Communities Health Inequalities Programme

- A year-long, £300k project co-producing solutions to tackling health inequalities in Brighton and Hove. Using community development principles, CHIP creates partnerships with primary care and communities experiencing the greatest health inequalities.
- Over 50,000 people have been reached with information, 8,000 have attended events and 3,000 people have been referred to clinical or preventative activities. Key projects include blood pressure checks, NHS and lung health checks, digital inclusion, and health events.
- Aligned with the Integrated Care Board (ICB) priorities, CHIP is a conduit between health and community improving health literacy, access to healthcare, and informing system change. CHIP enables a Return on Investment (ROI) only achievable through the trusted community relations and reach.
- This slide deck represents the mid-term independent evaluation of the programme by Ottaway Strategic Management Ltd.

Communities Health Inequalities Programme
Independent Mid-Term Evaluation

Introduction

This slide deck will:

- Outline the context for the Communities Health Inequalities Programme (CHIP).
- Identify CHIP's delivery themes, review its achievements and outputs, and highlight some example programmes.
- Establish the learning that has been gleaned from CHIP.
- Examine some of the challenges.
- Incorporate the perceptions of partners and residents.
- Address the core evaluation questions set in CHIP's Theory of Change Model.

CHIP's Programme Board

- NHS Sussex Integrated Care Board
  - Head of Health, Wellbeing, Partnerships & Integration – Brighton and Hove
  - Health Inequalities Involvement Lead
  - Head of Public Involvement
- Brighton and Hove City Council
  - Head Communities, Equality & Third Sector Team
  - Public Health Principal
- Joint Programme Director Integrated Service Transformation
- Trust for Developing Communities
- Ottaway Strategic Management Ltd

What is the Community Health Inequality Programme?

- The Community Health Inequality Programme (CHIP) pilot is running April 2023 to March 2024.
- £300k programme aiming to establish the extent to which a community development approach can support and inform the health sector in addressing health inequalities in the city.
- CHIP's work reflects the Integrated Care Board's (ICB's) pillars for integrated care:
  - Making changes to the health system by using evidence and working with communities;
  - Tackling health inequalities;
  - Integrating health and care services at local level and enabling seamless experience; and
  - Creating appropriate and accessible care for communities.
- CHIP provides additionality for the city's third sector commission and the Healthy Neighbourhood Fund.

The Context, Rationale and Objectives of CHIP

Context

The NHS, Office for Health Improvement and Disparities (OHID), ICB, Public Health, Primary Care Networks (PCNs) and key local partners have recognised the need to:

- Utilise community development and engagement activities.
- Increase access to health and wellbeing provision.
- Reduce health inequalities in the most deprived neighbourhoods, including PLUS groups LGBTQ+ and Black and Minority Ethnic (BME).
- Tailor and coproduce initiatives.

This will build on existing work in communities working alongside PCNs to build capacity in communities.

Rationale

Given the social and economic cost of health and wellbeing care, there is a need to co-design a community focus programme to reduce barriers to and increase residents' confidence and uptake in health and well-being services.

Priorities

- Neighbourhoods with high levels of deprivation.
- LGBTQ+ communities.
- Ethnically diverse communities.

Indicators of health inequalities

Project selected Core20PLUS5 indicators of health inequality including:

- Hypertension
- Early cancer diagnosis
- Chronic respiratory disease
- Maternity
- Severe mental illness
- Smoking cessation

Objectives

- Build on existing **local community development** activity & insight.
- Support people to **access** local health services & information.
- Make sure partners are **working together** to find solutions to local issues.
- Link community activity to **Primary Care Network** priorities.
- Make sure the **community voice** is fed back into health services & systems, with recommendations for improvement.

CHIP's Delivery Themes and Activity

CHIP's delivery themes

- Community co-production and design
- Community health engagement
- Health interventions
- System change & systemic approaches

CHIP is working with the core 20PLUS5 most deprived areas in the city and is focusing its activities on those with the greatest health inequalities. It is working with the city's LGBTQ+ communities and Ethnically Diverse/Black and Racially Minoritised communities.

Community co-production and design

- Outreach to the community to establish priorities.
- Outreach to Primary Care Networks (PCNs)/GP Surgeries for priorities.

Community health engagement

- Leaflet drops, social media, posters, newsletters.
- Doorstep engagement.
- Workshops.
- Health events .

