

Equality, Good Relations and Human Rights SCREENING

The Health and Social Care Board is required to consider the likely equality implications of any policies or decisions. In particular it is asked to consider:

- 1) What is the likely impact on equality of opportunity for those affected by this policy, for each of the section 75 equality categories? (minor, major or none)
- 2) Are there opportunities to better promote equality of opportunity for people within the Section 75 equality categories?
- 3) To what extent is the policy likely to impact on good relations between people of a different religious belief, political opinion or racial group? (minor, major or none)
- 4) Are there opportunities to better promote good relations between people of a different religious belief, political opinion or racial group?

See [Guidance Notes](#) for further information on the 'why' 'what' 'when', and 'who' in relation to screening, for background information on the relevant legislation and for help in answering the questions on this template.

As part of the audit trail documentation needs to be made available for all policies and decisions examined for equality and human rights implications. The screening template is a pro forma to document consideration of each screening question.

For information (evidence, data, research etc) on the Section 75 equality groups see the Equality and Human Rights Information Bank on the BSO website:

<http://www.hscbusiness.hscni.net/services/1798.htm>

Equality, Good Relations and Human Rights SCREENING TEMPLATE

(1) INFORMATION ABOUT THE POLICY OR DECISION

1.1 Title of policy or decision

Regional Dementia Care Pathway

1.2 Description of policy or decision

- **What is it trying to achieve? (aims and objectives)**
- **How will this be achieved? (key elements)**
- **What are the key constraints? (for example financial, legislative or other)**
 - Promote standardised best practice throughout the dementia journey.
 - by addressing the five key elements of the pathway which are: promoting healthy active ageing and Improved public awareness and understanding of dementia, ensuring timely and accurate diagnosis of dementia, helping people to live well with dementia, providing specialist supports to cope with the changes as dementia progresses and providing high quality end of life care.
 - Financial constraint as implementation of the full pathway requires significant financial investment in the region of £ 7m.
Cultural constraint as it requires significantly different ways of working particularly within primary care services.
Workforce constraint as new skills set required for new roles such as Advance Nurse Practitioner posts in primary care.

1.3 Main stakeholders affected (internal and external)

For example staff, actual or potential service users, other public sector

organisations, voluntary and community groups, trade unions or professional organisations or private sector organisations or others

The main stakeholders affected are people living with dementia, their families and carers, staff working in GP practices and staff working in specialist dementia services/memory clinics.

1.4 Other policies or decisions with a bearing on this policy or decision

- **What are they?**
- **Who owns them?**

1. DHSSPS Improving Dementia Services in Northern Ireland Regional Strategy (2011);
2. NICE Quality Guidelines CG 42 – Support People With Dementia and Their Carers In Health and Social Care updated 2016;
3. Royal College Of Psychiatrist Memory National Accreditation Programme – Standards for Memory Services Assessment and Diagnosis (2010);
4. Joint Commissioning Panel for Mental Health: Guidance for commissioners of dementia services February 2013;
5. House of Commons Library: Briefing Paper Number 7007, 17 October 2016 Dementia: policy, services and statistics;
6. IDS-TILDA longitudinal research study of ageing in intellectual disability in Ireland, McCarron M et al, Trinity College Dublin, 2016;
7. The British Psychological Society, Dementia and People with Intellectual Difficulties, Guidance on the assessment, diagnosis, interventions and support of people with intellectual disabilities who develop dementia April 2015;
8. Alzheimers Society, Learning disabilities and dementia Information sheet 430;
9. Northern Ireland Assembly Research and Information Service Research Paper, Health inequalities and people with a learning disability, November 2013;
10. Cooper. S & Holland, A. J. (2007). Dementia and mental ill-health in older people with intellectual disabilities;
11. Prasher, V. P. (2005)., Alzheimer’s disease and dementia in down syndrome and intellectual disabilities Oxford (2005):
12. DOH England,NHS England and RCGP, Dementia Revealed, What Primary Care Needs to Know, A Primer for General Practice, 2014;

13. NHS England, Dementia diagnosis and management, A brief pragmatic resource for general practitioners, 2015;
14. Dementia Partnerships, Dementia:10 Key Steps to Improving Timely Diagnosis, a resource pack for Commissioners and General Practices, 2014;
15. NHS Borders, Key Points in the Diagnosis of Dementia in Primary Care, 2010;
16. Ministry of Health, New Zealand Framework for Dementia Care, 2013;
17. DOH Delivering Together 2026; Belfast 2016.

