Brighton & Hove City Council

Overview & Scrutiny

Title:	**Adult Social Care & Housing Overview & Scrutiny Committee**
Date:	**9 September 2010**
Time:	**4.00pm**
Venue	**Council Chamber, Hove Town Hall**
Members:	**Councillors:** Meadows (Chairman), Wrighton (Deputy Chairman), Allen, Janio, Kemble, Older, Phillips, Pidgeon Non-Voting Co-optee: Steve Lawless (LINk)
Contact:	**Kath Vlcek** **Scrutiny Support Officer** 290450 kath.vlcek@brighton-hove.gov.uk

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ADULT SOCIAL CARE & HOUSING OVERVIEW & SCRUTINY COMMITTEE

AGENDA

Part One **Page**

14. PROCEDURAL BUSINESS **1 - 2**

(a) Declaration of Substitutes – Where Councillors are unable to attend a meeting, a substitute Member from the same Political Group may attend, speak and vote in their place for that meeting.

(b) Declarations of Interest by all Members present of any personal interests in matters on the agenda, the nature of any interest and whether the Members regard the interest as prejudicial under the terms of the Code of Conduct.

(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 exempt from disclosure 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.

15. MINUTES OF THE PREVIOUS MEETING **3 - 8**

16. CHAIRMAN'S COMMUNICATIONS

17. PUBLIC QUESTIONS

No public questions have been received.

18. LETTERS FROM COUNCILLORS & NOTICES OF MOTION

No letters or Notices of Motion have been received.

19. MEMBER DEVELOPMENT SESSION ON ADULT SOCIAL CARE & THE VOLUNTARY SECTOR

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 Kath Vlcek, (290450,

email kath.vlcek@brighton-hove.gov.uk) or email scrutiny@brighton-hove.gov.uk

Date of Publication - Wednesday, 1 September 2010

Agenda Item 1

To consider the following Procedural Business:

A. Declaration of Substitutes

Where a Member of the Committee 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 Committee. 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 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.

BRIGHTON & HOVE CITY COUNCIL

ADULT SOCIAL CARE & HOUSING OVERVIEW & SCRUTINY COMMITTEE

4.00PM 24 JUNE 2010

COMMITTEE ROOM 1, HOVE TOWN HALL

MINUTES

Present: Councillors Meadows (Chairman); Wrighton (Deputy Chairman), Allen, Janio, Kemble, Barnett and Harmer-Strange

PART ONE

1. PROCEDURAL BUSINESS

1A Declaration of Substitutes

1.1 Councillor Dawn Barnett announced that she was attending as a substitute for Councillor Averil Older.

Councillor Steve Harmer-Strange announced that he was attending as a substitute for Councillor Brian Pidgeon.

Councillor Alex Phillips sent her apologies; she was unable to attend due to a clash with another committee.

1B Declarations of Interest

1.2 Councillor Harmer-Strange declared a non-prejudicial interest in item 7 – Training Session; Rents as a member of the Board of Seaside Homes.

1C Declarations of Party Whip

1.3 There were none

1D Exclusion of Press and Public

1.4 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.

1.5 **RESOLVED – that the press and public be not excluded from the meeting.**

2. MINUTES OF THE PREVIOUS MEETING

2.1 **RESOLVED - that the minutes of the meeting held on 4 March 2010 be approved as a correct record.**

3. CHAIRMAN'S COMMUNICATIONS

3.1 There were none.

4. PUBLIC QUESTIONS

4.1 There were none

5. LETTERS FROM COUNCILLORS

5.1 There were none.

6. NOTICES OF MOTIONS REFERRED FROM COUNCIL

6.1 There were none.

7. TRAINING SESSION: RENTS

7.1 Sue Chapman, Head of Financial Services, presented a training session on rent setting for local authority and registered social landlord (RSL) properties and responded to members' questions.

7.2 In response to a query regarding whether the property value in the calculation was updated periodically, members heard that this was not the case as the formula had been designed to use the original 1999 valuation. The only exception to this was in the case of local authorities who had had properties in poor condition in 1999, and who had failed the Decent Homes Standard. If the local authority had renovated its properties, they had been able to apply for a revaluation.

7.3 In relation to a question about the discrepancy between RSL rents and local authority property rents, the committee heard that it was generally the case that RSL rents were higher than local authority rents. Currently RSL rents for one bedroomed properties were approximately 13% higher than local authority rents whilst RSL rents for two bedroomed properties were approximately 20% higher. The Government's system was designed so that the differing rents would converge at a future point; this was being managed in stepped rent increases each year.

7.4 Members asked whether it would be possible for the council to negotiate with RSLs about their rent levels. They heard that this was not possible and that it was the case that local authority rents were moving up towards the level of RSL rents, rather than RSL rents decreasing towards local authority rent levels.

7.5 Members also heard that both local authorities and RSLs had the option to charge new tenants rent at the highest available level. However if local authorities did so, this would negatively impact the level of subsidy received so there was a disincentive to do so. For RSLs, this was not the case, and they were able to keep any rent charged. Brighton and Hove City Council had chosen not to charge new tenants a higher rent level at this time.

7.6 Members expressed concern about how Housing Benefit levels might be affected by announcements in the new budget. They requested a training session be scheduled on Housing Benefits and how this affected affordability of properties in the city.

7.7 Members thanked Ms Chapman for her informative presentation.

8. TRANSFERS OF CARE FROM HOSPITAL

8.1 This item was introduced by Denise D'Souza, Acting Director, Adult Social Care and Health, and Jane Simmons, Head of Commissioning, and Partnerships. PCT colleagues had been unable to attend this committee meeting but would be willing to come to a future session to discuss the topic if Members wished.

8.2 The committee heard that in previous years, there had been a significant problem with delayed transfers of care in the city, with a number of people having to wait over 100 days to be transferred out of hospital. However work had been carried out to address this and delayed transfer time was now reduced to a level of between 13 and 20 days.

There was now a proposal to reduce the numbers of delayed transfers of care even further to fewer than eight people per week. It was unrealistic to assume that there could be a situation with no delays at all but it was important to work to reduce them as far as possible.

Members asked for recent figures for delayed transfers of care from hospital to be circulated; this was agreed.

8.3 Members asked questions on a number of issues including the pressures on the social work teams at the hospital, care packages, assessing care needs, making the decision to discharge someone from hospital, weekend discharge arrangements and coordination with health colleagues.

8.4 In response to a query about pharmacy delays, members heard that this was still an issue and it was not uncommon to have several hours' delay for medicine to be issued. This impacted on the time taken to discharge patients from hospital and meant that the bed may be unavailable for other patients' use. In Brighton and Hove, patients were moved to discharge lounges in such situations, so that drugs could be issued to the patients and the bed freed up for another patient.

8.5 **RESOLVED – to note the report.**

9. HEALTH INEQUALITIES - REFERRAL FROM THE OVERVIEW & SCRUTINY COMMISSION

9.1 This item was introduced by Martin Reid, Head of Housing Strategy and Development and Andy Staniford, Housing Strategy Manager.

9.2 Members heard that there was substantial evidence to show that poor quality housing affected peoples' health but that there was little evidence to show that improved quality housing led to improved health. This was a nationally recognised discrepancy and work was being done in various cities to gather data.

A Housing and Health Inequalities Group had been established in Brighton and Hove to look at the topic, involving officers from Housing, Adult Social Care and from Health.

9.3 Members heard about a number of initiatives that had been introduced locally and cost benefits analyses that had been carried out. These included:

- A cost benefit analysis of the Supporting People programme had been carried out; nationally, this showed that for every £1 spent on Supporting People, £2 was saved in other public spending costs. In Brighton and Hove, this saving was increased to £3.24 for every £1 spent.

- National research suggests that in a city the size of Brighton, slips and falls around the home and excess cold are expected to cost the NHS around £8m per annum (in addition to the impact on the quality of life of those affected) with the cost of works to remedy these issues being estimated at around £2m. Additionally, the cost to the NHS is estimated to represent only around 40% of the cost to society from these issues. Further research is being planned to determine if this national model reflects the reality in Brighton & Hove.

- Members heard about a 'repairs on prescription' service that was being piloted, linking the PCT and Private Sector Housing to deal with poor quality housing issues that affected residents' health.

- Age Concern was trialling a scheme researching involvement with health services over an extended period of time, to assess whether investment in home improvements had a positive effect on someone's health service take-up. The council was also looking at a similar toolkit to be used by hostel residents, drug and alcohol clients, and rough sleepers.

9.4 PCT commissioners were very keen to be involved with the health inequality work, recognising that it was important to try and tackle issues before they became problems for the city.

9.5 Members asked questions about the funding for various programmes, recognising that the Supporting People budget was no longer being ring fenced. They heard that various funding strategies were being considered, including a new loan system and the possibility of working with energy companies.

9.6 Members were interested to hear more about the Housing and Health Inequalities Group, and asked for a report to come to the Committee in six months time.

Members also expressed an interest in linking more with LSP groups covering housing and adult social care; it was agreed that representatives would be invited to future Committee meetings.

9.7 **RESOLVED – that members**

(i) noted the contents of the Audit Commission Health Inequalities report, and

(ii) determined what additional action to be taken in monitoring the implementation of the plan.

10. LETTER FROM CHAIRMAN OF HEALTH OVERVIEW AND SCRUTINY REGARDING POSSIBLE CO-OPTION OF A BRIGHTON & HOVE LOCAL INVOLVEMENT NETWORK (LINK) MEMBER

10.1 Members discussed the possible co-option of a Brighton and Hove LINk member to ASCHOSC as a non-voting co-optee.

10.2 Members heard that the LINk remit had been recently extended to cover Adult Social Care and that they had a legal right to sit on the Committee under the Local Government Involvement in Health Act. It was felt that a LINk representative could provide a valuable link between agencies and that the Committee would benefit from having the group represented.

10.3 **RESOLVED – that a LINk representative be invited to join the Committee as a non-voting co-optee.**

11. ADULT SOCIAL CARE & HOUSING WORK PROGRAMME

11.1 The work programme was noted.

12. ITEMS TO GO FORWARD TO CABINET OR THE RELEVANT CABINET MEMBER MEETING

12.1 There were none.

13. ITEMS TO GO FORWARD TO COUNCIL

13.1 There were none.

The meeting concluded at 5.50pm

Signed Chair

Dated this day of

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ADULT SOCIAL CARE & HOUSING OVERVIEW AND SCRUTINY COMMITTEE	**Agenda Item 21** Brighton & Hove City Council

Subject:	**Mental health Services in Brighton and Hove – service redesign proposals**	
Date of Meeting:	**September 2010**	
Report of:	**The Director of**	
Contact Officer:	Name: Margaret Cooney	Tel: 01273
	E-mail: Margaret.cooney@bhcpct.nhs.uk	
Wards Affected:	All	

1 Summary and context

1.1 The East and West Sussex consultation on the changes to and the location of their inpatient beds has been completed. There are no direct proposals from either area that will impact on either the Nevill or Mill View Hospitals in Brighton and Hove.

1.2 Sussex Partnership NHS Foundation Trust (SPFT) has responded to the request from the HOSC to provide their proposals to improve the community services to support the reduction of acute inpatient beds in the Mill View and Nevill Hospitals. The Trusts Improving Community Mental Health Services Paper is available on request.

1.3 These proposals for community services have been based on conversations with GP's users and carers and with operational staff in Sussex Partnership. It needs to be acknowledged that there are significant operational issues in such major redesign and that this is an area that will need to be addressed in all implementation plans.

1.4 Alongside the major changes being identified, there are a number of early high impact changes being proposed. These changes are aimed at making the most difference to the community teams that will be responding to crisis and early intervention and thereby reduce the pressure on inpatient beds.

1.5 The current funding for mental health services for adults and older people in the city is around £55million of which 70% are NHS funded and 30% council funded. Redesigns within Sussex Partnership Trust will impact on the whole system and on the services funded by the city council. These include the packages of care provided in residential and nursing homes, support in peoples own homes and the housing

options. There is work taking place within the city council to address the demand and value for money of these areas.

1.6 For the city council staff seconded into Sussex Partnership, the role and responsibilities will be considered by Adult Social Care management in order to meet the requirements of Putting People First and the need for a social care assessment where required.

1.7 All service redesign will take place with user and carer involvement through the user and carer networks in the city, clinicians are engaged in developing specific clinical pathways and all new specifications will require an equalities impact assessment.

1.8 There have been assurances from Sussex partnership trust that any changes to services will be gradual and that there will be local service retained in Brighton and Hove for adult and older peoples and for people with dementia. In the realignment of and older people's services, the needs of vulnerable older people will be protected and the staff skills and expertise in this area retained.

2 Recommendations

2.1 To note:

a) that the East and West Sussex plans for changes to inpatient beds does not include using the Mill View and Nevill Hospitals

b) the priority areas for change in crisis services as outlined below

c) the work taking within the City Council to develop supported housing and packages of care.

3 BACKGROUND INFORMATION

3.1 With respect to the on-going development of acute adult mental health services in Brighton & Hove, Sussex Partnership remains confident in the ability of the inpatient services to accommodate the proposed reduction of beds by up to 12 working age beds, 4 older peoples beds and 3 dementia beds. This will allow for 48 working age and older peoples beds to be provided out of the Mill View Hospital site and for the dementia beds to be relocated from the 1st floor in the Nevill Hospital to the ground floor in the same unit. The aim is for these changes to start taking effect from April 2011 subject to the successful delivery of a set of proposed high impact changes to community services. None of these proposals involve moving any remaining services outside of the city.

3.2 It has been agreed that there will be no changes to inpatient beds until there is significant evidence of the impact of the proposed changes below:

3.3 To make the most impact on the current community services and to provide sufficient crisis support outside of hospital beds, Sussex Partnership is proposing a number of early changes to their services. These include:

a. A refresh of the Crisis Resolution Home Treatment service (CRHT) to ensure these services are working in accordance with the national guidelines. The Trust is also developing plans to enable the CRHT service to support all adults over 18 (including those over 65) by March 2011.

b. A 7 days a week community services and extended hours within the working week.

c. The redevelopment and implementation of 4 priority clinical pathways to manage people's needs in the community. The priority areas are: Psychosis, Personality Disorder, Dementia and Depression.

d. The refreshed Care Programme approach.

e. The roll out of NICE related training programmes across community staff.

f. More closely managed performance in respect of observing eligibility thresholds into community services, throughput and discharge planning targets, waiting times from referral to assessment/treatment, carer assessment levels, 7 day follow up post discharge.

3.4 In parallel to these high impact changes there are the following major redesigns being proposed that will impact on all services and will be redesigned in collaboration between clinicians, and commissioners:

- A new primary care mental health services in Brighton and Hove
- New specialist assessment and therapy centre/s
- An integrated and extended community case management service

3.5 Not included in this paper but being taken forward as a priority is the emergency referral pathway and crisis service.

3.6 It is important to address the impact of redesigns and hospital bed reductions on the city council funded housing options and packages of care. There are delays in discharges from inpatient beds currently due to a lack of appropriate and available housing options.

3.7 There is a 3 month average to access appropriate placement due to availability and complexity of need. Gaps have been identified in dual

diagnosis (Mental health/substance and alcohol misuse), wrap around services for individuals with complex and changeable needs where they fall between a rehabilitation model and residential care. The enhanced community services could well lead to a reduction in

3.8 accommodation pressures as people remain at home and are not admitted. Being admitted can lead to losing accommodation and resulting in delays in discharge,

The follow are some of the key initiatives being led by the council to meet extra demand for supported accommodation:

- A review of the current contracting model for residential and nursing care and where quality and outcomes can be maximised.

- 'The Supporting People team is developing further tiered supported accommodation for around 50 people which will include support to reduce the risk of a crisis and to maintain people in the community

- Capacity for long term residential placements for the older people with mental health problems are being reviewed

4. CONSULTATION

4.1 The proposals for changes to services will continue to be commented on and influenced by users, carers and clinicians. These community development and restructuring plans have been influenced by a series of events with users and carers that have been managed by Commissioners and Brighton and Hove MIND. There are a number of sub groups being asked to make comments on specific redesigns as appropriate to their experience of current services.

5. FINANCIAL & OTHER IMPLICATIONS:

5.1 Financial Implications:
All service redesigns will be in line with new budget requirements and will need to demonstrate value for money.

5.2 Legal Implications:
None identified

5.3 Equalities Implications:
All redesigns will be based on improving access to services and on improving outcomes for people in the city. Within all redesigns, choice and control will be prioritised.

5.4 Sustainability Implications:

None identified.

5.5 Crime & Disorder Implications:
None identified.

5.6 Risk and Opportunity Management Implications:
The risk to implementation are being reviewed and will be included in a specific risk register.

5.7 Corporate / Citywide Implications:
The redesign of primary, secondary and community services will need to be considered in light of the changing emphasis for NHS commissioning. It will be important to set the basis for excellent primary care and community NHS services in the next 18 months.

