IVAR we listen, and learn together

How we're connecting health communities

in Cheshire East, Dudley, St Helens and Wandsworth

April 2024

CONNECTING HEALTH COMMUNITIES with IVAR

Introduction

Four areas are currently taking part in the Connecting Health Communities (CHC) initiative to address health inequalities through cross-sector partnership working that involves local people in the design and delivery of services: *Cheshire East, Dudley, St Helens and Wandsworth*.

Challenge-Action-Outcome statements

We have developed a series of 'Challenge-Action-Outcome' statements to describe each area's plans as of March 2024. The statements will adapt and change as the local partnerships' work evolves, in conversation with varied stakeholders.

Find more information about Connecting Health Communities on our website.

Cheshire East

Challenge

The East Timorese population in Cheshire East is at higher than average risk of tuberculosis (TB) – an infection that usually affects the lungs – as East Timor has one of the highest TB rates in the world.

After planned work to encourage the uptake of TB screening within the East Timorese community in Crewe was disrupted by the Covid-19 pandemic, a cross-sector group[1] has come together to explore ways to increase TB screening as well as identifying and acting to reduce broader health inequalities within this community.

A significant challenge is that there is a stigma attached to TB amongst the East Timorese community. We will focus therefore on broader prevention and living well within this community in Crewe. This is supported by GPs, TB nurses and midwifery with the shared goal of building trust and encouraging community members to access primary care services including TB screening.

Action

The cross-sector group will be working in Crewe with the Eaglebridge Primary Care Network (PCN) to **improve access to primary care** for East Timorese people by responding to the barriers raised by the community:

1. **Making the GP (General Practice) surgery more accessible:** Increase awareness about the GP registration process, the services available for the community and how to get appointments. This will help to increase GP registrations and access to GPs, who can then take steps towards building trust with East Timorese community members. The Eaglebridge PCN has raised awareness that there is no requirement for ID documents or immigration status documents for GP registrations.
2. **Increase the understanding of the community among hospital trust, primary care staff and the voluntary sector,** who are often the first point of contact for the community.
3. **Raise awareness** about TB prevalence among the East Timorese community in Crewe, and awareness about the treatment and prognosis, with the aim of increasing take-up of TB screening, which is essential in finding and treating latent TB.
4. Finally, explore ways to increase **integration with the wider community in Crewe**, by supporting the community to raise their profile through community events such as Independence Day celebrations.

> *'Health and wellbeing are important, but actually getting East Timorese people feeling part of rather than separate to the rest of Crewe is really important.'*

1 Cheshire East Council Public Health and Communities teams; Mid Cheshire Hospitals NHS Foundation Trust; UK Health Security Agency (UKHSA); Eaglebridge Health and Wellbeing Centre, Crewe; Central Cheshire Integrated Care Partnership; Cheshire and Wirral Partnership NHS FT (TB team); Healthwatch Cheshire CIC; Cheshire, Halton & Warrington Race & Equality Centre; Wishing Well Project; and East Timor Action Group.

Desired outcomes

Through this work, the group would like to ensure the East Timorese community in Crewe have better access to health and wellbeing services – particularly General Practice as the gateway to other services – and a good, safe life more generally. They are keen to do this through co-production and collaboration, directly working with communities and those with lived experience. They want to advocate for the East Timorese community, ensure it is an enjoyable process for all involved and help to build trust between community members and professionals. Overall, they are keen to learn from this approach to improving health outcomes and reducing health inequalities and to share and apply *'what works'* to other health and wellbeing priorities in the area.

The main outcomes of this work for the East Timorese population are:

- An improved understanding of the health and wellbeing needs of the community, as well as their strengths.
- An increase in GP registration including building trust in those and other services available in a surgery.
- A better understanding of TB, reducing stigma and highlighting the benefits of treatment.
- Ultimately, an increase in TB screening and treatment where necessary.
- Improved understanding of their rights as a community, i.e. their health, employment and housing rights, and of community groups, activities and social opportunities that facilitate integration into the community.

Dudley

Challenge

Dudley has higher levels of childhood obesity in comparison to the England average[2]: 24.6% of children aged 4-5 are overweight or obese, and 39.8% of children aged 10-11 are overweight or obese, with 20.7% of children living in poverty.

> *'Poverty will be leading lots of behaviour. It's hard to untangle* [childhood obesity] *from wider determinants.'*[3]

Childhood obesity is situated within broader social and health inequalities, including poverty and access to education and healthcare. Obesity and the link with poverty is particularly important at the moment within the current context of the cost-of-living crisis.

