North Kensington Recovery Programme
Outcome and Delivery Report
2023/24

The Health and Wellbeing Strategy (HWS) was developed by engaging and listening to the community aimed at addressing both immediate, medium-term and longer-term health needs that would support the recovery process. It detailed how the NHS will contribute to improving the health and wellbeing of the local community and building its resilience so it can be more self-reliant moving forward. It underpinned the services that were commissioned in response to the Regulation 28 report.

The HWS identified four aims one of which was:

- Ensure that we measure the impact and the outcomes of the work undertaken at individual and community level

The strategy gave clear expectation of NHS services and outcomes by detailing high level expected outcomes for each of the work streams.

This report presents information on the delivery against Regulation 28 and health outcomes indicators and measures. This includes detail on achievement of the programme against the outcomes.

The structure of the report is:

- Section 1 Executive Summary and Introduction
- Section 2 Delivery and outcome reporting for each work stream
- Section 3 Next Steps

1.1 Executive Summary

This report contains information about the delivery, reach and outcomes of the services commissioned as part of the NHS North Kensington Recovery Programme with particular emphasis on 2023/24.

A five-year business case was produced by West London CCG in 2018, underpinned by the NHS North Kensington Recovery Health and Wellbeing Strategy (HWS). The strategy gave clear expectation of NHS services and outcomes by detailing high level expected outcomes for each of the work streams. An outcomes framework has been developed to measure and assess the impact of support for people affected by Grenfell. This report attempts to summarise the delivery, reach and impact of services on health outcomes in the 12 months from the 1 April 2023.

1.1.1 Summary of Reach and Outcomes

Primary Care

- Since January 2019 there have been 5967 Enhanced Health Checks (EHC), in 2023/24 there were a total of 2,555 EHC delivered for 2,438 patients
- There has been a marked increase of uptake in the survivor and bereaved cohorts in 2023/24; with the uptake increasing from 66-72% in survivors and 56-64% in the bereaved cohorts.
- A number of measures have been put in place to measure outcomes from these services:
    - These are mainly reporting good feedback and outcomes.
    - More work needs to be done to increase the number of Patient Engagement Questionnaires (PEQs) that are returned.
    - Further analysis needs to be to look at health activity linked to the EHCs which will include any onward referrals and trends identified within the checks.

Dedicated Service

- In March 2024 there were 256 survivors and 120 bereaved actively using the Dedicated Service (DS), a total of 37% of those eligible. In total **96%** of eligible clients have been offered the service with 70% accepting the offer.
- Central and North West London NHS Foundation Trust (CNWL) report positive outcomes for their service as evidenced by the case studies and feedback received. Patient Engagement Questionnaires were launched this year to limited success with only 10 being completed in year.
- More work needs to be done to increase response rate for the PEQs and to put in place additional measurable outcome measures.

Specialist Services

Adult Respiratory Long Term Monitoring

- A detailed service evaluation was undertaken by the Adult Respiratory Long Term Monitoring service this year. The aims of the evaluation were:

    - To review the delivery of the service. This is detailed in section 2.3.1.1.
    - To assess the clinical outcomes of the individuals who have accessed the service.
    - Once these findings and outcomes have been shared with the community they will be reported further.

- 76 patients attended a Consultant review with 75 patients attending a Lung Function Test in 2023/24.
- As at March 2024 of the 182 adult survivors considered, 168 (93%) had been offered the service with 135 attending.
- Currently, there are no reportable evidence to show delivery against the outcomes for this service. The findings of the service evaluation pertaining to clinical outcomes need to be shared with the community, then they will be reported as part of the outcomes report.
- Further outcome measures have been agreed for 2024/25 to enable reporting against the health outcomes.

Paediatric Long-Term Monitoring detail can be found under Children and Young People.

Self-Care

- The reports from Kensington and Chelsea Social Council (KCSC) and ACAVA (Men's Shed) report a number of diverse services including offers targeted at specific ethnic groups or communities.
- There were over 5000 places offered over a number of individual sessions and workshops across the two services.
- The reported outcomes for both services indicate that service users have experienced positive health and wellbeing outcomes as a result of taking part in one or more of the services where outcomes have been reported.
- KCSC is working with the service providers to improve the recording and reporting of outcomes particularly for the smaller organisations.

Emotional Wellbeing

- Grenfell Health and Wellbeing Service (GHWS) offered a great number of services in 2023/24 which included:
    - 29 workshops including yoga, tree of life, older adults group, healing space together and Recovery College.
    - 25 collaborations including, Kensington and Chelsea Food Bank, Healing Space Together Arts Collaboration, Hand of Hope, Festive Stars and Hearts Arts Project and Kensington Christmas.
    - This includes a range of different therapies, groups and culturally adapted interventions.
        - In March 2024 there were 502 GHWS cases. There was an increase during the year but then numbers levelled out over the year to a similar level to March 2023. Overall **96%** of the survivor and bereaved cohort have been offered this service.
    - There were a total of 78 Groups run during 2023/24 including Gardening Group, Older Adults Wellbeing, Women Swim for Wellbeing. This was an increase in the number of groups offered compared to the previous year, showing an increase in culturally appropriate services delivered in the community.
- CNWL report positive outcomes for their services across all parts of their model evidenced by case studies, feedback and outcome measures which demonstrate the diversity of the work delivered.
- Further work needs to be done to increase the response rate for PEQs and identify and implement measurable outcomes for the group work and workshops.

Children and Young People

- Primary Care

    - There were 142 EHC delivered compared to 42 in the previous year. This was reflected in an increase from 47% to 62% for Children and Young People (CYP) survivors and 46% to 55% for CYP bereaved.
- Paediatric Long Term Monitoring
    - There has been a reduction in the number of did not attends (DNAs) and an increase in activity towards the end of 2023/24 which has continued into 2024/25.
    - There were a total of 36 paediatric review and 6 respiratory reviews.
    - As of March 2024, the total number of bereaved and survivor children recorded by the NHS DS is 221. Of these 142 have been referred and 113 seen.
    - Work is ongoing to identify those that have not been referred to ensure that they have all been offered the service.
    - The service completed a full comprehensive third audit in December 2023. It identified a number of health concerns and themes; mental health, respiratory concerns, vaccine uptake is low.
    - The service designed a Patient Reported Experience Form (PREM) for use with parents and patients. The overall feedback was very positive.
- Grenfell Health and Wellbeing Service (GHWS)
    - At the end of March 2024 there were 94 open cases with the GHWS. Overall **97%** of survivor and bereaved children have been offered the service with 50% accepting.

The information contained in this report shows the services are reaching significant numbers of survivors, bereaved and local community and that there has been an increase in activity within these groups in 2023/24. Further work is needed to ensure that all eligible people are offered all services that they are entitled to access.

The report shows that whilst we have ample data showing the activity of the services, there is still limited reporting on the outcome and impact of the services on health outcomes.

More detailed information for each of the workstreams can be found in Section 2 of this report.

1.2 Introduction

On the night of Wednesday 14 June 2017, a fire occurred in Grenfell Tower where 72 people lost their lives, many were injured and a whole community was significantly affected.

On the 19th September 2018, Dr Fiona Wilcox, HM Senior Coroner – Inner West London, published a Regulation 28 (report to prevent future deaths) regarding the Grenfell Tower fire. The Coroner noted eight concerns within the report requiring action to prevent future deaths. In response, the NHS Chief Executive announced that NHS England would be investing £50m to fund long term health screening and health support for those affected by the Grenfell Tower fire over the course of five years.

In December 2018, West London Clinical Commissioning Group (CCG) submitted a five-year business case to NHS England to address the health needs of the survivors, bereaved and wider North Kensington community, as outlined in the Regulation 28 report, in the aftermath of the fire, underpinned by the NHS North Kensington Recovery Health and Wellbeing Strategy (HWS).

The HWS was developed by engaging and listening to the community aimed at addressing both immediate, medium-term and longer-term health needs that would support the recovery process. It detailed how the NHS will contribute to improving the health and wellbeing of the local community and building its resilience so it can be more self-reliant moving forward.

It identified four aims one of which was:

- Ensure that we measure the impact and the outcomes of the work undertaken at individual and community level

The strategy gave clear expectation of NHS services and outcomes by detailing high level expected outcomes for each of the work streams. An outcomes framework has been developed to measure and assess the impact of support for people affected by Grenfell. This report attempts to summarise the impact of services on health outcomes in the 12 months from the 1 April 2023.

This report presents:

- Detail on the achievement of the programme against the health outcomes indicators and measures, and status on reporting against these outcomes.
    - The North Kensington Recovery Team worked with commissioned service providers to develop indicators and measures to report against the identified high level outcomes.
- Information about activities and services that contribute to the NHS delivery of regulation 28. The services were commissioned by the ICB and they meet the individual concerns set out in the Regulation 28 Report as follows:

	Regulation 28 Concern	Service(s)
1	That no structured health screening programme is in place for those who were exposed to risks of smoke and dust inhalation during the Grenfell Tower fire.	• Primary care led enhanced health checks • Adult respiratory long-term monitoring • Paediatric long-term monitoring
2	That those subject to smoke and dust inhalation are at risk of developing health conditions in particular respiratory illness after particulate and poison inhalation.	• Primary care led enhanced health checks • Adult respiratory long-term monitoring • Paediatric long-term monitoring

3	That there may have been exposure to asbestos during and after the fire that could possibly cause late onset health issues such as mesothelioma.	• Primary care led enhanced health checks and Grenfell related appointments • Adult respiratory long-term monitoring • Paediatric long-term monitoring
4	That without an appropriate system of health screening, there is a risk that illness may arise unnoticed or present later in survivors, first responders and site workers, and thus reduce their life expectancy.	• Primary care led enhanced health checks and Grenfell related appointments • Adult respiratory long-term monitoring • Paediatric long-term monitoring
5	That the NHS needs to undertake a risk evaluation and then consider an appropriate regular health screening programme for survivors of the fire and first responders and site workers.	• Primary care led enhanced health checks • Adult respiratory long-term monitoring • Paediatric long-term monitoring
6	That survivors and first responders and site workers, need to be given access to guidance and/ or information that would help them to understand what could be the health consequences of being exposed to the hazardous environment of the site of the fire.	• Primary care led enhanced health checks and Grenfell related appointments • Adult respiratory long-term monitoring • Paediatric long-term monitoring Healthcare advice is given on an individual basis when patients attend their annual appointments.
7	That the NHS needs to oversee and co-ordinate and provide appropriate mental health support for all those affected by their involvement in the incident, be they survivors, bereaved, local residents or first responders or other workers involved in the aftermath. The potential impact of this disaster is very wide ranging.	• Grenfell Health and Wellbeing Strategy • Self-Care Services
8	It may be that the provision of some care services, for physical or psychological damage may be provided by occupational health services outside the NHS, however a scale and risk assessment of need and care provision needs to be undertaken to minimise persons affected slipping through the net and being lost from appropriate supportive services.	• Grenfell Dedicated Service • Annual recall in place for: • EHC • Paediatric Long Term Monitoring, and • Adult Respiratory Long Term Monitoring

- This report details the impact that services provided by the NHS have on the Regulation 28 requirements. Other organisations also have responsibilities for meeting these requirements, such as employers of site workers. These are not covered in this report.

2.1 Primary Care work stream

The Primary Care Enhanced services are provided as part of the NHS response to the Grenfell Tower fire.

These enhanced services were designed to support patients whose existing conditions may have been exacerbated due to the impact of the fire and those who may have developed new health issues as a consequence of the fire, as well as provide assurance to the communities regarding their health.

The Primary Care Enhanced Services consist of:

- **Enhanced Health Checks (EHC)**

  GP practices are offering Enhanced Health Checks which give people an assessment of their current health and wellbeing, with a focus on lung function, breathing and emotional wellbeing. If anything is identified and requires further investigation, they are referred on to a specialist service.

- **Community Enhanced Health Checks (CEHC)**

  Enhanced Health Checks are also available at local community venues for those people who do not want to attend a clinical setting

- **Grenfell related appointments**

  You can arrange a time with your local doctor to discuss any health concern you may have. Ask your local GP surgery for help, say you have been affected by the Grenfell Tower fire.

Highlights from 2023/24

- Updates to Enhanced Health Checks (EHC)

  In January 2023, a series of articles were published in national newspapers detailing health issues in firefighters including those present at the Grenfell Tower Fire. These stories caused a heightening of concerns for survivors and community members around the potential physical health impacts of exposure to smoke and other toxins. In response to the feedback following these reports and as part of the regular annual review of the EHC template additions were made to the EHC. These are detailed in section 2.1.1.1.

- Increased uptake of EHC across all cohorts

  - There has been a significant increase in activity when compared to previous years with the total number of EHCs going up from 954 in 2022-23 to 2555 in 2023-24.
  - This has led to an increase in uptake across the survivor and bereaved cohort, especially CYP survivors which has increased 15%.

2.1.1 Primary Care Services and Activity

2.1.1.1 Enhanced Health Checks

The following additions to the Adult EHC were agreed by the North Kensington Recovery Clinical Reference Group (CRG) and NKR SMT and communicated to all practices. This was following the regular annual review of the EHC template and in response to feedback following newspaper reports of a study on firefighters that attended Grenfell.

Test offered	Clinical explanation
Urine dip (haematuria / proteinuria)	Accessible test in primary care. To screen for renal/bladder disease, diabetes. Urine dip is also offered in the 3 yearly firefighter health screen.
Annual bloods (HBA1C, glucose, diabetes, thyroid, kidney function, liver function, LFTs, FBC, cholesterol)	This annual blood test will be able to check for a number of conditions providing reassurance to those Grenfell affected patients whose concerns may be impacting on their health and wellbeing and to provide screening for diabetes, cholesterol and other conditions.
Spirometry (referred through accelerated pathway for asymptomatic patients, chest x-ray not needed to be done prior to referral)	For wider community/Bereaved during EHC (Survivors are referred to Imperial long term monitoring) if clinical indication or patient has concerns due to smoke exposure then you can offer spirometry. This follows discussions with Dr Laura Martin, Grenfell clinical respiratory lead -There are continuing concerns within the community about the long-term effect of harmful smoke exposure.
Chest x-ray (use normal ICE pathway)	For wider community/Bereaved during EHC (Survivors are referred to Imperial long term monitoring) if clinical indication or patient has concerns due to smoke exposure then you can offer a chest x-ray **at baseline.** This follows discussions with Dr Laura Martin, Grenfell clinical respiratory lead -There are continuing concerns within the community about the long-term effect of harmful smoke exposure. It is reasonable to include a CXR as part of a comprehensive health assessment. Any specific respiratory symptoms or concerns can be explored in more detail by the Long term respiratory monitoring service, with other investigations performed alongside as appropriate or with a respiratory referral to the relevant service in those who are not eligible for the service.

A similar review has been done for Children's Enhanced Health Check detailed in the CYP section.

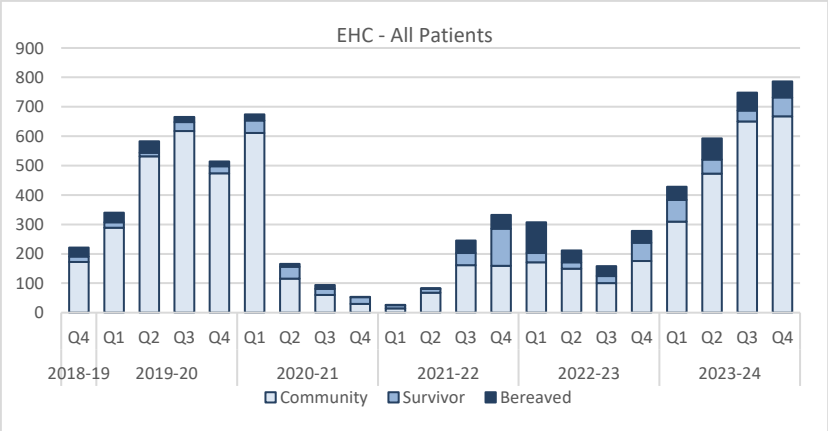
Activity

Since January 2019 there have been 5967 Enhanced Health Checks (EHC) completed across practices and the community.

In 2023/24 there were a total of 2,555 EHCs completed for 2,438 patients.

There has been a significant increase in activity when compared to previous years with the total number of EHCs going up from 954 in 2022-23 to 2555 in 2023-24.

The majority of this increase is driven by EHCs completed for patients from the wider community, going from 596 in 2022-23 to 2100 in 2023-24 which represents an 252% increase (or 1504 EHCs). EHCs for survivors also went up from 140 in 2022-23 to 224 in 2023-24 representing a 60% increase.



This increase has primarily been driven by a program led by the NKR team to raise awareness amongst Practices to undertake more EHCs and an increase in need for health assurance. Our data shows large increases in activity this year at the following GPs:

- **Golborne Medical West Ten GPs:** Up from less than 5 last year to 813 EHCs this year
- **The Foreland Medical Centre**: Up from 34 last year to 459 this year
- **Exmoor Surgery**: Up from 264 last year to 649 this year

Patient Type	1st EHC	Yearly EHC	Total EHCs	% 1st EHC
Survivor	27	161	188	14%
Bereaved	43	156	199	22%
Community	1657	394	2051	81%
Grand Total	**1727**	**711**	**2438**	**71%**

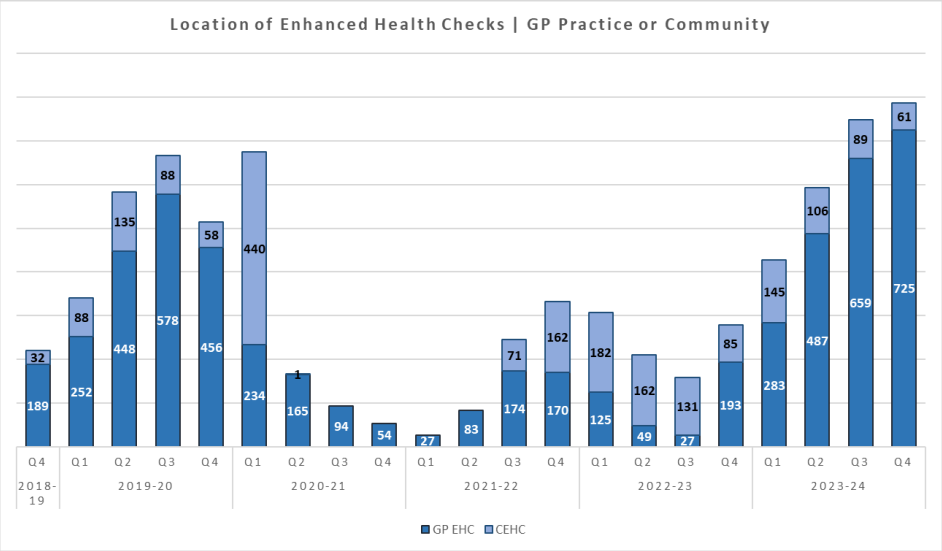
The table above provides a breakdown of EHCs completed, categorised by patient type and whether it was their initial EHC or a follow up. It highlights a number of Survivors and Bereaved received their first EHC this year. This has increased the uptake of EHC across the survivor and bereaved cohort when compared with March 2023.

The table below shows the uptake amongst survivors and bereaved with 67% across both groups.

		Cohort	Uptake March 2024	% uptake March 24	% uptake March 23
Survivors (including residents of Grenfell Walk)	Adults	348	258	74	70
	CYP	89	55	62	47
	Total	437	313	72	66
Bereaved	Adults	449	292	65	57
	CYP	40	22	55	46
	Total	489	314	64	56
Total	Adults	797	550	69	63
	CYP	129	77	60	47
	Total	926	627	67	60

Note: The numbers of bereaved and survivors reported in this table are the numbers as recorded in the Primary Care system (SystmOne) not from the Dedicated Service.

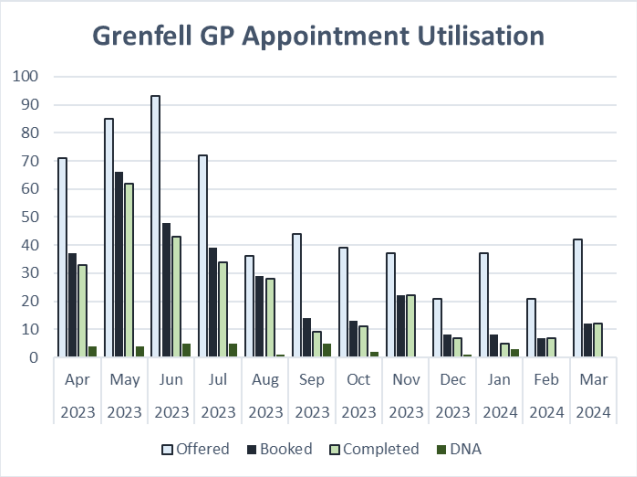
There has been an increase in uptake across all cohorts, particularly CYP survivors which has increased 15% in year.

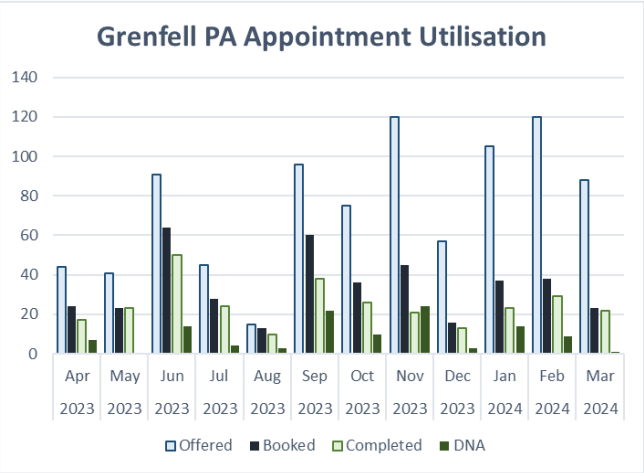


Community Enhanced Health Checks are now being sited in additional community locations with the location rotating between the sites, with the community clinics offering one evening and one weekend session. They are also running home visits for especially vulnerable Grenfell

Community Enhanced Health Checks

- The spirometry service expanded this year and the test is being offered to patients where it is clinically indicated or who request the test. Audits on the service do not show any trends.
- Phone appointments are offered for patients who DNA twice, these appointments can be used to reassure patients and to offer services such as spirometry even if they do not want to attend for a full check.
- A Warm and Well pilot has started in Golborne Ward. Patients are funneled into this service who report excessive mould in their council properties. The Warm and Well service consists of a community nurse and an RBKC surveyor who visit homes to review mould and perform physical health checks and can implement changes to improve the environment inside the home.
- The Community EHC has expanded to more community centres in 2023/24. There is also attendance at community days to promote the EHCs and there is a schedule for this Spring and Summer for clinicians and care coordinators to attend. The care coordinator that was recruited in 2023/24 comes from an SPLW background and has strong ties with the local community. There is a set timetable where she is in the community visiting centres and promoting health checks.
- Clinical staff remain the same ensuring continuity when we recall patients every year for reviews.
- DNA rates are high. Strategies such as telephone reviews and updating the text messaging to make instructions clearer for patients to avoid appointment confusion have been implemented to try and bring the rates down.





During 2023/24 there were 1496 appointments offered, 710 booked with 569 completed. There was a 20% DNA rate over the whole year but strategies have been put in place to try to improve this.

2.1.1.2 Grenfell Appointments

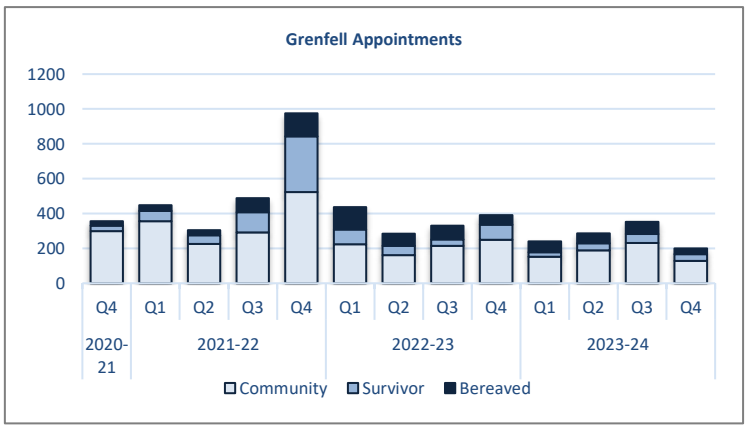
Historically, the purpose of a North Kensington Extended Appointment was to provide longer appointments with a GP. Following feedback, this specification was updated to encourage more practices to offer Grenfell enhanced services and acknowledges the complexities that exist in North Kensington.

Service Aim

- To acknowledge the additional complexities to North Kensington Community and that this requires additional appointments and resource.
- To provide additional clinical time/appointment, if needed to patients worried and affected about their health as a result of the Grenfell Fire.
- To support the key principles from North Kensington Recovery Plan.

A number of key performance indicators have been identified for the practices. The detail can be found in section 2.1.2.1.

Activity



2.1.2 Outcomes

High Level Outcomes with indicators

The table below details the high level outcomes identified in the HWS for this work stream, alongside the agreed indicators and methods of measurement.

High Level Outcome	Indicator	Method of measurement
1. A consistent high standard of service across all practices	1. Practices level of service is the same	a. Agreed key performance indicators (includes clinical review of notes)
	2. Patient feedback on level of service	a. Patient Engagement Questionnaire (PEQ)
		b. Annual GP Patient Survey
2. Skilled in identifying mental and physical impact of the fire on the local population Patients reporting services culturally sensitive and appropriate	3. Improvement in Health following Enhanced Health Check (EHC) or Extended Appointments (EA)	a. Reporting of health activity linked to EHC and GRAs. Improvement in patient health
	4. Staff upskilled following training	a. Evaluation of Leads Training
	5. Patients report improved level of service (including cultural competence)	a. PEQ

Summary

1. Consistent High Standard of service across all Practices

A number of measures have been put in place to evaluate the standard of services across all practices. More detail is provided in section 2.1.2.1.1 and 2.1.2.2.

These measures show good feedback and outcomes mainly but more work needs to be done to increase response rates to the Questionnaires.

<u>Key Performance Indicators</u>

- There are 4 Grenfell Related KPIs.
- 2 are hitting 100% achievement.
    - Outcome 2: 90% of patients say that they were able to have a face to face appointment if they wanted one and
    - Outcome 3: 85% of patients say that they had a ‘very good’ or ‘good’ patient experience
- 2 are not achieving the expected levels
    - Outcome 1: A patient is seen on average within 4 days has a 73% achievement
    - Outcome 4: The practice must have 10% more completed appointments per 1000 than the borough average for the eligible population: this is achieved by 52% of the relevant practices.
    - An email has been sent to each practice highlighting the achievement against each KPI. Where the practice is below the agreed target support has been offered.

Clinical Audit

- Due to Information Governance Issues the Quality and Clinical audits did not take place in 2023/24, these problems have now been resolved and the audits will start in Q2 2024/25.

Patient Engagement Questionnaire

- Feedback via the PEQ following an EHC or Grenfell Related Appointment is predominantly positive.
    - EHC – 89% said their experience of the Health Check was good or very good, but only 69% said that it helped to assure them about their health following the fire. This is being reviewed alongside the additional text feedback.
    - GRA – 91% of the patients reported a good experience of their appointment will all levels of feedback above 90% other than those asking about access to appointments. The issues with access and ease of making an appointment is a reflection of the issues in Primary Care.
    - Unfortunately, there has been a drop in response rate, the work stream lead is looking at ways of improving the response rate, including sending the PEQs out more regularly.

GP Patient Survey

- The GP Patient Survey (GPPS) is an England-wide survey, providing data about patients' experiences of their GP practices.
    - In the 23/24 survey there were a number of areas where some practices are showing as more than 5% below the English Average. The West London GP Team worked with the practices looking at the areas highlighted, the work stream lead linked in with them and prioritised working with the practices around access to the enhanced offer.
    - Foreland and Barlby are outliers, meetings were set up with these practices in quarter 3.

2. Skilled in identifying mental and physical impact of the fire on the local population Patients reporting services culturally sensitive and appropriate

The measures in place currently show limited evidence of achievement against these outcomes.

Reporting of health activity linked to EHCs and GRAs.

- Work has been undertaken to extract and analyse data captured during the EHCs focusing on a number of measures with no findings. Further measures have been identified for further investigation.
    - Onward referrals from these appointments have also been analysed. These show the numbers are reducing over the years, with health and fitness now the most referred to category with respiratory no longer in the top five referred to category.
    - It is planned to continue analysis of this data with further clinical input. They will also be looked as part of an audit to be undertaken by the GP Clinical lead in 2024/25.

Evaluation of Leads training

- The schedule of training in 2020/21 and 2021/22 was postponed due to covid-19 pressures and despite work being done by the work stream lead a new schedule has not been put in place.

- The Grenfell Clinical Network was set up during 2023/24 to provide a space where multi professional NHS clinical staff and frontline non-clinical staff representatives, to come together. Its role includes identifying training needs and providing a space where learning and development opportunities can be offered to clinical staff across physical and mental Grenfell specific services.
- The engagement team worked in partnership with the North Kensington community to develop a training module on Developing a Culturally Competent General Practice. Unfortunately, due to sickness within the NKR team the rollout of the training has been slower than hoped, 10 sessions were run in 2023/24 all with positive feedback

PEQ

- 99% of patients who stated it was relevant said the healthcare professional recognised/understood cultural or religious needs when attending an Enhanced Health Check.
- 91% of patients who stated it was relevant said the healthcare professional recognised/understood cultural or religious needs when attending a Grenfell Related Appointment.

2.1.2.1 Primary Care Outcome measures detail

2.1.2.1.1 Grenfell Related Appointment Key Performance Indicators

- A patient is seen on average within 4 days – All eligible patients should be seen within an average of 4 days as measured via the PMS Access specification across the year.
- 90% of patients say that they were able to have a face to face appointment if they wanted one - As measured via the text survey questions.
- 85% of patients say that they had a ‘very good’ or ‘good’ patient experience - As measured via the text survey questions.
- The practice must have 10% more completed appointments per 1000 than the borough average as measured through the PMS Access specification.

  The borough average for the first 6 months of the year was 70 completed appointments per 1000 patients per week. The additional 10% required under this specification applies to ‘the eligible population.’

The table below details the practice achievement against each KPI.

Pulled from Sept PC access dashboard and overall EA survey data (26 people completed the survey Apr-Dec)

Practice Code	Practice Name	Contract	**Outcome 1**: A patient is seen on average within 4 days	**Outcome 2**: 90% of patients say that they were able to have a face to face appointment if they wanted one	**Outcome 3**: 85% of patients say that they had a 'very good' or 'good' patient experience	**Outcome 4:** The practice must have 10% more completed appointments per 1000 than the borough average for all eligible patients **Borough Av. 80 10%^ is 88**
Y01011	Barlby Surgery (AT Medics)	Signed	1	92%	100%	82
E87067	Colville Health Centre	Signed	3	92%	100%	65
E87047	Earls Court Medical Centre	Signed	4	92%	100%	106
E87733	Exmoor Surgery	Signed	6	92%	100%	78
E87706	Foreland Medical Centre	Signed	2	92%	100%	88
E87024	The Golborne Medical Centre (Dr Ramasamy)	Signed	3	92%	100%	73
E87742	Golborne Medical Centre (Razak)	Signed	2	92%	100%	124
E87762	The Good Practice	Signed	3	92%	100%	85
E87016	Holland Park Surgery Lower Ground Floor	Signed	9	92%	100%	76
E87720	Kensington Park Medical Centre	unsigned	3	92%	100%	55
E87063	Kings Road Medical Centre	Signed	3	92%	100%	76
E87738	Knightsbridge Medical Centre	No contract	7	92%	100%	92
E87003	North Kensington Medical Centre	Signed	5	92%	100%	71
E87065	Notting Hill Medical Centre	Signed	5	92%	100%	110
E87029	The Portland Road Practice	Signed	3	92%	100%	92
Y00200	Portobello Medical Centre	Signed	5	92%	100%	61
Y00507	St Quintin Health Centre	Signed	7	92%	100%	116

An email has been sent to each practice highlighting the achievement against each KPI. Where the practice is below the agreed target support has been offered.

Quality/Clinical Audit

Planning has started with the GP lead for the Audit. It is envisaged to start with a quality audit which will concentrate on:

1. First Stage Quality. Enhanced Health Checks. Reviewing the completion of the templates, a clear history taken, onward referrals, treatment plan. Appropriate referrals being made, followed up/actioned.
2. Second Stage Quality. Reviewing Survivor/Bereaved patients – Have they had an EHC? Been referred to Long Term monitoring? Referred to GHWS/have they required mental health input? Do they have a DS worker?

This will be followed by a clinical audit which will review referrals from EHCs, whether patient health has improved after multiple EHCs, etc. It will also look at those patients who have had a LTM appointment to ensure that that the practice has coded any diagnosis/referrals/outcomes into SystmOne.

This process was held up because of IT issues and IG clearance but it is scheduled to start early 2024/25.

2.1.2.1.2 Patient Engagement Questionnaires (PEQ)

From July 2022 Patients have been sent a text link inviting them to complete an online questionnaire following a EHC or GRA.

Feedback from the questionnaires is primarily positive.

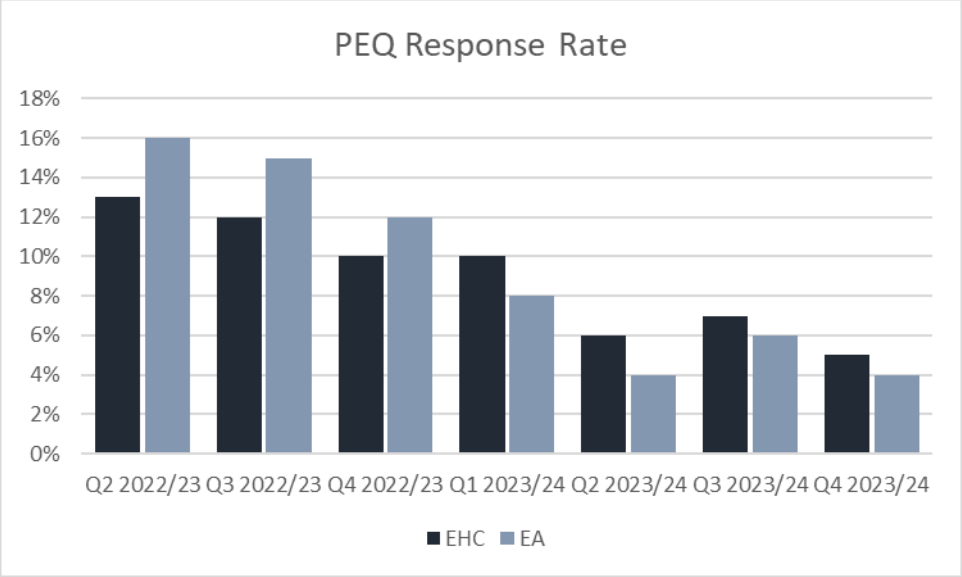
The questionnaire now has a dropdown for the practice where the EHC or GRA took place, so any feedback, good and bad, is fed back via quarterly meetings with each practice.

In 2023/24 there was a response rate of

Service	Texts Sent 2023/24	Responses in 2023/24	Response Rate 2023/24	Response Rate 2022/23
GRA	932	51	5%	13%
EHC	1641	111	7%	11%

The response rate has dropped by 8% for the Grenfell Related Appointments and 4% for the Enhanced Health Checks when compared with the response rate for 2022/23.

The work stream lead is looking at ways of improving the response rate, including sending the PEQs out more regularly. This is currently being held up due to IG and data clearance.



Enhanced Health Check responses

Of the 111 responses 25 did not consider that they had had a recent EHC, but 8 completed the questionnaire.

For the 111 people who answered the questions following an EHC.

92%	Had to wait a less than two weeks after the appointment was booked
95%	Very easy or fairly easy to make an appointment for the EHC at the practice
69%	Definitely or to some extent the EHC helped to assure about their health following the fire
93%	The Healthcare professional was good or very good at listening
99%	The healthcare professional recognised/understood cultural or religious needs (where stated it was relevant)
89%	Experience of the Enhanced Health Check good or very good

The feedback is mainly positive for the Enhanced Health Check.

There has been an increase across all of the questions detailed in the table above when compared to the responses in 2022/23.

The additional text feedback, shown below, is mainly positive. All feedback will be discussed with the relevant practices.

<u>Grenfell Related Appointments responses</u>

Of the 53 patients that responded; 4 responded that they did not request such an appointment, 12 had a regular appointment and 1 had not had any GP appointment

For the 36 people who answered the questions following an appointment:

67%	Had to wait a week or less after the appointment was booked
75%	Very easy or fairly easy to make an appointment at the practice
92%	The appointment helped with their health concern
92%	Needs met, definitely or to some extent
91%	The healthcare professional recognised/understood cultural or religious needs (where stated it was relevant)
91%	Experience of last appointment good or very good

The table above shows good feedback for the appointments across most of the questions. There has been an increase across all of the questions detailed in the table above when compared to the responses in 2022/23. The issues with access and ease of making an appointment is a reflection of the issues in Primary Care.

There is additional feedback shown below. All feedback is shared with the relevant practices.

Feedback/Outcomes from Community Enhanced Health Checks

Patient feedback has been very good,

After each appointment the patient is asked to complete a feedback form. The results are detailed in the following table.

The feedback shows that of the 216 responses over 94% were very satisfied or satisfied with their appointment.

	Feedback							Actions
How did you find out about the Community Enhanced Health Check?	GP Practice			11.57%			25	'other' included referrals, community centre staff, and resident association groups.
	Care coordinator			42.59%			92	
	Community Centre			13.43%			29	
	Friend/Relative			7.41%			16	
	Other			25.00%			54	
	TOTAL						216	
Did you try to contact your GP for the same issue, prior to booking into our service?	Yes			25.12%			54	
	No			74.88%			161	
	TOTAL						215	
Would you have preferred to have spoken to your GP or our clinician?	Own GP			12.09%			26	
	Our Clinician			43.26%			93	
	Either			44.65%			96	
	TOTAL						215	
How easy was it to find our clinic?	1	2	3	4	5	TOTAL	AVERAGE	Scale from Easy to hard
	59%	17%	16%	4%	4%	210	1.79	
	123	35	34	9	9			
How satisfied were you with your appointment?	Very Satisfied			70.83%			153	
	Satisfied			23.61%			51	
	Neither Satisfied or Dissatisfied			5.09%			11	
	Dissatisfied			0%			0	
	Very Dissatisfied			0.46%			1	
	Total						216	

2.1.2.1.3 Annual General Practice Patient Survey

The GP Patient Survey (GPPS) is an England-wide survey, providing data about patients' experiences of their GP practices.

In the 23/24 survey there were a number of areas where some practices are showing as more than 5% below the English Average. The West London GP Team worked with the practices looking at the areas highlighted, the work stream lead linked in with them and prioritised working with the practices around access to the enhanced offer.

Foreland and Barlby are outliers, meetings were set up with these practices in quarter 3. Each PCN has a capacity and access plan to try and improve access and promote consistency across the borough, this is part of the North West London General Access Plan for Primary Care.

There is relatively good access experience in WL and there has been a lot of work done on access improvement which has translated into positive patient experience with some of the best GP Patient Experience scores across London and in indeed across the whole of England. This does

not of course mean people can't still experience poor Access in West London or that we should be complacent. There is definitely variation which needs to be managed.

