Overview & Scrutiny Commission

Title:	**Adult Social Care & Housing Overview & Scrutiny Dementia Select Committee**
Date:	**4 December 2009**
Time:	**10.00am**
Venue	**The Bar, Hove Town Hall**
Members:	**Councillors:** Hawkes (Chairman), Barnett, Older and Wrighton Robert Brown (non-voting co-optee)
Contact:	**Giles Rossington** **Senior Scrutiny Officer** Giles.rossington@brighton-hove.gov.uk Tel: 29-1038

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For information: (1) minutes of the 17 July Select Committee meeting; (2) a note of the 09 September scoping meeting (papers attached).

13. Chairman's Communications	
14. Case Study: Low Level Need (managing dementia in the community)	**11 - 12**

This item will be introduced by Kathy Caley, Commissioner for Older People Mental Health. Officers providing city Access Point and Intermediate Care services will be on hand to explain what they do and to answer members' questions (papers attached).

15. Dates of next meeting

To be agreed at the meeting. Members are requested to bring their diaries to this meeting.

The City Council actively welcomes members of the public and the press to attend its meetings and holds as many of its meetings as possible in public. Provision is also made on the agendas for public questions to committees and details of how questions can be raised can be found on the website and/or on agendas for the meetings.

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For further details and general enquiries about this meeting contact Giles Rossington, (01273 291038 – email giles.rossington@brighton-hove.gov.uk) or email scrutiny@brighton-hove.gov.uk

Date of Publication 27 Nov 2009

Agenda Item 11

To consider the following Procedural Business:

A. Declaration of Substitutes

No substitutes are permitted on ad hoc scrutiny panels or select committees.

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 a 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.

AGENDA ITEM 12(A)

BRIGHTON & HOVE CITY COUNCIL

ADULT SOCIAL CARE & HOUSING OVERVIEW & SCRUTINY DEMENTIA SELECT COMMITTEE

10.30am 17 JULY 2009

COMMITTEE ROOM 1, HOVE TOWN HALL

MINUTES

Present: Councillor Hawkes (Chairman)

Also in attendance: Councillor Barnett, Older and Wrighton;
Mr Robert Brown, LINk co-optee

PART ONE

6. PROCEDURAL BUSINESS

6a Declarations of Interest

6.1 There were none.

6b Apologies

6.2 John Beeton, Senior Manager, Older People's Mental Health Services for Brighton and Hove, Sussex Partnership Foundation Trust, gave his apologies.

6c Exclusion of Press and Public

6.3 The Committee 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 Schedule 12A, Part 5A, Section 100A(4) or 100 1 of the Local Government Act 1972 (as amended).

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

7. MINUTES OF THE PREVIOUS MEETING

7.1 The minutes of the previous meeting were agreed.

8. CHAIRMAN'S COMMUNICATIONS

8.1 The Chairman welcomed the Committee members and thanked the expert witnesses for attending the meeting.

9. EVIDENCE FROM WITNESSES

9.1 Kathy Caley, Acting Joint Commissioner for Older People from Brighton & Hove PCT, gave a presentation on current local practice for diagnosing dementia, using information kindly provided by a psychologist at Sussex Partnership Foundation Trust.

9.2 Ms Caley said that, as requested, she had tried to arrange for a GP to speak to the committee about how they diagnosed dementia but that this had not proved successful as GPs did not appear to have the confidence to speak as an ‘expert’. Ms Caley commented that this showed the need for the PCT to carry out more development with GPs, in order to build their confidence in the subject. Ms Caley said that she would continue to try and arrange for a GP to attend in the future.

9.3 In addition to the information given in the presentation, Committee members heard:

- The blood tests carried out as part of the early diagnosis process were in order to screen out people who might have a dietary/ mineral deficiency rather than dementia as the presenting symptoms could be similar in both cases.
- Approximately 60% of the work of the Community Mental Health Teams (CMHTs) was dementia –based.
- The brain scans were carried out at Royal Sussex County Hospital. The person with suspected dementia could choose whether or not to have the scan; this was a personal choice.
- Members asked whether there were any funding pressures limiting the number of people who might be eligible for scans; they heard that this was not the case.
- Members wished to explore the idea of having a ‘circle of support’ for people with dementia. Denise D’Souza, Director of Community Care, commented that the current emergency planning arrangements being put into place for the possible swine flu pandemic meant that the department is already working to identify the most vulnerable residents

and develop support plans. This might be a useful starting point for establishing any 'circles of support'.

