City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Report of the Strategic Director of Health and Wellbeing to the meeting of the Health and Social Care Overview and Scrutiny Committee to be held on Thursday 24th January 2019.

AC

Subject:
Support for people with dementia and their carers post diagnosis

Summary statement:
The Committee last received a report in 2018 as part of an annual update this report will update progress made since the last report. The Bradford District Dementia Strategy group oversee the implementation of the dementia strategy implementation plan.
Dementia is a progressive disease characterised by memory loss and cognitive deficits and it is estimated that 5200 people will be living with Dementia across the District; this is expected to rise over the next 10 years as the number of older people increase.
It is therefore fundamentally important that people and their carers are supported by services which work together to enable people to plan and live their lives in the way they would choose after a diagnosis of dementia.

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Overview & Scrutiny Area:
Health and Social Care

1. SUMMARY

The Committee last received a report in 2018 as part of an annual update this report will update progress made since the last report. The Bradford District Dementia Strategy group oversee the implementation of the dementia strategy implementation plan.
Dementia is a progressive disease characterised by memory loss and cognitive deficits and it is estimated that 5200 people will be living with Dementia across the District; this is expected to rise over the next 10 years as the number of older people increase.
It is therefore fundamentally important that people and their carers are supported by services which work together to enable people to plan and live their lives in the way they would choose after a diagnosis of dementia.

2. BACKGROUND

2.1 Context

2.1.2 The Bradford Dementia Strategy and Action Plan 2015-20 was presented to Health and Social Care Overview and Scrutiny in autumn 2014, followed by its initial launch in June 2015. It was refreshed in November 2017 to re-focus local action and align the actions to the Well Pathway for Dementia set out in the 2016 Challenge on Dementia 2020: implementation plan and used in the NHS England Transformation Framework.

2.1.3 In March 2018 the Dementia Strategy Group presented a report on Post Diagnosis Support for People with Dementia to the Health and Social Care Overview and Scrutiny. The committee noted the report and requested a further update in one year. It was requested that the report should focus on the gap between diagnosis and specialist dementia care services.

2.1.4 We are currently reviewing our approach to post-diagnostic support for people with dementia, taking into account both the feedback from people living with dementia and their carers, and the recent guidance described above. The Clinical Commissioning Groups , Health and Wellbeing department (Public health and Adult services) are working together to develop integrated commissioning arrangements with the aim that multi agency integrated services will be provided to support people living with dementia and their carers to live their lives as independently as possible. The recent guidance **NICE guideline [NG97], June 2018. Dementia: assessment, management and support for people living with dementia and their carers** provides a good structure for the desired services, and we are working towards understand how this can and should be applied in Bradford.

2.2 Overview

2.2.1 Dementia is a progressive illness characterised by memory loss and reduced cognitive function. Often, dementia impacts on mood and behaviour in addition to the ability to carry out daily living activities. Dementia is not a single disease, rather it is a disorder caused by a number of underlying disease processes - the most common of which being Alzheimer's disease and vascular dementia.

2.2.2 Surveys between 1991 and 2011 found that the percentage of people aged 65 or over in the UK who living with dementia had reduced from 8.3% to 6.5%[1]. This may be related to a healthier population with better education, prevention and treatment of risk factors than in previous cohorts. In care settings, however, 70% of residents in 2011 were diagnosed with dementia – a large increase compared to 1991.

2.2.3 Services for people with dementia and their carers in Bradford aim to keep people diagnosed with the disease active and independent for as long as possible, following the principles of Happy, Healthy and at Home. Services should maximise people's autonomy and dignity, and should strive towards shared decision-making and personal control over their lives through person-centred community and social and health care.

3. Bradford population

3.1.1 The population of older adults in Bradford is expected to rise by 43% by 2035. This has clear implications for services for older people, and dementia is no exception. It is expected that the need for dementia services in Bradford over the next 10 – 20 years will increase vastly. An increase in the number of cases of dementia across all age groups is likely, increasing from around 5,200 cases today to 8,900 cases in 2035.

3.1.2 Of people aged 65 or more in the District, around 4,300 people were recorded on a GP register as having a diagnosis of dementia as of September 2017. This represents around 4 in every 5 people who are thought to have dementia and is one of the highest rates of diagnosis for those with dementia in the region, reflecting Bradford's success in diagnosing people. A timely diagnosis enables people living with dementia, their carers, and health and care staff to plan accordingly and work together to improve health and care outcomes.