Supporting documents: Sussex Partnership Improving Community Mental Health Services, internal document (distributed by email and available on request)

ADULT SOCIAL CARE & HOUSING OVERVIEW AND SCRUTINY COMMITTEE	**Agenda Item 22** Brighton & Hove City Council

Subject:	**In –year Grant Reductions 2010-11**			
Date of Meeting:	**09 September 2010**			
Report of:	**The Acting Director of Housing, Culture & Enterprise**			
Contact Officer:	Name:	Narinder Sundar	Tel:	(29)3887
	E-mail:	narinder.sundar@brighton-hove.gov.uk		
Wards Affected:	All			

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 The Secretary of State for Communities & Local Government announced details of 2010/11 in-year grant reductions for all local authorities on 10 June. These totalled £3.55m for Brighton & Hove City Council covering both revenue and capital grants. There was a further announcement of a reduction in grant received from the Department for Culture, Olympics, Media and Sport on 17 June. On the 5 July the Secretary of State for Education announced reductions to the Education Capital programme relating to the Building Schools for the Future and Academies programme as well as high level reductions in the End Year Flexibility (EYF) allocations. Further details of the EYF allocations were announced on 14 July.

1.2 The in-year budget reductions have been considered by Full Council and the Cabinet.

1.3 The Overview and Scrutiny Commission (OSC) has considered all of the planned in-year grant reductions as a whole. The OSC has asked each Overview and Scrutiny Committee to individually consider the in-year grant reductions for their departments.

1.4 A Scrutiny Review Panel is being set up to consider all of the in-year budget cuts and their effects on Brighton & Hove City Council services.

1.5 For the Adult Social Care and Housing Overview and Scrutiny Committee, the only relevant in-year grant reduction is in terms of the Supporting People Administration Grant. This is being reduced by £164,000, which is 100% of the grant.

2. RECOMMENDATIONS:

2.1 That members:

(1) Note the report;

(2) and consider whether to refer any issues to the Scrutiny Review panel that will be considering the reductions in detail.

3. BACKGROUND INFORMATION

3.1 There will be a £164,000 reduction (100%) in the Supporting People Administration Grant from central Government.

3.2 The government's expectation is that Supporting People Administration could be incorporated into the administration of other related activities. The in-year cut to the Supporting People Administration Grant will be funded from an underspend that is created through low utilisation/voids in some services, re-charging, subsidy payments and a saving generated as a result of one service closing earlier than planned. There is no reduction in any current funding levels for any of our Supporting People services in this financial year and therefore there will be no impact on existing services.

3.3 As part of the planning for the 2011/12 budget consideration will be given to how the administration of Supporting People could be delivered alongside other services across the Housing Strategy Division to achieve this saving on a recurrent basis.

3.4 The Supporting People Commissioning Body is the key decision making body that governs and oversees implementation of the

Supporting People Strategy. Its key role is to direct the administering authority on the use and application of the Supporting People grant, ensuring expenditure profile is prudent and taking into account existing and proposed commitment to fund services. The Commissioning Body's role is also to identify opportunities for joint commissioning of services and collaborative working with key partners in Health and Probation to commission services. Membership includes representation of Chief Officers from Primary Care Trust, Probation, Housing Strategy and it is chaired by the Cabinet Member for Housing.

3.5 Communities and Local Government commissioned a report into the financial benefits of the Supporting People Programme in 2007. This research indicated that for every £1.61 spent on Supporting People services there was a £3.41 benefit for this investment. The methodology developed is based on the projected costs of alternative, appropriate support if Supporting People services were not available. The projected costs take into account costs for housing departments, Department of Work & Pensions, Health and other social costs such as crime and homelessness. This methodology has been applied to the local Supporting People Programme in Brighton and Hove and identified a benefit of £3.24 for every £1.00 spent on Supporting People services locally.

3.6 Local Authorities will receive an announcement on future allocation of the Supporting People Welfare Grant from April 2011 onwards after the Spending Review in October 2010. In previous years, allocations have been made on a 3-year basis and for 2008-11 we received an 11% cut over 3 years.

3.7 At a national level, National Housing Federation, SITRA and Homeless Link (all member organisations for supported housing) have published a joint submission to Communities and Local Government that presents a business case for ongoing investment in housing-related support. It also includes a number of recommendations to the Spending Review to maintain the same levels of investment in housing-related support and homelessness services that meet the support needs of vulnerable people that offer good outcomes, prevention through early intervention and value for money.

4. CONSULTATION

4.1 There has been early consultation with the Trades Unions on the in-year grant reductions. Statutory consultation will be required

with staff affected and the Trades Unions once the detailed proposals are agreed. Preliminary discussions have taken place with Sussex Police, the Community & Voluntary Sector Forum and the Primary Care Trust on the potential implications for services that are jointly funded. These will need to be continued as more detailed information on implementation is developed,

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 These are contained in the main body of the report.

Finance Officer Consulted: James Hengeveld Date: 19 July 2010

Legal Implications:

5.2 The respective powers of Council and Cabinet in the decision-making process are set out in the body of the report. The details of how the in year reductions announced by the government are implemented in Brighton & Hove is a matter for the City council's discretion. In exercising its discretion, the council is required to act reasonably. This includes a requirement not to fetter its discretion by adopting rigid/inflexible rules or policies, the need to consider the particular circumstances of each service affected, the need to undertake any necessary consultation with those affected where relevant and proportionate given the practical limitation imposed by time. Above all, the council needs to show that it considered all available options with an open mind. The council should also avoid taking any action that involves a breach of its statutory duty or failure to provide services that are mandatory.

Lawyer Consulted: Abraham Ghebre-Ghiorghis Date: 19 July 2010

Equalities Implications:

5.3 Equalities implications have been taken into account when prioritising the areas for grant reductions.

Sustainability Implications:

5.4 None have been identified.

Crime & Disorder Implications:

5.5 None have been identified.

Risk and Opportunity Management Implications:

5.6 5.6 As part of the process of drawing up the proposed expenditure reductions risk implications have been taken into account for example:

- Considering any legal and contractual implications
- Considering the implications on wider schemes particularly provided by the community and voluntary sector
- The lead in times required for delivery of savings

The one off risk provision of £0.5m has been set aside to deal with any residual risks that may arise during the detailed implementation of the proposals and any unforeseen delays.

Corporate / Citywide Implications:

5.7 Covered in the body of the report.

SUPPORTING DOCUMENTATION

Appendices:

1.

Documents in Members' Rooms:

Background Documents:

1.

ASC & Housing Overview & Scrutiny Committee	Agenda Item 23 Brighton & Hove City Council

Subject:		***Annual Safeguarding Report 2009/2010***		
Date of Meeting:		**9th September 2010**		
Report of:		***Acting Director, Adult Social Care and Health***		
Contact Officer:	Name:	***Karin Divall***	**Tel:**	**29-4478**
	E-mail:	Karin.divall@brighton-hove.gov.uk		
Wards Affected:	All			

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT

1.1 Brighton & Hove City Council produce an annual report which sets out the performance and practice across the City in safeguarding vulnerable people.

1.2 The report outlines the work that has been carried out in 2009/10 by all the City Council Partners, and the work of the Multi-Agency Safeguarding Adults Board which is chaired by the statutory Director of Adult Social Services.

2. Recommendations

2.1 To note the work that has been carried out by agencies across the City to safeguard vulnerable adults

2.2 To provide comments on improvements that could be made to further strengthen safeguarding work.

3.0 RELEVANT BACKGROUND INFORMATION

3.1 The Annual Report is set out in Appendix 1

4. CONSULTATION

4.1 None

5. FINANCIAL & OTHER IMPLICATIONS:

5.1 Financial Implications:
There are no direct implications arising from the recommendations of this report. The cost of safeguarding activity and training support forms part of the budget strategy of the different agencies involved.

Finance Officer Consulted: Anne Silley *Date: 10 August 2010*

5.2 Legal Implications:

Safeguarding Vulnerable Adults is a key function of the Local Authority in partnership with other statutory agencies. Proper procedures for ensuring the protection of vulnerable adults by their nature have regard for individual's Human Rights as enshrined in the Human Rights Act 1998; in particular Articles 2 (Right to Life), 3 (Right to be free from degrading and inhumane treatment), 8 (Right to Privacy and Family Life) of European Convention on Human Rights. This report provides for scrutiny of the monitoring of Safeguarding procedures and comment on any improvement which in itself forms an essential part of ensuring the best possible safeguarding arrangements to be in place.

Lawyer Consulted: Sandra O'Brien *Date: 10 August 2010*

Equalities Implications:

5.3 Older people, people with disabilities and mental illness can be vulnerable to abuse.

Sustainability Implications:

5.4 There are no sustainability implications.

Crime & Disorder Implications:

5.5 Vulnerable people can be subject to financial abuse and physical and sexual violence which are forms of adult abuse that are reported within the Annual Report.

Risk and Opportunity Management Implications:

5.6 The Annual report collates evidence about the issues affecting vulnerable people living in our City and explains the practice and procedures in place across different organisations to strengthen our work in safeguarding these people.

Corporate / Citywide Implications:

5.7 The report is produced on a City wide basis and includes the work of other organisations working in statutory and other organisations across the City.

6. EVALUATION OF ANY ALTERNATIVE OPTION(S):

6.1 Safeguarding is a core statutory and multi-agency responsibility and it is important that there is good monitoring and oversight of performance and that this is presented publicly each year.

7. REASONS FOR REPORT RECOMMENDATIONS

7.1 To ensure that Scrutiny are advised of the work carried out to Safeguard Vulnerable People and to contribute to developing practice.

SUPPORTING DOCUMENTATION

Appendices:
Safeguarding Vulnerable Adults; Annual Report

Documents In Members' Rooms
None

Background Documents
None

Brighton & Hove

Safeguarding Adults Board

ANNUAL REPORT

2009/2010

TABLE OF CONTENTS

1. Foreword

I am pleased to introduce this annual report of the Brighton and Hove Safeguarding Adults Board. This report sets out the work that has been achieved over the last year to help keep vulnerable people in Brighton and Hove safer from being abused or neglected, and also makes clear the plan for the work that still needs to be done. It also shows data on the referrals and investigations that have been undertaken over the last year, showing the types of abuse that vulnerable people suffer, and where the abuse is alleged to have taken place and how we are receiving reports about abuse. This data is crucial in gaining an understanding of the patterns and prevalence of abuse, and can then help us to raise awareness with professionals and the public in recognising and reporting abuse, and to help vulnerable people to keep themselves safe.

Since the last annual report there have been changes in the management of Adult Social Care, and I have again taken on the role of Chair of the Brighton and Hove Safeguarding Adults Board. As you may be aware, more changes are to come in the management structure within the whole of the City Council, but I can reassure you that this crucial work to ensure that the City's most vulnerable people are kept safe will continue to be a priority for us all.

This year has also resulted in close scrutiny of the work that has been achieved due to an inspection by the Care Quality Commission. The Care Quality Commission is the independent regulator of health and adult social care services in England, and has a programme of inspections of local authorities and health providers. The inspection was to look at how well Brighton and Hove was safeguarding adults whose circumstances made them vulnerable. It was a very thorough process which involved meeting vulnerable people directly and listening to their views, meeting staff from many of the organisations in the City who work with and support vulnerable people, and looking at case files to closely monitor the work that has been done when abuse has been investigated.

Such close scrutiny of the work that is done here in Brighton and Hove was obviously a daunting experience for all involved, but also a positive one as it confirmed the really good work that was being done. It also helped us to clearly identify any areas that needed improvement. I am delighted to now be able to report that following the inspection the Care Quality Commission has concluded that Brighton and Hove is **performing well** in safeguarding. This is extremely positive and encouraging, and I give my wholehearted thanks and appreciation to all the staff who are so dedicated in working with vulnerable people. The result of the inspection is a real credit to you all.

We now look to the year ahead, with a clear plan of action to ensure this good work is built on and continues. The action plan at the end of this report sets out the plans for the years ahead, so the hard work will continue to make 2010-11 an even more positive year!

Denise D'Souza

Denise D'Souza, Acting Director

2 Summary of the Year

Developments in 2009/10 and Challenges for the Year Ahead

Safeguarding Adults Board

In February 2010 Joy Hollister left Brighton and Hove to take up a new post, and Denise D'Souza has taken up the role of Director for Adult Social Care and Health, and as the Chair of Brighton and Hove Safeguarding Adults Board. The Board has continued to work to the Business Plan agreed in 2009, which is updated quarterly for each Board meeting. The version updated at the Safeguarding Board in June 2010 is included in this report.

A Monitoring and Development Group for Mental Capacity and Deprivation of Liberty Safeguards (DoLS) has started, and is in the process of developing an action plan which will link in with the Safeguarding Business Plan. This group will report to the Safeguarding Board on a quarterly basis.

Multi-Agency Safeguarding Vulnerable Adults Procedures and Operational Instructions

In 2009 Pan Sussex Operational Instructions for safeguarding investigations were written, and shared with staff in draft. During the process of writing these it became apparent that the current Multi Agency Policy and Procedures, launched in 2005, now needed to be updated. The Safeguarding Boards in East Sussex, West Sussex and Brighton and Hove all agreed that this piece of work was required, and that the updated Policy and Procedures should include the recently written Operational Instructions. This piece of work is currently going ahead, with a plan for the new draft policy and procedures to be circulated for comment by the end June 2010.

Safeguarding Investigations Auditing

This year an ongoing process for auditing safeguarding investigations has been introduced. Senior Managers are auditing a number of cases every quarter and reporting their findings into the Safeguarding Adults Board. The key themes from this will be used to influence training plans, procedures and the Board's Business Plan.

The next step for the year ahead is to develop this audit process so that it includes feedback from service users who have been part of a safeguarding intervention, so as to gather information from them as to how the process was for them, and whether in their view the outcome was positive.

Training

In December 2009 the 5th Multi-Agency Safeguarding Adults Conference was held. This was attended by 120 staff from all partner organisations, and was a full day of guest speakers and workshops focusing particularly on Hate Crime, with Kathryn Stone from Voice UK giving a very inspirational, emotional and thought provoking talk. 5 different workshops were held, covering topics such as Hate Incidents, the Vetting and Barring scheme, Dignity, Domestic Violence and the future regulation of Adult Social Care. This year's conference is still in the process of being planned, but is to focus on the vulnerable person's experience of the safeguarding process.

A Pan Sussex Competency Framework for social care and health staff was also launched this year.

Data Collection

This annual report summarises the safeguarding activities for the period April 2009 to end March 2010. From this we can see that there has been a large increase of alerts this year, 51% more than last year. This has obviously put pressure on staff who are responsible for investigating alerts, and measures are being put into place to support this increase in volume.

More detailed data has been able to be collected this year, and in this report we can see data such as the source of alerts, and the location where the alleged incident took place.
From 1st May 2010, Adult Social Care staff started to use Care Assess, an improved database, for safeguarding work. This means that data will continue to be more detailed and accurate with this system. Care Assess also ensures a robust management sign off for all safeguarding investigations.

Self Directed Support

The Council continues to contract with the Brighton and Hove Federation of Disabled People (a user-led organisation) to provide a range of services to support all service users to control their own support. They provide the Direct Payments Support Service which is funded via a multi-agency contract, including Adult Social Care; Learning Disabilities; Sussex Partnership Foundation Trust; and Children and Young Peoples Trust, ensuring that all services users receive support with the options of accessing a Direct Payment. The service is available to both individuals funded by the Local Authority and those who pay for their own support needs. The service provides advice and information; support with recruitment, including assistance with producing Job Descriptions; PO Box numbers for application forms; involvement where requested in the interviewing process; facilitating CRB (funded by the Council); and template contracts.

Additionally they provide two further services which can be purchased either by the Council or by the individual directly. These are the Payroll Service and Supported Bank Account (SBA) service. The latter provides a comprehensive service managing the administration of the Direct Payment account. The use of the SBA can be to support individuals who lack capacity, or those who may potentially be at risk of financial abuse. Additionally the Council can provide Indirect Payments to an authorised individual to manage a Direct Payment on behalf of an individual who lacks capacity. Those individuals who currently receive their Personal Budget via a Direct Payment have access to all of the above services, and work is being done with the Federation to identify more support to individuals who wish to take greater control, this would include a potential Personal Assistant register and an Induction Pack for employers to work through with new employees.

In addition to the above we have a local Peer Support Group made up of service users who access Direct Payments. The group is jointly facilitated by the Federation and the Adult Social Care Self Directed Support Lead. This group provides peer support and can be involved in consultation activities

3. Performance and Practice

3.1 Activity and performance information key points for 2009 to 2010

The following data refers to distinct elements of safeguarding vulnerable adults process.

An '**alert**' refers to an individual reporting a suspected incident of abuse or possible harm. Not all alerts will result in a safeguarding investigation, as there may be other processes that will resolve the situation more appropriately, for example an assessment of the person's needs. There are also times when there are real concerns, but the person who is being harmed is adamant that they do not want an investigation to take place.

Seven categories of abuse have been agreed by Sussex agencies. These are **Discriminatory, Physical, Sexual, Psychological, Financial, Neglect/acts of omission and Institutional.** These are described in more detail in **Appendix 1**.

