



Workshop Community Engagement and Health

Meeting Report

14 June 2010, Cheadle House, Cheshire, 09.45-16.30

On 14 June 2010 a workshop on community engagement and health was organised by the European Health Management Association and the Stockport Metropolitan Borough Council. The workshop brought a team from Gothenburg, Sweden, over to Stockport to discuss effective community engagement in practice and gave colleagues from Stockport with a direct role in community engagement and health improvement the opportunity to come together to discuss experiences and help to shape future approaches to community engagement in health in Stockport.

The workshop took place at Cheadle House in Cheshire and was attended by 45 delegates including representatives from the PCT, Foundation Trust, Stockport Council, Voluntary Sector and Sports Trust.

**Given the confidential character of the workshop, some comments/ideas are kept out of the meeting report.*

Welcome/Introduction

The meeting started with an introduction from **Jeni Bremner**, EHMA Director. Ms Bremner stated that the intention of the workshop is not to present 'one' model but to offer participants a chance to hear what is happening in other countries – in another context – and to see which elements inspire, excite or challenge; and what that might mean in a Stockport context.

Ms Bremners' introduction was followed by some introductory words from **Cllr Pantall**, Executive Cllr for Adults and Health. Cllr Pantall made two main points - that when engaging with communities it is important to identify and be aware of the different neighbourhoods and needs of the community and to try to overcome the challenge of professionals working in silos. Shared systems and approaches should be considered when it comes to engaging with citizens. There are also many learning opportunities available outside the specific health arena, and internationally.

Swedish experiences of community engagement and health: Angereds Närsjukhus

After the introduction, the Swedish team was presented to the group. The Swedish team was: **Håkan Linnarsson**, politician and president of the local health and medical care committee in Sweden; **Marianne Olsson**, currently managing a quality improvement project at the county council of Sörmland and former project director of the Angereds Närsjukhus; and **Lars Geland**, head of the pediatric clinic and chief medical officer of the Angereds Närsjukhus. The Swedish team presented their approach to engaging with communities including 'hard to reach' communities in Gothenburg. The team is currently designing and building a new hospital in the city of Gothenburg – called Angereds Närsjukhus - based on the needs of the population by putting the opinions of patients and citizens at the heart of the development of plans for the new hospital.

A. Background

Håkan Linnarsson presented on the political and social economic background against which the project was established. The hospital is being built in the North Eastern part of Gothenburg, a deprived area comprising four city districts and 95000 inhabitants. Over 40% of the population in North East Gothenburg is born overseas and the majority of the immigrants are refugees. Unemployment is higher than in other areas of Sweden and the region has a high proportion of inhabitants with a low income. In UK terms, the communities served by the hospital could be considered to be multiply-deprived, with clear health inequalities compared to other parts of Gothenburg and Sweden.

Mr Linnarsson then reported on how the project started by bringing a group of people together (key stakeholder seminar), to agree how to engage with their community and to agree a vision. To date, the vision has been revised three times and it probably will be revised at least three times in the future. Key to the vision is the aim to improve the health of the population by (1) creating an innovative hospital that helps to mobilize the local community and (2) acting through partnerships and promoting community 'participation' in identifying and responding to their health needs.

The starting point for their work was the acceptance that they did not know the real needs of the population living in the deprived areas of the North east Gothenburg. They found that they often have social problems, they work in lower-skilled and lower paid jobs, and suffer from mental wellbeing problems, sometimes post-traumatic stress as a result of their refugee status.

The stakeholder seminar included representatives from the voluntary sector, community sector, near hospitals and sports academies.

Questions from the audience:

- *Should they have the chance to re-establish an advisory board, would they have invited different people?*

They would probably have invited the county executive board (equivalent to the UK strategic health authority). The executive board encourages innovation and they know how to get some of the technical issues right. Recently the project team has set up a board just for the Angereds Närsjukhus.

- *You talked about doing something new in an old structure. Does the old structure need to disappear according to you?*

No, a key lesson from this project is that innovation can prompt incremental change and small islands of 'doing things differently' can spread across the wider system. Try to start with small changes and continue to work in cooperation recognising the importance of strong alliances and partnerships.