This is a complex problem with many drivers (including behaviour, environment, genetics and culture). Children who are overweight or obese are more likely to come from families where the adults are obese, and also more likely to remain obese in adulthood and develop significant health disorders as a consequence.

Why does it matter?

Obesity doubles the risk of dying prematurely[4] – obese adults are seven times more likely to become a type 2 diabetic than adults within a healthy weight range, and more likely to develop heart disease, some types of cancer and depression[5]. By addressing obesity in childhood, we can reduce these risks from materialising.

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2 Rates of Childhood obesity in England in 2021/22: 10.1% of reception-age children (age 4-5) were obese, with a further 12.1% overweight. At age 10-11, 23.4% were obese and 14.3% overweight. This data is from the National Child Measurement Programme and published by NHS Digital.
3 Unattributed quotes are quotes from steering group members.
4 T. Pischon, M.D et al. (2008) General and Abdominal Adiposity and Risk of Death in Europe. *The New England Journal of Medicine*.
5 Health and Social Care Information Centre (2015) Health Survey for England 2014.

Action

A cross-sector steering group[6] is working in Dudley to reduce rates of childhood obesity within broader social and health inequalities, including poverty and access to education and healthcare. The steering group is focusing on children in the context of their families, their learning, education, and housing. Their aim is to explore approaches that can support the reduction of childhood obesity while also effecting wider positive change – *'what will help Dudley residents to live a happy and healthy life?'*

> *'You can't focus on just one issue. If you are on a health journey, and have kids who are unhealthy, it's not just about working with the kids. It's a whole family thing and needs a holistic approach.'*

> *'Long-term, sustainable change will only be achieved through the active engagement of schools, communities, families and individuals.' (Childhood obesity: a plan for action)*

The starting point has been to better understand the root causes of childhood obesity and existing barriers to living a healthy life in Brockmoor and Pensnett Ward. While childhood obesity may not be recognised by local residents as a priority issue, working collaboratively with them, and being led by their priorities, will develop greater understanding of the complex web of factors that influence health in the area. This will also inform how best to involve communities in tackling some of these factors.

Why Brockmoor and Pensnett?

This ward is characterised by a relatively young population: 40% of the ward's residents are under the age of 30, compared to 35% for Dudley Borough overall. It has the second highest level of deprivation in Dudley according to the Index of Multiple Deprivation and has one of the highest age standardised mortality rates in comparison to both Dudley and England. People in this ward have increased health needs[7].

6 The steering group for this work comprises cross-sector leaders from Healthwatch Dudley, Dudley Council, Dudley Integrated Health and Care NHS Trust, and Dudley CVS.

7 In comparison to statistics across England, people living in Brockmoor and Pensnett have lower uptake of cancer screening; higher rates of obesity; poorer follow-up for mental health; higher rates of diabetes, COPD, asthma and arthritis; and higher prevalence of smoking.

Next steps

Between July 2023 and January 2024, the steering group has compiled data on childhood obesity within the ward, alongside hearing insights and ideas from community members and health professionals – through community conversations, a survey and a partnership workshop. The focus has been on understanding how childhood obesity interrelates with wider determinants of health and inequality. Working with wider stakeholders, including residents, the group has surfaced six potential solutions to promote a healthier Brockmoor and Pensnett community:

1. **Develop peer groups in community settings:** Set up places of welcome and 'warm spaces' for peer group meetings based on a particular health issue/theme (cooking, eating healthily on a budget, building confidence). These sessions will aim to reduce community isolation and shift behaviours to be more supportive of health and wellbeing.
2. **Community champions and workshops to inspire physical activity:** Connect with community leaders and local sports clubs/groups to promote more accessible and social sports opportunities. These workshops will aim to reduce levels of inactivity and promote a more active and healthy lifestyle in the ward.
3. **Break unhealthy generational habits:** Further understand the engrained behaviours, habits and attitudes that lead to unhealthy choices and outcomes in Dudley (Public Health plans to develop a 'health-related behaviour questionnaire' to surface trends amongst children and young people in Dudley in support of this). The group could explore what intergenerational offers are available in this area and share the results from the questionnaire via an intergenerational 'fun day'.
4. **Flexible, diverse, emotional and social support and life skills in schools and employment:** Develop outreach programmes with schools to share life skills and careers advice, and to develop targeted interventions for SEND/neurodiverse young people to aid transitions to work. Work with young ambassadors to develop this.
5. **Community champions to share messages about health and wellbeing:** The Community Researcher at Healthwatch Dudley will work with community leaders to champion healthy habits and signpost to pro-wellbeing actions.
6. **Develop hubs for men to connect:** Work with existing groups in the area (e.g. Tough Enough to Care) to bring men together to share and connect. This action aims to reduce poor mental and physical health, related to isolation, among men in the area. A connected, less isolated dad in a family will be more likely to be a positive role model for children growing up.

