**SSA EQUALITY IMPACT AND NEEDS ANALYSIS**

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| **Directorate** | ASC & Public Health |
| **Service Area** | Public Health  |
| **Service/policy/function being assessed** | Dementia Health and Care Strategy  |
| **Which borough (s) does the service/policy apply to** | Richmond |
| **Staff involved in developing this EINA** | Dr Nike Arowobusoye, Tammy Macey |
| **Date approved by Directorate Equality Group (if applicable)** | N/A: updated from previous EINA DEG |
| **Date approved by Policy and Review Manager**All EINAs must be signed off by the Policy and Review Manager | New draft reviewed by Jaimie Fisher, October 2022 |
| **Date submitted to Directors’ Board** |  |

1. **Summary**

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| **Please summarise the key findings of the EINA.** The key findings of the EINA are that * There is not much change in the available date and most of the findings remain.
* The census showed that there has also been an 55% increase in people aged 70–74-year-old and 90-year-olds was up by 10%.
* We should ensure that mainstream services can accommodate people with dementia from protected characteristic groups and also develop a plan to develop more targeted approach to support protected groups have their specific needs addressed for example, LGBTQi populations.

**Background:** A new 10 year dementia strategy has been developed following completion of the joint dementia strategy refresh 210-2021. In 2019, a comprehensive data driven Dementia Health Needs Assessment was carried out looking at dementia related health needs, with a focus on prevention and social care. Opportunities to improve were identified across three thematic areas:* dementia awareness
* access to equitably distributed dementia-related services
* quality of local dementia-related services

A review of the Joint Dementia Strategy was carried out in 2019. To examine the potential impact of the dementia refresh, the service reviewed the original EINA and carried out a light touch Equality Impact Needs Assessment (EINA), which re-considered the protected groups in the London Borough of Richmond. The main findings of the EINA indicate that the changes will be of most benefit to the ageing population that will be positively affected by the refresh. The EINA recommends a targeted approach that builds on existing best practice to maximise opportunities for all protected groups. Any potential negative impacts may result in disengagement with services. To mitigate this risk, the service will instil a culture of feedback, stakeholder engagement and adaptation throughout the process.**Briefly describe the service/policy or function:**The 2022 strategy builds on the successful implementation of the 2016-2021 joint dementia strategy developed between the London Borough of Richmond upon Thames Council and Richmond CCG that described 5 key strategic objectives to improve dementia prevention and care in the borough (preventing well, diagnosing well, living well, supporting well, dying well) with an aim to improve dementia services to ensure the best service delivery for residents across the borough. The Dementia Prevention and Care Pathway Framework for the strategy refresh was agreed by the Public Health DMT and Adult Social Care and Public Health SMT in September 2019. The refresh sets out how the council delivers the 2016 five-year Joint Dementia Strategy, with refreshed actions and activity using a dementia priority phases pathway and action plan framework and set out a refresh for 2019-2021.Enacting a comprehensive dementia prevention, and care support offer for residents affected by and living with dementia remains a key focus for the council. The Public Health dementia prevention and awareness offer has been strengthened, and comprises dementia awareness and training, expert public health approach support across the SSA and support to the Richmond DPLG groups and undertaking appropriate evaluation. Other gaps identified in the Richmond Health Needs Assessments in 2019 were being addressed as part of this refresh, with planned initiatives to be overseen by the Richmond Dementia Pathway Leadership Group which will inform the development and publication of the next 10 -year plan.A dementia awareness and training programme is in place and a Dementia Awareness Survey measure was carried out in 2021. The findings will inform the strategic approach to dementia raising awareness in health and social care staff, with an emphasis on improving understanding in areas where knowledge was found to be lower for example, responders did not identify ethnicity as a risk factor for dementia and so ensuring the awareness training highlights this as a risk factor. The learnings will also be incorporated into the Richmond Health & Care Dementia Strategy.This Equality Impact and Needs Assessment (EINA) will identify the potential effects of the strategy refresh on different population groups and ensure that mitigating measures are put in place to minimise them. |

1. **Evidence gathering and engagement**

**a. What evidence has been used for this assessment? For example, national data, local data via DataRich or DataWand**

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| **Evidence** | **Source** |
| Local data | 1. Richmond Dementia Health Needs Assessment, 2019 -

