Grenfell JSNA Refresh Appendices

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Appendix 1

Air Quality Monitoring

UK Health Security Agency (UKHSA) previously known as Public Health England

The air quality in the area surrounding Grenfell Tower has been assessed and monitored since the start of the fire on 14 June 2017, firstly by Public Health England (PHE), and then by UKHSA when it took over PHE's remit on 1 April 2021.

Initial risk assessments, using data from the Met Office, carried out in conjunction with partner agencies, including the Environmental Agency, London Fire Brigade, Royal Borough of Kensington and Chelsea Environmental Health Department, focused on the smoke plume from the fire which rose upwards rapidly and was carried in a northerly direction by the wind. This meant that potential impact on local air quality from the smoke was considered to be low.

Assessment of data from the London Air Quality Monitoring network was used to confirm the initial risk assessment that levels of particulate matter were low and remained so over the next 10 days. A small elevation in particulate matter concentration was observed at two monitoring stations to the northwest on the morning on 14 June 2017, these peaks could have been due to the smoke plume but the elevated levels occurred for less than an hour. [1]

Data in the next table (Table 1) is taken from the North Kensington monitoring station in the grounds of All Saints College (previously known as Sion Manning School), St. Charles' Square, North Kensington, less than 1km north of Grenfell Tower. Further information about this site is available on the LondonAir and Defra UK-Air websites. The table also includes the London Mean dataset, produced by King's College London, and based on mean measurements across the London Air Quality Network.

Table 1. Monitoring data from North Kensington LAQN site from 12 June to 23 June 2017

Date	24 hour mean: North Kensington PM_{10} µg/m³	24 hour mean: London mean PM_{10} µg/m³	60 minute maximum: North Kensington PM_{10} µg/m³	60 minute maximum: London mean PM_{10} µg/m³
Mon 12/06/17	17	17	20	20
Tue 13/06/17	21	21	28	25
Wed 14/06/17	23	25	33	32
Thu 15/06/17	26	25	42	36
Fri 16/06/17	21	22	27	28
Sat 17/06/17	23	23	28	26
Sun 18/06/17	25	22	31	25
Mon 19/06/17	32	32	40	40
Tue 20/06/17	39	38	68	59
Wed 21/06/17	34	37	44	49
Thu 22/06/17	29	28	41	40
Fri 23/06/17	17	18	20	24

Measured particulate matter concentrations are compared against the Daily Air Quality Index: a colour and numbered banding system that gives information on the level of air pollution and associated health advice. The index is numbered from 1 to 10 and is divided into 4 bands, low (1) to very high (10), as illustrated below and its application is shown in Table 1.

Index bands

1	2	3	4	5	6	7	8	9	10
Low			Moderate			High			Very high

[1] London Air Quality Network on Grenfell Tower Fire

Following the fire, multiple agencies acknowledged that residents in the area remained concerned about air quality and debris deposited in the area. Therefore, to supplement the initial risk assessments, plume modelling and the information available from the London Air Quality Monitoring Network, PHE was requested to organise air quality monitoring for particulate matter in close proximity to Grenfell Tower, which started on 24 June 2017. Monitoring of asbestos fibres commenced on 30 June 2017; and monitoring on dioxins, furans and dioxin-like polychlorinated biphenyls (PCBs), and polycyclic aromatic hydrocarbons (PAHs) were implemented on 3 July 2017.

It is important to note that fires are not the only source of these contaminants; there are other sources in the environment, for example traffic and industrial sources. However, it is also important to ensure that the fire had not resulted in significantly higher levels of these chemicals in the local area, and to also ensure that as work progressed on the site, this did not result in notably elevated levels of these contaminants.

The results of the monitoring have been published weekly online.[2] The results to date show that the air quality around the tower has been similar to the rest of London with no significant elevation detected.

During summer 2018, activity on the site was reduced and the tower was fully covered. Therefore, the strategy was changed to stop monitoring for dioxins and PAH as these chemicals are no longer likely to be released and no significant elevations were detected for these chemicals after 12 months of monitoring.

The air quality monitoring strategy is periodically reviewed based on activities around the site, and we are in regular dialogue with the site management team to ensure the strategy is appropriate. Agency partners will be consulted if the strategy is to be changed.

What protection will be given to residents during tower deconstruction?

The Grenfell Tower site is currently managed by the Department of Levelling Up, Housing and Communities (DLUHC), and would be best placed to answer questions about the future of the tower.

Because of this, we have reached out to DLUHC for their response, and they confirm that a decision on the future of Grenfell Tower has not yet been taken, and the government will not make a decision about the future of the tower without having further conversations with bereaved families, survivors and local residents.

DLUHC remain committed to making sure that all work carried out at the site is considerate and minimises disruption for those living, studying, and working nearby.

If you have any questions about the Grenfell Tower site, or would like to talk to DLUHC, please get in touch via:

Email: GrenfellTowerSite@levellingup.gov.uk

Phone: 0303 444 001

You can find the most recent environmental monitoring reports and data update on the UKHSA website.

Any comms that were produced and distributed by central government following the tragedy can be located Grenfell Tower - GOV.UK (www.gov.uk).

RB Kensington and Chelsea Council

Air quality remains a priority area of interest for the survivor and bereaved cohort as well as the wider community. Improving air quality is also a Council priority. The Council is responsible for carrying out ambient air quality monitoring throughout the borough and has many different sites. Those within the vicinity of North Kensington are shown in the Map below - some sites provide data in real time (the fixed automatic station and mobile sensors), whereas others provide monthly average concentrations (the diffusion tubes). We take the data from our fixed station and the diffusion tubes and compare these against national standards and objectives and the World Health Organisation Guideline Values. Data from mobile sensors is used to look at trends over time. More information

[2] Environmental monitoring following the Grenfell Tower fire

about the Council's air quality monitor programme can be viewed here https://www.rbkc.gov.uk/environment/air-quality/air-quality-monitoring.

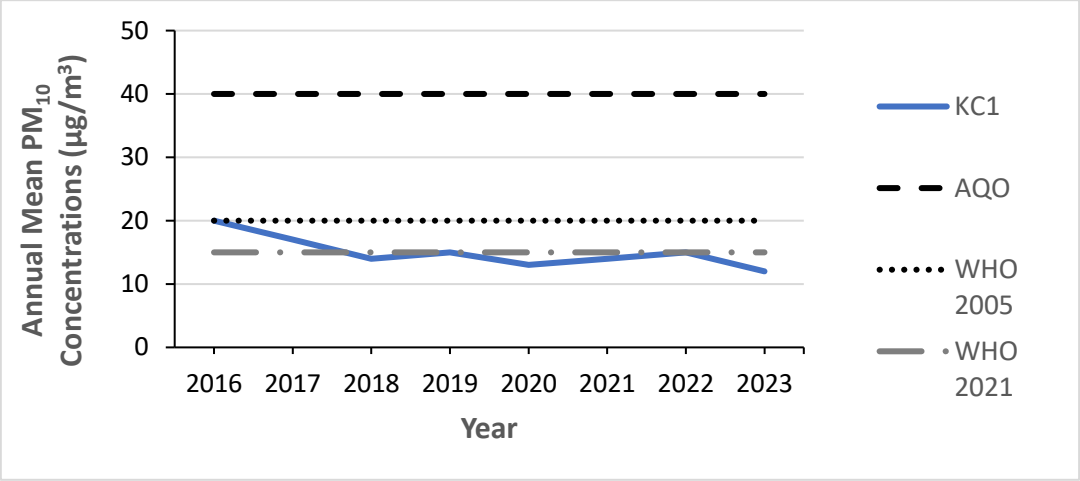
The graph below shows annual mean concentrations for nitrogen dioxide at the locations of the fixed station and diffusion tubes shown in the map since 2017. Concentrations have reduced significantly and now meet the National Air Quality Objective of 40 µg/m^3 but do not yet meet the 2021 more stringent World Health Organisation Guideline Values.

Another air pollutant of concern is particulate matter. This is measured as concentrations of PM_{10} and the even smaller size $PM_{2.5}$. KC1, the automatic monitoring station in North Kensington monitors both of these pollutants in real time. Mobile sensors in the area also do monitor $PM_{2.5}$ but the sensors are not 'reference grade' and do not go through the same audit procedure, therefore we do not rely on this data to compare against national objectives and targets. Data from the mobile sensors can be viewed at https://www.breathelondon.org/

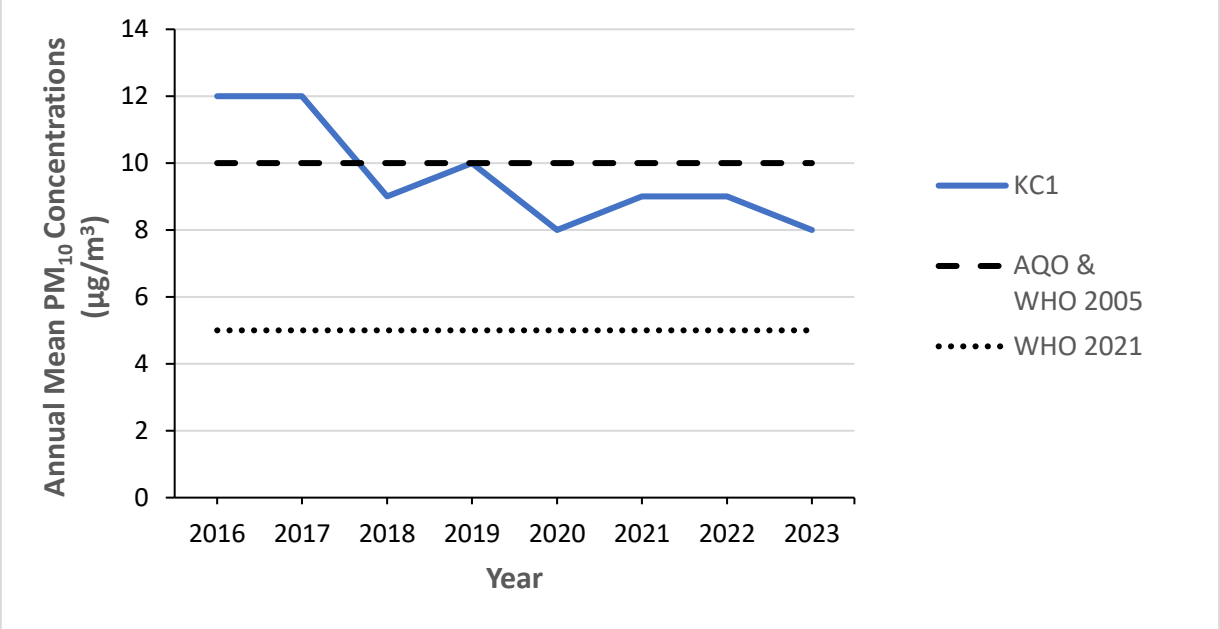
The graph below concentrations of PM_{10} and $PM_{2.5}$ recorded at KC1 since 2016. This site currently meets all the annual targets for PM_{10}. For $PM_{2.5}$, the national targets are met, and the site is getting closer to meet the 2021 WHO Guideline Values.

Every year, the Council produces an 'Annual Status Report' on air quality monitoring across the whole borough and progress with improving it. Copies of these reports can be viewed here https://www.rbkc.gov.uk/environment/air-quality/air-quality-reports-and-documents.

Graph to show annual average concentrations of NO_2 at sites in North Kensington.



Graph to show annual average concentrations of PM_{10} at KC1 (All Saints College).



Graph to show annual average concentrations of $PM_{2.5}$ at KC1 (All Saints College).

Appendix 2

Population Health Monitoring

Introduction

Population Health Monitoring tracks the health and wellbeing of the population in Notting Dale over a long period of time, comparing it to similar locations to identify changing needs. Public Health at local authority are processors of NHS data, they do not have ownership of this data and they are required to gain NHS permission to publish and or share the information they monitor.

We use NHS data (patients cannot be identified from the data) to review health conditions, medication that has been prescribed and the use of services to identify any trends. If we find any changes, there is a process in place to investigate these further and decide on possible necessary service changes.