3.1.3 The proportion of younger people (aged under 65 years) recorded as having a diagnosis of dementia is higher in Bradford than the rest of the country on average. This may be due to either better diagnosis of dementia in this younger age group in Bradford, or a higher proportion of people having the disease, or a combination of the two.

3.1.4 People caring for a friend, family member or loved one with dementia play a vital role in the care of many people with dementia. In order to support those living with illness, it is essential that this group of people have the support they need. Compared to the rest of the country as a whole, more carers in Bradford report good quality of life measures. However, this still means that more than half of carers do not have as much social support as they wish.

3.1.5 Emergency hospital admissions can be distressing and disorientating for anyone. This is particularly true for people with dementia. In 2016/17, Bradford had a rate of emergency hospital admissions for people aged over 65 where dementia was mentioned which was similar to England, and lower than Yorkshire and the Humber. Considering that the rates of recorded dementia in Bradford and Airedale's CCGs are higher than the regional and national averages, this suggests that local services are doing well at keeping people with dementia out of emergency care. This equated to 2,060 unplanned admissions to BRI with a primary or secondary diagnosis of dementia and 1,156 unplanned admissions to Airedale

[1] Matthews F. E., Arthur A., Barnes L. E., Bond J., Jagger C., Robinson L., et. al. (**2013**) A two-decade comparison of prevalence of dementia in individuals aged 65 years and older from three geographical areas of England: results of the Cognitive Function and Ageing Study I and II. The Lancet. 382; 9902: 1405-1412

in 2016/17 (please note that these are all admissions and could be for people registered outside Bradford and Airedale CCGs).

3.1.6 Dementia is often a life limiting illness. However, mortality rates can be compared against other areas to give an idea of the geographical variation in death rates of people with dementia. Bradford appears to have a higher mortality rate for people with dementia than Yorkshire and the Humber or England as a whole. The causes for this are unclear.

3.1.7 An important marker of quality of care is where people with dementia die. When asked in surveys, people tend to express a desire to die in their own home, with the least popular location to die being in hospital[2]. In Bradford, more people with dementia are dying in their usual place of residence than in the rest of the country. Locally this means that fewer people are dying in hospital and more people are dying in care homes than in the country as a whole.

3.2 Current service provision

3.2.1 Diagnosis usually occurs in a Memory Assessment and Treatment Service (MATS). These are delivered by Bradford District Care Trust (BDCT) through their Older People's Community Mental Health Teams (CMHTs).

3.2.2 There are three Older People's CMHTs in the Bradford and Airedale areas. Each team will offer assessment, treatment and other interventions to older people with mental health conditions. The Teams are currently based within existing Trust properties at Horton Park Health Centre (South & West), Manningham Health Centre (Bradford City & North), Meridian House and Craven Centre (Airedale Wharfedale and Craven Team).

3.2.3 MATS are delivered weekly from 13 community-based GP practices across the district and an Older People's CMHT base in Keighley. There is an annual capacity for around 1,400 new referrals per annum from GP practices across the district, with average waiting times currently around 5-6 weeks in Airedale, Wharfedale and Craven, and 12-15 weeks in Bradford. In 2016/17 over 1750 new referrals were received, resulting in over 6000 planned contacts.

3.2.4 MATS provide initial assessment, diagnosis, treatment and initial review support to people suspected of having dementia. Around 50% of referrals result in a confirmed diagnosis of dementia. Combined, MATS services offer in excess of 3,000 appointments per annum across the district with input from psychiatry, psychology and nursing professions. Around 15% of all referrals are for patients from BAME communities, varying between 55% in Bradford to 6% in Craven. Only 9% of referrals are for patients of working age, with 91% aged 65yrs and above.

3.2.5 The Older People's CMHTs and Memory Services work closely with the carers' hub/ carers' resource in order to ensure support and advice for carers, having strong links with the Alzheimer's society through the memory clinics, and other age/cultural appropriate VCS organisations.

