Enhancing Social Prescribing Through Community Health Advisers:

A Demonstrator Health Equity Project

Evaluation report produced by Newham New Deal Partnership incorporating research results from a commissioned qualitative research study by University of East London

March 2024

Contents

Executive Summary

Funding and timeframe

- The Health Equity project was a demonstrator project, funded and supported by North East London (NEL) NHS and Newham Council, which was set up and delivered in 2023.

Aim of the project

- The aim was to reach communities with low engagement of health services, and test whether a project which engages grass roots community groups – and where people already have a sense of belonging, and which are better placed to achieve access, relevance and trust for residents - can reduce health inequalities rather than projects which are delivered by groups that are too big or wide for people to identify with.

Activity levels

- The Health Equity Project recruited 116 participants, through the three grass roots organisations 86 of which were new clients registered as a result of the project (3.1). The target groups (Somali, West African and SE Asian heritage clients) were reached.
- 46 group sessions were organised by the grass roots organisations at which health was discussed: topics were determined largely by the interests of the group (4.2)

Participant access issues and support needs

- Around half the participants in the projects had one or more access issues. The most significant was speaking no or only a little English, but many had physical disabilities or sensory impairments which required extra support (3.4).
- The top two support needs of clients were support with housing problems and finance. These were followed by loneliness/social isolation, and then managing long term health conditions and mental health (5.1)
- Of the 20 clients who completed a standardised mental health questionnaire, 95% reported perceived mental wellbeing that was in the range for the lowest 15% of the UK population
- 138 referrals were made for clients to other agencies: these were mainly direct rather than through the JOY portal. Health Advisers generally referred their clients to more than one external agency, as the majority of clients identified both socio-economic and health needs (5.4)
- Housing and finance problems were the top issues for community organisations which referred, with referrals to GPs second. (The largest agency for referrals on available JOY data was Our Newham Money.)

Outcomes and impact

- Over 50% of participants who repeated health and well-being questions a second time self-reported an increase in their health and wellbeing after engagement with the Project's Health Advisers, and two-thirds were more confident in managing their health, with Health Equity Project participants showing a slightly stronger improvement than data available on JOY clients (6.1)

- The participants interviewed by the University of East London (UEL) who undertook both before and after standardised mental health questionnaires showed an improvement in their scores after engagement with the project (6.3)
- UEL in-depth interviews demonstrated the value of group activities to reduce participants' sense of loneliness and social isolation. Trust and confidence that the Health Adviser could practically help – across both health and non-health matters - was also strongly affirmed (6.3, 6.4)
- Health Advisers through their casework were able to identify unmet health needs (6.5)
- Participants attending Group sessions run by Heal Together and Blossom cited community groups as the top source of help on health and wellbeing, slightly ahead of their GP surgery (7.2)

Challenges in implementation

- Health Advisers found it challenging to explain and collect wellbeing data which they felt was not culturally appropriate from clients who were unused to being asked to complete formal forms (8.2)
- Extra time needs to be allocated for compliant and safe storage of client data on any online system (8.3)
- Health Adviser staff working with volunteers in small grass roots organisations requires open communication on role boundaries and responsibilities (8.4)

Learning

- Generally, appropriate channels for clients to access support were identified, although more video and social media for health education communications might have been undertaken if the project was longer term (9.1)
- Grass roots organisations with experience of running face to face groups had the best success in delivering project outcomes; but not all communities are able/want to attend a face to face programme (9.2)
- Success factors for grass roots organisations wishing to take part in the model are identified (9.3)
- Getting consistency in health and wellbeing metrics (standardised questionnaires) across social prescribing projects would support benchmarking for impact; however any survey questions need to be short, translatable, explained for cultural bias, and easy to administer for clients who have no experience of questionnaires (9.5)
- Health advisers in made some comments on what services need to look like to reach minoritised communities (see Annex 4)

Recommendations going forward (9.6)

- Delivery partners were very excited about the future possibilities of delivering this type of service, and the potential for One Newham to continue to foster the development of collaborative delivery and partnership working amongst a greater range of grassroots groups.
- A longer period for delivery of the service would not only allow for deeper trust and access for clients, and allow more time for any re-scoping of marketing or delivery plans, but make it more likely that key skilled people in small grass roots organisations would be interested and available to take on a staff role.
- Because of the short term nature of the project, formal engagement with social prescribers in Newham was limited. However, in any roll out, more dialogue between social prescribers as to appropriate referrals and levels of support by Health Advisers to ensure support for clients referred out should be made.

Delivery partners made the following additional recommendations (see Annex 5):

- They believed that developing advocacy skills set amongst the staff and volunteers was important, and suggested developing an accredited programme (for example, an Adviser Academy) to achieve this, with One Newham having a role in this;
- Involving more grass roots organisations, would enable the model to refine its reach to particular sections of communities, for example, men, pregnant women, young people and older people in specific communities;
- Some communities do not necessarily fall into neat administrative areas, and consideration should be given to work across a wider area, which the Integrated Care System might offer.

1. Introduction

1.1 The project was commissioned to support learning and innovation in social prescribing. The aim was to evaluate the impact of involving paid community Health Advisers from local grass roots voluntary organisations to engage residents in social prescribing activities which could increase engagement levels among communities where data indicate lower engagement.

1.2 The initial approach was developed by One Newham, the membership organisation for voluntary and community groups in Newham, in consultation with grass roots member organisations whose constituency had low engagement with health services.

1.3 The delivery model was of a host community organisation with experience of delivering health projects and appropriate policies and procedures (Newham New Deal Partnership), supporting smaller grass roots organisations through recruiting a paid community part-time Health Advisers from each of the community organisations themselves, to engage directly with residents.

1.4 The community organisations working with or as community Health Advisers were: Blossom Place (Southeast Asian community engagement and health support); Heal Together: (Somalian resident engagement and well-being assistance) and Salem Health (West African and French-speaking community focus).

1.5 The three Health Advisers developed, delivered and co-ordinated a range of activities in their grass roots community organisations designed to help residents from these communities to improve their health and wellbeing. Activities were tailored to the needs of each community, but included group health information sessions, one to one information, advice and signposting.

1.6 The delivery period of the project was eight months (May to December 2023), with a co- production and set up phase February to April 2023. Adviser induction and training took place April, May and June, with access to on-going training via Newham's Social Welfare Alliance online training programme.

1.7 The Institute for Connected Communities, University of East London was the external evaluation partner for the project. Its role was to support the co-design of the evaluation framework, undertake independent qualitative research (in-depth interviews with participants), and review impact data for comparison.

2. Methodology

2.1 *Alignment to social prescribing data capture and processes*

116 participants recruited by the three grass roots organisations completed a client registration form (see Annex 1). This was designed to align as closely as possible to client data currently captured by Newham social prescribers identifying support and access needs, but also to be relatively easy to administer. The registration form was translated into community languages upon request.

Given the short timeframe, it was decided that the project would not be promoted to Link Workers specifically; however two of the three community groups (Blossom and Heal Together) were already registered on the JOY platform and did get some inward referrals for their group sessions and for one to one support.

2.2 Data collection

The project used an online client management system (Lamplight) to store information from the registration form, and subsequent client activities. Health Advisers were trained to use the system and uploaded information, with the Project Coordinator checking information was entered correctly.

