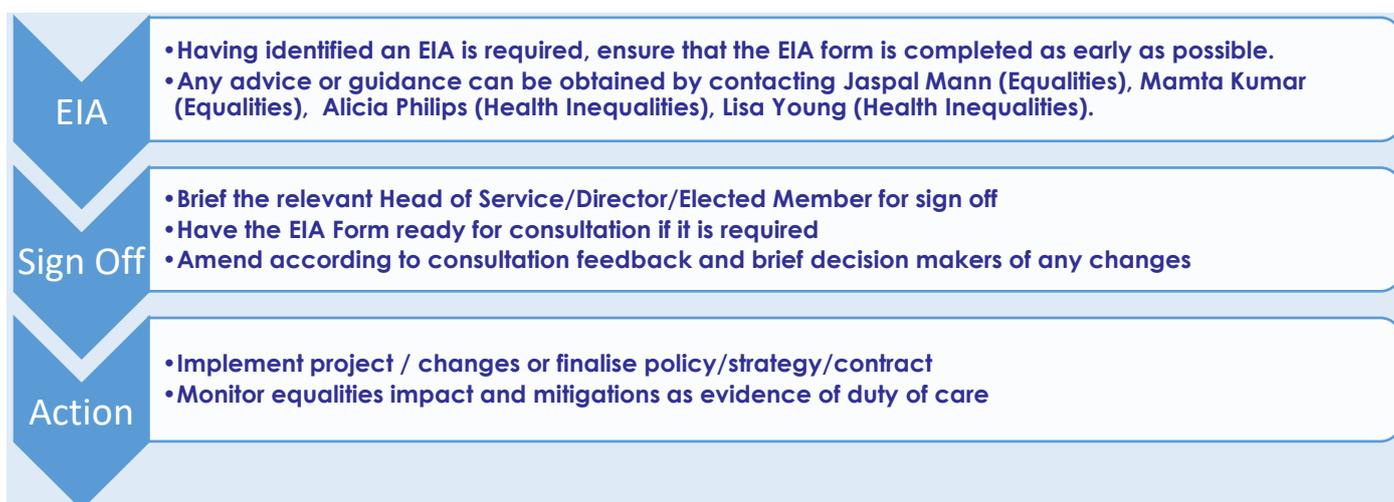


Appendix 2 EQUALITY IMPACT ASSESSMENT (EIA)



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*)

Appendix 2 EQUALITY IMPACT ASSESSMENT (EIA)



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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Appendix 2 EQUALITY IMPACT ASSESSMENT (EIA)



	<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
<p>2.3a What HIs exist in relation to your work / plan / strategy</p>	<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>

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	<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>

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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**

Appendix 2 EQUALITY IMPACT ASSESSMENT (EIA)



	<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	

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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