Brighton & Hove City Council

Overview & Scrutiny

Title:	**Overview & Scrutiny Commission**
Date:	**7 September 2010**
Time:	**4.00pm**
Venue	**Council Chamber, Hove Town Hall**
Members:	**Councillors:** Mitchell (Chairman), Pidgeon (Deputy Chairman), Bennett, Cobb, Elgood, Kennedy, Morgan, Older, Peltzer Dunn, Wakefield-Jarrett and Meadows
Contact:	**Tom Hook** **Head of Overview & Scrutiny** 29-1110 tom.hook@brighton-hove.gov.uk

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AGENDA

Part One **Page**

OVERVIEW & SCRUTINY COMMISSION

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For further details and general enquiries about this meeting contact Mary van Beinum, Overview & Scrutiny Support Officer, (29-1062, email mary.vanbeinum@brighton-hove.gov.uk) or email scrutiny@brighton-hove.gov.uk

Date of Publication - Friday, 27 August 2010

Agenda Item 24

A. Declaration of Substitutes

Where a Member of the Commission is unable to attend a meeting for whatever reason, a substitute Member (who is not a Cabinet Member) may attend and speak and vote in their place for that meeting. Substitutes are not allowed on Scrutiny Select Committees or Scrutiny Panels.

The substitute Member shall be a Member of the Council drawn from the same political group as the Member who is unable to attend the meeting, and must not already be a Member of the Commission. The substitute Member must declare themselves as a substitute, and be minuted as such, at the beginning of the meeting or as soon as they arrive.

B. Declarations of Interest

(1) To seek declarations of any personal or personal & prejudicial interests under Part 2 of the Code of Conduct for Members in relation to matters on the Agenda. Members who do declare such interests are required to clearly describe the nature of the interest.

(2) A Member of the Overview and Scrutiny Commission, an Overview and Scrutiny Committee or a Select Committee has a prejudicial interest in any business at meeting of that Committee where –

(a) that business relates to a decision made (whether implemented or not) or action taken by the Executive or another of the Council's committees, sub-committees, joint committees or joint sub-committees; and

(b) at the time the decision was made or action was taken the Member was

(i) a Member of the Executive or that committee, sub-committee, joint committee or joint sub-committee and
(ii) was present when the decision was made or action taken.

(3) If the interest is a prejudicial interest, the Code requires the Member concerned:-
(a) to leave the room or chamber where the meeting takes place while the item in respect of which the declaration is made is under consideration. [There are three exceptions to this rule which are set out at paragraph (4) below].
(b) not to exercise executive functions in relation to that business and
(c) not to seek improperly to influence a decision about that business.

(4) The circumstances in which a Member who has declared a prejudicial interest is permitted to remain while the item in respect of which the interest has been declared is under consideration are:-

(a) for the purpose of making representations, answering questions or giving evidence relating to the item, provided that the public are also allowed to attend the meeting for the same purpose, whether under a statutory right or otherwise, BUT the Member must leave immediately after he/she has made the representations, answered the questions, or given the evidence,

(b) if the Member has obtained a dispensation from the Standards Committee, or

(c) if the Member is the Leader or a Cabinet Member and has been required to attend before an Overview and Scrutiny Committee or Sub-Committee to answer questions.

C. Declaration of party whip

To seek declarations of the existence and nature of any party whip in relation to any matter on the Agenda as set out at paragraph 8 of the Overview and Scrutiny Ways of Working.

D. Exclusion of press and public

To consider whether, in view of the nature of the business to be transacted, or the nature of the proceedings, the press and public should be excluded from the meeting when any of the following items are under consideration.

NOTE: Any item appearing in Part 2 of the Agenda states in its heading the category under which the information disclosed in the report is confidential and therefore not available to the public.

A list and description of the exempt categories is available for public inspection at Brighton and Hove Town Halls.

BRIGHTON & HOVE CITY COUNCIL

OVERVIEW & SCRUTINY COMMISSION

4.00PM 20 JULY 2010

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Present: Councillors Mitchell (Chairman); Pidgeon (Deputy Chairman), Bennett, Cobb, Kennedy, Morgan, Older, Peltzer Dunn, Wakefield-Jarrett and Watkins

PART ONE

12. PROCEDURAL BUSINESS

The Chairman announced that the meeting was being recorded and would be available on the Council's website for repeat viewing.

12a Declarations of Substitutes
Councillor Watkins was substituting for Councillor Elgood.

12b Declarations of Interests
There were none

12c Declaration of Party Whip
There were none.

12d Exclusion of Press and Public
In accordance with section 100A(4) of the Local Government Act 1972, it was considered whether the press and public should be excluded from the meeting during the consideration of any items contained in the agenda, having regard to the nature of the business to be transacted and the nature of the proceedings and the likelihood as to whether, if members of the press and public were present, there would be disclosure to them of confidential or exempt information as defined in section 100I (1) of the said Act.

RESOLVED: That the press and public be not excluded from the meeting.

13. MINUTES OF THE MEETING HELD ON 8 JUNE

13.1 The minutes of the meeting held on 8 June 2010 were agreed and signed by the Chairman.

13.2 It was noted that a letter was sent to the Chief Executive with comments and concerns on Intelligent Commissioning, following discussions at 8 June OSC. An Executive response to the Staff Disabilities scrutiny review is scheduled for September Cabinet.

14. CHAIRMAN'S COMMUNICATIONS

14.1 The consultation period on suitable topics for scrutiny ends on 28 July and a report will be presented to OSC in September. About 15 suggestions have been received so far; ideas can be contributed directly to the scrutiny team or via the on-line consultation portal.

15. PUBLIC QUESTIONS/LETTERS FROM COUNCILLORS/REFERRALS FROM COMMITTEES/NOTICES OF MOTION REFERRED FROM COUNCIL

15.1 There were none.

16. CLIMATE CHANGE SCRUTINY REVIEW

16.1 The Chairman warmly welcomed Professor Gordon MacKerron as Chair of the Climate Change Adaptation Scrutiny Panel to introduce the report. Professor MacKerron, Director of the Science Policy Research Unit (SPRU) at Sussex University is a Member of the Royal Commission on Environmental Pollution and has a long career in energy and environment.

16.2 He said whilst the term 'Climate Change' could be viewed as rather abstract, the description 'Extreme Weather Events' better described the importance of the matter; with weather also becoming less predictable. The evidence shows there will be significant climate change. This will bring some opportunities – for example long spells of hot weather could benefit tourism - but flooding, coastal erosion and sea level rise were areas of risk for Brighton & Hove. The City Council had already seen threats to business continuity and these were likely to increase.

16.3. Brighton & Hove City Council has a good record in mitigating the effects of climate change including use of renewable energy but significant adaptation to the effects of climate change is also needed in addition to mitigation, he said.

16.4 The Scrutiny Panel took longer than planned but the time was well spent in hearing good evidence and following up. A full record of the evidence - Volume 2 of the report - is available to view on request.

16.5 When agreed the 13 recommendations now needed to be embedded at a high level. A Cabinet Member should take responsibility for action in adapting to climate change. It was important for Local Authorities to work together and to learn from good practice.

16.6 Professor MacKerron said it had been a pleasure to Chair the panel. He thanked Councillors Mitchell, Janio and Wakefield-Jarrett as Panel Members and Karen Amsden, the scrutiny officer.

16.7 Answering questions Professor MacKerron emphasised the need for active cooperation between authorities and said that the Environment Agency could advise on the geographical ranges of potential impacts for Brighton & Hove. He could not confirm that national indicator NI188 would be retained but in his opinion the process was useful.

16.8 Councillor Janio had not supported Recommendation 8 as he felt the adaptation test would be too onerous for some organisations; however Professor MacKerron said that in his own view, most organisations would have thought about adaptation. The other three Panel Members did wish to include this recommendation as part of an on-going process of awareness and encouragement, especially within Intelligent Commissioning.

16.9 Regarding how much could be achieved in Brighton & Hove, a relatively small geographical area with its own microclimate, Councillor MacKerron stated that Climate Change Adaptation is an extremely local issue compared with mitigation which generally requires a wider approach. Much work had been at a national level and there was a raft of help and advice for local authorities.

16.10 Asked about flooding and cold winters of the past, Professor MacKerron explained it was impossible to ascribe individual extreme weather events to climate change. However in the past ten years, events are happening more frequently and with more intensity. Across Europe 8 out of 10 of the hottest years were recorded in the last decade.

16.11 Extreme variability was a major factor in climate change and even if there was some scepticism it would not be expensive to take steps to become more prepared for significant risks.

16.12 Professor MacKerron said he had enjoyed working on the scrutiny review as an external Chairman and would provide feedback on the process.

16.13 **RESOLVED;** that members

(1) Endorse the Scrutiny panel report and express their thanks to Professor MacKerron and all the Scrutiny Panel Members
(2) Refer the report recommendations to the council's Executive and to appropriate partner organisations
(3) Instruct officers to prepare a progress report for OSC after 6 months and 12 months and as required.

17. TBM PROVISIONAL OUTTURN 2009 - 2010

17.1 Overview and Scrutiny Commission receives TBM information throughout the year to monitor financial performance against the budget set and the Strategy and Resources Manager presented the Targeted Budget Management provisional outturn 2009/2010 that had been reported to 17 June Cabinet.

17.2 This shows an underspend of £235,000 that allows for contributions to reserves, set out in paragraph 3.4. At the time of budget setting an overspend of £66,000 had been expected; therefore the overall financial position of the council has improved by around £300,000.

17.3 **RESOLVED** (1) That the report be noted.

17A TARGETED BUDGET MANAGEMENT 2010/2011 AND VALUE FOR MONEY PROGRAMME UPDATE

17A.1 The Strategy and Resources Manager presented the Targeted Budget Management 2010/2011 and Value for Money Programme Update. This report to 22 July Cabinet meeting was included as a late item to OSC at the request of the OSC Chairman as it provides up to date financial context for the next item 17(B) on this agenda.

17A.2 The TBM report was being presented earlier than usual. This is an early estimate which shows a forecast overspend of around £2.4 million on council controlled budgets. There was time to achieve a balanced budget by year end; action plans to mitigate directorate forecast overspends would be reported to 16 September Cabinet.

17A.3 Answering questions, the Head of Strategic Finance and Procurement said the forecast £235,000 underspend in 2009/2010 was proposed to be used to fund any overspend in 2010/2011; it was not available to offset grant reductions. The forecast outturn included all the impacts of the adverse weather and loss of parking income; the Council holds financial provision for risk.

17A.4 Other queries were on; whether the bursary scheme to attract newly qualified social workers is continuing (Appendix 1, Children and Young People's Trust); and if at paragraph 3.9, the £250,000 'programme management support, business analysis and communications resources' refers to consultants fees.

17A.5 RESOLVED (1) That the report be noted.
(2) That information as minuted at 17A.4 above be requested.

17B 2010/11 IN-YEAR GOVERNMENT GRANT REDUCTIONS

17B.1 The Strategy and Resources Manager presented the 2010/11 In-Year Government Grant Reductions. This report to 22 July Cabinet meeting was included as a late item on this agenda for comment, as the result of a Liberal Democrat Notice of Motion at 15 July Council.

17B.2 It sets out proposals for managing 2010/2011 in-year grant reductions, following recent Government announcements and agreement by 17 June Cabinet on the principles for dealing with the reductions.

17B.3 The Head of Strategic Finance and Procurement further clarified the details of the proposals, pointing out that the reduced Local Delivery Support Grant outlined in Appendix 3 was new information from the Department for Education that had not been available at 15 July Council.

17B.4 The reduced Youth Capital Fund grant was also a new DfE announcement. A series of government statements set out in Appendix 3 were still being analysed.

17B.5 The Commission was particularly concerned that grants for children and young people were affected. Because of the potential effect on the numbers of young people not in education employment or training (NEETs) it was agreed to refer to CYPOSC the

Equalities Impact Assessment of the Connexions Service reduction (report paragraph 5.3)

17B.6 Members were dismayed at proposals that road safety and dropped kerbs should lose funding priority in year 2010/2011.

17B.7 Answering questions officers told the meeting that some £80,000 of the £600,000 allocated to Playbuilder in 2010/2011 had already been spent; the Council's contractual commitments to these schemes would be checked.

17B.8 Following recommendations from scrutiny of budget proposals for 2010/2011, Directorates were being asked for Equalities Impact Assessments where necessary.

17B.9 Members noted the speed required under difficult circumstances to make the in-year reduction decisions. They argued that more information was needed on the basis for new funding proposals and the potential effects, especially on equalities, that these decisions would have over time on communities.

17B.10 They also felt that the underlying financial assumptions made in making decisions on grant reductions should be carefully monitored. Officers reassured the meeting that this would be included in the December budget update report.

17B.11 The Commission agreed to establish a cross-party scrutiny review of the effects of grant reductions decisions on communities including the impact on equalities.

17B.12 On behalf of the Commission the Chairman thanked the officers.

17B.13 RESOLVED (1) That the report be noted

(2) That the Equalities Impact Assessment of the Connexions Service reductions be referred to CYPOSC..

(3) That a scrutiny review be established as minuted at 17B.11 above.

18. ANNUAL COMPLAINTS REPORT

18.1 The Standards and Complaints Manager introduced the Annual Complaints report for 2009/2010.

18.2 Overall numbers of Stage One complaints had fallen during the year and as would be expected for large directorates providing services directly to the public, Environment and Adult Social Care and Housing received the largest proportion of complaints. The Complaints Team are working with the Council's Youth Advocacy Practice to make the complaints process more accessible for young people so they can feel confident about contacting us.

18.3 Answering questions the Standards and Complaints Manager said a complaint was an expression of dissatisfaction however made about something the council has or has not done. He outlined the Council's complaints procedures.

18.4 He frequently provided feedback to the Directorates and had regular contact with the service areas, Heads of Service and Directors. Some complaints information is reported to the

Standards Committee; the annual complaints report is now presented to Overview and Scrutiny Commission.

18.5 Some services, particularly City Clean and Adult Social Care, are resolving complaints by having direct contact with customers. This is proving to be a good way to resolve complaints and improve services and this seemed to be happening more.

18.6 Benchmarking against other local authorities for Stages One and Two complaints was not in place. The Local Government Ombudsman provides comparative information on complaints referred to him.

18.6 The Standards and Complaints Manager explained how complaints data could be presented to distinguish been dissatisfaction with a policy or decision reached compared with a service received.

18.7 Complaints against Councillors were reported to the Standards Committee. Complaints about the decisions of Licensing Committee are outside of the complaints process.

18.8 Members were concerned at the significant rise in complaints about Repairs and Maintenance, especially in that the probable reason was transferring work between contractors. (Report paragraph 3.37) They felt strongly that in the context of a move to Intelligent Commissioning this learning should be shared widely. The matter would be referred to Adult Social Care and Housing Overview and Scrutiny Committee.

18.9 Chair of the Environment and Community Safety Overview and Scrutiny Committee Councillor Warren Morgan reminded the meeting that individual complaints were excluded from the remit of the scrutiny panel investigating the response to the severe weather, of which he was also Chair. This was a one-off event but because these complaints had been omitted from this report the data here might be misleading, he said. (Report paragraph 3.52).

18.10 The Standards and Complaints Manager stated there had been too many complaints to process in the usual way. There was a significant strength of feeling from complainants in the December period of snow that had reduced to some extent by the time of the January spell of snow. He had provided evidence to the scrutiny panel, whose full report of key findings was available.

18.11 There is an established protocol with health organisations to allow for a combined response to complaints. Where services are shared between partnership bodies, clarifying the process for complaining or creating a one-stop shop would be useful, he said.

18.12 **RESOLVED** That as minuted above at 18.8 learning from complaints about Repairs and Maintenance in the context of Intelligent Commissioning be referred to ASCHOSC.

19. COMMUNITY ENGAGEMENT FRAMEWORK UPDATE

19.1 The Community Engagement Improvement Officer and the Head of Communities and Equalities introduced the report. Overview and Scrutiny Commission had a role in monitoring progress and any areas of concern.

19.2 Replying to questions the officers said guidance on community engagement was being developed on Intelligent Commissioning and would form part of the toolkit.

19.3 Members remarked that Community Engagement was central to the Big Society that had recently been announced nationally. They noted it was important to ensure that people without access to the internet were engaged. Members also asked to see notes of the Third-Sector-led Task Group helping develop policy principles to support asset transfer; these meetings were not formalised.

19.4 The Head of Policy told the meeting that the Public Service Board was working to support stronger joint working between partners. The two needs assessments for the two Intelligent Commissioning pilot areas; Domestic Violence and Drugs and Alcohol Abuse were in progress.

19.5 Learning reports from the pilots were expected to be completed in September. The Chairman of ECSOSC requested that these be brought to his Committee in September and this was agreed.

19.6 Members noted that at present there were some weaknesses in implementing the Framework.

19.7 There was a reminder that third sector organisations can ask scrutiny to look into areas of difficulty.

19.8 The Commission requested that the next update include some of the reasons for poor practice plus good exemplars.

19.9 The meeting noted that more work was under way for example towards training, communications and formalising the role of officers and Councillors with regards to community engagement.

19.10 There was a comment on the balance of the 'ward communications' content of the City News council publication.

19.11 **RESOLVED;** that further information be provided at the next update as minuted above.

20. DUAL DIAGNOSIS SCRUTINY REVIEW; SIX-MONTH IMPLEMENTATION REPORT

20.1 The Chairman of the Scrutiny Panel Councillor David Watkins welcomed the interim implementation report. This scrutiny review had taken a long time and involved a lot of work. The recommendations would have long-lasting impacts and it was pleasing to see the progress being made.

