NHS Providers

HEALTH INEQUALITIES

Welcome to the Health Inequalities webinar

Supporting staff to drive health inequalities improvements in services

Wednesday 7 December, 4.00pm-5.00pm

This virtual event will be recorded and published to our website.

NHS Providers

NHS
Health Education England

Bringing population health to the front-line

Dr Maslah Amin

National Clinical Advisor & Associate Director

December 2022

We need more population health approaches

- Evidence is clear
- Policy is clear
- NHS principles are clear
- We cannot leave it all to our public health colleagues: COVID-19 reminded us!

Benefits

- Aimed at improving the health across a population
- Addresses physical and mental health outcomes and wellbeing of people, whilst reducing health inequalities
- Includes action to improve prevention, whilst also addressing wider determinants of health, and requires working with communities and partner agencies

Skill-mix

1. Enhanced level practice

2. Advanced level practice

National Population Health Fellowship

- **First** national population health fellowship (PHF) – truly multiprofessional across the health and care workforces
- Launched to develop a sustainable model for increasing the number of healthcare professionals who have the skills and capabilities required to support ICS and
  - Improve **health outcomes** for populations
  - Improve the **wellbeing** of populations
  - **Prevent** long term conditions through population level interventions
  - Reduce **health inequalities** and unwarranted variation in health outcomes.

What happens on the fellowship?

- Fellows undertake a population health placement for 2-days/week for 1 year to work on a health inequalities project

- Fellows undergo a formal taught programme

- It is an intense year and learning is set at the enhanced level practice

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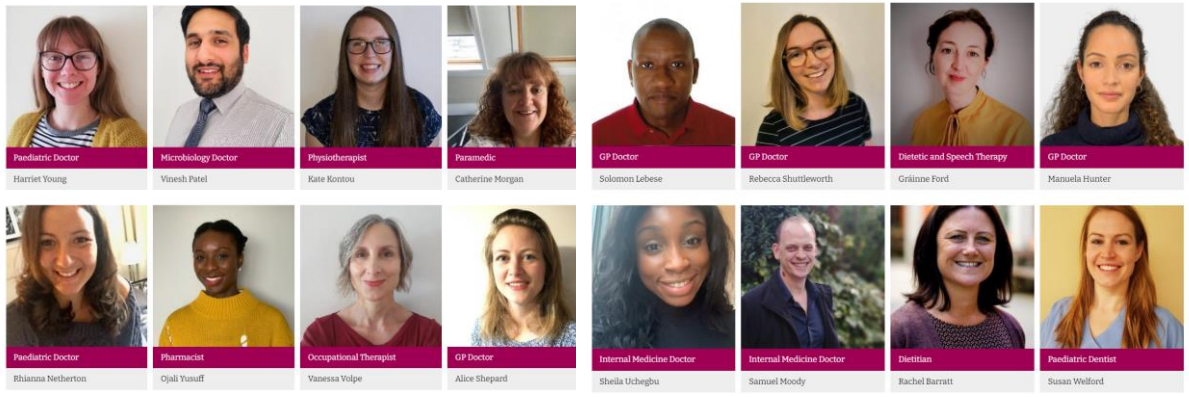
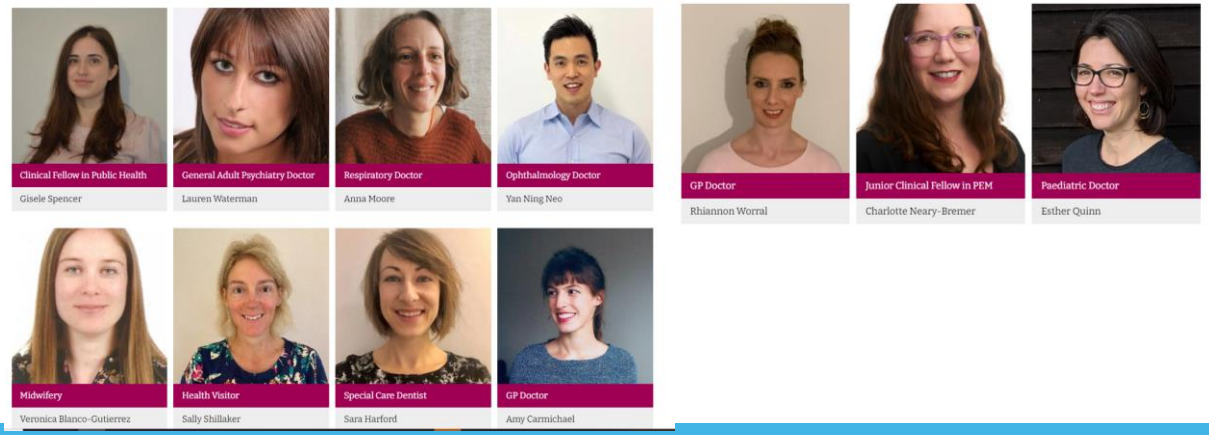




