

**Directorate**

**Adults, Health and Housing**

**Service area**

**Integrated Commissioning Team**

**Name of policy, strategy, review or function being assessed**

**Derby City Dementia Strategy 2014-2016**

**Date of assessment**

**Wednesday 12th November 2014**

**Signed off by**

**Cabinet, Personnel Committee or Chief Officer Group’s decision**

**Date published on website**

Equality impact assessment form
Arial Black, 36pt

**Equality impact assessment – please read this section first before you do the assessment**

This is our equality impact assessment form to help you equality check what you are doing when you are about to produce a new policy, review an older one, write a strategy or plan or review your services and functions. In fact you need to do an equality impact assessment whenever a decision is needed that affects people and **before** that decision is made.

So why do we need to do equality impact assessments? Although the law does not require us to do them now, the courts still place significant weight on the existence of some form of documentary evidence of compliance with the **Public Sector Equality Duty** when determining judicial review cases. This method helps us to make our decisions fairly, taking into account any equality implications, so yes we still need to do them.

The Public Sector Equality Duty is part of the Equality Act 2010 and this Duty requires us as a public body to have ‘**due regard’** to eliminating discrimination, harassment and victimisation and any other conduct that is prohibited by or under the Act. It requires us to advance equality of opportunity and foster good relations between people who share a ‘**relevant protected characteristic’** and people who don’t.

Having ‘due regard’ means:

* removing or minimising disadvantages suffered by people due to their protected characteristics
* taking steps to meet the needs of people with certain protected characteristics where these are different from the needs of other people
* encouraging people with certain protected characteristics to participate in public life or in other activities where the participation is disproportionately low.

The protected characteristics are:

* age
* disability
* gender reassignment
* marriage and civil partnership
* pregnancy and maternity
* race
* religion or belief
* sex
* sexual orientation

This completed form should be attached to any Chief Officer Group, Cabinet or Personnel Committee report to help elected members make their decisions by taking the equality implications into account. Equality impact assessments **must be done before** decisions are made. Include the Cabinet or Personnel Committee’s decision on the front sheet when you know it.

You’ll find that doing these assessments will help you to:

* understand your customers’ and communities needs
* develop service improvements
* improve service satisfaction
* demonstrate that you have been fair and open and considered equality when working on re-structuring
* make sure you pay due regard to the requirements of the Public Sector Equality Duty.

Don’t do the form by yourself, get a small team together and make sure you include key people in the team such as representatives from our Diversity Forums and employee networks and you could invite trade union representatives too – the more knowledge around the table the better. You also need to decide how and who you will consult with to help inform the equality impact assessment. Our Lead on Equality and Diversity can help with useful contacts – we have a team of people who are used to doing these assessments and can help with information on barriers facing particular groups and remedies to overcome these barriers.

You’ll need to pull together all the information you can about how what you are assessing affects different groups of people and then examine this information to check whether some people will be negatively or positively affected. Then you’ll need to look at ways of lessening any negative effects or making the service more accessible – this is where your assessment team is very useful and you can also use the wider community.

Agree an equality action plan with your assessment team, setting targets for dealing with any negative effects or gaps in information you may have found. Set up a way of monitoring these actions to make sure they are done and include them in your service business plans.

When you have completed the assessment, get it signed by your Head of Service or Service Director and send it to our Lead on Equality and Diversity for checking and to publish on our website. It is a public document so must not contain any jargon and be easy to understand.

Remember, we need to do these assessments as part of our everyday business, so we get our equality responsibilities right and stay within the law – Equality Act 2010.

**Equality groups and protected characteristics**

These are the equality groups of people we need to think about when we are doing equality impact assessments and these people can be our customers or our employees and job applicants…

* Age equality – the effects on younger and older people
* Disability equality – the effects on the whole range of disabled people, including Deaf people, hearing impaired people, visually impaired people, people with mental health issues, people with learning difficulties and people with physical impairments
* Gender reassignment – the effects on trans people
* Marriage and civil partnership equality
* Pregnancy and maternity equality - women who are pregnant or who have recently had a baby, including breast feeding mothers
* Race equality – the effects on minority ethnic communities, including newer communities, gypsies and travellers and the Roma community
* Religion and belief or non-belief equality – the effects on religious and cultural communities, customers and employees
* Sex equality – the effects on both men and women and boys and girls
* Sexual Orientation equality – the effects on lesbians, gay men and bisexual people

In addition, we have decided to look at the effects on families and people on low incomes too as we feel this is very important.

