Lewisham Community Connections – Interim Evaluation Report

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1. Introduction

In November 2013 Lewisham Council funded a Consortium led by Age UK Lewisham and Southwark to deliver Community Connections (CC). Community Connections is a preventative community development programme aimed at supporting any vulnerable adult in Lewisham who may benefit from services to improve their social integration and wellbeing. Individuals are supported through person centred plans to identify their skills and interests as well as what is important to them. Individuals are then matched to relevant groups and organisations in their local area.

Community Connections also works with local community based organisations to assist in their development and capacity building. This is key to the overall success of the work to ensure that there are strong and sustainable organisations, networks and activities in place so that individual older people and vulnerable adults can access the support and activities they are looking for.

Community Connections is seen as playing a key role in increasing integration of health, social care and community based services, and in working in the borough's four cluster areas.

This report aims to review Community Connections progress over the first 10 months of its work looking at the activities that have been carried out, the numbers of individuals and organisations that have engaged with the service, and the impact and benefits for them.

The original bid had included a proposal for a full project evaluation led by Goldsmiths College. However the final funding agreed did not allow for this, therefore Age UK Lewisham and Southwark (AUKLS) have commissioned this report which is based on the activity monitoring data, survey data collected from participants by the project team and interviews with consortium/delivery partners and stakeholders.

This report will form the basis for a paper to Lewisham Health and Wellbeing Board to:

i. inform the Board of Community Connections progress;
ii. engage partners in discussions about the ongoing development of the project;
iii. highlight issues raised that affect Health and Wellbeing Partners in the borough.

2. Project outline

The original consortium, which consisted of Age UK Lewisham and Southwark, Carers Lewisham, VAL, Lewisham Disability Coalition, Sage Educational Trust, submitted a grant application to Lewisham Council in June 2013. Following discussions with the Community Connections Consortium and with Volunteer Centre Lewisham (VCL) the project was established in November 2013 for an 18 month programme.

VCL are responsible for the recruitment and placement of volunteers as part of the CC initiative and report separately on their activities and outcomes. However there is close working between the CC team and VCL to ensure a co-ordinated approach

The CC programme started in November 2013 aiming to support 1,200 individuals and 40 community organisations over the 18 months.

The project has a team of 9 staff, a Team Leader, 4 FTE Community Support Facilitators, and 4 FTE Community Development Workers. A part time administrator has recently joined the team. All staff are located within Lewisham Council offices at Lawrence House in Catford.

The original bid envisaged that staff would be employed by different organisations in the Consortium. However due to the closure of one key partner since the start of the project (Sage Educational Trust) now AUKLS are the employer for all staff apart from one CSF who is employed by Lewisham Disability Coalition.

Community Support Facilitators – receive referrals, work with individuals to develop a person centred plan to identify their skills and interests as well as what is important to them. Individuals are then matched to relevant groups, organisations and activities in their local area. Each CSF is allocated to one of the four cluster areas in the borough. Their role with individuals is time limited with the aim of assisting people to identify their needs, to find solutions and put in place ongoing activities and support.

Community Development Workers are also allocated to one of the four cluster areas. They work closely with the CSFs to understand the gaps and priorities in each area as identified through individual plans. They are then able to work with local groups and centres to sustain and develop services, and assist with capacity building and creating opportunities. The aim is to strengthen community resources offer to local people.

2.1 Governance

The CC Consortium members meet monthly to monitor development and progress of the project and to consider extending the consortium membership as part of considering development of additional projects.

The CC Steering Group also meets on a monthly basis to review and monitor progress. The membership of the steering group includes Lewisham Council, the CCG, VAL, VCL and Healthwatch Lewisham which enables the group to assist with extending networks, providing information on additional opportunities and identifying local resources and activities.

2.2 Establishing and launching Community Connections

The first staff came into post in November 2013, and following a brief induction period, were immediately at work to promote and publicise CC, receive and assess referrals,

develop and implement Person Centred Plans for individuals and development plans with community organisations. The team needed to promote and introduce the service to ensure a steady flow of referrals. They also set up systems and processes for referrals and delivery of the project, which have continued to evolve over the life of the project. It took some weeks for the office and IT hardware and systems to be established so the team could function to full capacity.

This all meant that at first referrals came in slowly and systems and processed were developed gradually. However it is clear that the team dealt effectively with these challenges. Council officers and others report that the Community Connections service has established itself well, is widely known about in the borough, and has a growing reputation as a responsive and effective service.