Desired outcomes

Stakeholders on this programme are working to understand more about childhood obesity and its link with poverty, and how to work together as a cross-sector group to co-produce an action plan with communities.

There are three specific aspirations for this work:

1. **Reducing health inequalities in Brockmoor and Pensnett:** Demonstrate a reduction in the rates of childhood obesity over five years (and further). As part of this, developing fair, accessible and equitable primary care services for the local population is a key aspiration. Through this work, local primary care services are involved in discussions as well as promoting the suite of services on offer within GP practices that work towards prevention of ill health. For example, health and wellbeing coaches, dieticians, nurse-led long-term conditions review, the NHS health check offer and routes into the ABL-led health improvement service (weight management and smoking cessation being prime examples). We will invite representatives from the three practices serving the area (Kingswinford Medical Practice, High Oak Surgery and AW Surgeries) to contribute to, and provide promotional materials for services.
2. **Greater collaboration between health and voluntary sector:** This programme is seen as an opportunity to foster joined-up working between sectors and organisations. There is *'untapped potential'* within voluntary sector organisations that need to be seen as *'an equal partner'*. The group is keen to co-design solutions that rely on multiple stakeholders to create meaningful and long-term changes in Dudley, as opposed to solutions within silos. The group hopes to develop an action plan that all partners will work together to deliver, with shared goals and a distribution of work: *'Develop a culture we can all subscribe to and shape'*.
3. **Developing a clear process for communities' role in reducing health inequalities:** Test out different models of involving community members in the discussions and solutions about health inequalities. The Health Creation Network, developed by the Bromley by Bow Centre, was mentioned as a potential model to aspire to develop in Dudley. Another suggestion was to engage with communities in a more creative way through Connecting Health Communities (CHC) – going where the appetite is from community members and engaging outside of meetings. A core aspiration of this work is to increase residents' control, influence and responsibility over their own health, wellbeing and care.

St Helens

Challenge

ONS data from 2021 has highlighted that 11% of people in St Helens felt lonely 'often' or 'always', compared to 7% nationally. Hospital admissions for self-harm are almost double the national average in the 10- to 24-year age group (OHID 2022). In addition, 9% of children in St Helens had low happiness levels with their lives as a whole, compared to a national average of 5% (Good Childhood Inquiry, 2020). Rates of under-18 hospital admissions and adult admissions for alcohol-specific reasons are also nearly double the national average. A study on Deaths of Despair[8] published in February 2024 highlighted that St Helens ranks 24th of 302 boroughs in England.

Loneliness is associated with higher rates of depression, high blood pressure and dementia. It can lead to higher rates of premature mortality comparable to those associated with smoking and alcohol consumption – around 30% higher than for the general population (Local Government Association, 2018).

Therefore, the St Helens Place-based Partnership and the Inequalities Commission is prioritising work to address social isolation and loneliness, and how it interacts with concerns around self-harm, increasing anxiety levels, poor mental health, poor attendance at work or lack of productivity.

'While social isolation and loneliness is the focus of the work, the impact would be reducing suicide rates in St Helens.'
– A steering group member

8 Deaths of despair (DoD) are socially patterned fatalities encompassing those attributable to drug and alcohol misuse and suicide.

Action

A cross-sector group[9], is working in two neighbourhoods in St Helens to reduce social isolation and loneliness, using a placed-based approach and the ASPIRE model – Assess, Plan, Intervene, Review, and Evaluate. The two areas are:

1. **Town centre (Central PCN)** with a focus on young people and the prevention strand of social isolation and loneliness.
2. **Fouracre (South PCN)** with a focus on families and older people, and service delivery.

> *'Community in Fouracre feels more desperate than others as there is a lack of optimism and dearth of physical community assets.'*

The starting point for this work has been to understand the local barriers by hearing from communities and local leaders. This is especially useful as the ONS data for the borough doesn't provide information on who is disproportionately affected and more likely to be isolated or lonely. Between October 2023 and February 2024, the group has run a survey with residents alongside community conversations in both the areas. They also brought together cross-sector stakeholders and leaders to understand the barriers.

