SOUTH GLOUCESTERSHIRE COUNCIL

EQUALITY IMPACT ASSESSMENT AND ANALYSIS (EqIAA)

GUIDANCE

Introduction

The following provides guidance for all council officers involved in conducting EqIAAs. Where there is any doubt, or where you would like to have a supportive discussion on any aspect of any EqIAA, the Corporate Equality Officer should be contacted for support and guidance.

EqIAAs are not forms, templates, checklists or tick boxes; nor are they one-off documents. They are a way of recording:-

1. the gaps/disparities/issues in relation to a topic;
2. the **actions** which will be taken to reduce and eliminate them; and
3. the extent to which those gaps/disparities/issues are being reduced **on an ongoing basis.**

However, there is the following document designed to help you structure your work:

1. Full EqIAA Tool

Key Points

- The **purpose** of an EqIAA is to proactively identify gaps/disparities/issues and identify the **actions** which will be taken to reduce and eliminate them. It is a statutory requirement to be **proactive** about identifying gaps/disparities/issues and to take action to eliminate them.
- EqIAAs are **ongoing**. It is a statutory requirement to continuously **measure** the extent to which the gaps/disparities/issues identified have been/are being reduced and record this in your EqIAA.
- EqIAAs are a statutory requirement in respect of **every single** aspect of council activity whether that activity is delivered in-house, commissioned or procured, a pilot etc.
- Heads of Service are responsible for the equality performance of activities and premises under their control. This requires them to:
  - Ensure Eq|AAs are included from the outset as part of policy development and review; and that EqIAAs are included as part of all decisions on changes to service.
  - Ensure Eq|AAs are included from the outset as part of all commissioning and procurement activity.
  - Carry out EqIAAs on a regular basis (Business As Usual) using performance measures and engagement & consultation results to identify imbalances in outcomes related to protected characteristics, and to implement changes to address these imbalances where appropriate.
- Line Managers are responsible and accountable for ensuring equality both in the delivery of their service and in the management of their staff. Line managers will often be called upon by Heads of Service to work on EqIAAs.
- EqIAAs require qualitative and quantitative data and information – the SGC 'Customer Insight' policy contains the **required** equalities monitoring approach to be used by every area of the council – whether delivered in-house or commissioned etc.
- **NB.** Following rules/regs/frameworks etc. from any bodies (e.g. The Care Act, DfE equality monitoring requirements/returns, DfT regs etc.) will **not** automatically mean you comply with the Equality Act requirements. You will still need to check against the Customer Insight Policy and this EqIAA procedure to ensure your actions meet legal and council policy requirements.
- The council's Corporate Equality Officer can provide you with advice, guidance and support with any aspects of your EqIAAs. Officers are strongly encouraged to take this support up.
- **Every** team member should know the information contained within EqIAAs relevant to their work – this gives them opportunity to know about disparities, address them in their day-to-day work, come forward with their own ideas and have knowledge about the progress being made. It is up to Heads of Service and Line Managers to use the most appropriate route (e.g. team meetings) to provide all staff with updates and information in this regard on an ongoing basis.

Broadly, there are two 'types' of EqIAA which are discussed below:

1. EqIAAs accompanying a decision report	2. Business As Usual EqIAAs
Decisions cannot be taken without decision-makers being furnished with a complete EqIAA.	It is a statutory requirement to continuously monitor your performance i.e. the extent to which you are reducing gaps/disparities/issues in respect of all protected characteristic groups and modify the actions you are taking to address them where those gaps are not being reduced effectively. This is to be done via a 'Business As Usual' EqIAA.
Considering the huge variety of activity that Local Authorities deliver, it is noted that some EqIAAs will be quite short and others will need to contain much more information. This is dependent upon the individual topic of each EqIAA. Check with your Head of Service or the Corporate Equalities Officer if you are unsure (strongly recommended).	The council has a Business As Usual EqIAA digital dashboard in place and Heads of Service are responsible for updating this on a quarterly basis. Progress is reported to the Senior Leadership Team and publicly via the council's statutory Annual Equality report.
Your EqIAA must be started at the earliest opportunity – it is a statutory requirement that EqIAAs influence decisions and are therefore carried out from the very outset of a decision making process. EqIAAs carried out retrospectively or at a stage which is too late to genuinely influence decisions will be unlawful in all instances.	All Business As Usual EqIAAs are to be updated regularly. A Business As Usual EqIAA is a single document which will: 1. Identify gaps/disparities/issues; 2. Identify actions which will reduce them; (Deliver those actions); 3. Measure the extent to which gaps/disparities/issues have been/are being reduced; 4. Identify new and/or continuing actions; 5. Repeat the above process i.e. it is an ongoing process. This is a continual process that does not end; it is an ongoing process that requires continual action to eliminate gaps/disparities/issues.
EqIAA documents must be appended to decision reports and the 'Equalities Considerations' section contained within the councils reports template must be completed so that it provides an overview of the EqIAA outcomes.	Your Business As Usual EqIAAs will grow as you add to them over time.
Once a decision has been taken, the EqIAA then becomes 'Business As Usual'. It does **not** end with a decision – in reality, an EqIAA **begins** with a decision. Remember that the purpose of EqIAAs is to identify actions that will address gaps/disparities and will therefore contain actions to be taken. Measuring and reporting success against the delivery of these actions and the impact they are having is a statutory requirement.	Information from your EqIAA will be required for 'update reports' - all update reports are required to contain information which updates decision-makers on your equalities performance.