Even where data does not suggest increases in incidence of health conditions, there may be significant community concern, for example about the long-term physical impacts of the tragedy, which must be addressed when thinking about the provision of future services.

In this appendix we describe:

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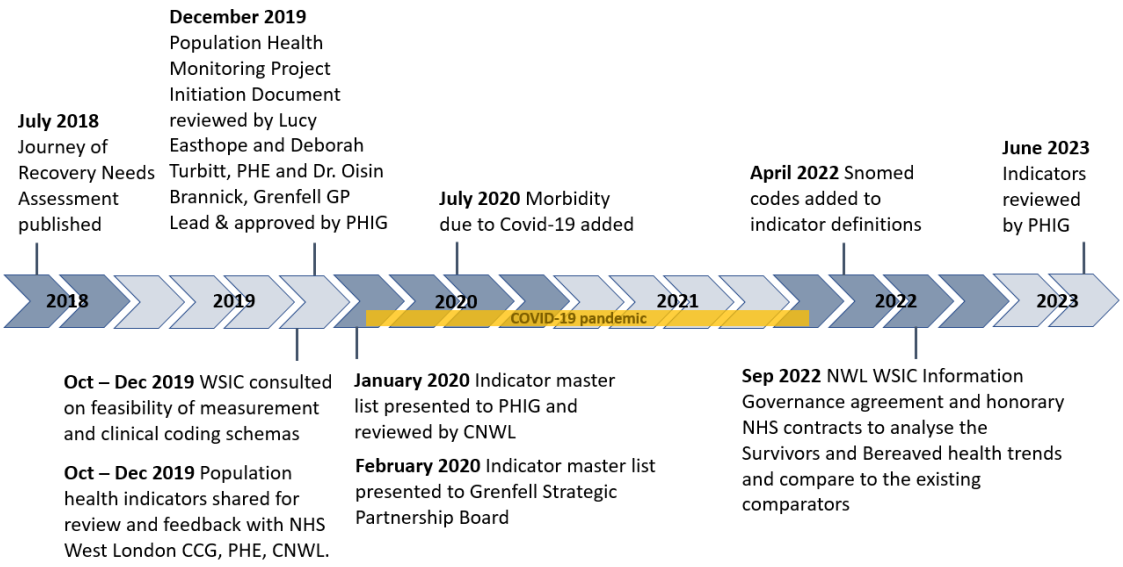
- *How Population Health Monitoring* was **developed**
- *What conditions are monitored?*
- *Where does the data come from?*
- *Survivor and Bereaved Residents*
- *How are the findings considered?*
- *What have we found to date*?
- *The future of population health monitoring*

How Population Health Monitoring was developed

The local program of Population Health Monitoring was instigated following the Coroner's Prevention of Future Deaths Notice in September 2018 with support and guidance from Public Health England (as it was known at that time).

The methodology and the conditions considered to be relevant to the type of tragedy were agreed with local clinical experts, academics and resident input.

The diagram below demonstrates the development of the Population Health Monitoring programme:



Abbreviations:

NWL WSIC = North West London Whole Systems Integrated Care team

PHE = Public Health England

CNWL =Central and North West London NHS Foundation Trust

PHIG = Public Health Implementation Group

What conditions are monitored?

Public Health monitor overall health and wellbeing as well as conditions relevant to this type of tragedy:

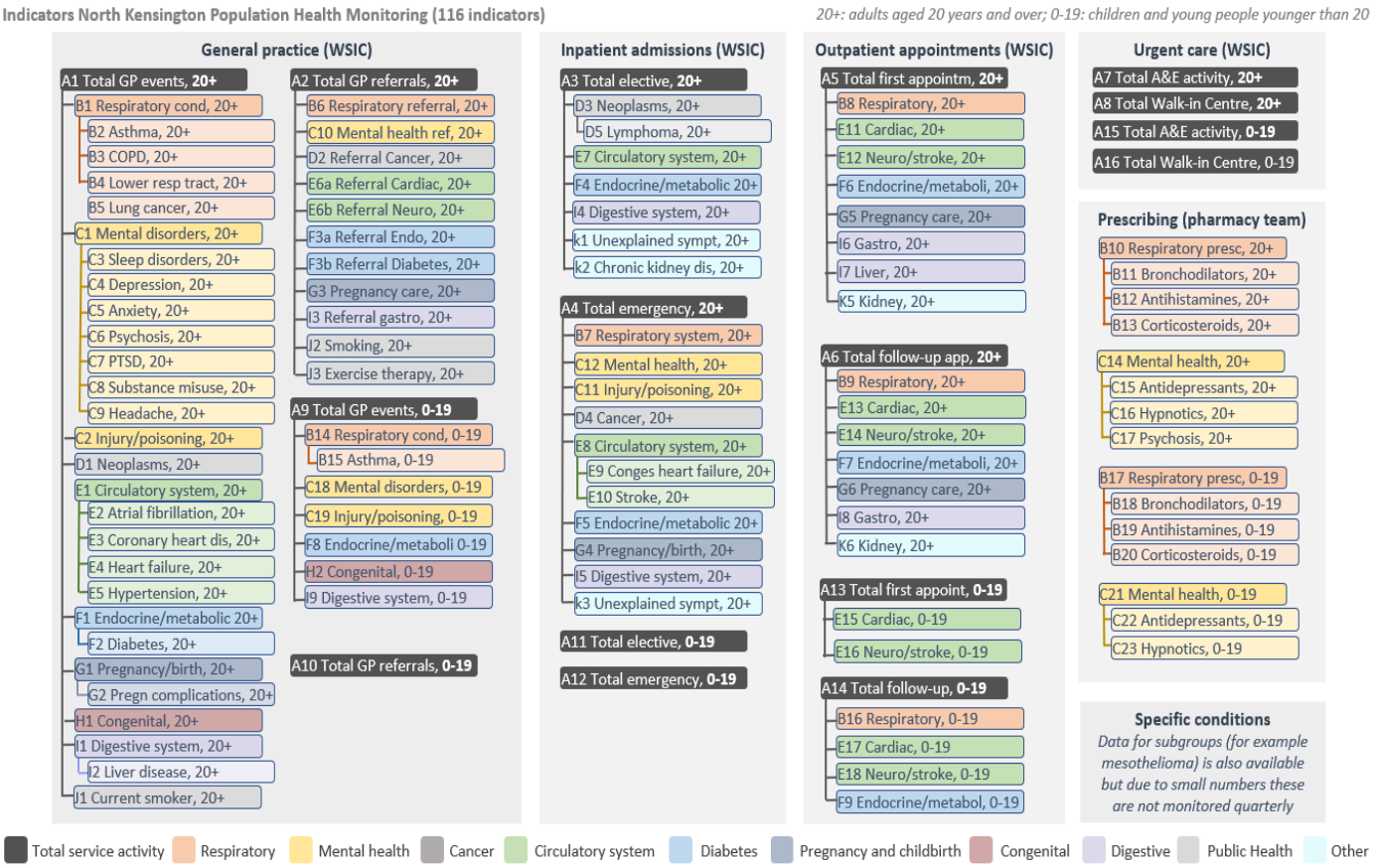
- Illnesses of the lungs and airways. This includes conditions such as asthma, a swelling of the breathing tubes that carry air in and out of the lungs that causes breathing difficulties that may happen randomly or after exposure to a trigger. Annually, we also monitor rarer lung conditions such as asbestosis, a lung condition caused by breathing in dust from asbestos used in construction, and mesothelioma, a type of cancer affecting the lining of lungs linked to asbestos. We also monitor the prescribing of medications such as bronchodilators, a type of medication that make breathing easier by relaxing the muscles in the lungs and widening the airways, and preventer inhalers which suppress the airways swelling in the first place.
- Mental health and wellbeing. This includes for example, depression, anxiety, sleep disorders and post-traumatic stress disorder. We also monitor the prescribing of medications such as antidepressants or sleeping tablets.
- Cancer. Diagnoses and treatment for cancer is monitored quarterly, and annually we also monitor specific types of cancer, in particular lung cancer, prostate cancer, bone cancer and blood cancer.
- Pregnancy, childbirth and infants. This includes pregnancy and labour complications, conditions affecting a baby's development and health during pregnancy and conditions present at birth.
- Other physical health conditions. Other physical health conditions monitored include conditions of the heart and blood vessels, diabetes, and conditions of the digestive system.

For each condition we look at data from different health services and within different age groups, covering:

- GP visits, GP referrals to other services and prescribing of medications by GPs
- Admission to a hospital bed, including planned and emergency inpatient admissions
- Day visits to hospital for treatment, including first and follow-up outpatient appointments

among adults aged 20 years and over and children and young people aged 0-19 years.

116 ‘indicators’ have been monitored quarterly since 2019:



Three further conditions (18 ‘indicators’) were added in 2023, incorporating feedback from residents and clinicians:

- Autoimmune conditions. Your immune system is your body’s defence against infection and disease. If you develop a problem with your immune system, it can start to attack your own healthy tissues and organs. This is called an autoimmune disorder. The immune system is sensitive to stress and research studies have suggested a link between post-traumatic stress disorder and development of autoimmune conditions. Autoimmune conditions we monitor include for example inflammatory bowel disease, rheumatoid arthritis, psoriasis and multiple sclerosis.
- Musculoskeletal conditions. These are conditions that can affect your joints, bones and muscles and sometimes associated tissues such as your nerves. There is some evidence that psychological trauma and stress is related to muscular pain, and there may also be an indirect link via a lack of exercise. Musculoskeletal conditions we monitor include joint, soft tissue, neurological and degenerative conditions and injuries.
- Skin conditions. Stress can aggravate skin conditions such as eczema and psoriasis. Skin conditions we monitor include skin rashes, skin infections and lesions.

A further 337 indicators are reviewed annually, covering 71 conditions. These are subcategories of the indicators monitored quarterly. For example, GP activity relating to all illnesses of the lungs and airways is monitored quarterly while activity specific to asbestosis is monitored annually.

These include:

- Illnesses of the lungs and airways: asthma, COPD, lower respiratory tract, lung cancer, asbestosis, pulmonary embolism, pulmonary fibrosis, pulmonary hypertension, mesothelioma
- Mental health and wellbeing: sleep disorders, depression, anxiety, psychosis, Post-Traumatic Stress Disorder, substance misuse, headache, alcohol dependency, bedwetting, fatigue, health anxiety, learning

disability, obsessive compulsive disorder, suicide, nightmares, bipolar affective disorder, injury and poisoning
- Cancer: lung cancer (see 'illnesses of the lungs and airways'), lymphoma, prostate cancer, thyroid cancer, bone cancer, leukaemia, myeloma
- Pregnancy, childbirth and infants: pregnancy complications, placenta praevia, labour complications, obstetric hypertension, foetal problems, abortive outcome, foetal abnormalities, perinatal conditions, congenital abnormalities
- Conditions of the heart and blood vessels: atrial fibrillation, coronary heart disease, heart failure, hypertension, myocarditis, pericarditis, stroke
- Diabetes: diabetes, pre-diabetes, Addison's disease, Cushing's disease
- Other: liver disease, smoking, exercise therapy, unexplained symptoms, chronic kidney disease, motor neurone disease
- Autoimmune conditions: rheumatoid arthritis, inflammatory bowel disease, psoriasis, systemic lupus erythematosus, multiple sclerosis
- Musculoskeletal conditions: arthropathies, degenerative conditions, injury, neurological conditions, soft tissue conditions
- Skin conditions: infection, lesion, skin rashes, other skin conditions.

Where does the data come from?

Public Health at the local authority has access to pseudonymised (removing any identifiable information and using random code instead) patient level data through Whole Systems Integrated Care Data (WSIC) for analysis to ensure data security and maintain confidentiality. No person can be identified from the analysis findings. This covers GP visits and referrals, planned and emergency inpatient admissions, and first and follow-up outpatient appointments.

The WSIC System links provider data from health and social care organisation to generate a summary integrated care record stored in a secure dedicated data warehouse.

