



North

Yorkshire County Council

# Equality Impact Assessment Template

## Dementia Strategy

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যদি আপনি এই ডকুমেন্ট অন্য ভাষায় বা ফরমেটে চান, তাহলে দয়া করে আমাদেরকে বলুন।

如欲索取以另一語文印製或另一格式製作的資料，請與我們聯絡。

اگر آپ کو معلومات کسی دیگر زبان یا دیگر شکل میں درکار ہوں تو برائے مہربانی ہم سے پوچھئے۔



## Undertaking an Equality Impact Assessment

Equality Impact Assessments (EIA) should be undertaken at the business case stage when:-

- You are developing a new service or policy
- You are reviewing an existing service or policy
- You are proposing a change to an existing service or policy
- You are reviewing a service or policy carried out on behalf of the council or another organisation
- Your service is re-organised.

They should be referenced in your final recommendations on the service changes so that decision makers can reach an informed decision on the service/policy.

An EIA should cover all the social identity characteristics protected by equality legislation – referred to as ‘protected characteristics’ or equality strands. These are;

- Sex
- Sexual orientation
- Religion or belief
- Ethnicity
- Race – this include ethnic or national origins, colour and nationality
- Disability (including unpaid carers)
- Pregnancy and maternity
- Gender reassignment

There is a lot of information available to support you in completing this assessment on the EIA pages on the NYCC intranet

**Equality Impact Assessments are public documents. Full EIAs accompanying reports going to County Councillors for decisions are published with the committee papers on our website and available in hard copy for people attending the relevant meeting. To make it easier for people to find equality impact assessments the Council will also publish full equality impact assessments on the NYCC website.**

<b>Name of the Directorate and Service Area</b>	Health and Adult Services; North Yorkshire and York PCT; City of York Council		
<b>Name of the service/policy being assessed</b>	North Yorkshire & York Dementia Strategy 2011-2013		
<b>Is this the area being impact assessed a</b>	<b>Policy &amp; its implementation?</b>	X	<b>Service?</b>
	<b>Function</b>		<b>Initiative?</b>
	<b>Project?</b>		<b>Procedure &amp; its implementation?</b>
<b>Is this an Equality Impact Assessment for a</b>  (Note: the Equality Impact Assessment (EIA) is concerned with the policy itself, the procedures or guidelines which control its implementation and the impact on the users)	<b>Existing service or a policy and its implementation?</b>		
	<b>Proposed service or a policy and its implementation?</b>		X
	<b>Change to an existing service or a policy and its implementation?</b>		
	<b>Service or Policy carried out by an organisation on behalf of NYCC?</b>		
<b>How will you undertake the EIA?</b> Eg team meetings, working party, project team, individual Officer	Project coordinating group		
<b>Names and roles of people carrying out the Impact Assessment</b>	Judith Knapton, lead Commissioner PCT Jan Cleary, Strategic Commissioning Manager HAS [Norma Sutton, Commissioning & Change Officer ACS]		
<b>Lead Officer and contact details</b>	Seamus Breen, Assistant Director		
<b>Date EIA started</b>	13/10/10		
<b>Date EIA Completed</b>	30/11/11		
<b>Sign off by Assistant Director (or equivalent)</b>	 Seamus Breen		
<b>Date of Publication of EIA</b>			
<b>Monitoring and review process for EIA</b>			

# 1. Operating Context

Please consider issues around impacts (positive or negative) raised for **all protected characteristics** and show your evidence

## 1.1 Describe the service/policy

**What does the service/policy do and how? Who does it benefit? What are its intended outcomes? Who is affected by the policy? Who is intended to benefit from it and how? Who are the stakeholders?** How would you describe the policy to someone who knows very little about Council Services?

**How is the policy, plan or service linked to relevant legal frameworks (including equality legislation) and national and local performance targets?** Are there any other policies or services which might be linked to this one? Have you reviewed the EIA for these policies/services? What do they tell you about the potential impact?

