

The Royal Society of Medicine

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.

Shortlisted posters

Addressing equity of access to culturally specific resources for asthma patients

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



Addressing Equity of Access to Culturally Specific Resources for Asthma Patients



Dr Llinos Jones¹, Dr Michelle Bartholomew², Harriet Smith³, Dr Mike Snowden²,

1) Midyorkshire Teaching NHS Trust; 2) University of Huddersfield; 3) Health Innovation Yorkshire and Humber

Introduction and Methods

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 and Discussion

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.

Multilingual Resources

The poster features the NHS logo and logos of partner organizations including Accelerated Access Collaborative, Yorkshire & Humber ARNS, and Health Innovation Yorkshire & Humber. The main title is "Guides to help you manage your asthma" with a lung icon. Below the title, there are 15 QR codes arranged in a grid, each labeled with a language: ARABIC, BENGALI, ENGLISH, GUJARATI, URDU, HINDI, POLISH, PUNJABI, SOMALI, WELSH, BRITISH SIGN LANGUAGE, CZECH, HUNGARIAN, MANDARIN, ROMANIAN, and RAMADAN. At the bottom, there is a three-step instruction diagram: 1. Scan the QR code, 2. Find your guide, 3. Watch the video. The poster is produced by NHS Mid Yorkshire Teaching.



With thanks to all who have supported the project, and in particular the Accelerated Access Collaborative for the Pathway Transformation Fund which funded this work

Shortlisted posters

Use of anchor institutions to reduce smoking prevalence and smoking related inequalities

By Caitlin Robinson, Rachael McIlvenna, Dr Ruth Sharrock

North East
North Cumbria
Health & Care
Partnership



USE OF ANCHOR INSTITUTIONS TO REDUCE SMOKING PREVELANCE AND SMOKING RELATED INEQUALITIES



North East and
North Cumbria

Caitlin Robinson, Rachel McIlvenna, Dr Ruth Sharrock
North East North Cumbria ICS

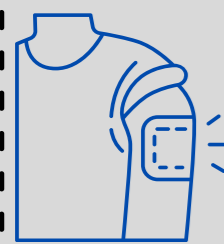
BACKGROUND

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.

"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!!"



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

Produced on behalf of the NENC Smokefree NHS / Treating Tobacco Dependency Taskforce

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

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

29.5% from IMD 1

51.2%

QUIT SMOKING

Based on self reported 28 day quit status



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.**

Shortlisted posters

A targeted approach to identifying and reviewing patients with respiratory 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

HEALTH INNOVATION North West Coast | **chcp** | **Optum** | **torus** | **NHS** | **Knowsley Council** | **ST HELENS BOROUGH COUNCIL** | **ENERGY PROJECTS PLUS** | **Cheshire and Merseyside** | **Mersey and West Lancashire Teaching Hospitals NHS Trust** | **Graphnet** | **Liverpool Heart and Chest Hospital NHS Foundation Trust**

A targeted approach to identifying and reviewing patients with respiratory conditions at risk of poor health outcomes due to fuel poverty

Rhiannon Clarke (1) Lucy Malcolm (2) Kathy Daley (2) Dianne Green (3) Sophie Wotherspoon (4) Rowan Pritchard-Jones (2)
 1. Health Innovation North West Coast 2. Cheshire & Merseyside ICB 3. Mersey & West Lancashire Teaching Hospitals NHS Trust
 4. Liverpool Heart & Chest Hospital NHS Foundation Trust

INTRODUCTION / OBJECTIVES

Fuel poverty is causing physical and mental illness across the whole population and further straining already stretched health and care services. Collaborative partnerships with several providers across Cheshire & Merseyside ICS (Integrated Care System), has resulted in individuals most at-risk from poor outcomes being proactively identified using the CIPHA (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 Johns Hopkins 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 evidenced by the reduction in hospital admissions, attendances (A&E, GP, other) and exacerbations 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 be those most in need of support.

Detailed cohort definitions were agreed for:
 1. Adults with high risk COPD, who are at high risk of exacerbation
 2. Pre-school aged children with a respiratory wheeze.

Multiple stakeholders have come together at Place (formally CCG) level in St Helens and Knowsley, to review the CIPHA dashboard and design pathways of holistic support, providing clinical and non-clinical interventions, including medication reviews; referrals to weight management; pulmonary rehabilitation; smoking cessation; housing support; financial support; social prescribing and other wellbeing support.

Work is currently being delivered for cohort 1 patients in 3 Places within the ICS. Cohort 2 delivery has begun in 1 Place with others due to start in the New Year.

RESULTS

The latest referral data from cohort 1 Places is displayed in the figure on the right.

SPREAD AND ADOPTION

Further engagement is underway with Place Directors, to identify other trailblazer sites to go live in 2024. As more patients benefit from these pathways, the ICB programme team will work with local projects to develop a full evaluation to help them to understand the impact these interventions are having on patient outcomes and demand on primary care and hospital services.

A project implementation toolkit has been developed, to help support organisations wishing to adopt this approach. Please scan the QR code to access the toolkit.

The toolkit includes a blueprint of the work done to date, case studies from the existing projects and their process maps and SOPs; information on how to access and use the dashboard; an asset map of organisations, services and projects that support the fuel poverty agenda and funding opportunities to support this work.

This project has been shortlisted in 2 categories in the 2024 HSJ Partnership awards, "Best Consultancy Partnership with the NHS" and "Most Impactful Project Addressing Health Inequalities".

Cohort 1 - Severe COPD - Delivery to date

Criteria - IMD most deprived quintile, COPD diagnosis in primary care, not in a care home, 50% or higher risk of emergency admission, 20% most Fuel Poor quintile neighbourhood

St Helens WarmHomes for Lungs Project

Process
 Key partners: ICB - Place; MWL - Community COPD service; Council - Affordable Warmth Unit & Revenue & Benefits; CHCP Wellbeing service; MCF - Pulmonary Rehabilitation team, Energy Projects Plus - Operating Energy Efficiency Projects in C&M, Torus - Housing Association

Pathway developed with COPD service accessing the dashboard and identifying patients, undertaking a review and onward referral.

Feedback to COPD team to collate activity and patient feedback questionnaire.

Funding provided through the project.

Impact
 As of 21st November 2023, 159 patients have been successfully contacted by the COPD team, with the following outputs:
 • 100% (159) referrals to Wellbeing Team.
 • 100% (159) referrals to Affordable Warmth Team.
 • 11% (18) referrals to Pulmonary Rehabilitation (PR) Team (since PR became part of the project on 01 June 2023).
 • 13% (20) patients were onboarded to COPD Telehealth Service.
 • 84% (133) patients received £500 payments from household support funds. Further payments are being sent from Oct-23.
 • 64% (101) patients sent feedback forms and 26%(26) returned.
 • 100% patients received Winter Warmth Pack.
 • A total of £66,500 paid to households to date.

