



Cabinet Member for Adult Services

Time and Date

11.00 am on Monday, 3rd October, 2022

Place

Diamond Room 5 - Council House

Public Business

1. **Apologies**
2. **Declarations of Interest**
3. **Minutes** (Pages 3 - 6)
 - a) To agree the minutes of the meeting held on 13th July 2022.
 - b) Matters arising
4. **Coventry and Warwickshire Living Well with Dementia Strategy 2022-2027** (Pages 7 - 58)

Report of the Director of Adult Services and Housing
5. **Developing a Coventry Dementia Hub** (Pages 59 - 78)

Report of the Director of Adult Services and Housing
6. **Outstanding Issues** (Pages 79 - 82)

Report of the Director of Law and Governance
7. **Any other items of public business which the Cabinet Member decides to take as matters of urgency because of the special circumstances involved**

Private business

None

Julie Newman, Director of Law and Governance, Council House, Coventry

Friday, 23 September 2022

Note: The person to contact about the agenda and documents for this meeting is Usha Patel Email: usha.patel@coventry.gov.uk

Membership: Councillor: M Mutton (Cabinet Member)

By invitation Councillor: Councillor B Mosterman (Shadow Cabinet Member)

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Usha Patel

Email: usha.patel@coventry.gov.uk

Coventry City Council
Minutes of the Meeting of Cabinet Member for Adult Services held at 10.00 am on
Wednesday, 13 July 2022

Present:

Members: Councillor M Mutton (Cabinet Member)

Employees Present:

S Caren, Adult Social Care
C Dutton, Adult Social Care
P Fahy, Director Adult Services and Housing
L Lawson, Adult Social Care
U Patel, Law and Governance
J Reading, Adult Social Care

Apologies: Councillor B Mosterman

Public Business

1. Declarations of Interest

There were no declarations of interest.

2. Minutes

The minutes of the meeting held on 17 March 2022 were agreed and signed as a true record. There were no matters arising.

3. The Introduction of an Adult Social Care Offer

The Cabinet Member considered a report of the Director of Adult Services and Housing which sought endorsement to the introduction of an Adult Social Care Offer and the publishing and sharing of the statement of intent in relation to the provision of services.

The introduction of an Adult Social Care Offer was in line with an overall approach to improving the information, advice and guidance produced by Adult Social Care. This element of the service provision was one of a range of key performance indicators included within the Adult Social Care Outcomes Framework (ASCOF) which measures how well care and support services achieve the outcomes that matter most to people. In addition, the quality of our information, advice, and guidance provision was a duty included within the care Act 2014 and would be considered by the Care Quality Commission as part of the new Assurance Framework process commencing in 2023.

This was the first time Adult Social Care had shared information in this format, incorporating a revised vision for Adult Social Care. The intention was that Adult Social Care Offer would provide a straightforward and accessible statement describing what people could expect from Adult Social Care in Coventry, how services would be provided and the processes that those eligible for services

would take part in. It also included useful sources of additional information, contact information and addresses. The Coventry Adult Social Care Offer was attached as Appendix 1 of the report.

The Adult Social Care Offer would be shared widely amongst staff, health and other partner organisations. Voluntary sector organisations, providers of social care and prospective new employees in several ways including the council web site, briefings, email, social media, posters and leaflets. The Adult Social Care Offer has been co-produced by the Adult Social Care Extended Management Team and incorporates contributions and feedback from the Adult Social Care Stakeholder Group following engagement.

As well as the specifics on what people could expect, the offer also adopted the Health and Care partnership vision for Coventry and Warwickshire which superseded the previous Adult Social Care vision. The offer contained three parts as follows:

- Part One: Our approach – this section states the vision along with a set of commitments that underpin the service's work.
- Part Two: How the offer is delivered – this section describes what people can expect when they first make contact with Adult Social Care, what types of support is available in Coventry and what people can expect through the stages of assessment, support planning and review.
- Part Three: Useful information – this section provided summary information on the Care Act 2014 and a series of contact numbers for key adult social care organisations along with a short description of what each organisation does.

Once implemented, the service would continue to encourage feedback from its customers and stakeholders and would monitor performance in the provision of information and how well the Adult Services Care Offer was being delivered using both local intelligence and performance data, e.g. results of annual surveys, customer feedback and the results of the annual ASCOF performance measures. The service would continue to demonstrate the effectiveness of this through the Adult Social Care Annual Report.

The Cabinet Member congratulated everyone involved in this fundamental piece of work. It made the service transparent and accountable. It was noted that a copy would be circulated to all members for information and noting.

RESOLVED that, the Cabinet Member for Adult Services:

- 1. Approves the introduction of the Adult Social Care Offer.**
- 2. Approves the publication and sharing of the Adult Social care Offer with a wide range of stakeholders.**

4. Adult Social Care Quality Assurance and Management of Market Failure

The Cabinet Member considered a report of the Director of Adult Services and Housing which provided an update on adult social care quality assurance and management of market failure.

Where people within Coventry are eligible for a care and support service following a needs and wellbeing assessment under the Care Act 2014, the quality of that care was critical to ensuring that the person with care and support needs has a good experience of social care and that their needs and outcomes were met.

The majority of care and support services in Coventry were provided under contracts by the City Council with independent providers of care and support. Therefore, effectively managing and monitoring contracts is a key responsibility for Adult Social Care alongside ensuring that effective mechanisms are in place to respond to issues of provider failure (where a provider is no longer able to continue to deliver their contract).

The report was produced following a review of the processes currently in place. The review was initiated as a result of the learning from the Covid pandemic which had proved to be a major and persistent challenge to the care market.

The report covered revisions to the following two key processes for ensuring quality and business continuity in commissioned care and support services:

1. How contracts and the quality of care and support was monitored, based on a set of indicators and the risks associated with specific services.
2. How the City Council responded to issues where a provider, or number of providers, cannot continue to deliver services due to a range of factors including quality issues, cost issues, or provider choice not to continue. This was often referred to as 'market failure'.

During the height of the Covid pandemic, quality assurance visits had to be scaled back from in person to a largely remote function with on-site visits made in exceptional circumstances. This change was due to infection prevention and control restrictions. During this period visits were still conducted where absolutely necessary to those services where the most significant concerns were apparent and were supplemented with other means of understanding the quality of provision and user experience.

A number of providers of care and support also ceased trading during and following the pandemic. This was due to a number of reasons including financial stability as a result of high numbers of vacancies and provider choice where owners of care and support organisations decided to no longer operate. Each of these situations, although managed effectively by the City Council, prompted a review of how provider failure of this kind is managed to ensure continuity of service for people affected.

The City Council has a number of duties in respect of the social care market under the Care Act 2014 including to facilitate and shape the care market to ensure a sustainable and diverse range of care and support, continuous improvement in quality and choice and the delivery of cost-effective outcomes.

The main changes from the previous approach for managing and monitoring quality within social care and support were:

- The introduction of an improved risk-based approach with greater clarity on levels of concern and appropriate oversight and action for all provision (reducing the risk of poor quality care not being uncovered).
- Improved processes and management of providers where there are quality concerns with clear escalation process within shorter time scales (reducing the time taken for improvements to be implemented).

The changes proposed with the refreshed market failure plan were as follows:

- Precision around emergency situations of service closure
- Enhancement of the number of transport options available in the plan to ensure appropriate transport is available in an emergency
- An updated and increased number of agencies who may be available to support in an emergency to include recruitment agencies

Further detail on the approach to emergency provider failure was outlined in the Market Failure Plan attached at Appendix 2 of the report.

The Health and Social Care Scrutiny Board (5) considered the report on 6 July 2022 and were fully supportive of the Adult Social Care Quality Assurance and Management of Market Failure report and recommended that the Cabinet Member agrees the recommendations contained within the report.

The Cabinet Member having considered the report, commented that the pandemic had highlighted risk areas which had resulted in subsequent improvements to the system. She noted that there were other reports in the pipeline and was eager to get scrutiny involved from the outset.

RESOLVED that, the Cabinet Member:

1. **Approves the revised risk-based approach to Quality Assurance.**
2. **Endorses the revised Market Failure Plan including the approach to managing provider failure in the event of an emergency.**
3. **Considered comments from the Health and Social Care Scrutiny Board (5) resulting from their meeting on 6 July 2022 in relation to the above.**

5. **Outstanding Issues**

The Cabinet Member considered a report of the Director of Law and Governance which detailed one outstanding item that was the subject of an update report at a future Cabinet Member meeting.

RESOLVED that the Cabinet Member notes the Outstanding Issues report.

(Meeting closed at 10.25 am)



Public report
Cabinet Member

Cabinet Member for Adult Services

03 October 2022

Name of Cabinet Member:

Cabinet Member for Adult Services - Councillor M Mutton

Director Approving Submission of the report:

Director of Adult Services and Housing

Wards Affected:

All

Title: Coventry and Warwickshire's Living Well with Dementia Strategy 2022-2027

Is this a key decision?

No - although the proposals affect more than two electoral wards, the impact is not expected to be significant.

Executive summary:

Coventry's Living Well with Dementia Strategy (2014) has been refreshed to create a revised five-year document across Coventry and Warwickshire Integrated Care Board and Warwickshire County Council. The Strategy builds on the 2014 document and reflects current policy, priorities, and ways of working.

The strategy sets out ways of working and use of existing allocated resources for continuing the improvements for people living with dementia that have been progressing since publication of the 2014 strategy. There is no additional funding requirement associated with the strategy.

To ensure that the strategy remains relevant over a five-year period, it will be delivered and monitored via annual delivery plans. The strategy will also be reviewed as appropriate dependant on publication of any relevant policy documents related to dementia.

In developing the strategy consultation was carried out on the draft strategy in Autumn 2021, and groups of people with dementia will be consulted when developing annual delivery plans to ensure our priorities reflect those of people in Coventry affected by dementia.

Recommendation:

Cabinet Member is requested to approve the joint Coventry and Warwickshire Living Well with Dementia Strategy 2022-2027.

List of Appendices included:

Appendix 1. Coventry and Warwickshire's Living Well with Dementia Strategy 2022

Appendix 2. Equality Impact Assessment

Background papers:

None

Other useful documents

2014 Living Well with Dementia Strategy

Has it or will it be considered by scrutiny?

No

Has it or will it be considered by any other council committee, advisory panel, or other body?

Warwickshire Cabinet

Coventry and Warwickshire ICB Board

Will this report go to Council?

No

Report title: Coventry and Warwickshire's Living Well with Dementia Strategy 2022-2027

1. Context (or background)

There are an estimated 3,690 people in Coventry living with dementia, and this number is predicted to increase to 4,882 by 2040. While most people with dementia are over 65, dementia can affect people of all ages, and over 80 people aged under 65 in Coventry are estimated to be living with dementia.

Under the Care Act (2014) the Council has duties to prevent, or delay needs for care and support and to provide people in its area with information and advice relating to care and support for adults and support for carers. It also has duties to promote the integration of care and support with health partners where to do so is likely to promote the wellbeing of adults with needs for care and support in its area, contribute towards the prevention duty and improve the quality of care and support in its area.

Coventry's Living Well with Dementia Strategy was first published in 2014 and contributes towards these duties. Warwickshire County Council published similar strategies in 2011 and 2016. Given the creation of the creation of Integrated Care Systems and the opportunities for alignment across Coventry and Warwickshire in our support for people with dementia and their carers it was proposed to develop a single strategy that was relevant across the ICB area as opposed to separate strategies.

To develop this single strategy the City Council has worked closely with colleagues through the Health and Care Partnership Dementia Board, which includes Warwickshire County Council, and Coventry and Warwickshire Partnership NHS Trust. The strategy has been informed through national guidance and local evidence plus extensive engagement with people living with dementia, carers and those working within the dementia system. This use of guidance and evidence

combined with engagement help to ensure that the proposals contained within will make a real impact to our ability to support people living with dementia and their carers and families and will therefore be fully supported by NHS colleagues and delivered in partnership with the voluntary and community sector.

Improvements under the 2014 strategy

Examples of improvements made under the 2014 strategy include:

- **Greater public awareness about dementia** - how to reduce the risk of developing it and how to help support people with dementia to live well for longer. There are now over 37,000 Dementia Friends in Coventry and Warwickshire. Information is shared via websites, events, and information in public places.
- **Increased diagnosis rate** - through a programme of work including community dementia assessment, training different staff groups, better recording and efficiencies and streamlining processes within the Memory Service. Coventry's Memory Service has now achieved MSNAP accreditation, which recognises high quality memory assessment services, and works to a contractual 12 week waiting time compared to 52 weeks in 2014.
- **Training for GPs** - significant training and education was conducted with GPs with 68 Coventry GPs receiving specialist training enabling them to conduct dementia assessment and diagnosis in the community. Waiting times for assessments have been reduced and processes made clearer to avoid rejected referrals. The support offer has been developed and shared with GPs, and is accessible on their online portals, improving the quality and consistency of information GPs are able to share with patients.
- **There is more post-diagnostic support for people with dementia and their carers.** Everyone diagnosed with dementia is offered a Next Steps group and information pack. Dementia Connect (Alzheimer's Society) were recommissioned and alongside the GP Alliance we commissioned Admiral Nurses to provide additional support particularly around more complex needs and end of life. There is capacity for all people diagnosed to be referred to a support service, and an 'opt out' model is being developed to improve reach. Books on Prescription is available in all Coventry libraries.
- **People with dementia are supported to maintain their independence** - the Dementia Promoting Independence and Locksmith services help at least 73% of users return to independent living following a hospital stay that could otherwise have led to a move to residential care.
- **When people with dementia do require additional care, there are more options** – for example, Arden Grove, a specialist housing with care facility. Extensive quality work has been done with dementia care homes in the City, including intensive Occupational Therapist input, in-reach support on techniques for meaningfully engaging people with dementia and behaviour that challenges, and training in supporting people with delirium.
- **There is more support for carers** - Alzheimer's Society offer a formal 4-week training course to carers and a peer support group. Carers can also access advice and support through "Next Steps" groups and receive support from Dementia Connect and Admiral Nurses. A new Carers Strategy is being developed and will include specific reference to carers of people with dementia.

Priorities for the refreshed strategy

The strategy priorities are aligned with the NHS Well Pathway for Dementia, and feed into the aims of the original strategy which are:

- **Reducing the risk of developing dementia** - We will promote and support healthy lifestyles, aiming to reduce people's risk of developing dementia.
- **Diagnosing Well** - We will work to ensure people receive a timely, accurate diagnosis of dementia and that they are linked in with support soon after diagnosis.
- **Supporting Well** - We will work to ensure people living with dementia and their family and carers have access to safe, high-quality support and care, that is strengths-based and personalised.
- **Living Well** - We will work to ensure people affected by dementia can live in safe and accepting communities, where they can access a range of support services and enjoyable and meaningful activities.
- **End of Life care** - We will work to ensure people with dementia are supported to die with dignity in the place of their choosing, and that their families are supported.
- **Training Well** - We will work to ensure training and awareness opportunities are offered to support communities to increase their awareness of dementia, and that staff who work with people affected by dementia have access to appropriate, accredited training.