**How will the policy be put into practice? Who is responsible for it?**

**The purpose** of the strategy is to: (address the 17 objectives within the national dementia strategy (NDS))

- Provide a strategic quality framework within which services can deliver quality improvements to dementia services and address health inequalities relating to dementia;
- Provide advice, guidance and support for health and social care commissioners, SHAs (*Strategic Health Authorities*), local authorities, acute trusts, mental health trusts, PCTs (*Primary Care Trusts*), independent providers and the third sector, and PBCs (*Practice Based Commissioners*), in the planning, development and monitoring of services,
- And provide a guide to the content of high quality health and social care services for dementia to inform the expectations of those affected by dementia and their families.

### **Desired outcomes / beneficiaries: 2. Aim**

The strategic aim is by working with service users and carers and other agencies NHS North Yorkshire and York, City of York Council and North Yorkshire County Council will develop services for people with dementia that:

- Are sensitive to each person's individual circumstances
- support people to live independent, productive, fulfilling and active lives for as long as possible
- encourages people and their carers to be actively involved in the decisions made about their care.
- Support people in negotiating along the care pathway as and when they choose as appropriate
- Provide information in a way that is understood and helps to support the person and their carers in the options available from diagnosis to end of life.
- Are in line with best practice and wherever possible good evidence based practice and are cost effective.
- Adhere to the principles of Dignity in Care and the Human Rights Act 1998.

The strategy is intended to secure better mental health for everyone who is suspected of having or has a diagnosis of dementia and lives within the boundaries of North Yorkshire and York and will also consider those primarily over the age of 65 who have a functional mental health problems (such as

	<p>depression, anxiety, psychosis).</p> <p>It should be noted however that everyone should be entitled to services irrespective of age and this strategy aims to ensure that the best and most effective mental health care is available to all the constituent population based upon need, in line with forthcoming legislation on age discrimination under the Equality Act 2010.</p> <p><b>Who is affected by the policy and stakeholders?</b>          People with dementia , or suspected dementia, carers, health and social care commissioners, SHAs (<i>Strategic Health Authorities</i>), local authorities, acute trusts, mental health trusts, PCTs (<i>Primary Care Trusts</i>), independent providers and the third sector, and CCGs (<i>Clinical Commissioning Groups</i>),</p> <p><b>How is the policy, plan or service linked to relevant legal frameworks (including equality legislation)</b> -see page 3 of strategy. Re equalities legislation, there is evidence that some groups have general poorer health access / outcomes than other sectors and this is likely to be the same with dementia</p> <p><b>How will the policy be put into practice? Who is responsible for it?</b> The joint health / LA commissioning bodies will monitor progress. There is a 3-5 year action plan with named lead bodies, which needs translating into named individuals. All Providers, GPs, are identified with areas to improve provider services, commissioners will amend service specs and contract and the Dementia network will receive reports on implementation and progress.</p>
<p><b>1.2 How do people use the policy/service?</b></p> <p>How is the policy/service delivered? How do people find out about the policy/service? Do they need specialist equipment or information in different formats? How do you meet customer needs through opening times/locations/facilities? Can customers contact your service in different ways? How do you demonstrate that your service/policy is</p>	<p>The strategy is aimed at commissioners and service providers and sets out to make all services work well for a person with dementia. The policy will be published on the websites of the three commissioning organisations and disseminated widely through the Dementia Network. The strategy sets out an action plan which will result in the wider network of service providers providing information in accessible formats and making services accessible to all, regardless of disability or ethnic/cultural background.</p> <p>Two main partners, NHS and Local Authorities have different charging policies, which can impact on the willingness of people to accept a service from Social Care.</p> <p>Adherence by services commissioned by NYCC to equality expectations are monitored by NYCC's</p>

welcoming to all groups within the community?

Does the policy/service support customers to access other services? Do you charge for your services? Do these changes affect everyone equally? Do some customers incur greater costs or get 'less for their money'? Are there eligibility criteria for the service/policy? Does the Council deliver this policy in partnership or through contracts with other organisations? How do you monitor that external bodies comply with the Council's equality requirements? How do you ensure that staff/volunteers delivering the service follow the Council's equality policies?

Quality Assessment Framework via regular reviews.

The 'dementia champions' staff training pilot currently running in NYCC contains a unit on equality, diversity and inclusion. It is planned that this model of training be rolled out to the wider sector.