Knowsley Fuel Poverty COPD Project

Process
 Key partners: Public Health; Community Respiratory Team; Energy Project Plus; social prescribing; wellbeing services.

Physician Associate based in West Knowsley PCN invites identified patients for a 1-hour review and onward referral.

Funded through ARRS.

Impact
 As of 1st December 2023, 35 patients have been seen in clinic, with the following outputs:
 • 11 Inhaler changes
 • 3 azithromycin work up
 • 35 vaccine advice
 • 8 radiology referrals
 • 8 pulmonary function referrals
 • 15 PR referrals
 • 6 smoking cessation referrals
 • 5 social prescribing referrals
 • 23 fuel poverty referrals
 • 5 mental health referrals
 • 6 cardiology referrals
 • 3 oxygen referrals

HSJ PARTNERSHIP AWARDS | **WE ARE PROUD TO BE A FINALIST** | **Most Impactful Project Addressing Health Inequalities** | **Best Consultancy Partnership with the NHS**

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

By Tim Lloyd and Caroline Thickers

nbct | **Health Innovation East Midlands** | **Integrated Care Northamptonshire**

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

Innovation for Healthcare Inequalities Programme (InHIP)

The project has been designed and delivered by NHS Northamptonshire ICB, Northamptonshire Black Communities Together and Northamptonshire Healthcare NHS Foundation Trust.

"Informative, educational and relatable"
Participant feedback

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 (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

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

Method – to use virtual monitoring technology (Docobo) to aid testing, alongside NHFT clinical support to interpret and refer participants to their GP. An attitudes questionnaire will capture lifestyle feedback, alongside information about vaccination, use of GP services and heart health awareness. Focus groups will gather additional lived experience feedback in relation to engagement with health and care services.

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
- Shared learning and sustainability of the project approach

Testing data and questionnaire feedback will be shared across the integrated care system to support design and delivery of future community project interventions. We also hope research findings might influence change to existing testing, vaccination and health service delivery for minority communities, as well as how Community Champions can help to improve engagement and reduce inequality.

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Participant feedback:
 "The community felt valued and cared for, more than at any other activity provided in the past"
 "In a community setting where people are used to each other, there is more engagement and participation"
 Docobo: "This clinical model will significantly contribute to the crucial first line of defence in identifying these critical health issues, allowing for timely interventions"

Shortlisted posters

Breaking Barriers, Building Bridges: Innovations in Maternal Aid in Bangladesh

By Iman Yahya, Maisha Syed, Mithila Sharmin, Fahimah Ali, Farhin Ahmed, Jameela Abdul-Raheem, Tasnim Alam, Tafsir Ahmed, Aqil Jaigirdar



Breaking Barriers, Building Bridges: Innovations in Maternal Aid in Bangladesh

Iman Yahya, Maisha Syed, Mithila Sharmin, Fahimah Ali, Farhin Ahmed, Jameela Abdul-Raheem, Tasnim Alam, Tafsir Ahmed, Aqil Jaigirdar



BACKGROUND

Maternal mortality remains a significant challenge in developing countries, with 95% of maternal deaths in 2020 occurring in low-and middle-income countries (LMICs) [1]. Maternal mortality rates (MMR) are 50 to 100-fold higher than those in high income countries and stillbirths are 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, ranging from delays in: seeking care, reaching care and receiving adequate healthcare.

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 disease prevention, increasing the availability of healthcare professionals, improving access to medications and emergency services, and promoting safe abortion practices.

Delay in decision making to seek help	Delay in reaching care	Delay in receiving adequate healthcare
<ul style="list-style-type: none"> Financial implications Acceptance of maternal death Previous poor experience of healthcare Limited understanding of pregnancy complications, when to seek medical assistance Maternal stigma and biases 	<ul style="list-style-type: none"> Distance to health centres and hospitals Availability and affordability of transportation Poor roads and infrastructure 	<ul style="list-style-type: none"> Poor facilities and shortage of medical supplies Inadequately trained staff Understaffing Inadequate referral systems Complex operational environments

Table 1: Factors influencing maternity mortality rates [3]

MATERNAL MORTALITY IN BANGLADESH

85% of maternal deaths worldwide in 2020 occurred in Sub-Saharan Africa and Southern Asia, encompassing Bangladesh within this statistic [4]. Bangladesh, with an estimated population of 173 million has seen that approximately 5200 mothers die (172 maternal deaths and 100,000 live births) per year as a result of maternal complications [5]. Mortality rates are significantly higher in remote regions and socioeconomically disadvantaged communities, such as the tea gardens in Bangladesh. Recent reports indicate that maternal mortality rates (MMR) were higher amongst women with no education (351 per 100 000 live births) compared to women with at least a secondary education (135 per 100 000 live births) [6]. Figure 1 displays factors that contribute to mortality rates in Bangladesh.

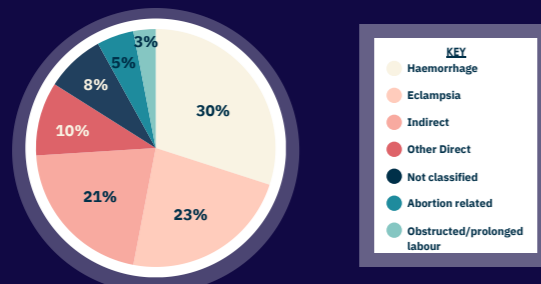


Figure 1: Factors contributing to maternal mortality in Bangladesh (N=175). Indirect causes are related to heart, liver, lung or brain dysfunction. Adapted from [6]

MATERNAL AID ASSOCIATION (MAA)

MAA is a student-led charity operating at the grassroots level, dedicated to enhancing conditions in resource-poor settings like Bangladesh, with the goal of ensuring: safe, effective, and high-quality maternal healthcare. MAA achieves this objective by supplying medicine, resources, and educational initiatives. The organisation conducts seminars and workshops for mothers and young women, providing essential knowledge about safe pregnancies and newborn care. MAA also conducts free health checks to identify potential concerns early on. The overarching aim is to minimise delays experienced by pregnant women in making decisions about seeking care, reaching care, and receiving the necessary healthcare.