B. What they have done so far

Håkan's presentation was followed by an input from **Marianne Olsson**. Marianne started her presentation by referring to examples of community engagement work in Cornwall, UK which had very much inspired her and from which she learned that "you need to talk to citizens, patients first before you start to impose your vision on them".

The hospital is still a work in progress. They are half way through now. They have used the term "hospital" to make it clear and popular to the population but the focus of the project is on the delivery of health care, not a building.

As mentioned before, the reason for establishing a hospital in the North Eastern part of Gothenburg was that they knew the health status of the population was poor. After having compiled all statistics from the area they found out that the situation was even worse than thought. Mortality rates from cardiovascular disease, COPD/lung cancer, alcohol related deaths are significantly higher than in other parts from the region. Also higher are the rates of obesity, daily smoking, physical inactivity and stress. These conditions and lifestyle issues are typically associated with health inequalities in the UK.

At the key stakeholder seminar it was decided that they wanted to create an attractive, accessible and welcoming hospital with a dynamic and joyful working environment.

In order to do so, the following actions were undertaken by the project team:

Recruiting staff

The team placed particular emphasis on recruiting staff of the right calibre who could share the values of the project. They wanted their staff to mirror the cultures represented in the deprived areas of the city. This was possible when it came to recruiting nurses but more difficult when it came to recruiting medical doctors. Furthermore, they aimed to employ as far as possible local people, and to use local skills, create employment opportunities and support local businesses.

Dialogue projects

Dialogue projects were used by the project team to do extensive interviews with residents, patients and their own staff and to identify the real needs of the population.

The interviews are usually first done individually and then in groups. Following each cycle the dialogue leader produces feedback reports and then further dialogue groups are formed where staff and residents meet to discuss the feedback reports. The dialogue groups have resulted in a series of recommendations on how to shape the system and the ongoing work of the project. Dialogue groups were for instance recently used for the set up of a gynaecological department. The model for the dialogue projects was developed by Volvo, a company that has used the dialogue method to improve their diversity work.

Patient narratives

The project team has also set up methods to listen to patient stories. Regularly individual patients are asked to relate their experiences of the health care system with a group of health professionals from Angereds Närsjukhus. The health professionals have the chance to reflect back on what they have heard and the choices they could make to improve the situation for the patient. The fact that the patient is able to hear the discussions between the health professionals is very effective and makes a huge difference to the tone of the discussions. This technique is based on the principle that we need to change professional behaviour at least as much as changing the behaviour of the community to create and sustain health improvement.

Local meetings and local community activities

The project team has taken part in various events organised in the area (from city council meetings to health awareness days, from school events to cultural and religious network meetings) to increase visibility of the project and the connection with residents. The project also organises meetings where patients and inhabitants are invited to discuss healthcare.

The use of social media

The team has worked with professionals on communication and marketing to engage with citizens. Marianne acknowledged that when it comes to communication and marketing, branding and other traditional marketing techniques can be put to positive effect and there is no contradiction in 'selling' public sector services and actively making them attractive to potential users. Professional expertise is beneficial, especially when you want to reach a new community you have not worked with before. A facebook group has also been set up by the project team to engage with the community as well as a blogspot.

Study circles

The team has also set up study circles as a way to listen to the experiences and expectations of particular groups and to provide them with appropriate health information. The first study circle was held for Somali women. The circles allowed the project team to find out where healthcare is not working and where core processes are to be redesigned to meet the needs of the particular group.

An inclusive, integrated approach

In what they do, the project team aims to have an open, inclusive and creative attitude. The team has for instance worked together with a group of ballet dancers from Gothenburg that through their dances mirrored the work they are doing at the hospital. Through the eye of the dancers the project team has learned a lot about themselves. The dances also helped to visualise what exactly the new health system is doing for the population.

The team has also integrated public health and epidemiology as much as possible into the work they are doing.

