# Appendices

**Scrutiny Review – Engaging with hard to reach communities**

## APPENDIX A – Contributors to the review

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## APPENDIX B – Review submissions

### AFRIKCARE

Presented by: Ibi Campbell (Volunteer, AFRIKCARE)

**WHO WE ARE:**
Afrikcare was set up in 2006 as a Befriending service to the Sierra Leonean (West African) Community many of whom were Refugees fleeing the 15 year brutal civil war in Sierra Leone between 1990 and 2005. Immigration advice and support to enable Refugees settle in Haringey and neighbouring Boroughs were originally provided by Sierra Leone Family Welfare Association. The project's objectives were achieved successfully but was time limited and ended in 2007. Afrikcare then took over and continued to provide Befriending, advocacy and culture specific counselling services for this group of people. We are not funded by the council, we relied on members voluntary contributions because we support people living in Hackney, Islington, Enfield as and when needed. Determined to make sure people from our community do not suffer in silence, we were later able to identify more older Sierra Leonean people in need of support and others of West African origin, who were found to be isolated, lonely, some of whom have lost contact with families and friends and lack understanding of the social system.

**HOW WE DID IT:**
Many of the people we found were through:

- 'word-of-mouth' – talking to other compatriots
- network with other groups in the South East/West London – asking if they know who has arrived and whether they live in Haringey or surrounding boroughs
- attending social functions and events
- attend local Churches/Faith groups or,
- by hearing one of the Country's ethnic language spoken in local markets and shops.

We try to first establish a dialogue and rapport, to build confidence. (Many Africans are friendly and tend to trust all and sundry, however, because of the decades of war which has affected some parts of that continent, there is lack of trust , suspicion and apathy amongst those who manage to escape to a safe place. Therefore, we use certain skills based on our culture to attract these people in order to befriend and find out what there issues are, in order to signpost to other services if need be or provide direct support to the individual or families.

**BARRIERS TO PARTICIPATION:**
Many Older African people tend not to seek assistance because they are not aware that they could benefit from services.

- Services are usually labelled as BME, but when accessed found that they are either for Caribbean or Asian people
- Perceptions that Africans are economic migrants therefore isolate themselves from mainstream services.
- Some older African people living here felt because they have not contributed to tax and national insurance they are not entitled to benefits

- Older family members who are invited to come over as childminders and later become ordinary resident do not understand the social system , and when they fall ill or there is a family rift, they are immediately send back home because families here cannot cope with looking after them. They have limited time to engage with the Council if they are full-time childminders.

- The stigma of HIV/AIDS prevent many African sufferers not to discuss/disclose their issues, but secretly attend private clinics

- BME classification does not always provide a solution for all Africans because of the different customs/cultures/language and values.

**WHERE IMPROVEMENTS CAN BE MADE**

We recognise that there are limited resources, however, effort should be made to reach out to all communities. This will enable the local authority to learn and understand that we are all unique in different ways as well as contribute to the welfare of our individual communities.

- A recognition/celebrating the diversity of the Boroughs Communities by organising events for and with the different community groups.

- Advertise and promote the services available, eg. Pensions, Disability Allowance, Community Transport, Mental Health Awareness; Dementia, Sicklecell, Prostate Cancer, etc; etc at community events.

- Support the development of culture specific services

- Encourage more partnership/consortia working to manage resources

- Engage with more African led churches as they provide a vehicle for reaching out to those who would not engage with mainstream.

- Ensure that older parents who are child minders do not become vulnerable to abuse.

## BME Carers

**Presentation by** **Cenk Orhan**
**(Project Officer – Black & Minority Ethnic Carers Support Service)**

## Who are the 'Hard-to-Reach'?

Black and Minority Ethnic Groups

Younger and Older People

People with disabilities

Lone parents

Lesbian, gay, bisexual and transsexual people

Homeless people

Carers

## Common difficulties

**1. Written information**
**General measures for providing accessible written information:**
The following tips will ensure your documentation is accessible:
• Text should be 12pt, preferable 14pt and in 'Arial' – Times New Roman can be difficult for those with dyslexia
• Checked for Plain English and proof read
• Avoid use of italicised fonts
• Use an even type spacing
• Justify left margins and leave right margins ragged
• Avoid printing over a background image

**2. Intimated or alienated by approach**
There may be a number of reasons that prevent people from confident participation. The following measure should be considered:
• Consider using telephone or face-to-face methods of consultation
• Go along to support group meetings

**Staff**
• Ensure that staff involved in carrying out consultation work are adequately trained in equalities issues and avoid the use of stereotypes, assumptions on behaviour or any approach, which may appear patronising or discriminatory
• There are many regular Diversity Awareness courses to assist with this

**Negative Connotations with the 'Council'**
• It may be appropriate to engage a consultant or other specialist organisation that can provide consultation services.
• Some voluntary organisations are very good at providing services in this field of work, as are community workers.

**Lack of confidence or self-esteem 'my opinion is worthless or won't be listened to'**
• Engaging with people in situations and environments that they are familiar with can break down numerous barriers, so may help in situations such as this
• Emphasise that there are no right or wrong answers

**3. Etiquette**
The Council's Etiquette Guide includes good practice tips on meeting and addressing people from a diverse range of backgrounds.

**4. Venue Accessibility**

**Transport Issues**
• Consider whether the venue is easily accessible or whether alternatives can be provided for people that cannot get to the venue e.g. weblinks.
• What about parking, bus fares and the cost of attending? Will they be barriers to hard-to-reach groups who may want to attend?

**People with Disabilities**
• Is it DDA complaint?
• Is a hearing loop already available and do you know how to use it? If there isn't one already available, can you provide one?
• Do you need a sign language translator for the meeting or focus group?
• Are there disabled parking bays available or can you provide transport to the meeting?

**5. Timing and resources**
• Does it clash with school holidays?
• Does it clash with the 'school-run'?
• Will the meeting be held during dark nights (a real consideration during winter)
• Does it coincide with any major religious festivals?
• If it is held during the day, have you considered those that are working?
• If you are involving other groups or organisations, does it allow sufficient time for consideration during their cycle of meetings?

**Lack of time or resources**
• If you are engaging with busy working families and parents, would it be better to go to them directly? Schools, after school clubs, pre-school groups etc

**People unable to respond within the period for consultation**
• The government usually allows around six weeks for major consultations to allow for those individuals or groups that may be busy for periods of time and may be unwittingly excluded from engaging
• With regards to the voluntary sector involvement, you may wish to refer to the Haringey Compact

**6. Rarely reached by publicity material**

**Publicity material is in an inappropriate format**

• Take advice from the Communications team on this - use their expertise and experience
• Do you need to use specialist media to engage with some groups?
• What other innovative ways can you use? Religious meeting points, Local Organisations, doctors' surgeries, schools, libraries, local food shops?

**No access to internet**
• Research suggests that internet-only consultation exercise may engage young people but almost certainly will not enable services to engage with all hard-to-reach groups
• Consider who is likely not to have access to the internet and those who are most likely to respond the online consultations. Will they distort the results?

**Consultation Overload**
Hard-to-reach groups tend to be small in numbers. We have to be aware that there is always a risk of consultation overload. Always refer to the earlier question: **will the information that I gather from this consultation enable the service to improve as a result?**

Speak to your colleagues and Organisations that know your client group well and keep everyone aware of what you are intending to do. It is likely that others' input can greatly enhance the quality of your consultation and enable a more successful path to engaging hard-to-reach groups.

**Providing Incentives**
The issue of paying or providing other incentives for those participating is a complex one. Options include:
• Vouchers or cash sums for focus groups
• Meals
• Childcare facilities
• Respite
• 'goodie' bags
• Discounts
• Entry to competitions
However, remember to ask yourself the following questions:
• Is it ethical? (always seek advice if in any doubt)
• Is it appropriate to the type of consultation that you are undertaking?
• Can we supply the rewards speedily?
• Can we meet a potential increase in demand that may be created by the incentive?