**Contact for help**

Ann Webster – Lead on Equality and Diversity

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**The form**

We use the term ‘policy’ as shorthand on this form for the full range of policies, practices, plans, reviews, activities and procedures.

Policies will usually fall into three main categories…

* Organisational policies and functions, such as recruitment, complaints procedures, re-structures
* Key decisions such as allocating funding to voluntary organisations, budget setting
* Policies that set criteria or guidelines for others to use, such as criteria about school admissions, procurement methods, disabled facilities grants, on street parking bays

If in doubt - do one! You never know when we may get a legal challenge and someone applies for Judicial Review.

**What’s the name of the policy you are assessing?**

2014-2016 Derby City Dementia Strategy

**The assessment team**

Team leader’s name and job title –

Jenny Appleby - Strategic Commissioning Manager

Other team members

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Job title** | **Organisation**  | **Area of expertise** |
| Susan Sanghera | Commissioning Officer | Derby City Council | Dementia Strategy Implementation Plan |
| Helen O’Higgins | Senior Commissioning Manager | NHS Southern Derbyshire Clinical Commissioning Group | Dementia Strategy Implementation Plan |
| Honor Simpson | Team Leader | Making Space | Dementia Support Services |
| Suzanne Couldwell | Member | Dementia Action Forum | Dementia |
| Maureen Parker | Member | 50+ Forum | 50+  |
| Councillor Bill Wright | Member | Disability Diversity Forum | Disability |
| Councillor Anne MacDonald | Councillor / Member | Disabled People’s Diversity Forum | Disability |

**Step 1 – setting the scene**

Make sure you have clear aims and objectives on what you are impact assessing – this way you keep to the purpose of the assessment and are less likely to get side tracked.

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| **What are the main aims, objectives and purpose of the policy? How does it fit in with the wider aims of the Council and wider Derby Plan? Include here any links to the Council Plan, Derby Plan or your Directorate Service Plan.**Dementia is the one of the biggest health and social care challenges of the present day. In Derby the numbers of people with dementia are expected to grow by 16% by 2025. Derby City Council and NHS Southern Derbyshire Clinical Commissioning Group have joined together to develop a joint Derby City Strategy (2014-2016) which sets out plans for improving services for people with dementia in Derby. The strategy is informed by national guidance on dementia care as well as local information specific to Derby. The strategy aims to highlight local needs; looks at how dementia affects different sections of the community; looks back at progress made since the first strategy in 2010, and highlights actions for the next 2 years (please see hyperlink below).Derby City Dementia Strategy 2014-2016The strategy supports the objectives within the Derby City Council Plan 2014-2015 as follows;* Promote good health and well-being and prevent ill health
* Create an inspiring place to live
* Improved value for money for our customers
* More efficient and effective processes
* A skill and motivated workplace

The Departmental Service Plan for Integrated Commissioning 2014/15 within the wider Adults Health and Housing Directorate, has a key role in delivering the Directorate objectives; 1. To improve people’s health and well-being and reduce health inequalities 2. To improve the resilience of individuals, families and communities and promote self-help 3. To improve our information and advice so people can make good choices for their well-being and to promote financial inclusion 4. To build more affordable homes and bring empty housing back into use 5. To put recovery, independence and control at the heart of what we do 6. To support people to live in their own home and lead “ordinary lives”, with opportunities for education, employment and an active cultural and social life 7. To support carers and sustain them in their caring role 8. To safeguard adults at risk The Dementia Strategy also supports the CCGs high level objectives including: -Ensure that the CCG has a constant focus on safeguarding and improving the quality of care for patients- Develop a high performing organisation which listens to and is receptive to the membership, and has well informed and involved clinicians, practices and commissioning staff -Develop an inclusive organisation that listens and responds to the needs of the public, patients and their carers across the communities that we serve -Integrate services and improve the experience of health and social care for older people and people with long term conditions -Continue to improve the performance, quality and range of services provided within primary care and extended primary care settings |

1. **Who delivers/will deliver the policy, including any consultation on it and any outside organisations who deliver under procurement arrangements?**

