NHS
South West London

People and Communities Engagement Assurance Group

Engagement at Place

22 February 2023

Overview

NHS South West London

- These slides describe our engagement work at Place between September and December 2022 – Quarter 3
- These reports are also being reviewed and assured by each Place
- We group our engagement work at Place in these areas – as illustrated by the overview slide to follow:
  - Demand management and pressures
  - Health inequalities and community outreach
  - Primary care and Primary Care Networks (PCNs)
  - Prevention and early intervention
  - Horizon scanning and issues management
  - Service improvement and change
- For each Place, these slides include:
  - An overview slide for each Place
  - Worked examples of Place based engagement work – demonstrating the impact and the difference made for local people and communities
  - A case study - a local example of our engagement work and its impact on services

Members of the People and Communities Engagement Assurance Group are invited to:

- Review the content of this report
- Comment on the format and style of the paper for assurance purposes and future review

South West London

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Demand management and pressures

Getting people to the right place at the right time

- **Behaviour change** – communicating to support demand management
- **Reassurance and Confidence** – outlining the robust health and care system response to winter pressures

Prevention and early intervention

For longer, happier lives

- **Living longer and happier** – the NHS long term plan set out our responsibilities to not only treat people, but also prevent them from getting ill in the first place. This activity supports residents to live longer happier lives and allows us to treat avoidable illness early on.

Health inequalities and community outreach

Building trust and identifying health gaps sooner

- **Understanding our communities and potential barriers** – to access, we need a meaningful, ongoing conversation with communities we serve, in an appropriate way and in places familiar to them.
- **Building relationships, improve trust and increase health literacy** – to reduce the gaps we see amongst our population. We also collate insights, identify emerging themes to influence the way we provide services and ultimately reduce health inequalities.

Place–based communication and engagement

Horizon scanning, issues and crisis management

Preparing, connecting and responding

- **Current issues** – staying aware of current issues to advise on and plan for media or stakeholder interest and management
- **Crisis** – working with senior leaders to manage the comms and engagement elements during issues and crisis management and link between SWL and place during incidents as part of ICB EPRR role

Supporting primary care and PCNs

Being receptive to local needs

- **Primary care networks** – supporting primary care networks to hear from their patients and the wider communities they serve.

Service improvement and change

Meeting legal responsibilities

- **Legal duty to involve** – people where services or access to services change from the earliest stages
- **Understanding changes** – making sure that residents, external stakeholders and staff understand what the changes might involve, why we are making them and any potential implications

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Croydon engagement assurance report

Quarter 3: October to December 2022

Croydon

Croydon South West London Integrated Care System

NHS South West London

Demand management and pressures

Getting people to the right place at the right time

- **Behaviour change** – communicating to support demand management
- **Reassurance and Confidence** – outlining the robust health and care system response to winter pressures

Examples of current activity:

Mental health:
- Ethnic Minorities Health Improvement Project (EMHIP)
- Health and Wellbeing Space
- Be Well Hubs
- Community hubs

- **Pharmacy campaign**
- **Urgent and emergency care**
- **Virtual wards**: core narrative and staff and patient case studies to explain

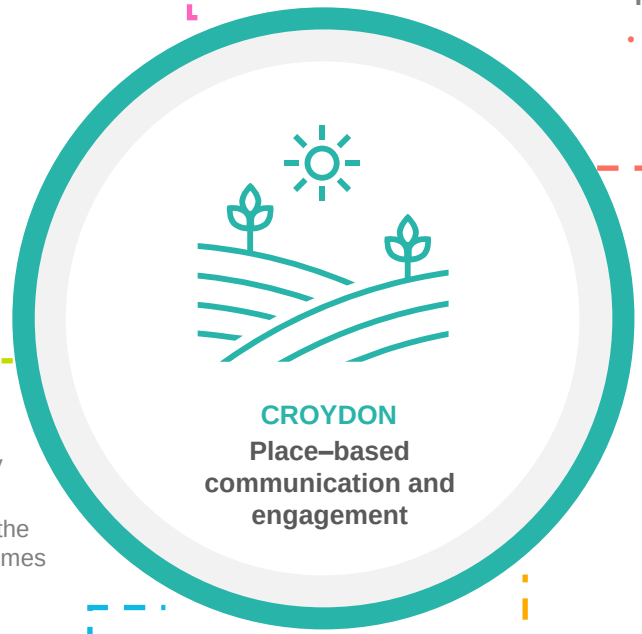
Health inequalities and community outreach

Building trust and identifying health gaps sooner

- **Understanding our communities and potential barriers** – to access, we need a meaningful, ongoing conversation with communities we serve, in an appropriate way and in places familiar to them.
- **Building relationships, improve trust and increase health literacy** – to reduce the gaps we see amongst our population. We also collate insights, identify emerging themes to influence the way we provide services and ultimately reduce health inequalities.

Examples of current activity:

- **One Croydon:** strategic engagement approach followed by all partners and transformation teams – ensures engagement throughout service prioritisation, development and change; information and materials are accessible and translations available for key campaign messages and health access information
- **Community Champions:** recruitment, training and retention of community champions in health inequalities groups across the borough, in partnership with VCSE, hearing what they tell us, acting on it, feeding back and building trust
- **Croydon People's Panel:** Developing a joint health and care panel by going out into communities for recruitment, rather than those already engaged – drawing on this group of people with lived experience for specific task and finish groups as they arise



Supporting primary care and PCNs

Being receptive to local needs

Supporting primary care networks to hear from their patients and the wider communities they serve.

Examples of current activity:

- **Enhanced access for primary care** following national change in provision – communications and engagement advice and framework development for local PCN engagement
- **Primary care** dashboard

Prevention and early intervention

Preparing, connecting and responding

- Working with senior leaders to manage the comms and engagement elements during issues and crisis management and link between SWL and place during incidents as part of ICB EPRR role
- Staying aware of current issues to advise on and plan for media or stakeholder interest and management

Horizon scanning, issues and crisis management

For longer, happier lives

The NHS long term plan set out our responsibilities to not only treat people, but also prevent them from getting ill in the first place. This activity supports Croydon residents to live longer happier lives and allows us to treat avoidable illness early on.

Examples of current activity:

- **Vaccines:** Covid-19, Flu, Polio
- **Cost of living** information and sign posting
- **Dementia Strategy**
- **Frailty Strategy**
- **Healthy weight –** tier 3 for both children and adults

- **ICS Strategy and Joint Forward Plan** – collating feedback from Croydon residents to influence the development and delivery of the ICS Strategy and Joint Forward plan
- Working with system partners and local residents to ensure the investment in **Family hubs** is co-designed to meet local need

Service improvement and change

Meeting legal responsibilities

- **Legal duty to involve** – people where services or access to services change from the earliest stages
- **Understanding changes** – making sure that residents, external stakeholders and staff understand what the changes might involve, why we are making them and any potential implications

Examples of current activity:

- **Community Diagnostic Centre** planning and development programme
- Planned **new estate facilities**

- **Urgent and Emergency Care** pathways and CUCA contract
- **Dementia and frailty strategy**: potential for service change – key to engage early

Croydon: Winter Outreach Programme

NHS South West London

Engagement Lead: Jo Austin, Senior Communications and Engagement Lead, Croydon

September to December 2022

Why did you seek the views of local people and or communities?

The **winter outreach programme** aims to:

- reduce demand across the system, particularly Urgent Emergency Care (UEC) by making people aware of the services available to them and how to use them appropriately
- increase vaccine uptake by providing accurate information about the vaccine and how to access clinics.
- signpost people to keep well services including support for cost of living increases and to gather insights to help us plan appropriate services for local residents.

In Croydon we focussed on our Core 20 health inequalities communities including New Addington, Thornton Heath, Central Croydon, Selhurst and then Town Centre. We also wanted to hear from people from Black, Asian and Minority Ethnic backgrounds, people seeking asylum, those experiencing homelessness and parents of children aged under ten.

What activities did you do?

Our engagement team, primary care team and clinicians attended 16 events attended by over 360 people between September and December 2022.

These outreach events were to support groups including people experiencing homelessness, addictions, asylum seekers and refugees. For some events we were able to work alongside vaccinators. To encourage people who might not otherwise come to this kind of event, we also had other activities alongside including stalls from other voluntary, community and social enterprise (VCSE) groups such as Off the Record, Mind and Grow, Live, Change. Some events included music, clothes, food and drink and dental checks. The BME Forum and Asian Resource Centre of Croydon carried out health checks to help spot the signs of long term conditions.

The ‘Ask me’ team – a specially trained team from the local community, commissioned via Croydon Voluntary Action - worked from community hubs such as libraries and children centres, as well as talking to people on the streets – offering people the chance to get correct information about vaccines on offer including polio, flu and winter covid boosters. During this period, the team focused their work on children centres and libraries and in community hubs in Thornton Heath, Central Croydon, Shirley, Selhurst, East Croydon and the Town Centre.

Who did you speak to and why?

Over 360 local residents attended these events and our Ask Me team had 470 individual conversations.

Both the Ask Me Team and outreach events focused engagement with those living in deprived wards in the north of the borough and New Addington in the south as well as those Black, Asian and Minority Ethnic communities, those experiencing homelessness, those experiencing alcohol or drug misuse. We know that people living in our Core20 populations are less likely to have a-vaccination, lower access to and trust in public services and experience significantly worse health outcomes than the general population.

In line with other vaccines, parts of Croydon had low uptake of the polio vaccine, with significant numbers of children having no protection at all. We wanted to makes sure we included parents of children aged 0-9 to find out why this might be and make sure that parents were accessing accurate information about the vaccine.

What were the key themes that people raised?

People at these events told us:

- It can be confusing knowing where to go for help.
- Some would rather rely on their immune system than have the vaccine (feedback from parents talking about themselves and children)
- Desire to allow immune systems to develop ‘naturally’
- Some told us they were scared of needles or that their children were and they did not want to put their children through that again
- Would get the flu & COVID-19 vaccine if child had a health condition.
- Questions about where to get the flu vaccine
- Many within the Indian community had their vaccines and felt it was important to help look after their health
- Concerned no one is speaking about COVID-19 and people are encouraged to go out when the virus still exists in the community
- Questions on whether they need to have the 4th booster vaccine and duration of protection from the vaccine
- Many people told us they don’t know where to go for cost-of-living support.

What difference has this feedback made?

110 people received their flu or covid vaccine on the day of the four events we attended with a vaccine team.

Information cascaded to all 840 people who we hope they will then share this onwards with their friends, families and communities

Feedback and response is shared with Place Leaders at Croydon Health Management Board, Croydon A&E Delivery Board and via local commissioners to influence service delivery.