The CC team has also benefited from being located with the Council's Adult Social Care office. This has enabled closer working and an understanding of the role of CC, so council staff are confident in making referrals and ongoing communication is good.

3. Support for individuals – review of activity and impact

CC received 515 referrals between November 2013 - September 2014 (11 months). 463 are active or completed cases, 52 are currently on the waiting list.

The total target for referrals over 18 months is 1,200, and if this was to be achieved evenly over the length of the project, CC would have expected to have received 733 referrals by this stage. Therefore in order to meet the original target of 1,200 the team are seeking and planning for approximately 100 referrals each month for the next 7 months.

As the project has become better known more widely and there is evidence of its success the number of referrals has increased. However there is more work to do to ensure that referrals come from a wider range of sources as the table below shows. In particular the team have identified the scope to increase the number of referrals from primary care.

Referral sources:

Adult Social Care	54.55%	GP practices	7.44%
Community Matron	0.83%	Community organisations	5.79%
NHS enablement	5.79%	Self referrals	1.65%
LINC/ LATT	8.26%	Community mental health	2.48%
Physiotherapists	9.92%	Admissions avoidance	3.31%

To date the majority of referrals have come through social care rather than health, and the low number coming from GP practices is of particular concern. There are many older people and vulnerable adults who may not be engaged with other services, but who do have contact with their GP practice. Older people have often seen their GP practice as a place to go for help and advice of all kinds, not purely related to health. The Community Development Team have worked to build links in different ways with various practices in the borough, but overall there are still few referrals being made. Therefore it should be a priority to explore ways to continue to raise awareness of CC across all practices and to make the referral process as straightforward as possible for GPs and other practice staff.

This would include looking at whether it would be possible for the GPs to make referrals directly through their own IT system, as has been achieved in other areas of London.

Referrals can come in batches so for example there was a rush of referrals following the recent "Techy Tea Party" in September which have yet to be fully allocated.

The project has also learnt that some individuals are looking for signposting and information rather than ongoing support and development of a personal support plan. The referral system has been updated in response to this to ensure that there is a fast track response to those clients, so that people who only require a brief intervention and are able to make their own arrangements are not kept waiting for signposting.

Who is being referred?

CC is for all older and vulnerable adults in the borough. To date the breakdown of referrals across the population is:

Age		Gender		Religion	
18-30	7.02%	Male	39.0%	Christian	70.76%
31-40	7.02%	Female	60.8%	Hindu	1.72%
41-50	9.21%	Transgender	0.02%	Islam	3.93%
51-60	13.60%			Buddhist	0.74%
61-70	11.40%			Other	1.72%
71-80	23.90%			None	17.94%
81+	27.85%			Undisclosed	3.19%

Ethnicity			
Asian or Asian British (Indian)	2.09%	White British	47.67%
Asian or Asian British (Other)	0.93%	White Irish	2.09%
Black or Black British (African)	10.23%	White Mixed (White & Asian)	0.70%
Black or Black British (Caribbean)	23.26%	White Mixed (White & Black African)	0.47%
Black or Black British (Other)	3.95%	White Mixed (White & Black Caribbean)	1.16%
Other Ethnic Group	1.63%	White Mixed (White & Other)	0.23%
Chinese	0.23%	White Other	3.72%
Turkish Cypriot	0.70%	Undisclosed	0.93%

This demonstrates that CC is reaching across the different communities in the borough, however it would be useful to do further analysis of the data to see how this relates to area of need or disability. Over 60% of service users are over 60 so the project is reaching older people as planned. This is significantly higher than the percentage of older people in the population.

Feedback from the team and council staff is that many of the referrals have higher levels of need than had originally been anticipated, but the data collected is not able to confirm this. Issues raised by the CC team around higher levels of need are focussed on requirements for accessible and affordable transport, support for individuals with dementia, day long activities rather than short classes, suitable activities for individuals who need higher levels of care or who are not able to travel on their own, or who are housebound.

Impact:

The aim of CC is to help increase people's sense of wellbeing and reduce their isolation. There are also more specific aims about reducing the numbers of GP visits and hospital admissions. At this stage the information and feedback collected from service users has focused on their wellbeing and isolation.

All service users are asked to complete a wellbeing questionnaire at the start of their involvement with CC, and again when their case is closed. I have looked at a sample of 66 cases that have been completed since the project began.

