General Practice community engagement approaches to tackle health inequalities (HiQUALITY) study

Highlight Report: Summary of Key findings (October 23 - March 24)

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Content

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Executive Summary

Introduction

This report summarises key findings of the HiQUALITY (Health Inequality) Study commissioned by the NHSE Legacy and Health Equity Partnership (LHEP). The project was a partnership of LHEP, UKHSA London, NHSE London, and SCARU Imperial over a 6-month timeline (Sep 23-Mar 24).

The COVID-19 pandemic and cost of living crisis exacerbated existing health inequalities amongst London's diverse communities. Community engagement has been an important aspect of the multisectoral approach towards tackling these health inequalities, and General Practices (GPs) and Primary Care Networks (PCNs) have contributed to this work. A great deal of community engagement activity is already occurring in General Practice, however scoping conversations with leaders in this area had suggested that exploration of a baseline of activity and an understanding of need would be beneficial to inform possible next steps for community engagement in General Practice.

The HiQUALITY Study aimed to characterise variations in community engagement approaches by GPs/PCNs across London, exploring reasons behind these variations, perceived outcomes, best practice and what support is needed to sustain community engagement to reduce health inequalities.

Methods

A mixed-methods approach was used. We disseminated an electronic survey to the GP workforce across London, yielding quantitative data from a convenience sample of 377 respondents. We then analysed the perspectives of 182 respondents who completed the survey from the total pool of 377. The survey evaluated perceptions of the prevalence of community engagement by General Practices, strategies used, their effectiveness and implementation barriers and facilitators to address health inequalities in London. This was supplemented concurrently with contextual qualitative data from 20 participants (18 personal semi-structured interviews and 1 focus group discussion). The interviews explored perceptions of community engagement, what community engagement strategies are used, why some initiatives might succeed or fail, the barriers and facilitators to their implementation, and what further support General Practice needs.

Results

More than a third (41%) of survey respondents stated that they often or always engaged communities to reduce health inequalities, 56% sometimes or rarely, and 3% never. The most popular strategy (67% of respondents) involved informing communities through letters or digital methods like texts/apps/website/social media. In contrast, two-way strategies such as discussing in community forums (31%) and collaborative or co-production approaches (33%) were less commonly employed.

The interviews highlighted that although there is good knowledge of local communities, a "population" or "community" approach to tackling health inequalities is not the norm, and some professionals prefer "personalised" approaches. Large GP practices or PCNs were reported to be more likely to undertake community engagement, commonly focusing on health promotion and disease prevention.

Evaluation of effectiveness of interventions was not consistently conducted, however 79% of survey respondents rated their community engagement strategies as low to moderately effective (0-6 rating out of 10) in reducing health inequalities. Interviewees reported other overwhelmingly positive perceived outcomes from community engagement, including improving staff satisfaction, reinforcing community cohesion and notably, increasing the sense of community ownership of interventions. They however also reported that initiatives did not always reach all who need them.

Key barriers reported in the survey to influence implementation of community engagement approaches to reduce health inequalities in General Practice included funding constraints, leadership and governance factors, workforce capacity limitations and systemic challenges within health information systems. Interviewees reported similar barriers, and additionally highlighted hesitancy amongst some clinicians to work with communities, a lack of robust leadership at a GP/PCN level, and difficulties in recruiting and sustaining communities in engagement activities.

Interviewees reported that good community engagement needed community-centeredness, strong leadership and buy-in from all relevant stakeholders in a place. Although clinicians were vital, non-clinicians often also led initiatives and were vital to their success. Survey respondents also highlighted clear strategic direction, accessing funding and a supportive organisational culture as significant enablers.

Survey respondents and interviewees revealed the type of support required for community engagement. From the survey, these included through financial resources (79%), leadership development (58%), targeted workforce training programs (56%), peer support networks (53%), streamlined/integrated technology (52%), evaluation support (51%) and comprehensive guidelines/toolkits (41%). Interviewees reported the need for developing health inequalities leads, facilitating identification of local assets and collaborations, and an interactive and sustained way of sharing best practice.

Ambition for next steps and guiding pillars

Considering these findings, we consulted with policymakers on suggestions for next steps to help improve how General Practice leverages community engagement approaches to tackle health inequalities. It was suggested that the overarching ambition for next steps should be **building trust with communities and reducing health inequalities in London through creating a local enabling environment and culture that prioritises community engagement in General Practice, including through co-design and co-production.** Underpinning this ambition were **four** main guiding pillars including:

⇒ ***Fostering partnerships with communities***

- Facilitate co-design and co-production through mapping local assets supported by Directory of Services, pathways, guidelines and toolkits produced on a wider footprint to support General Practice.
- Specific support for outreach and effective engagement with vulnerable groups in London including asylum seekers, undocumented migrants and refugees, homeless populations, ethnic minorities groups, people with disabilities, and low-income households.
- Leverage technology to enhance engagement & accessibility recognising that there will be digital barrier for some communities.

⇒ ***Strengthening governance and leadership across the system***

- Develop and deliver a community engagement plan/strategy that considers effective and sustainable approaches, resources, and clearly defined roles and responsibilities across involved organisations.
- Create leadership opportunities and mechanisms for collaborative community engagement across General Practice, neighbourhood, place, and systems to

enable sharing of focus, learning, best practice, and resources such as premises or workforce.

- Support General Practices in inter-sectoral and multi-sectoral working in neighbourhoods for community engagement, reviewing commissioning and funding models to facilitate true integration and reduce silo working.

⇒ ***Workforce development***

- Expand the General Practice workforce to support community engagement with increased capacity to include social prescribers, community health and wellbeing workers or care navigators.
- To identify and respond to training needs of the workforce on community engagement and how to use Quality Improvement approaches through Training Hubs and peer support.

⇒ ***Bolstering data and evaluation***

- Working across systems and sectors to improve data collection and insights with the aim of identifying the vulnerable communities who might best benefit from community engagement in General Practice. This includes improved coding for specific communities and ethnicities.
- Facilitate evaluation of community engagement strategies to measure realistic and relevant impact that can support commissioning models. This includes utilising evaluation toolkits, training in Quality Improvement methodology, and academic partnerships, ensuring that communities are involved in evaluations.

Conclusion

In conclusion, at baseline GPs/PCNs report engaging with communities through approaches that more often involve “doing to” communities rather than “doing with” them. Whilst there are examples of best practice, effectiveness of current strategies is generally perceived to be low to moderate. As we move forward towards a neighbourhood health service, embedding co-production and participatory methods into routine practice, supported by robust leadership, targeted funding, and workforce development, is critical.

Introduction

London's population density is 14 times higher than the average of England and Wales, with a significant proportion (40.6%) of residents born outside the UK, making it the most ethnically diverse region in the UK[1]. Health inequalities are prevalent across various demographics, including deprivation levels, genders, geographies, ethnicities and inclusion health groups. The COVID-19 pandemic and the cost-of-living crisis have exacerbated these inequalities, with the highest regional excess mortality ratio in England observed in London during the pandemic, particularly affecting ethnic minority groups, inclusion health groups and low-income families.

The NHS and partners have implemented strategic plans to address these inequalities, with Integrated Care Boards (ICB) adopting a CORE20PLUS5 approach that includes engaging communities[2]. GPs/PCNs have also adopted this approach to address neighbourhood health inequalities as part of the Network Contract Directed Enhanced Service (NCDES). Community engagement is defined as "a range of approaches to maximise the involvement of local communities in local initiatives to improve their health and wellbeing and reduce health inequalities"[3].The importance of engaging with communities through co-production to reduce health inequalities is recognised, yet GPs/PCNs face challenges such as high demand and limited staff resources.

Discussions with primary care colleagues and a review of the available literature demonstrated that extensive community engagement with the aim of reducing health inequalities is being carried out in General Practice. To develop next steps for further supporting and developing community engagement in General Practice, it was highlighted that exploration of a baseline of activity and an understanding of need would be beneficial. Our review of the literature further revealed that there is limited UK-based evidence on the effectiveness of community engagement in General Practice for reducing health inequalities, highlighting a gap in both practice and research. Guidance is also limited, though NHS England has produced a communication toolkit for those working with socio-economically deprived areas.

[1] Greater London Authority, Institute of Health Equity, Office for Health Improvement and Disparities, NHS England. Health Inequalities in London: An update to the snapshot of health inequalities in London https://data.london.gov.uk/dataset/snapshot-ofhealth-inequalities-in-london [Accessed February 2025].

[2] NHS England. Core20PLUS5 (adults) – an approach to reducing healthcare inequalities. https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalitiesimprovement-programme/core20plus5/ [Accessed February 2025].

