London Borough of Hammersmith & Fulham

Health, Adult Social Care and Social Inclusion Policy and Accountability Committee

Agenda

Monday 12 December 2016
7.00 pm
Courtyard Room - Hammersmith Town Hall

MEMBERSHIP

Administration:	**Opposition:**
Councillor Hannah Barlow Councillor Rory Vaughan (Chair) Councillor Natalia Perez	Councillor Andrew Brown Councillor Joe Carlebach
Co-optees:	
Patrick McVeigh, Action on Disability Bryan Naylor, Age UK Debbie Domb, Disabilities Campaigner	

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DATE ISSUED 14 December 2016

London Borough of Hammersmith & Fulham

Health, Adult Social Care and Social Inclusion Policy and Accountability Committee

Agenda

12 December 2016

Item		Pages
1.	**MINUTES OF THE PREVIOUS MEETING**	1 - 18

(a) To approve as an accurate record and the Chair to sign the minutes of the meeting of the Health, Adult Social Care and Social Inclusion PAC held on Thursday, 20th October 2016 and Wednesday, 2nd November 2016.

(b) To note the outstanding actions.

2. APOLOGIES FOR ABSENCE

3. DECLARATION OF INTEREST

If a Councillor has a disclosable pecuniary interest in a particular item, whether or not it is entered in the Authority's register of interests, or any other significant interest which they consider should be declared in the public interest, they should declare the existence and, unless it is a sensitive interest as defined in the Member Code of Conduct, the nature of the interest at the commencement of the consideration of that item or as soon as it becomes apparent.

At meetings where members of the public are allowed to be in attendance and speak, any Councillor with a disclosable pecuniary interest or other significant interest may also make representations, give evidence or answer questions about the matter. The Councillor must then withdraw immediately from the meeting before the matter is discussed and any vote taken.

Where Members of the public are not allowed to be in attendance and speak, then the Councillor with a disclosable pecuniary interest should withdraw from the meeting whilst the matter is under consideration. Councillors who have declared other significant interests should also withdraw from the meeting if they consider their continued participation in the matter would not be reasonable in the circumstances and may give rise to a perception of a conflict of interest.

Councillors are not obliged to withdraw from the meeting where a dispensation to that effect has been obtained from the Audit, Pensions and Standards Committee.

4. END OF LIFE CARE 19 - 31

Please note, that this item has been WITHDRAWN. Please contact Bathsheba Mall Committee Co-ordinator, for further information (Bathsheba.mall@lbhf.gov.uk or telephone 020 8753 5758).

5. COMMUNITY CHAMPIONS 32 - 51

The Community Champions is a neighbourhood based volunteer project which focuses on health. The paper describes the current 6 projects and activities delivered, and reports on the key findings from the Social Return on Investment Evaluation from 2014. The committee is asked to review the approach and make recommendations about how the approach could be extended or developed.

6. ADDRESSING SOCIAL ISOLATION AND LONELINESS IN HAMMERSMITH AND FULHAM 52 - 83

The Cabinet Member's Social Inclusion Board was established in February 2015. During its first year, the Board identified social isolation and loneliness as a priority for action, agreeing to develop a strategy for how best it might be prevented and addressed in Hammersmith and Fulham. The Committee considered a report on this issue at its meeting on18th April 2016.

7. WORK PROGRAMME 84 - 86

The Committee is asked to consider its work programme for the remainder of the municipal year.

8. DATES OF FUTURE MEETINGS

Tuesday, 31st January 2017
Wednesday, 8th March 2017
Wednesday, 26th April 2017

London Borough of Hammersmith & Fulham

Health, Adult Social Care and Social Inclusion Policy and Accountability Committee

Minutes

Wednesday 2 November 2016

PRESENT

Committee members: Councillors Andrew Brown, Joe Carlebach, Rory Vaughan (Chair) and Natalia Perez

Co-opted members: Patrick McVeigh (Action on Disability), Bryan Naylor (Age UK) and Debbie Domb (HAFCAC)

Other Councillors: Vivienne Lukey, Sharon Holder

Officers: Helen Banham, Strategic Lead, Professional Standards and Safeguarding, Harley Collins, Health and Wellbeing Manager, Mike Howard, Independent Chair, Safeguarding Adults Executive Board, Sarah McBride, Director of Partnerships, ASC

99. APOLOGIES FOR ABSENCE

Apologies for absence were received from co-optees Debbie Domb and Patrick McVeigh, and, Councillors Hannah Barlow, Sue Fennimore, Sharon Holder.

100. DECLARATION OF INTEREST

A declaration of interest was received from Councillor Joe Carlebach in respect of Agenda Item 3, in his role as Vice-chairman, of the Board of Trustees for the Royal National Orthopaedic NHS Hospital Trust.

A declaration of interest was received from Councillor Andrew Brown, in respect of Agenda Item 4, as a former member of the Safeguarding Adults Executive Board.

101. DEVELOPING THE JOINT HEALTH AND WELLBEING STRATEGY

Councillor Vaughan welcomed Sarah McBride, Director of Partnerships, Adult Social Care and Harley Collins, Health and Wellbeing Manager, who provided a joint presentation. The joint report between the Council and the CCG set out the development details of the Joint Health and Wellbeing Strategy, 2016-21 and emerging priority areas including mental health, children, young people and families and long term conditions. The development process had been structured in three phases: The first, from January to March, involved a large-scale review of the evidence of need; the second phase, covering April-May, included a series of workshops with patients and stakeholders; the third phase has included a fourteen-week period of public consultation during July-October.

It was explained that consultation and engagement was a key principle throughout all stages of the work and had been an opportunity to share emerging thinking. During the public consultation, an online questionnaire was set up and sent to over 500 local organisations, details of which had been provided by Sobus. 40 responses had been received from a mixture of businesses and individual residents, and greater weight had been given to those from organisations. The responses indicated strong support for the four draft priority areas and for a preventative approach that sought to proactively keep people well rather than reactively treat people who were sick. There was support for a healthy diet and exercise, and, early identification and intervention for people with mental health disorders.

Co-optee Bryan Naylor thanked the presenters for the report and observed that there was no direct mention of older aged people. As a group that was increasing in number, many were users of health and adult social care services and the only inference was under the section on long term conditions. By extension, he expressed additional concerns about the lack of reference to elderly social isolation and loneliness in the strategy and about who had been consulted, reporting that the Older Peoples Consultative Forum had not been consulted. In response, Harley Collins acknowledged the lack of reference to older people and explained that an event had been held in RBKC which 142 people had attended, the details of which would be made available. It was noted that whilst older people were referenced under long term conditions, many of these, such as mental health, were not specific to any one group and that the aim had been to avoid isolating conditions as specific to, elderly people. Sarah McBride added that there was growing evidence indicating a link between social isolation, loneliness, and mental health issues, addressed in the strategy and that more detailed plans would be set out in the delivery and action plan in terms of how it would be tackled. Councillor Lukey and Harley Collins accepted an invitation attend the next meeting of the Older People's Consultative Forum, taking place at 10.30am, on 22 November.

Councillor Natalia Perez offered her congratulations on the draft strategy and whilst she appreciated it was work in progress, enquired whether consideration of welfare reforms informed the development of

recommendations within the strategy. Councillor Perez also asked, referring specifically to children families and vulnerable groups living in poverty who might be affected by benefit reform, if such concerns had been mentioned by mentioned by respondents. Harley Collins responded that this had not materialised in the responses given. The issue had been raised by organisations such as MIND, which had indicated that there were concerns about welfare thresholds in the context of seeking employment.

Councillor Joe Carlebach observed that there was no reference to community Health Champions, who were very good at accessing hard to reach groups such as those with learning disabilities. Concurring that health champions offered a strategic benefit, Harley Collins acknowledged that they could have an important role in facilitating health concerns and communicating information about services, throughout the community. This was the first year of the strategy and such issues could be further included.

Councillor Carlebach observed that a strategic communications plan should form a critical part of implementation and delivery plans. Cllr Carlebach illustrated the importance of sensitive communications highlighting as an example how letters from the National Child Measurement Programme, informing parents that their children had been categorised as 'obese', had caused great upset 'turned parents off' to important preventative messages. Mike Robinson, Director of Public Health, who had attended the meeting as an observer, was invited to respond. He explained that there was a need to engage in a non-threatening way and to learn from such experiences, encouraging and supporting healthy eating choices. Referring to the TCOT (Tackling Childhood Obesity Together) programme, he hoped that the letters achieved a balance between being clear but inoffensive and welcomed any suggestions that might assist. Mike Robinson confirmed that officers from the TCOT programme would contact Councillor Carlebach to discuss the way in which they communicated with parents.

ACTION: PUBLIC HEALTH

Councillor Carlebach further noted a lack of reference to medical advances in treatment, or innovative developments such as DNA sequencing. Harley Collins conceded that this had not been considered as part of the strategy.

Councillor Carlebach commented that he was aware of a reluctance by primary care physicians to refer to secondary and tertiary care, highlighting as an example how the Royal Marsden was a centre of international excellence for cancer and yet there were only very small numbers of borough residents who were referred there. Councillor Carlebach commented that there many cases where support or appropriate intervention at an early stage would have resulted in different or improved outcomes. Noting that a strategic communications strategy should be formulated as part of the delivery and action plan, Sarah McBride also acknowledged that access to healthcare needed to be made more obvious within the strategy. Mike Robinson confirmed that officers from the TCOT programme would contact Councillor Carlebach to discuss the way in which they communicated with parents.

ACTION: PUBLIC HEALTH

Councillor Brown welcomed the level of strategic detail included in the strategy, but requested more contextual data, that should be included in the strategy e.g. the 'population at a glance' table, which he thought was important. Specifically, Cllr Brown wanted data on air pollution (NO2 and particulate matter levels) included in the table and specific outcome measures that would allow the Health and Wellbeing Board to be held to account.

Cllr Brown observed that the transient nature of the Borough meant that up to 10% of the local population moved each year. The focus on vulnerable older people and young families with children, were less transient, offering greater opportunities for contact. Sarah McBride welcomed the comments and assured the Committee that these would be taken on board as part of the Committee's feedback. On a final point, Councillor Brown added that it would be helpful to have sections on, for example, housing, linked to related long term conditions, with overall aim to utilise different areas of the Council and drive forward engagement.

Cllr Brown also stated how he thought the strategy presented good opportunities to make improvements to the public's health through housing, environment, education, employment and the other 'wider determinants of health' and would like this to feature heavily in the delivery plans to follow.

ACTION: HASCSIPAC

Welcoming the draft strategy, Councillor Vaughan referenced the Public Health Annual Report 2015/16 (considered, at the 20th October PAC meeting) and how the data was sourced in that was used to set targets, enquiring what the Committee should be looking for in terms of improved outcomes. Mike Robinson responded that this was an important but difficult area of work. Public Health aimed to develop a trajectory of how they envisaged key outcomes changing over the next 5, 10 years. This also required long term investment, with programme and project outcomes predicted well into the future. He acknowledged that a more sophisticated model, factoring in the way in which trends and population movements were modelled would be helpful.

Councillor Vaughan commented that he looked forward to seeing how the strategy and corresponding implementation and development plans proceed. Noting that healthy living initiatives were cross cutting, he enquired if there was a broad understanding as to how the changes could be made and how this could be captured in targets to monitor behavioural changes. Mike Robinson explained that there were health and lifestyle survey undertaken were a sample group of residents were contact and asked questions about their lifestyle and health choices. This formed part of routinely collected data and considered together with national data that could be locally applied. The aim was to ensure that the development plan could be orchestrated to address identifiable outcomes, to see how they can be measured and demonstrate if the policies and programmes are achieving hoped for results.

Sarah McBride commented that achieving small, behavioural changes was continually in the process of development, with our personal self-esteem impacting on the quality of our health. She observed that working with our community leaders and champions was one way in which this could be successful. Harley Collins highlighted how discussions with QPR about targeting health messages to captive demographic on match days was an example of how behavioural change could be affected locally. Councillor Sharon Holder observed that robust communication was essential for ensuring that the strategy captured the views of all, particularly through the consultation process.

RESOLVED

1. That comments from members of the Committee be included as part of the formal consultation and engagement process on the draft strategy;
2. That officers consider whether older people should be a specific priority;
3. That the Committee receive a further report to consider the draft development and action plans, when they have been formulated; and
4. That the Committee endorse the report and recommend the Joint Health and Wellbeing Strategy to Cabinet.

102. ANNUAL REPORT OF THE SAFEGUARDING ADULTS EXECUTIVE BOARD

Councillor Vaughan welcomed Mike Howard, Independent Chair of the Safeguarding Adults Executive Board (SAEB), and Helen Banham, Strategic Lead, Professional Standards and Safeguarding, Westminster City Council. The report presented the third annual report of the SAEB, which worked across the three boroughs. The key statutory agencies involved were: the local authority, police and health professionals including directors of public health, NHS trusts, including The Royal Marsden, Imperial, West London Mental Health Trust, Central and North West London and Central London Community Healthcare.

The SAEB was responsible for conducting Safeguarding Adult Enquiries (section 42) and reviews (section 44), stipulated under of the Care Act 2014 (CA, 2014) and offered guidance to employers on how to recruit staff safely. Safeguarding adults was a matter for all agencies and Mike Howard explained that they were fortunate in the high level of involvement and commitment offered by residents operating at the heart of safeguarding. Focusing on harm, neglect and scams, Trading Standards had a pivotal role in ensuring that residents are made aware frauds targeting vulnerable adults. A key message was to ensure that the language used was simple and effectively communicated and connected with people. To illustrate, two consultation events were held, with feedback used to inform and develop the SAEB strategy. The role of community champions was also essential to ensure local input and were now represented on the SAEB.

Setting out the methods under which the SAEB conducted itself, Mike Howard explained that the aim was understand why a situation had developed, what

were the causal factors that resulted in harm or neglect. The SAEB had not yet experienced a situation where they have had to invoke section 45 of the CA 2014 because of the co-operative nature of the relationships with the organisations or agencies they worked with.

Councillor Carlebach welcomed the report and enquired about the role of the SAEB in relation to the Children's Safeguarding Board, with regards to children with Local Offers transitioning to adult support services, commenting that this group was particularly vulnerable and difficult to identify. Helen Banham confirmed that were there locally agreed protocols for working with local safeguarding committees. The main area of overlap was with children that were transitioning. Those under a Local Offer usually go on to have planned care. Those who do not for some reason move to receiving adult services, may become vulnerable at a later stage and come to the attention of ASC. It was important to note that there were no eligibility criteria for adult safeguarding.

Councillor Natalia Perez referred to an earlier comment regarding the simplicity of the language used and enquired what methods were used to ensure that information about adult safeguarding was fully communicated to black and minority ethnic groups or to those whose first language was not English. Mike Howard responded that the SAEB consultation events were open to all and confirmed that the Board relied on the operational capacities within individual organisations to ensure that the information was communicated in a variety of ways. He was aware that this was area that required them to work more closely with the community and commended the work of community champions, whom they relied on to communicate key messages. Helen Banham added that there was also a website and printed information that was easy to read. Training sessions were also run to train managers and community champions.

Councillor Brown referenced his personal involvement with the work of the Board and commended work undertaken on highlighting incidences of pressure sores in the NHS. It was explained that the pressure sore protocol work was one area work and that the theme this year was scams. Part of the criteria selecting areas of work to focus on was to establish which vulnerable groups were identified as being in most need of protection. They had recently dealt with three reviews of three deaths of individuals who were either homeless or lived in hostels and the SAEB role in responding to these deaths was treated as a priority. Another area of work was with the fire brigade, who had dealt with several incidences of death linked to cases of extreme hoarding (Earls Court).

Bryan Naylor commented that the Age UK Consultative Forum had received several presentations informing them about scams and thanked the Board for raising awareness about them. Highlighting examples of inappropriate sexual behaviour that had been brought to his attention, he enquired about the way in which the SAEB would proceed. Helen Banham explained that it would depend on individual victims as to how they wished to proceed and what their expectations were as to what they would like to see happen next. Additionally, they would need to establish if there was a public interest issue.

Councillor Vaughan commented that the report was relevant, easy to read and accessible although noted that the term 'safeguarding' was not one which was commonly used. He asked what mechanisms were used to ensure that they were aware of peripheral issues that were emerging and how these could be captured. Mike Howard responded that at a strategic level, he attended one meeting per annum of the Children's Safeguarding Board and the Violence Against Women and Girls Group. There was also a reference to human trafficking in the report. They were also working on creating stronger links with the borough commanders and strengthening the referral links for adult Multi-Agency Service Hub or "MASH". Statistics on the numbers of vulnerable adults without care and support (133,000) were circulated to the Committee for information. Safeguarding was a personal issue and the SAEB worked with adults aged over 18. To date, 55 safeguarding reports had been issued.

ACTION: HASCSIPAC

Councillor Vaughan thanked the presenters for the report and summarised several points including the difficulties of communicating with hard to reach groups, peripheral issues, priorities such as self-harm and neglect.

RESOLVED

That the report be noted.

103. WORK PROGRAMME

The Committee discussed the Older Peoples Housing Strategy and the Sheltered Housing Review reports recently considered by the Economic Regeneration, Housing and the Arts Policy and Accountability Committee (ERHA). It was agreed that both items would be circulated and members would discuss further at the next meeting of the Committee. Councillor Lukey suggested that this might form part of a joint PAC meeting with ERHA, to also discuss the strategy for people with learning disabilities. Councillor Andrew Brown asked that an item on tuberculosis be added to the Work Programme, and this was agreed.

ACTION: HASCIPAC

RESOLVED

That the report be noted.

104. DATES OF FUTURE MEETINGS

The Committee noted that the date of the next meeting will be Monday, 12th December 2016.

Meeting started: 7pm
Meeting ended: 9.25pm

Chair .....

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Health, Adult Social Care and Social Inclusion Policy and Accountability Committee

Minutes

Thursday 20 October 2016

PRESENT

Committee members: Councillors Andrew Brown, Joe Carlebach, Rory Vaughan (Chair) and Natalia Perez

Co-opted members: Patrick McVeigh (Action on Disability) and Bryan Naylor (Age UK)

Other Councillors: Sue Fennimore and Vivienne Lukey

Officers: Cynthia Folarin, Deputy Director of Public Health, RBKC
Colin Brodie, Public Health Knowledge Manager, Angela Caulder, CAMHS Joint Commissioning Manager, NW London CCG, Fiona Murray, Transformation Project Manager, NW London CCG, Lesley Watts, Chief Executive,
Iain Beveridge, Consultant Physician & Gastroenterologist / Associate Medical Director, Chelsea and Westminster NHS Foundation Trust, and, West Middlesex University Trust

91. MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting held on 12th September 2016 were agreed as a correct record.

92. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillors Hannah Barlow, Sharon Holder and Sue Macmillan and Co-optee Debbie Domb.

93. DECLARATION OF INTEREST

Councillor Andrew Brown declared an interest in Items 5 and 6, as Managing Director of Santevis Limited, and provided healthcare consultancy advice to

Leidos Health UK. Councillor Joe Carlebach declared an interest in Items 5 and 6, as an Ambassador for Mind, that his wife was a trustee for Mind and that his niece was employed by Mencap.

94. ANNUAL PUBLIC HEALTH REPORT 2015-16

The Chair welcomed Cynthia Folarin, Deputy Director of Public Health, RBKC and Colin Brodie, Public Health Knowledge Manager, who jointly presented the Annual Public Health Report, 2015-16, from the Director of Public Health covering the three boroughs. The report, "Sitting is the new Smoking" was a statutory requirement and focused on three key messages: physical activity is good for mental health; any physical activity was better than none; and everybody active, everyday. The report focussed on the importance of physical activity, to those segments of the population that are physically inactive. The report particularly contributed to improving the health and well-being of the local population and highlights health inequalities.

Bryan Naylor, Co-optee, expressed concern about the repetitive nature of the report and that it only addressed one part of the overall subject. He referred briefly to the loss of funding for a variety of activities within the borough, several of which were recommended in the report. Colin Brodie responded that the intention had been to produce a document with a short, focussed message that would be easily accessible by the public, to highlight the dangers of physical inactivity. Councillor Vivienne Lukey added that the Director of Public Health had selected this as the theme for the report and was in addition to other, more detailed public health reports focusing on LBHF, which she suggested be circulated to members. It was accepted that the aim of the report was to provide a brief, clear message but Mr Naylor also asserted that the report failed to convey it's intended message with sufficient depth.

Councillor Natalia Perez referred to the increasingly sedentary lifestyle resulting from the amount of time spent using smart technology. Referring to the activities highlighted in the report such as cycling, walking and swimming she enquired if any of the recommendations had been informed by the provision of subsidised services at a local level, observing that privately-run gyms were expensive. Colin Brodie affirmed that the recommendations demonstrated a case for longer term investment in activities to save on the possible cost of future healthcare needs. Opportunities for health benefits resulting from low cost physical activities such as gardening and housework could form part of a daily routine, as set out in the get going campaign, signposting no cost and low cost activities. Councillor Lukey added that the Council was in the process of refreshing its sports and leisure strategy, in addition to a physical exercise strategy.

Councillor Lukey also referred to a free event in Normand Park being organised in partnership with Queens Park Rangers Football Club. It was acknowledged that whilst there might exist an association between the use of smart technology and less physical activity, the evidence to refute this required further analysis. Colin Brodie continued, observing that activities requiring physical exertion were being filtered out of our daily lives, by for

example, multiple car ownership or not walking to school. It was acknowledged that it was difficult to obtain local empirical evidence to support this link, which was only available at a national level.

Patrick McVeigh, Co-optee, welcomed the report and briefly referenced his personal experiences and subsequent cardiovascular rehabilitation treatment. He suggested that more could be done to raise awareness of the way in which blood pressure indicated changes in health and that better education would be helpful in identifying possible ill-health earlier. He referred to page 78 of the report, indicator 30, Under 75 mortality rate: cardiovascular, and, indicator 9, Obese children (Y6), both of which were higher than RBKC and WCC. He enquired if it was possible to initiate a programme to capture data about levels of physical activity in schools and suggested that this could be used to engage with children about what it means to be healthy.

