Developing a Population Health Approach in Homerton Healthcare

Contact: Nazia Ahmad (Head of Adult Therapies, Homerton Healthcare NHS Foundation Trust) nazia.ahmad@nhs.net

Population health is included as one of Homerton Healthcare's trust priorities, and we are developing offers to support staff engage with working at population health / health inequalities.

This programme of work will provide a supportive experiential way for staff to learn about population health and identifying how they and their teams can contribute to reducing health inequalities. The trust will be using the Kings Fund framework in developing people's contribution to tackling inequalities:

City & Hackney Rehabilitation (CoRe) Long Covid Support Service

Provider: Homerton Healthcare

Contact: Stephanie Poulton (City and Hackney Covid Rehabilitation Service Lead) stephanie.poulton1@nhs.net; Amina Eddeen (Long Covid Engagement Lead) amina.eddeen@nhs.net

The City & Hackney COVID Rehab (CoRe) Service, which supports people with Long COVID, identified that service referrals did not reflect the population of City & Hackney or those who were disproportionately affected by COVID-19 infection.

Initial engagement work from clinicians within the service sought to create relationships to raise awareness of Long COVID and understand the issues that may be leading to minoritized groups not accessing the support they may need. Additionally, the service was keen to create sustainable support within communities for people with Long COVID beyond discharge from clinical services.

This preliminary work led to an agreement with C&H CCG to fund a dedicated Engagement Lead role to further address this. The service also was successful in securing an NHS Charities Together grant to support partnership working with voluntary sector organisations.

The aims of the project include: - raising awareness of Long COVID, particularly within underserved communities (including training for staff and delivering accurate information to residents) - encourage people to seek support for Long COVID; - provide sustainable support beyond discharge from clinical services for Long COVID

Three main areas of development are:

- Long COVID Awareness Initiative (LCAI)
- Return to Activity (R2A)
- Peer Support Groups (PSG)

Scoping has also involved working with the Population Health Hub to generate a report of numbers within City & Hackney likely to be affected by Long COVID. A resident survey is underway in conjunction with Healthwatch Hackney to ascertain the current status of people's experiences within the community relating to Long COVID.

Some of the organisations that we have been working with include: Healthwatch Hackney, SWIM; Coffee Afrique; BME Access Service; Information Exchange; HCVS Grants Forum; Hackney Phone Bank; Shoreditch Trust; Neighbourhoods Project Team; Hackney Public Health; Bikur Cholim; Derman; Community Champions; The Peer Partnership.

Minor Ailments Scheme

Planning team: NEL ICB, City and Hackney: Prescribing and Medicines Management

Contact: Rozalia Enti, Program Director, r.enti@nhs.net

The City and Hackney (C&H) Health First Pharmacy Minor Ailment Scheme (HFP MAS) commenced in September 2020 to replace the decommissioned NHS England Minor Ailment Service, Pharmacy First. In Hackney, income deprivation impacts people's ability to purchase over the counter medication (OTC). The aim of the HFP MAS was to provide timely access to advice, information and if necessary, a supply of medicines for minor ailments for socially vulnerable patients in City &Hackney (C&H) who are unable to afford OTC medicines (for 20 conditions).

Service Objectives:

1. To provide access to advice, information and if necessary, a medicine for patients unable to afford self- care for minor ailments
2. To minimise demand on GP practices and urgent care providers, for care for minor ailments in patients who are unable to afford to purchase OTC medicines
3. To ensure patients are not referred back to GP practices unless there is a clinical need for the patient to be seen by a doctor
4. To ensure community pharmacies are supporting self-care for all patients in City & Hackney
5. To promote the principle that community pharmacies are the first port of call for minor ailments
6. To increase the supply of information to patients with minor ailments.

Patients are eligible if they receive free NHS prescriptions in income related categories, as well as young people in education; dependents on someone receiving Universal Credit or any other benefits or children of anyone eligible.

Potentially, 7,900 to 8,700 consultations were diverted by the minor ailment service from C&H GP practices during the period 14 September 2020 and 20 January 2022. There were 10,459 consultations where advice, information and, where needed, medicines were supplied to patients during the period. Service beneficiaries were mostly patients under 16 who have at least one parent who is eligible for the service (n = 5967, 57%). The next major category was those receiving benefits which makes them eligible for free NHS prescriptions (approx. 18%) followed by those on tax credits and have NHS Tax Credit Exemption Certificate (approx. 15%, n = 1555).

