

NORTHAMPTON BOROUGH COUNCIL
Scrutiny Panel 2 – Dementia Friendly Town

Your attendance is requested at a meeting to be held in The Jeffrey Room,
The Guildhall, St. Giles Square, Northampton, NN1 1DE on
Thursday, 21 September 2017 commencing at 6:00pm

Simon Bovey
Interim Chief Executive

If you need any advice or information regarding this agenda please phone Tracy Tiff, Scrutiny Officer, ext 7408 who will be able to assist with your enquiry. For further information regarding **Scrutiny Panel 3 Dementia Friendly Town** please visit the website www.northampton.gov.uk/scrutiny

Members of the Panel

Chair	Councillor Cathrine Russell
Panel Members	Councillor Rufia Ashraf Councillor Mohammed Azizur Rahman (Aziz) Councillor Sally Beardsworth Councillor Dennis Meredith Councillor Brian W Sargeant
Co-opted Member	Gwyn Roberts

Calendar of meetings

Date	Room
27 November 2017 6:00 pm 25 January 2018 26 March	All meetings to be held in the Jeffery Room at the Guildhall unless otherwise stated

Northampton Borough Scrutiny Panel 3 Dementia Friendly Town

Agenda

Item No and Time	Title	Pages	Action required
1. 6:00pm	Apologies		The Chair to note apologies for absence.
2.	Deputations and Public Addresses		<p>The Chair to note public address requests.</p> <p>The public can speak on any agenda item for a maximum of three minutes per speaker per item. You are not required to register your intention to speak in advance but should arrive at the meeting a few minutes early, complete a Public Address Protocol and notify the Scrutiny Officer of your intention to speak.</p>
3.	Declarations of Interest		Members to state any interests.
4.	Minutes	1 - 3	The Scrutiny Panel to approve the minutes of the meeting held on 20 July 2017.
5. 6:05pm	Witness Evidence	4 - 7	<p>The Scrutiny Panel to receive a response to its core questions from:</p> <ul style="list-style-type: none"> • Cabinet Member – Community Engagement and Community Safety • Cabinet Member – Housing and Wellbeing • Head of Housing and Wellbeing
6. 7:05pm	Site Visits		The Scrutiny Panel to decide upon the towns that it will visit regarding Dementia Friendly Towns.
7. 7:20pm	Relevant Legislation	8 - 15	The Scrutiny Panel to receive a briefing note around various relevant Legislation.

NORTHAMPTON BOROUGH COUNCIL

MINUTES OF SCRUTINY PANEL 3 DEMENTIA FRIENDLY TOWN

Thursday, 20 July 2017

COUNCILLORS PRESENT: Councillor Sally Beardsworth (Deputy Chair – In the Chair)

CO-OPTED MEMBER: Gwyn Roberts, Deputy CEO, Northamptonshire Carers

OFFICERS Louise Musson, Call Care Manager (Agenda Item – 5)
Tracy Tiff, Scrutiny Officer

1. APOLOGIES

Apologies for absence were received from Councillor Cathrine Russell (Chair). Councillor Sally Beardsworth (Deputy Chair) was in the Chair for the meeting.

The Chair welcomed Gwyn Roberts, Deputy CEO, Northamptonshire Carers to the Panel and advised how pleased she was to have him on this Review.

2. DEPUTATIONS AND PUBLIC ADDRESSES

There were none.

3. DECLARATIONS OF INTEREST

There were none.

4. MINUTES

The minutes of the meeting held on 14 June 2017 were signed by the Chair as a true and accurate record.

5. PRESENTATION TO SET THE SCENE

The Scrutiny Panel received a comprehensive presentation that set the scene. The salient points were highlighted.

The Panel made comment, asked questions and heard:

- It would be useful for Councillors to collect anonymised case studies of people they are aware of who have dementia and also provide anonymised case studies from carers of people with dementia. The Chair would contact all members of the Panel in this respect.
- Communities where young and older people mix work very well. It was suggested that a potential recommendation for the final report could be the introduction of a

Dementia and Alzheimer's Forum. The Forum could introduce, for example, dog walkers, to each other.