[3] National Institute for Health and Care Excellence. Community engagement: improving health and wellbeing and reducing health inequalities. https://www.nice.org.uk/guidance/ng44/chapter/Committee-discussion#evidence [Accessed February 2025]

Study aims

The primary aim of this study was to characterise the different types of community engagement strategies currently employed by GP practices and PCNs to tackle health inequalities. The secondary objectives were to:

- Establish a baseline of current practices, exploring the success or failure of these approaches
- Identify the common barriers and enablers for the routine use of these community engagement strategies.
- Identify best practice examples and synthesise actionable recommendations for the consideration of commissioners

Methods

Study design

A protocol for a cross-sectional study to collect primary data from both surveys and interviews was developed. To ensure robust study design and execution, a multidisciplinary, multi organisational Project Reference Group was convened. This group included representatives from primary care commissioning, NHS England and LMC, who reviewed the survey and interview guides, address potential risks and provide strategic oversight, ensuring that the project met its objectives efficiently.

Quantitative data collection (eSurvey)

The survey was co-produced by the research team with the LHEP team. The revised survey was piloted with a small number of respondents (professional contacts at Imperial Department of Primary Care & Public Health, and collaborators of LHEP). Comments to the pilot survey were used to arrive at final revised version for wider dissemination to healthcare professionals within GPs and PCNs across London. Participants eligible for this study were General Practice professionals aged 18 years or older. Recruitment strategies included social media advertisements, outreach through professional contacts (Departmental contacts via LHEP, Integrated Care Boards, NHS England and Imperial Department of Primary Care & Public Health, etc.), email invitations to the General Practice workforce addressed from NHSE London regional director and direct recruitment during local health events. The Participant Information Sheet (PIS) provided detailed information about the study's aims, data protection measures and participants' rights. The survey was administered using a secure platform, Qualtrics, which excluded IP address collection to ensure anonymity and data security.

Data collection and analysis

The electronic survey consisted of 24 questions, focusing on current community engagement practices, perceived effectiveness and barriers to successful engagement. A consent-to-contact section was included for participants willing to engage in follow-up interviews. The survey data were analysed using descriptive statistics to provide a comprehensive overview of the current engagement practices. The Statistical Package for the Social Sciences (SPSS) was utilised for data analysis, adhering to best practices in survey reporting. Additionally, a comparative analysis across different professional roles was conducted and summarised in Table B.1, Appendix B, providing insights into varying perceptions and practices between GP and PCN roles regarding community engagement.

Qualitative data collection (Interviews and focus group)

Participants indicating a willingness to provide further insights were contacted for semi-structured interviews and focus group discussions. A convenience sample of healthcare professionals was selected to ensure a diverse representation of roles and experiences within General Practice. Interviews and focus groups were conducted virtually using Microsoft Teams to ensure privacy and security. These sessions were audio-recorded and transcribed verbatim. An interview guide facilitated the discussion, focusing on personal experiences, challenges, successes and nuanced insights into community engagement practices.

Data analysis

Thematic analysis was applied to the qualitative data to identify, analyse and report patterns within the data. This approach allowed for a nuanced understanding of the qualitative aspects of community engagement, complementing the quantitative survey findings.

Ethics

The study received a favourable opinion by the Imperial College Research Ethics Committee (ICREC #6903517 on 31/01/2024).

Results

Data was collected from 377 primary care professionals via an electronic survey. 18 in-depth personal interviews were completed as well as another 2 participants in a focus group (n=20). A summary of key findings is presented below.

Quantitative findings

This analysis covers the perspectives of 182 respondents from a total pool of 377 who only completed part of the survey. Data from a total of 195 respondents were excluded before analysis because they did not consent (n=2), submitted blank surveys (n=21), consented but did not answer (n=108) or answered only one question (n=64).

Demographic data from the 182 respondents showed a concentration of respondents in the 35-54 age range, making up over 60%, with a notable female predominance at 66.4%. Ethnically, 58.4% were White, with the next largest group being Asian/Asian British at 28%. Professionally, the majority were GPs (66.9%), with other roles like practice managers and administrators making up smaller fractions.

The distribution of respondents by years of service in primary care indicated a significant proportion with over 10 years of experience (60.5%), while 21.8% had 5-10 years of experience and 10.5% had less than 3 years. The data also indicates a spread across different Integrated Care Systems, with the largest group in Northeast London (32.8%); Table 1. The main survey findings are presented in Table 2.

Among the study participants, 38.8% reported concurrent roles in both General Practitioner (GP) and Primary Care Network (PCN) capacities and chose to respond to the survey questions emphasising their PCN role. A predominant 48.9% of respondents opted to provide perspectives primarily from their GP role, whereas 12.4% focused solely on their GP role despite holding dual appointments (Table 2).

Table 1: Respondent characteristics (n=182)

	N	(%)
Age		
18 - 24	2	(1.6)
25 - 34	17	(13.6)
35 - 44	38	(30.4)
45 - 54	38	(30.4)
55 - 64	24	(19.2)
65 - 74	6	(4.8)
75 and older	0	(0.0)
Gender		
Male	42	(33.6)
Female	83	(66.4)
Ethnicity		
White	73	(58.4)
Mixed/Multiple ethnic groups	5	(4.0)
Asian/Asian, British	35	(28.0)
Black/African/Caribbean/Black British	7	(5.6)
Other Ethnic Group (please specify)	4	(3.2)
Prefer not to say	1	(0.8)
Designation		
GP (Partner, locum, salaried etc.,)	83	(66.9)
Nurse (Practice nurse, nurse practitioner, etc.)	1	(0.8)
Practice Manager	13	(10.5)
Physician assistant	0	(0.0)
Administrator	4	(3.2)
Social prescriber	2	(1.6)
GP Practice Pharmacist	1	(0.8)
Other (please specify)	20	(16.1)
Years of service in primary care		
<3 years	13	(10.5)
3-5 years	9	(7.3)
5-10 years	27	(21.8)
10 years+	75	(60.5)
ICS /ICB		
NWL	21	(16.8)
NCL	28	(22.4)
NEL	41	(32.8)
SWL	16	(12.8)
SEL	19	(15.2)

Table 2: Survey Findings

Please select one option:		
I have a GP and PCN role & I would like to answer questions about my PCN role	69	(38.8)
I have a GP role and would like to answer questions from my GP role perspective	87	(48.9)
I have a PCN role and GP role and would like to answer questions only about my GP role	22	(12.4)
On a scale of 0-10, where 0 is not at all important & 10 is extremely important, how important do you think it is that your GP/PCN is involved in engaging communities in the design or delivery of health interventions to reduce health inequalities?		
Low Importance (0-4)	9	(6.6)
Moderate Importance (5-7)	34	(24.8)
High Importance (8-10)	94	(68.6)
How often does your GP/PCN engage communities in the design or delivery of health interventions to reduce health inequalities		
Never	6	(3.3)
rarely	37	(20.6)
Sometimes	63	(35.0)
Often	55	(30.6)
Always	19	(10.6)
Which strategies does your GP/PCN use in engaging communities in the design or delivery of health interventions to reduce health inequalities? Select all that apply.		
Informing communities through letters or digital methods like texts/apps/website/social media	116	(66.7)
Involving or consulting communities in designing services through Patient Participation Groups virtually or face-to-face.	102	(58.6)
Forums and discussions for improving health and wellbeing virtually or face-to-face	53	(30.5)
Using community hubs or the GP practice for health events or fairs.	89	(51.1)
Collaborative approaches like co-produced projects or community-based participatory research	58	(33.3)
Working with volunteers or people in peer roles such as community champions or faith groups or volunteers in community outreach	73	(42.0)
Other (please specify)	27	(15.5)
Do you know who the most underserved groups are in your community?		
Yes	144	(80.4)
No	35	(19.6)
Are your GP/PCN community engagement initiatives successful in reaching the most undeserved population?		
Extremely unsuccessful	6	(4.8)
Somewhat unsuccessful	34	(27.0)
Neither successful nor unsuccessful	41	(32.5)
Somewhat successful	39	(31.0)
Extremely successful	6	(4.8)
Do you actively engage communities facing barriers to GP registration to increase their registration at your GP/at practices in your PCN?		
Yes (please specify how)	62	(49.2)
No	30	(23.8)
Unsure	34	(27.0)
Which (if any) of the following communities does your GP/PCN need to engage with more to help reduce health inequalities?		
Refugees & asylum seekers	84	(69.4)
Undocumented migrants (people who are living in a country without the proper legal documents or permission)	64	(52.9)
Homeless population	83	(68.6)

