Our Place

Royds Our Place

Operational Plan

Royds
Helping people to help themselves

Contents

1. Our Vision

Our vision is that the community can take a more active role in the co-design of more appropriate local health services, and that health providers are more able to serve, understand and engage with local residents who do not currently fully engage. The creation of the Health Buddies scheme will enable better health choices and a system of coming alongside vulnerable people who need that bit of help to empower them to take control of their own health through better self-care.

2. Context and background

Royds Our Place is an innovative programme exploring initially the reasons and causes of staggering levels of health inequality in the Royds ward and a lack of patient engagement with the 'hard to reach' or easy to ignore. Despite the best efforts of the NHS, the local authority, local groups and individuals, the comparative health of residents in the Royds ward is significantly less than in more affluent areas of the district, and this has been the case for the last forty years or more. Rather than working out solutions, which has been the strategy for a long time, we have decided to spend time with health professionals and local residents to work out why things don't change. Only then can we start to co-design the solutions, and then only by bringing together those who endure health inequality with those responsible for delivering their services.

The lead body for this project is Royds Community Association, which is the anchor organisation in the Royds ward. Royds is a mature charitable company established in 1994 which is sustainable today through rental income; contract and commission income; consultancy and earned income; as well as grants and a huge amount of voluntary effort. We work in partnership and on our own to support neighbourhoods and individuals across Bradford in health, employment and community development.

3. Demographics and need

The Royds area has one of the highest health inequalities in the country.

51% of residents in live in SOA's within the top 10% of disadvantage and life expectancy can be up to 12 years less than more affluent areas in Bradford district. High level of poverty especially in the social housing estates in the ward can lead to poor lifestyle choices, which is proven to increase the risks of diabetes and some types of cancer, especially related to smoking.

In the Royds ward the number of deaths per 1,000 population due to all causes, including cancer, stroke and CHD numbers is higher than both area and district levels. The number of deaths per 1,000 population due to coronary heart disease (CHD) is also higher than both area and district levels. Higher numbers of respondents in our surveys feel they are not being encouraged and supported to be physically active as compared to other wards. Higher numbers of respondents feel that older people get services and support to live at home as compared to other wards. The childhood obesity rate of reception children is higher than both district and area levels.

The ward suffers from multiple deprivation with above district average worklessness, school attainment, numbers of NEETS and levels of domestic violence. The level of hospital admissions per 1,000 is higher than most other wards, particularly In relation to cancer, COPD and trauma, and is relatively high in relation to stroke, diabetes and hyper tension. Many residents choose to attend A&E regardless of the reason, often with relatively minor ailments. This is not always due to lack of understanding of the NHS – frequently it is to get medical advice and assistance on the same day rather than waiting several days for a doctor's appointment.

For too long residents have not engaged well with health services and do not have the same aspirations for better health due to lack of knowledge of the health system.
For over 40 years the health inequalities gap has continued to widen and as doing the same things the same way has been described as being the definition of insanity this explains why we are looking at new creative solutions. We recognise the subject area is very broad, but our goal is to research the main concerns affecting people in the area by asking "why" and gathering views and evidence on the way to make change happen.

The inappropriate use of A&E services for non-emergency cases and of GP appointments for run-of-the-mill cough and colds is something our clinical partners want addressing in the project. Local CCG's are keen to work with Royds on self-care approaches to reducing health inequalities and patient engagement as part of the Bradford Health Strategy

4. Our partners

PUBLIC SECTOR

- Bradford District CCG
- Bradford South Health Hub
- Bradford Teaching Hospitals Trust
- BMDC Public Health and Neighbourhood Management
- 3 Ridge GP practices

VOLUNTARY AND COMMUNITY SECTOR

- Healthy Lifestyles CIC (health and Wellbeing VCS practitioners)
- Footprints Family Centre
- New Horizons older people care
- David Barrett
- R Von Hipple
- Community participants

THE PUBLIC

- The community
- David Barrett (local health activist and resident)
- Richard Von Hippel (local resident, activist and alternative therapist)

5. Royds approach to Our Place

Our approach has been one of community development, listening and speaking to people, keeping the language plain. Helping people, whoever they are from communities to clinicians, to be allowed to express their views whilst being treated as equally valuable and important. We galvanised all concerned around the "cause" to find new and innovative solutions to problems that have been around for a long time. The basis of engagement was that for years inequalities are widening, engagement diminishing and usual solutions have not worked, and what do you think would work better?, peoples contribution is valuable. This has been both a revelation and a liberation for people to be free to contribute honestly.
The creation of space for honest conversation has been appreciated and productive.The involvement of local people with their live experience of engagement issues with health professionals is key to buy in and attempting to do things differently. Gaining confidence of the community was key to them feeling able to contribute to co-designing new solutions to the identified important challenges we were exploring

5.1 Community involvement undertaken

We conducted a range of community consultation for this project with over 300 members of the general public in the Royds area.

5.2 Methodology

We did street surveys and went into pubs, takeaways and shops and gathered comments and views on the factors relating to good health and wellbeing. We did face to face interviews with residents who were willing to engage around the subject of health. We had round table discussions and workshops, gathering information that has helped to inform this operational plan.

5.3 Findings

- Excessive smoking: females 32%, males 43% (total smokers 75%)
- Excessive alcohol consumption over recommended limit more than once a week.
- Low employment aspiration
- Lack of physical exercise
- Lack of varied nutritious diet
- Low self esteem
- Lack of confidence
- Low engagement with health professionals
- Multiple health conditions
- Lack of understanding where to go A&E, GP, or pharmacy
- Lack of awareness of 111 or where to get health advice

The people surveyed were very cooperative with over 40% wanting to be involved further with the Royds Our Place project. The lack of aspirations around health was very evident. An overriding view that 'I am happy with my lot' gave cause for concern. People with serious health issues considered themselves as happy and once questioned further appeared not to be aware there are alternatives to current lifestyles, as 'just getting by' seemed to be the attitude. From these findings we developed a forward strategy with partners and community involvement in the following way:

Focus groups conducted were with:

- Royds Enterprise (Royds) Mixed group (Appendix 7)
- Healthy Lifestyles Health MOT (Appendix 8)

Health surveys were undertaken in:

- The Ridge Buttershaw/Wibsey/Great Horton GP practices (Appendix 7)
- Footprints Family Centre (Appendix 9)
- In the Community

Health workshops were held in:

- Bradford South Health Hub (joint working around setting the neighbourhood plan)
- Carlisle Business Centre CCG and VCS professional engagement with over 50 participants.
- Douglas Mill NHS CCG offices GP's and health professionals (See priorities for GP commissioning Appendix 10)
- Care Navigation and Building Health Partnerships (Douglas Mills)

5.4. Use of social media and electronic media to get the message out

We have created a wider engagement medium of Twitter and set up #askbradford the Royds Our Place tool for wider consultation with the community. We are testing some of the issues with a wider audience and canvassing solutions from a virtual audience.

Video evidence

We have taken few sample short clips to record community diaries. These give a snap shot of life and the challenges people in deprived communities face, often short of income or on benefits, low wages, and the challenge of just getting by and surviving. Residents speak more freely openly on video, and can gain the confidence to become involved in other engagement processes, including challenging behavior of professionals and starting to co-design new service delivery Available on Twitter **#askbradford**

6. Priority issues for the community

The major issues from the community are accessing GP's through the appointment system, which was mentioned by over 55% of people interviewed. Some people are having to ring up more than 200 times. Having a more flexible appointment system was the solution that featured highly. People disliked the way staff talked down to them and were dismissive of their issues. Jargon and the language used was off putting for people.

People are more likely to go to Calderdale Royal Hospital A&E as lead times lower under one hour whereas Bradford Royal Infirmary (BRI) was up to 4/5 hours. Patients surveyed stated that they didn't feel safe in the BRI and would prefer Calderdale Royal Hospital.

The consultation exercise gave comments such as "I feel as though you care and are listening to me". This perhaps indicates that the health system doesn't seem to listen fully or effectively. This response and many others reflect the House of Care model versus the Broken House of Care model provided by the Bradford District CCG, and that patient experience is less important than clinical effectiveness and safety. The need to invest in an alternative engagement model like Health Buddies is clearly evident throughout the consultation.