All participants were asked to rate their responses to the following questions:

1. Are you seeing your friends as often as you want to?
2. Do you see your family as often as you want to?
3. Do you feel safe in your home
4. Do you take part in activities you enjoy?

86% reported an improvement in their overall wellbeing following their support from CC, 8% reported no change and 6% reported a reduction in their wellbeing.

The project is probably less able to have an impact on questions 1 and 2. The area where CC has most to offer is in offering information and access to a range of activities. In response to question 4. 79% reported an increase in activities they enjoyed. 21% stayed at the same level of enjoyment but they were mostly people who already had a positive response to this question at the time of their initial assessment.

The average length of time CC worked with the people in this survey was 14 weeks, against an initial target of a six week input. These users were part of the project before the new fast track stream came into operation so this may impact on future working times. It is clear that it is not always possible to work quickly with people to explore what activities and support they are looking for and to put these in place. However as the project establishes longer term working relationships with community services, and resources are developed through the community work support, the Community Support Facilitators will be able to suggest activities and support more quickly.

The shortest length of work with an individual in the sample was 4 weeks, but this was a younger person with a learning disability who already leads a busy and active life and was only seeking assistance with identifying employment and training opportunities.

The longest period of those in the sample was 31 weeks which was a woman with a learning disability who lives independently but was inactive and lonely. With the assistance of CC facilitator she has taken up volunteering opportunities and other new activities and fed back that she was a lot more confident, and felt able to sustain her new activities.

The team have identified that there are people who need an ongoing period of support and assistance to overcome their fears about going out more, or joining clubs or activities. The proposed volunteer Befriending Service that will be hosted by VCL, will look at recruiting volunteers to provide shorter term support in this area, as well as others who offer a longer term befriending relationship.

Case Study: Harry's Story

Harry lives with his daughter who became his full-time carer a couple of years ago due to him suffering from a rare disease known as Pseudomyxoma peritonea (PMP), which is a form of cancer and has similar principal traits to those of Parkinson's in the way that it effects his physical form. Harry undergoes dialysis three times a week which therefore takes up most of his time and leaves him tired and exhausted. His free time was spent in front of his TV watching whatever was on.

Community Connections supported Harry and his daughter in their home where his hobbies, interests and needs were identified and matched to community services. Harry told the Community Connections worker on that first visit that he felt tired all the time and unmotivated to do anything, though he did want this to change.

A number of options were discussed such as the Parkinson's Group as well as the Rehab Exercise Class at the Ringway Centre which involves exercises he can do from a seated position. Harry attends these groups regularly and is now more motivated to maintain his own wellbeing.

Case study: Alice's Story

Alice was referred to the project by her sister, Sarah who described Alice as lonely and depressed.

Friendship Fridays, a local lunch and activity group was identified as a manageable start to increasing Alice's engagement with the community. Although initially nervous, Alice attended the group with a CC support facilitator to assist with increasing her confidence.

Since then, Alice attends the club every Friday and also assists with the set up of activities after the lunch club. Alice is now also taking the bus alone to go shopping and visiting her sister, Sarah, something she had previously not felt confident to do. Sarah is delighted with the positive change in Alice.

Alice now wants to help others in the same position by becoming a volunteer and has registered with Volunteer Centre Lewisham.

4. Support for community organisations: review of activity and impact

The targets and achievements for development work with community organisations:

	18 months total	Completed by end Sept
Development visits	160	160
Development plan for individual organisation	40	27 action plans agreed with and signed off by the community organisation and CC.
Launch event	1	1

The development visits include a wide range of groups and organisations and provide the team with information about what is available in the community, what additional resources and capacity may be needed.

The Community Development Worker role includes offering information about good practice, funding opportunities, making links and connections between projects, and maximising use of community resources.

Community Connections held a launch event in March 2014 which was attended by representatives of over 30 organisations working in the borough. The team facilitated workshops on Reaching Vulnerable Adults; Transport options; Volunteering.

The CDW team also attends a wide range of neighbourhood and borough wide forums and meetings. The purpose of attending these meetings is to:

a) tell groups and individuals about Community Connections, including seeking referrals for individual support;
b) make contact with community groups who may benefit from individual development work;
c) build connections between community groups, health and social care services to contribute to better integrated provision.

