

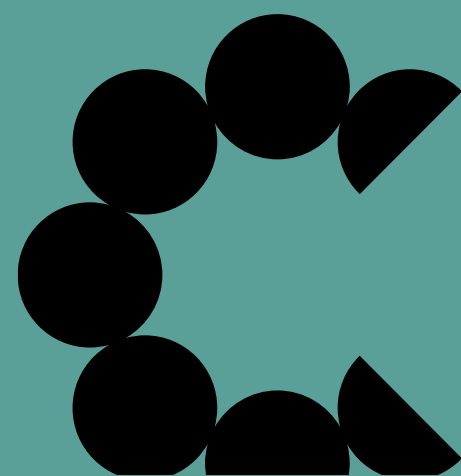


Communities Health Inequalities Programme

Kaye Duerdoth

DCEO, Trust for Developing Communities

Trust for Developing Communities
Community Base, 113 Queens Road, Brighton, BN1 3XG
A Company Limited by Guarantee Registration No. 3939332 | Registered Charity No. 1106623 01273
262220 | info@trustdevcom.org.uk | trustdevcom.org.uk





Community Voice



Co-production



Community development



Support PCN outreach



Referrals to services



Core20Plus5 Objectives

National clinical areas

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

Place & Plus Groups

- Working in most 20% deprived areas
- Racially minoritized communities
- LGBTQ+ communities





Mid Term Evaluation Findings: Themes and Activity

Community co-production and design

Outreach to the community to establish priorities and to PCNs / surgeries for priorities

Community health engagement

Leafleting, social media, posters, newsletters, door-step engagement, health events

Health interventions

BP monitoring, health checks, screening and monitoring activity, referrals to primary care

Lifestyle health interventions, health support activity and targeted community activity, aging well, smoking cessation etc.

System change and systemic approaches

Policy review, service reorientation and reprioritisation of interventions



Headlines

- Over **50,000** reached with information
- **8,000** attended events
- **3,000** referred to clinical or preventative activities
- Over **750** accessed checks or screening



One Story

Wellsbourne CIC in East and Central PCN

- **Outreach and engagement**
 - Male patient, 60's, attended for NHS Health Check following CHIP invitation.
 - Had not visited GP routinely, no health conditions diagnosed.
- **Identification – NHS Health Check**
 - Blood pressure extremely high - QRISK score of almost 26%,
 - Chance of a stroke or heart attack in the next ten years was 1 in 5.
- **Treatment**
 - Anti-hypertensive medication
 - Stop smoking clinic
 - Healthy lifestyles team
 - Local community services offering exercise - Manor Gym
- **Outcome**
 - Blood pressure under control, health and community support



Learning

- **Mobilisation.** Time it took to mobilise CHIP.
- **Outcomes maximised.**
CHIP has helped maximise other local health programme outcomes.
- **Community health fora.**
Enablement to address community issues raised at fora.
- **Health literacy.**
Helping increase health literacy both on an individual and community level.
- **Engagement.**
Events bringing communities and practitioners together for meaningful interface.
- **Effective community development.**
Success in getting people to contribute and collaborate with people through trust and familiarity.



Has CHIP done what it set out to do?

- **Inequalities**

- Meeting ICBs Pillars for integrated care
- Addressing the city's +5 target cohorts
- Targeting those with the greatest health inequalities

- **Community Development**

- Community Development central to the success of CHIP
- CDOs have extensive reach
- Community Development can save the health sector resources

- **Value to health**

- Increase in new patients
- Early diagnosis
- Focusing on shared priorities
- Reduction in misused services



CHIP legacy

Model of working

Integrated Community Teams

- Gathering insight to inform development
- Glue linking communities with the system - health and Council
- Feed CHIP learning in as the ICT model and core offer is developed.
- Opportunity to mobilise the extensive reach and trusted relations that a community development approach brings to tackling health inequalities.