Communities Health Inequalities Programme

- A year-long, £300k project funded by NHS Sussex 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 180,000 people have been reached with information, 12,000 have attended events and 5,100 people have been referred to clinical or preventative activities. Key projects include blood pressure checks, NHS and lung health checks, digital inclusion, health events and many more.
- 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 final independent evaluation of the programme.
  NB an addendum report will follow, incorporating the final projects which are still due to complete, especially the grants programme to the LGBTQ+ and Black and Racially Minoritised communities.

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

Ottaway Strategic Management

Communities Health Inequalities Programme
Independent Final 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
- Examine the learning and challenges experienced by CHIP
- Incorporate the perceptions of partners and residents
- Address the core evaluation questions set in CHIP's Theory of Change Model
- Outline activity in the east, north, central and west areas of the City
- Provide case studies and programme reviews
- Assess cost impact
- Highlight partner and resident perceptions
- Review the programme's legacy implications

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 of 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 ran from April 2023 to March 2024.
- £300k programme funded by NHS Sussex 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.
- 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 and insight.
- Support people to **access** local health services and 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 and 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 and 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 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

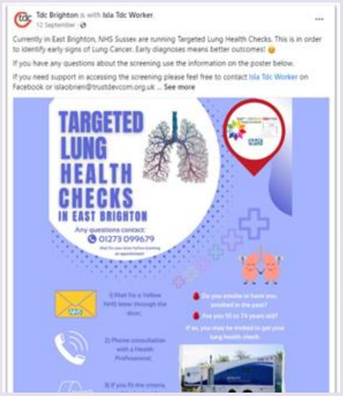
Achievements and Outputs April 2023 to March 2024

Table of achievements and outputs enabled by CHIP and partners across the 12 months of the full programme, including reach, engagement of local people, checks/screens provision and onward referrals.

Interventions	Online reach	Flyer reach	Event attendees	Checks/screens	Clinical referrals	Prevention referrals
Blood Pressure	18,455	3,659	939	318	89	322
Health checks	15,768	110	1,110	198	74	141
Digital inclusion	36,627	1,440	2,990	467	104	227
Lung checks	17,998	2,170	1,041	-	69	57
Health events*	140,639	40,100	5,896	-	**932**	**3,125**
Total	**140,639**	**40,100**	**11,976**	**983**	**1,268**	**3,872**

* This total captures health event numbers but includes many of the numbers above.

CHIP has delivered some 75 projects examples include:



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:

- 36,627 engaged online
- 1,440 engaged via leaflets
- 2,990 at events
- 400 with 1-to-1 support
- 100 signposted to clinicians
- 220 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:

- 18,455 engaged online
- 3,659 engaged via leaflets
- 939 at events
- 300 checked
- 90 signposted to clinician
- 320 signposted to community support or self-help

Example 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:

- 140,000 engaged online
- 40,100 via leaflets
- 5,900 attendees
- 932 signposted to clinician
- 3,125 signposted 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:

- 300 Practice staff trained.
- 63% of those attending would make changes in their Practice/organisation.
- Extensive legacy as the award and training will continue and the product is working

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

Aim: Improve health literacy and confidence in accessing services

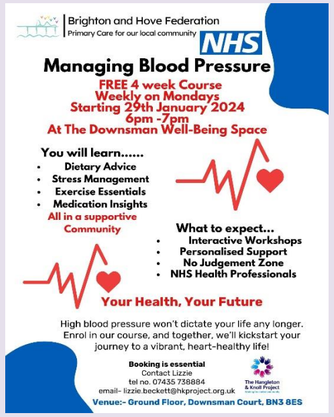
Action: Co-producing wellbeing sessions with clinicians, communities, schools and the Mosque.

Outcome:

- 500 people reached

switchboard
connecting you to LGBTQ+ support

Example CHIP project continued:



Community based peer support

Aim: Bring people together experiencing similar symptoms for support and education around their condition

Action: 18 Diabetes and 4 Menopause peer support sessions delivered

Outcome:

- 79 people attended the Diabetes sessions
- 55 people attended the Menopause sessions

Quote from participant –

"Still trying to understand diabetes but feel much better informed! Thank you!"

