (4)	Total results	Checked
Web of Science	Lesbian OR Gay OR Bisexual OR Homosexual OR Queer OR LGBT* OR Transgender	Older OR elderly OR ageing* OR geriatric OR senior	Asset based & “Asset based” (2 searches)	“Social Care”	0 x 2 (0 x 0 on second search)	18/05/2020 16/10/2020
Web of Science	Lesbian OR Gay OR Bisexual OR Homosexual OR Queer OR LGBT* OR Transgender	Older OR elderly OR ageing* OR geriatric OR senior	“Asset based”	NOT HIV OR AIDS	0 0	18/05/2020 16/10/2020
Web of Science	Lesbian OR Gay OR Bisexual OR Homosexual OR Queer OR LGBT* OR Transgender	Older OR elderly OR ageing* OR geriatric OR senior	Voluntary services	“Social Care”	0 0	18/05/2020 16/10/2020
Web of Science	Lesbian OR Gay OR Bisexual OR Homosexual OR Queer OR LGBT* OR Transgender	Older OR elderly OR ageing* OR geriatric OR senior	“Asset based”	NOT HIV OR AIDS	0 0	18/05/2020 16/10/2020
Web of Science	Lesbian OR Gay OR Bisexual OR Homosexual OR Queer OR LGBT* OR Transgender	Older OR elderly OR ageing* OR geriatric OR senior	"Community Provision"	“Social Care”	0 0	21/05/2020 18/10/2020
Web of Science	Lesbian OR Gay OR Bisexual OR Homosexual OR Queer OR LGBT* OR Transgender	Older OR elderly OR ageing* OR geriatric OR senior	"Voluntary Provision"	“Social Care”	(1) 0	21/05/2020 18/10/2020

Appendix 4 - SPIDER analysis of included papers

Title of Paper, Author/ Year	Sample	Phenomenon of Interest	Design	Evaluation	Research type
Smith, R. & Wright, T. 2021. *Older lesbian, gay, bisexual, transgender, queer and intersex peoples' experiences and perceptions of receiving home care services in the community: A systematic review*	103 lesbian women, 58 gay men, 5 bisexual people, 1 transgender person Age 60+	Perceptions & experiences of receiving homecare	Systematic review	Fear of accessing home care services due to perceived threat of homophobia and past negative experiences of discrimination were common. Some concealed any LGBTQI+ materials in their homes to try and hide their sexuality from home care workers. Despite fear of discrimination, lesbian women and gay men reported wanting and expecting the same level of care, dignity and respect as their heterosexual counterparts. Mandatory LGBTQI+ sensitivity training for homecare workers was identified for reducing homophobia and increasing the inclusivity of service providers.	Quantitative
Alba, Beatrice;Lyons, Anthony;Waling, Andrea;Minichiello, Victor;Hughes, Mark;Barrett, Catherine;Karen Fredriksen-Goldsen;Edmonds, Samantha 2020 *Health, well-being, and social support in older Australian lesbian and gay care-givers*	230 lesbian women & 503 gay men, of which 218 were caregivers. Age 60+	To compare care-givers and non-caregivers in a range of health, wellbeing and social support variables. To compare health, wellbeing and social support for those caring for an LGBTI person versus those caring for a non-LGBTI person. To examine differences between lesbian women and gay men.	Survey comparing care-givers and non-caregivers, care-givers caring for LGBTI person and those caring for non LGBTI people. Measured positive mental health, psychological distress, physical health, social support and socio-demographic variables. Profile of descriptive statistics with chi-square tests to measure variables. Analysis of variances on psychological distress, positive mental health, physical health and social support followed by	39.6% of women reported being carers, 25.2% of men. 38.5% were caring for members of family of origin (mostly women), 11% family of choice, 22% relationship partners, 34% to friends (mostly men). With men, those caring for LGBTI person felt significantly less supported in their caring role than those caring for a non-LGBTI person. With women, those caring for LGBTI person were significantly higher in psychological distress, lower on positive mental health, physical health and social support. Results indicated overall exposure to stigma and marginalisation greater when both the care-giver and care-receiver are LGBTI - in line with	Quantitative

Title of Paper, Author/ Year	Sample	Phenomenon of Interest	Design	Evaluation	Research type
			analysis of covariance using socio-demographic variables as covariates.	Minority Stress Theory. Caring for someone who is LGBTI increased visibility of the care-givers sexuality, exposing them to stigma and discrimination not otherwise experienced. Female carers experienced a greater burden and poorer health and wellbeing than male carers. LGBTI carers faced additional challenges when caring for LGBTI people and support in the carer role facilitated coping with these challenges, important to ensure support services are welcoming and inclusive - having an understanding of complexities around experiences of discrimination and disclosure.	
Boule, Jess; Wilson, Kimberley; Kortes-Miller, Kathy; Stinchcombe, Arne 2020 *We Live in a Wonderful Country, Canada, but horizontal ellipsis : Perspectives From Older LGBTQ Ontarians on Visibility, Connection, and Power in Care and Community*	21 gay, lesbian, bisexual, trans and queer adults aged 60-79 years. 10 identified as gay, 1 as queer, 6 as lesbian, 4 as bisexual. 1 person was transgender. 10 male, 10 female. Most reported having 'good' or better health.	Investigation of the health and ageing experiences of older LGBTQ people, to identify their perceived care and support needs.	Four semi-structured focus groups. Data analysed using inductive thematic approach. Familiarisation of data via transcribing and repetitive readings, coding at semantic level with initial themes identified. Electronic coding, thematic mapping followed by team coding into three themes and 9 subthemes.	Participants anticipated age-related losses and expected greater use of and dependence on health/social care services. Despite greater LGBTQ visibility and inclusive care, participants perceived care services and facilities as unsafe and without competent support. Participants described employing positive strategies to overcome discrimination, contributing to participants' health and ageing experiences. Themes = living invisibly, stigma, discrimination and maturing under extreme circumstances and fearing ageing. Sub Themes included shifting policies, attitudes and identities, (dis)connection from the community,	Qualitative

Title of Paper, Author/ Year	Sample	Phenomenon of Interest	Design	Evaluation	Research type
				facilitating community support, underground community, LGBTQ not one single community, power(lessness), (de)energisation, fighting for rights and visibility, declining power and energy and anticipation and planning for ageing in the future.	
Grant, Ruby; Walker, Briohny 2020 *Older Lesbians' experiences of ageing in place in rural Tasmania, Australia: An exploratory qualitative investigation*	13 rural Tasmanian lesbians over the age of 55	Perceived barriers and enablers for 'healthy ageing' in their communities	Qualitative interviews	Geographical isolation was a literal barrier to accessing lesbian-inclusive services. Perception that community initiatives and social activities aimed at 'healthy ageing' in rural towns were heteronormative and unappealing for lesbians. Some cases of women reporting experiencing homophobic discrimination in these social groups. Findings suggest that specific approaches to lesbian-inclusive rural health and social care are required.	Qualitative
Lof, Jenny; Olaison, Anna 2020 *I don't want to go back into the closet just because I need care': recognition of older LGBTQ adults in relation to future care needs*	5 bisexual /lesbian women, 5 bisexual/ gay men, 5 transgender aged between 70 - 81	Understanding of what older LGBTQ adults consider important aspects to promote recognition and inclusion on equal terms as those of other older adults in a future elder care context.	15 semi-structured interviews with four main themes. Between 45 minutes and 2.5 hours. Thematic analysis through data processing and encoding of material followed by manual theming & peer-debriefing	Three main themes emerged from the data: Openness and recognition - some indications that because of a lack of general open practice, this was dependent on interviewees expectations of individual employees to treat them in competent and affirmative ways. The level of importance participants put on being open was dependent on their own openness. Some focus on feeling included rather than the exclusion presented by heteronormative assumptions within service structure	Qualitative

Title of Paper, Author/ Year	Sample	Phenomenon of Interest	Design	Evaluation	Research type
				and delivery. Also the use of visual markers and affirmative language. Preferences - some participants identified that 'equal treatment' was problematic and wanted attention paid to specificity i.e. personalised approaches and emphasis on all aspects of identity should be recognised. Others wanted to be treated the same as others without focusing on their LGBTQ identity but still expressed wishes around personalised approaches - it was acceptable to ask but then actions should follow. Overarching desire to be respected for individuality, to be themselves but outside heteronormative structures (deconstruction of distinctions). Respect and acceptance clear factor Housing options - split between wanting specialised and generic. Mostly single participants that wanted specialised housing. Some had a wish to be around people with shared history or experiences of discrimination and hardship related to sexual identity.	
Lottmann, R 2020 *Sexual and gender diversity and care for older people - intersectional perspectives and the relevance of situations and contexts*	Three cis-female (lesbian) and three cis-male (gay) senior citizens, one transgender and one intersex person, 59 to 92 years	How gender and sexual diversity can be respected in elderly care, in what contexts they become relevant and how they interact with other differentiators	Secondary data analysis of 8 biographical narrative interviews from research project "Same-sex ways of life and care in old age" (GLEPA), selected on characteristic aspects from data of population group and to allow reflection of heterogeneity.	Non-heterosexual seniors and those in need of care report fear of rejection and dependence on third parties with regard to healthcare in old age, who do not adequately recognise their life situation and life stories. The intersectional analysis perspective enables the recognition of situations and contexts in which sexual and gender identity is / become	Qualitative

Title of Paper, Author/ Year	Sample	Phenomenon of Interest	Design	Evaluation	Research type
			Evaluated using methods of reconstructive social research.	(ir-) relevant for LGBTI * seniors. Furthermore, hetero and cis normativity in elderly care can be problematised. The intersectional perspective opens up the opportunity for needs-based and person-centred care for the elderly (not only) for LGBTI * people.	
Lottmann, R; King, A 2020 *Who can I turn to? Social networks and the housing, care and support preferences of older lesbian and gay people in the UK*	175 50 years or above who self-identified as LGBT living in two specific areas (major inland city and provincial county). 50% identified as women, 47% as men. 7% identified as transgender. 42% lesbian, 43% gay men, 5% bisexual women, 2% bisexual men, 2% heterosexual women, 1% heterosexual men, 4% provided their own terms, 1% did not identify.	Looks at social capital theory and its suitability for assessing networks of care and support among older lesbian and gay people towards the end of their lives. Considering the significance of family choice and social connections which capture the commitment of chosen, rather than fixed, relationships and ties of intimacy, care and support.	Survey (study also included 4 focus groups but these are not discussed in this article). Secure, Accessible, Friendly, Equal (SAFE) Housing study. Purposive sampling. Descriptive statistics and tests of significance carried out.	⅔ in relationship, ⅓ single. 42% gay men and 41% lesbian women lived alone. 92% live without formal support. Spouse/partner viewed as significant person for all categories of support (emotional support, practical help, personal care and full-time assistance) but friends also extremely high (66% lesbians, 58% gay men believed they would rely on friends). Lower for personal care than emotional support and practical help. Neighbours not viewed as possible sources. Many felt they had no-one to turn to for practical help or full-time assistance. Considered comfortableness with homecare workers, public officials (eg social worker), tradesperson, neighbours and health professionals entering their homes. 64% felt comfortable with health professionals, but only 40% with homecare workers. ⅓ of lesbians felt it was important to have a carer of the same gender - only 13% of gay men felt the same. No significance with sexual identity although 25% of gay men felt it was important (so more important than gender).	Mixed methods

Title of Paper, Author/ Year	Sample	Phenomenon of Interest	Design	Evaluation	Research type
				Differences regarding desirability of living in residential care between generic care and LGBT specific - much more keen for LGBT specific (over 50% in most categories). Inferential analyses showed only weak association between preference for LGBT specific care homes and feeling part of the LGBT community. Majority did not have networks to turn to for help so would likely require formal support.	
Hoekstra-Pijpers, Roos 2020 *Experiences of older LGBT people ageing in place with care and support: A window on ordinary ageing environments, home-making practices and meeting activities*	115 LGBT people aged 65 or over who are weekly and monthly receivers of health and social care services including homecare, home aid, informal care, day care, meals and transportation services. Approximately 68 male & 47 females (only percentages noted)	Understanding the experiences of LGBT people over 65. How older LGBT people are enacted as care receivers, how they respond to the care they receive and does it link to their life histories and identities.	Survey of 115 people and follow-up interviews with 10. Interviews were semi-structured and lasted between 1.5-2 hours. Analysis via SPSS using frequencies and crosstabs. Interviews were coded with an inductive coding procedure followed by qualitative content analysis in which quotations were interpreted as representations of shared themes.	Older LGBT people's experiences with ageing in place are related to differences in how ageing environments are able to accommodate LGBT lifestyles. Three overarching themes: experiences with ageing in place in ordinary environments, notably urban extension areas, experiences with ageing in place and care-receiving in the home (where negotiating openness to caregivers and home-making practices come together) and the challenges to include older LGBT people in LGBT community activities and neighbourhood based activities. 38% of survey respondents and 1 interview participant received regular support from their neighbours. 30% of survey respondents had experienced discrimination or prejudice from formal caregivers with respect to their sexual orientation. Almost all were open about their identity and they felt this improved the perceived quality of contact with	Mixed methods

Title of Paper, Author/ Year	Sample	Phenomenon of Interest	Design	Evaluation	Research type
				caregivers. This potentially showed that there were benefits linked to disclosure. One participant in interviews where the sexual identity of the caregiver (i.e. LGBT) influenced experience - positively. Heteronormative language but also carers talking about children and grandchildren upsetting some interview participants. 75% of survey respondents used LGBT community activities. 16% did not because they feared ageism. Some disliked the format and focus of LGBT community activities i.e. hypersexualised or inappropriate, designed for younger people, not welcoming, too far away to practically access. 53.5% of survey respondents accessed activities in their local neighbourhood such as low-threshold meetings through to social work professionals organised groups. Many survey respondents and interviewees had negative experiences relating to disclosure and some chose to suppress this information. Recommendations include investing in caregivers' knowledge and awareness and them being more proactive in signalling acceptance of LGBT people, neighbourhood service organisers should learn moderating skills to encourage inclusion and validation of older LGBT people’s identities.	

Title of Paper, Author/ Year	Sample	Phenomenon of Interest	Design	Evaluation	Research type
Siverskog, A; Bromseth, J 2019 *Subcultural Spaces: LGBTQ Aging in a Swedish Context*	33 self identified LGBTQ older adults between ages of 59 -94.	Explore meanings of community, belonging, subcultural spaces at different times and different ages, finding, entering and creating these spaces and how time and geographical context plays into these experiences, what it is like to age within these communities and enter these queer spaces later in life.	Life story interviews using queer theory and critical gerontology as points of departure. 13 were ethnographic studies based on participants observation and interviews. 20 were interviewed. Thematic analysis was conducted using Ahmed's concept of orientation to explore how bodies are situated in time and space.	Participants talked about historical experiences of social spaces being very 'secret' and underground in nature - exacerbating the invisibility and shame. LGBT spaces provide a collective resistance where people have come together to demand liveable lives. Not just sharing sorrows/hard experiences but formulating meaningful spaces through shared experiences. Friendship and chosen families are given great importance in narratives. Some interviewees had very small networks and little support in everyday life. Factors influencing this included health status, geography & class where social, cultural and economic capital mattered. Experiences included attending LGBT activities that had been enjoyable in the past which led to a feeling of being disconnected to other participants as a result of differences in age but also changes in subculture as happens over time, this having a different meaning for people - spaces that previously felt safe can, in old age be experienced as places one does not belong. Conversely, some had experiences where old age was a valued position of experience and history, adding to one's social capital within these subcultures. Interviewees talked about changes in desire to link in to traditional LGBT subcultures such as clubs and bars replaced with wishes for spaces with	Qualitative

Title of Paper, Author/ Year	Sample	Phenomenon of Interest	Design	Evaluation	Research type
				more varied activities. Also, to avoid previous experiences of violence, safer meeting spaces have been created in response to repression e.g. meetings during the day in well populated areas. Geography, class, economy, health and social networks all played into people's ability to take part in LGBT communities meaning analysis of people's needs requires taking these things into account.	

Title of Paper, Author/ Year	Sample	Phenomenon of Interest	Design	Evaluation	Research type
Waling, A; Lyons, A; Alba, B; Minichiello, V; Barrett, C; Hughes, M; Fredriksen-Goldsen, K; Edmonds, S 2019 *Experiences and perceptions of residential and home care services among older lesbian women and gay men in Australia*	19 older lesbian women and 14 gay men. 76% resided in urban areas, 73% aged between 60-70 yrs, 64% were retired, 88% were not using home-care services	Perceptions and experiences of residential aged-care and home-based aged-care services in Australia.	Semi structured interviews. Thematic analysis using preliminary coding, with subsequent key thematic categories reviewed independently	Three major themes emerged, similar for both genders: perceptions and experiences of residential care and home care (negative re lack of inclusivity, loss of community & autonomy and quality of care), alternative strategies to residential care (supportive housing or communities, housing adaptations, home care and euthanasia) and hoping to never need residential care (reliance on friends, current good health as a predictor) with a number of sub themes within each of these. Most participants only spoke about residential care when asked about aged-care services, most were unaware of availability of home-care based solutions.	Qualitative
Butler, SS 2018 *Older lesbians receiving home care: formal and informal dimensions of caregiving*	20 lesbian women aged 65 or older using homecare services, four partners of the participants receiving homecare and two additional informal caregivers	How formal homecare services for older lesbians fit into networks of informal care, what sort of relationships develop between older lesbians and their homecare workers and how do study participants describe lesbian ageing?	Qualitative interviews, semi-structured telephone interviews based on a list of questions covering related topics, continued until saturation reached. Constant comparative method of grounded theory inductively identifying themes through open-ended coding.	Tasks carried out by informal caregivers included medical research, advocacy, insurance, errands, finances, shopping, cooking, transportation, personal care, health care. 7 described some degree of isolation. Two described levels of overt discrimination within their elderly community. 25 participants reported family, friends & neighbours as part of support systems. 5 reported experiencing homophobia from care workers. More than half had not disclosed their sexual orientation. 17 described good connections. The care workers sexual identity appeared not to correlate with whether or not care was perceived as good.	Qualitative

Title of Paper, Author/ Year	Sample	Phenomenon of Interest	Design	Evaluation	Research type
				25% indicated ideal long-term vision included intentional lesbian communities with lesbian caregivers although the majority received care from straight care workers (including immigrants from cultures where homosexuality negatively viewed). Several formed long term social relationships with care workers. 8 (40%) said being a lesbian did not affect their ageing process or current life activities, 2 (10%) felt it was intimately connected to all parts of their lives. Comments regarding previous independence being more noted so therefore having to move to dependence perhaps harder than for heterosexual counterparts. Some characteristics of care workers seemed to influence experience, including gender & age.	
Jones, Rebecca L;Almack, Kathryn;Scicluna, Rachael 2018 *Older bisexual people: Implications for social work from the 'Looking Both Ways' study*	12 people over the age of 50, all of whom had significant histories of sexual relationships with more than one gender and half of whom currently identified as bisexual. 7 female, 4 male, 1 transgender.	Broad scope to focus on ageing and bisexuality, to add to knowledge, particularly for social work practitioners to work holistically with older LGBT service users.	Interviews with schedules combining a narrative life history and discussion of issues to do with ageing. Thematic analysis followed by use of a coding framework of 15 nodes. Summary case studies checked by participants.	Participants would not necessarily engage with LGBT groups for fear of discrimination from lesbians and gays. Participants wanted to be themselves when receiving social care support but found it difficult to be 'out' as bisexual due to presumptions made according to their current partner. Difficulties specific to other non mainstream choices such as vegan, polyamorous. Variety of informal support systems including birth families, adult children and families of choice. People had made arrangements to future proof like 'deals' with people.	Qualitative

Title of Paper, Author/ Year	**Sample**	**Phenomenon of Interest**	**Design**	**Evaluation**	**Research type**
				Three main findings: Biphobia may impact on those with histories in ways that affect health and wellbeing increasing the need for social care while simultaneously making it more difficult for them to access these services; concerns around receiving care similar in some ways but different in others to lesbians and gays; people with bisexual histories may have developed stronger support networks which may be beneficial in later life. Recommendations include need for better understanding of biphobia, recognising the legitimacy of concerns about receiving care, asking about support networks rather than assuming family support.	
Simpson, P; Almack, K; Walthery, P 2018 *We treat them all the same': the attitudes, knowledge and practices of staff concerning old/er lesbian, gay, bisexual and trans residents in care homes*	187 individuals, including service managers and direct care staff. 89 completed a survey online and 98 were distributed during 7 visits to care homes. Care homes ranged from small (<40 residents), medium (>40 but <80) and large (80+)	Considering practitioners' perspectives on meeting the distinct needs of old(er) LGBT people living in care homes. Exploring how well equipped care homes and staff were in terms of attitudes, knowledge, skills and the support measures required to enable them to meet the needs of LGBT residents. To provide information to help staff and homes take practical steps to advance inclusion of LGBT residents.	Non-randomised Survey	Employees' attitudes generally indicated a positive disposition towards LGBT residents, but was not matched by staff ability to recognise such individuals and knowledge of the issues and policies affecting LGBT residents/people. Failure to recognise LGBT residents' distinct health and social care needs means they may be subject to a uniform service, which presumes a heterosexual past and cisgender status and is thus likely to reinforce inequality and exacerbate invisibility. LGBT residents are obliged to depend largely on the goodwill, knowledge and professional reflection of individual staff to meet their distinct care and personal needs.	Quantitative

Title of Paper, Author/ Year	Sample	Phenomenon of Interest	Design	Evaluation	Research type
Willis, Paul; Raithby, Michele; Maegusuku-Hewett, Tracey 2018 *It's a nice country but it's not mine: Exploring the meanings attached to home, rurality and place for older lesbian, gay and bisexual adults*	29 LGB-identifying adults (50-76 years) - self-selected. 19 female, 10 male.	Examination of the meanings attached to home and place for older LGB adults living independently across 3 dimensions: rural places as "home," connections to LGB communities, and social care provision in the home.	Semi-structured interviews	Thematic findings from interviews indicated varying and contradictory meanings attached to home life in rural places, the importance of connection to communities of identity across geographical and online localities, and a high degree of ambivalence towards the prospect of receiving social care services in the home. Conclusions: a more nuanced understanding of the subjective meanings attached to home, rurality and community for older LGB people is needed to fully support LGB citizens to continue to live independently in their homes.	Qualitative
Yang, J; Chu, Y; Salmon, MA 2018 *Predicting Perceived Isolation Among Midlife and Older LGBT Adults: The Role of Welcoming Aging Service Providers*	222 adults aged 45 and over who self-identified as LGBT. 113 gay people, 100 lesbians, 17 bisexual, transgender and chose not to identify.	Examination of whether having experienced welcoming ageing service providers can serve as a protective factor for perceived social isolation and whether it buffers the negative impact of living alone.	Needs assessment survey with an outcome variable of isolation. Non probability sampling strategy. Logistic regression analysis controlling for potential confounders and demographics.	Odds of feeling isolated 61% less if experienced welcoming ageing service providers. Being open about their sexual identity reduced the odds of perceived isolation. Hate violence was positively associated with perceived isolation. For those who lived alone, the effect of welcoming ageing service providers was statistically significant - reduced the odds of perceived isolation by 84% - for those who lived alone and had not experienced welcoming ageing service providers, the odds of perceived isolation was 5.3 times that of those who were not living alone. Findings suggest that for those who live alone, welcoming ageing service providers in their areas can be very beneficial, making people feel less isolated. Welcoming service providers	Quantitative

Title of Paper, Author/ Year	Sample	Phenomenon of Interest	Design	Evaluation	Research type
				may be serving as a substitute for close friends and family and not only address perceived isolation but also increase likelihood of accessing services, further reducing disparities i.e. in health.	
Boggs, Jennifer M.; Portz, Jennifer Dickman; King, Diane K.; Wright, Leslie A.; Helander, Kenneth; Retrum, Jessica H.; Gozansky, Wendolyn S. 2017 *Perspectives of LGBTQ Older Adults on Aging in Place: A Qualitative Investigation*	Participants (N = 73) identified primarily as lesbian or gay, aged 50-69, and lived with a partner	Identification of barriers and supports to ageing in place	Focus groups, interviews, and a town hall meeting	Ageism, heterosexism, and cisgenderism emerged as cross-cutting themes that negatively impact access to health care, housing, social support, home assistance, and legal services. Resilience from weathering a lifetime of discrimination was identified as a strength to handle ageing challenges. Recommendations for establishing an ageing in place model included welcoming communities/resource centres and increasing cultural competence of service providers.	Qualitative
Proctor, AR; Krusen, NE 2017 *Time to ask and tell: Voices of older gay and bisexual male veterans regarding community services*	6 male, 1 gender neutral US veterans, aged over 50, identified as gay or bisexual. 4 Caucasian.	Determining community-based service needs for health and wellness of lesbian, gay, bisexual, transgender and queer veterans.	Data collected in the first stage of Participatory action research (6 stages). Participant semi structured interviews using a categorised interview guide including topics, observations of activities and site visits. Phenomenological analysis using open coding followed by theming.	Four common issues emerged from data: communal meals, transportation, housing and the coming out process. Participants valued engagement as part of the community. Community services facilitated community engagement to support health and wellness. Further recommendations for research noted.	Mixed methods
Czaja, SJ; Sabbag, S; Lee, CC; Schulz, R; Lang,	124 people aged between 50 - 85+	Gathering and understanding in-depth knowledge about the concerns and needs of	Focus groups and questionnaires. Participants completed a	Main themes identified were concerns regarding lack of financial security, lack of family and social support, fears	Mixed methods

Title of Paper, Author/ Year	Sample	Phenomenon of Interest	Design	Evaluation	Research type
S; Vlahovic, T; Jaret, A; Thurston, C 2016 *Concerns about aging and caregiving among middle-aged and older lesbian and gay adults*	77% gay men, 23% lesbian women. 72% Caucasian.	lesbian and gay older adults and to gather some preliminary information on concerns about caregiving in terms of both receiving needed care and serving in the caregiving role.	demographic questionnaire and a basic questionnaire related to caregiving. Focus group discussions followed a flexible semi-structured format. Questionnaire data was summarised using descriptive statistics, chi-square used to examine differences between gays and lesbians. Focus groups coded through an iterative process into topics, then integrated into larger conceptual categories. Similarities identified and themes.	about not having someone to provide needed care and discrimination/prejudice in the healthcare or service communities. Noted loneliness and financial concerns align with concerns of all older adults but were unique concerns relating to stigma, discrimination and lack of services and resources. Expressed need for venues to promote socialisation and better knowledge of community resources available to the LGBT community. Expressed concerns about continued discrimination with examples given. Important that services are made available and accessible and providers are informed about the unique needs and concerns of lesbian and gays service users and carers. Desire for support groups specifically for lesbian and gay caregivers.	
Jones, SM; Willis, P 2016 *Are you delivering trans positive care?*	Nine trans people, across a range of age spectrums living in the US, Canada and Europe self-selected to participate. A convenient sampling method was used as a suitable approach to recruiting participants from a hard-to-reach population.	To understand expectations of services, amplify the voices of participants and share the priorities to influence future service design and practice. To canvas concerns, priorities and expectations for future care in later life, if needed, and to articulate a vision of trans-positive care for social care services.	Semi-structured interviews. Thematic analytic approach for results.	Low confidence in the ability of current aged care services to meet the needs of trans elders due to a limited understanding of the relationship between health and social care specific to trans people. Undervaluing the networks in trans people's lives. The need to demonstrate culturally competent services. Concerns regarding tackling discrimination and abuse. Despite legislative advancements, a sense that activism is central to tackling these issues and trans people	Qualitative

Title of Paper, Author/ Year	Sample	Phenomenon of Interest	Design	Evaluation	Research type
				are articulating their demands for shaping future provision.	
McGovern, J; Brown, D; Gasparro, V 2016 Lessons Learned from an LGBTQ Senior Center: A Bronx Tale	7 women, 2 men. Ethnically diverse. 3 women identified as straight, the rest as LGBT.	Exploring the impact of LGBTQ senior centres on the lives of centre members, identifying their key concerns	One focus group and three key informant interviews, purposive sampling. Data analysis following grounded theory, coding identifying key concepts based on recurrence or emphasis, grouped into themes to determine significance, then contextualised in literature.	Centre provided a wide range of recreational, social and educational activities and services in addition to meeting concrete needs. Initial conversation focussed on emotional attachment to centre and no one mentioned meeting of any social care needs or the LGBTQ focus as reasons for such strong feelings. Had formed an alternative family of choice/support network within the centre. Feeling accepted reported as an important part of the benefit of a centre, non-judgemental atmosphere. Importance put on being at the heart of community and fitting with the local area and the people who live there.	Qualitative
Spatenkova, N; Olecka, I 2016 *Experiences of providers of care for the elderly with LGBT+ clients*	Six managers in total, two managers of health care institutions and four managers of social care facilities Focus group one: 10 employees (direct caregivers) of an elderly care home Focus group two: 9 students of social and health care with the minimum of one year professional experience	Are providers of care to the elderly prepared to provide services to LGBT+ people?	Semi-structured interviews Interpretative Phenomenological Analysis Focus group discussions Interpretative Phenomenological Analysis	No need to differentiate between LGBT+ older adults & heterosexual older adults. Consensus that any specific approach draws attention and might potentiate problems. Person's behaviour is a crucial factor, not sexual orientation or other characteristics. Experience of direct caregivers with LGBT+ clients was negligible (3 stated such experiences). Participants felt issues related to LGBT+ older adults not addressed as not subject of discussion. Direct caregivers perceived other problems related to older adults, but thought issues related to LGBT+ older	Qualitative

Title of Paper, Author/ Year	Sample	Phenomenon of Interest	Design	Evaluation	Research type
	in the area of care for the elderly Ages 19-50			adults were socially urgent and should definitely be discussed and addressed. They would therefore allow themselves to be educated, trained or informed about this topic.	
Westwood, S 2016 *We see it as being heterosexualised, being put into a care home': gender, sexuality and housing/care preferences among older LGB individuals in the UK*	60 older LGB individuals, 36 women, 24 men. Of the women, 29 identified as lesbian, one gay, two bisexual and four did not identify using a label. Mean age was 64.	Analyses of concerns around mainstream sheltered accommodation and residential care in terms of visibility, unequal openness and compulsory co-occupation, considering different sheltered housing/care preferences and significance of gender.	Semi-structured interviews followed by thematic analysis in order to make interpretive analysis without generalising into an overarching theory. Staged approach to thematic analysis.	Concerns about mainstream provision included lack of visibility - perceptions that services were explicitly heterosexual (even though they weren't). Social exchanges are difficult to reinforce heterosexist reproductive/family norms through relationship discourse. Risky visibility - fears of isolation caused by prejudice and discrimination, particularly problematic with older people's attitudes and values. Concerns about homophobia of staff and evidence of concealment on that basis. Inequality of openness - reliance on home as a safe space for identity performance which is removed when in areas such as residential care homes. Compulsory co-occupation - enforced engagement with others especially where may already be in the minority eg male in predominantly female care home. Large number of female participants expressed concerns about sharing space with men, including unwanted advances and a sense of heightened vulnerability to deal with them. Lack of confidence that staff would address issues. 45 of 60 expressed a preference with regard to residential care - 44%	Qualitative

Title of Paper, Author/ Year	Sample	Phenomenon of Interest	Design	Evaluation	Research type
				mainstream, 16%/9% lesbian/gay only, 24%/0% women/men only, 16% LGBT mixed. Noted importance of mainstream needing to be integrated. Sexuality is more significant for men, gender and sexuality more significant for women.	
WILLIS, PAUL;MAEGUSUKU-HEWETT, TRACEY;RAITHBY, MICHELE;MILES, PENNY 2016 *Swimming upstream: the provision of inclusive care to older lesbian, gay and bisexual (LGB) adults in residential and nursing environments in Wales*	41 Care staff and managers employed in residential and nursing homes. 29 Older adults who identified as LGB - 19 lesbians, 9 gay men, 1 bisexual.	Examining the synergies and differences between older LGB individuals expectations for future care provision and the expectations of care staff in providing services to older LGB people. How are the sexual identities and relationships of older LGB people perceived and supported in residential care environments.	Self-administered questionnaires and focus groups (staff) with set topics including previous experiences of providing care to LGB residents, good practice, barriers to social inclusion and staff training and policy. Transcripts analysed line-by-line thematically, core themes generated. Semi-structured Interviews (older people) with purposive and snowball sampling, self-selecting participants	Interview participants identified markers of inclusivity including welcoming partners, uphold privacy, facilitating time with partners, displaying physical signs of LGBT affirmation (Rainbow signs, pictures of same sex couples), comfortable environment to discuss personal and sexual lives with other residents and staff. Hopes did not match expectations. Key finding was the importance of LGB histories and impact of past experiences on current or future perceptions of health and social care services. Nearly all had encountered discrimination across life courses. Concerns around heterosexualisation, presumptions of straightness, not being able to talk about lives. Half indicated preference to live in LGBT-specific facilities, and women keener of gender specific facilities. Absence of discussion with staff re LGB lives and identities, lack of training, lack of information within people's information when arriving all clear in staff responses. Some differences in attitudes towards gay staff than residents (seemingly more accepted). Evidence that equality	Mixed methods

Title of Paper, Author/ Year	Sample	Phenomenon of Interest	Design	Evaluation	Research type
				equaled sameness for some staff - care regardless of sexual identity and social background - interview participants felt respect and privacy were intertwined with recognition of LGB identity. Was concerned about preventing distress to other residents by disclosure and lack of clear approach to addressing other's homophobic comments or feelings. Rights of heterosexual, homophobic residents to voice opinions freely outstripped the right of LGB residents to feel safe. Unhelpful conflation of person centred care and menial tasks/routines, separating out LGB identity from individual and their needs. Assumption that it is the responsibility of LGB residents to initiate discussions and correct presumptions. General desire of managers to understand and do more. Management is viewed as fundamental to driving this forward.	
Wilkens, Jill 2016 *The significance of affinity groups and safe spaces for older lesbians and bisexual women: creating support networks and resisting heteronormativity in older age*	29 lesbian, 3 bisexual and 3 who did categorise their sexual identity.	Investigating the impact of belonging to a same-sexuality social group or network for older lesbians and bisexual women predicated on shared age and sexual identity. Looking at loneliness, group composition and benefits conferred by membership	In-depth face to face interviews followed by thematic analysis focussing on the intersection of sexual identity, class and gender role 'transgressions', LGB traditions of belonging and resistance and the importance of affinity groups and spaces in resisting heteronormativity	Many participants talked about loneliness and feeling different, with mainstream groups exacerbating this. Most showed a preference for same-sex, same-sexuality, same-generation groups. Significantly the bisexual participants did not express the same preference. Benefits included safety, a sense of belonging and acceptance and a validation of lesbian sexuality - having somewhere where people will not be uneasy or aggressive. Key benefit was a sense of belonging.	Qualitative

Title of Paper, Author/ Year	Sample	Phenomenon of Interest	Design	Evaluation	Research type
			and providing social connectedness.	Many groups had rules, hierarchies and exclusions eg transgender women. Proximity also had an impact on attendance and type of groups attended. Similar ages of attendees had an impact on longevity - some wished for intergenerational contact to grow grassroots groups, others felt groups run by organisations/paid leaders would avoid them dying out. Most participants noted groups were a key mechanism for reducing isolation and maintaining wellbeing. Suggests funding required for cross-sexuality, cross-gender and intergenerational alliances would prove to have multiple benefits. In relation to social care, concerns included loneliness, isolation, living amongst men, having to hide sexual identity.	
Sagie, O 2015 *Predictors of Well-being Among Older Gays and Lesbians*	209 gay men and lesbian women aged 55 or above. Calculations of gender are approximately 146 males, 63 females (percentages only noted)	Examine the predictors of subjective wellbeing in older gay and lesbians across multiple domains including health, function, personality and socio-environmental factors	Survey measuring socio-demographics and subjective scale questions regarding life satisfaction, physical and mental health, hope, functions of daily living, participation in social, community and religious activities, accessibility and availability of community services, environment and living conditions. Statistical analysis of data undertaken including regression analysis.	Significant, positive correlations between subjective wellbeing and physical and mental health, community availability and accessibility, function, objective and social participation, environment and living conditions and hope. Hope, physical and mental health and community availability and accessibility were significant predictors of subjective well-being. Social participation was predictive of subjective wellbeing on a level approaching significance. Demonstrates subjective wellbeing multidimensional and largely predicted by personality, environment and social	Quantitative

