TOWER HAMLETS

**Meeting of the**

# HEALTH SCRUTINY PANEL

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**Tuesday, 14 October 2008 at 6.30 p.m.**

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**A G E N D A**

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**VENUE**
**Room M72, 7th Floor, Town Hall, Mulberry Place, 5 Clove Crescent, London, E14 2BG**

| **Members:** | **Deputies (if any):** |
|---|---|
| **Chair: Councillor Stephanie Eaton**<br>**Vice-Chair:Councillor Motin Uz-Zaman** | |
| **Councillor Lutfa Begum**<br>**Councillor Ann Jackson**<br>**Councillor Abjol Miah**<br>**Councillor Bill Turner**<br>**Vacancy** | Councillor Denise Jones, (Designated Deputy representing Councillors Ann Jackson, Bill Turner, Md. Abdus Salique and Motin Uz-Zaman)<br>Councillor Azizur Rahman Khan, (Designated Deputy representing Councillor Stephanie Eaton)<br>Councillor Abdul Matin, (Designated Deputy representing Councillor Stephanie Eaton)<br>Councillor Abdul Munim, (Designated Deputy representing Councillor Abjol Miah)<br>Councillor Tim O'Flaherty, (Designated Deputy representing Councillor Stephanie Eaton)<br>Councillor M. Mamun Rashid, (Designated Deputy representing Councillor Abjol Miah)<br>Councillor Dulal Uddin, (Designated Deputy representing Councillor Abjol Miah) |

**[Note: The quorum for this body is 3 Members].**

**Co-opted Members:**

Mr Nuruz Jaman
Mr John Lee
Dr Amjad Rahi

If you require any further information relating to this meeting, would like to request a large print, Braille or audio version of this document, or would like to discuss access arrangements or any other special requirements, please contact: Amanda Thompson, Democratic Services, Tel: 020 7364 4651, E-mail: Amanda.Thompson@towerhamlets.gov.uk

# LONDON BOROUGH OF TOWER HAMLETS

# HEALTH SCRUTINY PANEL

## Tuesday, 14 October 2008

## 6.30 p.m.

## 1. APOLOGIES FOR ABSENCE

To receive any apologies for absence.

## 2. DECLARATIONS OF INTEREST

To note any declarations of interest made by Members, including those restricting Members from voting on the questions detailed in Section 106 of the Local Government Finance Act, 1992. See attached note from the Chief Executive.

| | | PAGE NUMBER | WARD(S) AFFECTED |
|---|---|---|---|
| **3.** | **UNRESTRICTED MINUTES** | **3 - 6** | |
| | To confirm as a correct record of the proceedings the unrestricted minutes of the ordinary meeting of Health Scrutiny Panel held on 22 July 2008. | | |

## 4. REPORTS FOR CONSIDERATION

| | | | |
|---|---|---|---|
| **4a** | **Tobacco Cessation Review Action Plan - Update** | | |
| | Jill Goddard, Tobacco Control Lead, THPCT and Dave Tolley, Trading Standards, LBTH, will provide an update on last year's review. | | |
| **4b** | **Early Intervention Service** | **7 - 10** | |
| | Brigid Macarthy, Consultant Clinical Psychologist, East London NHS Foundation Trust, will present a report about the proposed early intervention service. | | |
| **4c** | **Adult Protection** | **11 - 26** | |
| | Deborah Cohen, Service Head for Disability and Learning, LBTH, will present the annual report. | | |
| **4d** | **Joint Strategic Needs Assessment** | **27 - 30** | |

Somen Banerjee, Associate Director for Public Health, THPCT, will update the panel about the work being undertaken on the first Joint Strategic Needs Assessment which will inform the commissioning process for health and social care services.

**4e Improving Health and Wellbeing Strategy Refresh**

Alwen Williams, Chief executive, THPCT to give a presentation.

## 5. ANY OTHER BUSINESS WHICH THE CHAIR CONSIDERS TO BE URGENT

# DECLARATIONS OF INTERESTS - NOTE FROM THE CHIEF EXECUTIVE

This note is guidance only. Members should consult the Council's Code of Conduct for further details. Note: Only Members can decide if they have an interest therefore they must make their own decision. If in doubt as to the nature of an interest it is advisable to seek advice **prior** to attending at a meeting.

## Declaration of interests for Members

Where Members have a personal interest in any business of the authority as described in paragraph 4 of the Council's Code of Conduct (contained in part 5 of the Council's Constitution) then s/he must disclose this personal interest as in accordance with paragraph 5 of the Code. Members must disclose the existence and nature of the interest at the start of the meeting and certainly no later than the commencement of the item or where the interest becomes apparent.

You have a **personal interest** in any business of your authority where it relates to or is likely to affect:

(a) An interest that you must **register**

(b) An interest that is not on the register, but where the well-being or financial position of you, members of your family, or people with whom you have a close association, is likely to be affected by the business of your authority more than it would affect the majority of inhabitants of the ward affected by the decision.

Where a personal interest is declared a Member may stay and take part in the debate and decision on that item.

**What constitutes a prejudicial interest?** - Please refer to paragraph 6 of the adopted Code of Conduct.

**Your personal interest will also be a prejudicial interest in a matter if (a), (b) and either (c) or (d) below apply:-**

(a) A member of the public, who knows the relevant facts, would reasonably think that your personal interests are so significant that it is likely to prejudice your judgment of the public interests; AND
(b) The matter does not fall within one of the exempt categories of decision listed in paragraph 6.2 of the Code; AND EITHER
(c) The matter affects your financial position or the financial interest of a body with which you are associated; or
(d) The matter relates to the determination of a licensing or regulatory application

The key points to remember if you have a prejudicial interest in a matter being discussed at a meeting:-

i. You must declare that you have a prejudicial interest, and the nature of that interest, as soon as that interest becomes apparent to you; and

ii. You must leave the room for the duration of consideration and decision on the item and not seek to influence the debate or decision unless (iv) below applies; and

iii. You must not seek to improperly influence a decision in which you have a prejudicial interest.

iv. If Members of the public are allowed to speak or make representations at the meeting, give evidence or answer questions about the matter, by statutory right or otherwise (e.g. planning or licensing committees), you can declare your prejudicial interest but make representations. However, you must immediately leave the room once you have finished your representations and answered questions (if any). You cannot remain in the meeting or in the public gallery during the debate or decision on the matter.