(2) CONSIDERATION OF EQUALITY AND GOOD RELATIONS ISSUES AND EVIDENCE USED

2.1 Data Gathering

What information did you use to inform this equality screening? For example previous consultations, statistics, research, Equality Impact Assessments (EQIAs), complaints. Provide details of how you involved stakeholders, views of colleagues, service users, staff side or other stakeholders.

- NISRA for Northern Ireland (NI) Census 2011
- NISRA Estimates of the population aged 85 and over NI 2016
- NISRA Long-term International Migration Statistics for NI 2016
- Alzheimers Research UK
- Alzheimers International
- Alzheimers Europe 2013
- DHSSPS Improving Dementia Services in NI Regional Strategy (2011)
- IDS – TILDA Longitudinal Research Study of Ageing in Intellectual Disability in Ireland, McCarron M et al, Trinity College Dublin, 20167
- SCIE Dementia and Sensory Loss

- NI Assembly Research and Information Service Research Paper, Health Inequalities and People with a Learning Disability, November 2013
- Race Equality Foundation: Black, Asian, Ethnic Communities and Dementia - Where are we now? 2013
- Consultations with people living with dementia (Dementia NI), carers of people living with dementia (Alzheimers Society Carer Support Groups), Alzheimers Society NI, Learning Disability and Dementia Working Group, Integrated Care Partnerships and HSC Trusts memory services and specialist dementia services.

2.2 Quantitative Data

Who is affected by the policy or decision? Please provide a statistical profile. Note if policy affects both staff and service users, please provide profile for both.

It is estimated that there are currently 23,000 people living with a dementia in Northern Ireland of whom approximately two thirds have a confirmed diagnosis. Projections are that with an increasing ageing population, and as yet no known cure for dementia, that number will rise to 60,000 by 2051. This is a major social, economic and health care challenge into the future. (DHSSPS Improving Dementia Services in Northern Ireland Regional Strategy (2011)).

| Category | <i>What is the makeup of the affected group? (%) Are there any issue or problems? For example, a lower uptake that needs to be addressed or greater involvement of a particular group?</i> |
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| Gender | Both males and females are affected by dementia. According to Alzheimers Research UK the gender profile for dementia in 2014 was 62% female and 38% male. In the young onset dementias males predominate over females with a gender ratio of 1.7 to 1. (Alzheimers Disease International and World Health Organisation-Dementia; a Public Health Priority 2012). As the average life expectancy for men in Northern Ireland is 78.3 years, with the average life expectancy for women 82.3 years, more women are affected by dementia in the older age groups. Women account for two thirds (66.8%) of those aged 85 years and over. 86.7% of centenarians were female. (NISRA Estimates of the population |

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| | <p>aged 85 and over Northern Ireland 2016).</p> <p>GIRES 2014 estimate the number of gender nonconforming employees and service users, based on information assembled for the Home Office and subsequently updated:</p> <ul style="list-style-type: none"> • gender nonconforming to some degree (1%); • likely to seek medical treatment for their condition at some stage (0.2%); • receiving such treatment already (0.03%); • having already undergone transition (0.02%); • having a GRC (0.005%); • likely to begin treatment during the year (0.004%). <p>Applying GIRES figures to NI population n = 1,810,900 would suggest the following estimates:</p> <ul style="list-style-type: none"> • 18,109 people who do not identify with gender assigned to them at birth; • 3,622 likely to seek treatment; • 362 having undergone transition; • 91 have a Gender Recognition Certificate. |
| Age | <p>Research into dementia indicates that it is largely a disease affecting older people. It is estimated that there are currently 22,000 people aged 65 and over living with a dementia in Northern Ireland (0.07% of the over 65 population). The prevalence doubles with every five year increment in age after 65. The NI population continues to age with the number of those over 65 (297,8000) making up 16% of the population (NISRA 2016 Mid-year population estimates for Northern Ireland). The population aged 85 and over (36,500) makes up 2% of the population. According to NISRA the population of older people is expected to rise by 65.1% by 2040 with the proportion of the population aged 85 and over predicted to double to 4% of the population. There were 278 centenarians in mid-2016 (NISRA Estimates of the population aged 85 and over Northern Ireland 2016). According to different estimates between 2% and 10% of all cases start before the age of 65. It is thought that as many as 1,000 people living with a dementia in Northern Ireland are under the age of 65 years. Two-thirds of all young onset dementias are aged 55 years and over.</p> |