Title of Paper, Author/ Year	Sample	Phenomenon of Interest	Design	Evaluation	Research type
				factors but also highlights the importance of hope. Findings support new models of 'aging in place' which seek to maintain communal relations among community dwelling older people who remain in their homes and highlight older persons' agency with regards to shaping their communities of residency, supporting that environmental and communal resources serve to increase older gay and lesbian wellbeing via increasing their sense of agency.	
Brennan-Ing, M; Seidel, L; Larson, B; Karpiak, SE 2014 *Social Care Networks and Older LGBT Adults: Challenges for the Future*	210 LGBT older adults. Average age 60 years 71% men, 24% women, 5% transgender or intersex. One-third Black, 62% Caucasian.	Examining the social care networks of older LGBT adults, with a focus on the viability of the social support network, formal service utilisation, and unmet needs for assistance.	Survey collecting qualitative and quantitative data. Demographic and health profiles of a sample, descriptions of informal social networks, service utilisation patterns, and services needs based on quantitative measures (correlational design). Qualitative examination of unmet service needs (grounded-theory approach).	Some LGBT older adults rely on LGBT-focused organisations to meet their needs, yet tend to mainly rely on mainstream providers, such as government offices and agencies (1.7 services, on average), community-based social support, and health care providers (2.6 services, on average). Challenges existed when trying to access mainstream services. Some fear doing so due to real and perceived discrimination. Accessing mainstream providers also raised issue of sexual identity disclosure to non-LGBT providers, exacerbated by fear of discrimination. This was supported by qualitative data specifically around accessing religious and spiritual programs. Without a concerted effort to address unique issues of LGBT ageing and intentionally create safe and welcoming spaces, it remains likely that LGBT older adults may be	Mixed methods

Title of Paper, Author/ Year	Sample	Phenomenon of Interest	Design	Evaluation	Research type
				reluctant to access mainstream services. Thus, imperative mainstream providers improve LGBT cultural competency through training and capacity building efforts.	
McCann, E; Sharek, D; Higgins, A; Sheerin, F; Glacken, M 2013 *Lesbian, gay, bisexual and transgender older people in Ireland: Mental health issues*	Survey respondents: 93 males, 39 females, 10 transgender & 1 other. 87 gay, 28 lesbian, 13 bisexual, 9 non-identifying, 3 heterosexual, 3 other. All aged 55+ Interview participants: 22 males, 11 females, 2 transgender, 1 other. 22 gay, 13 lesbian, 1 bisexual All aged 55+	To detail older LGBT persons' usage, experiences and concerns with accessing healthcare services. Considering disclosing identity to professionals, preferences for care and suggestions for improvements in services in order to make policy, service and practice recommendations.	Questionnaire concerning use of healthcare services, experiences and needs, analysed using descriptive statistics. In-depth interviews analysed through constant comparative processes to generate themes	Half the survey participants (47%) reported a physical health condition. Of 64 respondents, 77% were taking medication. 2 reported using mental health services, 1 using home help/personal care attendant. None using day care. 43% reported feeling respected as an LGBT person by health professionals. 50% actively sought out LGBT friendly health professionals because of negative prior experiences. 44% felt it was not necessary for health professionals to know their LGBT identity. Presumption of heterosexuality and use of heterosexist language viewed as reinforcing invisibility. Strong preference for living in own homes as they aged, followed by living with other LGBT people, least preferred option living in residential care - felt would be forced back into or out of closet, entrapped in a heterosexual world, sexuality not respected or taken seriously. 30% felt they were getting more lonely as they aged. Loneliness was a particular concern for interview participants who lived rurally or were not connected to LGBT community.	Mixed methods

Title of Paper, Author/ Year	**Sample**	**Phenomenon of Interest**	**Design**	**Evaluation**	**Research type**
				Education and awareness raising with professionals key to providing inclusive experiences.	
Price, E 2012 *Gay and lesbian carers: ageing in the shadow of dementia*	10 gay men, 11 lesbian women who care, or cared for, a person diagnosed with dementia. 16 cared for parents, two for other relatives, two for friends and one person cared for their partner. All were White British and ranged in age from 23 to 67 years.	To explore the experiences of gay men and lesbian women who care, or cared, for a person with dementia, through the lens of a person's gay or lesbian sexuality.	Semi-structured interviews, conducted in the style of a 'guided conversation' Data analysis was undertaken using a constant thematic comparative method.	Two related themes emerged – respondents' hopes, fears and plans for the future and, specifically, the way in which their caring experiences had coloured their views and expectations of how their own health and social care needs may be met.	Qualitative
Hughes, Anne K;Harold, Rena D;Boyer, Janet M 2011 *Awareness of LGBT Aging Issues Among Aging Services Network Providers*	87 staff from services networks across a geographical location	To understand how aging services networks currently work with LGBT older adults, what services are available, how comfortable providers in the network are working with this population and what they perceive their training needs to be.	Survey, non-probability convenience sample from attendees at conference for services networks including various topics and demographic data. Frequencies and averages calculated using statistics database and thematic analysis of open-ended questions.	63% felt the needs of LGBT adults are different to heterosexual counterparts. Most (68.2%) rated themselves as very comfortable with providing assistance to older LGBT adults or as somewhat comfortable (22.4%). 63% indicated they wanted training, 37% did not want training. Delivery preferences included 45% in-service, 28% online, 26% written materials. 32% respondents said their service saw meeting LGBT needs as low priority, 26% as not a priority. 75% indicated there were no activities or efforts within the service to address the needs of LGBT individuals. Where there was, it was staff training, workshops. 69% of respondents said service did not ask about sexual orientation, 16%	Quantitative

Title of Paper, Author/ Year	Sample	Phenomenon of Interest	Design	Evaluation	Research type
				were unsure, 5.7% said yes and 4.6% felt it did not apply to their agency as there was no LGBT intake (systemic negligence). Most (74.4%) did not have materials or information available specifically for LGBT older adults. Few are planning any outreach or specific work going forward.	
Fannin, Ann 2006 *Gay and grey: lifting the lid on sexuality and ageing*	100 survey participants, 30 interview participants *(*emailed 12/10/2020 to see if further information is available)*	To investigate older lesbians and gays needs, fears, aspirations and experiences related to their age, to identify factors and issues contributing to exclusion from the wider community of older people, from the gay community and from support services and activities for older people, to find how these issues could be addressed and to promote greater social inclusion, to plan steps and actions for solutions and to actively involve older lesbians and gays in place.	Participatory action research. Questionnaires and in-depth face to face interviews.	*Unclear from article whether findings come from survey participants or interviews 47% felt positive about being gay. 60% of participants reported some degree of isolation, 32% felt they had an active social life, 10% felt they had none, 25% felt they did not have adequate support/social networks. Only 1.4% looked to statutory agencies to provide emotional, social, physical or financial support, 40% turned to friends for these things, 19.4% to family, 21.5% their partner, 4.4% to groups, 1.4% to church and 11.1% said they had no-one. Strong responses regarding being visible in care settings and being accepted by gay friendly carers in their homes. Many (40%) stated a preference for gay specific residential care, 38.5% wanted gay friendly. Preferences for sheltered housing included 40% for gay specific, 44% for gay friendly. The majority wanted their sexuality to be taken into account although some felt gay exclusivity would be counterproductive and would not help integrate into society.	Mixed methods

Title of Paper, Author/ Year	Sample	Phenomenon of Interest	Design	Evaluation	Research type
				There was continuing fear of discrimination and worries about isolation as well as a need to be recognised as being sexually active. Main theme was the desire to have homosexual identities validated and accepted by society. Four key areas highlighted: significant and invisible population present; personal identity and acceptance of key importance; isolation and exclusion commonplace; responsive and accessible public services can reduce isolation and exclusion. Recommendations included awareness raising, counteraction against heteronormativity, meaningful anti-discriminatory policy enshrined in codes of practice, LGBT friendly services, development of support for social outlets, gay specific info in public areas, and continued research.	
Brotman, S.,l Ryan, B., Cormier, R., 2003 *The Health and Social Service Needs of Gay and Lesbian Elders and Their Families in Canada.*	32 participants - older gay men and lesbians from LGBT senior groups (7), professionals from both gay and lesbian health organisations (9), voluntary mainstream elder care organisations (3), public sector delivery organisations (8) and governmental policy bodies (5). 21 of these identified as lesbian or gay.	To gather information about the experiences and realities of gay and lesbian seniors and their families accessing a broad range of health and social services in the community, and to examine the role of health and social service organisations in shaping access and service delivery	Semi-structured focus group interviews covering experiences of health, particular health needs and access/service delivery issues. Iterative analysis leading to coding into themes, validation through researchers and participants.	Main theme was profound marginalisation experienced by older gays and lesbians in all aspects of social and political life. Five critical issues: historical experiences of discrimination, homophobia within present-day context, profound invisibility of gay and lesbian seniors in all segments of society, long term care services and gay and lesbian support networks. High levels of mistrust as result of experiences, extreme caution as to whether societal attitudes and historically persecutory social systems have really changed. Discrimination	Qualitative

Title of Paper, Author/ Year	Sample	Phenomenon of Interest	Design	Evaluation	Research type
				still apparent in many social and institutional environments. Idea of reliance on discriminatory systems provokes anxiety and fear. Fear of disclosure exacerbates invisibility which creates barriers to development of social and political voice, lack of willingness to place issues on the agenda for discussion. Issues faced poorly understood by academics, communities and professionals. Important aspects of social lives overlooked within assessment for care. Discomfort of professionals coupled with desire to avoid discrimination promotes a vicious cycle of oppression. Outward signs e.g. of affection would cause conflict in many services. Forced to depend on networks and social institutions traditionally intolerant. Recommendations include education and raising awareness of the needs of the population with professionals, development of supportive and safe environments, improvements to ways information collected and policy initiatives that incorporate homophobia as grounds for abuse.	
Langley, Jackie 2001 *Developing Anti-Oppressive Empowering Social Work Practice with Older Lesbian Women and Gay Men*	11 women, 8 men between 51 and 68 who self identified as lesbian or gay. All Caucasian.	How older lesbian women and gay men perceived their needs should they become ill or disabled as they age.	Questionnaire about perceived future needs, potential support networks and attitudes towards agencies providing health and social care services, HIV, disclosure, views of life now and in future.	Most survey participants identified discrimination as an important issue. There was a lack of knowledge among participants of legal rights and places to go to get appropriate advice. Interviewees all expressed problems living as themselves, difficulties being accepted by their neighbours/neighbourhood, not being	Mixed methods

Title of Paper, Author/ Year	Sample	Phenomenon of Interest	Design	Evaluation	Research type
			8 participants (four men, 4 women) then took part in in-depth interviews exploring current lifestyles, past experiences, future needs and aspirations. No information given regarding how analysis of data was conducted or heading/themes reached.	accepted as a couple or being able to show affection in public. After partners, two thirds of survey respondents sought practical and emotional support affirmative of their sexuality from friends rather than biological family. 10 of 11 female survey respondents looked mainly to other lesbian women for their social life - 6 expressed wariness joining hobby or interest groups seen as heterosexual. All female interviewees described the affirming nature of lesbian social networks. Only 2 had retained ‘straight’ friends. 5 survey respondents said they would turn to their GP or social services if they needed practical support. Only 2 for emotional support. Concerns included services on offer would not be appropriate and fear of non-acceptance. Interviewees did not want day care but wanted to continue valued activities with people from existing social networks (similar to heterosexual ageing people). Fears about losing independence coupled with homophobia and isolation meant residential care was not a popular desire.	

Appendix 5 - Coding framework for included papers

Colour	Theme	Colour	Theme
🟩	Recognition of identity	🟥	Challenges of Ageing
🟦	LGBTQ+ Identity Factors	🟪	Community
🟨	Cultural competence in services	🟧	History/discrimination

Number	Authors/date	Number	Authors/date	Number	Authors/date
1	Alba et al (2020)	12	Simpson, Almack & Walthery (2018)	23	Wilkens (2016)
2	Boule et al (2020)	13	Willis et al (2018)	24	Sagie (2015)
3	Grant & Walker (2020)	14	Yang, Chu & Salmon (2018)	25	Brennan-Ing et al (2014)
4	Löf & Olaison (2020)	15	Boggs et al (2017)	26	McCann et al (2013)
5	Lottmann (2020)	16	Proctor & Krusen (2017)	27	Price (2012)
6	Lottmann & King (2020)	17	Czaja et al (2016)	28	Hughes et al (2011)
7	Hoekstra-Pijpers (2020)	18	Jones & Willis (2016)	29	Fannin (2006)
8	Siverskog & Brometh (2019)	19	McGovern, Brown & Gasparro (2016)	30	Brotman, Ryan & Cormier (2003)
9	Waling et al (2019)	20	Spatenkova & Olecka (2016)	31	Langley (2001)
10	Butler (2018)	21	Westwood (2016)	32	Smith & Wright (2021)
11	Jones et al (2018)	22	Willis et al (2016)		

Recognition of identity

Disclosure	
4	Transgender people have less control as it can be physically obvious. Some evidence that being open historically affected how open people were now.
7	80% felt disclosing sexual or gender identity to caregivers was useful.
9	Repeated disclosure to new staff is problematic and distressing about both LGBT status but also needs and often fearful of whether staff will be tolerant and inclusive.
9	Repeated disclosure to new staff is problematic and distressing about both LGBT status but also needs and often fearful of whether staff will be tolerant and inclusive.
10	More than half did not disclose their sexual orientation to homecare workers.
13	Some people had considered removing items from within their homes in order to not be identified as gay. Several felt that disclosure at an early stage was vital in order to screen out unsuitable carers.
17	Several participants withheld information about sexual preferences due to fears about receiving adequate treatment.
31	Participants noted the ongoing need to disclose being problematic, with a mixture of positive and negative responses helping to increase internalised anxiety about one's own sexual identity. One person noted it as a constant and exhausting process.

Openness	
2	Some changed appearance & behaviours to align with socio normative expectations. Repression.
4	Overarching desire to be open for all participants but differences in what is considered important in reaching the goal. Differences in how much attention they want paid to their identity. Importance of being able to talk about themselves and their lives including aspects of their sexuality.
7	Evidence that although some discrimination happened with caregivers (30%), openness has almost always improved the perceived quality of the contact with caregivers.
11	People wanted to be free to be their whole selves including being out but found it difficult due to lack of understanding of bisexuality. Being in a relationship (whichever gender) means being recognised as something you are not eg straight or gay
12	70% of staff were aware of LGBT colleagues as opposed to only 41% being aware of LGBT residents.
13	Those who reported having positive relationships with neighbours and local communities noted that this was possible through selective openness about sexual identity. Some were concerned that having people in their homes meant they would be identified as homosexual because of the signs within their environments.

14	Where people were open about their sexual orientation or gender identity, this reduced the odds of perceived isolation.
21	Many participants talked about ways they themselves or others they knew were not open about their sexual identity and this made them feel invisible. They had concerns relating to being open and what the response to that might be from others they lived in close proximity to ie in sheltered accommodation.
22	Participants reported withholding disclosure on many occasions to protect themselves from anticipated discrimination. Many had come out later in life and did not feel safe to discuss their sexual attractions and relationships during their youth. There were concerns about having to go back in the closet.
31	One respondent pointed out that sexual identity is about as important as being left handed but society's prejudices and fears make it a disadvantage. Some felt being open was about being able to talk with others about their sexuality without discrimination but for others it was about positively owning their sexuality and gaining recognition from the 'straight world'.

Invisibility	
1	Caring for LGB person more exposed to being visible
2	Identified as theme. Recognition that historical discrimination led to living invisibly. Some local communities force invisible living. Recognition of impact on developing and maintaining connections.
3	Concerns that heteronormative structures and attitudes of others in residential care particularly would mean going back into the closet.
4	Evidence that heteronormative environments made invisibility more likely.
7	Fear of being open leads to virtual invisibility within neighbourhoods and especially senior living facilities.
22	Older participants talked about having to make parts of their existence invisible, their histories and their sexual lives. A lack of recognition of individual histories.
30	Many maintain vigilance in maintaining secrecy which results in invisibility within a service context. This invisibility is then perpetuated by those in the system overlooking the possibility that older people may be LGBT, further marginalising them. This also leads to creation of a barrier to this group developing a voice, excluding them from planning, discussion and evaluation.
31	Participants actively hid their sexual identity to avoid the expected segregation and invisibility.

Problematic equality	
4	Some wanted to be treated like everyone else without focusing on LGBTQ identity.

Responsibility

2	Sense of responsibility to continue to support social change and educate.
4	Some recognition that it is individual responsibility to clearly articulate what is required/desired through education and familiarity with preferences.
5	Some focus on individuals' responsibilities to bring their own identity into the fore to allow for reasonable and inclusive treatment.
10	Partners sometimes left with responsibility to source appropriate services/living space without support.

Fighting	
2	Identified as a theme. Less energy for activism commitments. Fighting to show lives had value. Shaped identities as has been life long. Some were fatigued from fighting. Unclear why younger people are not doing this now.
4	Transgender people felt they needed to stand up for themselves and be open in their disclosure. Some that didn't want LGBT specific services as all areas should be inclusive.
9	One noticeable issue is that without family support networks to advocate on people's behalf, people have to do this themselves or be in a safe environment where this is not needed. Perception that of those that had suffered abuse or discrimination in services, only those with strong support (usually from family) would survive the experience. Some felt that LGBT specific provision did not help the fight for equality and acceptance.
10	Those with partners listed research and advocacy as part of the support provided for them.
23	Some women, who had been instrumental in activism and setting up support groups and things in the past felt that they had 'done their bit' and were keen to move on and allow others to become those activists. A protective stance was also taken about the groups that had traditionally been fought for, now potentially being compromised through the inclusion of trans women which was problematic for some. One person was prepared to fight for her right to be openly gay in care settings, stating that she had to put up with heterosexual people all her life.

Person Centred	
2	Fear of loss of rights and wider care provision not meeting unique needs. Lack of individualisation in being part of a disparate LGBT community.
3	Views that services were not in areas of interest to them. Worries about lack of recognition of relationships.
4	Focus for several on being themselves and this being about respect for individuality, personal integrity however expressed.
6	Inadequate recognition of life stories and individualities impacts on the level of fear of accessing services and support.
7	Attention to life stories, similarities and differences, loneliness, feelings of safety identified as important factors when making a judgement of quality of contact with caregivers.
10	Ability of workers to listen is an important factor in judging quality of care - recognising a person as an individual.

18	Preferences for the ideal types of service provision were focussed on a person-centred model of care where every level of care was available in one geographical location where the overall ethos was inclusive and repeated disclosure was avoided.
22	Older people felt that to have a truly person centred approach, recognition of their LGB identity was crucial to this. Staff viewed person centred care as things like maintaining daily routines, dietary preferences without recognition of someone's sexual biography could be a source of knowledge and understanding to be able to provide a more holistic service - person-centred care did not include sex, sexual identity or biography, essentially removing any individuality. Non-normative sexual identities were viewed as separate or irrelevant to providing care. Care staff communicate motivation to be attentive and responsive but lack the communication tools and confidence to be attuned to differences in sexual identity and life history.
27	Many carers had observed providers struggle to provide genuinely person-centred services, which resulted in them having fears for themselves if they needed care in later life. Anxieties included the quality of care they might receive in relation to their sexual minority identity. Some were worried of the influence of homogenous stereotypes getting in the way of delivery of person centred care.

LGBTQ+ Identity Factors

LGBT Community	
2	Disconnection from community & LGBTQ not one community identified as themes. Finding ways to identify other members of the community to create 'circles of support'. Recognition of discrimination within LGBT community itself - not a cohesive community. Some felt this was more recent. Was an active/visible member of the community but now single/older become invisible.
4	Some wanted to deconstruct identity groups based on sexual and gender identity. Deconstruction of structures and distinctions may be a preference. Main differences talked about were between transgender and LGB.
6	Was only a weak association between preference for LGBT specific care and feeling part of LGBT community.
7	Some evidence that self acceptance as part of the LGBT community influences acceptance by others (self identity). Some evidence that LGBT community is a victim of stereotyped ideas of enjoyable activities not reflective of the whole community. Some experiences where engagement with LGBT activities are negative as groups already formed and hard to infiltrate, especially as older people.
8	Being part of the LGBT movement includes a sense of belonging and a collective resistance. Helps to confirm your own identity, feel more comfortable leading to a better sense of self. Although creating spaces is viewed as liberating and strengthening, simultaneous experiences of friction and negotiating narrow norms of acceptable ways of identifying and expressing gender and sexuality. Evidence that transgender and bisexual people are often not accepted and some parts of the community can take a purist approach to being included, with one even talking about the type of clothing that is acceptable (i.e. no skirts) making members feel choked within these supposedly liberating communities.
9	Being cut off from the LGBTQ community and no longer being able to share those experiences viewed as potentially problematic.

10	Many participants noted important links to LGBT community but also to non LGBT community through groups and activities. Many had fond memories of being part of active LGBT communities and activism in younger years but only a few remained active members in older age and these tended to be specifically for older lesbians. Some participants noted again that it meant less connection to lesbian friends and that others (straight people) have different priorities. Evidence that several participants had connections formed in earlier life within LGBT communities that prevailed although were different now.
11	Participants gave evidence of discrimination from within LGBT community
13	Participants identified the importance of maintaining connections to LGB social networks where beliefs, politics, identity and experiences were common with others. Some felt that it wouldn't be enough to physically be located in LGB communities in larger cities but that networks then needed to be built within that community.
15	People reported benefits to remaining part of the LGBT community including continued activism, building of resiliency and availability of resources. People were keen to contribute to community efforts to support successful ageing. Older participants were proud of their social justice achievements and wanted to maintain momentum. Was an appetite for connecting with other LGBTQ older adults within community settings but variability in those who felt connected to a welcoming community and those who did not. Some were uncomfortable with the younger LGBTQ community, felt lack of appreciation for previous fights for civil liberties and social change and lack of acceptance of older LGBTQ people. One recommendation of study is community based advocates within LGBTQ communities who can identify isolated individuals and connect them to services.
17	Some participants noted that LGBT community based resources were usually focussed on younger people.
19	Participants spoke about the value of being part of a 'family', the local LGBT community. Some participants had families of origin but felt that they didn't necessarily have things in common with them and had a preference for forming networks within the LGBT community, creating families of choice. People spoke of the importance of feeling accepted. Article questions the definition of community in this setting as being broader than family or geographical location but actually more about the networks that people are part of and the importance of people having opportunities to be part of those 'communities'.
21	People were concerned about being unable to continue to link with their LGBT community connections such as specific groups. This connection to the community was felt to be important and was seen as a place to be able to talk about past experiences. In terms of care spaces, particularly focussed on housing options, mixed LGBT options were not considered positive, recognising that lesbian and bisexual women, older gay men and bisexual men had very little in common. Some felt there was no such thing as the LGBT community even with regard to fighting the same battles which was felt not to have a bearing on social connections.
22	Many older participants had forged 'families of choice' which helped them develop affirmative perceptions of themselves as LGB identifying individuals. Many female participants relied on primarily women-only networks within their local communities.

23	Some had been extremely proactive in the LGBT community in the past, establishing specialist centres of support. Some people were not out to the wider community and the opportunity to link with their lesbian community gave them the opportunity to have one safe space to be out. There had been much debate in some groups about the inclusion of trans women. Some services offered discrete groups but this was also challenging from a financial point of view but also some viewed it as politically or ideologically undesirable. Some spoke about the desire for non-scene social spaces where they felt excluded from LGBT events and places because of their age. Suggestions for ways to ensure groups continued was to look at intergenerational contact, and to have funded groups and paid leaders who would maintain impartiality and stop cliques forming.
25	One of the issues identified by participants in the quantitative data was the need for venues to connect with the LGBT community outside of the bar scene. People wanted opportunities to meet people their own age in a healthy setting, chances to meet other LGBT people, and reconnect with friends. Problems related to ageism were voiced in relation to socialisation within the LGBT community.
27	Many carers, regardless of age, felt maintaining links with other LGBT networks was very important. One person commented that LGBT people have specific ways of experiencing difference and belonging, and this meant that it was vital to have ways to be and stay connected to this. They saw value in being part of a majority, sharing culture, not having to explain, having the same reference points. One person talked about the misconceptions of gay people being problematic, that it is focussed on the act of sex rather than the wider existence and lifestyle.
30	Many face barriers within the LGBT community including with LGBT specific organisations who often have a poor understanding of the needs of seniors - spending energy responding to the needs of younger members but putting much less effort into developing support mechanisms for older people. This group has remained invisible even here. Many are youth-centred and do not represent older people, but also mean older people can be victims of age discrimination from within. LGBT community activists are well placed to advocate for changes to the system and provide education. However, they also need to link with this population first to fully understand the needs to be able to advocate effectively which means tackling ageism within the community.
31	Some of the men said that being a gay man hadn't affected their social lives but others commented that it was difficult to find opportunities to socialise with others from the gay community and it was difficult to find suitable gay outlets. A focus for younger gay men was clubbing and youth orientated activities which exclude older people. Many women spoke of the value of maintaining lesbian networks and lesbian friends, talking about the positive and affirming nature of these - greater inner resources to survive.

LGBT specific provision	
2	Some social care tasks are very specific (eg transgender personal care) that need specialist provision.
3	Additional challenges around sensitivity and continuity of inclusive care
4	Primarily single participants wished for or lived in LGBT specific provision i.e. senior housing. Those that didn't still saw its value and place.
6	52% les, 42% gay selected undesirable for living in care/nursing home for anyone. Over half felt LGBT specific provision was desirable.

7	75% respondents accessed activities specifically designed for LGBT older people, only 53% wider activities in their neighbourhoods. Some benefits in terms of connections with having LGBT carer. 40% of those who didn't access LGBT specific community activities said it was because there were too few people their age there. Some did not like the way LGBT identities were expressed eg hypersexualised. Some negative experiences due to age.
8	Common that those who had been part of activist movements previously had formed long standing relationships and connections from this, so although not LGBT specific provision, was long lasting benefit from links with LGBT organisations. Issues with discrimination within these groups also, particularly for transgender people. Ageing does not necessarily mean these kinds of LGBTQ spaces become less important in later life and the potential need to identify with these subcultures remains important for some.
9	Some talked about the lack of sense of community within some services which does not reflect LGBT people who have built communities themselves historically in order to be resilient against experiences of discrimination and violence. Most participants already intentionally live in lesbian or gay friendly communities. Many expressed a preference for services that were LGBT specific based on beliefs they would fit better in such environments, have more in common with others and be able to be open without fear of discrimination. Those less keen still saw value for others.
10	Around one quarter indicated their vision of ideal long term care would be an intentional lesbian community with lesbian caregivers. 60% of participants felt being lesbian affected who they were and how they interacted with the world and that their experiences and identities needed to be understood by systems and care workers in order to feel safe accessing the services.
11	Some would not access LGBT specific provision because of concerns of LG demonstrating prejudice towards them as B.
13	Many sought connection to the LGB community through specific LGB networks, on and offline. Some used online tools as a way to organise group meetings or connect with forums, with men using it more for one-to-one connections.
15	Many participants felt that LGBT specific provision was more desirable than wider services although some were open to the inclusion of straight allies potentially demonstrating a desire for acceptance as being key. People suggested that any kind of resource centre needed to be both age and LGBT specific - a trusted source of information and education. Some noted that this would need to be available more discreetly also for those not 'out'.
17	Participants talked about the need for opportunities to link with the LGBT community and to be able to access specific support. It was important that this included knowledge of the needs of LGBT communities and where resources would be available. There was a need for services that either specialised or were sensitive to LGBT needs. A need for a range of opportunities was included such as socialisation opportunities, exercise, awareness raising around legal rights but all geared specifically to LGBT older people.
18	Was a recognition that for trans people, the opportunity to build and sustain community connections with other trans people may have supported them to feel included, supported and understood and that providers had a responsibility to create these networks and this sense of belonging. Also needs to be a recognition that LGB inclusive services would not necessarily be trans inclusive as gender and sexuality are not the same. There were mixed feelings about Trans specific services, with some feeling this would be positive, some wanting access to support that wasn't necessarily trans focussed but specific to them and their sexual and gender identity individually - so not just trans but also 'queer'.

19	Although LGBT provision, it was also accessed by allies and greatly valued. People were enthusiastic about being accepted, the lack of judgement provided by the resource and its members, awareness of the issues faced without needing to explain things. One person had accessed other generic resources and felt they were not as welcoming and had a different focus. People felt that the centre would continue to help and support people as their needs became more complex, demonstrating a reliance that may not be seen in a generic service as there was recognition that LGBT people might be less likely to have that kind of support and advocacy as they aged.
21	Of the 45 participants who had a preference for future care, the majority of women wanted this to be either women only or lesbian only (lesbian only being the top choice) and mixed LGBT provision being at the bottom, although the majority of men wished this to be mixed mainstream provision with gay men only second and mixed LGBT provision being at the bottom of the list. Mainstream provision was noted by some as the better option to avoid segregation. The LGBT spaces were considered to offer solidarity, reciprocity and support. Research argues that failure to provide some of these required, specialist options could be seen as discriminatory under the Equalities Act as it does not reflect the identities and cultural needs of this group of people. Also an issue with self-directed support (designed to personalise care options) can not then be used to purchase individualised support as it is not available in the market.
22	Over half the participants had a preference for LGB specific facilities, imagined environments where heterosexual norms and assumptions would not feature in care delivery and this would therefore mean feeling safe and valued. It was a more common preference among women-only networks and was related to mutual support. There was an element of seeking environments where contact with partners, lovers and friends is facilitated.
23	Many women talked about mainstream groups exacerbating feelings of isolation and loneliness. Struggles included heteronormativity structured activities e.g. speed dating, and discourse being focussed on these heteronormative structures. These groups were seen as ways of affirming lesbian identity in a straight world. Most participants wished for same sex/age/sexuality groups. For those that attended mixed LBGT groups, they felt these were dominated by gay men. People felt that same sex/age/sexuality groups offered safety, a sense of belonging and acceptance and a validation of lesbian sexuality. Many participants felt that if they were no longer able to access these groups that they would lose part of their lesbian identity. Mainly groups were spaces that offered friendship and company.
27	Some respondents were very much in favour of LGBT provision, particularly with care and support delivered by people who were LGBT themselves, or from those who recognised and accepted LGBT service users that may have non-standard needs. There was also recognition of the dangers of LGBT specific services effectively ghettoising and further separating LGBT people from mainstream society. Some felt it would bring a sense of safety and relaxation as LGBT identities were the norm, where you were no longer the minority. There was also recognition that those who had worked hard to keep their identities private may feel this threatened their carefully constructed control mechanisms. Many felt that specialist provision and more culturally competent mainstream services would be the norm in the future and these issues were time sensitive because of this generations historic experiences.
29	Some people stated a preference for gay specific residential care and most noted the importance of their sexual identity being taken into account. Others felt that gay exclusivity might be counter productive as it would isolate people further from society. This was complex though as it was broken down into lesbian, gay male, gay mixed, single sex, mixed gender, gay friendly. The biggest single majority chose 'gay friendly' rather than gay specific although the others added together were slightly higher in total. This was also true for sheltered housing options.

Preferences

2	Traditional LGBT specific spaces and activities designed with young people in mind, does not account for older people and different preferences.
3	Types of service seemingly gendered eg around traditional feminine roles and activities
7	Expressing staff preferences and self advocating useful strategies for ensuring care and support is of quality desired.
8	Preferences for types of activities change with age and this doesn't always fit with the ways the LGBTQ community gather and spend time together.
9	Overall preference for people to be able to stay in their own homes than go into any more formal care. Definite preference to be able to have staff that were gay friendly.
13	Women in particular voiced a preference for female carers, either lesbians or those with an LGB family member, so as to feel understood and respected.
23	Some felt that inter-generational groups were important but did not necessarily want to engage with them - referring to the possible lack of shared experiences. Some felt that a main group that was the same age would then allow for choosing to also engage with inter-generational groups as an additional opportunity.

Safe spaces	
2	Underground community identified as theme. Safe spaces remove concerns about what local attitudes might be in a community. Ability to find safety & comfort in those shared experiences.
3	Community services experienced as ambiently heterosexual spaces, not safe spaces.
4	Those in LGBT specific housing felt it was a less risky environment and it allowed openness in a natural way.
7	Receiving care at home means caregivers/staff entering people's own safe and identifiable/visible gay spaces. Some evidence that domestic materialities and broader home-making practices were identified as sources of understanding which could potentially improve quality of contact with care - home making practices even as private expressions of LGBT life histories and identities may have transformative dimension beyond the homespace.
8	Spaces not only feel safe but can bring something meaningful, belonging to something beyond the heteronormative world. Also gives the opportunity to formulate strategies for change. These safe spaces change over time and can feel less welcoming and appropriate as people age.
9	A safe environment is viewed as extremely useful when unable to advocate for self due to age and needs, so as to negate the need for this advocacy.
11	Practical issues such as polyamorous family of 3 not being able to find suitable accommodation
13	Where groups want to provide safe spaces to meet and connect with LGB people/ groups/ networks, there are some problems with local businesses willing to provide the physical spaces. Some were using online spaces as a safe place to connect with others. Some people worried about care in the home as their sexual identity was visible within this environment. However, there was also evidence that this was an important way for people to express their LGB identities.
15	Recommendations of study included a safe place that older LGBTQ adults could gather for social interaction and to gather information.

19	The centre provided a safe space for participants and this was highly valued. The value of the connection with others using the centre was talked about by all participants - none spoke about the centre meeting other concrete needs. The centre offered a safe space regardless of sexual identity which was viewed as important by the LGBT people who have suffered discrimination as they were keen this did not happen to others.
23	Some women saw the possible inclusion of trans women a threat to their safety - many identified empathetically with them but displayed conflict and a feeling of compromising by including them in women-only groups. Some justified this because they had fought hard for that space in the first place.
31	People sought out safe spaces like gay cafes, hotels and amenities where they felt free and accepted. They did not want to engage with 'day care' but wanted to continue valued activities with people from their existing social networks (also common to heterosexual people).

Heteronormativity	
2	Still felt to be pervasive. Providers of care need to avoid assumptions perpetuating harmful stereotypes or normative discourse.
3	Women perceived community based health/social activities aimed at healthy ageing as heteronormative.
4	Participants connected the level of openness to heteronormativity of setting. Wanted to be themselves but not have to act in line with heteronormativity or gender binarism.
5	Heteronormativity even more impactful when looking at intersectional perspectives
8	Some issues with creating safe or LGBTQ specific spaces caused by surrounding heteronormative society and practical issues such as caretakers of buildings being uncomfortable so the group is no longer able to rent physical space.
9	Noted by several as everyday experiences of heteronormativity difficult to manage and would be more so within care settings.
12	To address some of the findings in relation to the lack of policies, staff training and inclusivity markers in services, it may be that services require a rudimentary and step by step approach to challenge the heteronormativity seen that results in the invisibility and problematic equality treatment of people in services.
15	Many participants felt that social care services relied on models of practice that excluded sexual orientation, gender identity and family context meaning they were more likely to fail to address the specific needs of LGBTQ people.
21	Most participants felt that older age housing/care spaces were inherently heterosexualised. One was involved in the committee of a day centre they wouldn't attend themselves because of its heteronormative structure. This was related to simple things like language used, topics of conversation.
22	Many older people felt that heterosexual norms and assumptions were embedded in care settings, milestones such as marriage and birth of children dominating discourse. Even those that had been married and had children framed it as a separate life chapter from their present lives and resented the prospect of being presumed straight.
23	Women viewed future care options, particularly residential care as heteronormativity structured.