<https://www.datarich.info/wp-content/uploads/2019/07/LBRuuT_Dementia_Health_Needs_Assessment_2019.pdf>1. Richmond Carers Needs Assessment, 2019
2. Richmond Joint Dementia Strategy 2016-2021
3. Summary of 2016 Dementia Strategy Review Findings, 2019
4. Framework for Dementia Priority Phases
5. Summary of Richmond resident engagement sessions related to dementia care and support (Summer 2019)
6. Data Rich - <https://www.datarich.info/>
7. Joint Strategic Needs Assessment (JSNA) 2021 <https://www.richmond.gov.uk/media/22818/richmond_jsna_age_well.pdf#page=51>
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| National data | 1. Census 2021 Data

Please note, the 2021 census data has only released Rounded population and household estimates for England and Wales to date. All other releases are due from November 2022 and early 2023. |

**b. Who have you engaged and consulted with as part of your assessment?**

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| **Individuals/Groups** | **Consultation/Engagement results**  | **Date** | **What changed as a result of the consultation** |
| Extensive work has been done prior to the strategy refresh (consultation on the existing strategy in 2016) | Comments informed development of the refreshed strategy and EINA | 2016 | Comments informed development of the EINA |
| Engagement sessions with people living with dementia and their carers  | Carried out in Summer 2019 and learning fed back into dementia refresh 2020-2022 | 2019/2020 | Learning fed back into dementia refresh 2020-2022 and action planning. More support provided to carers. |
| Additional EINA carried out before DFR mobilised | Recommendation was to encourage membership from groups that represent residents with certain protected characteristics | 2020 | DFR coordinator continually reviews membership to reach out to organisations that represent these communities and supported them to identify actions that address their experiences |
| DFR service provision includes KPI on engagement  | Engagement with people living with dementia and unpaid carers fed back into ongoing action planning | 2020-2022 | Learning fed back into any new dementia action plans  |
| SSA Directorate Equalities Meeting | Identified that actions need to include what are the data gaps, what is the targeted approach.Discussed the strong link with people with dementia and religion.  | Feb 2020 | Focus on this through the DFR, and the DFR coordinator continually reviews membership to reach out to organisations that represent these communities and supported them to identify actions that address their experiences |
| DPLG members | Consultation on EINA development for refresh and ongoing EINA review of actions | 2020-2022 | All partners agreed to sign up to a DPLG position statement to help support EINA outcomes, resulting in improvements in data collection in the Dementia Friendly Richmond (DFR) contract in relation to protected characteristics. Head of Community Services in Adult Social Care has also been addressing how data collection would need to change to reflect service users living with a formal diagnosis of dementia. Going forward, the Adult Social Care Commissioner in DPLG attendance will be ensuring the number of people with dementia from a protected characteristic within the Community Independent Living Service (CILS) contract will now be collected and provided. Alzheimer’s Society continue to provide a service to young onset dementia Richmond population in 2021/22, with a focus on pathway access for this group.LGBTQi included in new draft strategy 2022-31. |
| Dementia Prevention and Care Showcase Event  | to reflect on the programme of work undertaken throughout 2020-2022 in Richmond. This provided an opportunity for new learning, sharing good practice, networking, and future planning, including a discussion focus: Co-production dementia hub | Feb 2022 | Learning fed back into developing new strategy  |
| Co-production - Presented to Care and Support Partnership | Discussion focus: vision, principles, approaches and action planning and what they think still needs doing  | July 2022 | Learning fed back into developing new strategy |
| Co-production - Mental Health and Older People Group  | Co-production early discussions and development with presentation | July 2022 | Learning fed back into developing new strategy |
| Co-production Meeting (Fiona Wright, and Bruno Meekings, Chair  | Discussion focus: Dementia hub and vision, principles, approaches | Sept 2022 | Learning fed back into developing new strategy |
| Co-production – Positive Care Conference | Discussion focus: 5 priority phases, proposed aims and objectives, views on delivery from all partners. |  September 2022 | Learning fed back into developing new strategy |
| Co-production - Richmond DPLG - Strategy development | Discussion focus: 5 priority phases, proposed aims and objectives, views on delivery from all partners. | Feb, May, July, September 2022 | Learning fed back into developing new strategy |
| Co-production - Richmond Community Health Champions | Discussion focus: Co-production and comment on patient pathways or Hub TBC/ development (with presentation) | September 2022 | Learning fed back into developing new strategy |
| Co-production - Public Health DMT  | First draft for comment  | September 2022 | Learning fed back into developing new strategy |

1. **Analysis of need**

**Potential impact on this group of residents and actions taken to mitigate impact and advance equality, diversity and inclusion**

The latest and most up to date data and information used to carry out this EINA was found in the following sources:

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| **Protected group** | **Findings** |
| **Age** | Findings from the Richmond HNA indicates that age remains the single biggest and non-modifiable risk factor for dementia with a person’s risk doubling approximately every 5 years above the age of 65. In Richmond there are currently estimated to be 30,631 residents ≥65, accounting for 15.4% of the total borough population. It is estimated that by 2035 this this number is to increase by 73%.The findings of the HNA show that prevalence is growing, with a higher proportion of Richmond’s population are living with a diagnosis of dementia than the average for London, (0.6%) than average in the rest of London (0.5%). This is, in part, due to the high proportion of people aged ≥65yrs in the borough (15.4%). Approximately 7.2% of this older cohort in Richmond are currently living with dementia. It is anticipated that there will be a 74% increase in the number of people aged ≥65yrs living in Richmond between 2018 and 2035.The CPEC working paper 5 suggests that projected dementia prevalence rate in the over 65s in Richmond will almost double from 6.9% in 2019 to 12% 2030[[1]](#footnote-2)The latest Census 2021 shows there has been an increase of 24.9% in people aged 65 years and over, a decrease of 0.2% in people aged 15 to 64 years, and an increase of 6.1% in children aged under 15 years[[2]](#footnote-3). There has also been an 55% increase in people aged 70–74-year-old and 90-year-olds was up by 10%. The overall population in Richmond upon Thames has increased by 4.4%, from around 187,000 in 2011 to 195,200 in 2021.Young-onset dementia continues to demand particular attention, as services designed for those with older onset dementia are often unsuitable for people with young-onset dementia. |
| **Disability** | Learning disabilities, particularly Downs Syndrome significantly increase the risk of developing dementia but also earlier onset dementia. In 2018/19 there were 561 people, known to their GP, affected by a learning disability in Richmond. When people with Down's Syndrome develop dementia, this is usually due to Alzheimer's disease. However, there is a growing awareness that people with Down's Syndrome can develop other forms of dementia.In 2017/18, there were 10 people with learning disabilities living with dementia and accessing ASC services in Richmond. We currently do not have robust data on the actual number of dementia patients in Richmond with a disability.  It is difficult to be exact with the number of people with a learning disability both nationally and locally because there are a range of complex factors that underlie the predictions in numbers of people. |
| **Sex** | The HNA indicates that Alzheimer’s disease is more common in women than men even after accounting for the greater life expectancy in women. This is not seen for other dementia types (e.g., vascular, LBD or FTD). This is reflected in Richmond where 63% (1,416) of dementia patients ≥65 are women, even though women make up 56% (17,000) of the total ≥65 population.Women are far more likely to end up as carers of those with dementia than men. Women are also more likely to reduce their hours or stop working to care for someone with dementia, and some feel penalised at work for taking on care responsibilities.Men are at higher risk of early-onset dementia. The underlying cause for these differences is uncertain. |
| **Gender reassignment** | Estimates of the prevalence and incidence of gender dysphoria and Transsexualism are difficult to quantify due to the lack of robust national data.It is accepted that gender dysphoria, if not treated, can severely affect a person’s quality of life and health status. High levels of depression are reported within Trans communities, therefore indicate that this population group may require greater access to support. The Alzheimer’s Society consider that as dementia progresses a person may not recall their current gender and they may see themselves being pre-transition and be surprised at the physical changes to their bodies. It is therefore important the specific needs of transgender dementia patients are met to ensure they are cared for appropriately.The Alzheimer’s Society provide advice on dealing with the impact of dementia on disclosure. Patients may have to make decisions on a day-to-day basis about whether to disclose their sexual orientation or gender identity – whether to be ‘out’. As dementia progresses, patients may lose their ability to make this decision. They may also be unable to stop themselves disclosing their orientation or gender identity by mistake.  |
| **Marriage and civil partnership** | **Census 2011 Marriage and Civil Partnerships in Richmond upon Thames** Census date (2011) indicates that 48 % of population is married.

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| Status  | % of Population  |
| Single | **37%** |
| Married | **48%** |
| Divorced | **8%** |
| Separated | **2%** |
| Widowed | **5%** |

2011 Census data relating to Civil Partnerships shows that 665 people (0.35% of the population in the borough) responded as being in a registered same sex civil partnership.it is important that health and social care services are aware of and respectful of the legal equivalence of marriage and civil partnership when dealing with individuals with dementia, their partners and families. Many carers of people with dementia are partners/spouses and their health and care needs will also need to be taken into consideration across the dementia pathway.Data has not yet been released for 2021 census  |
| **Pregnancy and maternity** | Not applicable**.** |
| **Race/ethnicity** | The HNA and JSNA indicates that Black African- Caribbean and South Asian UK ethnic groups have higher rates of dementia than other ethnicities. The increased rate is thought to be due to the higher prevalence of high blood pressure, diabetes, and strokes within these ethnic groups.