7. Peer support in the community

Our programme implementation is principally a Health Buddy system, which is the notion of health buddies from the community being trained in health prevention techniques such as:

- Taking blood pressure
- Measuring BMI
- Diabetes finger tests

The idea of local people who are known and trusted becoming peer champions within communities and getting health messages out in order to engage at the heart of the community with people who would normally avoid contact with officialdom e.g. Health, DWP, Police etc.

The 'trust element' is the most powerful factor of the programme, as health buddies bridge the fear gap and help the community into the most appropriate health system. This approach can help to detect otherwise unknown health issues which can save the NHS significant amounts of money.

Our partners in the Clinical Commissioning Group (CCG) and Bradford Teaching Hospitals NHS Foundation Trust, have welcomed this innovative idea and are willing to look at a prototype model in the Royds area to prove it could be beneficial as part of a social prescribing model of engagement. Obviously this model is more holistic and proactive than social prescribing and more directly on health inequality.

8. Jargon busting and creating an open safe space

Health professionals often talk in clinical code and people in the communities are often turned off with engaging, or may feel deliberately excluded. Plain English and simplifying jargon for the lay person is a key priority for the community. People better understood when we simplified the language and the issues. This creates better engagement. Being listened to was a rare experience as people had been talked at for too long and had not experienced two way dialogue. Researchers were consistently thanked for listening.

9. Implementation Plan

We have chosen the option of Health Buddies as a continuation of this work past the March project end for the following reasons:

- Support from CCG and Bradford Teaching Hospitals NHS Hospitals Trust will allow further development into the issues of health engagement and inequalities
- The proto typing to be developed could have national significance, as the methodology can be applied to any community
- Too many models are the one cap fits all approach and they do not meet the needs of many in the community.
- Eliminating failure demand or waste is key to the success of this project.
- Too many health systems are designed in a vacuum and without proper community/patient input and do not take into account the needs of 'easy to ignore' people
- Doing the same without reducing health inequalities is not an option, with austerity measures wasting money is not an option either.

HEALTH BUDDIES MODEL

Appendix 4 Health Buddy Model: Our Place, Royds, Bradford

The Health Buddies program aims to target particular niched communities and achieve impact on three levels: with individuals, families and the community. Key outcomes will be: Individuals

- Improve self care by understanding health conditions and self care leading to better health
- Access services appropriately such as misuse of A&E and GP surgeries
- Gain confidence to discuss their health needs across a range of agencies

Improved employment opportunities for the volunteers training in health and social care

Families and neighbours

- Training for volunteers to NVQ level 2-3 in health and social care
- Peer support networks to improve self care
- Potential to create local support groups for specific conditions
- Partnership model being worked up with Hospital trust around apprenticeships.

Community

- Health promotion leading to the creation of a supportive community environment
- Extend contact to hard to reach easy to ignore groups not accessing mainstream provision through peer networks
- Consultation groups engaged to feedback on service provision to health professionals to improve how services are used and how messages are communicated.

The level 2 NVQ in Health and social care confirms competence in the following areas:

- care assistants/support workers/key workers in residential settings
- healthcare assistants/support workers in community and primary care environments
- healthcare assistants/support workers in acute health environments
- care assistants/support workers/ key workers in domiciliary services
- care assistants/support workers/ key workers in day services
- Support workers in supported living projects
- Community based care assistants/support workers/key workers including those working in specialist areas, e.g. dementia, learning disabilities.
- Personal assistants employed directly by the individual they support or their families
- emerging new types of workers and multidisciplinary health roles crossing traditional service barriers and delivery models

Each unit within the Diploma has a credit rating. Learners must achieve a minimum of 46 credits to gain the Level 2 Diploma in Health and Social Care (Adults) for England.

Learners must take 9 mandatory units and usually takes 3 to 6 months to complete. They then have the choice of optional knowledge and competence units covering

different areas of health and social care such as support person-centred approaches, advocacy, healthcare, supporting those with disabilities, learning disabilities and dementia.

Learners have the opportunity to take a general qualification in health and social care, or they may follow specialist pathways in Dementia Care or Learning Disabilities.

Progression is possible to NVQ level 3.

The model

The model will work in a defined neighbourhood and CCG area. It has been tested in Birmingham, and at Royds Bradford the consultation groups covered a number of health issues such as skin problems, blood thinning services and older peoples services.

The program will recruit 1 Volunteer and staff co-ordinator 6 paid part time health buddies, part time administrator and 45 volunteers who will actively engage for 2 hours per week.

It will engage with local health professionals to understand key local health issues and work with them to develop health promotion messages. Taking blood pressure, BMI and diabetes readings in the community and reporting back to individuals GP after receiving patient consent.

Costs and Costing

We anticipate that training should be accessed for free through a Prime contractor on Innovation code of Skills Funding Agency The value of the training per 15 cohort £10,545 is as follows:

Tutor cost out of this	**£2000**
Room hire 20 weeks	**@£50**
Training materials	**£110 per delegate**
Certification	**£50-£120 per delegate**

Costing Health Buddies Model Royds Our Place 2015/16

	Total Funding A	Funding Request B
Course cost @ 703 per person incl accreditation, certification, tutor time, course materials 15 per course = 10,545 X 3 courses = £31,635 College funding for 50% contribution	31,635	15,817.5
Administration @7.85 x 8hrs p wk	3,592	3,592
Project coordinator @30 hrs per week @ 24,000 FTEpro rata plus employer on costs @ 20% 23351	23,351	23,351
Employment of 6 part time local people to pilot programme as support to community patient engagement within GP practice reach areas £7:85 phr (living wage) x 216hrs = 7,837.44 X 6 = 47,025	47,025	47,025
Travel and telephones for coordinator and three health buddies@1200 per employee	3600	7200
Evaluation	1,250	1,250
Publicity @ 300 per course	1,500	1500
Recruitment 1200	1,200	1,200
Health and Safety, risk assessments and HR 100 per course	500	1,000
Kit and equipment for trainees	3750	3,750
Programme Cost	117,403	105,686
Management and supervision costs @15% programme cost	23,480	15,852
	140,884	**121,538**
Value for money 1100 health checks and people supported into self help		110
Y1 VFM £125,163 divide by 1100 equals £110 per intervention representing good value		1100

USING THIS METHODOLOGY ALLOWS EFFECTIVE ENGAGEMENT.

Royds Helping people to help themselves

NHS Bradford District Clinical Commissioning Group

NHS Bradford Teaching Hospitals NHS Foundation Trust

Footprints Family Centre

Bradford District Council www.bradford.gov.uk

ysustain

healthy lifestyle

the ridge Medical Practice

- Too many times the listening to people most affected by system change in order to gather context does not happen and this causes new badly though out systems to fail.
- Often the community have the most valuable insight into what isn't working and when listened to can provide valuable information to better plan change.
- The model is based on training local volunteers to be Health Buddies, some will be employed and become part of the health system, we are discussing at high level to ensure a continuum of learning for the Health Buddies in local communities.
- Viability of the model is sound as 5/6 volunteers to one paid employee is the ratio envisaged with the new way of working.
- The aim is to connect people from deprived communities into the health arena, with aspirations to gain employment and provide well trained volunteers into hospitals and local services.
- We intend to develop employment buddies as well as money buddies as we recognise that all inequalities are not health based as socio-economic factors are at play too
- As part of the integrated care working group we can influence a joined up working with the introduction of the new model.

10. Governance

We have developed a community governance reference group comprised of:

SB	a CCG engagement officer Bradford District and City CCG. Helped with thinking attended York Peer review
NN	Local Ridge Practice Manager, of five GP practice, has set up space for interviews at three local practices as part of contribution. Represents health from GP perspective
AS	a local resident of Buttershaw, community leader and a church elder
KW	a local resident of Wyke, runs community older peoples work and attended York peer review
TD	the CEO of Royds, helps with strategy setting and developing business model
SK	a youth worker in Holme Wood, engaging with younger people in surveys
RV	a local resident in Buttershaw, helped with some research and thinking around alternative engagement methods
SR	a local VCS service provider, carried out health MOT's and developed questions for surveys and focus groups
DB	a community health activist, attended focus groups helped scope questions

Communication with the group is face to face and virtual over the internet.
People agreed to be involved as long as it wasn't meeting for meetings sake.
All professionals stated time poor due to work pressures

11. Business cases

HEALTH BUDDIES

We are working up business cases with the CCG's, Bradford Teaching Hospitals NHS Foundation Trust. Public Health, local authority, local community service providers in the area. (A draft costing and delivery model is in appendix 4). The business options are detailed below.