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| Religion | <p><u>Population - Census 2011 figures on religion:</u></p> <ul style="list-style-type: none"> • Catholic -738,033 (40.76%) • Presbyterian Church in Ireland – 345,101 (19.06%) • Church of Ireland – 248,821 (13.74%) • Methodist Church in Ireland – 54,253 (3%) • Other Christian (including Christian related) – 104,380 (5.76%) • Other Religions – 183,164 (10.11%) • Religion not stated – 122,252 (6.75%) <p>No specific data in relation to religion and people living with a dementia and those caring for someone living with a dementia. The NI Census 2011 data presented is used as proxy data in this instance.</p> |
| Political Opinion | <p><u>NI Population Statistics (Census 2011:</u></p> <ul style="list-style-type: none"> • British only – 722,379 (39.89%) • Irish only – 457,482 (25.26%) • Northern Irish only - 379,267 (20.94%) • British and Irish only - 11,877 (0.66%) • British and Northern Irish - only 111,748 (6.17%) • Irish and Northern Irish only - 19,132 (1.06%) • British, Irish and Northern Irish - only 18,406 (1.02%) • Other - 90,572 (5.00%) <p>No specific data in relation to carers of people living with a dementia and those people living with a dementia. The NI Census 2011 data presented is used as proxy data in this instance.</p> |
| Marital Status | <p><u>NI Population Statistics * (NI Census 2011):</u></p> <ul style="list-style-type: none"> • 47.56% (680, 840) of those aged 16 or over were married • 36.14% (517, 359) were single • 0.09% (1288) were registered in same-sex civil partnerships • 9.43% (134, 994) were either divorced, separated or formerly in a same-sex partnership • 6.78% (97, 058) were either widowed or a surviving partner <p>No specific data on Martial status and those caring for a person living with a dementia and those people living with a dementia. The NI Census 2011 data presented is used as proxy data in this instance.</p> |
| Dependent | People living with dementia generally require a significant amount |

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| <p>Status</p> | <p>of care. The largest proportion of family carers tend to be spouses, followed by children and children-in-law, mostly female. The typical profile of a dementia caregiver is a middle-aged or older female child or spouse of the person with dementia. (Alzheimers Research UK).</p> <p><u>Carers NI and Census Statistics:</u></p> <ul style="list-style-type: none"> • One in eight people in NI provide unpaid care (almost 214,000); • 3% of people providing 50+ hours a week (56,310 at census 2011); • 12% of 75-84 year olds and 7% of 85+ (census); • 15% of adults (NI health survey) females = 17%; • 62,340 on Carers' allowance in NI (2013); • 2% of 0-17 year olds (census); • 33.86% of all households in NI are with dependent children. <p>According to Patient and Client Council research on <i>Young Carers in Northern Ireland</i> (2011), 1 in 10 young people are carers. Moreover, the share of children, per head of population, who provide care to their families, is higher than in the rest of the UK.</p> <p>It is likely therefore that a sizeable group of those living with the early stages of dementia themselves have caring responsibilities.</p> |
| <p>Disability</p> | <p>More than one person in five (300,000) people in Northern Ireland has a disability.</p> <p>People with learning disabilities may have a higher risk of dementia because of premature ageing and, in the case of Down's syndrome, genetic factors. People with significant learning disability are at increased risk of dementia at a younger age than the general population, with studies suggesting it is four times higher. Cooper 1997, Lund 1985 and Patel 1993, suggest a prevalence of 13% of 50 years and over and 22% of 65 years and over.</p> <p>About 20% of people with a learning disability have Downs syndrome. Figures from one study (Prasher 1995) suggest the following % of people with Downs syndrome have dementia:</p> <p>30-39 years 2%</p> |

40-49 years- 9.4%
 50-59years- 36.1%
 60-69years- 54.5%

Census Statistics (for the NI population as a whole)

Deafness or partial hearing loss – 5.14% (93,078)
 Blindness or partial sight loss – 1.7% (30,785)
 Communication Difficulty – 1.65% (29,879)
 Mobility of Dexterity Difficulty – 11.44% (207,163)
 A learning, intellectual, social or behavioural difficulty – 2.22% (40,201)
 An emotional, psychological or mental health condition – 5.83% (105,573)
 Long-term pain or discomfort – 10.10% (182,897)
 Shortness of breath or difficulty breathing – 8.72% (157,907)
 Frequent confusion or memory loss – 1.97% (35,674)
 A chronic illness (such as cancer, HIV, diabetes, heart disease or epilepsy – 6.55% (118,612)
 Other condition – 5.22% (94,527)
 No condition – 68.57% (1,241,709)

People living with dementia are often living with other disabilities/illness (co-morbidities) particularly in the older population with dementia.

