

Equality Analysis Form

It is desirable to undertake an Equality Analysis as part of our commitment to patients, staff and the public, to be attached to any procedural document and submitted to others as required or needed. A separate action plan may be needed to mitigate impacts.

Does the proposed policy, or changed practice, impact differentially on any of the protected characteristics (as defined in the Equality Act, 2010)?

Name of Strategy/Policy/Plan: Dementia Specialist Services Review

Name of person undertaking the assessment: Diane Bardwell

Date of the assessment: 26/4/2016; 25/07/2016 Update by Jane Austin; 12/06/18 reviewed and updated (Jane Austin); 18/08/18 reviewed and updated (Jane Austin); 12.12.18 reviewed and updated (Jane Austin)

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

NHS Dorset Clinical Commissioning Group (NHS Dorset CCG) Vision and its local authority partners vision is for people with dementia and their family/carers to be enabled to live well with dementia, no matter what the stage of their illness or where they are in the health and social care system.

Nationally it is recognised that the mental health needs of the ageing population are set to increase. The term 'dementia' is used to describe a syndrome which may be caused by a number of illnesses in which there is progressive decline in many areas of function, including decline in memory, reasoning, communication skills and the ability to carry out daily activities. Alongside this decline, individuals may develop behavioural and psychological symptoms such as depression, psychosis, aggression and other challenging behaviour. The majority of people who are diagnosed with dementia have either Alzheimer's disease or vascular dementia, or a combination of the two. It is estimated that about 6 per cent of the population over 65 has dementia and that after the age of 60 the prevalence of dementia doubles every five years so that about 30 per cent of those aged over 95 years are affected.

Across Dorset there are 187,456 people aged over 65, from this figure it is estimated locally that NHS Dorset CCG has 9,658 (nationally prevalence is estimated at 13,089) people aged over 65 in Dorset living with dementia. Dementia is not just an illness associated with older ages. It is estimated that early onset accounts for 2.2% of all people with dementia in the UK.

Many older people choose to retire to Dorset and there are a higher proportion of people aged 65+ in Dorset compared to the England average. As a consequence, there is a higher demand for care homes

in Dorset. Estimates suggest that one third of people with dementia live in care homes and of these two thirds are estimated to have dementia. Data from Adult Safeguarding, Mental Capacity Act and Mental Health Act and Continuing Health Care (CHC) will be investigated as part of this review as agreed by the lead agencies – the three local authorities.

Numbers of patients diagnosed with dementia have been increasing over last few years with around 1,400 diagnosed during 2017/18 and a 61.2% diagnosis rate.

In terms of dementia services across Dorset it is recognised that currently there is inequity of provision across East and West parts of the county. It is also noted that Dorset needs to review the current availability of post –diagnostic treatment and support across Dorset and consider how to ensure patients with dementia and their family carers needs are met.

To continue to progress this priority area, a programme to review all specialist dementia services, and design a consistent model across Dorset, was prioritised and included in the Clinical Commissioning Programme's 5 year plan, 2014-2019.

This project will take a co-production approach in order to identify the needs of people with dementia and their carers across Dorset and review all specialist dementia services across Dorset during 2016-2019. If necessary following the review this project will redesign and re-commission services to ensure the dementia service model is better able to meet the desired needs and outcomes for dementia patients and their family carers across all Dorset, Bournemouth and Poole localities.

The objectives of this review are:

- to complete a Joint Strategic Needs Assessment for dementia across health and social care;
- to use a co-production approach engaging with key stakeholders, patients and families/carers throughout the review;
- to review the current services and resources in the east and west of the county, including Intermediate Care Service for Dementia, Older People's Community Mental Health Teams, day hospitals, dementia inpatient provision, inclusive of beds currently temporarily not in use;
- to review the Memory Gateway Service including Memory Support and Advisory Service and Memory Assessment Services;
- to evaluate the Intermediate Care Service for Dementia service model in the east of the county against the agreed outcomes in the service specifications;
- to scope the current interdependence with other relevant services across the CCG area and service developments including Psychiatric Liaison Services, Integrated Community Services, Frailty care pathway developments, Mental Health Acute Care Pathway and the Clinical Services Review
- to undertake a gap analysis of current services against identified needs;
- with a co-production approach develop a model/s based on need and forecast prevalence of dementia in the different localities across Dorset;
- to identify short-term good practice and improvement opportunities;
- to undertake a consultation on the proposed models of care, including Health Scrutiny Committees, should significant change be indicated;
- develop a business case with options appraisal for approval at the Governing Body.

