Addressing Equity with Quality Improvement Methods

Journey through collaboration and integration

Babies Children and Young People Multi Focal Demonstration Collaborative – NHS England – London
Maternal and Neonatal Mortality and Morbidity Learning and Action Network – NHS Race and Health Observatory
Core 20 Plus 5 Collaborative Multi Focal Demonstration Collaborative – NHS England

Conflict of Interest

Presenters have no conflict of interest in relation to this presentation.

Institute for Healthcare Improvement

Why QI Approaches Can Help Address Inequities

Pedro Delgado, Vice President – Europe, Institute for Healthcare Improvement

Disproportionate impact requires…

NHS

Black women in England suffer more serious birth complications, analysis finds

They are six times more like to have pre-eclampsia compared with their white counterparts, as health inequalities persist

‘I had no idea my baby was at risk’: The fight to raise awareness of pre-eclampsia

Tobi Thomas
Health and Inequalities Correspondent

Mon 8 Apr 2024 06.00 BST

Share

- Structural violence?
- Violent inaction?
- Mile wide, inch deep won’t work
- Inch wide, mile deep

Inch wide, mile deep

NHS Lancashire and South Cumbria Integrated Care Board

Aim: Improve earlier cancer detection and earlier stage diagnosis within the specific population - Bowel (Colorectal) Cancer, South East Asian, Women and Men, St Mathews area, all ages but specific screening for over 55

Approach: "Inch wide mile deep" - focussed work with one specific population group

Strategy: Through direct engagement with a specific population to

1. Improve awareness of cancer symptoms and body vigilence,
2. Improve education of cancer treatment and outcomes
3. Improve access to cancer screening and services

NHS England

Aim: Nottinghamshire Integrated Care System

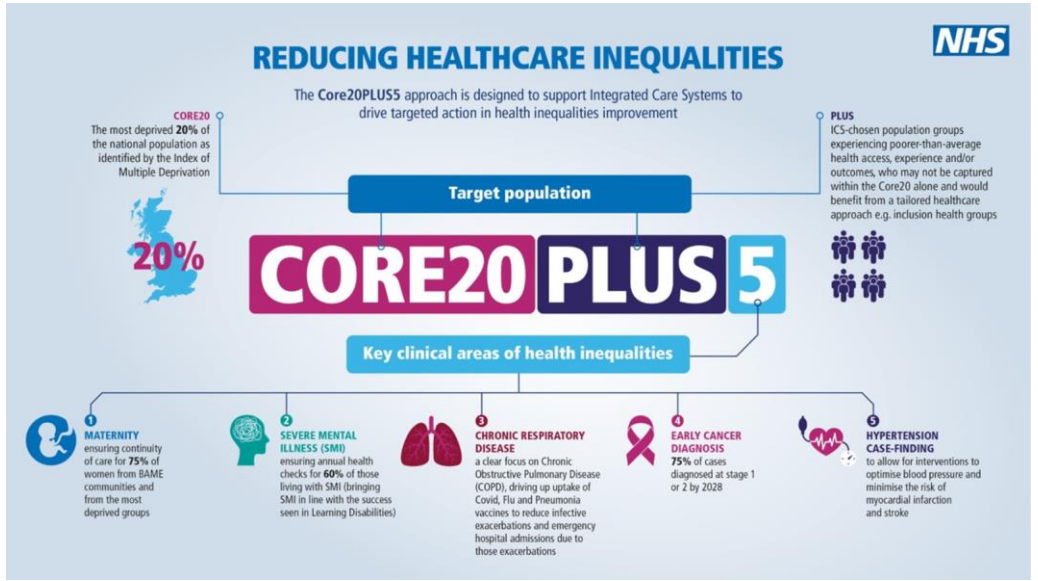
By December 2028, the proportion of people dying before aged 75 of CVD in the most deprived areas of Nottingham and Nottinghamshire will reduce (per 100,000), becoming more similar to those in the least deprived areas.

Our Initial Key Population Group:

People in a Core20 Population aged 40 without a Blood Pressure Reading in the last 5 years with an additional risk factor for CVD.

With an additional focus on people from a Black African/Caribbean Ethnicity who are overrepresented in this cohort.

NHS England



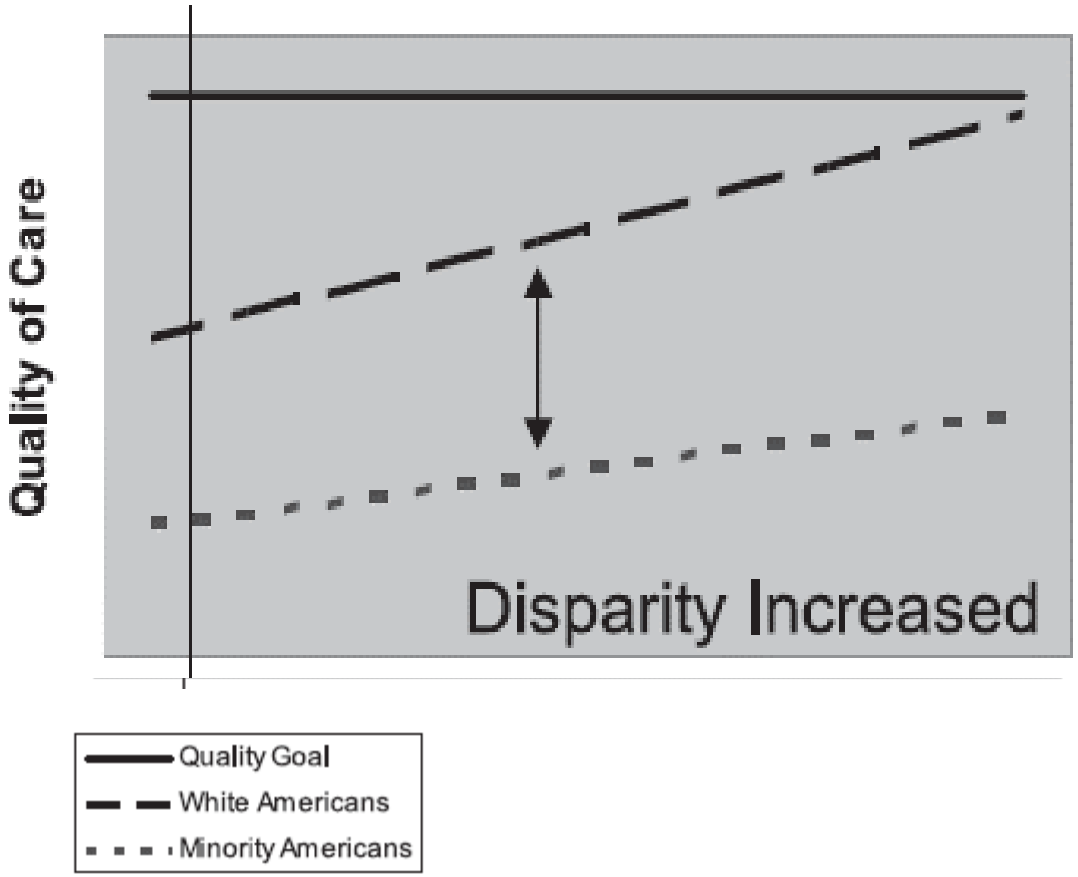
Inequities are variation
Inequities are harm
Created by systems.

Quality Improvement & Equity

Our systems are perfectly designed to create inequities

The benefits of quality tend to accrue to the powerful before others

Improvement tools can reduce inequities, but not without deliberate aims



Green, Alexander R., et al. "Leveraging quality improvement to achieve equity in health care." *The Joint Commission Journal on Quality and Patient Safety* 36.10 (2010): 435-442.

Who we are

Pedro Delgado
Vice President, IHI

Minara Chowdhury
Senior Director, IHI

Corinna Parisi
Senior Project Manager, IHI

Shubhi Tandon
Project Manager, IHI

Charlie Goodwin-Smith
Project Manager, IHI

Auz Chitewe
Improvement Advisor, IHI

Dr. Nandi Simpson
Director of Implementation, RHO

Dr. Aoife Malloy
Sr Clinical Advisor for Healthcare Inequalities Improvement, NHSE

Sara Nelson
Joint Head of CYP Transformation Programme, NHSE London

Our Roadmap for Today

Welcome and Icebreaker

Driver Diagram a tool building a hypothesis for testing :

Babies Children and Young People

Centering Equity in Data: Race and Health Observatory Learning and Action Network Part 1

Afternoon Break

Centering Equity in Data: Race and Health Observatory Learning and Action Network Part 2

Coaching for Improvement: Core20Plus5 Accelerators

Reflections and Wrap-up

Icebreaker : 25 to 10 Co-Production Ideas

Instructions:

- In silence, write down on a flash card, your top tip for doing successful co-production
- We'll do 5 rounds of shuffling cards around. At the end of each round please give each card a score from 1 to 5, with 5 being the best idea ever.
- After the 5 rounds, we'll read out to scores for the top 3 ideas!

Institute for Healthcare Improvement

Driver Diagram: Planning for Integration in London for Babies Children and Young People

Sara Nelson, Joint Head of CYP Transformation Program London, NHS England
Charlie Goodwin Smith , Project Manager, Institute for Healthcare Improvement
Minara Chowdhury, Senior Director, Global Delivery, Institute for Healthcare Improvement

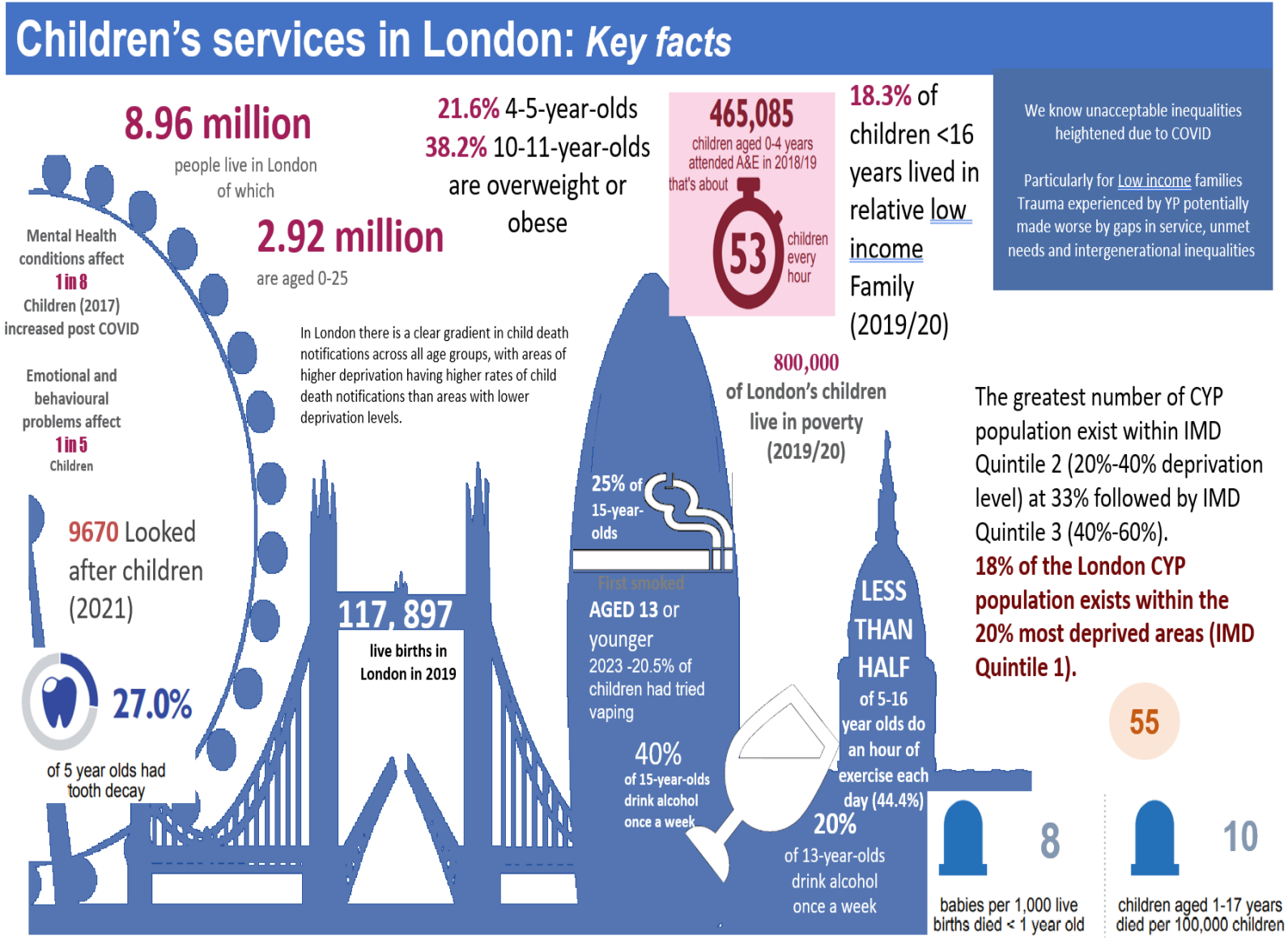
International Forum on Quality and Safety in Healthcare – London 10 April 2024

Children and young people's health – current picture

The health and outcomes for children and young people in London are deteriorating.

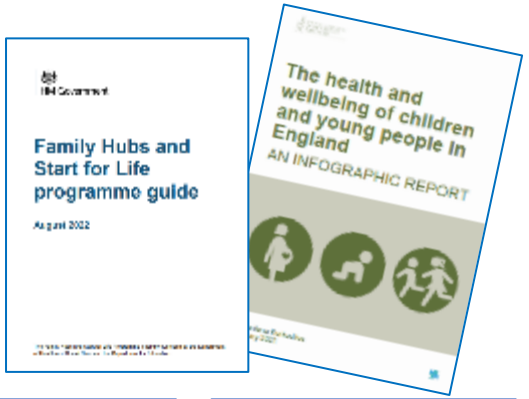
Key challenges include:

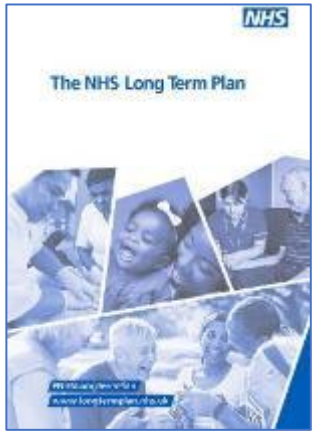
- **Rising child mortality**
- **Poorer health outcomes**, across rates of mortality, serious illness, and mental health , obesity and long-term conditions
- **Link between poorest outcomes and inequalities**, with higher asthma rates and higher levels of obesity reported in CYP from BAME groups. Children from the most deprived areas have more than twice the level of tooth decay than those from the least deprived
- Rises in demand for mental health services with a **lack of coordination between physical and mental health** leading to delays and sub-optimal care.
- **Variation fragmentation in access** and high attendance at UEC
- **25% of calls to 111 and 25% of attendances at A&E** are for under 16s and 25% of appointments in primary care are for CYP with 56% of children having a long term condition.
- **Transition** to adult care is confusing and relevant interventions and plans are not routinely shared between providers or sectors, which can adversely impact on personal progress
- **Backlogs in paediatric elective care**, with a slower pace of recovery for CYP compared to adults and **in community services**, the biggest increase is among the community paediatrics (ASD/ADHD) and speech & language therapy
- **Rising numbers** of children living in **poverty/suffering food insecurity**