BUSINESS MODELLING: Approach 1

AREA	ACTION	RESOURCES	BY WHO	WHEN
Develop Health Buddies strategy to achieve £121,538 budget (12 months prototype)	Negotiate with CCG District and Bradford Teaching Hospitals NHS Trust	Staffing time information	Royds Senior Leadership Team	31st May 2015
Recruit Coordinator	Create Job description and person specification Undertake selection and recruitment process Undertake induction process	Staff time Finance	Royds Senior Leadership Team with representative of Governance group	May/Junel 2015
Training	Design Health Buddies Training programme to support volunteer development	Time Information finance	Project Coordinator, Royds Staff and Partner Agency members	April/May/June 2015
Recruit Health Buddies 6	Create Job description and person specification Undertake selection and recruitment process Undertake induction process	Staff time Finance	Royds Senior Leadership Team with partner agencies	June/July/Aug 2015
Activity Programme for Health Buddies	Draw together a coordinated approach to programme across network of support	Time information	Project Coordinator and Partner agency members	May/July 2015
Recruit and Train 45 Volunteers	Draw up Volunteer role description Advertise role locally Interview volunteers Implement volunteer training programme	Time Finance	Project Coordinator Partner agency member	August 2015
Referrals	Develop signposting/ referral system for involving local people in process	Time	Project Coordinator Partner agency member	August/September 2015

RISK ANALYSIS of approach 1

RISK DESCRIPTION	IMPACT	PROBABILITY	EXISTING CONTROLS	ACTION REQUIRED
Medium CCG/hospital trust fail to give funding	Unable to proceed with Project	Low/medium	Funding Strategy	Submit New Funding Applications DOH innovation grants
High Royds staffing involvement	Overstretching staffing recourse	mMedium	Draw on partner agency support	Ensure availability of support from partners agencies to support/supplement CCG, Teaching Hospital trust and partner staffing
High level of voluntary agency commitment	Overstretching capacity	Medium	Large pool of agency support to draw on	Clarity of the potential support needed to ensure project meets outcomes
Failure to recruit volunteers	Capacity to deliver severely reduced	Medium	Draw on support from existing volunteers	Look to volunteer referrals from a variety of agencies e.g Volunteering Bradford New Horizons
Failure to receive referrals	Outcome impact	Low	Use of member networks	Coordinator to forge links across a variety of agencies to inform referral process

BUSINESS MODELLING: Approach 2

AREA	ACTION	RESOURCES	BY WHO	WHEN
Referrals (200)	Develop coordinated approach to referrals amongst network of support and public sectors agencies	Time information	All local agency partners	July /August2015
Volunteering	Identify 20 local volunteers willing to enable 200 local residents to undergo Develop training to support this activity	Use info from Campaign against Loneliness	All local agency partners	July 2015
Activity Programme for local residents	Draw together a coordinated approach to programme across network of support	Time information	Staff and Partner agency members	June/July /August2015
Assessment tool	Develop simple baseline indicator assessment tool	Time information	Staff and Partner agency members	May/June 2015
Community Development to raise awareness of Health	Carry out option appraisal of community awareness opportunities	Time information	Staff and Partner agency members	October/November 2015
Evaluation	Draw up Volunteer role description Advertise role locally Interview volunteers Undertake 6 month Project Review Undertake Project evaluation	Time information	Staff and Partner agency members	Feb/April 2016

RISK ANALYSIS of approach 2

RISK DESCRIPTION	IMPACT	PROBABILITY	EXISTING CONTROLS	ACTION REQUIRED
Failure to receive referrals	Outcome impact	Low	Membership referral process	Broaden referral agencies
High level of Royds staffing input	Overstretching staffing capacity	High	Partner involvement	Anticipate level of commitment before embarking on approach
Lack of financial resource input	Limits resource in all areas of project	High	Level of commitment, energy from all partner agencies Garner support from Public Health	Opportunity to secure small amount of neighbourhood funding to create increased resource for project
Voluntary input	Overstretching voluntary commitment input	Medium / High	Reasonable pool of resource to draw on	Anticipate level of input before embarking on approach 2
Volunteer involvement	Failure to encourage volunteer level	Low / Medium	Work on Campaign to highlight project to ensure it takes off	Recruit to process through Integrated Care awareness partnership

Appendices

Appendix 1: **ROYDS LOGIC MODEL**

Contextual Conditions

The Royds area has one of the highest health inequalities in the country and the gap is widening. 51% of residents in the most disadvantaged SOA's. Life expectancy is 12 years less than more affluent areas in the Bradford district. Health inequalities impact upon life expectancy and the quality of life for people living with ill health or chronic conditions. High levels of poverty exist leading to poor lifestyle choices, leading to increased risks of diabetes and some types of cancer.

Key Policy Conditions

New CCG's have been formed and have to engage patients locally in decision making. The system is flawed as they are unable to speak to and engage with easy to ignore groups. Public Health migrated to local authority control, but funds are under pressure due to cuts which does not encourage innovation. Welfare reform impacts on those with the poorest health causing further inequality. Child poverty. Introduction of Universal Credit will have a dramatic effect in the area

Intended Impacts

Increased patient/resident participation in accessing and designing local health service delivery.

Reduction in GP visits

Reduction in hospital admissions and attendance at Accident and Emergency

Reduction in new diagnosis of diabetes and cardio-vascular disease

Increase in level of self-reported well-being

Improvement in employment rates leading to reduction in family poverty and ill health

Programme objectives

Better decision making by local residents of where, when and how to access health services.

An increase in use of local third sector delivery by health professionals with working models of co-designed and co-created local health services.

Change and dispel old mind sets that things can't change among both the community and the health professionals by developing new partnerships.

Improved data access between clinicians and partners for the benefit of patients

Rationale

There are multiple causes of health inequality in the area and a poverty of aspiration and ambition.

By bringing providers and patients together in meaningful ways they can better understand each other and co-design better services that will be used by more people from the target group to address health and wellbeing.

Mapping and encouraging local third sector provision brings services closer to local people, and can engage more effectively.

Health buddy role models based on showing what buddies have learned promotes engagement and self-care, and addresses poverty of aspiration and ambition

Inputs

CCG patient engagement

Co-ordinator (app.£6k)

Ridge practice manager

(app. £5k)

LA ward planning team (app.£5k)

Royds CEO (app.£6k)

Volunteer time (app.£5k)

Self-care awareness events CVD diabetes etc(app.£15k)

5000 leaflets on diabetes and CVD into resident's homes in pilot area

Patient consent forms

CCG and Hospital trust bid to develop a health buddy programme - A volunteer

Co-ordinator for health buddies and buddy training (app. £125k).

Activities

2 x co-design workshops with health professionals and patients

Video diaries to capture typical life experiences of focus groups.

Using local champions to foster better understanding of key issues such as diabetes

Increasing local ambition around taking control of own health

A communications strategy for Royds Our Place including residents including Twitter

2 x patient self-care awareness work shops

Start recruitment of resident patient volunteers to become health buddies.

Outputs

1000 homes receive information re cardio vascular disease and diabetes.

Patient consent form designed and agreed by professionals.

5% of patients identified at risk through risk stratification worked with (app. 65 patients)

Approximately 50 people through health MOTs

Plan to recruit 6 Health Buddies to be trained.

Documented pilot for reflection and learning

Intended outcomes 3 year target

Raised awareness of a 'small steps' approach to adopting a more healthy lifestyle and the potential benefits for residents and their families.

Lower health aspiration addressed through better and more sustained engagement.

Residents feel they have a greater say in local health service delivery.

Better understanding and appreciation of resident's needs and potential solutions between partners and residents leading to trial and testing of new approaches.

