TACKLING INEQUALITIES

Through innovation and entrepreneurship

Poster competition
For the first time, NHS England and the Royal Society of Medicine hosted a poster competition to showcase work in tackling health inequalities. The aim of the competition was to invite individuals to share their work on tackling inequalities through innovation and entrepreneurship, whilst demonstrating the following themes:

- The creation of new ideas, products, services or models of care
- The adoption of something that has worked elsewhere
- Helping to share good practice
- Entrepreneurial projects

This competition was open to anyone working in innovation or healthcare on a project or initiative to tackle health inequalities.
Addressing equity of access to culturally specific resources for asthma patients

By Dr Llinos Jones, Dr Michelle Bartholomew, Harriet Smith, Dr Mike Snowden

Introduction

Self-management is the cornerstone of asthma care. However, in the UK, there is a paucity of information available in languages other than English and a lack of information in other formats. Many people in the UK cannot speak or read English well and suffer poorer health outcomes, using acute health resources more frequently. Translated health information is largely absent from strategies to tackle such health inequalities. Indubitably, self-management is harder to embed in communities where health literacy is poor. Indeed, a previous evaluation revealed a lack of culturally appropriate multilingual resources for asthma self-management and proposed a redesign and delivery of such resources, ensuring fitness for purpose.

Aim

The purpose of this project was to design and develop culturally specific, multilingual resources to aid the self-management of asthma. The project also aimed to develop and train Community Asthma Champions from within the local community.

Methods

Drawing upon a project framework that embraced collaboration and collegiality enabled the development of a relationship of respect and participation with all partners. This upstream focus involved people from South Asian and disadvantaged communities, and health care professionals working together through all stages of the design, development, and evaluation process. Evaluation and testing were conducted by group and individual interview and content analysis.

Results

Following in-depth discussions with all partners, the need for a video type resource was made. 7 multilingual videos in 15 languages were curated using a computer-generated avatar chosen by our community members themselves. A QR code poster was produced to publicise the resources. Evaluative data collected was positive. The resources were reported as culturally sensitive, accurate, impactful, and accessible. Positive evaluative comments were also made by wider community members and health care professionals. The Patient Information Forum approved the processes involved in the production of the resources and the links have been hosted on the Multilingual Resources area on the British Thoracic Society Respiratory Futures website. The Community Asthma Champion work initially centred around a local Mosque and Community Centre also evaluated positively and facilitated grass roots spread of messages harnessing the wisdom.

Discussion

Inequalities are complex and amongst professionals there is often a lack of understanding, partly due to a lack of actionable data. Inequity in literacy can be mitigated by utilising upstream interventions. During this work, an attempt was made also to address misconceptions surrounding asthma and its treatment. Messages were spread using not only the poster, which was spread internationally, but also asthma community champions who were trained as part of the project.

During the course of this project, the team did not encounter “Hard to Reach Populations,” but rather felt the need to reflect upon how hard our services are to reach. We remain committed to improving equitable access to information, diagnosis and treatment of asthma.
Smoking is the single biggest preventable cause of death and illness, and the single largest driver of health inequalities in England. In NE England, 13.1% of adults still smoke. Whilst smoking prevalence has reduced, smoking still disproportionately affects people from certain groups. People who live in high levels of deprivation are more likely to smoke, and 1 in 4 routine and manual workers smoke compared to 1 in 10 in professional and managerial roles. Through the use of anchor institutions (NHS Foundation Trusts), this offer aimed to reach NHS staff who smoke to offer access to support to make a quit attempt, with a specific focus on reaching R&M workers and staff with low income.

**THE OFFER**

**FREE NICOTINE REPLACEMENT THERAPY OR VAPE**
For up to 12 weeks

**FLEXIBLE BEHAVIOURAL SUPPORT**
With a specialist advisor via a smoking cessation service or Smokefree app

**OUTCOMES**

1972 NHS COLLEAGUES
Accessed support to make a quit attempt
Between December 2021 & September 2023

73% OPTED TO USE A VAPE as part of their quit attempt

**BASED ON DATA FOR 710 STAFF SUBMITTED FROM APRIL 2022-SEPTEMBER 2023:**

13.3% **WORK IN ROUTINE AND MANUAL ROLES**

19.2% **WORK IN CLINICAL SUPPORT ROLES**

51.2% **QUIT SMOKING**
Based on self reported 28 day quit status

52.8% FROM IMD 1 AND 2 (MOST DEPRIVED QUINTILES)
29.5% from IMD 1

**LEARNING AND IMPACT**

- Offering vapes as a tool to quit encouraged people to access support. The direct shipment to end user model has now been applied in multiple smoking cessation pilots nationally.

- Cost of NRT point of access has been removed in 5/13 local stop smoking services – removing barriers to access.

- In a sample of 500 people coming forward for support, 89% had made a quit attempt previously, but only 33% of these had accessed support to do so. This highlights that the service reached a cohort of people who weren’t previously accessing typical Stop Smoking Services.

I am pleased to say I have remained smoke free for nearly 8 months now and am reaping the benefits both physically, mentally, and financially, and my family are so proud and thankful I finally made the step!!

"I am pleased to say I have remained smoke free for nearly 8 months now and am reaping the benefits both physically, mentally, and financially, and my family are so proud and thankful I finally made the step!!"
A targeted approach to identifying and reviewing patients with respiratory conditions at risk of poor health outcomes due to fuel poverty

By Rhiannon Clarke, Lucy Malcolm, Kathy Daley, Dianne Green, Sophie Wotherspoon, Rowan Pritchard-Jones

**INTRODUCTION / OBJECTIVES**

Fuel poverty is causing physical and mental ill-health across the whole population and further straining already stretched health and care services. Collaborative partnerships with several providers across Cheshire and Merseyseyde CCG (Integrated Care System), have resulted in individuals most at-risk from poor outcomes being proactively identified through the CIPA (Combined Intelligence for Population Health Action) fuel poverty dashboard. This brings together several data sets including GP data, Index of Multiple Deprivation, risk of admission calculated using the James Interoler risk stratification model, and fuel poverty data.

The aim of the project is to have a positive impact on the wellbeing of those most at risk of poor health resulting from fuel poverty. Outcomes evaluated by the reduction in hospital admissions, attendance (A&E, GP, other) and expectations and patient experience of reduced anxiety related to fuel poverty.

**METHOD**

The defined cohort groups in the dashboard could be cut by Place, PCN or GP Practice with additional filters available to further refine the cohort as appropriate. This enabled small, realistic numbers of patients to be identified from the dashboard, which organisations felt able to support and which would pose those most in need of support.

**RESULTS**

The cohort data from cohort 1 is displayed in the figures on the right.

**SPREAD AND ADOPTION**

Further engagement is underway with Place Directors, to identify otherlicher data to go live in 2023. As more patients benefit from these pathways, the CIP system will work with local projects to develop a full evaluation to help them understand the impact.

**Project numbers:**

- 245 participants tested so far
- 17 identified with potential AF
- 56 with possible high BP
- 11 other cardiac issues
- Collaboration with 8 community groups
- 500 combined target number for testing

**Aims**

- To opportunistically test for atrial fibrillation and Hypertension
- Community Champions to deliver project in community venues
- To capture attitudes and views about healthcare and lifestyles
- To build relationships and trust with communities
- To support heart health education

**Impact**

- Improved understanding of lived experiences and potential barriers to the access of services within the community
- Shared learning and sustainability of the project approach

**Outputs**

- Early detection of AF and high blood pressure
- Review of the approach involving community leaders and champions
- Increased trust and engagement with communities
- Improved understanding of lived experiences and potential barriers to the access of services within the community
- Sharing and sustainability of the project approach

**Documentation authors:**

Tim Lloyd (tim.lloyd1@nhs.net), Caroline Thickens (caroline.thickens@nhs.net)

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**Healthy Heart campaign for Black African, Black Caribbean and South Asian communities in Northamptonshire**

By Tim Lloyd and Caroline Thickens

**Method**

- To opportunistically test for atrial fibrillation and hypertension
- Community Champions to deliver project in community venues
- To capture attitudes and views about healthcare and lifestyles (using a QR code—scan to see the attitudes survey)
- To build relationships and trust with communities
- To try to reach people who do not always engage with health services
- To support heart health education

**Results**

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Tim Lloyd (tim.lloyd1@nhs.net), Caroline Thickens (caroline.thickens@nhs.net)
**BACKGROUND**

Maternal mortality remains a significant challenge in developing countries, with 99% of maternal deaths in 2020 occurring in low- and middle-income countries (LMICs) [1]. Maternal mortality rates (MMR) were 52 to 100-fold higher than those in high-income countries and 10 to 20-fold higher than rates in high-income countries [2]. As per Table 1, a plethora of factors contribute to high maternal mortality rates. Existing literature on global maternal mortality in low-income countries proposes numerous recommendations to address these challenges [3]. These include maternal health education with a focus on awareness, prevention, screening, the availability of healthcare professionals, improved access to medications and emergency services, and promoting safe abortion practices.

**MATERNAL MORTALITY IN BANGLADESH**

65% of maternal deaths worldwide in 2020 occurred in Sub-Saharan Africa and Southern Asia, encompassing Bangladesh within the former (4). Bangladesh, with an estimated population of 173 million as of 2020, had a maternal mortality rate of 290 deaths per 100,000 live births from 2014-2016 [5]. Bangladesh is ranked 141st in the World Health Organization’s Health System Performance Index [6]. Most women in Bangladesh experience poor access to essential health services, leading to poor maternal health outcomes. The leading causes of maternal deaths in Bangladesh are hemorrhage (30%), sepsis (25%), and obstructed labor (15%) [7].

**MATERNAL MORTALITY ASSOCIATION (MAA)**

MAA is a student-led charity operating at the grassroots level, dedicated to enhancing conditions in rural and underserved environments, with the goal of ensuring: safe, effective, and high-quality maternal healthcare. MAA achieves this objective by supplying medicine, resources, and educational initiatives. They focus on training health brigade members (HBM) to provide antenatal care (ANC) to pregnant women, providing essential knowledge about safe pregnancies and newborn care. MAA also conducts free health checks to identify potential concerns early on, conducting maternal education, and identifying and referring high-risk pregnancies.

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**Med Lingual: Improving patient-doctor communication**

**By Dyan Pancharatnam, Atharv Patankar, Fay Fathima Imtiaz Fareed, Harshita Buragapu, Prince Tandukar, Lavanya Gupta**

**Introduction**

Approximately 61% of the working population in England have difficulty comprehending healthcare and well-being information provided to them. In 2019, 21% of NHS patient concerns related to staff-patient communication. After interviewing healthcare professionals at Stoke Mandeville Hospital, it was revealed that post-appointment communication was inefficient. Additionally, the diverse population in the UK results in language barriers in healthcare that can impact the quality of care.

Inspired by the latest advancements in machine learning, we developed Med Lingual to tackle these challenges. Our user-friendly web-based application has 3 main functions: simplifying medical letters, providing translations, and offering an audio format. We aim to improve patient understanding, adherence to treatment plans, reduce missed appointments, and enhance patient satisfaction.

**Methods**

**How does our application work?**
- It uses optical character recognition technology (OCR) to scan medical correspondence via camera.
- Artificial Intelligence (AI) is used to simplify medical terminology and then provide the option to translate the text into various languages. This allows the information to remain accurate.

**How did we think of Med Lingual?**

We undertook an innovation-focused module seeking out clinical issues faced at hospital and used the Design Sprint method to tackle these. A common issue reported was the incoming frequency of non-essential follow-up appointments arranged to clarify contents of correspondences and medication instructions. We hypothesized that this may have been due to patients receiving complex medical letters that were not specific to the patient’s comprehension level.

**How did test this theory?**

We created a survey providing 3 anonymized options of medical letters: the original letter synthesized by an experienced NHS healthcare professional, an intermediate simplified by the same healthcare professional and a final ‘Med Lingual’ simplified version. The letters contained the same information but differed in the complexity of the terminology used, ranging from expert-level health literacy to basic-level health literacy. The survey gathered data from 45 participants, whose ages ranged from 10 to 75 years old. We selected participants from varying levels of education and identified those who had English as their first language.

**Results**

Which of the 3 letters would you prefer to receive about your healthcare?

- Decision: Simplified Intermediate Letter 33%
- Med Lingual Simplified Letter 12%
- NHS Professional to GP Letter 55%

In brief, the majority (84%) of our participants preferred a simpler version of their medical letter; from this 51% preferred the letter developed by our prototype. To investigate further, we explored the level of education and first languages of our respondents. More than half of our respondents had a Bachelor's degree and a further 25% had a PhD or Master's degree. In fact, for 30% of our cohort, English was not their first language.

Med Lingual has the potential and the demand. However, the road is not without challenges. These include but are not limited to:
- Handling sensitive information and ensuring user data has adequate privacy and protection whilst upholding compliance with data regulations.
- Monetary and time costs for marketing and user acquisition and retention.
- Challenges in balancing the user experience with monetisation strategies for a web-based application.
- Translating medical terminology accurately by overcoming nuances in different languages.

**Discussion and Conclusion**

Smartphones are an integral part of our lives. With Med Lingual being a few taps away, it is an opportunity for patients to get involved in their care. Med Lingual reduces the communication barrier in healthcare by promoting inclusivity, simplifying medical jargon, and supporting patients with varying individual communication needs. Prospects of Med Lingual include creating a seamless medical letter system directly from healthcare services to patients by collaborating with GP practices and hospitals. Providing this platform eliminates the need for physical letters, providing great sustainability benefits and directly cutting costs for the NHS by reducing postage costs (£/letter).