Adapted local campaign materials to help further promote services in Croydon including health and wellbeing centres, community hubs and how to access additional GP capacity following insight that people didn’t always know where to go and how to access services

Ask Me team evaluation showed that 30% of people reconsidered their stance on vaccine following their conversation.

Are you planning any further engagement work on this programme or a related programme?

Worked with partners in our health inequalities steering group to plan ongoing roving vaccine team including those with learning disabilities, those experiencing homelessness and people seeking asylum – we anticipate a further eight sessions in January and February with vaccinators.

Funded 30+ health and wellbeing events through the SWL NHS Winter Engagement Fund across Croydon through Jan-March building on the trust gained during previous events.

Re-commissioning of the ‘ask me’ team through Jan-Mar

Croydon: One Croydon Professional Engagement Network

NHS South West London

Engagement Lead: Jo Austin, Senior Communications and Engagement Lead, Croydon

September to December 2022

Why did you seek the views of local people and or communities?	What activities did you do?	Who did you speak to and why?	What were the key themes that people raised?	What difference has this feedback made?	Are you planning any further engagement work on this programme or a related programme?
One Croydon professional engagement network Working with partners to develop a 'One Croydon' approach to engagement. As engagement professionals in Croydon we want to make sure that we are working in a smart way, maximising opportunities to engage, joining up, identifying emerging themes and provide insights and information to our leadership teams in a timely way.	Discussion in our Communications and Engagement Professional Network. 1:1 meetings with key partners. Engagement workshop attended by key statutory and VCSE colleagues. Setting up a professional network to share good practice, team up where appropriate, manage a pool of active citizens to be involved in health and care issues and to assure each others' work. Mapped existing groups and hubs to identify gaps.	Engagement teams rep Croydon Health Services, Croydon Council (public health and social care), Healthwatch Croydon, Croydon Voluntary Action, Croydon BME Forum, Asian Resource Centre for Croydon, One Croydon PMO	All in agreement that this is a Place priority. Agreed a forward plan for the year focusing on three main priorities: 1. Tracking our engagement to identify emerging themes to feedback to decision makers. 2. Evidencing the impact of our work. 3. Feeding back to communities.	We are able to propose an appropriate model that had been codesigned to our leadership team. Partners have set of shared objectives and commitment to share insights and track impact together.	Quarterly meetings for Engagement Professional Network, extending invite to other relevant partners Targeted recruitment to our pool of 'experts by experience' to ensure it is broadly demographically representative Gather insights from local residents, including community champions, via Bang the Table, Local Community Partnerships, Dedicated Communication and Engagement Professional network session.

Croydon: Supporting Primary Care Networks

South West London

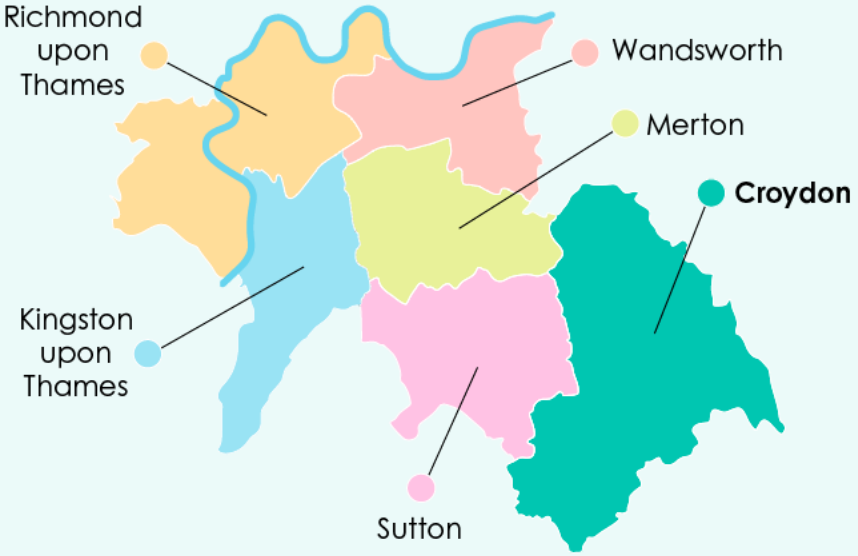
Engagement Lead: Jo Austin, Senior Communications and Engagement Lead, Croydon

September to December 2022

Why did you seek the views of local people and or communities?	What activities did you do?	Who did you speak to and why?	What were the key themes that people raised?	What difference has this feedback made?	Are you planning any further engagement work on this programme or a related programme?
Supporting PCNs – transforming enhanced access As enhanced access moved from being commissioned by NHSE to Primary Care Networks (PCNs), PCNs wanted to hear from local communities about how they would improve access to out of hours appointments (evenings and weekends) in future.	Provided support to PCNs on how to get the most out of surveys and focus groups and how to encourage answers from the people they most want to hear from. Online and text surveys were sent out from each PCN. Meetings with Patient Participation Groups where appropriate. They cascaded the surveys through their networks encouraging people to respond.	All Croydon residents aged over 18 who are registered with a GP were asked about how they would like to access GP appointments at the evening and weekends in future.	People told us that they would like to see an increase in appointments, particularly face to face appointments and that they would prefer to access appointments close to home. People of working age (18-64) told us that they would like to use extended access for more routine appointments such as screening tests rather than on the day emergencies.	PCNs used this feedback to design their model for enhanced access. All Croydon PCNs will now offer at least 50% of their appointments in person. All PCNs plan to deliver an increased variety of clinical services including routine general practice care, childhood immunisations, smears, wound care, flu vaccination and phlebotomy. This came out of people saying that they would prefer to have more 'routine' appointments available outside of working hours. There will be wider coverage across Croydon from more local hubs and locations with many PCNs offering extended access from their own practice (previously delivered from three hubs across Croydon).	Planned review to take place in April 2023 after six months of operation.

Empowering Croydon voluntary sector and resident voices

South West London Integrated Care System



Proud to be working together to create healthier communities

Partners involved

Croydon Health Services NHS Trust
One Croydon's alliance of Voluntary and Community Sector organisations
Croydon Council
NHS South West London

Find out more

Learn more about our work and get involved at www.southwestlondonics.org.uk

How we're making a difference

Through the Healthy Communities Together programme, which was developed in partnership between The National Lottery Community Fund and The King's Fund, One Croydon was awarded £500,000 over 4 years to support local partnership working to improve the health and wellbeing of Croydon's local communities. This work aims to develop a 'One Croydon' approach to engagement.

Six Local Community Partnerships (LCPs) have been implemented covering the whole of Croydon. Each LCP has two co-Chairs elected from the local community and will bring greater local ownership, collective voice and leadership to our partnership.

The programme of LCP events gives the opportunity for local residents, community groups, charities and health and social care teams to co-produce community action plans and work collaboratively to put these into action. You can read more about LCPs, including profiles of the Chairs, here: Local Community Partnerships - Croydon Voluntary Action (cvalive.org.uk)

Locality partnership working has improved the connections between our clinical teams, our community assets and community organisations. It's empowered people to improve their quality of life.

Lynda Graham
Social Prescribing Link Worker-Team Leader

NHS
South West London

Kingston engagement assurance report

Quarter 3: October to December 2022

Kingston

Demand management and pressures

Getting people to the right place at the right time

- **Behaviour change** – communicating to support demand management
- **Reassurance and Confidence** – outlining the robust health and care system response to winter pressures

Examples of current activity:

- **Mental health:**
  - New online directory of MH services for CYP in K&R
  - Promoting local MH services through winter outreach with VCSE groups
- **Pharmacy campaign**
- **Urgent and emergency care**
- **Virtual wards**: core narrative and staff and patient case studies to explain

Health inequalities and community outreach

Building trust and identifying health gaps sooner

- **Understanding our communities and potential barriers** – to access, we need a meaningful, ongoing conversation with communities we serve, in an appropriate way and in places familiar to them.
- **Building relationships, improve trust and increase health literacy** – to reduce the gaps we see amongst our population. We also collate insights, identify emerging themes to influence the way we provide services and ultimately reduce health inequalities.

Examples of current activity:

- **Community Champions/Core Connectors:** recruitment, training and retention of community champions in health inequalities groups across the borough, in partnership with Richmond Council and Kingston Voluntary Action, hearing what they tell us, acting on it, feeding back and building trust
- **Community led health & wellbeing project (LTCs):** recruitment and training of volunteer community health coaches who will be empowered to work within their communities completing health checks and promoting health lifestyles
- **Community Voice Groups:** To hear from those experiencing health inequalities and bringing together and sharing what local people are telling us, evolve Richmond community involvement group and the Kingston patient and public forum into a broader community voice group for each Place.

KINGSTON

Place–based communication and engagement

Supporting primary care and PCNs

Being receptive to local needs

Supporting primary care networks to hear from their patients and the wider communities they serve.

Examples of current activity:

- **Enhanced access for primary care** following national change in provision – communications and engagement advice for local PCN engagement
- **Supporting PCNs** to engage with local communities eg New Malden & Worcester Park PCN wellbeing hub

Prevention and early intervention

Preparing, connecting and responding

- Working with senior leaders to manage the comms and engagement elements during issues and crisis management and link between SWL and place during incidents as part of ICB EPRR role
- Staying aware of current issues to advise on and plan for media or stakeholder interest and management

Horizon scanning, issues and crisis management

For longer, happier lives

The NHS long term plan set out our responsibilities to not only treat people, but also prevent them from getting ill in the first place. This activity supports Kingston & Richmond residents to live longer happier lives and allows us to treat avoidable illness early on.

Examples of current activity:

- **Vaccines:** Covid-19, Flu, Polio
- **Cost of living** information and sign posting
- **Long term conditions**
- **Frailty**
- **Health Inequalities & PHM**
- **ICS Strategy** – collating feedback from Kingston & Richmond residents to influence the development and delivery of the ICS Strategy and priorities

Service improvement and change

Meeting legal responsibilities

- **Legal duty to involve** – people where services or access to services change from the earliest stages
- **Understanding changes** – making sure that residents, external stakeholders and staff understand what the changes might involve, why we are making them and any potential implications

Examples of current activity:

- **Proactive and Anticipatory Care Model**

Kingston: Winter Outreach Programme

South West London

Engagement Lead: Hannah Keates, Engagement Manager, Kingston and Richmond

October 2022 to January 2023

Why did you seek the views of local people and or communities?

Winter outreach programme – focusing on our core 20 communities in areas of high deprivation and health inequalities.

To ensure people understand and know how to access local support during the winter.