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|  | Residents with Dementia diagnosis | Borough population |
|  | Number | Proportion |
| White | 89 | 62% | 86% |
| Asian/Asian British | 39 | 27% | 7.3% |
| Other Ethnic Minority | 16 | 11% | 6.7% |

This suggests a highly disproportionate representation of people from ethnic minorities amongst those with a diagnosis of dementia in Richmond. However, 90% of people with a diagnosis of dementia in the borough do not have their ethnicity recorded. Consequently, whilst these figures may rationalise further investigation, they should be interpreted with extreme caution. There are increasing indications that the prevalence of dementia and depression in Black African- Caribbean and South Asian UK populations are greater than the White UK population. Although not related to Richmond specifically, research has indicated that there is parity of access to memory clinics between Caucasian and Black, Asian and Minority Ethnic groups in London overall. Research has found that within 13,166 referrals to memory services across London, the percentage of people from Black, Asian and Minority Ethnic groups was higher than would be expected indicating that generally people from Black, Asian and Minority Ethnic groups are accessing memory services. Seventy-nine percent of memory services had more referrals than expected or no significant difference for all Black, Asian and Minority Ethnic groups. When there were fewer referrals then expected, the largest difference in percentage for an individual ethnic group was 3.3%. |
| **Religion and belief, including non-belief** | In Richmond as a whole, 55.3% identify as Christian, 28.4% as no religion, 3.3% Muslim, 1.6% Hindu, 0.8% Jewish, 0.8% Sikh, and 0.4% other religions. The final 8.2% did not state their religion.There is no data on religion of dementia patients.Data has not yet been released for 2021 census. |
| **Sexual orientation** | The 2011 census did not have a specific question regarding sexual orientation but found that 665 people (0.35% of the Borough population) reported being in a same sex Civil Partnership. The 2019 HNA highlighted that the collection of data on sexual orientation and gender amongst Adult Social Care users is not sufficient to understand how needs related to sexual orientation and gender are distributed in the borough in relation to dementia.More work has been done and recent qualitative work findings are LGBTQ+ individuals may not reach out for services and support because they fear poor treatment due to their LGBTQ identity, because they fear the stigma of being diagnosed with dementia, or both. While dementia disproportionately affects people over the age of 65, younger people may also develop dementia- young onset dementia, and face particular challenges related to their age, as well as their LGBTQ+ status.Data has not yet been released for 2021 census. |
| **Across groups i.e., older LGBTQi service users or Black, Asian & Minority Ethnic young men.** | As the dementia strategy focuses on older people, there will be cross cutting across older people/protected groups as identified above. Alzheimer’s Society EDI task force locally and LGBTQi work is part of a wider stream. Underserved communities affected by dementia are diagnosed later, use services less etc which leads to worse outcomes for families; LGBTQi families are less likely to have children, may be alienated from blood relatives, more likely to distrust medical authorities due to previous trauma/ conversion attempts |

**Data gaps**

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| **Data gap(s)** | **How will this be addressed?** |
| There is comprehensive data in the strategy for older people, however, several data sets that are unclear/ missing from current data provision. These sets include statistics on gender reassignment, sexual orientation and marital status | A focus of the DFR Coordinator is on ensuring that organisations who represent and/or support residents with protected characteristics are members. This is reflected in the contract KPIs.The new dementia strategy ensures that there will be enough care resources to meet current and anticipated service demand in the borough, with an improved understanding of how different groups access services, to ensure provision is equitable. |
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1. **Impact**

The new dementia strategy will support a renewed partnership way of working, working towards a renewed Public Health offer, a focus on carers, and facilitating seamless pathways across the NHS, community and social care with a better experience for people living with dementia and their carers and outcomes along all of the dementia and care pathway.

Adult Social Services is undertaking a ‘dementia in care homes programme’, and these actions to improve dementia services and access will be considered as part of the transformation.

As with everything we do, inequalities could widen, due to the inverse care law, we may not get the clinical and voluntary organisation engagement needed so to mitigate this risk the DPLG and multiagency partners oversee the strategy development and implementation and will have will monitor and evaluate our actions through the DPLG.