Colin Brodie responded that data was not routinely collected from schools and that latest available data was from 2009/10. He understood that there was currently work being undertaken as part of the Healthy Schools Partnership and explained that they had planned to meet with sports and leisure colleagues to explore how the key messages could be embedded within existing campaigns. He added that the slightly poorer performance figures may be due to several factors but could warrant further exploration.

Councillor Joe Carlebach acknowledged that physical activity improved mental health but commented on the life expectancy of people with physical and learning disabilities and asked how this could be addressed and enquired about the lack of reference to mental health champions. Colin Brodie referenced a list at the back of the report giving useful contact links. He acknowledged that in trying to keep the document short, the positive message about physical activity and good mental health had not come through. Whilst it did much to raise the profile generally, it could go further. To illustrate, they were aware of the health inequalities affecting black and ethnic minorities or people with long term health issues, and the link to deprived areas.

Councillor Brown commented that he appreciated frustrations inherent in trying to make small changes in public behaviour, to effect bigger changes, referencing the Mayor's bike scheme which he hoped to see further extended across London boroughs. He also expressed the view Public Health needed to be more revolutionary and that Public Health was about affecting changes in behaviour. Councillor Fennimore informed the meeting that Councillor Lukey had recently attended a second meeting of the Disability Commission, and anticipated that they would cover several of the issues raised by Members, which could be reported back to the Committee.

Councillor Vaughan welcomed the report and commented that whilst it had focussed well on one issue, it would have benefitted from having more local and recent data, particularly the data around schools, although acknowledging the difficulties in obtaining the latter. He went on to say that the report succeeded in being a readable and accessible, public document and supported the short, focussed approach taken. In response to a final question, Colin Brodie explained that there were several local events and

activities being undertaken across the borough, broadly supporting the key messages in the report. He commented that they did not want to duplicate local campaigns that were also conduits for promoting health messages and welcomed further input as to how such messages might be promoted.

Councillor Vaughan concluded by enquiring how the Council could assist Public Health in obtaining the data required and what work was required. Councillor Fennimore observed that positive impacts on health resulting in, for example, lower levels of heart disease, would not result in immediate changes but would have long term impact.

RESOLVED

1. That the planned work on the sports and leisure strategy, in addition to physical activity, be considered by Health, Adult Social Care and Social Inclusion Policy and Accountability Committee and included in the Work Programme; and
2. That the report be noted.

95. CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST - ACQUISITION OF WEST MIDDLESEX UNIVERSITY NHS TRUST: POST-ACQUISITION REVIEW

Councillor Vaughan welcomed Lesley Watts, Chief Executive, and, Iain Beveridge, Consultant Physician & Gastroenterologist / Associate Medical Director from Chelsea and Westminster Foundation NHS Trust (CWFT) and West Middlesex University Trust (WMUT). The presentation provided an update, one year after CWFT acquired WMUT, bringing together two acute hospitals, providing care for between 850,000 and 1 million people, with approximately 1000 beds, combined. With the aim of delivering specialist care to a wider demographic, Lesley Watts explained that they were engaging closely with CCG colleagues to better understand how care could be better integrated. Part of this involved building the right culture, embedding shared values across both sites. Both hospitals retained distinct identities, with healthy competition driving good practice. Staff were highly committed to the integration and commended strong performance to clear governance and leadership. Lesley Watts reported that targets in A&E wait times, RTT (referral to treatment) and cancer and access outpatient waiting targets, had all been met, with A&E being the best performing unit in London. Another positive was lower than expected mortality rates in both hospitals, against the "required improvement" CQC assessment on both sites, prior to the merger. There were continuing challenges, such as the patent experience and staff engagement rates which were expected to decline given the change and integration of the past year, and achieving the £3 million surplus required to release sustainability and transformation plan funding, for which they were on target.

Councillor Brown acknowledged that his perception of the merger had changed, and reflected that he was now convinced that this had been the right course of action, with a rare and successful evolution of the two hospitals, setting a highly positive example to other NHS organisations. In

response to a question as to what could be identified as a failing and what the Council could do to assist, Lesley Watts explained finances remained her biggest concern, together with trying to persuade the organisation that maintaining a surplus was a good strategy to encourage greater investment. She continued that staffing recruitment and the turnover of staff was another issue. WMUT was very much a local hospital, staffed and served well by its local community, with the average age of staff at WMUT being approximately 47, by contrast, there was a very young workforce at CWFT, where the average age was 27. Iain Beveridge confirmed that there was a real crisis in maintaining a medical workforce currently and that because of the changes in the previous year, they were behind the curve on recruitment and retention.

Patrick McVeigh sought assurance that following the EU referendum and the UK's decision to leave the EU, the views of the Trust would be communicated to NHS England. Lesley Watts responded that they had been asked to articulate information about current staff skill levels. As an aside, she reported that CWFT and WMUT had dealt robustly with both staff and patients, who had expressed negative or vitriolic comments about overseas NHS employees following "Brexit", and who had been, respectively, dismissed or removed from patient lists (without jeopardising treatment or care). It was intended that a clear message from the trusts signalled that such negative, ill-informed behaviour was not to be tolerated.

In response to a question from Councillor Carlebach, Lesley Watts explained that they had undertaken considerable work on both appraisals and mandatory training, which were both linked to incremental salary increases. This was built into the induction process and staff were encouraged to think about how appraisals will inform career development. It was acknowledged that workforce retention was an issue, with the turnover rate at 16.2% in London, with one outcome being increased reliance on bank or agency staff.

Councillor Carlebach highlighted a recent constituents experience, following treatment and hospitalisation after a stroke and queried the way in which responsibility for patient care during transfer was managed. Iain Beveridge explained that one of the advantages of the merger was the availability of a wider range of services. The health service was moving towards increasingly collaborative working, forging links with, for example, Imperial College Healthcare NHS Trust.

Councillor Carlebach asked if the Trust could expand on how it would work with the mental health trusts in terms of identifying patients. Iain Beveridge responded that they worked with two acute mental health trusts, in addition, there was an adolescent mental health ward at CWFT. Patients presenting with mental health concerns could be seen within the A& E unit.

Councillor Perez enquired about cuts to local health services, for long term HIV positive outpatients. Iain Beveridge explained that the service, which had been transferred from Charing Cross hospital to Hammersmith Broadway, had received good feedback but the decline in this specialist support service was largely due to reduced resources. Lesley Watts added during the past twenty years, there had been a change in clinical practices,

with more effective treatments, a better understanding of HIV and the greater resilience of patients living with this condition long term.

Bryan Naylor expressed concern about end of life care and the transfer of resources from hospital into the community if “bed blocking” was to be avoided. Lesley Watts responded that community based and GP resources were under pressure and that they were looking at undertaking ward rounds in residential nursing homes. She recognised the need to design and provide such services effectively. Iain Beveridge added that the Trust accepted criticism about the end of life care offered in a hospital setting, which presented challenges, and understood the need to improve palliative care. Referring to the Care Quality Commission recommendations on “Do Not Resuscitate” (DNR), Bryan Naylor highlighted additional concerns about the miscommunication and application of DNR protocols. Iain Beveridge explained that the Trust had well-rehearsed guidelines, developed by senior clinicians, together with families, recognising the inherent sensitivities and challenging circumstances that arise. Conversations around end of life were best undertaken at home and not in the sudden and clinical or acute setting of a ward or hospital.

Councillor Vaughan enquired about electronic patient record system and it was noted that Trust was working with Imperial College Healthcare NHS Trust to develop the new system, which was not yet in place. This was attributable to several factors including patient flow, financial and the introduction of a new system over an existing one. The joint working with Imperial had been a positive learning experience with lessons being learned.

Summarising the discussion, Councillor Vaughan thanked the presenters, noting that the electronic patient records system was work in progress and looked forward to receiving further updates. He welcomed the continuing partnership with Imperial and the fact that WMUT had maintained its own, strong identity and relative autonomy within the structure of the merger, whilst sharing best practice and services. Challenges around staff recruitment, retention and reliance on bank or agency staff were acknowledged, as was the robust approach to staff and patient attitudes, post Brexit. Councillor Vaughan welcomed the work around end of life care, (an item being considered in December) and the collaborative approach sought on palliative care.

RESOLVED

That the report be noted.

96. CHILDREN AND YOUNG PEOPLE'S MENTAL HEALTH 'TRANSFORMATION PLAN' UPDATE

Councillor Vaughan welcomed Angela Caulder, Joint Commissioning Manager, and, Fiona Murray, Transformation Manager, North West London CCGs, who jointly presented the Children and Young People’s Mental Health (CAMHS) ‘Transformation Plan’ Update. The report brought together the findings of Councillor Alan D’eath’s Child and Adolescent Mental Health

Taskforce Report 2016 and the development of the CAMHS transformation plan. In 2015, the CCGs in collaboration with local authorities, agreed proposals to improve mental health services for young people, which included establishing a community eating disorder service for under 18s, and, to 'transform' local mental health services for young people in line with the recommendations made in 'Future In Mind'. Angela Caulder highlighted the following three achievements:

- The H&F schools pilot, a successful bid to become one of fifteen national sites. This linked ten schools together with CAMHS provision from the West London Mental Health Trust, with two hours per week in school (with a specially trained mental health lead in each school) and several young people seen in school, with a further four schools added to the programme, now extended to March 2017;
- The eating disorders service, established on 1st April 2016, in collaboration with Ealing and Hounslow CCGs, as a hub (Ealing) and spoke (LBHF) model. This was as self-referral service, with cases being seen within four weeks, and, a one week wait for urgent cases and linked to the CAMHS national specifications for eating disorders; and
- Out of hours' service, working with 8 CCGs across North West London, involving both Central and North West London Foundation Trust (CNWLFT) and the West London Mental Health Trust (WLMHT), which had received positive feedback, with the pilot being continued.

In terms of next steps, there were several actions required, including the further integration of CAMHS within existing mental health provision, and, for local authority supported, early intervention help in schools and within the wider local community. Fiona Murray explained that they were working towards developing seamless transition, alignment, and provision with other boroughs, highlighting the mental health referral route and ensuring that the provision is sustainable. In terms of co-production, it was explained that flexible approach was required and that they were working with Rethink, to develop a strategy for LBHF, WCC and RBKC. A children and young people conference was planned, to better understand what worked well and what could be improved, highlighting the use of apps and whether these were helpful.

Councillor Perez welcomed the report and commended the encouraging approach undertaken which was notably child-centred. She sought confirmation about how inpatient beds translated at local level. Angela Caulder explained that within H&F, children did not spend long in A&E. Those that did were offered a CAMHS professional and could be discharged without seeing a doctor. They were looking to increase the number of beds available in 2017/18 and it was noted that whilst there were sufficient beds in London, there was significant take up of them from patients outside London, creating further pressures. WLMHT and CNWL were working jointly on one-year pilot (from April 2017), a new model of care to establish community based, priority local beds for local children. This was in partnership with the Priory Group, who would provide the beds.

Councillor Carlebach also welcomed the report and asked if they had engaged with young people who had learning disabilities, or had approached organisations such as Mencap or the National Autistic Society for input in developing CAMHS services. It was explained that Mencap had contributed when they had attended one of the Anna Freud seminars, in September 2016. Whilst there had not been large numbers of young people with learning disabilities contributing to the development of CAMHS, several charities and organisations had contributed, together with parent champions.

Patrick McVeigh referred to page 24 of the report, and the admission to in-patient rate of 13.4% per 1000 of the and whether this could be viewed as positive or negative. Angela Caulder responded that this was not a question she could answer as the data was from NHS England, covering 2014/15 and could not be viewed as comprehensive. It was agreed that more current data would be sought for inclusion in the report being submitted to the Health and Wellbeing Board meeting the 14th November.

ACTION: CCG

Responding to the issue of transition raised by Patrick McVeigh, Angela Caulder concurred that this had been a long standing concern but offered assurances that the number of children that required transition support services at this age was relatively low. It was noted that the eligibility criteria for adult services was significantly lower. Whilst children with mental health needs that were transitioning would also usually have a comprehensive Local Offer in place, this would end at 18. Normally, there would not be a difficulty in transitioning unless an individual found it difficult to engage with the new, adult service. Angela Caulder informed them that they were currently piloting a tapered transitions model of care for 14-25 year olds with learning disabilities could elect to continue to be seen within the CAMHS service. The pilot would require a pooling of budgets and formed the basis of on-going dialogue amongst health, adult social care and children's services colleagues. Patrick McVeigh questioned whether this approach would succeed in addressing the challenges of transitioning. Fiona Murray acknowledged that whilst there was considerable work to be undertaken, her role was to identify the way in which the pilot was successful, how this could be replicated and the mechanisms by which it could be made to be effective and sustainable.

Councillor Brown welcomed the report but commented that he would have liked to have seen a greater focus on addressing factors such as drug abuse and how this impacted on young people's mental health. From his experience as a governor at the Bridge Academy, he had encountered several cases, where the misuse of drugs had been a significant factor affecting the mental health of a young person. In response, Councillor Fennimore informed the Committee that a meeting was planned with MIND the following week. It was recognised that whilst this had been a continuing problem for several years, MIND had advised her that recent figures had shown improvement, as result of the approach taken by the current administration, although there remained much work to be done. Councillor Fennimore explained that she was currently on the board of governors at the Bridge, and that there was a significant amount of work on going around

drugs misuse and the link to mental health. They were examining the work of the youth offending service in the context of mental health provision, encompassing restorative justice, to address concerns early on.

Bryan Naylor highlighted the issue of those parents who were less able to navigate the network of services and providers, or those who struggled to find the support necessary for them to best assist their children. He was concerned that the same experiences encountered personally for his extended family ten years previously, remained unchanged. The most significant factor was the support, knowledge and expertise of individual social workers. Angela Caulder responded that whilst she acknowledged the challenges inherent within the existing system, diagnosis of neuro-developmental disorders took up to one year to establish, and that waiting times within the borough were amongst the lowest in the country. She continued that there were many different support services available within LBHF, some of which were duplicated and she acknowledged that there was a lack of awareness about services. Information was available online, together with a resource pack which was provided to parents. It was recognised that there was a need for a greater integration of services and that the variety of appointments needed required greater co-ordination and consolidation, benefiting from a joined up approach with possibly co-located teams. The aim eventually would be to have a more integrated, child centric service.

Councillor Vaughan summarised the main points of the discussion which included the achievements of the transformation plan to date and the notable contribution of the Taskforce Group in producing their report, the stigma associated with mental health illness and the responsiveness of the local authority in ensuring the provision of CAMHS. Members agreed that they would like to continue to monitor the development of the CAMHS transformation plan and that it be added to the work programme.

RESOLVED

1. That the Committee continue to monitor the on-going work on developing sustainable Children and Mental Health Services and include this in their Work Programme for 2016/17; and
2. That the report be noted.

97. WORK PROGRAMME

Councillor Joe Carlebach requested that the Committee consider the Sheltered Housing Review report, recently considered by the Economic Regeneration Housing and the Arts Policy & Accountability Committee, at their meeting on 6th September 2016. It was agreed that a copy of the report be circulated to members for consideration, with a view to taking a decision at the next meeting of the Committee as to whether to include the item on the Agenda for the Committee.

Referring to Councillor Lukey's comment about planned work on the sports and leisure strategy, in addition to physical activity, Councillor Vaughan asked that that this be included in the Work Programme.

Councillor Brown requested that an item on increased number of cases of tuberculosis be added to the work programme, considering also a public health strategy for addressing this. An item on the Disability Commission was also agreed for inclusion.

RESOLVED

That the Work Programme be noted.

98. DATES OF FUTURE MEETINGS

The Committee noted that the date of the next meeting will be Wednesday, 2nd November 2016.

Meeting started: 7pm
Meeting ended: 10pm

Chair .....

Contact officer: Bathsheba Mall
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London Borough of Hammersmith & Fulham **HEALTH, ADULT SOCIAL CARE AND SOCIAL INCLUSION POLICY & ACCOUNTABILITY COMMITTEE/COUNCIL** **12 December 2016**	
End Of Life Care	
Report of: Director of Public Health	
Open Report	
Classification - For Policy and Accountability Review and Comment **Key Decision:** No	
Wards Affected: All	
Accountable Director: Mike Robinson, Director of Public Health	
Report Author: Colin Brodie, Public Health Knowledge Manager Toby Hyde, Head of Strategy, H&F CCG Matthew Mead, Integrated Care Programme Manager, H&F CCG Bridgitte Moess, Joint Commissioning Team (Older People and Vulnerable Adults)	**Contact Details:** 020 7641 4632 Email: cbrodie@westminster.gov.uk

1. EXECUTIVE SUMMARY

1.1. This report summarises the work and findings of the JSNA on End of Life Care including the recommendations for key partners. The JSNA was presented for discussion and approved by the Hammersmith and Fulham Health and Wellbeing Board on 21 March 2016.

1.2. The report also summarises the local direction of travel for End of Life Care in Hammersmith and Fulham, and continuing progress made against the JSNA recommendations since publication of the report.

2. RECOMMENDATIONS

2.1. The Policy and Accountability Committee are invited to consider and endorse the End of Life Care JSNA report and recommendations

2.2. The Policy and Accountability Committee are invited to note progress made against the recommendations

3. END OF LIFE CARE JSNA

Background to the JSNA

3.1. People approaching the end of their life experience a range of physical symptoms, and emotional and spiritual needs. To manage these issues effectively requires integrated and multidisciplinary working between teams and across sectors regardless of whether the person is in their home, in hospital, a care home, or hospice.

3.2. Families and carers of people at end of life also experience a range of challenges and will have their own specific needs which must be addressed before, during and after the person's death

3.3. While some people experience good and excellent quality end of life care, many people do not. In order to address this variation and identify local issues for end of life care a request for a JSNA was submitted and approved by the JSNA Steering Group, a sub-group of the Health and Wellbeing Boards, July 2014

3.4. The JSNA provides a comprehensive evidence base to inform local strategic and commissioning approaches to end of life care. It draws on a range of information and data, both quantitative and qualitative, including national and local data, policy and strategy, literature, as well as views of patients, service users and the public. It provides an opportunity to understand the whole landscape for people approaching end of life, and their carers' and to highlight areas of improvement to be addressed in joint strategic planning.

JSNA Findings and Recommendations

3.5. The overarching theme emerging from the JSNA is the need for a whole scale 'culture shift', for all practitioners that may come into contact with dying people to consider End of Life care as 'everyone's business', not just a service provided by specialist palliative care.

3.6. The recommendations were drawn from the evidence contained in the JSNA and in development with key stakeholders. Many of the recommendations cut across a number of different themes and service areas, and were presented in a format for commissioners to consider whether they are appropriate for local implementation.

3.7. Recommendation 1 refers to an ambition for the local delivery of high quality, person- centred end of life care designed to improve the experience of the dying person and their families, carers and friends. Recommendations 2 to 5 describe the culture, governance, processes and systems that need to be in place in order to achieve this ambition

3.8. The detailed recommendations are presented in the End of Life Care JSNA Key Themes document but are also summarised below.

Recommendation	**Summary**
Recommendation 1: Maximise choice, comfort and control through high quality effective care planning and co-ordination	Everyone with a life limiting long term condition should have care plans which address their individual needs and preferences, particularly as they approach the last phase of life. Their care must be coordinated, with a clear oversight of the respective roles and responsibilities of all health, social care and third sector service providers.
Recommendation 2: Promote end of life care as 'everybody's business' and develop communities which can help support people	The overall focus of end of life care must be a community model, with input from specialist services when needed. Local leaders, commissioners, professionals and our populations should generate a culture where talking about and planning for the last phase of life is 'normal', and all practitioners are willing and able to give end of life care.
Recommendation 3: Identify clear strategic leadership for end of life care across both social care, health and the independent sector	A lead organisation should be identified with responsibility for ensuring developments are cohesive. Leadership should reflect a community based model across a range of services, with a clearly articulated end of life care vision and ambitions.

Recommendation 4: Develop a coordinated education and training programme for practitioners, the person dying, carers and for family and friends (if they wish)	Formal and informal training and education programs for all frontline practitioners needs to be coordinated, systematic, visible and evaluated, in line with good practice guidelines.
Recommendation 5: Everyone should have easy access to evidence and information	More information needs to be easily available. Accessibility in terms of language, style, culture and ability should be reviewed. Evidence and information must be available to commissioners and providers and used to actively improve services.

4. END OF LIFE CARE IN HAMMERSMITH AND FULHAM/CURRENT WORK PROGRAMMES

4.1. **Recommendation 1: Maximise choice, comfort and control through high quality effective care planning and co-ordination**.

Hammersmith and Fulham utilise the Co-ordinate My Care (CMC) system along with the other 31 CCGs across London to record the care plan of those identified as being at the end of life. The CMC platform has been updated to facilitate the creation and updating of records and the Three Borough End of Life Care Steering Group regularly review the reports and discuss what additional support can be provided to increase the number of patients whose care information is shared on the system.

4.2 Central London Community Healthcare (CLCH) have convened six working groups, closely aligned to the recommendations of the JSNA with three groups looking at:

- High quality, relationship centred, compassionate care
- Advance care planning/risk stratification
- Assessment and care planning

The individual working groups report back on the progress of achievement against each of the outcomes, to the newly formed End of Life Care Operational Group.

4.3. **Recommendation 2: Promote end of life care as 'everybody's business' and develop communities which can help support people**

Supporting people in the Last Phase of Life (LPOL) has been identified as a priority area in the North West London (NWL) Sustainability and Transformation Plan (STP) submitted in October 2016. The shift to consider people in the last phase of life rather than those at the end of life recognises

the more gradual functional decline that characterises the progression of various long term conditions and increasing frailty. This reinforces the need to recognise when people are in the last phase of life and to have discussions at an early stage with them and their families regarding their preferences and what support is required. This will allow a shift from an existing hospital-based model of care, often through emergency services, to a new community and person-focused model of delivering care with input from specialists when needed.