- If a person with suspected dementia did not accept the diagnosis, the CMHT would work to assess their capabilities in different areas and work with their families and support network as much as possible to try and minimise risks.
- It could often be the case that family members were too close to the person to recognise the onset of dementia.

9.4 Deborah Becker, Team Leader at the East Sussex Memory Assessment and Support Team (MAST), gave a presentation to the Committee about a person's pathway through the MAST team.

9.5 In addition to the information given in the presentation, Committee members heard and discussed:

- The team had been set up as a pilot scheme in 2006. It covered residents from Bexhill, Rother, Hastings and St Leonards.
- Its remit was to work with people in the early stages of memory problems; if it appeared that their needs were more advanced than this, the team would refer them on to a more appropriate service.
- The team aimed to carry out short-term intervention work for a period of approximately 12 weeks although this could be extended if needed.
- The MAST team is unable to make a formal diagnosis of dementia; the person would be referred on in this case.
- The team received approximately ten new referrals a week but was only able to see nineteen new referrals a month, leading to a waiting list building up.
- The service was age-inclusive.
- Members queried when the memory screening clinic had been closed in Brighton & Hove. Alan Wright from the Alzheimer's Society said that his recollection was that it had been funded by charity funding (http://www.ardis.org.uk) which had been withdrawn in late 2006.
- The East Sussex MAST team had very recently relocated to sit alongside the CMHT. Ms Becker said that she hoped that this would lead to improved communication between the teams. In addition, the MAST team was working to secure dedicated appointment slots with the psychiatrists for their clients so that they would not have to wait for a diagnosis.
- The Committee members agreed that they would have to think about what type of MAST service was best for Brighton & Hove, as there were a number of different models in existence. It would be necessary to have a service that GPs were happy to link into; Ms Becker said that her experience was that GPs welcomed a single point of access into a service.

- The East Sussex MAST team would always require a GP referral to begin their involvement as the initial GP tests could be invaluable in screening out those without dementia. They had produced literature to be distributed in voluntary organisations to give details of their service to residents.
- It was essential for GPs to have continuing training in a variety of matters including dementia.
- Croydon's memory clinic was recognised as a national example of good practice.

9.6 Alan Wright, Branch Manager from the Alzheimer's Society Brighton & Hove, spoke to the Committee and responded to questions.

9.7 Mr Wright explained that he wished to draw members' attention to the importance of early diagnosis of dementia for carers as well as for the person with dementia. The sooner that a carer could receive support and assistance, the quicker that they would be able to learn about coping strategies and to be aware of the various forms of dementia and of the different stages of dementia that they might experience.

9.8 The Alzheimer's Society would try to work with both people in a couple, to assist with the journey for both of them. For every person diagnosed with dementia, there would probably be a dozen more that were affected by the diagnosis.

9.9 The Alzheimer's Society was working to position itself to be able to deliver training to various different groups including healthcare professionals, people in care homes and carers. They were also part of the 'Caring with Confidence' project for carers.

9.10 In Croydon's memory clinic, seen as good practice nationally, the Alzheimer's Society was based within the memory clinic, forming a 'one-stop shop'. Mr Wright felt that this would be a key step for the Brighton & Hove memory clinic service, as it would enable the carer to get as much information as possible as soon as possible. The Alzheimer's Society could work to help support the carer from the earliest opportunity.

9.11 The Alzheimer's Society was working to try and avoid crisis situations building up for carers. The Society saw part of its remit to provide as much information and assistance to the carer as necessary, and from as early a point as possible. Their service was more successful in those situations where the consultant embraced the help provided by the third sector. Experience had shown that some consultants welcomed the help whilst others were less forthcoming.

9.12 The Alzheimer's Society in Brighton and Hove held its clinics at the various CMHTs in the city. It was necessary for the service to be available in a location where people with dementia or their carers would already be attending. They found that by moving the service, it

meant that the Society was able to see more people at an earlier stage of diagnosis, and consequently saw less carers reaching breaking point.

9.13 It was vital for work to be carried out with more of the hard to reach communities in the city. Brighton & Hove had recently won the bid to become a demonstrator site pilot; the associated funding could help to carry out work with hard to reach groups.