Royds better placed to facilitate health initiatives and bridge the gap between patient and professional and a key player in providing up to date health care information.

improved local JSNA data

70% raised awareness of personal health and self-care management.

Increased patient/resident participation in accessing and designing local health service delivery

Appendix 2: **VOLUNTEER FOCUS GROUP AT ROYDS OUR PLACE**

We have enlisted volunteers from the community who are interested in the health agenda to be involved in shaping the consultation in order for it to be a meaningful experience. We had a focus group of local people where we gathered opinions on which was the best way to go about gathering information that would be meaningful and not "do it to consultation" There were several points of view and lively debate.

Key points gathered: Focus Group Our Place –2014

Name	AGE	DOB	Post Code
L D Rodrigo	32		
T Purja	41		
H Todd	85	09.06.29	BD12 9QH
P Todd	86	15.12.28	BD12 9QH
Pat W	68	20.08.46	BD7 4RN
Haroon R	32	32	BD3
Brian M	47	15.10.67	BD4 8PE
Dr Alec P	72	72	BD12
Carol P	67	67	BD12
K W	54	24.12.61	BD4 6ES
Carol T	60	30.01.54	BD12 9BX
Helen F	41	19.08.73	BD19 3ES
Kathryn M	33	27.09.81	BD19 4RQ

The Forum

Forum to discuss the following questions:

1. What do you believe is causing Health inequalities?
2. How do you think patients engage with Health Services well? or not so well??

Welcome from David and brief introduction into why we were all met and what the bigger picture was with regards to ongoing dialogue etc between healthcare professionals and the general public. Focus on new programmes and delivery where Community have a say. Looking at new ways to co-design services that are more accessible to the community. Helping people who stay away from GP surgeries to engage with health before it is expensive and serious illnesses that are costly to treat and quality of life is adversely affected.

Introductions were made.
Floor opened to free discussion by all persons present.

Question 1

Poverty – concerns regarding affordability of nutritious and healthy foods vs the availability and low costing of junk foods.

Duty – comparisons drawn between generations with the older generations harbouring a duty of care towards neighbours and relatives in times of need vs perceived lack of selflessness in today's society.

Education – overall opinion that more focus should be put upon educating children regarding value of balanced diet, how to prepare wholesome meals and the best way to make the most of what you have.

Confusion – constantly changing press releases which challenge how we view foods and recommendations to increase/decrease our intake ie. Benefits of red wine and butter

Rising living costs - poorer households who actively have to choose between healthy fresh foods and basics such as heating, running a fridge, cleaning products to lessen spread of bacteria and clothing etc.

Industry – awareness of contamination and air pollution in heavily crowded areas.

Labour – comparisons made between past generations of physical labour vs desk jobs and robot assistance.

History - the aftermath of hard toil, coal dust, asbestos and general working/living conditions which manifest in later life as disease etc for older patients

Career – observations made that more ambitious and successful people tend to take better care of themselves by eating well and attending gyms vs unmotivated people who are satisfied to neglect exercise and eat junk food.

Priorities – individuals who value cigarettes and alcohol over a decent meal and clothing.

Revenue – benefits to the National Treasury by allowing sales of harmful goods i.e. cigarettes and alcohol

Question 2

Trust – patients automatically trust professionals in most cases so they do not engage heavily with them

Take health for granted – patients can misuse their bodies and still demand/expect the health services to fix them

GP dependant – patients readily accept prescriptions from GPs and expect to be given medications upon visiting GPs. If GPs were to explain conditions, causes, preventative measures and cures to patients it would enable them to look after themselves better. GPs need to speak to patients as if they are people who might well understand rather than idiots who don't.

Moderation – encourage people to have a little of all food groups instead of championing diets which isolate and remove individual foods. This should help empower dieters to make a permanent difference and manage their health better.

Waiting times – to book a GP appointment in advance can take up to 2 weeks and sometimes months in the case of appointments for specialist treatment.

Education – many patients do not know their Rights.

Regulated checks – no GP surgery seems to work the same ie appointment times, out of hours services

Pressure and Targets – acknowledgment of how difficult it is for GPs and professionals with tight timescales in which to see, diagnose and treat patients. Leading to misdiagnosis, overmedication, lack of reviews and strain on resources.

Language barriers – lack of readily available interpreters in GP surgeries leading to communication lapses, GPs not fully understanding patient circumstances and patients not understanding GPs either

Pressure on GPs – specific pressure from patients and Government leading to questions around manpower within frontline services and number of clinics vs population and demand

Individual perception – patients who view their own circumstances differently due to education, family values, priorities with money and time i.e. one person may not think twice before visiting GP with a cold whereas another might try to remedy it themselves or not even acknowledge it as a problem

Access – issues surrounding clinic opening times and distance to be travelled for GPs. More surgeries need to look at appointment times suited to those who work away from home. GPs accept patients in relation to where they live but they may travel in excess of an hour to get to work so clinics which open 8am to 5pm force people into taking valuable time off work.

Marketing and Advertising – questions raised relating to putting pressure on supermarkets and industry to emphasise healthy living products, food and lifestyle options in their advertising rather than junk foods etc

Vulnerability – people do not always know where to get help or what help is available to them so they continue to be untreated or they attend hospitals and put strain on the emergency Doctor services there

Social issues – Doctors sometimes have to deal with patients who would be better served by a Social Worker or other assisting body so their time as a medical professional becomes diluted and they have to assess which service patients actually require

Immigration – the reintroduction of TB has come through from other countries where immunisation does not take place as a matter of routine in schools etc

Encouragement – discussion over the importance of Vitamin D for bone structure and the lack of enthusiasm in communities for outdoor activities. Generational differences highlighted again here i.e current children have far more entertainment options available without having to leave the house

Drop in centres – concerns raised that free services and drop ins tend to be manned by skeletal professionals and a majority of volunteers so they act as a divert for services but not a replacement

Awareness – more can be done to signpost which services are available for patients. If people were more informed, they would be able to go direct to the service they need rather than clogging up the front line and GP slots

Behaviours – medical terminology must be made transparent so patients can understand their situation better. Patients must not feel pressurised into submission if treatment is not seeming right to them, they should be able to ask for a second opinion without prejudice. "The Doctor must be right" belief system has led to symptoms being undiscovered or unmentioned because the patient has felt under pressure.

Reception in GP surgeries – reception staff are challenged to "field" patients when clinics become full but they are not trained in patient diagnosis. Demeanour towards persistent patients can be disgraceful and patients are made to feel like liars and time wasters.

Blood donations – lack of blood types necessary for specific minorities in cities ie. B+ for people of Indian heritage within Bradford (although no evidence other than hearsay was provided to back up the claim that all Indian people have type B+ blood)

Conclusion and thanks for participation from David, even though not all questions were discussed due to time. Participants were asked generally if they would be willing to take part in further engagement and forums and all agreed they would.

Appendix 3: **PEER REVIEW, YORK**

We attended a peer review session in York and were questioned around the approach and scope of the project.
Key review points were:

Royds Community Association
Peer Review Feedback 2 December 2014

a. Vision & Overall fit with Our Place:

• In your presentation, you gave a very engaging introduction to the presentation which really set the scene. The panel commented that this should be reflected in the plan
• The community engagement is a strong element of the project and should be an important part of the operational plan

b. Service transformation:

• You are tackling a hugely ambitious and complex area (which is great) but the panel wondered whether it might be worth narrowing the focus initially and identifying some key areas/statistics you want to change, or set out some short term and longer term goals with associated measures of success i.e. being clear about what activities you are doing, and how you will know whether you are succeeding in what you set out to do

c. Business model:

• Although you are not undertaking a full CBA because you are in the early stages of developing your project, the panel felt that in the longer term this would be beneficial for you to attempt because it would provide the evidence to back your case

d. Pooling or devolving budgets:

• Still at an early stage, and sustainability was discussed
• In your presentation, you noted a challenge in that partners became concerned with the logic model and started to stake their own territory ie protecting themselves to ensure they can continue to meet their own government issued targets.

e. Partnership, leadership and governance:

• Really positive to see a representative from CCG attending, supporting the project and on-board with what you are trying to achieve
• Challenges around engaging GP services due to health funding challenges; suggestions that the CCG could become more involved either to encourage GP services/speak to difficult Practice Managers/offer incentives

• Is there scope for the Local Council to be more engaged?
• Good use of peers to promote the message and help people find a voice

f. Implementation plans:

• Longer term plans for implementation –looking at a very complex area and changing culture with the possibility of it taking 20 years to see the results

g. Resources:

• Realigning budgets/resources is being discussed with the CCG and will need teasing out.

