Dementia Strategy (2026-2036): Equality Impact Assessment

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DESCRIBE AND EXPLAIN THE IMPACT OF THE PROPOSAL ON PEOPLE WITH PROTECTED CHARACTERISTICS AS DESCRIBED IN THE EQUALITY ACT 2010.

How will the proposal promote equality (Please see the general duties)?

The new Dementia Strategy for Wales recognises the specific needs of those with protected characteristics, in terms of dementia. The plan emphasises the impacts of inequality, taking on the views of stakeholders who called for the plan to include a focus on inequalities, social barriers, language, power imbalance, age, gender, sexuality, disability, ethnicity and race. It also references intersectionality - the distinct forms of harm, abuse, discrimination and disadvantage experienced by people when multiple categories of social identity interact with each other.

The plan sets out how we want dementia care and support in Wales to work, to ensure everyone has access to the right support, at the right time. Furthermore, one of the underpinning principles of the strategy is “equity of access”, in terms of access to dementia services and support for the individual, without stigma or discrimination.

The new Dementia Strategy aims to align with the Welsh Government’s Strategic Equality and Human Rights Plan 2025–2029. Both frameworks share a commitment to tackling inequality, promoting equity of access, and embedding a rights-based approach across all policies and services. The Strategic Plan sets out a vision for a fairer, more inclusive Wales, where everyone is treated with dignity and respect, and where the needs of those most at risk of discrimination are prioritised[1].

The Dementia Strategy is underpinned by the following vision:

‘Wales will be a nation where people living with dementia are respected, supported, and empowered to live independently and with dignity in their communities. We envision a society where stigma is not accepted and an increased awareness of dementia, supports people living with dementia and their families to live and socialise in inclusive and compassionate communities, that will empower people to live independently and with dignity in their communities through diagnosis, care, and treatment. Achieving this vision requires a united, cross-government and multi-agency effort, grounded in the voices and experiences of those living with dementia. Together, we will build a future where rights are upheld, support is person-centred, and no one faces dementia alone’.

The key principles of the Dementia Strategy are:

Person-centred: Offering care and support which is coordinated and individualised, whilst ensuring that people are empowered, included in decision making and treated with dignity, compassion and respect.

Rights-based approach: Supporting people to recognise and develop their own strengths and ability to make informed decisions about their own health and care.

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[1] Strategic Equality and Human Rights Plan 2025 to 2029 [HTML] | GOV.WALES

Ensuring that care and support is provided in a way that respects, protects and fulfils the rights of individuals, and fully considers the specific rights some groups have, for instance disability rights.

Co-production: A way of working whereby people with lived experience and practitioners work together as equal partners to plan and deliver care and support.

Equity of access, experience and outcomes without stigma and discrimination: Across all settings, stages of dementia, and regions, we will focus on**:**

- Equity of access to information, including that to support brain health and dementia care
- Reducing stigma and misconceptions about dementia.
- Equity of access to other essential services for people living with dementia.
- Promoting equality, diversity, and inclusion in all aspects of care.

Recognising *intersectionality:* understanding how different aspects of a person's identity—like race, gender, sexuality, disability, and more—combine and interact to shape their experiences. This will look at how multiple factors overlap to affect someone's life, taking a person-centred approach rather than focusing on just one aspect at a time.

Ensuring **timely and accurate diagnosis**: enabling early access to support and planning.

Taking a **preventative approach** by focusing on brain health**, improving resilience and reducing risk,** but recognising people will still develop dementia and we need to ensure people are supported to live healthier for longer.

Services will be **integrated and coordinated**, and will foster collaboration across health, social care, housing, and community services and will develop **evidence-based care and support.**

Support for unpaid carers and families will provide emotional support, education and access to respite. We will recognise the rights that unpaid carers and families have, ensuring they are key partners in care and be supported to be involved in care planning.

We will ensure we **develop our workforce**, enabling staff across health, social and voluntary sectors can recognise dementia symptoms, understand the impact of dementia and use this knowledge to deliver compassionate and quality care.

We will support **research and innovation,** including by supporting people living with dementia to be involved in research on causes, care, and potential cures and support innovation in service delivery and care models.

Engagement with stakeholders

The Dementia Strategy has been developed following extensive engagement with stakeholders across Wales, including an independent review of the current Dementia Action Plan, where 79 people with lived experience provided their views as part of phase 2 of the Voices of dementia evaluation report[2]. This was followed by a public survey which yielded over 412 responses from stakeholders and people with lived experience. The Dementia Strategy consultation document and supporting documents have been produced using the feedback from these sources and continued engagement with stakeholders and people with lived experience.

The next stage of engagement includes a public consultation on the draft strategy. Throughout this process, specific stakeholder and lived experience groups will be involved through targeted engagement.

What are the possible negative impacts on people in protected groups and those living in low-income households and how will you mitigate for these?

The Dementia Strategy includes a vision statement and supporting principles for improving dementia care and support of the people of Wales. We have given specific consideration to the needs of under-served groups and those with protected characteristics. The plan supports the changes we know need to happen to reduce inequalities in dementia care, including inequitable access to dementia care services, brain health and prevention.

We do not anticipate any negative impacts for those with protected characteristics, as a result of the strategy, however, it is important to acknowledge that the plan is being developed in a period of considerable financial constraint, and as such it is a key vehicle in which we will prioritise action across Wales.

Although the plan does not anticipate negative impacts for those with protected characteristics, it acknowledges the importance of monitoring for unintended consequences. Barriers may still exist, such as inequitable access to dementia care services, especially for people in low-income households or those living in rural areas.

The strategy will need to continue to focus on equity of access. For example, as services increasingly move online, there is a risk that older adults, disabled people, and those in low-income or rural areas may struggle to access digital services. People who cannot speak English or Welsh may also face difficulties navigating services, particularly where local provision is limited. These issues could lead to further exclusion if not proactively addressed.

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[2] Voices of dementia: diagnosis, care and support in Wales

What, if any, barriers do people who share protected characteristics face? Can these barriers be reduced, removed, mitigated?

There is a body of evidence in relation to dementia and those with protected characteristics. In developing the Impact Assessments for the Dementia Strategy, this has been considered, and a summary of key data and research is set out below. We have also drawn on the Impact Assessments developed by other policy areas in Welsh Government, where the focus has been on dementia.

Summary of evidence identified in relation to people with protected characteristics through an evidence review.

Disability

Disability and dementia are closely linked, with dementia being a significant cause of disability among older adults[3]. Dementia is a progressive neurological condition that affects memory, thinking, behaviour, and the ability to perform everyday activities[4].

The Social Model of Disability makes an important distinction between 'impairment' and 'disability'[5]. Impairment is an injury, illness, or congenital condition that causes or is likely to cause a long-term effect on physical appearance and/or limitation of function within the individual that differs from the commonplace. The Social Model of Disability recognises that people with impairments are disabled by barriers that commonly exist in society[6].

Statistics show that almost half of the UK population (45.7% of men and 50.1% of women) reported having a long-standing health problem[7]. This underscores the need for proactive measures to address chronic health conditions and promote healthy living. Understanding the different types of disability and their links with dementia is crucial for providing appropriate care and support.

Physical impairments refer to conditions that affect a person's mobility, dexterity, or physical functioning. These can include conditions such as spinal cord injuries, cerebral palsy, and arthritis. People with physical impairments may face challenges in maintaining an active lifestyle, which is essential for brain health. Studies have shown that physical activity can reduce the risk of cognitive decline and dementia. In the UK, approximately 24% of the population reported having a disability in 2022/23, with physical disabilities being a significant component[8].

Neurodivergence refers to the variation in the human brain regarding sociability, learning, attention, mood, and other mental functions. Conditions such as autism, ADHD, dyslexia, and dyspraxia fall under this category. Research indicates that neurodivergent individuals may experience cognitive challenges that could increase their risk of developing dementia later in life. For example, people with autism may

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[3] Dementia: comorbidities in patients - data briefing - GOV.UK
[4] About Dementia | Alzheimer's Disease and Dementia | CDC
[5] The Social Model of Disability - Welsh Government
[6] Social Model - Disability Wales
[7] UK health indicators - Office for National Statistics
[8] UK disability statistics: Prevalence and life experiences - House of Commons Library

have a higher prevalence of cognitive impairments, which can be linked to an increased risk of dementia[9].

Learning disabilities are conditions that affect how individuals understand and process information. These can include dyslexia, dyscalculia, and other cognitive impairments. People with learning disabilities, particularly those with Down's syndrome, are at a higher risk of developing dementia. About 1 in 5 people with learning disabilities over the age of 65 will develop dementia, and this risk is even higher for those with Down's syndrome, with about 2 in 3 people over the age of 60 developing dementia[10]. Early diagnosis and tailored support are essential for managing dementia in individuals with learning disabilities.

Mental health conditions, such as depression, anxiety, and bipolar disorder, can also be linked to an increased risk of dementia. Depression has been identified as a significant risk factor for cognitive decline and dementia. In the UK, depression affects around 22% of men and 28% of women aged 65 years and over[11]. Addressing mental health issues and providing appropriate support can help mitigate the risk of dementia and improve overall well-being.

Recent research has shown that individuals with psychiatric disorders have a significantly increased risk of developing dementia. The risk is highest for those with more severe disorders, such as schizophrenia and bipolar disorder, but is also elevated for depression and anxiety. Notably, the risk of dementia rises further with the number of co-existing psychiatric conditions. These findings highlight the importance of recognising psychiatric disorders as key risk factors for dementia and suggest that late-onset psychiatric symptoms may sometimes be an early sign of dementia. Ongoing research is needed to clarify the mechanisms underlying these associations and to inform targeted prevention and early intervention strategies[12].

People who are D/deaf

Research shows that hearing loss is a significant and potentially modifiable risk factor for dementia[13]. A recent study, conducted over 12-years with over 600 participants found that mild hearing loss doubles the risk of developing dementia, moderate hearing loss triples the risk, and severe hearing loss increases the risk fivefold[14].