2.3 University of East London Commissioned research

The qualitative research programme ran from June to December 2023 and comprised repeated one-to-one qualitative interviews with beneficiaries (*N*=6) who were receiving services from one of the three participating grass roots organisations. The subsequent report (see references) identified and discussed participant views of the barriers to access health services, and social, economic, language and cultural barriers that prevent some clients from leading a healthy lifestyle or accessing health services to improve their health and wellbeing. It is a rich resource with significant participant feedback.

2.4 Grass roots organisation community of practice

The three grass roots organisations together with the host organisation came together on a monthly basis to evaluate progress and discuss key areas of the programme. The insights shared helped shape the development of the project and provide understanding on challenges and how they were overcome.

At the end of the November, all the participating organisations attended an externally facilitated workshop to review learning and recommend next steps (see references for this Report).

3. Participant profiles

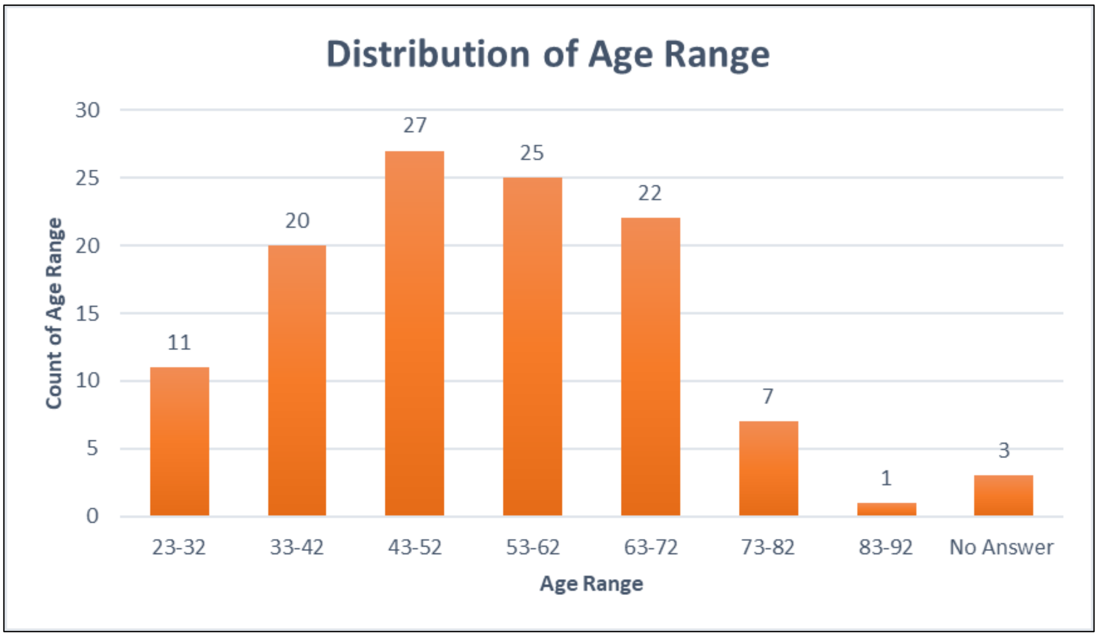
Demographic data were derived from the registration form (see Annex 1).

3.1 Participants, by age and gender

The Health Equity Project recruited 116 participants, through the three grass roots organisations. 70 of the 116 participants were women (60%), 43 (37%) were men and three did not say.

86 participants were registered as a result of the project. Prior to engagement in the project, Blossom (31 new clients) was not delivering services in Newham, and whilst Salem Health (36 new clients) had delivered health education and awareness in Newham in the past, but was not currently delivering group services. Heal Together, which was already delivering services, also registered 19 new clients during the project. The vast majority of participants were of working age.

Chart 1



3.2 Participants by location

Clients of grass roots organisations came from all parts of the Borough, apart from E20 (Stratford Olympic Park), which has a different demographic from the rest of Newham.

Table 1

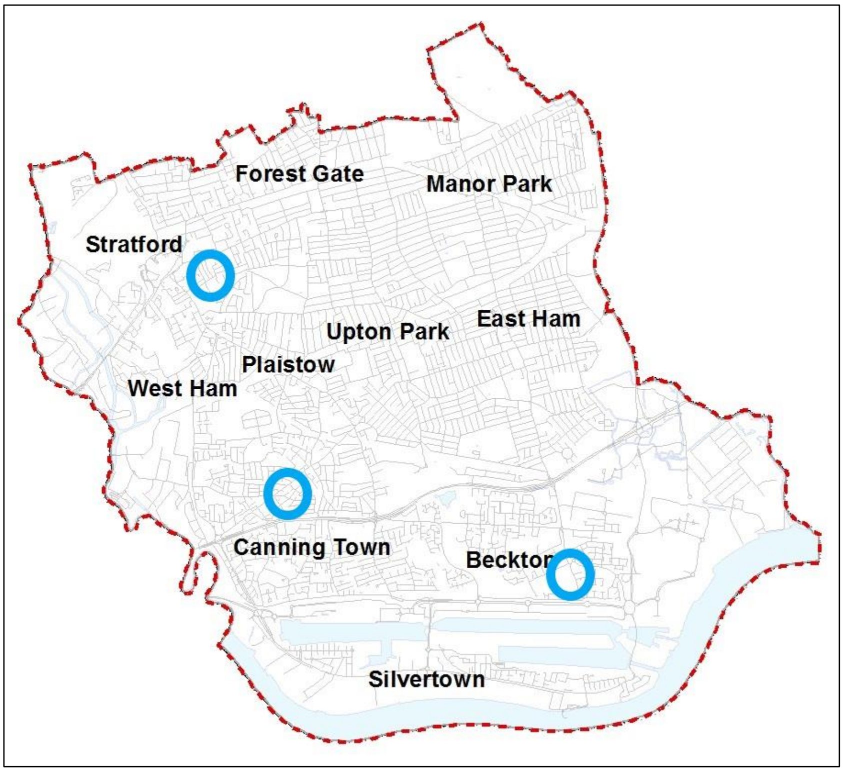
E6	E7	E12	E13	E15	E16	E20	Out of area*	N/a	TOTAL
20	26	11	12	20	18	1	3	5	116

** Clients in safe accommodation due to domestic violence.*

Blossom Place ran weekly Togetherness Cafes from Stratford Library (E15) but later undertook outreach work at faith centres in the east of the Borough. HealTogether is based at Community Links at Canning Town (E16) and both one to one support sessions and the Shaah & Sheeko group were run from these premises.

Whilst the Health Adviser for Salem Health worked from offices in Beckton, he travelled to locations around Newham to meet with clients, and group health education sessions were held in community premises in Forest Gate (E7).