4.4 The CCG are also working with the new provider of the Community Independence Service to consider how the service can work alongside local hospices, district and community nursing, primary care practitioners and specialist palliative care teams to provide support to those in the last phase of life.

4.5 Recommendation 3: Identify clear strategic leadership for end of life care across both social care, health and the independent sector

In the NWL area, a programme of work is being undertaken as part of the Sustainability and Transformation Plan (STP) to improve the quality of care for people who are in their 'last phase of life'. This includes patients in Hammersmith and Fulham.

4.6 Providers working across Hammersmith and Fulham have end of life care strategies with key leaders within the organisations identified and governance mechanisms in place for monitoring progress.

4.7 Imperial College Healthcare NHS Trust (ICHT) and Chelsea & Westminster NHS Foundation Trust both have organisational end of life care strategy documents. The CLCH End of Life Care Strategy (2015-2018) was launched in March 2015 and sets out plans to improve end of life care and the experience for people and carers using CLCH services at the end of their lives. This encompasses improving access to end of life care services, improving choice and the coordination of services to reduce inequalities of service provision and increasing the proportion of patients who are cared for and die in their preferred place of care.

4.8 The strategy covers generalist and specialist palliative care, including care given in all settings of CLCH (at home, all community based services, in-patient, specialist in-patient palliative care services, day Hospice, specialist community palliative care services, prison health, nursing and residential care).

4.9 The Health and Wellbeing Board approved the End of Life Care JSNA at their meeting on 21 March 2016 and agreed to take on a leadership role for End of Life Care, providing a steer for local implementation.

4.10 Recommendation 4: A coordinated education and training program for practitioners, the person dying, carers and for family/friends (if they wish)

The NWL LPOL programme has identified consistent training and education across the NWL Collaboration of CCGs as one of the six key interventions and discussions have been initiated with HENWL to agree a funding mechanism.

4.11 The CLCH EOLC Strategy includes a working group dedicated to training and education which categorises staff groups and supports the delivery of appropriate training in relation to the end of life care components of their jobs.

4.12 ICHT and CLCH have delivered end of life care training to staff including difficult conversations training.

4.13 The dementia workforce development programme is due to commence in February 2017. It will include a range of modules, including a focus on end of life care and dementia. The modules will include a range of learning approaches including e-learning, workshops, training and a communication strategy.

4.14 The module will focus on living well with dementia and supporting a person with dementia to die well, or as they would have wished. It will include exploring advanced decision making, the range of symptoms that a person with dementia may experience at the end of life. It will also include supporting family carers and help them to understand what is happening at the end of life.

4.15 Recommendation 5: Everyone should have easy access to evidence and information

One of the interventions which has been recommended and prioritised by the North West London Last Phase of Life programme is to deliver a **telemedicine clinical support facility**, to help staff in care homes (initially) to be able to access generalist healthcare and end of life care advice and support. The next phase of the programme will then be to focus on the wider cohort of residents, including those people being cared for by district nursing, intermediate care services, and by formal and informal carers.

4.16 The service will be staffed by experienced clinical professionals who are capable of providing rapid triage and advice / guidance to both clinical and non-clinical staff. Best practice from elsewhere has shown that this model allows professionals and carers to better facilitate the wishes of patients at the end of their life, and support them to die in their preferred place, and can also reduce inappropriate A&E attendance and hospital admissions

5. CONSULTATION

5.1. A workshop was held at the BME Health Forum in June 2015. Feedback from the workshop was incorporated into the findings, particularly the Policy and Evidence Review (Supplement 2)

5.2. A workshop was held at the End of Life Care Steering Group in September 2015 to inform the development of the recommendations. The End of Life Care Steering Group consists of CCG and GP End of Life Care leads as well as community and secondary care providers

5.3. The JSNA was presented to the Hammersmith and Fulham CCG Governing Body Seminar on 03/11/2015. In addition, CCG and GP End of Life Care leads were interviewed for the JSNA.

5.4. The draft JSNA was disseminated to key stakeholders in November 2015, including colleagues in Local Authority, Adult Social Care, CCGs, Central London Community Healthcare, Hospices, Specialist Palliative Care Teams, Healthwatch, and Community and Voluntary organisations. Feedback was collated and reviewed by the Task and Finish Group and informed the final report.

6. EQUALITY IMPLICATIONS

6.1. JSNAs must consider the health, wellbeing and social care needs for the local area addressing the whole local population from pre-conception to end of life.

6.2. The “local area” is that of the borough, and the population living in or accessing services within the area, and those people residing out of the area for whom CCGs and the local authority are responsible for commissioning services

6.3. The “whole local population” includes people in the most vulnerable circumstances or at risk of social exclusion (for example carers, disabled people, offenders, homeless people, people with mental health needs etc.)

7. LEGAL IMPLICATIONS

7.1. The JSNA was introduced by the Local Government and Public Involvement in Health Act 2007. Sections 192 and 196 Health and Social Care Act 2012 place the duty to prepare a JSNA equally on local authorities (LAs), Clinical Commissioning Groups (CCGs) and the Health and Wellbeing Boards (HWB).

7.2. Section 2 Care Act 2014 imposes a duty on LAs to provide or arrange for the provision of services that contribute towards preventing, delaying or reducing care needs.

7.3. Section 3 Care Act 2014 imposed a duty on LAs to exercise its Care Act functions with a view to ensuring the integration of care and support provision with health provision to promote well-being, contribute to the prevention or delay of care needs and improve the quality of care and support.

7.4. JSNAs are a key means whereby LAs work with CCGs to identify and plan to meet the care and support needs of the local population, contributing to fulfilment of LA s2 and s3 Care Act duties.

7.5. Implications verified by: Kevin Beale, Principal Social Care Lawyer, 020 8753 2740.

8. FINANCIAL IMPLICATIONS

8.1. There are no financial implications arising directly from this report. Any future financial implications that may be identified as a result of the review and re-commissioning projects will be presented to the appropriate board & governance channels in a separate report.

9. IMPLICATIONS FOR BUSINESS

9.1. None identified.

10. OTHER IMPLICATION PARAGRAPHS

10.1. None identified.

11. BACKGROUND PAPERS USED IN PREPARING THIS REPORT

None.

12. LIST OF APPENDICES:

Appendix 1: CLCH End of Life Care Operational Update August 2016

Appendix 1

Central London Community Healthcare NHS
NHS Trust
Your healthcare closer to home

END OF LIFE CARE STRATEGIC GROUP July 2016	
Report title:	The review of the End of Life Care Strategy
Agenda item number:	
Report of:	Hilary Shanahan; Compassion in Care Coordinator and End of Life Care Nursing Lead.
Contact officer:	Hilary Shanahan; Compassion in Care Coordinator and End of Life Care Nursing Lead.
Relevant CLCH priority (delete as appropriate)	1. **Quality.**
Freedom of Information status	Report can be made public.

Executive summary:

The Trust End of Life Care Strategy (2015-2018) was launched in March 2015 and through the End of Life Care Model of Care and work programmes, it sets out plans to improve end of life care and the experience for people and carers using CLCH services at the end of their lives. This encompasses improving access to end of life care services, improving choice and the coordination of services to reduce inequalities of service provision and increasing the proportion of patients who are cared for and die in their preferred place of care.

The End of Life Care Strategy includes the provision of end of life care for children and adults with any advanced, progressive or chronic illness regardless of diagnosis. It focuses on generalist and specialist palliative care, including care given in all settings of CLCH (at home, all community based services, in-patient, specialist in-patient palliative care services, day Hospice, specialist community palliative care services, prison health, nursing and residential care).

The End of Life Care Operational group is responsible for implementing the Strategy supporting incremental improvements and the continued spread of high quality, competent, compassionate end of life care to all those who need it. The Strategy is supported by a robust programme of work delivered through a number of different work streams. Considerable progress has been made in all of the work streams.

The End of Life Care Nursing Lead is now undertaking a review of the End of Life Care Strategy to ensure it encompasses current National guidance, patient and staff involvement and commissioners intentions.

This report provides an update on the Strategy and the actions being undertaken within the Operational End of Life Care group.

Assurance provided: The End of Life Care Strategy is supported by a robust work programme to provide assurance against the delivery of the Strategy; the work programme is reported to the End of Life Care Operational Group, the End of Life Care Strategic Group and the Quality Committee.

Report provenance: The Strategy was developed with the involvement of key clinicians, stakeholders and specialist palliative care providers. The Strategy was approved by the End of Life Care Steering Group.	
Report for:	Decision ☐ Discussion ☐ Information ■
Recommendation: For the End of Life Care Strategic Group to be updated on the actions that will be taken for the review of the End of Life Care Strategy.	

1 Purpose

1.1 The purpose of this paper is to provide an update on the actions that will be taken for the review of the Trusts End of Life Care Strategy.

2 Introduction

2.1 The Trust End of Life Care Strategy (2015-2018) was launched in March 2015 and through the End of Life Care Model of Care and work programmes, sets out plans to improve end of life care and the experience for people and carers using CLCH services at the end of their lives. This encompasses improving access to end of life care services, improving choice and the coordination of services to reduce inequalities of service provision and increasing the proportion of patients who are cared for and die in their preferred place of care.

2.2 In order to achieve the aims of the Strategy, the Adults work programme currently focusses on six objectives, based on the End of Life Care model and outcomes for CLCH. These are:

- High quality, relationship centred, compassionate care
- Advance care planning/risk stratification
- Assessment and care planning
- Symptom management, comfort and well-being
- Support for families including bereavement care
- Education and training

2.3 The six work streams of the End of Life Care Strategy are led through individual working groups, which report back on the progress of achievement against each of the outcomes, to the newly formed End of Life Care Operational Group.

2.4 The current model for End of Life Care for Children in CLCH is delivered against the core care pathway for children with life limiting and life threatening conditions, which is divided into three stages, comprising of six standards which specify the level and quality of care that every family should expect.

2.5 There is also an End of Life Care Working Group for Children's Services. The working group is representative of staff working in End of Life Care within the Division. The purpose of the group is to take forward the six standards of the End of Life Care for Children. The working group reports to the End of Life Care Operational Group and meets bi-monthly.

3 Adult objective work stream update

3.1 High quality, relationship centred, compassionate care

3.1.2 The CLCH Compassion in Care model, patient outcomes and staff competencies have been taken

forward through 'Knowing you Matter and 'Leading with Compassion' sessions across the Trust. There were a number of sessions in June and July 2015 for all Trust staff. A specific 'Knowing you Matter' and 'Leading with Compassion' Programme has taken place on Jade ward and with the Quality Leadership Team. The sessions have been extremely well evaluated and a final report and recommendations regarding the sessions were presented to the Compassion in Care Board meeting on January 15th 2016. Further funding from Health Education North West London, to implement a Train the Trainer programme for the delivery of 'Compassion in Care- it starts with us' sessions within the Trust and with other neighbouring organisations to create a Compassion in Care Community Provider Network has been recently approved. The delivery of the Train the Trainer sessions commenced in April 2016 and a number of sessions have taken place. The first Compassion in Care Provider Network meeting is being held in September 2016 in partnership with Chelsea and Westminster Hospital and Trinity Hospice. A Compassion in Care outcomes dashboard has also been developed and is due to be piloted in one of the clinical areas in September 2016.

3.1.3 The Patient Experience Team is also introducing the concept of patient stories and dynamic patient stories within palliative care services.

3.2 Advance care planning/risk stratification

3.2.1 Two national Advance Care Plan documents are being implemented within the Trust and initial Advance Care Planning teaching sessions took place in July 2015 in each Borough. The sessions have been facilitated by The Royal Marsden Hospital through commissioned education funds.

3.2.2 Further Advance Care Planning teaching sessions have taken place in each Borough in June and July 2016, facilitated by The Royal Marsden Hospital. The Advance Care Plan documents have been uploaded onto System One and Cross Care and are also available on the End of Life Care section on the hub.

3.3 Assessment and care planning

3.3.1 A review of documentation related to end of life care assessment and care planning has taken place and a working party was convened to re- develop the end of life care assessment and care planning documentation. An individual plan of care and support for the dying person in the last days and hours of life document has been developed for use across the Trust from November 30th 2015. This has been fully implemented at The Pembridge Palliative Care Centre. Care planning guidance and a patient/relative information leaflet has also been developed to be used in conjunction with the individual plan of care and support for the dying person in the last days and hours of life. A Train the Trainer one day education programme for staff, regarding care and support for the dying person in the last days and hours of life, and the use of the individual plan of care and support for the dying person commenced in February 2016. One hundred and sixty staff in the B staff grouping have been trained to date and further training dates are available until September 2016. The individual plan of care and support for the dying person document has been uploaded onto System One and Cross Care. The documents are also available on the End of Life Care section on the hub.

3.3.2 A review of documentation related to end of life care assessment and care planning has taken place and a working party was convened to re- develop the end of life care assessment and care planning documentation. An individual plan of care and support for the dying person in the last days and hours of life document has been developed for use across the Trust from November 30th 2015. This has been fully implemented at The Pembridge Palliative Care Centre. Care planning guidance and a patient/relative information leaflet has also been developed to be used in conjunction with the individual plan of care and support for the dying person in the last days and

hours of life. A Train the Trainer one day education programme for staff, regarding care and support for the dying person in the last days and hours of life, and the use of the individual plan of care and support for the dying person commenced in February 2016. One hundred and sixty staff in the B staff grouping have been trained to date and further training dates are available until September 2016. The individual plan of care and support for the dying person document has been uploaded onto System One and Cross Care. The documents are also available on the End of Life Care section on the hub.

3.4 Symptom management, comfort and well-being

3.4.1 End of Life Care symptom control guidelines for prescribing/symptom management have been agreed and circulated throughout the Trust. The guidelines will also be presented in a leaflet format for CLCH staff use. The Syringe Driver Policy was approved at the Medicines Management Committee in November 2015.

3.5 Support for families including bereavement care

3.5.1 Staff focus groups have taken place across the Trust to understand the bereavement support that is available for staff and patients. From the focus group findings, Schwartz rounds are now being taken forward across the Trust for all staff. The first Schwartz facilitators were trained in November 2015 and the first Schwartz round took place in March 2016. A specific End of Life Care Schwartz round is taking place in July 2016 at The Pembridge Palliative Care Centre. The bereavement information on the End of Life Care section of the hub has also been reviewed.

3.6 Education and training

3.6.1 Recommended End of Life Care Education Standards document, linked with the Priorities for Care for the Dying Person, for all staff has been approved. This outlines the behaviours, attitudes, competencies and skills for staff who work in any care setting of the Trust where dying people and their relatives receive care. A paper detailing the implementation of the end of life care standards document was presented and approved at the Education Committee in November 2015. Divisional End of Life Care Champions are now in place for each of the divisions to work with the Compassion in Care Co-ordinator and End of Life Care Nursing Lead. They will support the Train the Trainer educational programme for staff regarding care and support for the dying person in the last days and hours of life, and the use of the individual plan of care and support for the dying person. The education programme commenced in February 2016. One hundred and sixty staff in the B staff grouping have been trained to date and further training dates are available until September 2016.

4 Children's objectives update

4.1 The core care pathway for children with life limiting and life threatening conditions, which is divided into three stages, comprising of six standards which specify the level and quality of care that every family should expect are in use within the Trust.

4.2 Recommended End of Life Care Education Standards for staff working within the Children's Division are being developed.

5 Review of the Strategy

5.1 In order to review the End of Life Care Strategy, the following actions will be taken by the end of October 2016 by the End of Life Care Nursing Lead-

- A review of current National End of Life Care policy will be incorporated into the reviewed Strategy
- The current objectives of the End of Life Care Strategy will be benchmarked against the six ambitions of the Ambitions for Palliative and End of Life Care Framework(2015-2020) and incorporated into the reviewed Strategy objectives as appropriate
- Current End of Life Care Strategies from relevant stakeholders will be reviewed and incorporated into the reviewed Strategy objectives as appropriate

- An Adult patient /carer co-design event is planned in September with adult patient group representatives to inform the review of the Strategy
- A Children's patient /carer co-design event is also being discussed to inform the review of the Strategy
- A staff co-design event is also being discussed to inform the review of the Strategy

6 Recommendations

6.1 For the End of Life Care Strategic Committee to be updated on the review of the Trusts End of Life Care Strategy and approve the actions as the process for review.

London Borough of Hammersmith & Fulham **Health, Adult Social Care and Social Inclusion Policy and Accountability Committee** **12 December 2016**	
Community Champions	
Report of: Director of Public Health	
Open Report	
Classification - For Policy and Accountability Review and Comment **Key Decision:** No	
Wards Affected: Addison, College Park and Old Oak, Shepherds Bush Green, North End, Fulham Reach, White City and Wormholt	
Accountable Director: Dr. Mike Robinson, Director of Public Health	
Report Author: Christine Mead, Behaviour Change Commissioner, Public health	**Contact Details:** Tel: 020 7641 4662 E-mail: cmead@westminster.gov.uk

1. EXECUTIVE SUMMARY

1.1. The Community Champions is a neighbourhood based volunteer project which focuses on health. The paper describes the current 6 projects and activities delivered, and reports on the key findings from the Social Return on Investment Evaluation from 2014. The committee is asked to review the approach and make recommendations about how the approach could be extended or developed.

2. RECOMMENDATIONS

1. To develop a 'community champions lite' approach over the next 18 months which would give residents living in other wards opportunities for engaging in this way in their own neighbourhoods; and
2. To consider and comment on the report.

3. PROPOSAL AND ISSUES

3.1 Community Champions background

The community champions began as a project in White City in 2008, one of 16 projects under the Well London programme. The White City project, which ran for 5 years, was particularly successful in the recruitment and development of volunteers, supporting healthy activities for residents and supporting the volunteers into employment. White City Residents Association, who were responsible for the project together with Public Health, developed White City Enterprise at the end of the project to take forward a body who could continue to deliver similar work in the community.

3.2 Developed Projects: Old Oak, Edward Woods, Parkview

These projects have been running already for two years and have developed partnerships and programmes.

- Old Oak, delivered by Family Mosaic/Old Oak Housing and co –funded by them, also run a maternity champions pilot.
- Edward Woods, delivered by Urban Partnership Group, also have developed additional work around youth champions. They are also supported by Notting Hill Housing Trust.
- Parkview, delivered by White City Enterprise, are the only CC project to be based in a health and social care centre, and are developing models where champions help to link residents with centres and centre activity, so that there is a greater sense of a centre belonging to the community.

3.3 Each project started with a residents' survey to set the agenda for the community champions, who then deliver activities, campaigns and events which are highest on residents' priorities and interests for that area. In this way, although every project will have some healthy eating groups and some physical activity groups, how they develop will be shaped locally. The interests of the individual champions, and the views of the residents, and the support of public health campaigns and services, contribute to the development of the projects. They are all commissioned with local community organisations who already have strong local networks which support the projects to thrive.

3.4 Projects starting this year: West Kensington and Gibbs Green, Addison, Bayonne and Field Rd

These projects all began in June or July this year, so are at very early stages of development.

- West Kensington/Gibbs Green, delivered by Pinnacle Housing, and based in Gibbs Green tenants Hall, has recruited a manager and the first champions and is beginning the survey with residents. They are

launching with a Winter Health campaign, and are supported by the HFCCG as well.

- Bayonne and Field Rd, delivered by HF Volunteer Centre, and based in Wentworth Court Sheltered Housing Community Hall, has recruited a manager and a champion and is in the process of designing the survey.
- Addison, covering Roseford, Woodford, Bush and Shepherds Courts – Romney, Charecroft and Rockley Courts- Sulgrave, Netherwood, Woodger and Lakeside Roads, delivered by the Urban Partnerhsip Group and supported by the HFCCG. This project bagan working the week of the fire in Shepherds Court and have developed close working relationships with the Charecroft Tenants and Residents Association, and are based in Charecroft Community Hall.

3.5 Social Return on Investment Evaluation

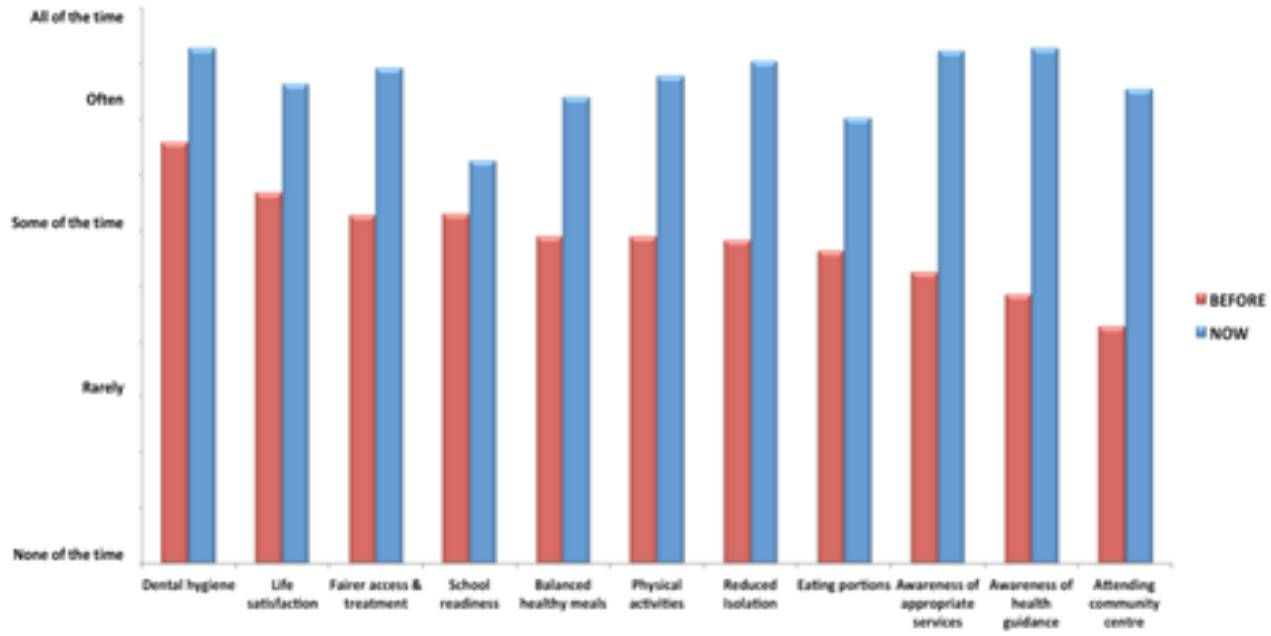
The 6 Community Champion projects in LBHF are part of a programme that includes 15 neighbourhood projects connected together across the three boroughs. This enables the sharing of good practice and contacts across the projects, and allows functions like training, website, communications, evaluations and reports to be delivered efficiently through programme support. The Champions project managers meet together on a quarterly basis to share ideas, and all the Champions are invited to an annual conference to celebrate their work and recognise their achievements, and to make links for development for the following year. The conference in particular has fostered the sense that the Champions are part of something much bigger than themselves and their neighbourhoods. It will be held next in Hammersmith in November 2017.