[2] Gomes B., Calanzani N. and Higginson I. J. (2011) Local preferences and place of death in regions within England 2010. Available online at: http://www.endoflifecare-intelligence.org.uk/resources/publications/lp_and_place_of_death

3.2.6 Each of the three Older People's CMHTs have a Care Home Liaison Practitioner dedicated to providing support to Care Home staff and residents within their CMHT catchment. The service operates Monday-Friday on a consultancy referral basis to offer guidance and advice in relation to and where appropriate assessment of, individual care home residents experiencing psychological distress as a result of mental health conditions including depression, anxiety, psychosis and dementia. This service supports around 120 care homes across the district. In 2016/17 it received 753 new referrals, delivering almost 300 contacts. The current provision needs to be linked with developments planned as a result of the CQC system review in February 2018 to work in partnership with care providers to improve services by developing an integrated service improvement team to include health, social care and therapeutic support.

3.2.7 The current service provision does not provide a 24 hour multiagency Support service for people living with dementia who are in crisis either in their own Home or in a care home this does not effectively support people to remain in their usual place of residence .This is a key issue to address in our integrated planning and operations as a health and care system and will involve urgent care, mental health crisis services, and out of hospital services working in partnership to connect up support across all sectors in order to coordinate personalised support planning and integrated multiagency responses.

3.3 Post-diagnostic Support

3.3.1 Post-diagnostic specialist support for people with dementia is commissioned partially by the Local Authority and partly by the three Bradford and Airedale CCGs via BDCT. A number of different services are commissioned, ranging from universal provision to highly specialist support.

3.3.2 People living with dementia will be supported with personal care services as outlined in the Care Act 2014 whether they are eligible for support under the Care Act funded by the Local Authority or are self-funding their own support .The Local Authority has a legal requirement to ensure there is sufficient supply of care services available. Some people will be eligible for fully funded continuing healthcare and this will be funded by the Clinical Commissioning Groups.

3.4 Community Services

3.4.1 A number of community services provide support, information and advice to people with dementia and their carers.

3.4.2 People diagnosed with dementia are automatically offered onward referral to a Dementia Advisor, making contact within two weeks of referral to provide information about diagnosis & treatment, carers' needs, community support, local services, benefits and legal advice. The Dementia Adviser works alongside Dementia Support Workers from diagnosis and throughout the dementia journey. This is run by the Alzheimer's Society and funded by both the Local Authority and the CCGs, and subsidised with voluntary income. As of September 2018 3,749 people with dementia and 3,650 carers of people with dementia were on the Bradford Alzheimer's Society database: 85% of all those registered with dementia in Bradford.

3.4.3 In addition, daytime community activities, including Wellbeing Cafés provided by the Alzheimer's Society, are run across Bradford. Dementia-specific cafes host different activities and events for people with dementia and their carers.

Table 1: Dementia Cafés, with numbers attending 2018

Wellbeing Cafes	**Apr**	**May**	**June**	**July**	**Aug**	**Sept**
Ilkley	27	32	14	29	26	38
Eccleshill	34	27	35	18	28	35
Singing For The Brain						
Undercliffe	34	26	22	21	25	44
Ongoing Peer Support Activities						
Evening Cafe	12	4	10	0	15	20
Westcliffe Carers' Group (Re-launched Oct 2018)	N/A	N/A	N/A	N/A	N/A	N/A

3.4.4 A café for patients from South Asian communities is currently being set up in Girlington Community Centre by the VCS organisation Sharing Voices. This service is being developed with the following aims:

- To raise awareness of dementia and challenge stigma among South Asian communities
- To support early diagnosis through improved access to memory assessment services
- To provide post-diagnostic support through the provision of advocacy
- To support carers from South Asian communities
- To build their knowledge and capacity within other services to work more effectively with the target communities
- To have a friendly and welcoming culture at the dementia café
- Language and cultural support
- Involvement in social activities and community events
- Confidence building activities to encourage independence
- Physical and mental health improvement activities
- To support access to other services around Bradford District

- Tackle lower rates of diagnosis among people living with dementia from BME and religious minority communities

- Set up a weekly dementia friendly swimming group for men and women

3.4.5 The Link worker for this service will also help people with dementia and their carers to understand the illness and manage symptoms, provide support to keep up community connections and make new ones, offer the chance to meet other people with dementia and their carers and family, and help to plan for future decision-making and support.