20.2 **RESOLVED:** that a further 6-month implementation update be requested.

21. O&S COMMITTEE UPDATE: CTEOSC

21.1 Councillor Amy Kennedy as new Chair of CTEOSC updated the Commission on the work of her Committee. She paid tribute to Councillor Randall, former CTEOSC Chair and thanked the support officers for their work.

21.2 Recent agenda items had included: the archaeological review of artefacts in our Museums Service; Renaissance Funding; the city's programme for 2012 Olympics; an update on creative industries; and New England House. CTEOSC would continue to receive updates on these.

21.3 Other reports had been on the city's approach to tourism and the LAA annual figures. The performance reports now had a particular focus. The recession relief work (phase 2) was covered at the July meeting and the focus of the next performance report is to be worklessness.

21.4 Major Projects is a regular report as a Part 2 item.

21.5 The Committee used workshops to explore policy issues or look at draft strategies. Previous workshops had covered mobile libraries, the cultural strategy for the city, golf courses, the museums forward plan, and the business retention and inward investment strategy. There would be a workshop later this month on the leisure management contract.

21.6 The panel set up to look at the cultural provision for children and young people in the city had finished holding public evidence sessions and would be reporting towards the end of the year.

21.7 Referred to the work programme for 2010/2011 Councillor Kennedy said amongst the important items the Committee would be looking at Value for Money and the Business case for culture. She noted that that the tri-partite meetings held between the Cabinet Members and Scrutiny Committee Chairman were especially helpful.

21.8 **RESOLVED** that the report be noted.

22. OSC WORK PLAN

22.1 The next Overview and Scrutiny update for 7 September OSC meeting would be HOSC

22.2 **RESOLVED** that the report be noted

23. ITEMS TO BE REFERRED TO CABINET MEMBER, CABINET OR FULL COUNCIL

23.1 Items 17A and 17B: Extracts from the draft minutes would be forwarded to 22 July Cabinet.

23.2 Item 16; To be forwarded to Cabinet and subsequently Full Council

The meeting concluded at 6.30pm

Signed Chair

Dated this day of

OVERVIEW AND SCRUTINY COMMISSION	Agenda Item 28 Brighton & Hove City Council

Subject:		**Select Committee on Dementia: Report**		
Date of Meeting:		**7 September 2010**		
Report of:		**The Acting Director of Strategy and Governance**		
Contact Officer:	Name:	Giles Rossington	Tel:	29-1038
	E-mail:	Giles.rossington@brighton-hove.gov.uk		
Wards Affected:	All			

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 In 2009 the Overview & Scrutiny Commission (OSC) established a Select Committee to examine local dementia services. The immediate contexts for this were the recent publication of a National Dementia Strategy and the ongoing re-design of the local Dementia Care Pathway.

1.2 Select Committee members were: Cllr Pat Hawkes (Chair), Cllr Dawn Barnett, Cllr Averil Older, Cllr Georgia Wrighton and Mr Robert Brown (representative of the Brighton & Hove Local Involvement Network).

1.3 The Select Committee report on dementia is included as **Appendix 1** to this report.

2. RECOMMENDATIONS:

2.1 That members endorse the Select Committee report on dementia.

3. BACKGROUND INFORMATION

3.1 Dementia is the term used to describe the effects of a group of conditions which progressively affect people's memory, thinking, orientation, comprehension, calculation, learning capacity, language and judgement. The best known and most common cause of dementia is

Alzheimer's disease, but there are several other types of dementia which affect significant numbers of people.

3.2 Dementia is most prevalent amongst older people, and, as the average age of the UK population increases in the next few years, so the morbidity of dementia is expected to grow. This has major implications for people with dementia and for health and social care systems.

3.3 Whilst there is a good deal of ongoing activity aimed at treating/curing dementia, including some very exciting work in Sussex, the main focus of the National Dementia Strategy is on improving assessment, care and support services. In consequence, the Select Committee chose to focus on these areas also.

3.5 More detailed information on dementia and the Select Committee investigation may be found in the Select Committee report (**Appendix 1**).

3.6 The bulk of the recommendations in the Select Committee report are intended to inform the re-design of the local Dementia Care Pathway. If endorsed by the OSC, these will be presented to the council's Executive, who may then choose to refer them to the partnership group charged with re-designing the care pathway. Other recommendations are directly for the council's Executive or for NHS Brighton & Hove.

4. CONSULTATION

4.1 A draft version of the Select Committee report was shared with senior clinicians from Brighton & Sussex University Hospitals Trust and with the city Commissioner for Long Term Conditions and Independence, and their comments were taken into consideration when compiling the final report.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 There are none directly for the OSC

Legal Implications:

5.2 There are none directly for the OSC

Equalities Implications:

5.3 Information on equalities issues is contained in the main report (**Appendix 1**)

Sustainability Implications:

5.4 None directly

Crime & Disorder Implications:

5.5 None directly

Risk and Opportunity Management Implications:

5.6 Detailed information on the risks posed by dementia is included in the main report (**Appendix 1**)

Corporate / Citywide Implications:

5.7 Ensuring that people with dementia, their families and their carers live lives of quality and dignity is a key challenge for city health and social care partners.

SUPPORTING DOCUMENTATION

Appendices:

1. Select Committee report on Dementia

Documents in Members' Rooms:

1. Volume 2: Minutes of Select Committee

Background Documents:

1. National Dementia Strategy

Report of the Select Committee on Dementia

Chair's Foreword

Dementia is undeniably one of the most frightening of all illnesses: to lose aspects of one's memory and the ability to act rationally is an awful prospect, and many of us who have witnessed the effects that dementia has had on our family and friends can attest to how devastating a condition it can be.

Even in the recent past the impact of dementia was often made worse by the fact that it was a condition that people did not speak about: the stigma that attached to mental illnesses meant that many people with dementia and their carers felt lost and isolated, uncertain what support was available and how to access it.

In the past few years much has changed for the better: health and social care services have begun to work together more effectively; the dementia 'care pathway' – the way in which different aspects of dementia care are integrated with each other – has been re-designed to make it easier to understand and negotiate; the Alzheimer's society and other organisations have been tireless in championing the cause of people with dementia. Most importantly, society has begun to hold a mature conversation about dementia; and, although there is still a long road to travel, there is now hope that we are beginning to break down the secrecy and stigma which still cloaks the illness, moving towards recognising it as an issue for communities as well as for individuals and their families.

How we deal with dementia over the next few years is going to be crucial. Whilst there is a very real chance that medical research will develop effective treatments in the relatively near future, we cannot afford to be sanguine: with the average age of the UK population increasing, dementia is likely to become an even more urgent problem than it is today. We have to get better at dealing with dementia and do so quickly. There is much work going on both nationally and locally to achieve this aim, and we hope that this Select Committee report will contribute in some way to this. Even if dementia cannot be cured in the foreseeable future, we can, as a society, strive to ensure that people with dementia and their families receive the support and understanding that they need and deserve.

I would like to thank all the people who took time to give evidence to the Select Committee, and particularly thank Kathy Caley and Carey Wright, who attended every meeting and offered us invaluable support and advice.

Councillor Pat Hawkes, Chair of the Dementia Select Committee

Executive Summary

Anyone looking at the issue of dementia is bound to be struck by how much is currently going on. Ideas about curing, treating and supporting people with dementia have rapidly evolved in recent years. In part this is because the prevalence of dementia is growing quickly as the average age of our population increases, making finding solutions to the problem even more urgent. In part, it is also because we are becoming better at understanding dementia; and, although there is as yet no cure for the condition, huge advances are being made in the field of disease-modifying treatments for diseases causing dementia, including Alzheimer's disease. These advances offer the possibility that effective prevention of or a cure for dementia may be developed in the relatively near future.[1]

For the moment, however, the focus, in terms of the recently published National Dementia Strategy and local strategies which complement it, is largely on providing practical support for people with dementia. Select Committee members are pleased to say that they have been able to make a number of sensible and practical recommendations intended to help the city commissioners of health and social care improve services for people with dementia. There is much, much more to be said about dementia – too much for any single review to deal with. And there is certainly an argument for scrutiny to re-visit this issue in the future, perhaps with a really strategic examination of local services and their outcomes and how they compare with those of neighbouring areas. A future review might also usefully focus on the ongoing research to prevent or find a cure for dementia, particularly in terms of the innovative local work led by Brighton & Sussex University Hospitals Trust.

However, this review has had a pragmatic focus, looking at how local services can be maintained and improved. Detailed explanations of the recommendations are included in the main report, but in brief they are:

1 When re-designing the local dementia care pathway, the city commissioners should ensure that all city healthcare workers are appropriately trained in dementia issues, in order to improve early diagnosis of dementia. This should specifically address the issues of GP expertise and that of people working in the acute sector, given the key role that these workers play in the diagnosis of dementia.

[1] Information provided by Dr Dennis Chan, Senior Lecturer in Neurology and Honorary Consultant Neurologist, Brighton and Sussex University Hospitals Trust. More information on recent developments in the treatment and prevention of dementia can be found in the (USA) report: A National Alzheimer's Strategic Plan: the Report of the Alzheimer's Study Group (2010).

2 That whatever model of memory assessment service model the city adopts, the commissioners should be able to demonstrate that the service: a) provides a homely environment for diagnosis and/or assessment; b) has the capacity to deal with all referrals in a timely manner; c) is able to maintain its core focus if integrated within a team with broader responsibilities.

3 That in re-designing the local dementia care pathway, the city commissioners should explicitly address the issue of carer bereavement, ensuring that dementia services support carers as well as people with dementia, and that supports services do not cease suddenly following the death of patients.

4 That in re-designing the local dementia care pathway, the city commissioners should explicitly address the issue of how the wishes of people with dementia and their carers can best be reflected in terms of planning appropriate end of life care.

5 That the city commissioners should seek to ensure that all their staff and the organisations they commission (e.g. equipment providers as well as health and social care providers) are aware of the need to treat bereaved people with understanding and sympathy.

6 When the city commissioners make their decisions on the future of in-patient acute dementia beds, they should bear in mind the position of dementia Select Committee members: that locating this service outside the city should not be agreed unless there are overriding therapeutic benefits to such a move.

7 The city commissioners should be able to demonstrate that they have planned for sufficient capacity in terms of in-city nursing and residential home placements to ensure that everyone with dementia who requires such a placement is normally able to access one.

8 That NHS Brighton & Hove should arrange the invitation of a representative of the Access Point to forthcoming Locality GP meeting(s) or otherwise facilitate the promotion of the Access Point's work amongst city primary care practitioners.

9 That the Access Point should continue to be encouraged to promote its services via all appropriate council/city initiatives (such as Get Involved Day etc.)

10 When re-designing the local dementia care pathway, the city commissioners should specifically address the issue of support service capacity in the light of anticipated growth in demand for these services in the near future.

11 When re-designing the local dementia care pathway, the city commissioners should explicitly address the issue of ensuring that all aspects of the pathway are as easy to negotiate as possible, so as to reduce the pressure on advocacy and advice services.

12 The city commissioners should investigate the potential benefits of engaging with local communities in order to encourage them to better support people with dementia and their carers.

13 When re-designing the local dementia care pathway and commissioning city dementia services, the city commissioners should specifically address the needs of people with early onset dementia, ensuring that appropriate support services are in place to deal with current and likely future demand.

14 The issue of dementia and the ongoing changes to local dementia services should inform Overview & Scrutiny work planning, particularly with reference to the work programmes of the Adult Social Care & Housing Overview & Scrutiny Committee (ASCHOSC) and to the Health Overview & Scrutiny Committee (HOSC).

Most of the above recommendations are intended to inform the ongoing partnership project to re-design the local dementia care pathway. This project is expected to be completed in Autumn 2010, and to be ratified by the Joint Commissioning Board shortly thereafter. It should therefore be possible to report back on the implementation of the Select Committee recommendations in early 2011.

This type of scrutiny report – i.e. making a series of recommendations to inform the design of a commissioning strategy, care pathway etc. – is likely to become much more common when the council moves to its 'Intelligent Commissioning model'. For Overview & Scrutiny to work effectively with a commissioning system, it is particularly important that scrutiny work is synchronised with commissioning cycles, so that scrutiny reports influence the development of commissioning plans rather than reporting when a strategy has already been finalised.

Introduction

In 2009 the Overview & Scrutiny Commission decided to form a Select Committee to investigate issues relating to dementia services in the city. The immediate context for this decision was the publication of a new national Dementia Strategy[2] and the imminent re-design of the local dementia care pathway[3].

Select Committees can be established either for major pieces of work or for work which cuts across Overview & Scrutiny committee boundaries. Dementia is just such a cross-cutting issue, as dementia services directly involve both health and social care and can impact even more broadly. The Dementia Select Committee therefore sought members from the Adult Social Care and Housing Overview & Scrutiny Committee (ASCHOSC) and the Health Overview & Scrutiny Committee (HOSC), as well as other backbench Councillors with a particular interest in this subject. The Select Committee also included a representative from the Brighton & Hove Local Involvement Network (LINk), the city's main representative body for members of the public wishing to engage with health and social care issues.

Dementia presents perhaps the single biggest single challenge to health and social care services in the foreseeable future, with the number of people suffering from dementia expected to increase rapidly over the next few years. Furthermore, the situation with regard to dementia is extremely fluid, with national and local policies being rapidly developed in very uncertain financial and political circumstances. Given this background, it was never really possible that this Select Committee should provide a definitive review of dementia services[4]. Nor was it intended that this review should be principally strategic in its focus: there might well be considerable value in a strategic review of city dementia services, but the local dementia care pathway is currently being revised, as are all mental health services provided by the Sussex Partnership NHS Foundation Trust (SPFT), the main provider of statutory services for dementia across Sussex. Whilst this certainly provides an opportunity for scrutiny to feed into strategies in development, it also makes it rather difficult to run a strategically-focused review, there being no established medium-term strategy or service model to scrutinise and no 'stable' high-performing service in Sussex to benchmark local services against.

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[2] Living Well With Dementia: A National Dementia Strategy; Department of Health, 2009.

[3] A 'care pathway' describes a way of looking at, and designing services for particular conditions which aims to make access to each aspect of the care provided, and the transitions between various types of care, as simple and logical as possible, even when a number of different organisations are involved in delivering that care. In recent years, care pathways have become an integral part of UK health and social care planning and commissioning.

[4] This mirrors experiences at neighbouring local authorities. In West Sussex, for example, Overview & Scrutiny members have been involved in three separate reviews of dementia services in the past 3-4 years.

Therefore, given these issues, Select Committee members decided to limit the scope of their investigation and to make mainly practical rather than strategic recommendations. Generally, these recommendations are intended to support the city commissioners in their ongoing task of revising the local dementia care pathway (working together with a range of partners to achieve this). The Select Committee offers its recommendations with the important caveat that there is much more work to be done on this issue, particularly in terms of evaluating the effectiveness of the local dementia strategy, scrutinising funding for Brighton & Hove dementia services and overseeing the SPFT 'Better By Design' reconfiguration, which may include significant changes to the provision of some city dementia services, particularly in terms of acute bed capacity and/or location.

The Select Committee was made up of Councillors Dawn Barnett, Pat Hawkes, Averil Older and Georgia Wrighton, and Robert Brown, Chair of the Brighton & Hove LINk Steering Group. Councillor Hawkes was chosen to be the Select Committee Chair.

The Select Committee held four evidence-gathering meetings in public, as well as several private scoping meetings. Amongst the witnesses were Brighton & Hove City Council officers responsible for Adult Social Care services; commissioners from NHS Brighton & Hove; clinicians and managers from the Sussex Partnership NHS Foundation Trust; representatives of the Alzheimer's Society and witnesses who had direct experience of caring for people with dementia.

The Select Committee did not interview staff from Brighton & Sussex University Hospitals Trust (BSUHT). In part this was because the focus of this review (in line with the focus of the National Dementia Strategy) was on assessment and support services, rather than the research, diagnosis and treatment services typically provided by acute hospital trusts. In part though it was because scrutiny support staff advising the Select Committee were insufficiently aware of the key role that BSUHT plays in the local dementia care pathway, particularly in terms of specialist services providing diagnosis of young onset and atypical dementias, and in terms of a number of clinical research initiatives.[5] In hindsight, we should clearly have involved BSUHT in the work of the Select Committee.

The Select Committee would particularly like to thank Kathy Caley, Commissioner for Long Term Conditions and Independence for Brighton & Hove, and Carey Wright, Community Mental Health Team Manager for the Sussex Partnership NHS Foundation Trust. Kathy and Carey supported the Committee throughout the scrutiny process, and their input was greatly appreciated by committee members.

[5] Information provided by Dr Dennis Chan, Senior Lecturer in Neurology, Brighton & Sussex University Hospitals Trust.

The following report begins with a general explanation of what dementia is and the national and local problems it poses, followed by the Select Committee's recommendations and the reasoning behind them.

Information on Dementia

What is dementia?