Hypertension Courses

Aim: Increase take up of BP checks and provide courses promoting healthy lifestyle choices.

Action: 3 courses delivered with BH Fed and 3 targeted community drop-in sessions, outreach to targeted groups

Outcome:

- 147 Blood Pressures taken
- 70% of course participants had increased their understanding of how to manage high blood pressure.

ICT Insight – ICT Data Packs

Aim: Establish local priorities from Integrated Community Team (ICT) Areas

Action: Community meeting and guided conversations

Outcome: Meetings in East, North & Central (TDC) and West (HKP)

- Community insight is essential to supplement the formal data
- Community groups are part of the solution
- Tailored approach – different needs and community strengths in all four areas
- Start of the conversation

Case Studies

BP Case Study from Health Check clinic in October 2023:

- Male patient, 60's, attended for NHS Health Check following TDC invitation. Had not visited GP routinely in recent years. No health conditions diagnosed at the time he attended the appointment. Following NHS Health Check: blood pressure extremely high and found to have high QRISK score of almost 26%, meaning the chance of a stroke or heart attack in the next ten years was 2 in 10.
- Because of high QRISK, had follow-up appointment with Nurse Practitioner: diagnosed with hypertension and started on anti-hypertensive medication, also referred to stop smoking clinic, healthy lifestyles team, and signposted to local services offering exercise (Manor Gym and Crew Club).
- Has now started weekly fitness classes, blood pressure under control, and engaged with healthy lifestyles team.

Blood pressure awareness – champion project

- Blood pressure monitors are now available in community spaces supported with short training sessions for Hollingdean and Moulsecoomb volunteers to help around the area. Partners include, food projects, community centres, North Health Forum
- There is clear evidence that regular sessions for blood pressure are needed, and community champions can take these on as well as providing monitors for community members to borrow, but it was especially helpful for people to talk to a health professional and talk through other issues they don’t get seen for.
- Hollingdean Development Trust is keen on continuing these advice and health and wellbeing sessions. It was very useful bringing advice services out to the community to show them how easy outreach is. Some older people got special advice from Together Co, with direct referrals to NHS and other services. Money advice was very popular especially because currently there is a long waiting list and call back time for new people.

Case Studies

NHS App Support Sessions:

- A central tenet of work for CHIP was the support it gave the community to make better use of the NHS App. This clearly has a value to the NHS as it streamlines patient access to services as well as accessing patient records etc. To this end almost 40,000 people were engaged for this support either online or via leaflets and just under 3,000 people were engaged at events. Specifically, over 400 people were supported with 1-1 support to 'get onto' the NHS App and to make best use of it. Additionally, in the Goldstone PCN over 80 members of NHS Staff were trained in the use of the NHS App to enable them to support patients to make best use of the App going forward.
- Specific support included uploading the App, registering, and enabling access to consultations and appointments, reviews of upcoming and past appointments, hospital referrals and additional appointment information. Much of this work supported patients to be less confused with the use of the App and to enable them to confidently use this service.

Diabetes support programmes in the West

- HKP researched and co-produced with a local GP a best practice model for delivering group consultations for diabetic patients at Mile Oak Medical Centre, incorporating the 9 NICE recommended diabetes care processes. HKP also researched and developed a pre and post questionnaire to form part of the end of project evaluation.
- 45 patients from Mile Oak Medical Centre with a recent (less than 1 year) diabetes diagnosis were called by HKP and offered a place on the 7-week course, 18 people signed up to the course, 17 attended with an average of 14 per session.
- Each session was facilitated by two HKP staff and a GP/Nurse from the surgery, a healthy treat using recipes from the Diabetes UK website were provided at each session, in addition to Diabetes UK recipe cards for patients to take home.
- Headlines from the completed pre and post evaluation forms show that 100% of those who completed the forms felt more involved in the decisions about their care than they did at the start of the course and 100% felt their knowledge of diabetes had improved over the 7 week course.