User survey supports the need for the service (a few excerpts of feedback are included here): "*someone on low income (exempt from prescription fees) cannot afford to buy items; it is virtually impossible to get a GP appointment for minor ailments; 111 is too complex and cannot supply medication; so minor ailments will go untreated if the scheme stops."*

Uncontrolled Blood Pressure Review

Planning team: NEL ICB, City and Hackney: Prescribing and Medicines Management

Contact: Rita Shah (Medicines Optimisation Project Pharmacist) rita.shah4@nhs.net

The purpose of this project was to review patients with uncontrolled blood pressure. Local data showed that 5% of black patients in City and Hackney have uncontrolled blood pressure compared to 2.5% of non-black patients.

Black people (African or African-Caribbean origin) have a higher prevalence of hypertension and subsequent cardiovascular disease, stroke, renal failure, and dementia. Therefore, the potential risks associated with uncontrolled blood pressure are greater for this patient group. The aim of the project was to identify the reasons for this with an aim to review and improve blood pressure in this cohort of patients.

253 patients were seen by a practice pharmacist for an initial consultation and results showed that 112 (48%) of patients were not taking their antihypertensive medication as prescribed. There were multiple reasons for non-adherence, including patients forgetting to take their medicines (e.g., due to irregular patterns of work), and patients not believing that their medicines were working and therefore not feeling motivated to take them. 117 of these patients went on to see the same pharmacist for a second follow up appointment.

Following pharmacist input and advice on medication and lifestyle changes, results showed that 66 (58%) of patients had a reduction in blood pressure and this was mainly due to pharmacists' input leading to improved adherence to medication. The pharmacists also discussed health and lifestyle which was particularly important for this group of patients as results showed that 91% were either overweight or obese.

This data highlights the important role that pharmacists played in improving the management of blood pressure in this group of patients, by listening to their perspectives and identifying areas of improvement jointly and employing shared decision making in their approach to empower the patient. Anecdotal responses from patients were very positive. Many patients wanted to lose weight, and this is an area that should be focused on in the future as it is a contributory factor to increased blood pressure and increases the risk of cardiovascular disease.

This project provided a new model for reviewing patients holistically within City and Hackney. The project demonstrated that following intervention by a pharmacist, adherence to medication can improve and a subsequent improvement in blood pressure and cardiovascular health can result. A particularly important aspect of this project was identifying patients' concerns and expectations. Patients felt they were able to be honest with pharmacists about the management of their condition and a shared discussion was had, involving the patient in the decision-making process.

Following this project, a recommendation was to ensure that people are adhering to medication and blood pressure control advice and this needs to be embedded into every consultation. Advice and support should be given about matters such as nutrition, exercise, stopping smoking and reducing alcohol intake. Information should also be collected on past and future cardiovascular events to support future analysis of this patient cohort.

Community Befriending Project

Provider: Volunteer Centre Hackney

Contact: Lauren Tobias (CEO, Volunteer Centre Hackney) lauren@vchackney.org

Volunteer Centre Hackney delivers a Community Befriending project, carefully matching volunteers with people who have been identified as socially isolated, to provide company and emotional support.

We have over 150 matches, with referrals made by professionals and services across Hackney, for people of all ages, demographics and support needs, but the majority of whom have mental health issues. Throughout COVID and beyond, this service has become a lifeline for so many, with volunteers providing much needed company, a listening ear, someone to talk to, and have helped people overcome anxiety, agoraphobia and depression, giving them confidence to re-engage with society and community activities.

Together Better

Provider: Volunteer Centre Hackney

Contact: Lauren Tobias (Volunteer Centre Hackney) lauren@vchackney.org

Together Better is a joint project among seven GP surgeries around Hackney and Volunteer Centre Hackney, funded by City and Hackney Placed-based Partnership (part of NEL ICB). We support patients to volunteer/share their skills and deliver activities to other patients. These include walking groups, peer support groups, art workshops, and exercise classes. We also support patients to engage in these activities, most of whom are isolated and struggling with mental or physical health issues, as we know this will benefit their health and wellbeing long term. Patient to patient peer support is a key aspect of the programme. The programme supports the GP practices by recruiting volunteers to help within the surgeries - to help lighten the load on the surgery, help people feel more connected to their surgery and build a sense of community.

Community Champions

Provider: Volunteer Centre Hackney

Contact: Joanne Hunt (Programme Manager, Public Health Community Champions joanne@vchackney.org

The purpose of this project is to improve awareness, understanding and access to treatment, care and support for residents at risk of/with Type 2 diabetes, specifically those facing health inequalities, such as language barriers and other associated health inequalities e.g. digital literacy/access.