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**NHS Haringey**

**What do patients want?**

- information, communication and involvement in decision-making about care
- being treated as an individual
- choice where it makes a difference
- predictable and convenient access
- equitable care and health outcomes
- being safe and protected in healthcare settings.

**Findings**

- better provision of information to and communication with patients
- engagement of the patient in shared decision-making about treatment options
- geographic convenience and ease of transport to health services
- improvements in patient safety.

**Patient Feedback**

**Qualitative:**

- Complaints
- PALS /PPI/ LiNKs
- Local Consultation
- Qualitative Surveys
- Informal conversations
- Setting staff KPI's to include Patient Experience training
- Working with the Hard to Reach groups

**Quantitative:**

- Patient Surveys
- Staff surveys
- Real time Patient surveys
- Web based polling

**Reaching patients and Hard to Reach Groups**

Exhibitions

Exhibitions aim to convey information in a primarily visual form, with the support of one or more members of staff to distribute written information and respond to immediate questions.

Surveys and questionnaires

Surveys and questionnaires can help to generate information from a large number of respondents.

One-to-one interviews

One-to-one interviews can be conducted face-to-face or on the 'phone. Semi-structured interviews allow for more qualitative information, and aim to get feedback or explore and issue and enable interviewees to express their own feelings and concerns.

Patient diaries
Patients or carers follow a set of guide questions to keep a personal written record of their treatment and care over a period of time. This method can be used as an alternative to in-depth face-to-face interviews. In planning a patient diary exercise, involve service users in designing the guide questions to ensure they cover the areas you are interested in and areas of concern for service users.

Mystery shoppers
'Mystery shoppers' are volunteers who audit services by pretending to be service users, and then report on what they find. Mystery shopping has been used most commonly with young people to assess services such as those providing sexual health advice.

Citizens' panels
Citizens' panels are generally used to build a picture of a community's priorities, or to get a measure of public opinion on a specific issue a health organisation is working on.

Health Panels
Health panels are primarily used for exploring local people's views on policy issues and the allocation of NHS resources. Panels are usually made up of 8 to 12 people drawn from patients and the public to reflect local demographics. Each panel member has a fixed term and is then replaced by a new member.

Citizens' Juries
Citizens' Juries are particularly appropriate for involving the wider public in decision-making, about setting priorities and strategic planning choices. NHS organisations can pose difficult questions, for example on the prioritisation of services, which involve value judgements in reaching a decision. The jury consists of 12 to 16 members of the public, and members are drawn from a cross-section of the local population.

Open space events
Open space events are a large group event (15 people upwards), where participants themselves create their own programme around a pre-determined theme. Apart from the theme, there are no speakers and no set agenda, so participants decide exactly what is discussed and when. Open space events are generally run over one to three days, although it is possible to run shorter versions.

Working with lay representatives
Lay reps generally bring some experience or expertise in the issues. Because lay reps attend meetings on an on-going basis, you can build a positive relationship with them and as they are involved on an on-going basis, they can develop additional expertise in the issues. – A trial User Payments policy project is being led by Age Concern Haringey.

Service User Forums/Patient Groups
User forums are groups to 10 to 20 service users who meet on a regular basis to discuss topics of concern to them as users of a project or service.

People with cognitive and learning disabilities
A key issue for this group is the assumption that they are unable to understand the issues and make choices. It is important to explore the best ways of communicating with individuals, particularly people with more than one impairment. They may need advocacy support to prepare for and participate in meetings or discussions-but do not just talk to the advocate. Engage the service user and talk to them, even if the advocate needs to answer on their behalf. Families trying to protect those they see as vulnerable can restrict their participation so work with advocacy and self-advocacy groups.

Older people

Work with existing older people's groups and voluntary organisations, such as Age Concern. When you gather people together, always ensure the venue is accessible, offer travel expenses and provide refreshment. Be aware that technology-based systems of communication and engagement, such as email and the internet, may not be effective at reaching older people.

Homes for Haringey

**The Homes for Haringey approach – a briefing note**

**Simon Godfrey, Involvement & Equalities Manager**

"People say we are hard to reach, but young black men don't seem hard to reach when the Police want to find us".

Reaching people is not the issue, but engaging with them is. A fairly sure way to get people to make their views known is to give them a terrible service, but of course we don't want to do that. Otherwise, our attempts to engage people competes with the many other things they want and need to do with their time.

In Homes for Haringey, we run checks each year on the demographics of people who have worked with us more formally over the last 12 months.

Two years ago, we found that we had almost no engagement with young people. We decided to fund a year's contract for one full time equivalent youth worker, in practice two half time posts, and we set out to find out what this section of the community thought of our services.

Initial attempts were largely failures. Young people have more interesting things to do than to commit to a long term formal group. Attempts to bribe them into discussion with pizza or to offer MP3 players in prize draws for completing surveys gave us very little real insight. Schools are not only for the children of Council tenants so it was difficult to address their issues in classes from mixed tenures.

Our workers kept saying that the national thinking is that something must be in it for young people; in other words, payment, pizza and so on. When we turned to video, we finally found something. It turns out that, given the right approaches, some young people are perfectly happy to spend some time telling us about where they live through video, with a professional film crew making it and teaching young people about the process.

On four estates we collected some really clear points about issues that affected young people there. Not all, or even most, were about housing. We were able to test the films with the wider communities to see if they agreed, and largely they did. It was then possible to take the issues out to service providers and try to provide solutions.

Neither the making of the videos nor the solutions would have been possible without the partnership and trust of colleagues from other services, especially Neighbourhoods and the Youth Service, but others too. Collectively, we can open doors to reach communities that might have been shut to any of us working alone. Here is an area for further development: if we have even quite fuzzy objectives such as 'engage young people', we can put our heads together to find out how, and the results are likely to be far better.

The biggest gap that we have demographically is in the age group between 26 and 55, which is unsurprising considering the demands on people at this time of life. They don't tend to commit to established forums, but many are quite willing to give us feedback in other ways. Recent examples have been:

- The door knocking exercise in which staff knocked on the door of every property we manage and had surveys back from 4,500 as well as picking up lot of other issues
- Our Aspirations project used 25 focus groups and a series of web-based surveys
- Analysis of complaints and satisfaction surveys have identified common problems
- Running an open day instead of a conference in 2008 increased attendance from 70 to 500 across 18 ethnicity categories compared with the previous 11
- Telephone surveys were used to check residents' views on the repairs service

Increasingly we are having to broaden our view of who our 'customers' are. Where once we thought along the lines of those with whom there is a contractual relationship (tenants and leaseholders), there is a growing understanding that estates are also inhabited by their partners, children, extended families and so on. One third of leasehold properties are now sublet to people we do not provide services to directly, and we may not even know who they are, yet they are part of those communities. The kids who hang out there may live somewhere else, yet still see our housing as their patch.

Residents' associations can be tremendously useful for communities, and we do our best to support them, including providing training and funding. Yet overall, the numbers stay relatively constant – as new ones arise, old ones die out. We have added estate advocates and we are introducing 'key leaseholders' who will scrutinise the cost of communal services. All these act as conduits through which we can gather information on local issues, though obviously residents' associations can go far beyond that.

Hopefully, it goes without saying that we offer interpreters, alternative formats, accessible venues, childcare and travel support and induction loops – all the usual methods to overcome the barriers that individuals may face.

Finally, it is all about results. They don't always come, and we don't always get it right. But the one thing that makes it worth engaging is that something happens as a result and that people know something has happened. Engagement for the sake of ticking boxes is very short term. Once experienced by residents, they are very unlikely to want to engage ever again.