## **2. Data (qualitative and quantitative) and monitoring**

Please consider issues around impacts (positive or negative) raised for **all protected characteristics** and show your evidence

### **2.1 Who is using the service?**

What data do we use now? Is it broken down across protected characteristics (and are these categories consistent across all data sets)? How current is the data? Where is it from? Is it relevant?

A demographic profile of dementia across the Yorkshire & Humber region commissioned by the Yorkshire & Humber Improvement Partnership showed that for NY&Y the levels of dementia are predicted as:

	<u>2008</u>	<u>Predicted for 2025</u>
Early onset dementia	175	200
Late onset dementia	8,264	13,876

The numbers predicted to have late onset dementia by sub-type within NY&Y

Alzheimer's	5,196
Vascular dementia	1,382

Vascular and Alzheimer's	855
Lewy bodies	333
Frontotemporal	111
Parkinsons dementia	139
Other	248

Source: Dementia UK & POPPI

There are 1344 adults with a learning disability known to care management and health services in North Yorkshire and over 550 in York.

Consistent with the national prevalence of the population with Down's syndrome and dementia, the large majority of people with Down's in Yorkshire & Humber region have early onset dementia with 64% aged between 55 and 64 years old and 32% being between 45 to 54 years. This is set to change by 2025 to 67% for 55 to 64 ages while the 45 to 54 years group will increase in absolute terms, the overall proportion will decrease by 2025 to 29%.

*(Dementia in Y&H: A demographic profile July 2009)*

National research would suggest major under-reporting due to people not seeking or being offered early diagnosis.

The Adult Social Care customer profile in North Yorkshire shows 4,737 people aged 18 to 64 receive a social care service and 10,096 people aged over 65. In addition to this NYCC Adult Social Care supported 4,163 carers with carer's specific services or information and advice throughout the year 1<sup>st</sup> April – 31<sup>st</sup> March 2011.

Within the 18-64 age group, there is a small number (23) of people with a primary client type of dementia. There are 1,551 people who have a learning disability and 1,654 with a physical disability (including 182 people with a sensory impairment and 273 who are frail or suffering a temporary illness); people with mental health problems or substance misuse issues make up the rest of the 18-64 group.

In the 65 and over age group, there are 587 people recorded as having a diagnosis of dementia. There are also substantial numbers of people with mental health problems (396). There are also a small number of people with learning disabilities accounting for 116 older people. This age group is made up primarily of people with physical disabilities or temporary illness (8,866).

Main Category	Primary Client Type	Adults	Older People			Total Older People	Grand Total
		18 - 64	65 - 74	75 - 84	85 and over		
Phys Dis	Phys Dis	1199	701	1352	1620	3673	4872
	Frailty/Temporary Illness	273	541	1646	2275	4462	4735
	Dual	18	4	11	53	68	86
	Hearing	69	31	77	152	260	329
	Visual	95	45	110	248	403	498
Phys Dis Total		1654	1322	3196	4348	8866	10520
Mental health	Mental health	1487	142	156	98	396	1883
	Dementia	23	75	240	272	587	610
Mental health Total		1510	217	396	370	983	2493
Learning Dis Total		1551	71	34	11	116	1667
Subs Misuse Total		12	4	1	1	6	18
Vulnerable Total		10	10	31	84	125	135
Grand Total		4737	1624	3658	4814	10096	14833

**Gender:** There are differences in the incidence of dementia according to gender with a higher proportion of men in the ages 65-74 years and a higher proportion of women aged over 75 having dementia, and there is likely to be under-reporting.

There may be more likelihood of under-reporting for males, as research indicates that they are generally less likely to access primary health care at an early stage (Equality and Human Rights Commission), and, for example, although prevalence rates for mental health issues are thought to be roughly the same for both genders, women are twice as likely to receive a diagnosis and treatment (MIND).

In terms of type of dementia, research from the Alzheimer's Society indicates that gender affects different types of dementia in different ways:

- Women are slightly more likely to develop Alzheimer's disease than men, even if we discount the fact that women are more likely to live longer. One factor that has been suggested in the development of Alzheimer's disease is a lack of the hormone oestrogen in women after the menopause.
- Vascular dementia, on the other hand, seems to be more common in men than women. This may be because common risk factors for vascular dementia, such as heart problems and high blood pressure, are more common in men than women.

