Lewisham Community Connections –Evaluation Report

June 2015

Julia Shelley, Independent Consultant

1. Introduction

This report follows the interim Community Connections Evaluation Report which was presented to the Lewisham Health and Wellbeing Board in November 2014.

Since that date the Consortium led by Age UK Lewisham and Southwark (AUKLS) has continued to deliver Community Connections (CC) across the borough.

The pilot project ran from November 2013 to March 2015. From April 2015 AUKLS and its partners have been awarded a three year grant by Lewisham Council mainstream grant fund under the Communities That Care/Connecting and Supporting theme to continue to provide and develop Community Connections.

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

i. inform the Board of Community Connections achievements during the pilot phase
ii. inform the Community Connections Steering Group in their oversight and planning for the project
iii. engage partners in discussions about the ongoing development of the project
iv. highlight issues raised that affect Health and Wellbeing Partners in the borough

2. Background

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.

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 were responsible for the recruitment and placement of volunteers as part of the CC initiative during the pilot phase and reported separately on their activities and outcomes.

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

3. Governance, management and staffing

Governance

The CC Steering Group was established at the start of the project and to date has met on a monthly basis to review and monitor progress. The membership of the steering group currently includes Lewisham Council (ASC, Public Health, Culture Community Development), Lewisham 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.

The Steering Group has supported the team and development of systems over the past 18 months.

The CC Consortium members also meet monthly to monitor development and progress of the project. Since the start of the project several Consortium members have faced changes and pressures to their organisations. From April 2015 Voluntary Services Lewisham (VSL) and Rushey Green Time Bank have joined the Consortium, and the Volunteer Centre are no longer running a volunteer befriender scheme to support the project.

Management and staffing

The project has a team of 11 posts: a Team Leader, 4 FTE Community Facilitators (CF), 4 FTE Community Development Workers (CDW) and a part time Administrator. 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 CF who is employed by Lewisham Disability Coalition.

The Team Leader co-ordinates and manages the team, as well as playing a key role in liaison and work with Consortium partners and other agencies across the borough. There have been a small number of changes of staff during the pilot period but these have been managed so that there has not been an impact on the project delivery.

Community Development Workers are allocated to one of the four cluster areas. They work closely with the CFs 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 offered to local people.

The CDW's receive and monitor all referrals, and pass them on to the appropriate CF. The system identifies referrals who are looking for information or signposting so they are dealt with quickly. Other referrals are then passed on to the appropriate CF who will make contact with the clients.

Community Facilitators 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 CF is also 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.

4. Establishing and promoting 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 processes were developed gradually. There was also an issue relating to set up of monitoring systems as there had been no clear agreement on monitoring and evaluation at the start of the project.

However it is clear that the team dealt effectively with these challenges. At the time of the interim evaluation report Council officers and others reported that the Community Connections service had established itself well, is widely known about in the borough, and has a growing reputation as a responsive and effective service.

The team have continued to promote Community Connections effectively and it remains a well known service in the borough. Links have been made with different teams and sections within the Council and the CCG, including Public Health and the Falls Team.

Community Connections has been included in Lewisham plans for implementation of the Care Act in April 2015.

The recent consultation document on Day Care Services in the borough referred to working with Community Connexions (sic) to support people in identifying local services. Earlier in the year when there were changes to services for younger adults with learning disabilities,

the Council referred the current service users to Community Connections who held a meeting to talk to people about the options that were available for them.

Community Connections uses its website to promote events and activities, as well as a Twitter account. At present project progress reports do not include information on how well the website is used, number of Twitter followers etc so it is hard to assess how successful this activity is in reaching new clients or organisations.

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.

5. Support for individuals – review of activity and impact

Referrals

By the end of March 2015 CC had received approximately 700 referrals, which is 58% of the original target.

Once the project was established the level and sources of the referrals have remained fairly consistent over the 18 month period. The target for the first year of the new programme is 600 which is a more realistic and achievable target for the team, but will still require a plan for increasing referrals particularly from the health sector.

