healthwatch Croydon

Health Goes Local

Thornton Heath

ICN+ model resident feedback

February 2020

Findings in brief

Confusion about the ICN model as it is currently presented

Link worker can have role in engaging communities as well as offering funding streams

Don't underestimate the personal approach

More information on pathway changes and timetable for delivery needed

New and creative ways needed to build community engagement

Look at ways to empower people to get involved

Recommendations in brief

Present the ICN model from the **patient perspective**

Look to build relationships **beyond NHS and social care**

Go to where the people are. Don't expect them to come to you

Manage expectations through clear timetables and regular updates

Engage in community mapping with residents to build knowledge and shared responsibility

Show how people can **get involved clearly and concisely**

Executive Summary

As part of an NHS England grant to Healthwatch England, Healthwatch Croydon were asked to provide patient insight to support the local Health and Care Plan development.

One of the aspects of the new plan is the development of Integrated Care Networks and Primary Care Networks to deliver services at local neighbourhood levels of 30,000 to 50,000 people. As a pilot exercise, we focused on one area, Thornton Heath.

In early May 2019, Healthwatch Croydon, in association with NHS Croydon Clinical Commissioning Group, ran two successive two-hour public events in Thornton Heath to gain insight into how this new model of services would be received by local residents.

There were four aspects that were explored:

- Views on the new model of care
- How can providers engage better through ICNs?
- How can new models of co-production be created?
- How can health providers be locally accountable?

These were discussed at the Health and Wellbeing Board in June 2019 and have been the basis for future discussions on how Primary Care Networks and Integrated Care Networks will develop in Croydon in the coming years, where many of the points listed below were recognised.

Partly as a result of this report, Healthwatch Croydon were commissioned by NHS Croydon Commissioning Group in January 2020 to undertake further work on the impact of this new model of health and care in neighbourhoods with hard-to-reach groups. This is due to be published in March 2020.

These are our findings based on the conversations had with attendees:

Understanding the model:

- **Confusion over the Integrated Care Network/ Primary Care Network model:** It is seen by the public as too difficult to understand and with much terminology. It is difficult to see the individual resident's place in this. It is seen as unclear where the GPs have a role.
- **The focus of the model is still too much from the NHS perspective:** It needs to emphasise the community more and the wider partners where health and social care impact such as Department of Work and Pensions and schools.

Widening access

- **Link workers have a role to play in understanding communities:** They can have a crucial role in bringing together different parts of the community.
- **Accessing younger and working populations:** Model looks good for those who are currently older or ill, but the younger and working populations are not really represented.
- **Funding opportunities:** Many community groups where community life happens, or could be developed, need funding. This could be an incentive to work with providers in developing the ICN+ model.

Communications

- **Don't underestimate the personal:** While it is sensible to digitize some services and reduce unnecessary GP appointments, many people value personal contact whether for information or advice.
- **More effective communication is needed on why people do not need to see a GP.** The GP is still seen as the reliable and trusted part of the health service. Communication needs to increase the confidence of residents that other providers can meet their needs so well.

- **Clearer, simpler explanation of pathways is required particularly where they do not involve a GP**.
- **Little information on how long it is going to take to get to this new model.** This may create expectations on how quickly this can be delivered.

Building community ownership and representation

- **New and creative ways need to be considered to engage and build a sense of community.** This needs to be done physically as well as digitally and needs to reflect diversity of approaches and languages, encouraging ethnic group representatives to support these initiatives.
- **The process of influencing and representation is seen as confusing by residents and there is the issue of balancing these:** There is a need to explain this in simple terms using models understood beyond health and care. This includes level of formality, whether the role is paid, how much experience representatives need to be effective and whether training and mentoring could be given to widen access.
- **There is an interest in developing a community engagement model that leads to ownership and then leadership in neighbourhoods:** This should explore ways of empowering people at each stage to be involved, take ownership and responsibility for leadership roles in each locality.

These are our recommendations which are relevant to provider and commissioner:

Understanding the model

- **ICN/PCN model needs to be presented from the patient perspective:** Healthwatch Croydon can provide a neutral role and advise on simplifying the language and setting this out from the patient perspective
- **Look to build strong relationships and learn from organisations beyond health and social care services such as schools and relevant government departments.**

Widening access

- Enhance the link workers role to be the facilitators of real community engagement, co-production and representation, or create new roles in terms of community development.
- Focus activity on engaging those of working age and younger populations by going where they are and not expecting them to come to providers.
- Create or maintain funding streams to build community assets and raise profile of new ICN/PCN networks.

Communications

- Create opportunities for personal face to face contact to occur.
- Expectations need to be managed concerning rollout and timescale, with communication of clear timetables and regular updates to build confidence.

Building community ownership and representation

- Community mapping to build networks across different groups and relevant materials to get out to hard to reach groups.
- Apply principles that worked with Department of Work and Pensions 'Yes We Can' event and SLAM membership schemes to build a community engagement and empowerment structure.
- Look beyond current approaches to ask the public for their ideas around some simple questions.
- Consider a community engagement model that leads to ownership and then leadership in neighbourhoods.

1 Background

1.1 Context

About Healthwatch Croydon

Healthwatch Croydon works to get the best out of local health and social care services responding to the voice of local people. From improving services today to helping shape better ones for tomorrow, we listen to people's views and experiences and then influence decision-making. We have several legal functions, under the 2012 Health and Social Care Act.

Context

As part of an NHS England grant to Healthwatch England, Healthwatch Croydon were asked to support the development of the Health and Care Plan for Croydon by providing patient insight.

One of the aspects of the new plan is the development of Integrated Care Networks and Primary Care Networks to deliver services at local neighbourhood levels of 30,000 to 50,000 people.

Croydon's heath and social care providers are committed to this approach to:

"make sure local people have access to integrated services that are tailored to the needs of local communities – locality matters. We want to keep people well and out of hospital. Making sure local people have access to services, closer to home, wherever they live in the borough. Services must be accessible and responsive to their individual needs." (One Croydon Alliance, p10). [1]

Furthermore, "community services to be organised around localities – Building on our current Integrated Community Network model, ICN+ will develop wider health

[1] Croydon Health and Care Transformation Plan 2019/2020 – 2024/2025 A discussion document https://www.croydonccg.nhs.uk/news-publications/Documents/Health%20and%20Care%20Plan%20Discussion%20Document%20%28005%29.docx.pdf

and care models of care around 6 GP networks, with wider council services delivered around 3 gateway localities. Health and care need, the responding models of care and affordability will determine whether interventions need to be delivered at locality level, across localities or borough wide. Models of care will focus on a range of services that will go beyond working jointly but will work in an integrated way. That means the workforce will be multi-skilled to work across traditional but sometimes, artificial professional boundaries and also joint locality management teams." (ibid, p12).

