London Borough of Hammersmith & Fulham

Health and Adult Social Care Policy and Accountability Committee
Agenda

Wednesday 20 July 2022 at 7.00 pm
Meeting Room 1 (2nd Floor) - 3 Shortlands, Hammersmith, W6 8DA

MEMBERSHIP

Administration	**Opposition**
Councillor Natalia Perez (Chair) Councillor Genevieve Nwaogbe Councillor Patricia Quigley Councillor Ann Rosenberg	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 Roy Margolis	

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Tuesday, 12 July 2022

London Borough of Hammersmith & Fulham

Health and Adult Social Care Policy and Accountability Committee

Agenda

20 July 2022

Item		Pages
1.	**MINUTES OF THE PREVIOUS MEETING**	4 - 13

(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 23 March 2022.

(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 HEALTH UPDATE

This is a standing item for the Director of Public Health and the Director COVID-19 & Refugee Lead to provide an update about health issues and services affecting the borough and it's residents.

5. NWL ICS UPDATE ON COMMUNITY– BASED SPECIALIST PALLIATIVE CARE SERVICES IMPROVEMENT PROGRAMME

14 - 58

This report sets out details of the North West London Integrated Care System (NWL ICS) ongoing review of the Community-based specialist palliative care (CSPC) services for Adults (18+) across eight NWL boroughs. It continues the palliative care review work undertaken in 2019/20 across Brent, West London, Central London and Hammersmith & Fulham CCGs.

6. H&F SAFEGUARDING ADULTS BOARD ANNUAL REPORT 2020/21

59 - 93

This report sets out the Safeguarding Adults Boards annual report for 2020/21 and provides details about its work, progress and analysis of safeguarding priorities.

7. HEALTHWATCH H&F UPDATE

94 - 114

This report provides an update about the activities and workstreams of Healthwatch h&f.

8. WORK PROGRAMME

115 - 120

The committee to discuss potential work programme items within the remit of the committee's terms of reference (HASC is at page 110) and are included for information and noting.

9. DATES OF FUTURE MEETINGS

Wednesday, 16 November 2022
Wednesday, 25 January 2023
Wednesday, 22 March 2023

London Borough of Hammersmith & Fulham

Health and Adult Social Care Policy and Accountability Committee

Minutes

Wednesday 23 March 2022

PRESENT

Committee members: Councillors Lucy Richardson (Chair), Bora Kwon and Amanda Lloyd-Harris

Co-opted members: Jim Grealy - H&F Save Our NHS and Roy Margolis

Other Councillors: Ben Coleman

Officers: Charlotte Allenby, Imperial College Healthcare NHS Trust; Jo Baty, Assistant Director, specialist support and independent living, H&F; Anna Bokobza, Imperial College Healthcare NHS Trust; Clare Caccavone, Programme Director, Ambitious about Autism; Peggy Coles, Dementia Action Alliance; Kevin Croft, Chief of People Officer, Imperial College Healthcare NHS Trust; Helen Green, Service Manager Engagement and Planning, H&F; Merril Hammer, HaFSON; Linda Jackson, Director Covid-19 and Refugee Lead, H&F; Sue Jenkins, Head of Inclusive Learning, West London College; Dr Nicola Lang, Director of Public Health, H&F; Professor Tim Orchard, Chief Executive Officer, Imperial College Healthcare NHS Trust; Tom Perrigo, Industrial Strategy Officer, H&F; Sharon Probets, Head of Learning, Imperial College Healthcare NHS Trust; Oliur Rahman, Head of Employment and Skills, H&F; Lisa Redfern, Strategic Director of Social Care, H&F

1. MINUTES OF THE PREVIOUS MEETING

The notes of the meeting held on 26 January 2022 were noted. The committee was provided with a brief overview of the actions set out in appendix 1 of the minutes which contained a list of outstanding actions for the West London Trust.

2. APOLOGIES FOR ABSENCE

Apologies for absence were noted from Councillors Caleb-Landy and Umeh, and co-optees, Lucia Boddington, Victoria Brignell, and Keith Mallinson.

3. ROLL CALL AND DECLARATION OF INTEREST

None.

4. PUBLIC PARTICIPATION

No questions were submitted.

RESOLVED

That order of business be varied to take agenda items 7.1 and 7.2 first, followed, by agenda item 6, then item 5.

5. IMPERIAL COLLEGE HEALTHCARE TRUST - PHYSIOTHERAPY HYDROTHERAPY (AGENDA ITEM 7.1)

5.1 Professor Tim Orchard, supported by Imperial Trust health colleagues Charlotte Allenby and Anna Bokobza, provided an update on changes to the way adult musculoskeletal physiotherapy hydrotherapy services were provided at Charing Cross Hospital and pilot trials undertaken to support a change in delivery. He Commended the collaborative work with Councillor Ben Coleman, Lisa Redfern, and H&F senior social care staff to develop robust changes to the hydrotherapy service model through active engagement with residents.

5.2 The committee were provided with a timeline of key activities between October 2018 and February 2022 which saw a temporary closure of the hydrotherapy facility due to prohibitively increasing maintenance costs and service unpredictability. An options appraisal in October 2018 had initially prompted a change in how aquatic therapy should be delivered and concerns about maintenance. This latter issue had led to numerous unplanned cancellations and poor service provision for patients.

5.3 The outcome of the engagement led was a two-part pilot project in February 2019. Part one included the temporary use of pool facilities at the Jack Tizard school site. The second part involved the use of the pool at the sports club on the Charing Cross hospital site for those who were transitioning towards self-directed care and recovery. The two pilots were run in tandem and evaluated but unfortunately the pandemic meant that there was a hiatus, and the projects did not properly commence until after the third wave in February 2022. The results of the pilots were included in the report together with generally positive patient feedback, although accessibility issues were highlighted. It was anticipated that the proposal would be to permanently close the existing therapy pool at the Charing Cross hospital site and to continue with the two pilot services across two sites. This would improve patient experience, and address maintenance and cost issues.

5.4 Councillor Lloyd-Harris welcomed the summary and update, which had improved on the April 2019 report to the committee. Recognising that there were limitations on the use of the Jack Tizard school site she asked if the option to further develop the Charing Cross sports club site had been explored, querying whether the limited use of the school site was sufficient to provide a robust service. She also referenced the views of a local GP who had actively contributed to the April 2019 committee discussions by outlining

his patients' difficulties in obtaining referrals to the hydrotherapy pool and queried why this remained unchanged, given the demand. Merril Hammer commended the Trusts response which sought a solution that recognised the value and benefits of aquatic therapy. Councillor Richardson emphasised the importance of including the "patient voice" through stakeholder engagement and commented on the disruption to the pilots and asked about the level of assurance testing undertaken. Councillor Coleman welcomed the Trust's encouraging approach and asked whether this could incorporate additional hours at the Jack Tizard site during school break periods or if patients could be transferred by Uber from the hospital site, given the significant savings achievable from not maintaining capital investment in the current hydrotherapy facilities. The issue of the changing rooms issue at the Charing Cross site was also raised.

5.5 In response to Cllr Lloyd-Harris's questions, Professor Orchard felt that the referral pathway from clinicians to the service was appropriate but there was a concern that the temporary service might become overloaded. It was confirmed that there was an option to extend the hours of use at the Jack Tizard site with further investment, provided that the logistics permitted this. Professor Orchard agreed that a proper evaluation of an extended period of the pilot services was required. The points raised by Councillor Coleman were regarded as reasonable and Professor Orchard agreed to explore these further following the meeting but caveated a need to balance the suggestions against other competing priorities.

5.6 Professor Orchard indicated that it had never been the Trusts intention to close the facilities as a cost saving exercise but the evidence base supporting aqua therapy was insufficient across the range of conditions, although specific benefits were acknowledged for some such as axial spondylarthritis. Anna Bokobza added that it was important to maintain a service that was accessible to patients in both the north and south of the borough and to consider the logistics of delivering a service across two sites. She felt that a proper evaluation of the pilots should be based on minimum of 12 continuous weeks of operation without interruption to achieve robust evidence-based outcomes and informed decision making. Councillor Coleman commended the Trust response, recalling that they had received robust challenge at the April 2019 PAC meeting and that health colleagues had responded with openness and accountability.

RESOLVED

That the report be noted.

6. IMPERIAL COLLEGE HEALTHCARE NHS TRUST - WORKFORCE SUSTAINABILITY DRAFT (AGENDA ITEM 7.2)

6.1 Professor Orchard presented the report which emphasised the importance of recruiting and supporting health staff. NHS staff had been at the forefront of dealing with community transmission and it was not easy to now recall the level of fear and daily challenges of dealing with the pandemic from March 2020 onwards. The swift transmission and progression of the virus in some

cases meant that not much time elapsed between admission, intensive care treatment and mortality, with 70% of deaths occurring on acute wards. Having met with staff in across the Trust, and in particular Charing Cross and St Mary's, Professor Orchard expressed his deep admiration for the resilience of his staff and how they had responded.

6.2 The paper offered three priorities shaped around building a sustainable workforce, improving staff health and wellbeing with a counselling offer and improvements made to catering and rest area facilities. This had been well received by staff and had made a significant difference. Focusing on recruitment and retention it was reported that the vacancy rate was in decline. In terms of the metrics and to add context, it was reported that about 200 nurses had been recruited to deal with increased demand following Covid-19 and the recovery period to address a treatment waiting list backlog of six million people.

6.3 The NHS nationally had been strategically exploring recruitment and retention and how this could be enhanced by local recruitment. It was acknowledged that most staff who left did so within a year of joining and that those who remained, stayed long term. Most importantly, the NHS weakness was around ethnicity, diversity, and inclusion (EDI) need to be addressed. There was an acceptance that although 50% of staff were of Black and Asian ethnicity, this was not reflected at higher levels within the Trust. An inclusive recruitment policy had been implemented to constitute diverse (gender and ethnicity) interview panels, and a follow up letter from the interview panel called "Dear Tim" was required, to justify all senior Band 7 and above appointments. The scheme had achieved modest success but needed to be tested with proper feedback as to how individuals increase their chances for a successful appointment. In addition, it had also been recognised that Black and Asian staff were less likely to apply for study leave or access training opportunities. A new programme would be launched to facilitate improvement through people management to set out clear expectations.

6.4 Co-optee Jim Grealy commended Professor Orchard for the commitment of his staff who continued to work in challenging circumstances and welcomed the report for its combination of analytical rigor, determined to tackle the difficulties inherent in recruitment and retention. He asked if the Trust had considered an age categorisation of staff, referencing the large number of older GPs retiring from practice as an example. He also asked if the staff policies referred to would be rolled out across the wider North West London Integrated Care System (ICS). Councillor Bora Kwon welcomed the focus of the paper on improving the work culture but asked about how staff improvements were perceived by patients what service delivery could look like long term. Carleen Duffy endorsed earlier comments and reported that Healthwatch H&F was working to encourage NHS applications from Black and Asian ethnic minority groups and asked how the Trust was addressing unlearning cultural bias, re-educating staff through, e.g., anti-racist workshops or similar. Clare Caccavone asked if the Trust had addressed the issue of cultural competence in adjusting recruitment practices, and how a sustainable workforce could operationally include more ethnic and gender diversity with the workplace.

Councillor Coleman referred to recent funding awards from the Department for Levelling Up and the NHS to continue progress on these areas. Referring to question 14 of the staff survey included in the report, Councillor Coleman asked about the 10% decline in positive staff perceptions about career progression, between 2019-20. There was a slight increase observed in response to the question about whether staff had personally experienced discrimination at work from patients, service users or their family members. More of a concern was the 4% increase in discrimination at work from a manager or team leader, and specific specialist departments were reporting similar metrics. Councillor Coleman asked how the Trust could tailor and adapt its approach according to the improvements required in different departments. Councillor Lloyd-Harris referred to the departure of staff within a year of joining the NHS and asked if the Trust had undertaken any analysis or research to explore the reasons for this and asked what these might be.

6.5 Professor Orchard Responded to each of the questions and points raised:

- Jim Grealy's point about age categories was particularly important in respect to staff who were 50+, and who might be reflecting on whether to continue within the NHS, considering retirement or new career pathways, and exploring their options. The Trust was prepared to be flexible to retain experienced senior staff, but this needed to be addressed across the North West London acute trusts as part of the collaborative, and at ICS (Integrated Care System) level.
- At ICS level there was an opportunity to think long term and strategically about the provision of health and social care and how this intersected, and to improve community engagement through patient involvement. He referred to a group of service users at Imperial called the Strategic Lay Forum.
- There had been useful feedback from HaFSON (H&F Save our NHS) with insights into patient views on services and treatment.
- It was recognised that a happy and content workforce offered better quality services and care with a greater focus on the needs of the individual rather than the organisation.
- Clinical outcomes at Imperial were very good and standardised mortality rates were consistently amongst the best nationally.
- There was a desire to improve the patient experience of care and improving staff care was part of this process.
- In response to Carleen Duffy's point, Professor Orchard was keen to ensure that staff were not racist but to go further and be positively anti-racist, referring to the Trusts white ally's anti-racist programme.
- There had been a slightly slower but no less active response to addressing disability issues, through the I Can network, a leadership programme for staff with disabilities run by Dr A. Stewart.
- Reasonable adjustments were being made in the workplace and Professor Orchard recognised that there had been varying levels of effectiveness and a central funding repository had been established to ensure that reasonable adjustments were being made to support people with disabilities and neurodiversity.

- Professor Orchard agreed with the point made by Clare Caccavone and acknowledged that the mechanisms to encourage cultural competency might not be in place consistently yet.
- With regards to the staff survey, it was acknowledged that these were not always helpful, but the questions could not be interpreted in isolation. The aim was to get a good number of staff to respond and have a broad perspective, including the clinical workforce. The Sodexho staff had been the first cohort to complete the survey and while they had done an amazing job during the pandemic, many issues still remained and tailored approach was required for different parts of the organisation. Nationally, pulse surveys were also being undertaken to get achieve more granular detail.
- Professor Orchard observed that there was much that had been implemented with a keen focus on the EDI agenda, and that the cycle of surveys, analysis and follow-up would take time to embed and recoup the benefits of this. The EDI results were not atypical for London but there were many positives to focus on which was encouraging.
- In response to Cllr Lloyd-Harris's question, Professor Orchard confirmed that a series of detailed exit interviews were being undertaken to ensure that the Trust avoided assumptions about why people chose to leave.

6.6 Councillor Richardson asked how the Trust could work with the council as it sought to offer a job brokerage service for inclusive apprenticeships and ensure that residents most in need of work opportunities would be able to access them. Many residents that were neurodiverse or with disabilities were a big source of untapped employment and would work well in the NHS environment. Professor Orchard confirmed that Trust was very keen to engage with the council and develop some initiatives. Engagement with local communities in this way was a positive, supporting health and wellbeing as well as offering financial security. Professor Orchard thanked Cllr Richardson for varying the order of business and was warmly thanked in return for his contribution to the meeting.

RESOLVED

That the report was noted.

7. INCLUSIVE APPRENTICESHIPS (AGENDA ITEM 6)

7.1 Councillor Richardson welcomed H&F officers Oliur Rahman, Tom Perrigo from The Economy department, Jo Baty from Adult Social Care and Helen Green from Children's Services. Additional guests and contributors included Sharon Probets from Imperial, Sue Jenkins from West London College, and Clare Caccavone and Charlotte Warner, from Ambitious about autism.

7.2 Oliur Rahman provided highlights from the report which included businesses reporting a skills shortage exacerbated by the impact of Covid-19. This was a good opportunity to engage with employers to identify and access employment opportunities for an untapped talent pool of disabled residents. Current local data about apprenticeship take up indicated that 60 disabled residents had begun an apprenticeship. There were approximately 8400

employed disabled residents in H&F in the borough. The borough as an employer was one of only three London boroughs that offered an inclusive apprenticeship and there was an intention to increase the number of available opportunities. Nationally, there were 116 inclusive apprenticeships available and as of March 2022, 11 of these were available with employers that were registered as disability confident.

7.3 The council intended to work with 130 employers locally and tap into established networks to grow opportunities. Adjustment was key but there were opportunities following the pandemic with significant movement in the employment market reflecting people's choices and changes in direction. The council was also reviewing the varied support that was available through partners and how resources could be allocated to ensure that support provided through coproduction was available for disabled residents.

7.4 Sue Jenkins commented on inclusive apprenticeship and how the lack of GCSE maths and English qualifications prevented many from being eligible in accessing the apprenticeships. The West London College had worked with four inclusive apprenticeships and about 100 people had progressed into full time employment. This had taken significant amount of effort and commitment which extended beyond making reasonable adjustments. Lobbying for an adjustment to the structure was necessary to maximise opportunities and remove barriers which would allow people to achieve vocational standards.

7.5 Clare Caccavone agreed that there were many who were autistic and did not regard themselves as disabled, but this was a long-term health condition. Many were also unaware that they fell within the category of protected characteristics rights offered within the Equalities Act 2010. Many young people were traumatised by the requirement to achieve the minimum standard academic qualification which was a contradictory gateway and barrier. It was suggested that given the skills gap, sustainable work opportunities would be better delivered by changing the way in which job applications and interviews were structured, using e.g., job trial periods. Referencing a Manchester based provider, Clare Caccavone explained that the GCSE qualification requirement had been removed with adaptations to the process to support autistic apprenticeship applicants. Depending on the development of robust evidence-based data, the aim was to replicate this approach nationally, working with councils and providers, and Ambitious about Autism welcomed the opportunity to work with H&F on this.

7.6 Councillor Richardson asked how inclusive apprenticeships could be coproduced with disabled residents, particularly given the reformation of Work Zone in H&F. Councillor Lloyd-Harris referenced the gender statistics in the report and enquired about the reasons why there were more females than males accessing both intermediate and advanced apprenticeships, and why the data in some categories appeared similar.

7.7 Oliur Rahman supported the need to lobby for a change through both the employer and provider engagement networks, acknowledging that the entry requirements issue was a huge challenge, as referenced in the report. He agreed that limiting progression at level two was an unacceptable barrier. He

also endorsed the suggestion to change recruitment and interview processes and that this had been raised with the local employer network. Referring to the similarity of the data, a possible explanation was that data had been rounded up to the nearest 10 or 20, and why there appeared to be more females than male apprentices. The opportunity to meet with Ambitious about Autism to discuss how H&F autistic residents could be better supported was welcomed.

7.8 Sharon Probets concurred with points made, highlighting the difficulties of meeting the level two qualification in English and maths and that this had presented a significant barrier for NHS staff who had been unable to complete the qualification component of the standard. It was suggested that a reasonable adjustment would be disconnect maths and English from the qualification component of an inclusive apprenticeship. This would have risky financial implications for providers.

7.9 Kevin Croft welcomed an opportunity to follow up with Clare Caccavone about job trials, building on the discussion in the previous item about supporting staff in their career development. He suggested that a campaign could be developed to address this with providers.

7.10 Roy Margolis commended Oliur Rahman and colleagues on the development of this excellent work. Based in the Careers and Enterprise Company and an aim of the organisation was to support the amplification of technical routes in schools, which meant promoting apprenticeships. He asked if there were any strategies being employed to make career advisors in schools and colleges aware of inclusive apprenticeships. Tom Perrigo referred to Clare Caccavone's view on the culture of retaking exams and questioning whether a young person had a disability in a job centre environment and agreed that this was traumatising for many young people. Reflecting on this and other similar points made, there was a disconnect between the need to evidence level 2 qualifications and what training providers received funding for. Expanding on this, he referred to green volunteering and skills which were much sought after by innovative green technology firms which would value and invest significantly in nurturing creative, vocational talent, and skills.

7.11 A query was submitted on behalf of Councillor Umeh regarding two residents who had been in a 6-month Kickstart programme but were unable to access any other opportunities. Oliur Rahman responded that Work Zone had helped create many vacancies through Kickstart and the intention was to continue to support residents that had completed the programme in identifying other opportunities. He agreed to follow up with Councillor Umeh after the meeting.

ACTION: Further information to be provided by Councillor Umeh to The Economy Department officers

7.12 Councillor Richardson commended officers for their work and support of inclusive apprenticeships and welcomed the integration of this within the council's industrial strategy. Much progress had been made since this area

had first been discussed by the PAC and Councillor Richardson thanked officers for supporting the scrutiny efforts of the committee.

RESOLVED

That the report was noted.

8. COVID-19 UPDATE (AGENDA ITEM 5)

8.1 Dr Nicola Lang provided a brief update on the council's response to Covid-19, supporting Professor Orchard's thought-provoking remarks about the resilience of NHS staff and how this was mirrored by a similar impact on social care staff. It was reported that case rates were increasing in the borough with about 1 in every 400 cases confirmed as Covid positive and that a similar trend was being replicated across London and nationally, but this increase was slowing down. Hospital admission rates linked to Covid-19 were being carefully monitored. The highest rates had been identified in the 25-29 age bracket and a new variant of the ba2 Omicron variant had begun to appear, which was 30 times more infectious than the original Omicron variant. This coupled with a relaxation in social distancing rules, increased socialising, waning levels of immunity through vaccination had combined to provide an increased rate. Vulnerable older groups could continue to protect themselves through the Spring Booster programme. Loosening restrictions was difficult to manage as some people found it psychologically harder to adjust to a more open regime.

8.2 Councillor Lloyd-Harris asked if it was time to reintroduce publicity to remind people that Covid-19 was still present, and that the vaccination programme was still open to those who had not been vaccinated. Dr Lang welcomed the question and reported that the council's communication team continued to disseminate NHS guidance. Spring boosters and third doses were currently open to the over 75s and people aged over 12 with immunosuppression or other conditions. It was difficult to judge the public appetite for further Covid-19 publicity as there were other important health communication campaigns that needed attention e.g., measles, mumps, and rubella (MMR). This was difficult as some parents had not managed to get young children immunised during the pandemic.

RESOLVED

That the verbal update was noted.

9. WORK PROGRAMME

9.1 Councillor Richardson provided brief background details about the North West London Collaborative of Clinical Commissioning Groups end of life engagement work and the work the committee in scrutinising the temporary closure of in-patient palliative care services at the Pembridge Hospice. A formal decision about this was delayed because of the pandemic and remained under discussion, whilst further engagement work was undertaken. Jim Grealy added that the movement from the initial local engagement

covering RBKC, H&F and Brent, had now evolved to a North West London focus, covering significantly greater numbers. Also worth noting was that this review covered adult palliative care and not children and young people. Although the Integrated Care Partnership had been helpful, it was suggested that an integrated, more inclusive review would have been helpful. Patient choice was another emerging theme, with a need for more structured pathways that more appropriately accommodated a person's needs and final wishes, with timely transition from home to hospice care. It was confirmed that re-engagement on this issue would commence following the local elections on 5 May. HaFSON had prepared a report which was available to members.

