Chat from Session five. Health Creation and Core20PLUS5

Resources

https://thehealthcheationalliance.org/wp-content/uploads/2022/07/THCA-marginalised-communities_cancer_CVD-learning-from-community-response-to-COVID_19-FINAL.pdf

Building Back Together: 10 Key Messages

https://thehealthcreationalliance.org/wp-content/uploads/2021/05/Building-Back-Together.pdf

https://thehealthcreationalliance.org/building-back-together-my-vision-for-a-healthier-future-communities-and-contacts-2/

https://shamawomenscentre.co.uk/

What works – community connectors?

https://thehealthcreationalliance.org/wp-content/uploads/2022/01/THCA-Report-Findings-and-comment-from-the-workshop-for-Prequel-FINAL_January-2022-.pdf

Lots of information below if you'd like to learn more about the Connectors programme and how different projects are implementing their local projects

https://scwcsu.nhs.uk/issues/health-inequalities/health-inequalities/core20plus-connectors

With many others and with huge support from the community we have spent many months planning an integrated care hub to tackle our local Core20plus 5 agenda. We have an evidence-based and absolutely innovative plan, integrating primary, secondary and community care. It was all funded - until yesterday. See our MP Luke Pollard @LukePollard

Is there any way we can think of providing service to a mix of communities + doing some intergenerational work?

NHSE have just completed recruitment for wave 1 Core20PLUS ambassadors. There will be a scheme in the next year; would be really pleased to keep in touch with everyone is interested as there are other opportunities to stay connected and spread the word!

Is there any opportunity to feed into the programme the very specific challenges facing asylum seekers and refugees?

Yes, this is a key "PLUS" group. West Yorkshire Core20PLUS Connector site are focusing specifically on asylum seekers and refugees.

https://www.scwcsu.nhs.uk/issues/health-inequalities/health-inequalities/core20plus-connectors

Will you also be looking at areas that have not worked as I think this is where lessons are learnt?

Learning about what has not worked is really key, as well as sharing learning across systems who may have found different challenges to each other.

Are you also looking at people who chew tobacco?

We are aware of the high usage of chewing tobacco in our local BAME community, this is something we can raise in our sessions in the community about Cancer screening . Facts and figures would help us to do this.

Royal London Dental Clinic have done a lot of work on this - if you want to contact them.

I was engaged in a Mouth Cancer project in 1990's we carried out research in Gujrat India.

It has to be done in w very cultural awareness way. I'm using models and keeping the chat light, more about awareness of "the bad thing" and how to spot the signs. I'm also introducing the Holistic Health slowly to the groups.

We had Trading Standards involved with Tobacco chewing - not sure where they are these days !!!

We attended an oral cancer conference and through our twin city Rajkot we engaged with the cancer hospital there and brought back lots of processed tobacco project which was given to Trading Standards and we managed to get the age of these products same as other tobacco products.

To what extent will Connectors work with communities to identify issues that matter to them and work with them to address those issues? Or do you think that the Connectors will end up delivering NHS priorities in a more community-centred way. A step forward, but not health creating?

We need to consider ourselves as influencers during this programme, rather than spectators, this is a great step forward, but needs to keep the voices of community at the fore.

Aren't link workers the same as connectors. We like to give our link workers and health coaches confidence and time building relationships and trust when they judge this as most important for that person or community. These should be a universal skill set.

The name doesn’t really matter - it is the role and what people allowed/encouraged to do (and have the skills to do).

We are experiencing this in cancer services, with lots of names for similar roles. If we are confused, how can we expect our communities to understand.

I wonder how many people (who don't have an organised community) will be left behind?

Do you ask the champions to divulge information on their conditions and also other personal data?

Our champions are our staff, so no need to divulge.

How do we support communities to organise themselves?

Many areas have this already going on and working well. As I understand it, the CORE20+5 approach / connectors etc., is to support existing practice, and to help those areas without a framework for addressing inequalities to consider this approach [or aspects of it] that might prove helpful.

The role of community development worker has been shown repeatedly to be able to do that. These Connectors can play that role.

This is very interesting for me to feedback to ICS Northern Ireland as we create community/ locality partnership boards. We worry how we can build health creation and preventative approaches from the community up as we see these new structures being created here.