Details of the vision are shown opposite. There is an emphasis on local populations being actively engaged in understanding the new the delivery of services as well as being involved in co-production and representation to ensure services are accountable and relevant to local needs. There will be an accountable team for each ICN, and this is an opportunity for patient and resident participation, co-production and representation to be built into the structure before it is finalised, rather than after it has been established

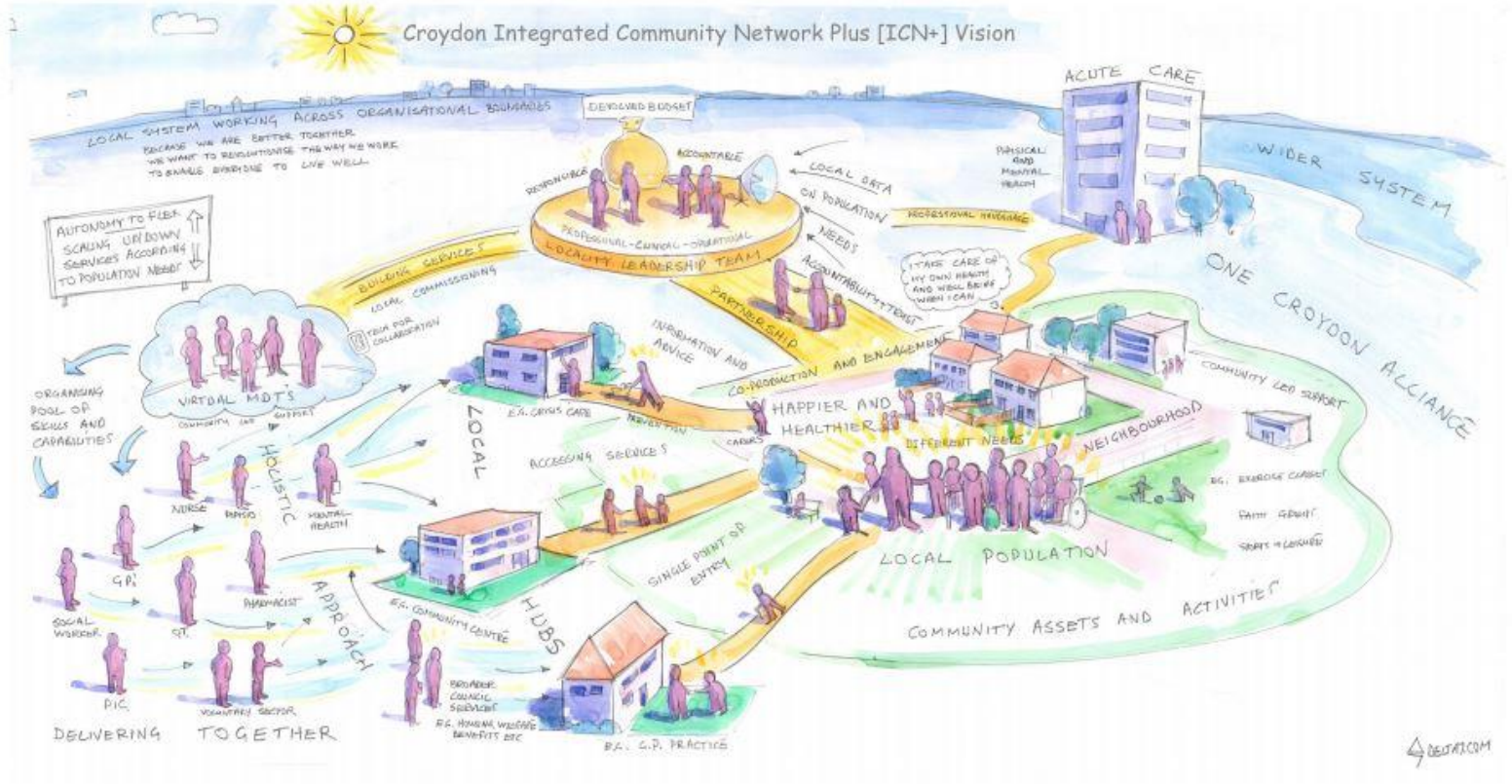
As this is a significant change for the delivery of services in Croydon, it was suggested that some insight into what residents might think of the proposals would help the planning process. The Health and Care Plan was subject to public discussion in May and June 2019, including a public event held by Healthwatch Croydon[2] before final approval by all members of the One Croydon Alliance in late summer 2019. The new plan was published in October 2019[3].

As a pilot exercise, it was agreed that Healthwatch Croydon would focus on one area which was Thornton Heath which was undertaken in May 2019.

[2] See Let's Discuss the Health and Care Plan https://www.healthwatchcroydon.co.uk/wp-content/uploads/2020/01/Lets-discuss-the-Health-and-Care-Plan-Healthwatch-Croydon-October-2019.pdf

[3] One Croydon Alliance (2019) Croydon Health and Care Transformation Plan: **http://www.croydonccg.nhs.uk/get-involved/croydon-health-and-care-plan/Pages/default.aspx**

The emerging vision for ICN+



People can get a different support easily and quickly and feel empowered
Staff are empowered, feel trusted & are able to use their time better
Resources are used better - move from acute to community
Staff are part of a "team" who know their neighbourhood
Population health outcomes are the focus
People are happier and healthier

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Figure 1: Croydon's Integrated Care Network+ vision

1.2 Rationale and Methodology

On Tuesday 7 May at 1800 and Wednesday 8 May at 1100, Healthwatch Croydon in association with NHS Croydon Clinical Commissioning Group ran two, two-hour public events in Thornton Heath to gain insight into how this new model of services would be received by local residents.

The events were led by a facilitator, Gordon Kay, Healthwatch Croydon Manager, and began with short presentations on the case for ICNs, the challenges for health service providers, and an overview of community assets. Members of NHS Croydon Clinical Commissioning Group, One Croydon and Thornton Heath GPs and other organisations and staff also attended these events.

The floor was then open for discussion and four aspects that were explored:

- Views on the new model of care.
- How can providers engage with the community over this change?
- How can new models of co-production be created?
- How can health providers be locally accountable?

1.3 Method

The full open discussions were recorded and transcribed professionally. Full transcripts can be available on request.

These were analysed and themes derived which are the basis of this report. This is a qualitative data set based on the discussions that took place.

Limits of the research

Despite significant promotion, six residents attended on Tuesday 7 May evening and two residents on Wednesday 8 May mid-morning. This reflects the challenges of asking the public to engage on complex change in a traditional event method.