Various events have taken place/in the planning phase to facilitate the link between marginalised communities, VCS and health services. For example, a recent event hosted by Halkevi (a community provision based in Dalston Junction primarily for Turkish/Kurdish communities) attracted 24 members, a large proportion with/at risk of developing diabetes, many of whom had limited understanding, links and access to essential health information/interventions. The event facilitated this link with a significant number of positive outcomes - for example, at least 1 participant was directly signposted into diabetes support services with no previous awareness of having the condition.

Insights gathered during the event by Public Health Community Champions and from the Turkish speaking lay educator at Homerton hospital were vital in terms of informing future events and continued partnership working. This event highlighted the need for careful facilitation of /enabling connections between health services and under-represented communities in partnership with the VCS sector.

Inequalities Lead Role (Hackney Downs PCN)

Contact: Charity Santeng (Health Inequalities Lead, Hackney Downs PCN)
csanteng@nhs.net

In my health inequalities lead work for Hackney Downs PCN, we used local data to identify health needs in the area, then surveyed residents about which to prioritise, eventually leading to a healthy lifestyles event to link residents with local organisations.

Additional information: https://youtu.be/zyNmDRx3Kq4

Nutrition in Management of Sickle Cell Disease in Shoreditch Park and the City PCN

Contact: Claudine Matthews (Dietician, Shoreditch Park and the City PCN)
claudine.matthews1@nhs.net

Nutrition service provision in Sickle Cell is an overlooked management option in the condition and is not currently integrated or embedded into standard sickle cell care provision. Moreover, there is no policy and practice to support nutrition service provision making it an unmet need and growing health inequality. This means sickle cell patients have poor access, experience and poor nutritional health and wellbeing outcomes. My project is the first of its kind in nutrition in sickle cell – to demonstrate the benefit and role of the dietitian in primary care to improve patient access, experience and outcomes.

Young Black Men Project

Provider: Coffee Afrique

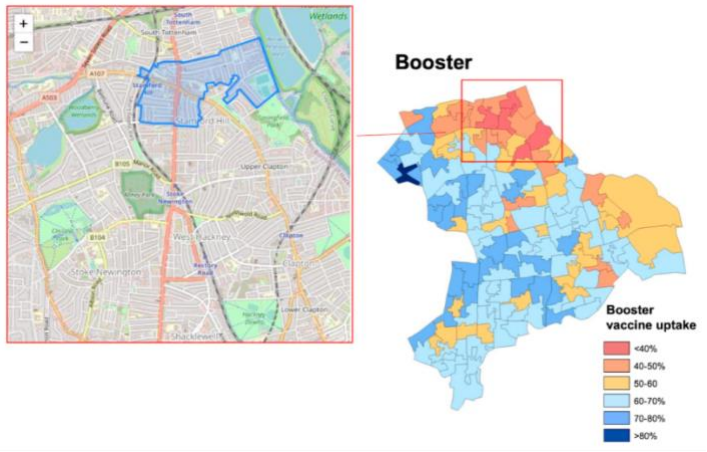
Contact: Abdi Hassan (Founder, Coffee Afrique) a.hassan@coffeeafrique.co.uk

We co created a project with radical help principles, pathways unique to our young Black men, with both enterprise, mental health, and trauma informed Community of Practice (COP) models at its core. A space to explore fertile soil to develop emerging futures with a healthy dose of dream matter, some new economic possibilities grounded in neighbourhood life and maybe a sprinkle of reimaging governance/regenerative organisation design.

Somali males in Hackney have previously identified socio-economic factors such as poverty, unemployment and homelessness, trauma, language barrier between mother and child, and family separation and conflict as causes behind mental health issues.

Improving Immunisations Uptake in Springfield PCN

Contact: Tehseen Khan (GP at Spring Hill Practice; Joint Clinical Director Springfield Park Primary Care Network; Senior Clinical Advisor Covid Vaccination Programme NHS England – London) tehseen.khan@nhs.net



Stamford Hill and North Hackney had some of the lower uptake of Covid-19 vaccines in Hackney.

Insight on barriers:

Confidence

- Language barriers
- Female health, fertility, pregnancy
- Long term health and side effects
- Concerns about vaccine efficacy

Convenience

- Not registered with a GP but happy to take vaccine when directed to a walk-in
- Not willing to travel to LVS, lack of transport

Complacency

- Too many other competing priorities

Interventions:

Good quality data

Align community organisation and champions to support a hyperlocal approach

Targeted Interventions

- Engagement→ marketing/ comms → increase access (pop-ups)
- Engagement with faith/ community leaders
- Alignment of CYP COVID vaccination to hyperlocal approach

Partnership working with specialist services, ensuring focus on CEV & health inclusion groups

Additional information:
https://docs.google.com/presentation/d/1I1o2ZE63nEV4LKioHwe56Kg8gibaMrTAFdUfFOc6hAQ/edit#slide=id.g120648f65c9_0_53