Delivery objectives under the strategy will initially be prioritised by the Health and Care Partnership Dementia group in consultation with other stakeholders. An annual Delivery Plan will be developed and will include the actions to be taken, what organisation or person will lead each action, timescales for achieving the actions, costs, and measures of success. The draft delivery plan for each year will then be reviewed and agreed by the Dementia Strategy Board.

2. Options considered and recommended proposal

2.1 Recommended Option – Approve the dementia strategy

Producing and publishing a dementia strategy sets out with clarity what the City council, working with partners aims to achieve in order to improve the support for people with dementia and their carers. Producing this strategy across the ICB footprint and in partnership with other stakeholders ensure alignment of our approach across Coventry and Warwickshire.

2.2 Other Options

Not recommended – develop a stand-alone strategy for Coventry

It is possible to develop a stand-alone strategy for Coventry City Council. This is not recommended as to achieve buy-in from health organisations we need to increasingly be working on an ICB footprint. The annual delivery plans give the opportunity to undertake actions and developments specific to Coventry where there is justification for doing so

3. Results of consultation undertaken

- 3.1.** During Autumn 2021 officers carried out an extensive programme of engagement with key stakeholders (including people living with dementia, carers, the public and professionals / front-line workers) on the draft Dementia Strategy. Feedback was used to revise the draft strategy into its current form.

3.2. A wide variety of engagement methods were used with the aim of reaching as many interested stakeholders as possible. This included a survey and focus groups with people living with dementia and their carers, and individual and group sessions with people involved in providing dementia care and support.

4. Timetable for implementing this decision

4.1. Should the strategy be endorsed, we aim to publish in November 2022. The strategy covers a five-year period and annual delivery plans will be produced, implemented, and reviewed.

5. Comments from Chief Operating Officer (Section 151 Officer) and Director of Law and Governance

5.1. Financial Implications

The dementia strategy has been developed jointly with local partners, including NHS partners and the voluntary and community sector. Achievement of the strategy's ambitions and priorities, outlined in the Delivery Plan, will utilise existing partner resources and include individual provider and partnership bids for funding.

5.2. Legal Implications

Local authorities have a unique role to play in supporting people following a diagnosis of dementia. As well as providing care and support on a statutory basis, they have a role to lead on prevention and early intervention by promoting good health and wellbeing. They also have responsibilities to provide good quality information and advice. Local authorities have an influential leadership and place shaping role in the community and have strong links with local partners.

Therefore, the continuation of the Dementia strategy supports the Local Authority to meet its various statutory responsibilities towards people with dementia, such as those outlined in the Equality Act 2010, the Care Act 2014, the Mental Capacity Act 2005, the Mental Health Acts 1983 and 2007, and the Human Rights Act 1998.

The Council has a legal obligation under section 149 of the Equality Act 2010 to have due regard to the need to eliminate discrimination, advance equality, and foster good relations between those with a protected characteristic and those who do not share it. These matters have formed an integral part of the decision-making processes in relation to the continuation of the Dementia strategy. The Council continues to engage with service users and representative groups, and use the information and views gathered in its consultation and equality impact in order to achieve accessible and inclusive service provision.

6. Other implications

6.1. How will this contribute to the achievement of the council's key objectives / corporate priorities (corporate plan / scorecard) / organisational blueprint / LAA (or Coventry SCS)?

The strategy will contribute to the Council's objectives in a number of ways i.e.

- Improving the quality of people's lives in Coventry and focussing on improving health and wellbeing and supporting people to live independent lives.
- Helping people to maintain their independence and supporting them when they need help.
- Enabling people to exercise choice and control in their daily lives.

- Helping support people facing multiple and complex needs.
- Putting local people and their needs at the heart of the customer journey.

6.2. How is risk being managed?

No specific risks have been identified in terms of the recommendations in this paper. Identification and mitigation of risks will form part of the implementation planning for the strategy. Any future risks identified will be managed through City Council and ICB governance mechanisms in partnership with Warwickshire County Council.

6.3. What is the impact on the organisation?

None

6.4. Equalities / EIA?

An EIA has recently been conducted. The impact is mainly on people aged 65+, which will be a positive impact of more aligned and improved services for people living with dementia and carers. The strategy also covers people with early onset dementia aged under 65, and it is recognised that carers are likely to be in both age groups.

The EIA has identified that people from minority ethnic groups are often under-represented in dementia assessment and support, so actions have been included around understanding and improving access to information, assessment, and support, including for family carers. Digital exclusion is a risk for this group so we will ensure services and the wider system are not overly or exclusively reliant on digital provision of information, assessment, and support and will offer help to enable access to digital options where appropriate. Further engagement and support will recognise the gap in health inequalities experienced by people living with dementia with protected characteristics and work to reduce such inequalities through delivery plans.

6.5. Implications for (or impact on) climate change and the environment?

None.

6.6. Implications for partner organisations?

The strategy supports the Health and Care system vision that we will do everything in our power to enable people across Coventry and Warwickshire to pursue happy, healthy lives and put people at the heart of everything we do.' Partner organisations involved in the development of the strategy will contribute to the delivery of the strategies priorities.

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Members: Councillor M Mutton	Cabinet Member for Adult Services	-	15.09.2022	15.09.2022

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Appendix 1 : Coventry and Warwickshire's Living Well with Dementia Strategy 2022 – 2027

Please note: Communications will professionally design and format the strategy before publication. Blue text is for information and will not be included in the final strategy

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Coventry and Warwickshire's Living Well with Dementia Strategy 2022 - 2027

Executive Summary

Why have we developed a Coventry and Warwickshire Living Well with Dementia Strategy 2022 – 2027?

There are over 6,500 people with a diagnosis of dementia, and over 11,700 people estimated to be living with dementia across Coventry and Warwickshire. However, dementia also affects families, friends, colleagues, and neighbours.

Although significant developments and improvements in diagnosis, care, and support have been made in recent years, we know that people with dementia and their carers still experience challenges. Some of the key issues include:

- There can still be stigma surrounding dementia, which may result in people not seeking diagnosis, or accessing care and support at an early stage. **We need to do more to raise awareness and understanding of dementia.**
- Although support is available after a diagnosis of dementia (known as post-diagnosis support), for various reasons people do not always access services which can help them to understand the condition, develop plans, and access a range of support until things become much more difficult. **We want people to access the support they need at an earlier stage.**
- Family and friends who are caring for a loved one with dementia do not always have support for themselves. There is a risk of carer burnout as the demands of caring for their loved one increase. **We need to ensure that carers are better supported.**
- There may be many services involved in supporting and caring for someone with dementia. Carers tell us it can be difficult finding out about services and support, and that understanding what different services do can be confusing. **We need to ensure that people affected by dementia are supported by the right services at the right time.**
- As a result of the COVID-19 pandemic, some voluntary sector services have closed. This has increased geographical inequalities in the availability of services and support for people affected by dementia. **We need to ensure that the voluntary sector is supported to ensure it can continue to help people affected by dementia.**
- The number of people living with dementia is increasing. **We need to ensure that services work more closely together so limited resources are used in the best way possible to support people with dementia and their carers.**

This strategy seeks to recognise the complexities and individual experience of dementia, both for the person living with dementia and for those who care for them. With support, information and guidance, people can live well with dementia and continue to take part in activities and do things that they enjoy.

The strategy brings together all the agencies that may support people affected by dementia (including health, social care, and the voluntary sector) and outlines the commitment we will make in working more closely to ensure that people with dementia and their carers have access to the right support, at the right time, in the right place, throughout the entire dementia journey – from diagnosis through to, and beyond, end of life.

Within this strategy, we will use the term ‘affected by dementia’ to include people who have dementia and people who are caring for a person with dementia.

The strategy is a partnership strategy across health, local councils and the voluntary and community sector in Coventry and Warwickshire. Organisations across the area are already working closely together with the aim of supporting people affected by dementia, and we want to build on this work through the Dementia Strategy for 2022-2027.

At the time of publication, we are awaiting details of a new national 10 Year Plan for Dementia from government, due in late 2022. Actions from this will be reflected in annual delivery plans.

What will Coventry and Warwickshire’s Living Well with Dementia Strategy (2022-2027) do?

The Dementia Strategy sets out six key priority areas that will help to ensure people with dementia, as well as their carers, receive the appropriate support, information, and advice along their journey with dementia. Each of these six priority areas includes several objectives, which summarise what actions will be taken, and outcome measures that will enable us to track our progress.

How will the strategy be achieved?

The strategy is supported by a Delivery Plan which will include the specific steps that will be taken to ensure the strategy is achieved. The delivery plan for the forthcoming year will be developed annually and will include exactly what actions need to be taken, what organisation or person will lead each action, resources needed (including, for example, human and financial resources), timescales for achieving the actions, and detailed measures of success.

Achievement of the Delivery Plan will be the shared responsibility of all the agencies that support people affected by dementia (including health, social care, and the voluntary sector). Targets for each outcome measure will be set annually as part of the development of the Delivery Plan and these will be monitored regularly. Monitoring of progress towards achieving the Strategy Delivery Plan will be by the Dementia Strategy Board, who will report to other Boards, such as the Health and Wellbeing Board as requested. Please see the section 'How we will deliver this strategy' for more detail about this.



We want to ensure that the Dementia Strategy makes a real difference to the lives of people with dementia and their carers and so we will involve people with dementia and carers in a range of activities to enable them to shape the delivery of the strategy and to provide feedback.

Please see more information about this in 'Dementia Statements and Co-production Approach'.

Foreword

Our vision is that throughout Coventry and Warwickshire people with dementia and their carers are supported, included, and respected so they can enjoy the best possible quality of life and remain independent longer. We will focus on strength-based support, early intervention, enablement, support to live well for longer, and development of personal and community resilience to help people to lead healthy, safe, and fulfilling lives. We will do this by working with communities and those who live with, and are affected by, dementia to improve support and services and ensure people know about the support available. We recognise that people affected by dementia will need help and changing levels of support as the condition ebbs, flows and progresses. This will include support through to end of life, and ongoing support for bereaved families.

The COVID-19 pandemic has been particularly challenging for people with dementia and their carers. Whilst we know there have been many examples of excellent care and support, we also know many people have experienced significant challenges including social isolation, lack of engagement in meaningful and enjoyable activities, and concerns about accessing services. This has further increased the health inequalities that existed before the pandemic.

Although dementia diagnosis rates were improving prior to the COVID-19 pandemic, we still need to do more to encourage and support people to come forward for a memory assessment if they have concerns about their memory. The benefits of receiving a timely diagnosis include access to treatment, support, and services. Many local organisations, groups and individuals are working to become dementia-friendly, which has done a great deal to reduce the stigma associated with dementia. We are confident that as we work towards achieving our strategy, we will be able to ensure more people receive support following a diagnosis of dementia which will help them to live well and remain at home and independent for longer.

The strategy shows our strong commitment to supporting family and friends who provide care and support for a loved one with dementia. This is important because, without support, informal carers are at risk of isolation and experiencing poor health outcomes. The links between the Dementia Strategy and strategies that focus on carers will help to ensure carers of people living with dementia are well supported.

Cllr Margaret Bell

Portfolio Holder for Adult Social Care and Health

Warwickshire County Council

Dementia Statements

The key priorities described in this strategy are in line with the Alzheimer’s Society’s Dementia Statements. These reflect what people with dementia have said are essential to their quality of life. Find out more about the Dementia Statements [here](#):

Dementia Statement	Key priority in the strategy that will help achieve the statement
We have the right to be recognised as who we are, to make choices about our lives including taking risks, and to contribute to society. Our diagnosis should not define us, nor should we be ashamed of it.	Diagnosing Well, Supporting Well, Living Well
We have the right to continue with day to day and family life, without discrimination or unfair cost; to be accepted and included in our communities, and not live in isolation or loneliness.	Diagnosing Well, Supporting Well, Living Well
We have the right to an early and accurate diagnosis; and to receive evidence-based, appropriate, compassionate, and properly funded care and treatment, from trained people who understand us and how dementia affects us. This must meet our needs, wherever we live.	Diagnosing Well, Supporting Well, Living Well, Training Well
We have the right to be respected and recognised as partners in care; provided with education, support, services, and training which enables us to plan and make decisions about the future.	Diagnosing Well, Supporting Well, Living Well, End of Life, Training Well
We have the right to know about and decide if we want to be involved in research that looks at cause, cure and care for dementia, and be supported to take part.	All priorities

Co-production approach to development and delivery of the Dementia Strategy

An extensive engagement programme was undertaken to ensure the views of people with dementia and carers were included in the development of this strategy.

We will continue to work with people affected by dementia to ensure they are able to contribute to activities, projects and / or work programmes to support achievement of the Strategy Delivery Plan.

People with dementia and carers will also be supported to be involved in monitoring progress towards achieving the strategy through, for example, sharing their experiences and providing their feedback on services. This will help to ensure that the strategy makes a real difference to people affected by dementia. We will work to provide a range of opportunities such as through focus groups, interviews, questionnaires or 'mystery shopper' type activities to enable people to take part in a way that suits them.

If you are affected by dementia and wish to get involved, please email:

Warwickshire

peoplestrategyandcommissioning@warwickshire.gov.uk

Coventry

socialcarecommissioning@coventry.gov.uk

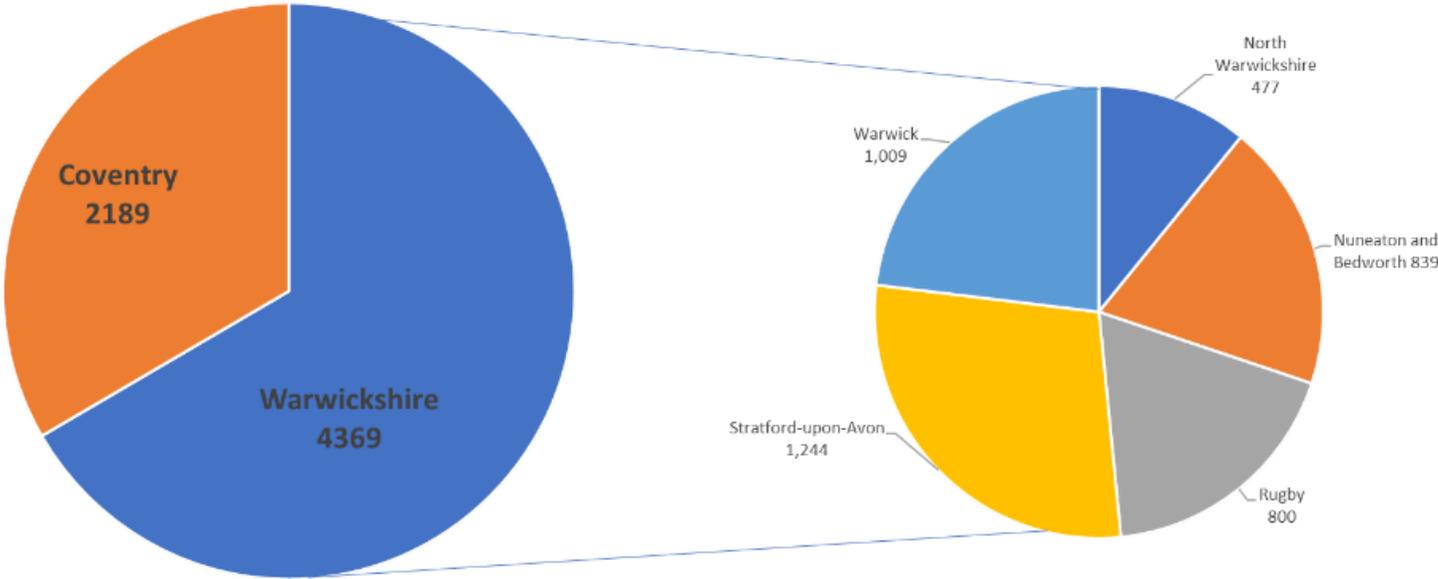
Key data about people living with dementia in Coventry and Warwickshire

Communications will design this section which will make the numbers more visual and easier to understand

There are 2,189 people in Coventry and 4,369 in Warwickshire with a dementia diagnosis.