31	Women in the survey looked mainly to other lesbian women and lesbian venues for their social life with a large proportion demonstrating caution around accessing hobby or interest groups which were seen as heterosexual.

Gender	
1	Carers - Lesbian women fared worse than gay men in line w gen pop
5	Gender identity was the starting point for experiences of discrimination in some types of care. Gender of carers is also significant to experience.
6	Gender of homecare workers deemed important or very important by 35% of lesbians (only 13% of gay men, where 45% felt it was very/unimportant).
8	Many examples of lesbian women being clear that part of creating safe spaces is the link to women only being central to the 'safe' element of a 'community', reflecting on the feminist view that the gay community is dominated by men in a similar way to the rest of society. Extremely problematic for some trans lesbian women.
10	The relationships that were formed between people and their care workers sometimes impacted the social support systems in place - these were almost exclusively women, often older.
13	Some lesbians had sought women-only networks in their local areas (rural). Some also identified a preference for women-only carers or those with direct experience of an LGB family member.
21	Many female participants (with a wide range of sexual identities) were concerned about being made to mix with men demonstrating that this was not linked directly to lesbians but all women who had a preference for female only care in the future. Evidence within this study and others carried out previously that for women, gender is as significant as sexual identity.
22	Many female participants were concerned about contact with males, something they had not had in the rest of their lives and something undesirable. This included male carers.
23	When thinking about future care needs, many women suggested that being cared for by or with men was problematic or distressing. This included the risk of harassment.

Cultural competence in services

Staff competence	
2	Having informed care providers sensitive to unique needs.
3	Evidence that rurally based services were less likely to have trained staff or have staff with LGBT awareness.
4	Desire to talk with staff about life stories that don't follow heteronormative structures. One said staff asking is acceptable as it's about delivering the care that's right but that also tired of instructing people.

5	Participants recall being treated with disgust by staff. Identified that staff having some knowledge and awareness is crucial for good delivery of care.
6	Sexuality of homecare workers deemed important/very by 34% lesbian women (not by gay men).
7	Evidence of discrimination from caregivers for 32%. Markers within home environments could be used as ways to start conversations but are not usually picked up by staff. Some awareness training around this might be helpful in recognising those markers. Also work to be done to ensure newcomers are welcomed to activities and groups.
9	Those using services cited workforce skills and capacity as being problematic in terms of their experiences. Several felt staff needed better training.
10	One example of homecare expecting an able partner to pick up care tasks. Sexuality of staff did not correlate with whether participants felt good care was provided. Maturity, caring nature, reliability and competence felt to be key factors. Young carers often felt to be less reliable, less attentive.
12	More than 4/5 staff would not feel embarrassed to talk about LGBT issues. 83% did not think homosexuality was wrong. 2/3 felt staff should receive specific training on the needs of LGBT. Majority had not received LGBT specific training in the workplace, in contrast to number reporting training in other areas of cultural sensitivity. Only 5/6% in the current workplace. 56% were either unsure of need or deemed it unnecessary, 44% wanted more training.
14	People were less likely to feel isolated if they had experienced a welcoming service provider. Although not statistically significant for those that lived with others, for those that lived alone, welcoming service providers was statistically significant i.e. more likely to have had a positive effect, with a reduced odds of 84% for perceived isolation. In comparison, those who had not experienced welcoming service providers were 5.3 times more likely to report perceived isolation than those who were not living alone.
18	Perception that overall poor care delivery was exacerbated for trans people by a lack of insight, awareness and readiness to offer good quality services. Being willing to learn and educate about things, open to experiences was viewed as positive. Was also felt that providers needed to facilitate this and create cultural experiences that could expand knowledge and contribute to good practice. People were happy to help with that education but needed the opportunities to do that. Was also a desire for services to be mindful of how they needed to adapt to remain relevant to the needs, expectations and assumptions of older people, especially those who had previously been involved in activism and wanted to continue with this activity, as well as being able to benefit from ongoing social changes.
21	One participant who worked in care regularly witnessed care staff telling gay jokes or using slang words and this not necessarily being recognised as abuse, but as a result being unable to disclose their own identity.
22	Fear included negative treatment from staff, physical or verbal abuse, being separated from partners and significant others, losing contact with people, having restrictions placed on their privacy within their own homes, especially where partners were younger. Staff gave examples where they were not necessarily challenging inappropriate behaviour from older heterosexual residents (mostly towards themselves). Also evidence that sexual identity wasn't spoken about in front of some residents because they would have objections rather than tackling this prejudice. Staff demonstrated limited understanding of sexual identity, LGB symbols and in some instances didn't even use the words 'lesbian, gay, bisexual' aloud. Some staff had limited awareness of historical discrimination and social/legal rights and attitudes. Taking a 'how to work with LGB people' approach to training would imply distinct health and social care needs as a separate cohort which potentially increases social divisions and overlooks diversity within and between LGB lives - should really be more about cultural competence, increasing interpersonal skills and attentiveness to all residents sexual biographies, not just LGB.

27	The author discusses the possibility that things like markers of sexual identity may be less noticed or needed by younger generations who have not experienced the social change that older people had and that could be problematic for younger care staff, who may not consider the significance of sharing or disclosing this identity. Many were worried about damaging and misleading stereotypes influencing the way they would be treated in services.
28	68% of staff stated they would feel very comfortable providing care or support to older LGBT people, 22% felt somewhat comfortable, with just 5.9% somewhat uncomfortable and 3.5% as very uncomfortable. 63% indicated they would like more training around a range of topics and issues. Staff education and comfort level was noted as a challenge by some services to being able to effectively support older LGBT people.
29	People felt that if in receipt of homecare, they should be accepted by gay or gay friendly carers. They wanted to continue to have cultural visibility in their own homes.
30	Some were confident that services could be improved through adjusting their views, thinking about this marginalised group specifically through education and awareness raising, educating professionals and staff. Improving communication would help with building trust. Services that have historically excluded people will need to build trust before people will feel comfortable to access them confidently and in a timely way.
31	Recognition in conclusions drawn from study that services in general focus inappropriately on bringing people with similar needs together, these needs being frailty, loneliness and being an older person. These do not then focus on ways to enhance self-respect, enjoyment or promoting independence.

Markers of inclusivity	
2	May not be just about service actions, but history and attitudes of local area service situated in. Felt displaying LGBTQ symbols, adopting inclusive organisational mission statements and employing LGBTQ staff/volunteers and allies all positive.
3	LGBTI inclusion is often left to singular 'change champions' so conditional on individual staff.
4	Would be careful and choose staff who seem trustworthy before being open. Reliance on individual employees to treat competently and affirmatively. Using visual markers and affirmative language.
7	53% would be more open if caregivers use more neutral words. 68% would like to see LGBT visual materials. Having sexual identity clearly noted in files avoids repeated need for disclosure and avoidance of heteronormative discourse. Problematic even when staff talking about their own heterostructured families.
9	Most people only spoke about residential care when asked about aged-care services - were not aware of availability of say, homecare.
10	Older workers with common interests helped to formulate positive relationships with care workers.
12	Low numbers of staff able to report positively on a range of practices designed to promote inclusion. Measures included encourage residents to talk about LGBT issues (25%), links with LGBT organisations (8%), availability of LGBT literature (8%), recognition of distinct LGBT needs (35%), use of LGBT in publicity (5%), appropriate language on assessment forms (42%), LGBT issues discussed openly (30%). Although 85% of staff felt their service welcomed LGBT people, this was not backed up by the above measures indicating a lack of institutional support and commitment to fostering inclusion.

14	Demonstration and understanding of inclusiveness potentially served as a substitute for other missing networks and connections and meant people were less likely to feel alone. This demonstrates the importance and potential impact of culturally competent providers of support and care. Also potential to influence whether people access additional services as required in future.
15	People felt that advocacy, buddy programs, competent providers and a welcoming community were the way forward for providers to meet the community's needs. Positive attitudes and experiences of a buddy system which might include some forms of assistance as well as companionship. Providers who are aware of and comfortable with LGBTQ orientationand ask informed questions as well as being welcoming.
18	Participants felt that cultural competence was as much a mind-set as as possession of a set of skills, information and associated good practice - being open-minded, non judgemental and assumption free. Simple actions such as using the appropriate pronouns was fundamental to that person's experience. Several participants' descriptions of ideal services included individualised options available in one place so that the need to change care when needs changed was mitigated including avoiding having to disclose repeatedly. Some felt the opportunity to access independent advocacy for negotiating support would also help with this.
21	People noted opportunities to have privacy, have markers of their own lives available were important in a service feeling inclusive. People were unkeen on forced participation, especially where this was likely to be heteronormative in its structure.
22	For older people this included welcoming partners and friends, upholding privacy, facilitating time with partners, physical signs of affirmation such as rainbow signs, same sex couples in pictures and an ability to comfortably discuss personal and sexual lives with other residents and staff. Hopes did not match expectations. It included a combination of respect for the LGB identity and life story/history that went along with that. Respecting individuals includes recognising preferences and wishes in relation to clothing, gender of carers, language used to describe identities and relationships, difficulties related to mixed-gender environments, willingness to respond to instances where safety and wellbeing might be compromised by the actions of others, being prepared to challenge oppressive views when those compromise the right to feel safe
27	Carers identified basic issues such as respect, privacy and personalised care to be markers of good quality care, as well as simple acts such as knocking on the door, dressed in their own clothes, ability to make choices about how life was lived, opportunities to express sexual preferences, have important people acknowledged and validated. Access to gay literature and entertainment was also a factor for some. There were also concerns about providers coming into people's homes and recognising their sexual identity and not subsequently respecting the privacy of that. One person pointed out the simplicity of a kite mark system and how that could be adopted by services as a simple way to demonstrate the cultural competency of their organisation. Conclusions include that spaces, practices, language and symbols that suggest services are providing a non-discriminatory environment would be important.
28	75% indicated that there were no activities or efforts by their service to address the needs of older LGBT individuals. Where there were, these were usually staff training. 74.7% did not have materials or information available specifically for older LGBT adults, 16% were unsure, 8% did have them available. Some respondents felt that there was nothing their service did that could be classed as strengths or challenges in providing support to older LGBT adults. Nearly half the respondents did not answer that question. Several noted their openness to work with them as a strength, some had LGBT board members or employees, some noted open minded staff.

Management/ policy	
1	Access to benefits & support when caring for partner as not always recognised as significant other
2	Identified as theme. Generally felt more inclusive due to policy/law but seen as temporary and inferior to hetero. Fear these might change again in future. Vital that organisations implement policies to promote inclusion.
3	Rural healthcare providers are less likely to have LGBTI inclusive principles. Political situations used to frame discrimination.
7	Benefits identified in communication with care provider organisations about which caregivers are compatible.
9	Lack of inventiveness in how to tackle isolation from services, why homecare didn't do more to build community. Staff turnover in homecare noted as problematic.
12	Desire for staff training increased with increasing age of staff, 70% managers keener than the 58% of care assistants. Managers considered themselves most knowledgeable about LGBT issues as did older staff. Policy knowledge is higher in mixed nursing/residential but still only 41%. Only 17% could give specific information regarding laws affecting LGBT residents. 72% didn't know if the workplace integrated law into policies. Lack of policies and measures marking inclusivity could effectively result in erasing gender and sexuality and bear out as toleration but fall short of genuine equality and inclusion.
15	Many participants were not aware of their own rights in relation to care planning or legal rights. This was felt to be an important part of any service that might be offered, up to date information and explanations about LGBTQ policies and rights and other resources. Recommendations of study include a centralised knowledge resource housed within a welcoming community setting that can be easily accessed. Recommendations of study included efforts to educate service providers to increase awareness and acknowledgment that older individuals may have experienced a long history of oppression and may be wary of disclosure despite efforts to provide a welcoming environment.
17	People wanted access to services that focussed on strategies to enhance knowledge as well as more community based resources than are currently available. Recommendations included that providers of services are informed about the unique needs and concerns of lesbians and gay older people and carers, that services are available and accessible.
18	Was an overarching feeling from participants that because a lot of services are delivered one-to-one, there needed to be a commitment from management and structures in services to build skills, knowledge, confidence, articulacy and empathy for frontline care staff to successfully engage with trans people. This all needed to be reinforced through management practice and policy. Removing and challenging assumptions that explicitly or implicitly exclude people is a key expectation as it was acknowledged that management set the tone, culture and ethos of the service. Some noted that many services managed their equalities responsibilities through meeting minimum requirements to avoid prosecution rather than having a genuine commitment to diversity.

22	Managers felt that it was appropriate to seek to prevent emotional distress by shielding people from discriminatory views rather than tackling them. They felt that initiating discussions about sexual identity might cause offence to individual residents or infringe on privacy, relegating LGB identity to the private sphere and not for public discussion. One even defended individuals rights to to express views even if these were homophobic or racist, stating that the person who was the target should be the supported one 'picking up the pieces'. There was no indication of how the perpetrator might be addressed - assuming fixed beliefs and an unwillingness to consider others. Also means LGB people's right to feel safe is superseded by the rights of others or to express views freely. Managers did recognise the need to do more to enhance knowledge around sexuality more widely as well as LGB issues. Some sought experiences from others, some talked of guidelines on how to work with people. Strong leadership was perceived to be fundamental in driving this forward. Should also feature in a statement of purpose that service is inclusive.
27	Some carers identified their wishes if needing care to have opportunities to express themselves sexually which may be problematic with providers who fail to recognise older people's sexuality, particularly those with dementia where it is often pathologised, People were worried about homophobia from other residents.
28	60.9% felt their services were appropriate for LGBT older people, 10.3% felt they weren't and the rest were unsure. However, the rates in response to the level of priority that would be given to the needs of older LGBT people were much lower (29.9% somewhat a priority, 32% low priority, 26.4% not a priority. Overall results indicated that although there were individuals within services who could act as advocates, there was little institutional interest or support to guide them. Resources were not being directed and although staff understood the potential for different needs, agencies were not structured to recognise that, in contrast, not collecting data so effectively causing invisibility of the population or stating that they served everyone regardless of sexual orientation, again effectively ignoring the potential different needs and approaches required.
30	People reported that when the needs of LGBT older people are raised at national seniors meetings and conferences, the most prominent reaction is one of discomfort and a lack of willingness to place the issues on the agenda for discussion. It was felt that there would be a real benefit to added protection through policy initiatives that incorporate homophobia as grounds for elder abuse, entrenching it as a category of discrimination providing an opportunity to embed this as a legitimate right, to be free of this discrimination. Institutional policy changes need to be made, followed by advertising the affirmative nature, reaching out and participating in community events, inviting community groups into their settings to create an atmosphere of partnership. Many organisations place little importance on privacy, ignoring the potential sexuality of all older people.
31	It was felt by the author that anti-oppressive practices were unlikely to develop within organisations that did not demonstrate their opposition to homophobia and heterosexism. Conditions need to be created where homophobic and heterosexist comments are systematically addressed and challenged but without protective legislation these conditions are unlikely to develop.

Problematic equality	
2	Singular narrative discounts intersectionality and discrimination within LGBTQ community.
4	Want attention paid to their specificity rather than equal treatment. Having a discussion with a person about this is helpful. Particular focus on qualities of individual and LGBTQ identity. Transgender people have stronger support for equal treatment.
12	Some issues highlighted with lack of knowledge of laws specific to LGBT rights.Some evidence within analysis of answers given that tolerance mistaken for thorough understanding. Staff mistakenly thought that lack of training was due to the fact that people should be treated the same or that there were no LGBT residents.

20	Both direct caregivers and social and healthcare students felt there was no need to differentiate between older heterosexual adults and older LGBT adults. They felt that their care needs would be similar and the approaches needed would not need adapting. They felt that behaviour was much more significant. However, most did not have experience of caring for an older LGBT person. Reasons given included drawing attention to them as individuals which could cause problems.
22	Older participants emphasised the importance of equal treatment through shared values of respect and dignity, so equal treatment was not seen as problematic. One staff member stated that there were none in their service. A staff member stated that it wasn't discussed because when you are providing care for someone you tend to their needs or what's good for them rather than considering that element, intimating that their sexual identity is separate to/not relevant to their needs. For many staff equality equated to sameness - an approach that you are the same with everyone, in detriment to recognising individual differences in sexual identity and biography. Older participants felt that equal treatment meant respect and recognition for identity and the role of significant others, including privacy and respect being intertwined with recognition of LGB identity. Within the sameness discourse is an assumption that it is the responsibility of the LGB person to initiate discussions about their sexual lives, significant others and to correct heteronormative assumptions.
28	63% of respondents recognised that LGBT people might have different needs from their heterosexual counterparts although responses varied including one which noted that they could not think of anything they would do differently in terms of delivering care.

Invisibility	
2	Recognition that historical discrimination led to living invisibly.
4	Crucial to increase knowledge throughout organisations.
5	Intersex person - Moved from general care area even though not justified/paid for
7	Care receiving in home brings in aspects of visibility.
9	Examples given of staff not recognising some very clear signs eg not recognising that someone's regular visitor was a partner.
11	Complexity of coming out when bisexual/polyamorous.
12	67% of staff said that they had never had a resident disclose homosexual identity, 59% said they were unaware of any LGBT residents. Results showed that 79% didn't know/said no to if workplace monitored civil partnerships, 76% didn't know/no re trans identity, 72% didn't know/no to monitoring of sexual identity. Staff equated lack of training provided to the fact that there were not any LGBT residents. Lack of clear markers and policy driven measures means non-normative expressions of gender and sexuality could be effectively erased from practice.
17	Participants note that invisibility starts with the forms you fill in before you have even accessed any services which do not acknowledge any other lifestyle.

22	Staff were not able to readily identify LGB residents. There was no evidence of discussion of LGB lives, no allowances made for heterosexual couples e.g. adjoining rooms, LGB identities and histories were absent from staff development activities. Staff identified that this information was not included in resident's care plans which made it difficult to build rapport. LGB staff and staff relatives were much more visible. Managers' feelings that open discussions were not appropriate meant that LGB identities become invisible on the basis that it may offend others or be infringing on privacy. Openness from people requires trust and confidence and staff to initiate ongoing discussions with people.
28	69% stated their service did not ask about sexual identity, 16.1% were unsure, 5.7% said they asked and 4.6% felt it did not apply to their agency.
30	Invisibility is exacerbated by systems which do not collect the right data. Many noted that assessments overlook important aspects of people's lives such as sexuality sometimes due to professionals discomfort with having those discussions. Clients wish to remain invisible to protect themselves and professionals discomfort with raising the topic creates a vicious cycle of oppression and these professionals then don't need to develop better knowledge and understanding of what the issues are.
31	Points made by the author about the problematic system include the recognition of the heteronormative structure of forms, assessments, referral forms etc and how these can exacerbate invisibility but very easily could be adapted to avoid that.

Challenges of ageing

Isolation	
2	Discussion related to the need for invisibility impacting on opportunities to develop and maintain connections.
6	Large number of respondents who felt they had no-one to turn to for any type of support, especially full-time assistance.
8	Evidence that many who had not been part of activist groups in earlier life did not have historical networks to call on, had little support and very small networks.
9	Concerns related to being separated from partners and less options when a gay couple in comparison to heterosexual couples. Disappointment that care services didn't do more to link older people together -when using homecare this is a solitary activity and policy doesn't allow linking up.
10	One third of the sample described a degree of isolation. Two attributed this partially to homophobia in the local community /neighbourhood.
13	Was evidence of people using online tools to combat isolation, with men using it for one-to-one communication and women using it to connect with forums and as a platform for organising group meetings.
14	Isolation was much less likely if people had experienced a welcoming provider. People were less likely to feel isolated if thay had experienced a welcoming service provider. Although not statistically significant for those that lived with others, for those that lived alone, welcoming service providers was statistically significant i.e. more likely to have had a positive effect, with a reduced odds of 84% for perceived isolation. In comparison, those who had not experienced welcoming service providers were 5.3 times more likely to report perceived isolation than those who were not living alone.
15	Many participants had a fear of increased isolation as they aged.
17	People were fearful of being alone and socially isolated, or that their partners would be isolated if anything happened to them.

23	A sense of belonging was associated with lower levels of perceived isolation and depression. Many had struggled in previous history to make and maintain friendships as they were forced to conceal their identity. These people talked of the benefit of being a member of the group as going beyond the benefits of attending, that belonging and knowing the group was there helped to alleviate feelings of isolation at other times as well. Being a member of the group actually removed feelings of isolation. There was clear consensus that groups were an important way to reduce isolation and improve wellbeing. Many had great fears of isolation if they were no longer able to connect with these groups. There was evidence that the groups offered the capacity to provide comfort, support and resilience, reducing isolation and loneliness and the mental health problems associated with these.
25	One of the clear areas of need highlighted within the quantitative section of the data was the unmet needs concerning opportunities for socialisation, often motivated by feelings of loneliness and isolation.
29	Around 60% of respondents reported some degree of isolation, 10% felt they had no social life and 25% felt they did not have adequate support. The majority wanted opportunities to meet people socially. conclusions drawn included that responsive and accessible services can reduce isolation and exclusion.
31	Was a recognition that placing someone in an inappropriate service e.g. day centre to tackle loneliness and isolation could actually increase those feelings if people were subsequently excluded or ostracised in those settings.

Wellbeing	
10	The level of informal support as well as the degree of need determined when formal care services were sought.
15	Participants were concerned about their future social care, support and care needs.
24	Study found positive correlations between subjective well-being and physical and mental health, level of function, community availability and accessibility, objective and social participation, environment and living conditions. Hope, physical and mental health and community availability and accessibility were significant predictors of subjective well-being, with social participation being almost significant. This continued to be the case when variables controlled for background, health and function - subjective well-being and accessibility and participation remained significantly linked. The results demonstrate that communal resources serve to increase LG well-being and sense of agency.
25	16% of respondents reported having moderate levels of depressive symptoms, 1 out of 5 had severe levels of depression. Older gay men were significantly more likely to have severe symptoms.
26	Several interview participants highlighted the disenfranchised nature of their own grief and others they knew who had lost a same-sex partner. Some also spoke of grief like experiences after coming out and being ostracised by family members.

Age discrimination	
2	Identified as part of a wider theme. Particularly noticeable within LGBT community but also in wider existence so twice the impact.

5	Gender, age intersect as older women are asexualised.
7	Of those who didn't utilise LGBT specific service provision, 16% feared ageist attitudes. Some of those who had tried LGBT activities found they were not suitable for older people or not welcoming of older people.
8	Can be challenging to fight against age discrimination within the gay community itself, especially in regards to relationships and connections. This results in older people feeling excluded from the community.
12	4/5 of staff recognised residents as sexual beings and 2/3 believed residents could be sexually active.
21	Some participants demonstrated age discrimination themselves, stating opinions of stereotypical older people's services being smelly, singing war songs. This was also seen when female participants were talking about their preference for women only care, with assumptions made that old men would be disinhibited and sexually aggressive or inappropriate.

Power	
2	Power(lessness) and (de)energisation identified as themes. Felt not taken seriously. Stated that volunteering and contributing to the local community was empowering, provided visibility, value and connection.
5	Worries that will be less able to defend themselves against discrimination in older age, less self determination.
8	Some situations where age and experience holds power, there are opportunities to teach, guide and support younger members of the community. This knowledge and the previous fights the generations have been part of may add to one's social capital within the subcultures. Recognition that both physically and mentally, fighting discrimination and abuse is harder in old age - less power and resilience.
9	Loss of privacy, autonomy and independence, inability to make choices.
10	Some noted being stronger, less dependent, more active and less constrained by societal expectations than hetero peers. Comments included being less vain, less out to impress others.
15	Participants noted that being part of the LGBT community had provided them with resilience, and that ageing demonstrated that a person had good coping skills as they had survived through the difficult history of LGBT. Was some appetite for older LGBT people to be part of an offer for advocacy to younger people as natural activists.
16	Volunteering and helping to run some of the community based activities gave some participants purpose and allowed for formation of networks.
18	Participants who had been activists talked about wanting to be able to continue this activity in their older years, to benefit from the social changes that were to come but also to be able to continue having an opportunity to challenge discrimination, exclusion and invisibility. This power would need to be accepted by providers as people would be less likely to tolerate this kind of treatment and would have the experience, confidence, abilities and networks to challenge exclusion through both social and legal action.

21	When some felt discrimination was being displayed, because they were not comfortable to openly identify, it removed their ability to challenge these views for fear of disclosing one's own identity in a situation where this did not feel safe. This also extended to women who talked about the lack of ability to fight off unwanted advances or behaviour from older men. There was also a linked perception that care staff would not deal with this with the gravity it deserved, further disempowering women and excusing men's inappropriate behaviour.
24	Findings, predominantly links between well-being, hope and social accessibility and participation demonstrate that hope may mediate the relationship between well-being and social participation and environment and living conditions.
26	Although many participants had experienced low points with their emotional well-being, the majority considered their mental health to be good, related to positive coping strategies and resilience developed over time.
29	Some felt that getting older allowed them an increased confidence to share their sexuality with others and of having well established networks.
30	Many spoke about the fact that historically remaining invisible had been a strategy that has subsequently resulted in an increased capacity for resilience against the onslaught of discrimination, experiences of discrimination leading them to develop skills that help protect them from hostile environments. Some gave examples of ways people had worked around the system. The flip side of this is the possible delay in seeking support when needed due to being reliant on own resources beyond the limits of functional capacity.
31	People had come up with ways to bypass problems, especially related to legal rights e.g. changing surnames to pass as siblings for next of kin issues.

Lack of planning	
2	Identified as theme. Fear of ageing is clear. Some talked about researching options, developing active coping strategies eg mentally preparing for discriminatory encounters, changing providers, joining community based organisations eg choirs, social groups that offer inclusive support, moving to geographic locations with inclusive values.
3	Concerns related to residential care being religion based providers. No real evidence of robust planning to avoid unwanted outcomes (eg non-inclusive residential care) other than one preferring option of suicide.
6	Large majority (66% of lesbians, 58% of gay men) imagined emotional support in the future would come from friends, practical support also higher than partner/children although personal care highest chosen option was no-one. Was general evidence that people had not planned for the event of needing intensive care and support and were likely to turn to formal support provision.
9	Many expressed hope that they would not need care and support. Some referred to possible future reliance on friends, current good health. Some were planning moves to facilitate easier living eg one storey accommodation or assisted living. Several participants considered Euthanasia as an alternative to needing to use particularly residential care. Understood as a way to maintain autonomy, dignity and freedom of choice.
11	Many identified existing informal support systems that they imagined they would draw on further in later life. Several had concrete plans for when older which did not rely on birth families or partners including mutually beneficial arrangements with others, more accessible living environments, utilising the advantages bought with polyamorous arrangements

15	Some participants had done some planning - one person had developed an action plan with someone at work to perform welfare checks if they missed work.
17	Many participants felt it was likely they would need to provide care for others in the future e.g. partners, friends or family members. 70% thought they were very or somewhat likely to need care themselves in the future, but only 38% had given serious thought to the possibility and only 34% had made preparations if they needed care. Many worried about who would make medical decisions if they lacked competence in the future.
21	When asked about future plans, most participants had not made concrete plans or given too much thought to preferences but 6 (of 60) stated that they could not bring themselves to think about it, 3 were focussed on the present, 1 didnt feel they would live long enough, 9 planned to explore euthanasia as a possible option with 5 of those only considering that and no other alternatives.
27	Some, as a result of what they had witnessed in their caring roles, had already started to take actions to ensure that their sexual identity wasn't lost e.g. making photo books noting significant partners so that people knew who they were. Another had clear ideas on what they would want their care to look like. There was clear evidence that carers had some understanding of providers inability or unlikelihood of offering culturally competent services, so planning for their own futures was a way of mitigating this. Other plans included marriage/civil partnership to legalise unions, writing wills. There was clear superimposing of caring experiences over expectations, concerns and possibilities about ageing and meeting care needs in the future.

Social needs	
1	Feeling unsupported key issue as carers
2	Less energy for activist commitments.
16	Participants identified opportunities to share meals, a valuable part of community services in relation to the human connection during communal meals. Some stated that the weekly community based shared meal was the only contact with others.
17	People wanted services and programmes that provided emotional support and counselling as well as a focus on socialisation and social support including entertainment, exercise.
18	Overall perception that aged care provision was poor for the general population.
23	Although the groups offered many benefits in terms of social isolation and loneliness as well as connection to the LGBT community and a safe space for people, very few met any real social care needs and many participants felt that although there were a few smaller support tasks that group members might pick up on occasion eg shopping, that these networks would not offer any robust support when people developed real social care needs.
25	The most reported functional difficulty was housework, followed by difficulty getting to places out of walking distance, shopping and meal preparation. 37% reported at least one area where they had difficulty. Only 17% had accessed homecare services, or institutional care (5%). 25% used senior centres, 21% meal and nutrition programmes, 15% self help groups. 51% indicated that they needed somewhere to socialise.

Loss of independence	
2	Identified as theme (fearing ageing)
5	Fear of dependence is rooted in rejection and inadequate recognition of life stories.
6	Less comfort with homecare workers in home could be related to reliance on this type of care.
7	Higher likelihood of living alone and less likely to have a partner throughout life has the knock on effect that loss of independence can be more of a transition and the need to mobilise social contacts made more difficult if not been open in earlier life and made those connections.
9	Those using services felt they experienced sense of loss (autonomy, community, partners) and poor quality of care (abuse)
10	Notes that have historically been more independent and difficult to adjust to being older and not being able to maintain this. More comfortable taking care of ourselves than perhaps others to difficult transitions.
11	Concerns about not being able to express selves sexually if in care settings.
17	Many participants were concerned about loss of independence and the vulnerability of old age.
18	Concerns related to support with personal care and intimacy of this.
22	Several older women participants were concerned about loss of control over things like their appearance, being assumed as fitting into conventional roles and feminine attributes with consent or control.
27	Loss of privacy and control was something many respondents spoke about. Some of this related to fears about cognitive decline and the inability to self advocate, which in turn might lead to loss of control over disclosure.

Intersectionality	
2	Discussed ageing, ableism, racism & classism as problematic
3	Religiously based residential care providers a concern.
5	Disabled people suffered discrimination within LGBT community also.
10	Those that felt isolated reported that age and disability contributed to this. Most didn't feel that sexuality was relevant to ageing experiences. Some noted being more isolated from lesbian friends.
11	Trans participants are more worried about this than biphobia.
15	Some participants reported being stigmatised because of their age as well as their sexual or gender identity.

Community

Geography	
2	Impact of geographical location in participation in the local community. Experience can be influenced by where service is located (ie attitudes locally). Some identified moving to an inclusive geographical area as part of their future planning.
3	Geographical isolation was a literal barrier to accessing lesbian-inclusive services. Rurality was also positively associated with good quality of life (nature, reciprocity with neighbours and communities).
7	Evidence of travelling long distances to access appropriate older LGBT groups which is not sustainable, with some having to withdraw as becoming more frail. One person stated lack of transport was an insurmountable barrier.
8	Geography played a part in how linked into LGBTQ networks people were.
13	Those who lived in rural locations talked of positives of places of serenity and the quality of life that bought. Some had returned to familial locations in later life. Many identified geographical distance as a barrier to accessing LGB networks and activities and bringing LGB people together. Was a general feeling from lesbians that they would need to move to larger towns to build peer networks.
16	Availability of transportation was a determining factor for engagement in community based services
19	Geography was an important factor for people accessing the services, not only from a practical point of view but because it was rooted in the local community and this was seen as important, providing a safe space, opportunities to connect with other locals and place-based affirmation of self. By being situated more locally, more people were able to access it, therefore decreasing their isolation
23	Many put importance on having a physical place, a space that belonged to the group, in turn offering belonging to those that attended. Some had previously used other community based spaces but this had been problematic. This was not so true of those groups who used spaces attached to health facilities or shared with other community groups. Some of this was about the physical environment not including key markers of inclusion e.g. promotional material all heterosexualised. Geography played a part in the connections with groups, where in some areas people travelled distances to connect as there was little for them geographically and those in more built up areas had a wider range of opportunities to attend a range of activities. Access to public transportation had an impact on this also. There was a recognition that this made membership of the groups limited, especially for older people who were unable to drive and meant that the practical element would impact at a point when the groups would potentially be most impactful in meeting needs.
24	Availability and accessibility of community based sites and services was a significant predictor of subjective well-being. This demonstrates the importance of a sense of community and supports models of ageing in place which seek to maintain communal relations among community dwelling older people who remain in their homes.

Access	
3	Most had to travel 2 hours to access care.

7	More people accessed LGBT specific activities than those wider activities based in their local communities.
13	Some experienced discrimination within standard services in the local community e.g. refusal to do haircut of choice in hairdressers, being whispered about in fish and chip shops and having beer spilled on them in the pub. One issue for bringing people together was willingness of local businesses to provide meeting spaces.
17	Of the 74% of participants that were providing care, 25% of those indicated they had problems accessing needed services.
18	It was a recognition that social care services had a role to play in people's level of comfort with accessing health services, almost as an advocate in terms of experiences and levels of understanding of what those needs might be.

Community	
2	Importance of facilitating community based support identified as a theme. Value base of the local community has an influence on experience. Many are involved in volunteering in the local community and providing care. Spoke of the importance of building community. Felt community based efforts were empowering.
3	Concerns related to accessing community based services where people were conservative and structure heteronormative.Explicit homophobia from community members.
4	Those in LGBT specific housing felt it was safer.
6	Neighbours were not viewed as a source of emotional, practical support.
7	People living parallel lives. Several experiences of both local neighbours and local children using abuse and intimidation. Evidence with one participant that prior contribution to the local community now resulted in robust support from that community in later age. 53% were accessing neighbourhood activities. Some evidence this was as an alternative to LGBT activities and were experienced as less attractive.
13	Those who lived in rural locations were more likely to talk about positive relationships with neighbours and local residents although there was an element of selectivity about openness in these settings.
31	Some participants spoke about the difficulties of being accepted by their neighbourhoods and neighbours, not being accepted as a couple or being able to show affection in public, having to pretend to be heterosexual to avoid unwanted attention or face the risk of hostility.

Class	
2	Impact of relationship and socioeconomic status on connecting with other older LGBTQ people.
8	Some evidence that social, cultural and economic capital mattered when it came to access to LGBTQ contexts.

Networks	
2	Some considered expanding formal and informal support networks as a way to plan for the future.
3	Lot of importance is put on being an active part of the local community. Acceptance based on contribution to wider community.
4	Some evidence that shared history helped to build stronger networks.
5	Elective family networks helped with life-world orientation and participation.
6	More participants imagined support coming from families of choice than origin but only for certain types of support, rarely focussed on care needs.
7	75% had not lost contact with family members because of sexual identity. 53% received informal care from friends, 38% from neighbours, 58% from family of origin/partner.
8	Importance given throughout narratives about friends and chosen families - support socially, materially, facing conflict.
10	Those participants that were partnered received quite intensive support from them. For some this negated the need for more formal support. Almost all noted wider networks as providing some element of support although the level of support varied. Examples of geographically widespread networks formed in earlier life are still important.
11	Evidence of individuals not being open to building networks for fear of judgement even if recognition that this would contribute to wellbeing. Some evidence that former relationships are more likely to make up part of social networks than is common with hetero. Several participants drew on informal support systems.
13	Was evidence of people using online networks of communication to form LGB friendships locally and internationally. Women used online tools to connect with forums and to organise in person meetings and activities.
15	Participants spoke of families of choice or family support networks that were made up of partners, friends and neighbours as opposed to traditional families of origin.
16	Some participants formed networks via volunteering and running community based activities.
18	Participants noted the wide ranging benefits brought to them from their networks of support. They felt these nourished and stimulated them politically, socially, academically, philosophically, emotionally and artistically. These were sustained through real life and online contact. They replaced or expanded family relationships and offered potential for support. Also important for services to recognise the importance of these networks when considering care planning as well as allowing development of wider community networks through proactive outreach and online.
19	A clear sense of the network that had formed through use of the centre that participants referred to as family - provided an opportunity to nurture those networks.
22	Many of the female participants relied solely on women-only networks in their local communities and were concerned about needing to come into more contact with men in care settings.