9.2 Councillor Richardson reported that a former member of the PAC, Brian Naylor had suggested that the PAC review the provision of ophthalmic services and the Western Eye hospital. Locally, the NHS was the main provider of services to about 6000 H&F residents with visual impairment, a figure estimated to increase by 27% within 10 years. It was agreed that this would be develop as a future scrutiny item for July or a future meeting. Suggested items for July included:

- West London Trust (MINT, CAMHs transition and single point of access update)
- Ophthalmic services and Western Eye
- Supporting local GPS (long list)

10. DATES OF FUTURE MEETINGS

Councillor Richardson noted that this was the last meeting of the 2021/22 municipal year and took the opportunity to thank all officers, guests and contributors, and committee members for their hard work and support. Councillor Richardson also thanked the committee co-ordinator for her organisation and support of the committee's work. Councillor Lloyd-Harris echoed the comments and thanked Councillor Richardson for her leadership of the committee. The date of the next meeting was noted as 20 July 2022.

Meeting started: 6.30
Meeting ended: 8.38pm

Chair .....

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LONDON BOROUGH OF HAMMERSMITH & FULHAM

Report to:	Health, Inclusion and Social Care Policy and Accountability Committee
Date:	20 July 2022
Subject:	NWL ICS update on Community– based Specialist Palliative Care Services Improvement Programme
Report Author:	Andrew Pike, ICS Communications Programmes Lead Michelle Scaife, Programme Delivery Manager – Last Phase of Life Sue Roostan, Borough Director – Hammersmith and Fulham Chakshu Sharma, Programme Manager – Integration & Delivery, H&F Borough
Recommendation:	For Committee to note and comment on the report
Wards Affected:	All
Contact Officer:	The paper is provided by the NWL ICS team. For more information and queries please email nhsnwlccg.endoflife@nhs.net
List of appendices	Update on Community-based Specialist Palliative Care Services Improvement Programme – Report from NWL ICS to London Borough of Hammersmith & Fulham Health, Inclusion and Social Care Policy and Accountability Committee

Summary

North West London Integrated Care System (NWL ICS) team are currently carrying out a review of the Community-based specialist palliative care (CSPC) services for Adults (18+) across eight NWL boroughs. This programme is following on from the palliative care review work undertaken in 2019/20 across 4 of our CCGs – Brent, West London, Central London and Hammersmith & Fulham CCG.

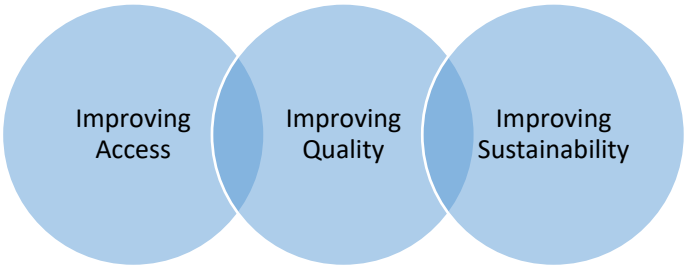
By Community-based Specialist Palliative Care (CSPC), we are a referring to specialist level of palliative care that is delivered in a setting that is not within a hospital or a GP surgery, but rather in a patient's own home, a care home, a hospice and a community hospital or centre. Examples of these types of care services include – hospice bedded inpatient care, Hospice day and outpatient services, community specialist palliative care nursing team providing care and support in the patient's home, Hospice@home service and specialist palliative care input if you are living in a care home.

Why are we doing this work?

- Improving Palliative and end of life care (PEOLC) is a national and ICS priority
- We have some excellent community-based specialist palliative care services and committed partners and we want to build on this excellence and support our services to be as sustainable as possible for the future.
- We do however have variation in access, quality and level of service available to our residents across NWL – trying to achieve consistency will drive our approach
- There are also some immediate challenges - workforce, sustainable funding (given impact on the charitable sector during the pandemic) and one our inpatient units is suspended.

Our Vision:

- NW London residents and their families/ carers have equal access to high quality community-based specialist palliative and end of life care and support, that is coordinated, and which from diagnosis through to bereavement reflects their individual needs.
- Our priorities of this programme of work are in line with the NHSE/I triple aim for Palliative and end of life care



Public Engagement

NWL ICS Engagement:

- The NW London ICS wants to work with patients, their families/ carers/ those important to them and other stakeholders to understand how we can improve the experience for all adults who use our community-based specialist palliative care services in North West London. The NWL ICS team have led a series of public engagement sessions between Dec 21 and May 2022. An interim outcome report was published recently and can be viewed online at: The full interim engagement outcome report is available here
- An engagement period started on 18 November 2022 and was extended to mid-March due to Omicron – during the winter key partners were largely deployed to the immediate response and as such the pause in work was regrettable but unavoidable. Further engagement has/is occurring to ensure that all boroughs have the opportunity to have discussions including the Westminster, Kensington & Chelsea, Hammersmith & Fulham event that took place on the 15 March 2022 and the Hammersmith & Fulham engagement event that took place on 11 May 2022.

Place Based Engagement by H&F Health and Care Partnership (HCP):

- In H&F, as part of the HCP, we have made a commitment that coproduction is at the heart of everything we do. Our aim is to work with the residents and communities from the very start, to understand what matters to them, to redesign services in a way that works for them, and to work with them to make changes. In order to ensure an effective engagement; the H&F team worked closely with the lay partners and members of HAFSON to develop the engagement strategy. We worked together:
    - To design the engagement material, agree the narrative for a rich conversation,
    - looked at ways to promote our event via voluntary sector organisations, tapping into their network to ensure we reach out to all the cohorts and everyone intending to share their feedback has a platform to do so e.g. via online surveys, written feedback via email or post to the NWL ICS team and virtual engagement events.
    - To facilitate the conversation at the public engagement event
- Locally, it was agreed to extend the scope of the engagement to include the breadth of "out of hospital" Palliative Care Services within H&F (generalist and Specialist Palliative Care together). The feedback gained will feed into local service development as well as the NW London programme.
- HAFSON provided a welcome submission at a NW London level and we include this and our response published on the NWL ICS Website at www.nwlondonics.nhs.uk/get-involved/cspc/how-get-involved/interim-engagement-outcome-report-key-finding
- Full engagement report from H&F local public event can be found at: H&F Local Engagement Report

Key points for Hammersmith & Fulham and NW London

- A North West London wide steering group has been established that consists of NHS providers, hospices, local authority and resident representatives. Our Issues Paper sets out the key reasons why we are looking at community-based specialist palliative care and helps us have a conversation on what future care could look like.
- There are some things that we have found that needed to be addressed immediately. We found not all boroughs had the same level of in and out of hours' access to end of life care and anticipatory medication. The gap in West London, Central London and Hammersmith & Fulham boroughs was closed by commissioning an equivalent service meaning that during the pandemic all NW London residents have equal access to these medications 24 hours a day.
- An interim engagement outcome report was published on Thursday 9 June 2022 which contained all the feedback given following discussions with local residents and those who have first-hand experience of palliative and end of life care received in NW London. We would like to thank all those who have already taken part. The report will be revised as further feedback is received with a final report published at the end of July 2022.
- The outcome report was sent to stakeholders across NW London including council and NHS leadership, MPs and Healthwatch. We also used our established channels to communicate with other stakeholders and North West

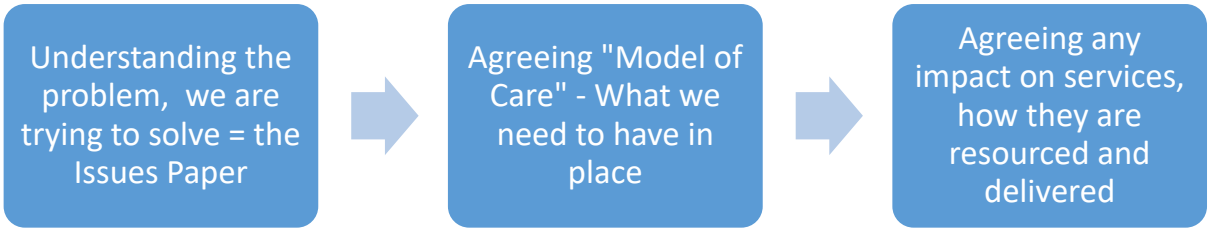
London residents. A short video was produced to accompany the launch and a newsletter that has been distributed widely.

- All the public feedback received is currently being used by our CSPC model of care working group, which is responsible for designing, planning and recommending options for the future model of care for adult community-based specialist palliative care to the steering group.
- Membership of this group consists of local residents, clinicians and other palliative and end of life care stakeholders. The group has been asked to:
    - agree a common specification / common core offer for community-based specialist palliative care
    - develop a new model of care to deliver the specification / common core offer
    - map out how this can be implemented in each borough.
- The work will draw on the national service specification for adult palliative and end of life care, the previous NW London 4 CCGS palliative care review programme work and qualitative and quantitative feedback from residents and healthcare professionals obtained through our engagement. We will also utilise activity trend data obtained through the programme's data working group and undertake further work looking at the structure of our services workforce.
- The expected output is a set of core service standards, requirements and service functions that will need to be delivered across NW London. There will also be a number of additional localised requirements that the local Borough Based Partnerships will have responsibility for implementing these in view of their local context and population needs.
- We will work with the Health & Care Partnerships, local residents and stakeholders to decide whether the new service standards can be delivered by existing service structures or whether a service change is needed. If substantial service change is needed, we will then need to consider if a public consultation is needed.
- Moving forward, our expectation is that there will be wide ranging resident and stakeholder involvement throughout this process. If significant service change is proposed, we would undertake a formal consultation.
- The inpatient unit at Central London Community Healthcare NHS Trust's (CLCH) Pembridge Palliative Care Centre continues to remain suspended until further notice following its closure due to a lack of specialist palliative care consultant cover and being unable to recruit due to that national shortage of trained personnel. It takes significant consultant resource to run and oversee an inpatient unit and based on current capacity CLCH would not be able to run this safely in the absence of SPC consultant cover. All other services (24/7 advice line including palliative care consultant support, community specialist palliative care nursing service, rehabilitation team support service, social work and bereavement support service, and day hospice services at the Pembridge Palliative Care Centre are unaffected and continue to operate as usual.

Next Steps

We want to work with local residents, clinicians and partners from volunteer, community and faith organisations to jointly identify and decide what high-quality community-based specialist palliative care looks like. We will then develop a new model of care for our community-based specialist palliative care provision that broadly

defines the way that services are delivered, in a way that can be maintained, is culturally sensitive and better meets our diverse population's needs. The new model of care must be affordable and financially sustainable in the short and long term and will be delivered across the whole of North West London to make sure that everyone receives the same consistent high standard of care.



This involves a respectful and responsive approach to the health beliefs and practices, and cultural and linguistic needs, of diverse population groups. However, it goes beyond just race or ethnicity and can also refer to characteristics that are protected by the Equality Act, such as a person's age, gender, sexual orientation, disability and religion, and also social exclusion and socio-economic deprivation (deprivation caused by factors such as being unemployed or on a low income, or living in a deprived area), education and geographical location. (For more information, visit www.equalityhumanrights.com/en/equality-act)

When we have completed our research and received everyone's feedback, we will look to develop the model of care that will deliver the high-quality safe and fair care that people deserve. Our next step will be to look at what services are needed in the future to deliver this new high-quality model of care, that is not only affordable, but sustainable in in the long term, and to bring forward proposals that set this out.

So, for now, we are not looking at or discussing what current community-based specialist palliative care services look like or what their future should be, or how many beds we need in a community setting. That will come in due course when we have agreed what good-quality care looks like and the model of care we need to develop in order to provide it.

In summary, we are having a conversation about what we need to do to improve the quality of care our residents and their families and carers receive when they need community-based specialist palliative care.

From this starting position, we want to work with patients, clinicians and the wider community to develop and introduce a new model of care which is fairer, more joined up, high quality and can be maintained in the long term. It must also meet the clinical and individual needs of patients from diagnosis through to the end of their life, and reflect the choices that people want to make on the care they receive and where they receive it.

Conclusion

- We are undertaking a wide range of engagement and events to understand the improvements residents and health care professionals want in terms of community-based specialist palliative care.

- We have reviewed the feedback and published an interim engagement outcome report that is being used by the model of care working group which is responsible for designing, planning and mobilising the future model of care for adult community-based specialist palliative care.

- It is anticipated that the model of care working group will complete its work in Autumn 2022. We will then move into a development phase where we will carry out a gap analysis, costing exercise and develop the costing model. This will be accompanied by the commencement of an assurance process with NHS England/NHS Improvement and the London Clinical Senate.

- The inpatient unit at the Pembridge remains closed, however, we are currently providing alternative provision through neighbouring local hospices.

- We recognise that services need to be accessible locally and will review inpatient provision as a key part of the review, but cannot pre-empt what this means at present.

We welcome further feedback and suggestions from Hammersmith & Fulham Council. Please let us know by emailing nhsnwlccg.endoflife@nhs.net

North West London Integrated Care System
Working together for better health and care

Community-based specialist palliative care improvement programme

Report to:	**LBHF Health, Inclusion and Social Care Policy and Accountability Committee**
Date:	**20 July 2022**
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1. Introduction

Working together with residents, the London Borough of Hammersmith & Fulham and other councils across North West London (NW London) it is going to be critical to ensure we best meet the needs of those who require community-based specialist palliative care.

We are undertaking a NW London exercise so we can learn good practice across our eight boroughs and meet the ICS objectives around equality of access, experience and outcomes, however within that the specific concerns and needs in each borough are important.

This paper describes the overall NW London approach but seeks to draw out for Hammersmith & Fulham specifically:

- The co-production and engagement taking place at a local Hammersmith & Fulham level through the auspices of the Hammersmith & Fulham Health & Care Partnership (HCP) – see page 14
- Details on the area we know to be of most ongoing concern – and our efforts to address this – see page 10

We will continue to engage with Hammersmith & Fulham residents, stakeholders and teams to ensure the outputs of this review work for Hammersmith & Fulham, and will deliver improvements in the experience of your residents, their family and carers.

We welcome the chance for a discussion today on the balancing of these issues. When we come to mutual decisions we need to know they are backed up by robust engagement and that we have worked through the pros and cons transparently.

Key points for Hammersmith & Fulham and NW London

- The NW London ICS wants to work with patients, carer and families and other stakeholders to understand how we can improve the experience for all adults who use community specialist palliative care services in North West London.
- A North West London wide steering group has been established that consists of NHS providers, hospices, local authority and resident representatives. Our Issues Paper sets out the key reasons why we are looking at community-based specialist palliative care and helps us have a conversation on what future care could look like.
- An engagement period started on 18 November 2022 and was extended to mid-March due to Omicron – during the winter key partners were largely deployed to the immediate response and as such the pause in work was regrettable but unavoidable. Further engagement has/is occurring to ensure that all boroughs have the opportunity to have discussions including the Westminster, Kensington & Chelsea, Hammersmith & Fulham event that took place on the 15 March 2022 and the Hammersmith & Fulham engagement event that took place on 11 May 2022.
- In order to ensure effective local engagement; the Hammersmith & Fulham Health and Care Partnership (H&F HCP) worked closely with lay partners and members of Hammersmith and Fulham Save our NHS (HAFSON) to develop a local engagement strategy.

- Locally, it was agreed to extend the scope of the engagement to include the breadth of “out of hospital” Palliative Care Services within H&F (generalist and Specialist Palliative Care together). The feedback gained will feed into local service development as well as the NW London programme.
- HAFSON provided a welcome submission at a NW London level and we include this and our response published on the NWL ICS Website at www.nwlondonics.nhs.uk/get-involved/cspc/how-get-involved/interim-engagement-outcome-report-key-finding
- There are some things that we have found that needed to be addressed immediately. We found not all boroughs had the same level of in and out of hours’ access to end of life care and anticipatory medication. The gap in West London, Central London and Hammersmith & Fulham boroughs was closed by commissioning an equivalent service meaning that during the pandemic all NW London residents have equal access to these medications 24 hours a day.
- An interim engagement outcome report was published on Thursday 9 June 2022 which contained all the feedback given following discussions with local residents and those who have first-hand experience of palliative and end of life care received in NW London. We would like to thank all those who have already taken part. The report will be revised as further feedback is received with a final report published at the end of July 2022.
- The outcome report was sent to stakeholders across NW London including council and NHS leadership, MPs and Healthwatch. We also used our established channels to communicate with other stakeholders and North West London residents. A short video was produced to accompany the launch and a newsletter that has been distributed widely.
- All the public feedback received is currently being used by our model of care working group, which is responsible for designing, planning and recommending options for the future model of care for adult community-based specialist palliative care to the Steering group.
- Membership of this group consists of local residents, clinicians and other palliative and end of life care stakeholders. The group has been asked to:
    - agree a common specification / common core offer for community-based specialist palliative care
    - develop a new model of care to deliver the specification / common core offer
    - map out how this can be implemented in each borough.
- The work will draw on the national service specification for adult palliative and end of life care, the previous NW London 4 CCGs palliative care review programme work and qualitative and quantitative feedback from residents and healthcare professionals obtained through our engagement. We will also utilise activity trend data obtained through the programme’s data working group and undertake further work looking at the structure of our services workforce.
- The expected output is a set of core service standards, requirements and service functions that will need to be delivered across NW London. There will also be a number of additional localised requirements that the local Borough Based Partnerships will have responsibility for implementing these in view of their local context and population needs.
- We will work with the Integrated Care Partnerships, local residents and stakeholders to decide whether the new service standards can be delivered by existing service structures or whether a service change is needed. If substantial service change is needed, we will then need to consider if a public consultation is needed.

- Moving forward, our expectation is that there will be wide ranging resident and stakeholder involvement throughout this process. If significant service change is proposed, we would undertake a formal consultation.
- The inpatient unit at Central London Community Healthcare NHS Trust's (CLCH) Pembridge Palliative Care Centre continues to remain suspended until further notice following its closure due to a lack of specialist palliative care consultant cover and being unable to recruit due to that national shortage of trained personnel. It takes significant consultant resource to run and oversee an inpatient unit and based on current capacity CLCH would not be able to run this safely in the absence of SPC consultant cover. All other services (24/7 advice line including palliative care consultant support, community specialist palliative care nursing service, rehabilitation team support service, social work and bereavement support service, and day hospice services at the Pembridge Palliative Care Centre are unaffected and continue to operate as usual.

We share with Hammersmith & Fulham Council and residents a focus on palliative care because of the importance of getting care and service provision right

> ""We have seen what a difference specialist palliative care services can make to a patient and their families and carers as they come to the end of their life but unfortunately we have seen what can happen if the care and support is not there and the damaging legacy for those left behind. That is why it's important that we work together to develop services that are clinically to a high standard but also meet what patients and family's need."
>
> **Dr Lyndsey Williams,**
> **NW London GP Clinical Lead for End of Life and Care Homes**

It is widely recognised that when caring for someone in the last year of their life, we have only one chance to get it right.

Anyone at the end of their life should be able to live and be cared for where they want to be and be with the people they want to be with. They (and their family, loved ones and carers) deserve the best quality care and support, regardless of their circumstances. We live in a

> "We need to remember how scattered families can be and how people in theory would often like to think of dying at home, and so would their families. But the reality and the lack of properly seamless care means that it becomes an impossibility or can lead to a very, very negative death. The repercussions upon individuals of experiencing negative death of somebody they care about go on to have psychological and other repercussions throughout their lives."
>
> **Quote from member of the public attending the engagement event on 13 December 2021**

rapidly ageing society, where people are living longer but are more likely to live with multiple complex long term conditions. As a result, the need for high-quality palliative and end-of-life care is expected to increase dramatically by 2040.
Too many people experience poor care as they approach the end of their life, with many people spending their last months and weeks in hospital, often dying there, which may not be what they want. Not only can this be distressing for the patient and their loved ones, but it also adds more pressure on acute hospitals.

Palliative and end-of-life care is a national priority, as well as a priority for health and social care partners across NW London. In NW London we have some excellent palliative and end-of-life care services for adults (aged 18 and over), provided by very committed partner organisations, but we know that we need to improve the care we provide in hospitals, community settings (such as hospices and day centres), primary-care settings and patients' own homes. We want to make sure
all patients have equal access to accessible, consistent, high-quality care across all palliative and end-of-life care services.

More also needs to be done to make sure the care provided by different organisations is more joined up. This includes looking at the IT challenge of not all services having appropriate access to clinical information held electronically by partner providers for patients under their care; and making sure all patients have a personalised care plan that has been agreed with them, and that the plan is available to the different care sectors supporting them and their family.

2. Our focus on community-based specialist palliative care

We are focused on community based specialist care for adults at this stage because of the fragility of those services.

In North West London we have eight community-based specialist palliative care providers providing services. These include seven hospices with inpatient units, as well as separate community specialist palliative care nursing services.

The providers deliver a wide range of services (including inpatient and community-based specialist palliative care nursing, day hospices and outpatient services) as well as some additional specialist services (including lymphedema, well-being services and complementary therapies).

Three providers – Central London Community Healthcare NHS Trust, London North West University Healthcare NHS Trust and Central and North West London NHS Foundation Trust – receive all their funding from the NHS. The other five providers are charitable hospices and receive their funding from a combination of NHS and charitable income.

- Royal Trinity Hospice is based in South London. It provides services to parts of Hammersmith & Fulham, Westminster and Kensington & Chelsea.
- St John's Hospice is based in Westminster. It provides services to Brent,
- Hammersmith & Fulham, Westminster and Kensington & Chelsea. It is located in St John's Wood on the St John and St Elizabeth's Hospital site.
- Marie Curie Hospice is based in Hampstead and provides services to Brent.
- Marie Curie's London Nursing Service provides end-of-life rapid response and nursing services to Ealing and Hounslow.
- St Luke's Hospice is based in Harrow. It provides inpatient and other hospice services to Harrow and Brent, with their community specialist palliative care nursing team only providing cover to North Brent.
- Harlington Hospice is based in Hillingdon. It also provides the Michael Sobell hospice inpatient unit which is located at the Mount Vernon Hospital in Hillingdon. Both services serve Hillingdon.
- Meadow House Hospice is based at Ealing Hospital, and is run by London North West University Hospital Trust. It provides services to Ealing and Hounslow.
- Pembridge Palliative Care Service is in North Kensington. It provides services to Hammersmith & Fulham, Westminster, Brent (South) and Kensington & Chelsea (please note, the inpatient bed part of this service is currently suspended).
- Harrow Community Specialist Palliative Care Team is also provided by Central London Community Healthcare NHS Trust, and provides services in Harrow only.
- The Hillingdon Community Palliative Care Team and Your Life Line Service are provided by Central and North West London NHS Foundation Trust. These services are provided in Hillingdon.

The NHS and its partners are committed to making improvements in community-based specialist palliative care for adults within this review process, but will continue to seek to improve other areas of palliative and end-of-life care where possible in parallel.

Beyond this review there are opportunities for improvement across the wider palliative care landscape

We also want to raise awareness of the importance of palliative and end-of-life care in general, and discuss what we want to see in the future from high-quality, safe, community-based specialist palliative care for adults, which also delivers an excellent patient experience. We want to:

- Make sure everyone receives the care they need, when they need it, regardless personal characteristics such as their gender, ethnicity, social standing or where they live (this is known as equity of access), and improve the quality of care our residents and their families and carers receive.
- Improve the experience for our patients, and their families and carers, by developing services that reflect what is important to them at the end of their lives, from diagnosis through to death.