Number of people with a diagnosis of dementia in Coventry and Warwickshire

Number of people with a recorded dementia diagnosis



Source: NHS digital Recorded Dementia Diagnoses - NHS Digital

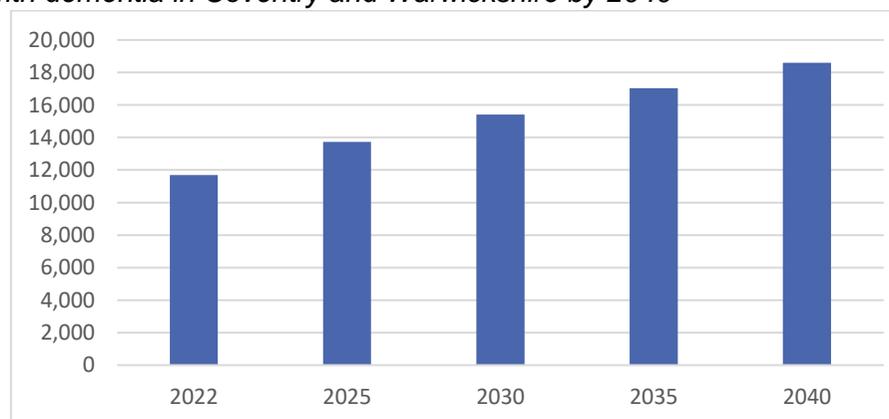
It is estimated that a higher number of people are living with dementia in Coventry and Warwickshire than those who have been diagnosed, and that by 2040 there will be 4,882 people with dementia living in Coventry and 13,721 in Warwickshire¹.

Estimated number of people living with dementia in Coventry and Warwickshire currently and in future years.

	2022	2025	2030	2035	2040
Coventry	3,690	3,831	4,193	4,490	4,882
Warwickshire	8,087	9,907	11,227	12,549	13,721
North Warwickshire	883	1,150	1,337	1,473	1,638
Nuneaton and Bedworth	1,548	1,858	2,069	2,234	2,383
Rugby	1,317	1,690	1,950	2,121	2,337
Stratford-on Avon	2,463	2,813	3,255	3,716	4,055
Warwick	1,876	2,322	2,670	2,968	3,234
Coventry and Warwickshire total	11,777	13,738	15,420	17,039	18,603

Source: NHS digital Recorded Dementia Diagnoses - NHS Digital and Poppi, 2022

Projected increase in people living with dementia in Coventry and Warwickshire by 2040

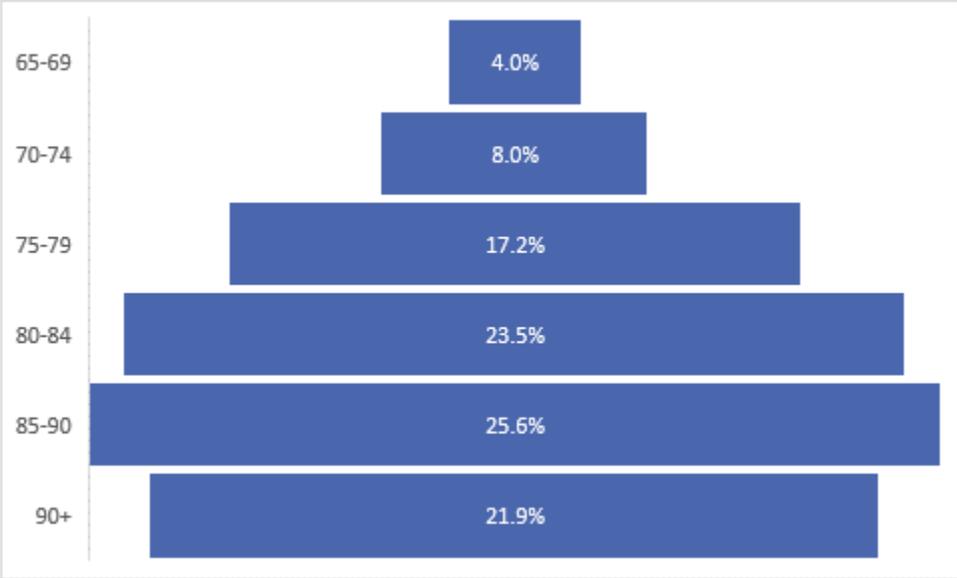


Source: NHS digital Recorded Dementia Diagnoses - NHS Digital and Poppi, 2022

¹ Reasons for the higher prevalence rate against diagnosis rate include the point at which people seek a diagnosis after onset of dementia, personal choice over whether to seek formal diagnosis, time taken to undertake necessary full assessment (particularly in younger people and more complex presentations) and public understanding of symptoms and when to seek assessment. The strategy discusses various ways Coventry and Warwickshire are seeking to increase dementia diagnosis rate to the national target of 66.7%.

Risk of developing dementia increases with age, and therefore most people with dementia are in older age groups. However, dementia can occur at any age. While data only cover diagnosed dementia for people over 65, it is estimated that currently 76 people in Coventry and 158 people in Warwickshire under 65 have early onset dementia (PANSI 2022).

Spread of the over 65 dementia population in each age group in Coventry and Warwickshire



Approach to development of the strategy

Local Engagement

This strategy has been developed following engagement with a wide range of stakeholders, including people living with dementia, carers, and practitioners; to understand the issues facing those affected by dementia and the barriers to overcoming these challenges. The engagement reports and a summary of how the findings were used to develop the strategy can be viewed at: www.warwickshire.gov.uk/dementia.

This strategy builds on work achieved through Coventry City Council and Warwickshire County Council's previous dementia strategies.

National and Local Policy / Strategic Context

Our work to improve the lives of people affected by dementia through this strategy links to a number of other key programmes of work.

To achieve our ambitions of improving the lives of people affected by dementia, there are national policy frameworks, national and local strategies, and evidence which have been used to develop the strategy and which will support delivery of the strategy. Many of these have involved significant engagement and co-production with practitioners, people living with dementia, and carers. Some of the key references are below:

- [Care Act 2014](#)
- [Coventry and Warwickshire Health and Care Partnership Plans](#)
- [Coventry City Council Plan \(2016-2024\)](#)
- [Coventry Health and Wellbeing Strategy \(2019-2023\)](#)
- [Health and Social Care Integration: Joining up care for people, places and populations \(2022\)](#)
- [National Institute for Health and Care Excellence Guidance \(NICE\) \(2018\) Dementia: assessment, management and support for people living with dementia and their carers \(NG97\)](#)
- [NHS Long Term Plan \(2019\)](#)
- [People at the Heart of Social Care: adult social care reform \(2022\)](#)
- [Prime Minister's Challenge on Dementia 2020 \(2015\)](#)
- [Tackling Social Inequalities in Warwickshire \(2021-2030\)](#)
- [Warwickshire County Council Plan \(2022-2027\)](#)
- [Warwickshire's Health and Wellbeing Strategy \(2021-2026\)](#)
- [Coventry and Warwickshire's Carers Strategy \(to be published 2023/24 with reference to this strategy\)](#)

At the time of publication, we are awaiting details of a new national 10 Year Plan for Dementia from government, due in late 2022. Actions from this will be reflected in annual delivery plans.

Coventry and Warwickshire's Living Well with Dementia Strategy Priorities

We plan to achieve the strategy aims by focussing on the following six priorities, which are aligned to the national priorities of The Well Pathway for Dementia:



Priority One: Reducing the risk of developing dementia

We will promote and support healthy lifestyles, aiming to reduce people's risk of developing dementia.

Priority Two: Diagnosing Well

We will work to ensure people receive a timely, accurate diagnosis of dementia and that they are linked in with support soon after diagnosis.

Priority Three: Supporting Well

We will work to ensure people living with dementia and their family and carers have access to safe, high-quality support and care, that is strengths-based and personalised.

Priority Four: Living Well

We will work to ensure people affected by dementia can live in safe and accepting communities, where they can access a range of support services and enjoyable and meaningful activities.

Priority Five: End of Life care

We will work to ensure people with dementia are supported to die with dignity in the place of their choosing, and that their families are supported.

Priority Six: Training Well

We will work to ensure training and awareness opportunities are offered to support communities to increase their awareness of dementia, and that staff who work with people affected by dementia have access to appropriate, accredited training.

Challenges and response to the COVID-19 pandemic

We recognise the challenges that the COVID-19 pandemic has brought for people affected by dementia. This strategy aims to work to overcome these and build on some of the positive developments that have emerged. This includes:

- Individualised and flexible assessment and support options delivered in a way that suits the people receiving the service, and
- The option of virtual support (whether online or by phone) and activities alongside face-to-face support where this is possible, which has provided a wider choice of wellbeing programmes involving arts, music, and physical activity.

Delivery of the Strategy

The Dementia Strategy Board will oversee the development of a Delivery Plan to support achievement of the strategy. This will be updated annually with a focus on activities and targets for the following year.

The Delivery Plan will be reviewed every six months and achievements monitored by the Dementia Strategy Board. This will ensure we remain on track to achieving the strategy, including identifying any additional funding required, and sources of funding. It will also enable us to modify or develop the strategy if necessary, for example to reflect policy changes coming from the national 10 Year Plan for Dementia due to be published in late 2022.

The Strategy Board includes representatives from:

- Warwickshire County Council (WCC)
- Coventry City Council (CCC)
- Coventry and Warwickshire Partnership Trust (CWPT)
- Coventry and Warwickshire Clinical Commissioning Group (CCG) / Integrated Care System (ICS)²
- South Warwickshire Foundation Trust (SWFT)
- George Eliot Hospital (GEH)
- University Hospitals Coventry and Warwickshire (UHCW)
- Voluntary sector organisations including Alzheimer's Society, Dementia UK/ Admiral Nurses, Age UK and Carers' Trust
- People living with dementia and their carers

Working groups will be established focusing on individual priorities and will include practitioners from a range of organisations. Where possible people with dementia and carers will also be involved (directly or indirectly).

The working groups will report on progress into other local groups and Boards as appropriate. This may include the Health and Care Partnership Boards, Joint Commissioning Boards, Health and Wellbeing Board, Corporate Boards and Cabinet.

² The Integrated Care System (ICS) across Coventry and Warwickshire (from July 2022) will see the development of new partnerships between the organisations that meet health and care needs across an area. The ICS will help to coordinate services and plan in a way that improves population health and reduces inequalities between different groups. This will improve the health and care of people affected by dementia.

Key measures will be developed for each priority area and we will monitor progress towards achieving the strategy by regularly reviewing these key measures.

The Coventry and Warwickshire Carers Strategy is expected to be published in 2023/24 and delivery of the two strategies will be closely linked.

The Delivery Plan will address issues that may exist in particular areas across Coventry and Warwickshire, this will ensure an approach reflective of the particular characteristics of areas and communities. The Delivery Plan will also include a range of actions to be undertaken across Coventry and Warwickshire as well as actions targeted within specific areas as appropriate.

Many of the objectives will need to be achieved through existing funding and partnership working. However, we will also seek additional funding, which will enable us to enhance projects and activities to support achievement of some of the objectives.

Equality Impact Assessment

An initial Equality Impact Assessment has been completed and will be reviewed on a regular basis to ensure we meet our responsibilities in respect to the Equality Act 2010 and the Public Sector Equality Duty. The assessment highlighted there is additional work to do to ensure services and support are inclusive, and that people with protected characteristics are not disadvantaged. An Equality Impact Assessment is a systematic and evidence-based tool, which enables us to consider the likely impact of work on different groups of people, for example people of different ages or people from different ethnic backgrounds. We will look to address inequalities as part of the Delivery Plan.

Priorities

The following pages detail each of the six priorities. For each priority area, we have included a summary statement of the overall aim of the priority. This is followed by background information. A table for each priority shows some of the key developments and highlights in recent years, and a summary of progress to date. The table also shows where we want to get to by the end of the strategy in 2027 and a summary of how we will measure success. We have included both actions we are already working on, and others that we plan to undertake over the next five years. The Delivery Plan for the forthcoming year will be developed annually and will include exactly what actions need to be taken, what organisation / person will lead each action, any funding required, timescales for achieving the actions, and detailed measures of success.

Priority One: Reducing the risk of developing dementia

We will promote and support healthy lifestyles, aiming to reduce people's risk of developing dementia.

Only about a third of people think it's possible to reduce their risk of developing dementia, compared to 81% who think it is possible to reduce their risk of developing diabetes.

Although there are risk factors for dementia that cannot be changed, for example increasing age and genetics, there is strong evidence that the risk of developing dementia can be reduced by leading a healthy lifestyle. Unfortunately, even if people lead very healthy lifestyles, they can still develop dementia, but a healthy lifestyle may help lessen the symptoms for those currently living with dementia.

People can reduce their risk of developing dementia through the following:

- Being more physically active
- Not smoking
- Avoiding harmful use of alcohol
- Being a healthy weight for their height
- Eating a healthy diet
- Reducing salt intake
- Keeping blood pressure, cholesterol, and blood sugar levels in a healthy range.

“What's good for the heart is good for the brain”

There is also strong evidence for the benefits of staying mentally and socially active. Research has found that regularly challenging our brain and staying mentally and socially active can help protect brain health as we age, which can reduce the risk of developing dementia. Activities such as reading, doing puzzles or crosswords, singing or learning a new skill can help us to stay mentally active. Meeting friends or family, joining a club or volunteering can help us to stay socially active. These activities can be a good way to feel happier and more positive in life, relieve stress, reduce loneliness and improve mood, which can all help to look after our brain health.

What we have achieved	Current actions	New actions	How we will measure success
<ul style="list-style-type: none"> Through health awareness campaigns we have raised awareness that the risk of developing dementia can be reduced through healthy lifestyles. NHS Health Checks now include information about ways people can reduce their risk of developing dementia. 	<ul style="list-style-type: none"> Raising awareness of the benefits of healthy lifestyles and of staying mentally and socially active to reduce the risk of developing dementia. Supporting people with Mild Cognitive Impairment and early-stage dementia to access local physical activity on referral services. 	<ul style="list-style-type: none"> We will encourage greater up-take of NHS Health Checks for those aged 40-74. Everyone who has an NHS health check should be made aware that the risk factors for cardiovascular disease are the same as those for dementia. People aged 65-74 should be made aware of the signs and symptoms of dementia and be signposted to memory services if this is appropriate. In our awareness-raising we will include targeted communications and support for those at greater risk (e.g., those with Mild Cognitive Impairment, individuals with learning disabilities and people from Black and Minority Ethnic backgrounds). We will promote opportunities for carers to take part in a range of activities and programmes to enhance their physical and mental health. We will promote and support Making Every Contact Count across Coventry and Warwickshire, enabling practitioners to support their clients/customers/patients to make positive changes to their physical and mental health and wellbeing, and rolling this out across a wider staff group. 	<p>Note that annual measures and targets will be set via delivery plans.</p> <ul style="list-style-type: none"> Reported understanding of ways to reduce the risk of developing dementia will increase by 30% between 2022 and 2027. Dementia risk reduction messages in at least 10 local public health campaigns per year by 2024. Commitment from all relevant organisations to regularly deliver dementia risk reduction messages.

