Welcome to the Population Health & Equity Conference

One year on -
From Design to Delivery

29 June 2023
Kia Oval

SOUTH EAST LONDON COALITION

FOR BETTER HEALTH AND EQUITY

WORKING TOGETHER TO IMPROVE THE HEALTH OF OUR COMMUNITIES

Jill Lockett & Andrew Bland

Co-chairs, KHP-SE London ICS Population Health & Equity Executive

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South East London Integrated Care System

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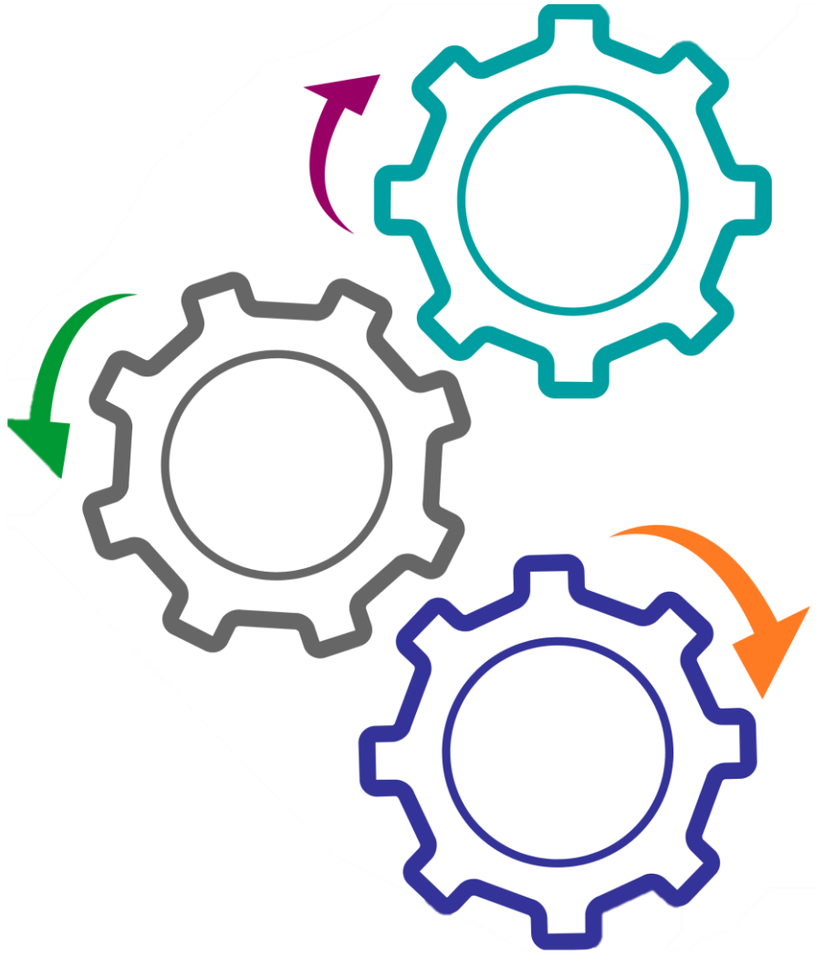
KHP & SEL ICS together strengthens the system's ability to reduce disease burden and health inequalities and improve health equity



Cog 1:Population Health Management

Cog 2: Prevention and Equalities

Cog 3: Making the most of our assets

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Our partnership builds on our assets and helps us be stronger than the sum of our parts for the benefit of local citizens.

ASSETS

Our assets and capabilities are significant. We need to be more co-ordinated and tactical in our approach. The development of the Health Data Science Blueprint provides a significant opportunity along with development across One London. We have a global population on our doorstep, with active citizens to help drive our programmes and modernise how we work

OPPORTUNITIES

Academic partnerships and joint grant developments add value to the NHS interface in place based and primary care teams. Lambeth HEART £5m. There is a significant brand potential here and a show case for clinical academic partnership & citizens voice.

INNOVATION

We have the building clocks for a stronger innovation pipeline connecting the innovation teams in providers, the voluntary sector and with the AHSC & AHSN.

Maudsley Charity Backing Better Mental Health.

Impact on Urban Health

CITI

NHS Digital

hin Health Innovation Network South London

King's College London

NHS Guy's and St Thomas' NHS Foundation Trust

NHS King's College Hospital NHS Foundation Trust

NHS South London and Maudsley NHS Foundation Trust

NIHR | National Institute for Health and Care Research

Population Health Management

Improving population health by data driven planning & delivery of care to achieve maximum impact

Chaired by Dr Jonty Heaversedge

Joint Medical Director, Lead for Population Health, SE London ICS

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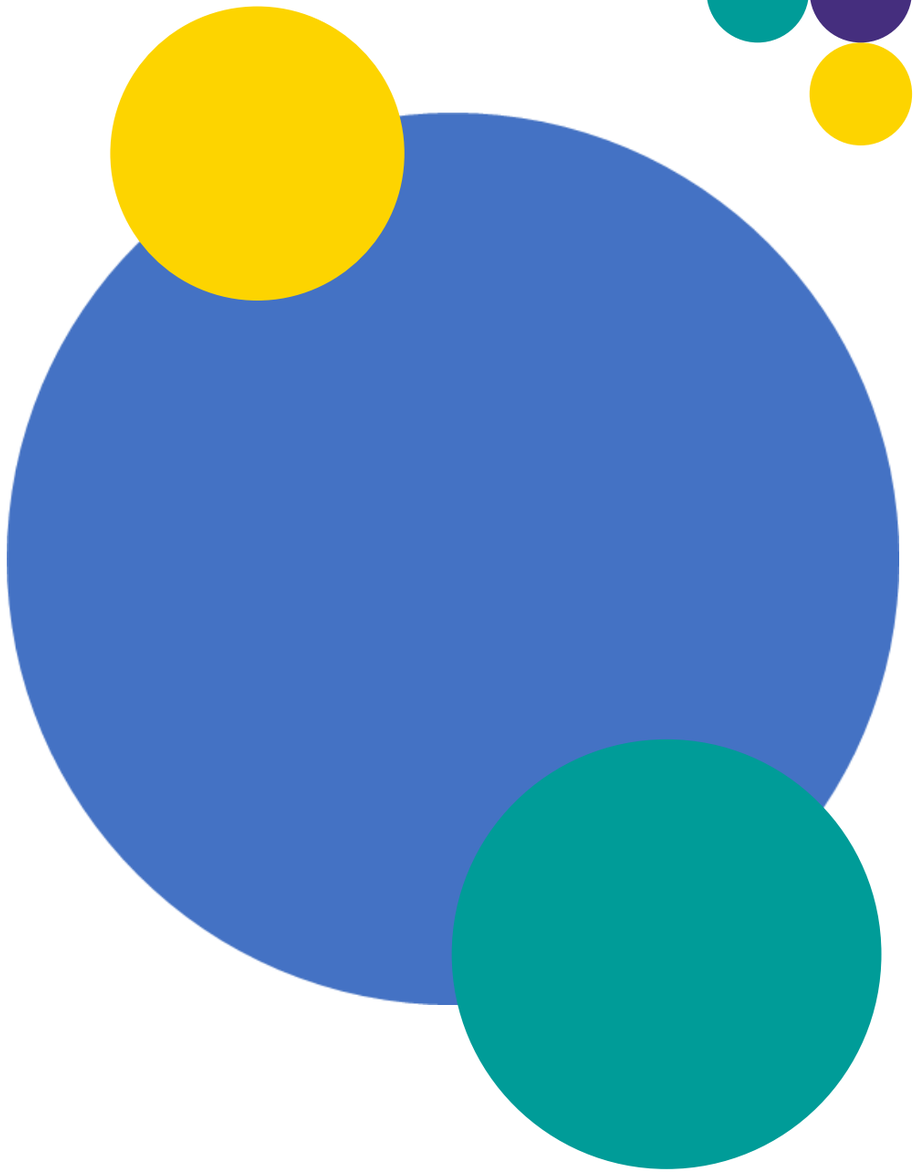
Dr Jonty Heaversedge

Joint Medical Director, Lead for Population Health,
SE London ICS

Dr Siân Howell

Clinical & Care Lead for Population Health Management & Equalities,
SE London ICS



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NHS South East London

A vision for population health management

Siân Howell and Jonty Heaversedge

June 2023

Say what we mean and mean what we say

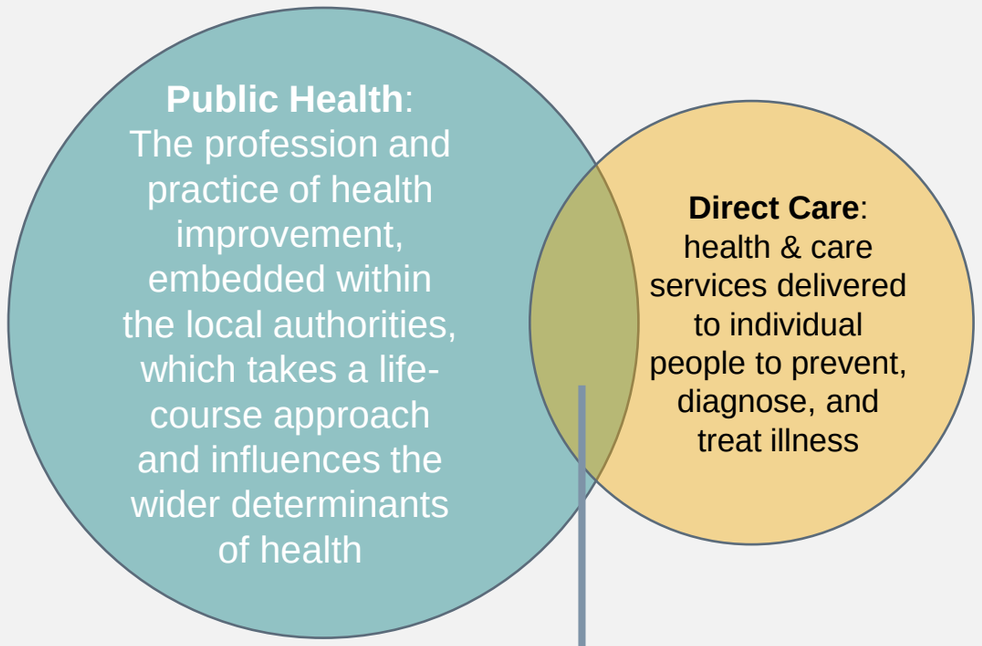
South East London Integrated Care System

- New concepts can be useful in bringing new insights, but **buzzwords** can also cause ambiguity.
- Through the description of **'Population Health',** and its attendant concept of 'Population Health Management', we have a tremendous opportunity to make genuine progress in reframing the purpose and practice of local public services and improving the outcomes, and reducing the inequalities, experienced by our communities.
- However, to make that progress we need to have a **clear description of the concepts** that we are talking about, **how they interact**, and **how they relate to specific agencies** with the resources and responsibilities to do things.
- It does not need to be perfect, but it needs to separate out **who needs to do what** so that, in aggregate and across agencies, policy and practice are aligned to make improvements. We are nowhere near that clarity yet.
- So we need to say what we mean, **being clear about the consequences** for individual agencies, and then mean what we say by managing the implementation of those roles and responsibilities.

Say what we mean…

Population Health, Public Health, and Population Health Management are three **important and <u>distinct</u> ideas**. They are not synonyms, but they are inter-related.

Population health: a description of the overall health of the population and how this is distributed across the population

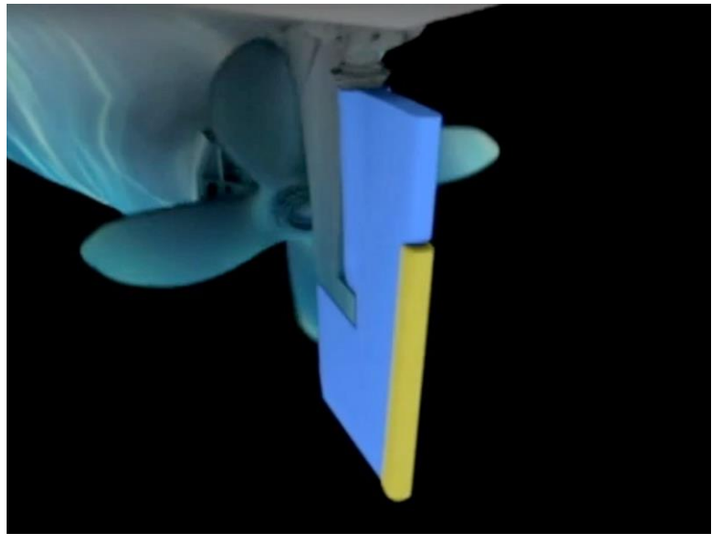


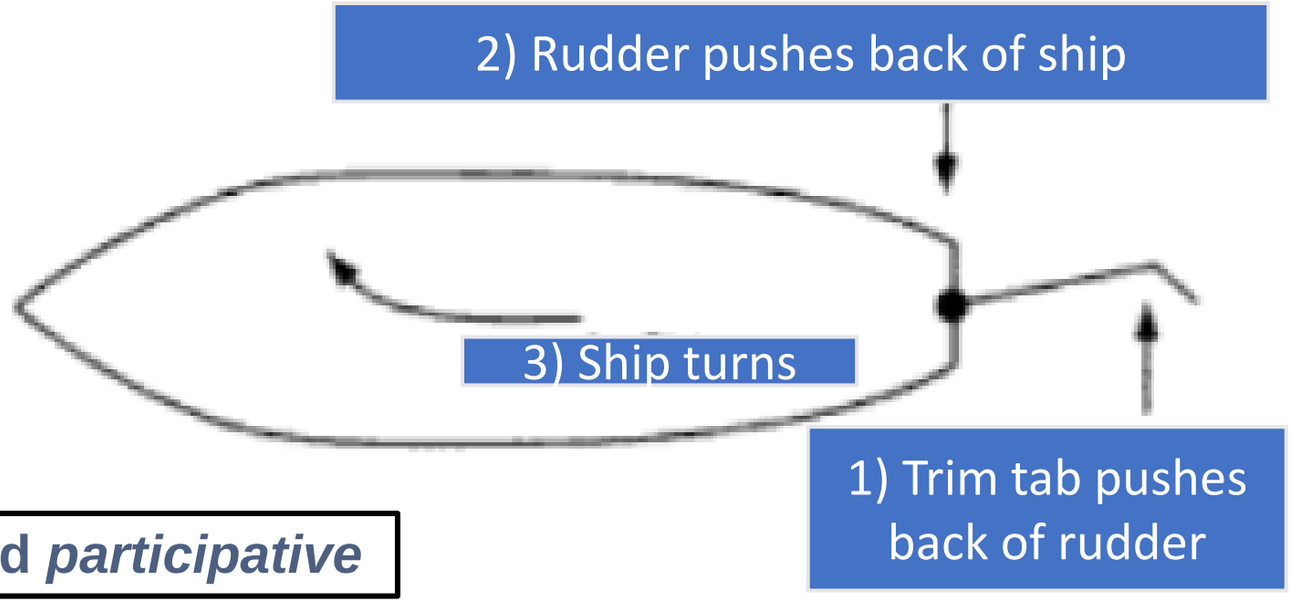
<u>Population Health Management for a list-based population</u>:
the activities undertaken by providers of health and care, using clinical and analytical methods, to systematically identify and address prevention gaps, diagnosis gaps, treatment gaps, and to provide more tailored support for people with complex needs. These need to be commissioned by health and care systems based on a good understanding of population health needs.

Systematically using insight to drive improvement and change - providers of care supported to identify and act on:
Prevention Gaps | Diagnosis Gaps | Treatment Gaps | Complex Needs

- PHM is about ensuring we do effective things, with an eye to improving equity
- This is a general approach, and can be used across a lot of pathways
- Need to get going with one or two examples – **avoid boiling the ocean**, so focus on areas where we can get traction

And mean what we say…



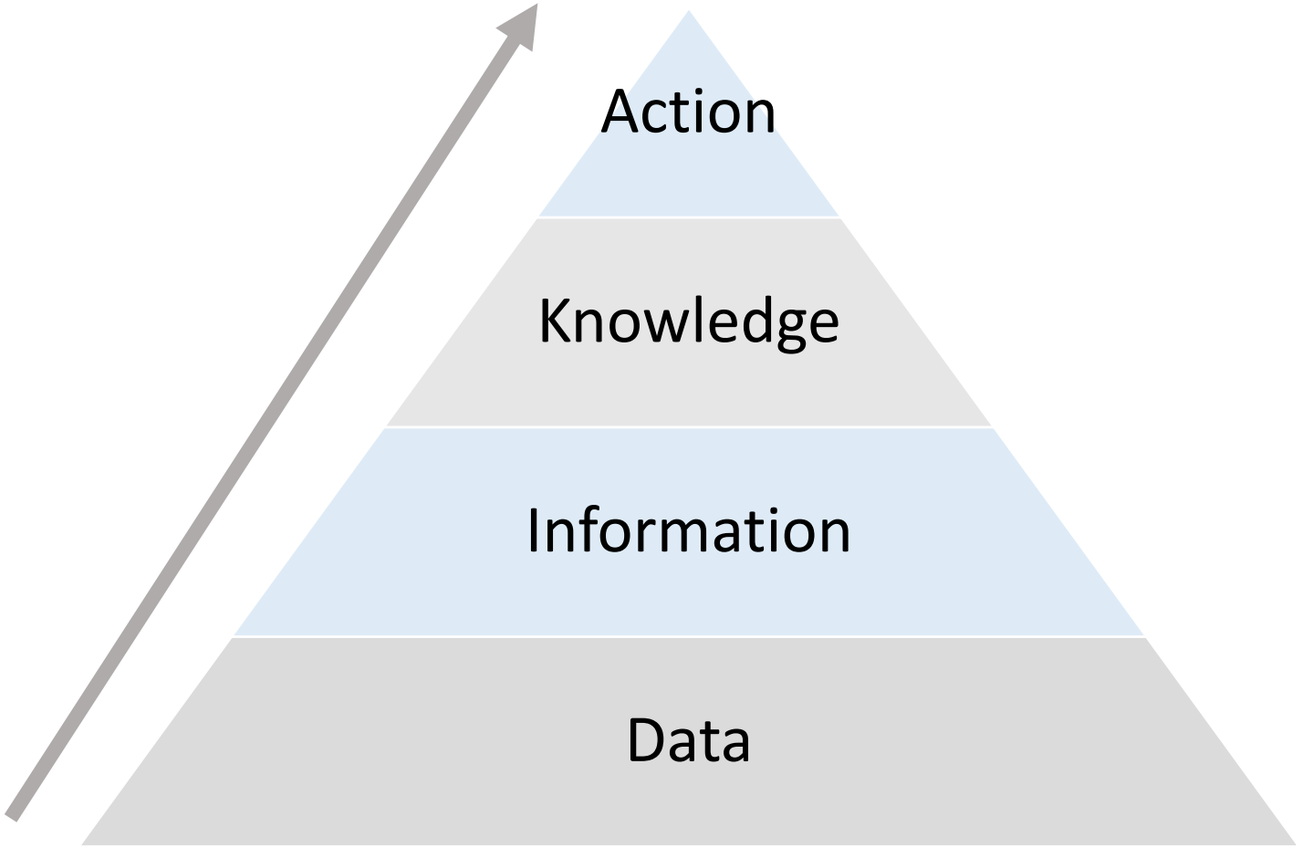


Choose priorities that are *possible, powerful* and *participative*

PHM Catalyst – investing in enabling capabilities to effect change

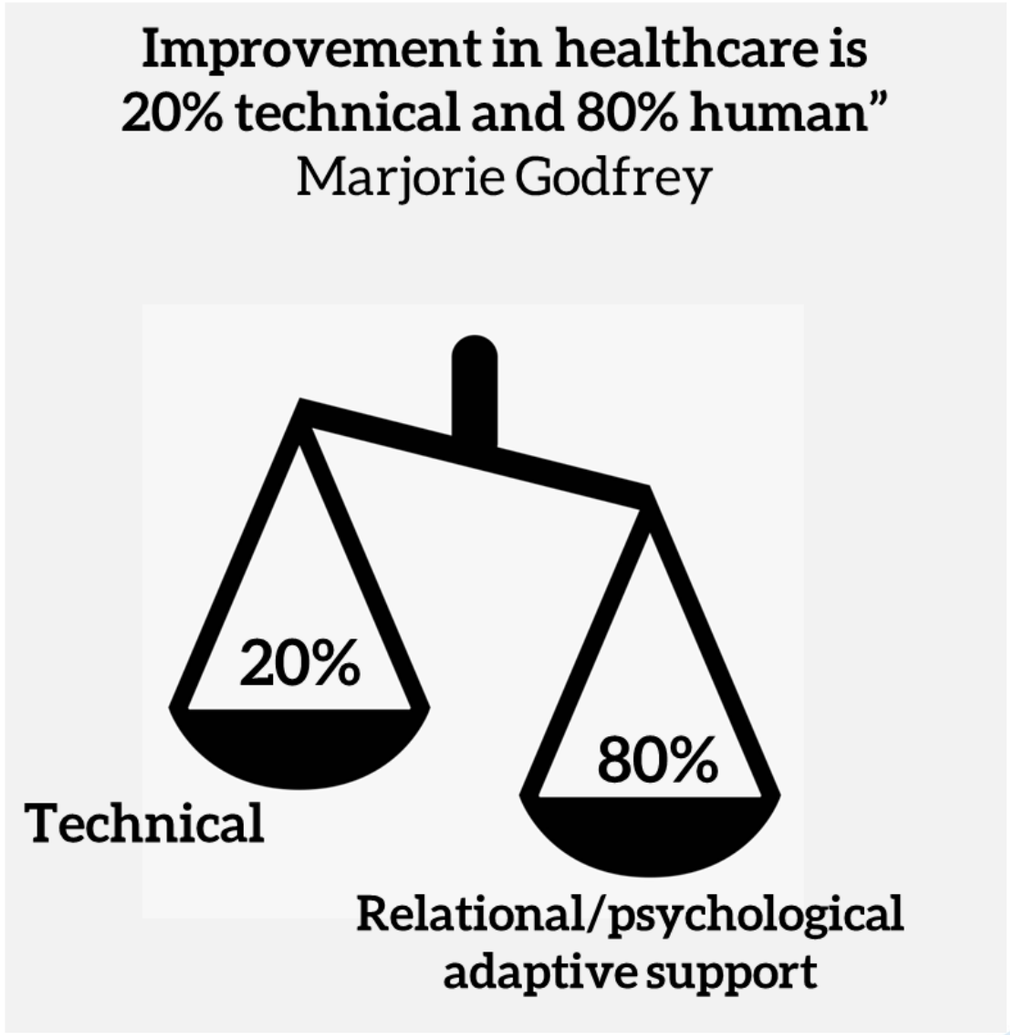
- Use the ‘what’ to drive the ‘how’ – take an **applied approach**
- **Make the invisible visible** – never forget the power of data
- Join forces – **multidisciplinary design teams**
- Be **systematic** – ‘process’ is your friend
- Experiment – **learning** is the antidote to complexity

How do we turn data into action?



