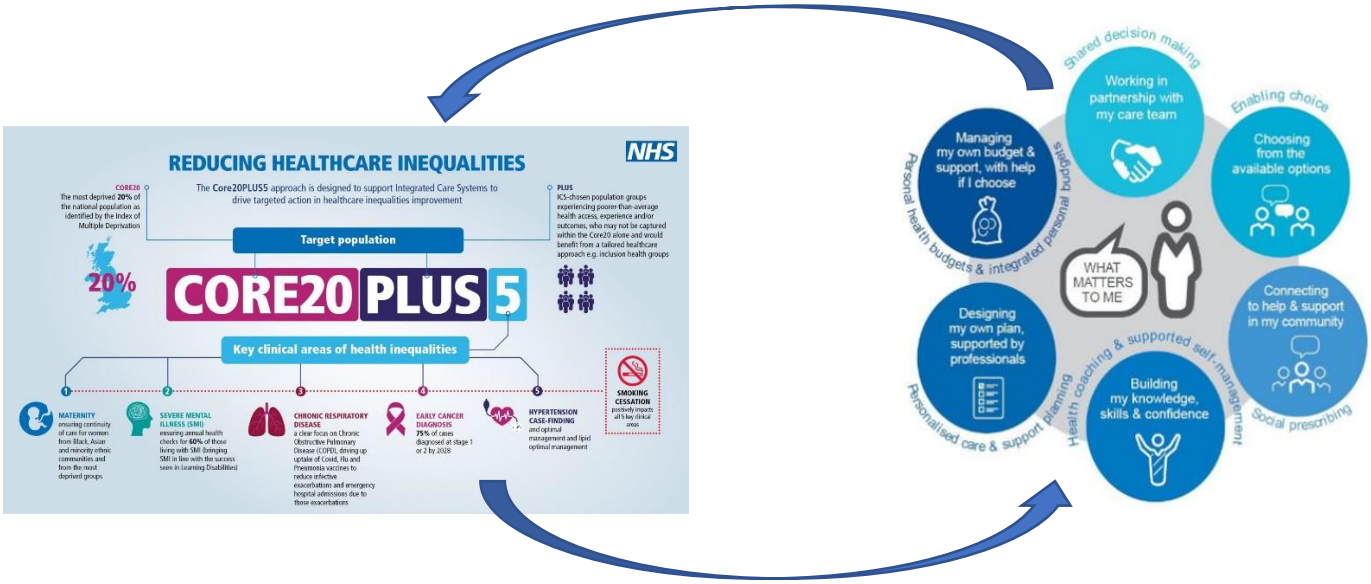
Coventry and Warwickshire Integrated Care System

Tackling health inequalities with person-centred approaches

Personalisation Programme Health Inequalities Focus October 2023



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1. Personalised care and support planning, and reducing health inequalities – our focus in Coventry & Warwickshire for 2023-25

Reducing health inequalities is a fundamental part of the NHS Long Term Plan and the Coventry & Warwickshire ICS Strategy. It means focusing on what matters to people, taking into account their circumstances, challenges and assets, and in turn enabling everyone the opportunity to lead a healthy life, no matter where they live or who they are.