Pharmacy

Dentistry

Speech & Language Therapy

Orthotics

Nursing

Paramedicine

Dietetics

Managerial

Midwifery

Physiotherapy

Medicine

Further developments

- The PHF is very popular, particularly among GPs, pharmacists and AHPs.

- We now have a pilot where GP trainees are doing the fellowship as part of their GP training to developed enhanced population health skills.

- Increasingly we have systems sponsoring their own staff to join the fellowship

Advanced Clinical Practice (ACP) in Public Health

- HEE has developed a Core Capabilities Framework for healthcare professionals to work at the advanced clinical practice level with expertise in public health.
- The ACP is characterised by a high degree of autonomy and complex decision making
- It is set a higher level than the PHF and develops healthcare professionals to master's level award

ACP Aims

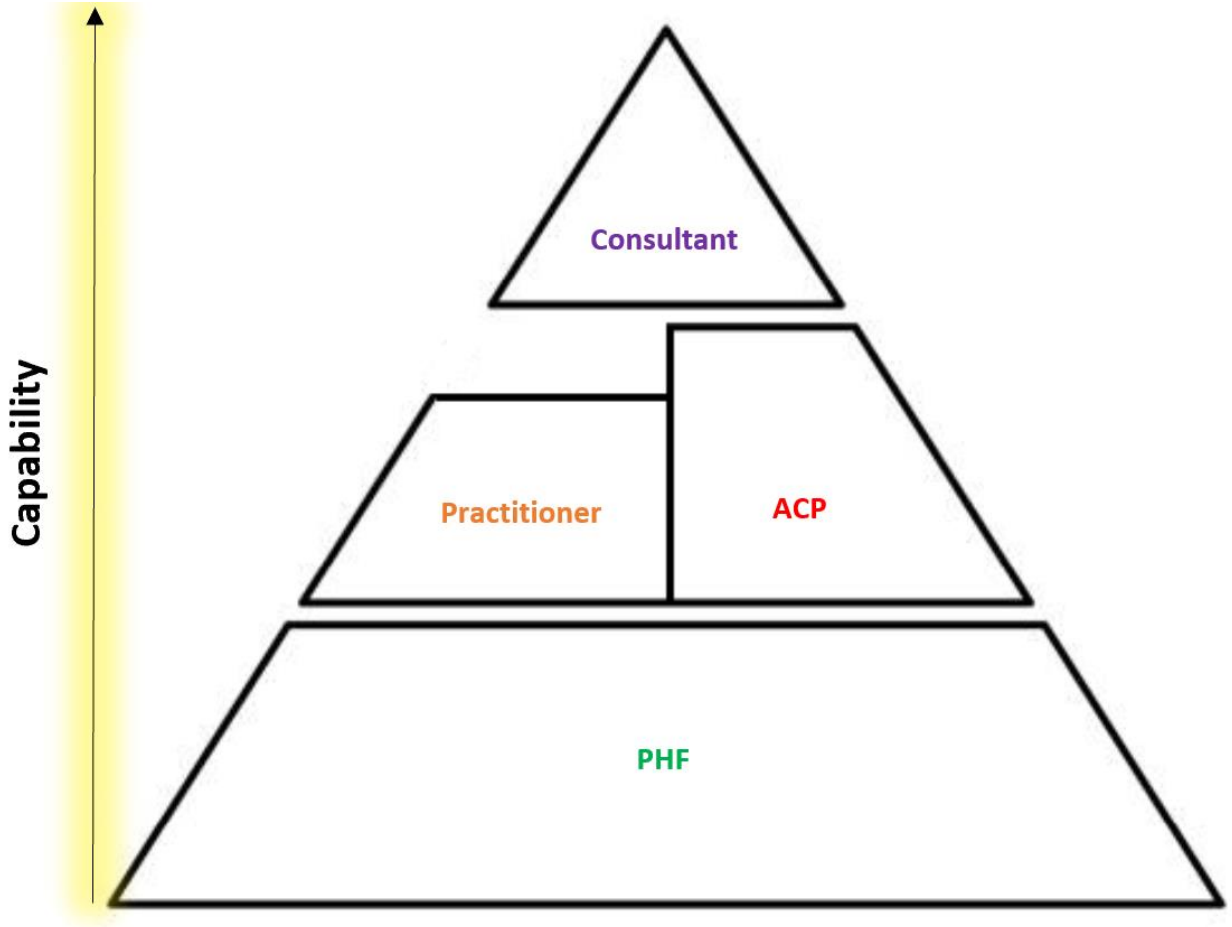
- Incorporate population health into their local work systems to improve outcomes
- Develop capability to promote and influence healthcare policy
- Encourage and support the development of PH strategies and approaches within relevant organisations and systems (e.g., integrated care systems).