The NHS organisations are the data controllers, they retain control over how its own contributed data is accessed, transferred, stored within the data warehouse. Public Health have been granted access to the specific data requested for the purpose of Population Health Monitoring and can use a fully de-identified version of the WSIC data in a separate secure data warehouse[3].

Public Health also use primary care prescribing data as shared by the pharmacy team.

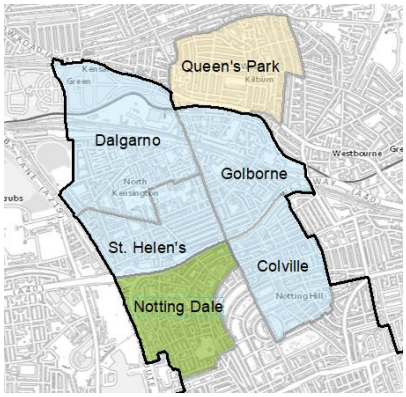
How do we monitor health and wellbeing?

We monitor the health and wellbeing of:

- Survivors of the tragedy
- Those bereaved by the tragedy
- Residents of the Notting Dale ward
- Residents of the other four wards which comprise the North Kensington Area (Colville, Dalgarno, Golborne, St Helen's)

We look at these groups alongside a comparator area: residents of the Queen's Park ward in Westminster – an area with similar characteristics and make up to Notting Dale.

[3] Statement of Information Sharing SIS (nwlondonccg.nhs.uk)



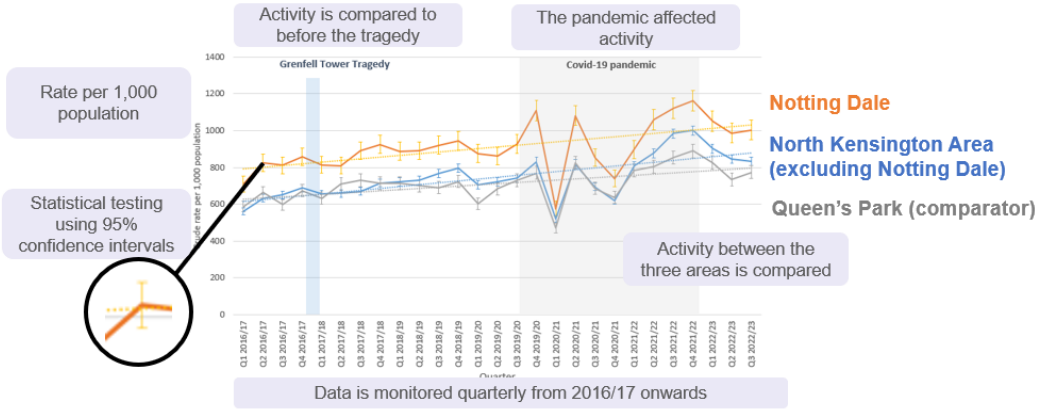
We do not track the health of individuals, but instead look at the needs of a population as a whole each quarter. This means each year the number of individuals that lived in Notting Dale at the time of the tragedy will decrease as residents may move out of the area.

Age and other social and demographic factors may differ between the areas and affect health**,** but these are not taken into account, although findings are compared to an area selected because of its similar characteristics and make up to Notting Dale.

Data for the 'indicators' described above is reviewed every three months (116 'indicators' and the 18 new 'indicators' added in 2023).

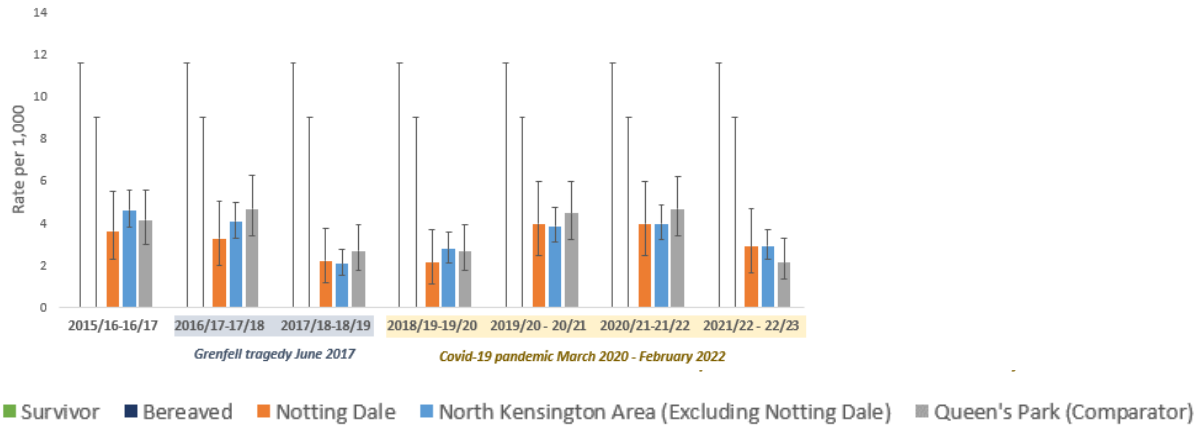
Every three months we review:

- Is activity significantly above or below the previous quarter, before the COVID-19 pandemic, or before the tragedy?
- Is activity significantly different between the three areas?
- Any other patterns of interest observed.



Example chart showing one of the indicators (Total outpatient first appointments in aged 20 years over)

In addition, an annual review covers a further 337 'indicators'. Data is combined for 2 years so that the numbers are large enough to compare.



Example chart showing one of the annual indicators (GP events for pulmonary embolism, adults 20+)

For this indicator the number of visits is below 5 in Survivor cohort and Bereaved cohorts.

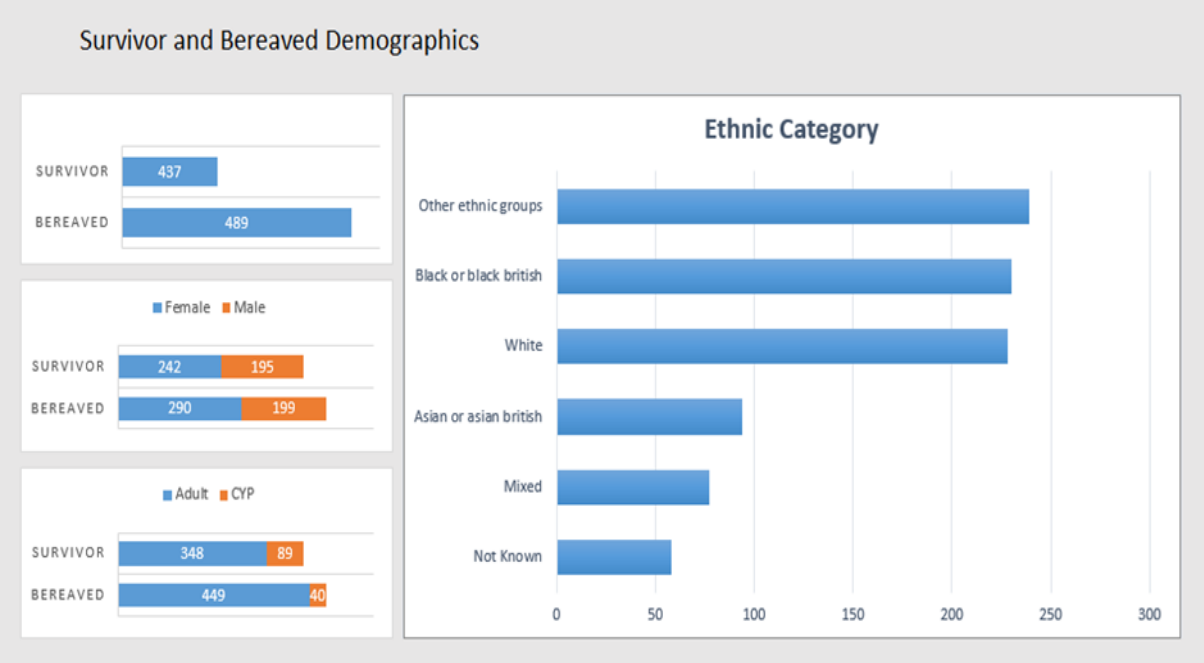
Survivor and Bereaved Residents

From September 2022, data sharing agreements are in place between the NHS and RBKC and Public Health to regularly monitor and assess health data for survivors and bereaved (in addition to residents of the five wards surrounding the Grenfell Tower).

To assist NHS services in identifying individuals affected by the Grenfell tragedy, two discreet codes were created to distinguish Survivors and Bereaved. These codes were then assigned to patients by their GPs. GPs have also assigned the survivor code to patients born as survivors, while the bereaved code is also applied to patients who have self-identified as bereaved following the incident.

The image below provides a breakdown of our Survivor and Bereaved cohort as of August 2023. Data is only available for those patients that are still registered with a North West London GP, which accounts for the disparity with Dedicated Service numbers.

There are 437 patients coded as Survivors and 489 coded as bereaved. Both groups consist of a higher number of females then males. Furthermore, the cohort represents a diverse ethnic background, with the largest ethnic category being Other Ethnic Group, closely followed by Black or Black British and White.



How are the findings considered?

Data monitoring and interpretation is a joint endeavour between local authority and NHS colleagues.

Data analysts and clinicians meet quarterly to look at data trends to pick up on any changes early.

When a change is observed, the team go through a process of checking the data more thoroughly, triangulating this with the experience of clinicians on the ground and trying to understand what might be driving this change. Sometimes this can be as simple as a particular health campaign or a change in service provision that is responsible for a spike in a diagnosis or service use. For example, we may observe an increase in GP visits related to asthma, but when investigated further we find it due to a single practice changing the code they use to record routine annual asthma reviews, and not an increase in new diagnoses or worsening of symptoms.

If there are any signals in the data that might be a real increase in disease, there is a process in place to investigate this further and decide on necessary service changes. Findings are shared regularly in clinical reference meetings with NHS colleagues to contextualise with clinical understanding of the services and arrive at meaningful conclusions and actions. NHS then interpret the data, as the local authority do not have full access to the information contained within NHS services.

What have we found to date?

From the 116 local NHS indicators we monitor routinely for Notting Dale, very few have identified an increase in health needs, when compared to the borough as a whole, or to Queen's Park, a ward with a similar population profile.

For some conditions and long-term health impacts, we would not necessarily expect to see an increase in the current timeframe as these may not present for a long time.

As described in the 2018 JSNA Journey of Recovery there were some increases shortly after the tragedy, which were to be expected, but have fortunately since returned to activity levels prior to the tragedy and the comparator area:

- In the month of the tragedy (June 2017) there was an increase in overall use of urgent care by Notting Dale residents compared to June 2016, and in particular for conditions of the lungs and airways.
- Following the tragedy, there was increased GP activity in Notting Dale ward for mental health diagnoses in adults including post-traumatic stress disorder, sleep disorders and the prescribing of medications used to assist with sleep disorders.

Since then, as described in more detail in the main document, we've observed the following for Notting Dale residents:

- We have not seen any increases in the occurrence of respiratory conditions in Notting Dale or the North Kensington Area other than for seasonal influenza or due to the COVID-19 pandemic. This is also the case for the rest of Kensington and Chelsea, and Westminster.
- There was an increase in GP appointments for asthma in adults, however investigation established the increase was due to coding activity by the GP practice and not due to an increase in the diagnosis of asthma.
- Respiratory prescribing in Notting Dale during the COVID-19 pandemic was above the comparator area, due to increased inhaler prescription used to relieve symptoms of asthma and chronic obstructive pulmonary disease (COPD) such as coughing, wheezing, and feeling breathless. Following the pandemic this has returned to a lower rate of prescribing that is similar to before the pandemic, before the tragedy and the comparator area.
- In all areas GP visits relating to respiratory health by children and young people show seasonal fluctuation, with winter peaks relating for example to influenza or RSV. No change in pattern is observed compared to before the disaster and the comparator area.
- GP activity for pregnancy and childbirth is in line with the pattern before the tragedy and not different from the comparator area.
- In both adults and children, there has been an increase in the prescribing of medication for mental health conditions, which is in line with a longer-term increasing trend also observed in the comparator area and the wider North Kensington area. This may reflect increased anxiety in general and the impact of the COVID-19 pandemic and the rising cost of living.
- The Public Health Population Health Monitoring programme has not detected any increased occurrence of cancer in the Notting Dale population or within the wider North Kensington area to date.

