London Borough of Hammersmith & Fulham

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Health, Inclusion and Social Care Policy and Accountability Committee
Agenda

Wednesday 10 November 2021 at 6.30 pm
Virtual meeting

MEMBERSHIP

Administration	Opposition
Councillor Lucy Richardson (Chair) Councillor Jonathan Caleb-Landy Councillor Bora Kwon Councillor Mercy Umeh	Councillor Amanda Lloyd-Harris
Co-optees	
Lucia Boddington Victoria Brignell - Action on Disability, Action On Disability Jim Grealy - H&F Save Our NHS, H&F Save Our NHS Keith Mallinson Roy Margolis	

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Date Issued: 2 November 2021

London Borough of Hammersmith & Fulham

Health, Inclusion and Social Care Policy and Accountability Committee

Agenda

10 November 2021

Item		**Pages**
1.	**MINUTES OF THE PREVIOUS MEETING**	4 - 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 7 October 2021; and

(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. PUBLIC PARTICIPATION

This meeting is being held remotely. If you would like to ask a question about any of the items on the agenda, either remotely or in writing, please contact: bathsheba.mall@lbhf.gov.uk

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5. COVID-19 UPDATE

For the Committee to receive a verbal update from the Director of Public Health on Covid-19 and Director COVID-19 & Lead for Afghanistan refugees, with a focus on Covid vaccination.

6. MENTAL HEALTH SERVICES UPDATE 19 - 35

This report aims to provide members with insight into the range of available mental health services delivered for Hammersmith and Fulham residents and to improve opportunities to understand care pathways, and to provide a snapshot referral demand and service challenges.

7. DISABLED PEOPLES HOUSING STRATEGY 2021 36 - 73

Disabled People's Housing Strategy 2021 sets out the approach for meeting the housing needs of disabled people through the provision of a co-produced housing service shaped and influenced by, and for, disabled people.

8. WORK PROGRAMME

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

9. DATES OF FUTURE MEETINGS

26 January 2021
23 March 2023

Agenda Item 1

London Borough of Hammersmith & Fulham

Health, Inclusion and Social Care Policy and Accountability Committee

Draft Minutes

Thursday 7 October 2021

PRESENT

Committee members: Councillors Lucy Richardson (Chair), Jonathan Caleb-Landy, Bora Kwon, Mercy Umeh and Amanda Lloyd-Harris

Co-opted members: Lucia Boddington, Victoria Brignell, Action on Disability; Jim Grealy, H&F Save Our NHS; Keith Mallinson and Roy Margolis

Other Councillors: Councillor Ben Coleman

Officers/guests: Lucy Allen, Head of Community Independence Service (CIS), CNWL; Jo Baty, Assistant director specialist support and independent living; Dr James Cavanagh, Chair, H&F CCG; Gail Dearing, Associate Director mental health, WLT; Helen Green, Service Manager Engagement and Planning, The Education Service; Merril Hammer, H&FSON; Dr Nicola Lang, Director of Public Health; Dr Christopher Hilton, Executive Director of Local and Specialist Services, WLT; Mary Lamont, Strategic Head of People and Talent • Transformation, Talent and Inclusion; Helen Mangan, Deputy Director of Local Services, WLT; Oliur Rahman, Head of Employment and Skills • Economic Development Lisa Redfern, Strategic Director of Social Care; Sue Roostan, Susan Roostan, Borough Director, H&F CCG; Wendy Lofthouse, Mental Health Commissioning Manager, H&F CCG; Sue Roostan, Borough Director H&F CCG; Linda Stradins, Service Manager, H&F MINT, WLT; and Matt White, Interim Tri Borough Head of Hospitals, Health Partnerships

1. MINUTES OF THE PREVIOUS MEETING

RESOLVED

That the minutes of the previous meeting held on 30 March 2021 were agreed as an accurate record.

2. APOLOGIES FOR ABSENCE

None.

Minutes are subject to confirmation at the next meeting as a correct record of the proceedings and any amendments arising will be recorded in the minutes of that subsequent meeting.

3. ROLL CALL AND DECLARATION OF INTEREST

The attendance of committee members was noted and there were no declarations of interest.

4. PUBLIC PARTICIPATION

None.

6. COVID 19 UPDATE - TO INCLUDE FOCUS ON VACCINATION

6.1 Councillor Richardson introduced this item which was a verbal update provided by Sue Roostan and Dr Nicola Lang. Sue Roostan took questions and Dr Lang followed up with a brief update on phase three of the borough's vaccination programme.

6.2 Councillor Richardson recognised that the borough had one of the lowest vaccination rates in North West London and asked what was being done to address this. Councillor Ben Coleman reported similar concerns about the most recent developments which included the closure of the mass vaccination centres, the indecision of NHS England about pharmacies operating as vaccination hubs and a shortage of vaccinators. Residents were limited to four pharmacy locations offering a Covid vaccination. There were also variations in reporting, with the borough's progress reported differently by both NHS Foundry System and NWL Integrated Care System. Whilst planning was ongoing the cumulative affect presented a difficult picture which ignored the point that making vaccination simple and easy was a proven approach, for example, using pop buses.

6.3 Sue Roostan confirmed that there were some data anomalies in the calculations and where the borough was placed in the league tables, but the borough was middle of the pack in terms of NWL figures. The borough was offering the vaccines to those that were eligible in line with the JCVI delivery programme (Joint Committee for Vaccination and Immunisations). Booster vaccines were being offered, in addition to first and second doses, working with the local authority to implement a targeted approach, in partnership with GP practices.

6.4 There was not a shortage of vaccinators but there was a requirement to have a minimum number of registered healthcare professionals on site when vaccinators were working, and this was a significant issue. In addition to being responsible for the preparation of the vaccine and overseeing the clinical work of the vaccinators, they were also responsible for participating in the primary care recovery work and supporting pop ups and vaccine buses, supported by the local authority and Imperial staff. A vaccine bus at the Claybrook, and the Stephen Wiltshire facilities had been very well received. While concerns about low take up were understandable it could not be attributed to low resources. There were currently five pharmacies with a further eleven expected to be authorised and functioning shortly. There were also four primary care network (PCN) sites. Low take up was attributed to vaccine hesitancy but there had been

significant and ongoing work being undertaken by the NHS and the local authority to tackle this.

6.5 Councillor Coleman highlighted that there had been three pop ups that had not gone ahead at the Claybrook, Shepherds Bush Market and at the Lyric Theatre because there were no vaccinators available. Mobilising at short notice also made things very difficult. Sue Roostan accepted this criticism and explained that they were also supporting the school's vaccine programme, at the same time, prioritising 12-15-year olds, within a short period of time ahead of half term. This required short term adjustments to the management and delivery of pop up vaccine clinics. Whilst the process was imperfect there was a lot of effort going on in the background to trying and improve the situation. The difficulties were not limited to hesitancy but overconfidence in those who had received two vaccine doses.

6.6 Dr James Cavanagh reported that the vaccination site at his practice had been operating below capacity for three days. This was very different to that of the initial campaign when people were lining up an hour early to receive their vaccine. He acknowledged the need to establish staff and co-ordinate resources efficiently and at the same time offer the booster vaccine, in advance of winter pressures.

6.7 Victoria Brignell asked for data on the percentage of care workers who had been vaccinated and a breakdown of figures for those who had been vaccinated in care homes employed by agencies and those directly employed by disabled people through the direct payments scheme. A second question was asked about the number of people who were clinically vulnerable and who might delay their booster jab as they already had appointments for flu jabs and were concerned about the timing of this. Sue Roostan explained that the data was available and could be shared following the meeting, but the coverage varied between providers, for example, with some private sectors vaccination for care workers working with the clinically vulnerable was mandatory. Dr Cavanagh confirmed that both the flu jab and the Covid jab could be administered on the same day and that this choice but there were issues for those that were immunocompromised. Considerable work had been done to vaccinate residents and care workers in care homes and that the borough was one of the top performers in this area.

ACTION: To provide data on the percentage of private and public sector agency staff, and direct payment employees.

6.8 Lisa Redfern confirmed that the borough's performance on vaccinating in staff and residents in care homes was the second highest in London. With the exception of one nursing home, there was almost 100% coverage. It was possible to retrieve data about the number of those who were employed by the direct payment scheme and it was suggested that this could be by email. It was likely that the number of care home staff was higher as the vaccine roll out began earlier and because of the mandatory nature of vaccination staff working with the clinically vulnerable.

6.9 Concurring with Dr Cavanagh's earlier observation about slower take up Keith Mallinson asked how information about how to obtain a booster jab was being communicated and advertised. It was also concerning to note the lack of enforcement on public transport regarding mask wearing, or indoor shopping areas such as Westfield and Kings Mall. Councillor Amanda Lloyd-Harris endorsed Councillor Coleman's comments, and that it should not have come as a surprise that pharmacies would be needed to deliver Covid vaccines, given that vaccination hubs were being decommissioned and this indicated a lack of foresight and planning. She asked what incentives might be put in place to encourage vaccine take up, given the low rates of take up within the borough, for first, second and booster jabs, and the schools vaccine programme. Jim Grealy was also concerned about the lack of enforcement on public transport and was keen to understand how the booster would be promoted as there appeared to be less urgency about people obtaining a booster jab.

6.10 Despite a significant increase in flu jab take up, Dr Cavanagh highlighted the risk of a return to a culture of not having the flu jab and he drew a comparison with current pattern of Covid vaccination take up and a similar trajectory in declining figures whereas the long term expectation was that it should become a routine part of self-health care. There was a gradually evolving narrative of returning to "normality" and a campaign was required to reinforce message about the greater risks of not vaccinating. A further added concern was about the pressure on practices to return to in person appointments. Social distancing was hard to maintain in the average practice waiting room when clinically vulnerable patients must be distanced from, for example, coughing young children. Sue Roostan responded to the questions raised:

- Communications – A national communications strategy was anticipated to promote the booster campaign which had already started locally.
- Public transport – It was disappointing to see that enforcement had been relaxed and that fewer passengers were wearing masks, and that this was a matter for TfL.
- Pharmacies – H&F CCG did not commission pharmacies but had been pushing for some time now to increase the number of pharmacies able to provide the vaccine, but this was within the jurisdiction of NHS England. Locally, assistance had been offered to pharmacies by pharmaceutical advisors to expediate and increase current capacity. It was hoped that a further seven would be brought on stream.
- A communication's strategy would help drive up demand, and capacity was in place to meet this. A planned and targeted focus was being developed, working closely with colleagues within the local authority.
- Flu vaccine take up – This was poor across the borough and work was being undertaken with a combined approach to also address Covid take up with the intention to co-administer vaccines.

6.11 Merrill Hammer commented on the issue of booster jabs which had already been raised and that there was a need for stronger, consistent messaging in the form of a local campaign using leaflets and posters, about when people were eligible for their booster (six months after a second dose). Unclear messaging was a concern, as was the lack of alternative options for those who could not access digital appointments. Sue Roostan confirmed that a text message would only be sent to those who were eligible and also met the six-month criteria. It was acknowledged that communication could be more consistent and that more could be done to improve messaging and that this required conversations at a local level with the council. For example, regular updates on the council website and text messages from GP practices. In the discussion that followed, members anecdotally reported inconsistencies in who was receiving messages, particular those being invited for boosters when they were not eligible and vice versa. Councillor Richardson felt that there was considerable variation in individual experiences and that addressing inconsistencies in communication was critical.

6.12 Councillor Coleman pointed out that a different approach by moving provision from large hubs to a pharmacy might have made it easier for people to get vaccinated. Vaccination buses had been successful through a targeted, hyper-local focus with buses placed in Normand Park opposite the Clement Atlee estate making it a quick and easy process. The use of pharmacies had been strongly argued for by the borough and other councils. While the feasibility of this had been initially contested, NHS England had recently reversed their position. Although there would eventually be more pharmacies within the borough on stream, Councillor Coleman felt that NHS England let the borough down and that more pop up buses and vaccinators were required. Sue Roostan agreed that the buses had proved to be popular in targeted communities with low vaccine take up, but these had been relatively low numbers ranging from 10-30 and there was a need to use resources efficiently. Councillor Coleman pointed out that Dr Lang and Lisa Redfern had advocated an approach that targeted those who could not leave their homes or were clinically vulnerable, with little response. Having nineteen vaccinated on a bus was good and Councillor Coleman questioned the logistics behind what would be the most efficient use of valuable resources. Sue Roostan responded that they could not offer a door to door service because of the resources required. Dr Cavanagh observed that the intent was the same, to achieve a balanced approach in getting most people (including the vulnerable) vaccinated within the available resources which was an evolving process.

6.13 Councillor Coleman acknowledged this however, it appeared that billions were being spent on purchasing the vaccine, but the vaccination process itself was being delivered on the cheap. He stated that he had not formally been presented with the argument that it was not feasible to provide a door to door service but argued that there were groups that felt unable to attend PCN sites who did not meet the criteria of clinically vulnerable. Sue Roostan confirmed that a request from Councillor Richardson that data on this be provided and presented at the next HISPAC meeting to help inform a pilot piece and this was agreed. Councillor Coleman suggested that

information reported anecdotally was followed up and highlighted concerns about working within the Integrated Care System, particularly on local H&F vaccination in the context of historically poor take up rates.

6.14 Councillor Kwon enquired if people will be invited for their booster jabs in waves (as per the JCVI eligibility groups) or what people could do if they had not yet been contacted and were expecting an offer to book their appointments. Dr Cavanagh offered an assurance that there was not a shortage of the vaccine in the borough but that eligible patients would be contacted by GP practices in line with the data and information in patient records. Although an automated system was in place Dr Cavanagh advised that if a person had not been contacted after the six-month period had elapsed then they should contact their GP practice. He acknowledged that there might be mistakes in the system, but the vast majority would receive a timely notification. Dr Cavanagh explained that he would be open to any suggestions as to what further measures could be put in place to improve vaccination.

6.15 Expressing her concern that the CCG would not mandate a door to door approach, Merrill Hammer referenced the work of Imperial College NHS Healthcare Trust on vaccine hesitancy and whose board had advocated a door to door approach. She concurred with Councillor Coleman and argued that those who were more resistant to being vaccinated had just as great a need as those who were housebound.