The vision

- Because of the great overlap of subject matter between the PHF and ACP, after completing the PHF, individuals will be able to progress to the ACP

- Together (i.e. fellowship and ACP) they can demonstrate one part of a population health development pathway for healthcare professionals and potential careers escalator, sitting within a wider suite of population health development opportunities and careers.

Pathways for clinical practitioners



Population Health Toolkit - ELfH

- A free, inclusively accessible, blended suite of e-learning modules and complementary online resources for all health and social care staff on e-LfH Hub
- Launched November 2021
- Ongoing evaluation to inform future development

Gaining buy in from clinicians on their role in addressing health inequalities

Dr Esther Mireku,
Consultant in Public Health, North Tees and Hartlepool NHS Foundation Trust

7 December 2022

Key considerations for engaging clinicians in reducing health inequalities

- Acknowledge that NHS role on health inequalities is a new area and overwhelming for clinicians and not considered as ‘normal practice’ in the NHS – it takes time for cultural change
- As a leader, be visible and authentic
- Make a compelling case for change with clinicians – make your narrative clear
- Be realistic about current pressures on clinicians and keep the ask simple
- **I**nvest sufficient time to ensure that you understand your authorising environment (internal and external)
- Gain the executive and clinical leadership mandate to support change - this is not a short term fix
- Empower others to own the agenda
- Provide support for knowledge, capability and capacity - take time to understand their needs and must do’s e.g. quality improvement, clinical audits etc
- Provide an enabling environment for facilitating change e.g. alternative referral pathways of support
- Provide the necessary support mechanisms e.g project management, BI to help facilitate change
- Accept that not everybody will be enthusiastic about change at the initial stages

Levels of influence

- Board and Executive as champions and advocates
- Clinical leadership and Directors as drivers for change/enablers
- Clinicians and staff as implementers of change

Focus – clarity of approach

- Staff
- Patients and carers

The tools

- The narrative – communication is key
- Data and intelligence – make it simple
- Knowledge, capability and capacity
- Strategic framework for delivery
- PMIO support and other support systems

My role

System navigator

and

change facilitator

Sample of approaches to engagement, knowledge and capability development

1. Board and Executive
- Chief Exec as SRO for health inequalities
- Executive team sessions
- Board seminar
- Transformation committee

2. Directors and clinical directors
- Trust Directors' group – monthly meeting with slot for health inequalities
- Grand round – CPD sessions