3.4.6 Other local community services include:

- Online resources covering Self-Care and prevention of dementia: https://www.bradford.gov.uk/health/self-care/self-care/

- Memory Tree groups have recently been commissioned in Low Moor, Shipley & Idle, and Keighley

- A number of Wellbeing Cafés and other community projects across the district which anyone can attend

- Dementia counselling for all ages is commissioned by the Local Authority and provided by Relate

- Sharing Voices provide support for older people with dementia and mental health needs

- Carer's Resource provides support to all carers in the Bradford District and Craven including carers. This includes wellbeing reviews for the carer

- The Royal British Legion has a community Admiral Nurse in Bradford, who provides support to ex-service people with dementia and their families.

3.4.7 In the wider community, organisations (places of worship, healthcare providers, etc.), businesses and communities are encouraged and supported to become Dementia Friendly. This is a national initiative led by the Alzheimer's Society aiming to ensure that communities are "aware of and understand dementia, so that people with dementia can continue to live in the way they want to and in the community they choose". In order to become Dementia Friendly, organisations must be aligned to a Dementia Friendly community .Through the Dementia Strategy Group Bradford has recently become Dementia Friendly in order to support any organisation which wishes to in the District to become Dementia Friendly. The governing body for the three CCGs has recently taken the decision to become a dementia friendly organisation.

3.5 Social Care

3.5.1 The Care Act 2014-The Care Act (2014) introduced duties on local authorities to facilitate a vibrant, diverse and sustainable market for high quality care and support in their area, for the benefit of their whole population regardless of how the services are funded. It also places a duty on the local authority to ensure that there are prevention and wellbeing

services to support people and their carers to remain independent. The statutory guidance to the Care Act states the market should include a variety of different providers and different types of services. This should include a genuine choice of service type, not simply a selection of providers offering similar services. It must include services for older people. We want to move forward with offering personalised services for older people including people living with dementia. The guidance for Bradford Council has been refreshed in order to implement the Home First Vision. This is supporting the implementation of key benefits within the Happy, Healthy and at Home integrated health and care plan, including all social care and support providers workforce development - with the shared goal of ensuring a trained, quality workforce who have the relevant skills and appropriate working conditions, this includes supporting people living with dementia.

Connect to Support is a website for people looking for adult social services, advice and support. It has everything from local to national products and services, as well as links to information, specialist advice, local activities and community groups. It has a register of personal assistants to make it easier for people who want to take up a direct payment to find a PA.

Individual service funds (ISFS) are a personal budget option for adults assessed as being eligible for social support they give the opportunity to have more support flexibility to people who do not want or choose a direct payment. The person can choose a fund holding organisation (provider, Voluntary and Community organisation) to manage the direct payment and the organisation then work with the person or carer to design and develop personal support to meet their assessed needs.

Community Led Support principles –locally services are designed using these principles ,including co-production (bringing people and organisations together around a shared vision);a focus on individual communities (including community partnerships) ;enabling people to get support and advice when they need it so that crises are prevented; the culture becoming based on trust and empowerment; people are treated as equals , building on their strengths and gifts; keeping bureaucracy to a minimum ;and having a responsive, proportionate system which delivers good outcomes

3.5.2 **Safe and Sound and use of technology to support independence**

Safe and sound provides technology with a person's home to support them to live as safely as possible, it includes an alarm system which responds to various triggers and the call handlers can call nominated family or friends to respond, a response team including a response to a fall, ambulance and other emergency services. The technology is extensive but not fully utilised so we have plans in the next year to optimise its use to enable people to remain in their own home for as long as possible.

3.5.3 **Time out and Shared lives**

Time out is a service which provides support in a person's own home to enable a carer to have respite or a holiday. We have expanded the service to respond in a crisis to support a carer who maybe ill or a person with dementia who maybe unwell so that they can remain at home while they are treated with support from a trained carer in their own home while they recover, we hope this will prevent some admissions to hospital. Shared lives provides support to people in the carers home enabling a person's carer to have respite while the person cared for is supported in a carers own home.

3.5.4 Specialised Support is provided through specialist day care centres at Woodward Court (Allerton), Holmewood Resource Centre (Keighley) Local Authority Respite & Assessment Units are available at Woodward Court (Bradford), Holmewood (Keighley),

3.5.5 Extra care and supported living is supporting people with dementia to live independent lives and more developments are being planned. A new development in Keighley will open in April which will include 38 apartments specifically for people living with dementia, along with a 50 bed short term residential unit with specialist services for people living with dementia.