We are not reviewing children's and young people's palliative and end-of-life care services, community nursing which provides generalist palliative and end-of-life care services, or acute hospital services which provide specialist palliative care services.

However, we will be working hard to make sure that our work links closely and joins up with hospital specialist palliative care and all other generalist palliative and end-of-life care services in North West London. We will also work with a number of NW London ICS's other service-improvement initiatives that are already looking to reduce differences in and improve the quality of non-specialist (generalist) palliative and end-of-life care services. This includes the NW London Community Nursing Review and NW London Enhanced Health in Care Homes programme.

Difference between generalist and specialist

Palliative and end-of-life care can be generalist or specialist. By community-based specialist palliative care services, we mean care and support services that are not provided in an acute hospital, GP surgery or by district nurses or community matrons. Instead, they are provided in a patient's own home, a care home, a hospice, a community hospital or health centre by specially trained multi-disciplinary teams.

Specialist palliative care professionals, such as palliative care doctors, nurse specialists, therapists and psychologists, are experts in providing palliative and end-of-life care and have specific training and experience. They usually become involved
in a patient's care to help manage more complex care problems that go beyond the expertise and knowledge of a patient's generalist and usual care team (for example, their GP and district nurses). They work closely with the patient's GP and district nurse to offer advice on controlling pain and managing symptoms, provide emotional and practical support for patients, their loved ones and carers in preparing for the end of their life and, after the patient dies, offer bereavement support to their loved ones.

Generalist palliative and end-of-life care is provided on a day-to-day basis by many health and social care professionals, such as GPs, district nurses, social workers and care home staff. A patient's family and carers can also provide generalist palliative and end-of-life care in the patient's home.

3. Building on feedback from previous engagement

We must build on feedback previously given – valuing people's time and views, by showing progress where ever possible

When we talked to people about community-based specialist palliative care services previously, we heard what a crucial role the services play. The feedback confirmed that people really value their local specialist services and people with experience of these services are very positive about the care they have received.

We have also heard that services need to be made available to more people 24 hours a day, particularly that out-of-hours services (those provided between 5pm and 9am) need improving to make them more inclusive and adaptable, and to offer more choice and be more co-ordinated. People told us it is important to improve access to these services so more people receive care and are supported to die in their preferred setting, whether this is at home, in a hospice or in hospital. It is also important that people don't have to travel too far to access service.

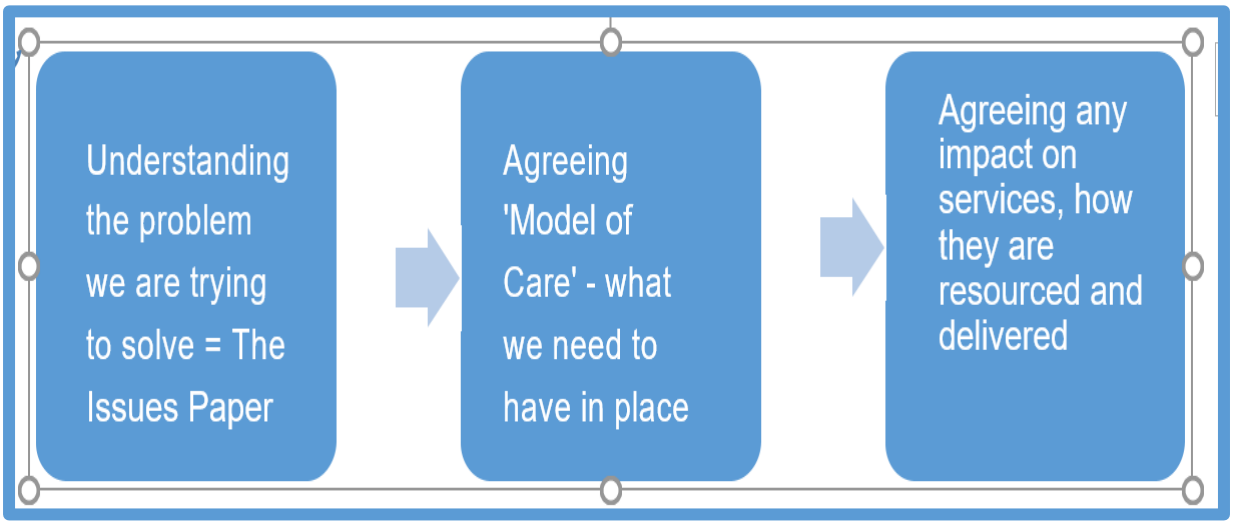
The feedback showed that people have different views on how we should make these improvements. We want to build on the feedback and what we have learnt from it. We also want to fully understand the role culture and religion can play in influencing the way people relate to their health, the support they want to receive and the way they experience loss and grief. We will then use this insight to develop services that can take this into account.

For more information on the Palliative care services improvement programme in the London Boroughs of Brent, Hammersmith & Fulham, Kensington and Chelsea and Westminster, visit www.nwlondonics.nhs.uk/get-involved/cspc/how-get-involved/building-feedback-previous-engagement

4. Next steps

We cannot resolve the current situation and issues unless we work in partnership with residents and other stakeholders –we welcome Hammersmith & Fulham Council support to do this

We want to work with local residents, clinicians and partners from volunteer, community and faith organisations to jointly identify and decide what high-quality community-based specialist palliative care looks like. We will then develop a new model of care for our community-based specialist palliative care provision that broadly defines the way that services are delivered, in a way that can be maintained, is culturally sensitive and better meets our diverse population's needs. The new model of care must be affordable and financially sustainable in the short and long term and will be delivered across the whole of North West London to make sure that everyone receives the same consistent high standard of care.



This involves a respectful and responsive approach to the health beliefs and practices, and cultural and linguistic needs, of diverse population groups. However, it goes beyond just race or ethnicity and can also refer to characteristics that are protected by the Equality Act, such as a person's age, gender, sexual orientation, disability and religion, and also social exclusion and socio-economic deprivation (deprivation caused by factors such as being unemployed or on a low income, or living in a deprived area), education and geographical location. (For more information, visit www.equalityhumanrights.com/en/equality-act)

When we have completed our research and received everyone's feedback, we will look to develop the model of care that will deliver the high-quality safe and fair care that people deserve. Our next step will be to look at what services are needed in the future to deliver this new high-quality model of care, that is not only affordable, but sustainable in in the long term, and to bring forward proposals that set this out.

So, for now, we are not looking at or discussing what current community-based specialist palliative care services look like or what their future should be, or how many beds we need in a community setting. That will come in due course when we have agreed what good-quality care looks like and the model of care we need to develop in order to provide it.

In summary, we are having a conversation about what we need to do to improve the quality of care our residents and their families and carers receive when they need community-based specialist palliative care.

From this starting position, we want to work with patients, clinicians and the wider community to develop and introduce a new model of care which is fairer, more joined up, high quality and can be maintained in the long term. It must also meet the clinical
and individual needs of patients from diagnosis through to the end of their life, and reflect the choices that people want to make on the care they receive and where they receive it.

5. Insight report

We understand it is really frustrating for people to provide feedback, not see any action, and then be asked again for their views

We have received a tremendous amount of feedback which we are responding to and have taken to date. There are also some areas we are currently developing and implementing or propose to do in partnership, to address the issues raised to support improved care and support for patients, families and carers in the last phase of life. We also detail feedback received where we do not feel able to take action, with the reason for that given.

Our aim is to continue to work collaboratively with our public, patients, clinicians and other system partners to build on this work as it is a key part of the next phase of this programme when we look to explore the model of care and service design options to meet our NW London population's community-based specialist palliative care service's needs.

Feedback	Action taken
• Align GPs more closely with individual care homes and develop enhanced care service for care home residents. • This needs to include the development of personalised care plans to support their care needs and expressed wishes and involve relevant health professionals and the families and carers in these care planning conversations in as much as possible.	• As part of the PCN Direct Enhanced Service (DES) all care homes in NW London have a named GP and where possible are aligned to a single PCN. We are currently working on developing a NW London wide common core standard that will provide enhanced support to care homes and cover the provision of Multi-Disciplinary Team (MDT) working and personalised care and support planning. This includes advance care planning and use of Coordinate my Care/Urgent Care Plan.
• Increased access to end of life and anticipatory medication in the community. Community Pharmacists should be included in the engagement and review process to understand the issue of availability and timely access to end of life medication for patients, families / carers and clinicians in the community.	• Not all boroughs had the same level of in and out of hours' access to end of life care and anticipatory medication. The gap in West London, Central London and Hammersmith & Fulham boroughs was closed by commissioning an equivalent service meaning that during the pandemic all NW London residents have equal access to these medications 24 hours a day. The NW London Medicines Management Team have recently reviewed the service contracts and are putting plans in place to ensure ongoing 24-hour access to end of life and anticipatory medications in the community. • NW London has implemented the Pan-London Symptom Control Medicines

	Authorisation and Administration (MAAR) Chart, developed by the End of Life Care Clinical Network . This MAAR chart supports safe administration of complex injectable regimens.
Feedback	**Action being take**
• Include clinicians in public engagement meetings and patients in programme working groups for the purpose of transparency and trust.	• During the previous review of palliative care that took place in Brent, Hammersmith & Fulham, Kensington & Chelsea's and Westminster in 2020, we had a clinical reference group who worked on development of the new model of care and options. We did not have any public and patient representation on this group. For this programme we have developed a model of care working group that will have public, clinical and operational lead representatives.
• Access to 24/7 end of life care advice and support for patients, families, carers and clinicians, which includes a single point of access and co-ordination service. This is of particular importance during the out of hours period between 5pm and 8am when the patient may be experiencing a lot of pain and the family and carer may not be able to contact the usual care team or know which services to contact for support.	• All of the hospices that provide services in NW London now provide 24/7 nurse led advice lines that have 24/7 palliative care consultant support. • A further gap was identified for the Harrow Community Specialist Palliative Care team who did not have seven day working and visiting available. We have secured funding to support the development of this service and work is underway to mobilise this as soon as possible.
Feedback	**Action we propose to take**
• Having hospice inpatient services locally is very important, particularly for residents where the spouse, carer and family of the patient requiring hospice inpatient care is elderly or has family and work commitments and are negatively impacted by increased travelling time. Consideration should be given to re-opening the Pembridge inpatient service as part of the service review.	• This programme will be reviewing the role specialist palliative care inpatient beds play in community-based specialist palliative care provision so that we understand the level of need and capacity required across NW London using data to support this work. Discussions about the level of need and sites will happen at a later stage in the review once the new model of care has been developed.
• Not enough support available or consistent offer of bereavement	• Bereavement care and support really came to the fore as a gap nationally, regionally

support (pre and post death) available to patients, families and carers. Could this reviewed as part of the latest programme of work to understand current provision and what more could be done to improve this offer.	and locally during the Covid-pandemic. Through the community-based specialist palliative care review programme we will be scoping current provision and gaps for NW London which will then be considered as part of the new model of care development work.
Feedback	**Reason why we are not able to take action at this stage**
• We have heard from local residents and stakeholders that they would like the NHS to reopen the **Pembridge Palliative Care Unit in-patient beds.**	• The inpatient unit at Central London Community Healthcare NHS Trust's (CLCH) Pembridge Palliative Care Centre continues to remain suspended until further notice following its closure due to a lack of specialist palliative care consultant cover and being unable to recruit due to that national shortage of trained personnel. • It takes significant consultant resource to run and oversee an inpatient unit and based on current capacity CLCH would not be able to run this safely. All other services (24/7 advice line including palliative care consultant support, community specialist palliative care nursing service, rehabilitation team support service, social work and bereavement support service, and day hospice services at the Pembridge Palliative Care Centre are unaffected and continue to operate. • In April 2020, the inpatient beds at Pembridge were temporarily re-designated for the for rehabilitation of Covid positive patients. We were able to staff the service – which was not consultant led- because we had national guidance to pause many other services. It is unlikely that Pembridge will be required to fulfil this function again due to the knock on impact on those other services. • We do recognise that local residents are disappointed with the need to suspend this inpatient service and confirm that a decision on the future of the unit will only take place following the completion of the community-based specialist palliative care review that the North West London Integrated Care System is leading and is currently underway.

	• We confirm that qualitative factors such as local accessibility and stakeholder views will be an important consideration alongside quantitative factors such as capacity and referrals when making any decisions regarding future provision of community-based specialist palliative care service in NW London including the future of the Pembridge in-patient beds. • For more details visit www.nwlondonics.nhs.uk/get-involved/cspc/how-get-involved/pembridge-palliative-care-service

Moving forward, we will continue to update the Insight Report and the actions we have taken as a result. You can find the most up to date Insight Report here.

6. Hammersmith and Fulham Health and Care Partnership (HCP) Local Engagement Update

H&F Engagement Planning/ Strategy

In H&F, as part of the HCP, we have made a commitment that coproduction is at the heart of everything we do. Our aim is to work with the residents and communities from the very start, to understand what matters to them, to redesign services in a way that works for them, and to work with them to make changes. In order to ensure an effective engagement; the H&F team worked closely with the lay partners and members of HAFSON to develop the engagement strategy. We worked together:

- To design the engagement material, agree the narrative for a rich conversation,
- looked at ways to promote our event via voluntary sector organisations, tapping into their network to ensure we reach out to all the cohorts and everyone intending to share their feedback has a platform to do so e.g. via online surveys, written feedback via email or post to the NWL ICS team and virtual engagement events.
- To facilitate the conversation at the public engagement event.

H&F Engagement Scope

We wanted to engage meaningfully on the issues that affect people at the end of life and recognised it is difficult to separate out Specialist Palliative Care and general palliative / end of life care, therefore we decided with all the HCP partners in agreement to extend the scope of our engagement to include the breadth of “out of hospital” Palliative Care Services within H&F (generalist and Specialist Palliative Care together).

Event Promotion

We wanted to ensure the engagement options (Event and surveys) become visible throughout the Hammersmith and Fulham for all the communities and cohorts therefore we reached out to all our partners, a number of charities and voluntary sector organisations to promote our event.

- Colleagues from HAFSON (Marion Summerfield, Merril Hammer and James Grearly) have been instrumental throughout the engagement process and key in promoting our engagement event and online surveys. They advertised the event on HAFSON website and promoted the link to their network members.
- Initial findings from the ICS work revealed that the Ethnic minorities, LGBTQ+ and faith groups were not using the service as much so we linked in with BAME Health forum and Opening Doors London to tap into their network to spread the word and encourage residents to come share their views with us. BME Health forum published our event details on their website, included it in their newsletter and also sent it to their network individually. Opening Doors London promoted our event on twitter and Facebook.
- SOBUS published the H&F event on their website and promoted it via their April and May newsletter. Sharon Tomlin from SOBUS has offered to help us arrange individual engagement sessions with specific communities and faith groups in phase 2 of the engagement.

- Providers of Older Peoples services (POPS) forum - It is an initiative to get the voluntary sector in Hammersmith and Fulham working in collaboration with older people's issues. The Borough team presented at the forum 19 April 22 and requested all providers to promote our event and surveys. This forum was attended by over 30 provider organisations.
- Older Peoples Care Homes and DOM care providers within H&F circulated the survey link and event details to their existing and previous clients.
- Local authority team advertised the event through their social media channels.
- The event details were shared with the Patients / Citizens Panel that have over 220 members signed up for H&F.
- In addition to the above following organisations promoted the event via their website, newsletters and social media handles e.g. twitter, Facebook, Instagram etc.
    - Carers Network
    - Healthwatch Hammersmith & Fulham
    - Imperial Warf Resource centre
    - White City Community e-newsletter
    - Royal Trinity Hospice
- The HCP team linked in with various other forums and voluntary sector organisations / charities including: Age Uk, H&F Community champions, Maggie's, Marie Curie, H&F Disability Forum etc. to promote the event.

H&F Engagement

Virtual Event & Meetings:

- Engagement via End of Life HCP subgroup meeting held on 8 March 22
- Engagement via End of Life HCP subgroup meeting held on 3 May 22
- Hammersmith and Fulham Health & Care Partnership Public Involvement Event held on 11 May 22

Questions we asked at the engagement event

H&F has a diverse population and it important for us to understand our communities' views on death and dying.

- What is good about Palliative and End of life Care in our area? What is working well for our residents at the moment?
- What needs improving?
- What does "good death" mean for our communities considering their cultural, religious and ethnic background?
- What do we need to consider and change about palliative and end of life care services to make it more equitable and accessible for our diverse population?
- If there is one thing you would change, what would that be?

Other feedback Options

Online Surveys

- **Long survey for those with experience of community-based specialist palliative care** - Community-based specialist palliative care - full survey (jotform.com)

- **A short online survey for those with no experience of community based specialist palliative care**.- https://form.jotform.com/213391249977367
- **Small-scale survey, by clicking on this link -** https://form.jotform.com/220603723913348

Feedback in writing

- **Via Email to** nhsnwlccg.endoflife@nhs.net
- **Via post to:** Community-based specialist palliative care review, North West London Clinical Commissioning Group , Ferguson House, 15 Marylebone Road, London NW1 5JD

H&F Health & Care Partnership (HCP) Engagement Outcomes / Feedback

Key Highlights from the Public engagement event held on 11 May 22:

- **Support for patients with addiction, isolation, loneliness and vulnerability** - A question was raised on how to refer vulnerable patients to palliative care who have addiction and live in Isolation. An example given of a man in mid 40s who had alcohol addiction, his GP was aware of the addiction and supporting the gentleman. However, the concern raised was how people like this have access to EOL services. There is evidence that people with addiction and loneliness have shorter life span therefore Palliative care needs to consider everybody regardless of their circumstances or location. ***We need to use the borough partnership to find effective way to link between primary care and primary care network and the services available in the borough to support those in isolation and enable them to get the support they need.***

- **Saving Pembridge Hospice** – Questions were raised on why the Hospice in patient unit is still closed? Care needs to be delivered closer to home especially for patients in last days of their life. It is a vital part of the offer to the local people, particularly those who don't have any family to rely on. The ICS was asked to consider seriously bring it back into use as it is a very good example of what can be done to help people have a good death. Due to closure of these beds, patients and their families, carers have to travel further for EOL service which is not ideal. We need to consider making resources available locally. Nearly 2000 signatures have been collected to save the hospice and these will be sent to the ICS Programme team via email to nhsnwlccg.endoflife@nhs.net

- **Simplify documentation** – A call was made for Palliative care consultation documentation to be made simple and easy to read for local communities. The current materials need to be put in non-jargonistic terms.

- **Out of hours' access to nurses and care** should also be considered as there is limited or no support available in some areas in evenings, nights and weekends. We heard an example of a patient receiving care at Royal Marsden Hospital who was continuously unwell. It was difficult to get access to a Macmillan nurse after 5pm and

this lack of support when it was needed was very stressful for the carer and patient, who understandably wanted to avoid A&E at all costs as not an ideal environment for someone on chemotherapy.

- **Patient's choice matter –** a patient's story was shared. He was told he had days to live, he was not able to communicate well and without an informed discussion with him or family, he was suddenly moved to a care home where the wife could not visit. Patient died alone in a care home and the wife is now suffering the effects of this. about this. We need to improve the system to ensure everyone gets to choose and care is delivered at the chosen point of delivery on time without delays. This is another example showing Pembridge being closed have an impact on local people.

- **Concerns about separating specialist palliative care from totality of palliative care support** – we need to ensure a holistic picture is considered as part of the review. **Continuity of care between places and forms of care is vital** and when it breaks down it creates problems – the value of hospital, hospice, District Nurses and GPs are important to the patients in all this and must be considered together. - *We will do this by connecting the work in the boroughs with local teams and the work of the NWL team working on the Community Specialist Palliative Care review, alongside other NWL teams working on other parts of the system.*

- **Flexibility is important** - patients and their carers need to know that the patient can be moved between places of care, between caring agents as needs change and it needs to happen quickly without delays. It should include assessment of needs, rehabilitation, respite as well as ongoing care.

- **ParaDoc Model of Care –** A suggestion was made to introduce ParaDoc model of care in H&F. This is working very well for communities in Hackney especially for patients with hospice at home. The team comprises of a Paramedic and a Nurse in a car. They have support from the GP where required and have access to summary care records. Rather than taking the patient to A&E, they can carry out advanced assessment, prescribe medication, stabilise the patient at home. They carry treatment equipment along with a range of oral and injectable drugs, including End of life drugs. This was a good example of new developments to support people to remain in the community.

- **Access to relevant Information is critical** – we need to ensure that people who are caring for somebody have access to the record and the patient notes.

- **Equitable Care provision** – We need to consider equity in care provision. Improvement is needed in the current core services. Care plans should be based on patient's needs (clinical and social).

- **Improve integration between NHS service & Council Service** – concerns were raised whether palliative care is joined up with the social care delivered by the local authority. A member shared their experience where her mum had 2 carers coming four times a day. Frequent change between carers did not work and was very unsettling, however the palliative care provided by the district nurses was excellent during working hours and out of hours. On three occasions, social carers called for an ambulance instead of having a discussion with the family. On one occasion, the district

nurse had to visit to talk to the ambulance crew, she explained them that the patient was dying and did not want to be moved to the hospital. The crew agreed and left. The patient died peacefully after three days. After the death, District nurses remained in contact with the daughter to support her and came back to remove the catheter. Patient's family felt supported through the NHS side but believe that the linkage between NHS service, Council service and voluntary service should to be looked at. It needs better integration.

- **Guidance and training for Social Carers** - A member shared their experience and mentioned she had an excellent support from District Nurses and GP. She felt very supported but suggested that guidance and training for social carers on how to make the last days of a person's life palatable/comfortable would be helpful.

- **Death Café / Coffin Club** – a suggestion was made to explore having Death Café / Coffin Club in H&F. A charity organisation currently runs this service in a neighbouring borough. They have social gathering about beginning conversations about death, looking at death in a creative way and normalising the conversation.

- **Spiritual support in EOL and education to facilitate this**- Spiritual support / service is important for many ethnic minority communities. Training not only from the perspective of the patient whose life could be coming to an end soon but also for spiritual leaders so they have a better understanding of palliative care is important. Some faith leaders are actively involved and very aware however some are not because they are busy and stretched, supporting their congregation and their members. It was suggested that education and raising awareness amongst various communities would be very helpful.

- **Inequalities in accessing services** - We need to consider Inequalities in accessing palliative and end of life care for people from different ethnic backgrounds. Having regular death cafes will help raise awareness. We need to continue the engagement to identify inequalities. Sharon Tomlin from SOBUS mentioned there are different ways to engage with communities and offered to help with targeted listening around palliative care.

- **Assessment tools in borough** – A question was asked about how we take note of what the Community says about their extensive experience about life and death and the palliative care service generally? How is the feedback documented and how is it is it assessed? How is it fed up the chain within the system to create meaningful listening and dialogue?
  Response – Today's conversation is an example of meaningful listening, our team has tried to reach out far and wide to ensure we hear from our local residents from all communities. All the feedback gathered for Specialist Palliate care will be submitted to the ICS programme team to inform the current review. One of our Campaign groups in our borough based partnership has a subgroup focussed on End of Life – this is an on-going piece of work and all the general palliative care related feedback from this event will be submitted to that group to help them shape their work and agree priorities. In terms of keeping this conversation going and getting input from our communities we are open to any ideas this group can share.