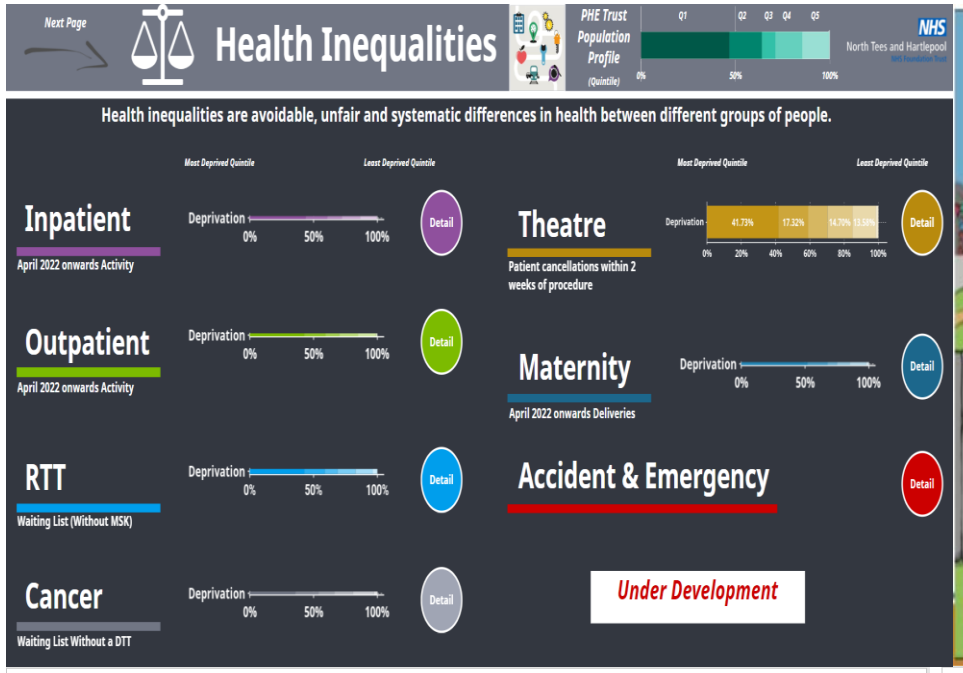
3. Senior managers and medical consultants
- Specialty specific directorate clinical governance meetings
- MECC CPD module
- Grand round – CPD sessions

4. Other medical staff
- Grand round – CPD sessions
- Medical education – teaching sessions for specialist trainees, Foundation doctors
- MECC CPD module
- Population health fellowship

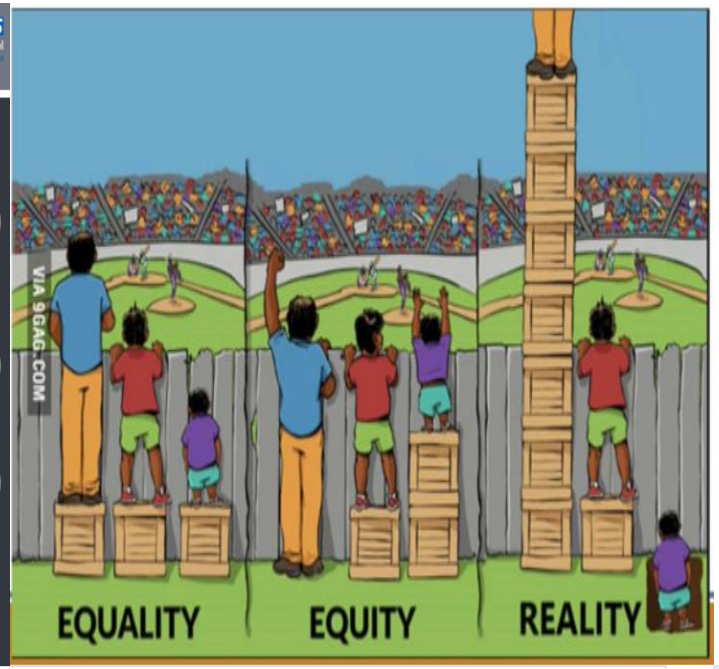
5. Other clinical staff
- Grand round – CPD session
- MECC CPD module
- MECC train the trainer
- Foundation programme in Public Health
- Population health fellowship

6. Non-clinical staff and volunteers
- Grand round CPD session
- MECC train the trainer
- Health inequalities training for Trust analysts