Ethnic minority groups (please specify)	67	(55.4)
Low-income families	62	(51.2)
People with disabilities	65	(53.7)
Other vulnerable groups (please specify)	34	(28.1)
On a scale of 0-10, where 0 is not at all effective & 10 is extremely effective, how effective do you think these strategies have been in reducing health inequalities in your local population overall?		
Low Effectiveness (0-3)	38	(30.9)
Moderate Effectiveness (4-6)	59	(48.0)
High Effectiveness (7-9)	26	(21.1)
How often do you evaluate the effectiveness of these strategies on reducing health inequality?		
Never	12	(9.4)
Rarely	40	(31.3)
Sometimes	51	(39.8)
Often	22	(17.2)
Always	3	(2.3)
Please indicate what you perceive are barriers /challenges to implementing community engagement strategies at your GP/PCN (choose all that apply)		
Leadership/Governance		
Lack of a clear strategy on community engagement	74	(57.8)
Low buy-in	56	(43.8)
Low accountability	35	(27.3)
Other (please specify)	53	(41.4)
Workforce		
Conflicting priorities	74	(57.8)
Lack of awareness of policies	28	(21.9)
Lack of organisational culture	34	(26.6)
Limited number and distribution of workforce	79	(61.7)
Other (please specify)	24	(18.8)
Funding		
Lack of funding for community engagement to reduce health inequalities	102	(79.7)
Lack of weighting for deprivation in funding available	75	(58.6)
Other (please specify)	20	(15.6)
Health Information System		
Lack of ethnicity coding in GP records	21	(16.4)
Lack of coding for different types of community in GP records	40	(31.3)
Non-streamlined use of Health information systems	56	(43.8)
Digital silos/poor use of technology	57	(44.5)
Other (please specify)	23	(18.0)
Communities		
Lack of trust for health services	74	(57.8)
Language barriers	85	(66.4)
Knowledge and beliefs of health interventions	98	(76.6)
Other (please specify)	23	(18.0)
Please indicate what you perceive are Drivers/Enablers to implementing community engagement strategies at your GP/PCN (choose all that apply)		
Leadership/Governance		
Clear strategy on community engagement	89	(73.0)
Buy-in	64	(52.5)
Accountability to meet targets	52	(42.6)
Other (please specify)	24	(19.7)
Workforce		
Clear priorities	86	(70.5)
Awareness of policies	55	(45.1)
Organisational culture readiness	80	(65.6)

Other (please specify)	16	(13.1)
Funding		
Funding for community engagement to reduce health inequalities	95	(77.9)
Weighting for deprivation in funding available	66	(54.1)
Other (please specify)	14	(11.5)
Health Information System		
Ethnicity coding	41	(33.6)
Community coding	44	(36.1)
Streamlined use of Health information systems	57	(46.7)
Good use of technology	65	(53.3)
Other (please specify)	10	(8.2)
Communities		
Trust for health services	76	(62.3)
Language services	65	(53.3)
Knowledge and beliefs of health interventions	80	(65.6)
Other (please specify)	13	(10.7)
How likely is it that you will engage communities in the design or delivery of health interventions to reduce health inequalities in the future?		
Extremely unlikely	9	(7.2)
Somewhat unlikely	13	(10.4)
Neither likely nor unlikely	16	(12.8)
Somewhat likely	47	(37.6)
Extremely likely	40	(32.0)
What support do you need to engage communities to reduce health inequalities? (tick all that apply)		
Peer support networks	67	(53.2)
Comprehensive guidelines/toolkits	52	(41.3)
Targeted workforce training programs	71	(56.3)
Financial assistance or grants	100	(79.4)
Evaluation support	64	(50.8)
Leadership development and support	73	(57.9)
Streamlined/integrated Technology	66	(52.4)
Other (please specify)	25	(19.8)

⇒ *Community engagement in reducing health inequalities*

GP/PCN involvement in community engagement as a strategy to mitigate health disparities was deemed highly important by 68.6% of respondents (scoring 8 to 10 on a scale of importance), while 24.8% considered it moderately important (scoring 5 to 7) and a minor 6.6% viewed it as of low importance (scoring 0 to 4). Engagement frequency varied, with 35.0% of respondents indicating that their GP/PCN sometimes engaged with communities, 30.6% often did and 10.6% always engaged. In contrast, 20.6% rarely engaged and 3.3% never engaged communities (Table 2). A comparison of perspectives showed that respondents representing PCNs reported more frequent engagement (38.2% often and 17.6% always) compared to those in GP roles (25.9% often and 6.5% always; $p = 0.007$); Table B.1, Appendix B.

Various strategies were employed to engage communities, including the dissemination of information via letters or digital methods (most commonly at 66.7%), involving communities in service design through Patient Participation Groups (58.6%) and organising health events at community hubs or GP practices (51.1%). Strategies of collaboration and volunteering were noted by 33.3% and 42.0% of respondents, respectively (Table 2), with those from a PCN background more likely to engage in collaborative approaches (35.4% vs. 2.7% from GP roles); Table B.1, Appendix B. Some example of case studies shared as part of the survey are highlighted in Appendix A.

⇒ ***Awareness and efficacy in targeting underserved populations***

80.4% of respondents were aware of the most underserved groups within their community. Respondents identified asylum seekers, refugees (69.4%), the homeless (68.6%), undocumented migrants (52.9%), individuals with disabilities (53.7%), ethnic minority groups (55.4%) and low-income families (51.2%) as key communities requiring enhanced engagement efforts. Tools commonly employed to identify these groups included demographic data, Integrated Care Board (ICB) data, deprivation indices and disease registers, with the CVDAction dashboard, EMIS and public health reports, which are instrumental in recognising health disparities and directing resources effectively.

Nonetheless, only 31.0% felt that their community engagement initiatives were somewhat successful in reaching these populations, with a mere 4.8% considering their efforts extremely successful. Regarding proactive engagement, 49.2% of respondents reported endeavours to increase GP registration among communities facing barriers to GP registration (Table 2). Respondents discussed approaches such as accepting verbal confirmations of addresses, aiding with online registration and promoting 'safe surgeries' that do not require proof of address. Engagement strategies also included outreach at community events, pop-up clinics and collaborations with support groups, emphasising multilingual support and simplified registration processes.

Various methods were used to gauge the success of community engagement initiatives, including patient feedback, event attendance, service uptake, health outcomes and specific metrics such as vaccination rates and Quality and Outcomes Framework (QoF) data. However, the complexity and diversity of the populations served posed challenges in quantifying success was also highlighted.

⇒ *Effectiveness of engagement strategies and evaluation*

Respondents' assessment of the effectiveness of their strategies in reducing health inequalities showed that 48.0% rated them as moderately effective (scoring 4-6), 21.1% as highly effective (scoring 7-9) and 30.9% as low effective (scoring 0-3) (Table 2). PCN representatives perceived a higher effectiveness of their strategies, with 30.4% rating them as highly effective, compared to 16.0% among GP roles (Table B.1, Appendix B). The evaluation of these strategies varied significantly; 39.8% reported evaluating sometimes, 17.2% often and 2.3% always. Conversely, nearly a third (31.3%) rarely conducted evaluations whereas 9.4% never evaluated their engagement strategies (Table 2). Participants representing PCNs reported a higher frequency of evaluations (26.5%) compared to their GP counterparts (11.7%);

Several barriers to implementing community engagement strategies were identified. Leadership and governance issues reported included a lack of a clear strategy (57.8%), low buy-in (43.8%) and low accountability (27.3%). Workforce-related barriers highlighted included conflicting priorities (57.8%), limited awareness of policies (21.9%), lack of organisational culture (26.6%) and limited workforce distribution (61.7%). Funding issues was a significant theme emerging, with 79.7% indicating a lack of funding for community engagement and 58.6% noting a lack of weighting for deprivation in available funding. Challenges related to health information systems included non-streamlined use (43.8%), digital silos (44.5%) and lack of coding for different community types (31.3%). Community-related barriers encompassed a lack of trust in health services (57.8%), language barriers (66.4%) and varied knowledge and beliefs about health interventions (76.6%); Table 2. These barriers were similarly perceived across both PCN and GP roles, with some variation in specific areas, such as conflicting priorities and workforce distribution, Table B.1, Appendix B.

⇒ *Drivers and enablers of successful community engagement*

Key drivers and enablers for successful community engagement encompassed several domains. In terms of leadership and governance, clear strategic directions (73.0%), stakeholder buy-in (52.5%) and accountability for meeting targets (42.6%) were crucial. Workforce enablers included having defined priorities (70.5%), awareness of relevant policies (45.1%) and readiness of organisational culture (65.6%). The availability of funding specifically earmarked for community engagement (77.9%) and appropriate weighting for deprivation factors (54.1%) were mentioned as significant enablers.