Details of the next survey will be in the Q1 report for 24/25.

2.1.2.1.4 Improvement in Health following EHC

Reporting of health activity linked to EHC and Grenfell Appointments.

Work has been undertaken to extract and analyse data captured during these EHCs. The primary focus has been on the following measures:

- **Sleep:** Examining the proportion of patients reporting good sleep patterns versus those experiencing difficulty sleeping.
- **Respiratory:** Assessing patient's respiratory symptoms, distinguishing between symptomatic and asymptomatic cases.
- **Smoking:** Identifying patients as smokers, ex-smokers, or those who have never smoked.
- **GPAQ:** Categorising a patient's level of physical activity. Notably, one of the most common referrals resulting from enhanced health checks relates to diet and fitness.
- **GAD-2 score:** Measuring the level of generalized anxiety disorder symptoms.
- **Diet:** Categorising patient's dietary habits as good, average, or poor.
- **Cough symptoms:** Looking at the proportion of patients presenting with cough symptoms

Initial findings were presented to the PC work lead and two clinical leads who supporting this work. Since then a new GP clinical leads have started within the team.

Further investigation is underway to compare the data with appropriate borough averages. Additionally, the clinical leads have identified the following measures for further exploration:

- **Alcohol intake**
- **BMI:** Body Mass Index
- **ONS4:** An assessment of personal well-being using four measures

Information from the EHC will also be analysed as part of the Audit to be undertaken by one of the GP clinical leads. The audit is scheduled for early 2024/25.

Onward Referrals

To analyse onward referrals following an Enhanced Health Check (EHC), we examined data on referrals made by GPs. Upon the clinical lead's recommendation, we focused on referrals made within 31 days of the EHC. This timeframe ensured that GPs had sufficient information to make referrals to other services while considering their workloads. By working closely with our clinical lead, we categorised the resulting data, which covered a wide range of services patients were referred to. This categorisation made the data more manageable and easier to analyse.

The table below shows the five most common onward referral categories following an Enhanced Health Check (EHC) for the Survivor and Bereaved cohort. It demonstrates the change in need over these two years:

Survivor or Bereaved Patients (2022-23)	Survivor or Bereaved Patients (2023-24)
Health & Fitness	MSK
MSK	Respiratory
Mental Health	Health and Fitness
MDT	Mental Health
Respiratory	MDT

Changes and Trends

- **Rising Importance:** MSK and Respiratory referrals have become more prominent, highlighting increasing physical and respiratory health needs.
- **Consistent Needs:** Mental Health and MDT referrals show steady importance, indicating ongoing support requirements in this area.
- **Changing Importance:** Health & Fitness referrals have decreased in rank but continue to be significant.

Looking at the data for the wider community we also see a shift in requirements:

Wider Community Patients (2022-23)	Wider Community Patients (2023-24)
Choose and Book	Health and Fitness
MSK	MSK
Mental Health	Mental Health
Health and Fitness	Referral to Community
Respiratory	MDT

Changes and Trends

- **Rising Importance:** Health and Fitness has become the top priority, showing a shift towards physical wellness.
- **Consistent Needs:** MSK and Mental Health remain consistent priorities, indicating ongoing support requirements in these areas.
- **Emerging Needs:** Referral to Community and MDT have entered the top five, indicating new areas of focus.
- **Changing Importance:** Choose and Book and Respiratory referrals have dropped out of the top five, showing a change in priorities.

It is planned to continue analysis of this data with further clinical input. These will also be looked as part of the audit which will be undertaken by the GP Clinical lead.

2.1.2.1.5 Staff Upskilled following training

To support practices in identifying the impact of the fire on their patients' training requirements were identified and programme was put in place.

Grenfell Leads Training Programme

The schedule of training in 2020/21 and 2021/22 was postponed due to covid-19 pressures.

There was a training session held in September 2023 led by Professor Lucy Easthope about Disaster Recovery, what the evidence and data say to expect 6 years on from a disaster. It was attended in person by five key Grenfell clinicians, and it gave an opportunity to share their experiences. Further Grenfell clinician briefings are scheduled to take place quarterly.

The Grenfell Clinical Network was set up during 2023/24 to provide a space where multi professional NHS clinical staff and frontline non-clinical staff representatives, across various West London Borough geography-wide health and wellbeing services provided specifically focused on populations affected by the Grenfell Tower fire including the Survivor and Bereaved population cohorts, to come together.

Its role includes providing a confidential space where Grenfell specific clinical concerns that require peer review, escalation or further investigation can be brought for discussion, to identify training

needs and provide a space where learning and development opportunities can be offered to clinical staff across physical and mental Grenfell specific services.

Cultural Competency Training

The engagement team worked in partnership with the North Kensington community to develop a whole systems approach that seeks to link together many of the influencing factors that lead to culturally-appropriate services. This led to the development of a training module on Developing a Culturally Competent General Practice.

This module had been successfully piloted and received CPD-accreditation from the Royal College of GPs (RCGPs), the accreditation of the training has gone through the renewal process for another year.

The roll out to Primary Care has been discussed at GP contract meetings. Logistics were developed and the roll out of the training commenced.

Unfortunately, due to sickness within the NKR team the rollout of the training has been slower than hoped.

- Online training commenced in June
    - 4 online training sessions, 11 attendances
- Four face to face GP training sessions were delivered across June and July
    - 9 attendances
- Training was given in July for West London Social Prescribers
    - 12 attended.
- An additional training session was run for ICB staff which was well attended.

The feedback from the Social Prescribing Session was very positive.

"It helped me understand that the way we phrase something will support the patient in encouraging the patient to make changes in their lifestyle and thoughts and beliefs for their benefit."

"I have a better understanding about certain communities and natural remedies that they have used for generations and have strong beliefs in. Also, how important family are in some communities and how this replaces MH support for many."

"Really useful and I gained some new information and perspective with regards to certain cultural norms and preferences."

"It was very useful and informative in understanding my patients as many of my patients come from different cultural backgrounds. It has mainly made me aware of where certain resistance of engagement can be routed from example what health and wellbeing means to them. From this I will be more sensitive and conscious in ensuring I tailor support based on patient cultural belief for instance the language used."

2.1.2.1.6 Patients report improved level of service (including cultural competence) – PEQ

PEQ detail can be found in section 2.1.2.1.2

99% of patients who stated it was relevant said the healthcare professional recognised/understood cultural or religious needs when attending an Enhanced Health Check.

91% of patients who stated it was relevant said the healthcare professional recognised/understood cultural or religious needs when attending a Grenfell Related Appointment.

2.2 Dedicated Service work stream

The NHS Dedicated Service (DS) is designed to support and coordinate survivor and bereaved families to access a range of emotional and physical wellbeing health services.

The NHS Dedicated Service (DS) aims to provide:

- a coordinated integrated physical and emotional wellbeing care and support
- Support for clients to access NHS and non-NHS support services
- Multiagency case management support for complex cases

In addition to the NHS Dedicated Service which is accessible to the bereaved and survivors, the NHS also commissions a separate case management service from Central London Community Healthcare NHS Trust (CLCH) for the wider community who have been impacted by the fire

Highlights from 2023/24

NHS Dedicated Service

- The DS has developed a PEQ specific for this team to ascertain whether or not the clients feel they have met their health needs.
    - It was officially launched on 16th March.
- **Aquamotion**
    - Project for Dedicated Service women's in collaboration with Kensington Leisure Centre that offers Aquamotion classes followed by a wellbeing session - an informal coffee and chat.
    - Following the hugely popular Aquamotion classes set up by two GHWS DS colleagues at Kensington Leisure Centre the same two members of staff managed to access funding for women only swimming lessons.
- **7th Anniversary**
    - Supported bereaved and survivors in the lead up to and on the 7th Anniversary

Wider Grenfell Case Management

- CLCH began to produce a quarterly report with details about the following agreed outcome measures
    1. PREMS (feedback survey)
    2. Care plan reviews
    3. Case studies
    4. Use of ONS4 form

2.2.1 Services and Activity

2.2.1.1 NHS Dedicated Service (GHWS)

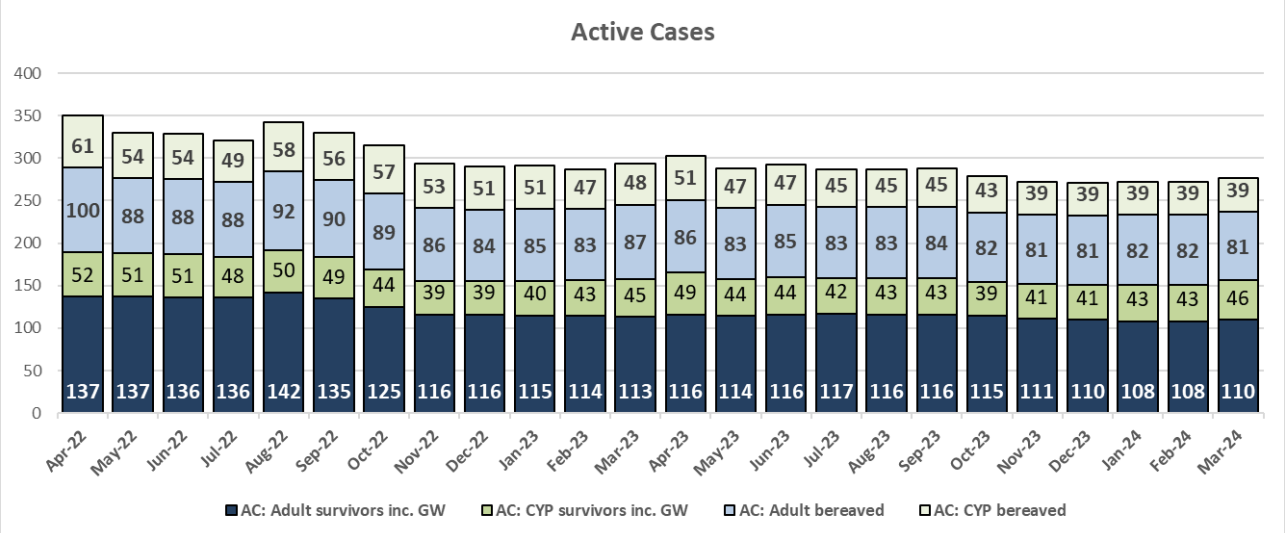
The DS team have been proactively offering and facilitating access to the appropriate NHS and non-NHS physical health services contained in the NHS Dedicated Services portfolio, to all those who are eligible for the service and whose contact details it has;

- Clients who take up the offers are classified as 'Active'
- Clients who do not take up the offer or who are not contactable are classed as 'Inactive'

All 'Active' clients are offered a health review which is carried out by their Dedicated Service health worker to understand what they feel their health needs are, and navigate them towards the relevant services.

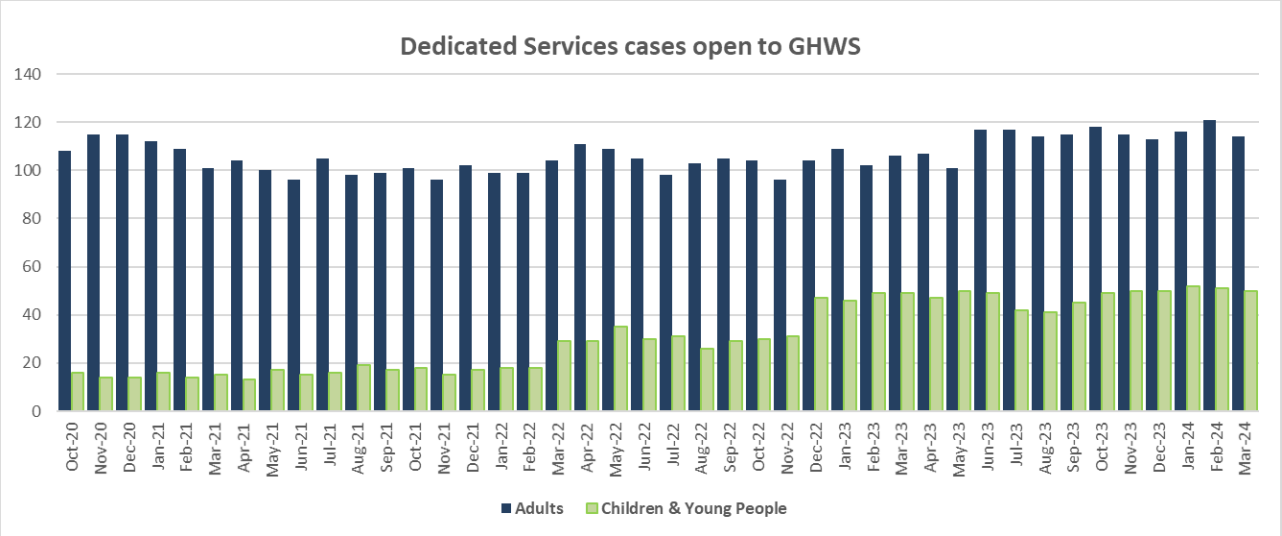
	Cohort	Number in cohort	Accessing DS March 2024	% Accessing
Survivors (including residents of Grenfell Walk)	Adults	331	110	35%
	CYP	123	46	36%
	Total	454	156	35%
Bereaved	Adults	217	81	39%
	CYP	100	39	45%
	Total	317	120	42%
Total	Adults	548	191	36%
	CYP	223	85	40%
	Total	771	276	37%

At the end of March 2024 there were 156 survivors and 120 bereaved actively using the DS, a total of 37% of those eligible. In total **96%** of eligible clients have been offered the service at some time with 70% accepting.



All survivors and the bereaved are open to the NHS DS. Initially where a case has been reviewed or a single interaction with a client had taken place these were counted as an 'open' cases, since April 2022 the service has reported cases as 'active' and 'inactive' to more accurately reflect the level of demand on the service.

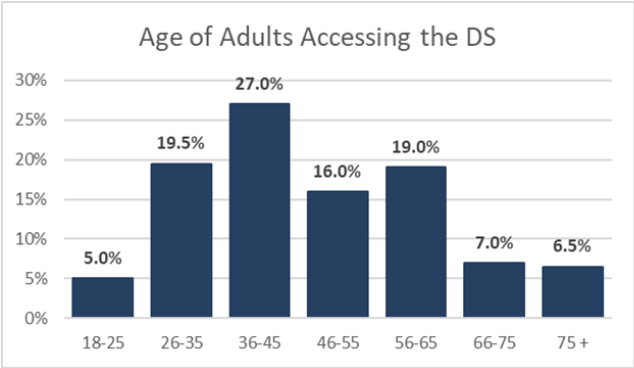
End of March 2023/24 shows a slight a very slight increase in the numbers of clients active with the NHS DS compared to the numbers accessing at the end of Quarter 3 but shows a decrease in numbers compared to March 2022/23. The numbers fluctuate, clients pass away and babies are born. It also depends on the time of the year, closer to the anniversary or specific world events result in people needing more support than at other times.

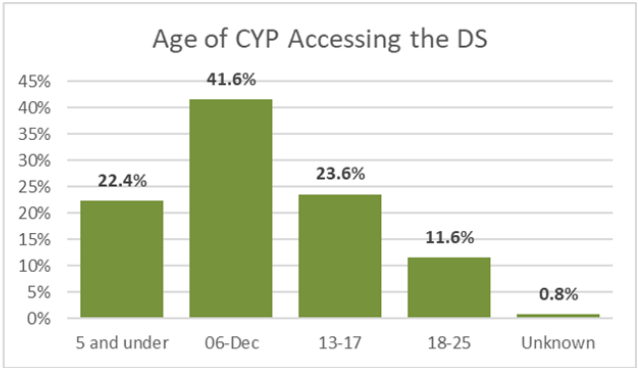


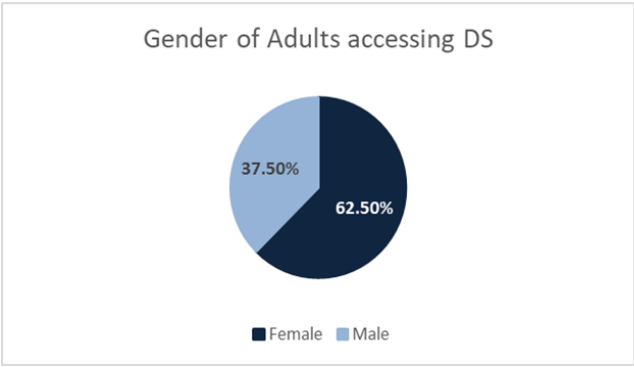
(The proportion of children also open to the GHWS increased notably from 33.7% in M8, to 52.2% in M9, as figures now include those open to a DS CYP therapist.)

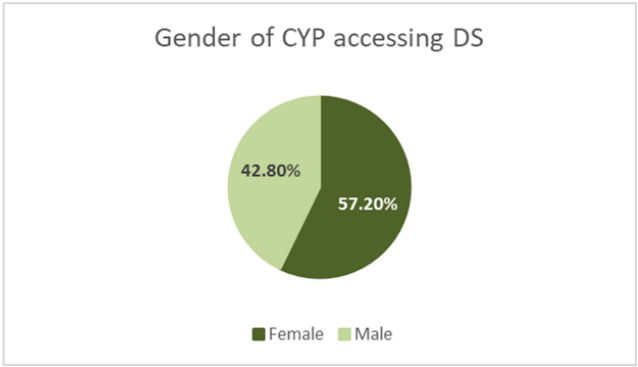
Demographics

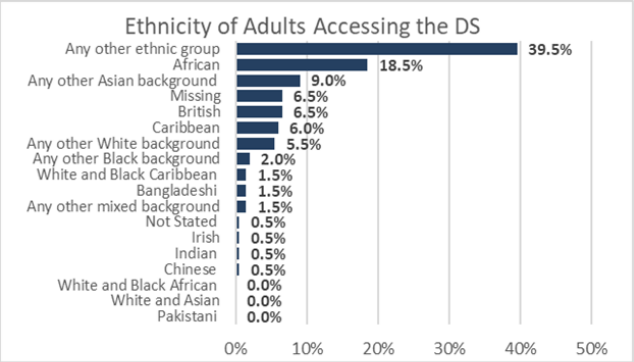
Basic demographic information is collected for the DS service users. These numbers represent clients who are actively receiving support from the DS Team. These are shown below.

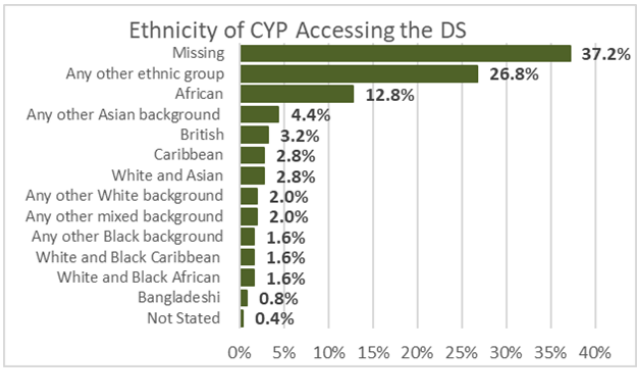


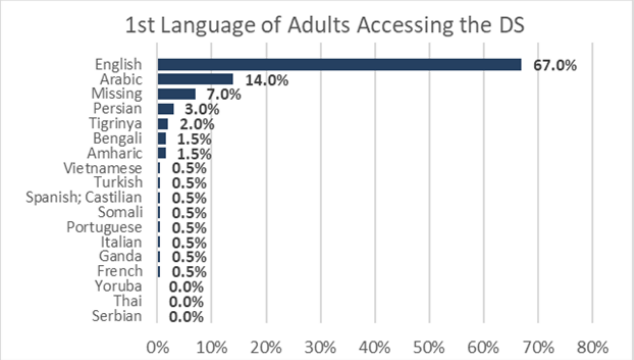


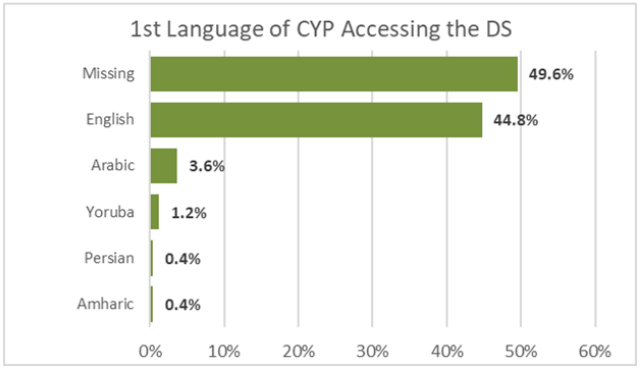












2.2.1.1.1 Collaborations

Aquamotion

- Project for Dedicated Service women's in collaboration with Kensington Leisure Centre that offers Aquamotion classes followed by a wellbeing session - an informal coffee and chat.
- The project aims to provide an opportunity for the ladies to form new relationships that can reduce social isolation and increase their social networks in the community whilst also taking care of their physical and mental health.
- This is a safe space that women have used to discuss topics of interest to them. The group has also provided a social network space for the women, which allowed them to form relationships outside the group as a support network.
- The women from the group have reported Aquamotion has improved their general flexibility, increased strength and improved mobility and has help to boost their mood and reduce their stress levels.

Kina Mama Post Anniversary Event

DS staff and one of the Community Connectors attended the annual Kina Mama post-Anniversary community gathering. The event is organised by one of the DS clients and took place on Saturday, 9th September 2023, at Bay 20.

GHWS staff supported by offering art activities to S&B (Survivors and Bereaved) and wider Grenfell affected children, and emotional wellbeing support to families that attended on the day.

2.2.1.2 Wider Grenfell Case Management

In addition to the NHS Dedicated Service which is accessible to the bereaved and survivors, the NHS also commissions a separate case management service from CLCH for the wider community who have been impacted by the fire.

- Case Management of complex cases with a physical health focus, however, signpost and support with mental health and social care needs.
- Joint care planning with patients to focus on their goals and priorities utilising health coaching techniques and motivational interviewing.
- Support the service users to achieve their individual health goals
- Work collaboratively with GP's, mental health services and voluntary sector to ensure patients' needs are met
- Chronic disease management and health promotion
- Arrange multidisciplinary team meetings and professionals' meetings, as required
- Signpost patients to NHS and non-NHS services such as the self-care offer from Kensington and Chelsea Social Council

The service started in September 2019 with a caseload of 45 patients upon which the Case managers started building, through proactive case finding. However, progress was interrupted by Covid in March 2020, which necessitated a shift in focus from case management to supporting the local Covid response.

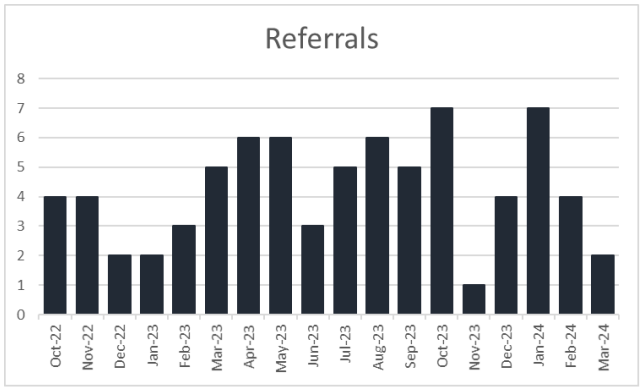
Post Covid 19 recovery, the caseload has seen a progressive increase, partly attributed to proactive case finding incorporating traditional direct referral pathways and community engagement. The total caseload currently stands at 184.

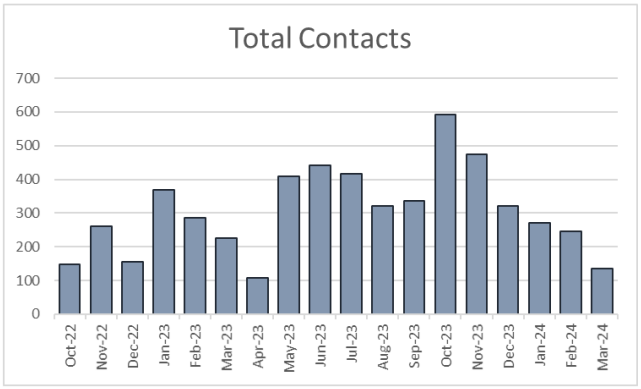
The team have demonstrated resilience with no Health and Social Prescribing Coordinator (HSPC) between November 2023 – June 2024 as well as the uncertainty of the future of their own roles.

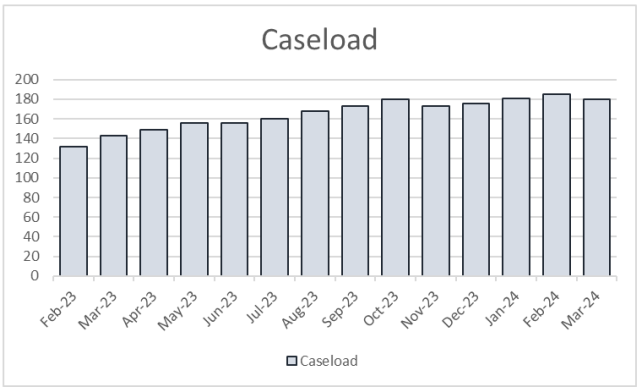
The team enjoyed meeting Baroness Scott for her visit in February and show casing what the MCMW Wider Grenfell team do to support their patients

Activity

Activity was reported from October 2022, there were known discrepancies in the data. The data is correct from February 2023 onwards.







The number of contacts has been decreasing since October this is due to a number of reasons:

- The HSPC left in November 2023, and the post has only been successfully filled in June 2024
- Sickness in November, Leave in December and Training in February.
- The front-line staff fed back there was a drop in contacts for March 2024, due to Ramadan (10th March-9th April). Patients did not want to be contacted during this time. As well as some team A/L.
- During March 2024, whilst still pending confirmation of the extension of the team contracts, there was a drop in referrals.

2.2.2 Outcomes

High Level Outcomes with indicators

The table below details the high level outcomes identified in the HWS for this work stream, alongside the agreed indicators and methods of measurement.

High Level Outcome	Indicator	Method of measurement
1. Health needs identified and physical, emotional and wellbeing services are in place and sufficiently flexible to meet community needs Clients are empowered to self-manage their health needs, along with awareness of asset based community offers to support self-reliance.	1. People are offered and navigated to the correct health services depending on their individual circumstances, to increase awareness of services available to them as part of the North Kensington Recovery offer. People improve their health literacy and are confidently able to access relevant health	a. CNWL report: • Questionnaire to be developed with clients to see if service has helped to meet their health goals, confidence with accessing services, etc. • Case studies and client feedback b. CLCH Report • PREMs feedback survey

	services independently by themselves.	• Care Plan Reviews • Case Studies • Use of ONS4 form

Summary

CNWL Report

- CNWL report positive outcomes for their service as evidenced by the case studies and client feedback detailed in section 2.2.3.1 which demonstrate the diversity of the work delivered by the service. This includes very positive feedback for the Aquamotion collaboration.
- The PEQs were launched this year to limited success with only 10 being completed in year. The feedback received through these was all positive.
- In the year ahead more work needs to be done to increase the response rate for the PEQs and to put in place additional measurable outcome measures.

CLCH Report

- CLCH first produced the report in Q2 2023/24 and report good outcomes from the service as evidenced by the case studies and client feedback detailed in section 2.2.3.2.
- There has been a limited response to the feedback form with only 21 completed in year. 100% of patients are satisfied with the support that they have received. Work is ongoing to increase the response rate for the form.
- The service aims for every patient referred to the service to have a comprehensive assessment followed by a care plan comprised of goals based on agreed priorities.
    - As at March 2024 49 patients (26%) did not have a care plan. The service acknowledges that this is a large proportion and aim to make this a key focus in the coming months.
- The aim is to undertake ONS4 assessment at every initial assessment and thereafter every 6 months or as determined by significant factors affecting a patients wellbeing. There has been an increase in numbers and percentage of ONS4 assessments for Q4 which indicates that staff are more proactive in completing the assessments.
    - The number of referrals from the service is also captured as a measure of positive outcomes and this has been increasing each quarter over the past year.

2.2.2.1 NHS DS Outcomes and Feedback (CNWL Report)

2.2.2.1.1 Patient Engagement Questionnaire

The DS has developed a PEQ specific for this team to ascertain whether or not the clients feel they have met their health needs. This PEQ proposal was reviewed by the DS Service User Consultants and further changes implemented based on the suggestions that were received. It was officially launched on 16th March.

The PEQ was made available as hard copy and electronically via Survey Monkey, so clients could provide feedback through different routes.

There were limited PEQs completed during the year.

In order to increase the numbers of PEQ's completed, the service has sent a text to all active clients on the DS system with a link to complete a PEQ online. This has resulted in an initial uptick in completion and we will continue to monitor progress.

Additionally, the team:

- Explored the translation of the DS PEQ to other languages besides English.
- Reviewed the best approaches to request DS clients' feedback.
- In Q2, no DS PEQ were completed. This was because DS staff joined forces with the wider GHWS team to:
  - Relaunch GHWS PEQs.
  - Plan and participate in the GHWS Feedback week that took place between 11th and 15th of September.
  - Promotion of GHWS Feedback week among GHWS clients, including DS cases.
- In Q3 (October to December 2023), GHWS continued the promotion of feedback collection among DS clients. A total of 4 DS PEQs were collected.
- In Q4 unfortunately there were no DS PEQs collected.

PEQ	Mar 2023	Apr-Jun 2023	Jul-Sep 2023	Oct-Dec 2023	Jan-Mar 2024	Year total
Dedicated Service	3	13	0	4	0	**20**

Feedback collection varies throughout the year, and there are ongoing strategies. A new feedback team has been set up that is reviewing feedback mechanisms, including for DS patients.

Summary of feedback:

- A total of 20 PEQs were collected
- The majority of clients were satisfied with the DS service
  1. Most DS clients that responded are happy with the support they receive, the reasons given for this are:
     - Improvement of mental health and wellbeing
     - Feeling heard
     - Valuable guidance to address clients' needs

     Two clients provided negative feedback and this is being followed up by the service
     - Client needs and support provision
     - Client having difficulty to reach professionals

  2. 100% of clients feel that they had proactive involvement in their care decisions. DS clients felt that they had a proactive involvement in their care decisions and a broad diversity of options that properly address their needs, as shown by the high rates obtained.

     One client rated the involvement as 1, which arises from the fact that involvement in care decisions depends from the DS worker that is supporting you. This aspect is being properly addressed.

  3. 1 client did not respond to this question. The majority of DS clients are satisfied with the NHS offer.

     The main aspects mentioned are:
     - Good care
     - Health checks provision took time

     Two clients are not pleased with the offer:
     - Rated 0: no further details were provided.

- Rated 1: difficulty to book an appointment. This was flagged to the team and is being addressed

4. 1 client did not respond to this question. The majority of DS clients felt their needs were properly addressed.

   Two clients are not pleased with the offer:
   - Rated 0: no further details were provided.
   - Rated 1: Needs addressing and support experience has been stressful. This was flagged to the team and is being addressed

5. 100% of NHS DS clients who completed a PEQ consider they are treated with dignity and respect by the service

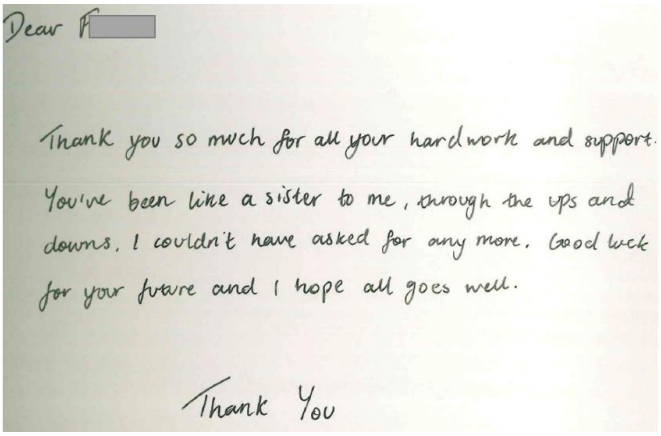
2.2.2.1.2 Feedback

There was some email and verbal feedback about the service, which is shown below. There are also a number of case studies detailed that demonstrate the diversity of the work delivered by the service alongside positive outcomes.

A RBKC DS worker shared the positive feedback given by a client in relation to the support provided by one of the NHS DS workers.

> "As you may know, I am the RBKC DS worker for 'M', who is supported by 'X' through the NHS Dedicated Service. 'M' wanted me to get in touch with 'X' manager to explain how much she values her support. 'X' has been a great help to 'M' over the years, always going above and beyond to meet her healthcare needs and 'M' is so grateful for her warmth, compassion and availability. 'M' feels lucky to have someone who genuinely cares for her wellbeing and is always there when she needs her. She knows there are not many workers who are as committed and hardworking as 'X' and she wanted it to be documented how much she appreciates her."

A DS family provided positive feedback

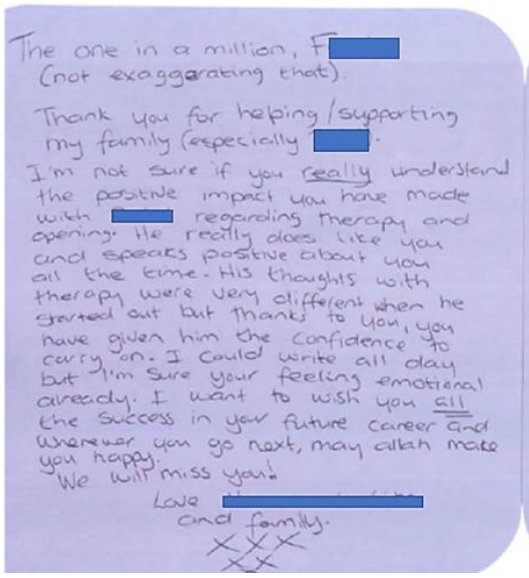

Dear [redacted]

Thank you so much for all your hardwork and support. You've been like a sister to me, through the ups and downs. I couldn't have asked for any more. Good luck for your future and I hope all goes well.

Thank You

Another DS family expressed their gratitude to the support received

Mum



Son

One GHWS Staff member recently received some positive feedback from a client who was grateful for their intervention and support with a GP surgery. The client had previously not been able to get a reply from their GP regarding their care. The DS worker went in to the GP surgery and explained the client's problem and anxiety around not being well informed about his diagnosis and encouraged the surgery to call him and support him with this. Following this the client has decided they would like to continue to get support from Dedicated Service. This is extremely positive as the client had not previously engaged with the service. In 2021 the client had been moved to 'Inactive' status following many attempted calls and letters. The client was then referred to us by the RBKC DS service for some temporary support in getting an appointment but this intervention with the GP helped to build a more trusting relationship and the client will remain on the 'Active' caseload.

2.2.2.1.3 Case Studies

DS Case Study 1
History: Client moved to UK with their family following the tragic loss of their family in the Grenfell fire. The children have high needs. The family have limited knowledge of English. **Presentation:** Parents are experiencing lots of stresses due to children's high needs as well as parental physical and emotional health needs. **Intervention:** Fortnightly welfare contacts and emotional support to parent. Discussion around children's wellbeing and access to support services within the local community. While working with client a safeguarding concern was disclosed by parent, and NHS DS worker supported the parent by creating safety plan and discussions around risk issues disclosed. Worker attended network meetings with professionals involved with family to discuss concerns and agree a support plan for the child and family. Support client to register children in dental surgery and arrange appointments. Face to face support to client prior to operation. Support parent in communication with GP regarding physical health following her operation.

Outcome:
Client can communicate their needs and their children's needs with services. Client has implemented safety plan to safeguard their child and network agreed the risk is low. Child is accessing therapeutic support to equip them with strategies they can use when they are overwhelmed or unable to communicate their needs.

Dedicated Service - Case Study 2

History:
Client is a survivor of the tower

Presentation:
The client has physical and mental health concerns. Since the fire the client has stopped working but has recently expressed an interest to go back to work. The client enjoys going to the gym to keep fit but lacks motivation and the knowledge to maintain a healthy diet. They have also expressed an interest in engaging in community groups.
The client is also experiencing ongoing issues with their current housing and is in the process of bidding for more suitable accommodation.

Intervention:
DS worker has:

- referred client and supported them to attend the weekly GHWS group therapy.
- supported the client to create a healthy meal plan to help manage their weight.
- referred the client to numerous groups in the community to increase social contact as well as the DS Employment Specialist to help them back into employment.
- supported with the client's housing issue
- supported the client to attend house viewings to identify suitable accommodation.
- continues to provide emotional support by visiting them at home or meeting in the community.

Outcome:
The client has been successful in gaining employment. The client continues to attend 'Aquamotion' at the local leisure centre with the support of the DS worker. The client is now linked with local services and is starting to feel more confident to engage in community activities and is reporting feeling more included in the local community now that they are making new friends. The DS worker continues to support the client to manage their health and wellbeing and educating them about food.

Dedicated Service - Case Study 3

History:
Client is bereaved
Presentation:
Since the fire the client has been diagnosed with PTSD and depression. The client also suffers from severe physical pain. The client and family lives accommodation that is feeling very crowded. The housing situation is having a significant impact on the client's mental health, and likely their children's. The client believes their health and personality have changed completely as a result of the fire. They previously worked full-time but since the fire have not been able to return to work. This along with the housing situation has led to feelings of anger and frustration and also some difficulty in regulating their emotions. The client feels let down by services and has struggled to engage consistently.
Intervention:

- The DS worker has worked with RBKC to attempt to build a trusting relationship with the client to assess their needs and the needs of children.
- The client has a long-standing relationship with their RBKC worker so it is important to work together to build trust.
- The client requires support to evidence how their housing situation is affecting their mental and physical health.

Outcome:
As a result of this new trusting relationship the client has given the DS worker consent to meet with their eldest child (in their late teens) to assess their individual needs.
The DS worker has also now had a successful joint home visit where the client gave consent for further home visits to meet with the client and their eldest child.
The DS worker continues to build a relationship in order to support the client and the family through their housing and with their health needs.

2.2.2.1.4 Collaborations

Aquamotion

- The women that took part in the group have shared positive feedback:
    - "Group leaders are very helpful; the exercise is very beneficial to my physical health and wellbeing as I cannot do physio therapy because of my backpain but with Aquamotion its easier because doing exercise in the water relieves the pain. It would be helpful if we can have more than one day a week".
    - "Having supportive staff, my physical health is improving and getting better understanding of my feelings".
    - "The group motivates me to come regularly and I enjoy very much to socialise with the members of the group and the facilitators".
    - I would like the group to continue as it helps me to look after my physical health since I have some medical problems. They ease up with regular exercise especially in the water".

Kina Mama Post Anniversary Event

Feedback from families and the host of the event that was attended by approximately 110 people, including approximately 50 children of different ages.

- Families feedback
    - "Lovely event, lots to do for the children, my children enjoyed creative activity. Thank you for all you do"
    - "Very enjoyable event for the whole family. Children enjoyed bouncy castle and drawing. I liked participating in the creative activity and to learn about Haku poem."

- "Thank you for all that you do for this community and supporting this event."
- "The creative activity on the theme ... Home is... is very relevant to this event and it brings families together."
- "Lovely event, very relaxing with lots of fun activities. Thank you for supporting. Children enjoyed learning about and writing Haku poem."
- "Really enjoyed the project and having something to do (project) which was already pre-planned – 2 x 15 yr old girls."
- "Doing art reminded her of memories of her old home – 8 yr old."
- "This reminds me of making art with my uncle who passed away" – 8 yr old."