Area Summaries CHIP East

Community co-production and design

- 4 Neighbourhood Community Forums liaised with about best ways to engage.
- 3 Public Health Healthy Neighbourhood Fund administrating community organisations around priority projects that matched against PCN priorities. Access to checks in community agreed priority.

Community health engagement

- Online health events promotion 55,307
- Community newsletters & leaflets at events 13,680
- Summer Health event (August) 200 attended; input to bowel cancer screening media design
- Community events in other school holidays 400 attendees
- HPV vaccine outreach to youth clubs January
- 140 signposted Community Activity

Health interventions

- Health checks outreach 15 completed
- Diabetes support workshops 160 attendees and 35 part of monthly group
- Carbon monoxide breath tests 50 completed
- 61 people signposted to GP or clinician

System change & systemic approaches

- Integrating patient participating groups for East & Central PCN to forum.
- Greater coordination of PCN and community health engagement.
- Continuing health check outreach with Wellsbourne CIC.
- Mainstreaming condition-based group in community setting.
- Community newsletter sharing information on public and community health services.

Successes

- Health checks - reaching people who wouldn't normally go to community events.
- Clearer connection between health priorities and Healthy Neighbourhood funding priorities – e.g. dementia pilot.
- Diabetes group reaching people through foodbank drop-in.
- Evolution into ongoing wellbeing group and courses in the community around staying well, promoted by local volunteers.

Area Summaries CHIP North

Community co-production and design

- 4 Neighbourhood Community Forums liaised with about best ways to engage.
- 5 Public Health Healthy Neighbourhood Fund administrating community organisations around priority projects that matched against PCN priorities. Access to checks in community agreed priority

Community health engagement

- Online health checks and Know Your Numbers checks 13,130
- Community newsletters and leaflets at events 11,825
- Health event in July 200
- Know Your Numbers at markets September 137
- Home blood pressure outreach to community groups Oct-March 300+
- Hollingdean Wellbeing Hub – Jan-March 337
- HPV vaccine outreach to youth clubs January

Health interventions

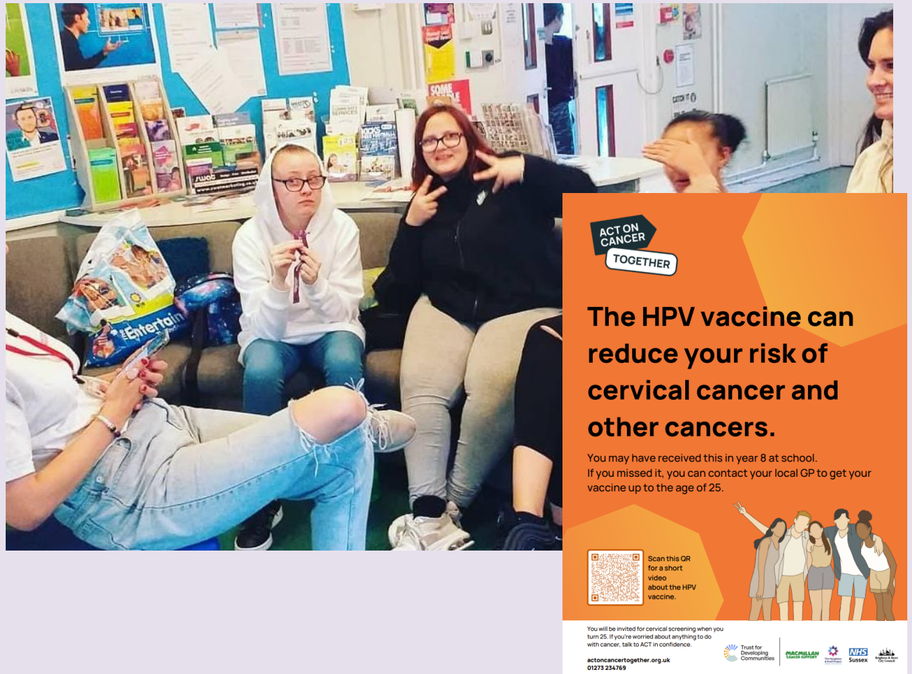
- 105 blood pressure checks, community markets, groups and events (302 citywide)
- 85 carbon monoxide breath tests
- 15 health checks at MSK events
- 118 signposted to other service or community activity
- 29 signposted to health professional

System change & systemic approaches

- Heath Forum improved coordination with PCN launched in January.
- Increased health checks and group advice in community settings- trained community champions/ navigators.