Recognise it is not all about the data

Improvement in healthcare is 20% technical and 80% human"
Marjorie Godfrey



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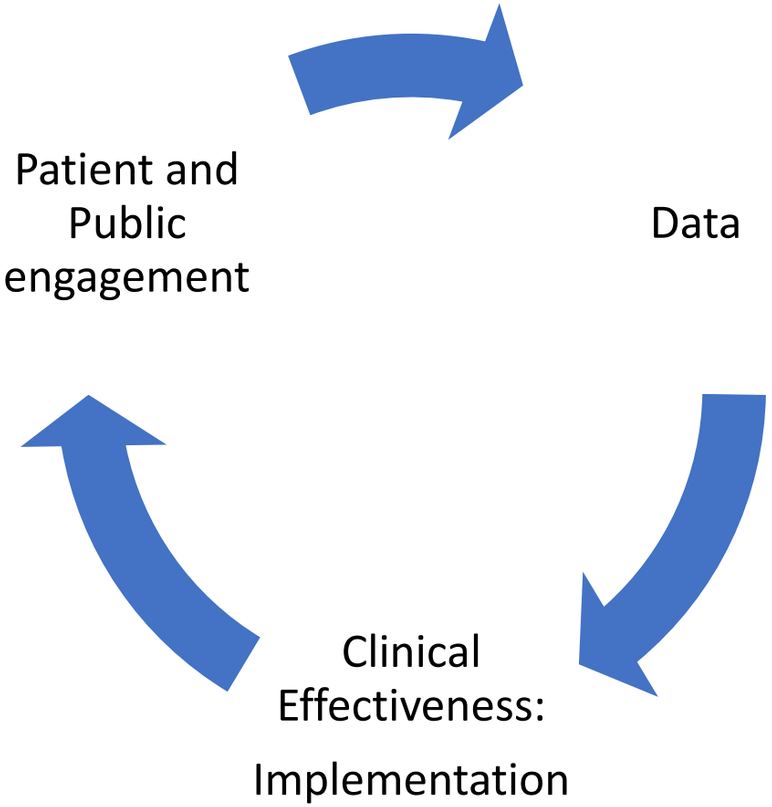
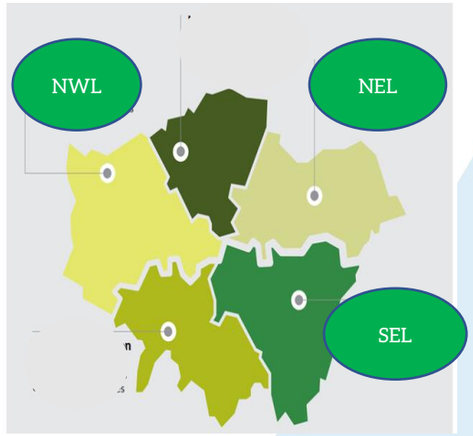
One London Hypertension Pathfinder Project

NHS South East London

To better detect, manage and reduce inequalities in hypertension





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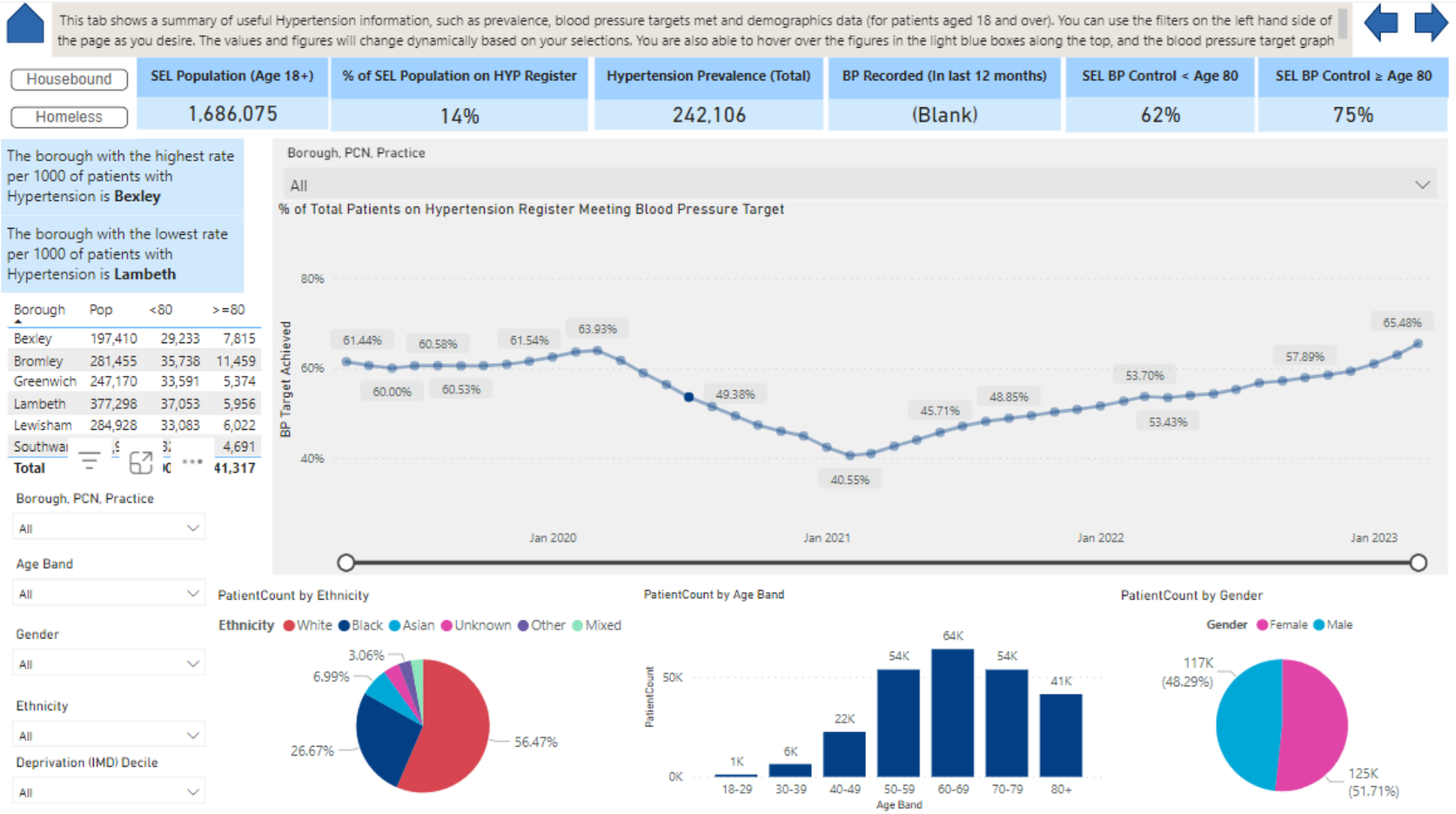
A collaboratively developed dashboard

NHS South East London



Technical Infrastructure

+

Multidisciplinary Team

+

Agreed framework

Evidence Based Implementation

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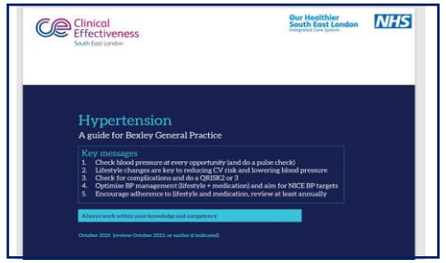
NHS South East London

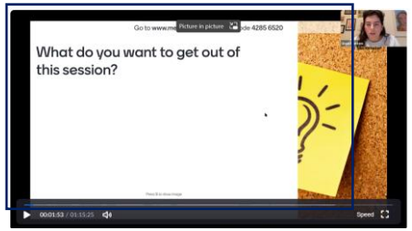
Clinical Effectiveness (CESEL)

Clinical Effectiveness South East London

Help people know what is best-practice (Guides + Education)



Help people put best-practice into action (Templates + Searches)



Facilitation

Help people know how about progress (Data + Analytics)

Quality improvement for primary care by primary care

Meaningful Patient and Public Engagement

“You can't expect the community to change, and you are not changing. That don't make sense. You change. They change. Yeah?”

MAB ADI LIKO

Trust - systemic medical mistrust emerged as a significant factor that limits and lack of interpersonal trust between patient and HCP is a barrier to anti-hypertensive medication adherence.

Action:

- Discuss the impact of discrimination on health (study participants expressed a desire for HCP to discuss this)
- Patient-centred consultations improve interpersonal trust with HCPs and shared – decision making improves adherence to anti-hypertensive medication.
- Cultural awareness training for HCPs can improve cultural understanding and prevent discrimination. Cultural humility training assists healthcare providers to acknowledge and challenge power imbalances, their own culture and systems as opposed to cultural competency training which assumes competency in an alternative culture is static and can be learnt

Access and preference for Hypertension care

Action:

- Offer community-based blood pressure testing/ advice (high acceptability among participants) such as community pharmacies and where available community spaces e.g. churches, community halls, community led events
- Preference for face-to-face hypertension monitoring and management support
- Promote and increase access to home BP monitors and out of hours drop-in GP attendance for BP testing.

What next for PHM in SEL?

How do we build on what we have?

How do we operationalise PHM?

How do we bring people with us?

What do we need to be able to achieve this?

Jacqui Kempen

Head of Maternity, SE London ICS, & Local Maternity & Neonatal System (LMNS)

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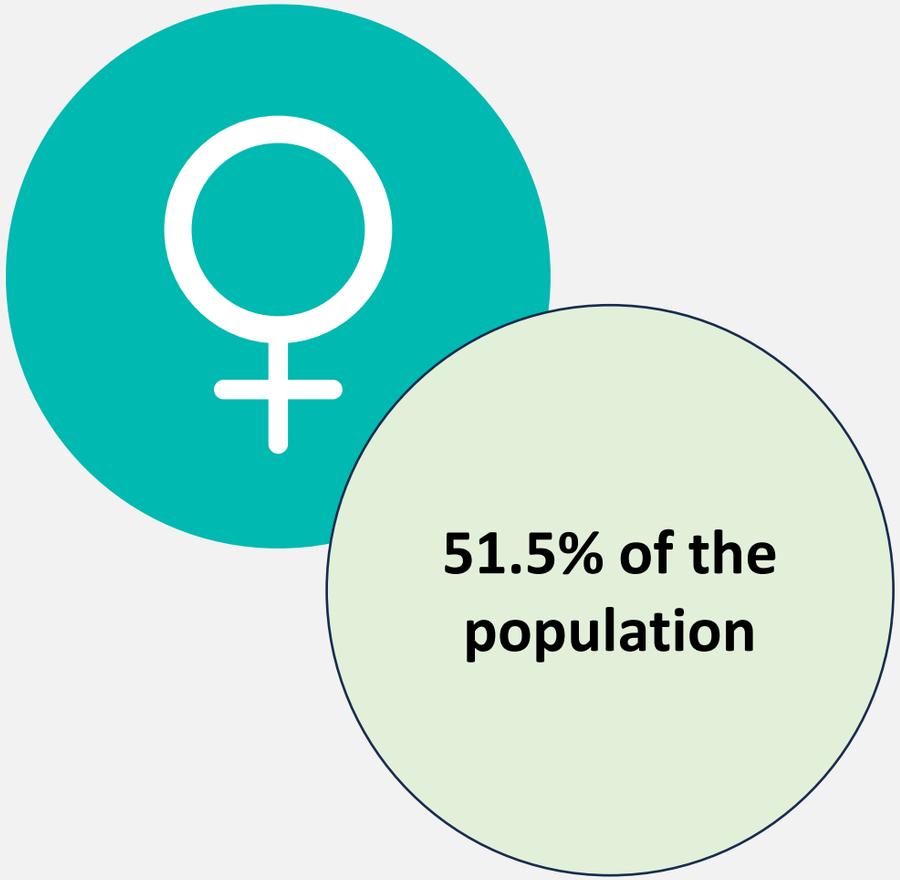
Women's Health Inequalities - the maternity perspective

Jacqui Kempen
Head of Maternity

South East London Integrated Care System



- Women live for longer in poorer health
- Research exclusion
- More women are unemployed
- Women experience more delays in diagnosis of health conditions
- 50% more likely to receive a wrong initial diagnosis for a heart attack
- Financial gender gap – unpaid work, lower pay, less opportunity for senior positions, pension inequity

Women's Health Overview

Focusing on women's health will positively affect future populations

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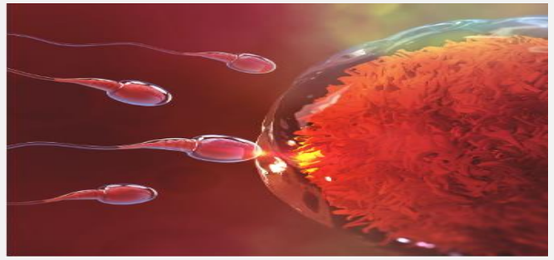
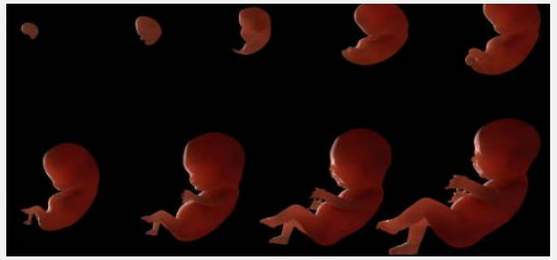


Genetic risk factors



Fetal programming

Puberty and menstruation

Menopause

Girls and Women

Women's Health overview

South East London Integrated Care System

Nearly 50% of pregnancies in the UK are unplanned

Complex medical conditions

Ethnicity

Racism

Deprivation

Smoking

Parental support

Infant feeding

Outcomes of pregnancy and birth

Migrant population

Obesity

Mental health

Social needs

Maternity infrastructure

Maternity and the life course

Girls and Women

Women's health overview

South East London
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- Better understanding of need
- Women's Health Strategy
- Maternity and Neonatal Programme
- Pre-conception Strategy
- Infant Feeding Strategy
- Improved data
- Cultural Sensitivity
- Anti-racist framework implementation

Listen and collaborate with Women

Women's Health Overview

Girls and Women

Maternity and the life course

Future needs

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Integrated Care System

Thank you

Maddie Smith

Population Health Intelligence Officer Apprentice, Bromley Healthcare

Vicky Sanderson

Head of Anticipatory Care, Bromley Healthcare

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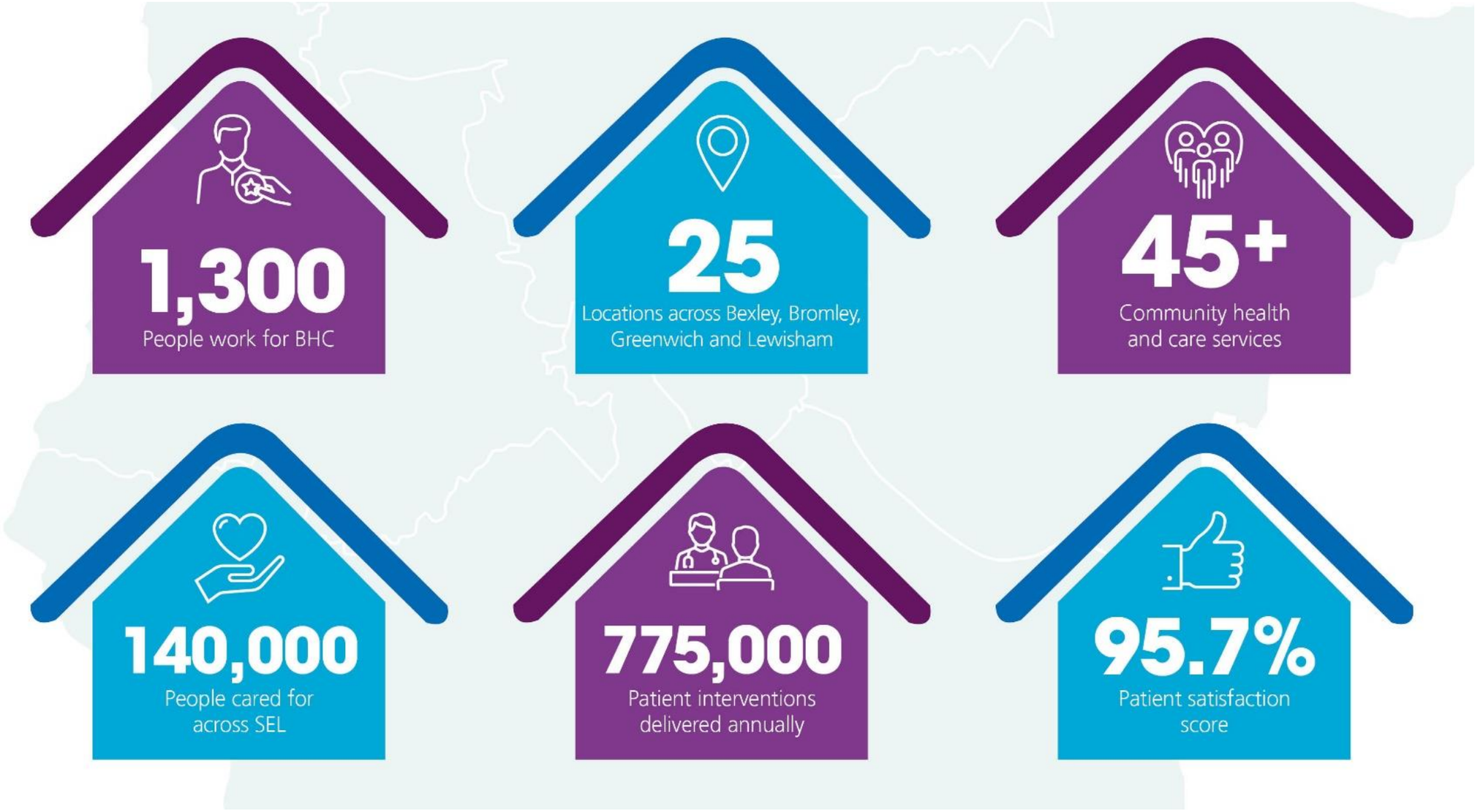
Harnessing the power of neighbourhoods – data and collaboration in Orpington and The Crays

Vicky Sanderson and Madeleine Smith

A community-first approach to population health management

About Bromley Healthcare



Community First

Bromley Healthcare Strategy 2023-2028

Empowering people to live their fullest lives at the heart of their communities

Grow
Build a culture of growth and opportunity for our people

Lead
Become a leader in integrated care

Invest
Invest in our communities

Belonging

Health and Wellbeing

Continuous Learning and Innovation

Compassion

What does the population of Orpington look like?

- 60,240 residents in Orpington
- Very large Primary Care Network with 10 practices (including Bromleag Care Home Practice, which provides a service to all Bromley care homes)
- The Primary Care Network has an above average proportion of older people and a higher proportion of pensioners and carers
- From the PCNA Practice visits, surgeries have provided feedback that patients have multiple long-term conditions and experience social isolation

Neighbourhood Working in Orpington

- Closely working with Orpington Primary Care Network, we have been able to adopt a Neighbourhood Team approach.
- This includes working collaboratively on areas such as recruitment, pathways and estates to provide better care for the patients in the Neighbourhood.