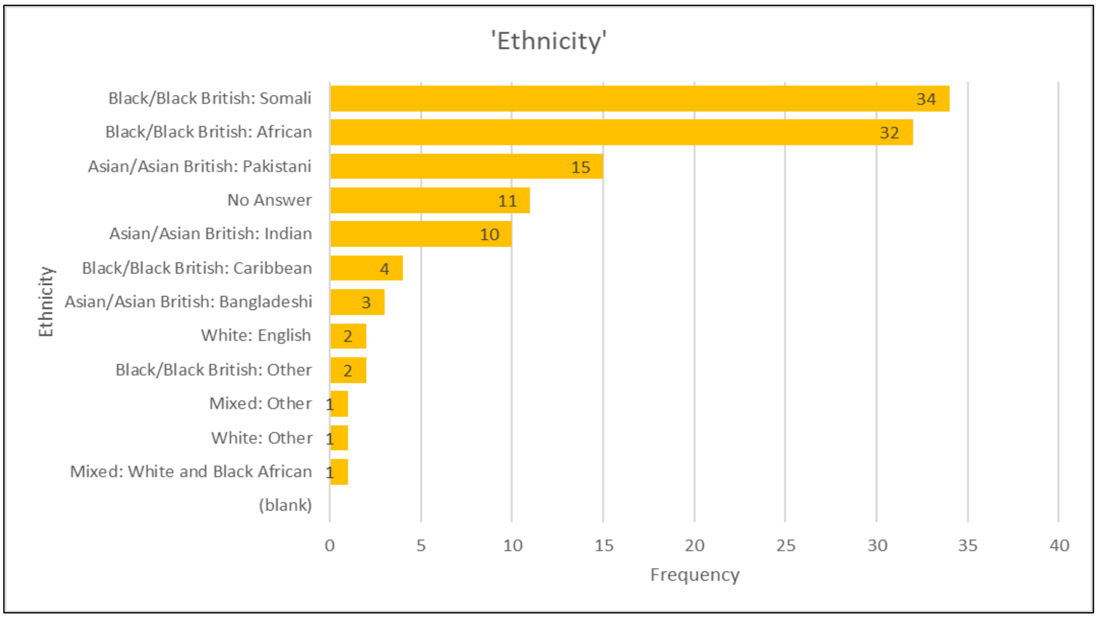
Map of Newham showing location of the three Health Advisers



3.3 *Participant ethnicity*

The three grass roots organisations had been set up to meet the needs of specific underserved cultural groups in the Borough. They recruited participants predominantly from their own networks but welcomed organisational and self-referrals.

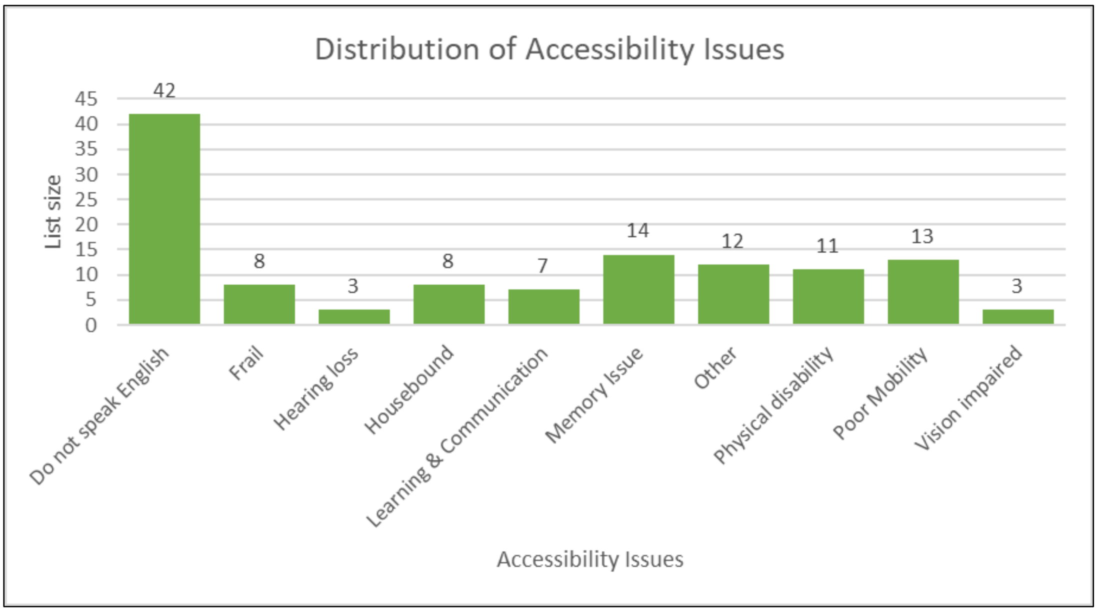
Chart 2



3.4 *Participants' access issues*

Around half the participants in the projects had one or more access issues. The most significant was speaking no or only a little English, but many had physical disabilities or sensory impairments which required extra support.

Chart 3



4. Project activity levels

Overall activity levels across the project, and by grass root organisation, are described by: one to one support and casework, group sessions, and outreach activity.

4.1 One to one support (information and casework)

4.1.1 Total numbers and hours of one to one support sessions

Around 70% (n=83) of participants on the project were registered for one-to-one support, which included almost all Heal Together and Blossom clients.

Table 2

One to one support	Project TOTAL	Group A	Group B	Group C
Number of one-to-one clients	83	37	44	2
Number of one-to- one hours	287	102	175	10

4.2 Group sessions

4.2.1 Overview of activity

HealTogether (Group A) were able to continue to facilitate and run an existing group programme, 'Shaah & Sheeko', for older Somali women at Community Links, Barking Road. These were held on Thursdays.

Blossom (Group B) marketed and ran weekly sessions of Togetherness Café a new group established for the Health Equity Project. A group of Blossom's volunteers and friends took part to launch and support this new group which was a safe space for participants to socialise, to seek help and to get educated about the latest public health and civic information. It ran every Monday at Stratford Library.

Salem Health (Group C) focused on making contact with individuals for their project, although they did have three group health awareness sessions over the summer period at Durning Hall in Forest Gate.

Health and health awareness topics for group sessions were generally chosen according to participant interests, although some topics aligned with awareness weeks (for example, Alzheimer's Awareness Week in May). See Annex 2 for health topics covered.

4.2.2 Number of group sessions

Over the lifetime of the project, grass roots organisations facilitated 46 group sessions of two or three hours' duration, totalling 116 hours. Group size was generally quite large – averaging around 20-22 participants - so total number of participant visits was 991 visits.

Table 3

	Project TOTAL	Group A	Group B	Group C
Number of group sessions	46	21	22	3
Number of group hours	116	63	44	9
Total number of participant visits (attendance)	991	525	407	59

4.3 *Outreach sessions*

Table 4

	Project total	Group A	Group B	Group C
Number of outreach sessions	20	0	14	6
Number of outreach hours	67	0	42	25
Number of people engaged at outreach sessions (total)	245	0	208	37

Heal Together (Group A) did not undertake outreach sessions.