Of these there was around 50% male to female and 50% white to BME, which is representative of demographics for this area.

We did have other representatives attend from Croydon Council, Department of Work and Pensions and other organisations did give insight from their positions which contributed significantly to the discussions.

It therefore gives an illustration of the views of some Thornton Health residents and should not be seen as representative of a population of up to 50,000 people.

A key learning point from this exercise is that to fully engage on this development, commissioners and providers need to go where residents are and not expect them to come to them. This consideration is further developed in the next section and is a recommendation for future engagement work.

2 Insight results

These are our findings based on the conversations had with attendees, the date reference appears at the bottom of each speech bubble

2.1 Understanding the model

Confusion over the Integrated Care Network/ Primary Care Network model:

It is seen by the public as confusing and too difficult to understand. There was confusion on how it will work, and a need for an explanation of the process. There was also a need to show how individual can access services, and a fuller understanding of the role of each service and how that helps in individual. Even with an all-in-one diagram, services seem segregated and dispersed.

The use of language and terms also added to the confusion. There were too many acronyms which would only be understood by those providing or commissioning the services.

There was also a view that residents could not see easily what services are there in the community and how they can access them. The diagram doesn't really show this.

Some of this information is irrelevant to people. They just want to know that they can get the support they need. It doesn't matter to them who is organising it.

The overriding view was that it just needs to be simplified.

There was also confusion over the role of the GP compared with the role of others on the diagram. There needs to be a better explanation of each of the roles, for example such as the link worker, and how they work together.

Use of ICN diagram confused more than illustrated:

F: Do you think the pictures are confusing? It is to me. Is it quite difficult to understand?

M: I'm not very technical. We spoke earlier about the CCG. I didn't even know what that means.

F: I'm still trying to process everything and I'm observing from the expertise that we've got here this evening. I'm gaining a lot of knowledge, but I haven't got a view as such at the moment.

Can you see where you might sit within this or if you needed services where you might be in it? Does it look like a map?

F: Yes, this is kind of like a map, really, isn't it?

Yes, it's got a map feel.

F: Are the GPs involved in there?

Yes, GPs are at the bottom.

F: Yes, because I think a lot of the attention needs to be focussed on GPs and the patients.

F: So maybe the GP needs to go more centrally than it being underneath.

This is very good as a population, but I wonder whether there needs to be, 'Me.'

F: The terminology 'local population' could be 'us' or the 'people who live there' rather than 'residents.' 'Accessing services' even is quite, 'What does that mean?' The terminology like 'worship' and whatever-, if you just had there 'church' and 'mosque,' because we understand that language.

(7.5.2019)

Concern on whether is going to put more work on GPs:

F: I've been looking at it and thinking. I'm still trying to process it. It's a very good idea trying to get it under one umbrella and targeting various issues, like health, social, and mental issues. However, I'm still trying to comprehend how it's going to work. Is it going to create more pressure on the already existing services or are people thinking of employing more people and more specialists to try to take some pressure off? Is it going to be a more uniform, quick, and understanding service or is it going to be even more confusing? If you want to go to a GP for an issue, sometimes they're not available. You book onto one of their other services. Then you're back to the GP. Sometimes I think it creates a communication <<issue>>. Most of the time GPs don't get the letters. Then the patients get the letter. That's a very good thing. The question is whether it's going to create more work for people or less.

(7.5.2019)

Need for better communication between NHS staff and other key service deliverers:

M: What's the communication like? Within GPs, mental health workers, and social workers, what's that like? They're still quite siloed rather than an integrated system. I'm from Live Well and we still have issues with people who have problems with receiving care and products from pharmacies. They're not up to date with services. They're not given regular information about what's going on. How is this looking in terms of communication?

(8.5.2019)

The focus of the model is still too much from the NHS perspective: It needs to emphasize community more and the wider partners where health and social care impact such as Department of Work and Pensions and schools.

F: I am a disability employment advisor. I work for the Jobcentre. What we want to do is work closer with the NHS and mainly with GPs because of what you mentioned. There is a lot of isolation. We are not GPs and we are not going to contradict GPs, but there are people in the receipt of benefits. Sometimes they might get confused and be losing out or being overpaid. We would like to work with yourselves to think of some activities and some sort of help in the surgery to people who really need it. People in this area are in very low earnings. They may be able to take some benefits. We would like to bring that up, help them out, and give them the information. Mental health for us is a very big thing. Some of us are qualified first aiders. Mental health, integrate more with the community. Our aim is to work closer with the NHS, and this is perfect.

It's to get wider agencies in. It's very NHS-y. There's a little bit of social care, but bringing in something wider.

F: Exactly, with the referrals to the council about for example safeguarding referrals where we see people who are exploited or taken advantage of. We want to see if we can support people. That's why we feel we should be under the same umbrella, because we are delivering services to the community.

(7.5.2019)

2.2 Widening access

- **Link workers have a role to play in understanding communities:** They can have a crucial role in bringing together different parts of the community. They could work more closely with the community navigators as they are seen by some as having a similar skill set, even though they have different roles.

> F: If you're saying people keep coming back to the GP, maybe within the GP service there is a link worker. They could have that relationship with that person. If the keep fit class doesn't work out, there could be other things. You don't have to keep going back to the GP, but there's somebody who could connect you to those things.
>
> (7.5.2019)
>
> M: What I don't understand though is they've got care navigators in social prescribing. I don't know whether this is done by architectural design or great fortune, but they've got some of the best community engagement workers that this borough has ever seen. Every organisation has lost a member of staff to social prescribing. I would imagine these people would be the best-suited people to be commissioned as part of their role to encourage engagement within the community. They've got all the contacts with all the group leaders.
>
> M: I don't know, but it would make sense because they're so in touch and so engaged. That's made each of the umbrella groups in Thornton Heath a lot stronger because we all have great working relationships with all these people. It's a wonderful symmetry that makes life so much easier.
>
> (8.5.2019)

- **Accessing younger and working populations:** Model looks good for those who are currently older or ill, but the younger and working populations are not really represented.

F: We need to think about young people. They are there and they have a lot of needs. They want to ask about so many things. Young people could be from 14-24, or you could have gaps in there, like 14-18 and 18-24. Young people really need somewhere to go and find information for themselves.

F: There is another silo project to this that <<council official>> is leading on for early years. We have to make sure it's all connected.

When you say young people, do you mean people over the age, so 18-24?

F: That can come in here. This is really from 18 plus. When we often look at prevention services for people who aren't working, and we're missing a whole gap of people who are working.