The Integrated Care Network

The ICN Team:

1 Lead Community Matron
9 Community Matrons
3 ICN MDT Liaisons
1 Health Care Assistant

Based across 3 hubs:

Willows Clinic (Bromley)
Global House (Beckenham)
St Pauls Cray Clinic (Orpington)

- The pathway mainly sees people with frailty but also sees many others with multiple comorbidities, people who are high users of services, those with mental health problems and mental illnesses, social challenges, and carer stress.
- Patients are historically assessed by a Community Matron using the comprehensive geriatric assessment tool.
- The patient is presented at an MDT by the Community Matron.
- The MDT consists of a GP Chair, Geriatrician, Community Mental Health Representative, Social Care, Care Navigators (Age UK) & Hospice.

"Having someone there who can give advice and provide a good support network has benefited me and my husband greatly. The fact that there is someone overseeing my care and knowing things will get done is invaluable." - a patient on the pathway

Referrals into the Integrated Care Network: GP's, Internal Referrals from Bromley Healthcare services for example: District Nursing, Rapid Response
Externally: Self Neglect and Hoarding Panel, A&E High Intensity Users Panel, Frailty Unit, Frequent Fallers attending A&E.

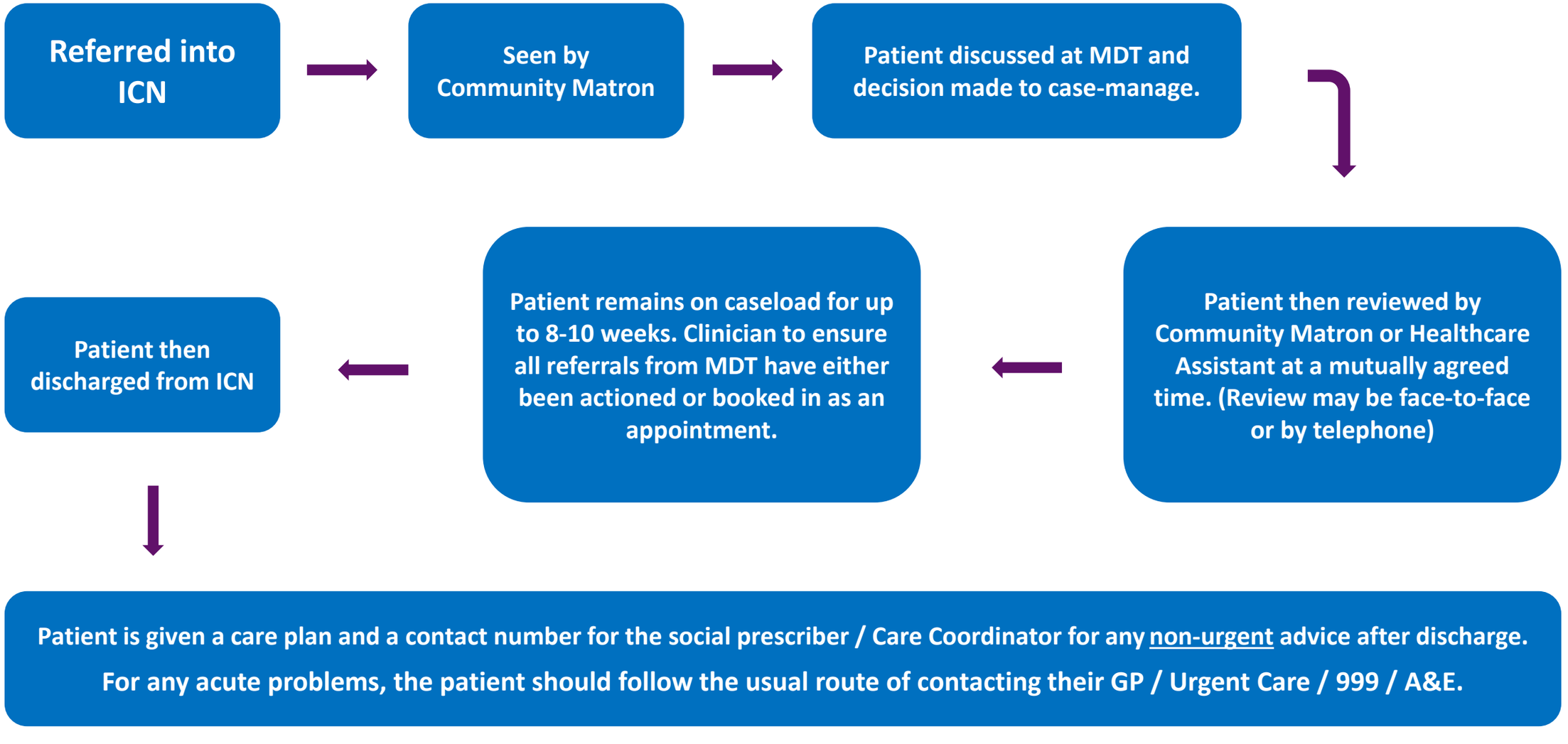
ONE BROMLEY

Data & Analytics as Key Enabler: Health & Social Economy Outcomes

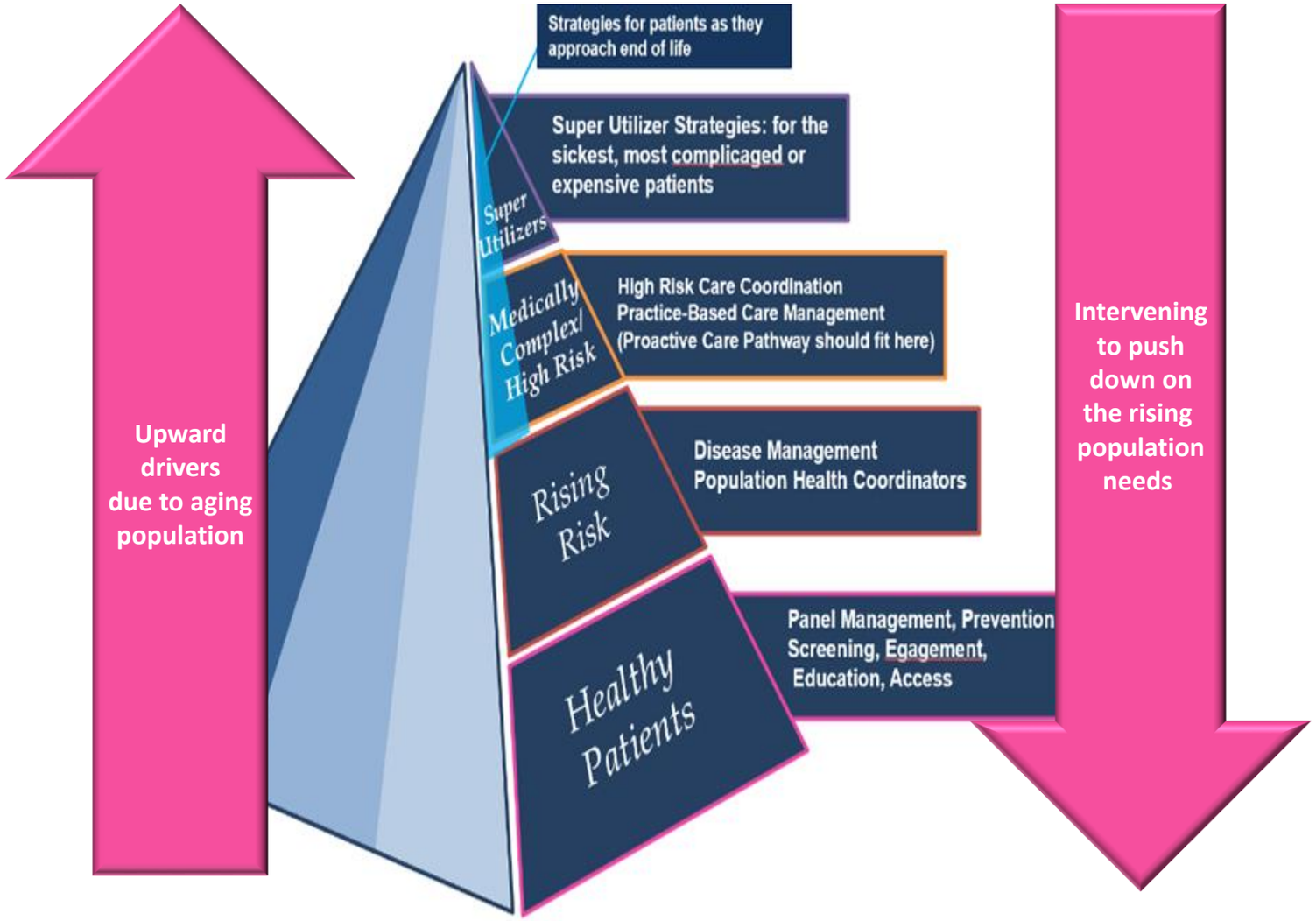
ED attendances: 32% reduction in admissions

Inpatient Admissions (Emergency): 27% reduction in admissions

Case Management



Stratifying populations for interventions



Case management
(managed from data primarily from Bromley Healthcare business intelligence)

Integrated Care network MDT
(managed from data primarily from Bromley Healthcare business intelligence)

Long-term condition/frailty/wellbeing hubs
(managed from data primarily from primary care registers)

Self-care and prevention
(managed from data primarily from primary care registers)

The Orpington Wellbeing Café – Wrap around compassion

- Collaboration between Orpington PCN and Bromley Healthcare - using a community centred approach to address isolation and health challenges faced by older populations
- Established the Orpington Wellbeing Café in July 2022
- Provides a safe, inclusive space for local people to socialise and access advice, and attracts 70-100 attendees, primarily older and vulnerable residents
- Sessions are informed by participant feedback and requests.
- Diverse range of activities offered, from arts and crafts to chair exercise and mindfulness
- Sessions provided by healthcare teams including ICN, Bladder and Bowel, Rapid Response, IAPT and Respiratory
- Proven successful in enhancing health awareness and supporting communities during financial stress
- Inspiring model for other PCNs, paving way for integrated health hub

Going further with our Neighbourhood Approach

Following the vision highlighted in the Fuller Report (2022) we saw an opportunity to expand our Neighbourhood…

- The Crays Primary Care Network is located next to Orpington and a high number of their patients attend the Orpington Wellbeing Café. This meant more opportunities to learn from other PCNs' work and share resources like staff and estates to improve patient care.
- Overall, our vision is to integrate services to make care for the patient joined up and feel seamless to ultimately improve patient outcomes and health.
- Bromley Healthcare has some new and exciting projects in the pipeline: working with other Primary Care Networks on areas that aim to cover the Core20Plus5.

Video of the Orpington Wellbeing Café (Impact)


NHS
King's College Hospital
NHS Foundation Trust
Bromley Healthcare
community first
Oxleas
NHS
StChristopher's
More than just a hospice
BTSE
Bromley GP Alliance
Bromley
Primary Care Networks
Bromley
NHS
South East London
ONE BROMLEY

Dr Camille Hirons

GP and Health Equity Fellow for North Lewisham PCN

Dr Diane Biondini

GP and Health Equity Fellow for Sevenfields PCN

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Husseina Hamza

CEO, Red Ribbon

Tim Oshodi

Founding member, Downham Community Land Trust

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Lewisham Health Equity Partnerships

a model in tackling health inequity

Dr. Camille Hirons, Dr. Diane Biondini, Husseina Hamza, Tim Oshodi

Red Ribbon Living Well

SOCIAL LIFE

Sevenfields Primary Care Network

North Lewisham PRIMARY CARE NETWORK

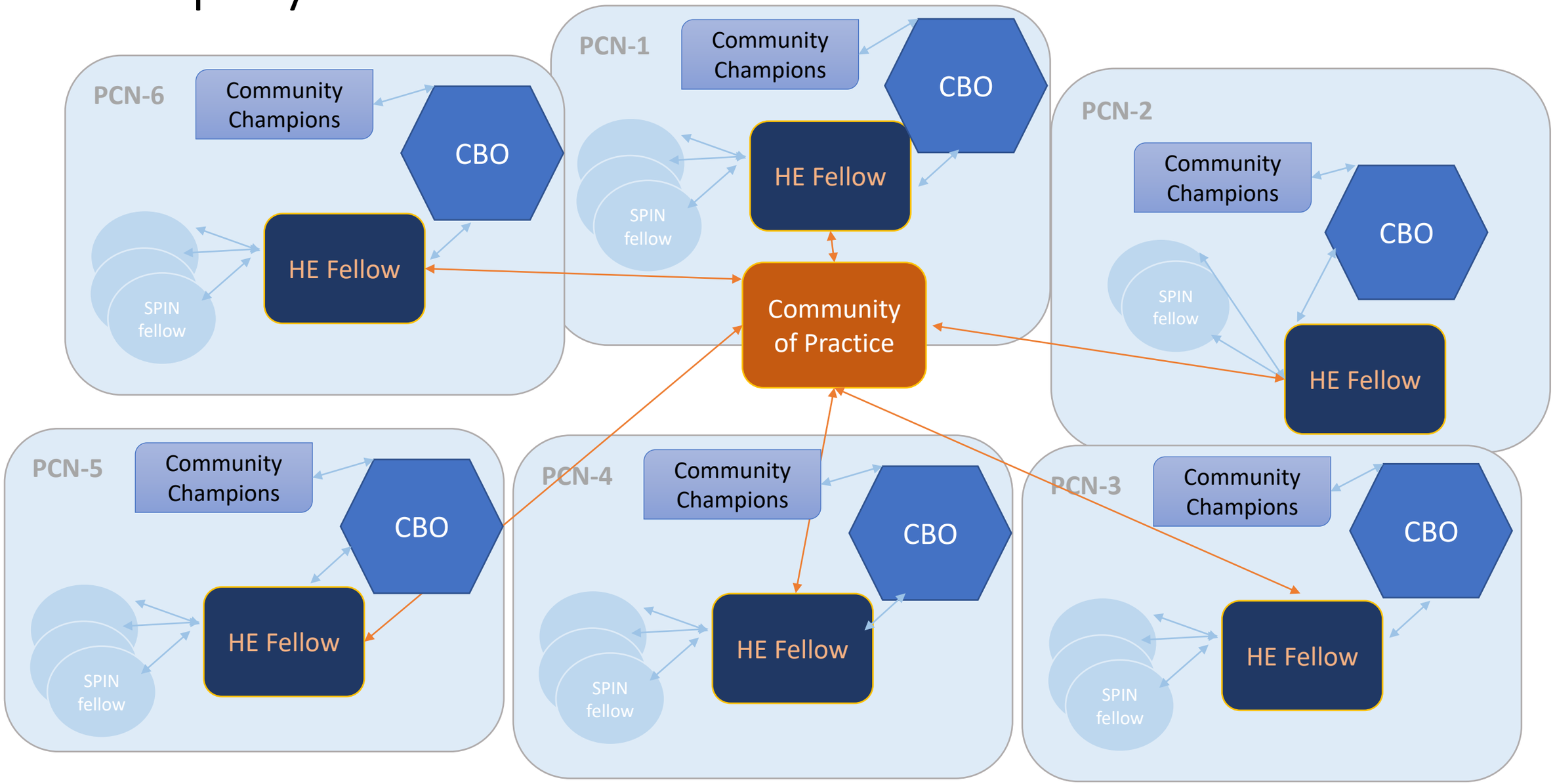
South East London Integrated Care System

Lewisham

Lewisham and the Health Equity Fellowship

- Vibrant and diverse population. Large Black, Asian and other minority ethnic background communities, higher than average deprivation and inclusion health cohorts.
- Poorer health outcomes, with NL and Downham having worse outcomes.
- 33 practices divided into 6 PCNs. Each PCN has a HEF funded for 2 years.
- Academic support Kings College London Supporting delivery and evaluation.
- Community based organization partnership and co-design.

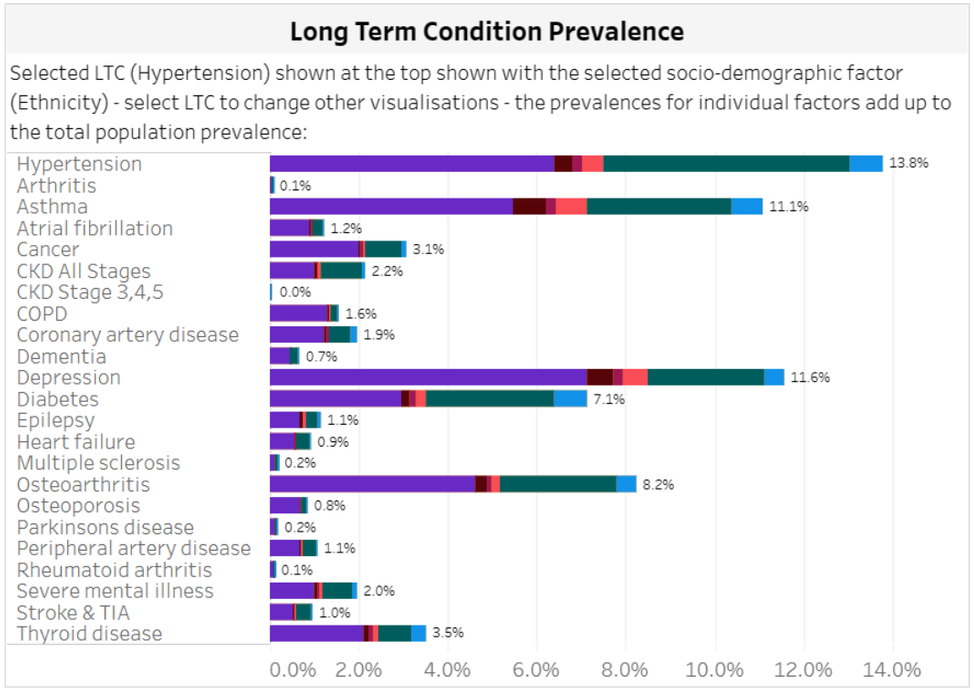
Health Equity Teams

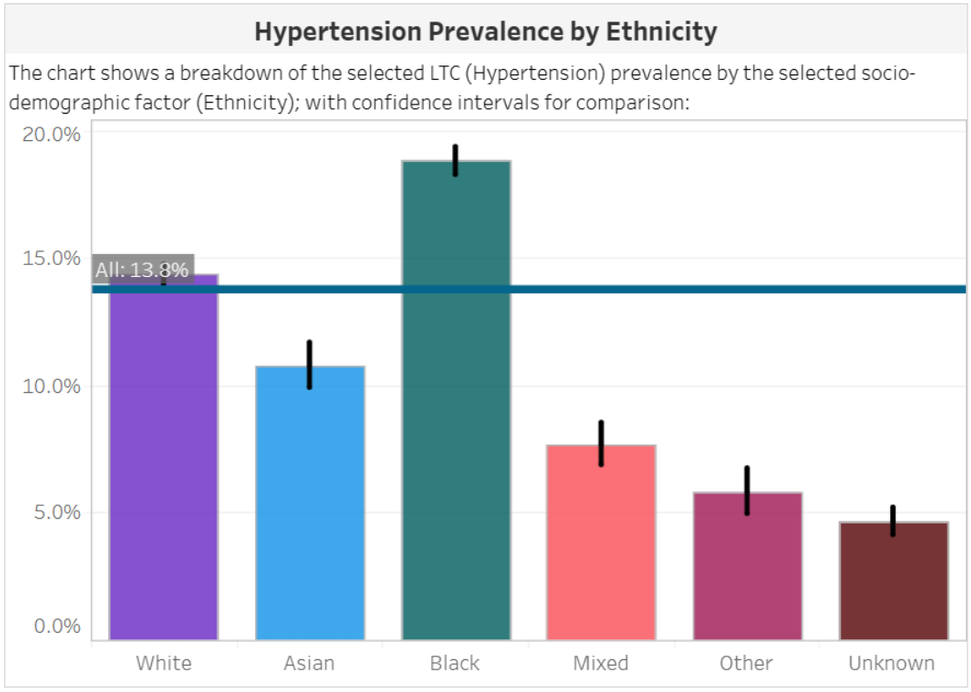


Data Dashboard

- Live data across the borough as well as by PCN and by practice

Total Prevalence	Prevalence of 2 or more LTCs including:	Aged 65+ Prevalence	Most Deprived Quintile Prevalence	BAME Population Prevalence
Hypertension	Hypertension	Hypertension	Hypertension	Hypertension
13.8%	59.2%	61.1%	13.8%	15.0%
9,025	4,338	4,087	3,388	4,580