Response levels refer to the level of investigation agreed for each safeguarding vulnerable adults investigation. There are 4 levels of response, and they are decided by assessing the potential seriousness of the alert, and should be proportional to the perceived level of risk and seriousness. See **Appendix 2** for further detail on each level of response.

Outcomes of investigations are determined at the end of an investigation, as to whether abuse has happened or not.
The outcome can be either;
Substantiated – the allegation of abuse is substantiated, on the balance of probability.
Not Substantiated – it is not possible to substantiate on the balance of probabilities the allegation of abuse made
Inconclusive – it is not possible to record an outcome against either of the other categories. For example, where a suspicion remains but there is no clear evidence.

Case Conference – for all level 3 and 4 investigations there should be a case conference. The purpose of the Case Conference is to ensure an effective protection plan is in place, to agree the outcome of the investigation to ensure feedback to those that need to be advised, and to ensure the views of the person alleged to have been harmed are heard.

Summary of Main Points to Note

- There has been a year on year increase in safeguarding alerts for adults since 2004. Last year showed the smallest increase of 2%, when in previous years the increase has been between 20% and 60%. This year there have been 1,288 safeguarding alerts, making an increase of 437 alerts from last year, a 51% increase, which is the highest increase for 3 years.

- The proportion of alerts which were not considered appropriate for investigation under the safeguarding procedures is 17.3%. This is slightly higher than last year, where alerts not for investigation were 13.8%. This year 1,065 investigations have been undertaken, compared to last year's figure of 734.

- The proportion of alerts by client category continues this year at similar proportions to last year. For

example, the proportion of alerts for people over 65 was 52%, and this year it is 54%. For people with a learning disability it was 23% and this year it is 22%.

- Allegations of physical, psychological and financial abuse and neglect are the most frequent. This is similar to last year, although this year allegations of physical and psychological abuse have increased slightly, and allegations of financial abuse have decreased from 23% to 18.8%, and allegations of neglect have decreased from 22% to 15%.

- The levels of investigation have had some change since last year. Last year Level 1 was 34%, Level 2 28%, Level 3 34% and Level 4 was at 4%. This year Level 1 has increased to 39.3%, Level 2 has increased to 31.2%, and Level 4 has increased to 6%. Level 3 investigations have decreased to 25%.

- Despite the decrease in Level 3 investigations, the general increase in numbers of alerts and investigations across all client groups is having an impact on investigating teams. It is as yet unclear as to why safeguarding alerts have increased so steeply this year, although safeguarding work continues to be increasing nationally, as well as locally. Measures are in place to ensure that the right staff are in the right place so that this work can be dealt with appropriately.

- Figures 7-9 show information for 8 months, from October 2009 to end March 2010. This information started to be collected from October as this is data that is now required to be reported on nationally. This is therefore the first time we have been able to analyse this information. From figure 9 we can see that for the 6 month period allegations of abuse in the vulnerable person's home and in supported accommodation are the most frequent. Figure 8 shows that the most common relationship of a person alleged to have caused harm to a vulnerable person is a relative or partner, followed by other family members and other vulnerable adults.

- Figure 7 shows the source of safeguarding referrals, for the 6 month period. The highest source of referrals come from staff working in health services, and staff from the private and voluntary sector. The data in figures 7-9 will now continue to be collected, and a full year's data will be available in next year's annual report.

- The outcome from investigations is shown in figure 10. This shows that 48.7% of completed investigations into allegations of abuse have been either substantiated or partially substantiated. This is an increase from last year, where 'inconclusive', 'substantiated' and 'not substantiated' were evenly divided.

3.2 Performance Data 2009 – 2010

Figure 1: Shows the proportion of safeguarding alerts raised divided into the needs of the vulnerable person

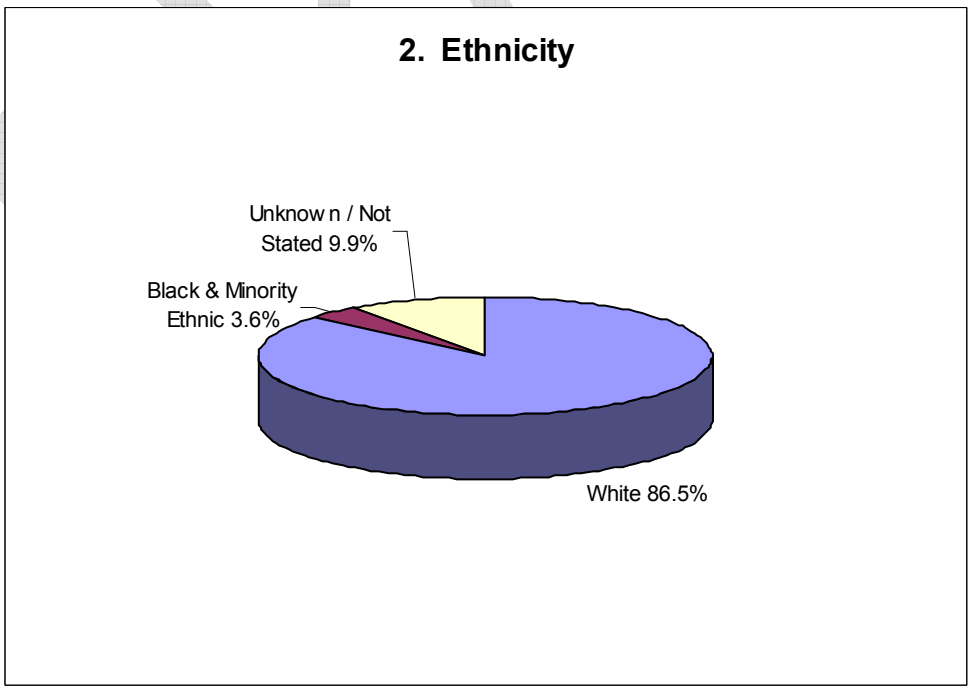
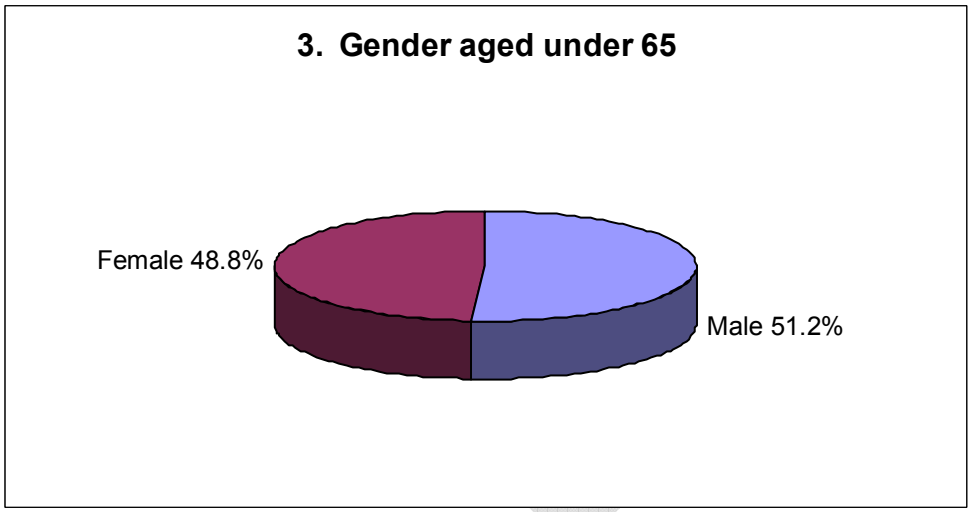
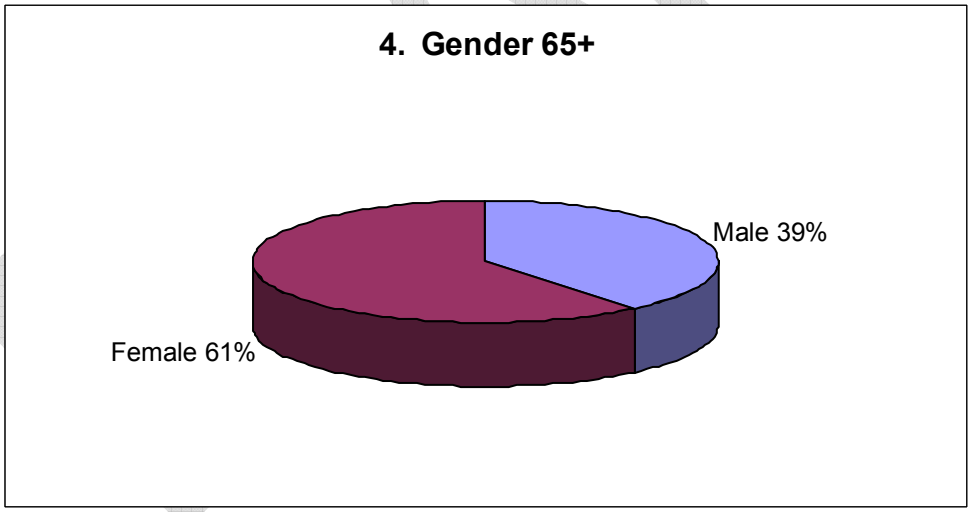


Figure 2: Shows the ethnicity of the vulnerable person for whom a safeguarding alert has been raised





Figures 3 & 4: Shows the Gender of the vulnerable person for whom a safeguarding alert has been raised, divided into under and over 65 years of age

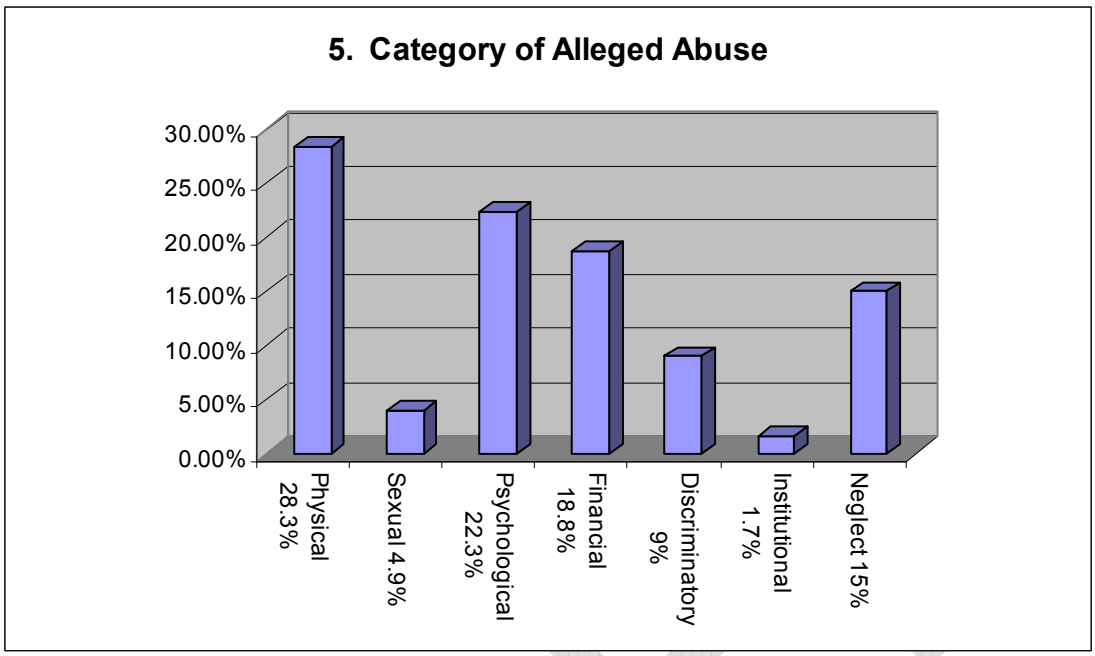


Figure 5: Shows the type of abuse alleged against the vulnerable person

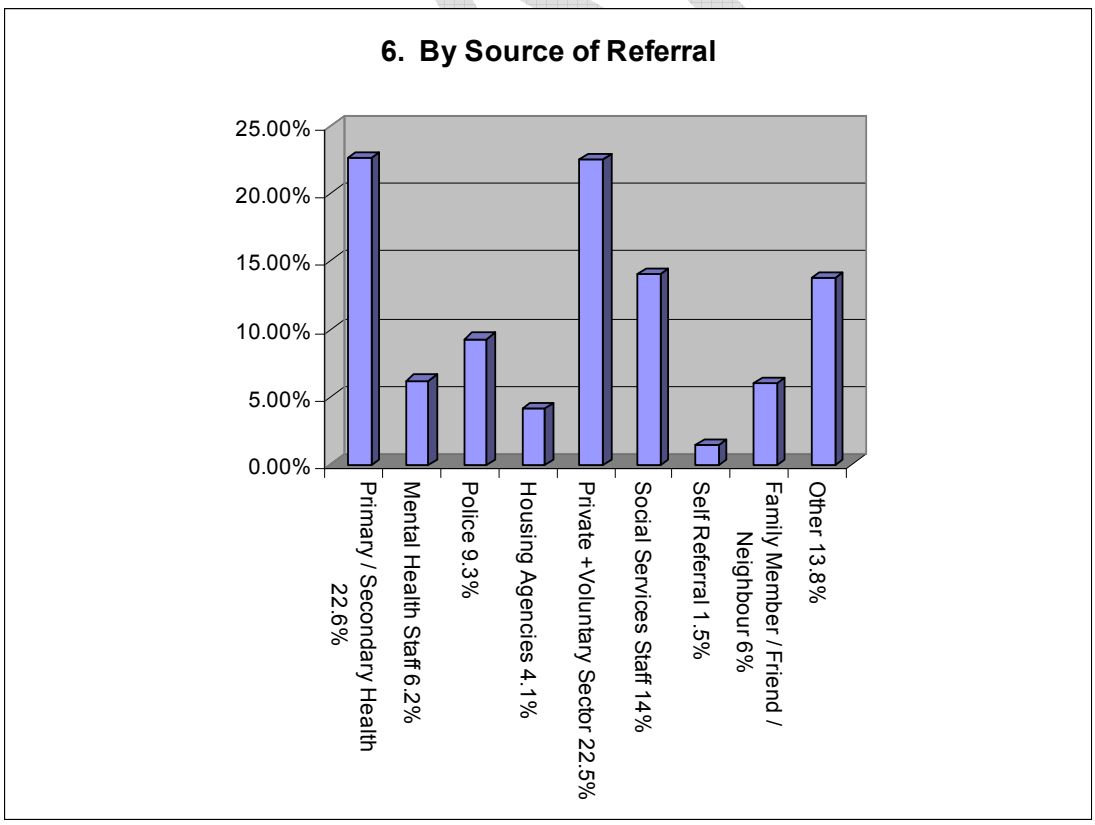


Figure 6: Shows the breakdown of the source of the safeguarding alert, showing who has raised the concern with social services

Figure 7: Shows the relationship to the vulnerable person of the person alleged to have caused the vulnerable person harm

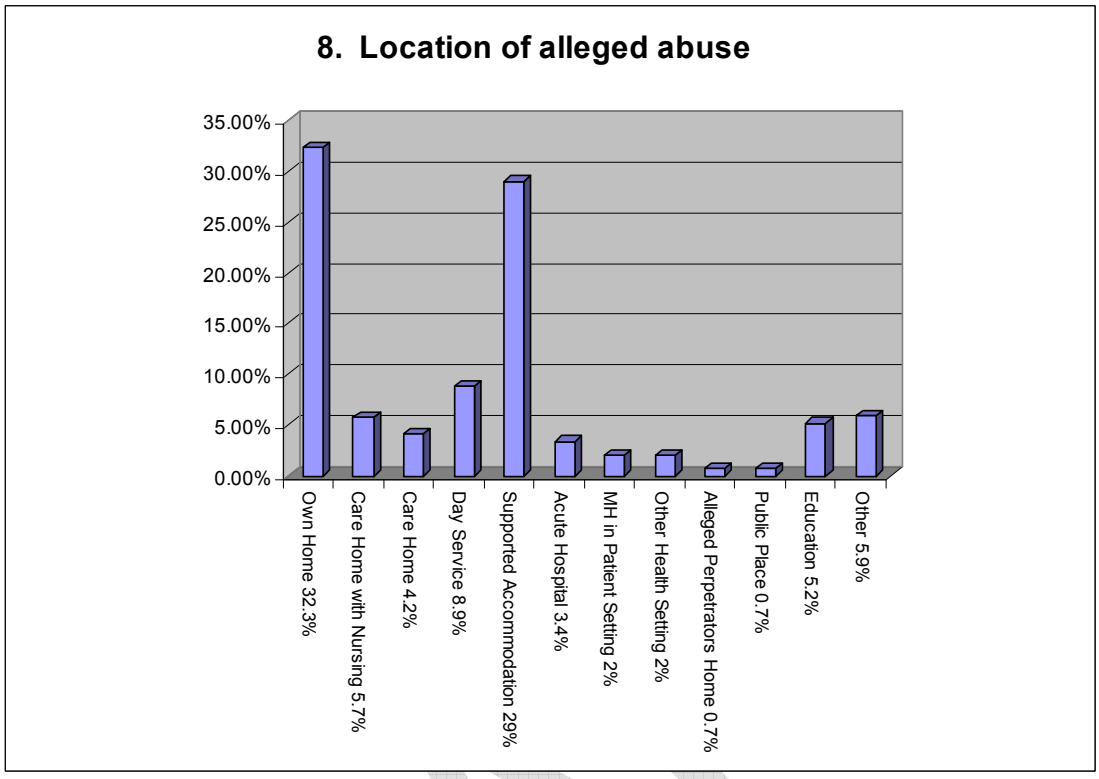


Figure 8: Shows the breakdown of safeguarding alerts by location of alleged abuse

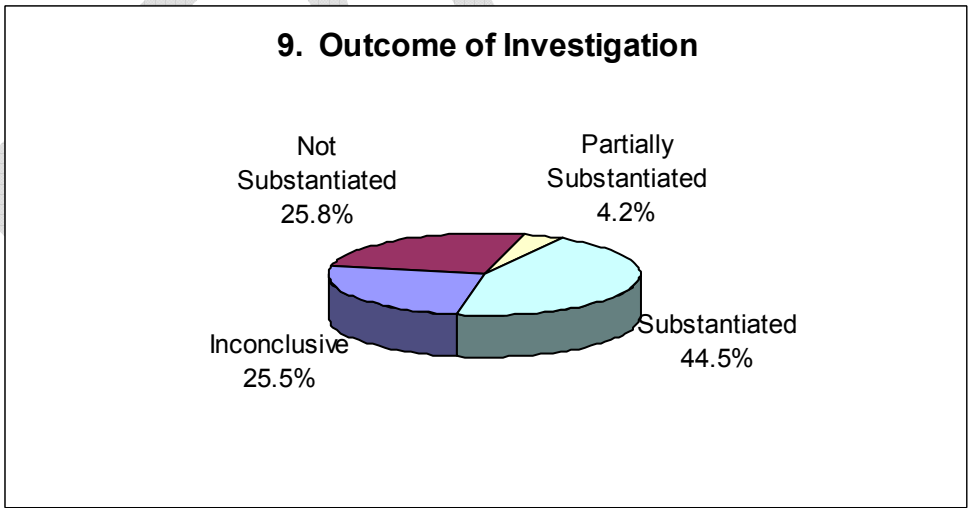


Figure 9: Shows the outcome of concluded safeguarding investigations, showing proportionally the number of investigations where abuse was substantiated

Partner Organisation Reports

4.