The breakdown of referral sources in March 2015 was

Adult Social Care	55.2%	GP practices	6.1%
Community Matron	0.5%	Community organisations	14.8%
NHS enablement	9.8%	Self referrals	5.3%
LINC/ LATT	2.8%	Community mental health	0.9%
Physiotherapists	4.2%	Admissions avoidance	0.4%

This is a similar pattern across the 18 months.

Approximately 50% of referrals have come from Adult Social Care over the whole length of the pilot, demonstrating the strength of understanding of the project and the benefits of being co-located. However the CC team have expressed concerns that some people are being referred who have higher levels of needs and dependency that can be safely met by most community based organisations, and that they have therefore been unable to identify suitable support or activities for them.

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. Changes to council services and reductions on eligibility will inevitably have an impact on the referrals made to CC. And although many of the local community organisations are developing and

building their services they may still not be suitable for service users with a need for intensive or specialist support.

The project has seen a steady increase in the numbers of people referred by Community Organisations, as the project becomes better known and integrated into the wider community sector provision.

Health referrals have gone up and down with some months showing significant referrals from Community Matrons, Enablement and Physiotherapists in particular.

The team have focused considerable effort in the past six months on building relationships with GP practices, and while this has resulted in regular referrals from a small number of practices overall there has been limited success. This issue is further addressed in the section 6 of this report.

Who is being referred?

CC is for all older and vulnerable adults in the borough. Up to the end of March 2015 the breakdown of referrals across the population is:

Age		Gender		Religion	
18-30	6%	Male	36.53%	Christian	72%
31-40	6%	Female	63.3%	Hindu	2%
41-50	9%	Transgender	0.17%	Islam	4%
51-60	12%			Buddhist	1%
61-70	12%			Other	2%
71-80	23%			None	15%
81+	32%			Refused	4%

Ethnicity			
Asian or Asian British (Indian)	2.63%	White British	48.34%
Asian or Asian British (Other)	1.52%	White Irish	2.35%
Black or Black British (African)	10.11%	White Mixed (White & Asian)	0.42%
Black or Black British (Caribbean)	20.08%	White Mixed (White & Black African)	0.28%
Black or Black British (Other)	3.32%	White Mixed (White & Black Caribbean)	0.83%
Other Ethnic Group	1.39%	White Mixed (White & Other)	0.14%

Chinese	0.42%	White Other	5.12%
Turkish Cypriot	0.83%	Undisclosed	2.22%

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. 67% of service users are over 60 so the project is reaching older people as planned, including a large number of the 80+ population. This is significantly higher than the percentage of older people in the population.

Signposting and onward referrals

Towards the end of the pilot project a Signposting Assessment section has been added to the Person Centred Plan form completed with all referrals. The aim of the new section is to identify additional needs for individuals and refer them on to appropriate support or advice. The questions cover issues such as falls, substance misuse, sensory impairments, nutrition, education, memory loss, mental health.