- **Reducing Unnecessary Hospital admissions in EOL** - Concerns were raised regarding the figures included in the presentation i.e. 49% died in hospital and the need to reduce this further. A member questioned how would this be achieved especially with the new bill it is going be even more problematic. The view was that most of these people died in hospital because there was no alternative place such as a hospice or a care facility or the social workers could not sort care for them at home. ***Response*** - In response to this the Chair stated that we don't have an immediate answer to that at the moment but the intention is to design a system that tackles this issue. The ask for tonight is to feed views into the NWL system so that we can design a model of care for the future. The development of new model starts in mid-May and completes in end of August. The aim is to design something that is going to provide good quality care and equity of access and choice and all the things we've talked about in terms of being really important.

- **Equivalent Support for people who do not associate with spirituality or religion** – A view was expressed that we need to consider at what point do you start a conversation with them and at what point would you start to introduce the Death Café, Coffin club? Many people have different ideologies around death and we need to be mindful that not everyone would need / prefers spiritual support.

- **Role of carers and how they are supported** – A lot of carers are unpaid volunteers from voluntary sector or are family members and a lot of burden is often put on them. It is important to consider what is asked of carers and to think carefully how they are supported by the system. It was felt that carers are on the whole not recognised well by the system and need more support.

- **Helpline/ Single point for contact** – strong views were expressed around the need for the EOL patient and their family/ carer having a single person or a single team identified at all times that they can contact for advice and support. People need assurance that there will be somebody, a name person or a team easily contactable when needed and that decisions related to the patient's care will be made on time without any delay.

- **Consider Gender issue** – a point was raised regarding the gender of carers, and the impact on women carers as also there is an increasing number of women living alone in H&F and in NWL. It has a real implication for what care might, could, should be provided at end of life.

- **Promote information and understanding of available services for local residents** – a simple and easy to read format for older population and people with Mental health conditions should be made available and readily distributed. This will help create awareness on what is available and who to call on when needed.

- **Continuity of care for people with Dementia –** changing carers often and seeing a different carer frequently is not appropriate for people with dementia- it causes confusion and is difficult to cope with. We need to lobby for longer carer calls than 15 minutes for people with dementia at that stage of life. Patients' needs should be properly considered.

- **Religious & Spiritual support for BAME population** –feedback was shared from previous engagement with BAME residents outlining Islamic, non-Islamic and Jewish communities who said they prefer dying at home rather than in a hospital. They would like religious / faith leader or regular Muslim clerk or Imam be available in last days of life. There should be an emphasis on the need to build cultural awareness in the services.

- **Break Language Barrier** – Views were raised around language support for non-English speaking residents to be considered at each stage in care provision. Information should be made available in people's preferred language, and interpreters should be made available at appointments or wherever required.

- **Dignity, Choice, Personalised Care –** there was an ask to consider patients' needs. If for example someone wants someone religious, it needs to be someone they can relate to and not some appointed standard personnel. Dignity and choices is most important and it needs to be personalized.

- **Quality and Consistent Care Closer to home** – there was a strong view that care facilities need to be close to home as it is vital for both patient, their family and carers. Hospices at one point played a hugely valued role but are less available than previously. A lot of families would love to have the choice of hospice care as they don't want their loved one to be in a hospital. There needs to be a consistency and transparency in services. We need to consider how we create consistency? How we make sure everyone has an equitable offer based on their needs regardless of postcode.

- **Make Palliative care accessible for people** – views were expressed that there's no point having an amazing specialist palliative care services if we don't have the palliative care accessible for the majority of people in the community. It needs to start with the primary care services. The primary care services starting from the GPs and district nurses are critical to leading the palliative care provision and to recognize when someone is reaching the end of life and to be able to provide the basic care to them because it will be the very few that will need the specialist palliative care provisions i.e. hospice provision. We have been living with death and dying for thousands of years without the existence of specialist palliative care. So now we are very fortunate that the specialist palliative care exists, but it's not necessary for the vast majority of people. If we have primary care services that can reach people where they live and if we have GP's that can go out and meet people in their own home, we will avoid a lot of unnecessary hospital admissions at the end of life. A member highlighted that we may not be using the specialist palliative care service the best way we could e.g. we are not using Royal Trinity Hospice at 100% of its capacity as it has 28 beds and a part of the hospice was closed during COVID. It caters for H&F and K&C so we need to consider if we really need to have two inpatient units for H&F (i.e. Royal Trinity and Pembridge)? From a practical and financial prospective, it is very expensive e.g. the palliative care provision in a Hospice bed that can be around £500 per day, while with someone at home, it may be cost about £100 or £150 a day. Key is to invest more in general palliative care and have the GP's/primary care services and district nurses leading on the palliative care provision.

- **Empower Family and Carers to handle medication-** Views were expressed that we should consider experience from other countries. It doesn't need to be only a healthcare professional to give essential end of life medication to the patient at home. We can train relatives to give medication including injectable medication. This is happening in other countries and it saves a lot of distress for patient as they don't need to wait for a nurse to come and give injection. It also helps the relatives/ carers to have a sense that they are helping that person to live better until they die.

- **Care Homes as potential resource to support with EOL care** – consider having gold standard care homes specialised in the provision of palliative care and end of life care for residents.

- **Support for Family and Careers** - a question was asked about what happens after death and consider how we should support the relatives and carer of the deceased patient. Psychological support, access to bereavement service is very important.

- **Choice of dignified death at a chosen place** – Patient's choice is important and should be at the centre of care. A care/ nursing home is still very clinical. It is almost like a hospital and are often understaffed. It's equivalent of a hospital because people don't have a choice. Sometimes people go to a care home because they can't get into hospital. It is appropriate for some people, but it should not be a decision that's made for people without their choice. There are not enough hospices around and we need more hospices as it gives patients the feeling of cosiness, homeliness, warm personalised space/ environment that may be lacking if one cannot be in their own home. Hospices provide music therapy and all sorts of support and therapies to create a good death.

- **Integrate knowledge sources**– it was thought that our system is complex and not joined up with acute hospital, GPs, Care homes, Hospices. The challenge for the public and all partners is what our current infrastructure looks like and how we bring the good work together so it is understandable and integrated.

<u>One thing you would like to change?</u>

The following points were made

- **Information hub** / **Recognised system** – We need to build a recognised system i.e. a point of contact an identifiable team of people which is known to public (not just the doctors) that people can contact for advice or to get information on what services /support is available for them and what choices they have. We need a point of contact in our borough where people can contact when they think they need. Within that it is important that people feel they have actually got a choice and perhaps not every choice can be met but the option of having an informed choice and not being forced into making a choice that is good for the NHS because it is under pressure. We need to provide **assurance that people have a choice which is going to be listened to and respected and as much possible met.** It is important to have a choices recognised by system and to have the flexibility to change your mind if needed.

- **Consider what is it about the hospice that we need to create in other settings** and how we foster that? how we make this available outside hospice and in community?

- **Remain updated** - staff should be aware and be educated about the changes happening within the system.

- **All the GPs & nurses need to feel confident about palliative care** as they are the ones that are more in close contact with the patients and can give them options in terms of the care according to the people's wishes and preferences, they can make it make it happen and then all the other services would need to work around it to ensure people can die where they want to die.

Key Highlights from EOL meeting 8th March 22 & 3 May 22

- **Service Awareness and Effective Triage** - We need to ensure the service is cohesive and delivered in a connected way. Sufficient information on what is available within the system should be available for healthcare professionals, carers and service users to ensure timely and effective triage.

- **Proactive Approach instead of reactive** - It is important to have a discussion prior to a crisis to record patient's choice i.e. finding out where the patient would like to spend their last days of life e.g. home, Hospital, hospice, Care home etc. and encouraging them to make decisions.

- **Improve GPs awareness** of end of life services and support from the hospices.

- **Improve communication** between primary care, secondary care, social care and district nurses in terms of seamless discharges whatever day of the week which make things happened quickly and enables people's wishes to be carried out.

- **Ease of access, awareness, peoples wishes to be at the centre** – Patient's choice is important and should be at the centre of care. Early communication between district nurses, patients and family members is required especially when patient's choice and families' wishes don't match as this can creates conflict and negative experience in the end of life care.

- **Include patient, family & Carer** in the early stages of care planning and communication.

- **Family and Carers** – Support the carer who is on that journey – think about how do we navigate the carer's needs, what support is available for them in the system and how we can raise awareness on what is available? – signposting is important.

- **Staff Awareness** - Support the staff in improving their understanding of Carer's psychological impact of losing someone, through stories i.e. patient, family and carer stories.

- The group suggested a small scale pilot – a leaflet outlining first point of contact and available services – look at what services are available within the borough and create a single point of information leaflet outlining these for patients, family members and carers.

Next Steps

- All the feedback collated on Specialist Palliative care has been reported to the NWL ICS Programme team to support the NWL wide review of CSPC services. It will be used by the model of care working group responsible for designing, planning and mobilising the future model of care for adult community-based specialist palliative care. Membership of this group consists of local residents, clinicians and other palliative and end of life care stakeholders. H&F Lay partners and members from HAFSON are active members of this working group.

- Overall engagement feedback including General Palliative care has been reported to the "End of Life Subgroup" under Frailty campaign of the H&F HCP. This working group will utilise the engagement feedback to identify areas for improvement and agree priorities for delivery on a borough level. This group has representation from Carers Network, Lay partners, HAFSON, acute providers, community providers, district nursing teams, community response and enablement team, Local authority and CCG.

- H&F HCP team will continue to support the NWL ICS programme team with further engagement and delivery throughout the review.

- We will continue to work collaboratively with all our partners, communities and residents to co-produce change.

7. Interim engagement outcome report

During the involvement period, we arranged a number of events and webinars, attended external meetings and arranged numerous one on one interviews with local residents and representatives of the voluntary, community and faith sectors. This engagement will continue throughout the length of the review.

The table below detail the engagement activity that has taken place or is planned.

Event	Boroughs	Date	Link to Meeting / Outcome
Hounslow Integrated Care Patient & Public Engagement (ICPPE) Committee	Hounslow	07 December 2021	Find out more
Public involvement event	NW London wide	13 December 2021	Find out more
NW London Joint Health and Overview Scrutiny Committee	NW London wide	14 December 2021	Find out more
Older people's Engagement at the Pavilions Shopping Centre in Uxbridge	Hillingdon	28 January 2022	Find our more
BME Health Forum Director interview	Hammersmith & Fulham, Kensington & Chelsea and Westminster	08 February 2022	Find out more
SOBUS Community Lead interview	Hammersmith & Fulham	10 February 2022	Find our more
BME Stakeholder Event	Kensington & Chelsea and Westminster	22 February 2022	Find our more
North Kensington Health Partners	Kensington & Chelsea	03 March 2022	Find out more
RBKC Adult Social Care and Health Select Committee	Royal Borough of Kensington and Chelsea	03 March 2022	Find out more
Trustee, Kosher Dementia UK	NW London wide	04 March 2022	Find out more
Public involvement event with a focus on ethnic minorities	Hounslow and Ealing	Thursday 10 March 2022	Find out more
Public involvement event with a focus on ethnic minorities	Westminster, Kensington & Chelsea, Hammersmith & Fulham	Tuesday 15 March 2022	Find out more
Hounslow and Ealing Integrated Care Partnership Engagement Event	Hounslow and Ealing	Thursday 17 March 2022	Find out more

Event	Boroughs	Date	Link to Meeting / Outcome
Public involvement event with a focus on ethnic minorities	Brent, Harrow and Hillingdon	Thursday 17 March 2022	**Find out more**
Public involvement event feeding back what we have heard so far and actions we have taken as a result	NW London wide	Friday 18 March 2022	**Find out more**
Hammersmith and Fulham Integrated Care Partnership end of life meeting 08 March & 03 May 2022	Hammersmith & Fulham	08 March and 03 May 2022	**Find out more**
Hammersmith and Fulham Integrated Care Partnership Event	Hammersmith & Fulham	Wednesday 11 May 2022	**Find out more**
Harrow Palliative Care and End of Life Webinar	Harrow	Wednesday 11 May 2022	**Find out more**
Come and help us shape the end-of-life care in Brent	Brent	Wednesday 15 June 2022	**Find out more**

We have committed to transparent and meaningful engagement at every stage of the work

We also linked in with experts both locally and nationally in certain areas including learning disabilities and homelessness. Their advice led us to carry out two literature reviews which have been published and used as evidence in the review.

We received a large amount of feedback which we are responding to and some actions have already been addressed as a result. There are also areas we are currently developing and implementing, or propose to do so, in order to address the issues raised. Some local residents have been kind enough to share their stories so we could use them as case studies to illustrate the good experiences and the challenges that people face when using community-based specialist palliative care services, so that we can learn from their experiences.

In addition to these meetings, we developed a number of online surveys through which local residents and health and social care professionals could give their views. Open-ended questions were also included to give respondents the opportunity to express their opinions in their own words. We also received a number of written submissions which were responded to.

It is our expectation that engagement with local residents will continue as we move forward. All boroughs have had the opportunity to be involved in a webinar or complete a survey.

Further webinars are already planned or being planned for Kensington and Chelsea and Westminster. The output of the webinars will be used to support the final report and new model of care working group.

All the public feedback received will be used by our model of care working group, which will be responsible for designing, planning and mobilising the future model of care for adult community-based specialist palliative care.

Membership of this group will consist of local residents, clinicians and other palliative and end of life care stakeholders. The group will be asked to:

- agree a common specification / common core offer for community-based specialist palliative care
- develop a new model of care to deliver the specification / common core offer
- map out how this can be implemented in each borough.

The work will draw on the national service specification for adult palliative and end of life care, the previous NW London palliative care review programme work and qualitative and quantitative feedback from residents and healthcare professionals obtained through our engagement. We will also utilise activity trend data obtained through the programme's data working group and undertake further work looking at the structure of our services workforce.

The expected output is a set of core service standards, requirements and service functions that will need to be delivered across NW London. There will also be a number of additional localised requirements that the local Borough Based Partnerships will have responsibility for implementing these in view of their local context and population needs.

We will work with the borough based health & care partnerships, local residents and stakeholders to decide whether the new service standards can be delivered by existing service structures or whether a service change is needed. If substantial service change is needed, we will then need to consider if a public consultation is needed.

We understand and share local residents' feedback that having good community-based specialist palliative care services is really important. In some cases, the feedback that has been provided has led us to make changes to services where possible and have plans to do some more of this via this review programme. This is detailed in an insight report where we also detail areas where we are not able to make changes.

We would like to reiterate our commitment to work collaboratively with our public, patients, clinicians and other system partners as we move forward to develop the future model of community-based specialist palliative care for adults, which includes consideration of current services and where the locations we need our services in

Key findings from the feedback received

As laid out in the Issues Paper, there are eight broad reasons why we need to improve the way we deliver our community-based specialist services to make sure everyone receives the same level of high-quality care, regardless of their circumstances.

We have carried out an analysis of all the feedback received through the webinars, surveys, one to one conversations, meetings attended and literature reviews and grouped the feedback received against the eight broad reasons.

1. **To review the valuable learning and feedback received from previous reviews of palliative and end-of-life care services carried out in Brent, Hammersmith and Fulham, Kensington and Chelsea, and Westminster, and the further engagement activity carried out in Ealing, Harrow, Hillingdon and Hounslow.**

In the previous review of community-based palliative care provision in in 2019 and 2020 we talked to people about community-based specialist palliative care services and heard what a crucial role the services play. The feedback confirmed that people value their local specialist services and would like to receive them as close to home as possible, and people with experience of these services are very positive about the care they have received. Local residents and stakeholders said they would like the NHS to reopen the Pembridge Palliative Care Unit in-patient beds following their temporary closure in October 2018 due to a lack of specialist care consultant cover and being unable to recruit due to the national shortage of trained personnel (see Section 1.2 Insight report and actions taken for further details).

We also heard that services need to be made available to more people 24 hours a day, availability of care needs to be improved during the out-of-hours periods (between 5pm and 9am) particularly, services need to be more inclusive and adaptable, offer more choice and more be more joined up. People told us it is important to improve access to these services so more people receive care and are supported to die in their preferred setting, whether this is at home, in a hospice, or in hospital. It is also important that people don't have to travel too far to access services.

The feedback showed that people have different views on how we should make these improvements. We want to build on the feedback and what we have learnt from it.

See the Palliative care services Independent review - full report Review of provision in Kensington & Chelsea, Hammersmith & Fulham and Westminster.

See the Palliative Care Services Public Engagement Report July 2020 In the boroughs of Brent, Hammersmith & Fulham, Kensington & Chelsea and Westminster.

In January 2020, Hillingdon Commissioning Group (HCCG) performed a review of End of Life Services looking at the views of general practitioners (GPs) and the lesbian, gay, bisexual, and transgender community (LGBT).

See the Review carried out on End of Life Services in Hillingdon in January 2020.

2. **To bring services in line with national policy. Such as**
    a. **the national Six Ambitions for Palliative and End of Life Car**
    b. **the NHS triple aim of improving access, quality and sustainability**
    c. **Ensure providers follow the National institute of Care and Excellence (NICE) guidelines for palliative and end-of-life care services.**

- We will utilise the learning and gaps in improvements taken from the borough and ICS level self-assessments against the six national ambitions for palliative and end of life care.
- Future community-based specialist palliative care services will need to align with national standards and guidelines.
- This includes adhering to the national service specification for community-based specialist palliative care.

3. **To meet patients' changing needs arising from changes in the population.** ***By 2040, the number of deaths within England and Wales is expected to rise by 130,000 each year. More than half of the additional deaths will be people aged 85 or older, so there will be an increased need for palliative and end-of-life care services.***

- We will need to take into account aging population with likely increased demand on community-based specialist palliative care.
- The number of people living with dementia is increasing which brings increased complexity of care needs.
- The number of elderly people living on their own is increasing with no one to care for them. Often they can live away from their family leading to social isolation.
- This includes support for the family and carer supporting them.

4. To reduce health inequalities and social exclusion, which act as a barrier to people receiving community-based specialist palliative care.

- Review should look at ways of tackling the widening Health Inequalities for people who require palliative and end of life care and support service.
- Attention should be given to isolated people, those with family outside the country or in different regions, elderly couples that are physically or mentally unable to care for each other, the large number of disabled people that require specialist care and those who experience homelessness.

5. To make sure that everyone receives the same level of care, regardless of where they live. At the moment there are differences in the quality and level of community-based specialist care services that patients, families and carers across North West London receive. This means that depending on where a patient lives, they and their family and carers may always be able to get the support they need, and may not be able to have their wishes supported at the end of their life. We want to do all we can to make sure this is not the case.

- Implement a 24/7 telemedicine co-ordination, advice and support service for care home staff to better support their residents at end of life.
- To improve co-ordination and navigation of care and support available, implement a single point of access (preferably a single telephone line) for patients, family, carers and clinicians to contact to obtain information about what palliative and end of life care services are available, how to access them, support with getting medication and equipment etc.
- To build flexibility into the service model that supports a person and their family to change their mind about place of care and place of death even if it is at the last minute.

This could be where a person has always said they wanted to die at home but change their mind as they and the family are scared or believe it is too hard on the family who initially thought they could cope. Instead they want to go to a hospice or a hospital.

- Align GPs more closely with individual care homes and develop enhanced care services.
- Pembridge in-patient service should be reopened.
- A review of the number of hospice inpatient beds should take place.
- The number of and quality of care plans need to be improved. Patients and families need to be given access. More needs to be done to ensure health professional access the care plan routinely when seeing patients.
- There needs to be improved record keeping around preferences, treatment etc. and more needs to be done to make sure they are automatically accessed by the people providing care.
- The need to identify that someone is dying and recognise this earlier was identified as an important point that feeds directly into the patient and families choices about appropriate treatment etc.
- We need to make sure that there are wrap around care to provide support to the patient if they are to stay at home.
- Care needs to be holistic, and include clinical and non-clinical support e.g. Home adaptations, advice and support on what to do when a patient passes away.
- There is a lack of bereavement support across NW London for families and carer. A review of current provision is needed to understand what type of support is needed and how it could be delivered.
- We need to ensure we consider the impact of caring for someone who is dying on family and carers. Concerns were raised about impact on:
    - unpaid carers and those who are older
    - Those who have their own health issues and are struggling
    - Are trying to hold down employment or have kids and are busy and what that means for them trying to undertake a caring role.
- The way someone dies can have a big impact on the person caring for them and we need to ensure that support for relatives and carers continues after the person has died.
- Palliative and end of life care needs to be patient centred and the importance of family/carers/those of importance to the person being involved in decision making and kept informed.
- We need to think about how we design more integrated services, between the patient and family, the community, social care and clinical services.
- Care and support needs to be available 24/7 365 days a year (including pain relief). out-of-hours service (OOH), consider including an OOH service to impatient services to enable carers and patient seek help when needed.
- Lack of clarity for carers/family around medication. Medication for EoLC patients should be thoroughly explained to carers/family members so they are able to identify which medications are missing and act quickly.
- Family members and carers should be kept informed at every point during a patient's care pathway.
- Professionalism, Confidentiality and Compassion - Clinicians visiting family homes to see EoLC patients should be briefed fully on the patient's condition/situation and maintain the highest level of confidentiality when they are communicating with other clinicians in the presence of the patient and other family members.

6. **To make it easier for people to access services, particularly across our more diverse communities. Some of our services are not joined up and do not work well together, and we need to change this.**

- More needs to be done to create culturally competent services that take into account cultural and faith beliefs.
- We need services that are able to care for people from ethnic minorities who may not speak or have difficulty speaking and understanding English.
- Participants identified a need for existing care and support services to do more in reach into different communities in a culturally sensitive way.
- More needs to be done to promote community-based specialist palliative care, encouraging people to think, talk and plan about end of life care.
- The importance of having local services was stressed with reference to the cost, time and difficulty of using public transport.
- Need to design services that take into account people cultural and faith needs.
- Creating seamless service provision with services properly integrated with other ancillary services like 111 would make them easier to access and improve patient experience of care.

7. **To cope with the increasing financial challenge, the NHS is facing and the effect this has on community-based specialist palliative care.**

- Consider a proper financial settlement for hospices as their financial situation has been exacerbated by Covid.
- Local residents wanted to know more factual information on finance, demography and the help available locally.
- Look at ways of clawing back some funding from the NHS service providers when patients with intensive clinical needs decide to die at home.

8. **To reduce the difficulty, we are having finding, recruiting and keeping suitably qualified staff, and the knock-on effect this has on our ability to provide services.**

- A comprehensive workforce plan is needed to address the workforce challenges mentioned in the report.
- More needs to be done to educate and train all workforce to identify need. This should be NHS, Local Authority (social care) and voluntary groups so they can capture and signpost potential need.
- Need to build extra capacity and extra staff to meet growing demand.