For survivor and bereaved residents we've observed the following:

- We note an increase in overall use of urgent care such as A&E visits and an increase in GP visits by survivors at the time of the tragedy, returning to levels similar to the wider area in the years following.
- GP activity for lung conditions in adults increased after the tragedy in survivors and has remained high. When we investigated this further**,** we found that the increased activity was explained by extra services offered through Grenfell Survivors Respiratory & Paediatrics Monitoring.
- GP events for mental disorders and post-traumatic stress disorder increased after the tragedy in survivors and to a lesser extend in bereaved residents and remained high over 2018/19 and 2019/20. This is what would be expected following a major tragedy such as the Grenfell tower fire.
- GP activity for sleep disorders by Survived and Bereaved residents increased after the tragedy and has remained above the other areas, in line with mental distress.
- No significant changes have been observed for cancer.
- Apart from an increase in GP cardiac referrals shortly after the tragedy (which has since returned in line with the wider area), activity related to conditions of the heart and blood vessels is similar to the wider area.
- Activity for diabetes was above the wider area before the disaster and this has remained unchanged.

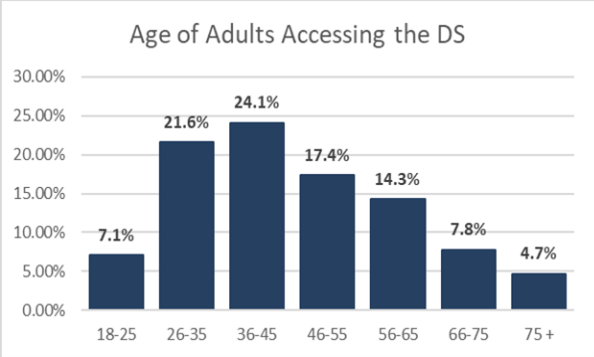
The future of population health monitoring

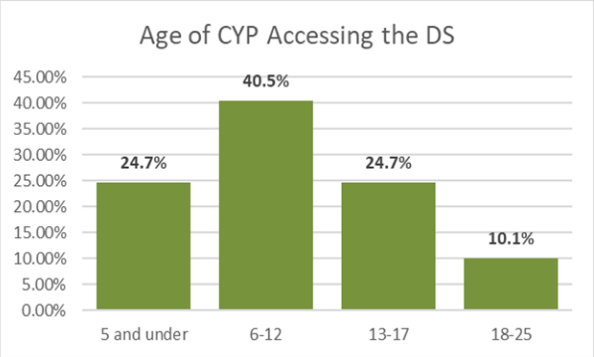
The introduction of a Grenfell Dashboard that is being produced by the North West London Whole System Integrated Care (WSIC) team will allow for better transparency and ease of reporting.

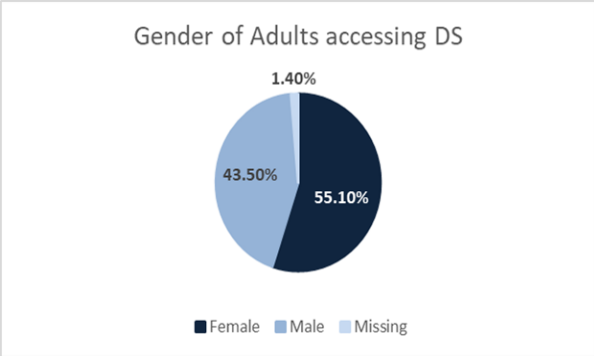
Appendix 3

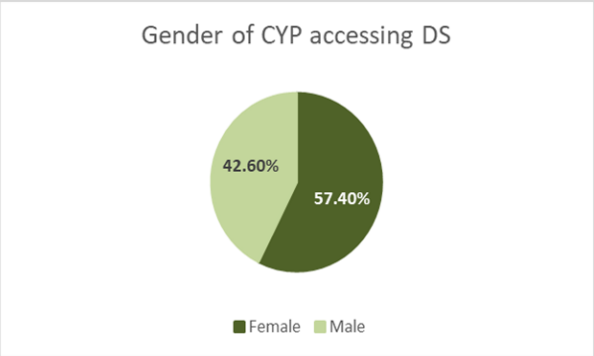
NHS Dedicated Service, Survivor and Bereaved patient demographics

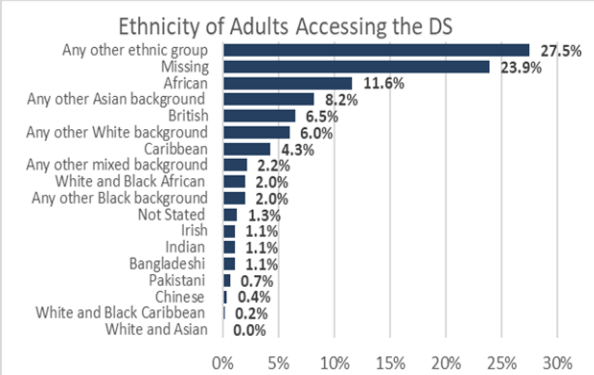
Basic demographic information is collected for the DS service users. These numbers represent clients who are actively receiving support from the DS Team. They are categorised below as Adults and Children and Young People (CYP):

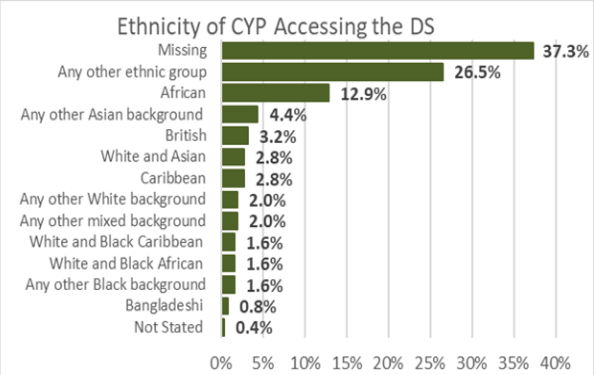


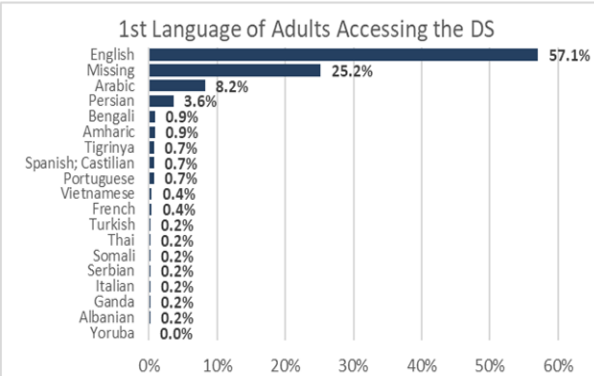


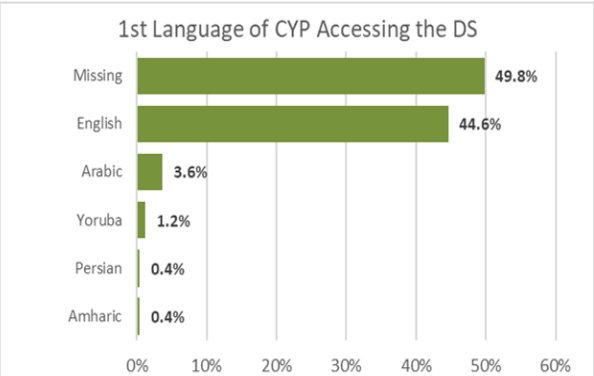












Of those active in the DS, 61% live in Kensington and Chelsea, 12% in neighbouring boroughs of Westminster and H&F, 3% outside London and the remaining 24% in other London Boroughs.

Appendix 4

Specialist Services cont.

The NHS commission several specialist services to diagnose and treat any health conditions which arose from smoke, particulate and poison inhalation during the fire. Services commissioned were:

- Paediatric Long Term Monitoring Service (Imperial College Healthcare Trust [ICHT])
- Adult Respiratory Long Term Monitoring Service (ICHT) - includes an annual lung function test to identify any signs of respiratory disease and changes in breathing patterns and capacity. This service is designed for survivors who had prolonged smoke exposure. The service has support and close working links with psychology services at St Charles hospital (commissioned separately and physiotherapists. In exceptional circumstances the service sees people who were outside the tower with complex health needs.

  People within the adult respiratory long-term monitoring service are re-called annually to keep any emerging or existing health conditions under review, and to ensure there are no long-term respiratory consequences as per the coroner's concerns. The service also offers onward referrals to sub-specialties including a physiotherapy breathlessness clinic the lung cancer service, the interstitial lung disease service, the pulmonary rehabilitation service or recommendations for input from other specialties.

- Guy's & St Thomas NHS Foundation Trust was commissioned from November 2019 to provide a toxicology service for the survivors, though this is also accessible to the bereaved and Grenfell Walk residents who have concerns about poison inhalation if they were in proximity to the Tower. The service offers an appointment with a Consultant Toxicologist for a clinical toxicology review and the opportunity for people to discuss their individual needs/concern.

Paediatric Long Term Monitoring Service

The Paediatric Long-Term Monitoring Service provides a holistic integrated health and wellbeing annual review for all survivors, bereaved, and Grenfell Walk children and young people.

The Paediatric long-term monitoring is a service for children and young people who are survivors or bereaved of the Grenfell incident, or children of survivors. This is an annual 90-minute appointment with a paediatric consultant, who undertakes comprehensive physical examination including lung and breathing functions, review of emotional health and wellbeing, how they are getting on at school, sleeping patterns, height, weight and diet, and immunisation checks.

Activity (as of January 2024)

- Since the launch of the service in September 2019, 138individual patients have been referred to the Imperial College Healthcare Trust (ICHT) Paediatric Long-Term Monitoring Service (83 survivors, 54 bereaved)

- Out of the 138 children that have been referred into the ICHT Long Term Monitoring Service 107 individual children have been seen.

Of the those:
- 73 are survivor children and young people (67% all CYP survivors).
- 34 are bereaved children and young people. (53% of all CYP bereaved)

Of the 44 children that were in the tower
- 43 (98%) have been offered this service with 41 (93%) accepting and being referred.
- 35 of 41 have been seen, 5 deferring for a year and one booked in.

Lung Function Tests

Respiratory concerns within children and young people are monitored, through formal lung function tests and review by a consultant Paediatric respiratory specialist.

- All patients within the Paediatric Long-Term Monitoring Service have been offered formal Lung Function Testing, irrespective of their whereabouts on the night of the fire. The Lung Function Tests are supported by a paediatric respiratory consultant who provides clinical guidance and interprets the results of the test for the family.
- 31 children have taken up the offer of the Lung Function Test.
- From observation, the uptake for Lung Function Testing is low due to patient choice as of December 2022, 22 patients have had lung function tests.

Any clinical concerns that have arisen in the consultations have been reviewed by the Paediatric clinical team, looking for trends and potential issues that may be meaningful to the whole population.

The Paediatric Long-Term Monitoring service observes that his population is living with a wide range of medical conditions and general health concerns. Some, if not all these conditions reflect the prevalence of the general population.

Clinicians conducting appointments observed that many symptoms are heightened by the traumatic experiences of the child, young person, or family in relations the fire. Therefore, this population needs more time and clinical input to manage all health issues, compared to the background population. The most frequent concerns discussed at the consultations are respiratory and mental health concerns.

Attendance activity

The table below shows how many patients from cohort have attended their annual appointments with small numbers suppressed.

		Number of Yearly Attendances				
Patient Type	**Referred**	**1**	**2**	**3**	**4**	**5**
Survivor	79	90%	56%	24%	<5	<5
Bereaved	58	62%	33%	<5	0%	0%

Focusing on our survivor cohort, out of the initial 79 referrals, we observe that 90% attended at least one appointment. However, this percentage decreases to 56% for those attending two appointments and further drops to 24% for three appointments.

The bereaved cohort consists of 58 referrals with 62% of these having at least one attendance.