- Host of the event
  - "It completes the event. GHWS are part of the community now and having their support and presence is very important to this community."

2.2.2.2 Wider Grenfell Case Management Outcomes and Feedback

The following outcome measures were agreed for the MCMW Grenfell Service.

1. PREMS (feedback survey)
2. Care plan reviews
3. Case studies
4. Use of ONS4 form

The first report was produced in Q2 2023/24.

2.2.2.2.1 PREMS

A Grenfell MCMW specific patient feedback form was completed and came into use in August 2023. Initial cascading of the questionnaire to patients was undertaken via bulk sending of the link and QR code or directly by text message. Since the December, the team commenced offering physical support to some patients to log into the survey and complete it during face-to-face contact, when appropriate.

There has been a limited number of responses but all responses were positive.

Quarter	Jul-Sept 2023	Oct-Dec 2023	Jan-Mar 2024
Number of Responses	4	10	7

100% of patients are satisfied with the support they have received from the team.

- Involved them in setting their goals and plans for addressing their health.
- Supported and advised them regarding where to get further help to manage their health and wellbeing.
- Took time to find out about them as individuals.
- Treated them with dignity and respect.

Feedback was particularly positive about staff attitude; some of the comments include:

"Staff really care for your wellbeing"
"The staff are there for my own good"
"Very happy felt relaxed during consultation."
"very helpful, understanding - great service"

Direct verbal feedback from patient is also encouraged by staff and this too, has been totally positive, with some patients commenting:

"Due to your help and intervention, the support has been ongoing, and I have been able to take care of my wellbeing both physically and mentally - I started to paint my flat"

"I just wanted to say a massive thank you to you for all the help- I've been receiving the food vouchers every week - bless you"

"Thank you for your support while I was in hospital it means a lot to me, please I'm home now can you arrange for transport for me on the 6 Dec 23…… would really appreciate that Thanks" -Text message

Feedback on where the service can improve was generally constructive and has been taken note of for future practice.

Please tell us where the Grenfell Case Management service could be improved in order to support your health and wellbeing

"Case Manager should have phoned me more often between assessments."
"very happy with the service"
"Would appreciate more follow-ups."

Efforts to rectify the low response rates are underway; postal questionnaires have now been sent to capture feedback from patients likely to face challenges with providing digital feedback. Staff also aim to collect feedback during face-to-face contact where appropriate.

One of the team met with the Trust Patient Engagement team to review how the patient feedback collection could be streamlined. The Trust Patient Engagement teams' suggestions include adding the URL/QR code on written communication, letters, in email signatures or sending it to patients following a visit. Additionally, the team have received support on converting the feedback form in various languages.

2.2.2.2.2 Care Plan Reviews

- Every patient referred to the service will have a comprehensive assessment followed by a care plan comprised of goals based on the clinician's and patient's agreed priorities.
- The service aims to carry out the initial assessment and care planning at the first appointment with the patient and have a review every 6 months or when the patient's circumstances change, for instance following hospital admission.
- At the review period, the service aims to ascertain goals met as well as the impact of intervention. However, due to some patients being referred with immediate needs requiring urgent intervention, assessment and care planning is often deferred to prioritise patient's needs.

The table below show the number of care plans by quarter.

Quarter	Q1	Q2	Q3	Q4
Number of Care Plans	80	53	50	52

The number of care plans completed in quarter 4 rose by 4%, the first indication of increase since quarter 1. This can be explained by the fact that the number of patient's due care planning varies across the year.

The percentage of patients with a CP within the last 12 months has remained stable overall (it dropped by 2% but this can be explained by the fact the caseload has increased recently, so the number as an overall percentage understandably fell.

Care plan compliance.

Total caseload	No CP last 12 months	Percentage of patients with no CP last 12 months	Last report
182	49	26%	24%

There is a 2% increase in number of patients without a care plan which is attributable to multiple factors, predominantly of which is patient factors such as non-attendance at scheduled care plan appointments. There is also a small proportion of patients whose goals are fully met or no longer require the service and the service is in the process of establishing discharge or step down standard operating procedures.

The service acknowledges there are a large number of patients without care plans and aim to make this a key focus of our activity in the coming months.

2.2.2.2.3 Case Studies

The case studies below have been produced with patients' verbal consent and were obtained to be shared with Stakeholders to provide an insight into how Grenfell Wider Community service works and the benefits of MCMW Care planning (Holistic Approach). All identifiers and patients have been anonymised.

Case Manager (Exploratory) - Case Study 1

History:

Mr x is a 54-year-old man who was referred by his GP for support with his multiple social and health concerns.

Problems/Goals:

- Upon assessment, Mr x was at risk of becoming unwell due to a chronic physical health problem. Mr x was experiencing problems with finance, housing, and lifestyle.
- We have improved his housing situation now by working with partners such as RBKC and Gas company provider. We got funding from local charities to clear outstanding Gas bill. We collected some warm clothing from Age Uk and sleeping bags.
- We accompany and organise transport so that Mr x, does not miss his investigation Appointments. We also organise and liaise with MDT, team for his Respiratory care.
- We are also in the process of helping him get a suitable housing via RBKC.
- We encouraged Mr x, to take responsibility with engaging with other health professionals such as the Drug and Alcohol team.

Intervention:

Case Manager care plan

For Mr x, particular focus was placed on early mental health support, debt and benefits, social isolation, and Cardiovascular health -including smoking cessation and access to physical activity. We saw Mr x, as part of a marginalised risk group who, without intervention or support, was at risk of developing further chronic conditions. We believed that with that a proactive, personalised intervention would offer him an opportunity to make significant improvements and improved Wellbeing.

Health and Social Prescribing co-ordinator plan

- Assessed areas of strength and challenges, including his perceived ability to self-manage.
- Sign posted to appropriate agencies (Housing)
- Provided ongoing personalised support.
- Rapport building and establish trusting relationships.

Health education and Advice focussed on:

- Benefit advice and support
- Sign posting to local voluntary organisations.
- Cardiovascular health (Smoking cessation still under the care of Drug and alcohol team)
- Social isolation
- Information gathering.
- Support signposting around Financial and legal affairs.
- Housing
- Bereavement support

Case Manager - Case Study 2

History:

A 50-year-old man with a diagnosis of schizophrenia. Referred in August 2023 via his GP.

Assessment:

- At risk of suicide as he self-reports ongoing suicidal thoughts - he has ongoing support from the Mental Health Team.
- Weight gain, due to medication.
- He also mentioned he struggles with social interactions, making it difficult for him to go to the gym.
- Chronic insomnia- Manages to sleep for only 2-3 hours a night.
- Needed guidance with PIP application, getting assistance as an inpatient as part of the discharge plan.

- Long term plans to join his relatives in the USA and requested support with visa application.
- Medicines optimisation: Following a health review, patient was flagged with the GP; joint GP/community mental health team review and medicines optimised.
- In-house pharmacist supporting medicines management by regularly monitoring medication changes and amending medicines list.
- Support with booking GP appointments.
- Referral for annual Enhanced Health Check.

Care Plan/Intervention:

- Intensive health navigation within primary and secondary care, working jointly with GP and Mental Health Team to ensure patient's complex health needs are met.
- Supporting community engagement, accessing culturally appropriate social activities / support groups.
- Consultation, liaison, and advice with other services such as housing and health.
- Attending the ward meetings and involved in patient care planning whilst an inpatient.
- Supporting the family during this difficult time by offering his sister time to just listen to her concerns; at the same time gaining insight into John's life from the family perspective (holistic support).
- Reflecting with team on what could have been done better.
- Involved in discharge planning of the patient.
- Referred to Specialist Weight Management Service (SWMS).
- Building a trusting relationship for both relatives and patient.
- Sleep hygiene to support healthy lifestyle.
- Support and signposting around financial and legal affairs.

Outcomes:

- There is better joined-up working; patient is now on an ongoing multi–disciplinary complex case list which ensures early recognition of health concerns and intervention.
- Improved physical and emotional wellbeing**.**
- Referral to other specialists such as OT, which was done whilst an inpatient.
- Increasing understanding of mental health problems and their impact on daily activities.
- The rapport and trust the team has built with John is key to him being able to talk about his feelings and needs.
- Learning opportunities for the team as we were able to understand the gravity of his anxieties and distressing experiences he had endured in the past.
- John is in a Rehab ward now; this remarkable progress demonstrates the positive impact of continuous support and reassurance on individuals facing complex mental health challenges as well as integrated management of his care.
- Grenfell Wider Community Team continue to support X in his discharge planning. X will be shortly discharged into the community with relevant support networks in place so he can lead a healthy and improved quality life.

Feedback fromX's sister via email

> "Good morning …….,It was nice talking with you! Please let's keep in touch so we can help X, my brother in these times of need"

Positive feedback from GP about the proactive case management. The work is done in collaboration with X during ward meetings and is the focus of the ongoing clinical consultation team meetings, of which the Case Manager is a key member. X is included in the meetings to help him to problem-solve.

2.2.2.2.4 ONS4

Grenfell My Care My Way activity has a significant social prescribing component as identified from analysis of activity data and health needs assessment.

The service acknowledges that social prescribing decisions are based on various aspects of holistic assessment, however, the focus on ONS4 scoring was deemed to provide the most statistical verification. They aim to undertake ONS4 assessment at every initial assessment, and thereafter every 6 months or as determined by significant events/factors affecting a patient's wellbeing.

The following table shows quarterly comparative data on ONS total assessments, undertaken by the team for the last 3 quarters.

Quarter	Q2	Q3	Q4
ONS Assessments undertaken	35	23	27

The table below shows the % of Grenfell Caseload that has an ONS4 assessment.

Quarter	Grenfell Caseload	Has ONS4	%
Q3	177	115	65
Q4	182	129	71

There is an increase in numbers and percentage of ONS4 assessments for Q4, which indicates staff are more proactive in completing the assessments. It is worth noting however that the numbers of assessments will always naturally fluctuate in consistence with type of activity for that period as not all patients ONS assessments and reassessments are due in the same period. Although this number includes patients who are not able to have the assessment for different reasons, we aim as a service to ensure that this upward trend continues towards achieving 100% compliance in as far as feasible, quarter on quarter.

The aim for The aim for Q1 of 24/25 is to ensure that staff focus on those patients with only one ONS4 and look to do follow-ups.

The following tables represent data on referrals out of the service as analysis of improvement in patients' wellbeing and has been collated to give an insight into some of the interventions after care planning and ONS 4 assessments.

Quarter	Q1	Q2	Q3	Q4
Referrals out of service	32	41	43	57

The percentage increment in referral data is double the percentage increment in ONS 4 assessments which is consistent with the fact that data captured on referrals also includes referrals not directly linked to ONS 4 assessments and some patients having multiple referrals at a time.

Patients w/multiple ONS4s, proportion experiencing improvement, decline, or no change

Category	Total	Percentage	Change since last time measured
Improvement	12	40%	↓ - 8%
Decline	16	53%	↑ + 10%
No change	2	7%	↓ - 3%

Overall patients with a decline or static outcome following ONS 4 make up a higher proportion than those with improvement. This is in part associated with the fact that uptake of health and wellbeing services patients are referred to by the team is not always guaranteed.

2.3 Specialist Services work stream

The NHS commissioned a number of specialist services to diagnose and treat any health conditions which arose from smoke, particulate and poison inhalation.

- **Paediatric Long Term Monitoring Service**

  Children and young people impacted by Grenfell are able to access an annual 90-minute appointment with a paediatric consultant, who undertakes comprehensive physical examination using a number of assessments. This includes lung and breathing function, review of emotional health and wellbeing and how they are getting on at school, sleeping patterns, height, weight and diet, and immunisation checks.

  See section 2.6 Children and Young People for detail on the delivery, outcomes and impact of the service.

- **Adult Respiratory Long Term Monitoring Service**

  The Adult Respiratory Long Term Monitoring Service, provided by Imperial College Healthcare NHS Trust is designed for survivors who had prolonged smoke exposure. In addition to a detailed review of the individual's lung health, the service is able to link into other subspecialty respiratory services and perform further detailed imaging and diagnostic tests when indicated, such as CT scans. This service includes an annual lung function test to identify any signs of respiratory disease alongside a review by a respiratory consultant.

  People within the Adult Respiratory Long-Term Monitoring Service are re-called annually to keep any emerging or existing respiratory conditions under review, and to ensure any long-term respiratory consequences would be identified and treated as per the coroner's concerns.

  The service also arranges referrals to other sub-specialties for further detailed evaluations, where indicated, including a chest physiotherapy & breathlessness clinic, the interstitial lung disease service, the respiratory infection service, the lung nodule service and the fast track lung clinic. The service has a dedicated administration coordinator who is able to offer flexible appointments according to the individuals' preferences with respect to virtual or face to face reviews at either the St Charles Hospital (run by Central and North West London NHS Foundation Trust) or Chelsea & Westminster Hospital (run by Chelsea and Westminster Hospital NHS Foundation Trust). Evening and weekend clinics are available to improve accessibility.

- **Toxicology Service**

  Following concerns raised by survivors and bereaved about the long-term effects of smoke inhalation a clinical toxicology review is available to those affected by the Grenfell fire. The service provides a specialist 90-minute appointment review that looks at people's health, answers questions and addresses any concerns. The consultants provide advice on health issues raised and will liaise with the person's GP or dedicated health worker to help facilitate ongoing care.

Highlights from 2023/24

Adult Long Term Monitoring Service

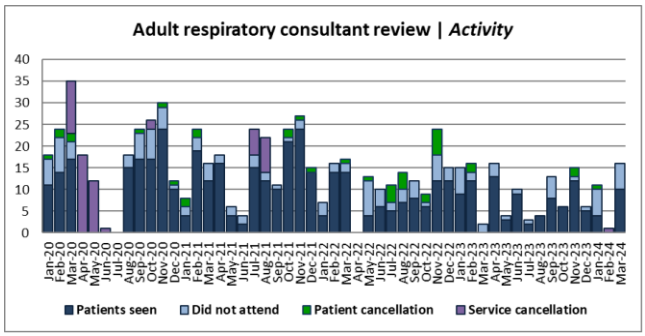
- A detailed service evaluation was undertaken by the service this year. The aims of the evaluation were:
    - To review the delivery of the service. This is detailed in section 2.3.1.1.
    - To assess the clinical outcomes of the individuals who have accessed the service. Once these findings and outcomes have been shared with the community they will be reported further.
    - This assessment of the respiratory health conditions observed in this population will enable the clinical team to plan respiratory services going forward.
- Appointments at Chelsea and Westminster Hospital NHS Foundation Trust were expanded to weekends. These appointments have helped to improve accessibility to the service and reduce DNA's.
- Lung Function Booking processes were streamlined to ensure individuals were offered slots at a convenient time in a timely fashion

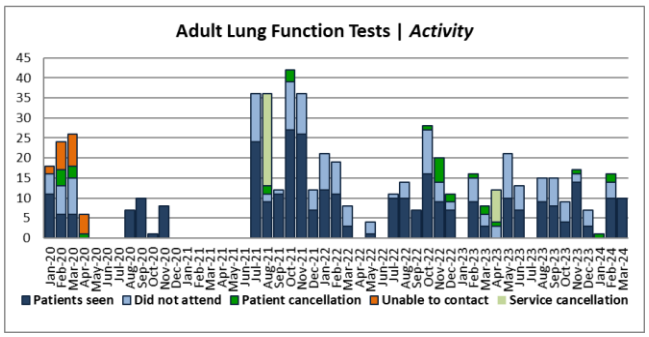
2.3.1 Services and Activity

2.3.1.1 Adult Respiratory Long Term Monitoring Service

During 2023/24

- 76 patients attended an Adult Respiratory Consultant Review this a slight increase on 2022/23 when 59 patients attended.
- 75 patients attended a Lung Function Test this is the same number that attended in 2022/23.





As at March 2024, of the 182 adult survivors considered, 168 (93%) of survivors had been offered the service by the NHS Dedicated Service (2 are overseas, 9 have not been able to be contacted and 2 are 'not known').

There are high DNA rates within this service, and people who are unable to attend a face to face consultant appointments are subsequently offered virtual appointments. The service is also run at both Imperial College Hospital Trust and Chelsea and Westminster Hospital Trust to offer a choice of location and to ensure capacity. Expanding the offer of appointments to weekends has also helped to slightly reduce DNA rates from 28% in 2022/23 to 24% in 2023/24.

A piece of work has been undertaken by the administrative staff within this service and the BI support in the NKR team, linking with the NHS Dedicated Service, to understand who has been

offered, referred and attended the monitoring service, and to ensure that none of the tower survivors had been missed. This work supported the service evaluation.

Service Evaluation

The service evaluation was split into two parts.

The first part an evaluation of the delivery of the service was performed looking at:

- Referrals and attendance to the service, both clinic appointments and lung function tests
- Onward referrals from the service
- The provision of imaging by the service

A total of 149 individuals (79%) from the public inquiry list have been referred to the service, along with an additional 58 survivors, resulting in 207 referrals.

Of the total 189 applicable patients from the public inquiry list, 40 were not referred including those who had died, declined follow up or could not be reached.

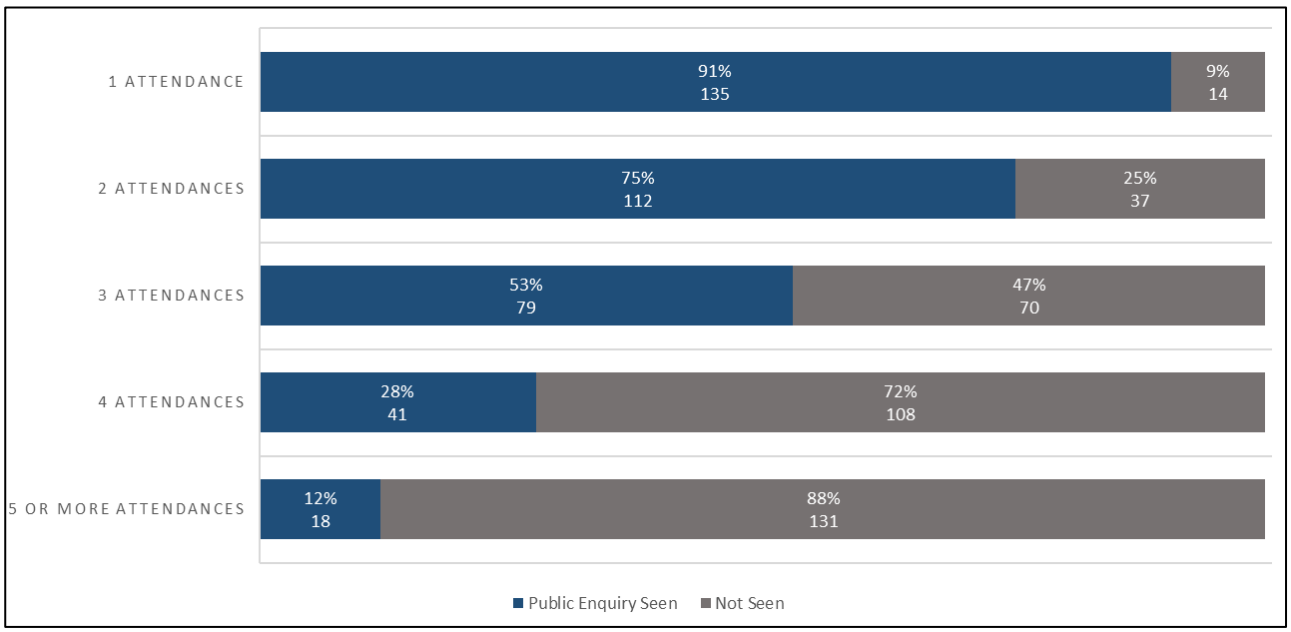
An ongoing collaboration with the NHS Dedicated Service aims to ensure all eligible individuals are able to access the service if they wish to.

<u>Consultant Respiratory Review:</u>

A yearly clinical follow-up was offered. Individuals could choose between:

- Face to face or remote appointments
- The location where they accessed the service
- The dates and times they preferred

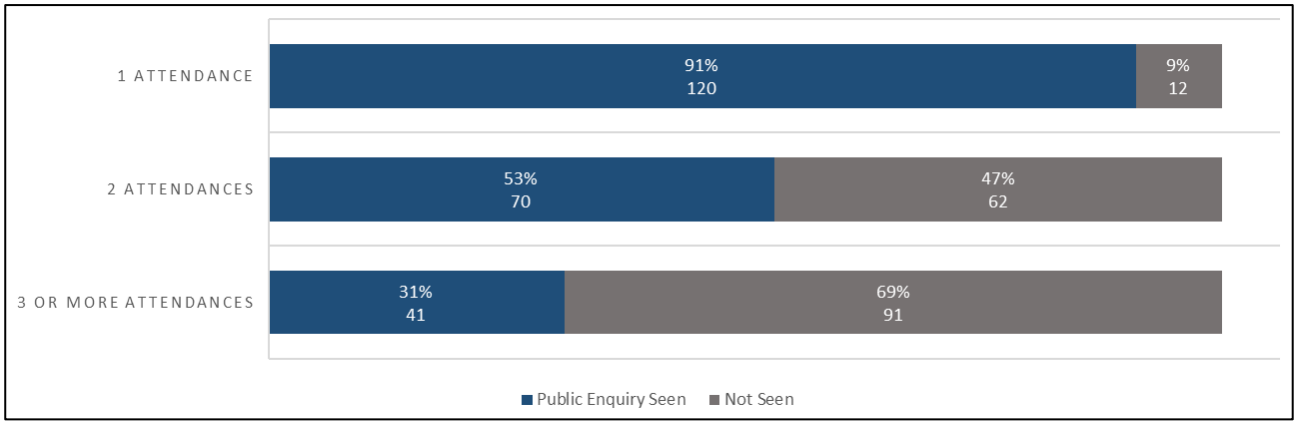
The table below has numbers based on 149 referred patients.



<u>Lung Function Screening:</u>

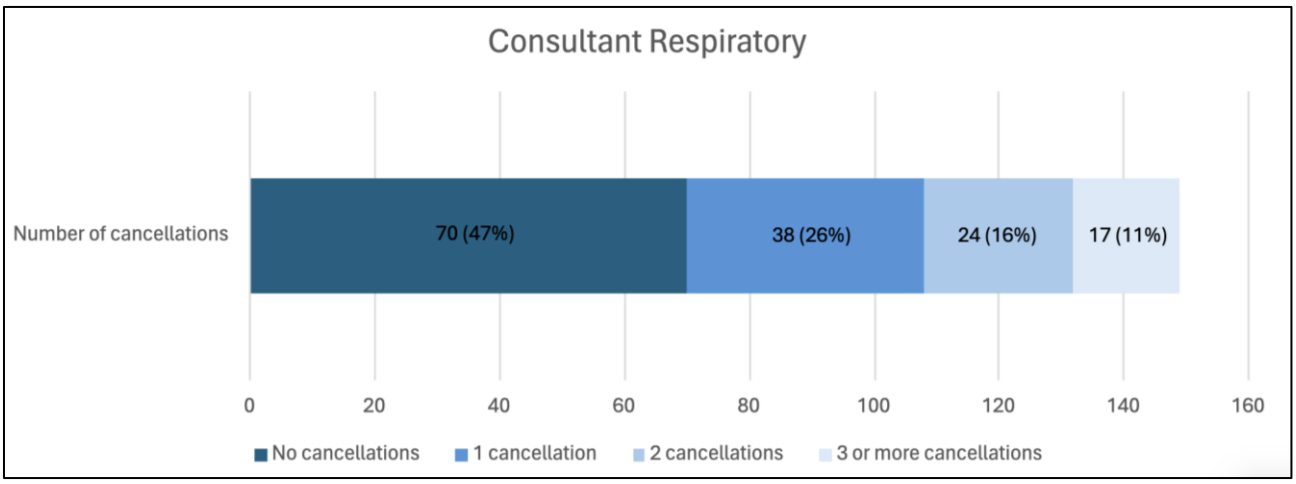
At least one lung function test was offered with repeat testing offered if required based on clinical indication.

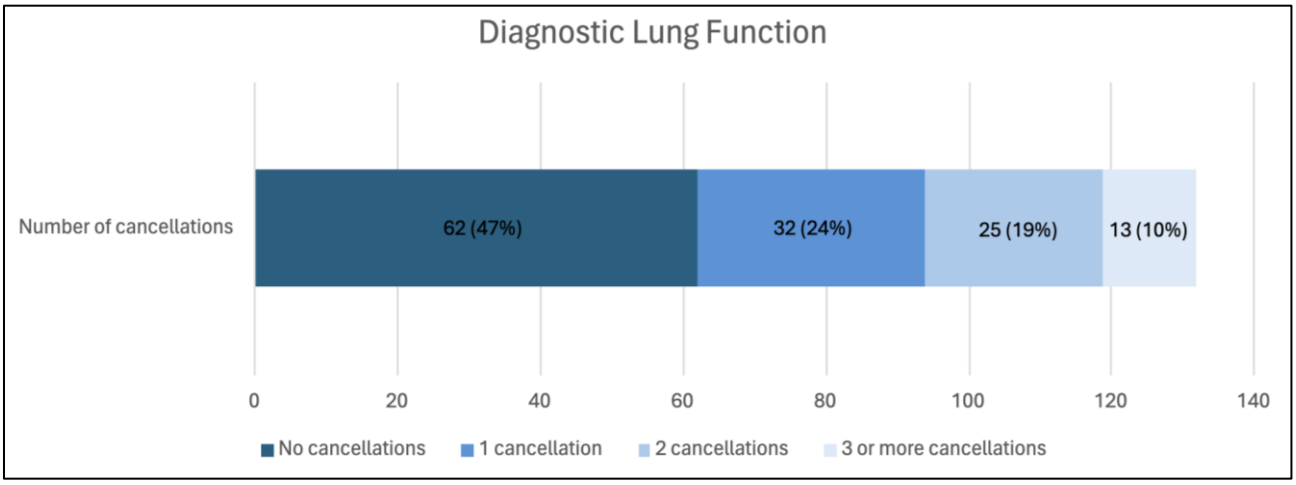
The table below is based on 132 referred patients as 17 of the 149 do not have any lung function activity recorded.



DNAs and Cancellations by Individuals:

The tables below show that 53% of patients have cancelled 1 or more appointments with 11% persistently DNA.

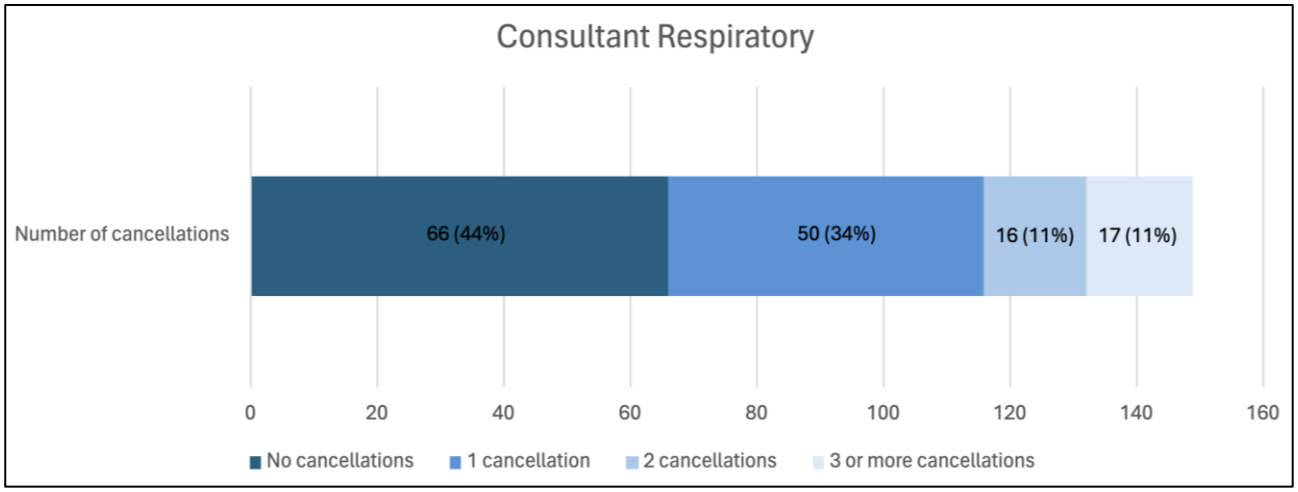




Cancellations by the service

Cancellations by the service are much lower. The diagnostic lung service experienced 10 cancellations across all patients

Within the consultant respiratory service 72% of the cancellations were in 2020-21 due to the effects of the Covid-19 pandemic.



Summary and Future Plans:

- 149 people from the public inquiry list have been seen by the service
- The Covid-19 pandemic had a significant impact in 2020-21, causing appointment cancellations
- Cancellation and DNA rates were significant, 53% patients cancelled or DNA'd one or more appointments

Ongoing work:

- Some individuals were unable to access the Service due to personal circumstances, which now may have changed. The Dedicated Service team are working to access as many survivors as possible to offer them respiratory monitoring.
- The broader Grenfell Health Assessment will provide the opportunity to highlight the Service to individuals.

Service changes:

- Systematic collection of continuous feedback re: preferred service access to continue designing the service around patient needs.
- Build on streamlined appointment system with the Paediatric Service to ensure families can access health monitoring with ease and support the Paediatric to Adult transition process

2.3.1.2 Community Respiratory Service

For the bereaved and wider members of the community, the community respiratory service provides a multidisciplinary, hub -based clinical service that supports the early identification of possible respiratory conditions via assessment and diagnosis, with onward management and support. Care is provided for respiratory illnesses such as COPD, asthma, and bronchiectasis, with the service offering pulmonary rehabilitation classes and facilitation of self-management, and advice on smoking cessation.

2.3.1.3 Toxicology Service

Following concerns raised by survivors and bereaved about the long-term effects of smoke inhalation a clinical toxicology review is available to those affected by the Grenfell fire. The service provides a specialist 90-minute appointment review that looks at people's health, answers questions and addresses any concerns. The consultants provide advice on health issues raised and will liaise with the person's GP or dedicated health worker to help facilitate ongoing care.

54 survivors from inside the tower have been referred into the service. So far the service has not identified any clinical indicators of poor health that could be caused by poisoning. Most issues found so far have been either respiratory or mental health related and the service has recommended to GPs onward referrals to those services where applicable. There have been no referrals or activity recorded for 2023/24.

2.3.2 Outcomes

High Level Outcome	Proposed Indicator	Proposed method of measurement
1. Any short or long term impacts are identified, information shared with providers and services commissioned. Patients are better equipped to manage physical health conditions, build confidence to access local services Assurance and peace of mind for service users that health has not been negatively impacted as a result of smoke inhalation, and debris/fallout of building materials	Improvement in peoples' health as it is monitored long-term to ensure improvement and maintenance. Better capturing of those with poor health issues to ensure they are higher prioritised for early treatment. Improved self-management of health Young People are supported with transition to adult health services Increased awareness of any health conditions which are considered abnormal against usual population health baselines	1. Report from Imperial from the Adult long-term respiratory service detailing: a) Respiratory illness: Detailing whether patients have suffered new respiratory illness as a consequence of the fire. b) Anyone identified with signs consistent with lung cancer or mesothelioma is referred to the fast track cancer service. Patients with other abnormal results are treated within the respiratory specialty. c) Referral to breathlessness clinics for holistic/physiotherapy support with breathlessness where appropriate. d) Patient Experience data 2. Report from Imperial from the Paediatric long-term monitoring service 3. Report detailing any concerns raised by: PH epidemiologist team to review general health concerns raised by service users via toxicology service. Immediate treatment, investigation, or onward referrals to other services for conditions categorised as abnormal.
2. Ensure local offer within North Kensington is mirrored for those who are no longer in-area.	Increased uptake of services for displaced people who have moved elsewhere ensuring they have equity of service. Improved sharing of knowledge of health outcomes across providers to inform commissioning decisions	2. Report from Imperial: Assurance that local providers (eg. ICHT) maintain oversight of health outcomes for all those affected by the fire, regardless of their physical location 'at arm's length'. Findings which could trigger safety concerns to be fed back at local level.

Summary:

1. **Any short or long term impacts are identified, information shared with providers and services commissioned.**
   Patients are better equipped to manage physical health conditions, build confidence to access local services
   Assurance and peace of mind for service users that health has not been negatively impacted as a result of smoke inhalation, and debris/fallout of building materials

Report from the Adult Respiratory Long Term Monitoring Service

Currently there is no reportable evidence to show delivery against the outcomes.

The second part of the service evaluation undertaken by the service:

> "To assess the clinical outcomes of the individuals who have accessed the Respiratory service" is not detailed in this report.

Once these findings and outcomes from the evaluation been shared with the community they will be reported further. This will be used to report against some of the indicators in the table above.

The service evaluation will not be repeated annually so the NKR work stream lead has been in conversation with the Adult Respiratory Long Term Monitoring service to agree and finalise what measures can be reported against the high level outcomes identified by the community and to support Regulation 28. This is detailed in section 2.3.2.1.

Report from the Paediatric Long Term Monitoring Service

This can be found in the CYP section

Report from the Toxicology Service

There have been no referrals or activity in the toxicology service in 2023/24. Service will be reviewed to ensure that it is still appropriate.

2. **Ensure local offer within North Kensington is mirrored for those who are no longer in-area**

Report from Imperial

As detailed in the activity section of this report, the service worked with the ICB information analyst and the NHS Dedicated Service to ensure that everyone who was entitled to access the Adult Respiratory LTM service had been offered the service.

The Paediatric LTM service detail is in the CYP section of the report.

2.1.2.1 Adult Respiratory LTM Outcome measures detail

The second part of the service evaluation to describe the clinical outcomes of individuals who have accessed the Respiratory service. Involved analysis of:

- Respiratory diagnoses in the population
- Reported symptoms
- Lung Function Test Results.

Once the findings and outcomes from the evaluation have been shared with the community they will be reported further. These will be used to report against some of the indicators in the table above.

The service evaluation will not be repeated annually so the NKR work stream lead has been in conversation with the Adult Respiratory Long Term Monitoring service to agree and finalise what measures can be reported against the high level outcomes identified by the community and to support Regulation 28.

The following measures have been agreed:

- Report from Primary Care data with information of diagnosis, etc. at Adult LTM appointment
- Report from the Adult LTM service detailing
    - Onward referrals data
    - Patient Experience data

To enable reporting against patient experience:

- a process to send out PEQs following appointment will be implemented
- the administrator will use the conversations with patients as an opportunity to ask about aspects of the service.

These will be reported from Q2 2024/25.

2.4 Self-Care work stream

As part of the NK programme, access to a range of self-care services has been provided in recognition of the challenge of maintaining wellbeing and managing long term conditions for a community impacted by the disaster. In doing so, the NK programme is attempting to promote an 'asset-based' approach to health care, providing investment and support to local 'assets' to help deliver self-care opportunities.

The opportunities provided for the North Kensington community include a diverse range of non-medical activities, training and support services provided by local community-based organisations. Access to services is coordinated via Social Prescribing Link Workers (SPLWs) and multiple referral routes into the services. The SPLWs enable primary care to better manage health concerns of patients with multiple needs and a Grenfell specific SPLW has been commissioned to meet the additional need.

The table below lists the 'Healthier Futures' (contract delivered by Kensington and Chelsea Social Council (KCSC)) self-care services financed by the NKR programme at some point during 2020-2025, the period of time each service was commissioned varies. These include a number of offers targeted at specific ethnic groups or communities.

<table>
<tr><th>Individual offers</th><th>Community offers</th></tr>
<tr><td>▪ Community centre-based massage
▪ Online meditation
▪ Online self-care
▪ Information, Advice & Guidance
▪ Legal advice</td><td>▪ Cooking and Nutrition-related groups (Lockdown Cookup and Community Cookery)
▪ Digital exclusion peer support
▪ Peer support group for disabled people.
▪ Young People's volunteering projects
▪ Men's and Women's Boxing and Fitness groups
▪ Women's-only Yoga
▪ Culturally appropriate health condition guidance, walking activities, and health knowledge support for targeted ethnic groups including sub-Saharan African and Somali groups</td></tr>
<tr><th>Family Offer</th><th>Training Offer</th></tr>
<tr><td>▪ Family Support Worker for SEN
▪ Creative Gardening
▪ Music and Movement Classes
▪ Family Therapy Services</td><td>▪ Mental Health First Aid training (Completed)
▪ Health Coaching for frontline support workers (Completed)
▪ Breathwork training for North and East African groups (Completed)
▪ Trauma informed Yoga teacher training (Completed)</td></tr>
<tr><td colspan="2">Other activities

▪ Social prescribing resource to design and manage signposting and referral pathways
▪ Support to community groups and organisations to develop services, record and report monitoring data, and improve other governance measures
▪ Engagement activities to monitor emerging areas of need and collate feedback.
▪ (Not within Healthier Futures) – Maxilla Men's Shed services.</td></tr>
</table>

As part of the Healthier Futures/Self-Care contract. KCSC focused on building the capacity of local groups and organisations by offering training and support. This is bespoke to the organisations needs but includes:

- Business case writing and constructing applications for funding and looking for sustainable funding longer term.
- Supporting all funded organisations to develop new policies and procedures.
- Assisting grass roots organisation that works on Healthier Futures to set up as a Community Interest Company.
- Facilitating organisations to form official partnerships
- Developing familiarity and confidence in organisations for measuring, recording and reporting outcomes.
- Regular organisational development training - 22 training sessions offered per year for example; managing partnerships, recruitment, safeguarding, funding.
- Creating links between organisations, and with NHS providers, to develop relationships and service collaborations.
    - Setting up a bi-monthly NK VCS network forum
    - Healthier Futures Provider meetings (quarterly)
    - Health & Wellbeing VCS Forum (quarterly)
    - Producing the North Kensington Self-Care Directory for NK health professionals and setting up meetings at each NK GP practice to promote services and educate staff.
    - Developing four referral pathways into the NK self-care services.
- Supporting organisations to adopt governance practices that reflect the diversity of the local community.

Grenfell Social Prescribing Link Worker

The Grenfell Social Prescriber works as part of an Integrated team within a Primary Care Network (PCN) to deliver a coordinated and high-quality social prescribing Link Worker service in North Kensington – supporting residents affected by the Grenfell Tower to access and engage with the extensive range of support in the community.

Highlights from 2023/24

KCSC

- The reported outcomes indicate that service users have experienced positive health and wellbeing outcomes as a result of taking part in one or more of the services
- KCSC have worked hard to deliver their projects and achieve their targets for the year, and the programme overall has achieved over 100% in both clients seen and sessions delivered figures.
- Providers and projects continue to share invaluable feedback on the needs of their communities, and the majority engage well with KCSC and the NHS. This includes attendance at quarterly provider meetings and sending in monthly and quarterly monitoring data.

ACAVA (Men's Shed)

- Recorded two new creative evaluation sessions to engage their regular shed members in monitoring and evaluation
- Delivered 172 Tinkering sessions, with total attendance of 2152

- The Men's Shed has been amplifying the circular economy ethos through programming. The Make and Reuse courses have influenced the facilitators, the Shedders, and the wider community, promoting creative reuse and environmental sustainability.