Health Equity Partnership

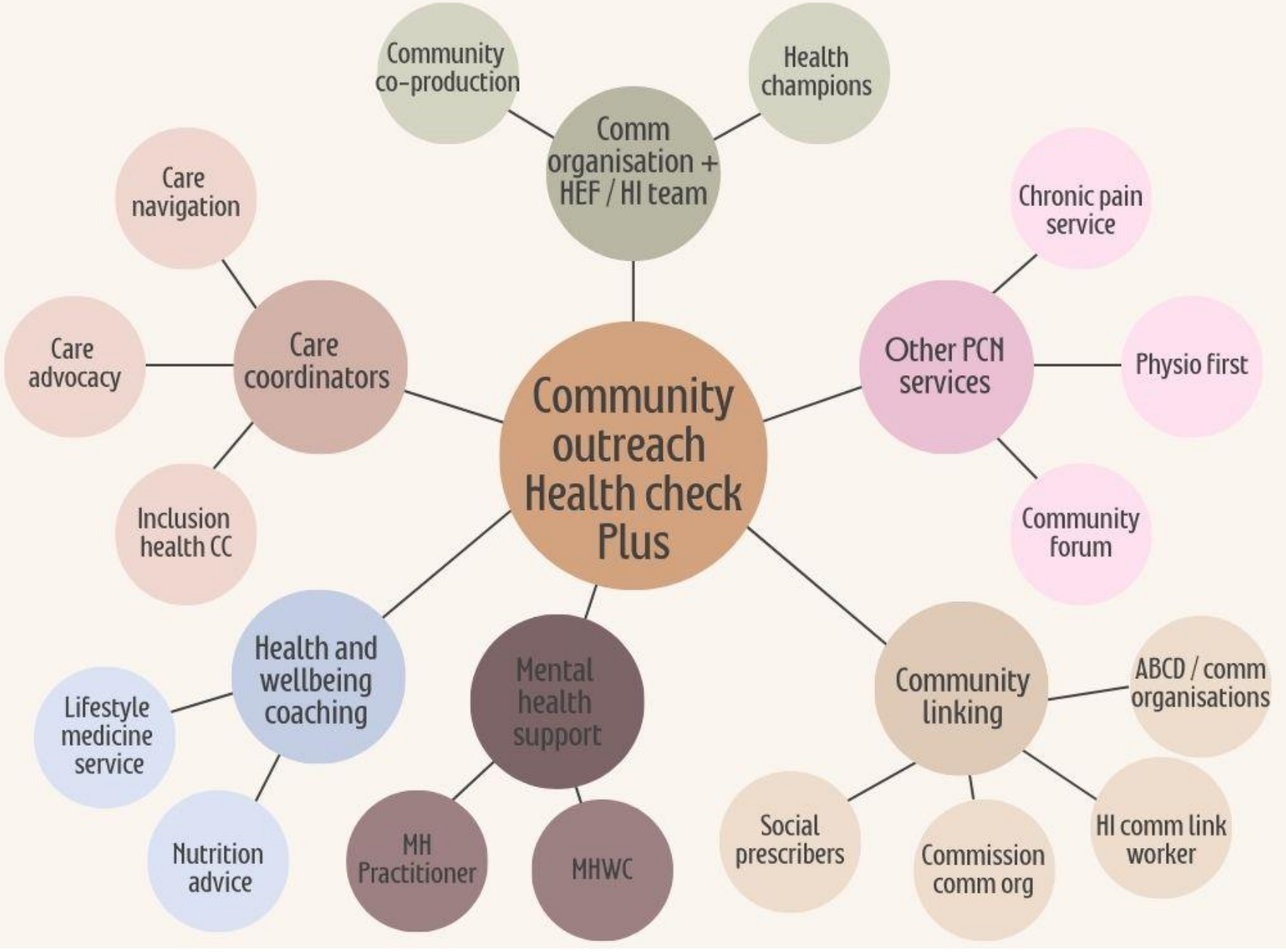
Red Ribbon Living Well

North Lewisham PRIMARY CARE NETWORK

HEALTH CHECK PLUS

Community outreach proposal

NLPCN



Downham Community Land trust

Asset based solutions to Marmot

People and communities have economic value

Measure it and reward it

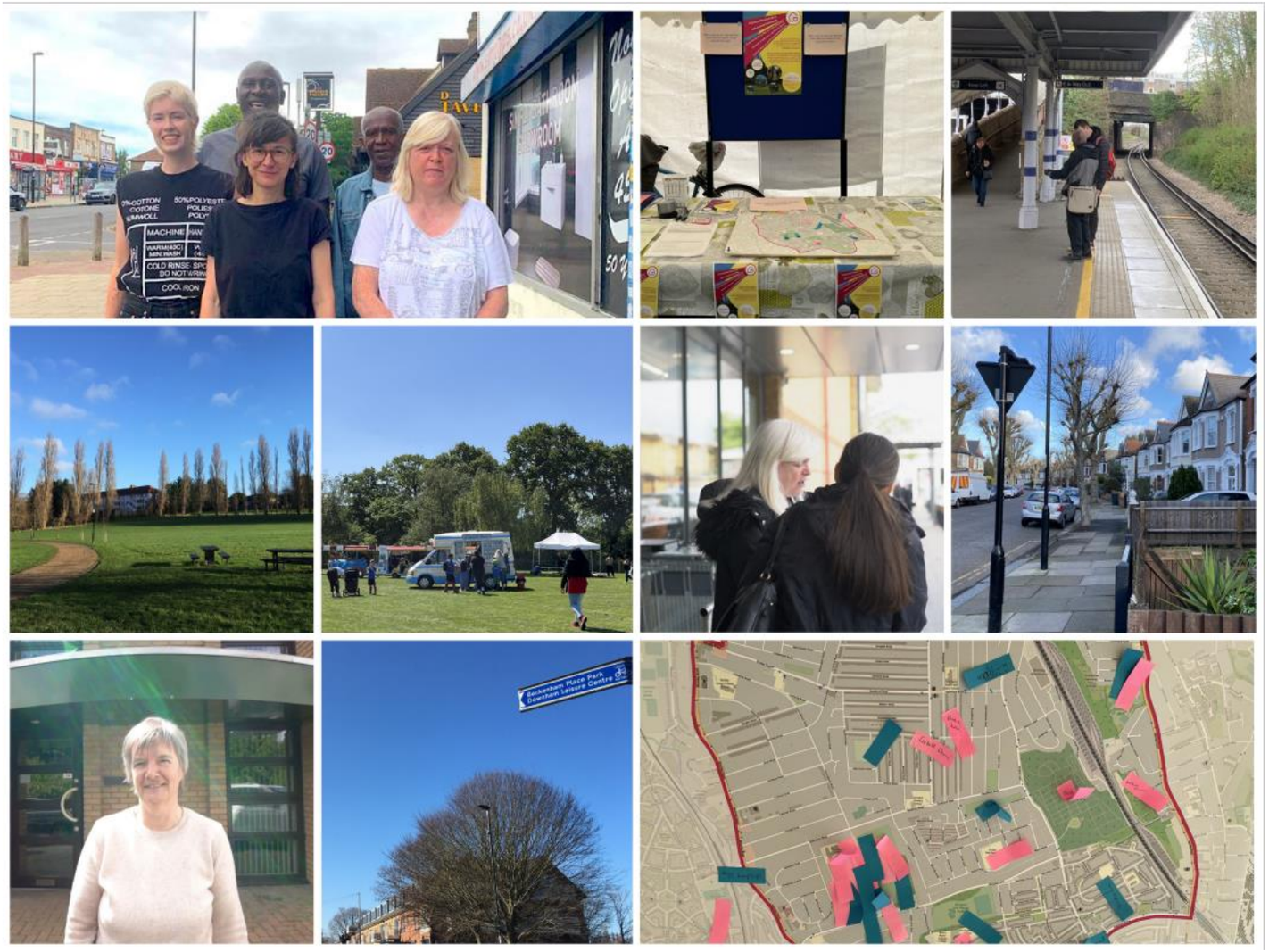
Data driven – place shapes forces

Sevenfields
Primary Care Network

- Healing comes only from within
- Trauma informed both individual, community
- Trust build networks, feminist
- Power dynamics / conflict resolution

SOCIAL LIFE

Social Life and Downham community Land Trust



SOCIAL LIFE

Sevenfields
Primary Care Network

Thank you

Dr Chloe Macaulay

General Paediatrics Consultant, Evelina London

Emma Matthews

Paediatric Asthma Clinical Nurse Specialist, Guy's and St Thomas' NHS Foundation Trust

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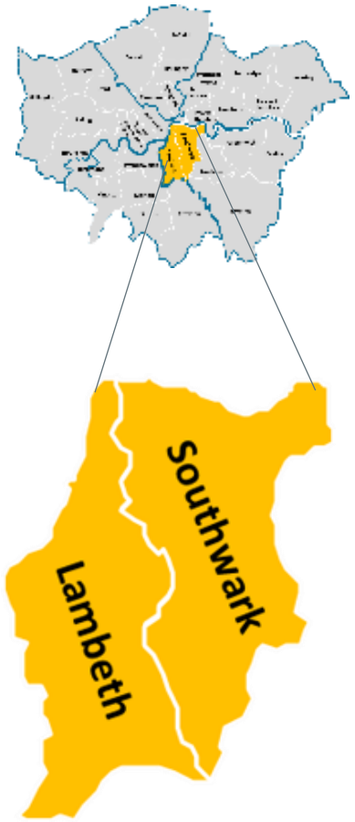
Reducing health inequalities in children with asthma

Emma Matthews
Paediatric Asthma Clinical Nurse Specialist

Chloe Macaulay
General Paediatric Consultant

29 June 2023

We proactively find and treat children with asthma



We search primary care records to find children and young people with asthma or wheeze

Parents are then asked to fill in an online bio-psycho-social health check

Health check responses are triaged by the paediatric nursing team

ALL parents are provided with an asthma health pack

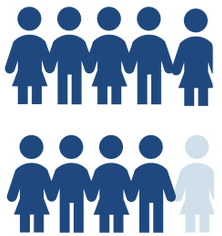
Those with uncontrolled asthma or frequent GP or A&E attendance are seen by the nursing team.

CHILDS FRAMEWORK

CHILDREN & YOUNG PEOPLE'S HEALTH PARTNERSHIP

We reduce uncontrolled asthma in children and young people

In 2017 **62%** of patients triaged had uncontrolled asthma symptoms at initial assessment…by 2021 this had reduced to **51%**



90% of patients who had uncontrolled asthma at their initial assessment were discharged by the nursing team with reasonably or well controlled asthma

90% of patients had a **clinically significant improvement in symptom control** (an improvement of 3+ points in ACT score)

CHILDS FRAMEWORK

CHILDREN & YOUNG PEOPLE'S HEALTH PARTNERSHIP

We improve the quality of care for children with asthma

Compared to children receiving usual care, children receiving this service were:

- 3x more likely to have their asthma control checked by their GP
- Nearly 4x more likely to have an asthma action plan
- 1.5x more likely to be prescribed spacer devices

These are key processes associated with improved outcomes and reduced deaths (*National Review of Asthma Deaths).*

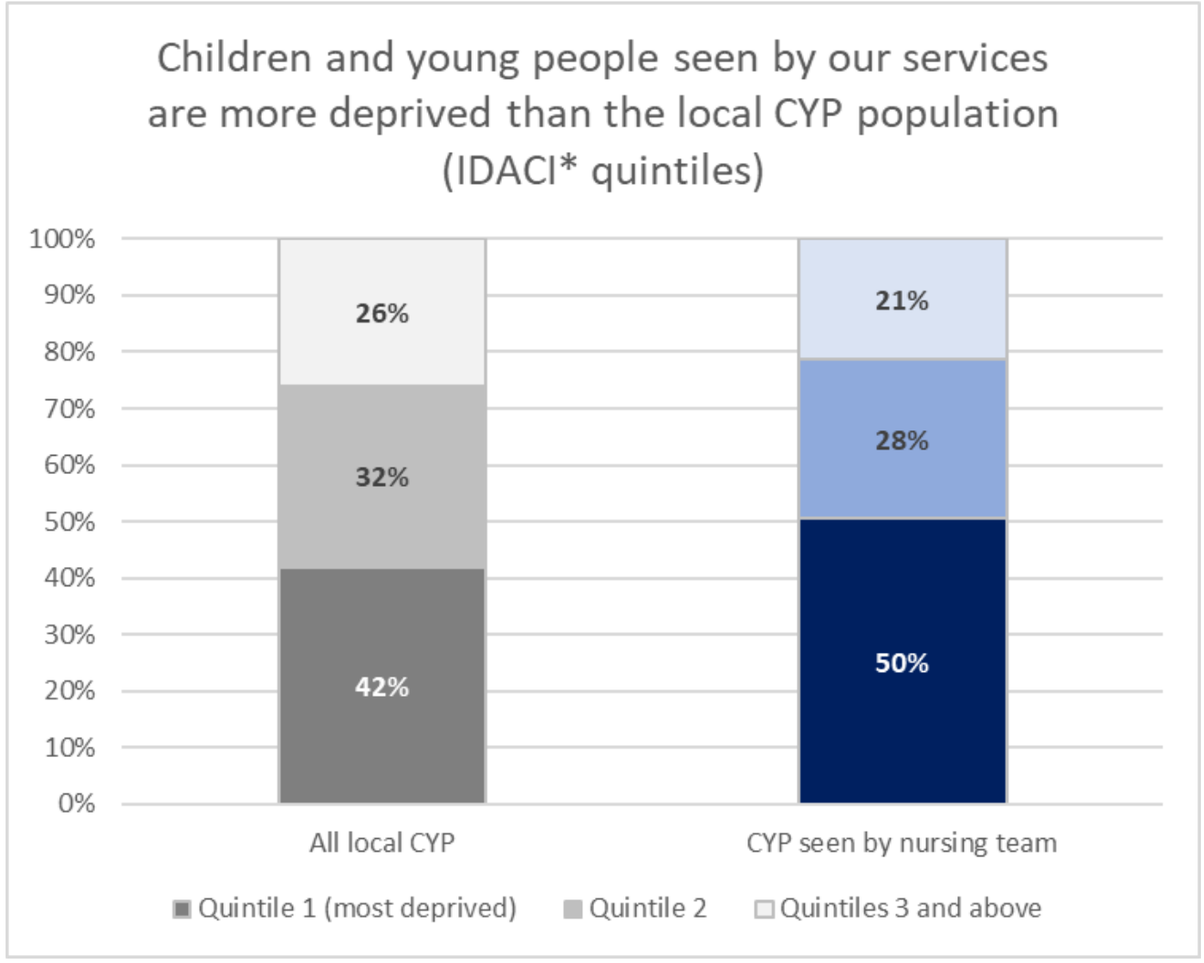
We are reducing health inequalities for local children

We reach proportionately more children from the most deprived quintile

We are **improving equity of access** compared to usual care

We are **reversing the Inverse Care Law** (patients most in need are least likely to access care).

The ethnic and age profile of our patients matches the local population



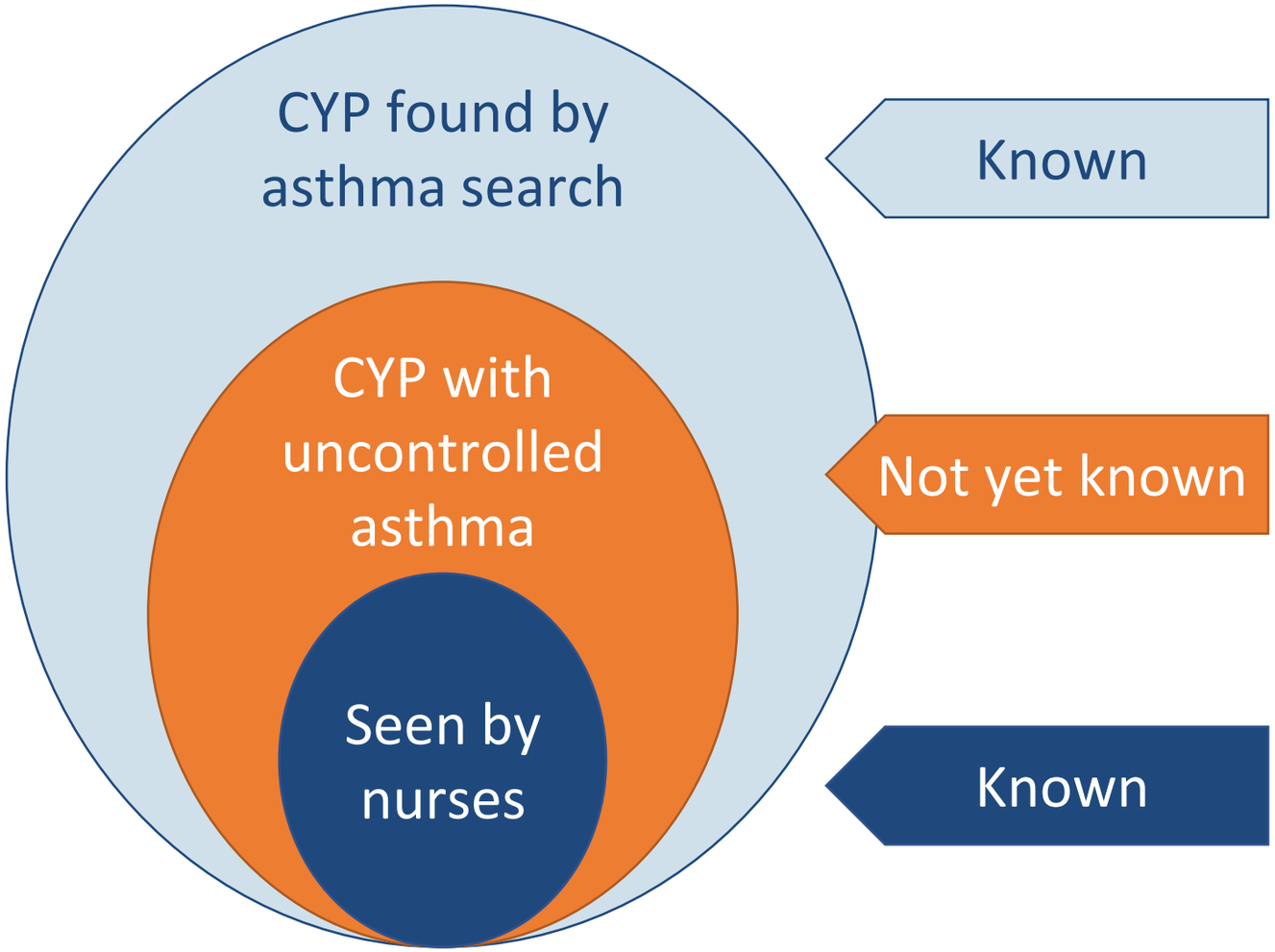
CHILDS FRAMEWORK

CHILDREN & YOUNG PEOPLE'S HEALTH PARTNERSHIP

** IDACI: Income Deprivation Affecting Children Index*

What's next?
Targeted identification of CYP with uncontrolled asthma

- Analyse linked data to **identify risk factors for uncontrolled asthma in CYP**
- Model risk factors to **understand level of unmet need and plan workforce capacity** to meet needs
- **Refine searches to find CYP with uncontrolled asthma** – working closely with primary care colleagues.



What's next?
Technology Enhanced AsthMa care trial (TEAM care)

- We will be testing out two new asthma devices to improve outcomes among children with asthma, as a randomised control trial (RCT).
- The devices are:

wheezo® - detects wheeze

Propeller - a smart inhaler

CHILDS FRAMEWORK

CHILDREN & YOUNG PEOPLE'S HEALTH PARTNERSHIP

In summary

We proactively find and treat children with asthma

We reduce uncontrolled asthma in children and young people

We improve the quality of care for children with asthma

We are reducing health inequalities for local children

We will identify CYP with uncontrolled asthma and enhance asthma care through technology.

CHILDS FRAMEWORK

CHILDREN & YOUNG PEOPLE'S HEALTH PARTNERSHIP


Thank you

Prevention & Inequalities

Focusing on the Vital 5 which have the biggest impact on health inequalities

Chaired by Dr Ruth Hutt, Director of Public Health, London Borough of Lambeth, and

Dr Nicole Klynman, Director of Public Health, London Borough of Bexley

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Dr Abimbola Fadipe

Executive Medical Director, Oxleas NHS Foundation Trust

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Improving lives

The Oxleas Focus on Equality and Equity

Dr Abimbola(Abi) Fadipe
Executive Medical Director.
Oxleas NHS Foundation Trust.

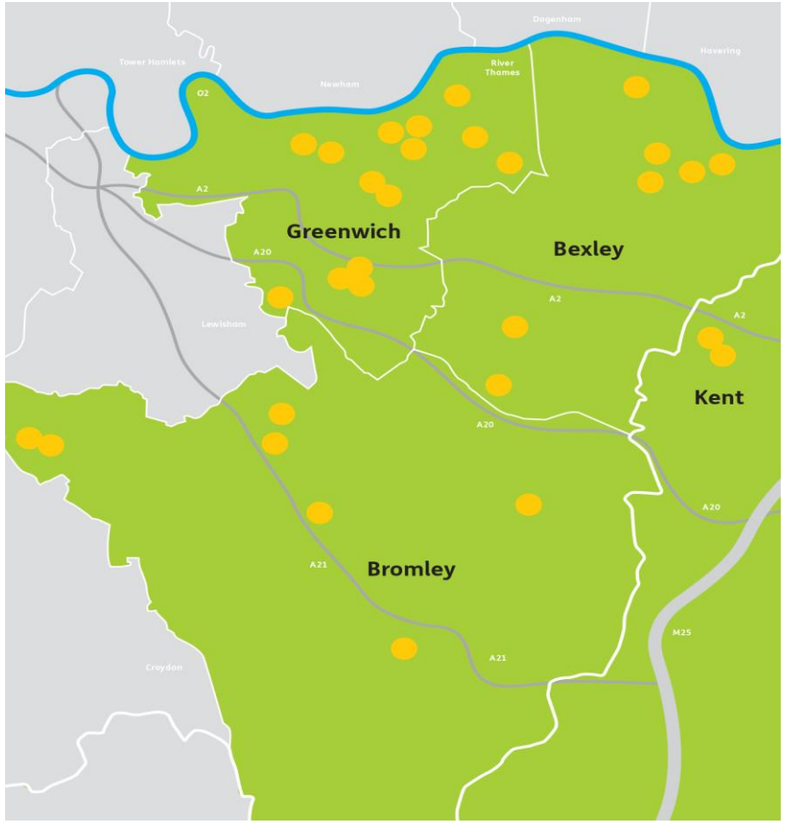
EQUITY MATTERS for all

Oxleas NHS

Improving lives

About Oxleas

- We provide local NHS services in south London and health care services in prisons in London, Kent and south west England.
- We specialise in community health, mental health and learning disability services.
- We work from a wide range of sites including local schools, children's centres, prisons and, of course, in people's homes.
- We have approx. 4500 members of staff working in a wide range of clinical professions
- Our largest sites are Queen Mary's Hospital, Sidcup, Memorial Hospital, Woolwich and Goldie Leigh.