Dementia is the term used to describe the effects of a group of conditions which progressively affect people's memory, thinking, orientation, comprehension, calculation, learning capacity, language and judgement. The best known and most common cause of dementia is Alzheimer's disease, but there are several other conditions which cause dementia in significant numbers of people.[6] Other types of dementia include: Vascular Dementia (sometimes known as multi-infarct dementia); Dementia with Lewy bodies (DLB); Alcohol Induced Persisting Dementia; Frontotemporal lobar degeneration; Creutzfeldt-Jakob disease; Dementia Pugilistica; and Posterior Cortical Atrophy. It should be noted that dementia is not in itself a disease: it is the state brought about by a number of diseases, such as Alzheimer's, which each have distinctive pathological and cognitive signatures.[7]

The effects of dementia can vary considerably according to the stage that the disease has reached. People with mild or moderate forms of dementia may well be able to live relatively independent lives providing they have appropriate support; people with severe dementia may well require round the clock care. At any one time, most people with dementia exhibit 'mild' rather than 'moderate' or 'severe' manifestations of their condition (although the older a person is, the more likely it is that their dementia will be of the moderate or severe type). It is estimated that around two thirds of people with dementia live in the community, and around one third in residential or care homes.[8]

Causes

Dementia is caused by the conditions listed above. Some of these conditions may have a genetic links, but others (including Alzheimer's) seemingly do not. It is also well established that poor health, particularly in terms of diet and/or

[6] Evidence provided by Dr Chris Smith, Specialist Registrar in Psychiatry in Old Age, Sussex Partnership NHS Foundation Trust. See minutes to the Select Committee meeting of 12 June 2009.

[7] Information provided by Dr Dennis Chan, Senior Lecturer in Neurology, Brighton & Sussex University Hospitals Trust.

[8] Dementia UK: the Full Report: Albanese/Banerjee, 2007: p34. The ratio of people living in the community to those in residential care decreases as age increases, and more people over 90 with dementia live in residential care than live in the community. This may be because dementia tends to be more severe amongst older people and/or because older people are less likely to be able to call on carers to help support them at home, and/or are more likely to have co-existing physical problems which restrict their ability to live independently..

cardio-vascular health, can significantly increase the likelihood of developing some dementias.[9] Excessive drinking may also be a significant factor in developing some conditions which lead to early onset dementia, although it is not considered to be a significant factor in developing dementia in general.[10]

Age

Dementia is generally associated with older people, and is most prevalent in the oldest populations. It is estimated that 1 in 14 people over the age of 65 has dementia, with this figure rising to 1 in 6 of over 80s.[11] Given this strong correlation with age, one would expect dementia to be more of a problem at times when the average age of the population increases or in areas with lots of older people.[12]

Some types of dementia affect younger people, although these 'early onset' dementias are currently relatively uncommon, with only around 15,000 people currently diagnosed in the UK.[13]

Morbidity

'Late onset' dementia is, in contrast to early onset dementias, a relatively common condition, and its incidence is set to rise as the average age of the UK population increases. It is thought that at least 700,000 people currently suffer from dementia across the UK. It is estimated that, by 2038, this will have risen to around 1.4 million people. As well as having a devastating impact upon people's quality of life, dementia also significantly reduces life expectancy. Dementia is estimated to contribute to almost 60,000 deaths per year.[14]

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[9] For example, it is estimated that up to 50% of dementia cases have a vascular health component. See Living Well With Dementia: The National Dementia Strategy: p27.

[10] See evidence from Dr Chris Smith, Specialist in Psychiatry in Old Age, Sussex Partnership NHS Foundation Trust, 12.06.09: point 4.7.

[11] Dementia UK: The Full Report: p2.

[12] There is a considerable variation in the prevalence of dementia across England, ranging from 0.51 per 100 people in Newham, to 2.09 per 100 in Torbay. The national average prevalence is 1.1 per 100 people (Dementia UK: the Full Report p25).

[13] Dementia UK: the Full Report p27. Early onset dementia is not predicted to increase as rapidly as late onset dementia, as it is not linked to an ageing population. However, some early onset dementias, such as Korsakoff's Syndrome, are linked to excessive alcohol consumption, so increased levels of hazardous drinking across society may impact upon early onset dementia morbidity.

[14] Dementia UK: the Full Report, p37.

Sex

Approximately twice as many women as men are living with late onset dementia. However, this imbalance is thought to be mainly due to demographics (there are more elderly women than there are men, and dementia is most prevalent amongst the elderly) rather than any greater susceptibility in women.[15]

Ethnicity

It is currently unclear whether late onset dementia is more prevalent amongst any particular ethnic groups. However, it is anticipated that dementia rates will rise far more quickly amongst some minority ethnic groups than across the population as a whole, as the age profile of some of these groups is significantly higher than for the general population (the bulk of immigrants to the UK in the first wave of mass immigration in the 1950s and 60s were young adults; this cohort is now in its late 60s and 70s - the age groups most likely to develop dementia.)[16]

Treatment

Dementia is incurable and worsens as the condition progresses. However, there are some drug treatments which may work to slow or even temporarily halt the progress of the disease in some patients. The best known of these drugs is marketed in the UK as 'Aricept'. The use of drugs to treat dementia is a relatively recent development but one which has considerable potential to change radically medical approaches to dementia in the relatively near future. In particular, there are a number of drugs currently undergoing late phase clinical trials which may have true disease-modifying potential.[17]

However, the current NHS position is essentially that medical treatments for dementia are of relatively limited value and should be used only in a minority of cases. This position is based upon an objective analysis of evidence by the National Institute of Clinical Excellence (NICE). NICE collates evidence on the effectiveness of treatments and maps this against cost and the improvement they can make to people's quality of life in order to determine whether to approve treatments or not. There is therefore likely to be little value in lay people challenging NICE's analysis of the efficacy of particular treatments.

However, Select Committee members did feel that it was worth stating that they believed it was important that the threshold for dementia treatment was

[15] Dementia UK: the Full Report, p31. Considerably more relatively young men (e.g. aged 65-69) have late onset dementia than do women, by around a factor of 1.4/1; but as people get older, this ration is reversed: in the over 90s category for instance, there are more than three times as many women with dementia as there are men.

[16] Dementia UK: the Full Report, p36.

[17] Information provided by Dr Dennis Chan, Senior Lecturer in Neurology, Brighton & Sussex University Hospitals Trust.

set fairly low (i.e. that treatments such as Aricept should be offered even when there was relatively weak evidence of their efficacy), given the impact of the condition on sufferers, their families and their communities. NICE is due to review treatments for dementia in 2012, which is also when the patent period ends for currently licensed dementia drugs (meaning that prices should fall as any manufacturer can produce generic versions of drugs not protected by patent), so it may well be that there is a general move towards providing treatments on the basis of benefits to patients and families rather than on a cost basis.[18]

Financial Impact

Dementia has a major impact upon health and social care budgets. The Government estimates that the cost of dementia services is currently around £17 billion per annum, a figure which is set to rise to over £50 billion by 2038[19]. To put this in context, the total 2009 budget for the NHS was approximately £110 billion. If rates of dementia grow as anticipated and unit costs do not diminish, the NHS will struggle to provide the current level of dementia care in the future, even assuming that healthcare budgets will continue to rise in line with or faster than inflation.

The Future

As the average age of Britain's population grows, so conditions such as dementia are likely to become much more problematic, in terms both of their impact upon individuals, families and communities and of their financial impact upon health and social care services. It is widely recognised that current services for dementia are expensive and by no means as good as they might be; without a major re-design it is certain that they will not be able to cope with the anticipated increase in demand.

The NHS has identified dementia as a key national health challenge, and the Department of Health has issued a National Dementia Strategy aimed at improving dementia services across England. Local Primary Care Trust (PCT) areas are also expected to develop their own dementia strategies and care pathways. Re-design of the Brighton & Hove dementia care pathway is an ongoing piece of work.

Local Issues

In local terms, Brighton & Hove is bound to experience many of the same problems as other parts of the country. However, as noted above, the incidence of dementia closely maps the age of a population, and Brighton & Hove is unusual in having an age-profile that is not expected to rise very much in the medium term. On the face of things, this should mean that city dementia

[18] Information provided by Dr Dennis Chan, Senior Lecturer in Neurology, Brighton & Sussex University Hospitals Trust.

[19] Living Well With Dementia: The National Dementia Strategy: p9.

services will not experience the same pressures as services in many other parts of the country. However, this has to be balanced against other demographic factors such as the relatively high ratio of very elderly people in the local population (the over-80s are the group most likely to contract dementia, the group most likely to manifest severe forms of the disease, the group most likely to experience complicating co-morbidities, and the group least likely to be supported by carers), and other factors such as poor general health across communities (poor cardio-vascular fitness is a factor in developing some forms of dementia). Currently, approximately 2.6% of city residents are aged 85+, in comparison to a national average of 2.1%. By 2031 it is estimated that around 9% of people in Brighton & Hove will be 85+, compared to an average nationally of around 3%.[20] In any case, even if Brighton & Hove faces less of a challenge than many areas in terms of the capacity of its dementia services, the challenge of improving services is still a very considerable one.

Other local issues which will be touched on later in this report include the city provision of nursing home places for people with dementia, the relatively high costs of city Older People's Mental Health (OPMH) services, and the local provision of in-patient acute mental health beds for people with dementia.

Dementia Services

Prevention

Whilst research to find effective treatments for dementia is ongoing, there is little expectation that a 'cure' will be discovered in the very near future. Given this, how are services going to be improved?

One major focus is likely to be on prevention.[21] Although it might not always be possible to prevent the appearance of dementia in an individual, it may be feasible to delay its appearance across populations - for example by encouraging better diet or lifestyles which minimise the risk of having strokes (both poor diet and cardiovascular health are key risk factors for certain types of dementia). If the onset of dementia across the population could be delayed for an average of five years, this would halve its prevalence, improving many thousands of lives and drastically reducing the potential financial burden on health and social care services.

This is clearly an important area, and one in which Overview & Scrutiny should be engaged. However, for the purposes of this report Select Committee members felt that most if not all preventative health work which might have a positive impact upon dementia had a broader remit rather than being specifically dementia-focused - i.e. in terms of campaigns to encourage

[20] See the Annual Report of the Brighton & Hove Director of Public Health 2009: Dr Tom Scanlon. P48.

[21] See Living Well With Dementia: The National Dementia Strategy: pp28, 29.

healthier eating, smoking cessation, sensible drinking, cardio-vascular health etc. These issues are probably best dealt with by general scrutiny of city Public Health services rather than via the Dementia Select Committee.

Diagnosis and Support

The other major focus is likely to be on supporting people with dementia to live full lives. This has a number of aspects. Firstly, it assumes that dementia will be diagnosed at a relatively early stage, whilst the effects of the illness are still relatively mild[22]. Early diagnosis significantly increases the opportunity to enable people to cope with more severe manifestations of their condition. For obvious reasons this becomes much harder as cognitive impairment and memory loss get worse. A similar point can be made about supporting carers: if people with dementia are diagnosed at an early stage, their carers can be appropriately trained and supported; if diagnosis occurs further down the line and carer support has not been provided, the carers may be 'burnt out' by the time that support arrives. If dementia is only diagnosed when people suffer a crisis, then it may often be too late to support them or their carers effectively.[23]

However, it seems currently to be the case that there is little effective early diagnosis of dementia, since it is estimated that only around 30% of people with dementia ever have their condition diagnosed[24]. This means that the majority of dementia sufferers and their carers are left to cope without the most appropriate support, and it also means that the cost of dementia care is increased (as late diagnosis is strongly correlated with heavier use of residential care services, which tend to be considerably more expensive than community support).

Why are diagnosis rates so poor? In part this may be because of the stigma which still attaches to dementia – people are reluctant to acknowledge that they have cognitive or memory problems because they don't want to admit to themselves or others that they may have dementia. People therefore often try and develop coping mechanisms to disguise their worsening mental states. Such coping mechanisms may not be much help in making people's lives easier, but they may well be enough to ensure that medical or social care professionals fail to accurately diagnose their condition.

In part it may also be because the principal contact that most people have with the medical profession is with their GPs, and there are problems with GP diagnosis of dementia. These problems include the length of GP appointments (these have actually increased in recent years, but still average

[22] It now seems widely accepted that early diagnosis of dementia once symptoms begin to manifest is a good thing. There is however still a debate about whether pre-symptomatic diagnosis (e.g. through people with no symptoms of dementia arranging to have brain scans etc.) is useful or whether it risks 'medicalising' people for no good reason. See evidence from Dr Chris Smith, 12.06.09: point 4.7.

[23] See evidence from Alan Wright, Alzheimer's Society, 17.07.09: point 9.7.

[24] Living Well With Dementia: The National Dementia Strategy: p17.

less than 15 minutes, which is clearly not long enough to do much other than to deal with the ostensible problem with which the patient is presenting); the fact that the great majority of GP appointments take place in GP surgeries rather than patients' homes (it is generally held to be easier to make an accurate assessment of someone's mental health when seeing them in their own home, as many people find the process of visiting a doctor highly stressful and may act in atypical ways, whether or not they have any underlying mental health condition); the fact that patients (and often their partners/carers) will try and conceal cognitive/memory problems from GPs (or will simply eschew GP services in order to hide these problems); and the fact that older people (and especially the 'old old' – i.e. 80 plus) may quite naturally evince some of the symptoms of dementia (e.g. occasional confusion, forgetfulness etc.) whilst generally being in full control of their faculties.

It may also be the case that GPs have been historically reluctant to diagnose dementia because they believe that there is little point in so doing as there are inadequate high quality services to refer people onto, or because they are not always fully aware of the range of services available (particularly in terms of non-NHS support services provided by Social Care or '3rd sector' organisations). Indeed, if proper support is not available, a diagnosis of dementia can itself aggravate problems, as poorly supported patients may well suffer from increased anxiety and/or depression occasioned by their diagnosis rather than by their organic mental health condition.

Finally, it maybe that GPs simply tend not to be as good as they might be at diagnosing dementia - although a high percentage of a GP's caseload is likely to feature mental health problems, many GPs have traditionally not been as well versed in mental health matters as they are in general health.[25] The Select Committee asked NHS Brighton & Hove to contact city GPs and invite them to give evidence. However, no GP came forward, and Committee members were told that this was may have been because no city GP was comfortable with presenting themselves as an 'authority' on dementia.[26] However, it may equally have been because GPs were busy or because some of them did not hear about the invitation in time. It is, nonetheless, a matter of concern that there appears to be no city GP with a specialism or even a particular expertise in the field of dementia, and it does seem as if this is an area where NHS Brighton & Hove could do more to encourage the professional development of the GPs it contracts with, although it must be acknowledged that PCTs have often very limited means of influencing local GP practices to do things not stipulated by their contracts.[27]

[25] See evidence from Louise Channon, 15.01.10: point 20.3-20.6.

[26] See evidence provided by Kathy Caley, Commissioner for Long Term Conditions and Independence, in the minutes to the Select Committee meeting 17.07.09, point 9.2.

[27] This was true at the time of gathering evidence for this report. However, NHS Brighton & Hove has subsequently appointed a GP lead for dementia. The Select Committee welcomes this advance.

A similar general point can be made about those working in acute healthcare, and particularly the older people's wards of General Hospitals. Given the prevalence of dementia in the 'old-old' population, it seems likely that a significant percentage of elderly people admitted to hospital for falls, general ill-health etc. may also have dementia, but (at any rate in national terms) it seems relatively uncommon for hospital clinicians to identify dementia or refer people into diagnosis services. This may be because of poor training of hospital staff – i.e. staff simply do not recognise the signs of dementia. It may also be because of the pressures that acute hospital staff are under – i.e. staff do not have the time to do anything other than their core jobs. It may also be because staff are not familiar with the dementia care pathway: they do not know how to refer people into dementia services or are not confident that such services exist. It may also be the case that there are pressures on hospital staff to expedite the discharge of their patients which tend to work counter to the holistic well-being of these patients (i.e. referring a patient for dementia assessment is very unlikely to speed up their discharge and may well delay it). In such instances, the 'fault' may lie, not so much with acute hospital staff, as with the local provision of specialist community beds (e.g. Intermediate Care beds) for people with suspected dementia to be discharged into.

The Select Committee did not have the time to talk with officers of Brighton & Sussex University Hospitals Trust (BSUHT) about their staff training in regard to dementia issues. It may very well be that BSUHT is doing more than many trusts to ensure that its staff are aware of dementia. However, given the national picture, it seems likely that there is more work to be done here.[28]

Neither was the Select Committee able to progress the issue of GP training as far as members would have wished. Nor did the Select Committee have the time to ask similar questions about people employed in community healthcare (e.g. district nurses). Whilst the Select Committee has no hard evidence that training in dementia issues across city healthcare is poor, it does seem reasonable to suggest that the bodies responsible for the development of the city dementia strategy should ensure that training is of a high quality, and that it is given to all those who require it, including independent contractors to the NHS (such as GPs).

It should be stressed that there is no intention here to criticise either clinicians or healthcare managers. Dementia has not been a national health and social care priority until relatively recently, and this has inevitably meant that the focus of attention has been on other issues. There is no culpability in this, but it is clear that the situation must change.

RECOMMENDATION – When re-designing the local dementia care pathway, the city commissioners should ensure that all city healthcare workers are appropriately trained in dementia issues, in order to improve early diagnosis of dementia. This should specifically address the issues of GP expertise and that of people working in the acute

[28] See Living Well With Dementia: The National Dementia Strategy: pp51-55.

sector, given the key role that these workers play in the diagnosis of dementia.

Specialist Diagnosis/Assessment[29] Services

Even if the dementia training of primary and acute healthcare workers were to be improved it might not be enough to solve the problem of poor diagnosis/assessment of dementia; it could be argued that effective early assessment and diagnosis will only be achieved via a dedicated service – essentially this is the Department of Health's position as set out in the National Dementia Strategy.

The National Strategy proposes creating local dementia diagnosis/assessment services. However, the model for these services is to be determined locally rather than nationally imposed. There are several possible models for an assessment service, ranging from a dedicated site-based specialist memory assessment and support team (as piloted in Croydon via the Croydon Memory Service); through dedicated teams which works alongside Community Mental Health Teams: CMHTs (as piloted in East Sussex via the East Sussex Memory Assessment and Support Team: MAST); to a community-based service delivered by suitably trained CMHTs.