I think the name of the role doesn't matter but helpful to think about scope. I always like to look at the family of community centred approaches to consider what focus make sense in particular circumstances:

https://www.gov.uk/government/publications/health-matters-health-and-wellbeing-community-centred-approaches/health-matters-community-centred-approaches-for-health-and-wellbeing

A lot of communities are already working in this way - some need a little bit of funding, some need training and information; one way that one of the Councils has helped is commissioned a Facilitator who has proved invaluable to support community groups and individuals to help each other in managing and growing in open spaces. She helps find funding and helping with writing bids - it has really worked well, and the groups are getting to know each other and helping each other; part of this will be supporting mental and physical health

I love the idea of connectors… key role… perhaps should be part of many current roles.

https://qube-oca.org.uk/about/

Yes, Bola, the name doesn't matter, but the role does. These Connectors are real steps forward. I'm trying to understand to what extent they will be supported to not only deliver NHS priorities but also issues that matter to communities. These are key elements in community-strengthening as outlined in that document you quote.

Yes, the connectors have a key role in listening and working with communities to understand local issues that matter to the communities.

And then respond to those issues with those communities. Those issues may have nothing to do with the Core20+5.

Yes - although the projects each have a focus on the 5 clinical focuses, there is the flexibility for local programmes to work with communities to identify and address local issues as they are raised. Local connectors and delivery partners are working towards feeding into the ICS/NHS to address service and system change.

Picking up on some of the chat, it is essential that the Core20Plus Connectors are linked up with existing/developing roles across our communities (SPLWs, Covid Recovery Workers, Care Coordinators, Community Connectors etc.).

Key enabler for this is mindset shift in our system - so people (key decision makers, and everyday workers) recognise the value of health creation. Then staff being given time and expectation that they will priortise this work (above other things they have to spend time on). what do I stop doing, so I can dedicate time to this? New roles dedicated to this approach (connectors, coaches, link workers, community developers….) can create a resource, but current staff still need time to learn and understand the part they play. Has to be whole system.

This is a really key point. the system is completely overburdened, and we need to make space for this work

I think our collective challenge is how we start to re-locate authority to the community and allow the community to lead on health creation with our support. I've heard connectors described as being the caddies and the community the golfers - I like this!

Many informal 'connectors' just do it because they want to- as volunteers, and that's OK for people like me with a job [and white/middle class],but this often isn't possible from communities

experiencing deprivation and poverty, unemployment etc. whose voices are crucial [as we have heard], but would need financial/childcare/transport/other assistance [access to tablets/laptops /written letters !!etc.] to enable them to engage.

How do you recruit from groups that don't want to talk about cancers as it is a taboo subject in lot of communities.

I'm a Service user for Greater Manchester Cancer Alliance, and we are present at Board level in decision making for many cancer types, and link to 'small communities' of people with lived experience of those cancer types to ensure a wider voice. We were active in planning last week's Cancer conference in Manchester and are involved in all aspects of planning cancer care. A great example.

Enabling individuals in the 'target' communities is key in developing trust and faith in health services.

My concern re Cancer Care is that recently a patient who was in ITU and palliative, nobody from the Palliative Care Team who talk to the family as he had liver failure and did not have a big C diagnosis!

Professionals can play an important role in making it easier of people to join in and take a lead.

The approach must be more holistic. We can't take a clinical pathway approach to this. People are not their illness.

The core connector programme funding has enabled us to develop this programme which will have impact on people presenting and attending for cancer screening I keep that as my focus individuals lives changed.

Colleagues get diverted to where the money is spotlighted. we need time and permission to work in this way. Our PCN is doing health creation, as an add on. DES/QoF is unhelpful distraction.

Health Creation as BAU will take a much bigger, broader commitment that goes way beyond any individual programme.

Raising health literacy and self-efficacy is a big step forward.

Ultimately, this is all about relationships and connections. And to coin a well-used phrase, "relationships will move at the speed of trust". We must remain patient and put in the groundwork to realise our vision of equitable access to services, excellent experience, and optimal outcomes.

https://www.cmcanceralliance.nhs.uk/work/patient-experience-and-health-inequalities

The projects presented are inspiring - and the connector role have a real co-production potential. However, is focus just another way to create fragmentation and lack of sustainability?

How does this approach address the structural factors that make Inter sectoral work and community engagement possible across all communities and professional groups?

We are often critical that programmes haven't delivered quickly but we are resisting that and building relationships to effect change.

We need to think of structural changes, incentives that would shift the balance of work towards health creation.

Yes, I think we need some real thought about what this would look like that would translate for frontline clinical staff.

A good start would be to ensure that key members of GP practices, PCN's, ICS's etc. have someone with an 'Inequalities' brief, so that it is discussed at all levels, kept on every agenda, and ensure that the voice of key target groups are heard effectively.