The **outcomes** expected by the project will be:

- Patients can get access to similar services wherever they live in Dorset;
- Patients along with their family/ carers will continue to have access to suitable services to be appropriately assessed and diagnosed when worried about their memory;
- Patients along with their family/carers after being diagnosed will be appropriately supported in order to live well with dementia and minimise anxiety associated with this diagnosis;
- Patients won't have to wait longer than necessary in an inpatient bed when they are well enough to be discharged;
- Patients will be supported to stay where they live and stay as independent as possible for as long as possible;
- Patients will only go to hospital when it is absolutely necessary, not because there isn't the right support in their community;
- Patients won't experience as many crises and it becomes rare to be admitted to a hospital under the Mental Health Act;
- People who support patients in their home, care home and hospitals will really understand dementia and treat them with understanding relevant to this illness;
- The places where patients get support will have welcoming environments that help them;
- Service user and carer satisfaction regarding the dementia care pathway will be increased;
- National dementia targets will be achieved, and
 - Effective and efficient use of public funds will be ensured.

The main objective of the Equality Analysis is to track each step of the review to ensure that insight into diverse communities are taken on board, through robust engagement with relevant stakeholders and that the equality analysis of the services in scope are obtained and analysed from the service providers. The equality analysis will be updated on a regular basis to ensure that it stays timely and relevant to the different stages of the review.

The review has now reached the stage of the completion of the draft Strategic Outline Case and this includes four model options that have been co-produced with stakeholders. Stage 1 NHS Assurance has been approved and Stage 2 is now being planned. Consultation is proposed to be taken forward from May 2019. In particular, the four options and various service changes and developments will be considered within this update.

Dementia and making reasonable adjustments:

<https://www.gov.uk/government/publications/people-with-dementia-and-learning-disabilities-reasonable-adjustments>

Please consider impact (among others) in terms of:

- **Accessibility; physical environment?**
- **Communication needs;**
- **Appropriateness of the service;**

- And any other relevant matters such as rurality, deprivation, .

| Initial impact assessment | Description of impact, and outline of any mitigation. |
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| <p>Race / ethnicity / nationality</p> <p><i>Attitudinal, physical and social barriers.</i></p> | <p>In the UK there has been research on the prevalence of dementia in black and minority ethnic communities (SCIE)¹. There are increasing indications that Black African- Caribbean and South Asian UK population prevalence is greater than the white UK population and that the age of onset is lower for Black African-Caribbean groups than the white UK population. These differences are thought to be due to increased prevalence of stroke and diabetes in these populations². Although a smaller population minority white ethnic groups such as Irish travellers/Gypsies is an ageing population and dementia may be more prevalent.³</p> <p>Black and minority ethnic people with dementia may be at particular risk of misdiagnosis, particularly of being labelled as ‘mentally ill’ and treated with (inappropriate) medication.</p> <p>There may be inequality in access to GP appointments where people may first present as part of concerns around their memory.⁴</p> <p>There are various initiatives in other parts of the country with larger South Asian populations which may offer guidance on supporting carers and people living with dementia.⁵</p> <p>Diagnostic and screening tools need to be culturally appropriate. When the diagnostic and screening tools are not culturally appropriate, over-diagnosis or misclassification are potentially significant issues.</p> |

¹ [Social Care Institute for Excellence \(SCIE\) website](#)

² https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/465274/Dementia_Equality_Literature_Review_Matrix_Report_-_Final_for_web_-_01102015.pdf

³ [Race Equality Foundation Better Health Briefing number 38 Dementia and Cancer in the Irish Community in Britain \(2015\)](#)

Also, [Dementia in Gypsy and Traveller communities, Dementia Action \(2018\)](#)

⁴ [“State of Care 2017-18”](#)

⁵ [South Asian older adults with memory impairment: improving assessment and access to dementia care” International Journal of Geriatric Psychiatry 2014 \(extract\) . Meri Yaadain-“Caring for Dementia: Exploring good practice on supporting South Asian carers through access to culturally competent service provision”](#)