ACTIONS:

1) **That data be compiled to demonstrate the number individuals that might benefit from a door to door service;**
2) **That the members of the committee who had been invited to book their booster jabs before the six month period had elapsed share the details with the Chair, who will provide this to Sue Roostan; and**
3) **That the process of obtaining the booster jab be included in the agenda for the next meeting.**

RESOLVED

That the committee noted the report and actions as set out.

5. INCLUSIVE EMPLOYMENT UPDATE

5.1 This report provided an update on progress made to reshape the local offer which has been completely transformed post Covid-19 highlighting improved areas developed across Social Care, Children's Services and The Economy council departments. The improved local offer was intended to support young people and help them to overcome obstacles to employment and educational opportunities. The committee had previously considered this on 10 September 2020 and Councillor Richardson welcomed Mary Lamont, Mandy Lawson, Jo Baty, Helen Green, and new starters Yvonne Okiyo and Oliur Rahman.

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5.2 Jo Baty introduced the update which set out the collective, corporate work undertaken on inclusive employment.

5.3 Helen Green outlined the approach of Children's Services which considered a person-centred employment pathway and a "stepping-stone" approach. A young people's cross departmental inclusive employment operational group had been established bringing together the council and voluntary sector partners. This collective approach allowed the voice of young people to inform and to contribute to the development of pathways. There were 27 supported internship programmes across North West London, including one at the council. Young people had presented at a senior manager forum informing them about their needs and aspirations and other events to consider employment opportunities which had received positive feedback.

5.4 Oliur Rahman continued with an outline on where the council was on the labour market and unemployment rates which although high following a sharp increase following Covid-19, remained steady. At the end scheme in September 2021, 5200 residents were on furlough when the scheme ended. It would take some time to evaluate the economic and social impact of this. Building on a broad West London study commissioned by the West London Alliance (WLA). Recovery to pre-pandemic levels could be expected across the area by 2023. The council had supported the creation of 134 vacancies through the Kickstart programme working with partners across the council and externally, which compared favourably with, for example, Camden, with 100 vacancies. The council worked closely with the Department for Work and Pensions (DWP) to help deliver partnership work with funding to target and support residents that had been most affected by the impact of the pandemic, in addition to matching local need and aligning this work with the council Industrial Strategy. Statutory programmes such as Work and Health and Jets targeted the long term unemployed to address health barriers to employment.

5.5 An integrated approach was also being taken in terms of work with schools and students, aiming to raise aspirations and awareness, and a youth hub was planned on the Barons Court campus, West London College (WLC). The council had been working to add social value by ensuring that all contracts exceeding £100k in value were able to deliver additional value for residents. The results of these were beginning to emerge and this would be key to generating work experience as well as improved job outcomes.

5.6 Mary Lamont emphasised the collaborative work taking place across key departments and the development of a 12-month list of priorities and work plan to deliver this. A new diversity and inclusion lead, Yvonne Okiyo had been appointed and a manager's initiative had pledged to provide support with for example, interview techniques, sharing best practice and guidance. The apprenticeship programme currently had 83 apprentices across the council and a new quarterly young people's network would commence in October 2021, open to anyone working at the council under the age of 30. All of these initiatives combined to ensure that the council learned, developed, and continued to improve practices and behaviours, embedding equality, diversity, and inclusion across the council. Key to this was the collation and use of robust data.

5.7 Jo Baty described the work collaborative work undertaken between Social Care and West London College to modernise day services with a specific focus on pathways to employment. The department was also working with Certitude (previously known as Yarrow) using a "market shaper" role, the aim was to promote pathways to employment, signposting across the borough to allow people to access different services supporting them into work. Jo Baty also referenced mental health working through the Integrated Care Partnership (ICP) supporting residents with mental health issues into employment. A new Independent Living Delivery Group had been established in Social Care to focus the energies of the Service on how best the Council can give residents choice and control, including co-produced pathways to employment.

5.8 Lucia Boddington asked about employment pathways from the perspective of an autistic young person. Working collaboratively for someone who was autistic was difficult and she asked if this could be addressed through training or perhaps included in an animated graphic. Jo Baty reported that she had met earlier with Queens Mill Academy to discuss training for providers in social care for day services and short breaks on autism. With its new autism strategy informed by the views of parent carers and families, there was a recognition that it was essential to embed an understanding of autism across the base and that training be rolled out to local employers. A suggestion about the visual impact of using creative, animated graphics to promote employment to young people with learning disabilities or autism was welcomed.

5.9 Roy Margolis welcomed the presentation and commended the excellent work being progressed. He asked about school careers provision for students with special educational needs, what resources were used, and how school leaders and students were targeted so that they were aware of opportunities. Helen Green explained that Matthew Coulbeck, Schools Advisor, Children's Services supported an inclusive careers leader's network, through the Careers Enterprise Network and this included the participation of some of the borough's special schools.

5.10 Jim Grealy welcomed the presentation and details that focused on targeting of work opportunities. He asked about the high percentage of pupils whose families were on Universal Credit, and the connection between health inequalities and the ability to work, and, whether in monitoring the connection to being on benefits was an impediment to work for some people. Councillor Lloyd-Harris asked about vibrant places, and what the council was doing in relation to bring culture into the community. Oliur Rahman explained that upstream work with partners already focused on working with organisations like Hammersmith Society, and the Mayor to support local activities. Work had also been undertaken on understanding the statistical link between being on benefits and the potential obstacles this presented to advancement through access to employment opportunities. A working group had been established to explore the data that might support this perception, that would feed into a review action plan.

ACTION: Oliur Rahman to share key highlights set out in a briefing note on the impact of Universal Credit cuts on residents.

5.11 Councillor Jonathan Caleb-Landy enquired what measures could be used to identify what progress was made, particularly as the local economy recovered from Covid-19. Data on groups with neurotypical disabilities would help to identify the whether the right interventions were being applied. Understanding how these could be used to measure progress would help improve outcomes. Gathering robust data across different departments which use varying criteria could skew the data and officers had discussed the feasibility of developing an in-house database that can draw data at a local level and reported on a regular basis.

5.12 Councillor Richardson thanked Councillor Caleb-Landy for an insightful question and comment. It would also be helpful to have details about the 16 of the 300 people on supported internships, whether they were in full time employment, their destinations, if they were placed within the borough, and to also celebrate those businesses that are employing them. Councillor Richardson felt that it was important to focus on outcomes for young people who might not achieve English and maths at GCSE level, which would mean that they would find it extremely difficult to access post 16+ educational and employment opportunities. On behalf of herself and h&f colleagues Jo Baty extended thanks to Councillor Richardson who had provided encouragement and support to officers and contributed significantly to the ongoing development and shaping of the h&f offer.

ACTION: Jo Baty and colleagues to provide further update on progress, particularly in developing the use of data and dashboard, to include a range of information, as highlighted in the discussion.

RESOLVED

That the committee noted the report and actions as set out.

7. HOSPITAL DISCHARGES

7.1 Councillor Richardson introduced a verbal update that outlined recent developments on hospital discharges which had been brought to her attention by a resident who had been recently discharged. It would examine the discharge process to understand how this was managed and to ensure that the correct protocols were in place, and areas of staff accountability, transparency, and sound administration. Councillor Richardson welcomed Matt White, Jo Baty and Lucy Allen to provide the update.

7.2 It was explained that Matt White had previously worked across the three boroughs service (H&F, WCC and RBKC) and had returned in an interim capacity covering hospital discharges. There were checks and balances on the system to monitor people going through the discharge to assess process and within this different were levels of assurance. The process was multi-disciplinary involving different relationships and cost sharing between health and social care teams. There had been an impact on

discharge success caused by Covid and this had changed the process significantly. An emergency process had been implemented at that point but more recently, there had been a slow down which offered some breathing space ahead of the winter pressures. This offered a timely opportunity to review services across all three boroughs. More recent developments included working with Charing Cross Hospital discharge leads to review and share learning when mistakes occur.

7.3 Councillor Richardson welcomed the assurance that reviews were undertaken to review errors which serve as checks and balances, offering accountability to patients and their families and about who was consulted about care, including family members, to ensure that clear information is provided was essential. Matt White explained that following Covid the service had updated its documentation with information about new arrangements. It was recognised that having a family member in hospital resulted in a chaotic time for family members so there was a great deal of information and leaflets offered to support them. In response to a follow up question, Matt White outlined how the homeless pathway operated which also incorporated additional homeless support services offered by providers such as Imperial and St Mungos. Key to the success of this was clear communication. Jo Baty added that H&F, Social Care colleagues participated in a weekly discharge meeting, including officers from hospitals, reablement, commissioning, brokerage, homeless and finance teams. This ensures that the right, focussed support is being provided to residents and that any areas of concern are tackled promptly with agility.

7.4 Councillor Amanda Lloyd-Harris commended the work being undertaken and asked how a homeless person could be helped when they were fit to be discharged but you were aware that they were not necessarily well enough to be in the community by themselves. Matt White explained that adults with capacity had the right to choose to leave, if they were fit to be discharged. There were street medical services that could support a homeless person on discharge, but the golden rule was that a person with capacity has complete autonomy over decisions about their care. Where a person does accept medical help, this can be a gateway to onward pathways leading to long term change away from homelessness.

7.5 Lucy Allen briefly provided a Community Independence Service (CIS) perspective and mentioned that their aim was to support people so that they did not have to into hospital in the first place. There was a considerable amount of collaborative work that supported more complex need in the community with a multiagency approach. This recognised that hospitals were not best placed to aid recovery. Lisa Redfern added that that services like the CIS were critical in preventing unnecessary hospital admissions and also facilitating reablement care following discharge. This would be a key area of focus of work for the ICP, particularly given the elective care backlog resulting from Covid and the currently high rate of discharge and related high pressures. This was a long-term issue and would be exacerbated by winter pressures with increased acuity of need. In closing Matt White explained that on his return to this area of work in 2020/21, he had never in his thirty years of work in social care

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experienced the level of demand and pressure that arose in during this period. He commended outstanding health and social care staff who had made a fantastic commitment to support patients in the most challenging of circumstances.

7.6 Councillor Richardson commended Matt White and his colleagues for their dedication and looked forward to receiving further updates on the service and how it progressed.

RESOLVED

That the committee noted the verbal report.

8. MENTAL HEALTH UPDATE

8.1 Councillor Richardson welcomed Helen Mangan and Dr Christopher Hilton from WLT, Gail Dearing, Wendy Lofthouse, Linda Stradins from WLT and Jo Baty who provided an update on the work of the ICP adult Mental Health Campaign (MHC) and the implementation of the Mental Health Integrated Network Teams (MINT) across H&F, and areas yet to be developed. The committee had been expecting a fuller report which had been previously postponed in September as it was not ready, and Councillor welcomed this interim update.

8.2 Helen Mangan provided an outline highlighting the significant work being undertaken collaboratively, post Covid, and the work that was planned through the ICP. The MHC had met throughout the summer and the core group tasked with delivering this work comprised of mental health staff, community trust social care PCN and voluntary sector colleagues, underpinned by a wider stakeholder group. The objectives of the MHC were currently in development and emerging. It was important to identify barriers to care for those who were passionate about working in mental health to improve the physical health care of people with serious mental illness. The core group had developed networks, connections and built trust and these were key in ensuring a better system. A key component of was the collaborative approach of the ICP responding to acuity of need and demand. Helen Mangan apologised for the absence of detail in the paper but there were ongoing discussions to identify formal objectives and to agree health and social care leads which would emerge in the coming weeks, and a more detailed paper would be provided at the January meeting of the committee.

8.3 A key outcome of the ICP was the ability to respond to demand with agility, and a positive illustration of this was the development of vaccination hubs. It was well recognised that those service users with serious mental illnesses were also those who were likely to be vaccine hesitant. Take up within this group was about 50% and they had lobbied for a bus to be located at Charing Cross Hospital site where the WLT mental health main unit (The Claybrook) was located. The bus encouraged service users, with the support of a mental health team to make contact and get vaccinated. 12 service users had been vaccinated and this was on going work. Most importantly, this was achieved through partnership working, bringing

together colleagues from the CCG, social care, and public health and had been an invigorating approach.

8.4 Helen Mangan briefly spoke about the Children and Young People core group, the work of which was not as advanced as the mental health core group as it was started later. Three key areas that planned to explore included pathway mapping, CAMHs (Children and adolescent mental health services) transformation funded by new money coming into the health service, and the funding of services for 16-25 year olds (transition group) which would be a new model being developed across North West London. This new model would be introduced as an initiative in H&F first.

8.5 Continuing the presentation Jo Baty explained that a stakeholder group had been established through the ICP MHC with at least 50 members drawn from the mental health community, including residents with mental health issues. The group recognised that the only way to move forward was to work in partnership and some co-produced ideas had already begun to emerge, replicating the council's approach to co-production, "nothing about us without us", within the ICP. An illustration of this was the work with black, minority ethnic communities to explore how best to allocate trust community grants, bridging a gap from the community to the decision makers. Linda Stradins reflected on the MINT project which was gaining traction and building momentum. As part of the transition process new roles had been established and would be embedded within the teams, with peer support to successfully manage the merger of primary and secondary mental health with as a single point of access. This would allow them to manage referrals, provide consultation and opportunities to engage, with GPs networks were connected within that structure. Other operational changes that were emerging would utilise non-statutory voluntary and community sector resources, the relocation of resources within the community and outreach work building on existing networks. Specialist teams would provide an enhancement to existing provision, and also being explored was upstream intervention for individuals with eating disorders.

8.6 Councillor Richardson sought clarification about what different MINT had made since it was established, and had it made a difference in terms of specific service and provision. Linda Stradins responded that MINT was work in progress but was breaking down barriers. The service had gone live during the summer and the PCNs had engaged well with it. GPs regularly attended weekly network meetings which offered good opportunities for consultation and to escalate patient concerns. The move to the use of System One would allow direct communication with GPs, to set tasks, gain access to the patient's notes to help with decision making.