Overall comments:

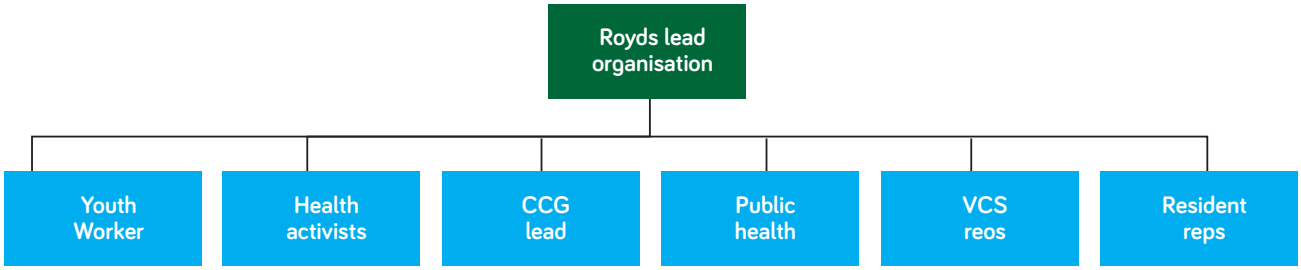
• The Panel felt that this is a worthwhile but very challenging area to work in. The discussions at your presentation generated lots of questions, but it was a bit more difficult to nail down answers for example; how do you engage with the 'hard to reach' or measure patient experience? How do we understand the changes people what to see? How do you use change to work better?

- Margaret offered to share her learning from work with NHS
- Key Challenge: disconnect between CCG initiatives and practice manager's actions
- Careful about terminology such as 'hard to reach'
- Need to define strategy and operational plan
- Social Investment Bonds – speak to Dan (LGA) & Cabinet Office
- If you can get this right, and be successful there is potential to be rolled out nationally
- All Bradford areas to share learning as working on different aspects of health

Having reflected on the feedback and agreeing the merits of the vision being huge we have concentrated our efforts in developing an engagement and early warning system for tackling health inequalities in consultation with the CCG partners we are pushing on in developing HEALTH BUDDIES as a community engagement and social prescribing 'with a difference' model.

We are working with partners to develop some cost benefit evidence to justify redirection of funds to pilot Health Buddies.

Appendix 5: **GOVERNANCE STRUCTURE**



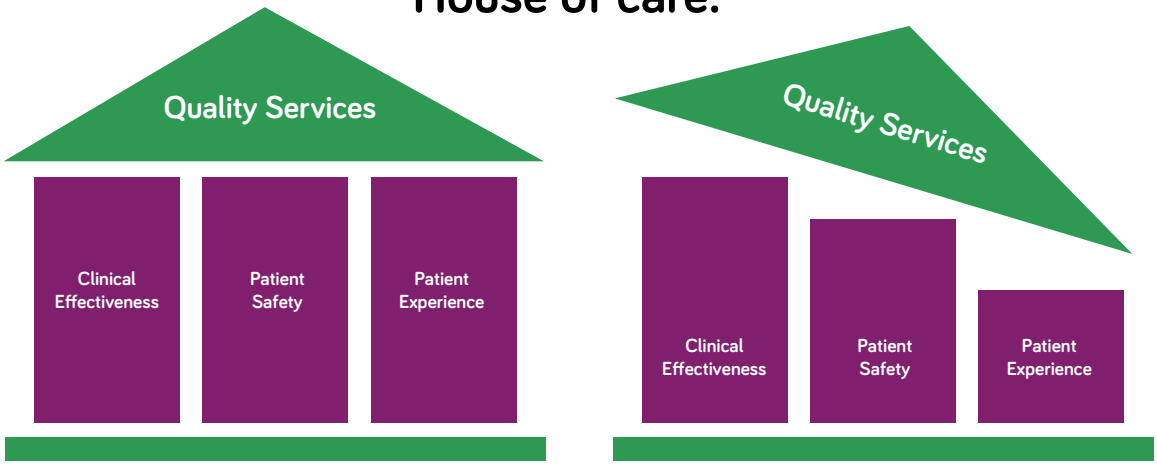
Appendix 6: **HOUSE OF CARE**

High quality care

Good Service:

access + listening + understanding **= experience**

House of care:

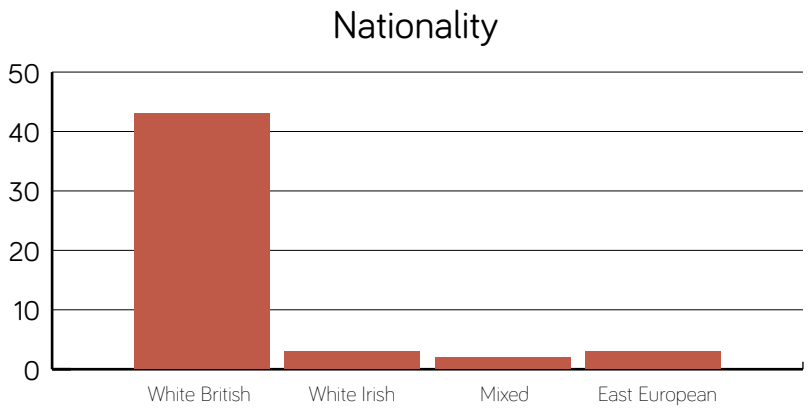


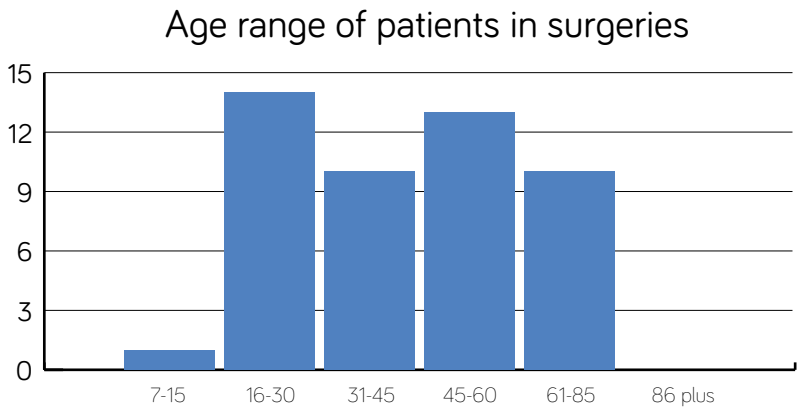
Ideal house of care

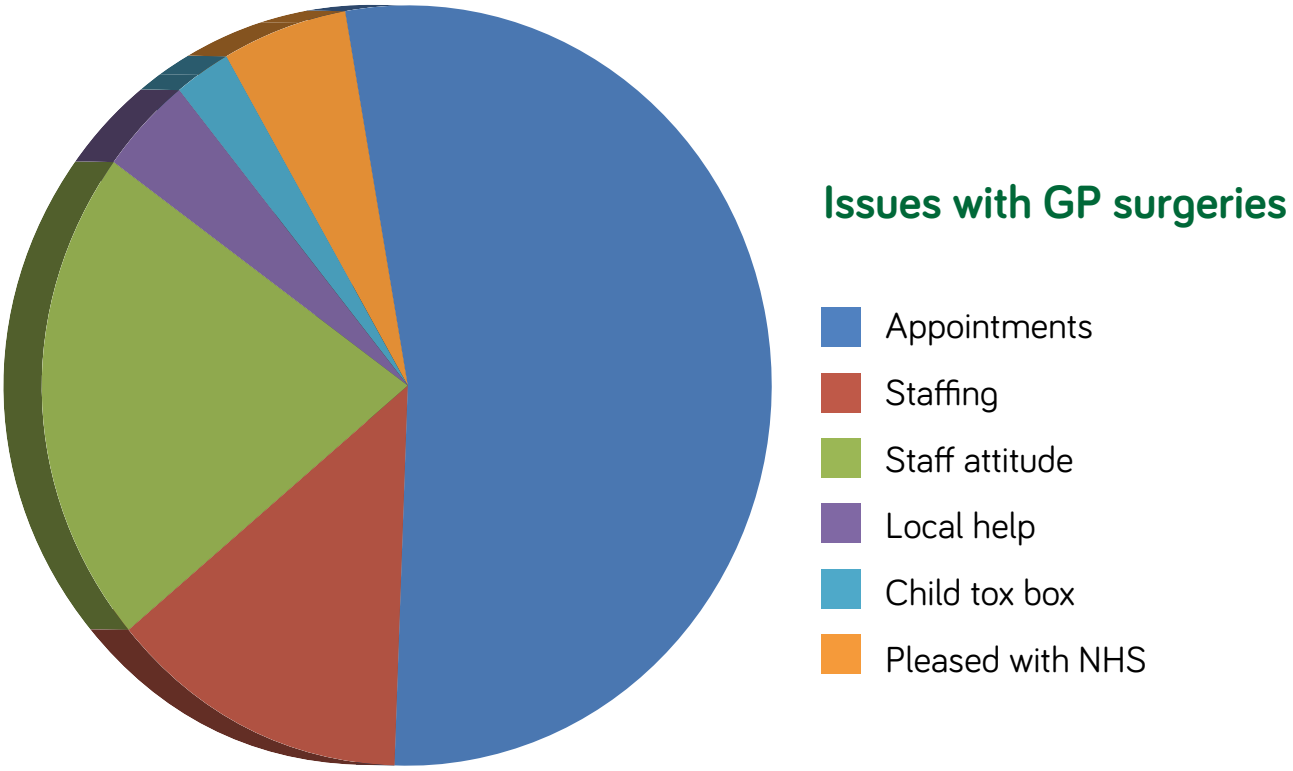
damaged house of care model

Appendix 7: **INTERVIEWS**

Interviews with patients in GP Surgeries Ridge Great Horton/Wibsey/Buttershaw







We attended 3 GP surgeries at our GP practice partners the Ridge.

We had interviews one to one with patients from the local area.

The most outstanding issue was getting appointments when needed, some patients had been waiting 4 weeks to get an appointment, some had made over 200+ calls to get through to someone.

Staff attitude was an issue in that people thought the attitude was poor and middle class talking down to them.

Urgent cases were not being dealt with as a child patient had been flagged as an urgent case with the child having sepsis and describing a battle to have her child seen by a GP.

Overall patients are happy with the service once they get to the GP and are pleased with the care shown, it is just the struggle to get passed the receptionist who is acting as a gate keeper.

There is concern at the Buttershaw practice where The ridge took over running the service about 15 months ago that the place was not as friendly and that regularly in all kinds of weather older people and parents/carers had to wait outside from 7.30 to get an appointment from 8.15 when the surgery opened. The patients felt there was not a concern about patient's wellbeing and this was demonstrated with several comments during interviews regarding attitudes of staff talking down to patients.

The appointment system in the opinions of the patients needed a review as soon as possible.

In the opinion of the interviewers 30% of the patients interviewed could have gone to pharmacy or managed own health without the aid of a General Practitioner.

25% of respondents had considered going to A&E rather than not be seen by a Dr, although their ailments were relatively minor and could have been managed in other ways rather than spending GP time.
Education of using pharmacy and other less costly means of treatment ie local supermarket could help reduce the flow of patients in GP surgeries.

Appendix 8: **HEALTH MOT HEALTHY LIFESTYLES**

Evaluation of Health Checks for Royds

Sharon Rushworth: Healthy Lifestyle Solutions CIC
Health MOT Checks taken over 2 days in BD4 11th and 12th February 2015
37 attended: 11 male and 26 female

Age ranges:

15 – 20 = 2	66 – 70 = 7
31 – 35 = 3	71 – 75 = 4
46 – 50 = 3	76 – 80 = 2
51 – 55 = 3	81 – 85 = 4
56 – 60 = 3	86 – 90 = 3
61 – 65 = 3	6 people said they had a disability

Referrals for clinical support

Out of the 37 who attended:
3 people were referred to their GP for High Blood Pressure
6 people were referred into other health projects in the locality

BMI results:

Underweight:	2
Normal weight	6
Overweight:	11
Obese:	16
Extreme obesity:	2

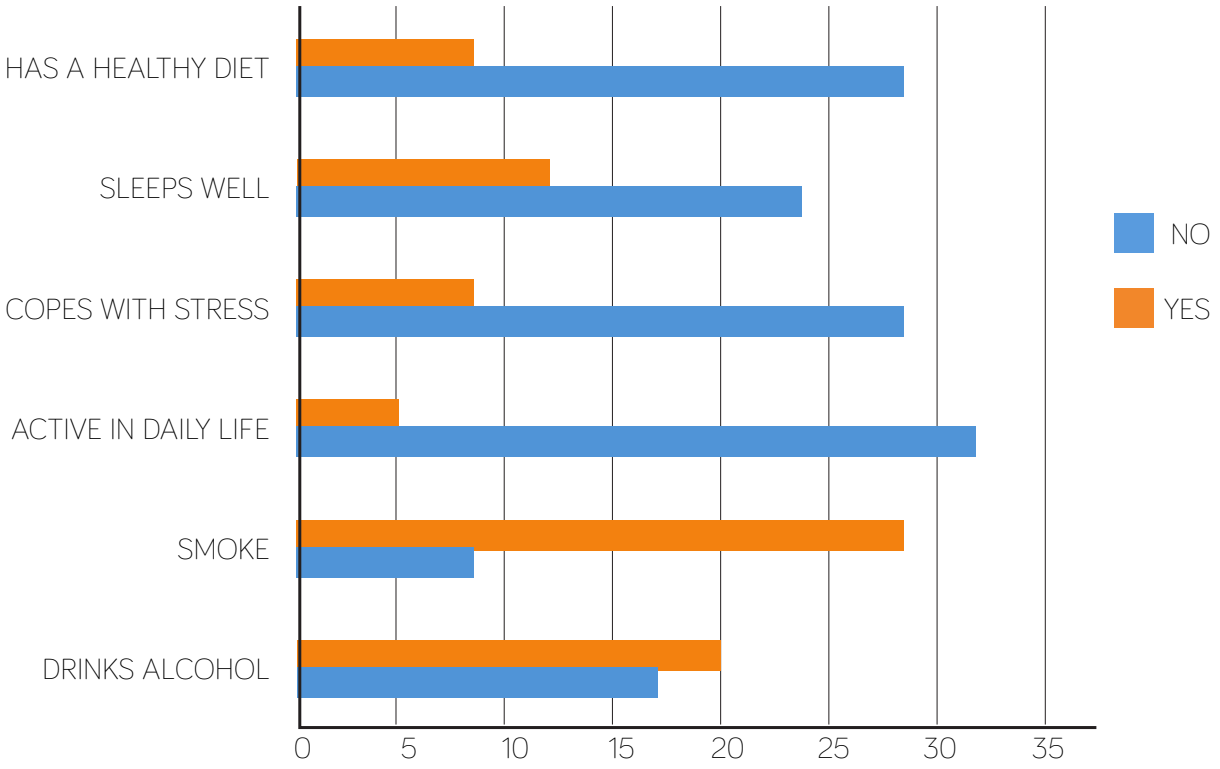
It is interesting to note that 29 people are overweight, obese or extremely obese and yet in the questionnaire about their life style (below), the majority of people had the perception they had an active daily life and a healthy diet.

An activity to show people the alcohol units they drink in a week was successful as people were surprised how many units they actually drink.

Sleep and mental health are closely linked and more people had problem with their sleep than smoked. This is an area which is underfunded, although we have used a sleep therapist for workshops in schools which were very popular.

Two people who were 'definitely' going to attend the Latin Fusion dance exercise class, did not turn up. It is easy for people to say they will do something, participating is a different matter.

LIFESTYLE OF THE ATTENDEES



In discussions with those who attended, people welcomed the opportunity to have a health check and informal chat.

An assortment of health focused booklets were available and people did help themselves to these to read later.