Priority Two: Diagnosing Well

We will work to ensure people receive a timely, accurate diagnosis of dementia and that they are linked in with support soon after diagnosis.

An estimated 11,700 people in Coventry and Warwickshire live with dementia (NHS Digital, 2022), but only around 56% of these have a formal diagnosis. A diagnosis can help people prepare and come to terms with the changes that are happening and access a wide range of support for themselves and their families. It can also help loved ones to understand and support them. There is no cure for dementia but for some types of dementia it is possible to take medication to slow the progression of the disease. With support, people can live well with dementia and keep doing activities they enjoy.

Norman's story (diagnosed with dementia at 50)

"An early diagnosis of dementia is so, so important. Once diagnosed, I knew what I was up against. As they say: know your enemy. If I hadn't been diagnosed early and I hadn't been seen by consultants on a regular basis, I wouldn't be as well as I am today. I don't know what my future holds, but at least I'm prepared for it"

What we have achieved	Current actions	New actions	How we will measure success
<ul style="list-style-type: none"> Increasing dementia diagnosis rates from 48% of those estimated to have dementia in 2012 to 56% in 2022, through 	<ul style="list-style-type: none"> Raising public awareness of dementia and the benefits of receiving a prompt diagnosis, with particular focus on communities who may not 	<ul style="list-style-type: none"> As part of the Integrated Care System (ICS) framework, develop partnerships to identify where additional dementia diagnosis can be carried out, and what resources are needed (training, after-care 	Note that annual measures and targets will be set via delivery plans.

<p>specific schemes and increasing the capacity of the service.</p> <ul style="list-style-type: none"> • Many General Practitioners (GPs) are now trained to offer memory assessments for less complex cases, meaning patients can be diagnosed closer to home by staff they already know. • The introduction of post-diagnosis support packs and sessions for people newly diagnosed with dementia, and for their carers. • The Memory Assessment Service in Coventry has achieved Memory Service National Accreditation Programme (MSNAP) accreditation, recognising a high-quality service. 	<p>recognise dementia or where there may be cultural challenges to seeking a diagnosis.</p> <ul style="list-style-type: none"> • Expanding training and support for GPs on undertaking diagnosis of dementia where appropriate. • Ensuring that carers' perspectives and information regarding their loved one is considered as part of the diagnostic process. • Working towards ensuring every practitioner who tells a person they have dementia being appropriately trained and offering post-diagnosis support. • Ensuring that everyone receiving a diagnosis of dementia receives a health care plan at the point of, or soon after, diagnosis, which is then reviewed annually. • Ensuring everyone is given the option of being referred to a post-diagnosis dementia support service and is followed up within three months of diagnosis. 	<p>support) if diagnosis is carried out in a setting other than memory clinic.</p> <ul style="list-style-type: none"> • Ensure waiting times for a diagnosis of dementia return to pre-pandemic levels and then, that they are made within 6 weeks of referral (unless specialist assessments/investigations are required). • The joint Coventry and Warwickshire memory assessment service work to achieve MSNAP accreditation. • Through our local networks, ensure that culturally sensitive assessment and diagnosis is developed and embedded across all dementia support services. • Work towards ensuring that everyone with a dementia diagnosis has a Named Worker and that this role is well understood. • Improve access to support through better integration of services supporting people at all stages of dementia. • Publish information on the key dementia services and support available, making it easier for people affected by dementia and different health and care practitioners to access the same information to improve care for people with dementia • Promote and strengthen the links between hospitals and Memory Assessment Services to help to identify and support diagnosis of dementia and those affected by dementia after a diagnosis has been made. • Review pathways from the Memory Service for those diagnosed instead with Mild Cognitive Impairment or another mental health issue, via other CWPT services. 	<ul style="list-style-type: none"> • Dementia diagnosis rate reaches at least 66.7%, meaning two-thirds of those likely to have dementia have a formal diagnosis (national target). • Everyone diagnosed will be offered an annually reviewed health care plan following diagnosis. • Everyone will be offered post-diagnosis support and followed up 3 months later if they decline. • Reported satisfaction with the assessment process and post-diagnosis support offer will increase by 40% between 2022 and 2027.
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Priority Three: Supporting Well

We will work to ensure people living with dementia and their families and carers have access to safe, high-quality support and care that is strengths-based and personalised.

Post-diagnosis support helps the person living with dementia and their family come to terms with the diagnosis, access information, ask questions, find support and plan for the future. We will ensure people are linked in with sources of support and information as early after diagnosis as possible. Coventry City Council (CCC), Warwickshire County Council (WCC) and Coventry and Warwickshire Clinical Commissioning Group (CCG) fund other organisations to provide post-diagnostic support locally.

"I can get through this as long as I keep getting your support and your calls, I don't trust just anyone coming to my house"

Feedback from individual with dementia using Dementia Day Opportunities service (delivered by Age UK Coventry and Warwickshire) during the COVID-19 pandemic

What we have achieved	Current actions	New actions	How we will measure success
<ul style="list-style-type: none"> Everyone receiving a dementia diagnosis is offered a 'Next Steps' course. Further post-diagnostic support is available as needed from Dementia Connect (delivered by Alzheimer's Society and funded by WCC, CCC and CCG) and Admiral Nurses (delivered by Dementia UK and funded by Coventry and Rugby GP Alliance). The Dementia and Memory Assessment Service in Coventry has achieved MSNAP, recognising high 	<ul style="list-style-type: none"> Raising awareness of post-diagnosis support available for people affected by dementia; ensuring that information is easily accessible, available in a range of formats, and easy to understand. This involves bespoke campaigns within different parts of the community as required. Improving access to services for people with dementia and their carers, ensuring geographical equity of commissioned services. Promoting key dementia support services to GPs and other practitioners, so that they can ensure everyone has the chance to be linked in with a support service at diagnosis. 	<ul style="list-style-type: none"> Ensure people with dementia can access an annual review of their health care plan. This facilitates access to other sources of support and services and checking in, in case of any changes. Ensure understanding and appropriate implementation of the Mental Capacity Act in care homes. Redesign the dementia day opportunities offer, introducing a blended model with greater choice of how support is delivered. Work to develop the broader provision of, and raise awareness of, person-centred respite support, appropriate to 	<p>Note that annual measures and targets will be set via delivery plans.</p> <ul style="list-style-type: none"> Everyone diagnosed will be offered an annually reviewed health care plan following diagnosis. Everyone will be offered post-diagnosis

<p>quality memory assessment services.</p> <ul style="list-style-type: none"> • The use of Assistive Technology (MySense technology used by South Warwickshire Foundation Trust (SWFT), and the Dementia Promoting Independence Service (used in Coventry) to enable people with dementia to live at home independently for longer. • Arden Grove has been developed to deliver specialist housing with care for people living with dementia, based on the Eden Alternative model, and other dementia residential provision has been strengthened. • South Warwickshire Foundation Trust have been delivering specialist nursing assessment and support through their Admiral Nursing Service since 2019, providing psychological and practical support to patients, families, and health professionals. From 2021 this provision was extended to provide outreach visits on discharge from hospital. 	<ul style="list-style-type: none"> • Ensuring carers of people with dementia are supported by the local Carer Wellbeing and Support Service. • Developing the Living Well with Dementia website, including a map of services: www.warwickshire.gov.uk/dementia • Supporting the voluntary sector to restore and maintain local support services e.g., Dementia Cafes, as several of these were affected by the COVID-19 pandemic. • Developing and promoting the use of assistive technology to help people stay independent for longer, such as AskSARA, and MySense. • Working towards reducing the digital divide by supporting people with dementia and their carers to use a range of technology to enjoy a variety of virtual activities and stay connected to others. • Working towards equality of access to dementia support services for everyone, including people with protected characteristics. For example, ensuring that services are accessible and culturally appropriate and that there is geographical equity of commissioned services. • Building on good practice and sharing learning, such as the Admiral Nurse role in Warwick Hospital who supports advanced care planning for patients going back home to the community. 	<p>the needs of the person with dementia, to ensure carers can have a break.</p> <ul style="list-style-type: none"> • Stimulate the market to increase the supply of high-quality care and support for people with dementia in line with increasing numbers, including for those with challenging and/or complex behaviours. • Further improve the offer of domiciliary care, housing with care and residential and nursing care to meet the needs of people with dementia, towards equity with those without dementia. This may include enhancing training and skills for the workforce, having a named clinical lead for dementia in care homes, forming multidisciplinary teams to support care homes, maximising places available, and reducing unplanned hospital admissions, delayed discharges, and placement breakdowns. • Review and strengthen the dementia pathway for people with dementia entering and leaving hospital to minimise moves and changes in environment for people with dementia. 	<p>support and followed up 3 months later if they decline.</p> <ul style="list-style-type: none"> • Reported satisfaction with the post-diagnosis support offer will increase by 40% between 2022 and 2027. • Reduction in acute/emergency attendances to hospital due to dementia (baseline to be identified in Year 1). • Care providers report greater confidence in supporting people with dementia (baseline to be identified in Year 1).
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Priority Four: Living Well

We will work to ensure people affected by dementia can live in safe and accepting communities, where they can access a range of support services and enjoyable and meaningful activities.

There is a lot we can do to support people living with dementia to live in safe and accepting communities, promoting understanding and acceptance and taking steps to make our communities more accessible. This means ensuring people with dementia remain able to access community provision such as shops, pubs, restaurants, libraries, entertainment venues and leisure centres, but also sometimes means bespoke activities for people living with dementia and their carers.

Case Study: Books on Prescription and your local library

Coventry and Warwickshire Library Services have been members of the Coventry and Warwickshire Dementia Action Alliance (DAA) since 2013. Libraries can help people to keep learning, stay connected and reduce isolation and loneliness. Many of the library staff work directly with the public and have become Dementia Friends, (these are individuals who have taken the time to learn more about what it is like to live with dementia and the small things that they can do to make a difference) to enable them to recognise and support the different needs of people with dementia who wish to use the library. Libraries offer [Books on Prescription - dementia](#) collections to help people improve their health and wellbeing. All the books are selected and recommended by healthcare professionals and follow National Institute for Health Care Excellence (NICE) guidance. Books on dementia include personal stories and support for relatives and carers. Visit www.warwickshire.gov.uk/booksonprescription or <https://www.coventry.gov.uk/info/126/libraries/3218/libraries-core-services/7> to find out more about how to borrow Books on Prescription or ask at your local library.

What we have achieved	Current actions	New actions	How we will measure success
<ul style="list-style-type: none"> • People in Coventry and Warwickshire can access information, details of services, and support via the Warwickshire Living Well with Dementia website. • Reading Well Books on Prescription offers a selection of self-help books about dementia in all local public libraries. Over 90 organisations have signed up to the Coventry and Warwickshire Dementia Action Alliance (DAA). These organisations have committed to raising awareness of dementia and supporting people with dementia in their communities. 	<ul style="list-style-type: none"> • Ensuring a variety of support services and activities are available for people with dementia and their carers to maintain their mental and physical health and wellbeing. These will be appropriate and tailored, considering age, ethnicity, religion, gender, and sexual orientation. • Working to ensure ongoing support from a dementia support service (whether Dementia Connect, Admiral Nurses or another support service) for people with dementia and for carers to offer practical and emotional support. Practical support can include supporting with issues such as obtaining a Power of Attorney, claiming carers allowance, applying for a blue badge, managing behaviour that challenges, and planning for end of life. • Promoting a range of arts and cultural opportunities (for example, access to singing, music, arts, and crafts activities) to people living with dementia and their carers. • Promoting Dementia Friends, supporting an increase in numbers in Coventry and Warwickshire each year. • Ensuring information about benefits and entitlements are communicated to people living with dementia and they are supported to apply for these. • Reviewing how we can deliver accessible and effective support services and activities following the COVID-19 pandemic. 	<ul style="list-style-type: none"> • Work to ensure equity of provision of community-led services where this is possible (e.g., for non-commissioned services). • Ensure people can access an annual review of their health care plan. This facilitates access to other sources of support and services and checking in, in case of any changes. • Promote dementia-friendly events and activities to encourage people living with dementia to continue to engage in a range of interests, hobbies, and activities. • Work closely with social prescribing colleagues to ensure people living with dementia and their carers are encouraged and supported to continue to take part in the activities they enjoy, and to develop new interests. • Establish a Dementia Forum across Coventry and Warwickshire to ensure closer links with, and support for, voluntary sector dementia support groups. 	<p>Note that annual measures and targets will be set via delivery plans.</p> <ul style="list-style-type: none"> • An additional 3,000 Dementia Friends in Coventry and Warwickshire by 2027. • An additional 20 organisations join the Dementia Action Alliance. • 30% increase in how dementia-friendly people feel the local community is between 2022 and 2027.

Priority Five: End of Life Care

We will work to ensure people with dementia are supported to die with dignity in the place of their choosing, and that their families are supported.

This priority focusses on end of life, which includes conversations about, and planning for end of life, as early as possible and appropriate. Dementia is a terminal condition and a quarter of people over the age of 65 will die with some form of dementia. In care homes, around two thirds of people will have dementia as a factor in their death. A person in the later stages of dementia may have symptoms or other conditions that make it harder to know when they are nearing the end of their life. This uncertainty can make it difficult to plan and put things in place.

Where possible, the person with dementia should be encouraged to plan for the future as soon as possible, including arranging for someone like a family member or friend to make decisions if that is needed. This is called a 'Lasting Power of Attorney' (LPA). Planning can also include stating preferred care options. This can help to reassure families that they are doing what's best for their loved one. People with dementia should be encouraged to talk about their wishes for end-of-life care while they are able to do so; for this reason it is important that end of life discussions start early in a person's journey with dementia, during the 'living well' phase where possible. Staff should understand individual wishes and preferences to ensure people are able to die with dignity and respect, free from pain and in a place they have chosen.

Case Study: End of life care

A gentleman was diagnosed with young onset dementia. Shortly after his diagnosis, his healthcare team encouraged him and his family to consider advance care planning while he was able to be fully involved in the conversations. He was clear that he didn't want to be in hospital unnecessarily if things got worse and his condition wasn't reversible, and that in this case he would not want to be resuscitated. A ReSPECT form (Recommended Summary Plan for Emergency Care and Treatment) was completed so these wishes were known to whoever was caring for him at the time.

A few years later, his condition deteriorated and he needed to be admitted to the dementia ward at the hospital. He had developed vascular complications and after review by doctors and vascular surgeons, it was clear there were no surgical options and he was likely to be in the last days of his life. This was discussed with his family who agreed that, as hospital care was needed to manage his pain, he should stay on the dementia ward where his needs were understood, and he felt settled. As the ward did not frequently provide end of life care, the staff were supported by the specialist palliative care team to provide symptom control for his pain and the Admiral Nurses to provide appropriate care to ensure his dignity was maintained. Though he died in hospital, having spoken about his wishes early on, his family were able to ensure the environment was peaceful and he was surrounded by the people and things that were most important to him.