3.5.6 For those needing Residential and Nursing Home Care long term , homes suitable for patients with dementia are provided in 'EMI' registered facilities, with support from the Care Home Liaison Team and the Complex Care Team / Community Matron. This is an area where more needs to be done to support and work with care home providers to support staff and people living with dementia in their homes as identified in the Care Quality Commission System review in February 2018.This development is included in the enhanced care and health care in care homes work and will be monitored as part of the Integrated care system partnerships.

3.6 Specialist support

3.6.1 An annual review of physical health, changes in memory, and medication should be done each year for people with dementia by their general practitioner. This review includes advanced care planning, allowing people to make decisions about what they want for the future. Patients in all three CCGs in Bradford are more likely to have had a review in the past year than patients from the rest of the country on average.

3.6.2 In addition, a nurse review is undertaken three months after diagnosis, covering physical health, social needs, practical support, medication, wider mental health, any necessary sign-posting.

3.6.3 BDCT provides a dedicated mental health hospital liaison service for people aged 65yrs and above for each of the 5 general and community hospital sites across the district (BRI, St Luke's, Airedale General, Westwood Park & Westbourne Green). The service operates 6 days per week 9am-5pm supplementing the Accident & Emergency Mental Health Liaison Service by providing by direct referral guidance, advice and assessment of hospital in-patients experiencing psychological distress as a result of mental health conditions including depression, anxiety, psychosis and dementia.

3.6.4 The Hospital Liaison Service consists of a band 6 mental health nurse, occupational therapist, general nurse and consultant psychiatrist to provide a multi-disciplinary approach, working in active conjunction with general hospital MDTs and social work teams. Focus is on enhancing approaches to supporting patients with mental health needs in general hospital settings and ensuring effective and timely discharge support. The service receives around 750 referrals and provides over 1000 direct contacts per year.

3.6.5 For patients with or suspected of having dementia presenting with complex needs and / or behaviour that challenges, there is a 22-bedded specialist in-patient assessment unit for people from across Bradford & AWC Districts. The unit provides multi-disciplinary assessment, treatment and therapy, mainly under the auspices of the Mental Health Act, with patients experiencing an average length of stay of around 90 days. There are strong links with Older People's CMHTs and Care Home Liaison as the majority of patients either arrive from or are discharged to care home settings.

We have plans this coming year to develop a multiagency integrated team to support people who may be at risk of admission and to support transfers from the specialist unit .There is an opportunity to enhance the integrated offer in the local authority managed specialist dementia units for assessment and enablement to support people to remain the community.

3.7 What people have told us

3.7.1 We are currently undertaking a small scale engagement with people living with dementia and their carers on what is most important to them, and what enables them or would enable them to live in a way which is positive for them. This consultation is expected to be completed in January 2019. However themes have already emerged from recent feedback:

- Support from family is valued, particularly if this is a number of people and so we need to consider how we support rather than replace that.
- Carers' emergency plans were felt to be helpful, and the quality and level of detail in care plans important.
- The quality and reliability of care wherever that was provided was important, as was the ability to contact care services easily when needed
- Need for respite and support for carers
- The need for financial advice, including bank accounts, benefits & pensions
- Information about dementia and support available, including what to do in an emergency
- Strategies for carers to help them cope with daily practical issues, such as what to do when the person living with dementia can no longer drive
- Support with finding care homes was important
- Equipment and speed of delivery of this
- Support for people and their carers with early onset dementia was felt to be less well developed than services for older adults
- Importance of good communication between services and organisations
- Support through transitions, including transitions between services (e.g. from residential to nursing homes) and the changes in condition as the illness progresses.

3.8 National guidance

3.8.1 Two new pieces of guidance have recently been released, which are summarised below and included in full as appendices.

3.8.2 The National Collaborating Centre for Mental Health has recently published guidance for implementation of the Dementia Care Pathway, available online: https://www.rcpsych.ac.uk/improving-care/nccmh/care-pathways

3.8.3 NICE guideline [NG97], June 2018. Dementia: assessment, management and support for people living with dementia and their carers

3.8.4 This guidance places high emphasis on person-centred care, asserting the importance of human value, individuality, experiences, perspective, and relationships for people living with dementia and the needs of their carers.