Health interventions

- Blood Pressure (BP) monitoring, health checks, screening activity, monitoring activity.
- Referrals to Primary Care.
- Lifestyle health interventions, health support activity.
- Targeted community activity, aging well, smoking cessation etc.

System change & systemic approaches

- Policy review.
- Service reorientation.
- Reprioritisation of interventions.

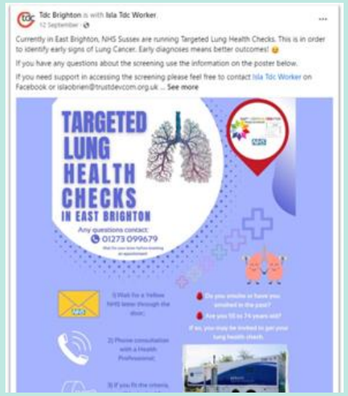
Achievements and Outputs April to November 2023

Table of achievements and outputs enabled by CHIP and partners during initial 7 months, including reach, engagement of local people, checks/screens provision and onward referrals.

Interventions	Online reach	Flyer reach	Event attendees	Checks/screens	Clinical referrals	Prevent referrals
Blood Pressure	16,605	3,290	807	286	75	253
Health checks	15,768	110	1,110	198	74	141
Digital inclusion	3,170	1,100	1,556	286	93 **	182
Lung checks	17,998	2,100	1,041	-	69	57
Health events*	57,027	34,440	3,702	-	676	1,535
Total	**53,541**	**34,440**	**8,216**	**770**	**987**	**2,168**

* This total captures health event numbers but includes many of the numbers above. ** This supported access to provision digitally.

Current CHIP project examples:



Targeted Lung Checks

Aim: Maximising engagement from communities most at risk.
Action: Community flyer - online and offline.
Outcome:

- 18,000 engaged online
- 2,000 engaged via leaflets
- 1,000 at events
- 70 directly signposted to a clinician
- 49% were high risk patients
- 60 signposted to community support or self-help.

Digital Inclusion

Aim: Increase NHS App use.
Action: Events to support NHS App use including 1-to-1 support to register and use.
Outcome:

- 3,000 engaged online
- 1,000 engaged via leaflets
- 1,500 at events
- 300 with 1-to-1 support
- 100 signposted to clinicians
- 200 signposted to community support or self-help.

Blood Pressure (BP) Checks

Aim: Prevent/identify and treat Hypertension.
Action: Outreach BP checks as part of Know Your Numbers week.
Outcome:

- 16,500 engaged online
- 3,000 engaged via leaflets
- 800 at events
- 300 checked
- 75 signposted to clinician
- 250 signposted to community support or self-help.

CHIP is currently running more than 50 projects.

Current CHIP projects continued:

Events & Workshops

Aim: Bring service providers to community-run clinics and workshops and raise awareness.

Action: General Health Events stalls, workshops and activities.

Outcome:

- 56,000 engaged online
- 34,000 via leaflets
- 3,500 attendees
- 675 signposted to clinician
- 1,400 to community support and self-help.

LGBTQ+ Switchboard Inclusion Training and Award

Aim: Bring LGBTQ+ inclusive practice to Primary Care.

Action: Training, Practice review, NHS England (NHSE) monitoring, strategic support and advice.

Outcome:

- 200 Practice staff trained.
- 63% of those attending would make changes in their Practice.

switchboard
connecting you to LGBTQ+ support

Black and Racially Minoritized ~ 15 grassroots grants including Bridging Change Wellbeing Sessions

Aim: Improve health literacy and confidence in accessing services

Action: Co-producing wellbeing sessions with clinicians, communities, schools and the Mosque.

Outcome:

- 500 people reached.

Learning and Challenges

Learning

- **Mobilisation:** Critically important to recognise the time it takes to mobilise programmes like CHIP.
- **Maximised outcomes:** Clear recognition that CHIP is not operating in isolation and will inevitably align to other programmes and local priorities to maximise all outcomes.
- **Community health fora:** Attendee expectations about broader health concerns and needs will come to health fora as issues that clinical staff can address.
- **Health literacy:** Helping increase health literacy both on an individual and community level.
- **Engagement:** Events are a strong way to bring communities and practitioners together. If developed properly, they are meaningful interfaces where good health engagement work can be done.
- **Effective community development:** Success in getting people to activities and events. A key value is the ability to contribute and collaborate with people through trust and familiarity.

Challenges

System capacity and pressures have been the main challenges to CHIP.

Measuring impact and monitoring community development engagement outcomes is not straightforward.