4.1 Supporting People, Brighton & Hove City Council

Primary Role

To ensure that service users who receive support funded by "Supporting People" are safeguarded from abuse.

Key responsibilities

To ensure that Supporting People contractors fulfil their obligations under the Supporting People Contract by:

- Assessing each service under section 1.3 "Safeguarding and Protection from Abuse" of the Quality Assessment Framework to ensure a commitment to safeguarding the welfare of adults and children using or visiting the service and to working in partnership to protect vulnerable groups from abuse.
- There are robust policies and procedures for safeguarding and protecting adults and children that are less than three years old and in accordance with current legislation.
- **Ensuring that staff are aware of policies and procedures and their practice both safeguards clients and children and promotes understanding of abuse.**
- **Ensuring that staff are made aware of and understand their professional boundaries and their practice reflects this**
- **Ensuring clients understand what abuse is and know how to report concerns**
- **Ensuring the service is committed to participating in a multi-agency approach to safeguarding vulnerable adults and children**
- **Ensuring that contractors are appropriately alerting Adult Social Care of incidents of suspected abuse.**
- **Ensuring that there is a planned approach to victim support and to dealing with perpetrators.**
- **Ensuring that staff receive appropriate training in the safeguarding of adults.**

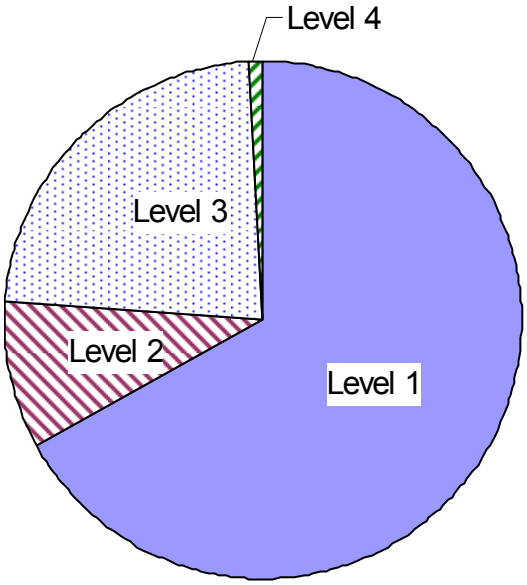
Safeguarding Adults alerts recorded in SP services 2009-10

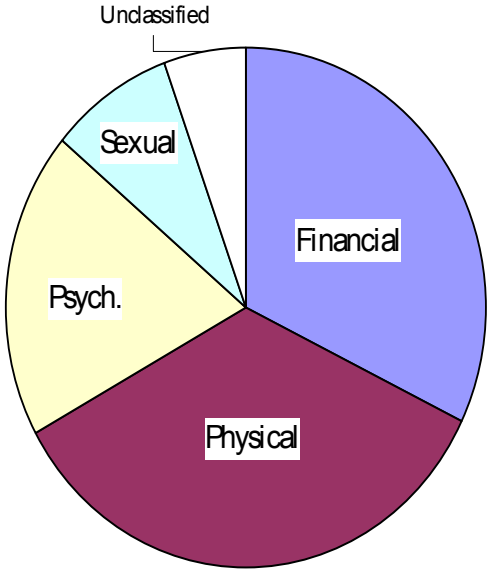
Since April 2008, services have been feeding back quarterly to the Commissioning Team (Supporting People) on the nature and management of Safeguarding issues in their services. All alerts are brought to the attention of the SP Project Officer monitoring the contract.

The following is a summary of alerts recorded for financial year 2009-10:

Nature of abuse	Total	Level 1	Level 2	Level 3	Level 4
All	**109**	**73**	**10**	**25**	**1**
Financial	**35**	22	6	7	0
Physical	**38**	30	2	6	0
Psychological / Discriminatory	**21**	18	1	2	0
Sexual	**9**	2	1	5	1
Not defined	6	1	0	5	0

The figures show the forms of abuse recorded for each alert. Note that in some instances more than one form of abuse are being investigated.





In this second year of monitoring, recording has significantly improved with a reduction in the proportion of unclassified cases from 20% to 6%.

The cases that have been classified indicate:

- Financial abuse and physical abuse remain the most common at 34% and 37%, respectively.
- Psychological/discriminatory abuse incidents comprise 20% of cases
- Of 103 alerts, there were 9 cases of Sexual abuse.

In terms of vulnerability:

- Nearly 40% of cases concerned vulnerable adults in the Single Homeless Integrated Support Pathway, three-quarters of which were recorded at level 1. There were 5 cases at level 3, 3 in relation to the same individual.
- 28% of alerts were recorded by services for people with Learning Disabilities. 7 cases were assessed at level 3, 3 concerning suspected sexual abuse. The service has sought capacity assessment of the affected service user and the alleged perpetrator has been

bailed pending charges.

- 16% of cases are with a specialist money advice service, where in many cases the service has been brought in as part of the protection plan for the client. All but one of the cases relate to financial abuse. Half also address physical threats.
- Levels of abuse in Sheltered services have reduced from 13% to 6% in 2009.
- 6 cases in Mental Health services, including 2 at level 3 relating to domestic violence and sexual assault.
- Alerts at level 4 have reduced from 18 in 2008-9 to 1 in 2009-10. The later case led to a criminal investigation and application for an Emergency Protection order.

Provider reports indicate all services act promptly and decisively in addressing concerns.

Queries are sometimes raised over how alerts are investigated and resolved in cases where clients do not fit within established categories of vulnerability (e.g: homeless clients who do not meet statutory thresholds but whose vulnerability is compounded by a number of issues). Amongst measures being taken to address this, the Rough Sleepers Street Services Relocation Team is opening up its Safeguarding Hub to hostels in the city, to address alerts and associated risks.

4.2 Sussex Police

Safeguarding Vulnerable Adults 2010 – Brighton and Hove

Sussex Police Specialist Investigation Branch (SIB) oversees the policing of Adult Safeguarding across the whole of Sussex. The Branch representatives attend the Adult Safeguarding Board and Performance, Quality and Audit Group. SIB reps. now chair a Pan-Sussex Adult Safeguarding Group which encourages consistency across the whole of Sussex. Reps. also attend the Pan Sussex Investigative Training Group to develop expertise in investigations. Adult Safeguarding investigations continue to be an important part of the role of the Anti-Victimisation Units (AVU) located in Brighton police station managed by a dedicated detective inspector.

In April 2009 the DASH (domestic abuse stalking harassment and honour based violence) risk tool was introduced fully in by Sussex Police and all officers have had the opportunity to attend briefing sessions. Abuse by family members is recorded as domestic abuse and DASH has increased the opportunity to identify vulnerable of victims. Risk management training is now being rolled out to all officers for a better understanding of DASH and vulnerable adults. Newly promoted supervisors are trained to identify vulnerability and safeguarding concerns.

During 2009 police investigators in Brighton and Hove video interviewed 146 vulnerable adult witnesses in the course of investigations, 12 (8%) of these were recorded as having been joint interviews with a police interviewer and a trained social worker. A joint ABE refresher/update training event was held at Slaugham Manor in October 2009 for police officers and social workers to encourage more use of joint interviewing. The ABE interview process will be changing to a digital format and an audit process will be developed by SIB to ensure more accurate data is collected about each interview undertaken. National data is now being collected on the use of intermediaries; used 9 times in Sussex in the last 6 months of the year. Work is now being done to increase awareness of this service and encourage more extensive use to support vulnerable witnesses at court.

The Sussex Police Vulnerable Adult at Risk form is now in use by police officers and recently became an auditable electronic form. More vulnerable adults in need are now being routinely flagged to social

services by police officers. Changes to the form have already been implemented based on feedback from adult services teams and future plans include a secure email link directly between police and social services to aid communication.

The service at the Saturn Centre (sexual assault referral centre for Sussex) has continued to develop over the last year. This has included the opening of a second medical room to avoid delays at busy times. During 2009 a total of 24 vulnerable people from Brighton and Hove used the service and a further 13 vulnerable people self referred.

2010 will see a new Safeguarding Vulnerable Adults Policy for Sussex Police to incorporate elements of the forthcoming Sussex Policy and Procedures. This will include a more standardised response to adult safeguarding serious case reviews which are placing an increasing demand on statutory agency resources. The introduction of the Domestic Homicide Review process in 2010 will present further challenges but will hopefully improve services across the board through learning the lessons in every serious case.

From April 2010 we welcome a new head of branch, Detective Superintendent Jane Rhodes

Detective Superintendent Steve Fowler
Specialist Investigation Branch, Sussex Police

4.3 South Downs Health NHS Trust (SDHT)

Safeguarding Adults' Report for April 2009 – March 2010

SVA Role	Name
Executive Lead	Andrew Harrington Interim Director of Nursing and Governance
Operational Lead	Janet Heath Lead Nurse Manager

SDHT Safeguarding Vulnerable Adults Development and Operational Group, update:

A new group was formed in July 2009 entitled the 'Safeguarding Vulnerable Adults (SVA) Development and Operational group. The purpose of this group was to:

- Produce a SDHT SVA policy and underpinning procedures that provided a framework for action, emphasising good practice in the prevention of abuse.
- Make recommendations and to ensure robust processes are developed to support SDHT staff in their safeguarding adult's work
- Share recommendations with the Brighton and Hove City Council (BHCC) SVA lead and multiagency safe guarding adults board.

The membership of this group includes managers from all SDHT clinical services (nurses and social workers), BHCC SVA lead, SDHT Clinical Education Manager.

The group is chaired by the SDHT Lead Nurse Manager SVA operational lead with key issues and areas of risk reported to the SDHT 'Clinical Governance Patient Safety Committee'

The group have so far:

- Produced a SDHT SVA policy and discussed in teams with front line staff
- Produced a SDHT procedure for a 'request by BHCC for a Health Investigation Officer (HIO) to support a SVA investigation'.
- Developed a process for recording an alert and the outcome of the investigation
- Designed a Health Investigation Officer training programme
- Reviewed SVA training statistics for 2009/10 and made recommendations for 2010/11

The new process for recording an alert and the outcome will enable SDHT to analyse the number and level of alerts raised, types of abuse and outcomes of investigations. This information will be collated on a quarterly basis, presented to the SVA Development and Operational group where lessons learned and recommendations for future improvements will be made.

For this year the number of incidents raised by SDHT and investigated by BHCC will be included in the statistics and analysis section of this report and therefore not referred to in this chapter.

Safeguarding Adults' Training update:

Basic Awareness Level SVA training

Over the last financial year (2009/10) South Downs Health Trust has been working to a target of training 388 staff in Basis Awareness. The Trust was able to train a total of 305 staff during this period (85% of yearly target). These staff were trained using face to face sessions and the KWANGO e-learning package.

In 2010/11 the Trust has a target of training an additional 200 staff in Basic Awareness, with a further 200 staff requiring a 3 yearly update.

Provider Manager Training

No Provider Manager Training was run in 2009/10. Following publication of the BHCC SVA training competency framework in March 2010, SDHT will be reviewing this training in 2010/11 with a view to running additional sessions for the remaining managers who require this training.

Health Investigation Officer Training

In 2010/11 the Trust will be introducing Health Investigation Officer Training for identified clinical experts to support any potential health investigations within the Trust.

Mental Capacity Act/ Deprivation of Liberty Safeguards Training

Bespoke training for in-patient areas to be developed in 2010/11
The National Learning Management System (NLMS), a free NHS e-learning library, has published programmes for both MCA and DOLS. The suitability of these programmes to meet Trust needs will be reviewed in 2010/11 with a view of using them as part of the Trust MCA/DOLS training plan.

Executive Board

The new SDHT SVA policy identifies that all the executive team will be trained in SVA basic awareness training.

The Care Home (with nursing) Specialist Team (CHST) update:

The SDHT CHST provides support to 27 Care Homes with Nursing (CHwN) including EMI homes in Brighton and Hove. The overriding aim of this service is to work proactively with CHwN to raise standards for residents with both complex and end of life care needs, provide education and clinical skills training, expert advice, reduce unnecessary admissions to hospital and improve the experience of care received by residents.

During the year there have been a number of large scale SVA level 3 and 4 investigations in (CHwN) BHCC have requested input from CHST in the investigation of the health component, when SVA alerts have been raised. This activity is not currently commissioned by NHS B&H PCT and therefore an unmet need, with the CHST being the default service to undertake this work.

The investigation of SVA incidents is often seen by the CHwN to be in direct conflict with the proactive safeguarding role of the CHST that compromises working relationships with the home. During 2009/10, the service spent on average 14 hours a week in SVA work.

Recommendations to review the commissioning of SVA in the nursing home sector with NHS B&H PCT have been stated in a recent review of this service by SDHT.

Partnership developments

Self neglect guidance

SDHT have a representative on a multi agency group to help develop guidance for practitioners to refer to for when someone shows signs of significant neglect.

Mental Capacity and Deprivation of Liberty group

SDHT have a representative on this multi-agency group

Future organisational changes and new SVA model

SDHT is undergoing transformation and organisational changes and will be integrating with West Sussex NHS Trust this year, while also being awarded the management contract for East Sussex. To support such changes a project is underway to determine a SVA model for the new Sussex Community NHS Trust.

4.4 Brighton and Sussex University Hospitals Trust (BSUH) – Safeguarding Vulnerable Adults 2009/10

Brighton and Sussex University Hospitals Trust (BSUH) – Safeguarding Vulnerable Adults 2009/10

BSUH Internal organisation of Safeguarding Vulnerable Adults
In accordance with 'No Secrets' (DoH 2000), the Trust has a Board lead for Safeguarding Adults.

The Chief Nurse is an active member of the multi-agency Safeguarding Adults Committee.

The table below describes the roles, responsibilities and named individuals for SVA in BSUH:

Role	***Named individual***
Lead Director for Safeguarding Adults	Alison Robertson, Chief Nurse 'till February 2010 Sheree Fagge Chief Nurse from February 2010
Operational Lead for Safeguarding	Caroline Davies, Senior Nurse, Practice Development

The Quarterly steering group meetings with the individuals responsible for Safeguarding Adults in Brighton and Sussex University Hospitals NHS Trust (BSUH) and the Hospital Social Work managers from Brighton and Hove, East Sussex and West Sussex Local Authorities are well established and continue to further develop the Safeguarding Adults agenda in BSUH. At each meeting a summary report of SVA Alerts raised in BSUH is compiled by both West Sussex and Brighton and Hove for discussion.

An Annual Report on Safeguarding is received by the Trust Board.

The Directorate of Professional Standards and Governance holds a database on which all SVA alerts raised concerning BSUH staff or services provided by BSUH are logged.

All these alerts are investigated in accordance with local adult protection investigation arrangements. The Operational lead for SVA monitors the database and the actions arising from the SVA investigations and provides feedback to Matrons and the relevant Associate Chief Nurse as appropriate.