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| | <p>Information about dementia needs to be made available in appropriate languages, delivered in a culturally appropriate way, use terms and explanations that are relevant to different cultures, and address concerns and misconceptions relevant to different cultures.⁶ And therefore we need to link with culturally appropriate voluntary and community groups and interpreters.</p> <p>There is a revised diagnostic pathway that is proposed within the Strategic Outline Case (SOC). The points noted above will be included within the new options.</p> |
| <p>Gender <i>Men, Women, Boys and Girls.</i></p> | <p>Gender has long been widely reported as associated with the prevalence of dementia. Of the 850,000 people with dementia in the UK, 500,000 are women. It is estimated that 61% of people with dementia are women and 39% are men. This is likely to reflect the fact that women live longer than men and age is the biggest known risk factor for the condition - nearly three in four people over the age of 90 are women. While some studies have suggested that other factors may affect the number of men and women with dementia, there is no firm evidence that women are more likely than men to develop dementia at any given age. Dementia is the leading cause of death for women and the third leading cause of death for men⁷</p> <p>After the age of 65, the risk of developing Alzheimer’s disease doubles approximately every five years. According to population data, 72.5% of people aged 90 or over in the UK in 2012 were women. Today, an 85 year old woman has an average further 6.8 years of life remaining. The unfortunate result of these trends is that many women are living their extra years in ill health.</p> <p>Women are far more likely to end up as carers of those with dementia than men, suffering physical and emotional stress and job losses in the process⁸</p> <ul style="list-style-type: none"> • 60-70% of carers for people with dementia are women. • 17% of working women carers felt penalised at work. • Women carers report feeling less supported than their male counterparts. |

⁶ [Moriarty, Sharif and Robinson \(2011\) Black and Minority Ethnic people and their access to support services, SCIE.](#)

- Race Against Dementia Alliance: Race Against Dementia, (2015)

⁷ <http://www.alzheimersresearchuk.org/wp-content/uploads/2015/03/Women-and-Dementia-A-Marginalised-Majority-Infographic.pdf>

⁸ <http://www.alzheimersresearchuk.org/wp-content/uploads/2015/03/Women-and-Dementia-A-Marginalised-Majority1.pdf>

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| | <ul style="list-style-type: none"> • Women carers are 2.3 times more likely to provide care for someone with dementia for over 5 years. • Women are 2.5 times more likely to provide intensive 24 hour care. • Women carers are more likely to feel isolated and depressed. <p>Support for carers needs to recognise specific issues affecting women and men separately.</p> <p>The review options have included specific support and training for carers. It has been recognised that the terminology used will often lead to males not engaging as they don't recognise themselves sometimes as 'carers'. A pilot of the Emotional Support and Dementia Education has therefore been called 'Dementia Workshop' and this has been found to attract more male carers than anticipated. This issue will be carefully considered within the new option of Dementia Roadshows to ensure that both genders attend.</p> <p>The options around specialist dementia inpatient units recognises the needs of males and females in this specific environment can be different and demand identifies that more males are admitted than females and that sometimes males are more difficult to identify appropriate care home placements due to challenging behaviours.</p> <p>The unit at Alderney hospital will remain with 40 beds and separate male and female wards.</p> |
| <p>Religion or belief</p> <p><i>Christianity, Islam, Non Abrahamic religions, Agnostics, Atheism</i></p> | <p>Different ethnic groups, especially Hispanic and African-American groups, received delayed and inadequate health care services for dementia. Efforts to narrow this health disparity will require understanding of how the religious and cultural beliefs of these communities influence their understanding of dementia and their willingness to seek support from health services for these conditions. Some of the culturally specific conceptualisations of dementia as a normal part of ageing or of having a spiritual, psychological or social cause have prevented many groups from seeking support.</p> <p>Specific work in Australia suggests that some of the causes are due to culturally mediated misconceptions and that culturally appropriate campaigns and educational interventions may be part of the approach needed⁹.</p> <p>When thinking about activities and encouraging meaningful engagement, a person's religion¹⁰, nationality or culture are likely to</p> |