**References**

Addressing Urban-Rural Health Disparities: Bridging Gaps Through Mobile Hospitals

By Joshua Ching
Norwich Medical School

**INTRODUCTION: Place-based inequalities**

Place-based health inequalities refer to disparities in health outcomes and healthcare access across localities. This geographical location where individuals live, particularly proximally to a hospital. Research from (Caudy,R), as a programme focused on evacuating patient care in England, revealed that 70% of emergency admissions occurred within 6.2 km (10min) of a patient’s home, while only 3% of people were admitted to a hospital more than 30km (10min) from home. However, individuals in more rural areas must travel over ten times the distance compared to their urban counterparts.2

On the other hand, changes in services can significantly change distances to emergency care. For example, after the closure of the A&E department at Bournemouth General Hospital in 2007, the average distance for an emergency admission in Bournemouth District rose from 3.2 miles in 2000/01 to 8.7 miles in 2008/09. Therefore, the establishment of new hospitals played a crucial role in reducing distances for faster emergency admissions.6

**What are Place-based inequalities?**

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**Feasibility**

One department to retain is the Emergency Department (ED), considering the impact that increased travel distance has on mortality rates and time delays for patients during emergency situations. Prolonged delays in care have contributed significantly to a spike in patient deaths, increasing twofold in the last 5 years, from 27 deaths in 2015 to 59 in the most recent year. Individuals experiencing “severe harm” have also risen from 96 to 152 during the pandemic, while the overall number of people suffering some degree of harm in such circumstances has surged from 3,797 in 2019 to 7,858 in 2022, making it a 97% increase.4

Why prioritise the ED over other departments? The rationale lies in not entirely substituting traditional hospitals, as the operational demands of a mobile hospital surpass those of a traditional setup. The ED can be regarded as a self-sufficient mini-hospital, equipped comprehensively with the necessary technical, technological, and treatment infrastructure, encompassing both surgical and diagnostic capabilities. By integrating key focus areas, prioritising the ED, we can optimise the functionality of mobile hospitals to address the urgent healthcare needs of individuals in remote areas efficiently and timely.5

**Limitations**

However, several challenges must be considered and addressed before the establishment of mobile hospitals.1

1. The necessity to establish proper connections between various areas of the hospital to organise the flow of patients, personnel, and materials, and to enable access control to each individual suite of care.4

2. The importance of adhering to high standards by establishing systems which involve integrated health management and control of air-flow directions and pressures.1

**Background**

Health inequalities is widely prevalent in the borough of Brent; having a major influence on physical and mental health.

COVID-19 exacerbated existing health inequalities in Brent, which had the highest mortality rate during the pandemic. Highlighting the urgent need to address health in deprived and ethnic minority communities.

A partnership between the NHS, local authority and voluntary organisations; setup to understand the barriers patients face in gaining access to healthcare and social care. Adopting a co-production model utilising an integrated neighbourhood team across Brent.5

**Objectives**

- Medicines optimisation
- Reducing polypharmacy
- Bridging the gap in health inequalities via education
- Advisory and counselling

**Methods**

**Results**

- **Interventions**
  - 140 patient reviews completed (Aug 2022 to Nov 2023)
  - 675 interventions (Aug 2022 to Nov 2023)
  - Average Reduction of 30 medications after review per Patient

<table>
<thead>
<tr>
<th>Risk Significance of the MH interventions</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>86</td>
<td>43</td>
</tr>
<tr>
<td>Medium</td>
<td>85</td>
<td>42</td>
</tr>
<tr>
<td>Low</td>
<td>88</td>
<td>43</td>
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**Aims**

To provide a Structured Medication Review to patients identified as having complex medication needs falling within the health inequalities cohort. To improve patient outcomes and optimise long term disease management.

**Discussion**

By reviewing the medications and health outcomes in individual cases, the evaluation can provide insights into the effectiveness of the medication interventions and highlight areas for improvement. By prioritising the ED, we can ensure the success of mobile hospitals.

In conclusion, tackling place-based inequalities in healthcare is crucial to ensure equitable access to healthcare services across urban-rural disparities, a key dimension addressed through mobile hospitals. While maintaining a comprehensive mobile hospital may pose practical challenges, prioritising essential departments such as the ED can optimise the functionality of these facilities. It is important to address challenges such as the establishment of mobile hospitals and maintaining infection control standards to ensure the success of mobile hospitals. By taking advantage of the scalability and critical nature of these facilities, we can mitigate gaps in healthcare access, reduce travel distances, and ultimately improve health outcomes for individuals in rural areas.
Submitted posters

Bridging Health Inequality: The potential of innovation within stem cells in tackling inequalities in healthcare

By Karish Visvanathan

Introduction:

Health inequality is a pervasive issue that affects individuals worldwide, creating disparities in access to medical treatments and overall well-being. It is essential that steps are taken to eliminate these disparities. In this research poster, I will delve into the promising potential applications and use of stem cells, and gene-edited stem cells as a means to tackle health inequality.

Background:

Health inequality in society is a complex challenge that is influenced by various factors including socio-economic status, education, and access to health care resources. Investment into these stem cell techniques could potentially influence the way certain procedures and treatments are administered in revolutionary ways. Stem cells, with their unique ability to differentiate into specialized cell types, offer a plethora of potential treatments, from the manufacture of synthetic organs and combatting otherwise untreated conditions. Furthermore, existence of gene-editing technologies such as CRISPR have further enhanced our ability to modify and optimize these cells for specific purposes.

Applications of Stem Cells and Impacts:

Tackling blood shortage and inequalities concerning access to donated blood:

The availability of safe and sufficient blood is crucial for medical intervention, surgeries, and emergency care. However, there is a massive global challenge in ensuring there adequate and equitable supply of blood bags. Certain blood types are donated less frequently, leading to shortages and challenges in meeting the diverse need of patients. Furthermore, certain ethnicities have unique blood groups and types and it can be almost impossible to find a match on certain occasions. Approximately 15 million units of red blood cells are collected in the United States on a yearly basis, and only 5% are transfused. Additionally, the need for blood bags for transfusions is expected to rise due to increased healthcare demands from the aging population in most developed nations. Although the frequency of disease transmission from infected individuals is low, it is due to rigorous testing and blood donor screening, many developing nations lack the infrastructure required to achieve this level of safety.

One way of potentially solving this crisis, is by utilizing stem cells in manufacturing the specific required blood type. Red blood cells, the body’s most abundant cell type are highly specialized cells, uniquely adapted for their primary function of delivery of oxygen around the body. The specific process of stem cell differentiation known as ‘erythropoiesis’. Proerythroblasts, first formed from multipotent haematopoietic stem cells, undergo a complex process of differentiation. The rate of ongoing production of new red blood cells is at a rate of approximately 2 million cells every second.

One research tested the viability of red blood cells produced by stem cells through testing on mouse, and results found that the Hemoglobin saturation at certain partial pressures of oxygen was very similar and in line with that produced by the control. From this, we can take away that the red blood cells produced in vitro, are just as viable in performing their core function as human-produced erythrocytes. One major difference noticed was that the stem cell produced red blood cells were 40% larger than donor erythrocytes with the same concentration of hemoglobin but 50% more hemoglobin per cell due to the larger size. This mouse model could potentially be used as a rapid pre-clinical test of the stemRBC (stem cell red blood cell) effectiveness prior to transfusion in humans.

This alongside a proposed method of large-scale production of red blood cells, where through first producing a culture that undergoes expansion and differentiation to produce high yield enucleated RBCs. Additionally, the potential of upscaling using a ‘G-Res bioreactor’, provides a large-scale, cost-effective method of producing customizable RBCs, that negate potential risk of alloimmunization and increase precision medicine, personalizing treatments more. This will be particularly essential for certain obscure blood groups present in certain individuals due to genetics, where proportion of those donating blood by population may be low, thus helping to address the inequality in access to blood bags for that population.

Tackling shortage of organ donors and high demand for organ transplants:

Organ donations present a major medical challenge and deciding between who receives the available organs are tough decisions to make, and have many ethical arguments. By utilizing stem cells, from the person requiring stem cell themselves, we mitigate any potential rejection or autoimmune response from the body, thus reducing the need for expensive immunosuppressant drugs.

Additionally, a breakthrough in forming embryonic stem cells from adult stem cells allows for further differentiation and specialization as embryonic stem cell can differentiate into any type of cell in the body. This can apply in conditions such as heart failure, liver failure, Type 1 diabetes and Parkinson’s disease, where certain cells are failing to perform their function. This would mitigate the need for transplantation of an entire organ thus freeing up organs for those with a greater clinical need.

Conclusion:

The future prospect of being able to generate any type of cell using embryonic stem cells obtained from adult stem cells to reduce the need for organ transplantation as well as the potential for solving the blood bag shortage and lack of blood donation is very promising. These advances will be quintessential in tackling inequalities that are brought about lack of access to blood as well as lack of organ donors to meet the demand of organ transplants. Additionally, they present a very cost-effective method of producing blood and treatments for conditions which will help those in developing countries that lack the infrastructure to provide such treatments. Overall, pursuing stem cell research will unlock many promising methods that can increase access to good healthcare for all.

Bibliography

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5. https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0166657
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Individuals facing multiple disadvantages are enmeshed in a complex web of challenges stemming from a convergence of factors, including poverty, trauma, and discrimination. Weight stigma perpetuates and magnifies health disparities in already marginalised populations (Shaw, Meadows 2022). Weight stigma, a pervasive form of prejudice and discrimination based on body size, stands as a significant factor further complicating the lives of those already facing multiple disadvantages and health conditions correlated with higher weight (Meunnig 2008).

However, a comprehensive approach to improving public health, independent of weight change, is offered by a lived experience-led and culturally sensitive promotion of health and weight maintenance, through accessible and enjoyable physical activity, realistic and balanced nutrition, and unpressurised reduction of alcohol and cigarettes. Utilising social prescription to rebuild trust, through training, and not focusing on weight as a health metric can re-engage individuals facing multiple disadvantages.

In 2021/22 a £30.5m spend on Tier 2 Weight Management led to 1311 people achieving 5% of their bodyweight (OHID 21/22 WMS). In 2023 England spent c. £785m in contracts with a weight management element.

Outcomes:
- During a series of hear and learn pilots we used Happiness Pulse (SWEWBS and ONS4) for quantitative scoring and anonymous feedback routes for qualitative evaluation.
- Working weight inclusively can help an organisation to:
  - Increase recall and engagement with core health groups and general population.
  - Contribute to reductions in health inequities.
  - Refocus on managing health instead of weight change.
  - Improve inclusive staff wellbeing.
- What people tell us after attending the course to realise...
  - I want to feel positive about my body.
  - I want to be more comfortable with less critical, stop thinking about myself.
  - I want to be stronger and look after myself.

The discussions, supportive regular classes have been helping people become more accepting and supportive of each other.

Healthy Lifestyles Habits and Mortality

- In 2023 England spent £185m in contracts with a weight management element (Bidstats 2023).
- In 2020/21 £253m was spent on Tier 2 Weight Management led to 1311 people achieving 5% of their bodyweight (OHID 21/22 WMS).

Evaluation outcomes:
- 85% of participants felt the programme was delivered well.
- 91% felt the programme was led and managed well.
- 87% found the training group identified and invited participants.
- 75% felt the programme was easy to access.
- 70% felt the programme was effective.
- 71% enjoyed the sessions.
- 67% found the programme was easy to access.
- 67% found the programme was effective.
- 39% found the programme was easy to access.

Data correct July 2022.

By listening to lived and tempting experiences, since 2015, we’ve gathered ongoing consensus to co-design workforce training and citizen courses for continued knowledge maximisation. Creating an evidence alternative to ‘slimming clubs’ internal and strengthening social prescribing systems in the process.

Active
- 85%
- 75%
- 91%
- 87%
- 70%
- 67%
- 39%

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- 75%
- 91%
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The Importance of the Student-led Website, Skin for All, on Tackling Racial Inequalities in Medical Education

Naibil Khan, Third Year BMBS Student, University of Exeter

Introduction

It is vital that the issue of ethnic minority representation is understood and campaigned for in the medical community. This will drive the movement towards a future of proportionate representation within medical education, and in turn, improve the recognition rate and risk perception of diseases in all skin tones.

Skin For All aims to improve patient knowledge, and patient wellbeing by being a source of accessible information for commonly seen conditions. It also aims to provide medical students with a comprehensive and well-rounded level of understanding when discussing skin conditions and their presentations on different skin tones.

COMPONENTS OF SKIN FOR ALL [4]

- **Summary:** Can be used to gain a clear and accessible summary of these conditions before delving into the more detailed elements of disease profiles.
- **Epidemiology:** Aimed at medical students who can use it in case studies, problem-based learning and understanding the general prevalence of conditions. They range in areas affected across the globe with studies and reports gained from organisations such as the WHO.
- **Pathophysiology and Management:** This has been split into two parts according to the level of medical knowledge held by the user. Medical jargon is defined for non-medical users and simplified sentences are written to improve accessibility to the website’s content.
- **Image Inclusion:** The images used were chosen to represent multiple skin tones and types. It also includes a variety of condition stages to understand how these conditions impact differently on a range of skin tones.
- **Myths:** These are included to clear misinformation and support users as much as possible. This also allows the user to research further into conditions they are interested in with helpful and relevant links.
- **Questions:** Based on conversations, the use of questions for each condition has proven useful for everyone. By providing a list of recommended questions, the consultations with doctors can also be less intimidating and more structured and informative to the patient/individual.
- **Support:** These links allow users to delve into further reading and support surrounding the conditions mentioned on the website.