The Chair advised that she would be very interested to attend a seminar in Birmingham on 5 December regarding issues around dementia. Her attendance was supported by the Panel and a report would be given to a future meeting of the findings from this Seminar. The Scrutiny Officer undertook to liaise with Councillor Russell, Chair, regarding Councillor Beardsworth's attendance at the Seminar.

AGREED: That the information provided informs the evidence base of this Scrutiny Review.

6. CORE QUESTIONS

The Scrutiny Panel considered the draft core questions, making suggestions for improvement.

AGREED: That the core questions, as attached, are approved and sent to the expert providers to provide responses.

7. COMMUNITY IMPACT ASSESSMENT

The Community Impact Assessment for this Review was approved and would be published on the Overview and Scrutiny WebPage.

The meeting concluded at 6:50pm

NORTHAMPTON BOROUGH COUNCIL

OVERVIEW AND SCRUTINY



SCRUTINY PANEL 3 – DEMENTIA FRIENDLY TOWN

CORE QUESTIONS – EXPERT ADVISORS

The Scrutiny Panel is currently undertaking a review: Dementia Friendly Town that is investigating the town of Northampton can become a Dementia Friendly Town. The projected outcome is to make recommendations for Northampton becoming a Dementia Friendly Town

CORE QUESTIONS:

A series of key questions have been put together to inform the evidence base of the Scrutiny Panel:

1. Are you aware of what Dementia is, and its symptoms, please provide details?
2. Are you aware of the effect on the health, wellbeing and the safety of people with dementia and their carers/families, if so, please provide details?
3. Please can you supply details of the current and potential partnership working regarding supporting people with dementia.
4. Are you aware of any specific groups that are not accessing services, please provide details.
5. In your opinion please provide information of the benefits of Northampton becoming a Dementia Friendly Town.
6. Do you have any other information you are able to provide in relation to a Dementia Friendly Town?

NORTHAMPTON BOROUGH COUNCIL

OVERVIEW AND SCRUTINY



SCRUTINY PANEL 3 – DEMENTIA FRIENDLY TOWN

CORE QUESTIONS – EXPERT ADVISORS

The Scrutiny Panel is currently undertaking a review: Dementia Friendly Town that is investigating the town of Northampton can become a Dementia Friendly Town. The projected outcome is to make recommendations for Northampton becoming a Dementia Friendly Town

CORE QUESTIONS:

A series of key questions have been put together to inform the evidence base of the Scrutiny Panel:

1. Are you aware of what Dementia is, and its symptoms, please provide details?

Dementia is when part of the brain is damaged, it can be through disease (such as Alzheimer's) or strokes, brain damage or other factors. The most common cause of dementia is Alzheimer's disease. Common symptoms of Alzheimer's disease and other forms of dementia include:

- ***memory loss – especially problems with memory for recent events, such as forgetting messages, remembering routes or names, and asking questions repetitively***
- ***increasing difficulties with tasks and activities that require organisation and planning***
- ***becoming confused in unfamiliar environments and problems with perception***
- ***difficulty finding the right words***
- ***difficulty with numbers and/or handling money in shops***
- ***changes in personality and mood***
- ***depression***

2. Are you aware of the effect on the health, wellbeing and the safety of people with dementia and their carers/families, if so, please provide details?

ii Effects of dementia	Impact on individual
Cognitive effects	<ul style="list-style-type: none"> • Difficulty in recognising people and places • Remembering pin & phone numbers • Remembering where they live and difficulty in finding their way home • Poor short term memory • Easily confused and muddled • Poor concentration, attention and easily distracted • Unable to think clearly or problem solve • Difficulty in learning new things
Functional effects	<ul style="list-style-type: none"> • Difficulty in completing the everyday tasks and activities of independent living • Difficulty in handling and managing money • Difficulty in keeping safe with appliances e.g. gas and electric cooking, ironing, boiling kettles etc. • Difficulty in knowing what to do next especially if out of routine • Problems following social cues • Word finding difficulty or loss of verbal skills • Slower reactions
Behavioural effects	<ul style="list-style-type: none"> • Loss of social skills • Over active response to changes or stimuli in the environment • Repetitive behaviour patterns • Physical or verbal aggression • Inappropriate responses or behaviours
Psychological effects	<ul style="list-style-type: none"> • Irritability • Mood swings • Frustration and anger with self and others • Changes in personality • Anxiety • Loss of motivation • Depression

3. Please can you supply details of the current and potential partnership working regarding supporting people with dementia?

