



National Dementia Strategy

Equalities Action plan

Equality analysis

Title: National Dementia Strategy Equalities Action Plan

What are the intended outcomes of this work? *Include outline of objectives and function aims*

This Equalities Action Plan sets out a series of planned actions in relation to the implementation of the National Dementia Strategy *Living Well With Dementia* and the Dementia Commissioning Pack.

Living Well With Dementia was published on 9 February 2009 and is being implemented over a five-year period to 2014. It sets out 17 objectives for transforming dementia services, with the aim of achieving better awareness of dementia, early diagnosis and high quality treatment at all stages of the illness and in all settings.

The Strategy was followed in November 2009 by the publication of a report addressing the over-prescription of anti-psychotic medication for people with dementia¹. The Government accepted the report's findings and the implementation of its 11 recommendations is an integral part of improving the care and experience of people with dementia and their carers.

On 8 September 2010, the Department of Health published a revised, outcomes-focused implementation plan for the National Dementia Strategy (NDS). *Quality outcomes for people with dementia: building on the work of the National Dementia Strategy* updates the previous implementation plan for the Strategy, which was published in July 2009, and is aimed at accelerating the pace of improvement through a greater focus on local delivery and local accountability and empowering citizens to hold local organisations to account.

The implementation plan sets out the Department's four priority objectives for securing improvements in dementia care, which are:

- good quality early diagnosis and intervention for all;
- improved quality of care in general hospitals;
- living well with dementia in care homes;
- reduced use of anti-psychotic medication.

Improving outcomes for carers underpins each of these priority areas.

The evidence in this Action Plan is grouped in line with the four priority areas for securing improvements in dementia care set out above.

In October 2010, the Department of Health published a commissioning pack for cardiac rehabilitation and announced the development of two further packs on dementia and chronic obstructive pulmonary disease (COPD), demonstrating that dementia had been singled out by Ministers as a high priority area for commissioners. The Dementia Commissioning Pack was

¹ *The use of antipsychotic medication for people with dementia: Time for action*, A report for the Minister of State for Care Services by Professor Sube Banerjee, Department of Health, 2009

published on 21 July 2011.

The commissioning pack consists of a set of materials to help commissioners in health and social care commission better services for people with dementia and their carers. The pack covers the four priority areas in the 2010 National Dementia Strategy implementation plan – Good quality early diagnosis and interventions; Better care in hospitals; Better care at home and in care homes and Reduced use of anti-psychotic medication.

The pack aims to take the hard work out of the commissioning process by providing commissioners with a self-assessment tool, the case for change, specifications for services that can be adapted for local use and dropped into the national contract and a costing tool. There is also an accompanying handbook to explain how to get the best out of the pack. The use of the pack is not mandatory and it will be for commissioners to determine locally the needs of their local populations and to commission services appropriately to meet those needs. Commissioners will be expected to carry out their own Equality Impact Assessments for their commissioning strategies and for specific services.

The expected outcomes from the commissioning pack project are:

- that the pack will become the standard for commissioning dementia services agreed by the NHS Commissioning Board;
- that by using the pack, commissioners will improve local services for people with dementia and their carers and achieve better outcomes for individuals.

An Equality Impact Assessment was published alongside the National Dementia Strategy in 2009 and considered the Strategy's possible impact on people according to ethnicity, disability, gender, age, religion or belief and sexual orientation. This Equalities Action Plan supplements the Equality Impact Assessment and has been developed in line with the requirements of the Equality Act 2010.

Who will be affected? *e.g. staff, patients, service users etc*

In relation to the National Dementia Strategy as a whole, people with dementia and their carers and families will be affected through better awareness of dementia, early diagnosis, good quality information and high quality care and treatment at all stages of the illness and in all settings. More specifically, the commissioning pack will equip commissioners with practical tools to help them drive improvements in service provision through better commissioning.

Health and social care professionals will be affected by the National Dementia Strategy through improved professional awareness and understanding of dementia, improved education and training and the provision of high quality care and treatment at all stages of the illness and in all settings. The commissioning pack includes the facility for commissioners to include requirements relating to workforce development in the acute sector and in the community care domain.