Memory assessment models differ in several ways, including whether they are discrete units or integrated into larger teams; whether they are community based or situated in a clinic; whether they formally diagnose dementia or refer diagnosis to specialist clinicians; and in terms of the degree to which they offer support services in addition to performing assessment/diagnostic duties.

The Select Committee took evidence from the East Sussex Memory Assessment Team (MAST). Deborah Becker, Team Leader at MAST, explained that the service was set up in 2006 as a pilot project to work with people experiencing relatively mild memory problems.[30] MAST carries out short-term intervention work with these clients, aiming to make an accurate assessment of people's care and support needs and to signpost the relevant services for them. MAST has the capacity to assess people in their own homes, which can be advantageous, as it is generally the case that people will feel less stress in their home environment and therefore act as they normally do, facilitating accurate assessment. When people are assessed in more stressful environments (e.g. hospitals), they frequently act in atypical ways, making it much more difficult to get an accurate picture of their needs.

[29] Dementia assessment services do not necessarily make formal diagnoses of dementia, in large part because they do not necessarily have consultant psychiatrists as part of their teams. However, in practical terms, this may be largely irrelevant: dedicated assessment teams should be highly skilled in recognising the symptoms of dementia, and their activity is therefore likely to improve diagnosis rates whether or not they refer to hospital consultants to make actual diagnoses.

[30] See evidence provided by Deborah Becker at the 17.07.09 Select Committee meeting, points 9.4 and 9.5.

Whilst MAST is a dedicated memory assessment and support team, it is co-located with the East Sussex Community Mental Health Teams. The Select Committee also heard from Russell Hackett, Director of Business Development at Sussex Partnership NHS Foundation Trust (SPFT), on the subject of memory assessment services. Mr Hackett confirmed that the MAST model was SPFT's preferred model of memory assessment service across Sussex: the trust would like to run such clinics at six sites across the patch, including a clinic in Brighton & Hove[31]. Clearly, however, the final decision on the model for local memory assessment services will not be made by providers alone, but by the city commissioners after consultation with local providers.

It is quite evident that current memory assessment and support services, both nationally and locally, are inadequate. It is equally evident that some form of improved memory service is needed to serve every local area. However, it is not nearly so clear which model of memory service would be best suited to Brighton & Hove. Any new service has to effectively integrate with the current configuration of local services; as these differ widely from area to area, it is unlikely that any single memory service model is going to prove a successful fit in every local health economy.

Moreover, 'ideal' service models have to fit with actual NHS and local authority finances: with the expectation of very significant real terms cuts to NHS and council budgets in the coming years, and the likelihood that local commissioners will also be looking to reduce expenditure, particularly on services where the local spend is significantly higher than national or regional averages or than the spending of comparable organisations – e.g. Older People's Mental Health services. It may therefore not be practical to roll out very expensive memory services (e.g. based on the 'Croydon' model), even if such services were proven to be most effective.

The Select Committee does not therefore propose to recommend any particular model of memory assessment services, as the local decision on the model to be adopted should properly be the result of a complex piece of work by health and social care professionals, balancing the needs of people with memory problems together with the unique configuration of local services and the budget available for this initiative.

However, members do feel that their research qualifies them to make a couple of suggestions in relation to memory assessment services.

In the first place, members believe that there are considerable advantages to assessment delivered in people's own homes or in a homely environment. As noted above, hospitals and GP surgeries can be very stressful places for people to attend, particularly people who fear that they may be developing dementia. On the other hand, the Select Committee heard that one of the most successful aspects of the Croydon memory clinic was that it was co-

[31] See evidence from Russell Hackett, Director of Business Development, Sussex Partnership NHS Foundation Trust, 12.06.09: point 4.5.

located with the local Alzheimer's Society services, meaning that people with memory problems and their carers could access a range of assessment and support services in one place.[32] However, it may not be absolutely necessary to have a dedicated building-based memory service in order to take advantage of close links to the Alzheimer's society etc: really good signposting of 3rd sector services might be just as effective, as might co-location of these support services with CMHTs etc.[33]

Secondly, it is very important that people who are diagnosed with dementia, as well as (at least some) people with memory problems who are diagnosed as not having dementia, and people who are unwilling to be diagnosed (e.g. people who do not want to have brain scans etc), are supported by assessment and support services in a timely fashion. A failure to do so significantly increases the risk of people developing problems with anxiety, depression and social isolation. GPs who encounter lengthy waits when they try and refer their patients into memory assessment services are unlikely to be convinced that they should continue to be pro-active in diagnosing dementia. Therefore, any local assessment service needs to have the capacity to deal with demand promptly.

Thirdly, a memory assessment and support service needs to be well publicised and easy for health and social care professionals to refer into, so as to encourage as many people as possible to use it. At least part of the problem with dementia services as they are currently configured is that the pathway of care and support is not clear, particularly in terms of how people can be referred into the pathway – explaining, to some extent, the apparent reluctance of health professionals to identify dementia. There is potentially an issue here about who should be able to refer into assessment and support services: should it just be GPs, consultants etc? Should it include a much broader range of health and social care professionals? Should it include individuals themselves? (i.e. people could seek memory assessment without having to involve their GP, care workers etc – which might have value for people worried about the stigma of being diagnosed with dementia.)

Fourthly, current practice in the public sector tends not to favour establishing discrete specialist teams, preferring to train generalist workers and teams so that they can themselves deliver much of the specialist input that a dedicated team might provide. There is obviously a good deal to be said for this way of working, and it is central to the development of the Community Mental Health Team model. However, in the context of memory assessment services there do seem to be some real advantages to having a dedicated team available, particularly in terms of the memory service being able to ensure that its staff can concentrate on their core duties.

Therefore, whilst the Select Committee does not seek to recommend any particular model of memory service, it does seem reasonable to recommend

[32] Evidence provided by Alan Wright, the Alzheimer's Society, 17.07.09: point 9.10.

[33] This already occurs in Brighton & Hove: see evidence from Alan Wright, 17.07.09: point 9.12.

that the commissioners consider the above points when they do choose their preferred model.

RECOMMENDATION – That whatever model memory service the city adopts, the commissioners should be able to demonstrate that the service: a) provides a homely environment for diagnosis and/or assessment; b) has the capacity to deal with all referrals in a timely manner; c) is able to maintain its core focus if integrated within a team with broader responsibilities.

The Memory Assessment Clinic model described above does not, in any formal sense, provide diagnoses of dementia. Indeed, it could not, since dementia is not itself a disease, but rather the consequence of a range of diseases. Therefore, while memory clinics can detect the presence of objective cognitive impairment which indicates a state of dementia, they are not themselves sufficient to diagnose the diseases causing dementia. This requires specialist investigation, although not necessarily new services: there are already a number of specialist diagnostic services available across Sussex, mainly provided by Brighton & Sussex University Hospitals Trust and Sussex Partnership NHS Foundation Trust. Improving diagnostic services may therefore principally be a matter of ensuring better collaboration between primary care, mental health and acute neurological services. Brighton & Sussex University Hospital Trust has recently proposed a new model of collaborative working across the local health economy to provide a more comprehensive and integrated diagnostic service.[34] This is not an area that the Select Committee examined, but it is one which the hospital trust was very keen to explore. The Select Committee regrets that it did not do more work in this area: should dementia be the subject of further scrutiny (as the Select Committee recommends), the issue of diagnostic services should certainly be treated in depth.

Carers

Carers are central to delivering effective dementia services. It is the nature of dementia that it can render people exceptionally vulnerable and that it can do so at utterly unpredictable times. Whilst it is certainly possible to support people with mild dementia in the community via professional carer-support, it is much easier (and generally much cheaper) to rely upon partners, friends or family members to provide support, and most people living with dementia in the community do rely principally on 'non-professional' carers. Without this network of carers it is hard to see how support for people with dementia could effectively be delivered, even in terms of the current scale of the problem.

However, for carers to provide an appropriate level of support over the long term, several things need to be in place.

[34] Information provided by Dr Dennis Chan, Senior Lecturer in Neurology, Brighton & Sussex University Hospitals Trust.

Firstly, it is very important that people with dementia are accurately identified in the early stages of their illness. Without this, people are likely to be fulfilling the role of carer, but without any of the financial or practical support and advice available to official carers. This is bound to diminish the effectiveness of carers and may impact on their ability to deliver care over the longer term. For instance, if people are identified as carers, then the authorities can support them by offering respite, augmenting their care with professional carers, ensuring that they receive all benefits to which they are entitled, sign-posting them to groups where they can exchange ideas and experiences with other people in a similar situation etc. This support can enable people to care for longer and to live fuller lives as care-givers.[35]

Secondly, once people are assessed as having dementia, support for them and their carers has to be readily available and easily accessible. There is little point in aspiring to support carers if the necessary resources are not in place, particularly as a diagnosis of dementia can itself be very unsettling and can lead to serious depression and anxiety both for people with dementia and those close to them.

Thirdly, there is a strong argument for providing appropriate financial support for carers. No one becomes a carer for the money, but many may be forced to relinquish their caring responsibilities for lack of money, and it will almost invariably be the case that this will result in a much greater financial burden on social and health care – the option, essentially, is not whether to support carers properly financially, but whether to support them properly or to pay professional carers much, much more to provide the same levels of support. However, whilst the argument for properly supporting carers is very easy to make in theory, it is evident that the current national financial situation is one which makes increased spending in any sector unlikely in the short term, even if there is a very sound case to be made for spending now to achieve greater savings in the future.

Fourthly, although it is important to think of supporting carers in terms of helping them to give support to the people for whom they care, it is also necessary to think holistically, viewing carers as people with their own needs. For example, carers often compromise their own independence in order to provide care, giving up jobs, tenancies etc. to concentrate on their caring role. If the person being cared for passes away, there is a danger that the carer may find themselves dealing with their bereavement at the same time as finding themselves no longer entitled to financial support etc. There is a clear need here for a care system which supports carers while they are carers and for a reasonable time after their caring responsibilities have ceased.[36]

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[35] See evidence from Alan Wright, 17.07.09: point 9.11.

[36] There may be a specific issue here with day care services. The traditional model of care provision for people with dementia (and others) has typically involved ‘day centres’ where people with a particular condition are brought together to undertake therapeutic and social activities. These types of service can be regarded as rather old-fashioned and institutionally-driven: centred upon the service providers’ convenience rather than the wishes of service users (particularly in the light of the recent moves towards ‘personalisation’ of social care). There may be good reasons to move away from this type of service, particularly if service

In some instances there are already systems in place. For example, Brighton & Hove City Council's Housing Management service has done a good deal of work around bereavement and has produced a policy which all council employed housing staff must adhere to.[37] Similarly, there is a city carers' strategy which spells out the support that carers should receive.

It is however evident that this support is not always as reliably provided as it ought to be, and that carers of people with dementia are not always as involved in making decisions about their loved ones as they should be.

End of Life Care, Death and Bereavement

There is a particular issue around the death of people with dementia, especially given the extremely close and emotionally intense relationship that can develop between people who live in constant proximity for a long period of time, as is often the case with people with dementia and their carers. It is therefore important that carers are supported and treated with sensitivity when they suffer bereavement.

Sadly, this is not always the case. The Committee heard from Louise Channon, who had cared for her mother for 16 years. Ms Channon told members that, following her mother's death she had been offered no emotional support, and there had been little or no recognition from health professionals etc. of the distress she was feeling. For example, when Ms Channon made arrangements to return 'disability' equipment that her mother had used, the equipment providers made no effort to acknowledge or offer sympathy for her bereavement, despite it being obvious that people returning this type of equipment after long term hire would probably be doing so shortly after the death of a loved one.[38]

Ms Channon also noted that, although she was not personally reliant upon carers' benefits, she felt that the abrupt ending of such benefits once the person being cared for had passed away could potentially be extremely distressing for carers.[39]

Committee members also discussed their personal experiences of dealing with, or helping others deal with, bereavement. One member noted that there could be a particular problem in terms of council tenancies, where a carer who lived with a tenant as their live-in carer, but who was not entitled to succeed to the tenancy, found themselves under pressure to vacate the property when

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users would prefer alternatives – e.g. receiving more services at home. However, day services do provide very important respite for carers, and the carer perspective must be considered when contemplating the re-design of day care.

[37] See 'When a Tenant Dies – Customer Care, Succession and People Left in Occupation', agreed at Brighton & Hove City Council Housing Cabinet Member Meeting, 06 Jan 2010.

[38] See minutes 15.01.10 point 20.13.

[39] See minutes 15.01.10 point 20.13.

the person they were caring for died. Following a history of complaints from tenants, the council's Housing Management service has recently revised its procedures around bereavement and tenancy succession (see footnote 37 above).

There are also issues concerning end of life care, and the degree to which carers and families are involved in planning for the latter stages of their loved ones' lives – i.e. that it may too often be the case that decisions are taken on behalf of people who lack capacity to plan their own end of life journey without sufficient reference to their carers. End of life services are one of the areas currently being focused upon as regional NHS priorities, and the development of regional and local end of life strategies and pathways, particularly in terms of dementia care (i.e. in situations where the person dying lacks the capacity to themselves make their care decisions) should certainly include and involve carers to a high degree.

RECOMMENDATION – That in re-designing the local dementia care pathway, the city commissioners should explicitly address the issue of carer bereavement, ensuring that dementia services support carers as well as people with dementia, and that supports services do not stop suddenly following the death of patients.

RECOMMENDATION – That in re-designing the local dementia care pathway, the city commissioners should explicitly address the issue of how the wishes of people with dementia and their carers can best be reflected in terms of planning appropriate end of life care.

RECOMMENDATION – That the city commissioners should seek to ensure that all their staff and the organisations they commission (e.g. equipment providers as well as health and social care providers) are aware of the need to treat bereaved people with understanding and sympathy.

In-patient Beds

Local health economies need to maintain a relatively small number of specialist mental health in-patient beds for acutely ill patients with dementia (the great bulk of people with dementia who cannot be supported in the community will be placed in nursing homes). In Brighton & Hove these beds are currently provided by Sussex Partnership NHS Foundation Trust (SPFT) at the Nevill hospital in Hove.

It has long been apparent that there are problems with the location of this service: SPFT does not own the Nevill hospital site, and the lease arrangements make it expensive to run. In addition, although the Nevill is not a particularly old hospital, it is a far from ideal environment for people with dementia.

For these reasons, it has for some time been common knowledge that SPFT has been actively investigating other locations for in-patient dementia beds. It is clear that the city's other acute mental health hospital, Mill View, would not be an appropriate location for these beds, since it is generally considered poor practice to co-locate dementia beds with general mental health beds. This essentially leaves four options in the short term: to remain at the Nevill; to purpose-build a new city facility for these beds (surely highly unlikely given the current pressures on NHS capital funding); to co-locate these beds with existing city (general) hospital services; or to re-locate the beds to a site outside the city, presumably an NHS-owned site with lower running costs than the Nevill. (In the longer term it may well be that the local health economy can significantly reduce demand for these beds by more effectively managing community services, enhancing intermediate care provision etc.)

SPFT is currently undertaking a major re-design of its services across Sussex, which will include the reconfiguration of in-patient beds: this initiative is called 'Better By Design'. The Select Committee had hoped to address the issue of the future of dementia beds at the Nevill Hospital as part of its review, as public consultation on changes had originally been scheduled for early 2010. However, the initial timetable for the Brighton & Hove element of in-patient bed reconfiguration has been extended to allow for full canvassing of stakeholder views, and consultation around reconfiguration plans will not now commence until the autumn of 2010.

There are obvious pitfalls involved in taking a view on a possible relocation of services without knowing whether such a relocation is actually being planned, or if it is, what the detailed proposals are. For instance, if plans to relocate dementia beds included a significant enhancement of the therapeutic value of services offered (e.g. to a specially designed environment for dementia rather than to a 'standard' mental health ward), they might appear much more attractive than plans which essentially offered a 'like for like' service in another location.

However, it would surely seem remiss to publish a scrutiny report on dementia services in Brighton & Hove without mentioning this issue at all. In particular, members are very concerned by any plan which would involve the relocation of dementia beds out of the city. Although they may only be used by a relatively small number of people, there is surely a point of principle here: that a city of almost 300,000 people ought to be able to provide all but the most specialised healthcare services within the city, especially for services for the most vulnerable city residents and their families and carers. It seems wholly unacceptable to demand that carers and other family members, many of whom may themselves be elderly and frail, should be required to travel out of the city to visit and support people receiving relatively standard healthcare services. Therefore, whilst the Select Committee would welcome initiatives which sought to reduce reliance upon in-patient dementia beds by improving community services etc, committee members do not believe that there is any justification for relocating dementia beds outside Brighton & Hove, unless perhaps as part of a very significant improvement of service.

RECOMMENDATION – when the city commissioners make their decisions on the future of in-patient acute dementia beds, they should bear in mind the position of dementia Select Committee members: that locating this service outside the city should not be agreed unless there are overriding therapeutic benefits to such a move.

Nursing Homes

It is actually far more likely that people with dementia who are unable to cope with living independently will be placed in a nursing home than that they will require a hospital bed. Therefore issues about the adequacy and location of nursing care places are probably more important to most people than issues concerning in-patient bed provision.

In common with the rest of the country, the Brighton & Hove health economy is largely reliant upon relatively small independent sector firms for the provision of nursing care places. This tends to create two potential problems: in terms of the quality of the provision on offer, and in terms of capacity.