The full interim engagement outcome report is available here.

8. The model of care working group

The model of care working group was set up by the NW London ICS to develop a framework and action plan to ensure that high quality community based specialist palliative care is delivered equitably and sustainably across NW London, and that all residents are able to access the service if it is needed.

Membership of the group which meets on a weekly basis consists of local residents, clinicians and other palliative and end of life care stakeholders. Patient/carer members contribute and provide feedback on the group's work, which reflects the voice of patients, carers and their families. They also work on projects which, have been identified as an area of focus by the membership group. Minutes of the meeting and presentations are available online.

This is not a plan to replace work that is already going on. It is a plan to build on the great stuff already happening and recognise where there are gaps and opportunities.

The work draw on the national service specification for adult palliative and end of life care, the previous NW London palliative care review programme work and qualitative and quantitative feedback from residents and healthcare professionals obtained through our engagement. We will also utilise activity trend data obtained through the programme's data working group and undertake further work looking at the structure of our services workforce.

Objectives

- Agree a set of key 'ingredient' standards/ common core offer / single service specification for NW London
- Develop new model of care for community-based specialist palliative care
- Develop options for delivery of model of care
- Develop action plan for implementation

The expected output is a set of core service standards, requirements and service functions that will need to be delivered across NW London. There will also be a number of additional localised requirements that the local Borough Based Partnerships will have responsibility for implementing these in view of their local context and population needs.

We will work with the Integrated Care Partnerships, local residents and stakeholders to decide whether the new service standards can be delivered by existing service structures or whether a service change is needed. If substantial service change is needed, we will then need to consider if a public consultation is needed.

Who are the members of the model of care working group?

Members of the group included representatives from:

- NW London NHS community SPC providers
- NW London Hospice SPC providers

- Patients
- Primary Care
- Acute SPC
- Discharge teams
- Care homes
- Local Authority and social care
- Voluntary sector
- Meds management
- 111/OOH GP
- LAS
- Community nursing
- Continuing health care (CHC)
- Cancer programme

Model of Care – what do we mean?

There are many, many definitions of what constitutes a 'Model of Care'. We have set out below what we think the scope of this stage of work is:

Defining what the core elements of delivery are	Yes	This is the kind of detail within the national service specification and the starting point
Defining how much of these key elements we need	Yes	This isn't covered in the national spec but is critical to be able to ensure common approach across NW London how much" could include hours, staffing, capacity etc.
Defining how services should be delivered	Partially	For example, we may want to define elements such as access (including geographical availability) but not how services are integrated at place.
Who delivers elements	No	But substantial change not anticipated
How much costs	No	Not at this stage

The work will draw on the national specification for adult palliative and end of life care, the previous NW London palliative care review programme work, qualitative and quantitative feedback from residents and healthcare professionals obtained through our engagement and further data obtained through the programme's data working group.

9. Ambitions for Palliative and End of Life Care: A national framework for local action 2021-2026

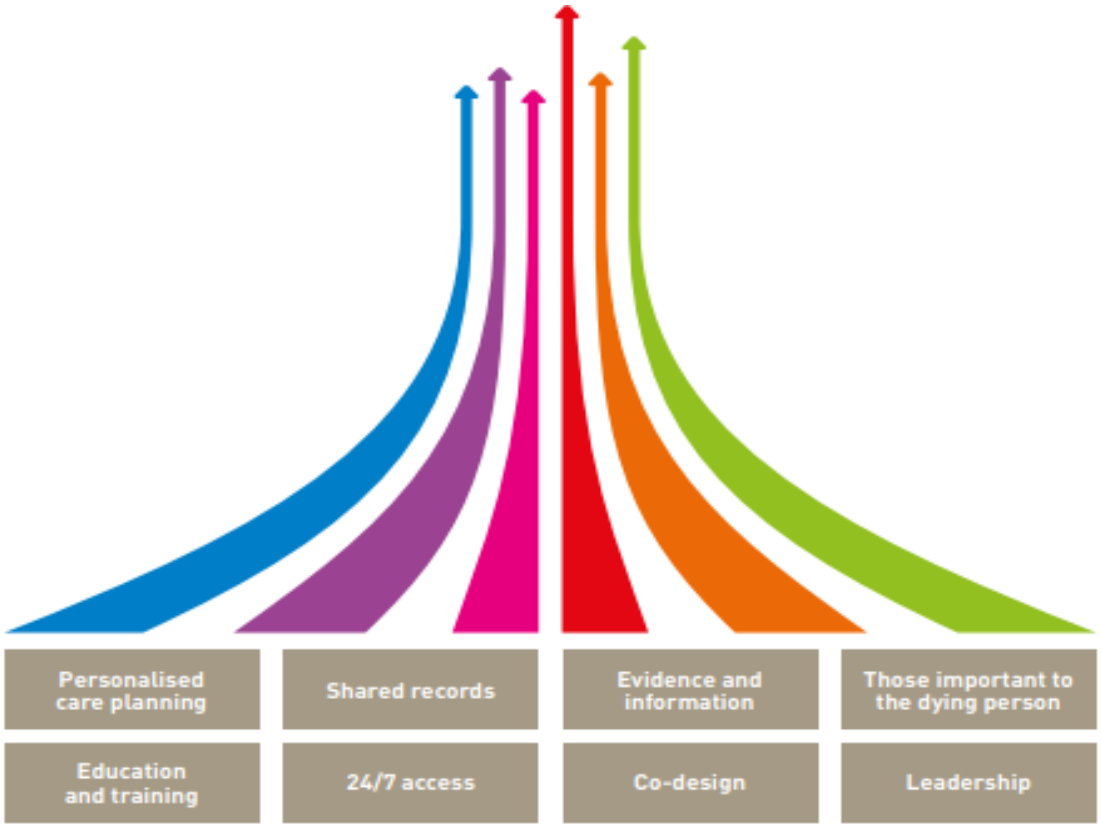
In 2015 The National Palliative and End of Life Care Partnership published the **Ambitions for Palliative and End of Life Care: A national framework for local action (2015-2020)** to improve palliative and end of life care (PEoLC), building on the 2008 Strategy for End of Life Care and other strategies and reports.

It describes what is needed to realise that ambitions, and calls for local health and social care leaders to use these foundations and building blocks to collaboratively build the accessible, responsive, effective, and personal care needed, via a process that is open, transparent and effective.

A refresh of the Ambitions Framework (2021-2026) was published in May 2021, with a reminder that more must be done, building on the learning from COVID-19 pandemic to focus more efforts on personalised palliative and end of life care, to improve support for people of all ages including those bereaved, and to drive down health inequalities.

Each ambition includes a statement to describe the ambition in practice, primarily from the point of view of a person nearing the end of life. Each statement should also be read as our ambition for carers, families, those important to the dying person, and where appropriate for people who have been bereaved.

The eight foundations that underpin the ambitions and are required to bring about this improvement. Different individuals and organisations can lay these foundations, either on their own or collectively.



Foundations for the ambitions

To support delivery of the six ambitions, the NHS England & NHS Improvement Palliative and End of Life Care Team worked alongside stakeholders to further develop the Ambitions for Palliative and End of Life Care self-assessment tool as a national resource.

This tool provides a self-assessment framework and process to support localities/ boroughs to

- Support a more coordinated response for localities to determine their current level of delivery of services against the Ambitions for Palliative and End of Life Care - A National Framework for local action (2021-2026).
- To understand where there are strengths and opportunities for improvement and growth that need prioritising within future strategy for palliative and end of life care.

In order for this self-assessment process to become a meaningful and useful exercise, localities are encouraged to be as honest as possible, with cross-organisational collaboration to complete the tool and achieve the improvements being vital. Localities are strongly encouraged to ensure health and social care are equal partners in this assessment process.

All eight Borough Based Partnerships (BBP) were asked to complete the self-assessment tool and came together in two workshops facilitated by the NW London last phase of life

programme to facilitate its completion. Participants included representatives of Hammersmith & Fulham Council, HAFSON and local residents.

All BBP's have now completed the self-assessment tool. The rich discussions that took place in each BBP breakouts, and feedback from multiple workshop stakeholders, that completing the self-assessment tools with multiple stakeholders locally for each BBP was really beneficial:

- To ensure the information on the tool is as accurate as possible for each BBP and ultimately for completion of the NW London self-assessment.
- To raise the profile of PEoLC locally and regionally.
- To identify the relevant PEoLC stakeholders and building place-based links.
- To start the basis for driving PEoLC improvement work forward at place and within other programme areas.

An analysis has now taken place and a NW London level and this will be used to inform the new CSPC model of care (MOC) in development by the CSPC MOC working group. In addition:

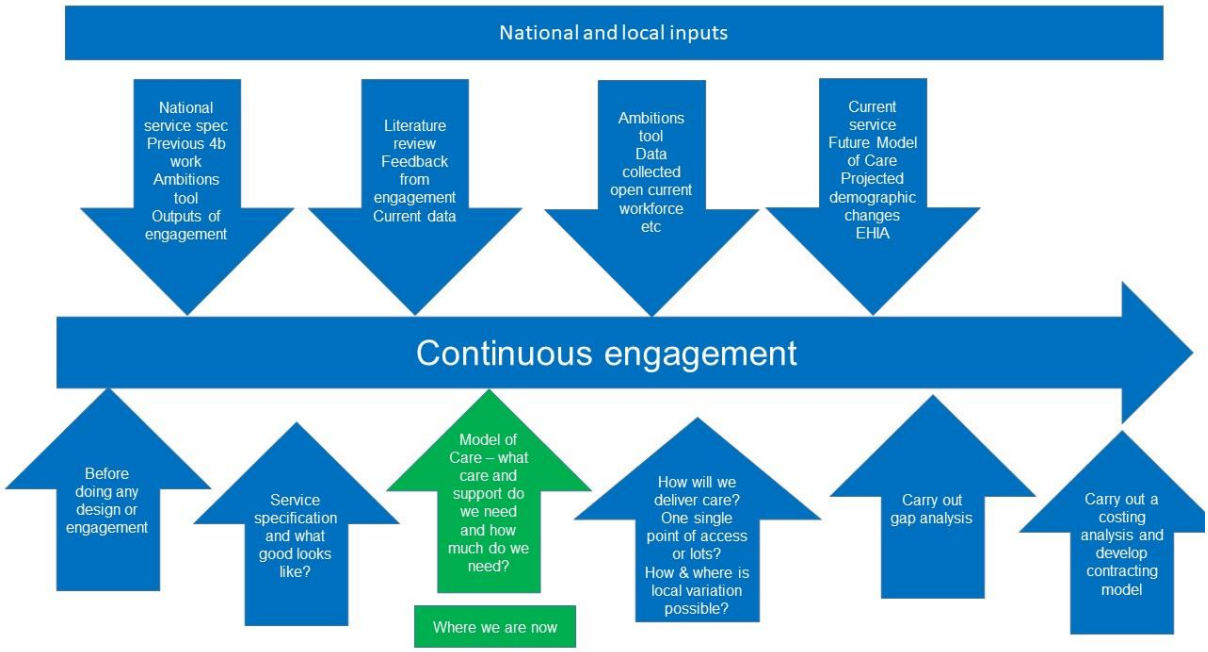
- Key gaps/ areas of improvement identified for other parts of the end of life pathway will be shared with other NW London programme areas.
- BBP self-assessments will be shared with BBP and borough directors with an ask to support any local PEoLC improvements using the findings to inform this work.
- NW London Last phase of life programme will host a 3rd workshop later in the year for all PEoLC stakeholders across the system to share the outcome of the NW London self-assessment, learning and areas of good practice identified.

We would like to thank partners and local residents for taking part in the workshops and contributing to their success.

10. Timeline

We are taking a flexible approach to the timeline to make sure that we can carry out meaningful conversations with local residents and our partners within the Integrated Care System.

The diagram below shows the national and local inputs into the development of the model of care and immediate next steps.



It is anticipated that the model of care working group will complete its work in Autumn 2022. We will then move into a development phase where we will carry out a gap analysis, costing exercise and develop the costing model. This will be accompanied by the commencement of an assurance process with NHS England/NHS Improvement and the London Clinical Senate.

11. Conclusion

- We are undertaking a wide range of engagement and events to understand the improvements residents and health care professionals want in terms of community-based specialist palliative care.

- We have reviewed the feedback and published an interim engagement outcome report that is being used by the model of care working group which is responsible for designing, planning and mobilising the future model of care for adult community-based specialist palliative care.

- It is anticipated that the model of care working group will complete its work in Autumn 2022. We will then move into a development phase where we will carry out a gap analysis, costing exercise and develop the costing model. This will be accompanied by the commencement of an assurance process with NHS England/NHS Improvement and the London Clinical Senate.

- The inpatient unit at the Pembridge remains closed, however, we are currently providing alternative provision through neighbouring local hospices.

- We recognise that services need to be accessible locally and will review inpatient provision as a key part of the review, but cannot pre-empt what this means at present.

We welcome further feedback and suggestions from Hammersmith & Fulham Council. Please let us know by emailing nhsnwlccg.endoflife@nhs.net

LONDON BOROUGH OF HAMMERSMITH & FULHAM

Report to: Health and Social Care Policy and Accountability Committee

Date: 20/07/2022

Subject: H&F Safeguarding Adults Board Annual Report 2020/21

Report author: Christopher Nicklin, Assistant Director for Independent Living and QSP

Responsible Director: Lisa Redfern, Strategic Director of Social Care

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SUMMARY

This report sets out the Safeguarding Adults Boards annual report for 2020/21 and provides details about its work, progress and analysis of safeguarding priorities.

RECOMMENDATIONS

That the committee note the annual report 2020/21 and provides comments.

Wards Affected: All

Our Values	Summary of how this report aligns to the H&F Values
Creating a compassionate council	The annual safeguarding report sets out the work of the Board to protect adult residents, working collaboratively with statutory multi agency partners to help prevent harm.
Doing things with local residents, not to them	The Safeguarding Adults Board works proactively with residents through our partners to support and protect against those who would seek to take an advantage.

Background Papers Used in Preparing This Report

None.

LIST OF APPENDICES

H&F Safeguarding Adults Board Annual Report 2020/21

H&F SAFEGUARDING ADULTS BOARD ANNUAL REPORT 2020/21

Working together to prevent abuse and neglect of adults in need of care and support in Hammersmith & Fulham

METROPOLITAN POLICE
TOTAL POLICING

NHS

h&f
hammersmith & fulham

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Foreword

The Care Act 2014 states that every local authority must have a Safeguarding Adults Board (SAB). The SAB is a partnership of organisations working together to prevent abuse and neglect of adults in need of care and support.

If someone experiences such behaviour, the agencies have a duty to respond in a way that supports their choices and aids their wellbeing. The Act also requires each SAB to produce an annual report listing its activities, progress and achievements.

A key aspect of all safeguarding work is to listen to, and, whenever practical, take into account the wishes and experiences of those adults who have been victims of abuse and or neglect, and therefore 'Making Safeguarding Personal'.

The Board believes that the best way to show how we apply this concept is by asking local people 'What is important to you?'.

Their replies led us to create our adult safeguarding strategy. One key message was that any strategy should be written in easy-to-understand language, therefore our strategy is displayed as a 'house' which is built upon the foundations of wellbeing and safety.

People said that they do not want to be seen as victims, and want to be in control of the decisions they make about their life, even when they have experienced abuse or neglect.

Residents want to know what to do when they themselves, or someone they know, is being neglected or abused, by someone else. Most importantly, they want to be listened to and involved in any decisions made by other people about them.

We said that we want to be leaders who listen and learn from what people are telling us. Our strategy underpins the work of the Board; all its safeguarding adults' activity is focused on being led by the individual to ensure that the resolution of their concerns meets their needs and improves their quality of life, wellbeing and safety.

The 'House strategy' is shown in more detail in the report using two, sadly too common, examples together with the member agencies' responses.

Like many other organisations, our work too has been impacted by the pandemic over the last two years. The report outlines how member agencies have responded to the unprecedented challenges and demands of Covid.

To illustrate the workload, the report includes a timeline of the issues faced by the Board since the first lockdown on 23rd March 2020. In respect of Covid, these have included the immediate responses to the outbreaks of Covid in the borough's care homes prior to the introduction of the vaccine, coping with the consequences of the impact of the disease on residents' mental health and the potential impact of 'long' Covid.

The Board also recognised the pressures placed upon those members of staff responsible for providing care and assistance to Covid patients, when frequently they were short staffed due to infection among their colleagues. The report details one such example from the council's Reablement Team which serves as a testament to their commitment and going 'the extra mile', together with that of many other teams within the council.

I have been very humbled by the dedication and resilience shown by so many people working to make everyone safe, particularly when some of them have suffered personal loss as a result of Covid.

In response to helping staff cope with the pressures caused by the Covid pandemic on their own mental health and wellbeing, the local Clinical Commissioning Group funded specialist training for everyone. I am pleased to report that this training has been very well received and will continue throughout this spring.

However, as the timeline shows, the Board also confronted other important safeguarding issues. Some were emerging over the past year or so such as the increasing prevalence of suicide amongst young male adults, and others, which emerged with little notice; the arrival of displaced Afghan evacuees at the end of last summer.

Examples of our response to both issues are included in the report.

Thank you to all the Board members who have contributed to the report. I would like to single out Jessie Ellis for a special 'thank you' for all her hard work in compiling the report.

Mike Howard
Chair of the Hammersmith & Fulham Safeguarding Adults Board
April 2022

Summary of the Board's activities

This report can only be a summary of the work of the Board. Like every other aspect of society since the imposition of the first Covid lockdown, our work has at times been overwhelmed by how member agencies have individually, and collectively, responded to the impact of Covid on everyone.

In March 2020, the Board suspended its activities and meetings to allow members to concentrate all their resources in responding to the many issues arising from the pandemic.

It soon became apparent that whilst the response to consequences of Covid for both patients and carers should remain a priority, there was a need to discuss and intervene in other safeguarding matters. So, the Board started to meet again in the summer of 2020.

The year in brief

This summary of the matters discussed at SAB meetings since the first lockdown demonstrates the versatility and capacity of members to respond not only to Covid, but resulting issues such as Suicide Prevention, and unforeseen priorities, such as the resettlement of hundreds of Afghan evacuees.

23 March 2020

- **UK put into Lockdown in response to Covid-19**
- Board suspends meetings in response to demands placed on members

Summer 2020

- Local Authority responds to outbreaks of Covid-19 in care homes following the deaths of 23 residents e.g., PPE equipment and additional resources
- Partners discuss resilience plans for care homes

Autumn 2020

- Second Covid wave
- Recognition and discussion about how to work collectively to respond to increase in incidences of suicide

Winter 2020-21

Consequences of members' response to Covid third wave:

- Discharge at speed – recognising need for hospital beds but can care homes cope?
- Impact of latest wave on designated care settings – state of readiness?
- Staff resilience

Spring 2021

- Impact of Covid causing increasing concerns around domestic abuse and mental health

Summer 2021

- Discussion responding to increasing prevalence of suicide among males – Papyrus training initiative/Covid related suicide/bereavement support

Autumn 2021

- Hundreds of evacuees arrive in H&F
- Placing Afghan evacuees in hotels in the borough, housing them, setting them up with GPs, enrolling in schools etc
- Demonstration to over 140 staff of the R;pple internet suicide prevention tool

What is safeguarding?

The word 'safeguarding' is not a term used in everyday speech. So, what does it mean?

Adult Safeguarding means protecting people's right to live in safety, free from abuse and neglect. It means making sure that their views, wishes, feelings and beliefs are actively considered when agreeing on any action.

Any adult can be at risk of harm, but some people's situations may make them less able to protect themselves from harm or abuse.

Some examples of the types of abuse are:

- Domestic
- Physical
- Psychological
- Financial
- Organisational
- Modern Slavery
- Discriminatory

TELL ME MORE...

Understanding what being safe means

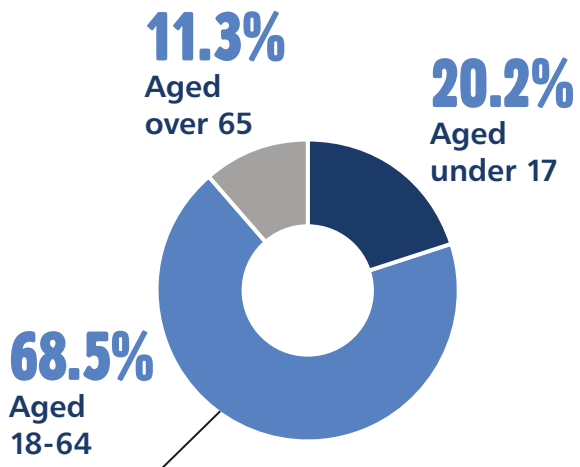
Take a look at the online video, created by one of our safeguarding partners at The Advocacy Project, which explains the meaning of 'being safe'.

"Adult Safeguarding means protecting people's right to live in safety, free from abuse and neglect"

A few facts about the residents of Hammersmith & Fulham

Population

Hammersmith & Fulham (H&F) has 183,544 residents of which 37,111 are aged under 17 years, 125,746 are 18 to 64, and 20,687 are over 65 (source: Office for National Statistics mid-year population estimate).