The public will be affected by the National Dementia Strategy through improved public awareness and understanding of dementia.

The commissioning pack is designed to be useful and relevant to both current and future commissioning arrangements, including clinical commissioning groups, and supports the role of Health and Wellbeing Boards as key strategic drivers of change across the whole system.

Evidence *The Government's commitment to transparency requires public bodies to be open about the information on which they base their decisions and the results. You must understand your responsibilities under the transparency agenda before completing this section of the assessment. For more information, see the current [DH Transparency Plan](#).*

What evidence have you considered? *List the main sources of data, research and other sources of evidence (including full references) reviewed to determine impact on each equality group (protected characteristic). This can include national research, surveys, reports, research interviews, focus groups, pilot activity evaluations etc. If there are gaps in evidence, state what you will do to close them in the Action Plan on the last page of this template.*

A full list of the evidence considered and referred to in this Action Plan is provided below.

General

Antidementia drugs: Prescription by level of cognitive impairment or by socio-economic group? Claudia Cooper, Martin Blanchard, Amber Selwood and Gill Livingston, *Aging & Mental Health* Vol. 14, No. 1, January 2010, 85-89

Attitudes and support needs of Black Caribbean, South Asian and White British carers of people with dementia in the UK, Vanessa Lawrence, Joanna Murray, Kritika Samsi and Sube Banerjee, *British Journal of Psychiatry*, 2008 193: 240-46

Deaf with Dementia project, University of Manchester

www.nursing.manchester.ac.uk/deafwithdementia

Delivering the National Dementia Declaration for England Action plans 2010-2014, Dementia Action Alliance, 2010

Dementia and Parkinson's Information Sheet, Parkinson's Disease Society, March 2009

Dementia care-giving in Black and Asian populations: reviewing and refining the research agenda, Briggs K, Askham J, *J Community Appl Soc. Psychol* 2005: 15: 319-37

Dementia Memory assessment and Diagnosis Service for Cornwall and Isles of Scilly, NHS Cornwall, 2009

Dementia UK The full report, Alzheimer's Society, 2007

Equality Impact Assessment Living well with dementia National Dementia Strategy, Department of Health, February 2009

Estimating the absolute number of cases of dementia and depression in the black and minority ethnic elderly population in the UK, Shah A, *International Journal of Migration, Health and Social Care* 4 4-15, 2008

Research Findings No. 10: the experiences and needs of people with dementia and serious visual impairment: a qualitative study, Thomas Pocklington Trust, November 2008

See Me, Not Just the Dementia: Understanding People's Experiences of living in a Care Home, Commission for Social Care Inspection 2008

Social Care Institute for Excellence website

<http://www.scie.org.uk/publications/dementia/index.asp>

Working with lesbian and gay people with dementia, Mackenzie Jenny, *Journal of Dementia Care*, 17(6), November/December 2009, pp. 17-19. 2009

Younger people with dementia: a multidisciplinary approach, Robert Baldwin and Michelle Murray, 2003

Dementia Commissioning Pack

The commissioning pack draws on evidence used for the National Dementia Strategy, published in February 2009. The Strategy used the following research findings:

Dementia UK The full report, Alzheimer's Society, 2007

Improving the quality of care for people with dementia, National Audit Office, 2007

In addition, the following evidence has been used:

National audit of dementia services, 2011

NICE-SCIE Guideline 42 - *supporting people with dementia and their carers in health and social care*, National Collaborating Centre for Mental Health, 2007

Stay, Support, Save, Alzheimer's Society, 2011

Counting the Cost, Alzheimer's Society, 2009

Out of the Shadows, Alzheimer's Society, 2008

Leaving Hospital – the price of delays, Commission for Social Care Inspection, 2004

Leaving Hospital – Revisited, Commission for Social Care Inspection, 2005

See me, not just the dementia, Commission for Social Care Inspection, 2008

Feedback from the National Dementia Strategy Implementation Reference Group

Discussions and feedback from the Reference Group for the commissioning pack

Feedback from the commissioning pack News Bulletins disseminated around the regions

Feedback from “road-testing” the pack at two events with commissioners in the South West

Examples of practice from around England.