People in receipt of personal social care may prefer to receive that care from people of the same gender for reasons of privacy and decency, and this should be identified as part of the assessment and support planning process. This may apply to both men and women. It may provide challenges for workforce planning, as the majority of the social care workforce is female.

**Transgender:** we have no figures to indicate the number or proportion of Transgender people in North Yorkshire and receiving social care support. In our client database, we respect people's self-reported gender identification. However, we are aware that we have a small number of clients who are Transgender and we have responded to specific issues as they arise, including via the provision of targeted staff training and guidance. This will continue to be an element of our staff development. In terms of issues around dementia and Transgender identity, there does not seem to be much research, although it can be extrapolated from other research and good practice that it is important in terms of equality and dignity that a person is supported to maintain their preferred gender identity, and this is particularly the case where a person is experiencing cognitive impairment and is less able to make their choices known. In addition, some of the issues experienced by Lesbian, Gay and Bisexual (LGB) people may apply, including fewer family carers, and higher prevalence of mental health issues inc. depression and anxiety (often due to the experience of discrimination throughout their lives).

**Sexual orientation:** we do not have data on the sexual orientation of people accessing social care services as this information is not currently collated. However, from national research including research carried out by the Commission for Social Care Inspection (now CQC), and from local consultation, we are aware that Lesbian, Gay and Bisexual (LGB) people may be wary of accessing social care due to concerns about discrimination and lack of culturally appropriate services. We are helping to address this through inclusive language (for example, in our needs assessment questionnaire) and staff development, and through such inclusive projects as our Rainbow project for residential care homes.

National estimates (Stonewall) indicate that 5-7% of people are LGB. National research indicates that LGB people have a higher prevalence of mental health issues, perhaps linked to their experience of social exclusion and discrimination. There can also be issues with access to gender-appropriate health care. In North Yorkshire, LGB people may experience additional disadvantage due to social isolation, particularly if living in rural areas.

For some LGB people, it may be from their friendship connections that they draw their main support, including informal caring, than from traditional family relationships.

LGB people, particularly older people may be wary of services due to experience of discrimination and exclusion throughout their lives – for older people, many will have lived through times when their sexual orientation was illegal (see ‘the Whole of Me’, Age UK). This may impact on early diagnosis – LGB people may be less likely to present to primary health care or social care in order to then obtain a diagnosis of dementia at an early stage.

### **Faith and belief**

North Yorkshire’s majority religion is Christian, with a higher proportion of people self-declaring as Christian than the national average.

There are small, often dispersed groups of people of other faiths across North Yorkshire, and a small number of places of worship, for example a mosque in Skipton, an Islamic Centre under development in Scarborough, a synagogue in Harrogate. People may find it more challenging to access places of worship to meet their faith needs. Some people access community support and places of worship in neighbouring authority areas, such as Leeds and Middlesbrough.

This data is collected by Adult Social Care, but not by Health services. In a review of access to NYCC adult social care services conducted in 2009, it was noted that people of Christian faiths are represented roughly in accordance with the wider demographics of North Yorkshire. Those of non-Christian faiths are slightly better represented in terms of numbers at all stages of the care pathway than the North Yorkshire average but, although there were very small numbers involved, those of non-Christian faiths were less likely to receive an assessment or service compared to the other groups.

It is important to recognise faith when supporting people with dementia, as they may a) need support to maintain their cultural identity including faith observances; b) may find faith and spirituality important to maintain their wellbeing, and c) support to maintain their identity and familiar routines could contribute to lessening confusion and anxiety. This is a complex area and would need to be put in place as part of good assessment and care planning with the individual and their care network.

**Ethnicity / nationality:** this data is collected by local authorities but may not be collected by Health services. We have access to Census 2001 data, and Census 2011 data will be available from 2012. The Census 2001 data indicates that 1.12% of North Yorkshire’s population was minority ethnic, 1.37% including York. This is anticipated to have risen considerably over the last 10 years – ONS mid 2009 population estimates put it at approx 4.5% - and is projected to rise over the next 10. The BME population tends to have a younger age profile than the White population, but again this is likely to change over time.

The above figure will not have captured the Gypsy and Traveller population of North Yorkshire.