User Feedback

"Such a fantastic website aimed at an extremely important topic – our education needs to represent our population and Skin for All can play a part in that!" – Abigail, Fourth Year Nottingham Medical Student

"This is an absolutely incredible resource. This is on the same level as the excellently written Mind The Sugary Snack guide –” – Ricci, Second Year Stellenbosch Medical Student

"Skin for All is such a transformative website. It is so useful for both the general public and medical professionals to be informed. It is very big step for representation in healthcare!" – Sara, member of the public

"I’m amazed at how much information there is. I found out loads on one of the pages, thanks for the content, I’m very grateful!" – Ron, BMBS committee member

Research [4]

- I used 6 different sites to determine the most common conditions that affect patients.
- 1. Global Skin Disease Morbidity and Mortality: Update from the Global Burden of Disease
- 2. Epidemiology and Management of Common Skin Diseases in Children in Developing Countries
- 3. The Burden of Skin and Subcutaneous Diseases: Findings from the Global Burden of Disease Study
- 4. Adequate Institute of Arthritis and Musculoskeletal and Skin Diseases: Skin Diseases
- 5. Skin, hair and nails: Mise Inform
- 6. Amott the Gap by Malwane Makwane

The sites used also cover the multiple, international populations that may use this website, so studies and reports from developing, and developed countries were chosen.

Aims of Skin for All

- To utilise inclusive language for all patients and medical students
- To present diverse images to improve case exposure
- To provide supportive links to educate users on myths/misconceptions
- To promote student-led initiatives in reducing racial inequalities within medical teaching materials

References

- 1. Global Skin Disease Morbidity and Mortality: Update from the Global Burden of Disease
- 2. Epidemiology and Management of Common Skin Diseases in Children in Developing Countries
- 3. The Burden of Skin and Subcutaneous Diseases: Findings from the Global Burden of Disease Study
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Conclusion

The importance of bottom-up engagement of students in projects like Skin for All can help support the movement towards more representation and diversity in the medical school curriculum. Other methods of change include calling for more cases regarding ethnic minority patients to be integrated within seminars, lectures and problem-based learning (PBL) groups. As well as a call for the inclusion of images and recommended reading lists which will further enable the normalisation of diversity.

Further research is required to present the outcomes of Skin For All, however, it has currently gained public attention through social media and television coverage. It’s prominence in medical academia is growing with the use of presentations, broadcasts, PBL integration and cross-university lectures.
How adopting the Australian website “Health Translations” into regular medical practice within the NHS can reduce health inequalities within the UK for individuals with limited English proficiency (LEP)
By Aditya Bose- Mandal

**BACKGROUND**

The United Kingdom remains a diverse country with many different cultures and individual living together within its many communities. Within London itself, over 300 different languages are spoken everyday. However, this diversity is far reflective in our healthcare setting with translation services and information scarcely available in non English formats. This in itself identifies a larger issue within our healthcare system; The ever growing gap in health care outcomes and health inequalities between those who have limited English proficiency and those who do not. Migrants within the UK are already reportedly less likely to seek medical attention if required due to cultural beliefs but the further alienation can occur if receiving information regarding health care you need is delivered in a format that you already struggle to understand an interpret. So the question at large is how can we readily, affordably and practically tackle this issue?

**The resource**

Health translations is a program made by the Australian state government of Victoria. The centre for Culture, Ethnicity and Health (CEH) maintain the content of the website and ensure that it is up to date. The Heal Translations website is a free to use online resource which contain translated healthcare information in a majority of languages. It is particularly useful for Australian health care professionals who require resources when discussing healthcare with individuals who’s first language is not English. This resource an be found at https://www.healthtranslations.vic.gov.au

Adapting this website into regular practice within the NHS can reduce health inequalities by allowing patients with different linguistic requirements to better understand their physicians and their own health issues. This would in turn reduce health inequalities as patient’s with limited English proficiency would be able to understand more about their health issues and gain confidence with asking for help.

**How does the resource work?**

The website itself does not have original content but rather it provides links to reliable and vetted third party websites that provide health care information in the required language. The resource can then be viewed or download of the third part website. To ensure the quality and safety of the resources, each resources must meet the criteria outlined by the website’s editorial guidelines.

Healthcare professionals can easily navigate the website on their phones or electronic devices simply by searching the directory using a key word or phrase regarding the desired procedure or condition they want to provide information on and then searching the language required. This will then direct the clinician to a verified resource in the patients own language that can be printed off or given to the patient to read or it can be used to supplement information within a consult.

**Implementation and Benefits**

How could this be implemented?

This website can be readily implemented into clinical practice simply by using the existing Australian website which can be accessed within the United Kingdom. Although the website is relatively straightforward to use, a pamphlet explaining how to optimally use the website could be produced in multiple languages so that patients could explore the website themselves.

Potential benefits of implementation

Clinicians would be able to regularly provide patients with further information in the patient’s own language which can greatly improve patient and doctor rapport. This resource can also reduce the requirement for translators in medical settings and can allow for treatment to move at a more efficient pace as understanding from patient’s will be more complete. Patient’s who’s first language is not English may also feel more at easy with their condition or procedure being explained in their own languages and may be more inclined to be involved in health care decision making.

**Studies assessing the validity of using these resource types in clinical practice**

Study A

Study A is a mixed methods exploratory study which trialed three mobile translation apps within health care settings in Australia to address language barriers in everyday care between healthcare staff and older people with limited English proficiency (LEP). This study used a standard for reporting of qualitative research checklist to analyse the responses from patient’s using the translation apps. At the end of the three month trial period, the conclusion was that translation apps helped improve communication between health care staff and older people with limited English proficiency for basic care needs. 65% of the health care professionals felt that using translated materials in the future can help them improve health outcomes for patients with LEP.

Study B

Study B is a systemic review identifying published studies or the implications of language barriers in healthcare using two databases. The study found that language barriers within healthcare can lead to significant miscommunication between patients and health care professionals leading to a increased risk of harming patients and decreasing the standard of health care provided to the patient. The review also concluded that interpreter services contributed to the increasing cost and length of treatment visits. The study also concluded that online translation services and online translation resources increased satisfaction of both medical providers and patients with LEP by up to 92%, overall decreasing the negative health outcomes.

**References**


### Project Title
Anti-Stigma Campaign (Talk Listen Change (TLC), Luton Young Voices (LYV), BLMK Prevention inspired)

### Authors
Fiona Mackay (Public Health Manager in Mental Health, Luton Borough Council)

### Tell us about your project?
What is the project? Luton’s Mental Health (MH) Campaign, Phase 1: ‘5 ways of wellbeing,’ encouraged individual self-care. This is Phase 2, aimed at communities, to improve social support from the general public, towards those who are feeling distressed.

Who are you targeting? The general public, with the intention of improving the quality of social connections towards those experiencing distress. This increased social support within communities, is intended to help with MH prevention, reducing need for mental health services.

Where is it happening? Bus stops, social media. (Future: Training materials)

### What did you do?
What did you do? I created a set of images for use at bus stops, on social media, and to be adapted for use in training for organisations, in collaboration with many people with lived experience, and professionals. These are aimed at the general population, to tackle stigma, by encouraging family and friends to stay connected to support, rather than withdrawing socially from others who are feeling distressed. The idea is to create more supportive communities, who can be there for currently vulnerable members, as a preventative approach to mental health care. The topics covered in the images include ‘Power’ (advantages for some), strong communities that tackle discrimination, resilience, normalising, validating, social determinants, and more.

How have you engaged with your target group? Findings from TLV and LYV have informed this project. Co-production has taken place across BLMK and nationally, across adults and young people, and including professionals, voluntary sector groups, and those with lived experience.

What techniques did you use? These resources are aimed towards members of the general public, with support from an artist. Focus groups took place, showing images, with a script for questions, and their answers recorded. Iterations on images took place, in response to feedback from focus groups.

Who is involved in the project and why? (LE = Includes people with lived experience):

- All LE RMHCC (Re-imaging Mental Health Collaborative), Luton + BLMK ELFT + BLMK Lived Experience Participation Group + CAMHS Luton + See Me (Anti-stigma group). + British Psychological Society Power Threat Meaning Framework Group = Focus group series of 7, shaping images and messaging.

### What have you learned?
What learning can you share?
- Importance of engagement to get the materials right for the people of Luton, including wording, images, and representing diversity, all as per local people’s suggestions.

What was challenging and how did you overcome the challenges? Sourcing funding for preventative work in mental health is a main challenge. For example, employment in mental health roles tend to be fixed term, and not renewed, and so there has been a lot of staff turnover over the course of this project.

What’s next?
Tell us what your next steps are?
- Seeking funding for media campaign experts to support Fiona to create narrative suitable to roll out as a campaign.
- Fighting for parity of esteem= Funding MH prevention work.
- Evaluation of effectiveness of approach, before wider roll out.

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Tell us what your next steps are?
- Seeking funding for media campaign experts to support Fiona to create narrative suitable to roll out as a campaign.
- Fighting for parity of esteem= Funding MH prevention work.
- Evaluation of effectiveness of approach, before wider roll out.

### What will you continue doing?
As above + supporting wider roll out.

### What will you stop doing?
N/a.

### References:
* [https://www.seemescotland.org/stigma-discrimination/stigmastudy](https://www.seemescotland.org/stigma-discrimination/stigmastudy)*
* [https://explore.bps.org.uk/binary/bpsworks/16203439cce733cf/bcea9befa8a62c15b6371b9d76f24e2172687489283b3c4ca6e5d219826310f988a_2018.pdf](https://explore.bps.org.uk/binary/bpsworks/16203439cce733cf/bcea9befa8a62c15b6371b9d76f24e2172687489283b3c4ca6e5d219826310f988a_2018.pdf)*

### Acknowledgements
Add names and organisations that you have worked with: BPS (various groups), RMHCC, See Me, BLMK ELFT, BLMK Lived Experience Participation Group, CYP Focus Group via CAMHS Luton.
HEALTH INEQUALITIES IN MENTAL HEALTH SERVICES: INTRODUCING AYO. ARE YOU OKAY?

BY DEVON LLOYD-MORRIS

Background
- Around 1 in 4 adults in the UK experience mental health (MH) issues such as depression and anxiety.1
- For those who seek help, NHS waiting times for talking therapies can reach up to 229 days in some parts of England.2
- Lack of accessibility to MH services – the extent of this inequality is not seen in physical health services.3
- In primary and secondary centres, there are many missed opportunities to address MH issues.
- This initiative aims to bring MH to the forefront of our minds, widening participation in discussions surrounding MH.

Objectives
- Provide space to talk about MH issues
- Manage transient and mild MH disorders
- Support patients in need of MH advice
- Reduce stigma around MH

Current issues
Inequalities in MH services
- Underfunding, understaffing and overworking in MH services.
- Long waiting list times
- Barriers to accessing MH services

Loneeliness is a significant risk factor for MH issues. Around 1 in 2 adults (49.6%) reported feeling lonely.7 Loneliness was more common in disabled people, young adults, elderly, the homeless and other vulnerable patient groups.7

Method: rolling out the initiative
Survey patients and healthcare professionals (HCPs) to gauge the need for “AYO”.
Recruit HCPs who are interested in providing talking sessions to their patients
Recruit a multidisciplinary team of psychiatrists, psychologists and counsellors to create an online training programme
The programme will train basic psychotherapy training such as Cognitive Behavioural Therapy, Solution focussed brief therapy and person-centred therapy.
HCPs will wear the “AYO” badge to show their training and willingness to talk about MH issues.
Participants will volunteer minimum 1 hour of their time (4 x 15-minute consultations).
Start a pilot study in a local area and monitor the MH outcomes of the population in a 6-month period.

Discussion: What will this achieve?
- Integrate MH services with other physical health specialities and place MH at the forefront of our minds
- Provide a lifeline for those who want MH support
- Complement and support the work of MH professionals
- Improve the accessibility of MH support
- Remove the stigma and fear of talking about MH

Limitations
Increase in work-load for HCPs, potentially precipitating burn-out.
AYO relies on many HCPs volunteering their time which may be impractical.
Participation with AYO may need incentives such as financial bonus or CPD points.
Lack of supervision can lead to mis-management of patients as the programme doesn’t replace formal psychiatry training.
An average of 12 – 20 sessions are needed to reach MH goals.8

Conclusion
MH issues affect us all, so in a team approach, we can all address the inequalities in MH services. Through “AYO”, we can ensure that every patient has access to MH support, regardless of what healthcare setting or speciality they present to.

More than 2 in 5 (43%) said their MH worsened whilst waiting for the talking therapy.5
Over 2 in 5 (43%) said their MH worsened whilst waiting for the talking therapy.5
More than 3 in 4 (78%) of those waiting resorted to emergency services or a crisis line.5
More than 1 in 4 young people (26%) tried to take their own life whilst waiting for MH support.5

References:
Submitted posters

INSPIRE Mentorship Programme: Pilot Study

**OVERVIEW OF INSPIRE MENTORSHIP PROGRAMME**

The INSPIRE Mentorship Programme is a 12 month programme for clinical medical students across the UK. We will deliver four face-to-face sessions, longitudinal mentorship for students interested in Plastic Surgery and regular online teaching. We hope to support those interested in Plastic Surgery but who may feel discouraged by barriers or misconceptions. This will be a Pilot Study delivered to 20 medical students following a competitive application process solely based on interest in the specialty rather than academic background.

**RATIONALE FOR INSPIRE MENTORSHIP**

An online questionnaire was designed and distributed using a recognised survey website (Google Forms) via social media. A total of 206 responses were received from 26 different medical schools.