9.14 All of the positive steps that the Alzheimer's Society was taking would lead to greater challenges for the Society and for support services. The Committee heard that numbers of people diagnosed with dementia were rising and were expected to reach a million people nationally in the next ten years.

The rise in early diagnosis would inevitably mean that an increased demand for all support services.

The consistent media coverage of dementia related issues was welcome but this always led to highly increased demands for support services and information.

The newly agreed pilot for the dementia advisor service would be a signposting service, which would invariably refer people to the Alzheimer's Society and similar for assistance. This would lead to a higher demand for services which were already stretched to full capacity.

9.15 The Committee heard about the cost effectiveness of providing effective support services from the outset. If the support were provided, this could save costs in residential home fees, in carers' respite and in mental health provision for the carers themselves.

9.16 Mr Wright said that there were four significant service gaps in the current local provision for people with dementia. It was hoped that the Committee could make recommendations that might assist with all four points.

(a) In hospitals, there is an inadequate level of care with dignity for people with dementia. Unfortunately, Brighton & Hove had been unsuccessful in its bid for carers' advisor funding under the National Carers' Strategy. However the Committee might still wish to recommend a carers' advisor role to be established.

(b) Better early diagnosis will inevitably lead to a higher rate of dementia in younger people (those under 65). The Towner Club was established to support younger people with dementia; they meet twice a week and are only able to accommodate ten people. The Towner Club is very successful in maintaining and developing skills in people with dementia. However the current provision is insufficient to meet the

demand and this will become more of an issue as diagnosis rates are increased.

(c) For younger people with dementia whose needs have progressed beyond that which the Towner Club can accommodate, there are no other appropriate services to use. This means that at the time of greatest need, the services might be withdrawn, leading to a person either being at home permanently, or being admitted to long-term residential care amongst other residents that are much older.

(d) It can be hard for the Alzheimer's Society to help people with dementia living alone. Most Society funding is allocated for carer relief, but if the person does not have a carer, the funding cannot be used to help that person. They need to be supported properly too.

10. DATE OF NEXT MEETING

10a The next meeting will be on 11 September 2009 in Hove Town Hall. This will be a further scoping meeting and will be held in private.

The meeting concluded at 12.30pm

Signed Chair

Dated this day of

Agenda Item 12(b)

Select Committee on Dementia: note of informal meeting 11.09.09

Present:

Cllrs Georgia Wrighton, Averil Older

Cathy Caley (joint commissioner, OPMH), Carey Wright (SPFT), Giles Rossington (O&S)

Apologies:

Cllrs Pat Hawkes, Dawn Barnett

1 Discussion:

1.1 Members met to review progress and to discuss the future direction of the Select Committee.

1.2 Having already examined services for diagnosis and early intervention, members thought it would be sensible to further explore the pathway of dementia care, looking separately at community support (i.e. care provision which aims to maintain patients in their own homes, including 're-ablement') and at residential services (e.g. care homes and end of life care).

1.3 Members also thought it might be valuable to hear from people with dementia and their carers. It was not considered appropriate to hold a large scale public meeting, as this might prove logistically challenging (also the Select Committee is not really in a position to investigate individual issues with care provision which would likely arise from a large public event) . Rather, it was decided that the Alzheimer's Society (or other stakeholders) should be approached to see if they could suggest some possible witnesses from their contacts: witnesses willing to talk generally with members about their experience of living with/supporting people with dementia.

1.4 Members therefore proposed holding three additional meetings:

1. Community Support
2. Users and Carers
3. Residential Services

1.5 Members also discussed some other potential topics, including:

- Local PCT policy re: the prescription of Aricept (donepezil) for Alzheimer’s (and more generally, the local application of NICE guidance for treating/supporting dementia)

- Housing Strategy re: dementia - e.g. whether the council considers dementia issues when determining its OP/Sheltered Housing/Extra Care Housing provision (i.e. whether people with dementia are prioritised for supported housing which might enable them to continue living independently etc.)

- Acute Hospital Care - e.g. what provision is there for dealing with people who have dementia/diagnosing dementia in terms of general hospital care (i.e. how do hospital staff communicate with patients who have dementia but are in hospital for the treatment of another condition? Do hospital services actively seek to determine whether patients admitted for falls etc. have dementia?)