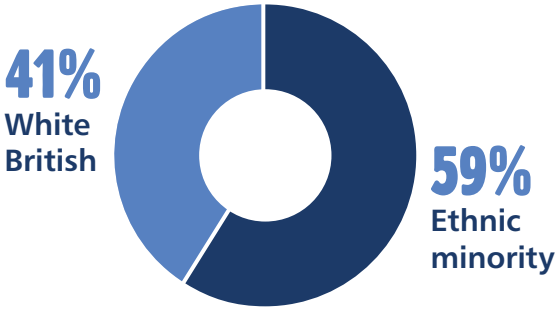


A few facts about the residents of Hammersmith & Fulham

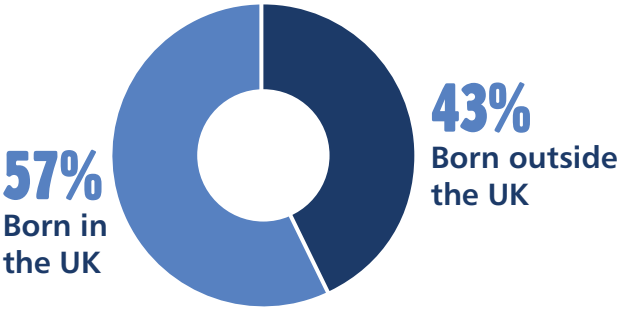
Diversity

- 59 per cent of residents are from a minority ethnic background
- 43 per cent were born outside the UK

Ethnic background



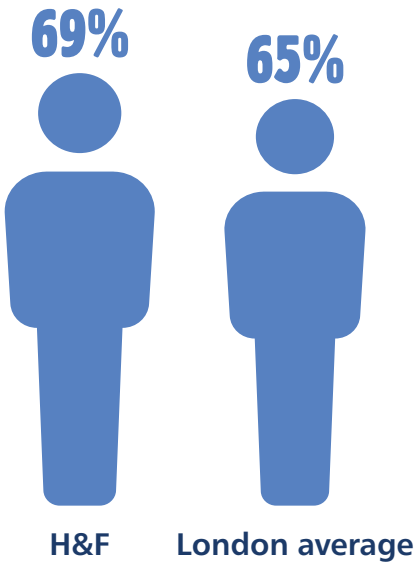
Place of birth



Age profile

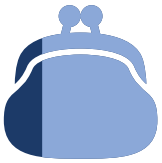
69 per cent of people in H&F are aged between 18 and 64, compared to the London average of 65 per cent

The number of 18 to 64 year olds in H&F compared with London



Poverty

- 24 per cent of residents are income deprived
- 31 per cent are home owners
- 59 per cent are without a car



24%
income deprived

31%
homeowners

59%
without a car

A few facts about the residents of Hammersmith & Fulham

Population growth

- There is a projected increase of 9 per cent by 2031, to 202,500 residents
- Currently the 65+ population accounts for 11 per cent. This is expected to rise to 14 per cent by 2031

Population today: 185,143

Projected increase by 2031: 202,500 +9%

The projected rise in the proportion of over-65s in H&F

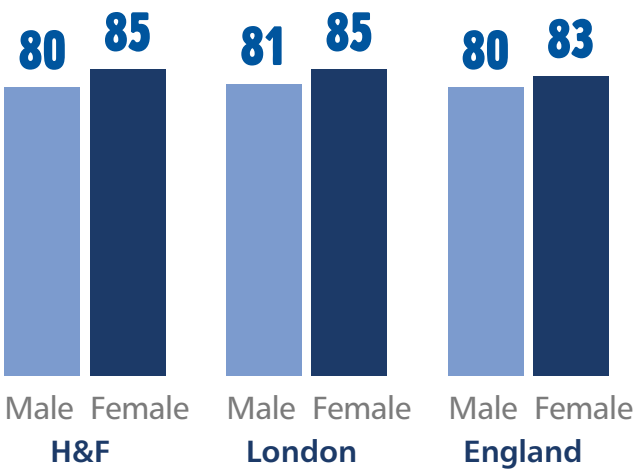
11% TODAY → 14% BY 2031

Life expectancy

The life expectancy for male and female residents in H&F is 80 and 85 years respectively.

This compares with London: 81 years for males and 85 for females, and England: 80 years for males and 83 for females.

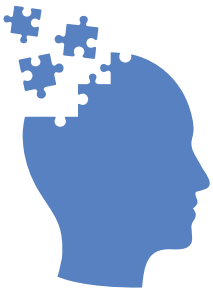
Life expectancy in H&F compared with London and England (by age)



Dementia

In July 2021:

- 770 people were recorded as having dementia
- Dementia prevalence in older people was 3.5 per cent compared with the London average of 4.2 per cent



770 people had dementia

3.5% of older people in H&F had dementia

4.2% of older people in London had dementia

Who are the Board?

The Care Act 2014 states that every local authority must have a Safeguarding Adults Board (SAB). The SAB is a partnership of organisations working together to prevent abuse and neglect of adults in need of care and support. The following organisations provide membership at a senior level to the SAB.

Health

- Imperial College Healthcare NHS Trust
- North West London Clinical Commissioning Group (NWL CCG)
- Chelsea and Westminster Hospital
- West London Health Trust
- Central London Community Healthcare

Local authority

- Adult Social Care (ASC)
- Housing
- Community Safety
- Children Services
- Trading Standards

Emergency services

- Met Police
- London Fire Brigade (LFB)

Voluntary sector

- Carers Network
- Advocacy Service

Other statutory sectors

- Probation
- Department of Work and Pensions (DWP)
- HMP Wormwood Scrubs

So, what do they all do?

The following examples demonstrate how the Board works together to have a positive impact on peoples' lives in the borough.

Example 1: Afghan evacuees

The foreword mentioned the speedy and impressive response of the Board's member agencies to the mass evacuation of Afghan evacuees last summer.

Hammersmith & Fulham were one of the first London councils to take evacuees from Afghanistan. Since August 2021, we have resettled six families into H&F and welcomed more than 190 residents in Home Office 'bridging' accommodation in the borough whilst they await permanent resettlement in the UK.

On arrival, the new residents were placed by the Home Office into temporary accommodation (normally bridging hotels) across the UK including in our borough; many arrived with no money, very few clothes and in need of support following their traumatic experiences.

A multi-partner response sprang into action: registering the new residents to GPs, enrolling children into schools, registering for benefits, opening bank accounts, providing training and employment, encouraging vaccinations, finding permanent accommodation and more to aid resettlement and welcome them into the community.

The flow diagram on the next page depicts this humanitarian response, led by the council but delivered by a range of partners to support and integrate families into our community.

H&F Council Leader Stephen Cowan welcomes the first Afghan family to H&F

So, what do they all do?

The multi-partner response to the arrival of Afghan evacuees

Housing

- Found affordable homes for six families to resettle
- Provided intensive casework support to resettling families in the borough and within the bridging hotel

Children's Services

- All children enrolled at school, nursery or college
- Provided children's centre sessions, ESOL (English for Speakers of Other Languages) and Family Learning
- Development of an education offer for 16+, including finding appropriate courses for three university level students
- Educational Psychologist provided wraparound and network support to schools for individual pupils and staff

Department of Work and Pensions (DWP)

- Worked with DWP to ensure residents have access to cash and benefits, identifying eligibility for Personal Independence Payments (PIP)

Prevent* and the Gangs, Violence and Exploitation Unit

- Regularly visited hotel to engage with teenagers and parents
- A community and youth engagement officer has been assigned and comes regularly to meet with the young people at the hotel

Health

- Worked closely with North West London Clinical Commissioning Group (NWL CCG) to ensure all families are registered with GPs. Working together to establish a practice nurse at the hotel
- Childhood immunisations provided
- Local dentists provided free dental check-ups to residents in December

Public Health

- Encouraged residents to get Covid vaccinations and boosters
- Continue to promote good hygiene within the hotel, encouraging residents to wear masks, wash hands

Adult Learning & Skills

- Adult Learning & Skills and the Shaw Trust have assisted evacuees into training and employment

Voluntary organisations

- Extra-curricular programme organised, including: women's cooking groups, men's football, circus skills, sessions for young men, sports and the Harrow Club
- Contacted mosques, majids and churches, and worked with community groups, to collect donations – clothing, pushchairs, toys etc
- Donations received from local football clubs – kits, trainers etc

*Prevent is the government-led, multi-agency programme which aims to stop individuals becoming radicalised.

Resettlement

H&F Council have committed to rehousing six families, four have already moved in. The council are committed to rehousing more, awaiting Home Office approval.

The first resettled family were very open about the difficult journey they've had and spoke highly of the support they've received to resettle in the UK. The story was published on the Guardian website.

"For the first time since the Taliban took over Afghanistan, I felt safe and slept well when we arrived in the UK. Here we can start again."

TELL ME MORE...

Christmas at the bridging hotel

Christmas activities for families at the hotel were organised by the council under the H&F Afghan Resettlement Programme. The programme included:

- Donated Christmas gifts given to all of the children ages 0 to 11.
- 35 vouchers of £25 each (from National Union of Education) given to the secondary age children.
- Raffle drawn for five donated hampers.
- A traditional Afghan dinner on Christmas day. Working together with the residents, the hotel sourced Afghan ingredients and created a special menu for the Afghan families.
- Bollywood movies played for guests in the hotel conference room.
- A regular schedule of activities at a local youth club continued between Christmas and New Year.

"For the first time since the Taliban took over Afghanistan, I felt safe and slept well when we arrived in the UK. Here we can start again"

Example 2: Suicide Prevention Needs Assessment and R;pple

The SAB Chair represents the London SAB Chairs network, at the Thrive LDN Suicide Prevention Group. This pan London group has members from health, the police, the voluntary sector and other interested parties all of whom are working to reduce the incidence of suicide. The impact of someone taking their own life spreads far and wide; it is said that one suicide typically directly or indirectly affects 130 people.

Hammersmith & Fulham, like all London boroughs, is affected by suicides; it is particularly prevalent amongst men under 35 years old. The SAB have discussed our response throughout the past year and have embraced the R;pple suicide prevention tool, devised by Alice Hendy in tribute to her brother Josh, who committed suicide in his early twenties.

The Director of Public Health leads on suicide prevention. There is an H&F Suicide Prevention Needs Assessment which examines local data from the coroner's office, NHS, and police services, to create a detailed and meaningful picture of people at greatest risk of suicide.

It describes relevant national policies and reflects on national and international evidence of successful suicide prevention methods and describes local services for prevention and bereavement support.

TELL ME MORE...

What is R;pple Suicide Prevention?

R;pple is an interceptive tool designed to present a visual prompt when a person searches for harmful keywords or phrases relating to the topic of self-harm or suicide. These phrases include any words or terminology which have been identified as displaying potentially damaging online content.

R;pple was created when Alice lost her brother, Josh, to suicide. Josh had been researching techniques to take his own life via harmful internet searches.

Alice set up R;pple Suicide Prevention to ensure more help and support is given to individuals searching for harmful content online.

Example 3: Covid response

The local response to the pandemic has been a constant safeguarding priority over the past year. Much has been broadcast and written about the pandemic, but it is important to show, from a local perspective, how each SAB member has dealt with the challenges imposed by Covid.

Emergency services

- Despite all the government-imposed restrictions, the police and fire brigade continued to attend incidents in person.
- Police noted an increase in domestic abuse allegation between partners and the corresponding increase in referrals to social care.
- The imperative of Covid prompted some innovative thinking as to how some services could be put online, these included: stalking protection orders and domestic abuse protection notices.

Health

NHS West London Trust (delivery of mental health services in the borough):

- The safeguarding functions continued throughout the pandemic with the Safeguarding team contactable virtually.
- A weekly Safeguarding briefing was in place to provide updates of safeguarding practice and provided 'top tips' for recognising safeguarding in the new way of working.
- The team hosted regular webinars and has been fortunate to have external experts facilitate the sessions.

Imperial College Healthcare NHS Trust (St. Mary's, Hammersmith and Charing Cross hospitals)

- All staff tried to make sure that every contact, physically or virtually, with hospital staff mattered.
- The safeguarding nursing team maintained a seven-day service and fully engaged with other external agencies to ensure safety for service users.
- **The wellbeing of staff was a priority.**
- It became a priority to identify domestic abuse for service users and staff.
- Despite frontline staff having to make quick decisions around safeguarding concerns the service user's mental capacity and best interests were also considered in all cases.

Chelsea and Westminster Hospital

- The safeguarding team remained intact and were not re-deployed to cover frontline work.
- The small hospital safeguarding team set up weekly supervision sessions to reflect and support key care management decisions within cases.
- The links between the domestic abuse team and the adult safeguarding team were extended and strengthened as the pandemic revealed a significant number of safeguarding cases involving domestic abuse by adult children towards parents.

Voluntary sector

The Advocacy Project

- The advocates continued to talk with people virtually and met face-to-face, if needed.
- The project produced factsheets for both professionals and service users which was available on our website.
- The project created a community noticeboard for people to find out about wellbeing events, activities to get involved in and information on how to stay safe and well.

Hammersmith & Fulham Council

Community Safety

- The Local Enforcement Team worked with a range of partners to support mass vaccinations e.g. 'Super Saturdays' at Stamford Bridge.
- Multiple services worked together to enforce against an anti-vax protest on Shepherds Bush Green.

Adult Social Care

- Created a Conversation Matters team that carried out daily safety and wellbeing calls to over 4,000 residents deemed vulnerable or at risk.
- Put further safeguards in place to support residents that were shielding, and who were at risk of loneliness and isolation.

People queuing for their Covid vaccination. The Local Enforcement Team worked with a range of partners to support H&F's mass Covid vaccinations events

Example 4: Safeguarding response to fatal fires

As well as the responses to Covid, evacuees and suicides, the Board has considered two fires which resulted in the deaths of two adults.

In December 2020 a 69-year smoker, who was in receipt of a care package involving four visits from care workers per day and the provision of fire safety equipment (including fire retardant blankets), died after smoking in bed. The risk of fire was seemingly understood by the victim; nevertheless she died after a lit cigarette set her bedding alight.

The following year, in December 2021, another woman who also had an extensive care package, including fire prevention measures, also died after smoking a cigarette led to a fatal fire.

Following the first fire, the London Fire Brigade (LFB) and Adult Social Care (ASC) worked together to devise an action plan which is summarised below.

Action plan in summary

ASC Commissioning

- Reviewed risk assessments for main homecare providers (still waiting for MiHomecare to submit). Some areas for improvement and need to follow up in regard to escalation procedure, review of risk, management oversight.
- Added Fire Safety as a standard item to contract monitoring meeting agendas.

Housing

- Community fire safety team host training for all H&F staff.
- Appointed two Building Safety Managers responsible for Fire Safety within our residential blocks seven storeys and above.
- Heads of services in Housing carrying out fire safety review as part of fire safety in housing programme of works.

ASC/Mosaic

- New fire risk warning sign is in use.
- Person centred fire risk assessment is mandatory at assessment and review stages – going live in the new year.
- Manager sign-off for assessment and fire risk assessment is now council practice.

Quality assurance and workforce development

- Home care quality visit template amended to include questions on fire risk assessment and action taken by provider.
- Fire safety training is now a part of our ASC training and lunch and learn schedule.
- Ensure our providers' staff attend and refresh fire risk safety training.
- Liaison with Care Quality Commission
- Fire safety included in H&F's home carers monthly induction.

Careline/IT

- Careline overseeing all new referrals to capture and identify potential risk of fire.
- All installations and planned home visits seek to identify potential risks.
- Extra field added into our Jontek system to identify smoking/hoarding status.
- Business Support apprentice to create a Careline database to capture fire risks and actions.

London Fire Brigade

LFB provide:

- Smoke alarms
- Specialist alarms that are used by Hard of Hearing, these have a strobe light and vibrating pad synced to the alarm so those who are hearing or visually impaired can be alerted to a fire.
- Fire retardant bedding (single sets, double sets and throws).
- Aprons
- Arson proof letterboxes

ASC grants and adaptation

- Adaptation surveys includes fire risk assessment as part of their survey and refer complex risk to housing repairs and ASC.

Safeguarding

- Fire risk safety plan shared with SAB to evidence learning.
- Monthly multi-agency group meeting to formulate Fire Safety Action Plan.
- Service specific monthly catch ups.

How do we assess what lessons have been learned?

Following the second fire, which had many similarities to the one a year earlier, the SAB is organising a workshop to examine what lessons were applied from the first fire to the one a year later.

However, it is important to state that both fires show one key aspect of Making Safeguarding Personal. Both women had the mental capacity to make decisions about how they chose to live their lives and that included smoking despite the risks to their own safety. The Fire Brigade provide appropriate fire prevention equipment but it is the choice of the individual whether to use it or to comply with advice designed to reduce their risk of harm.

This freedom of choice is fundamental to the work of all safeguarding. It recognises that everyone has the capacity to make their own decisions on how to live their life. However, the Mental Capacity Act recognises that this decision-making ability may be impaired due to a variety of circumstances. Professionals use the term 'has' or 'lacks' capacity to describe the situation.

> "The Mental Capacity Act recognises that a person's decision-making ability may be impaired due to a variety of circumstances"

Mental capacity

Having mental capacity means being able to make and communicate your own decisions.

Someone may lack mental capacity if they can't:

- understand information about a particular decision
- remember that information long enough to make the decision
- weigh up the information to make the decision, or
- communicate their decision.

We all make decisions, big and small, every day of our lives. Most of us are able to make these decisions for ourselves. For some people, however, their capacity to make certain decisions about their life is affected. For example:

- A person with a learning disability may lack the capacity to make major decisions such as where to live or how to invest their money, but can still make decisions about what to eat, wear and do each day.
- A person with mental health problems may be unable to make decisions when they are unwell, but able to make them when they are well.
- A person with dementia is likely to lose the ability to make decisions as their dementia progresses.

For more information please go to the **Mental Health Foundation's website**.

TELL ME MORE...

Deprivation of Liberty (DoLs)

Article 5 of the Human Rights Act states that 'everyone has the right to liberty and security of person. No one shall be deprived of his or her liberty [unless] in accordance with a procedure prescribed in law'.

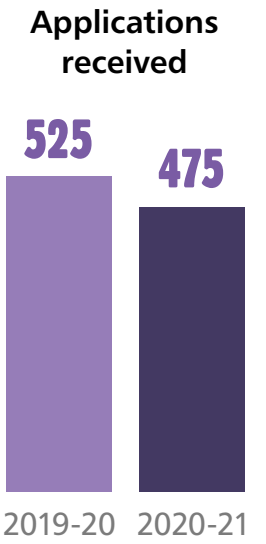
The Deprivation of Liberty Safeguards is the procedure prescribed in law when it is necessary to deprive of their liberty a resident or patient who lacks capacity to consent to their care and treatment in order to keep them safe from harm.

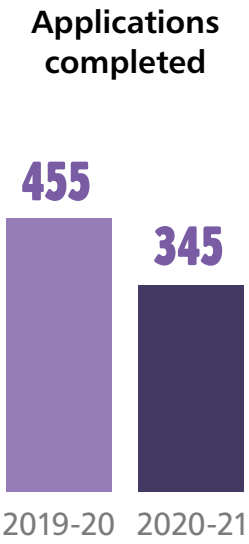
For more information please go to the Social Care Institute for Excellence's page on **Deprivation of Liberty Safeguards**.

How many people in H&F are affected by this legislation?

How many DoLS applications were received and completed

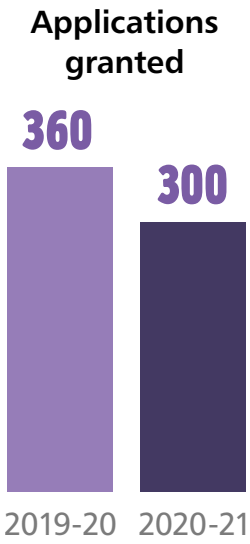
- 475 applications were received in 2020-21, which was 10% lower than the previous year
- 345 applications were completed, this was 24 per cent lower than the previous year





How many DoLS applications were granted

- 300 applications were granted in 2020-21, which was 17 per cent lower than the previous year
- 45 applications were not granted, this was 53 per cent lower than the previous year



How do we work together to safeguard our residents from the risk of harm?

About section 42 (s42)

A local authority is required to make enquiries (or cause others to do so) if it believes that an adult with care or support needs is experiencing, or is at risk of, abuse or neglect; and if so, by whom (section 42, the Care Act, 2014). The findings are used to decide if the abuse has happened and the adult needs a protection plan to keep them safe.

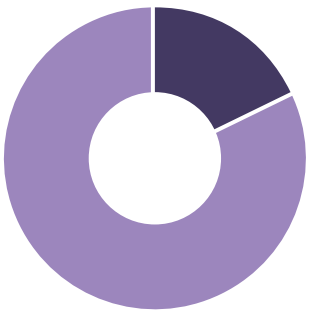
Some comparative data is shown in the following infographics.

How many concerns led to s42 enquiries

The council received 1,065 concerns about an adult believed to be at risk.

After further consideration, 190 of these concerns led to section 42 enquiries to ascertain if abuse or neglect occurred (18 per cent)

Calls that led to s42 enquiries



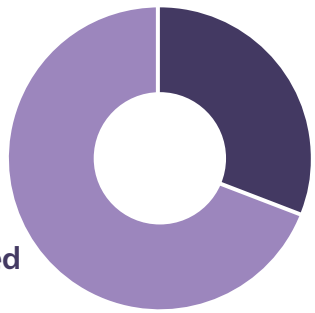
18% led to an enquiry

82% did not lead to an enquiry

The age of the adult concerned

31 per cent of section 42 enquiries concerned adults aged 18 to 64, while 69 per cent concerned those aged 65 and over.

s42 enquiries by the age of the adult



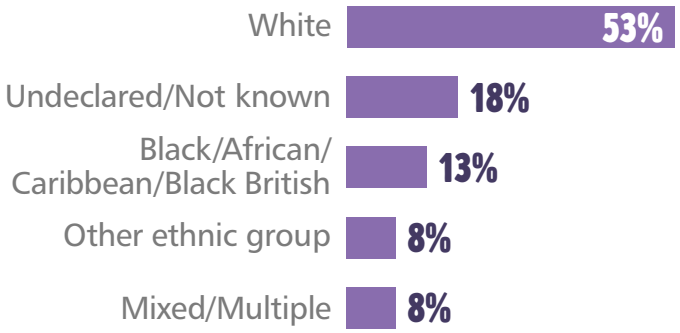
31% concerned adults aged 18-64

69% concerned adults aged 65 or over

The ethnicity of the adult

Over half of section 42 enquiries concerned White adults (53 per cent), followed by 13 per cent Black/African/Caribbean. 8 per cent were of mixed/multiple ethnicity and 8 per cent identified as 'other ethnic group'. The ethnicity of 18 per cent of adults was undeclared or not known.

s42 enquiries by ethnicity of the adult



The gender of the adult

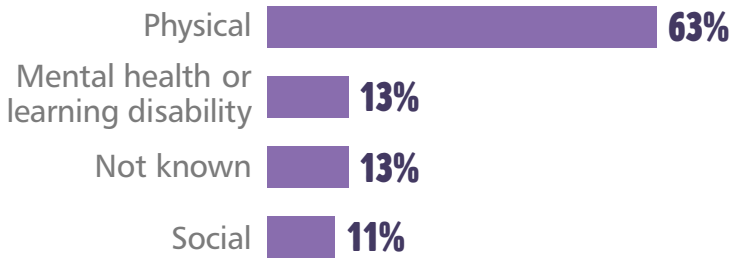
There were more section 42 enquiries concerning female adults than male adults (61 per cent compared to 39 per cent).

s42 enquiries by gender of the adult

The primary support needs of the adult

63 per cent of Section 42 enquiries concerned an adult with physical support needs and 11 per cent with social support. 13 per cent of adults needed mental or learning disability support. None needed sensory support. 13 per cent of cases had unknown needs.