In line with the requirements for Equality Action Planning, this plan focuses particularly on information from the last two years. However, where we have found information from previous years which is particularly relevant and more up-to-date information is not available, this information has been included.

Disability Consider and detail (including the source of any evidence) on attitudinal, physical and social barriers.

General information

Dementia is one of the major causes of disability in older people, affecting personal care, cognitive abilities and everyday social activities. Many people with dementia have physical co-morbidities.

In 2010 at least 100,000 people in the UK had dementia and **sight loss** (*Delivering the National Dementia Declaration for England Action plans 2010-2014*). The experience of joint sight loss and dementia in older adults was found to lead to:

- an increased sense of disorientation;
- a high level of vulnerability to isolation;
- concerns about safety, threatening independence;
- a struggle to accept the multiple losses;
- common and disruptive visual hallucinations;
- exceptional demands on family caregivers;
- challenges for sight loss services;
- minimal significance attached to sight loss by dementia care professionals;
- a lack of joint working between mental health and sensory impairment teams (*Research Findings No. 19: the experiences and needs of people with dementia and serious visual impairment: a qualitative study*).

There has been no research into whether **Deaf people** are more or less likely to experience dementia than hearing people. Deaf people with dementia experience the double stigmatisation of being marginalised from society because they do not communicate in conventional terms and then further marginalised within the Deaf community (Deaf with Dementia project, University of Manchester).

Dementia occurs in 15-30% of cases of **Parkinson's disease** (*Dementia and Parkinson's Information Sheet*).

Up to three-quarters of people with **Down's syndrome** over the age of 50 will develop

dementia (*Younger people with dementia: a multidisciplinary approach*).

An estimated two thirds of vascular dementia is caused by **strokes** or transient ischaemic attacks (TIAs) (*Delivering the National Dementia Declaration for England Action plans 2010-2014*).

Early diagnosis and intervention

There is almost no information available to ordinary **Deaf people** about dementia that is in BSL. Poor levels of literacy (the average reading age in the Deaf community is under 9 years) mean that written information is not always understood. This means that Deaf people are less likely to report early memory difficulties or to receive early diagnosis. It is very difficult to diagnose dementia in people who are deaf as conventional testing and assessment is not possible. The Deaf with Dementia project at the University of Manchester is developing a screening instrument for dementia in BSL that is culturally appropriate and normed for the Deaf population (Deaf with Dementia project, University of Manchester).

GPs may not have the expertise to recognise when a patient with **learning disabilities** is developing symptoms of dementia and may therefore not make a referral to the relevant specialist.

Vascular dementia is often missed in people who have had a **stroke** because there is little awareness of the condition and a firm diagnosis cannot be made for up to three months afterwards (*Delivering the National Dementia Declaration for England Action plans 2010-2014*).

Care of people with dementia in hospital

Although there are a few specialist mental health services for **Deaf adults** in the UK where BSL is used, these are not for patients over the age of 60. Other research shows that Deaf people who use BSL usually have very poor access to health services in general (Deaf with Dementia project, University of Manchester).

Care of people with dementia in care homes

The dual burden of dementia and **sight loss** creates particular challenges for people with dementia and their carers and is often the trigger for increased care services, including the move to a care home (*Delivering the National Dementia Declaration for England Action plans 2010-2014*).

Reducing the use of anti-psychotic medication

People with **learning disabilities** are subject to over prescription of anti-psychotic medication, similar to people with dementia. If they also have dementia, the problem is compounded.

Sex Consider and detail (including the source of any evidence) on men and women (potential to link to carers below).

General information

A higher proportion of men in the ages 65-74 years and a higher proportion of women aged over 75 have dementia (*Equality Impact Assessment Living well with dementia National Dementia Strategy*).

The majority of those aged under 65 with dementia – 70% - are men (Social Care Institute for Excellence website).

Overall estimates are that 222,925 men and 445,641 women have late onset dementia, approximately two women for every man affected. Both the higher mortality among men and the higher age-specific dementia prevalence in women contribute to the pre-ponderance of women among the 'oldest-old' with dementia (*Dementia UK The full report*).