(8.5.2019)

The other aspect is school and playgrounds. There are issues about people coming in and safeguarding with children. All the GP staff are well trained in that kind of thing. You've got to go where they are. You can't expect them to come to where you are. There are school nurses and school closing time.

The one thing that's missing here is an involvement between the people who buy services and the local schools. Going to their head teachers and talking to the governors and saying, 'What are the health issues that you see?'

(7.5.2019)

I like the idea of talking to people at train stations or on buses because I think the challenge is, we do tend to engage and have events like this. You tend to get a certain age group at a certain time. This is rare, because it's an evening one. Most are in the day. If you're trying to get working people, the challenge is they're working. Maybe catching them at a bus stop. A 3-minute survey could be done, or you could do a stall where you offer some kind of food. 'Take a sandwich and give us a couple of minutes to think about services.' I think there's an in for a bit of creativity here. Starting at railway stations, it's an underutilized place. Almost no one surveys people at railway stations. Maybe because Network Rail have an issue over it. Maybe outside.

F: I think that's a very good point. We as practices all have our own patient groups, but our patient groups tend to be those with the time to come to those meetings, which tends to be the older population. We will be talking about how we can draw them together and form one group, but it's about pitching the views of the population more. The younger working population who haven't got the time to come to daytime meetings or may not even have the time to come to evening meetings, but may do something online and a quick survey by email. I think it's something to think about.

(7.5.2019)

- **Funding opportunities:** Many community groups where community life happens, or could be developed, need funding. This could be an incentive to work with providers in developing the ICN+ model.

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M: When you spoke about the grants that Healthwatch released, a lot of those organisations that applied were supported by the umbrella bodies that exist in Croydon. They were all involved in supporting these organisations. The connections with these groups have always been there. Where you might find a challenge is people show a lack of interest in health-related issues. When the grants were there, there was some impetus for them to get involved. I can see where funding can be a motivation based on the topics that we're dealing with, but the reality is these organisations exist. I'm leading some work with the church groups. There are so many areas in our community where the churches are embedded, and they lead by example. You can get St Paul's building any time if you're a community group running almost anything. The social prescribing work that's been spoken about, they don't pay for venues. It's our churches and mosques that are made available. The council's been supporting in some of the community centres and youth clubs. There are roles of these organisations, but it's about coming up with a common strategy that we utilise for accessing and dispensing information.

Befriending is quite difficult because a lot of people don't want to be bothered to do this. If we have the funding and the people who are really interested in people away from all the top bits and pieces, then the community will be reached easier. I just look at myself with the computer. I just think that sometimes many people, it's not that we can't be bothered. We go to the library to learn, but they've got set times and set people. Maybe half an hour or an hour. I've had the experience. That area, if we could touch it somehow, there would be many of us here who have had the experience, how do you reach these people who are unable? (8.5.2019)

2.3 Communication

- **Don't underestimate the personal:** While it is sensible to digitize some services and reduce unnecessary GP appointments, many people value personal contact whether for information or advice.

> So, information is an important part. It strikes me you want information face-to-face, but the Internet is useful.
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> M: There are so many places to get information that you get confused.
>
> So, you want informed advisors?
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> M: Yes.
>
> I think the challenge is if you have the same issue you don't want to have to come back and say it to the same person. There's something about information, but there's also something about personal service. It depends on the complexity of your condition.
>
> F: I think in my view it would be old-fashioned personal sessions, which you're getting less and less. They're going to be more online consultations and less and less seeing the GP. I think it has a positive effect when you see a doctor. Sometimes emotionally or psychologically one felt better. For me, it's usually quite good.
>
> (Considering a nurse or pharmacist instead of a GP): That's not the same thing. Obviously that person does not have the same level of specialisation as the GP. That is the reassurance that you know this person probably has a solution. He is supposed to be on the top. You go back to the GP to get your condition diagnosed.
>
> (7.5.2019)

- **More effective communication is needed on why people do not need to see a GP.** The GP is still seen as the reliable and trusted part of the health service. Communication needs to increase the confidence of residents that other providers can meet their needs so well.

> M: I'm interested in how as a patient one feels about the services being shown so segregated and dispersed. When I first got involved with things to do with health at my local surgery, the general concern of others around me seemed to be one of, 'I go to my GP for this sort of information or advice. How's some guy or gal somewhere else going to know about this and deal with my problems?' I've been involved in enough of the discussions that have taken place around this sort of thing to have some feel about how they might be dealt with. I haven't heard from other people here who are patients saying what they feel as patients rather than as providers. Can you go back to our patients here if they've got a view on that? I think it would be useful to understand whether there is an attachment from patients to their GPs or whether it's something that only comes from old fogeys like me.
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> For medical treatment, the role of the GP is there. Once you're diagnosed and now it's a case of managing it, would you still want to see the GP?
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> F: Once you are diagnosed like that, that's fine. You don't need any further seeing the GP. Obviously if you are on challenging medicines, then you need to know whether you're going downhill or uphill.

Clearer, simpler explanation of pathways including social prescribing is required particularly where they do not involve a GP:

M: Let's say your GP surgery had other people who could take on the soft stuff and then you could have more time with your GP and have a 20-minute consultation rather than the 10 minutes you have now, would that be a good deal?

F: I don't know. If you're seeing different people who then go back to the GP, which in the first place the GP could have done in one go.

M: There are certainly things the GP doesn't need to get involved in. If we could take those away from the GP, then the GP has more time to sit down with you?

F: I don't know. It's just an idea in my head at the moment. I don't see the full application of it.

F: There is the aspect through social prescribing that it's no good to keep going back to your GP every month to say, 'I still feel this.' There are ways of helping to combat that condition. This is where the social prescribing bit comes in. If you're a diabetic and with that comes some cardiovascular aspects, that could be helped by doing any form of exercise. It's down to the patients to take the responsibility to access the things being offered to them and reduce the workload on GPs. It's almost breaking that idea that people just keep going to their GPs because they don't feel well and seeing there are other ways to alleviate. I think people need to be more aware of this. I'm quite aware of it, but other people aren't.

F: If it's appropriate to that patient, potentially suggesting where there are local services available for them to go to a keep fit club or an exercise class or a yoga class or a mindfulness or a gardening group. It's not always about exercise. Exercise is great. Sometimes it's more about mental health and isolation. You want access to something that occupies and engages you.

M: Would that have weight if it came from the GP?

F: Yes. It is the sense that you've had a clinical assessment that points you towards a non-clinical result.

Confusion about the pathways particularly with self-referral:

F: How do people get referred to your service?

M: It's people who are ready to make behavioural changes. Those who go onto our website Just Be Croydon, there's a health MOT questionnaire on the website that asks various lifestyle questions. The main health behaviours are discussed. I work in the 2 GP surgeries on Brigstock Road, a local practice and a family practice.