To gain insight on local health services to feed back into operational plans.

What activities did you do?

We reached out to local community and voluntary groups by email and telephone calls offering to talk to their communities and clients.

7 events with 40 people directly spoken to providing feedback on winter messaging and experiences of local health services.

Provided a briefing to our local Core Connectors to help support the messaging through trusted voices.

Who did you speak to and why?

We spoke to:

- Asylum seekers/refugees
- Homeless
- Those experiencing drug/alcohol dependence
- People living in areas of deprivation: Cambridge Road Estate
- People with mental health conditions
- People with diabetes
- Gypsy, Roma, traveller community at Swallow Park

What were the key themes that people raised?

Main themes:

- People rely on the organisations and groups that support them for trusted health advice and information.
- Gypsy, Roma and traveller community use local pharmacy for information/advice.
- All groups feedback on GP practices - difficulties getting an appointment, variation in how practices work across Kingston.
- Impact of rising cost of living, particularly for homeless, asylum seeker/refugee and areas of deprivation - cost of medication, heating and food all impacting.
- Increasing feedback that people are now using food banks and warm spaces in all communities.

What difference has this feedback made?

Through our networks of voluntary groups and strong community links we were able to provide information on health services and information to residents through trusted voices.

We changed our local winter messaging, e.g. our local signposting leaflet now includes Connected Kingston as a direct result to local issues/concerns.

Feedback will be shared with Place Quality Committee and Place Committee, with a view this will start to influence and shape operational plans for local health services.

Are you planning any further engagement work on this programme or a related programme?

This is an ongoing programme until the end of March 2023 with more opportunities for outreach in Jan/Feb including activity funded by the Winter Engagement Fund 2023.

Kingston: Place engagement approach

South West London

Engagement Lead: Hannah Keates, Engagement Manager, Kingston and Richmond

October 2022 to January 2023

Why did you seek the views of local people and or communities?

Place engagement approach – the involvement of people and local communities is really important in ensuring that our Kingston Place engagement infrastructure is inclusive of the populations we serve. As part of this we sought the views of voluntary and community sector (VCS) organisations, grassroots/community groups, Healthwatch and Council. This is because we know that the VCS often has a greater reach into our communities and can represent views that are often not heard.

What activities did you do?

Asked for feedback on proposals which include setting up new Community Voice Group Kingston, a neighbourhood engagement approach and setting up a K&R engagement assurance group.

Options were presented and views sought at various networks and meetings, including:

- Kingston patient and public forum
- 3 briefings with system leaders.
- Primary Care Network (PCN) Clinical Directors meeting.
- Borough communications and engagement group

Who did you speak to and why?

Healthwatch Kingston and Kingston Voluntary Action (KVA) as key organisations that have the reach with our diverse communities.

Kingston Patient and Public Forum which comprises of residents, PPG reps and reps from community groups with an interest in health.

PCN Clinical Directors for input to neighbourhood engagement approach as they have good knowledge and reach into communities at neighbourhood level.

What were the key themes that people raised?

Feedback was to:

- Build on and use existing established engagement networks, for example through Public Health Team and via Public Health community development team, KVA health networks, HWK Youth Out Loud forum.
- Ensure representation on community voice groups of Kingston borough where possible – understanding that there is not always a group to represent every community.
- Whether PCNs have the capacity to engage with their local communities?

What difference has this feedback made?

Engagement will ensure an inclusive approach by setting up these new structures we will enable people and communities voices to be represented in the local Place infrastructure.

Are you planning any further engagement work on this programme or a related programme?

Once the community voice groups are launched in Feb 2023 we will review in three months to check in with people and communities involved to find out how they feel it is going and adapt the approach as appropriate.

Kingston: Supporting Primary Care Networks

South West London

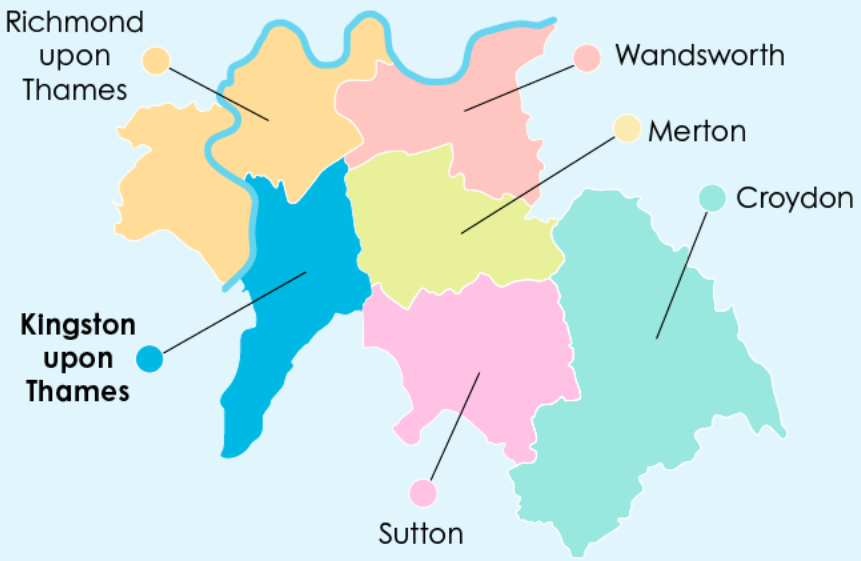
Engagement Lead: Hannah Keates, Engagement Manager, Kingston and Richmond

July 2022 to September 2023

Why did you seek the views of local people and or communities?	What activities did you do?	Who did you speak to and why?	What were the key themes that people raised?	What difference has this feedback made?	Are you planning any further engagement work on this programme or a related programme?
Supporting PCNs – to engage with their local communities on their Enhanced Access model to ensure their views can be included in decisions made by PCNs. This included the hub model and whether people would be willing to travel to a GP practice which is not their own for an appointment.	Provided support and advice to PCNs on how to engage, survey questions, holding focus groups and how to reach different groups within communities. Online surveys were run by each PCN, promoted on social media and patients were sent text messages to complete. Meetings were held with PCN Patient Participation Groups (PPGs).	All Kingston registered patients aged over 18 were asked to give preference on evening and weekend appointments, type of appointment (e.g. face to face, online, phone) and location (in own practice, others within PCN).	Overall across all PCNs there was a preference for face to face appointments, with weekday evenings more popular than Saturday appointments. People over 65 were more likely to support early morning appointments, with 16-64 year olds preferring early evening weekdays. The majority of people wanted to be seen at their own practice but many willing to travel to another GP practice if not further than three miles.	PCNs used the insight to inform their decision making on their Enhanced Access model that was rolled out in October 2022. Each PCN has taken the feedback to shape their hours and appointment schedules.	Moving forward a new survey will be run in spring 2023 evaluating the new model for enhanced services.

Cambridge Road Estate – health events in Kingston

South West London Integrated Care System



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Kingston Voluntary Action
RBKares – local charity
Kingston Council
Kingston Mind

Find out more
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How we're making a difference

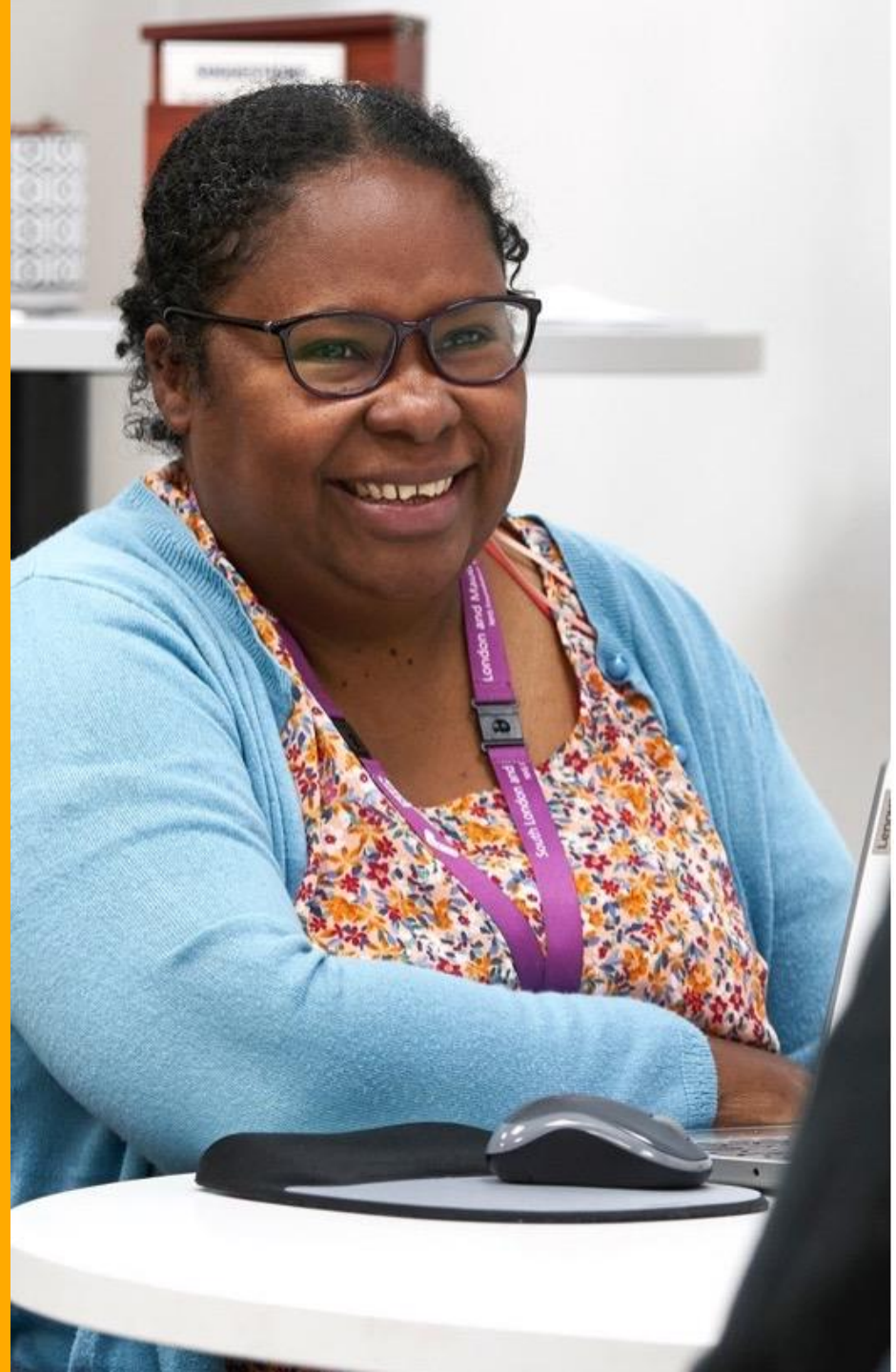
Partnership working and the considerable power of an active community are bringing healthcare and well-being services to some of Kingston's most vulnerable residents.