Partnerships and Communities Team have supported by becoming 'dementia friends', we have all received the training. Nisha Mejer, Partnerships and Communities Support Officer is trained as a Dementia Champion and has provided training for the women's forum also.

As part of the Northamptonshire and Northampton DAA, NBC work with health, education, care and voluntary organisations to gain a better understanding of the issues surrounding people living with dementia and their carer's.

There is potential to work with local business and organisations to promote awareness and to work with others to ensure NBC is Dementia Frinedly.

4. Are you aware of any specific groups that are not accessing services, please provide details.

In 2013 Alzheimer's report identified that there may be some cultural barriers for BME groups at accessing Dementia Support. One of which was lack of awareness and the support available.

5. In your opinion please provide information of the benefits of Northampton becoming a Dementia Friendly Town.

- ***Business owners, bank owners, and faith communities might interact more positively with dementia residents, rather than react with avoidance or embarrassment.***
- ***Community leaders could help connect community members with dementia resources.***
- ***Community safety would increase through better protection of elders, and those with cognitive impairment, from harm and abuse.***
- ***More family members would seek diagnosis earlier, resulting in better treatment/care management, earlier connection to support resources, and improved decision making.***
- ***Dementia friendly communities provide more opportunities for people with dementia to experience feelings of normalcy and personal value. People with dementia would be able to contribute to the community and have intergenerational interaction – which is both health-enhancing and***

energizing. Dementia friendly communities would result in better quality of life for both the family caregiver and their loved one. (Alzheimer's and Dementia blog, 14th October 2015).

6. Do you have any other information you are able to provide in relation to a Dementia Friendly Town?

There are currently 16 Dementia Friendly Communities in the East Midlands and many more around the Country.

ⁱ <http://www.nhs.uk/Conditions/dementia-guide/Pages/symptoms-of-dementia.aspx>

ⁱⁱ <http://ilearn.careerforce.org.nz/mod/book/tool/print/index.php?id=256>



NORTHAMPTON BOROUGH COUNCIL

SCRUTINY PANEL 3 DEMENTIA FRIENDLY TOWN

21 SEPTEMBER 2017

BRIEFING NOTE: BACKGROUND DATA – RELEVANT LEGISLATION

1 INTRODUCTION

1.1 At its inaugural scoping meeting, Scrutiny Panel 3 (Dementia Friendly Town) agreed that it would receive details of relevant Legislation to inform its evidence base.

1.2 Short summaries of the key points of the Legislation, for consideration by the Scrutiny Panel at its meeting on 21 September 2017, are:

- The Care Act 2014
- Mental Capacity Act 2005
- Human Rights Act 1998
- Mental Health Act 1983
- Deprivation of Liberty Safeguards (2009)

1.3 The Care Act 2014

1.3.1 The Social Care Institute for Excellence has produced an easy read summary of the Care Act 2014, which highlights the key aspects of the Act:

“The Care Act is a new law that means councils must have an independent advocacy service for people who find it difficult to have a say in their care and services and do not have someone to help them with this. Independent means the service is not controlled by the council and only thinks about what people they are helping want.

Independent advocacy is about giving people as much control as possible in their lives. It helps people understand information, say what they want and what they need and get the services they need.

Advocates work with people as partners and are always on their side.

Advocacy helps people in general and helps everyone to live together. It helps people to be part of things, be equal with other people and get their rights.

The new law means more people are likely to use advocacy and councils will need to plan for this. This might be hard because there will be times when

there are more people using advocacy services and times when there are not so many.