Efficient use of technology (53.3%) and streamlined operations within health information systems (46.7%) were highlighted as enablers to support effective engagement. On the community level, enablers included trust in health services (62.3%) and enhanced community knowledge and beliefs regarding health interventions (65.6%); Table 2) These enablers were recognised by both PCN and GP roles, with slight differences in their emphasis (Table B.1, Appendix B).

⇒ *Prospective community engagement*

Future intentions regarding community engagement revealed that 32.0% reported being extremely likely and 37.6% somewhat likely to engage in upcoming health interventions. A smaller proportion, 10.4%, were somewhat unlikely and 7.2% were extremely unlikely to engage (Table 2). Engagement likelihood was notably higher among PCN participants, with 41.7% being extremely likely, compared to 26.7% from GP roles (Table B.1, Appendix B).

⇒ *Support needed for enhanced community engagement*

The survey highlighted the desire for various supports to enhance community engagement. Financial assistance or grants were cited by 79.4% as crucial, followed by targeted workforce training programs (56.3%). Leadership development (57.9%) and comprehensive guidelines or toolkits (41.3%) were also frequently mentioned as necessary supports (Table 2). Other aspects highlighted as potentially valuable were the establishment of a normalised culture of community engagement across all sectors of primary care, public health, and education, as well as greater recognition and validation of the efforts that were currently unfunded.

Participants stressed the importance of specific designations and professional development opportunities for roles dedicated to community engagement. The need for continuous, sustainable funding was also emphasised, not just for engagement activities but also to directly enhance the living standards of disadvantaged communities. Some advocated for more integrated and collaborative working arrangements across different sectors. They called for investment in proven models like the Deep End project, enhanced community leadership in planning processes, evidence-based approaches to measure the effectiveness of interventions, dedicated time for engagement activities, strong support from Integrated Care Boards (ICB). Finally,

respondents stressed the importance of a long-term commitment to community engagement efforts to ensure sustainability and impact. Collectively, these insights illustrate the complex and multi-dimensional support required to promote effective community engagement in healthcare settings.

Qualitative findings

18 semi-structured interviews were conducted as well as a focus group discussion with two participants, leading to a total of 20 participants overall. Participants included General Practitioners, Nurses, PCN clinical director, health inequalities lead, a health equity champion, a population health manager and administrative staff (table 3).

Table 3: Participant characteristics

	N	(%)
Total	20	(100)
Gender		
Female	15	(75)
Male	5	(25)
Designation		
General Practitioner	12	(60)
Practice Manager	3	(15)
Nurse	1	(5)
Administrative staff	1	(5)
PCN Health equity champion	1	(5)
Care coordinator	1	(5)
Population Health Manager	1	(5)

Some of the main emergent themes were categorised into defining and serving communities, the community engagement initiatives, perceived outcomes, features of good community engagement, barriers to implementation and the support needed by General Practice. These are summarised in table 4 and described in further detail in the sections that follow.

Table 4: Themes

Category	Theme	Description
Defining and serving communities	Awareness of local communities	Communities are well identified not solely on geography, but also ethnicity, gender, age and other sociodemographic factors.
	Rather than a "community" approach to health inequalities, a "personalised" approach is sometimes preferable	In some GPs, "Community" can be too large a concept, exclude some people, and lead to overgeneralisations. Sometimes deprivation overarches all communities and is more important.
	Large GPs or PCNs favour community engagement	Large GP practices or those with specific populations may be involved in community engagement like PCNs.
	All members of the GP workforce should be involved	It was felt that community engagement should involve clinicians and non-clinicians. New roles such as social prescribers or patient navigators can be vital.
The community engagement initiatives	A focus on health promotion and disease prevention	A wide array of interventions was used to focus on lifestyle education, health service outreach, encouraging supportive environments, and facilitating community action for health.
	Doing to communities, rather than with or by them	Communities were said to rarely lead or co-produce initiatives in General Practice. They were sometimes involved in evaluating interventions and were most often informed of the initiatives and acted as subjects or participants.
Perceived outcomes	Community engagement initiatives are highly beneficial	The benefits were said to include staff satisfaction, the reinforcement of community cohesion and notably, increasing the sense of community ownership over the interventions.
	Reach is limited	Some described that the initiatives do not always reach all who need them.
Features of good community engagement	Community-centeredness	It was highlighted that emphasis needs to be placed on needs of communities, and they identified that insights should be gathered to design and deliver interventions tailored needs.
	Strong leadership and collaborations	Partnerships with various stakeholders are needed to access resources needed. These need to be nurtured and sustained.
	Buy-in from all stakeholders	All need to be encouraged to get involved and support needs to be provided for them.
Barriers to implementation	Financial Constraints	The sporadic and poorly timed nature of funding was said to disrupt long-term planning efforts and limit progress
	Competing Priorities	The demand of healthcare priorities was said to conflict with the allocation of resources for community engagement.
	Lack of leadership and strategic direction	It was reported that often people do not know who to contact for support, and often there is lack of clarity and guidance for those leading
	Difficulty in recruiting and sustaining communities in engagement	This was said to be displayed in low turn-out rates, not sharing demographic details, and difficulty in communicating due to linguistic barriers
	Hesitancy in some clinicians	Some clinicians are concerned that this work may blur the boundaries of the doctor-patient relationship. Others that GP plays a small role in the wider determinants of health.
Support needed	Leadership	Developing and training leaders, particularly health inequalities leads, was thought by some to be key for the advancement of effective community engagement.
	Supporting collaborations	A need to identify local assets such as voluntary organisations or academic partners and supporting collaborations with General Practice
	Sufficient resourcing	Adequate and sustainable funding, time and staff were thought to be crucial for sustaining engagement efforts.
	Sharing of best practice	A need for an interactive and sustained way of sharing best practice amongst peers

⇒ *Defining and serving communities*

The interviewees echoed the survey findings by displaying a robust awareness of their communities. Communities were identified not solely on geography, but also ethnicity, gender, age and other sociodemographic factors.

> ***"We need to leave the practice… your community is not only practice based, it's wider than that"*** *– interviewee*

Despite being aware of their local communities, some interviewees felt that General Practice tends to prioritise personalised, individual care over population health. They noted that defining individuals as part of specific communities can be complex and risks stereotyping or making broad generalisations. Furthermore, the small size of some General Practice patient lists may limit the ability to effectively target specific communities, especially if only a few community members are registered. As a result, efforts to address health inequalities are more commonly undertaken within Primary Care Networks (PCNs), which serve larger and more diverse populations.

> ***"Some people in our team didn't like the word community because it sort of suggested that you either belong to it or you don't and it's a bit of a sealed thing and maybe homogeneous, which it isn't obviously there's so many different groups within it" -*** *interviewee*
>
> ***"And there's also there's so many communities, like how many do you have to do?" -*** *interviewee*

Nonetheless, PCNs alone should not perform this role as General Practices that want to target their own unique communities may find the PCN structure inflexible. It was also felt that all staff in the GP workforce should play a role in community engagement.

> ***"We need the whole team to actually get involved in working with communities"*** *– interviewee*

⇒ The community engagement strategies

A diverse array of interventions in General Practice described by those interviewed has been implemented to target communities in reducing health inequalities. These range from educational initiatives delivered through either one-way information streams or interactive discussions, to outreach endeavours like mobile health screenings and

immunisation campaigns. Additionally, activities such as culinary workshops and patient led fitness groups have been adopted. The focus of these intervention has often been on proactive preventative healthcare.

> ***"We'll have a pop up. You'll be able to talk to a pharmacist. You'll be able to talk to a nurse whilst this is being done. What other concerns do you have and also linking in with our social prescribing team"*** *- interviewee*

Community engagement in these programs typically occurs with communities involved as participants rather than through co-design or co-production. At times, communities are consulted to help prioritise issues important to them, and occasionally collaboration occurs—particularly at the PCN level—through initiatives such as neighbourhood forums and co-production cafés. However, strategies aimed at community empowerment, like employing social prescribers or engaging peer champions from target communities within General Practices, are still relatively uncommon, they have proven to be highly impactful when implemented.

> ***"We have volunteers who run groups within our practice for things like coffee mornings, walking groups etc" -*** *interviewee*

⇒ *Perception of outcomes*

The interviews revealed a range of potential benefits from involving communities in the design and delivery of interventions aimed at reducing health inequalities. These benefits included increased staff satisfaction, stronger community cohesion, and a greater sense of community ownership over the interventions. Additionally, positive outcomes in patient health indicators—such as improved vaccine uptake—were attributed to these efforts. However, concerns were raised about the potential to unintentionally exclude other communities or individuals, which could worsen health inequalities. There was also recognition that some groups were not engaging with these initiatives, highlighting a need to improve outreach and accessibility.