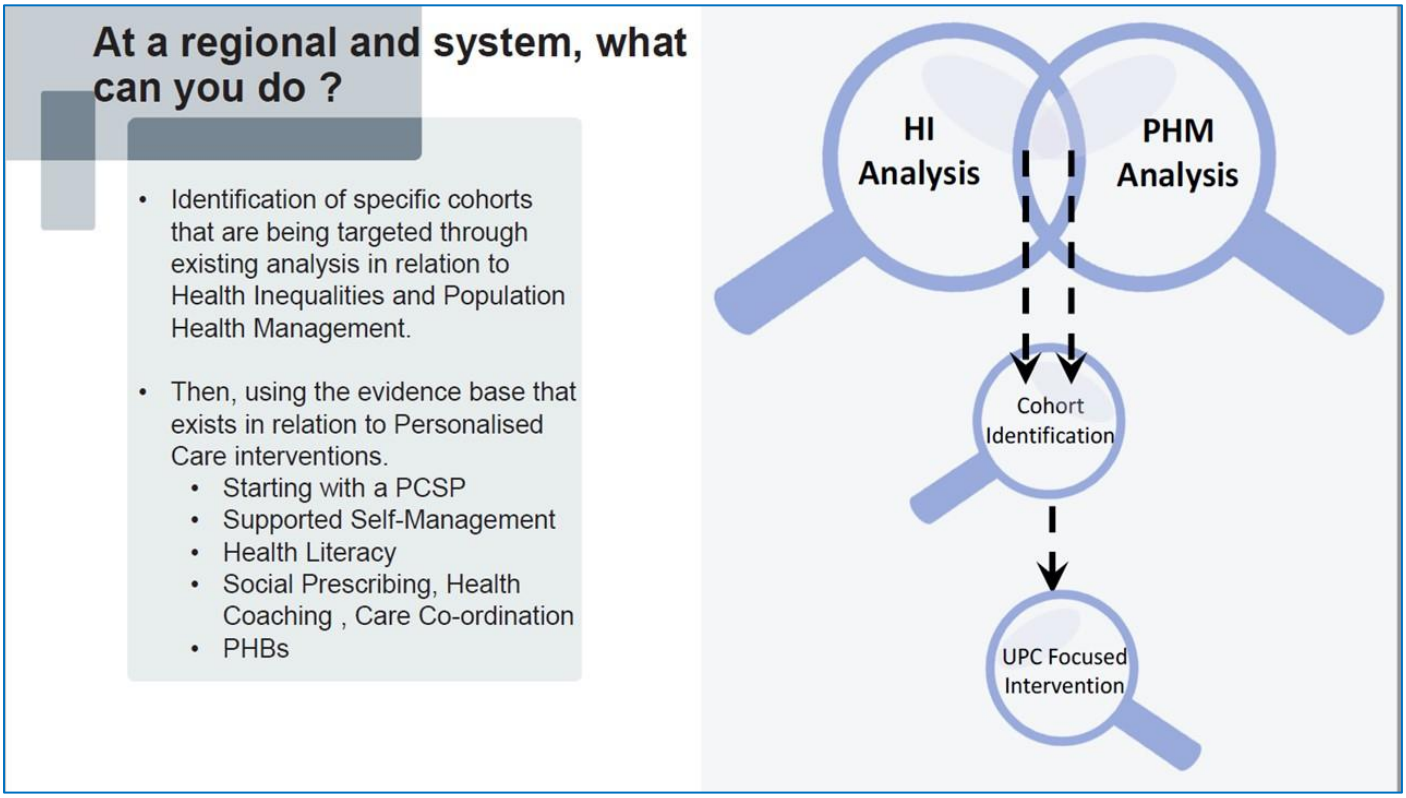
A key driver for the embedding of personalisation across our health and care systems is the May 2022 Fuller Stocktake report, which requires personalised care for those who need it:

*"People should be able to access **more proactive, personalised support** from a named clinician working as part of a multi-professional team...this model of care should offer greater **shared decision-making** with patients and carers and maximise the role of non-medical care staff, such as social prescribers, so people get the care they need as close to home as possible".*

Read more about the evidence of personalisation's impact on reducing health inequalities in NHS England's report **Universal Personalised Care: Implementing the Comprehensive Model,** summarised on our website.

2. Personalised care – and the ICS spotlight on Personalised Care and Support Planning

There are six components to delivering personalised care, as you'll have seen in the image above. The full comprehensive model is demonstrated in this video. This slide from the Midlands Regional Personalised Care and Health Inequalities Collaborative clearly demonstrates the link between personalised care, population health management and health inequalities – and how to work with the different components:



In Coventry & Warwickshire, we are supporting some excellent projects in which teams are applying the six components across our communities. (You can read more about some of them below.)

For the immediate future, the ICS has committed to the following for 2023-25:

"We will increase the uptake of Personalised Care and Support Plans each year, with a focus on individuals experiencing health inequalities."