Crucial Steps
Making the difference to create safer community

**THE HARD TO REACH Groups:**

***A Crucialsteps' Perspective***

Haringey Council

Can Do

# A brief Profile

Crucialsteps established in 2001

Worked on the following projects:

1. New Deal (2001/02)
2. Learning support projects to NEET young people at local learning centres;(2004/06
3. Specialist Appropriate Adult (AA) Volunteers training.(2006 to date)

## Local Strategic P/Ship Involvement

1. CLF (Comm. Link Forum) Board member:
2. CLF Representative on Children's Trust Board (formerly Children & Young People Partnership Board)
3. Safeguarding Adults working group member
4. Hard-To-Reach Scrutiny Review Panel

## WHO ARE OUR CLIENTS / BENFICIARIES

1. **Juveniles: (10 – 16yrs olds) and Vulnerable Adults 17+**
   - **PACE requests from local police stations.**
2. **people 18+ years and live / work locally**

- **Trained as Appropriate Adult (AA) Volunteers**

*Appropriate Adult Volunteers make welfare representations for Juveniles and Vulnerable Adults in police custody*

## Our Success Stories to date….

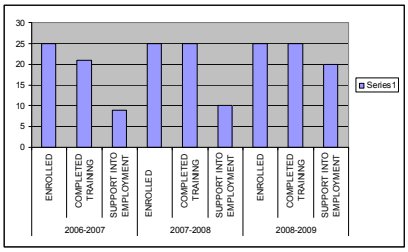
New Deal initiative: moved over 1000 long term unemployed into sustainable employment in Haringey 2001/2002.

NEET young people: a third participants retained in self development/employment goals (2004 / 2006). For more on their progress to date, visit ww.myspace.com /frisco;jme;skepta;shorty;maximum; to mention but a few

Appropriate Adult (AA) Volunteers training: AA volunteers' retention in the borough to date

## Our Success Stories Cont'd….

**AA TRAINING PROJECT PERFORMANCE (2006 – 2009)**



**Who are the 'hard to reach' (HTR) groups in our work environment?**

*Our HTR Groups are the already identified groups of varied -*

1. *religious,*
2. *social and economic and;*
3. *gender backgrounds.*

## What are we doing to engage them?

- Continued 121 After-Care support to monitor and sustain individual's progression;
- Sharing our experiences with others
- Seeking closer partnership framework with other strategic partners
- Keeping our trainees aware of HSP's agenda for developing the borough and its community members

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***WORKING WITH LOCAL COMMUNITIES TO PROMOTE SOCIAL INCLUSION FOR EVERYONE***

REGISTERED IN ENGLAND NO: 4265696

# Engaging Hard to Reach Groups

## North Middlesex University Hospital Trust

Director of Service Development

November 2009

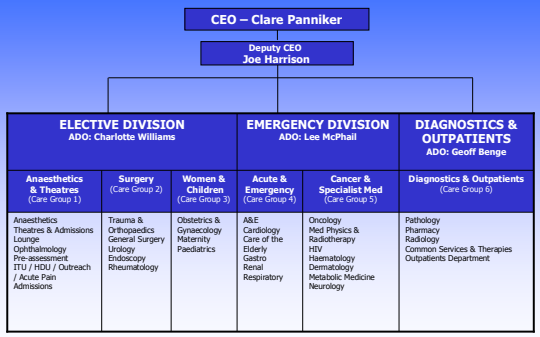


# Background to the Trust

- Income around £155m a year
- Diverse patient population of c.500k (Haringey, Enfield & Waltham Forest),
- Employ almost 2500 staff, most living locally
- Activity split is 70% emergency and 30% elective
- Bed base of 280 - 330
- One of London's busiest A&Es c.130k patients a year
- Around 35,000 inpatient and day cases a year



# The services we provide






# Taking "HtR" seriously

**Plays a key role across our organisational objectives**

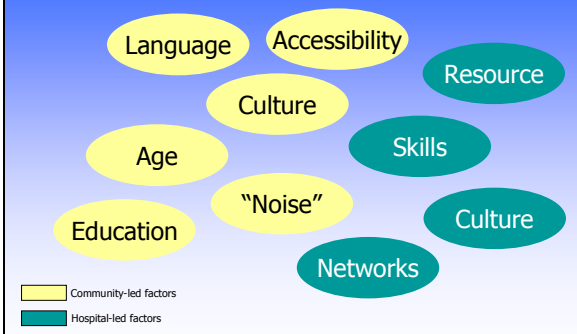
| | | |
|---|---|---|
| 1 | | That the patient experience is improved |
| DN | 1A | Provide patients with a safe environment through the introduction of the Safer Patient Initiative |
| | 1B | Implement improved system for gaining patient feedback and acting on results |
| | 1C | **Introduce methods to improve staff attitude/behaviour when dealing with patients and relatives (person care)** |

| | | |
|---|---|---|
| 5 | | That we become the hospital of choice for local people, providing access to the full range of health services |
| DSD | 5A | Develop relationships with Primary Care and General Practitioners |
| | 5B | Establish a focused approach to marketing |
| | 5C | **Develop cultural awareness across the organisation** |

| | | |
|---|---|---|
| 10 | | That the Trust's role as a socially responsible "corporate citizen" is improved |
| DCEO | 10A | **Establish NMUHT as a focal point in the community** |
| | 10B | Continue to develop the Foundation Trust agenda |
| | 10C | Minimise the carbon footprint of the Trust |



# What makes a patient "HtR" for us?






# What are we doing about it?

| | |
|---|---|
| Accessibility | Way-finding Group<br>Better signage |
| Language | Interpreting<br>Translation |
| Culture | Interpreting<br>Translation |
| Age | League of Friends<br>Third sector |
| Noise | Building and borrowing networks |
| Education | SEN groups<br>HAVCO |

| | |
|---|---|
| Resource | Investing in communications |
| Skills | Training staff in relevant competencies |
| Culture | Setting standards<br>Managing performance |
| Networks | Building and borrowing networks |

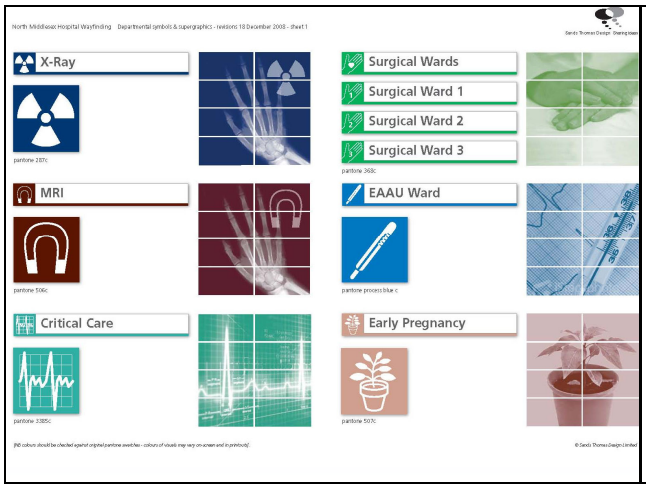
## Where we still need to improve

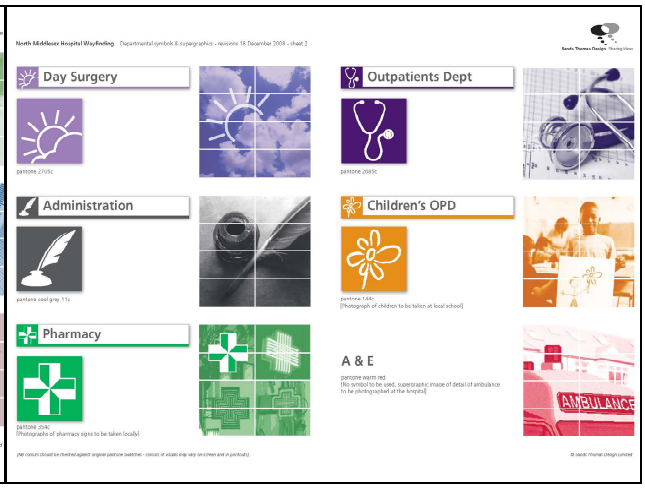
- Working out who/where the silent groups are
- Ensuring services are as accessible as possible for all (meeting a wide-ranging set of needs)
- Increasing satisfaction across our diverse users