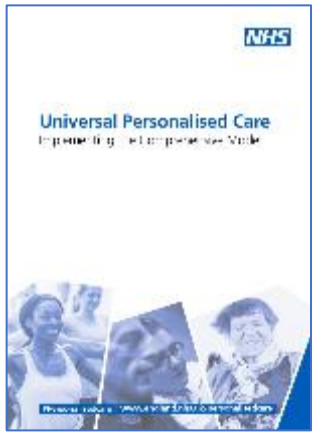


Background drivers and policy context supporting integration

- **National Integration agenda** - Long Term Plan
- Fuller review - Developing Integrated Neighbourhood Teams
- Family Hubs
- Beyond Boundaries early years integration report
- Core20PLUS5
- Anne Eden's report and NHS Impact
- Personalised, team-based approach to chronic disease management and complex care (**social prescribing**)
- Engagement with CYP and families







Healthy London Partnership (2014) Better Health for London | London Health and Care Vision (2019) | Healthy London Partnership (2019) BCYP Case for change | Mayor of London (2018) The London Health Inequalities Strategy

Engagement with CYP and families

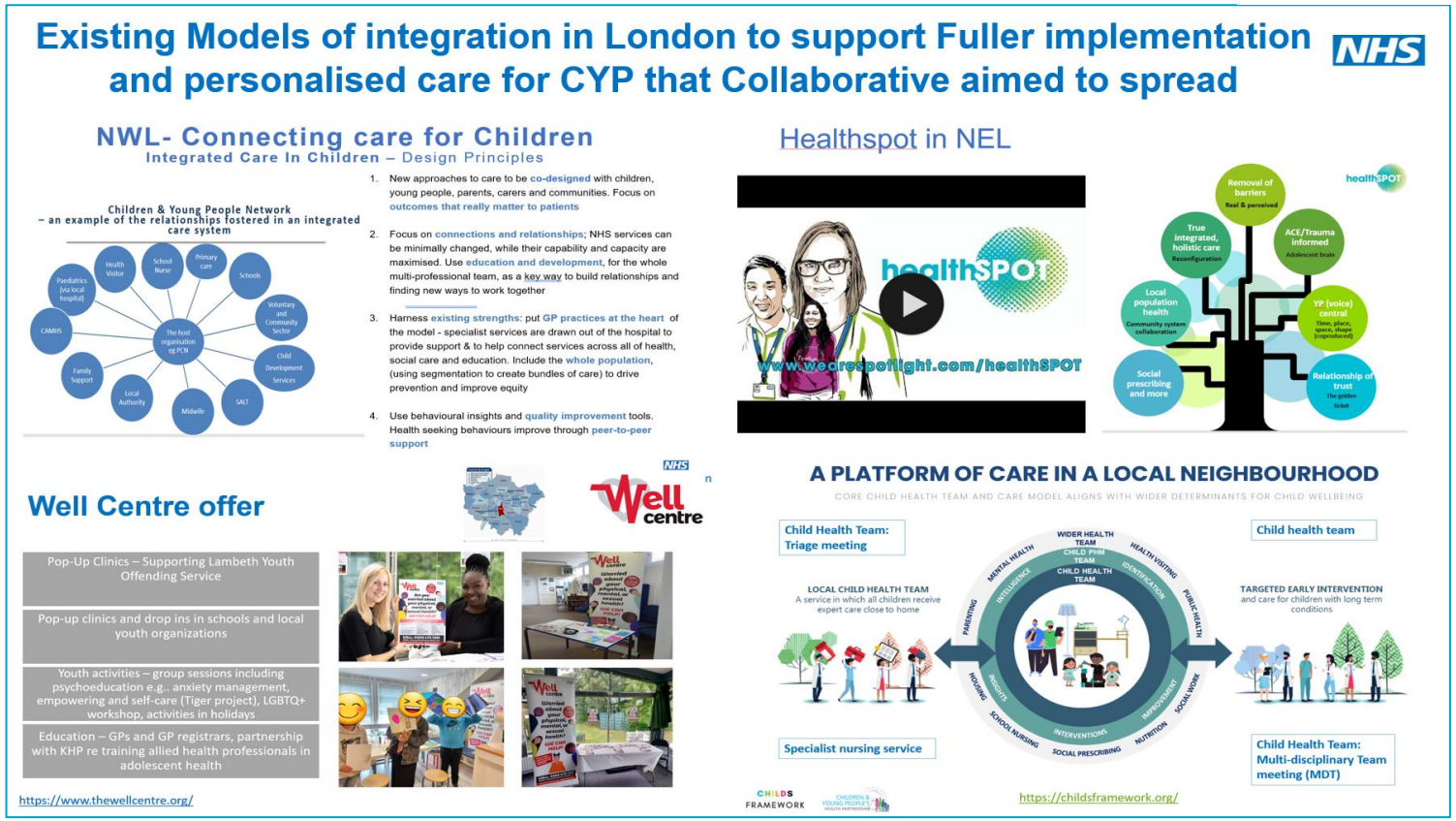
Young people identified they wanted **culturally appropriate**, **less fragmented services**, designed around needs, **supporting transition and wellbeing**

Offer to Integrated Care Systems:

NHS England London

We partnered with the Institute for Healthcare Improvement (IHI) to develop a **BCYP Improvement Collaborative** using the triple helix of integration to provide opportunities for **joined up work between health, social care, education and voluntary sector**.

1. primary and secondary care
2. health and physical care
3. health and social care/ education



Collaboration rather than Competition

Taking a pan London approach that achieves impact at speed and is scalable to other areas

- CC4C in NWL
- CYPHP in SEL
- Well Centre
- Healthspot
- Learning Together Clinics
- Social Prescribing

Multi agency collaboration: Family hubs and ‘child health hubs’

are complimentary, with some shared workforce, however there are fundamental differences in the function and purpose - BOTH are required within an integrated care system and we drew them into the programme during the second year

NHS England London

Multi-agency Improvement Collaboration

Collaboration rather than Competition

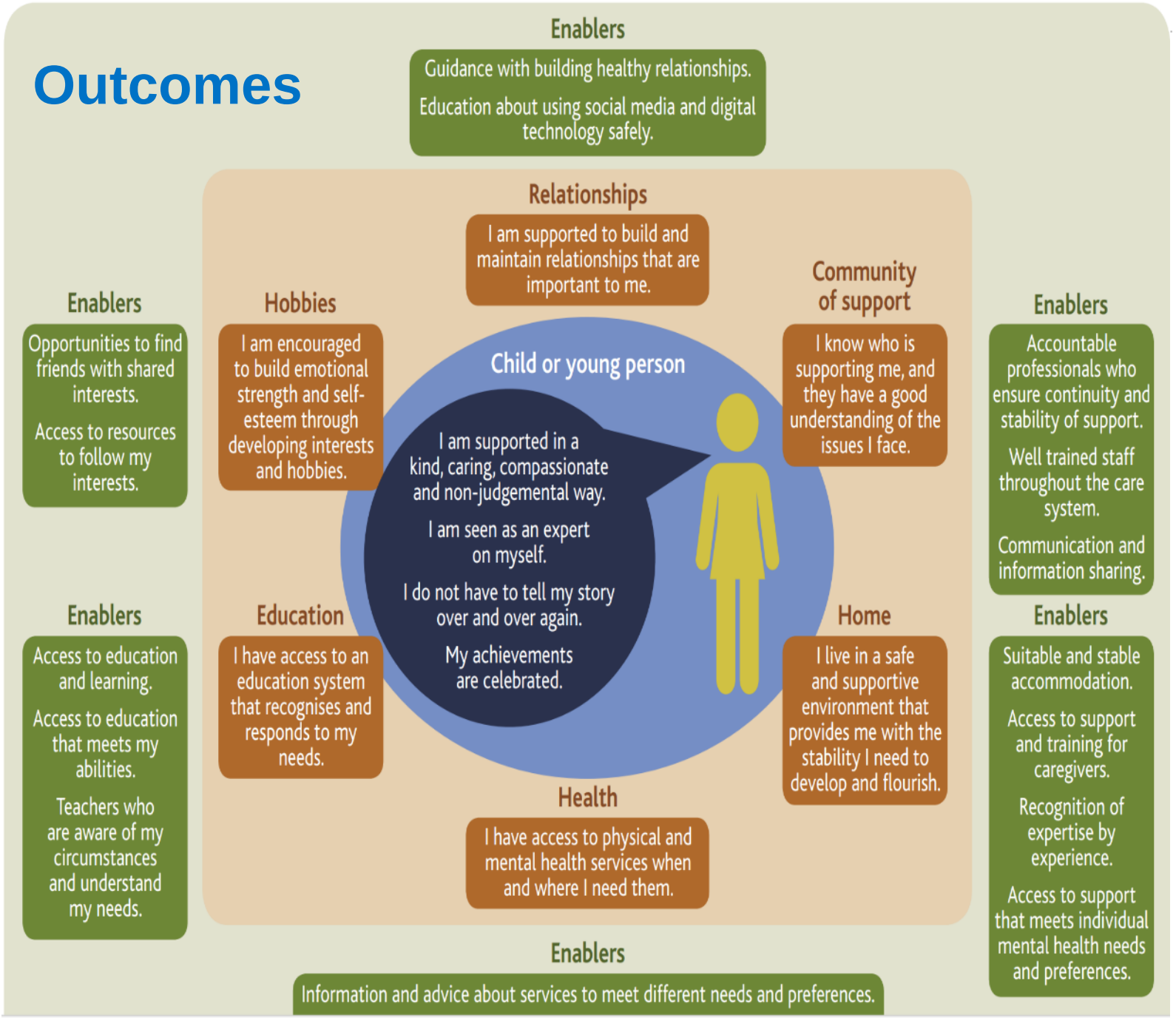
Integrating Child health and Family hubs

Child Health Hubs based in primary care bring together secondary and primary care to support children and young person where there is an identified health need.
All children and young people within primary care can be supported through this model (0-25 years)

Family hubs and ‘child health hubs’ need to work together, and some of the workforce may overlap including midwifery, health visiting and early years professionals, wellbeing and mental health practitioners. Shared colleagues will ‘glue’ the system together and help with shared learning

Family Hubs offer universal services for children and families which means that all families are offered support.
They are focused on families and early years and are Local authority funded services
They offer perinatal mental health, breast feeding support, community support etc amongst others.

Outcomes



East London Health & Care Partnership

NHS

The need for integrated, consistently high-quality engagement and interventions taking into account the voice of the child and family

A Whole Population Approach: Patient Segments in Child Health

Integrated care is often built around patient pathways. In stratifying children and young people we strongly advocate a 'whole population' approach, where 6 broad patient 'segments' can be identified:

Healthy child	• *Advice & prevention* eg: Immunisation / Mental well-being / Healthy eating / Exercise / Dental health
Child with social needs	• eg: Safeguarding issues / Self-harm / Substance misuse / Complex family & schooling issues / Looked after children
Child with complex health needs	• eg: Severe neurodisability / Down's syndrome / Multiple food allergies / Child on long-term ventilation
Child with single long-term condition	• eg: Depression / Constipation / Diabetes / Coeliac Disease / Asthma / Eczema / Nephrotic syndrome
Acutely mild-to-moderately unwell child	• eg: Upper respiratory tract infection / Viral croup / Otitis media / Tonsillitis / Uncomplicated pneumonia
Acutely severely unwell child	• eg: Trauma / Head injury / Surgical emergency / Meningitis / Sepsis / Drug overdose

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Case Study: Planning for Integration in North West London Integrated Care system – Driver Diagram

GP Child Health Hubs in north-west London

Integrated child health model of care

- Each hub is typically 1 PCN
- Serving a population of 30,000 – 50,000
- Running a clinic & MDT meeting once per month

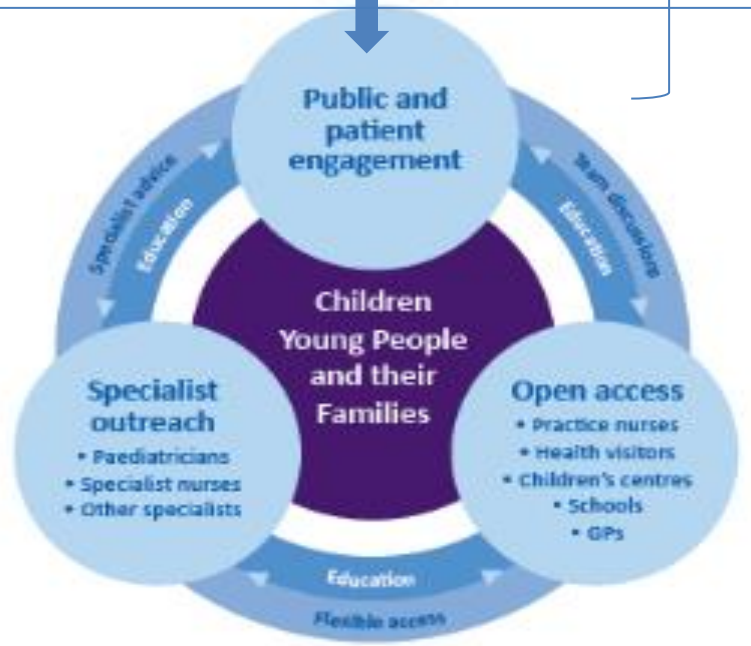
Tertiary Care Sub-specialty Paediatrics

Secondary Care General Paediatrics

Horizontal integration *across multiple agencies*

Vertical integration *between GPs and paediatric services*

Health Visitors
School Nurses
Dieticians
Community Nurses
Practice Nurses



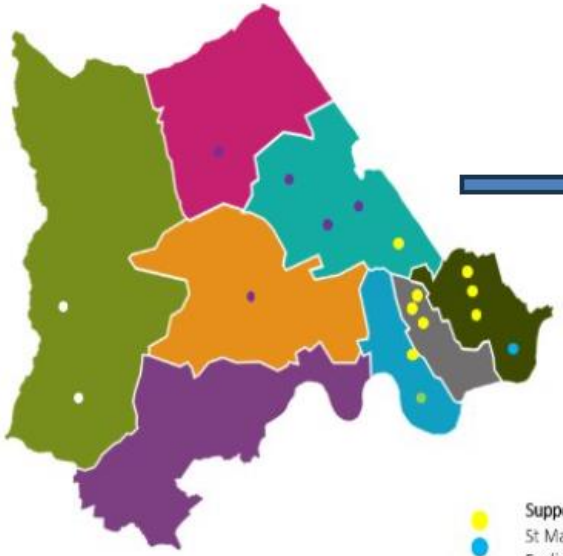
CAMHS
Voluntary sector
Schools
Social Care
Children's Centres