8.7 Keith Mallinson enquired about membership of the monthly mental health stakeholder forum. The organisation that he worked for, Shepherds Bush Families Project dealt with vulnerable families and would be interested in joining the forum. He also shared details of a deeply concerning situation affecting a vulnerable client who had attempted to end their life on multiple occasions. He reported that he had raised a serious safeguarding concern through PALs (Patient Advice and Liaison Service) with WLT and received

responses that were entirely unhelpful and unconstructive. Helen Mangan apologised for the experience and offered to assist.

ACTION: Helen Mangan to contact Keith Mallinson with details of the forum and to help address the safeguarding concern outside the meeting.

8.8 Jim Grealy noted that this was an ambitious program but lacked data which made it difficult to identify the baseline. Given the council's commitment to equalities it was concerning that there was an absence of poverty and ethnicity data that would be helpful in supporting sections of the community which experienced health inequality and did not trust the NHS as an institution. A final observation that it conveyed a "top down" approach, that the patient voice was absent and little co-production. An inclusive, co-produced approach meant that service provision and decision making was better informed. Wendy Lofthouse welcomed the observation about the report lacking data and that this would be covered as part of the work of the ICP which they would discuss with the committee at the next meeting (November 2021). She highlighted the work of Safe Space Hammersmith, a local hub that was community space offered by MIND.

8.9 Lucia Boddington reference paragraph 3.1 of the report and asked about the timeframe of a referral to CAMHs being 18 weeks for treatment. However, realistically there were very long delays for CAMHs treatment. She asked if WLT were recruiting more psychologists. There was a two-year timeframe for an Autism Spectrum Disorder (ASD) or Attention Deficit Hyperactivity Disorder (ADHD) diagnosis from CAMHs. She asked about what the timeframe for support was for 18-25 year olds who were transitioning, given that a number of 17 or 18 year olds sometimes fell through the gaps in service provision, and what ongoing treatment there was once a child reached the age of 18 and if this would be provided by MINT. Helen Mangan explained that there was a moderate amount of funding available to complete the model of care by December 2021 and a local implementation group would take this forward. It was confirmed that MINT would pick up 18-year olds and upwards. While there was a detailed transition process this formed part of a wider discussion than could be undertaken at the meeting. Where an 18-year-old presented in advance of their 18th birthday, it was likely that they might be picked up by adult services. Lucia Boddington felt that this was not what happened in practice in h&f.

ACTION: WLT to provide in formation in relation to the timeframe for treatment for ASD / ADHD similarly for 18-25 year olds who were transitioning.

8.10 Councillor Lloyd-Harris enquired about the eating disorder service for 18-25 year olds and commented that in her experience, that considerable work was required if they were going to be referred to Improving Access to Psychological Therapies (IAPT), which was currently limited to six sessions which was insufficient. She reported that many of her clients had issues that had escalated because they had not been able to access IAPT. They were also not able to see their GPs as there appears to be a

perception in some practices that an eating disorder was not a significant medical condition. She asked the Trust (WLT) that when this work was progressed it included a review about the number of IAPT sessions available. Councillor Lloyd-Harris also sought further information about Safe Space Hammersmith. Wendy Lofthouse outlined the operational aspects of the self-referral service which was from 6-8pm, seven days a week, open to 18+ year olds and based in Lillie Road, Hammersmith. The intent was to see people who were relapsing or in danger of crises and it was hoped that this would offer a different pathway and avoid A&E. Councillor Lloyd-Harris reported anecdotally that a client contemplating ending their life had not been able to access the service and her concern that the support was not available to a young person in crises. Linda Stradins explained that secondary care eating disorder services were provided by CNWL, from the Vincent Square site. However, the MINT service was expanding their offer to include support for people with an eating disorder in conjunction with other co-morbid conditions.

8.11 Councillor Richardson observed that it would be helpful to have information about preventative services in the borough which would help to gain a fuller perspective as to what was available.

ACTION: WLT to share details about the Safe Space Hammersmith service and information through a community asset mapping exercise.

8.12 Merril Hammer commented on the earlier point made about the absence of robust data which was not available. This meant that it was not possible to identify a benchmark to compare and track progress, both in terms of service provision and take up. It was recognised that MINT was a new initiative being funded by new money but without information about what other new initiatives there were, it was hard to draw an informed comparison or to evaluate without historic data.

8.13 Councillor Richardson summarised a request to WLT based on the discussion to provide data which provided information about what services where available in the borough, the diversity and background of people accessing services, what the different types of referral were (self-referral or GP).

8.14 Councillor Coleman focussed on specific points that had been highlighted during the meeting. He welcomed the positive perception of the vaccination bus and how effective it had been in vaccinating groups that were resistant. This work was currently on pause due to the unavailability of enough vaccinators. Commenting on the mental health updated provided by WLT, Councillor Coleman welcomed the insights offered by the committee members in terms of coproducing provision with programmes like Safe Space and MINT. He felt that this important work needed to embody the ethos of doing things with people rather too them, a powerful point emphasised by the committee.

RESOLVED

That the committee noted the report and actions as set out.

9. WORK PROGRAMME

The following items would be brought to the November and January meetings of the committee:

- Covid-19 update - vaccination
- WLT data provision on services and local take up;
- Update on the ICP mental health campaign

10. DATES OF FUTURE MEETINGS

The next meeting of the committee was confirmed as 10 November 2021.

Meeting started: 6.30pm
Meeting ended: 8.48pm

Chair ....

Contact officer: Bathsheba Mall
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London Borough of Hammersmith & Fulham

Report to: Health Inclusion and Social Care Policy & Accountability Committee

Date: 10 November 2021

Subject: Mental Health Services Update

Report of: Dr Christopher Hilton, Executive Director of Local Services
Helen Mangan, Deputy Director of Local Services
West London NHS Trust

Responsible Director: Dr Christopher Hilton

Summary

This report aims to provide members with insight into the range of available mental health services delivered for Hammersmith and Fulham residents and to improve opportunities to understand care pathways, and to provide a snapshot referral demand and service challenges.

Recommendations

For the Committee to note and comment.

Wards Affected: All

H&F Values

Our Values	Summary of how this report aligns to the H&F Priorities
• Creating a compassionate council	Better supporting residents with a wide range of mental health needs to receive timely and effective support

Contact Officer(s):

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West London NHS Trust

Background Papers Used in Preparing This Report

The attached Appendices of performance and activity information has been prepared at the request of the Committee Chair by the Business Intelligence Team in West London NHS Trust, and will be referred to in the report.

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1. **Background**

1.1 West London NHS Trust is the main NHS provider of mental health services in Hammersmith and Fulham, working closely with Hammersmith and Fulham Council and other partners in the Hammersmith and Fulham Integrated Care Partnership.

1.2 West London NHS Trust is one of the most diverse healthcare providers in the UK and delivers a range of mental health, physical healthcare and community services for children, adults and older people living in the London boroughs of Ealing, Hammersmith and Fulham, and Hounslow. The Trust also provides a number of regionally and nationally commissioned specialist and forensic mental health services. The Trust serves a local population of 800,000 residents and employs 3,982 staff.

1.3 Local and Specialist Services and organised into clinical service lines, each overseen by a clinical director:

- Child and adolescent mental health services
- Psychological medicine services, including psychological therapies (Back on Track)
- Acute mental health services (including the Single Point of Access, Crisis Teams and Inpatient mental health services)
- Community and recovery mental health services
- Older people's mental health services (both inpatient and community)
- Integrated care services

1.4 This report examines services from our service lines, in respect of healthcare provided to citizens in Hammersmith and Fulham, with the exception of:

a. Community and recovery mental health services for adult patients and older persons mental health care – this is because a separate report is planned for a future meeting into the transformation of mental health services into Mental health Integrated Network Teams (MINT) in line with the NHS Community Mental Health Framework for Adults and Older Adults.
b. Integrated care services – this is because this service line primarily provides physical healthcare (for example our Community Independence Service in Hammersmith and Fulham) and is out of scope for this report.

1.5 The aim is to provide members with insight into the range of available services delivered and to improve opportunities to understand care pathways, and to provide a snapshot referral demand and service challenges.

1.6 The Committee chair invited focus on a range of areas and this report seeks to respond to the following areas of inquiry:

- Information about numbers of people accessing mental health services, categorised by demography e.g.: ethnicity, locality, gender, age
- Demand for mental health provision post-Covid, including which services have seen particular increases, what the capacity has been

for meeting the demand and any barriers to people accessing services
- Sources of information available to patients in terms of signposting services and access points
- How demand is measured
- Any increased demand for mental health crisis services
- Plans to manage and predict future demand, and short-term actions to meet demand and plan resource requirements for the future
- The impact of the introduction of the North West London Integrated Care System in 2022 upon service operations and where mental health services sit within the framework of the ICS.

2. Demographics

2.1 The information contained in the appendix section 1, illustrates the demographic profile of patients accessing IAPT (Back on Track), Crisis Care, Older People's Care and CAMHS services.

2.2 The Trust is undertaking a range of initiatives to compare the demography of individuals accessing our services to the demography of the local population, and to modify our services better to meet the needs of local communities. The Ethnicity and Mental Health Improvement Project is one example of this, and our increasing partnership with voluntary sector and community organisations with whom we work jointly to improve our reach.

3. Child and adolescent mental health services

3.1 We provide mental health care for children and young people in Hammersmith and Fulham. To note that neurodevelopmental diagnostic pathways (e.g. for Autism) do not sit with the Trust, these are delivered locally by Chelsea and Westminster Hospital NHS Foundation Trust through the Cheyne Child Development Centre.

3.2 The data in the appendix section 2 show referrals went down by 16% last year (during Covid) but demand has risen by 30% this year.

3.3 Demand has increased overall, and the services also observe a greater degree of clinical complexity in referrals received.

3.4 Demand has increased across all pathways in CAMHS, except for Tier 2 which remains in line with previous years (fairly consistently). Two years ago, the CAMHS Outpatients Team divided into two areas of Specialist CAMHS (Children and Families Team and the Adolescent Team), which explains the changes in reporting between 2019 and 2020.

3.5 The Mental Health team for children with neurodevelopmental needs, has seen largest growth, related to co-morbid mental health needs associated with autism, ADHD and Tic Disorders.

3.6 Capacity has remained largely the same – but NHS England Long Term Plan and reinvestment from our leadership of the specialist commissioning Provider Collaborative this year means more staff are being employed.

3.7 Recruitment remains a challenge across CAMHS nationally, however, and we are struggling to fill the number of new posts we have available (the position is similar in neighbouring Trusts and across London). However, we continue to meet waiting time targets.

3.8 In Alliance (our home treatment team) this is 7 days – most are seen well within this.

3.9 For other teams the target is 18 weeks to second appointment (126 days) and we are meeting this at <70 days.

3.10 Covid-19 restrictions meant a shift to offering an increased range of work digitally during the pandemic, and for many pathways this has remained in place. This is not the best option for all, and where indicated face to face has always been offered. Some families prefer digital, but issues like digital poverty and literacy and socio-economic differences have become more evident as a result of the pandemic.

3.11 The majority of young people accessing CAMHS in H&F come from 'other' heritage, with the second being white British. We are actively engaging with local communities (e.g. local Somali community recently to increase understanding of CAMHS).

3.12 We have information coproduced with young people on our Trust website and engage with local referrers, through GP forums.

3.13 We have written to all school head teachers reminding them of the CAMHS offer.

3.14 A new Crisis Helpline "Speak CAMHS" (**0800 328 4444 – option 2**) has been developed and is widely advertised including to all schools, primary care and MPs.

3.15 CAMHS accept referrals from any professional involved with a young person, not just GPs or schools.

Recent key developments:

- Speak CAMHS Helpline launched. Named in collaboration with service users.
- Engagement with local communities – e.g. Somali Community Links, Tier 2 Manager interviewed on a podcast for local youth group
- "Best for You" project launched – we are working with CW+ charity to develop expanded digital service for children's mental health and wellbeing including early help, and access for professionals to a curated library of health and wellbeing apps
- The Trust successfully took on the Lead Provider role for the North West London Tier 4 CAMHS Provider Collaborative in October last year – this successfully delivered an expansion in Crisis and Eating Disorders services, led to the development for the first time of specialist inpatient services in North West London (adjacent to Chelsea and Westminster Hospital) we are seeking further to expand the bed base for the NWL sector.

4. **Psychological medicine services (Back on Track)**

4.1 The data in the appendix section 3 show that after a significant drop in demand during Wave 1 of the pandemic the service has seen sustained increase in demand and is now at the highest levels the service has ever experienced.

4.2 This is believed to be primarily due to a backlog of demand from 2020/21 when many people did not access healthcare due to the Covid pandemic. From Feb – June 2020 our rates of referral fell significantly, for many different reasons, including some people managing without help because they didn't want to burden the NHS or were too anxious about Covid or couldn't prioritise their own mental health with everything else happening. Some of these individuals are now coming forward to seek help, once society began to reopen and vaccinations were available. It also coincided with more people returning to work in person – and that has been a trigger for some to seek help (e.g. agoraphobia, social anxiety getting worse with the move to greater social interactions).

4.3 **Capacity:** The increase in demand has coincided with planned expansion. The service currently has commissioned capacity for approximately 750 referrals per month and from Jan 2022 onwards they are due to expand and will have capacity for 850 referrals per month. Currently referral rates are 900-1000 per month so even after the next step of expansion if referrals continue at current rates demand will continue to outstrip the commissioned service capacity. At the moment this is most evident with increasing waiting times for treatment, particularly for longer-term treatments at Step 3.

4.4 **Additional expansion of the service is required in 2022/23 in order to align with** NHS England (Five Year Forward View) trajectories but dates for this have not yet been agreed by NWLCCG.

4.5 There are also some recent concerns about recruiting to all of the new posts due to start in Jan 2022, but the service is working with our recruitment teams and sub-contracted partner services in order to manage this.

4.6 **Barriers:** There are a number of barriers that the service has identified: stigma associated with seeking psychological treatment (particularly in specific communities including some BAME groups), reluctance to burden the NHS during the Covid pandemic, tendency to 'live with' mild to moderate mental health symptoms and only seeking help when they are more severely unwell and may no longer be able to benefit from shorter-term Back on Track interventions. There are also barriers created due to current IPC rules. The service provides telephone, video or face-to-face appointments. But for face-to-face treatment both service user and therapist must wear a face mask. Many service users find this a barrier to therapy and this has led to large numbers choosing virtual appointments.