F: Are they signposting their patients to fill out the questionnaire?

M: Yes, and then we see them as part of the programme.

Is it self-referral?

M: Yes. Once they have the consultations with either the nurses or physios, we try to use the MEC model.

What's the MEC model?

M: Make Every Contact Count. If there's an opportunity to talk about health, they use that. If any of the patients from those practises want to stop smoking or lose weight, they would get them to see us.

F: I think we need you to support us with developing the approach. See the talking points we've got here? It would be that we could suggest that people do the self-referral. It could also maybe be part of the assessment that the district nurses or social workers do.

It's good that you've come, because it's certainly missing. About the NDPN, that's more when people have been diagnosed with a condition.

F: No, it's not, because we're doing preventative.

Yes, but within that area. (8.5.2019)

- **Little information on how long it is going to take to get to this new model.** This may create expectations on how quickly this can be delivered. Confidence in change is based on strong regular communication, so timescales and updates are important.

> I wanted to tie that in with the workforce problem that you started to illustrate earlier and to timescale. To timescale because as I understand it, what's being proposed here is likely to take a number of years to reach the sort of ambition that this points to. I hope you're able to advise people here that they shouldn't raise their expectations too greatly this year because this isn't all going to happen next week or even next year. That's partly dependent upon the availability of these link workers. That there will be money available to hire link workers of sufficient knowledge and ability to do the work you anticipated, is going to be a very tall order given the shortage that there is and the pool of talent to train and to be trained within the next few years.
>
> (7.5.2019)

2.4 Building community ownership and representation

- **New and creative ways need to be considered to engage and build a sense of community.** This needs to be done physically as well as digitally and needs to reflect diversity of approaches and languages, encouraging ethnic group representatives to support these initiatives.

F: Do you think it's about engaging people about what's there and what's missing?

M: I think so. None of us in the room know that in Parchmore they have a wonderful signposting pack of what they call social prescribing. They have long lists of social support places in Thornton Heath. Once we get our hands on that, we can help to put things on a map of Thornton Heath. Residents of Thornton Heath can help to say, 'There's the Darby and Joan Club.' Centre from 12-1 on a Wednesday.

I know in my disability work, there's a Palace for Life football session in the Thornton Heath Leisure There are Books Beyond Words for people with learning disabilities in Thornton Heath Library.

There are all sorts of flags you could put on a map to build up a picture of the community.

M: It's funny you say that because the same project, the social prescribing, are trialling a piece of work on a smaller scale where they take refugees in Crystal Palace, and they're doing a walk along a map and showing them the key points. They have no idea of the services that exist.

A walking tour.

F: As part of the engagement, it would be about getting the community to help us identify.

F: I'm a resident. I've lived here for God knows how long. What I've heard in this meeting is unbelievable. If I were in social care for several years I wouldn't have heard of this

F: In St Paul's Road there are a lot of clubs as well for different aspects of life, and people who are isolated can go there and have a good time. There's also the West Thornton Community Centre where things happen. I go to the Muslim group and they accept people of all faiths as well. I go for the exercise and knitting groups, and lunch as well. Everybody's welcome. That's on a Tuesday.

M: Those are great examples. That's the sort of thing you could put on the map and have links to the details of when it is, what is costs, and accessibility.

That information needs to be shared. This idea of a walking tour, you end up with a chain of people in a chain of different networks, and then you publish that so it's more widely available. (8.5.2019)

More than information - community ownership and leadership is needed:

I struggle with this sort of work. We're talking about creating these maps and inventories of services and getting out into the community and making sure everyone hears, which we never achieve. I think we should do an inventory and create a flow chart as to how we disseminate information. What are the core groups we're looking at? Who are the champions who need to have the information so they can disseminate that information through their channels? How do we reach the grassroots level? What you'll find is a lot of events take place and it's the same faces at every single meeting. We'll talk and talk and say the same things over and over again.

I'd agree. I've been to some similar events that <<community worker>> has been to. There's a lot of optimism of things we could do, but there's not much follow up. Where's the action? You're absolutely right. Someone needs to take ownership of it all.

M: I think that's part of the problem. In creating a flow chart, we need to have somebody not take ownership in that we're too guarded with our information and sources. Everybody wants to be engaged. I'm about community. If we want the community to thrive, let them share it themselves.

I think that's the challenge. The put something up and say, 'This is for younger people.' There are other people walking past that need the service. I think there's an idea here that rather than replicate-, I know the council have different departments doing different things. It's the challenge of, if you are doing that for over 65s, well actually you'll probably save money in the long run by having that information available for all ages. The interesting thing about languages, traditionally what organisations do is get a translator in, which is very expensive. Maybe there's someone within the community that could translate. Then they're contributing and feel a part of that. It's about finding community solutions.

M: Sometimes you miss the core of the community. If you went to Thornton Community Centre and asked, 'Do you know who in your community has these skills because we'd love the information in a way that they can understand it and benefit,' you're more likely to get someone who's really enthused and is committed long term and feels that feeling of upliftment every time it's produced in their community.

That's not just language as well. It's people with learning difficulties as well to translate or maybe working with a support worker to be able to do that. It really needs to come from the community outwards.

(8.5.2019)

- **The process of influencing and representation is seen as confusing by residents and there is the issue of balancing these:** There is a need to explain this in simple terms using models understood beyond health and care. This includes level of formality, whether the role is paid, how much experience representatives need to be effective and whether training and mentoring could be given to widen access.

Do you have a view of how we could get people more involved in influencing decisions on how services are delivered?

F: I think I need to think a lot more before I speak.

I'd like to focus on the final question. Accountability. The money that's going to come into this will be held locally in Thornton Heath. There's local power. There's going to be an accountable officer or clinical team based on Thornton Heath who are responsible only for Thornton Heath. They're accountable to you, the public. In what ways can they be accountable? What needs to be put into place?

F: A member of the public on the team. Maybe pay them.

Would they be independent once you start paying?

F: They'd still be working for the people. It would have to be done on rotation so they can't just sit. You're right, that money might corrupt that.

F: We have a lot of people who are professionals who would like to devote some time to that. Rather than paying, maybe they would like to do some voluntary work for the community.

I like the idea of one person right at the top. Having someone at the top of the leadership team who isn't in the Health Service gives representation. You're still asking for one person to represent 40,000 people.

Structures to support effective representation need to be considered:

What other structures need to be behind that?

F: They can engage with the MP. They do have surgeries as well. They may be able to enhance what we're trying to do.