The distribution of subtypes is different in men and women. Alzheimer's disease is more common in women, while vascular dementia and mixed dementias are more common in men (*Dementia UK The full report*).

Dementia affects men and women in all social groups. Most family carers and paid support staff are women.

Care of people with dementia in care homes

The prevalence of dementia among people in institutions varied little by gender (*Dementia UK The full report*).

Race Consider and detail (including the source of any evidence) on difference ethnic groups, nationalities, Roma gypsies, Irish travellers, language barriers.

General

The number of people with dementia in minority ethnic groups is estimated to be around 15,000 in England – approximately 3% of the estimated overall number of people with dementia (*Equality Impact Assessment Living well with dementia National Dementia Strategy*).

The number of people from ethnic minorities with dementia, and their proportion of the population as a whole, is set to rise sharply with the aging of ethnic minority populations (*Equality Impact Assessment Living well with dementia National Dementia Strategy*).

6.1% of all people with dementia among BME groups have early onset dementia, compared with only 2.2% for the UK population as a whole, reflecting the younger age profile of BME communities (*Dementia UK The full report*).

South Asian and Black Caribbean populations represent the largest ethnic minority groups in the UK, yet the evidence on dementia care in these communities is profoundly limited (*Dementia care-giving in Black and Asian populations: reviewing and refining the research agenda*).

Early diagnosis and intervention

Cultural and social differences may be a barrier for some ethnic communities accessing health and social care services, such as the stigma or lack of understanding of mental health problems. There is, for example, no word for dementia in five South Asian languages.

People of South Asian origin in the United Kingdom may recognise symptoms associated with dementia but not conceptualize these as part of an illness even when they are severe. They may consider that individual and family efforts will ameliorate symptoms of dementia (*Attitudes and support needs of Black Caribbean, South Asian and White British carers of people with dementia in the UK*).

Other factors related to BME patients and family members not engaging with formal services include the belief that nothing can be done, a lack of awareness of available services, a lack of awareness of access procedures for available services, the belief that available services are inadequate, inaccessible and culturally insensitive, previous poor experience of services and stigma attached to mental disorder (*Estimating the absolute number of cases of dementia and depression in the black and minority ethnic elderly population in the UK*).

Most of the current generation of minority ethnic elders in the UK moved here as adults, and relatively few have acquired fluency and literacy in English. In one study, 35% of older Asians in a UK city could speak English, 21% could read and write in English, and 73% could read and write in their first language. Any tests requiring numeracy, or literacy either in English or in their first language, may therefore disadvantage these older people. They will be further disadvantaged by any test item assuming familiarity with a different culture to the one they

experienced while growing up (*Dementia Memory assessment and Diagnosis Service for Cornwall and Isles of Scilly*).

This combination of factors may have a substantial impact on people's experience of ill health and of seeking help.

Care of people with dementia in hospital

The available evidence suggests that people from black and minority ethnic (BME) groups have higher rates of psychiatric admissions than the general population. Research also suggests that people from BME groups stay in hospital for longer, and they have a higher tendency than the general population to be secluded (*Estimating the absolute number of cases of dementia and depression in the black and minority ethnic elderly population in the UK*).

Age Consider and detail (including the source of any evidence) across age ranges on old and younger people. This can include safeguarding, consent and child welfare.

General information

The incidence of dementia undoubtedly increases with age, but it is far from being inevitable and is certainly not a natural consequence of the aging process. Dementia can affect people of any age.

One in six people over 80 has a form of dementia and one in 14 people over 65 has a form of dementia (*Dementia UK The full report*).

Two-thirds (68%) of all people with dementia are aged 80 and over, and one sixth (17%) aged 90 or over (*Dementia UK The full report*).

Although dementia is primarily an illness associated with older people, in 2010 there were thought to be 64,037 people under 65 with dementia in the UK. Younger people make up 8% of the total number of people with dementia (Social Care Institute for Excellence website).

Dementia can affect people as young as 30, although this is extremely rare. Most younger people with dementia are middle aged: in their 40s, 50s and early 60s. The term 'young onset dementia' refers to people diagnosed with dementia under the age of 65 (Social Care Institute for Excellence website).