Following this engagement with communities, the group is exploring practical solutions or suggestions on activities and/or services that would help reduce social isolation and aims to then test these solutions. Deciding what is working and helping the groups and populations is essential:

> *'We would like to get the reassurance that the work is helping, is appropriate and reaching the most vulnerable and that we are doing our best to meet those needs.'*

These include:

1. **Adapting services** provided by both the voluntary and statutory sectors by listening to what residents and communities need. This can ensure that the services to reduce loneliness and social isolation are delivered in a way which actively reduces the barriers faced when accessing and engaging with those services.
2. **System changes** including looking at ways to better understand how the language used to describe areas and places can devalue the people living in them and exacerbate stigma.
3. **Prevention**, i.e. building capacity within the local community and empowering people with ways to support their own health outcomes and quality of life in terms of loneliness and isolation.

9 The steering group for this work is a group of cross-sector leaders from St Helens Borough Council, Torus Foundation, YMCA St Helens, St Helens & Knowsley Hospital Trust, Halton & St Helens Voluntary and Community Action, St Helens Wellbeing Service, City Healthcare Partnership CIC, St. Helens Place, Haydock Medical centre and Healthwatch St Helens

Desired outcomes

1. **A co-produced plan**: To develop a joined-up approach with the Integrated Care Board (ICB), Public Health and Voluntary, Community and Social Enterprise (VCSE) organisations that considers community voices and identifies solutions or interventions that respond to community needs.
2. **Develop better structures to draw on the lived experience of communities and residents** when designing interventions or reflecting on system behaviour.
3. **Outcomes for residents**: Through this work, the group would test out solutions that help reduce social isolation and loneliness so that:
    - Residents and communities feel that they belong, by reducing barriers and providing people with more capacity to connect and flourish.
    - People report the benefits, including better health outcomes, from being less lonely and isolated. A big part of this is reducing the stigma associated with feeling this way.
    - The steering group has a greater understanding of commuunity needs and possible solutions to improve wellbeing through social connection.
4. **Learn '*how to make it all stick together*'**: Explore how to sustain the work begun, evidencing and measuring change while ensuring we do not duplicate existing work where it is not needed.
5. **Highlight the potential of the VCSE sector in St Helens to influence commissioning decisions**: The group would like to step back to explore the strategic insights and learning gathered from this work which can influence social value and procurement strategies. This would include commissioning approaches to map what investment and resources are needed and align these with the local ambition for health equity.

Wandsworth

Challenge

Prevention and early diagnosis are core components of the Wandsworth Health and Care Plan 2022-24 and the Wandsworth Joint Health and Wellbeing Strategy 2024-29. The need for this is supported by existing cancer screening data, which shows that London boroughs, including Wandsworth, have some of the lowest cervical screening coverage in England.

In Wandsworth, cervical screening uptake is thought to be particularly low amongst 25- to 49-year-olds. There are also fewer cervical screens in areas of higher deprivation.

The steering group[10] for Wandsworth has identified cervical screening uptake as their focus for the Connecting Health Communities (CHC) project. They carefully considered the data and decided to focus on South Asian communities in Wandsworth who have some of the lowest uptake in the area.

Action

The steering group approached several Primary Care Networks (PCNs) in Wandsworth which have below 50% attendance to cervical screening. These practices are all in areas with high levels of deprivation (including some large estates). Two PCNs – Grafton and West Wandsworth – said they would like to get involved, seeing an opportunity through CHC to explore barriers to cervical screening in their areas and work with the voluntary sector and local communities over the next 18 months to test out ways of improving screening uptake.

Scoping conversations with local South Asian community leaders suggest an outreach approach is needed to engage more widely on this issue. This will start with the two PCNs giving a steer on which group(s) within South Asian communities they are hoping to engage and then working with local representatives – e.g. community leaders, individuals already engaged in work with these communities, etc. – to look at how they might structure some conversations about cervical screening.

Desired outcomes

The aim of CHC in Wandsworth is for the voluntary sector, communities, Public Health and health services to work together to better understand how health inequalities are preventing some South Asian community members from attending cervical screening. The goal is to then develop and test out approaches that improve access to information and take up.

The Wandsworth CHC steering group also hopes that this work will shed further light on how to bring patients and the voluntary sector into decisions about service design and delivery in Wandsworth.

10 The steering group for this work compromises cross-sector leaders from Central London Community Healthcare NHS, RM Partners West London Cancer Alliance, Richmond and Wandsworth Council, Wandsworth Care Alliance, Putneymead Group Medical Practice, and Southwest London ICS.