C. Lessons learned so far

Ms Olsson ended her presentation by summing up some of the key lessons learned so far:

1. When engaging it is important to start with the needs of the population and not with your own beliefs.
2. Try to align epidemiology, public health and health care delivery with each other. All three fields need to be integrated in the work you do.
3. Involve the local community in the inception of new ideas or projects and continue this systematically throughout the life of the service – developing an ongoing patient/residents' narrative.
4. Be prepared to constantly redesign your vision and processes. You need to maintain a learning attitude from the start till the end.
5. Use social marketing and branding and make use of the expertise provided outside the health sector.
6. Try to understand the needs of co-workers.
7. Create and maximise alliances.

D. Population demands

After Marianne Olsson's input, **Lars Gelerander** presented on the specific demands of deprived communities in Gothenburg and the importance of communication to identify those demands. Some of the key issues mentioned by Lars are summarized below:

- Efforts were made by the project team to make the new health system comprehensible for migrants and non native residents. A Google translator was for instance inserted on the website of the Angereds Närsjukhus to provide basic translation. For the ten most common community languages the team has provided more specific translations.
- Also voluntary doula groups were set up to provide physical, emotional and practical knowledge – in the mother's native language – before, during and after childbirth. Traditionally doulas are regarded as professionally trained women experienced in childbirth. For the purposes of the project, the team opted to set up voluntary rather than professional doula groups.
- Local news papers and radio stations have played an important role in bringing the project closer to the citizens and translating the project in a comprehensible way.
- Dr Gelerander also presented the profile of an average patient from North East Gothenburg. They would most likely have diabetes, vascular diseases, be obese, have sleep problems and smoke. It was discovered that patients with multiple problems do not want to be treated for all those diseases separately in different departments. The service has been established so no matter where the patient presents they would automatically be screened for the other conditions and be given health education information.

The multiple actions undertaken to engage with the community have given the project team an overall understanding of what citizens from North east Gothenburg want and do not want from a health system. A key finding was that citizens want to feel listened to, that communication with health care providers should be a dialogue (not one-way), that they want to be treated with patience, to receive information about self care and when needed to have

access to translators to help them to understand the medical doctors and staff, to be treated as a person, not as a thing, to be well informed about available treatments, benefits and side-effects and to meet staff with cultural competence and empathy. Residents do not want to wait in a queue to see a doctor, feel that healthcare is inaccessible or always see new doctors but instead prefer consistency.

Questions from the audience:

- *Continuously engaging with patients and your community might easily take you away from your normal work and tasks. How do you convince everyone that this is of major importance and that they should not give up on this?*

The team recognised the difficulty of working with deprived communities. They were working with people who are often angry with life and who typically have persistent, multiple health problems. Work needs to be planned in such way that there is time to listen to the needs of patients and citizen and dialogue projects and patient narratives had proved to be a powerful way of doing that. This type and depth of engagement takes time and managers need to take responsibility to equip staff with the skills and the time that they need to commit to community engagement.

- *You earlier said that patients need to be treated as a person and not as a thing. How much money is spent on the training of receptionists, etc... It would ease the patient journey and it is something that we in Stockport recognise as very important.*

The team has ongoing training sessions for staff members and agreed that administrative and reception staff were key in creating a welcoming atmosphere. They acknowledged that more can always be done to improve the patient journey. The team has designed some areas of the hospital to create the best possible first experience. For instance, glass screens are not used at the reception and low tables and chairs are provided so that the first contact with the hospital is comfortable and welcoming.

Facilitated reflections on the Swedish case study

After the coffee break delegates were divided into groups and were asked to reflect on two specific questions:

- (1) What excited, inspired or challenged you in hearing the presentation from Sweden?
- (2) How might these be translated/developed in a Stockport context.

A summary of the ideas raised by the delegates is provided below:

New approach from outside

Genuine communication with patients

Cooperation between different organisations

Focus on “wellbeing” rather than on “illness”

They did not engage with the community because they had to but because they genuinely wanted to change the way of working

What has excited you?