EqIAAs are not forms or templates or checklists or tick boxes. They are a way of recording the gaps/disparities/issues in relation to a topic, the **actions** which will be taken to reduce and eliminate them and the extent to which those gaps/disparities/issues are being reduced.

However, to assist officers in this, there is the following document designed to help:

1. Full EqIAA Tool

The Full EqIAA Tool is scaleable, meaning that the information you include will be dependent on the topic of the EqIAA e.g. an EqIAA concerning a topic in Adult Social Care will very likely contain far more information than an EqIAA concerning high street bin collections.

Defining what actions to take

So, you've done your research, you know what the gaps/disparities/issues are in relation to your topic and now you need to identify the actions you will take in response and the measures you will use to understand the impact those actions are having.

Many actions will be very clear and evident as a result of your research and your consultation and engagement activity. However, there will certainly be times when support to define the most effective and valuable actions you could take will be very helpful to you. The following lists the support you can access (this is not an exhaustive list):

Support	Further Detail
Corporate Equality Officer	This will often be a good first port of call – arrange to meet the Corporate Equality Officer and discuss – it's part of their role to provide you with this support!
South Gloucestershire Equalities Voice support panel	This is a group made up of our external equalities partner organisations. The group meets quarterly and has been specifically designed to provide council officers with the opportunity to speak with a supportive group of equalities experts about **actions**. This group can support you to develop your action plan and is specifically why this support panel is in place. Contact the Corporate Equality Officer to arrange your slot on a forthcoming agenda.
South Gloucestershire Equalities Forum	This groups consists of our external equalities partners as well as many other public and VCS organisations. You can attend to present and have a discussion around actions. Contact the Corporate Equality Officer to arrange your slot on a forthcoming agenda.
SGC Staff Equalities Groups	There are 4 Staff Equality Groups in place at the council. They are: The BME Staff Network The Disabled Employees Group The LGBTQ+ Staff Network The Women's Staff Network There can very often be topics which would benefit greatly from discussions with one or more of these groups. Contact the Chair of the groups to make arrangements – their contact details are on the intranet here.
Community Engagement Forums (CEFs)	CEFs aim to provide a platform for building strong and cohesive communities in which everyone, regardless of background, has a real sense of community involvement.

	To find out more and to make arrangements contact our internal team here.
Armed Forces support groups	The council commissions a support service for veterans which is provided by 2 organisations:- Assist-Plus and SSAFA – The Armed Forces Charity. As part of this, a peer support group has been set up and you can arrange to attend and discuss issues and actions directly with the Armed Forces Community. You can also meet with the organisation's representatives. Contact the Corporate Equality Officer to help making the arrangements you need.
Young Ambassadors	Contact the young people's participation team for help making the arrangements you need.
Council research and information	The council has a significant amount of information that will help you. Check out the latest Council Revenue Budget and Capital Programme EqIAA here which provides an appendix giving many years worth of data (you will find it helpful to skip straight to the appendices). Contact the Corporate Research and Consultation Team here.
National research and information	The Equality and Human Rights Commission produces a 'state of the nation' report on a regular basis which provides a huge resource of information. Professional bodies will have many reports and examples that you can learn from.
Past EqIAAs	Access our database of past EqIAAs (this is not a list of every EqIAA, it is a list of major EqIAAs) for ideas.
Partner organisations	There are many partner organisations that you can liaise and engage with – ask your Head of Service for details.
South Gloucestershire Low Vision Service Users Committee	You can attend to present and have a discussion around actions. Contact the Commissioning Team to arrange your slot on a forthcoming agenda.
South Gloucestershire Deaf, Deafened and Hard of Hearing Group	You can attend to present and have a discussion around actions. Contact the Commissioning Team to arrange your slot on a forthcoming agenda.

EQUALITY IMPACT ASSESSMENT AND ANALYSIS (EqIAA)

SECTION 1 - INTRODUCTION

Set the scene by briefly describing the service/function/issue under consideration.
Note:- you will often be able to paste this from elsewhere (e.g. a PID document, a Strategy document etc.)

This strategy provides a framework for commissioning and service delivery in South Gloucestershire (SG), aiming to ensure that people with dementia and their carers can live well and are supported to do so throughout the progression of the disease. It sets out our local picture in context, our priorities for change, and how we are going to work towards these.

We look to create an inclusive and supportive environment that enables individuals affected by dementia to thrive with dignity and respect, and a commitment to creating a dementia-friendly community. We will continue to work towards a joined-up health and care offer and improve access to support and leisure opportunities, to empower pursuit of physical and mental wellbeing that enable people to remain independent and well for as long as possible.

Recommendations include:

1. Focus on inequalities
2. Strengthen community involvement & representation
3. Improve awareness and understanding
4. Ensure a good dementia journey
5. Deliver better social care support
6. Support carers of people living with dementia
7. Improve access to community support
8. Develop our workforce
9. Improve the interface between community and secondary care
10. Better end-of-life planning
11. Use data and insights better
12. Create age friendly communities

SECTION 2 - RESEARCH, ENGAGEMENT AND CONSULTATION

Dementia is a term used to describe a group of conditions that result in the progressive loss of mental abilities. It can cause complex symptoms and can be unpredictable. Every person's journey with dementia is individual, and people may progress at different rates.