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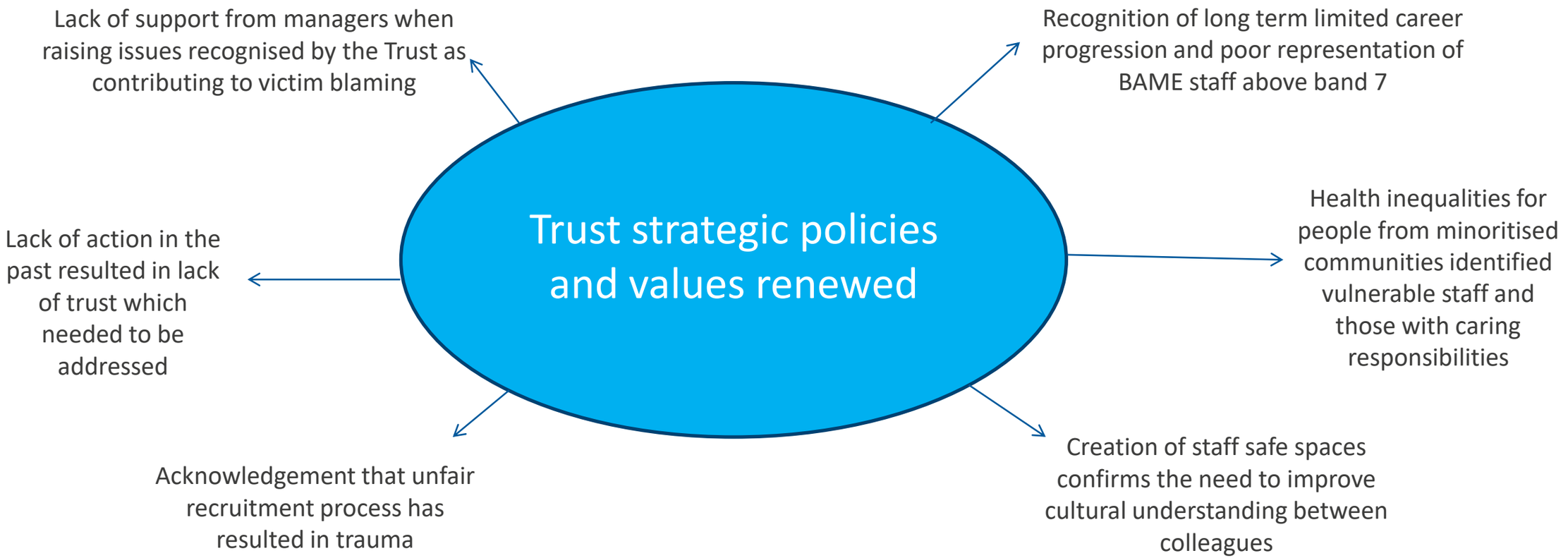
Background to Oxleas Equity Journey



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Our strategy 2021 - 24

This short film reminds us of our current strategy

1 Achieving zero delays

2 Delivering great out-of-hospital care

3 Making Oxleas a great place to work

For details of the whole strategy,
visit our strategy page on our website

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Oxleas Equality and Human Rights Strategy Framework

The development of the Equality & Human Rights Strategy framework in consultation with the staff networks, continues to provide a focus for the Trust to comprehensively address equity and reinforcing the Trust values :

- Removing barriers to people accessing our services
- Delivering person centred care and support
- Making Oxleas the best place to work
- Improving our culture
- Responding to new equality & human rights legislation and mandatory standards

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Oxleas actions for tackling inequality for staff

Building A Fairer Oxleas workstream

Establishment of a Trust Well-Being Lead to build a robust programme of support

Establishment of a Shadow Executive consisting of staff of many different backgrounds

Policies to address needs of staff with disabilities

Consistent campaigns to encourage BAME staff career progression including diverse interview panels

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Improving lives

Key programme(s) of work undertaken to tackle inequalities for Staff

Building A Fairer Oxleas (BAFO) provided and continues to be a key focus on embracing true inclusion:

- The establishment of well-being sessions aimed at addressing staff concerns and needs
- Improved offer of reasonable adjustments, disability leave and flexible working to address staff well-being especially for those with disabilities/long term conditions
- More work to support staff in career progression /aspirations
- Promotion of BAFO 5 Step Challenge as a way to identify and tackle discrimination experienced by staff and improve Trust culture of inclusion
- Ensuring diverse recruitment processes for roles at Band 7 and above – diversity is not only about race but addressing difference as identified in the Equality Act 2010
- The establishment of a well-being lead for the Trust to improve the well-being offer to all staff.

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Key programmes of work undertaken to address inequality for service users

Accessing Fairer Oxleas Services

Establishment of the Service User Equality Group with a range of activities to address service issues for people from all protected characteristics through 5 specific workstreams:

1) Improved use of data
2) Equity of Access
3) Equity of Experience
4) Equity of Outcomes
5) Supporting staff to value diversity.

Early adopter site for Patient & Carer Race Equality Framework (PCREF) to address the needs of BAME mental health service users and carers more effectively than ever before

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Success to date of Oxleas equity and equality activity

The Trust NHS Staff Survey results in 2022 allowed Oxleas to achieve a **top 5** position of Community and Mental Health Trusts in the country.

Our NHS Staff Survey 2022 saw the Trust improve figures in all 40 survey questions with a remarkable 11% improvement in respondents feeling that the organisation prioritises staff well-being; and a move to over 75% of disabled staff expressing satisfaction with adjustments offered in support

The Workforce Race Equality Standard submission for 2022/23 shows an average increase across pay bands 7 – 8D of 28.3% including an increase of 45% in 8B and 33.3% in 8D roles. This is a positive result of the work undertaken to address this.

The Workforce Disability Equality Standard submission for 2022/23 shows an increase in the number of disabled staff being appointed from shortlisting meaning for that metric, the Trust has achieved the required standard as disabled staff are more likely to be appointed than their counterparts.

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Success to date of Oxleas equity and equality activity

Healthcare People Management Association (HPMA) Excellence in People Award 2022 for The Oxleas Building A Fairer Oxleas workstream in recognition of our passion and performance in tackling a culture of historic racism and inequality

The Employers Network for Equality & Inclusion (ENEI) awarded The Oxleas Shadow Executive their Innovative Approach to Diversity and Inclusion 2022 because of the commitment to including staff from as many different backgrounds across all the protected characteristics (Equality Act 2010) in the decision-making process of the organisation.

Oxleas has been recognised in the Sunday Times June 2023 best places to work in the Very Big Company category, as well as winner in the Best Places to Work for disabled people category. The awards recognise and celebrate organisations with the highest employee engagement and wellbeing levels, the awards will help us to attract, retain and recruit to our workforce.

These awards and improvements will provide the spur for the Trust to continue on this equity journey and help us to attract, retain and recruit to our workforce.

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Thank You

Dr A Fadipe
Medical Director

Dr Lucy Goodeve-Docker

GP, Streatham High Practice &
Lambeth Regional Medical Director
for Operose Health

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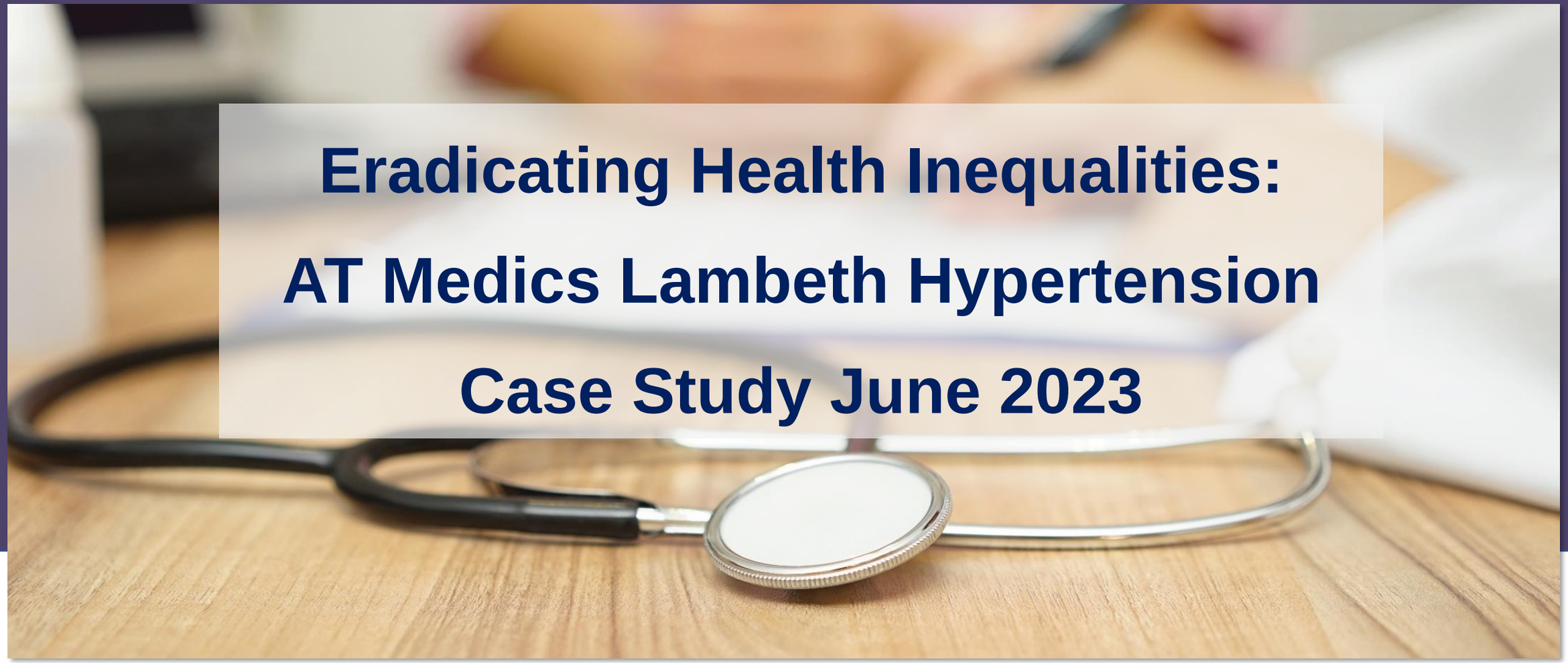


Eradicating Health Inequalities: AT Medics Lambeth Hypertension Case Study June 2023

Dr Lucy Goodeve-Docker

Regional Medical Director for Lambeth AT Medics Operose Health

Overview

A 12 month project to improve overall control of hypertension for our patients in Lambeth - with a particular focus among patients of black African and black Caribbean descent.

It is well documented nationally that blood pressure control amongst this community is significantly lower than for white patients.

During the project, we achieved the best PCN outcomes ever seen in South East London for overall hypertension control.

The existing inequality gap of 12% for blood pressure control between our black and white patients was completely eradicated.

Hypertension Project Lambeth – The Problem

- Lambeth is an inner South East London borough with around 322,000 residents
- The borough has high levels of deprivation with a quarter of the population living in poverty
- Black or Black British backgrounds account for 22% of the population, with 43% BAME population overall.

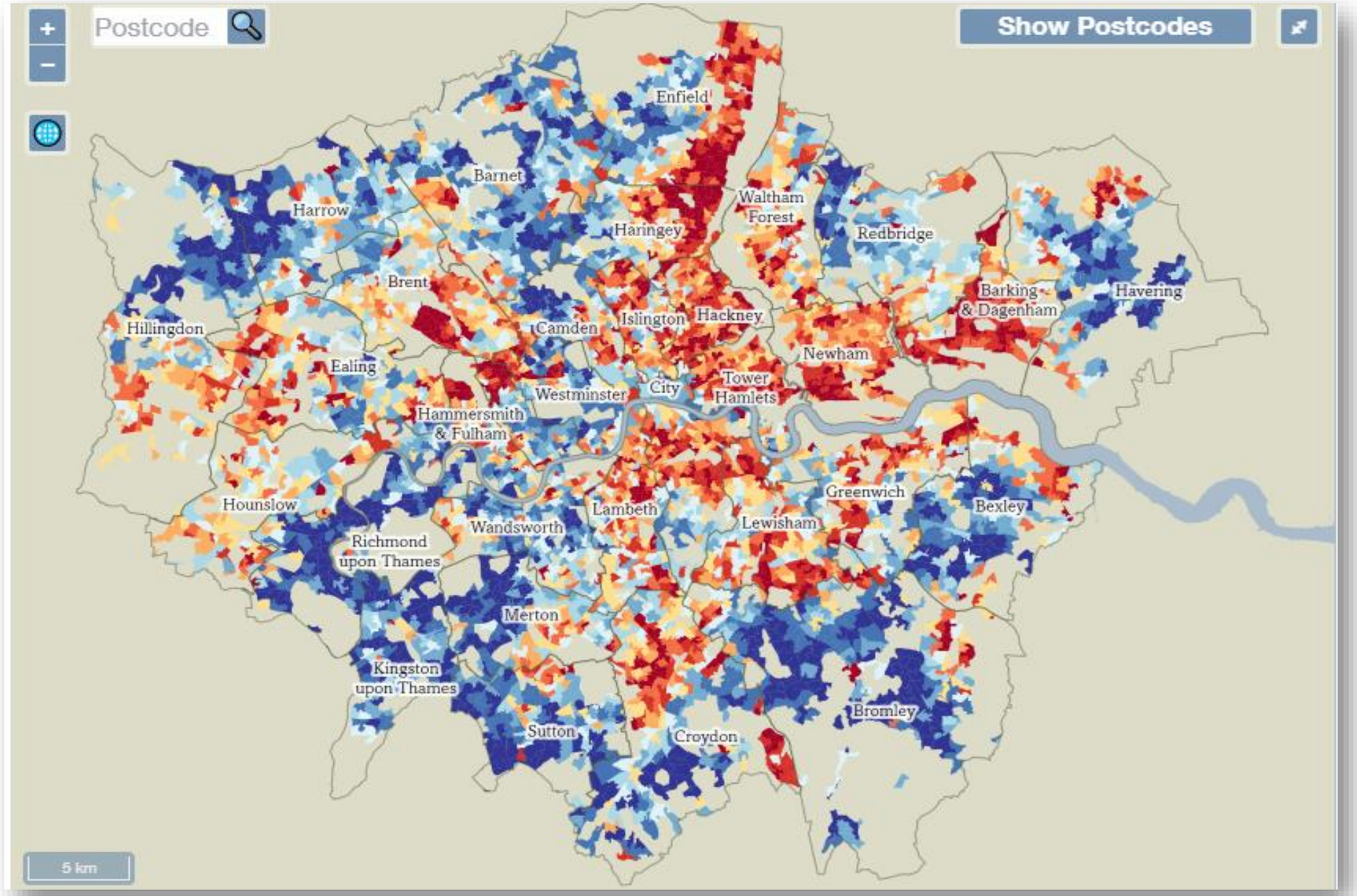
Image courtesy of: https://www.tripadvisor.co.uk/Attraction_Review-g186338-d189226-Reviews-Brixton-London_England.html

Wide variation in health outcomes across the South East London Integrated Care System. Blood pressure outcomes have declined since COVID, with wide variations in control and the inequality gap worsening.

Our Primary Care Network (PCN) in Lambeth cares for 45,000 patients registered at Edith Cavell Surgery and Streatham High Practice.

Around 3,100 of these patients are diagnosed with hypertension.

AT GROUP
PRIMARY CARE | EDUCATION | TECHNOLOGY



London deprivation map

Baseline data April 2022 – AT Medics Streatham PCN

- **Hypertension prevalence in black ethnic groups = 13.7%**
- **Hypertension prevalence in white ethnic groups = 5.3%**
- **Controlled BP < 80 year olds in 2021/22:**
  - White population = 67%
  - Black population = 55%
  - 12% negative variation.

Our approach

Ambition:	To deliver the best hypertension outcomes in South East London for all members of the community regardless of background	To achieve this without any additional investment to prove that inequalities can be tackled sustainably and at scale.
Commitment:	to narrow the inequality gap between black and white patients.	
Implementation:	planning and prioritisation sessions in February/March 2022.	
Data-driven:	a dedicated health inequalities app developed on our in-house data analytics platform EZ-Analytics.	
Team:	led by a senior GP and PCN manager with centralised recall and pharmacist teams working alongside practice-based pharmacists and HCAs.	

Making best use of PCN resources

- Central recall and pharmacist teams
- Practice based pharmacists and HCAs
- Social prescribers and care co-ordinators
- Strong regional clinical and managerial oversight.

Role specific training and education

- Non clinical: varied recall methods, extra focus on under-served populations
- HCAs: proactive health promotion, screening for CVD risk, raised Hba1c and CKD, flagging off-target BP to pharmacists
- Pharmacists**:** treating to target based on NICE guidelines

Making best use of data

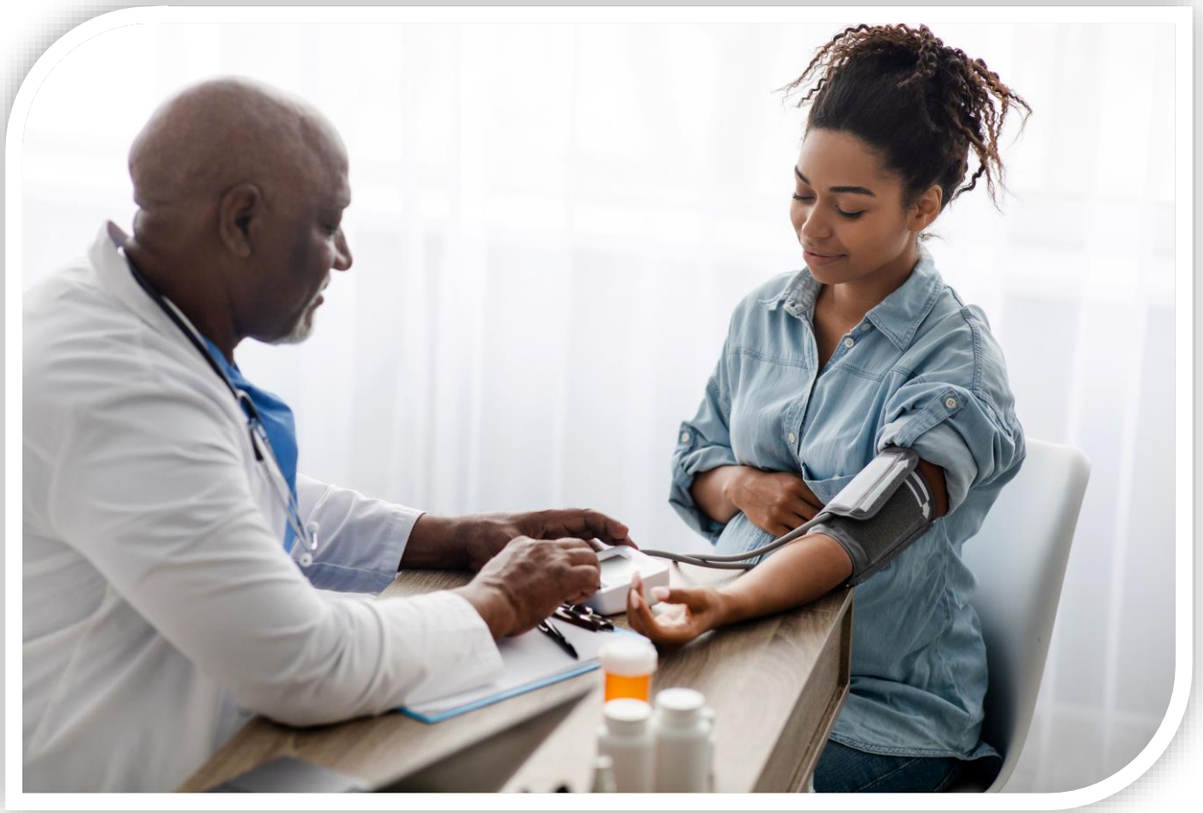
- Targeted recall of most at risk patients with focus on reducing ethnic variation
- Regular data socialisation and democratisation – in house communication channels - with fortnightly updates and reviews of data
- Guided resource allocation for specific recall of black ethnic and patients with serious mental illness
- Motivated workforce including staff from communities reflective of local area.