We will be working in partnership with key stakeholders from our ICS to deliver this ambition in the coming months. If you would like to be involved, please contact Karen Higgins, Programme Manager, on karen.higgins@geh.nhs.uk.

a. Why PCSPs are important for improving health literacy and tackling health inequalities

A personalised care and support planning process focuses on a person-centred approach to the management of long-term conditions, recognising the context in which people live their lives, and including what is important to them with a focus on mental health and psychological wellbeing.

In practice it may look like this:

- A single **information gathering appointment** with a healthcare assistant is undertaken which includes both the medical considerations and the wider determinants of someone's health. The focus will be on what matters to someone, and understanding their individual circumstances, assets and challenges – therefore enabling a person-centred approach and outcome.

- **Patient preparation**: sharing information with people ahead of their PCSP conversation (agenda setting prompts and routine results) so they are able to understand and participate more fully in decision making and planning around their self-care.

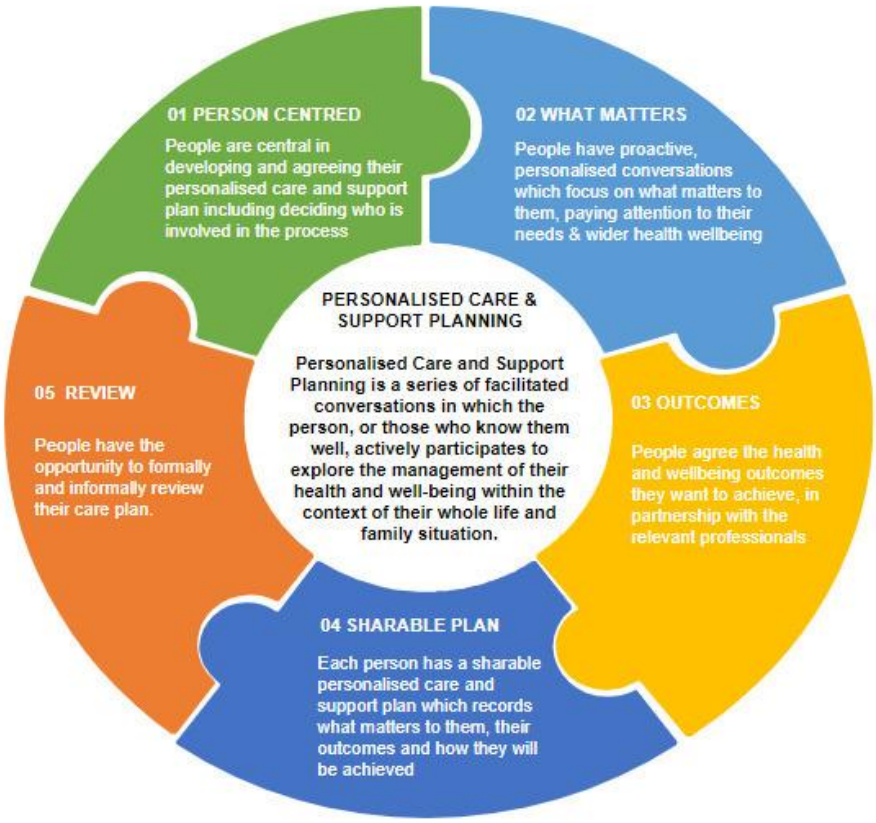
- Structured medication reviews **involving the person** in how they will manage their medicines.

Take a look at our **It's OK to Ask** materials, ready to adapt for all patient-facing situations:

Find them all here

- A holistic personalised care and support planning consultation (conversation) using a **person-centred, solution focused approach** including the development of a personalised care plan.

b. Streamlining care with Personalised Care and Support Planning: what good looks like



NHS England has developed a set of five criteria to define personalised care and support planning, and provides strong quality indicators for personalised planning.

These criteria have been co-produced with people with lived experience and clinicians and demonstrate what is required from a personalised care and support planning experience rather than seeking to adopt a one size fits all approach.

c. *Personalised Care and Support Planning Workshop – please register your interest*

To support our Coventry and Warwickshire integrated care system to improve the use, and increase the uptake, of PCSPs for people with health inequalities, we are in the process of planning a workshop. If you would be interested in attending, please register your interest by emailing geh.cwpersonalisation@nhs.net and we will be in touch as we firm up the detail.