It is one of the most common conditions affecting the elderly, with nearly a million people estimated to have dementia in the UK. People with severe symptoms of dementia make up around half this number.[1]

Dementia does not affect just the individual, with significant impacts also felt by families, friends, carers, and communities. The cost of dementia to the UK in 2024 is estimated at £42billion, nearly two thirds of which is borne by individuals and their support networks, through unpaid care or other costs[1].

As of April 2024, there were 2,407 people diagnosed as having dementia in South Gloucestershire. This is an all-age prevalence of 0.82%, or 4.41% of over 65-year-olds. Based on population estimates, our expected number of people with dementia in South Gloucestershire would be 3,578. Therefore, our rate of diagnosis is around 62%, and there are likely more people who could benefit from a diagnosis. Multiple factors are required for a timely dementia diagnosis from public health awareness and the training of health and social care professionals, to recognising the symptoms of dementia and initiating referral[2]. Individuals and families may not seek a diagnosis due to a lack of awareness of symptoms, fear or denial, difficulty in getting an appointment, or other reasons. The estimated number of people with dementia (including undiagnosed) in South Gloucestershire in 2030 is 5,500, an increase of 57%. We need to prepare for these population changes.

Between the censuses in 2011 and 2021, the population of South Gloucestershire increased by 10.5% to a little over 290,000 people. South Gloucestershire's population median age is 40 years, which is in line with the figure for England, and lower than the Southwest. However, we have a slightly greater percentage of people over 75 compared to England as a whole.

A small but significant number, 64 people as of April 2024, are less than 65 years old and are classed as having 'young onset' dementia. Providing the right support for people with young onset dementia can be more challenging. They may have different needs, including young families, and the support available to older people may not be appropriate to them. The table below show the local prevalence of young onset dementia.

Table showing the prevalence of young onset dementia in South Gloucestershire local authority in April 2024, using locally analysed data from primary care, adult social care, and secondary care data.

Prevalence of young onset dementia in South Gloucestershire Local Authority, 2024					
Age (years)	<50	50-54	55-59	60-64	Total
Number	<10	<10	21	30	64

A higher proportion of females over age 85 have dementia in South Gloucestershire compared to males of the same age. Below this, numbers are similar between sexes.

People from all ethnic groups in South Gloucestershire have dementia. Rates in groups are statistically similar, but we know there is more to do to understand differences experienced by all people. A significant number of people are coded in primary care records as 'unknown ethnicity' which hinders our understanding of their experience. We know that nationally there is inequality of diagnosis for people from ethnic minority communities, who may be more likely to present late or only following crisis[3].

We have heard through our engagement that more could be done locally to provide culturally sensitive information and help reduce stigmas or taboos. We are committed to working with partners, including our strong representation in the voluntary sector, to understand better the different barriers to access of diagnosis and care, and work to make our diagnostic pathways more culturally accessible.

Prevalence of dementia in the most deprived IMD decile in South Gloucestershire is higher than in the least deprived (5.9% vs 3%), although the increase between deciles is not linear.

People with learning disabilities may be at increased risk of dementia and can present with different symptoms in the early stages. We recognise that people with learning disabilities may have increased difficulty in accessing healthcare appointments and face increased barriers to accessing diagnostic services[4]. Methods used for diagnosis are often not appropriate for people with learning disabilities. People living with dementia with learning disabilities also face additional barriers to accessing appropriate end of life care, acknowledging that dementia is a life-limiting condition.[4] As the population with learning disabilities ages, additional specialist services will need to be provided to meet the needs of older people with learning disabilities and dementia.

Satisfaction with council services relating to 'care for older people' is high amongst survey respondents to council assessment in 2024/5[5]. A significant programme has been underway for some months to make South Gloucestershire an 'Age Friendly Community'[6]. This work is governed by the Age Friendly Communities Board and has involved substantial community engagement. It is our hope that the continuation of this work will continue to improve reported experience with services.

As part of development of this dementia strategy, we have attended the Learning Disability Partnership Board, run several outreach community engagement workshops, and had many conversations and workshops with stakeholders, including those in VCSE organisations such as Southern Brooks who oversee the Dementia Action Alliance, Alzheimer's Society, Age UK, Sirona, Care and Support West, Bristol Black Carers, The Chinese Community Wellbeing Society, and Healthwatch South Gloucestershire. Information gathered and experiences heard, are reflected in the above paragraphs.

a) *Describe what your research tells you about the experiences (service take-up, satisfaction and outcomes) of the below listed groups. Sources of evidence used should be locally collected data and regional & national data, as well as data and information that the service area in question currently holds.*
Helpful starting points include:
- *The Equality and Human Rights Commission report 'Is Britain Fairer?' – access via EHRC website;*
- *Look at this council webpage which lists SGC completed EqIAAs - open the most recent EqIAA entitled "Revenue Budget and Capital Programme" – the appendix in this document provides a huge amount of data and information in regard to perceptions of council services.*

b) *Describe what ongoing engagement activity with residents and service-users tells you about gaps/disparities/issues.*

c) *Describe what consultees from the below listed groups have told you.*

Groups:

1. Age
2. Disability
3. Gender Reassignment
4. Marriage & Civil Partnership
5. Pregnancy & Maternity
6. Race
7. Religion or Belief
8. Sex
9. Sexual Orientation
10. Socio-economic groups i.e. poverty/financial hardship/receipt of benefits, un/employment, long-term unemployed/never worked, level of education, geography, housing type, student etc.
11. Armed Forces Community i.e. Members of the Regular and Reserve Forces, Former members of any of Her Majesty's forces who are ordinarily resident in the UK; and relevant family members (partners and dependants). This 'group' **must be covered for any service/function/issue in the areas of Education, Health, Housing and Employment**. EqIAAs outside of these 4 areas are not required to take this 'group' into account, but it will be good practice to do so.