What we have achieved	Current actions	New actions	How we will measure success
<ul style="list-style-type: none"> A range of training has been delivered for professionals to support end of life care for people with dementia. This includes Dementia Awareness Training for Palliative Care Teams and Hospices; Training in Advance Care Plans for Community Dementia staff, and a workshop on end-of-life care for people with Dementia for clinicians from a variety of services. Dementia support services and Next Steps groups are able to support people in making end of life plans. 	<ul style="list-style-type: none"> Rolling out communication training to all those working with people with dementia and their families to improve skills in talking about end-of-life care. Working with system partners to offer advance care planning conversations as soon as possible and appropriate after a person receives their dementia diagnosis. Promote linking this to retirement conversations with major employers. Ensuring that all patients with a dementia diagnosis are offered a conversation regarding ReSPECT (Recommended Summary Plan for Emergency Care and Treatment), which details a person's care and treatment recommendations, and is completed as appropriate (including taking account of the care setting they are in). Other needs and wishes should also be discussed and documented. These records should follow the patient, for instance if they go into hospital. Promoting the availability of Admiral Nurses, as experienced dementia nurses, who can provide support to people living with dementia and their families in complex situations, including end of life. Ensure that Admiral Nurses are trained in end-of-life care and communication. Ensuring that families of people with dementia are supported as their loved one approaches the end of life and after the death of their loved one. This will include support with financial advice after the death of their loved one. 	<ul style="list-style-type: none"> Ensure the Ambitions for Palliative and End of Life Care Framework (2021 – 2026) and the local system-wide (meaning health, social care, and voluntary sector) End of Life Strategy are used to build accessible, responsive, effective and personal care needed at the end of life Link with the work on the creation and use of an Integrated Care Record and other digital solutions to ensure improved coordination of care (including care at end of life) to ensure clinicians can access information to support appropriate care and understand people's wishes. Ensure equitable access to specialist palliative care, including hospices and NHS teams. Link with hospices and community teams within Coventry and Warwickshire Partnership Trust (CWPT) and South Warwickshire Foundation Trust (SWFT) to help ensure the specialist palliative care service offer is inclusive to needs of people with dementia. Ensure staff who care for people in care homes have access to training in End-of-Life care. For Admiral nurses / specialist palliative care teams / other appropriate teams to support nursing homes in offering advance care plans and ReSPECT forms to all residents to ensure appropriate treatment decisions and prevent inappropriate admissions. 	<p>Note that annual measures and targets will be set via delivery plans.</p> <ul style="list-style-type: none"> Everyone diagnosed will be offered advance care planning. Everyone with dementia will have EPaCCS (Electronic Palliative Care Coordinating Systems) records. Alignment to measures developed as part of the broader End of Life strategy, for people with dementia.

Priority Six: Training Well

We will work to ensure training and awareness opportunities are offered to support communities to increase their awareness of dementia. We will work to ensure staff who work with people with dementia and their carers have access to appropriate, accredited training.

There are a range of excellent training and awareness-raising opportunities available in a variety of formats (such as online training, webinars, face to face courses) and for different audiences, such as the general public, informal carers, and practitioners. Many are free of charge. It is important that people are made aware of these training opportunities and encouraged to undertake them.

For staff, the national Department of Health and Social Care [Dementia Training Standards Framework](#) aims to ensure quality and consistency in dementia education and training. It details the essential skills and knowledge necessary for workers in health, social care, and housing.

The Care Certificate is the minimum training induction requirement for anyone entering health and social care, including staff across all commissioned services. The Care Quality Commission (CQC) require evidence of compliance with the Care Certificate for all providers registered with CQC. For other providers it is regarded as best practice and should be a minimum requirement. The Care Certificate can be accessed through the [Social Care Information and Learning Service](#) (SCILS).



Virtual Dementia Tour

What we have achieved	Current actions	New actions	How we will measure success
<ul style="list-style-type: none"> • There are now over 37,000 Dementia Friends in Coventry and Warwickshire. • Dementia Awareness sessions have been delivered to a range of organisations including Local Authorities, library services, voluntary sector, dental practices, general practices, hospices, and leisure centres. • Frontline social care staff (including care home staff) can access training via Social Care Information and Learning Service (SCILS). 	<ul style="list-style-type: none"> • Promoting dementia training and awareness opportunities to people affected by dementia, and people with an interest in dementia to increase awareness of dementia. • Offering further opportunities for people to participate in the Virtual Dementia Tour, which offers a sensory experience of what it is like to live with dementia. • All Local Authority staff and commissioned service staff being encouraged to undertake dementia awareness training. • Monitoring that everyone starting work in health and social care completes the relevant units of the Care Certificate. 	<ul style="list-style-type: none"> • Collate and promote a range of courses aimed at carers, delivered by local and national groups. • Develop a tiered learning platform on the Living Well with Dementia website to ensure access to learning opportunities is as easy as possible. • Local Authorities will aim to ensure that all direct and commissioned service staff who are working with people living with dementia are trained to at least Tier 2 of the Dementia Training Standards Framework. • Promote via our quality assurance processes that all home and residential care staff working with people living with dementia receive mandatory training. This should be equivalent to Tier 3 of the Dementia Training Standards Framework. • Develop Dementia Champions provider network for specialist and non-specialist residential and nursing homes, promoting good practice and person-centred care for all residents living with dementia. 	<p>Note that annual measures and targets will be set via delivery plans.</p> <ul style="list-style-type: none"> • An additional 3,000 Dementia Friends in Coventry and Warwickshire by 2027. • Increase in number of local authority and commissioned services staff trained to at least Tier 2 (baseline to be set in Year 1).

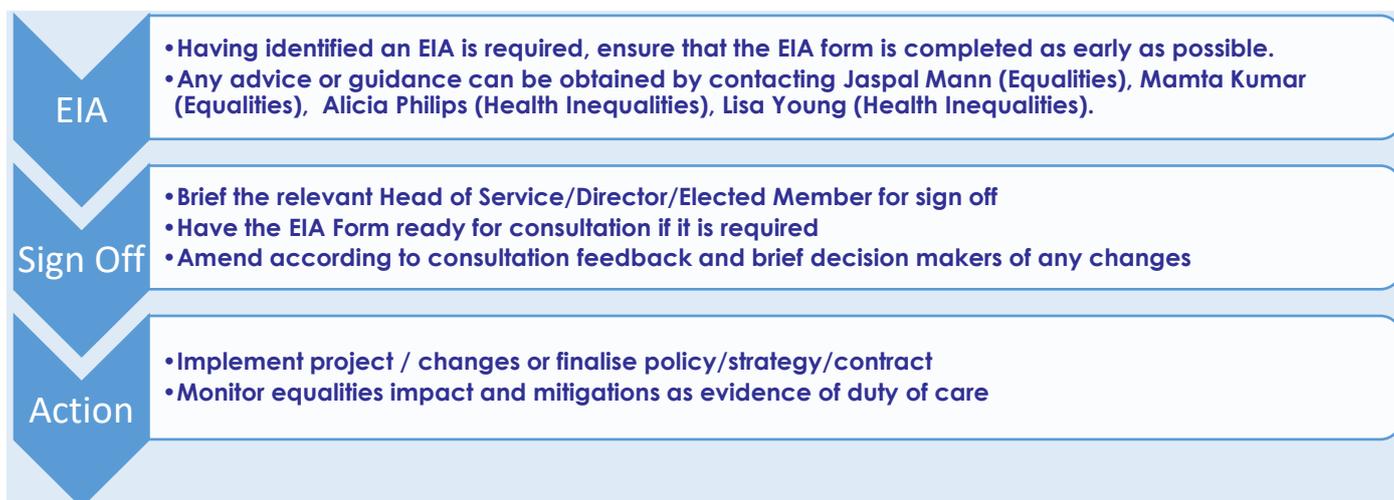
Logos of all of the partner agencies will be on this page:

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Appendix 2 EQUALITY IMPACT ASSESSMENT (EIA)



Title of EIA	Coventry and Warwickshire Dementia Strategy	
EIA Author	Name	Sharon Atkins
	Position	Joint Commissioning Manager Dementia and Mental Health
	Date of completion	15.09.2022
Head of Service	Name	Jon Reading
	Position	Head of Commissioning and Quality
Cabinet Member	Name	Cllr Mal Mutton
	Portfolio	Adult Services



PLEASE REFER TO [EIA GUIDANCE](#) FOR ADVICE ON COMPLETING THIS FORM

SECTION 1 – Context & Background

1.1 Please tick one of the following options:

This EIA is being carried out on:

- New policy / strategy
- New service
- Review of policy / strategy
- Review of service
- Commissioning
- Other project (*please give details*)



1.2 In summary, what is the background to this EIA?

Coventry and Warwickshire's Living Well with Dementia Strategy is being refreshed, based on engagement and alignment with national and local strategies and guidance. As part of this, we wish to ensure services and support are inclusive to maximise access and uptake by people with dementia and their carers. We also wish to further develop work to raise awareness and understanding of dementia, and access to, and uptake of services in specific groups with protected characteristics as we know this has been challenging to date and has the potential to further increase inequalities in health.

1.3 Who are the main stakeholders involved? Who will be affected?

- People Living with Dementia and their families
- The City Council
- Coventry and Warwickshire Integrated Commissioning Board
- Warwickshire County Council

1.4 Who will be responsible for implementing the findings of this EIA?

Sharon Atkins – Joint Commissioning Manager for Dementia and Mental Health

SECTION 2 – Consideration of Impact

Refer to guidance note for more detailed advice on completing this section.

In order to ensure that we do not discriminate in the way our activities are designed, developed, and delivered, we must look at our duty to:

- Eliminate discrimination, harassment, victimisation, and any other conflict that is prohibited by the Equality Act 2010
- Advance equality of opportunity between two persons who share a relevant protected characteristic and those who do not
- Foster good relations between persons who share a relevant protected characteristic and those who do not

2.1 Baseline data and information

Appendix 2 EQUALITY IMPACT ASSESSMENT (EIA)



Please include a summary of data analysis below, using both your own service level management information and also drawing comparisons with local data where necessary (go to <https://www.coventry.gov.uk/factsaboutcoventry>)



There are an estimated 3,690 people in Coventry living with dementia, and this number is predicted to increase to 4,882 by 2040. While most people with dementia are over 65, dementia can affect people of all ages, and over 80 people aged under 65 in Coventry are estimated to be living with dementia.

Many people with dementia are older, and prevalence of dementia increases with age although younger people are still affected.

Carers can be any age, but a range of potential issues could be faced at different ages, e.g. older carers may be experiencing their own health issues and younger carers may be juggling demands of working and caring for family members.

People with dementia are more likely to be over 65 and, in consequence, can face both ageism and the stigma associated with dementia. For example, older people may be denied access to the full range of mental health services that are available to younger adults. This could particularly disadvantage people with dementia who are more likely to be over 65 and require mental health support. People may delay seeking a diagnosis, assuming symptoms are just part of ageing.

Dementia is a disability, according to domestic law and international convention. Thousands of people who responded to the All-Party Parliamentary Group (APPG) inquiry agreed that they see dementia as a disability. However, they told the APPG that society is lagging in this understanding and failing to uphold the legal rights of people with dementia. (APPG, 2019)

People with dementia may have other conditions which impact the timing of when they come forward for a diagnosis, when and how they receive a timely diagnosis and their ability to access services.

A study undertaken by PHE in 2015 found that Learning disability and lower socio-economic position both increased the prevalence of dementia. We need to consider numbers of people with dementia who have learning disabilities and the impact of this on diagnosis and support.

Carers of people with dementia may have disabilities and we need to consider how these carers can be supported.

Data regarding transgender individuals with dementia is not widely available or collected by commissioned services. This needs to be addressed.

Data on ethnicity of people diagnosed with dementia is sparse. Data from NHS digital shows that 68% of people do not have ethnicity recorded 28% are white, 3.5% Asian or Asian British. (<https://digital.nhs.uk/data-and-information/publications/statistical/recorded-dementia-diagnoses/November-2020>)

Alzheimer's Society report that 3 per cent of people with dementia are from BAME communities – around 25,000 people. This number is expected to double by 2026 with the steepest increase expected in South Asian communities.

- Research suggests BAME communities often face delays in dementia diagnosis and barriers in accessing services.

<https://www.alzheimers.org.uk/for-researchers/black-asian-and-minority-ethnic-communities-and-dementia-research>



A PHE study in 2015 found Dementia was more common in people from African American, black-Caribbean, or Hispanic backgrounds. There was no information published on people from south-east Asian backgrounds.

A new study led by researchers from University College London has looked at difference in dementia diagnosis rates among different ethnic groups in the UK. The paper, published (on Wednesday 8 August 2018) in the journal *Clinical Epidemiology*, suggests that black men and women are more likely to develop dementia than their white counterparts. (Published in Alzheimer's research UK, 2016) <https://www.alzheimersresearchuk.org/ethnic-differences-dementia-diagnosis-up/>

An article in Nursing Times (2018) found that rates of dementia diagnosis are higher among black ethnic groups compared to white and Asian groups in the UK. They found that the incidence of dementia diagnosis was 25% higher among black women than white women, and 28% higher among black men than white men. Asian women and men were 18% and 12% less likely than white women and men, respectively, to have a dementia diagnosis. <https://www.nursingtimes.net/news/research-and-innovation/likelihood-of-dementia-higher-among-black-ethnic-groups-08-08-2018/>

Deaths from people in certain ethnic groups from dementia have been widely reported as being very high during the coronavirus pandemic.

Understanding and acceptance of dementia is limited / challenging in some cultures. Lower rates of diagnosis than expected in some BAME groups may affect access to support services. The number of people with dementia from BAME communities is expected to increase seven times by 2051. However, people from BAME communities are less likely to be diagnosed or receive post-diagnosis support (All-Party Parliamentary Group on Dementia, 2013). People from BAME groups face significant barriers when accessing support. There is a lack of culturally sensitive dementia services and families can be reluctant to use services that do not meet cultural or religious needs. Risk of dementia is greater in some BAME groups due to increased cardiovascular risk factors and diabetes etc.

A study conducted by PHE in 2015 found that there was no information to help understand if religion changed the prevalence of dementia.

Dementia is more common in women (PHE, 2015). Data by age and sex indicates that from the ages 65 to 79 years the split between males and females with dementia is quite similar. However, from the age of 80 ~~years~~ females make up an increasing proportion of recorded dementia prevalence.

Early onset dementia

Dementia is 'young onset' when it affects people of working age, usually between 30 and 65 years old. It is also referred to as 'early onset' or 'working-age' dementia. In 2019, the crude recorded prevalence of dementia in those aged under 65 for Coventry and Rugby was 2.54 per 10,000 population slightly below the England figure. *Source: Fingertips/PHE/Dementia profiles, August 2020*

Priority three of the Strategy "Supporting Well" includes the specific aim of raising awareness of and adapting services to work towards equality of access for people with protected characteristics.

Appendix 2 EQUALITY IMPACT ASSESSMENT (EIA)



2.2 On the basis of evidence, complete the table below to show what the potential impact is for each of the protected groups.