25	86% of respondents reported having a close friend, 77% a functional friend, in comparison to much lower percentages for functional families of origin (26% parent/23% child). People also reported having social networks in their neighbourhoods. There was evidence of receiving functional support from family members for some participants, but the number was higher for families of choice, demonstrating the importance of people's non-kin support networks.
29	Participants expressed a need to develop ways of making social networks. 39% looked to friends to provide them with emotional, social, physical or financial support, 1.4% went to statutory agencies. Conclusions drawn included that there was a need for development of and support for social outlets for older L&G.
31	After partners, two-thirds of respondents stated they would seek practical and emotional support that is affirmative of their sexuality from friends rather than biological family and saw these friends as their families.

History

History of discrimination

2	Was lots of discussion about historical experiences of discrimination.
3	Lack of recognition of previous relationships and lifestyle.
4	Some evidence that being open historically affected how open people were now. Shared history of discrimination helps build connections.
5	Links made between previous negative experiences and concerns about defending self in older age.
7	36% had experienced discrimination by caregivers
8	History of shared struggles brings kinship and connection. Also, many strong connections formed from early activism. Historic separation of transgender from wider LGBTQ movement historically continues to have a legacy for those who fit in to this category, and when broken down to 'gay' excludes transgender completely.
9	Lifetime of discrimination and restricted human rights led some to believe that Euthanasia was way to maintain autonomy, dignity and freedom of choice.
13	Some felt their reluctance to be out in smaller rural communities was based on their childhood experiences in those places but also on having been previously protected from hostile treatment in childhood.
14	Having experienced hate violence was positively associated with perceived isolation.
15	All participants reported some experience of historical discrimination, although current experiences varied.
22	Most older participants had experienced discrimination and this appeared to impact on both current and future perceptions of social care support.
26	Many participants associated their mental health and distress with their struggle to come to terms with their LGBT identity in a society that was discriminating and alienating. 47% had been verbally insulted, 19% punched or kicked on the basis of their LGBT identity, 25% had been threatened with physical violence and 20% had people threaten to 'out' them.

30	Many participants mistrusted health and social care as a result of life-long experiences of marginalisation and oppression. Many had experienced pervasive social stigma and maintained a sense of extreme caution as to whether attitudes have really changed.

Continued discrimination	
1	LGB Carers caring for LGB fared much worse
2	Recognition that past experiences continued to influence perceptions of the future.
3	Experience of discrimination within social groups. Homophobic political views voiced/promoted in community groups by members.
7	40% of respondents have experienced discrimination and prejudice from neighbours. Neighbourhood activities have included some uncomfortable or awkward situations with both staff/volunteers and members of the local community.
10	25% of participants had been subjected to homophobia from care workers.
13	One person suffered damage to property when moving to a rural location. Some experienced discrimination within standard services in the local community e.g. refusal to do haircut of choice in hairdressers, being whispered about in fish and chip shop and having beer spilled on them in the pub.
15	Some participants reported strong experiences of discrimination from their communities. Experiences made worse through perceived discrimination from authorities e.g. police.
17	Many participants had witnessed or experienced ongoing discrimination in health and care settings as well as in local communities.
21	Was evidence of microaggressions that could not be challenged for the fear that this would then 'out' the person.
22	Many reported continuing discrimination or exclusion, lack of acknowledgement even when others know of their sexual identity - no recognition of this.
30	Participants were able to identify ways they continued to be discriminated against, many reported incidences of overt homophobia.

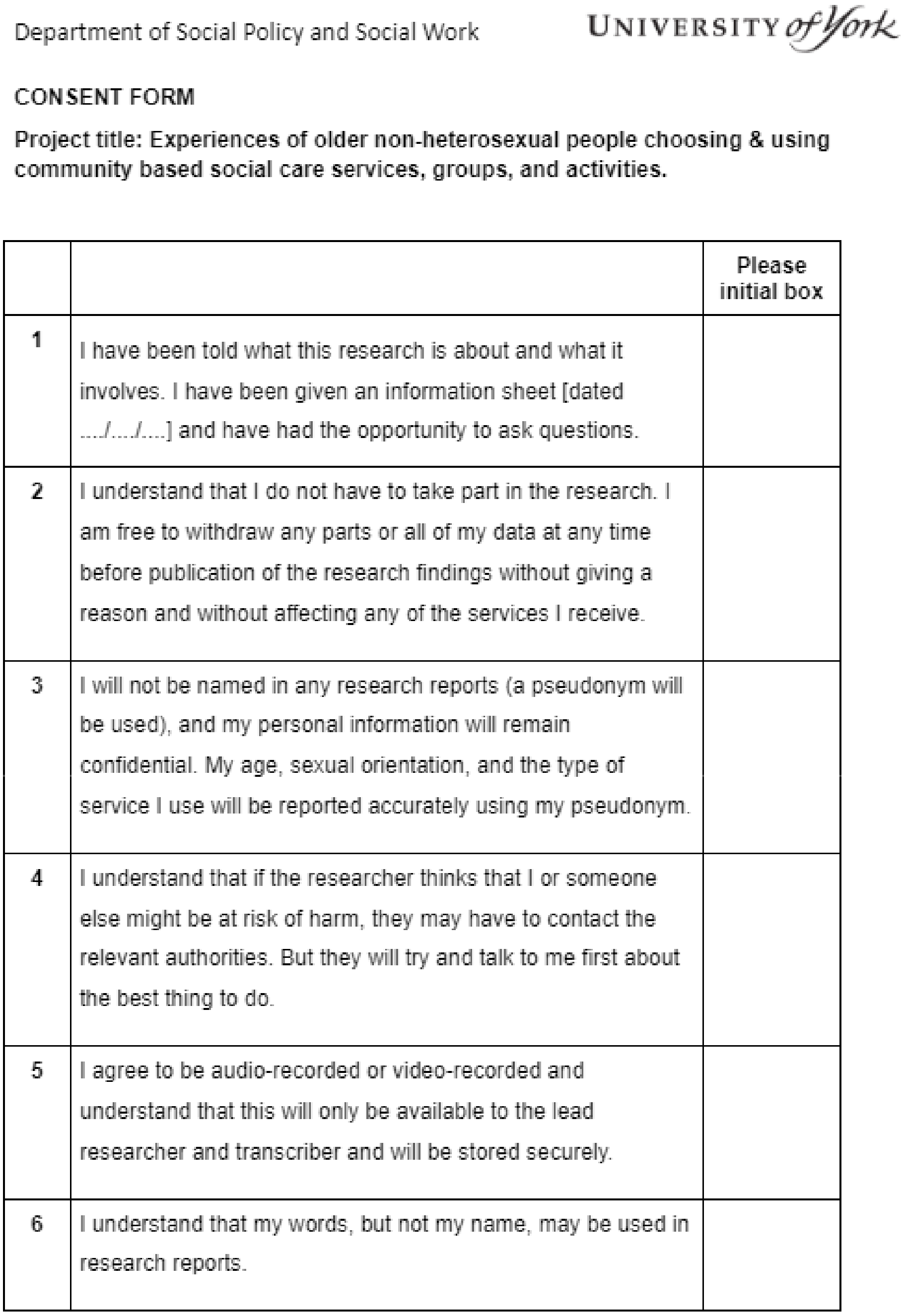
Perceptions/ expectations	
2	Anticipated dependence on institutional care at the end of life resulted in fear for safety, comfort and rights. Still strong expectation that health and social care would be discriminatory and not inclusive.
3	Some felt care was more likely to be inclusive in urban areas. Some perceived microaggressions from providers.
6	People are less comfortable with homecare workers entering home than healthcare professionals.
7	Some evidence that circular relationship - discomfort with neighbours will not go away until feeling safe to be open about identity.
8	Previous negative experiences can influence how groups and activities are set up and run through fear of ongoing discrimination.

9	Most participants perceived services would lack inclusivity, deliver poor quality care and ignore people's identities and histories. Mention of no access to internet/tech - ie perception that this would not be available.
11	Perception that LGBT specific provision would be likely to include prejudice from LG. One person expected to encounter discrimination but expected to use charm to overcome it.
13	People had a general concern that bringing carers into the home was risky as they expected homophobia as well as breaches of privacy.
21	Some perceived older age services to be inherently heterosexualised. Participants viewed themselves as more vulnerable i.e. more likely to be victims of abuse in relation to their status. Many felt it necessary to hide their identities due to an expectation of discrimination or non-acceptance.
22	Although older participants' views demonstrated hopes of equality of treatment, this was not what was expected to be the case and may have expressed concerns about future care.
27	Many carers made assumptions that services would not acknowledge, respect or celebrate their sexual identities, based on what they had seen for those they cared for.
30	Many felt it was unwise to place trust in individuals and systems that may have historically persecuted them at a point where they were becoming dependent. They feared being victimised against, so avoided accessing services. Staff felt that people would be anxious about their ability to express themselves openly if in care settings.
31	Only a small number of people stated that they would seek out practical support from social services, and this was even lower for emotional support because they feared that services would not be appropriate or would not accept them.

Lack of planning (fear)	
2	Anticipation of health disparities, discrimination and planning for end of life require great expenditure of emotional energy.
3	Expression of dread about entering residential care in future.
6	Less comfortable with homecare workers in home, could indicate a relationship with fear of needing this in later life indicating reliance. Although would be clear likelihood of reliance on formal care provision going forward, concerns about this prospect had not resulted in detailed planning

Appendix 6 - Consent forms

6.1 Older LGBTQ+ people



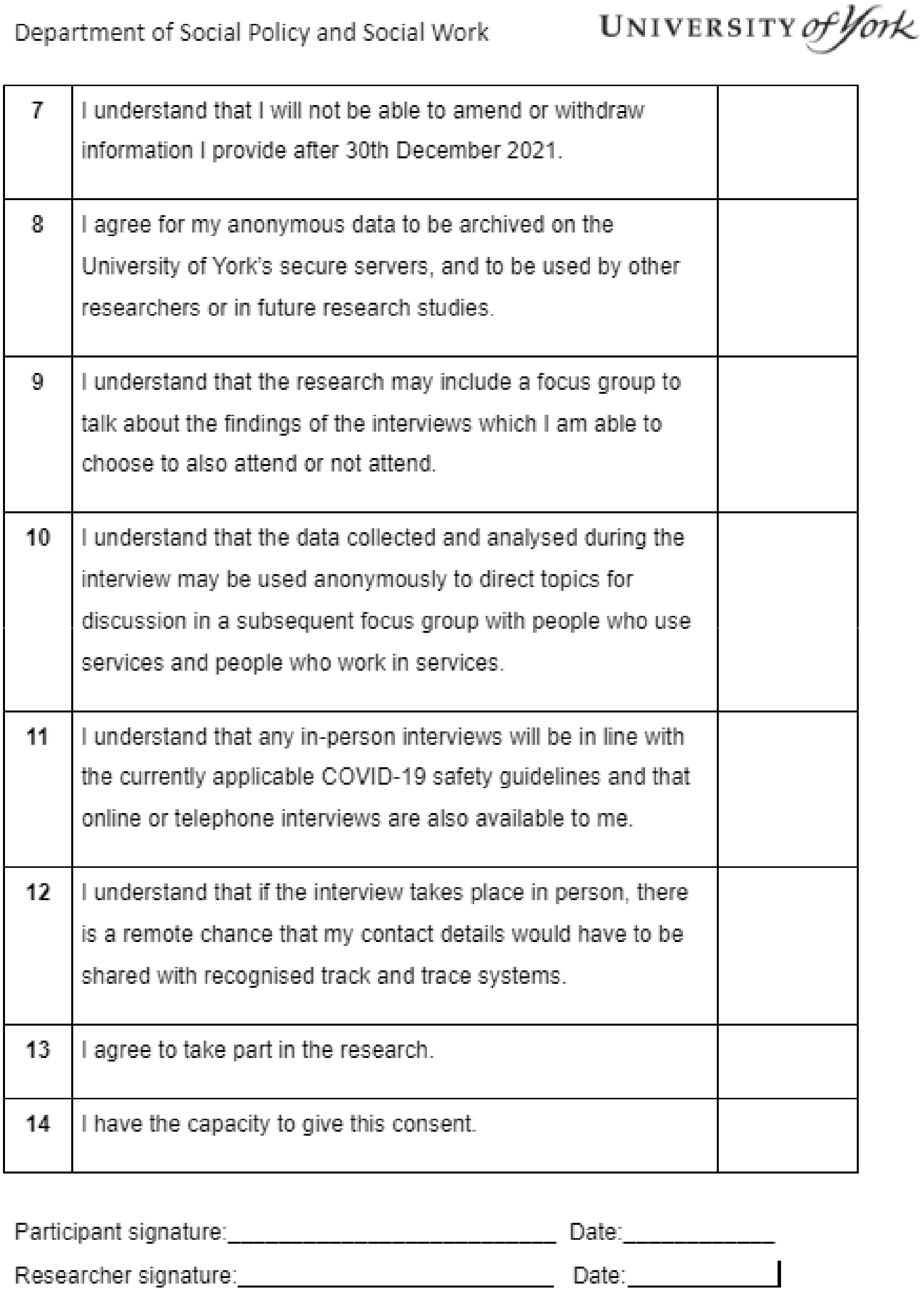
Department of Social Policy and Social Work

UNIVERSITY of York

CONSENT FORM

Project title: Experiences of older non-heterosexual people choosing & using community based social care services, groups, and activities.

		Please initial box
1	I have been told what this research is about and what it involves. I have been given an information sheet [dated ..../..../....] and have had the opportunity to ask questions.	
2	I understand that I do not have to take part in the research. I am free to withdraw any parts or all of my data at any time before publication of the research findings without giving a reason and without affecting any of the services I receive.	
3	I will not be named in any research reports (a pseudonym will be used), and my personal information will remain confidential. My age, sexual orientation, and the type of service I use will be reported accurately using my pseudonym.	
4	I understand that if the researcher thinks that I or someone else might be at risk of harm, they may have to contact the relevant authorities. But they will try and talk to me first about the best thing to do.	
5	I agree to be audio-recorded or video-recorded and understand that this will only be available to the lead researcher and transcriber and will be stored securely.	
6	I understand that my words, but not my name, may be used in research reports.	



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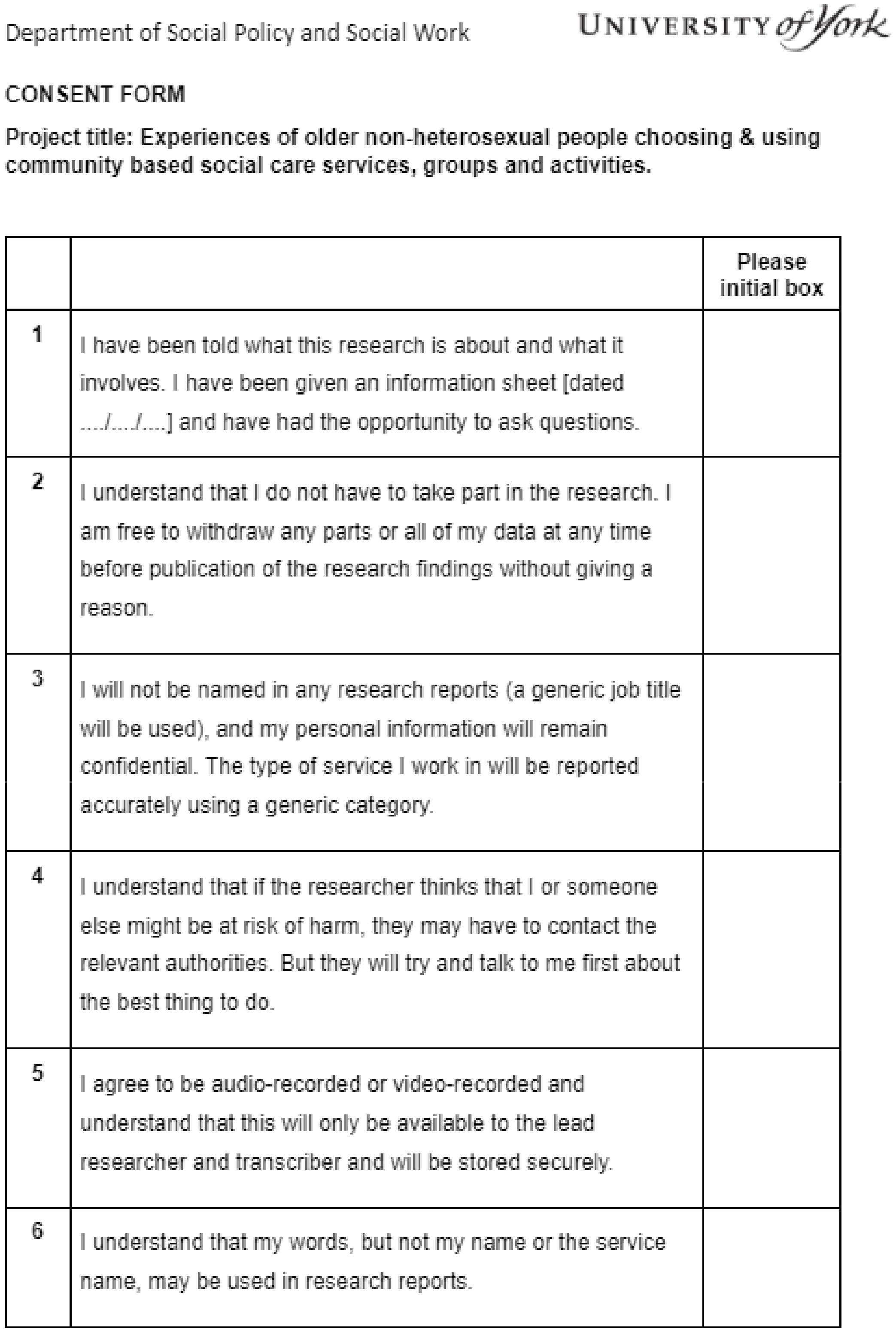
7	I understand that I will not be able to amend or withdraw information I provide after 30th December 2021.	
8	I agree for my anonymous data to be archived on the University of York's secure servers, and to be used by other researchers or in future research studies.	
9	I understand that the research may include a focus group to talk about the findings of the interviews which I am able to choose to also attend or not attend.	
10	I understand that the data collected and analysed during the interview may be used anonymously to direct topics for discussion in a subsequent focus group with people who use services and people who work in services.	
11	I understand that any in-person interviews will be in line with the currently applicable COVID-19 safety guidelines and that online or telephone interviews are also available to me.	
12	I understand that if the interview takes place in person, there is a remote chance that my contact details would have to be shared with recognised track and trace systems.	
13	I agree to take part in the research.	
14	I have the capacity to give this consent.	

Participant signature:__________________________ Date:____________

Researcher signature:_________________________ Date:____________

6.2 Service Providers

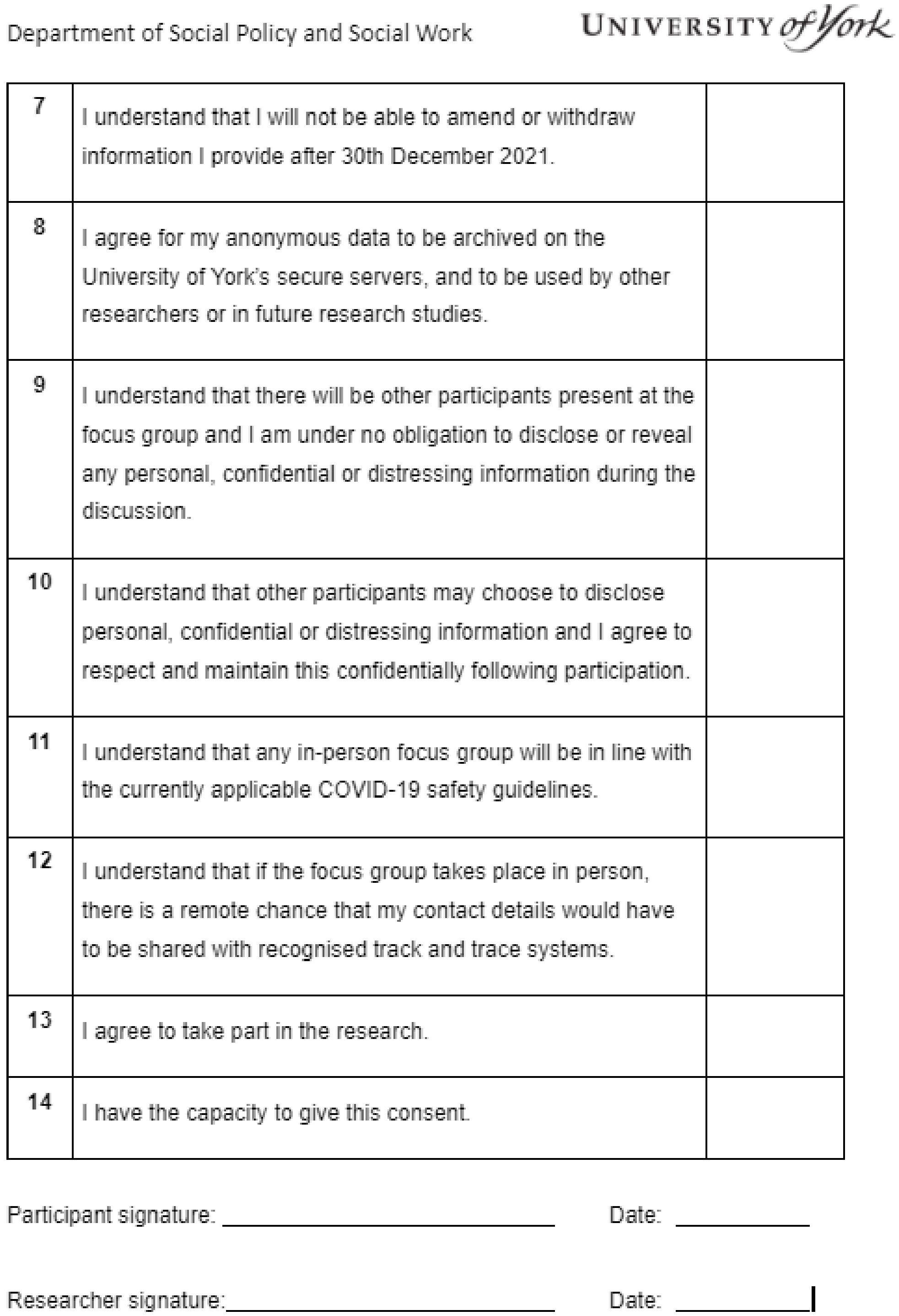


Department of Social Policy and Social Work UNIVERSITY of York

CONSENT FORM

Project title: Experiences of older non-heterosexual people choosing & using community based social care services, groups and activities.

		Please initial box
1	I have been told what this research is about and what it involves. I have been given an information sheet [dated ..../..../....] and have had the opportunity to ask questions.	
2	I understand that I do not have to take part in the research. I am free to withdraw any parts or all of my data at any time before publication of the research findings without giving a reason.	
3	I will not be named in any research reports (a generic job title will be used), and my personal information will remain confidential. The type of service I work in will be reported accurately using a generic category.	
4	I understand that if the researcher thinks that I or someone else might be at risk of harm, they may have to contact the relevant authorities. But they will try and talk to me first about the best thing to do.	
5	I agree to be audio-recorded or video-recorded and understand that this will only be available to the lead researcher and transcriber and will be stored securely.	
6	I understand that my words, but not my name or the service name, may be used in research reports.	



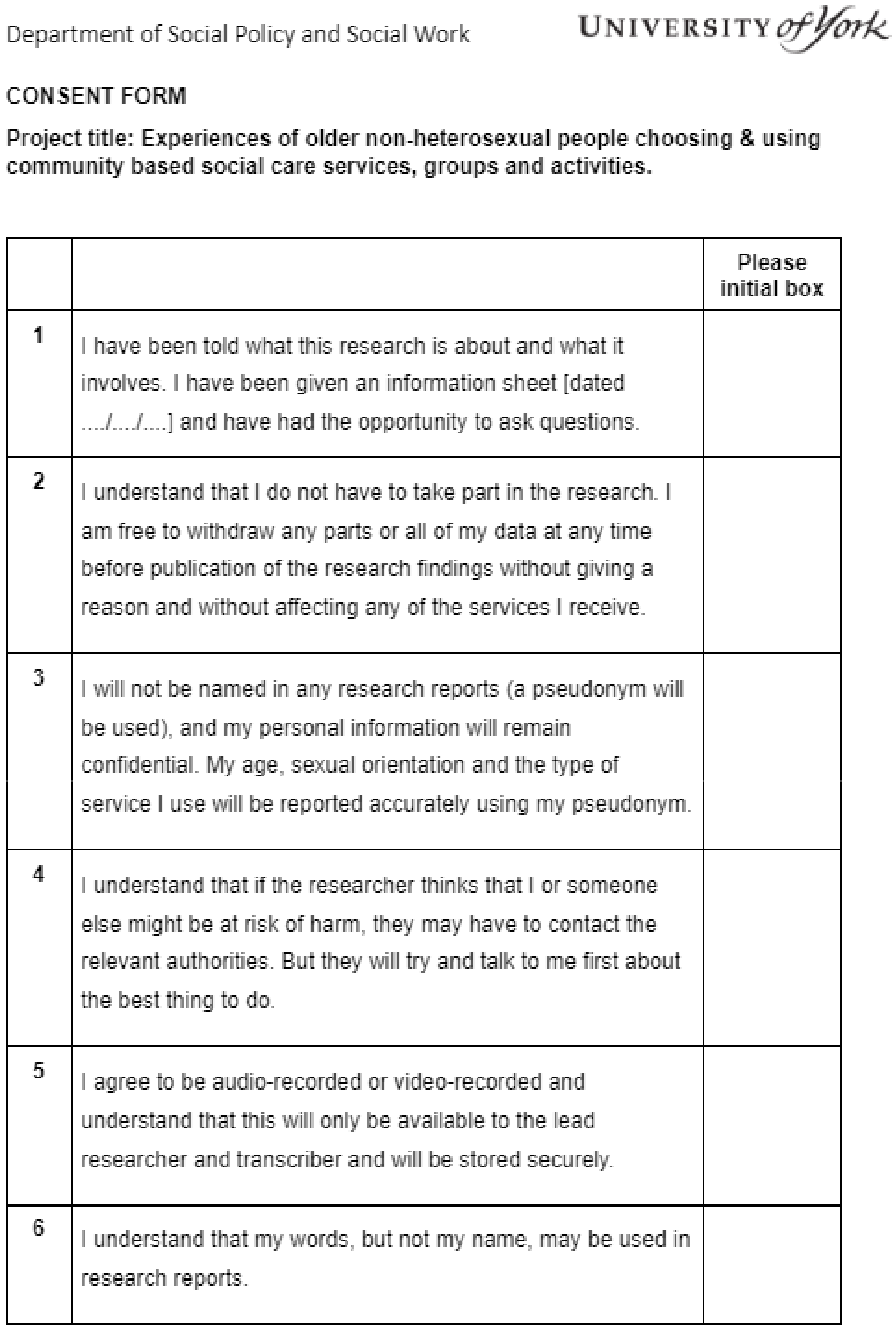
Department of Social Policy and Social Work UNIVERSITY of York

7	I understand that I will not be able to amend or withdraw information I provide after 30th December 2021.	
8	I agree for my anonymous data to be archived on the University of York's secure servers, and to be used by other researchers or in future research studies.	
9	I understand that there will be other participants present at the focus group and I am under no obligation to disclose or reveal any personal, confidential or distressing information during the discussion.	
10	I understand that other participants may choose to disclose personal, confidential or distressing information and I agree to respect and maintain this confidentially following participation.	
11	I understand that any in-person focus group will be in line with the currently applicable COVID-19 safety guidelines.	
12	I understand that if the focus group takes place in person, there is a remote chance that my contact details would have to be shared with recognised track and trace systems.	
13	I agree to take part in the research.	
14	I have the capacity to give this consent.	

Participant signature: ______________________________ Date: ____________

Researcher signature:______________________________ Date: ____________

6.3 Focus Groups



Department of Social Policy and Social Work

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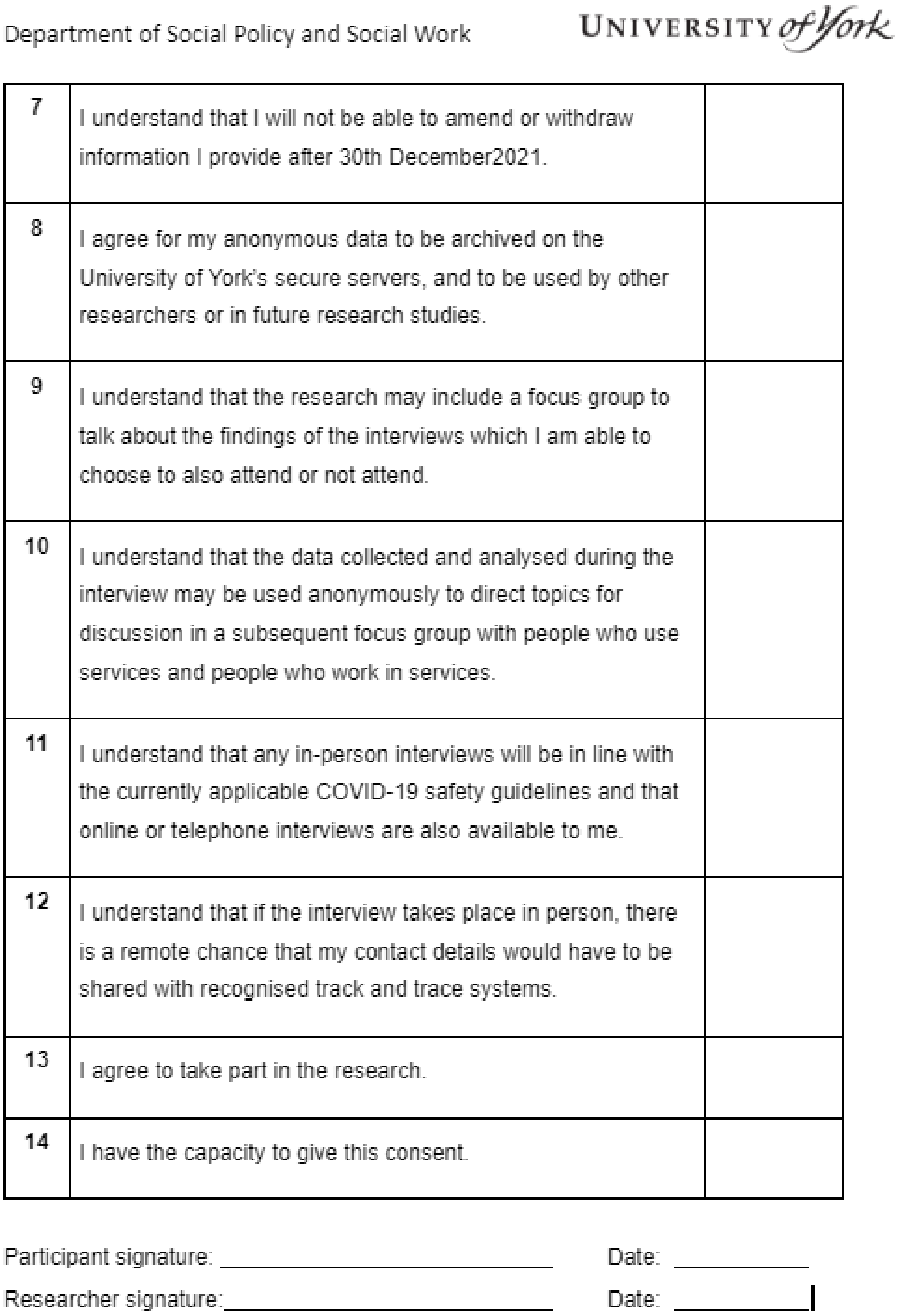
CONSENT FORM

Project title: Experiences of older non-heterosexual people choosing & using community based social care services, groups and activities.

		Please initial box
1	I have been told what this research is about and what it involves. I have been given an information sheet [dated ..../..../....] and have had the opportunity to ask questions.	
2	I understand that I do not have to take part in the research. I am free to withdraw any parts or all of my data at any time before publication of the research findings without giving a reason and without affecting any of the services I receive.	
3	I will not be named in any research reports (a pseudonym will be used), and my personal information will remain confidential. My age, sexual orientation and the type of service I use will be reported accurately using my pseudonym.	
4	I understand that if the researcher thinks that I or someone else might be at risk of harm, they may have to contact the relevant authorities. But they will try and talk to me first about the best thing to do.	
5	I agree to be audio-recorded or video-recorded and understand that this will only be available to the lead researcher and transcriber and will be stored securely.	
6	I understand that my words, but not my name, may be used in research reports.	



Department of Social Policy and Social Work

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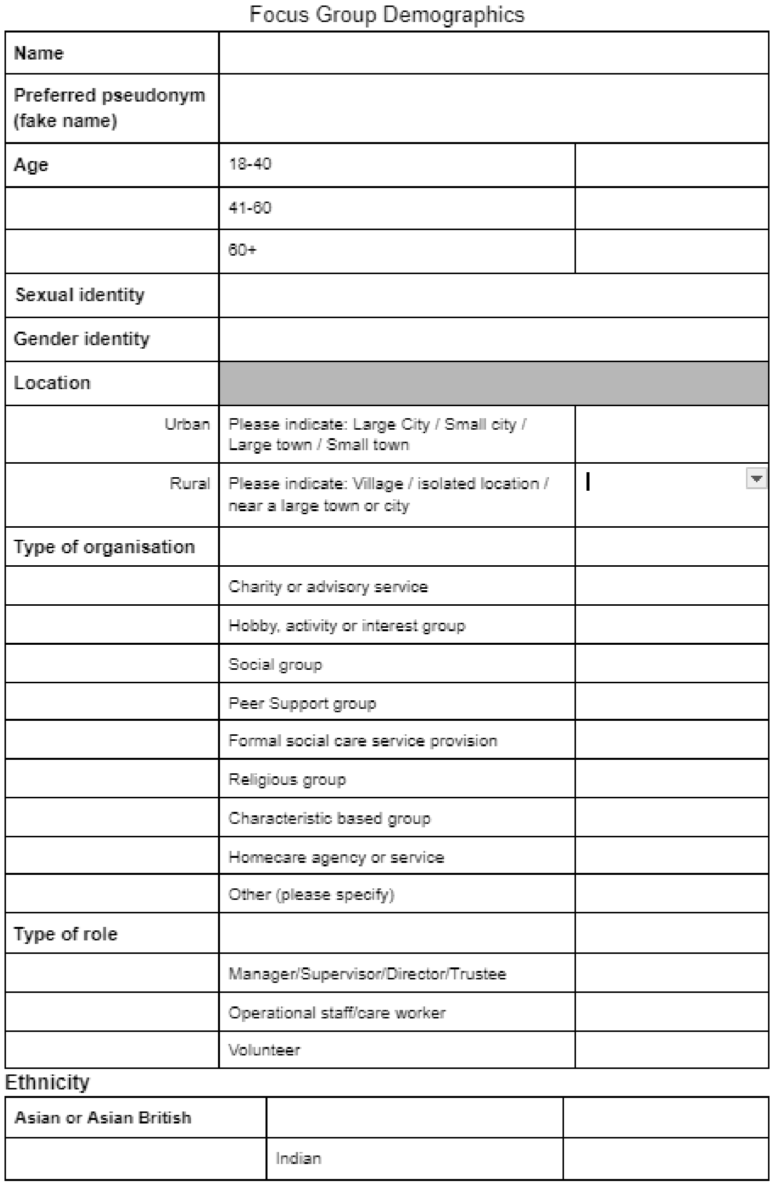
7	I understand that I will not be able to amend or withdraw information I provide after 30th December2021.	
8	I agree for my anonymous data to be archived on the University of York's secure servers, and to be used by other researchers or in future research studies.	
9	I understand that the research may include a focus group to talk about the findings of the interviews which I am able to choose to also attend or not attend.	
10	I understand that the data collected and analysed during the interview may be used anonymously to direct topics for discussion in a subsequent focus group with people who use services and people who work in services.	
11	I understand that any in-person interviews will be in line with the currently applicable COVID-19 safety guidelines and that online or telephone interviews are also available to me.	
12	I understand that if the interview takes place in person, there is a remote chance that my contact details would have to be shared with recognised track and trace systems.	
13	I agree to take part in the research.	
14	I have the capacity to give this consent.	