D/deaf people with dementia, especially those who use BSL as their first or primary language, often encounter barriers to diagnosis and support. These barriers include a lack of accessible information, limited availability of BSL-fluent healthcare professionals, and insufficient D/deaf awareness among staff. Under-diagnosis and under-treatment are more common in the D/deaf community, likely due to language barriers and a lack of culturally appropriate assessment tools. Studies have found that D/deaf people are at higher risk of experiencing dementia risk factors such as

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[9] Understanding neurodiversity across the UK population - study - University of Birmingham
[10] Learning disabilities and dementia | Alzheimer's Society
[11] Older people: statistics | Mental Health Foundation
[12] Severe psychiatric disorders are associated with increased risk of dementia | BMJ Mental Health
[13] Good Work framework: working with people living… | Social Care Wales
[14] 12-Year Study: Severe Hearing Loss & Fivefold Dementia Risk - Hearology

social isolation, depression, and other health conditions, which can further complicate their experience of dementia[15].

The use of hearing aids to manage hearing loss can improve communication, thus contributing to maintaining an individual's wellbeing as well as helping with issues such as pain articulation. Managing hearing loss through hearing aids also supports social engagement, which is a key factor in maintaining brain health. More research is needed to fully understand how managing hearing loss might impact dementia risk[16].

Recent work led by RNID is helping to shape the future of support for D/deaf people with dementia. The James Lind Alliance Priority Setting Partnership and RNID recently identified key research priorities at the intersection of hearing loss and dementia, highlighting the urgent need for more evidence-based interventions and inclusive research practices for people who have hearing loss and dementia[17]. The top research questions include better understanding how hearing loss and dementia are linked, what factors influence this relationship, how early detection, training, and routine checks might help, and what individual and systemic actions can reduce risk and improve support for those affected.

The All-Wales Dementia and Hearing Loss Pathway, published in May 2025, requires that hearing assessments are a standard part of dementia care, ensuring that hearing needs are identified and addressed as part of a holistic approach[18]. Along with this, the Welsh Government's Accessible Communication and Information Standards set out clear expectations for health and social care providers to deliver accessible information and communication support for people with sensory loss, including those who are D/deaf and living with dementia[19].

Barriers to accessing support

People with dementia and other impairments may face a range of barriers when trying to access support services. These barriers are multifaceted and include physical, attitudinal, cultural, and systemic challenges. Physical barriers may involve inaccessible environments or lack of appropriate assistive technology. Attitudinal barriers, such as stigma, stereotyping, and discrimination, can discourage individuals from seeking help or fully participating in society. Communication barriers, such as for people that have disabilities that affect hearing, speaking, reading, writing, and/or understanding can delay diagnosis and limit the effectiveness of support[20].

Disabled carers of people with dementia encounter unique and compounded barriers when accessing support. These include a lack of information and awareness about available services, complex and lengthy processes for obtaining support, and financial constraints that can make formal care unaffordable. Disabled carers may

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[15] Dementia and the Deaf community: prevalence, assessment and management in people with hearing loss
[16] Hearing aids slow cognitive decline in people at high risk | National Institutes of Health (NIH)
[17] The future of hearing and dementia research: the James Lind Alliance Priority Setting Partnership - RNID
[18] All Wales Dementia Hearing Loss Pathway
[19] Accessible communication and information standards in healthcare [HTML] | GOV.WALES
[20] Disability Barriers to Inclusion | Disability Inclusion | CDC

also face additional physical or health-related challenges that make it harder to engage with services, and they often report that their own needs are overlooked in favour of the person they care for. Furthermore, many carers may be unaware of their entitlement to needs assessments or support[21].

Ethnicity

Rates of dementia across ethnic minority groups

Studies show that the prevalence of dementia varies significantly across different ethnic and racial groups. Understanding these variations is crucial for developing targeted interventions and support systems.

A study conducted by University College London found that dementia rates are 22% higher among Black people in the UK compared to White people[22]. The study, which analysed primary care and hospital health records from 1997 to 2018, also revealed that Black and South Asian dementia patients tend to die younger and sooner after diagnosis than their White counterparts. Specifically, the overall prevalence of dementia among people over 65 in the UK was found to be 11.8%, with Black people having a 22% higher incidence and South Asian people having a 17% lower incidence compared to the average.

In Wales, the Community Ageing Research Across Ethnicities (CARE) Network has highlighted the urgent need for dementia research focusing on older people from minority ethnic backgrounds. The study noted that there are approximately 25,000 people with dementia from Black, Asian, and ethnic minority groups in England and Wales, with this number expected to double by 2026 and rise to over 172,000 by 2051. Despite this, individuals from ethnic minority communities often face delayed diagnoses and lack adequate support due to specific risk factors and treatment needs[23].

The Alzheimer's Society has also reported on the barriers to dementia diagnosis for ethnic minority communities in the UK. The report found that community-led issues, such as language barriers, stigma, and cultural perceptions of dementia, deter people from accessing formal support for dementia symptoms. Additionally, the lack of culturally appropriate diagnostic tools and services further exacerbates the inequality of diagnosis for people from ethnic minority backgrounds[24]. These findings highlight the importance of considering ethnic and racial diversity in dementia care.[25].

Barriers to accessing support

Ethnic minority groups may face several barriers when accessing dementia support services. These barriers can significantly impact their health outcomes and overall

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[21] Do people with dementia and carers get what they need? Barriers in social care and carers needs assessments
[22] Dementia rates over 20% higher among black adults than UK average | UCL News - UCL – University College London
[23] Community Ageing Research across Ethnicities - CARE Network - Health Research Authority
[24] Ethnic minorities increasing access to diagnosis
[25] Dementia - Diverse Cymru

well-being. Understanding these challenges is crucial for developing effective strategies to improve access and equity in dementia support services.

One of the most significant barriers is language. Many individuals from ethnic minority groups may not speak English as their first language, which can hinder their ability to communicate effectively with healthcare providers and access necessary services. In the 2021 census in England and Wales, 1.5% (880,000) could not speak English well, and a small percentage (0.3%, 161,000) of the overall population could not speak English at all[26].

Stigma and cultural perceptions of dementia can also deter individuals from seeking support. Some languages do not explicitly recognise the concept of dementia, or there may be stigma or taboo around the condition. Cultural perceptions, particularly around health, caregiving, or dementia itself, affect the willingness of individuals and families to seek support for symptoms of possible dementia. This can lead to delays in diagnosis and treatment, exacerbating the condition[27].

Socioeconomic factors, such as income, education, and employment, can also impact access to dementia support services. Ethnic minority groups are more likely to experience poverty and unemployment, which can limit their ability to afford healthcare and other support services. In Wales, areas with higher percentages of ethnic minority populations, such as Cardiff and Newport, also report higher levels of socioeconomic deprivation[28].

Gypsy, Roma and Traveller communities

Gypsy, Roma, and Traveller communities in Wales, face unique challenges when it comes to dementia. Despite the relatively low life expectancy of Gypsies and Travellers, which is between ten and 25 years shorter than the national average, dementia remains a significant concern within these communities[29].

Research indicates that 80% of participants from Gypsy and Traveller communities knew someone within their community who had been diagnosed with dementia. However, awareness of dementia and its symptoms vary, with only 65% recognising changes in behaviour as a sign of dementia[30]. Additionally, there is a lack of awareness about ways to reduce the risk of dementia, with 55% of participants unaware that healthy eating, physical activity, and managing existing health conditions can help.

Barriers to accessing dementia support are also prevalent. Evidence from the 2021 census showed that many Gypsies and Travellers would not attempt to access support for dementia due to concerns about not receiving culturally appropriate care. The preference for carers from within their own communities further complicates access to external support services. These challenges are often compounded by

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[26] Language, England and Wales - Office for National Statistics
[27] Ethnic minorities increasing access to diagnosis
[28] Welsh Index of Multiple Deprivation (WIMD): identifying groups of small areas based on deprivation indicators [HTML] | GOV.WALES
[29] Gypsies' and Travellers' lived experiences, health, England and Wales - Office for National Statistics
[30] Dementia in Gypsy and Traveller Communities

factors such as discrimination, lack of cultural competence among healthcare providers, and socioeconomic deprivation.

Asylum seekers, refugees and migrants

While specific data on dementia prevalence among asylum seekers, refugees, and migrants is limited, global trends suggest that these populations may be at increased risk. Migrants of an older age are at a particularly higher risk of developing dementia due to factors such as stress, trauma, and disrupted social networks[31].

Along with this, migrants, refugees, and asylum seekers often face significant barriers in accessing dementia care services. These barriers include language differences, cultural misunderstandings, and a lack of culturally and linguistically appropriate care. Stigma and discrimination related to both dementia and migrant status can further hinder access to care[32]. These populations may experience additional layers of stigma, making it difficult to seek and receive appropriate support. Legal status and financial constraints can also impact access to dementia care. Asylum seekers and refugees may not have the same entitlements to healthcare services as other residents, and financial limitations can restrict their ability to access private care options.

Language barriers

Language barriers significantly impact dementia care for non-English speaking people. In the UK, migrants and refugees often face challenges in accessing dementia care due to linguistic discordance between patients and healthcare professionals. This can lead to communication difficulties, resulting in lower quality of care and poor health outcomes. The British Journal of General Practice highlights that linguistic diversity, compounded by the digitalisation of healthcare, has amplified inequalities in primary care for migrant groups. The report showed that there are still substantial barriers, including difficulty in requesting language support and a lack of confidence in discussing health concerns with interpreters[33].

The provision of dementia care in the Welsh language is an important issue that is vital to get right. As dementia progresses, individuals who are bilingual may lose their ability to communicate in their second language. It is vital that care and support are provided in Welsh where it is the person’s first language to ensure they receive an appropriate level of care[34].

Studies have shown that when people with dementia are supported in their first language, they are more likely to engage, express themselves, and maintain relationships, which can significantly improve their quality of life. The Welsh Government’s “Active Offer” policy places responsibility on service providers to ask

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[31] Modifiable Risk Factors for Dementia Among Migrants, Refugees and Asylum Seekers in Australia: A Systematic Review - PMC

[32] WHO calls for urgent action on dementia among refugees and migrants

[33] Addressing language as a barrier to healthcare access and quality | British Journal of General Practice

[34] Language and Culture in the Caregiving of People with Dementia in Care Homes - What Are the Implications for Well-Being? A Scoping Review with a Welsh Perspective | Journal of Cross-Cultural Gerontology

about and record language preference, ensuring that Welsh speakers are proactively offered services in their language without having to request it.