The quality of nursing home care was largely beyond the scope of this review. It is clearly an important issue, and there is a quite reasonable concern that small scale independent sector providers may offer services of much more variable quality than the public or corporate independent sectors. However, this may be an issue that is best dealt with in terms of how the commissioners of *all* nursing care places assure the quality of providers (and how they are assisted by national regulators) rather than focusing on issues relating to nursing homes specialising in dementia care ('EMI' homes). It is not clear that there is a particular quality issue with EMI care which might warrant it being examined separately from other types of nursing care. This may be an area that either or both the council's Health Overview & Scrutiny Committee and its Adult Social Care and Housing Overview & Scrutiny Committee wish to pick up on.

In terms of nursing home capacity, relying upon a number of small independent sector providers can also pose problems. It is well established that the number of nursing home places available within a given area can vary according to fluctuations in housing markets, demand for hotels etc. For example, should residential property prices rise, some nursing home owners may be tempted to 'cash-in' by selling their properties for housing. This means that it can be difficult for the local health economy to plan nursing care provision effectively, because this planning may always be undermined by events outside the control of the commissioners of health and social care services.

Should demand exceed capacity, then it may be necessary to commission nursing home places in other areas. Clearly it is not desirable for people to be placed in areas against their wishes, particularly if they have lived in one place for much or all of their lives. (Of course, people and/or their families and

carers may actively choose to be placed in an 'out of area' nursing home: this issue concerns those who may be placed out of area contrary to their wishes.)

There may be ways around this issue. One possibility is for local authorities and/or NHS trusts to themselves provide nursing home services. This might make it much easier to guarantee local levels of capacity over the medium term, as well as making it easier to ensure quality. In some instances it may also reduce costs, although this may not always be the case (i.e. public sector providers may not seek to make unreasonable profits, but on the other hand they generally have higher wage costs etc. than the private sector). In local terms this is also an area where there has been recent positive experience, with the local authority investing in its own residential provision for some services traditionally commissioned from other sectors (e.g. housing for some people with physical or learning disabilities).

Currently, city capacity for nursing care, including specialist 'EMI' care, is generally sufficient to meet demand. Given this, the Select Committee was reluctant to devote too much time to exploring problems which may prove to be of a hypothetical nature. However, Select Committee members do assume that the local health economy is engaged in long term planning on this matter. If not, then there is a clear need for this planning to be undertaken as part of the development of local dementia services – whether this entails the public sector being encouraged to start providing these services or it involves longer term planning and contracting with existing providers. The aim should always be to ensure that there are sufficient in-city nursing home places to cope with the demand, including that for EMI placements.

RECOMMENDATION – the city commissioners should be able to demonstrate that they have planned for sufficient capacity in terms of in-city nursing and residential home placements to ensure that everyone who requires such a placement is normally able to access one.

Housing

The Select Committee did not have time to look in detail at how people with dementia living in the community have their housing needs met. However, members would like to note that this is an area in which social landlords, obviously including the council, could help people to live relatively independent lives in the community for longer by granting them high priority for appropriate types of supported housing: e.g. particularly places on Sheltered and 'Extra Sheltered' housing schemes. These schemes offer general needs housing with additional services such as 'CareLink', warden support etc. and could have an important role to play in supporting people with relatively mild dementia.

It is currently the case that the local Housing allocations system *does* allow for people with overriding medical needs (including needs allied to a diagnosis of dementia) to gain priority access to vacant properties, so the system does already recognise the needs of people with dementia. However, depending on how highly dementia services are prioritised, there is presumably room to alter

the allocations system in order to further encourage people with dementia to use Sheltered and other supported housing. Whilst the Select Committee has no specific recommendation to make in this area, it is certainly something which should be considered when planning dementia services across the city.

Better Cross-Service Working

One of the greatest challenges for health and social care is to work out how best to support people who have multiple needs – e.g. in terms of healthcare, social care, housing support, benefits advice, adaptations for disability etc. Since these services have traditionally been delivered by different organisations or by separate teams within an organisation, it can be very difficult to co-ordinate services effectively. All too often people have to undergo assessment by several different bodies, which can be very frustrating for individuals as well as representing an often unnecessary expense. Perhaps even more seriously, people may never be signposted to a service they could benefit from, because they never hear about it, or because the teams supporting them do not know the entire care system etc. These problems can be aggravated by different services having incompatible IT systems, differing thresholds for taking on clients, different types of team structure etc.

Anyone with multiple needs risks encountering poorly co-ordinated care and support services. However, people with dementia may face particular challenges. This is firstly because they tend to be older people, and are therefore very likely to face multiple challenges, with physical as well as mental health problems (i.e. insofar as older people are more likely to experience general health problems such as poor mobility, breathing difficulties etc). Secondly, the nature of dementia means that it can be very difficult for people, even in the very early stages of the disease, to negotiate labyrinthine health and social care systems. Thirdly, the advanced age of most people with dementia means that they may be socially isolated – unable to draw on the support of friends and family to help them negotiate the care pathway. Even when people do have carers supporting them, the carers themselves may be older people who will struggle to understand opaque care systems.

In order to mitigate the potential atomisation of services delivered across a number of teams and/or organisations, recent years have seen a number of attempts to foster better co-working. Sometimes this may amount to the formal integration of services; in other instances the formation of multi-disciplinary teams or improved ‘whole-system’ training for specific teams. The Select Committee received presentations from three such teams integral to providing support for people with dementia: the Community Mental Health Teams, Intermediate Care Services and the Access Point.

Access Point

The Access Point is a ‘one stop shop’ for people presenting to city social care services. The Access Point team supplies information and advice on social

care issues as well as providing a range of services itself. These include: minor adaptations, repairs and equipment, day services, meals on wheels, CareLink, information on self-directed support, and access to the Daily Living Centre (where people can 'road-test' disability equipment in a 'home' environment).

The Access Point can also assess clients and determine their eligibility for a number of services, saving money and minimising the stress caused by multiple assessments.[40]

Members were impressed by the Access Point and considered it to be an excellent example of a service designed around client needs. Clearly though, for the Access Point to work as effectively as possible, it needs to be very well publicised – people will only use a service like the Access Point if they know that it exists and they understand that it functions as a social care gatekeeper.

To this end the Access Point team has already done a great deal to publicise its service, and these efforts are to be applauded. However, the Select Committee did hear about one specific problem in this context: it seems to be the case that some city GP surgeries do not display information on the Access Point as the practice managers at these surgeries are unwilling to display non-health related information (or information not directly supplied by the NHS).[41] Whilst it seems perfectly sensible for GP surgeries to limit the amount of information they have on display, it is surely perverse that they should decline to display information on the Access Point, as this is likely to be of considerable interest to many people attending surgeries. Furthermore, there would seem to be an obvious benefit for GPs in making their patients as aware as possible about the Access Point, as a large proportion of enquiries to GPs will probably be social care related. Therefore, GPs who actively promote the Access Point service are likely to find that by doing so they can actually reduce their workload by diverting patients to a more appropriate resource.

It may be that there is a danger of placing too much emphasis on what is a fairly minor problem: it is clear that the majority of city GP surgeries are happy to display information on the Access Point. However, the problem should not really exist at all, and to this end, Select Committee members feel that local GPs might be encouraged to better understand the Access Point and to promote it to their patients.

RECOMMENDATION – that NHS Brighton & Hove should arrange the invitation of a representative of the Access Point to forthcoming Locality GP meeting(s) or otherwise facilitate the promotion of the Access Point's work amongst city primary care practitioners.

[40] See evidence from Guy Montague-Smith, Access Point Manager, 04.12.09: point 14.3-14.6.

[41] Evidence from Guy Montague-Smith, 04.12.09: point 14.8.

More generally, members felt that it was important for the council to support the Access Point, particularly in terms of publicising this service; and key that this support was over the long term rather than fading away after a time. To this end members suggested that they should recommend that the Access Point should be routinely included amongst the council services given the opportunity to promote themselves via events such as 'Get Involved Day'.[42]

RECOMMENDATION – that the Access Point should continue to be encouraged to promote its services via all appropriate council/city initiatives (such as Get Involved Day etc.)

Community Mental Health Teams

Community Mental Health Teams (CMHTs) are integrated, multi-disciplinary teams, bringing together nurses, social workers and occupational therapists, and supported by specialist psychiatric services. CMHTs are designed so that they can either directly provide or arrange for all the support that a patient requires, whether in terms of healthcare, social care, help with financial matters, help with housing, arranging housing adaptations etc.[43]

CMHTs are an example of a formally integrated team providing and signposting a wide range of services for clients with particular types of problem. When CMHTs work well, as they often do in Brighton & Hove, they provide a compelling argument for the formal integration of services.

Intermediate Care Services

Intermediate Care Services (ICS) provide residential beds for people who are temporarily unable to live in the own homes, aiding recovery, avoiding needless acute hospital admission and facilitating quicker discharge from hospital. There are currently 61 ICS beds across the city, either in NHS, local authority or independent sector facilities. ICS is also heavily involved in delivering community services, supporting people to live in their own homes.[44]

ICS is by no means a dedicated service for people with dementia, but an increasing amount of the ICS workload consists of clients with dementia, with perhaps two thirds of patients in ICS having either diagnosed or undiagnosed dementia.[45] However, many of these patients will have other issues too – such as mobility problems: dementia is not necessarily always the main reason why these patients are in ICS.

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[42] See 04.12.09, point 14.9.

[43] See evidence from Carey Wright, CMHT Manager, Sussex Partnership NHS Foundation Trust, 15.01.10: point 19.4.

[44] See evidence from Eileen Jones, Intermediate Care Team Manager, 04.12.09: points 14.11-14.12.

[45] See 04.12.09: point 14.5.

In order to better deal with the changing nature of its workload ICS has recently employed a Registered Mental Health Nurse. This nurse is responsible for a number of tasks including supporting ICS staff in dealing with patients with mental health problems; assessing patients already in the service; risk-assessing the service taking on particular patients; and liaising with CMHTs, GPs, mental health advocacy services etc.[46]

Select Committee members welcomed ICS's recognition of the increasing importance of dementia, and its attempts to establish effective relationships with key dementia services. Intermediate Care services are likely to increase in importance in the next few years, in the context of dementia and many other conditions, as NHS commissioners try and decrease the use of very expensive acute hospital beds, and it is important that the local system is geared to make the necessary changes.

It seems very likely that the key to improving city dementia services in the current financial climate lies with ensuring that existing support services work together effectively, integrating where necessary, and avoiding unnecessary duplication whilst retaining important specialist knowledge. It is clear that the actual situation in Brighton & Hove, as in many parts of the country, is still some way from this ideal, and that much work needs to be done. However, Select Committee members were heartened by the examples of really good practice from the Access Point, city Community Mental Health Teams and the Intermediate Care Service described above. It is to be hoped that the city can build on these examples to develop and further coalesce services in the future.

Support Services

As there is currently no cure and relatively few effective treatments for dementia, most interventions seek to support people with dementia and their carers via services like day centres, home help, respite care etc. Many of these support services are provided by 'third sector' organisations such as the Alzheimer's Society. These services are key to ensuring that people with dementia and their carers live relatively full lives, and critically, that people are able to live in the community rather than in residential care – not only does this accord with most people's wishes, but it has very significant cost implications as residential care can be very expensive.[47] However, there are several potential problems with dementia support services.

In the first place, the 'map' of support services that people with dementia can access can be rather complicated, particularly since there is no single service provider.[48] There is therefore the real danger that people will not be aware of services which might benefit them. In part the move to more integrated 'gate-

[46] See evidence from Dennis Batchelor, ICS Registered Mental Health Nurse, 04.12.09: point 14.4.
[47] See evidence from Alan Wright, 17.07.09: point 9.15.

[48] See minutes to 12.06.09 meeting: point 4.2.

keeping' teams such as the CMHTs and the Access Point should ensure that this problem is minimised: these gate-keepers are aware of the range of services available to people with dementia and should be able to ensure that clients are directed to the most appropriate services. Organisations such as the Alzheimer's Society are also key here: the Alzheimer's Society has an unparalleled knowledge of dementia and is very well placed to help people. The Select Committee was glad to learn that in Brighton & Hove the Alzheimer's Society is already co-located with CMHTs. Innovative close-working arrangements such as this are to be encouraged, and when a local memory assessment service is established it will presumably establish similarly close links with the Alzheimer's Society etc.

Another issue with support services is that of capacity. Even if local capacity is currently not an issue, it may well be in the near future, both because the prevalence of dementia is set to rise (albeit perhaps not as steeply in Brighton & Hove as in other localities), and because improved diagnosis of dementia should mean that many more people present for support services.[49] It is vital that there are sufficient services on the ground to cope with this anticipated spike in demand: diagnosing dementia but then failing to provide appropriate levels of information and support is likely to have a detrimental impact upon service users and their carers. The city commissioners therefore need to be confident that there are sufficient support services in place to cope with both current and likely future demand.

Finally, organisations like the Alzheimer's Society also offer key advocacy and advice services for people with dementia, their families and carers. These services are extremely important, and to a large degree are always going to be needed. However, they are also, at least in part, a reaction to the complexity of dementia services – e.g. if it is necessary to fill in complicated forms in order to access statutory support, then there is an obvious need for advocacy services to help people do this. Therefore, whilst the need for these support services is never going to go away, it might be that making statutory services easier to access will reduce the need for people to rely on third parties to help them negotiate the care system. This is potentially very important in an environment where demand is likely to increase more quickly than resources.

RECOMMENDATION – When re-designing the local dementia care pathway, the city commissioners should specifically address the issue of support service capacity in the light of anticipated growth in demand for these services in the near future.

RECOMMENDATION – When re-designing the local dementia care pathway, the city commissioners should explicitly address the issue of ensuring that all aspects of the pathway are as easy to negotiate as possible, so as to reduce the pressure on advocacy and advice services.

[49] See evidence from Alan Wright, 17.07.09: 9.14

Community Support

In addition to support from the statutory services, from third sector organisations, and fundamental support from carers, friends and family, people with dementia can benefit from local community support. At its most obvious, this might take the form of neighbours checking that someone was OK, helping them with shopping or gardening chores, looking out for them in bad weather etc – i.e. the type of support that traditional communities are often said to have provided, but which has dissipated in modern, atomised, urban environments.

This type of community support would certainly not replace professional support, but it might augment it, improving the quality of people's lives (and perhaps particularly the quality of carers' lives, if they could feel that their caring burden was being shared, even to a small degree). It should also be relatively low cost, an important factor given the likely constraints on health and social care spending in the foreseeable future.

There are some successful instances of these types of community support networks having been developed, particularly in terms of providing community support to people with Learning Disabilities (e.g. the 'Circles of Support' model), and is this type of initiative which might potentially be developed for dementia.

Even if the practical level of community support for people living with dementia and their carers was relatively low, encouraging communities to accept some 'responsibility' for people with dementia might pay major dividends in terms of countering the isolation that many people with dementia and their carers experience. In particular, it might prove effective in raising the esteem in which carers are held - this is an issue commonly raised by carers – i.e. that they perform a difficult and vital role for little or no recompense, and get relatively little recognition of what they do. Better community support might help carers to themselves feel better about the sacrifices they are required to make.

RECOMMENDATION – The city commissioners should investigate the potential benefits of engaging with local communities in order to encourage them to better support people with dementia and their carers.

Early Onset Dementia

Most of this report is concerned with late onset dementia, as late onset dementias affect far more people and are set to increase very rapidly. However, a relatively small number of people will contract forms of dementia characterised as 'early onset' – types of dementia which can manifest in people in their 40s, 50s and early 60s.

Although early onset dementia is not a problem on anything like the scale of late onset dementia, it can be a very distressing condition to deal with, and its morbidity is set to rise (albeit not so quickly as late onset dementia with its close demographic tie), both because some of the societal/environmental

factors which can lead to early onset dementia, such as very heavy drinking, are increasing; and because better diagnosis of dementia is bound to lead to more under-65s being diagnosed.[50]

Given this likely spike in demand it is important that services for people with early onset dementia have sufficient capacity. Even in terms of current demand this is not necessarily the case. For instance, the Select Committee heard about the Towner Club, a support service for younger people with dementia and their carers. The Towner Club has proved extremely successful and is widely regarded as a model for dementia support services. However, it can only accommodate 10 people, which is not sufficient to cope with current demand. If people with early onset dementia cannot be accommodated by the Towner Club, the only realistic options are to offer them support at a service designed for people with late onset dementia or to not offer them any support at all. The latter is clearly very undesirable, and supporting relatively young people via services intended for much older people can also be problematic.[51]

Therefore, when thinking about city capacity for dementia support services, the commissioners should consider the issue of early onset dementia services, and ensure that city provision is sufficient to meet likely demand without having to divert people into inappropriate services.

RECOMMENDATION – When re-designing the local dementia care pathway and commissioning city dementia services, the city commissioners should specifically address the needs of people with early onset dementia, ensuring that appropriate support services are in place to deal with current and likely future demand.

Future Scrutiny

It is evident that this is a time of considerable flux for mental health services. On the one hand, we are entering into a period when it seems very likely that there will be extreme pressures on health and social care budgets, with most commentators predicting a long period of austerity. Healthcare commissioners will inevitably have to react to real-terms reductions in funding by looking very carefully at the services they commission, and particularly at those areas where their commissioning spend is higher than national averages, the spend of comparable organisations etc. Sussex Primary Care Trusts have already begun this benchmarking process with regard to mental health, as Sussex spending (particularly in relation to services for older people) is considerably higher than that in many other areas.

The Sussex Partnership NHS Foundation Trust (SPFT) is also undertaking a major review of all its activity, and is expected to make significant changes to the way in which it provides services, potentially including services for dementia. These changes are likely to focus on providing value for money, but

[50] See evidence from Alan Wright, 17.07.09: point 9.16(b).