Monthly events over the last year on the Cambridge Estate have seen partners working together to provide a range of services. This includes the offer of basic health checks, some of which have resulted in potential long term conditions being found early, Covid-19 and flu vaccinations, podiatry, smoking cessation advice and mental health support. A core group of around 40 residents join each session and have the opportunity to meet with council staff to find out more about accessing benefits to support with the cost of living crisis and find out how to tackle digital exclusion.

Working closely with local organisations to reach into communities we engaged with local residents to have conversations about what people thought about local health and care services. This is building trust between health services and local people and is also helping to shape our local communications and future engagement.

"I am blown away by what's on offer at these events, and the kindness shown to me. I've spoken to a few people today that have helped me with things I've been worried about for ages. I also had a Covid jab."

Local resident from the Cambridge Road Estate



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Richmond engagement assurance report

Quarter 3: October to December 2022

Richmond

Richmond South West London Integrated Care System

NHS South West London

Demand management and pressures

Getting people to the right place at the right time

- **Behaviour change** – communicating to support demand management
- **Reassurance and Confidence** – outlining the robust health and care system response to winter pressures

Examples of current activity:

- **Mental health:**
  - New online directory of MH services for CYP in K&R
  - Promoting local MH services through winter outreach with VCSE groups
- **Pharmacy campaign**
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- **Virtual wards**: core narrative and staff and patient case studies to explain

Health inequalities and community outreach

Building trust and identifying health gaps sooner

- **Understanding our communities and potential barriers** – to access, we need a meaningful, ongoing conversation with communities we serve, in an appropriate way and in places familiar to them.
- **Building relationships, improve trust and increase health literacy** – to reduce the gaps we see amongst our population. We also collate insights, identify emerging themes to influence the way we provide services and ultimately reduce health inequalities.

Examples of current activity:

- **Community Champions/Core Connectors:** recruitment, training and retention of community champions in health inequalities groups across the borough, in partnership with Richmond Council and Kingston Voluntary Action, hearing what they tell us, acting on it, feeding back and building trust
- **Community led health & wellbeing project (LTCs):** recruitment and training of volunteer community health coaches who will be empowered to work within their communities completing health checks and promoting health lifestyles
- **Community Voice Groups:** To hear from those experiencing health inequalities and bringing together and sharing what local people are telling us, evolve Richmond community involvement group and the Kingston patient and public forum into a broader community voice group for each Place.

RICHMOND

Place–based communication and engagement

Supporting primary care and PCNs

Being receptive to local needs

Supporting primary care networks to hear from their patients and the wider communities they serve.

Examples of current activity:

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- **Supporting PCNs** to engage with local communities eg New Malden & Worcester Park PCN wellbeing hub

Prevention and early intervention

Preparing, connecting and responding

- Working with senior leaders to manage the comms and engagement elements during issues and crisis management and link between SWL and place during incidents as part of ICB EPRR role
- Staying aware of current issues to advise on and plan for media or stakeholder interest and management

Horizon scanning, issues and crisis management

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- **Frailty**
- **Health Inequalities & PHM**
- **ICS Strategy** – collating feedback from Kingston & Richmond residents to influence the development and delivery of the ICS Strategy and priorities

Service improvement and change

Meeting legal responsibilities

- **Legal duty to involve** – people where services or access to services change from the earliest stages
- **Understanding changes** – making sure that residents, external stakeholders and staff understand what the changes might involve, why we are making them and any potential implications

Examples of current activity:

- **Proactive and Anticipatory Care Model**

Richmond: Winter Outreach Programme

South West London

Engagement Lead: Hannah Keates, Engagement Manager, Kingston and Richmond

October 2022 to January 2023

Why did you seek the views of local people and or communities?

Winter outreach programme – focusing on our core 20 communities in areas of high deprivation and health inequalities.

To ensure people understand and know how to access local support during the winter.

To gain insight on local health services to feed back into operational plans.

What activities did you do?

We reached out to local community and voluntary groups by email and telephone calls offering to talk to their communities and clients.

10 activities with 33 people and 5 support workers directly spoken to providing feedback on winter messaging and experiences of local health services.

We attended a health and wellbeing day hosted by SPEAR where 35 COVID booster jabs and 27 Flu jabs were given. 7 residents had a Liver Fibroscan and 6 had blood borne virus (BBV) tests.

Provided a briefing to our Richmond Health Champions to help support the messaging through trusted voices.

Who did you speak to and why?

We spoke to:

- Asylum seekers/ refugees
- Homeless
- Older people
- Ethnic minority communities
- Focussing on areas of deprivation, e.g. Hampton North & Ham
- People with mental health conditions

What were the key themes that people raised?

Main themes:

- People rely on the organisations and groups that support them for trusted health advice and information.
- Gypsy, Roma and traveller community use local pharmacy for information/advice.
- All groups feedback on GP practices - difficulties getting an appointment, variation in how practices work across Kingston.
- Impact of rising cost of living, particularly for homeless, asylum seeker/refugee and areas of deprivation - cost of medication, heating and food all impacting.
- Increasing feedback that people are now using food banks and warm spaces in all communities

What difference has this feedback made?

Through our networks of voluntary groups and strong community links we were able to provide information on health services and information to residents through trusted voices.

Feedback will be shared with Place Quality Committee and Place Committee, with a view this will start to influence and shape operational plans for local health services.

Are you planning any further engagement work on this programme or a related programme?

This is an ongoing programme until the end of March 2023 with more opportunities for outreach in Jan/Feb including activity funded by the Winter Engagement Fund 2023.

Richmond: Place engagement approach

South West London

Engagement Lead: Hannah Keates, Engagement Manager, Kingston and Richmond

October 2022 to January 2023

Why did you seek the views of local people and or communities?	What activities did you do?	Who did you speak to and why?	What were the key themes that people raised?	What difference has this feedback made?	Are you planning any further engagement work on this programme or a related programme?
Place engagement approach – the involvement of people and local communities is really important in ensuring that our Richmond Place engagement infrastructure is inclusive of the populations we serve. As part of this we sought the views of voluntary and community sector (VCS) organisations, grassroots/community groups, Healthwatch and Council. This is because we know that the VCS often has a greater reach into our communities and can represent views that are often not heard.	Asked for feedback on proposals which include setting up new Community Voice Group Richmond, a neighbourhood engagement approach and setting up a K&R engagement assurance group. Options were presented and views sought at various networks and meetings, including: • Richmond Community Involvement Group (CIG). • Richmond PPG Network. • Briefings with system leaders. • PCN Clinical Directors meeting. • Borough comms and engagement group.	Healthwatch Richmond and Richmond CVS as key organisations that have the reach with our diverse communities. Richmond CIG which comprises of community and voluntary organisations with an interest in health. Richmond PPG Network of representatives of practice PPGs from the borough. PCN Clinical Directors for input to neighbourhood engagement approach as they have good knowledge and reach into communities at neighbourhood level.	Feedback was to: • Build on and use existing established engagement networks, for example e.g. via RCVS, HW Youth Out Loud forum. • Ensure representation on community voice groups of Richmond borough where possible – understanding that there is not always a group to represent every community. • Whether PCNs have the capacity to engage with their local communities.	Engagement will ensure an inclusive approach by setting up these new structures we will enable people and communities voices to be represented in the local Place infrastructure.	Once the community voice groups are launched in Feb 2023 we will review in three months to check in with people and communities involved to find out how they feel it is going and adapt the approach as appropriate.

Richmond: Supporting Primary Care Networks

South West London

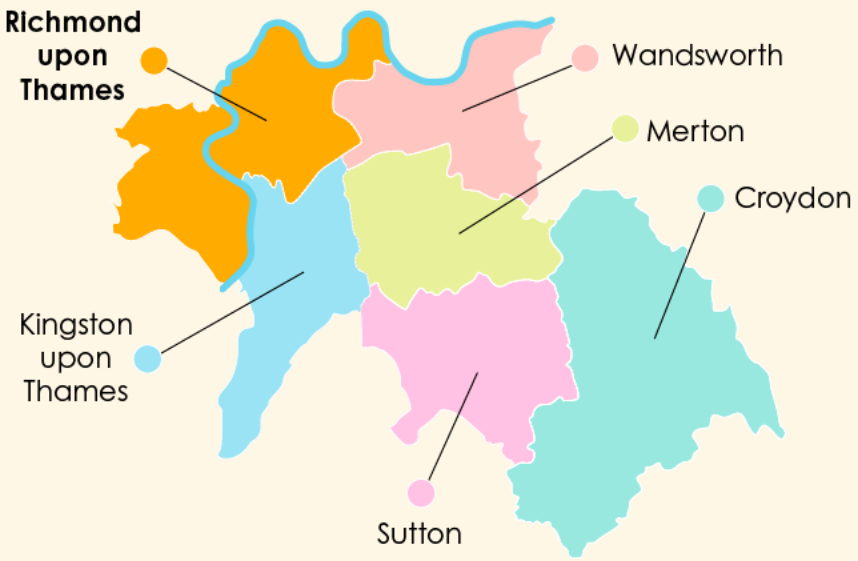
Engagement Lead: Hannah Keates, Engagement Manager, Kingston and Richmond

July to September 2022

Why did you seek the views of local people and or communities?	What activities did you do?	Who did you speak to and why?	What were the key themes that people raised?	What difference has this feedback made?	Are you planning any further engagement work on this programme or a related programme?
Place engagement approach – From 1 October 2022 PCNs were required to deliver enhanced access. In order to plan the future service in Richmond, the PCNs looked to gather information from local people about where and what services should be delivered.	A survey was delivered and sent to patients (18 and above) via text. The enhanced access service started on 1st October, run by the Richmond General Practice Alliance Limited (RGPA) for 25 Richmond practices to provide access to a GP service outside of core hours.	All Richmond registered patients aged over 18. 17,367 people responded to the survey. Patients were able to have a say in shaping primary care services in their areas which included asking how far patients were willing to travel helped inform how the RGPA would divide up the borough to provide the service.	The survey reinforced that the River Thames was a physical barrier for patients in Richmond as a reason they weren't willing to travel too far. Many people who are retired did not want to have to travel for an appointment elsewhere, when they were able to get one during the day closer to home.	The findings were used to inform the Enhanced Access proposals for the borough.	Moving forward a new survey will be run in spring 2023 evaluating the new model for enhanced services.