⁹https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/465274/Dementia_Equality_Literature_Review_Matrix_Report_-_Final_for_web_-_01102015.pdf

¹⁰ [Cultural and religious needs of people with dementia- SCIE,](#)

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| | <p>have a major influence on their preferred music, food, clothes and everyday routines. But with memory loss, this may change.</p> <p>There are various sources of information to assist us and the new services. For example, with supporting people living with dementia in the Jewish community.¹¹</p> <p>Within the options developed it will be important that all members of the dementia services are aware of this issue and educational interventions may be needed. In particular, the Dementia Co-ordinator role whom will be assisting with Care Plans, GPs and Memory Assessment Services to encourage individuals to seek support and a diagnosis if appropriate.</p> |
| <p>Sexual orientation <i>Lesbian, Gay, Bi-Sexual and Transgender</i></p> | <p>The Public Health review¹² found that LGBT people were unwilling to declare their sexuality on admission to residential care. This would prevent diagnoses of dementia from being linked with sexual orientation data and therefore impede the ability of health services to identify issues that relate to dementia and sexual orientation.</p> <p>There are various examples of research into the prevalence or impact of dementia upon people who are LGBT¹³. Consultation with these people could identify further issues for consideration.</p> <p>Information about dementia and services needs to be inclusive of LGBT people. This could include representing LGBT people in pictures on leaflets and websites, and in case studies and other written material. Services should be following equalities legislation and processes should be inclusive. The workforce should be aware of equalities issues for LGBT people. This includes LGBT people who may have dementia and LGBT families/carers.</p> <p>Within the options developed it will be important that all members of the dementia services are aware of this issue and educational interventions may be needed. In particular, the Dementia Co-ordinator</p> |

¹¹ [Supporting people living with dementia in the Jewish community](#). “: Race Equality Foundation

¹²https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/465274/Dementia_Equalities_Literature_Review_Matrix_Report_-_Final_for_web_-_01102015.pdf

¹³ [“LGBT Individuals Living with Dementia- concepts, practice and rights” \(2018\) Taylor and Francis edited by Sue Westwood and Elizabeth Price. Routledge.](#)

Also [“Dementia Care and LGBT Communities” :National Care Forum](#) (April 2016)

And [“Over the Rainbow” :University of Worcester and the Dementia Engagement and Empowerment Project \(DEEP\) \(2015\)](#)

[There are also LGBT groups within Dementia Engagement and Empowerment Project \(DEEP\)– it is the UK network of dementia voices. Dementia Action Alliance. For example, D-mob, based in Brighton. Could contact?](#)

[“Foundations for the future: Dementia care for LGBT communities” National Care Forum \(2016\)](#)

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| | <p>role whom will be assisting with Care Plans and signposting to other support services, GPs and Memory Assessment Services to encourage individuals to seek support and a diagnosis if appropriate.</p> |
| <p>Age</p> <p><i>Detail across age ranges on old and younger people. This can include safeguarding, consent and child welfare.</i></p> | <p>The main risk factor for developing dementia is increasing age. After the age of 65, the risk of developing Alzheimer’s disease doubles approximately every five years.</p> <p>There are increasing indications that the age of dementia onset is lower for Black African-Caribbean groups than the white UK population.</p> <p>All individuals with Down’s Syndrome have the characteristic neuropathology of Alzheimer’s disease by the age of 40, and although not all will develop dementia, it is extremely common¹⁴.</p> <p>Life expectancy is increasing and so it is expected that the number of people with Down’s Syndrome over the age of 40 will increase.</p> <p>Services need to be tailored to meet the needs of minority groups including people with Down’s Syndrome and Black and Minority Ethnic groups. People with early-onset dementia (before age 65) are not always eligible for the same support as over 65s due to age – for example over 65 nursing homes, older people’s community mental health teams. People younger than 65 may not want the same services and may not want to live in a home with older people.</p> <p>There are differences in local authority funding of care services per person, based on age and disability. This may contribute to people having different experiences of care. For example, a higher level of funding may allow more spending on activities, enabling people to have their individual needs met. On average, local authorities pay £543 a week towards residential care for an older person with a physical impairment. For people aged under 65 the average is £898. There are even wider differences when looking at disability. The average weekly funding is £1,436 for people with a learning disability aged under 65, compared with £550 for older people with dementia.¹⁵</p> <p>As dementia is so often associated with older people, younger people who develop it (and those who care for them) face different challenges.¹⁶ It is noted that there are approximately 200 people diagnosed with dementia whom are under 65 years (both sexes). All options apart from the ‘Do minimum’ include Early Onset Dementia Co-ordinators whom will offer bespoke support and guidance for this client group whose needs can differ quite significantly from much older people. For example, they may still be providing for a family or in employment.</p> |