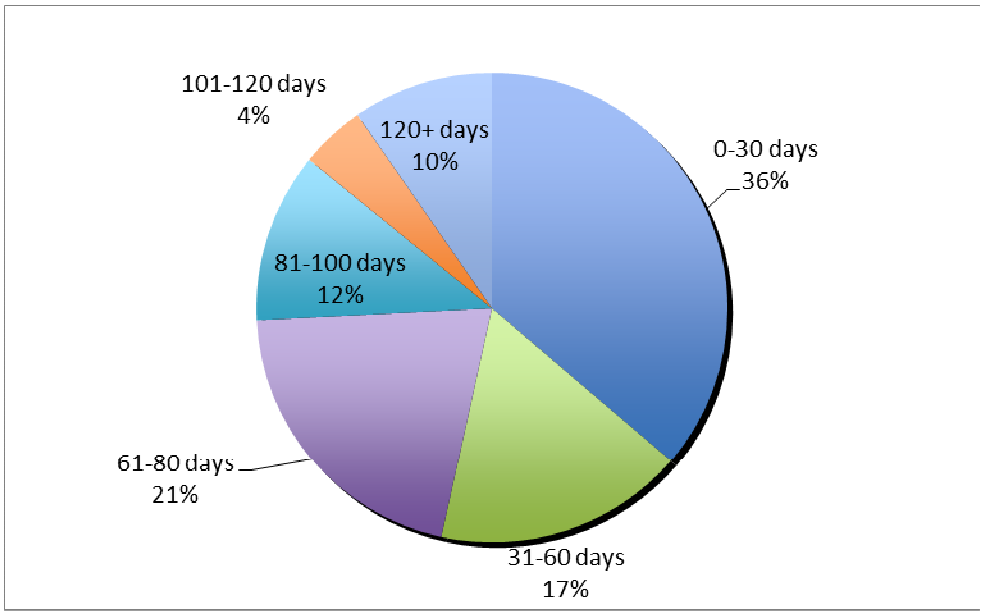
This is a significant addition to the project and builds on the successful delivery of the SAIL project by AUKLS in Southwark. However at present in Lewisham further work is needed to build up the network of referral agencies to receive these referrals from CC. The current experience of the Community Facilitators is that the referrals they send on are not always responded to. Experience in Southwark shows that this type of project will only be effective if the network of referral agencies are active members of the scheme. It is also important to keep a full record of referrals made and received as part of the regular monitoring.

These issues are the subject of ongoing discussions between Community Connections and the council to take the work forward.

Length of contact

The original target was for a 30 day input by CC for each service user. However experience has shown that the project needs longer to develop and implement each individual's Person Centred Support Plan. It was only possible to complete the work with 36% of people within the original target time.

Fig 1: Length of contact



The average contact period was 56 days.

The team have identified that there are people who need a longer period of support and assistance to overcome their fears about going out more, or joining clubs or activities. The data above confirms that service users are being offered a longer period of support and the team feel this is consistent with delivering a person centred approach.

There are also a number of cases that have remained open while a suitable Befriending volunteer is identified and this has will impact on the length of contact time.

The project is working on the recruitment of Community Connectors volunteers who would be able to provide some of the ongoing contact and support for individuals whilst they are waiting to be allocated a Befriender or for another activity or opportunity. The aim is for these volunteers to take on some work currently preventing CFs from carrying out more assessments.

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. The interim evaluation reviewed the outcomes reported by 66 service users following their support and involvement with the project.

I have looked now at another sample of 66 cases completed between October 2014 and May 2015.

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?

The project is probably less able to have an impact on questions 1 and 2 about friends and family. 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 in the first sample and 53% in the second sample.

In the first sample 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.

In the second sample 56% reported an improvement in their overall wellbeing following their support from CC, 39% reported no change and 4% reported a reduction in their wellbeing. The higher level of people reporting of no change reflects those with restricted mobility, or cognitive impairment where there are fewer options for increased activities and making new friends. It was noticeable that for many much older people that the answers to questions 1-3 did not vary at the different stages they completed the wellbeing questionnaire, and several included comments about how many friends and family had died.

The wellbeing questions have been changed since May 2015 to elicit a broader and more useful measure of wellbeing and impact of the CC input for individuals. The new questions are:

1. How content do you feel with your life at the moment?
2. Are you able to manage your health?
3. How socially connected do you feel?
4. How physically active are you
5. Do you have access to information when you need it?

Participants will asked to score each response on a scale of 1-5, and these questions will provide a broader view of peoples sense of wellbeing as they are less tied to home, friends and family.

The following case studies demonstrate the range of needs that the project is seeking to address, and some of the successes that they have achieved.

<u>Case Study 1:</u> A Hundred And One – And Still Going Strong!