The proportion of people considered to have severe dementia increases with increasing age, from 6.3% of those aged 65 to 69 years to 23.3% for those aged 95 years and over (*Dementia UK The full report*).

Overall, 10% of deaths in men over 65 years, and 15% of deaths in women over 65 years, are attributable to dementia (*Dementia UK The full report*).

Early diagnosis and intervention

Because it is relatively rare for younger people to be diagnosed with dementia, services and interventions tend to be geared towards people aged 65 years and over. This means it is often very difficult for younger people and their families to access support, especially at the beginning (Social Care Institute for Excellence website).

Care of people with dementia in hospital

40% of people in hospital have dementia. As discussed in the general information section above this is most common among, but not limited to, older people.

Care of people with dementia in care homes

It is estimated that 36.5% of those with late onset dementia live in care homes (*Dementia UK The full report*).

The proportion of those with dementia living in care homes rises steadily with age, from 26.6%

of those aged 65-74, to 60.8% of those aged 90 and over (*Dementia UK The full report*). The prevalence of dementia among people in institutions varied little by age – increasing from 55.6% among those aged 65-69 to 64.8% in those aged 95 and over (*Dementia UK The full report*).

Activities in care home settings are often planned with older and physically frail people in mind. An activity that is suitable for a 90-year old with limited mobility may be completely inappropriate for an active 50-year old with dementia (Social Care Institute for Excellence website).

Gender reassignment (including transgender) *Consider and detail (including the source of any evidence) on transgender and transsexual people. This can include issues such as privacy of data and harassment.*

We are not aware of any specific evidence in relation to gender reassignment and dementia. However, there may be issues concerning the provision of personal care at home or in care homes, which local commissioners would need to ensure were included in their service specifications.

Sexual orientation *Consider and detail (including the source of any evidence) on heterosexual people as well as lesbian, gay and bi-sexual people.*

General information

No firm figures exist, but applying an estimate of 5-7% of the population identifying as gay or lesbian to those with dementia, suggests more than 34,180 gay or lesbian people are living with dementia (*Working with lesbian and gay people with dementia*). Lesbian women and gay men are likely to face particular challenges in caring for partners or friends with dementia, which are not faced by others in society. There will be similar challenges for lesbians and gay men receiving care from paid carers.

Care of people with dementia in care homes

The transition from living at home to moving into residential care may be particularly challenging for older people from the LGBT community. Older people from this community are fearful of the attitudes and potential prejudice of possibly staff, other residents and their family. Some older people choose not to disclose their sexual identity within the home, having a detrimental effect on their well being and quality of life (*See Me, Not Just the Dementia: Understanding People's Experiences of living in a Care Home*, Commission for Social Care Inspection, 2008).

Religion or belief *Consider and detail (including the source of any evidence) on people with different religions, beliefs or no belief.*

At present there is a general lack of available data on religion in relation to people with dementia, although religion is of course closely associated with the cultural and ethnic differences described in the section on race above. Feedback from the consultation on the National Dementia Strategy highlighted that religion can play an important part in the lives of people with dementia and religious organisations may be able to provide a link between individuals and health and social care services.

Pregnancy and maternity *Consider and detail (including the source of any evidence) on working arrangements, part-time working, infant caring responsibilities.*

We are not aware of any issues concerning pregnancy and maternity in relation to dementia

other than those that may arise for carers generally.

Carers *Consider and detail (including the source of any evidence) on part-time working, shift-patterns, general caring responsibilities.*

Carers provide a significant proportion of the care delivered to people with dementia, costed at approximately £5.4 billion by the National Audit Office (2007). The National Dementia Strategy includes a specific objective to ensure that the Carers' Strategy is implemented for the benefit of carers of people with dementia. The NICE/SCIE guideline summarises the evidence for different interventions to support carers and recommends the following:

- individual or group psycho-education;
- peer support group with other carers;
- support and information available by telephone or the internet;
- training courses about dementia, services and benefits, communication and problem solving in the care of people with dementia; and
- involvement of other family members as well as the primary carer in family meetings.