Some examples of the impact of Community Development Work:

Africa Advocacy Foundation (AAF) provides advice, support, training and advocacy for people of African descent, particularly those affected by long term health conditions. AAF currently runs 2 regular groups in Lewisham for vulnerable adults living with Mental Health difficulties or HIV.
The Community Connections project identified introduced AAF to The Reader, an organisation that delivers shared reading groups where members of the group read a chosen text aloud and discuss the themes, ideas and characters together. The Reader groups use literature to help people explore their own feelings and personal experiences within a safe context.
Bringing together the Reader and AAF was huge success. 19 people signed up to be part of the AAF Reader group starting in October. This will provide a new opportunity for people with long term health conditions to socialise and meet new people as well as spark self-reflection and expression.

Ageing Well Fun Club (AWFC) runs every Monday afternoon, bringing together a group of older people in New Cross to chat, to drink tea and to do arts and crafts activities together. On the day I attended the group were being taught how to do decoupage by an arts and crafts instructor. There was a friendly, bubbling atmosphere. One volunteer who had appointed himself as DJ was playing music from a stereo in the corner.

I met Muriel, the chair, who was struggling to keep up with all the admin work needed on top of organising the weekly activities and applying for funding to keep activities running. Over the course of the afternoon I helped Muriel to identify some specific areas that she felt she and the club needed support with. These included:

- Monitoring demographics of members and service users
- Finding ways to deliver more health-related activities to members
- Help learning to use computer software (eg Microsoft Word)
- Applying for funding
- Completing Annual Charity Return

We agreed a plan for this work and I put her in touch with other contacts in the borough and also ensured she had an invitation to the "Techy Tea Party" at the House of Commons.

By October we have completed the annual Charity Return, introduced two new regular users to the groups, successfully applied for additional funding and the groups AGM will look at future plans, including hoping to open for a second day each week.

Community Connections at South Lewisham Group Practice

Community Connections worked together with the Patient Participation Group (PPG) at South Lewisham Group Practice to organise and pilot a Health and Wellbeing Market Place event for patients to showcase some of the groups and organisations available to them in the area. Initially this was to be for SLGP patients only; however, due to the great response this was opened up subsequently to the local residents also.

The PPG group designed a poster and publicised the event, where 20 organisations had stalls.

The event was held on a Saturday morning in March and there was positive feedback from both visitors and stall holders. The PPG are now in the process of organising a mini market place every Friday morning during open surgery hours at SLGP, with 1 or 2 stalls each time. Again the stallholders will be from groups and organisations serving the Lewisham area, including Community Connections, and provide information and advice on what is available in the area.

South Lewisham Group Practice is now one of the local practices who regularly refer individuals for support from Community Connections.

5. Community Connections - Summary of achievements and impact:

- Successful start-up
- Full staff team in post, co-located with council teams
- Raised profile across borough, held launch event, established website and social media communications
- Bringing together information about community resources that were previously unknown to health and social care
- Built links and contributing to range of neighbourhood forums and groups.
- Received 515 referrals from a range of social care, health and community providers

- 86% of service users report an increase in their wellbeing following support from CC
- Volunteer Centre Lewisham launched a new Befriending Service on 1st October in response to needs identified by CC
- Development visits to 160 community groups and organisations in Lewisham
- Detailed development plans in place with 27 community groups.

6. Areas for further work and development:

- Impact monitoring – particularly in relation to impact on use of health and social care services
- Monitoring longer term impact for service users
- Continue to identify gaps in resources and services
- Balance of expectations, targets and resources – need streamlined systems and process, consistency of approach
- Increase level of referrals from health services, particularly GPs/primary care. Look at IT systems that make it easier for GPs to refer.
- Further develop Community Development Worker liaison with GP practices and Patient Participation Groups to support practices to refer individuals for community support and services
- Explore possibilities for introduction of Social Prescribing in Lewisham
- Consider development of SAIL (Safe and Independent Living) checklist in Lewisham
- Continue to develop work with Falls Prevention Service
- Review role and membership of the Consortium
- Look at how CC can contribute to the introduction of the Care Act 2014 in Lewisham
- Continue to develop and streamline referrals and assessment process to enable team to respond within agreed timeframes
- Review outputs and outcomes from Community Development Work to ensure a consistent approach across all neighbourhoods.

Lewisham Community Connections Interim Evaluation Report commissioned by Age UK Lewisham and Southwark.

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