2.4.1 Healthier Future Services and Activity

The reports from Healthier Futures (Kensington and Chelsea Social Council (KCSC) and ACAVA (Men's shed)) report a number of diverse services including offers targeted at specific ethnic groups or communities. There was an overall increase in the number of services offered from 6 in April 2021 to 21 in April 2022. The number of services has now stabilised and the focus has been to increase awareness of these services in the community.

2.4.1.1 KCSC

The providers continue to build their networks and partnerships locally, which support effective collaboration at a local level. They cite the Healthier Futures providers quarterly meeting as a useful way to learn about each other's projects and make connections.

Monitoring and reporting continues to be an issue for VCS organisations. Providing monthly monitoring data with supporting text and case studies works well, however outcomes reporting is problematic due to the insensitivity and/or irrelevance of a number of the questions being asked. For example, asking a client who has come to an advice project in crisis '*overall how happy do you feel nowadays*' is insensitive and irrelevant; asking a client who has come to a yoga session '*how confident do you feel in yourself today'* takes time that could be used to have a quick chat with the person about how they are feeling rather than ticking boxes.

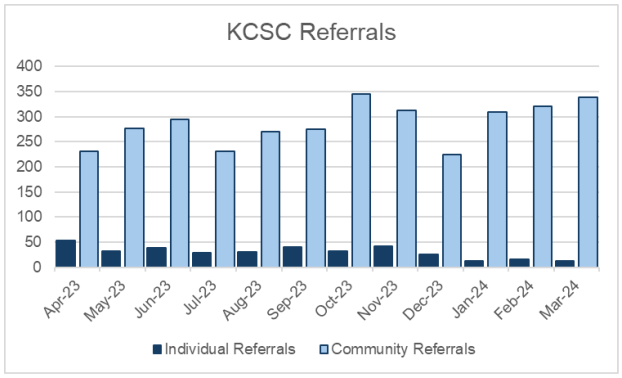
Going forward (during this transitional year) it would be helpful to co-design the future monitoring together with providers to agree an approach that works for them, and satisfies NHS reporting structures. For example, using one relevant KPI (which may differ from project to project) and adapting that question so that it is easily asked and understood, along with supporting narrative from the project manager about the changes seen pre- and post- engagement.

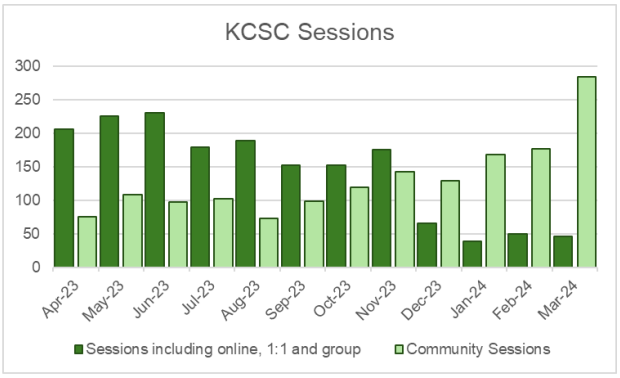
A streamlined reporting spreadsheet in excel has been created which brings all provider monitoring into one template. Previously it had been split into 'individual' and community' pages which was confusing and misleading for all users.

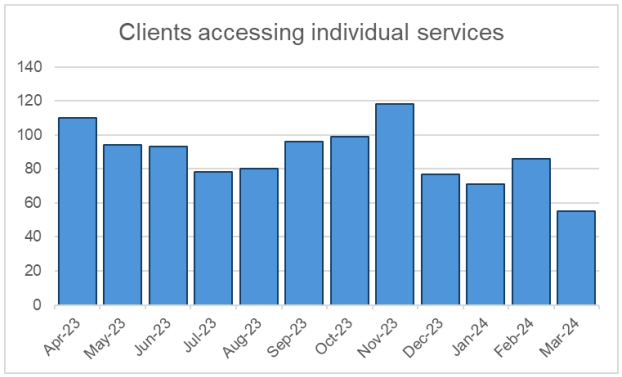
Activity

In 2023/24

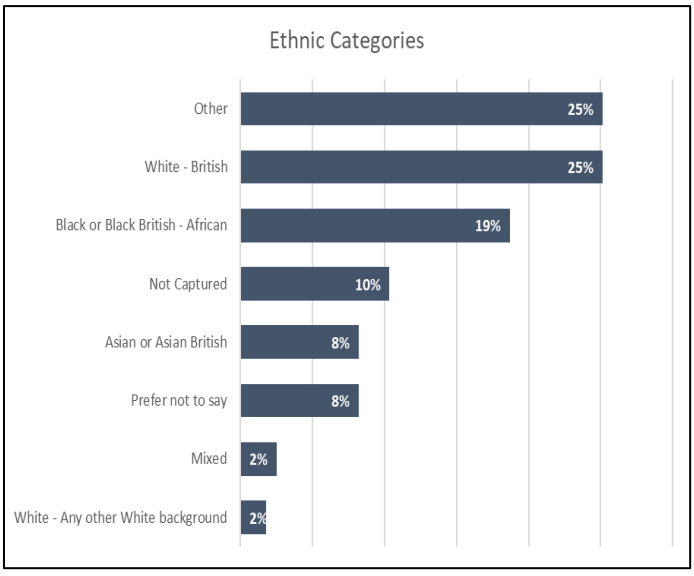
- 364 individual referrals which is a decrease from the 400 in 2022/23
- 3429 community referrals, these were not reported in 2022/23
- 1057 people accessing 1:1 services which again were not reported for the whole of 2022/23
- 3290 sessions including 1:1, group and community, which is a slight decrease in the numbers for 2022/23.
- The lower activity numbers for Q4 2023/24 are thought to be due to the uncertainty of funding and the need for services to wind down. Some of the providers had delivered more than they were contracted to deliver in the first 3 quarters of the year and subsequently delivered lower activity in the final quarter of the year.







Data was submitted by 13 service providers with valid responses from 561 respondents. For those providing demographic data:



Of the 561, 79% identified as a woman

There was also significant ethnic representation.

12% (67) identified themselves as having a disability. Majority under the following categories:

- Autism spectrum disorder and learning difficulties
- Mental health conditions / illness
- Chronic mobility or musculoskeletal conditions
- Chronic illnesses (Diabetes)

For age ranges the greatest attendance is seen in the 45-54 age group.

Age Range	%
45-54	24.2
55-64	22.2
65-74	15.5
25-34	14.7
35-44	13.5
16-24	7.1
75+	2.8

2.4.1.2 ACAVA Men's Shed

Initiated in 2019, in partnership with Kensington and Chelsea Social Council and the NHS Grenfell Recovery Team, the Shed was inspired by the international Men's Shed movement, designed to primarily reach older men, many of whom were not engaging with other community led post-Grenfell support.

In 2023 the majority of Shedders were men, but everyone is welcome and they operate an open-door policy for Tinkering Sessions, when community members are welcome to come and pursue their own projects and hobbies, share skills, or simply have a cup of tea and a chat in a vibrant creative community space.

To grow the community and introduce new skills, the shed programme also incorporated specialist courses – the current programme Make and Reuse, focuses on the circular economy, it aims to help community members reduce their carbon footprint and reduce waste.

Tinkering Sessions

Tinkering sessions remain the core shed activity. The time in the shed allows members to work on practical projects and enjoy the benefits of socialising and meeting others. The sessions are delivered weekly and are designed to create a welcoming and engaging workspace, aiding participants to work on practical projects, explore existing or newly learnt skills, and enjoy the benefits of socialising and meeting others.

Make and Reuse Creative Workshops:

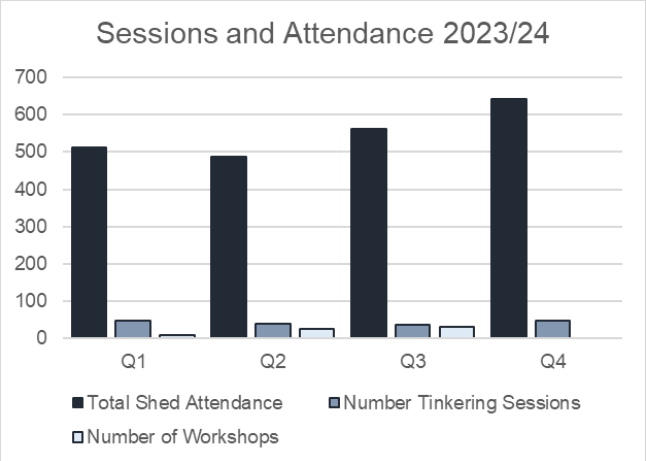
Make and Reuse Creative Workshops is a programme of free creative courses to inspire the community of makers to reuse materials, contribute to the circular economy and make their everyday more sustainable, running from our community makerspace Maxilla Men's Shed.

Activity

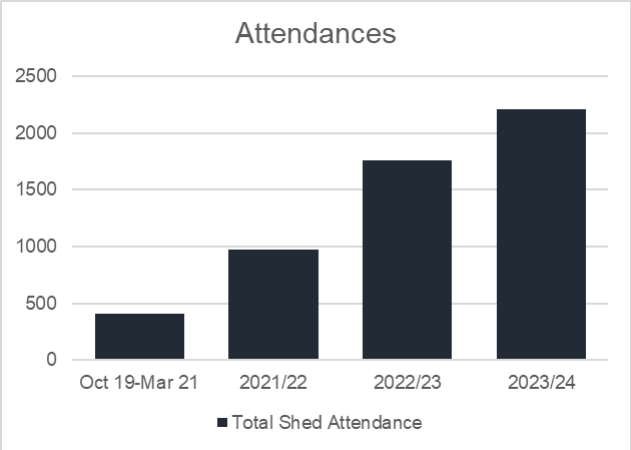
Since opening in October 2019 to June 2023, Maxilla Men's Shed has welcomed over 614 unique individuals through its doors.

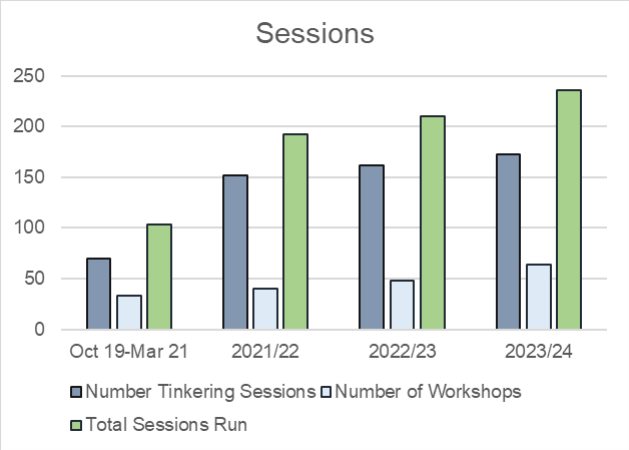
In 2023/24 it provided 2,207 places, over a number of sessions and workshops, for local people to come and work on projects, share and learn skills or simply socialise.

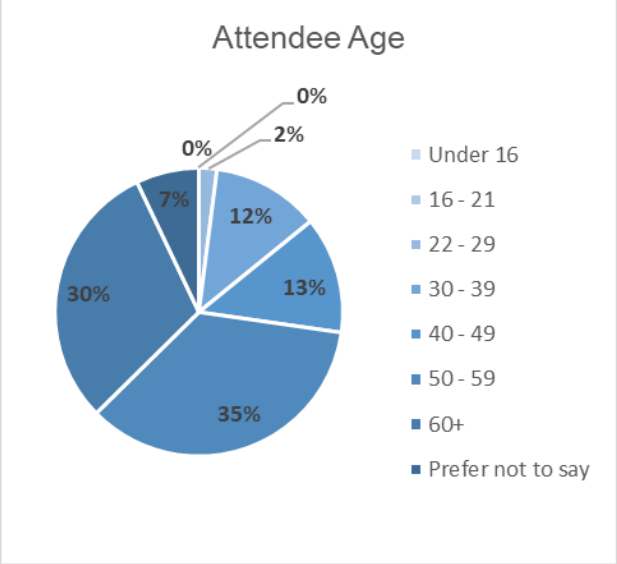
From April 2023 to March 2024, they delivered 172 Tinkering sessions, with total attendance of 2207.

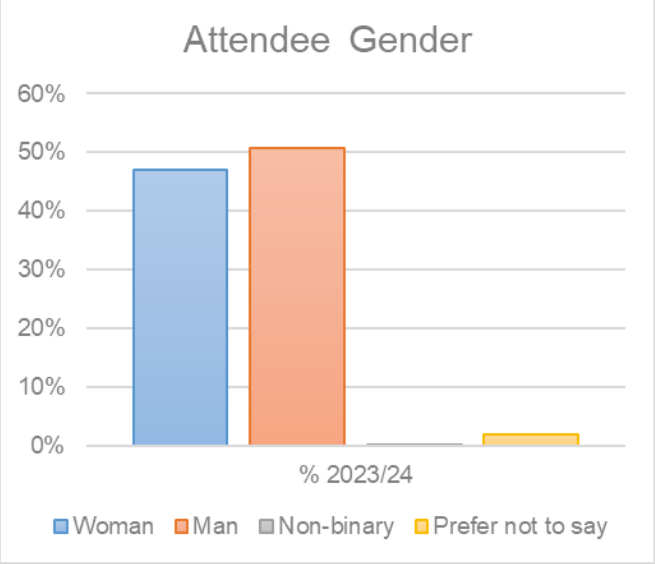


The total number of attendances and sessions run have been increasing year on year: with the number of total shed attendances increasing to 2207 in 2023/24 compared with 1756 in 2022/23.









The gathering of detailed demographic data is a barrier to participation so ethnicity or disability data is not routinely collected.

However, the delivery of the Make and reuse courses provided an opportunity to gather additional data via the sign up form.

The following data represents the 67 individuals who participated in a course during 2023/24.

Ethnicity

- White *Includes any White background : **36%**
- Black, African, Caribbean or Black British *Includes African, Caribbean or any other Black background: **24%**
- Other *For example, Arab or any other Black background: **16%**
- Mixed or multiple ethnic groups *Includes White and Black Caribbean, White and Black African, White and Asian or any other Mixed ethnic group: **15%**
- Asian or Asian British *Includes Indian, Pakistani, Bangladeshi, Chinese or any other Asian background: **9%**

Of the 67 individuals surveyed **72%** identify as having a disability or long-term health condition.

2.4.1.3 Grenfell Social Prescriber 2023/24

An in-depth report was received in Q2 for the Grenfell Social Prescriber role. A further report was received in Q3. Unfortunately, due to staffing shortages a report was not produced for Q4. The report detail is summarised below.

They work as part of an Integrated team within a Primary Care Network (PCN) to deliver a coordinated and high-quality social prescribing Link Worker service in North Kensington – supporting residents affected by the Grenfell Tower to access and engage with the extensive range of support in the community.

Activity for Q3

The service provided ongoing support for an allocated but short-term time-frame to promote engagement with identified services and achievement of goals.

- **New Referrals -** 35 in this quarter to the Grenfell Social Prescriber.
- **Caseload** - 31 patients this quarter
- **Waiting List** - An average of 6 people per month were on the waiting list to be triaged within 2 weeks of referral in this quarter.
- **Active caseload supported and Discharged Up to 2 weeks** – 1 patient
- **Active caseload supported and Discharged between 2 weeks and 1 month -** 1 Patient
- **Active caseload supported and Discharged between 1-3 months** - 12 patients
- **Active caseload supported and Discharged between 3-6 months** - 14 patients
- **Active caseload supported and Discharged 6 months** - 7 patients
- **Inappropriate referrals -** 4
- **Returning patients** - There were 1 returning patient in this period who had previously received social Prescribing support and discharged.
- **Number of appointments** - Patients on the active caseload receive between 8 to 12 appointments
- **Average time** - each appointment is between 60 minutes and 90 minutes. 10% of these appointments received 180 minutes appointments, these often include a home visit, combining a home visit with handholding the patient to a service/ advice. This would take place on the 3rd visit with the patient.
- **Mental Health** - Most people referred to the service have some level of active anxiety, depression, or stress factors. This contributes to the main reason for referral and taking agency over their life at that time. It is also found patients are not always aware of the service in the community. When they are aware of services in the community, they are unsure of how to access the service. The Social Prescriber interaction supports to break down this barrier.

Top 6 services accessed more than 10 times in this quarter in order of frequency:

1) North Kensington Law Centre
2) Clement James
3) CAB
4) K&C Council
5) Maximilla Men's Shed
6) Nova employment

Representation, advocacy, information and advice and support with form filling for benefits are the main needs the patients who are seen by the Grenfell Social Prescriber experienced in this period.

Often information and advice are wide ranging, inclusive of housing repairs, overcrowding, debts, food poverty and access to benefits. Half of the patients have a medical need, or a learning need that affects their ability to utilise and access the services without support from the Grenfell Social Prescriber.

The Grenfell Social Prescriber works one day a week from the office of KCSC to support further embedding the role into the tapestry of VCS services. A form has been developed to address direct referrals from the VCS into the Grenfell Social Prescriber. A target of 5 referrals a month was agreed. However, there has been no referrals to date through this pathway into the service. There is an open opportunity to support the embedding of this into the pathway so that referrals can begin through this pathway.

2.4.2 Outcomes

High Level Outcomes with indicators

The table below details the high level outcomes identified in the HWS for this work stream, alongside the agreed indicators and methods of measurement.

High Level Outcome	Indicator	Method of measurement
1. Increased self-care and self-management opportunities taken up and initiated by the community Increased access to culturally appropriate self-care options	1. Increase in self-care options and activity numbers	a. Number of options, number referred, number of activities, number attending
2. Improved Quality of life Improved feeling of wellbeing Reduced loneliness	1. Improvement tracked whilst accessing self-care programme, Self-reported improvement from patient feedback	a. Appropriate outcome questionnaire, b. Case studies c. PEQ

Summary

1. **Increased self-care and self-management opportunities taken up and initiated by the community & Increased access to culturally appropriate self-care options**

    - There was an increase in the number of services offered from 7 in April 2021 to 22 in April 2022. The number of services has now stabilised and the focus has been to increase awareness of the services in the community.

        - The Men's Shed has offered eight Make and Reuse courses in 2023/24, each taught over eight sessions, totalling in 64 sessions delivered between June 2023 and December 2023.

2. **Improved Quality of Life; Improved feeling of wellbeing; Reduced Loneliness**

All Healthier Futures services are monitored against a common outcomes framework, which includes nationally recognised indicators, such as the Warwick-Edinburgh Mental Wellbeing Scale, the ONS4 Wellbeing questions, with some additional questions around happiness with the service.

- The reported outcomes indicate that service users have experienced positive health and wellbeing outcomes as a result of taking part in one or more of the services
- This is evidenced by:
    - KCSC outcomes framework reporting positive health and wellbeing outcomes across all services
    - KCSC, ACAVA and social prescribing link worker case studies showing the diverse services provided and the positive outcomes from these services
    - ACAVA creative evaluation session
      When asked if coming to the shed helps them feel more satisfied with their life
        - 33% replied “Yes always”
        - 67% “Yes sometimes”
    - Make and Reuse Feedback reporting 100% rated the sessions 4 or 5 stars.

2.4.2.1 Outcomes and Client Feedback

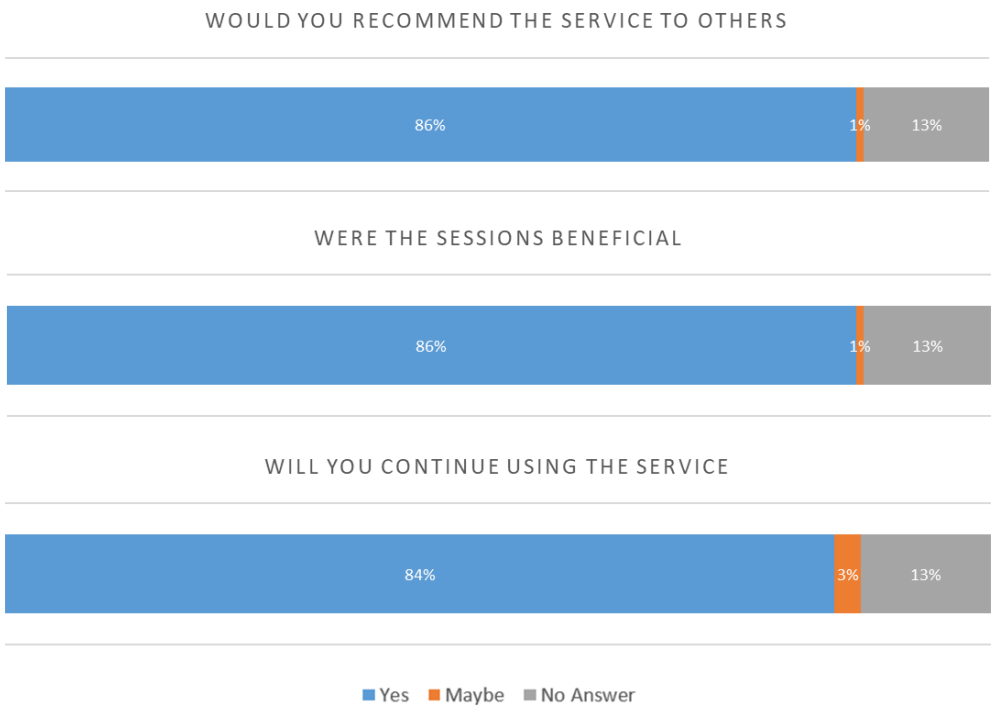
All Healthier Futures services are monitored against a common outcomes framework, which includes nationally recognised indicators, such as the Warwick-Edinburgh Mental Wellbeing Scale, the ONS4 Wellbeing questions, with some additional questions around happiness with the service.

2.4.2.1.1 KCSC Outcomes and feedback

Data was submitted by 13 service providers with valid responses from 561 respondents (12 service providers). Work is ongoing with the service provider with invalid responses to ensure that the data can be used in the future.

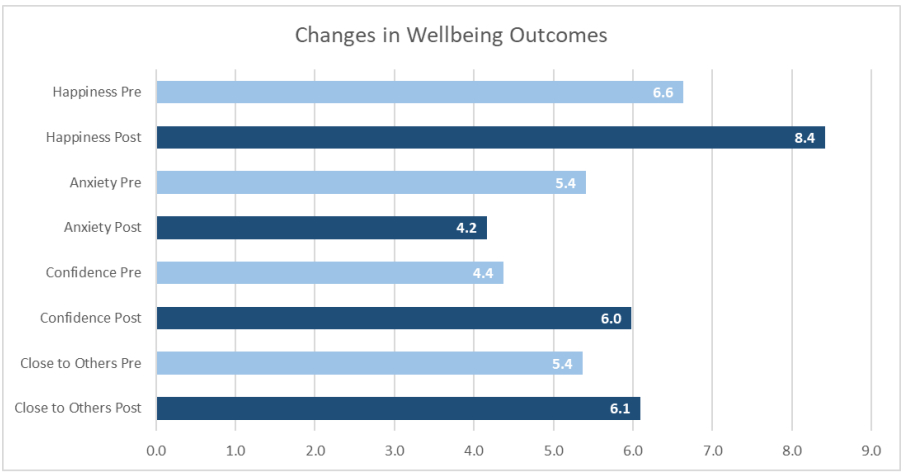
Service Feedback

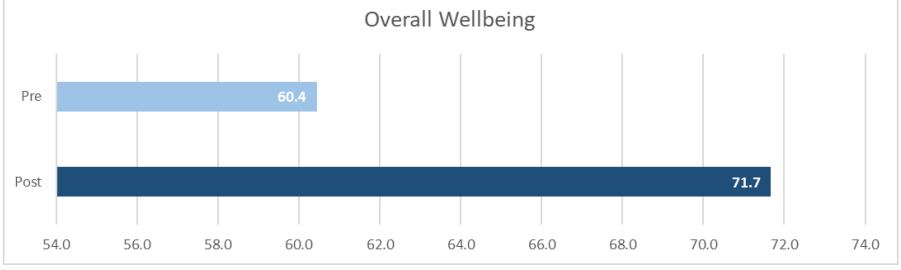
Over 84% of users answered “Yes” to all three quality questions



Health and Wellbeing Findings

The reported outcomes indicate that the service users have experienced positive health and wellbeing outcomes as a result of taking part in one or more of the services. The graph below illustrates the data available for the providers that measured change in the core wellbeing indicators.





Case Studies

A number of case studies were also shared which show the diverse work that is undertaken along with the positive outcomes.

FAWA

A woman aged 55-64 of European origin going through cancer shared; “The exercise is very good, sometimes I find it difficult but it makes me feel better. I feel more flexible, more close to people with more motivation. It is nice to socialise. I will keep coming back”

Dalgarno Trust – Digital Champions

X has been attending our outreach sessions at Venture Community centre since November 2023. They have limited mobility due to medical conditions and was relying on support from her daughter who lives in Essex. However, their daughter had to have a leg amputation so that left her unable to travel to see her mother. We have supported X in learning how to use their new smart phone for everyday tasks such as receiving and making calls and sending messages. We also supported X in using WhatsApp so that they could confidently make video calls and answer video calls so that they could still speak to and see their daughter who they relied on as they are unable to physically meet.

VCKC – Yoga

“I always benefit from these classes and I have gained more flexibility and strength since I have been attending. Also, I feel more relaxed and I can cope with the daily life challenges better thanks to your positive affirmations and encouragement. Thank you for all you do for the community and your continuous dedication and support. Amazing work!”

2.4.2.1.2 ACAVA Men’s Shed Outcomes and Feedback

The Outcomes achieved in 2023-24 were:

1. Reduce isolation and loneliness by providing a meaningful social network
2. Improve mental health
3. Improve wellbeing through social activities
4. Teach new skills

Additional outcomes they have achieved include:

A number of shedders told them that the shed was making a difference to them and others during the current cost of living crisis:

- ‘In the cold months it’s a place to keep warm for some.’
- ‘Being a female on my own and living in a house which needs a lot of repair… I receive advice and suggestions; I can straighten my wonky cut floorboards; I can borrow tools, I also find the atmosphere relaxing and friendly. I am 60+ and do not earn a wage / salary the shed helps by me not forking out a lot of money in repairs so the money I save I am able to pay my energy bills and treat myself now and again, thank you.’

- ‘You have no idea how the Shed has changed Christmas for us this year. We were able to hand craft beautiful leather presents for our children, family, and friends. We couldn’t afford a Christmas this year. Thank you’

Sustainability and the circular economy:

“We have been amplifying the circular economy ethos of the Men’s Shed through our programming. Our Make and Reuse courses have influenced our facilitators, the Shedders, and the wider community, promoting creative reuse and environmental sustainability.”

Creative Evaluation Session:

In August they held a creative evaluation session with a cross section of regular attendees. Using the ‘World Café’ method, they posed five questions for open responses, and a set of closed questions based on the ONS4 questions to measure wellbeing.

The ONS4 based questions were adapted to ensure they maintained their trauma informed approach.

This is what was learnt:

- Shedders tell us that going to the shed supports them to strengthen their social networks:
- “I get to meet people when I would normally be isolated”
- “I would say I am more confident to approach my friends and neighbours to talk about the shed and the skills I am learning, and also showing them the products I made in the shed. I also encourage them to join the shed”

Attending improves individual’s mental health:

- When asked if coming to the shed helps them feel more satisfied with their life
  - 33% replied “Yes always”
  - 67% “Yes sometimes”
- 66% said that coming to the shed helps reduce feelings

Coming to the Shed is an opportunity to learn new skills, both practical and ‘soft’:

- “I look forward to learning something new, a new skill, and to continuing with the project which I have already started”
- “It has allowed me to appreciate different personalities and therefore I have more understanding and have become more compassionate in general”

Make and Reuse Creative Workshops

Make and Reuse Creative Workshops is a programme of free creative courses to inspire their community of makers to reuse materials, contribute to the circular economy and make their everyday more sustainable, running from Maxilla Men’s Shed.

Make and Reuse delivered eight courses, each taught over eight sessions, totalling in 64 sessions delivered between June 2023 and December 2023.

There were over 90 submissions of interests for the courses. All 90 were referred to Maxilla Men’s Shed’s Tinkering sessions.

There were 67 individual participants with a total attendance of 536 engagements.

Feedback

At the end of every course, participants were asked to complete a feedback form. All feedback is anonymous, to encourage participants to share honest thoughts and feedback.

- 53/67 have provided feedback via feedback forms.
- Of individual responses collected, 53/53 reported positive outcomes.

How would you rate the workshops?

- 90% responded 5/5 stars
- 10% responded 4/5 stars

What were you most looking forward to about these workshops? (Tick all/any that apply)

- 100% responded - Learning new skills
- 60% responded - Improving wellbeing through social activities
- 47% responded - Meeting new people

Did you learn any new skills?

- 100% responded – Yes

By attending one of the workshops... (tick all/any that apply)

- 80% responded - I enjoyed interacting with others
- 86% responded - I felt inspired by being in a creative environment.
- 77% responded – I had the opportunity to work with new tools
- 84% responded - I feel more confident approaching new things.
- 84% responded - I felt part of a meaningful social network
- 56% responded - I feel this has had a positive impact on my wellbeing

Would you like to continue using the new skills you have learned?

- 96% responded – Yes, I will continue during Tinkering sessions
- 86% responded – Yes, I will continue at home
- 0% responded – I probably won't practice this skill again

Course participants - anonymous feedback:

"I really enjoyed the Marquetry. It is definitely a skill that needs a lot of time and patience, but it is also enjoyable. The teacher Amber was very patient and helpful to everyone. I really admire her skills and talent. I would like to continue learning and improving my skills at Marquetry"

"I really enjoyed the Leather Craft workshop with Candace Lau. I had not done anything like it before, I learnt a lot working with Leather and the various tools etc. I will definitely continue to make Leather Craft"

"I think this is one of the best workshops. Sasha and Wojtek are so passionate and helpful. I learned a lot. I can now carry this on in other projects"

“I thoroughly enjoyed this carpentry workshop with Sasha and Woldjat. They were great teachers and helpers and two lovely all round guys. I learnt a lot like working with the various machines to cut the wood etc. With their teaching we created an iconic masterpiece chair of which I am very proud of making. I loved the course and the comradery”

Taking the above into account, the Men’s Shed considers the wider impact of their work this year to include:

- Improved wellbeing – leading to reduced reliance on NHS services
- Improved community cohesion – growing and strengthening social networks
- Improved confidence and skills – increasing self-esteem and sense of achievement.

Maxilla Men's Shed, Case Studies, 2023/24

The following case studies highlight the positive outcomes from attending the Men's Shed.

MMS - Case Study 1
X talks about the joy she experiences from being part of the Shedder community in North Kensington, she calls it 'her chosen family.' **History:** X came to Maxilla Men's Shed after the pandemic, and after covid had had an adverse effect on her mental health journey. 'Pre-covid I didn't want to mix with people, didn't want to mix with men at all, and I was told that was wrong – but then covid came along and we weren't allow to mix with people at all.' X had been aware of the Men's Shed before but had thought it was just for men. Through local networks she heard that women are welcome and about the new series of 'Skill Up' courses running from the Shed in partnership with the RBKC (Royal Borough of Kensington & Chelsea) Grenfell Recovery Programme. As soon as X met Rasha (El-Sady, Programme Manager for the Shed) she knew it was for her. X felt at home, she recognised Rasha from being around locally and felt a connection. 'When I met you (Rasha) I knew this was a place I want to be, I could have a bad day and still come here and do something and have a win – achieving my own social goals as part of my recovery.' X talks about the joy she experiences from being part of the Shedder community in North Kensington, she calls it 'her chosen family.' **ONS4 Based Wellbeing Questions** The following questions have been inspired by the ONS4 Questions on Wellbeing. They have been adjusted in line with ACAVA's commitment to a trauma informed approach across our social practice programming. These are the same questions we ask of other shedders during our creative evaluation sessions. **Does coming to the Shed help you feel more satisfied with your life?** Yes – without it I don't think I would have that connection to other services, I wouldn't be pushed or challenged to socialise, a big challenge for me to trust people and get out of isolation. **Do you feel that your time in the Shed is worthwhile?** Absolutely! The best thing for me is that constant reminder that I help people, even if I don't get anything done, if I have helped someone else that is such a big boon. I felt failure at the end of my work in retail, so coming here and being useful, this I where I get my worth from. **Does coming to the Shed bring you happiness?** Yes! But not just happiness, a lot of emotions, challenges to overcome, sadness when someone else is having a bad day, happiness is not just the important thing, being in a social group isn't about being happy, about being part of it. **Does coming to the Shed help reduce feelings of anxiety?** No, and yes. The challenge for me isn't reducing anxiety, I need to learn to live with anxiety, I was a depressed and anxious child, I have been medicated thoughout my live – my challenge is having a 'normal life,' while living with anxiety. I get it wrong sometimes, but important thing is coming back.

MMS - Case Study 2

When he first heard about Maxilla Men's Shed he thought 'A place full of tools? That sounds good! My life has been that sort of stuff.' He was also interested that it was linked to ACAVA, he thought 'I might be an artist!'

History:
Since the start of the pandemic in spring 2020, Y has felt that he is less supported by his housing provider. His neighbours have mental health needs which are not always adequately supported, with some displaying aggressive behaviour which has an impact on Y's wellbeing. Y developed coping strategies which included isolating himself from certain people. While he still feels like he lives in a community, it is much smaller than it was, in part due to pandemic and age related deaths among his peer and friendship groups.

Before the pandemic Y describes the Grenfell Tower Fire in June 2017 as an event that 'flipped him on his back'. His local councillor at the time sign-posted him to the Grenfell Health and Wellbeing Service (GHWS), where he was able to access much needed mental health support. It was from the GHWS that he found out about Maxilla Men's Shed.

When asked what kept him coming back he told us 'The Tea!'. He also credits the people, sense of purpose, and shared experiences with 'birds of a feather.' Of the Shed community he says:

'If people want to tell me things I'll listen. If people have issues, you can have a cup of tea and give them space. You can see it fall away in a matter of days.'

The shed is an important focus for Ys weekly routine. He structures his time around the support he gets from the Shed community:

'On a Monday I don't like to do difficult things because I know Tuesday and Wednesday I'll have been hanging out at the Shed and will feel more positive and able to deal with things on the Thursday or Friday. It's a refocus… Coming to the Shed takes my mind off issues, it's a huge distraction from these things. Tinkering sessions is a mood enhancer which puts me in a better frame of mind to deal with other situations later in the week.'

ONS4 Based Wellbeing Questions
The following questions have been inspired by the ONS4 Questions on Wellbeing. They have been adjusted in line with ACAVA's commitment to a trauma informed approach across our social practice programming. These are the same questions we ask of other shedders during our creative evaluation sessions.

Does coming to the Shed help you feel more satisfied with your life?
'Yes – I've got a bike now, a street find I refurbished in the Shed. It's an odd bike to me, it could be a kids frame, it was dayglo pink, I couldn't deal with the cat calls! So I got it sprayed, another Shedder helped me with that. Some paint from the Shed, some from Lidl. Daniel (ACAVA's Workshop Technician) helped make it safe, helped with getting all the bits I needed. I've fallen off about five times, the last time I chose a safe place to fall off, it was on a zebra crossing!'

Do you feel that your time in the Shed is worthwhile?
'Yes – of course, although I feel I could be more worthwhile if other things my life were easier.'

Does coming to the Shed bring you happiness?
'Some days! I may not show up here all sweetness and light, but by the time I've been hanging out here, I'm happier.'

Does coming to the Shed help reduce feelings of anxiety?
'Yes – it helps me loose that a bit. It's with me when I wake up, but I force myself to stand up at five in morning and make myself do stuff to lose it, get over it. It's destabilising, but later on when I come here, it's starting to work. I come and make jokes and find solutions. My mood fluctuates from hour to hour, day to day, so there is no straight answer. When RBKC get on my case the wheels come off, I can't make plans - but I know if I come here I'm going to be alright.'

2.4.2.1.3 Grenfell Social Prescriber Outcomes and Feedback

- Use social prescribing to empower people to take control of their health and wellbeing.
- Spend time with residents to help them to focus on 'what matters to me' and
- Connect residents to community groups and statutory services for practical and emotional support.

The case studies are written by the Grenfell Social Prescriber and highlight the positive outcomes from this service.

Social Prescriber - Case Study 1

A GP referred a young family to the social prescribing service to support their 2 year old with accessing nursery

Background:
This family is not very fluent in English, they were unsure of how to apply, and they were not sure of their entitlements. The social prescriber utilised the interpreting service to understand the family's needs.

The family intended for their two-year-old to attend a nearby nursery, but it was at capacity, and they were looking for different nurseries to apply to.

Outcomes:

- The Social Prescriber got in contact with the family's local children's centre (Holmfield Childrens centre) and family hub service.
- The Social prescriber liaised with an "Early years Family Practitioner" and they advocated for the family's needs. This service provided reasonable adjustment to support the family with the language barrier.
- The service supported this family with completing the nursery application. The child is waiting for their start date, and they are accessing the services weekly playgroup.
- The family is now aware of their local children's services, and they understand what services they offer, and they have early years professionals in their child's care. This increases better outcomes for the family and child's development.

Social Prescriber - Case Study 2

The GP referred to a 54-year-old patient with complex physical and mental health issues. This patient suffers from PTSD, they witnessed the Grenfell fire

Background:
This patient was initially referred because they began disengaging with VCS services due to mental health issues. The social prescriber worked with this patient to understand the reasons they were disengaging.

Outcomes:

- The social prescriber did a home visit and identified the patient was struggling to climb up and down the stairs, resulting in them not being able to go out as much.
- The social prescriber supported the patient with acquiring an Occupational therapist from the council. The occupational service adapted the patient's property, such as implementing handrails in the bathroom and the hallway to support their physical health issues. This patient can move around better and can leave their property.
- The patient had long term disrepair dating back to 2018. The patient gave up on raising complaints because nothing was being done. The social prescriber liaised with the patients housing team and they are working on the disrepairs.
- The social prescriber informed the patient of services such as the North Kensington Law Centre, Nucleus and Citizens Advice. This is to support them for future complex housing queries.
- This patient needed financial advice; the social prescriber referred them to the Clement James Centre. The social prescriber signposted to Citizens Advice for financial and legal advice pertaining to their benefits rights.
- This patient has reengaged with services such as attending Mind community groups, The Volunteer Centre projects. This patient is working on looking for voluntary roles.
- This patient feels more comfortable attending weekly community wellbeing/ reading workshops/Community group trips.
- The social prescribing engagement has supported the patient to reengage.

Social Prescriber - Case Study 3

The GP referred a 24-year-old patient who needed housing and financial support to the social prescribing service.

Background:
The social prescriber supported the patient with integrating with local resources.

Outcomes:

- The patient completed a homeless application. The patient was referred to a local homeless charity called “Beam” where they received assistance for housing advice.
- The social prescriber linked this patient with relevant housing/homeless services such as Glassdoor, St Mungos, Kensington Law Centre and Nucleus. This patient now been housed in a hostel and the council has offered the patient long-term accommodation and is waiting for a move in date.
- This patient needed financial advice, The Social Prescriber signposted the patient to The Clement James Centre, CAB, Stepchange, Nucleus. This patient is now receiving assistance with that and working on his personal development.
- The social prescribing service has provided support and knowledge to this service user.
- This patient is in touch with local resources, and they feel more confident accessing services when they need support. This is imperative to reduce health and social inequalities in the community.