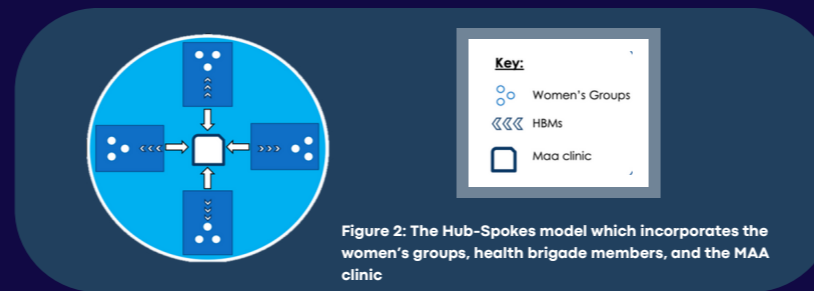


Figure 2: The Hub-Spokes model which incorporates the women's groups, health brigade members, and the MAA clinic

Baseline And Percentage Increase In Positive Health Seeking Behaviours

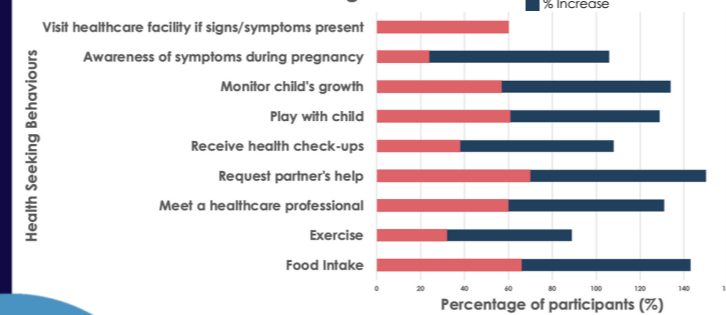


Figure 3. explores the baseline and percentage increase in certain health seeking behaviours before and after the Maternal Health Education seminar.

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MAA HUB-SPOKES MODEL

MAA has implemented a Hub-spokes model for delivering antenatal care, designed to reach remote and resource-poor populations and provide them with integrated and efficient healthcare. As illustrated in Figure 2, the model consists of a central hub, the MAA clinic, where specialised doctors, trained through an intensive UK-recognised program by the Royal College of Obstetrics and Gynaecologists, identify and manage high-risk pregnancy cases.

To identify women in rural communities, health brigade members and women groups play a crucial role. Health brigade members, who are fifth-year medical students, deliver antenatal care in the homes of mothers. Their responsibilities include recording and interpreting observations, educating pregnant women, and identifying and referring high-risk pregnancies. Furthermore, they collect data on maternal and neonatal health outcomes which will be transitioned to our secure app in the making, Gravida. High-risk mothers are referred to the MAA clinic for review by specialised doctors, who manage red-flag symptoms that may necessitate urgent referral in emergencies.

Women's groups, consisting of regular fortnightly meetings facilitated by local women, serve as a platform for women to express concerns. A facilitator attends these meetings to educate and support women, encouraging the development of positive health-seeking behaviours and practices during pregnancy, labor, and the postnatal period. Some findings from a Maternal Health Education (MHE) Seminar are shown in Figure 3 where the main positive changes were seen in physical activity, seeking health check-ups, monitoring their child's growth and an awareness of red-flag symptoms during pregnancy.

MAA ANTENATAL CARE

Antenatal care (ANC) are paramount in screening for high-risk pregnancies, promoting healthy pregnancy, and preventing diseases permitting for timely interventions. A recent study reported that Northern Bangladesh observed low prevalence of timely ANC uptake, with only 14% (n=378) women receiving their first ANC at the first trimester [7]. Barriers to the widespread adoption of ANC are related to socioeconomic standing, availability and distance of medical facilities, biases, and maternal education. MAA addresses these obstacles by training health brigade members (HBM) to provide ANC and postnatal care in the mother's home. This involves bespoke maternal education, conducting investigations (blood pressure, blood glucose, urine analysis). Abnormal results incite a referral to the specialised doctors in the MAA clinic, whereby the pregnant women are monitored through routine check-ups, prescribed medications as needed and referred to tertiary centre when necessary.

SCALABILITY AND IMPACT

MAA currently implements the Hub-spokes model in Moulvibazaar, Bangladesh with aims towards adopting the model across different developing countries. While significant progress has been achieved in the current hub-spokes models that currently operates in primary and secondary care, including the implementation of a natural delivery centre, contributing to ongoing advancements towards reducing maternal mortality within primary, secondary and tertiary healthcare settings.



Shortlisted posters

Med Lingual: Improving patient-doctor communication

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

BEIU THE UNIVERSITY OF BUCKINGHAM



Med Lingual: Improving patient-doctor communication

Dyan Pancharatnam¹, Atharv Patankar¹, Fay Fathima Imtiaz Fareed¹, Harshita Buragapu¹, Prince Tandukar¹, Lavanya Gupta¹
¹ Faculty of Medicine, University of Buckingham

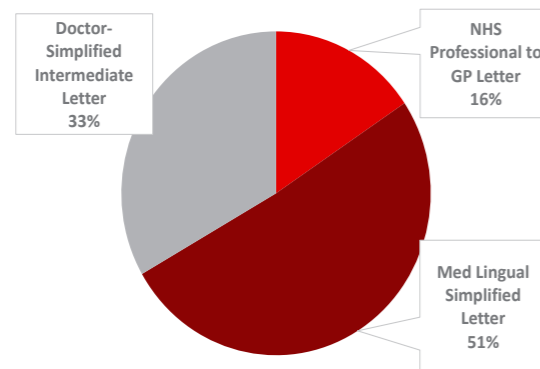
Introduction

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.

Results

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



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.

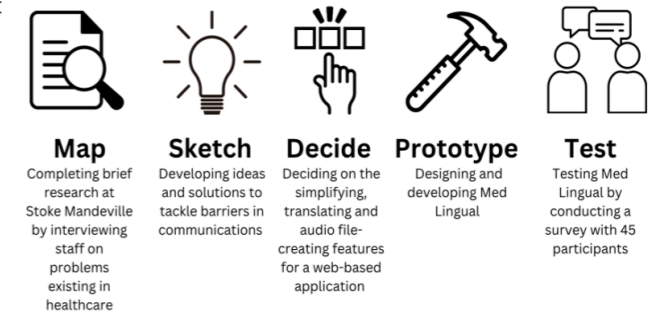
How did we think of Med Lingual?

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 increasing 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

Design Sprint Process



Discussion and Conclusion

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.

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 (£1/letter).