The Dementia Strategy has been written jointly by the Council and the CCG. Other partners that have been involved in putting this document together include colleagues from within the Derbyshire NHS Healthcare Foundation Trust; local voluntary providers including Making Space and Derbyshire Carers Association; local customers and carers including representation from the Dementia Action Forum,

1. **Who are the main customers, users, partners, employees or groups affected by this proposal?**

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| Those affected by this proposal will include people with dementia, their families/friends, carers, employees within the Council, CCG, and other partner agencies. The EIA will ensure that the implementation of the strategy meets the diverse range of needs of local citizens and is fully inclusive.  |

**Step 2 – collecting information and assessing impact**

**4 Who have you consulted and engaged with so far about this policy, and what did they tell you? Who else do you plan to consult with? – tell us here how you did this consultation and how you made it accessible for the equality groups, such as accessible locations, interpreters and translations, accessible documents.**

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| A significant amount of consultation and engagement has been undertaken with people affected by dementia and their carers over the last few years and has informed the approach being followed. This has included:• Wide scale engagement work as part of the development of Derby’s first Dementia Strategy in 2010: five sequential workshops drawing in a broad range of stakeholders and customers to define the action plan for the city. • Engagement work to update this current strategy (2014-2016) took place within dementia support/ carer support groups, and day centres – both in creating a first draft of the strategy, and in confirming that the draft version was reflective of people’s needs.Locations were chosen that were familiar to people using dementia support services or statutory services - as it was important to conduct engagement where people naturally met.Interpreters were used on a couple of occasions when visiting a Muslim Asian women’s project in Peartree. At each group/ visit the key points were explained to customers affected by dementia and their carers. It was sometimes not possible to go through all aspects of the strategy with citizens and on these occasions the conversation was led by those present and their particular interests/ concerns.The feedback received was substantial and has all been embedded into the strategy and implementation plan. |

**5** **Using the skills and knowledge in your assessment team, and from any consultation you have done, what do you already know about the equality impact of the policy on particular groups? Also, use any other information you know about such as any customer feedback, surveys, national research or data. Indicate by a tick for each equality group whether this is a negative impact, a positive one or if you are not sure**

According to the national evidence base – specific equality groups are at greater risk of developing dementia including:

* Women (Alzheimer’s Disease)
* Men (Vascular dementia)
* People with learning difficulties
* South Asian and African Caribbean communities
* People with hearing loss/ Deaf community
* Older people (over the age of 65)