Enhanced access for Richmond patients

South West London Integrated Care System



Proud to be working together to create healthier communities

Partners involved

NHS South West London
Richmond Council
Richmond General Practice Alliance (RGPA)

Find out more
Learn more about our work and get involved at www.southwestlondonics.org.uk

How we're making a difference

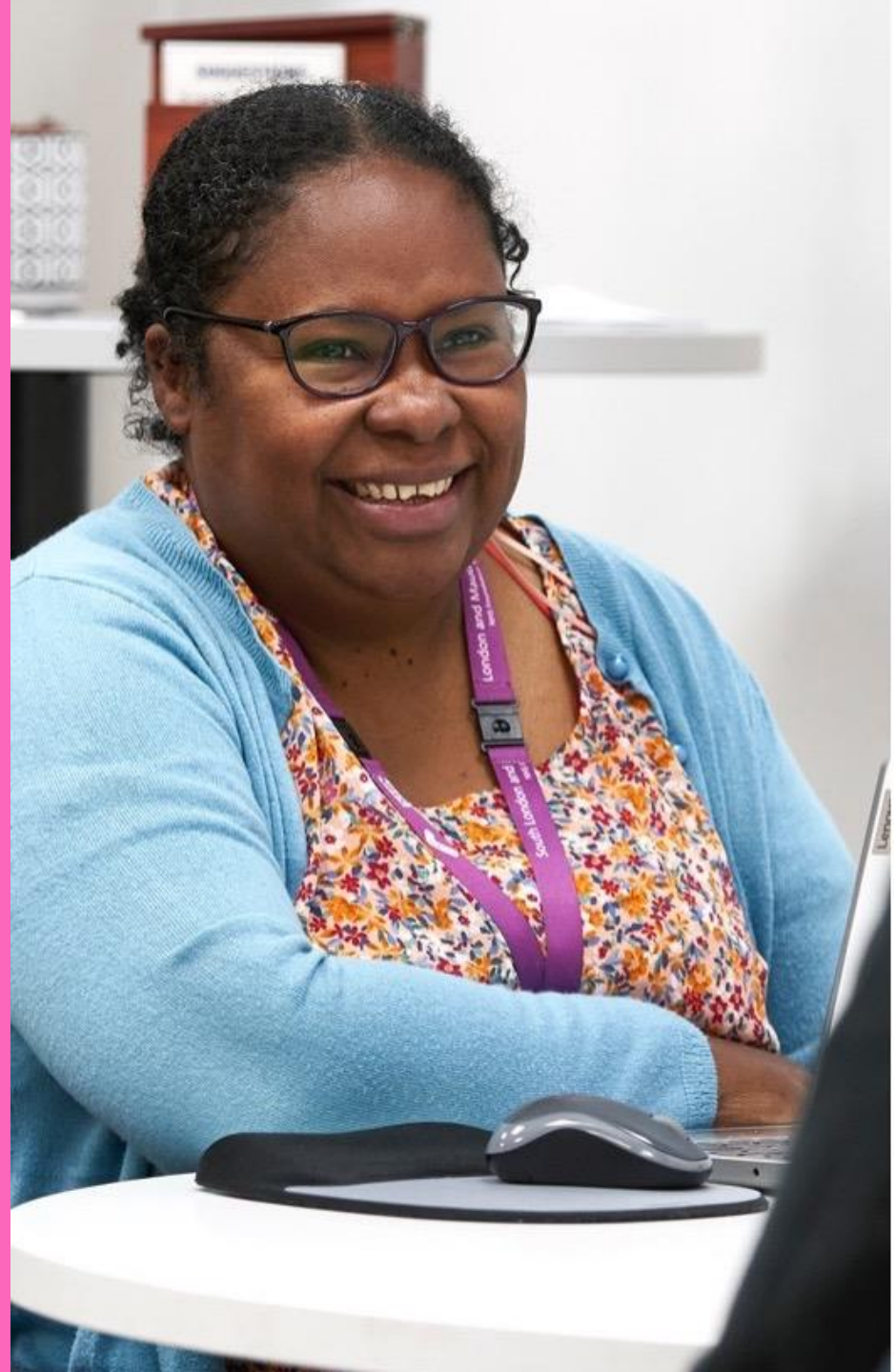
Over 17,000 patients in Richmond have been able to have their say about how GP appointments are available in their local area.

Patients were sent a text message which included a link to a series of questions which has led to the design of enhanced access in the borough.

Patients in each PCN were asked how far they were willing to travel, what time they would prefer to seen and whether weekend appointments would be well received. Responses helped inform the enhanced access services for each PCN, better serving their populations.

The results of the survey told us that older people really appreciated the option of early morning appointments, residents in full-time work preferred evening appointments and that offering some same day appointments can help to divert people away from A&E.

In July 2022 Richmond General Practice Alliance (RGPA) designed a patient survey which was distributed, by text, to all patients aged 18 years and over registered with a Richmond GP.



NHS
South West London

Sutton engagement and assurance report

Quarter 3: October to December 2022

Sutton

NHS South West London

Demand management and pressures

Getting people to the right place at the right time

- **Behaviour change** – communicating to support demand management
- **Reassurance and Confidence** – outlining the robust health and care system response to winter pressures

Examples of current activity:

- **Mental health:**
  - Ethnic Minorities Health Ethnic Minorities Health
  - Stay Warm and Well Hubs
  - Sutton Crisis Café
  - Housing estate health
- **Pharmacy campaign**
- **Urgent and emergency care**
- **Healthier Together website**
- **Virtual wards:** core narrative and staff and patient case studies to explain

Health inequalities and community outreach

Building trust and identifying health gaps sooner

- **Understanding our communities and potential barriers –** to access, we need a meaningful, ongoing conversation with communities we serve, in an appropriate way and in places familiar to them.
- **Building relationships, improve trust and increase health literacy –** to reduce the gaps we see amongst our population. We also collate insights, identify emerging themes to influence the way we provide services and ultimately reduce health inequalities.

Examples of current activity:

- **Core 20 connectors:** working with voluntary community connectors in deprived communities to reach those residents who experience health and inequality within their community.
- **Partnership working:** Delivering health and wellbeing talks including health checks alongside primary care colleagues including social prescribers and health coaches. Also working closely with housing managers to reach those most in need and ensure they have available resources and information to help address their health and social care needs.
- **Housing estate community outreach events:** 'delivering health and wellbeing events to deprived communities as identified wards as per Core 20 data
- **Community Voice:** A group of voluntary organisations representing residents with protected characteristics

SUTTON

Place–based communication and engagement

Supporting primary care and PCNs

Being receptive to local needs

Supporting primary care networks to hear from their patients and the wider communities they serve.

Examples of current activity:

- Enhanced access for primary care following national change in provision – communications and engagement advice and framework development for local PCN engagement
- Community Ward based in St Helier Hospital providing support who are being discharged into the community
- Community health and inequality team supporting the engagement outreach events in derived areas

Prevention and early intervention

Preparing, connecting and responding

- Working with senior leaders to manage the comms and engagement elements during issues and crisis management and link between SWL and place during incidents as part of ICB EPRR role
- Staying aware of current issues to advise on and plan for media or stakeholder interest and management

Horizon scanning, issues and crisis management

For longer, happier lives

The NHS long term plan set out our responsibilities to not only treat people, but also prevent them from getting ill in the first place. This activity supports Sutton residents to live longer happier lives and allows us to treat avoidable illness early on.

Examples of current activity:

- **Vaccines:** Covid-19, Flu, Polio
- **Cost of living information and sign posting**
- **Family Hubs**
- **SEND strategy**
- **ICS Strategy** – collating feedback from Sutton residents to influence the development and delivery of the ICS Strategy and priorities
- **Family hubs** – Working with system partners and local residents to ensure the investment in Family hubs is co-designed to meet local need

Service improvement and change

Meeting legal responsibilities

- **Legal duty to involve –** people where services or access to services change from the earliest stages
- **Understanding changes –** making sure that residents, external stakeholders and staff understand what the changes might involve, why we are making them and any potential implications

Examples of current activity:

- Model of care for Lifestyle and Wellbeing pilot for people with musculoskeletal conditions with obesity, hypertension or depression
- Planned Sutton Place review of contract portfolio
- Planned implementation of Sutton Place Frailty Model

Sutton: Shanklin Village Estate

NHS South West London

Engagement Lead: Nadine Wyatt, Sutton Place Engagement Senior Manager

April 2022 to January 2023

Why did you seek the views of local people and or communities?

Data shows strong correlation between areas of high deprivation (Shanklin Village Estate) and risk of loneliness.

Cheam and South Sutton Primary Care Network has the highest number of older people aged 65 years and over in Sutton, many of whom live alone in houses and flats without any social support.

We are aiming to:

- Connect isolated residents with local neighbourhoods
- Increase their access to care and community support and improve their health and well-being.
- Increase our understanding of loneliness and develop relationships necessary to help us truly codesign improvements.

What activities did you do?

Identified who already had connections with the residents, including Sutton Housing Partnership and Local Councilors, who facilitated introductions with the Chair of Shanklin Resident Association. The first visit took place in March 2022 with Sutton Council and Sutton Housing Partnership. This was an opportunity to start a conversation with residents to build trust, develop trusted relationships to get a better understanding of what factors affected their loneliness.

Activities were set up based on insight gathered:

- Monthly health and wellbeing topics facilitated by the Sutton Integrated Team.
- Residents were very interested in learning more about healthy eating and incorporating gentle exercise in their lives – weekly “Happy Eaters” club was formed facilitated by a dietician and a health coach followed by chair exercise class.
- Health checks including blood pressure, height and weight checks.

We seek ongoing feedback on session content and further support the residents would find useful. Insight and themes are documented.

Who did you speak to and why?

We connected with the Estate Community Connectors through invitations via Shanklin Village Estate social media sent by the resident association and flyers through doors.

GP surgeries sent texts to residents.

Up to 30 residents were actively engaged at the engagement activities.

The population on the estate is diverse and people from a variety or ages and ethnicities including people from the Black Caribbean, Black African, Asian, Polish and ethnic minority communities, attended the early sessions.

The residents who attend the engagement sessions are living with at least one LTC condition (self reported by residents).

What were the key themes that people raised?

Lack of community cohesion between people from diverse backgrounds.

The estate has a rich mix of demographics and high proportion of residents for whom English is not their first language.

More events/activities in the local community are needed to reduce feelings of loneliness.

Lack of understanding about local health and social care services.