2.5 Emotional Wellbeing work stream

A diverse strategy to support emotional health and wellbeing across the community. Supporting non-physical needs such as feeling anxiety and distress.

Grenfell Health and Wellbeing Service (GHWS)

The GHWS was commissioned from Central and North West London NHS Foundation Trust (CNWL) with a remit to provide resilience building support and interventions to the North Kensington community and to individuals and families experiencing trauma and loss related distress as a result of the Grenfell Tower fire.

This service was acknowledged as a requirement to address emotional health and wellbeing needs arising from the Grenfell Tower fire with research clearly evidencing the requirements to have these services in place to support the health needs of the community.

. The GHWS service is an enhanced service in addition to business as usual and offers a primarily trauma-informed therapeutic based service to clients. There has been continuous engagement with the Grenfell community and other stakeholders to support planning the next steps in the overall community recovery journey. Following feedback from the Community and service users, it is recognised that the GHWS offer has adapted, and will continue to adapt over time to meet the changing need and environmental context.

As a result, and in line with NHS England Community Mental Health Framework, the GHWS service had undertaken a process of redesign in 2022 to provide a more integrated offer in order to improve the quality and diversity of care received by the community. This included diversifying the services multidisciplinary approach to include additional interventions such as Occupational Therapy, Social Work, Employment Support as well as a dedicated Community collaborative arm of the service, on top of the enhanced therapeutic offer that remains. All this together is aimed at providing a holistic, joined up, culturally informed and community led provision of services.

Since this service transformation there has been improved access to culturally appropriate services.

Highlights from 2023/24

Grenfell Health and Wellbeing Service

- GHWS Open Day on 23 May 2023 to promote broad range of support available.
- The Community Report was officially launched in November 2023 to improve accountability to the community.
- Healing Space Together Art Exhibition took place on 7 March 2024, which was a collaboration using art therapy to transform the GHWS environment making it more welcoming for clients.
- Feedback Week took place in September 2023 to improve feedback on the service.
- Goal Based Measures were introduced for Adult Clients in January 2023, they had been in use for CYP Clients since late 2021. After a slow start there has been a significant increase in goal completion for both Adult and CYP clients during 2023/24.
- Discovery College
    - A CYP version of the Grenfell Recovery College which is part of a collaboration with the CNWL Recovery & Wellbeing College and offers free wellbeing workshops to anyone living in Kensington & Chelsea or anyone affected by the Grenfell fire.
    - From July to September 2023, GHWS focused on setting up the Discovery College

- GHWS actively supported a number of key events during the year including:
  - Anniversary
  - Testimony Week
  - Phase 2 of the Grenfell Tower Inquiry

2.5.1 GHWS Service updates and activity

The following section of the report is structured in line with the GHWS 5-part model, which is a clinical model designed to holistically support the community.

It includes information from the GHWS monthly activity reports, monthly DAPB updates and the GHWS Quarterly reports. The latter report gives qualitative details of the GHWS including feedback received each quarter. Some key themes from this have been extracted for the purposes of this report.

1.1. 2.5.1.1 Information and Self-Care

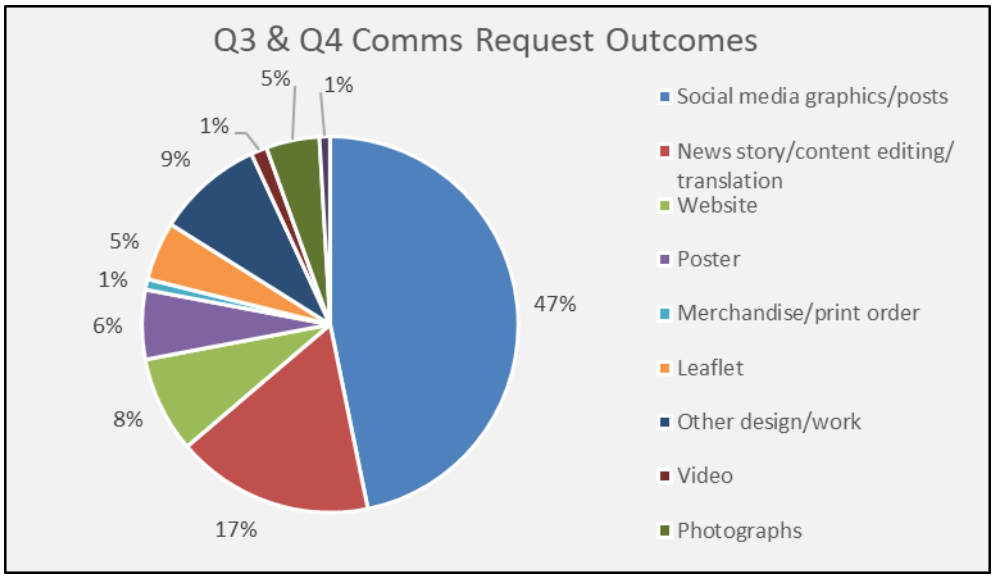
- Providing relevant health and wellbeing information from their service as well as partners to all clients and wider community in a variety of formats, languages and platforms (GHWS website, X (formerly Twitter), Instagram and Facebook)
- Where appropriate navigating/referring individuals to other relevant service/support such as housing, financial, employment, education and social etc. and providing a warm handover where necessary.
- Ensuring local services are fully up to date on the services GHWS offer and a clear referral process to enable people to access the service.

Communications

A new Communications Manager joined GHWS in October 2023 which resulted in new communication requests. Reporting resumed from Q3.

The following table shows the outcomes for Q3 and Q4:

Activity Area	Q1	Q2	Q3	Q4	Year Total
Total Comms Requests	N/A	N/A	17	28	45
New Project	N/A	N/A	10	20	30
Amendment to existing project	N/A	N/A	7	8	15
One-off project	N/A	N/A	12	17	29
Recurring project	N/A	N/A	5	11	16



GHWS Open Day

GHWS organised an Open Day on 23rd May 2023. It aimed to promote the broad range of support available within the service to the community and ongoing partnership with other organisations.

The open day was well attended and over 150 local people came to visit the service on the day, including a special visit from Baroness Scott.

The Open Day resulted in a good uptake by the community and feedback was collected through different routes: (i) Feedback form and (ii) Comments book. The feedback is detailed in the outcomes section 2.5.2.

1.2. 2.5.1.2 Early Intervention and Prevention

- Provide psychoeducational workshops to adults, parents and children and young people, accessible to all community members focusing on key emotional health and wellbeing topics
- Tailored training for local organisations, residents' associations, individuals who are working with affected population etc.
- Working in partnership with other community providers who are delivering services at a primary and secondary level.
- There are employment specialists within the GHWS who work to support both GHWS and DS clients with their employment needs.

- GHWS has Community Connectors that maintain an important link between the community and the service. They participate in different activities within the community and their insight is crucial for developing and improving existing support provision. They provide presence and support at local community events.

- Key areas this report focuses on include:
    - Workshops
    - Employment Support
    - Community Connectors

Workshops

An increase in workshops delivered in 2023/24 compared to previous years shows that there has been an increase in delivery of services within the community, in collaboration with community providers, in response to feedback from the communities and the desired outcomes from the communities.

Activity Area	Q1	Q2	Q3	Q4	Year Total
Number of workshops delivered in quarter	13	3	10	3	29

There were less workshops run during Q2 due to the summer break of the Recovery College and during Q4 as the topics for the new year were reviewed to align with community needs. Outcomes and feedback from the workshops is included in the outcomes section 2.5.2.

There have been a number of different workshops run during 2023/24 which were all well attended and received positive feedback including:

- Yoga
- Sleep and how to improve it
- Tree of Life
- Older Adults Group – Tree of Life
- Healing Space Together
- Recovery College
    - The GHWS Recovery College delivered a number of workshops over 2023/24

Recover College Workshops	Date
Understanding Anxiety	19/04/2023
Understanding and Managing Emotions	26/04/2023
Getting a good night's sleep	04/05/2023
Managing Emotions	18/05/2023
Understanding Depression	22/06/2023
Being kinder to ourselves: Developing self-compassion	23/11/2023
Changing habits in a way that works for us	25/01/2024
Introduction to assertiveness'	29/02/2024
Mindfulness	28/03/2024

- Discovery College

    - The Discovery College delivered a number of workshops over the year. Feedback received was positive and is in the CYP section of this report.

Discovery College Workshops	Date
Being kinder to ourselves: Developing self-compassion	02/11/2023
Ways to manage stress and feel calmer	06/11/2023
Being kinder to ourselves: Developing self-compassion	27/11/2023
Body confidence: Loving the skin I'm in	14/12/2023

Employment Support

Activity Area	Q1	Q2	Q3	Q4	Year Total
Number of employment referrals received in quarter	13	18	20	12	73
Number of employment outcomes received in quarter	4	8	6	3	21

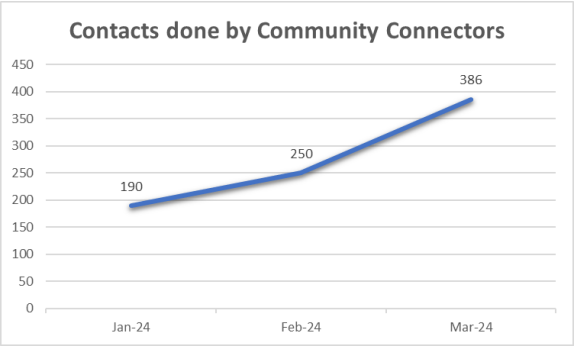
There are employment specialists within the GHWS who work to support both GHWS and DS clients with their employment needs

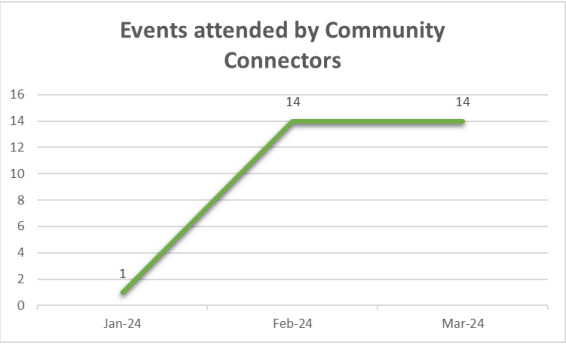
- There were over 60 referrals to the service in 2023/24
- GHWS are working to improve the reporting on this area of their provision and aim to include this in their next quarterly report

Community Connectors

The new community connectors report was officially launched in January 2024.

The graphs below show the community connectors activity in Quarter 4.





January 2024

- The Community Connectors attended a training day at Kensington Palace with the Community Access Scheme. The training aims to engage local people with the stories and historic spaces in ways that are meaningful and relevant to them
- Community Connectors have supported the women only swimming group with the children's creche and feedback on how the children are managing separation. This has allowed the women to focus on the swimming session

- A Community Connector has been assisting with the GHWS Lancaster West project and the Older Adults Group and another with the internal GHWS Cultural Consultation steering group and the Healing Art Space together project.
- Other activity has included distributing leaflets for CFT events and planning for the Eritrean collaborative women's group.

February 2024

- A Community Connector attended a meeting for the Discovery College to discuss the set-up of a new workshop on emotions and relationships. They also attended local council meetings and met with local community members.
- A Community Connector attended the final women's swimming session looking after children in the creche. Feedback from clinicians was this support helped both mothers and children with separation and lifted the confidence of the adults to participate in an activity that focused on their own well-being.
- Community Connectors assisted with the Healing Art Space together project. This involved attending weekly project meetings to plan the exhibition, working with GHWS clinicians in the set up of the final exhibition of art work and connecting the lead artists with the community.
- A Community Connector supported clinicians in co-facilitating a new 6-week arts project at The Reed. Their role was to assist with the activities. The same Community Connector also worked with a GHWS Occupational Therapist and The Space to develop new projects at the venue itself and organising outside visits to places of historical interest for health and wellbeing purposes.

March 2024

- Community Connectors attended the Iftar at the North Kensington Resource Centre, on Lancaster West Estate. During the event they were able to have conversations about the community's concerns over the future of the tower as well as being part of a significant cultural event.
- A Community Connector joined a GHWS CYP therapist on visits to 3 local organisations, Harrow club, Fit for Life and Rugby Portobello with a view to introduce themselves and the service and find out if they would be interested in co-producing/ collaborating on therapeutic offers the service have available. There was a lot of interest especially from Rugby Portobello Club who would like to work with our dance/ drama therapists in their girl's groups. The same two staff members attended a youth worker's forum on 17th April to continue networking.
- On International Women's day two of the Community Connectors held a stall on Portobello Road to promote GHWS, hand out leaflets on sleep hygiene and grounding techniques and lavender bags. They spoke with members of the community and found that a surprising number of people were not aware of the GHWS service (most were from global majority). A GHWS art therapist also joined and brought along art materials so people could sit down and engage whilst being creative.

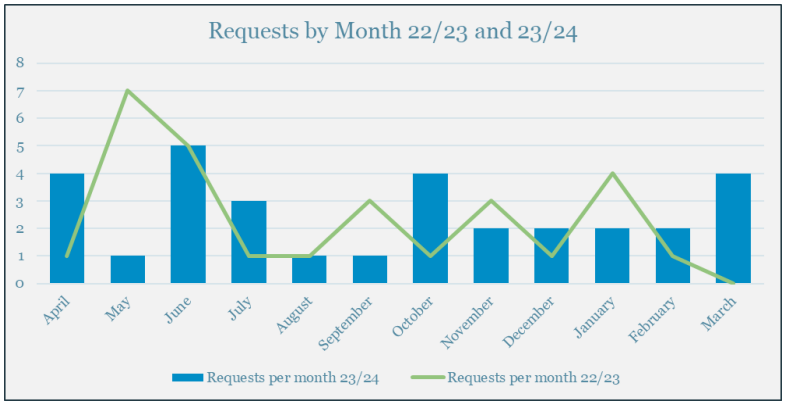
Other on-going groups and projects regularly supported by the Community Connectors are the Older Adults Group, the Lancaster West drop in sessions, the Latimer Road Veterans Football Team, the Eritrean Women's Group, the Barbers project and GHWS Cultural Consultation.

Themes and issues that have come up in the Community are the continuing impact of the Grenfell fire, the cost of living crisis, the long wait for the Phase 2 Inquiry report and the war on Palestine. The Community Connectors report that these issues are having a cumulative effect on the mental health of community members.

1.3. 2.5.1.3 Collaborations

A key element of the work of GHWS is to build and maintain relationships with the local community groups and organisations along with statutory services also working with the North Kensington Community. This includes developing co-produced projects around mental health and wellbeing in partnership with multidisciplinary colleagues, residents and 3rd sector organisations.

Activity Data



Activity Area	Q1	Q2	Q3	Q4	Year Total
Number of collaboration requests received in quarter	11	5	8	8	32
Number of ongoing collaborations	49	39	40	41	N/A
Number of collaborations completed in quarter	4	3	13	5	25

Where attendance numbers have been recorded estimates showed that the collaborations reached over 477 people with positive feedback.

Collaborations carried out in 2023/24 include:

<u>Kensington & Chelsea Food Bank</u>

The Kensington & Chelsea Food bank takes place every Tuesday and Friday. A GHWS member of staff is present to provide general support:

- Voucher issuing
- Signposting
- Engagement and referral to relevant parties, including GHWS.

<u>The Healing Space Together Arts Collaboration Project</u>

- Two GHWS Art Therapists, two community connectors, two therapists, one member of the DS team and one Adult SUIT member joined forces with local artists to create diverse, relevant and inclusive art work for permanent display in the GHWS waiting room and clinical spaces.
- This project has benefited all who use the space, and involved working with a community artist/group to produce meaningful artwork for the space. The final images/installations resulted in an explorative project and was co-produced by all involved.
- In order to create this artwork, four sessions were organised by the team across dates in October and November.

- GHWS held an exhibition to launch the artwork made during the Healing Space Together Project on Thursday 7th March.
    - The event was very well attended (over 65 people) and everyone took the time to look at all the amazing pieces of artwork, as well as the newly painted reception area, some clinical rooms and corridors.
    - Feedback from service users in particular has been really positive, with many sharing how the change in colours, together with the artwork brings a more vibrant, warm and welcoming feel to the space.
    - In addition to viewing the artwork, there was an opportunity to hear from participants and artists who have all been involved in this project. One service user shared a poem which poignantly spoke of their experience after witnessing the Grenfell fire and the hope that they saw through their artwork and in humanity. There was also a 72 second silence held to remember every life lost in Grenfell.

Hand of Hope x Movement Psychotherapy

- New round of the collaboration between Grenfell and Al-Hasaniya Women centre.
- It consisted of a set of workshops offered to Arabic speaking women about Hand of Hope x Movement Psychotherapy.

Festive Stars and Hearts Arts Project

- The Festive Stars and Hearts project took place again in November and December 2023.
- The events, where residents could decorate wooden stars and heart decorations, took place in partnership with many local organisations: Lancaster West Residents Association, Better Leisure Centre, Westway Sports and Fitness, the ClementJames Centre, St Quintin Centre for Disabled Children and Young People, ACE Supplementary School, Response Community Projects and groups internal to Grenfell Health and Wellbeing Service i.e. the Older Adults Group.
- The decorations were then hung on 3 trees in the Community: in the GHWS waiting room, the Westway Sports Centre and the Better Leisure Centre.

Kensington Christmas

- GHWS staff supported a family day at Maxilla Social Club on December 21st. This was an engagement session with local community members to provide purposeful activity as a means of engagement and for people to access support and information about the service.

Community Report

GHWS has developed a report for the Community that highlights GHWS work in terms of:

- Activity numbers: referrals and open cases.
- Clinical Wellbeing groups.
- Events supported.
- Community Collaborations.

An example is shown below:

1.4.

1.5. 2.5.1.4 Interventions

The GHWS aims to work alongside clients in a way that is tailored to them, their family and community. The offer includes a range of different therapies, groups and culturally adapted interventions.

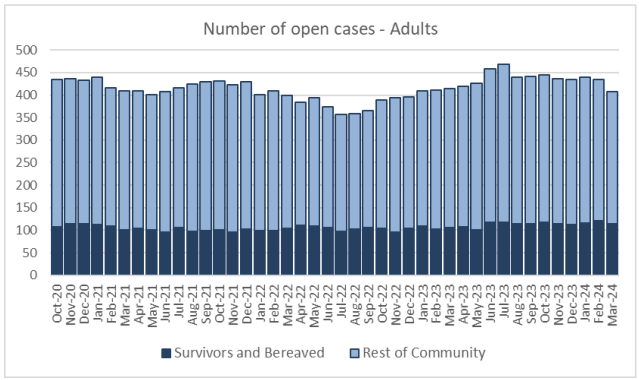
As well as face-to-face support, the offer has been extended to include remote support via telephone and video conference facilities such as MS Teams/Zoom due to the COVID-19 pandemic which has been extremely useful and well received by clients.

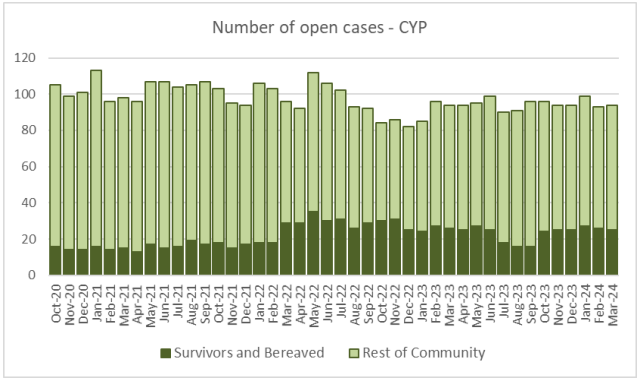
This section focuses on the following areas:

- Therapy Activity
- Client Demographics
- Group Activity

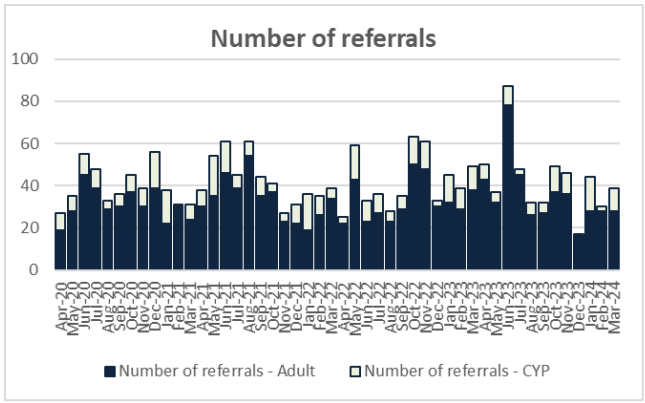
Therapy activity

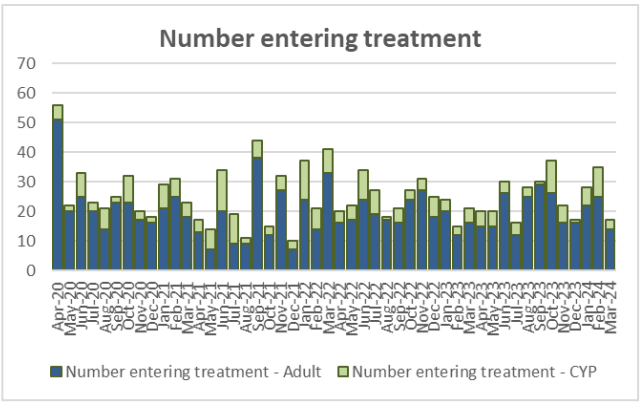
In March 2024 there were 502 open GHWS cases of those 139 were survivors and bereaved. There had been an increase during the year but the numbers had then levelled out to similar levels to that of March 2023.

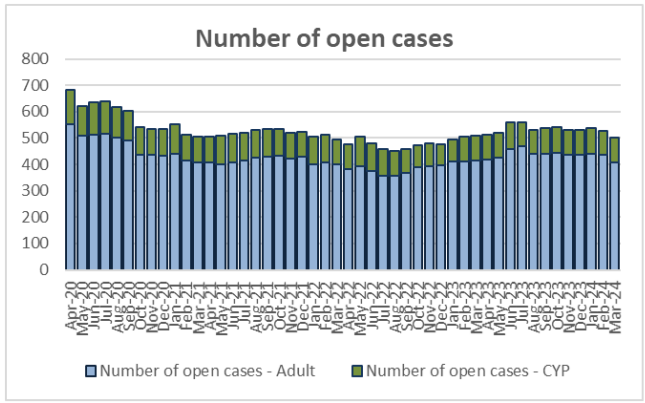


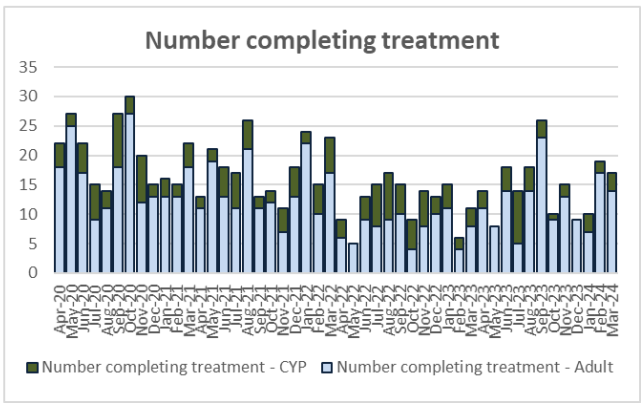


Overall **96%** of survivors and bereaved had been offered the service with **71%** accepting and **64%** seen. The 4% that have not been offered are not contactable.









GHWS activity numbers fluctuate based on the needs of the community as well as external factors Inquiry, Tower discussions, news articles etc.

Summary Activity Area		Total for Previous Years*		
		FY 21/22	FY 22/23	FY 23/24
GHWS Referrals	Number of Adult referrals to GHWS (all presentations)	403	394	425
	Number of Adult referrals signposted to more appropriate support	N/A	34	40
	Number of Adult referrals declined GHWS support	N/A	16	11
	Number of Adults referrals for GHWS	N/A	344	374
	Number of CYP referrals to GHWS (all presentations)	112	112	87
	Number of CYP referrals signposted to more appropriate support	N/A	3	3
	Number of CYP referrals declined GHWS support	N/A	8	1
	Number of CYP referrals for GHWS	N/A	101	83
Interventions: Therapy Activity - Adults	Number of referrals entering GHWS Adult Therapy	213	226	242
	Number of referrals starting GHWS Adult Therapy within agreed timescale (8 weeks)	N/A	220	232
	Number of referrals completing GHWS Adult Therapy	167	92	144
Interventions: Therapy Activity - CYP	Number of referrals entering GHWS CYP Therapy	82	59	59
	Number of referrals starting GHWS CYP Therapy within agreed timescale (8 weeks)	N/A	57	57
	Number of referrals completing GHWS CYP Therapy	46	50	34
Interventions: Group work	Number of groups run in month	N/A	37	78

The table above shows the number of referrals, patients starting therapy and completing therapy compared with the last two years. There were a number of referrals into the service in June due to private therapy providers with links to GHWS ceasing their activity and referring relevant clients to GHWS.

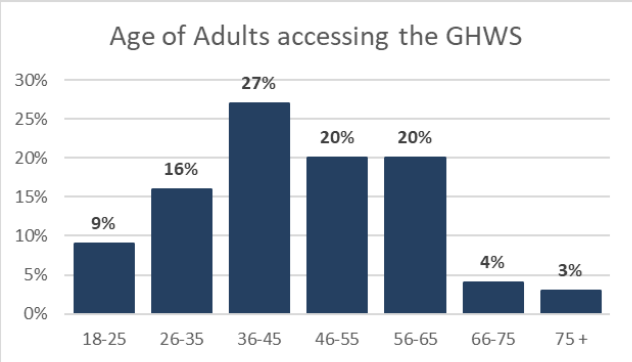
Adult		CYP	
4,894 referrals (2,708 clients) Total Adult Referrals since 2017	1,109 Clients with repeat episodes of treatment	1,541 referrals (1,170 clients) Total CYP Referrals since 2017	864 Clients with repeat episodes of treatment
2,477 referrals (1,647 clients) Adult Entered Treatment: Total since 2017	508 Clients engaging in long term therapy (over 40 sessions)	791 referrals (541 clients) Adult Entered Treatment: Total since 2017	167 Clients engaging in long term therapy (over 40 sessions)
3,830 referrals (2,437 clients) Adult Discharged since 2017		1,418 referrals (1,087 clients) CYP Discharged since 2017	

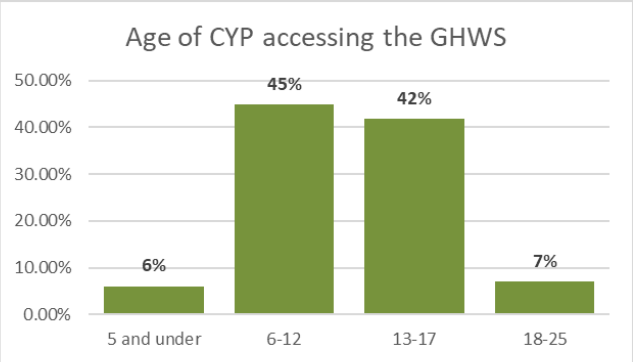
- Due to the nature of trauma some clients disengage from the support but then re-refer to the service at a later stage and some clients may complete treatment and be re-referred to the service for further support at a later stage.
- Not all referrals require GHWS support and are signposted to other services/support as appropriate
- Clients may access other GHWS support and this is not counted towards the 'entered treatment' figures

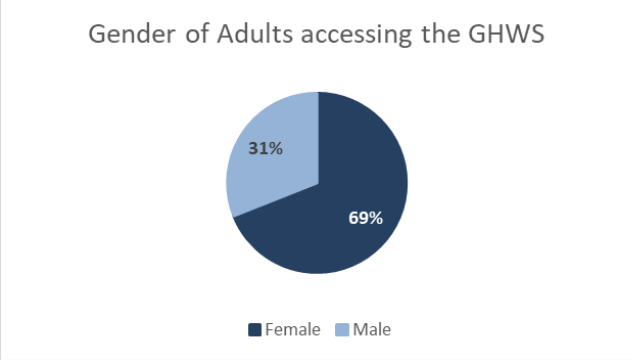
Sessions are not capped, as they are in business as usual services, so clients can have as many sessions as needed.

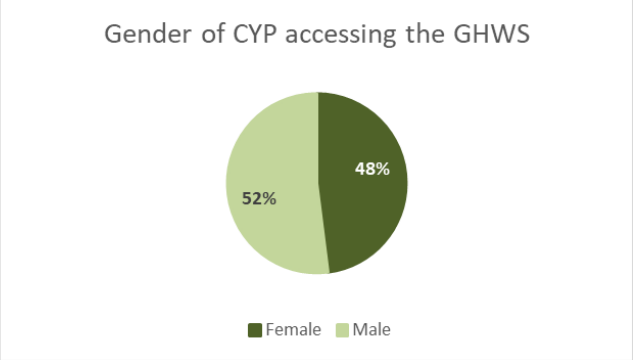
Client Demographics

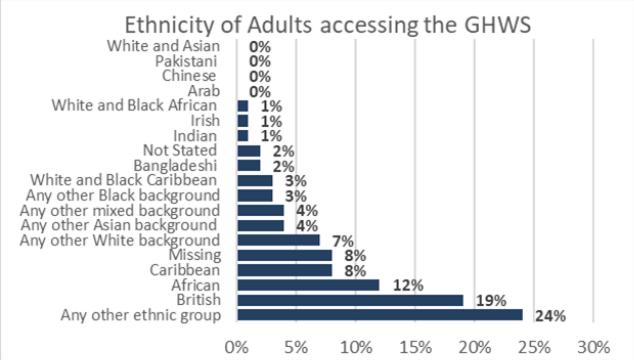
The GHWS collects basic demographic information for their service users to enable them to ensure their service is inclusive and representative. The detail can be seen below. Further work is being undertaken to see if the service coverage is representative of the community, linked with dropout and disengagement.

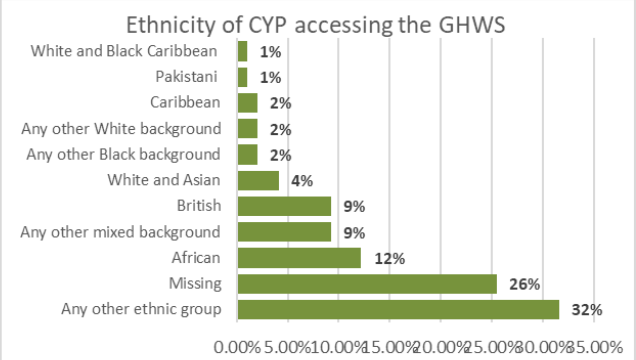

Age of Adults accessing the GHWS
30%
25%
20%
15%
10%
5%
0%
9%
16%
27%
20%
20%
4%
3%
18-25
26-35
36-45
46-55
56-65
66-75
75 +

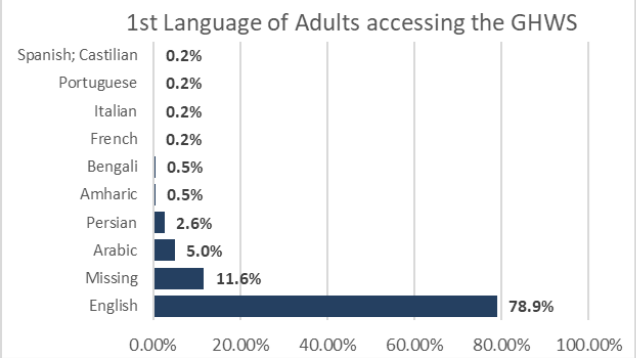

Age of CYP accessing the GHWS
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
6%
45%
42%
7%
5 and under
6-12
13-17
18-25

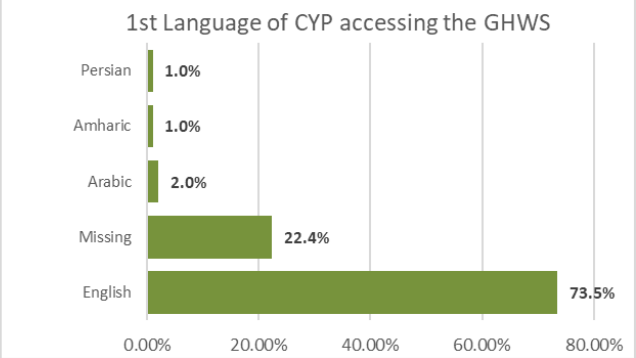

Gender of Adults accessing the GHWS
31%
69%
Female
Male


Gender of CYP accessing the GHWS
48%
52%
Female
Male


Ethnicity of Adults accessing the GHWS
White and Asian 0%
Pakistani 0%
Chinese 0%
Arab 0%
White and Black African 1%
Irish 1%
Indian 1%
Not Stated 2%
Bangladeshi 2%
White and Black Caribbean 3%
Any other Black background 3%
Any other mixed background 4%
Any other Asian background 4%
Any other White background 7%
Missing 8%
Caribbean 8%
African 12%
British 19%
Any other ethnic group 24%
0%
5%
10%
15%
20%
25%
30%


Ethnicity of CYP accessing the GHWS
White and Black Caribbean 1%
Pakistani 1%
Caribbean 2%
Any other White background 2%
Any other Black background 2%
White and Asian 4%
British 9%
Any other mixed background 9%
African 12%
Missing 26%
Any other ethnic group 32%
0.00%
5.00%
10.00%
15.00%
20.00%
25.00%
30.00%
35.00%


1st Language of Adults accessing the GHWS
Spanish; Castilian 0.2%
Portuguese 0.2%
Italian 0.2%
French 0.2%
Bengali 0.5%
Amharic 0.5%
Persian 2.6%
Arabic 5.0%
Missing 11.6%
English 78.9%
0.00%
20.00%
40.00%
60.00%
80.00%
100.00%


1st Language of CYP accessing the GHWS
Persian 1.0%
Amharic 1.0%
Arabic 2.0%
Missing 22.4%
English 73.5%
0.00%
20.00%
40.00%
60.00%
80.00%

Group Work Activity:

The number of group work has increased compared to the previous year, which shows an increase in culturally appropriate services delivered in the community.

GHWS offers a range of group work including:

- Nature's Way: Gardening group
- Older Adults Wellbeing
- Women Swim for Wellbeing
- Children and Young People's Gardening Group
- Compassionate Focused Therapy for Arabic speaking Women

Activity Area		Q1	Q2	Q3	Q4	Year Total
Interventions: Group Work	Number of group session run	17	13	22	26	78

* Some of the groups run more than once a month

1.6. 2.5.1.5 Community Issues and event responses

- GHWS support unexpected occurrences which may be triggering to the community where possible. The support provided is developed collaboratively with local community members who are responding on the ground to manage expectations and provide support where appropriate.
- GHWS have a presence at planned community events such as the silent walks, anniversary, public meetings including the Inquiry etc. to show solidarity and to be on hand should anyone require emotional health and wellbeing support.
- This section focuses on the following areas:
    - GHWS Community Issues and event Response Activity Data
    - Key GHWS Community Issues
    - Key GHWS Event Responses
    - Service User Involvement Team

GHWS Community Issues and event Response Activity Data

Activity Area	Q1	Q2	Q3	Q4	Year Total
Number of community issues supported	1	0	0	0	1
Number of events supported	9	9	3	9	39

Key GHWS Event Responses

GHWS actively supported a number of events during the year including:

- Follow-up article in the Mirror about firefighters
- Phase 2 of the Grenfell Tower Inquiry
- 6th Anniversary
- Grenfell Tower visits
- Kensington Eid celebrations
- Memorial Commission Report: Remembering Grenfell

- Family day at Maxilla Social Club
- Testimony Week
- Grenfell Diversity Awards
- Revive and Thrive Spring Wellbeing Fair
- GHWS Staff supported Survivors, Bereaved and the wider community at the Tate to unveil Grenfell inspired artwork.
- Grenfell: In The Words of Survivors play at the National Theatre.

Service User Involvement Team (SUIT)

Service User Consultants (SUCs) are involved in various activities and projects within GHWS to ensure that they are listening to and acting upon the feedback received wherever possible to ensure they are providing best service they can. There is an Adult SUI team, a Young People's SUI Team (13 -19-year olds and a children's SUI Team (8-11 year olds), who named themselves the 'Grenfell Young Heroes'. Detail on the CYP SUIT teams can be found in section 2.6.1.3.5 of this report.

Adult SUIT

For 2023/24 some of the Adult SUIT projects are detailed below:

- **CNWL Therapies Conference:** On Wednesday July 5th the annual CNWL Therapies Conference was held in Milton Keynes. This year the theme was 'Equity in Care: Working with our communities to overcome health inequalities'. GHWS was well represented:
- **GHWS Feedback Week 11th to 15th September:** Adult SUIT members support the planning of this event and had an active participation in supporting client's feedback collection. Their contribution was crucial for the success of this initiative.
- **Mentoring:** Adult service user consultants continue to mentor Young service user consultants
- Interview panels for all GHWS roles recruited in this quarter.
- Supporting staff in setting up the Discovery College
- The team is also working to co-produce a written document outlining and reflecting on our journey as a Service User Involvement Team within GHWS. This project involves four service-user consultants. During this period, there were also one-off projects, including a service user consultant involved with feedback and promotion of the sensory room at GHWS.

2.5.2 Outcomes

1.7. High Level Outcomes with indicators

The table below details the high level outcomes identified in the HWS for this work stream, alongside the agreed indicators and methods of measurement.

High Level Outcome	Indicator	Method of measurement
1. Level of trauma, anxiety, depression and distress to be reduced. Emotional health does not get in the way of daily life to a disproportionate extent for those who have suffered as a result of the fire.	1. Improvement in self-reported Health and Wellbeing 2. Improvement in mental health – Central and North West London NHS Foundation Trust (CNWL) outcome measures 3. Reduction in number of service users suffering crisis / in need of emergency support	1. Qualitative report for Grenfell Health and Wellbeing Service (GHWS) including Goal based outcome measures for current therapy services, detail and outcome measures of transformed services, Patient Engagement Questionnaires and case studies 2. Self-care work stream outcomes and services show improvement in access to culturally appropriate services and improvement in self-reported health and wellbeing. Options for accessing services for the community not dependent on statutory agencies 3. A&E data, referrals to crisis services
2. Improved Access to culturally appropriate services and self-care programmes that enable understanding of physical and psychological changes. Options for accessing other services for the community are not dependent on statutory agencies.	4. Patient reported improvement in access to culturally appropriate services, increased access to self-care services	

Summary

1. Level of trauma, anxiety, depression and distress to be reduced

- **Emotional health does not get in the way of daily life to a disproportionate extent for those who have suffered as a result of the fire**.

1.a GHWS Qualitative report

- CNWL report positive outcomes for their services across all parts of their five-part model, evidenced by case studies, feedback and outcome measures, detailed in section 2.5.2.1, which demonstrate the diversity of the work delivered by the service
- All workshops and group work collect feedback forms which give positive feedback on the sessions. Work needs to be done to identify ways of measuring the health outcomes of these services.
- Goal based measures have been using goals since 2021 for CYP and launched for adults in January 2023. The expectation was to have 100% of cases that are currently in therapy with a Goal Based

Measure (GBM) or GBM not relevant by April 2024. For Adults, it has reached 89% which is an improvement on 36% in June 2023. Thematic analysis on measures has begun but further analysis on Adult outcomes will be reported in Q1 2024/25. Detail on CYP GBM can be found in the CYP section of this report.