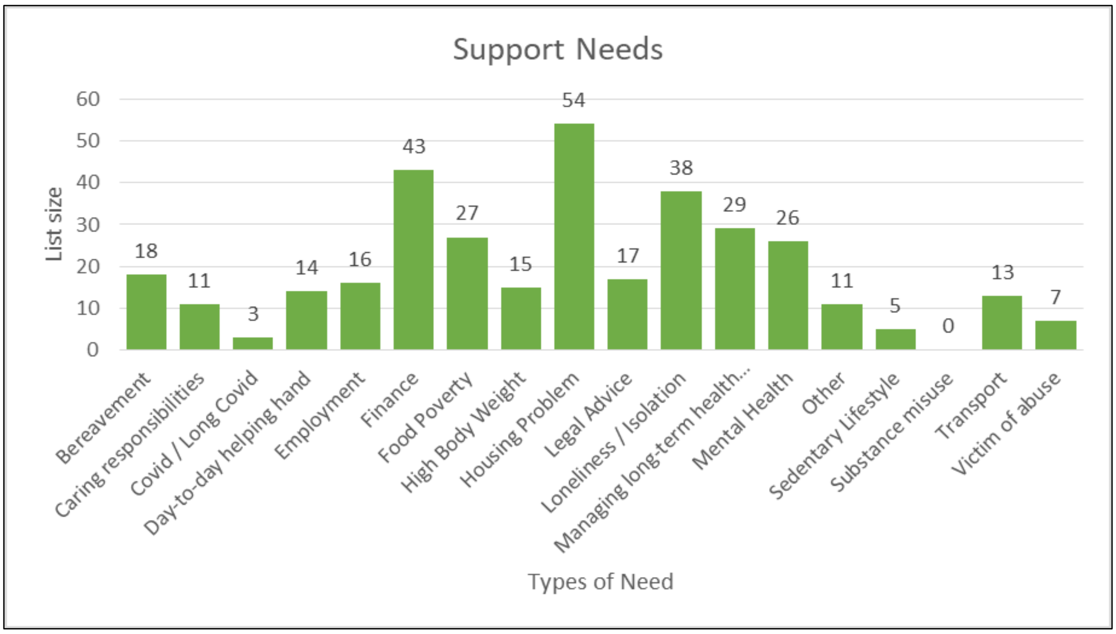
Blossom's Health Adviser set up a regular outreach session at Ibrahim Mosque, from August-November to provide advice, signposting and referrals and a peer support group. He was also invited to run an information stall at two health events at the Gurdwara in Neville Road.

Salem Health (Group C) tested outreach at social venues over the summer - a barber's shop and a local restaurant - in order to talk to people about health issues, give information, and register individuals for health advocacy.

5. Project outcomes

5.1 Support needs of clients

Chart 4



The top two client needs were support with housing problems and finance. These were followed by loneliness/social isolation, and then managing long term health conditions and mental health.

5.2 Clients referred out to other agencies

Heal Together (Group A) and Blossom (Group B) made a number of referrals out to other organisations. The Health Advisers in both these organisations had current or past experience of working in Newham, and were confident in making referrals, in many instances having established relationships and trust with organisations to whom they were referring clients, including culturally appropriate domestic violence organisations. As a consequence most referrals were made direct rather than through the JOY portal.

Table 5

Referrals out	TOTAL	Group A	Group B	Group C
Number of referrals	138	56	80*	2

*including onsite signposting at Stratford Library to the Well Newham Team.

The Blossom Health Adviser found that some health-related referrals were not successful due to the client not engaging in the referral. For instance, a client referred to a bereavement drop in session fed back that they didn't stay to the end because they felt ‘it was not for them’. In some cases the Health Adviser was unable to match existing services appropriately enough to the need.

5.3 *Multiple referrals out*

Health Advisers generally referred their clients to more than one external agency. Multiple referrals for clients is unsurprising, as the majority of clients identified both socio-economic and health needs.

Table 6

Number of referrals made per client	Organisation A Number of Clients	Organisation B Number of Clients
5 or more referrals	2	2
4 referrals	6	2
3 referrals	15	6
2 referrals	8	17
1 referral	6	17
Total number of clients	37	44

5.4 *Comparison in referrals between the Health Equity Project and JOY data*

The subject expert at the Institute for Connected Communities undertook a broad comparison between Health Equity Project (HEP) and Joy data in relation to type of outbound referrals from Health Advisers.

Table 7

	Referrals out	**Top 3 areas for number of referrals**
Heal Together	Community Link Foodbank	15
	Newham GP	8
	HPAS Newham[1] /Housing Benefit Team	6
Blossom	Newham Housing Team	4
	Newham GP	3
	West Ham Foundation	3
	Age UK /Money A4E	4
Joy data	Our Newham Money	85
	Hyla Health and Wellbeing – Live Well Newham (weight loss)	66
	Newham Talking Therapies	37

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[1] Homeless Prevention and Advice Service

He concluded:

“It is a broad comparison as the Joy data is not yet representative of all the services available in the Borough. It is my understanding that data from other services will be entered over the course of this year. Social needs are top across the two projects and Newham (JOY data) with foodbank, housing and money featuring as the top priorities across the three data sources. “

“Referrals to GP practices are important in both community projects (second priority) and perhaps similar to the more health-related concerns in the Joy data too (weight loss and mental health). Other Joy data (not too dissimilar from the previous point) show that the top clients need were (12.3% finance problems, 11.4% housing, 12.2% mental health, 10.2% high body weight). “

6. Project impact

6.1 Impact on participant health and wellbeing (Registration form data)

Project participants across all three grassroots organisations completed two wellbeing questions as part of the initial registration form, self-assessing on a scale of one to five:

- “How do you describe your health & wellbeing?”
- “How confident are you about managing health & wellbeing for yourself?”

The Health Advisers in the grass roots organisations returned to registered clients at the end of eight weeks, or the end of the project, and asked them to repeat the self-assessment questions again. Around 30% (n=34) of registered clients were able to revisit the initial health and wellbeing questions.

Over half of those responding reported an increase in their health and wellbeing, and two thirds said they were more confident in managing their health.

Table 8

Health and wellbeing questions	Number of clients	Average initial score	Average[2] final score	Average change	% clients with increased scores	%clients with decreased scores
“How do you describe your health & wellbeing?”[3]	34	2.03	3.15	1.12	58.8	14.7
“How confident are you about managing health & wellbeing for yourself?”[4]	33	1.85	3.03	1.18	66.7	18.2

6.2 Comparison with JOY data

The subject expert at the Institute of Connected Communities noted:

“The JOY platform has data about personal wellbeing (ONS4) and one question about wellbeing, although the exact details of such a question are not available. I chose this last question, as the ONS4 is made up of 4 questions and so did not seem suitable. According to the single wellbeing JOY question, 53% of clients have shown

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[2] for indicators using the Likert Scale, the ‘mode’ (most frequent response) should be used rather than ‘mean’ as the variable is categorical rather than continuous, however this was not possible with the project management software used

[3] (5-point scale: excellent, good, okay, poor, very poor)

[4] (5 point scale: v. confident, confident, okay, unconfident, very unconfident)

an improvement in wellbeing[5] in comparison with 58.8% from the Health Equity Project data (HEP) shown in the table. As a result, clients to the HEP have shown a stronger improvement than social prescribing clients completing Joy Data.

However, it is important to consider that the clients of the HEP were more likely to have longer, sustained and purposeful relationships with their Health Advisers. Furthermore, when Joy data is examined specifically for ethnic minorities[6], the difference between the HEP and Joy Data is reduced to 2.8% (58.8% HEP versus 56% Joy Data). "

6.3 Participant starting point and journey travelled – Short-Warwick Edinburgh Scale

In addition to completing brief health and wellbeing questions at registration, participants were asked to complete the Short Warwick Edinburgh Mental Wellbeing Scale (SWEMWBS), a standardised measure of mental health with seven items, at the commencement of their engagement with the project.