North Middlesex University Hospital NHS

## One improvement example: Wayfinding

North Middlesex University Hospital NHS



The Whittington Hospital NHS
NHS Trust

## Engaging with hard to reach communities

**Chris Giles**
**Development Manager**

...the hospital of choice for local people

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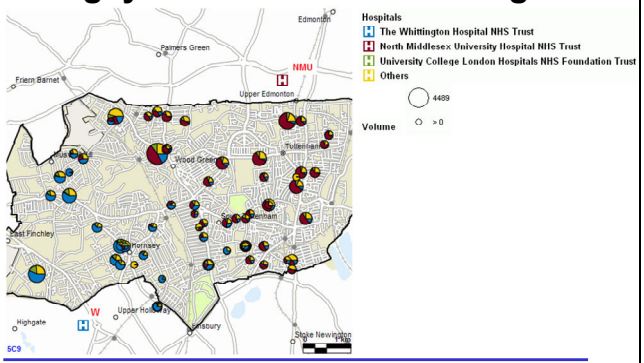
NHS Trust

## Haringey Patients at the Whittington

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## Haringey Patients at the Whittington
Inpatients

Haringey Inpatient ethnic group split Apr 2008 - Mar 2009

| Ethnic Group | Percentage |
|---|---|
| A: White British | 34% |
| B: White Irish | 3% |
| C: Any other White background | 15% |
| D: White and Black Caribbean | 1% |
| E: White and Black African | 0% |
| F: White and Asian | 0% |
| G: Any other mixed background | 1% |
| H: Indian | 2% |
| J: Pakistani | 1% |
| K: Bangladeshi | 1% |
| L: Any other Asian background | 2% |
| M: Black Caribbean | 8% |
| N: Black African | 7% |
| P: Any other Black background | 2% |
| R: Chinese | 1% |
| S: Any other ethnic group | 11% |
| Z: Not stated | 13% |
| **Total** | **17819** |

| Age Group | Percentage |
|---|---|
| 0-15 | 16% |
| 16-24 | 7% |
| 25-34 | 18% |
| 35-44 | 16% |
| 45-59 | 16% |
| 60+ | 28% |
| **Total** | **17819** |

| Gender | Percentage |
|---|---|
| Female | 63% |
| Male | 37% |
| **Total** | **17819** |

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## Haringey Patients at the Whittington
Emergency (ED) Attendances

| Ethnic Group | 08/09 Haringey ED Attendances % |
|---|---|
| **White: British** | **34%** |
| White: Irish | 3% |
| White: Other White | 15% |
| Mixed: White and Black Caribbean | 1% |
| Mixed: White and Black African | 0% |
| Mixed: White and Asian | 0% |
| Mixed: Other Mixed | 2% |
| Asian or Asian British: Indian | 2% |
| Asian or Asian British: Pakistani | 0% |
| Asian or Asian British: Bangladeshi | 1% |
| Asian or Asian British: Other Asian | 2% |
| Black or Black British: Black Caribbean | 8% |
| Black or Black British: Black African | 6% |
| **Black or Black British: Other Black** | **4%** |
| Chinese or Other Ethnic Group: Chinese | 1% |
| **Chinese or Other Ethnic Group: Other** | **17%** |
| Not Recorded/Not Stated | 6% |

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## Patient Engagement

- PPI (Patient Public Involvement)
- Improving the Patient Experience
- Patient Interviews
- Focus Groups
- Community Based Services
- Complaints
- Trust Membership

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## Engaging Hard to Reach Groups

- Interpreters/Advocates
- Minority Group Engagement
- Clinically Focussed Engagement
- Community Representation
- Schools/Further Education
- Press/Advertorial

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## Engaging Hard To Reach Communities

Neighbourhood Management

## Neighbourhood Management Supporting resident involvement

- Overall aim to increase resident involvement, participation and community cohesion.
- Neighbourhood Management Teams act as intermediaries between service providers and residents
- Neighbourhood Management Teams work with residents, services and partners to identify and define local needs and priorities

## Supporting Community Groups

- Fundraising – developing bids, identifying funders
- Capacity building and Access to Services
- Mentoring and training programmes
- Project Development
- Small project grants
- Involvement in Neighbourhood Management activities
- Access to resources (publicity, meeting space)

## Identified Hard To Reach Groups

- Refugees and Asylum Seekers
- Kurdish, Somali, Congolese, Angolan, Turkish etc
- Polish, Romanian and other Eastern European Countries
- Haredi Jewish
- Elderly and Disabled
- Young people
- Gay, Lesbian and Transsexual communities

## What NM is Doing to Identify and Engage 'Hard to Reach' Groups

- Working in Partnership e.g. Children's Centres, Resident Associations, multi-faith working
- Communication and information share with HAVCO & Voluntary Sector
- Research Community Groups, Internet, HAVCO, Schools/ Children Centre, GP Surgeries and Community Organisations

## The Barriers To Engaging Hard To Reach Communities

Partnerships

- Lack of resources and capacity within community to actively participate
- Community groups do not understand the benefits of partnership working
- Unequal partnerships
- Lack of understanding of needs and priorities, culture

Individuals

- People distrust the council and the services
- Communication, Jargon, language distribution format and sites
- Services are not tailored to community needs and there can sometimes be a 'one size fits all'
- Not enough resources (financial & Human)
- Perception that nothing changes 'powerlessness'

## Where Improvements Could Be Made

- Improved strategic planning
- Joined Up working - operational
- Targeted Outreach In the Neighbourhoods
- Resources and Funding to Empower Individuals and Community Groups
- Capacity Building local groups

## Engaging with hard to reach groups

## Adult Services, ACCS

### 1.0 Who are our hard to reach groups?

Who is considered hard to reach can vary greatly within adult social care. There are however there are a number of common groups considered hard to reach in relation to adult services including:

- Older people from some community groups
- Asylum seekers
- Gypsy/travellers
- LGBT communities
- BME communities
- Some informal carers
- Vulnerable adults
- Some single parents

### 2.0 Why are these groups hard to reach/barriers to engagement?

- May have misgivings about contacting the local authority when in need
- Language barriers
- Physical disabilities
- Mental health
- Lack of time to engage
- Lack of interest in engaging

### 3.0 Policy context in Adult Social Care

Engaging with hard to reach communities is a critical success factor within adult social care services, to ensure that we are delivering quality services to our whole community. One key area that adult social care must ensure we do well is facilitate people to make a positive contribution; including:

- Support to take part in community life, by continuing to engage with hard-to-reach and minority groups
- Facilitate active voluntary sector engagement and contribution in improving services for people of all communities
- Take on board all community experiences and views (people who use services, carers and residents) in how service improvements are shaped.