> *"**What we find is that the people who attend are very positive about it, and there's not necessarily much they would change. I think the missing piece is probably reaching out to the people who don't attend and see if anyone's willing to give feedback about why."*** *– interviewee*

⇒ Key characteristics of successful community engagement initiatives

An emerging theme was the importance of community-centeredness in driving successful initiatives. Interviewees emphasised the need to focus on the specific needs of communities and highlighted the value of gathering insights to design and deliver tailored interventions. It was also noted that the voices contributing these insights should reflect the diversity of the communities being served, and that services should be extended and adapted to reach people where they are.

> ***"As I say, we have gone out and said, what do you want? What would be useful for you and from that feedback we shape the programmes or the sessions accordingly."*** *- interviewee*

Strong leadership and effective collaboration were also seen as essential. Interviewees highlighted the need for partnerships with a range of stakeholders—including GP leads, third-sector organisations, academic institutions, and government or health sector bodies—to provide comprehensive support. Such collaboration was considered crucial for accessing smaller funding streams and securing support for evaluation. Engaging trusted community leaders and drawing on local voices and assets were also seen as vital for building trust and developing meaningful engagement. While these partnerships can take time to develop, and are well-established in some areas, they must be carefully nurtured and maintained to support the success of future initiatives.

> ***"I think that the relationships that people have within this PCN and the fact that the clinical director is... trying things in a different way to make it happen"*** *- interviewee*
>
> ***"What we don't want is for people to helicopter in, do something and then go away and we never see you again."-*** *interviewee*

Finally, securing buy-in from all stakeholders was considered essential. Clinicians, for example, require enabling resources—such as protected time—to support their involvement. It was also suggested that volunteers should be compensated for their contributions, in recognition of the value of their time and effort.

⇒ Barriers to implementation

There were reported barriers to reducing health inequalities through community engagement in general practice. Firstly, it was perceived that the demands of daily practice leave little time for meaningful engagement with communities. Quality and Outcomes Framework (QOF) and other routine tasks were described as burdensome and detracting tick box exercises.

> ***"Day-to-day that there's not a lot of scope for the behind-the-scenes preventative kind of projects and engagements, a lot of the time it depends on the sort of interests of the partners in the practice or the PCNs" -*** *interviewee*

Limited resources were also mentioned as being another significant obstacle. This was said to inhibit the appointment of Health Inequality leads and undermining the sustainability of interventions. Even when resources are allocated, some interviewees reflected on the sporadic and poorly timed nature of funding disrupting long-term planning efforts and limiting progress. Lack of physical infrastructure and building space was another common barrier for health and wellbeing initiatives.

> ***"You can't plan things because you never know… we still haven't been told what's happening with our funding for like next year or the year after." -*** *interviewee*

Another reported challenge was the need for stronger direction and leadership in this area. It was noted that Health Inequality leads are often not adequately trained for their roles, and there is frequently a lack of visible guidance to support them. Some interviewees also expressed uncertainty about the level and nature of support provided by Integrated Care Boards, particularly in relation to project evaluation. This lack of clarity and support was seen to contribute to a gap in visionary leadership, resulting in initiatives that struggle to gain the momentum needed for long-term success.

> ***"The job description (population health management lead) was vague from the beginning. It was almost like, well, make this what you want it to be kind of thing"*** *- interviewee*

Engaging communities also presented challenges such as low turnout by communities at events. To address this, strategies such as scheduling events outside of standard office hours—including evenings and weekends—have been adopted, though these approaches can present challenges and require flexibility from both organisers and participants. Limited access to translators was also highlighted as a significant barrier,

particularly where language differences exist or where individuals may be reluctant to share personal demographic information.

Some interviewees expressed hesitancy about their involvement in community engagement further acting as a barrier. Concerns were raised about the potential blurring of doctor-patient boundaries through informal, non-clinical community engagement activities, as well as the perception that clinicians may lack appropriate training for such roles. Additionally, there was a sense among some that General Practice has limited influence over the wider determinants of health, leaving practitioners feeling powerless—though there was broad agreement that they still have an important role to play

> ***"it's quite difficult to broach that gap we have with our patients and to interact with them in a more informal way"*** *– interviewee*
>
> ***"I'm not even sure the answers are in primary care. I'm also aware that… 80% of health is generated by social determinants and not by anything that we do."*** *- interviewee*

⇒ ***Support needed***

Interviewees proposed a range of solutions to address these challenges. Key suggestions included providing leadership training and establishing dedicated roles within PCNs to lead community engagement. They also emphasised the importance of allocating protected time and resources for this work, as well as conducting asset mapping to enhance collaboration.

> ***"What works well is having a named person that we know we can contact."***
> *– interviewee*

Sharing best practices was considered essential, with a strong call for more interactive and user-friendly platforms that enable knowledge exchange and collective learning. Current online tools were seen as unintuitive and in need of improvement. In addition, the development of comprehensive best practice guidelines was recommended to support consistent and effective approaches.

> ***"I think that sharing and that learning but in an accessible way, you know not another meeting, not another face to face."*** *– interviewee*

Discussion

Summary of the main findings

The HiQUALITY study highlights significant variability in community engagement strategies among General Practices (GPs) and Primary Care Networks (PCNs) in London. While community engagement was broadly acknowledged as important, practical implementation often relied on traditional, unidirectional methods such as disseminating information through digital platforms. Collaborative approaches like co-production and community-based participatory research were underutilised, representing a missed opportunity to deepen trust and engagement with underserved populations.

Quantitative data revealed that more than half of respondents either rarely or sometimes engaged communities, and evaluations of these strategies were infrequent, with effectiveness often deemed low to moderate. Key barriers included resource limitations, such as inadequate funding and workforce capacity, as well as leadership and systemic challenges. Despite these obstacles, examples of promising practices demonstrated the potential of community-led health initiatives, particularly when supported by strong governance and adequate resources. Qualitative findings further highlighted the need for tailored, population-specific strategies and greater leadership buy-in to address health inequalities comprehensively.

Limitations

This study faced several limitations that may have influenced the findings. the evaluation of effectiveness did not include standardised objective metrics, relying instead on subjective perceptions. This may introduce the possibility of response bias around the extent of effectiveness and may not fully capture all outcomes. Additionally, the sample size and geographic focus on London potentially limit the generalisability of the results to other regions with different healthcare systems and population demographics.

The exclusion of a number of incomplete responses from the survey narrowed the dataset, potentially biasing the findings towards those more invested in or aware of community engagement. Finally, the qualitative component, though rich in detail, had a small sample size and reliance on convenience sampling, which may not represent the diversity of experiences across the broader GP workforce.

Ambition for next steps and guiding pillars

Considering these findings, we consulted with policymakers on suggestions for next steps to help improve how General Practice leverages community engagement approaches to tackle health inequalities. It was suggested that the overarching ambition for next steps should be **building trust with communities and reducing health inequalities in London through creating a local enabling environment and culture that prioritises community engagement in General Practice, including through co-design and co-production.**

Underpinning this ambition were **four** main guiding pillars including:

⇒ ***Fostering partnerships with communities***

- Facilitate co-design and co-production through mapping local assets supported by Directory of Services, pathways, guidelines and toolkits produced on a wider footprint to support General Practice.
- Specific support for outreach and effective engagement with vulnerable groups in London including asylum seekers, undocumented migrants and refugees, homeless populations, ethnic minorities groups, people with disabilities, and low-income households.
- Leverage technology to enhance engagement & accessibility recognising that there will be digital barrier for some communities.

⇒ ***Strengthening governance and leadership across the system***

- Develop and deliver a community engagement plan/strategy that considers effective and sustainable approaches, resources, and clearly defined roles and responsibilities across involved organisations.
- Create leadership opportunities and mechanisms for collaborative community engagement across General Practice, neighbourhood, place, and systems to enable sharing of focus, learning, best practice, and resources such as premises or workforce.
- Support General Practices in inter-sectoral and multi-sectoral working in neighbourhoods for community engagement, reviewing commissioning and funding models to facilitate true integration and reduce silo working.

⇒ ***Workforce development***

- Expand the General Practice workforce to support community engagement with increased capacity to include social prescribers, community health and wellbeing workers or care navigators.
- To identify and respond to training needs of the workforce on community engagement and how to use Quality Improvement approaches through Training Hubs and peer support.

⇒ ***Bolstering data and evaluation***

- Working across systems and sectors to improve data collection and insights with the aim of identifying the vulnerable communities who might best benefit from community engagement in General Practice. This includes improved coding for specific communities and ethnicities.
- Facilitate evaluation of community engagement strategies to measure realistic and relevant impact that can support commissioning models. This includes utilising evaluation toolkits, training in Quality Improvement methodology, and academic partnerships, ensuring that communities are involved in evaluations.