Successes

- North Health Forum established - improving PCN and community connection.
- Community members trained and championing lifestyle changes around hypertension and diabetes.
- Wellbeing Hub established from cost-of-living pilot; mitigating impacts of poverty on health.
- Young people having health conversations at Hub and Clubs.



Area Summaries CHIP Central

Community co-production and design

- 2 Neighbourhood Community Forums liaised with about best ways to engage.
- 2 Public Health Healthy Neighbourhood Fund administrating community organisations around priority projects that matched against PCN priorities..
- 2 health themed meetings with community and services networks looking at ICT data

Community health engagement

- Online 20,420 reached
- Community newsletters and leaflets at events 6,290
- Tarner Youth Festival, Albanian, Ukrainian, Syrian and Sudanese events., as well as community drop-ins, 1000+

Health interventions

- 101 blood pressure and general health checks and digital support offered at Inclusive Jobs Fair and 11 signposted to clinician
- 28 offered health checks at Family Day and 6 signposted to clinician.

System change and systemic approaches

- Health focused meetings reviewing ICT data.
- Health checks outreach through community activity, particularly communities of identity – links to UOK wellbeing groups.

Successes

Generating interest in an ongoing health forum across services and community groups.

Identifying and learning about mitigations to barriers for communities where English is a second language and building links with key community of identity partners.

PCN liaising with community leaders and BHCC housing on health engagement and community venues.

Area Summaries CHIP West

Community co-production and design

- Group consultations
- ICT Model created with stakeholders
- Access to diabetic eye screening
- Menopause Workshops
- Breathing Workshops
- Perinatal with ethnically diverse communities

Community health engagement

- Group consultations
- ICT model created with stakeholders
- Access to diabetic eye screening
- Menopause Workshops
- Breathing Workshops
- Perinatal with ethnically diverse communities

Health interventions

- Breathing workshops and blood pressure

System change & systemic approaches

- Diabetic Eye Screening – review of patient invite letter
- Perinatal – review of materials
- Menopause –translated materials
- Creation of primary care and community diabetes response

Successes

- 1816 people were reached through hard copy information about events/activities/drop-ins.
- 51,782 people reached via social media
- 1291 people attended events/activities/drop-ins
- 87 health events/activities took place
- 321 people were signposted to a GP/Clinician
- 1103 people were signposted to community health groups and activities
- 150 people received support to access health services online. E.g. NHS App
- 147 people had their blood pressure taken

Thematic Summaries LGBTQ

Activities

LGBTQ+ people experience poorer access, experience and outcomes from health and social care and experience or fear discrimination/hostility on the grounds of their sexual or gender identity.
Two programmes were developed via CHIP to address these issues.

- The Primary Care Training and Inclusion award, which delivered bespoke LGBTQ+ inclusion training to 2 primary care networks and then supported practices to identify where change is needed.
- The allocation of Grants for grassroots projects to support them to target health improvement activities with members of the city's LGBTQ populations they work with.