Understanding healthcare inequalities – Trust dashboard



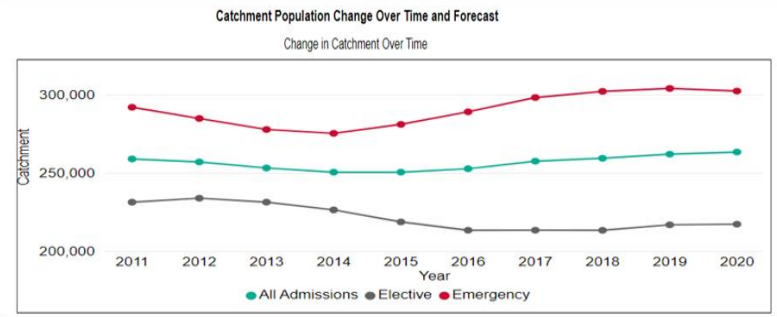
What are we trying to achieve?

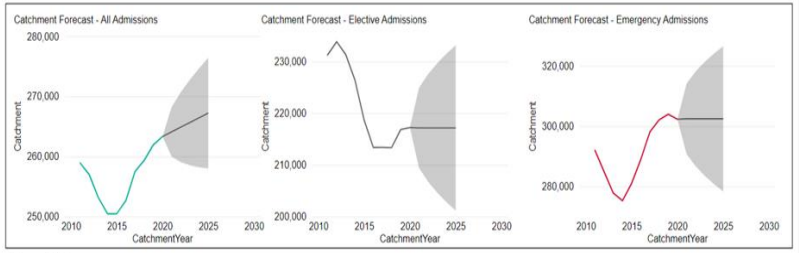


What does this mean for the Trust?

NHS North Tees and Hartlepool

Changes and forecast for health care services demand - NTHFT



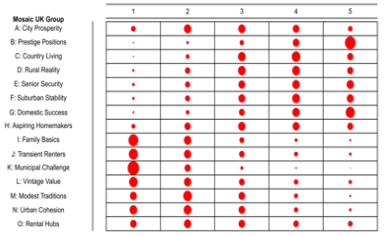


Source: OHID

Understanding our communities - Behaviour insight

"State-of-the-art health care resources don't mean much if only some of our communities have access to them. Whether it's through a lack of affordability, availability or any other '5 A's of access', too many people are struggling to receive the services they need to receive healthy lives." – Missouri Foundation

(a). IMD Quintiles: 1 (most deprived) to 5 (least deprived)



Description and key features of Experian's Mosaic Groups.

Source: © 2016 Experian Limited., Mosaic UK Generation 6 Data Profile. Available Online: www.experian.co.uk/marketing-services, [Accessed 13 December 2017].