A feeling of being “forgotten” as the estate is not perceived to be as deprived as other areas in Sutton.

Cost of living concerns.

Socio economic factors affecting the estate such as housing, anti social behaviour and drug use.

What difference has this feedback made?

The pilot contributed to social connectedness and is having a positive impact on residents’ health and wellbeing.

Better understanding around loneliness.

Relevant information sessions on topics that mattered to residents of the Shanklin estate.

Local community pharmacist, GPs, nurses and paramedics attended sessions and connected directly with residents – building trust in local NHS services and providing health and wellbeing advice for residents to better manage their health and wellbeing.

‘Bring a neighbour' initiative enabled networks to naturally form indirectly supporting social connectedness.

Partnerships have formed and strengthened. For example – Sutton Housing Partnership was involved with the food and diet sessions, providing a forum for residents to also discuss and raise housing issues. Partnership events are continuing into 2023.

Are you planning any further engagement work on this programme or a related programme?

This has informed the successful bid for Health Inequalities Fund by framing a vision for working across all estates within Sutton with high levels of deprivation and health inequalities. Link to the bid can be found here.

The next phase will be focussing on participatory research.

This has created the opportunity to develop a one “Shanklin Team” comprised of professionals from primary care, voluntary sector and social care to build on the work in the estate.

Residents will be gradually provided tools to facilitate some sessions – for example ‘Happy Eaters’ – supporting local community development and sustainability.

Sutton: Sutton Crisis Cafe

NHS South West London

Engagement Lead: Nadine Wyatt, Sutton Place Engagement Senior Manager

August 2022 to January 2023

Why did you seek the views of local people and or communities?

In August 2021, the Sutton Mental Health Foundation (SMHF) set up the Sutton Crisis Café pilot, funded by NHS South West London CCG. It was set up in response to the need for appropriate support to be available outside of hospital in Sutton to reduce A&E attendances for mental health crises when medical intervention is not required. It was also designed to give service users a better mental health experience and improve their quality of life.

What activities did you do?

In partnership with Healthy Dialogues who have been commissioned as an evaluation partner to take a mixed-methodological approach to evaluate the Crisis Café service.

The evaluation comprised of:

- service user data
- Surveys
- qualitative interviews
- focus groups
- Online polls sent to service users

The feedback was then broken down by demographics, gender and reasons for attendance

Who did you speak to and why?

Service users:

- Current service users of the Crisis Café service including carers to ensure the services is meeting their needs.
- The evaluation focused on service user experience and access to the service.

30 stakeholders:

- Stakeholder feedback was very positive. The only feedback raised was to reach more diverse cohort of people in the borough to reach various ages and ethnicities.

What were the key themes that people raised?

Key themes from service users and carers included:

Poor access to the service (given it is referral only, opening times not long enough).

The information was complex and service users did not understand information relating to their mental health condition.

Key themes from staff included:

- Lack of space for staff to work from
- Lack of clear guidance on referring service users onto other services
- Lack of training opportunities to staff

Key themes from stakeholders:

- Crisis Café has linked up well to other mental health services.
- Most stakeholders felt that the service had enabled its users to self manage their distress and reduce their dependency on mental health services, helping them to manage their mental health crisis.

What difference has this feedback made?

The service has produced clear guidance for staff, referring agencies and service users (in the referral criteria) on when a service user will no longer be eligible to access the service.

SMHF is providing staff with training on mental health topics beyond mild to moderate crisis management that they are encountering regularly to enable them to support people most effectively.

Are you planning any further engagement work on this programme or a related programme?

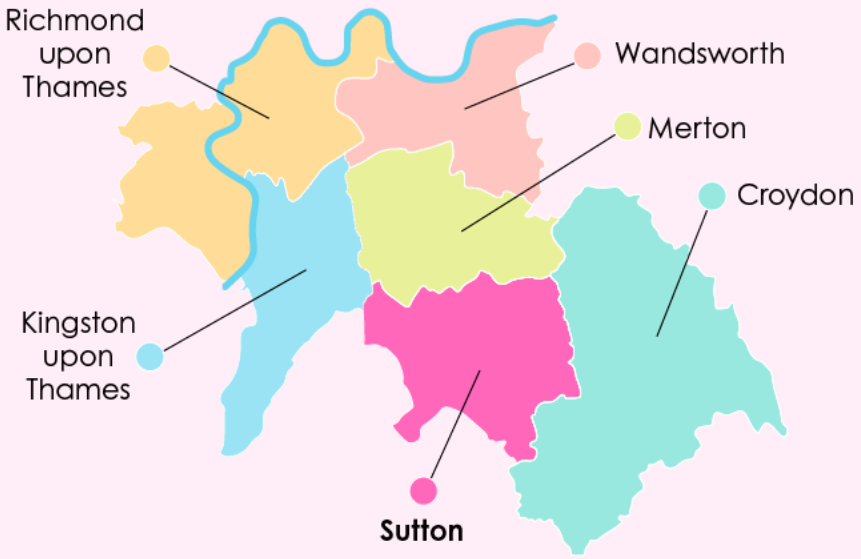
This work is ongoing.

Sutton Healthwatch will be leading on a survey to baseline the service user experience in year two.

This insight and learning is being used as a starting point for further engagement as part of the Health Inequalities bid which has a particular focus on Sutton's Cre20 communities.

Shanklin Village Estate in Sutton

South West London Integrated Care System



Proud to be working together to create healthier communities

Partners involved

NHS South West London
GPs, pharmacists, health coaches, social prescribers, Community Connectors
Sutton Council

Find out more
Learn more about our work and get involved at www.southwestlondonics.org.uk

How we're making a difference

After asking Shanklin Estate residents what matters to them, we worked with our partners to run a programme of community health and wellbeing activities. Not only is this making residents feel more connected to each other, but it is also positively affecting their physical and mental health.

These activities have included GPs, community pharmacists, health coaches, social prescribers and local Community Connectors coming together to start building trust with Shanklin Estate residents, by providing information and advice about local health and care services.

We've also been running a weekly chair exercise class and a Happy Eaters healthy eating session to discuss diet and weight. As a result, residents have told us their mobility has improved. Similarly, by encouraging people to 'bring a neighbour', new friendships are forming across the estate, improving their sense of connection and community.

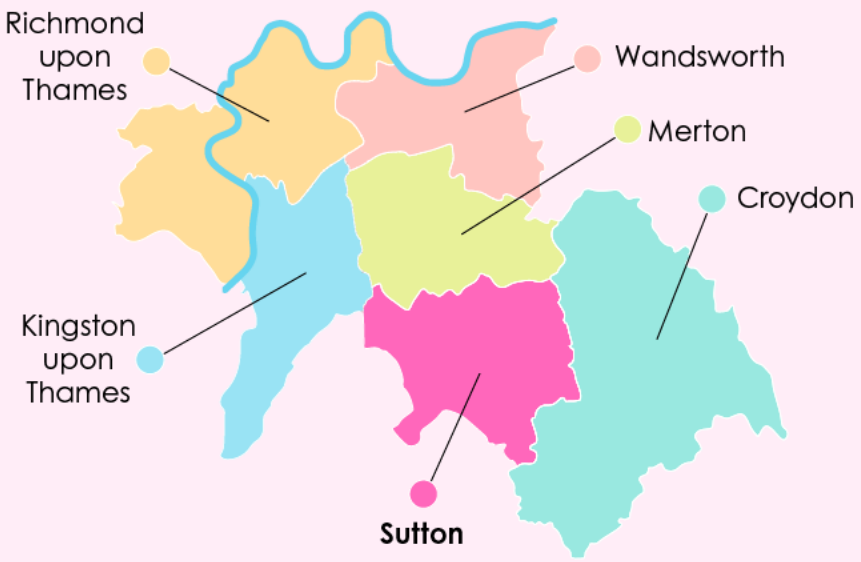
Given the success of this project, we're working with the voluntary sector and the local authority to take this approach to three other estates in Sutton where local people are facing deprivation and health inequalities.

"I have seen a significant improvement in everyone's willingness to take part and their positive attitude to receiving the benefit of the workshops and exercises that will make a massive difference in their lives. Now that they are willing to stand, I can do standing strength exercises and seated. All are gentle but will all help to improve balance and prevent falls."

Chair Exercise Instructor

Sutton's crisis cafe

South West London Integrated Care System



Proud to be working together to create healthier communities

Partners involved

Sutton Mental Health Foundation
NHS South West London CCG

Find out more
Learn more about our work and get involved at www.southwestlondonics.org.uk

How we're making a difference

Sutton Crisis Café is a safe, calm, and supportive place for people experiencing a mental health crisis to go to and is an alternative to A&E.

Since its launch in August 2021, the Cafe has supported over 100 people and there have been almost 300 one-to-one crisis support sessions. 75% of visitors to the café have also self-referred.

To ensure the Café is supporting people the best it can, the Café asked for feedback from people using the service. As a result, the Café has created clear guidance for staff, referring organisations and people using the Café on who is eligible to use it and when someone will no longer be able to access their support.

Staff have also been provided with training on several mental health topics that people using the café are often experiencing. As a result, Café staff can better personalise how they support people, leading to more effective care.

I was amazed to find such a facility available and accessible. It makes such a difference knowing that there is a clean, safe, comfortable place I can go to talk or just be. That I can bring my dog has also been great. I am so grateful to everyone involved in this. I don't know how my story will end but, just for today, Sutton Crisis Café has made a very significant positive difference for me. Thank you.

A recent visitor to the cafe

Merton engagement and assurance report

Quarter 3: October to December 2022

Merton

Demand management and pressures

Getting people to the right place at the right time

- **Behaviour change** – communicating to support demand management
- **Reassurance and Confidence** – outlining the robust health and care system response to winter pressures

Examples of current activity:

- Supporting local Council-led cost of living campaigns
- Merton link workers pilot campaign – working with Wide Way medical centre to promote online self-referral route
- Support SWL wide campaigns – MH crisis line, vaccination

Health inequalities and community outreach

Building trust and identifying health gaps sooner

- **Understanding our communities and potential barriers –** to access, we need a meaningful, ongoing conversation with communities we serve, in an appropriate way and in places familiar to them.
- **Building relationships, improve trust and increase health literacy –** to reduce the gaps we see amongst our population. We also collate insights, identify emerging themes to influence the way we provide services and ultimately reduce health inequalities.

Examples of current activity:

- **Community voice forums** Merton health and care community voice bi monthly forum to discuss community needs , support heath inequalities agenda and provide updates about projects programmes and developments across the system, opportunity for co production and involvement in service development

MERTON

Place–based communication and engagement

Supporting primary care and PCNs

Being receptive to local needs

Supporting primary care networks to hear from their patients and the wider communities they serve.