Transforming Social Care is another important policy driver in working with hard to reach communities, with a much higher emphasis placed on local authorities to facilitate all communities having access to appropriate preventative, universal services; more choice and control over the assessment and service planning/delivery processed; and facilitating the growth of 'social capital'[1] across community groups. The key deliverables of Transforming Social Care are represented in the diagram below:

[1] **Social Capital** describes the pattern and intensity of networks among people and the shared values which arise from those networks. Greater interaction between people generates a greater sense of community spirit http://www.statistics.gov.uk/CCI/nugget.asp?ID=314

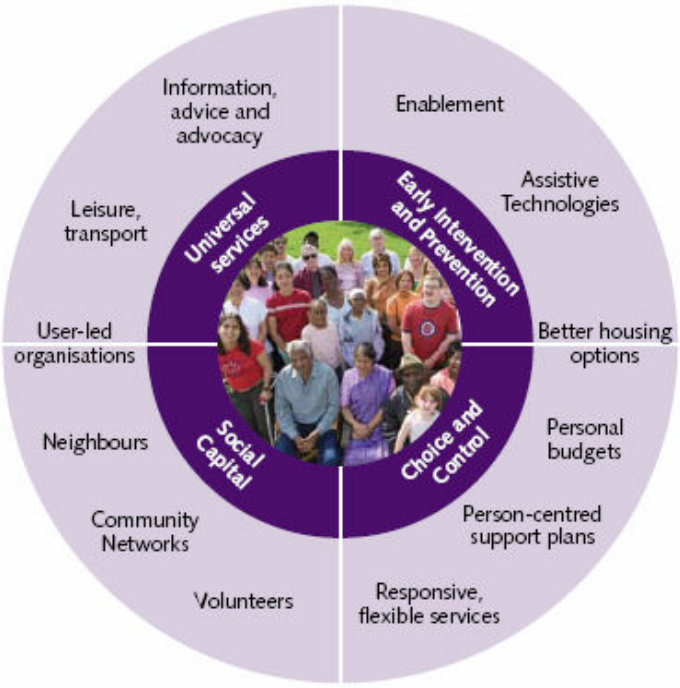



*Figure 1 – the four quadrants of transforming social care*

## 4.0 What we are doing to reach these groups?

### 4.1 Use of evidence - Needs Assessments

- The **Borough Profile** draws upon a wide variety of information and data to build a detailed and comprehensive picture of Haringey. It provides statistical data and analysis on demographics and socio-economic factors within the borough.

- **Case Recording** We collect information on the equality strands of Age, Gender, Disability, Religion & Ethnicity. This is reported upon quarterly and measured against the demographic profile of the borough. This information is reported into the ACCS equalities forum and to DMT. It has also influenced the business plans with projects such as free swimming for over 65s.

- **Research Governance Framework**
  In April 2008 we implemented the Research Governance Framework for social care, an ethics framework, to protect the rights and interests of social care service users in any research and consultation that involves them, their personally identifiable data, or the staff who work with them. As research is completed and the results analysed, the resulting knowledge will be available to inform strategic planning.

- The **Joint Strategic Needs Assessment (JSNA)** is a continuous process of gathering information about the current and future health, care and well-being needs of the population. The JSNA will be used to inform service planning and commissioning strategies, by looking at the 'big picture' of the local population, specifically groups whose needs are not being met. To address some of the knowledge gaps further needs assessments are being undertaken in relation to:
  - Older People (phase 1 complete)
  - Sexual health (led by NHS Haringey)
  - Mental Health
  - Vulnerable children and young people

- Population change and growth
- Autistic Spectrum Disorder
- Learning Disabilities
- Alcohol
- Turkish/Kurdish Community

These assessments will identify needs of particular groups but may also identify groups with needs of which we were unaware. For example the Mental Health Needs Assessment looks at BME access to mental health services, cultural barriers to accessing mental health care such as stigma and discrimination and ways to overcome this.

Consultation will be completed as part of each assessment. For example as part of the Mental Health Needs Assessment, stakeholder interviews were undertaken with health and mental health services and service users were engaged through a consultation day.

The development of the JSNA is overseen by a Steering Group with members form Haringey Council, NHS Haringey, HAVCO and Homes for Haringey. A new shared data platform for population needs assessment or Haringey: Our place, Local Information System, is currently being developed. The JSNA data along with the borough profile and other needs assessment information will form part of the evidence base available to partners to use to target resources and services more effectively.

**5.0 Examples of what we are doing to reach these groups?**

**5.1 Consultation**

**5.1.1 Experience Still Counts**

Older people living in Haringey have been fully involved in developing Haringey's strategy for older people, Experience Still Counts by helping to plan the consultation, participating in a one-day event and focus group meetings throughout autumn 2008. The information feedback to us by Older People was used to inform the priorities of the strategy. Pre-consultation, HSP reps from council, health and the voluntary sector met with older people from the Older People's Partnership Board and the Haringey Forum for Older People to discuss how the event should be organised and what factors needed to be considered to make this engagement with older people work effectively.

This included:

- Offering transport or help with travel
- Ensuring the event started at an appropriate time for older people, e.g. giving them time to travel there using bus passes (at the date of the consultation, freedom passes could be used only after 9.30am).
- Providing refreshments and, if the day included food, ensuring that choices were culturally appropriate with options for special dietary needs.
- Using the invitation to ask about requirements for hearing loops, translation needs, food and travel.

Feedback was provided to all those who influenced the development of the strategy through consultation:

- The strategy, delivery plan, equalities impact assessment and information on how community views influenced its development can be viewed on Haringey Council's website.
- Paper copies of the strategy and delivery plan have been distributed to all older people who participated in the development of Experience Still Counts 2009-2012.
- Older people will continue to be engaged in the implementation of the strategy as the Older People's Partnership Board has the responsibility for monitoring the delivery of the strategy.

### 5.1.2 Haringey Adult Carers Strategy consultation

The following groups were key stakeholders involved in shaping the revised Strategy (January-April 2009):

- Unpaid adult carers of adults living in the borough of Haringey (via Carers Register)
- Voluntary sector and community organisations
- Health partners
- Council partners

The main methods of consultation were a questionnaire survey of carers views and a carers consultation event. A Carers Strategy sub-group, of eight carers, was involved from the outset in developing the Strategy including consultation.

### 5.2 Cultural awareness community events

- Haven Day Centre- a Turkish breakfast to celebrate the last day of Ramazan Byrami, Diwali celebration and a two day Black History celebration.
- Abyssinia Court Drop-in Centre Black History Month celebration

These celebrations linked in with the Council's values of working together, offering choice, life long learning and the opportunity to socialise to service users, in the wider context of the Well-being Strategy for Adults 2007-10.

### 5.3 Surveys and Campaigns

### 5.3.1 Carers Survey 2008/09

150 carers who have been assessed since April 2008 were selected through using Department of Health techniques for picking random samples. Translated surveys were provided when required, at the service user's request and support was offered in completing the survey if a disability/ language barriers prove completion difficult at the service user's request.

### 5.3.2 Claim-It

In September 2008 officers from across the Council, in partnership with staff from Haringey Citizens Advice Bureau, Haringey Carer's Centre, Haringey Age Concern and the Department for Works and Pensions, ran a week long awareness campaign in Wood Green High Road to promote the uptake of benefits. Members of the public were given leaflets as they passed on the street and invited to a benefits check in the Wood Green Library. 500 people were provided with advice through the Claim It initiative and 200 people were identified as likely to be entitled to some additional benefits.

### 5.4 Partnerships

We have revitalised our Carers' Partnership Board; it is now chaired by the dignity in care champion, a councillor who is herself a carer, and has 19 other carers as members, with a high representation from BME communities.

There are a number of other forums that are designed to meet the special needs of particular groups, all of which have strong representation from a cross section of community groups – for example: the Learning Disabilities Partnership Board; Haringey Forum for Older People; and Mental Health User Forums. This engagement takes place on an ongoing basis, and in many different forms.