Reasons for not attending:

Out of the 138 patients referred to this service, 107 have attended their appointments. 12 have relocated and are now out of the area, 6 have been invited but have not scheduled appointments yet, 5 did not attend their appointments and have now reached adulthood, while fewer than 5 declined their appointments, and fewer than 5 have deferred their appointments.

Patient Reason for cancellation and DNAs
Child/ other sibling being unwell
Parent being unwell and COVID-19
Parent unable to bring the child
Appointment no longer suitable
Transportation issue
Travelling
Family member being in hospital/ other family related affairs
Provisional bookings (checking with school, work, and other commitments)

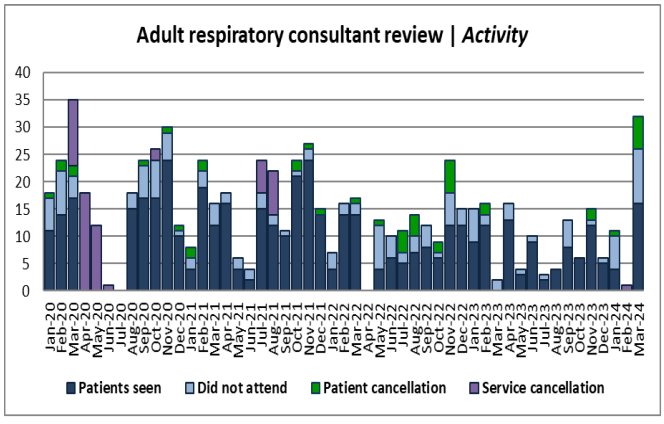
Adult Long Term Respiratory Monitoring Service

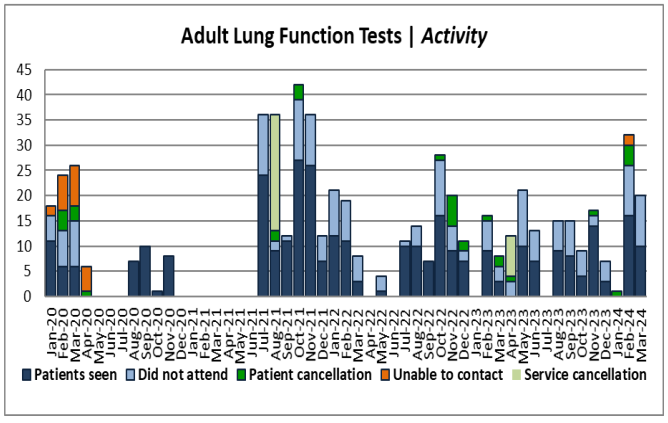
Imperial College Healthcare Trust (ICHT) figures state, there were 207 referrals into the service of which 149 are tower survivors, which accounts for 89% of the 189 adult tower survivors.

Forty patients have not been referred, this includes a number who declined, could not be reached or have subsequently died.

There are high did not attend (DNA) rates within this service, and people who are not able to attend their 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. Patients are also offered a choice of dates and times. The NHS Dedicated Service team are working to access as many survivors as possible to offer them the Respiratory monitoring.

Lung Function Tests were not carried out for 10 months during the Covid pandemic due to it being an aerosol generating procedure.





Attendance

120 adult survivors have been seen at least once for a lung function test from. At least 70 individuals have been re-called for subsequent annual appointments. These figures do not include the attendances of those individuals that were not tower survivors. 135 adult survivors have been seen for at least one Consultant Respiratory Review with 112 being seen for 2 or more.

Breathlessness Clinic

The breathlessness clinic was set up as a result of the recognition of trauma and stress these individuals had been through. It is well recognised that both mental and physical stress can lead to breathing pattern disorder (breathing that is disproportionate to need). This is an unpleasant sensation that needs breathing pattern training often alongside addressing the stressor.

22 individuals have been onward referred to the breathlessness clinic, which was set up for people with abnormal breathing patterns or disproportionate shortness of breath with normal lung function. It has been found that the health outcomes of people are greatly improved when psychologists are present for these appointments. The breathlessness clinic provides an opportunity for other health concerns, not necessarily related to breathing, to be discussed in a holistic way, for example considering how stress and anxiety may be contributing to difficult symptoms. Collaborative working between psychology and physiotherapy was essential to address the psychological impact of trauma on the individual.

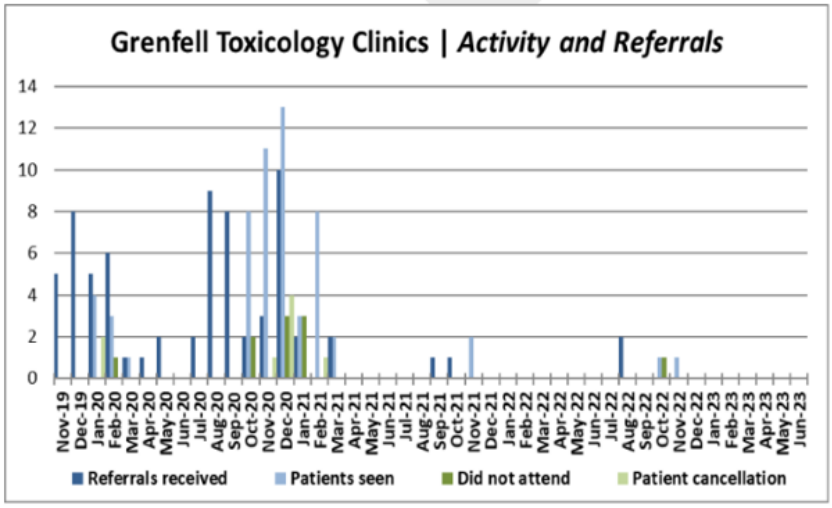
Its paramount that we continue with population health monitoring of the survivor and bereaved cohort. People undertaking annual health checks is a crucial part of the NHS and Public Health responsibility for long term monitoring of health needs, as it will enable us to spot possible health consequences as early as possible. To encourage this**,** we must continue to offer the monitoring and make it as accessible as possible. As we transition from the 5-year Grenfell recovery plan and re-establish which services are meaningful to the community. The aid of clinical perspective and user feedback will help shape a future offer. The role of a clinical reference group is the perfect forum to make these distinctions.

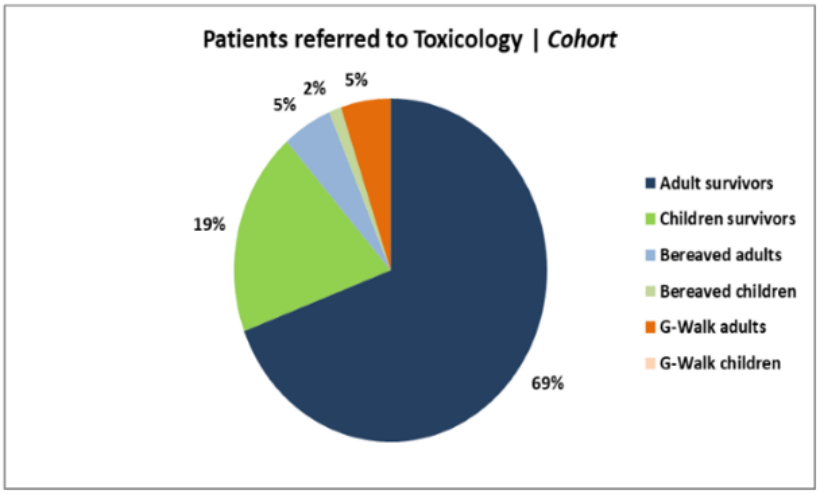
NHS Community Respiratory Service

While not formally commissioned by Grenfell specific funding. This local community respiratory service stepped up and offered fast track pathways as a response to the fire to people who were both inside and in the vicinity of the tower. Once the commissioned service started, the community respiratory pathway was adapted based on service demand. It was deemed appropriate to discontinue the fast tracking of asymptomatic outside-tower individuals, solely on the basis that they visited or resided in areas proximate to the tower. The service continues to triage and see these people within wait times that reflect the clinical severity and complexity of their symptoms.

NHS Toxicology service

The uptake of this service has been substantially lower than others within the programme. Only 69 survivors, 5 bereaved and 4 Grenfell Walk residents have been referred into the service (mostly adults), and then 55 have gone on to be seen.





Our ongoing dialogue with the communities suggests that the low uptake may in part be due to word of mouth of the experiences people have had with the service in relation to expectations. The service does not formally collect patient experience feedback, though regular conversations with patients and engagement with the community reflect a range of experiences for people, from those who feel content with the clinicians' explanation and reassurance provided by the service, to those who are dissatisfied with the absence of blood and biometric testing. The service has reported that biological samples taken 2-3 years after the event are unlikely to yield any insightful results, as symptoms people have, are now likely to be due to environmental factors that they are normally exposed to.

Carrying out tests as a core function of toxicology is a common misconception perceived by many people nationally, and the service has had to explain to patients why tests are only taken when certain conditions are met. Most people have been understanding of this, some have been less accepting, and some have sought tests in the private sector. To date the NHS has not been informed of any tests carried out in the private sector which have shown an impact of poisoning.

One concern raised by a few members of the community was potential hypoxia caused by smoke inhalation. This stems from a single case with no one else presenting to the service with memory loss; neuro-psychometric cognitive testing would have been used to determine whether this cause was organic or non-organic. A few individuals have presented with dermatological conditions in other services within the recovery programme. This has not been raised in any toxicology appointments, and the toxicology consultants have deemed that such conditions are likely to have been brought on by stress or anxiety.

58% of people seen within the service mentioned Respiratory concerns, and 58% of people had psychological symptoms; individuals have been onward referred to the Grenfell Health & Wellbeing Service and adult respiratory

long-term monitoring service for these specific health needs. There has been no pattern of ongoing symptoms in the individuals reviewed to date to suggest issues of toxicological concern.

Appendix 5

NHS Grenfell Health & Wellbeing Service (GHWS)

GHWS was established by Central North-West London (CNWL) NHS Trust following the tragedy in 2017. The initial response was to identify those who had been affected by establishing a proactive screening approach and providing therapy for those who needed it.

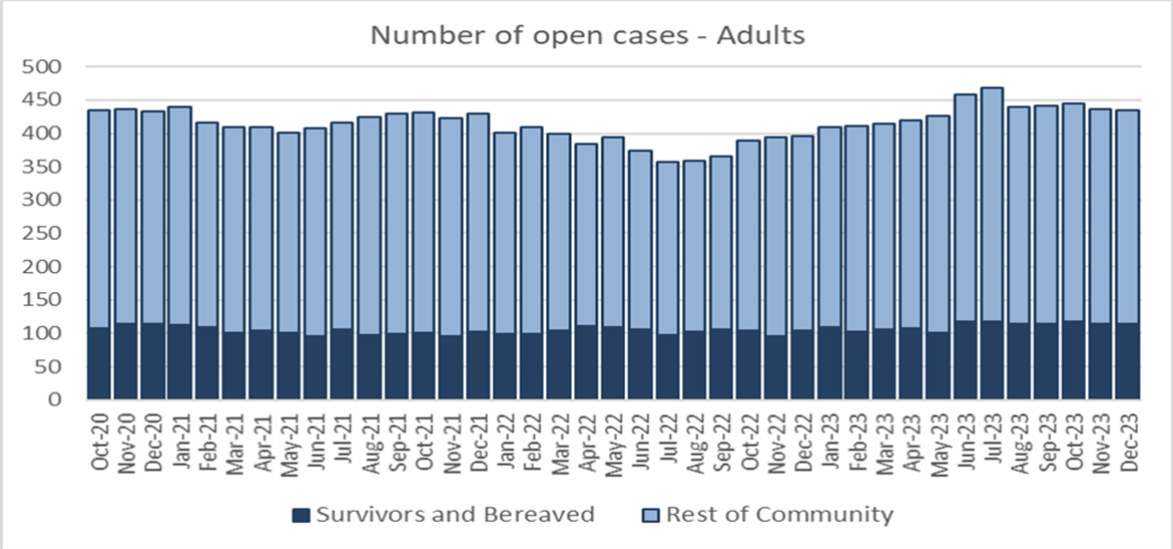
The GHWS was then formally commissioned with a remit to provide resilience building support and interventions to the North Kensington community and to individuals and families experiencing trauma and loss-related distress as a result of the tragedy. The proactive screening approach ended in 2019, and the GHWS continued shifting from a traditional therapeutic model of clinical support to one which is more holistic.