connecting care for children

Scaling up Child Health Hubs - Children's Collaborative

North West London
Child Health Hubs **2019:**

North West London
Child Health Hubs **2024:**

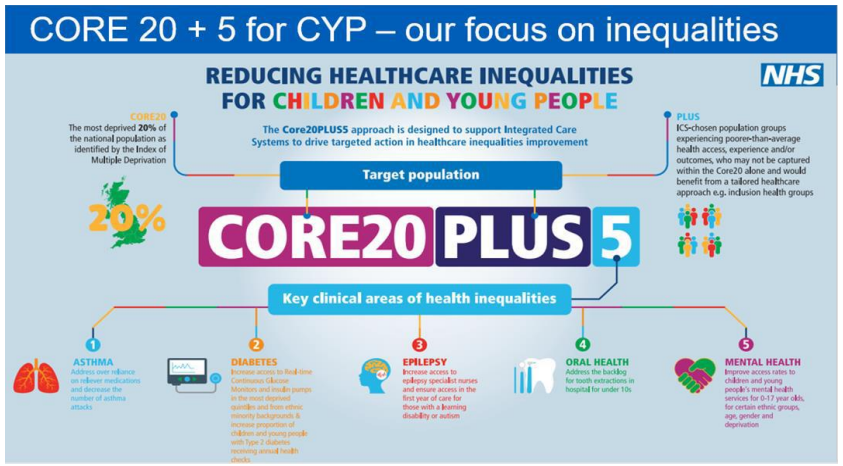


Plan for 45

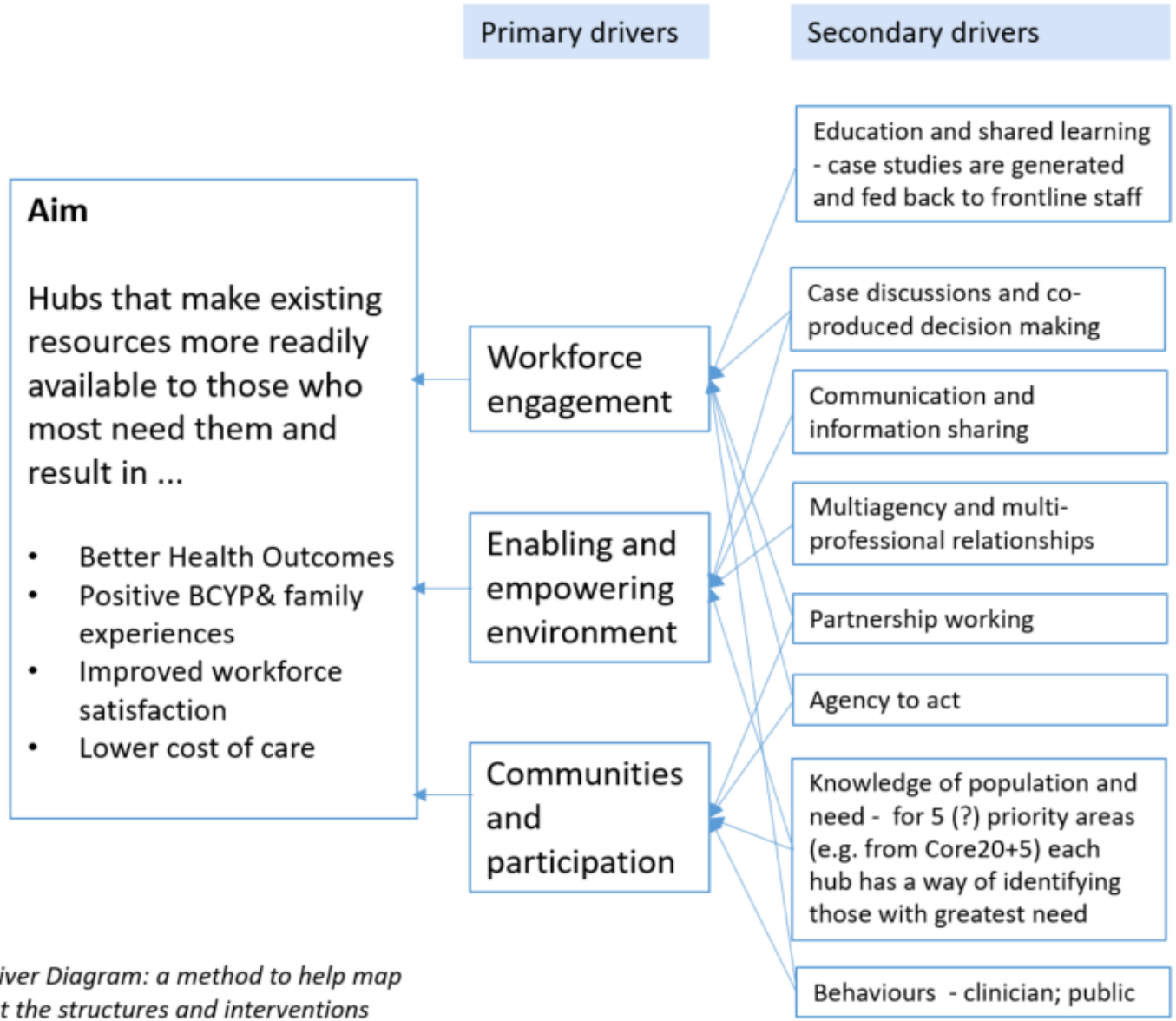
Supported by
St Mary's Hospital
Evelina Children's Hospital
Hillingdon Hospital
Northwick Park Hospital
Chelsea & Westminster Hospital

Business case approved **to expand from 17 to 45 Child Health Hubs** – ambition is for one for each PCN (initially).
Child Health Hubs will have more resource and ability to focus on locally-defined areas of need

Child Health Hubs planned to be one of the key ways for NHS NWL to deliver against the **CORE 20 PLUS 5** methodology for CYP through the IHI Quality Improvement work



NWL ICS will establish Child Health Hubs and support the implementation Family (Health) Hubs.
These will deliver Integrated Neighbourhood teams. The Hubs make existing resources more readily available to those who most need them
NWL will have 1. CHHs in all areas by March 2025 2. Early Years model prototype established in 3 sites by March 2025



Driver Diagram: a method to help map out the structures and interventions that we believe will deliver the aims – it is organic and evolving

Activities

As part of the Child Health Hub programme

- Develop shared understanding of what makes the Hubs fly (and what gets in the way), using stories, analysis and tools for sharing + creation of an accreditation tool
- Developing pop health mx and coordination resource in each Hub
- Asthma, develop early intervention through the GP practice
- Adapt electronic records (S1 and EMIS) in the GP practice that support child health
- Develop the electronic referral system (REGO) to nudge towards Hub pathways

Both

- Teach qualitative evaluation & co-production & reverse mentoring methodologies to borough based child health leads, using Hub/early years programmes for context
- Mental Health; reducing its separation from physical health
- Pop health case finding (inc WSIC); securing high-quality methods for identifying needs, including the development of PCN CYP data packs
- Working with IHI; using QI methodology and London-wide interventions to facilitate change
- Working with ICS INTs; using ICS-wide interventions to facilitate change
- What more can we do together; developing and implementation the 'bridge' between Child Health (GP) Hubs and Family Hubs
- Personalised Health Budgets; designing and implementing the effective use of small grants to support individual cases

As part of the Early Years (Who are the babies) programme

- Establish a hyper local preventative team with a major focus on optimising the health and well-being of parents and infants

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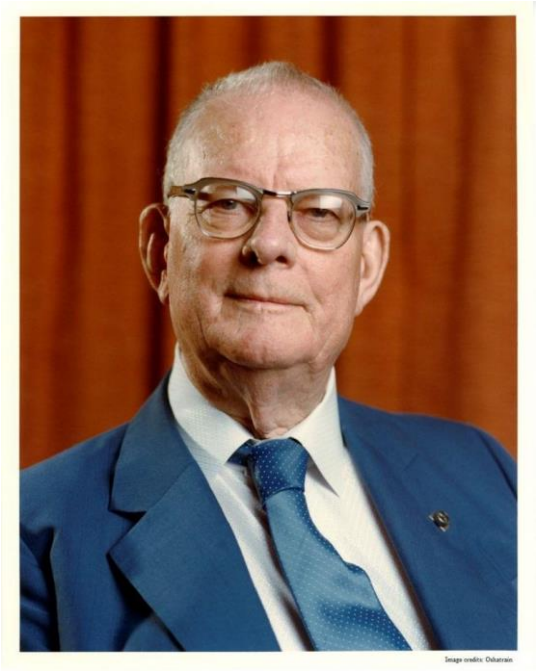
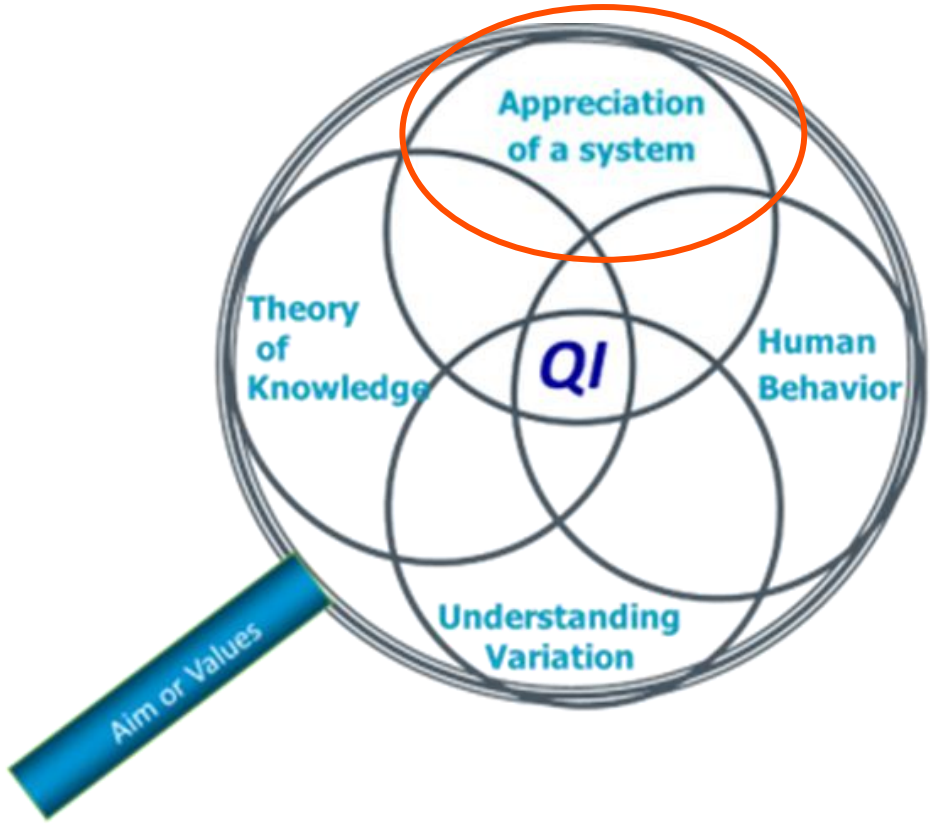
Developing a Driver Diagram

The lens of profound knowledge



W Edwards Deming



Every system is perfectly designed to get the results it gets

- By examining the drivers within the system, we can see the structures, processes and norms that make it what it is.
- We can also do this for the change we want to see, understanding the system and the processes that drive the outcomes we want.
    - What is the need we are trying to address?
    - What do we need to influence?
    - How do we need to influence?
- Chain of causality

We start with an aim

What

How much

By when

Aim

To run the Edinburgh Marathon in <4h on 26 May 2024

Primary Drivers

- Training
- Healthy Weight
- Motivation

Secondary Drivers

- Conforming to a training plan
- Increasing weekly mileage
- Physical fitness
- Calories in/out
- Nutrition balance
- Reduced alcohol intake
- Feeling good about running
- Confidence

Measures

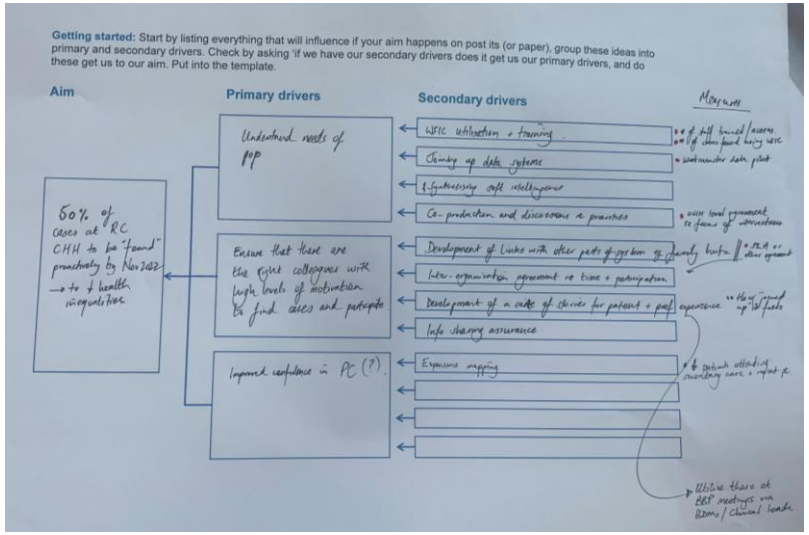
- Days in a row I stuck to the plan
- Km per week
- Speed/Heart rate zone
- MyFitnessPal
- Weekly weigh-in
- Drinks p/w
- Journaling

Change ideas

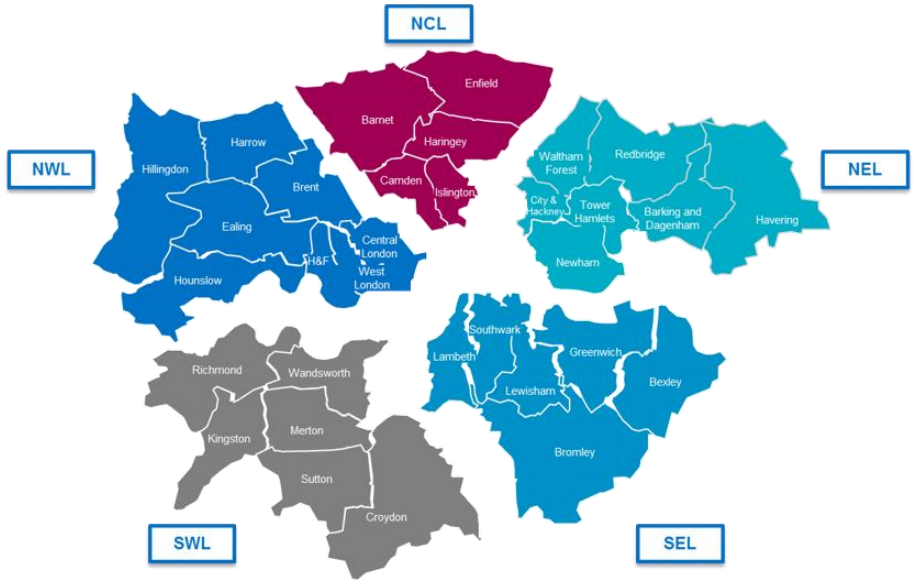
- Early morning training
- High Protein breakfast
- Step counter with goals
- No beer on a school night
- Running with friends
- Motivational music

Mapping your improvement

- Embedding equity drivers from the start
- Refer back to it
- Use it to plan your testing and review your measurement
- How do the drivers interact? Make it a living document



Summary



Driver diagrams help us to:

- Understand and appreciate the system
- Organise our improvement work
- Visualise complex connexions
- Refine our theory of change
- Understand why a change is happening