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Submitted posters

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

By Jeshar Ching
Norwich Medical School



01 INTRODUCTION: Place-based inequalities

Health inequalities, as defined by Public Health England, refers to the unfair and avoidable differences in health across the population and between different groups within society. These disparities arise from unfair systems that negatively impact people's living conditions, access to healthcare, and overall health status.¹ Health inequalities manifests across four key dimensions, highlighting disparities in:

Socio-economic status and deprivation:

Affecting those who are unemployed, experience low income, or reside in deprived areas, these disparities encompass challenges such as poor housing, limited educational opportunities, and unemployment

Protected characteristics:

Disparities based on age, sex, race, sexual orientation, and disability

Vulnerable groups of society, or 'inclusion health' groups:

Certain populations, such as vulnerable migrants, Gypsy, Roma, and Travellers, homeless individuals, and sex workers, encounter heightened health risks and barriers to healthcare access.

Geography

Disparities between urban or rural areas, including variances in healthcare infrastructure and resources.

Hence, As one of the four key dimensions where health inequality manifests, this poster aims to shed light on the task of eliminating place-based inequalities, specifically on urban-rural discrimination.

02 What are Place-based inequalities?

Place-based health inequalities refer to disparities in health outcomes and healthcare access linked to the geographical location where individuals live, particularly their proximity to a hospital. Research from QualityWatch, a programme focused on evaluating patient care in England, revealed that 70% of emergency admissions occurred within 6.2 miles (10km) of a patient's home, while only 3% of people were admitted to a hospital more than 18.6 miles (30km) from home. However, individuals in some 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 Burnley General Hospital in 2007, the average distance for an emergency admission in Burnley District rose from 3.2 miles in 2006/07 to 8.7 miles in 2008/09.² Therefore, the establishment of new hospitals played a crucial role in reducing distances for faster emergency admissions.

03 What are Mobile hospitals?

The concept of a mobile hospital is not entirely new; consider the deployment of mobile field hospitals in the aftermath of disasters. They play a critical role for governments, cities, municipalities, hospitals, response agencies, and medical organisations, offering rapidly deployable, life-saving medical facilities following a disaster or emergency.³

So, what is usually included in mobile hospitals? According to BLU-MED®, the global leader in mobile field hospitals, their units comprises of trauma clinics, emergency rooms, ICU/ post-operative care, operating rooms, obstetrics and gynecology care, scalable ward spaces, optometry clinics, ear, nose, throat care, dental clinics, mental health clinics, triage and isolation facilities with positive or negative pressure, immunisation and drug distribution, ancillary clinical support, emergency operation centers, outpatient clinics, decontamination and mortuary facilities.³ These features emphasise the ability of mobile hospitals in meeting various medical needs.



04 Feasibility

However, do we truly need all the aforementioned units in a mobile hospital to address the sole purpose of reducing travel distance for people in rural areas? The practicality of maintaining such a comprehensive mobile hospital is questionable, given its intricate organisational structure and technological demands. So which department should we keep?

One department to retain is the Emergency Department (ED), considering the impact that increased travel distance has on mortality rates and the potential for exacerbated injuries during emergency situations. Prolonged delays in care have contributed significantly to a spike in patient deaths, increasing fivefold in the last 3 years, from 21 deaths in 2019 to 112 in the most recent year. Individuals experiencing "severe harm" have also risen from 96 to 152 during this period, while the overall number of people suffering some degree of harm in such circumstances has surged from 3,979 in 2019 to 7,856 in 2022, marking a 97% increase.⁴

Why prioritize 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 strategically focusing on key departments, particularly the ED, we can optimize the functionality of mobile hospitals to address the urgent healthcare needs of individuals in rural areas efficiently and feasibly.⁵

05 Limitations

However, several challenges must be considered and addressed before the establishment of mobile hospitals, including:

- The necessity to establish proper connections between various areas of the hospital to organize the flow of patients, personnel, and materials, and to enable access control to each individual suite of rooms.⁵
- The importance of maintaining high standards for infection control, which involves implementing HVAC systems for operational procedures, along with strict control of air-flow directions and pressures.⁵

06

Conclusions

In conclusion, tackling place-based inequalities in healthcare is vital to ensure equitable access to healthcare services. Urban-rural disparities, a key dimension of health inequalities, can be effectively 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 establishing proper connections and maintaining infection control standards to ensure the success of mobile hospitals. By taking advantage of the adaptability and critical nature of these facilities, we can bridge gaps in healthcare access, reduce travel distances, and ultimately improve health outcomes for individuals in rural areas.

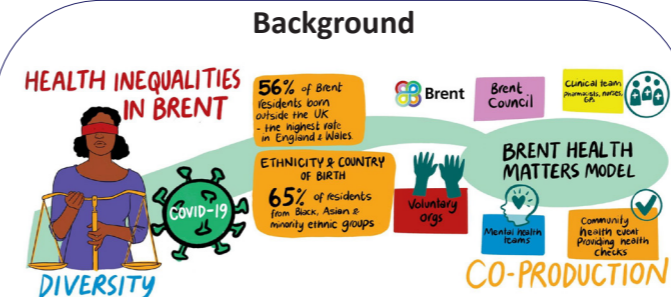
07

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Pharmacists role in reducing health inequalities

Nilam Kalyan & Gopal Patel
Specialists Clinical Pharmacists, Brent Health Matters



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

COVID-19 exacerbated existing inequalities in Brent, which had the highest mortality rate during the pandemic. Highlighting the urgent need to address ill 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 health and social care. Adopting a co-production model-utilising an integrated neighbourhood team across Brent.

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.

Objectives

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

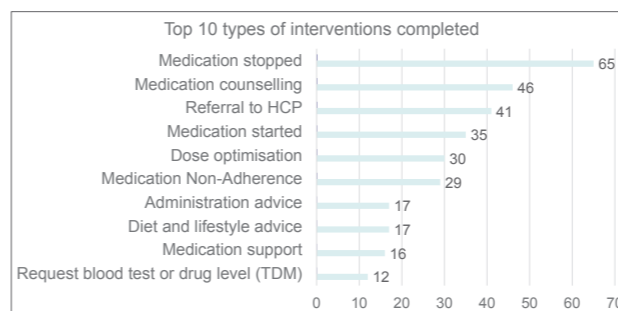
Results

Interventions

- 149 patient reviews completed (Aug 2022 to Nov 2023)
- 675 interventions (Aug 2022 to Nov 2023)
- Average Reduction of 1.92 medications after review per Patient

Clinical Significance of the MOPs Interventions	Total	%
I - Non-Clinical Reason for the intervention	32	5%
II - Minor benefit to patient care	373	56%
IIIa - An incident or situation which could have led to an increased length of stay was prevented or improved upon.	111	17%
IIIb - Evidence based treatment/according to Guidance	106	16%
IV - Reversible harm or admission to hospital	47	7%
V - Averted Death or major permanent harm	0	0%

* Adaptation of King's College Hospital NHS Foundation Trust (2015). Pharmacy Clinical Contributions severity rating scale for potential patient outcome.