**LONDON BOROUGH OF TOWER HAMLETS**

**MINUTES OF THE HEALTH SCRUTINY PANEL**

**HELD AT 6.30 P.M. ON TUESDAY, 22 JULY 2008**

**ROOM M72, 7TH FLOOR, TOWN HALL, MULBERRY PLACE, 5 CLOVE CRESCENT, LONDON, E14 2BG**

**Members Present:**

Councillor Stephanie Eaton (Chair)

Councillor Ann Jackson

**Co-opted Members Present:**

Dr Amjad Rahi – Barts and The London Patient Public Involvement Forum (Chair)

**Guests Present:**

- Barts and the London NHS Trust
- Tower Hamlets PCT
- NEL Cardiac and Stroke Network
- East London NHS Foundation Trust

**Officers Present:**

Afazul Hoque – (Acting Scrutiny Policy Manager, Scrutiny and Equalities, Chief Executive's)

Shanara Matin – (Scrutiny Policy Officer)

Amanda Thompson – (Team Leader - Democratic Services)

**THIS MEETING WAS INQUORATE BUT THOSE MEMBERS PRESENT AGREED TO PROCEED ON AN INFORMAL BASIS**

## 1. APOLOGIES FOR ABSENCE

Apologies were received from Councillors Mohammed Abdus Salique and Bill Turner, and from Nuruz Jaman, Co-opted Member.

## 2. DECLARATIONS OF INTEREST

No declarations were made.

## 3. UNRESTRICTED MINUTES

The minutes of the meeting held on 26 June 2008 were agreed as a correct record subject to the following amendment:

**7. Health Scrutiny Work Programme 2008/09**

i) Joint working with the NHS in respect of end of life care.

## 4. REPORTS FOR CONSIDERATION

### 4.1 Health Scrutiny Work Programme 2008/09 - 2009/10

As the meeting was inquorate it was agreed that the work programme should be circulated separately to all Members of the Panel for their comments.

### 4.2 Primary Care Trust Response to Draft Health Scrutiny Protocol

Martin Cusak, Assistant Chief Executive of Tower Hamlets Primary Care Trust, presented a report detailing the PCT's response to the draft Health Scrutiny Protocol.

He advised that the PCT supported the protocol but were suggesting a number of changes to clarify when issues should be submitted for scrutiny to the Panel and the particular role of the PCT as a commissioner of health services for the local community.

In response to a question concerning why the Panel would be concerned with major expansions of service, the Chair advised that while generally these were considered a good thing, they did have an impact on Council services and the Panel would wish to be informed of these in advance.

The Chair also stressed the need for the PCT to make the Panel aware of what was required of it.

Dr Amjad Rahi said that he would like to see a reference to LINKs in the protocol as these were able to provide information to the Council directly, not just through the PCT.

### 4.3 North East London Stroke Services

Jane Davis, Network Manager of the North East London Cardiac and Stroke Network, presented a report detailing the current developments and the future direction of effective stroke provision in North East London.

The Panel noted that NEL had traditionally scored poorly overall against all the key indicators and standards for stroke targets, however this was being addressed in line with the National Stroke Strategy, and also by the

introduction of a 'Hyper Acute' Stroke Pathway pilot scheme in September 2008.

While the report was only for information at this stage, Ms Davis advised that there could be an impact on the Council's provision of social care in the future if there was a high number of early supported discharge patients.

**4.4 Complaints and Performance by NHS Trusts**

PCT

Martin Cusack presented the annual report on complaints which the PCT presented to its Board for 2007/2008. The report summarised the complaints and compliments received, what had been learnt from the main categories of complaints, the processes that were followed and the standards that had been achieved.

The Panel noted that there had been a total of 61 formal complaints in comparison to 113 during the same period the previous year. While service improvements in some GP practices had led to a fewer number of complaints, there was still a need to be proactive in encouraging people to make complaints and streamline the processes for doing so.

East London NHS Foundation Trust

Leeanne McGee, Borough Director, presented the annual report detailing the number of complaints received and the performance against timescales as set out in the NHS Complaints procedure.

During the period 1 April 2007 to 31 March 2008 the Trust had received 252 formal complaints, an increase on the previous year of 66%.

Reasons for this included lack of training for staff and problems with translation services, however both issues were already being addressed. A new complaints procedure was being launched in 2009 and the Trust was currently taking part in the Early Adopter Programme to support the development of an innovative approach to responding to complaints.

Barts and The London NHS Trust

Jane Canny and Jay O'Brien presented the quarterly complaints report.

Since April 2008, there had been an increase in the amount of formal complaints received in the Trust, compared to the same period the previous year. Much of the increase was due to the problems experienced by patients accessing the appointment system. Alerts from the complaints team and PALS have prompted early detection and actions from the executive team. There had also been an increase in the number of complaints about diagnosis and treatment, although complaints about transport - one of the Trust's top

five causes of complaint - had decreased following actions taken by the Trust and Carillion.

The Trust had undertaken surveys of complainants and staff who have been involved with the complaint process in order to better understand what was required from the Complaints team and the process itself. The results had supported investment in staff training and provided some clear messages from complainants about resolution.