Specific enablers

Specific enablers cont…

Importantly, a pharmacist case study for the PCPEP provided additional insight on the impact of representation and recognising the importance of a diverse workforce to represent the community it serves

"Our patient mentioned that one significant factor that may have contributed to her improved readings was the fact that she was seeing a clinician who looked like her"



Outcomes April 2023: hypertension and ethnicity

- The project has eradicated the 12% inequality gap for BP control between our black and white patients in under 12 months.

- The latest figures show:
  - **BP control in white ethnic patients <80 years old = 86.9% (increased from 67.3%)**
  - **BP control in black ethnic patients <80 years old = 87.4% (increased from 55.2%)**

- This meant the inequality gap had been completed eliminated with all hypertensive patients now enjoying the same level of control irrespective of ethnicity.

- Blood pressure control for black patients in our PCN is now 21% higher than the Lambeth average.

Outcomes April 2023: overall hypertension control

87% of all patients < 80 years are now controlled, compared to 61% a year earlier

95% of all patients aged 80 years or more are now controlled, compared to 77% a year earlier.

98% of hypertensive patients had a recorded blood pressure reading in the last 12 months.

*Over 2000 NHS health checks were carried out by our HCA team in the last 12 months. This has contributed to over 300 patients newly diagnosed and managed for hypertension.

Gracie Tredget

Programme Manager, Mind & Body, King’s Health Partners

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Addressing Health Inequalities for People Living with Serious Mental Illness

With particular thanks to the following contributors to this presentation: Dr Julie Williams, Researcher, Centre for Implementation Science, Institute of Psychiatry, Psychology & Neuroscience at King's College London and Dr Mary-Jane Docherty, Deputy Medical Director at South London and Maudsley NHS Foundation Trust.

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A few words…

…from **Dr Mary Docherty**
Consultant Liaison Psychiatrist, King's College Hospital NHS FT
Acting Chief Medical Officer, South London and Maudsley NHS FT

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Premature mortality in adults with severe mental illness

“Severe mental illness (SMI) describes people with a group of conditions that are often chronic and so debilitating that their ability to engage in functional and occupational activities is severely impaired. SMI generally includes diagnoses such as schizophrenia, bipolar disorder or other psychotic illnesses that cause severe functional impairment.”

QOF prevalence reports **587,025** people living with an SMI in England.

Adults with SMI:

- are **5 times more likely to die prematurely** than people who do not have an SMI – a level of inequality seen in both males and females.
- **are at greater risk of premature death** as a result of gender, age and geographical location.

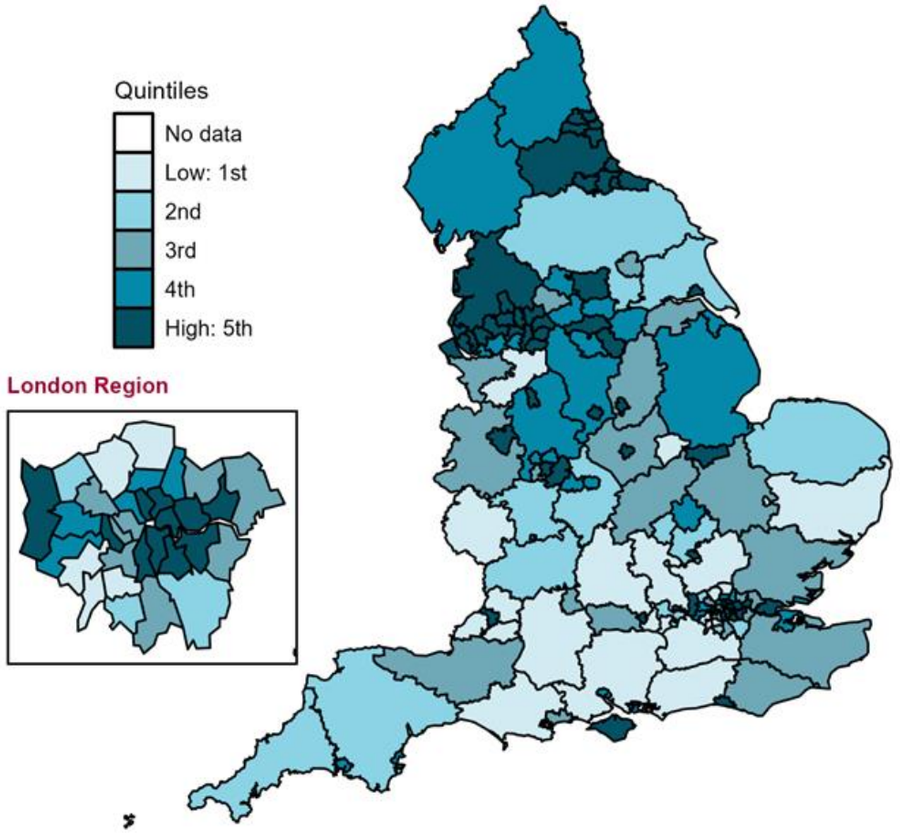

Figure 1: map of upper tier local authorities (April 2020 to March 2021) in England for premature mortality in adults with severe mental illness. Directly standardised rate - per 100,000, 2018 to 2020

Report: [Premature mortality in adults with severe mental illness (SMI). Updated April 2023.]

Physical health inequalities for people with severe mental illness

It is estimated that for people with SMI:

- 41.4% of patients with an SMI have one or more of physical health conditions (pictured right)
  - Prevalence of 2 or more physical health conditions in SMI is 1.8 times higher than all patients

- 2 in 3 deaths in this population are from physical illnesses that can be prevented, with major causes of death including cardiovascular disease, obesity, respiratory disease, diabetes, liver disease, heart disease, hypertension, COPD, asthma.

- Patterns of multi-morbidity occur irrespective of gender, age, or geographical location.

Prevalence (age and sex standardised) of physical health conditions for severe mental illness (SMI) and all patients aged 15 to 74

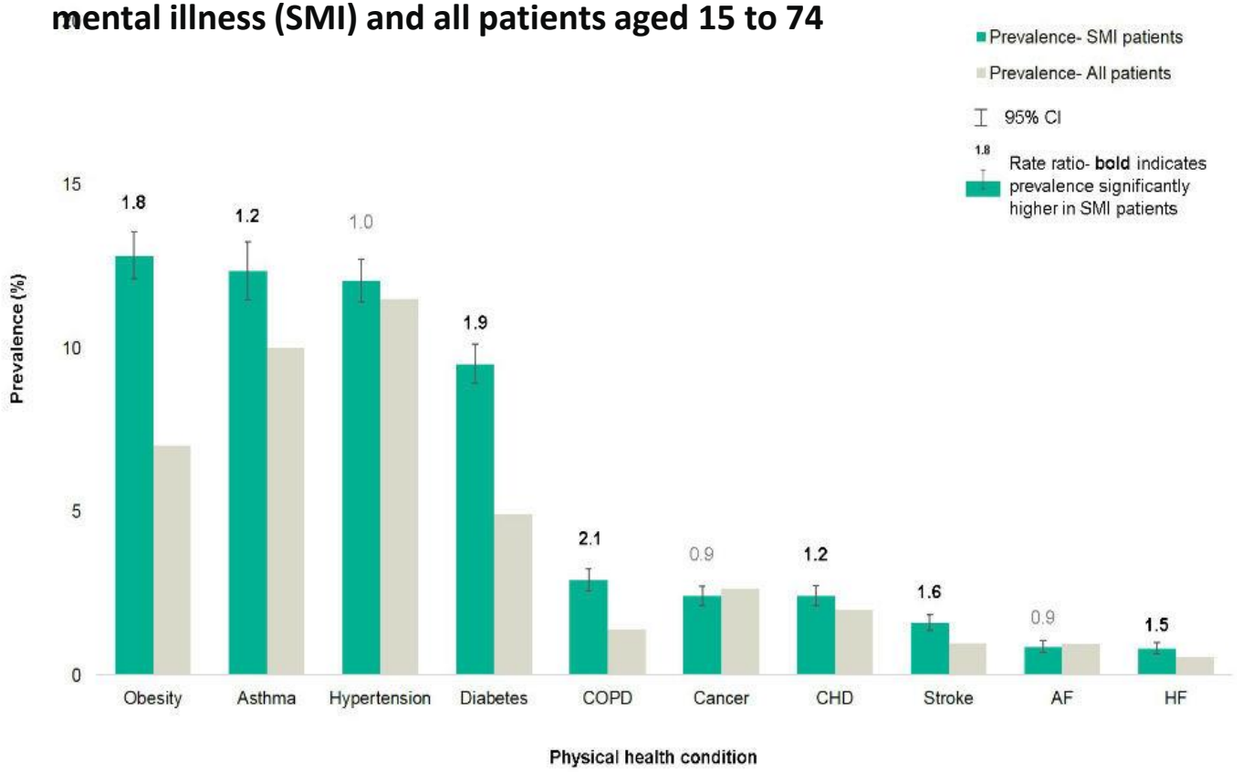

Figure 2: atrial fibrillation (AF), coronary heart disease (CHD), chronic obstructive pulmonary disease (COPD), heart failure (HF). Source: The Health Improvement Network (THIN), Active patients in England; data extracted May 2018 in Public Health England (2018). Severe mental illness (SMI) and physical health inequalities: Briefing. https://www.gov.uk/government/publications/severe-mental-illness-smi-physical-health-inequalities/severe-mental-illness-and-physical-health-inequalities-briefing. Accessed 30.01.2023.

How we understand and address determinants of poorer physical health amongst adults with SMI is ongoing.

Research suggests that improvements in physical health of people with SMI can be achieved by addressing and reducing the impact of:

- health behaviours
- multiple risk behaviours rather than one health risk factor at a time
- side effects of antipsychotic medication
- difficulties in accessing treatment
- disconnected and irregular approach to health and care provisions
- non-compliance with care process
- the effect of SMI on poor self-management of conditions
- socio-economic determinants such as poverty, poor housing, reduced social networks, lack of employment and social stigma

As well as the bringing together of physical and mental health services as set out in the NHS Five Year Forward View.

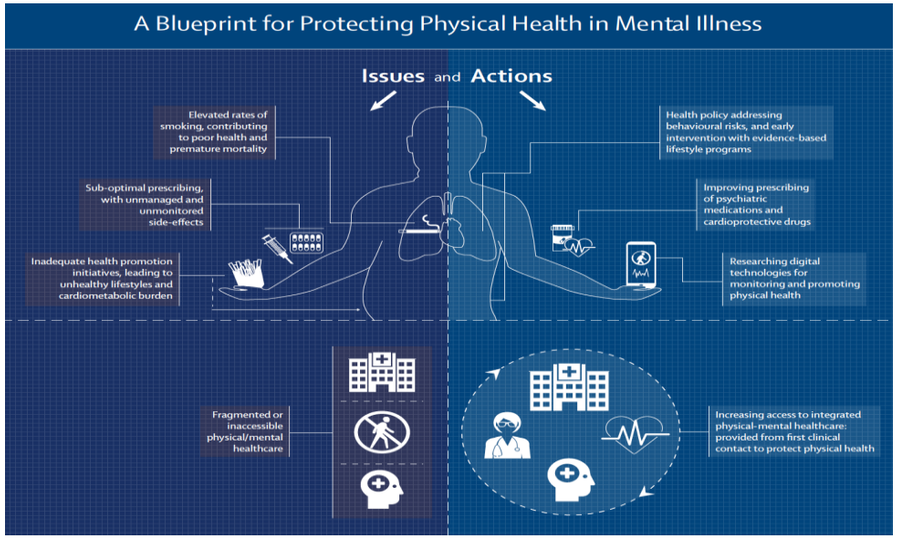

Figure 3: Firth J, et al (2019).. The Lancet Psychiatry Commission: a blueprint for protecting physical health in people with mental illness. Lancet Psychiatry. 2019 Aug;6(8):675-712. doi: 10.1016/S2215-0366(19)30132-4.

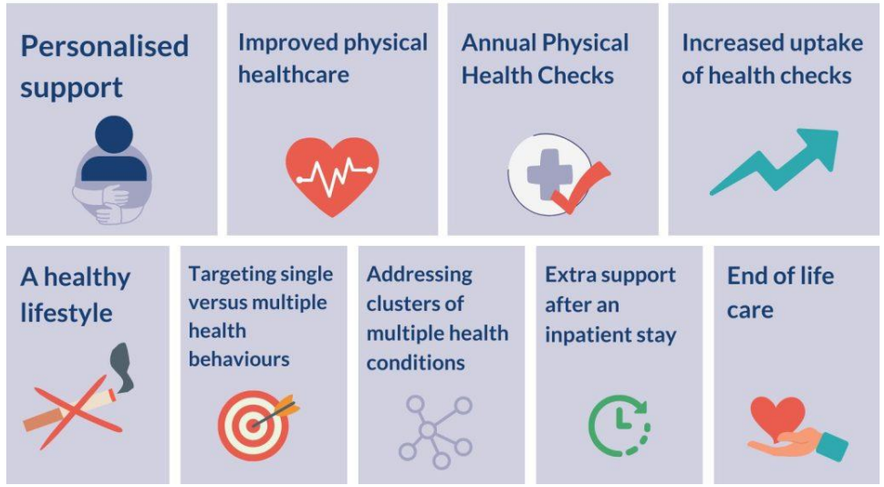

Figure 4: NIHR Evidence; Supporting the physical health of people with severe mental illness; April 2023; doi: 10.3310/nihrevidence_57597

FORUM – THE NEED FOR A COMPREHENSIVE APPROACH TO EXCESS MORTALITY IN PERSONS WITH SEVERE MENTAL DISORDERS (in collaboration with the World Health Organization)

Excess mortality in persons with severe mental disorders: a multilevel intervention framework and priorities for clinical practice, policy and research agendas

World Health Organization

Table 1 Multilevel model of risk for excess mortality in persons with severe mental disorders (SMD)

Individual factors	Health systems	Social determinants of health
Disorder-specific	***Leadership***	***Public policies***
• Severity of disorder	• Absence of relevant policies and guidelines	• Discriminating policies
• Family history	***Financing***	• Low financial protection and limited coverage in health packages
• Symptoms/pathophysiology	• Low investment in quality care	***Socio-economic position***
• Early age of onset	***Information***	• Unemployment
• Recency of diagnosis	• Limited health information systems	• Homelessness
Behaviour-specific	***Service delivery***	• Low health literacy
• Tobacco use	• Verticalization and fragmentation of health services	***Culture and societal values***
• Poor diet	• Lack of care coordination and management	• Stigma and discrimination in society
• Inadequate physical activity	• Limited access to services	• Negative perceptions about persons with SMD
• Sexual and other risk behaviours	***Human resources***	***Environmental vulnerabilities***
• Substance use (alcohol and drugs)	• Poor quality service provision	• Infections, malnutrition
• Low motivation (e.g., treatment seeking, adherence)	• Negative beliefs/attitudes of workforce	• Access to means of suicide
	• Poor communication	• Impoverished or unsafe neighbourhoods
	Medications	***Social support***
	• Antipsychotic medications (no treatment, polypharmacy, higher than recommended dosages)	• Limited family, social and community resources

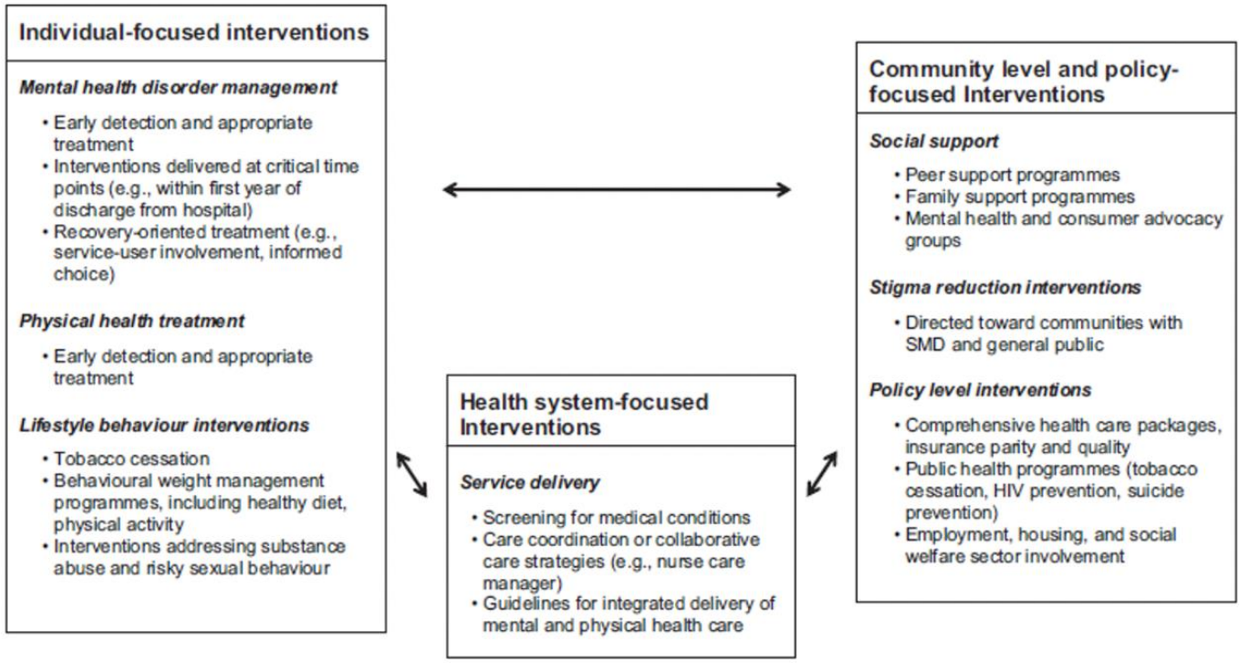

Figure 5: Multilevel model of interventions to reduce excess mortality in persons with severe mental disorders (SMD)

Liu et al (2017). Excess mortality in persons with severe mental disorders: a multilevel intervention framework and priorities for clinical practice, policy and research agendas. World Psychiatry, 16, 30-40.

National drivers to address inequalities for the SMI population

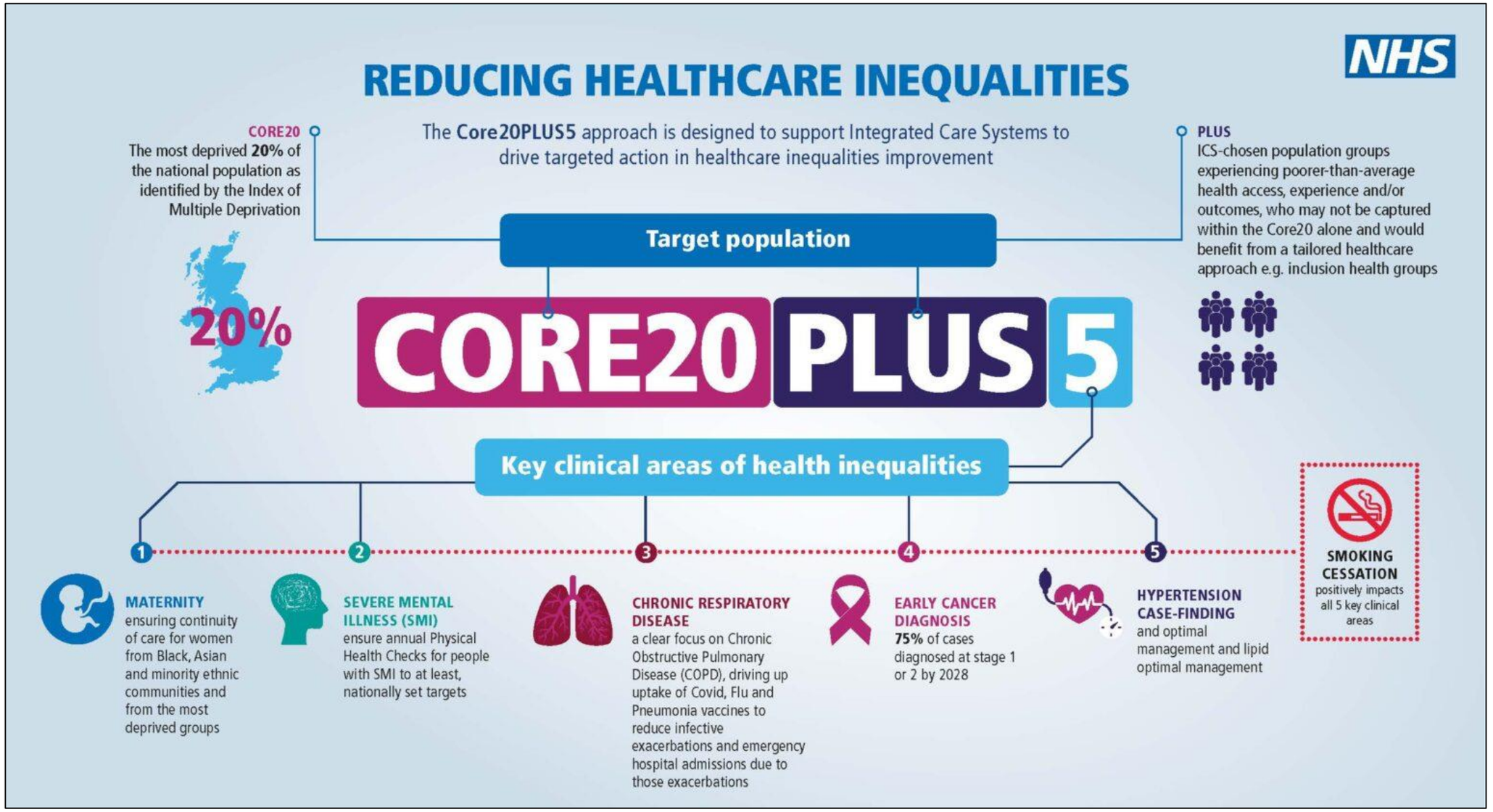

Figure 6: NHS England, Core20pLUS5: https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/core20plus5-cyp/. Accessed 21.06.23.