SECTION 3 - IDENTIFICATION OF DISPARITIES, IMPACTS AND ISSUES

We have, and will continue to, seek feedback and hear experiences from people affected by dementia. This includes co-design of workplans and involvement on governing boards, such as the Age Friendly Partnership Board. We have an actively fostered partnership with our Dementia Action Alliance and seek feedback from them and others about people's experiences with the services provided by South Gloucestershire Council.

Age

Dementia becomes more common as we age, however it is not a normal part of ageing. Some older people could face stigma and ageism in relation to dementia. There is also a need to address the misconception that dementia only affects older people[7].

Young onset dementia is the name given to any dementia that presents before an individual is 65 years old, though this specific age is a historic cut off with no medically significant basis. In South Gloucestershire as of April 2024, 64 people are classed as having 'young onset' dementia. Providing the right support for people with young onset dementia can be more challenging. They may have different needs, including young families, and the support available to older people may not be appropriate to them. Misconceptions and lack of understanding of young onset dementia may result in later diagnosis, increasing the inequalities this group may experience. We have heard from our engagement activities that of a lack of specific and suitable services and support can exist for some people with young onset dementia.

Disability

People with dementia may have other health conditions or disabilities including physical disabilities, sensory impairments, neurodiverse conditions, mental health conditions and others, that have an impact on when they seek and receive a diagnosis or their ability to access services and support.

Dementia is recognised as a disability, but 2019 national research suggests that people with dementia may not have their disability rights upheld, including around employment and financial help[8]. Services provided for those with dementia need to be accessible and we will work with partners to ensure that access is not limited for those with disabilities.

People with pre-existing conditions such as diabetes, heart disease or depression are also at greater risk of developing dementia.[9] Efforts should be made in promoting health before a diagnosis, as well as after one is made.

Learning disabilities

People with learning disabilities, particularly those with Down's syndrome, have an increased risk of developing dementia. Getting a diagnosis of dementia can also be more difficult and take longer for people with learning disabilities and their dementia can progress more quickly than for someone without a learning disability[10]. Early recognition signs of dementia can also be missed, sometimes masked by other health problems or attributed to the individual's learning disability[11]. We heard through local engagement of increased difficulty experienced in accessing healthcare appointments, including in navigating online systems.

Gender reassignment

The Alzheimer's Society[12] identifies particular issues around gender identity and trans people such as that due to memory problems, the individual may not remember that they have transitioned (or are in the process of doing so) or that they may forget who they have shared their gender identity with and may 'out' themselves without meaning to do so. The strategy and engagement activity provides opportunity to consider challenges experienced by people and how we can improve this and better meet their needs.

Marriage and civil partnership

We have examined this protected characteristic in relation to dementia data and community insights in South Gloucestershire. We have found no particular disproportionate impact on access or outcomes based on marriage or civil partnership.

Pregnancy and maternity
We have examined this protected characteristic in relation to dementia data and community insights in South Gloucestershire. We have found no particular disproportionate impact on access or outcomes based on pregnancy and maternity.

Race *(including colour, nationality, ethnic or national origin)*
2023 research suggests that factors that increase the risk of dementia (e.g. hypertension, obesity, diabetes etc) have a greater impact on risk for people in minority ethnic groups[13]. There is a greater prevalence (up to four times greater) of dementia in Black and South Asian ethnic groups. People from minority ethnic groups in England are also less likely to receive a diagnosis of dementia for reasons including difficulty in accessing health services, poor understanding and awareness of dementia, stigma that may be greater in some communities, reducing likelihood to seek support[9]. Some research suggests that people from ethnic minorities are more likely to reach dementia services at a later stage of their condition than people of White British ethnicity.

People from all ethnic groups in South Gloucestershire have dementia. Local primary care data shows that rates of diagnosed dementia by ethnicity are statistically similar within South Gloucestershire. Given that we might expect higher dementia rates among South Gloucestershire's non-white population, this suggests that there may be greater underdiagnosis within non-white groups. A significant percentage of patient records for people with dementia have ethnicity coded as 'unknown'. To allow us to understand better the experience of service users by ethnicity, it is important to improve this coding. In addition, the strategy recognises that not enough is known locally about the use and experience of service users from minority ethnic groups. The strategy recommends that

We have heard through our engagement that the currently available diagnostic services, pathway, and information may not be seen as fully culturally sensitive. There are reported cultural barriers, including in accessing translations. People from different ethnic groups may have different health seeking behaviours, and more could be done to provide information in more accessible and tailored formats, and in helping to reduce stigmas or taboos. We are committed to working with partners, including our strong representation in the voluntary sector, to better understand different barriers to access and work to make our diagnostic pathways more culturally accessible. Recommendations within the strategy around strengthening community involvement & representation and workforce development will help ensure that services are culturally appropriate and accessible to our diverse communities.