The Welsh Language Commissioner and Alzheimer's Society Cymru have highlighted the need for specific implementation plans to develop Welsh-medium dementia care pathways, ensuring that the linguistic needs of Welsh-speaking patients are met[35]. This includes workforce training and development to improve confidence in Welsh language skills among staff and the use of consistent Welsh-medium diagnostic tests and assessment resources.

The Evaluation of the Dementia Action Plan for Wales (2018–2022) highlighted the need to enhance assessment and diagnosis pathways, ensuring consistent and equitable access to needs assessments, and providing a single point of contact post-diagnosis. It recommended strengthening the provision of dementia care in the Welsh language, improving data collection on language preference, and supporting workforce training to deliver bilingual services. The evaluation also called for ongoing and long-term funding to sustain improvements and for the development of a successor strategy that continues to address linguistic and cultural needs[36].

Complementing these findings, the Welsh Government report on validating memory assessments in Wales also included a number of recommendations related to the Welsh language. These included validating Welsh language versions of cognitive assessment tools so that they may be routinely offered to Welsh speakers. The report emphasised the importance of clinicians having confidence in the accuracy and cultural appropriateness of these tools[37].

Together, these recommendations underscore the critical importance of language-sensitive dementia care and the need for ongoing research, workforce development, and policy commitment to address language barriers in dementia diagnosis and support.

Religion or Belief

Religion and belief are important factors in the experience and care of people living with dementia. Spiritual needs, including religious beliefs, practices, and cultural identity, can influence how individuals and families cope with dementia, shape their sense of meaning, and affect their wellbeing.

A recent Welsh study explored how the spiritual needs of dementia patients are addressed within Care and Treatment Plans across three Health Boards. The research found that spiritual care, including respect for religious beliefs, compassion, dignity, and person-centred approaches, was essential for supporting people with

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[35] Policy Brief: An update on dementia care for Welsh speakers
[36] Evaluation of the Dementia Action Plan 2018 to 2022: main findings and recommendations for future strategies
[37] Validation of Welsh language cognitive assessment tools (CATs): stage one

dementia. The study also highlighted that spiritual needs are often under-assessed or inconsistently documented in care plans, suggesting a need for greater awareness and training among healthcare professionals[38].

Research shows that religion and spirituality can provide comfort, help maintain identity, and support coping strategies for people living with dementia. Spiritual support has been linked to improved quality of life, reduced depression, and better cognitive outcomes. However, there are challenges in delivering culturally and religiously sensitive care. Barriers such as stigma, communication difficulties, and lack of tailored services can prevent individuals from accessing appropriate support. Healthcare professionals are encouraged to receive training in cultural and religious awareness to ensure person-centred care that respects each individual's beliefs and experiences[39] [40].

Recent reviews also emphasise the need for validated tools to assess spiritual and religious needs in dementia care, and for more research to understand how best to support people from diverse faith backgrounds in care settings[41].

The new strategy will recognise the importance of understanding and supporting the spiritual and religious needs of people living with dementia. The plan commits to strengthening staff training on cultural, spiritual, and religious awareness, ensuring that practitioners are equipped to provide person-centred and holistic care that respects individual beliefs and values.

Co-production with faith communities will be prioritised, involving representatives from diverse backgrounds in the design, delivery, and evaluation. The plan will also establish mechanisms for ongoing monitoring and evaluation, gathering feedback from people with dementia and their families to assess whether spiritual and religious needs are being met. Good practice will be identified and shared across services, supporting continuous improvement and the development of inclusive approaches that recognise the full diversity of people affected by dementia.

Age

This action plan takes a life-course approach to dementia, ensuring that action is taken early and appropriately across the life course to protect and promote brain health. Important periods include childhood and adolescence, working age adulthood and older adulthood. The strategy provides examples of the preventable risk factors across the life course, based on the 2024 update from the Lancet Commission.

The Lancet Commission on dementia prevention, intervention, and care identifies 14 modifiable risk factors that, if addressed, could prevent or delay up to 45% of

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[38] BASS dementia paper

[39] Measures of religion and spirituality in dementia: An integrative review - Britt - 2022 - Alzheimer's & Dementia: Translational Research & Clinical Interventions - Wiley Online Library

[40] Cultural and religious awareness within dementia care - Dementia UK

[41] Spiritual Support for People Affected by Dementia: A Scoping Review

dementia cases worldwide. The report emphasises that interventions across the lifespan, such as improving education and reducing smoking, can have a significant impact on reducing dementia incidence. The risk factors are grouped by life stage and also include hearing loss, high cholesterol, depression, traumatic brain injury, physical inactivity, diabetes, hypertension, obesity, alcohol consumption, social isolation, air pollution and vision loss[42]. The strategy emphasises that it is never too early or too late to do something about an individual's brain health.

Children and young people

Childhood dementia is an umbrella term for rare genetic neurodegenerative disorders with symptoms before age 18. These conditions involve cognitive decline and loss of developmental skills, with examples including Sanfillippo Syndrome and Niemann Pick disease.

Although children and young people are not the group at greatest risk of dementia, it is important to consider them from a life course perspective. Modifiable risk factors for children and young people include healthy eating, alcohol and drug use, exercise, hearing loss, smoking, pollution, and social isolation. Addressing these factors could reduce dementia diagnoses globally by up to 45%[43]. Both individual and population-level interventions are important, such as promoting healthy habits, monitoring blood pressure, legislating for healthier foods, and creating low emission zones.

Good brain health is influenced by factors from pre-conception through to adulthood, including nutrition, prenatal care, safe environments, and healthy lifestyle choices. Research suggests that interventions such as compulsory education and reducing smoking rates can reduce dementia incidence.

Awareness and early intervention are also key. Children and young people may be carers for family members with dementia, which can affect their health and wellbeing. Support groups and resources are available across Wales. Reading Well for dementia provides recommended reading and digital resources for people living with dementia and their families, including age-appropriate materials for children[44].

Initiatives like Dementia Friends, developed by the Alzheimer's Society, aim to reduce stigma and help communities understand dementia. Regional Partnership Boards in Wales are responsible for improving health and wellbeing, including dementia care and support. Some schools now deliver awareness training to help children understand dementia and make a positive difference.

Encouraging healthy behaviours in children and young people, such as a balanced diet, physical activity, good sleep, and social interaction, is vital for reducing dementia rates. The importance of good quality sleep for cognitive, emotional, and physical health is highlighted, as is the need to limit screen time.

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[42] Lancet infographic - Dementia Risk Factors 2024 update
[43] Risk factors for dementia - Lancet Commission
[44] Reading Well for dementia - The Reading Agency

Working-age adults

A significant number of people experience symptoms of dementia while still of working age. In Wales, it is estimated that 1 in 1,000 people have young onset dementia (diagnosed under the age of 65), with slightly higher rates in some regions. Across the UK, over 70,000 people are living with young onset dementia, and many remain in employment at the time of diagnosis[45].

The impact of dementia on working age adults is profound, affecting not only cognitive and physical health but also social and economic wellbeing. People diagnosed while still working often face unique challenges, including the need for tailored support and adjustments in the workplace. Unlike older adults, younger people with dementia may be physically fit and not have other co-existing long-term conditions, but they may have rarer forms of dementia and different support needs.

Many individuals remain in work for a period after diagnosis, especially when supported by understanding employers and flexible workplace policies. Staying in work can help maintain physical and mental health, social connections, and a sense of purpose[46]. Employers in Wales are increasingly recognising the importance of supporting employees with dementia. Guidance from Dementia UK and the Alzheimer's Society highlights the need for reasonable adjustments, such as flexible working hours, changes to duties, and access to occupational health support. Training for managers and colleagues is also recommended to reduce stigma and foster a supportive environment[47]. The Equality Act 2010 protects people with dementia from discrimination in the workplace. Employers are required to make reasonable adjustments and ensure that staff affected by dementia are treated fairly.

Caring for a person with dementia often places significant pressure on working carers, leading many to reduce their hours or leave employment altogether, with women particularly affected. Carers who remain in work frequently experience higher levels of stress and unplanned absence, especially in unsupportive workplaces. However, with flexible working arrangements, special leave, and access to support networks, carers can better balance employment and caring responsibilities, retaining their skills, income, and wellbeing[48].

Recent research shows that the risk of suicide is significantly elevated in specific groups of people with dementia, particularly those who are younger, recently diagnosed, or have comorbid mental health issues[49]. While a general association is complex and inconclusive, suicidal ideation and suicide deaths are reported as being more prevalent in certain groups of people with dementia compared to the general population[50][51]. The risk of suicide may also be higher during the earlier stages of dementia when cognitive function is more intact. In advanced stages, the ability to

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[45] Dementia at work - Dementia UK

[46] Work and dementia | Alzheimer's Society

[47] Creating a dementia friendly workplace supporting staff with dementia

[48] The impact of dementia on the workplace - supporting dementia carers at work

[49] Risk of Suicide After Dementia Diagnosis | Psychiatry and Behavioral Health | JAMA Neurology | JAMA Network

[50] Suicide and dementia: A systematic review and meta-analysis of prevalence and risk factors - ScienceDirect

[51] Suicide ideation, attempts and deaths in people living with dementia (PLWD): A systematic review and meta-analysis of prevalence and risk factors - Stott - 2023 - Alzheimer's & Dementia - Wiley Online Library

plan and carry out a suicide attempt can be diminished, potentially lowering the risk[52]. Findings indicate that diagnostic services should target suicide risk assessment to patients who are recently diagnosed with young onset dementia.

Older adults

Dementia is one of the most significant health challenges facing older adults in Wales and the UK. Age is the greatest risk factor, and as the population ages, the prevalence of dementia is rising sharply. Recent estimates suggest that at least 51,000 people over the age of 65 are living with dementia in Wales, with projections indicating this could rise to nearly 70,000 by 2040[53]. One in 14 people over 65 in the UK has dementia, and this increases to one in six among those over 80[54]. Dementia is the leading cause of death for females in Wales, with almost twice as many women dying from dementia than men[55].