Table 9

SWEMWBS item	Pre-intervention average score (*n*=20)	Pre-intervention average score (clients with pre and post data *n*=3)	Post-intervention average score (clients with pre and post data *n*=3)
I've been feeling optimistic about the future	2.55	3.67	4.33
I've been feeling useful	2.50	3.00	4.33
I've been feeling relaxed	2.00	2.33	3.67
I've been dealing with problems well	1.70	2.33	4.00
I've been thinking clearly	1.80	2.33	4.33
I've been feeling close to other people	2.40	2.33	3.67
I've been able to make up my own mind about things	2.05	3.33	4.33
Total scale score	**15.62**	**18.31**	**25.89**

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[6] Mixed or multiple ethnic groups; Asian or Asian British; Black, African, Caribbean or Black British; other ethnic groups

In total, three research participants completed pre- and post-assessment on their mental health and wellbeing (within an eight-week period), and a further 17 participants completed their pre-assessment only.

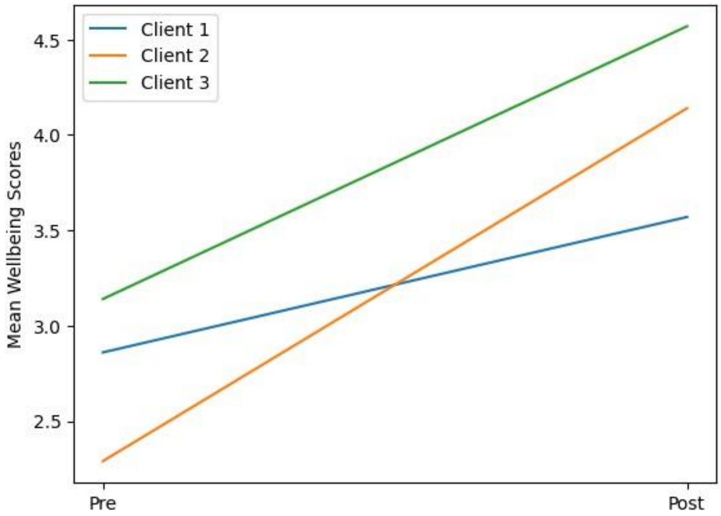
The results indicate that of the 20 clients, 95% reported on perceived mental wellbeing that was in the range for the lowest 15% of the UK population (i.e., 19.5 points or lower), suggesting that the clients represented those groups most in need of intervention to improve their mental wellbeing.

Clients scored the lowest on the item **"I've been dealing with problems well"** in the pre-intervention data, which was also supported by the qualitative results emphasising that one of the programme benefits was getting support to deal with problems, including accessing services, and dealing with issues with housing and other negative life-circumstances identified by other data, including presenting need and client group evaluation sessions. Among clients who completed the pre-and post-measurement as well, the highest level of improvement is shown in the item "**I've been thinking clearly".**

A fuller analysis and discussion of the data is available in the University of East London's Evaluation Report.

Three clients completed both pre- and post-intervention data. The pre-intervention average for these **three clients was 18.31 points** (range: 16.36–19.98), while the post-intervention average was **25.89 points** (range: 22.35–29.31). One client's score reached the UK population upper 15% threshold, indicating good perceived mental wellbeing post-intervention.

Chart 5: pre and post SWEMWBS[7] scores (UEL participants)



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[7] Short Warwick-Edinburgh Mental Wellbeing Scale. https://warwick.ac.uk/fac/sci/med/research/platform/wemwbs/about/wemwbsvsswemwbs/

6.4 *UEL qualitative research – in-depth interviews with Health Equity Participants*

University of East London postgraduate students undertook six interviews with participants. The findings are grouped under five central themes: client satisfaction; health literacy; language and culture; specific areas of health community that the grass roots organisations are dealing with; and the role of GPs as gatekeepers to services. A rich source of data, including quotes, appears in the full evaluation report (see References).

Two case studies are appended (Annex 3).

The evaluation report concludes: “The research participants’ subjective accounts express how exposure to the health equity projects have helped them to reduce levels of anxiety and increase their health literacy, despite living in adverse life circumstances, compounded by a sense of social isolation and loneliness. Research participants have in effect increased their health literacy as a direct result of being involved in the projects. In view of that, their motivation to build healthy lifestyles is centred on the trusted relationships with the Health Advisor and peers. Undoubtedly, the opportunity to get involved in tailored group-centred and person-centred sessions has been the catalyst for change captured by the research participants.”

6.5 *Identifying unmet health needs*

The Health Advisers noted that there were a number of clients with unmet health needs - even though they were registered with a GP - who were not being reached by health services prior to being supported by the Project. For example:

- A female client who had been hiding or masking memory issues and had not recognised or engaged with the early signs of dementia was supported to identify her health issues and attend a memory clinic;
- A male client had not left the house for eight years due to their mental ill-health. They were connected to the service through a female relative and it was identified the person had been receiving repeat depression medication for years without seeing a medical professional.

7. Participant and customer satisfaction

7.1 Popular health education topics

Annex 2 summarises the health topics that were covered in the regular groups run by Heal Together and Blossom.

Heal Together (30th October) and Blossom (9th November) hosted celebration sessions at which the host organisation facilitated an evaluation by participants of the group sessions. For Heal Together the most popular health topics were Vitamin D deficiency, wellbeing and mental health, diabetes and dementia. For Blossom the most popular topics were healthy eating, wellbeing and mental health, how to deal with trauma, and meeting healthcare professionals.

7.2 Where participants go to ask for help on health and wellbeing

Participants were asked to discuss the question, and then were given three votes each to allocate to pre-determined areas.

Community groups (Shaah & Sheeko or Togetherness Café) were most frequently mentioned as a source of help, followed by the GP surgery. Interestingly there was significant divergence on how important family was as a source of health and wellbeing information.

Table 10

Where would you go to get help on your health and wellbeing? (no. of votes)	
Heal Together participants	*Blossom participants*
Community groups (incl Shaah & Sheeko) - 21	Community groups (incl Togetherness Café) 19
GP Surgery (GP, nurse, social prescriber) - 15	GP surgery (GP, nurse, social prescriber) - 17
Family members - 11	Family members - 1
Faith places - 9	Faith places - 8
Online - 8	Online - 11
Friends - 4	Friends - 6
Newham Council services - 4	Newham Council services - 1
Other professionals - 0	Other professionals (pharmacist, dentist) - 11
Other - 0	Other - 1
I don't go anywhere to ask - 0	I don't go anywhere to ask - 1
72/3 = 24 respondents	75/3 = 25 respondents

7.3 What did people get from participating in a group?

Participants at each of the evaluation sessions were allowed three votes each. The groups clearly fulfilled personal, social and belonging needs, but getting information about health was also highly valued, as was the chance to learn something new.