Religion or belief
We have considered this protected characteristic, and have found no significant disproportionate impact based on religion or belief. There is, however, some evidence to suggest that some 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[9]. Recommendations within the strategy around strengthening community involvement & representation and workforce development will help ensure that services are culturally appropriate and accessible to our diverse communities.

Sex
Women have a higher risk for developing dementia. The main reason for this is that on average women live longer than men, and age is the biggest risk factor for dementia. In South Gloucestershire, a higher proportion of females aged over 85 years have dementia compared to males of the same age.
Women are also more likely to be carers, though engagement and proposed workplans for carers are primarily held within our Carer's strategy[14]. During our engagement, we heard of the additional burdens that may disproportionately fall on women as carers.

Sexual orientation
People in the LGBTQIA+ community may face unique challenges whilst living with dementia. The Alzheimer's Society describes how may have previously encountered prejudice or discrimination from services including health and social care services. They may therefore not want to access or contact sources of support, or they may feel uncomfortable being open about their sexual orientation or gender identity around professionals including GPs, nurses or social workers[15]. A Stonewall report in 2018[16] found that one in seven LGBTQ+ people, including more than a third of trans people, have avoided treatment for

fear of prejudice. This could have an impact on seeking support for dementia. Recommendations within the strategy around strengthening community involvement & representation and workforce development will help ensure that services are culturally appropriate and accessible to our diverse communities.

Socio-economic groups

There are a number of factors related to an individual's socio-economic position that can increase the risk of developing health conditions that, in turn, increase the risk of dementia. Some of these relate to physical health such as a lack of physical activity but also more broad factors such as receiving a poorer early year's education. There is a strong link between smoking and socio-economic group and smoking is one of the biggest risk factors for dementia. Some evidence suggests that smoking can double the risk of developing dementia[9]. More information on these risk factors, and their local prevalence, is held within the strategy.

There is also evidence to suggest a relationship between socioeconomic background and early-onset dementia with people from a lower socio-economic status having a three times greater risk of developing early onset dementia in comparison to those from a higher socioeconomic background[17].

People with low levels of educational attainment may experience inequality around diagnosis and assessment of dementia. People within this group may need greater support to understand and complete dementia assessment tools and be at increased risk of an incorrect diagnosis[18].

Socioeconomic inequalities also intersect with other issues, such as digital inclusion. People with dementia who are homeless are potentially disadvantaged as they have no address; are acutely vulnerable due to the impact of dementia in a transient situation and are at a higher risk of exploitation if symptoms of dementia are obvious to others[19].

People living in more rural areas or with limited transport may find it more difficult to access local support services or to attend appointments.

Armed Forces Community

There is a higher prevalence of traumatic brain injury and post-traumatic stress disorder in the military population compared to the civilian population. There is some evidence to suggest that moderate-to-severe traumatic brain injury increases the risk of being diagnosed with Alzheimer's disease[20].

In this section, set out the issues your research and consultation results show in a concise manner. E.g. people from a Caribbean heritage have a higher level of unemployment, women are under-represented within managerial level job roles, boys from a Black African heritage continue to have a lower level of GCSE attainment across South Glos, disabled people report a significantly lower level of satisfaction with parks and open spaces etc.

Look back at your research, engagement and consultation results – this section simply sets out the key points arising in a clear and concise manner.

If your EqIAA concerns a decision to be taken, you will also need to describe the likely impacts that will be experienced by the listed groups should the decision be taken e.g. *Gay men have a high level of smoking and high rates of positive outcomes from the stop smoking service; therefore, should a decision be taken to reduce a stop smoking service, gay men will be disproportionately negatively impacted.*

SECTION 4 - ACTIONS TO BE TAKEN

The actions from the EqIAA have been incorporated into the dementia strategy and will be drawn into the subsequent action plan which will be held and reviewed regularly by the Dementia sub-group of the locality partnership. This will report into the oversight group for Age Friendly work, and ultimately be accountable to the Health and Wellbeing Board.

Actions held in the strategy will be given named accountability, and a method of evaluation and target aim where possible.

The strategy sets out 12 recommendations, which have been developed with partners in response to the key issues identified. Each recommendation is presented alongside specific actions that we will take together with an ambition statement.

The recommendations include:

1. Focus on inequalities
2. Strengthen community involvement and representations
3. Improve awareness and understanding
4. Ensure a good dementia journey
5. Deliver better social care support.
6. Support carers of people living with dementia.
7. Improve access to community support & connectedness.
8. Improve and interface between community & secondary care.
9. Better end-of-life planning.
10. Develop our workforce.
11. Use data and insights better.
12. Create age friendly communities.

How we will deliver the Strategy

Strong governance with community representation at all levels will be crucial to delivering this strategy over the next five years.

This strategy will be owned by the South Gloucestershire Health and Wellbeing Board (HWB). This ensures that all partners required for strategy delivery will have oversight of progress and own the recommendations.

It is our proposal that SGC create a new Age Friendly Communities Partnership (AFCP) which will report into the HWB and represents the next level of oversight.