The impact of dementia on older adults is profound, affecting memory, cognition, independence, and overall wellbeing. Individuals with dementia are living longer, even accounting for their older age, which presents ongoing challenges for health and social care systems. Dementia currently costs Wales £2.3 billion per year, with this figure expected to double by 2040. As dementia severity progresses, health care utilisation increases, particularly in inpatient, primary, and community care settings. One in six hospital beds in the UK is occupied by a person with dementia, and dementia accounts for over 410,000 bed days annually in Wales[56].

Stigma remains a significant barrier for older adults, with negative stereotypes and misconceptions about dementia leading to social isolation, discrimination, and reluctance to seek support. Media portrayals often reinforce ageist attitudes, contributing to feelings of shame and exclusion among older people[57].

The new Dementia Strategy will be closely aligned with other key policy areas, such as the National Action Plan to Prevent the Abuse of Older People, which sets out a vision for an age-friendly Wales, where older people are protected from abuse, empowered to live independently, and treated with dignity and respect. The plan emphasises the need for better data, workforce training, joined-up services, and a robust communication strategy to raise awareness and challenge negative stereotypes about ageing[58].

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[52] Early dementia diagnosis and the risk of suicide and euthanasia - ScienceDirect
[53] Alzheimer’s Society: Annual Costs of dementia 2024annual-costs-of-dementia.pdf
[54] Alarming rise: New cases of dementia surging in elderly population of Wales, UK
[55] Planning ahead: dementia services in Wales
[56] A New Dementia Action Plan for Wales
[57] Dealing with stigma and discrimination of dementia - Dementia UK
[58] National action plan to prevent the abuse of older people [HTML] | GOV.WALES

Digital exclusion is another growing concern, as the shift towards online services leaves many older people, particularly those with dementia, unable to access essential information, healthcare appointments, and social activities[59]. Around a third of people over 75 in Wales are not online, and barriers such as lack of digital skills, affordability, and trust in technology further compound the issue. The move to 'digital first' approaches in public services risks undermining older people's rights to access support, especially when offline alternatives are limited or poor quality[60].

The strategy will work collaboratively with other policy areas to address and reduce digital exclusion among older people and people with dementia. The Digital Strategy for Wales sets out a national vision for using digital, data, and technology to improve lives, with a strong emphasis on digital inclusion as a cross-cutting priority. This includes ensuring that public services are designed around the needs of end users, not just organisational requirements, and embedding digital inclusion within existing services such as health and social care[61].

Key actions include supporting people to develop basic digital skills, providing access to appropriate devices and connectivity, and ensuring that offline alternatives remain available and of good quality for those who cannot or do not wish to engage online. The Digital Inclusion Wales programme acts as a central hub for advice and support, helping organisations across sectors to recognise and address digital exclusion. Community-based initiatives, such as digital skills workshops in libraries and mobile connectivity vans for rural areas, further support those most at risk of exclusion[62].

These challenges are often intensified for those living in rural areas, minority ethnic communities, or with disabilities, where access to tailored support and culturally appropriate services may be limited. Addressing stigma and digital exclusion is essential to ensure older adults with dementia can participate fully in society, maintain their independence, and access the care and support they need.

Sexual Orientation / LGBTQ+

LGBTQ+ people living with dementia in Wales face unique challenges that can impact their health, wellbeing, and access to care. Research shows that LGBTQ+ individuals are at higher risk of developing dementia and may experience delayed access to health and social care services, earlier entry to long-term care, and inequitable access to end-of-life care compared to heterosexual people. These

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[59] Access Denied: Older people's experiences of digital exclusion in Wales
[60] Literature Review: How Ageist is Wales?
[61] Digital strategy for Wales [HTML] | GOV.WALES
[62] Digital inclusion | GOV.WALES

disparities are often compounded by a lifetime of discrimination, social marginalisation, and minority stress, which can negatively affect both mental and physical health[63] [64].

A systematic review of the needs and experiences of LGBTQ+ people with dementia found that many face actual or anticipated discrimination in care settings, leading to concerns about safety, identity disclosure, and the ability to maintain meaningful relationships. The fear of prejudice can result in LGBTQ+ people concealing their sexual orientation or gender identity, which may limit their access to appropriate support and inclusion of loved ones in care decisions. Trusted partners and chosen family often play a pivotal role in recognising early symptoms and providing support, especially as LGBTQ+ individuals are statistically more likely to live alone and lack traditional family networks[65] [66].

Transgender people are an increasingly recognised population within dementia research, but the evidence base remains limited. Recent studies suggest that trans adults may be at higher risk of developing dementia, partly due to a greater prevalence of risk factors such as depression, cardiovascular disease, diabetes, and social isolation[67].

The literature consistently notes that the epidemiology and lived experiences of trans people with dementia are largely unknown, and that further research is urgently needed. There is a call for more inclusive studies, better data collection on gender identity in ageing and dementia research, and the development of culturally competent, person-centred care models for trans people living with dementia[68]. Robust epidemiological data on dementia prevalence and outcomes in trans communities are lacking, and most research to date has focused on broader LGBTQ+ populations rather than trans people specifically[69].

In their 2025 evidence summary, Social Care Wales highlights the importance of person-centred and dignified support for older LGBTQ+ people, noting that public perceptions often overlook the needs of older LGBTQ+ generations. Inclusive care requires staff training, awareness of diverse identities, and the creation of safe environments where individuals feel able to express their identities without fear of discrimination[70]. National frameworks and toolkits are being developed to support workforce development and ensure services are responsive to the needs of LGBTQ+ people with dementia[71].

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[63] How do we care for older LGBTQ+ people at risk of developing cognitive decline or dementia? | BMJ Open Quality

[64] The needs, preferences, and experiences of LGBT + people living with dementia: a systematic review with thematic synthesis | BMC Geriatrics | Full Text

[65] Unique challenges for LGBTQ+ people with dementia - Dementia UK

[66] Study highlights diagnostic challenges for LGBTQ+ people living with dementia - BSMS

[67] Transgender and gender diverse older people: health, aging and dementia

[68] Frontiers | Neurocognitive health in LGBTQIA+ older adults: current state of research and recommendations

[69] The needs, preferences, and experiences of LGBT + people living with dementia: a systematic review with thematic synthesis | BMC Geriatrics | Full Text

[70] Supporting older LGBTQ+ people in social care - Social Care Wales - Research, Data & Innovation

[71] Intersecting sex and gender diversity with sexual rights for people living with dementia in later life: an example of developing a learning framework for policy and practice

Pregnancy and Maternity

Emerging research in the UK has explored the relationship between pregnancy-related factors and the risk of developing dementia later in life. Large-scale cohort studies, such as the UK Biobank, have found that certain reproductive factors such as the age at first birth, number of pregnancies, and menopause timing, may influence dementia risk. For example, women who have never been pregnant were found to have a slightly reduced risk of developing dementia, while early age at first birth and early menopause were associated with increased risk of dementia[72].

Hypertension (high blood pressure) during pregnancy, including conditions such as preeclampsia, has also been investigated as a potential risk factor for dementia. Recent research indicates that while midlife hypertension is a strong risk factor for dementia, hypertension during pregnancy alone is only weakly associated with later dementia risk[73]. However, other studies have shown that women who experience high blood pressure during pregnancy may have an increased risk of developing vascular dementia, highlighting the importance of monitoring and managing cardiovascular health during and after pregnancy[74].

While the direct link between pregnancy and maternity, and dementia risk is still being explored, current evidence underscores the importance of comprehensive maternal health care, cardiovascular risk management, and support for women with complex needs as part of a life-course approach to dementia prevention.

Gender

Gender plays a significant role in the risk, experience, and outcomes of dementia. In the UK, women are disproportionately affected by dementia, with two out of every three people diagnosed with dementia being women[75]. This is partly due to women's longer life expectancy, as age is the greatest risk factor for dementia, however, biological, social, and economic factors also contribute to this disparity. For example, hormonal changes during menopause, particularly the decline in oestrogen, may increase dementia risk in women. Women who experience menopause before age 45 have been found to have a higher risk of developing dementia compared to those who experience menopause later in life[76].

Social determinants that are more prevalent among older women such as lower levels of education, reduced access to skilled employment, and increased likelihood of social isolation and depression, are also linked to higher dementia risk. Women are also more likely to be prescribed antipsychotic and psychotropic medications for

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[72] Reproductive factors and the risk of incident dementia: A cohort study of UK Biobank participants | PLOS Medicine
[73] Hypertension in pregnancy and in midlife and the risk of dementia: prospective study of 1.3 million UK women - Floud - 2025 - Alzheimer's & Dementia - Wiley Online Library
[74] High blood pressure during pregnancy linked to an increased risk of dementia - Alzheimer's Research UK
[75] The Impact of Dementia on Women - Alzheimer's Research UK
[76] Sex, gender and dementia - Alzheimer's Research UK

longer periods than men and may experience different responses to both pharmacological and non-pharmacological interventions[77].

Recent reviews highlight that gender differences extend to access to diagnosis, quality of care, and effectiveness of treatments. For example, cognitive stimulation therapy has shown greater cognitive improvements for women, while some disease-modifying therapies may be less effective in women than in men[78].

In the UK, around two-thirds of unpaid dementia carers are women, often taking on the primary responsibility for the practical and emotional support of loved ones. The 2021 Census results showed that there are approximately 310,000 unpaid carers in Wales, equating to 10.5% of the usual resident population. In Wales, the percentage of people providing unpaid care was higher in females than males, with 12.0% of females providing unpaid care compared with 9.0% of males[79].

This care is frequently intensive, with many carers providing 24-hour support, which can significantly impact their own health, wellbeing, and financial security. The demands of unpaid caring can lead to social isolation, loss of identity, and difficulties in maintaining paid employment, as women are more likely to reduce their working hours or leave the workforce altogether to meet caring responsibilities. Recognising and addressing the needs of unpaid carers, particularly women, is essential to ensuring equitable outcomes for all those affected by dementia.

The relationship between hormonal contraception and dementia risk is an emerging area of research, and current evidence remains inconclusive. A recent systematic review found that while some studies suggest hormonal contraceptive use may be associated with a lower risk of Alzheimer's disease and related dementias, as well as better cognitive outcomes and larger grey matter volume, other studies report no significant association[80]. The evidence is inconsistent, with variations depending on the type and duration of contraceptive use, as well as the populations studied. Most available studies are retrospective and focus on post-menopausal women, with very limited data collected during the actual period of contraceptive use, so the review concludes that further research is needed, particularly studies involving younger adults.