[51] See evidence from Alan Wright, 17.07.09: point 9.16(b) and (c).

also on shifting the focus of mental health care from the use of acute hospital beds to a more community-based service.

And, as noted above, demographic change is likely to see an explosion in demand for dementia services across most of the country. Although the effects may not be as severely felt in Brighton & Hove as in East or West Sussex, there is bound to be sharply increasing demand for services in the near future.

For these reasons, it is clear that this review should be considered as the beginning of Overview & Scrutiny's involvement with the issue of dementia rather than any kind of final word. Local dementia services will be evolving very quickly in the coming months and years as ways are found to make less money go further and to help people with dementia and their carers live full and satisfying lives. At this point it is still not clear what reconfigured local services will look like, or indeed whether changes to dementia care will improve things for the people of Brighton & Hove. It is therefore important that Overview & Scrutiny continues to keep a watch on issues relating to dementia – either by constituting further scrutiny panels (perhaps to undertake a more thorough strategic review of local dementia services), or by requesting regular updates to the adult social care and health scrutiny committees.

RECOMMENDATION – that the issue of dementia and the ongoing changes to local dementia services should inform Overview & Scrutiny work planning, particularly with reference to the work programmes of the Adult Social Care & Housing Overview & Scrutiny Committee (ASCHOSC) and to the Health Overview & Scrutiny Committee (HOSC).

As is common practice with Scrutiny reports, the recommendations of this report, assuming that they are endorsed by the Overview & Scrutiny Commission (OSC), will then be submitted to the appropriate executive body/bodies for consideration. If recommendations are accepted, then their implementation will be reviewed by OSC approximately six months after their acceptance. Further monitoring will take place at six monthly intervals until the OSC is satisfied that implementation is complete.

Most of the recommendations in this report are intended to feed in to the re-design of the local dementia care pathway. This re-design is expected to be completed in Autumn 2010, with ratification by the Joint Commissioning Board following shortly after. It should therefore be possible to report back on implementation of the Select Committee recommendations in early 2011.

Cost

It is clear that we are living through a time of very real financial uncertainty, with exceptional pressures on all kinds of services. This will undoubtedly include services for dementia: we already know that local spending on Older People's Mental Health (which includes the bulk of dementia spending) is well above national and regional averages and higher than most comparators. In

an era of fiscal restraint, there is therefore bound to be considerable pressure on this and many other budgets.

When drawing up its recommendations, the Select Committee did bear the financial environment in mind: none of the above recommendations are likely to cost very much to implement, and, where there is a cost involved (for example in providing better training on dementia to healthcare staff), there is always a 'spend to save' argument to support the recommendation. That is, a relatively small expenditure at the 'front' of the system (i.e. at assessment stage) is likely to result in greatly reduced expenditure later on (e.g. by supporting people to live for longer in the community and thereby reducing nursing home costs).

The Select Committee has drawn up its recommendations in this way because members wanted to be realistic about what is practically achievable at the present time, and it is evident that proposals to significantly increase expenditure are unlikely to be welcomed, unless there is a clear argument to show that short term cost increases will lead to longer term value for money improvements.

However, Select Committee members do want to be clear that they would oppose any real terms cuts to the dementia budget or dementia services, even in the context of real terms reductions across health and social care budgets. Dementia is such a major problem that cuts would be bound to be counterproductive in the longer term, as well as impacting upon some of the neediest and most vulnerable people in our society. Moreover, the increasing prevalence of dementia means that it is unlikely that even the present standards of support and treatment could be maintained for very long with falling budgets. Committee members do recognise the very difficult job facing the commissioners of city health and social care services, but urge that maintaining dementia spending should be considered a priority.

Overview & Scrutiny

General Election May 2010

6 September 2010

The Election 'stakeholders'

- Voters
- Parties, Candidates and Agents
- Returning Officer and his staff
- Ministry of Justice
- Electoral Commission, the Police and the Courts

The Elections Team

- The Returning Officer – John Barradell
- Deputy Returning Officers – Valerie Pearce, Paul Holloway, Claire Wardle
- Electoral Services – 5
- Polling Staff - 440
- Count Staff - 220
- Postal vote and other clerical staff – 80
- Divisional and Organisational support

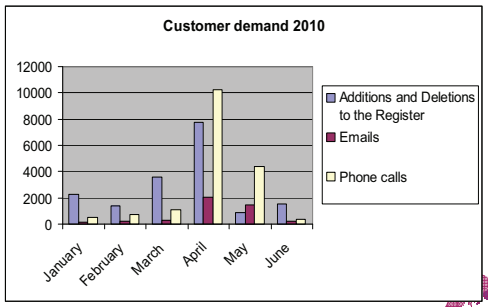
Planning and Preparation

- Project Plan
- Monitoring and Review
- Risk Assessment
- Budget and Resources

The Election Timetable

- Timing of the election not fixed
- 17 day statutory timetable
- 20 April 2010 – deadline for nominations, postal vote applications, and voter registration

Customer demand



Printing and delivery

- Poll Cards
- Ballot Papers
- Postal Votes
- Royal Mail

Polling Stations

- 145 polling stations
- Busy – but no queues
- Accessibility
- Polling station review 2011-12

The Count

- Length of the count
- Postal votes
- Mini-count organisation
- Health & Safety – staff

Feedback

- Turnout
- Customer Satisfaction
- Polling / count staff
- Candidates and Agents
- National issues

Looking forward

- More challenges
- Referendum on Alternative vote system
- More by elections and local referendums?
- Boundary changes
- Individual Voter Registration

Supporting documents

- Customer satisfaction survey
- Presiding Officer feedback
- Electoral Commission – Report on the Administration of the 2010 UK general election

OVERVIEW AND SCRUTINY COMMISSION	Agenda Item 31 Brighton & Hove City Council

Subject:		**Scrutiny Panel Annual Work Programme**
Date of Meeting:		**7 September 2010**
Report of:		**Acting Director of Strategy and Governance**
Contact Officer:	**Name:**	**Tom Hook** **Tel: 29-1110**
	E-mail:	**Tom.hook@brighton-hove.gov.uk**
Wards Affected:	**All**	

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 Each Overview and Scrutiny Committee has the power to establish scrutiny panels to undertake short, focused reviews on specific issues. At its March meeting the Overview and Scrutiny Commission (OSC) supported the idea of an annual trawl of ideas for scrutiny panels involving Members, partner organisations and residents. This report sets out the results of this consultation.

2. RECOMMENDATIONS:

2.1 That the Overview and Scrutiny Commission:

(1) Agrees which panels to establish under its own remit as per appendix 1

(2) Notes and comments upon the consultation responses for panel work to be taken forward to individual scrutiny committees for agreement based upon appendix 2

(3) Notes the scoping report (appendix 3) for the panel on Alcohol Related Hospital Admissions and agrees to delay work on this panel

(4) Notes the panel update attached as appendix 4

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

OSC has previously agreed that a more strategic and coordinated approach to the selection of panel topics would be beneficial. To this end a consultation was held asking residents, Members and partner organisations for their ideas for scrutiny panel topics.

The public consultation ran during the course of July with a total 69 separate suggestions for scrutiny topics received. The consultation was promoted through a number of means:

1. All Members of the council were invited to submit ideas
2. All LSP themed partnerships were written to and scrutiny officers attended a number of partnership meetings
3. Citynews and the Argus both carried articles promoting the consultation
4. A press release was issued and promoted on Facebook and Twitter
5. Information was added to the Consultation Portal at http://consult.brighton-hove.gov.uk/portal

3.3 Consultation responses have been grouped together where similar, for example a number related to parking issues and a number to primary school admissions. Preliminary research has been undertaken to see which suggestions are suitable topics for scrutiny. This has been based on criteria agreed previously at OSC and outlined below:

- Length of review – Topics need to be achievable within 3-4 meetings, or undertaken as Select Committees in around 6 meetings.
- Relevance to Brighton and Hove – The focus needs to be a local issue, or at least an issue that is within the decision making power of a local organisation.
- Policy Context – What is the policy/strategy development cycle, are changes expected to legislation, or has a local strategy just been finalised?
- Alignment to LSP and Council priorities – Reviews of issues identified as key to improving the lives of residents are by definition the best use of scrutiny resources.
- Highlighted as an issue within performance regimes – Is the issue in question something that has been shown as requiring improvement during performance monitoring? With limited resources scrutiny should avoid reviewing issues which the council and partners are seen as doing well.
- Avoiding duplication with existing work-streams – If a suggestion would replicate work already ongoing there is limited utility in also scrutinising it.
- What is the outcome a scrutiny review could achieve? Will the review be able to add value to the issue?

3.4 Appendix 1 outlines all of the topics put forward that fall within the remit of OSC. For the topics suggested the scrutiny team has undertaken some brief preliminary scoping. Capacity within the scrutiny team will allow for OSC to establish 1 panel immediately with another to commence prior to Christmas once work on the impact of budget savings is complete.

3.5 There is an existing informal convention that each O&S Committee only runs 1 scrutiny panel at a time, with OSC occasionally running 2 staggered panels. Members will see in appendix 4 that there are currently 4 review panels established. There is however no reason why each Committee should have a panel if Members were to decide a specific area is a priority.

3.6 HOSC, through the Commission, has established a select committee to look at alcohol related hospital admissions. Members however are being asked to place this panel on hold whilst a number of relevant pilot schemes are running, the results of which will be of direct interest to panel members. If this panel is placed on hold additional capacity will exist for other panels.

3.7 In establishing panels Members need to be mindful of the resources commitment required, both in terms of officer resource but also critically relating to Members time and interest.

3.8 Those topics that are not taken forward as panels will be addressed in alternative ways, for example reports to committee. Where possible individuals who submitted a response will be contacted to inform them of action that will be taken.

3.9 Urgent matters that require detailed review can still be addressed during the year; this will however require their prioritisation over existing pieces of work.

3.10 Reports will be taken to the other O&S Committees for them to prioritise scrutiny reviews for their areas of responsibility; any comments OSC has on suggested other topics will be included in these reports.

4. CONSULTATION

4.1 This report summarises the consultation responses received from residents, Members, officers and partner organisations. Consultation was undertaken throughout July.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 There are no financial implications as all panel work will be undertaken within the existing resource envelope allocated to scrutiny.

Legal Implications:

5.2 The recommendations at 2.1 is consistent with the statutory framework for overview and scrutiny committees under section 21 of the Local Government Act 2000. It is also consistent with the role of OSC in co-ordinating and maximising the efficiency and effectiveness of scrutiny panels.

Equalities Implications:

5.3 In undertaking detailed scoping work on panels equality implications will be addressed. The consultation as a whole has highlighted some equality issues that can be taken forward.

Sustainability Implications:

5.4 A number of sustainability issues were raised as possible scrutiny topics. Members are being asked to recommend that some of these topics are taken forward through scrutiny panels.

Crime & Disorder Implications:

5.5 Scrutiny enjoys powers under the Police and Justice Act 2006 to look at crime and disorder issues. A protocol agreed by Council has established guidelines between scrutiny and the Community Safety Forum to avoid duplication of effort. In prioritising reviews OSC will need to be mindful of this protocol.

Risk & Opportunity Management Implications:

5.6 The consultation exercise was undertaken to ensure that scrutiny resources are focused on the most appropriate areas. There is an opportunity for scrutiny to influence some of the key issues facing the city.

Corporate / Citywide Implications:

5.7 An annual work programme for scrutiny reviews should enable the scrutiny function to respond to those issues that affect the city as a whole and take a more active role in place-shaping.

SUPPORTING DOCUMENTATION

Appendices:

1. OSC consultation responses and scoping reports
2. Full list of consultation responses
3. Alcohol related hospital admissions scoping report
4. Scrutiny panel update

Documents in Members' Rooms

None

Background Documents

1. The Community Engagement Framework
2. Report to March OSC

Item 31 – Appendix 1

1. Living Wage for Brighton and Hove

Suggestion:
Review of the costs and benefits to the council/city of introducing a Living Wage for all council employees and those employed by companies contracted by the council.

Background:
There is a significant amount of research already on this topic nationally:

- Joseph Rowntree report, 2010, Minimum Income Standard that one cannot live an adequate life on the minimum wage
- 57% of British children living below the poverty line in Britain live in households where at least one adult is in work (Fair Pay Network)
- Four London councils (Ealing, Lewisham, Tower Hamlets and Southwark) and a number outside London (Manchester, Glasgow, Norwich and Oxford) have passed motions to implement a Living Wage.
- Equality angle. There is evidence that this is also an issue which affects women disproportionately: women are three times more likely to be in low paid employment than men (Fawcett Society).
- Case studies from http://www.livingwageemployer.org/case-studies-2/ include evidence that:
  - Turnover amongst staff has more than halved
  - Morale has been raised
  - Productivity has improved; attitudes are more flexible and positive
  - Service has improved: our help desk gets far fewer complaints
- This is an issue which is reported to significantly affect those in low paid council work most and disproportionately affects women and children (http://www.fairpaynetwork.org/index.php?page=low_pay_victims). However, there is an argument that poor pay also has a negative knock on effect on Brighton's local economy as a whole, in that increases in the wages of the poorest are far more likely to be recirculated around the local economy than spent abroad or elsewhere in the UK.

Possible scope:
This review would examine its feasibility examining:

(a) What this will cost
(b) What savings may be made (in terms of benefits to low waged individuals which would not apply to those on the Living Wage; and in terms of increased staff retention and morale)
(c) How many council employees are currently below a Living Wage
(d) How many are on the National Minimum Wage

(e) How many employees of companies contracted by the council are currently below a Living Wage
(f) How many employees of companies contracted by the council are on the National Minimum Wage
(g) What are the job titles and wages of those in categories (c) and (e) and the companies they are employed by
(h) At what level a living wage for B&H would be set at (£7.85 in London, £7 Oxford)

A review could consider whether introducing a Living Wage would encourage people who are currently unemployed and caught in the 'benefits trap', reluctant to take very badly paid jobs, to take jobs; and what the estimated savings on job seekers allowance and increased employment might be.

Witnesses:
- Professor Peter Ambrose, University of Brighton
- Council employees
- Campaign groups
- Other local authorities/companies that have introduced a living wage/ decided not to

Outcomes:
- Pros and cons as to the idea of a living wage including costs
- Practical issues that would need to be overcome if it were found to be a good idea

2. Pro-active sharing of information on Vulnerable People

Suggestion:
Proactive information sharing for vulnerable people - how effective is it and how can it be further improved?

Background:
A number of different agencies/organisations keep lists of 'vulnerable' people. This includes BHCC adult social care services, BHCC housing, NHS Brighton & Hove and East Sussex Fire Authority. It also includes the major utility companies.

People may be classified as vulnerable for a number of reasons (there is no universally accepted definition of vulnerability, and different organisations may interpret vulnerability differently). For example, a person with a physical disability which limits their mobility may be at particular risk from a house fire since they may be unable to leave their home without assistance. If the Fire Service know that there is a vulnerable person at a particular address, then they can respond appropriately.

In other instances, it may be inappropriate to pursue payment of bills etc aggressively – and particularly to discontinue utility supplies etc (e.g. a person may have learning disabilities or mental health problems which make it difficult for them to respond to requests for money/make it unsafe to cut off their utilities. If utilities, council tax etc are aware of this they can choose to chase debt in a more appropriate manner – e.g. by liaising with someone's support worker etc.)

It is evident that registers of vulnerable people have an important role to play in ensuring that vulnerable individuals are able to lead independent, safe lives.

However, whilst a number of organisations maintain registers of vulnerable people, there is currently relatively little sharing of data, even across the public sector. Inevitably this means that there is a great deal of duplication going on – with a number of organisations each maintaining their own databases. It also means that a large number of people are likely to appear on one database but not others, with the risk that they will require interventions from services which do not realise they are vulnerable. In addition, this means that carers/support workers face an unnecessarily Sisyphean struggle to register people as vulnerable, particularly people whose conditions regularly change/deteriorate.

There is therefore an obvious case to be made for moving to some kind of shared vulnerability register. This would surely reduce costs, reduce needless duplication, make the customer experience more pleasant and make it much more likely that vulnerable people receive the services most appropriate for them. It therefore tallies with the current council initiatives to improve the customer experience and gain better value for money. In addition, the notion of the city commissioning a single integrated service to replace a number of discrete services matches precisely with the aims of the intelligent commissioning initiative.

There are obvious obstacles here also – client confidentiality, the fact that people may be vulnerable in some ways but not others, the question of who should host a shared database and how they should be recompensed, the problem of IT compatibility across organisations etc – but these are all the type of issues which might benefit from being explored via a panel.

Possible scope:
This could include a review of the potential for multi agency 'one source' home safety/health support for vulnerable people and look at the concept of 'Added Value' to communities (i.e. the collective worth of effective multi-agency working for a particular vulnerable group). The council is already looking into how its own departments link up to share information about vulnerable people, a wider remit for a scrutiny panel could help push the concept of this 'Golden Thread' further forward, enabling partners to explore how we currently share information about vulnerable

people and work with them pro-actively to improve their safety and quality of life and what improvements are needed for collective overall benefit.

This theme could be closely aligned with the council's priorities around improving health and well-being. While provision of good neighbourhood services is important and will continue, the City will be bringing together public, private and voluntary sector work to provide better joined-up services for the most vulnerable families and households.

The normal scrutiny panel set-up (3-4 meetings in public) should be sufficient to deal with this issue.