Participant signature: ____________________________ Date: ___________

Researcher signature:____________________________ Date: ___________

Appendix 7 - Demographic information sheet for focus groups/providers

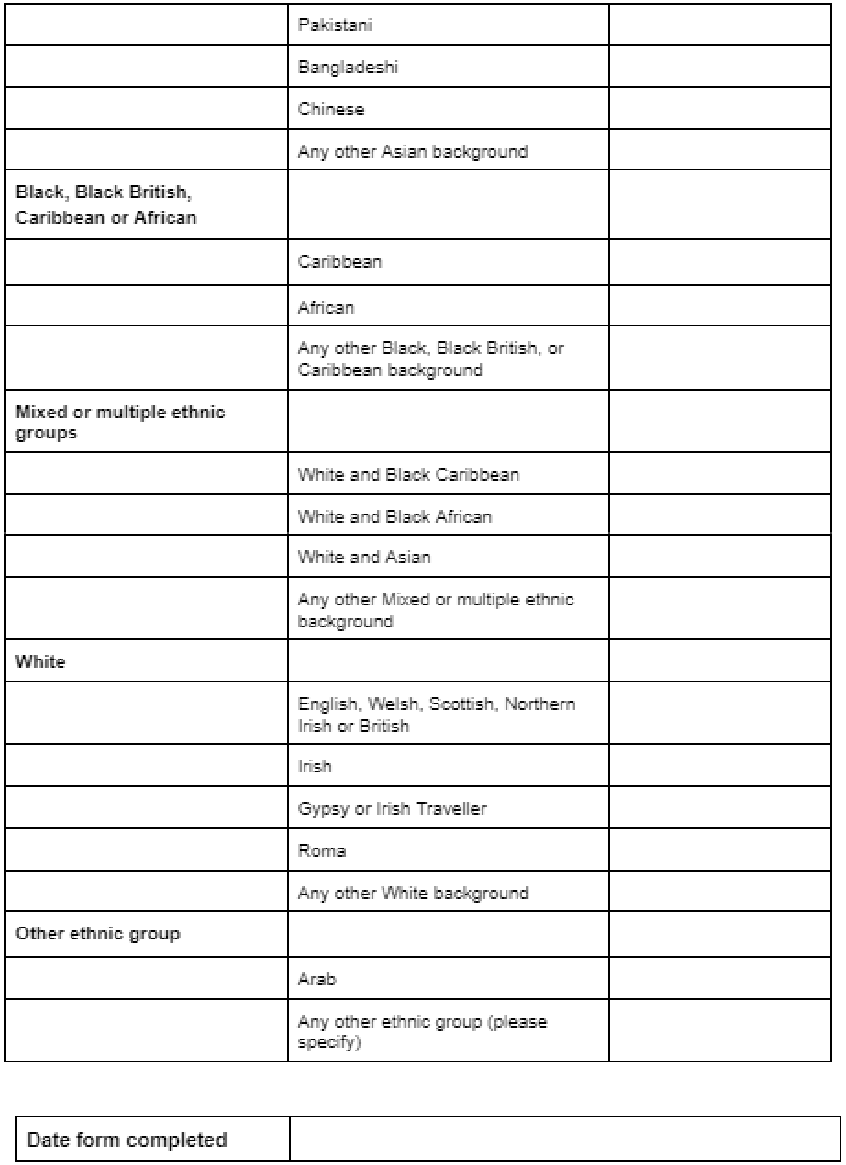


Focus Group Demographics

Name		
Preferred pseudonym (fake name)		
Age	18-40	
	41-60	
	60+	
Sexual identity		
Gender identity		
Location		
Urban	Please indicate: Large City / Small city / Large town / Small town	
Rural	Please indicate: Village / isolated location / near a large town or city	
Type of organisation		
	Charity or advisory service	
	Hobby, activity or interest group	
	Social group	
	Peer Support group	
	Formal social care service provision	
	Religious group	
	Characteristic based group	
	Homecare agency or service	
	Other (please specify)	
Type of role		
	Manager/Supervisor/Director/Trustee	
	Operational staff/care worker	
	Volunteer	

Ethnicity

Asian or Asian British		
	Indian	

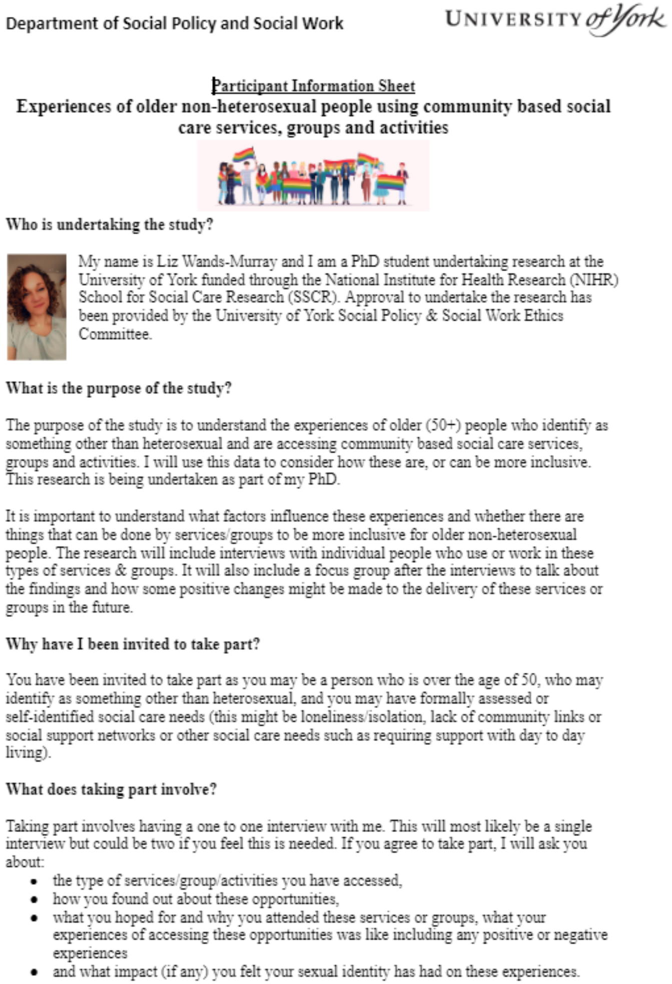


	Pakistani	
	Bangladeshi	
	Chinese	
	Any other Asian background	
Black, Black British, Caribbean or African		
	Caribbean	
	African	
	Any other Black, Black British, or Caribbean background	
Mixed or multiple ethnic groups		
	White and Black Caribbean	
	White and Black African	
	White and Asian	
	Any other Mixed or multiple ethnic background	
White		
	English, Welsh, Scottish, Northern Irish or British	
	Irish	
	Gypsy or Irish Traveller	
	Roma	
	Any other White background	
Other ethnic group		
	Arab	
	Any other ethnic group (please specify)	

Date form completed	

Appendix 8 - Information Sheets

8.1 Older LGBTQ+ people



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Participant Information Sheet

Experiences of older non-heterosexual people using community based social care services, groups and activities

Who is undertaking the study?

My name is Liz Wands-Murray and I am a PhD student undertaking research at the University of York funded through the National Institute for Health Research (NIHR) School for Social Care Research (SSCR). Approval to undertake the research has been provided by the University of York Social Policy & Social Work Ethics Committee.

What is the purpose of the study?

The purpose of the study is to understand the experiences of older (50+) people who identify as something other than heterosexual and are accessing community based social care services, groups and activities. I will use this data to consider how these are, or can be more inclusive. This research is being undertaken as part of my PhD.

It is important to understand what factors influence these experiences and whether there are things that can be done by services/groups to be more inclusive for older non-heterosexual people. The research will include interviews with individual people who use or work in these types of services & groups. It will also include a focus group after the interviews to talk about the findings and how some positive changes might be made to the delivery of these services or groups in the future.

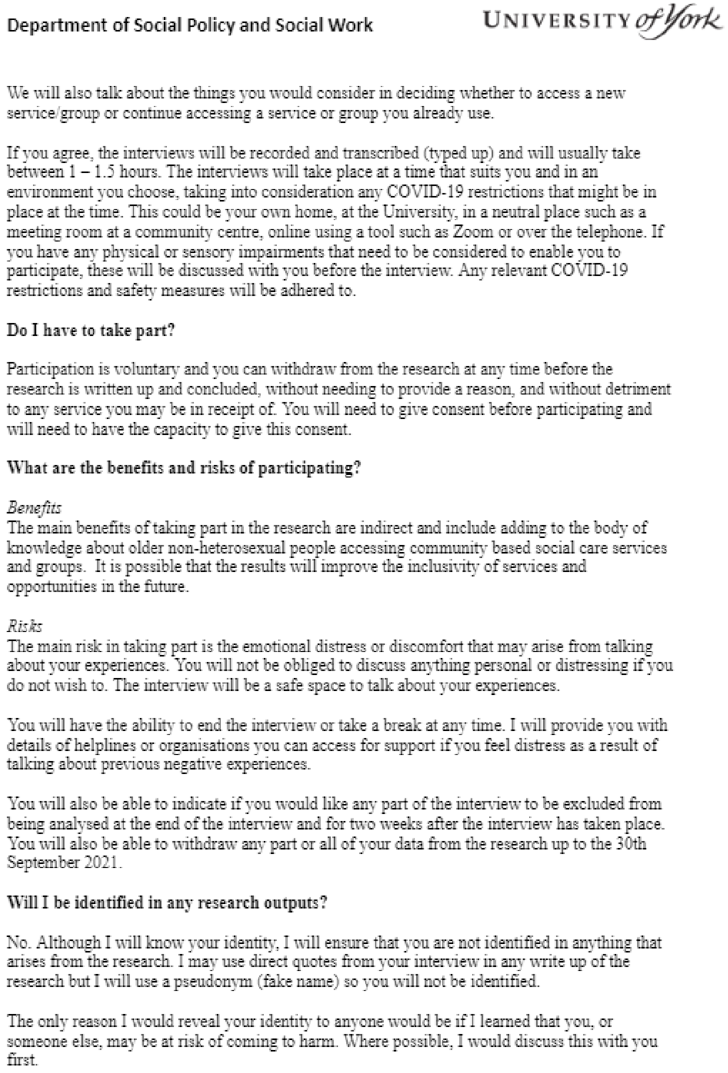
Why have I been invited to take part?

You have been invited to take part as you may be a person who is over the age of 50, who may identify as something other than heterosexual, and you may have formally assessed or self-identified social care needs (this might be loneliness/isolation, lack of community links or social support networks or other social care needs such as requiring support with day to day living).

What does taking part involve?

Taking part involves having a one to one interview with me. This will most likely be a single interview but could be two if you feel this is needed. If you agree to take part, I will ask you about:

- the type of services/group/activities you have accessed,
- how you found out about these opportunities,
- what you hoped for and why you attended these services or groups, what your experiences of accessing these opportunities was like including any positive or negative experiences
- and what impact (if any) you felt your sexual identity has had on these experiences.



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We will also talk about the things you would consider in deciding whether to access a new service/group or continue accessing a service or group you already use.

If you agree, the interviews will be recorded and transcribed (typed up) and will usually take between 1 – 1.5 hours. The interviews will take place at a time that suits you and in an environment you choose, taking into consideration any COVID-19 restrictions that might be in place at the time. This could be your own home, at the University, in a neutral place such as a meeting room at a community centre, online using a tool such as Zoom or over the telephone. If you have any physical or sensory impairments that need to be considered to enable you to participate, these will be discussed with you before the interview. Any relevant COVID-19 restrictions and safety measures will be adhered to.

Do I have to take part?

Participation is voluntary and you can withdraw from the research at any time before the research is written up and concluded, without needing to provide a reason, and without detriment to any service you may be in receipt of. You will need to give consent before participating and will need to have the capacity to give this consent.

What are the benefits and risks of participating?

Benefits
The main benefits of taking part in the research are indirect and include adding to the body of knowledge about older non-heterosexual people accessing community based social care services and groups. It is possible that the results will improve the inclusivity of services and opportunities in the future.

Risks
The main risk in taking part is the emotional distress or discomfort that may arise from talking about your experiences. You will not be obliged to discuss anything personal or distressing if you do not wish to. The interview will be a safe space to talk about your experiences.

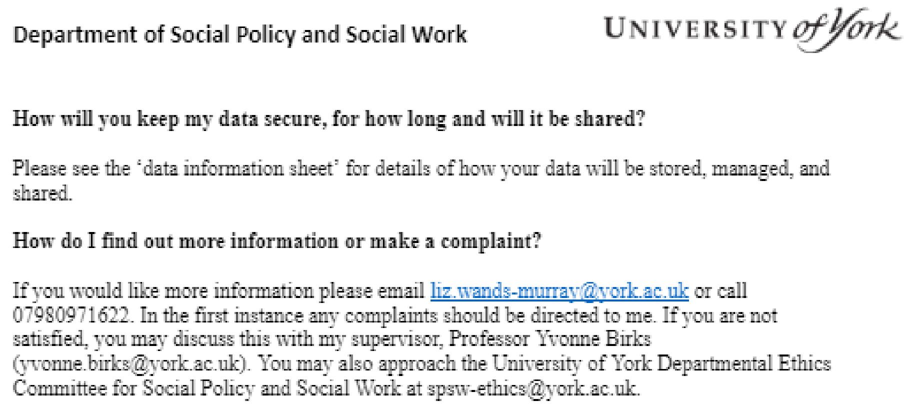
You will have the ability to end the interview or take a break at any time. I will provide you with details of helplines or organisations you can access for support if you feel distress as a result of talking about previous negative experiences.

You will also be able to indicate if you would like any part of the interview to be excluded from being analysed at the end of the interview and for two weeks after the interview has taken place. You will also be able to withdraw any part or all of your data from the research up to the 30th September 2021.

Will I be identified in any research outputs?

No. Although I will know your identity, I will ensure that you are not identified in anything that arises from the research. I may use direct quotes from your interview in any write up of the research but I will use a pseudonym (fake name) so you will not be identified.

The only reason I would reveal your identity to anyone would be if I learned that you, or someone else, may be at risk of coming to harm. Where possible, I would discuss this with you first.



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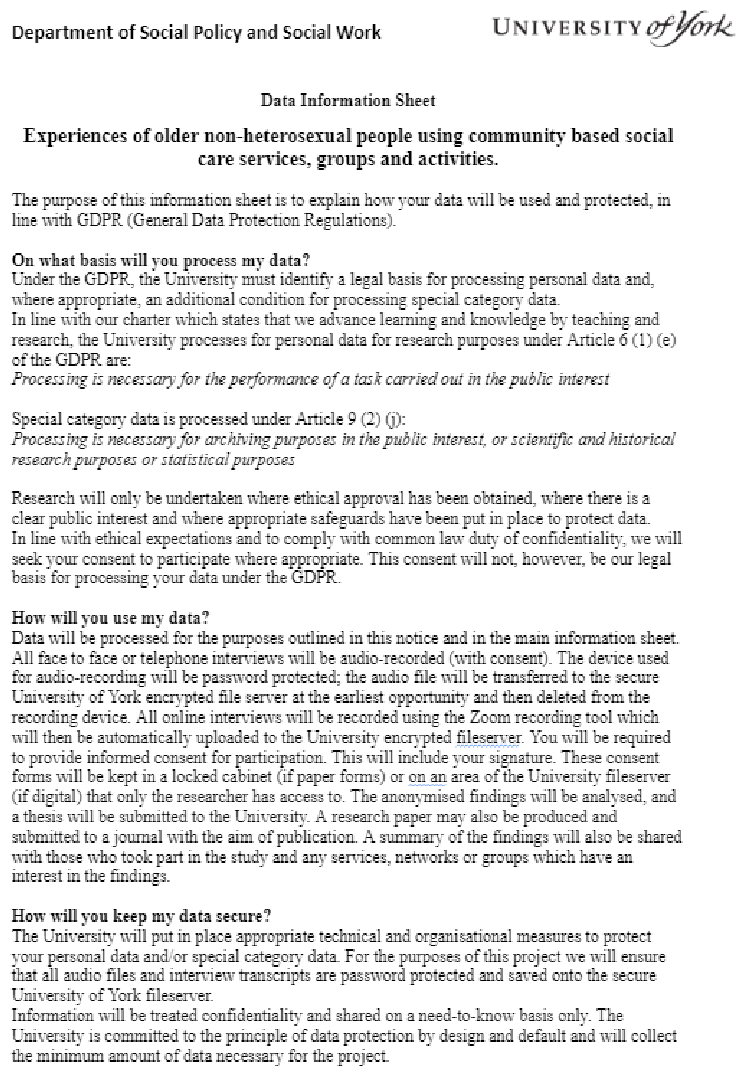
How will you keep my data secure, for how long and will it be shared?

Please see the 'data information sheet' for details of how your data will be stored, managed, and shared.

How do I find out more information or make a complaint?

If you would like more information please email liz.wands-murray@york.ac.uk or call 07980971622. In the first instance any complaints should be directed to me. If you are not satisfied, you may discuss this with my supervisor, Professor Yvonne Birks (yvonne.birks@york.ac.uk). You may also approach the University of York Departmental Ethics Committee for Social Policy and Social Work at spsw-ethics@york.ac.uk.



Department of Social Policy and Social Work

Data Information Sheet

Experiences of older non-heterosexual people using community based social care services, groups and activities.

The purpose of this information sheet is to explain how your data will be used and protected, in line with GDPR (General Data Protection Regulations).

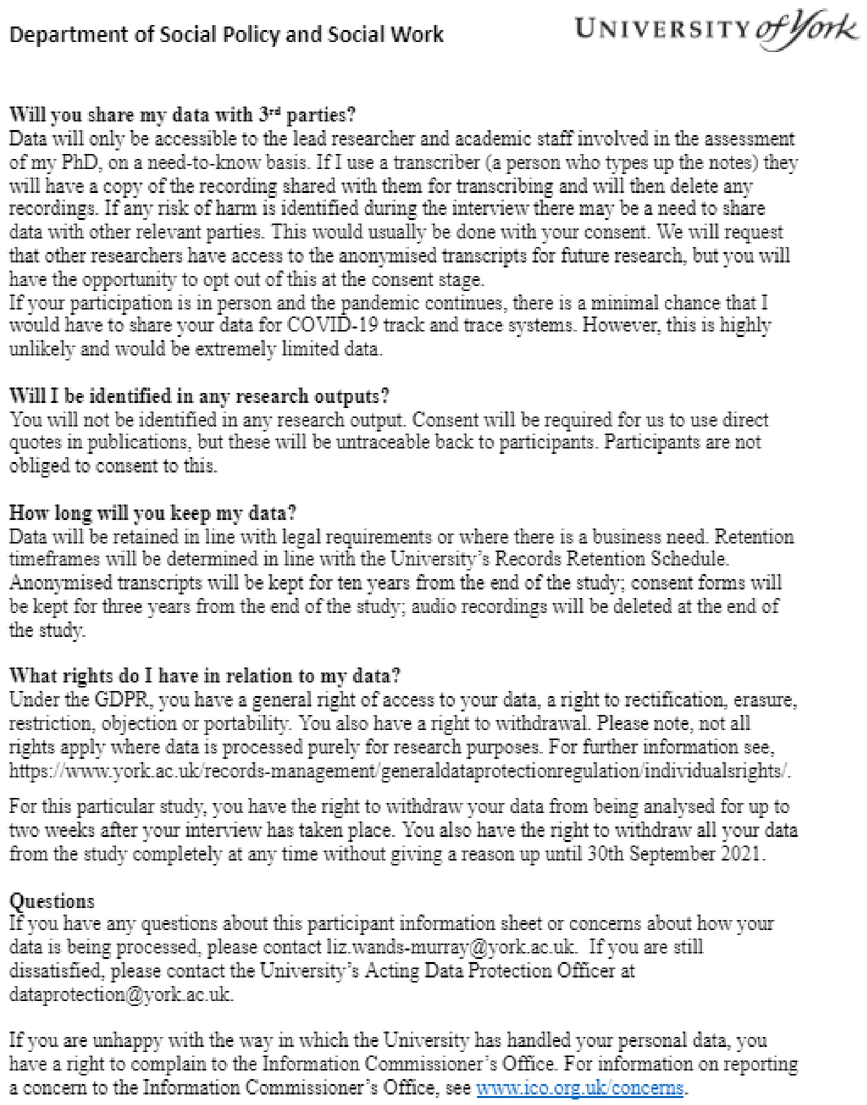
On what basis will you process my data?
Under the GDPR, the University must identify a legal basis for processing personal data and, where appropriate, an additional condition for processing special category data.
In line with our charter which states that we advance learning and knowledge by teaching and research, the University processes for personal data for research purposes under Article 6 (1) (e) of the GDPR are:
Processing is necessary for the performance of a task carried out in the public interest

Special category data is processed under Article 9 (2) (j):
Processing is necessary for archiving purposes in the public interest, or scientific and historical research purposes or statistical purposes

Research will only be undertaken where ethical approval has been obtained, where there is a clear public interest and where appropriate safeguards have been put in place to protect data.
In line with ethical expectations and to comply with common law duty of confidentiality, we will seek your consent to participate where appropriate. This consent will not, however, be our legal basis for processing your data under the GDPR.

How will you use my data?
Data will be processed for the purposes outlined in this notice and in the main information sheet. All face to face or telephone interviews will be audio-recorded (with consent). The device used for audio-recording will be password protected; the audio file will be transferred to the secure University of York encrypted file server at the earliest opportunity and then deleted from the recording device. All online interviews will be recorded using the Zoom recording tool which will then be automatically uploaded to the University encrypted fileserver. You will be required to provide informed consent for participation. This will include your signature. These consent forms will be kept in a locked cabinet (if paper forms) or on an area of the University fileserver (if digital) that only the researcher has access to. The anonymised findings will be analysed, and a thesis will be submitted to the University. A research paper may also be produced and submitted to a journal with the aim of publication. A summary of the findings will also be shared with those who took part in the study and any services, networks or groups which have an interest in the findings.

How will you keep my data secure?
The University will put in place appropriate technical and organisational measures to protect your personal data and/or special category data. For the purposes of this project we will ensure that all audio files and interview transcripts are password protected and saved onto the secure University of York fileserver.
Information will be treated confidentiality and shared on a need-to-know basis only. The University is committed to the principle of data protection by design and default and will collect the minimum amount of data necessary for the project.



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Will you share my data with 3rd parties?
Data will only be accessible to the lead researcher and academic staff involved in the assessment of my PhD, on a need-to-know basis. If I use a transcriber (a person who types up the notes) they will have a copy of the recording shared with them for transcribing and will then delete any recordings. If any risk of harm is identified during the interview there may be a need to share data with other relevant parties. This would usually be done with your consent. We will request that other researchers have access to the anonymised transcripts for future research, but you will have the opportunity to opt out of this at the consent stage.
If your participation is in person and the pandemic continues, there is a minimal chance that I would have to share your data for COVID-19 track and trace systems. However, this is highly unlikely and would be extremely limited data.

Will I be identified in any research outputs?
You will not be identified in any research output. Consent will be required for us to use direct quotes in publications, but these will be untraceable back to participants. Participants are not obliged to consent to this.

How long will you keep my data?
Data will be retained in line with legal requirements or where there is a business need. Retention timeframes will be determined in line with the University's Records Retention Schedule. Anonymised transcripts will be kept for ten years from the end of the study; consent forms will be kept for three years from the end of the study; audio recordings will be deleted at the end of the study.

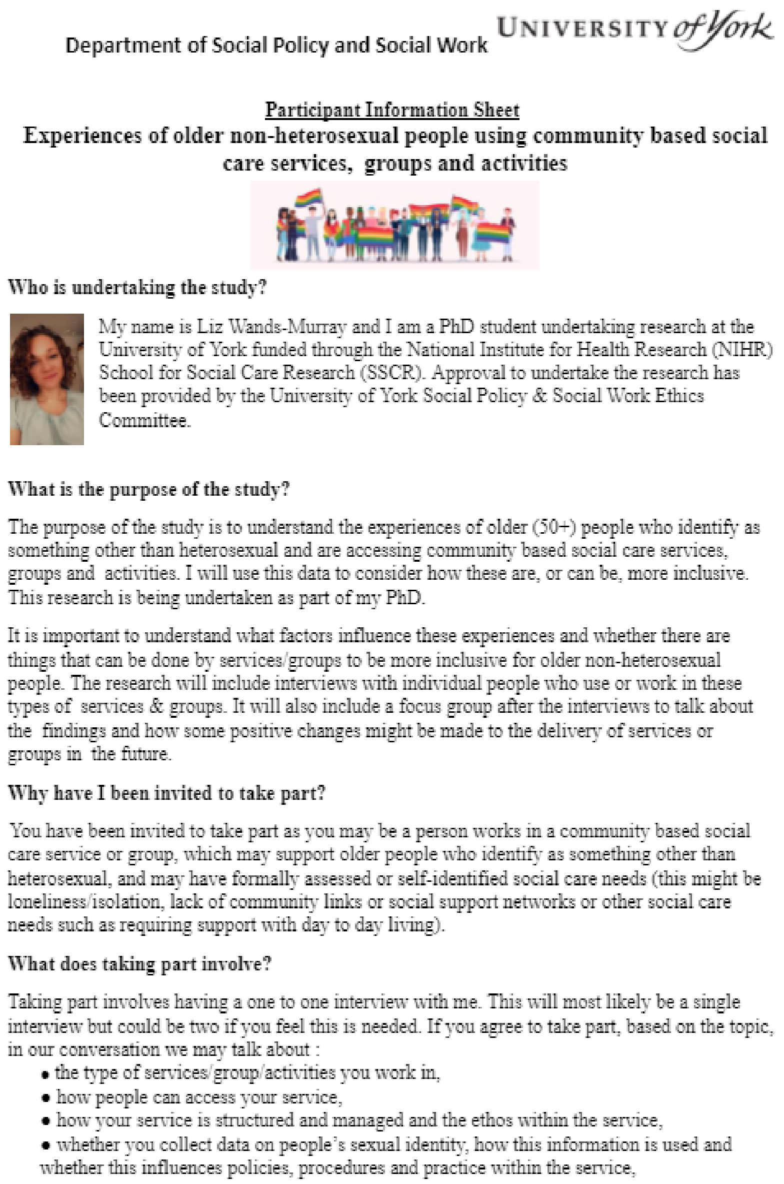
What rights do I have in relation to my data?
Under the GDPR, you have a general right of access to your data, a right to rectification, erasure, restriction, objection or portability. You also have a right to withdrawal. Please note, not all rights apply where data is processed purely for research purposes. For further information see, https://www.york.ac.uk/records-management/generaldataprotectionregulation/individualsrights/.

For this particular study, you have the right to withdraw your data from being analysed for up to two weeks after your interview has taken place. You also have the right to withdraw all your data from the study completely at any time without giving a reason up until 30th September 2021.

Questions
If you have any questions about this participant information sheet or concerns about how your data is being processed, please contact liz.wands-murray@york.ac.uk. If you are still dissatisfied, please contact the University's Acting Data Protection Officer at dataprotection@york.ac.uk.

If you are unhappy with the way in which the University has handled your personal data, you have a right to complain to the Information Commissioner's Office. For information on reporting a concern to the Information Commissioner's Office, see www.ico.org.uk/concerns.

8.2 Service Providers



Department of Social Policy and Social Work UNIVERSITY of York

Participant Information Sheet

Experiences of older non-heterosexual people using community based social care services, groups and activities

Who is undertaking the study?

My name is Liz Wands-Murray and I am a PhD student undertaking research at the University of York funded through the National Institute for Health Research (NIHR) School for Social Care Research (SSCR). Approval to undertake the research has been provided by the University of York Social Policy & Social Work Ethics Committee.

What is the purpose of the study?

The purpose of the study is to understand the experiences of older (50+) people who identify as something other than heterosexual and are accessing community based social care services, groups and activities. I will use this data to consider how these are, or can be, more inclusive. This research is being undertaken as part of my PhD.

It is important to understand what factors influence these experiences and whether there are things that can be done by services/groups to be more inclusive for older non-heterosexual people. The research will include interviews with individual people who use or work in these types of services & groups. It will also include a focus group after the interviews to talk about the findings and how some positive changes might be made to the delivery of services or groups in the future.

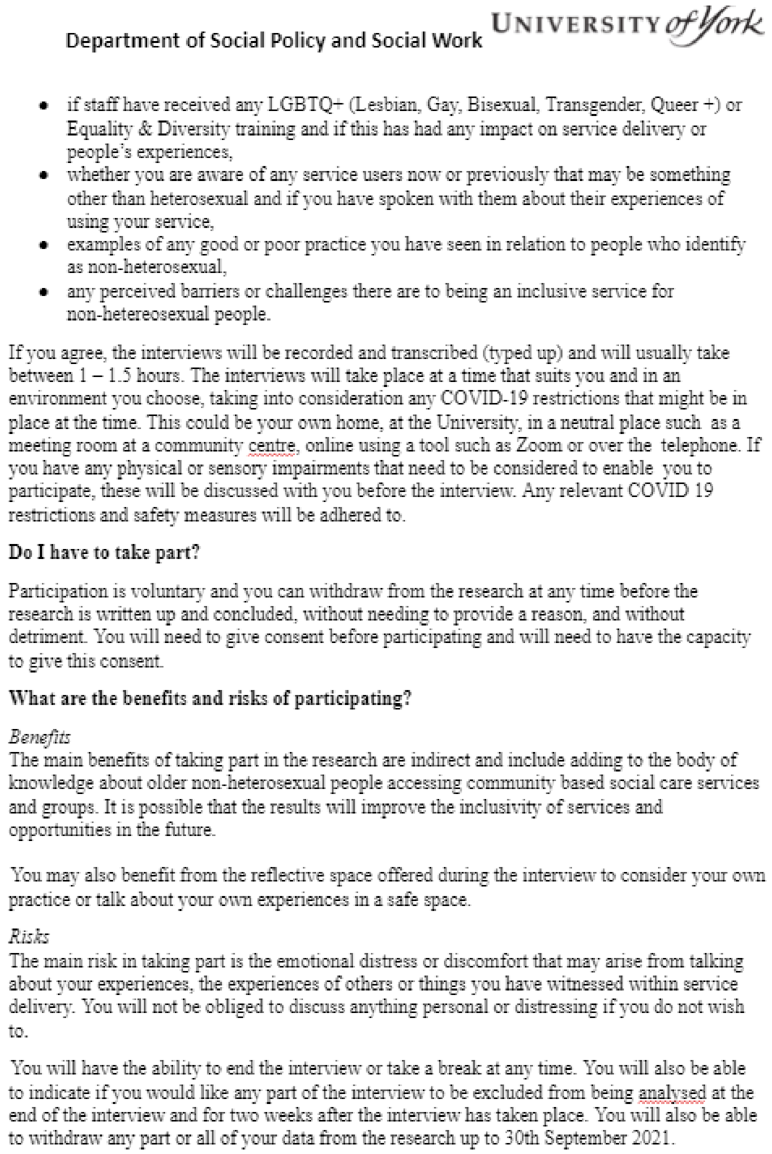
Why have I been invited to take part?

You have been invited to take part as you may be a person works in a community based social care service or group, which may support older people who identify as something other than heterosexual, and may have formally assessed or self-identified social care needs (this might be loneliness/isolation, lack of community links or social support networks or other social care needs such as requiring support with day to day living).

What does taking part involve?

Taking part involves having a one to one interview with me. This will most likely be a single interview but could be two if you feel this is needed. If you agree to take part, based on the topic, in our conversation we may talk about :

- the type of services/group/activities you work in,
- how people can access your service,
- how your service is structured and managed and the ethos within the service,
- whether you collect data on people's sexual identity, how this information is used and whether this influences policies, procedures and practice within the service,



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- if staff have received any LGBTQ+ (Lesbian, Gay, Bisexual, Transgender, Queer +) or Equality & Diversity training and if this has had any impact on service delivery or people's experiences,
- whether you are aware of any service users now or previously that may be something other than heterosexual and if you have spoken with them about their experiences of using your service,
- examples of any good or poor practice you have seen in relation to people who identify as non-heterosexual,
- any perceived barriers or challenges there are to being an inclusive service for non-hetereosexual people.

If you agree, the interviews will be recorded and transcribed (typed up) and will usually take between 1 – 1.5 hours. The interviews will take place at a time that suits you and in an environment you choose, taking into consideration any COVID-19 restrictions that might be in place at the time. This could be your own home, at the University, in a neutral place such as a meeting room at a community centre, online using a tool such as Zoom or over the telephone. If you have any physical or sensory impairments that need to be considered to enable you to participate, these will be discussed with you before the interview. Any relevant COVID 19 restrictions and safety measures will be adhered to.

Do I have to take part?

Participation is voluntary and you can withdraw from the research at any time before the research is written up and concluded, without needing to provide a reason, and without detriment. You will need to give consent before participating and will need to have the capacity to give this consent.

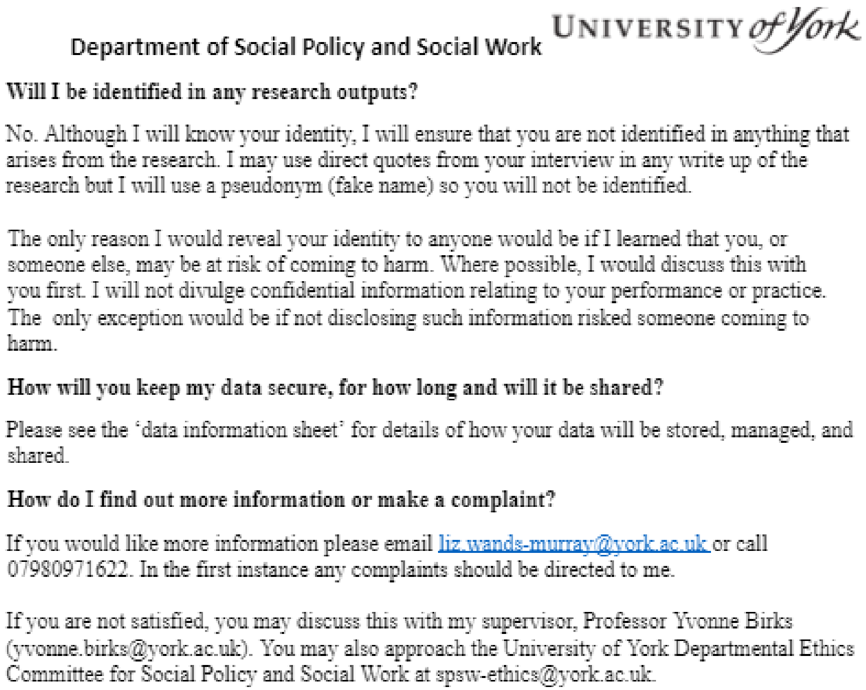
What are the benefits and risks of participating?