Haringey Forum for Older People (HFOP) have a successful and innovative 'reaching out' programme of visits, which enables peer-to-peer conversations between older residents to capture the views that need to inform commissioning arrangements. The Forum reports back regularly to the Older People's Partnership Board regards the outcomes of their programme visits. This has for example included:

- Visits to for example, the Phoenix Group, Nigerian Organisation of Women, African Women's Welfare Group, Mitelee Centre, various Sheltered Housing,
- Reviewing how to get more older men actively involved in the forum itself

Additional engagement includes the following:
- Dignity in Care Champion
- Older People's Champions
- Public Forums for Leisure Centres
- Haringey Mobility Forum
- Mental Health User Forums
- Learning Disabilities Outcomes Survey
- User Outcomes Survey
- Haringey LINk
- Patient representatives' input into customer care standards
- Expert patient programme
- Patient representative on procurement panel for diabetes service users
- BME Mental Health Network
- BME Mental Health Carers Network
- Making a positive contribution sub-group
- Haringey Advisory Group On Alcohol – client forum
- Haringey Learning Disability Partnership Board
- Haringey Learning Disability Partnership Carers Forums
- Drug and Alcohol Action Team service user involvement
- Drug and Alcohol Action Team carer involvement

**6.0 Where improvements can be made?**
- Increased use of complaints information to improve services
- Improved equalities monitoring of services, to inform strategic planning and service delivery, to ensure services are being accessed by a wider range of community groups.
- Better use of existing data to inform service delivery.
- Using 'Transforming Social Care' as a lever to enable hard to reach groups gain access to services where appropriate, and support the growth of 'social capital', including social enterprise.
- Developing other innovative approaches to building 'social capital', including strengthening volunteering arrangements, and working with groups such as 'Participle', who have approached the Council to be a strategic partner in launching their 'Get Together' service (successfully piloted in Westminster in 2009.) This is a people matching, telephone based service, using technology to match isolated older people with one another, offering: individual introductions between people who have similar interests and hobbies; phone groups of up to 7 members to discuss specific topics, using teleconferencing technology; trips with group members, including transport and access to mobility scooter hire; and, activities at home.

**From:** MARGARET FOWLER [mailto:margaretfowler638@btinternet.com]
**Sent:** 18 January 2010 21:46
**To:** Ponomarenko Melanie
**Subject:** RE: Engaging with hard to reach communities

Melanie,

When I came back from 12 years voluntary work overseas I couldn't get back into work with CONEL or HALS because I was past retirement age and didn't have a PGCE. I have ESOL and TEFL and Literacy qualifications but you now need a PGCE as well.

I was very conscious from meeting friends I have and from my family's friends that there are many people out there who do not understand enough English language to manage their lives, especially women. In my experience, educate the women and you educate the world! My daughter is married to a Turkish man and my son to a Nigerian girl.

I tried to contact HAVCO about linking up as a volunteer but they weren't very responsive so I wrote to BME women's groups in the Borough offering basic English lessons, conversation, form filling, letter writing etc. I used to do this type of work in the Borough in 1980- as part of the Literacy Scheme which ran in Mattison Rd.

I received more responses than I could cope with and started at The Mitalee Centre and The African Child. PHASCA offered some time for lessons to Mums who take their children to their Homework Club and often need to fill in forms and discuss issues of health and education as well as have a social chat in English. I have since changed The African Child for AWWG. The Directors of these Groups have persuaded their members to come and regard it as an opportunity to get the women to discuss and chat in English as well as filling in forms etc. I encourage them to bring forms and letters they need to respond to and we do some general reading and comprehension and discuss issues arising around their family's health and education and life in general. I take along leaflets on current issues which I pick up in the library and other places where information is on show. This is the only way some of them get any idea of what is happening around them. Their husbands are not always very informative and often don't encourage English speaking. Many of the women are not literate in their own language let alone English so fall out of the present areas of education. All ages are included. I encourage discussion and asking and providing of information. They often realise they can support one another's needs. The sessions are for 2 or 4 hours a week.

I would like to be able to produce an annotated list of where to find basic information and support ,perhaps on a Ward basis as part of the Community Engagement Framework in Haringey.

The background for all this actually stems from my younger son telling me in 1980 that he had to tell his friends off at the Drayton School (now the Gladesmore) for making fun of their mums in shops because they couldn't read the instructions on the produce in English.

Best Wishes
Margaret

**Engaging with Hard To Reach Groups**
**Drug & Alcohol Action Team**

## 1.0 Introduction

- Drug/and or alcohol users are one of the most marginalised groups within Haringey
- Within this group there are those who are arguably even more vulnerable/difficult to engage, namely
- BME drug and alcohol users
- sex workers
- economic migrants
- those with a Dual Diagnosis
- parents – particularly single parents
- those who 'care' for people with drug and alcohol problems
- women experiencing DV
- LBGT

## 2.0 What are the issues

This group face a wide range of health/public health
and social problems for different reasons:

- Housing/employment issues – key drivers for migrant street drinker's alcohol use and factor in preventing drug/alcohol users re-integrate following treatment.
- Lack of recourse to public funds (cannot access specialist alcohol treatment.
- Language Barriers
- Non registration with GP (many Drug users will not have a GP).
- TB in Haringey's Somali Community – through the use of Khat in Mafrishes
- Violence from 'punters' to female sex workers (often unreported to the Police).
- Fear of loosing children if disclose drug/alcohol use
- Stigma/shame of being drug users and 'victim' of DV
- Carers of people with D & A problems hidden and their needs not recognised within wider carer field
- Dual Diagnosis clients being balanced between mental health and drug/alcohol services.

## 3.0 What are the DAAT doing to address this

**Migrant Impact Funds Monies**

Haringey Drug & Alcohol Action Team were successful in securing time limited monies from Home office to:
Do three projects

1. **Migrant Street Drinkers Project –** Research and action planning into developing longer term approach to street drinkers, in particular migrant street drinkers (interim report available) – actions will be carried forward into next years Alcohol; Strategy Action Plan.

2. **Migrant Sex Workers Project** – bolt onto SHOC's existing provision. Aim to better understand needs of migrant sex workers and get a handle on how many may be 'trafficked – evaluation/research built into this so we can share best practice across London and develop appropriate model.

3. **TB in the Somali Community** – monies to raise awareness of spread of TB through the chewing of Khat and encourage more people to come forward for screening/ treatment if necessary.

The original proposals and PIDS are available upon request.

**Building Unity Back into the Community (BUBIC)**

The DAAT have worked alongside BUBIC in supporting the development of a user led service, set up by predominantly ex BME crack users. The service has been commissioned since 2005 as a key means of accessing BME communities into drug/alcohol treatment. The service won the 2008 Home Office London Drug Awards and plays an important part in providing a 'whole family' culturally specific service to people with drug and alcohol problems in the borough. It is co-located with EBAN (see below).

**EBAN**

The need for a crack/poly drug service that was relevant to people from the African Caribbean community, the homeless and sex workers was identified in the DAAT 2005 annual Needs Assessment. The service was tendered for and operates out of premises in Bruce Grove – with BUBIC. The National Treatment Agency For Substance Misuse - at a recent celebration event (Nov 09) recognised the service as 'being years ahead and what we want drug services to look like'.

**SHOC**

Sexual Health on Call have been commissioned for several years by the DAAT and NHS Haringey to provide a much needed outreach/flat based service to female sex workers.

**Chrysalis – Carers Project**

A small project offering support/group work to family members (usually mothers) caring fro someone with a drug or alcohol problem.

**DUAL Diagnosis Service**

A service commissioned to meet the dual needs of those with substance misuse and mental health problems –works in the community and on the wards at St Anns. The contract for this service will be reduced due to reduction in the PTB in 2010/11.