Possible Witnesses: BHCC ASC, BHCC emergency planning, BHCC housing management, NHS Brighton & Hove, South Downs Health Trust, Sussex Partnership Trust, Utilities, BHCC Council Tax, BHCC Benefits, ESFA, Police Authority, SECamb, 3rd sector representative organisations (MIND, Alzheimer's Society, Autistic Society, RNIB, RNID), CVSF

Outcomes:
Recommendations on the development of improved cross-agency information sharing.

3. Developing Better Ties between City Partners and the City Universities

Suggestion:
We need to establish whether we access our two University research and development facilities as much as we might in terms of helping us to commission and deliver, as appropriate, real societal behavioural change to help us meet cash savings in the future through lower dependency on access to our services. Are we capitalising on the net worth of intellectual knowledge available locally?

We understand that this is already starting to happen in some areas of the City, with Total Place trialling work with drugs and alcohol abuse. It is important to work proactively, to drive out problems at source with our partners, rather than having to deal with the more expensive end results, such as arson, road traffic collisions, etc.

Background:
There is already a well developed practise of co-working between city public sector organisations and Brighton & Sussex Universities, particularly via the LSP. However, this is mainly at a strategic level. What this scrutiny request appears to be identifying is the potential to develop better links at a 'service' level, matching university research and teaching foci with related work by city partners. There are clear opportunities here: for partners to get access to relevant university research, and perhaps to steer or even part-commission some of that research in order to obtain useful data. There are potential

opportunities for the universities too – in terms of accessing public sector data resources, providing placements for under/post graduate students etc.

This is by no means an original idea – there are already examples of city partners working effectively with university departments – for instance, the council's research team has close links with the universities; the University of Brighton urban geography department does a good deal of co-working with the council's Housing Strategy department and with the Strategic Housing Partnership; the joint council/PCT public health team has excellent links with the universities etc.

However, it is probably fair to say that these relationships have developed in a fairly piece-meal way: there has been no systemic attempt to match university research with public sector provision across the various organisations, and there is no clearly defined pathway via which one city organisation might attempt to synchronise research with another.

The council's Value for Money programme aims to provide city residents with better value services by reducing waste and duplication within the council. Closer working across city public sector organisations and the city universities could have a similar beneficial effect: making best use of city resources, and potentially reducing costs for individual partners, if some usefully symbiotic working could be facilitated.

The council's move to a commissioning model is also intended to reduce duplication and ensure the best possible use of city resources. A scrutiny panel exploring how best to utilise the resource of the city's universities might be a valuable contribution to the development of this commissioning model.

Partner priorities in the current economic climate are bound to feature better co-working in order to deliver quality services for less.

Similarly, the financial squeeze on universities and the increasing need to be shown to offer students a practical, work-oriented learning experience should mean that universities are receptive to the general idea of co-working at a departmental level.

Scope:
A scrutiny panel would first need to establish what existing links there are between the city universities and city public sector partners, and get some idea of where there already exists really effective co-working. It would be very important that this topic was approached both from the perspective of the public sector and the perspective of the universities – closer ties could only realistically be developed if there were incentives for both sides to engage. This might take a little time,

although it is obviously something for officers to do rather than members.

Members would then look at some of the existing effective partners, seeking to develop recommendations to improve partnership relations/make the process of building partnerships easier.

Possible Witnesses:
ESFA; Police Authority; Council Executive; University of Sussex executive; University of Brighton Executive; NHS Brighton & Hove; People from partner/university departments with well-established co-working set-ups; student unions

Outcomes
Whilst one could imagine this becoming a very involved piece of work – looking at setting up complex organisational structures to facilitate better town-gown co-working etc – current economic circumstances make this rather unlikely (i.e. there's no money for new services, and limited opportunity for spend to save initiatives…). It's much more likely that members would want to focus on making some practical suggestions to foster better co-working arrangements (and maybe set out some visions for future development). This should be readily achievable within the normal 3-4 meeting scrutiny panel time table.

4. Future of Pride

Suggestion:
The Trustees of Pride have approached the council requesting that an independent scrutiny review be undertaken. Scrutiny has no formal powers to review Pride; however informal discussions with the Pride Chair and other Trustees have identified that a scrutiny review could provide a platform for debate on some of the challenges facing the event.

Scope:
This could be seen as facilitating a city-wide conversation. An indicative list of issues that could be included in any review is outlined below:

1) General funding issues.
    a. Should there be a charge to enter Preston Park?
        i. Level of charge - voluntary/suggested/compulsory?
        ii. Cost of policing this (fencing/stewards etc)
    b. Sponsorship arrangements
    c. Cost of running stalls/tents/catering etc
    d. What is the economic value of Pride to the city?
    e. Should businesses that benefit from the event contribute more to its organisation?
    f. Tendering processes
2) Is Preston Park the right place for the event?
    a. Not big enough?

   b. Should it be fenced off?
   c. Pros/cons of other locations?
3) Stalls within Preston Park?
   a. Need for a main stage?
   b. Toilet facilities
   c. Refuse disposal/recycling
4) Organisational capacity of Pride
   a. Number of staff
   b. Cost of running event/revenues received
   c. Membership of Board
5) Is the event too commercial – does it need to become more community focused? If so, how? Is it no-longer LGBT focused? Advocacy role beyond the main event?
6) Balance between the park and the parade?
7) Health impacts – drug/alcohol use especially teenagers
8) Policing/community safety issues/clean-up arrangements

Given Pride is an annual event, any review would need to be completed fairly rapidly to allow sufficient planning time for any agreed changes to be made. This could be accomplished by holding 3-4 meetings in early October with a view to reporting early November. Witnesses could be drawn from participating community groups, charities, businesses, volunteers and public sector bodies.

Recommendations would probably be primarily directed towards Pride. The Trustees have indicated recommendations would be voted upon by the wider Pride membership, rather than just be kept as a Board decision.

A review of Pride would be a new development for scrutiny and there are questions as to how this would work and whether the scrutiny function is best placed to conduct the review. To date no other major external events have been subject to formal council scrutiny in this manner. In deciding whether to scrutinise Pride, members will want to reflect that the council has a number of roles to play with regard to Pride; as landowner, licensing and highways authority, events calendar, equalities, cultural offer for example.

Prior to the Pride event this year, the Leader of the Council successfully hosted and chaired three meetings with cross party Councillors, community group representatives and Trustees from Pride in order to facilitate the resolution of some specific issues. In addition to these, the Leader agreed to host one further meeting following Pride to evaluate the event and discuss the way forward for future years. The council could also support a non-council led review to be undertaken with funding and input to the specification.

If Members were minded to look at Pride through a scrutiny panel this would need to dovetail with other review plans.

Outcomes:
Recommendations to Pride on the future of the event.

5. Councillor Ward Surgery Review

Suggestion:
Review of Members ward surgeries including security, location, publicity, support.

Background:
The majority of Councillors hold regular surgeries to allow residents to raise issues of concern. Surgeries are often held in community venues around the city, with Cllrs either working alone or in small numbers.

Scope:
Issues that could be covered include:

1) Survey all BHCC Councillors – how they currently operate surgeries. What's good, what's not etc
2) What do other councils offer in this regard?
3) Possible options for improvements
    a. Coffee mornings?
    b. Use of social media
    c. Different locations
    d. Publicity

This could primarily be a desk based undertaking with Members meeting once most of the research has been produced. This would allow for a short focused panel.

Outcomes:
Suggestions for ways to develop/improve/support Members surgeries

6. Locally Devolved Power

Suggested topic:
Scrutiny into ward devolution - what are the costs and benefits, the models from elsewhere, etc. For example, a panel could consider community committees which can spend money locally on environmental improvements etc, using profits from Controlled Parking Zones for example. In addition, some areas e.g. Oxford have community planning committees for some planning applications, and this could be considered too.

The Strengthening Communities Review currently being undertaken by the Communities and Equalities Team is looking at a range of issues including local decision-making. It is suggested that this review should report before any scrutiny work is undertaken to avoid duplication.

Members may wish to return to this issue following the publication of the review.

7. Review of mechanisms for BME communities to get their voice heard

The Strengthening Communities Review currently being undertaken includes work on how BME groups are supported and mechanisms for getting their voices heard. Any scrutiny intervention should therefore wait until this review is concluded.

8. Impact of budget reductions on the third sector

OSC established a panel to review the societal impacts of the budget reductions at its July meeting. This panel will want to talk to third sector representatives. It is also suggested that Members will want to consider the role of third sector representatives within the budget scrutiny process in December/January.

9. Impact of Section 106 Agreements

This is on OSC work-programme for October already. Members will be able to undertake more detailed scrutiny if desired once the initial report has been published.

10. Review of the policy of mainstreaming equalities

OSC has developed a watching brief over equality issues with six-monthly updates on work being undertaken across the council and city. As OSC Members will be aware the council is working to achieve 'Excellent Level' of the Equality Framework for Local Government by December 2010. The action plan for the Single Equality Scheme, which OSC has been monitoring, outlines the actions being taken to reach this standard.

OSC could almost already be seen to be undertaking continual review of equality policy through its proactive monitoring role. Where issues/areas for improvement have been identified, for example through the peer review, these are being addressed; the obvious example being the scrutiny panel on staff disabilities. If there are specific areas where Members feel that mainstreaming has been unsuccessful these can be reviewed.

Members can continue to review equality policies through the regular monitoring and decide on specific interventions as the need arises.

11. Council Forward Plan

Every item on the Council's Forward Plan needs to be assigned to one of the Scrutiny Committees on date of first publication (according to a scheme (to be published) to match FP items to relevant/responsible Scrutiny Committees) so that, at each Scrutiny Committee meeting, there is a standing Agenda item to consider all assigned additions to the FP since the last meeting of that Committee, and to determine, for

each new item, whether the Cttee wants more information, whether it already wants to initiate scrutiny, or whether it is satisfied that it wishes to take no further action prior to the Cabinet (or Cabinet Member) making the planned Decision.

OSC considered the Council's Forward Plan at its March meeting and work is ongoing to improve its utility. The number of pre-decision items being tabled at O&S Committees is already increasing. The move to the Intelligent Commissioning model should ensure that O&S is involved in the development of needs assessments and service plans at an early stage.

12. Council Procurement

With particular regard to sustainability. This is a huge area for improvement. Officers agree the need for significant movement. A review could help transform BHCC into a model spender.

It has been agreed that Sustainable Procurement will be a standing item on the Sustainability Cabinet Committee Agenda. Additionally work on procurement is ongoing as part of the move to Intelligent Commissioning. It would therefore seem sensible to wait to see what developments these two initiatives result in; this issue could usefully be added to the OSC work-programme for mid-2011.

13. Review of the council consultation processes and procedures

Review of consultation procedures across the council highlighting the

a. *the difference between providing information and consulting*
b. *the outcome of consultation – were any policies or implementation strategies changed as a result of consultation*
c. *who is consulted and on what?*

At its last meeting OSC considered paper on the Community Engagement Framework, which relates directly to how the council consults with residents and local communities. OSC has agreed to have regular updates on the implementation of the strategy which will allow members to review consultation processes and procedures.

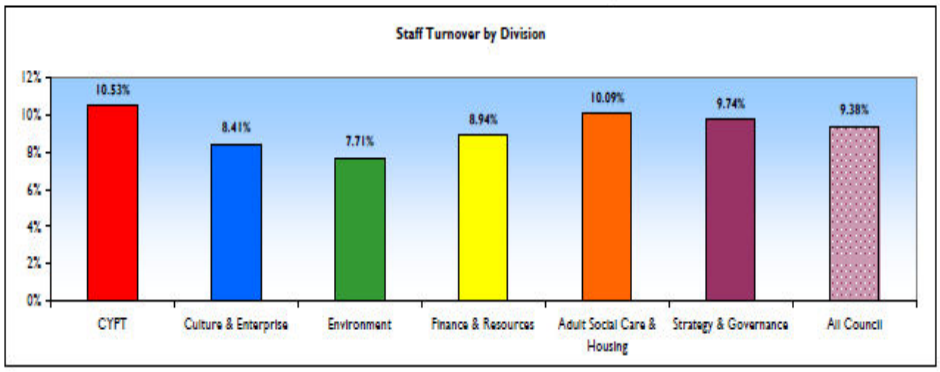
14. Staff Retention

Information from HR, as displayed below, indicates there is not a problem with staff retention within the council. Monitoring is in place across all directorates which would flag if this were to become an issue.

Number of Leavers and Turnover by Division - Year Ending at Quarter

Leaver Reason	CYPT	Culture & Enterprise	Environment	Finance & Resources	Adult Social Care & Housing	Strategy & Governance	All Council
Dismissal	4	2	13	1	4	2	26
Ill Health	6	4	9	3	4	2	28
Redundancy/Early Ret	17	11	9	15	27	3	82
Retirement	1	1	1	5	6	0	14
Voluntary Resignation	94	18	48	40	97	22	319
End of Contract	17	28	66	6	37	11	165
Death	1	0	1	0	1	1	4
No of Transfers	106	25	83	73	165	33	485
Total	246	89	230	143	341	74	1123
Total Headcount	1168	428	1051	716	1377	308	5045
Wastage Turnover*	10.53%	8.41%	7.71%	8.94%	10.09%	9.74%	9.38%

*= Wastage Turnover does not include Transfers



Extracted on the 30th April 2010 using Source data from Teamspirit

15. How /when the council publishes information plus the license terms it uses

The topic relates to the new government requirements for councils to publish their spending information, amongst other things. The council produces a wide variety of data from recycling statistics, licence applications to webcasts. At the moment these are all copyrighted - however, as other public sector bodies are doing - they are publishing the data under more permissive licences which allow free re-use of the data, which makes sense given that it was paid for by the tax payer.

This is a topic of significant interest to the new media community here in the city. An example of a body promoting this approach is the Open Knowledge Foundation, http://www.okfn.org/

The council provides significant amounts of information on its website, in hard copy and in response to specific enquiries. The copyright of that information is generally retained by the council.

Organisations such as the Open Knowledge Foundation aim to promote:

- Free and open access to material
- Freedom to redistribute material
- Freedom to reuse the material
- No restriction of the above based on who someone is (e.g. their nationality) or their field of endeavour (e.g. commercial or non-commercial)

This issue could be looked at in a narrow manner, i.e. copyright issues, or more broadly at accessibility and transparency. The more narrow issues, whilst important are probably too focused for scrutiny work however accessibility, transparency and open governance are topical issues with the Government currently promoting 'armchair auditors' and requiring public bodies to publish expenditure over £500.

Initially it is suggested that this item is placed on OSC's work-programme for 2011 once details regarding how the council publishes it's expenditure over £500 have been released. Cllr Elgood submitted a question to July's Council meeting regarding this issue. This and the response are set out below:

Councillor Elgood
"What progress is being made to implement the requirement by the coalition government to publish all items of spending over £500 and to publish all tender documents in full?"

Reply from Councillor Young, Cabinet Member for Finance.
"The Administration has two options available to it with regards to publishing all council spend over £500. The first would be to generate a report from our creditor system which would consist of raw spend data extracted from invoices paid. We are in a position to do this now subject to ensuring that the appropriate data protection issues are addressed (for example – the publication of individual carer details that currently appear on the system).

However, raw data is sometimes difficult to interpret into meaningful information and the Administration want to ensure that the public have information that is easy to understand and means something to them. Therefore we are currently in discussions with an existing supplier who can provide an innovative web-based solution which has been designed to improve the accessibility and relevance of data. This solution will present the information in a user friendly way and data will also be categorised, therefore providing the public with information that will be useful to them such as spend per full time employee, spend with small and medium sized enterprises, spend relative to the number of households, working population, persons of pensionable age and number of children that make up the resident population. There is also the facility to make comparison between authorities of differing sizes.

This solution would be accessed via the Council's website and will be free to the public. It is being offered to the Council at no cost. I am discussing the options with officers and hope to start publication shortly.

The publishing of tenders and contracts over £500 is much more complex however. We have a number of contract registers across the council and therefore it is a large resource intensive task to bring these together and identify the full list of documentation over this low level of spend. The need to have a comprehensive central repository of tender and contracts documentation has already been identified and the sourcing of this forms part of the Procurement work stream under the VFM project."

