

Reducing Inequalities in City

17th August 2020

Why Create a RIC Programme?

News

28th July

'Shocking' health inequality and poverty go hand-in-hand, meeting told

News

10th September

Councillor highlights District's health inequalities by pointing out he'll likely live shorter life than people in Ilkley

News

26th October

Life expectancy 'drops two years for every mile' when travelling from Bingley to Bradford

News

18th November

Bradford's health data below UK average - but healthy lifestyle is cheaper

Why Create a RIC Programme?

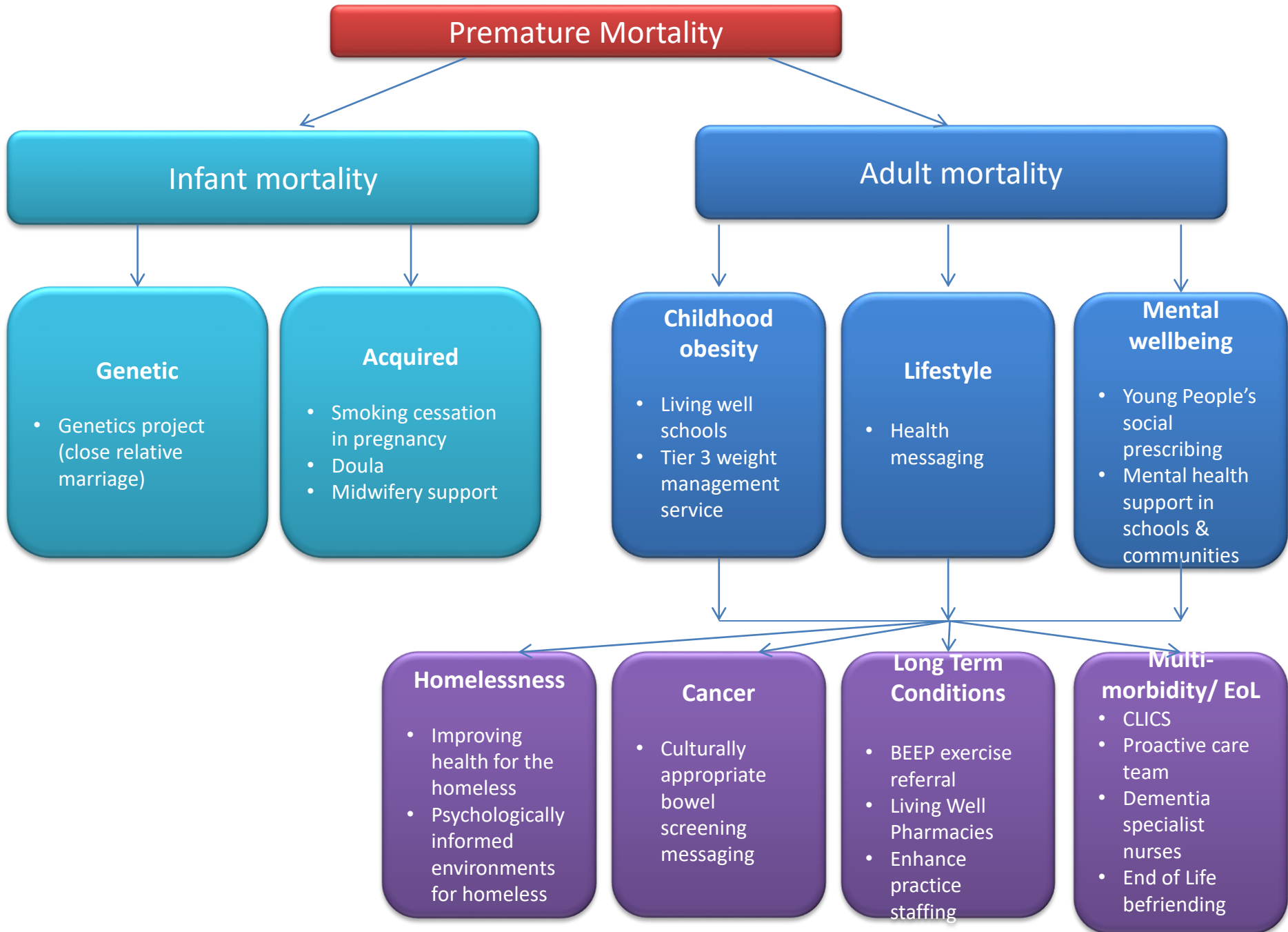
Needs in City:

- Health inequalities increasing indicating we need to do something different
- Reliance on reactive health care
- People view GP as the main professional to see... and want to see them
- Poor engagement with provision
- Low levels of health literacy

Current thinking...