Carers with symptoms of depression and anxiety should be offered psychological therapy. Interventions with carers not only have a positive effect on them, but also on the person they are caring for in terms of behaviour or the length of time they are able to remain living at home (NICE-SCIE guideline, 42, 2007). Lack of adequate support for carers has a negative impact on the person with dementia's general health (Alzheimer's Society, 2011).

Early diagnosis and intervention

Carers often initiate seeking help on behalf of the person they are caring for who is presenting symptoms of possible dementia. However, they report difficulties in being listened to by GPs and other professionals and are often not included as equal partners in planning and decision making. Lack of information about the condition and what to expect and about sources of help and support are consistent complaints from carers (Alzheimer's Society, 2008 and feedback from commissioning pack reference group and NDS Implementation Reference Group).

Care of people with dementia in hospitals

Again, carers are often excluded from planning and decision making, particularly in relation to hospital discharge. When caring at home breaks down, people with dementia may be admitted to hospital. They are more likely to experience delays in discharge from hospital and in many cases are discharged straight from hospital to a care home (Alzheimer's Society, 2009; CSCI 2004, 2005).

Other identified groups *Consider and detail and include the source of any evidence on different socio-economic groups, area inequality, income, resident status (migrants) and other groups experiencing disadvantage and barriers to access.*

Socio-economic factors – general information

Dementia affects people from all socio-economic groups. The implementation of the National Dementia Strategy will mean that all people with dementia and those who care for them, regardless of their background, will have access to the best possible healthcare and support.

The commissioning pack promotes the concept of a dementia friendly society to ensure that people with dementia, whatever their background or social circumstances, can continue to benefit as citizens from universal and mainstream services and to contribute to their local communities through participation and inclusion.

Socio-economic factors – reducing the use of anti-psychotic medication

People with dementia who owned their own homes were four times more likely to be prescribed certain anti-dementia drugs than those who did not (*Antidementia drugs: Prescription by level of cognitive impairment or by socioeconomic group?*)

Engagement and involvement

Was this work subject to the requirements of the cross-government [Code of Practice on Consultation](#)? N

How have you engaged stakeholders in gathering evidence or testing the evidence available?

Stakeholders were widely involved in the development of the National Dementia Strategy. The Strategy was developed with the support of an External Reference Group (ERG) and three ERG working groups, all including people with dementia and carers. A draft strategy was issued before publication, with a three month formal consultation exercise to take account of the views of stakeholders and others. As well as receiving approximately 600 written responses, the Department held over 50 stakeholder events across the country involving over 4000 people including, among others, NHS and social care professionals, people with dementia and family carers. Following the publication of the Strategy an Implementation Reference Group, also involving people with dementia and carers, was established to support and advise on implementation.

With regard to the commissioning pack, the main evidence is that used for the development of the National Dementia Strategy, which stakeholders are familiar with. That evidence has been drawn on in discussions at the Reference Group and in the Experts group that drafted the pack.

How have you engaged stakeholders in testing the policy or programme proposals?

As discussed above, the National Dementia Strategy was developed with the support of an External Reference Group and subsequently an Implementation Reference Group was established by the Department to support and advise on its implementation.

The commissioning pack has been developed with an external reference group involving commissioners, clinicians, voluntary and independent sector representatives, people with dementia and family carers who have provided feedback on the pack as it has been developed. The costing tool and the viability of the pack in relation to the new commissioning architecture have also been “road tested” with a group of commissioners in the South West region. Innovations in Dementia (a social enterprise company) have been commissioned to work with people with dementia to obtain their feedback on the pack and to help develop the accompanying patient information leaflet.

For each engagement activity, please state who was involved, how and when they were engaged, and the key outputs:

The approach to engagement for both the development and implementation of the National Dementia Strategy and for the development of the commissioning pack has been fully inclusive of people with dementia and carers. Where appropriate the Department has commissioned

support for people with dementia and carers to facilitate their attendance at and involvement in meetings. The Reference Group for the commissioning pack also included a person with dementia and a number of carers.

Summary of Analysis *Considering the evidence and engagement activity you listed above, please summarise the impact of your work. Consider whether the evidence shows potential for differential impact, if so state whether adverse or positive and for which groups. How you will mitigate any negative impacts. How you will include certain protected groups in services or expand their participation in public life.*

Dementia affects people from all backgrounds and with a wide range of protected characteristics. People with dementia can suffer from stigma and discrimination and difficulties in accessing services. In particular, the challenge of living well with dementia can be significant for people also living with other conditions, as discussed in the above section on disability.