## 3.0 How we Engage/listen

### User Involvement Strategy

The DAAT developed a User Involvement strategy in 2005 which spelt out to service users how they could get involved in the planning and commissioning of services. User involvement operates at a service level and strategic level with user reps on the DAAT, JCG and TTG Boards/Groups. Appropriate renumeration has been key to the continued involvment and success of the strategy. The Wellbeing Board have used this as a model for developing payment system for service user involvement across the partnership.

## Carer Involvement

The involvement of carers in the planning and commissioning of services is not so well developed as User involvement – however, carers are represented on the DAAT Partnership Board, Joint commissioning Group and Treatment Task Group. As mentioned above the DAAT have commissioned a separate carers support group in recognition of the unique needs of these carers who do not feel 'comfortable' in main steam' carer services.

## Annual Needs Assessment

The annual Needs Assessment informs the planning and commissioning of drug/alcohol services in the coming year. A key part of the assessment is hearing the views of existing service users and trying to access that not in treatment to hear what the gaps are and how we can improve services.

## 4.0 How could things be improved?

All of the services/projects described above are reliant on external funding/grants e.g. the Pooled Drug Treatment Budget/and or time limited e.g. the Migrant Impact Fund.

Year on year reductions to the Pooled Drug Treatment Budget has resulted in the DAAT having to decommission services that are not strictly focused on meeting the key National Drug Indicator (NI40) – which aims to maximise the number of crack/heroin users (exclusively) entering and being retained in structured drug treatment. This leaves little room for innovation and the ability to respond to the diverse needs of Haringey's drug/alcohol population. It also makes it more difficult to continue to commission lower threshold (tier 2) services.

**Improvements could be made by:**

- mainstreaming some of this work - so that is not solely reliant on external funds - with exception of limited PCT funding into SHOC all other services are commissioned out of DoH PTB monies.
- recognising that drug and alcohol issues are multi-faceted and cut across all of the key priorities of the Community Strategy and many of our chosen NI from worklessness through to crime (particularly acquisitive crime) – so by addressing drug and alcohol issues the partnerships also meets the wider targets.
- Better joining up of the public health agenda with the drug/alcohol agenda – this has partly been helped by having DAAT representation on Wellbeing Board
- Better joining up with ACCS – particularly in terms of commissioning and the Personalisation Agenda
- Developing greater awareness of the hidden harm agenda in relation to child protection – again recently improved by addition to DAAT to LSCB.

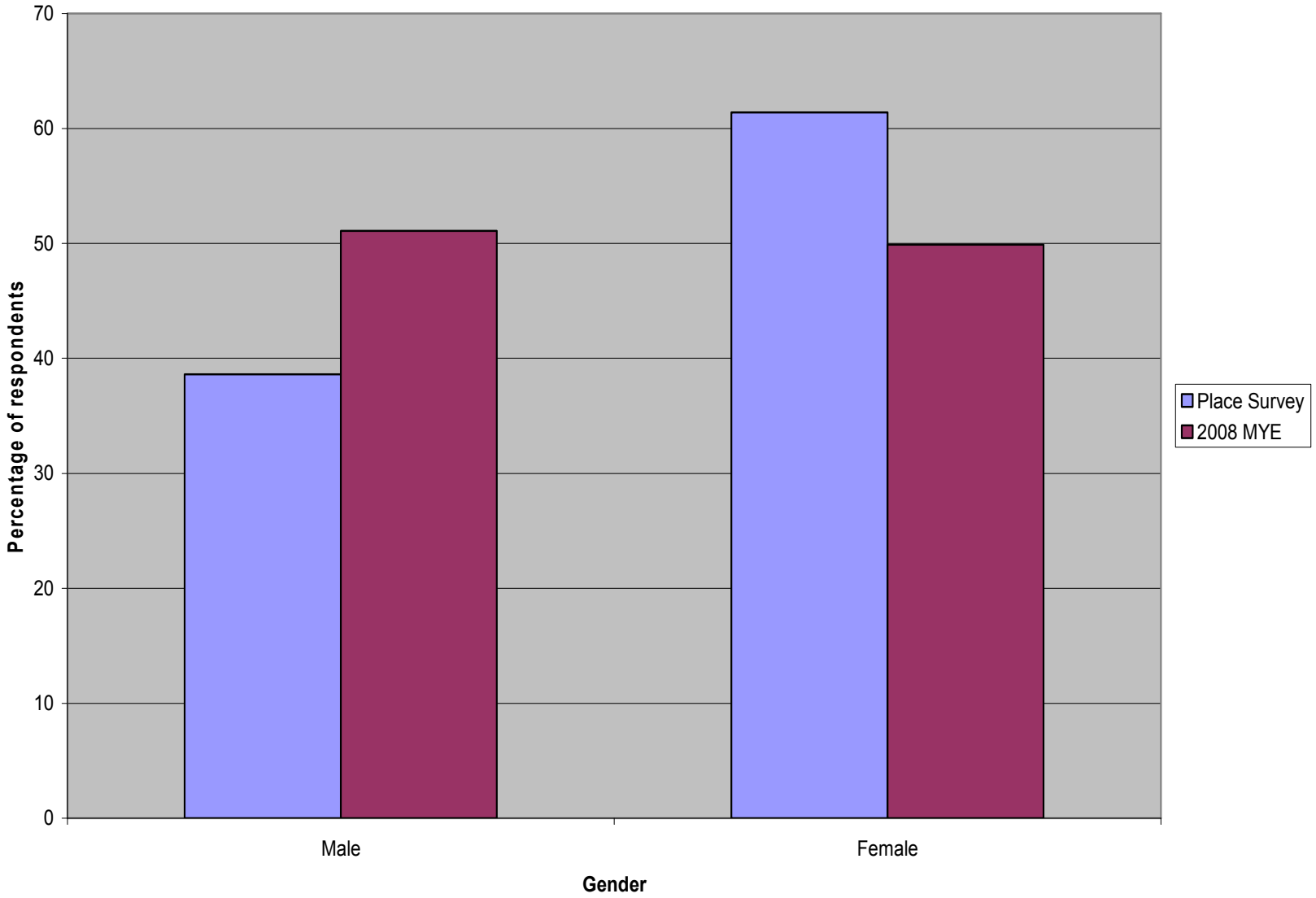
**APPENDIX C – hard to reach groups**

The following groups were identified as ‘hard to reach’ during the course of the review, in submissions, discussions or at panel meetings.