Councils already have to have some advocacy services. These services are called Independent Mental Capacity Advocacy, Independent Mental Health Advocacy and NHS Complaints Advocacy. Some councils also have other advocacy services as they think they would be useful for people. Complaint means saying that something is wrong with a service and asking for it to be sorted out. When councils are thinking about what the Care Act says advocacy services they should use what is already there and work with organisations who already do advocacy.

The councils should make sure the organisations they pay to run advocacy services under the Care Act can be flexible and can give help to all the people that need it. A lot more people are likely to use advocacy services when the Care Act takes effect in April 2015.

Councils should get as much information as possible about advocacy services so they can plan for the future.

They should use this information to help them work out who should run advocacy services, how they work out who needs advocacy, how advocacy services should work and working out where new services are needed.

Training is important for everyone who is working on advocacy services including the people in the council who choose the organisations to run the services. They need to know about everything the law says the council has to do including how people first get advocacy, how advocacy works and how people get the service

It is best for councils to do all these things using co-production with local people who use services and carers. It is also important to work with organisations that run advocacy services or might run them in the future. Co-production means working together with people who use services and carers as equal partners.”

Source: <http://www.scie.org.uk/care-act-2014/advocacy-services/commissioning-independent-advocacy/easy-read/>

1.3.2 The Act is [available](#).

1.4 Mental Capacity Act (MCA) 2005

1.4.1 The Social Care Institute for Excellence has produced an easy read summary of the Mental Capacity Act 2005, which highlights the key aspects of the Act:

“Key Messages

- *The Mental Capacity Act (MCA) 2005 applies to everyone involved in the care, treatment and support of people aged 16 and over living in England and Wales who are unable to make all or some decisions for themselves.*
- *The MCA is designed to protect and restore power to those vulnerable people who lack capacity.*
- *The MCA also supports those who have capacity and choose to plan for their future – this is everyone in the general population who is over the age of 18.*
- *All professionals have a duty to comply with the Code of Practice. It also provides support and guidance for less formal carers.*
- *The Act’s five statutory principles are the benchmark and must underpin all acts carried out and decisions taken in relation to the Act.*

- *Anyone caring for or supporting a person who may lack capacity could be involved in assessing capacity – follow the two-stage test.*
- *The MCA is designed to empower those in health and social care to assess capacity themselves, rather than rely on expert testing – good professional training is key*
- *If capacity is lacking, follow the checklist described in the Code to work out the best interests of the individual concerned*
- *Understanding and using the MCA supports practice – for example, application of the Deprivation of Liberty Safeguards*

Introduction

This Act a glance summary presents an overview of the Mental Capacity Act (MCA) 2005, which is important to health and social care practice.

The MCA has been in force since 2007 and applies to England and Wales. The primary purpose of the MCA is to promote and safeguard decision-making within a legal framework. It does this in two ways:

- *by empowering people to make decisions for themselves wherever possible, and by protecting people who lack capacity by providing a flexible framework that places individuals at the heart of the decision-making process*
- *by allowing people to plan ahead for a time in the future when they might lack the capacity, for any number*
- *Reach*

About two million people in England and Wales are thought to lack capacity to make decisions for themselves. They are cared for by around six million people, including a broad range of health and social care staff, plus unpaid carers. Those working in health and social care include: doctors, nurses, dentists, psychologists, occupational, speech and language therapists, social workers, residential and care home managers, care staff (including domiciliary care workers), and support workers (including people who work in supported housing).

- *A lack of mental capacity could be due to:*
 - *a stroke or brain injury*
 - *a mental health problem*
 - *dementia*
 - *a learning disability*
 - *confusion, drowsiness or unconsciousness because of an illness or the treatment for it*
 - *substance misuse.*

Five key principles

The Act is underpinned by five key principles (Section 1, MCA). It is useful to consider the principles chronologically: principles 1 to 3 will support the process before or at the point of determining whether someone lacks capacity. Once you've decided that capacity is lacking, use principles 4 and 5 to support the decision-making process.