Examples of current activity:

- **Enhanced access for primary care** following national change in provision – communications and engagement advice and framework development for local PCN engagement
- **Primary care** dashboard

Prevention and early intervention

Preparing, connecting and responding

- Working with senior leaders to manage the comms and engagement elements during issues and crisis management and link between SWL and place during incidents as part of ICB EPRR role
- Staying aware of current issues to advise on and plan for media or stakeholder interest and management

Horizon scanning, issues and crisis management

For longer, happier lives

The NHS long term plan set out our responsibilities to not only treat people, but also prevent them from getting ill in the first place. This activity supports Merton residents to live longer happier lives and allows us to treat avoidable illness early on.

Examples of current activity:

- **Winter engagement events**
- **Vaccines:** Covid-19, Flu, Polio
- **Signposting to Mental Health Crisis line**
- **ICS Strategy** – collating feedback from Merton communities to influence the development and delivery of the ICS Strategy and priorities
- **Closing feedback loop** by updating partners at community voice forums with the progress of the ICP strategy

Service improvement and change

Meeting legal responsibilities

- **Legal duty to involve –** people where services or access to services change from the earliest stages
- **Understanding changes –** making sure that residents, external stakeholders and staff understand what the changes might involve, why we are making them and any potential implications

Examples of current activity:

- Wilson health and wellbeing hub development
- Rowans surgery engagement
- Merton community rehab service transformation

Merton: Community Voice forums

Engagement Lead: Nadra Gadeed, Engagement and Equalities Lead
August to November 2022

Why did you seek the views of local people and or communities?

Place engagement approach – this comprises of two parts:

- To repurpose community voice forums in Merton in line with the system reconfiguration creation of the ICB.
- To develop governance structure for engagement to feed into Place committee

What activities did you do?

Community voice forums:

- Workshops with the Patient experience Group in Merton and two workshops to discuss a new collaborative forum.
- 'Merton Place Networking event' at Commonside in Pollard's Hill to discuss new model of working.
- The group were asked to agree a new name for the forum, which is "Merton Health & Care Community Voice Forum".

Developing a governance structure:

Compiling and utilising all feedback from Place and wider system partners on a proposal of the new governance presented to the Merton Health and Care together Committee for approval.

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Who did you speak to and why?

In development of the community voice forums, it was important for the members of the Patient Engagement Group to feel supported and comfortable with the changes, to encourage buy in to make the new voice forum be purposeful and work effectively for those involved. Members of the Patient engagement Group include:

- Healthwatch Merton
- Adults First (MENCAP)
- Merton Vision
- Merton seniors group
- Nelson Medical Practice PPG rep
- Attendees at the Commonside event.

In development of the governance structure, partners involved were:

- VCSE and Healthwatch
- Patient and Participation Groups
- ICB
- Merton Council
- Faith and belief forum.

What were the key themes that people raised?

Feedback on the community voice forums included:

- Opportunity to shape and influence assurance so there is real scope for influence and ability to change process and redesign.
- More coproduction and collaboration opportunities.
- Transparency, clarity and involvement opportunities to be widely promoted and shared.
- Sustainable relationships are built with trust over time.

Feedback on the governance structure included:

- How insights gathered from people and the community will truly shape and influence programmes of work and priorities at Place.
- How will local people and communities be aware about upcoming service change and key development that affect them.

What difference has this feedback made?

Community voice forums:

- Co produced terms of reference.
- Closing feedback loop when insights are gathered.
- Built in mechanism to ask Merton Health and Care Community Voice Forum what needs to be discussed/priorities for meeting, e.g. asking groups before the meeting for agenda items and discussion points.

Governance structure:

- Designed an accessible infographic on how the flow of insight and feedback influences and shapes local priorities and programmes.
- Utilising the community Merton voice forums to provide timely updates to Place Committee.
- Championing people/patient voice at Place committee and the need to ensure it is kept on the radar. This is supported by the Engagement and Equalities Manager attending both and acting as bridge between the Place Committee and the Merton Health and Care Community Forum.

Are you planning any further engagement work on this programme or a related programme?

To adopted a themed based approach asking the group to contribute to bi monthly themes based discussion.

Proactively engaging with the specific groups for specific areas e.g. children, young people, older adults.

Merton: Health on the high street

Engagement Lead: Nadra Gadeed, Engagement and Equalities Lead
August 2022 to January 2023

Why did you seek the views of local people and or communities?

To ensure the health on the high street project is embedded in the local community and delivers on activities that matter and in places that matter to people.

What activities did you do?

Health on the high street project lead has organised:

- Dementia café with Alzheimer's Society.
- Health and Wellbeing days in Raynes Park (21 Jan) and one in Mitcham (11 Feb).
- Online and in person mindfulness course
- Four workshops about assertiveness provided by Wimbledon Guild for the new year.
- Health and Wellbeing event in February for the LGBTQ+ community (also working to have some LGBTQ+ film nights, with a view to have a user base in the community who can feedback on any commissioning of services etc).
- Community events in libraries
- Music sessions at Dementia hub in Mitcham.

As part of these activities people are asked about local services that need to be provided in the borough.

.

Who did you speak to and why?

Local community groups, stakeholders and local people. This was to not only ensure the activities meet the needs of people but to also build trusted relationships.

What were the key themes that people raised?

Cost of living is increasing issue.

Access to services – e.g. having services in libraries, wellbeing hubs. The need for accessible heath information and raising awareness of local services.

VCSE feedback that insecure funding for the VSCE (e.g. for one year only) and not knowing how they can be sustainable and provide these in the borough.

What difference has this feedback made?

More heath and wellbeing events and opportunities readily available for Merton residents.

Are you planning any further engagement work on this programme or a related programme?

Broaden service offer for LGBTQ +

Host more health and wellbeing across Merton.

Merton: Rowans Practice changes

Engagement Lead: Nadra Gadeed, Engagement and Equalities Lead
August to October 2022

Why did you seek the views of local people and or communities?

To engage with patients at the Rowans Practice:

- on proposals to close the GP practice and ask registered patients to register at an alternative practice of their choice
- to support a seamless move of patients to other local GP practices in line with the list dispersal
- to understand any support needs of patients transferring to new practices, including translations and support needed to re-register
- to understand the experience of being a patient at the Rowans Practice.

What activities did you do?

Two drop in sessions at the Rowans practice for patients and carers.

Patient letter and FAQ sent to all patients.

Evening community event and virtual event for wider local community input at New Horizons.

Equality impact assessment to assess the service change impact on protected characteristics and population groups.

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Who did you speak to and why?

- Patients of Rowans GP Practice
- Local community groups
- Local MP
- Voluntary, community and social enterprise (VCSE) sector.

What were the key themes that people raised?

A lot of feedback was that patients had poor patient experience at the Rowans (appointments, quality to medical care, access to information).

Lack of information about the wider development to the community over a long period of time.

What difference has this feedback made?

Opportunity to provide timely information to the community about the practice closure and services.

Provide support to patients with additional needs for moving to a new practice and re-registering e.g. information in other languages.

Provided opportunities for patients and local community to ask questions about the situation to Executive locality lead

Head of Primary Care

Clinical lead for East Merton PCN. This has built better relationships between the community and visibility of senior NHS staff.

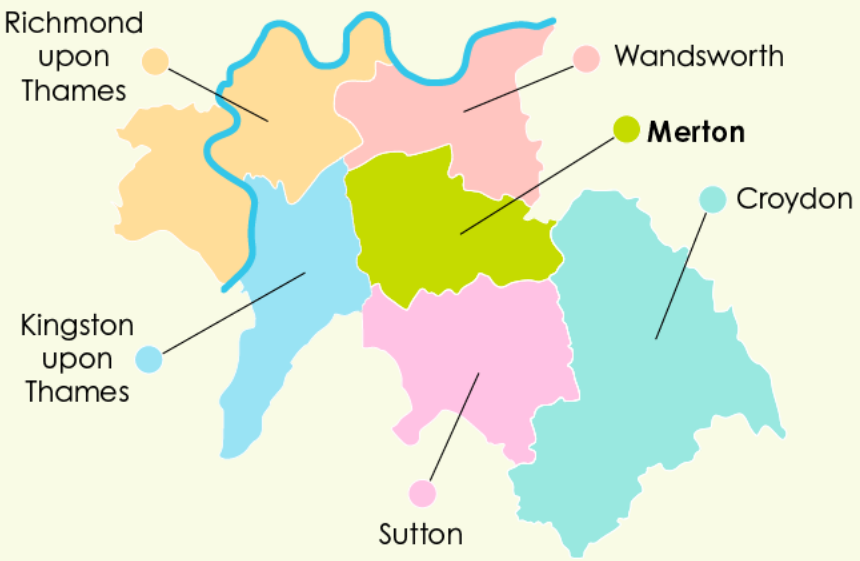
Are you planning any further engagement work on this programme or a related programme?

Local residents will be kept up to date as the new development at Rowan Park progresses – this will include primary care facilities.

Learning from the process will inform future primary care service development and engagement.

A chance to talk about memory worries

South West London Integrated Care System



Proud to be working together to create healthier communities

Partners involved

NHS South West London
Merton Council
Alzheimer's Society
Metronome café

Find out more
Learn more about our work and get involved at www.southwestlondonics.org.uk

How we're making a difference

People worried about their memory, or that of a friend or family member, can pop into, Morden's Metronome café to talk to the experts - or just enjoy a free cup of tea or coffee and a chat.

The project is part of the Health on the High Street initiative, jointly funded by NHS South West London and Merton Council, which seeks to bring wellbeing services into communities by working with businesses, libraries and other facilities.

According to Bill Gibbons of Alzheimer's Society Merton, many people have concerns about their memory, but aren't sure where to turn - which is the idea behind the cafe.

"Our aim is to get people to drop in for a coffee, so they can chat about anything that's bothering them. People have questions about dementia – what exactly is it, how you get it, what you should do if you're worried?"

"We are truly passionate about creating a space that the community feels welcome in. We decided to make Metronome Morden a dementia friendly space right back at the planning stage. It is only when we work together that communities can truly be accessible to all."