Ethnicity

NI Population Statistics * (Census 2011)

| | Number | Percentage |
|-----------------|-----------|------------|
| White | 1,778,449 | 98.21% |
| Chinese | 6,303 | 0.35% |
| Irish traveller | 1,301 | 0.07% |
| Indian | 6,198 | 0.34% |
| Pakistani | 1,091 | 0.06% |
| Bangladeshi | 540 | 0.03% |
| Other Asian | 4,998 | 0.28% |
| Black Caribbean | 372 | 0.02% |
| Black African | 2,345 | 0.13% |
| Black other | 899 | 0.05% |
| Mixed | 6,014 | 0.33% |
| Other | 2,353 | 0.13% |

Language (Spoken by those aged 3 and over):

- English – 96.86% (1,681,210)
- Polish – 1.02%(17,704)
- Lithuanian – 0.36% (6,249)
- Irish (Gaelic) – 0.24% (4,166)
- Portuguese – 0.13% (2,256)
- Slovak – 0.13% (2,256)
- Chinese – 0.13% (2,256)
- Tagalog/Filipino – 0.11% (1,909)
- Latvian – 0.07% (1,215)
- Russian – 0.07% (1,215)
- Hungarian – 0.06% (1,041)
- Other – 0.75% (13,018)

In the calendar year to December 2016 the top five most common countries of previous residence for international inflows to Northern Ireland were Poland, the Republic of Ireland, Romania, China and Lithuania (NISRA Long-term International Migration Statistics for Northern Ireland 2016).

No specific NI data available in respect of ethnicity and people with a dementia and those caring for a person with a dementia. However, the majority of the NI black and minority ethnic population are of working age and therefore it can be reasonable to assume that those of ethnic minority living with a dementia would make up a smaller share compared to the NI average of 1.5% of the population.

According to Alzheimers Europe 2013 the prevalence of dementia in Poland, ROI, Romania and Lithuania was below the EU average of 1.55%, specifically as follows:

Poland 1.13%

ROI 1.08%

Romania 1.26%

Lithuania 1.44%

In China, from an age of 60 years, the prevalence of dementia almost doubles every 5 years and, as elsewhere, about half of those who have survived to an age of at least 90 years are affected by dementia. (Alzheimers International).

There are increasing indications that the prevalence of dementia in

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| | <p>Black African-Caribbean and South Asian UK populations is greater than the white UK population (Turner et al, 2012) and that the age of onset is lower for Black African- Caribbean groups than the white UK population. Since these groups are also more likely to experience high blood pressure, it is suggested that the increased risk of vascular dementia contributes to increased prevalence (Bhattacharvva, 2012).</p> <p>The percentage prevalence of late onset dementia (over 65) for all dementias in these ethnic groups by age cohort (adapted from Alzheimers Society and population figures from the 2011 Census Office of National Statistics, 2013) is as follows:</p> <p>Age 65 – 69 – 1 in 100 Age 70 -89 – 1 in 25 Age 80+ - 1 in 6</p> |
| Sexual Orientation | <p>There is variation in estimates of the size of the LGBT population in Northern Ireland. Estimates are as high as 5-7% (65-90,000) of the adult population Northern Ireland (based on the UK government estimate of between 5-7% LGBT people in the population for the purposes of costing the Civil Partnerships Act. These figures include the transgender population, however, and it has to be borne in mind that gender identity is not related to any particular sexual orientation.</p> |

2.3 Qualitative Data

What are the different needs, experiences and priorities of each of the categories in relation to this policy or decision and what equality issues emerge from this? Note if policy affects both staff and service users, please discuss issues for both.