The implementation of the National Dementia Strategy will mean that all people with dementia and those who care for them, regardless of their background, will have access to the best possible healthcare and support. The Department of Health considers the overall impact of both the implementation of the Strategy and the commissioning pack to be positive, including for people with protected characteristics.

In addition, the NDS implementation plan and the commissioning pack support and complement the work of other initiatives, including the Dementia Action Alliance which is working to ensure quality outcomes for people with dementia and their carers, counter negative perceptions of dementia and promote the inclusion of people with dementia in mainstream services.

The aim of the commissioning pack is to help commissioners to commission services that improve quality of life based on evidence of what works best and what is cost effective. The pack is not mandatory and it will be for commissioners to determine locally whether to use it or not and, if so, how to prioritise their commissioning activity. The pack includes a self-assessment tool to help commissioners determine how well they are performing against measures of quality, capacity and access. These include the needs of groups with protected characteristics and a focus on ensuring that universal and mainstream services are “dementia friendly”. Each of the specifications includes reference to the need to ensure equity of access for all disadvantaged groups and that services can meet the particular needs of groups with protected characteristics.

Now consider and detail below how the proposals impact on elimination of discrimination, harassment and victimisation, advance the equality of opportunity and promote good relations between groups.

Eliminate discrimination, harassment and victimisation *Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation).*

People with dementia complain of being treated differently and of feeling excluded from society. This difficulty can be compounded where people with dementia have one or more of the protected characteristics, particularly in relation to other disabilities which affect their ability to communicate. Both the National Dementia Strategy and the commissioning pack emphasise the importance of enabling all people with dementia to live well with the condition and to continue to participate in society. The Department’s recent media campaign to increase awareness of and understanding about dementia also builds on this approach.

Advance equality of opportunity *Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation).*

The commissioning pack makes it clear that specific attention should be given to disadvantaged groups to ensure equality of access and that services are sensitive and appropriate to particular needs. In relation to dementia, groups who require particular attention include:

- people with learning disabilities;
- people with early onset dementia;
- people from BME communities;
- carers.

Each specification in the commissioning pack asks that at a local level, commissioners consider specific issues of equality of access that are relevant to their community.

Promote good relations between groups *Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation).*

The commissioning pack promotes the concept of a dementia-friendly society and provides tools to enable commissioners to adapt service specifications to ensure that universal and generic services can meet the needs of people with dementia. People with dementia live in communities and neighbourhoods, on their own or with families and friends; the number who use specialist mental health services is small as a proportion of the total number of people with the condition.

What is the overall impact? *Consider whether there are different levels of access experienced, needs or experiences, whether there are barriers to engagement, are there regional variations and what is the combined impact?*

The overall impact of both the National Dementia Strategy and the commissioning pack is positive in terms of supporting people with dementia, their carers and families to access support, regardless of their background or the presence of protected characteristics. There is nevertheless, of course, always scope for improvement and this is considered in the action planning section below.

Addressing the impact on equalities *Please give an outline of what broad action you or any other bodies are taking to address any inequalities identified through the evidence.*

In relation to the implementation of the National Dementia Strategy as a whole, this is considered in the action planning section below.

The commissioning pack is not mandatory. It will be for local commissioners to determine priorities and subsequent actions to meet the needs of their local populations. The status of the pack is that of a good practice guide, not formal guidance. However, the pack makes clear the need to address the requirements of people with protected characteristics.

Action planning for improvement *Please give an outline of the key actions based on any gaps, challenges and opportunities you have identified. Actions to improve the policy/programmes need to be summarised (An action plan template is appended for specific action planning). Include here any general action to address specific equality issues and data gaps that need to be addressed through consultation or further research.*

The Action Plan template sets out a series of specific actions which have been identified in order to address equality issues relating to the implementation of the National Dementia Strategy and the Dementia Commissioning Pack. On a more general note, this action planning exercise has raised awareness within the DH dementia policy team of the need to ensure that equalities issues are an integral part of our work and are considered in all future work planning.