4.7 **Sources of information:** There has been a NWL-wide communications campaign (nhsTalk2us.org) to increase knowledge of IAPT services following drops in referrals during the pandemic. This has included production of leaflets, posters, a website and social media campaigns. Back on Track accepts self-referrals and can be contacted by telephone or via an online form. GPs and all

other medical and social care professionals can make referrals to the service via online referral forms.

4.8 **Service pathway and patterns of referrals:** Over the past few years the number of people self-referring to the service has increased as a proportion of total referrals.

4.9 Currently 76% of all referrals are self-referrals and 16% of referrals originate from GPs.

4.10 The remainder originate from a large variety of services (e.g. respiratory team, health visitor, pain/MSK service, social prescriber link workers, maternity services, post-Covid assessment clinics) as well as other mental health services.

4.11 The increase in self-referrals has been extremely beneficial to allow rapid access and reduce barriers to access psychological therapy. It does make it harder to interpret patterns of referrals because the figures are dominated by self-referrals and referrals originate from such a wide range of services.

5. Acute mental health services – single point of access

5.1 The West London NHS Trust's mental health Single Point of Access (SPA) (**0800 328 4444**) provides 24/7/365 access to mental health advice and support for patients, carers and professionals.

5.2 The aim of the service is to provide and co-ordinate a rapid response for people in crisis or with an urgent need of help, deliver earlier intervention, and improve the access to and response of secondary mental health care for local people.

5.3 Where a patient needs secondary adult mental health services, the SPA accesses the local Crisis, Assessment & Treatment team for any case that requires a response within 24 hours. For those people who require a routine 28-day assessment the SPA will make a referral to the appropriate team. It provides advice, signposting and short-term telephone support where on-going input from secondary mental health service is not required.

5.4 As the data in the appendix section 4 show, the Single Point of Access Service (SPA) has had a significant increase in the number of calls from Hammersmith and Fulham residents in the last 18 months and we certainly saw a peak during Covid lockdown and post lockdown. From the current projections, there is a further expected increase in calls into SPA given the need for mental health provision post Covid. The service has also seen an upward trend in the number of referrals received through the SPA route.

5.5 **Performance:** There is an expectation that calls are answered in 30 seconds. All callers to the SPA, who are not answered within 30 seconds, have the option of using a call-back facility

5.6 During the Covid pandemic, we increased our complement of Mental Health Advisors and Band 6 and 7 clinicians by 5 staff per day to meet the additional demand and improve response time.

5.7 As of the month of September 2021, we were at 66% calls answered within 30 seconds and at 90% on the number of answered calls successfully before the caller abandoned the call.

5.8 This KPI has been impacted on the complexity of calls we get through our Crisis line, which would then require a Mental Health Advisor to spend more time on the phone while supporting a service user in crisis.

6. Acute mental health services – crisis assessment and treatment teams, and inpatient care

6.1 The crisis assessment and treatment team (CATT) provides rapid interventions for individuals in mental health crisis, including those with suicidal thoughts and plans, within 4 – 24 hours of referral, and supports individuals at home through regular visits and contacts as an alternative to admission to inpatient psychiatric care. It is nationally agreed best practice that treatment at home is considered before any admission is arranged to a psychiatric bed – a process known as "gatekeeping".

6.2 The H&F CATT has experienced a 15% increase of referrals within the last 18 months. The data provided in the appendix, section 5, show the timing of this increase appears to be in line with the end of the first and second Covid waves. Our hypothesis is that that during the lockdown periods there was a reduction in informal and professional community support, and this may have impacted upon need for crisis interventions.

6.3 The team recruited additional temporary staff to meet increased demands. Capacity has also been created through transfer of some lower urgency activity into our MINT teams to release capacity to meet urgent care demand.

6.4 The team reflected that some barriers to accessing crisis care relate to Covid-related changes to Emergency Pathways with individuals discouraged from accessing over-burdened urgent care pathways. This may have contributed to mental health patients not accessing help and support in a timely manner.

6.5 The team also observed that patients with no fixed abode have historically experienced delays access to timely support, although recent targeted investment in Rough Sleepers Mental Health teams has sought to address this.

6.6 Crisis mental health pathways are also reliant upon close collaboration with Local Authority staff, and pressures upon out of hours' social services / Emergency Duty Team / Approved Mental Health Professionals can contribute to delays in assessments or access to services.

6.7 The H&F Partnership Primary Care Network is the highest user of H&F CATT, and the ethnic group with the highest number of presentations is White British in comparison to Black and Asian and other groups. Patients aged between 25 and 49 years have the highest number of referrals to CATT.

6.8 West London NHS Trust has 82 beds for adults (general and psychiatric intensive care) and older adults in the mental health unit co-located with Charing Cross Hospital, and operates the overall bed base of over two local mental hundred beds, and our 17 bedded Recovery House in Ealing, across a

three borough footprint to provide flexibility to ensure patients are admitted within the local system where required. This has supported the trust to have no unwarranted out of area admissions for over two years, even when wards were closed to admissions due to Covid-outbreaks at the height of the pandemic.

6.9 The data in the appendix, section 6, show steady demand for acute psychiatric beds for Hammersmith and Fulham residents, but periods of high rates of delayed discharges (DTOCs) attributable to health and social care. The Trust is seeking to work closely with the Local Authority partners to address pathway delays.

Recent key developments:

6.10 The Trust has partnered with Hammersmith, Fulham, Ealing and Hounslow Mind to provide a Safe Space for local people in Hammersmith and Fulham, The service provides a safe and more appropriate alternative to Accident and Emergency departments for people who are in or near mental health crisis. Trained staff are available to provide support and advice in an informal setting at 309 Lillie Road.

6.11 The service is available to anyone over the age of 18 years who lives in or is registered with a GP within Hammersmith and Fulham (similar services are also available in Ealing and Hounslow). They can self-refer, call or email to book an appointment or to get advice or they can drop-in.

7. **The impact of the introduction of the North West London Integrated Care System in 2022 upon service operations and where mental health services sit within the framework of the ICS**.

7.1 Subject to legislation, the North West London Clinical Commissioning Group is expected to be replaced in April 2022 by the North West London Integrated Care System (comprising an Integrated Care Board (ICB), and an Integrated Care Partnership (ICP)) gaining statutory status.

7.2 A number of additional partnership and delivery structures will operate within the ICS at a system, place and neighbourhood level.

7.3 Within ICSs, NHS providers are also expected to work together at scale through Provider Collaboratives.

7.4 West London NHS Trust is working in partnership with Central and North West London NHS Foundation Trust (CNWL) in an emerging **Mental Health, Learning Disabilities and Autism Provider Collaborative**.

7.5 The two Trusts have numerous examples of partnership working across North West London to improve mental health services, and over the last 18 months developed a joint Partnership Programme to oversee, in shadow form, mental healthcare purchased outside of the two organisations. The primary aim of this is to improve links for patients placed outside of the local system (particularly in relation to long term and complex mental health care needs, for example for mental health rehabilitation) with local services, and to ensure that every opportunity is taken to offer care closer to home and that expensive placements are reviewed regularly.

7.6 NHS Mental Health Services across North West London are overseen by a Mental Health, Learning Disabilities and Autism Board, which has a number of experts-by-experience, representatives of local authorities and primary care within its membership.

7.7 At borough level, the Trust is a member of the **place-based partnership in Hammersmith and Fulham**, and in future it is anticipated that this ICP will continue to oversee local commissioning of voluntary sector activity, joint work with Local Authorities, and under the oversight of the Health and Wellbeing Board, and ensuring local mental health and community services work alongside primary and social care to meet the needs of the local population.

8. The Committee is invited to note and comment upon the report.

Dr Christopher Hilton
Helen Mangan

List of Appendices:

1. Data pack

NHS West London NHS Trust

H&F HISPAC meeting 29/10/2021

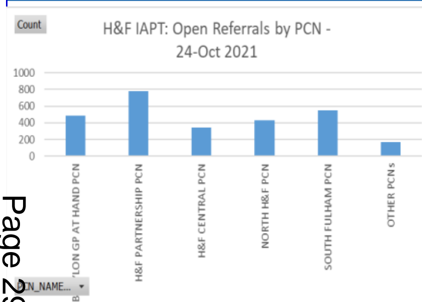
Hammersmith & Fulham Demographics and Mental Health Demand

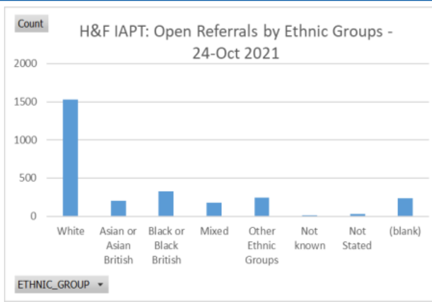
1.Demographics

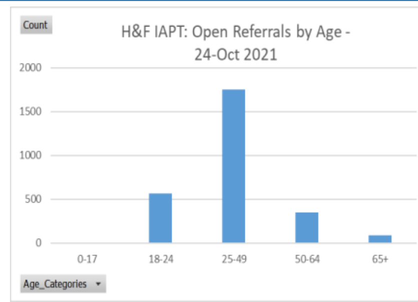
NHS West London NHS Trust

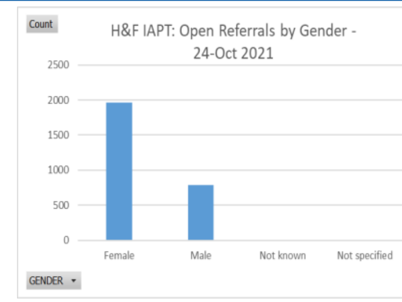
Hammersmith & Fulham - Open Referrals as at Oct 24, 2021- Demographic profile