The Panel noted that work was focusing on resolving patients' complaints and concerns through proactive joint working with PALS and the Patient Public Involvement team. The teams would be reviewing and making recommendations for change in response to the new complaints process.

**4.5 St Paul's Way Medical Centre**

Martin Cusak provided a written response to the previous queries raised by Members with regard to the contracting out of services at St Paul's Way Medical Centre.

The Panel noted that since the contract had been taken over there had been an increase in the range of services provided to patients as well as access to clinical staff. Performance monitoring took place monthly, quarterly and annually with weekly meetings to address any operational issues.

In response to questions Mr Cusak advised that there was no longer a need for a 'walk-in' facility as more appointments were available, also the financial risks were the same as the NHS and risk management procedures were in place.

The Panel asked for a report back at the end of the Centre's first year of operation.

**4.6 Local Involvement Network Update**

Mr Amjad Rahi (former Barts and The London PPI representative) gave an verbal update on the progress towards procuring a host organisation for the Local Involvement network in Tower Hamlets.

The meeting ended at 9.00 p.m.

Chair, Councillor Stephanie Eaton
Health Scrutiny Panel

| Committee | Date | Classification | Report No. | Agenda Item No. |
|---|---|---|---|---|
| Health Scrutiny Panel | 14th October 2008 | Unrestricted | | 4.2 |
| **Report of:**<br><br>**Brigid Macarthy, Clinical Psychologist, East London NHS Foundation Trust** | | **Title:**<br><br>**Briefing Paper on the Proposed Development of an Early Intervention Service in Tower Hamlets**<br><br>**Ward(s) affected: borough wide** | | |

## 1. Summary

1.1 This briefing paper has been prepared to inform Members of the Health Scrutiny Panel about the proposed development of an early detection service for mental health.

## 2. Recommendations

It is recommended that Members:

2.1 comment on the proposals set out within this briefing paper.
2.2 Suggest further ways to ensure the proposed service meets the needs of residents within Tower Hamlets.

**LOCAL GOVERNMENT ACT, 2000 (SECTION 97)**
**LIST OF "BACKGROUND PAPERS" USED IN THE PREPARATION OF THIS REPORT**

| Background paper | Name and telephone number of and address where open to inspection |
|---|---|
| Scrutiny Review File held in Scrutiny Policy Team | Afazul Hoque<br>020 7364 4636 |

## 3. Background

3.1 East London NHS Foundation Trust is seeking to establish an early detection service in Tower Hamlets, to refer 'at risk' patients with initial signs of schizophrenia to its established Tower Hamlets Early Intervention Service (THEIS). This new service will be granted significant funds, with a budget of £250K (part year effect) for 08/09.The intention is to develop a thoroughly innovative service.

3.2 **What is an Early Intervention Service?**
Early Intervention is a new but important field for mental health services. Young people between 18 and 35 years old are treated by a specialised team of psychiatrists, psychological therapists, occupational therapists, nurses and social workers, who intervene at the first onset of a psychotic disorder. There is evidence that working with those individuals and monitoring their well-being over a three-year period, can increase the success of treatment and in turn increase the chances for the young person of achieving a fulfilling future. Every PCT is required, via the NHS Operating Framework 07/08, to increase the number of patients with First Episode Schizophrenia who are provided with this specialist intervention. THEIS was one of the pioneers of Early Intervention Services in London and was one of the few Early Intervention teams to achieve their set targets in London SHA in 2007/08.

3.3 **Why is Early Detection important?**
The shorter the Duration of Untreated Psychosis (DUP) the greater the success of Early Intervention Services in speeding up initial recovery and reducing social disability and the social exclusion which is a consequence of delayed recovery. Thus an early detection service is needed, to achieve a truly comprehensive strategy of care for young people at risk of their life chances being destroyed by the onset of psychosis.

3.4 An Early Detection Service (EDS) broadly aims to make contact with young people between 16 and 25 who appear to be at risk of developing schizophrenia, in order to offer support and monitor their mental health and well-being over a period of 2 years. There may be a family history of schizophrenia, or they may have reported one or more of a list of odd or disturbing experiences which do not yet justify a diagnosis of schizophrenia: these are:

- Personalised voices / visions
- Jumbled or confused thoughts
- Feeling that others may want to harm them (paranoia)
- Frightening / unusual ideas
- Changes in behaviour and functioning at college and work

3.5 Approximately 20 to 30% of these young people would be expected to make the transition to experiencing a full psychotic episode in the two year monitoring period. At that point, with the help of an EDS, they would rapidly and with the minimum of distress, be offered active interventions and full care co-ordination from the Early Intervention Service. A recent case study in Norway using an Early Detection Service (TIPS) has shown good evidence of success in the achieving the crucial reduction in DUP.

3.6 In Tower Hamlets there is a growing population in the under 19 age group. This population has particular characteristics which make it additionally important that we devise a service which is both acceptable and accessible to the young people of the borough with mental health needs. Close to 60% of the school population are Bangladeshi; there is a fast-growing community of young Somalis. Epidemiological data tells us that we are failing to make contact early enough with young people in mental distress from these communities, so that when they do eventually encounter mental health services, they are likely to be more ill. Behind the evidence for this delay are stories of young people and their families living in turmoil and increasing despair for far longer than need be, if services were able to offer support and interventions which were unstigmatising and accessible. Existing services acknowledge that they are not good at engaging young people generally. Engagement strategies will need to be especially creative to

reach young people in these communities where mental health problems are particularly stigmatised and stigmatising.

3.7 **What will the new service look like?**
Currently there is no clinical (non-research) service for early detection of schizophrenia in the UK, so that there are few equivalent models of good practice available on which to base our service design.. East London Foundation NHS Trust therefore took the decision to invest in a thorough option appraisal and scoping exercise which has involved consultation with all major stakeholders. This process started during August and the Central Office of Information (COI) was commissioned to undertake this initial piece of work and a draft report has now been submitted to the Trust for consideration.