3. How personalisation is being used to tackle health inequalities across Coventry and Warwickshire – a few examples:

a. Supporting the street homeless community in South Leamington PCN with shared decision making and personalised plans

Homeless people have a life expectancy which is ***30 years lower*** than that of the general population. South Leamington PCN is embedding personalised care in primary care services for people who are street homeless, running a drop-in clinic at Helping Hands on Tuesday mornings. Staff are being trained in shared decision making, and people are supported to ask questions about their care. They are also provided with a Personalised Care and Support Plan and support to self-manage. Where appropriate, they are referred to a personalised care workforce (social prescriber). One user, who has been homeless for more than 12 months and who suffers with back issues and COPD, explains that he didn't see a GP for more than seven years, and that all he could focus on when living on the streets was just getting through the day. Speaking of the clinic he says 'I don't know where I'd be without them. They have put me in touch with places I didn't know existed. I have a place now; I have a base, and I can go on from there'.

b. Sowe Valley PCN – working with diabetics in a deprived region

Sowe Valley is taking a personalised approach to an intervention with a cohort identified using Population Health Management techniques and based in a deprived area of Coventry. Their MDT includes social prescribers and community connectors, and is developing a community-based pathway for this cohort enabling them to manage their diabetes. You can hear PCN Manager Tim Morris talk about the results they are already seeing as they make progress.

c. Supporting a diabetic patient who wasn't taking their insulin – because they couldn't afford to heat their home

This is a great example of how looking at the wider circumstances of patients' lives can stop the 'revolving door' of representing with the same issue. In this case, a diabetic patient was continually re-presenting at UHCW. A community nurse discovered that the patient didn't have the money to pay for heating at home, and that meant they were too cold to take their insulin. The patient was signposted to community services, supported to get the benefits needed to help with heating, enabled to follow their treatment plan, and the cycle of re-presenting at UHCW ended.

d. Giving a dementia patient a better quality of life with the help of social prescribing

An elderly CWPT patient with complex needs, including Parkinsons and diabetes, had an increasing number of falls. These led him to lose the confidence to go out – and in particular he lost the confidence to go to walking football sessions, which were his social lifeline. With his medical conditions he will continue to deteriorate over time, but rather than allow this to just happen - with obvious ramifications for his mental and physical health, and those of his carer wife - CWPT brought in a wider team including a social prescriber and care navigator to work together with physio and OT professionals. This MDT rebuilt his confidence, reviewed his benefits, sorted a Blue Badge, arranged a fire safety check at home, and got him back to his walking football sessions. The team noted that 'What he really responded to was our push at supporting him to self-management with the message that "The only person stopping you is you"'.

e. Developing the skills to identify MSK physio patients in need of non-medical support

At GEH, every Monday's MSK Physio clinic is currently running with social prescriber, Jacqui Anywar from HealthExchange, on-site. Jacqui makes herself available to support staff and see the patients they refer.

Staff are developing their patient conversation and shared decision making skills, and learning to identify patients who meet any of a range of criteria, including having one or more long term condition, are socially excluded, lonely or isolated; have complex social needs which affect their wellbeing. Carers of a person experiencing any of the criteria can also be referred.

We will be measuring the impact of this intervention over time, and looking to demonstrate that - as well as improving a patient or carer's wellbeing (as well as that of staff) - there are opportunities with personalising care to produce quantitative financial savings through data collection including reductions in DNAs and patients re-presenting.

f. Virtual reality helps migrant communities to navigate our healthcare system

An eight month project in Coventry aims to use Virtual Reality simulation to help refugee and asylum seekers better understand and access healthcare services provided by the NHS. This joint NHS/Coventry City Council project will address the specific needs and challenges faced by this vulnerable population in Coventry. It is being co-produced with direct input from refugees and asylum seekers, and in conjunction with refugee organisations, Coventry University students, and the UHCW Innovation Team.

g. Coventry Central PCN and UHCW working together on lower back pain

We know that people with persistent back pain often receive mixed messages, many of which are not evidenced-based, can result in low value investigation and treatment cascades, and poor patient experience. Frequently people with back pain do not get to see the right person for their condition, in the right place and at the right time, with people being 'bounced' around the system. This can then lead to ongoing pain and disability for individuals, causing severe disruption to their lives and enormous costs to the healthcare system and society. Coventry Central will be producing a video resource underpinned by the lived experience of people with persistent back pain who have followed evidenced-based advice. The content of the video will include risk factors, facts, myth-busting, and the role of self-management. You can learn more about the project in this video.