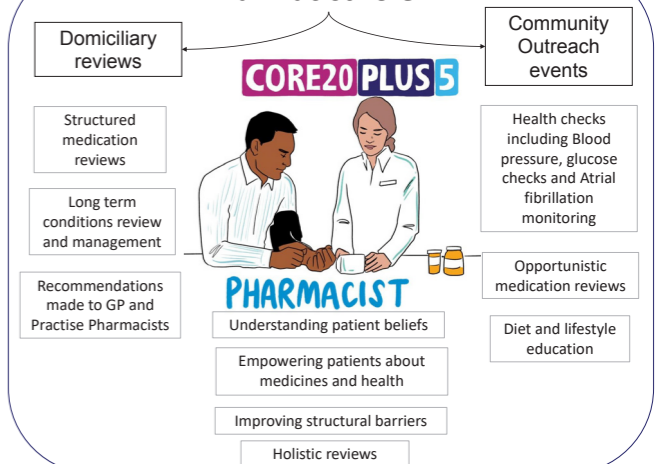


Waste removed from home



£1000 worth of medicines removed from one home. Due to non-compliance and majority expired but still using

Pharmacist role



Feedback on Pharmacist role



Mr LH, 76 years old from Pakistan. Patient found incidentally while visiting another patient in same building. Multiple issues identified:

- Housing issues: Patient and two children live in a single room within a shared flat
- Schooling: 2 children under 10 not attending school
- Health: Coronary angioplasty with stent insertion in Pakistan, taking medications that are posted over from Pakistan by wife

Pharmaceutical interventions completed:

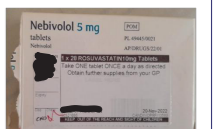
- After procedure in Pakistan was prescribed 6 medications, but only issued 2 medications by GP (one of which based on outdated guidance). Referral to cardiology made by GP at the recommendation of the pharmacist. Chased by Pharmacist several times
- Seen by Cardiology and appropriate medicines prescribed. During medicines reconciliation following error identified from hospital:
 - Prescribed nebivolol 1.25mg tablets
 - Given nebivolol 5mg tablets instead of 1.25mg (4x the dose)
 - Wrong label attached to medication – rosuvastatin label
 - No rosuvastatin supplied from hospital

Actions taken:

- Prescribing hospital and pharmacy notified of error
- Incorrect medications removed from home
- Correct medications prescribed by GP
- DATIX completed

Clinical and social outcomes:

- Total of 5 medications prescribed after cardiology review
- Patient no longer experiencing chest pain to the same extent
- Housing issue currently under investigation
- Local school admission provided for his two children



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

By Kailash Viswanathan

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:

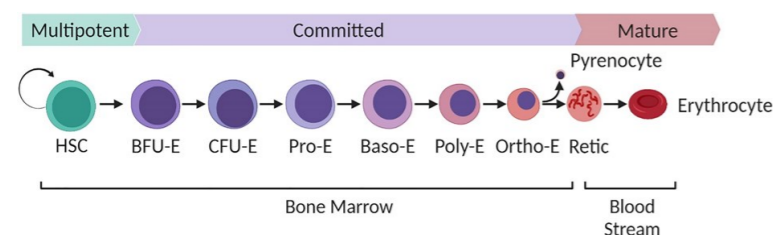
Health inequality in society is a complex challenge that is influenced by various factors including socio-economic status, education, and access to health care resources. Investment into these stem cell techniques could potentially influence the way certain procedures and treatments are administered 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 untreatable 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:

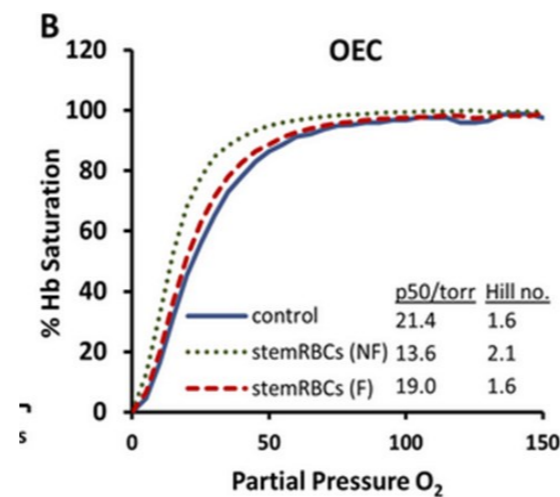
Tackling blood shortage and inequalities concerning access to donated blood:

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 all but 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 in developed nations such as the US are low 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 specialised 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-Rex 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 quality healthcare for all.

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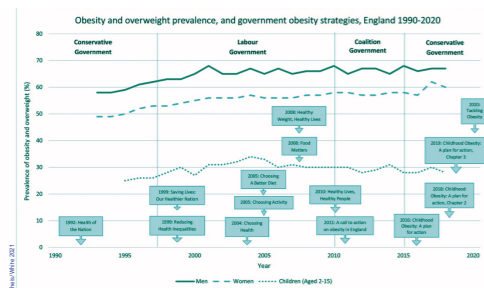
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Submitted posters

Navigating the Labyrinth of Multiple Disadvantage: Harnessing Social Prescription to Combat Weight Stigma - Helen James VCSE Nutriri Innovating in the 'slimming club' and 'weight management' domains to reduce health inequities and support engagement in beneficial behaviours.

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. (Meunig 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 the significant number of higher weight individuals who currently delay or withhold from engagement in healthcare, food, and movement (Ryan et al. 2022). By addressing the underlying social determinants of health and fostering more inclusive communities to empower individuals to make informed choices about their health, we can create a society where everyone has more opportunity to flourish.

WHY...

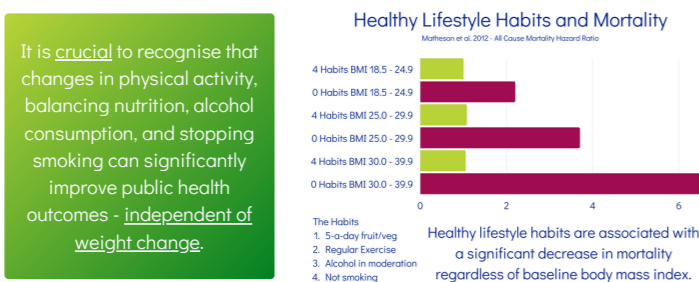


'The energy deficit approach to weight management has a high long-term failure rate... Dietetic literature on weight management fails to meet the standards of evidence based medicine' (Aphramor 2010)

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

what people tell us...