| Category | Needs and Experiences |
|-----------------|---|
| Gender | <p>The best practice outlined in the pathway is equally relevant to both genders. For transgender people, living with dementia can be additionally stressful. Not only are they less likely to have family members and children who can support them as they deal with the disability (although this is of course not the case for all transgender people), they are also more likely to live on their own. Many fear that mainstream care services will not be willing or are not able to understand how to meet their needs. Transgender people may not feel safe to disclose their transgender history to new people such as staff and be fearful of rejection. They may worry that they will be isolated from others in a care home and dread that they may experience discrimination or abuse from staff or other residents. In the past, they may have experienced aggression or rejection from others because of their sexuality or gender identity. Transgender people may fear ‘being outed’ and worry that, when their dementia develops to a greater extent, their privacy will be exposed or that staff and residents will not understand their personal history. Transgender people with dementia have specific health and care needs along with the usual care and support issues as everyone else as they age. The need for a person-centred approach among staff and visitors is paramount.</p> <p>Focus – the Identity Trust highlights that there is a particular need for awareness training for staff working with people with dementia, if the person regresses to a time before they transitioned. This will be particularly important for older men who have not had full surgery (information provided at a Nov 2017 consultation event).</p> <p>Transgender people living with dementia are an especially marginalised group and the issues impacting on them are under-represented in general dementia groups and charities (Alzheimers Society, 2013; Westwood, 2014).</p> |
| Age | <p>The pathway acknowledges that adults of all ages can develop a dementia but acknowledges that dementia is predominantly a disease of older people. The pathway emphasises a person centred approach to each person who has a diagnosis of dementia and that any supports should be tailored to each person’s individual circumstances and wishes.</p> |

| Category | Needs and Experiences |
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| Religion | Faith and spirituality can be important for people living with dementia in helping them cope with the condition and particularly important at the end of life stage. According to Alzheimers Research UK, spirituality is also one of the coping strategies employed by carers. |
| Political Opinion | None identified. |
| Marital Status | Spouses and adult children provide significant informal care to people living with dementia. Given that the typical profile of a dementia caregiver is a middle-aged or older female child or spouse of the person with dementia. This brings its own particular demands and limitations with being an older carer. Being a middle aged female carer often results in being a “sandwich carer” whereby caring responsibilities span both younger and older relatives at the same time. Given that 2/3 of people living with dementia live in their own homes, those who are single/widowed/divorced or separated may face specific challenges in accessing informal support and care. |
| Dependent Status | <p>Informal/family carers are recognised in the pathway and their right to be supported and involved in decision making for the person living with dementia.</p> <p>Caring for a loved one with dementia is a particularly emotional experience. Dementia often changes the relationship from an adult relationship to a parent-child relationship. Carers UK suggest that 57% of carers lose touch with family or friends as a result of their caring responsibilities, leading to increased isolation and emotional distress. Despite this isolation, carers strongly emphasise the positive aspects of being able to provide support at such a crucial time in their loved one’s life. Caring for a family member with dementia can be both emotionally and physically exhausting and is often prioritised over the carer’s own well-being, personal time, holidays and romantic relationships. Existing research suggests that stress is a common health problem for carers of people with dementia associated with the changes in the behaviour and personality of their loved one living with dementia. The negative impact on carer’s psychological well-being is exacerbated by the sadness of feeling that they are gradually losing their loved one. Family carers are anxious about the future due to the unpredictable nature of dementia. Like all carers the need to be flexible limits the type of jobs carers can do and can limit their income. (Alzheimers Research UK, Dementia in the Family: the impact on carers 2015).</p> <p>People living with dementia can themselves be carers particularly in the earlier stages of the condition and therefore have to cope with both the impact of the condition as well as the impact of caring. It is important to recognise that they may need additional support to ensure that their own needs and those of the person they care for are met.</p> |