IAPT

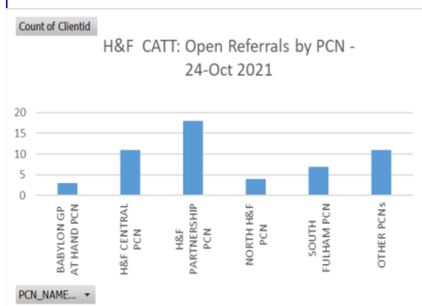


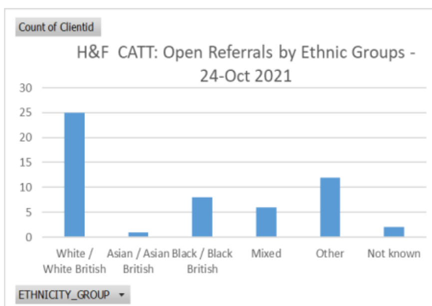


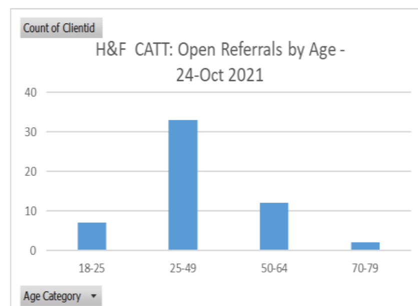


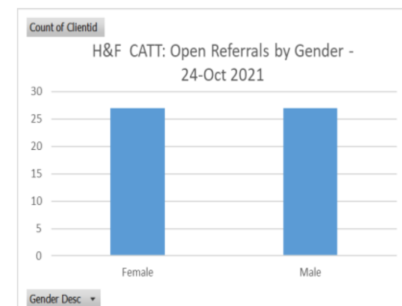


CATT





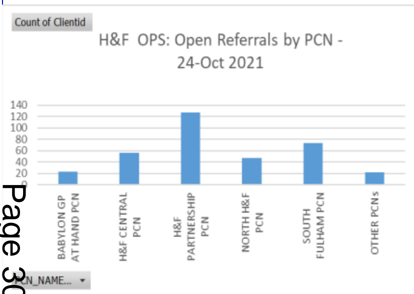


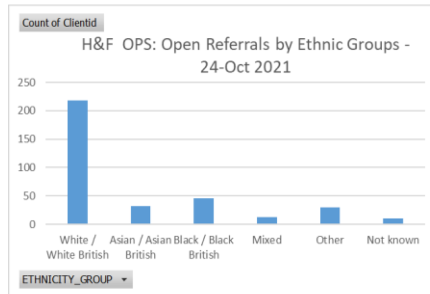


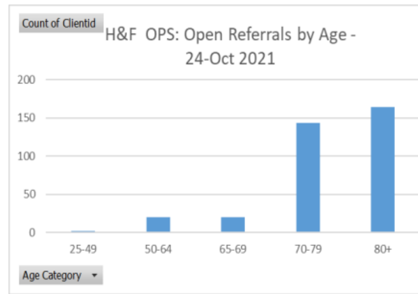
1.Demographics….cont

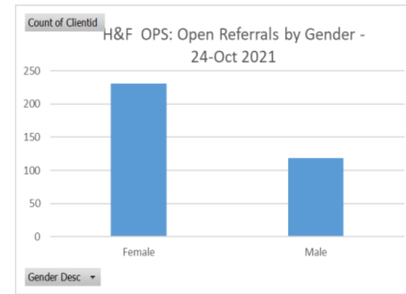
West London NHS Trust

Older Peoples

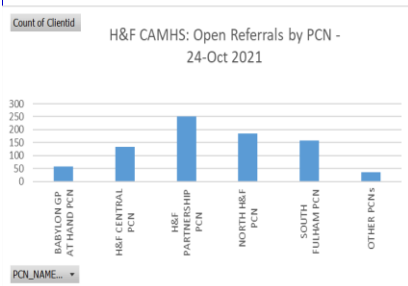


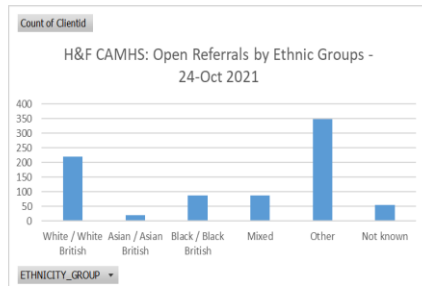


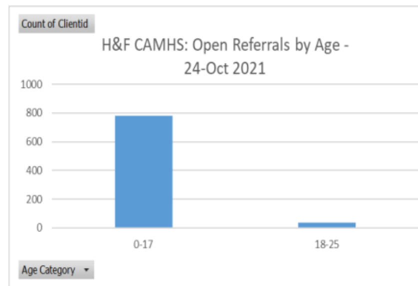


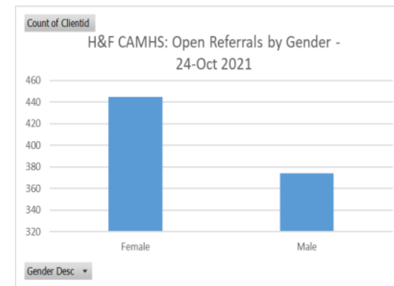


Children & Adolescent MH services





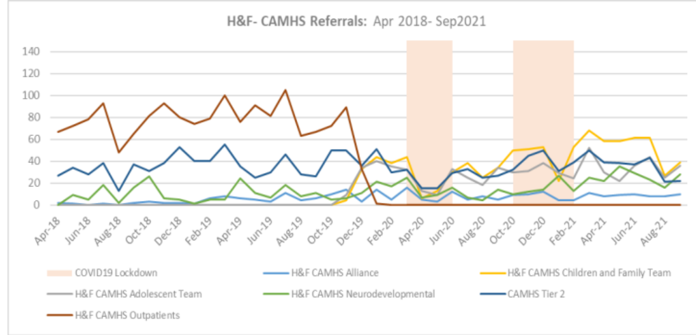




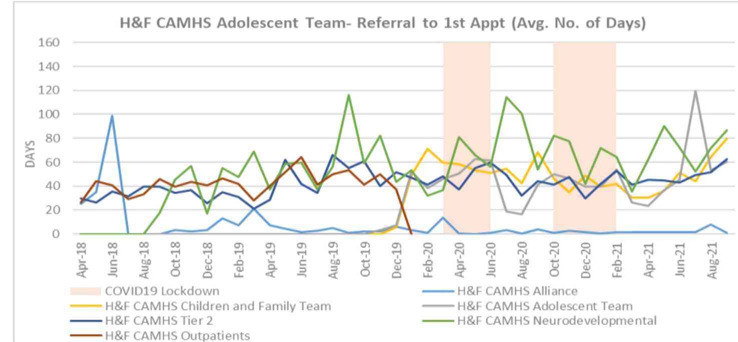
2.Demand- CAMHs

NHS West London NHS Trust

1. Referral demand -



2. Response time -



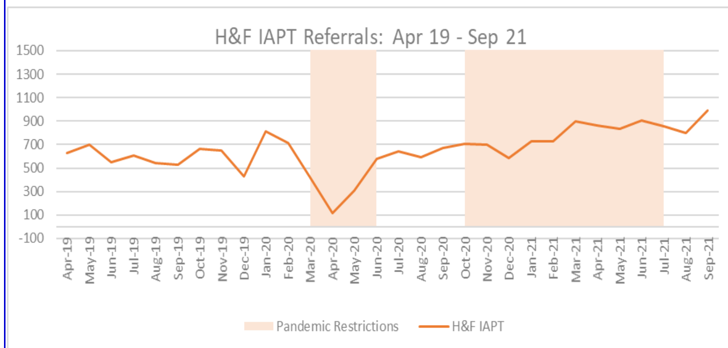
	2018/19	2019/20	2020/21	2021/22 ytd *6mths	
H&F CAMHS Alliance	28	97	88	55	
H&F CAMHS Adolescent Team	0	150	336	197	
H&F CAMHS Children and Family Team	0	163	443	306	
H&F CAMHS Neurodevelopmental	98	164	158	158	
H&F CAMHS Outpatients	930	678	0	0	
H&F CAMHS Tier 2	434	439	391	202	
Total H&F CAMHS	**1490**	**1691**	**1416**	**918**	
% Growth (yr)	**10%**	**13%**	**-16%**	**30%**	Forecasted for year

	Ref to 1st Appt (Days)			
	2018/2019	2019/2020	2020/2021	2021/2022
H&F CAMHS Alliance	19.0	5.4	1.6	2.8
H&F CAMHS Adolescent Team	-	42.5	42.2	50.1
H&F CAMHS Children and Family Team	-	52.2	45.6	49.1
H&F CAMHS Neurodevelopmental	49.5	53.7	65.9	80.4
H&F CAMHS Outpatients	38.4	47.5		
H&F CAMHS Tier 2	31.7	47.4	44.9	50.0
Total H&F CAMHS	**35.0**	**43.2**	**42.1**	**47.9**

3.Demand- IAPT

NHS West London NHS Trust

1. Referral demand - IAPT H&F

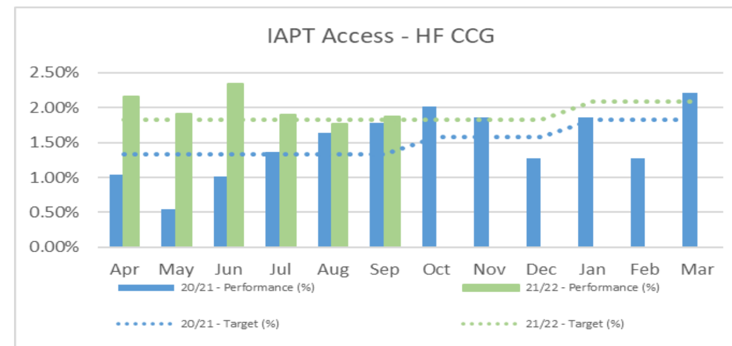


LSSMT report

	2018/19	2019/20	2020/21	2021/22 ytd *6mths
H&F IAPT Referrals	7035	7249	7247	5253
% Growth (yr)	**12%**	**3%**	**0%**	**40%**

Forecasted for year

2. IAPT Access Rate



LSSMT report

3 Response Rates

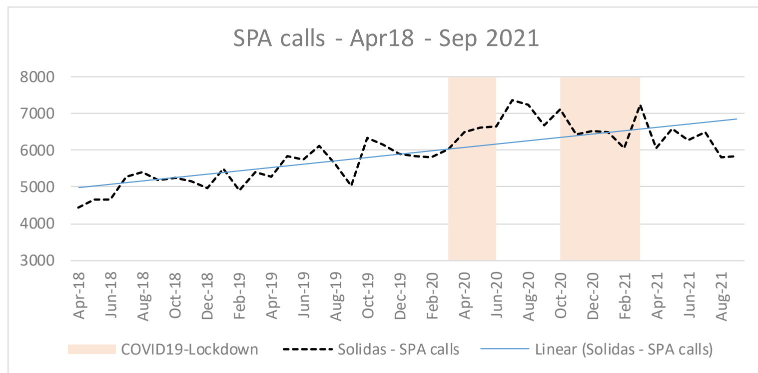
Measure	Target	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Proportion of people moving to recovery	>=50%	48.0%	48.7%	53.6%	48.1%	52.5%	55.4%
Treatment waiting time within 6 weeks	>=75%	90.7%	89.8%	95.7%	93.6%	93.9%	93.1%
Treatment waiting time within 18 weeks	>=95%	100.0%	99.6%	100.0%	99.6%	99.6%	99.8%

CCG Report

4.Demand- SPA

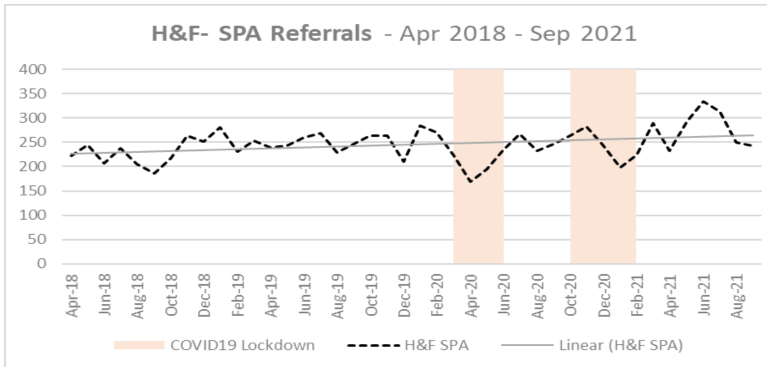
West London NHS Trust

1. Referral demand - SPA Calls (Solidas)



	2019/20	2020/21	2021/22 ytd *6mths
Solidas Calls - SPA	69764	80965	37054
% +/- growth	15%	16%	-8%

2. SPA Referrals H&F

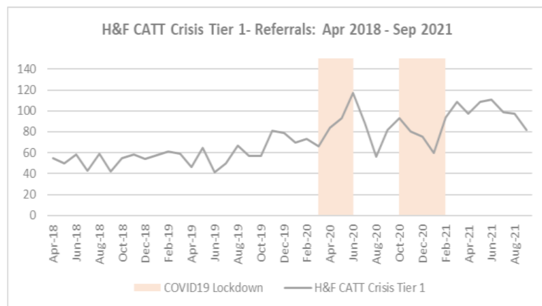


	2019/20	2020/21	2021/22 ytd *6mths	
H&F SPA referrals	3001	2849	1665	
% Growth (yr)	7%	-5%	17%	Forecasted to year end

5.Demand- CRISIS

NHS West London NHS Trust

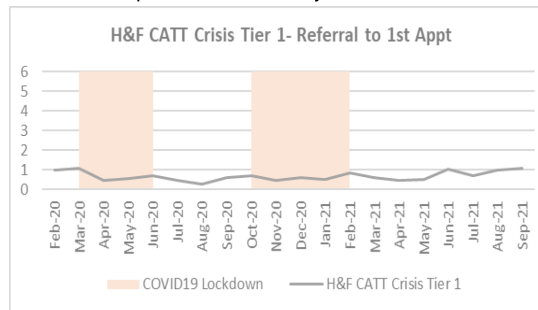
1. Referral demand -CATT



	2018/19	2019/20	2020/21	2021/22 ytd *6mths
H&F CATT Crisis Tier 1	652	752	1031	595
% Growth (yr)	**0%**	**15%**	**37%**	**15%**

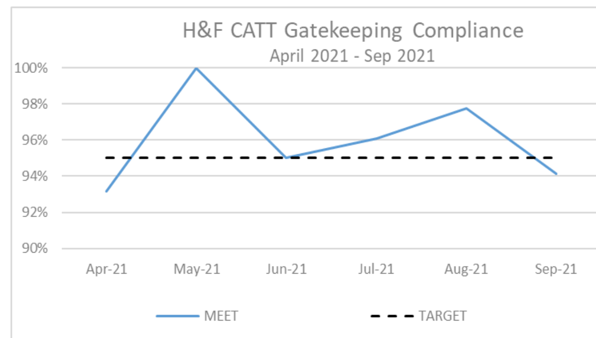
Forecasted for year

2. Crisis - response Times- in days



	Ref to 1st Appt (Days)	
	2020/21	2021/22 ytd *6mths
H&F CATT Crisis Tier 1	0.6	0.8

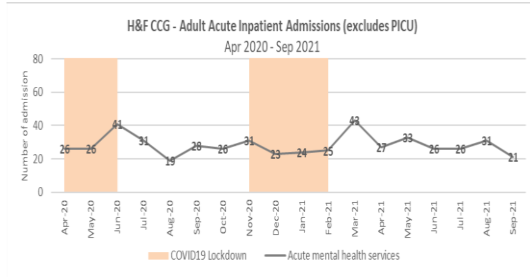
3. Gate keeping



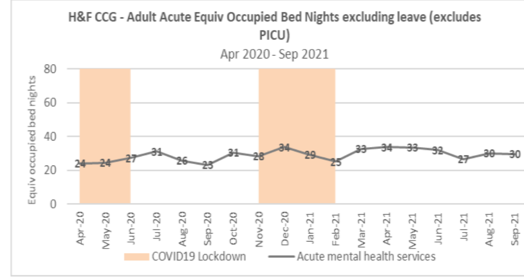
6.Demand- Adult Acute Inpatients

West London NHS Trust

1. Admissions - Acute demand

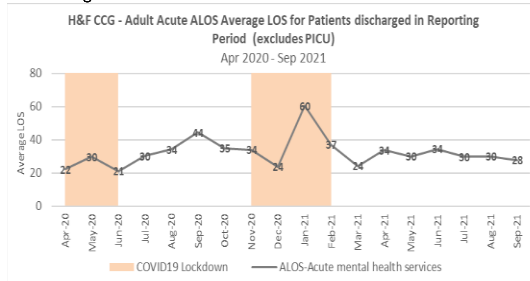


2. Bed Occupancy - Equivalent beds



	2019/20	2020/21	2021/22 ytd *6mths
Adult Acute	347	343	164
% Growth (yr)		**-1%**	**-4%**

3. Average LOS



Agenda Item 7

Disabled people's housing strategy 2021

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Foreword

We've listened to what disabled residents have told us about the changes needed in housing. We know how important it is to do things with residents, not to them. That's why we have co-produced this strategy.

We're determined to provide accessible housing, and services, which work for disabled residents. For that purpose, we listened to the Disabled People's Commission. The commission looked at ways of improving public services in Hammersmith & Fulham. In 2018 the commission published their final report, '*Nothing About Disabled People Without Disabled People*'. The report recommended co-production with disabled residents. To that end, we set up a working group with disabled residents to create this strategy together.

We know that disabled people know best about what they need in housing. It was important that we heard from as many disabled people in our housing as possible. That's why we also set up focus groups, to have in-depth discussions about housing issues. Those discussions highlighted key points which now shape our action plan. Disabled residents will now work with us to carry out that action plan.

We have made four key commitments in this strategy. We will create a culture of co-production with disabled residents and work together with those residents to improve their influence in shaping housing service. We will improve access to housing information with disabled residents including housing options and housing services. We will also improve the council's services as a landlord for disabled residents. Finally, we will identify ways to increase the supply of accessible and affordable housing to meet the needs with disabled residents. Our action plan explains exactly how we will work with disabled residents to fulfil these commitments.