Item 31 – Appendix 2
ECSOSC
Renewable energy potential of the city - Community and private renewable energy developers have real ambitions to see more renewables installed locally and are looking for opportunities here. To date there has been no large scale support or uptake of renewable energy in the city, and it seems other UK cities are moving ahead on this at a greater pace. o Why and what can we learn from them? o What is the renewable energy potential here and which technologies should we realistically go for? o How can we overcome barriers to much more renewable energy generation? o What support is needed to enable more generation, especially community schemes / those which have multiple benefits (e.g. environment industries sector, low income households' energy bills)?
Supermarkets – The ways in which supermarkets are working through the planning procedures, the way that small businesses are being threatened at this difficult economic time by large chain supermarkets in residential areas, and the loss of green recreational space
Dog fouling – to see if the Council needs to put in extra dog bins and to scrutinize the clean up times
State of local environment – mapping the current state of the local environment, what are the priorities for future intervention
Steps to low carbon city – what do we need to do across all sector to become a low carbon city
Biomass v air quality – look at the apparent trade-off
Commitment to 10:10 campaign - Brighton & Hove City Council 's commitment to 10:10 campaign, and the impact on carbon emissions of council services, and also in terms of education for residents
Evaluation of LIFE firefighting programme – how successful has this been, what lessons can be learnt?
Parking – Specific parking consultations/schemes, general review of the parking strategy, parking in specific roads, parking on pavements
Pedestrianisation/Congestion Charging in city centre
Pedestrian Crossings – Criteria for their introduction/how they are prioritised
Free bikes scheme – Look to see if the city could have a similar scheme to London
No-passing of buses restriction within the city – cars shouldn't be allowed to overtake buses at bus stops to ensure swifter bus journeys
Affordable Travel in the city – General review of affordable travel options
Cycling on the pavement/seafront - Brighton and Hove seem very keen to get people cycling, but there seems to be a lack of tolerance of cyclists who are keen to do just that. Hove promenade is so wide there is plenty of room for people to move along it by foot, bike or skateboard. Cyclists in a hurry should use the road, but recreational cyclists should be allowed to use the prom. Cycling on the pavement hazardous for pedestrians
Transport - reduce the number of buses, a major overhaul of the road networks and maybe provide some kind of circular tram service for the buses to connect to & create more pedestrian zones.
Lewes Road Traffic – To get the traffic on the Lewes Road moving, remove one set of

traffic lights between the Level and Saunders Park, [there are too many] and re-think the cycle lane provision on the section, the road is too narrow to accommodate a cycle lane both sides of the road, and that bit of road is almost at gridlock most days. And enforce no parking both sides. They seem to be permanent parking spaces between the Level and Sainsburys, yet they are double lined.
Give Brighton facilities for children and families that we can be proud of, the old paddling pool which was ideal in design has just been removed, and a small fancy one supplied, nowhere for parents or grandparents who accompany these children, to sit down, or toilets. it is just paying lip service to the huge demand for children's play areas. It seems the council and therefore the town doesn't want families here.
Hove Lawns – BBQ provision – Suggestion that fixed BBQs should be provided either on Hove Lawns or on the prom.
Removal of trees from wild park - Why scrutiny could not look at the situation with the removal of trees from Wild park. Consultation for Wild Park? Where did the timber go? Why is the sheep contract not put out to tender? Should there be barbed wire in a public park? Should enclosure be taking place?
Street lighting – reduce the amount of light pollution, caused by inefficient outdoor lighting, in Brighton. This, in turn, would lead to considerable financial savings.
Wheelie Bins – More households should have wheelie bins to encourage recycling and make it easier for the refuse collectors
Winter Service Plan – In view of the problems faced by (among others) older people in Brighton and Hove as a result of the severe weather last winter, we would suggest that a further review of the Winter Service plan would be appropriate: bearing in mind the provisions made by the council following the problems experienced last winter, a subsequent review of the effectiveness of the modified Service Plan during and following the coming winter would be extremely welcome by older people, and by those with mobility and/or other disabilities
Bonfires – What laws exist to prevent problem bonfires? What action does the Council take re this?
Air Quality in the city – Measure it, does it need to be improved, if so how?
Insufficient public toilets along the seafront at night e.g. Madeira Drive
Staff bus/free staff car parking – Should the staff bus be removed, do council staff need car parking
Bees - Given the worrying decline in the UK's bee population, scrutiny into how we can make B&H the most bee-friendly city in the UK. Some things a scrutiny panel on bees might consider would be: a) using council-owned land (eg Stanmer nurseries) to establish city hives b) producing city honey from these hives which can be sold to the public c) a review of pesticides used on council-owned farm-land d) seeking external funding for bee-related projects from the Co-operative's 'Plan Bee' fund, and Waitrose (who have recently given some funding to Sussex)
CYPOSC
Support/outcomes for YP 16-25 from the care system – transition into adulthood
Obesity in C&YP. Planning powers re fast food outlets, particularly near schools, what powers are there to stop this.
Teenage Pregnancy – What is being done to combat it?
School Appeals System – review of the current system, timescales etc

Local Primary Schools admissions – lack of school places in Hove/ lack of school places generally.
HOSC
Royal Sussex Hospital Park and Ride – A P&R for the hospital should be located at the Marina.
CTEOSC
The provision of Arts for disabled people In working with the city's deaf community and John Walker (Convenor of Deaf Studies, Sussex Uni), an issue has emerged surrounding the lack of theatre and cinema performances in B&H where there is provision of a British Sign Language interpreter, and the general exclusion experienced by the city's deaf community in terms of the arts. This might make a good topic for a one-day session, as per the snow scrutiny.
Music venues – Building upon mapping exercise that was undertaken. Looking at does the city have the right mix of venues, what support do smaller
Personal Finances – Advice/support available for people struggling with personal finances. Can the council/partners provide more support?
Developing B&H as a destination (party town versus other opportunities)
End of renaissance funding – Funding stream for museums is due to end. How can museums continue to be supported in the future
Innovative ways to support culture – cultural offer is important to the city, how can it be supported, how do other cities manage culture?
ASCHOSC
Supported housing – does type/mix of housing meet city's needs
HIV/AIDS services – in particular the transition between child and adult services
Provision of care for LGBT elders in the city - Many older LGBT people feel they have to go "back in the closet" when they enter sheltered accommodation or nursing homes. Age UK have highlighted this issue, and there was recently a documentary about this on Radio 4 ('Glad to be Grey?'). A panel might like to consider the potential for encouraging dedicated accommodation for older LGBT people in B&H
Private Sector Letting Agents - Council on 18 March considered a Notice of Motion concerning the findings of a national Citizens Advice report 'Let Down' on the activities of private rented sector Letting Agents. In light of the CAB report findings and discussion at Council it was proposed a cross party working group be set up to look into the issues raised and that this group feed back into Strategic Housing Partnership. At the meeting of the cross party working group attended by Cllr Caulfield, Cllr Watkins, Cllr Marsh and Cllr Randall it was felt that this would be an area suited to scrutiny consideration.
Affordable Housing in the city - scrutiny into housing co-ops would be particularly welcome
Homelessness in the city - rates, support, reporting
Older Leaseholders There are a great many leasehold properties in Brighton and Hove, including some in Council owned buildings and Brighton & Hove Older People's Council is seriously concerned about the problems for older leaseholders, often associated with the service and other charges imposed on lessees by freeholders

Item 31 Appendix 3

Alcohol Related Hospital Admissions (ARHA): scoping note

ARHA is a serious problem, nationally and locally, with increasing numbers of people admitted to hospital with alcohol-related conditions – both in terms of emergency admissions following falls, fights, RTAs etc. and in terms of emergency/elective admissions for people with long term alcohol related health problems (liver disease etc).

There are several ways of reducing the number of ARHAs.

1 **Reducing the amount that the general population drinks and encouraging people to drink in less hazardous ways.** This can potentially be achieved by:

- increasing the price of alcohol (higher duty or a minimum price per unit)
- employing differential duty rates (making it more attractive to drink certain types of drink than others – e.g. making it relatively cheaper to drink weak beer than alcopops, spirits etc.)
- limiting the availability of alcohol by restricting where or when alcohol can be sold (e.g. by restricting licensing hours; by reducing the number of alcohol licenses granted; by making supermarkets etc sell alcohol separately from other goods)
- increasing the age at which it is legal to purchase alcohol (e.g. from 18 to 21)
- limiting or banning alcohol-related advertising, branding and sponsorship
- stronger enforcement of existing laws (i.e. it is already an offence to sell alcohol to people who are visibly inebriated, but one which is rarely enforced)
- more public health information on the dangers of excessive drinking
- reducing the legal limit for driving after drinking to near zero and/or more zealous enforcement of current drink-driving laws

2 **Providing better support, advice and treatment for people drinking hazardously.** This mainly involves identifying people who may be hazardous drinkers and offering them 'Brief Interventions' – a short session with a counsellor who explains the risks of drinking excessively. Brief Interventions (BI) have a high success rate for this type of treatment, with 1 in 8 people drinking less following their BI.

3 **Providing better support for dependent drinkers.** This includes having readily accessible detox programmes.

4 **Mitigating the immediate dangers of hazardous drinking.** If people are determined to binge drink there is little that can be done to stop them. However, it may be possible to reduce the immediate risk of ARHA by measures which include:

- requiring bars to use only plastic glasses/bottles
- discouraging licensees from selling products particularly linked to hazardous drinking ('shots', double measures as standard etc)
- discouraging organised binge drinking events (Freshers' Week pub crawls etc.)
- better policing of areas typically used for binge drinking (e.g. parks)
- 'taxi marshals' (minimising violent flashpoints around taxi ranks)

5 **Diverting injured drinkers away from acute hospital services.** This can include initiatives to provide first aid stations in town centres, so that people with minor injuries need to attend A&E; encouraging city centre GP clinics (esp. 'walk-in' clinics) to stay open late at night; using non-ambulance transport to get distressed city centre drinkers to hospital (i.e. using a minibus to transport several people rather than individual ambulances – such schemes reduce inappropriate ambulance use, particularly as drinkers who are sick in an ambulance may take that ambulance out of commission for well over an hour).

It would seem therefore that there is plenty for a Scrutiny Select Committee to investigate here. However, this may not necessarily be the case.

In the first place, many of the above suggestions for reducing ARHA would require national legislation – there is no local ability to vary alcohol duty, to ban advertising, to vary drink-driving limits etc. Even where there is, in theory, some local power to act (for instance in terms of applying conditions to Licensees), it may be practically almost impossible to act in ways contrary to national Government policy. It is not necessarily the case that local Scrutiny should not look at nationally determined matters – there may well be considerable value in local lobbying for legislative changes etc. However, this is most likely to be effective in instances where there is relatively little national awareness of issues. This is not the case with alcohol-related harm (and ARHA) – the issue receives a great deal of publicity, and there is a considerable amount of lobbying going on (for instance, recent reports from the Parliamentary Select Committee for Health and from the British Medical Association). Given this, it is not clear what more local lobbying could add.

Secondly, it is not currently clear what the Coalition Government intends to do about alcohol-related harm, but there have been suggestions that ideas such

as minimum pricing per unit and tightening the 2003 Licensing Act are being actively considered. There is questionable value in conducting a scrutiny review in advance of (relatively) imminent Government policy announcements which may well change the licensing regime etc.

Thirdly, whilst there is considerable scope for mitigatory actions to reduce ARHA (as noted in point 4 above), Brighton & Hove has achieved Beacon status for our management of the city's night time economy. There is generally limited value in scrutinising areas of high performance.

Fourthly, there is already a good deal of ongoing work looking at the issue of ARHA. There are currently around 30 different pilot projects running across England, looking at offering Brief Interventions, improving A&E data recording, offering enhanced detox services etc. The evaluation of these pilots has not yet been completed, but when it has been it is likely to provide a very useful tool in terms of determining what really works to reduce ARHA and what doesn't.

For these reasons, we do not consider the time to be right for a Select Committee on ARHA. OSC would be better advised to delay this piece of work for several months until we have a clearer idea of the new Government's policy with regard to licensing and alcohol-related harm, and until we can begin to get information from the ongoing ARHA reduction pilots.

Item 31 Appendix 4 – Scrutiny Panel Update

Panel Title	Current Status
Dual Diagnosis (OSC)	Reported to Council with Executive response
Students in the Community (ASCHOSC)	Reported to Council with Executive response
Older people and community safety (ECSOSC)	Reported to Council with Executive response
GP Led Health Centre (HOSC)	Reported to Council with Executive response
Children and alcohol related harm (CYPOSC)	Reported to Council with Executive response
Environmental Technologies (CTEOSC)	Reported to Cabinet in July
Dignity at Work (OSC)	Reported to Governance in July
Street Access Issues (OSC)	Reported to CMM and Licensing July
Winter Service Plan (ECSOSC)	Reported to CMM in July
Staff Disability (OSC)	Cabinet in September
Support Services for the Victims of Sexual Violence (ECSOSC)	Cabinet in Sept/Oct, CSF July, CDRP July
20 mph (ECSOSC)	CMM in September
School Exclusions (CYPOSC)	CMM in October, Head Teachers Steering Group in Sept
Climate Change Adaptation (OSC)	Cabinet in Sept/Oct
Dementia Strategy (ASCHOSC)	OSC in Sept
Cultural provision for children (CTEOSC)	To report November CTEOSC
Autism Services for Adults (ASCHOSC)	First meeting early Sept
Alcohol related hospital admissions (HOSC)	Established
Impact of in year budget savings (OSC)	Established

Agenda Item 32

Overview and Scrutiny Commission Work Plan 2010 - 2011

Issue	Overview & Scrutiny Activity	Outcome & Monitoring/Dates
26 January 2010		
Recommendations on budget proposals from O&S Committees	OSC to report to 11 February Cabinet.	Comments and minutes of all O&S budget meetings to be forwarded to 11 February Cabinet.
Third Sector Recovery Plan	Pre-decision. Commenting on draft plan.	Commission comment and queries to be taken forward in the development of the Plan.
Health Inequalities Referral from Audit Committee	OSC asked to agree to refer to ASCHOSC.	Report referred to ASCHOSC for further consideration.
CAA –One Place Assessment	Results of the CAA process. Sets context for scrutiny prioritisation and working with the LSP.	Overview and Scrutiny Committees to take account of the CAA report and action plan when developing work programmes.
Good Governance; Report of the Audit Commission	To note report of Audit Commission and proposed action in response.	Specific areas to be brought to OSC for monitoring as necessary.
OSC Work Plan	To be agreed at a future date.	A new draft annual plan to be reported to a future meeting. More public involvement to be encouraged.
Call-in Request for Hangleton Bottom	To consider call-in request.	That the decision be not referred back to the CMM.

16 March 2010		
Targeted Budget Management Month Nine	Ongoing budget monitoring.	Replies to questions from Acting Assistant Director, Financial Services.
Council's Forward Plan	Report as requested at OSC 20 October 2009.	Recommendations made to progress development of the Forward Plan.
Process to prioritise Scrutiny reviews	For agreement.	Process agreed for scrutiny panel annual work programme.
Budget Scrutiny Feedback	To consider budget scrutiny process.	Improved process welcomed and request for early information to be available for the 2011/12 budget.

27 April 2010		
Street Access Scrutiny Panel Report	OSC to endorse the report.	Agreed. Referred to Executive.
Dignity at Work scrutiny panel report	OSC to endorse the report.	Agreed. Passed to Governance Committee and referred to Executive.
Mandatory Development for Planning Committee	For approval to refer to Governance Committee.	General support for the idea. Comments to be forwarded to Governance Committee.

Volunteering Strategy	For O&S Comment.	Endorsed the strategy and made comments. Strategy scheduled to go to Cabinet.
Referral from HOSC	To determine whether or not to establish a Select Committee on alcohol-related hospital admissions.	Agreed to establish a Select Committee to report back to OSC.
ASCHOSC Update	O&S Committee Chairs to update OSC on their work-programme and key issues.	Noted work of the ASCHOSC.

8 June 2010		
Creating a Council the City Deserves	OSC to comment.	Chairman to write to the Chief Executive on behalf of OSC
Equalities 6-monthly update	Regular update.	Questions on staff profile for older and younger workers, stolen Blue Badges and disabled access to park cafes and polling stations
Staff Disabilities Scrutiny Panel report	OSC to consider the report to endorse.	Report referred to Cabinet for response
ECSOSC Update	Chair to provide update on work of the Committee.	Suggestions for agreeing subjects for scrutiny
General Scrutiny Update	For noting and comment.	Officer report on election processes requested for September meeting

20 July 2010		
Targeted Budget Management Outturn 2009/10	Ongoing budget monitoring.	Report noted
TBM update and VFM progress report to 22 July Cabinet	OSC comments to be forwarded to Cabinet	Further information requested
In-Year Grant Reductions Report to 22 July Cabinet	OSC comments to be forwarded to Cabinet	Scrutiny Review established to investigate impact of grant reductions on communities including equalities impacts Current Equlaities Impact Assessment of Connexions to be referred to CYPOSC
Climate Change Scrutiny Panel Report	OSC to consider the report for approval.	Report endorsed and passed to Cabinet. Six-month progress report requested
Community Engagement Framework Update	OSC has a role in monitoring the Community Engagement Framework. First update. .	Information on good examples and reasons for poor practice asked for in next update
Annual complaints report	Provides background information which can be used to focus future scrutiny work.	In the context of Intelligent Commissioning, learning on Repairs and Maintenance complaints to be

		forwarded to ASCHOSC.
CTEOSC Update	CTEOSC Chairman to provide update on the work of the Committee.	Noted the report.
Dual Diagnosis Monitoring	Monitoring implementation to scrutiny panel recommendations.	Progress in many areas welcomed and further 6 month update requested.

7 September 2010		
Election Processes	Presentation – Members to decide whether further work required.	
Dementia Select Committee	Select Committee report to be considered for approval.	
Annual Scrutiny Panel Work Programme	Consultation responses regarding panel topics. To agree priority list of panels for 2011/12.	
HOSC Update	HOSC Chairman to provide update on the work of the Committee.	

19 October 2010		
Discussion with the LSP Chairman	Part of Scrutiny/LSP protocol. Will include feedback from the Partnership Development Workshops.	
Review of discretionary rate relief for small businesses	Pre-decision input on three year review	

S106 Agreements	Seeking Members' input into strategic approach.	
Targeted Budget Management month 4	Ongoing budget monitoring.	
CYPOSC Update	Chairman to provide update on the work of the Committee.	

30 November 2010 - Meeting Cancelled

14 December 2010 Moved from 30 November 2010 to enable scrutiny of budget proposals		
Targeted Budget Management Second Quarter	Ongoing budget monitoring.	
Draft budget strategy following Cabinet		

1 February 2011 (Moved from 11 January 2011)		
Equalities Review – 6-monthly update		

1 March 2011 – Meeting Cancelled

5 April 2011		
Targeted Budget Management Third Quarter	Ongoing budget monitoring.	
Monitoring Staff Disabilities scrutiny review		
Monitoring of Climate Change scrutiny actions		

To be added to work plan during 2011:

Annual Community Engagement Framework report
Annual Complaints report
Dual Diagnosis scrutiny review - monitoring