The new Dementia Strategy aims to work closely with other Welsh Government policy areas to ensure a coordinated, whole-system approach that minimises gender-based inequalities. A key piece of recent policy is the Women's Health Plan, which shares a commitment to equity, prevention, and person-centred care. Both strategies acknowledge that women face unique health challenges, including higher dementia prevalence, increased caring responsibilities, and barriers to diagnosis and

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[77] Sex and gender differences in access, quality of care, and effectiveness of treatment in dementia: a scoping review of studies up to 2024 | Archives of Public Health | Full Text

[78] Gender, citizenship and dementia care: a scoping review of studies to inform policy and future research - Bartlett - 2018 - Health & Social Care in the Community - Wiley Online Library

[79] Unpaid care by age, sex and deprivation, England and Wales - Office for National Statistics

[80] Hormonal contraception and risk for cognitive impairment or Alzheimer's disease and related dementias in young women: a scoping review of the evidence - PMC

support. The Women's Health Plan sets out a ten-year vision to close the gender health gap, with actions spanning menopause care, mental health, ageing well, and support for unpaid carers[81]. The new Dementia Strategy will align its priorities with these, ensuring that dementia-specific actions are embedded within broader efforts to improve women's health and wellbeing.

The new strategy will also align with the National Strategy for Unpaid Carers that will be published in 2026. This will refresh the strategic priorities for unpaid carers (referenced in the 2021 strategy) including respite/ short breaks, access to information and carers' needs assessments and support. There will be alignment between the Dementia and Unpaid Carers strategies.[82].

The new Dementia Strategy will also work in partnership with the Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) Policy to safeguard and support people with dementia who may be at risk of abuse, as well as carers who may themselves be affected by violence or coercion. This will include embedding trauma-informed approaches in dementia care, training staff to recognise and respond to signs of abuse and ensuring clear referral pathways to specialist support services[83].

Marriage and Civil Partnership

Research shows that marital status is associated with the risk of developing dementia[84]. A large systematic review and meta-analysis led by University College London found that people who are married have a lower risk of developing dementia compared to those who are lifelong single or widowed. Specifically, lifelong single individuals had a 42% higher risk, and widowed individuals had a 20% higher risk of dementia compared to married people. No significant difference was found for divorced individuals. The authors suggest that the protective effect of marriage may be partly due to healthier lifestyle behaviours, increased social engagement, and better physical health among married people[85].

More recent research has challenged the assumption that marriage always protects against dementia. A large 18-year study found that unmarried individuals, including those who are widowed, divorced, or never married, had a lower risk of developing dementia compared to married people. The reasons for this are not fully understood, but possible explanations include earlier diagnosis among married people (due to spouses noticing symptoms), or differences in social and lifestyle factors. These findings highlight the complexity of the relationship between marital status and

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[81] Women's health plan for Wales launched to close the gender health gap | GOV.WALES

[82] Strategy for unpaid carers | GOV.WALES

[83] Violence against women, domestic abuse and sexual violence: strategy 2022 to 2026 [HTML] | GOV.WALES

[84] Marriage may help stave off dementia, study finds - Alzheimer's Society comments | Alzheimer's Society

[85] Marriage and risk of dementia: systematic review and meta-analysis of observational studies | Journal of Neurology, Neurosurgery & Psychiatry

dementia risk and suggest that social engagement and support may be important modifiable factors[86].

Socio-economic duty / living in poverty

Socio-economic status and poverty are significant factors influencing both the risk of developing dementia and the experience of living dementia. Research from Wales has shown that people with dementia from lower socio-economic backgrounds often face greater difficulties in accessing timely and appropriate care. A large-scale study using Welsh health data found that individuals from more disadvantaged backgrounds were admitted to care homes later after diagnosis, potentially reflecting barriers to accessing support or a preference to remain at home due to financial constraints. Living in rural areas was also associated with slower rates of care home admission, highlighting geographical as well as economic inequalities[87].

Across the UK, people in lower socio-economic groups are exposed to a higher risk of developing dementia and may face additional barriers such as limited access to healthcare services, lower health literacy, and increased exposure to risk factors like poor nutrition and air pollution. Recent research has demonstrated that poverty is linked to a significantly increased risk of developing dementia, regardless of genetic risk. This association is particularly strong for those living in the most deprived neighbourhoods, where environmental and social factors compound the risk[88].

Unmet care needs are also more common among people with dementia who have lower financial means, both in Wales and across the UK. Studies show that support for older people with substantial care needs and limited resources often remains insufficient. Addressing and tackling these inequalities could prevent or delay a significant proportion of dementia cases[89].

Other under-served groups

People in prison

The number of older adults in prison in Wales is rising, leading to a growing prevalence of dementia and mild cognitive impairment among the prison population. Recent studies estimate that around 7-8% of prisoners aged 50 and over have dementia, a rate significantly higher than in the general community. Despite this, dementia is often under-recognised in prisons, and many affected individuals do not receive a formal diagnosis or appropriate support[90].

The prison environment presents unique challenges for people with dementia, including difficulties with daily functioning, increased risk of harm, and limited access

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[86] Marital status and risk of dementia over 18 years: Surprising findings from the National Alzheimer's Coordinating Center - Karakose - 2025 - Alzheimer's & Dementia - Wiley Online Library

[87] Socio economic predictors of time to care home admission in people living with dementia in Wales

[88] Poverty linked to increased dementia risk - PenARC

[89] Socioeconomic inequality of long-term care for older people with and without dementia in England | Ageing & Society | Cambridge Core

[90] Prevalence of dementia and mild cognitive impairment among older prisoner population in England and Wales

to specialist care. There is a recognised need for better training for prison staff, improved care pathways, and consideration of compassionate release for those with significant cognitive impairment[91].

People in contact with the criminal justice system

People with dementia may come into contact with the criminal justice system in a variety of ways, including as victims, witnesses, or suspects. These interactions can be complex and challenging, both for the individuals involved and for professionals across policing, courts, and probation services.

People living with dementia are at increased risk of becoming lost or confused in public, which can lead to police involvement. Police forces across Wales, have adopted the Herbert Protocol, which gathers vital information about vulnerable people with dementia to assist in missing person searches and reduce risk. The Herbert Protocol is a national scheme used across the UK to help safeguard people living with dementia who are at risk of going missing. The protocol was developed to provide police and emergency services with rapid access to vital information, enabling a quicker and more effective response when a person with dementia is reported missing[92].

People with dementia may also be under community supervision or probation, where cognitive impairment can impact their ability to comply with conditions or understand requirements. Probation services in the UK are increasingly recognising the need for dementia awareness and training among staff, as well as the importance of reasonable adjustments to support compliance and reduce the risk of breach or reoffending. However, research highlights that there is still a lack of systematic screening for dementia in community justice settings, and staff often feel underprepared to identify or manage cognitive impairment[93].

People impacted by violence, domestic abuse, sexual violence and assault

There is growing recognition that experiences of violence, domestic abuse, sexual violence, and assault can have impacts on the risk of developing dementia, as well as on the experience of living with dementia. Research from the Dewis Choice project in Wales, which is the first global longitudinal study of older victim-survivors of domestic abuse, has highlighted that dementia featured in a fifth of their cases involving older people who had experienced abuse from intimate partners or adult family members. This underscores the need to better understand and support this hidden population of victim-survivors and perpetrators, particularly as the co-existence of dementia and abuse can create complex safeguarding and care challenges[94].

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[91] Providing appropriate health and social care for people with dementia or mild cognitive impairment in the criminal justice system of England and Wales: a thematic analysis of prisoner and staff interview data | Health & Justice | Full Text

[92] Herbert Protocol

[93] The Interface between Dementia and the Criminal Justice System (Chapter 14) - A Clinician's Brief Guide to Dementia and the Law

[94] Domestic abuse and the co-existence of dementia

Older people experiencing domestic abuse are often underrepresented in services and may experience abuse for twice as long before seeking help compared to younger adults. Abuse may be perpetrated by intimate partners, adult children, or others in a position of trust, and can include physical, emotional, financial, and sexual abuse. It is also sadly common for older adults with care needs to experience multiple forms of abuse[95].

There is emerging evidence that traumatic life events, including violence and abuse, are associated with an increased risk of developing dementia. A recent systematic review found that traumatic life events, including actual or threatened violence and sexual assault, were associated with a 21% increased risk of dementia. Childhood trauma and war-related trauma were also linked to higher dementia risk[96]. In addition, a large study using Welsh electronic health records found that traumatic brain injury (a common consequence of physical violence) was associated with more than double the risk of developing dementia, particularly vascular and unspecified dementia[97].

Sexual violence and abuse against older people, including those with dementia, is a significant issue. Data collection on sexual violence in older adults is limited, but available evidence suggests that older people are at risk of sexual assault in both community and institutional settings. Cognitive impairment may increase vulnerability and reduce the ability to report or seek help[98].

Trauma-informed dementia care is increasingly recognised as essential. Social Care Wales recommend that practitioners explore a person's life history with empathy, avoid re-traumatisation, and tailor care to individual needs. Family members can provide valuable insights, and support should be sensitive to triggers and past experiences[99]. Specialist services, such as those developed by Dewis Choice, offer practical guidance for supporting older victim-survivors of abuse who have dementia, including safety planning, legal literacy, and multi-agency working[100].

People who are care experienced

People who are care experienced face significant health inequalities throughout their lives, including an increased risk of poor mental and physical health outcomes in adulthood. While direct research on the link between care experience and dementia risk is still emerging, there is growing evidence that the social and health disadvantages faced by care experienced individuals may contribute to a higher risk of developing dementia later in life. Care experienced people may also face barriers to accessing timely and appropriate dementia care. These can include a lack of

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[95] Domestic abuse against older adults—What can s42 case files tell us? | The British Journal of Social Work | Oxford Academic

[96] Traumatic life events and risk for dementia: a systematic review and meta-analysis | BMC Geriatrics | Full Text

[97] Dementia Risk Due to Traumatic Brain Injury in Subtypes of Dementia in the Welsh Population

[98] Sexual Violence and Assault Against

[99] 6. Dementia and trauma-informed care | Social Care Wales

[100] Dewis Choice – Centre for Age Gender and Social Justice, Aberystwyth University

stable support networks, lower health literacy, and difficulties navigating health and social care systems[101].