Please give an outline of your next steps based on the challenges and opportunities you have identified. *Include here any or all of the following, based on your assessment*

- *Plans already under way or in development to address the **challenges** and **priorities** identified.*
- *Arrangements for continued engagement of stakeholders.*
- *Arrangements for continued monitoring and evaluating the policy for its impact on different groups as the policy is implemented (or pilot activity progresses)*
- *Arrangements for embedding findings of the assessment within the wider system, OGDs, other agencies, local service providers and regulatory bodies*
- *Arrangements for publishing the assessment and ensuring relevant colleagues are informed of the results*
- *Arrangements for making information accessible to staff, patients, service users and the public*
- *Arrangements to make sure the assessment contributes to reviews of DH strategic equality objectives.*

Specific actions have been identified in the Action Plan template below, together with target dates for their completion. During 2011/12, the Department is continuing to engage stakeholders through a range of mechanisms, including two further meetings of the National Dementia Strategy Implementation Reference Group, the Antipsychotics Working Group, the NDS Workforce Advisory Group and its membership of the Dementia Action Alliance.

For the record

Name of person who carried out this assessment: Rebecca Sidwell

Date assessment completed: 5 July 2011

Name of responsible Director/Director General: Shaun Gallagher

Date assessment was signed: 8 July 2011

Action plan template

This part of the template is to help you develop your action plan. You might want to change the categories in the first column to reflect the actions needed for your policy.

Category	Actions	Target date	Person responsible and their Directorate
Involvement and consultation	Invite members of the Dementia Action Alliance to consider equality issues and the needs of people with protected characteristics at one of their future quarterly meetings.	August 2011	Becky Sidwell, SCLGCP
	Invite the National Dementia Strategy Implementation Reference Group to consider equality issues and the needs of people with protected characteristics at one of their forthcoming meetings.	September 2011	Jerry Bird, SCLGCP
Data collection and evidencing	Take into account the gaps in the information currently available on protected characteristics in the future commissioning of research on dementia. In particular, request the National Institute for Healthcare Research and the Medical Research Council to ensure that equality issues are addressed in funded research programmes and that particular attention is given to filling the gaps in evidence.	Ongoing	Jerry Bird, SCLGCP
	Ensure that work to develop a new indicator on dementia considers equality issues.	Ongoing	Raj Kaur, SCLGCP
Analysis of evidence and assessment	Learn from the national evaluation of the demonstrator site programme for the NDS.	Summer 2012	Jerry Bird, SCLGCP
	Consider the results from the national audit of dementia services from an equalities perspective.	Ongoing	Raj Kaur, SCLGCP
Practical actions	Give specific consideration to equality issues in the commissioning of all future work on dementia.	Ongoing	DH Dementia Team
	Continue to work with the Personal Social Health & Economic education (PSHE) Association on dementia awareness-raising among young people in schools.	Ongoing	Jerry Bird, SCLGCP
	Ask the Design Council to consider equality issues in their innovation programme to engage leaders in the	July 2011	Helen Wiggins, SCLGCP

	<p>design industry and the private and third sectors to develop innovative solutions for the future of dementia care.</p> <p>Invite the Dementia Action Alliance to consider whether there is any shared work they could do on equality issues in relation to dementia.</p> <p>Give specific consideration to equality issues in current work on improving hospital care for people with dementia.</p> <p>Ask the National Dementia Strategy Workforce Advisory Group to consider issues relating to equality in education and training and opportunities for work in this area.</p> <p>Ensure that work on the transition to the new health and social care system addresses equality issues.</p>	<p>September 2011</p> <p>Ongoing</p> <p>July 2011</p> <p>Ongoing</p>	<p>Becky Sidwell, SCLGCP</p> <p>Professor Alistair Burns, National Clinical Director for Dementia Becky Sidwell, SCLGCP</p> <p>DH Dementia Team</p>
Transparency (including publication)	<p>Ensure that future good practice examples on dementia published on the DH website are checked to ensure appropriate consideration of equality issues.</p>	<p>Ongoing</p>	<p>DH Dementia Team</p>