Benefits
The main benefits of taking part in the research are indirect and include adding to the body of knowledge about older non-heterosexual people accessing community based social care services and groups. It is possible that the results will improve the inclusivity of services and opportunities in the future.

You may also benefit from the reflective space offered during the interview to consider your own practice or talk about your own experiences in a safe space.

Risks
The main risk in taking part is the emotional distress or discomfort that may arise from talking about your experiences, the experiences of others or things you have witnessed within service delivery. You will not be obliged to discuss anything personal or distressing if you do not wish to.

You will have the ability to end the interview or take a break at any time. You will also be able to indicate if you would like any part of the interview to be excluded from being analysed at the end of the interview and for two weeks after the interview has taken place. You will also be able to withdraw any part or all of your data from the research up to 30th September 2021.



Department of Social Policy and Social Work

Will I be identified in any research outputs?

No. Although I will know your identity, I will ensure that you are not identified in anything that arises from the research. I may use direct quotes from your interview in any write up of the research but I will use a pseudonym (fake name) so you will not be identified.

The only reason I would reveal your identity to anyone would be if I learned that you, or someone else, may be at risk of coming to harm. Where possible, I would discuss this with you first. I will not divulge confidential information relating to your performance or practice. The only exception would be if not disclosing such information risked someone coming to harm.

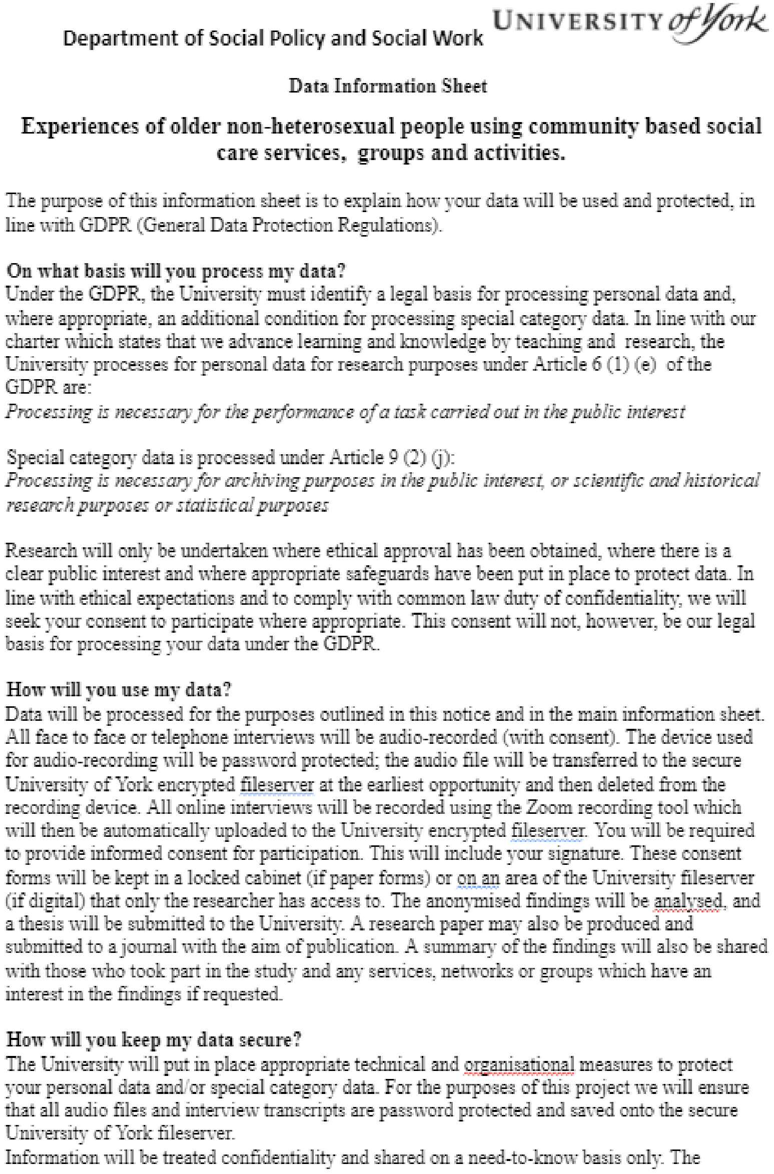
How will you keep my data secure, for how long and will it be shared?

Please see the 'data information sheet' for details of how your data will be stored, managed, and shared.

How do I find out more information or make a complaint?

If you would like more information please email liz.wands-murray@york.ac.uk or call 07980971622. In the first instance any complaints should be directed to me.

If you are not satisfied, you may discuss this with my supervisor, Professor Yvonne Birks (yvonne.birks@york.ac.uk). You may also approach the University of York Departmental Ethics Committee for Social Policy and Social Work at spsw-ethics@york.ac.uk.



Department of Social Policy and Social Work

Data Information Sheet

Experiences of older non-heterosexual people using community based social care services, groups and activities.

The purpose of this information sheet is to explain how your data will be used and protected, in line with GDPR (General Data Protection Regulations).

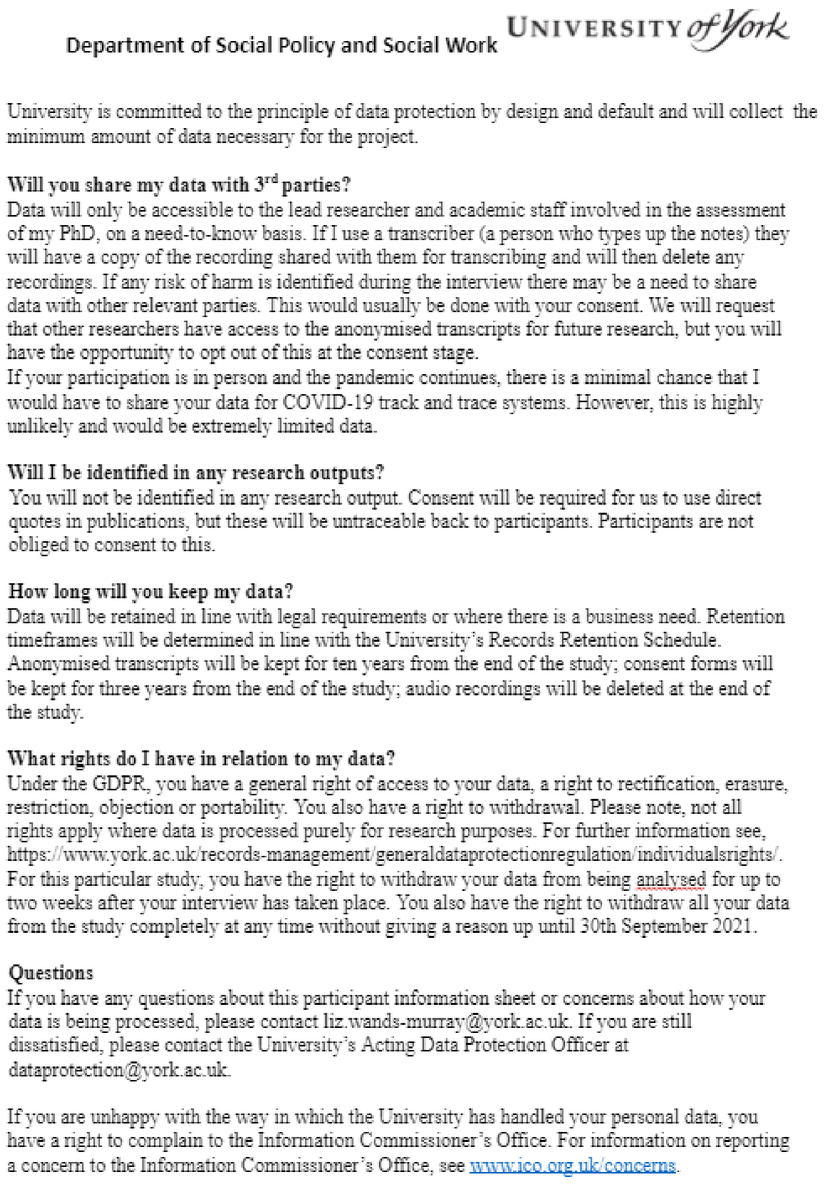
On what basis will you process my data?
Under the GDPR, the University must identify a legal basis for processing personal data and, where appropriate, an additional condition for processing special category data. In line with our charter which states that we advance learning and knowledge by teaching and research, the University processes for personal data for research purposes under Article 6 (1) (e) of the GDPR are:
Processing is necessary for the performance of a task carried out in the public interest

Special category data is processed under Article 9 (2) (j):
Processing is necessary for archiving purposes in the public interest, or scientific and historical research purposes or statistical purposes

Research will only be undertaken where ethical approval has been obtained, where there is a clear public interest and where appropriate safeguards have been put in place to protect data. In line with ethical expectations and to comply with common law duty of confidentiality, we will seek your consent to participate where appropriate. This consent will not, however, be our legal basis for processing your data under the GDPR.

How will you use my data?
Data will be processed for the purposes outlined in this notice and in the main information sheet. All face to face or telephone interviews will be audio-recorded (with consent). The device used for audio-recording will be password protected; the audio file will be transferred to the secure University of York encrypted fileserver at the earliest opportunity and then deleted from the recording device. All online interviews will be recorded using the Zoom recording tool which will then be automatically uploaded to the University encrypted fileserver. You will be required to provide informed consent for participation. This will include your signature. These consent forms will be kept in a locked cabinet (if paper forms) or on an area of the University fileserver (if digital) that only the researcher has access to. The anonymised findings will be analysed, and a thesis will be submitted to the University. A research paper may also be produced and submitted to a journal with the aim of publication. A summary of the findings will also be shared with those who took part in the study and any services, networks or groups which have an interest in the findings if requested.

How will you keep my data secure?
The University will put in place appropriate technical and organisational measures to protect your personal data and/or special category data. For the purposes of this project we will ensure that all audio files and interview transcripts are password protected and saved onto the secure University of York fileserver.
Information will be treated confidentiality and shared on a need-to-know basis only. The



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University is committed to the principle of data protection by design and default and will collect the minimum amount of data necessary for the project.

Will you share my data with 3rd parties?

Data will only be accessible to the lead researcher and academic staff involved in the assessment of my PhD, on a need-to-know basis. If I use a transcriber (a person who types up the notes) they will have a copy of the recording shared with them for transcribing and will then delete any recordings. If any risk of harm is identified during the interview there may be a need to share data with other relevant parties. This would usually be done with your consent. We will request that other researchers have access to the anonymised transcripts for future research, but you will have the opportunity to opt out of this at the consent stage.

If your participation is in person and the pandemic continues, there is a minimal chance that I would have to share your data for COVID-19 track and trace systems. However, this is highly unlikely and would be extremely limited data.

Will I be identified in any research outputs?

You will not be identified in any research output. Consent will be required for us to use direct quotes in publications, but these will be untraceable back to participants. Participants are not obliged to consent to this.

How long will you keep my data?

Data will be retained in line with legal requirements or where there is a business need. Retention timeframes will be determined in line with the University's Records Retention Schedule. Anonymised transcripts will be kept for ten years from the end of the study; consent forms will be kept for three years from the end of the study; audio recordings will be deleted at the end of the study.

What rights do I have in relation to my data?

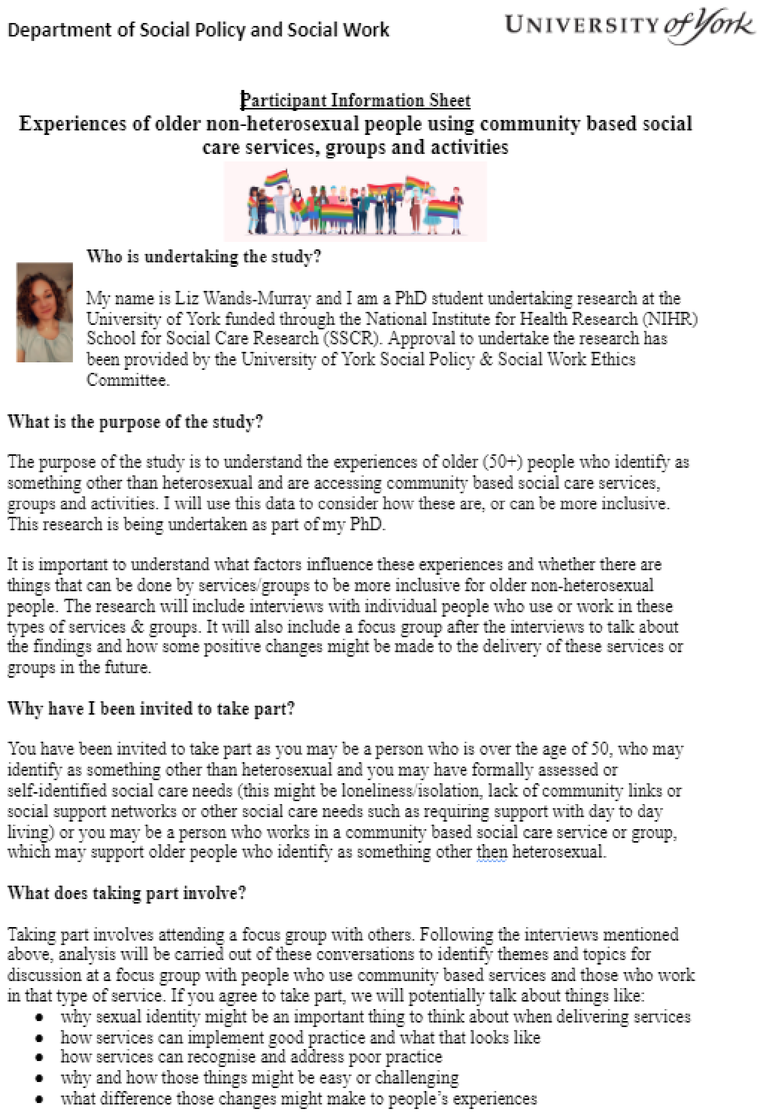
Under the GDPR, you have a general right of access to your data, a right to rectification, erasure, restriction, objection or portability. You also have a right to withdrawal. Please note, not all rights apply where data is processed purely for research purposes. For further information see, https://www.york.ac.uk/records-management/generaldataprotectionregulation/individualsrights/. For this particular study, you have the right to withdraw your data from being analysed for up to two weeks after your interview has taken place. You also have the right to withdraw all your data from the study completely at any time without giving a reason up until 30th September 2021.

Questions

If you have any questions about this participant information sheet or concerns about how your data is being processed, please contact liz.wands-murray@york.ac.uk. If you are still dissatisfied, please contact the University's Acting Data Protection Officer at dataprotection@york.ac.uk.

If you are unhappy with the way in which the University has handled your personal data, you have a right to complain to the Information Commissioner's Office. For information on reporting a concern to the Information Commissioner's Office, see www.ico.org.uk/concerns.

8.3 Focus Groups



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Participant Information Sheet

Experiences of older non-heterosexual people using community based social care services, groups and activities

Who is undertaking the study?

My name is Liz Wands-Murray and I am a PhD student undertaking research at the University of York funded through the National Institute for Health Research (NIHR) School for Social Care Research (SSCR). Approval to undertake the research has been provided by the University of York Social Policy & Social Work Ethics Committee.

What is the purpose of the study?

The purpose of the study is to understand the experiences of older (50+) people who identify as something other than heterosexual and are accessing community based social care services, groups and activities. I will use this data to consider how these are, or can be more inclusive. This research is being undertaken as part of my PhD.

It is important to understand what factors influence these experiences and whether there are things that can be done by services/groups to be more inclusive for older non-heterosexual people. The research will include interviews with individual people who use or work in these types of services & groups. It will also include a focus group after the interviews to talk about the findings and how some positive changes might be made to the delivery of these services or groups in the future.

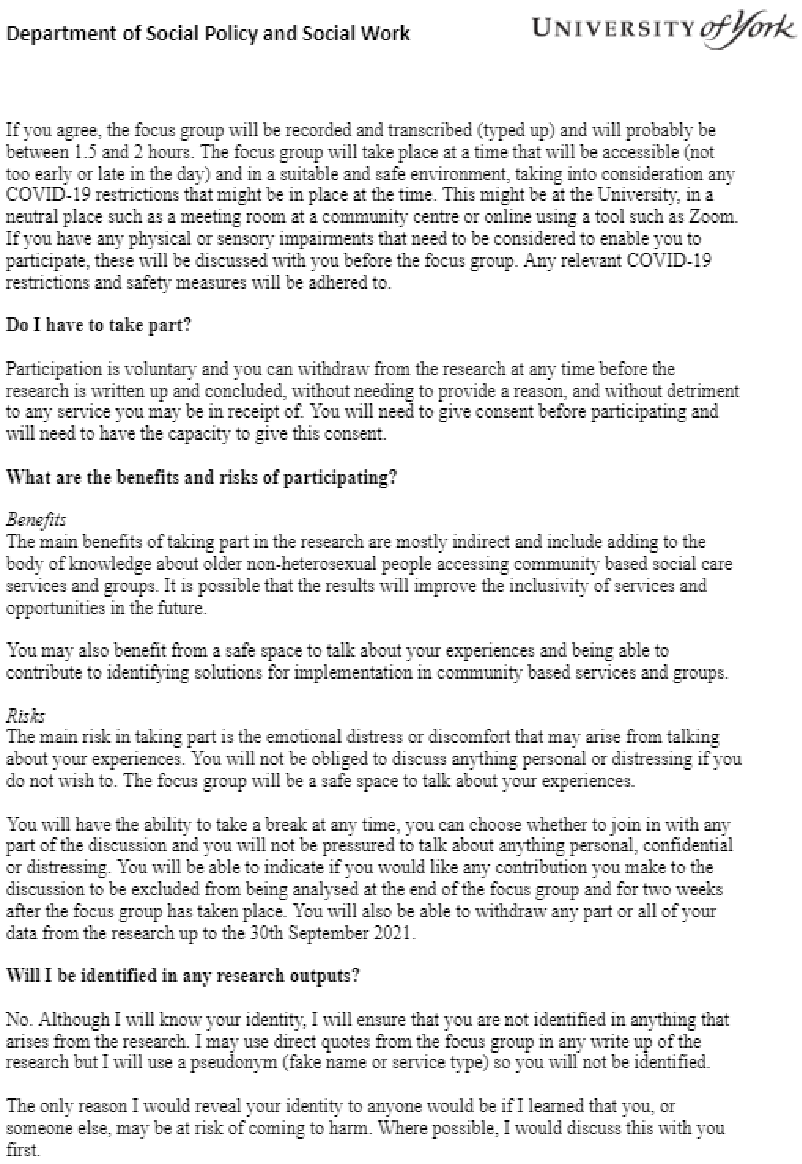
Why have I been invited to take part?

You have been invited to take part as you may be a person who is over the age of 50, who may identify as something other than heterosexual and you may have formally assessed or self-identified social care needs (this might be loneliness/isolation, lack of community links or social support networks or other social care needs such as requiring support with day to day living) or you may be a person who works in a community based social care service or group, which may support older people who identify as something other then heterosexual.

What does taking part involve?

Taking part involves attending a focus group with others. Following the interviews mentioned above, analysis will be carried out of these conversations to identify themes and topics for discussion at a focus group with people who use community based services and those who work in that type of service. If you agree to take part, we will potentially talk about things like:

- why sexual identity might be an important thing to think about when delivering services
- how services can implement good practice and what that looks like
- how services can recognise and address poor practice
- why and how those things might be easy or challenging
- what difference those changes might make to people's experiences



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If you agree, the focus group will be recorded and transcribed (typed up) and will probably be between 1.5 and 2 hours. The focus group will take place at a time that will be accessible (not too early or late in the day) and in a suitable and safe environment, taking into consideration any COVID-19 restrictions that might be in place at the time. This might be at the University, in a neutral place such as a meeting room at a community centre or online using a tool such as Zoom. If you have any physical or sensory impairments that need to be considered to enable you to participate, these will be discussed with you before the focus group. Any relevant COVID-19 restrictions and safety measures will be adhered to.

Do I have to take part?

Participation is voluntary and you can withdraw from the research at any time before the research is written up and concluded, without needing to provide a reason, and without detriment to any service you may be in receipt of. You will need to give consent before participating and will need to have the capacity to give this consent.

What are the benefits and risks of participating?

Benefits
The main benefits of taking part in the research are mostly indirect and include adding to the body of knowledge about older non-heterosexual people accessing community based social care services and groups. It is possible that the results will improve the inclusivity of services and opportunities in the future.

You may also benefit from a safe space to talk about your experiences and being able to contribute to identifying solutions for implementation in community based services and groups.

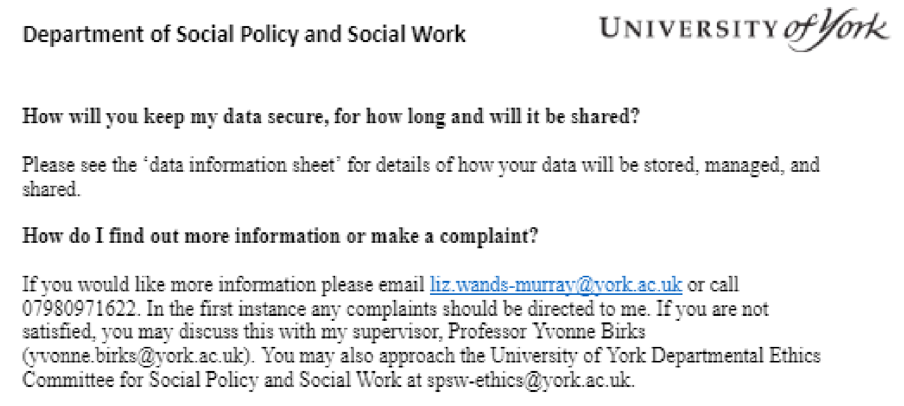
Risks
The main risk in taking part is the emotional distress or discomfort that may arise from talking about your experiences. You will not be obliged to discuss anything personal or distressing if you do not wish to. The focus group will be a safe space to talk about your experiences.

You will have the ability to take a break at any time, you can choose whether to join in with any part of the discussion and you will not be pressured to talk about anything personal, confidential or distressing. You will be able to indicate if you would like any contribution you make to the discussion to be excluded from being analysed at the end of the focus group and for two weeks after the focus group has taken place. You will also be able to withdraw any part or all of your data from the research up to the 30th September 2021.

Will I be identified in any research outputs?

No. Although I will know your identity, I will ensure that you are not identified in anything that arises from the research. I may use direct quotes from the focus group in any write up of the research but I will use a pseudonym (fake name or service type) so you will not be identified.

The only reason I would reveal your identity to anyone would be if I learned that you, or someone else, may be at risk of coming to harm. Where possible, I would discuss this with you first.



Department of Social Policy and Social Work UNIVERSITY of York

How will you keep my data secure, for how long and will it be shared?

Please see the 'data information sheet' for details of how your data will be stored, managed, and shared.

How do I find out more information or make a complaint?

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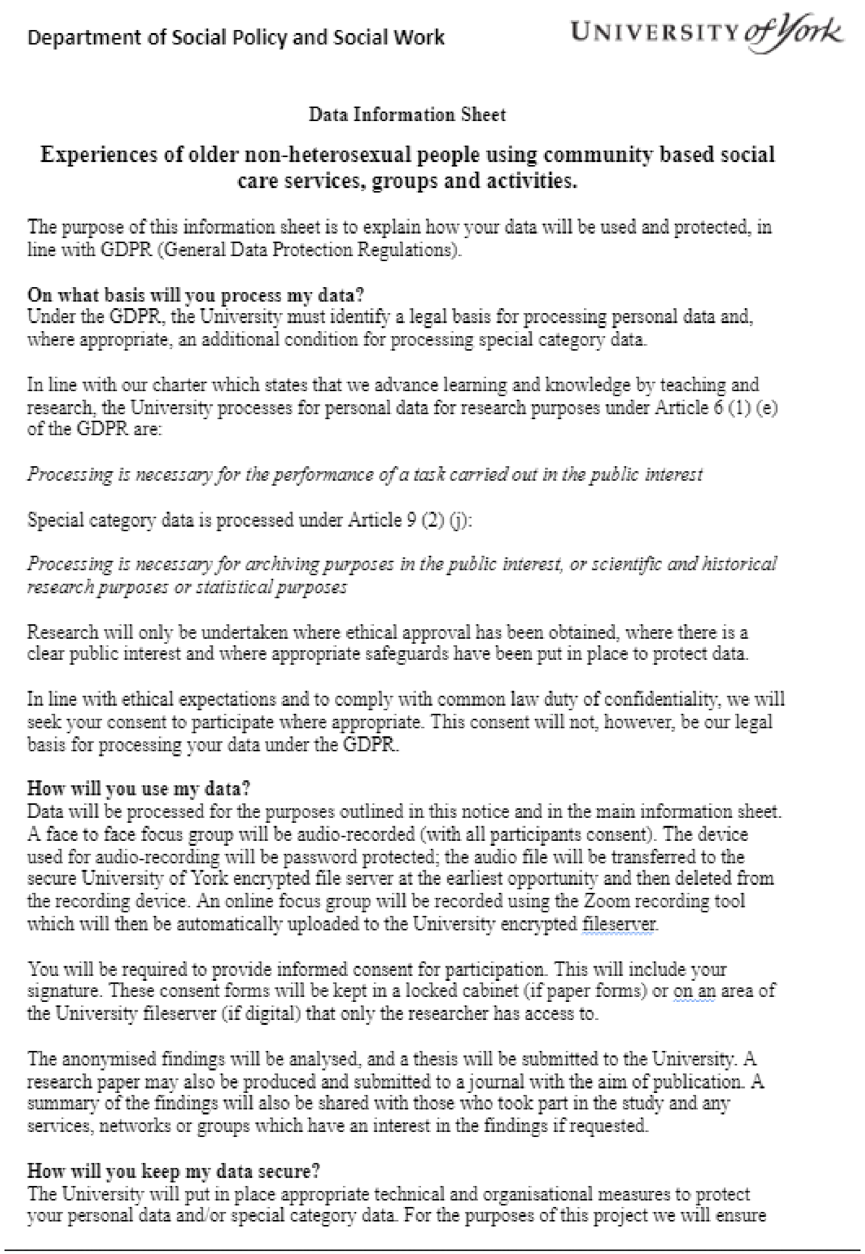

Department of Social Policy and Social Work UNIVERSITY of York

Data Information Sheet

Experiences of older non-heterosexual people using community based social care services, groups and activities.

The purpose of this information sheet is to explain how your data will be used and protected, in line with GDPR (General Data Protection Regulations).

On what basis will you process my data?
Under the GDPR, the University must identify a legal basis for processing personal data and, where appropriate, an additional condition for processing special category data.

In line with our charter which states that we advance learning and knowledge by teaching and research, the University processes for personal data for research purposes under Article 6 (1) (e) of the GDPR are:

Processing is necessary for the performance of a task carried out in the public interest

Special category data is processed under Article 9 (2) (j):

Processing is necessary for archiving purposes in the public interest, or scientific and historical research purposes or statistical purposes

Research will only be undertaken where ethical approval has been obtained, where there is a clear public interest and where appropriate safeguards have been put in place to protect data.

In line with ethical expectations and to comply with common law duty of confidentiality, we will seek your consent to participate where appropriate. This consent will not, however, be our legal basis for processing your data under the GDPR.

How will you use my data?
Data will be processed for the purposes outlined in this notice and in the main information sheet. A face to face focus group will be audio-recorded (with all participants consent). The device used for audio-recording will be password protected; the audio file will be transferred to the secure University of York encrypted file server at the earliest opportunity and then deleted from the recording device. An online focus group will be recorded using the Zoom recording tool which will then be automatically uploaded to the University encrypted fileserver.

You will be required to provide informed consent for participation. This will include your signature. These consent forms will be kept in a locked cabinet (if paper forms) or on an area of the University fileserver (if digital) that only the researcher has access to.

The anonymised findings will be analysed, and a thesis will be submitted to the University. A research paper may also be produced and submitted to a journal with the aim of publication. A summary of the findings will also be shared with those who took part in the study and any services, networks or groups which have an interest in the findings if requested.

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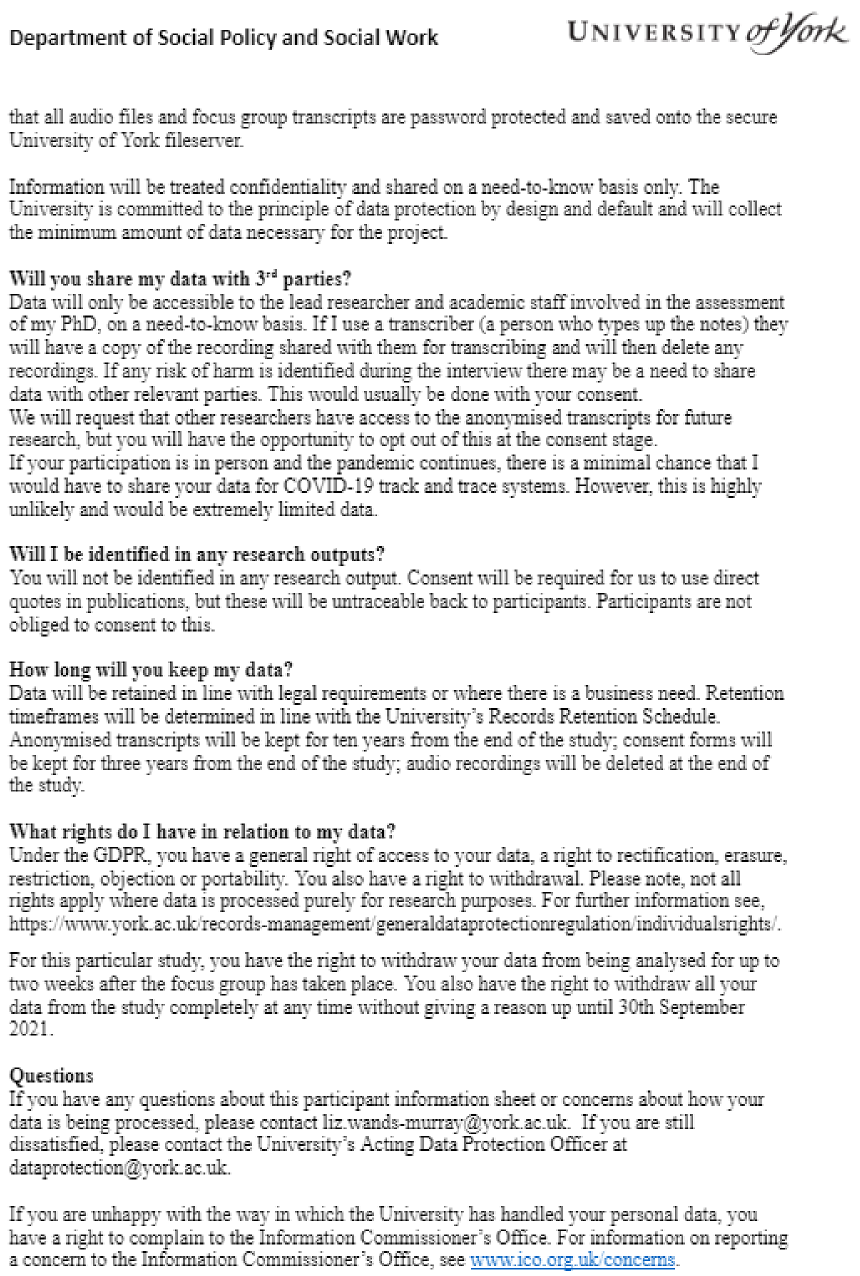

that all audio files and focus group transcripts are password protected and saved onto the secure University of York fileserver.

Information will be treated confidentiality and shared on a need-to-know basis only. The University is committed to the principle of data protection by design and default and will collect the minimum amount of data necessary for the project.

Will you share my data with 3rd parties?
Data will only be accessible to the lead researcher and academic staff involved in the assessment of my PhD, on a need-to-know basis. If I use a transcriber (a person who types up the notes) they will have a copy of the recording shared with them for transcribing and will then delete any recordings. If any risk of harm is identified during the interview there may be a need to share data with other relevant parties. This would usually be done with your consent.
We will request that other researchers have access to the anonymised transcripts for future research, but you will have the opportunity to opt out of this at the consent stage.
If your participation is in person and the pandemic continues, there is a minimal chance that I would have to share your data for COVID-19 track and trace systems. However, this is highly unlikely and would be extremely limited data.

Will I be identified in any research outputs?
You will not be identified in any research output. Consent will be required for us to use direct quotes in publications, but these will be untraceable back to participants. Participants are not obliged to consent to this.

How long will you keep my data?
Data will be retained in line with legal requirements or where there is a business need. Retention timeframes will be determined in line with the University's Records Retention Schedule. Anonymised transcripts will be kept for ten years from the end of the study; consent forms will be kept for three years from the end of the study; audio recordings will be deleted at the end of the study.

What rights do I have in relation to my data?
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For this particular study, you have the right to withdraw your data from being analysed for up to two weeks after the focus group has taken place. You also have the right to withdraw all your data from the study completely at any time without giving a reason up until 30th September 2021.

Questions
If you have any questions about this participant information sheet or concerns about how your data is being processed, please contact liz.wands-murray@york.ac.uk. If you are still dissatisfied, please contact the University's Acting Data Protection Officer at dataprotection@york.ac.uk.

If you are unhappy with the way in which the University has handled your personal data, you have a right to complain to the Information Commissioner's Office. For information on reporting a concern to the Information Commissioner's Office, see www.ico.org.uk/concerns.

Appendix 9 - Ethical Approval

9.1 Ethics approval letter

Department of
Social Policy and
Social Work
Heslington, York YO10 5DD
Direct Telephone (01904) 321231
www.york.ac.uk/spsw
mark.wilberforce@york.ac.uk

16 November 2020

Liz Wands-Murray
PhD Student

Dear Liz

Application to Social Policy and Social Work Ethics Committee

Project title: Experiences of older LGB people within community based social care activities, groups and services
Reference: SPSW/P/2020/4

Thank you for submitting your application to the SPSW Ethics Committee for the above named research project.

Your application has been reviewed by the Committee and I am pleased to inform you that they have approved your application. Where relevant, any conditions attached to this approval are enclosed.

As your project progresses, please do let the Committee know via spsw-ethics@york.ac.uk if there are any material changes to the project that will require further ethical approval (for example, changes to your research methods).

Yours sincerely

Dr Nicola Moran

9.2 Ethics application form (updated version following changes)

UNIVERSITY of York

SOCIAL POLICY AND SOCIAL WORK
DEPARTMENTAL ETHICS COMMITTEE

APPLICATION FOR ETHICAL REVIEW OF RESEARCH

Instructions

The Social Policy and Social Work Departmental Ethics Committee (DEC) oversees all research studies undertaken in the Department. This form must be used for all submissions for ethical approval, including student research. Please note that research activity (including contacting prospective participants) cannot begin until a letter of approval has been issued by the DEC.

Please complete all sections as applicable and sign the undertaking (electronically). Once completed, email it - with all required attachments - to spsw-ethics@york.ac.uk for review by the DEC.

Do I need to apply?

If your study will be reviewed by an equivalent ethical review body then you do not need to apply separately to the DEC. For example, submissions to an NHS Research Ethics Committee, or an ethics committee from another UK university, does NOT need further ethical approval from the DEC. However, you are required to notify the DEC that such a review has taken place (see the Documents Library). Research using only archived secondary data is also outside the DEC review process.