4. Funding available to address health inequalities in Coventry and Warwickshire

1) Care Collaboratives and the Health Inequalities Funds

The Care collaboratives are involved in prioritising how the funding is spent this year. More information on the funds can be found here: Health Inequalities Innovation Fund - Happy Healthy Lives

a) **Coventry Care Collaborative** is developing plans for spending the health inequalities funding. Our priorities are:
   i) Tackling health inequalities identified as part of our focus on older people – linked with proactive care, integrated services, reducing urgent and emergency care need and Core20+5.
   ii) Place-based approach to Core20+5 with a focus on prevention.
   iii) Supporting and sustaining population health innovations.

Please direct any Coventry queries to Rachel.chapman@uhcw.nhs.uk.

b) **Warwickshire Care Collaborative** has nominated Warwickshire North Place to lead the process for the county because of the levels of deprivation in the area – 19 of the county's 22 areas in the top 20% of national deprivation are in Warwickshire North.

An allocative approach has been agreed where the funds will be split across Warwickshire by Place, depending upon the percentage of the population living in high deprivation. This means that of the county's available health inequalities funds, Warwickshire North receives 85%, Rugby receives 11% and South Warwickshire receives 4%. Warwickshire Care Collaborative is using a partnership approach of investing in geographical and clinical areas of greatest need, led by the data, to produce health inequalities investment plans at Place level, aligned to Place priorities.

Please direct any Warwickshire queries to Ryan.coffey@geh.nhs.uk.

2) Applications open for funding to address mental health inequalities

The Coventry and Warwickshire Mental Health Collaborative (MHC) is inviting expressions of interest for funding to support the mental health and wellbeing of residents. The Collaborative has been established to improve the mental health and wellbeing of children, young people, and adults by working together at scale and at place, and has secured £1 million funding to address mental health inequalities.

The fund is open to collaborative Expressions of Interest from all Provider organisations (including VCFSE partners); links must be made with existing clinical pathways. More details of the criteria and application process can be found in **this form.**

The deadline for Expressions of Interest is **Wednesday 8th November.**

3) Already have funding in place for a Health Inequalities project? We can help.

Have you received funding to deliver a project supporting people with health inequalities? If so, we are keen to support you to embed person-centred approaches with your interventions - this may be social prescribing, shared decision making or supporting people to self manage - we have lots of resources to help you tackle health inequalities with a person-centred approach. Please contact us at geh.cwpersonalisation@nhs.net.

5. Tools and resources – support for developing individuals, teams and organisations

We have an ever-expanding range of tools and other resources to help you and your teams develop their personalised care skills and embed a personalised approach throughout our ICS. Please visit Personalising care for our people - Happy Healthy Lives.

6. News and events

For the latest news and events in personalised care, please visit Personalised Care News and Events - Happy Healthy Lives

Midlands Health Inequalities Conference

Wednesday 29th November 2023 09:30-16:30, The Studio, Cannon Street, Birmingham

Please join us as we bring together a range of stakeholders from across the Midlands region to discuss and showcase the work underway to tackle Health Inequalities. The day will involve keynote speakers from Professor Bola Owolabi, Director, National Healthcare Inequalities Improvement Programme and the Institute of Health Equity. We will also hold workshops on inclusive restoration, mitigating against digital exclusion, inclusion health groups, the Core20Plus5 clinical areas as well as other topic areas. Additionally, there will be a marketplace event showcasing work on inequalities from different organisations across the region. Throughout the day we aim to provide numerous opportunities for networking and learning.

This is a face-to-face event taking place in central Birmingham, for further information and to book a place please follow this link: https://forms.office.com/e/pZUJEDjV5b

7. Contact us

For information on personalised care and how the Coventry and Warwickshire Personalisation Programme can help you, please complete the form you'll find here or email geh.cwpersonalisation@nhs.net.

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