Skills in ‘managing upwards’ is so critical to achieve system transformation from the ground up.

We need a systems approach to health creation. In Kingston we have become a 'Marmot Borough' - taking a Health in All Policies Approach e.g. all system partners adopting the London Living Wage and have made this commitment at our Health & Wellbeing Board. We shouldn't have to fight for the basics such as decent wages -we all know poverty impacts on poorer health outcomes.

Mainly through developing our local Health & Wellbeing Strategy with system partners. Focused on Marmot principles and opportunities to make a difference, together -using H&WBB Board and new Place Boards.

We’re looking at inviting local GPs etc. to our coffee morning's which will be No Propaganda / No Agenda just a place to meet and chat.

Our PCN proposed a ‘person centered Diabetes clinic.’ The patients and community told us they didn't want this. They want a ‘life enhancing clinic, tailored for people that happen to live with diabetes’… this dynamic shift has changed how we design our approach and what we measure as success. new markers of success will be -how many local people join in, and how much the work inspires the staff… we think rest will follow…

Really great to see this holistic and collaborative approach from within the NHS, and also the recognition of the impact of place based communities and the physical environment on health inequalities. This type of work is complex and takes time - relationships and places are by their very nature longer-term. To make a success of it, investment is key, both £ funding and persistence/effort from individuals and organisations.

From an NHS perspective, we need to shift our thinking as to what 'value' means. Often in the NHS, this means £/cost savings. In the context of this programme, value means so much more than cash.

Value isn't £ saved now, it's £££ saved down the line.

Any preventive interventions can take at least 10 years to see the results and so data needs to reflect this - I think.

The 6 features of health creating practices can be measured … and we know they create health … they need the status with the NHS.

If the community tells us they want life enhancing focus - that is our prime outcome. Have we enhanced your life (above sugar levels/ blood pressure). As people trust, engage and learn, they are likely to get interested in their predictors of good health down the line. Our health agenda is not necessarily our community or people's agenda…

It is possible to measure social capital. Fairly easily.

Sometimes need to put process aside...in Sparkbrook , Birmingham this July, from an idea to do hypertension checks capitalising on increased footfall due to Commonwealth Games, the Leisure centre and specialist Stroke nurses organised hypertension checks for the whole weekend - over 140

people attended, over 20% referred for further assessment - not paid, no meetings/bureaucracy - they just did it...the data came later, but they knew it was needed, managers were supportive, they were keen and dedicated wanting to prevent ill health and work for their communities...Great work ! Just DO it...try and do thing differently !

I think we should bring in some support for the Staff and I wonder how should this look like? Gardening etc???

We are currently looking at doing the same for Gypsy/Traveller sites, Placed Based incentives.

Demonstrating the power of preventative and proactive engagement with communities can deliver such impact, it will be key to ensure learning is shared beyond the 'already converted' at the end of this programme. Sustained investment in this way of working (and living and communing!) only comes with influencing those in power. Thank you for sharing your inspiring stories.

I am all for health creation -worked with Hazel Stuteley and C2 project and did similar in Plymouth - but in the end we need targeting of resources to poor areas. Communities soon get disillusioned if constantly told to do it themselves. If CORE20plus5 can bring extra help to communities who are actively trying to make change it will work.

Also health services in those area need better funding to be able to provide the proportionate universalism approach.

I really like this idea of champions pushing in each area of clinical focus.

Equity key feature- community cohesion often very strong in 'deprived' communities. not about Big Society plugging gaps in service. How do you make it feel good to be involved, in the way people want to be.

Agree longer term resources locally and nationally otherwise will be seen as a time limited token gesture.

It is everyone's business and amplifies the need for Making Every Contact Count principles the foundation of the Core20Plus5 approach. We must maximise every touch point with people in our communities.

We find a lot of people in the NHS who think they're doing Health Creation … but there are very big gaps … the 3Cs and 6 features framework shows up the gaps almost instantly.

Do people believe the ICBs are directing resources/investment into social care and health including unity of the community to solve challenges? If not, how can they better do this?

SELECTION OF FEEDBACK

- Thank you for an excellent session
- Great session, thank you very much
- Thank you for a really interesting session
- Thank you all, for a great session - very inspiring and helpful

- Another brilliant session
- Thank you very much great session
- Thank you all. Really good sessions & speakers & great to meet so many interested people
- Thank you for a really interesting session
- Thanks great session, very informative
- Thanks everyone - Fantastic session and looking forward to meeting someone of you tomorrow!

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