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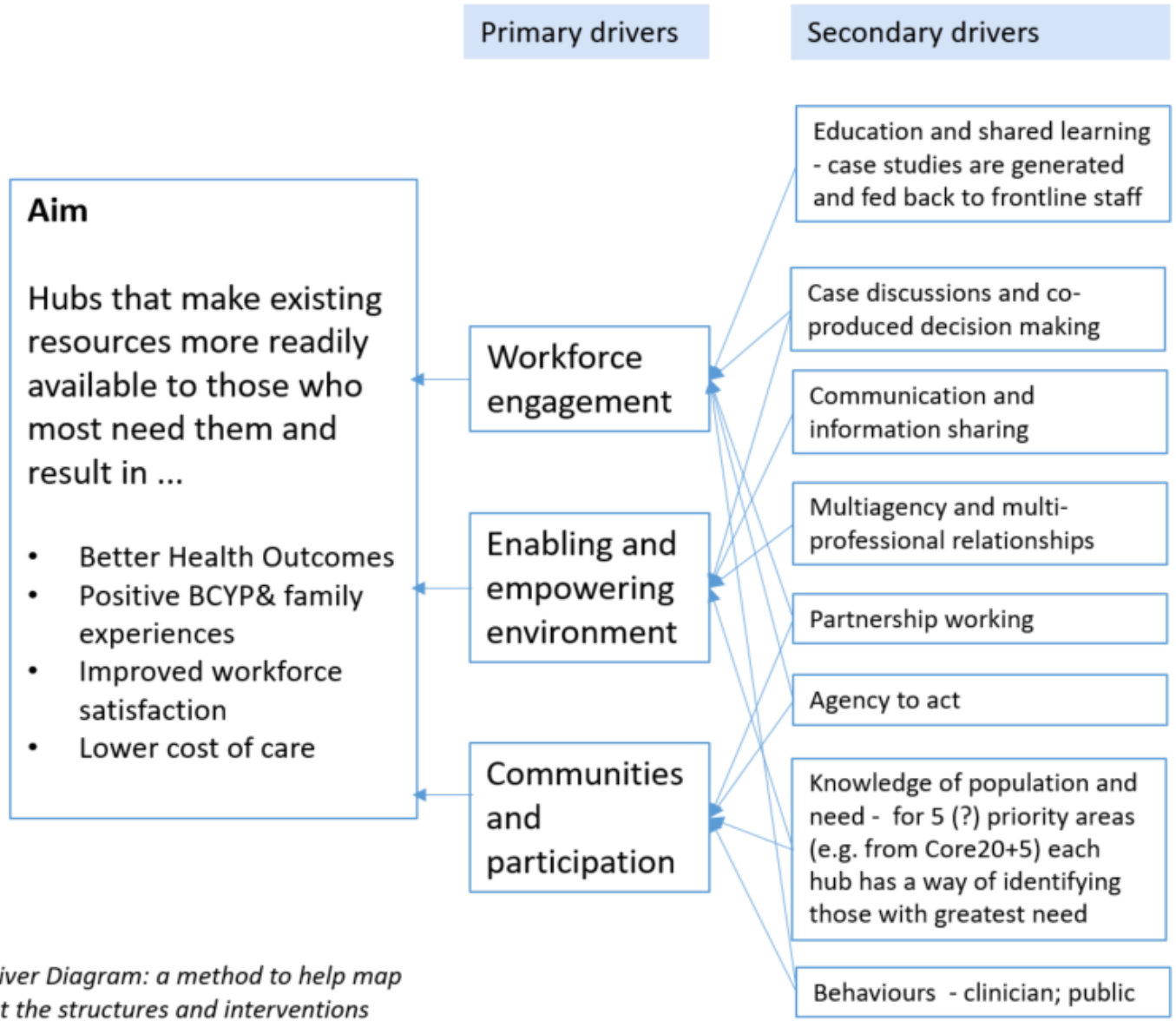

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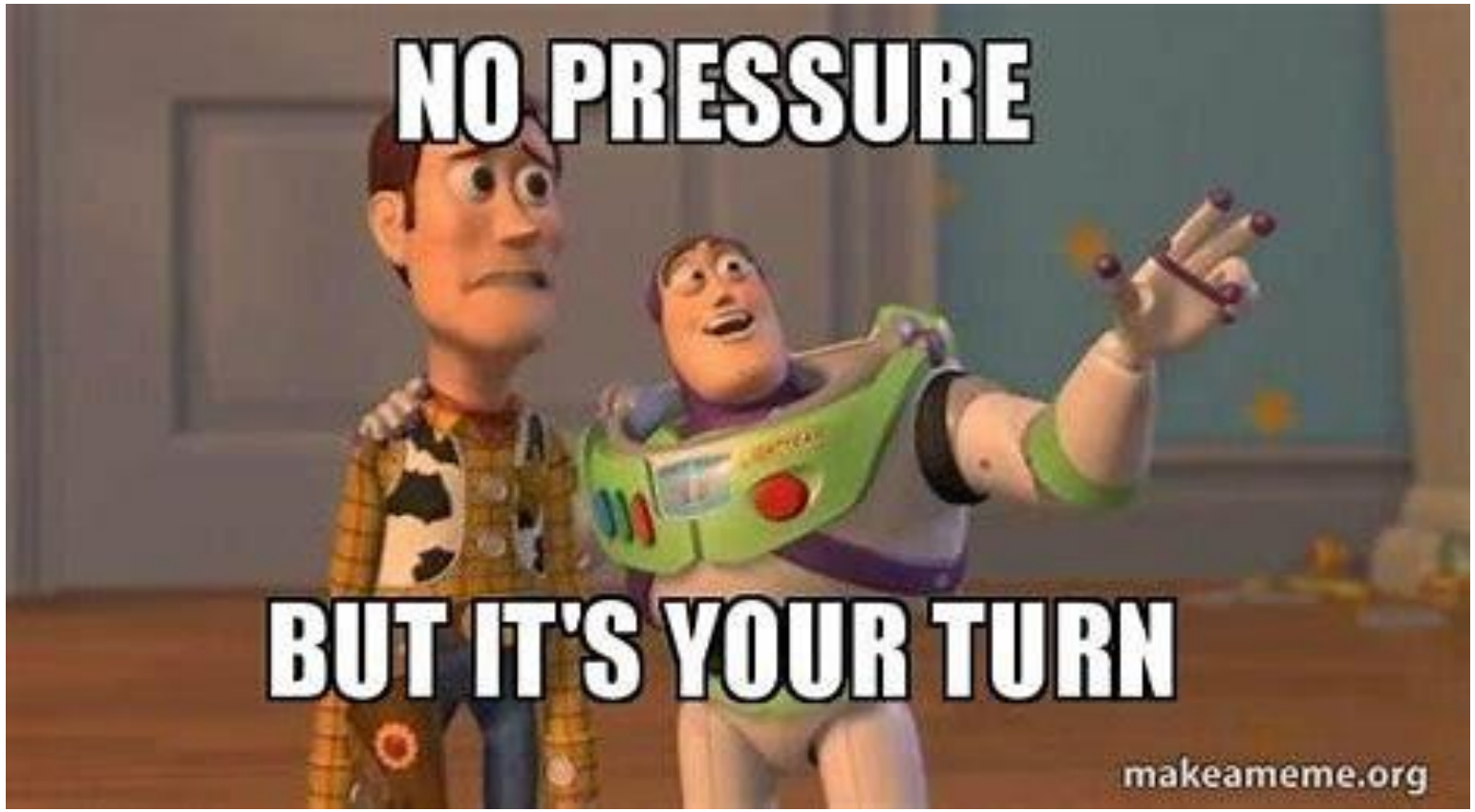
Now its your turn!



Activity: Develop a Driver Diagram

Scenario : Your aim is to reduce your expenditure on fuel for your car by £40.00 per month within the next 6 months

Task : Take the next 15 minutes to draw out your driver diagram setting out the following:

- Primary Drivers
- Secondary Drivers
- Change Concepts (or Actions)
- Measures

We will discuss your experience of developing your own Driver Diagram

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Summary

Key take aways

- Learnt that the DD can be applied to different scenarios – examples which have been shared
- Driver Diagram is a tool that helps to breakdown an overall aim into actionable projects that will help to achieve the goal.
- Equity Projects are well suited to DD's as the full extent of the project and its relationships can be seen in one place
- DD's can sometimes be confusing left to right or right to left and what makes sense to do first
- Don't forget… the Driver Diagram is the first step it is a plan and an approach… it helps to get started and the testing can start from then

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NHS RACE & HEALTH OBSERVATORY

Centering Equity in Data: Race and Health Observatory Learning and Action Network

Nandi Simpson, Director of Implementation NHS Race and Health Observatory
Corinna Parisi, Senior Project Manager, Institute for Healthcare Improvement
Minara Chowdhury, Senior Director, Institute for Healthcare Improvement

Setting the Scene: NHS Race and Health Observatory

NHS RACE & HEALTH OBSERVATORY

ETHNIC HEALTH INEQUALITIES IN THE UK

BLACK WOMEN ARE **4x** MORE LIKELY THAN WHITE

women to DIE in PREGNANCY or childbirth in the UK.

Ref: https://bit.ly/3ihDwcN

24% OF ALL DEATHS IN ENGLAND & WALES, IN 2019,

were caused by CARDIO VASCULAR DISEASE in Black and minority ethnic groups.

Ref: https://bit.ly/3CYz22P

BLACK AND MINORITY ETHNIC PEOPLE HAVE UP TO **2x**

the mortality risk from COVID-19 than people from a WHITE BRITISH BACKGROUND.

Ref: https://bit.ly/3EZS2Qd

BLACK AFRICAN AND BLACK CARIBBEAN PEOPLE ARE OVER **8x**

more likely to be subjected to COMMUNITY TREATMENT ORDERS than White people.

Ref: https://bit.ly/3zK5IjL

IN BRITAIN, SOUTH ASIANS HAVE A **40%** HIGHER DEATH RATE

from CHD than the general population.

Ref: https://bit.ly/3iifo9V

SOUTH ASIAN & BLACK PEOPLE ARE **2-4x** MORE LIKELY TO DEVELOP

Type 2 diabetes than white people.

Ref: https://bit.ly/3ulDy88

ESTIMATES OF DISABILITY-FREE LIFE EXPECTANCY ARE

10 YEARS

LOWER FOR BANGLADESHI MEN living in England compared to their White British counterparts.

Ref: https://bit.ly/3urjmIt

CONSENT RATES FOR ORGAN DONATION ARE AT **42%**

for Black and minority ethnic communities and 71% FOR WHITE ELIGIBLE DONORS.

Ref: https://bit.ly/3ogH3fm

ACROSS THE COUNTRY, FEWER THAN **5%** OF BLOOD DONORS

are from BLACK AND MINORITY ETHNIC communities.

Ref: https://bit.ly/3ulg17r

IN THE UK, AFRICAN-CARIBBEAN MEN ARE UP TO **3x**

more likely to DEVELOP PROSTATE CANCER than white men of the same age.

Ref: https://bit.ly/39KWqEs

NHS RACE & HEALTH OBSERVATORY

NHS RHO: focus on the impact of racism on health


Jackass's Johnny Knoxville 'I've almost died a few times now'

How to put the fizz back into your relationship

The Guardian

For 200 years

News provider of the year

Damning race report reveals vast inequalities across health service

Exclusive Call for radical action after review finds gross failings in the NHS

Andrew Gregory
Health editor

'Inequalities are evident at every stage from birth to death'

The findings in the 166-page NHS race and health review

- Evidence of the damaging role of racism in health and healthcare inequalities
- Barriers to seeking help for mental health problems rooted in distrust & fear
- People from ethnic minority backgrounds not well represented in large GWAS
- Ethnic minority staff in the NHS endure racist abuse from staff and patients
- Stereotyping, disrespect, discrimination and cultural insensitivity in maternity

NHS RACE & HEALTH OBSERVATORY
Breaking barriers for better health

NHS RHO: from knowledge to action

1 **EVIDENCE –** We produce evidence about racial and ethnic inequality in health;

- commissioning original research to fill knowledge gaps
- synthesising and mobilising existing evidence

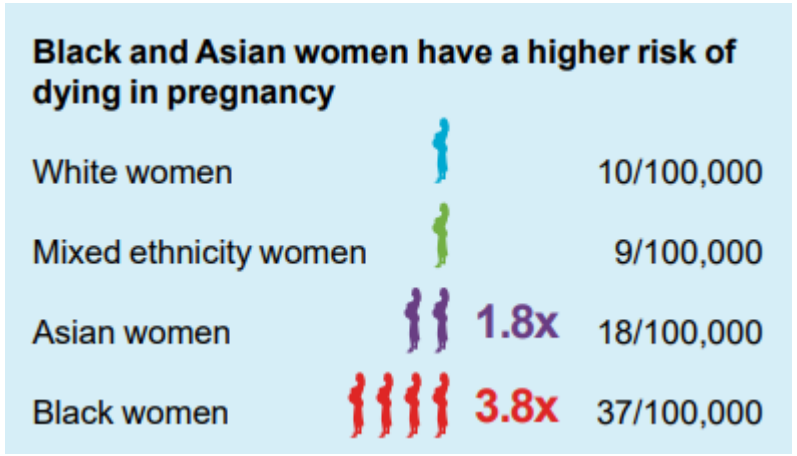
2 **INFLUENCE**- We use the evidence we commission and mobilise to

- influence leaders through practical recommendations for policy and practice

3 **IMPLEMENT**- On the basis of our recommendations, and in response to the needs of the communities we work with, we work to support the implementation of new policies and practice at the grassroots

NHS RACE & HEALTH OBSERVATORY
Breaking barriers for better health

Health inequalities for women and babies from Black, Asian and minority ethnic backgrounds persist




JAMA Network Open

Original Investigation | Pediatrics

Race and Ethnicity, Deprivation, and Infant Mortality in England, 2019-2022

David E. Odd, MD; Sylvia Stoianova, MSc; Tom Williams, BSc; Dawn Odd, MSc; Ngozi Edi-osagie, MBBS; Charlotte McClymont, MSc; Peter Fleming, PhD; Karen Luyt, PhD

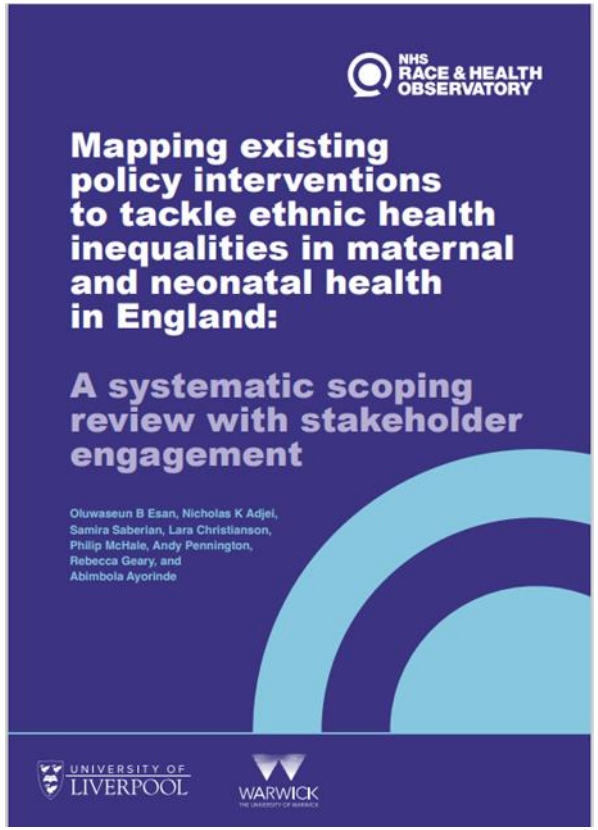
- Risk of death 12% higher for non-White children in England
- Almost half of the additional risk for non-White infants was found to be due to preterm birth, which is much more common in families of Asian or Black ethnicity.

NHS RACE & HEALTH OBSERVATORY
Breaking barriers for better health

MBRRACE-UK Saving Lives Improving Mothers' Care - Lessons learned to inform maternity care from the UK and Ireland

Confidential Enquiries into Maternal Deaths and Morbidity 2019-21

RHO review of interventions to reduce maternal and neonatal ethnic health inequalities



- Commissioned by NHS RHO in 2022
- Aim: to map existing policy interventions designed to tackle ethnic health inequalities in England

- Systematic scoping review of literature
- Call for evidence
- Stakeholder engagement: experts by education & experience

NHS RACE & HEALTH OBSERVATORY
Breaking barriers for better health

RHO review highlighted paucity of interventions targeting ethnic health inequalities

- Very few interventions set out explicitly to improve health outcomes for Black, Asian and minority ethnic pregnant women and people and their babies
- Limited effectiveness of specific interventions aimed at reducing ethnic inequalities in maternal and neonatal health outcomes
- None of the studies included baseline measurements of ethnic health inequalities

Interventions at the organizational level targeting structural and institutional processes which perpetuate racism and ethnic health inequalities are lacking

RHO/IHI Learning & Action Network

Aim: To reduce clinically avoidable severe maternal morbidity, perinatal mortality and neonatal morbidity while improving experience of care of pregnant women and people from Black, Asian and minority ethnic groups

What

Racism is one of the factors that underlies the persistence of the maternal & neonatal ethnic health inequalities

Why?