The Dementia Subgroup will be responsible for strategy delivery and ongoing monitoring. The group reports into the AFCP. This group has broad membership from the local health and care system, including members from the voluntary and community sectors. It will recruit a member with lived experience of dementia to ensure that communities are involved in designing local services. The Subgroup will develop an action plan and monitoring framework in response to recommendations and report on progress to the AFCP and HWB.

As a result of the information so far, what will you DO to address the gaps/disparities/issues emerging?
BY WHEN will you do them? WHO is responsible for delivering them? WHO is accountable for them? What will you ACHIEVE by doing them i.e. how will you measure success? Are there any other public sector organisations that you will need to communicate your actions to?

This is a **critical** section. The **purpose** of an EqIAA is to identify gaps/disparities/issues and **take action** to reduce and eliminate them. Therefore, **action is essential**. As a rule of thumb, an EqIAA is likely to be inadequate (unlawful) if there are limited or no actions identified.

Make sure that your actions are transposed into relevant action plan(s) so they are not 'lost'. EqIAAs are statutory, publicly available documents and, when asked, you will need to provide information about progress against your actions and the extent to which the gaps/disparities/issues you have identified have been reduced e.g. *50% of gay men achieved a positive outcome when attending our stop smoking service and this has now increased to 75% of gay*

men achieving a positive outcome. This compares against an overall rate of 85% of all people achieving a positive outcome, indicating the need to continue to work on our actions to further reduce the gap experienced by gay men.

SECTION 5 - EqIAA OUTCOME

Outcome	Response	Reason(s) and Justification
Outcome 1: No major change required.	☐	
Outcome 2: Adjustments to remove barriers or to better promote equality have been identified.	☒	Adjustments have been identified as a result of this EqIAA – please see the table below for details of these adjustments.
Outcome 3: Continue despite having identified potential for adverse impact or missed opportunities to promote equality.	☐	
Outcome 4: Stop and rethink.	☐	

Protected Characteristic	Adjustments and Rationale
Age [Children and Young people 0 to 19; Older People 60+]	Increased awareness of young onset dementia amongst clinicians, those involved in service delivery and the public. Review and redesign as necessary our dementia pathway through a process of community engagement.
Disability Physical Impairment; Sensory Impairment; Mental Health; Learning Difficulty; Long-Term Condition	Reviewing services and support for people with dementia to understand whether they are accessible for those with disabilities including learning disabilities. Involve people with disabilities in these reviews. Provide comprehensive information and support for people with dementia and learning difficulties and their carers, ensuring that this is fully accessible for people with all types of disability. Improved understanding of the early recognition signs of dementia amongst clinicians, support services and carers of people with learning disability to increase the likelihood of a timely diagnosis and access to support.
Gender Reassignment	A person-centred approach is needed to take into consideration the individual's needs, perspective and experiences. Services and support should be sensitive to trans people, both the person with dementia and their carer. Improved understanding from commissioners and stakeholders of the particular needs of individuals living with dementia or their carers who have had gender reassignment.
Marriage and civil partnership	No negative or differential impact currently identified.
Pregnancy and maternity	No negative or differential impact currently identified.
Race (including colour, nationality, ethnic or national origin)	Continue to work with ethnic minority communities to increase awareness, increase diagnosis rates and reduce dementia related stigma.

	Work with partners including the voluntary sector to understand better the barriers to accessing support and services. Work with partners to ensure that information and support is culturally sensitive and is developed with service users. Review the diagnostic assessments used in primary and secondary care and whether they are culturally appropriate for ethnic minorities. Improve access to translated resources and consider the most accessible formats for sharing information.
Religion or belief	In some cases religion is closely associated with cultural and ethnic differences. For others religion, belief or lack of either will not be associated. Religion, belief or lack of either to be considered in person-centred planning of an individual's care and support including culturally sensitive resources and information. This will have particular relevance to end-of life planning for people with dementia.
Sex	A person-centred approach is needed to take into consideration the individual's needs and perspective. When developing engagement and initiatives, we need to be mindful of the need to meet the requirements of men as a minority group. We also need to be mindful that unpaid care is predominantly done by females and reflect this awareness in our engagement and interventions.
Sexual Orientation	A person-centred approach is needed to take into consideration the individual's needs and perspective. Services and support should be sensitive to an individual's sexual orientation, both for the person with dementia and their carer.
Other characteristics:	
Carers	It is important that needs of person with dementia and all carers are both considered. Caring for someone with dementia can have an adverse impact upon a carer's physical and emotional health. We need to ensure that there is information and support in place to support carers fully. The Strategy fully supports all recommendations set out in the South Gloucestershire Carers Strategy.
Socio-economic groups	Reducing inequalities, including those related to socio-economic factors, is at the heart of the Strategy and its work to develop local systems. A person-centred approach is needed to take into consideration the individual's needs and perspective. This may include sensitivity to an

	individual's requirements for the presentation or delivery of information. Accessibility and location of service provision should be considered to ensure those living rurally or with limited transport are able to access services and support. There should be continued health promotion activity to reduce rates of smoking and other modifiable risk factors that increase an individual's likelihood of developing dementia. Increased awareness amongst organisations supporting people who are homeless of the pathways for diagnosis & care and the support available for people with dementia. Ensuring information can be accessed 'offline' and in different formats so that those without internet access are not digitally excluded from information and support.
Armed Forces Community	Increased awareness amongst those in the Armed Forces Community and organisations and services supporting the community of the risks of dementia.