3.6 A Social Return on Investment Evaluation was commissioned in 2014 to assess the actual outcomes of the projects. The SROI model goes direct to the beneficiaries and asks them what the actual outcomes are for them, and then seeks to assess the value of these outcomes. The evaluation found that on average, each project engages with 1000 residents a year through campaigns and community events, and of those 200 residents are actively engaged in 3 activities a year. The estimated ROI is £5.05 for every £1 invested.

Changes for Residents:

Magnitude of change

Graph 1: Frequency of occurrence of key health and well-being outcomes amongst Residents (Before contact with Champion, and Now)



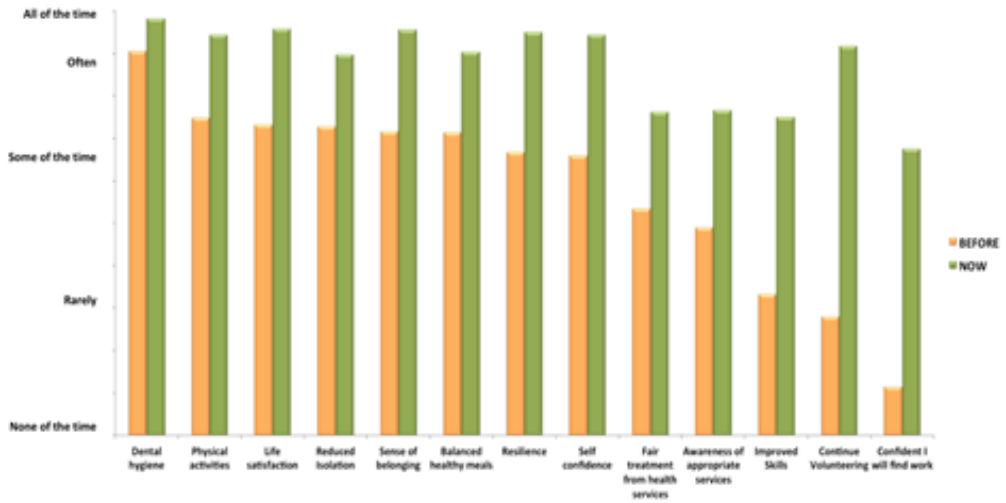
Health research indicates **1 in 8** likelihood of developing type 2 diabetes over-65s

[1] Estimate of 10 years reduced life expectancy from developing type diabetes taken from: Department of Health, National service framework for diabetes (2012), & *Diabetes in the UK* by diabetes.org.uk (2010)

Changes for Champions:

Magnitude of change

Graph 2: Frequency of occurrence of key health and well-being outcomes amongst Champions (Before becoming a Champion, and Now)



38% of Champions report WAIST SIZE reduction by up to one size with WEIGHT LOSS (**Average 4kg**)

Paid work (FTE) gained by **10%** of Champions & **20%** into **further training, PPG or public speaking**

Over 1,300 children reached, leading to improved health actions, knowledge, oral hygiene & exercise

4 OPTIONS AND ANALYSIS OF OPTIONS

4.1 The model for the community champions' projects to date has been to focus on specific neighbourhoods where there are greater health inequalities, and to focus activities and resources there. Projects are funded for five years, with the intention that at the end of that time they will have created another way of taking this type of activity forward, and the funding could be moved to another neighbourhood. In addition, over the course of the projects we have sought co-funding relationships with HFCCG and with housing providers, to make the projects more sustainable and to stretch the local authority funding to more areas. However, our funding is limited and unlikely to increase, so we have been exploring other models for extending this type of activity.

4.2 Other models of community champion activity are based on individual champions, who are not part of a group activity but decide to do something they want to do from their own initiative. Peabody run an example of this type of project, Community Activators, where they encourage their tenants to apply for small pots of money to do something for their neighbourhood, for example plant a patch of wasteland with vegetables, or start an after school homework club, or take care of a notice board. There is no monitoring, evaluation, training or organisation, simply the administration of a small funds process.

4.3 Other models, such as Altogether Better, base champion activity in GP surgeries as community gathering points, and use surgery resources to provide spaces for people to meet and decide what to do without funding.

4.4 The overall intention of the community champions project is to support residents who are interested in health to develop projects. Does the committee have a view about the best way of developing and extending the work of the champions in Hammersmith and Fulham?

5 CONSULTATION

5.1 The consultation that takes [place happens in the locality of each project at the beginning, where residents are asked about what they are interested in and what sorts of activities they would like to see developed locally.

6 EQUALITY IMPLICATIONS

6.1 The project areas so far have been chosen because they are in the most deprived areas of the borough with the greatest health inequalities, and poorest use of health services. In contributing to employment and employability, as well as reducing the risk of long term diseases, the projects direct resources in a way to reduce unequalities.

7 LEGAL IMPLICATIONS

7.1 Not applicable

8 FINANCIAL IMPLICATIONS

8.1 Not applicable

9 IMPLICATIONS FOR BUSINESS

9.1 Not applicable

10 OTHER IMPLICATION PARAGRAPHS

10.1 Not applicable

11 BACKGROUND PAPERS USED IN PREPARING THIS REPORT

No.	Description of Background Papers	Name/Ext of holder of file/copy	Department/ Location
	Social Return on Investment, 2014	http://www.communitychampionsuk.org/work-with-us/reports-and-publications/	Public Health
	LBHF Highlight Report 2015-16	http://www.communitychampionsuk.org/work-with-us/reports-and-publications/	Public Health

COMMUNITY CHAMPIONS' HAMMERSMITH & FULHAM
END OF YEAR HIGHLIGHT REPORT

COMMUNITY Champions

April 2015 – March 2016

Community Champions hubs in Hammersmith & Fulham

THERE ARE currently three hubs and a pilot project in Hammersmith and Fulham; however, this year sees the Community Champions programme in Hammersmith & Fulham set to double in size: A lot of market development work has been undertaken in the last year and we start the 2016-17 year with the announcement that three new hubs are being established in the borough from June and July 2016. These will be focussed on Shepherds Bush Green, Bayonne & Field Road, and Gibbs Green and West Kensington estates. There will be more on these projects next year but this report focuses on the three existing hubs:

Hubs

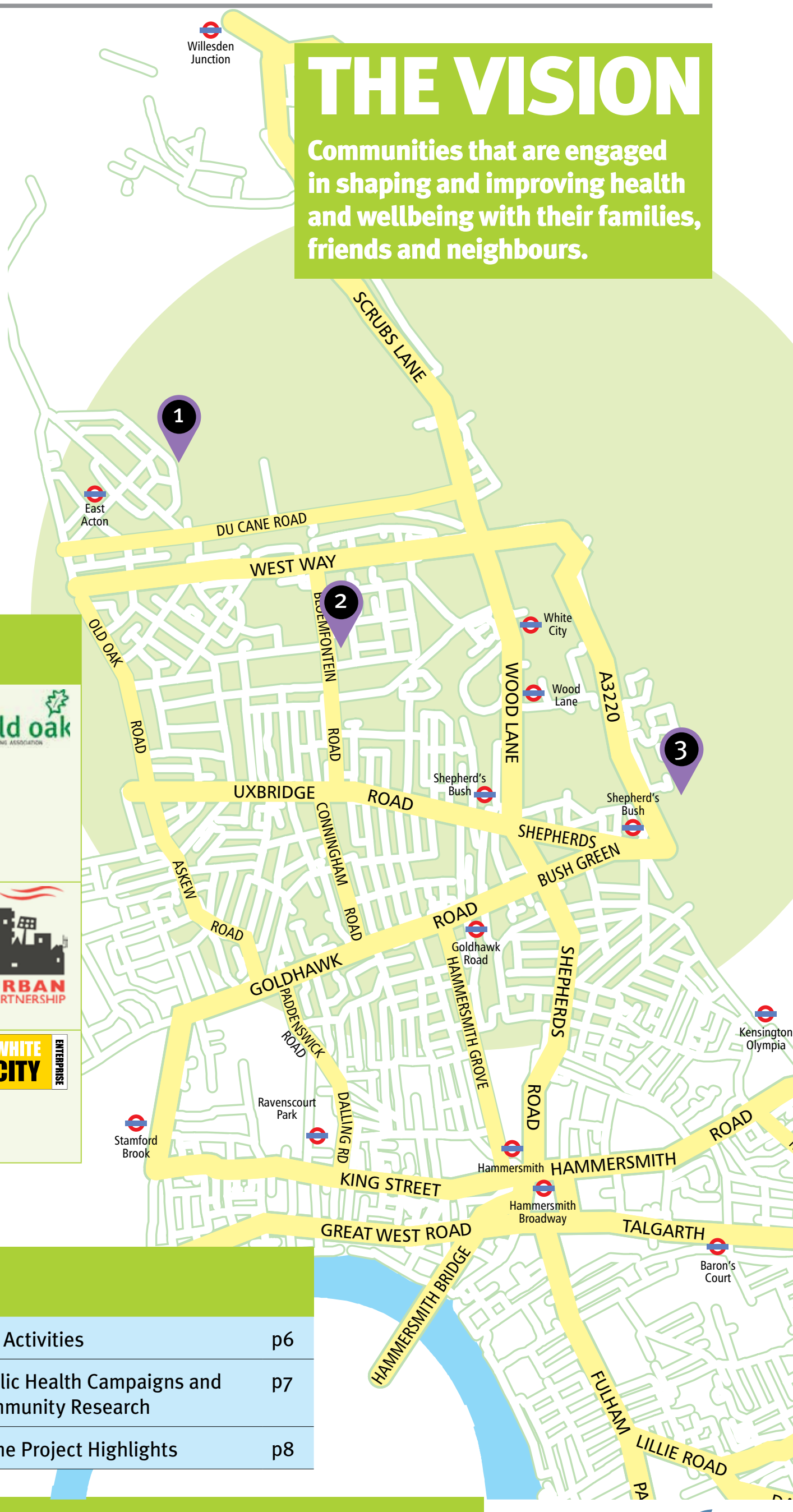
1 Old Oak
hosted by Old Oak Housing Association's Community & Children's Centre and based there. Also the host for the Old Oak Maternity Champions pilot.
Old Oak Community, & Children's Centre,
76 Braybrook Street, East Acton W12 0AP
020 8740 8008

2 Parkview
hosted by White City Enterprise and working in and around Parkview Health & Wellbeing Centre.
White City Community Centre,
India Way, White City W12 7QT
020 8811 2494

3 Edward Woods
hosted by Urban Partnership Group
Edward woods Community Centre,
60-70 Norland Road, London W11 4TX
020 7602 4500

THE VISION

Communities that are engaged in shaping and improving health and wellbeing with their families, friends and neighbours.



In this report...

FOR INFORMATION ABOUT THE PROGRAMME CONTACT:
Programme Office: •0207 642 4834/4662 •info@communitychampionsuk.org
•www.communitychampionsuk.org

h&f hammersmith & fulham

The People – the Champions

Buggy walk with Old Oak Maternity Champions

NOW WITH 73 Community & Maternity Champions registered, there are some 45 - 50 active at any one time in Hammersmith & Fulham. Volunteers give their time and energy in a variety of ways, for anything from 3-6 hours per month to 3-6 hours per week. The profile of our Champions remains fairly consistent with: 90% women; 92% from an ethnic minority background, 85% ages 25-44, 84% parents. We are just beginning to see some results in increased recruitment of older and male Champions which we hope to build on in future – Old Oak for example has recruited two new male Maternity Champions which helps to give added support to fathers to be and new fathers. Here's what two of our Champions have to say:

> "I have met interesting people from local organisations, got some qualifications in health subjects, made good friends with other Champions"

Case study: Doris

Edward Woods Community Champion

'I WAS a nurse in Ecuador and when I came to this country I hoped to be able to use my knowledge to help people. I'm a single mum with 3 small children and so going back to work was not possible until recently. I joined the Edward Woods Champions a couple of years ago and found somewhere I could use my knowledge to help others and also learn new skills to help me in the future. Becoming a Champion meant so much. I learnt a lot about the area we live in, about where to go for information or advice. I have met interesting people from local organisations, got some qualifications in health subjects, made good friends with other Champions and even broadcast on community radio. Everything I have learnt I have passed on to friends and family. My community has benefited through the work I have done with other Champions putting on events, signposting, working on health campaigns. Sharing knowledge, being connected and talking to others has helped me to feel less isolated. That's why I now spend a lot of time encouraging friends and neighbours to get involved in our activities. I was given the opportunity to study on the Health Trainers Course, a level 3 qualification. Having to write, research and talk about health issues has increased my confidence and at the moment I am studying to be a Teaching Assistant. Everything I have achieved with the Champions will be really helpful when I start working in a school and I'm also sure that one day, when the children are a bit older, I can be a nurse again.'

> "I wanted to be a Maternity Champion because I want to give back to the community and help others"

Case Study: Heba

Old Oak Maternity Champion

HEBA, ORIGINALLY from Jordan, has lived in London for 20 years. As the mother of five girls aged 5 to 16 years, Heba felt she had good experience to give back to her community and to other mothers whose lack of English had isolated them from the community (Heba speaks Arabic). When she first started as a Maternity Champion 18 months ago, she did not feel very confident to speak to people as she felt her English was not great but, over time, her confidence grew, she became fluent at giving positive health messages and was able to signpost hard-to-reach women. In most cases the women said that Heba was the first person they felt confident with because of her relaxed, non-judgmental approach. She has become a well-known, greatly respected volunteer. As a Maternity Champion, Heba has completed lots of training courses: NCT's Breast Feeding Peer Supporter and Birth & Beyond Peer Supporter, Baby Massage, Walk Leader training and Level 2 Awards in Understanding Health Improvement and Understanding Behaviour Change. Following the Breast Feeding Peer Supporter training, Heba is now able to help new mums with breast feeding at Queen Charlotte's Hospital.

Heba says: "I wanted to be a Maternity Champion because I want to give back to the community and help others who have and are going through what I have experienced as a new mother far away from my family and community. It's also a great chance to help other mothers as it can be lonely at times. I am a mum to five daughters and I have a lot of experience to share. Since becoming a Maternity Champion I have attended lots of accredited training which will help me with further employment. I love meeting new mums and giving them advice to help with their babies' health - I feel the future is very bright for me and my family since becoming a Maternity Champion."

Maternity Champions offer peer support at Bumps'n'Babies drop-in

170 training days' attendances

INVESTING in our volunteers' professional and personal development continues to be a key component of the programme with all Champions benefiting from our comprehensive learning & development offer. This includes funded and nationally accredited courses and much that is accessed locally for free from partner organisations and LBHF's training offer. 170 days training attendances means an average of almost 4 full days training for every one of our 45+ active Champions. Courses have included:

- Level 2 Understanding Health Improvement (Royal Society for Public Health)
- Level 2 Understanding Behaviour Change (Royal Society for Public Health)
- Induction course
- National Childbirth Trust's (NCT) Birth & Beyond Peer Supporter
- NCT's Breast Feeding Peer Supporter
- Nutrition / Oral health / Weight management
- Oral health for babies
- Introduction to radio skills
- Physical activity - outdoor gym use induction
- MHFA England's Mental Health First Aid
- IAPT Back on Track: Introduction to Mental Health
- Team building
- HSE First Aid (Health & Safety Executive) Level 2
- CIEH Food Hygiene (Chartered Institute of Environmental Health) Level 2
- Food hygiene e learning
- Mindfulness
- Drug awareness / Khat awareness with Blenheim Project
- LBHF's Level 1 & Level 3 safeguarding
- Walking for health LBHF Walk Leader
- Stop smoking - Kick-It
- HIV Testing Service – Terrance Higgins Trust
- World Cancer Research Fund cancer prevention
- Breast Cancer Awareness
- Healthier Homes
- Hammersmith & Fulham Advice Conference 2016
- Introduction to foodbanks

Annual Tri-Borough Community Champions Conference 2015: Championing Happiness

Champions learn new radio skills

Training Highlight: Introduction to Radio Skills Course

A HIGHLIGHT of the year has been the radio training programme developed in partnership with the Women's Radio Group for Champions across the three boroughs. An introduction to radio in its different forms, the 10 weeks course included interview techniques, use of portable recording equipment and editing using audacity. 12 Champions from Old Oak, Edward Woods, Dalgarno and World's End & Cremorne joined the course led by two women radio professionals. Some participants had previous radio experience, others none. All were really enthusiastic and, by the end of the course, convinced of the role that radio could play in delivering the Community Champion message.

> "I was worried about my computer skills... I'm a bit of a technophobe! The course gave me a lot of confidence and to my surprise I found that I'm really good at editing and I really enjoy it."
>
> "First time doing anything like this. I've really enjoyed the experience and would like to do more. You can really see how lots of what we learnt can be put to good use in spreading the word about Champions."
>
> Participant's comment

The Events

16 LARGE community events took place bringing together health and social care providers with residents in our three areas. These achieved a **total of 3043 attendances** including adults and children. Numbers varied between 50 to over 1400, depending on the type of event. Some were led and organised by the Community Champions, others were partnership events to which the Champions contributed. Examples included:

Parkview Champions promote healthy living

Old Oak...

started the year in June with **60 people** attending its **Volunteers Week Awards Ceremony** aimed at celebrating the achievements and contributions of its Community Champions and other volunteers. The same month saw **400 turn out** to its ever popular **Summer Fun Day**. An interactive family fun and community information day, the event has some serious messages, featuring a vitamin D promotion, health information quiz, a focus on staying healthy during Ramadan and a summer survey; amongst the many children's activities, adult's taster dance classes and family football and other games.

October saw the **Old Oak Maternity Champions** host an **Information and Activities day at Parkview** Health and Wellbeing Centre as a promotional event for their services in the White City area, which was a busy day with almost **70 in attendance**.

The year ended with **150 residents** attending a seasonal **Children and Families Health event** focussed on healthy eating, sugar and oral health for babies, toddlers and children.

Edward Woods...

continued its healthy eating activities from last year with its **Cookery Workshops for Kids**! Running over 2 days during each half term and summer holidays, these healthy eating gardening and cookery workshops attracted **over 200 children** and parents in total. Healthy recipes were prepared by children from 6-10 years of age with nutritionist and Champions support; then eaten together with parents. Children and their parents were then sent off with a bag of ingredients, recipes and nutritional information – one to definitely try at home!

August saw the Champions contribute to the annual Masbro Community Fun Event, providing an afternoon of healthy eating & face painting at the children's event. Over 100+ children and many more parents accessed the healthy eating options.

In September, the Champions, in collaboration with Edward Woods Community Centre once again played host to over 70 residents, for a MacMillan Coffee Morning / Light lunch to increase cancer awareness and raise funds for the charity.

The new year began with a new 'Tea & Chat 60+' Elders event attended by 55 residents. The event aimed to encourage older members of the community to meet up and talk as a means of reducing isolation and at the same time access useful information and services.

> "I learnt to cook vegetable stir fry with my two children. Happy dad."
>
> Comment from parent

At Parkview...

the annual W12 Festival in August is a popular street based festival offering local residents the chance to showcase their talents and achievements. Parkview Champions coordinated and ran the **Health and Wellbeing zone** which saw **over 1400 residents** pass through a range of stalls and displays including Stop Smoking, Health Trainers, drugs and diabetes information; and taster physical and relaxation activities.

At **White City Play Day** in October, the Champions used edible pictures to reinforce messages about healthy eating and the benefits of involving children in food preparation. 80 children and parents were supported to use wholemeal wraps as paper and purees, fruit, etc. to draw pictures they could eat. Finishing the year in December, the 'Loving the Winter' event packed Parkview Centre atrium with **over 250 people**.

Parkview promotes Dry January: Mocktail anyone?

> "Never give up on someone with a mental illness, when I is replaced by We, illness becomes wellness"

Championing Happiness

THE YEAR saw a strategic drive across the programme in the promotion of mental health and wellbeing and reducing social isolation. All of our projects are building partnerships and good working relationship with their local IAPT (Improving Access to Psychological Therapies) 'Take time to talk' and other mental health services such as Depression Alliance. Some of the activity generated as a result is highlighted throughout this report.

Investment in MHFA (Mental Health First Aid) Train the Trainer courses for project staff is now growing a pool of trainers within the programme qualified and licenced to deliver MHFA England's validated MHFA course. This is beginning to see results in the roll-out of this 2 days course to Community Champions and local residents; not to mention several local professionals in partner organisations who were unable to access this training at affordable rates. We are excited about the potential of the key messages these courses convey in our communities to really make a difference: As the quote by Shannon L. Alder says: 'Never give up on someone with a mental illness, when I is replaced by We, illness becomes wellness'.