Alerts made to Brighton and Hove Council April 2009 – April 2010

The following tables summarises the number of alerts made and received:

	Concerning BSUH Services	Alerts made in BSUH about other services (e.g. Nursing Homes)	Total
Level 1	**22**	**4**	**26**
Level 2	**0**	**6**	**6**
Level 3	**7**	**6**	**13**
Level 4	**0**		
Total	**29**	**16**	**99**

The number of alerts made about BSUH services, has risen from 19 in 2008/9 to 29 in 2009/10. This increase is likely to reflect an increase in awareness and the phenomena has found in other organisations.

About two thirds of alerts concerning BSUH services were at level 1 and investigated internally. The results of these investigations were 8 unsubstantiated and 10 inconclusive in outcome. 1 investigation is still ongoing and the results of the remaining 3 are not recorded.

The total number of alerts raised concerning patients from other services was 16, a reduction from 41 the previous year. The reason for this decrease requires further investigations as it appears to go against the wider trend.

There was a total of 6 alerts raised, both by and about BSUH services, which were deemed not be to safeguarding issues.

37% of all level 1 investigations were completed within the timescales required. The average overrun of the other investigations was approximately 14 days (range 1 – 41 days).

The process for Level 1 investigations has undergone review. There has been investment in investigators training and there are now a pool of 21 investigators (increased from 18), the majority of which are at matron grade. All Level 1 investigations are carried out by an investigator who is external to the area in which the alleged incident occurred to ensure greater objectivity and transparency.

A protocol has been devised to support and clarify the process for performing SVA investigation and internal BSUH Human Resources investigations concurrently, and is currently at the final consultation stage. This aims to ensure efficient and fair investigation of all aspects of an alert by eliminating duplications in the investigation process.

Interagency working across the Health and Social Care Economy

The Senior Nurse for Practice Development has monthly meetings with Brighton and Hove senior hospital social workers to develop practice and improve process. This has proved an effective means of monitoring the quality of Level 1 investigations and raising issues relating to SVA.

The Senior Nurse for Practice Development is an active member of the Sussex NHS SVA Leads forum, which is developing joint working across all NHS organisations and undertaking peer reviews of SVA cases in each others' organisations.

Training

Safeguarding Vulnerable Adults basic awareness training is mandatory for all clinical staff in BSUH. An introductory SVA session is included in the corporate induction process and 754 staff have attended these sessions during 2009-2010. 384 staff have attended the mandatory Basic Awareness training during the past year. This represents a significant improvement on previous the previous years activity (250) but still short of the target of 400. Since 2006 1488 staff have had the Introductory session and 1078 have attend Basic Awareness; about 36% of the total workforce.

There has been an issue with locating and uploading historical training records before April 2009, which means these numbers are likely to be conservative as it is thought that more training may have occurred for which the records are unavailable.

It has been agreed that two yearly update of SVA training will be mandatory. A self assessment tool and associated process has been developed to support this initiative and is currently at the pilot stage.

A briefing on SVA is now part of the Corporate Induction Programme for all staff. All new staff have received this briefing, which outlines everyone's responsibility for SVA and how to alert the Local Authority to concerns.

SVA basic awareness has been running since February 2009 on a monthly basis, as part of a day on Safeguarding Adults, children and domestic abuse and has proved a very popular means of delivery. Ad

hoc sessions are undertaken in specialist areas. To address the shortfall in training numbers; specialist clinical educators in areas such as ITU, renal and cardiac have trained to deliver this teaching. It is proposed to run further 'train-the-trainer' sessions during the coming year and to arrange the first Annual update session in late 2010.

A joint workshop was held September 2009, which will concentrated on SVA investigations which have human resources implication. An update session for investigators will be held in late 2010 to focus on any changes in process or guidance, give investigators the opportunity to share experiences and lessons learnt, and to provide peer support. It is planned to make this an annual event.

The Senior Nurse for Practice Development remained an active member of the multi agency Training Group for SVA, which has been instrumental in the development of accreditation for SVA Training across Brighton and Hove.

Future Plans

1. To transfer responsibility for SVA to the Nursing Delivery Unit, with the Operational Lead for SVA being assigned to the Senior Nurse for Standards and Quality
2. To explore how intelligence derived from monitoring and investigating alerts can be best used to focus support and effect improvement
3. To introduce Annual Updates for SVA trainers
4. To introduce Annual updates for SVA investigators
5. To roll out self-assessments tools to support the introduction of 2 yearly mandatory updates to SVA training
6. To agree and implement protocol for the concurrent running of SVA and internal investigations
7. To develop and improve the feedback mechanisms to alerters.

Caroline Davies/Shaun Marten

May 2010

4.5 Sussex Partnership NHS Trust – Brighton & Hove Locality

The Trust provides integrated services across Brighton and Hove. The Trust manages a number of Adult Social Care staff in mental health and substance misuse services under a Section 75 Health Act secondment arrangement..

Performance and Practice

Overall the data for 2009/10 shows an increase in reporting year on year in seconded services in Brighton and Hove and across the City. Activity is anticipated to continue to increase in the coming year. All care group areas; Older People Mental Health, Working Age mental health and Substance Misuse Services report an increase in adult safeguarding work. A safeguarding audit of case files and electronic recording in Brighton and Hove that included community mental health and substance misuse highlighted the need for improvement to integrated recording and reporting systems. The development of a specific social care admin support team in working age mental health and older peoples services will enable a more stream line pathway for safeguarding referrals in to the Trust from the adult social care "access" point.

Brighton & Hove "provider" training to substance misuse residential provider services have significantly increased alert activity. Most alerts have been dealt with at level 1 of the process and have also led to a number of new service users being engaged into treatment for their substance misuse as a positive outcome

Increase alerts have also led to a renewed action to train more health staff within the integrated teams beyond awareness of safeguarding so they can also act as safeguarding investigators and managers.

Better Information from Safeguarding alerts is also providing valuable data and indicators in some cases around quality of care this is now being used alongside other data such as Serious Untoward Investigations to inform the focus of governance/ service reviews.

Training and Governance
All social care staff receive information on Safeguarding Vulnerable Adults at induction. Further training is provided according to the involvement and requirements of staff specific to there post, role and responsibilities. Those staff groups who have most involvement with service users will have a system of mandatory training and during 2009 the Trust along with Adult Social Care have made further investment in specific e-learning software to further support broader understanding and awareness of safeguarding within the specific context of mental health, and substance misuse services.

Structural management changes within the Trust has ensured there is a clear link to each of the new integrated governance teams (IGT) in which accountability for safeguarding will come for each care group, whilst also facilitating appropriate accountability to the existing local Safeguarding Adults Boards .

4.6 Brighton and Hove Domestic Violence Forum

Primary Role

The Brighton & Hove Domestic Violence Forum is the multi agency forum that enables and promotes joint working, co-operation and mutual support to workers and their organisation in dealing with domestic violence. Furthermore it aims to increase awareness of domestic violence and its effects within the community and the public at large, voluntary organisations and statutory agencies. The chair of the forum sits on the Domestic Violence Senior Officers Group which in turn feeds into the Crime and Disorder Reduction Partnership.

Key Responsibilities regarding Safeguarding Adults

- To give the Domestic Violence Forum perspective in the development of Safeguarding Adults policies and procedures
- To contribute and to comment on Safeguarding Adults documents
- Representatives attend Safeguarding adults meetings and conferences
- To promote greater awareness of domestic violence issues, developments and services, and to disseminate information, policies and procedures to Safeguarding Forum members
- To promote greater awareness of Safeguarding adults policies and procedures and issues for Domestic Violence Forum members and to disseminate information
- To work jointly with forum representatives to develop joint protocols, policies and procedures and practices in protecting vulnerable adults affected by domestic violence
- To identify gaps in service provision and training needs for members of both forums
- To promote effective communication between safeguarding adults and domestic violence forums

Summary of Activities for 2008-2009

- The Domestic Violence Forum representative regularly attended Safeguarding Adult meetings
- A workshop on Domestic Violence was co facilitated by members of the Domestic Violence Forum and Adult services at the November 2008 Safeguarding Adults Conference
- Domestic Violence Forum members also attended the conference

- A joint protocol for working with domestic violence and safe guarding adults was developed
- Rise (formerly the Women's Refuge Project) runs Domestic Violence Awareness training for the Brighton and Hove City Council
- Representatives from Adult services attend Multi-Agency Risk Assessment Conferences (MARAC)

Objectives for 2009-2010

- A Domestic Violence and Safeguarding workshop will be facilitated by Rise and the Domestic Violence Strategic Co-ordinator at the December 2009 conference

- The new domestic violence and sexual violence occupational standards will be integrated into the way training for adult services teams are developed and domestic violence awareness training will be further developed

- Understanding and further development of the multi-agency forced marriage guidance will be integrated into the working practice of all frontline workers

- Consultation and training and access to training on adult protection policies and procedures for voluntary sector members of the forum to be formalised

- Further embedding of good practice related to identifying, assessing risk and safety of survivors and their families and supporting them through multi-agency working when adults disclose domestic violence

- Review and consolidation of the joint working practices and protocols.

4.7 Practitioner Alliance against abuse of Vulnerable Adults (PAVA)

The Practitioners Alliance Against the Abuse of Vulnerable Adults works in partnership with practitioners in the statutory, voluntary and private sectors to generate positive outcomes in working with vulnerable adults who may suffer from abuse.

The Brighton and Hove PAVA Group is in its 4th year and meets quarterly. Meetings are attended by representatives from a wide range of organisations with an interest in Safeguarding Adults who take the opportunity to network, share information and good practice, receive updates on legislation and procedure and hear from a diverse range of speakers.

The terms of reference of the Group include increasing skills, knowledge and awareness of Safeguarding Adult issues. Input from Brighton and Hove City Councils Safeguarding Adults Manager and Learning and Development Team provides a unique opportunity for practitioners to liaise, raise concerns and keep abreast of local practice. A PAVA group representative sits on the Safeguarding Adults Board and vice versa and this reporting mechanism formalises and strengthens the link between practitioners and those responsible for the safeguarding in the city.

Activities in the year
Updates on changes in legislations and procedures and advance notice on forthcoming changes, such as consultation on a new alerting form, sharing of the new safeguarding Operational Instructions, sharing of safeguarding data for the Brighton and Hove area, and changes to the 'vetting and barring scheme' and the Independent Safeguarding Authority.

Discussion topics include; feedback on alerting and investigations, training, Safeguarding Adults

Conference and Hate Crime reporting.

This year the structure of the meetings has changed, with 2 meetings per year being held as workshops, with case studies being used for learning and reflection.

Workshops held have been

- Financial abuse case studies, looking at recognising signs of financial abuse, and the options available to support someone to manage their monies safely.
- Understanding the levels of investigation, with case studies to consider risk and the impact on the vulnerable person, in order to agree an investigation level.

Speakers for this year

- The Dignity Lead in Brighton and Hove Council, giving an overview of the Dignity Campaign and the 10 dignity practice challenges.
- Sussex Police, from the Chief Inspector who has a lead for domestic violence cases, looking at the similarities and differences between safeguarding adults procedures and those used in domestic violence investigations.

Future Plans

PAVA Group involved in CQC Inspection
Older People's Event
Disability Day
To use 2 meetings per year as workshops.

4.8 Social Care Contracts Unit

The role of the Social Care Contracts Unit is set out in the *Sussex Multi-Agency Policy and Procedures for Safeguarding Vulnerable Adults* which states that it "should assist and support operational colleagues in the event that adult protection concerns are raised in settings where a service user is receiving services under contract, for example in a care home or at home." This role includes attendance at Safeguarding meetings, and the Head of that Unit deciding, from evidence received from the investigating team, whether or not to suspend placements in the case a care home, or preventing the provider from taking on new work in the case of home care agencies.

Throughout the previous year the Contracts Unit has built on its recently acquired role of escalating concerns about individual providers to operational managers in cases where there is a pattern of negative reporting about that service. This is particularly pertinent if there is a flurry of level one alerts, particularly when they relate to a specific area of service provision (e.g. manual handling, diet, equalities), or where these alerts resonate with other concerns, such as poor quality standards, a high number of incident reports submitted to the Unit, or poor outcomes for service users evidenced through completed service user satisfaction questionnaire returns. Within the reporting period there have been two occasions when the Contracts Unit has escalated concerns, both of which related to Older People Mental Health (OPMH) care home services.

The Contracts Unit also has a preventative role, through its monitoring of contracted services. The most intense monitoring occurs in those services involved in providing direct care to vulnerable people. Whilst within care home services this is achieved through the completion of Desk Top Reviews and subsequent monitoring, annual audits are undertaken on all approved providers of domiciliary care. Aligned to nursing home provision is the role of the Clinical Quality Review Nurse who undertakes clinical audit on all in-City nursing homes. Whilst there is no clear evidence to suggest that the monitoring which the Contracts Unit

undertakes on these providers has reduced the number of safeguarding alerts, there has been a definite improvement in the quality of provision within the City as a direct result of these interventions.

Conversely, the Contracts Unit will also address ongoing quality standard issues at the point a safeguarding investigation has reached closure, and more routinely at Contract Review meetings where previous and current safeguarding alerts are included as a standard item across all services, thereby providing a good way of picking up on any outstanding issues in this respect, both from a Council and a service provider perspective.

The Contracts Unit is routinely invited to meetings relating to alerts relating to Older People, OPMH and physical disability care homes. However, this does not happen with the same frequency in Working Age Mental Health Services, and is sporadic with those alerts relating to domiciliary care services, and Learning Disability Services.

There is a Safeguarding lead in the Contracts Unit who meets regularly with the Council's Safeguarding Adults Manager, and attends the Safeguarding Board, and the Safeguarding Adults Multi Agency Forum. The Unit also collates information relating to alerts received and reports these to the Board on a regular basis.

In the year ahead the Contracts Unit will continue to build on its existing roles, and continue to develop relations with those operational teams who do not routinely engage with the Unit over safeguarding matters relating to contracted services. The Unit will be reviewing and amending this role in the light of planned changes within the CQC, and the ending of the star rating system. The Unit has already made a start on this by forming a Care Governance Panel whose aims include co-ordinating the quality monitoring of social care services, and developing a quality rating system to replace that previous used by the CQC.

4.9 DoLS Safeguarding

The Deprivation of Liberty Safeguards (DoLS) became law in April 2009. These safeguards apply to people in England and Wales who have a mental disorder and lack capacity to consent to the arrangements made for their care and treatment; but for whom receiving care and treatment in circumstances that amount to a deprivation of liberty may be necessary to protect them for harm and appears to be in their best interests. These safeguards only apply to people detained in a hospital setting or a care home registered under the Care Standards Act 2000.

The Deprivation of Liberty Safeguards came into being due to the European Court of Human Rights ruling in 2004 on the Bournewood case which highlighted the need for additional safeguards for people who lack capacity and might be deprived of their liberty. The Bournewood case concerned an autistic man with severe learning disabilities who was informally admitted to Bournewood Hospital in Surrey under common law. The European Court of Human Rights found that he had been deprived of his liberty unlawfully, because of a lack of a legal procedure that offered sufficient safeguards against arbitrary detention and speedy access to a court. The Deprivation of Liberty Safeguards have closed the 'Bournewood Gap' and will ensure compliance with the European Convention on Human Rights.

In Brighton and Hove the Deprivation of Liberty Safeguards service is being run in partnership with the City Council and the Primary Care Trust (PCT -NHS Brighton and Hove) in order to meet the statutory requirements. The City Council carries out assessments for both the Council and the PCT in their role as a Supervisory Body but separate arrangements for authorisations are maintained.

Figures & Trends:

Within the first year of implementation 21 referrals for full DoLS authorisation were received from Managing Authorities (care homes and hospitals). Brighton & Hove City Council was the Supervisory Body for 14 received from care homes and NHS Brighton & Hove was the Supervisory Body for 7 received from hospitals. When arranged into service user groups 10 were known to Mental Health Services for Older People, 5 to Learning Disabilities, 4 for Working Age Adults Mental health services and 2 to Physical Disabilities. Numbers of assessments are reported directly to the Department of Health on a monthly basis. More detailed performance information is reported on a quarterly basis.

Nationally Supervisory Bodies received fewer than planned referrals for DOLS assessments.

48% of referrals led to full DOLS authorisations and 52 % were assessed as not meeting the criteria. This is a higher rate of authorisation than anticipated by the Department of Health but in line with national trends. It was anticipated that only 30% of referrals would lead to authorisation. This might be evidence of a greater level of DOLS knowledge than anticipated and perhaps indicative of an initial cautious approach to the legislation.

The Department of Health anticipated that 80% of authorisation requests would come from care homes and 20% from hospitals. In Brighton & Hove in the first year 33% of authorisations have come from hospitals. The Care Quality Commission has paid particular attention to the numbers of authorisations from hospitals; both psychiatric and acute medical and it will be a challenge in Brighton & Hove to maintain these figures.

The Access Point in Adult Social Care is the central point of contact for all DOLS referrals and enquiries on behalf of both the City Council and the PCT. Within the first year 87 DOLS enquiries were logged by the Access Point in addition to the requests for assessments. The majority of those are clinical case work enquires which are passed on to trained staff to answer.