Research by the Social Care Workforce Research Unit and Kings College London for SCIE (The future ageing of the ethnic minority population: ethnicity and dementia, 2009) made the following observations:

- The age profile of the BME population in the UK means that the numbers of almost all BME communities is set to increase and they are likely to become more dispersed across all parts of the UK (Lievesley, 2010)
- The impact of world events upon migration to the United Kingdom (UK) has meant that there are now new communities such as Iraqis, Afghans, and Somalis among the older UK population with whom practitioners must engage (Butt, 2005)
- Prevalence rates of depression among BME older people are broadly similar to those for the White UK population (Shah *et al.*, 2009)
- Number of BME people with dementia and/or depression will rise especially quickly as first generation migrants enter their 70s and 80s
- Hypertension and heart disease increase risks of developing vascular dementia: evidence that higher rates of vascular dementia exist among Black Caribbean (Adelman 2010; Richards *et al.*, 2000) and Asian older people
- Research suggests lower levels of awareness among BME groups (Adamson, 1999, 2001; La Fontaine *et al.*, 2007; Bowes and Wilkinson 2004; Turner *et al.*, 2005; Purandare *et al.*, 2007):
  - More likely to see symptoms of dementia as 'normal ageing'
  - Impact is severe as means that present at later stages
  - Fewer opportunities for early intervention
  - Not having the chance to plan for future directives, lasting power of attorney, advance directives
  - Carers may be severely stressed

Stigma is found in all cultures but way it is expressed varies between cultures (Mackenzie, 2006):

- Context is that public understanding of dementia has improved among White UK population
- In many South Asian languages there is no equivalent word for 'dementia'

- Dangers of stereotyping but stigma appears to be greater among BME communities (La Fontaine et al, 2007, St John, 2004; Seabrooke and Milne, 2004, Mackenzie 2006)
- 'Keeping face' and concern about what others in the community may think are barriers to seeking help

The consequences of seeing dementia as normal ageing may lead to assumptions that nothing can be done. There may be high levels of uncertainty about how to access services and whether they can help (La Fontaine, 2007) and there may be an impact on family carers and individuals with dementia of expectations about the role of family in support ("traditional caregiver ideology, Lawrence et al, 2008)

NYCC Adult Social Care: we know from consultation and from our data that service take-up is low amongst BME communities, including Gypsy and Traveller communities. There may be several reasons for this, including lower levels of need related to the younger age profile of BME communities in North Yorkshire, a view amongst some BME communities that adult social care will not meet their needs, or issues with accessing adult social care.

There may also be language and literacy barriers to accessing services, and some people who speak English as an additional language may lose this skill as their dementia progresses, and so revert to their first language.

**Disability (including unpaid carers):**

Evidence suggests that people with a general learning disability have the same risk of developing dementia as the general population. However, people with Down's syndrome have an increased genetic risk of developing dementia and at an earlier age, than the general population. Currently, services are challenged in meeting the needs of this client group.

People with dementia also have other disabling conditions unconnected with the dementia itself, which will complicate the nature of the care they require. There is potential that the diagnosis of dementia may override other health care needs. This is exemplified by the acknowledged over prescribing of anti-psychotics for people with dementia, which is currently being addressed. A study has shown that prescribing paracetamol as an alternative to anti-psychotics is as effective in reducing the incidence of challenging behaviour, as the behaviour may be related to untreated pain.

American research shows that carers of people with dementia are at risk of developing depression, and that women have higher rates of depression than men and that white and Hispanic carers report fewer depressive episodes than African Americans. (Gruetzner 2001, McGrath et al 1992, Farn, Miller,

Kaufman & Davis, 1997). It should be noted that American research findings may not apply to the UK. This information should be cross referenced with the Carers Strategy.

There may be under-diagnosis of sensory impairment in people with dementia, as it may be 'masked' by dementia diagnosis.

We know from community engagement with Deaf people in North Yorkshire that Deaf people who use British Sign Language are experiencing barriers in access to primary and secondary health care, due to a lack of provision of BSL interpreters. This could lead to later diagnosis and poorer health outcomes, including dementia, due to communication barriers.