No large scale maternal and neonatal improvement programme has focused specifically on ethnic inequalities and there are evidence gaps around translatable interventions to reduce maternal and neonatal ethnic health inequalities

How?

We aim, through this programme, to:

1. **develop an anti-racism focused QI model**, that supports practitioners to identify and address racism within maternity services;
2. **Identify, scale and spread improvement approaches that embed anti-racism into services and improve maternal and neonatal health outcomes**

We will evaluate the RHO/IHI LAN to **understand factors influencing effectiveness and scalability of the anti-racism QI model for maternity and neonatal** services.

NHS RACE & HEALTH OBSERVATORY
Breaking barriers for better health

RHO anti-racism principles

1. **Name racism**
2. **Establish a mutually accepted model of racism and health**

Acknowledge racism exists
Understand how it operates
Commit to addressing it

3. **Involve racially minoritised individuals in every stage of development**
   — Pay attention to whose voices are heard
4. **Collect and publish data**
   — Use data stratified by ethnicity, develop approaches to enable this where gaps exist
5. **Identify racist bias**
   — Consider who is disadvantaged/ favoured by policies and decision-making
6. **Follow the thread of racism**
   — Recognise the levels racism operates at
7. **Apply a race-critical lens to the adoption of interventions to be tested**
   — Involve minoritised people, focus on equity
8. **Evaluate**
   — Recognise racism as a determinant of health

NHS RACE & HEALTH OBSERVATORY
Breaking barriers for better health

Centering Equity in Data

NHS RACE & HEALTH OBSERVATORY

Purpose of measurement for improvement

- Understand the current state of the problem and aim which we would to achieve
- Help teams to make decisions
- See whether changes are leading to improvement

Top Tips

- Collect just enough and good enough data
- Look at data each time you meet as a team
- Stop collecting when data is no longer being used

Understanding Needs and Assets through Three Lenses

Needs and Assets

Quantitative Data

Care Providers in Health System / Service Providers in Community

Individuals / Clients / Patients

Why engage in a deep dive of this nature?

- Advancing population health and equity while dismantling racism and other systems of oppression **requires deeply understanding the experiences and realities of those in a specific population of focus**
- Allows you to draw on **asset-based inquiry (rather than deficit-based thinking)**, to surface not only “needs” and/or “opportunities” but, importantly, to **understand the ways in which systems have discarded or undervalued the assets of individuals and communities**
- Ensures that **all can contribute to dismantling inequities and advancing population health and well-being**

3-Part Data Review

1. Review available data on your chosen sub-population

2. Interview 2-5 care teams/professionals providing care and external collaborators/partners/service agencies supporting the population

3. Interview 5-10 individuals/clients/patients in your chosen sub-population

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Data Review: How-to

Review available data from IT systems

- Claims/utilization data from payer or your own system encounter information from inpatient, emergency room, and/or primary and specialty care systems
- Primary care electronic health record notes to include problem list, diagnosis codes, care plan, After Visit Summaries
- Demographics

Or, if you already have identified your focus population

- Identify ten people in the focus population and review their data as suggested above

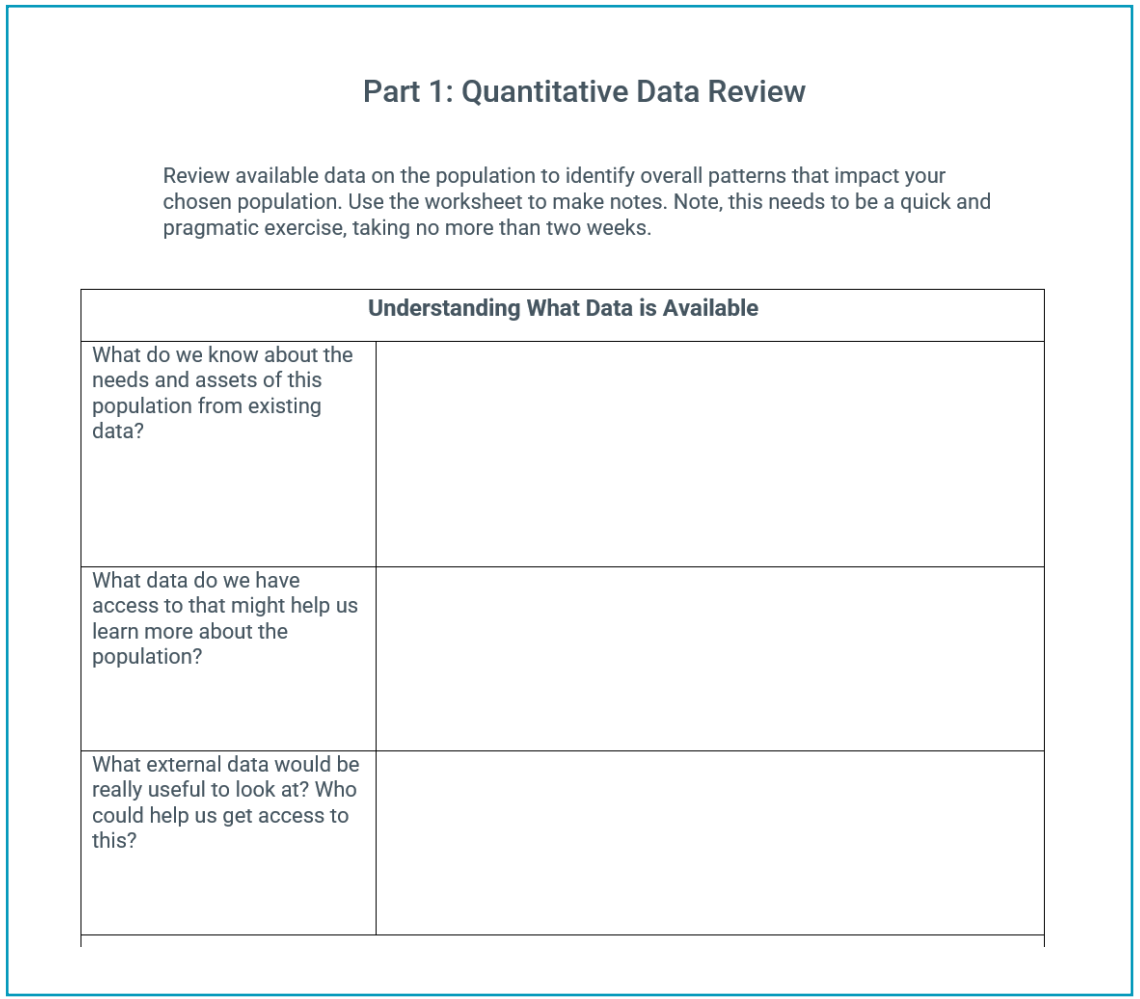
Data Review: Dive Deeper - Segmenting for Equity

Level One: Data Analysis

- Stratify by protected characteristics (age, disability, gender reassignment, marriage or civil partnership, pregnancy and maternity, race, religion or belief, sex) and equity elements you are focused on (e.g. social isolation, food insecurity) – take an intersectional approach
- Provide staff with training and support on obtaining the data
- Articulate the reasons for stratifying the data
- Characterize any missing data
- Assess the accuracy of the data
- Determine how to display stratified data
- Ensure utilization of stratified data

Level Two: How are you choosing your measures?

3 Part Data Review Guide



Part 1: Quantitative Data Review

Review available data on the population to identify overall patterns that impact your chosen population. Use the worksheet to make notes. Note, this needs to be a quick and pragmatic exercise, taking no more than two weeks.

Understanding What Data is Available	
What do we know about the needs and assets of this population from existing data?	
What data do we have access to that might help us learn more about the population?	
What external data would be really useful to look at? Who could help us get access to this?	

- Understanding what data is available
- Distilling learning: what surprised you? What new questions do you have?

3-Part Data Review

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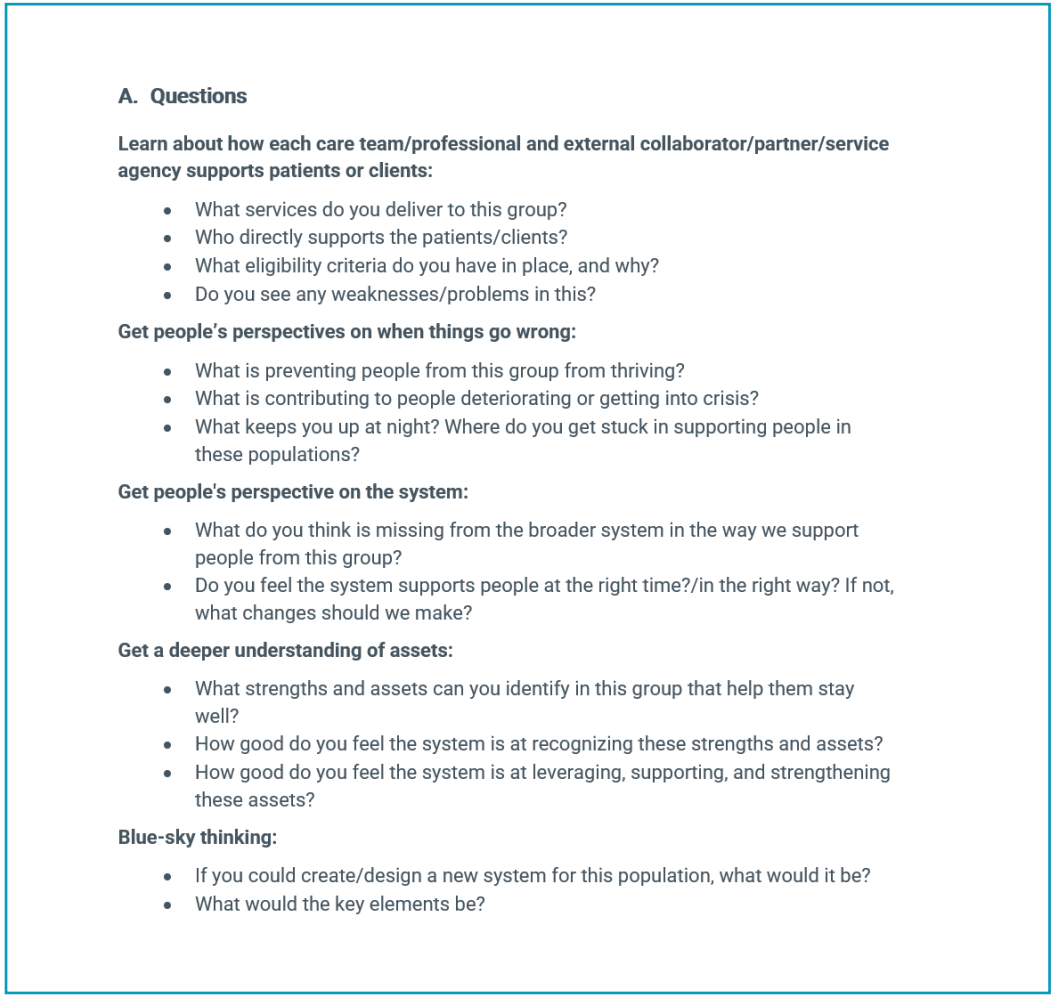
Interviewing Providers:
Care Providers in Health System & Service Providers in Community

At the level of sub-populations:

- What strengths and assets can you identify in this group that the system currently does or can better leverage, support, and strengthen?
- What systems are preventing people in this group from thriving? Are there differences such that some people are more affected than others in disparate or inequitable ways?



A. Questions

Learn about how each care team/professional and external collaborator/partner/service agency supports patients or clients:

- What services do you deliver to this group?
- Who directly supports the patients/clients?
- What eligibility criteria do you have in place, and why?
- Do you see any weaknesses/problems in this?

Get people's perspectives on when things go wrong:

- What is preventing people from this group from thriving?
- What is contributing to people deteriorating or getting into crisis?
- What keeps you up at night? Where do you get stuck in supporting people in these populations?

Get people's perspective on the system:

- What do you think is missing from the broader system in the way we support people from this group?
- Do you feel the system supports people at the right time?/in the right way? If not, what changes should we make?

Get a deeper understanding of assets:

- What strengths and assets can you identify in this group that help them stay well?
- How good do you feel the system is at recognizing these strengths and assets?
- How good do you feel the system is at leveraging, supporting, and strengthening these assets?

Blue-sky thinking:

- If you could create/design a new system for this population, what would it be?
- What would the key elements be?

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3. Interview 5-10 individuals/clients/patients in your chosen sub-population

Understanding Needs and Assets: Engaging Individuals / Clients in Chosen Sub-Population

Deep listening with 5-10 Individuals

1. Identify 5-10 individuals / clients in your chosen population
2. Use a semi-structured set of questions to gain insight into individual perspectives

Review your findings

3. Identify similarities, differences, and common themes
4. Come together as a team to discuss what was learned
5. Consider what you have learned as you begin to choose projects and investments to work on

Afternoon Tea Break

Please be back here at 3:15!

Activity: 3-Part Data Review: Your Turn

NHS RACE & HEALTH OBSERVATORY

Review the 3PDR Section 3 at your tables. How would you interview a service user?

Summary

Data for Improvement to reduce inequities

- Without data how can we see how we are reducing the equity gap?
- Without data will people believe us ?
- Without data can we assure ourselves that we have achieved what we set out to do?
- Is the quantitative data enough ?