"I first met Ivy in April. Despite being 100 years old, she was living on her own and even doing her own cooking. Ivy was happy with her life and had many people who supported her with day to day living- however she felt like something was missing…….

It soon transpired that Ivy was missing the social elements of being with people in her own age group. Ivy and I spoke about where she might like to go. We finally settled on The Deptford Mission that runs a day centre three days a week.

The next hurdle was transport. Ivy has very poor mobility and is not able to get on public transport. Although The Deptford Mission do provide transport, there was a waiting list for this and so we agreed on using Access Lewisham – a volunteer driving service who provide return journeys in the borough for a flat fee of £5.50.

So I set about filling out all the paperwork and we arranged to visit The Deptford Mission using Access Lewisham as soon as possible.

On the day of Ivy's first visit, I escorted her and to say she was nervous was putting it mildly! However, Ivy could not have had a warmer welcome! From the Access Lewisham Driver to Erica and all the staff and members at The Deptford Mission, Ivy was treated wonderfully.

She was first given a nice cup of tea and then shown the menu for the three course lunch. At this point, I bid farewell to Ivy, telling her that I didn't want to cramp her style!

I later called Ivy who was still on a high from her visit to the Mission. She said she has had a wonderful time and was especially impressed by the food!

Ivy has since turned 101 and was delighted to receive a card from all the members of The Deptford Mission wishing her a happy Birthday!"

Case study 2: Danny's Story

Danny, 47 years old, was referred to the Community Connections team by his Physiotherapist in July 2014. He suffered a debilitating back condition in 2005 when he "popped three spinal cords" which left him often in chronic back and leg pain and needing the support of a crutch to walk. He subsequently had to give up work as a skilled self-employed carpenter, a job he loved as he was able to travel the world, building exhibition stands. Shortly after giving up work, Danny suffered further ill health including some abdominal surgery and a diagnosis of Type 1 Diabetes. His emotional wellbeing deteriorated as he became isolated and lonely. Danny had no family or friends to support him. Danny also experienced some financial difficulties having had his Disability Living Allowance stopped. This caused him much stress and anxiety. He received counselling and medication for depression. His low self-esteem affected his lifestyle and for several months, he became a recluse in his own home. When I first met Danny in my role of Community Support Facilitator, he told me amongst other things, how much he enjoyed his past work as a Carpenter. Together we explored suitable day time activities that matched his interests. We felt that it was important that we looked locally to where Danny lived due to his difficulty in standing or walking for long periods of time. CC also supported him in seeking expert advice in completing his appeal for the reinstatement of his Disability Living Allowance

I contacted the Lewisham Southwark College (LESOCO) and Danny was able to become a student in Carpentry and Brick Laying. I met up with Danny each week to help build up his confidence. Danny now travels alone to the college 3 days a week by bus. The best bit however is that he is so good at carpentry, he has ended up assisting the teacher in training 13 students aged from 17 to 30! In his own words — Danny says "this has woken me up. It's been great! I have a group of youngsters that have latched onto me. My best friend last night told me that he has not heard me so upbeat in years. I've just knitted in — all these youngsters have latched on to me. Community Connections have helped me build my self-

confidence back up and make me try to feel proud about myself, which is something I haven't felt for a long time.

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

The targets and achievements for development work with community organisations:

	18 months total	Completed by March 2015
Development visits	160	192
Development plan for individual organisation	40	42
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.

A key area of work for CDWs over the past six months has been to build links with GP practices across the borough to ensure that both GPs and practice staff are aware of Community Connections and how make referrals into the project.
A recent Citizens Advice report[1] finds that GPs spend almost a fifth of their time (19%) on social issues that are not principally about health which means they have less time for other patient's health needs.