**SESSION 1: INTRODUCTORY SESSION A CAREER IN PLASTIC SURGERY AND OVERCOMING CHALLENGES AND BARRIERS**

Exposure to plastic surgery subspecialties, discussion of barriers/challenges from senior trainees/consultants from diverse backgrounds.

**SESSION 2: ACADEMIC CAREERS IN PLASTIC SURGERY**

Students will be provided with an insight into academic plastic surgery. Talks from academic trainees (SFP, ACF, ACL and research fellows) and how to access and get involved in research early, often such opportunities are difficult to access at medical school.

**SESSION 3: ESSENTIAL SKILLS IN PLASTIC SURGERY**

Often courses and workshops are costly and can disadvantage students from less financially well-off backgrounds. This will be a free session covering essential plastic surgical skills such as microsurgery and tendon repair.

**SESSION 4: CAREER INSIGHTS & NETWORKING**

Students have access to network with trainees and consultants from all backgrounds. A time to showcase their work and present their learning from the programme.

Help us build a vibrant and inclusive plastic surgery community through the pilot of the INSPIRE Mentorship. Once validated this will be rolled out across the UK and can be incorporated to other specialties.

UMAR REHMAN* 1, GARIKAI KUNGWENGWE* 1, ELENA WHITEMAN 1, SIMON FILSON 2

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*UR & GK ARE JOINT STUDY LEADS

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*UR & GK ARE JOINT STUDY LEADS
Collection and reporting of Equality Act 2010 protected characteristics within studies and audits of pulmonary rehabilitation in the United Kingdom

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1 Department of Respiratory Sciences, University of Leicester, Leicester, UK
2 Centre for Exercise and Rehabilitation Science, NIHR Biomedical Research Centre – Respiratory, University Hospitals of Leicester NHS Trust, Leicester, UK

Background
- Under the Equality Act 2010 (which came into force on 1st October 2010), it is illegal to discriminate based on protected characteristics (Figure 1)1,2.
- Following the Public Sector Equality Duty, it is good practice to collect the protected characteristics of service users2.
- The extent to which protected characteristics are reported in pulmonary rehabilitation research studies and audits are unknown.

Objective:
To describe the extent to which Equality Act 2010 protected characteristics have been reported in UK research studies and audits of pulmonary rehabilitation to date.

Methods
A systematic scoping review following PRISMA-ScR guidelines was conducted across five databases. UK studies and audits collecting data on pulmonary rehabilitation after 1st October 2010 (date of Equality Act 2010 inception) were eligible.

Systematic scoping review PICOS for eligible articles:
- Population: Adults (≥18 years)
- Setting: Any pulmonary rehabilitation setting in the UK
- Intervention: Pulmonary rehabilitation
- Comparator: Any comparator

Age: Reported by 97% (k=34) of studies and 100% (k=4) of audits.
Race: Reported through ethnicity in 3% (k=1) of studies. Reported by 75% (k=3) of audits.
Sex: Reported by 43% (k=15) of studies. 23% (k=9) reported gender with only male and female categories.
Gender Reassignment: Reported by 50% (k=2) of audits. Not reported by any studies.
Disability: Not explicitly reported in any studies or audits. Disease severity reported in all studies and audits e.g. Medical Research Council Dyspnoea Scale (63% (k=22) of studies and 100% (k=4) of audits).

Conclusion
- Apart from age, Equality Act 2010 protected characteristics are either not commonly reported and/or are inconsistently reported in UK pulmonary rehabilitation studies and audits.
- Without reporting protected characteristics, health inequalities relating to pulmonary rehabilitation will remain unclear.
- Development of a reporting framework would be beneficial to support good practice.

References
1. www.gov.uk/discrimination-your-rights
2. www.equalityhumanrights.com/en/equality-act/protected-characteristics

Acknowledgements: This is a summary of independent research funded by the Wellcome Trust and carried out at the National Institute for Health and Care Research (NIHR) Leicester Biomedical Research Centre (BRC). The views expressed are those of the author(s) and not necessarily those of the Wellcome Trust or the NIHR or the Department of Health and Social Care. This study was funded by the Wellcome Trust [204801/Z/16/Z] as part of the Leicestershire Health Inequalities Improvement Doctoral Training Programme [223512/Z/21/Z].
**Submitted posters**

**QI Project: Refusal of Childhood Immunisations**

Why were childhood vaccinations refused at the 6-8 week baby check between 1 September 2021 - 1 September 2023?

What measures can be implemented to increase the uptake of childhood immunisations at the 6-8 week baby check?

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**Overview**

This quality improvement project looked at the number of patients who declined childhood immunisations at the 6-8 week baby check between 1 September 2021 to 1 September 2022.

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**Methodology**

- A patient search was carried out on SystmOne for vaccination refusal at the 6-8 week baby check between 1 September 2021 to 1 September 2022.
- Feedback was collected on the reasons why patients refused vaccinations and how these could be addressed.

---

**Results/Finding**

- **Health Visitor Team Feedback:**
  - They contact parents between 10-14 days after the 6-8 week check.
  - They feel that a physical leaflet would be more beneficial for them to discuss with anxious parents.
  - It is possible to access digital resources during the 10-14 day period.

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**Conclusion**

The role of the community health team in childhood immunisations was explored to assess whether leaflets could be used as a tool to improve vaccine uptake. This can be used by the practice, Centre for Family & Fun (CFF) and health visitors.

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**References**

1. [Link to reference 1](https://www.example.com/1)
2. [Link to reference 2](https://www.example.com/2)
3. [Link to reference 3](https://www.example.com/3)
4. [Link to reference 4](https://www.example.com/4)
5. [Link to reference 5](https://www.example.com/5)
ANTENNAE STUDY: ADDRESSING INEQUALITIES IN RENAL RESEARCH

Neerja Jain

HOW ARE WE ADDRESSING THIS?

Antennae: Addressing NeQualiTiEs in renal research is a QI project being undertaken in partnership with Northern Care Alliance (NCA) NHS Trust renal unit and NHS England for the Future Fund.1 Using Kidney Research UK’s evidence base and multi award winning initiative, Peer Educators have been recruited, supported and trained through accredited training (equivalent to a Higher National Certificate (HNC)).

WHO WILL BE INVOLVED?

Representative of the target communities of the study, and most, kidney patients themselves with experience of research. They are reaching out to under-represented communities and patients at Trust renal units including community events and in hospital units. The target areas are Salford, Oldham and Rochdale, aiming to specifically engage with socio-economic status, Bangladeshi and Pakistani communities.

20% of the people seen at the Trust renal unit are people of South Asian origin. 

"Within a NICE CRF Greater Manchester ‘cotton for approach’ initiative. The service helps people find out about and take part in research and help researchers involve, engage and recruit the right people...researchfortheresult.com"

PROJECT AIM

The aim is to engage, provide information, help them, and explain the importance of their need for involvement and participation in renal research. Then to encourage registering onto NHI’s database to express interest in a preferred type of research. Registered people will only be contacted if a suitable study becomes available and only then, do they sign a consent form to continue to withdraw at any time and indeed have their data removed from the database at any point.

EARLY RESULTS

Some early results demonstrate the impact of a focus on inclusivity has had on empowered, trusted individuals who have lived experience of the issues. Given this is a sensitive subject with historical mistrust, this is a challenging subject to address and lessons learnt will be important for future progress in this area.

Addressing INEQUALITIES

ADDRESSING INEQUALITIES

22 % of the UK population is made up of people with a disability, that’s more than 14 million disabled people in the UK.

"All the way in": Improving access to sexual health services for Disabled People

Dr Cordelia Chapman, Consultant in Sexual Health and HIV, Bournemouth and Lorraine Stanley, GEO SWAD (Sex With A Difference)

Introduction:

Sexual health services pride themselves in being free and available to everyone. In reality, for disabled people, this is far from the truth. Although services have the desire to become accessible for all, funding, staffing and pressures such as the MPox epidemic have meant that other changes to services have been put further behind in priority.

After the HIV Prevention England Conference in September 2022, the local service contacted SWAD to invite them to review our service, and from this, develop a joint plan to improve patient experience.

EARLY RESULTS

• 88% said it is harder for women with physical disabilities to attend or access cervical screening
• 49% said that they have chosen not to attend cervical screening
• 88% said it is harder for women with physical disabilities to attend or access cervical screening
• 49% said that they have chosen not to attend cervical screening

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Aims:

• To improve inclusive access to the service for all local residents.
• To develop a bank of ‘quick wins’ that could be used both in our service and for others.

Method:

• Members of SWAD attended the local service to undertake an assessment as a patient pathway, and to give advice on improvements and changes that would make the service fully accessible.

Results:

• The visit was an extremely valuable process for both SWAD, who could see our service, the environment and facilities, the pathway for patients, and for ourselves, who realised that although we had managed to be accessible to some, there was a long way to go before we were truly accessible to all.

• Suggestions to work on; some of which could be solved quickly and some that were going to be more challenging.

• These ranged from website improvements, communication with patients prior to appointment and at the first point of contact, logistics within the service, advertising and outreach work.

References:

1Gov.uk  https://commonslibrary.parliament.uk/research-briefings/cbp-9602/

Considerations for ongoing practice:

• Visual impairment may not be possible in the clinical setting due to lack of lighting and needs supports for patients with visual impairments, neurological conditions etc.

• Respect dignity/intimacy — in some cases it may be necessary to carry out a home visit, as there may be safeguarding concerns related to professional carers taking intimate photographs of their client.

• It’s important to understand that while lots of people are eligible for the NHS Cervical Screening Programme, a significant number of disabled people have not attended cervical screening due to access problems. Actual data is below.

Existing research of disabled women

49% said that they have chosen not to attend cervical screening in the past for reasons such as previous bad experiences linked to their disability, or worries about how people might react.

Ebook available that can help you to:

• Take action to address health inequalities and promote accessibility for all patients
• Empower yourself to deliver inclusive care and put patients first

https://www.swadstreet.e ia/accessibility-ebook-published/

"I think it’s an awesome and informative booklet. It’s a great checklist for thinking about what needs to be put in place to make services more accessible and the resources and links to the guidance and best practice are extremely useful."

Reviewed by Dr Cordelia Chapman, Consultant in Sexual Health of SWAD's Access Guide.

Copyright © 2023 Dr Cordelia Chapman, Consultant in Sexual Health & HIV, & Lorraine Stanley, GEO SWAD (Sex With A Difference) Email: CChapman@bedsandhants.nhs.uk

Published 19th September 2023

Scan the QR code above to see more information about SWAD's eBook.
What is the problem?

• To equitably improve public health, we need medical literature which is robust and widely accessible.
• Unfortunately, current literature often requires financial incentive to publish and obtain full-access to read publications. It also often requires basic to advanced scientific literacy to understand and apply this information to practice.
• This risks creating inequalities in terms of who is able to contribute to health research and the audience which can receive this information.
• The risk is that this can subsequently translate into health inequalities.

Our mission

• Universal Medicine is a not-for-profit research collaborative and e-learning tool founded in 2016 by 4 students. Since then, we have recruited in excess of 30 members onto our editorial board and team of writers.
• We believe that medical research should be curated with the aim to widen access and participation, and minimise inequalities with who can contribute.
• We have developed a platform for writers to safely publish medical research posts which can be quality-checked by our editorial board to ensure accuracy of information and appropriate standards of referencing.
• Our platform aims to improve the confidence of our writers to ultimately contribute in impactful research which has the scope to change clinical practice.
• Since the time of launch, Universal Medicine has published 191 posts till date, attracting over 58,000 views from across 18+ countries.

The scale of the impact

![Chart showing views and comments over time]

Figure 1: Universal Medicine views charted by date (extracted on 03/12/2023)

Top Locations

![World map showing geographical distribution of views]

Figure 2: Geographical distribution in the readership of Universal Medicine (extracted on 03/12/2023)

Future directions

• We aim to introduce speciality sections to segregate our posts into themes and optimise research retrieval.
• We aim to increase our recruitment drive over our social media platforms and promote international recruitment.
• We aim to diversify our readership to ‘hard-to-reach’ and less developed nations.
• We aim to continue to develop our collaborative and welcome recommendations from the wider public and our internal working group to improve our platform.

Disclaimer

• Universal Medicine is a not-for-profit research collaborative and e-learning tool. We have no conflicts of interest to declare and do not sponsor any products nor services.
• Published posts are produced by the contributing author and reviewed by our internal editorial board.
• The information is published to our best knowledge and Universal Medicine does not accept any liability for inaccurate information.
• The published posts are not to guide health decisions, please consult your responsible care physician for any health-related inquiries.

Affiliated groups

• Universal Medicine Blog
• UniversalMedicine Blog
• UniversalMedicineBlog
• UniversalMedicineBlog@gmail.com

https://universal-medicine.blogspot.com/
INTRODUCTION: Why Tackle Fuel Poverty?

Fuel poverty exists when a household spends more than 10% of its income on energy costs. In England, around 2.3 million households are living in fuel poverty, and this is a significant issue as it affects the most vulnerable groups in society, such as those with disabilities, the elderly, and families with young children. Living in cold homes can have serious health impacts, including increased emergency hospital admissions, increased demand on healthcare services, and higher mortality rates. The UK government has set a target to eliminate fuel poverty by 2021, but this remains a challenge due to the persisting issue of fuel poverty, especially in certain areas.

The concept of fuel poverty is complex and multifaceted, involving factors such as income, energy efficiency, and the cost of energy. A household is considered to be in fuel poverty if it spends more than 10% of its income on energy costs, which can lead to financial stress and affect the household's ability to meet other basic needs such as food, clothing, and healthcare.