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| **Equality groups**  | **What do you already know?** | **No impact** | **Positive impact** | **Negative impact** | **Not sure** |
| **Age** | Age is strongly associated with dementia. One in three people over the age of 65 will develop dementia at some point during their lifetime.There are an estimated 2,980 people with dementia over the age of 65 in Derby. By 2020 the number of older people (aged over 65) in Derby is expected to rise to 43,500. In Derby the number of people estimated to experience early onset dementia (under 65 years) in 2014 is 57, and is projected to rise to 64 by 2020.Derby can expect to have approximately 3,358 people with dementia by 2020**.** |  | **x**  |  |  |
| **Disability** | People with learning difficulties are at a particular risk of developing dementia although this has not been extensively researched. There is a 1 in 3 chance that a person with Down’s Syndrome aged in their 50’s will have dementia (most commonly Alzheimer’s disease).In total in Derby those aged 18-64, those predicted to have a learning difficulty is 3,816 in 2012 and is projected to rise to 4,107 by 2020. Hearing loss or deafness is also linked with dementia. Action on hearing loss in a joint report with the Deafness Cognition and Language Research Centre showed that 44 per cent of over 70 year olds have moderate to severe hearing loss. There are around 720,000 people aged over 70 in the UK with dementia which means that there are at least 316,000 people aged 70 years and older with hearing loss and dementia. Since we now know that people with hearing loss are more likely to go on to develop dementia, this figure is likely to be much higher. It is also estimated that at least £28 million could be saved in delayed entry to care homes in England if hearing loss was properly diagnosed and managed in people with dementia.Other general health factors may influence whether people develop dementia as people who are more at risk of cardiovascular disease and strokes are also more likely to develop dementia. Other co-morbidities such as diabetes, blood pressure, COPD (chronic obstructive pulmonary disease) amongst other health conditions are risk factors for the possible onset of dementia. There is a correlation between dementia and co-morbidities. Co-morbidities may further impact on dementia if not managed well. This may advance the dementia further. |  | **x** |  |  |
| **Gender reassignment - trans** | There are no known enhanced risks for Gender reassigned/ trans customers although local activities should be inclusive and address sensitivities and needs of this group.  | **x** |  |  |  |
| **Marriage and civil partnership** | No known risks – however activities and services should be fully inclusive of carers needs | **x** |  |  |  |
| **Pregnancy and maternity** | No known risks – services and activities should be supportive of family members affected by dementia, and be inclusive of customers affected by dementia of working age. Refer to age and the early onset of dementia | **x** |  |  |  |
| **Race**  | Current evidence in this area is limited, but it does indicate there might be lower awareness, higher levels of stigma, and different cultural understandings of dementia among people from BAME communities. Research also suggests that people present later to general dementia services than their white British counterparts, when their dementia has become more severe. The report Dementia Does Not Discriminate (July 2013) confirms BAME communities are under-represented in services and are not experiencing equal outcomes. Local service access data suggests that services for people with dementia mirror this with access amongst BAME communities not matching the local population data.Other general health factors may influence whether people develop dementia as people who are more at risk of cardiovascular disease and strokes are also more likely to develop dementia. There is a higher prevalence of high blood pressure, diabetes, stroke and heart disease amongst Asian and African-Caribbean communities which are all risk factors for dementia. There is a correlation between dementia and co-morbidities. Certain minority groups may have a higher prevalence of certain co-morbidities due to lifestyle factors. |  | **x**  |  |  |
| **Religion or belief or none** | No known risks – services and activities should be supportive of family members affected by dementia, and be inclusive of customers affected by dementia. Cultural appropriateness in designing and shaping services would need to be considered.A person centred approach would take into consideration goals to support customers and involve carers. Strengthened partnership work with local communities will also support effectivepractice of religious and belief systems. | **x** |  |  |  |
| **Sex** | Alzheimers disease is more common in women, whilst vascular dementia is more common in men. There is a perception that men are reluctant to seek medical help due to denial of ill health conditions or choose not to engage in services. Research shows that men are significantly less likely than women to visit their GP or dentist, ask the pharmacist for advice and information, or attend contraception clinics, although they are more likely to end up in hospital because they delay in getting a diagnosis (Your Doc Medical 19th November 2014) |  | **x** |  |  |
| **Sexual Orientation** | No known risks – services and activities should be supportive of family members affected by dementia, and be inclusive of customers affected by dementia. A person centred approach would take into consideration goals to support customers and involve carers. Strengthened partnerships with local specialist providers will support effective practice  | **x** |  |  |  |
| **Families and people on low income** | Services and activities should be supportive of family members affected by dementia, and be inclusive of customers affected by dementia. There is a correlation between ill health due to lifestyle, poverty and diet. Some of these factors will impact on access to support services due to financial implications, for example, the cost involved in gaining access to the internet or getting transport to attend support providers. |  | **x** |  |  |

**Important** - For any of the equality groups you don’t have any information about, then make it an equality action at the end of this assessment to find out. This doesn’t mean that you can’t complete the assessment without the information, but you need to follow up the action and if necessary, review the assessment later. You can get lots of information on reports done from organisations’ websites such as the Equality and Human Rights Commission, Stonewall, Press for Change, Joseph Rowntree Trust and so on. Please don’t put down that the impact affects ‘everyone the same’ – it never does!

**6 From the information you have collected, how are you going to lesson any negative impact on any of the equality groups? How are you going to fill any gaps in information you have discovered?**

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| Those identified with a higher risk factor;* Age
* Disability
* Race
* Sex
* Families and people on low income

To note a summary of action plan following EIA working group meetingAny additional actions will be added as an appendix to the ‘Derby City Dementia Strategy’ which will be reviewed by all partners at the Southern Derbyshire Dementia Implementation Group. |

**Step 3 – deciding on the outcome**

**7 What outcome does this assessment suggest you take? – You might find more than one applies. Please also tell us why you have come to this decision?**

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| --- | --- | --- |
| **Outcome 1** |  | **No major change needed** – the EIA hasn’t identified any potential for discrimination or negative impact and all opportunities to advance equality have been taken |
| **Outcome 2** | **x** | **Adjust the policy** to remove barriers identified by the EIA or better advance equality. Are you satisfied that the proposed adjustments will remove the barriers you identified? |
| **Outcome 3** |  | **Continue the policy** despite potential for negative impact or missed opportunities to advance equality identified. You will need to make sure the EIA clearly sets out the justifications for continuing with it. You need to consider whether there are:* sufficient plans to stop or minimise the negative impact
* mitigating actions for any remaining negative impacts
* plans to monitor the actual impact.
 |
| **Outcome 4** |  | **Stop and rethink** the policy when the EIA shows actual or potential unlawful discrimination |

Our Assessment team has agreed Outcome number(s)

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| --- |
| Outcome 2 |

Why did you come to this decision?