### **Age:**

The Alzheimer's Society states that age is the most significant known risk factor for dementia. It is possible to develop dementia early in life, but the chances of developing it increase significantly as we get older. One in 50 people between the ages of 65 and 70 has some form of dementia, compared to one in five people over the age of 80. This increased risk may be due to factors associated with ageing, such as:

- higher blood pressure
- an increased incidence of some diseases (for example, heart disease and stroke)
- changes to nerve cells, DNA and cell structure
- the weakening of natural repair systems.

For early onset dementia, SCIE research indicates that:

Dementia can affect people as young as 30, although this is extremely rare. Most younger people with dementia are in their 40s, 50s and early 60s. The term 'young onset dementia' refers to people diagnosed with dementia under the age of 65.

In 2010 there were thought to be 64,037 people under 65 with dementia in the UK compared with just 16,737 in 1998. The majority of those affected in this younger age group – 70 per cent – are men. Younger people with dementia make up 8 per cent of the total number of people with dementia (from ART, 2010).

The chances of developing dementia before 65 are relatively small. Men aged between 30 and 59 have a 0.16 per cent chance; for women it is 0.09 per cent. The chances increase slightly once a person

reaches 60. Men aged between 60 and 64 have a 1.58 per cent chance of developing dementia; for women it is 0.47 per cent. The chances of developing dementia are highest for people between 90 and 94 (32 per cent) (from ART, 2010)

Young people may be more likely to experience stigma as they are not expected to have the condition (SCIE).

Typically, people who are diagnosed with young onset dementia are in very different circumstances in life to older people with dementia. They are more likely to be in paid employment, have young or teenage children living at home, be physically fit and healthy, and have significant financial and other commitments, such as caring for an older parent. All these factors influence the experience of living with dementia, and mean services need to work hard to be accessible and appropriate for a younger person and their family (SCIE).

**Pregnancy and maternity**

Not aware of any impact – would be picked up in services for people with early onset dementia.

**Marriage and civil partnership**

Not aware of any impacts apart from anything to relating to maintenance of family life and support for carers which is picked up elsewhere.

**Rural nature of North Yorkshire**

North Yorkshire is a rural county. This brings both opportunities and constraints to communities and individuals. Whilst quality of life and social support can be high, there can also be social isolation which can impact on mental wellbeing, particularly for those from minority groups, lack of easy access to services and poor public transport links. Access to services for those living in rural areas is a challenge for all statutory services.

**2.2 Are there areas where we need more information? How could we get this information?**

**What data is available? Do other directorates, partners or other**

We need more information from health services about the profile of people who access their services. If this data is not currently gathered, services should consider how to remedy this gap.

We need more information about the impact of dementia for Lesbian, Gay and Bisexual people and Transgender people.

<p><b>organisations hold relevant information?</b> Is there relevant information held corporately e.g. compliments and complaints? Are there national datasets that would be useful? Is there relevant census data? <b>Do you need to collect more data?</b> How could you do this?</p>	
<p><b>2.3 What does the data tell you?</b></p> <p>Does the data show any differences in outcome for different groups e.g. differences in take up rates or satisfaction levels across groups? Does it identify the level of take-up of services by different groups of people? Does it identify how potential changes in demand for services will be tracked over time, and the process for service change?</p> <p><b>Please include data and analysis as an appendix</b></p>	<p>See section 2.1 above.</p> <p>People with dementia and learning disabilities, receiving end of life care will often only be able to receive appropriate care out of county.</p> <p>Local NYCC Adult Social Care and Alzheimer’s Society contact with the S. Asian community in Skipton indicates that there is no ‘word’ for dementia; that it is an under-recognised problem, and that until recently little contact was made with health and social care services. South Asian people have a higher likelihood of vascular dementia, due to tendency towards high blood pressure, cardiovascular disease and diabetes. The discussions indicated that dementia is not currently an issue, however may become so as a) the population ages and b) awareness of dementia is raised, hopefully leading to earlier diagnosis. National research by the Alzheimer’s Society indicated that dementia is likely to be interpreted as mental illness, and due to the stigma associated with this, diagnosis may be delayed.</p> <p>Recent discussion with a group of older Chinese people in Harrogate indicated that dementia is not currently an issue. However, the age profile of the Chinese community is still relatively young compared with the White community and it is therefore possible that issues may start to emerge as this population ages.</p> <p>Gypsies, Roma and Travellers are one of the largest minority ethnic communities in North Yorkshire. Evidence from national research shows that Gypsies and Travellers experience poor health outcomes in comparison to non-travellers. This is related to / compounded by environmental factors, cultural attitudes to illness, social exclusion and poverty. A Department of Health report in 2004 found that Travellers had poorer health than other minority ethnic or economically deprived White groups (Health Status of Gypsies and Travellers, Uni of Sheffield, 2004). Travellers are also less likely to access social care services at an early stage, although in North Yorkshire recent research (2008) does indicate that the majority of Travellers are registered with and visit a GP.</p>