3.8 Standardly the work of an EDS has the identification, engagement and monitoring of young people at risk as its core task. However, over the 2 year period of engagement, it will offer a range of psychosocial interventions, designed primarily to combat social exclusion, and enhance the young people's capacity to cope with the challenging transitions which dominate this life-stage. To support this work, it is essential to conduct a mental health awareness campaign in the wider community, to promote accurate understanding and de-stigmatisation of mental distress of this severity.

3.9 We have learnt from the consultation exercise so far, the importance of developing an acceptable public identity for the service, which defines it as distinct from statutory services; the need to use pro-active outreach, not wait for traditional health-care pathways to deliver clients to our door; designing a flexible service which is accessible for those highly visible groups we are already aware of, while also being able to reach out to hidden need, for instance in young Bangladeshi women, or new migrant communities.

4.0 In order to implement a service this innovative, we plan to develop a partnership with existing non-mental health youth services, and with 3rd sector organisations with local roots and expertise, operating from a 'shop-front' which is acceptable to young people. We have learnt through the consultation exercise about how youth services in the borough are organised in a system of 'hubs' and pursuing close links with this system seems an exciting option.

## 4. Concurrent Report of the Chief Legal Officer

4.1 N/a

## 5. Comments of the Chief Financial Officer

5.1 N/a

## 6. Equal Opportunity Implications

**6.1** The service as a whole is conceived to challenge health inequalities;
**6.2** the approach is also predicated on an understanding of the causal links between inequalities of opportunity, differentially higher rates of poor mental health and subsequent social exclusion

## 7. Anti-Poverty Implications

7.1 The onset of psychosis occurs with greatest frequency just at the point when a young person is becoming independent and active economically. Those experiencing severe and enduring mental health problems are amongst the poorest and most socially

disadvantaged in society. This service is designed both to divert a small but significant number of people with the potential to develop a severe mental health problem from making that transition, and also to significantly reduce the social disability associated with developing psychosis.

## 8. Sustainable Action for a Greener Environment

8.1 N/a

## 9. Risk Management Implications

9.1 N/a

| Committee<br>Health Scrutiny Panel | Date<br>14 October 2008 | Classification<br>Unrestricted | Report No. | Agenda Item No. 4.3 |
|---|---|---|---|---|
| **Report Of**<br>Service Head Disability and Health<br><br>**Originating Officer (s)** | | **Title:**<br>**Adult Protection Annual Report 2007- 08**<br><br>**Ward(s) Affected: n/a** | | |

## 1. SUMMARY

1.1 This report is the Annual Report of the Adult Protection Service in Adults Health and Wellbeing.

## 2. RECOMMENDATION

2.1 That the report be noted.

## 3 BACKGROUND

3.1 Adult Protection is the responsibility of the Adults Health and Wellbeing Directorate within the Council In discharging this responsibility the Directorate works to the No Secrets Guidance (Department of Health 2000) which sets out a multi agency framework to protect adults (individuals over the age of 18) who may be vulnerable to abuse.

3.2 Members should note that, unlike Child Protection, there is no statutory framework for Adult Protection in England at present. There is a ministerial review of No Secrets about to report and a consultation on the findings will follow.

**LOCAL GOVERNMENT ACT, 1972 SECTION 100D (AS AMENDED)**
**LIST OF BACKGROUND PAPERS USED IN PREPARATION OF THIS REPORT**

| Brief description of background paper | Name and telephone number of holder and address where open to inspection |
|---|---|

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# Adult Protection in Tower Hamlets

# Annual Report April 2007 to March 2008

# Contents

## Chapter

## 1. Overview of the Year

### *Adult Protection Team*

The Adult Protection Team was fully established in 2007/8. Capacity was enhanced, initially through funding from the Neighbourhood Renewal Fund but subsequently mainstreamed by the Council. This extra capacity has enabled us to deal with an increase in referrals from 315 to 473 over this year. The team now comprises the Adult Protection Coordinator, two senior practitioners, and a full time team assistant.

### *Campaigning*

The year started with the launch of our Borough-wide publicity campaign to raise awareness of the abuse of vulnerable adults within our locality. The launch was chaired by Lady Anne Riches who on behalf of Barts and the Royal London Hospital gave real encouragement and a commitment to inter-agency working. The publicity included bus stop posters, a plasma screen presentation to run in the One Stop Shops, leaflets, business cards and wall mountable posters. Additionally a centre spread page, followed by an inserted leaflet in "East End Life", was distributed to all households within the borough.

This start continued with a very successful "Best Practice" Seminar on Neglect and Financial Abuse, run in conjunction with Action on Elder Abuse (AEA) at Toynbee Hall. This was attended by 69 participants representing 25 different organisations including the Police, Acute Trust, the PCT and Third Sector providers in both the private and voluntary sector.

### *London Adult Protection Network*

The Adult Protection Team has played a significant role within the London Adult Protection Network in taking forward the development of London-wide Adult Protection Policy and Procedures. This work is being managed and funded by the Social Care Institute of Social Excellence (SCIE) along with Care Services Improvement Partnership (CSIP). In this work, the Tower Hamlets Team has represented other local authorities in the North East London sector - Newham, Waltham Forest, Barking and Dagenham, Hackney, Havering and Redbridge.

### *Working with the Police*

We have also provided support to the Metropolitan Police in delivering their advanced Achieving Best Evidence Course that specifically focuses on vulnerable adults. Obtaining evidence in Adult Protection work can be very difficult and needs to be handled with the utmost sensitivity.