We are committed to working with disabled residents on issues that affect them – together we will deliver the housing and services disabled residents want and need. This strategy is also the start of a new way of working better together – towards true co-production.

Councillor Lisa Homan
Cabinet Member for Housing
Hammersmith & Fulham Council

Overview

Summary

This strategy addresses how Hammersmith & Fulham Council (H&F) will work to ensure the best housing outcomes for disabled residents in the borough and puts into action some of the recommendations of the Disabled People's Commission (DPC) in the context of housing service delivery.

The strategy underlines the importance of co-production with disabled residents in service design and review, and the key role good quality housing has in supporting disabled residents to have choice and control in their lives.

The Disabled People's Commission defines co-production as:

"local disabled residents are working together with decision makers; to actively identify, design, and evaluate policy decisions and service delivery that affect our lives and remove the barriers we face"[1]

To achieve the changes and improvements proposed in this strategy, we will work using the Social Model of Disability.[2] The Social Model reflects disabled residents' real-life experience and puts forward a radical and practical approach to ending disabled residents' exclusion that does not require disabled residents to change who they are in order to be deemed to be entitled to the same rights and opportunities as non-disabled residents.

The Social Model of Disability recognises that people with impairments are 'disabled' by the physical, attitudinal, economic and environmental barriers in society and therefore the focus should be on removing these barriers.

H&F's vision is to support disabled residents to live as independently as possible (with support where appropriate) and have opportunities to access the appropriate housing options and suitable accommodation that meet their needs.

The council knows that both internal and external partners are critical to delivering the best services with disabled residents in the borough, and this strategy is underpinned by commitments to joint working and creation of a culture of co-production with disabled residents.

[1] Source: 'Nothing About Disabled People Without Disabled People' report, www.lbhf.gov.uk/dpcreport

[2] Source: Inclusion London website, https://bit.ly/2xsglbz

The strategy contains four key objectives:

1. Create a culture of co-production with disabled residents and work together with those residents to improve their influence in shaping housing services
2. Improve access to housing information with disabled residents including housing options and housing services
3. Improve the council's services as a landlord for disabled residents
4. Identify ways to increase the supply of accessible and affordable[3] housing to meet needs with disabled residents

Key actions arise from four objectives, which will continue over the life of the strategy are:

- We will work with disabled residents (and those who support disabled residents) to provide comprehensive information and advice on housing options in H&F
- We will increase disabled residents' participation through our resident involvement work to shape and influence housing services
- We will continue to engage directly with disabled residents to ensure that they are aware of this strategy, their rights and housing options
- We will engage with and strengthen our partnership working with Disabled People's Organisations (DPOs) in the borough, including DPOs run by adults with learning difficulties
- We will continue to improve our homes and services to better meet the needs of disabled residents
- We will continue to review and, where necessary, amend the Local Plan to facilitate the development of new housing to meet the needs of disabled residents
- We will continue to press for Greater London Authority funding to facilitate the delivery of specialist housing in the borough
- We will develop and monitor the quality and availability of signposting information available to disabled residents through housing services
- We will implement service feedback protocols such as exit surveys and feedback forms to help us improve housing services to meet the needs of disabled residents

Attendees at a Hammersmith & Fulham Disabled People's Commission event

[3] See appended glossary for definitions

Introduction

The term 'disabled people', as defined in the Equalities Act 2010, refers to people who have a 'physical or mental impairment that has a substantial and long-term limiting effect on their ability to do normal day-to-day activities'. However, this is a broad definition and individuals' housing and support needs will differ greatly.

We spoke with disabled residents and local organisations to understand the challenges disabled residents face in accessing housing services and information and securing good housing that meets their needs.

This strategy aims to set out the council's approach for meeting the housing needs of disabled residents through provision of housing services shaped and influenced by and for disabled residents.

In a climate of increasing financial challenges for local authorities particularly in social care expenditure, and an increasing demand of an aging population, this strategy emphasises the importance of partnership working and co-production with disabled people and Disabled People's Organisations (DPOs) to develop better information services and streamline processes to deliver better housing services for disabled residents. Our approach will help us anticipate future needs of disabled residents and better plan future housing provision in the borough.

We will aim to provide a range of options; particularly as more disabled people are choosing to remain in their homes. These options include repairs and adaptation services, and the provision of new homes built to meet disabled residents' changing circumstances over a lifetime.

The council are committed to having housing provision for disabled residents fully integrated within housing developments. Housing provision extends beyond the home itself, such as making sure play areas in housing developments are accessible to disabled children and young people (including those with SEN – special educational needs) and their families, and housing management practices which address and prevent discrimination against disabled people.

This sort of investment in housing and related services can reduce the spending on social care and improve residents' wellbeing and quality of life and support independent living as much as possible.

People with unmet need for accessible housing are estimated to be four times more likely to be unemployed or not seeking work due to sickness/disability than disabled people without accessible housing needs or whose needs are met.[4]

[4] Source: LSE Report 'No Place Like an Accessible Home' (July 2016)

The Disabled People's Housing Strategy responds to:

1 **The council's Housing Strategy 2015** which sets out the council's intention to increase the amount of genuinely affordable housing being delivered. The council is currently developing its new Housing Strategy which will emphasise the importance of implementing the principles of co-production.

2 **The Local Plan 2018** which is the borough-wide policy that guides decisions on whether or not planning applications can be granted. For example, the Local Plan contains policies on accessibility and affordability requirements for homes being developed in H&F.

3 **The Disabled People's Commission Report** which contains eight recommendations that help make H&F become the most accessible and inclusive borough in London.

Members of the Hammersmith & Fulham Disabled People's Commission

Vision and objectives

H&F's vision is to create a culture of co-production in housing services to enable disabled residents in the borough to live independently, access suitable accommodation that meets their needs, and have more control over the housing options and housing services available to them.

To ensure this strategy supports the council's delivery of effective people-centred services, it is underpinned by three key principles:

1 Commitment to co-production and shared decision-making

We want disabled residents to work together with us to shape council services to offer better quality housing and related services.

2 Partnership working

We will work together with disabled residents and colleagues in adult social care, social services and the third sector to deliver good housing options. Safe, secure, and affordable housing is essential in delivering better outcomes for disabled residents.

3 People-focused approach

Through applications of co-production principles and partnership working we want to make every contact count, so disabled residents access the right services at the right times for them.

Consultation

In creating this strategy, we worked with members of the **Disabled People's Commission** who helped shape the themes of the strategy.

We also spoke to **Adult Social Care**, **H&F Mencap**, **Safety Net – People First** and crucially, we held three **focus groups** and spoke with disabled residents for first-hand feedback on their experiences and their vision of co-production and working with the council to provide better services to disabled residents in the borough.

Participants at a Hammersmith & Fulham co-production event

National and local context

21 per cent (13.3 million) of people reported living with a disability in 2015/16, an increase from 19 per cent (11.9 million) in 2013/14. Most of the changes over the two years came from an increase in working-age adults reporting a disability (16 to 18 per cent).[5]

The prevalence of disability rises with age: in 2015/16, 7 per cent of children were disabled, compared to 18 per cent of adults of working age, and 44 per cent of adults over state pension age. There are more disabled women than men in the UK.[6]

In London, the Mayor's draft New London Plan 2017 includes requirements for 10 per cent of all new build housing in London to be wheelchair user dwellings (wheelchair adaptable or wheelchair accessible), and the remaining 90 per cent to be accessible and adaptable dwellings (previously lifetime homes standards.)

In Hammersmith & Fulham, the largest predicted population growth over the next 10 years is expected to be of the over 85 age group although the number of people aged 65 to 85 is also expected to grow by a fifth.[7]

The September 2016 Strategic Joint Needs Assessment (JSNA) noted that the likelihood of having a disability increases with age, and that the large number of working age residents in the borough means the 45 to 64-year-old age group has the largest number of people reporting long-term illness or disability. This is backed up by the national trends highlighted above.

People are living longer and at the same time there is a gradual shift in the older population of people living longer with disabling barriers. Just over 51 per cent of older people living in the borough stated that their day to day activities were limited (either a little or a lot).[8]

The 2011 Census shows that, in respect of physical disabilities, 12.6 per cent of Hammersmith & Fulham's residents reported having long-term illness or disability (14.7 per cent in 2001). The percentage by ward ranges from 9.9 per cent in Parsons Green and Walham to 15.8 per cent in Wormholt and White City.

As regards learning difficulties, the Learning Disabilities JSNA shows that there were 1,014 people aged 18 to 64 with a learning disability known to Adult Social Care in 2013/14.

Particularly important to note is that, in the same period, 14 per cent of people with learning difficulties receiving services and support from Adult Social Care were aged 65 and over.

[5] Source: Department for Work and Pensions – Family Resources Survey 2015/16
[6] Source: Department for Work and Pensions – Family Resources Survey 2015/16
[7] Source: GLA population projections 2014
[8] Source: 2011 Census, Office for National Statistics DC3404EW

Covid-19

The relationship between housing and public health is well known. The Covid-19 coronavirus pandemic has seen housing services across the country respond to the biggest health crisis that the UK has faced this century. The virus has impacted residents of Hammersmith & Fulham in many ways. In this crisis, we have been working hard to mitigate risks for some of our residents who have required additional support during the pandemic.

Residents have made big sacrifices to keep themselves and their loved ones safe. Many people in shielding groups, and those that have had to self-isolate, have spent months in their homes. This period at home has highlighted how housing quality, accessibility of services and housing suitability affect our mental health and wellbeing.

We as a council have also made changes to prevent the spread of the virus, including:

1. **Adapting quickly to provide services online.**
2. **Getting 'Everyone In' and supporting rough sleepers.**
3. **Reducing risks while making sure our services keep running and remain accessible to residents.**
4. **Looking at ways of reducing loneliness and isolation.**
5. **Engaging with community groups online and making sure that residents have the support to access online meetings.**

We are facing changing and challenging times in the future. But, as we've shown, we won't let this stop us providing high quality housing and inclusive services to disabled residents.

Objectives

Objective 1 – introduce a culture of co-production with disabled residents to shape housing services

Background

The council is committed to working closely with disabled residents to make decisions about the support and services they receive. The council set up the Disabled People's Commission (DPC), which was made up of 10 disabled people. The DPC delivered its report which was unanimously approved at Cabinet in December 2017.

The report '*Nothing About Disabled People, Without Disabled People*' contains eight key recommendations focusing on creating a culture of co-production within the council. Members of the commission have been directly involved in shaping the Disabled People's Housing Strategy, chairing focus groups and providing critical feedback throughout.

One of the fundamental tenets of co-production in the report is empowering disabled residents to work together with the council to identify barriers for disabled people, co-produce solutions to these barriers and review the solutions after implementation.

In addition, there are statutory duties on local authorities to involve the public in their decision-making at an early stage. This is underpinned by the Public Sector Equality Duty which flows through all decision-making and requires proper consideration of, and engagement with, disabled residents affected by policies and decisions.

To demonstrate our commitment to co-production we can point to, and build on, the work on the West King Street Renewal project. Council officers worked in partnership with a team of disabled residents from pre-application engagement, inclusive design discussions to meaningful engagement throughout the evolution of the project. This significant achievement included a statement on co-production which addressed successes and challenges of the collaborative effort that led to delivery of a fully accessible development for all.

Artists impression of the West King Street Renewal project which was co-designed with disabled residents

What is co-production?

The Disabled People's Commission's report explains that co-production is "working together means local disabled people living in an area are working together with decision makers. Co-production means disabled residents and decision makers together planning, designing and reviewing policy and services that affect our lives to get rid of barriers."

Co-production is different from consultations, reviews and surveys which are often undertaken as ways of gauging views to shape an outcome or decision. Members of the DPC, and other disabled residents we engaged directly in creating this strategy, were clear that co-production is a combination of many elements together as part of a successful working relationship between the council, disabled residents, and the wider community.

For most local authorities, to realise true co-production involves a step-change from the current way of doing things. It also requires building capacity of disabled residents to be involved in co-production (working together) with professionals.

This housing strategy will initiate that change in housing and we are aware that co-production is a journey. The strategy's key actions will be approached through the principles of co-production particularly the first steps of continuous engagement, consultation, and co-design.

Many disabled residents have told us they will welcome this new approach. However, the council is aware of the challenging task ahead in bringing more disabled residents on board. This was highlighted in our focus group sessions with disabled residents. Many disabled residents told us that there had been many years of perceived apathy and lack of engagement with them and that the council will have to regain their trust through action and delivery on commitments. We are committed to building trusted relationships with disabled residents.

We also know that, of the council staff who responded to the DPC's survey, 94 per cent want to involve local disabled residents who get support and/or use council services, in the council's work.

Our commitments

We will…	Which will mean…
Publicise resident engagement and co-production options to disabled residents and Disabled People's Organisations (DPOs)	More disabled residents are aware of the options
Publicise the different DPOs that disabled residents can access in the borough	Stronger relationships with DPOs and the third sector to deliver better services for disabled residents
Develop a co-production strategy with disabled residents to include different levels of engagement	Disabled residents are empowered and involved from the beginning to affect change in council services

Our action plan

Action	Service or team responsible	Outcome
Promote the work of the Resident Involvement Teams particularly the resident involvement groups	Housing Services	Increased awareness of the Resident Involvement Teams amongst disabled residents
Review the recruitment strategy for resident involvement groups so that all groups and activities are explicitly accessible to disabled residents, to increase disabled residents' participation Identify budget for access requirements	Housing Services	Recruitment to groups is more accessible
Implement the updated recruitment strategy for the involvement groups	Housing Services	More disabled residents are recruited to resident involvement groups
Review the impact of resident involvement groups on Housing Services	Housing Services	Measurable impact of the work of the groups on Housing Services
Promote and raise awareness of the work of DPOs in Hammersmith & Fulham	Housing Services/ Housing Solutions/ Adult Social Care	More H&F customers are aware of the work of local DPOs

Action	Service or team responsible	Outcome
Develop a co-production strategy with the full range of DPOs in Hammersmith & Fulham, including DPOs led by people with learning difficulties	Housing Strategy to coordinate and liaise with relevant stakeholders	Closer working between the council and DPOs
Develop ways of gathering information about housing from disabled residents	Housing Services	More information held by the council on housing for disabled residents

Possible measures

- Number of disabled residents engaged
- Number of disabled residents recruited to groups
- Number of DPOs meaningfully engaged and promoted
- Number and type of changes made in partnership with disabled residents

Attendees at a Hammersmith & Fulham Disabled People's Commission event

Objective 2 – improve access to housing information

Background

The council will make sure that disabled residents applying for housing assistance understand the processes and decision-making mechanisms involved, on a customer journey that is accessible, person-centred, and clearly defined.