- Positive impact (P),
- Negative impact (N)
- Both positive and negative impacts (PN)
- No impact (NI)
- Insufficient data (ID)

**Any impact on the Council workforce should be included under question 2.6 – not below*

Protected Characteristic	Impact type P, N, PN, NI	Nature of impact and any mitigations required
Age 0-18	NI	
Age 19-64	P	<p>Many people with dementia are older, and prevalence of dementia increases with age although younger people are still affected.</p> <p>Carers can be any age, but a range of potential issues could be faced at different ages, e. g older carers may be experiencing their own health concerns, younger carers may be juggling demands of working and caring for younger family members with their caring role.</p> <p>Implementation of the strategy is expected to have positive benefits through e.g. encouraging younger people to come forward if concerned about memory. Addressing misconception that dementia only affects older people. Healthy lifestyles incorporated into the strategy can reduce risk of early onset dementia. Support to younger adult carers will help reduce the burden on this group.</p>
Age 65+	P	<p>Most people with dementia and many carers are aged 65 and over. The strategy will support raising awareness that people can live well with dementia - positive examples / case studies. Develop use of arts programmes and other interventions such as Cognitive Stimulation Therapy (CST) Opportunity with re- commissioning dementia support services to consider unique challenges and therefore support required</p> <p>Implementation of the strategy will help to establish whether all service settings likely to be accessed by people with dementia are accessible, whether or not they have additional disabilities.</p>
Disability	P	Dementia is now recognised as a disability which may help people access services, benefits, and support.

Appendix 2 EQUALITY IMPACT ASSESSMENT (EIA)



		There is an opportunity through re-commissioning dementia support services to consider unique challenges and therefore support required
Gender reassignment	P	The needs assessment and engagement provide an opportunity to consider how we can improve meeting needs of all potential clients. Implementation the Strategy should improve our understanding of the particular needs of those individuals living with dementia or their carers who have had gender reassignment
Marriage and Civil Partnership	NI	
Pregnancy and maternity	NI	
Race (Including: colour, nationality, citizenship ethnic or national origins)	P	Implementing the strategy will open up opportunities to raise awareness of issues concerning dementia for BAME groups. Use of a range of images of people of a people from different backgrounds on resources. Translation of resources into different languages. Need to build on risk reduction messages for all but tailored to specific at-risk groups. The needs assessment and engagement provide an opportunity to consider how we can improve meeting the needs of people from different communities.
Religion and belief	ID	A study conducted by PHE in 2015 found that there was no information to help understand if religion changed the prevalence of dementia.
Sex	P	The needs assessment and engagement provide an opportunity to consider how we can improve how we best meet needs of both males and females. There is an opportunity to consider how we work with local voluntary groups to support people with dementia in the community, recognising that there are many more females than males living with dementia.
Sexual orientation	ID	A study conducted by PHE in 2015 found that there was no information to help understand if sexual orientation changed the prevalence of dementia.

HEALTH INEQUALITIES

2.3	Health inequalities (HI) are unjust differences in health and wellbeing between different groups of people which arise because of the conditions in which we are born, grow, live, work and age. These
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	<p>conditions influence our opportunities for good health, and result in stark differences in how long we live and how many years we live in good health.</p> <p>Many issues can have an impact: income, unemployment, work conditions, education and skills, our living situation, individual characteristics, and experiences, such as age, gender, disability, and ethnicity</p> <p>A wide range of services can make a difference to reducing health inequalities. Whether you work with children and young people, design roads or infrastructure, support people into employment or deal with welfare benefits – policy decisions and strategies can help to reduce health inequalities</p> <p>Please answer the questions below to help identify if the area of work will have any impact on health inequalities, positive or negative.</p> <p>If you need assistance in completing this section, please contact: Alicia Philips or Lisa Young in Public Health for more information. More details and worked examples can be found at https://coventrycc.sharepoint.com/Info/Pages/What-is-an-Equality-Impact-Assessment-(EIA).aspx</p>	
Question	Issues to consider	
2.3a What HIs exist in relation to your work / plan / strategy	<ul style="list-style-type: none"> ● Explore existing data sources on the distribution of health across different population groups (<i>examples of where to find data to be included in support materials</i>) ● Consider protected characteristics and different dimensions of HI such as socio-economic status or geographical deprivation 	
	<p>Response:</p> <p>Service users and residents living with dementia who are council funded will have met eligibility criteria under The Care Act (2014), specifically that their needs relate to a physical or mental impairment effecting a number of aspects of their daily life. Services are designed to support individuals in meeting their health and wellbeing outcomes – including health inequalities - and meet individual support needs in a tailored way. Such care is delivered equitably, fairly and in a proportionate way, recognising the individual need of the person.</p> <p>There is not an equal likelihood of having good physical and mental health in later life in England. Risks for poor physical health and poor mental health are higher for people in lower socioeconomic groups, some BAME groups and for women. https://www.instituteofhealthequity.org/resources-reports/inequalities-in-mental-health-cognitive-impairment-and-dementia-among-older-people/inequalities-in-mental-health-cognitive-impairment-and-dementia-among-older-people.pdf People from households with the lowest income are 30% less likely to take part in physical activity.</p>	



	<p>Women, people from BAME communities, carers, people with a history of unemployment or unstable, poorly paid employment, manual workers, and people living in areas of deprivation are at a greater risk of isolation, physical inactivity, and lack of mental stimulation because of the environments and circumstances in which they live. Poverty and low income, living alone, caring responsibilities, living in poor housing conditions or degraded neighbourhoods, lack of access to green space and learning opportunities prevent older people from remaining socially connected, physically active and mentally stimulated in later life, increasing their risks of developing poor mental health, MCI and dementia.</p> <p>https://www.instituteofhealthequity.org/resources-reports/inequalities-in-mental-health-cognitive-impairment-and-dementia-among-older-people/inequalities-in-mental-health-cognitive-impairment-and-dementia-among-older-people.pdf</p>
<p>2.3b How might your work affect HI (positively or negatively).</p> <p>How might your work address the needs of different groups that share protected characteristics</p>	<p>Consider and answer below:</p> <ul style="list-style-type: none"> ● Think about whether outcomes vary across groups and who benefits the most and least, for example, the outcome for a woman on a low income may be different to the outcome for a woman a high income ● Consider what the unintended consequences of your work might be
	<p>Response:</p> <p>a. Potential outcomes including impact based on socio-economic status or geographical deprivation</p> <p>The Strategy will support improved diagnosis through Priority 2 “Diagnosing Well” with timely and accurate diagnosis leading to appropriate health and wellbeing support. Good diagnostic services will be available across the Coventry and Warwickshire footprint. Continued engagement with people with dementia and their carers will further illuminate additional disadvantages and inform service development and delivery.</p> <p>b. Potential outcomes impact on specific socially excluded or vulnerable groups e.g. people experiencing homelessness, prison leavers, young people leaving care, members of the armed forces community.</p> <p>People with dementia and their families can be subject to stigma and thus specific social exclusion. Priority three of the Strategy “Supporting Well” includes the specific aim of raising awareness of and adapting services to work towards equality of access for people with protected characteristics.</p>



Implementation of the strategy will consider significant cost of living increases and how service offers for people with dementia and their carers are adapted to offer support as appropriate.

2.4 Next steps - What specific actions will you take to address the potential equality impacts and health inequalities identified above?

- Ensure EIA is considered and regularly reviewed as part of development and delivery of Delivery Plans.
 - Themed workshops / meetings will be considered for multi-agency professionals to review current support service offer at various stages of the Dementia pathway and design future offer. To have a focus on issues identified in the EIA in relation to impact on individuals with protected characteristics and health inequalities.
 - Consideration to be given as to how current and potential users of dementia support services can be engaged with and involved in co-production.
 - Engagement approach to consider the barriers for some groups to participate in surveys / focus groups etc and identify ways in which this may be overcome. For example, consider sessions with BME community, sessions with people with a learning disability and / or physical disability and groups with socio-economic disadvantage to health equality.
-
- Continue to review data relating to delivery of Dementia support services in terms of access by people with protected characteristics

DIGITAL INCLUSION

- 2.5** The Covid-19 pandemic accelerated the uptake of digital services nationally, whereby people who are digitally enabled have better financial opportunities, can access new information and are better connected to others (Lloyds Consumer Digital Index, 2021). However, for those who are digitally excluded, the digital divide has grown during the last two years, and without intervention people will be left behind with poorer outcomes across employment, health and wellbeing, education and service access. Some people are more likely to be excluded including: older people, people from lower income households, unemployed people, people living in social housing, disabled people, school leavers before 16 with fewer educational qualifications, those living in rural areas, homeless people, or people who's first language is not English ([NHS Digital.](#))
- Some of the barriers to digital inclusion can include lack of:
- **Access** to a device and/or data
 - **Digital skills**



	<ul style="list-style-type: none"> • Motivation to get online • Trust of online safety <p>Digital exclusion is not a fixed entity and may look different to different people at different times.</p> <p>Example 1. Person A, has access to a smartphone and monthly data and can access social media apps, however lacks the digital skills and confidence, and appropriate device to create a CV, apply for jobs and attend remote interviews, and/or access educational and skills resources.</p> <p>Example 2. Person B, is digitally confident and has their own laptop, however due a lower household income and other financial priorities, they cannot afford their monthly broadband subscription and can no longer get online to access the services they need to.</p> <p>Example 3. Person C has very little digital experience and has heard negative stories on the news regarding online scams. Despite having the financial resource, they see no benefit of being online and look for alternatives whenever possible. A new council service requires mandatory online registration, therefore they do not access it.</p> <p>It is important that we all consider how we can reduce digital inequalities across our services, and this may look very different depending on the nature of our work.</p> <p>Please answer the questions below to help identify if the area of work will have any impact on digital inequalities, positive or negative.</p> <p>If you need assistance in completing this section please contact: Laura Waller (<i>Digital Services & Inclusion Lead, CCC</i>). More details and worked examples can be found at https://coventrycc.sharepoint.com/Info/Pages/What-is-an-Equality-Impact-Assessment-(EIA).aspx</p>	
Question	Issues to consider	
<p>2.5 What digital inequalities exist in relation to your work / plan / strategy?</p>	<ul style="list-style-type: none"> • Does your work assume service users have digital access and skills? • Do outcomes vary across groups, for example digitally excluded people benefit the least compared to those who have digital skills and access? • Consider what the unintended consequences of your work might be. 	
	<p>Response: Implementation of the dementia strategy does not assume that all stakeholders are proficient in digital skills, nor does it assume digital access. It is appreciated that some will be potentially disadvantage in this respect.</p>	

Appendix 2 EQUALITY IMPACT ASSESSMENT (EIA)



<p>2.5b How will you mitigate against digital inequalities?</p>	<ul style="list-style-type: none"> • If any digital inequalities are identified, how can you reduce these? For e.g. if a new service requires online registration you may work with partner organisations to improve digital skills and ensure equitable processes are available if someone is unable to access online.
	<p>Response: To address inequities in digital access people living with dementia and their carers will be involved using a wide variety of media including written material telephone conversations etc. Should Cabinet Member approve the establishment of the Dementia Hub this will be a rich source of information and advice both through visits to the building and through outreach work. As part of strategy implementation communication with stakeholders will be monitored to try and ensure that harder to reach stakeholders do not remain additionally disadvantaged. The strategy includes work towards reducing the digital divide by supporting people with dementia and their carers to use technology to enjoy a range of virtual activities and stay connected with others</p>

2.6 How will you monitor and evaluate the effect of this work?

As part of strategy implementation communication with stakeholders will be monitored to try and ensure that harder to reach stakeholders do not remain additionally disadvantaged.

2.7 Will there be any potential impacts on Council staff from protected groups?

There may be positive impacts on council employees who are carers of people living with dementia, however, numbers are not currently available

You should only include the following data if this area of work will potentially have an impact on Council staff. This can be obtained from: Nicole.Powell@coventry.gov.uk

Headcount:

Sex:

Age:

Female	
Male	

Appendix 2 EQUALITY IMPACT ASSESSMENT (EIA)



Disability:

Disabled	
Not Disabled	
Prefer not to state	
Unknown	

16-24	
25-34	
35-44	
45-54	
55-64	
65+	

Ethnicity:

White	
Black, Asian, Minority Ethnic	
Prefer not to state	
Unknown	

Religion:

Any other	
Buddhist	
Christian	
Hindu	
Jewish	
Muslim	
No religion	
Sikh	
Prefer not to state	
Unknown	

Sexual Orientation:

Heterosexual	
LGBT+	
Prefer not to state	
Unknown	

3.0 Completion Statement

As the appropriate Head of Service for this area, I confirm that the potential equality impact is as follows:

- No impact has been identified for one or more protected groups
- Positive impact has been identified for one or more protected groups
- Negative impact has been identified for one or more protected groups
- Both positive and negative impact has been identified for one or more protected groups

4.0 Approval

Signed: Head of Service:	Date: 15.09.2022
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Appendix 2 EQUALITY IMPACT ASSESSMENT (EIA)



Name of Director: Pete Fahy	Date sent to Director: 20.09.22
Name of Lead Elected Member: Councillor Mal Mutton	Date sent to Councillor: 20.09.22

Email completed EIA to equality@coventry.gov.uk



Public report
Cabinet Member

Cabinet Member for Adult Services

3 October 2022

Name of Cabinet Member:

Cabinet Member for Adult Services - Councillor M Mutton

Director approving submission of the report:

Director of Adult Services and Housing

Ward(s) affected:

All wards

Title:

Developing a Coventry Dementia Hub

Is this a key decision?

No - although the proposals affect more than two electoral wards, the impact is not expected to be significant.

Executive summary:

The provision of day opportunities serves an important function in meeting our responsibilities to Adults with Care and Support needs and their carers in two primary ways:

1. They provide meaningful activities including stimulation, and recreation, these activities all help with promoting the health and wellbeing of people with dementia
2. They provide valuable daytime respite for informal carers

The Council directly provides or commissions day opportunities for older adults which are all currently centre-based services and activities.

The expectations of people with care and support needs are changing and this became more evident during the COVID-19 pandemic. Historically day centres providing solely 'in centre' support were the only available support model. However, user and carer expectations have changed and for many the provision of centre-based support complemented with the opportunity to undertake activities, with support, outside of the centre environment better achieves the outcomes that people are seeking. Any changes to the services being proposed support the intentions and the priorities for the proposed Coventry and Warwickshire Living Well with Dementia Strategy 2022-2027.

In response to this the future model for delivery of daytime services to support people with dementia and their carers has been developed in partnership with a range of stakeholders including people with lived experience.

Following an informal engagement exercise with all stakeholders, and primarily with a focus group from Alzheimer's Society (people with dementia) who co designed the vision for the Coventry Dementia Hub, on 2nd September 2021 permission was granted to commence a formal public consultation on the proposal to redevelop Maymorn Day Centre into a single Dementia Hub for Coventry.

This progression to a more blended approach accelerated over the Covid-19 pandemic. This was a direct response to the closure of centres during the first lockdown in spring 2020 and subsequent partial reopening of centre-based day opportunities. The City Council has worked with providers to adapt day centre-based approaches, to pilot a blended approach that optimises safe interaction but minimises the risk of Covid-19 infection: an issue that many service users and carers remain concerned about despite the lifting of all national restrictions.