- food is very stressful
- my child gets bullied
- dieting has taken over my whole life
- i feel judged every day
- i won't go to the GP
- the GP blames my weight every time
- people assume i am lazy
- people assume i eat too much
- i have lost weight so many times
- i have felt depressed about this for so long



- working 'weight neutrally' is not in contra-position to the science of metabolism
- different weights can impact health in different ways
- trying to 'solve obesity' at population level has not worked out (Theis, White 2021)
- remaining focused on 'weight change for health' is widening the health equity gap
- all cause mortality is near equalised across BMI through behaviours - not weight change!

WHAT...

Addressing weight stigma and its intersection with multiple disadvantage requires a holistic approach that reduces individual blame, and focuses on cohesive action, within the community, to shift societal biases.

By listening to lived and living experiences, since 2015; we've gathered ongoing consensus to co-design workforce training and citizen courses for continued knowledge mobilisation. Co-creating a viable alternative to 'slimming club' referral and strengthening social prescribing systems in the process.

Anti-bias workforce training hosted on a co-learning hub adapted for social prescribers, fitness professionals, nutritionists and any role required to talk about weight. 'Weight Management' transformed into Nutrition Management - Movement Management



...leading to social prescribing for holistic 'weight neutral' food and body ease courses, memberships, physical activity referrals - digital and in-person weekly meetings...

body ease	food ease
<p>AS YOU ARE '8 billion kinds of normal' your BODY thoughts</p> <p>BODY TRUST body appreciation letting go of attachments</p> <p>MOVE FOR JOY acknowledging all movement unattaching from outcomes</p> <p>ACTIVE ACCEPTANCE empowered by acceptance the 'mechanics' of judgement</p> <p>THOUGHT WELLBEING you've always been your best self compassion</p>	<p>FEEDING HUNGER finding what matters to you your FOOD thoughts</p> <p>DESIRED FOODS improve food relationships food for fuel and pleasure</p> <p>IN THE MOMENT getting present with food vs. past/future food thinking</p> <p>FINDING FULL to let go of restriction building self-trust</p> <p>CRAVINGS NEXT TIME breaking the cycle where are you now?</p>

OUTCOMES...

During a series of test and learn pilots we used Happiness Pulse (SWEWBS and ONS4) for quantitative scoring and anonymous feedback routes for qualitative evaluation.



Data correct July 2022

working weight inclusively can help an organisation to...

- increase recall and engagement with core health groups and general population
- contribute to reducing health inequalities
- refocus on managing health instead of weight change
- sustain beneficial behaviours and reduce long term all cause mortality risk
- support inclusive staff wellbeing

what people tell us after...

- i want to look after myself now
- i feel better about my body
- i am accepting and building a happier me
- i like the groups and hypnotherapy
- i feel included here
- not making this about weight takes the pressure off
- i am building stamina
- i worry about food less
- my confidence and self esteem is growing
- i am enjoying exercise for the first time

Submitted posters

THE IMPORTANCE OF THE STUDENT-LED WEBSITE, SKIN FOR ALL, ON TACKLING RACIAL INEQUALITIES IN MEDICAL EDUCATION



Naabil 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.

CONTEXT

There is a longstanding issue of underrepresentation and racism in medical history, education, and research, particularly concerning ethnic minority patients. The lack of representation extends to medical textbooks, as highlighted by a 2018 study from the University of Washington. The Atlas of Human Anatomy, a widely used learning tool, features less than 1% of images with dark skin [1].

This misrepresentation also has real-life consequences, with non-white patients facing higher mortality rates associated with dermatological diseases despite skin cancers being more prevalent in white populations [2]. Emphasising the impact of ethnic minority underrepresentation on clinical outcomes. There is an urgent need for increased diversity and accurate representation in medical education and research to address deeply rooted biases and improve healthcare equity.

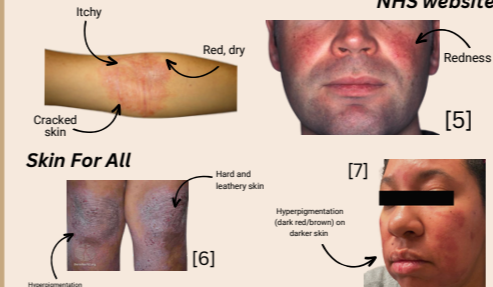
According to NHS England's equality, diversity, and inclusion improvement plan [3], one of the biggest goals is to acknowledge the use of language which isolates certain groups, alongside identifying what barriers are present with certain patients that result in a reduction of clinical care quality and experience. Skin For All aims to fill these gaps by covering the most commonly seen skin conditions with reliable, inclusive, language and a myriad of images from verified sources.

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.

"In patients of African descent, perifollicular (around the follicle) and extensor areas are more commonly affected... After an inflammatory episode, hypo/hyper-pigmentation is more likely to occur in skin of colour than white skin." - Example of inclusive language used to describe Atopic Dermatitis; Skin For All [4]

"Sclerotherapy induces thrombophlebitis reaction (a reaction that causes a blood clot to form) to block the vein, but recannulation (the process of inserting a tube to free blockages) may occur in many cases." - Example of medical jargon being defined for non-medical users in Varicose Veins; Skin For All [4]



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

RESEARCH [4]

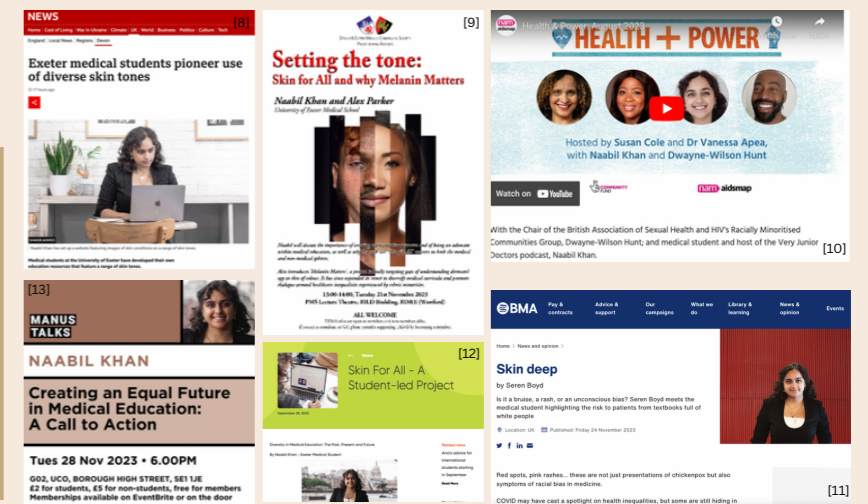
- I used 6 different sites to determine the most common conditions that affect patients.
 - Global Skin Disease Morbidity and Mortality: Update from the Global Burden of Disease
 - Epidemiology and Management of Common Skin Diseases in Children in Developing Countries
 - The Burden of Skin and Subcutaneous Diseases: Findings from the Global Burden of Disease Study
 - National Institute of Arthritis and Musculoskeletal and Skin Diseases: Skin Diseases
 - Skin, hair and nails: NHS inform
 - Mind the Gap by Malone Mukwende
- 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.