1.6 Rather than hold an additional meeting to cover these topics, members agreed to try and discuss prescribing and NICE guidance in the first meeting, and Housing Strategy and Acute Hospital Care in the third meeting. The revised meeting schedule is therefore:

1 Community Support (+ NICE guidance/Aricept)

2 Users and Carers

3 Residential Services (+ Housing issues + acute care issues)

However, extra meetings can be scheduled if necessary.

1.7 If all members are OK with this way forward, we will be in touch to agree on dates for future meetings.

Agenda Item 14

Low level need case study for dementia select committee – Friday 4th December 2009

Bill and Edith
Bill and Edith have been married for 54 years. Bill is 84, and following a minor heart attack 12 years ago, has been diagnosed with heart disease. He takes a number of different medications to manage this and, other than some age related frailty, is in good health. Edith is 79, has no known health conditions and appears to be a very robust, healthy woman. Bill and Edith have one daughter, Sue, who lives in London. Sue visits them once a month.

Bill and Edith moved into sheltered accommodation six months ago, when the three storey town house they were living in became unmanageable. They have a tendency to keep to themselves and have not shown an interest in participating in any arranged activities within the sheltered accommodation. They do not attend any day centres, nor do they receive any other form of support. Once a month when Sue comes to visit, she takes them to the supermarket to buy all the heavy household products they need. They buy the rest of their shopping as and when required from local shops. Their home is always clean and tidy, and they make use of the communal laundry room within the sheltered accommodation block.

To all around them, Bill and Edith have the appearance of a very self sufficient, able couple.

Change in circumstances
When out shopping with Edith one day Bill has a sudden stroke and is hospitalised for two weeks. Sue comes to stay with her mum in this period, and together they visit Bill in hospital. Bill is discharged with a reabling care package. This includes visits twice a week from occupational therapists and physiotherapists. Bill also attends a rehab centre two days a week. Bill's mobility is greatly affected, and he is only able to support himself standing for short periods of time. The therapy he is receiving is helping him to regain his mobility, and in time he should recover well. But at present he is unable to leave the flat unaided, or undertake housework activities..

With Bill less mobile, it becomes apparent that Edith is finding it difficult to cope. The flat is unkempt and Edith seems to be confused when undertaking day to day activities. Bill is supported to attend the rehab centre two days a week, and Edith is left at home alone. She often stays in her nightwear until Bill returns.

When Sue next visits she is surprised to find that there is very little food in the flat and Bill says that Edith is anxious about going outside on her own. When she did leave the flat she had to be helped home by a neighbour. The neighbour tells Sue that her mum did not seem to know her way home, and was quite distressed. Sue begins to feel concerned about her mum's behaviour and asks her dad about it.

Bill confides that when he was well, he had been supporting both of them in the flat. He was doing most of the housework, and was taking responsibility for shopping and cooking. He was also sometimes having to assist Edith in getting washed and dressed each day as she has become quite confused about doing this herself. Bill also states Edith's short term memory has been troubling her.

Sue is very surprised to hear this information from her dad, and is very upset that she was not aware of what he was having to cope with. She is surprised to find that she had not noticed any of these behaviours in her mum when she has visited in the past.

Support for Bill and Edith
Sue takes her mum to see her GP, and the GP refers Edith to the local Community Mental Health Team for an assessment. In the meantime, the GP recommends that Sue help her parents to contact the Brighton and Hove City Council ***Access Point****. The Access Point will provide them with information and advice on what support is available, and help assess them to get a better understanding of what type of support they may need. As it is anticipated that Bill should make a recovery, the level of support needed may reduce once he is physically better.*

Edith breaks her ankle
With Bill on the mend, he and Edith are able to go out together again during the day. Whilst out shopping, Edith slips and breaks her ankle. After an operation and some recuperation, Edith can be safely discharged from hospital. It is evident that Edith will require some ongoing support for a short period of time and she is referred to the Intermediate Care Service (ICS). The ICS team are able to provide support to Edith in her own home. It is apparent that the trauma of her injury/operation and the time spent in hospital have enhanced the confusion that Edith experiences. The ICS are able to support her, and the Registered Mental Health Nurse (RMN) based within the ICS team is able to visit Edith, assess her needs and support the ICS team in supporting Edith.