The Public Sector Equality Duty requires councils and health authorities to advance equality of opportunity between people who share a protected characteristic i.e. disabled person and people who do not share it.

The Disabled People's Commission's 2017 report, *'Nothing About Us, Without Us'* identified lack of accessible information as a barrier to equality affecting disabled residents.

Feedback from focus groups of disabled H&F residents carried out in 2017 and 2018 identified key areas for H&F to improve access to information:

- Clarify the Housing Register, Allocations, and Transfers processes
- Explain the adaptations process
- Identify the different contact points for different services
- Provide information on support services i.e. transition to adulthood
- Explain the full range of housing options available to disabled residents
- Explain the local and legal contexts, "what are our rights?"

Participants in the focus groups also highlighted that housing assessment can appear to be an opaque process.

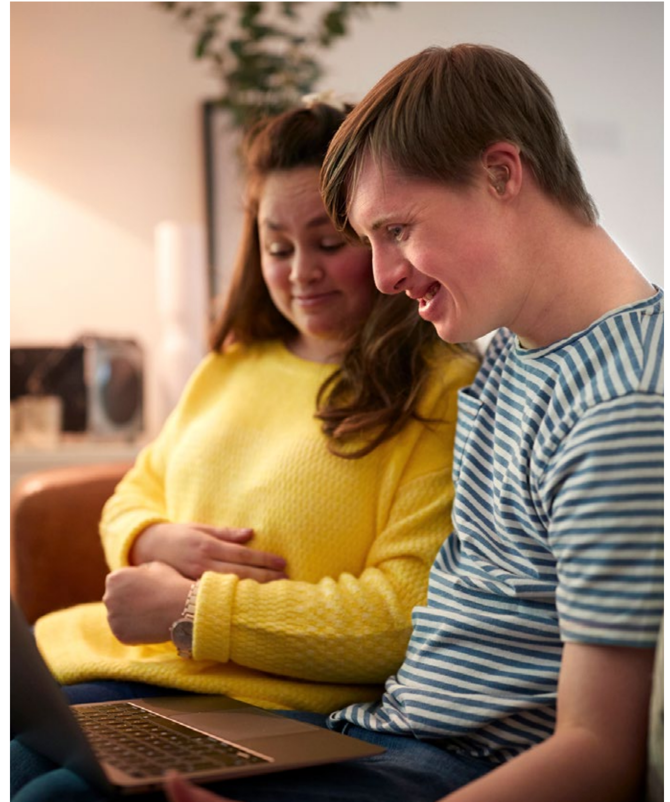
Improving access to information for disabled residents

Hammersmith & Fulham Council can support disabled residents' access to housing services by providing information which meets high standards of accessibility, transparency, and consistency.

Key ways to improve accessibility of information include:

- Exploring the possibility of adopting single accessibility standard e.g. NHS
- Using simple language when announcing key changes
- Listening and asking the right questions
- A culture of awareness about the barriers to housing that disabled residents experience including those disabled residents with hidden impairments/health conditions
- Access to British Sign language interpreters
- Clearly defined terms, i.e. 'accessible'
- Awareness of communication barriers
- Clear and publicised information about processes and services
- Clearly defined points of contact
- Tailored services: what works for one resident may not work for another
- Excellent customer service.

Availability of accessible information will improve access to services and foster equality for disabled residents in the borough. Hammersmith & Fulham Council will improve our relationship with residents by addressing current concerns. For example, at a recent focus group with council tenants, only half of the attendees knew the name of their housing officer.



In the focus groups, you told us that you want us to:

- Explain the process for adaptations
- Explain the full range of housing options
- Tell you more about HomeSwapper, and affordable rent options
- Explain the intermediate and shared ownership options
- Let you know about local development plans
- Explain the legal information relating to your housing options
- Give you information on housing options for young disabled residents entering adulthood

It is important that disabled residents know how the allocations and transfers processes work, including decision making mechanisms, criteria and appeals processes. Disabled applicants need to know what they can expect when, and who to contact with questions or issues.

Our commitments

We will…	Which will mean…
Work with DPOs to develop tailored housing options and advice for disabled residents	More disabled residents will be advised of the housing options they have available to them, and understand a clearly articulated offer
Publicise the full range of housing options and services available to disabled residents, as well as the processes and procedures involved	Disabled residents will have a clear idea of what to expect, and who to contact about what, when accessing housing services
Publicise information on how disabled residents can find out about development plans in the local area	Disabled residents will have a clear idea of what developments are taking place locally, and what land is being used for
Strengthen internal and external links, co-working and signposting	Disabled residents will have a smooth journey through H&F Council services, and be better informed about services outside of the council

Our action plan

Action	Service or team responsible	Outcome
Develop new information in everyday language explaining the full range of housing options available to disabled residents. This should include: • Housing Options advice leaflet • DFG and Adaptations information leaflet	Housing Solutions/ Housing Services/ Adult Social Care	Leaflets are more accessible
Ensure accessible easy-read information on the council's responsibilities as a landlord, and legal duties to disabled residents under housing legislation, are made available	Housing Strategy/ Housing Solutions	Increased access to information on landlord responsibilities and legal duties
Produce accessible easy read versions of the Housing Strategy, Housing Allocation Scheme and Home Buy Allocation Schemes	Housing Strategy/ Housing Solutions	Increased access to the Housing Strategy, Housing Allocation Scheme and Home Buy Allocation Schemes

Action	Service or team responsible	Outcome
Distribute up-to-date contact information to disabled council tenants with useful H&F contacts including tenants' housing officer details	Housing Solutions/ Housing Services	More disabled residents have information on who to contact at H&F
Engage DPOs and housing associations to identify housing demand from disabled residents in the borough	Housing Solutions/ Housing Strategy	Improved data on demand
Develop signposting materials to link to Disabled People's Organisations and other useful local contacts	Housing Solutions/ Housing Strategy	Disabled residents have increased access to information on DPOs and local contacts
Develop ways to provide tailored housing information early in preparation for key transitions i.e. the transition into own accommodation when reaching adulthood or a move to supported housing	Housing Solutions/ Social Services	Disabled residents given tailored information earlier
Review the accessibility of the council's website	Housing Strategy/ Corporate Communications	The council website is more accessible

Possible measures

- Number of disabled residents signposted to appropriate services
- Number of disabled residents who received updated accessible housing services information
- Number of people engaged through working with DPOs
- Analysis of numbers of visitors to council website
- Analysis of feedback following production of accessible information material

Objective 3 – improve housing services with disabled residents

Background

There is strong evidence that poor quality or inappropriate housing can trigger health and social care needs, worsen existing needs and lead to early loss of independence and more intensive and costly interventions.

Some existing housing stock in the borough is already suitable for disabled residents, including those with support needs, whether through original design or subsequent adaptation. The council are also able to adapt some of our existing stock because we are committed to supporting disabled residents to have choice and control in their lives. Unfortunately, some of the council's housing stock does not meet the needs of disabled residents.

The main funding stream for Disabled Facilities Grants (DFGs) comes from the Government for councils to support these improvements. Funding for DFGs has increased in recent years but the cap on individual grants (of £30,000) has not changed since 2008.

Training and development

One of the council's most valuable resources is its staff. However, many disabled residents engaged during the creation of this strategy spoke of examples where they felt misunderstood and, in some instances, dismissed when receiving housing services from the council.

Particularly, residents felt that council contractors who carry out repairs and adaptations are not empathetic to the needs of disabled residents.

This highlights a need for regular and continuous training, including Disability Equality Training and development of staff from the council and its contractors in dealing with disabled residents. Finally, as part of Objective 2, the council's housing services must provide clear and well publicised ways for disabled residents to contact the council.

Housing stock

The council is the biggest landlord in the borough. The council has around 11,353 general needs homes. Three quarters of these are flats with almost half of them having no ground floor entrance and some having no lifts. In addition, 35 per cent of the council's housing stock is one-bedroom properties[9] which is a higher proportion than London as a whole.

Many of the council's existing homes need to be adapted and improved to be more accessible to disabled residents. It is therefore crucial that future housing provision in the borough, should at the very least be built to Lifetime Standards and able to meet the needs of a range of disabled residents based on good data and adapting to remain current with demographic changes in the borough.

[9] Source: Council housing stock data Oct 2017

Disabled Facilities Grants (DFGs)

DFGs are administered by the council to help disabled residents adapt their home to make it easier for them to continue to live there or maintain their independence. Adaptations produce improved quality of life for 90 per cent of recipients and improved quality of life for carers and of other family members.[10]

To obtain a DFG, applicants are means-tested and determinations of the level of grant is made on a case-by-case basis.

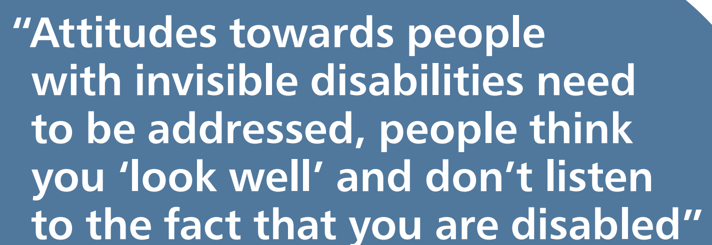
From our focus groups, we found that some disabled residents are; not aware of DFGs, do not fully understand the process and the steps involved or are extremely dissatisfied with the length of time it takes for adaptations to be undertaken.

Participants in the groups pointed to improvements in their quality of life by having good quality adaptations carried out properly and in a timely manner. The importance of this reaches beyond the physical improvements, they mentioned that it helps them to be more in control, live independently and with dignity and feeling safer in their homes.

Accessible Housing Register

In the council's Older People's Housing Strategy and the Mayor of London's draft London Housing Strategy 2017, there are clear expectations that social landlords must be well-informed about the accessibility of their housing stock using tools such as the Accessible Housing Register.

As part of the recently published Older People's Housing Strategy, the council pledged to update and maintain information on its Accessible Housing Register to identify which properties are accessible for disabled and older residents.



[10] Source: Heywood and Turner (2007)

Our commitments

We will…	Which will mean…
Improve our systems for allocating and matching all accessible and adapted homes to which the council can nominate	Disabled residents seeking to move will be matched to housing that better meets their needs
Working with disabled residents, review and improve the current disabled facilities grant and aids and adaptations service	The process of adapting existing accommodation in line with disabled residents' needs is people-focused, enabling disabled residents to live in their own homes for as long as possible and maintain their independence
Develop a training programme for frontline officers, to include Disability Equality Training	Disabled residents who contact the council deal with informed staff and receive the best customer service
In partnership with housing associations and DPOs, develop detailed housing demand profile from disabled residents	Being able to identify opportunities and develop homes to meet the needs of disabled residents

Our action plan

Action	Service or team responsible	Outcome
Recruit disabled residents to co-produce a review of the Disabled Facilities Grant and Adaptation Service	Housing Services (with Housing Property Services and Occupational Therapy)	Disabled residents are involved in the review process
Review the current Disabled Facilities Grant and aids and adaptations service	Housing Services (with Housing Property Services and Occupational Therapy)	Disabled Facilities Grant and the aids and adaptations service is analysed
Implement recommendations from Disabled Facilities Grant and adaptations service review	Housing Services (with Housing Property Services and Occupational Therapy)	Recommendations are put into practice and the service is clearer and more efficient

Action	Service or team responsible	Outcome
Co-produce accessible information that details the applicant journey through the Disabled Facilities Grant process	Property Services and Occupational Therapy)	Disabled residents have better access to information about the improved process
Identify the council's accessible housing stock and update the accessible housing register	Housing Services	The accessible housing register accurately represent accessible housing stock
Create a training programme (Disability Equality Training) for frontline officers dealing with repairs and adaptations (including contractors), including training delivered by DPOs	Property Services	An increased number of frontline officers receive training
Property adaptations to be retained at the end of tenancies and property to be re-allocated to another disabled person	Housing Solutions	Fewer properties have adaptations at the end of tenancies
Ensure that fire safety measures in council properties (such as fire doors) are suitable for use by disabled tenants	Housing Services	Improvement in accessibility of fire safety measures
When tenancy checks are carried out, gather up-to-date information on disabled tenants	Resident Involvement	More current data held regarding disabled tenants

Possible measures

- Number of disabled residents engaged to help review the DFG process
- Number of homes improved so they are future-proofed for disabled residents' needs
- Length of time to deliver adaptations for disabled residents
- Create and monitor feedback/exit surveys following repairs and adaptations

Objective 4 – identify ways to increase supply of accessible housing

Background

The current housing stock is largely inaccessible to most disabled residents. With the supply of existing accessible or adaptable housing so low, the only option for some disabled residents may be new housing. The Mayor of London and Hammersmith & Fulham Council requires developers to provide 90 per cent new accessible housing and 10 per cent new wheelchair housing. There are also policies on achieving new affordable housing. However, the high cost of land and development in London means that most new housing is unaffordable to disabled residents on benefit or low incomes.

Accessible housing

Approved Document M of the Building Regulations in 2015 included minimum specifications for accessibility of all homes.

The London Plan requires 90 per cent M4(2) accessible and adaptable homes (formerly lifetime homes) and 10 per cent M4(3) wheelchair user dwellings. Wheelchair user dwellings are further divided into wheelchair adaptable (with potential to be adapted for a wheelchair user) or wheelchair accessible (suitable for immediate occupation for a wheelchair user). This ensures new housing with step free access to meet the needs of the occupant as they change over time.