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.

PRESS/RESPONSE



USER FEEDBACK

"Such a fantastic website aimed at a really important topic - our education needs to represent our population and Skin For All can play a part in that!" - Aisha Lea, Fourth Year Nottingham Medical Student

"This is an absolutely incredible resource. This is on the same level as the award-winning Mind The Gap! Keep up the great work" - Rhys David, Third Year Exeter 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 a very big step for representation in healthcare" - Sohaira Sultan, a 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" - Ian Hope, DYVV committee member

Example of supportive links/ myth busting/ questions for users [4]



- Myths
- Raynaud's is a rare disease
 - It only affects fingers/ toes
 - Raynaud's phenomenon is caused by poor circulation
 - The only treatment is to stay warm
 - Symptoms only include red, white and blue discoloration

- Questions to ask your doctor
- How can I avoid the recurrence of symptoms?
 - How is it diagnosed?
 - Is it a hereditary condition?
 - Will Raynaud's get worse over time?

- Support
- Raynaud's Association
 - NICE Guidelines
 - NHS Inform



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Submitted posters

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 from 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 n 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 reliable 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.

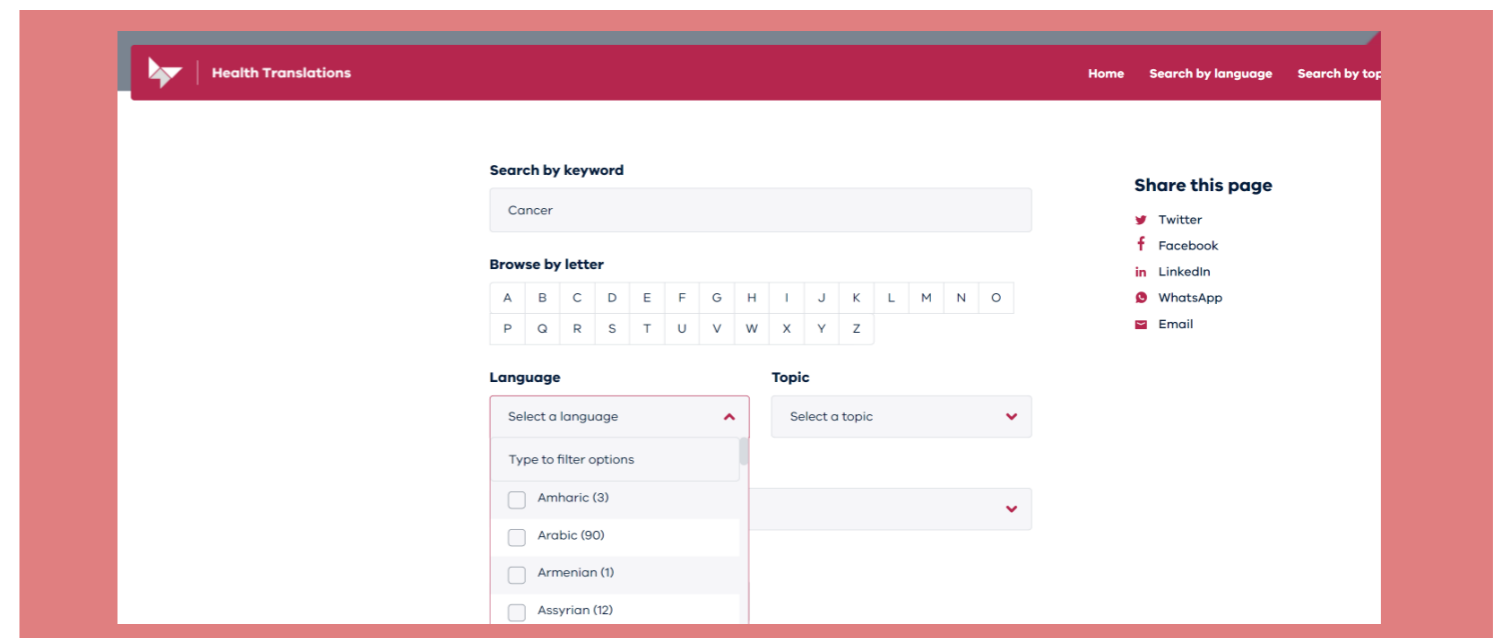
Healthcare professionals can easily navigate the website on their phones or electronic devices simply by searching the directory using a key word or phrase regarding the desired procedure or condition they want to provide information on and then searching the language required. This will then direct the clinician to a verified resource in the patient's 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.

References

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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 ease 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 o 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

Submitted posters

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 have you achieved?

Describe your successes and why it is a success?

- Responsive to literature, MH anti-stigma campaigns require to improve quality of social connections *
- Innovative due to being 1st known anti-stigma campaign to use trauma-informed, needs based, approach ** as is now required ***.
- Improving social support within communities, this being preventative to MH within communities, reducing need for services, working at the level of Social Determinants of Health ****.
- Talk Listen Change (TLC) informed*****
- Luton Young Voices (LYV) informed.
- BLMK Prevention Concordat informed.
- Co-produced, Diversity represented.

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

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**https://explore.bps.org.uk/binary/bpsworks/16203439cce733cf/bcea9befa8a62c15b6371b9d76f24e2172687436f8283ccfec8a53e452198263/inf299a_2018.pdf

*** <https://www.gov.uk/government/publications/working-definition-of-trauma-informed-practice/working-definition-of-trauma-informed-practice>

**** <https://reader.health.org.uk/reframing-the-conversation-on-social-determinants>

Acknowledgements

Add names and organisations that you have worked with: BPS (various groups), RMHC, See Me, BLMK ELFT, BLMK Lived Experience Participation Group, CYP Focus Group via CAMHS Luton.

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.

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

What will you stop doing? N/a.

Is there anything you require? Funding!

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



Loneliness 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










Over 2 in 5 (43%) said their MH worsened whilst waiting for the talking therapy.⁶

More than 3 in 4 (78%) of those waiting resorted to emergency services or a crisis line.⁶



More than 1 in 4 young people (26%) tried to take their own life whilst waiting for MH support.⁵

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.








- Prototype of the AYO badge
- Helps patients identify people who are happy to talk about MH issues.

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.

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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 speciality rather than academic background.

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 2 DEPARTMENT OF PLASTIC SURGERY, EVELINA CHILDRENS HOSPITAL, LONDON
 *UR & GK ARE JOINT STUDY LEADS

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.