¹⁴https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/465274/Dementia_Equality_Literature_Review_Matrix_Report_-_Final_for_web_-_01102015.pdf

¹⁵ [.\(CQC State of Care 2018\) Adult Social Care Activity and Finance report \(NHS Digital\)](#)

¹⁶ [SCIE “Young Onset Dementia”](#)

Age alongside dementia will also impact on the ability to drive and therefore the ability to attend appointments. Age will also impact on family carers in a similar way. The Dementia Co-ordinator role and other community provision through the dementia team will be able to attend people's home's if required so there should not be a negative impact as a result of the new community options.

Options include either changes to Melcombe Day hospital to align with the model at Poole which offers support in crisis and is part of the 'Intensive support team' resource. Should this options be accepted within the consultation this would impact on current patients and their family carers. Approximately 10 people attend each day (open 4 days per week) for around a 3 month period. Further analysis work is being taken forward to consider the impact and to ensure this is minimised. At this point it is envisaged that both the functional and dementia patients utilising Melcombe for an assessment would have their needs met through social care provision.

Another option proposes the closure of both day hospitals and this would therefore include Haymoor patients whom have approximately 8 patients attending daily for 2 – 3 times per week. Further analysis work is being taken forward to consider the impact should this option be approved during consultation.

The current options proposed for Dementia Specialist Inpatient beds will have a negative impact potentially due to the fact they will be in one location at Poole and travel analysis (noted in the SOC appendix) has shown that for people from Weymouth, Portland, Gillingham, West Dorset areas such as Beaminster and Lyme Regis would require car travel of over 45 mins. If measured by public transport this is considerably longer taking over 3 hours in many occasions.

Whilst the services in scope include 2 previously closed units based in Blandford and Weymouth both of these units were temporarily closed due to safety grounds. This was due to the inability to recruit and retain registered staff and as this remains an ongoing issue particularly for the West of the county it is highly unlikely either unit could re-open in the future.

It is therefore proposed that during the Full Business Case options for accommodation and travel support are considered and costed. These could include local accommodation support and support for travel for carers with particular considerations for those whom are unable to drive.

The Community Services Review is proposing a range of step up and down beds based within care homes and community hospitals. This will minimise the need for dementia specialist beds overall. Alongside this

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| | <p>the further expansion of the Intensive Support service (previously known as the Intermediate care service for dementia) across the whole of Dorset will provide support in patients own homes for those in crisis and again minimise the need for an inpatient admission where possible.</p> |
| <p>Disability</p> <p><i>(e.g.) learning disabilities, physical disability, sensory impairment and cognitive impairment.</i></p> | <p>People with developmental disabilities have more than four-fold risk of dementia compared with the general population. In addition, see the section on Age above for the impact on people with Down’s Syndrome.</p> <p>Services for people with disabilities need to recognise the signs of dementia and know the pathways for diagnosis, treatment and support, especially for early-onset dementia which is more likely amongst people with developmental disabilities.¹⁷</p> <p>Since August 2016, all organisations that provide NHS care and / or publicly-funded adult social care are legally required to follow the Accessible Information Standard¹⁸. Information, services and support need to be inclusive, for example in Braille, large print, audio-formats and easy-read. Services need to be accessible by telephone, online and in person for people with disabilities.</p> <p>It is proposed within the options to link with a national helpline and these issues will need to be considered within this option.</p> <p>Furthermore, the Dementia Directory will need to be considered and ensure it meets all various needs. There will need to be clear pathways developed with the new options to align with the Learning Disability teams and other community teams.</p> |
| <p>Marriage and civil partnership.</p> <p><i>Part-time working, shift-patterns, general caring responsibilities.</i></p> | <p>There is evidence to show that being married may help to lower the risk of dementia. A study undertaken by the University of Loughborough found that people who developed dementia were less likely to be married, had fewer social relationships, and reported greater loneliness and this is supported by a longitudinal study of ageing¹⁹.</p> <p>Previous engagement from the South West Dementia Partnership in 2012 found a noticeable theme among women married to people with dementia, that their husbands with dementia would not “let them out of their sight” or would “not accept anyone else in the</p> |