### *The Multi Agency Steering Group and subgroups*

The Multi Agency Steering Group has meet bi-monthly throughout the year, giving leadership and direction to Adult Protection across all agencies in the Borough. It provides a forum for discussion and development of the work undertaken by the Adult Protection team. The Group is supported by the Adult Protection Working Group that is also multi-agency and focuses on case work.

The complexities of Adult Protection have led this year to the development of the Protection of Vulnerable Adults (POVA) Support Group. This is for third sector private and voluntary agencies to seek advice, support and guidance in the referral of perpetrators to the POVA List. This group will ultimately become the Vulnerable Groups Support Group once the Vulnerable Groups Act comes into force in October 2009. To date, the group has attracted membership from 25 providers.

***Adult protection within the Local Strategic Partnership***
The safeguarding of vulnerable adults has been identified as a Crime and Disorder Reduction Partnership priority, and is highlighted as such in the Crime and Drugs Reduction Strategy 2008-2011 which was approved by the Council's Cabinet n September 2008. The Adult Protection Coordinator is a core member of the Safe and Supportive Community Plan Delivery Group, established as part of the recent refresh of the Community Plan and LSP structures.

Finally, the Adult Protection Team would like to express its gratitude to all the agencies that have played an active part in the development of adult protection work within Tower Hamlets during 2007-08.

**2. How do we know safeguarding is safe?**

One of the main questions for adult protection is how we do we know if our involvement in the protection of vulnerable adults has made a difference. We do this in a number of ways:

***Referral***
As each referral comes in to the Adult Protection Team it is discussed and evaluated with the referrer. Even if it is not identified as an Adult Protection case these discussions often lead to a more focussed approach to the case work in question and are helpful to the referring agency.

***Investigation***
All adult protection cases are tracked from the point of referral through the investigation and protection planning processes by the Adult Protection Team. This process requires the investigating professional to report the assessment of risk against eleven risk indicators, and the action taken. All cases are held open within the Adult Protection Team until the Adult Protection Co-ordinator is satisfied that all issues have been appropriately dealt with. This role has also included participation in or monitoring the outcomes of 130 adult protection strategy meetings in 2007/8.

This process involves:

- Ensuring safety of alleged victim
- Direct contact with the identified investigating team manager to ensure allocation
- Liaising and offering advice to the allocated officer
- Setting time limits and offering advice in consideration of potential decisions to be made
- Report from the allocated worker is considered with regard to further actions
- A strategy meeting may be called at any time during this process, minutes of which are clarified by the Adult Protection team
- Adult Protection Team ensure actions are completed in agreed time frames
- Further considerations will be given to conclusion, on going monitoring via case conference or review

Throughout the above process the adult protection team will offer advice, guidance, planning and strategies within agreed and appropriate time frames.

***Ongoing Monitoring***

After investigation, even though actions have been completed, on going monitoring may be required over an agreed period of time to ensure that the individual is safe.

***Advice and Consultation***
The Adult Protection Team encourages all those working in the care of vulnerable adults to contact the Team where there is a question mark about adult protection. The Team is able to offer immediate advice and guidance and follow this up with the referrer thereby often preventing abuse or alternatively gaining a clear picture of any potential risks that can be addressed through case allocation and work with the service user.

The Adult Protection Working Group has been very successful in 2007-08 in bringing together parties from the independent and statutory sector, to increase confidence in dealing with Adult Protection. This is reflected in the continuing increase in referrals shown in the activity data later on in this report.

***Education and Support***
The Adult Protection Team has given talks to a number of service user groups this year on perceptions of abuse and what support could be offered to themselves or friends who may be either being abused or at risk of abuse. The Team works closely with a local voluntary organisation that provides awareness briefings with particular reference to elder people.

**3. Developments in Adult Protection Work**

***Prevention***
A significant development in our work over the last year is a slow but steady increase in the preventative side of adult protection where risks are being identified earlier and action being undertaken to prevent abuse. The Team see this area of work developing further especially in the context of the personalisation of services.

Perhaps the most significant event occurring over the next 12 months is the Government review of “No Secrets”. Tower Hamlets is represented by a member of the Adult Protection team on the Advisory Group that will play a major role in submitting to the Government proposed changes and developments within the field of Adult Protection.

***New Legislation***
During 07-08 there have been various changes in legislation, highly relevant to Adult Protection. Some of these changes have come into being in the year and there are other areas of law that will be implemented in 2008-09. These include:

***Mental Capacity Act 2007***
This Act came into force in autumn 2007 and introduces new rules regarding the definition and assessment of mental capacity. This legislation is there to protect vulnerable individuals and provides for the provision of Independent Mental Capacity Advocates to support individuals where their capacity to make decisions may be impaired. The Adult Protection Team has worked with in-house and third party providers in providing advice on the use of the Act.

The second part of the above Act will come into force in April 2009: the provisions regarding the Deprivation of Liberty (DOL). This part of the Act deals with the detention of individuals where they lack capacity. It will apply to people who are over 18 years of age and will apply to people in care homes, nursing homes and

hospitals. The Adult Protection Team is part of the Local Implementation Network and will ensure that adult protection is enshrined within the new local procedures.

***Safeguarding Vulnerable Groups Act 2006***
This Act will be implemented in October 2009. It will bring into being the new Independent Barring Board (IBB) along with the Independent Safeguarding Authority (ISA) which will bring together a range of existing mechanisms designed to ensure that unsuitable people do not gain employment with or access to vulnerable adults or children. The Adult Protection team are currently preparing for the introduction of this legislation in order to integrate its principles within our work in the future.

## 4. Training

It has been a busy year for the Adult Protection team in that we have reviewed our Raising Awareness/Guided Study Training programme to include the relevant parts of the Mental Capacity Act 2007. We will be reviewing this package in light of further anticipated legal and policy changes in 2008/09.

- Raising Awareness/Guided Study

  A 1½ day training course over six weeks enabling participants to recognise abuse and respond skilfully.