The Council has responded to this changing need by, on an interim basis, operating its centre-based activities over fewer days and providing alternatives where required. This interim position has been piloted at Maymorn Day Centre which previously operated centre-based activities over 5 days but since summer 2020 has reduced centre-based services to 3 days a week and introduced a pilot offering an Outreach Service. This interim outreach pilot has proven popular with many people preferring to use the outreach service instead of the traditional day service, and as a result a formal consultation exercise commenced on 20th September 2021 to look to progress the hub and mainstream this new model of support.

This report presents the outcomes of both public and staff consultations and seeks permission to implement the development of a dementia hub.

Recommendations:

Cabinet Member for Adult Services is recommended to:

- (1) Approve the development of a Dementia Hub and the reduction of traditional services to 2 days per week, creating 96 hours of outreach and drop in opportunities.
- (2) Approve the adaptation of the Maymorn building and commencement of building works to create the hub.

List of Appendices included:

The following appendices are attached to the report:

Appendix A - Equality Impact Assessment

Background papers:

None

Other useful documents

No

Has it or will it be considered by scrutiny?

No

Has it or will it be considered by any other council committee, advisory panel or other body?
No

Will this report go to Council?
No

Report title: Developing a Coventry Dementia Hub

1. Context (or background)

1.1 The provision of day opportunities serves an important function in meeting our responsibilities to Adults with Care and Support needs and their carers in two primary ways;

- They provide meaningful activities including stimulation and recreation, these activities all help with promoting the health and wellbeing of people with dementia.
- They provide necessary and valuable daytime respite for informal carers.

The Council directly provides or commissions day opportunities for older adults which are all currently centre-based. Maymorn Day Centre is a Council operated Monday to Friday service for people with advanced dementia with a long history of providing a valued service. Prior to the pandemic, the centre was significantly underutilised; at the time of the closure, only 29 people were accessing the service utilising approximately 66 spaces per week despite the fact we had the capacity to provide 125 spaces per week. Of the 29 that attended, only 9 returned, 5 passed away, 6 went into residential, 5 chose to remain at home and 4 have needs that changed (bed bound, fluctuating health/dementia). The data reflects a cohort of people with advanced dementia whereby traditional day services would not be sustainable for them longer term. The long days was considered a negative factor as often attendees would fall asleep by the afternoon or experience sundowning, whereby people with dementia can become distressed and unsettled late afternoon into the evening. However, for carers, this provided a full day's respite for them. Since the service reopened, shorter days were accommodated to alleviate this barrier however there continues to be a low uptake on the traditional day service option. The current day service is supporting 15 people utilising 23 of the available 45 spaces. The pilot outreach is supporting 21 people, the new model will enable more people to access the broader range of services.

1.2 The centre initially closed in March 2020 to protect vulnerable service users during the Covid-19 Pandemic. The service partially reopened in August 2020, gradually increasing to 3 days a week. At the time and since, the number of referrals received do not necessitate a need to reopen 5 days a week.

1.3 However, the expectation of people with care and support needs are changing to a position where the opportunity to engage in bespoke and meaningful activities both on and off site is preferred. This move to a more blended approach was accelerated over the Covid-19 pandemic when, in response to the closure of day services and the subsequent partial reopening of centre-based opportunities, it was identified that the Council needed to review its model of support

1.4 The council responded to this changing position by operating the Maymorn Centre on fewer days and as a pilot, providing alternatives to centre-based activities delivered through the provision of outreach over 5 days. The outreach service offers 1-1 support to people with dementia to participate in activities of their choosing either in their own homes or in the community e.g. going for a walk. This offer has helped the development of a more diverse day opportunity offer which is delivering better outcomes for our service users. This outreach pilot has been hugely successful with service users reporting a significant improvement in their health and well-being. The outreach service provides one to one interaction with support workers and is person centred. There are currently 21 people in receipt of outreach services equating to 58 hours per week

- 1.5 For some carers, access to a 5-day support is essential to their well-being, providing meaningful respite from their caring responsibilities or enabling them to combine paid employment with their caring role. The new model still provides opportunities 5 days a week but would offer a mixture of personalised support including outreach, drop-in sessions which can be half day or 1-2 hour sessions along with access to 2 days a week traditional day service. The new model provides for more options for people with dementia that are not currently available.
- 1.6 As an organisation, and since the reopening of day facilities there has been a conscious move away from any one person accessing 5 days of traditional day service which often entails a very long day when transport and the day service provision itself are factored in. The new model ensures that each person's package of care is personalised to their needs, providing a variety of day opportunities rather than the limited sole offer of traditional day services.
- 1.7 Following Cabinet Member approval on 2nd September 2021, a formal public consultation was undertaken for 3 months from 20th September 2021. There was an overwhelmingly positive response to the consultation with a higher proportion of respondents wanting to see the new model implemented.
- 1.8 There were delays in starting the staff consultation due to attempts to secure additional funding which if we had been successful may have changed the core staffing model to be consulted on. The staff consultation began on 10th May 2022 and ended 9th June 2022 and included several 1:1's with staff who wanted to discuss their personal circumstances. All issues raised during the staff consultation were responded to on Friday 12th August 2022 in line with our HR processes.
- 1.9 The proposals within this report are to develop a dementia hub at the Maymorn Centre in response to changing service demands and engagement with partners, people with dementia and their families/carers. Should proposals be approved the hub's core offer would provide a range of day opportunities, traditional, drop-in sessions and outreach. The core offer would include multi-agency working and sessions held at the hub would be provided by a range of health, voluntary and council led services. It is anticipated that the hub would start small and develop over 2 to 3 years. Over this period of time, it is intended that the social space will be the 'go to' place for people with dementia to socialise and access support. The hub would have different services offering a variety of flexible sessions for people with dementia and/or their carers and be accessible to hard-to-reach groups who are currently not accessing services.
- 1.10 The Enhanced Offer: The hub's core offer will be further enhanced by the investment of £150,000 from the Coventry and Warwickshire Integrated Care Board which will fund additional posts for a period of 12 months. This includes capacity to operate a dementia friendly café, posts to work with young onset dementia and a lifestyle co-ordinator to focus on developing opportunities for carers and to target under-represented groups in the community. These additional roles are expected to be in place from April 2023 and will be reviewed in January 2024 to inform future funding.
- 1.11 In the event that funding, through ICB or elsewhere is not available beyond April 2023 this capacity would cease and the only the core offer would continue.

2. Options considered and recommended proposal

2.1 Option One: Implement a Dementia Hub (Recommended Option)

- 2.1.1 This option is to develop Maymorn into a single Dementia Hub for Coventry, extending the service to include outreach, drop-in sessions over 5 days and retain 2 days of the existing traditional day service model.
- 2.1.2 Coventry would be one of the first cities in the country to develop a Dementia Hub, offering a single location for those with dementia and their carers to find support and information. One of the key benefits of the hub is that it would be accessible to people pre and post diagnosis of dementia. This would lend itself towards timelier diagnoses as the reputation of the hub grows, it will become the recognisable go to place for all queries relating to dementia. Those reluctant to seek help or acknowledge that there is an issue, could pop into the café/social space where they can get to know people and build the courage to seek help and support from variety of people including buddy support from people successfully living with dementia. Key members of the Alzheimer's Society Focus Group are particularly keen to provide this buddy/peer support, often referring to how they wish they had had the opportunity when they were first diagnosed, to meet someone who was living proof that you can live well with dementia.
- 2.1.3 This is the favoured option of those who use the service with 61% of respondents being in favour of this option and the opportunities it presents to broaden the types of services available for people with dementia and their carers. The demand for traditional days services has declined steadily over the years prior to the pandemic and there is no indication that the demand for traditional day services would increase again.
- 2.1.4 Developing the hub to reach its full potential will take a period of time and commitment. Other partner organisations are keen to work with the council to develop the offer at the hub and are in support of the intention to broaden the service offer for people with dementia beyond traditional day services. The Hub will also lend itself to multi agency usage with various organisations able to utilise the shared office space and rooms for hire to run their own events along with a café and social space at the heart of the hub for people living with dementia.

2.2 Option Two: Retain the standard operating model (Not Recommended)

- 2.2.1 This option is to retain the existing five-day service for people with advanced dementia.
- 2.2.2 Only 30% of respondents preferred this option and based on usage it is no longer a viable option as due to the low level of demand for this model it would generate significant inefficiencies if it was to continue.
- 2.2.3 Despite numerous attempts being made to increase the number of referrals, including raising the profile of the service with social workers and other professionals who make referrals, there has not been sufficient demand to warrant the continued operation of a 5 day service.

3. Results of consultation undertaken

- 3.1 The public consultation was undertaken over a 12-week period from 20th September 2021 to 12th December 2021. A range of stakeholders with an interest in Dementia Services were included in the consultation which was available as an online and paper survey. Paper surveys were issued to service users and their carers at Maymorn Day Centre and a supply was provided at the University Hospital of Coventry and Warwickshire and a number of libraries across the city. The online survey was available via the Council's Let's Talk website and the link was also emailed directly to various stakeholders including Adult Social Care staff and Carer's Trust who have sent weekly emails to their members (over 5000).

- 3.3 Although the focus group from Alzheimer’s actively co-designed the vision for the Dementia Hub, they also received the surveys directly. Whilst some of those with advanced stage dementia who would benefit from the services could not be consulted directly, due to issues of capacity, a concerted effort was made to try and reach carers and professionals involved who could offer a voice on their behalf.
- 3.4 We received 162 responses, a breakdown of those responses are as follows;

Respondent Category	Percentage of overall respondents
Carer of a person with Dementia	24%
Local Resident	30%
Staff working with people with Dementia	36%
Representatives of Organisations	10%
Preferred Option	Percentage of overall respondents
Option A	61%
Option B	30%
No preference	9%

- 3.5 The staff consultation took place from Tuesday 10th May 2022 and concluded Thursday 9th June 2022.

4. Timetable for implementing this decision

- 4.1 Should Cabinet Member endorse the recommendation it is proposed that implementation will have a phased approach. To manage the transition with existing employees and undertake recruitment to the additional ICB funded posts are likely to be during the same period. Overall, it is likely to be April 2023 before the first phase of the Dementia Hub is operational and with a 2–3-year plan to enable the hub to reach its maximum potential.
- 4.2 The building works would commence from November 2022 to extend the building to create a separate area for the traditional day service, additional car parking spaces and to refurbish the kitchen. This work is expected to take five months to complete.

5. Comments from Chief Operating Officer (Section 151 Officer) and Director of Law and Governance

5.1 Financial Implications

- 5.1.1 It is proposed to fund capital works at the Maymorn building at a cost of £300,000; from existing Disabled Facilities Grant resources within the Better Care Fund Pool. The revised core day service offer of outreach, drop in and traditional day services will be funded from existing revenue budgets.
- 5.1.2 The enhanced offer is funded via a one-off grant allocation that has been secured from ICB to fund the running of the café, young onset dementia and lifestyle coordinators posts for a 12 month period. There are robust plans in place to mitigate the fallout of this time limited funding, including identifying alternative funding sources or the cessation of these specific enhanced services.
- 5.1.3 As referenced above alternative funding will continue to be explored for both the enhanced offer proposed as well as any further enhancement opportunities that are identified as the hub evolves.

5.2 Legal Implications

- 5.2.1 The Care Act 2014 requires Local Authorities to meet the assessed eligible needs of service users and their carers, but discretion over how to do so. This enables each Authority to respond to the needs of its population and provide personalised care and / or support packages to individuals and to be creative in the development of support options to meet the needs of its population.
- 5.2.2 The Council also has a responsibility to consult with stakeholders in connection with proposed significant changes to service delivery to ensure that anyone who may be affected is able to contribute to the discussions and comment upon the proposals.
- 5.2.3 Public authority decision makers are under a non-delegable ongoing duty to have regard to the need to eliminate discrimination, advance quality of opportunity and foster good relations between persons who share a protected characteristic and decision makers must be consciously thinking about these aims as part of the decision-making process, with rigour and an open mind. The duty is to have "due regard" not to achieve a result, but to the need to achieve these goals and consideration must be given to the potential adverse impacts and the measures (if any) that are available to minimise any discriminatory effects. Members must therefore ensure that they read all relevant papers to enable them to assess the risk and extent of any adverse impacts and the ways in which any such risk can be eliminated. This requires more than just an awareness of the equality duty, it requires rigorous analysis by the public authority, beyond broad options. This is important both at this consultation stage and at any point when Members make any final decisions on any proposals that may be presented to them.

6. Other implications

6.1 How will this contribute to the Council Plan (www.coventry.gov.uk/councilplan/)?

- 6.1.1 The development of the Dementia hub supports the Council Plan by contributing to the following objectives:
- Improving the quality of life for Coventry people
 - Improving health and wellbeing
 - Protecting our most vulnerable people
 - Reducing health inequalities
 - Enabling active communities and empowered citizens

6.2 How is risk being managed?

There is a detailed project plan for the development of the Dementia Hub. This will be overseen by the project team with risk escalated as appropriate.

6.3 What is the impact on the organisation?

- 6.3.1 There are no post deletions associated with the proposals contained in this report. Changes to existing roles will be managed through the Council's management of change process.
- 6.3.2 The additional funding of £150,000 via Integrated Care Board will provide new job opportunities for 12 months ranging from lifestyle co-ordinator post, café co-ordinator posts and additional outreach worker posts to focus on young onset dementia.

6.4 Equalities / EIA?

- 6.4.1 An EIA has been undertaken and is attached in **Appendix A**. In summary there are positive and negative impacts to both service users and Council staff with the proposed service changes.
- 6.4.2 The broader range of services will positively impact service users from an age perspective, making the service more accessible to those with young onset and offering more diverse activities to those who access the traditional day service. The reduction of the day service operation will negatively impact the older age group, however this is mitigated by maintaining a day service, on a reduced number of days.
- 6.4.3 The proposed service will positively impact service users Race with an element of the service targeting people living with dementia and their carers from various ethnic minority backgrounds with the aim of setting up culturally sensitive activity sessions.
- 6.4.4 If the demand is there, gender specific sessions will be provided to respect cultural boundaries and enable people to access sessions which they would not be able to if mixed genders. Mixed gender sessions would still be available.
- 6.4.5 It has been identified that the change in work location has a negative impact on employees of the service with disabilities, these can be mitigated by offering the following;
- Additional travel time to reach work locations.
 - Allocating work in locations which are easier to reach/closer to staff home location.
 - Ensure staff are allocated a realistic case load and number of visits required during the working day are achievable.

6.5 Implications for (or impact on) climate change and the environment?

No Known Implications

6.6 Implications for partner organisations?

Partner organisations such as NHS, Arden Memory, Admiral Nurses as well as the voluntary sector e.g. Alzheimer's Society should all benefit from having a single location. The ability to base themselves at the hub, run sessions and work more closely with us can only serve to enhance the quality of services provided to enable a person to live well with dementia.