¹⁷ Refer to [Social Care Institute for Excellence \(SCIE\): Learning Disabilities and Dementia](#)

¹⁸ [Accessible Information Standard.” NHS England.](#)

¹⁹ [Loneliness, Social Integration, and Incident Dementia Over 6 Years: Prospective Findings From the English Longitudinal Study of Ageing](#) Oxford University Journals of Gerontology (2017)

house". This meant that they felt they could not seek practical help and/or could not leave their husbands in the care of anyone else for even short spells of respite. Beliefs like this were strongly held and these wives felt under intense pressure. Yet talking about this to skilled practitioners, it was clear that such beliefs might be open to gentle, careful challenge to the benefit of both partners; this could be achieved in the context of practitioners building relationships with people living with dementia at an early stage. Where practitioners and people living with dementia did have such relationships, carers were able to accept interventions, and consequently were able to get some practical help.

Anxieties again identified from previous engagement highlight issues for partners/married couples. For example:

- a petite woman was worried that she would not be able physically to manage helping her tall, well-built husband if he became incontinent or unable to wash himself
- another woman was worried about sex with her husband as his condition progressed ("No-one talks about it")
- what would happen if the family needed help out of hours.
- what would happen if the main carer became ill or needed an operation (including hospitalisation and after discharge)
- how to cope with changing finances
- sleep management
- what to do if a partner became aggressive
- several people were worried about how to find out about the quality of local residential care options. Some had been given lists of local care homes but had no idea how to differentiate between them, could not visit them all, and were given no help to make decisions.

Importantly, as well as improving life with dementia and ameliorating anxieties, it is clear that addressing many of the questions raised could help prevent crises and costly admission to hospital or residential homes. For example, many concerns were about coping at home with challenging situations and behaviour, which if left to escalate, could lead to failure to continue to manage at home. Yet few people found themselves able to access this kind of 'thinking ahead' on the part of services. Where they did, they found it inestimably helpful. In particular Dementia Co-ordinators role will be very important to assist with such questions and ensuring early planning

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| | <p>and consideration also of the role of a civil partner is caring for the person living with dementia, and the difficulties that can be associated with this and provision of resources to help to deal with the challenges of caring.</p> <p>Early onset Dementia Co-ordinators are included in the options and these workers will be able to offer support to align with people with dementia whom are still in employment, have family responsibilities.</p> |
| <p>Pregnancy and maternity. <i>Detail on working arrangements, part-time working, infant caring responsibilities.</i></p> | <p>No information is available on the prevalence or impact of dementia on people who are pregnant or with infant caring responsibilities. However, pregnant women may be acting as carers (second/younger wives of men who are older) so this should be borne in mind re support required.</p> <p>This group of people should be included in consultation and engagement to understand their needs.</p> <p>Early onset Dementia Co-ordinators are included in the options and these workers will be able to offer support to align with people with dementia whom are still in employment, have family responsibilities.</p> |
| <p>Gender Reassignment <i>This can include issues such as privacy of data and harassment</i></p> | <p>We will remain mindful of the views of this community as someone with gender reassignment could develop dementia at later stages in their lives. Providing support and personal care to transgender individuals whose bodies may or may not be congruent with their gender identity can be challenging and can be further complicated by memory loss.²⁰ The impact on communication, privacy and cultural understanding will be reflected within the review.²¹</p> |
| <p>Other identified groups <i>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.</i></p> | <p>Socio-economic position has long been seen as an independent predictor of dementia. People with a low socio-economic position have increased prevalence of Alzheimer's disease, such that it is routine practice to statistically control for socio-economic position when reporting rates of dementia. The mechanism by which this leads to dementia is not clear, as it appears to be, in part, independent of education. Research has considered the lifelong deprivation effect upon mental health. ²²Research suggests People in more socially</p> |

²⁰ LGBT Individuals Living with Dementia- concepts, practice and rights” (2018) edited by Sue Westwood and Elizabeth Price.