Community collaborations to improve Health and Wellbeing in Hackney Marshes

Provider: Hackney Council

Contact: Lola Akindoyn (Head of Programme - Sport England Local Delivery Pilot)
lola.akindoyin@hackney.gov.uk

London Borough of Hackney would like to share information on two projects taking place in the Hackney Marshes neighbourhood that involve a range of partners - King's Park Moving Together and Partnerships for People and Place. We would like to invite the Hackney School of Food and potentially Dr Nick Brewer (if he is attending) from Lower Clapton Surgery to speak about their work with us as partners. We have also included links to two short films that could be used as part of the event and happy to work with you to scope this further if of interest.

Get Together Men's Group

Provider: Family Action

Contact: Sahir Ahmed (Social Prescriber) Sahir.ahmed@family-action.org.uk

The project started back in 2021 with the vision to support one of the hardest to reach demographic, older socially isolated men. We have formed a weekly social get together for men in the Shoreditch Park and City PCN. It is a safe and welcoming space for men to get together, share opinions, views and their experiences of the world and local area and debate in a safe and healthy way. We provide free teas, coffees, fruits, and biscuits.

As well as acting as a social drop in, I have also been able to provide some social prescribing support during these sessions - Anything from information and advice, issuing foodbank vouchers, referrals to support services and reading/ understanding letters.

On some occasions I have been able to identify gaps of need and have completed grant applications for two attendees who were the most in need. We have been fortunate to reach dozens of men in the last year and we hope to see even more in the future. These men have been identified as lonely, socially isolated, and other than attending the group, some don't have much social connection outside in the real world.

Leading for Health Equity: Virtual Community of Practice (Royal College of General Practitioners)

Contact: Lili Risi LRISI@nhs.net

Several initiatives addressing the inverse care law have their origins in the University of Glasgow 'Deep End' Project and focus on supporting communities of practice in areas of socio-economic deprivation. In March 2019, an inclusive, formative social movement for health equity was facilitated in London, drawing from the ‘Deep End’ Project. From September 2020 this used virtual connecting opportunities offered by the pandemic to support local healthcare leaders to focus on advocacy.

An initial group of six GPs came together around shared values. They recognised the allostatic load, moral distress, loneliness, loss of trust and perceived helplessness of those working in areas of deprivation and built a platform on which to connect, exchange information and share dialogue. The aim was to promote a culture of support, inclusion, and belonging for GPs and teams, and to move to a narrative integrating social and medical causation with a vision of health equity encompassing fairer systems and healthier places.

Three thematic phases emerged over an 18-month period which matched the emotional trajectory of the pandemic. Firstly, the ‘beacon in the storm’ phase aimed to build trust in a vulnerable GP and primary care workforce disproportionately affected by Covid-19 and structural racism. This was through linking with a virtual pre-tested ‘Deep End’ improvement program which addressed learning needs and provided evidence. This phase culminated in a 'Health Equity Festival' where stories of health creation during the pandemic were shared. Secondly, there was a phase of ‘restoring hope’ where stories of change were shared, culminating in a second festival where change ideas were harvested. A third phase has focused on regeneration, health creation and the restoration of trust by 10% in every conversation.

We have tested: the sharing of skills such as a trauma informed care approach which has been taken up and disseminated by one training hub; the facilitation of learning and evidence to inform equitable care in practices and networks; the embedding of health equity modules at the local medical school; integrating narratives in four open-access free festivals, a symposium exploring a Syndemics Framework in Health Creation. Most recently there has been a reflection on compassionate Appraisal with a focus on GMC Domain 4: Maintaining Trust which is the domain of ‘fairer care’. Each festival has marked the evolution of this movement which is now London wide and inclusive of leaders in all roles in Primary Care Networks and wider system.

This movement now has over 170 emerging leaders from the primary and secondary healthcare workforce, local commissioners, and public health consultants. We believe we have identified the necessary components for supportive engagement with professionals and communities to deliver health equity at scale and to address the health equity needs of leaders in the co-creation of health.

Growing Minds

Provider: City and Hackney CAMHS Alliance

Contact: Maria Garciaedo (CAMHS Alliance Programme Manager)
maria.garciaedo@nhs.net

The Growing Minds programme, funded jointly over three years (2019-2022) by the Department of Health and Social Care and City and Hackney CCG, aimed to tackle inequalities faced by young people (9-25 y/o) from African and Caribbean Heritage (ACH) backgrounds within the mental health system.