If you are unsure if you need to apply to the DEC please contact us for advice: spsw-ethics@york.ac.uk.

Checklist (click on the box to enter a cross)

✔ I have answered all relevant questions of the application form.

✔ I have attached a data management plan (an SPSW requirement).

✔ I have attached a risk assessment form (an SPSW requirement).

✔ I have attached all additional documents that will be used to recruit participants, such as information sheets, consent forms, recruitment materials (e.g. posters or flyers).

N/A I have attached any quantitative data collection instruments (e.g. questionnaires) the research will use.

✔ *For student applicants:* My supervisor has reviewed and signed my application (using an electronic signature)?

Part 1: Overview of the research

1. Please provide details about the Principal Investigator (lead staff researcher or student).

Name	Liz Wands-Murray
Course (students only)	PhD
Supervisor (students only)	Yvonne Birks Mark Wilberforce
Job title (staff only)	
Email address	Liz.wands-murray@york.ac.uk
Telephone	07980971622

2. When do you expect the fieldwork to start and end?

I will start networking activities in January 2021, with all fieldwork including interviews completed by July 2022.

3. *For staff*: List any SPSW DEC member who might have a conflict of interest so should not act as reviewers for the project, such as those consulted in the development of the project, or close colleagues. *A list of members can be found in the Ethics for Research section of the Yorkshare VLE*.

Mark Wilberforce is my second supervisor for my PhD. Rowan Jasper is my second TAP member.

4. What is the full title of the research project?

Experiences of older non-heterosexualLGB people within community based social care activities, groups and services

5. Is the research funded? If so, please name the funding body(ies)

Yes – NIHR School for Social Care Research

6. If the research is funded, does the funding source create any ethical concerns and/or actual or perceived conflicts of interest?

See section 4 "Funding" of the University's Code of practice and principles for good ethical governance

No

7. What are the research aims?

- To understand the experiences of older non-heterosexualLGB people using community based social care activities, groups and services
- To understand the ways older non-heterosexualLGB people have identified appropriate activities to meet assessed or self-identified social care needs
- To understand the factors that indicate inclusivity within services for older non-heterosexualLGB people
- To understand the activity of services to address inclusivity
- To identify the ways in which these services might or do support the delivery of culturally competent care that better meets the needs of older non-heterosexualLGB people

8. Please summarise the research methods, listing **each** research activity (e.g. focus groups, telephone interviews, online questionnaire etc)

A phenomenological approach will be used, using qualitative interviews and a focus group, with narrative analysis and coding of data collected.

Interviews with individual older (50+) non-heterosexualLGB people who have accessed community based services, activities or groups to talk with them about their experiences - with an effort to sample to ensure participants are distributed across groups eg gay men, lesbian women, bisexual men & women.

Interviews with service managers who run community based services, activities or groups to talk with them about their experiences, processes and approaches with this group - with an effort to sample different types of services in different geographical areas.

*Focus group with those who run, work/volunteer in, or commission community based social care activities, groups or services (possibly with interview participants in attendance) to reflect on the findings from the interviews and consider how these findings identify ways to implement good practices.

*Please note - this may be after the conclusion of the fieldwork period during the Year 3 write up of the thesis or after the conclusion of the project.

Ideally both the interviews and focus group will be face to face activities but this will be dependent on the situation with COVID19 at the time they are carried out and these may need to be partly or exclusively online/telephone activities or in extreme circumstances, written submissions.

9. Please briefly summarise the key ethical issues or risks that you have identified in this research.

Older non-heterosexualLGB participants may feel distress as a result of disclosing difficult experiences.This will need managing by the researcher and appropriate responses will be offered if this arises.

Involvement of participants may be unlikely to result in direct impact for them individually in relation to improvements to service delivery - this will require management of participator expectations.

Older non-heterosexualLGB participants may revisit previous frustrations with service provision that they are still reliant on as a result of discussing these experiences during interviews.

Participants may feel obliged/pressured to reveal intimate/sensitive information during interviews which may cause them distress or present ethical dilemmas for the researcher and the participant. This will need managing by the researcher and appropriate responses will be offered if this arises.

Service provider participants may experience distress or frustration when revisiting negative experiences or recounting observed behaviours from their employer or work colleagues. Participants from services may reveal evidence of discriminatory practices within their services.

Service provider participants may be concerned that revealing poor practice puts their employment status or service reputation at risk.

Participants may reveal evidence of criminal activity (eg hate crimes, discrimination) or safeguarding issues.

Participants may be concerned about sexual identity being revealed or being identifiable within research data. They may also be concerned about broader data sensitivity within the data collection and in any write up.

The lead researcher may be at risk of feeling distress during interviews and focus groups due to the nature of the stories that may be told by participants. This risk is mitigated due to the researchers extensive experience of interviewing individuals about distressing situations.

The lead researcher may be faced with moral or safeguarding dilemmas as a result of participants' disclosures.

Focus group participants may feel anxious about confidentiality or feeling judged by others.

Focus group participants may feel distress when talking about their own experiences or listening to the negative experiences of others.

Differences of opinion during the focus group may cause participants conflict or distress and this will need to be managed appropriately by the lead researcher.

If the focus group or interviews are carried out in person and COVID19 remains a concern at that point, there may be anxiety caused to participants due to risks associated with face to face meetings.

If the focus group or interviews are carried out online there may be a risk of challenges in relation to participation if people do not have the appropriate technology or ability to use online tools.

Participants may have physical or sensory impairments that require consideration and adaptations in order to allow participation.

Using a snowball approach during recruitment could present issues of confidentiality, difficult power dynamics and the possibility of participants recognising other's contributions in any output (eg articles/thesis/focus group discussions).

If COVID-19 restrictions result in needing to carry out interviews online or over the telephone, participants may feel less able to contribute fully or feel less supported by the lead researcher due to the reasonably impersonal nature of online/telephone conversations in comparison to in-person interactions.

See section 20 for details of how these risks will be mitigated or managed.

Part 2: Research participants and activities

10. Please describe the research participants taking part in each activity listed in Q8.
If your study has explicit inclusion / exclusion criteria, please list them.

Interviews with service users:
People aged 50 or over who identify as gay, lesbian or bisexual, (excluding transgender people) and have accessed any community based activities, groups or services.
All participants will be required to give informed consent.

As research participants will be self selecting, carers of those who are Lesbian, Gay or Bisexual and have accessed community based activities, groups or services will be considered for inclusion if interest is shown (these people will not be sought specifically).

Interviews with service managers:
Staff who work in community based social care services - this will be focussed on managers and those who make/influence process, policy and working approaches to supporting minority groups.

Focus Group:
Those who run, work or volunteer in community based social care activities, groups or services may be invited to take part in a focus group with interview participants in attendance to reflect on the findings from the interviews and consider how these findings could add to understanding of how they can be more inclusive in the future.

Exclusions:
Participants who are diagnosed with dementia or other conditions that mean they do not have ability to consent, meaning their experiences or perceptions of services may be altered, or they may have very specific needs related to their condition will not be included.
Participation will not be sought from people who are transgender, have a learning disability or exclusively use HIV/AIDS related services.
These exclusions are made on the basis that these groups may have very specific needs that warrant focused research rather than being included in more generic research or may require specialised services rather than those provided for wider generic groups in the community.
Participants who reside in care or nursing homes, due to receiving formal care provision on a residential basis and are likely to be in receipt of 24 hour formal care, will be excluded.

11. Approximately how many participants will take part in each activity listed in Q8.

Interviews	20 - 40 participants
Focus group around findings	20 - 40 participants

12. If the research may involve 'vulnerable' populations or children, please describe the ethical challenges that arise and how these will be managed.

By 'vulnerable' we mean anyone disempowered and potentially susceptible to coercion or persuasion. This may include people vulnerable through social context (e.g. homelessness, poverty); through experiences (e.g. of trauma or abuse); through learning difficulties, dementia or mental health needs; or through other factors. Please also provide details of the relevant DBS checks and/or ISA registration that have been undertaken.

Older interview participants are potentially likely to be identified as vulnerable as they are older people accessing services, activities or groups on the basis of externally assessed or self-identified social care needs, indicating a potential vulnerability. This will require discussion between the Lead Researcher and the participant to ensure that they understand what participating in the research involves, their ability to withdraw at any time, the aims of the research and the scope of work that is likely to result from the research.

Older interview participants may be vulnerable due to their membership of a minority group (non-heterosexualLGB), their older person status, or the requirement to identify their sexual identity in order to take part in the research which may include elements of susceptibility to disempowerment or undue influence.

There is also an unknown risk related to the current COVID pandemic which will mean that all participants and the researcher will need to adhere to the physical guidelines in place at the time of the fieldwork - this will influence the way the research is carried out to minimise any risks related to the physical health and infection risk for all.

Participants may be vulnerable due to sensory or physical impairments. This may affect their ability to fully participate in either the interviews or the focus group and result in them feeling disempowered or discriminated against due to their additional needs. If the activities are carried out in person the lead researcher will inquire prior to the meeting about any sensory or physical needs. If physical access is a consideration, the lead researcher will look to arrange the meeting in a suitable environment where the person is not excluded from participation due to physical restraints. If sensory impairment is a consideration, the lead researcher will work with the participant to identify ways to allow the person to participate. This will include looking to make any reasonable adjustments and working collaboratively with the participant to understand any needs they have and how these can most effectively be met. If the activities are to be carried out online due to continuing COVID19 restrictions, any physical or sensory impairments will be taken into consideration in terms of methods used. Options will be made available such as using the phone instead of a computer or the use of the participants chosen software/communication channels if this allows participation that would otherwise not be possible. If participants do not have the technology or ability to take part in an online meeting, then a phone interview will be offered or the option to delay the interview until such time that COVID19 restrictions allow some form of face to face interview (although this would still need to fall within the timescales for fieldwork/data collection). Information regarding notifying the lead researcher of any physical/sensory impairments/associated requirements is included on the information sheet.

People, particularly those with a diagnosis of early stage dementia or similar condition, may request the presence of a carer. This will need to be carefully managed.

Research lead has previously held multiple full clear DBS and full Home Office clearance and will seek an updated DBS prior to field work commencing to provide participants with reassurances where required. This application is already in process.

See 20 for further information.

13. Please describe how will research participants be identified, and who will be involved in the process?

Participants will be identified in a range of ways.

For both older non-heterosexualLGB people and staff/managers working in services, advertising and direct contact with local services/charities/groups who may provide support to appropriate participants (initially contacting online but subsequently through information sheets distributed to services/groups that have agreed to advertising). Opportunities to be involved in the research may also be advertised through local and national social care networks, local and national service provider networks, local and national LGBT+LGBT networks and if required, via local authority contacts including Local Area Coordinators and social prescribers.This information will include access to an information sheet with an overview of the research, what participation involves and the aims of the research as well as the lead researchers contact details.

Interview participants:
For older participants
The lead researcher has started to link in with local and national LGBT+LGBT specific networks and advocacy groups in order to canvas for those older non-heterosexualLGB people who are actively part of these networks and may be eligible and wish to take part in the research. Agreement has already been reached with two specific local networks regarding assistance with identifying and recruiting participants. This approach will be explored with wider local and national networks going forward. An information sheet about the research will be distributed to all these networks for wider distribution to enable those interested in participating to self select. The

information sheet will include the contact details of the lead researcher and clear guidance on how to indicate interest in participating (through direct contact with the lead researcher). The information sheets include the inclusion criteria.

A snowball approach may be encouraged with any participants that indicate interest through these LGBT+LGBT specific networks by asking them to share information with other eligible contacts/groups they may have. It will be suggested that the information sheet is shared with other potential participants if felt appropriate by the individual. No information will be shared with participants about others choosing to participate on the basis of this information being shared with them to ensure the confidentiality of participants is maintained.

Where there are specific groups for older people run through networks, at network meetings for local and national active networks and organisations such as local Healthwatch, AgeUK and Voluntary Network forums such as Ageing Well Without Children, LGBT+LGBT Forums etc the lead researcher will make contact and disseminate the information sheet and then subsequently seek to attend group meetings (in person or virtually) to give a short presentation (based on the information sheet) of the work being undertaken and to answer any questions people may have prior to becoming a participant. These are likely to be being held online for the foreseeable future so the lead researcher’s attendance will be via online tools eg Zoom. Each attendee will receive a copy of the information sheet which includes the lead researcher’s contact details, inclusion criteria, information on what participation involves and clear guidance on how to indicate interest in participating. These networks will also be asked if there are other smaller, local networks or organisations that may have suitable participants available. If any are identified, these networks will be approached and an information sheet will be provided, again with an offer for further information or presentation to appropriate groups from the lead researcher if required.

Some direct approaches will be made to services, groups or activities that are aimed at or suitable for people over the age of 50 where information about the group is widely available in the public domain. This will include the information sheet and an offer will be made of further information/presentation about the research which will include a request for participants who meet the inclusion criteria. The information sheet will include the contact details of the lead researcher and clear guidance on how to indicate interest in participating. The information sheet includes the inclusion criteria.

An appeal will be made using social media (Twitter) for people who may be eligible to take part, making use of existing networks, groups and suitable hashtags. This will be a Twitter account created specifically for recruitment to the research and will be linked to the lead researchers university email address. This will include a link to the information sheet with an overview of the research, what participation involves, and the aims of the research as well as contact details for the lead researcher. The post will include limited information detailing the inclusion criteria (i.e. Are you a 50+ non-heterosexualLGB person who uses community based social care services, groups or activities? Would you be interested in sharing your experiences? Click the link for further information). See section 22 for details of how people’s data will be managed and protected in relation to this.

Where appropriate, and following discussion with those who organise or lead groups/services, the lead researcher may also use individual contact details of members to make direct contact about participation in the research. This method would only be used where the service/group feels this is the most appropriate way to contact people and the lead researcher will request that the service gain the person’s permission before being given their contact details.

Advertising within local community hubs/centres where community based groups and services may access e.g. CVS, GP surgeries, town halls, community centres etc (through posters/information sheets).

For service based participants:
An approach will be made to local and national provider networks. An information sheet about the research will be distributed to all these networks for wider distribution to enable those interested in participating to self select. The information sheet will include the contact details of the lead

researcher and clear guidance on how to indicate interest in participating (through direct contact with the lead researcher). The information sheets include the inclusion criteria.

Some direct approaches will be made to services, groups or activities that are aimed at people over the age of 50 where information about the group is widely available in the public domain as well as to some of the larger national providers. This will include the information sheet and an offer will be made of further information/presentation about the research which will include a request for participants who meet the inclusion criteria. The information sheet will include the contact details of the lead researcher and clear guidance on how to indicate interest in participating. The information sheet includes the inclusion criteria.

An appeal will be made using social media (Twitter) for people who may be eligible to take part, making use of existing networks, groups and suitable hashtags. This will include a link to the information sheet with an overview of the research, what participation involves, and the aims of the research as well as contact details for the lead researcher. The post will include limited information detailing the inclusion criteria (i.e. Do you manage or run community based social care services? How do you support 50yrs+ non-heterosexualLGB people? Would you be interested in sharing your experiences and practice? Click the link for further information)

Participants will be self selecting and will independently opt to take part in the research through the methods demonstrated.

Focus group participants:

All the interview participants will be informed (if appropriate) about the focus group both before and following their interview and asked if they may like to take part in this at a future time. Information about their wishes to participate will be retained by the researcher and if/when the focus group is being planned, these participants will be contacted and asked again if they would like to take part. A separate information sheet will be distributed to this group to inform them of the focus and structure of the focus group prior to them committing to attendance. This will allow participants to identify whether they would like to be involved in this additional activity. The information sheet will include the contact details of the lead researcher and clear guidance on how to indicate interest in participating. A separate consent form will be used for participation in the focus group.

Staff and managers of the services that have been included in the interview participant recruitment or service provider interviews will be contacted if/when the focus group is being planned. A separate information sheet regarding the focus and structure of the focus group will be distributed to this group with clear information about who is eligible to attend. The information sheet will include the contact details of the lead researcher and clear guidance on how to indicate interest in participating. The information sheet includes the inclusion criteria. A separate consent form will be used for participation in the focus group.

Direct contact and advertising will also be carried out with local Healthwatch groups, AgeUK local groups, local and national social care networks, local and national service provider networks, local and national LGBT+LGBT networks, local services/charities/groups who may provide support to appropriate participants (and have previously been contacted regarding interview participant recruitment) and if required, via local authority contacts including Local Area Coordinators and social prescribers to request dissemination of the information sheet and make an offer of a presentation or attendance at a meeting to further describe the work and to seek participants.The information sheet will include the contact details of the lead researcher and clear guidance on how to indicate interest in participating.

Online advertising for participants will be carried out through Twitter if there have not been enough participants who have registered for the focus group one to two months before the arranged date. The post will include a link to an information sheet with an overview of the research, what participation involves, and the aims of the research as well as the lead researchers contact details.

The lead researcher will maintain responsibility for writing, disseminating and advertising all relevant information throughout all the recruitment cycles.

Part 3: Choosing whether to participate

14. Please describe the process by which prospective participants will receive information about the research, including who will provide information, when and how.
If a different process will be used for different participants or different activities, please describe each separately.

Participants will indicate their interest by contacting the lead researcher directly through contact details included on all documentation.

Participants will be self-selecting. This will include choosing which element they wish to participate in (eg interview and/or focus group). They will indicate their interest by contacting the lead researcher directly.

When participants have confirmed their wish to be involved, the information sheet will be provided to the person again with a consent form for the relevant activity. The participant will be unable to participate in any activities prior to receipt of a signed consent form or having given recorded verbal consent at the start of an online or telephone session. The lead researcher will ensure that all participants are able to give consent to participate and where people are not deemed to have the capacity to consent they will be informed that they are not eligible to participate at this stage. The lead researcher will ensure that the consent form has been understood through verbally confirming this and offering any additional information/assurances required when the person submits the form.

At the start of the interview the lead researcher will revisit the information sheet with the participant, check understanding, highlighting key sections and giving an opportunity for the participant to ask any further questions they may have.

Following completion of the interviews with each participant, an offer will be made to share any relevant outputs and findings from the research if they would like it (this will not be sent automatically). If the research results in any articles, these will be shared with participants if they indicate they would like the information. If the research does not result in an article, a shorter version of the thesis detailing background and context, methodology, findings and conclusions will be prepared to share with participants if they would like it.

For the Focus group:

When participants have confirmed their wish to be involved, an information sheet will be provided to the person with a consent form for the specific activity. The participant will be unable to participate in any activities prior to receipt of recorded or signed consent form. The lead researcher will ensure that all participants are able to give consent to participate and where people are not deemed to have the capacity to consent they will be informed that they are not eligible to participate at this stage. The lead researcher will ensure that the consent form has been understood through verbally confirming this and offering any additional information/assurances required.

At the start of the Focus group the lead researcher will remind the group of the purpose of the discussion, answer any questions participants may have, check that they are still happy to participate, detail some ground rules for the discussion and that they have given appropriate consents.

Following the focus group an offer will be made to all participants to share any relevant outputs and findings from the research if they would like it (will not be sent automatically). If the research results in any articles, these will be shared with participants if they indicate they would like the information.

If the research does not result in an article, a shorter version of the thesis detailing background and context, methodology, findings and conclusions will be prepared to share with participants.

The lead researcher will make and maintain contact with networks during the recruitment stage and throughout the research fieldwork.

15. Please describe how prospective participants will give their consent to the research.
If a different process will be used for different participants or different research activities, please describe each separately.

Following receipt of full details of the research, participants will be asked to inform the lead researcher of their desire to take part in the research via contact directly with the lead researcher. The lead researcher will then send a fully detailed consent form for participation.

If it is not possible to obtain written consent due to issues outside of the lead researcher or participants control (such as participants not having access to the appropriate technology, pandemic restrictions impacting on people's ability to post a written and signed consent form), when the interview takes place, an audio recording of consent will be gained through reading each clause of the consent form and asking the participant to signal their agreement with each section.

There will be three forms, one for the focus group and more detailed forms for the two different groups of interview participants.

When participants have confirmed their wish to be involved, the information sheet will be provided to the person again with a consent form for the relevant activity. The lead researcher will check with the prospective participant that they have the capacity to consent to taking part in the research. If the person has been deemed unable to give informed consent, for example, because of a condition such as advanced dementia, the person will be told they are unable to participate as they do not meet the inclusion criteria. This information is included in the information sheet.

The participant will be unable to participate in any activities prior to receipt of signed consent form or confirmation via the audio recording that the participant has agreed to all clauses within the consent form.

The lead researcher will ensure that the consent form has been understood through verbally confirming this and offering any additional information/assurances required when the person submits the form.

16. If you do *not* envisage providing an information sheet and/or obtaining a signed (or audio recorded) record of consent, please justify and explain the measures taken to compliance with data protection legislation.

N/A

17. If research participants are to receive any payments, reimbursement of expenses or other incentives for taking part in the research, please give details.

For interviews:
If held in person, all expenses incurred will be reimbursed (eg travel expenses). 'Time spent' will not be reimbursed/incentivised (including if interviews are held in an online setting).

For focus group:
If these are held in person, refreshments will be offered during the sessions. No other incentives will be offered.

Part 4: Research activities

18. Please describe what participation in each research activity involves (e.g. what activities, how often / for how long, with whom, in what setting)?

Interviews:

These will involve a 1-1 semi-structured interview with the participant and lead researcher. These will either occur online via Zoom, on the telephone or in a place of the participants choosing (pandemic dependent), with the lead researcher facilitating any required arrangements (e.g. neutral accessible meeting room, guidance on using Zoom, any adaptations required due to physical or sensory impairments). These will last between 1-1.5 hours.
Each participant will be interviewed once unless the participant and the lead researcher agree that a second session would be useful and contribute to better data collection (this is unlikely to happen).
Interview participants will be able to have a carer present if they feel they require this and the lead researcher will explain that this is at their own discretion in relation to divulging personal experiences. This will not be offered overtly but will be agreed to where appropriate and requested by the participant.

Focus group:

Attendance at a group session where semi-structured topics of discussion will be introduced and facilitated by the lead researcher. This is likely to be 2.5 hours maximum with an extended break half way through to allow for social contact and refreshments. This will be run in a community based venue independent from the University campus (eg community centre) if possible or online via Zoom if pandemic restrictions are still in place. If the focus group is to be held online and this results in some people being unable to participate, these people will be offered the opportunity to view a breakdown of topics to be covered (if before the focus group) or a written summary of discussion points (if after the focus group) to be able to contribute in writing if they wish.

Focus group participants will be able to have a carer present if they feel they require this.

19. Please provide a summary of the headings you will use in any research instruments eg topic guide / questionnaires.

You should ensure that these headings are included within the Participant Information Sheet

Interviews with older non-heterosexualLGB people
(All questions will be framed in relation to the participant’s experience as a sexual identity minority)
Type of services - What services/group/activities have you accessed?
Knowledge of services - How did you find out about these services or groups?
Why required - Did you seek these opportunities to meet any specific needs (assessed or self-identified)?
Experiences - What were your experiences of accessing these opportunities?
What positive experiences have you had?
What negative experiences have you had?
Sexual identity - (if not already discussed through previous questions)
What impact, if any, do you feel your sexual identity has had on your experience?
Delivery of provision - What are the factors you would consider in deciding whether to access/continue accessing a service or group?

Interviews with service staff/managers
(All questions will be framed in relation to providing services to sexual minorities)
Type of service - Overview of the service being provided including structure, management and governance arrangements, focus and ethos of service, staff culture within service, local context of service delivery (if applicable)

Access to service -How are services are accessed eg by referral only and/or through wider advertising and promotion in local communities?
Policies - Are there any particular policies or procedures in place within the service that cater for the needs of sexual minority groups? What kinds of things are in place?
Staff training - Have staff received any kind of E&D training? Are these topics discussed with staff? Has there been any impact or changes following staff being trained around non-heterosexualLGBTQ+ awareness?
Data collected - Does the service collect E&D information and if so, how is this information subsequently used? Has the service spoken to non-heterosexualLGB service users about their experiences? Have there been any problems/issues/complaints specifically related to sexual identity?
Approaches used - Does the service do anything specific to cater for sexual minorities, are there any good or poor practices within the service in relation to being inclusive for sexual minorities? Interviewees perspectives and opinions on the relevance of sexuality, treatment of people from sexual minority groups, things the service could improve in relation to recognising sexual identity or to be more inclusive?

Focus group
Common themes from analysis of interview data including elements of good practice, barriers & challenges when delivering, choosing or using a community based service, activity or group.

Practical and systemic challenges in implementing good practice within delivery of these services, activities or groups.

20. Do you think research participants may be distressed by their involvement in the research? If so, what action will you take to mitigate these?

Participants may become distressed if talking about negative experiences. If this occurs then the conversation will be paused, stopped or redirected depending on the context. If the person wishes to continue then this will be double-checked by the lead researcher with reminders given of ability to withdraw from participation or choose for information to be excluded from data retained. If appropriate, information regarding further support and alternative networks the participant can access to discuss the issues further (ie with a professional, charity or therapeutic provision) will be provided by the lead researcher.

The nature of the research means that older non-heterosexualLGB participants may feel it important to reveal negative experiences or evidence of mistreatment/discrimination by services which may cause them to revisit frustrations with service provision they are perhaps still reliant on. If this occurs, the lead researcher will look to allow the person to talk of their experiences without judgement and reassure the person that any information shared will be reported on anonymously with the study and not shared directly with any service provider.

Using a snowballing approach during recruitment could mean that confidentiality is compromised. Any referrals that are utilised will not be shared with participants and pseudonyms will be used throughout any write up or discussion regarding the data collected. If any participant identifies concerns about this, potential ways to avoid recognition will be discussed with the participant and supervisors. If any data would possibly result in recognition between participants, this will be considered for removal from the data retained. This would be agreed with the participant themselves.

Promoting a snowball approach to recruitment for interviews may incite challenging power dynamics i.e. someone may feel pressured or forced to participate by others. Each participant will be asked for their full consent to taking part and will be given the opportunity to withdraw from the study at any time until data analysis has been completed. This would allow for anyone who has felt pressured to participate in the interview to subsequently withdraw all their data. This right is made clear within the consent form.

The nature of the research means that service/provider participants may feel it important to reveal negative experiences or evidence of mistreatment/discrimination by their own organisation which may cause them to feel uncomfortable or ashamed about service provision/management in an organisation they are still working in. If this occurs, the lead researcher will look to allow the person to talk of their experiences without judgement and reassure the person that any information shared will be reported on anonymously with the study.

Service/provider participants may be concerned that revealing poor practice puts their employment status or provider reputation at risk. These participants will be reassured that all their contributions will be anonymised and the service will not be identifiable in any write up. We will not divulge confidential information relating to the person's performance or practice (good or bad) to their employer. The only exception would be if not disclosing such information risked someone coming to harm. An example might be if we heard evidence of abuse. Services will be categorised using generic categories that will make identification of a specific service impossible. Service/provider participants will be made aware that they do not need to reveal the name or any identifying features of the service to the lead researcher prior to the interview starting. During the focus group, service/provider participants will be given the option to keep all identifying details of the service they work for confidential if they feel that this is helpful or necessary to allow their full participation in the discussion. Where any data is collected during either the interviews or focus group that the lead researcher judges would potentially compromise the confidentiality of the service, this will be further discussed with supervisors and if appropriate with the participant themselves to consider exclusion or adaptation of the data to allow for anonymity.

As older non-heterosexualLGB participants, particularly in the interviews, will be focussing on the perceived impact their sexuality has on their experiences of services, groups or activities it is possible that they will also wish to talk about other scenarios (not social care related) where they have been discriminated against or received what they perceived to be unfair treatment and this may cause them distress. If this occurs, the lead researcher will redirect the conversation if appropriate, or alternatively allow them to talk about these experiences in order to validate their feelings and experiences and then redirect the conversation back to the topic being focussed on when this is appropriate. As noted above, where the person is distressed, the conversation will be paused, stopped or redirected and reminders given of their ability to withdraw. Where the content is not applicable to the focus of the study, the participant will be reassured that the data will not be included if not relevant but their right to share the story with the lead researcher will be retained.

If participants feel distress, the lead researcher may be challenged to provide constructive and appropriate support. The lead researcher has worked in services, with vulnerable people and as an Inspector of social care services and is therefore extremely experienced at carrying out interviews with vulnerable groups and discussing distressing experiences so will utilise the skills learned in dealing with any arising situation and is well positioned to deal with such discussions. This will also be managed by ensuring that information about available support is at hand to share with the participant and that anything that requires additional input is discussed with supervisors.

If COVID19 continues to be a concern at the time of either the interviews or the focus group and meetings are to be held face to face, anxiety around this will need to be managed by the lead researcher. Every participant in the interviews will be given the choice of whether to carry out the interview in person or, for instance, through an online meeting such as Zoom. If the participant wishes to carry out the interview in person, the lead researcher will ensure that all safety measures appropriate at the time are adhered to. Depending on the situation this might include meeting outside, wearing masks during the interview, maintaining a 2m distance.

For the focus group, if COVID19 continues to be a concern then the lead researcher will seek to carry out the group discussion online if possible. This will ensure that physical risks are minimised. This will potentially have the unintended consequence that those who do not have the ability to attend an online meeting will be excluded from participation. Other ways to participate in the discussion will be explored with individuals such as being able to phone in, or provide some written feedback before or after the main discussion. In this scenario, a written summary of the discussion could be provided to those who have been unable to participate in the live online discussion for them to be able to add comments and suggestions to. This will be clearly identified as post-focus group input in any write up.

If COVID19 restrictions are still in place at the time of the focus group but are less restrictive than currently and would allow for an in person meeting, any restrictions that remain will be adhered to. This might include ensuring the physical space used is large enough to allow for physical distancing, open windows to allow flow of fresh air, participants wearing masks, provision of hand sanitiser, utilisation of rooms in buildings that fully adhere to COVID infection control measures and the lead researcher monitoring adherence to COVID safe practices during the meeting. All participants will be informed of the measures taken by the lead researcher to adhere to recommendations and regulations prior to the focu group taking place and all will be given the option to withdraw if they do not wish to participate because of the continued risks associated with the pandemic.

The focus group discussions will centre around the findings from the interviews and the ways that themes from the analysis might be taken forward and practically implemented as potential solutions or good practice within services rather than on individuals sharing their personal experiences (although this will not be discouraged). Therefore it is hoped that the sharing of distressing experiences will be a minimal part of the discussion. Where appropriate, the lead researcher will try and ensure the discussion remains focussed on the findings of the interviews and ways forward.

Within the focus group, differences of opinion between group members may cause conflict or distress. This will be managed by the lead researcher setting ground rules at the start of the session regarding conduct, facilitating and monitoring the conversation, and intervening if any disrespect or inappropriate treatment is witnessed. It will be made clear to participants through the information sheet and introduction at the start of the session that involvement is optional, can be withdrawn at any time and there is no onus on participants to share any information they feel is confidential or makes them feel vulnerable.

Within the focus groups, participants may feel anxious about confidentiality. All participants will be asked at the start of the discussion to respect people’s privacy. Participants will be guided by the researcher at the start of the discussion to only share experiences they feel comfortable sharing and to show respect for others who are sharing experiences that may be distressing. Participants will be told they are free to leave the discussion if they find topics upsetting or a trigger for distress. The researcher will monitor this throughout the discussion. All participants will be told they are free to abstain from joining in discussions or to leave the session if they wish to.

During the focus group, if there are any exchanges or discussions that appear to make individuals or groups feel judged, the researcher will remind the group to be respectful of others experiences and responses to those experiences. Participants will be encouraged to listen to all contributions without judgement, with empathy and understanding and overall to treat each other respectfully. If a discussion continues to feel or appear judgemental, the researcher will look to end that portion of the discussion and move to another topic.

The group will be reminded at the start of the session the importance of holding discussions respectfully and to listen and value all contributions. Ground rules relating to showing respect for others contributions, not talking over people, respecting other people’s opinions, reflections and experiences and not being judgemental within discussions as well as respecting confidentiality after participation will be made clear to the group at the start of the session.

If any participant appears to show signs of distress when hearing others talk about their experiences, the lead researcher will tactfully pause the person talking and endeavour to check with the distressed participant whether they would prefer to leave the conversation or take a break for a short time. Participants who wish to share distressing experiences will be encouraged to let people know before sharing their experience that it may cause distress.

21. Is any element of the fieldwork taking place outside the UK? If so, you should refer to the University of York 'Guidance on conducting research outside the UK' and paragraph 2.13 of the Code

of practice and principles for good ethical governance and explain how you will take account of political, social and cultural sensitivities.

No.

Part 5: Data processing and protection

***Please note**: all applications include a completed Data Management Plan. You should refer to the University's guidance on Research Data Management*

22. State any promise you will make to participants about how their data will be used, including in publications and dissemination, for example whether names, job titles, or direct quotations will be used, and state what protection of anonymity you are offering.

Please be aware of your Funder's requirements for data to be made available for reuse. If your funder does not have a policy, the University Research Data Management Policy should be followed. This states: 'Where possible, relevant elements of research data must be deposited in an appropriate national or international subject-based repository, according to their policies. Data should be kept by the researcher in an appropriate manner when suitable subject repositories are not available.'

Research data will be coded with pseudonyms for all interview participants to ensure confidentiality is maintained. For older non-heterosexualLGB participants information such as gender, sexual identity and age will be included - participants will be informed of this and written consent sought. For service provider participants information such as service type, method of service users access (eg referral) and whether service is aware of any non-heterosexualLGB participants will be included - participants will be informed of this and written consent sought.

More detailed data will be collected as part of the data collection (eg people's names, service names) but will not be included in any write up (thesis/articles). This data will be stored according to GDPR regulations through protected data storage systems provided by the University. The data will be retained for the appropriate period of time.

Data collected and required to be available indefinitely will be captured using coding to ensure that accounts can be matched to the participants profile but do not break confidentiality laws and agreements made with participants.

Attendance at the focus group for non-heterosexualLGB participants will capture gender, sexual identity, age and types of services accessed (not names of service). Participants will be informed of this and written consent will be sought.

Attendance at the focus group for service staff & managers will capture type of service and job role. If the job role title would identify an individual, the lead researcher and participant will agree an appropriate alternative. Service providers will be given the option to be named within the research if they wish but otherwise the *type* of service will be used to denote participation. This categorisation will be agreed with the service provider and may be fairly generic dependent on the likely identification if very specialised or locality specific.

Where snowball sampling is utilised to recruit participants, the initial contact will not be informed whether the person recommended has chosen to take part or not, maintaining the privacy and confidentiality of the person from the initial contact.

When advertising is used on Twitter for participants, a link will be provided to an online copy of the information sheet, with the lead researchers' contact details included. This will not be an interactive site, but a static PDF of the information sheet that potential participants can use to gather more information. This will ensure that any contact with the lead researcher is done via email or telephone, offering data protection through the University system and servers. If any contact is made with the lead researcher through other means, the lead researcher will redirect the person to the University related account (Twitter), online information sheet or University email address. Participants will be able to comment directly on the post but the lead researcher will enable 'hide all replies' which will ensure that only the lead researcher is able to view any comments made directly on the post.

23. What will you do if information is disclosed to you that legally requires further action or where further action is advisable?

If any participant reveals information that might indicate someone was at risk of coming to harm (e.g. safeguarding concern, serious criminal activity etc), further guidance will be sought by the lead researcher in terms of any actions required.

Discussions would take place with the lead researcher's supervisors and we would jointly take decisions on next steps. Wherever possible, we would include the participant in the decision about how we would disclose information.

Information sheets will include a disclaimer regarding this to ensure transparency and pre-activity knowledge of the duties of the lead researcher.

24. GDPR Declarations (please check box to confirm)

X I have considered whether any personal or special category data being collected is the minimum necessary to answer the research question(s)

X I have considered anonymising or 'pseudonymising' data to mitigate data protection risks.