Moving beyond the Quantitative

- We all recognize that the voice of the service user is critical to what we do and how we provide those services especially for those that need the services the most and we are reducing inequities
- Involving people with lived experience from diverse backgrounds in the improvement process will help us to understand what matters most.
- Seeking these inputs upfront when we are planning and designing our interventions will inform the process
- The 3-part data brings together the quantitative aspect, the staff perspectives and the service users' thoughts
- A different way to collect a baseline to reduce inequities

Institute for Healthcare Improvement

Coaching for Improvement: Core20PlUS5 Accelerators

Minara Chowdhury (IHI), Shubhi Tandon (IHI), Auzewell Chitewe (IHI), Aoife Molloy (NHSE)

Agenda

- Introduction and Overview of Core20PLUS5
- Deep dive into the role of coaching in delivering good results in equity work
- Do’s and Don’t’s of Coaching – What makes a good coach?
- Activity: Coaching for equity role play scenarios
- Reflection and Close

CORE20PLUS5

NHS England

Dr Aoife Molloy

Senior Clinical Advisor, National Healthcare Inequalities Improvement Programme

Vision

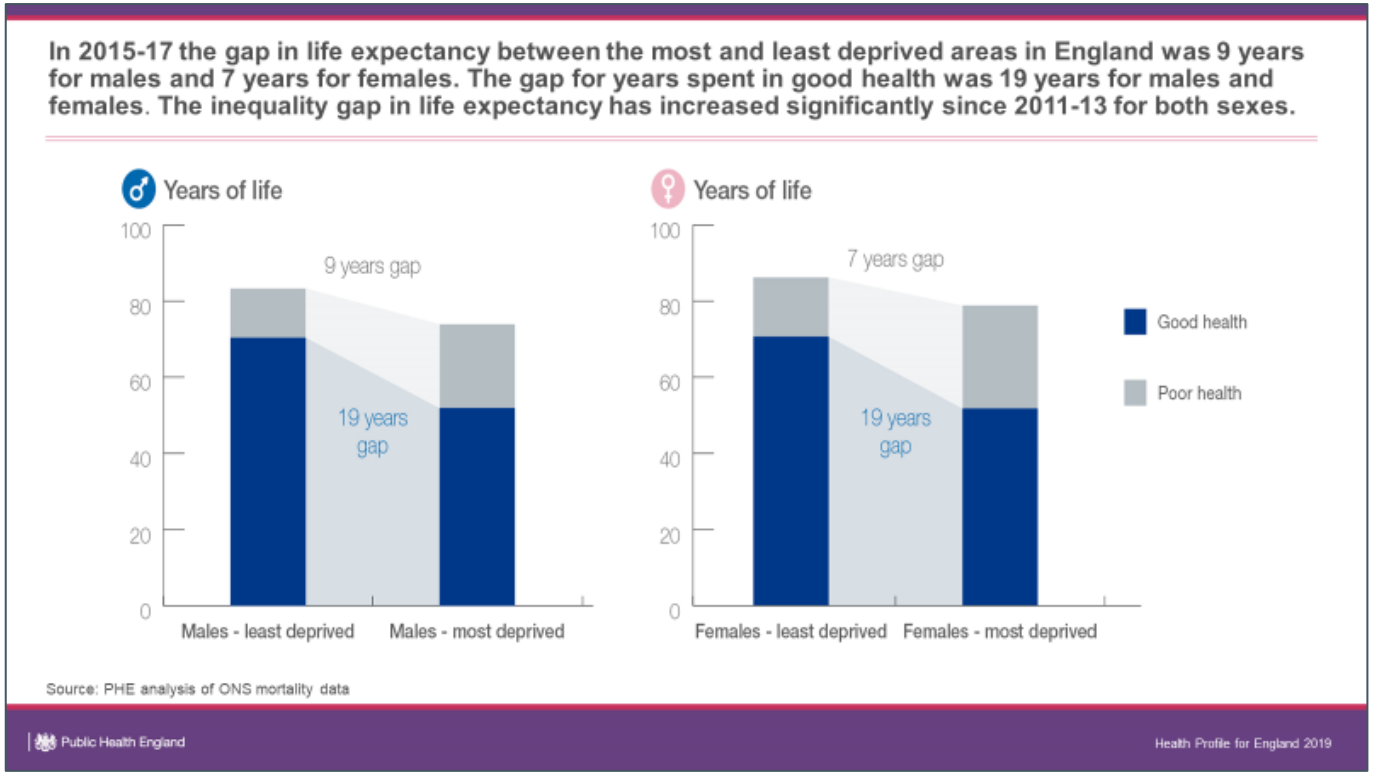
Exceptional quality healthcare for all through **equitable access, excellent experience** and **optimal outcomes**

The people cost of healthcare inequalities…

…the pandemic has exacerbated inequalities

Disproportionate deaths from COVID-19 between those living in the most deprived areas and those living in the least deprived areas.

People in more **deprived areas spend more of their shorter lives in ill health** than those in the least deprived areas.



For **women in the most deprived areas** of England, **life expectancy fell** between 2010 and 2019

In the areas of England with the lowest healthy life expectancy, **more than a third of 25 to 64 year olds are economically inactive due to long-term sickness or disability**

Recurrent **hospital admissions** (for acute exacerbations of chronic respiratory disease) are more prevalent in more deprived neighbourhoods.

Social isolation and loneliness are associated with a **30% increased risk of heart disease and stroke**

Economic disadvantage is strongly associated with the prevalence of **smoking, obesity, diabetes, hypertension**

Living in **poverty** in early childhood can have **damaging consequences for long-term health**

A Business Case for tackling Healthcare Inequalities

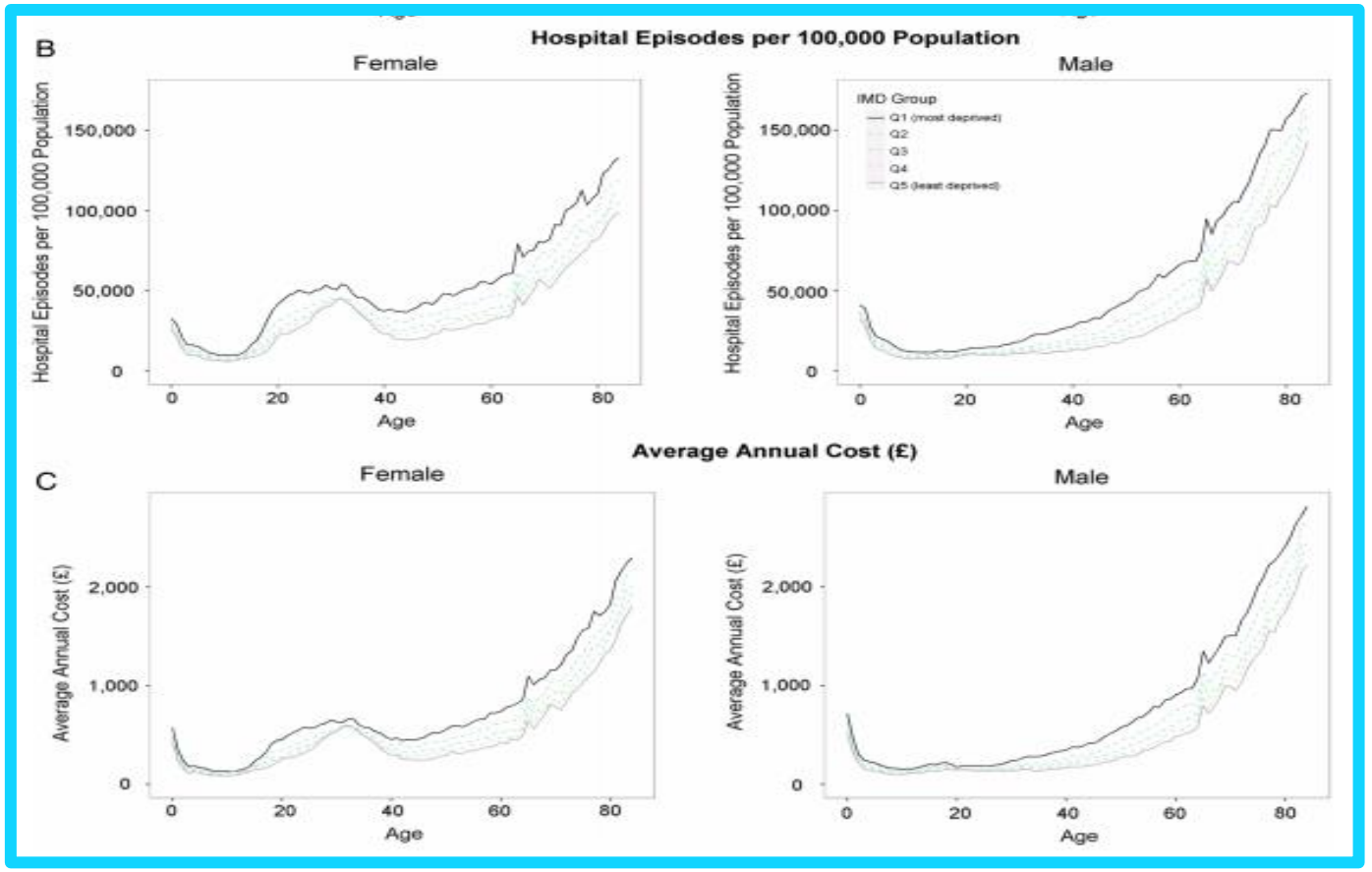
Increased NHS treatment costs
- **> £5 billion**

Losses from illness associated with health inequalities

Productivity losses
- **£31 billion - £33 billion**

Reduced tax revenue and higher welfare payments
- **£20-£32 billion**

People from the most deprived areas have a lower life expectancy compared to those in more affluent areas, yet the per capita cost of healthcare due to emergency admissions, LTCs, prolonged LOS & spend on healthcare is higher for those from more deprived areas



Fair Society, Healthy Lives The Marmot Review of Health inequalities in England post 2010 - PowerPoint PPT Presentation
https://www.slideserve.com/daniel_millan/fair-society

REDUCING HEALTHCARE INEQUALITIES

The **Core20PLUS5** approach is designed to support Integrated Care Systems to drive targeted action in healthcare inequalities improvement

Target population

CORE20
The most deprived **20%** of the national population as identified by the Index of Multiple Deprivation

PLUS
ICS-chosen population groups experiencing poorer-than-average health access, experience and/or outcomes, who may not be captured within the Core20 alone and would benefit from a tailored healthcare approach e.g. inclusion health groups

CORE20PLUS5

Key clinical areas of health inequalities

1. **MATERNITY**
ensuring continuity of care for **75%** of women from BAME communities and from the most deprived groups

2. **SEVERE MENTAL ILLNESS (SMI)**
ensuring annual health checks for **60%** of those living with SMI (bringing SMI in line with the success seen in Learning Disabilities)

3. **CHRONIC RESPIRATORY DISEASE**
a clear focus on Chronic Obstructive Pulmonary Disease (COPD), driving up uptake of Covid, Flu and Pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations

4. **EARLY CANCER DIAGNOSIS**
75% of cases diagnosed at stage 1 or 2 by 2028

5. **HYPERTENSION CASE-FINDING**
and optimal management and lipid optimal management

SMOKING CESSATION
positively impacts all 5 key clinical areas

REDUCING HEALTHCARE INEQUALITIES FOR CHILDREN AND YOUNG PEOPLE

NHS

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Key clinical areas of health inequalities

1. **ASTHMA**
   Address over reliance on reliever medications and decrease the number of asthma attacks

2. **DIABETES**
   Increase access to Real-time Continuous Glucose Monitors and insulin pumps in the most deprived quintiles and from ethnic minority backgrounds & increase proportion of children and young people with Type 2 diabetes receiving annual health checks

3. **EPILEPSY**
   Increase access to epilepsy specialist nurses and ensure access in the first year of care for those with a learning disability or autism

4. **ORAL HEALTH**
   Address the backlog for tooth extractions in hospital for under 10s

5. **MENTAL HEALTH**
   Improve access rates to children and young people's mental health services for 0-17 year olds, for certain ethnic groups, age, gender and deprivation

Learning from the Core20PLUS Accelerator sites

CORE20PLUS5

NHS England architecture to support delivery of **Core20PLUS5**; NHS England's approach to reducing healthcare inequalities

CORE20PLUS CONNECTORS

Connectors are those with influence in their community who can help engage local people with health services.

CORE20PLUS INNOVATION

Projects to improve access to innovative health technologies and medicines are being run with local communities. This work aims to identify, address and minimise healthcare inequalities for Core20PLUS groups through schemes such as the Innovation for Healthcare Inequalities Programme (InHIP).

CORE20PLUS COLLABORATIVE

The collaborative brings together strategic partners and experts working to reduce and prevent healthcare inequalities. Members are drawn from NHS England's key stakeholders, the wider NHS and strategic system partners including arms length bodies, think tanks, charities and academic partners.

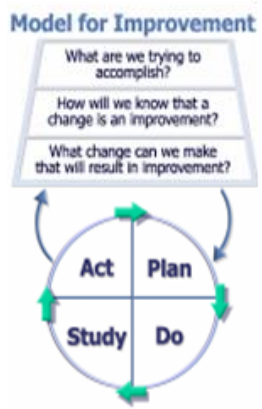
CORE20PLUS ACCELERATORS

Accelerator sites help to develop and share good healthcare inequalities improvement practice across integrated care systems (ICSs)

CORE20PLUS AMBASSADORS

The ambassadors are people working within the NHS who are committed to narrowing healthcare inequalities and ensuring equitable access, excellent experience, and optimal outcomes for all – particularly Core20PLUS populations who are more likely to experience healthcare inequalities.

CORE20 PLUS 5 Accelerator Sites Learning Journey



Pre work and getting started

7 Teams recruited from selected Accelerator Sites

Progress & Learning Shared Nationally

Learning Event 1
In Person
(1.5 days)
Feb 23

AP1

Learning Event 2
In person
(1.5 days)
Jun 23

AP2

Learning Event 3
In person
(1.5 days)
Oct 23

AP3

Celebrate progress, capture learning & evidence
Disseminate to wider stakeholders

Virtual Sessions
(monthly)

Leadership engagement as sponsors and to support teams and coaches during and between events

Project Support

Monthly virtual project & local project coaching
Progress summaries & improvement stories
Shared learning across ICS boundaries

AP = Action Period

NHS England

Content Theory
Draft

Co-producing High Quality Healthcare with individuals in Core20 and PLUS populations as measured by improvement in:

- The Core20PLUS5 Key Clinical Areas

Identification and Access
Identification of and access for individuals in the Core20 and PLUS populations

- Neighborhoods incorporated in care model
- Mechanisms to identify these populations
- Mechanisms to raise awareness for populations to access care
- No wrong entry: opportunities for multiple access points

Positive Interactions
Once engaged with NHS services the interactions are positive and user friendly

- Cultural competency; Language services
- Ease of navigation
- Location and geography: can get to the services needed
- Links made to others who can address current (non-healthcare needs)

Healthcare Delivery
Providers know how to and have time/space to facilitate access and deliver care with the individual

- Clear materials and training on clinical interventions
- Linkages: Know when someone has been signposted
- Information is able to be shared
- Data: how are we doing in our practice
- Staffing to deliver the care
- Navigation tools
- Know what to do: overlap of services (linking opportunities)

Service User Partnership
Service users are active, receptive to and ready for healthcare delivery and co-production

- Social Marketing - Why does this matter?
- Literacy level: 10-12 years old; multiple languages and mediums
- Location of materials for learning; multiple learning modalities
- Finding trusted individuals to share knowledge
- Affirmation that it is safe to engage with the NHS
- All Core20PLUS components

Learning Framework
Ability to lead, learn, and improve

- Data, coding: need to process & outcome measures
- Learning Opportunities: shared successes & challenges
- Separation of Innovation and Improvement
- Ability to intentionally spread successes
- Leadership commitment at all levels
- Collaboration: Working across groups

NHS England

Themes, Aims and Objectives

Cornwall	Early **cancer diagnosis rates** across the GRT community in Cornwall
Humber and North Yorkshire	Develop an **assessment, planning and care coordinated model, for integrated neighbourhood teams**, supported by a practice culture that is teamwork oriented and person centered
Mid and South Essex	Increase **life expectancy for people with Severe Mental Illness (SMI)** in mid and south Essex
North Central London	To help improve **early diagnosis of lung cancer** by identifying key insights into the reasons for low uptake of the Targeted Lung Health Checks (TLHC) programme amongst deprived communities in Enfield
Surrey Heartlands	**Increase cancer screening uptake and coverage for those with learning disabilities (LD)**. Test within the cervical screening programme in the Guildford and Waverley place of Surrey Heartlands
Nottingham	**Proportion of people dying early due to CVD** in the most deprived areas of Nottingham and Nottinghamshire will be more similar to those in the least deprived areas
Lancashire and South Cumbria	**Improve access to cancer screeni**ng and earlier care with the aim of achieving 75% of cancers identified at stage 1 and stage 2 in specified cancers by 31st October 2023.