The low number of GP referrals was identified as a priority in the interim evaluation report. Since October the CDWs have been meeting with GPs through practice meetings, neighbourhood meetings and currently 2 PPGs that are being set up with support from a

[1] A very general practice – Citizens Advice Policy Briefing May 2015

CDW. Due to the various characteristics of each GP, different strategies are being used, ie, training around how to engage with the local services, information through presentations.
The CDWs have contacted all GP practices in the borough at least once, but there are still a number that have not responded at all, despite follow up with both GPs and Practice Managers.
For example there are 7 Practices in one CDW's patch. Six of these did not respond at all to the first communication in 2014, and one offered a meeting with Practice Manager and to display CC leaflets. Following a further round of emails and introductions in January 2015 three of these practices still did not respond, three responded positively and each made a small number of referrals. The seventh invited the CDW to a practice meeting but has still made no referrals. The CDW has continued to make contact with all seven practices but there is no steady flow of referrals.

There has also been discussion about the easiest ways for GPs and practices to make referrals and Community Connections is being flexible about this, so some use the referral form, others refer by fax or email without using the form. The team leader is also talking with the CCG about ways to enable GPs to use their existing intranet system to refer into Community Connections.

However it would appear that further information, promotion or training is needed to reach a stage where GP practices are using CC as an early option when dealing with people who are presenting with non-health related issues. Options could include CC presence at GP training and information events, inviting practices or CCG members who are using the scheme to act as CC champions when meeting with other practices.

The team has made extensive and continuous efforts to engage with GP practices and will continue to do so, but to further embed CC into both GPs and other health professionals daily practice, it would be beneficial to have further support and active championing of the project from the CCG and other leaders.

Identifying and filling gaps in provision
Both CDWs and CFs have highlighted that there are some people for whom they are frequently unable to identify suitable activities or support. These are people with advanced dementia or considerable short term memory loss or who require personal care or one to one support. Community support services rarely have the capacity or facilities to offer such high levels of care to their service users.

People who are housebound are restricted by lack of access to suitable transport as are others with other mobility or travel safety needs as there is very limited access to travel buddies or escorts. There have been changes and reductions to Befriending Services although CC is now working with VSL and others to strengthen befriending resources in the borough.

Activities and services for adults of working age with a physical or sensory disability are also lacking. This is particularly difficult for male clients in this age range. Apart from Headlines, a

men's coffee morning in Catford established by Community Connections there is very little else for available.

Outcomes and Impact

In February 2015 the CDWs conducted a survey of organisations they had worked with across 3 of the 4 neighbourhoods to get feedback on their outcomes. 15 organisations responded and reported positively on their strength, connections and confidence in their own management structures. However there had been no similar survey at the point of starting work with each organisation so that it is not possible to judge the level of impact from the support and guidance offered by Community Connections. In future it would be useful to carry out a survey of each organisation at the start and end of their contact with CC.

However the survey did provide some very positive and useful feedback:

"Community Connections has linked AAF with over 10 other community voluntary organisations and services locally."

"We think that Community Connections has genuinely addressed a gap in information and knowledge of services within diverse communities in Lewisham. The ability of CC to research, visit and match or link organisation/services with others greatly contributes to better health and care outcomes for Lewisham residents."

"The Team add a level of support that we would not be able to offer. They don't just hand out leaflets and info, but accompany individuals when attending activities until they feel comfortable."

Some examples of impact of Community Development Work:

The South East London Tamil Elders & Family Welfare Association *is a lunch club for older people from the Tamil community. The group meets once a week for companionship, celebration of important cultural events, trips in during the summer months and a hearty vegetarian meal. When I first met with the group we discussed some of the challenges they felt they faced. The top 3 challenges were, 1) accessing funding to make the group financially sustainable, 2) promoting the health and wellbeing of members 3) insecurity about where the group will be based in light of the management of Calabash centre going to tender.*

Over the 12 month period I worked with the group, some of the key outcomes achieved together include:

- Collaborating with the Community Health Improvement Service to deliver a 6 week wellbeing programme to members involving; health checks, functional fitness, exercise and healthy eating talks. One of the Tamil group members also became a Healthy Walk leader and now leads a walk at Ladywell Fields every Tuesday.