Conclusion

The HiQUALITY study highlights the need for a shift in community engagement within General Practice in London. While efforts to address health inequalities are evident, the reliance on unidirectional communication strategies limits the potential impact of these initiatives. As we move forward towards a neighbourhood health service[4], embedding co-production and participatory methods into routine practice, supported by robust leadership, targeted funding, and workforce development, is critical.

To achieve sustained improvements, a comprehensive framework for evaluating engagement strategies should be prioritised, ensuring that interventions are well-intentioned and demonstrably effective in reducing health disparities. By leveraging local assets, fostering partnerships, and creating an enabling environment for innovation, GPs and PCNs can play a pivotal role in achieving equitable health outcomes. Addressing systemic barriers and embracing a culture of shared ownership with communities will be essential in bridging the gap between ambition and action.

[4] NHS England. Neighbourhood health guidelines 2025/26. https://www.england.nhs.uk/long-read/neighbourhood-health-guidelines-2025-26/ [Accessed February 2025]

END.

Supplementary material overleaf >>>

Appendix A: Case studies

Appendix A contains case studies written by participants of the survey and qualitative studies.

Case study 1: Community Health and Wellbeing Workers

Community health and wellbeing worker (CHWW) Programmes are becoming a critical element in tackling health inequalities by improving individual and community-level population health via their ability to build trust and relationships and deepen communication between patients and healthcare providers. CHWs have a deep understanding of their communities through lived experience, which makes them uniquely qualified to address social and behavioural determinants of health.

At **Battersea Fields Practice** we continue to pilot this model of primary care intervention in our deprived and diverse area of South London. We continue to offer an intervention to a set ~240 households in our local estate which offers a monthly household visit and host a monthly community event which welcomes a wider group of residents than just these households. We also continue to involve our CHWWs in a network considering the health needs of our local residents.

We have involved 2 local partner organisations, the public health team and the council in our steering group which meets quarterly. We also involve the CHWW team in discussions around ongoing delivery and evaluation as they meet very regularly with our community members.

Working at a household level is complex from a data point of view due to the dynamic population in and out of accommodation and often residents registered with different practices locally. Some residents have met the CHWWs with hesitation but broadly have fed back very positively about the proactive monthly visit. A clear benefit of working with communities is a new angle in growing our practice and PCNs knowledge of our communities health and wellbeing concerns and barriers to healthcare.

We have numerous case studies detailing improvements in patients wellbeing and engagement in the community. Our data details hundreds of visits, referrals on to GP, social services, community organisations and services, and professional services like CAB. We have showed some hypertension case finding and flu vaccine delivery at our monthly events. The impact of numerous health promotion events is yet to be quantified. We are currently working on our longer term evaluation to given further quantitative outcomes/impact.

Case study 2: Women's Health Network

At **Hills, Brooks & Dales PCN**, we recognise that meaningful patient activation and behaviour change through personalised support and health education takes time. Using our knowledge and trusted relationships, we tested a holistic approach to bridge the gap between Link Worker support and community-based services, leading to the Women's Health Network (WHN).

This network tackles health inequalities by supporting women from marginalised backgrounds. Majority of them are from ethnic minority backgrounds, face language difficulties or have a low-income. We identified these patient cohorts by analysing referral data of patients frequently accessing Link Worker services and explored associated health inequalities. This proactive approach shifted our focus to prevention.

A calendar of support sessions was developed in accessible community spaces. We offered opportunities to speak with Link Workers, engage in exercise, participate in health education workshops, and access local services. Workshops covered topics such as healthy eating, cost-of-living support, mental health, pain management, diabetes, menopause, cancer screening, digital health tools, creative health activities, and support for carers.

Ensuring content is appropriate and accessible to diverse audiences remains a priority. Feedback from patients, colleagues, and partners informs materials, delivery methods, and session content, allowing flexibility to meet evolving needs.

Over the past five years, our Link Workers have built strong relationships with community partners, strengthened by monthly networking breakfasts. These connections have been instrumental in tailoring WHN sessions to community needs.

Funding has also sustained WHN for 2.5 years, earning system-wide recognition and support from PCN general practices. Inclusion in the South East London Women & Girls Health Hubs pilot has secured funding to continue until March 2027.

Kings Health Partners evaluated the programme, and ongoing feedback continues to refine its approach. WHN has made several achievements including:

- ⇒ Partnered with 20+ local community projects and services.
- ⇒ Over 1,000 women attended sessions between October 2022 and February 2025.
- ⇒ Increased patient awareness of available support and well-being options.
- ⇒ Reduced waiting times for Link Worker referrals.
- ⇒ Faster patient referrals to community support and services.
- ⇒ Expanded sessions to West Norwood and Central Brixton (August 2023).
- ⇒ Smaller peer support groups established in response to feedback.
- ⇒ Some attendees have progressed to volunteering and paid employment.
- ⇒ Continuous engagement, inviting over 1200 women to group sessions (Aug 2023 - Jan 2024)

Case study 3: Asylum seeker health initiative

Grand Union Health Centre (GUHC) has long supported individuals facing deprivation and marginalisation. In 2021, with no formal funding, the practice voluntarily took on 400 Afghan refugees. In August 2022, they extended support to 120-150 asylum seekers in contingency hotels, including 47 children. These individuals, from 23 different countries and speaking 15 languages, live in cramped, unsanitary conditions with inadequate food provision. Recognising their extreme vulnerability, GUHC launched a project to improve health outcomes and overall wellbeing for these communities.

GUHC mobilised its team, providing 30-minute appointments with interpreters and prioritising urgent healthcare needs, including childhood immunisations. Observing distressing weight loss among young children, they collaborated with partners to improve food provision. The practice also initiated wellbeing activities, including a Thursday evening hub with exercise classes and creative sessions, and a Monday cookery club at a local community centre, allowing families to prepare their own culturally appropriate meals. They advocated for school placements, medical referrals, and relocation for families in critical need.

Community engagement was key. The team met hotel management and residents informally, gathering insights to shape services. Through collaborations with Connecting Care 4 Children (CC4C), local authorities, and charities, they co-designed sustainable programmes and improved community health outreach.

The initiative faced several challenges. The cohort spoke 15 languages from 23 different countries. The team worked with expert patients as interpreters and designed multilingual sessions. Food provided at the hotel was also often inedible for young children due to spiciness or spoilage. GUHC collaborated with public health and local charities to improve food provision and established a weekly cooking club. Furthermore, many residents were hesitant to engage with services outside the hotel, fearing discrimination or negative effects on their asylum claims. The team built trust through informal engagement, providing safe, non-clinical spaces for discussions and activities.

The main outcomes of this initiative include:

- ⇒ Ensured all school-age children were placed in asylum-seeker-friendly schools.
- ⇒ Organised successful vaccination campaigns, preventing disease outbreaks.
- ⇒ Reversed malnutrition trends among children, preventing the need for paediatric referrals.
- ⇒ Created sustainable partnerships with local health, education, and charity sectors, ensuring long-term support for asylum-seeking families.
- ⇒ The initiative demonstrated the impact of holistic, community-driven healthcare, transforming GUHC into a hub of support for asylum-seeker families.

“This team is so kind and helpful. We were stuck in a box – now we are outside.” – Parent of a 6-year-old asylum seeker.

Case study 4: The Orpington Wellbeing Café Initiative

To address the pervasive issue of social isolation among the elderly, the **Orpington PCN** launched the Orpington Wellbeing Café. Established on 21 July 2022, at the Orpington Methodist Church, this initiative was designed as a response to the discovery that a significant number of local elderly individuals had not been in contact with healthcare services for over two years. The café operates bi-weekly from 11 AM to 1 PM, providing a comfortable and secure environment where residents of Orpington and The Crays can engage with healthcare professionals.

The café has rapidly become a cornerstone for community health, attracting an average attendance of 80 individuals per session, with many returning weekly. The initiative employs a co-design approach, integrating feedback from attendees to shape the services offered, including mindfulness sessions, art classes and fit-to-sit sessions, facilitated by various professionals such as social prescribers and digital inclusion supporters.

Data collection at each session aids in monitoring attendance and the impact of services provided. A notable success story from the café was that of a participant named Pearl, who discovered her high blood pressure during a routine check at the café. This early detection allowed for timely medical intervention, demonstrating the café's role not just in social support but also in preventative healthcare. In addition to its primary function, the Wellbeing Café serves as a prototype for expanding neighbourhood-based health interventions. It emphasises the importance of local and accessible health services, particularly for vulnerable populations who might otherwise remain disconnected from necessary care.