Partner and Resident Perceptions

Partners

“The CHIP project is just the sort of ‘pocket of marvellous’ work that we want and need to see being scaled up and embedded, which is why robust evaluation is so important.” - *Nicky Saynor, OHID SouthEast*

"The work you did this week will have impacted on reducing the risk of future heart and attacks and strokes in Brighton & Hove, a fantastic example of Place partnership working." - *Lisa Douglas, NHS Sussex*

“HKP definitely engaged with the local community and offered support to help improve their health and well-being.” - *Tory Lawrence, West Hove PCN*

"We had a great uptake of over 45 people for blood pressure and blood glucose checks and associated education. We picked up 5 potential hypertensives and two people with high glucose readings, all were signposted to their GP." Being Well in West, *Karen Cox, Sussex MSK Partnership*

Residents

"I have benefitted so much physically and mentally from the short time I have been attending." - *Women’s Wellbeing Group*

"Thanks to the [EB Health] event I met a health trainer and am getting some really good advice on exercise" - *Diabetes Group*

"I had been stuck in bed for months and now through attending the class I’m starting to get movement back in my legs and arms." - *Gym at Patching Lodge*

"I'm going to give one of these to my niece, she's 30 and still hasn't had one! I keep telling her she needs to go!" - *Tarner Family Hub Breast Screening*

"You never think it’s going to happen to you, but it does. I count myself lucky that I caught it early." - *Whitehawk 50+ Group*

“It is difficult to book something that I don’t want to do in the first place." - *Cervical Screening Patient*

Key findings: Why choose the Community Development approach to tackling health inequalities?

- **Established community relations:** Community Development Organisations (CDOs) like the Trust for Developing Communities (TDC), the Hangleton and Knoll Project (HKP), Switchboard and the ethnically-diverse Community and Voluntary Sector (CVS) are intrinsically part of their local communities, due to the relationships built over numerous years.
- **Trust and connection:** From the evidence available, CDOs are trusted by and in touch with their communities.
- **Reach:** CDOs' reach is great, and their involvement with their communities is extensive; going beyond health and wellbeing. CDOs are extremely well placed to reach those who simply would not normally access provision.
- **Promotional activity:** Promotion by CDOs is extensive and far beyond publicity in pure marketing terms. Activity and event promotion is facilitated and aligns people's needs with the health agenda and priorities; enabling collective mutual benefit.
- **Conduit between health and community:** CDOs understand and can interpret the priorities of the health sector and are thereby able to design community engagement that fits the health sector's agenda.
- **Quality Engagement:** Engagement in these situations isn't just about the number of people engaged, but also the quality of the engagement within settings that are familiar to local people.
- **Value:** CDOs can spark enthusiasm in their communities to maximise the value of health activities and events.
- **Outcomes:** CDOs are the conduit to accessing and bringing communities together with providers so that outcomes are real, relevant and valued.
- **Return on Investment (ROI):** CDOs enable a ROI which cannot be achieved without their established local relationships and ability to target those experiencing inequalities, to address people's needs in a meaningful way.

Has CHIP answered its key evaluation questions?

To what extent has CHIP been able to address health inequalities in targeted localities?

- All CHIP activity is being delivered in the city's areas of high deprivation; hence fitting into the Core 20 profile.
- CHIP meets the Integrated Care Board (ICB) pillars for integrated care.
- Meets patients in the city's +5 target cohorts.
- By accessing provision, early diagnosis and improvement to health and wellbeing, CHIP monitoring suggests that it has targeted those with the greatest health inequalities.

Has a community development approach supported the health sector to achieve greater access to provision from key target audiences?

- The community development approach is central to the success by targeting access to provision for those who have least access.
- Community Development Organisations (CDOs) have extensive reach.
- CDOs are able to save the health sector resources going forward.

What has been the value to the health sector in securing new participants into services?

- Increasing numbers of new patients.
- Early diagnosis and hence intervention resulting in likely cost savings.
- Focusing on shared local priorities make sense in prioritising resources.
- Reduced misuse of services due to increased knowledge/behaviour change.

How has CHIP met its defined objectives?

- Strong project management.
- Experienced community development teams.
- Establishment of monitoring systems.
- Initial targets were general and through co-production can now be more focused.

Contact details and further information

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Trust for Developing Communities

Brighton & Hove City Council

The Hangleton & Knoll Project
Working for a better community

NHS Sussex

switchboard
connecting you to LGBTQ+ support

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Ottaway Strategic Management