The split between accessible and adaptable homes M4(2) and wheelchair user homes M4(3) is spread across both private housing and affordable housing to give people choice.

Wheelchair adaptable housing

If it is new private housing or new affordable housing for shared ownership or discount market sale, then the requirement is to meet Building Regulation M4(3) (a) wheelchair adaptable dwellings with the potential to be easily adapted for a wheelchair user.

Wheelchair accessible housing

If it is affordable housing for social or affordable rent where the housing department nominates wheelchair users for new housing, then the requirement is Building Regulation M4(3) (b) wheelchair accessible dwellings on completion. This is suitable for immediate occupation by a wheelchair user.

Housing schemes with support

These include both supported housing and extra care housing schemes. Supported housing is for people with physical disabilities and complex needs, people with learning disabilities or people with mental health conditions who need support to live independently in their homes.

Extra care housing

Extra care housing is for disabled and older people who need purpose-built housing with full time support to meet their care needs.

However, these schemes traditionally require capital funding to build homes, and revenue funding to provide the support services required and meet the housing costs.

Disability Forum Planning Group (DFPG)

The Disability Forum Planning Group is an independent group run by disabled volunteers with lived experience of using housing, public buildings and public open space. It provides invaluable advice to the council's housing and planning services to make sure new public buildings and new housing are step free and accessible to all disabled residents, people with long term health conditions and older disabled residents.

The DFPG reviews proposals at various stages of the planning process to help planning and housing officers ensure housing providers and developers submit planning applications that comply with Building Regulations. The group are particularly concerned to ensure that all new social/affordable rent housing are fully compliant with both Building Regulations M4(2) accessible and adaptable dwellings and Building Regulations M4(3) wheelchair user dwellings.

The DFPG is not funded. However, the council is keen to support members of the group to identify funding streams to build capacity of disabled residents to be involved in co-production and working together with the council on planning applications. The council will also help facilitate training and recruitment to the group under the management of the existing disabled volunteers.

Key recommendations from the DFPG:

- Planning and housing departments work together with disabled residents and include them in the process throughout development
- Co-produce information to make the planning system more transparent
- Co-produce accessible easy-read information on standards for new housing
- Improve access to information of major developments
- Council to ensure developers to build and fit out homes for disabled residents post completion
- Council to ensure all wheelchair user dwellings are always occupied by households with a wheelchair user from Hammersmith & Fulham housing waiting list

Affordable Housing Development Framework for council owned sites

In addition to the traditional housing supply pipeline through the planning system, the council has approved an Affordable Housing Development Framework.

This innovative framework enables us to work with housing providers to deliver up to 800 new affordable homes in the borough on council owned sites over six years. The overall objectives of the framework are to:

- Deliver more genuinely affordable homes outside the regeneration/opportunity areas through creative partnerships with housing providers
- Give the council nomination rights
- Deliver these homes as soon as possible and within six years
- Use council resources to support affordable housing

The homes delivered will be genuinely affordable and meet the housing needs of many groups including disabled residents.

The council has clear policy on housing development which can be viewed online in the borough's Local Plan.[11] The Local Plan is a policy document that sets out the council's vision for the borough until 2035, including placing more people in decent, affordable homes in a stronger local economy that provides training and job opportunities for residents.

For development that will provide 11 or more homes, the affordable housing component should be provided in line with the following:

a) A borough wide target that at least 50 per cent of all dwellings built should be affordable

b) 60 per cent of additional affordable housing should be for social or affordable renting, especially for families

c) 40 per cent should be a range of intermediate housing

d) Affordable dwellings should be located throughout a new development and not concentrated on one part of the site

e) The provision of affordable rented and social rented housing in ways that enable tenants to move into home ownership

The above policy works alongside other policy documents such as the GLA's London Plan which requires developments on private land to provide at least 35 per cent affordable housing, and developments on public land to provide at least 50 per cent affordable housing.

[11] www.lbhf.gov.uk/planning/planning-policy/local-plan

Our commitments

We will…	Which will mean…
Deliver genuinely affordable homes that meet the needs of disabled residents	Disabled residents can access homes they can afford that meet their needs
Identify funding to build capacity of disabled residents to continue advising the council on new development proposals	Disabled residents are empowered and involved from the outset in the development of new housing in the borough
Support the DFPG to recruit and train interested disabled residents	Disabled residents are empowered to influence decision making regarding the provision of housing the borough
Work together with disabled residents to review the Local Plan and consider revisions and amendments	Disabled residents are able to influence the Local Plan to ensure planning applications meet the needs of disabled residents
Work with Greater London Authority (GLA) on specialist housing and identify funding opportunities	More funding in the borough for the delivery of specialist housing appropriate to the needs of disabled residents

Our action plan

Action	Service or team responsible	Outcome
Promote the work of the Disability Forum Planning Group (DFPG)	Housing Strategy and DFPG	Increased awareness of the work of the Disability Forum Planning Group (DFPG)
Support the DFPG to recruit and train members	Housing Strategy and DFPG	Increase in trained members of DFPG
Support the DFPG to leverage and secure funding for capacity building of disabled residents	Housing Strategy and DFPG	Stronger relationship between the council and DPFG
Together with the DFPG, produce accessible information on housing development and accessible housing standards	Housing Strategy and DFPG	Improved access to information on housing development and accessible housing standards

Action	Service or team responsible	Outcome
Work with the DFPG to secure housing for disabled residents that meets Building Regulations Part M4 (2 and 3)	Housing Strategy and DFPG	More housing for disabled residents that meets that meets Building Regulations Part M4 (2 and 3)
Together with the DFPG, review Local Plan content and recommend changes	Housing Strategy and DFPG	Recommendations made on the Local Plan which reflect the housing needs of disabled residents
Ensure disabled tenants receive seamless support through sign up, allocations, moving and tenancy management, and linked to H&F Link for benefit support where necessary	Housing Solutions	Improved customer satisfaction on consistent support

Possible measures

- Number of disabled residents involved with DFPG
- Sustainable funding of the DFPG
- Number of genuinely affordable housing delivered to meet the needs of disabled residents
- Number of disabled residents provide feedback on housing for them
- Disabled residents participation in reviewing updates to the Local Plan

Appendices

Appendix 1: Glossary

Term	Definition
Accessible housing	Broadly means building (or modifying) a home to enable independent living for a disabled person. Accessibility can be achieved through design as well as integrating accessible features such as furniture and fittings. (See Appendix 2 for accessible housing standards).
Affordable housing	This is housing for people whose needs are not met by the market. It includes: • **Social rented homes:** these are typically the cheapest rented housing available in the market. • **Affordable rented homes**: typically, these are higher than social rented homes but lower than market homes. • **Intermediate housing:** these are homes that are for rent and sale below market levels and include products like Shared Ownership and London Living Rent.
Affordable rented housing	Affordable rented housing are homes let by local authorities or housing associations to people who are eligible and qualify for the council's housing register. The rents are above social rent levels, but do not exceed of 80 per cent of local market rent.
Disabled Facilities Grant (DFG)	A 'means-tested' (income and savings assessed) financial grant that helps meet the cost of adapting a property where a disabled person lives.
Greater London Authority (GLA)	A devolved strategic governance body for London. It has powers over planning, transport, policing and fire and rescue services.
Housing associations	Housing associations are not-for-profit organisations that rent houses and flats. They aim to provide good, low cost and affordable housing for people in need.

Term	Definition
Intermediate housing	This type of affordable housing is aimed at people who do not qualify for social housing but cannot afford to rent or buy in the private market. It includes products such as Shared Ownership, shared equity and discounted market sales – as well as affordable rented products such as London Living Rent. To be eligible for intermediate housing a household's income must be less than £60,000 per annum if they want to rent, and £90,000 if they want to buy. These incomes are updated annually by the GLA.
London Affordable Rent	A rent level similar to social rent, set by the Greater London Authority. The rent excludes service charge and is updated annually by the GLA.
London Living Rent	London Living Rent is a type of Intermediate housing product for middle-income Londoners. These homes will have lower rents, so cash you save on rent can go towards a deposit for your own home.
Shared ownership	This intermediate housing product is the Part Rent/Part Buy option that enables customers to buy a home on leasehold basis. Customers can buy between 25 per cent and 75 per cent of the property value and pay rent on the remaining share to the provider. The rent is initially capped at a maximum of 3 per cent of the open market value of the unsold share. The buyer will also be responsible for payment of service charges.
Social rent	Sometimes also known as 'Target rent', Social rent is the rent charged for socially rented properties like council properties. Rent levels are worked out using a nationally set formula and are regulated by the Social Housing Regulator.
Discount Market Sale	Also known as 'DMS', this is a low-cost home ownership product where a newly built property is purchased at a discounted price with the unsold equity held by the council in perpetuity.
Local Plan	The Local Plan sets out the council's planning policies in one document and contains a section on the council's housing policies. All planning applications are determined in accordance with the local plan.

Term	Definition
Registered providers	Registered providers are housing providers registered on the statutory register of social housing providers maintained by the Social Housing Regulator. They include housing stock-owning councils and non-profit and profit-making organisations. Most non-profit providers are also known as housing associations.
Section 106 agreement	This is a planning agreement between the council and a developer. The council only grants planning permission if the developer offers some benefit to the local community, for example affordable housing, education facilities or improved public spaces. The agreement applies to the land, not the developer, so future owners will need to take it into account.

Appendix 2: Accessible housing standards

New accessible and adaptable dwellings (formerly lifetime homes)

In London since 2015: 90 per cent of all types of new housing must meet this Building Regulation M4(2) standard. This ensures all new housing has step free access to meet the needs of the occupant as they change over time.

Main requirements for 90 per cent new housing at M4(2) standard:

- Step-free access to dwelling, any parking space and communal areas
- Dwellings above ground floor to have lift access (with some exceptions) in addition to accessible stairs (shallow steps with handrails etc)
- Step-free access to toilet at entrance level and to any private outdoor space
- Wide range of people including older and disabled people and some wheelchair users can use the dwelling (including bathrooms and toilets)
- Common adaptations can be carried out in future to increase access
- Wall mounted switches; socket outlets and other controls are reasonably accessible to people who have reduced reach

Wheelchair user dwellings (formerly wheelchair housing standard)

In London since 2015: 10 per cent of all types of new housing must meet this Building Regulation M4(3) standard. This ensures all new wheelchair housing meets the needs of wheelchair users.

Main requirements for 10 per cent new housing at wheelchair user standard M4(3):

- Step-free access with lift to every private entrance to the dwelling and to every private outdoor space, parking space and communal areas
- Enough room for wheelchair user to turn safely outside communal lift
- Enough room for wheelchair user to move around dwelling and communal areas
- Step-free access to toilet and every other room in dwelling
- Door and corridor widths to be wide enough for wheelchair user around dwelling and communal areas
- Transfer and storage space for two wheelchairs inside dwelling
- Wall mounted switches; socket outlets and other controls are reasonably accessible to people who have reduced reach

The split between accessible and adaptable homes M4(2) and wheelchair user homes M4(3) is spread across both private housing and affordable housing to give people choice.

There are two categories of wheelchair user dwellings:

- **Wheelchair adaptable dwellings: M4(3) (a)**. Requirement in new private housing, affordable shared ownership and discount market housing. Fixtures and fittings in kitchens and bathrooms can be easily adapted in future to make dwelling fully wheelchair accessible.
- **Wheelchair accessible housing: M4(3) (b)**. Requirement in new social rent, affordable rent housing or shared ownership/discount market sale where the council nominates households with wheelchair user from the housing waiting list. No adaptations are required because all fixtures and fittings in kitchens and bathrooms should be fully wheelchair accessible on completion.

Appendix 3: Disability Forum Planning Group

What is the role of Disability Forum Planning Group (DFPG)?

We are a group of disabled residents with lived experience of barriers disabled residents face when using housing, public buildings and public open space.

We give advice to the council's planning department on planning applications for new buildings. It is Planning and Development Control Committee or council officers who decide on planning applications.

Which planning applications do the DFPG look at?

- Major developments with 10 or more housing units
- Public buildings e.g. schools and colleges, hospitals, GP surgeries, theatres, community centres, sports facilities etc
- Public open space e.g. around housing developments, public buildings, offices, hotels etc
- Parking for blue badge holders (disabled parking) in developments
- Changes to shop fronts

What does DFPG think about when looking at planning applications?

- Pedestrian routes across development
- Public open space inside development
- Kerbs and tactile paving at pedestrian crossings
- Drop-off points for taxis or visitors etc
- Parking for blue badge holders inside development
- Shared space (where vehicles and pedestrians share the same space)
- Step-free access to main entrances etc
- Inside of buildings and common areas
- Accessible toilets
- Space for wheelchair users
- Equal access to facilities provided

What does DFPG not consider?

DFPG does not consider:

1. Height; size of buildings or coverings for outside walls. This is carried out by planning officers.
2. General highway issues (streets and pavement).

Housing developments

We look at new housing with 10 or more housing units. DFPG checks statements and drawings for:

- 90 per cent new housing at accessible and adaptable standard (old lifetime homes)
- 10 per cent new housing at wheelchair housing standard

Hotels

DFPG checks statements and drawings for:

- 10 per cent hotel bedrooms at wheelchair-accessible standard
- Step-free access to hotel facilities

Obstructions on the footway (pavement)

Main issues for DFPG: pedestrians able to use pavement safely with as few obstructions or clutter as possible e.g:

- Advertising boards outside shops and cafes etc
- Tables and chairs outside restaurants, pubs, cafes etc

Parking for blue badge holders (disabled parking)

N.B. there are different rules for blue badge parking at new housing developments, shopping centres and offices etc.

DFPG checks statements and drawings for:

- Correct number and per cent of blue badge parking bays
- Layout and position of blue badge parking bays
- Parking management plan to reduce abuse by non-disabled residents

Sport facilities or stadiums

DFPG checks statements and drawings for:

- Wheelchair-accessible seating
- Easy access and family-friendly seating
- Accessible toilets

Student housing

DFPG checks statements and drawings for:

- 10 per cent student rooms to be wheelchair accessible or wheelchair adaptable
- Step-free access to communal areas or student facilities

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