Outcomes Training and Inclusion Award

Core to this work was the delivery of the training and the inclusion award with 2 primary care networks. The training was received by over 300 members of staff working in the primary care networks. The training and award was extended to Citizens Advice Brighton particularly focused on their services based in health care settings. The practices are continuing to work towards the award making changes to practice.
The award involved:

- Training sessions
- A full practice policy review and support with template policies
- Access to Switchboard's compendium of research & guidance
- Implementing demographic monitoring in line with NHSE
- Visual merchandise, resources, posters & lanyards
- Strategic support
- Work in partnership to identify where change is needed
- Ongoing support and advice

Outcomes Grants Programme

The grants programme has successfully funded:

- Radical Rhizomes £5000. A programme of health and wellbeing workshops by and for queer, trans and intersex people of colour (QTIPoC).
- Fat Club Brighton £2772. Inclusive swimming for health.
- Grow Your Life £3500. Facilitate activity workshops around food to empower people to manage their own health and wellbeing and decrease social isolation.
- LGBTQ+ Neurodiversity Meet-up £2500. For support, signposting and empowering self-management of challenges related to neurodivergence.
- Trans Sauna Takeover £1545.46. Impacting isolation and mental and physical health benefits in a safe space.
- Brighton Care Collective £4242.27 to host a fully accessible event for queer and trans Disabled, D/deaf and neurodiverse people. Providing signposting to health services including health checks, GP sign up, access devices for marginalised people who often do not leave the house.

Legacy

All these projects will continue over the next year, developing leadership within communities, creating sustainability for groups, improving increased access to health services and developing self-management skills around health and wellbeing.

Thematic Summaries Racially Minoritised

Activities

1. Hangleton and Knoll Project (HKP) – awarded £5,000. HKP's work with racially minoritised communities has been delivered through a combination of target and integration into mainstream activity.
Themes covered include cancer awareness and screening, menopause, diabetes mellitus, hypertension, and men's health.

2. The Trust for Developing Communities (TDC) - TDC distributed grants to small groups totaling £8,500. These groups are Euromernet, Blues Dancers, Sudan Support and Newcomers group, Moulsecoomb Bangladeshi Women's Group, BMECP 50+ group, Friends at BMECP (2 sub-groups), Lunch Positive, and Sudanese of Brighton and Hove.
Themes covered include mental health and well-being, hypertension, diabetes mellitus, maternity (mother and baby care), cancer awareness and screen enhancing health literacy.

3. Switchboard – awarded £5,000 to Radical Rhizomes, the city's only regular social and support network for QTIPoC (queer, trans & intersex people of colour).
Themes – general health and wellbeing, mental health

4. Bridging Change – awarded £5,000, The award was channelled towards women's Mosque wellbeing and health awareness sessions (Al Medinah Mosque). Change worked with individual members of the women's Mosque group to help build up leadership within the group to be able to support themselves indepen
Themes – NHS services (including social prescribing and pharmacy), health checks and other available screening, cancer awareness and screening, me diabetes mellitus, and mental health.

Learning

Communities prefer engagement via texts, WhatsApp and in-person to social media.
Community groups feel some health inequalities many not be priorities for them, thus a need to get communities to understand why these are priorities.
The benefits of this intervention are likely to be broader than the initial expected outcomes.
There is an opportunity to support grassroots groups in building the knowledge, skills and connections to secure future grants and drive sustainability.
Several who attended the sessions were not up to date with current information about the health system and were unaware (or did not understand) the different services they could access.

Outcomes

Across this programme over 1,000 were engaged and upwards of 500 took part in activity.

Cost impact analysis

CHIP targeted those communities that are the hardest to reach by way of enabling access to healthcare. These costs must be seen in this light. The table below sets out some basic cost impact analysis. The first row shows CHIP's unit cost performance based on an estimated split of the area-based CHIP costs. This excludes the BRM and LGBTQ+ grants programme as this is still to complete, and a further report including this information will be made available at that point.

The unit cost of community engagement based on total reach is £0.43/engagement. The unit cost outreach sessions/participant was £9.05, the unit cost of events/participant was £4.59, and the unit costs of referrals (cost per patient found) was £6.42 per patient.

The return on reach was 10% or circa 1 in every 10 people contacted.
The overall subsidy per head of beneficiaries was £12.71 per person participating.