Principle 1: A presumption of capacity

Every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise. This means that you cannot assume that someone cannot make a decision for themselves just because they have a particular medical condition or disability.

Principle 2: Individuals being supported to make their own decisions

A person must be given all practicable help before anyone treats them as not being able to make their own decisions. This means you should make every effort to encourage and support people to make the decision for themselves. If lack of capacity is established, it is still important that you involve the person as far as possible in making decisions.

Principle 3: Unwise decisions

People have the right to make decisions that others might regard as unwise or eccentric. You cannot treat someone as lacking capacity for this reason. Everyone has their own values, beliefs and preferences which may not be the same as those of other people.

Principle 4: Best interests

Anything done for or on behalf of a person who lacks mental capacity must be done in their best interests.

Principle 5: Less restrictive option

*Someone making a decision or acting on behalf of a person who lacks capacity must consider whether it is possible to decide or act in a way that would interfere less with the person's rights and freedoms of action, or whether there is a need to decide or act at all. Any intervention should be weighed up in the particular circumstances of the case.
Assessment of capacity and best interests decision-making (Sections 2–4, MCA)*

What is mental capacity and when might you need to assess capacity?

Having mental capacity means that a person is able to make their own decisions. You should always start from the assumption that the person has the capacity to make the decision in question (principle 1). You should also be able to show that you have made every effort to encourage and support the person to make the decision themselves (principle 2). You must also remember that if a person makes a decision which you consider eccentric or unwise, this does not necessarily mean that the person lacks the capacity to make the decision (principle 3). Under the MCA, you are required to make an assessment of capacity before carrying out any care or treatment – the more serious the decision, the more formal the assessment of capacity needs to be.

When should capacity be assessed?

You might need to assess capacity where a person is unable to make a particular decision at a particular time because their mind or brain is affected by illness or disability. Lack of capacity may not be a permanent condition. Assessments of capacity should be time- and decision-specific. You cannot decide that someone lacks capacity based upon age, appearance, condition or behaviour alone.

The test to assess capacity

Two-stage functional test of capacity

In order to decide whether an individual has the capacity to make a particular decision you must answer two questions:

Stage 1. *Is there an impairment of or disturbance in the functioning of a person's mind or brain? If so,*

Stage 2. *Is the impairment or disturbance sufficient that the person lacks the capacity to make a particular decision?*

The MCA says that a person is unable to make their own decision if they cannot do one or more of the following four things:

- *understand information given to them*
- *retain that information long enough to be able to make the decision*
- *weigh up the information available to make the decision*
- *communicate their decision – this could be by talking, using sign language or even simple muscle movements such as blinking an eye or squeezing a hand.*
-

Every effort should be made to find ways of communicating with someone before deciding that they lack capacity to make a decision based solely on their inability to communicate. Also, you will need to involve family, friends, carers or other professionals.

The assessment must be made on the balance of probabilities – is it more likely than not that the person lacks capacity? You should be able to show in your records why you have come to your conclusion that capacity is lacking for the particular decision.

Best interests decision-making

If a person has been assessed as lacking capacity then any action taken, or any decision made for or on behalf of that person, must be made in his or her best interests (principle 4). The person who has to make the decision is known as the ‘decision-maker’ and normally will be the carer responsible for the day-to-day care, or a professional such as a doctor, nurse or social worker where decisions about treatment, care arrangements or accommodation need to be made.

What is ‘best interests’?

The Act provides a non-exhaustive checklist of factors that decision-makers must work through in deciding what is in a person’s best interests. A person can put his/her wishes and feelings into a written statement if they so wish, which the person determining capacity must consider. In addition, people involved in caring for the person lacking capacity have to be consulted concerning a person’s best interests.”

Source: <http://www.scie.org.uk/mca/introduction/mental-capacity-act-2005-at-a-glance>

1.4.2 The Act is [available](#).

1.5 Human Rights Act 1998

1.5.1 The Human Rights Act, came into full force on 2 October 2000.

The intention of introducing the Act is –

"To help create a society in which people’s rights and responsibilities are properly balanced and where an awareness of the Convention rights permeates our government and legal systems at all levels."