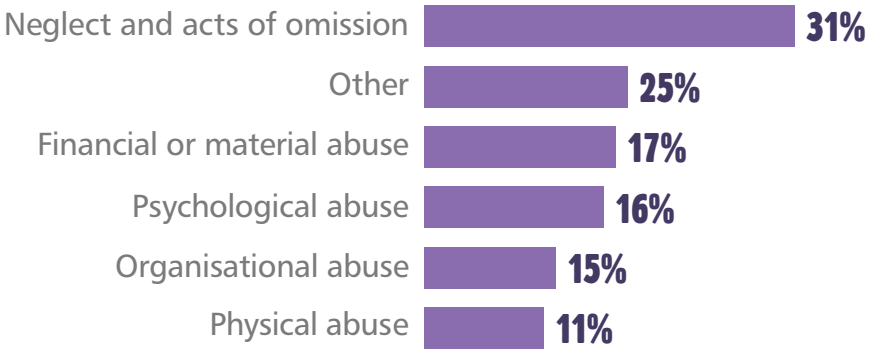
s42 enquiries by support needs of the adult



The reasons for investigation

The most common types of alleged abuse experienced by the adult prompting an s42 enquiry were neglect and acts of omission (31 per cent), followed by financial or material abuse (17 per cent). 16 per cent allegedly experience psychological abuse, 15 per cent organisational abuse and 11 per cent physical abuse. Other types of abuse (25 per cent) include domestic, sexual and self-neglect.

s42 enquiries – the reasons for investigation

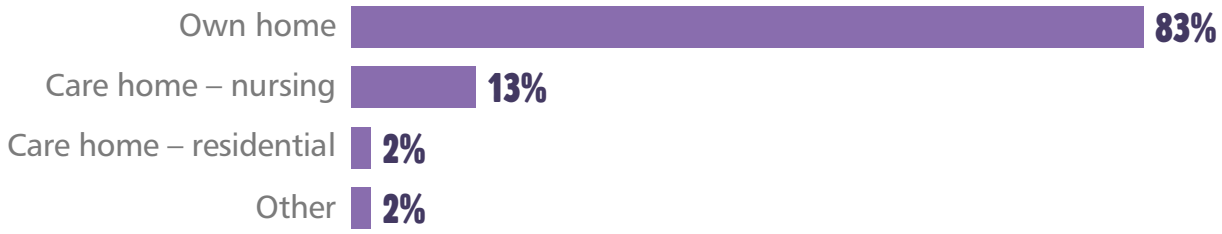


Where the alleged abuse took place

83 per cent of the alleged abuse took place in the adult's own home, followed by 13 per cent in a nursing care home.

2 per cent of abuse took place in a residential care home. The remaining 2 per cent took place in other unspecified locations.

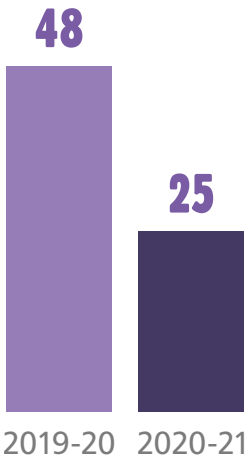
s42 enquiries – the locations where the alleged abuse took place



How many s42 enquiries involved adults who lacked mental capacity

In 2020-21, 25 of 190 s42 enquiries involved adults who lacked mental capacity, compared to 48 of 370 s42 enquiries in 2019-20.

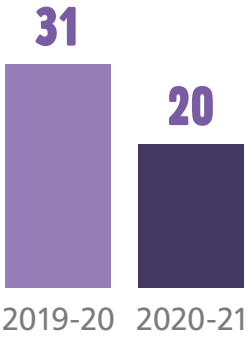
The number of s42 enquiries involving an adult who lacked mental capacity



How many of those enquiries involved support from an advocate

In 2020-21, 20 out of 25 people who lacked mental capacity were supported by an advocate such as a friend or relative compared to 31 out of 48 cases in 2019-20.

The number of s42 enquiries involving support from an advocate



The Board's response

This data is collated in our safeguarding dashboard which identifies trends, patterns and themes. It will inform the Board's actions.

For example, our response to financial abuse ('scamming') has been to emphasise to residents 'what is out there' to help prevent them becoming victims. Tools we have promoted include YouTube videos, the police's **Little Book of Big Scams** and national campaigns.

TELL ME MORE...

The most common types of abuse

Neglect and acts of omission includes ignoring medical, emotional or physical care needs, the withholding of the necessities of life such as medication, adequate nutrition and heating.

Financial or material abuse includes theft, fraud, internet scams, misuse of benefits.

Physical abuse includes assault, hitting, restraint, misuse of medications.

Psychological abuse includes emotional abuse, threats, controlling behaviour, verbal abuse, intimidation.

Making Safeguarding Personal (MSP)

Our House Strategy

Making Safeguarding Personal is about promoting a person-centred and outcome-focussed approach. This is fundamentally about having conversations with people about what they want to achieve, how to improve and achieve safety, wellbeing, resolution, and recovery, and mitigating risk wherever possible to support their life choices.

Our House Strategy, shown in the infographic below, describes our approach to Making Safeguarding Personal.

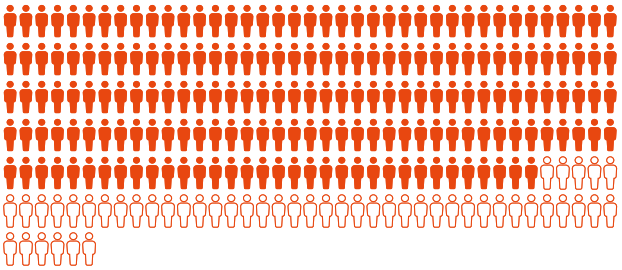
The application of MSP to s42 enquiries

How a person's desired outcome is assessed, actioned and achieved

1. Asking what the person wants

In 240 cases, 190 individuals (or their representative) were asked about their desired outcome from the enquiry. The rest did not wish to express an outcome or lacked the mental capacity to do so.

79% of 240 people were asked about their desired outcome



2. Listening to their views

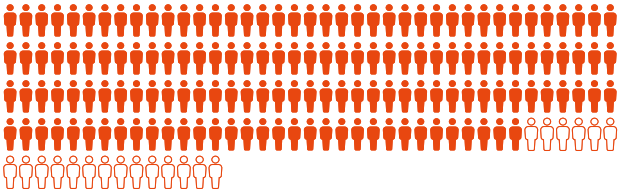
In 190 cases, 170 people who were asked what they wanted went on to express a view about their preferred outcome from the enquiry.

89% of those expressed a view about their preferred outcome

3. Achieving their desired outcome

In 170 cases, 150 people who were asked what they wanted and who expressed a view had their desired outcomes fully or partially achieved by the enquiry.

88% of the desired outcomes were achieved

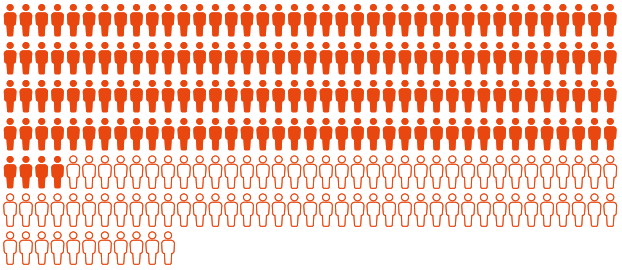


How a risk is identified, acted upon, and removed or reduced

1. Identifying if a risk exists

In 245 cases, 160 people (or their representative) said that they felt at risk, i.e. afraid of harm and abuse. This was irrespective of whether they expressed a view about the outcome of their enquiry.

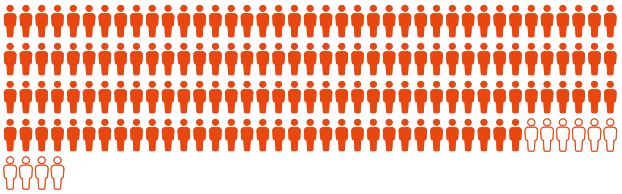
In **65%** of 245 cases a risk of harm or abuse was identified



2. Deciding whether to take action

Once the cause of the risk became known, 150 out of 160 cases had action taken to do something about it.

In **94%** of those cases, action was taken



3. Successfully removing/reducing the risk

In 135 of the 150 cases where action was taken in accordance with the person's wishes, the risk to their safety was removed or reduced.

In **90%** of those cases, action was taken

Case studies

Here are two examples used in safeguarding training that show the complexities of a safeguarding referral, the different possible responses, and how the organisations show the application of Making Safeguarding Personal.

DOROTHY'S CASE

H&F Council received over 400 referrals from concerned residents, staff and others concerning adults who they believed were at risk of harm through self-neglect. A typical case is outlined below regarding Dorothy.

The scenario

A concerned neighbour emails you about Dorothy, who lives next door. Dorothy is in her 80s and owns her own flat. She has been her neighbour for over 10 years.

Dorothy used to be seen a lot in the communal areas but since her husband died about two years ago, she is rarely seen.

The neighbour tells you that they have noticed that Dorothy seems reluctant to answer the door and doesn't engage on the rare occasions when she does see her. She appears unclean and smells of urine – she used to always look after herself.

There is evidence that Dorothy is hoarding and there is a strong smell emanating from the front door which she notices when she walks past.

She thinks social services should be helping her and when she has referred her nothing seems to change. She asks you why doesn't someone help her?

What would you ask?

(Health) To the neighbour:

- Do they believe Dorothy requires immediate medical attention?

(Health) To Dorothy:

- Do a capacity assessment first and try and get consent to chat
- Is she OK? Does she want support/help?
- What would she like?
- Has she seen her GP recently? Does she have a urine infection/incontinence issue?

(H&F Council) To the neighbour:

- Has the neighbour informed the resident of the referral to social care?

(H&F Council) To Dorothy:

- Does Dorothy feel like she could benefit from additional support? **What does she want to happen?**
- Does she have a support network? Family/friends/neighbours
- Does she consent to a referral being made to other services?
- How is the resident managing in home since the passing of her husband?
- Does Dorothy wish for the neighbour to be involved in the process?
- What does the resident need to help them cope with the present situation?

(Case study continues on the next page)

What would you do next?

(Health):

- Does Dorothy's behaviour present a risk to herself and her neighbours? Should action be taken by housing/environmental services/health to reduce this risk?
- Research to see if Dorothy is one of our patients and if necessary, share the information with social workers
- Try to build a support network for Dorothy based on existing social and community links
- To improve Dorothy's health, work with the GP, district nurse, practitioner
- Consider a fire risk assessment

(H&F Council):

- If Dorothy agrees, arrange for a welfare visit to help tidy up the flat, offer appropriate mental health bereavement support
- Assess Dorothy's ability to make rational decisions and ensure she has appropriate accommodation with any necessary care and support packages
- Discussion with friends/family/support network

RUTH'S CASE

H&F Council received 306 referrals from concerned residents, staff and others concerning adults who they believed were at risk of harm through financial abuse. A typical case is outlined below regarding Ruth.

The scenario

You receive an email from the son of an older woman, Ruth, who has a care package from Social Services of three visits a day to help her with personal care and domestic assistance. He lives around the corner from his mother.

He complains to you that social services are interfering with their lives and he is fed up with the carers who are always late and don't seem to be looking after his mother very well.

He tells you that he could do a better job and when social services came to see his mother last week, he was unhappy that they were asking his mother about a recent concern about her money. The bank had alerted to Ruth's daughter, who informally manages her mother's finances, that there had recently been several large withdrawals from her account.

They asked his mother about the money and what it was for – he tells you that it's nothing to do with social services and that they seemed to be suggesting he was taking his mother's money which he is very angry about.

He wants you to tell social services to 'mind their own business' and to leave them alone as they were fine before they started to interfere!

(Case study continues on the next page)

What would you ask?

This is how different agencies who are members of the Safeguarding Adults Board would respond to Ruth's case:

(H&F Council):

- Further discussion required with Ruth – possible advocacy referral to promote views and wishes – best interest assessments
- **Ruth should be spoken to without son being present, if possible, with someone who has a co-existing relationship with her, and asked:**
  - Is Ruth aware of transactions? – in an environment where comfortable
  - Who would she like to support her, her daughter?
  - How is she finding the care provisions? Any concerns regarding commissioned care?
  - Does she have any concerns about son's behaviour on a holistic basis? Does she consider him a good informal carer?
  - Is she happy for son to advocate for her? Does she agree with his decision making?

(Police) Does his mother have capacity?

- Who has lasting power of attorney for Ruth's financial affairs and health?
- What evidence/records does he have about the averred lateness of carers? How are the carers **not** looking after his mother? Has he raised these issues before, and with whom?

What would you do next?

- Open a dialogue with the family regarding Ruth's situation and what role do they want in her care and support?
- Direct payments could be an option
- Before 'case is closed' we need to ascertain Ruth is happy with suggested actions and outcomes

(Police)

- Dependent on Ruth's wishes, does she want police to investigate any thefts?

TELL ME MORE...

What is lasting power of attorney?

A lasting power of attorney is a way of giving someone you trust the legal authority to make decisions on your behalf if you lose the mental capacity to do so in the future, or if you no longer want to make decisions for yourself.

TELL ME MORE...

What are direct payments?

A direct payment is when the council gives an individual their Personal Budget and they arrange/purchase their own care and support needs. This can give someone greater flexibility and control of their support package.

Celebrating an outstanding contribution

Let's finish with an example of exceptional service during the pandemic.

The council's Reablement Team

This team is responsible for safely transferring residents from hospital to their homes. They maintained contact with vulnerable residents, which in some cases lasted as long as six weeks following the hospital discharge – even during the period when there were no vaccines available for protection.

Their work received an H&F Council star award for an **'Outstanding Contribution to our Covid-19 Response'**.

This is just one example of how agencies who are members of the SAB responded to the unprecedented challenges imposed by the Covid pandemic. Everyone showed extraordinary commitment and dedication to provide care and support for our residents who, as carers or patients, were affected by the pandemic.

We owe them all a big 'thank you'!

Design and accessibility: staffordtilley.co.uk
June 2022

METROPOLITAN POLICE
TOTAL POLICING

NHS

h&f
hammersmith & fulham

LONDON BOROUGH OF HAMMERSMITH & FULHAM

Report to: Health and Social Care Policy and Accountability Committee

Date: 20/07/2022

Subject: Healthwatch H&F

Report author: Carleen Duffy, Operational Manager, Healthwatch H&F

Responsible Director: n/a

SUMMARY

This provides details about the work, Healthwatch H&F, progress and analysis of patient group engagement.

RECOMMENDATIONS

That the committee note the update and provides comments.

Wards Affected: All

Our Values	Summary of how this report aligns to the H&F Values
Creating a compassionate council	The council actively supports the statutory work of Healthwatch in H&F.
Doing things with local residents, not to them	Engagement with residents through Healthwatch is critical for ensuring appropriate health services are provided for residents.

Background Papers Used in Preparing This Report

None.

LIST OF APPENDICES

Appendix - Healthwatch H&F, Patient Experience Monthly Update, June 2022

healthwatch Hammersmith and Fulham

Championing what matters to you

Healthwatch Hammersmith and Fulham Annual Report 2021-22

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Statement from Your Voice in Health and Social Care (YVHSC)

I am delighted to have the opportunity to introduce the second annual report for Healthwatch Hammersmith and Fulham (H&F) under Your Voice in Health and Social Care to reflect on what has been a hugely successful and ultimately challenging year. A year that has seen Health and Social Care continue to respond magnificently to extreme circumstances with the continuing pandemic.

During this time, Healthwatch H&F have continued their statutory responsibility to obtain the views of people about their needs and experience of local health and social care services, make those views known to those involved in the commissioning and scrutiny of care services, provide reports and make recommendations about how those services could or should be improved and promote and support the involvement of people in the monitoring, commissioning and provision of local health and social care services.

Healthwatch H&F received 4766 patient experiences to better inform our understanding of health and social care provision and to raise awareness of any on-going issues to improve care provision. 264 members of the community came to us for clear advice, this year the main areas were COVID-19 and mental health.

This year, working with our partners in health and social care, Healthwatch H&F launched a blood donation awareness campaign, highlighting the need for Black, Asian and Multi Ethnic communities to donate blood. Created a mental health directory to highlight suicide and bereavement support services and ran a month long stress awareness campaign.

Despite the circumstances Healthwatch H&F produced 19 reports on health and social care and made 10 Enter and View visits. Our most viewed report so far has been into Young People's Mental Health During the COVID-19 Pandemic.

34 Volunteers contributed 338 days of their time to support the service and as a result of this involvement and the staff team we have been able to provide advice and information to over a 1000 people.

As we continue our pandemic recovery journey I would like to take this opportunity to thank all the Healthwatch H&F staff and volunteers, who have continued to work with dedication to ensure a responsive and vital service continues to support the local community.

Tim Spilsbury
Your Voice in Health and Social Care CEO (YVHSC)

About us

Your health and social care champion

Healthwatch Hammersmith and Fulham is your local health and social care champion.

Our vision

A world where we can all get the health and care we need.

Our mission

To make sure your feedback is used to help make health and care better.

Our values

- Listening to people and making sure their voices are heard.
- Including everyone in the conversation – especially those who don't always have their voice heard.
- Analysing different people's experiences to learn how to improve care.
- Acting on feedback and driving change.
- Partnering with care providers, Government, and the voluntary sector – serving as the public's independent advocate.

"I would like to take this opportunity to commend the Healthwatch Staff, Volunteers and Student placements whose dedication, enthusiasm and tireless contributions are at the heart of the work we do. Your service and commitment towards Healthwatch Hammersmith and Fulham has allowed us to champion for Hammersmith and Fulham residents across many of our services in the health and social care sector. You should feel very proud.

I would like to thank each member of our Committee for their commitment, guidance and advice for the benefit of local residents. It is with great sadness and deepest sympathy I report on the loss of our dear committee member John Marshall who died earlier in 2022. He was a tireless fighter and advocate for patient rights across the whole of North West London. He will be greatly missed!

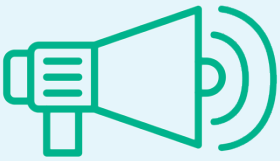
I would also like to thank our Health and Social care partners and providers for your determined efforts to improve patient safety and experience. I hope we can continue to do the same over the upcoming year. It has been a privilege to join Healthwatch and work with you all over the last 10 months."

Carleen Duffy, Ops Manager of Healthwatch Hammersmith and Fulham

Our year in review

Find out how we have engaged and supported people.

Reaching out



5,581 people

shared their experiences of health and social care services with us, helping to raise awareness of issues and improve care.

264 people

called us for clear advice and information about topics such as COVID-19 vaccination sites and Mental health support in the borough.

Making a difference to care

We published
19 reports

about the improvements people would like to see to health and social care services.

Our most popular report was

Young People's Mental Health During the Covid-19 Pandemic

which highlighted the struggles young people have finding help for and expressing their own mental health needs.

Health and care that works for you

We're lucky to have
34

outstanding volunteers, who gave up 338 days to make care better for our community.

We're funded by out local authority. In 2021-22 we received:
£122,000

We also currently employ
4 staff

who help us carry out this work.

Advice and information

If you feel lost and don't know where to turn, Healthwatch is here for you. In times of worry or stress, we can provide confidential support and free information to help you understand your options and get the help you need. Whether it's finding an NHS dentist, how to make a complaint or choosing a good care home for a loved one – you can count on us.

This year we helped people by:

- Explaining how and where to register for a GP or Dentist.
- Linking people up to local charities they could trust
- Supporting the COVID-19 vaccination and booster programme
- Helping people to find the Mental Health services they need

How we offered advice and information from April 2021 to March 2022

Spring

Our volunteers placed weekly orders and signposted isolating residents who needed food to the local foodbank/charities

To support the COVID-19 vaccination Programme we took calls from local residents and signposted them to their closest vaccination centre.

Summer

Teaming up with the North West London team we translated Covid-19 symptoms and Lateral flow testing information into several other languages.

When people struggled to find a GP or Dentist we shared information on where they could go to register at services taking on patients.

Autumn

With online appointments becoming the norm we campaigned for digitally excluded residents. Whether it was a device or digital skill training we signposted residents to the relevant charities.

We created a mental health directory signposting residents to local and national suicide and bereavement support.

Winter

We ran a blood donation awareness campaign alongside a team of consultants and patient at Hammersmith hospital, highlighting the importance and need for Black, Asian and Multi Ethnic communities to donate blood.

We ran a month long stress awareness campaign signposting residents to local services. We shared information on the signs of stress and burnout and provided daily tips to combat it.

Making hospital discharge safer

In 2020 rules around hospital discharge changed during the pandemic, to speed up the discharge process and free up beds. Following the implementation of the new discharge model, Healthwatch England conducted a research project together with British Red Cross where they spoke with nearly 600 people that had been discharged from hospital during the pandemic. This report highlighted the hard work by the NHS staff, but also raised some inconsistencies in the implementation of the model across NHS Trusts in England.

Based on their findings, Healthwatch England made a number of recommendations on how to improve the discharge model. In October 2021, an updated hospital discharge guidance that makes improvements to the issues highlighted was published.

> "It means so much to me that someone is finally listening to what we need here. It's really helped to have someone to talk to." Hospital Patient

The improvements include ensuring patient safety first by avoiding discharge at night and always informing patients of the next steps in their care. Other improvements include signposting to voluntary and housing sector partners; holistic welfare checks to determine the level of support needed; involving and assessing needs of carers in the discharge process; and ensuring clarity of which staff members are responsible for each step of the discharge process and arrangements.

Healthwatch Hammersmith & Fulham completed four visits to the Discharge hub in Charing Cross Hospital to observe how the patient discharge process is currently being implemented locally. From this we created a report that made 11 recommendations.

What difference did this make

- On our recommendation a new bedded area was built in the Discharge hub. This will allow frail patients to wait for transport in the lounge freeing up ward capacity.
- Recommendations were made to improve coordination and communication between the wards and discharge lounge. In response to this, the discharge unit will be included as part of any new staff's induction and the discharge unit team will also be invited to participate in periodic ward team meetings.
- We recommended that all patients in the discharge unit should be given a choice of whether they would like a meal and have the option to take it home if necessary, as we found a few patients had not received meals or had a lack of food at home on discharge. Following this feedback, the unit will now ask all patients if they have food at home and provide a lunch box if not.
- Recommendations to improve communication regarding waiting times for patient transport were also made - As a result, the discharge unit has said they will ensure the discharge lounge staff are using their current automated transport ordering and monitoring system, which will enable them to provide regular and realistic waiting times.

Primary Care Access

In October 2021 our GP access report highlighted the tremendous efforts GP staff had made to continue to provide a high standard of care during the Pandemic. It also identified that access to primary care was limited for digitally excluded residents and those for whom English was a second language. We also received negative feedback for eConsult apps and GP websites.

"Thank you for taking the time to listen and find me help. I've been feeling so stressed over this." GP Patient

To follow up on these finding in 2021/2022 We

- Provided 48 recommendations on primary care access directly to the GP practices. Some were provided to improve an overloaded GP booking system which caused frustration among patients.
- Compiled RAG ratings of GP practice websites.
- Completed 6 Enter and Views in GP practices in Hammersmith and Fulham in the PCN with the highest percentage of digitally excluded residents.
- Along with 6 other local Healthwatch, Healthwatch Hammersmith and Fulham have engaged with and co-designed a survey with the public on GP digital services, feeding the patient voice into the commissioning of a new consultation tool.

What difference did this make

- GP practices assured us there are alternative booking methods available for patients and that improvements have been made to their triage system in order to offer more same-day appointments and minimise delays
- Healthwatch Hammersmith and Fulham made recommendations to include more material in multiple languages to increase accessibility. Practices have responded to this and implemented the appropriate changes.
- We signposted 163 residents to the digital exclusion project so they were able to book appointments online and avoid long waiting times via the phone.
- We collected 384 survey responses from Hammersmith & Fulham for the NWL GP online consultation project. Healthwatch Hammersmith and Fulham will go on to recommend improvements to the North West London digital and data strategy workshops.