This initiative is part of a broader strategy under the Primary Care Network DES service requirements to improve health outcomes by tackling inequalities. The targeted approach for the café was informed by an action plan developed to identify and address the needs of specific patient cohorts, in this case, the elderly population. Initial outcomes have been promising, indicating a significant reduction in isolation among the targeted group and providing a scalable model for similar interventions across different regions.

Case study 5: Social Prescribing and integrated care

The Mission Practice in Bethnal Green, East London has 12,500 registered patients. Since 2020 we have looked after residents seeking asylum in dispersal accommodation in an old student halls. This social prescribing initiative emerged in response to the rapid arrival of over 450 asylum seekers accommodated in a few months. To meet their needs, the practice employed an additional part-time social prescriber (SP) focused specifically on the asylum-seeking population.

The initiative evolved organically based on the ongoing presentations, needs, and patterns of engagement seen among patients. A multidisciplinary team (MDT) was established, initially comprising a GP trainee, Specialist Health Visitor, and the SP, who met families in a local children's centre near the accommodation. Weekly informal liaison and email contact within the MDT allowed for unmet needs to be identified and for appropriate follow-up or signposting. The Health Visitor often flagged clinical issues like missed vaccinations or underweight children, while the SP focused on isolation, mental health, housing, and connection to community and educational resources.

Community involvement was central to the initiative's design and evolution. The SP regularly visited the accommodation, building trust and enabling informal conversations that identified individual and family needs. The flexibility and visibility of the SP created a valuable point of access for patients who might not otherwise engage with the healthcare system, while regular communication between MDT members allowed for rapid response to gaps in care.

Challenges included the high demand on primary care services due to gaps in statutory provision, language barriers requiring interpreters, and the emotional burden of supporting patients with complex trauma. To manage this, the team relied on informal weekly MDT communication, support from local partners, and emotional debriefing through a Balint group facilitated by Doctors of the World. Despite pressures, the benefits of this model were clear: asylum seekers gained access to essential care and public health interventions, including cancer screening, long-term condition management, and childhood immunisations. A standout moment was a one-off, well-attended polio booster event that resulted in higher vaccination coverage than the general practice population.

The initiative not only improved individual health outcomes but also fostered longer-term systems change. It led to the development of tailored community services, strengthened local networks, and showcased how social prescribing can effectively bridge medical and social care. Despite funding pressures—especially since the SP role is supported through core GMS funds—the team's work illustrates how integrated, compassionate, and community-facing approaches can significantly reduce health inequalities for one of society's most vulnerable groups

Case Study 6: Hiyos Live Channel Initiative for Digital Inclusion

The Hiyos Live Channel pilot, led by **Hiyos GP practice** in collaboration with local schools and healthcare organisations, aimed to address health inequalities through digital engagement and education. This initiative focused on engaging young individuals, particularly 16 to 17-year-olds and those considering a career change in the health sector, in a three-day work experience workshop. The program utilised digital platforms like TikTok, Eventbrite and Zoom to facilitate access to a variety of healthcare professionals and career advisors.

Over the course of the pilot, which ran between July 2022 and May 2023, Hiyos conducted five 3-day webinar programs attracting 3054 sign-ups with over 1500 attendees. These sessions were well-received, with the majority of participants rating their experience as either "very good" or "good". The workshops not only improved participants' understanding of various roles within the NHS but also enhanced their confidence in pursuing healthcare careers. Approximately 50% of participants took proactive steps toward healthcare careers following the workshops, such as applying for healthcare-related studies or updating their CVs.

The initiative successfully reached a diverse audience, with a significant number of participants from the most deprived postcodes in England. Moreover, the majority of participants were non-White and about 37% did not speak English as a first language, reflecting the program's reach among diverse communities. This inclusivity is pivotal in addressing health inequalities by ensuring that career opportunities in healthcare are accessible to a broad spectrum of society.

Financially, the Hiyos Live Channel was supported by a grant of £315,275 with expenses divided between central management and direct delivery, including costs for digital content creation and social media promotion. The experience highlighted several enablers for sustainability, such as effective engagement with local schools, direct personal testimonials from NHS staff and the utilisation of existing networks to streamline content delivery.

This case study exemplifies an effective model for digital inclusion, showing significant potential for replication across other regions. It demonstrates the effectiveness of integrating digital platforms with educational content to engage young people and diverse communities, thereby fostering a more inclusive healthcare workforce and addressing systemic health inequalities

Appendix B

Table B.1: Comparative Analysis of Community Engagement Perspectives Across GP and PCN Roles

	All (N=182) N (%)	PCN (N=69) N (%)	GP (N=109) N (%)	p-value
Age				0.62
18 - 24	2 (1.6)	0 (0)	2 (2.7)	
25 - 34	17 (13.6)	6 (12.2)	10 (13.5)	
35 - 44	38 (30.4)	17 (34.7)	21 (28.4)	
45 - 54	38 (30.4)	14 (28.6)	23 (31.1)	
55 - 64	24 (19.2)	11 (22.4)	13 (17.6)	
65 - 74	6 (4.8)	1 (2.0)	5 (6.8)	
75 and older	0 (0)	0 (0)	0 (0)	
Gender				0.19
Male	42 (33.6)	13 (26.5)	28 (37.8)	
Female	83 (66.4)	36 (73.5)	46 (62.2)	
Ethnicity				0.79
White	73 (58.4)	29 (59.2)	43 (58.1)	
Mixed/Multiple ethnic groups	5 (4.0)	2 (4.1)	3 (4.1)	
Asian/Asian, British	35 (28.0)	12 (24.5)	23 (31.1)	
Black/African/Caribbean/Black British	7 (5.6)	3 (6.1)	3 (4.1)	
Other Ethnic Group (please specify)	4 (3.2)	2 (4.1)	2 (2.7)	
Prefer not to say	1 (0.8)	1 (2.0)	0 (0)	
Designation				<.001
GP (Partner, locum, salaried etc.,)	83 (66.9)	27 (56.3)	56 (75.7)	
Nurse (Practice nurse, nurse practitioner, etc.)	1 (0.8)	0 (0)	1 (1.4)	
Practice Manager	13 (10.5)	1 (2.1)	11 (14.9)	
Physician assistant	0 (0)	0 (0)	0 (0)	
Administrator	4 (3.2)	1 (2.1)	3 (4.1)	
Social prescriber	2 (1.6)	1 (2.1)	1 (1.4)	
GP Practice Pharmacist	1 (0.8)	1 (2.1)	0 (0)	
Other (please specify)	20 (16.1)	17 (35.4)	2 (2.7)	
Years of service in primary care				
<3 years	13 (10.5)	4 (8.2)	7 (9.6)	0.93
3-5 years	9 (7.3)	4 (8.2)	5 (6.8)	
5-10 years	27 (21.8)	12 (24.5)	15 (20.5)	
10 years+	75 (60.5)	29 (59.2)	46 (63.0)	
ICS /ICB				0.005
NWL	21 (16.8)	12 (24.5)	9 (12.2)	
NCL	28 (22.4)	3 (6.1)	25 (33.8)	
NEL	41 (32.8)	17 (34.7)	24 (32.4)	
SWL	16 (12.8)	7 (14.3)	8 (10.8)	
SEL	19 (15.2)	10 (20.4)	8 (10.8)	