In its conception, Growing Minds aimed to be “one service with separate branches” bringing together Family Action’s therapeutic support for young people with frontline ACH community partners and schools to deliver collaborative, effective and culturally appropriate interventions, particularly at transition points in young people’s lives, under the one banner.

Growing Minds developed 3 separate intervention offers, targeted to young people, young adults and families from ACH communities, all delivered by Voluntary Sector Organisatons (VSO) partners from matching backgrounds.

- Counselling Offer
- Tree of Life in schools
- Nonviolent resistance (NVR) parent groups

The evaluation report, carried out by an external organization, showed the positive impact and results of all three interventions, and collected lots of feedback from young people and families about the benefits of this community approach, highlighting the importance of cultural relevance and matching of professionals.

Growing Minds faced two significant challenges from a very early stage. The COVID-19 pandemic was beyond its control, but delivery was also hampered by the fact there was no dedicated resource available within the service to effectively manage a multi-activity partnership project, foster relationships between partners, ensure the effective administration of those using the services.

Collaborative working with a Health & Wellbeing coach to increase referrals to Weight Management Programmes – a QI success story.

Provider: City and Hackney GP Confederation

Contact: Shaine Mehta (GP; Diabetes, TB & Infectious Diseases Clinical Lead for City & Hackney - NEL ICB; Remote monitoring lead at Digital First Team - NEL ICB; QI Clinical Lead | City & Hackney GP Confederation) shaine.mehta@nhs.net

- Targeted conversation with patients with raised BMI and hypertension or Diabetes over a 3-month period.
- A health equality focus: tailored conversations with patients from ethnic minority groups with poorer outcomes
- 40% of patients accepted onwards referral to a structured weight management programme
- More info here: Digital Weight Management Programme - NHS North East London (icb.nhs.uk)

Autistic Friendly Neighbourhoods

Contact: Jody Barrientos (Homerton Healthcare NHS Foundation Trust, Specialist Autism Coordinator) jody.barrientos@nhs.net

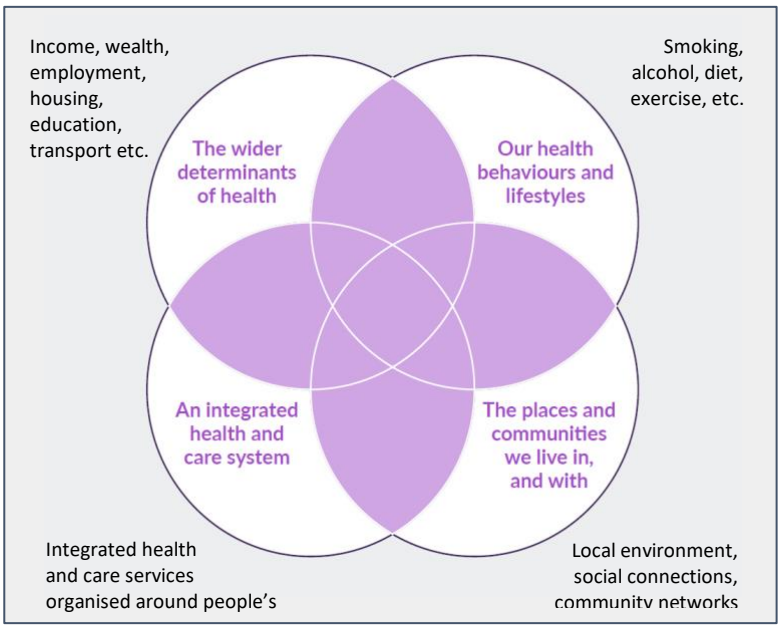
- This project aims to develop an Autistic Friendly Neighbourhood in the London Fields Neighbourhood of City and Hackney. The pilot will be used as a model for other Neighbourhoods in the future.
- The project sits within the five year City & Hackney Autism Strategy, and will assist local, statutory and non-statutory services to work in partnership to be more friendly to autistic people. It aligns to the vision of the National Strategy for Autistic people (2021-26), the NHS long term plan and supports a Hackney that is more inclusive in line with Hackney's corporate agenda.
- The work is focusing on supporting the London Fields Primary care network to be more accessible to autistic people. This includes adapting at the physical environment of the surgeries themselves, the processes when engaging with the GP surgeries and supporting practitioners to feel confident in communicating and supporting autistic residents. As a result, we hope to help Autistic people have more positive experience accessing primary care services, attend primary care services more promptly, more often and get access to health care they need earlier.
- We have also partnered with NHS England and Improvement to deliver a pilot for autism specific annual health checks.
- The work is coproduced, and we have an experts by experience panel and members of the experts panel sit on the project steering group.
- We are developing an 'autistic friendly charter' to support Primary care settings as well as local space to be guided to be autistic friendly and accessible.
- By presenting at the summit we aim to share progress so far on what it means to be autistic friendly and how health and social care partners can think about moving towards being autistic friendly themselves.
- We are consulting heavily with Autistic residents to measure their experiences accessing primary care service throughout the project.