Appendix 9: **FOOTPRINTS FAMILY CENTRE**

Footprint focus group

Footprints
Family Centre

Royds
Helping people to help themselves

NHS Bradford District Clinical Commissioning Group

NHS Bradford Teaching Hospitals NHS Foundation Trust

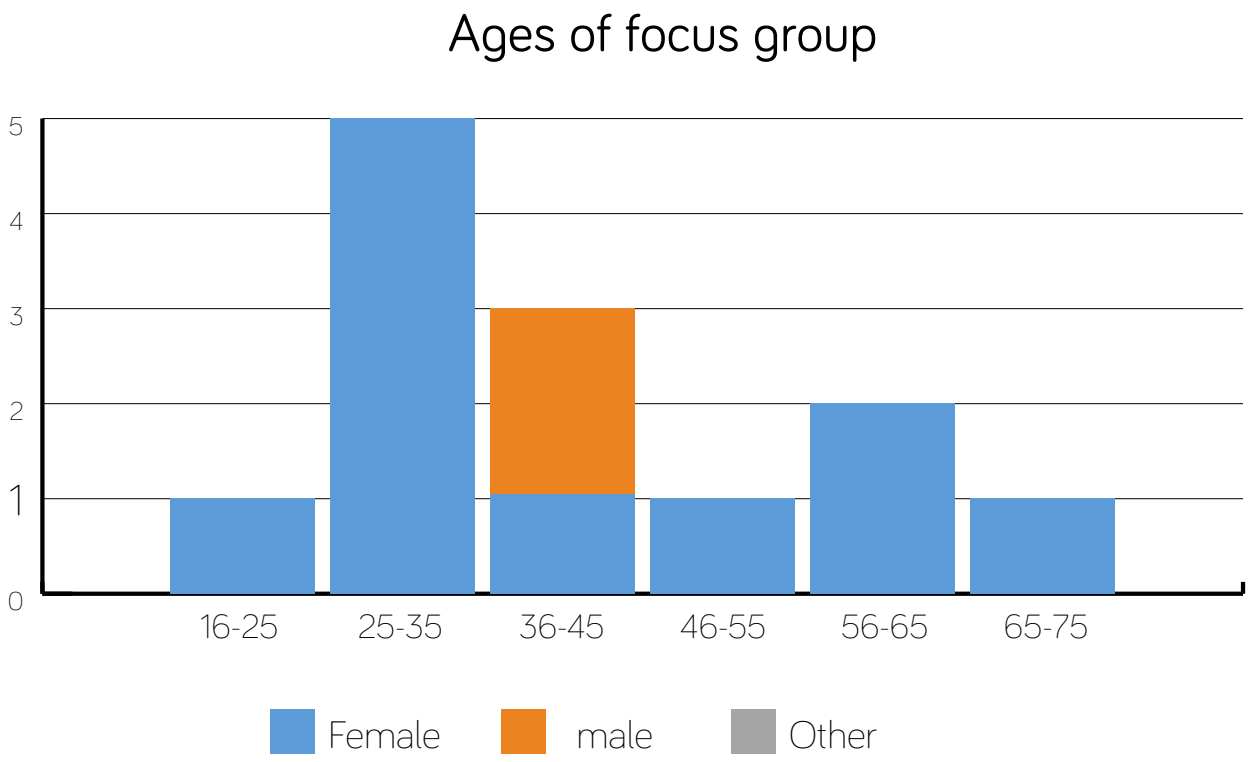
Footprints Family Centre

Bradford District Council
www.bradford.gov.uk

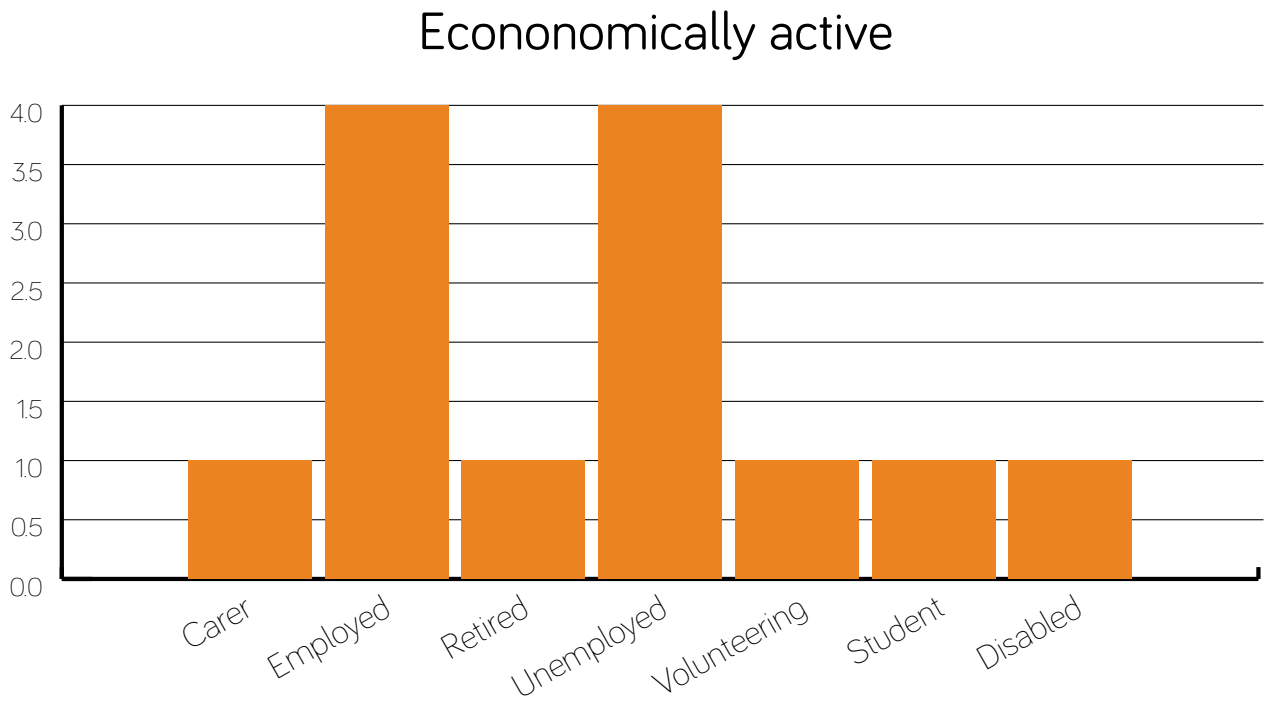
ysustain

healthy lifestyle

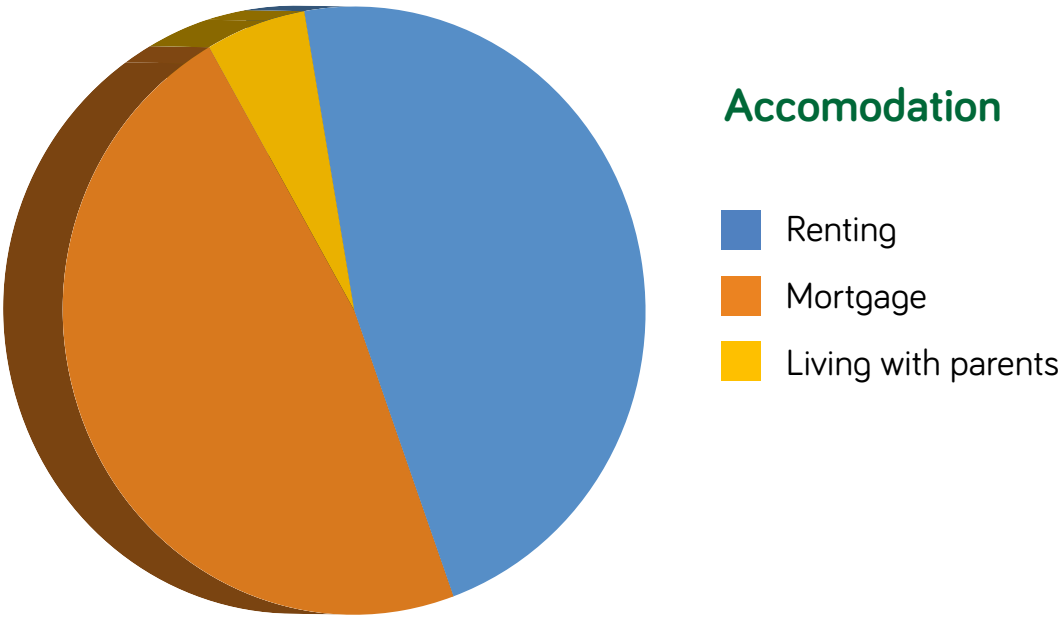
the ridge
Medical Practice



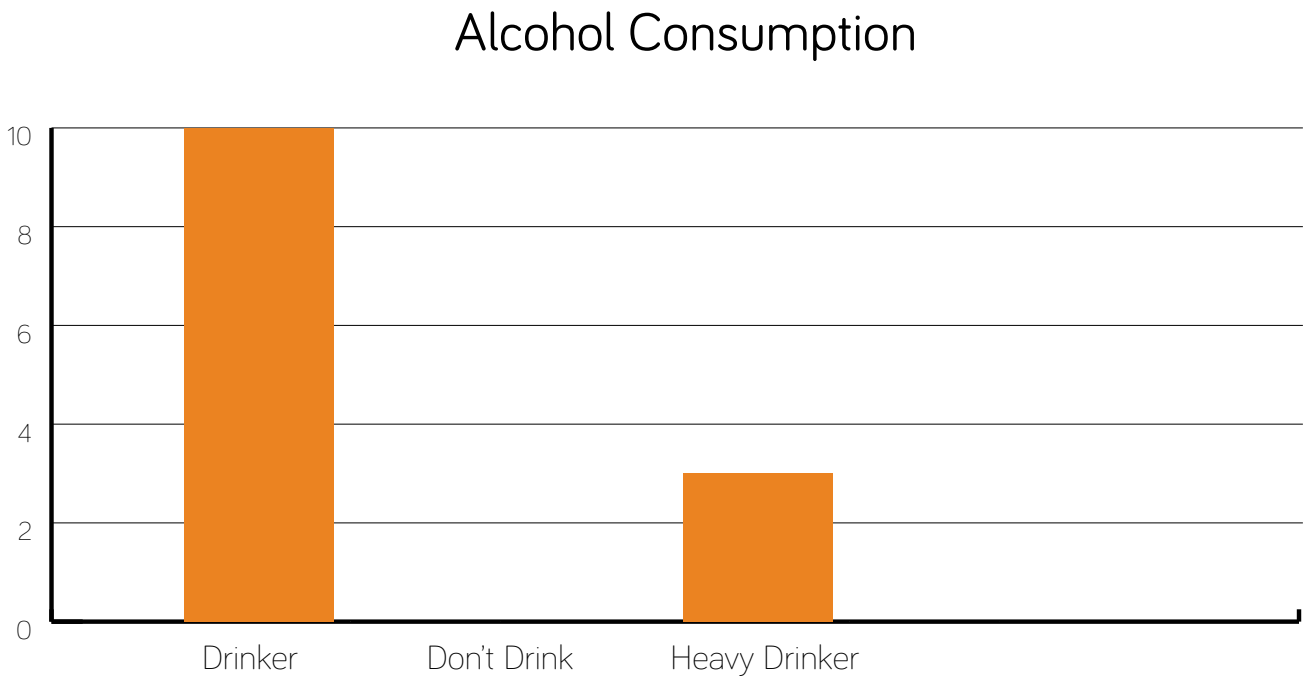
There was a good cross section of parent carers at the focus group. Due to snow a lower number of participants turned out.



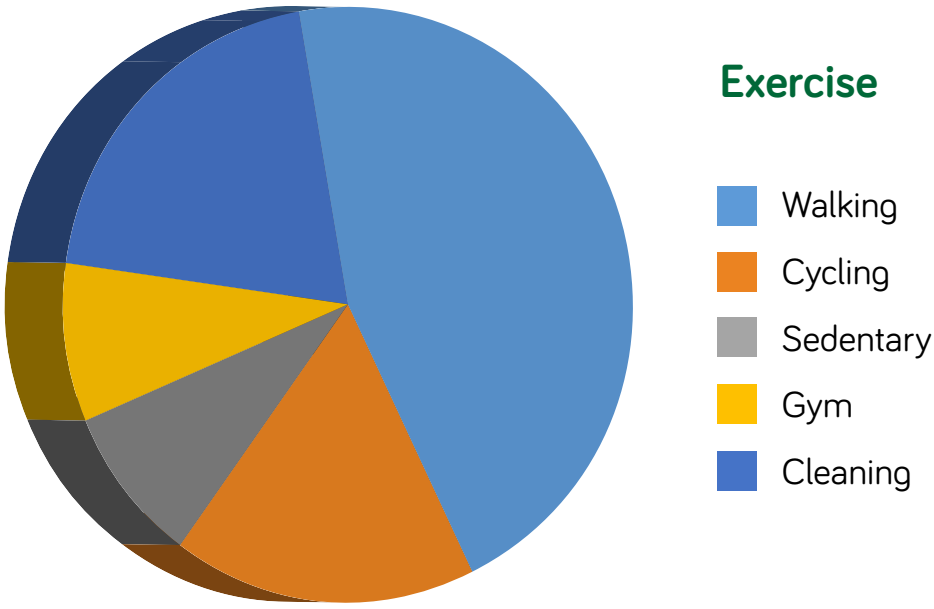
A balanced group from an employment perspective



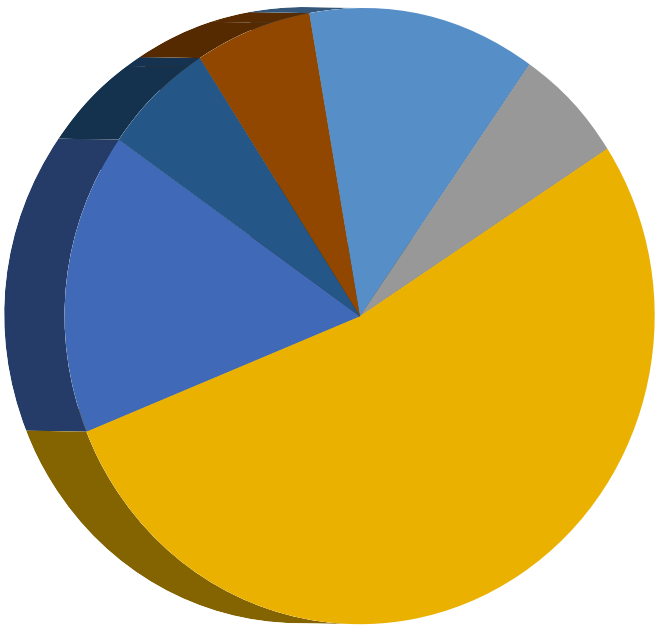
A balance of rented and mortgaged property tenure.



All who took part drink, common reason was to relax or socially 3 admitted drinking more than recommended allowance as it helped them cope.



Some people took part in more than one exercise per week. Two responded with little or no exercise per week.



Appendix 10: CCG CHATTERBOX EVENT WITH HEALTH PROFESSIONALS

CCG District, Airedale and Craven and City consultation event "Chatterbox" on priorities for General Practice Commissioning, how GP commissioning needs to change to be more effective.

Present: GP's, Health Commissioners, Nurses, Practice Managers, CCG Board Members, PPG steering group members.

Healthy discussions on how to improve the GP's effectiveness with over demand and shortage of capacity.

During in discussions Practice managers were drawn out on how many non- medical appointments were happening suggestions from practice managers were as much as 30% failure demand due to issues such as debt or housing where patients were under enormous stress due to non-health related challenges in life.

AREA 1 TWO KEY PRIORITIES

We do need to change how we deliver services

Must hang on to the list based system

AREA 2 TWO KEY PRIORITIES

Relook at key roles

Making the core work attractive

AREA 3 TWO KEY PRIORITIES

Build systems that respond to patient need

Educate and empower patients as they go through the system

AREA 4 TWO KEY PRIORITIES

Capacity of delivering proactive care

Patient education - peer to peer networks

Thank you for your time

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