F: They have a whole board as well, don't they? The rest of the team as well. The other representatives from various organisations. If they were working for the people, it would be a good idea to have a resident on there. The reason I say paid is that then it's not just your usual suspect, someone who's retired. Make it a job worth actually doing and having.

How would they be selected?

F: Put it to the people.

So almost like an election?

F: Have an election, yes.

M: Amongst whom do you hold the election? How different is that to a local councillor?

F: It's not political.

They would have to put up some element of what they stand for.

F: You could have someone from each network, so a few local people.

M: It's practical. We're talking about Thornton Heath network.

It could be each practise that draws up to this network. I'm interested in the idea that you have multidisciplinary groups. You've got a pharmacist, nurse, and social worker. Would it be useful for there to be a shadow representative who gives the patient experience of using pharmacy in the area who might build up the network of all the pharmacies in the area? What are they going to represent? What other systems do you need in place?

Local representation in a place like Thornton Heath is key - maybe a neighbourhood patient champion:

M: Could you go back on what group we're talking about? I'm a little confused. Is this the grand solution for Croydon and you're talking about the people that run that, or are you talking about the little networks?

We're talking about Thornton Heath. There would be a local leadership team here. There would be a representative to that particular team who is non-clinical and represents the patient experience and maybe a group behind them that feed into them.

F: Perhaps that member of the public isn't necessarily going to be able to have the entire views of 30,000 people, but what they can do is hold the team who are the clinical people accountable to what they are doing. What have you done? What is the feedback for services? Maybe be able to chair a meeting in part of the Thornton Heath network. 'Come along and hear about what's been happening in Thornton Heath for the last 6 months.'

It's like a Thornton Heath patient champion almost.

F: Yes, an in between person. They're not necessarily going to be able to garner the view of 30,000 people.

M: Should that be any patient or should that be a patient who has acquired some specialised knowledge?

F: You want someone who is going to be able to take information-,

F: Knows the area. Lives in the area. Uses services in the area. Works in the area. Raise children in the area.

Possibly a role for Patient Participation Groups:

F: They would have to, otherwise they wouldn't be able to have the input, but they have to understand something.

M: You're talking about the patient group that you've got.

F: We all should have them at each practise.

M: I know for a fact that very few do have them.

There are about 20.

F: There's an opportunity in them coming together into something that's quite powerful.

F: My patient would be very interested in what's happening. It makes sense for them to be coming together to work together.

M: It would make sense, wouldn't it, from somebody who had acquired some degree of knowledge in this area.

M: There has to be some structure.

(7.5.2019)

A range of ways to engage should be applied, sometimes using models that have been successful before in Croydon such as Yes I Can:

M: I'm of the opinion that running a survey to see whether people are satisfied or not is just one phase. There needs to be a physical stage where people are brought together and engage in some sort of activity that allow them to discuss and explore their views. It lets them start thinking about the decisions that are about to be made. There's that human element. You're able to bounce off each other.

F: I like what <<community development officer>> was saying. As a starter, you get some residents and then start mapping what's already there. That's the beginning of it. Then you can start looking at, 'How do people access this? These are the talking points.' Let it naturally develop. Maybe it's about organising the programme of events. I don't know how you get the people though.

T: We're did an event called Yes I Can, which is around employed people with disabilities and health conditions. Similar to what you were saying, having different residents with different disabilities come in and discuss what they access, what they don't access, and why they don't access it. Having GPs and social workers in and having those discussions. Doing little hub sessions and getting feedback. If you have a big discussion with different aspects, because there's complexity within Thornton Heath, then you can get an overview about what's happening in Thornton Heath.

(8.5.2019)

Youth representation and the things that support that, such as mentoring is important particularly in Thornton Heath:

M: I would imagine that the new governance strategist would have some kind of community rep involved. One of the things across the borough is you talk about engaging and empowering young people. There should be at least one rep in the government structure that comes from the category of 'youth,' so below the age of 25. You have to be over 16 years old to sit on the board of charities, so 16-25. We're not only giving them a voice and the ability to represent their community, but we're also promoting an opportunity for this person to update their skills and CVs for their university application. It can only speak positively.

F: Especially for the young people, they should be shadowed by an older person in the background. Although they come to take on that position, that's my personal view, that someone is shadowing.

Mentoring. I think that's a good idea. Especially if they're going to be making influence at the top level, you're going to need someone to be able to communicate in a way that they're going to be able to influence. Mentoring brings that extra element into it as well. How people are selected is the other challenge, whether they go through some semi-formal process or election. There was some success with the youth mayor, where they were actually elected. Should people apply? Should they get selected that way? You also have issues of representation. There might be a panel reflecting different groups. If it's diabetes, you might have a diabetes representative in Thornton Heath.

F: I think a lot of the young people become more interested into that area. For instance, if you have an election, at least the other young people will know that, 'If I do this or that, at least my voice will be heard and I'm going to be seen.' It's an incentive. I think those things work.

Other group representation is also needed including levels of formality, with SLaM membership seen as a model worth exploring:

Are there any other views on how people's views could be represented or making people who are making decisions accountable?

M: Wouldn't it work the same way as any other trust?

Yes. That's a question of informality. There are requirements that are needed so people are taking responsibility. The challenge is if you make the system too paperwork heavy that you'll only attract a certain kind of person, because they're prepared to do that whole application. We've just recruited our new board, and we just did a call out, but you did have to have an interview. We needed people at our level who were going to inform strategy. They're effectively the holders of strategy for our organisation and making sure they're meeting the needs of our service. We're in a slightly different scenario, which is more about representation.

M: I'm a member of SLAM (South London and Maudsley NHS Foundation Trust).

What do you mean by that?

M: They have a process by which you apply to be a member by filling out a registration form online. They respond to you almost instantly, and you're not a member. Their Make Me Smile grant, which closes at the end of this month, to apply for that, which is up to £750 for a project within the community focussed on wellbeing, you have to be a SLAM member. You can register now with your phone for 5 minutes, request an application form, and the person will send it to you right away. Then you're eligible to apply. As a member of SLAM, one of the benefits you get is a section on discounts for NHS workers. SLAM members get that as well, discount vouchers at certain shops. They also send out a call every other year saying they're seeking applicants for people who want to become board governors.

Some further discussion of the membership model:

If you'd like to submit, you fill in a form. After that, they have an election process. The document is sent to all of us as members, and we vote. If we run something like this in Thornton Heath and are looking for a board of governors, anyone who is eligible should be registered with a GP in Thornton Heath as a basic requirement.

F: Some of the GPs were here last night, and they were telling us they all have their own engagement meeting. They said some were working and some weren't. They're just thinking of having one across 6 practices. There might be an opportunity for us to build on that, but you want it to be a free community.