Population Health Hub – supporting partners across City and Hackney to understand and take action on population health

Contact: Anna Garner (Head of Performance and Population Health) anna.garner@nhs.net

Population health is described by the King's Fund as ...

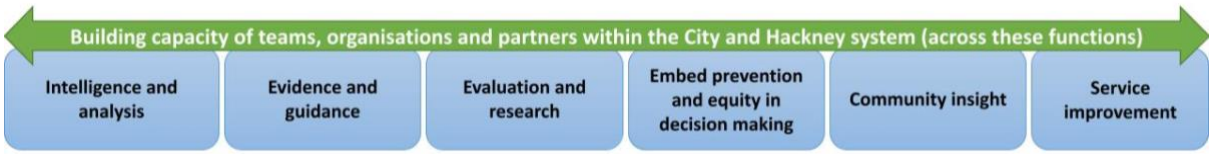
"*...an approach that aims to improve physical and mental health outcomes, promote wellbeing and reduce health inequalities across an entire population. Improving population health and reducing health inequalities requires action across all 'four pillars'* of a population health system.*"



The Population Health Hub (PHH) is a shared, system resource which aims to:

- lead specific projects to influence and support system partners to be more aware of what impacts population and their role in improving population health and reducing health inequalities.
- develop practical tools to support this
- provide timely and actionable intelligence

The functions of the Population Health Hub are across the following six areas, but also include building the capacity, confidence and skills across City and Hackney:



Advocating for Residents

Provider: Hackney Council for Voluntary Services (HCVS)

Contact: Jessica Lubin (Director of Health Transformation, Partnerships and Networks)
Jessica@hcvs.org.uk

Part 1 Case study:
Parent R was referred to Ihsan CC from the local women's refuge during the lockdown but has since been rehoused to a hostel in Hackney. She has been a regular user of the children's centre and was contacted by the staff to let her know about the voucher scheme.

She attended the children's centre the following day but seemed distressed, she was taken to a side room by staff members. Due to English being her second language it was difficult for the staff to understand the cause of her distress. Fortunately, they were able to find a local member of the community who was happy to interpret.

Parent R explained that she was finding her situation at the hostel very difficult. She needs access to the communal kitchen at the hostel as cooking in her small room is making her child's eczema flare up, leading to poor overall health. She felt that her needs and those of her children were not being heard by the hostel manager. As a result, she had not been able to cook food for herself and her children for the past few days. Parent R was tearful and upset, she explained that it was the month of Ramadan and she was no longer able to fast due to not being able to prepare a nutritious iftar meal for herself.

Parent R was offered some non-perishable food from the Ihsan food bank and attempts were made to contact the hostel manager to advocate and explain the needs of the family. Contact was successful after a few attempts. Staff explained the situation to the hostel manager who agreed to make arrangements for the family to cook with ease in the communal kitchen. Follow up meetings have taken place with parent R and longer-term support through a referral to the MAT team is in process to ensure all of the family's needs are being addressed. Parent R was also supported to access the household support fund vouchers and she reported back how useful they were.

Part 2 - Reflection from staff member on the situation

"The biggest factor for communities we work with is the language barrier. Where English is a second language you are not able to engage with professionals, and navigate these complicated systems which are different for housing, benefits etc. The housing with language can get further with their situations. The disparity is so large, that one family was unable to make a meal for her family during a month of fasting, because she couldn't articulate what she was trying to say to the hostel manager. She was so distraught when she came to see us it was heart breaking. When we helped her fix the issues, she was so grateful. She needn't have been so grateful for something that she had a right to. This is the issue I am finding with the families we support. Lots of these people are single mums coming out from the refuge, I just think that the support systems re set up all wrong. The person who shouts the loudest gets their voice heard.

There is a current family we are working with that stands out through the children's centre. Some of the families we come across by coincidence. We might be speaking about something else and the conversation arises, and this family in particular, the thing that he said that hit me, was that 'I was given no choice, if I had known my rights, I would have taken my choice'. This was in relation to housing. Lots of the people that we work with, housing seems to be embedded into the number of issues they have. There is always a housing issue, it's the theme. When he was offered a home, he wasn't given a choice,

nothing was explained to him. He kept saying - 'had I known my rights'. It's the wording that is used to almost take away one's decision to make an informed decision. They say 'you should be lucky to have a home, you have no choice'. There is a huge conversation to be had about things like this. I always raise these issues with council members."