X I have considered whether I need to consult with the Information Governance Office (e.g. where sharing data with third parties outside the university)

X I have considered whether the study requires a Data Protection Impact Assessment (see here)

25. Are there any other specific ethical problems likely to arise with the proposed study? If so, what steps have you taken or will you take to address them?

No additional issues expected.

Part 6: Signatures

I have checked this form carefully and I am satisfied that the project meets the required ethical standards.

Signature of Principal Investigator or student	Edwards-Murray
Date of submission	02/11/2020

	Amended submission 19/07/2021

For student applications

I (*the supervisor*) confirm I have seen and signed off the following supporting documentation for this application (*click on the box to enter a cross*):

X Information sheet (including GDPR details)

X Consent form

X Risk assessment form

X Data management plan

X Any additional documents that will be used to recruit participants (e.g. survey questions, recruitment posters, flyers).

Signature of supervisor	M. Willeforce

9.3 Project Risk Assessment

UNIVERSITY of York

Project Risk Assessment

When conducting a project risk assessment, the following definition of risk, and framework guiding responding to risk, should be used.

The **risk** is the *likelihood* of the harm occurring and the *severity* of the consequences of a hazardous event. The table below is an aid to assessing the level of risk involved.

		Likelihood		
		1 **Unlikely**	**2** **Likely**	**3** **Highly likely**
Severity	**1** **No or little harm**	Low	Medium	Medium
	2 **Moderate harm**	Medium	Medium	High
	3 **Severe harm**	Medium	High	High

The different levels of risk and action to be taken are set out below:

Risk level	**Definition and action**
Low	A low risk activity is one which is extremely unlikely to cause harm and/or would result in trivial or no injury/illness. The risk is of such a low level that there is no need for controlling action. Monitoring is required to ensure that the risk remains low.
Medium	A risk reduced to a manageable level that is reasonably practicable and is subject to regular monitoring and reviews. Where the moderate risk is associated with extremely harmful consequences, further assessment may be necessary to establish more precisely the likelihood of harm as a basis for determining the need for improved control measures.
High	A high risk activity is one which is very likely to cause harm and/or which may cause death or serious illness/injury. The risk requires the immediate implementation of management control to reduce the risk level to either medium or low. Work should not be started or continued until the risk has been reduced. If it is not possible to reduce risk with unlimited resources, work has to remain prohibited.

Title of project: _What are the experiences of older LGB people accessing community based social care activities, groups and services in York and the surrounding areas?__

Workpackage **(or other element of project to which fieldwork relates):**
____

Estimated fieldwork Start date: __June 2021____________

Estimated fieldwork End date: __September 2021_________

Evaluate the risks and decide on precautions State level of risk (**Low**, **Medium** or **High**) for each hazard identified, taking into consideration the *likelihood* and/or the *severity* of harm. Give full details of possible hazards, stating who might be harmed. Give details of control measures that will be employed to reduce the risk of harm - both standard control measures taken by the Unit (e.g. use of safety procedures, provision of guidance and training to fieldwork staff) and any special measures to address particular risks. Fieldwork (including telephone interviews) should not be undertaken if suitable control measures are not in place to reduce medium and high risks. **You should make use of SafeZone for lone working or any work related situation where you feel there is some level of risk to your activity. SafeZone is the University managed staff safety system. You will need to download the app and follow the SPSW procedure for using Safezone which is available on the Yorkshare VLE/SPSW Staff Intranet/Departmental Ethics Committee.**		
Hazard	**Risk level**	**Hazard details and control measures**
Risks to the researcher		
Travelling to the fieldwork site	Low	Travelling on roads using personal vehicles (car or bicycle) or public transport Control measure: Usual care to be taken when taken, all road laws to be followed
Time of day of fieldwork visits	Low	This will be at a time of the participants choosing. If they prefer evening/after dark the researcher will inform a 3rd party of whereabouts and travel mode prior to leaving. Arrangements will be made to check in with the 3rd party at an agreed time.
Location of the field work visit	Low	This will be at a place of the participants choosing. If they prefer their own home (this will be discouraged) then the researcher will inform a 3rd party of whereabouts, timings and travel mode prior to leaving. Arrangements will be made to check in with the 3rd party at an agreed time
Hazards within the environment/setting where the interview actually takes place	Low	The most likely environments are either the University campus or a local community centre or meeting venue which will be covered by public liability insurance and are not likely to include any hazardous environments or settings.
Characteristics of the participant group	Low	Although the participant group will be classed as vulnerable due to their social care needs and maybe recounting distressing memories,, it is unlikely to pose any risk to the researcher.
Interview topic potentially inflammatory or sensitive	Low	The interview topic may include some distressing conversations but these will be individual to the participants and will not be related to the researcher. Sensitive topics to the researcher are not included in the interview topics for discussion. The researcher has experience of speaking with people about distressing or sensitive topics through previous

		roles and is able to manage this from a personal point of view. Any distress that is suffered will be disclosed and discussed with supervisors.
Other		
Risks to the participant		
Interview topic causes upset or distress	Low	The interview topic may include some distressing conversations when remembering previous experiences which may be sensitive in nature. However, all participants will be aware of the topics for discussion prior to the interview and will give full consent. They will also have control over what experiences they recount and will have the ability to pause or cease the interview at any time.
Physical and mental health introduce additional vulnerabilities with respect to participating in the research	Low	As above.
Confidentiality compromised by presence of others	Low	Participants will give their full consent and will be able to withdraw from the interview or have their data withdrawn subsequently. All data will be stored safely as per data management plan. The only other person present during the interview will be the researcher.
Other		

Assessment led by:

Name: ____

9.4 Data Management Plan

York Data Management Plan (DMP) for PhD Student Research Projects

Student name: Liz Wands-Murray

Project title: Experiences of older LGB people using community based social care services, groups and activities in York (and surrounding areas)

Project start/end: January 2020 - December 2023

Funder (where applicable): NIHR School for Social Care Research
*To check through SSCR contract for all data management requirements and add in to this plan accordingly (which may change some sections)

Project context:

- To understand the experiences of older LGB people using community based social care activities, groups and services in place
- To understand the ways older LGB people have identified appropriate activities to meet assessed or self-identified social care needs
- To understand the factors that older LGB people might use to indicate an inclusive service
- To identify the ways in which these services do or might support the delivery of culturally competent care that better meets the needs of older LGB people

The project is part of my PhD within the Social Policy and Social Work department and will include interviews with self selecting participants carried out in a range of places - this will be predominantly online if the pandemic continues to be an issue. Otherwise participants will identify where they would like interviews to take place - this may be on campus, in their own homes, or in a neutral place such as a meeting room in a community centre.

Defining your data

1a. What data will you produce?
I will record interviews with my participants using a digital recorder and then transcribe them into text.

1b. What formats and what software will you use?
Audio recordings using portable audio recording devices saved as MP3 files (if interviews are in person) or video recordings of Zoom interviews (if interviews are carried out online) which will be saved as MP4.
Transcripts will be created and saved in Word or Google Docs.
Storage will be through uploading onto Google Drive, and then transferring onto the University's secure server using my IT profile (stored in my H Drive).

1c. Who owns the data you will generate?
The University will retain part-ownership of the data as part of my studentship agreement.
My contract with NHIR also includes their retention/ownership of the data collected.

1d. Does the data include personal and/or special category data (see guidance on GDPR)?
Yes, the data will include confidential and personal information as well as data regarding protected characteristics.

Looking after your data

2a. Where will you store your data?
The data will be stored on the University's centrally managed network, in my personal filestore (M Drive) and I will use the VPN to connect to my personal filestore and work on/add to my files while away from the office. This is backed up daily.

2b. How will you back-up your data?
There will only be one copy of the interview and transcription.
Data will be backed up as part of the standard back up of data on the University's servers daily.

2c. Who else has a right to see or use this data during the project?
My PhD supervisors (Yvonne Birks/Mark Wilberforce) may require access to the data. The data will also be shared with a transcriber if I require this assistance (this will be dependent on the amount of participants recruited). The transcriber will be instructed to electronically record all data using the pseudonym assigned to the participant but will know the participants real forename as this is likely to be used during the interview recording.

2d. How will you structure and name your folders?
Top structure: Fieldwork data
I
Participant folders, Data Analysis folders

Participant folders: Each participant will be given a pseudonym and the recordings and transcribing of the data for each individual will be stored in their own folders. These folders will include the real identity and contact details for the participants - this specific information will be kept in a password protected document within each participant folder and will only be accessible to myself.

Data analysis folders: Data will be extracted from the interviews and included in data analysis spreadsheets, word documents and inputted into data analysis software provided by the University. This will include statistical data in relation to age, type of service used (generic categories will be assigned) and sexual orientation. It will also include direct quotations from interviews.

2e. How will you name your files?
Participant interview data will be named using the participants chosen pseudonym and the date of the interview.
Data analysis files will be named according to the information contained within them. Statistical data will include participants ages, sexual orientation, service type, type of social care need. Categorised data will include service type categories (eg formal day service, homecare, special interest group, physical activity group, hobby group etc) and experience type categories (good practice, poor practice, discrimination by staff, discrimination by other attendees, structural discrimination etc)

2f. How will you manage different versions of your files?
Each time data is added to a file, a date will be added to the beginning of the file name (eg 240121 Lenny, 190321 Lenny) and this will be saved as a new version of the document to allow for access to archived versions if required.

2g. What additional information will be required to understand your data?
I may keep additional notes about interviews in a word document which will be saved in the participants folder. The audio recordings will also be saved into these folders.

2h. Could data be collected anonymously or pseudonymously? Will the data be anonymised?
Yes, the data will be anonymised using pseudonyms.

Archiving your data

3a. What data should be kept or destroyed after the end of your project?
Password protected documents within the participant folders containing the contact details and real identities of participants will be destroyed at the end of the project.
All audio recordings will be destroyed at the end of the project.
Edited transcriptions of the interviews (with all identifying information such as service names or staff/peer names redacted), and categorised data analysis documents will be retained to be made available to other researchers if required

3b. For how long should data be kept after the end of your project?
10 years, as per the University research data management policy.

3c. Where will the data you keep be stored at the end of the project?
Within the SPSW secure drive on the University servers. My funder (SSCR) may also require a copy of the data to be stored by them. This will be transferred securely.

3d. When will you archive your data?
I will provide a copy of the data supporting my thesis to the University for long-term retention when I submit my thesis, when a paper based upon them is accepted for publication and to my funder SSCR.

Sharing your data at the end of the project

4a. What data should or shouldn’t be shared openly and why?
Edited (redacted) transcriptions of the interviews should be made openly available to other researchers to allow further analysis if requested following any associated publication (eg journal article).
Categorised data analysis should be made openly available to other researchers to allow further analysis and conclusions if requested following any associated publication (eg journal article).
These will be sent securely using password protection where an appropriate request is received.
If a participant did not give informed consent for their anonymised data to be shared, I will exclude their results from the finalised data. However, all participants will be asked to give this level of consent prior to participation.

4b. Who should have access to the final dataset(s) and under what conditions?

Bona fide researchers who request the data within 10 years of any publication (eg journal article) - if required for further analysis.

Panel undertaking my VIVA - if required as part of the progression and completion process for my PhD.

PhD supervisors and TAP advisors - if required as part of the progression and completion process for my PhD.

These will be sent securely using password protection where an appropriate request is received.

4c. How will you share your final dataset(s)?

The dataset will make up the appendices of my thesis and will be available to those who require sight of all documentation related to this eg VIVA panel, TAP advisors & PhD supervisors.

A copy of the data supporting my thesis will be retained by the University, and the University will field any requests for access on my behalf and make the data available to the requestor.

Otherwise the dataset would only be shared upon request and will then be sent securely using password protection where an appropriate request is received.

Implementing your plan

5a. Who is responsible for making sure this plan is followed?

I will retain responsibility for following this plan while employed or attending the University as a student. I will take responsibility for carrying out the actions required by this plan and report them to my supervisor as appropriate. If I am no longer employed by the University following completion of my PhD, responsibility will move to the administrative section of the SPSW department within the university.

5b. How often will this plan be reviewed and updated?

6 monthly prior to fieldwork, monthly during data collection and analysis, and 6 monthly following completion of data collection.

5c. What actions have you identified from this plan?

Setting up folders and files onto my M Drive once recruitment of participants has started.

5d. What policies are relevant to your project?

Research Data Management Policy, GDPR, SSCR data management policy

5e. What further information do you need to carry out these actions?

Signed: Liz Wands-Murray	**Version: 3**
Date created: November 2020	**Date amended: July 2021**

Appendix 10 - Overview of participants

10.1 Older LGBTQ+ participants

Name	Age	Sexual identity	Gender identity	Location	Ethnicity	Disability	Social Care Assess
James	71-80	Gay	Cisgender Male	Small rural village	White English	No	No
Sally	71-80	Asexual	Cisgender Female	Small rural town	White British	No	No
Fifi	61-70	Gay	Cisgender Male	Large urban city	White British	No	No
Roy	71-80	Gay	Cisgender Male	Small rural town	White British	No	No
Cynthia	50-60	Lesbian	Cisgender Female	Rural village	White British	Yes	No
Michael	71-80	Homosexual	Cisgender Male	Large urban city	Chinese	Yes	Yes
Woodie	61-70	Gay	Cisgender Male	Large urban city	White British	Yes	No
Joseph	71-80	Bisexual	Cisgender Male	Large urban city	White British	Yes	Yes
Jason	50-60	Gay	Cisgender Male	Rural village	White British	No	No
Delia	61-70	Lesbian	Cisgender Female	Large urban city	White British	No	No
Rose	71-80	Bisexual	Cisgender Female	Large urban city	White British	No	No
Faith	50-60	Heterosexual	Transgender Female	Small urban town	White American	No	Yes

10.2 Service Providers staff/volunteers

Name	Age	Sexual identity	Gender identity	Location	Ethnicity	Service category
Cara	61-70	Lesbian	Cisgender Female	Small urban city	White British	Characteristic based group (AWOC)
Alex	71-80	Gay	Cisgender Male	Large urban town	White European	Characteristic based/social group (LGBTQ+)
Ruth	41-60	Lesbian	Cisgender Female	Rural village	White British	Hobby/interest/social group (LGBTQ+)
Zayn	18-40	Gay	Cisgender Male	Large urban city	White British	Formal social care provider (LGBTQ+)
Irene	41-60	Heterosexual	Cisgender Female	Small urban town	White British	Homecare service
Anna	41-60	Pansexual	Cisgender Female	Large urban town	White British	Homecare service
Brad	60+	Heterosexual	Cisgender Male	Large urban city	White British	Homecare service
Lyla	18-40	Bisexual	Cisgender Female	Large urban city	White British	Homecare service
Quinn	18-40	Lesbian	Non-Binary	Rural village	White British	Community wide service (Library)
Persephone	60+	Heterosexual	Cisgender Female	Small urban city	White British	Community wide service (Library)
Aubrey	41-60	Heterosexual	Cisgender Female	Large urban city	White British	Charity/advisory

Appendix 11 - Topic Guides

11.1 Older LGBTQ+ people using services

Before the interview begins:

- Check the participant has read and understood the information sheet
- Check the participant would still like to take part in the interview, reiterating that involvement is optional and they can change their mind at any time
- Talk through the consent form and get signed, or audio-recorded, informed consent
- Ask if there are any remaining questions before the interview starts

The overall purpose of the interview is to understand:

- What the person’s experience of using community based groups, services or organisations has been
- Whether they feel that their sexual identity has impacted on that experience
- What has made that experience positive or negative *in relation to their sexual identity or separate to it*
- What things might make future experiences more inclusive

Question asked	**Possible further prompts**
Tell me about yourself	Protected characteristic data: Describe your sexual identity Age bracket - 50-60, 61-70, 71-80, 81-90, 91 or above Describe your gender Type of residential area - Urban (Large city, small city, large town, small town) or Rural (Small town, village, no other homes within 1 mile) Describe your ethnicity Do you consider yourself to have a disability
	Did you have a social care assessment before accessing any groups or services?

Tell me about your experiences of community based social care services, groups or organisations	What type of groups or services have you accessed?
	What were your experiences of these services like? This can include positive or negative experiences.
	How did you find out about these groups or services?
	What did you hope for from attending these groups or services?
	Do you think that being based in the local community is an important aspect of your experience and why?
How do you think your sexual identity has influenced these experiences?	Did that service ask any questions about your sexual identity or relationship history?
	What impact, if any, do you think your sexual identity had on these experiences?
Are there things you would look for going forward?	What things might you look for when choosing a group or service to attend?
	Are there things that could have been done differently that would influence your experience of attending these groups/services?

11.2 Older LGBTQ+ people not yet using services

Before the interview begins:

- Check the participant has read and understood the information sheet
- Check the participant would still like to take part in the interview, reiterating that involvement is optional and they can change their mind at any time
- Talk through the consent form and get signed, or audio-recorded, informed consent
- Ask if there are any remaining questions before the interview starts

The overall purpose of the interview is to understand:

- What the person’s thoughts are about using community based groups, services or organisations in the future
- Whether they feel that their sexual identity should/does impact on that experience
- What might make experiences positive or negative *in relation to their sexual identity or separate to it*
- What things might make future experiences more inclusive

Question asked	**Possible further prompts**
Tell me about yourself	Protected characteristic data: Describe your sexual identity Age bracket - 50-60, 61-70, 71-80, 81-90, 91 or above Describe your gender Type of residential area - Urban (Large city, small city, large town, small town) or Rural (Small town, village, no other homes within 1 mile) Describe your ethnicity Do you consider yourself to have a disability
	Have you ever had a social care assessment?
Do you have any experiences of community based social care services, groups or organisations? If no, move to the next question set...	What type of groups or services have you accessed?
	What were your experiences of these services like? This can include positive or negative experiences.
	How did you find out about these groups or services?
	What did you hope for from attending these groups or services?
Thinking about the future, if you develop any care/support needs, what kinds of services or groups can you imagine accessing?	How will you find out what is available?
	What do you think will influence the types of services you choose?

	Do you think that being based in the local community will be an important aspect of your experience and why?
If you access community based social care groups or services in the future, what do you think will make that a positive experience?	What things might you look for when choosing a group or service to attend?
	If there are things that could be done differently to improve your experience of attending these groups/services, do you think you would feel comfortable feeding that back to the service or group?
How do you think your sexual identity might influence these experiences?	Would you want/expect services to ask any questions about your sexual identity or relationship history?
	Will you be happy to share that information and do you think it will make a difference to the experiences you might have?
What elements of your sexual identity do you think could be lost or ignored within services and groups that you would be keen to retain?	

11.3 Staff/volunteers non-LGBTQ+

Before the interview begins:
- Check the participant has read and understood the information sheet
- Check the participant would still like to take part in the interview, reiterating that involvement is optional and they can change their mind at any time
- Talk through the consent form and get signed, or audio-recorded, informed consent
- Ask if there are any remaining questions before the interview starts

The overall purpose of the interview is to understand:
- What the person’s experience of working in or running community based groups, services or organisations has been
- Whether they feel sexual identity has impacted on planning or delivering the group/service

- What has made experiences positive or negative in relation to people's sexual identity or in relation to their own experiences
- What things might make future experiences more inclusive for people

Question asked	**Possible further prompts**
Tell me about yourself	Protected characteristic data: Describe your sexual identity Describe your gender Age bracket - 20-40, 41-60, 61 or over Type of residential area - Urban (Large city, small city, large town, small town) or Rural (Small town, village, no other homes within 1 mile) Describe your ethnicity Type of service category - Hobby, activity or interest group, Social group, Peer support group, formal social care service provision, charity/advisory service, religious group, characteristic based group, homecare agency or service, other
Tell me about the group or service you have worked in	What type of service/group do you work in?
	How is it structured/managed?
	How would you describe the ethos of the service?
How do people access the group?	Do people have a social care assessment before accessing any groups or services?
	How do people find out about the group?
Do you have any experiences or opinions about older gay, lesbian or bisexual people using your service or group?	Are you aware of any service users, now or previously, that may be lesbian, gay or bisexual?
	If so, have you spoken with them about their experiences of using your service?

Do you think your service or group considers sexual identity?	Do you collect data on people’s sexual identity?
	How is this information shared and used?
	Does knowing how many people fit into this category influence policies, procedures and practice within the service?
	Have you or other staff received any LGBTQ+ (Lesbian, Gay, Bisexual, Transgender, Queer +) or Equality & Diversity training?
	Do you think this has had any impact on service delivery or people’s experiences?
Have you seen any good practice or have any ideas about what could be done to be more inclusive for groups?	Can you give examples of any good or poor practice you have seen in relation to people who identify as LGB
	What are the barriers or challenges to being an inclusive service for LGB people?

11.4 Staff/volunteers LGBTQ+

Before the interview begins:
- Check the participant has read and understood the information sheet
- Check the participant would still like to take part in the interview, reiterating that involvement is optional and they can change their mind at any time
- Talk through the consent form and get signed, or audio-recorded, informed consent
- Ask if there are any remaining questions before the interview starts

The overall purpose of the interview is to understand:
- What the person’s experience of working in or running community based groups, services or organisations has been
- Whether they feel sexual identity has impacted on planning or delivering the group/service
- What has made experiences positive or negative in relation to people’s sexual identity or in relation to their own experiences
- What things might make future experiences more inclusive for people

Question asked	Possible further prompts
Tell me about yourself	Protected characteristic data: Describe your sexual identity Describe your gender Age bracket - 20-40, 41-60, 61 or over Type of residential area - Urban (Large city, small city, large town, small town) or Rural (Small town, village, no other homes within 1 mile) Describe your ethnicity Type of service category - Hobby, activity or interest group, Social group, Peer support group, formal social care service provision, charity/advisory service, religious group, characteristic based group, homecare agency or service, other
Tell me about the group or service you have worked in	What type of service/group do you work in?
	How is it structured/managed?
	How would you describe the ethos of the service?
How do people access the group?	Do people have a social care assessment before accessing any groups or services?
	How do people find out about the group?
Why do you think older gay, lesbian or bisexual people use your service or group?	Do you know if people also access generic services?
	If so, have you spoken with them about their experiences of using your service and other generic services?
What differences are there between your LGBT+ specific group and other similar generic groups?	Do you collect data on people’s sexual identity?

	How is this information shared and used?
	Do you think this has had any impact on service delivery or people's experiences?
Have you seen or heard about any good practice in generic services that make them inclusive?	Can you give examples of any good or poor practice you have seen or heard about in relation to people who identify as LGB
Do you have any ideas about what can be done by these generic groups to be more inclusive?	
What are the barriers or challenges to being an inclusive service for LGB people?	

Appendix 12 - Focus Group Slides

Focus Group

Welcome!

Identity & community

"Some people don't want to discuss that but at least I think you need to give people the opportunity"
(Cara, 60s, lesbian woman, service provider).

"I thought…they were extremely good in the way that they…made no assumptions about who I was and… they asked all the right questions and once they've realised that you are a member of the LGBT community then they, you know, discuss it in the way you would… they would understand"
(Fifi, 60s gay man)

Do you think that services should collect this information?

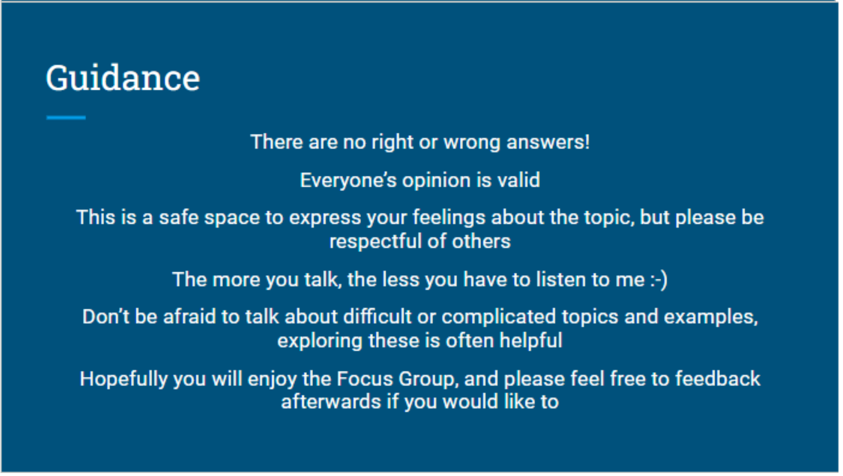
Why do you think it might be important or helpful?

What challenges does that present for your service?

What might help make that easier or more routine?

Identity & community

How important or relevant do you think people's sexual identity is to caring for them?



Guidance

There are no right or wrong answers!

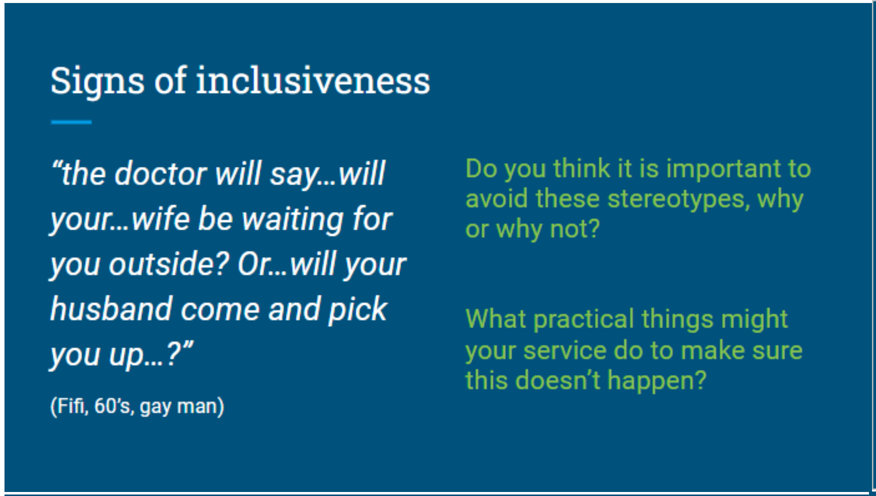
Everyone's opinion is valid

This is a safe space to express your feelings about the topic, but please be respectful of others

The more you talk, the less you have to listen to me :-)

Don't be afraid to talk about difficult or complicated topics and examples, exploring these is often helpful

Hopefully you will enjoy the Focus Group, and please feel free to feedback afterwards if you would like to



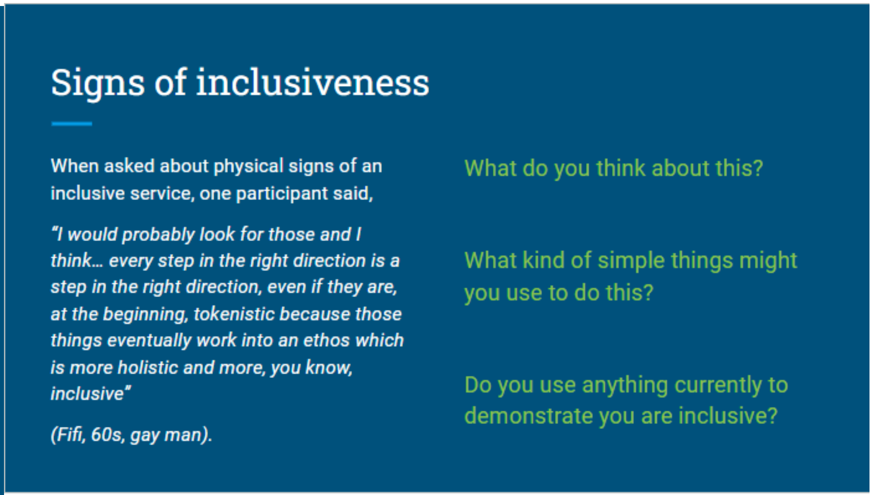
Signs of inclusiveness

"the doctor will say…will your…wife be waiting for you outside? Or…will your husband come and pick you up…?"

(Fifi, 60's, gay man)

Do you think it is important to avoid these stereotypes, why or why not?

What practical things might your service do to make sure this doesn't happen?



Signs of inclusiveness

When asked about physical signs of an inclusive service, one participant said,

"I would probably look for those and I think… every step in the right direction is a step in the right direction, even if they are, at the beginning, tokenistic because those things eventually work into an ethos which is more holistic and more, you know, inclusive"

(Fifi, 60s, gay man).

What do you think about this?

What kind of simple things might you use to do this?

Do you use anything currently to demonstrate you are inclusive?

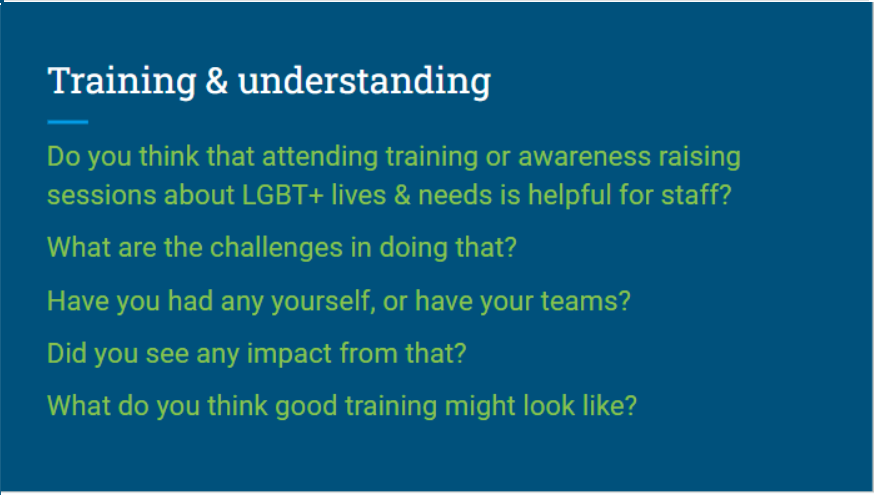
Identity & community

"Well there's a big difference because people just get you straight away…we have a lot of the same experiences and I feel that there's probably a lot of differences between other people and they wouldn't understand me" (Woodie, 60s, gay man).

"I think for me it's about just not having to explain anything isn't it? You don't have to explain yourself, you don't have to; people, people kind of get your experience" (Cynthia, 50s, lesbian woman).

Do you think services have a role in connecting people to their LGBT+ community?

How might you do that?



Training & understanding

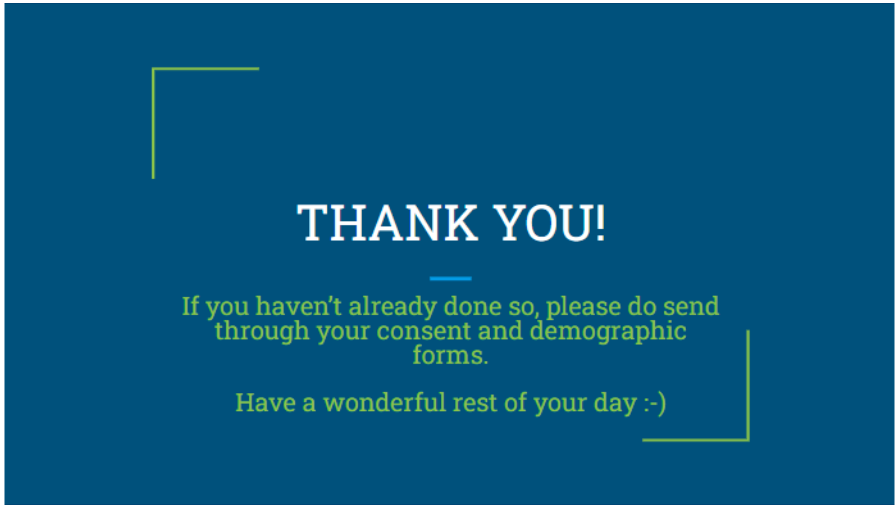
Do you think that attending training or awareness raising sessions about LGBT+ lives & needs is helpful for staff?

What are the challenges in doing that?

Have you had any yourself, or have your teams?

Did you see any impact from that?

What do you think good training might look like?



THANK YOU!

If you haven't already done so, please do send through your consent and demographic forms.

Have a wonderful rest of your day :-)

Sharing LGBT+ history

Staff discussion groups on topics

Plays or drama acts

Training focused on staff behaviour and attitudes rather than how LGBT+ people might be different

Training that assumes absolutely no knowledge and understanding

Presentations from speakers with lived experiences

Including LGBT+ topics within wider inclusivity training

Involving staff in updating or developing policies

Literature accessible to staff in staff rooms

Interactive and challenging training sessions

Training is mandatory for all staff

Appendix 13 - Response re inclusion of transgender people in study

Text/email response sent following some queries re inclusion of transgender people because of the use of the 'LGB' acronym on promotional recruitment material:

The research is focussed on the impact of sexual identity rather than gender identity. This is for several reasons, but mainly because we feel it is important to consider that transgender/non-binary people may have very specific experiences related to their gender identity which warrant separate research, rather than being arbitrarily grouped in with those who identify as lesbian, gay and bisexual. This conflation often happens and can mean that the importance of gender identity gets lost amongst the consideration/study of sexual identity and these are obviously different things.

Of course, transgender and non-binary people are able to put themselves forward for taking part in the research if they identify as lesbian, gay or bisexual.

The questions being asked during the interview focus on experiences related to sexual identity rather than gender identity and I would not want anyone to feel disappointed if they didn't get the opportunity to talk about the impact of their gender identity on their experiences, therefore I want to ensure I am managing expectations.

I am extremely pleased to say that there is an increasing amount of research being undertaken that focuses on transgender and non-binary communities specifically, giving them the opportunity to really speak about their experiences without being grouped with others who may have very different experiences. I am also aware that the lesbian, gay and bisexual community can demonstrate discrimination towards those who are transgender/non-binary and it would be vital for this to be captured as part of any research being done. However, this would fall outside the remit of my research topic and so I would not be able to give it the focus and time it so obviously deserves. I do not think for a moment that trans/nb people should not be part of the LGBT+ community, but my research is focussed on the impact of sexual identity and I have to try and remain true to the ethical approval I have for the focus of my research.

I hope this helps in explaining why the research participant call at this stage focuses on the impact of sexual identity. Please come back to me if you would like to ask any further questions or have any further conversation about this. I am always keen that I build understanding and consideration of all members of the LGBTQ+ community for my own learning.

Appendix 14 - Coding framework for analysis

Inclusion Guide

Nodes

Name	Description	Files	References
Actions and markers		0	0
Actions by services	Physical and other actions	16	201
Markers of inclusion	Markers used to denote inclusion	13	47
Drivers	Why services would make changes	8	16
Gaps	Gaps in provision	6	8
Neg Barriers to inclusion		8	16
Neg Homophobia		13	48
Neg Not meeting LGBT needs		6	12
Pos Recognition of relationships		9	21
Pos Representation		7	14
Intergenerational		11	19

Importance of relationships		3	4
Intergenerational differences		5	7
Ageing		11	33
Ageing without children		4	20
Resilience		1	1
Sexuality and ageing		3	4
Decisions		6	10
Advice seeking	Access to information	5	11
Choosing 'out' staff		6	10
Historic context on decisions		5	10
Stereotyping		5	14
Intersectionality		8	26
Gender		6	10
Importance of other identities		0	0
Religion		11	23

Knowledge and Activism	Insider knowledge helping to secure fair treatment, activism to force change, feathering nest through activism	11	43
Legislation and rights		3	5
Need to educate others		6	17
LGBT+ identity & community		12	54
Discrimination within LGBT+ community		5	8
Peer support		4	6
Families of choice & networks		7	8
Importance of links to LGBT+		4	8
Local community		11	27
Importance of links	To community, to others	4	11
Practical exclusions	Reasons why can’t access	1	3
Services		9	21
Data collection	Done/not done, value?	6	9
Heteronormativity	Specific examples	5	9
No gays here	Invisibility	3	4

LGBT+ specific services	Benefits, downsides	12	59
Staff training	Importance, impact, methods	11	36
Technology		8	13
Digital exclusion		5	8

Appendix 15 - Mapping of themes