- Gaining funding from SLAM to pay for continued exercise classes and recruiting a qualified tutor to deliver the 10 fitness sessions.

- Accessing further funding from the Mercer's Trust to contribute to support the general aims of the group e.g. for the venue hire, food costs and summer trips.

- Finding a new residence where the group could continue to prepare a hot vegetarian meal each week.

Mr Vethasuntharam, the secretary of the association commented that,

"Community Connections has done a great job for smaller organisations like us, supporting with getting funding and how to run the association".

Planning a "Techy Tea Party"
"Techy Tea Parties" were being held nationally to promote older people's engagement with technology. This was an opportunity to explore digital inclusion in Lewisham. I threw a "Techy Tea Party" at Crofton Park library, as a Time Bank member, Community Connections were able to use this space free of charge. I then got Lewisham Pensioners Forum involved. The aim of the party was to get local, older people together for a social event, whilst exploring technology. People were encouraged to bring along a mobile phone or tablet, that they wanted to learn more about.
Moving Towards a Regular "Techy Drop In"
I am in the process of advertising for a volunteer to lead a regular "Techy Drop In" at the library. From talking with older people in the community, I have found that many of them need help with technology, not just PC's but tablets, mobiles and lap tops.

***The Darby and Joan Club** is a coffee afternoon and entertainment group for older people based at the St Margaret's church in Blackheath.*
In the initial meeting with the club coordinator Cilla, we looked at the strengths and needs of the club. For example, it was a great advantage that the club had established transport provision using Dial-a-Ride and Lewisham Door-2-Door. However, the number of people attending the club was diminishing due to poor health and members passing away.
Cilla and I looked at how we could make the club more cost effective through attracting new members and utilising services within the community and voluntary sector rather than relying solely on paid performers.
Community Connections helped the Darby and Joan by introducing new members to the group, connecting the club to new free opportunities for members, for example; London Wildlife Trust's Potted History project and healthy eating and lifestyle activities with the Community Health Improvement Service.
After consulting with the members, they requested a signposting and information session from Community Connections to explore the different advice services in Lewisham. I have also offered to deliver this for them as well as to provide a Dementia Friends awareness session for the club to support the volunteers with concerns they may have when accepting new members with higher support needs.
I have also supported the group to access funding to provide summer trips for the group which will also be open to other older people in the area.

7. Volunteers and Community Connections

At the start of the project Lewisham Volunteer Centre was funded separately to develop and provide a volunteer Befriending Services that would enable CFs to refer on people looking for this type of support. The Befriending Service was slow to get off the ground but once up but the CFs report that this became an effective and helpful service once started, and service users were quickly matched with a volunteer.

Local volunteers were also recruited as Befrienders as part of the Winter Warmth campaigns and again some successful partnerships were set up, that have continued beyond the end of the Winter funding.

There are other Befriending schemes available, particularly the one run by Voluntary Services Lewisham, where the CFs can refer but they have experienced long waiting lists.

The two new members of the Consortium (VSL, RGB) both have a strong focus on volunteers. CC is also establishing its own volunteer team of Community Connectors as part of the plan for the year ahead. Completed support plans will be passed on to the Community Connectors who will work with the individuals for up to three months to support the implementation of the plan. Acting as a companion, they will befriend the individual and support them to access the activities and groups outlined in the support plan and build their confidence to take part in the community.
The volunteer recruitment process will start in summer 2015 the aim of recruiting at least 10 volunteers in the next year.