Primary Care Mental Health Case Study in Hackney Marshes PCN

Contact: David Mcbride david.mcbride@nhs.net

A 37-year-old female was identified meeting the below criteria

- Mental health Issues
- Age 20-49
- Live in the Highest areas of overall deprivation
- Highest areas of income deprivation
- Have been signed off work or not in the labour market in the last 2 years
- Infrequent GP visits i.e. likely to have unmet need as having not engaged with care

Initial contact made via telephone. Outstanding issues acknowledged that she hadn't been in contact with her GP recently in regards to her physical health, though was also at times struggling with her mental health. Social issues including not being able to hold down a job, current sick note, only working 2.5 hours a week. Following telephone consultation invited in for a 1:1 assessment with mental health practitioner. Finding it difficult holding down a job. Issues regarding sleep, linked with stress/anxiety.

Timeline of interventions.

Initial review - Mental Health Practitioner - Low mood/anxiety. Linked in with talking therapies to help manage symptoms and psychoeducation provided regarding sleep hygiene.

GP – Review of ongoing sleep difficulties, medication review, considering antidepressants and sleep hygiene. Following review antidepressants started.

Nurse- GP Practice nurse invited in for outstanding smear test, blood test etc.

Talk Changes – Referral accepted to help manage low mood/anxiety.

Vort Occupational Therapy – Client has considered help getting back into work and will link in via GP when feeling ready to link with VORT Occupational Therapy.

Charedi Women's Health Event: A partnership approach to supporting the health and wellbeing of the Charedi (Orthodox Jewish) community in London

Contact: Ana Zuriaga (Implementation Programme Manager London COVID Legacy and Equity Partnership NHS England) anazuriaga.alvaro@nhs.net

Background: Delivering the COVID-19 vaccination programme highlighted the inequalities in vaccine uptake. Whilst there is no available data on vaccine uptake by religion in the UK, COVID-19 case rates, proxy vaccine uptake data, and insights from engagement with community leaders, suggested a need for a specific programme of engagement with the Charedi Orthodox Jewish community in Stamford Hill, Hackney. After consultation with local community organisations, a co-produced live event for women was developed focused on COVID-19 safety and vaccination as well as wider health topics.

Methods: The event was designed and delivered by local community organisation Interlink, in partnership with regional and local health partners, NHS, UK Health Security Agency and community groups. The event provided information on COVID-19, childhood immunisations, oral health and dental hygiene, childhood respiratory infections and mental health. Attendees could visit health stalls, attend a panel session, and speak to health professionals regarding specific concerns. Co-designed, culturally competent resources and health bags with information were also provided.

An evaluation was conducted to provide insights and to inform future engagement with communities. This evaluation was conducted primarily using qualitative insights from attendees' feedback post-event and through a thematic analysis of semi-structured interviews with organisers from community and statutory organisations for further insights on the sustainability of the intervention. The evaluation was informed by a logic model and outcomes framework produced in collaboration with involved community organisations.

Findings: Over 100 women, aged 16 and over from the community attended the event. Feedback from attendees suggested that the focus on wider health issues was valued and a greater number of more targeted events would be beneficial (e.g., health for women over 40). Dental health, COVID vaccination and childhood immunisations were the topics identified as being most important to the audience.

Of respondents who answered the question "would you attend an event like this again?", 55% stated that they would, and an additional 41% stated that they were unsure, with only one respondent (3%) stating that they would not attend an event again. Informal feedback from the community has highlighted that the event was seen as useful, and has acted as a basis for further engagement and collaboration with the community.

Key lessons from this programme included the importance of co-designed resources to ensure that information is appropriate and culturally sensitive; that there is a focus on a broad range of health topics (not just the messages that health services want to promote) and ensuring the community is aware of available local services that are accessible. The event also highlighted the need to work in partnership with a lead community organisation in the design stage of the intervention to identify and address the principal health challenges within the community, to share community specific insights and promote the event through communication channels used by the community. The event itself has also acted as a basis for further programmes of work to address principal health and wellbeing challenges in the community.

Interpretation: The event was co-produced and developed in partnership with the community at all stages from its inception. Statutory institutions should engage with local

community organisations to support and facilitate public health interventions to increase relevant vaccine uptake but also to improve awareness around their wider health and wellbeing issues and services.

Additional information: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(22)02295-4/fulltext

Healthwatch Hackney report into migrant and refugee access to healthcare

Contact: (Deputy Director, Healthwatch Hackney) catherine@healthwatchhackney.co.uk

Our report into refugee and migrant access to health care in Hackney published in 2020 showed that apart from the language barrier, demands for documents such as passports or proof of address created a barrier for refugees and migrants as well as for some homeless to access basic health care. As a result, minor problems go untreated until they become serious, and individuals end up attending A&E instead.