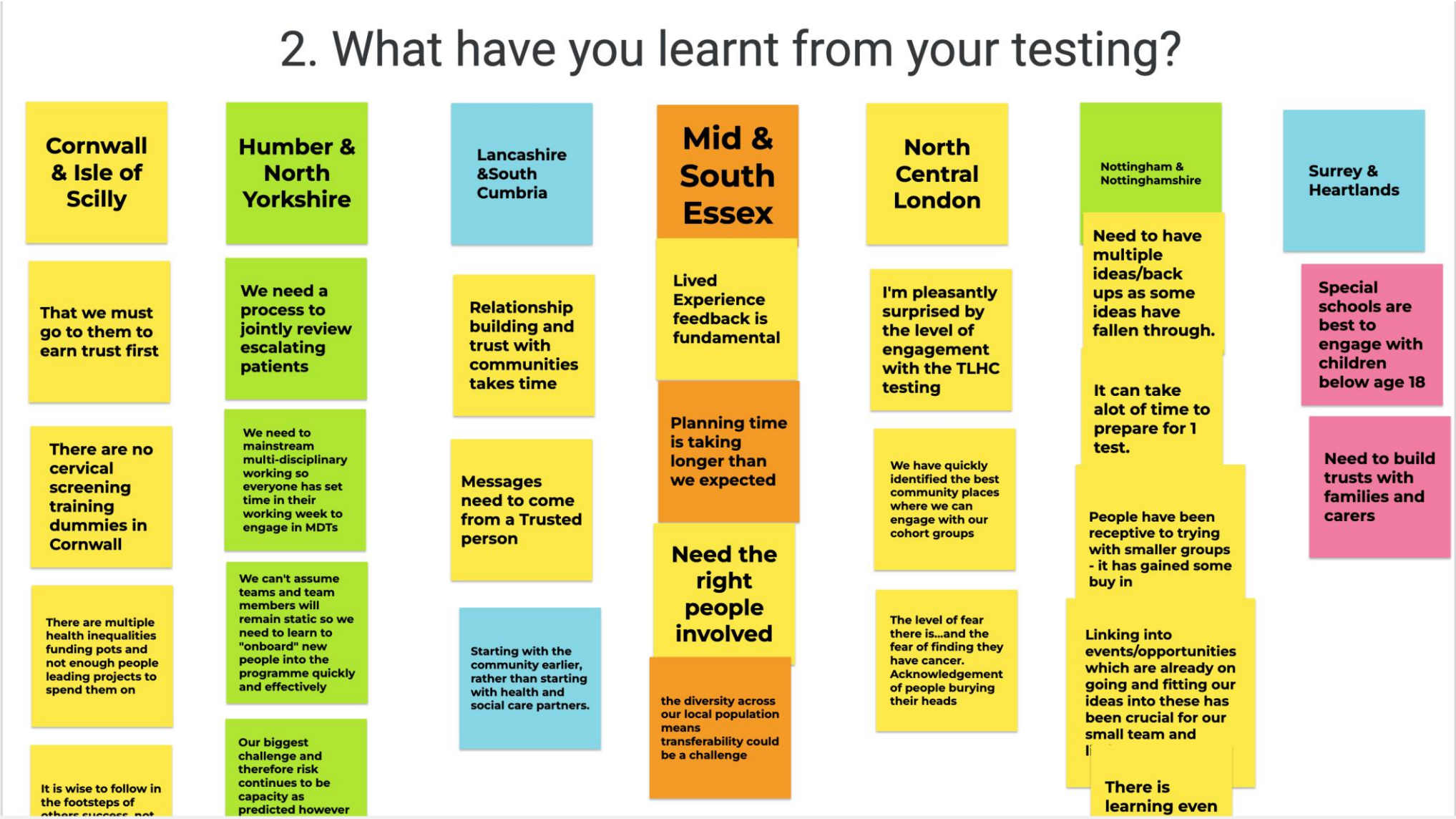
NHS England

Examples of Recent Tests

- The HCA's have started on some initial testing for our HC project with those with an SMI. Offering HC at home, all so far have accepted it, these were all DNA's in the past.
- A new approach to hypertension case finding which targets a different population group than current protocols, with a focus on unment need.
- Stakeholder Engagement – with PCN and GP practices, ward councillors.
- Engagement with primary care-based intervention - cervical smear/HPV vaccination.
- Engagement with individuals with lived experience.

NHS England

Shared Learning



Hull
Health and Care Partnership
Creating a healthier Hull

Title / Headline

Provide a short overview of your challenge, solution and results. Include exciting facts, impressive statistics or personal stories to make it as impactful as possible. What was important to service users? Don't forget to focus on the 'human angle' – stories are not merely descriptions of a process or procedure but rather they are personal/human stories.

PCN / service Name

123245	Service population
123	Patients in programme

Key Attributes

- Tell us 5
- Things about your PCN
- That help us
- Understand the
- Challenges you face

- **Include a quote here**
- *Who can you think of who would have positive remarks to say about your initiative?*
- *How did it affect someone personally?*
- *The quote should not exceed 250 characters.*

- *Name and role of person providing quote*

The issues we were facing

The Challenge

- *What was the problem or challenge you were trying to solve/change? How did people feel at the start? What were the different perspectives?*
- *How did the challenge negatively affect your programme?*
- *Were there barriers to implementing the change or solution?*

Finding a way forward

Our Solution

- *How did you address the challenges?*
- *Was there a "Wow moment", eg. a big piece of learning or moment that changed how people were thinking?*
- *How did you come up with the solution, is there anything innovative or different about the solution?*
- *Who/what was key to the success of the programme?*

Our impact

Our results so far

- *What positive results did your programme see? What was the impact? How did people feel?*
- *Consider the people around the individual you have worked with, what have been the benefits for them and the positive impact of this intervention?*
- *Is there a chart or image that demonstrates the results?*
  - *What have we learnt about assets of individuals, communities and organisations?*

Humber and North Yorkshire
Health and Care Partnership

Accelerator sites next steps

Collaboration with Core20PLUS5 Ecosystem

- ”How to” guides
- Harvesting learning, case studies, patient stories, best practice, quick wins, how can national team support
- Return on investment
- Evaluation
- Capability building
- Sharing learning, training and education
- Patient and public involvement, participation and experience

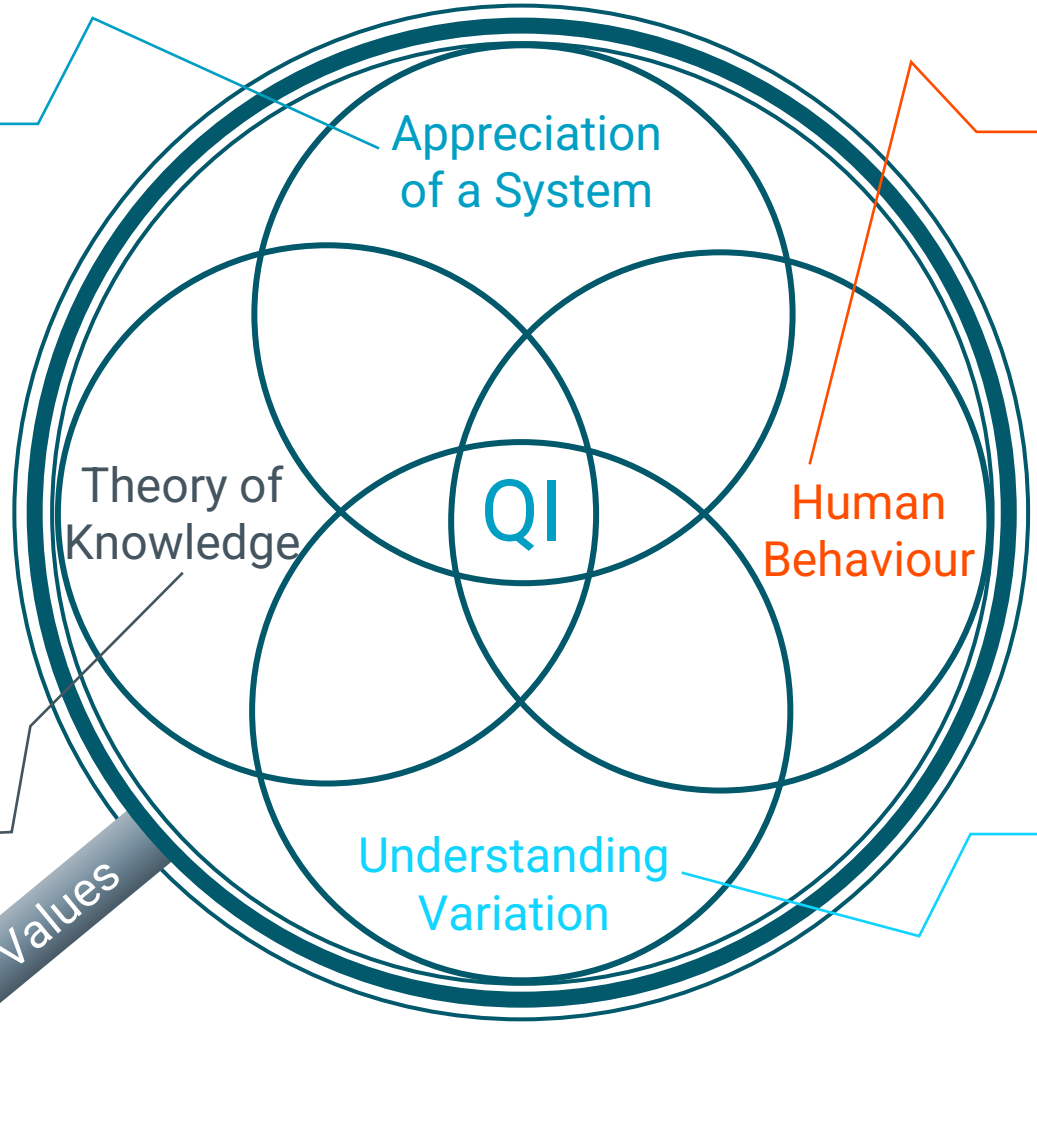
Deep dive into the role of coaching in delivering good results in equity work

Auzewell "Auz" Chitewe
IHI Faculty & Improvement Advisor

The Big Picture: Deming's System of Profound Knowledge

Recognizing how processes & elements work within the system to achieve/hinder equity.

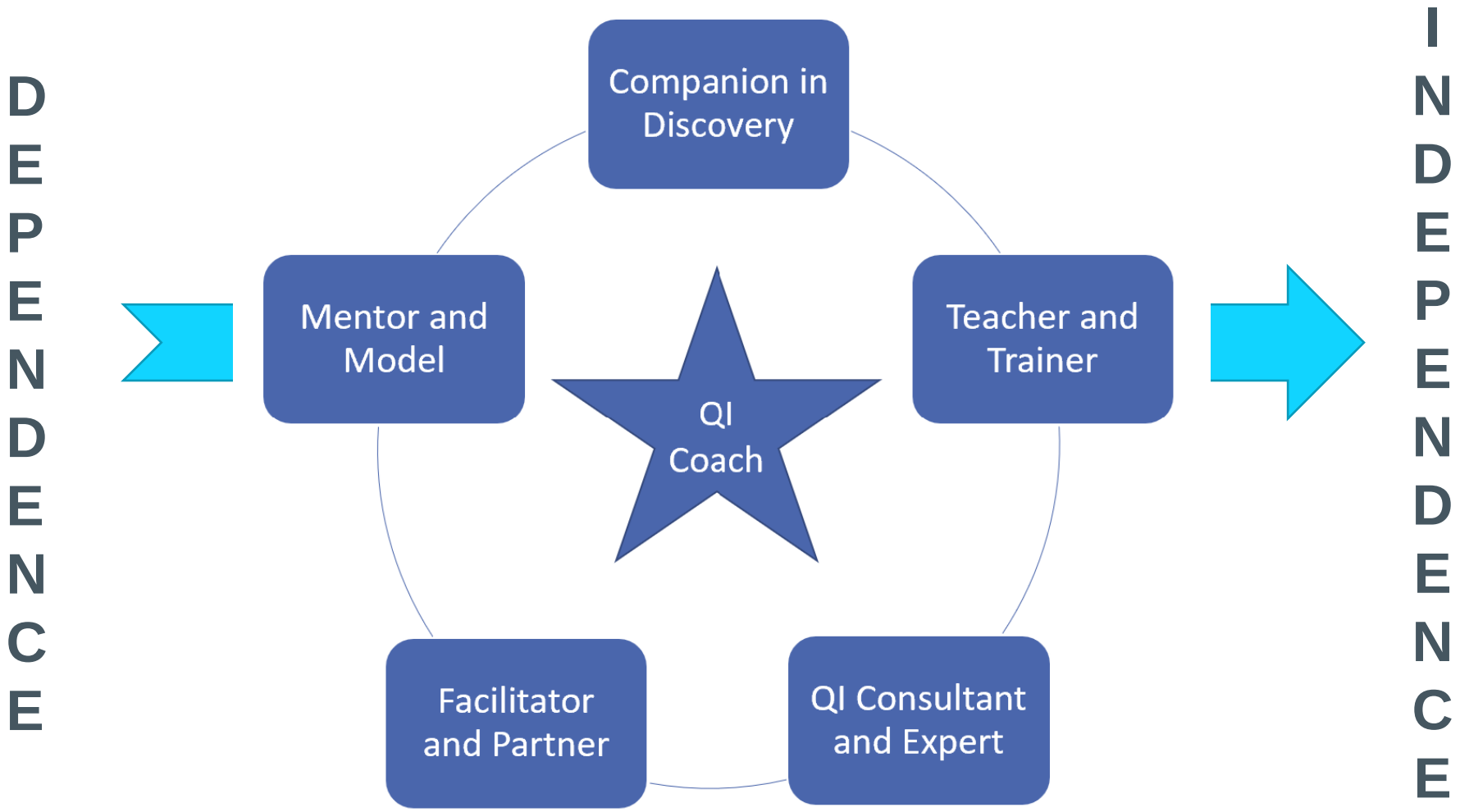
Understanding behaviors, motivations, and dynamics of people and organizations around the equity issue.



Understanding how knowledge of tackling the inequity is created & evolves. Encourage learning and continual improvement.

Understanding the causes of variation behind the inequity and working to reduce variation.

The Approach: The QI coach pivots to the team's needs



Adapted from John S. Dowd, Deming Collaborator and Consultant in Continual Improvement by Phyllis M. Virgil

The Detail: Coaching Skills

- Apply Improvement Science (Test & learn deeply for a population then scale-up)
- Guide team formation and role assignment (Include members of the population)
- Communicate effectively (Understand the community's language & experiences)
- Promote engagement and teamwork (Community assets and partners)
- Recognize different styles & team dynamics (What matters to you?)
- Facilitate and organize team meetings (Address inequities within equity work)
- Build self-awareness (What are our biases?)

…The Detail: Coaching Skills

- Build capability (teach) as needed (QI skills complement inequalities expertise)
- Manage difficult behaviors (Speaking truth to power)
- Trust the team & that they have the solutions (Draw on community assets)
- Use appreciative inquiry (Draw on successful outcomes)
- Maintaining momentum (Customer voice, team's degree of belief, sponsor support)
- Help identify & test targeted interventions (Test with 1 scalable unit ASAP)
- Pay attention to impact (Bring data, narratives and stories into all meetings)

Do’s and Don’ts of Coaching – What makes a good coach?

The discipline of coaching

The discipline of coaching focuses on how to help other people develop insights, skills, and capabilities to assess and improve their current health care experiences.

Coaching is not about “telling” health care professional groups what to do, but to engage in conversations and develop relationships to support self-reflection to explore new possibilities, innovations, and actions to result in desired improvements in health care.

The Dartmouth Institute: http://www.tdiprofessionaleducation.org/leading--coaching-quality-improvement.html

Coach vs. teacher/mentor

Many assume that a great coach is great because they have all in-depth technical knowledge and the ability to spot and rectify faults. The technical knowledge and other occupational requirements are important and they are the qualities instantly analysed when observing a coach.

However, these qualities are only the tip of the iceberg, with many others not instantly visible.

The coach will also possess personal traits that complement their occupational attributes, resulting in a greater coaching performance.