3.8.5 The guidelines make recommendations in 13 key areas, of which the most pertinent to post-diagnostic support are:

- Involving people living with dementia in decisions about their care
- Care co-ordination – including having a named care co-ordinator to assess the individual's needs, provide information about available services, develop and agree support plans, and to co-ordinate transfer of information between settings.
- Interventions to promote cognition, independence and wellbeing
- Assessing and managing other long-term conditions in people living with dementia
- Palliative care
- Supporting carers – including offering psycho/social education and skills training intervention that includes education about dementia; developing personalised strategies and building carer skills; training to help them provide care; training to help them adapt their communication styles; advice on how to look after their own wellbeing; advice on planning enjoyable and meaningful activities to do with the person they care for; information about relevant services and how to access them; and advice on planning for the future.

3.9 Dept. of Health &Social Care guidance, May 2018

3.9.1 The most important aspects of this guidance with regards to post-diagnostic support for people with dementia are:

- A care plan that sets out what sort of care the person with dementia and their carers might need & who will provide it
- A named person for support (care co-ordinator) as a contact point for information and a once-a-year review

- Help with day-to-day activities and help for carers including what support people and their carers can get from the Local Authority as outlined in the Care Act 2014.

- Person-centred and outcome-focused care training for health and care staff

- Support to making decisions about the future including end of life care

- Opportunities for people with dementia and their carers to feedback about support

- Details on where to go for more information that is in an accessible format

- Offer carers of people living with dementia a psycho/social education and skills training intervention

4. DRAFT PRIORITIES FOR ACTION PLANNING FOR THE COMING YEAR

4.1 Apply the DH and social care guidance as outlined in 3.9 and those relating to Dementia and older people in the NHS Long Term Plan 2019 (background document, Section 10.1).

4.2 Undertake analysis on the current spend on services for people living with dementia and their carers across the system and use this as the baseline for future changes/developments

4.3 Work together as a system to develop multi-agency 24/7 crisis services for people with dementia which aims top keep people in their place of residence and prevent unnecessary admissions to acute and mental health hospitals as outlined in the NHS Long Term Plan January 2019.

4.4 Work together as a system to develop multi-agency teams/services which supports people and their families to live well in their communities by incorporating the expressed views/needs of people living with dementia and their families into the integrated working we are currently doing in some of our programmes of work. Include the needs of people and their families within the Community partnerships/Community led support initiatives, as outlined in the NHS Long Term Plan, January 2019.

4.5 Include the needs of people living with dementia into the current refresh of the end of life planning which will be undertaken this coming year.

5. FINANCIAL & RESOURCE APPRAISAL

The local authority currently funds around 1900 people at a cost of £20m a year, people who are self-funding their care in a care home will pay from £487 a week –£937 a week.

6. RISK MANAGEMENT AND GOVERNANCE ISSUES

6.1.1 If there are no significant risks arising out of the implementation of the proposed recommendations it should be stated but only on advice of the Assistant Director Finance and Procurement and the City Solicitor.

7. LEGAL APPRAISAL

7.1 Duties of the LA under the Care Act 2014

7.1.2 Specific to this report are the principles of –

promoting individual wellbeing set out in s.1 and preventing needs for care and support s2.

7.1.3 In terms of promoting diversity and quality in provision of services this is set out in Section 5 (1) and includes the market shaping duty, the duty of the LA to promote an efficient and effective market of care and support services for people in its area available to meet people's needs. In s.5 (2) the following must be considered by the LA (this list is not exhaustive) –

- having and making available information about service providers and the types of service they provide
- current and likely future demands for services and how providers might meet this demand
- enabling service users and carers to participate in work, education or training, where they wish to do so
- ensuring market sustainability
- fostering continuous improvement in the quality, efficiency and effectiveness of services
- fostering a workforce that can deliver high quality services.

7.1.4 It is important to note that when commissioning services consideration must be given to the effect of commissioning decisions on the wellbeing of the people using the services (this duty is explicitly set out in s.5(4).