John Merriman, Metronome cafe

Wandsworth engagement and assurance report

Quarter 3: October to December 2022

Wandsworth

Demand management and pressures

Getting people to the right place at the right time

- **Behaviour change** – communicating to support demand management
- **Reassurance and Confidence** – outlining the robust health and care system response to winter pressures

Examples of current activity:

- Ethnic Minorities Health Improvement Project (EMHIP) – developing a campaign to promote community led hubs
- Supporting local Council-led cost of living campaigns
- Support SWL wide campaigns – MH crisis line, vaccination

Health inequalities and community outreach

Building trust and identifying health gaps sooner

- **Understanding our communities and potential barriers –** to access, we need a meaningful, ongoing conversation with communities we serve, in an appropriate way and in places familiar to them.
- **Building relationships, improve trust and increase health literacy –** to reduce the gaps we see amongst our population. We also collate insights, identify emerging themes to influence the way we provide services and ultimately reduce health inequalities.

Examples of current activity:

- **Community Grants:** Building capacity of grassroots organisations to deliver health projects with the capability to reach deep into the local communities as trusted partners
- **Roehampton health Community Champions:** Joint funded project for to facilitate the recruitment , training of local health champions
- **Community voice forums:** Thinking Partners bi monthly forum to discuss community needs , support heath inequalities agenda and provide updates about projects programmes and developments across the system, opportunity for co production and involvement in service development

Supporting primary care and PCNs

Being receptive to local needs

Supporting primary care networks to hear from their patients and the wider communities they serve.

Examples of current activity:

- **Enhanced access for primary care** following national change in provision – communications and engagement advice and framework development for local PCN engagement
- **Primary care** dashboard

Prevention and early intervention

Preparing, connecting and responding

- Working with senior leaders to manage the comms and engagement elements during issues and crisis management and link between SWL and place during incidents as part of ICB EPRR role
- Staying aware of current issues to advise on and plan for media or stakeholder interest and management

Horizon scanning, issues and crisis management

For longer, happier lives

The NHS long term plan set out our responsibilities to not only treat people, but also prevent them from getting ill in the first place. This activity supports Wandsworth residents to live longer happier lives and allows us to treat avoidable illness early on.

Examples of current activity:

- **Winter engagement events**
- **Vaccines:** Covid-19, Flu, Polio
- **Signposting to Mental Health Crisis line**
- **ICS Strategy** – collating feedback from Wandsworth communities to influence the development and delivery of the ICS Strategy and priorities
- **Closing feedback loop** by updating partners at community voice forums with the progress of the ICP strategy

Service improvement and change

Meeting legal responsibilities

- **Legal duty to involve –** people where services or access to services change from the earliest stages
- **Understanding changes –** making sure that residents, external stakeholders and staff understand what the changes might involve, why we are making them and any potential implications

Examples of current activity:

- Enhanced primary care hub – Queen Mary's Roehampton
- Sleaford St health centre development – primary care service
- Supporting Trinity medical engagement
- Wandsworth community rehab service transformation

Wandsworth: Rehabilitation and reablement

Engagement Lead: July to October 2022

Nadra Gadeed, Engagement and Equalities Lead

Why did you seek the views of local people and or communities?

Merton and Wandsworth are looking at redesigning home-based services, including hospital at home and virtual wards, to improve the support people receive.

As part of this work we're reviewing community-based rehab and reablement services. One of the types of support for people coming out of hospital is community-based rehabilitation and reablement. This can be delivered at home or through bed-based provision in a care home. These services include social work, care workers, physiotherapy, occupational therapy, speech and language therapy, or dietetics (advice on nutrition issues and eating habits) and support from nurses and doctors.

Bed based provision was available at Queen Mary's hospital and two care homes – Ronald Gibson house (which was no longer available from September 2022) and Heathlands.

What activities did you do?

Project Lead commissioned the voluntary and community sector (VCS) to undertake a series of telephone interviews, focus groups and questionnaires to find out about patient experience of hospital discharge and bedded rehab discharge.

Who did you speak to and why?

VCS organisations funded were Mushkil Aasaan, Wandsworth carer centre, Merton Vision and Age UK. This was because the VCS have better reach in to the target communities e.g. Age UK work with people who are being prepared to be discharged from hospital, Mushkil Aasaan run community groups of older people. They were commissioned to deliver the telephone interviews focus groups with their local populations.

What were the key themes that people raised?

- Discharge from hospital to home and people's need for rapid recovery with the right community provision. People felt that if the right support was in place, this led to faster improvement in their health and wellbeing.
- Discharge from hospital to bedded rehab. Most people who chose this option (when offered at discharge) did so because they didn't want to be a burden on their family. They were also concerned whether they had enough space for equipment at home.

What difference has this feedback made?

The feedback has informed the transformation of the process for rehabilitation and rehabilitation. This included:

- The need for staff training on assessments being culturally sensitive to patients' needs.
- The need for better recording on cultural needs and appropriate interventions.
- Transport needs to be factored into community care packages.

Are you planning any further engagement work on this programme or a related programme?

To develop a high level summary document for transformation teams. To outline processes for engaging with the VSCE for community insights when undertaking service change

Wandsworth: Enhanced Primary Care Hub

Engagement Lead: Nadra Gadeed, Engagement and Equalities Lead
October- November 2022

Why did you seek the views of local people and or communities?	What activities did you do?	Who did you speak to and why?	What were the key themes that people raised?	What difference has this feedback made?	Are you planning any further engagement work on this programme or a related programme?
To ensure the Enhanced Primary Care hub was renamed to reflective of the service provision. Roehampton Putney heath area. This engagement follows an extensive engagement exercise on proposals to change the model of care at the previous Urgent Treatment Centre.	Programme lead for Roehampton health champions (joint commissioned project ICB and LA) engaged the local community living locally and ran a series of focus groups.	30 local residents joined two focus groups in the Roehampton Putney heath area run by Estate arts.	• Feedback was that the name of the service has to reflect what the service does and provides – there was no agreement in this first phase of engagement on the new name. • People's experience of using the Enhanced Primary Care Hub has been positive	Feedback has informed a survey which has been developed for dissemination to the staff at the Enhanced Primary Care Hub for local Wandsworth residents. This will be shared in the Roehampton area through the Roehampton health champions and the local MP.	To build on existing relationships building trusted connections with the local community by providing opportunities for joint working and future co-production. Gathering community insights. Co producing workshops to better understand health and community needs.

Wandsworth: Roehampton Health Champions

Engagement Lead: Nadra Gadeed, Engagement and Equalities Lead
August to November 2022

Why did you seek the views of local people and or communities?

Estate Art Ltd (voluntary sector organisation) were commissioned to develop, manage and train a network of dedicated Community health champions for Roehampton and Putney Heath.

What activities did you do?

Champions:

- Induction meeting held
- 9 champions recruited
- Training session Making every contact count (MECC)
- Individual training for Champions on the use of the Health Inequality Survey to ask other residents health related questions.

Who did you speak to and why?

Local residents in Roehampton and Putney heath.

Roehampton Health Question Time residents attended, 8 organisations in attendance along with Councillor Graeme Henderson (Cabinet Member for Health), Councillor Mathew Tiller, Immunologist Robert Busch, Dr Farwa Hassan GP, Alton Practice.

The Lead for Champions project ran a men's health day to recruit champions. Organisations participating in the day included:

- The Alton Practice GP Surgery HCA Russell
- NHS Self-Management (Diabetes)
- Wandsworth Stop Smoking Service
- Wandsworth Community Drug & Alcohol Service
- Thinking Works (Energy Advice)
- Wandsworth Council Tenancy Support
- St George's Hospital Hepatology – providing Liver Scans in their mobile unit

What were the key themes that people raised?

- Cost of living concerns increasingly heard.
- Poor access to hospitals in the Roehampton and Putney Heath area and people feeling that there are a lack of health services around them.
- Lack of accessible health information on services.
- The need to build trust and relationships with the statutory sector

What difference has this feedback made?

The voluntary sector organisational reach and the building of trusted voices into areas with significant health inequalities. Reach via the trusted relationships that Champions hold within the community and with the Champions Project Lead.

Building sustainable relationship and capacity of the local community via the Project Lead attends and shares at the Thinking Partners.

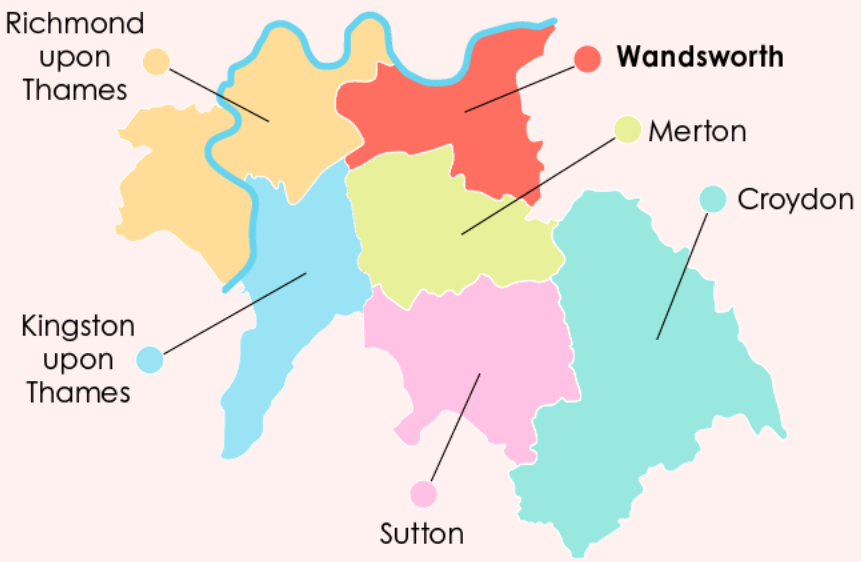
Are you planning any further engagement work on this programme or a related programme?

To link Estate Arts to other opportunities for funding.

Signpost Health champions into training and networking opportunities across Wandsworth.

Building a better future in Roehampton

South West London Integrated Care System



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How we're making a difference

An ambitious community project is addressing health inequalities on the Alton Estate in Roehampton by empowering local people.

Around 13,000 people live on the estate. Local residents are more prone to high blood pressure, diabetes and heart disease than people in more affluent areas nearby - and less likely to be fully vaccinated against Covid-19.

The Roehampton community health champions project aims to change this by recruiting a network of volunteers to share information with their neighbours through existing relationships and special events. The scheme is supported by NHS South West London and Wandsworth Borough Council – after it was shown to work well in other areas during the pandemic.

Lynne Capocciama, who is leading the project through her not-for profit company, Estate Art, said: "We live in a community full of big-hearted and talented people and I believe they deserve the best in health care and life opportunities."

"Covid was a tough time for local people but I'm proud of what we achieved in that time. I want us to grab hold of all that purpose and passion and turn it into something permanent. I think the community health champions project could be our chance to own our own future."

Lynne Capocciama, Estate Art