The Human Rights Act places a duty on all courts and tribunals in the UK to interpret legislation so far as possible in a way compatible with the rights laid down in the European Convention on Human Rights (section 3(1)). Where this is not possible, the court may issue a "declaration of incompatibility". The declaration does not invalidate the legislation, but permits the amendment of the legislation by a special fast-track procedure under section 10 of the Act.

The Human Rights Act applies to all public bodies within the United Kingdom, including central government, local authorities, and bodies exercising public functions. However, it does not include Parliament when it is acting in its legislative capacities.

Key aspects of the Act:

Absolute rights are those that cannot be infringed.

Limited Rights are those that can, under explicit circumstances identified in the Convention, be limited.

Qualified Rights are rights that can be interfered with if what is done:

- has a legal basis
- is necessary in a democratic society i.e. it fulfils a pressing social need, pursues a legitimate aim and is proportionate to the aims being pursued
- is related to the aim set out in the relevant article e.g. the prevention of crime, the protection of public order, health or morals

Qualified rights are:

- the right to respect for private and family life
- rights relating to religion
- the right to freedom of expression
- the right to freedom of assembly and association
- the right to the peaceful enjoyment of property
- the right to education

The Convention allows rights to be interfered with to support a democratic society.

1.6 Mental Health Act 1983 (amended in 1987)

1.6.1 The Mental Health Act is the Act which sets out when you can be admitted, detained and treated in hospital against your wishes. It is also known as being 'sectioned'. You have certain rights under the Mental Health Act, including the right to appeal and the right to get help from an advocate.

The Mental Health Act has a number of sections that contain information on:

- Your rights when you are detained in hospital against your wishes (see our legal pages on sectioning).
- Your family's rights when you are detained (see our legal pages on nearest relative).
- Your rights when you are detained in hospital and also part of the criminal justice system (see our legal pages on mental health and the courts, mental health and the police and sectioning).
- Your rights around consent to treatment when you are detained (see our legal pages on consent to medical treatment).
- Your rights when you are being treated in the community

1.6.2 The Act is [available](#)

1.7 Deprivation of Liberty Safeguards (2009)

1.7.1 The Deprivation of Liberty Safeguards were introduced in 2009. They are part of the Mental Capacity Act 2005 (MCA). They are used to protect the rights of people who lack the ability (mental capacity) to make certain decisions for themselves. The safeguards cover patients in hospitals, and people in care homes registered under the Care Standards Act 2000, whether placed under public or private arrangements.

Key Information

Key information regarding Deprivation of Liberty Safeguards as reported by the Social Care Institute for Excellence:

- *“The Deprivation of Liberty Safeguards are an amendment to the Mental Capacity Act 2005. They apply in England and Wales only.*

- *The Mental Capacity Act allows restraint and restrictions to be used – but only if they are in a person's best interests.*
- *Extra safeguards are needed if the restrictions and restraint used will deprive a person of their liberty. These are called the Deprivation of Liberty Safeguards.*
- *The Deprivation of Liberty Safeguards can only be used if the person will be deprived of their liberty in a care home or hospital. In other settings the Court of Protection can authorise a deprivation of liberty.*
- *Care homes or hospitals must ask a local authority if they can deprive a person of their liberty. This is called requesting a standard authorisation.*
- *There are six assessments which have to take place before a standard authorisation can be given.*
- *If a standard authorisation is given, one key safeguard is that the person has someone appointed with legal powers to represent them. This is called the relevant person's representative and will usually be a family member or friend.*
- *Other safeguards include rights to challenge authorisations in the Court of Protection, and access to Independent Mental Capacity Advocates (IMCAs).”*

Source: <http://www.scie.org.uk/publications/ataglance/ataglance43.asp>

2 RECOMMENDATION

- 2.1 That the information provided in this briefing note informs the evidence base of this Scrutiny Review.

Author: Tracy Tiff, Scrutiny Officer, on behalf of Councillor Cathrine Russell, Chair, Scrutiny Panel 3 Dementia Friendly Town

8 August 2017