7.2 Mental Capacity Act 2005 (MCA)

7.2.1 The Mental Capacity is a wide ranging piece of legislation which includes legal provision and protection for people who are assessed as lacking capacity to make specific decisions in relation to their care, treatment and accommodation. The Deprivation of Liberty Safeguards (DoLS) came into force in April 2009. The DoLS are designed to ensure that Human Rights are upheld for people who lack capacity to consent to care and treatment within care settings such as Care Homes and Hospital and who are under consistent supervision and control and not free to leave. People may also be deprived of their liberty in other settings, including their own homes or Supported Living settings. Authorisations for these DoLS must be sought through Court of Protection. The MCA recognises that The Local Authority is the Supervisory Body responsible for the authorisations of the DoLS. Care Homes and Hospitals are the Managing Authorities and have the responsibility of identifying deprivations of liberty that may be occurring within their settings.

7.3 Mental Health Act 1983

The Mental Health Act 1983 is the main piece of legislation that covers the assessment, treatment and rights of people with a mental health disorder. The Mental Health Act is structured in many sections. Section 2 of the Mental Health Act is for admission to hospital

for assessment for a period of not exceeding 28 days. The person is admitted to hospital on the grounds that they have a mental disorder of a nature or degree which warrants the detention in hospital and is being admitted in the interests of their own health or safety, or with a view to the protection of other persons. Medical treatment for the mental disorder is undertaken under section 3 of the Mental Health Act.

7.3.1 The majority of people who are admitted to the Dementia Assessment Unit are admitted under section 2 of the Mental Health Act. If they go on to receive medical treatment this is under Section 3 of the Mental Health Act. Once the person is ready to transfer from hospital there are rules under Section 117 about the after-care arrangements which requires clinical commissioning groups and local authorities, in cooperation with voluntary agencies, to provide or arrange for the provision of after-care to people who have been detained in hospital for treatment.

7.3.2 After care service are defined as those services which have the purpose of meeting a need arising from or related to the person's mental disorder and reducing the risk of a deterioration of the mental disorder requiring admission to hospital again for treatment for mental disorder. Section 117 aftercare arrangements in the Bradford District have recently been subject to a joint audit.

8. OTHER IMPLICATIONS

8.1 Equality & Diversity

8.1.1 The Public Sector Equality Duty under the Equality Act 2010 requires the Council when exercising its functions to have due regard to the need to:

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010
- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it
- relevant protected characteristics include age, disability, gender, sexual orientation, race, religion or belief.

8.2 Community Safety Implications

8.2.1 Older people with dementia and other long-term conditions are among the most vulnerable people in the community. Providing high quality care and appropriate environment for care services is consistent with the Council's statutory duty to safeguard vulnerable adults.

8.3 Human Rights Act

8.3.1 The Human Rights Act 1998 makes it unlawful for any public body to act in a way which is incompatible with an individual's human rights. Where an individual's human rights are endangered, Local Authorities have a duty to balance those rights with the wider public interest and act lawfully and proportionately. For this report, the most relevant rights from the 16 covered in the Human Rights Act (1998) are:

- the right to respect for private and family life

- the right to peaceful enjoyment of your property (if this were interpreted broadly as enjoyment of one's home)
- the right to freedom from inhuman and degrading treatment
- the right not to be discriminated against in respect of these rights and freedoms.

8.3.2 The definition of adult abuse, in guidance issued under statute, is based on the concept of human rights: "Abuse is a violation of an individual's human or civil rights by any other person or persons". (No Secrets, Department of Health, 2000).

8.3.3 As with the equal rights considerations, the proposed changes are expected to have an overall positive impact on these considerations though there is a risk of adverse impact for individuals who live in the homes currently. In line with legal requirements and Council policy, vulnerable individuals and their friends, families and advocates have been and will continue to be involved in any consultation process and planning of changes, and that planning of change is fair and proportionate, and seeks to mitigate any identified adverse impacts of decisions made.

8.4 NOT FOR PUBLICATION DOCUMENTS

None

9.0 RECOMMENDATIONS

- The committee are asked to note and comment on the report including the priorities for this coming year outlined in 3.9 and section 4.

10. BACKGROUND DOCUMENTS

10.1 The NHS Long Term Plan
Published January 2019
www.longtermplan.nhs.uk

10.2 Dementia: assessment, management and support for people living with dementia and their carers,
Published June 2018
NICE guideline
Nice.org.uk/guidance./ng97

10.3 The Dementia Care Pathway – Full implementation Guidance
National Collaborating Centre for Mental Health
Updated October 2018