Reducing fuel poverty is not only a matter of improving energy efficiency but also involves addressing the underlying causes, such as poverty, inequality, and social disadvantage. There are particular challenges in accessing care for people who may not be able to afford the necessary energy services, such as in areas of high deprivation.

ADVICE

In the advice service, we provide detailed energy advice for all residents in Leicester. The service works to ensure that residents have access to information about how to reduce their energy costs and improve their energy efficiency. The advice service offers a range of services, including energy assessments, detailed energy advice, and access to government support.

Energy efficiency is key to tackling fuel poverty. Homeowners who make energy-efficient changes can save money on their energy bills and improve their quality of life. The advice service also helps residents to access existing retrofit schemes and provides information on how to apply for government support.

COMMUNITY OUTREACH

Our programme understands the importance of delivering advice to the target audience in a way that is accessible and relevant to them. We have worked with community leaders to engage residents and provide them with the necessary information to make informed decisions about their energy usage.

Training

The training is for energy advisors, and we have delivered a series of webinars addressing key fuel poverty topics. The training is designed to help those who are new to this work or those who want to improve their knowledge and skills.

IMPACTS AND CONCLUSION

Our programme has shown that a multi-pronged approach is necessary to tackle fuel poverty. Through a combination of energy efficiency measures, government support, and community outreach, we have been able to make a difference in the lives of those affected by fuel poverty.

ACKNOWLEDGEMENTS

This work has been supported by the UK government and the Leicester City Council.

REFERENCES

The importance of diversity in patient involvement when co-creating artificial intelligence healthcare solutions

Kartina Mason, Sarah Khawandi, Ernest Lim, Sian Rees, Paul Hims, Barbara Loizzi, Nick de Pennington, Aisling Higham

About Ufonia
- Ufonia is a digital health company that has created ‘Dora’, an AI-driven clinical assistant which can conduct a natural language telephone conversation with a patient (1)
- Ufonia is a UKCA Class 1 approved medical device
- Dora is a UCRA Class 1 approved medical device
- Ufonia has partnered with the Health Innovation Oxford & Thames Valley to ensure robust PPI processes
- Marginalised and underrepresented populations in healthcare use Dora
- Dora is a UKCA Class 1 approved medical device
- Ufonia is a digital health company that has created ‘Dora’, an AI-driven clinical assistant which can conduct a natural language telephone conversation with a patient (1)

How Patients have been involved in Ufonia’s work
- Giving voices to marginalized groups (see Table 1)
- Testing Dora (2 to 1 technology trials)
- Proridalisation of next development steps
- Patient voice as representatives on steering groups

Table 1. Patient populations involved in PPI activities at Ufonia

<table>
<thead>
<tr>
<th>Patient Populations we have actively involved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients with Learning Disabilities</td>
</tr>
<tr>
<td>Neurodiversity (including Autism)</td>
</tr>
<tr>
<td>Cancer Patients (with cancers)</td>
</tr>
<tr>
<td>Ophthalmology patients with a diverse ethnic background</td>
</tr>
<tr>
<td>Non-English speakers (Polish language group)</td>
</tr>
<tr>
<td>Patients with mental ILL-health</td>
</tr>
</tbody>
</table>

How diversity in patient public engagement activities important when generating AI solutions?
- The importance of diversity in patient public engagement activities is crucial when generating AI solutions
- AI healthcare innovations must meet the needs of underrepresented populations
- AI healthcare innovations must meet the needs of underrepresented populations

You said
- Feeding back on patient involvement with ‘Dora’
- Ufonia has commissioned the Oxford AHM to ‘Understand public attitudes to the use of Artificial Intelligence in healthcare services’

We did
- Governments are asked for data before they sent them to the Dora call
- Some people with a learning disability are advised not to present ‘unknown number’ calls
- ‘How do I know I can trust Dora?’
- Removing the execution of cancer from the head & neck cancer treatment
- ‘Cancer is a scary intimidating term’
- Clear instructions from hospital teams, reminders in the Dora call
- ‘Not sure what to expect from a call’
- Watch a video of a patient talking to Dora

Figure 1. Visual representation of Dora, Ufonia’s AI-driven clinical voice assistant

The problem
- Lack of racial diversity in medical textbook illustrations is widely criticised
- Louie et al analysed 1,541 images from the top 4 medical textbooks in the United States and found overrepresentation of light skin tone and underrepresentation of dark skin

The Unofficial Guide to Surgery
- The Unofficial Guide to Surgery (UGS) is concise summary of the most common operations across all surgical specialties, detailing how the operation is performed, indications, contraindications, complications, the pre/post-op care and follow up
- Each operation is accompanied by illustrations, one of relevant surgical anatomy, the other a snapshot of the surgery itself

Methods
- UGS illustrations were reviewed. All images depicting skin were categorised according to the Fitzpatrick phototyping scale
- The British Association of Dermatology (11) and DermNetNZ (12) visual references for the Fitzpatrick Scale were used as reference
- Analyse separated illustrated images (patients) and photographic images (surgeons)

The Unofficial Guide to Surgery & Skin tone representation
- Crop the lack of diversity of skin tones in medical textbooks the editors proactively chose to re-dress the balance in both the representation of surgeons and patients
- Medical illustrators were employed to depict operations with patients with a variety of skin tones
- A black female surgeon was chosen for the front cover image in both the first and second editions

Results
- The UGS contained 187 images depicting skin
- Off the 172 illustrated patient images (6%), 13.6% (27), 10.4% (18), 23.4% (37) and 27.7% (48) were Fitzpatrick type 1, 2, 3, 4, 5 and 6 respectively (see Figure 1)
- Of the 15 photographic images 100% were black females, Fitzpatrick type 6

References

Katrina Mason, Gareth Rogers, Isabel Williams, Francesca Corra, Zeshan Qureshi

September 5, 2021

Digital Health Innovation Programme
Oxford & Thames Valley

THE EMPOWERMENT PROJECT

Poppy Sullivan, Natalia Olszewska, Parmis Vafapour

The Empowerment Project, a student-led initiative at Barts and the London Medical School, aims to reshape the medical curriculum to address and reduce stigma and marginalization within the NHS. Inspired by a panel talk event that revealed personal stories of challenges like accessibility issues, imposter syndrome, moral injury, and discrimination, the project advocates for proactive changes in the curriculum. Over the past two years, a three-step program has been implemented for first to third-year medical students, equipping them early in their medical journey to confront bias and discrimination.

STEP 1: ACTIVE Bystander Project
- Equips first and third-year medical students to handle open discrimination.
- Teaches the 5 D’s (distract, delegate, document, delay, direct) and the ABC approach (assess safety, be in a group, care for the victim).
- Addresses unconscious bias early - crucial for improving patient care [1].
- We aim to cultivate a generation of doctors who reflect on biases and treat patients more fairly, contributing to better healthcare [2].

STEP 2: “70kg MAN” Lecture
- Lecture exposing the biases within healthcare.
- Highlights the 70 kg man used as a standardised figure within medicine.
- Shows how medical science neglects group such as the BAME community and women.
- Uses examples of disparities in autoimmunity, nomenclature, pain management and history of medicine (particularly the lithotomy position).
- Demonstrates importance of questioning what is taught as the norm.

STEP 3: “ELEPHANT IN THE ROOM” Panel Talk
- Panel talk between medical students and healthcare professionals.
- Presents the realities of the medical profession and highlights pertinent issues present within the NHS.
- Each year, the themes are changed to best address the social climate.
- Encourages students to self-reflect on their own biases and assumptions.
- Fosters the notion of creating change for a more inclusive environment within medicine.

IMPACT ON HEALTH INEQUALITIES

Maternal health within BAME communities is one of the clinical areas in the NHS' Core20PLUS5 targets for reducing health inequality [3].
- A study on maternal death in the UK showed that improvement to care of the BAME women was more likely to change their outcome because they had faced a variety of microaggressions [4].
- The Women’s Health Strategy from the UK government found doctors do not discuss sexual health with older women because the presume they aren’t sexually active [5].

ENCOURAGING MEDICAL STUDENTS TO CONSIDER THESE ISSUES NOW, COULD ENSURE THAT THEY TREAT ALL THEIR PATIENTS FAIRLY AND GIVE THEM ALL AN EQUAL VOICE SO THEY ALL RECEIVE THE SAME STANDARD OF CARE.

FUTURE OF THE EMPOWERMENT PROJECT
- Encourage students to discuss bias, discrimination and life in the NHS.
- Introduce steps into medical school curriculums early to create a culture change within the NHS.
- Encourage our future doctors to consider the behaviour of their colleagues and themselves and to speak out about discrimination.
- Address health inequalities occurring due to bias.
- Roll out to other medical schools, other healthcare related university courses like nursing and midwifery, and potentially to healthcare staff in the NHS.
Launching a Primary Prevention Programme in 76 Secondary Schools Across the UK: A Transformative Acceleration Programme

A. Alam, L. Fernandez, A. Ghatane, L. Chajed, M. Shafi, J. Hayes, M. Gurko, S. Welling, L. Troylov

To enhance our future plans, we aim to establish strong partnerships with local councils and other education bodies to ensure the provision of high-quality education that meets the needs of all students. We also plan to advocate for governments to include more teaching about health inequalities within the curriculum, to educate students about the issues faced by society and help them develop solutions to address them. In addition, we aim to organise more community engagement projects, such as Hackathons, to foster creativity and innovation amongst students and encourage their active involvement in making positive contributions to their local communities.

REFERENCES


Feedback from Attendees:

"Yes, it has given me peace of mind that the advice given has helped"
Medical Aid Camps for Underprivileged

Dr Syed Ammar Husain
Academic Foundation Year One, University Hospitals Sussex

“Thar Desert” is known to be one of the poorest regions of Sindh with 47% of Tharparkar children malnourished and a lack of access to basic healthcare needs.” (1)

What did we do?

In my capacity as a healthcare volunteer, I was involved in various activities, including conducting baseline tests, reviewing patients and their families, prescribing and dispensing free medications, collaborating with senior physicians on complex patient cases, and distributing rations.

In my capacity as a healthcare volunteer, I was involved in various activities, including conducting baseline tests, reviewing patients and their families, prescribing and dispensing free medications, collaborating with senior physicians on complex patient cases, and distributing rations.

Disease Demographics:

- We provided critical assistance in diagnosing and treating numerous cases of Malaria, Scabies, Polio, seizures in children and Hepatitis in adults, offering free testing as a part of our efforts.
- A significant proportion of children presented with nutritional deficiencies, leading to the prescription of vitamin supplements, folate acid, and iron supplements to address underlying anaemia.
- Provided patient education to prevent and manage easily treatable chronic conditions, such as Type 2 Diabetes, Anxiety, Arthritis and high prevalence of Asthma and Allergies.

Interesting patient cases:

- Dermatology saw a vast range of complex cases including Allergic Vasculitis, Xeroderma Pigmentosum and Tuberous Sclerosis.
- Stroke episodes presenting at a late stage with hemiparesis of left side of face, arms and legs.
- Congenital Cardiac abnormalities in a young child presenting with a murmur and palpable apex beat.
- Other paediatric cases of Cerebral palsy, Malaria, Juvenile idiopathic Arthritis deformity, untreated late presentation of fractures.

Conclusion

- The team saw 2,400 underprivileged patients in total across four medical camps.
- The team delivered 300 ration distributions of water, food and clothing to the poor and needy children.
- Dispensing 97 types and formulations of free medications to the underprivileged.

Pharmacy Dispensing in Thar Institute Medical Camp

A pediatric consultant conducting a throat examination in the pediatric clinic of the Choor camp to diagnose the presence of tonsillitis infection.

A junior doctor is performing a respiratory examination in the General Medicine clinic located at the Dhoronaro camp.

A Junior Doctor and a supporting Nurse are engaged in a detailed discussion regarding a complex case with the Consultant Paediatrician at Thar Institute camp.

We aim to improve the accessibility and quality of medical care in remote areas by incorporating mobile diagnostic imaging technologies such as X-rays and CT scanners, as well as enhancing the efficiency of laboratory tests processing.

Future Developments

We aim to improve the accessibility and quality of medical care in remote areas by incorporating mobile diagnostic imaging technologies such as X-rays and CT scanners, as well as enhancing the efficiency of laboratory tests processing.

Reference

- Community World Asia (May 2016) Salvaging a crumbling system facilitating healthcare facilities in.
Neurodivergent individuals, particularly adults, are much more likely to die early and have poor health than the general population. The data for chronically ill or disabled people is unclear, due to stereotypes and biases in research practice and funding. We, SEDSConnective, were founded as a small, community-grown, user-led charity. Now we have 12000 members, most of whom are chronically ill, disabled, and often also carers. Our members are at disproportionally high risk of poverty, as we frequently lose all financial income and social mobility due to our disabilities. We are more likely to be gender diverse and face stigmatism. Our physical health has been misattributed or diagnostically overshadowed for centuries. This is health inequality is particularly stark for girls/women whose poor health is often overlooked and dismissed.

In 2018 SEDSConnective was founded as a user-led community voice charity. At the time, there was no support, no voice and no power for us. "I have been disbelieved all my life, to be neurodivergent and physically ill. This meant I lost nearly everything, physically and mentally."

Neurodivergent people (e.g., autistic, ADHD, dyspraxic, Tourettes syndrome, etc.) are 4 times more likely to have hypermobile joints and therefore experience more pain and dysautonomia symptoms than the general population. This is multisystemic.

SEDSConnective had no money, connections or power. The pressures to secure funding have been extremely difficult with no formal connections or assets.