Adverse childhood experiences (ACEs), which are more common among care experienced people, have been shown to increase the risk of cognitive decline and dementia in later life. A recent systematic review found that individuals who experienced ACEs had a significantly higher risk of developing dementia, with maltreatment in childhood being a particularly strong risk factor[102]. Public Health Wales has emphasised the importance of preventing and mitigating the impact of ACEs to improve long-term health outcomes, including brain health and cognitive function[103].

People living in rural areas

People living with dementia in rural areas of Wales face unique challenges that can impact their experience of diagnosis, care, and support. Wales is a predominantly rural nation, with a higher proportion of older people compared to other parts of the UK, and age is the greatest risk factor for developing dementia. Estimates suggest that over 17,000 people affected by dementia live in rural Wales, and this number is expected to grow as the population ages[104].

Access to dementia services in rural communities is often limited by poor transport links, fewer commissioned support services, and a lack of specialist provision. These barriers can lead to delays in diagnosis, reduced access to post-diagnostic support, and increased reliance on informal care networks, such as family and friends. Carers in rural areas are more likely to feel isolated and unsupported, and people with dementia may experience greater loneliness and social isolation, which are themselves risk factors for poorer outcomes[105].

Research highlights that rurality can intensify the strains placed on families and individuals affected by dementia. For example, a recent scoping review found that people with dementia in rural settings often face a delicate balance between being well-supported by their local community and being in crisis due to limited access to formal services. The review identified challenges such as difficulties with dementia care services and the need for innovation in local support provision[106].

Along with this, older people living in rural Wales may be particularly vulnerable to social isolation, in part because younger family members often move away to pursue work or education opportunities elsewhere. This trend of youth out-migration, which

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[101] The lifelong health and well-being of care leavers-Nuffield Foundation and UCL policy briefing
[102] Adverse childhood experiences and risk of late-life dementia: a systematic review and meta-analysis | Social Psychiatry and Psychiatric Epidemiology
[103] Adverse Childhood Experiences - Public Health Wales
[104] Dementia in rural Wales: The lived experiences
[105] Dementia in rural Wales: The three challenges
[106] Dementia in rural settings: a scoping review exploring the personal experiences of people with dementia and their carers | Ageing & Society | Cambridge Core

is especially pronounced in rural communities, reduces the availability of informal support networks that older people have traditionally relied upon[107]. As a result, many older residents are left with fewer family members nearby to provide practical help, companionship, or emotional support, increasing their risk of loneliness and making it more challenging to access the care and assistance they may need[108].

Veterans

Veterans may face unique risk factors for dementia, including higher rates of traumatic brain injury (TBI), post-traumatic stress disorder (PTSD), and depression compared to the general population. Research shows that moderate-to-severe TBI and PTSD are both associated with an increased risk of developing dementia, including Alzheimer's disease[109]. However, large UK studies have found that overall, veterans are not at greater risk of dementia than non-veterans, although those with a history of mood disorder or PTSD do have a higher risk[110].

Recent qualitative research in the UK highlights that veterans living with dementia often experience distinct challenges shaped by military culture, stigma, and barriers to accessing appropriate care. Many veterans report difficulties navigating health and social care systems, and some feel that their dual identity as both ex-military and a person with dementia is not fully understood or supported by existing services[111]. There is evidence that veterans may be more willing to engage with services designed specifically for the Armed Forces community, but such services are not always well advertised or joined up with mainstream dementia support[112].

In Wales, support for veterans with dementia is available through NHS Wales and the Royal British Legion, which provides Admiral Nurses, which are specialist dementia nurses who offer practical advice, emotional support, and advocacy for veterans and their families[113].

People with substance misuse needs

People with substance misuse needs have an increased risk of developing dementia. Research shows that chronic and heavy alcohol use is a major modifiable risk factor for dementia, including early-onset dementia. Recent studies have demonstrated that any level of alcohol consumption increases the risk of dementia, with the risk rising as alcohol intake increases, with genetic analyses suggesting a

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[107] Rural Youth Out migration and Population Change in Wales
[108] Tackling loneliness and isolation in Wales
[109] Dementia in military and veteran populations: a review of risk factors—traumatic brain injury, post-traumatic stress disorder, deployment, and sleep | Military Medical Research | Full Text
[110] Dementia in Scottish military veterans: early evidence from a retrospective cohort study
[111] Experiences and Support Needs of Veterans Living with Dementia
[112] SERVED: Exploring potential barriers and enablers to veterans seeking support for dementia | Centre for Evidence for the Armed Forces Community
[113] Admiral Nurses | Dementia Homes | Royal British Legion

likely causal relationship between alcohol use and increased dementia risk at all levels of intake[114].

Alcohol-related brain damage (ARBD) is a recognised condition that encompasses several disorders, including Wernicke-Korsakoff syndrome or alcohol-related dementia. These conditions are caused by sustained heavy drinking and can result in cognitive impairment, affecting memory, learning, and executive function. In Wales, older adults are particularly vulnerable, with 65% of all hospital admissions for alcohol-related issues occurring in those over 50[115]. Furthermore, between 50-80% of individuals with chronic alcohol problems will experience some degree of cognitive impairment, and this can make engagement with treatment services more challenging[116].

Hepatic encephalopathy is another consideration in the context of substance misuse and dementia. This condition arises when severe liver dysfunction, commonly caused by chronic alcohol use, allows toxins to accumulate in the bloodstream and reach the brain. The resulting cognitive symptoms, including confusion, memory problems, and overall cognitive decline, can closely mimic those of dementia. Recent studies suggest that up to 13% of dementia diagnoses may actually be misdiagnosed cases of hepatic encephalopathy, a condition that is potentially reversible with appropriate treatment[117].

Other forms of substance misuse, including illicit drugs, are also associated with increased risk of cognitive decline and dementia. Opioids account for a significant proportion of drug-related hospital admissions in Wales. People with substance misuse needs often experience additional risk factors for dementia, such as social deprivation, mental health problems, and poor physical health, which can compound their vulnerability[118].

People experiencing homelessness

People experiencing homelessness face an increased risk of developing dementia and other memory problems compared to the general population. Factors such as chronic physical and mental health conditions, substance use, head injuries, and persistent exposure to environmental stressors all contribute to this heightened vulnerability[119]. Research from Canada shows that the onset of dementia among homeless individuals often occurs at a younger age, with rates of cognitive decline occurring at a higher rate compared to housed individuals of the same age[120].

In Wales, the complexity of homelessness is underpinned by poverty, mental health

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[114] Alcohol use and risk of dementia in diverse populations: evidence from cohort, case–control and Mendelian randomisation approaches | BMJ Evidence-Based Medicine

[115] Latest data on substance misuse in Wales published - Public Health Wales

[116] Alcohol misuse and cognitive impairment in older people: An exploratory study | Alcohol Change UK

[117] A Possible Reversible Cause of Cognitive Impairment: Undiagnosed Cirrhosis and Potential Hepatic Encephalopathy in Patients with Dementia - ScienceDirect

[118] Data mining Wales: the annual profile for substance misuse 2023/24. Annual statistical report on alcohol and drug use from health, social care, education, and criminal justice services datasets in Wales. - Drugs and Alcohol

[119] Memory problems and homelessness: how to help | NIHR Evidence

[120] Prevalence of dementia among people experiencing homelessness in Ontario, Canada: a population-based comparative analysis - PubMed

issues, relationship breakdown, and substance misuse, all of which are risk factors associated with dementia. Homelessness makes consistent medical care and record-keeping difficult, and cognitive symptoms may be misattributed to substance misuse or mental health disorders, leading to underdiagnosis or misdiagnosis. Older people experiencing homelessness and memory problems often require more intensive support, have higher social care needs, and use more emergency services than those without memory problems[121].

Unpaid carers

Unpaid carers provide essential support to family members and friends living with dementia. According to the 2021 Census, there are over 310,000 unpaid carers in Wales, representing about 10.5% of the population. The majority of these carers are women, with females accounting for 58% of unpaid carers in the lowest poverty quintile[122] and 12% of all women in Wales providing unpaid care compared to 9% of men[123]. Many unpaid carers for people with dementia are older themselves, and a significant proportion provide more than 50 hours of care per week[124].

The impact of caring for someone with dementia is profound. Unpaid carers often experience significant emotional, physical, and financial strain. Research from Carers Wales shows that 76% of carers feel stressed or anxious about their financial situation, and more than half have had to cut back on essentials like food and heating[125]. Many carers report feeling invisible and undervalued, with 66% saying their caring role has prevented them from focusing on their career, and 3 in 10 having to reduce their working hours[126]. The intensity of care required for people with dementia can lead to social isolation, loss of identity, and poorer health outcomes for carers themselves[127].

A 2023 report by the University of Sheffield and Carers UK found that unpaid carers save Wales over £10bn every year by providing care that the NHS or social care services would otherwise have to provide[128]. Despite their vital contribution, unpaid carers often face barriers to accessing support. Many do not self-identify as carers, which can delay or prevent them from receiving help. Carers' needs assessments, which are a statutory right in Wales, are not always accessed or offered, and support services can be fragmented or difficult to navigate[129].

Welsh Government's Strategy for Unpaid Carers 2021 sets out a comprehensive framework to recognise, support, and value unpaid carers across Wales, including those caring for people with dementia. The strategy's delivery plan emphasises

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[121] A qualitative exploration of older people's lived experiences of homelessness and memory problems – stakeholder perspectives | BMC Geriatrics | Full Text
[122] Caring-in-Wales-census-2021-briefing
[123] Unpaid care by age, sex and deprivation, England and Wales - Office for National Statistics
[124] Carers-survey-report-final
[125] Carers Wales State of Caring 2024 The Impact of caring on carers health and wellbeing
[126] Wales facing a deepening carer crisis - Bevan Foundation
[127] Experiences of Unpaid Carers for someone with Dementia
[128] Unpaid care in Wales valued at £10.6 billion per year | Carers UK
[129] Review of evidence relating to unpaid carers' needs assessments in Wales

improved identification of carers, greater self-identification, and enhanced recognition by health and social care professionals. It also prioritises providing accessible information, advice, and assistance, as well as ensuring carers have opportunities for breaks and support to maintain their own wellbeing. The strategy's focus on regular needs assessments, tailored support, and the provision of short breaks aims to address the challenges faced by dementia carers, who are at increased risk of social isolation, stress, and poor health outcomes[130].