Table 11

What have you got from participation in the group? (no. of votes)			
Heal Together	*votes*	*Blossom*	*votes*
Good food	15	Learn something new	17
Sense of belonging to a group	13	Express and share experiences	12
Friendships, chat and laughs	13	Friendships, chat and laughs	11
Learn something new	11	Health and wellbeing information	11
Health and wellbeing information	9	Sense of belonging to a group	13
Feeling good	9	Feeling good	8
Personalised 1-1 support	9	Personalised 1-1 support	4
Dancing and exercise	8		
Express and share experiences	8		
Other	1	Other	4
96/3 = 32 respondents		77/3 = 26 respondents	

7.4 Feedback from clients participating in the University of East London research

UEL in-depth interviews emphasised the value of group activities to reduce their sense of loneliness and social isolation:

- “It helps ’cause you need other people, and then it just makes you realise that you’re not alone, you’re not struggling alone.”
- “You have a place where you can speak …and get good advice … now I know what views I wanna do to get a good job … I know exactly what steps I need to take because I’m going to that group.”
- “It [the project] provides a reason to leave the house and something to look forward to, making individuals feel less isolated. It is also helpful for those who do not speak the local language.”
- “It has helped reduced my loneliness as I socialise more and have increased my levels of exercise.”

Trust in the Health Adviser that they could practically help – across health and non health matters - was also strongly affirmed:

- “[The Health Advisor] is having a lot of relationship with a lot of services, which I usually wouldn’t have been able to access individually.”
- “So, whatever problem you’re having, if it’s a housing situation or if it’s a repair, or if it’s a medical thing, [the Health Advisor] being there to help you.”
- “I like the fact that [the Health Advisor] speaks the language, knows the culture, and she’s very in tune to what’s going on and non-judgmental, open and welcoming. Environment, where you feel like you are talking.”
- “To get a GP appointment is a struggle, and therefore [the Health Advisor] helps me in accessing my appointments.”

8. Challenges encountered during project implementation

8.1 Set up time

Grass roots organisations were on interview panels for recruitment of Health Advisers. Following formal recruitment processes took longer than expected: Health Advisers were required to have a recent Enhanced Disclosure & Barring Service certificate, and for one Adviser, this took several weeks to come through.

8.2 Project metrics

As a demonstrator project, metrics were very important. The client registration form was designed to be as easy to complete as possible. Where a community group favoured a fairly informal approach to collecting data, and clients were distrustful of authority, it could be challenging obtaining personal data.

A significant issue was the collection of wellbeing data using the shorter Warwick-Edinburgh questionnaire. Health Advisers were concerned that many of their clients were not familiar or comfortable with abstract questions about health, and that the barriers were not just language, but cultural ones including the concept of individual wellbeing itself.

8.3 Client reporting

None of the three community organisations had used a client management system (CMS) before, although some Health Advisers had previous experience of some CMS systems. Whilst Advisers received technical training, the time required to put information on the system was significant and underestimated. Some Advisers were supported by volunteers to upload information, whilst others did this themselves.

8.4 Navigating roles: the Health Adviser role within the community organisation

Two of the three paid Health Adviser staff, who reported to the host organisation, were also Directors of the participating grass roots organisations. This brought huge expertise, contacts and credibility to the project, but required a commitment to open and clear communications to discuss any issues around this dual role. One Health Adviser staffer had not been intimately involved in the community organisation they were working with. The community organisation leader was brought in to regular meetings and accessed training, but line management remained the role of the host organisation.

9. Some Learning points

The ART (Access, Relevance, and Trust) model used by LB Newham Public Health team was used as a framework for project learning.

9.1 Did we address the right barriers for people to access support?

9.1.1 The project's administration, and all the Health Advisers, addressed barriers identified at the co-production stage through a commitment to translation, a review of material for cultural appropriateness, being able to translate/summarise expert speaker presentations in community languages, and the ability of grass roots organisations to provide culturally appropriate support.

The project highlighted some of the finer points of these barriers:

- Comprehension – inability to understand health terminology, health care system or concepts – clients from one community organisation originally registered as sight impaired because they wore spectacles;
- Information – unable to access or understand information;
- Culture – disinclination to engage with health care that does not feel culturally relevant or respecting;
- Accessibility – inability to access health care services or support either due to physical inability to access a service or inability due to digital exclusion.
- Language support and assistance needs to be available to support clients being referred
- Holistic support discussions within culturally appropriate contexts.
- Active listening and non-judgmental interactions.
- Creating safe, trusted spaces for sensitive discussions.
- Community outreach in spaces like barbers, mosques, and other gathering places.

9.1.2 Offering explanations about health issues and health education in community languages and simplified formats is essential. Whilst the provision of translated materials or website pages by the NHS is positive, it still does not help many people, especially older people, who cannot read or write in their own language. Groups would like to have found the time to develop their own social media videos to communicate with their communities in their own spoken language.

9.1.3 The Project's Health Advisers gained deeper insights into how the financial and housing situation of clients directly impact on their health:

- Lack of appropriate housing was seen as preventing clients from being able to address their health concerns or in some cases causing new or additional health concerns. e.g., single mother already struggling in temporary housing with an autistic or disabled child found the health situation getting much worse as the child developed asthma and eczema, suspected to relate to the poor condition of their living accommodation.

- Lack of money, food and housing was seen to have a significant negative impact on mental health of clients. Very much in the same way as identified in Maslow's hierarchy of needs[8], people were unable to successfully grapple with their health issues without first addressing their immediate needs for food and safe accommodation.

9.1.4 Building trust, which takes time, was seen as absolutely essential by Health Advisers to enable clients to feel confident to "open-up" and discuss sensitive and private issues, especially when these relate to areas of health or wellbeing that can be connected to strong beliefs and taboos: their clients would not of their own accord discuss issues such as mental health in front of an NHS worker because of deeply held beliefs and mistrust.

9.2 What is a more appropriate way of providing support – Groups or one to one?

9.2.1 There was a variety of experiences of the role of group activities compared to one to one activities. Some Health Advisers started work with their clients on a one to one basis and then encouraged group activities as part of the follow up support. In other services, the work started off as a group activity and then individuals were supported one to one with their specific needs.

9.2.2 Different approaches might be appropriate depending on the circumstances of grass roots organisations, and whether the specific community has a preference for group activities, online or face to face. For organisations serving a small dispersed community across several Boroughs, the group format may not be one that works easily. However, it is clear that trust and discussion flourishes in face to face groups, and that health education can sit well here.

9.2.3 In the case of Salem Health, it delivered health education work both on a one to one basis and through group sessions. However it had no existing group format that could be rolled out for the project, and in this community the availability of potential and actual clients during the working day was limited. It may be relevant that the Health Adviser for Salem was the only Adviser recruited who did not have a previous close engagement in the client activities of their grass roots organisation.

9.2.4 It can be noted that for some communities, raising awareness about behaviour that risks health may be a more critical action to reduce health inequality than referring individuals through social prescribing channels.

9.3 What does a community organisation need to have in place to run a successful health advice and advocacy project?

With the caveats above, Health Advisers and the host organisation identified what community organisations should have in place to support this model of delivery.