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| **Protected group** | **Positive** | **Negative** |
| **Age** | The delivery plan recognises young onset dementia as well as dementia associated with age.Ensure equitable access to preventative services for communities at higher risk of dementia. The positive impact of the reactivation of the alliance will be through increased engagement with people living with dementia and unpaid carers. | No negative impact is anticipated |
| **Disability** | The delivery plan recognises that dementia tends not to be an isolated condition, but part of a range of co-morbidities. There is the opportunity to align the dementia plan to emerging work on learning disabilities. Which has a commitment to the provision of an appropriate service response to support people with early onset dementia.Ensure equitable access to preventative services for communities at higher risk of dementia.The positive impact of the reactivation of the alliance will be through increased engagement with people living with dementia and unpaid carers. | Clarity is needed about what information local learning disability services hold on those with dementia |
| **Sex** | Ensure equitable access to preventative services for communities at higher risk of dementia such as women higher risk than menThe positive impact of the reactivation of the alliance will be through increased engagement with people living with dementia and unpaid carers. | No negative impact is anticipated |
| **Gender reassignment** | The positive impact of the reactivation of the alliance will be through increased engagement with people living with dementia and unpaid carers. | As no specific data is recorded under the census data, specific analysis of the impact of a strategy refresh on gender reassignment is not possible.Further necessary measures need to be clear to prevent marginalisation. There is also a need to consider how members of the LGBTQI community transition into care and what the impact could be in terms of disclosure. |
| **Marriage and civil partnership** | Improved monitoring of service use by key population characteristics such as marriage and civil partnership.Improve accessibility of local carer support services.There is positive impact of the reactivation of the DFR through increased engagement with people living with dementia and unpaid carers. | No negative impact is anticipated |
| **Pregnancy and maternity** | No inequitable impacts upon pregnancy and maternity have been identified due the age cohort of service users and carers are above 65 and therefore this cohort will not be negatively impacted on any strategy refresh | No negative impact is anticipated |
| **Race/ethnicity** | Improved monitoring of service use by key population characteristics such as race and ethnicity.Increase awareness of dementia risk factors in the community and in the health and care system. Ensure equitable access to preventative services for communities at higher risk of dementia. The positive impact of the reactivation of the alliance will be through increased engagement with people living with dementia and unpaid carers. | No negative impact is anticipated |
| **Religion and belief, including non-belief** | Improved monitoring of service use by key population characteristics such as religion and belief, including non-belief.The positive impact of the reactivation of the alliance will be through increased engagement with people living with dementia and unpaid carers | No negative impact is anticipated |
| **Sexual orientation** | Improved monitoring of service use by key population characteristics such as sexual orientation.The positive impact of the reactivation of the alliance will be through increased engagement with people living with dementia and unpaid carers. | As no specific data is recorded under the census data, specific analysis of the impact of a strategy refresh on LGBTQi people is not possible. |

1. **Actions to advance equality, diversity and inclusion**

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| **Action** | **Lead Officer** | **Deadline** |
| For the Dementia Prevention and Care Pathway Leadership Group (DPLG) to continue to ensure that the action plans of the three subgroups address the five priority phases of the dementia prevention and care pathway, ensuring equitable and measurable outcomes.  | Nike Arowobusoye | OngoingMarch 2023 for new action planning  |
| For the Equality Impact Needs Assessment for the Dementia Friendly Richmond (DFR) to continue to ensure that the needs of people living with dementia and their carers from protected characteristic groups are considered and included in decisions and actions.  | Steve Shaffelburg  | Ongoing  |
| To ensure that mainstream services can accommodate people with dementia from protected characteristic groups and also develop a plan to develop more targeted approach to support protected groups have their specific needs addressed for example, Black, Asian and Minority Ethnic communities, and those with a disability. | Adult Social Care Dementia Commissioners  | March 2023 |
| Improve data collection in contracts (DFR, training). | Dementia Commissioners  | Ongoing |
| To improve staff awareness of transgender issues especially in relation to dementia. | Dementia Commissioners | March 2023 |
| Providing appropriately categorised forms for individuals to fill out e.g. gender options including an alternative to female/male binary. | Dementia Commissioners | March 2023 |
| For local learning disability services to share what information they hold on those with dementia through contract monitoring of service provision and ensure appropriate culture and protected characteristic engagements, surveys/information gathering are considered to inform service provision.  | Adult Social Care Commissioners  | March 2023 |

1. **Further Consultation (optional section – complete as appropriate)**

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| **Consultation planned**  | **Date of consultation**  |
| Co-production: Due to present to Richmond Carers Strategy Reference Group and SMT in November 2022 | 2022 |
| Public Consultation taking place from 9th November to 21st December 2022  | 2022 |

1. Wittenberg R, Hu B, Jagger C, et al. (2019a) Projections of care for older people with dementia in England: 2015 to 2040, Age and Ageing, https://www.lse.ac.uk/cpec/assets/documents/cpec-working-paper-5.pdf [↑](#footnote-ref-2)
2. https://www.ons.gov.uk/visualisations/censuspopulationchange/E09000027/ [↑](#footnote-ref-3)