Our local body of work in this area

NHS South London and Maudsley NHS Foundation Trust

Knowledge development, testing and evaluation within one mental health trust working with community and inpatient services to design, test and evaluate the effectiveness of physical health interventions for adults with SMI.

NHS South London and Maudsley NHS Foundation Trust

Oxleas NHS Improving lives

Translating knowledge across organisational boundaries with multiple providers within south east London. This work has led to our involvement with the Vital 5 Programme at King's Health Partners and development of a south east London wide review exploring the inequalities and needs of our local SMI population.

NHS England and NHS Improvement

Spread knowledge across the region, country and our international counterparts by contributing to a national agenda on physical health for adults with SMI and contributing to academia through our various publications.

Funders:

Funded by Maudsley Charity Backing Better Mental Health.

South East London Integrated Care System

What are we doing next?

Developing a best practice approach for south east London and beyond

1. **Translating tested and evaluated physical health interventions**

2. **SMI Population Needs Review and Mapping in South East London** – to inform local policy and practice, linking to the Vital 5 programme at King's Health Partners

3. **Developing a Community of Practice Approach** - to improving, sharing and using knowledge across organisational boundaries to reduce the mortality gap for people with SMI within the region and beyond

4. **Contributing to local and national policy for SMI**

Figure 7: South East London Integrated Care System. https://www.selondonics.org/icb/. Accessed 21.06.23

Get in touch

We want to continue raising awareness of the work we are doing as a professional community to improve equity of access, quality and outcomes of care experienced by the SMI population.

If you want to hear more about this work or how you can get involved, please get in touch:

Email: mindandbody@slam.nhs.uk
Twitter: @mindandbody_khp
Website: www.kingshealthpartners.org/our-work/mind-and-body

With special thanks to our partners South London and Maudsley NHS Foundation Trust, Oxleas NHS Foundation Trust and our funder South East London Integrated Care System.

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7. NHS England, Core20pLUS5: https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/core20plus5-cyp/. Accessed 21.06.23.

Dr Rachel Kesse-Adu

Consultant Haematologist,
Guy's and St Thomas' NHS
Foundation Trust

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A co-produced learning tool for SCD patient care

Presented on behalf of Sickle Centre of Excellence part of KHP Haematology and SELSE HCC

By Dr Rachel Kesse-Adu

Consultant Haematologist

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November 2021

NO ONE'S LISTENING:

AN INQUIRY INTO THE AVOIDABLE DEATHS AND FAILURES OF CARE FOR SICKLE CELL PATIENTS IN SECONDARY CARE

- Report commissioned by sickle cell society and APPG after 2 high profile sickle patient deaths in 2021

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Home › Latest updates › News › 2021 News ›

Inquest finds failure to appreciate sickle cell crisis symptoms in the death of 21-year-old Evan Nathan Smith

Inquest finds failure to appreciate sickle cell crisis symptoms in the death of 21-year-old Evan Nathan Smith

Richard Okorogheye: Police confirm body find as missing student

7 April 2021

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- APPG inquiry sought to:
  - examine the level of care sickle cell patients receive when accessing secondary care
  - determine the action that is required to improve care for sickle cell patients

APPG Findings

- Sub-standard care on general wards and in A&E
- Failings in providing joined-up sickle cell care
- Low awareness of sickle cell among healthcare professionals and inadequate training
- Negative attitudes towards sickle cell patients
- Inadequate investment in sickle cell care

Recommendations

- 31 total recommendations made aimed at
  - NHSE/I, DOH, NICE
  - NHS race and Heath Observatory
  - Royal colleges, HEE
  - Commissioners
  - Specific ones for the North London Trust and network

And **7 (of the 31) recommendations specific to all NHS Trusts**

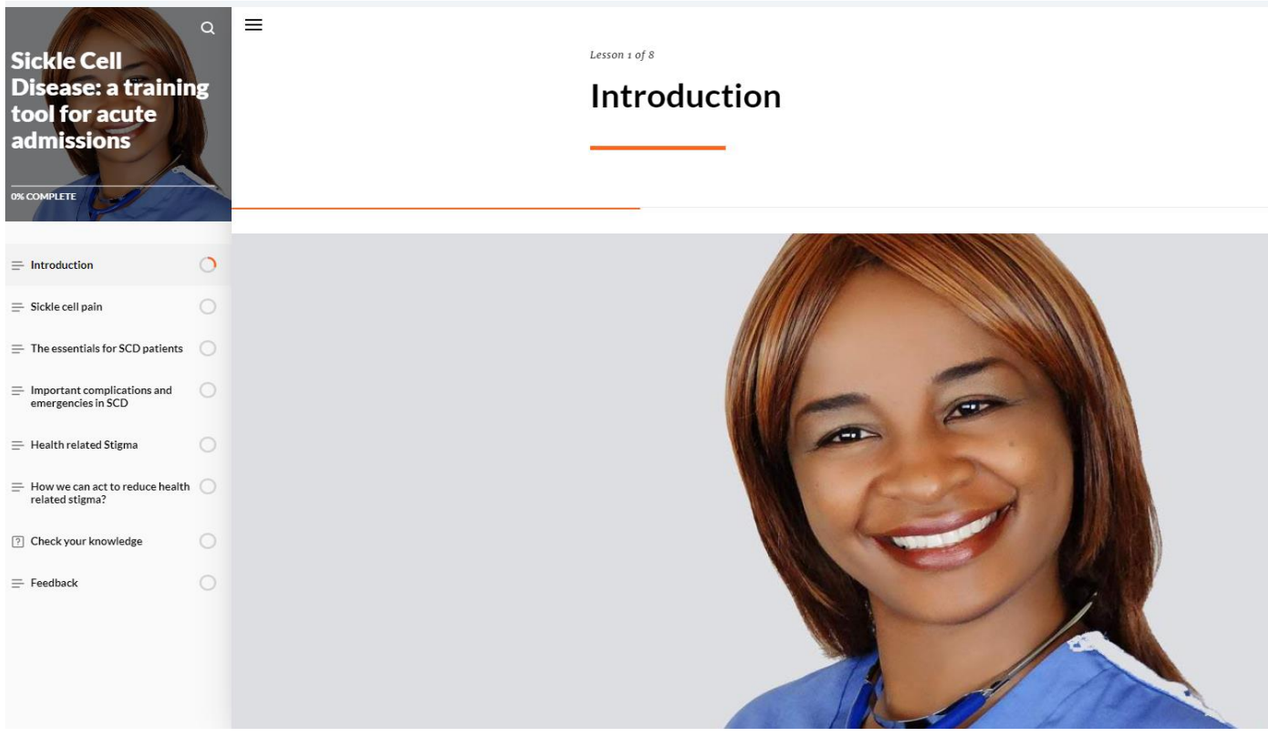
2. All NHS Trusts to develop an action plan setting out how they will ensure compliance with the NICE clinical guideline around the delivery of pain relief within 30 minutes for sickle cell patients, with appropriate advice from the NHS England Clinical Reference Group for Haemoglobinopathies pain sub-group

- **Sickle team action:** *time to analgesia audits since 2012 in ED achieve 35-63%*
- **GAP remains:**
  - **ED education,** ED Staff turnover, ED Sickle specific pathways
  - *Sickle specific admission pathways*

3. Royal College of Emergency Medicine and Royal College of Physicians to develop guidance for staff working in A&E and on general wards making clear that sickle cell patients should be prioritised for treatment as a medical emergency due to the high risk of fast medical deterioration, to be distributed by NHS Trusts.

Sickle teams action

- In 2019 leads team of SELSE HCC had recognised this need and started work on an e-learning tool, *with funding from EDI team at KCH and KHP haematology* this is now completed and on both Trusts training websites
- We have strongly ***recommended that this tool be adopted as Trust wide mandatory training*** to help us meet this recommendation
- **Includes sections on health-related stigma**




No One's
Listening

Cross Site Sickle Committee Chaired by Avey Bhatia (Chief Nurse, Guy's and St Thomas NHS FT)

Membership: all departments with contact with SCD patients and SCD teams both adult and paediatric

Purpose and Function:

- **review and support implementation of Trust actions in response to the APPG report**
  - review and support actions to resolve barriers to Trust wide implementation
- review of bi-annual PREMS
  - (patient reported experience measures survey) and actions required to implement valid change
- Sickle teams (adult and paediatric) from both site attend and report into meeting

Thank you

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Josh Wells (he/him)

Senior Clinical Lead, LVNDR Health

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Queer Eye for The Vital 5

Josh Wells (he/him)

Founding Clinician @LVNDR Health

jw@lvndr.com

www.lvndr.com

KHP - Pioneering better health for all

2

Obesity

1

Blood Pressure

3

Mental Health

5

Alcohol Intake

4

Smoking Status

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Health systems are not built for LGBTQ+ folks.

Extracts from almost 800 LGBTQ+ interviews

ALEXIS
(she/her)

"**Being continuously misgendered** and **asked questions about my genitalia** to invalidate me as a woman has been horrific. **I've avoided in-person services since**."

JASON
(he/they)

"When I first started exploring my sexuality **I didn't know how to be safe**, and what PrEP is - I was **too ashamed** to ask and **too scared** to seek care. "

DARKWAH
(they/them)

"After being kicked out of my home, I did sex work for a while and needed **regular check-ups.** I knew they knew by the way they treated me and **dismissed my pain**."

MUFSEEN
(he/him)

"Having to **wait months for an appointment** and trek to London was **exhausting**. I was so **terrified**, I wasn't ready to be out but I **needed to explore who I am.**"

LVNDR provides a user-centric experience with non-judgmental care

1. Test

Remote diagnostic tests

2. Talk

Virtual Consultations with LGBTQ+ specialist clinicians

3. Treat

Door to door delivery of medication

SYNLAB

UK CA

NHS
Providing NHS services

THE INDEPENDENT PHARMACY

General Pharmaceutical Council

NHS
Providing NHS services

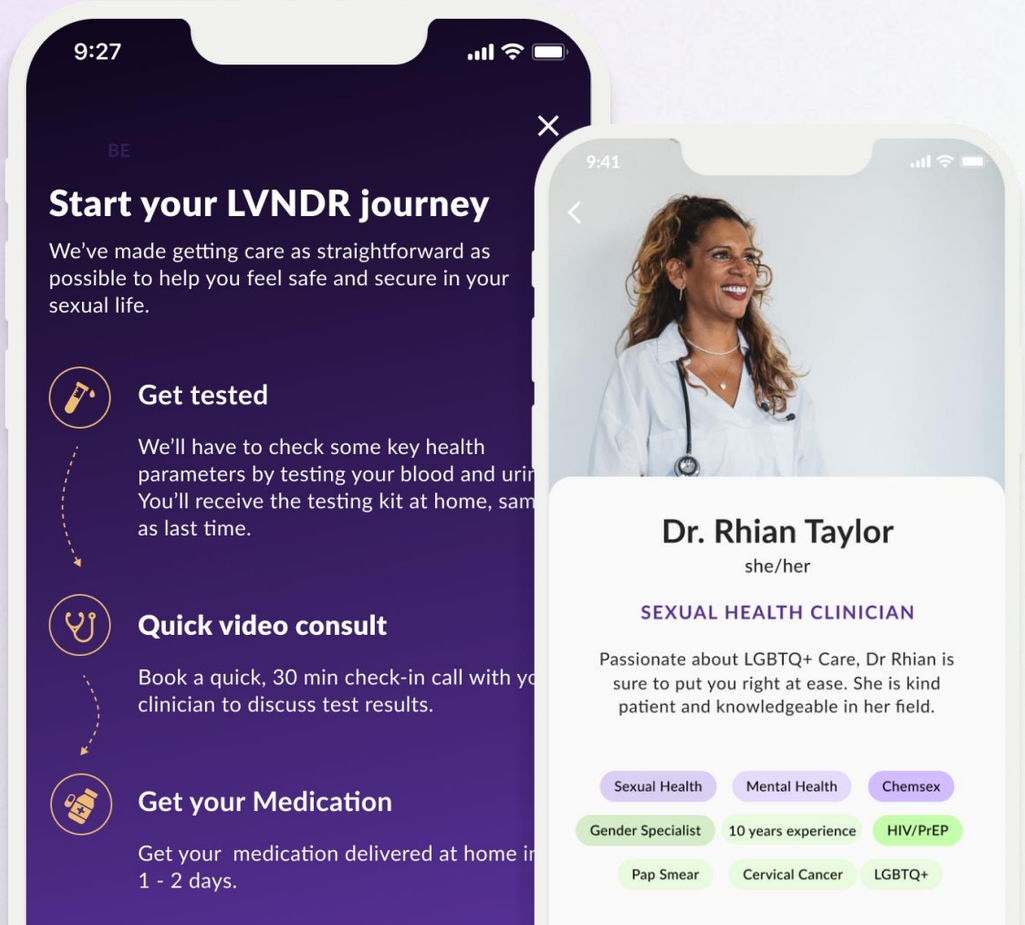
Curating the LGBTQ+ experience with LVNDR's Dual-Platform

Regulated by CareQuality Commission

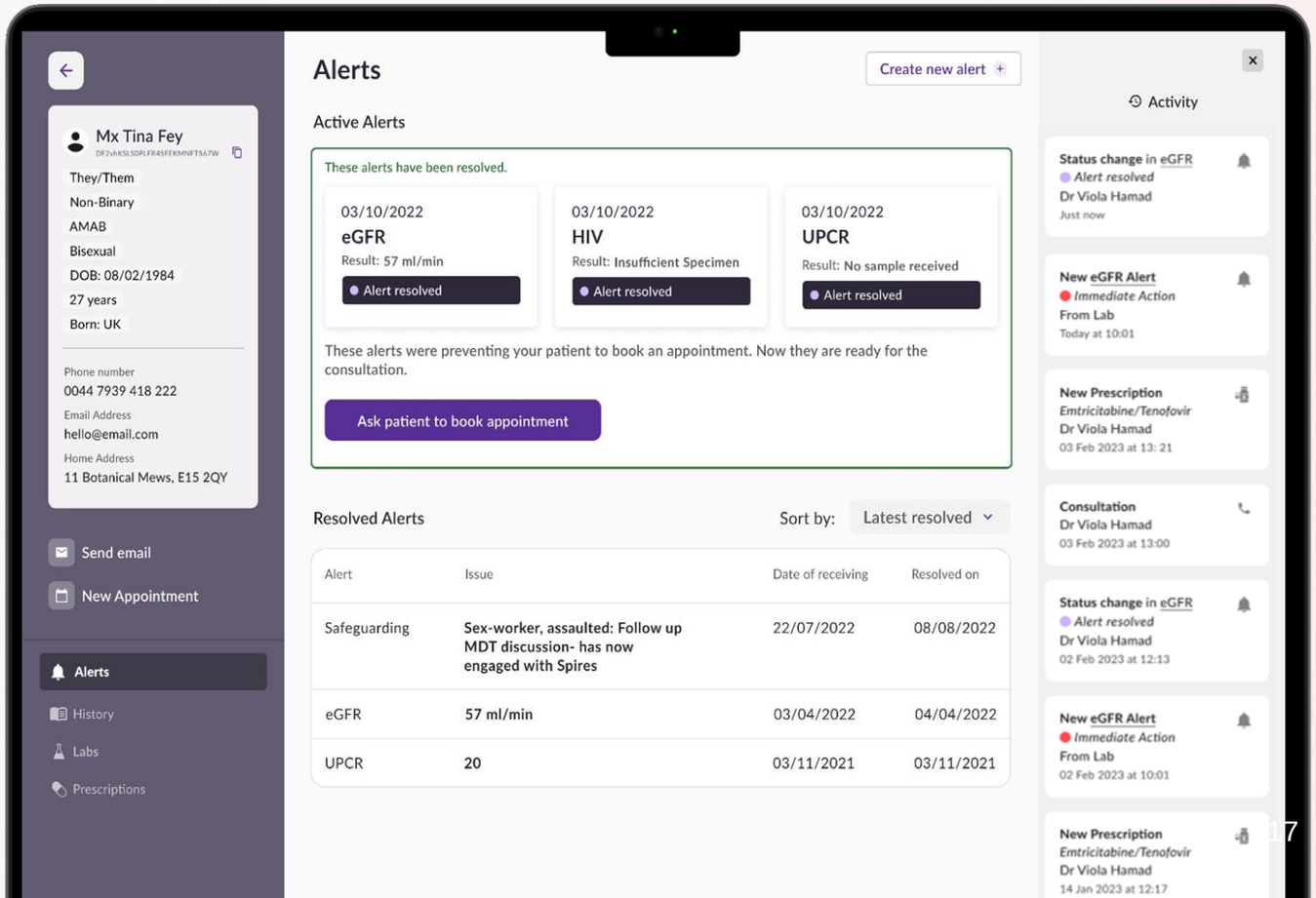
Empowering LGBTQ+ users with a seamless and personalised service

Enabling clinicians to provide superior clinical efficiency, and improved patient outcomes.

Mobile App

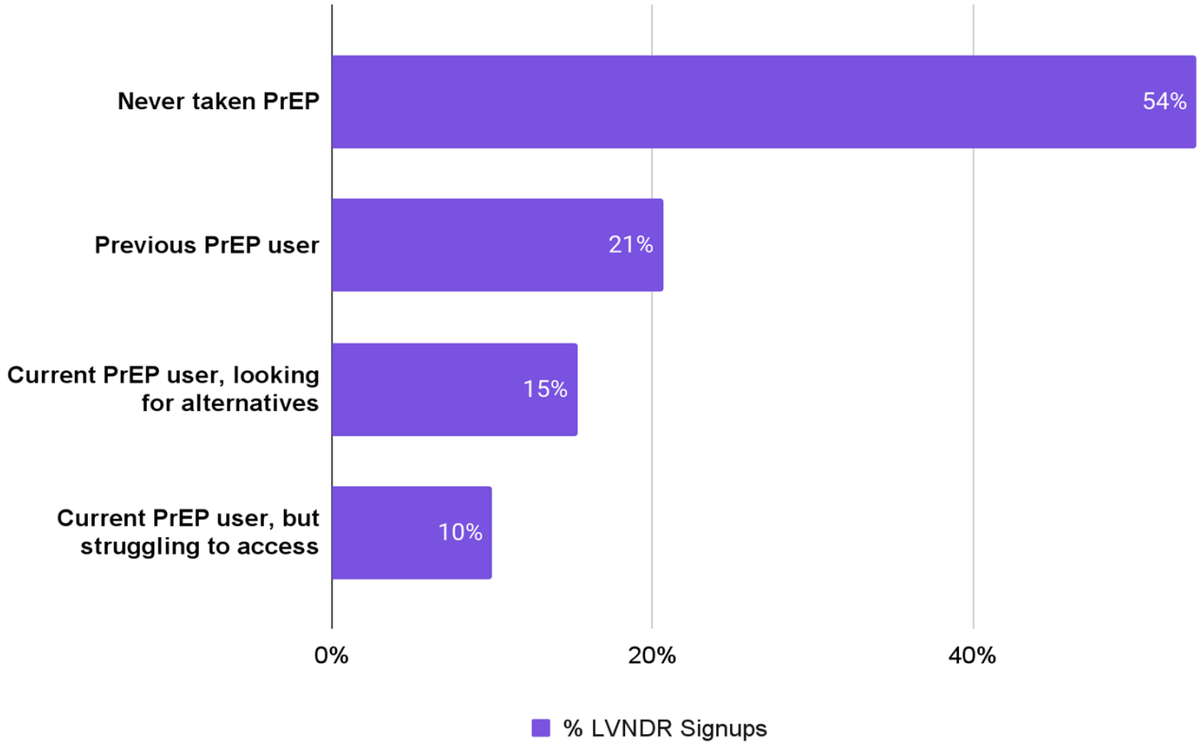


Clinician Dashboard



Unlocking access for key demographics

Almost 3/4 of signups have never taken PrEP or have discontinued PrEP.