Notably, the annual Community Champions conference in November, 'Championing Happiness', attended by over 180 participants, focussed on this theme and brought together more than 30 Hammersmith and Fulham Champions with other Champions in the three boroughs and nationally; health, housing and social care services; senior decision-makers; councillors and Westminster's Adult and Public Health Cabinet member and Mayor. Speakers from Altogether Better and Sheffield Cubed Health Champions in South Yorkshire and Connecting Care for Children's Practice Champions programme joined with several of our own Community Champions who gave testimonies about their journeys as Champions. Workshops on various aspects of mental health took place, all followed by a great lunch and Award Ceremony to celebrate the Champions' achievements over the previous year.

Old Oak residents enjoy the Big Tea event

The Activities

276 REGULAR activity sessions took place delivered, supported and/or promoted by Champions. Attendance ranged from 6 to over 30 per session: based on an average attendance of 8 residents per sessions, **total attendances exceeded 2,208**. Activity has included a diverse range of weekly, monthly and occasional sessions including:

Run by the Old Oak Maternity Champions twice weekly at Parkview Centre and Old Oak, 'Bumps & Babies' offering peer support, advice and information to expectant and new parents. Additionally to these sessions, 'Birth preparation and relaxation' includes pregnancy yoga and other techniques; while the 5 weeks 'Enjoy your Baby' course was delivered in collaboration with IAPT's Back on Track service.

Health-themed coffee mornings / drop ins and health talks / 'awareness lunches' – on a range of issues, often with visiting speakers. 'Kev's project' was a fortnightly, now weekly, weight management peer support group initiated and run by Champion, Kev at Parkview. 'Sugar Swaps' sessions and men's cooking classes have encouraged healthy eating and engaged more men in Community Champion and Centre activities at Old Oak.

Physical activity sessions of various sorts including zumba, badminton, table tennis, afro-beats dance classes; outdoor gym sessions and buggy walks. Relaxation, yoga and stress reduction sessions such as Parkview's 'Monthly Unwind' introducing massage, reflexology and stress reduction / relaxation techniques in collaboration with the IAPT service.

Curious Stories – an arts-based parenting programme in collaboration with Kensington Palace culminating in parents and children being hosted by 'Queen Caroline' at the Palace!

An 'About the Boys' course helped parents of teenage boys to understand and set healthy boundaries with their sons. A Khat focus group at Edward Woods explored the support needed to deal with the use of Khat in the Somalian community there. Several mental health first aid courses at Old Oak and Parkview have now been delivered to residents and Champions.

Old Oak's Coffee Club and Edward Woods' Over 60s Luncheon club have both seen small inroads to reducing isolation amongst older people in these areas.

> "Due to me attending Mary's classes I was able to give birth easily and midwives commented that I was a natural and gave them the impression, due to my breathing techniques and how relaxed I was that this must be my third or fourth child not that this was my first baby' ... 'It's really nice to have the Maternity Champions coming in after the yoga session as they help us with questions we have and point us in the right direction to get support and information."
>
> Comments from Birth Preparation & Relaxation participants

> "It was really important to see I was not the only one going through all these emotions and it was nice to speak to other mums and find out I was not the only one. From this group friendships developed and we now have a support network - we exchanged phone numbers and still support each other. It's a nice feeling to not feel alone.' ... 'Enjoy Your Baby helped me to feel that it was ok to feel this way (down) and helped me move forward - I found a way to manage the way I felt. The Maternity Champions were able to look after my baby so I could take part in the relaxation session which helped with my anxiety."
>
> Comments from 'Enjoy your Baby' participants

Edward Woods' families meet 'Queen Caroline' at Kensington Palace

> "Thank you and all of your team for the splendid Tea & Chat. We all found the contents of the goody bags really useful. It was a lovely event – when is the next one?!"
>
> Comment from Edwards Woods resident following Tea & Chat 60+ event

Public Health Campaigns and Community Research

12 PUBLIC HEALTH campaigns and research ranging in length from a month to most of the year took place reaching 3224 residents. Our campaigns always start with training for the Champions on the key public health messages for each topic to ensure they are giving accurate and up to date information to residents.

Parkview...

reached 237 residents and Parkview centre users with its **baseline health survey** by May. These app-based surveys, undertaken early in each project's life, aim to gather local intelligence about health attitudes and concerns from residents as well as what people want from their local Community Champions project. Findings have helped form the basis of Parkview's work since then. It also contributed in partnership with QPR to **reaching some 1900 people** through the **Know the Score Bowel Cancer awareness campaign** in April - handing out Star of Hope badges & telling people about the signs & symptoms of bowel cancer.

Between November and March, Parkview delivered four further campaigns reaching a total of 465 residents: a **PPG (Patient Participation group) awareness campaign** with some PPG members aimed at patients about how to influence delivery of their GP practice; **Dry January** - Alcohol awareness which included a mocktail bar giving out alcohol free drinks alongside drink wise information; **Sugar Smart** - raising awareness around the change for life sugar smart app; **International Women's Day Self Care** - sharing information and goody bags around self-care for women in celebration of International Women's Day.

Healthwatch consults new parents at Maternity Champions drop-in

Attack in action at Old Oak Primary school

Edward Woods...

started the year with its **'In your Hood' Youth consultation**. Using three young researchers the consultation aimed to find out the needs of young people on the estate and if the Community Champions could offer anything.

Its Health Needs Doorstep Survey, in partnership with Healthwatch and the Health Trainers Service, in June, aimed to find out the health needs of residents and promote services. The survey reached 54 residents.

Old Oak's...

'Snack Attack' healthy eating in to schools project continued this year. Aiming to help reduce childhood obesity, it ran throughout the whole school year, **reaching some 200 children** and their parents every week with its snacks and recipe cards. Community Champions, assisted by four year 6 children's champions, prepare healthy after school snacks for Old Oak primary school children. This campaign was so successful that the school has now taken it over.

Its ongoing **vitamin D campaign** aimed at pregnant women, parents and children with the distribution of free vitamin D drops for children, continued and reached a **further 50 residents** last summer. Its **Flu safe campaign** dealt sensitively with some controversial issues surrounding take-up of the flu vaccine within the Muslim community; explaining Islamic scholars stance on porcine gelatine to encourage take up.

The **Maternity Champions** undertook ongoing surveys with expectant and new mothers to help plan services **reaching some 250** between June and March. They were instrumental in supporting the Healthwatch research in to maternity services; as well as focussing on an oral hygiene survey for babies & toddlers.

Some Project Highlights

Edward Woods delivers 'What's your Hood Saying?' Youth Consultation

We commissioned this consultation to gain an insight into what young people think about their area, what they like and don't like. It also helped us to identify if there was a need for additional youth activities on the Edward Woods estate within the context of the Community Champions programme. The research ran over six weeks between April and May 2015 and was delivered by 3 young local residents supported by a Senior Youth Worker. Local young people were asked to put their thoughts on specially designed postcards and then invited to a number of focus groups to explore some of the ideas and suggestions. Reaching 65 local young people, it became clear that the Champions Programme could make a significant intervention with younger residents. One of the recommendations from the consultation report was the creation of a Youth Community Champions team. There is a core group of active and motivated young people living on the estate who are interested in contributing to community wellbeing and the survey immediately resulted in six young champions being recruited (15-18s) and beginning work around sexual health with other young people. Following the consultation, we applied for, and in January of this year, received funding from Hammersmith United Charities to support a six month youth development programme, '**Edward Woods Young Health Champions**'.

Young researchers deliver 'What's your hood saying?'

Old Oak delivers Mental Health First Aid training

As part of the Programme–wide drive to improve mental health and reduce social isolation, at Old Oak both our Project Co-ordinator and Maternity Champions Project Worker completed MHFA England's Train the Trainer qualification. Now licenced to deliver its accredited two days Mental Health First Aid training course, we started to deliver these courses at Old Oak in January and February 2016 and aim to train many more local residents during the coming months. As most of our Community Champions have now completed this training themselves they are in an ideal position to explain to others what it is about and work hard to promote and publicise these courses.


'Loving the winter' with Parkview Champions

Parkview delivers 'Loving the Winter'

This community information day aimed to support the local community to 'fall in love' with winter by getting ideas around: having a healthier home; how to eat and drink healthily; keeping active in winter; ways to relax and oral hygiene information for children. This was a new format for us and delivery partners who completed post-event feedback showing an increase in the number of residents they spoke to compared to previous events and participants reporting that they really liked the energy of the session and found it useful. We adopted more of a 'cafe' approach so participants and delivery partners where all sitting together around coffee tables rather than using information tables in a 'market stall' format. This feels like it suits our style far better and the warm nature of the event certainly reinforced this. We were also able to have an oral health themed Santa's grotto which worked beautifully with our lady Santa talking to children about brushing their teeth and giving out toothpaste and brushes. Unfortunately we were not able to administer the planned flu jabs on the day due to the pharmacist being unable to attend at the very last minute which was disappointing for us. Nevertheless this was a really successful, fun day attracting over 250 residents.

For further information about each project contact project managers:

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A Social Return On Investment (SROI) analysis of Community Champions Tri-Borough Public Health - Executive Summary

The Public Health White Paper, *Healthy Lives, Healthy People* (2010), recommends that addressing root causes of poor health and well-being requires better approaches to delivering health and care that is "*owned by communities and shaped by their needs*". The Health and Social Care Act (2012) gives local authorities the responsibility for improving the health of their local populations. It also sets out to "*tackle health inequalities across the life course, and across the social determinants* of *health*".

Consequently, the challenges for local authorities and health and care services are to work in more joined-up ways with their resources; to tackle socially embedded health issues, yet design approaches that increase quality and access, not solely reduce costs. This is very far from being easy; with an ageing population, available resources and public finances for health and care are set to continue reducing into the future.

A significant developing area is the role of social capital, and how unlocking this can lead to resource efficiencies across the NHS, public health and social care system. This means that improving health and access cost-effectively can be partly achieved by using local people's experience, relationships and ability to transfer health knowledge directly *and consistently* to their peers, about health services and health actions or behaviours. It also means a two-way conversation, including local people in how local health and care services are designed and accessed to better meet the needs that are most meaningful to the diverse range of residents, children and their parents.

Community Champions draw on the skills, relationships and knowledge of local communities. The current programme is partly built from the process, learning and skills developed in the 2008-2013 Community Health Champions project in White City, where Champions are still involved today in community-led support activities for residents. Champions are rooted in their community, and bring local people and services together to improve health and well-being, transfer knowledge, and help reduce health inequalities across different groups. In addition, they themselves learn more about health services and positive health behaviours. Between February and April 2014, Envoy Partnership conducted an independent Social Return On Investment (SROI) analysis of the Tri-Borough's Community Champions activities so far this year, covering six estate-based hubs at Church Street, Dalgarno, Edward Woods, Queens Park (Mozart Estate), Old Oak, and World's End and Cremorne. The SROI analysis estimates £5.05 of social and economic value is generated for every £1 invested - of which at least £1.65 of care resource savings are potentially generated for the local authority, related to diabetes, improved mental well-being, community cohesion, and reduced isolation of families and older people.

Community Champions and what they do

Community Champions are local people who volunteer through their local community centre, to promote the health and well-being of all residents - covering around 1,000 households per hub, and actively reaching between 150-200 households per hub a year. They support access and awareness of local services, and also motivate residents towards improving health and well-being behaviours, knowledge and community participation. Champions are trained to deliver guidance in a professional manner, in most cases to at least RSPH[i] Level 2 in Understanding Health Improvement. In a typical month, example types of activities can include participating in physical activity classes, (e.g. zumba, walks, affordable gym and aerobic exercises, "Booty Camp"), healthy cooking and budgeting courses, awareness-raising about diet, diabetes and cardiovascular issues, organising

and delivering community health events and promotional stands, one-to-one guidance with households, and sign-posting to appropriate support services. Each location, starting point and demographic profile of residents is different, and therefore the Champions' activities are designed around the needs that their local community has identified. We identified a range of material outcomes that resulted from the programme and were measured with key stakeholders (table 1 below).

Table 1: Community Champions Outcomes - Who benefits?

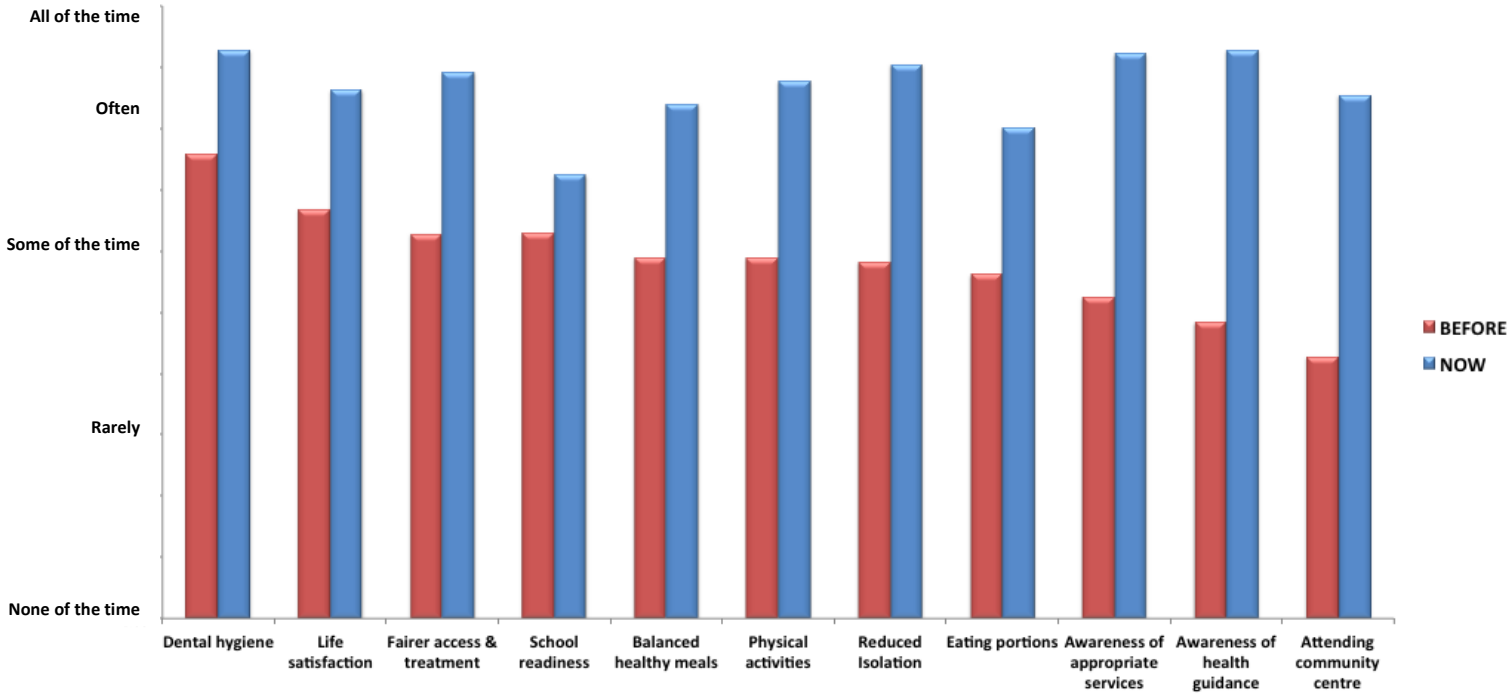
Stakeholders	Outcomes that changed as a result of the Community Champions programme
Champions	Improved physical health, healthier eating behaviours & weight reduction Reduced likelihood of contracting long term conditions (e.g. type 2 diabetes, obesity, cardio) Improved overall mental well-being Reduced social and emotional isolation Self confidence & Resilience New skills & Employability/Paid work Intercultural cohesion Fairness of access and treatment Courage to engage with health profession Improved Knowledge – about health, appropriate services and about local people
Residents	Improved physical health and weight reduction Healthier diet & eating behaviour (more veg, less oil, salt and sugar) Reduced likelihood of contracting long term conditions (e.g. type 2 diabetes, obesity, cardio) Improved overall mental well-being Sense of community and cohesion Fairness of access and treatment Courage to engage with health profession Economic savings from healthier eating on a budget Improved Knowledge
Children	Improved physical health and well-being Fairness of access and treatment Improved dental hygiene Improved relationships with family and friends School readiness Sense of community and cohesion Pride & Motivation Improved Knowledge
Local Services / Gov't	Resource value of reduced care need across diabetes, cardiovascular & long term conditions Resource value to GP clinics Improved health equality and quality of services Resource value of reduced need for children's dental health intervention Economic contribution through finding paid work Citizenship and further volunteering

Impact: what is the scale of change?

Through conducting 65 household surveys and 36 Champions surveys, group consultations and interviews with a range of key stakeholders (including over 35 Champions and local agencies), evidence was reported about the magnitude of change across material outcomes. In particular there has been significantly improved participation in community centre activities, improved access, take up and awareness of appropriate health services for specific conditions, reduced isolation and improved frequency of mild physical exercise. For Champions, there are also significant improvements in skills, self-confidence, respect from their spouse and families, and being able to find work in future. On average, Champions and Residents reported that if they were to forecast how long the actions, knowledge and behaviours they had learned would last, it would go **beyond three years** - and reported in many cases that their improved habits should last for most of their lifetime.

There were clear improvements in key outcomes for Residents and Champions, as illustrated in the graphs below. Note that the graphs below have been reconfigured to weight the distance travelled, to reflect a move from a score of "None of the time" to "Some of the time" as more meaningful than a move from a score of "Often" to "All of the time".

Graph 1: Frequency of occurrence of key health and well-being outcomes amongst Residents (Before contact with Champion, and Now)

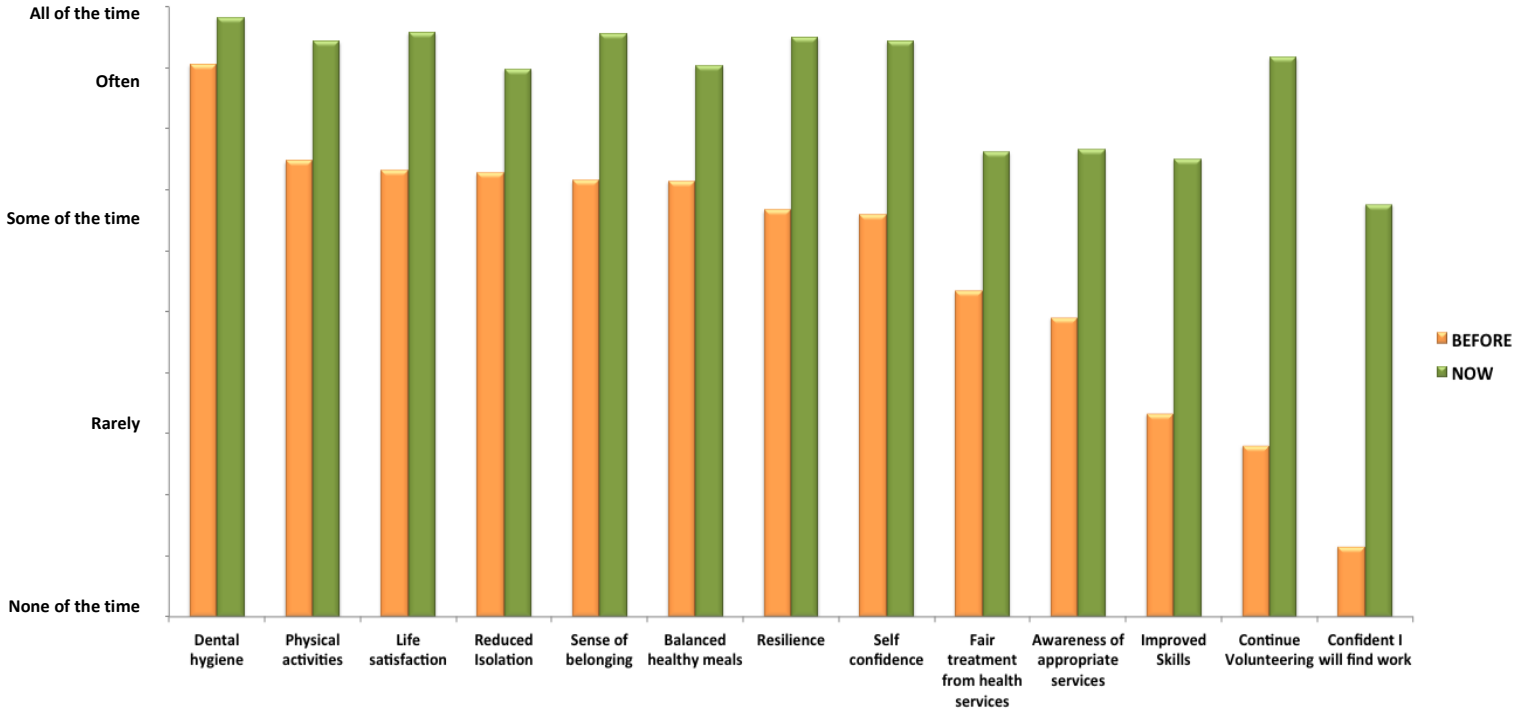


38% of Champions report WAIST SIZE reduction by up to one size with WEIGHT LOSS (**Average 4kg**)

Paid work (FTE) gained by **10%** of Champions & **20%** into **further training, PPG or public speaking**

Over 1,300 children reached, leading to improved health actions, knowledge, oral hygiene & exercise

Graph 2: Frequency of occurrence of key health and well-being outcomes amongst Champions (Before becoming a Champion, and Now)



33% of Residents report WAIST SIZE reduction by up to one size and WEIGHT LOSS (**Average 3.7kg**)

c. 180 residents AVOID 10 years reduced life expectancy from developing type 2 diabetes[ii]

Health research indicates **1 in 8** likelihood of developing type 2 diabetes over-65s [iii]

Generating Social Value

The Champions' strength is in being rooted to the their communities, and becoming preferred trusted public health advisors for local families, often from disadvantaged or lower income backgrounds. They fulfil a multi-faceted role for local agencies and residents, by making contact and listening, sharing public health knowledge, delivering an outreach function and sign-posting function, being pro-active and consistent in their presence, peer-to-peer motivation for improved family welfare, and feeding back to stakeholders. Champions are a respected key asset, not just towards delivering health and care that is "*owned by communities and shaped by their needs*", but also for consistent motivation of health and well-being behaviour change, and helping to significantly reduce isolation within their communities. They also inspire other local people to engage and train up to be Champions.