"Actively listened and took the time to find a range of organisations that could support me." GP Patient

Finding Mental Health Support

The pandemic's effect on mental health is likely to continue longer than its impact on population physical health. Although some people describe better mental wellbeing due to a more balanced work/homelife and new hobbies/interests. Some people still suffer the effects of social isolation, disruption to education, unemployment and economic consequences of the pandemic. Furthermore, the effects of mental health are distributed unequally across society, with some social groups carrying a greater share of the mental health burden. With mental health highlighted as a key concern in Covid Recovery we have

1. Conducted a survey with young people aged 11-18 to find out how the COVID-19 pandemic has affected their mental health. The survey received 324 responses in total. From this we produced a report outlining 15 evidence-based recommendations intended for borough health partners to collaboratively action.
2. Worked on the Hammersmith and Fulham Suicide prevention strategy. We provided 10 recommendations into the suicide prevention strategy.
3. The West London NHS Trust have supported and encouraged our recent prioritisation of Mental health support. We have worked with the West London NHS Trust providing them with feedback and helping them to develop their patient engagement programme and improve their communication with residents and patients.
4. Provided 6 recommendations to the IAPT Back on Track service.
5. Our Ops Manger was invited to the NIHR School for Public Health Research where we fed into the young peoples future projects. Going forward we will look to join up with some UK wide schools on the importance of trauma informed schools in the Borough.

What difference did this make

- All IAPT patients are able to access face to face appointments, telephone appointments or video appointments and the team will be reminded to offer these options routinely. The newly introduced MINT teams will hope to fill the gaps in service provision for H&F patients.
- IAPT team exercises were completed in the June and July 2021 with the whole team meeting reflecting on the changes that were made and what was working well. Time was also spent considering what was working less effectively and how this could be improved.
- From our young person study we have formed a co-production group that will take the recommendations forward and look at the local offer in Hammersmith and Fulham, particularly any gaps in the young persons mental health service.
- We signposted 48 unidentified Carers to Mental health services through our Carers Project
- We created the Local suicide directory of services for Health and Social Care partners.

Listening to Patient Experiences

Services cannot make improvements without hearing your views. That's why over the last year we have made listening to feedback from all areas of the community a priority. Through a mixed methods approach to patient engagement we collected 4,766 experiences from Hammersmith and Fulham residents throughout 2021/2022. During social distancing and infection control measures we utilised phone calls and online reviews. We have restarted our face-to-face engagement in GPs and Hospitals ensuring the safety of all staff and patients remain a priority.

In their feedback, patients highlight areas of good practice alongside recommendations for further improvements of the service. From this we produce quarterly reports outlining key themes and trends of areas of service delivery that are worth celebrating as well as those that can be further developed.

"The staff are highly skilled and professional and always treat their patients as individuals and with respect."
IMPERIAL COLLEGE NHS TRUST

"The service is great; the staff are helpful and understanding. The doctors are excellent. Easy to book an appointment over the phone. You don't need to wait long for the appointment."
GP SURGERY

"Very good, very fast , never issue with my medication when you go there it's ready."
PHARMACY

Healthwatch Hammersmith and Fulham has continued to develop our methods of outreach and improve the way in which we represent the voices of Hammersmith and Fulham communities in the borough's decision-making processes.

In collaboration with YVHSC and our neighbouring Healthwatch, we have produced an organisation-wide action plan to improve our Patient experience programme requesting feedback from commissioners, Healthwatch managers, Practice managers, committee members and patients.

This year we have created several patient experience reports on primary care, including; how individual communities and residents from differing ethnic backgrounds experience their GP and Hospital care. As well as a two-year comparative review of Hammersmith and Fulham GP surgeries ratings in comparison to other NWL borough GP patient experience data collected.

"The waiting times are too long. I had my appointment cancelled 3 times with no explanation"
IMPERIAL COLLEGE NHS TRUST

"The receptionists can be so rude that it actually makes you feel like a burden when calling."
GP SURGERY

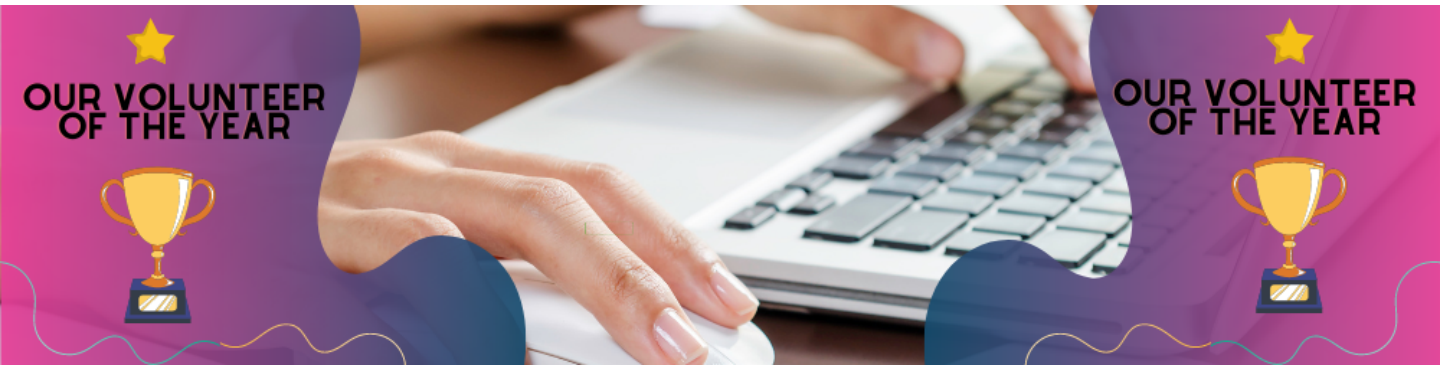
"It was fine, but it was not well organised, there was a long queue and I had to wait for my prescription."
PHARMACY

Volunteers

We're supported by a team of amazing volunteers who are the heart of Healthwatch. Thanks to their efforts in the community, we're able to understand what is working and what needs improving in NHS and social care.

This year our volunteers:

- Helped people have their say in a way that is easiest for them; whether that is through remote methods such as telephone calls or online, or through face-to-face engagement.
- Supported us in analysing patient feedback and creating presentations and reports on key findings to share with service providers.
- Created digital content for our website, social media, and newsletter.
- Assisted us to carry out our Enter & View programme by visiting local GP services and Charing Cross Hospital.
- Continued to help us to provide information and signposting services.



Amee, Volunteer Data Analyst

“I have been volunteering for Healthwatch Hammersmith and Fulham as a Data Analyst since July 2021. During my time here, my main contributions have included compiling the Annual GP Patient Experience report, creating the Annual Imperial College report, as well as contributing to the data analysis and report writing sections of the new Training Guide for YVHSC Volunteers and Interns.

I found it really interesting to read about what aspects of their GP treatment and care that patients valued and appreciated, as well as their concerns. My analysis explored in depth the issues and barriers patients experienced with regards to appointment availability, getting through on the phone and waiting times. This was a particularly topical project to get involved in, given the recent strains of the pandemic nationally on access to healthcare.

On the analytical side, I really enjoyed working with such a large data set, being creative in producing the graphs and charts and developing my report writing skills. I feel I have made an impact as the analysis and resulting recommendations will hopefully help increase awareness of the issues amongst Commissioners/Practice managers and local governing bodies, thereby influencing their decision making. Ultimately, I hope this will be beneficial in improving patient access to GP healthcare. A PowerPoint version of my analysis was shared with the Practice Managers at their recent Forum and published on the local Healthwatch website.

I have also been involved in producing a detailed training guide regarding data analysis and report writing to help other Volunteers and Interns. This will be made available on our YVHSC volunteer and intern hub and shared with our local Hammersmith and Fulham student placements. In this way, I hope to upskill our residents sharing the knowledge and skills I have acquired with other Healthwatch members.

On a personal level, I have very much enjoyed the opportunity to learn new things and take on fresh challenges, as this has really improved my confidence and personal development. It has been really nice to get to know the staff, fellow volunteers and interns in the office. This has also improved my communication and relationship building skills.

Finally, I feel volunteering in the Hammersmith and Fulham area has also given me a sense of community. This has been very rewarding, especially as I feel that the work that the team at YVHSC are doing is making a real difference in helping improve health and social outcomes in our local community."

Elena

"I became a volunteer with Healthwatch after graduating. I wished to expand my work experience while also having a positive impact on the community, and volunteering with Healthwatch was the perfect opportunity. I did not only learn a lot and had fun with the caring and knowledge team, but also became more aware of the issues faced by healthcare services."

Rebecca

"Working closely with local service users and listening to their personal experiences is such a privilege. Being able to signpost accessible services and provide helpful information to support patient's is very rewarding because you feel you have made even the smallest difference to that person's well-being."

Sirina

"I volunteered because I wanted to see from the patients point a view how their experiences are at hospitals and GP's face to face other than reading review about it as sometimes not all reviews are true. The difference I feel like I have made to the community is working closely with Healthwatch to help the NHS staff improve on how they run their hospitals and GP's."

Thank you

Thank you to all of our fantastic volunteers who give up their time to make Health and social care services better for our community

Monika

“My name is Monika, I work as a Support Officer with people with mental health problems. Alongside this, I volunteer for Healthwatch to earn more experience in research, meet new people and learn new things. I feel that by working with Healthwatch I can understand more of the issues that the patients from the community are facing by using the services such as GP, Pharmacy, Dentists, Hospitals etc. Additionally, I learned about how the services are good, and how [redacted] the services. I feel [redacted] be heard so they [redacted] give compliments. I [redacted] formation from the [redacted] the report I am [redacted] ovement of the

Holly

“As a volunteer at Healthwatch Hammersmith & Fulham, I have really enjoyed being able to develop my understanding about the different issues people can face in the community and contribute to research and projects that aim to make a positive difference. This opportunity has allowed me to broaden my skills and provided me with valuable experience that will be useful for me in my future work."

Do you feel inspired?

We are always on the lookout for new volunteers, so please get in touch today.

www.healthwatchhf.co.uk

0203 886 0386

info@healthwatchhf.co.uk

Patient Representation

We attended 116 key strategic and operational meetings where we represented the voices of Hammersmith and Fulham residents, encouraged public involvement and shared our intelligence.

Meetings Attended
Health and Wellbeing board
Health, Inclusion and Social Care Policy and Accountability Committee
Pharmaceutical Needs Assessment
H&F Local Borough Committee (Primary Care)
H&F Borough Based Partnership
H&F ICP Operational delivery group
H&F ICP Mental Health Campaign
Hammersmith & Fulham Mental Health Stakeholder Group
Co-Production Partnership Board
West London Trust Carers council
H&F Dementia Action Alliance
West London Trust Service User and Carer Experience Sub Committee
Digital inclusion strategy
H&F Safeguarding Adults Board
NWL Immunisation & Vaccination Board
R&A/Practice Manager Forum

Comments from Partners

Healthwatch have worked very closely with the public health team in the council, and were a key stakeholder in the suicide prevention needs assessment and strategy, taking the lead on compiling a directory of mental health services, which was an important gap identified by the work. Healthwatch have also been an instrumental partner in the health and wellbeing strategy working group, and will be sharing the work they are doing with the mental health trust so that this key group of patients' voices are reflected in any planning.

Dr Nicola Lang, Public Health

Your contributions and involvement with the Trust and this work have been greatly appreciated. We look forward to working with you on your future visits.

Imperial College Healthcare NHS Trust

Healthwatch have worked in co-production with the Youth Council, to carry out research and resulting recommendations into young people's access to mental health services in H&F in the aftermath of the pandemic. The findings and recommendations have been shared widely with service deliverers, commissioners and strategic leads and actions are now being co-produced with young people. This has been an interesting, fun, meaningful and impactful co-production and Healthwatch's support was highly valued by the young people and Youth Voice Coordinator. Healthwatch are as passionate about young people's voices and co-production as the Youth Council so it has been a really affective partnership and enjoyable experience.

Brenda Whinnett, Youth Voice Coordinator

We have worked closely this past year inviting the H&F Healthwatch team to attend our regular forums, which have been of great use to the attendees. Keep up the good work.

H&F GP Federation

Healthwatch Hammersmith and Fulham have been part of the Pharmaceutical Needs Assessment steering group for Hammersmith and Fulham. At the steering group the team have not only provided invaluable guidance on how to best engage with the public on their use of pharmacies but have contributed significantly to that engagement.

Ashlee Mulimba, Healthy Dialogues

Finance and future priorities

To help us carry out our work we receive funding from our local authority under the Health and Social Care Act 2012.

Income	
Funding received from local authority	£122,000
Additional funding	£0,00
Total income	£122,000

Income	
Staff costs	£95,000
Operational costs	£21,000
Support and administration	£6,000
Total expenditure	£122,000

Top three priorities for 2022–23

1. Community and Inpatient Mental Health services
2. Discharge into Social care from Hospital.
3. LA Carers needs assessment improvement.

Next steps

The pandemic has exacerbated the public requirement for mental health support. Now more than ever residents need to know about the different voluntary, community and statutory support available to them. Health and social care partners need to consider how residents are able to access treatment in an empathic environment without judgement and stigma.

The pandemic has put increasing pressures on our Primary care systems. We need to ensure these services are being best utilised while they work through long waiting lists. This includes looking into digital consultations, preventable delays and lack of communication between Medical, Transport and Social care services.

Healthwatch Hammersmith and Fulham will continue to work with the local authority, local carers' charity and Healthcare commissioners and recommend changes with the data gathered from our Carers Project. We hope this co-production will create a louder voice for carers in the borough and steer where the most impactful changes should take place. From this we will build and implement an action plan for the local carers strategy.

Statutory statements

About us

Healthwatch Hammersmith and Fulham, 141-143 King St, London, W6 9JG

Company holding local Healthwatch Contract

Your Voice Health and Social Care, 45 St. Mary's Road, Ealing, London W5 5RG

Healthwatch Hammersmith and Fulham uses the Healthwatch Trademark when undertaking our statutory activities as covered by the licence agreement.

The way we work

Involvement of volunteers and lay people in our governance and decision-making.

Our Healthwatch board consists of 6 members who work on a voluntary basis to provide direction and guidance around our work programme. Our committee ensures that decisions about priority areas of work reflect the concerns and interests of our diverse local community. Through 2021/22 the committee met 10 times and made decisions on matters such as strategies to maximise impact and reach of our carers' report as well as the need to work in partnership with Hammersmith and Fulham Age Uk and the community sector to engage with digitally excluded residents. We ensure wider public involvement in deciding our work priorities. Our priorities are informed by a combination of local intelligence, system priorities and issues or gaps which are identified through the Patient Experience Programme, research projects and advocacy/signposting services.

Health and Wellbeing Board

Healthwatch Hammersmith and Fulham is represented on the Health and Wellbeing Board by Nadia Taylor, Healthwatch Hammersmith and Fulham Committee Chair. During 2021/22 our representative has effectively carried out this role by highlighting the importance of support for digitally excluded residents and GP access as well as lack of support for carers. She continues to ensure that the experiences of residents remain a priority in the discussions and decision-making processes.

Responses to recommendations and requests

We completed 4 Enter and Views at Charing Cross Hospital Imperial College Healthcare NHS Trust. Response from Charing Cross "Your feedback is really helpful and we welcome your ideas and suggestions for improvement which we will now take forward."

We completed 6 Enter and Views at GPs in North Hammersmith and Fulham PCN. Response from several GPs "Your feedback is really helpful. Thank you for compiling this report. We appreciate your time and thank you for your input."

There were no issues or recommendations escalated by our Healthwatch to Healthwatch England Committee and so no resulting special reviews or investigations.

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Appendix 3 – Changes to the Policy and Accountability Committee Terms of Reference

Health and Adult Social Care Policy & Accountability Committee

Terms of Reference

Members
5 voting Councillors

Quorum
3 Members of the Committee

Political proportionality
4 Administration Members
1 Opposition Member

Co-opted Members
Up to 5 non-voting members

Principal Functions
All the powers of an Overview and Scrutiny Committee as set out in section 21 of the Local Government Act 2000 and Local Government and Public Involvement in Health Act 2007, in particular:

- To discharge functions under the Health and Social Care Act 2001
- To discharge any functions under the Health and Social Care Act 2012 and any subsequent regulations
- To develop policy within the scope of the Committee and make recommendations to the Cabinet
- Monitor the administration and spending in services within its scope
- To review the impact of decisions and policies implemented by the Council
- Lead responsibility for scrutinising the relevant Cabinet Members(s).

Scope:

- Health of both children and adults (including public health).
- The provision, maintenance and improvement of primary and acute NHS services in the borough.
- The provision of mental health services in the borough.
- Adult social care services in the borough, including the exercise of statutory responsibilities in relation to the scrutiny of health as set out in Article 6 and also the voluntary and community sector.
- Health and Adult Social Care commissioning services.
- Any other matter allocated by the Policy Unit and Overview Board.

Children & Education Policy & Accountability Committee
Terms of Reference

Members
5 voting Councillors

Political proportionality
4 Administration Members
1 Opposition Member

Quorum
3 Members of the Committee

Co-opted Members

Statutory with voting rights on education matters
2 Parent Governor representatives
2 Diocesan representatives

Non-statutory without voting rights
1 teacher representative
Up to 2 additional co-opted members

Principal Functions
All the powers of an Overview and Scrutiny Committee as set out in section 21 of the Local Government Act 2000 and Local Government and Public Involvement in Health Act 2007.

- To develop policy within the scope of the Committee and make recommendations to the Cabinet
- Monitor the administration and spending in services within its scope
- To review the impact of decisions and policies implemented by the Council
- Lead responsibility for scrutinising the relevant Cabinet Members(s).

Scope

- The education of children and young people in the borough
- The authority's functions in its capacity as education authority
- Services for children and young people with special educational needs and disabilities
- The authority's social services functions as they relate to children
- Safeguarding
- Child protection
- Children in care
- Children and young people leaving care
- The education and children's services budgets including social care
- Any other matter allocated by the Policy Unit and Oversight Board.

Social Inclusion and Community Safety Policy & Accountability Committee

Terms of Reference

Members:
5 voting Councillors

Quorum:
3 Members of the Committee

Political proportionality:
4 Administration Members
1 Opposition Member

Co-opted Members:
Up to 5 non-voting members

Principal Functions

All the powers of an Overview and Scrutiny Committee as set out in section 21 of the Local Government Act 2000 and Local Government and Public Involvement in Health Act 2007.

- To discharge of the functions and responsibilities of a Crime and Disorder Committee in accordance with section 19 of the Police and Justice Act 2006 and regulations made under section 20 of the Act.
- To improve the terms of participation in society, particularly for people who are disadvantaged, through enhancing opportunities, access to resources, voice and respect for rights.
- To develop policy within the scope of the Committee and make recommendations to the Cabinet
- Monitor the administration and spending in services within its scope
- To review the impact of decisions and policies implemented by the Council
- Lead responsibility for scrutinising the relevant Cabinet Member(s)

Scope:

- Improving Social Inclusion
- Enhancing the quality of life of residents
- Community safety and tackling anti-social behaviour
- Licensing and gambling.
- Neighbourhood governance
- Community engagement, consultation and empowerment activities
- The Council's equalities and diversity programmes and support for vulnerable groups.
- The Council's Voluntary Sector strategy
- Increasing access to opportunity in all aspects of social and economic life in the borough
- Other policies and initiatives supporting social inclusion in the borough
- Any other matter allocated by the Policy Unit and Overview Board.

The Economy, Arts, Sports and Public Realm Policy & Accountability Committee

Terms of Reference

Members
5 voting Councillors

Quorum
3 Members of the Committee

Political proportionality
4 Administration Members
1 Opposition Member

Co-opted Members
Up to 5 non-voting members

Principal Functions
All the powers of an Overview and Scrutiny Committee as set out in section 21 of the Local Government Act 2000 and Local Government and Public Involvement in Health Act 2007.

- To develop policy within the scope of the Committee and make recommendations to the Cabinet
- Monitor the administration and spending in services within its scope
- To review the impact of decisions and policies implemented by the Council
- Lead responsibility for scrutinising the relevant Cabinet Members(s).

Scope
To monitor the policy, administration and spending of all aspects of:

- The local economy
- Support for local businesses and high streets, including the ability of local businesses and the voluntary and community sector to procure from the Council and the Council's suppliers
- Local employment opportunities
- Public sports facilities
- Regeneration and renewal of deprived areas
- Arts and cultural services
- Adult education
- Libraries
- The local environment, parks and open spaces
- Street Scene
- Cemeteries
- Enhancing the quality of life of residents
- Any other matter allocated by the Policy Unit and Overview Board.

Housing and Homelessness Policy & Accountability Committee

Terms of Reference

Members
5 voting Councillors

Quorum
3 Members of the Committee

Political proportionality
4 Administration Members
1 Opposition Member

Co-opted Members
Up to 5 non-voting members

Principal Functions
All the powers of an Overview and Scrutiny Committee as set out in section 21 of the Local Government Act 2000 and Local Government and Public Involvement in Health Act 2007.

- To develop policy within the scope of the Committee and make recommendations to the Cabinet
- Monitor the administration and spending in services within its scope
- To review the impact of decisions and policies implemented by the Council
- Lead responsibility for scrutinising the relevant Cabinet Members(s).

Scope
To monitor the policy, administration and spending of all aspects of:

- Housing (including privately owned, council, housing association, sheltered and supported housing)
- Provision of homes for local residents
- Tackling and reducing homelessness
- Any other matter allocated by the Policy Unit and Overview Board.

Climate Change and Ecology Policy & Accountability Committee

Terms of Reference

Members:
5 voting Councillors

Quorum:
3 Members of the Committee

Political proportionality:
4 Administration Members
1 Opposition Member

Co-opted Members:
Up to 5 non-voting members

Principal Functions
All the powers of an Overview and Scrutiny Committee as set out in section 21 of the Local Government Act 2000 and Local Government and Public Involvement in Health Act 2007 and Sustainable Communities Act 2007, which provides the principal statutory powers by means of which local authorities are currently engaged directly in helping to tackle climate change.

- To discharge of functions contained in s.9FH of Schedule 2 to the Localism Act 2011 to review and scrutinise the exercise by flood risk management authorities of flood risk management functions which may affect the local authority's area
- To develop policy within the scope of the Committee and make recommendations to the Cabinet
- Monitor the administration and spending in services within its scope
- To review the impact of decisions and policies implemented by the Council
- Lead responsibility for scrutinising the relevant Cabinet Member(s)

Scope:

- Climate Change and the response to the Climate Emergency
- Transport, including roads maintenance, other transport infrastructure
- Parking policy, traffic management and the relationship with TfL
- Planning policy and performance and the impact of developments on transport infrastructure and the environment
- Recycling and environmental sustainability
- Waste-disposal, refuse collection, and street cleansing
- Ecology and Biodiversity
- Any other matter allocated by the Policy Unit and Overview Board.

Note: Planning decisions cannot be scrutinised