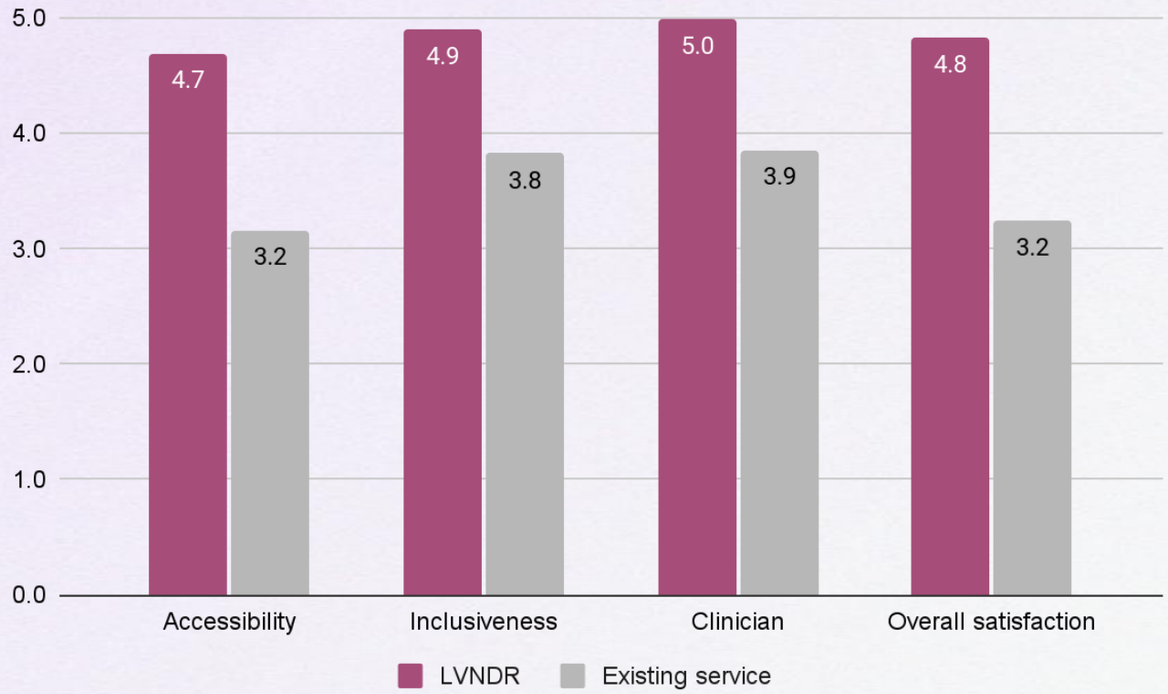


PrEP for overlooked populations

Metric	LVNDR	EmERGE
% SUs from non-white ethnicity	22%	9%
% SUs not born in the U.K	40%	-
% Transgender/ Non-Binary/Cis Female	13%	3%

User Feedback

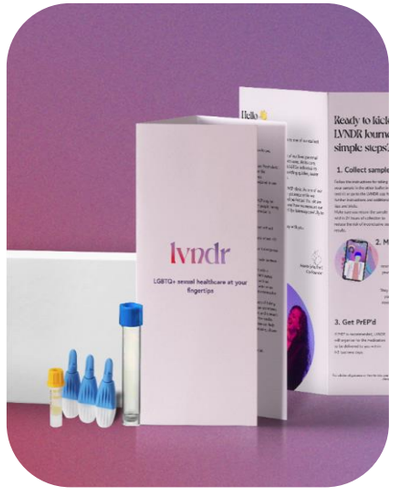
LVNDR vs Existing Services



Metrics	LVNDR
Net Promoter Score	**93** / 100
Customer Satisfaction *(vs Standard Care 3.2)*	**4.8** / 5
System Usability Scale Score* *(vs Average 68)*	**83** / 100
Likelihood of Switching to LVNDR when publicly available	**4.8** / 5

** The System Usability Scale (SUS) is an industry standard tool - reliable for measuring the usability of digital products. (Target >68)*

LVNDR provides a user-centric experience with non-judgmental care



Collect
Asynchronous patient data collection

1. Test

Remote diagnostic tests

2. Talk

Virtual Consultations with LGBTQ+ specialist clinicians

3. Treat

Door to door delivery of medication

SYNLAB

UK CA

NHS
Providing NHS services

THE INDEPENDENT PHARMACY

General Pharmaceutical Council

NHS
Providing NHS services

LVNDR Committed to Making Every Contact Count

Collecting robust data for richer patient profiles and timely interventions - *indicative of LVNDR's journey.*

Respiratory	Mental Health	Cardiac	Hypertension	FHx	BMI >25
10%	42%	10%	3%	16%	61%

BMI >30	Hep A/B/HPV	MPox	Smoking	EtOH	Drugs	Chemsex	Vulnerability Concerns
15%	25%	59%	21%	41%	41%	10%	14%

1. Blood Pressure
2. Obesity
3. Mental Health
4. Smoking Status
5. Alcohol Intake

Review

A review of minority stress as a risk factor for cognitive decline in lesbian, gay, bisexual, and transgender (LGBT) elders

Anthony N. Correro II , MS & Kristy A. Nielson , PhD

Pages 2-19 | Received 06 Jan 2019, Accepted 09 Jul 2019, Published online: 31 Jul 2019

Download citation https://doi.org/10.1080/19359705.2019.1644570 Check for updates

Review Article | Published: 13 July 2022

Hypertension in transgender individuals

Michael S. Irwig

Journal of Human Hypertension (2022) | Cite this article

LGBT Community, Social Network Characteristics, and Smoking Behaviors in Young Sexual Minority Women

Michelle Marie Johns, Emily S. Pingel, Emily J. Youatt, Jorge H. Soler, Sara I. McClelland & Jose A. Bauermeister

American Journal of Community Psychology **52**, 141–154 (2013) | Cite this article

Alcohol use among gender and sexual minorities: LGBT+ Drinkaware

Laetitia Zeeman, Catherine Meads, Nigel Sherriff, Kay Aranda

Sexual orientation–based disparities in food security among adults in the United States: results from the 2003–2016 NHANES

FREE

James K Gibb, Mostafa Shokoohi, Travis Salway, Lori E Ross

The American Journal of Clinical Nutrition, Volume 114, Issue 6, December 2021, Pages

Research Article

Apparel Consumption and Embodied Experiences of Gay Men and Transgender Women in India: Variety and Ambivalence, Fit Issues, LGBT-Fashion Brands, and Affordability

Vishakha Chauhan, MBA, Kelly L. Reddy-Best, PhD, Mahim Sagar, PhD, Arbuda Sharma, PhD & Karan Lamba, MBA

Pages 1444-1470 | Published online: 13 Dec 2019

LGBT Cultural Competence and Interventions to Help Oncology Nurses and Other Health Care Providers

Asa Radix, Shail Maingi

Homelessness among youth who identify as LGBTQ+: A systematic review

Edward McCann, Michael Brown

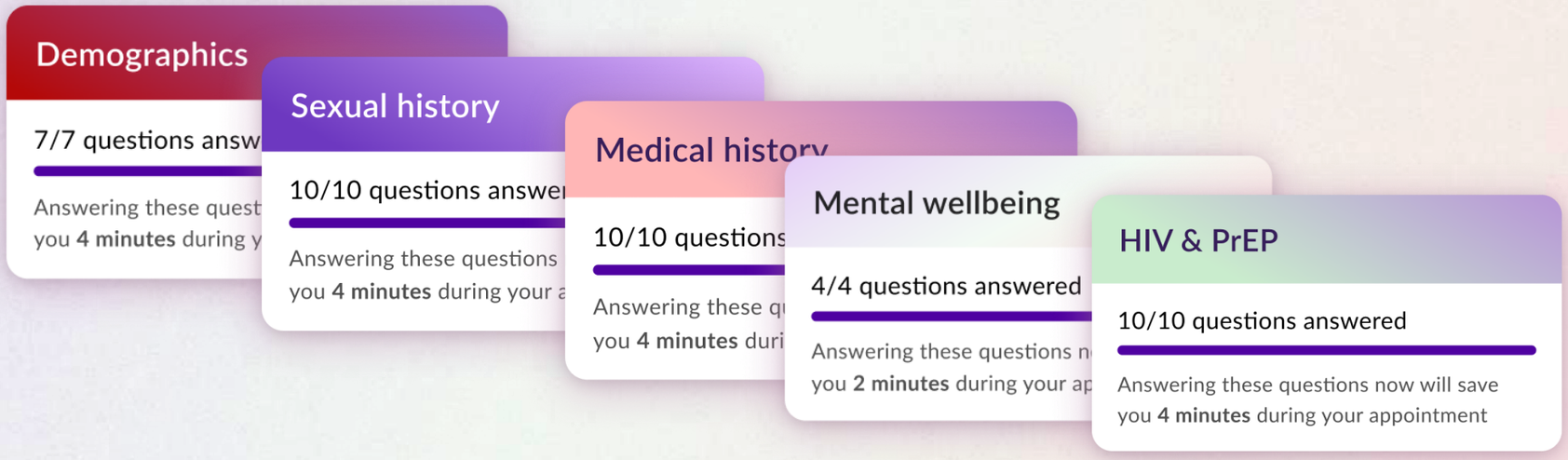
Building a longitudinal LGBTQ+ population health database

KING'S HEALTH PARTNERS

+ Collect over 80+ patient reported metrics covering holistic elements (Vital 5, Core20PLUS5, psychosexual history, PrEP...)

+ Building on trust to enhance a therapeutic alliance

+ 100% of users completion >2 packages, average completion 88%



Patient Love

*“I feel like **I was treated as anyone would want to be…** Thank you. This will be **a life changing service** for a lot of people.”*

- LVNDR Health Patient

Inclusive Healthcare *can't wait*

jw@lvndr.com
www.lvndr.com

Join our journey

THE TIMES

Forbes

sifted

backed by FT FINANCIAL TIMES

Making the most of our assets

Bringing together local people & communities with the health & care system to understand & address the wider determinants of health

Chaired by Prof Laia Becares

Professor of Social Science & Health, King’s College London

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Ranjeet Kaile

Director of Communications at SE London ICS & South London and Maudsley NHS Foundation Trust

Dr Kaneez Shaid

Health Organising Lead, Citizens UK

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Improving our Population's Health Through Community Organising

South London Listens and Anchor System Movements

Ranjeet Kaile, SEL ICB and Dr Kaneez Shaid, Citizens UK

The mental health challenge presented by COVID-19

Working together to promote recovery, prevent a mental ill-health crisis and find solutions to our most pressing challenges.

South London Listens

The mental health challenge presented by Covid-19

- Predicted 10 million people in the UK will need either new or additional mental health support as a direct consequence of the ongoing pandemic.
- Already impacting on mental ill-health in adults and young people
- Amplifying effect on pre-existing inequalities in both society and health services
- Affected communities and groups are those already experiencing significant health inequalities.

What I learned in lockdown Writers and readers on how they got through it

G2 Special issue

Monday
28 December 2020
£2.20
From £1.75 for subscribers

The Guardian

Covid's impact on mental health will last years, royal college warns

NHS urged to prepare for 'biggest threat since second world war'

Ian Sample
Science editor

The Covid-19 crisis poses the greatest threat to mental health since the second world war, with its impact set to last for years, the country's leading psychiatrist has warned.

Dr Adrian James, president of the Royal College of Psychiatrists, said a combination of the disease, its social consequences and the economic fall-out were having a "profound effect" on mental illness that would continue long after the epidemic was reined in.

Up to 10 million people, including 1.5 million children, are predicted to need new or additional mental health support as a direct result of the crisis.

The prediction comes as the virus is surging in the UK, and highlights the need for a plan that ensures those who develop mental illness or whose conditions worsen have swift access to effective support in the years ahead.

"This is going to have a profound effect on mental health," James told the Guardian. "It is probably the biggest hit to mental health since the second world war. It doesn't stop when the virus is under control and there are few people in hospital. You've got to fund the long-term consequences."

At the start of the epidemic, demand for mental health services dropped as people stayed away from GP surgeries and hospitals, or thought treatment was unavailable.

'The impact doesn't stop when the virus is under control'

Dr Adrian James
Royal College of Psychiatrists

But the dip was followed by a surge in people seeking help, which shows no sign of abating.

Data from NHS Digital reveals that the number of people in contact with mental health services has never been higher, with some hospital trusts reporting that their mental health wards are at capacity. "The whole system is clearly under pressure," James said.

Modelling by the Centre for Mental Health forecasts that up to 10 million people will need new or additional mental health support as a direct result of the pandemic.

An estimated 1.3 million people who have not had mental health problems before are expected to need treatment for moderate to

6


Don’t agonise, organise.
Florynce Kennedy

South London Listens Programme

Timeline and achievements to date

Organise

- 3 **major summits** across south London
- **System partnership** with statutory and Community
- **Taskforce** created to identify six key themes to address

June 2020 – October 2020

Listening

- **2000** people attended summits
- **350** community leaders trained to engage
- **5780** people directly involved in South London Listens (SLL) campaign

November 2020 – February 2021

Plan

- 6 Taskforce themes refined to 4 through SLL campaign feedback
- Co-producing proposals and action plan with community leaders through issue workshops

February 2021 – May 2021

Act

- Agreement on institutional asks on priority areas
- Community co-delivered action plan agreed
- 16 June (6-7.30pm) **Community summit**
- 2-year recovery action plan launched
- October 2021

May 2021 – Oct 2021

Evaluate

- Review achievements against agreed action plan and metrics
- Annual listening review with stakeholders and community
- Community survey

Jan 2022 – Nov 2023

South London Listens in numbers

6,000
local co-designers

3.7 million
people served

150+
voluntary, community and social enterprise organisations and community leaders

12 local authorities

Three
NHS mental health trusts

Two
Integrated Care Systems

South London Listens - priorities

Priority 1

Loneliness, social isolation and digital exclusion

1.1 Support the Mental Health Champions programme

1.2 Develop a social isolation, loneliness and digital inclusion strategy

Priority 2

Work and wages

2.1 NHS to become Living Wage accredited

2.2 Champion the Living Wage in the health sector

2.3 Local authorities to become Living Wage accredited

2.4 Local authorities to develop a Living Wage places scheme

Priority 3

Children, young people and parental mental health

3.1 Create a CAMHS virtual waiting room

3.2 Resource parent groups to offer peer-to-peer support

Priority 4

Access to mental health services for migrants, refugees and diaspora communities

4.1 NHS to invest in mental health practitioners embedded in community organisations

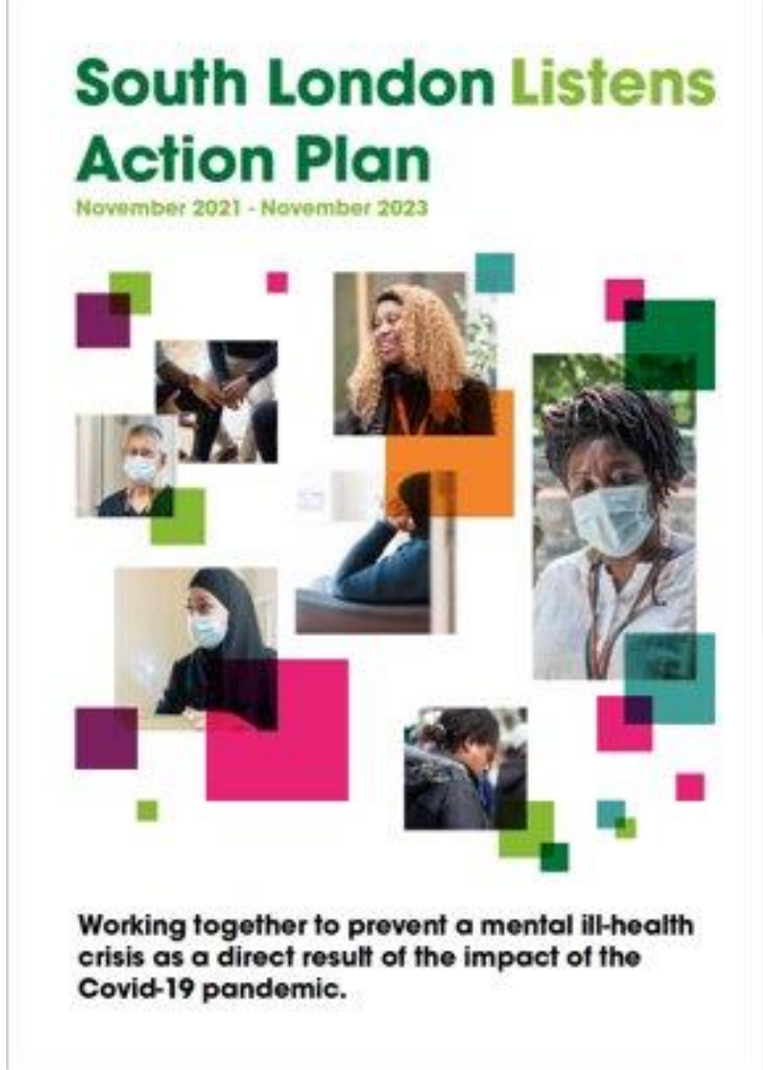
4.2 NHS to develop a culturally competent workforce

4.3 Local authorities to support 4.1 and 4.2

4.4 Support the 'Safer Surgeries' initiative

South London Listens – to South London Acts

From Listening, to Action, to Impact:



Download the Action Plan

IMPACT REPORT

Year One - 21/22

South London Listens is a partnership between the NHS, Citizens UK, Local Authorities and 150 community organisations.

Download the Impact Report

Adapting to new challenges – long term theory of change

Centre for Society and Mental Health

1. Building and growing relationships, trust, and power to enable mental health recovery –

2. Using community listening and organising to develop, test and scale up innovations that show the greatest potential for impact

3. Address the social and economic injustices that are exacerbating mental ill health in South London

Building our evidence base: Academic Advisory Board

Centre for **Society** and **Mental Health**

Professor Craig Morgan

Co-founder and director for the ESRC Centre for Society and Mental Health, King's College London

Dr Crispin Day

Head of Centre for Parent and Child Support and Visiting Professor/Head of CAMHS, South London and Maudsley NHS Foundation Trust

Professor Derek Bolton

Professor of Philosophy and Psychopathology, King's College London

Professor Stephani Hatch

Vice Dean for Culture, Diversity & Inclusion, Institute of Psychiatry, Psychology & Neuroscience (IoPPN), King's College London

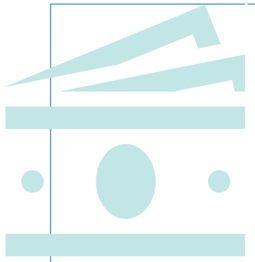
Greater than the sum of our parts

Creating an Anchor System to harness the power of our institutions for local residents

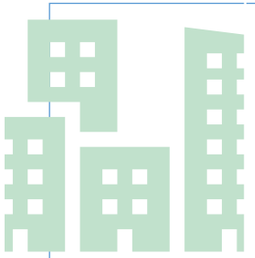
Anchor System Programme

Taking this further through the anchor system programme – our challenge and opportunity today

People in south east London face a **range of health inequalities that exist, and are exacerbated by, the environment in which people live, the air people breathe, the work people do and the income they earn**.



Anchor institutions in south east London **collectively employ over 100,000 people and spend billions annually** as well as attracting investment into local areas in south east London.



We are **uniquely placed to create good work, economic opportunity, and healthy places to support our local communities to thrive** during today's cost of living pressures

Individually, organisations in SEL are **already undertaking a wealth of projects at place to further the aim of better health for south east London communities**, but together we can go further, by working in partnership and doing more at scale where duplication exists.

Anchor alliance – shared commitment to shifting power to communities

Insights from anchor alliance brainstorm on opportunities for anchor collaboration – input from trust, local government, higher education and ICB partners

"Anchor institutions share a strong identity as providers of community service"

"Deepening community engagement is necessary to support their mission"

"Institutions' scale and number of employees allow for significant impact"

"Build trust with communities and break down barriers"

"Genuine engagement that is representative and truly open"

"Joint recognition that institutions can come together to prevent health inequalities

Listening and organising

Listening…	Involves being open to hearing and understanding the perspectives and priorities of local communities, rather than telling them what they need.
	Values the input of communities in shaping their lives and the decisions that affect them.
	Is an active process that builds relationships, develops leadership, and fosters mutual understanding for future partnerships.
	Aims to better understand what people care about and why, and to form a diverse group of individuals who are willing to work together on mutual interests to enact change.
	Requires questioning assumptions and being open to challenging traditional ways of working to facilitate positive outcomes.

“What puts pressure on you and your community’s ability to thrive?”

Building power with communities to tackle the wider determinants

South East London Integrated Care System

- At the heart of this is our organisations' role as anchor institutions – this is where a lot of our power is
- Taking a different approach to addressing the '80%' challenge – all the stuff that isn't healthcare.
- Not about sitting in an office and designing a project but working with communities to produce the ideas and solutions
- All about power and relationships
- Come to our workshop this afternoon at **3:05pm**: "Harnessing the power of communities in our work as anchor institutions"

Tosca Fairchild

Chief of Staff, SE London ICS

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Joseph Casey

Director, Partnerships & Programmes, King's Health Partners

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Thank you for joining us today

Please give us your feedback via the QR code

South East London Population Health & Equity Conference 29 June 2023

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