Along with this, the new Mental Health and Wellbeing Strategy sets out a ten-year vision to improve mental health and wellbeing for everyone in Wales, with a strong emphasis on prevention, early intervention, and person-centred support. The strategy recognises the unique pressures faced by unpaid carers and commits to better identification, support, and integration of carers' needs within mental health services. The strategy aims to ensure that carers are recognised as partners in care, have access to timely information and support, and are offered opportunities to maintain their own wellbeing and resilience[131].

Intersectionality

Intersectionality refers to the way in which different aspects of a person's identity interact to shape their experiences, opportunities, and outcomes. In the context of dementia, intersectionality is increasingly recognised as a critical factor influencing risk, diagnosis, care, and support[132]. Research in Wales and the wider UK shows that people living with dementia often face multiple, overlapping disadvantages that can compound inequalities in access to services, quality of care, and health outcomes[133].

A recent study found that age, ethnicity, gender, and social class intersect to shape the care experiences of people living with dementia. These intersecting identities can influence who is granted privileges or autonomy within care settings and who faces greater restrictions or control. The study concluded that institutional racism, attitudes to gender, social class, and ageing permeate the organisation and delivery of care, often resulting in poorer outcomes for those from marginalised groups[134].

A recent systematic review found that the experiences of older migrants with dementia are shaped by a combination of cultural values, language barriers, and gender roles. For older migrant women, these factors can lead to underdiagnosis, delayed access to services, and a lack of culturally appropriate care. The review also noted that expectations around family caregiving can place additional burdens on women, who may be expected to provide care while also navigating unfamiliar health

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[130] Strategy for unpaid carers | GOV.WALES
[131] Mental health and wellbeing strategy 2025 to 2035 | GOV.WALES
[132] Diversity and inequality in dementia care – Dementia Community
[133] Inequalities in Dementia OHE AS Report
[134] Privileges, and Permissions: Theorising Intersectionality and Cultures of Control in the Care of People Living With Dementia in Acute Hospital Settings - Mwale - 2025 - Sociology of Health & Illness - Wiley Online Library

and social care systems[135]. In Wales, reports have highlighted that people from Black, Asian, and minority ethnic backgrounds, including older migrant women, are less likely to access timely dementia diagnosis and support, often due to stigma, lack of information in their preferred language, and limited awareness of available services[136].

Summary

In summary, we know that some groups or communities are disproportionately at risk of developing dementia. Such groups may also have the most difficulty in accessing services, and even when they do get support, their experiences and outcomes may be poorer.

People's vulnerability to dementia is often linked to inequalities in society, such as those relating to protected characteristics, poverty, rurality and lack of access to education or employment.

We also know that there are gaps in dementia research and that addressing these gaps is essential to providing inclusive and evidence-based care to all.

How have you/will you use the information you have obtained from research to identify impacts?

Our analysis of impacts has informed the development of the Dementia Action Plan. There are specific commitments in the plan that will ensure the needs of those with protected characteristics are considered as we move into implementation (see Table 1 in the Record of impacts by protected characteristic section).

Our analysis has also highlighted that despite significant progress in dementia research, several important gaps remain. There is a persistent lack of high-quality data on dementia prevalence, diagnosis, and outcomes for certain protected groups, including LGBTQ+ communities, people with learning disabilities, and ethnic minorities. Timely and accurate diagnosis remains a challenge, particularly for under-served and marginalised populations, with new diagnostic tools yet to be validated across diverse groups.

Digital exclusion is an emerging concern, as increased reliance on online services risks leaving behind older adults, disabled people, and those in rural or low-income areas. Evidence on the effectiveness of interventions for specific groups, such as people with rare dementias, those in prison, or individuals with complex needs remains limited.

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[135] Frontiers | Intersectional research on dementia care for post-migrants and ethnic minority groups: a scoping review

[136] Leave No One Behind: Improving pathways to information, assessment, and management of dementia for older people from minoritised backgrounds in Wales - University of South Wales

There is also a shortage of dementia researchers, especially in social care and among allied health professionals, and a need for more co-produced research with people living with dementia and their carers. Addressing these gaps is essential to ensure that dementia policy and delivery are inclusive, evidence-based, and responsive to the needs of all communities. Our final strategy and associated delivery plan will need to consider what mitigating actions will need to be taken.

Alignment with Welsh Government Policies and Strategies

The new Dementia Strategy for Wales is designed to work in close alignment with a range of existing Welsh Government policies and strategies to ensure a coordinated, whole-system approach to dementia care and support. These include:

- **A Healthier Wales: Long Term Plan for Health and Social Care:** The plan sets out the Welsh Government's renewed vision for a seamless, person-centred health and social care system. The 2024 refresh places a strong emphasis on prevention, early intervention, and integrated care delivered closer to home. It recognises the changing needs of Wales' ageing population and the importance of addressing health inequalities, particularly for older people, those living with dementia, and individuals in rural or deprived communities. The new Dementia Strategy will work in close alignment with A Healthier Wales, with similar principles underpinning booth, actions will include supporting the development of community-based services, enhancing the use of technology, and fostering partnerships across health, social care, and the third sector. This approach will help ensure that people with dementia and their carers receive timely, accessible, and person-centred support, regardless of where they live.
- **Strategic Equality and Human Rights Plan 2025–2029**: Both the Dementia Strategy and the Strategic Equality and Human Rights Plan share a commitment to tackling inequality, promoting equity of access, and embedding a rights-based approach across all policies and services.
- **Accessible Communication and Information Standards**: The Strategy supports the delivery of accessible information and communication support for people with sensory loss, including those who are D/deaf and living with dementia.
- **Digital Strategy for Wales**: The Strategy is aligned with the national vision for digital inclusion, ensuring that digital transformation in public services does not leave older people, disabled people, or those in rural or low-income areas behind.
- **Digital Inclusion Wales Programme**: The Strategy supports initiatives to improve digital skills and access for those at risk of digital exclusion.

- **National Action Plan to Prevent the Abuse of Older People**: The Strategy works alongside this strategy to protect older people from abuse, empower them to live independently, and ensure they are treated with dignity and respect.
- **Women's Health Plan**: The Strategy recognises the unique health challenges faced by women, including higher dementia prevalence and increased caring responsibilities, and aligns its priorities with the Women's Health Plan's ten-year vision to close the gender health gap.
- **Strategy for Unpaid Carers**: The Strategy supports the recognition, support, and value of unpaid carers, ensuring their needs are addressed throughout the dementia care pathway.
- **Mental Health and Wellbeing Strategy**: The Strategy is closely aligned with this overarching strategy, ensuring a joined-up approach to prevention, early intervention, and holistic support for people with dementia and their carers.
- **Suicide and Self-Harm Prevention Strategy for Wales**: The Strategy works in partnership with this strategy to address the mental health needs of people with dementia and their carers.
- **Anti-Racist Wales Action Plan**: The Strategy references this cross-government strategy to address the needs of Black, Asian, and Minority Ethnic communities and tackle racial inequality in dementia care.
- **Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) Policy**: The Strategy works in partnership with this policy to safeguard and support people with dementia who may be at risk of abuse, as well as carers who may themselves be affected by violence or coercion.
- **Llwybr Newydd: The Wales Transport Strategy 2021:** Recognising that transport is a major barrier for older people, especially in rural areas, the Strategy acknowledges the importance to improve accessible and sustainable transport links to health and social care services.
- **Age Friendly Wales: Our Strategy for an Ageing Society:** The Strategy will contribute to the vision of an age-friendly Wales by addressing cross-cutting themes such as rurality, digital inclusion, and access to local services for older people.
- **Audiology Framework for Action in Wales (2017–2023):** The Strategy will support the integration of audiology services into dementia care, recognising hearing loss as a significant modifiable risk factor for dementia and a barrier to accessing care.

- **Regional Integration Fund (2022–2027):** The Strategy will support new models of integrated care, particularly for older people, unpaid carers and those in rural areas, through collaboration with regional partners and the third sector.

How will you know if your piece of work is a success?

A “theory of change” will be developed for the Dementia Strategy. The theory of change will set out the mechanisms by which the strategy is intended to achieve its outcomes. It will be used as the basis for planning an evaluation of the plan. It is intended that an evaluation of the action plan will be commissioned in due course.

There will also be ongoing monitoring of key workstreams through the National Dementia Ministerial Board and Dementia Advisory Board. Proposed governance and accountability arrangements are laid out in the consultation version of the strategy.

Have you developed an outcomes framework to measure impact?

An outcomes framework is being developed alongside the theory of change, and this will be a year one action. Each priority area within the new strategy will have a number of intended outcomes. Cross-government contributions to delivering the strategy are aligned with the Marmot Principles, which are outcomes focussed. Throughout the strategy we are also identifying a number of measurable indicators that that we will monitor as part of the implementation of the plan. These, and further indicators to be identified, will also support the evaluation of the action plan when commissioned.

Record of Impacts by protected characteristic

Lack of evidence is not a reason for *not assessing equality impacts*. Please highlight any gaps in evidence that you have identified and explain how/if you intend to fill these gaps. See Table 1.