From approximately £550,000 invested across 6 Community Champions hubs, Envoy valued the outcomes and changes identified using proportions of QALYS for physical health and mental health, local authority care costs of long term conditions such as diabetes, and government unit costs from a variety of sources, including National Audit Office, PSSRU (Personal and Social Service Research Unit), Department of Health, Institute of Diabetes for Older People and research from LSE, HACT, and the Kings Fund.

STAKEHOLDER OUTCOMES	PRESENT VALUE OF IMPACT (£ Attributed Value)	HOUSEHOLDS DIRECTLY REACHED per Hub
CHAMPIONS **i.e. Improved health (exercise, healthy eating)** **Improved well-being** **Skills & knowledge** **Employability** **Fairer access to treatment**	**£248,000**	**76**
RESIDENTS **i.e. Improved health (exercise, healthy eating)** **Reduced prevalence of long term conditions** **Improved well-being** **Knowledge** **Fairer access to treatment**	**£845,000**	**circa 150-200 households per Hub (or approx 1000 households)**
CHILDREN **i.e. Improved health** **Improved well-being** **Knowledge**	**£526,500**	**circa 150-200 households per Hub (or approx 1000 households)**
LOCAL AUTHORITY **i.e. Reduced care need for reduced diabetes** **Reduced adult and elderly care need due to poor mental health and isolation** **Improved school readiness**	**£907,500**	**circa 150-200 households per Hub (or approx 1000 households)**
Central GOVERNMENT SAVINGS **i.e. Resource savings to Health and Social care, and DWP**	**£255,500**	**circa 150-200 households per Hub (or approx 1000 households)**
SOCIAL & ECONOMIC VALUE over 12 month benefit period ONLY	**c. £2.56 million**	**-**
PRESENT SOCIAL & ECONOMIC VALUE forecasted across 3 year benefit period for specific outcomes	**Circa £2.78 million**	**-**

Challenges & Sustainability

Whilst there are significantly encouraging outcomes, impact and value generated by the Community Champions programme - especially for their children and local families - there remain a number of issues to address in future.

Sustainability will depend on:

- Being able to recruit a stream of volunteers
- Recruiting Champions from diverse background to ensure reflective representation of the community and range of service users
- Keeping the champions motivated and supported
- Feeding back achievements to the Champions and diversity of residents
- Collecting robust impact data
- Ongoing support from Triborough Public Health Service
- Co-design of indicators of success with Champion Coordinators
- Valuing the individual contribution of each champion
- Balance between scaling up and funding
- Maintaining autonomous processes for each hub
- Keeping enthusiastic hub co-ordinators
- Changing activities to meet local residents' needs and balancing this with cultural observations and respect
- Being able to use a local community centre/venue for activities
- Linking with other stakeholders, including housing associations, local authority agencies and health services, employment services, local businesses
- Meeting the needs of new communities and new service users in future, and sharing knowledge between hubs

The full SROI report will be available from end of May 2014 see overleaf for further details

What is SROI?

SROI is a stakeholder-informed cost-benefit analysis that uses a broader understanding of value for money. It is an approach which can translate the measurement of social values into economic language. It enables the assigning of values to social and environmental outcomes as well as economic outcomes, and can help organisations make improved spending decisions. Its development in the UK was funded by the UK (Cabinet) Office for Civil Society and the Scottish Government (through the *SROI Project*).[iv] It is increasingly used to measure value-for-money and is signposted by the National Audit Office for a range of sectors.[v]

The processes followed were:
1. Establishing scope and identifying key stakeholders
2. Mapping outcomes (with stakeholders' input)
3. Evidencing outcomes and giving them a value (with stakeholders' input)
4. Establishing impact
5. Calculating the SROI
6. Reporting and embedding

Specific SROI adjustment principles were followed, summarised below:

Attribution: Responses to surveys and consultation gave credit, or "attribution" of outcomes at around 60-65%, however this was further reduced to a third (21%) for residents, and half of this (11%) for Children, to account for other factors, and activities at the community centre or school, and other settings, that they may have attended.

Deadweight: The majority of respondents reported that it was highly unlikely that these outcomes would have occurred anyway or that alternative forms of outreach and access to health services would arise. However we have conservatively used a 50% counter-factual rate to further reduce the amount of impact claimed. Calculations are significantly sensitive to deadweight in this model, for example increasing the deadweight by 10% reduces the SROI to approximately £4:£1 and increasing to 75% deadweight reduces the SROI to £2.75:£1.

Displacement is zero, as we have assumed improving a person's health does not have a negative unintended consequence on another stakeholder.

Drop-off of impact is 66% drop off per year over a 3 year benefit period, although the majority of respondents felt the impacts would last well beyond 3 years, we have taken a conservative view. "Drop-off" is used to reflect that impact is reduced in strength over time.

Discount rate of 3.5% was used (suggested in HM Treasury Green Book) for calculating the present value of future benefits.

We have been advised by Tri-Borough Public Health co-ordinators to use a one third likelihood that Champions double-count or cross over the households they reach between them. Champions and hub co-ordinators identified the difference in number of new households and repeat households that they reach per month.

Full report will be available from end of May 2014 from Tri-Borough Public Health Department, further details at:

Envoy Partnership
1 Alfred Place, 2nd floor, WC1E 7EB
info@envoypartnership.com
www.envoypartnership.com

[i] Royal Society for Public Health

[ii] Estimate of 10 years reduced life expectancy from developing type diabetes taken from: Department of Health,:National service framework for diabetes (2012), & *Diabetes in the UK* by diabetes.org.uk (2010)

[iii] Health & Social Care Info Centre, 2013

[iv] http://www.scotland.gov.uk/Topics/People/15300/SROI

[v] See: http://www.nao.org.uk/successful-commissioning/general-principles/value-for-money/value-for-money-and-csos

London Borough of Hammersmith & Fulham **Health, Adult Social Care and Social Inclusion Policy and Accountability Committee** **12 December 2016**	
Addressing social isolation and loneliness in Hammersmith and Fulham	
Report of the Cabinet Member for Social Inclusion	
Open Report	
Classification: For discussion as part of pre-consultation engagement **Key Decision:** No	
Other services consulted: The draft strategy has been discussed at the Cabinet Board for Social Inclusion which includes representatives from each department of the council. Those services named in the work programme have also been consulted.	
Wards Affected: All	
Accountable Director: Kim Dero, Director of Delivery & Value	
Report Author: Anna Waterman Strategic Public Health Advisor	**Contact Details:** Tel: 020 7641 4651 E-mail: awaterman2@westminster.gov.uk

1. EXECUTIVE SUMMARY

1.1 The Cabinet Member's Social Inclusion Board was established in February 2015. During its first year, the Board identified social isolation and loneliness as a priority for action, agreeing to develop a strategy for how best it might be prevented and addressed in Hammersmith and Fulham.

1.2 This paper presents the draft strategy as part of pre-consultation engagement. It is built upon the framework developed by the Campaign to End Loneliness, which identifies four pillars:

- Foundation Services
- Direct Interventions
- Gateway services
- Structural enablers.

The committee is asked for feedback on the draft strategy and the (early draft) work programme.

2. RECOMMENDATIONS

1. To consider whether the draft document makes the case for a strategic response to isolation and loneliness.

2. To advise whether the draft strategy sufficiently conveys existing activity with the borough while also highlighting the need and scope for further intervention.

3. To approve the strategic commitments.

3. REASONS FOR DECISION

3.1. Social isolation and loneliness require a whole systems response. The strategy is being presented to the Committee at this pre-consultation stage to help ensure that a well-rounded approach to developing the strategy and work programme is being adopted.

4. PROPOSAL AND ISSUES

What is social isolation and loneliness?

4.1. The risk factors for isolation and loneliness, and their prevalence in the borough, means that doing nothing is not an option.

4.2. While isolation occurs at the level of the individual, interventions to reduce social isolation must act on the structural determinants, including economic disadvantage and discrimination, as well as supporting the immediate needs of socially isolated and/or lonely individuals.

Strategic landscape

4.3. There are a number of tools and levers which will facilitate co-ordinated and effective delivery of a work programme designed to address social isolation and loneliness and improve social connectedness and community cohesion.

Addressing the challenge: What does the evidence say?

4.4. While there are gaps in the evidence base for initiatives to reduce social isolation and loneliness, there are some clear messages from the emerging evidence base:

- Whole systems approaches are recognised as more effective;
- Asset based community development – offers the greatest gain for social capital and community resilience;

- For approaches to be sustainable, there must be a clear return on investment and this must be calculated incorporating returns for social value and social capital.

Where are we now?

4.5. Hammersmith and Fulham has many assets and offers many opportunities for engagement.

4.6. A more co-ordinated offer, which is appropriately marketed might aid awareness, facilitate greater neighbourliness and promote engagement.

4.7. The greatest impact might be secured through greater resident awareness of isolation and loneliness – encouraging people to come forward, encouraging people to look out for each other - spot it in themselves and each other and feel confident about taking action.

4.8. Encouraging residents to engage in addressing the detrimental factors in their community can aid connectedness as well as engender a sense of ownership and belonging.

5. CONSULTATION

5.1. This strategy is currently at the stage of pre-consultation engagement. It has been developed by a task and finish group of council officers drawn from the broader Cabinet Member's Board. The Board includes representatives from departments across the council as well as local voluntary sector agencies including CAB, the Trussell Trust and Shepherds Bush Housing Group, and Job Centre Plus.

6. EQUALITY IMPLICATIONS

6.1. The strategy specifically seeks to address inequalities experienced by those who are socially isolated and/or lonely. Those residents with protected characteristics are identified as being particularly at risk.

7. LEGAL IMPLICATIONS

7.1. Any legal implications associated with the implementation of the strategy will be considered and reported to Members as the strategy is developed.

8. FINANCIAL IMPLICATIONS

8.1. Any financial implications associated with the implementation of the strategy will be considered and reported to Members as the strategy is developed.

LOCAL GOVERNMENT ACT 2000
LIST OF BACKGROUND PAPERS USED IN PREPARING THIS REPORT

None.

LIST OF APPENDICES:

Appendix:	Tackling Social Isolation and Loneliness: A Strategy for Hammersmith and Fulham (DRAFT)

Appendix 1

Tackling Social Isolation and Loneliness
A Strategy for Hammersmith and Fulham

1. Background

In February 2015, Hammersmith and Fulham's Cabinet Member's Board for Social Inclusion was established to deliver the *Change We Need* manifesto pledge to: "fund a cross-cutting Social Inclusion approach and host a Social Inclusion Forum that will tackle exclusion [and] deliver in partnership improved social inclusion outcomes for local residents". This pledge was borne from recognition of the impact of social capital on the health and well-being of the borough's communities and neighbourhoods.

The Board provides a cross-sector platform for promoting social inclusion across the borough: drawing intelligence from analysing a range of data from varied sources; identifying and building on good practice. The Board helps to shape key council priorities and ensure a more joined-up way of working.

In its first year, the Board identified a particular issue around social isolation and loneliness which led to the inclusion in the Board's work programme of a commitment to develop a social isolation and loneliness strategy.

2. What is social isolation and loneliness?

Evidence shows that social relationships and in particular adequate social networks (in terms of quality and quantity) can promote health through four possible pathways:

- Providing individuals with a sense of belonging and identity
- Providing material support of increasing knowledge about how to access material needs and services
- Influencing the behaviours of individuals, for example through support or influence from family or friends to quit smoking, reduce alcohol intake, or to access health care when needed
- Providing social support that enables individuals to cope with stressors such as pressures at school or work, redundancy, retirement or the death of a close relative. (*Local action on health inequalities: Reducing social isolation across the lifecourse*, PHE and UCL 2015, p.12)

In order to identify the appropriate scope and focus of activity to address social isolation and loneliness in Hammersmith and Fulham, the Board staged a stakeholder workshop in April 2016 which was led by the Campaign to End Loneliness (report available upon request). A discussion paper was subsequently taken to the Health, Adult Social Care and Social Inclusion Policy and Accountability Committee in May to further shape the direction for the strategy.

2.1 Definitions

Social isolation describes the state of being deprived of social relationships that provide positive feedback and are meaningful to the individual (*Local action on health inequalities: Reducing social isolation across the lifecourse,* PHE and UCL 2015). It is defined as:

The adequate quality and quantity of social relations with other people at the different levels where human interaction takes place (individual, group, community and the larger social environment). (Zavaleta et al, 2014)

As such, it lends itself to objective measurement. Loneliness, however, is defined as:

An emotional perception that can be experienced by individuals regardless of the breadth of their social networks. (ibid)

Both can impact considerably on a person's quality of life, mental and physical health and on their use of health and social services. In the literature, social isolation is often discussed at the same time as loneliness. However, while most people who are socially isolated feel lonely, not all people who are lonely are socially isolated.

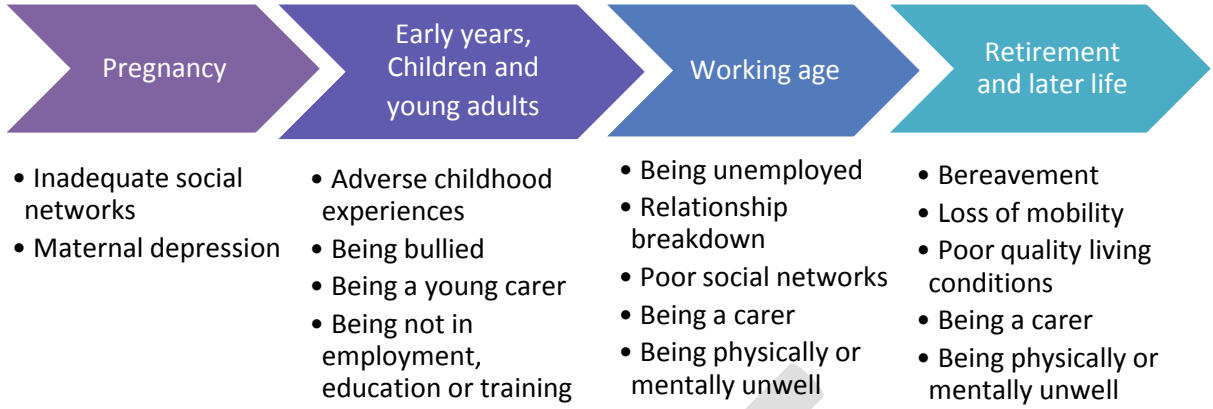
The literature also stresses the differential impact of transient loneliness and chronic loneliness, Griffin (2010) suggesting that it is long term, chronic loneliness which becomes a serious concern, when it creates a persistent, self-reinforcing loop of negative thoughts, sensations and behaviours, and is difficult to treat (p.4).

2.2 Triggers

Anyone can experience social isolation and loneliness. While social isolation is more commonly associated with later life, it can occur at any stage in the life course and can be cumulative. Some research suggests there is a U shaped curve with highest rates of loneliness in under 25s and over 55s (Victor and Yang 2012), other reports suggest the highest rates of loneliness are found in those aged >80 years (Thomas, 2015).

There are particular life events which are recognised as potential trigger points, particularly when they are layered on top of other risk factors. These are commonly found at particular stages along the lifecourse.

Figure 1: Risk factors for social isolation and loneliness along the lifecourse



Source: PHE & UCL, September 2015

i. Pregnancy

One in five mothers suffer from depression, anxiety or in some cases psychosis during pregnancy or in the first year after childbirth. A survey conducted on behalf of Family Action found that one in five mothers lack support networks to help them through pregnancy and are unaware of the services available to help with depression. A new mother who is socially isolated is more likely to suffer from depression and its effects are likely to be worse. This sets her at a disadvantage in providing a good start in life for her child. With the incidence of social isolation and lack of knowledge of services for depression rising to one in three among low income households, this demonstrates that social isolation can contribute to the transmission of disadvantage across generations and to the causes of health inequalities (PHE and UCL 2015).

ii. Children and Young People

The risk factors for social isolation among children and young people can be from life events (abuse, neglect, living with domestic violence, drug or alcohol abuse, being a young carer, having a long term condition or learning difficulties) or socially ascribed identities (gender, ethnicity, sexuality or physical appearance)[1]. Children who differ from the general population by appearance, language or behaviour may face difficulties integrating into peer groups at school. Other children who are considered particularly at risk include:

- Those in care (235 children in care in the Borough in March 2013; 71 per 10,000 children aged under 18, ONS data)
- Care Leavers (135 aged 19, 20 or 21 in 2014/15[2])
- Those experiencing family breakdown
- Young mothers: in 2015, there were 214 under the age of 25 in H&F, of whom 39 mums were under 20 (ONS data).
- Those with language barriers upon entering school: the proportion of

[1] Public Health England and UCL Institute of Health Equity. Local action on health inequalities Reducing social isolation across the lifecourse. September 2015

[2] Defined as all children that hit 19 who were looked after for a total of at least 13 weeks after their 14th birthday (including some time after their 16th birthday) – Department for Education

children (49.2%) in primary schools who speak English as an additional language (EAL) is nearly three times the national average, although still approximately 7 percentage points less than the average for inner London.

- Students living away from home for the first time, particularly where from lower socio-economic groups.
- Young people not in education, employment or training (The 2015 summary of those not in education, employment or training (NEET) percentage for Hammersmith and Fulham was 2.4% (a slight decrease from 2.5% on the previous year), which is below the London average of 3.1%3.

Data from ChildLine shows that, in 2014-2015, 35,244 children under 16 were counselled about loneliness as their main or additional problem (defined as low self-esteem, lack of confidence, feeling sad, low mood, lonely), representing 12% of all children counselled by ChildLine that year4.

Social isolation in childhood has a considerable impact on the whole lifecourse; children who experience social isolation tend to have lower educational outcomes and lower adult social class (based on occupation) and higher risk of smoking, obesity and psychological distress in adulthood than those children without social isolation[5].

iii. Working Age

Research suggests that having fewer local connections disproportionately affects men and that unemployment increases the risk of social isolation (Marmot 2010).

Employment rates for the borough are consistently high for age groups 25-34 years old and 35-49 years old. Over the past two years, rates of employment for the 25-34 year olds continued to grow, whereas it tapered off slightly for the 35-49 year olds. Since 2013, the age group 50-65 have also seen a growth in rates of employment (Source: Annual Population Survey, 2004-2015). However, 70% of JSA claimants in the borough are aged 35 years and over compared to 63% for London and 59% for England (Source : Nomis, Office of National Statistics).

Employment rates vary within the borough by ethnic group. 81.3% of the working age population from white ethnic backgrounds are in employment, compared to 66.5% for those from black and minority ethnic backgrounds and 51.1% for those from mixed ethnic backgrounds. Nationally, the borough ranks 140th out of 281 in relation to employment rates for people from minority ethnic backgrounds. The borough ranks 10th highest out of the London boroughs (Source: Annual Population Survey 2015, based on all local authorities with available data).

The employment rate for those people with a health condition lasting 12 months or more is 57.9%, which is lower than the London average of 63.5%

[3] https://www.gov.uk/government/statistics/neet-statistics-quarterly-brief-october-to-december-2015

[4] Childline. Always there when I need you. Childline review what's affected children April 2014 to March 2015.

[5] Lacey R, Kumari M, Bartley M. Social isolation in childhood and adult inflammation: Evidence from the National Development Study. Psychoneuroendocrinology 2014;50:9.

and has seen a reduction from 64.7% in 2014. 48.7% of those in the borough with problems or disabilities connected with arms, legs, hands, feet, back or neck are in employment, which is lower than the London average of 55.3% and has seen a reduction from 54.1% in 2014. The borough has a lower employment rate for people with seeing or hearing difficulties, and a lower rate of people living with blood or circulatory problems, stomach, liver, kidney or digestive problems or diabetes in employment than London as a whole. It is those people with depression, learning disabilities, mental problems and nervous disorders that have significantly lower employment rates than most other groups of people. Only 20.4% in the borough are in employment compared to 33.8% in 2014 and compared to 36.4% in London as a whole. In 2015, 44.4% of the working age population with disabilities are in employment, which has seen a reduction from 2014 which had a rate of 52.4%. The rate of employment in 2015 is lower than both London (50.1%) and England (50.6%). (Source: Annual Population Survey 12 months to Dec 2015, based on all local authorities with available data)

Employment rates for adults with learning disabilities across the country are substantially lower still. In Hammersmith and Fulham only 2.6% of those adults of working age with a learning disability are in employment, compared to a London average of 7.5% and a national average of 6% (Source: Department of Health, ASCOF, 2014-15).

iv. Older People

There are 16,413 residents in Hammersmith and Fulham aged 65 or over, almost 9% of the total population. 41.9% (20,778) of people aged over 45 are not in a family (never married, separated, divorced or widowed).

According to the Income Deprivation Affecting Older People Index, Hammersmith and Fulham has seen a dramatic rise in income deprivation of 63% between 2010 and 2015. This is higher than any other London borough. 68% of the older population live in areas in the top 30% most income deprived nationally, over 18% in the most deprived 10%.

As residents age they have a greater risk of physical, and mental, impairment: 51% of older people living in the borough state that their day to day activities are limited and 54.8% of older people living alone have a long term health problem or a disability. In addition, 10.6% of older people living in the borough provide informal, unpaid care.

In the Growing Older project, which surveyed 999 older people, 7% of older people (aged over 65 years) were often lonely, 31% sometimes lonely and 11–17% were socially isolated[6]. A more recent survey by Age Concern and Help the Aged found that 7% of people aged over 65 in England always or often feel lonely and a further 26% are sometimes lonely[7]. In Hammersmith and Fulham, 41% of c2,000 users of services funded by the 3rd Sector Investment Fund reported in 2015 that they were very isolated with few families and friends. Indeed, at March 2016, 15% of residents in

[6] Victor C, Bowling A, Bond J, Scambler S. Research Findings:17. Loneliness, social isolation and living alone in later life, 2003.