Training:

Prior to 1st April 2009 Brighton & Hove City Council held a 'think tank' in September 2008 attended by multi-agency partners from the NHS, council and the private and voluntary sector.

The Council's Learning and Development Team has provided DOLS briefings since March 2009 and these continue as part of the planned training programme. For the year 2009- 10 the Learning and Development Team delivered training on DOLS to 170 staff. This included staff in Adult Social Care, Learning Disability Services, and Sussex Partnership NHS Foundation Trust. In addition 193 staff from the independent and voluntary sector accessed the Council's DOLS training. 4 carers and personal assistants also attended.

The operational DOLS lead for the Council and the PCT delivered bespoke training sessions to Sussex Partnership NHS Foundation Trust in-patient units, Community Mental Health Teams for Older People, Adult Social Care Access Point, Transitional Care Team, Learning Disability Provider Forum, BSUH Matrons, Leaders Forums for both Sussex Partnership NHS Foundation Trust and Southdowns NHS Trust, Mind, Advocacy Partners, Alzheimer's Society and numerous nursing and care homes across the city. These sessions continue to take place.

Before April 2009 two DOLS bulletins were sent to all Managing Authorities within Brighton & Hove; both registered care homes and hospital trusts. There will be further similar publications in the future to support the on-going implementation of DOLS.

Best Interests Assessor Training was commissioned by the Council and the PCT prior to April 2009 and

delivered by Brighton University. Six members of staff across mental health, learning disability and older people's services passed the training and have been working as Best Interests Assessors since April 2009. Following a brief period with a dedicated worker the Best Interests Assessors have been operating on a rota basis. Further training was commissioned in April 2010 and a further 4 members of staff qualified and will be added to the rota during the summer of 2010. Brighton University has been commissioned by all the Council and PCTs across Sussex to provide the required annual refresher training for Best Interests Assessors whic took place in March 2010. Within Brighton & Hove there are regular Best Interests Assessor meetings to address practice and organisational issues.

Since the inception of the Mental Capacity Act there has been a multi- agency Local Implementation Networ hosted by the Council. This has now been incorporated into the Safeguarding Adults board and a specific Brighton and Hove Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) Monitoring an Development Group has been created to report directly to the Safeguarding Adults Board.

Out of Area

Brighton & Hove City Council and the PCT retain DOLS responsibilities as a Supervisory Body for service us placed in residential care or currently admitted to hospital outside of Brighton & Hove. A national protocol ha been written by the Association of Directors of Adult Social Services which details how to arrange out of area assessments.

As Brighton & Hove place significant numbers of service users in East and West Sussex it has been agreed the DOLS teams in East and West Sussex that they will carry out assessments on our behalf, subject to availability of staff, for service users within their boundaries. In return Brighton will provide independent assessors for their in-house provision. This arrangement has been working well. The Council and PCT retain their responsibilities as the Supervisory Body and continue to agree the authorisations.

Medical Assessment

All the local authorities and PCTs in Sussex have contracted with Sussex Partnership NHS Foundation Trus provide the medical and eligibility assessments for DOLS. The service specification details that all doctors instructed for DOLS assessments have received the appropriate initial and required follow up training. 10 medical assessments were requested in the first year for Brighton & Hove. Contract review meetings are he quarterly.

Independent Mental Capacity Advocates (IMCA)

Advocacy Partners contract was extended to provide the IMCA service for DOLS and also to provide the rol 'Paid Representative' for those people subject to a DOLS authorisation but who do not have anyone willing appropriate to act on their behalf. The IMCA contract provider changed to Pohwer on 1st April 2010. In the fi year 4 referrals were made for an IMCA during a DOLS assessment. A further 8 referrals were made to the IMCA service to act as 'Paid Representative' in the first year. The IMCA service is invited to the Best Interes Meeting and has delivered training jointly with the DOLS operational lead.

The year ahead

Nationally numbers of DOLS assessments have been lower than anticipated and further awareness training required across all Managing Authorities. This will be met by the Council's on-going training programme and bespoke training from the DOLS operational lead. Managing Authorities retain a responsibility to ensure they aware of the DOLS process and access training and remain accountable to the Care Quality Commission.

Additional Best Interests Assessors will increase the awareness in operational teams across client groups a on in-patients units. The newly formed Brighton and Hove Mental Capacity Act (MCA) and Deprivation of Lib Safeguards (DoLS) Monitoring and Development Group will continue to monitor areas of underreporting and respond accordingly.

At the time of writing an increasing number of assessment requests being submitted are granted authorisati This may be due to an increasing knowledge of DOLS in Managing Authorities who are subsequently identif those service users being deprived of their liberty and in need of protection from the safeguards.

East and West Sussex have reduced the numbers of dedicated Best Interests Assessors in their DOLS tean Potentially they will have less capacity to carry out assessments on behalf of Brighton & Hove so we may se staff having to travel further to carry out assessments and extending the periods of urgent authorisation to accommodate these issues.

The number of family members / partners / carers / friends prepared to commit to becoming a Relevant Pers Representative is very small and there is high referral rate to the IMCA service to act as the 'Paid Representative'. There remains a low level of awareness within the general public around DOLS and the Me Capacity Act more broadly. All assessment teams across client groups will have to continue to raise awaren throughout their daily work.

Links to Safeguarding

Whilst the safeguards directly protect the most vulnerable groups of society in care homes and hospitals the has been no clear link with Safeguarding Vulnerable Adults activity to date. The Department of Health has raised awareness of some practice issues which have clear implications for Safeguarding Adults work.

The DOLS assessment process does allow for a Best Interests Assessor to conclude that a service user is being deprived of their liberty which is not in their best interests. This would automatically trigger a Safeguar Alert. In Brighton there have been no such incidences to date and only 125 nationally within the first year.

If the DOLS authorisation is a culmination of a dispute between family members and an NHS Trust or a Loca Authority as to where a person without capacity should live it has been suggested that this should be resolve via the Court of Protection rather than via the DOLS process.

The Best Interests Assessor is able to recommend conditions which become binding for the Managing Autho on the granting of a Standard Authorisation. The conditions must relate directly to the deprivation of liberty a be in the service user's best interests. A safeguarding alert might be issued when the Managing Authority fa comply with the conditions as the care being delivered may not be the service user's best interests and compromise the DOLS decision.

Anecdotally the DOLS process has been used to manage contact issues between a person lacking capacity make decisions to protect themselves from someone poses a risk of harm or abuse. Good practice would suggest that these matters are referred to the Court of Protection and the DOLS procedures used only as a short term measure.

John Child
June 2010

4.10 Brighton and Hove Multi-Agency Adult Protection Training Strategy Group

A competency framework has been introduced in March 2010. A recommendation of *Safeguarding Adults* (ADSS, 2005) is that each organisation should have a competency framework for the different roles in safeguarding. The Board has asked that staff working in Adult social Care follow the framework, and that partner organisations consider how they will respond to the framework.

A new course has been introduced, *Understanding the Levels and the Investigators Role.* This is primarily aimed at people undertaking a level 2 investigation. This has been introduced to meet the development needs of people such as Care Managers assessment teams who are involved in adult protection investigations, but not at level 3 and 4.

Training figures are broadly in line with the previous year. The overall face to face training places coordinated by Brighton & Hove City Council Workforce Development Team is around 1,000 a year. (The National Minimum Data Set shows 3165 people working in the private and voluntary sector of adult social care in Brighton & Hove). The Workforce Development Team will always put on extra courses for safeguarding when demand exceeds scheduled supply, from which one can infer that the uptake of places has reached a plateau.

Accreditation Scheme continues to expand. The Training Strategy Sub Group has set some standards for basic awareness training, and offers accreditation to existing trainers in Safeguarding Adults. 10 training providers have attained accredited status (excluding statutory services). Most accredited trainers are either free lance or working for social care providers, and running the accreditation scheme has illustrated the extent of training activity across the city, and also provided a means to tap into this and work in partnership to ensure good standards.

Multi Agency Safeguarding conference held. This involved key note presentations on hate crime and also the vetting and barring scheme. The evaluations from this have been distributed to the Board. The actions that attendees undertook to implement in their work place include:

- Explore the dignity website and the idea of becoming dignity champion x 2
- Electing a dignity champion. Developing a dignity policy.
- Ensure staff have full understanding on reporting and knowledge of safeguarding procedures.
- Review safeguarding policy so it includes safeguarding regulations.
- Emphasise importance of recording and monitoring hate crime among the services I contract manage.
- Check with the helpline whether the staff and volunteers I manage need to register.
- Look into setting up workshops for Promoting Dignity in my workplace.
- Get the hate crime speaker in to train our staff.
- Will purchase the DVD on Dignity as this was an excellent session and of high value.
- Updating training.

Tim Wilson Development Manager
Workforce Development Team
Brighton and Hove City Council

4.10.1 Safeguarding Adults Training attendance to BHCC organised courses April 2009 – March 2010 (inclusive)

Course Title	Course identifier	Number of courses	Local Authority Attendance	Local authority non attendance	SPFT Attendance	SPFT Non attendance	SDHT attendance	SDHT non-attendance	IVS attendance	IVS non-attendance	Other attendance	Other non-attendance	Total non-attendance	Total attendance
Safeguarding Adults Conference	AD05	1	19	5	14	2	6	4	66	16	10 BSUH 1 CSCI 1 trainer 1 police	1 PA 1 CSCI 1 Police	30	117
Undertaking SVA Investigations (ABE)		1	4	0									0	4
SVA Investigating Managers	AD11	1	6	1	2	1	1	0	0	0	0	0	2	9
Undertaking SVA Investigations	AD34	1	9	0	2	0	0	0	0	0	0	0	0	11
Understanding Levels & Investigators Role	AD47	4	28	5	0	0	0	0	0	0	0	0	5	28
SVA Provider Managers	AD42	6	20	3	0	0	0	0	60	6	0	0	9	80
SVA Update (LD)	LDS18	3	32	5	2	0	0	0	7	0	0	0	5	41
SVA Update (Adults)	OP13	11	81	17	0	0	0	0	76	3	2	0	20	159
SVA Trainers Update	IND01	1	2	0	0	0	0	0	10	0	3	0	0	15
SVA Basic (Care Crew)	AD84	11	83	13	0	0	0	0	0	0	0	0	13	83
SVA Basic (LD)	LDS13	12	135	11	1	0	0	0	58	7	2	0	18	196
SVA for Admin	LDS51	1	10	1	2	0	0	1	1	0	0	0	2	13
SVA Basic (Adults)	OP12	16	79	26	0	0	0	1	122	30	0	1	58	201
SVA Basic (MH)	MH04	8	9	2	52	13	2	0	24	6	0	0	31	87
Totals		72	526	89	94	16	9	6	424	68	20	4	**193**	**1053**

Brighton & Hove Multi-Agency Safeguarding Vulnerable Adults Strategic Objectives and Training Plan 2010-2011

Stage	Learning Intervention	Strategic Objective	Actions to Meet Objectives
1a	Safeguarding Vulnerable Adults Basic Awareness	40 % of frontline workforce to be trained to stage 1 awareness	16 courses (OPS) 7 courses (LDS) 12 courses (MH) 6 (Care Crew)
1b	Safeguarding Vulnerable Adults Basic Awareness Update	29 % of frontline workforce to have been received stage 1 level training in preceding two years	9 courses
1c	Administrative Support for Safeguarding Vulnerable Adults Meetings	10 staff across services will have been trained to stage 1c. Minimum 1 per team.	Achieved – 1 course scheduled Feb 2010
2	Safeguarding Vulnerable Adults for Provider Managers	35 % of staff who manage other staff or who need to undertake level 1 investigations are trained to stage 2.	3 courses (BHCC & Ind & Vol)
3	Understanding the levels and the Investigators Role	50 % of people who undertake level 2 investigations will be trained to stage 3	2 courses
4a	Undertaking Multi-Agency Safeguarding Adults Investigations	90 % of staff in each social work team will be trained to stage 4a	1 course

5. Headline Standards for Safeguarding Vulnerable Adults, a National Framework of Standards for good practice and outcomes in adult protection work 2005

Standard 1	Each local authority has established a multi-agency partnership to lead 'Safeguarding Adults' work.
Standard 2	Accountability for and ownership of 'Safeguarding Adults' work is recognised by each partner organisation's executive body.
Standard 3	The 'Safeguarding Adults' policy includes a clear statement of every person's right to live a life free from abuse and neglect, and this message is actively promoted to the public by the Local Strategic Partnership, the 'Safeguarding Adults' partnership, and its member organisations.
Standard 4	Each partner agency has a clear, well-publicised policy of Zero-Tolerance of abuse within the organisation.
Standard 5	The 'Safeguarding Adults' partnership oversees a multi-agency workforce development/training sub-group. The partnership has a workforce development/training strategy and ensures that it is appropriately resourced.
Standard 6	All citizens can access information about how to gain safety from abuse and violence, including information about the local 'Safeguarding Adults' procedures.
Standard 7	There is a local multi-agency 'Safeguarding Adults' policy and procedure describing the framework for responding to all adults *"who is or may be eligible for community care services"* **and** who may be at risk of abuse or neglect.
Standard 8	Each partner agency has a set of internal guidelines, consistent with the local multi-agency 'Safeguarding Adults' policy and procedures, which set out the responsibilities of all workers to operate within it.
Standard 9	The multi-agency 'Safeguarding Adults' procedures detail the following stages: Alert, Referral, Decision, Safeguarding assessment strategy, Safeguarding assessment, Safeguarding plan, Review, Recording and Monitoring.
Standard 10	The safeguarding procedures are accessible to all adults covered by the policy.
Standard 11	The partnership explicitly includes service users as key partners in all aspects of the work. This includes building service-user participation into its: membership; monitoring, development and implementation of its work; training strategy; and planning and implementation of their individual safeguarding assessment and plans.

6. Brighton and Hove Safeguarding Adults Board Business Plan 2009/11 UPDATED 26.08.10

Action	Date to complete	Target Completion Date and Key Milestones	Progress	Sub group and Lead Officer(s)	Standard 3, 6 and 10 SVA National Framework	Green Achieved Amber Ongoing Red Pending
Objective 1 – All citizens to be able to access information about how to gain safety from abuse and violence, including information about the local multi-agency safeguarding procedures.						
1.1 Launch a Prevention Strategy and action plan for prevention of adult abuse, which links with Risk Policy and Self Neglect Guidance, as well as incorporating the ongoing Dignity Campaign work	April 2011	Prevention Strategy to be approved by all organisations represented at the SAB. Increase public awareness of the safeguarding process, demonstrated by an increase in safeguarding referrals from non professionals		Michelle Jenkins/Sara Fulford		ongoing
1.2 Create a new social work post, whose main purpose is to lead on the implementation of carers' needs, assessment/reviews and other interventions across a range of services – both internal and external to BHCC – in order to improve the support delivered to carers.	April 2011	Continue to monitor alerts raised by and regarding carers, with aim to show increase		Karin Divall/David Jennings		ongoing
1.3 Day Services 'Choices' to offer 'Feeling Safe at Home and in the Community' to people with learning	End Oct 2010	People with learning disabilities to feel more confident in knowing		Naomi Cox		ongoing

Action	Date to complete	Target Completion Date and Key Milestones	Progress	Sub group and Lead Officer(s)	Standard 3, 6 and 10 SVA National Framework	Green Achieved Amber Ongoing Red Pending
disabilities		how and where to gain support if they experience harassment – feedback from course participants				
1.4 Safeguarding training programme to include course for managers of services/teams on raising awareness of safeguarding for people who use services.	April 2011	Vulnerable people to feel more confident and knowledgeable on how and where to gain support if they experience abuse and harassment – increase in self referral for safeguarding alerts. Focus on data from clients with mental health needs.		Tim Wilson/Michelle Jenkins/Annette Kidd		ongoing
1.5 Produce information to aid the understanding of vulnerable people regarding the safeguarding investigation process	April 2011	Monitor feedback from audit of vulnerable people who have participated in the safeguarding process, aim to collate learning and use to update safeguarding action plan.		Prevention and Dignity sub group		ongoing

Action	Date to complete	Target Completion Date and Key Milestones	Progress	Sub Group and Lead Officer(s)	Standard 11 SVA national Framework	
Objective 2 – Engagement of service users and carers as key partners in all aspects of safeguarding work						
2.1 Engage with Gateway Providers so as to link to equalities groups and existing service user forums, in order to promote awareness across vulnerable groups about how to keep themselves safe, and also gather views about the safeguarding process	Dec 2010	Links to have been made with Gateway Providers, and input sought regarding raising awareness, and any material produced communicating with the public		Prevention and Dignity Sub Group		Ongoing
2.2 Ensure service users and their carers have participation in outcomes of investigations, and can feedback their views	Jan 2010	Develop audit tool for use following investigation process so vulnerable people's input can be monitored. Systematic user feedback to be in place and informing the audit process		Quality Assurance sub group		Ongoing
2.3 Complete Equalities Impact Assessment for safeguarding work	October 2010	Equalities Impact Assessment completed and recommended actions identified		Michelle Jenkins/Katie Sweeney-Ogede		Ongoing
2.4 Invite a representative from the Community and Voluntary Sector Forum to be a SAB member	Dec 2010	Audit current use of advocacy in safeguarding work. Gather information from		Denise DeSouza		Pending