²¹ [Betsi Cadwaladr University Health Board \(BCUHB\)- North Wales Health Board](#). First in UK to issue guidance on transgender dementia care.(2018)

²² [“Poverty and Mental Health” Joseph Rowntree Foundation and Mental health Foundation 2016](#)

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| | deprived areas are less likely to be prescribed anti dementia drugs ²³ Rurality is an additional, rarely reported, factor that would interact with socio-economic position. Rural living, especially in early life, is associated with increased risk of dementia ²⁴ |
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Engagement and involvement

Have you engaged stakeholders in gathering evidence or testing the evidence available? If not what do you intend to do?

Engagement has been throughout the Dementia Services Review and it has included various people with protected characteristics. All views have been captured within the View Seeking document initially and this has been followed with a detailed Design and Modelling Stage working with a wide range of stakeholders noted below.

If you have engaged groups please list below and include who was involved, how they were involved and the key outputs:

| Groups engaged | Date and type of engagement | Outputs from activity |
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| Dorset Dementia Partnership | On-going quarterly meetings. Attendance 25-50 approx | Gained views on current services and areas to improve Partnership kept informed on developments of the review and how to be involved. |
| Innovation Open Event | 16 May 2017 101 attended | |

[: "Observational cohort study: deprivation and access to anti-dementia drugs in the UK":UCL. "Age and Ageing" British Geriatrics Society \(2015\)](#)

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²⁴https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/465274/Dementia_Equality_Literature_Review_Matrix_Report_-_Final_for_web_-_01102015.pdf

This is OK as a source of information but only covers the period up to 2015. More recent research may be available.

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| Equality and Diversity workshop | 19 th February 2018. 20 attended | Ensure diverse community groups are informed of developments |
| Co-production design groups | May – Sept 2017 Attendance of 333 | 3 groups meeting in Dorchester, Bmth and Poole to reflect locality differences |
| Design and modelling working groups | Sept 2017 – April 2018 Approx 70 members | Groups with specific expertise to consider the different elements of care pathway with 6 sub groups with a mixture of stakeholders |
| Cross check event | 11 th April 2018 67 attended | Feedback and scoring on model options to enable prioritisation |
| Final Options event | 5 th Sept 2018 | Final event to consider models and costs and to shortlist |
| Sustainability and Transformational Partnerships Patient Engagement Group | 22 nd January 2018. 16 attended | Patient group of the STP to be informed of developments and be involved. |
| Poole Forum Learning Disability group | 17 th August 2017. 20 attended | Gave solutions and ideas to support modelling phase of the review. |
| Alzheimer’s society volunteer groups | 10 th January 2018 25 attended | Informed of the modelling phase of the review and how to be involved. |
| Poole and Bournemouth Forum Learning Disability group | 7 th June 2018 | Informed of the modelling phase of the review and how to be involved in the consultation phase. |
| Project Champions group meeting | 7 th August 2018 | Stakeholder meeting including Partnership members to give ideas on consultation. Ideas to consult with different communities, eg Chinese forum in Bournemouth |

Summary of Analysis of the overall impact *Considering the evidence and engagement activity you listed above, please summarise the impact of your proposals. 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.

Positive impact from engagement. All groups are invited to be involved in the review and attend modelling events and the consultation events to give their views on potential model options. Attendees are given the opportunity to ask questions and information is provided in formats suited to the audience, for example to ensure easy read presentations for the learning disability group.

Consultation plan will use different methodologies to engage with different communities and groups for example outreach, over 50 plus forums, day centres, carer groups, market days, lunch clubs, food banks.

Overall impact of the new options proposed is positive generally for the majority of groups. However, the inpatient unit based in Poole alone will have a negative impact for some people living in West and North Dorset. The impact will be minimised through considerations of travel and accommodation support. Furthermore, the expansion of the Intensive support team will ensure people are maintained in their own home for as long as appropriate and having a day hospital/s as an option will need careful consideration for the most appropriate location to minimise negative impact. The Step up and down provision based across the whole of Dorset will also help minimise the negative impact and ensure that only those with very high level of acuity and crisis are admitted to the dementia specialist inpatient beds.