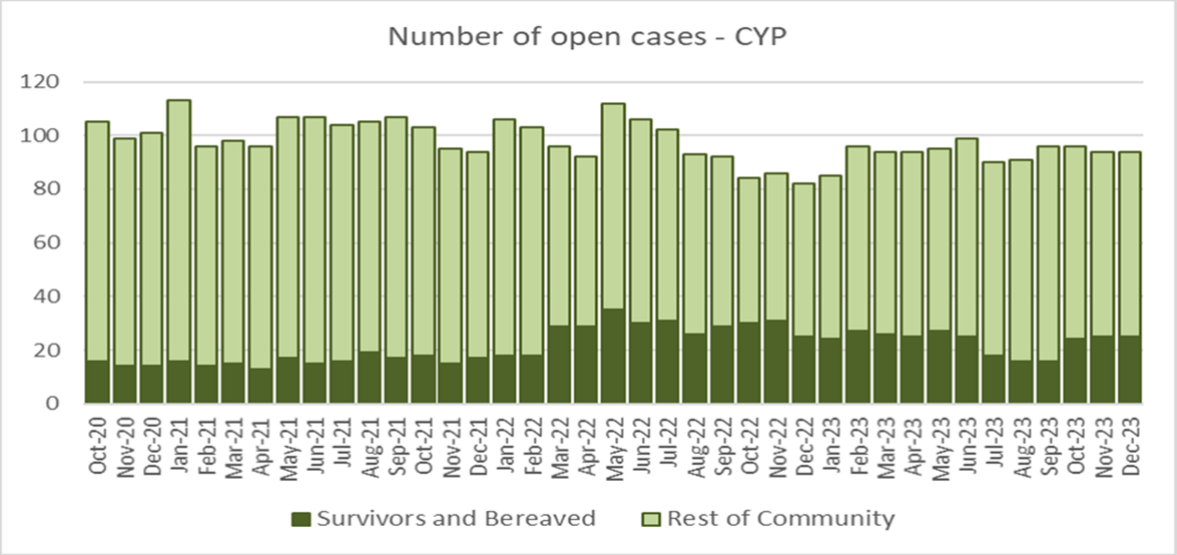
The adaptation of the service offer has been informed by regular engagement with North Kensington residents, community groups and other stakeholders. The GHWS conducted several focus groups in 2021 to get feedback on how the service should change and set up a dedicated community collaboration arm to improve partnerships with residents and community groups.

GHWS now provides mental health support, assessment, and a number of therapeutic services to all those presenting with trauma, distress, anxiety, depression and loss as a result of the fire. The support offered are tailored to the individual's circumstances and goals. The number of sessions a person can have is not capped, which often happens in other mental health services, so 'clients' can have as many sessions as needed. The GHWS model's integrated offer includes the expansion of the multidisciplinary approach to include Occupational Therapy, social work, and employment support.

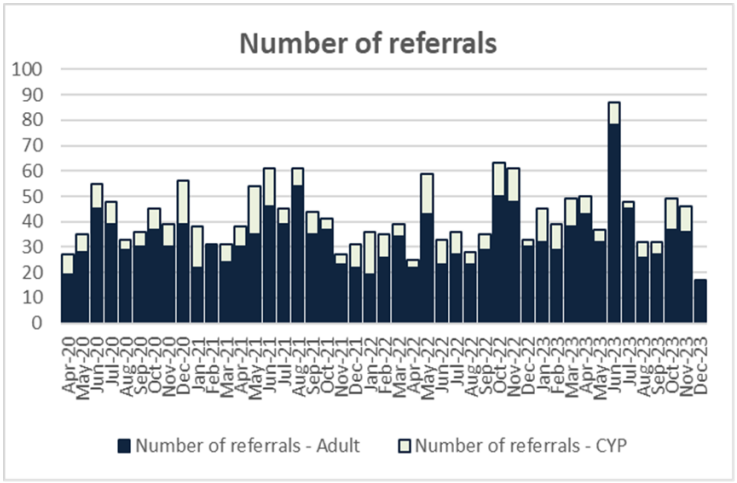
Activity – referrals and open cases

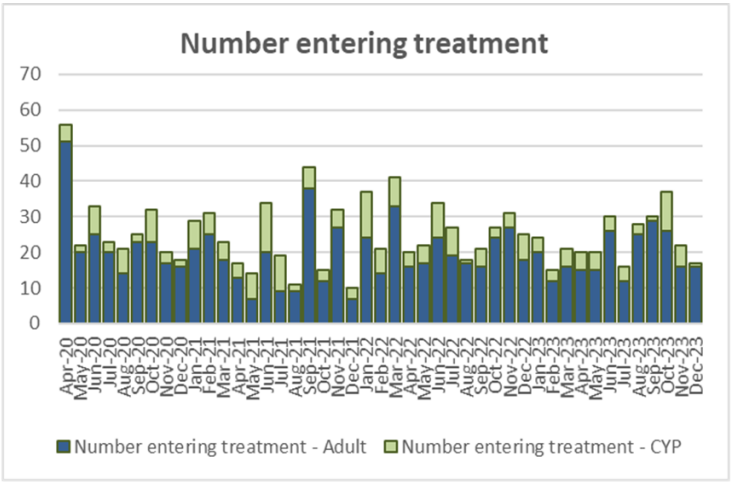
- GHWS activity numbers fluctuate based on the needs of the community as well as external factors Inquiry, Tower discussions, news articles etc. Since October 2020, the total number of open cases has fluctuated between 451 and 558, with no sustained trend in activity over this time.
- In June 2023 there was a large number of referrals into the services due to a transfer of care from private healthcare providers to GHWS.

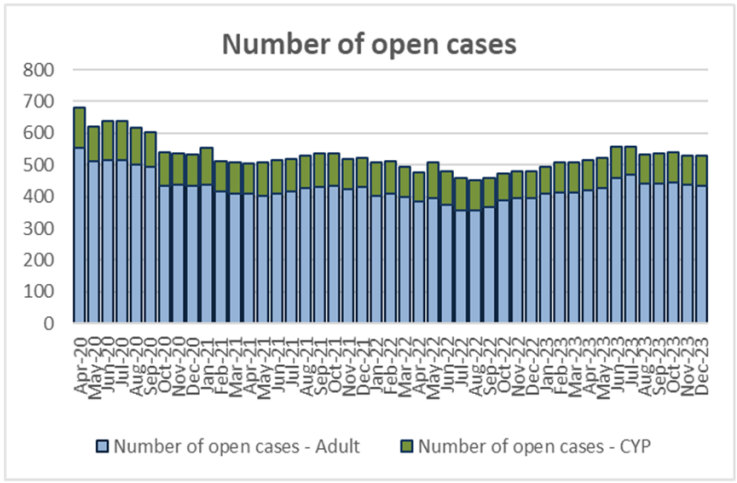


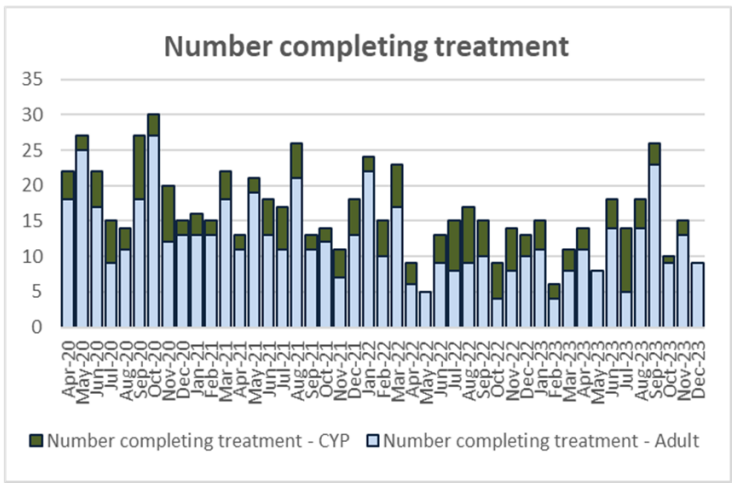


- Overall, 96% of survivors and bereaved have been offered the GHWS with 71% accepting and 64% seen. The 4% that have not been offered have not been contactable by the service.
- The number of adult survivor and bereaved open cases has fluctuated between 98 and 117, with the numbers increasing to 117 in June 2023
- CYP survivor and bereaved numbers have fluctuated between 13 and 35. There was an increase in the reported numbers in March 22 as the numbers of CYP open to a DS CYP Therapist began to be reported.







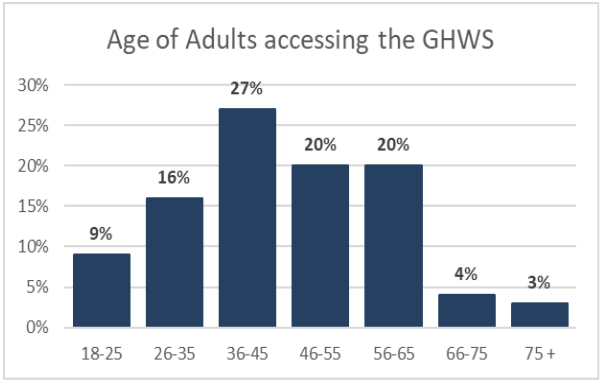


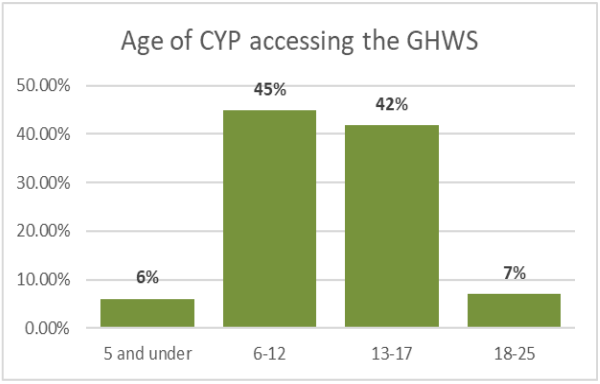
Adult Referrals since May 2022- by source and service

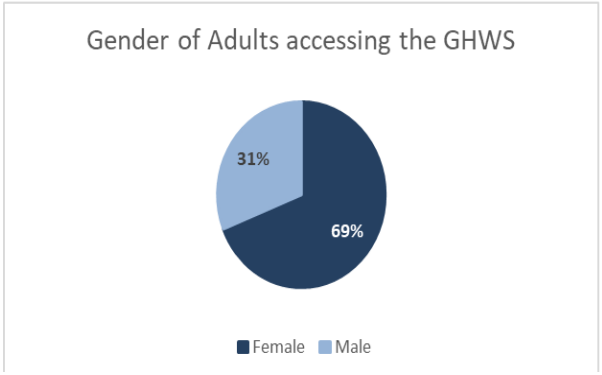
The following section provides an additional layer of detail to show the mental health needs of the people using the GHWS:

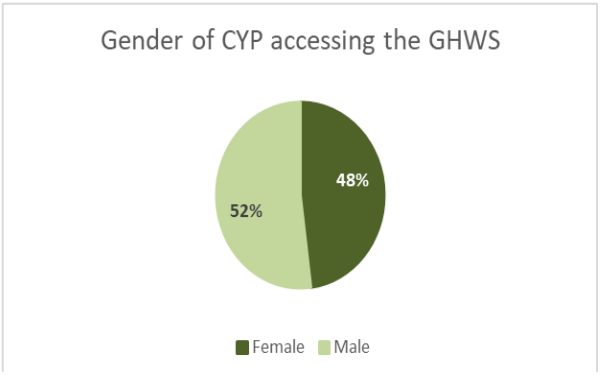
- The main sources of adult referrals are primary care and self referral. Other (unspecified) services also referred a smaller number of people into the service.
- For CYP, referral patterns are different, with more coming from internal CNWL teams and other agencies.
- Cognitive Behavioural Therapy and Trauma informed psychological therapies are the most utilised aspects of the service, treating a range of conditions – most commonly PTSD, depressive episodes and anxiety.
- The presenting conditions of people using the GHWS has not changed markedly over the period 2020-23, although the proportion of people with a diagnosis of depression (mild, moderate, severe, recurring or unspecified) has decreased, with a corresponding increase in the proportion of people with PTSD and anxiety related issues.
- As of September 2023, 34% of adult clients have been contacted by the service in the last week, and 65% within the last month.
- The average number of appointments per client is 35, showing the longer-term nature of the support required. However, 32% of the caseload had 0-5 appointments, which is more aligned to traditional Improving Access to Pyscholoigical Therapy (IAPT) models.