Report author(s):

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Service: Adult Social Care

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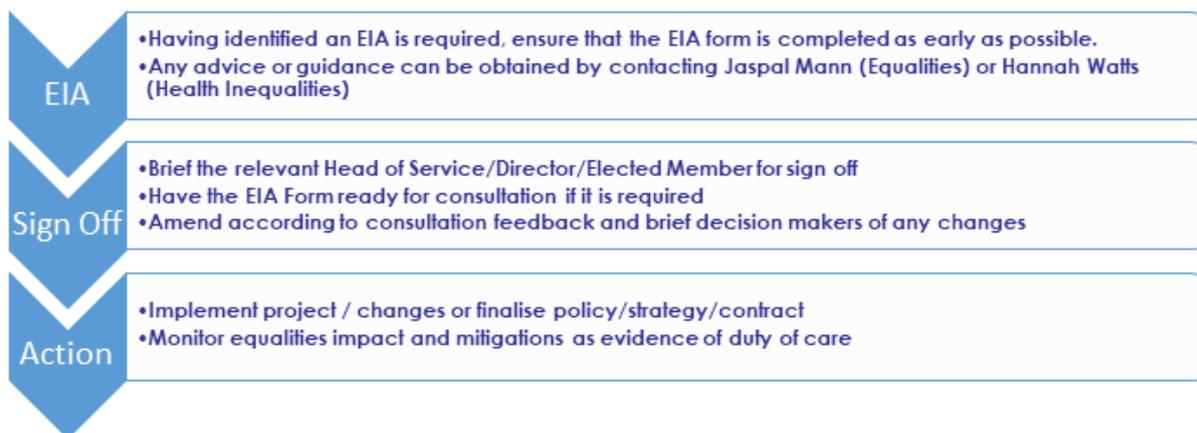
Enquiries should be directed to the above person

Contributor/approver name	Title	Service Area	Date doc sent out	Date response received or approved
Contributors:				
Tracey Denny	Head of Service, localities and Social Care Operations	Adult Social Care	13.07.22	09.08.22
Jon Reading	Head of Commissioning and Quality	Adult Social Care	11.08.22	12.08.22
Lisa Lawson	Adult Services Programme Delivery Manager	Adult Social Care	13.07.22	13.07.22
Diane Jones	Lead Accountant Business Partner	Finance	13.07.22	14.07.22
Claire Angell	Human Resources Business Partner	Human Resources	13.07.22	09.08.22
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Usha Patel	Governance Services Officer	Law and Governance	14.09.22	14.09.22
Names of approvers for submission: (officers and members)				
Finance: Ewan Dewar	Finance Manager		14.07.22	13.09.22
Legal: Janice White	Team leader	Legal Services	07.07.22	05.08.22
Director: Peter Fahy	Director of Adult Services & Housing		14.09.22	14.09.22
Members: Councillor M Mutton	Cabinet member for Adult Services			15.09.22

This report is published on the council's website: www.coventry.gov.uk/meetings

Appendix A - Equality Impact Assessment

Title of EIA		Dementia Hub Consultation
EIA Author	Name	April Ross
	Position	Service Manager
	Date of completion	8 August 2022
Head of Service	Name	Tracey Denny
	Position	Head of Service
Cabinet Member	Name	Councillor Mutton
	Portfolio	Adult Social Care



PLEASE REFER TO [EIA GUIDANCE](#) FOR ADVICE ON COMPLETING THIS FORM

SECTION 1 – Context & Background

1.1 Please tick one of the following options:

This EIA is being carried out on:

- New policy / strategy
- New service
- Review of policy / strategy
- Review of service
- Commissioning
- Other project (*please give details*)

1.2 In summary, what is the background to this EIA?

To convert Maymorn Day Service into a Single Multi agency Dementia Hub for Coventry. Maymorn is an existing 5 day service that has been reviewed with a proposal to develop a new service from the centre. Following both a public and staff consultation it is proposed to implement the

following model; expanding the service to offer an outreach service, a drop in social space and café for people with dementia and reducing the traditional day service to 2 days a week.

1.3 Who are the main stakeholders involved? Who will be affected?

Staff, people living with dementia and their carers.

1.4 Who will be responsible for implementing the findings of this EIA?

April Ross-Service Manager

SECTION 2 – Consideration of Impact

Refer to guidance note for more detailed advice on completing this section.

In order to ensure that we do not discriminate in the way our activities are designed, developed and delivered, we must look at our duty to:

- Eliminate discrimination, harassment, victimisation and any other conflict that is prohibited by the Equality Act 2010
- Advance equality of opportunity between two persons who share a relevant protected characteristic and those who do not
- Foster good relations between persons who share a relevant protected characteristic and those who do not

2.1 Baseline data and information

Please include a summary of data analysis below, using both your own service level management information and also drawing comparisons with local data where necessary (go to <https://www.coventry.gov.uk/factsaboutcoventry>)

There are currently 14 people who access the traditional day service, detailed data cannot be broken down and further due the low numbers making individuals identifiable. 9 are male and 5 are female.

Age group	Male	Female
50-60	2	
60-70		2
70-80		
80-90	7	1
90-100		2

Ethnicity, White British 78.5%, Indian 14%, White Irish 7%

2.2 On the basis of evidence, complete the table below to show what the potential impact is for each of the protected groups.

- Positive impact (P),
- Negative impact (N)
- Both positive and negative impacts (PN)
- No impact (NI)
- Insufficient data (ID)

**Any impact on the Council workforce should be included under question 2.6 – not below*

Protected Characteristic	Impact type P, N, PN, NI or ID	Nature of impact and any mitigations required
Age 0-18	NI	None
Age 19-64	P	<p>The new proposed model will allow broader range of services at both home and within the dementia hub.</p> <p>The broader range of services would be available to people with dementia with some targeting young onset (new service)</p> <p>Outreach, drop in sessions, social space and a café are the broader options not currently available to them at present.</p> <p>Outreach workers will be able to better serve their service users and enrich their lives with social interaction and activities the individual enjoys on a 1 to 1 basis.</p>
Age 65+	PN	<p>The new proposed model will allow broader range of services at both home and within the dementia hub.</p> <p>There would be fewer days of traditional day service but more choice of different services 5 days a week.</p> <p>The broader range of services would be available to people with dementia with some targeting young onset (new service)</p> <p>Outreach, drop in sessions, social space and a café are the broader options not currently available to them at present.</p>

		Outreach workers will be able to better serve their service users and enrich their lives with social interaction and activities the individual enjoys on a 1 to 1 basis.
Disability	P	<p>The new proposed model will allow broader range of services at both home and within the dementia hub.</p> <p>The broader range of services would be available to people with dementia with some targeting young onset (new service)</p> <p>Outreach, drop in sessions, social space and a café would the broader options not currently available to them at present.</p> <p>Outreach workers will be able to better serve their service users and enrich their lives with social interaction and activities the individual enjoys on a 1 to 1 basis.</p> <p>Service Users who have anxiety and become house bound will be able to receive support in their own home.</p>
Gender reassignment	NI	The new service is provided irrespective of gender reassignment for the most vulnerable members of our communities.
Marriage and Civil Partnership	NI	The new service is provided irrespective of marriage and civil partnership for the most vulnerable members of our communities.
Pregnancy and maternity	NI	The new service is provided irrespective of pregnancy and maternity for the most vulnerable members of our communities.
Race (Including: colour, nationality, citizenship ethnic or national origins)	P	An element of the service will be targeting people living with dementia and their carers from various ethnic minority backgrounds with the aim of setting up culturally sensitive activity sessions both at home and within the hub.
Religion and belief	NI	The new service is provided irrespective of religion and belief for the most vulnerable members of our communities.
Sex	P	There may be offers of gender specific sessions to respect cultural boundaries and enable people to access sessions which they would not be able to if mixed genders. Mixed gender sessions would still be available.

Sexual orientation	NI	The new service is provided irrespective of sexual orientation for the most vulnerable members of our communities.
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HEALTH INEQUALITIES

2.3	<p>Health inequalities (HI) are unjust differences in health and wellbeing between different groups of people which arise because of the conditions in which we are born, grow, live, work and age. These conditions influence our opportunities for good health, and result in stark differences in how long we live and how many years we live in good health.</p> <p>Many issues can have an impact: income, unemployment, work conditions, education and skills, our living situation, individual characteristics and experiences, such as age, gender, disability and ethnicity.</p> <p>A wide range of services can make a difference to reducing health inequalities. Whether you work with children and young people, design roads or infrastructure, support people into employment or deal with welfare benefits – policy decisions and strategies can help to reduce health inequalities.</p> <p>Please answer the questions below to help identify if the area of work will have any impact on health inequalities, positive or negative.</p> <p>If you need assistance in completing this section please contact: Hannah Watts (hannah.watts@coventry.gov.uk) in Public Health for more information. More details and worked examples can be found at https://coventrycc.sharepoint.com/Info/Pages/What-is-an-Equality-Impact-Assessment-(EIA).aspx</p>	
Question	Issues to consider	
2.3a What HIs exist in relation to your work / plan / strategy	<ul style="list-style-type: none"> Explore existing data sources on the distribution of health across different population groups (<i>examples of where to find data to be included in support materials</i>) Consider protected characteristics and different dimensions of HI such as socio-economic status or geographical deprivation 	
	<p>Response:</p> <p>People accessing Maymorn already have a diagnosis of dementia which is advanced, the average age is currently 80+ with the usual age related health conditions.</p> <p>The service will have a positive impact in terms of enabling individuals' participation within their community. The vision for the hub is created with people living with dementia, they will be actively involved in shaping the service and its continued developments.</p>	

	The positive impact of the lifestyle co-ordinator who will be targeting hard to reach groups to enable access.
<p>2.3b How might your work affect HI (positively or negatively).</p> <p>How might your work address the needs of different groups that share protected characteristics</p>	<p>Consider and answer below: Consider what the unintended consequences of your work might be</p>
	<p>Response:</p> <p>The proposed model would benefit hard to reach communities, supporting families to care for their loved one with dementia and signpost to other services ensuring accessibility and visibility of services available to them.</p> <p>The social space is accessible and free to all. The building is wheelchair and dementia friendly.</p> <p>Outreach workers going into people’s homes may mean they can observe when individuals are struggling e.g. no heating or food in the home and can alert/sign post to relevant services. The service is citywide and is based on assessed needs, those who do not qualify e.g. self funders will still be able to access the services.</p> <p>The hub would be working more closely with health partners to the benefit of people with dementia e.g. some assessment clinics and forgetfulness courses may operate from the hub. More timely access to health advice.</p> <p>b. Potential outcomes impact on specific socially excluded or vulnerable groups eg. people experiencing homelessness, prison leavers, young people leaving care, members of the armed forces community.</p> <p>Not applicable</p>

2.4 Next steps - What specific actions will you take to address the potential equality impacts and health inequalities identified above?

Each support offer would be tailored to the individual’s assessed needs and that of their carers

Fewer traditional day services offer would be mitigated by the broader range of services such as outreach, drop in sessions, café/social space. Majority of feedback from the consultation was positive and in support of the broader options

Offering gender specific sessions will enable those communities who do not allow females to mix with males to access sessions whilst respecting their cultural ways of living.

Health inequalities; attending day services means they access heat, food and social interaction, fewer days will impact on this however the home environment can be monitored for any risks.

2.5 How will you monitor and evaluate the effect of this work?

Staff Observations, reviews and carers and service user feedback. Use of user-friendly postcard feedback (happy or sad faces pictorial format with free self-addressed envelopes included)

2.6 Will there be any potential impacts on Council staff from protected groups?

Yes, workforce data extracted from Resource Link 1 July 2022 . There will be changes to job title and working location.

The change in work location has a negative impact on those with disabilities, this can be mitigated by offering the following;

- additional travel time to reach work locations;
- allocating work in locations which are easier to reach/closer to staff home location.
- Ensure staff are allocated a realistic case load and number of visits required during the working day are achievable

Travel to the first/last appointment will be within staffs normal travel time to/from work. Any travel required inbetween the first/last appointment will be completed within working hours.

Travel expenses including mileage costs and/or public transport costs will be paid inline with Council policy.

The potential negative impact on those with childcare and caring responsibilities can be mitigated through flexibility with diary management, staff will have the ability to self manage there own diaries.

Running Records [systems] can be accessed remotely via Council provided laptops to remove the need for staff to return to the centre at the end of their shift.

There is no requirement to carry equipment, other than basic items, such as a note pad and pens. System updates can be completed at the end of the working day to avoid the need to carry laptops.

You should only include the following data if this area of work will potentially have an impact on Council staff. This can be obtained from: lucille.buckley@coventry.gov.uk

Headcount:

Sex: Age:

Female	100%
Male	0%
16-24	0%
25-34	8%
35-44	17%
45-54	17%
55-64	50%
65+	8%

Disability:

Disabled	8%
Not Disabled	84%
Prefer not to state	0%
Unknown	8%

Ethnicity: Religion:

Any other	0%
Buddhist	0%
Christian	58%
Hindu	0%
Jewish	0%
Muslim	0%
No religion	25%
Sikh	0%
Prefer not to state	0%
Unknown	17%

White	83%
Black, Asian, Minority Ethnic	17%

Prefer not to state	0%
Unknown	0%

Sexual Orientation:

Heterosexual	83%
LGBT+	0%
Prefer not to state	0%
Unknown	17%

3.0 Completion Statement

As the appropriate Head of Service for this area, I confirm that the potential equality impact is as follows:

No impact has been identified for one or more protected groups

Positive impact has been identified for one or more protected groups

Negative impact has been identified for one or more protected groups

Both positive and negative impact has been identified for one or more protected groups

4.0 Approval

Signed: Head of Service:	Date:
Name of Director:	Date sent to Director:
Name of Lead Elected Member:	Date sent to Councillor:

Email completed EIA to equality@coventry.gov.uk

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Cabinet Member for Adult Services

3 October 2022

Name of Cabinet Member:

Cabinet Member for Adult Services – Councillor M Mutton

Director Approving Submission of the report:

Director of Law and Governance

Ward(s) affected:

None

Title:

Outstanding Issues

Is this a key decision?

No

Executive Summary:

In May 2004 the City Council adopted an Outstanding Minutes System linked to the Forward Plan, to ensure that follow up reports can be monitored and reported to Elected Members. The appendix attached to the report sets out a table detailing the issues on which further reports have been requested by the Cabinet Member for Adult Services, so that she is aware of them and can monitor progress.

Recommendations:

The Cabinet Member for Adult Services is requested to consider the list of outstanding issues and to ask the Member of the Strategic Management Board or appropriate officer to explain the current position on those which should have been discharged at this meeting or an earlier meeting.

List of Appendices included:

Table of Outstanding Issues

Background papers:

None

Other useful documents:

None

Has it or will it be considered by Scrutiny?

No

Has it, or will it be considered by any other Council Committee, Advisory Panel or other body?

No

Will this report go to Council?

No

Report author(s):

Name and job title:

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Enquiries should be directed to the above persons.

This report is published on the council's website: www.coventry.gov.uk/meetings

	Subject	Date for Further Consideration	Responsible Officer	Proposed Amendment to Date for Consideration	Reason for Request to Delay Submission of Report
1 *	Day Opportunities for Adults with Learning Disabilities Further report providing an update on the proposal for Older Peoples Dementia Day Services at Maymorn once the consultation exercise was completed. (Minute 13/21 of the Cabinet Member for Adult Services refers – 17 th March, 2022)	To be confirmed	Director of Adult Services Pete Fahy	3 October 2022	

*Item included on agenda

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