The use of existing networks

Strong sustained vision and leadership

Structured process for dialogue

Creativity

Focus

Use of social media to target the community

Fresh start – using a bottom up approach

Legacy and long term impact

Marketing and
Communication
strategy

Strong message about
supporting your staff and
management taking
responsibility

A learning approach underpinning everything you do

Involving other sectors
(football clubs, ballet
schools)

Quality of
engagement

What has inspired you?

Just do it!

The transferability of the model

Flexible attitude to meet the needs
of the population

Less
traditional
approach to
engage with
citizens

The need to change our
behaviour and not 'theirs'

How to engage effectively with professionals in particular with GPs?

To keep the motivation to prioritise engagement

The challenge of raising expectations of meeting all those desperate needs

The challenge of being progressive in a period of shrinking resources

What has challenged you?

To get politicians on board

To affect change within established structures

Future uncertainties

Evidence base: How do we measure success?

Breaking down professional/organisational boundaries

How might these things be translated into a Stockport context?

- ❖ Trying out the patient narrative methodology and involve clinicians in this
- ❖ Showcase good case studies
- ❖ Create more, new, different partnerships with the voluntary sector
- ❖ Carrying out interviews / dialogue groups to find out the real needs of the priority communities in Stockport
- ❖ Challenging our own attitudes
- ❖ Linking up grass roots with service provision
- ❖ Increasing social marketing to target the population
- ❖ Taking the risk to consult the public before having a professional answer ready
- ❖ Learning from already documented public consultations in Priority 1 communities
- ❖ Being inspired by individual actions
- ❖ Bridging cultures between the Council/PCT
- ❖ Understanding non users of health care and why they are non users
- ❖ Getting out of our silos
- ❖ Community engagement workers acting 'as a whole'
- ❖ Raising the profile of events in Stockport
- ❖ Working with the local hospital
- ❖ Feeding back -influencing upwards whilst recognising top-down priorities
- ❖ To keep the following message in mind: Innovation works best in a learning culture; and doing it differently does not always mean that you got it wrong in the past.

Afterwards, Jeni Bremner and the Swedish team reflected back on the issues and ideas raised by the delegates.

Consultations

With regard to the consultations carried out in priority communities from Stockport, Håkan Linnarsson explained that also in Angereds many consultations have been carried out in the past. Many projects have tried to change the situation in the deprived areas from Gothenburg. People in Angereds have been promised many things in the past and it is probably therefore that initially they were reluctant to the plans of designing a new hospital in the area. The team has overcome this problem by acting quickly to demonstrate change and by showing them that they are doing what they promised.

Measuring success

In terms of the challenge of measuring success, Marianne stated that it is not about quantity but much more about quality, what exactly you have been doing and whether it was the right thing for your population in the first place.

Transferability of the model

In theory, the model could be easily translated into other contexts; originally it was used by a car manufacturer. City planners from Gothenburg have used the project team's reference groups (built as part of the dialogue process) as a reference group for spatial planning within the municipality.

Sustainable leadership

Sustainable leadership is possible even if the initial project leaders leave the project. Marianne Olsson was responsible for the first phase of the creation of the Angereds Närsjukhus. She left the project last year. However, the tools and techniques have been embedded in the organisation, so the momentum is continued as the key clinical leaders have remained in post.

Action Planning Session

The afternoon was kept available for an action planning session with the delegates. Participants were divided into groups and reflected on two questions:

- (1) How could we express our common purpose / goal for improving community engagement in health improvement in Stockport's Priority Neighbourhoods
- (2) How might you achieve this common goal (with as sub questions: How can we do this/what methods might work; How do we start this and who should lead it; Who else should be involved; How do we make sure this happens; When should this happen.)

**Given the confidential character of the session, the outcomes of the action planning as well as the follow up discussion are kept out of the meeting report.*

The workshop was run as part of EHMA's Policy into Practice Programme, funded by the Department of Health in England. More information on the Programme and workshop is available on the [EHMA Website](#). To express interest in the programme or for questions, please contact Annemie Coëme at Annemie.coeme@ehma.org.