- Foundation Training

  This has been reviewed and is now a 1 day course that follows on from the Raising Awareness/Guided Study training focussing on partnership working, relevant legislative issues, local policies and procedures using case scenarios to share ideas and strategies to develop best practice.

- Best Evidence Training (BE)

  Following the introduction of the Adult Protection Initial Enquiry Form we ran 3 one day workshops in January, February and March as a pilot. Following consultation with the Police and our independent trainer it was soon realised that a 3 day course would be required to meet the demands of this course. As a result of this the issues were presented to the London Adult Protection Network which is attended by training representatives from the Metropolitan Police and it was agreed that other authorities, the Police and ourselves would work together to develop a multi agency training on Best Evidence across London. This process is anticipated to begin in April 2009.

- Chairing Strategy Meetings/Case Conferences

  This course has been developed further this year with the use of video equipment, and case scenarios.

- Minute Taking Course for Strategy meetings/Case Conferences

  This course is provided by the Directorate's Training Department and is due for review and update in 2008-09 to ensure a standardised quality throughout the Borough. The current people undergoing training will provide a rota of minute takers to ensure availability at strategy meetings conducted within the Borough.

- Best Practice Events

  Our first Best Practice Event focusing on neglect and financial abuse took place in January 2008. It is intended to make this into an annual event and plans are already in process to focus on Financial Abuse in more depth at an event in October/November 2008.

- Cascading Training – "Training the Trainers" Programme

  This course provides training to staff in all care sectors who wish to become trainers themselves. To be eligible for this training staff must have had experience of adult protection work and have themselves undertaken the Raising Awareness Guided Study programme. Attendees then become part of the group of Cascade Trainers delivering this course to other staff groups within Tower Hamlets, thus broadening their own experience of delivering training in a wider context and providing smaller staff groups in other sectors with their skills and experience. The Cascade Trainers are supported in their ongoing work by regular "Cascade Trainer Support Groups" organised by the Adult Protection Team.

- Training Activity

| **Course/event** | **Numbers** |
|---|---|
| Raising Awareness/Guided Study | 121 |
| Foundation Training | 34 |
| Achieving Best Evidence Training (ABE) | 31 |
| Chairing Strategy Meetings/Case Conferences | 12 |
| Best Practice Events | 87 |
| Minute Taking for Strategy meetings/Case Conferences | 8 |
| Cascading Training | 9 |

## 5. Future Plans

Adult Protection is shifting up a gear. With legislation in Scotland, and the Government Review of No Secrets in England, the profile of Adult Protection is increasing. Personalisation and the transformation of the delivery of services requires stronger than ever Adult Protection mechanisms to safeguard the more vulnerable members of our communities.

Our priorities for 2008/9 include the development of more preventive and proactive work, and closer joint working with NHS partners, including Barts and the London Trust. However, our overriding priority in 2008-9 is to build on the enhanced capacity that we now have in the Adult Protection Team to ensure that the systematic audit and review of casework is fully embedded in our safeguarding practice.

We will continue to raise awareness amongst the local population and specifically amongst those deemed "vulnerable". Our aim is to help people take more control of their own lives. We will do this by increasing our involvement with local day centres, nursing and residential care homes and working in partnership with organisations such as the Carers' Forum, Age

Concern and “Dignify”, the elder abuse awareness project based at Toynbee Hall.

We are working on a website that we hope will encourage local contribution to debate and enhance our service delivery.

We will continue with Best Practice seminars and continue to work with the Police on multi-disciplinary achieving best evidence training.

A new dataset is expected from the Department of Health during 2008-09 and we are using this change as an opportunity to review the data we collect and to strengthen our case tracking and review systems.

## 6. Activity Data 2007/2008

This chapter sets out some of the data available on the activity of the Adult Protection Team over the year. Comparative data for the preceding year are given where available.

**Table 1: Number of referrals received in 2007-08**

| | **2007-08** | 2006-07 |
|---|---|---|
| Individual referrals received in 2007-08 | **332** | 315 |
| Referrals relating to residential and nursing home residents (see below) | **141** | - |
| **Total** | **473** | 315 |

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n 2007/8 concerns around adult protection were raised and investigated concerning a number of residential and nursing care homes, involving potentially 141 residents and 15 different establishments, 11 of which were outside Tower Hamlets. These were all fully investigated on a multi agency basis. Grounds for adult protection concerns were identified in 29 cases, and appropriate action taken on both individual and institutional levels. These referrals were recorded in this way for the first time in 2007-08 which is why comparative figures are not available.

Data in the following tables refers to the 332 referrals of individuals.

**Table 2: Referrals by Ethnic Origin 2007-08**

| Referrals by Ethnicity Ethnic Origin | 2007-08 | 2006-07 |
|---|---|---|
| White: British | 193 | |
| White: Irish | 11 | |
| White: Any Other White Background | 17 | |
| **Total White** | **221** | **209** |
| Asian Or Asian British: Bangladeshi | 62 | |
| Asian or Asian British: Indian | 2 | |
| Asian Or Asian British: Pakistani | 4 | |
| Asian/Asian British/Other Asian Background | 2 | |
| **Total Asian** | **70** | **54** |
| Black Or Black Brit African: Somali | 1 | |
| Black Or Black British: African | 8 | |
| Black Or Black British: Caribbean | 12 | |
| Black/Black British/Other Black Background | 1 | |
| **Total Black** | **22** | **36** |
| Mixed: White & Black African | 1 | |
| Mixed: White & Black Caribbean | 1 | |
| Mixed: Any Other Mixed Background | 2 | |
| **Total Mixed** | **4** | **3** |
| Other Ethnic Groups: Chinese | 1 | - |
| Other Ethnic Groups: Vietnamese | 2 | |
| Other Ethnic Groups/any other group | 3 | |
| Other Ethnic Groups: Not Stated | 2 | |
| **Total Other** | **8** | |
| **Not Stated** | **7** | **13** |
| **Grand Total** | **332** | **315** |

The increase in the number of referrals from Asian communities is significant. It suggests that concentrated work to raise awareness of adult protection issues in all the communities of the borough is having some success.