Table 1: Impacts by Protected Characteristics

Protected characteristic or group	**What are the positive or negative impacts of the proposal?**	**Reasons for your decision (including evidence)**	**How will you mitigate Impacts?**
Age (think about different age groups)	This Dementia Strategy recognises the needs of particular age groups. The impact assessment has identified that there is a risk that older adults, disabled people, and those in low-income or rural areas may struggle to access digital services as services increasingly move online. The impact assessment identified stigma and negative stereotypes as a barrier for older people when accessing care and treatment.	See evidence summary on age.	The accompanying delivery plan with the final strategy will ensure services are accessible and tailored for all age groups, promoting early diagnosis and support for younger and older people. The plan will take a life-course approach to brain health and dementia prevention and involve people of all ages in co-producing services. The strategy will be aligned with the Digital Inclusion Strategy for Wales which aims to tackle barriers such as affordability, skills, and trust in technology. This integrated effort will help ensure that digital transformation in public services does not leave anyone behind, and that all people have equitable access to essential information, healthcare, and social opportunities. The strategy will recognise that reducing stigma and discrimination towards older people, including those living

			with dementia, requires a coordinated, cross-governmental approach. The strategy will be closely aligned with other key policy areas, such as the National Action Plan to Prevent the Abuse of Older People. The national action plan sets out a vision for an age-friendly Wales, where older people are protected from abuse, empowered to live independently, and treated with dignity and respect. The Dementia Strategy will work in close alignment with the new Mental Health and Wellbeing Strategy and the Suicide and Self-Harm Prevention Strategy for Wales, ensuring a joined-up approach to prevention, early intervention, and holistic support for people with dementia and their carers.
Disability (consider the social model of disability[137] and the way in which your proposal could inadvertently cause, or could be used to proactively remove, the barriers that	The strategy recognises that certain population groups may require additional support. You are disabled under the Equality Act 2010 if you have a physical or mental impairment that has a 'substantial' and 'long-term' negative effect on your ability	See evidence summary on disability.	The accompanying delivery plan with the final strategy will apply the social model of disability, aiming to remove barriers by providing information in accessible formats, making reasonable adjustments, and ensuring services are coordinated and person-centred. The strategy will focus on the need to improve access to qualified BSL interpreters across all stages of the dementia care

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[137] Welsh Government uses the social model of disability. We understand that disabled people are not disabled by their impairments but by barriers that they encounter in society.

disable people with different types of impairments)	to do normal daily activities.[138]		pathway. It also highlights the need for dementia information and resources to be available in BSL format, including visual aids and video content. People with visual impairments or other sensory disabilities may require adapted materials and support. The strategy commits to providing information in accessible formats such as Braille, large print and Easy Read, and to ensuring that environments are designed to be inclusive and navigable for people with sensory loss. The strategy will uphold the rights of disabled people and involve them in service design.
Transgender people	The strategy recognises that certain population groups may require additional support, and also in accessing services.	See evidence summary on sexual orientation / LGBTQ+.	The strategy commits to equity of access and a rights-based approach, with a focus on dignity, respect, and person-centred care. Staff training on inclusion and anti-discrimination is planned. The evidence summary identified trans people and dementia as a potential area of research requiring further work. Service data may be collected and analysed to monitor service uptake and outcomes in order to inform improvements.

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[138] Definition of disability under the Equality Act 2010 - GOV.UK (www.gov.uk)

Pregnancy and maternity	The strategy recognises that certain population groups may require additional support.	See evidence summary on pregnancy and maternity.	The strategy recognises the need for comprehensive maternal health care and cardiovascular risk management as part of dementia prevention. Support for women with complex needs is included in the life-course approach.
Race (include different ethnic minorities, Gypsies and Travellers and Migrants, Asylum seekers and Refugees)	The strategy recognises that certain population groups may require additional support, and also in accessing services.	See evidence summary on race.	We have considered the needs of Black, Asian and Minority Ethnic Communities, Gypsies and Travellers, and Migrants in the development of the strategy. Actions in the final accompanying delivery plan will include translated materials, interpreter access, culturally sensitive diagnostic tools, and engagement with community organisations. The plan references the Anti-Racist Wales Action Plan and other relevant strategies. We also know that marginalised groups who experience discrimination, racism or exclusion solely based on age, race, sex, sexual orientation, disability or other characteristics protected by the Equality Act 2010 will be disproportionately impacted.
Religion, belief and non-belief	The strategy recognises that certain population groups may require additional support, and also in accessing services.	See evidence summary on religion.	The strategy recognises spiritual and religious needs, with staff training in cultural and religious awareness. Person-centred care includes respect for beliefs and spiritual needs in care planning.

			The final delivery plan will need to consider how it will strengthen staff training in cultural, spiritual, and religious awareness to ensure person-centred, holistic care. It will need to support co-production with faith communities, ongoing monitoring and evaluation of service effectiveness, and sharing good practice to ensure that the diverse spiritual and religious needs of people with dementia are recognised and met.
Sex / Gender	The strategy recognises that certain population groups may require additional support, and also in accessing services.	See evidence summary on sex / gender.	The strategy will recognise and support the disproportionate impact on women as unpaid carers. The plan aims to provide targeted support, respite, and financial assistance, and ensure gender-sensitive policies. The link between hormonal contraceptives and dementia was identified in the evidence summary as an important area for future investigation to clarify any potential links between hormonal contraception and dementia risk. The strategy will work in partnership with other policy areas to ensure that gender inequalities are systematically addressed. Through joint action on prevention, support for carers, gender-sensitive service design, and robust governance, the plan aims to deliver

			equitable outcomes for all those affected by dementia in Wales.
Sexual orientation (Lesbian, Gay and Bisexual)	The strategy recognises that certain population groups may require additional support, and also in accessing services.	See evidence summary on sexual orientation.	The strategy commits to inclusive, person-centred care, with staff training inclusion and anti-discrimination. There is recognition of the unique challenges faced by LGBTQ+ people with dementia, including the need for safe environments and support for chosen families. The evidence summary identified research related to some specific groups of people and dementia may be an area where further work is needed. Service data may be collected and analysed to monitor service uptake and outcomes in order to inform improvements.
Marriage and civil partnership	The strategy recognises that certain population groups may require additional support, and also in accessing services.	See evidence summary on marriage and civil partnership.	The strategy's focus on equitable services applies, ensuring support is available regardless of marital status. Social engagement and support networks are promoted for all.
Children and young people up to the age of 18	The strategy recognises that certain population groups may require additional support, and also in accessing services.	See evidence summary on children and young people and also the Children's Rights Impact Assessment.	The strategy takes a life-course approach, promoting brain health from childhood, supporting young carers, and providing age-appropriate information and support. There is a commitment to involving people of all ages in co-production and awareness-raising.

Low-income households	The strategy recognises that certain population groups may require additional support, and also in accessing services.	See evidence summary on socio-economic duty / living in poverty.	The strategy aims to address socioeconomic barriers by designing flexible, accessible services, considering transport and digital exclusion, and promoting outreach and community-based support. There is a focus on tackling health inequalities and supporting those in deprived or isolated areas.

Human Rights and UN Conventions

Do you think that this policy will have a positive or negative impact on people's human rights? (*Please refer to point 1.4 of the EIA Guidance for further information about Human Rights and the UN Conventions).*

Table 2: Human Rights and UN Conventions

Human Rights	**What are the positive or negative impacts of the proposal?**	**Reasons for your decision (including evidence)**	**How will you mitigate negative Impacts?**
The Dementia Strategy specifically considers the wider determinants of dementia and recognises that certain population groups (including those with protected characteristics) may require additional dementia support.	We are anticipating positive impacts as the Dementia Strategy takes a rights-based approach.	A number of the priorities in the strategy are about empowering people to know and claim their rights, as well as increasing the ability and accountability of individuals and institutions who are responsible for respecting, protecting and fulfilling rights. Specific consideration has been given to how the strategy can support human rights and children's rights (for example by addressing inequalities in outcomes), in line with the Equalities Act 2010 and the Rights of Children and Young Persons (Wales) Measure 2011.	We will continue to review the impacts of the strategy. We will be establishing the "National Dementia Ministerial Board" and "Dementia Advisory Board" to ensure robust governance arrangements are in place to provide strategic oversight of the Dementia Strategy.

EU/EEA and Swiss Citizens' Rights

Part 2 of the EU-UK Withdrawal Agreement, along with the EEA EFTA Separation Agreement and Swiss Citizens Rights Agreement ("Citizens Rights Agreements") give EU, EEA[139] and Swiss citizens who were lawfully resident in the UK by 31 December 2020 certainty that their citizens' rights will be protected.

The Citizens Rights Agreements are implemented in domestic law by the European Union (Withdrawal Agreement) Act 2020 (EUWAA)[140]

Eligible individuals falling within scope of the Citizens Rights Agreements will have broadly the same continued entitlements to work, study and access public services and benefits, in as far as these entitlements have derived from UK membership of the EU as well as its participation in the EEA Agreement and the EU-Swiss Free Movement of Persons Agreement.

Subject to certain limited exceptions[141], individuals will need to have applied for a new residence status (either pre-settled or settled status) through the EU Settlement Scheme. The deadline for making such an application expired on 30 June 2021.

Policy considerations to take into account:

- Have you considered if your policy proposal will impact EU, EEA or Swiss citizens whose rights are protected by the Citizens Rights Agreements?
- If there is the potential for any negative impact on such EU EEA or Swiss citizens, how will any such impacts be eliminated or managed if management is deemed appropriate?
- Is legal advice required?

Please consider the impacts of your policy on the areas below, indicating whether the impact is positive or negative and any action required to eliminate potential negative impact. Please note the basis for your answer, including where legal advice has been sought and please also indicate where a right is not relevant for your policy:

If there is the potential for any negative impact on such EU EEA or Swiss citizens, how will any such impacts be eliminated or managed if management is deemed appropriate?

Residency – the right to reside and other rights related to residence: rights of exit and entry, applications for residency, restrictions of rights of entry and residence;

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[139] The EAA includes the EU countries as well as Iceland, Liechtenstein and Norway.

[140] Sections 5 and 6 of EUWAA.

[141] E.g. where an individual has Irish citizenship (including dual British and Irish citizenship) or where they had indefinite leave to enter or remain in the UK)

Mutual recognition of professional qualifications –the continued recognition of professional qualifications obtained by EU/EEA/Swiss citizens in their countries (and already recognised in the UK);

Access to social security systems – these include benefits, access to education, housing and access to healthcare.

Equal treatment – this covers non-discrimination, equal treatment and rights of workers.

Workers rights - Workers and self-employed persons who are covered under the Citizens Rights Agreements are guaranteed broadly the same rights as they enjoyed when the UK was a Member State. They have a right to not be discriminated against due to nationality, and the right to equal treatment with UK nationals.

(Frontier workers (those citizens who reside in one state and regularly work in another) can continue working in the UK if they did so by the 31 December 2020).

The proposed Dementia Action Plan proposal will not negatively impact EU, EEA or Swiss citizens whose rights are protected by the Citizens Rights Agreements.