On a scale of 0-10, where 0 is not at all important & 10 is extremely important, how important do you think it is that your GP/PCN is involved in engaging communities in the design or delivery of health interventions to reduce health inequalities?				0.36
Low Importance (0-4)	9 (6.6)	2 (4.1)	7 (8.2)	
Moderate Importance (5-7)	34 (24.8)	15 (30.6)	18 (21.2)	
High Importance (8-10):	94 (68.6)	32 (65.3)	60 (70.6)	
How often does your GP/PCN engage communities in the design or delivery of health interventions to reduce health inequalities				0.007
Never	6 (3.3)	0 (0.0)	6 (5.6)	
rarely	37 (20.6)	9 (13.2)	27 (25.0)	
Sometimes	63 (35.0)	21 (30.9)	40 (37.0)	
Often	55 (30.6)	26 (38.2)	28 (25.9)	
Always	19 (10.6)	12 (17.6)	7 (6.5)	
Which strategies does your GP/PCN use in engaging communities in the design or delivery of health interventions to reduce health inequalities? Select all that apply.				0.46
Informing communities through letters or digital methods like texts/apps/website/social media	116 (66.7)	47 (18.8)	66 (25.1)	
Involving or consulting communities in designing services through Patient Participation Groups virtually or face-to-face.	102 (58.6)	46 (18.4)	55 (20.9)	
Forums and discussions for improving health and wellbeing virtually or face-to-face	53 (30.5)	30 (12.0)	23 (8.7)	
Using community hubs or the GP practice for health events or fairs.	89 (51.1)	43 (17.2)	46 (17.5)	
Collaborative approaches like co-produced projects or community-based participatory research	58 (33.3)	30 (12.0)	28 (10.6)	
Working with volunteers or people in peer roles such as community champions or faith groups or volunteers in community outreach	73 (42.0)	40 (16.0)	32 (12.2)	
Other (please specify)	27 (15.5)	14 (5.6)	13 (4.9)	
Do you know who the most underserved groups are in your community?				0.69
Yes	144 (80.4)	55 (82.1)	86 (79.6)	
No	35 (19.6)	12 (17.9)	22 (20.4)	
Are your GP/PCN community engagement initiatives successful in reaching the most undeserved population?				0.79
Extremely unsuccessful	6 (4.8)	3 (6.1)	3 (4.1)	
Somewhat unsuccessful	34 (27.0)	14 (28.6)	18 (24.3)	
Neither successful nor unsuccessful	41 (32.5)	13 (26.5)	27 (36.5)	
Somewhat successful	39 (31.0)	17 (34.7)	22 (29.7)	
Extremely successful	6 (4.8)	2 (4.1)	4 (5.4)	
Do you actively engage communities facing barriers to GP registration to increase their registration at your GP/at practices in your PCN?				0.06
Yes (please specify how)	62 (49.2)	30 (62.5)	31 (40.8)	
No	30 (23.8)	9 (18.8)	20 (26.3)	
Unsure	34 (27.0)	9 (18.8)	25 (32.9)	
Which (if any) of the following communities does your GP/PCN need to engage with more to help reduce health inequalities?				0.94
Refugees & asylum seekers	84 (69.4)	28 (16.9)	54 (18.9)	
Undocumented migrants (people who are living in a country without the proper legal documents or permission)	64 (52.9)	25 (15.1)	38 (13.3)	
Homeless population	83 (68.6)	28 (16.9)	53 (18.6)	

Ethnic minority groups (please specify)	67 (55.4)	28 (16.9)	38 (13.3)	
Low-income families	62 (51.2)	22 (13.3)	39 (13.7)	
People with disabilities	65 (53.7)	22 (13.3)	42 (14.7)	
Other vulnerable groups (please specify)	34 (28.1)	13 (7.8)	21 (7.4)	
On a scale of 0-10, where 0 is not at all effective & 10 is extremely effective, how effective do you think these strategies have been in reducing health inequalities in your local population overall?				0.13
Low Effectiveness (0-3)	38 (30.9)	11 (23.9)	27 (36.0)	
Moderate Effectiveness (4-6)	59 (48.0)	21 (45.7)	36 (48.0)	
High Effectiveness (7-9)	26 (21.1)	14 (30.4)	12 (16.0)	
How often do you evaluate the effectiveness of these strategies on reducing health inequality?				0.18
Never	12 (9.4)	4 (8.2)	8 (10.4)	
Rarely	40 (31.3)	11 (22.4)	29 (37.7)	
Sometimes	51 (39.8)	20 (40.8)	29 (37.7)	
Often	22 (17.2)	13 (26.5)	9 (11.7)	
Always	3 (2.3)	1 (2.0)	2 (2.6)	
Please indicate what you perceive are barriers /challenges to implementing community engagement strategies at your GP/PCN (choose all that apply)				
Leadership/Governance				0.22
Lack of a clear strategy on community engagement	74 (57.8)	24 (5.3)	48 (7.3)	
Low buy-in	56 (43.8)	20 (4.4)	36 (5.4)	
Low accountability	35 (27.3)	16 (3.5)	19 (2.9)	
Other (please specify)	53 (41.4)	26 (5.7)	26 (3.9)	
Workforce				0.79
Conflicting priorities	74 (57.8)	32 (7.0)	42 (6.3)	
Lack of awareness of policies	28 (21.9)	9 (2.0)	17 (2.6)	
Lack of organisational culture	34 (26.6)	15 (3.3)	18 (2.7)	
Limited number and distribution of workforce	79 (61.7)	29 (6.4)	50 (7.6)	
Other (please specify)	2418.8)	11 (2.4)	13 (2.0)	
Funding				0.94
Lack of funding for community engagement to reduce health inequalities	102 (79.7)	39 (8.6)	61 (9.2)	
Lack of weighting for deprivation in funding available	75 (58.6)	29 (6.4)	46 (6.9)	
Other (please specify)	20 (15.6)	7 (1.5)	13 (2.0)	
Health Information System				0.70
Lack of ethnicity coding in GP records	21 (16.4)	9 (2.0)	12 (1.8)	
Lack of coding for different types of community in GP records	40 (31.3)	13 (2.9)	26 (3.9)	
Non-streamlined use of Health information systems	56 (43.8)	23 (5.0)	33 (5.0)	
Digital silos/poor use of technology	57 (44.5)	24 (5.3)	33 (5.0)	
Other (please specify)	23 (18.0)	12 (2.6)	11 (1.7)	
Communities				0.47
Lack of trust for health services	74 (57.8)	33 (7.2)	40 (6.0)	
Language barriers	85 (66.4)	33 (7.2)	50 (7.6)	
Knowledge and beliefs of health interventions	98 (76.6)	39 (8.6)	58 (8.8)	
Other (please specify)	23 (18.0)	13 (2.9)	10 (1.5)	
Please indicate what you perceive are Drivers/Enablers to implementing community engagement strategies at your GP/PCN (choose all that apply)				
Leadership/Governance				0.63
Clear strategy on community engagement	89 (73.0)	35 (7.8)	54 (8.6)	

Buy-in	64 (52.5)	29 (6.5)	34 (5.4)	
Accountability to meet targets	52 (42.6)	25 (5.6)	26 (4.1)	
Other (please specify)	24 (19.7)	12 (2.7)	12 (1.9)	
Workforce				0.79
Clear priorities	86 (70.5)	33 (7.3)	51 (8.1)	
Awareness of policies	55 (45.1)	25 (5.6)	29 (4.6)	
Organisational culture readiness	80 (65.6)	33 (7.3)	46 (7.3)	
Other (please specify)	16 (13.1)	8 (1.8)	8 (1.3)	
Funding				0.72
Funding for community engagement to reduce health inequalities	95 (77.9)	37 (8.2)	56 (8.9)	
Weighting for deprivation in funding available	66 (54.1)	29 (6.5)	37 (5.9)	
Other (please specify)	14 (11.5)	7 (1.6)	7 (1.1)	
Health Information System				0.74
ethnicity coding	41 (33.6)	16 (3.6)	24 (3.8)	
Community coding	44 (36.1)	17 (3.8)	26 (4.1)	
Streamlined use of Health information systems	57 (46.7)	21 (4.7)	36 (5.7)	
Good use of technology	65 (53.3)	27 (6.0)	37 (5.9)	
Other (please specify)	10 (8.2)	6 (1.3)	4 (0.6)	
Communities				0.75
Trust for health services	76 (62.3)	32 (7.1)	43 (6.8)	
Language services	65 (53.3)	22 (4.9)	41 (6.5)	
Knowledge and beliefs of health interventions	80 (65.6)	31 (6.9)	49 (7.8)	
Other (please specify)	13 (10.7)	4 (0.9)	9 (1.4)	
How likely is it that you will engage communities in the design or delivery of health interventions to reduce health inequalities in the future?				0.33
Extremely unlikely	9 (7.2)	4 (8.3)	5 (6.7)	
Somewhat unlikely	13 (10.4)	3 (6.3)	10 (13.3)	
Neither likely nor unlikely	16 (12.8)	4 (8.3)	11 (14.7)	
Somewhat likely	47 (37.6)	17 (35.4)	29 (38.7)	
Extremely likely	40 (32.0)	20 (41.7)	20 (26.7)	
What support do you need to engage communities to reduce health inequalities? (tick all that apply)				0.90
Peer support networks	67 (53.2)	23 (11.6)	43 (13.7)	
Comprehensive guidelines/toolkits	52 (41.3)	17 (8.6)	34 (10.8)	
Targeted workforce training programs	71 (56.3)	28 (14.1)	42 (13.3)	
Financial assistance or grants	100 (79.4)	41 (20.7)	58 (18.4)	
Evaluation support	64 (50.8)	25 (12.6)	39 (12.4)	
Leadership development and support	73 (57.9)	25 (12.6)	48 (15.2)	
Streamlined/integrated Technology	66 (52.4)	29 (14.6)	37 (11.7)	
Other (please specify)	25 (19.8)	10 (5.1)	14 (4.4)	