We had to change many minds and be innovative in unrecognised and very protected established arenas.
Infeasible access to healthcare is a crisis, especially prevalent in developing regions affecting over 5 billion people. Doctors serving large populations with substantial resource burden lack opportunities for training events due to the immense consuming and expensive nature of surgical training requiring specialist supervision (Meara et al., 2015). This underscores the pressing need for innovative solutions. We developed an immersive live streaming and retransmitting virtual reality (VR) technology for mobile phones. Our solution affords affordable, scalable, and accessible surgical training specifically tailored for low- and middle-income countries (LMICs).

Key Features and Benefits

- **Cost-effective**: VR training modules cost $25 per day, compared to $250 for traditional training methods.
- **Scalable**: Training modules can be scaled up to accommodate large groups of learners.
- **Interactive**: Learners can interact in real-time, enhancing engagement and learning outcomes.
- **Flexible**: Training can be accessed anywhere, anytime, making it accessible to learners in diverse locations.
- **Efficient**: Training modules are designed to be time-efficient, reducing the need for long-term commitments.

## Background

### Key Achievements

- **Narang et al. 2023**: Conducted in-depth interviews 1-4 months after a 4-day course involving 79 doctors and medical students from Uganda, along with 569 remote attendees. The findings of the study demonstrated 1) Enhanced learning with 560-degree visualization compared to traditional methods. 2) The immersive approach fostered increased connectivity among learners. 3) Potential for content and skill sharing, contributing to the program's capacity building. 4) Safe learning environment through simulation.

### Potential Weaknesses

- Need for feedback during the training.
- Less accuracy.
- Lack of physical interaction.
- Lack of muscle memory.
- Lack of haptic feedback.

### Future Projects and Beyond

- **Expansion of VR Training Modules**: Develop additional VR modules covering a broader range of surgical procedures and medical specialties.
- **Global XR Hubs Establishment**: Establish XR hubs in 20 LMICs over the coming year.
- **Collaborative Partnerships**: Strategic partnerships with international medical organizations, educational institutions, and technology innovators.

### Key Features

- **360° In-a-box**: 460 cadaveric surgical procedures.
- **Live streaming capabilities for real-time interaction.**
- **Immersive 360° visualisation.**
- **Affordable and accessible smartphone-enabled headsets.**
- **Extended reality (XR) hubs with advanced VR headsets and hand controllers.**

### Key Challenges

- **Lack of physical interaction.**
- **Lack of muscle memory.**
- **Lack of haptic feedback.**

### References

- Narang et al. 2023

### Key Achievements

1. The University of Buckingham
2. Brighton and Sussex Medical School
3. Princess Royal Hospital
4. Queen Victoria Hospital

### Affiliations

- **In-Person Live Streaming Courses**
- **Largest Surgical Training Resource**
- **Strengthened six-one-week courses to 600 participants in 600 countries.**

### Key Features

- **Innovative Elements of VR Training**: 360° visualisation, immersive interaction, interactive elements.
- **Assessment Tools**: Objective structured assessment of learners' (OSALT).
- **Innovative Experiences**: Personalised learning paths, interactive feedback.
- **Virtual Reality Integration**: Immersive training experiences.

### Global Impact in Action: VR Surgical Training Across Continents

- **Kenya**: Conducted a pilot study with 20 doctors in Kenya, resulting in enhanced learning outcomes.
- **Uganda**: الهاتف implanted a large-scale training initiative involving 79 doctors and medical students.
- **India**: Developed a comprehensive training program for 569 remote attendees, contributing to improved learning outcomes.

### Potential Weaknesses

- **Need for feedback during the training.**
- **Less accuracy.**
- **Lack of physical interaction.**
- **Lack of muscle memory.**
- **Lack of haptic feedback.**

### Future Projects and Beyond

- **Expansion of VR Training Modules**: Develop additional VR modules covering a broader range of surgical procedures and medical specialties.
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**Background**

- **People Experiencing Homelessness (PEH)**
- **VR surgical training**
- **Access to healthcare across LMICs**
- **Innovative solutions**
- **Affordable and accessible smartphone solutions**
- **Immersive 360° interaction.**
- **Vast library of +400 cadaveric surgical training modules.**

**Aims & Objectives**

- **Developing an understanding of these experiences will guide good clinical practice that considers HSW as an important stakeholder, rather than a bystander.**
- **Developing partnerships with international medical organizations, educational institutions, and technology innovators.**
- **Virtual reality training modules designed to enhance learning outcomes.**

**Methods**

- **Trials and mixed-methods studies.**
- **Half-day workshops involving 29 HSW from homeless hostels in the UK, for whom access to health care was significantly lower.**
- **Physical Health Framework**

**Results**

- **High levels of agreement** on things that need to be improved, such as "access to primary care," "lack of health awareness," and "the need for mental health support."

**Novel Findings & Conclusions**

- **The importance of HCS receptiveness to HSW knowledge** was a novel finding, indicating that collaborative experiences are underpinned by mutual awareness and understanding.
- **The significance of VR technology in enhancing HSW learning and engagement** was highlighted, providing a novel approach to healthcare education.
- **Virtual reality training modules** were found to be an effective tool for enhancing HSW understanding and engagement.

**References**

- Narang, K. (2023) "Breaking Barriers, Bridging Gaps: Working across sectors to improve access to healthcare for people experiencing homelessness: The experiences of Hostel Support Workers."
UCLP-Primrose: Tackling health inequalities by reducing cardiovascular disease risk in people with severe mental illness

Philippa Shaw, Zunera Khurshid, Danielle Lamb, Kristian Husband, Fima Stevenson, Niranthchap Reheli, David Ooster

Severe Mental Illness (SMI, diagnoses like schizophrenia and bipolar disorder):

- is more common in all ethnic minority groups and is associated with social deprivation
- is connected to an increased likelihood of poor physical health: inactivity, poor diet, smoking
- is linked to a higher risk of Cardiovascular Disease (CVD): conditions of the heart and blood vessels
- is associated with risk of multiple long-term conditions and dying about 15–20 years early
- care is commonly not provided in an integrated way, across mental and physical health care
- care is likely to focus on screening for physical health risk only and not prevention / intervention

In 2023, the Office for Health Improvement and Disparities reported a substantial excess of deaths of people with SMI compared to those recorded in 2022 in the UK, indicating a worsening of this health gap.

REDDUCING THIS HEALTH INEQUALITY WITH UCLP-PRIMROSE

UCLP-Primrose is an integrated evidence-based framework which guides healthcare staff in how to best care for their patients with SMI, working to address modifiable risk factors and improve patients mental and physical health. This maps onto key policy for the NHS like the Core20PLUS and links to the 2019 Lancet Psychiatry Commission recommendation to “focus not only on ‘adding years to life’ but also on ‘adding life to years’” (p. 10).

UCLP-Primrose makes sure those patients most at risk of CVD are seen first for their annual physical health check, that those patients who are not engaging are supported to attend their checks, and interventions are provided when modifiable CVD risks are identified. Intervention is matched to patient need and might be medication, intensive behavioural change sessions, peer coaching, and/or signposting to other support.

THE CURRENT RESEARCH PROJECT

Over a decade of research underpinning UCLP-Primrose including development with a lived experience advisory panel and a national randomised control trial. Now we turn our attention to exploring how UCLP-Primrose is continued to be delivered and spread in the pilot sites and is set up and delivered as part of normal care within new locations.

INSIGHTS SO FAR

Our research is set to end July 2024. We have seen UCLP-Primrose be locally adapted and be delivered across new sites, with patient-facing offers of support.

Implementing as part of service transformation highlights ongoing challenges in this complex and turbulent context. Key developments in the shift to integrated care still need such as joint up systems across primary and secondary care.

For implementation to progress there needs to be people championing UCLP-Primrose, internal ownership and team accountability. Sustainability is questioned due to changing NHS priorities and a need to refocus on a culture of within-system learning and prevention/ intervention to support innovative care.

To date we have:
- conducted 31 interviews with those implementing and delivering UCLP-Primrose
- completed 6 visits to GP practices
- collected over 170 documents of notes from meetings with those setting up UCLP-Primrose and training sessions

Data collection is ongoing including recording actions and patient outcomes in patients’ notes and patient interviews are due to start in January 2023.

We are analysing our data with:
- Consolidated framework for implementation research
- Reflective thematic analysis
- Normalisation process theory
- Stanford lighting reports
- Appropriate statistical tests

In HIP

Find out more about InHIP

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**Health Innovation**

**North East and North Cumbria**

Co-designing a bespoke approach to Cardiovascular Disease Prevention in Middlesbrough

an initiative to improve life expectancy in Core20PLUS5 communities through behavioural insights informed community outreach health checks

**What is the health inequality issue?**

North East and North Cumbria (NENC) has the lowest healthy life expectancy and highest health inequalities of any region in England.

The conventional model, whereby we ‘expect’ individuals to be motivated to attend a ‘health care setting’ to undergo Cardiovascular Disease (CVD) risk assessment (health checks and annual CVD reviews) has high levels of attrition, with populations most at risk frequently failing to engage with these pathways and attend appointments. It’s imperative that initiatives that aim to increase uptake of health checks are co-developed by the target communities to improve proportionate uptake.

**Project methodological approach**

The EAST framework developed by the Behavioural Insights Team was used to explore participants’ experience of accessing CVD heart health checks. The EAST framework which stands for how Easy, Attractive, Social and Timely Interventions are, was the framework of choice during focus group interviews to explore perspectives. Qualitative in-depth narrative from seven focus group interviews conducted were transcribed and then a framework analysis approach conducted to derive emerging themes.

**Initial findings**

**Health checks feedback**

“It was very useful because now I know where my body is physically and whole health.”

“I liked the fact that after the checks were done, the results were carefully explained to me. Partaking in this, especially for free is something very useful. Michael was extremely nice and helpful.”

**What is your experience of heart health checks?**

“It was important getting my heart checked, I am now well informed and plan to make changes and lifestyle modifications. I would encourage more ative people to get involved and get their hearts checked.”

“I have really learnt about my health which will help me to improve my daily activities. 1 really appreciate the entire team who is in charge of the screening they are doing a great job and I encourage others to keep it up. Thank you.”

**Project design**

A qualitative behavioural insights exploratory phenomenological study approach using focus group interviews, was employed engaging 45 participants (27 women and 18 men) recruited in Middlesbrough from various African, South Asian and underserved white British population groups and share to accelerate spread and adoption of innovations

**Phase one**

- undertaking insights research (45 participants) and co-designing proposed interventions with communities.

**Phase two**

- implementation of co-designed interventions through collaboration with key stakeholders and community leaders (in progress)

**Phase three**

- test suggested interventions, feedback progress to communities and share to accelerate spread and adoption of innovations

**References**

**Authors**

Dr Joe Chidanyika
Karen Yeadon
Health Innovation North England

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Want to know more?

www.healthinnovationnenc.org.uk

@HI_NENC

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Find out more about InHIP
Multidisciplinary Team (MDT) Approach Towards Equitable Asthma Management

E Nally, A Reeves, A Bhowmik, P Leonard, O Hawkins, D Wald, A Jamieson

1. Background

The Leicester University Hospitals NHS Trust (ULHT) launched an asthma management project in April 2020, led by a multidisciplinary team consisting of General Practitioners (GPs), Pulmonologists, and a Respiratory Nurse Practitioner. The project aimed to improve asthma care outcomes and reduce inequalities in care between the most and least deprived areas of Leicestershire.

2. Aims and Objectives

a. Improving Primary Care To Splendid Primary Care Staff ultimately reducing inequality in access and avoiding unnecessary emergency Department attendances.

b. Reducing inequalities in care between the Most and Least Deprived Areas

3. Focus Group Participants

- Patients discussed their experience of seeing a GP for their asthma.
- GPs discussed challenges in managing asthma patients.
- Asthma nurses provided insights on their role in the management process.

4. Results: MDT Outcomes and Survey of Community Outreach

- Among the 180 patients reviewed in the MDT meetings, the majority were in the under 21 and 31-40 age groups (10 in males and 80% in females; 31-40 age 12% and males (27, 80% of costs tie to poor control, and a link between socioeconomic factors and asthma outcomes, the project addresses severe, complicated by cardiopulmonary disease, those with a virtual collaboration with NE London and a respiratory physiologist, in one of the most deprived areas of Leicestershire.

5. Recommendations

- Early diagnosis and care.
- Improved communication and engagement.
- Education and increasing engagement.
- Using animations translated into English, and language.

6. Limitations

- Limited scope.
- High patient turnover.

References


Project Title: Digitalizing practice through video animations to reduce inequalities in care.

Supported by the Department of Business, Energy and Industrial Strategy (BEIS) grant.
Submitted posters

Intro

Working in a health tech start-up offers a unique experience, where the utilities of a multidisciplinary team can be extended far beyond the confines of hospital wards.

A doctor is far beyond just a leader; they are an entrepreneur with the skills to be a lawyer, an accountant, a marketer...

In this world, everybody has ideas, but it’s only the bold who build. And in our community, we don’t just inspire; we empower you to bring your ideas to life, quickly.

Offer

btrU AI - a patient Copilot to provide patients with reliable and personalised health information

btrU Blue - Health Tech & AI community of doctors and medical students

btrU Spaces - a space for people interested to learn about health tech and entrepreneurship by reading, listening, watching

Results

3 active WhatsApp platforms for medical students and doctors that has connected over 400 medical students and 125 doctors in under 3 weeks

Our most recent LinkedIn post had 143 likes and 605 comments

We have people in the community aged from 18 to 72 years old

Representation from 35 UK medical institutions and over 15 hospital trusts

Medical students and Doctors from England, Wales, Northern Ireland and Scotland ranging from 1st years to Consultants and Professors

Authors

Soh Shi Ian
Kavyesh Vivek
Alicia Kwan Su Huey
Joseph Tsai
Richard Bogle

Unlock a better NHS through a btrU

As highlighted by the GMC Good Medical Practice Domains and the Digital transformation in the NHS inquiry, digitisation and adaptation is paramount to the sustainability and fortitude of the NHS.