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[8] https://www.simplypsychology.org/maslow.html

Table 11

What do community organisations need to have in place?
1. The community group needs a community space that is, or can become quickly recognised, as a safe place for confidential dialogue on a one to one basis
2. The community group is already running regular group activities that encourage trust and engagement and which can be developed or extended to more clients to deliver health education, advice and advocacy
3. The community group can offer practical support, case work and referrals for cost of living and other problems to clients as well as health education and advice
4. The community group has appropriate skills within the staff and volunteer group to deliver quality practical support and referrals for clients
5. Members of the community served by the community group have sufficient trust to give personal information required for referrals and advice
6. The community group has a robust marketing plan to reach community members, which can be adjusted according to circumstances
7. The project uses culturally appropriate and translated materials for marketing, for health education work, and for client registration and monitoring
8. Health advisers should be bilingual: they must speak, write and read the language of the community they support but also be fluent in speaking, writing and reading English

9.4 Does GP registration mean wider health and wellbeing issues can be addressed?

The data showed that the majority of clients (93%) were registered with a GP. However at an externally facilitated evaluation session of the Health Advisers in November, participants noted some project clients revealed that they did not engage with their GP and some had not had a GP appointment for years. Other clients accessed their GP to manage specific medical issues <u>but did not engage with their GP to address wider health and wellbeing concerns</u>. Health Advisers felt therefore, that registering with a GP cannot therefore be taken as an indicator that health inequalities are being addressed.

9.5 Measuring and benchmarking client health and wellbeing

9.5.1 There was significant debate at set up stage of the project about implementing health metrics that could measure difference made. It was agreed to opt for the Shorter Warwick Edinburgh Mental Wellbeing Scale and use translations in relevant community languages.

9.5.2 It was noted that benchmarking in social prescribing is made difficult by the lack of a common metric. If one is being developed, the feeling from the Health Equity Project organisations is that it should be a short and easy to administer as possible, and available in community languages.

9.6 What would be helpful if the model was going forward?

9.6.1 Delivery partners were very excited about the future possibilities of delivering this type of service, and the potential for One Newham to continue to foster the development of collaborative delivery and partnership working amongst a greater range of grassroots groups.

9.6.2 A longer period for delivery of the service would allow community groups to recruit and support more new customers for the health advocacy service, both through marketing to particular segments in their community, for example men, and through having more time to build word of mouth reputation and peer referrals.

New services always take time to get set up and get known by potential customers and by social prescribers, and a longer time frame for delivery would also deepen relationships between Health Advisers, clients and social prescribers. Finally, a longer project time frame makes for a more attractive recruitment proposition for the key skilled people in small grass roots organisations who would be employed to deliver the service.

9.6.3 Because of the short term nature of the project, formal engagement with social prescribers in Newham was limited. However, in any roll out, more dialogue between social prescribers as to appropriate referrals and anticipated support for clients referred out to new services should be made.

9.6.4 Support for childcare for participants of group health education sessions through the provision of a dedicated person would optimise participation.

9.6.4 Delivery partners made the following recommendations (see Annex 5):

- Developing a health advocacy skills set for staff and volunteers of community organisations was an important step in reducing health inequity, and developing an accredited programme (an Adviser Academy?) to achieve this, with One Newham having a role in this;
- Involving more grass roots organisations would enable the model to refine its reach to particular sections of communities with lower engagement with health services, for example, men, pregnant women, young people and older people;
- Communities do not necessarily fall into neat administrative areas, and consideration should be given where appropriate to working in a wider geographical area, which the Integrated Care System might offer.

References

Institute of Connected Communities, University of East London: Health Equity Project Evaluation Report, January 2024

One Newham: Health Inequity Project, Self Evaluation Report, November 2023

Locality: Community Anchor Organisations – prevention services and the wider determinants of health, January 2023

https://locality.org.uk/news/creating-health-and-wealth-by-stealth-report-launched

Annex 1

Health Equity Project Client Registration Form

Section 1: Client Profile

Client's Name:	**Mr/Miss/Ms/Dr**		
Address:		**Post Code:**	
Contact No. / Email:			
Gender:	☐ **Female** ☐ **Male** ☐ **Transgender** ☐ **Prefer not to say**		
Date of Birth:	**Ethnicity:**	**Main Language:**	
Do you live alone? ☐ **Yes** ☐ **No**			
What do you need support with?	**Needs to support (A - I):** ☐ Bereavement ☐ Caring responsibilities ☐ Covid / Long Covid ☐ Day-to-day helping hand ☐ Employment ☐ Finances ☐ Food poverty ☐ High body weight ☐ Housing problem ☐ Immigration status	**Needs to support (L - Z):** ☐ Legal advice ☐ Loneliness / Isolation ☐ Managing long-term health condition(s) ☐ Mental health ☐ Sedentary lifestyle ☐ Substance misuse ☐ Transport ☐ Victim of abuse ☐ Other ( )	

Section 2: Health Background

Are you registered with a GP? ☐ **Yes** ☐ **No**				
How do you describe your health & wellbeing?				
☐	☐	☐	☐	☐
Excellent	**Good**	**OK**	**Poor**	**Very poor**
How confident are you about managing health & wellbeing for yourself?				
☐	☐	☐	☐	☐
Very confident	**Confident**	**OK**	**Unconfident**	**Very unconfident**

Do you have accessibility issues? If so, what?	☐ Vision impaired ☐ Memory issue ☐ Hearing loss ☐ Housebound ☐ Mobility issue ☐ Frail	☐ Speak little / no English ☐ Learning & communication ☐ Physical disability ☐ Other

Section 3: Client Information Consent

I give my consent to Newham New Deal Partnership collect my personal information in order to provide me with advice and services through the Health Equity Project.

I understand that:
- the law may require Newham New Deal Partnership to disclose information about me if there are concerns for my safety or wellbeing;
- where services are delivered by Newham New Deal Partnership with other organisations, information about me may be shared with partners in order to provide a service;
- Newham New Deal Partnership complies with the General Data Protection Regulation (GDPR) and will keep my personal data secure. I may be contacted occasionally so that Newham New Deal Partnership can check that my personal data is correct and up-to-date;
- Newham New Deal Partnership will keep my information confidential and not use it for anything except delivering, managing and evaluating services.

☐ I further give my consent that my contact details only can be shared with a partner organisation (Blossom/HealTogether/ or Salem Health) at the end of the project so that they can keep in touch with me about other/future services.

Consent & signed by:	
Date:	

Section 4: Client Photo / Video Consent

I give my consent to Newham New Deal Partnership to use photo(s) / video(s) of me for the Health Equity Project. I understand that photo(s) / video(s)

- will be used for project evaluations;
- might be used for publicity in Newham New Deal Partnership and the partner organisations: Blossom, HealTogether and Salem Health;
- will NOT be used for any commercial matters.

Consent & signed by:	

Annex 2

Health topics discussed/presented at Group sessions during the project

Group A (Heal Together)
Alzheimer’s Awareness (Including exercise sessions & brain stimulation workbook)
Bereavement Awareness
Cost of Living by Our Newham Money team.
Dementia Awareness (Including exercise sessions & brain stimulation workbook)
Diabetes
GP's services and lack of support for our community
Housing: Private Sector Housing - How to access support by Newham Private Sector Housing Team.
Housing Overcrowding - Discuss the effects of overcrowding on our health and well-being.
Medication (how to take medicine, especially the common medicines for high blood pressure, diabetes and high cholesterol.) with a pharmacist
Menopause Awareness and how to access GP services
Mental Health - Access and lack of access to services for our community.
Substance Misuse Awareness joint by CGL to discuss the effects of drugs & alcohol.
Suicide prevention Awareness by Newham Public Health Team
Vitamin D Deficiency Awareness by Newham public health team - Healthy Start.
Women's health – Awareness of Breast Cancer and Screening.