M: You don't want the same old faces. You want new people.

They've got great positives, but the demographic of people who come to PPGs tends to be retired and people who are quite well informed in the NHS and are interested in maintaining it. It's a very interesting idea. SLAM, I've been on their website many times. I have seen that membership thing, but I never fully understood it. The minute you're a member of a GP, you're automatically a member of the Thornton Heath Health and Social Care Network. Then you get a vote. Here, you had to opt in to be a member of SLAM. The minute you register with a GP, you get that automatic membership. That might be a way to engage people. Of course they have all the contact details, which is the other issue. (8.5.2019)

- **There is an interest in developing a community engagement model that leads to ownership and then leadership in neighbourhoods:** This should explore ways of empowering people at each stage to be involved, take ownership and responsibility for leadership roles in each locality.

> M: I don't want to sound like a one map pony, but to go on about the map again, we could invite a community group to make a beautiful map with all different parts and the streets. That map could be based in Thornton Heath library. People could help people to put things on the map. That could be over a week. The map could go out on the street on a Saturday if the sun's out. Make a thing of it. It's that visible, tangible, fun starting point. AS people put stuff on, we can learn things about what's out there. Your point about not replicating things is absolutely crucial. It can be a way of gathering stuff together and a starting point and making what we're trying to do visible. It's a bit iconic. It represents the locality. It's inclusive for everybody, because a map, you just put it on there.
>
> I get the sense that to get a sense of people's needs you need to do some event. It's an open invite to everyone. The challenge is to try and make something where people actually want to turn up so they can voice something. Not too agenda led that it starts to be closed, but not so freely open that people think, 'Why would I turn up in the first place?' You've shown a good model that you could do for a specific group as well.
>
> M: Sometimes it's all about putting our name or brand on the tin. It might be more effective to do it with another organisation, so you lot are secondary.
>
> (8.5.2019)

The need for neutrality between organisationns vs council or NHS branding it which might give it weight and purpose - ultimately where does ownership of this really lie?:

I don't think it should have any branding from the council. People want it to be from the community.

M: I don't know. Sometimes it's not just about it coming from the bottom. When I speak to you, 'What authority do you have to carry this out?'

It's finding that sense of neutrality or neutral space where it isn't just the council doing something, to break down the cynicism. .

I think that's part of the problem. In creating a flow chart, we need to have somebody not take ownership in that we're too guarded with our information and sources. Everybody wants to be engaged. I'm about community. If we want the community to thrive, let them share it themselves.

F: The council are commissioning the voluntary sector. That's up to them. They're sorting that out. Lots of social workers and frontline staff have lost that connection. Everyone's got to share it.

M: I've worked for 2 of the key support organisations as well and they're doing a great job. There are a lot of other small organisations that are also doing a great job. Maybe we need to give them more kudos for their work and embrace them more and come to this agreement where we're sharing all these pathways. There's a disconnect. There are too many new people who come into to do things and they're using valuable resources to carry on work that's already being done.

There's duplication of effort as well.

(8.5.2019)

Maybe it's the NHS and Council's role to fund ways to support community leadership?:

M: When I said ownership, I was being facetious, to be fair. Without leadership, nothing works. That's understandable. There are different strategies you can use, and I think one of the best examples of community spirit, getting the word out there, and connecting with all levels of the community is found in New Addington. If anyone uses Facebook, you can get access to the Pathfinders Facebook group. I think there are about 10,000 people who are part of it. Everything goes on there from, 'My cat's missing,' to, 'I found a child's Oyster card, does anyone this face?' 'There's an Audi driving around with tinted windows offering children sweets. Be careful. Let's look out.'

M: When you spoke about the grants that Healthwatch released, a lot of those organisations that applied were supported by the umbrella bodies that exist in Croydon. They were all involved in supporting these organisations. The connections with these groups have always been there. Where you might find a challenge is people show a lack of interest in health-related issues. When the grants were there, there was some impetus for them to get involved. I can see where funding can be a motivation based on the topics that we're dealing with, but the reality is these organisations exist. I'm leading some work with the church groups. There are so many areas in our community where the churches are embedded, and they lead by example. You can get St Paul's building any time if you're a community group running almost anything. The social prescribing work that's been spoken about, they don't pay for venues. It's our churches and mosques that are made available. The council's been supporting in some of the community centres and youth clubs. There are roles of these organisations, but it's about coming up with a common strategy that we utilise for accessing and dispensing information.

(8.5.2019)

3 Responses to our research

Dr Agnelo Fernandes, Clinical Chair of NHS Croydon CCG said:

"We are pleased to be working with Healthwatch Croydon to understand local views on the development of Integrated Care Networks for the borough. It's clear from the report and Healthwatch's recommendations that we need to continue to engage local people to make sure both local people and our partners can participate as fully as possible and help shape the development of engagement for a new primary care system in Croydon.

"We look forward to developing a strong approach for outreach engagement in the near future and we will work closely with Healthwatch to make sure we clearly

communicate our vision for the integrated care network plus model so that it can be brought to life for local people at future events."

From the Croydon Health and Wellbeing Board Minutes, 19 June 2019, p 4-5[4]:

> The Healthwatch representative, Gordon Kay, did a presentation to the Board regarding the two successive two-hour public events held in Thornton Heath; these were to gain insight into how the new ICN+ model of services would be received by local residents. He highlighted that the following areas were focused on:
>
> - Understanding the model
> - Widening access
> - Communication
> - Building community ownership and representation
>
> The Director of Public Health, Rachel Flowers, explained that the authority had services that could be provided to prevent residents relying on the NHS. The communication within the services needed to be developed but she noted that this was the first time in her career she has seen all areas starting to work together, which was positive.
>
> The Chair noted that the Board needed to be conscious of how they could measure success following the introduction of the localities work.

[4] Croydon Health and Wellbeing Board 19 June 2019 minutes: https://democracy.croydon.gov.uk/documents/g1961/Printed%20minutes%2019th-Jun-2019%2014.00%20Health%20Wellbeing%20Board.pdf?T=1

Councillor Hopley noted that there was cross-party support of the localities work. She expressed concern for the communications around the work to the public as a lot of residents were unaware of the ongoing work and how they could get involved. She requested quantitative data from officers, including; how many residents in the borough have dementia and how many residents were currently receiving social care. The Chair agreed with Councillor Hopley and echoed her comments regarding the data and explained that the Board Members needed this from the outset to monitor the impact.

Councillor Bird explained that it was positive to hear feedback that the localities approach was proving to be successful; however, the Board needed to have borough-wide data to measure success. The Vice-Chair noted that Croydon Alliance data was available and further data was being collected. The Director of Public Health added that qualitative data needed to be collected and for officers to not just focus on quantitative.