Our btrU community addresses health exclusion and strives to tackle health inequality by offering a broad curriculum that includes education on recognising biases in healthcare technology, ensuring equitable access and inclusive innovation in healthcare.

From the onset, our btrU community instills medical students with AI and digital health expertise, transforming them into healthcare innovators who can effectively advocate for patient welfare and system efficiency in the NHS.

Join the Community!

Digital transformation in the NHS
GMC Good Medical Practice
Creating Equal Opportunities in Medical School Interview Preparation
Dr Jack Plume, Dr Adrienn Gyori, Dr Brian Wang

Introduction
Medical school applications are extremely competitive; competition ratios range from 4-38:1 for Home/EU applicants (1), and a variety of paid services exist to assist applicants in entrance exams, personal statement review, and interview practice. The cost of these services can run into the hundreds of pounds (2-4), and thus can be highly prohibitive for those from underrepresented backgrounds. This has created a paradigm that allows those who can afford to pay for these services an increased chance of being accepted into medical school, reducing diversity and representation in the health service, which then no longer represents the public which it serves.

Methods
1) In2MedSchool recently ran a workshop on multiple mini-interviews (MMIs), a common interviewing format used by UK medical schools, entitled ‘MMI Interviews – The Good, Bad, Average’.
2) The structure of the MMI workshop consisted of an initial overview of good interview technique (showcasing the qualities of a good doctor), followed by live enactments of two MMI stations. Both stations were enacted in three separate iterations - good, bad and average. Volunteer actors (medical students) were provided with guidance in advance. The webinar ended with a Q&A session.
3) We surveyed participants on alternative resource options that would have been available to them, and their confidence levels both before and after the event.

Results
1) 95% (40/42) of participants would not have had access to any paid high-quality interview preparations.
2) 31% (13/42) of participants would only have practiced with friends, or not at all.
3) Wilcoxon signed rank test showed that on a scale of 1-5, participants' confidence in their interview technique increased by an average of 1.6 points following the workshop, indicating a statistically significant increase (Z = -5.335, p < 0.001), (Fig. 1).

Conclusion
These results demonstrate a need for readily available, high-quality free application resources for medical applicants from underrepresented backgrounds. 80% of UK medicine applicants come from only 20% of UK schools (5). Therefore, it is essential that events like these are regularly run to allow those from underrepresented backgrounds equal opportunities and access to high-quality medical school application materials.

References
Submitted posters

IMPROVING SUSTAINABLE APPROACHES TO HEALTHCARE AND HEALTHCARE EDUCATION IN PRACTICE
Adele Mazzoleni, Naireen Asim, Ashviniy Thamilmaran, Shazia Sarela, Nadhira Samsudeen, Vafie Sheriff

BACKGROUND
According to the General Medical Council (GMC), it is a mandatory requirement for graduates to hold awareness on sustainable healthcare education (ESH). However, 1.8% of 850+ surveyed medical students were found to not have received formal exposure to ESH.

Student MedAid London (SMAL), is a Community Interest Company created in 2020 which strives to address this gap, by promoting global health to healthcare students, as well as bridge the gap between sustainability and lack of resources in certain areas of the globe.

From 2020, SMAL has embedded ESH in various series of social media informative campaigns. Additionally, it has provided various learning opportunities to increase students knowledge and participation in global health.

METHODS
SMAL aims to promote sustainability and global health education to healthcare professionals and students, by designing advocacy and learning opportunities people can interact with, and by organising ways to redistribute unused medical equipment to low- and middle- income countries in need.

Data was collected from SMAL’s latest teaching series “Careers in Global Health & Development”, carried out during October 2023.

RESULTS
Out of 71 total answers, the majority had heard about the webinars through Medall (42%), followed by word of mouth (33%) (Figure 1).

Participants’ confidence in the topic increased by more than 50% during the first and second days of the series, and by 25% on the third day (Figure 2).

On average, engagement received 4.3*/5, and helpfulness 4.6*/5. Participants were eager to find out about more ways to get involved in global health in their future careers (Figure 3).

CONCLUSION
SMAL actively strives to achieve a positive impact on climate action by establishing a network of donating and receiving organisations. By promoting education on global health, the most recent teaching series showed positive impact and what great interest the participants had in making a positive impact, by engaging in global partnership and reducing waste.
Submitted posters

InIHIP (Innovation Health Inequalities Programme) Cardiovascular Disease (CVD) and Lipid Optimisation Project

Author(s): Pei-Theng Ailwood, James Chapman, Amy Brough, David Magson, Ashita Kundra, Rachel Hollis, Kimi Campbell, Nani Khatib

Our Vision:
We bring medicines optimisation to the heart of the community using a public health approach.

Our ambition:
To reduce cardiovascular risks of people living in most deprived areas of Leeds who are culturally diverse, specifically those whose genetic and diet predispose them to higher risks of cardiovascular events, where traditional access to the health system is a barrier.

Aims:
To improve cholesterol health, improve access to NICE-approved lipid lowering treatments and increase understanding of CVD prevention in underserved communities in most deprived areas of Leeds.

Preliminary results 9 weeks after service initiation:
- Table on the right showed data collected by MDT where 100 people were directly engaged.
- 15% (15 people) declined Point Of Care lipid testing.
- 27% (27 people) were referred to GP / community pharmacy / specialist if further investigation was needed.
- Overall, our MDT service and PoC® Lipid Test had very positive feedback from the targeted community members.
- 12 responses collected from patient survey: 100% would recommend to friends and family. Chart below showed other survey questions feedback which demonstrated positive impact to patients’ overall health belief to improve their heart health.

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The service delivery model:
- Identification of 3 community hubs to serve Beeston and Middleton areas and the Gypsy and Travellers’ communities:
  1. Hamara Healthy Living Centre
  2. Leeds GATE (Gypsy and Travellers’ Exchange)
  3. BITMO (Belle Isle Tenant Management Organisation)
- Weekly community outreach service provided by the InIHIP Outreach Multidisciplinary Team (MDT) of Pharmacist, Pharmacy Technician, Dietitian and Health and Wellbeing Coach, including blood pressure (BP) and lipid optimisation, medication review, pulse check, medicines adherence check, anticoagulation in Atrial Fibrillation (AF), dietary, wellbeing and lifestyle interventions.

Key outcomes
- Unique service delivery model to serve underserved, historically deprived communities.
- 100% patient satisfaction with the service.
- 4% (4 people) who were eligible started on lipid lowering medication.
- 15% (15 people) declined Point Of Care lipid testing.
- 27% (27 people) were referred to GP / community pharmacy / specialist if further investigation were needed.

Project 1: Migrant communities living in temporary accommodation

Aim
- To support migrant communities living in temporary accommodation by developing tailored health interventions and improving access to mental health and primary care services.

Main actions
- Signed up to the Safer Surgeries programme
- Worked collaboratively with Clear Springs hotel management to identify health needs of residents and support required
- Worked closely with Family Navigators providing support to residents
- Ensured the Newham and North East London wide health and migrant planning was informed by our work

Next steps
- Look to offer / provide on-site health checks and exercise classes
- Newham is striving to become a ‘borough of sanctuary’
- Introduction of migrant health champions in primary care

To support migrant communities living in temporary accommodation by developing tailored health interventions and improving access to mental health and primary care services.

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Project 2: Serious Mental Illness (SMI) patients monitoring of diabetes in Clozapine patients

Aim
- Identify diabetic / pre-diabetic SMI Clozapine patients who require proactive interventions, and improve systems of sharing information between primary care and ELFT.

Main actions
- Conducted audit for 17 Clozapine patients in PCN
- 82% had HbA1c result within past year
- 88% had an on target value at their last HbA1c test
- All diabetic patients with off target results were contacted by Clozapine clinic

Next steps
- To maintain current performance
- Primary care to review process of documenting Clozapine treatment

Proactive Social Prescribing Projects

Physical Health Checks for SMI Population

Patients were identified for further follow up and early intervention through physical health checks. A patient satisfaction survey was also developed.

Park Run – led by Patient Participation Groups (PPGs)

With support from PPGs, Docklands PCN promoted Park Run through the PCN newsletter and banners, and secured additional funding from Keeping Well NEL to purchase water bottles for all staff.

Repurposing external practice spaces for community gardens

Developed garden spaces at member practices with patient input, with the aim to eventually give patients ownership of the community garden.

A ‘Food Growing Toolkit for healthcare settings’ was developed by Telgte Medical Practice in partnership with a food growing expert from Newham Council. This was entered into the NEL Green Team competition and won second place.
Submitted posters

Tackling Neighbourhood Health Inequalities in Newham Primary Care

North Newham PCN

Project 1: Food Poverty, Weight Management

Aim
To prevent poor health outcomes such as obesity and diabetes.

Main actions
- Provided member practices with information on a healthy weight coach training programme
- Stressed the importance of timely advice and interventions
- Worked with practices to ensure patients were receiving available support
- Considered digital solutions or culturally accessible self-help tools

Key outcomes
- 1161 patients referred to weight management services in 2022/23
- 89 patients referred to the national diabetes programme
- 11 newly diagnosed diabetic patients signposted to Talking Therapies
- Introduced AccuRx self-book tool for patients to access online digital support tools

Next steps
- Continue working with diabetic patients to:
  - Collect feedback on patients’ experiences with weight management services
  - Improve their understanding of the disease
  - Increase health knowledge, awareness of self-care and the impact on life expectancy

Project 2: UCLP Proactive Care: Long Term Condition patients

Aim
To better control practice workload and improve patient satisfaction by prioritising patients by clinical risk and need.

Main actions
- Identified clinical and management lead and set up multidisciplinary team (MDT)
- Met with clinical team to review stratification process
- Applied UCLP proactive care framework to address inequalities
- Estimated 1 out of 5 targeted patients are using the Emergency Department less than the pre-Covid period
- 3 out of 10 of targeted patients have reduced their consultation time with the practice by over 50%
- Better management of high-risk patients and improved patient satisfaction

Key outcomes
- To commence projects with other identified cohorts
- Review patients in the first cohort of ‘top two priority areas’ later in the year

Next steps
- To share learning through system meetings and online conferences
- Engage with other practice partners to learn from them as to how progress can be secured in different localities

Project 3: Sharing learning of Covax model developed

Aim
To share a model of delivering Covid vaccinations which has clear evidence of sustainability and replicability.

Main actions
- Presented model of delivery member practices and at the GP webinar
- Signed collaborative agreement to bring Covax model to PCN level
- Supported member practices whose patients went to Woodgrange Medical Centre for flu clinic
- Vaccination uptake for eligible patients increased from less than 40% in January 2021 to over 80% in May 2023
- Practices worked together to deliver vaccination clinics at PCN level

Key outcomes
- To share learning through system meetings and online conferences
- Engage with other practice partners to learn from them as to how progress can be secured in different localities

Next steps
- To share learning through system meetings and online conferences
- Engage with other practice partners to learn from them as to how progress can be secured in different localities

Common mental health illness in housebound patients and carers

Patients who are pre-diabetic & with common mental health illness such as depression

Social prescribers are reviewing this patient cohort’s referrals to, and engagement with, voluntary and community services, to better evaluate how best to address their unmet needs.

Proactive social prescribing project

Aim
To identify current barriers to dental health services, and to work with system partners to improve on and develop new pathways for patients.

Key outcomes
- Engaged with Newham Oral Health Partnership to raise understanding of new NHS dental Health contract.
- Worked with Health Equity Fellow to develop patient resources on oral health.

Main actions
- Identified and shared current patient referral pathway with member practices
- Identified key messages to share with patients
- Clinicians completed dental health awareness training

Next steps
- Develop patient information sheet on where to go, what action to take in an DH emergency
- Hold event with patients to raise awareness of good oral health
- Work with Public Health to hold focus groups on oral health at planned events
- Distribute Brush for Life (BFL) kits to parents/carers of children under 3 years old
- Public Health to share findings from the focus group and needs assessment and support learning across primary care
- Share findings with Oral Health Partnership Group to plan next steps
Submitted posters

Tackling Neighbourhood Health Inequalities in Newham Primary Care

North West 2 Primary Care Network

Project: Supporting patients registered with a Learning Disability (LD) to improve uptake of annual LD health check and increase awareness and access to other health services

Aim

To encourage patients with Learning Disabilities to access LD health checks and wider health services.

Key outcomes

- The percentage of LD patients with completed health checks increased from 86.4% to 95% in May 2023
- Positive feedback from patients and local services who attended ‘Make Learning Disabilities Matter’ event
- Event for LD patients attended by 52 LD patients and 13 local authority and voluntary sector organisations

Main actions

- Social Prescribers completed GP Learning Disability and Autism training
- Researched barriers and secured information to suit patients including NHSE easy reading materials
- Organised ‘Make Learning Disabilities Matter’ event with funding secured from Newham Public Health

Next steps

- Social prescribers will review the information collected as part of the Learning Disability Health Check (LDHC) and proactively offer support with social needs identified
- Will look to use the NHS LDHC self-assessment toolkit to ensure that practices continue to improve on services provided to these patients.

Proactive Social Prescribing projects

Diabetic / pre-diabetic patients

Social prescribers proactively contacted patients who recently received pre-diabetic HbA1c results, to share information on support available, encourage preventative lifestyle changes, and to refer to weight management services.