[7] Age UK. Loneliness and isolation evidence review. 2010.

Hammersmith and Fulham aged 65 and over were divorced and we have the fourth highest proportion of residents aged 65 or over (43%; 7,050) that live alone in London. It is not possible to tease out the people who have co-existing loneliness and social isolation, but using a lower estimate of 7% and a higher estimate of 17% provides an estimate of the number of people in H&F aged over 65 years who are lonely and/or socially isolated, ranging between 11,489 and 2,791.

A number of factors impact on the risk of being lonely and/or socially isolated. Research from Age UK using data from ELSA, has identified the key factors associated with being 'often lonely' in people aged over 65 years and weighted them by their relative contribution to loneliness risk. This work has enabled the construction of an evidence-based model[8].

Promising approaches (CtEL; Age UK 2015) suggests that an important difference in the experience of older people is that they tend to suffer from chronic loneliness as opposed to transient loneliness and that 10% of those aged over 65 years at any time are experiencing chronic loneliness. It is also worth noting that with an ageing population, the number of individuals represented by this percentage is increasing.

The Marmot Review on Health Inequalities (2010) concluded that social networks and social participation act as protective factors against dementia or cognitive decline over the age of 65, with individuals who are socially excluded between two and five times more likely than those who have strong social ties to die prematurely. Interventions which support people to maintain social interaction and community networks are therefore likely to impact on mental and physical health and their associated care costs (Marmot 2010, p 138).

That there are triggers for loneliness across the lifecourse suggests that any strategy to prevent and alleviate loneliness needs to incorporate measures which might address effectively the needs of different age groups. These measures will need to be tailored to reflect the ways in which different sections of the community might be encouraged to engage.

While some triggers are most commonly found in particular places along the lifecourse, many can occur at any stage. Caring responsibilities, life limiting illness or disability, moving house and bereavement are all such triggers and intervention might be best targeted through services which might be accessed at these times, rather than through a focus specifically on the older age groups. In addition to the 7,050 older residents who live alone, there are another 23,098 aged 18-64 years.

In addition, particular individuals or groups may be more vulnerable than others regardless of age. In 2015:

- 17,700 working age adults were known to have one or more long term condition (10% of the population) and this number can be expected to rise by 11% by 2025
- Rates of severe mental illness as recorded by GP practices within the borough are the 12th highest out of 212 CCGs with 1,500 registered with

[8] Iparraguirre J. Predicting the prevalence of loneliness at older ages. Age UK.

severe and enduring mental illness

- Common mental illness, such as anxiety and depression can also lead to social isolation and loneliness as people find it harder to relate to others and less able to forge the relationships they need. Common mental illness such as anxiety and depression affects around 1 in 6 people at any given time; locally 27,803 people have mild to moderate depression and anxiety disorders.
- Half of those with lifetime mental health problems first experience symptoms by the age of 14 and three-quarters before their mid-20s.
- Almost half of all adults will experience at least one episode of depression during their lifetime.

The degree of risk for any one individual will, therefore, depend on a number of often inter-related factors. Individual factors such as physical and mental health, disability, income, ethnicity, language, culture, sexuality, gender and age, interplay with community factors, such as access to local shops, facilities and services, the local environment, and with societal factors such as the fact that more people are living alone, transience, housing policy, welfare reform and media coverage of crime and social issues, adds another important dynamic.

Building on this, while it is much harder to measure impact when seeking to prevent and/or alleviate loneliness across the whole population, evidence suggests that a whole systems approach will have greater impact, with more mutually supportive and thereby resilient neighbourhoods and communities.

2.3 Links to health inequalities

Social isolation is a health inequalities issue because many of the associated risk factors are more prevalent among socially disadvantaged groups (*Local action on health inequalities: Reducing social isolation across the lifecourse,* PHE and UCL 2015, p.10). The links between deprivation and poor health outcomes is well documented (Marmot 2010).

In addition, deprived areas often lack adequate provision of good quality green and public spaces, creating barriers to social engagement, exacerbating efforts to adopt and sustain healthy behaviours and prevent further deterioration of health and wellbeing. Access to transport is also vitally important in building and maintaining social connections.

2.4 Impact

It is recognised that loneliness can lead to greater demand on public services, as residents seek from professionals the support they might otherwise gain from family, friends and neighbours. In 2013 the Campaign to End Loneliness conducted a poll in communication with over one thousand GP practices:

- 89% of the GPs saw one or more patients every day whose main reason for the appointment was loneliness.
- Over three quarters said they were seeing up to five lonely people a day.

- One in ten doctors reported seeing between six and ten lonely patients a day.
- A small minority (4 per cent) said they saw more than 10 lonely people a day.

Source: www.campaigntoendloneliness.org/blog/lonely-visits-to-the-gp

Sobus, the umbrella organisation for the voluntary and community sector in Hammersmith and Fulham, undertook an engagement initiative to provide an assessment of health and wellbeing services in the borough from the viewpoint of service users aged 65 and over, together with input from voluntary/community and statutory services providers. They found that 'Older people are particularly concerned with the physical and mental health risks associated with loneliness and social isolation, and highly value socialising opportunities. Another recurrent topic was support required in the home such as cleaning, repairs and maintenance. Related to this was the absence of regular family support, as family members have to move out of the borough due to the housing crisis (shortage and cost).' (April 2016)

Social isolation and loneliness can have a severe impact on health and well-being. Work in the early 2000s by social neuroscientists has provided scientific evidence that loneliness causes physiological events that wreak havoc on health (Griffin 2010) associated with raised blood pressure, increased mortality and poor mental health, and lonely and socially isolated older people are more likely to have early admission to residential or nursing care (SCIE, 2011). A recent study also confirms that social isolation is associated with higher re-hospitalization rates (Giulim, Spazzafumo et al (2012)

Social relationships affect physiological and psychological functioning and health behaviours, which can have a negative impact on morbidity and mortality. Evidence suggests a 50% increased risk of coronary heart disease among those who are socially isolated and/or lonely (*Local action on health inequalities: Reducing social isolation across the lifecourse,* PHE and UCL 2015, p.9).

Key messages:

The risk factors for isolation and loneliness, and their prevalence in the borough, means that doing nothing is not an option.

While isolation occurs at the level of the individual, interventions to reduce social isolation must act on the structural determinants, including economic disadvantage and discrimination, as well as supporting the immediate needs of socially isolated and/or lonely individuals.

3. Strategic landscape

3.1 Smarter Budgeting Programme

This programme sought to take a fresh look at how the Authority manages its business, with a view to securing improved outcomes more efficiently. Eight outcomes were identified, outcome 6 being 'Supporting Vulnerable Adults' and outcome 7 'Safer and Healthier'. Social isolation was identified as an issue to be addressed in each of these outcomes, a cross cutting theme being the provision of foundation services to identify those at risk sooner and direct interventions to address their needs. Themes identified under other outcomes of the Smarter Budgeting programme also relate to this strategy:

- Outcome 1, Economic growth: focus on ensuring people are able to find employment
- Outcome 2, Children: focus on children in care
- Outcome 5, Reducing homelessness – has a focus on reaching people early to address tenancy issues.

3.2 ASC Prevention agenda – Fs of frailty;

Prevention is critical to the vision that the care and support system works to actively promote wellbeing and independence, and does not just wait to respond when people reach a crisis point. In line with this, the Adult Social Care (ASC) department has developed a local prevention offer which applies to all adults, from those with no established need to those who need a lot of care and support in order to prevent or delay need and deterioration of condition. The Council recognises that, although ASC plays a critical part, the responsibility for prevention is wider and approaches need to be integrated and aligned across departments and with other local partners. It identifies secondary and tertiary prevention as ASC's focus, in order to ensure that all services have a re-abling approach and encourage people to be as independent as possible. In relation to the development of preventative services we also take into consideration the 'Fs of Frailty'. This is seen as a good way to know when ASC can make an early intervention to prevent further needs as there is evidence that many of the conditions that can lead to frailty are amenable to preventative measures. These include: social isolation (loss of **f**riends and **f**amily), memory loss (**f**ailing memory), malnutrition (unhealthy **f**ood intake), **f**alls and living in cold damp homes (**f**uel poverty).

3.3 Mental health strategy

One of the key concerns and challenges within the borough is the known prevalence of poor mental health experienced by a significant number of local residents of all ages and cultural backgrounds. The effects of mental ill-health on physical health and well-being are well documented. The social consequences of undetected or untreated mental illness are also profound, leading to work related sickness, unemployment, homelessness, alcohol and substance misuse, social isolation and even offending behaviour. Unemployment in itself can lead to poor mental health. The emotional toll poor mental health places on individuals and their families are immeasurable in terms of impact on overall quality of life.

The strategy has a particular emphasis on the social determinants of "good" mental health. For example, the key benefits of a stable home, good education and training, stable employment as well as access to a wider range of community based services which promote mental health and well-being within our local population. The strategy seeks to establish a work programme which includes interventions which:

- Provide support for parents and parents-to-be for their own mental health and for the long-term mental health of their child.
- Promote better emotional, mental health and early intervention in schools.
- Promote good workplace mental health and wellbeing.
- Work with staff in frontline services across the system to build skills and awareness of mental health.
- Promote access to activities that promote wellbeing, volunteering and stronger social networking.
- Provide early support for older people through effective information and advice and signposting to preventative/universal services.
- Work with communities to help change attitudes and develop understanding of mental health.

The Like Minded Case for Change, which covers the eight North West London boroughs, highlights social isolation as an issue. Ambition 2 of their plan states: 'We will improve wellbeing and resilience, and prevent mental health needs for people in North West London, by supporting people in the workplace, building resilience in children and young people and reducing loneliness for older people' [Like Minded, 2015].

3.4 Housing support and care JSNA

This report focuses on the extent to which local agencies work effectively as a system to address the challenges posed to health and social care by housing conditions. It seeks to identify and facilitate progress on integrated solutions to what are integrated challenges, to support the development of a whole systems approach, informing strategic and commissioning intentions. It makes 12 recommendations, one of which focuses on social isolation:

Ensure that strategies are in place to promote community cohesion and prevent and alleviate social isolation. These should incorporate:

- *Recognition of community cohesion as a specific objective towards securing community resilience and promoting independence and self-reliance, with appropriate resourcing plans.*
- *Plans for identifying residents at risk of social isolation and the appropriate mechanism(s) to best engage and support them.*

3.5 Poverty and worklessness commission

Within the borough, entrenched pockets of poverty and worklessness still exist that, to date and despite multiple interventions over the years, have proved intractable. The aims of Hammersmith & Fulham Poverty and Worklessness Commission include:

- To identify the factors underpinning the continuing prevalence of both poverty

and worklessness in the borough;

- To formulate recommendations for interventions and/or service redesign to deliver better outcomes and increase economic, employment and other opportunities for all, promoting self-reliance.

While loneliness and social isolation are not specifically being considered as part of this work, there are clear links due to relative deprivation and unemployment as triggers. The following have been identified as priorities for targeted work:

- Improving employment opportunities for those with long-term conditions, with particular emphasis on mental health, and for people from BAME backgrounds;
- Improving wellbeing for vulnerable older people in the borough.

3.6 Digital inclusion strategy

Digital exclusion affects some of the most vulnerable and disadvantaged groups in society: the elderly, unemployed and low income individuals, social housing tenants and disabled citizens are key groups that have been highlighted at the national and London levels. These groups are also more likely to experience the effects of social isolation and loneliness.

In Hammersmith and Fulham, the overall likelihood of digital exclusion is low and there are no “not spots” (LGiU, Dot Everyone, 2016). However, there are significant pockets of the Borough where residents can find themselves digitally excluded, principally in wards to the North and Eastern parts of the Borough in areas such as the White City and Clem Atlee estates. There appears to be a close correlation between digital exclusion neighbourhoods and areas of social housing.

Government research and consultation, carried out at the beginning of 2014, has identified four key challenges that face people in going online:

- **access** - the ability to actually go online and connect to the internet;
- **skills** - to be able to use the internet;
- **motivation** - understanding why using the internet is a good thing, and;
- **trust** - a fear of crime, or not knowing where to start to go online.

The Council has established key principles underpinning a Digital Inclusion Action Plan:

- To work in partnership with a range of organisations to bring co-ordination and learning between organisations;
- To be resident focused and flexible with different approaches for different excluded groups;
- To embed digital activities and learning across services and programmes;
- To develop locality based solutions to address gaps in access, including disability friendly access, and skills training;
- To link our strategy to our partners’ digital strategies, to ensure service design and ICT provision improve digital inclusion;
- To underpin all elements with a shared communications strategy;
- To work towards sustainability wherever possible.

3.7 H&F's Drive to secure social value and social capital from all activity and contracts

Hammersmith and Fulham has pledged to maintain and develop local supply markets to meet local needs, wherever possible encouraging participation of local SME and 3rd sector organisations in the council's supply chain.

All organisations in receipt of grant funding are expected to deliver "added value" in providing local volunteering opportunities, and are required to monitor the take up of their services by local residents by age, as well as ethnicity, gender, location. Relevant services are also required to ascertain the "social connectivity" of users to identify those most at risk of loneliness and isolation in order to ensure services are being targeted at those most in need.

3.8 Healthcare

Our CCG colleagues have identified social isolation as a key determinant of physical and mental health and incorporates it as a priority in its STP Delivery Area one: Radically upgrading prevention and wellbeing. The work programme for DA1 is still under development, however, social prescribing initiatives, of which where are two in the borough, operating out of North End Medical Centre and Parkview Centre for health and wellbeing, which between them serve six GP practices, get a specific mention. There is also a commitment to identifying gaps in current service provision for addressing loneliness and, in addressing these, enhancing current provision.

Key messages:

There are a number of tools and levers which will facilitate co-ordinated and effective delivery of a work programme designed to address social isolation and loneliness and improve social connectedness and community cohesion.

4. Addressing the challenge: What does the evidence say?

Social isolation and loneliness are relatively new areas of interest, however there is a great deal of activity across the country and internationally to plug the gaps in our knowledge. It is important to recognise and support innovation with robust in-built evaluation to ensure that activity contributes to the emerging evidence base. It is also important to use existing evidence where it is available: it is widely accepted that whole systems approaches, while much harder to evaluate, will have greater impact, with more mutually supportive and thereby resilient neighbourhoods and communities. Together with UCL's Institute of Health Equity, PHE produced *Reducing social isolation across the lifecourse* (2015), which endorses the adoption of a whole systems approach.

4.1 Campaign to End Loneliness Framework

CtEL together with Age UK have developed a framework (illustrated in appendix one) to inform strategic, whole systems approaches to addressing loneliness. This sets out four interdependent categories of provision:

- Foundation services – services to reach and understand the specific needs of those experiencing loneliness, and to access appropriate interventions.
- Direct interventions – a menu of services that directly improve the number or quality of relationships people have, through supporting and maintaining existing services and supporting new social connections. The direct interventions category also includes psychological support through systems such as Cognitive Behavioural Therapy (CBT) and Mindfulness.
- Gateway Services – improving transport and technology provision to help retain connections and independence. The evidence base for the impact of technology (including telephone) based initiatives for older people is relatively well developed, particularly in maintaining existing relationships, for example with friends and family spread geographically and where technology provides an 'excuse' for new contacts, for example IT training. While the evidence base for transport initiatives is less developed, largely as transport initiatives have not been specifically evaluated for their impact on loneliness, still there is a recognition that transport is vital to connectedness and that, similarly to technogical interventions such as IT training, coach tours and day trips can provide an 'excuse' for new contacts.
- Structural Enablers – create the right structures and conditions in a local environment to reduce those affected by, or at risk of, loneliness. These might include neighbourhood approaches, asset based community development, volunteering networks and age positive approaches such as the establishment of dementia friendly communities. As with gateway services, the evidence base needs further development, not for the impact which structural enablers have for developing social capital, which is relatively strong, but for impact on reducing loneliness specifically.

Promising approaches (Jopling 2015) presents some valuable case studies of initiatives, following this framework.

4.2 **Local action on health inequalities: Reducing social isolation across the lifecourse** (Public Health England and UCL Institute of Health Equity, September 2015)

Communities that are more connected need fewer public services, create good places to live, and improve outcomes for residents. People are not passive recipients of services – they have an active role to play in creating better outcomes for themselves and for others, and they themselves will be the starting point for tackling emerging issues. PHE and UCL (2015) discuss the impact of the built environment on the prevalence of social isolation in a way which suggests it might be incorporated into the CtEL framework's 'structural enablers':

"Safe public spaces, with pavements to walk on and lighting, are also part of the physical infrastructure that helps people to maintain social connections. These factors cut across the whole of the life course as part of sustainable communities and places in which people are born, grow, live, work and age … Designing the built environment to make the streets conducive to walking is also likely to encourage social connectivity." (*Local action on health inequalities: Reducing social isolation across the lifecourse,* PHE & UCL 2015, p.14)

This is consistent with the emphasis CtEL giveS to asset based community development and to encourage service users to identify those direct services which would be of greatest benefit (p.11).

4.3 **A glass half-full: how an asset approach can improve community health and well-being** (Foot, J., Hopkins, T. & IDeA, 2010).

Empowering people and developing stronger, resilient communities which will work together to reduce social isolation and loneliness, requires the potential of local support networks to be unlocked (Foot, Hopkins, & Improvement and Development Agency (IDeA), 2010).

Services which offer opportunities for social contact and facilitate community cohesion, such as volunteer befriending services, health and wellbeing hubs, link up / connecting projects and the Community Champions are central to the preventative agenda; very often the best and most sustainable help comes from neighbours and peers. Some of these services will be provided or commissioned by the council, however many are not. Many are provided by third sector agencies and have been designed by local people.

Asset based approaches look first at the strengths within people's lives – their family and community networks, their interests and their abilities, in order to link people with the right sources of support and help which build upon these strengths.

4.4 Return on investment

Local Authorities are facing significant financial challenges at a time when demand for social care and health services is growing. NHS and ASC are under increasing pressure, through a combination of reduced budgets, an aging population and a requirement to implement significant reforms under the Care Act.

It is widely recognised that to meet this gap, investment is needed in preventing poor

health and wellbeing. However, finite resources render it difficult to shift resources upstream when demand on services among those with immediate needs is great. The nationally driven tightening of eligibility criteria for Adult Social Care recognises this demand but can mean that services are only able to provide care to residents once their wellbeing has decreased, rather than helping to prevent deterioration.

To respond effectively to the fiscal climate and to enable closer health and care collaboration with services weighted towards 'upstream' prevention and earlier intervention, commissioners are undertaking strategic commissioning reviews in order to build the evidence base; increase the use of pooled budgets; align funding streams; remove any duplication; rationalise the number of contracts managed; and achieve required savings.

The fiscal climate is such that interventions to prevent and/or alleviate loneliness need to vie for scarce resources alongside statutory services. However, much can be done using existing community assets, be these physical assets such as libraries, voluntary/community organisations, social capital or local businesses.

Key messages:

While there are gaps in the evidence base for initiatives to reduce social isolation and loneliness, there are some clear messages from the emerging evidence base:

- Whole systems approaches are recognised as more effective

- Asset based community development – offers the greatest gain for social capital and community resilience

- For approaches to be sustainable, there must be clear return on investment and this must be calculated incorporating returns for social value and social capital

5. Where are we now?

Tightening resources can both help and hinder the social isolation agenda – the greater focus on evidence based practice can help to clarify aims, objectives and performance indicators. Increasingly public and third sector agencies are working together better to address the needs of vulnerable residents and service users. There can also be a loss of targeted provision, however, as services and facilities are expected to achieve 'more for less'. The macro level pressure on resources has seen a shift in emphasis towards prevention, a recognition of the need to invest a greater proportion of resources 'upstream', keeping people health and independent, thereby reducing demand on health and social care services.

Front line services and facilities are natural assets for any programme seeking to address social isolation and loneliness. However we cannot assume that their full potential is realised. In environments where there are few extended family members within walking distance, many residents who commute out of the local area to work and a lack of community cohesion across age and ethnic boundaries, specific initiatives can commonly be found which actively seek to promote neighbourliness and increase social capital.

A broad range of other services provided by the public sector, private sector, third sector and others, have the potential to impact on social isolation, even if this is not their primary aim. For example, aspects of the built and natural environment and transport infrastructure can help or hinder efforts to enhance social connections.

This section seeks to consider assets in Hammersmith and Fulham, using the framework put forward by the Campaign to End Loneliness.

5.1 Foundation services: reach; understand; support access

The Council has a number of functions which either explicitly address this element of the framework or do this as a bi-product. Community based and front line staff are key to the identification of those 'at risk' and to understanding the nature or cause of their loneliness. Some front line staff will recognise and be able to address isolation and loneliness, particularly those operating in services such as day centres, children's services and community services visiting those who are housebound. There are, however, other front line staff who, while able to identify residents who are isolated or depressed are not necessarily able to address it. These might include staff in libraries and housing options, who may be very skilled in communication with a broad cross section of our population but do not have the tools at their disposal to provide 'warm transfer' to services which can address isolation and loneliness.

In addition to council staff, residents of Hammersmith and Fulham may be in contact with NHS or third sector staff. These too may vary in their capacity to identify and respond to isolation and loneliness to best effect. These staff will include GPs, Physiotherapists, Occupational Therapists, Podiatrists and A&E staff as well as those operating from front line services delivered by third sector agencies – advice centres, BME community organisations etc. The social prescribing pilots at Park

View and North End Road Medical Centre both respond to social isolation.