	<p>The Yorkshire and Humberside Improvement Partnership peer review identified geographical inequity of provision; a summary is recorded in the narrative on mapping services in the strategy. For example, in all areas except SWR and Selby, there is a training programme for newly diagnosed people and their carers. It is hoped that this will be expanded to cover the whole sub-region with funding for the Department of Health.</p>
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<p><b>2.4 How will you monitor progress on your policy/service, or take-up of your service?</b></p> <p>What monitoring techniques would be most effective? What performance indicators or targets would be used to monitor the effectiveness of the policy/service? How often does the policy/service need to be reviewed? Who would be responsible for this?</p>	<p>The Strategy will be monitored via reports to the Dementia Network, which will be accountable to the new Health and Wellbeing Board.</p>
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<p><b>2.5 How do you know whether your service meet the needs of all customers?</b></p> <p>What engagement work have you already done that can inform this impact assessment? Who did you talk to and how? What are the main findings? Can you analyse the results of this consultation across the protected characteristics? Are there differences in response between different groups? How did you feed back the findings of the engagement to those who were involved? How has this changed the plans for the policy/service?</p>	<p>In 2008/09 the NYCC Care &amp; Independence scrutiny committee met with Alzheimer's Society representatives and through them with people with dementia and carers. This formed the 20 point plan that preceded the National Dementia Strategy being published. 4 key points were raised that can be checked for progress in future:</p> <ol style="list-style-type: none"> <li>1) not knowing who to turn to when symptoms cause concern</li> <li>2) not being listened to in early stages esp by primary care</li> <li>3) cared for person not being listened to</li> <li>4) Lack of respite for carers.</li> </ol> <p>The Dementia Network includes a service user and carer forum; representatives attend the Network and take forward specific pieces of work, and also highlight areas of concern / new issues to the Network. An example of a piece of work: to identify a wider stakeholder group for the Network to engage with, including universal services such as opticians, travel agents and banks, to make their systems and processes dementia-friendly.</p> <p>The forum has also had the opportunity to read and comment on the NYY Joint Dementia Strategy.</p>
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<p><b>Please summarise the main findings from any engagement work.</b></p>	
<p><b>2.6 Do you need to do more engagement work to inform this impact assessment?</b></p> <p>Have you identified information in other sections of this EIA that you need to assess the impact on different groups of people? What do you want to find out? Which existing mechanisms can you use to get this information?</p> <p>Please refer to the Community Engagement toolkit on the NYCC intranet</p>	

### **3. Action Planning**

Please consider issues around impacts (positive or negative) raised for **all protected characteristics** and show your evidence.