8. Progress on areas for further work and development identified in interim evaluation report:

1) Impact monitoring – The team have worked on developing the questions and model used to assess impact on wellbeing. Having tested the approach over the pilot period a new format has been introduced from May 2015. This will need ongoing review, and the system developed to ensure that data is entered and monitored on an ongoing basis
2) Monitoring longer term impact for service users – the team have introduced a follow up questionnaire to be completed six months after a case is closed.
3) Clarify overall monitoring system so consistent information is collected over the remainder of the project life – A revised monitoring framework is being presented to the Steering group in June 2015.
4) Continue to identify gaps in resources and services – this is ongoing work, but having longer term funding secured will enable CDWs to continue to develop and trial groups and activities.
5) Balance of expectations, targets and resources – This is part of the ongoing project development and reflected in the plans submitted as part of the funding application. The team has responded to changes and adapted as necessary, for example: Fast track signposting service, development of Community Connector volunteers, establishing new groups on trial basis, reviewing and adapting monitoring and other systems
6) Working with Health and GP practices to increase level of referrals from health services – the CDWs have continued to build contacts with GPs and other health professionals and this has had some success. Despite their persistence the response has remained limited, and therefore the Steering Group should consider other ways to encourage and support GPs to refer to the project. It may be that the scheme needs to be publicly promoted and championed by GP leaders and the CCG to have a greater impact on changing current practice

7) Explore possibilities for the introduction of Social Prescribing in Lewisham – this is currently subject to discussions with CCG and Public Health and is ongoing work for Community Connections
8) Consider development of SAIL (Safe and Independent Living) checklist in Lewisham – the initial checklist has been added to the individual planning form but there is further work required to fully establish this as an effective service, with a greater input and buy in from the agencies who would receive referrals
9) Continue to develop work with Falls Prevention Service – this is ongoing work
10) Review role and membership of the Consortium – the Consortium membership has been changed to reflect the development needs of the project, and the needs of older and vulnerable adults in the borough.
11) Look at how CC can contribute to the introduction of the Care Act 2014 in Lewisham – the work around wellbeing, early intervention and prevention is contributing to this, together with the development of the council website
12) Continue to develop and streamline the referrals and assessment process to enable the team to respond within agreed timeframes – This is ongoing work, in response to changing needs and resources. The development of the volunteer Community Connector role is one example.
13) Review outputs and outcomes from Community Development Work to ensure a consistent approach across all neighbourhoods – the council has fed back that they feel this is now the case as the project has become established. To some extent different approaches across the neighbourhoods reflect the nature of those communities and the differing extent of community organisations in each area.

9. Community Connections - Summary of achievements and impact:

1) Successful start-up with full staff team in post, co-located with council teams
2) Raised profile across borough, held launch event, established website and social media communications
3) Pilot has become established part of local support planning framework
4) Effective resource for social workers, health professionals and others.
5) Assisted local groups to develop their offer and extend resources.
6) Brought together information about community resources that were previously unknown to health and social care
7) Built links and contributing to range of neighbourhood forums and groups.
8) Identified gaps in current provision
9) Established effective contact with number of GP practices who are making regular and appropriate referrals
10) Received 700+ referrals from a range of social care, health and community providers
11) 71% of service users sampled report an increase in their wellbeing following support from CC
12) Volunteer Centre Lewisham launched a new Befriending Service on 1/10/14 in response to needs identified by CC, and further befriending schemes currently under development
13) 192 development visits to community groups and organisations in Lewisham
14) Detailed development plans in place with 42 community groups

15) Secured further funding up to 2018
16) Plans and milestones in place for next three years
17) Work started on volunteer recruitment and development
18) Started to build in SAIL type questionnaire in CC assessments.

10. Community Connections – areas for further development

1) Further work to continuously refine and develop monitoring to understand impact for individuals and organisations
2) Feed learning and knowledge into local developments and planning of services and feedback on impact of changes for older people and vulnerable adults
3) Support development and expansion of volunteering opportunities in the borough
4) Contribute to strengthening joint working and information sharing between community organisations and statutory services
5) Continue to strengthen working links with health services, and particularly GP practices
6) Develop signposting and referrals by building network of referral agencies.
7) Continue to support implementation of Care Act

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

Researched and written by Julia Shelley, Independent Consultant,
julia.shelley@btinternet.com

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