Group B (Blossom)
Trauma
World Alzheimer's Day
Sepsis
Suicide Prevention
Hypertension
Meet with healthcare professionals and dietitians
Sickle Cell Disease
Bereavement
Pancreatic Cancer
Let’ s talk about my worries
Community Health discussion
Let’s play board games and cards
Bringing your old clothes back to life
Cardiovascular Heart diseases, strokes
Healthy Eating channa and chaat how to make your own
Well Diabetes Community Drop-in Event organised by Well Newham @St Bartholomew’s Church
Health Eating: CHAI AND CHAAT
Let's Talk about me-Togetherness Café

Annex 3

Case studies: Participants interviewed by University of East London

Case Study One (client of Heal Together)

Participant One is a young Somali female who has been experiencing homelessness, depression and anxiety. She is a mother of three children aged three, five and seven, and she is of Islamic faith. Despite her challenges, she has been attending the Heal Together group for two years, and she has recently joined a new group for women aged 18–35. Although she feels out of place due to her age and having children, she enjoys the mix of cultures in attendance, and she has been actively engaged in the group's discussions.

It is evident that the project has been beneficial to Participant Two, and she has faith in the Health Adviser to support her. However, she has been facing difficulties attending the Heal Together group consistently due to childcare issues, and she would benefit from some sort of provision for childcare if possible. Additionally, Participant Two is currently applying for disability benefits due to her deafness, but her first application was unsuccessful. It is crucial to support her through this process, and to ensure that she receives the necessary assistance to appeal the decision.

Overall, Participant Two's active seeking of support and engagement in various groups and projects is a positive step towards improving her wellbeing. It is essential to continue providing her with the necessary support and resources to ensure that she can continue to actively participate in these groups and access opportunities to improve her wellbeing.

Case Study Two (client of Blossom)

Participant Two's story is a testament to the importance of community support and access to healthcare services.

Despite facing physical challenges that prevented him from working, he found hope and support through the Blossom project. The project provided him with a support worker who helped him navigate the complexities of the healthcare system, and reduced his stress levels. Having someone who could communicate fluently in his native language also made a significant difference in his ability to access care and ask for help.

Moreover, the Blossom project has made a significant impact on Participant One's overall wellbeing. Through the project, he learned the importance of taking care of his health, and received guidance on healthy food choices and physiotherapy exercises. He also found a sense of routine and community through the project's Togetherness Café, which helped him feel physically and mentally stronger.

Annex 4

How can existing health and wellbeing services be more relevant and accessible to minoritised communities?

Key points made by Health Advisers at reflective learning sessions to support health equity

Culturally competent support for health education

For people do not understand the concept of maintaining good health, hospitals and tests are viewed as something for people who are ill. People often ignore letters inviting people for tests, as they do not understand them. This can be mitigated by:

- Health Explainers from the community - people who look like you and speak your language – who can explain and challenge views on vaccination, use of bloods, and diagnostic tests
- Information/videos in community languages on maintaining good health and wellbeing which is focused on life stages. (For example, for over 50s, the check-ups that are available such as mammogram, prostate cancer, colo-rectal cancer (poo tests), high blood pressure)

Support for GP and hospital appointments

- “People with language skills must be part of GP services. If people are accessing GP services and don’t get the services they need, they just drop out and when they come back it is too late – they have a serious health condition”
- “GPs generally do not utilise Language line to support diagnostic interviews. I have people who have been diagnosed with conditions who do not know what the conditions mean.”
- Some people did admit that they missed hospital appointments because no one will go with them. And they really struggle with the language. And they said someone would have said to us. I’d explain to them that there’s always people there to be an interpreter if they need to be provided.

Navigating the system

- Gaps in knowledge about community services and what is available out there
- How do we book an appointment with a social prescriber? Do we have to go to the GP first?
- Advocate/buddy support for those without family or friends to give confidence to attend appointments and referred services
- Digital/language exclusion to register and engage in services, including diagnostic tests

Space for trust, community groups working with other providers

“We need to create trusted spaces where community groups serving minoritised communities can work with health providers”

Culturally competent End of Life/Bereavement services

- “Not enough bereavement services available for minoritised communities and the ones that are available are over-subscribed”
- Difficult to navigate end of life, procedures, such as donation of organs
- What happens when someone dies at home?

Culturally competent Mental health services

Mental health is a huge issue in many minoritised communities, and is exacerbated by poverty, poor housing and trauma. People from these communities are particularly affected by long waiting lists.

“A speaker from the NHS said mental health is a stigma for certain communities. Our group said no it is not, but we want the space and trust and someone to talk in a way that we understand.”

“In our community we think about problems with a group and community mind-set. Our community benefits from shared experience. Mental health is dealt with in an individualised, Western manner which does not resonate.”

Women’s hubs

“Black women are highly likely to be dismissed and not diagnosed - they are talking, complaining, but people are not listening to them. We need more support for women’s hubs so people can talk through stuff like menopause, miscarriage, pregnancy. “

Annex 5

Developing the model further: Project community partner self-evaluation

Externally facilitated by Ruth Bravery, the delivery team for the Health Equity Project met on 27th November for an evaluation session. This is the feedback from that meeting about taking the project forward.

The workshop participants were very excited about the future possibilities of delivering this type of service, and the potential for One Newham to continue to foster the development of collaborative delivery and partnership working amongst a greater range of grassroots groups. Three further "wish list" items were identified for the future development of the programme:

Involve more grassroots groups
Workshop participants felt there were more residents in Newham who would benefit from the Project, including members of particular communities such as young people, elderly people and pregnant women. Participants said the Project had "barely scratched the surface" of the health inequality being experienced by Newham residents. Participants felt the Project would be enhanced by involving a greater number of grassroots groups, including groups focusing on other languages and particular groups of residents, for example, pregnant black women.

Adviser Academy
There was some debate amongst the workshop participants whether the Adviser should have advocacy skills or whether they needed to be a qualified advocacy worker. There was however agreement that One Newham could play a role in supporting the growth of advocacy skill set amongst voluntary sector people in Newham. It was postulated that there could be an Adviser Academy where people from the voluntary sector or the community in Newham who are performing the Adviser role can participate in a formal accredited training programme to raise the overall skill standard in the borough. It was thought this could be set up using a vocational Apprenticeship model, with Advisers learning whilst they worked. This was seen to have two further benefits: Firstly, it would provide a route for Advisers to have regular supported casework discussions to share experiences and expertise and participate in reflective practice. Secondly, the general upskilling of people in Newham through such an Academy would develop a strong workforce in the borough of people who could work in a wide range of roles including in the statutory, healthcare, care home and domestic care sectors.

Beyond Newham
Whilst it was well understood that for the purposes of the pilot the clients needed to be residents of Newham, all groups found this restrictive and meant they were unable to support potential clients living in neighbouring boroughs. It was clear that people are attracted to groups because of identification with faith, ethnicity or/and language and that membership of groups did not fall into neat borough boundaries. Members of those communities may also move home, whether voluntarily or imposed. Workshop participants welcomed the opportunity to support clients in more boroughs, perhaps under the wider geographic umbrella of the Integrated Care System.