Action	Date to complete	Target Completion Date and Key Milestones	Progress	Sub Group and Lead Officer(s)	Standard 11 SVA national Framework	
		case file audits.				
2.5An audit of current use of advocacy in safeguarding work to be completed	Oct 2010	Audit undertaken, and recommended actions identified		Michelle Jenkins		Pending

Action	Date to complete	Target Completion Date and Key Milestones	Progress	Sub Group and Lead Officer(s)	Standard 1, 5, 7 and 9 SVA National Framework	
Objective 3 – All work, by all partner organisations, undertaken in relation to adults safeguarding is of the highest quality and is based on best practice, in line with the multi-agency procedures.						
3.1 Sussex multi agency procedures to be reviewed Agree definitions and thresholds	Nov 2010	Letter from Chair SAB to Chairs for SAB East & West Sussex – by 30.11.09 Proposal from Consultancy for update and create web based access and updates	Achieved 01.12.09 Proposal agreed. Work in progress, aim draft end June 10.	SAB Chair		Ongoing
3.2 Hold Multi Agency Safeguarding Adults conference. To focus on service user experience in 2010	April 2011	Monitor feedback from audit of vulnerable people who have participated in safeguarding process, aim to collate learning and use to update safeguarding action plan	Programme agreed, invites sent out 23.10.09 Conference held 03.12.09 Conference 2010 on agenda SAB 07.06.10	Workforce Development and Training		Achieved 2009 To be updated for planned Conference 2010
3.3 Implement Training Strategy and Competency Framework	1	See Training Strategy 09/10 Competency Framework to be completed and	Competency Framework consultation completed in ASC	Workforce Development and Training		Achieved

Action	Date to complete	Target Completion Date and Key Milestones	Progress	Sub Group and Lead Officer(s)	Standard 1, 5, 7 and 9 SVA National Framework	
		implemented Agenda for SAB 01.03.10	Dec 09 Agreed at SAB 01.03.10			
3.4 Define practice and recording standards and ensure these are understood by all investigating officers and investigation managers. To link to the Competency Framework.	March 2011	Clear standards in place that are understood by staff reflected in consistency of practice and recording as monitored through audits and supervision		Quality Assurance sub group		ongoing
3.5 Strengthen and refocus existing case file audit regime, to ensure that any variability in practice and recording is identified and swiftly tackled.	Oct 2010	More robust audit regime that supports and evidences consistency in practice and recording		Quality Assurance sub group		ongoing
3.6 Management oversight if safeguarding work will be strengthened, to ensure that interventions are only closed once positive outcomes and the mitigation of risk have been secured	Oct 2010	Improved outcomes for service users and risk mitigated as evidenced through audit and monitoring processes		Quality assurance sub group		Ongoing
3.7 Involve a cross section of staff in improvement planning activities, so that their suggestions for change, and ownership of the agenda are secured	Oct 2010	Staff sessions to support improvement completed and their input into the process is confirmed		Quality Assurance sub group		ongoing

Action	Date to complete	Target Completion Date and Key Milestones	Progress	Sub Group and Lead Officer(s)	Standard 1, 5, 7 and 9 SVA National Framework	
3.8 Agree quality assurance processes and data requirements for work completed under the Mental Capacity Act	Dec 2010	Monitor data collected and quality audits through MCA/DoLS Group, aim to collate learning and use to update safeguarding action plan		Mental Capacity and Deprivation of Liberty Safeguards Monitoring and Development Group		ongoing

Action	Date to complete	Target Completion Date and Key Milestones	Progress	Sub Group and Lead Officer(s)	Standard 2,4 and 8 SVA National Framework	
Objective 4 – Key agencies responsible for safeguarding adults to work in partnership, to have a consistent and co-ordinated approach to safeguarding adults in the City						
4.1 Agree recommendations from SAB review. Confirm Strategic Plan and reporting arrangements. Agree SAB TOR To review the Safeguarding Adults Board and arrangements for Chair	Dec 2010	Finalise SAB 30.11.09 Review completed and recommendations identified	Achieved	S.A.B - Chair		Achieved For review SAB 06.12.10
4.2 Explore links to Safeguarding Boards in East and West Sussex, such as formal sharing of action plans, and learning from Serious Case Reviews	Dec 2010	Report to Board on recommended actions		SAB Chair		ongoing
4.3 Each partner agency to have a set of internal guidelines, consistent with the multi-agency procedures, which set out the responsibilities of all workers to operate within it	April 2011	Guidelines in place, and reported to SAB Chair	SDHT – Safeguarding Policy ratified May 10	SAB Chair		Ongoing
4.4Establish a multi-agency Quality Assurance sub group to the Safeguarding Board, to analyse the findings from audit reports and data reports	Dec 2010	Sub Group established, and quarterly reports made to Safeguarding Board		Michelle Jenkins		Ongoing

Action	Date to complete	Target Completion Date and Key Milestones	Progress	Sub Group and Lead Officer(s)	Standard 2,4 and 8 SVA National Framework	
4.5 Establish a multi-agency Prevention and Dignity sub group to the Safeguarding Board to action the work plan from the Prevention Strategy	Dec 2010	Sub Group established, and quarterly reports made to Safeguarding Board		Michelle Jenkins/Sara Fulford		Ongoing
4.6 Ensure links with Domestic Violence action planning, and Community Safety Team	April 2011	Strategies and Action Plans linked		Michelle Jenkins/Linda Beanlands		ongoing

7. Brighton & Hove Safeguarding Adults Board

The Safeguarding Adults Board is the multi-agency partnership that leads the strategic development of safeguarding adults work in Brighton and Hove.

Members

Denise D'Souza	Acting Director, Adult Social Care & Health	BHCC (Chair)
Karin Divall	Assistant Director, Adult Social Care & Housing	BHCC
Vincent Badu	Director Adult Social Care	Sussex Partnership NHS Trust
Steve Fowler	Detective Superintendant Specialist Investigation Branch	Sussex Police
Sherree Fagge	Director of Nursing	Brighton & Sussex University Hospital Trust
Gail Gray	CEO, RISE	Domestic Violence Forum
Jackie Grigg	Money Advice & Community Support	PAVA Group
Linda Beanlands	Head of Community Safety	BHCC
Andrew Harringdon	Director of Nursing	Southdowns NHS Trust
Marilyn Eveleigh	Head of Clinical Performance & Lead Nurse	Brighton & Hove NHS Trust
Jane Mitchell	Safeguarding Adults & Children Manager	South East Coast Ambulance Services
Philip Letchfield	Head of Contracts & Performance	BHCC
Michelle Jenkins	Safeguarding Adults Manager	BHCC

GLOSSARY

ABE	Achieving Best Evidence
ADSS	Association of Directors of Social Services
ASC	Adult Social Care
ASCH	Adult Social Care and Health
AVU	Anti-Victimisation Unit
B&H	Brighton and Hove
BHCC	Brighton and Hove City Council
BSUH	Brighton and Sussex University Hospital
CMHT	Community Mental Health Teams
CPS	Crown Prosecution Service
HR	Human Resources
IMCA	Implementing Mental Capacity Act
MCA	Mental Capacity Act
NHS	National Health Service
OPCAT	Older Peoples Care Assessment Team
PALS	Patient Advocacy and Liaison Service
PAVA	Practitioner Alliance against the abuse of Vulnerable Adults
SDHT	South Downs Health Trust
SPFT	Sussex Partnership Foundation Trust
SSW	Senior Social Worker
SVA	Safeguarding Vulnerable Adults
SW	Social Worker
CQC	Care Quality Commission

Appendix 1 – Categories of Abuse

Discriminatory abuse

The principles of discriminatory abuse are embodied in legislation including the *Race Relations Act 1976 (Amendments) Regulations 2003*, *Disability Discrimination Act 1995* and the *Human Rights Act 1998*. Discriminatory abuse links into all other forms of abuse.

Discriminatory abuse exists when values, beliefs or culture result in a misuse of power that denies mainstream opportunities to some groups or individuals.

It is the exploitation of a person's vulnerability, resulting in repeated or pervasive treatment of an individual, which excludes them from opportunities in society, for example, education, health, justice, civic status and protection.

It includes discrimination on the basis of race, gender, age, sexuality, disability or religion.

Examples of behaviour: unequal treatment, verbal abuse, inappropriate use of language, slurs, harassment, deliberate exclusion.

Physical abuse

The non-accidental infliction of physical force that results in bodily injury, pain or impairment. (Stein, 1991, quoted in McCreadie 1994)

Examples of behaviour: hitting, pushing, slapping, scalding, shaking, pushing, kicking, pinching, hair pulling, the inappropriate application of techniques or treatments, involuntary isolation or confinement, misuse of medication. Note: inadvertent physical abuse may also arise from poor practice e.g. poor manual handling techniques. (See also neglect).

Sexual abuse

Direct or indirect involvement in sexual activity without valid consent. Consent to a particular activity may not be given because:
_ a person has capacity and does not want to give consent
_ a person lacks capacity and is therefore unable to give consent
_ a person feels coerced into activity because the other person is in a position of trust, power or authority.

Examples of behaviour: Non-contact – inappropriate looking, photography, indecent exposure, harassment, serious teasing or innuendo, pornography. Contact – touch, e.g. of breast, genitals, anus, mouth, masturbation of either or both persons, penetration or attempted penetration of the vagina, anus, mouth, with or by penis, fingers, other objects. (Brown and Turk, 1992, 1994).

Psychological abuse

The use of threats, humiliation, bullying, swearing and other verbal conduct, or any other form of mental cruelty, that results in mental or physical distress. It includes the denial of basic human and civil rights, such as choice, self-expression, privacy and dignity.

Examples of behaviour: treating a person in a way which is inappropriate to their age and/or cultural background, blaming, swearing, intimidation, insulting, harassing, 'cold-shouldering', deprivation of contact.

Financial abuse

"The unauthorised and improper use of funds, property or any resources belonging to an individual".
(Stein, 1991, quoted in McCreadie, 1994)

Those who financially abuse may be people who hold a position of trust, power, authority or has the confidence of the vulnerable adult

Local Authorities have in place Appointee and Receivership procedures who may act as Corporate Appointee and/or Corporate Receiver, where a vulnerable adult needs someone to manage their financial affairs and is not able to undertake this themselves. Solicitors may also be appointed to provide this service.

Appointee and Receivership procedures ensure that:
_ the correct state pension and benefits are in payment
_ any private pensions or other investments are correctly paid
_ care fees are paid
_ personal allowances are made, and
_ other bills are paid (e.g. utilities and rates)

Monies held on behalf of the client are correctly banked and where appropriate excess funds are invested.

Where clients are still living in the community or sheltered accommodation, provision is made for them to be in control of sufficient sums of money to enable them to manage day to day expenditure.

More information on receivership and appointeeship can be found by visiting the Public Guardianship Office website, East Sussex website, or by contacting West Sussex Receivership Unit or Brighton and Hove Finance Department. The Department for Work and Pensions can also provide support and guidance.

Examples of behaviour: misappropriating money, valuables or property, forcing changes to a will and testament, preventing access to money, property, possessions or inheritance, stealing.

Neglect and acts of omission

The repeated deprivation of assistance that the vulnerable adult needs for important activities of daily living, including a failure to intervene in behaviour which is dangerous to the vulnerable adult or to others, poor manual handling techniques.

Note: under the *Mental Capacity Act 2005* wilful neglect and ill treatment become a criminal offence.

Self-neglect on the part of a vulnerable adult will not usually lead to the initiation of adult protection procedures unless the situation involves a significant act of commission or omission by someone else with established responsibility for an adult's care. Other assessment and review procedures, including risk assessment procedures, may prove a more appropriate intervention in situations of self-neglect.

Examples of behaviour: failure to provide food, shelter, clothing, heating, medical care, hygiene, personal care, inappropriate use of medication or over-medication.

Institutional abuse

Institutional abuse is abuse (as described above) which arises from an unsatisfactory regime. It occurs when the routines, systems and norms of an institution override the needs of those it is there to support. Such regimes compel individuals to sacrifice their own preferred life style and cultural diversity in favour of the interests of those there to support them, and others. This can be the product of both ineffectual and punitive management styles, creating a climate within which abuse of vulnerable adults, intentional or otherwise, by individual staff and others.

Managers and staff of such services have a responsibility to ensure that the operation of the service is focussed on the needs of service users, not on those of the institution. Managers will ensure they have mechanisms in place that both maintain and review the appropriateness, quality and impact of the service for which they are responsible. These mechanisms will always take into account the views of service users, their carers and relatives.

Poor practice and lack of skills can cause incidents of neglect, where the home is unable to fulfil specific care needs to service users. This may result in increased levels of user-to-user abuse due to insufficient and inappropriate support or residential homes taking placements where they are unable to meet the person's level of care.

Examples of behaviour: inflexible routines set around the needs of staff rather than individual service users, e.g. requiring everyone to eat together at specified times, bathing limited to times to suit staff, no doors on toilets. These can arise through lax, uninformed or punitive management regimes. The behaviour is cultural, and not specific to particular members of staff.

Appendix 2 - Levels of Response Framework

The framework described is intended to assist practitioners in deciding the most appropriate level of response to an initial adult protection referral. Whilst not exhaustive, it is a tool to help promote consistent decision-making. Furthermore, the level of response agreed should be kept under constant review. Managers need to be aware that the outcomes of their initial decision (level of response) may lead to further information coming to light, changing the perceived level of seriousness or risk. For example, the decision to review a vulnerable adult's package of health and social care support may result in further evidence that abuse is, or could be, taking place and that a formal Adult Protection Investigation should be undertaken.

The framework is described in terms of linking the presenting information with expected action and outcomes by level of response and then in the form of a flowchart.

Level 1 Investigations

Intervention by service providers.

Presenting the information

- 'One-off', isolated incident that has not adversely affected the physical, psychological or emotional well-being of the vulnerable adult.
- No previous history of similar incidents recorded for the vulnerable adult.
- No previous history of similar incidents recorded for the service provider.
- No previous history of abuse by the person alleged responsible
- Not part of a pattern of abuse.
- No clear criminal offence described in referral.
- No clear intent to harm or exploit the vulnerable person.

Action and outcomes

- Action taken by the service provider to address 'presenting concerns' and report outcomes to the Adult Assessment Teams , including Community Mental Health and Community Learning Disability Teams and other multi-disciplinary teams.
- May lead to minor alterations in the way service is provided to a vulnerable adult and/or alterations to the way staff or other resources are deployed in the delivery of health and social care.
- No on-going risk to vulnerable adult or other vulnerable people.

Level 2 investigations

Intervention by the Investigation Team to assess or review the needs of the vulnerable adult and/or the alleged perpetrator within the context of the presenting concern(s).

Presenting the information

- The physical, psychological or emotional well-being of the vulnerable adult may be being adversely affected.
- The concerns reflect difficulties and tension in the way current health and social care services are provided to the vulnerable adult (e.g. some perceived inadequacy in the services being provided).

- The concerns reflect difficulties and tensions within the network of informal support provided to the vulnerable adult (e.g. some perceived difficulties between the vulnerable adult and family/friends).
- Concerns have occurred in the past, but at lengthy and infrequent intervals.

Action and outcomes
- The 'needs' of the vulnerable adult and/or alleged perpetrator of abuse are formally assessed or reviewed by an appropriate member of the Adult Assessment Teams, including Community Mental Health and Community Learning Disability Teams and other multi-disciplinary teams.
- Adjustments may be made to the way health and social care services are provided to the vulnerable adult and/or alleged perpetrator, to ameliorate 'presenting concerns'.
- Support may be provided to enable the vulnerable adult to explore and negotiate relationships with 'significant others' in their support network.
- Current and future risks of harm or exploitation are significantly reduced or eradicated by changes to a 'Health and Social Care Plan' or adjustments with more informal support networks or personal relationships.

Level 3 investigations

Adult protection enquiry undertaken.

Presenting the information
- The physical, psychological or emotional well-being of the adult has been adversely affected by the alleged incident.
- A criminal offence may have been committed
- Possible breach of regulations provided by the Care Standards Act, 2000.
- Possible breach of Professional Codes of Conduct
- There is an actual or potential risk of harm or exploitation to other vulnerable people.
- There is a deliberate intent to exploit or harm a vulnerable adult
- There is significant breach in an implied or actual 'duty of care' between vulnerable adults and the person alleged responsible.
- The referral forms part of a pattern of abuse either against a particular individual, by a particular individual or by a health or social care service.

Action and outcomes
- Strategy discussion/meeting held to agree an 'investigation plan'.
- Investigation plan implemented with further strategy discussions/meetings if appropriate.
- Evaluation of investigation activity and evidence obtained.
- Determine if abuse has taken place.
- Case conference to agree a 'protection plan' that prevents or reduces risk of further abuse.
- Monitoring of protection plan.
- Review of protection plan.