- PEQs are collected across the service with positive feedback received.
- In the year ahead
    - Increase the response rate for PEQs.
    - Identify and implement measurable outcomes for the group work and workshops

1.b Self-care work stream outcomes.

- In addition to the self-care services offered by CNWL as part of the GHWS, self-care services from KCSC and ACAVA are detailed in the self-care section. There is an improvement in self-reported outcomes across all services. More detail can be found in section 2.4.

1.c A&E data, referrals to crisis services

- Current analysis of data does not show any trends. The data will continue to be analysed and any findings will be conveyed via this report.

2. Improved Access to culturally appropriate services and self-care programmes that enable understanding of physical and psychological changes.

- **Options for accessing other services for the community are not dependent on statutory agencies.**

2.a GHWS Qualitative report

- The GHWS quarterly Qualitative report gives details of workshops and community collaborations.
- GHWS provides workshops to adults, parents and children and young people, these are accessible to all community members. They work in partnership with other community providers There has been an increase in wellbeing workshops delivered within the community from 20 in 2022/23 to 32 in 23/24.
- The request for collaborations in 2023/24 more than doubled compared to the previous year, increasing to 78 from 37.

2.b Self-Care work stream

- This work stream is promoting an asset based approach to health care, providing investment and support to local 'assets' to help deliver self-care opportunities.
- There was an increase in the number of services offered from 6 in April 2021 to 21 in April 2022. The number of services has now stabilised and the focus has been to increase awareness of the services in the community.
- More detail can be found in Section 2.4.

2.5.2.1 GHWS Outcome measure detail

This section highlights some key outcomes that help to deliver the high level outcomes detailed above.

The service has standard clinical outcome measures for therapeutic work and has developed various methods of collecting data and feedback on all areas of the service to ensure their efficacy and usefulness to clients as per the table below. More work needs to be done across the service to record and report the improvement on clients emotional wellbeing after using the services:

5-Part Model	Agreed outcome	Description
Information and Self-care	**Web activity: Number of views/downloads on the website/Twitter/Facebook**	Web Digital Activity is being shared in the Quarterly reports
Early intervention and prevention	**Community connectors**	Data on engagement activities that community connectors support
	Feedback forms for workshops	Data on workshops delivered and respective feedback is being included on the Quarterly reports
	Case studies about Employment support	Continuous collection of case studies about Employment support where appropriate
Interventions	**Standard Clinical Measures**	Reported in case studies where relevant
	Goals questionnaire	Official launch of goals questionnaire during January 2023
	Case studies	Continuous collection of case studies from the distinct teams where appropriate
Collaborations*	**Evaluation form to organisations/resident groups re how they found the process (helpful/not helpful)**	Currently: a general evaluation form in under review process before being sent to relevant individuals/organisations to get a baseline Going forward aim to implement a consistent approach to collect feedback
Community issues and event responses*	**Evaluation form individual/ organisation who requested the support**	

1.8.

1.9. 2.5.2.1.1 Information and Self-Care

GHWS Open Day:

The open day was well attended and over 150 local people came to visit the service on the day, including a special visit from Baroness Scott.

The Open Day resulted in a good uptake by the community and feedback was collected through different routes:

- Feedback form
- Comments book.

Feedback Forms

Only nine (9) people completed the feedback from. This low number may result from having two simultaneous feedback routes on the same day.

Summary

- The majority of respondents corresponded to organisation representatives followed by service users.
- In terms of the layout, feedback has shown that this was not so optimal as the space was small when busy, as well there was no signs/volunteers directing people to relevant rooms.
- The majority of participants reported that have learned something new about GHWS.
- Overall, respondents considered that everything they were expecting was covered during the Open Day.

Comments Book

The feedback shared in the comments book is shown below. The comments were all positive.

1.10. 2.5.2.1.2 Early Intervention and Prevention outcomes

2.5.2.1.2.1 Workshops

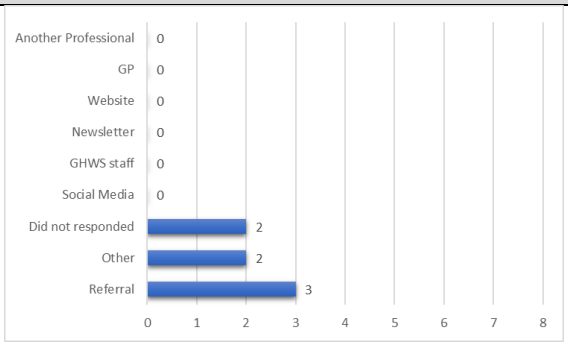
The feedback surveys show positive feedback for all workshops with 100% of participants that completed a feedback survey saying they would recommend the workshop to a friend or family member.

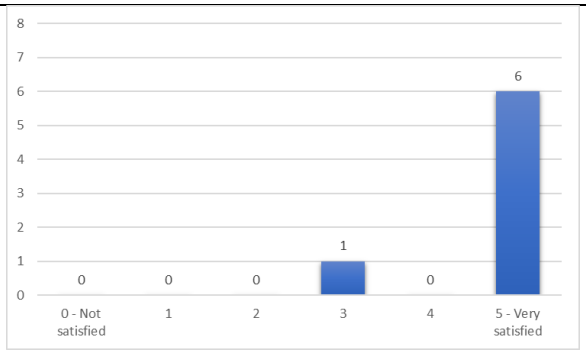
Below is a sample of the feedback from some of the workshops run during the year:

- Tree of life
- Healing Space Together
- Recovery College
- Discovery College

1.11. Tree of Life

Dates Run	05/04/2023
Location	The Clement James centre
Number of attendees	8

Number of surveys collected (where appropriate)	7
Demographics of attendees where possible	N/A
Feedback Survey Responses	
Did you find this workshop helpful?	
All 7 who fedback rated the workshop 5 – very helpful	
Would you recommend this workshop to a friend or family member?	
All 7 who fedback rated this 5 – would definitely recommend.	
What did you like about the workshop?	
• "Getting everything on paper. Seeing others art work. Discussing. Enjoyable." • "Everything. Trees draw and other staff." • "Drawing tree with beautiful colours markers. Speaking about family and friends. Thank you. It was very good." • "Thank you so much. Very helpful." • "Everything. Trees draw and other staff." • "The positive energy. It makes me happy. And great presenters." • "I love making art. I really enjoyed the holistic nature of the exercise in bringing lots of parts of me and my life together. It was great to have so many materials, especially loved paint stiches." • "Everything. I wish I could come every week."	
What could we do to improve the workshop?	
• "More colours." • "Mindfulness part." • "Maybe ways of helping more people to speak, e.g. going around. Being aware when a participant speaks a lot, leaving less time for others to speak."	
How did hear about this workshop?	
	
If you attended a workshop in person, how satisfied were you with the venue?	
All 7 were satisfied or very satisfied with the venue.	
GHWS is constantly striving towards providing a service that is culturally informed, understanding and respectful for everyone regardless of their gender, sexuality, race/ethnicity, language, religion, age and/or disability. How satisfied are you that we are meeting this aim? Is there anything else you would like to add?	



Additional feedback was shared by a member of staff from the Clement James centre:

"I thoroughly enjoyed yesterday's session. I felt the Tree of Life was such a lovely way of engaging with our history, strengths, community and hopes, and the four of you each provided such a safe, encouraging and compassionate presence. I can see how much this was appreciated by the group. Thank you so much!"

1.12. Healing Space Together

	Name	Date	Duration	Attendees
Name, date and duration of session(s) and Number of attendees	Unboxing inspiration	19/10/2023	2h (5-7 pm)	20
	Making pace	02/11/2023	2h (5-7 pm)	23
	Building together	09/11/2023	2h (5-7 pm)	20
	Creating our community environment	11/11/2023	5h (11 am - 4 pm)	17
Which outcome measures were used?	• UCL Wellbeing measures: The group reported an increase of 23.4% in positive feelings and a decrease of 40.3% of negative feelings			
What verbal/informal feedback did you receive?	• Participants shared very good and positive feedback: ○ "A coming together of great creative spirits." ○ "I loved to be welcomed with food how homely and caring." ○ "Very impressive and sociable."			
What are the key learning points?	• The Healing Space Together project has enabled a sense of belonging and community among participants, as well as wellbeing improvement via the different creative workshops. • This project has materialised into distinct art that is in the process of being displayed in the Grenfell waiting room and clinical rooms.			

1.13. Recovery College

The Grenfell Recovery College is part of a collaboration with the CNWL Recovery & Wellbeing College and offers free wellbeing workshops to anyone living in Kensington & Chelsea or anyone affected by the Grenfell fire.

The workshops provide a supportive, educational environment where people can learn from people with professional experience of mental health and from people with lived experience of mental health. All of the workshops are coproduced and are designed to contribute towards wellbeing and recovery.

The GHWS Recovery College delivered a number of workshops over 2023/24, feedback from these workshops was recorded via feedback forms.

- Workshop rating for all workshops as recorded on feedback forms was very good or excellent.
- Further feedback including was to improve the workshops from both the attendees and facilitators was recorded, as was ideas for future workshops

Feedback was shared by a professional about a Recovery College workshop at Clement James:

> "Hi 'S',
>
> Hope this finds you well. Just wanted to say a huge thank you for coming along and delivering yesterday's session. The content was so well-delivered, relevant and I really admired the way that all members in the group were encouraged to shape the conversation. We had smaller numbers than usual (as few people got in touch with me afterwards about illness etc), but I'm sure we'll be at our usual group size for the next workshop

1.14. Discovery College

Feedback is in the CYP section of this report alongside other CYP workshops and feedback details.

1.15. 2.5.2.1.2.2 Employment Support

A case study is included below to highlight the positive outcomes produced by this service.

Employment Support Case Study	
History:	Client with long-term mental health barriers and who is being supported by GHWS.
Presentation:	Client referred to Employment support as they were was interested in getting a job.
Intervention:	In the initial meetings, the Employment Support Specialist found out that the client had been working for many years doing similar work part-time and did not hold any qualifications for this. The entry requirements for this type of job included relevant qualifications. To address this, the Employment Support Specialist contacted the client's employer to plan the best support for the client to achieve this goal.
Outcome:	The client was able to join an apprenticeship within the employer's organisation, so they could gain the relevant qualification in-house. The Employment Specialist is still supporting the client through the course to ensure they are not getting overwhelmed and to build their own confidence in the knowledge and skills they have obtained in their role. The client has also obtained a bank role within the organisation they wanted to work with.

2.5.2.1.3 Intervention Outcomes

1.16. 2.5.2.1.3.1 Client Feedback

The GHWS aims to collect feedback from their clients in various ways. GHWS continue to work with their Service User Consultants and the wider community to ensure that they are listening to and acting upon the feedback received wherever possible to ensure they are providing best service we can.

This is an ongoing piece of work which is adapting based on the feedback that is received. GHWS are currently working on the following key areas:

- Patient Experience Questionnaires (PEQs)
- Feedback Week
- Digital Feedback Devices (Smiley Face Machines)
- Other Feedback: Verbal, Text and Email
- Therapy Outcome Measures:
    - Goal Based Measures
    - Adult
    - CYP
    - Groups

Patient Experience Questionnaires

Since January 2021, GHWS had the following PEQs, each designed to be appropriate for particular service users:

- General Adult PEQ (for anyone over the age of 18)
- Parent PEQ
- Adolescent PEQ
- Child PEQ
- Under 5's PEQ

During the year a number of strategies were undertaken to try to increase the response rate. These included:

- Reviewed PEQs with staff and service users, which were officially launched in September 2023 and are available as hard copy and online.
- Promoted feedback collection among clients.
- Planned and implemented GHWS Feedback week, which took place between 11th and 15th September. Further details about this event can be found below.

Following the feedback week in Q2, in Q3 there were 4 responses and Q4 there were 2 responses.

All responses were positive with no negative comments recorded.

Feedback Week

GHWS organised a Feedback Week from 11th-15th September. The aim was to ask clients for their opinion about the service and help us improve the quality of support that we deliver. Clients from across the service were asked for feedback via email, SMS and through informal conversations with service user consultants.

Total Feedback completion numbers for the week (all modes of feedback):

- PEQS: 64 in total

  - General PEQs: 58
  - Adolescent PEQs: 3
  - Parent PEQ: 1
  - Child PEQ: 1
  - Under 5s: 1
- Digital feedback device: 34 responses
- Comments books: 4 comments left by clients

From the feedback gathered:

- **PEQs:** clients were happy with the support received by GHWS are likely to recommend it to others. However, several aspects were flagged and GHWS is actively following up on them to improve the support we deliver.

  A summary is below.

  - The main referral sources into GHWS are self-referral followed by GP.
  - The most common types of support received were: counselling, psychotherapy and emotional support
  - The majority of clients were positively impressed with GHWS because they got a helpful and good service
  - Overall the clients were happy with the support received, their involvement in treatment planning as well as their clinician's skills based on the responses.
  - Clients reported the reception team were kind and competent.
  - GHWS therapy is now offered both in person and remotely, the clients can choose according to their preference and are satisfied with the options available.
  - GHWS was considered a cultural and respectful service by the clients.
  - Clients are mostly happy with the support given by GHWS and they are likely to recommend it to others, only 5 clients have had a bad experience and they would not recommend the service.
  - Negative feedback was also given by clients, GJWS properly investigated any points raised, following up with the relevant people and planning any required changes in order to improve the service.

- **Digital Feedback**: all of those who gave feedback using the digital feedback device stated they were 'Very Happy' or 'Happy' with the relationship with their therapist and their experience of the reception team. When asked (via the digital feedback device) how clients rate the information available in the reception area half selected 'Very Happy' and 37% selecting 'Happy'. Two people selected 'Average and one person selected 'Very Unhappy'. This highlights an area that could need some improvement, further review of the information in the reception area and discussion as a service (including SUITs) could be required to address.

- **Comments book**: all comments were positive with one client calling their family therapist "excellent" and that they "made me and my family feel at ease" another naming three GHWS staff members from different modalities and calling them "amazing".

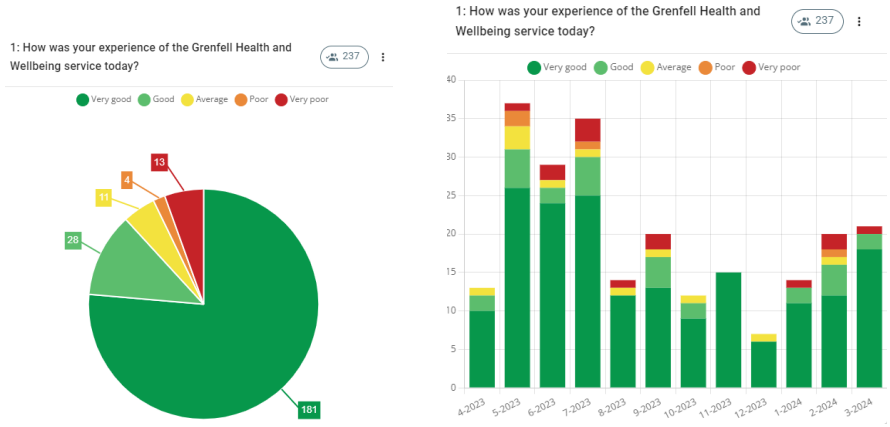
In response to Feedback week, a "You Said We Did" campaign to demonstrate to clients that feedback has been gathered and the service has responded. Posters were created for the GHWS reception area and posted online.

Digital Feedback Devices (Smiley Face Machines)

Two 'Smiley-face' machines, like the ones you get in shops and airports, are placed in the waiting room at GHWS for clients to give real time feedback.

The first device asks the question 'How was your experience of the Grenfell Health and Wellbeing Service today?'.

From 1st April 2023 to 31st March 2024 there were 237 responses. Below is a chart showing the breakdown of responses received.



Any additional feedback was fed back to the appropriate team.

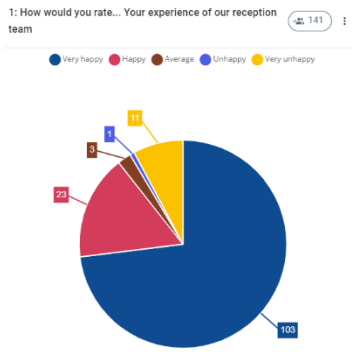
Following the GHWS feedback week in September 2023 the second device was updated to include the following questions:

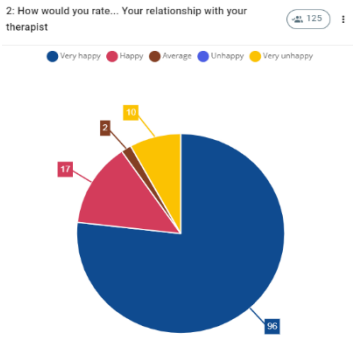
1. How would you rate… your experience of our reception team?
2. How would you rate… your relationship with your therapist?
3. How would you rate… the support you have had from us so far?

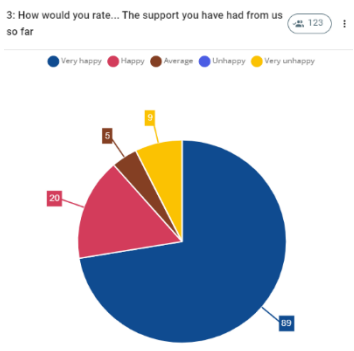
4. How would you rate… the information available in the reception area?
5. How would you rate… the cultural competence of the service?

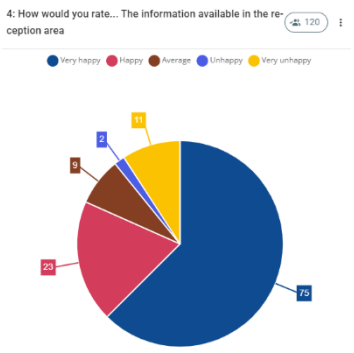
From the start of feedback week to 31st March 2024 there were up to 141 responses for any one question. These numbers included responses received during feedback week.

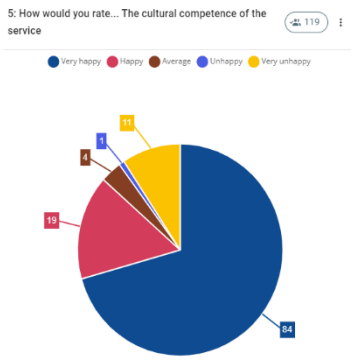
The charts below show a breakdown of responses received for each question:











Other Feedback: Verbal, Text and Email

Clients often text or email their clinicians directly with feedback and thanks. CNWL have set up a feedback email address (cnwl.ghwsfeedback@nhs.net) for client feedback. This is on their new website, to date this has not been used but they will continue to publicise the address.

Below are some examples of the feedback for 2023/24.

A school thanked a GHWS member of staff for the collaborative work done for supporting several children.

"If I don't get to see you, just want to say thank you for all of the utterly INCREDIBLE work you've done with 'C', 'B' and others

For 'C', you have made all the difference. Without your support I doubt he would have been able to come into school each day and show the resilience he has shown. You have also really supported us professionally in school to manage risk when we've been worried about his safety in school and at home. I know he and his family will be forever grateful for your skill and care in managing his really complex mental health and always making time for him – even at incredibly short notice. Thanks SO much; you've really gone above and beyond."

Also, a compliment via a North Kensington GP surgery was shared about GHWS:

"Just last week, I received a glowing report from a local person (who doesn't lightly give these) of how GHWS has evolved."

"C was very helpful and easy to talk to. She is really helping my daughter reach new heights."

"Been using the service for 6 years. 'H' made me and my family feel at ease. She was excellent. Not all therapist was that good but she left. But 'H' was amazing. First impression of therapist 'SM' was she was listening and attentive and she cares but it's early days. The building is always clean and nice."

"I've been part of the service for about 3 years now. 'SW', 'AM', 'C' and 'T' have been amazing. I hadn't been out my house for 7 years other than appointments and 'S' came to visit me @ home. I came 18 months after the fire. I was coming once a week to see 'S'. I have much praise for the service. Very clean area. The water machine is good."

"Dear 'J', I am writing how grateful I am to have you as my OT. It has been a year that I tried to be listened, however I was just ignored."

''We have really felt the benefit of our sessions with you both, it's been incredible to learn how to really listen to each other and it enable us to talk about some difficult things that we didn't know how to navigate. We have both felt really comfortable with you, and the dynamic of having two therapists has been really interesting! We just feel like we have reached a point where we can talk to each other and communicate better now."

A client who sees us for both individual and couple work has expressed that his GP's referral to our service has been the best thing that's happened to him, as it's really helping him express how he feels to others.

Below are some quotes and feedback from clients who use the Employment service provision:

"I just wanted to express, my gratitude for 'A' and 'C'.

Initially 'A' was my employment specialist. 'A' is tough but fair she pushes you when you feel like you can't keep going. Which is exactly what I needed.

When 'A' was ill, 'C' took over initially I was sceptical about Him only because 'A' set the bar so high.

But in truth I wouldn't be where I am today without 'C' or 'A'.

I managed to get a really good job, and when things were difficult they were still very supportive took time to listen and offer guidance.

Now that job has ended, I reached out and they are here supporting me again.

I don't know what I would without them.

This service that they offer is invaluable to

"Mr 'C' came to my life when I was in my most vulnerable and confused to stupor period.

Don't even know where to start because of lack of self confidence

Mr 'C' made me realize I had all the qualities, I had done the job before, I can still do it again and better. Brought out the hidden talent and confidence that where are buried due to long time of trauma, help me step by step to apply for a job, helped pursue the interview and other trainings.

Making sure I completed my online training and to getting shifts.

I really don't have enough words to describe the assistants I got from Mr 'C'

I thank God for his life and for all the help he has helped us, May Almighty Allah reward him in this world and in

1.17. 2.5.2.1.3.2 Therapy Outcome Measures

GHWS use outcome measures across the service to assess a service user's current status and to use this as a baseline to enable progress to be monitored. The outcome measures are specific to the interventions they offer their clients and are different for children and young people and adults.

Goal Based Measures

GHWS has officially been using goals since October 2021 for CYP clients and they have been set up for current open cases, when appropriate.

A strategy was explored to enable the recording and reporting of goals for Adults cases on the clinical platform. A questionnaire was devised that was officially launched during January 2023.

Every case, whether new or ongoing, on the GHWS staff's caseload undergoes an active review to verify the completion of a goal-based measure. Goals may not be applicable in certain circumstances, such as when a client declines the offer of goal recording or when the client's work does not justify the use of goals. The clinical system records such instances as 'GBM not relevant'.

In January 2024, GHWS set up a GBM QI (Quality Improvement) sub-team to promote and closely monitor goal completion among adults and CYP Open cases so that GBM becomes more prevalent. The expectation was to have 100% of cases that are currently in therapy stages of the IAPTUS Care Pathway with a GBM or 'GBM not relevant' label by the end of April 2024. Despite not yet reaching the 100% target yet, there has been a significant increase in completion during Q4.

The detail for CYP Goal based measures can be found in the CYP section of this report.

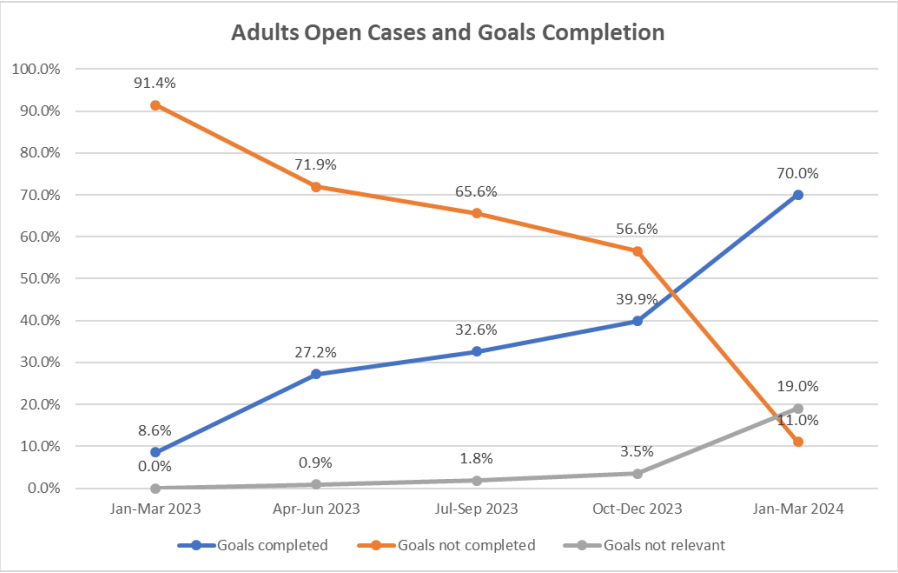
Currently, there are 360 Adults open cases:

- 253 cases have goals defined, which corresponds to 70% of the open cases.
- 40 do not have goals established, which represents 11% of the open cases.
- Goals are not appropriate/relevant for remaining 67 cases (19%).

Goals on Adult cases are defined using a questionnaire in the clinical platform that enables the **set-up and scoring of up to 5 goals**.

Goals scores range from: 0 = Not achieved to 10 = Achieved.

The plot below summarises the use of goal-based measures in Adult case:



- In Jan-Mar 2023, only **8.6%** of Adults open cases had goals defined. This was due to the recent launch of goal usage among adult cases in January 2023.
- In April to June 2023, there was an increase in goal completion to **27.2%.** This improvement was attributed to various strategies that GHWS implemented:
    - GBM guidelines were reviewed and updated.
    - Staff are given additional training.

    - Active promotion of goals among clients.
    - The clinical platform has a mechanism to document instances where goals are not suitable or pertinent for a specific case.
- July–September 2023, goal completion had increased from 27.2% to **32.6%.**
- This continuous increase tendency has also occurred between October to December 2023, with goal completion around **39.9%.** The ongoing promotion of goal completion among staff can explain this.
- In Q4 both goal completion and goals not relevant have increased significantly, reaching **70%** and **19%,** respectively. This is thanks to the GBM QI (Quality Improvement) sub-team, which is promoting and monitoring more closely goal completion among adults and CYP Open cases, so that GBM becomes more prevalent.

Goals thematic analysis

Thematic analysis of the Goals has begun and initial findings on themes are below:

Goal Themes:	
Trauma, loss and grief:	Improved relationships:
• "To come to terms with the loss of my friends and family who died" • "To stop having nightmares about Grenfell"	• "To make new friends and speak to people more" • "To improve relationships with my family and to stop arguing" • "To improve how I communicate with my mum" • "To respond more calmly to my kids"
Self-relating:	Managing emotions:
• "I want to be happy and content in myself" • "To know my story and rewrite it so I no longer blame myself for what happened to me" • "To feel more confident in myself"	• "To feel more relaxed when I'm reminded of the fire" • "To stop having panic attacks" • "To stop always thinking that a fire is going to happen to me"
Self-care:	(For CYP) Education:
• "To get the support I need" • "To do more sport and exercise" • "To get out more and meet new people"	• "To stop procrastinating around homework" • "To be better at school" • "To feel less anxious and worried about school"
(For CYP) Behaviour/parenting:	(For adults) Practical support:
• "For parents to understand X's needs to better respond to his behaviour" • "To set better boundaries with the children"	• "To get support with finding better housing" • "To get help with equipment to support mobility needs"

CYP Therapy

Detail can be found in the CYP Section of this report.

Adult Therapy

The GHWS Adult Therapy team use a range of measures linked to specific presenting problems as appropriate, including:

- **PHQ-9 (Patient Health Questionnaire)** – a nine-item self-assessment questionnaire designed to screen for depression in primary care and other medical settings. It is used to assess both the

presence of depressive symptoms as well as to characterize the severity of depression. It is linked to the DSM-IV criteria for diagnosing depression. The standard cut-off score for screening to identify possible major depression is 10 or above.

- **GAD-7 (Generalised Anxiety Disorder)** – a seven-item self-assessment questionnaire that assesses the presence of Generalised Anxiety Disorder symptoms and measures the severity of GAD. It takes key items from the DSM- IV to help in assessing the presence of GAD based symptoms. The standard cut-off score for screening to identify possible GAD is 7 and above.

- **PSSI (The PTSD Symptom Scale)** – is a flexible semi-structured interview holding 24 items linked to DSM-V criteria for diagnosing Post Traumatic Stress Disorder (PTSD). This interview allows clinicians who are familiar with PTSD to make a diagnosis of PTSD as well as obtaining an estimate of the severity of the symptoms.

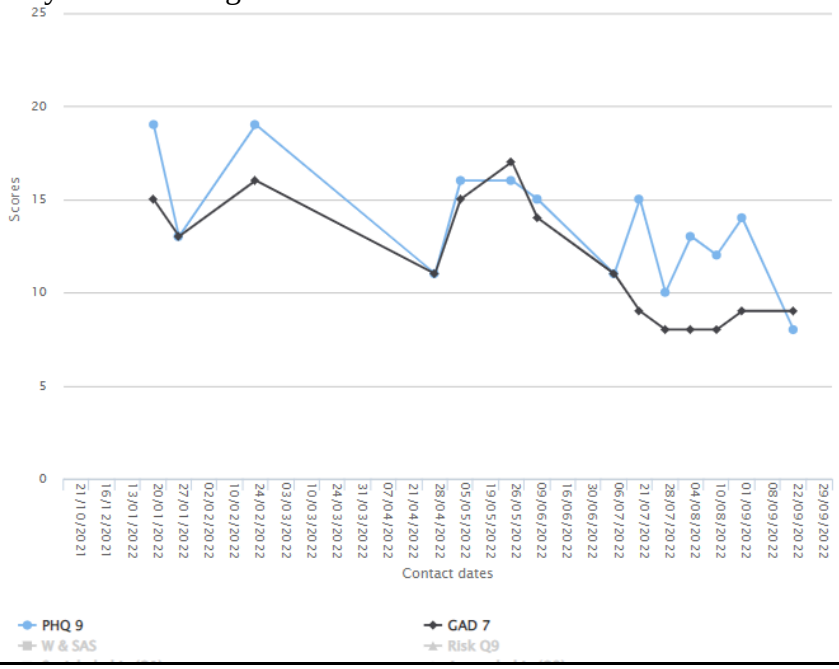
- **IESR (Impact of Event Scale)** – a 22-item self-report measure that assesses subjective distress caused by traumatic events and so it is not used to diagnosis PTSD but to highlight distress experienced. The standard cut-off scores for a preliminary diagnosis of PTSD is a score 33 and over.

- **PDS-5** – is a 24-item self-report measure that assesses PTSD symptom severity in the last month according to DSM-5 criteria. The PDS-5 begins with two trauma screen questions to assess trauma history and identify an index trauma. An item for each of the 20 DSM-5 PTSD symptoms is included, and an additional four items ask about distress and interference caused by PTSD symptoms as well as onset and duration of symptoms. Symptom items are rated on a 5-point scale of frequency and severity ranging from 0 (Not at all) to 4 (6 or more times a week / severe). Scoring above the cut-off point identifies a probable PTSD diagnosis.

Following are three case studies which show more of the positive outcomes from this service.

Adult Case Study 1	
History:	Bereaved of family in the Grenfell Tower Fire and relocated to the UK. Previously received NET and tf CBT. Cultural beliefs and practises between country of birth and UK have contributed to a horrific and painful loss.
Presentation:	PTSD presentation including intrusions, low mood, nightmares and poor sleep. Social isolation, which worsened during COVID. Long term physical health condition. Multiple losses. Barriers to accessing support due to physical disability and English as a second language.
Intervention:	Gardening Group. Started to attend the group as individual tfCBT was ending and continued thereafter. Access with respect to physical and language needs facilitated.
Outcome:	Client reports that they received significant benefit from the group including social support, being in nature, emotional and spiritual connection, access to a calm and grounding space, as well as a sense of achievement and personal mastery. They connected to stories of strength and resilience as well as an improved sense of community identity and is better able to access social support in the community.

Adult Case Study 2	
History:	History of trauma dating back to childhood.
Presentation:	PTSD and OCD.
Intervention:	EMDR assessment - creating timeline and formulating.
Outcome:	Client shared that this is the first time that they have sought therapy as they are usually a very private person who does not share any difficulties. Client has engaged with several sessions of assessment which included creating a timeline of adverse past experiences as well as identifying her strengths and resources. Client reported that since starting therapy, they feel much lighter from sharing difficulties that they have never told anyone about. Due to this feeling, they have challenged them self to resume activities that they had been avoiding due to their OCD. Client shared that they have now learned that "I can do it". Client shared that they are very glad that they were referred to our service and that they are very keen to work through past experiences.

Adult Case Study 3	
History:	Worked in Grenfell area, with bereaved.
Presentation:	Moderately severe depression and anxiety, keeping client off work and withdrawing from friendships (socially isolated). PTSD.
Intervention:	Stabilisation, psycho-ed on PTSD. 1-1 ACT work on defusion, acceptance, self-compassion. Also attended CFT group.
Outcome:	Depression and anxiety dropped from “moderately severe” to “mild” (see chart). Nightmares greatly reduced. Now actively socialising with friends and family and attending work. 

Groups:

The following details the feedback that has been received for some of the groups that have been run this year. It is all positive.

Nature's Way: Gardening Group

Details for the St Charles and Lancaster West Gardening groups can be found in the tables below.

St Charles Gardening Group	
Duration of session(s)	1.5h (from 12 to 1.30 pm)
Number of attendees	4
Which outcome measures were used?	N/A

What verbal/informal feedback did you receive?	• Positive verbal feedback shared by group participants:
	  ○ One member reporting she was having a very difficult day but was very glad she made it to the group as she felt very uplifted by being around the members.
	  ○ One client going abroad but wanting to join the group via video as he didn't want to miss any of the sessions.

What are the key learning points?	• Holding the space for the members appears to be the most valued aspect of the group - gardening is just a forum for this.

Lancaster West Gardening Group	
Duration of session(s)	2h (from 12 to 2 pm)
Number of attendees	Number of attendees varies – especially during the winter months as a few clients may find it cold to do gardening outdoors. Regular attendees are approximately 4-5, we also have ad hoc group members who attend less frequently.
Which outcome measures were used?	N/A
What verbal/informal feedback did you receive?	At the end of each session, group attendees can share feedback to help us co-create the upcoming sessions. Participants have expressed that they feel they benefit from attending a psychologically informed, open-relational community space.
What are the key learning points?	• Increasing access to psychological services by co-creating with the community. • Honouring the community's polyphony while reflecting on the impact of community trauma. • Witnessing the powerful journey of hope and resilience that our communities go through. • Learning to cope with uncertainty and fluid boundaries. • Using key narrative methodology principles, recognise faith, spirituality, and culture as core resources.

Older Adults Wellbeing

Name of Group	Older Adults Wellbeing March to September 2023
Dates Run	Every Tuesday morning
Number of attendees	5
Group Activities	
• The Older Adults group participants engaged in a variety of workshops and activities. These have included: ○ Workshops on 'Assertiveness', 'Exploring our values and beliefs', 'Managing stress', 'Managing fatigue' and 'Managing chronic health conditions' ○ Social events, including a visit to the Museum of Brands café ○ Memorial in honour of one of the group members who passed away in 2022. The event was appreciated by the attendees who had an opportunity to reflect and remember.	
Feedback	
• Some of the group members are currently dealing with difficult life events such as bereavement and terminal illness. One group member said that: 'The group helps me to cope because I know that I can share the pain of what I am going through and feel the care of everybody.'	

Compassionate Focused Therapy (CFT) for Arabic Speaking Women

CFT for Arabic Speaking Women	
Date of session(s)	9/11/23 – 14/12/2023
Duration of session(s)	1.5h
Number of attendees	15-18
Which outcome measures were used?	• CORE-10 (as per Midaye's policy). • The Self-Compassion Scale-Short form, translated in Arabic (given by Grenfell).
What verbal/informal feedback did you receive?	• Positive verbal feedback: ○ The group said they found the content and discussions very helpful, particularly linking CFT principles to faith and culture. They said that the faith-informed discussions helped them better understand and implement the techniques and accept self-compassion, as well as refer to Islamic literature. ○ They also found it helpful to talk about emotional acceptance and relate this, as well as principles of compassion, to current world events and how to cope with this as a community.
What are the key learning points?	• Adapting psychological models to more faith and culturally informed practice, as well as using community models to generate more culturally and socially appropriate groups, which in this case was more discussion-based. • Learn the importance of co-production and learn from clients and the community about what they have to share. A key learning point was that this group was quite large,

	and so making the group longer (e.g., 2 hours rather than 1.5), especially as an interpreter was involved, would have been more helpful.

1.18. 2.5.2.1.4 Community Issues and event responses

Feedback was shared about certain events supported by the Grenfell Team:

In July, GHWS Staff supported the Survivors and Bereaved at a private showing of the play, Grenfell in the Words of Survivors. The National Theatre provided the following feedback after the event:

'Thank you, your support is greatly appreciated!'

'Thank-you so much I found our meetings incredibly helpful; our conversations helped me remain steady'

'I really appreciate the time given. in the way you did, in what must be a very busy role.'

GHWS staff supported the Tate Britain with the opening of a new artwork about Grenfell and an artist who lost her life in the fire. Their role was to help the Tate team to offer a trauma-informed approach to introducing the artwork to key individuals prior to the piece being made public. GHWS staff were present on site to support the extended family of the artist and have also supported viewings for key Bereaved & Survivor groups.

Survivors, bereaved and community members verbally expressed thanks for their presence and support to staff members

The Tate Britain provided the following feedback after the event:

"Dear

I just wanted to send a quick note to thank you both very much for all your help in making our community views happen last week and for all your support over the past few months.

We had about 40 people attend across the three days, with the bulk on Sunday. Many of these were residents of the tower or knew 'K' personally. While the work of course produced an emotional reaction, it was received with huge positivity, reinforcing what we heard from community group leads during their views back in July.

On behalf of Tate I just want to say a huge thank you to you both for your invaluable support, as well as to 'R', 'H' and 'S' for their time over the weekend.

As you know we will be opening to the public tomorrow. 'A' will send across a link to the Guardian coverage and we may be in touch in due course if there is scope for us to work together again around this project.

For now, thank you again.

With very best wishes"

Key Learning Points from Tate Britain Event:

Whilst most feedback seems to be positive, there was one group from the community who attended on the Sunday who were less keen for there to be NHS presence there. A learning point from that might be to make sure any new staff are fully briefed on the community/political context before attending events in the community so they know what to expect, and how to act diplomatically in different situations.

2.6 Children and Young People (CYP) work stream

CYP commissioned services aims to offer a holistic approach to meet both the emotional and physical wellbeing of the children, young people and their families.

The aim of these services is to:

- Provide a holistic physical and mental health appointment that looks at the needs of the whole child or young person and understands what matters to them
- Monitor the health and wellbeing of each child or young person over multiple years
- Provide a coordinated call and recall response that sits as part the health offer within the Dedicated Service (for survivors, bereaved and walkway residents)
- Provide health promotion support and advice to increase knowledge and understanding of physical and mental health conditions and how to prevent and/or manage them
- Signpost or refer to an appropriate service (i.e. GP, mental health provision, specialist acute paediatric service, third sector support services)

Engaging local CYP to:

- Ensure that CYP impacted by the fire influence the design and delivery of the health and wellbeing service provision.
- Support the ICB with developing and guiding our engagement with social media strategy

Details of the services can be found in the Primary Care, Specialist Services and Emotional Health and Wellbeing Sections.