<p><b>3.1 Has an adverse impact been identified for one or more groups?</b></p> <p>Has this assessment shown anything in the policy, plan or service that results in (or has the potential for) disadvantage or discrimination towards people of different groups? Which groups?</p>	<p>There should be no adverse impact from the Strategy – it should be positive when implemented. However, there are some groups that may experience more barriers to services than others. The strategy will need to include actions to address such barriers.</p> <p>Groups that are more likely to experience barriers to access include:</p> <ul style="list-style-type: none"> <li>• BME people</li> <li>• People with learning disability</li> <li>• People with sensory impairment</li> </ul>
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	<ul style="list-style-type: none"> <li>• Young people</li> <li>• LGB people, particular older LGB people</li> <li>• People living in remote rural areas</li> </ul> <p>Barriers to early diagnosis and appropriate services for some groups will include lack of accessible and inclusive communication, for example for people with sensory impairment, English as an additional language, or people with literacy issues.</p> <p>Because some minority groups are in small numbers in North Yorkshire, services may be unaware of cultural, faith or language needs. This may result in late diagnosis and poorer outcomes.</p> <p>Some people, for example older LGB people or Transgender people, may have experienced or have an expectation of discrimination from services, and this may also be a barrier to access.</p> <p>People living in remote rural areas may experience difficulties in accessing services and public transport, and risk of social isolation may be compounded for people from minority groups. This could result in barriers to early diagnosis and treatment.</p>
<p><b>3.2 How could the policy be changed to remove the impact?</b></p> <p>Which options have been considered and which one has been chosen?</p>	<p>Ensure that the Dementia Network is aware of potential barriers to access, and considers ways to address these barriers.</p> <p>Health and social care staff must be trained in cultural competency, to support people to receive appropriate and personalised care. This should include GPs wherever possible.</p> <p>Diversity of the health and social care workforce should also be a target for workforce planning.</p> <p>Accessible communication should be a priority of the Strategy, including format, method of delivery and language (inclusive and neutral language, eg ‘memory problems’).</p> <p>Engage with communities, in particular seldom heard communities, to share information about dementia. This could take place through, for example, places of worship and other community hubs. Work with partners to achieve this.</p>

	<p>For people with learning disability, ensure that the Dementia Network links with the ongoing work via the Learning Disability Partnership Board to ensure that people with LD receive a good-quality annual health check.</p>
<p><b>3.3 Can any adverse impact be justified?</b></p> <p>If the adverse impact will remain, can this be justified in relation to the wider aims of the policy or on the grounds of promoting equality of opportunity for one target group?</p> <p><b>Please seek legal advice on whether this can be justified.</b></p>	<p>No adverse impact identified.</p>
<p><b>3.4 Are you planning to consult people on the outcome of this impact assessment?</b></p> <p>When and how will you do this? How will you incorporate your findings into the policy?</p>	<p>The Dementia Network and the user/carer forum have been involved in the development of the Strategy.</p>
<p><b>3.5 How does the service/policy promote equality of opportunity and outcome?</b></p> <p>Does the new/revised policy/service improve access to Council services? Are resources focused on addressing differences in outcomes?</p>	<p>The Strategy is aimed at ensuring that there are good quality and equitable services for people across the sub-region, with particular regard to those who have specific needs such as people with learning disability or early onset dementia.</p>
<p><b>3.6 Are there any other equality issues that haven't been covered through this impact assessment?</b></p> <p>Are there any other sections of the community that are affected? Why haven't these been included in the assessment? Are they picked up in other EIAs/services?</p>	<p>No.</p>
<p><b>Don't forget to transfer any issues you have identified in this section to the <a href="#">Equality Action Plan</a></b></p>	

<b>Action Plan</b>				
<b>Action</b>	<b>Officer responsible</b>	<b>Deadline</b>	<b>Other plans this action is referenced in (e.g. Service Performance Plan, work plan)</b>	<b>Performance monitoring arrangements</b>
Ensure that the Dementia Network is aware of the potential barriers to access and considers ways to address them	Jan Cleary	February 2012		Inclusion
Ensure that Health and social care staff are trained in cultural competency	Jan Cleary Judith Knapton Mike Webster Tim Smith	January 2013	Workforce Development Strategy/ Market Development Strategy	Inclusion of an expectation re cultural competency of staff in contract reviews.
Make diversity of Health and social care workforce a target for workforce planning via the Adult Integrated Workforce Strategy	Tim Smith Mike Webster	January 2013	Workforce Development Strategy	Via Adult Integrated Workforce Strategy Action Plan
Make accessible communication a priority when delivering	Anne Marie Lubanski	January 2013		

on the strategy, including format, method of delivery and language				
Engagement with communities to share information about dementia	CSMs	January 2013	Community Engagement Strategy	
Ensure that workers in sensory services are included in the roll out of dementia champion training, and that the links between START and sensory teams are robust	Jan Cleary	June 2012	Workforce Development Strategy	
Ensure that the Dementia Network links with the Learning Disability Partnership Board	Jan Cleary Judith Knapton	September 2012		Active engagement of staff from learning disability services in the Network