CHIP Cost Impact

Cost centres	Engagement	Outreach/Sessional activity	Events	Referrals	Total
Budget (proportionally split)	£77,000	£55,000	£55,000	£33,000	£220,000
Participation/outcome	180,739	6,080	11,976	5,140	203,935
Unit Cost	£0.43	£9.05	£4.59	£6.42	£1.08
Return on reach	10.01%	or circa 1 in 10 people engaged via CD model			participated
Number of beneficiaries	18,099				
Total Programme	£230,000				
Subsidy per head of beneficiary	£12.71				

Note: a beneficiary is defined as someone who has participated, it is not to be confused with those reached/engaged.

Note: a referral both to clinical and non-clinical interventions included signposting, making the referral, supportive engagement, and in some cases accompanying and travel support. Most referrals also included follow up conversations.

VFM from the CHIP programme was strong. It has made considerable savings for the health sector although this is hard to fully quantify. Comparative unit costs are set out here:

Unit cost of patient per case found	£6.42
Average post referral unit cost NHS tariff GP appointment	£44.20
Average cost of a referral for consultant led single and follow up appointment	£200.00
Average post referral unit cost of a preventive self-help / community-based activity	£12.50

Learning and Challenges

Learning

- **Mobilisation:** Critically important to recognise the time it takes to mobilise programmes like CHIP and the pace with which CHIP were able to get going.
- **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 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 Cervical 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.
- **Support for System Change:** Influencing system change by enabling the NHS to work with CDOs and this approach has influenced the Integrated Community Teams.

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 PLUS5 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 can 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 makes sense in prioritising resources.
- Reduced misuse of services due to increased knowledge and 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.

Summary view of key stakeholders

The learnings from CHIP were shared at a stakeholder event in March 2024, attended by decision makers from NHS Sussex and Brighton and Hove City Council. The learning has been shared by local councillors at the City's Health and Well-being Board.

Lola Banjoko, Executive Managing Director for Brighton & Hove, NHS Sussex described the next step for CHIP to be:

'injecting the learning into business as usual'.

Tanya Brown-Griffith, Director of Population Health and Inequalities, Personalised Care, Race Equality and Prevention Programmes, NHS Sussex described CHIP as:

'empowering and invigorating in that what we think can work at a strategy level is actually working in practice.'

Alistair Hill, Director of Public Health at Brighton & Hove City Council said:

'We haven't just seen one or two promising projects .... we've seen a whole ecosystem of communities working together to improve health and wellbeing.... a real feeling that this is happening at scale.'

Emma McDermott, Head of Communities, Equality and Third Sector, Brighton & Hove City Council said:

'This is a real showcase of community development in the city. How it's been able to mobilise the assets in our communities to improve health outcomes'

CHIP is a foundational model for bringing together different partners collaboratively and this will inform Integrated Community Teams development in Brighton and Hove. CHIP gathered crucial insight and became the glue linking communities with the wider system. CHIP learning is informing the local ICT model and is an opportunity to mobilise the extensive reach and trusted relations that the community development approach brings to tackling health inequalities.

CHIP is already informing the City's Physical Activity and Sports Strategy, the development of Primary Care network thinking about tackling health inequalities and moving the dial on hypertension screening and health checks.

Legacy

What does legacy look like?

The CHIP partners are ready to respond to any future funding to support community health inequalities; and to deliver a community development solution to targeting health services to the needs of those experiencing the greatest health inequalities

- There are plans to
  - Embed CHIP in NHS Sussex strategic commissioning policy
  - Use CHIP to inform the Inclusion Health Framework and self-assessment
  - Present CHIP learning at regional Prevention and Inequalities Board
  - Include learning in the Health Inequalities National Draft Strategy
  - Promote on the Population Health Academy
- With national sight, CHIP will help drive social movement for more of this approach and inform thinking about future commissioning.
- To this end CHIP is seeking to:
  - Establish a **provider collaborative** between local VCSE organisations to enable the swift delivery of community development approaches to targeting health services.
  - Work with PCNs to establish how community targeted budgets can be most effectively spent.
  - Build on established working relationships with health practitioners to enable remobilisation and to deliver against core commissioning targets.
  - Commitment to make community development a mainstream feature of health services in the city.

Contact details and further information

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