Tackling Neighbourhood Health Inequalities in Newham Primary Care

South One Primary Care Network

Project: Serious Mental Illness (SMI) comorbidities and weight management supporting patients with a BMI of over 30 or a BMI of over 27.5 for patients from black and ethnic minority groups

Aim

To deliver preventative work to SMI patients with long-term conditions and comorbidities.

Key outcomes

- 183 patients were referred to weight management
- 53 patients succeeded in losing weight, with an average 4.5% weight loss
- 77 patients were signposted to 18 different community services

Main actions

- Secured two specialist Health and Wellbeing coaches to work with social prescribers to lead project and bring expert guidance to our patient groups
- Encouraged patients to engage with the weight management offer and referred to Xyla services
- Followed up with each patient who did not engage to understand their reasoning and support with fuller understanding of impacts

Next steps

- To work with local partners to offer residents/patients healthy cooking classes
- Will incorporate processes developed in this project in day-to-day activities.

Project 1: Common mental health illness and diabetic / pre-diabetic patients aged over 65

Social prescribers and Health & Wellbeing coaches engaged with 94 pre/diabetic patients aged over 65, with common mental health illness. They:
- Explained what pre-diabetes is
- Ensured patients completed physical health checks
- Referred patients to local services, including Age UK East London and Xyla Health and Wellbeing services. PCN held cookery classes at Canning Town library to educate patients on healthy food substitutes and easy changes.

Project 2: Community Garden Project

South One PCN community garden takes place every Tuesday 11:00 – 12:00 at Star Lane Medical Centre, where patients volunteer to grow and share vegetables.

"Gardening together was a lifeline. And I found it through social prescribing. I would encourage anyone feeling low to reach out. There is help and hope." - Patient feedback

Author: Katy Szita / Rachel Ashworth
Newham Health Collaborative
North West 2 PCN

Author: Rachel Ashworth
Newham Health Collaborative
South One PCN
**Tackling Neighbourhood Health Inequalities in Newham Primary Care**

**Stratford Primary Care Network**

**Frailty Project**

<table>
<thead>
<tr>
<th>Aim</th>
<th>To support patients with moderate and severe frailty to remain healthy and independent in their own homes for as long as possible.</th>
</tr>
</thead>
</table>
| Key outcomes | • Patient satisfaction of support across health and social care increased by 18%  
• Positive feedback from patients and clinicians  
• Business case developed and presented at Clinical Directors meeting to roll-out project across all Newham PCNs  
• Four additional Newham PCNs have signed up to participate in the frailty project |
| Main actions | • Secured additional care coordinators to provide dedicated support to the PCN on frailty interventions  
• Identified and triaged 76 frailty patients  
• Provided case management to 37 residents  
• Discussed 34 patients with multidisciplinary team (MDT) |
| Next steps | • Plan to secure two further care coordinators bringing additional dedicated resources for this programme  
• Look to establish new MDT for geriatric assessments |

**Proactive Social Prescribing project**

Children and young people with low level mental health needs

Stratford PCN aimed to increase referral rates of patients aged 12-25 to social prescribers. They established a PCN Family hub to improve this cohort’s access to primary care and community services.

**Tackling Neighbourhood Health Inequalities in Newham Primary Care**

**Newham Primary Care Networks borough wide projects**

<table>
<thead>
<tr>
<th>Project 1: All age immunisations (focus on children)</th>
<th>Aim</th>
<th>To reduce the number of unvaccinated children and reduce the likelihood of a public health outbreak such as measles.</th>
</tr>
</thead>
</table>
| Key outcomes | • Newham average 6 in 1 uptake for children aged 12 months increased from 86.5% to 90.9%  
• Childhood seasonal flu vaccination uptake rose to 93.0%  
• 2,519 extra at risk 18-49 years received flu vaccination  
• Increased polio booster uptake to 77% of those eligible  
• 40 polio booster clinics held and 1,920 boosters administered  
• Provided 149 vaccines to children and young people who would otherwise not have received them  
• Convinced around 30 families, who were hesitant to be vaccinated, to attend vaccination clinics |
| Main actions | • Secured additional care coordinators to support delivery  
• Provided additional support to underperforming practices  
• Launched a targeted four-week pilot supporting child and young person immunisation  
• Established enhanced call / recall services, targeting families who were hesitant or declined vaccination  
• Tailored communications to maximise impact of key messages |
| Next steps | • Staff training on 6 in 1 tool  
• Quality Improvement (QI) work with Equip supporting five practices  
• Continue work on flu and COVID booster campaign  
• NHC roving team looking into delivering diphtheria vaccines for migrants currently living in dispersal hotels |

<table>
<thead>
<tr>
<th>Project 2: Increasing access to cancer diagnostic services</th>
<th>Aim</th>
<th>To improve cancer outcomes for patients through better prevention and creating multiple access routes to screening and diagnosis.</th>
</tr>
</thead>
</table>
| Key outcomes | • As of October 2023 (compared to the previous year) we see that  
  - the percentage of patients aged 25-49 screened for cervical cancer has increased from 72.8% to 73.9%  
  - The percentage of patients aged 60-64 screened for cervical cancer increased from 80% to 84.4%  
• Held health and wellbeing event targeting LD patients who had not accessed cancer screening  
• Information provided on what to expect at cancer screening appointments  
• Presentations from Nutrition Kitchen on healthy cooking, nutrition and diet, and all cancers  
• Exercise yoga class provided  
• Covid and Flu Vaccines offered |
| Main actions | • Worked with partners and Cancer Alliance to plan, share learning and identify key priority areas for additional support  
• Established NHC Newham Cancer Steering Group  
• Reviewed CEG cancer data to inform cohorts to target  
• Identified Roving Team support to be focussed on engaging with LD and SMI patients to access Cervical Smears  
• Promoted training for non-clinical staff on encouraging patients to take up cervical screening  
• Developed and provided to practices ‘Easy Read’ posters to display in waiting rooms  
• Identified SMI and LD patients who have not completed either breast, or cervical cancer screening and ensured they were offered more support  
• Roving team provided call and recall to LD patients to invite to cervical smear for patients who previously did not engage with services  
• Worked with partners to develop Easy Read materials and questionnaire on accessing cancer screening services |
| Next steps | • Start delivery of cervical smears clinics for LD patients and roll out across the borough  
• Obtain data on cancer screening coverage by ethnicity in Newham  
• Set target for increase in screening coverage using 22/23 as baseline  
• Sharing of case-based learning about multiple presentations and or late diagnosis  
• Re audit of attendance data introduced into system to complete audit cycle for continuous improvement |
Tackling Neighbourhood Health Inequalities in Newham Primary Care

**Central 1 Primary Care Network Proactive Social Prescribing projects**

**Project 1: Reducing the risk of young people entering crime / knife crime**

**Aim**
To reduce knife crime by providing support / interventions to at risk residents aged 11-18 years.

**Key outcomes**
- 35 patients to date referred to CYP link worker to receive specialist support

**Main actions**
- Secured specialist assistance with a dedicated Children and Young Person (CYP) link worker
- All patients who need this support were offered the assistance from the team with access to social prescribers and the personalised care team
- Patients were supported to know what young person’s mental health support was available

**Next steps**
- To invite link worker to share case studies and project outcomes on a regular basis, and to link up with Newham Training Hub and monthly Newham Health Inequalities Forum to share learning.

**Project 2: Low calorie diet group work**

**Aim**
To proactively manage, and effectively address, the high prevalence of diabetes and demand for diet education services in the borough.

**Key outcomes**
- Groups have been up and running for 3 months and continue to grow

**Main actions**
- Social prescribers signposted patients to Xyla Live Well Newham services
- Established diabetes group consultation sessions led by GP and health and wellbeing coach, to deliver advice, annual reviews and follow ups in a group setting

**Next steps**
- To review outcomes of diabetes group consultation and compare it to pre-existing processes
- To look to establish other long term conditions group sessions

**Project 3: Tackling Neighbourhood Health Inequalities in Newham Primary Care**

**North East 1 Proactive Social Prescribing**

**Project: Newly diagnosed cancer patients**

**Aim**
To ensure patients newly diagnosed with cancer have their social needs met and are receiving appropriate psychological and physical support.

**Key outcomes**
- Two cancer health and wellbeing events held
- 90.9% of patients rated the support received from a social prescriber as excellent
- All patients agreed that their social prescriber has improved their awareness of the support that is available in the community
- 90.9% of patients felt confident to reach out to social prescribers for non-medical issues

**Main actions**
- Social prescriber organised two cancer wellbeing events and invited local services such as Newham Talking Therapies, Weight Management Team, Diabetic Prevention Team
- Social prescriber contacted patients within the cohort to provide social support, such as housing, mental health, adult social care support. They also raised awareness of support available in the community

**Next steps**
- To continue with health and wellbeing events in collaboration with NEL Cancer Alliance, and to organise practice-based yoga sessions with support from the Newham neighbourhood senior officer

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**Patient Quote**
"Leo Joseph (Social Prescriber) was excellent with me and listened to all my problems and tried his best to help me solve my issues. He was a good listener and very good advisor and also very friendly. With Leo’s help and support I was able to solve many issues in my house fixed in terms of daily living. Thank you very much Leo."
Assessing and Improving Patient Awareness of Additional Services at The Forest Practice

**Background**

Potential enrolment of patients to additional services varies by socio-economic deprivation.

**Problem**

- Identified need to change current mindset that allied health services are not of equal quality to general practitioner services.
- Identified need to change current awareness of additional services among patients.
- Identified need to change current awareness levels of additional services among healthcare professionals.

**Aims**

- Assess current awareness levels of additional services among patients.
- Recommend potential interventions to raise awareness of current services among healthcare professionals.

**Methodology**

- Setting: The Forest Practice: 50 anonymous participants given self-reported printed surveys while in the waiting area before scheduled consultation by front desk staff over 2 weeks taking 30 minutes each.
- Analysis & Presentation: Analysis – identified common themes, patterns, concepts charted in excel.

**Results**

1. **Signposting**
   - 1. Financial Challenges: reiterate importance of financial challenges to bridge the knowledge gap.
   - 2. Transport: reiterate all additional services are available on site.
   - 3. To patients – by word of mouth.

2. **Intervention**
   - 1. Financial Challenges: reiterate importance of financial challenges.
   - 2. Transport: reiterate all additional services are available on site.

**Future Outlook**

- 1. Review whether lack of enrolment to these additional services has caused a decrease in quality of care received.

**Acknowledgements**

- The LTHT team: for their support in facilitating this study.
- The KCRH team: for their support in facilitating this study.

**References**


**Assess current awareness levels of additional services offered to patients other than GP**

**Key Survey Qps:**

- Demographics, Age, gender, ethnicity.
- Information availability: Do you feel well informed about the range of services available at our practice, including those beyond the GP practice?
- Physical & Occupational Therapy: Are you aware of the direct GP services to patients?
- Counselling & Psychotherapy: Did you know about counselling & psychotherapy services at our practice? Please look at the GM & talk.
- Financial Challenges: Reiterate importance of financial challenges.
- Language Barriers, Transport: Unable to get to service, Scheduling: Inconvenient.
- Appointment Scheduling, Financial Challenges, Others.

**Barriers of Access:**

- Language barriers, Transport issues, Waiting times

**Information availability:**

- 1. Showcasing the information in a targeted infographic.
- 3. Transport: reiterate all additional services are available on site.
- 4. To patients – by word of mouth.

**Figure 1:** Distribution of survey participants based on age.

**Figure 2:** Distribution of survey participants based on gender.

**Figure 3:** Summary of awareness of additional services.

**Figure 4:** Distribution of responses for preference of additional services.

**Figure 5:** Summary of barriers to access.

**Figure 6:** Information poster about additional services.

**Current awareness levels of additional services was assessed – identified as poor knowledge base**

**Recommended interventions to raise awareness of current services**

- 1. Showcasing the information in a targeted infographic.
- 3. Transport: reiterate all additional services are available on site.
- 4. To patients – by word of mouth.

**Conclusion**

- The greater the deprivation, the worse the healthcare inequalities in relation to knowledge, access, experience & outcome.

**Setting:**

- All participants completed The Forest Practice: 50 anonymous participants given self-reported printed surveys while in the waiting area before scheduled consultation by front desk staff over 2 weeks taking 30 minutes each.
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**Analysis & Presentation:**

- Analysis – identified common themes, patterns, concepts charted in excel.

**Results**

- Frequency distribution of responses for preference of additional services.

**Figure 5:** Distribution of responses for preference of additional services.

- Intervention & consider wider city use.

**Future Outlook**

- 1. Review whether lack of enrolment to these additional services has caused a decrease in quality of care received.

**Acknowledgements**

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- 1. Review whether lack of enrolment to these additional services has caused a decrease in quality of care received.

**Acknowledgements**

- I would like to thank The Forest Practice and staff for their support in facilitating this study.

**References**

Did not meet the submission criteria

While these submissions did not fully meet the specified prize requirements, we believe they deserve recognition and would like to give them a special mention.

- Creating a level playing field: Tackling inequalities in medical specialty training
  By I. Alberto

- Tackling inequalities between inborn and outborn infants with novel technologies
  By B. Simpson, D. Harvey, N. Thompson, M. Hopkin, C. E. Angelico, J. Kelleher, J. Lee, L. Turyanska, D. Sharkey

- Tackling inequalities: Through innovation and entrepreneurship
  By Mociran Bianca

- What are the current interventions and their barriers for trachoma in Car Nicobar, India?
  By M. Bianca and K. Amathally