Mosaic Group	Description	Key features
A: City Prosperity	High status city dwellers living in central locations and pursuing careers with high rewards	Highly educated; High value properties; Central city areas; High status jobs; Charity membership; High Internet use
B: Prestige Positions	Established families in large detached homes living upmarket lifestyles	Likely to be 56-75 years old-Well-educated; High value detached homes; Married couples; Charity membership; Strongly motivated by religious beliefs; High assets and investments; Online shopping and banking
C: Country Living	Well-off owners in rural locations enjoying the benefits of country life	Charity membership; Well-off homeowners; Attractive detached homes; Higher self-employment; Support environmental causes; High use of Internet
D: Rural Reality	Householders living in inexpensive homes in village communities	Aged most likely between 46 and 55 years-Support the community; Donate to charity shop; Agricultural employment; Most are homeowners; Affordable value homes; Slow Internet speeds
E: Senior Security	Elderly people with assets who are enjoying a comfortable retirement	Aged average 75+-Elderly singles and couples; Homeowners; Donate on a regular basis; Additional pensions above state; Don't like new technology; Strongly motivated by religious beliefs
F: Suburban Stability	Mature suburban owners living settled lives in mid-range housing	Aged 45 to 65-Older families; Some adult children at home; Suburban mid-range homes; Likely to donate soon; Donate low amounts; Research on Internet
G: Domestic Success	Thriving families who are busy bringing up children and following careers	Aged late 30s-40s-Families with children; Upmarket suburban homes; Support a friend through sponsorship; Support Health and medicine; High Internet use; Own new technology
H: Aspiring Homemakers	Younger households settling down in housing priced within their means	Age 20s & 30s-Younger households; Full-time employment; Support a friend through sponsorship; Affordable housing costs; Starter salaries; Willingness to donate
I: Family Basics	Families with limited resources who have to budget to make ends meet	Aged 25 to 40-Families with children; Limited charitable activity; Cannot afford to give to charity; Some rent from social landlords; Squeezed budgets
J: Transient Renters	Single people privately renting low cost homes for the short term	Age 20s & 30s; Private renters.; Low length of residence; Low cost housing; Singles and sharers; Prompted by colleague at work/school; Support Animal Welfare
K: Municipal Challenge	Urban renters of social housing facing an array of challenges	Social renters; Working age; Donate small amounts or nothing; Feel the state does not help those in need; Few employment options; Low income; Mobile phones
L: Vintage Value	Elderly people reliant on support to meet financial or practical needs	Aged 74 average-Elderly; Living alone; Low income; Unlikely to donate; Support traditional British charities; Low technology use
M: Modest Traditions	Mature homeowners of value homes enjoying stable lifestyles	Aged between 46 & 65-Mature; Homeowners; Affordable housing; Unlikely to donate; Interested in animal welfare; Modest income
N: Urban Cohesion	Residents of settled urban communities with a strong sense of identity	Aged 18-35; Private renting; Singles and sharers; Support Human rights; Support a friend through sponsorship; High use of smartphones
O: Rental Hubs	Educated young people privately renting in urban neighbourhoods	Aged 18-35; Private renting; Singles and sharers; Support Human rights; Support a friend through sponsorship; High use of smartphones

Opportunities for Trauma and Orthopaedics

Using trusted relationships with patients, families and communities to lower the risk of developing musculoskeletal health conditions

Objectives

- Understand specific interventions that will encourage people to make healthy behaviour changes to lower risk of MSK conditions and prevent falls
- Consider resources and services available in our area to sign post patients to for prevention and early detection.

Physical activity - active hospitals project

Healthy weight and balanced diet

Smoking – treating tobacco dependency initiatives

Mental Health

Make Every Contact Count gateway - MECC | Home (meccgateway.co.uk) on intranet page

One you resources Better Health - NHS (www.nhs.uk)

Social prescribing link worker (primary care) info.hash@nhs.net or 01642 061047

NTH internet – Live well page Live Well - North Tees and Hartlepool NHS Foundation Trust | North Tees and Hartlepool NHS Foundation Trust (nth.nhs.uk)

Tools

Population health management

- Population health management academy https://www.england.nhs.uk/integratedcare/what-is-integrated-care/phm/
- Trust HI dashboard (under development)

Preventative programmes for reducing health inequalities

- MECC – CPD module funded through Teesside University
- E-learning module on HEE elfh hub – 'All Our Health' HEE elfh Hub (e-lfh.org.uk)

West London NHS Trust

Carolyn Regan
Chief Executive &
Joint NW London SRO for Proactive Population Health Management & Reducing Inequalities

Supporting Staff to Drive Health Inequalities Improvements In Services

Strategic alignment and approach towards Health Inequalities Improvements In Services

1. Equality Act 2010
2. Public Sector Equality Duty (PSED)
3. Health and Social Care Act 2012

The Equality Delivery System for the NHS – EDS2

1. Better health outcomes
2. Improved patient access and experience
3. A representative and supported workforce
4. Inclusive leadership

+

London Health Inequalities Strategy

1. Healthy Children
2. Healthy Minds
3. Healthy Places
4. Healthy Places
5. Healthy Communities
6. Healthy Living

+

Core20PLUS5

Identifying deprived populations such as ethnic minority communities; people with a learning disability and autistic people; people with multiple long-term health conditions