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| Disability | <p>Living with both dementia and sensory loss presents challenges and compounds the problems of each condition. Living with dementia may make it hard to recognise sensory loss as it develops, and living with sensory loss may also make it harder to recognise the onset and progression of dementia. Dementia can cause problems with vision and hearing, without an eye or ear condition causing this. (SCIE Dementia and Sensory Loss).</p> <p>In a similar way, people with physical disabilities and long-term conditions may have more complex needs, for instance as regards the themes of 'Healthy lifestyle choices', 'Living well with dementia' and 'Coping with changes' regarding support for independent living.</p> |
| Ethnicity | <p>It is recognised that people from ethnic minorities can experience difficulties accessing public services based on language barriers as well as lack of familiarity with the services that are available. Cultural barriers may likewise play a role. This may have implications in relation to the theme of 'Finding out if it's a dementia' as to their help-seeking behaviour. People from black and minority ethnic groups may have specific information needs in relation to healthy lifestyle choices. Migrants tend to have less access to family and community support networks and may thus experience greater social isolation. This may pose particular challenges for them in relation to the themes of 'Keeping connected' and 'Living well with Dementia' as well as 'End of Life Care'.</p> <p>Understanding of dementia in black and ethnic minority communities is limited and the condition highly stigmatised. A more targeted approach to information and support for the person and their carers must be taken using a dementia navigator or some similar role and improved training in cultural competency amongst professionals throughout the dementia pathway would help them to support people with dementia from black and ethnic minority backgrounds (Race Equality Foundation: Black, Asian and Ethnic Communities and Dementia – where are we now? 2013).</p> |

| Category | Needs and Experiences |
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| Sexual Orientation | <p data-bbox="352 188 1433 398">Living with dementia as an LGB person can bring unique challenges, both for the person and those supporting them. Every person will experience dementia as an individual with their own experiences and life history, relationships, environment and support.</p> <p data-bbox="352 443 1437 1167">If an LGB person with dementia has had or still has difficult experiences in the past these could negatively impact their experiences of dementia. For example, if they have encountered prejudice or discrimination from professionals or services they may not want to access services, or they may feel uncomfortable being open about their sexual orientation or gender identity around professionals. While the person's identity as an LGB person may be an important part of who they are, it is not the whole of their identity. Feeling safe is important for people with dementia and is likely to be especially important if a person is LGB. Some LGB people may never have felt safe to express their identity, because of fear of how others will treat them. They may worry about seeing professionals, such as GP's, nurses or social workers, because of this. Intimate relationships, friends and LGB community can help the person to feel safe and be themselves, and to help their environment feel like a 'safe space' (Alzheimers Society).</p> <p data-bbox="352 1211 1422 1379">Lesbian, gay and bisexual people living with dementia are an especially marginalised group and the issues impacting on them are under-represented in general dementia groups and charities (Alzheimers Society, 2013; Westwood, 2014).</p> <p data-bbox="352 1384 1442 2231">For lesbian, gay and bisexual people living with dementia can be additionally stressful. Not only are they less likely to have family members and children who can support them as they deal with the disability, they are also more likely to live on their own. Many fear that mainstream care services will not be willing or are not able to understand how to meet their needs. Lesbian, gay and bisexual people may not feel safe to 'come out' to new people such as staff and be fearful of rejection. They may worry that they will be isolated from others in a care home and dread that they may experience discrimination or abuse from staff or other residents. In the past, they may have experienced aggression or rejection from others because of their sexuality or gender identity. Lesbian, gay and bisexual people may fear 'being outed' and worry that, when their dementia develops to a greater extent, their privacy will be exposed or that staff and residents will not understand their personal history. Lesbian, gay and bisexual people with dementia have specific health and care needs along with the usual care and support issues as everyone else as they age. The need for a person-centred approach among staff and visitors is paramount.</p> |

2.4 Multiple Identities

Are there any potential impacts of the policy or decision on people with multiple identities? For example; disabled minority ethnic people, disabled women, young Protestant men and young lesbians, gay and bisexual people.

People with multiple identities may face further exclusion or oppression due to race, disability, religion, lesbian, gay, bisexual and transgender issues. The aim of the Dementia Care Pathway is to provide standardised high quality dementia practice and care to all the citizens of Northern Ireland who come into contact with dementia friendly communities and dementia services and therefore the care pathway to be all inclusive.

2.5 Based on the equality issues you identified in 2.2 and 2.3, what changes did you make or do you intend to make in relation to the policy or decision in order to promote equality of opportunity?

| <i>In developing the policy or decision what did you do or change to address the equality issues you identified?</i> | <i>What do you intend to do in future to address the equality issues you identified?</i> |
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| <p>Within the introductory section of the care pathway there will be reference to an equality impact assessment having been completed. This includes a statement about alternative formats being available which will address disability issues such as large print, audio-visual and braille.</p> <p>An Easy Read version for people with learning disabilities including Downs Syndrome is currently in production. Case workers will adopt a stage by stage approach and face to face operating at the person's level of understanding/pace.</p> <p>The care pathway identifies that dementia is a disease that mainly</p> | <p>As the population ages, additional specialist services will need to be provided to meet the needs of older people with learning disabilities and dementia. Projections suggest that, by 2030, the number of people aged over 70 using services for people with learning disabilities will more than double (British Institute of Learning Disabilities, 2012).</p> <p>Ethnic minorities - the Health and Social Care sector will engage with BME groups to agreed priority languages for translation and will also employ the services of interpreters</p> |