Complete the following table. (NB. there will be very few instances where 'Outcome 1' can be selected).

Outcome	Response	Reason(s) and Justification
Outcome 1: No major change required.	☐	
Outcome 2: Adjustments to remove barriers or to better promote equality have been identified.	☒	The proposed Dementia Strategy 2025-2030 clearly identifies a full range of equalities related issues emerging from the Ageing Well Needs Assessment, consultation and engagement activities and the process of conducting this EqIAA. The next step in delivering the Dementia Strategy is to develop an action plan for delivery which is comprehensive in responding to the needs of all protected characteristic groups and which takes full account of the issues raised in Section 3 of this EqIAA.
Outcome 3: Continue despite having identified potential for adverse impact or missed opportunities to promote equality.	☐	
Outcome 4: Stop and rethink.	☐	

NB. Where a completed EqIAA is accompanying a decision report, the decision report itself will need to provide a summary of the EqIAA (a standard section of every council decision/update report is "Equalities Considerations"). To provide a summary, you must:

- Include the full EqIAA as an appendix to the report;
- Use your completed text from the above table as the basis for the text of your summary section in the report.

This means that your “Equalities Considerations” section within your report will read: “A full EqIAA has been conducted and is shown in Appendix XX. The EqIAA concludes that NOW INSERT THE TEXT FROM THE ABOVE TABLE and describe the actions you will be taking as per Section 4 above”.

SECTION 6 - SOURCES OF EVIDENCE INFORMING THIS EqIAA

Insert a list of the sources of information you have used to inform your EqIAA.
This is required so that you are able to evidence that you have undertaken robust research using appropriate information.

1 – Carnall Farrar. The economic impact of dementia, Module 1: The annual cost of dementia. May 2024. https://www.carnallfarrar.com/wp-content/uploads/2024/06/The-economic-impact-of-dementia-CF.pdf
2 – All Party Parliamentary Group on Dementia. Raising the barriers: An action plan to tackle regional variation in Dementia Diagnosis in England. October 2023. All-Party Parliamentary Group on Dementia | Alzheimer's Society (alzheimers.org.uk)
3 - Alzheimer’s Society. Ethnic minority communities: Increasing access to a dementia diagnosis. September 2021. https://www.alzheimers.org.uk/sites/default/files/2021-09/ethinic_minorities_increasing_access_to_diagnosis.pdf
4 - Office of Health Economics. Inequalities in Dementia: Unveiling the evidence and Forging a Path Towards Greater Understanding. June 2024. https://www.ohe.org/wp-content/uploads/2024/06/Inequalities-in-Dementia-OHE-AS-Report-v8.pdf
5 – South Gloucestershire Council. Equality impact assessment and analysis. Council revenue budget and capital programme 2024-25. https://beta.southglos.gov.uk/static/a4eb40721842d981f0c0098e200cbc2c/FULL-EqIAA-Budget-24-25-FINAL.pdf
6 – South Gloucestershire Council. Age Friendly Communities webpage: https://agefriendly.commonplace.is/
7 - British Psychological Society. Ageism in dementia. September 2021. https://www.bps.org.uk/psychologist/ageism-dementia
8 - All Party Parliamentary Group on Dementia. Hidden no more: dementia and disability. 2019. https://www.alzheimers.org.uk/about-us/policy-and-influencing/2019-appg-report
9 - UKHSA. Health matters: health inequalities and dementia. 2016. https://ukhsa.blog.gov.uk/2016/03/22/health-matters-health-inequalities-and-dementia/
10 - Alzheimer’s Society. Learning disabilities and dementia. 2024. Learning disabilities and dementia | Alzheimer's Society (alzheimers.org.uk)
11 - Public Health England. Dementia and people with learning disabilities: making reasonable adjustments – guidance. June 2018. https://www.gov.uk/government/publications/people-with-dementia-and-learning-disabilities-reasonable-adjustments/dementia-and-people-with-learning-disabilities
12 - Alzheimer’s Society. Memory problems LGBTQ+ people with dementia may experience. 2024. https://www.alzheimers.org.uk/get-support/help-dementia-care/lgbtq-dementia-memory-problems
13 - Mukadam et al. South Asian, Black and White ethnicity and the effect of potentially modifiable risk factors for dementia: A study in English electronic health records. October 2023. https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0289893
14 - South Gloucestershire Council. Carer Strategy 2022-2027. https://beta.southglos.gov.uk/static/8545ef5b9df1f448040d87fc80eb532c/South-Gloucestershire-Carers-Strategy-2022-27.pdf
15 - Alzheimer’s Society. Supporting an LGBTQ+ person with dementia. 2024. https://www.alzheimers.org.uk
16 - Stonewall. LGBT in Britain: Health Report. 2018. lgbt_in_britain_health.pdf (stonewall.org.uk)
17 - Rui et al. Associations of socioeconomic status and healthy lifestyle with incident early-onset and late-onset dementia: a prospective cohort study. The Lancet. 2023. https://www.thelancet.com/journals/lanhl/article/PIIS2666-7568(23)00211-8/fulltext
18 - NICE. Equality impact assessment: dementia. 2018. https://www.nice.org.uk/guidance/ng97/documents/equality-impact-assessment-6
19 - Scottish Government. Coronavirus dementia action plan: equality impact assessment. 2021. https://www.gov.scot/publications/equality-impact-assessment-dementia-covid-19-national-action-plan-continue-support-recovery-people-dementia-carers/pages/4/
20 - Raza et al. Dementia in military and veteran populations: a review of risk factors—traumatic brain injury, post-traumatic stress disorder, deployment, and sleep. Military Medical Research. October 2021. https://mmrjournal.biomedcentral.com/articles/10.1186/s40779-021-00346-z