+

Northwest London ICS

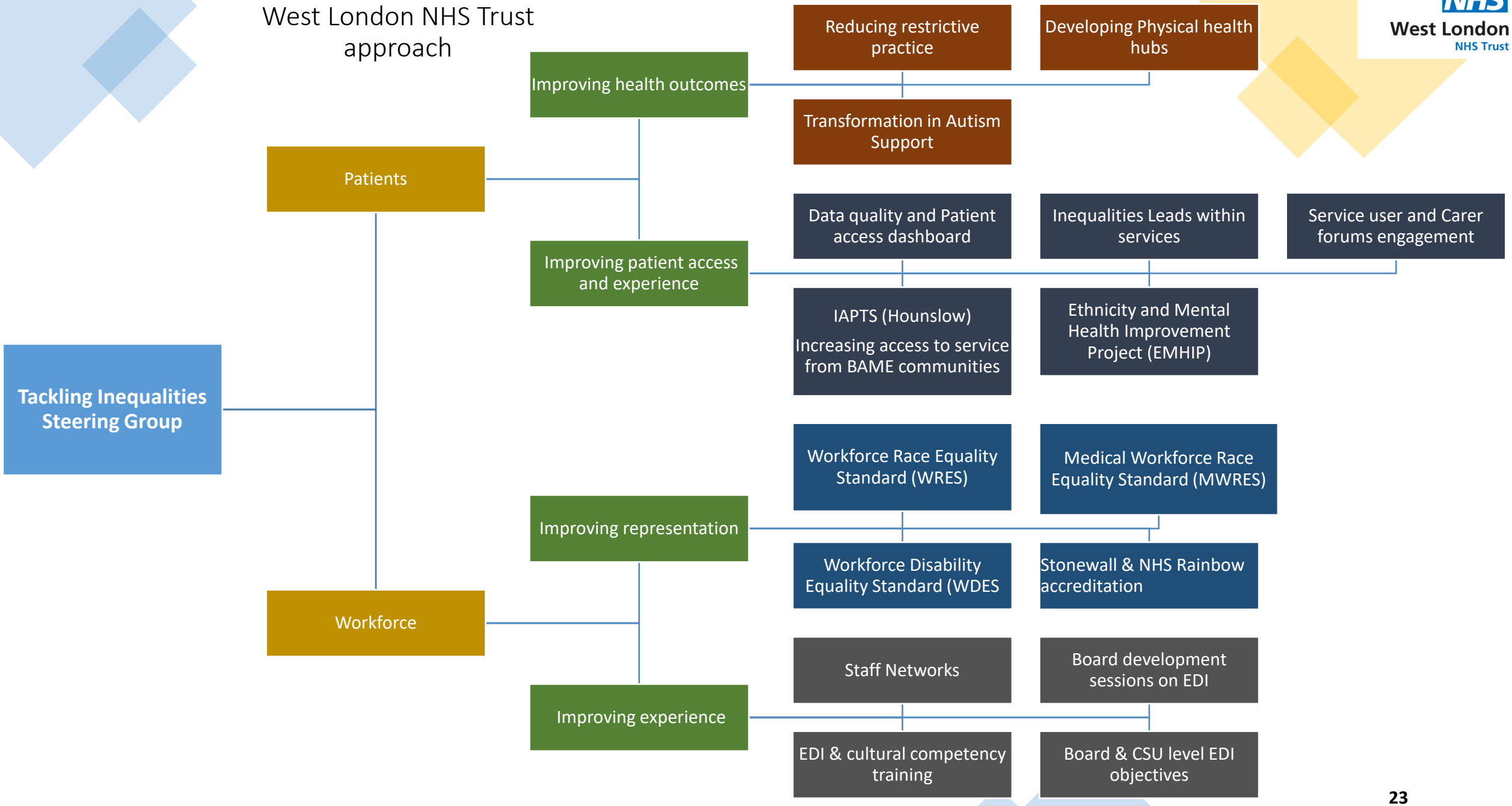
1. Focus on recovering elective care and addressing the backlog
2. Strengthen our out-of-hospital care; we have developed Borough based health and care partnerships with integrated leadership
3. Keeping staff and patients safe and our local public engaged meaningfully will be essential

↓

WLT Trust strategy

1. Lead and collaborate to ensure the best outcomes and experiences for patients, and careers
2. Co-produce and deliver high-quality, responsive care, tackling inequalities and focusing on the needs of our vulnerable and at-risk communities.
3. Attract, develop, support and retain talented, committed people, promoting an open, fair culture

The West London NHS Trust approach



What have we achieved?