**Table 3: Referrals by Age**

| Age Band | 07/08 | 06/07 |
|---|---|---|
| 18 – 25 | **37** | 22 |
| 26 – 35 | **25** | 18 |
| 36 – 45 | **33** | 27 |
| 46 – 55 | **37** | 38 |
| 56 – 65 | **45** | 38 |
| 66 – 75 | **55** | 57 |
| 76 – 85 | **56** | 68 |
| 86+ | **44** | 42 |
| Grand Total | **332** | 315 |

There is a significant increase in the number of referrals of younger adults. .

**Table 4: Type of suspected abuse**

| | 2007-08 | 2006-07 |
|---|---|---|
| Financial | **105** | 69 |
| Institutional | **3** | 0 |
| Multiple | **8** | 91 |
| Neglect and Acts of Omission | **60** | 61 |
| Physical | **86** | 75 |
| Psychological and/or emotional | **10** | 3 |
| Sexual | **16** | 14 |
| Not stated | **44** | 0 |
| **Total** | **332** | 315 |

The table above shows a significant increase in the reporting of financial abuse within Tower Hamlets. This reflects the greater attention paid to this issue this year, including the focus of the Autumn Best Practice Seminar on financial abuse.

**Table 5: Enquiries to Adult Protection Team**

The table below shows the range of reasons why the adult protection team is initially contacted. The advice and information only component can and often does prevent abuse and we see this as a positive development in the work of the Team.

| Case Type | 2007-08 | 2006-07 |
|---|---|---|
| Advice and Information Only | **107** | Not available |
| Court of Protection | **20** | |
| Adult Protection Referrals | **205** | |
| **Grand Total** | **332** | |

**Table 6: Police Involvement**

| | 2007-08 |
|---|---|
| **Police Involvement** | **No. of referrals** |
| Yes | 192 |
| No | 140 |
| **Grand Total** | **332** |

**Table 7: Strategy Meetings held**

| | 2007-08 |
|---|---|
| **Strategy Meetings** | **Total** |
| Yes | 130 |
| No | 95 |
| Advice / Guidance only | 107 |
| **Grand Total** | **332** |

The data in table 10 shows the number of cases where strategy meetings were convened with respect to all referrals. Advice and guidance is where we believe early intervention may have prevented a potential abusive situation from occurring.

**APPENDIX I**

**Adult Protection Team – London Borough of Tower Hamlets**

| Name | Job Title | Telephone |
|---|---|---|
| Tony Greenwood | Adult Protection Co-ordinator | **020 7364 2328** tony.greenwood@towerhamlets.gov.uk |
| Margaret Minoletti | Senior Adult Protection Officer | **020 7364 2329** margaret.minoletti@towerhamlets.gov.uk |
| Annelie Zaayman | Senior Adult Protection Officer | **020 7364 2019** Annelie.zaayman@towerhamlets.gov.uk |
| Marny Burns | Adult Protection Team Assistant | **020 7364 2019** marny.burns@towerhamlets.gov.uk |

**APPENDIX II**

Adult Protection Multi Agency Steering Group

| | |
|---|---|
| Deborah Cohen (Chair) | LBTH, Service Head, Disability & Health |
| Alice Peycke | Toynbee Hall |
| Ann Daly | Age Concern |
| Barbara Disney | LBTH, Commissioning |
| Karl Henson | LBTH, Supporting People |
| Catherine Weir | LBTH, Older People Services |
| Christine Sheppard | Age Concern |
| Deborah Kober | Mencap |
| Diane Jay | Excelcare Holdings |
| Elizabeth Wordsworth | Barts and the Royal London NHS Trust |
| Ian Williamson | LBTH, Advisor Mental Health |
| Jackie Loveridge | Mencap |
| John Wilson | Providence Row Housing Association |
| Julian Sainsbury | CSCI |
| Margaret Minoletti | LBTH, Adult Protection |
| Patrick Laffey | THPCT |
| Rachael Brady | THPCT |
| Robert Kidd | CSU, Metropolitan Police |
| Tony Greenwood | LBTH, Adult Protection |
| Tracy Shepherd | Excelcare Holdings |

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# Tower Hamlets Joint Strategic Needs Assessment

## Briefing for Health Scrutiny Panel – September 2008

The purpose of this paper is to brief the Health Scrutiny Panel on the Joint Strategic Needs Assessment process. This is a new duty commenced on the the 1st of April and the paper outlines what the JSNA is; what it involves; progress so far and next steps. The JSNA will be a critical process to inform the work and agenda of the Scrutiny Panel.

### 1. Joint Strategic Needs Assessment – What is it?

Joint Strategic Needs Assessment (JSNA) is a new duty placed on local authorities and PCTs that commenced on 1st April 2008.

The purpose of the JSNA is to ensure that local authorities and PCTs work together to understand the 'big picture' in terms of the extent to which their strategies are having an impact on meeting the health and wellbeing needs of the population.

This requires bringing local authority and PCT data together in new and innovative ways in order to get a richer understanding of how PCT and local authority initiatives are improving health and wellbeing and where there are gaps in our commissioning.

It also means listening to those people who are in need of services or interventions that improve or maintain their wellbeing and understanding the extent to which these needs are being met.

The JSNA is at the heart of the process that informs our targets and commissioning priorities and is driven jointly by the Director of Public Heath, Director of Adult Social Servies and Director of Children's Services.