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| <p>affects older people but also acknowledges that young onset dementia affects a proportion of the population under 65 years.</p> <p>65 years + often with co-morbidities including sensory loss alongside dementia – pathway document is dementia friendly in terms of content, layout and presentation.</p> <p>The care pathway also identifies that people with a learning disability and in particular people with Downs Syndrome are at a higher risk of developing dementia at an earlier age than the general population.</p> <p>Dependent Status – the Pathway recognises the needs of carers of people living with dementia and the importance that they are involved, consulted and supported in regard to the person they care for who is living with dementia.</p> | <p>when working with BME service users who have a suspected dementia, or are living with dementia as well as their families and carers.</p> <p>Ethnic minorities and LGB and T communities – Training under the Dementia Learning and Development framework will take account of training staff in the specific needs of people with dementia from the ethnic minority groups and LGB and T communities.</p> <p>Integrated Care Partnerships who will have responsibility for implementation of the pathway will consider capacity building in relation to dementia within the voluntary sector for ethnic minority groups eg; Chinese Welfare Association.</p> |
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2.6 Good Relations

What changes to the policy or decision – if any – or what additional measures would you suggest to ensure that it promotes good relations? (Refer to guidance notes for guidance on impact).

| <i>Group</i> | <i>Impact</i> | <i>Suggestions</i> |
|-------------------|---------------|--------------------|
| Religion | No impact | none |
| Political Opinion | No impact | none |
| Ethnicity | No impact | none |

(3) SHOULD THE POLICY OR DECISION BE SUBJECT TO A FULL EQUALITY IMPACT ASSESSMENT?

A full equality impact assessment (EQIA) is usually confined to those policies or decisions considered to have major implications for equality of opportunity.

How would you categorise the impacts of this decision or policy? (refer to guidance notes for guidance on impact)

Please tick:

| | |
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| Major impact | <input type="checkbox"/> |
| Minor impact | <input checked="" type="checkbox"/> |
| No further impact | <input type="checkbox"/> |

Do you consider that this policy or decision needs to be subjected to a full equality impact assessment?

Please tick:

| | |
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| Yes | <input type="checkbox"/> |
| No | <input checked="" type="checkbox"/> |

Please give reasons for your decisions.

The mitigating measures proposed in section 2.5 will address the identified needs.

(4) CONSIDERATION OF DISABILITY DUTIES

4.1 In what ways does the policy or decision encourage disabled people to participate in public life and what else could you do to do so?

| <i>How does the policy or decision currently encourage disabled people to participate in public life?</i> | <i>What else could you do to encourage disabled people to participate in public life?</i> |
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| <p>The care pathway has been produced in consultation with people living with dementia. The care pathway outlines that people living with dementia be enabled to remain independent for as long as possible and that they are seen as much more than their dementia and seen rather as the people they have always been but in need of new supports/services that enables them to continue living a meaningful life.</p> <p>The care pathway encourages peer support for people living with dementia.</p> | |

4.2 In what ways does the policy or decision promote positive attitudes towards disabled people and what else could you do to do so?

| <i>How does the policy or decision currently promote positive attitudes towards disabled people?</i> | <i>What else could you do to promote positive attitudes towards disabled people?</i> |
|--|---|
| <p>The care pathway seeks to promote dementia friendly communities that address the stigma associated with dementia and increase an awareness and understanding of the needs of those living with the condition.</p> | |

(5) CONSIDERATION OF HUMAN RIGHTS

5.1 Are Human Rights relevant?

Complete for each of the articles

| ARTICLE | Yes/No |
|--|--------|
| Article 2 – Right to life | Yes |
| Article 3 – Right to freedom from torture, inhuman or degrading treatment or punishment | Yes |
| Article 4 – Right to freedom from slavery, servitude & forced or compulsory labour | No |
| Article 5 – Right to liberty & security of person | Yes |
| Article 6 – Right to a fair & public trial within a reasonable time | No |
| Article 7 – Right to freedom from retrospective criminal law & no punishment without law | No |
| Article 8 – Right to respect for private & family life, home and correspondence. | Yes |
| Article 9 – Right to freedom of thought, conscience & religion | Yes |
| Article 10 – Right to freedom of expression | Yes |
| Article 11 – Right to freedom of assembly & association | Yes |
| Article 12 – Right to marry & found a family | No |
| Article 14 – Prohibition of discrimination in the enjoyment of the convention rights | Yes |
| 1 st protocol Article 1 – Right to a peaceful enjoyment of possessions & protection of property | Yes |
| 1 st protocol Article 2 – Right of access to education | Yes |

