SSA EQUALITY IMPACT AND NEEDS ANALYSIS

Directorate	Adult Social Care and Public Health
Service Area	Public Health
Service/policy/function being assessed	Dementia Prevention Care and Support Strategy Refresh
Which borough (s) does the service/policy apply to	Richmond
Staff involved	• Tammy Macey, Senior Public Health Lead • Steve Shaffleburg, Commissioning Manager, Adult Social Care and Public Health • Dr Nike Arowobusoye, Consultant in Public Health • Richmond Dementia Prevention and Care Leadership Group members
Date approved by Directorate Equality Group (if applicable)	To be submitted for 29 October 2020
Date approved by Policy and Review Manager	26 August 2020
Date submitted to Directors' Board	

SUMMARY

Summary of the key findings of the EINA

A joint dementia strategy is already in place for 2016-2021 with a completed EINA in 2016.

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 also carried out in 2019. As a result, a Dementia Care and Prevention Pathway Framework for the strategy refresh was agreed by the Public Health DMT and Adult Social Care and Public Health SMT in September 2019. In addition, there will be a re-energising of the DAA (Dementia

Action Alliance) to continue being a 'Dementia Friendly' community, of which we will do a separate EINA within the fullness of time. Engagement sessions with people living with dementia and their carers were carried out in Summer 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. This EINA is to be analysed alongside the Dementia committee paper. 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.

Background

Briefly describe the service/policy or function:

A joint dementia strategy was developed between the London Borough of Richmond upon Thames Council and Richmond CCG in 2016, describing 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.

Building on the 5 key strategic objectives in the dementia strategy, and the areas of need identified, the Public Health Division reviewed the strategy and working with other stakeholders produced a Dementia Prevention and Care Pathway Framework with 5 dementia priority phases.

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.

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 is being 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 are being addressed as part of this refresh, with planned initiatives to be overseen by the Richmond Dementia Pathway Leadership Group (a task and finish group) which will inform the

development and publication of the next 5 -year plan.

A key action of the preventing dementia group is to build on the initial success of the Richmond Dementia Action Alliance and learn from challenges the Alliance faced in terms of sustainability and resourcing. The Council has decided to reactivate the RDAA under the name Dementia Friendly Richmond in order to provide consistency with the Mayor of London's Dementia Friendly London initiative run by the Alzheimer Society.

Work is underway to create an accessible directory of dementia services in Richmond; this work is being led by the community nurses working with the council and NHS.

Local providers of support services for unpaid carers are reporting that residents who are looking after people with dementia are experiencing more stress than usual during the pandemic. In part, this is because many of the day services are closed and thus unpaid carers are needing to spend more time looking after their loved ones. Developing communities that are dementia friendly will help strengthen the resiliency of unpaid carers

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. Analysis of need and impact

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

1. Richmond Dementia Health Needs Assessment, 2019 - https://www.datarich.info/wp-content/uploads/2019/07/LBRuuT_Dementia_Health_Needs_Assessment_2019.pdf
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) data (draft 2020)
8. Richmond Carers Needs Assessment, 2019

Findings:

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. Young-onset dementia demands 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.
Gender (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 associated 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.

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<tr><td></td><td></td></tr>
<tr><td>Gender reassignment</td><td>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.</td></tr>
<tr><td>Marriage and civil partnership</td><td>The 2011 census did not have a specific question regarding sexual orientation. 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.</td></tr>
<tr><td>Pregnancy and maternity</td><td>Not applicable.</td></tr>
<tr><td>Race/ethnicity</td><td>The HNA indicates that South Asian, African or Afro-Caribbean ethnic groups have higher rates of dementia than other ethnicities. This increased rate is thought to be due to the higher prevalence of high blood pressure, diabetes and strokes within these ethnic groups. This is particularly relevant in Richmond given that although only 6% of the ≥65 population identify as Black, Asian and Mixed Ethnicity (BAME).

<table>
<tr><td></td><td colspan="2">Residents with Dementia diagnosis</td><td>Borough population</td></tr>
<tr><td></td><td>Number</td><td>Proportion</td><td></td></tr>
<tr><td>White</td><td>89</td><td>62%</td><td>86%</td></tr>
<tr><td>Asian/Asian British</td><td>39</td><td>27%</td><td>7.3%</td></tr>
<tr><td>Other Ethnic Minority</td><td>16</td><td>11%</td><td>6.7%</td></tr>
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	. 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 rationalize 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 BME communities in London overall. Research has found that within 13,166 referrals to memory services across London, the percentage of people from BAME groups was higher than would be expected indicating that generally people from BAME groups are accessing memory services. Seventy-nine percent of memory services had more referrals than expected or no significant difference for all BAME 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.
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 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.
Across groups i.e. older LGBT service users or BME young men	As the dementia strategy focuses on older people, there will be cross cutting across older people/protected groups as identified above.

Data gaps.

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	Complete an EINA for the DAA Evaluate the PH offer through the Public Health Quality Assurance process addressing differential commissioning The Strategy refresh 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. We can develop equality KPIs in new contracts such as the Dementia Action Alliance (Dementia Friendly Richmond) to ensure the needs of these protected groups are met. Improved monitoring of service use by key population characteristics such as religion and belief, including non-belief.

2. Impact

The refresh of the 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 Transforming the Future 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 mitigation of risk the DPLG and multiagency partners are to oversee the strategy refresh.

We will monitor and evaluate our actions through the DPLG.

Protected	Positive	Negative

group		
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
Gender (sex)	Ensure equitable access to preventative services for communities at higher risk of dementia such as women higher risk than men	No negative impact is anticipated

	The positive impact of the reactivation of the alliance will be through increased engagement with people living with dementia and unpaid carers.	
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. 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
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.	No negative impact is anticipated

	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.	
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 LGBT people is not possible.

3. Actions

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 Derek Oliver	Ongoing
To carry out an Equality Impact Needs Assessment for the refreshed Dementia Action Alliance 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 Shaffleburg	March 2021
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. BAME, those with a disability.	Adult Social Care Dementia Commissioners	Ongoing
Improve data collection in contracts (DAA, training)	Dementia Commissioners	March 2021
To improve staff awareness of transgender issues especially in relation to dementia	Dementia Commissioners	March 2021
Providing appropriately categorised forms for individuals to fill out e.g. gender options including an alternative to female/male binary.	Dementia Commissioners	March 2021
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 taken into account to inform service provision	Adult Social Care Commissioners	March 2021

4. Consultation. (optional section– as appropriate)

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- A preliminary consultation on the strategy in 2016
- Engagement following HNA 2019
- DAA service provision to include engagement processes

Further consultation was not applicable in this instance as extensive work has been done prior to the strategy refresh. There are no significant changes proposed to a service or new policy/service/service specification.