Activity: Coaching for Equity Role Play Scenarios

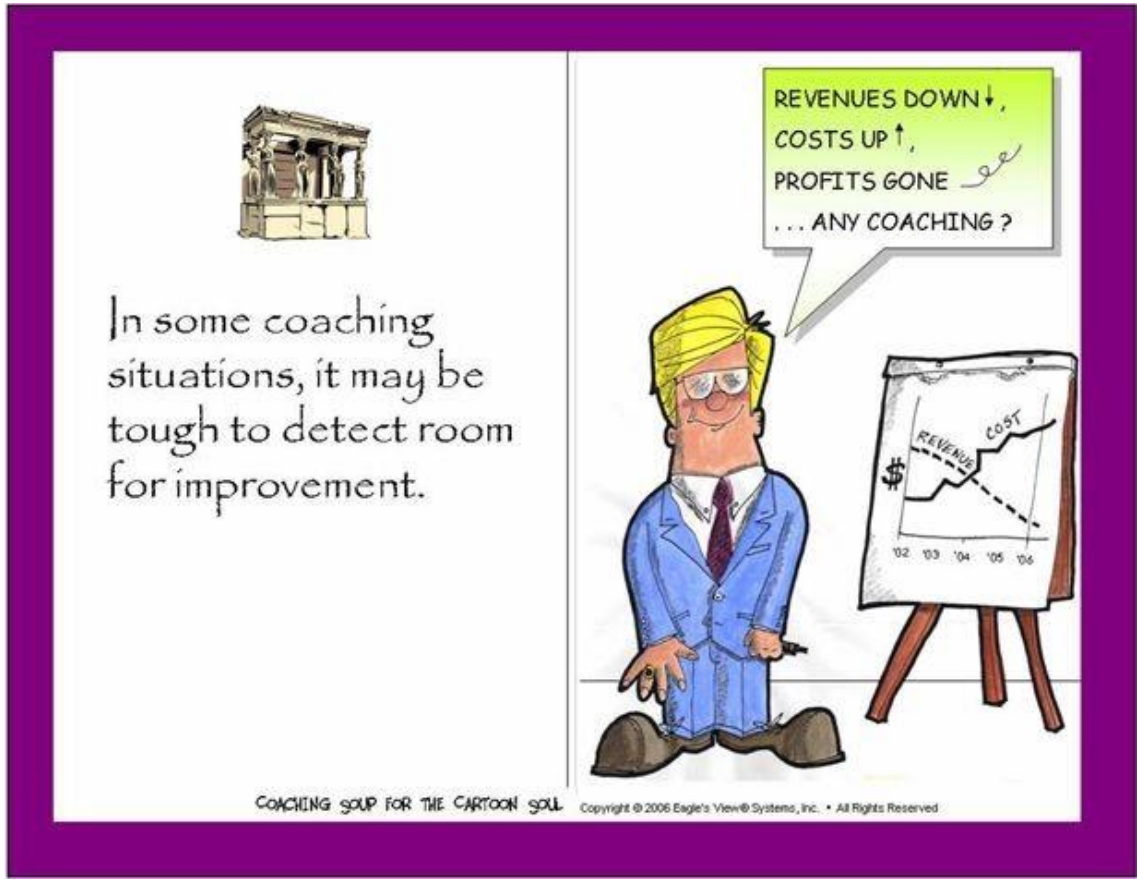
Activity: Coaching for Equity Role Play Scenarios

Turn to the person on your right and pair up! Decide who will play the role of the coach first and pick a coaching scenario. We'll do this for 6 minutes and then switch roles and scenarios!

Reflections from coaching activity

Coaching for success – reducing equity gaps

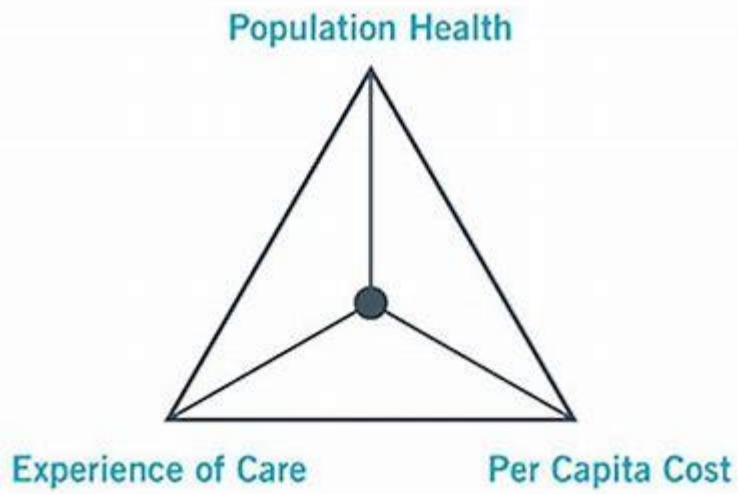
- Coaching is an important part of Quality Improvement when we are reducing the equity gap… the external perspective helps us to think more and overcome some of the challenges we face
- Coaching is not meant to have all the answer but it will help guide the process. Some examples of where coaching helps:
    - Understanding how to segment the population
    - Working through the data to decipher where inequities exist
    - Thinking about change packages incorporate interventions that reduce inequities

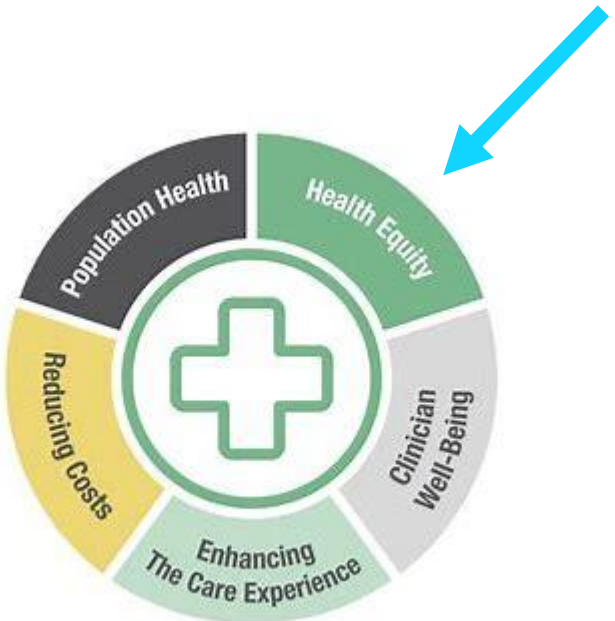


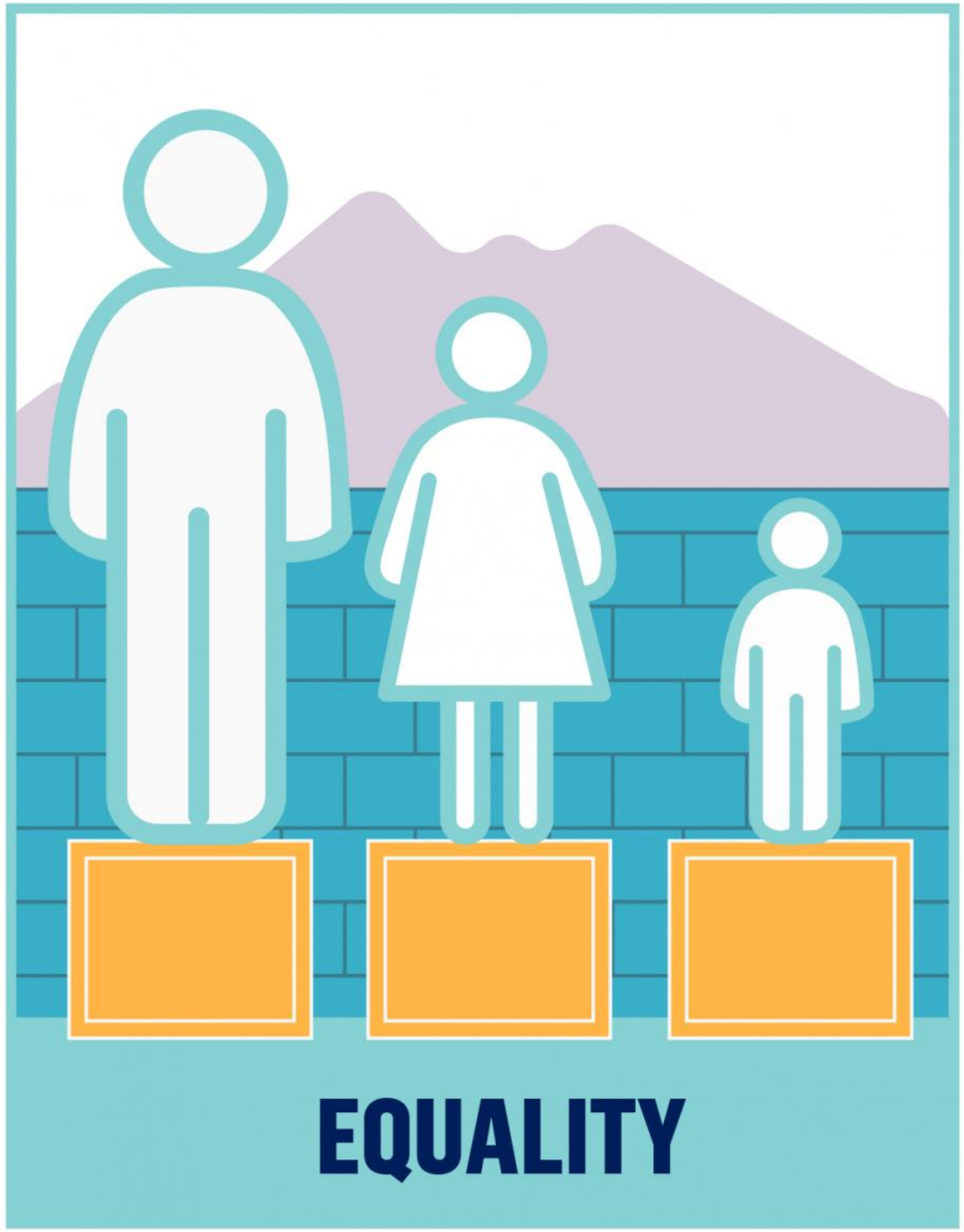
Institute for Healthcare Improvement

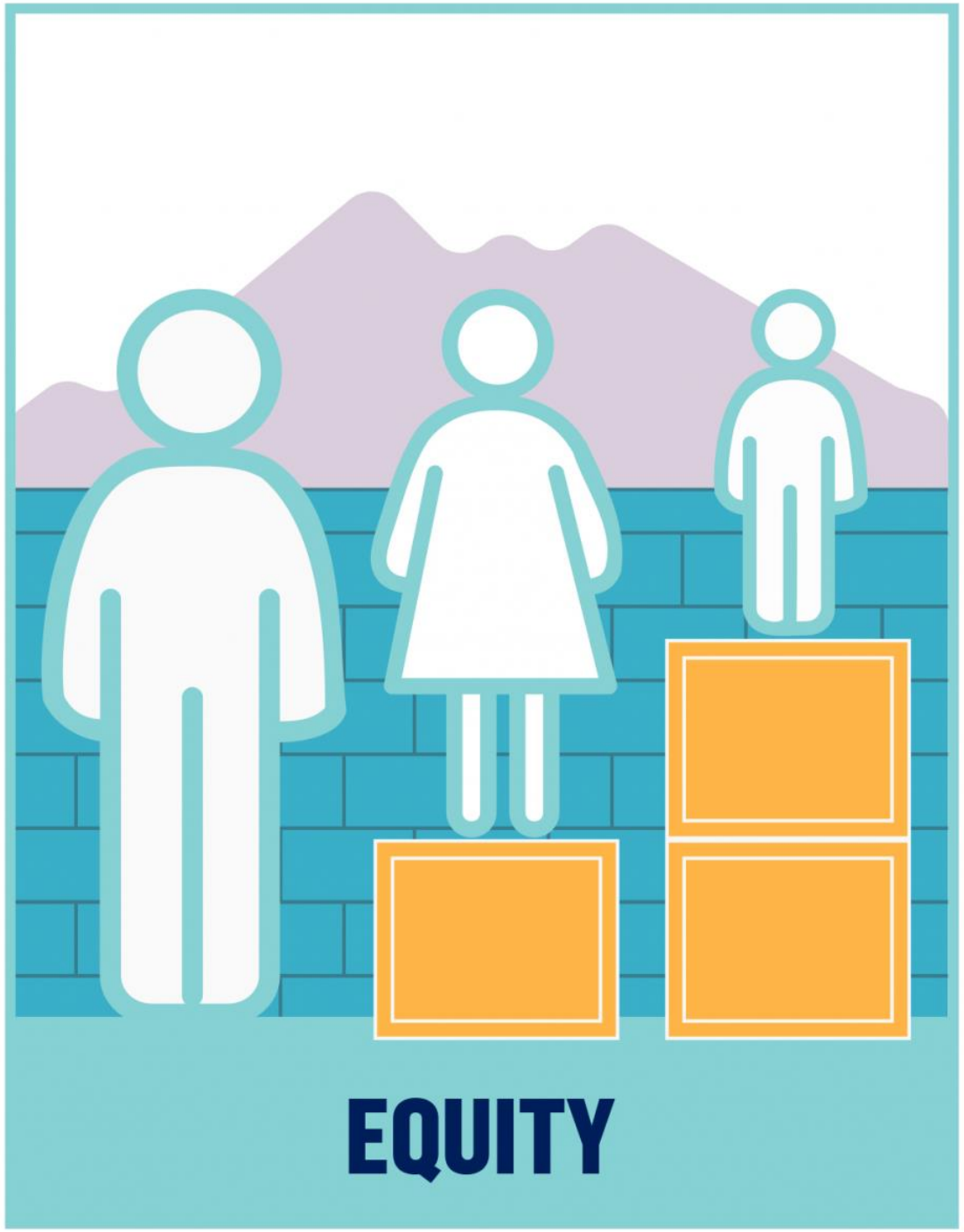
Overall Reflections and Wrap-up

The IHI Triple Aim



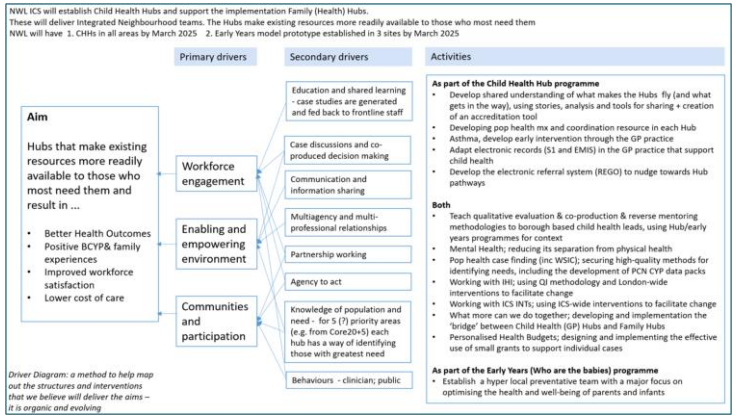



EQUALITY


EQUITY


INCH WIDE
MILE DEEP

Using QI tools to reduce the equity gap



1. Review available data on your chosen sub-population of pregnant women and babies

2. Interview 2-5 care teams/professionals providing care and external collaborators/partners/service agencies supporting the population

3. Interview 5-10 individuals/clients/patients in your chosen sub-population

Summary

- There are many approaches to reduce inequities in healthcare – it will always be for a specific population
- Being focused on which gap needs to be addressed and how it needs to be addressed is important
- Each situation and each community is different, customising to the context is the only solution
- **Understanding how to reduce the equity gap needs careful analysis and QI tools can help**

Thank you