Highlights from 2023/24

- Primary Care
    - Updates to Enhanced Health Checks (EHC)
        - Updated to reflect the changing needs of survivors and bereaved
    - CYP pilot
        - To examine whether existing commissioned services adequately meet the needs of CYP. It will be a chance to improve health literacy of health professionals, CYP and families through effective signposting and referral pathways.
- Paediatric Long Term Monitoring
    - Third Paediatric Long Term Monitoring Service Audit
- Grenfell Health and Wellbeing Service
    - In quarter two of this year, GHWS focused on setting up Discovery College (a Recovery College for young people). This aimed to expand the current offer of workshops to Young People.
    - Increase of Goal Based Outcomes for CYP open cases from 37% to 67%

2.6.1 CYP Services and Activity

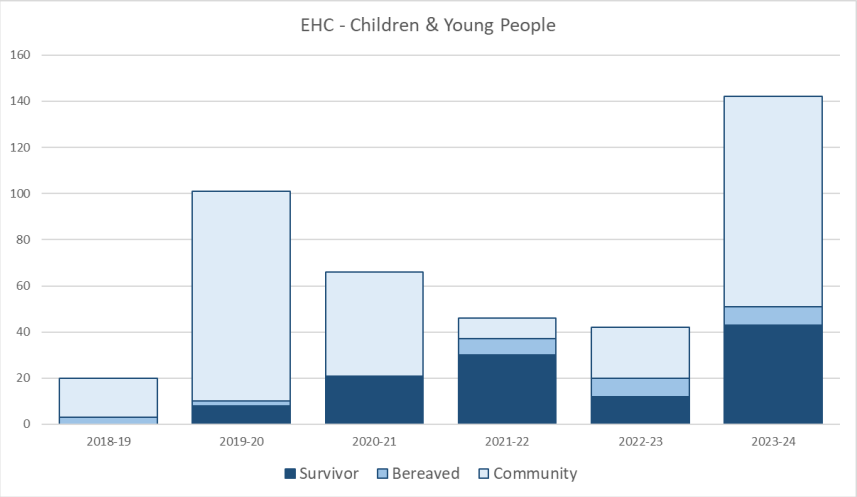
2.6.1.1 Primary Care Enhanced Services

- There was an increase from 42 to 142 Enhanced Health Checks for CYP compared with the previous year.
- EHC uptake numbers in the community via CYP Pilot The pilot started in November 2023. From November 2023 – March 2024 51 children were seen
- The Enhanced Health Check has been updated to reflect the changing needs of survivors and bereaved with a new template added to SystmOne.

- These changes included review of the appropriateness of the free text box to ensure qualitative data is captured
- It was agreed that GPs should have oversight of check, but can allow other appropriate staff to carry out health checks
- Sarah Northey from Grenfell Health and Wellbeing service suggested wording for conversation for questions around trauma.
- Capture feedback from families, why they have come for health check, to capture the various reasons family attend appointments

Activity

There were 142 Enhanced Health Checks completed in 2023/24 compared with 42 in the previous year. This is due to an increase in activity for survivors and the wider community.



In 2023/24 there were 138 individuals who attended EHC's, with 95 attending their first check across all the cohorts.

Patient Type	1st EHC	Yearly EHC	Grand Total	% 1st EHC
Survivor	13	27	40	33%
Bereaved	3	5	8	38%
Community	79	11	90	88%
Grand Total	**95**	**43**	**138**	**69%**

Since January 2019 there have been a total of 417 Enhanced Health Checks for CYP with the majority (275) for the wider community cohort.

Overall, the CYP cohorts shows a 61% uptake in survivors and 55% uptake amongst bereaved

	Number in cohort	1st EHC	% uptake
Survivor (inc residents of Grenfell Walk)	89	55	61%
Bereaved	40	22	55%
Total	129	77	60%

Note: The numbers of bereaved and survivors reported in this table are the numbers as recorded in the Primary Care system (SystmOne) not from the NHS Dedicated Service (DS).

Children and Young People (CYP) Community Project Summary

What is the aim of the project?

The principal aim of this project is to scope the proportion of local children and young people accessing support, identifying unmet needs and any barriers that cause this.

As an opportunity to evaluate the current capacity of services, to examine whether existing commissioned services adequately meet the needs of CYP. A chance to improve health literacy of health professionals, CYP and families through effective signposting and referral pathways.

What is the model of delivery?

A weekly session led by a GP, alongside a trainee GP and a family connector (CYP Link Worker) provided by Family Friends: a local charity set up to support low income families. Offering long-term practical and emotional support via volunteer befriending and mentoring services.

CYP were invited for an enhanced health check- using a newly revised template. Patients were offered a chance to be seen by the CYP link worker, who triaged referral from GP sessions and Child Health Hub MDT, which included M&E and assessment forms. Where appropriate, the CYP was signposted to self-care/ emotional well-being support via Family Friends who supported CYP to access services.

The pilot aimed to see approximately 232 children and young people over a 6-month period, with each session having a maximum capacity to see 8 CYP.

What does the Paediatric Enhanced Health Check (PEHC) involve?

A holistic check on the emotional and physical wellbeing of CYP aged < 18.

The offer includes: BMI check, diet and dental care, physical activity, school attendance, screen time, respiratory & allergies, emotional wellbeing including concerns about mental health such as low mood, anxiety or isolation.

CYP should leave with agreed health goals, discussing any concerns they have or highlighting any areas of lifestyle they would like to focus on improving.

More information about the pilot can be found in section 2.6.2.

2.6.1.2 Paediatric Long-Term Monitoring Service

During 2023/24:

- The service has continued to proactively engage with survivor and bereaved families.
- There has been a reduction of DNAs and an increase in patient uptake up the service towards the end of 2023/24, as can be evidenced by the activity numbers in March, which has continued into April and May.
    - However, there is still more to be done and the team are working with key stakeholders to ensure that all eligible CYP are offered the service, and a process is in place to record declined and deferred.
- Engagement activity is being continually monitored.
- A third service audit took place in November 2023.

Recommendations from the last audit:

- 2022: 'There is a requirement for there to be a method for following up onward referrals to services beyond the Paediatric Long-Term Monitoring Service which are of benefit to the patient'
    - 2023: addressed. After each appointment the Coordinator contacts the families regarding the onward referrals, and often checks in before or after the onward referral appointment. Liaising with other staff members also allows the Coordinator to follow up and to ensure that the families know the time and date of their appointment
- 2022 Develop the 'What Matters to Me' tool to capture what matters to Children and Young People so that it is a regular part of every Paediatric Long-Term Monitoring Service consultation and develop a way to capture this in the clinical record and record progress year on year'
    - 2023: addressed. See section 2.6.2.1.2
- 2022: 'Continue to develop the Patient Reported Experience Measure (PREM) increase the number of Patient Experience feedback collected'
    - 2023: addressed. See section 2.6.2.1.2

A number of other changes were made following the previous audit.

- Redevelopment of patient facing literature
    - The service leaflet has been redeveloped, based on feedback, to allow an improved way of communicating to patients what the long-term monitoring and lung function testing service is and what it entails
- Identifying survivors that have been referred into the service as well as those tower survivors who have not been referred into the paediatric service as per the Survivors list from GTI Phase 1 Inquiry
    - Using the tower inquiry exit list and data collected from the dedicated service, the paediatric long term monitoring service was able to identify all the children and young people in the survivor cohort; and then identify who has been referred into the long term monitoring service and who had not been referred but needed to be seen. Definitive action has been taken and it is established that sufficient monitoring is in place for every child on the Inquiry list.
- Robust categories that differentiate the survivors and bereaved
    - An agreement with North Kensington recovery team was reached to reduce the number of categories that are used to differentiate the survivors and bereaved. Reducing the number of categories to 4 allowed services to be more streamlined
- Standard Operating Procedure (SOP) developed
    - To show process of storing Out of area (OOA) patient letters the service may receive, assuming consent is given from the service user
- Using SystmOne to pull activity data activity
    - The ICHT Coordinator and BI analyst at NKR, are now able to pull and collect accurate data using a reporting feature on SystmOne, this allows the monthly reporting of long-term monitoring data to be accurate and the ability to fine tune any issues relating to figures

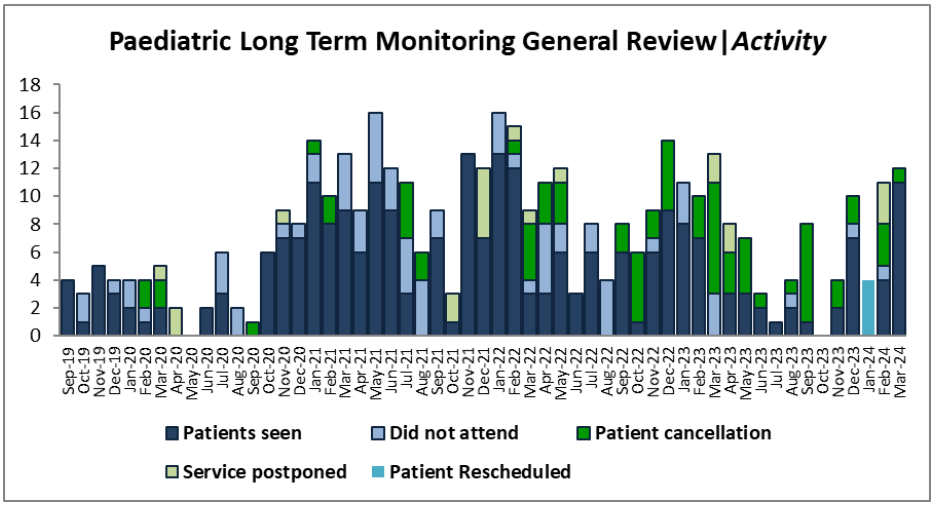
Activity

Paediatric Long Term monitoring activity started in 2019. The service continues to recruit new patients, some from families who previously were unengaged, others from families who have had new births.

Year appointment took place	Appointment 1	Appointment 2	Appointment 3	Appointment 4	Appointment 5
2019/20	18	-	-	-	-
2020/21	41	13	-	-	-
2021/22	39	24	11	-	-
2022/23	9	22	12	7	-
2023/24	7	12	10	1	5

In 2023/24 there were a total of 36 paediatric reviews (1 patient being seen twice in the year) and 6 respiratory reviews. These numbers were less than previous years, there were a large number of cancellations with several parents deferring appointments to the following year.

Following a change in process, there was an increase in patients booked and attended for March 2024, which has continued into 2024/25.



As at March 2024 the total number of bereaved and survivors recorded by the NHS Dedicated Service is 221. Of these children, 158 have been offered, a further 60 is not known and it has not been possible to contact 3.

Of the 43 tower survivors 98% have been offered the service by the Dedicated Service and 98% have been referred into the service (1 has moved to the adult service).

		Referred	Referred %	Seen	Seen %
Survivor in Tower	42	41	98%	38	90%
Survivor Other	80	47	59%	39	49%
Total Survivor	122	88	72%	77	63%
Bereaved	99	54	55%	36	36%
Total	221	142	64%	113	51%

The service has seen 38 of the 41 of the referred tower survivors, 3 have declined, 1 has moved to adults.

Work is ongoing to look at those 88 that have not been referred. Further work is happening with the Dedicated Service to understand the location of those that have moved out of the area, and the uptake of services for these children.

2.6.1.3 Grenfell Health and Wellbeing Service (GHWS) [Regulation 28]

The following section of the report is structured in line with the GHWS 5-part model and includes information from the GHWS Monthly Activity reports, DAPB updates and the GHWS Quarterly report. The latter report gives qualitative details of the GHWS including feedback received each quarter. Some key themes from this have been extracted for the purposes of this report.

More detail can be found in section 2.5 Emotional Wellbeing.

2.6.1.3.1 Information and Self-Care

To ensure that clients and the wider community know how to access the service and how to get the support when it is needed. The GHWS services are promoted in local community newsletters, posters, their website and via social media etc. A number of self-help resources which are available in hard copy and via their website has been developed. This is ongoing work and GHWS continue to refine the information and develop new content as required.

2.6.1.3.2 Early Intervention and Prevention

Workshops

During 2023/24 there were 8 workshops that were specifically run for CYP.

Workshop	Date
Creative Workshop	13/4/2023 14/4/2023
Recipes of Life	02/07/2023
Developing Resilience	22/6/2023
Ways to manage stress and Feel Calmer	28/9/2023
Being kinder to ourselves: Developing self-compassion	02/11/2023
Ways to manage stress and feel calmer	06/11/2023
Being kinder to ourselves: Developing self-compassion	27/11/2023
Body confidence: Loving the skin I'm in	14/12/2023

The feedback for all of the workshops was positive detail can be found in section 2.6.3 CYP Outcomes.

Community Connectors

GHWS has Community Connectors that establish an important link between the community and our service. They participate in different activities within the community and their insight is crucial for developing and improving existing support provision.

(Details can be found in the EWB section 2.5.1.2.3)

2.6.1.3.3 Collaborations

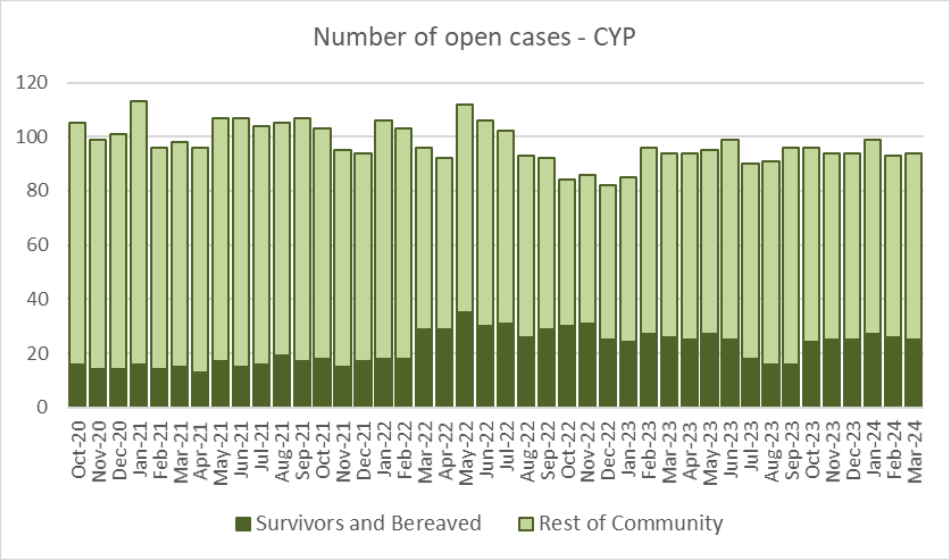
A key element of the work of GHWS is to build and maintain relationships with the local community groups and organisations along with statutory services also working with the North Kensington Community. Details can be found in section 2.5.1.3.

2023/24 collaborations with CYP included:

- Festive Starts and Hearts Arts Project
    - The events, where residents could decorate wooden stars and heart decorations, took place in partnership with many local organisations
    - The decorations were then hung on 3 trees in the Community
- Maxilla Social Club Family Day
    - This was an engagement session with local community members to provide purposeful activity as a means of engagement and for people to access support and information about the service.

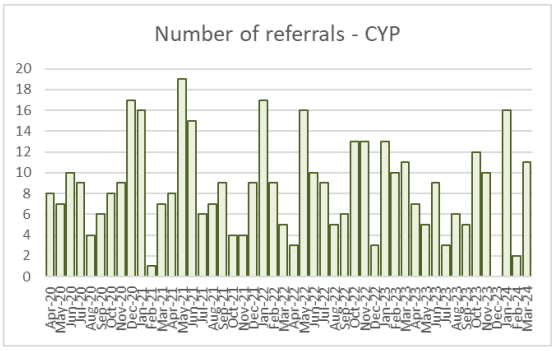
2.6.1.3.4 Interventions

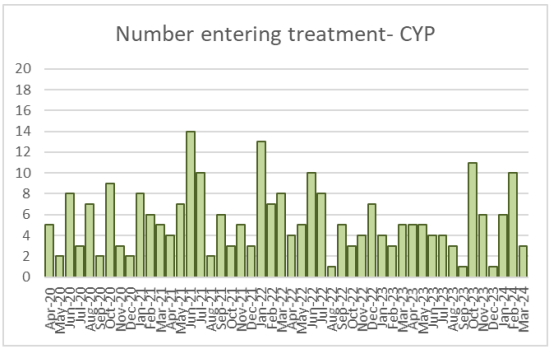
Therapy Activity

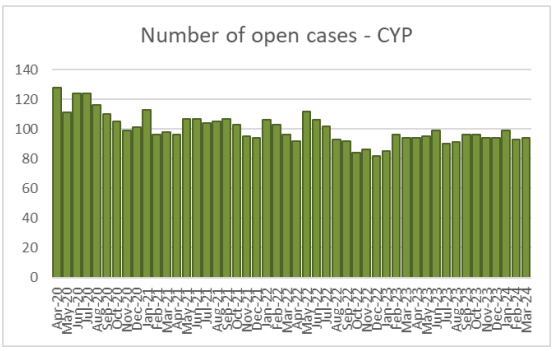


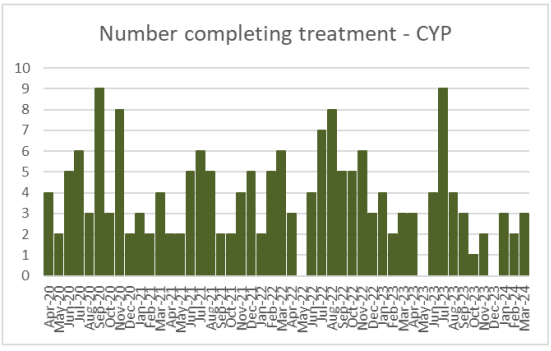
At the end of March 2024 there were 94 open cases of which 25 are from survivor or bereaved families. Additionally, 25 clients are open to DS CYP Therapist that provides long-term emotional support to DS clients.

Overall 97% of children and young people from survivor or bereaved families have been offered the GHWS by the Dedicated Service with 50% accepting. The 3% that have not been offered are not contactable.









GHWS activity numbers fluctuate based on the needs of the community as well as external factors e.g. Inquiry, Tower discussions, news articles etc.

Sessions are not capped as they are in 'business as usual' services, so clients can have as many sessions as needed.

Group work

The number of group work has increased compared to the previous year, which shows an increase in culturally appropriate services delivered in the community.

GHWS offers a range of group work aimed specifically at CYP including:

- Children and Young People's Gardening Group
- Wand Girls Group
    - WAND is a service located in St. Charles Hospital that supports women in isolated and excluded communities through drop-in sessions, outreach services, and networking events.
    - GHWS staff and WAND have co-developed a programme for their Girls Project up with many different staff members from GHWS facilitating the workshops.

WAND GIRLS PROJECT

Programme in partnership with the Grenfell Health and Wellbeing Service

2023 + 2024	
Topic	**Date**
Black History Month with Moyra	11th October
Tree of Life with Sheila & Anjlee	1st November
Tree of Life with Sheila & Anjlee	15 November
CYP Gardening Group with Angela, Jesse and Funeka - planting	6th December
Jewelry Making with Hannah & TBC	28th December
2024	
New Year resolutions with Creative Arts (journaling): Angela + SUITS	17th January
Jewelry making with Jo and Hannah	7th February
Jewelry making with Jo and Hannah	21st of February
International Women's Day with Christie	6th March
Making Presents for Ramadan with Angela—(decorating the pots and using the plants)	13th March
Assertiveness, Boundaries and Confidence Building with Sue	11th April
Body Image Workshop with Sue	1st May
Healthy Relationship Workshop with Sue	8th May
TBC	5th June
TBC	19th June
Excursion to Holland Park to Take Photos with Sandra	3rd July

2.6.1.3.5 Community Issues and Event Responses

GHWS support unexpected occurrences which may be triggering to the community where possible. The support provided is developed collaboratively with local community members who are responding on the ground to manage expectations and provide support where appropriate. More detail can be found in section 2.5.1.5.

Service User Involvement Team (SUIT)

Service User Consultants (SUCs) are involved in various activities and projects within GHWS to ensure that they are listening to and acting upon the feedback received wherever possible to ensure they are providing best service they can. There is an Adult SUI team, a Young People's SUI Team (13 -19-year olds and a children's SUI Team (8-11 year olds), who named themselves the 'Grenfell Young Heroes'.

<u>Young People SUITs</u>

In 2023/24, the Young People SUIT were involved in a number of projects including:

- Lavender walk

- Our Community Inheritance
    - As part of the Clement St James Wellbeing series. A young Suit helped deliver the arts-based intervention as a self- esteem project.
- Banner Making with the Royal College of Art
- The young SUITs were invited to speak at a conference run by the UK Trauma Council, about how school staff can support students after a critical incident.
- Video's with Young K&C promoting awareness of services for young people in the borough.
- GHWS Open Day
- Home is Project
- North Kensington Children's Festival
- **SUITS Feedback:** This corresponded to a concerted effort to get feedback about young people's therapy at GHWS. Two CYP Suits undertook 13 hours of waiting in reception during the second week of September and approached young people or parents and asked for feedback about their views about current treatment.
- **Discovery College Pilot**
- In addition, the SUITs co-ran a session with the WAND team.

Children's SUITs

The children's SUITs are a group of 8-11-year olds from the local community who use their voices to provide feedback and shape the Grenfell Health and Wellbeing Service. The group is called the 'Young Heroes'.

The Young Heroes met for their monthly meetings during the year. Through these meetings the Young Heroes have contributed to GHWS.

- They reviewed the new GHWS Goal Cased Outcome Measure sheets for CYP.
- They reviewed the design and contents of the Children's Therapy Room, as well as Room 10 which is being transformed into a sensory room.

Outside the monthly meetings,

- One Young Hero also came along to the GHWS Open Day, where she helped to co-facilitate the Team of Life taster to a group of attendees.
- Discovery College Project
    - Four young people have attended a one-hour briefing about the Discovery College Project. Each one has attended to shadow the session at Morley College with a view to contributing for five minutes in the next session.
- The young people spent December's SUIT meeting trialing the Mentimeter with a GHWS staff member and approved it for use. They also made recommendations about the handing out of follow-up literature after the session.
- The CYP SUITS have been able to assist and co-facilitate non-therapy groups, and one of the suits showed peer engagement skills with the Wand group on December 6th and at the Winter Warmer, a gardening group event on December 13th.

2.6.2 Outcomes

High Level Outcomes with indicators

The table below details the high level outcomes identified in the HWS for this work stream, alongside the agreed indicators and methods of measurement.

High Level Outcome	Proposed Indicator	Proposed method of measurement
1. CYP and families are better equipped to manage long-term physical and mental health conditions, self-manage simple illness and improved confidence to access local services Short or long term impacts are identified, information shared with providers and services commissioned	1. Improvement in CYP health Better capturing of those with poor health issues to ensure they are higher prioritised for early treatment with appropriate referral to allied health professionals Improved self-management of health Young people are supported with transition to adult health services Children gradually requiring less need for acute mental health services and able to develop coping strategies	a. WSIC reporting of health activity linked to Primary Care Enhanced Services b. Report from ICHT c. CNWL outcome measures including qualitative report including case studies, PEQ, goal based outcome measures and measures for transformed services that are being co-developed with the service users
2. The voice of children and young people impacted by the fire influences the design and delivery of health and wellbeing service provision Parents feel better supported by health and social care services to manage their children's emotional needs	1. Better and improved understanding of CYP needs following collaboration and engagement 2. Increase in number of parents who feel they can adequately support their child's emotional and behavioural issues	a. Production of reports based on engagement and how information is used to inform decisions b. Data from commissioned services and community feedback c. Feedback from parents and professionals who attend specialist training
3. Improve health literacy and knowledge of health provision and benefits so CYP and families can confidently access a consistent model across the PCNs delivered through a range of providers	To be developed	a. Report following Children and Young People (CYP) Community Project Summary More development needed

Summary

1. **CYP and families are better equipped to manage long-term physical and mental health conditions, self-manage simple illness and improved confidence to access local services**
   Short or long term impacts are identified, information shared with providers and services commissioned

A number of measures have been put in place across the different services to evaluate how the services are delivering against these outcomes.

WSIC reporting of health activity linked to Primary Care enhances services

During 2023/24 there has been an increase in the uptake of Enhanced Health Checks by the bereaved and survivor CYP cohort. An increase from 47% to 62% uptake for survivors and 46 to 55% of the bereaved cohort.

Work has been undertaken to extract and analyse data captured during the EHCs focusing on a number of measures with no findings. Further measures have been identified for further investigation. Due to the small underlying numbers the overall number of onward referrals are low so there is little that can be concluded from this analysis.

The onward referrals and outcomes from these referrals will be looked at in more detail as part of the Primary Care quality and clinical audit which is scheduled to begin in early 2024/25.

Report from ICHT

The Service completed a full comprehensive third audit in December 2023.

- The audit identified a number of health concerns and themes across the patients that they have seen.
    - The mental health burden is significant for children in this service.
    - Respiratory concerns from patients and families have persisted following the fire, although perhaps not in as many families as might have been expected, given the immediate effects of fire and prevalence of concerns in this community.
    - Common health issues arising from the consultations are the need for vitamins (especially vitamin D) and advice around a healthy diet. Vaccine uptake is low.
- The service acts as a health advocate for the individual child and their families
- It identified what is working well and should be continued within the service.
    - The service is a comprehensive, face-to-face service which provides an opportunity for patients to discuss their concerns and for clinicians to **provide a holistic appr**oach to their care.
    - The ability for patients to choose a **time that is convenient** for them
    - The coordinator has built **strong relationships** and created **a point of contact for patients**
    - The new template developed following the first audit has helped to make **discussion of wider child health indicators** a regular feature of the consultations.
    - The **social prescribing packs and resources** have worked well in terms of sharing information around activities, services and organisations available in and around the community.
    - **Continuing to monitor** for long-term adverse respiratory outcomes is an important priority of this service.
    - It is clear that health and wellbeing needs change over time and the service needs to remain flexible to address those changing needs.
    - The evaluation illustrated the importance of building trust and working WITH families
- The service designed a Patient Reported Experience (PREM) from, using patient and parent feedback.
    - The overall feedback from the patients and parents is very positive.

- The service developed a tool to capture what matters to CYP attending the clinic. It allows clinicians to understand what matters to young people and what they would like to achieve from their appointment.
  What matters to me feedback:

    - A majority of children and young people rated the WMTM for as excellent
    - The form allows children and young people to share what is important to them apart from just health
    - Allows joint conversations to be had with families and professionals

  The feedback showed that overall families have a positive experience and are happy with the care they have received.
- There were a number of improvements identified by the service including:
    - Increasing the numbers of Patient Feedback collected, continue to develop the PREM and What matters to me tool.
    - Families find it hard to navigate the system – ensure that families are aware that an Enhanced Health Check is not a replacement for a LTM appointment.
    - Increase social prescribing for all patients.

The CYP work stream lead has worked with the Imperial team to agree what can be reported regularly against the outcomes identified by the community within the parameters of their IG and data sharing protocol.

- Patient feedback as it is an important element of this service.
- Report emerging trends. Supporting the communication of data and emerging trends with key stakeholders and the communities.
- Supporting with addressing any emerging health trends/needs with raising awareness.
- Provide additional activity data, including onward referrals

<u>CNWL Report</u>

- CNWL report positive outcomes for their services across all parts of their five-part model, evidenced by case studies, feedback and outcome measures, detailed in section 2.5.2.1, which demonstrate the diversity of the work delivered by the service
- All workshops and group work collect feedback forms which give positive feedback on the sessions. Work needs to be done to identify ways of measuring the health outcomes of these services.
- Goal based measures (GBM) have been in use for CYP since 2021.
    - Out of 112 cases, 73 (66.7%) have goals set. This is an increase of 40% compared to March 2023, for 24 open cases GBM are not relevant or appropriate.
    - For goals where multiple scores are recorded the majority have resulted in either improvement or goal achievement.
- In the year ahead more work needs to be done to identify and implement measureable outcomes for group work and workshops.

2. The voice of children and young people impacted by the fire influences the design and delivery of health and wellbeing service provision
Parents feel better supported by health and social care services to manage their children's emotional needs

<u>Production of reports based on engagement and how information is used to inform decisions</u>

During 2023/24 a number of engagement and community events were attended and supported by the NKR work stream lead including:

- Child Health Advice and Tips (CHAT)
- Early Help Partnership
- CYP Health Partners sub meeting
- Healthwatch Young People's Mental Health coproduction event
- CYP listening workshop hosted by West London zone

This resulted in a number of insights. These insights have fed into the NKR business case.

There is limited evidence on how these insights are used further to inform decisions. In the coming year an improved process is needed to enable evidence to be recorded. Further detail can be found in section 2.6.2.1.3.

Data from commissioned services and community feedback

As detailed in the summary 1. Both GHWS and ICHT receive Patient Engagement Questionnaires and engage with CYP. They listen and use this feedback to improve the delivery of their services.

Feedback from parents and professionals who attend specialist training

There has been limited training in the past year and there has been no reported feedback.

3. Improve health literacy and knowledge of health provision and benefits so CYP and families can confidently access a consistent model across the PCNs delivered through a range of providers

Work needs to be done to identify appropriate further indicators and measures to measure health literacy, looking at best practice, engaging with the community and linking with other services across the whole programme to see how to work with them.

The Children and Young People (CYP) Community Project (see section 2.6.1.1) has one of its aims to improve health literacy. It will collect direct feedback from CYP about their experience of services commissioned.

The final report is not yet available so the analysis has not yet been undertaken to show whether this was one of the positive outcomes from the project.

2.6.2.1 CYP Outcome and Feedback detail

2.6.2.1.1 Primary Care Services

Onward referrals from Enhanced Health Checks

The CYP cohort is relatively small, resulting in a smaller number of Enhanced Health Checks (EHCs) being carried out and therefore a limited number of onward referrals. 2022-23 did not show a significant number of onward referrals following an EHC. Below is a table showing the five most common onward referrals for CYP patients following an EHC in 2023-24. Due to the small underlying numbers data from survivor, bereaved and community patients has been combined.

CYP Patients (2023-24)
Referral to Secondary Care Specialist
Mental Health

Although we have combined all patient types, the overall number of recorded onward referrals are low. It is important to note that Survivors and Bereaved within the CYP cohort have access to the Paediatrics Long-Term Monitoring Service (Paediatrics LTM) and have been seen there.

The onward referrals and outcomes from these referrals will be looked at as part of the Primary Care quality and clinical audit which is scheduled to begin in early 2024/25.

CYP Pilot - Children and Young People (CYP) Community Project Summary

What are the proposed outcomes of the health checks?

Being able to collect direct feedback from CYP about their experience of services commissioned, potentially reducing late presentation of CYP in crisis to services and in need of acute services.

The project also allows a measure of emotional and physical wellbeing of CYP pre and post-intervention, providing early intervention and robust signposting to services. This will streamline the pathway available for CYP to get support, optimising the capacity of practices to meet a greater proportion of demand.

Initial Feedback and data analysis

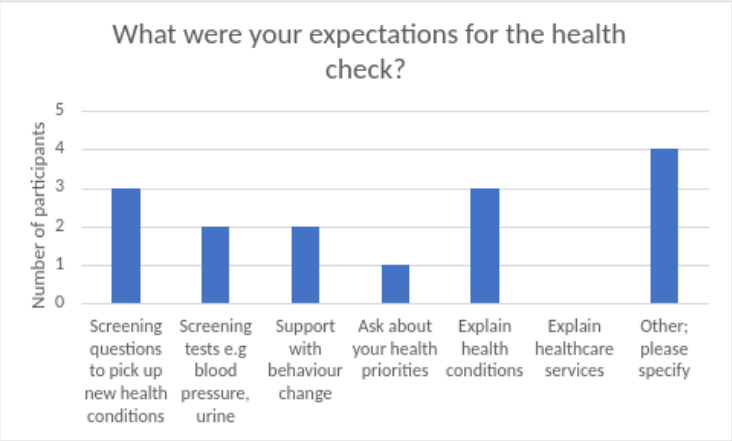
1.1 Measure of Spread comparing the benefit of separate sections of the enhanced healthcare visit (Q7)

Not enough data to do relevant tests

	Play area/ Prehealthcare	Time with doctor	Time with family friends
Mean (/100)	95.5	97.3	76.9
Median (/100)	100	100	100
Mode (/100)	100	100	100
Min (/100)	80	80	0
Max (/100)	100	100	100
Range (/100)	20	20	100
Q3 (/100)	100	100	100
Q1 (/100)	95	100	90
IQR	5	0	10
Stdev	7.6	6.0	42.1

1.2 What were your expectations prior to the appointments?

Participants had the opportunity to choose as many expectations as applicable. The people that chose 'other' either said they came for a checkup, or they did not have any expectations prior to the appointment.

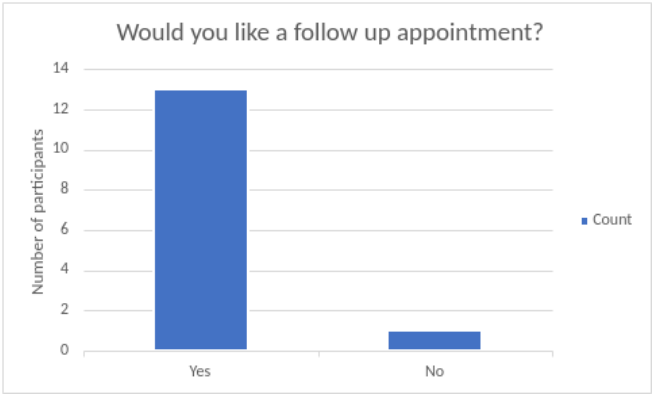


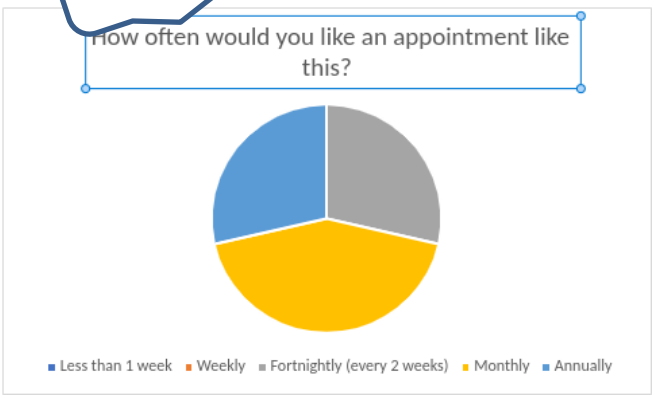
1.3 Was your expectation met?

Most people said their expectations were met and the people who said they were not met also described not having any expectations of the session in the first place.

Was your expectation met?	Count
Yes	8
No	2
Grand Total	**10**

1.4 Would you like a follow up appointment?





1.5 Distribution of people who filled out the survey (Q15)

The participants of this study included children from age 1 – 20.

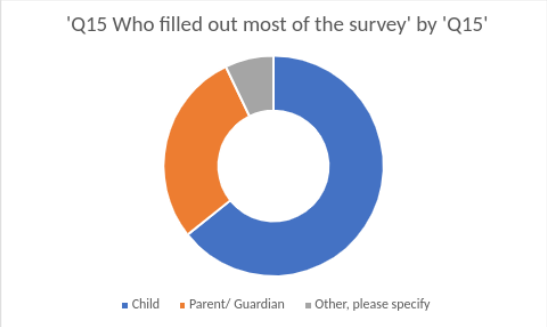
The 20-year-old did not feel adequately described by 'child' and chose 'other'; young adult.

The highest age of the participants that had a parent or guardian fill out the survey was 8 years old.

All nursery children included and children with special educational needs had their parent/guardian fill out the survey. However, the divide was not clearly between primary and secondary school children.

There was little variation between the responses when a child filled in the survey in comparison to when a parent/guardian filled in answering question 7.

The difference was seen in Q11 & Q12 when asking for feedback on what could be changed. The parents/ guardians were more likely to complain about waiting times (2) and the general timing of the appointment (2) while the children were more likely to complain about the lack of variation in the play area such as lack of comics or age-appropriate activities (5).



2.6.2.1.2 Paediatric Long Term Monitoring Service

Paediatric LTM Audit 2023

The Service completed a full comprehensive third audit in December 2023. Key highlights are below:

This service allows for direct medical concerns and general health and well-being concerns to be addressed. Analysis indicates that:

- The mental health burden is significant for children in this service.
- Respiratory concerns from patients and families have persisted following the fire, although perhaps not in as many families as might have been expected, given the immediate effects of fire and prevalence of concerns in this community.
- Common health issues arising from the consultations are the need for vitamins (especially vitamin D) and advice around a healthy diet. Vaccine uptake is low.
- The service acts as a health advocate for the individual child and their families.
- Patient feedback is an important element of this service and continual improvement and cycles of change are required to meet the needs of the children of the survived and bereaved from the Grenfell Community.
- Joining the CC4C Child Health GP Hub MDTs allows integrated working between professionals. As a result, professionals are able to work cohesively and provide patients with the best care and ability to navigate the healthcare system.

The evaluation identified what is working well and should be continued within the service:

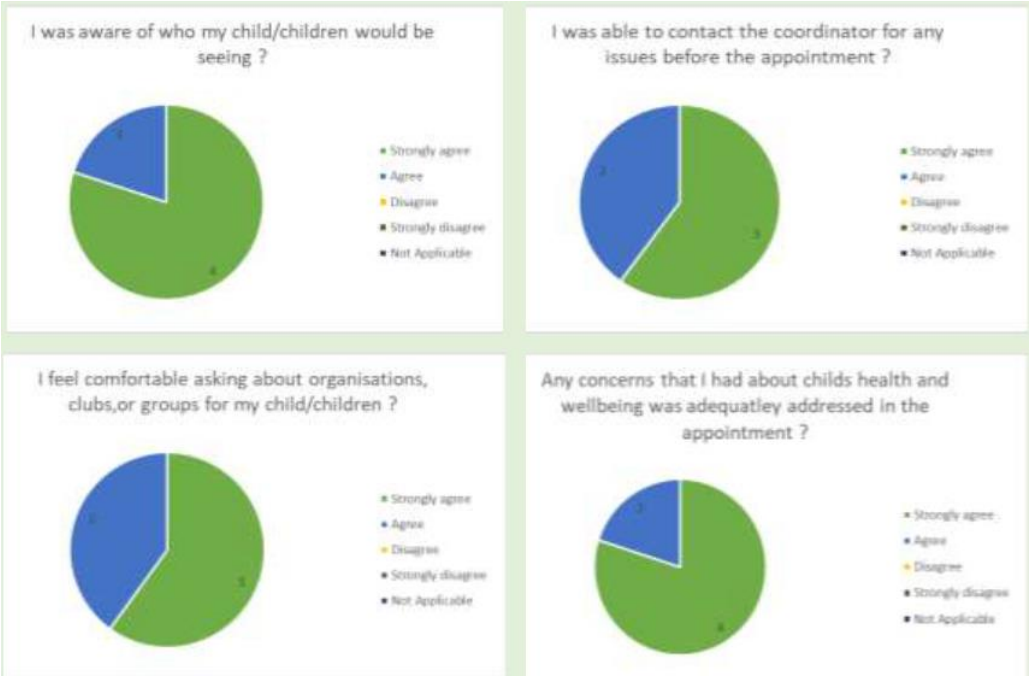
- The service is a comprehensive, face-to-face service which provides an opportunity for patients to discuss their concerns and for clinicians to **provide a holistic appr**oach to their care. Allocating 60-90 minutes to each appointment is fundamental to the ability of the service to provide high quality, complete care for each child.
- The ability for patients to choose a **time that is convenient** for them to attend their appointments allows families to make suitable arrangements after school.