Councillor Hall stated that it was important to ensure all residents from across the borough benefited by receiving the help and support needed. He noted that it was positive to have package support for residents and hoped that the communities would be strengthened through the work. It was added that the second Community Food Stop was to be introduced to Thornton Heath following the successful pilot scheme.

In response to the queries raised by Councillor Bird the Chair explained that the scheme was to be initially introduced to the areas with greatest need within the borough. The Director of Public Health added that evidence showed that those with a lesser income were often more at need but agreed that there was deprivation in all wards within the borough.

Councillor Hopley stated that there were a lot of residents unknown to the authority who could benefit from extra support, particularly in the south of the borough; these residents were often isolated as they were not part of a close community. It was noted that developing a tailored approach was important as different wards had different needs.

Councillor Flemming advised officers to collaborate with developing community groups within the wards to ensure the work was being promoted and to also relieve the potential stigma.

The Vice-Chair noted that social isolation affected residents across the whole borough and many people did not have access to the services needed; he was hopeful that the new localities approach would improve this greatly. From his experience as a GP, he noted that the figures regarding appointments and referrals were improving and patients had explained that they were feeling happier and more supported within the community. He added, though, that communication and engagement around the ongoing work did need to be improved.

Councillor Campbell noted that officers should collaborate with local schools, places of worship and all locations which provided community services.

The Director of Alliance Programme responded to the queries raised by the Board and explained that a communication plan would be introduced and this would focus on how reports were written particularly from the service user's perspective. She also noted that the data collected would be presented to a future Health & Wellbeing Board.

4 Quality assurance

Does the research ask questions that:

Are pertinent? The insight asks residents what they think of a proposed new service delivery model.

Increase knowledge about health and social care service delivery? This research helps both commissioners and providers of services both in the health and social care sectors. It also will help prepare improved communication about the change with residents and creates discussion on methods for future engagement, co-production and representation.

Is the research design appropriate for the question being asked?

a) Proportionate: The idea to was to gain views from residents living within Thornton Heath, this was achieved.

b) Appropriate sample size: Has any potential bias been addressed? The numbers for the event were ideally 10 to 12 per session, we had five on Tuesday and two on Wednesday. It gives an illustration of the view of residents but also the limitations of inviting people to engage an event where they need to attend in early evening or mid-morning. Future insight would be better conducted in places where people do not need to travel to give their views, such as GP surgeries, schools, community centre, shops and transport hubs.

Have ethical considerations been assessed and addressed appropriately?
Beyond the usual standards of anonymity, here were no further ethical considerations required for this insight.

Has risk been assessed where relevant and does it include?

a) **Risk to well-being:** None.

b) **Reputational risk:** That the data published is incorrect and not of a high-quality standard. All data comes from professional transcriptions which have been read again by the facilitator to ensure accuracy. NHS Croydon CCG's Engagement Manager also attended both events and can confirm it was an accurate record.

c) **Legal risk:** Have appropriate resources been accessed and used to conduct the research? There was no need to refer to legal resources for this research.

Where relevant have all contractual and funding arrangements been adhered to? This was part of a fund from NHS England which was given to Healthwatch England to support local Health and Care Plan preparation work. Healthwatch Croydon received the grant to undertake this work and some other work on respiratory services across the South West London footprint.

Data Collection and Retention

Is the collection, analysis and management of data clearly articulated within the research design? Yes.

Has good practice guidance been followed? Yes.

Has data retention and security been addressed appropriately? Yes.

Have the GDPR and FOIA been considered and requirements met? Yes.

Have all relevant legal requirements been adhered to ensure that the well-being of participants has been accounted for? ie the Mental Capacity Act. None required for this research.

Has appropriate care and consideration been given to the dignity, rights and safety of participants? Yes, it was confirmed that the event would be recorded and photographed.

Were participants clearly informed of how their information would be used and assurances made regarding confidentiality/anonymity? Yes.

Collaborative Working

Where work is being undertaken in collaboration with other organisations have protocols and policies been clearly understood and agreed, including the development of a clear contractual agreement prior to commencement? The funding of this research came from Healthwatch England and the terms were set that we would undertake insight on an aspect of work relevant to the South West London Health and Care Plan. It was decided on the theme of ICNs and Healthwatch Croydon provided the sub-themes for discussion which were agreed with NHS Croydon CCG.

Have any potential issues or risks that could arise been mitigated? These are shown below:

Risk factors	Level of risk	Contingency
Cannot access key people to research	Low	We invited people from Thornton Heath through our lists and that of our partners and network.
Organisations let you down	Low	Use social media.
Question set does not work with group	Low	Co-written with NHS CCG based on previous experience.
Data is seen as being out of date	Low	Report to be completed within a month of insight undertaken.
Not enough respondents	Medium	There is not the opportunity to run the event again, but any findings can contribute to future engagement.

Has Healthwatch independence been maintained? Yes, this research is shared with partner organisations before publication for their comment, but only factual inaccuracy would be reviewed. This does not affect the comments of experiences we receive.

Quality Controls

Has a quality assurance process been incorporated into the design? There was a proper process of scoping with NHS Croydon CCG.

Has quality assurance occurred prior to publication? Data collection was checked and re-checked.

Has peer review been undertaken? No peer review was undertaken. It was not required for this research project.

Conflicts of Interest

Have any conflicts of interest been accounted for? This work was commissioned by Healthwatch Croydon, on behalf of Healthwatch England for the South West London Health and Care Partnership and NHS Croydon CCG. All considerations concerning the theme were proposed by NHS Croydon CCG and agreed by Healthwatch Croydon. Healthwatch Croydon proposed the sub-themes of engagement, co-production and accountability. The further question on the feedback to the new ICN model was proposed shortly before insight began. Healthwatch Croydon is satisfied that it's independence and neutrality has been maintained through this project.

Does the research consider intellectual property rights, authorship and acknowledgements as per organisational requirements? The research is owned by Healthwatch Croydon, who are managed by Help and Care. Other organisations support has been recognised and suitably referenced.

Is the research accessible to the general public? It appears on our website as of XX February 2020.

Are the research findings clearly articulated and accurate? To the best of our knowledge, we believe they are.

5 References

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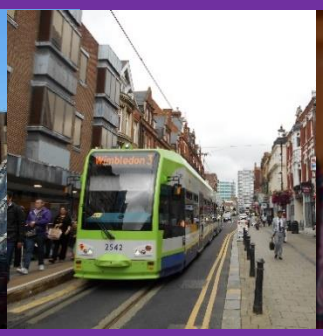


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