Following the findings from our report into refugee and migrant access to health care, and analysing the feedback we received from other sources, we contacted every GP practice in Hackney in March 2021 to ask about their requirements to register as a new patient. This review found that over 60% of the practices required documents for registration, with one practice strictly refusing registration to asylum seekers or undocumented migrants. We also reviewed the information on GP's websites and this showed that 45% of Practices asked for documentation to register.

When we told the CCG, they immediately wrote to each practice, telling them they must not demand ID documents or proof of address. The CCG commissioned us to repeat the review, which we did in October 2021. This demonstrated a great improvement. We also ran a public meeting on GP registration and interpreting support to increase people's awareness of their rights.

The second review in October 2021 showed a huge improvement, with over 80% of the practices changing their patient registration policy. It also led to GP staff receiving training on the registration process to ensure consistency in the approach.

Comparison: In March 23 (59%) of the practices asked for proof of identity and 27 (69%) practices asked for proof of address. In October 7 (18%), practices asked for proof of ID and 10 (26%) asked for proof of address.

The report was shared with different community organisations known to have new members coming recently to the UK such as the Chinese, Turkish and Somali communities as well as with other organisations that work with migrants, refugees and homeless people. It was reported to us on many occasions that thanks to the review, members of different communities have been able to register with a GP practice and access health care.

We are currently working on repeating our survey of GP registration using both mystery shopping calls and calls where we state we are calling from Healthwatch Hackney.

Green Doctors – Health Inequalities

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Background

Cold homes are bad for health. It increases risks associated with high blood pressure, an increase in incidents of colds and flu, heart attacks and pneumonia. It also has the potential for knock on effects such as increased absence from work due to illness, social isolation, sleep deprivation, mental and stress related illnesses and negative effects on friends and family.

Those with existing health conditions are especially vulnerable to the cold, such as those with respiratory problems such as asthma and COPD, those living with diabetes or arthritis, or individuals with mental health conditions such as depression and anxiety.

As well as those with existing health conditions, children and older people are also at high risk if living in a cold home.

Due to the current cost of living and rising energy costs, people may be struggling to heat their homes and may require additional support in addition to the support being provided by central government.

Green Doctors

The City Corporation are working with Green Doctors who are specialists in providing free impartial and practical advice that is easy to adopt and will be supporting residents of the City of London or who live on City of London social housing estates in other London Boroughs who are struggling with the cost of living.

Residents can be referred (or self-referred) to Green Doctors if they are:

- Are of state pension age
- Are receiving benefits
- Living with a long-term health condition or disability

The Green Doctors may be able to provide residents with the following free support:

- Energy efficiency advice
- Installation of energy saving devices
- Support for home improvement grant applications
- Impartial advice that will help residents heat their home for less
- Directing and connecting residents to further help

The initiative will also help households respond to climate change and reduce the carbon footprint of homes by making them more efficient, as well as tackling inequalities in the physical environment by helping vulnerable residents stay warm and healthy during the colder months.

Promoting the scheme to residents

The programme run by Green Doctors has been promoted in several ways. This includes sending printed leaflets to our housing estates, libraries, community centres and with our commissioned providers. It has also been shared digitally through a press release, social media and through our regular resident channels such as newsletters and bulletins.

Impact

The impact Green Doctors have had on supporting low-income and vulnerable people across London with energy-efficiency advice and support with energy bills has been beneficial. In the 15 years of operation, Green Doctors have:

- Carried out 35,990 visits to people's homes per year
- Distributed £350k+ in emergency energy top-ups
- Saves households over £5 million by improving the energy efficiency of their homes
- Trained 1,500 front line workers in energy awareness and fuel poverty

Green Doctors have been working in partnership with local authorities across the country to support those who are affected by fuel poverty. A partnership between Cheshire East council and Green Doctors has had a notable impact on residents.

Cheshire East council referred 'Jacquie' to Green Doctors who assessed her situation and provided her initial energy advice. They secured her some short-term help to pay her energy bills and helped her to apply for a Green Homes Grant.

The grant that was approved came to £10,492 to cover loft insulation, an upgrade from single to double glazing, an energy-efficient external door, and solar panels for her roof. As a result of these amendments, Jaquie's home's EPC improved from a D to a B rating, her CO2 production went from 6 tonnes to 1.8 tonnes, and her estimated running costs dropped from £750 to £175 per year. This has meant a vast improvement in her living conditions, as well as an improvement in her day-to-day financial anxieties.