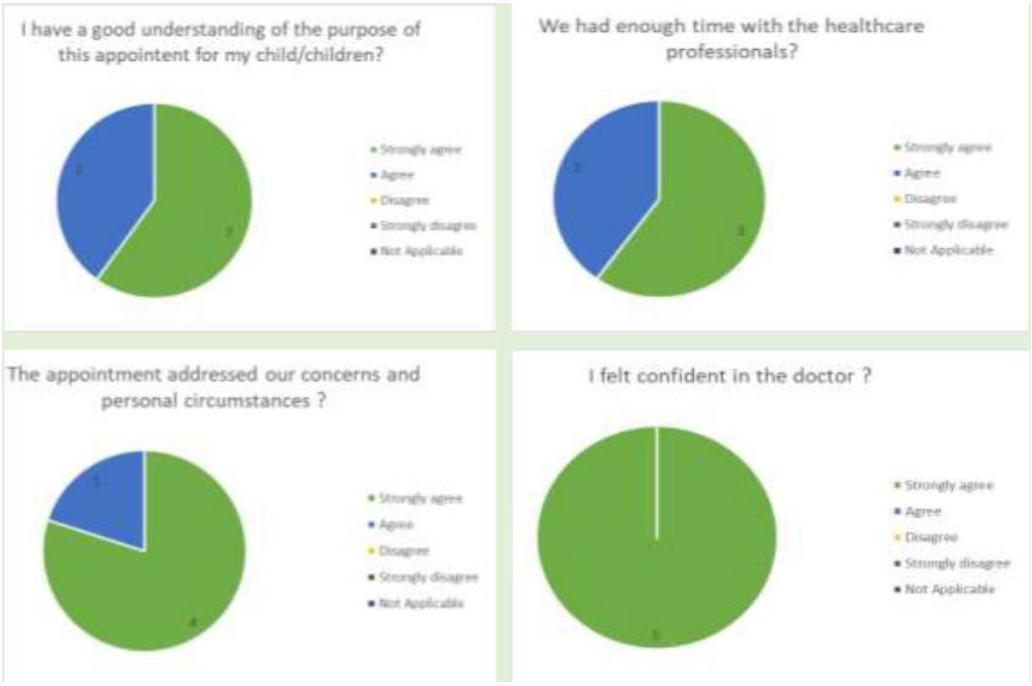
- The coordinator has built **strong relationships** and created **a point of contact for patients** and their families before and after consultations. This allows for reliable and efficient communication even in instances where an appointment has been deferred, or the family have queries or specific requests.
- **Care is coordinated well** between different health professionals with adequate record keeping between GP and specialists.
- The **coordinator being present at clinics** has received positive feedback from a majority of families who have attended, who say that they like being able to put a face to the person who has been contacting them via phone and email.
- The new template developed following the first audit has helped to make **discussion of wider child health indicators** a regular feature of the consultations.
- The **social prescribing packs and resources** have worked well in terms of sharing information around activities, services and organisations available in and around the community.
- The coordinator sourced **toy donations** which consist of toys, books, colouring resources and activities relevant to children and young people. These donations have helped to allow families to speak in depth with the consultant whilst children are occupied and having fun.
- **Continuing to monitor** for long-term adverse respiratory outcomes is an important priority of this service.
- It is clear that health and wellbeing needs change over time and the service needs to remain flexible to address those changing needs.
- The evaluation illustrates the importance of building trust and working WITH families

<u>Patient Feedback</u>

PREM form

The service designed and developed a Patient Reported Experience (PREM) form, using patient at parent feedback. The overall feedback from patients and their parents is very positive. (Feedback from PREMS forms over 12 months)





Written patient feedback:

Was there anything about this appointment that you thought was good?	Was there anything that you thought could have been better?
"It was good to go over all aspects of my child's health and wellbeing, our concerns and have them checked over"	"No, I thought the service was good and covered all our concerns"
"Very good"	
"Yes, seeing caring team"	"Everything was perfect"
"Lots of time with Dr Mando, very attentive, GP joined via zoom"	"Everything was perfect"
"Dr Sharon played with children and spoke to them individually"	"N/A" "Nothing "

"What matters to me": Shifting the focus from Paediatrician to Patient

The service developed a tool to capture what matters to Children and Young People (CYP) attending the clinic. The development of the 'What matters to me?'(WMTM) tool aligns with the ethos of the long-term monitoring service and allows clinicians to understand what matters to young people from their perspective and what they would like to achieve from their appointment

- During the consultation, the paediatrician uses the WMTM tool to capture what matters to the service user.
- The tool encourages young people to express what matters to them and the service considers, with the family, practical steps to support this
- The young person's area of focus will be reviewed with the paediatrician at the subsequent clinic appointment

What matters to me feedback:

- A majority of children and young people rated the WMTM for as excellent
- The form allows children and young people to share what is important to them apart from just health
- Allows joint conversations to be had with families and professionals

What did the feedback show:

Overall, families have a **positive experience** and patients are happy with the care they have received

This service provides an opportunity to discuss concerns that extend beyond direct clinical needs and so in partnership with the clinician, **productive targets can be made**

Communication between families and professionals has improved, due to better **coordination of the service**

The case study shows that the availability of these annual health checks means that they **feel more secure** about their health concerns as they are aware that they will be seeing a professional to discuss this in a timely manner. They are also able to **build a rapport** with the clinician which is important for **building trust**

The implementation of our 'What Matters to Me' tool is a method to increase the **productivity of the consultation** and provides Children and Young People an opportunity to discuss their priorities and set goals in order to achieve this

Recommendations for improvements:

- Increasing vaccination uptake in patients in this service should remain a priority in the coming year
- Families find it hard to navigate the health system. The recent efforts to increase uptake of the Enhanced Health Checks has the potential to confuse families and lead to reduced engagement with Paediatric Long-Term Monitoring as a result. Proactive steps should be taken in the coming year to inform all families that having an Enhanced Health Check is not a replacement for a Long-Term Monitoring appointment
- Patient feedback:
    - Continuing to develop the **Patient Reported Experience Measure**
    - Increase the number of Patient Experience feedback collected
    - Develop the **'What Matters to Me**' tool to capture what matters to Children and Young People and make it a regular part of every Paediatric Long-Term Monitoring Service consultation
- Increase breadth and depth of **social prescribing for all patients** and develop a better method to assess the effectiveness and utilisation
- of this offer
- Develop clinical record keeping tools that will help future audits and service reviews to improve consistency of data reporting

<u>Reported Outcomes</u>

The NKR CYP lead has initiated conversations with Imperial Paediatric Long Term monitoring team, to finalise and agree what can be can reported against the outcomes identified by the community within the parameters of their IG and data sharing protocol.

The following outcomes have been agreed:

- Patient feedback as it is an important element of this service. Continual improvement, and cycles of change are required to meet the needs of the children of the survived and bereaved from the Grenfell Community
- Report emerging trends and supporting the communication of data and emerging trends with key stakeholders and the communities.
- Supporting with addressing any emerging health trends/needs with raising awareness for example. Low vaccine uptake in this cohort has been identified, there will be targeted community outreach via Connecting Children for Care initiate for clinicians to host and attend community activities to share health promotion messages and engage in questions and answers sessions
- Provide additional activity data, including onward referrals

2.6.2.1.3 GHWS Feedback and Outcomes

The following section is structured in line with the GHWS 5-part model. It details some of the outcomes recorded and feedback received for the CYP specific GHWS.

Early Intervention and Prevention

Workshops

During 2023/24 there were 8 workshops that were run for CYP. The feedback from all workshops was positive. The feedback on how to improve the workshops has been fed back and the workshops have been amended accordingly.

The following details some of the feedback received for the workshops.

Recipes of life

Name of Workshop	Recipes of Life
Dates Run	02/07/2023
Location	St Quintin's Centre for Disabled Children and Young People
Number of attendees	N/A
Number of surveys collected (where appropriate)	6
Demographics of attendees where possible	N/A
Feedback Survey Responses	
Did you find this workshop helpful? (0 – Not at all helpful; 5- Very helpful)	**Would you recommend this workshop to a friend or family member?** (0 – Not at all helpful; 5- Very helpful)
• Rate 0: 0 • Rate 1: 0 • Rate 2: 0 • Rate 3: 0 • Rate 4: 2 • Rate 5: 4	• Rate 0: 0 • Rate 1: 0 • Rate 2: 0 • Rate 3: 1 • Rate 4: 1 • Rate 5: 4
What did you like about the workshop?	**What could we do to improve the workshop?**
• "Baking and doing other fun activities. The statues activity was also quite nice."	• "More games and activities that take your mind of things."

• "They are kind. We do fun things. We get to play outside." • "I liked how in all activities, we all worked together. I liked how we negotiated our ideas together in groups. I especially enjoyed our team work together in the kitchen." • "I liked that the workshop was inclusive for all age groups and that we were able to do different activities. We were able to express ourselves through different things, e.g. cooking and postcards. GHWS staff were very understanding and taught us many things. I really recommend this workshop for others." • "Fun day!"	• "More outside activities and games. I wish the best for the trampoline as I would love for it to work." • "I think that we could play more games and things that would pump our energy." • "Play more games."

Discovery College

Developing Resilience (22 June 2023)

- The feedback from the young people was very good and the young people gave a list of topics for future workshops.

Name of Workshop/Group	Developing Resilience
Dates Run	22/06/2023
Location	The Clement James centre
Number of attendees	9
Number of surveys collected (where appropriate)	9
Demographics of attendees where possible	N/A

Feedback Survey Responses	
How would you describe the value of the workshop for your own wellbeing?	**Was there anything that you found particularly helpful?**
• Excellent: 5 • Very Good: 2 • Good: 2 • Some Value: 0 • No Value: 0	• "All of it!" • "Developing resilience help us to deal with different situations in life." • "Discussions of strategies for developing resilience." • "Strategies and how everyone were so involved in sharing." • "The breathing exercises." • "Very informative! Good for people to say what they feel." • "How to be resilient." • "Learning coping mechanisms and being able to share." • "How to cope with difficult situations'"
Is there anything you would like us to do differently to help you learn in this workshop?	
• Workshop being a bit longer • More discussion time	

Ways to manage stress and Feel Calmer (29 September 2023)

9/12 who fed back rated the value of the workshop for the wellbeing very good or excellent. All of those who feedback rated it at least good.

Name of Workshop/Group	Ways to manage stress and Feel Calmer
Dates Run	28/09/2023
Number of attendees	12
Number of surveys collected (where appropriate)	12
Demographics of attendees where possible	Young people: 16-18 years old
Feedback Survey Responses	
How would you describe the value of the workshop for your own wellbeing?	**Was there anything that you found particularly helpful?**

• Excellent: 3
• Very Good: 6
• Good: 3
• Some Value: 0
• No Value: 0
	• Approaches to reduce your stress, such as:
	  ○ Breathing exercises
	  ○ Painting
	  ○ Going for walks
	  ○ Lavender bags

Is there anything you would like us to do differently to help you learn in this workshop?	
• More group activities or debates. • Interactive activities so we can get a better understanding.	

Collaborations

The collaborations that reported feedback all gave very positive feedback. This is detailed below. With the learning points fed back for future collaborations.

Festive Stars and Hearts Arts Project

Festive Stars and Hearts Arts Project	
Which outcome measures were used?	Online Feedback form
What verbal/informal feedback did you receive?	• An online survey was sent to the organisations who participated to get their feedback. ○ A total of 7 organisations replied and the feedback shared is summarised below.
	• Event rating: all organisations were quite happy with this initiative, as shown by the high rates given. All gave it a rating of 4 or 5.
	• How supportive GHWS staff were with this event o "Amazingly supportive. 'S' came to visit us before the event and made sure we had everything we needed to make the project a success." o "Hugely grateful for their continued support and dedication in involving local community groups to take part in such an important project." o " 'S' did a brilliant job of organising the event."

	○ " 'S' was informative and resourceful. She provided the equipment and made it easy for us to complete. The children really enjoyed making the decorations." ○ "Very." ○ "Very supportive." ○ "Very supportive, clear communication and organisation from the GHWS staff."
	• <u>What went well</u> ○ Event planning and delivery. ○ GHWS supplied most of the materials need and created a welcoming and supportive atmosphere for people to get involved in the event. ○ The collaborative aspect of walking with residents through the process of making the stars and other shapes. ○ Bringing the community together.
	• <u>What can be improved:</u> None of them would have changed or improved anything.
	• <u>Redo event with GHWS next year – 2024</u>: All organisations mentioned that they would be keen on repeating the Festive Stars and Hearts Project.
What are the key learning points?	• Using the same poster templates as last year and advertising well in advance was beneficial. • Making a data spreadsheet beforehand was an excellent idea. • Sticking to between 8 and 10 organisations is probably the most we should commit to. • It is important to have some projects south of the Borough • Less is more: 4 hours are not always required for open events.

Maxilla Social Club Family Day

Kensington Christmas	
Date of session(s)	21/12/2023
Duration of session(s)	3h
Number of attendees	50
Which outcome measures were used?	N/A
What verbal/informal feedback did you receive?	• The session included bracelet beading, filling lavender bags, creating hearts and stars decorations. • Voice recorded comments from children: ○ "I like it because you are customising." ○ "I liked it because I can make presents for my friends who are here with me." ○ "I like making bracelets because it is fun and I like making them for my friends."

	○ "It was very fun and very creative." • Adult voice recorded comments: ○ "It is for my daughter and I like the idea of creating something for her." ○ "I always did this kind of thing back home so I feel very relaxed." • Informal comments (not recorded) were that participants gained satisfaction from creating something that they could gift to others. Friendship and sibling groups joined, and the activity enabled connections, sharing amongst others, and helping each other.
What are the key learning points?	• The session was much more popular than anticipated, with a wider age range from pre-school children up to teenagers and adults. Initially, it was booked for a one-hour slot. However, upon arriving early, once we started setting up the tables, people joined right away, and the session extended until the end of the afternoon. • Bracelet beading: if offered again at a larger event, small trays are needed to prevent beads on the floor. For mixed-age events, some larger beads would be needed for younger children and elastic that is easier to tie. • Due to the popularity of the session, additional materials for alternative activities would have been helpful, e.g., more lavender for the bags, and although hearts and stars had not been requested, the few that we took proved very popular, so we could have offered more. • Three staff for this session was the minimum due to the range of ages and the level of assistance needed with the bracelet making. • Due to how busy the event was, feedback was difficult to obtain from everyone, but if offered in the future, we would ask for a spoken or written comment from each participant before they leave the session. Ideally, a quieter space at the side of the event would have enabled more discussions and allowed the session to provide a more relaxing, focused space.

<u>Interventions</u>

Therapy

Therapy Outcome Measures

The GHWS use outcome measures across the service to assess a service user's current status and to use this as a baseline to enable progress to be monitored. The outcome measures are specific to the interventions we offer our clients and are different for children and young people and adults.

Goal Based Measures (GBM)

Grenfell service has officially been using goals since October 2021 for CYP clients and they have been set up for current open cases, when appropriate.

Every case, whether new or ongoing, on the GHWS staff's caseload undergoes an active review to verify the completion of a goal-based measure. Goals may not be applicable in certain circumstances, such as when a client declines the offer of goal recording or when the client's work does not justify the use of goals. The clinical system records such instances as 'GBM not relevant'.

In January 2024, GHWS set up a GBM QI (Quality Improvement) sub-team to promote and closely monitor goal completion among adults and CYP Open cases so that GBM becomes more prevalent. The expectation was to have 100% of cases that are currently in therapy stages of the IAPTUS Care Pathway with a GBM or 'GBM not relevant' label by the end of April 2024. Despite not yet reaching the 100% target yet, there has been a significant increase in completion during the final quarter of 2023/24.

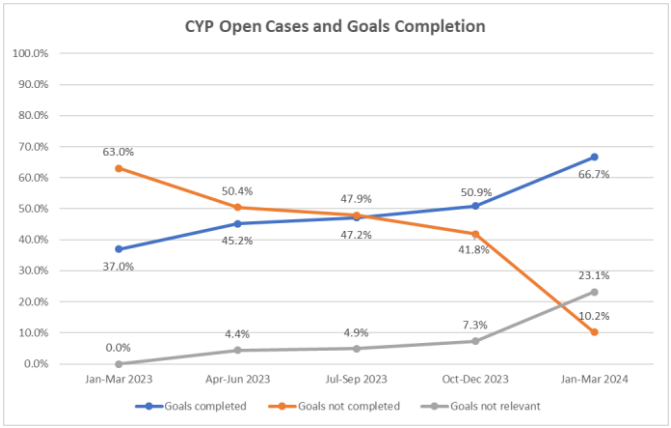
A total of **112** CYP cases that are currently in the therapy stage were considered in the analysis

- 86 cases are open to the CYP team.
- 26 cases are open to DS CYP therapist, staff member specialised in dealing with DS clients.

Out of 112 cases, 73 (66.7%) have goals set. This is an increase of 40% in terms of GBM completion compared to March 2023.

For 24 (23.1%) open cases, GBM are not relevant or appropriate. This corresponds to an increase of 15.8% in 'GBM not relevant' label usage compared to 4.4% in Q1 of this year when this was first recorded.

Staff are reviewing the remaining 15 (10.2%) cases to determine whether or not they can use goals. It is noteworthy that the percentage of cases without goals has decreased by 50% compared to March 2023 when it was 63%.



- Goal completion in CYP cases has continuously increased since 2023.
- From January to March 2023, **37.0%** of CYP open cases had goals defined. Goal completion increased during the April-June 2023 to **45.2%**, compared to **47.2%** during July-September quarters in 2023.
- The increase in goal completion from April to June 2023 was due to the following strategies:
  - GBM guidelines were reviewed and updated.
  - Staff are given additional training.
  - Active promotion of goals among clients.

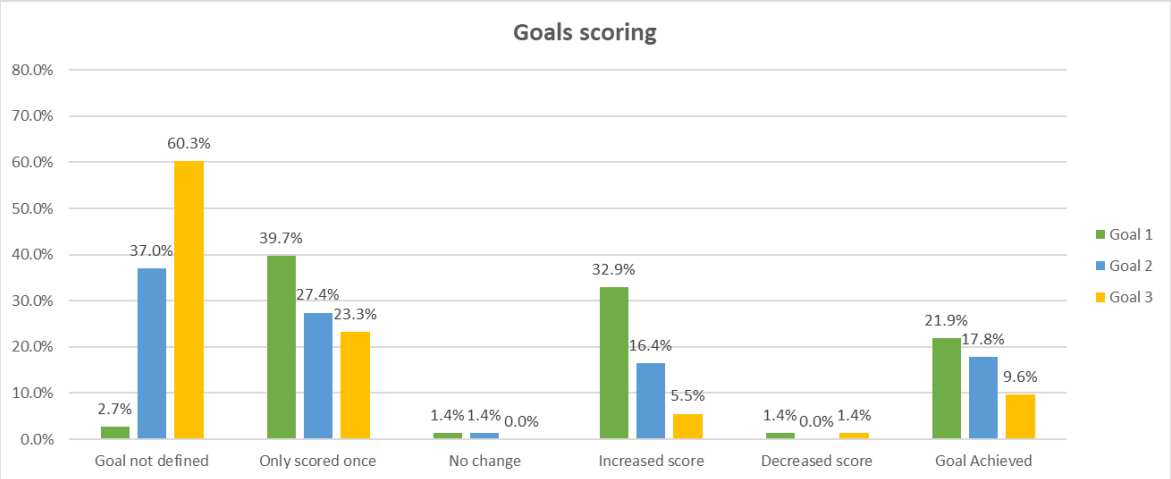
  - The clinical platform has a mechanism to document instances where goals are not suitable or pertinent for a specific case.
- There was a minimal increase (**2%**) in goal completion when comparing both quarters (July–September to April–June 2023). The summer break period, where clients frequently pause therapy provision until school resumes, partially explains this.
- From October to December 2023, there was an increase of **3.7%** in goal completion, and this is thanks to the continued promotion of goal usage among CYP Open cases.
- In Q4 both goal completion and goals not relevant have increased significantly, reaching **66.7%** and **23.1%**, respectively. This is thanks to the GBM QI (Quality Improvement) sub-team, which is promoting and monitoring more closely goal completion among adults and CYP open cases, so that GBM becomes more prevalent.

Goals in CYP cases are defined using an in-built functionality in the clinical platform that enables the set-up and scoring of up to three goals. Goal scores range from 0 = not achieved to 10 = achieved.

We evaluated and classified the goals' outcomes as follows:

- Goal not defined.
- Only one score is available: making it impossible to estimate score variation.
- No change: first and last scores are the same.
- Increased score: goal scores have increased over time.
- Decreased score: goal scores have decreased over time when considering the first and last scores recorded.
- Goal achieved: when a score of 10 has been recorded, which indicates the accomplishment of the goal.

For goals with multiple scores recorded, the majority have resulted in either improvement or goal achievement as shown below.



Other Measures

The Children and Young People's team use the following clinical outcome measures:

- **YCPS (Young Child PTSD Screen):** This is filled in by caregivers for children below 8 years old and aims to identify signs of PTSD.
- **CRIES (Child Revised Impact of Events Scale):** This is a questionnaire completed by children who are 8 years old and above and assesses the risk of PTSD.

- **RCADS-Child (Revised Children's Anxiety and Depression Scale):** This is completed by children who are 8 years old and above and aims to identify anxiety and depression.
- **Current View:** used for CYP of all ages and measures the complexity of the patient's case.

The following case studies show the positive outcomes and the diversity of the work delivered by the service.

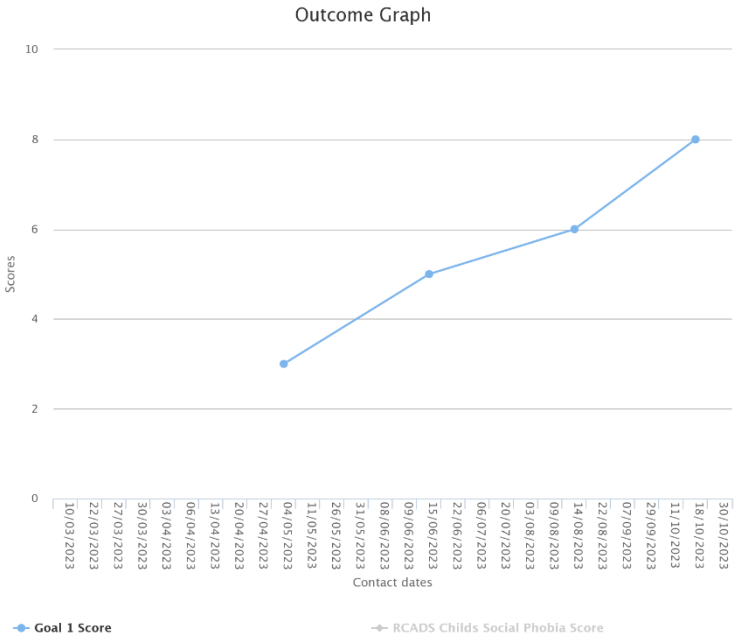
CYP Case Study 1	
History:	**14-year-old boy who did not attend his secondary school for half a term last summer. Lived very close to the tower in 2017 and affected by the Fire.**
Presentation:	Had a disagreement with school in the summer term and stopped attending. There was a risk that he dropped out of school. Then when he tried to return at the end of the term he experienced symptoms of panic and anxiety.
Intervention:	Processed the difficult episode with school with one session of EMDR and a session of a creative therapy with another therapist .Commenced graded exposure to the empty school building in August. He returned to school on time in September. We have a Goal Based Outcome about forgiving those who caused the school absence. Ability to forgive reduced through therapies from an eight to a five.
Outcome:	Returned to school

CYP Case Study 2	
History:	**Young person has experienced multiple losses and adversity in addition to the Grenfell fire.**
Presentation:	Young person presents with low self-esteem, eating difficulties, and difficulties with behaviour and concentration at school.
Intervention:	Multiple integrated offers from the service: mediation for parents in relation to the case that was on hold for a court hearing (this would not usually be provided by NHS services but was in this instance due to the high level of distress and the Grenfell connection). This was provided to help to negotiate how the parental relationship could change and adapt so that court proceedings could potentially be avoided. This was provided in addition to individual therapy for one parent and individual therapy for the young person to process loss and trauma, and neurodevelopmental assessment to help to assess support needs in school.
Outcome:	Sadly, only a temporary Improvement in parental co-parenting approach was achieved. However, the young person continues to access weekly psychotherapy and is engaging well. Neurodevelopmental assessment revealed significant issues with learning, feedback has been given to parent and young person and meeting planned with school to consider ongoing support and adjustment needs.

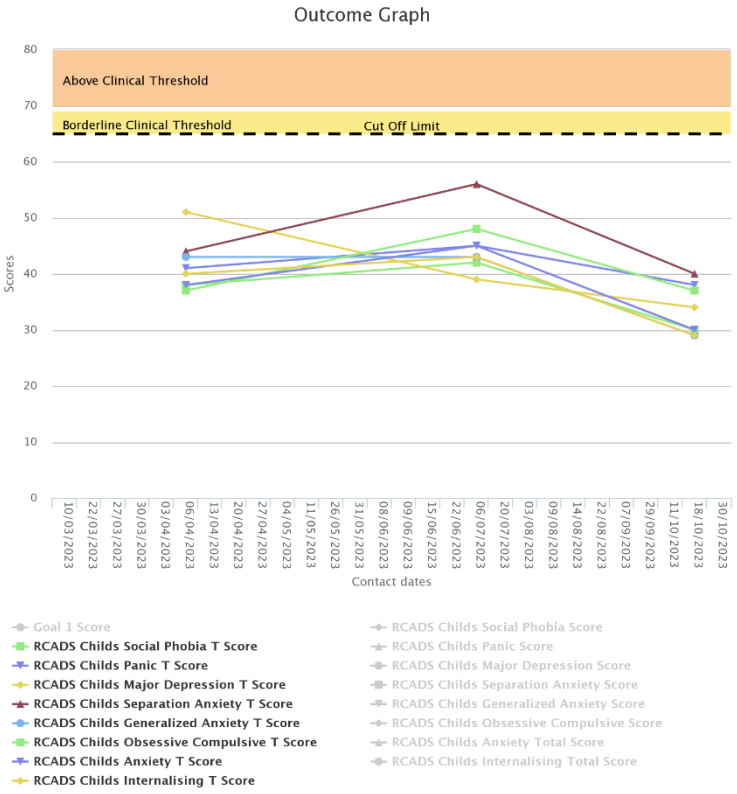
CYP Case Study 3	
History:	**Client lives in the area, knew children impacted by Grenfell and their Mother works in the community. Client is a young carer for their older sibling**.
Presentation:	Client presented with low mood, withdrawn, questioning their faith and emotionally eating.
Intervention:	Integrative therapy: psychodynamic therapy and emotional regulation techniques. 16 sessions total

Outcome:

- Goal Based measure: Client wanted to understand their emotions connected to family dynamics and past experiences. Higher scores in the goal demonstrated progress towards its achievement (maximum score is 10).



- RCADS measure: acquired at distinct times of support provision. RCADS done in an early session was potentially under reporting as the client seemed to minimise and mask their feelings. RCADS scores were higher on a second occasion as client was able to express their feelings and difficulties more easily and then decrease as the support provision took place, as shown in the graph below.



- Client has reported that they feel lighter, happier and less overwhelmed. They stated that they feel that past experiences are tidier and more packed

	away compared to when we started where they felt heavy, messy and spilling out. • Client's mother reported that the client is now more confident, self-aware, open with their feelings and is able to speak with her about things. She also reported that her child is now looking after themselves and has hope for the future.

Group work

GHWS offers a range of group work aimed specifically at CYP. The feedback received for these groups is positive and is detailed below.

Children and Young People's Gardening Group

Name of Group/Workshop	Children and Young People's Gardening Group
Dates Run	Every Wednesday from 4-5pm
Number of attendees	• At most, 5 children at one time. • Sometimes attendance is a bit hit and miss and this is due to a number of different reasons such as sickness, weather, children being tired after school and family commitments. • Parents get sent a text reminder the day before the group or the morning of the group.
Group Activities	
• This season, the children have sown seeds from scratch and we have had some collaboration with the RBKC Community Gardeners who have supported us at times. Examples of what we have grown are: yellow courgettes, aubergines, squash, sunflowers, potatoes, carrots and beans!	
Feedback	
• One member of the group said: "When you see the plants growing and the seasons changing, it feels really nice. Also, you're helping nature because it helps you breathe and gives nutrients to the world. When you eat something, you've planted you feel happier, which leads you to be healthier. That's why the gardening group has helped me a lot".	

WAND Girl's Group

The Girls group ran a number of workshops during 2023/24 most of which were well received. GHWS and WAND are working together on a feedback agreement as the current feedback is limited but any learning points have been fed back. Some of the feedback is detailed below:

New Year resolutions with Creative Arts (journaling)	
Date of session	17/01/2024
Number of attendees	7
What verbal/informal feedback did you receive?	• Received some feedback that journal writing and resolution making were unpopular. This activity shouldn't be done again. • Often, the resolutions they made included things like "accelerating learning". This probably resembled an activity they did at school. • Making bracelets with names was very successful across the age group.

What are the key learning points?	• Don't use a writing activity for an after-school activity. It's too much like school. It's much harder to organise an activity for a multi-age group.

Jewellery making & Interests	
Date of session	07/02/2024
Number of attendees	8
What verbal/informal feedback did you receive?	Verbal comments during the sessions: • In particular, the younger members made bracelets and keyrings for themselves as well as gifts for friends and family. They said that they enjoyed creating something that they could take away with them. • The older girls used the beads to make bracelets for friends who were not there and wanted to have a follow-up session, including earring making. They seemed to value having a space to talk together about school, friendships, and interests.
What are the key learning points?	• It would have been useful to check beforehand what WAND's ground rules are for the group about members coming and going during the session. · • Having a hands-on activity provides a focus and helps with conversations and the different age groups connecting. • Activities need to be able to accommodate various arrival times.

International Women's Day	
Date of session	06/03/2024
Number of attendees	8
What verbal/informal feedback did you receive?	• All of the participants were actively participating in the discussions and activities. • A couple said it was interesting. • Most, including adults, expressed learning some things and thinking of things that they hadn't thought of before, such as human rights and gender disparities.
What are the key learning points?	• Don't offer colouring as an activity to everyone (or not until later in the session), as they'll all take you up on it! • The facilitators had planned to do a couple more activities with the older girls and give the colouring to the younger ones, who were getting restless. Then everyone decided to colour. We eventually did another brief activity together, and we did talk about the themed sheets they were colouring (e.g., famous women's rights people), so at least it was still on topic. • The activity preparation was definitely useful to have done, even though we didn't do a good few of them, as it made the group facilitators more prepared for questions that came up in the discussions.

2.6.2.1.3 NKR Engagement and Learning

During 2023/24 a number of engagement and community events were attended and supported by the NKR work stream lead including:

- Child Health Advice and Tips (CHAT); Attended a session with 15 parents under 5 play group, the session was hosted by a GP.
- Joint meeting with RBKC colleagues (Grenfell Partnership Team), and Primary School Head Teachers.
- Tania Moore Chief Executive of Youth Alliance to talk through the current CYP Grenfell Services and Core CYP mental health offer.
- Early Help Partnership
    - 17th April 2023 provided an update on the Grenfell Health and Wellbeing Strategy
        - Actions were agreed, to reduce duplication there is an intention to map related strategies, to clarify where action is already taken in relation to likely areas of focus for the early help system
    - Workshop on 6th June 2023 the following was discussed:
        - Increased need to empower and support parents to understand the services being offered
- CYP Health Partners sub meeting
- Healthwatch Young People's Mental Health coproduction event
- CYP listening workshop hosted by West London zone
- Review of Thrive implementation plan and look at feedback from CYP on services.

CYP Insights

Throughout engagement, CYP have asked for increased aCcess to services currently commissioned. There has been no request for new services outside the scope of what is currently on offer. There needs to be consideration to how service providers can be supported to increase capacity to meet demand. This will require developing strong interagency collaborative working.
Please note the insights below relate to core CYP services

- CYP Would not like to be defined by Grenfell
- Peer Support to know how and when to access service, support themselves and peers
- Would like Self-referral pathways but also have access to support if they need assistance to build trust to take up referrals
- Employment opportunities
- Support with management of the impact of social media on their mental health
- The opportunity to access mental health in school and in the community to cater for individual needs
- Reduce waiting times to access service
- Improve transition between services and into adult services
- Access to green spaces and safe places to socialize
- Would like to be included in decisions for services being commissioned for school and in the community
- Worried about exams, the future and not being happy in life
- Would like to more self-care provision e.g massage
- Non-traditional forms of emotional wellbeing support, such as sports, music, drama and opportunities for creative expression

Young people's voices are important and need to be heard, especially **groups like NEETS** (people who are not in education, employment or training) as they may be mistrustful of engaging with services. This cohort of young people may have greater vulnerabilities than their peers, with

low health literacy and educational attainment, often inherited (ie: their parents may be in a similar position and not encourage the importance of completing education, to increase their life chances and opportunities in life). The aim is to **empower YP to share their views** and **take a lead** on discussing issues that matter to them.

The plan is to:

- Design engagement to facilitate CYP to **tell us what matters most to them** and help enhance the offer, rather than make assumptions about what they need or matters to them. Engaging with CYP will help **identify gaps and blind spots**, in particular assumptions about ease of access to services and challenges they encounter when trying to access services.
- CYP could be a source of scrutiny and provide insights to **support transformational priorities.**
- Take a whole family approach – especially for those with Special Educational Needs (SEN)

The programme is in the process of procuring CYP expert agency in co-design to support the aims listed above

2.7 Engagement

This section outlines the key highlights of engagement activities in North Kensington for the year 2023-2024.

2.7.1 Health and Wellbeing Refresh Engagement April – October 23

The primary focus of engagement during this period was on refreshing the Health and Wellbeing Strategy to guide future NHS services beyond 2023/24, particularly concerning the Grenfell-affected communities. Various initiatives were implemented to engage survivors, bereaved individuals, and local communities. This engagement phase prioritised both quantitative and qualitative methods to gather comprehensive feedback.

Key Activities for the Health and Wellbeing Engagement:

- Questionnaire and Online Survey: Created to collect input from survivors, bereaved individuals, and the local community. To ensure wider accessibility, survey materials were translated into French and Arabic.
- Survey Narrative Development: Collaboration with the Communications team led to the creation of a narrative explaining the survey's purpose and importance.
- **Engagement with Survivors and Bereaved (S&B)**: Surveys were sent to 600 S&B individuals via their GP practices. One-on-one engagement and telephone interviews were conducted to gather detailed feedback.
- **Engagement with the Wider Community**: A Health Needs Survey was designed and distributed online to gather community perspectives on health needs and priorities. The survey was shared with stakeholders, VCS, community organizations, health partners, and made available on the NHS website. Intensive qualitative engagement was conducted through focus group sessions with community groups and RA residents to gain deeper insights.
- **Documentation and Data Analysis**: Notes from focus groups and interviews were compiled and analysed. A comprehensive report was generated, presenting the results and insights from engagement activities.

Overall, these activities demonstrate a comprehensive approach to engagement, ensuring diverse community perspectives were integrated into planning and strategy development processes.

2.7.2 Cultural Competence training

Following the accreditation of a specialized training program by the Royal College of General Practitioners (RCGP), significant progress has been made in developing and delivering cultural competence training for General Practitioners, focuses on creating culturally competent practices to better serve the diverse population of North Kensington.

The training programme included online training for clinicians in North Kensington. Alongside this, additional training courses have been developed for other staff members working in GP practices, fostering a holistic approach to cultural competence throughout the healthcare system

More information can be found in the primary care section of this report.

2.7.3 Health Partners programme

Efforts to support and collaborate with health partners continued throughout the year through regular meetings and discussions focused on a community-led recovery. Additionally, a special meeting was convened for health partners to gain first-hand information on the work being done for children and young people (CYP) by the North Kensington team. Health partners wanted to find out what support and services were being offered and the level of engagement with community groups that had been undertaken. These engagements ensured that all stakeholders were aligned and actively contributing to the recovery process, with a particular emphasis on the needs and wellbeing of the younger population.

2.7.4 Grenfell Sixth Anniversary 14th June 2023

The community marked the sixth anniversary of the Grenfell Tower fire on June 14th, an important milestone as six years equate to 72 months, the same number of people who lost their lives. Several community events were organized throughout June and on the 14th to remember the victims and pay respects. Our health partners arranged events designed to bring people together for reflection and mutual support. We focused on supporting our health partners and community groups during this difficult period, ensuring that the necessary resources and assistance were available to help the community navigate their grief and continue the healing process.

2.7.5 Promoting Enhanced Health Checks through Community Partnerships

A key achievement was the active promotion of enhanced health checks to our health partners and community organizations, with whom we have built a trusting relationship over time. We created numerous community-based opportunities for the Federation to deliver these checks directly within the community. This initiative was specifically designed to address the issue of low uptake of health checks by the community, ensuring greater accessibility and encouraging more individuals to participate in these important preventative health measures. These checks were set up at Lancaster West RA, WAND Food Banks, Dalgarno centre, Space and Al Manar cultural centre.

2.7.6 Co-designing health services November 23 – March 24

Engagement efforts were centred on planning the community co-design of services for 2024 and beyond, in close collaboration with the community. This involved facilitating a series of community meetings that brought together health partners (HP) and service providers to discuss and strategize the community-led co-design process. These meetings aimed to foster collaboration and ensure that future health service plans were developed in partnership with the community

2.7.7 Rob Hurd visits in NK September 19th, 2023

Considerable time was spent in September preparing for the NK visit of Rob Hurd and Jeremy Benson.

The purpose of the community visit was to strengthen the bonds between the NHS and the local NK communities, assuring them of the unwavering commitment to their well-being. Through direct

engagement and open communication, the visit aimed to address concerns, foster transparency, and emphasise the NHS's dedication to a community-led recovery

2.7.8 Other engagement work

The NK Engagement team collaborated with RBKC Public Health on their JSNA, with a specific focus on gathering qualitative feedback regarding the health needs of the local NK residents. The assessment particularly emphasises the health needs of older people, individuals residing within a 200-meter radius of the tower, and BAME women.

3.0 Next Steps

- Continue to work within the North Kensington Recovery Team with work stream leads and commissioned service providers to improve the data gathered across the programme. Paying particular attention to where there are still gaps in reporting against delivery and outcomes.
- The next iteration of the outcome report for Quarter 1 2024/25 data will be produced by the end of September 2024
- Ensure that outcomes are front and centre with any future planning

This is an iterative process and adjustments to the outcomes and measures will be made following feedback from partners and the community and any changes to services.