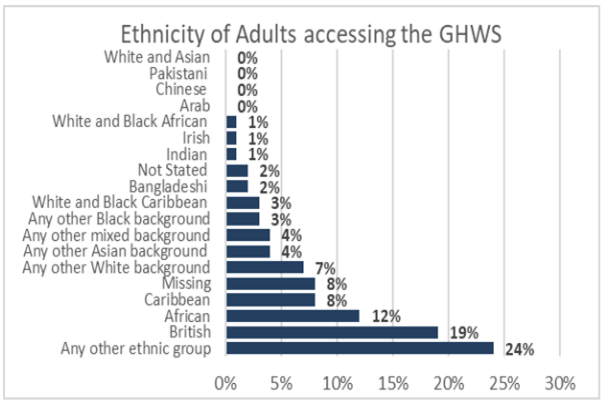
Demographics data

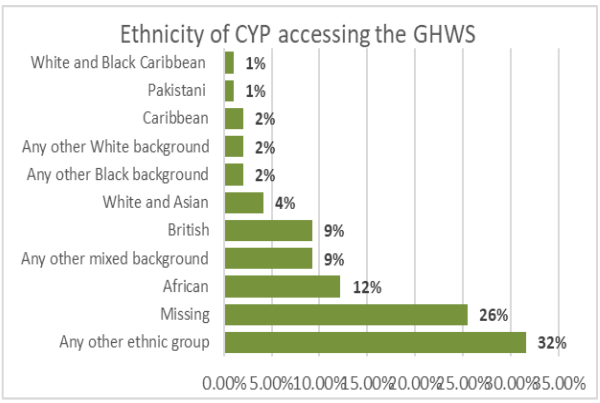


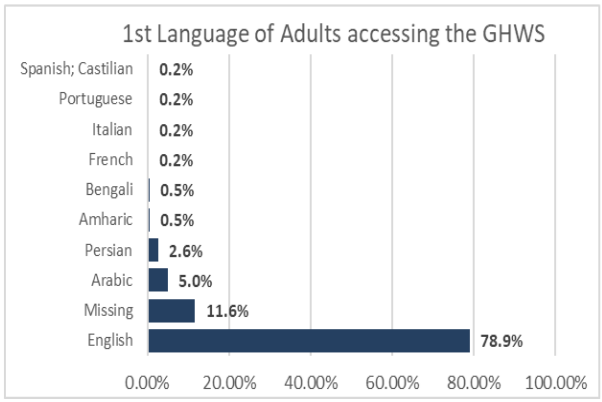


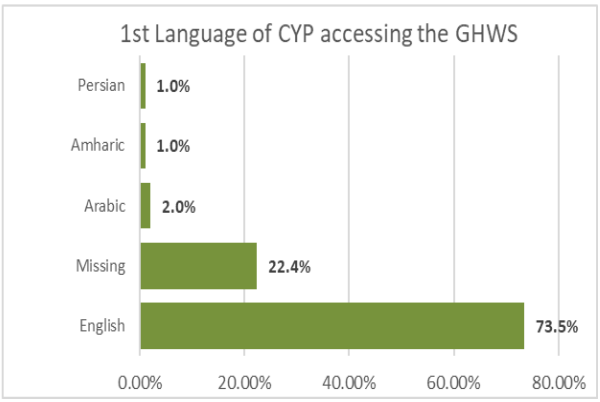












The GHWS collects basic demographic information for their service users. The charts below detail this information showing:

- The service is primarily used by working age adults, with the 36-45 age range currently accounting for 27% of the total number of clients.
- Only 7% of open cases are aged 65 and over.
- Males are underrepresented in the adult caseload of the GHWS (31%); whereas the CYP caseload is more evenly split (48% males; 52% females).
- Ethnicity – need community stats.

To support the needs of the community, it's important that we factor in culture and ethnicity, and the impact of wider intersectional needs. The use of spaces in the heart community that are tailored to meet these needs have proved popular and have complemented the services on offer.

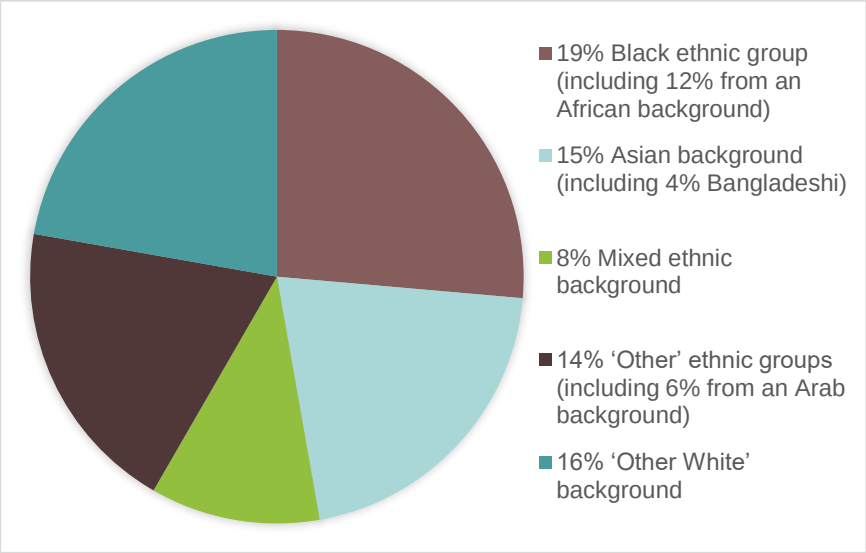
Service activity has shown that around 75% of patients in the GHWS have symptoms influenced by complex grief and trauma. The service codes these open cases under the umbrella category of 'Post Traumatic Stress Disorder', but improvements in the coding approach are required to further differentiate wide varieties in patients' symptoms and lived experiences. Feedback from community and professionals has also emphasised the strength of symptoms and the impact on people's day to day lives, such as associated sleep disorders and retriggering. Anxiety and, to a lesser extent over time, depression have also been significant mental health needs.

When reviewing mental health services outside of the NHS offer. There is a discrepancy between NHS and commissioned services methods for monitoring attendance and client feedback. This prevents the ability to directly compare findings There is a need for a better streamlined system that allows for robust and consistent monitoring system across all services to aid more precise data reviews.

Appendix 6

Notting Dale Ward Profile

The 2021 Census records the population of Notting Dale ward was 9,143, this corresponds broadly to the area within 500m of Grenfell Tower. It is a diverse community located in the North of Kensington and Chelsea, with an aging population and a high number of young families.



The population has increased over the last 10 years and has increased by almost 900 residents since the tragedy. Almost one in five (19%) residents are from a Black ethnic group (including 12% from an African background) and 15% of residents are from an Asian background (including 4% Bangladeshi residents). A further 8% are from a Mixed ethnic background, 14% are from 'Other' ethnic groups (including 6% from an Arab background) and 16% are from an 'Other White' background. Compared to 10 years ago, fewer residents identified as 'White', with the greatest increase in the number of residents from a Bangladeshi or Black African background. 23% of residents are Muslim, and 46% are Christian. Arabic, African languages and Spanish are the languages most spoken by residents after English.

Behind Golborne, Notting Dale is the second most deprived ward in Kensington and Chelsea and the ninth most deprived in London. Deprivation is measured with a composite outcome (Index of Multiple Deprivation) which takes into account the various challenges or disadvantages people in a community face related to their social and economic wellbeing.

Notting Dale has the second highest rates of long-term limiting illness and disability in the borough (after Dalgarno). This is similar to findings from the previous census 10 years ago.

There have been no large changes in the area's housing composition and tenure compared to 2011. Two thirds of residents live in social rented housing compared to 23% in London. 17% of households are overcrowded. The percentage of single person households is below the borough average but higher than the average for London.

There is a high rate of unemployment with 9.5% of working age adults claiming out of work benefits, the second highest ward in the borough, and nearly twice London levels. The long-term unemployment rate, defined as claiming Jobseeker's Allowance for more than 12 months, is also above national averages but given the relatively small size of the population it is unlikely to be statistically significant. Unemployment rates are similar to 2011.

The latest profile for Notting Dale, and for other wards, can be found on Public Health | Royal Borough of Kensington and Chelsea (rbkc.gov.uk) along with more information on the population health monitoring and annual survey.

Sociodemographic characteristics of Notting Dale

- Notting Dale is the second most deprived ward in RBKC and the ninth most deprived in London.
- 56% of resident are from a black or minority ethnic background compared to 36% of Kensington and Chelsea residents, 46% in London and 19% nationally.

- 67% of residents in Notting Dale live in social rented housing compared to 23% in London, and 17% in England.
- 17% of households are overcrowded, compared to 8% in Kensington and Chelsea, 11% in London and 4% in England.
- Notting Dale has the second highest rate of unemployment of wards in Kensington and Chelsea, with 9.5% of working age adults claiming out of work benefits. This is above the borough rate of 4.8%, the London rate of 5.6% and the national rate of 5%.
- The long-term unemployment rate in Notting Dale is 2.2 per 1,000, but given the relatively small size of the population, the difference between this rate and borough and national averages (1.4 per 1,000 and 1.9 per 1,000, respectively) is unlikely to be statistically significant'.

Health Outcomes

Note: Published data on death rates from all causes and data on premature deaths (those occurring under the age of 75 years) include the deaths that occurred at Grenfell Tower and may also include some deaths occurring early in the Covid-19 pandemic (2016-2020 pooled data). Life expectancy estimates for Notting Dale ward and Kensington and Chelsea are therefore impacted by the loss of life in the tragedy. Published data on emergency hospital admission ratios may also be impacted by the tragedy and the Covid-19 pandemic, as data on this activity is taken from the period 2016/17-2020/21.

Life expectancy

Life-expectancy at birth in Notting Dale ward for both males and females is the lowest in Kensington and Chelsea at 73.4 years for males and 75.7 years for female. Furthermore, within Kensington and Chelsea, the life-expectancy of males living in Notting Dale is estimated to be 17 years lower than males living in Queen's Gate (the ward with the highest male life-expectancy in the borough) and of females, 17.9 years lower than females living in Holland ward (the ward with the highest female life-expectancy in the borough).

The life-expectancy gap between the poorest areas of Kensington and Chelsea (including Notting Dale) and the most affluent areas has widened in recent years. This is in part due to the Grenfell Tower tragedy where 72 people lost their lives and also due to the impact of the Covid-19 pandemic which is known to have disproportionately affected poorer populations, those from a BAME background, and those with particular chronic health conditions, such as diabetes – as we know are experienced more in Notting Dale ward. Further published data are required to fully understand the impact of the pandemic.

Death rates

The rate of deaths (all causes), of premature deaths (deaths under the age of 75 years) and preventable death rates for Notting Dale ward are the highest of Kensington and Chelsea wards and statistically above the England average. However, rates of death from all cancers, all circulatory diseases, and coronary heart disease (all age and under 75 years) and age Stroke and Respiratory diseases (all age) are not statistically different to the England average.

Emergency admissions

Data published by the Office for Health Improvement and Disparities (OHID) on emergency hospital admissions rates occurring 2016/17 to 2020/21 show, compared to other Kensington and Chelsea ward rates (total 18 wards), residents of Notting Dale ward have the highest rate of adult emergency admissions and the highest rate of emergency admissions for heart attack.