Level 4 investigations

Complex adult protection enquiry undertaken with multiple service users/victims.

Presenting the information

- Institutional abuse.
- Number of people adversely affected.
- A number of criminal offences may have been committed.
- Multiple breaches of regulations issued under Care Standards Act 2000.

Action and outcomes

- Notify senior managers throughout the process.
- Allocate resources to undertake, and co-ordinate, the investigation (requiring senior management support)
- Strategy discussion/meeting held to agree an 'investigation plan'
- Investigation plan implemented with further strategy discussions/meetings if appropriate
- Evaluation of investigation activity and evidence obtained
- Determine if abuse has taken place
- Case conference to agree a 'protection plan' that prevents or reduces the risk of further abuse
- Monitoring of protection plan
- Review of protection plan

Select Committee on Dementia: Committee Report

Executive Summary

Anyone looking in any detail 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 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 national dementia strategy and local strategies, 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 memory 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 stop 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 demonstrable and 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 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).

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 Scrutiny 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 and depth 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. 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 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) do not. It is also well established that poor health, particularly in terms of diet and/or cardio-vascular health, can significantly increase the likelihood of developing some

[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..

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 the condition 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 rise 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]

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

[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.

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 set fairly low (i.e. that treatments such as Aricept should be offered even when there was fairly 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

[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.

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 figure 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 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

[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.

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 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

[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.

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 proper 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 less than 15 minutes, which is clearly not long enough to do much other than to diagnose 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 diagnosis 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

[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.

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, however, 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]

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 diagnose 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

[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.

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 very unlikely that there is not 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).

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

Specialist Diagnosis/Assessment[29] Services

[28] See Living Well With Dementia: The National Dementia Strategy: p51-55.

[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.

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 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.

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.

[30] See evidence provided by Deborah Becker at the 17.07.09 Select Committee meeting, points 9.4 and 9.5.
[31] See evidence from Russell Hackett, Director of Business Development, Sussex Partnership NHS Foundation Trust, 12.06.09: point 4.5.

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-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 effective 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.

[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.

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 diagnose 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 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.

Firstly, it is very important that people with dementia are accurately diagnosed in the early stages of their illness. Without this diagnosis, 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 diagnosed with dementia, support for them and their carers has to be readily available and easily accessible. There is little

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

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

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 the person 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]

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.

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[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 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.

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 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 30 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.

[38] See minutes 15.01.10 point 20.13.

[39] See minutes 15.01.10 point 20.13.

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 summer 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 old 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 demonstrable and 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 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 the independent sector (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 itself providing a range of services. 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]

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

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 very high number of enquiries to GPs are liable to be actually 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 may be 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 suitably 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.

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.)

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

[42] See 04.12.09, point 14.9.

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, helping 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.

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

[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.

[46] See evidence from Dennis Batchelor, ICS Registered Mental Health Nurse, 04.12.09: point 14.4.

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-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.

[47] See evidence from Alan Wright, 17.07.09: point 9.15.

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

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 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 – i.e. if it's difficult to fill in forms in order to access statutory support, then there's an obvious need for advocacy services to help people. 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 rather 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.

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

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

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, but 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 effect 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

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

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 major changes to the way in which it provides services, including services for dementia. These changes are likely to focus on providing value for money, but 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

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

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.

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 diagnosis 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 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.

ADULT SOCIAL CARE AND HOUSING OVERVIEW AND SCRUTINY COMMITTEE

Agenda Item 25

Brighton & Hove City Council

Subject:		**ASCHOSC Panel Options**		
Date of Meeting:		**9 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. During July consultation was undertaken with residents, partners and Members as to their priorities for scrutiny reviews during 2010/11. This report sets out the results of this consultation as relevant to ASCHOSC.

2. RECOMMENDATIONS:

2.1 That the ASCHOSC:

(1) Notes the results of the consultation

(2) Decides upon topics for future scrutiny panels based upon appendix 1

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 Public consultation on possible scrutiny panel topics 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 be added to the Consultation Portal at http://consult.brighton-hove.gov.uk/portal

3.2 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 ASCHOSC. For the topics suggested the scrutiny team has undertaken some preliminary scoping.

3.5 ASCHOSC is already running a scrutiny panel on services for adults with Autistic Spectrum Disorders and subject to decisions made at other scrutiny committees any additional panel will have to wait for this panel to end. However officers can usefully undertake preparatory work once a panel topic is identified therefore a decision on a future panel would be timely.

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.

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 There are no direct implications.

Crime & Disorder Implications:

5.5 There are no direct implications.

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. Panel scoping information

Documents in Members' Rooms

None

Background Documents

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

1. Private Sector Letting

A scrutiny enquiry could:

- Gain an understanding of the local context within which letting agents operate
- Look at the experience of different renting groups e.g. older people, young families etc
- Elements of the letting process e.g. fees, services provided etc
- The perspective of letting agents
- Innovative practice from other areas of the country

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. The full text of the motion is reproduced below.

“This council notes the findings of the national Citizens Advice report Let down (1) on the activities of private rented sector letting agents, which revealed:

- 73 per cent of tenants interviewed were dissatisfied with the service provided by their letting agent. Common concerns included difficulties in contacting the agent, serious delays in getting repairs carried out, inadequacies in the protection of clients’ money and the frequency with which additional charges were made.
- 94 per cent of letting agents surveyed imposed additional charges on tenants on top of the tenancy deposit and rent in advance. The size of these charges varied hugely. The charge for checking references ranged from £10 to £275 and the charge for renewing a tenancy ranged from £12 to £200. In some cases additional charges for a tenancy amounted to over £600.
- Less than a third of agents willingly provided full written details of their charges to CAB workers when asked.
- 61 per cent of the tenants surveyed said that paying these charges was a problem. Some had to borrow the money, others had difficulty paying other bills or went into debt.

This council further notes:

- That Brighton & Hove has the sixth largest private rented sector in the country with tens of thousands of its residents having dealings with letting agents in the City.

In addition, the Citizens Advice proposals call for:

(1) The licensing of letting agents who should be required to demonstrate professional competence, have adequate client money protection arrangements and operate a system for handling complaints and redress;

(2) The introduction of regulations specifying that no additional charges should be made to tenants for activities that are part of the routine letting and management process. The cost of this work should be included in the rent paid by the tenant and/or the management fee paid by the landlord. The ultimate sanction against letting agents breaching the regulations should be the withdrawal of the licence to operate.

It therefore calls on the council to request the Chief Executive to:

1. Write to the Government and the major political parties seeking their support for the Citizens Advice proposals; and

2. Ask the Office of Fair Trading to carry out an investigation into the activities of letting agents.

2. Older Leaseholders

There are a great many leasehold properties in Brighton and Hove, including some in Council owned buildings. 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.

Many of the issues that older lessees encounter would be picked up in a wider review of private sector letting agents (suggestion 1). Additionally there is already an Older People's Housing Strategy which ASCHOSC will want to monitor and review at some point before 2014.

3. Provision of care for LGBT elders in the city

To consider the potential for encouraging dedicated LGBT accommodation in B&H. 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.

National/ international research:

Housing Issues Affecting Older Gay, Lesbian and Bisexual People in the UK: A Policy Brief – 2008 policy brief from the Independent Longevity Centre.

The report considers whether it's appropriate to have LGBT specific accommodation or whether there is the demand for it. Some have been built in America and Germany but there is less demand than expected, partly because of the high costs of the homes.

The research that has been done in the UK shows that while older LGBT people may not necessarily want to have residential accommodation that is specifically for them, what they do want are mainstream service providers who recognize their specific needs and are willing to meet them. What is needed therefore, is to understand what the views and attitudes are of wardens of sheltered accommodation and care home managers to older LGB people and whether they have any understanding of what their specific needs may be.

Issues that might affect LGBT elders include:

- Lack of informal social and care networks (often provided by spouse or adult children)
- Having a potentially homophobic carer come into their home; having to hide personal information away
- Fear of stigmatization from other residents/ carers in sheltered accommodation

There are some housing issues specific to LBGT older people or which affect them more:

- LGBT older people may experience a lack of confidence in approaching mainstream agencies with issues that entail being out about their sexuality/ gender identity.
- inheritance and the passing on of property between partners, especially if they have not entered a civil partnership
- housing choices in later life and the difficulty for some LGBT older people moving into care and support options where they feel isolated or their sexuality becomes invisible dealing with homophobic harassment

The Equality Act (Sexual Orientation) Regulations 2007 make it unlawful for public authorities to discriminate when providing public services. This covers the work of local authorities including housing services.

Research suggests that there is a need for specific services targeting the LGBT community but that staff training, displaying LGBT friendly signs, publicity and partnerships with LGBT organisations all improve access to advice.

The Council has developed a LGBT Housing Strategy and an Elders Housing Strategy, both current and recently agreed so there would be a danger of duplication. It would seem sensible for ASCHSOC to add this item to its work-programme for 2011 to see what progress has been made.

4. Homelessness in the City

To look at homelessness in B&H, including how it is measured and steps to address it.

Figures: The Government's official figures for June 2010 show that 1,250 people were sleeping rough on any given night in England, of these 12 were in Brighton http://www.crisis.org.uk/pages/rough-sleeping.html

The national situation is that under the previous Government, rules for counting rough sleepers were very restrictive and eliminated a lot of people from the final count. The coalition government wants to change the way that rough sleepers are counted. Minister for Housing and Local Government, Grant Shapps is planning to consult with public and charities as to how to measure the problem

The Minister says he will publish guidance to help councils evaluate rough sleeping in their area, advising local authorities about by conducting more accurate counts. (http://www.guardian.co.uk/society/2010/aug/05/rough-sleepers-problem-housing-minister)

Locally the BHCC Homelessness Strategy spans 2008-2013; we are midway through its progress. ASCOHSC will want to be part of the review process and take note of the update on the Homelessness Strategy going to Housing Cabinet on 8 September.

It has been reported that housing benefit changes nationally are set to affect up to 12,550 families in the city. The housing team are currently working through the likely impact of changes to the city.
http://www.theargus.co.uk/news/8334197.34_000_Sussex_people_face_eviction_due_to_benefit_cuts/

Recommendation – It would seem sensible to wait for the changes at national level to develop and link any work into the development of a new homelessness strategy.

5. HIV/AIDs services:

- **Transition between children and adults services**
- **Services in the city aimed specifically at men of 50 years and over**

Review could focus on the current situation, how is transition managed? What are the numbers of people are affected, is this increasing or decreasing? What are services are offered and are there any gaps in provision?

National policy context:

Central Government is currently consulting on possible changes to the AIDS Support Grant. The Grant supports social care for people living with HIV/AIDS (and where appropriate their partners, carers and families). By contributing to the cost of individually tailored packages of care, adaptations to the home, occupational therapy, counselling and family support services, the grant enables those with HIV to live independently in the community for as long as possible. It assists with the cost of HIV training for social workers, as well as underpinning salary costs for HIV specialist social workers in a number of authorities.

Locally social services and a number of voluntary organisations work with families where a member is HIV positive to deal with any immediate problems, and to help the family plan for the long term care of children.

Given that this is quite an involved issue it would seem sensible for ASCHOSC to seek an initial report outlining how services are delivered and coordinated and what impact changes to funding from government would have before deciding upon further action.

6. Affordable Housing in the city – especially housing co-operatives.

The Housing Strategy 2009-2014 identifies affordable housing, both to rent and buy as a key priority. The Strategy states:

Brighton & Hove has one of the largest affordable housing programmes in the South East and supports the development of a mix of new homes for affordable rent and low cost home ownership. We aim to deliver an average of 60% as new affordable rented housing and 40% as new low cost home ownership housing.

Given that the strategy has only recently been agreed it would be sensible to wait to review its implementation.

Additionally government is in the process of making changes to planning requirements, including housing targets. It would difficult to undertake a meaningful scrutiny into the topic whilst a fluid policy context exists nationally.

The Strategy also recognises the ‘beneficial role that local housing co-operatives can play in offering housing and support to their members and also in community building and tenant empowerment’.

However affordable housing is an issue that is unlikely to go away so ASCHOSC will probably return to the topic at some point; this could usefully be dovetailed with monitoring of the Housing Strategy.

7. Supported housing in the city- does it meet the city's needs?

Possible questions that could be addressed include - What is supported housing? Who provides it? Who lives in it? How is this managed? What is the demand? Cost? How is the need analysis carried out? Can people move between the supported housing? What influence does the council have?

The Council's strategy says that supported housing includes housing for:

- Young homeless people
- Young parents
- People with substance misuse problems
- Older people with support needs
- Women and children fleeing DV
- Single homeless people
- People with Learning Disabilities
- Ex offenders

The council makes clear links between the Supporting People Strategy and Housing, Health, and Social Care. This has allowed the strategic housing function of the authority to become the accommodation commissioner for all services.

The current Supporting People Strategy needs reviewing in 2011 and ASCHOSC will want to take an active role in its future development, especially given likely resource constraints. It would therefore make sense to delay any scrutiny intervention to dovetail with this process.

ASCHOSC Work Programme 2010

Issue	Date to be considered	Referred/Requested By?	Reason for Referral	Progress and Date	Notes
Assessment Care Pathways	04 March 2010	ASCHOSC	Training session on how people's care requirements are assessed	Noted	
Scrutiny request re: services for adults with autism	04 March 2010	Cllr Wrighton	Cllr letter requesting establishment of scrutiny panel	Agreed to set up ad hoc panel	
Care Quality Commission assessment of ASC services	04 March 2010	ASC	Update members on most recent assessment of BHCC ASC services	Noted – report requested on ASC and voluntary sector	
ASC Green paper	04 March 2010	ASCHOSC	Update on BHCC response to Green Paper on funding of care for older people	Noted	
Care Quality Commission consultation on assessing quality	04 March 2010	CQC	National consultation on how CQC should best assess the quality of health and social care commissioners/providers	Agreed to form group to feed in to consultation	

Issue	Date to be considered	Referred By?	Reason for Referral	Progress and Date	Notes
Rent setting	24 June 2010	ASCHOSC	Training session on how social housing rents are set		
Transfers of Care	24 June 2010	ASCHOSC	Look at issue of delayed transfers from acute to community care – with view to setting up an ad hoc panel		HOSC is considering this health/ASC cross-over issue at a future meeting and will feed any concerns into ASCHOSC
Personalisation	24 June 2010	ASCHOSC	Not tabled at March meeting. Update to Committee.		

Issue	Date to be considered	Referred By?	Reason for Referral	Progress and Date	Notes
Dementia	09 September 2010	ASCHOSC	Report of Dementia Select Committee for information (moved from June)		
Voluntary Sector involvement in ASC	09 September 2010	Director of ASC	Report on how ASC works with voluntary sector		
Mental Health care in community – impact across city	09 September 2010	Cllr Meadows	Report on how the long term strategy to refocus MH care on community services impacts on city services (esp. ASC and Housing)		
Putting People First/ personalisation	09 September 2010	ASCHOSC	Update on progress of personalisation initiative. Combined this and Nov's item		CVSF to be invited to give a view.
Safeguarding report	9 September 2010	Director of ASC	Update from Karin Divall		
In year budget savings	09 September 2010	OSC	For all O&S committees to consider		
Suggested scrutiny panels 2010/11	09 September 2010	OSC	For ASCHOSC to decide on panels from suggested list		

Issue	Date to be considered	Referred By?	Reason for Referral	Progress and Date	Notes
Lease-Hold Issues	4 November 2010	ASCHOSC	Training session on important issues relating to lease-hold properties		Dave Arthur- postponed from September Comm.
ASC inspection report	04 November 2010	ASC	Report back on findings following CQC inspection of ASC		
New Repairs System	04 November 2010	ASCHOSC	Report on progress of new housing repairs system.		Link with info from complaints annual report to OSC 20 July 2010
Decent Homes	04 November 2010	ASCHOSC	Progress report on reaching decent homes standard		
Housing and Health Inequalities Group	04 November 2010	ASCHOSC	Update report following Housing Strategy paper at 24 June ASCHOSC		Andy Staniford/ Martin Reid
Autism Ad Hoc Panel	04 November 2010	Cllr Wrighton	Report of ad hoc panel on autism to be considered (moved from September)		
CQC Inspection Report	04 November 2010	Director of ASC	CQC Inspection Report		Postponed from Sept Comm

Issue	Date to be considered	Referred By?	Reason for Referral	Progress and Date	Notes
Housing Benefit	January ?	ASCHOSC	Training Session – requested at June ASCHOSC		May be in January?
Budget Strategy	06 January 2011	ASCHOSC	To consider executive plans for ASC & Housing budget strategy 2011-12		Single issue meeting

Overview Workshops

Issue	Date to be considered	Referred By?	Reason for Referral	Progress and Date	Notes
Housing CBRE Masterplan	Private Member's workshop to be arranged	Director	Policy development work. Opportunity for Members to comment upon the review of key estates, areas where new provision can be focused.		
Adult Social Care	Private Member's workshop to be arranged	Acting Director	Co-dependency between ASC & H.	Nov 2010	