- Multifactorial approach needed to reduce health inequalities, recognising that the communities we are born, live, work and socialise in have a significant influence on how healthy we are
- Importance of providing a proactive, holistic approach to delivering care and enabling people to take a more active role in their health and wellbeing.

Additional funds have been allocated to reduce inequalities. We must be able to evidence that we have used them effectively and have had a positive impact



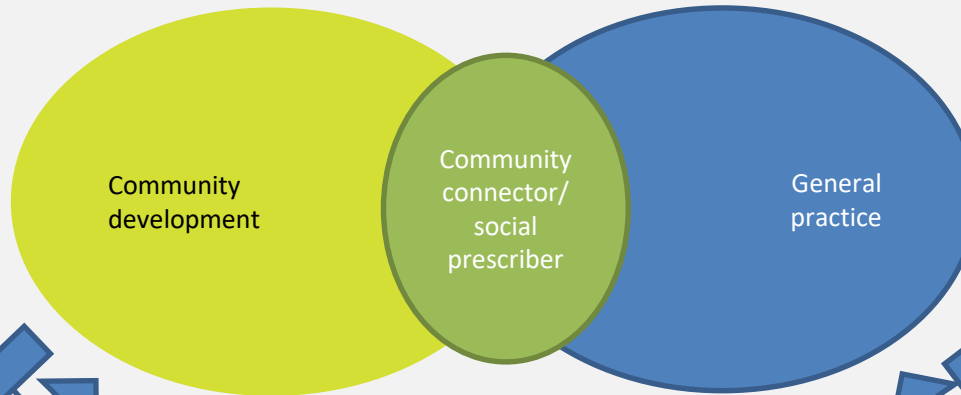
RIC proposals

MATERNITY AND CHILDREN

- Genetics (close relative marriage)
- Smoking cessation in pregnancy
- Doula service
- Midwifery support
- Living well schools
- Tier 3 weight management
- Young peoples social prescribing
- Mental health support for schools and communities
- Health messaging

CLICS (Central Locality Integrated Care Service)

Existing services & community assets



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PREVENTING PREMATURE MORTALITY

- **Primary care workforce development**
- BEEP exercise referral
- Living well pharmacies
- Culturally appropriate bowel screening
- Health for homeless (x2)

AGEING AND DYING WELL

- **PROACTIVE CARE TEAM**
- Dementia nurses
- Holistic end of life project

CLICS model: proactive care at practice level

Function: to integrate community assets with health service (general practice) to increase proactive, personalised care planning and self-care at a practice level

Key features of our model:

- Joint approach to proactive care planning = holistic approach to care
- More integration and utilisation of community assets by community development work (inc volunteer training)
- Care planning and monitoring embedded in general practice – GPs remain connected to patients and retain oversight
- Community connector is an integral part of team: co-located to encourage integration
- More integration and utilisation of community assets by community development work

CLICS model: making the most of community assets to promote holistic wellbeing

Community Development:

- One part time worker per VCS anchor organisation
- Map existing activities/groups/organisations (DIVA)
- Outreach work to build social capital and identify gaps to build new groups and sustain existing groups
- Liaise with Community Connectors & GP staff

Volunteer Training:

- One part time worker per VCS anchor organisation
- Recruit and support volunteers to deliver wellbeing messages
- Link with the Living Well Training Academy to deliver courses
- Link with other organisations working with volunteers locally

Support for the RIC Programme

- Promote the individual services to the people you work with
- Disseminate the information to smaller community groups who are not part of the VCS forums
- Engage with the Community Development and Volunteer training projects – get to know the staff and help us to link with
- Post and retweet through social media
- Give us feedback on the programme

Thank you for listening.

Any questions?

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