### 2. Joint Strategic Needs Assessment – What does it involve?

JSNA is a continuous process. However, it can be thought of in terms of the following questions:

***What are the health and wellbeing needs in the population?***

The Department of Health have defined a 'core dataset' that set out the minimal requirement to inform JSNA[1] and understand the health need in the population.

This covers data around:

- population trends (eg births, age structure ethnicity, population growth)
- the social and environment context (eg poverty, housing, employment, transport)
- lifestyle factors (eg smoking, diet, physical activity, alcohol)

[1] Guidance on Joint Strategic Needs Assessment, Department of Health
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081097

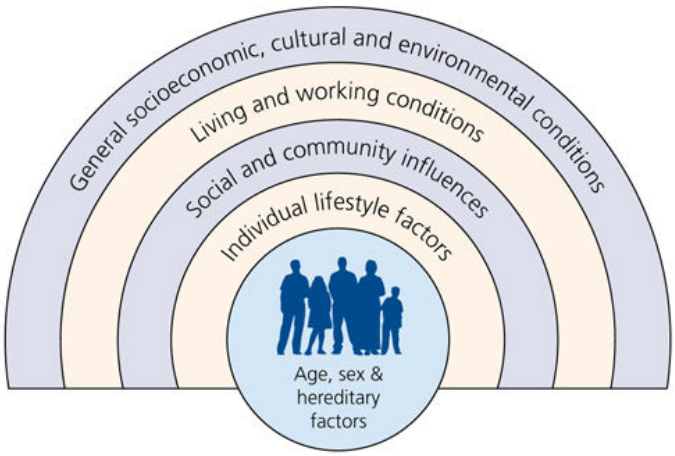
- diseases (eg diabetes, heart disease, cancer, lung disease)
- use of health and social care services including user perspectives

We expect to go well beyond this core dataset by using our local data as effectively as possible through a joint health intelligence function across the PCT and local authority. In addition, we need to look at ways to add 'community intelligence' into our local dataset. This means having a systematic and representative process to understand health and wellbeing need from the perspective of people living and working the Borough. The recently established Local Involvement Networks (LINks) will therefore play a critical role in informing the JSNA

***What are we doing to meet health and wellbeing needs in Tower Hamlets?***

This involves getting a clear understanding of the strategies and plans across the Partnership that have an impact on health and wellbeing in Tower Hamlets and ensuring that these are properly linked and joined up. It is important to recognise that the most powerful factors affecting health are the wider determinants of health such as economic status, education, poverty, environmental conditions and lifestyle (fig 1).

**Figure 1 The wider determinants of health**




A wide range of strategies will therefore need to be assessed (box 1)

Box 1 Examples of strategies and plans linking to JSNA[2]

- PCT and Local Authority commissioning strategies
- PCT Local Delivery Plans
- Children and Young People's plans
- Practice Based Commissioning plans
- Local Development Plans
- Community regeneration strategies
- Supporting People strategies
- Housing strategies
- Community safety strategies

***How well are we meeting need and what are the gaps?***

This involves assessing the extent to which the broad sweep of strategies across the partnership are having an impact on improving health and wellbeing in Tower Hamlets based on bringing together our best intelligence of population need and an assessment of the impact of our strategies. This assessment will highlight what is going well and where we are not addressing the needs of people in Tower Hamlets. It will look at ways we can effectively impact on unmet need and improve existing services. It will also identify areas where we need to gather more information to understand particular issues better.

***How can we engage with the population on these issues?***

Community engagement is central to the JSNA process. This means involvement of communities in Tower Hamlets throughout the process. There are three distinct elements to this as follows:

- Working with communities to identify the questions or issues that the JSNA should address
- Gathering community perspectives in relation to specific questions emerging from the JSNA
- Consultation of the public around documents emerging from the JSNA process

This will need to build on existing engagement and consultation strategies.

## 3. Joint Strategic Needs Assessment in Tower Hamlets - progress

There has been considerable work on developing the JSNA process in Tower Hamlets.

- The Core Data set collection outlined in section 2 was completed in July 2008
- Following this a JSNA workshop was attended by stakeholders across the PCT and Local Authority in order to explore how the JSNA process should be embedded in

[2] Guidance on Joint Strategic Needs Assessment, Department of Health http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081097

Tower Hamlets. This agreed a six stage process for the JSNA for the initial phase of JSNA this year

  - Production of core dataset
  - Audit of commissioning strategies
  - Gap analysis
  - 'Foundation JSNA' setting out findings
  - Consultation on Foundation JSNA
  - Summary JSNA – a summary of the key issues and recommendations

- The Foundation JSNA document is due to be produced by the end of October
- There is current discussion around aligning the consultation around the Improving Health and Wellbeing strategy refresh with the JSNA consultation
- A Joint Intelligence Group has been set up across the local authority and PCT

**4. Joint Strategic Needs Assessment – the longer term**

As highlighted above, JSNA is an ongoing process and the process does not end with the production of a document. The key priority is to embed joint strategic needs as the basis for jointly establishing local priorities to improve health and wellbeing in Tower Hamlets.

In order to achieve this, the next steps are as follows

- To formalise the Steering Group whose membership reflects the breadth of agendas that the JSNA will need to address.

- To establish a streamlined process for the collation and further development of a routine dataset to inform JSNA on an ongoing basis (using the Humana dataset as a basis)

- To agree an analytical work plan for 2008/9 – using the Humana work to establish further analyses for the year

- To agree a plan for community engagement around the JSNA for 2008/9

- To communicate plans at high strategic level across the PCT, LA and Partnership

- To ensure that processes are in place to enable JSNA to routinely inform commissioning priorities.

**The JSNA process will be a key resource for the Health Scrutiny Panel over the long term to understand the impact of partnership strategies impacting on health and wellbeing in Tower Hamlets and emerging issues.**