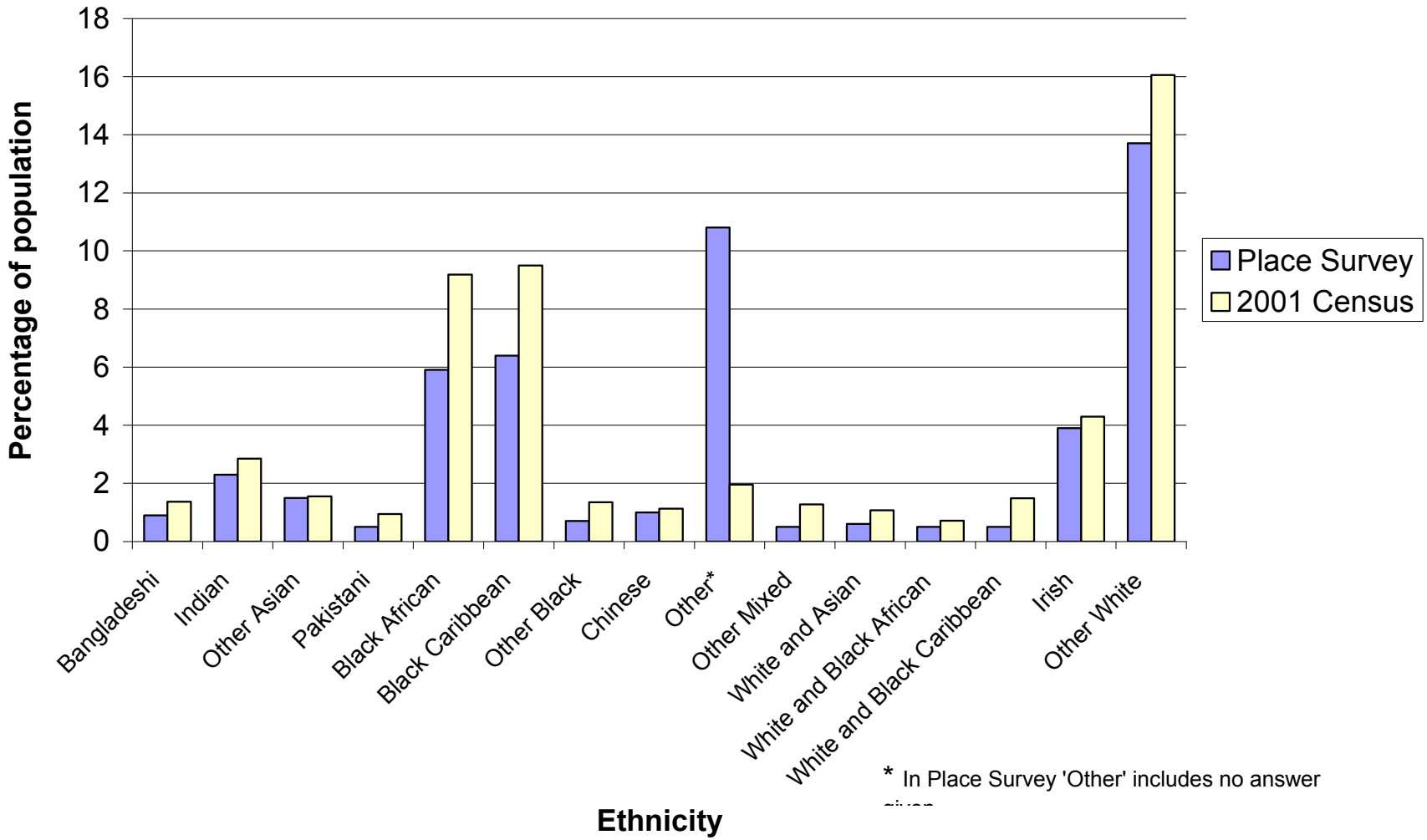
Bulgarian
Romanian
Illegal workers
New communities
Eastern European – e.g. Lithuanian and Albanian
25-34/40 Yr olds (time poor people)
Older Black
Tenants
Orthodox Jews
Drug users
Sex workers
Lone Parents
Muslim Women
Homeless (both those in Temporary Accommodation and rough sleepers)
Those not registered with a General Practitioner
Ex-Offenders
Older people with dementia
Lesbian Gay Bi-sexual and Transgender
Charedi Jews
Congolese
The Somalian Community
The Romanian Gypsy Community
The Irish Travellers Community
Elderly/Vulnerable
Persons with disabilities
Teenagers particularly young white males
Full time professional people
Landlords
Travellers
Turkish
Polish
Black and Minority Ethnic Groups
Older People
People with disabilities (outside of partner structure)
Lone parents
Homeless people
Carers
Dual diagnosis
Young people at conflict with the law
Faith Groups

## APPENDIX D – Place survey data

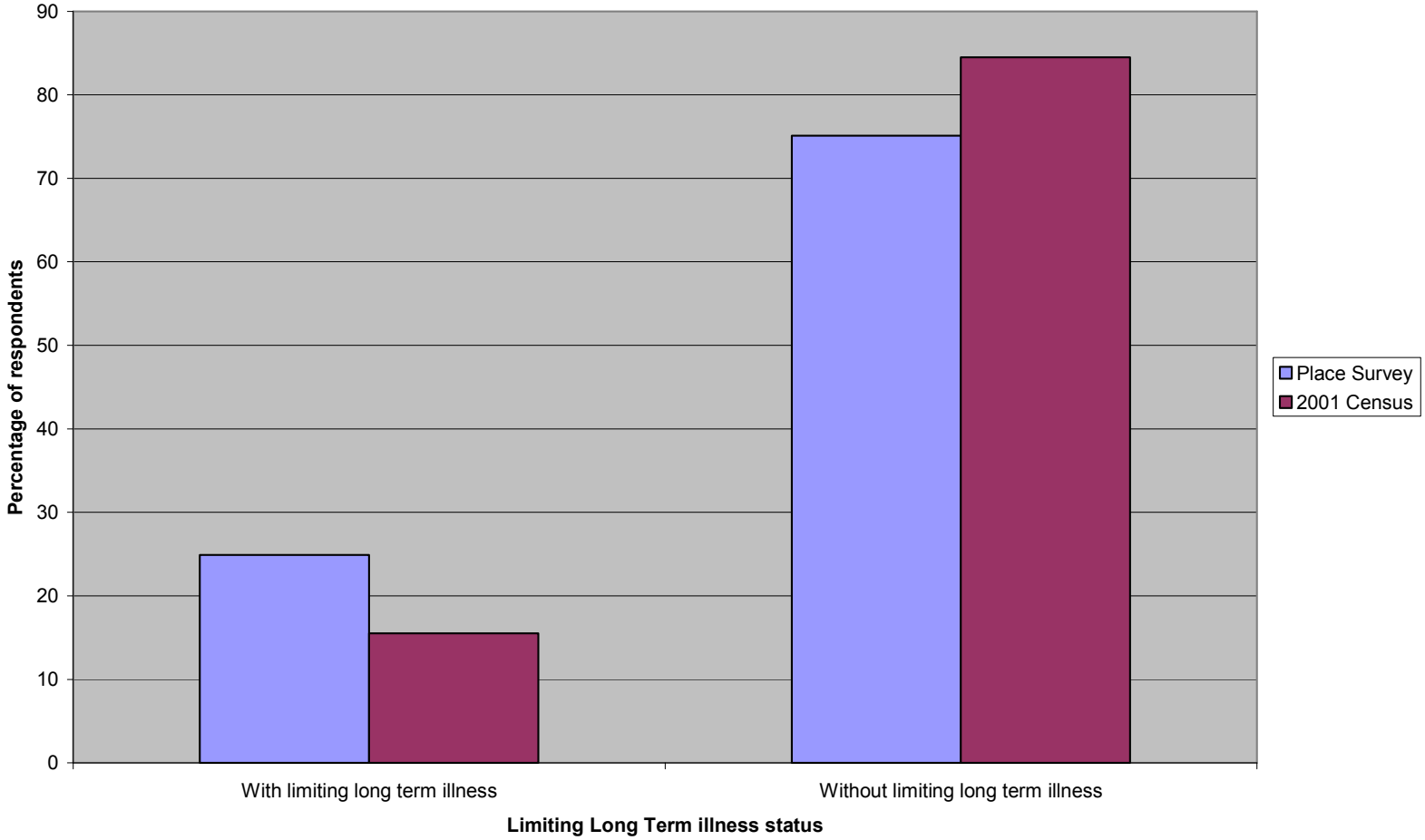
**Percentage of Place Survey respondents by gender compared with percentage of population by gender according the Greater London Authority Mid Year Estimates**



**Percentage of Place Survey respondents by ethnicity compared with percentage of population by ethnicity based on the 2001 census**




**Percentage of Place Survey respondents with/without limiting long term illness compared with percentage of population With/without limiting long term illness based on the 2001 census**


90
80
70
60
50
40
30
20
10
0
Percentage of respondents
With limiting long term illness
Without limiting long term illness
Limiting Long Term illness status
Place Survey
2001 Census