In addition, it is perhaps those not in contact with front line services who are most at risk of loneliness. The onset of loneliness and isolation can be gradual and individuals might not recognise it until it gets to the stage where it is chronic and their skills/abilities to overcome it have become reduced. Voluntary sector organisations have a good track record in engaging effectively with residents who are not otherwise known to services, particularly statutory services. The Community Champions, commissioned by Public Health, are another particularly good resource for reaching out to those residents who might not otherwise be engaged with council and/or health facilities. These make use of the large volume of social housing in the borough, which facilitates targeted work with many of our communities most at risk of social isolation / loneliness.

While front line services, particularly outreach services, are certainly an asset, we cannot assume that they are fulfilling their full potential to address isolation in the borough. Sobus (2016) identify it as a key theme, specifically highlighting that:

- Individuals and some communities, particularly BAME, are not engaging with services;
- Men are engaging with services less than women;
- There are fewer engagement opportunities for people with mobility issues;
- This lack of engagement and social support is leading to poor physical and mental health outcomes.

Public Health has established and is developing a 'Making Every Contact Count' (MECC) training programme. This seeks to ensure that maximum gain is secured from each contact with a resident regardless of the initial contact purpose. The intention is that raising awareness through healthy conversations of a wealth of services and support available; initiation of 'change talk' to engage the resident; followed by the offer of information as to how or where to progress 'a call to action' for the resident. In addition to face to face contact, both digital nudging, and, utilising 'warm transfer' by contact centres can assist confidence and motivation in residents. Currently the MECC programme is completing the first phase, and up scaling is proposed in phase two, which could, in turn, form part of the backbone of provision to reduce the risk of loneliness. The MECC programme offers a great tool for ensuring that the council and its partners make the most of the full range of staff working in the community – including street wardens and bin collectors as well as those more directly involved in support and care.

5.2 Direct interventions: support and maintain existing relationships; foster and enable new connections (1-1 and group based); psychological interventions

Services which offer opportunities for social contact and facilitate community cohesion, such as volunteer befriending, health and wellbeing hubs and link up / connecting projects are central to the preventative agenda. Despite this, these services can be reliant on short term funding which can undermine sustainability of outcomes and destabilise service provision. The Council is committed to supporting a thriving third sector and recognise their invaluable contribution to community cohesion and social capital. We are committed to ensuring, wherever possible,

longer term funding to aid stability and continuity.

A number of council initiatives: the Smarter Budgeting programme, Housing Support and Care JSNA and the Poverty and Worklessness Commission have each considered how better to prevent homelessness. The council has a Floating Support Service, which primarily supports those residents whose needs are not severe enough to kick in specific statutory services from Housing, ASC and/or Childrens Services but without support can easily spiral into a position of high dependency. Options for enhancing the offer, to become more proactive in reaching those at risk of homelessness and providing a gateway rather than referral service to tailored help, are being considered.

There are over 500 local third sector organisations in the borough, ranging from national charities to small volunteer led small community initiatives. While they have a strong track record of connecting with some of our most isolated residents, many are experiencing increasing financial pressures and are chasing the same pots of funding, which can deter partnership work which might deliver services to individual sooner and more effectively. There may be some value in supporting a more joined-up approach to ensure that gaps in provision are identified and any duplication resolved.

Examples of third sector initiatives which specifically seek to address isolation include the Bishop Creighton House Homeline Befriending Service, which is aimed at residents over 55 who feel they are living in isolation, some of whom are house bound. Volunteers link with residents primarily over the phone but might also visit and where possible accompany them outdoors to help rebuild confidence and ensure they are able to take regular exercise. One of the greatest challenges is encouraging people to go out and try new things – many are fearful of strangers, groups can be regarded as being “cliques” and being more suitable for particular “types” of people. While many are receptive to befriending support, there can be a lot of reluctance to be helped into a service. The Council commission Open Age to provide a ‘linked-in’ service, which finds isolated people and introduces them to groups/activities, accompanying them for the first couple of visits and then gradually withdrawing and the individual continuing to access the service. While successful in connecting with isolated residents, it is proving very difficult to achieve targets for the linking them successfully with other services.

Advice station, provided by H&F Citizens Advice, offers a single telephone number to access advice services using a triage approach to identify which local service or facility is best placed to support the individual. A referral with core information is then made (data sharing agreements in place between organisations) and where appropriate, a direct appointment made. The initiative also coordinates advice services led by H&F Community Law Centre, administrating the local Advice Forum where all organisations which provide community legal advice services and generalist advice services can discuss emerging issues and trends and work together to ensure services are up to date.

Silver Sunday is an annual initiative which celebrates older residents and promotes activities they might enjoy. A range of one-off events are provided as part of the celebration and to kick-start sustained engagement in regular activity. While 450 individuals attended evaluation found that only one third were not previously

engaged in regular activity and only 20% of these new customers continued to engage, perhaps as Silver Sunday is seen as an isolated event rather than an annual celebration of ongoing engagement and activity.

5.3 Gateway services

i. Transport

Whilst significant improvements in public transport have been achieved over the last decade (all buses being accessible, some underground stations having lift access and better bus and tube train design, the new transport provision around Westfield), there remains a number of barriers to public transport for many older people:

- Travelling at night or in the dark – a significant cohort of older people in particular remains reticent to venture out in the dark – mainly due to fear of crime or ASB and fear of slips/falls.
- Avoiding "school rush hour" a number of older people have reported an uneasiness or reluctance to attempt to travel by public transport (particularly by bus) between 3-4.30 when buses are often crowded with school children, who some older people have reported as being intimidating and/or impolite, making travel by public transport an uncomfortable experience. However, this is not necessarily borne out by data or feedback from TfL, and it may be a disproportionate concern.
- While there are limited North/South direct routes across the borough, there are good East/West links and it is thought that residents access services in neighbouring boroughs rather than those in other parts of Hammersmith & Fulham, if the transport links are more direct. As with schools and health services, people often access services which are closest to them, but may not be within the borough boundary.

Feedback from older people shows that the majority recognise the value and range of accessible and free transport available to them (via OP Freedom Pass) and make extensive and good use of these services.

ii. Digital inclusion

There are a number of on-line gateways to council services. These include the Family Information Service, which has recently been refreshed with improved accessibility and navigability which incorporates a facility for those residents needing materials in languages other than English.

Work is now underway to develop People First which is the primary web-based information service for adult residents aged over 50, their friends and family, to find and access support services and facilities. The website has a wide ranging content which is jargon-free and promotes over 100 events and activities per day and there is a set of 'Top 10 front porch questions' which link users straight through to related content. It is actively promoted via a number of agencies across the borough. The main aim of the developmental work is to improve quality and consistency to

a) facilitate timely delivery of preventative services,
b) facilitate improved targeting of services to ensure support for those

residents at most risk of losing functionality and independence (including those who are socially isolated)

c) provide professionals across sectors with an improved reference tool, and
d) achieve a joined-up service offer for residents.

ASC and Health partners have an ambition to establish a fully integrated health and social care system by 2020. A key aspect of this system includes an integrated front door that comprises a cutting edge digital platform and, where needed, a telephone service that is multi-disciplinary and led by experts. ASC's overall aim is to develop and deliver an effective 'Digital by Design' self-service, including signposting, information, advice and self-assessment where appropriate.

LBHF is moving towards Digital by Design to shift access towards digital mechanims rather than face to face or telephone channels. The Sobus report (2016) identifies Information Technology as a priority, specifically the need to explore how best to facilitate e-inclusion for the current generation of 65+, as many are not engaging with IT. They suggest training may help some to engage, as might intergenerational projects. The need to address the costs incurred by older people seeking to engage with digital technology is also highlighted. The Digital by Design programme is being supported by a digital inclusion strategy which ensures that those most at risk of isolation or facing barriers to digital channels are supported to develop digital skills, awareness and access, and that face to face and telephone contact continue to be provided for those who need it.

5.4 Structural enablers

Communal settings such as community centres, day centres, children's centres and libraries are key sites where targeted local information can be delivered. There are five community centres in the borough which, in the main, serve the local population well. Most people are aware of libraries, and these are often well used by residents who do not access other council services and therefore offer an important gateway. The council invests in a health and wellbeing initiative operating out of libraries to ensure that appropriate information is readily accessible.

Adult education facilities offer an important mechanism through which residents can make social connections as well as pursue interests and develop their skills.

The Community Champions (paragraph 5.1 above), who operate on a voluntary basis, live and operate in their own neighbourhoods and have a specific function to aid social connectivity within their community. This model might be extended to establish parent champions and block champions to help address isolation in particular groups. The Poverty and Worklessness Commission has identified a need for a revised approach to volunteering in the borough which recognises and builds on the social capital developed by volunteering initiatives such as the Community Champions. A strategic approach to volunteering, which recognises individuals' skills and expertise and helps them to share these with others might prove fruitful in addressing a number of council objectives though increased confidence and skills: maintaining health and wellbeing, promoting independence and greater employability as well as tackling isolation. Importantly, some vulnerable people can provide as well as receive voluntary support, securing confidence and self-esteem through the

social connections this brings. Cross generational initiatives have been proven to benefit both parties – particularly for those whose family and friends are dispersed. Volunteering can also be an invaluable way to prevent isolation becoming entrenched. Encouraging residents to engage more with their local community prior to retirement can establish social networks which in time can replace those based around work which can be lost with retirement. Businesses may also have an important role to play, through their workplace health programme, in preparing staff for retirement.

Social capital can also be secured through the council's commissioning functions and the council has introduced a requirement for the contribution that each contract and work programme might bring.

The neighbourhood environment itself must also be recognised as a structural enabler. The extent to which our neighbourhood offers an environment that facilitates social discourse, encourages people to recognise and engage with their neighbours through attractive communal spaces which provide for the needs of different age groups has an impact on community cohesion and inclusion. Facilities for active play, for taking a rest, core facilities being within a walkable distance, all contribute. Those neighbourhoods which are recognised as having a lesser offer might engage with residents to address this – an exercise which itself might aid connectedness if led appropriately. As Marmot records: "Public participation in designing public spaces that meet community needs is important in building a sense of ownership and belonging" (Marmot 2010).

Key messages:

Hammersmith and Fulham has many assets and offers many opportunities for engagement.

A more co-ordinated offer, which is appropriately marketed might aid awareness, facilitate greater neighbourliness and promote engagement.

The greatest impact might be secured through greater resident awareness of isolation and loneliness – encouraging people to come forward, encouraging people to look out for each other - spot it in themselves and each other and feel confident about taking action.

Encouraging residents to engage in addressing the detrimental factors in their community can aid connectedness as well as engender a sense of ownership and belonging.

6. Where do we want to get to and how will we get there?

The strategic objectives below were identified at a workshop held in April 2016. The themes developed through the process of reviewing the evidence base and examining best practice from other areas that have identified social isolation as a priority for action. A draft work programme outlining actions to address these objectives is attached as Appendix 2.

6.1 Improved levels of awareness among residents and front line workers

i. We will develop a communications and marketing strategy, with our partners in the statutory, business and third sectors, to raise awareness of the prevalence and impact of isolation and loneliness and of relevant services and facilities.

ii. We will sustain and promote our Making Every Contact Count programme, ensuring that front line staff in different agencies are supported to provide 'warm transfer' across all referral mechanisms, including digital.

6.2 Robust approach to ensuring social connectedness, preventing isolation and loneliness

iii. In addition to our existing work to secure social value and social capital through our approach to commissioning, we will ensure that our approach to community development and community engagement explicitly seeks to contribute to community resilience and social capital.

iv. We will work with our partners to establish a strategic approach to volunteering as a mechanism for connectedness, developing social capital.

v. We will develop existing mechanisms to establish a main portal to information and advice and ensure better links between that portal and other on line resources (including council webpages) – so that whichever route people follow to seek the information, they are able to do so quickly and easily.

vi. We will pursue our 'no wrong front door' approach to the provision of council services, exploring the desirability of and options for community hubs.

vii. We will consider whether there are gaps or fault lines in our transport network and the walkability of our neighbourhoods which might undermine social connectedness and seek to address these.

viii. Review digital access specifically for groups at risk of social isolation and inclusion and address gaps in provision.

6.3 Targeted activity, asset based (whole systems)

ix. We will review what is currently available to prevent and address social isolation for Hammersmith and Fulham residents to identify which 'at-risk' groups or neighbourhoods are not currently sufficiently supported and address the findings.

x. We will work with local partners to encourage robust retirement planning which incorporates the value of social connectedness and markets the available activities.

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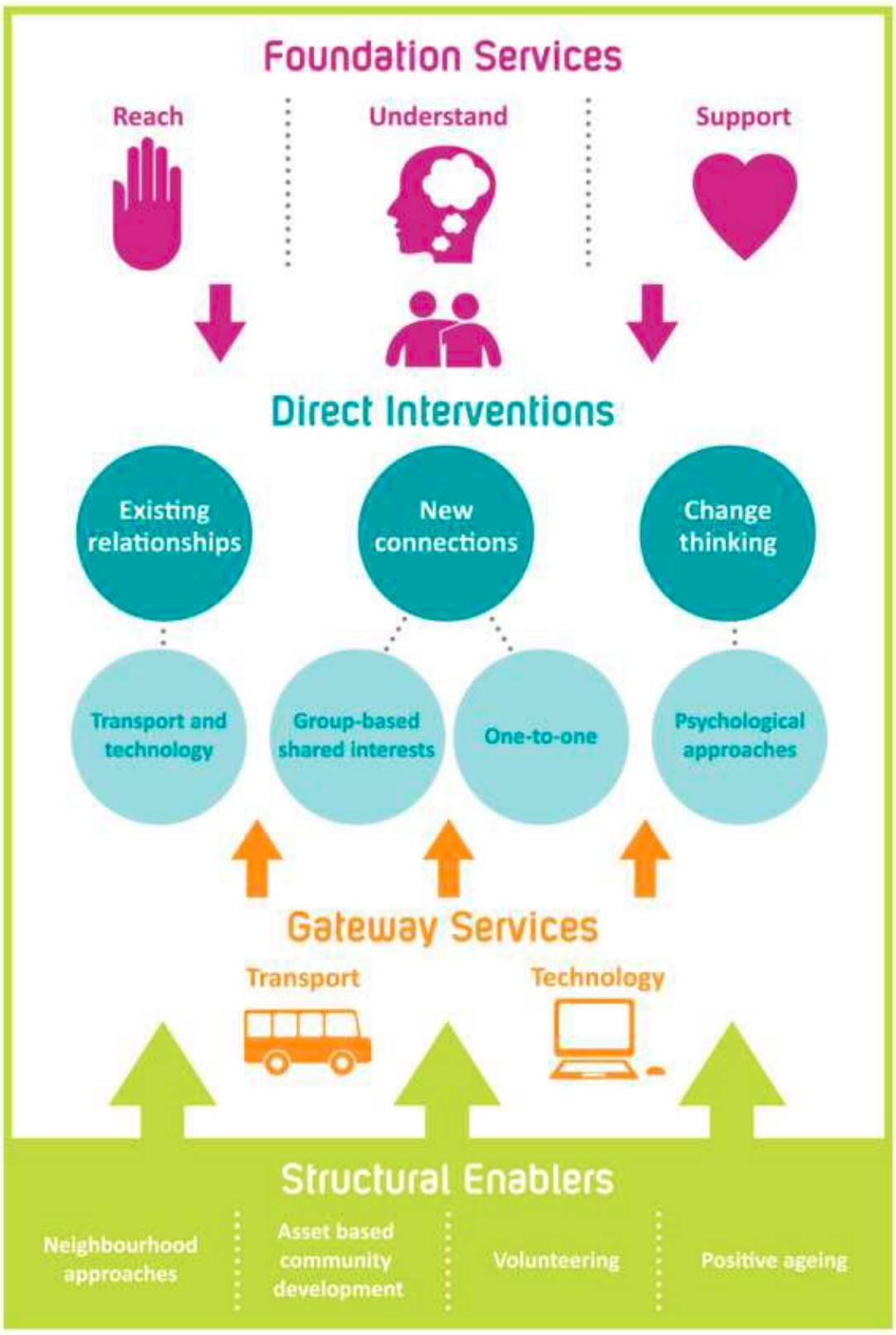
Appendix 1: Campaign to End Loneliness / Age UK Framework



Appendix 2: Draft work programme

Strategic objective and theme		Activity	Deadline	Progress	
6.1	**Improved levels of awareness among residents and front line workers**				
i	Develop a communications and marketing strategy Output: Sustained profile in local media of services and facilities Outcome: Raised awareness of the prevalence and impact of isolation and loneliness	Work with local media to secure regular feature	Apr 17		
		Establish shared branding to aid easy recognition of services specifically there to support connectedness	Apr 17		
ii	Sustain and promote the Making Every Contact Count programme Outputs: • 72 staff trained at L1 15 staff trained at L2 Outcome: • Front line staff in different agencies provide 'Warm transfer' • Increased resident engagement in services.	Identification of priority front line officers	Dec 16		
		Delivery of 6 level one (half day) MECC training sessions with a focus on social isolation and loneliness	x3 by Mar 17, 3 more Apr-Jun		
		Delivery of one level two (2 day) MECC training sessions with a focus on social isolation and loneliness	Jun 17		
6.2	**Robust approach to ensuring social connectedness, preventing isolation and loneliness**				
iii	Approach to community development and community engagement contributes to community resilience and social capital Output: Outcomes:	TBC			

Strategic objective and theme		Activity	Deadline	Progress	
iv	Establish a strategic approach to volunteering as a mechanism for connectedness, developing social capital. Output: Outcomes:	TBC			
v	Establish a main portal to information and advice and ensure better links between that portal and other on line resources. Output: Outcomes: • Improved access to information, advice and services	TBC			
vi	Establish a 'no wrong front door' approach to the provision of council services. Output: Outcomes: • Clarification of approach to community hubs.				
vii	Review transport networks and walkability within and between neighbourhoods and across the borough: address faultlines Output: Outcomes: • Greater social connectedness in neighbourhoods • Geographical connectivity between	TBC			

Strategic objective and theme		Activity	Deadline	Progress	
	different neighbourhoods within the borough				
viii	Review digital access specifically for 'at risk' groups and address gaps Output: Report identifying Outcomes: • Identification of groups who cannot or do not access advice, information and/or social networks digitally, and why • Tailored interventions for 'at risk' groups – either improving digital access or offering alternative opportunities	Four digital inclusion pilots on estates			
		Conduct mapping exercise of digital exclusion rates and review provision of wifi across public buildings and social housing: supported accommodation, sheltered accommodation, residential care.			
		Provide targeted support for residents most in need of Digital Skills, including for residents moving onto Universal Credit, job seekers, disabled residents, parents and older residents			
		Review demand for library facilities for digital access			
		Increase the number and range of places residents can access free public wi-fi in both Council and partners buildings and residents' homes.			
		Focus groups with those who are able but do not choose digital access.			
6.3	**Targeted activity, asset based (whole systems)**				
xi	Review current offer to identify which 'at-risk' groups or neighbourhoods are not currently sufficiently supported and address findings. Output: Outcomes:	Consider how best to facilitate support and contact with families members out of borough.			
		Consider how best to support young people in further or higher education who have disabilities and might be more at risk of social isolation as a result.			

Strategic objective and theme		Activity	Deadline	Progress	
	• Clarification of priority groups • Improved return on investment	Consider how best to support those in sheltered accommodation to maintain existing and develop new social contacts.			
		Consider how best to support those in supported accommodation to maintain existing and develop new social contacts.			
x	Encourage robust retirement planning Output: Outcomes: • Older residents maintain activity levels • Volunteering activity among 50+ age group increases.	TBC			

London Borough of Hammersmith & Fulham **HEALTH, ADULT SOCIAL CARE AND SOCIAL INCLUSION POLICY & ACCOUNTABILITY COMMITTEE** **12 December 2016**	
WORK PROGRAMME 2016-17	
Report of the Chair	
Open Report	
Classification: For review and comment **Key Decision:** No	
Wards Affected: All	
Accountable Executive Director: Kim Dero, Director of Delivery and Value	
Report Author: Bathsheba Mall, Committee Coordinator	**Contact Details:** Tel: 020 87535758 E-mail: bathsheba.mall@lbhf.gov.uk

1. EXECUTIVE SUMMARY

1.1 The Committee is asked to give consideration to its work programme for the municipal year 2016/17.

2. RECOMMENDATIONS

2.1 The Committee is asked to consider the proposed work programme and suggest further items for consideration.

LOCAL GOVERNMENT ACT 2000
LIST OF BACKGROUND PAPERS USED IN PREPARING THIS REPORT

None.

LIST OF APPENDICES:

Appendix 1 – Work Programme 2016

Appendix 1

Health, Social Care and Social Inclusion Policy and Accountability Committee

Item – Report Title	Report Author / service	Status
12 December 2016		
Tackling Social Isolation and Loneliness" Strategy	Fawad Bhatti / Policy & Strategy	Confirmed
Community Champions	Christine Mead / Public Health	Confirmed
End of Life Care: JSNA and CLCH Update on Action Plan	Colin Brodie / Public Health	Confirmed
31 January 2017		
Budget – ASC; Public Health	Finance	
Poverty and Worklessness Commission Report	Tom Conniffe / Policy & Strategy	TBC
8 March 2017		
Digital Inclusion	Policy & Strategy	TBC
Community Independence Service		TBC
26 April 2017		
NHS Trust winter resilience	Imperial College NHS Trust	Confirmed
Impact of devolution on Local Health Services		Planning

Items for future agenda planning:

- Meal Agenda
- Impact of devolution on Local Health Services
- Commissioning Strategy: Providers
- Customer Journey: Update
- Equality and Diversity Programmes and Support for Vulnerable Groups
- H&F CCG Performance
- Immunisation: Report from the HWB Task and Finish Group
- Immunisations update – 2017
- Integration of Healthcare, Social Care and Public Health
- Listening to and Supporting Carers
- Self-directed Support: Progress Update
- Antibiotic prescriptions
- West London Mental Health Trust: Update
- Tuberculosis
- CAMHS update
- Disability Commission
- Sports and leisure strategy
- Physical exercise strategy