NHS West London NHS Trust

Workforce

1. Workforce strategy includes a section on a 'fair and inclusive workplace' and developed with 250+ staff

2. Improved against all nine workforce race equality standards (**WRES**) indicators in 2021, an organisation first

3. **WDES** (workforce disability equality standards) in 2021, we were the top (best) performer nationally in addressing bullying and harassment from line managers

4. Increase in BAME representation at band 8a+ from 32% to 36%, exceeding Model Employer targets in 2021 and 2020

5. **Award winning BAME development programme** that support Model Employers

6. Strong and vibrant staff networks, sponsored by different Executive Directors and meet with Board

1. **Restorative resolution approach** to resolving workplace conflict – we have gone from one of the worst to one of best in London for BAME staff experiencing disciplinaries

Patient Services

1. **A Service User and Carer Engagement (SUCE) Commi**ttee that receives feedback from a variety of service user and carer forums held within the Trust

2. **Carers' Council** which has been established to ensure the carers' collective voice is strengthened

3. **Cultural competency training** is being implemented

4. We have developed **cultural care plans** designed to support the staff to be able to develop an awareness of religious and cultural diversity in care planning

5. **EMHIP** - Through a series of service projects, the organisation now has a better understanding of the long-standing concerns regarding disparities in patient experience and treatment between BAME and white patients.

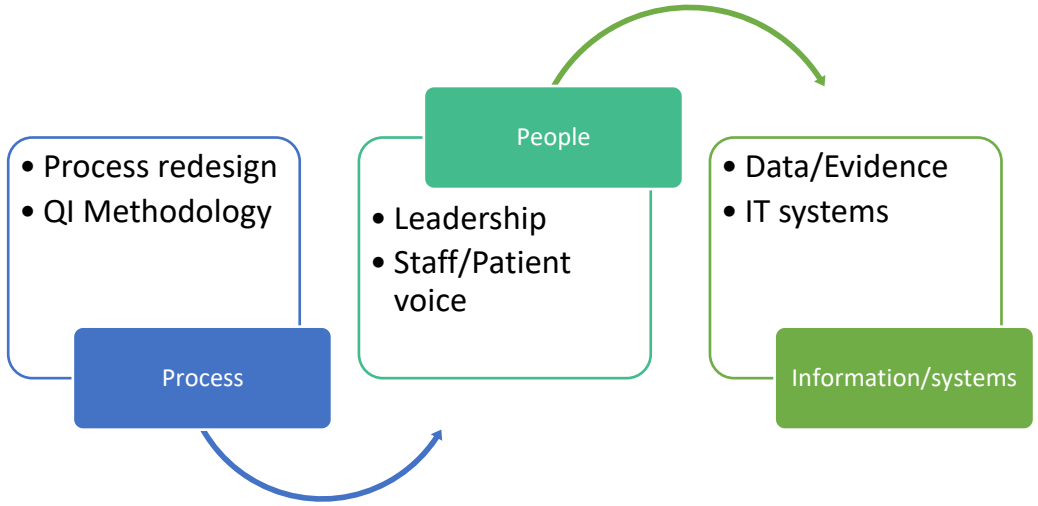
6. The Trust is now implementing a **new service model for community mental health services** known as MINT for better holistic and integrated care in community recovery teams

7. Invested in resources to improve management of **restrictive practice**, collating data to evidence impact of change

Reflections on what drives change

- Making improvements requires **sustained leadership** and a desire to make tackling workforce inequalities a priority
- **Investment is required –** in dedicated posts e.g. MWRES/user engagement resources, development programmes, training or staff time
- A **strong staff/patient voice** plays in a vital role in developing workplace/services we can be proud of holding leadership to account
- **Comms and engagement** – pivotal to ensuring plans, actions and outcomes are visible within organisations to teams leading change

Quality improvement approach



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HEALTH INEQUALITIES

Thank you for attending the webinar today

Please complete our evaluation form by scanning this QR code or click on the link in the chat.

Our next event dates are taking place in February and will be available to book on soon.

Reply to your joining instructions to be added to our Health Inequalities mailing list.

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