If it would be helpful to see completed EqIAAs, you may find the following EqIAAs to be helpful:

South-Gloucestershire-Drugs-Strategy-Equalities-Impact-Assessment-2020.pdf (southglos.gov.uk)
South-Gloucestershire-Alcohol-Strategy-2020-Equality-Impact-Assessment.pdf (southglos.gov.uk)
South Gloucestershire Waste Strategy 2015-2020

[1] Carnall Farrar. The economic impact of dementia, Module 1: The annual cost of dementia. May 2024. https://www.carnallfarrar.com/wp-content/uploads/2024/06/The-economic-impact-of-dementia-CF.pdf

[2] All Party Parliamentary Group on Dementia. Raising the barriers: An action plan to tackle regional variation in Dementia Diagnosis in England. October 2023. All-Party Parliamentary Group on Dementia | Alzheimer's Society (alzheimers.org.uk)

[3] Alzheimer's Society. Ethnic minority communities: Increasing access to a dementia diagnosis. September 2021. https://www.alzheimers.org.uk/sites/default/files/2021-09/ethinic_minorities_increasing_access_to_diagnosis.pdf

[4] Office of Health Economics. Inequalities in Dementia: Unveiling the evidence and Forging a Path Towards Greater Understanding. June 2024. https://www.ohe.org/wp-content/uploads/2024/06/Inequalities-in-Dementia-OHE-AS-Report-v8.pdf

[5] South Gloucestershire Council. Equality impact assessment and analysis. Council revenue budget and capital programme 2024-25. Equality Impact Assessment and Analysis - Council Revenue Budget and Capital Programme 2024-25 (southglos.gov.uk)

[6] South Gloucestershire Council. Age Friendly Communities webpage: https://agefriendly.commonplace.is/

[7] British Psychological Society. Ageism in dementia. September 2021. https://www.bps.org.uk/psychologist/ageism-dementia

[8] All Party Parliamentary Group on Dementia. Hidden no more: dementia and disability. 2019. https://www.alzheimers.org.uk/about-us/policy-and-influencing/2019-appg-report

[9] UKHSA. Health matters: health inequalities and dementia. 2016. https://ukhsa.blog.gov.uk/2016/03/22/health-matters-health-inequalities-and-dementia/

[10] Alzheimer's Society. Learning disabilities and dementia. 2024. https://www.alzheimers.org.uk/about-dementia/types-dementia/learning-disabilities-dementia

[11] Public Health England. Dementia and people with learning disabilities: making reasonable adjustments – guidance. June 2018. https://www.gov.uk/government/publications/people-with-dementia-and-learning-disabilities-reasonable-adjustments/dementia-and-people-with-learning-disabilities

[12] Alzheimer's Society. Memory problems LGBTQ+ people with dementia may experience. 2024. https://www.alzheimers.org.uk/get-support/help-dementia-care/lgbtq-dementia-memory-problems

[13] Mukadam et al. South Asian, Black and White ethnicity and the effect of potentially modifiable risk factors for dementia: A study in English electronic health records. October 2023. https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0289893

[14] South Gloucestershire Council. Carer Strategy 2022-2027. https://beta.southglos.gov.uk/static/8545ef5b9df1f448040d87fc80eb532c/South-Gloucestershire-Carers-Strategy-2022-27.pdf

[15] Alzheimer's Society. Supporting an LGBTQ+ person with dementia. 2024. https://www.alzheimers.org.uk

[16] Stonewall. LGBT in Britain: Health Report. 2018. lgbt_in_britain_health.pdf (stonewall.org.uk)

[17] Rui et al. Associations of socioeconomic status and healthy lifestyle with incident early-onset and late-onset dementia: a prospective cohort study. The Lancet. 2023. Rui et al. Associations of socioeconomic status and healthy lifestyle with incident early-onset and late-onset dementia: a prospective cohort study. The Lancet. 2023. https://www.thelancet.com/journals/lanhl/article/PIIS2666-7568(23)00211-8/fulltext

[18] NICE. Equality impact assessment: dementia. 2018. https://www.nice.org.uk/guidance/ng97/documents/equality-impact-assessment-6

[19] Scottish Government. Coronavirus dementia action plan: equality impact assessment. 2021. https://www.gov.scot/publications/equality-impact-assessment-dementia-covid-19-national-action-plan-continue-support-recovery-people-dementia-carers/pages/4/

[20] Raza et al. Dementia in military and veteran populations: a review of risk factors—traumatic brain injury, post-traumatic stress disorder, deployment, and sleep. Military Medical Research. October 2021. https://mmrjournal.biomedcentral.com/articles/10.1186/s40779-021-00346-z