Long-term conditions

Data from the Whole Systems Integrated Care database shows Notting Dale ward to have higher rates of long-term conditions than most other wards in Kensington and Chelsea. For example, Notting Dale ward (in comparison to Kensington and Chelsea averages) has the highest rates of chronic obstructive pulmonary disease (COPD) – 2.7% compared to 1.2%. It also has the highest rates of diabetes - 8.4% compared to 3.9% respectively. (WSIC DID June 2022)

Unfortunately, there is currently limited published NHS data on the health outcomes for residents of Notting Dale and North Kensington. What is available does not provide data in the same format prior to Grenfell Tower tragedy. This means we cannot assess how resident health outcomes in Notting Dale have changed over time compared to areas of similar socio-demographics, London, or England.

We are, however, able to analyse local NHS data from 2016 and local deaths data from 2014 to monitor over time and identify any changes in health since the tragedy in Notting Dale and North Kensington. Outcomes can be compared to averages for RBKC and WCC and to outcomes for residents of Queen's Park ward in WCC - an area with similar social and health challenges to Notting Dale prior to the tragedy.

It is recognised that it is still too soon to assess all the long-term health impacts however there is an agreed alert process in place between the NHS and Public Health, and intensive clinical follow-up of people exposed.

Long-term Limiting Illness and Disability

Data from the 2021 Census show that compared England (17.5%), and Kensington and Chelsea (12.8%), Notting Dale ward residents have higher rates of long-term limiting illness and disability (19.6%), which is the second highest rate of the 18 Kensington and Chelsea wards.

It is important to consider the broader health and wellbeing inequalities set out above when thinking about the impacts of the Grenfell tragedy. These provide the context in which the immediate local community continues to experience the specific impact of the fire.

Appendix 7

The Healthier Futures Service (Kensington & Chelsea Social Council)

NHS Self-Care & Social Prescribing work stream

A range of 'self-care' services are open to anyone who has been affected by the fire. These services promote and enable people to manage their own emotional and physical health, building confidence and resilience through non-medical health and wellbeing services, information, and support.

Currently, there are 14 services delivered by community organisations that reach different parts of the community. The North Kensington self-care programme is called 'Healthier Futures.' The name and logo were developed and voted on by the VCS with their services users. Over 5000 referrals to Healthier Futures services have been made since 2020 (this number does not include the previous training offer), and over 7000 sessions delivered (including individual and group sessions).

You can find more information about this service listed in the accompanying Appendix 3: *The Healthier Futures Service (Kensington & Chelsea Social Council)*

The Healthier Futures Service

The Healthier Futures services are integrated into primary care and other additional services provided to support those affected by the Grenfell Tower Fire. They can be accessed through a number of different routes including GP practice, VCS organisations, Social Prescribing Link Workers, Dedicated Service, NHS case managers, the Grenfell Health & Wellbeing service, and self-referral. Patients are supported and encouraged through the referral process and attending their first session. Please see diagram below, which explains how services fit together.

Kensington and Chelsea Social Council (KCSC) are commissioned by the NHS to distribute and manage the Healthier Futures services. As part of this contract, they produced an outcomes and impact evaluation over 12 months to August 2022.

The findings of this evaluation are that KCSC's Healthier Futures community activities, and wider social prescribing initiatives are generating positive health and wellbeing outcomes for the borough.

- 94% of 335 users agreed that they would recommend their service to others,
- 93% said they would continue to use the service,
- 96% found the services beneficial.
- Across all services that measured impact on participants' overall wellbeing, average wellbeing indicators improved as a result of the service.

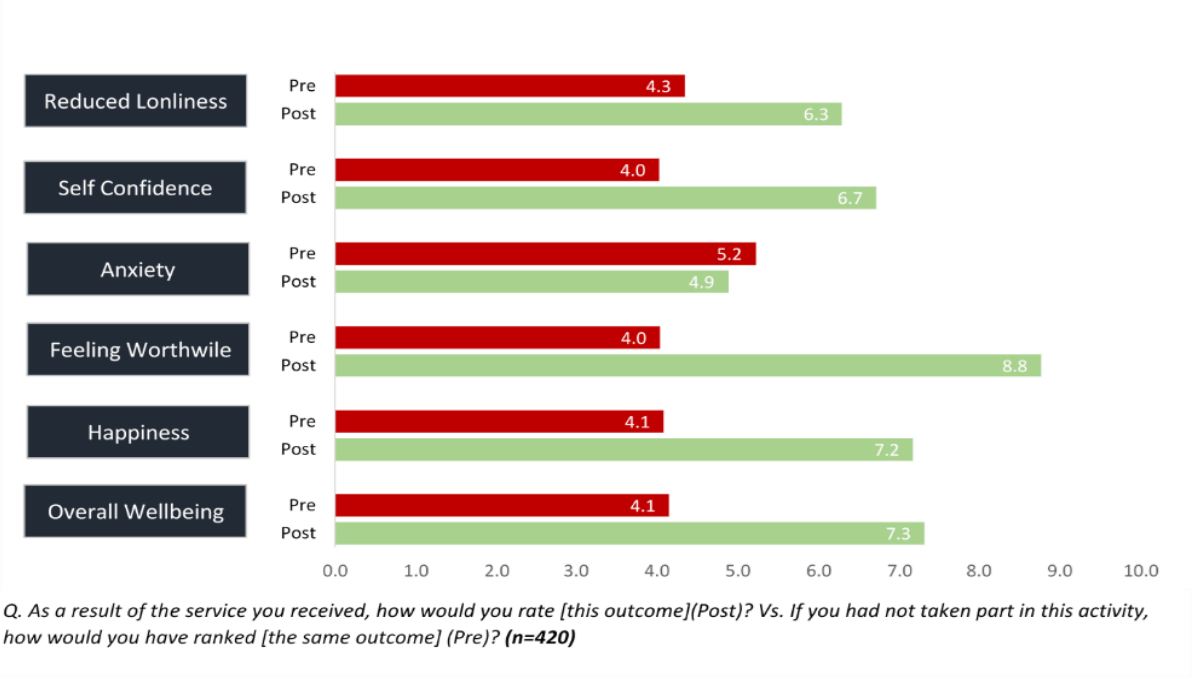
The sample ranged from c. 300-406 throughout the outcome's questions. Of the sample:

- 92% identified as women.
- The average age was 50.
- 16% (59) identified themselves as having a disability. Majority under the following categories:
    - Autism spectrum disorder and learning difficulties.
    - Mental health conditions / illness
    - Chronic mobility of musculoskeletal conditions
    - Chronic illness (diabetes)
    - Cardiovascular problems

- There was significant ethnic diversity in the sample group.
    - Black African - 32%
    - Arab - 20%
    - Other - 15%
    - Black Caribbean - 7%
    - White & Black African - 5%
    - White British - 4%
    - Asian Bangladeshi - 4%
    - White English - 3%
    - White & Black Caribbean - 2%
    - Prefer not to say - 1%
    - Latino - 1%
    - Asian Indian - 1%
    - Chinese - 1%
    - White Irish - 1%

Health and Wellbeing Findings

This research indicated 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 indicators. This included 335 users from eight community offer services, four from individual offer services, and two additional Healthier Futures organisations.



Q. As a result of the service you received, how would you rate [this outcome](Post)? Vs. If you had not taken part in this activity, how would you have ranked [the same outcome] (Pre)? ***(n=420)***

After engagement with the community, the initial Healthier Futures offer was focused on training and skill building opportunities for the VCS and communities. This included:

- Mental health first aid training
- Health coaching
- Breath work

- Trauma informed yoga training for existing local yoga teachers

Further engagement produced evidence that some communities wanted whole family services as they wouldn't usually attend things independently and welcomed health and wellbeing initiative for the whole family to learn together. As a result, four family services were commissioned:

- Cultivate Create (ACAVA) – family gardening project.
- Evolve NK (Family Friends) – Family support worker including a focus of families with children who have special educational needs.
- Music & Movement (Meanwhile Gardens) – weekly sessions for children under 6
- Family Forever (Total Family Coaching) – family coaching in 7 different community languages

Case Study: Maxilla Men's Shed

Maxilla Men's Shed is a community workshop and maker space with a focus on tackling social isolation, connected with an international Men's Shed movement. It has provided:

- Number of Tinkering sessions - 250
- Places on a course, workshop or drop in - 800
- Lockdown 1:1 support - 126 hours
- Individuals supported - 392, of which:
    - 59% are male.
    - 87% over 50
    - 66% of regular members have multiple long-term conditions.
    - 33% attend to improve health and wellbeing, 25% to learn a new skill, 17% to stay active.

Monitoring of feedback and satisfaction has provided the following information from people attending:

100%	of attendees 'feel more confident approaching new things'
77%	'enjoy it a lot' and 'enjoy interacting with others'
77%	have gained experience of using new materials and/or tools
100%	of past course participants told said they would like to attend another course, and that they would continue developing the taught skill in drop-in sessions.
93%	'Very satisfied' with their experience at the Shed
100%	The Shed has a positive impact on their mental health

Self-care services are highly valued and have a significant positive impact on people's self-reported wellbeing but predominantly accessed by working age and older women.

Feedback is that services are still too limited and want more community-based wellbeing services to be funded by statutory partners.

A significant minority of residents are unaware or confused about funded service offers from the NHS and RBKC and want consistent or single points of access into services.

Client testimonies

“The shed has given me a purpose and helps keep me active and less isolated.”

“When I show up on day one, I'm feeling approximately 2/3. Leaving day 2 feeling more 8/9. If only international world leaders would all show up in place like the shed in overalls.”

Past Engagement

Individuals, community groups and voluntary organisations have regularly been engaged with in the establishment and improvement of self-care services for North Kensington communities.

Themes
Housing/house repairs/noise
Difficulty with sleep (children and adults)
High levels of stress, anxiety, and other mental health conditions
Digital inclusion – increasing ‘digital literacy’ and access to technology to support people to take up virtual services.
Social isolation/loneliness – the wide-ranging impact of social isolation and the need to support people with confidence and motivation to leave the house and to access and interact with friends, family, and other groups
Increasing the awareness of self-care offers with continuous and varied communications (including information in different languages)
Respecting the importance of faith, ethnicity, culture and gender in provision and approach
Maximising opportunities to enjoy the limited local green spaces
Low intensity exercise for people with mobility issues and unhealthy lifestyles
Health literacy– improving the ability to understand and use information given to residents about their own health
The impact of alcohol & drug addiction and people not being able to commit to needed mental health support due to addiction
Trauma training for community organisations
Scale up/expand existing services
Recognise the importance of the strong family structures and relationships to individual and community healing

Help people to manage long-term conditions which have worsened due to displacement and stress
Support to find employment
MH first aid training to help members of the community support their neighbours, friends, and relatives (training delivered in 2021)
Support for professionals to deal with housing issues
The impact on staff and services of support people with complex needs in VCS services without clinical support- not always appropriate
Provide ongoing support for organisations and staff providing services.

The key messages from those exercises related to self-care services were:

- People recognise the importance of exercise, healthy living choices, social connections to their health, but do not always have the motivation or means to act.
- Self-care support options are popular and effective in supporting community and survivor and bereaved groups to address health issues and help them cope with triggers that could affect physical and emotional wellbeing.
- The self-care services people are most likely to have accessed are swimming, yoga, and massage; but a wide range of other support has been accessed and help people to address a range of health and social needs.
- Preferences for community-based support with emotional wellbeing issues
- Support should be tailored to the needs of the communities (cultural competency)
- Self-care services can reduce the stigma around seeking support for mental illness, particularly in ethnically diverse communities.
- Community workers and organisations feel stretched and should be supported with training and clinical support to support their sustenance for the longer-term and maximise the knowledge and experience they have.
- Joint publication of all self-care and peer support available as part of the NHS and Council's Grenfell offers – as residents aren't interested in who is funding the service, they just want to have clearer communications on what is on offer.
- A significant minority of people continue to feedback that they aren't aware of the services they can access, or how to access them.
- Services should focus on building skills within the community.
- Family projects are a good example of adaption of services based on resident feedback and show the importance of a whole family approach when supporting residents with their physical, mental and social challenges.