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| --- |
| * some minor additions may need to be considered for the action plan, however the strategy does not need to be amended as a whole
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If you have decided on **Outcome 3**, then please tell us here the justification for continuing with the policy. You also need to make sure that there are actions in the Equality Action Plan to lessen the effect of the negative impact. This is really important and may face a legal challenge in the future.

If you have decided on **Outcome 4** then if the proposal continues, without any mitigating actions, it may be likely that we will face a legal challenge and possibly a Judicial Review on the process - it is really important that the equality impact assessment is done thoroughly, as this is what the Judge will consider.

**Step 4 – equality action plan – setting targets and monitoring**

**8** **Fill in the table (on the next page) with the equality actions you have come up with during the assessment. Indicate how you plan to monitor the equality impact of the proposals, once they have been implemented.**

Each partner responsible for actions within the implementation plan will take responsibility for monitoring and reporting relevant core datasets and outcome measures which will demonstrate the benefits and impact of the proposals, including impact on equalities. The partnership will also consider ways that it can collectively evaluate the impact of the strategy in relation to equalities – for example via engagement work.

**Equality action plan – setting targets and monitoring**

|  | **How are we going to do it?** | **When will we do it?** | **What difference will this make?** | **Lead officer** | **Monitoring arrangements** |
| --- | --- | --- | --- | --- | --- |
| Each organisation is responsible in ensuring equal outcomes across the equality strands, taking into account key data sets and customer/ carer feedback | Each organisation to monitor against their section of the implementation plan | On-going | Reporting back to Southern Derbyshire Dementia Implementation Group (SDDIG) will ensure any risks around equality are minimised  | Various within local partnership | A rolling reporting schedule exists to ensure all actions within implementation plan are covered by partnership |
| Partnership activities to specifically identify how they can be inclusive of the following needs or communities who may be at greater risk as identified within the EIA:men who may be reluctant to seek medical/ social helpPeople with co-morbidities;People from BAME communities as discussed in section 5; Hearing loss or deafness; people with other long term conditions such as diabetes, asthma, sight loss and cardiovascular disease; families/ carers; identify any needs around people who are LGBT; people who are on a low income; people with learning difficulties  | Each organisation to monitor against their section of the implementation plan and report back to the Southern Derbyshire Dementia Implementation GroupAll partner organisations to work together in designing any joint initiatives such as dementia awareness raising initiatives/ health promotion events/ media campaigns – ensuring that these communities and groups are central to any activities | In line with implementation plan within strategy | Activities will be measured in terms of their impact by partners involved. Our aim will be to ensure greater awareness and equal access/ outcomes to these groups. | Lead officers within SDDIG | The chair and partners of the SDDIG will oversee the success of any initiatives and activities  |
|  |  |  |  |  |  |
| Each organisation to continue to audit the physical environments for those living with dementia – ensuring they are fit for purpose to meet the needs of people affected by dementia and reflect the diverse needs of local communities  | Each organisation to monitor against their section of the implementation plan | On-going | Reporting back to Southern Derbyshire Dementia Implementation Group will ensure any risks around equality are minimised – each organisation will in turn report back through their internal structures to make recommendations as appropriate | Various within local partnership | A rolling reporting schedule exists to ensure all actions within implementation plan are covered by partnership |
| Ensure the dementia strategy and other key documents/ publications/ campaigns are accessible in various languages and formats | Through the work of the information task group that exists to deliver part of the strategy’s implementation plan | In line with actions within implementation plan | Information is vital to the successful delivery of the strategy; ensuring inclusivity is key to its success | CCG lead with group with involvement from various partners | The group reports back to SDDIG |

**Make sure you include these actions in your Directorate service business plans.**