*If you have answered no to all of the above please move onto to move on to **Question 6** on monitoring.*

5.2 If you have answered yes to any of the Articles in 5.1, does the policy or decision have a potential positive impact or does it potentially interfere with anyone’s Human Rights?

| List the Article Number | Positive impact or potential interference? | How? | Does this raise any legal issues?* |
|-------------------------|--|--|------------------------------------|
| | | | Yes/No |
| 2 | Positive | By promoting that a person living with dementia can live a meaningful life with the condition | No |
| 3 | Positive | By promoting respect for the individual for who they are as well as providing dignified care/support. Staff involved in provision of care and support to people with dementia in all care settings including the home, to attend Equality, Good relations and Human Rights training and Adult safeguarding training. | No |

| | | | |
|-------------------|----------|---|---|
| 5 | Positive | By promoting inclusion of the person's wishes and choices and best interests when capacity is impaired through personal wellbeing plans and advance directives | Legislation already exists via the Office of Care and Protection and the pathway references this organisation and the Mental Capacity Bill (NI) 2016 in the useful links section. |
| 8 | Positive | By supporting people living with dementia to remain in their own home with supports and by supporting their families and carers. | No |
| 9, 10 , 11 and 14 | Positive | By outlining that decisions will be made in conjunction with the person /their family/carers or when deemed to lack capacity that decisions will be taken in the person's best interests and taking account of any expressed wishes about future treatment and care | Legislation already exists via the Office of Care and Protection and the pathway references this organisation and the Mental Capacity Bill (NI) 2016 in the useful links section. |

** It is important to speak to your line manager on this and if necessary seek legal opinion to clarify this*

5.3 Outline any actions which could be taken to promote or raise awareness of human rights or to ensure compliance with the legislation in relation to the policy or decision.

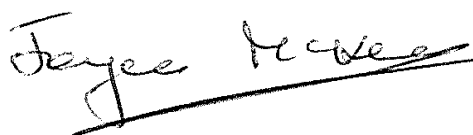
The care pathway seeks to promote the human rights of all people living with dementia and includes a statement that the rights of people with dementia should be respected.

(6) MONITORING

6.1 What data will you collect in the future in order to monitor the effect of the policy or decision on any of the categories (for equality of opportunity and good relations, disability duties and human rights)?

| Equality & Good Relations | Disability Duties | Human Rights |
|--|--|---|
| <p>eNISAT the regional adult assessment of need tool collects data on gender, age, religion, marital status, dependent status, disability, ethnicity and relationships (sexual and other).</p> <p>Target the equality groupings currently under-represented in Dementia NI to widen the range of voices and experiences.</p> | <p>Dementia NI an empowerment group for people living with dementia and Alzheimers Society NI can be contacted to provide data on public participation by people with dementia and their carers.</p> | <p>A new monitoring return has been created to capture all HSC Trust memory assessment and dementia activity which will measure wait times for specific services against ministerial targets.</p> |

Approved Lead Officer:



Position:

Programme Manager Adult Services

Policy/Decision Screened by:



Position:

Service Improvement Lead

Date:

17th May 2018

Please note that having completed the screening you are required by statute to publish the completed screening template, as per your organisation's equality scheme. If a consultee, including the Equality Commission, raises a concern about a screening decision based on supporting evidence, you will need to review the screening decision.

**Please forward completed template to:
Equality.Unit@hscni.net**

Template produced November 2011

If you require this document in an alternative format (such as large print, Braille, disk, audio file, audio cassette, Easy Read or in minority languages to meet the needs of those not fluent in English) please contact the Equality Unit:

2 Franklin Street; Belfast; BT2 8DQ; email: Equality.Unit@hscni.net;
phone: 028 95363961 (for Text Relay prefix with 18001); fax: 028 9023
2304