Lack of resources/opportunities to gain additional exposure to Plastic Surgery	84.3%
Perceived high academic requirements	82.0%
Perceived elitism within the speciality	75.4%
Perceived favoritism of candidates from affluent socioeconomic backgrounds	73.0%

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 a chance to network with trainees and consultants from all backgrounds. A time to showcase their work and present their learning from the program

Longitudinal mentorship: provided with monthly teaching on research skills. Mentorship with plastic surgeons for career advice, research guidance, taster days and involvement in research projects.

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 specialities

UKPlasticsrc@gmail.com
 www.UKPRC.co.uk
 @UKPRC



Science Communication, coloniality and BAME communities in Britain: An analysis of peer-reviewed publications and social media posts around the COVID-19 pandemic

Elizabeth Neri, University of Cambridge Faculty of Education, EN358@cam.ac.uk

Introduction

The inequalities in health faced by ethnic minorities were brought to the forefront by the COVID-19 pandemic. Through the lens of 'Coloniality of Knowledge' (Quijano, 2000), which concerns the legacies of colonialism on modern knowledge-building, this research explored the role of science communication in perpetuating these health disparities in the UK by devising guiding analytic points to identify markers of coloniality. Although there exists literature exploring coloniality-related issues in Public Health, there lacks a focus on COVID-19 science communication practices, particularly social media.

Research Questions

RQ1: In which ways, if at all, can elements of coloniality be observed within science communication about ethnic minorities between academics through peer-reviewed science papers regarding COVID between 3rd March 2020 to 23rd June 2021?
 RQ2: In which ways, if at all, can elements of coloniality be observed within science communication about ethnic minorities to the public through social media regarding COVID between 3rd March 2020 to 23rd June 2021?

Methodology

The study adopted a documentary research approach analysing peer-reviewed papers (communication among experts) and Tweets (communication among non-experts). Using keywords related to COVID-19 and ethnic minorities (see Figure 1), 44 peer-reviewed papers and 73 tweets were selected and analysed for literature-based markers of coloniality (see Figure 2). Papers and tweets were then colour-coded and cross-analysed (see Figure 3 for an example of coding).



Figure 1: Guiding keywords and terms used to select papers from journals and tweets.

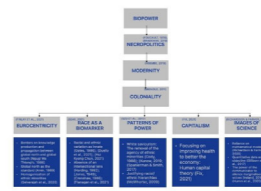


Figure 2: Schematic illustrating the devising of my initial guiding analytical points.

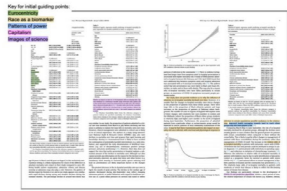


Figure 3: Schematic illustrating the devising of my initial guiding analytical points.

Thematic Analysis, Findings and Discussions

RQ1: Issues of classification, homogenisation and hierarchisation

Draw a conclusion that implied a biological causality, used the term 'BAME' to contrast ethnic minority self-identified on ethnicity. Used the term 'Indian subcontinent' to classify those otherwise classified under 'South Asian'. The use of these classifications homogenised diverse socio-historico-cultural groups into single classifications. Their position 'white' patients the standard to which all other patients should be compared to and is evidence of Eurocentricity. This homogenisation also creates hierarchies between those classed as 'white' and 'non-white' as well as between the different groups within these homogenising classifications, exemplified through the use of the term 'Indian subcontinent'. The positioning of India as the dominant country within this region serves as a reminder of the ethnic hierarchy established during colonial times.

Risk factors and the absence of intersectionality

Used the term 'non-white' to explain the lack of vaccine records observed in a high proportion of ethnic minorities. Discussed 'improved health messaging' to hard-to-reach ethnic groups as the only physical intervention suggested to have resulted in a decline in COVID hospitalisation. Positioned racism and structural discrimination, taking into account socioeconomic factors as a key element of an intersectional approach, rather than race, as a cause of worse COVID outcomes. Most of the papers analysed described, to different degrees, correlations between ethnic/racial differences and COVID outcomes as being biological, positioning those negatively impacted by COVID as being to blame for their ill health. This results in the oversimplification of the causes of illness and therefore in measures to address disparities such as the vague example of 'improved health messaging' (Gray et al., 2021, 7). I must acknowledge that some papers did position racism and structural discrimination as being to blame for worse COVID outcomes and so can be viewed as subverting coloniality (Sze et al., 2020, 11).

Scientific research, data and silencing

Viewed the generalisability of findings through, like ethnicity, as a key benefit of using the electronic health record as their source for modelling data. Aimed to address the existence of COVID-related risk factors among career supervisors and did not discuss or include data on ethnic minorities, even though citing a paper on racial disparities. Excluded data sources that were not in English in meta-analysis studies about the potential impact of ethnicity on COVID outcomes. A lot of the papers analysed used quantitative methods like models to help generalise results in place of recruiting patients from diverse backgrounds and still drew conclusions they deemed robust (Carriera et al., 2020, 7, 8). The exclusion of work with participants from minority groups is an important element of coloniality as explored by De Sousa Santos (2014) and Wood et al. (2021) referenced such a paper but failed to discuss it in their study. Furthermore, the prioritisation of English as the language criterion for meta-analysis studies will inevitably exclude data and knowledge from the Global South, dominated by non-English speaking communities, therefore leading to their silencing.

Conclusion

Overall there were observations of elements of coloniality within the selected papers and tweets. When considering the limitations of my study, most can be attributed to time and resource limitations. I only analysed 44 research papers from 2 journals and 73 tweets from 15 accounts on Twitter. This means that conclusions can only be drawn specifically about the sources of science communication analysed. I started this study with a third research question: "What does the response from Asian, Black and other global majority ethnic people on social media tell us about how this coloniality is experienced by them?" This was dropped due to time limitations. Therefore, I acknowledge that this dissertation is missing the direct perspective from ethnic minorities and so a full understanding of the impact of the coloniality of science communication still needs further exploration. Furthermore, this study only focused on the UK, so it would be interesting to see how other countries and language communities compare these practices of science communication. Particularly, a country which had good COVID outcomes with limited disparities among diverse groups, exploring whether this may be attributed to science communication strategies. This would be helpful for those, like me, interested in better understanding the role of decolonial science communication in tackling health concerns, mistrusts and disparities across diverse communities. Overall, I hope the guiding analytical points I have created are used to continue to question sources of coloniality in science.

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Collection and reporting of Equality Act 2010 protected characteristics within studies and audits of pulmonary rehabilitation in the United Kingdom

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Funded by Wellcome



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 users³.
- 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:

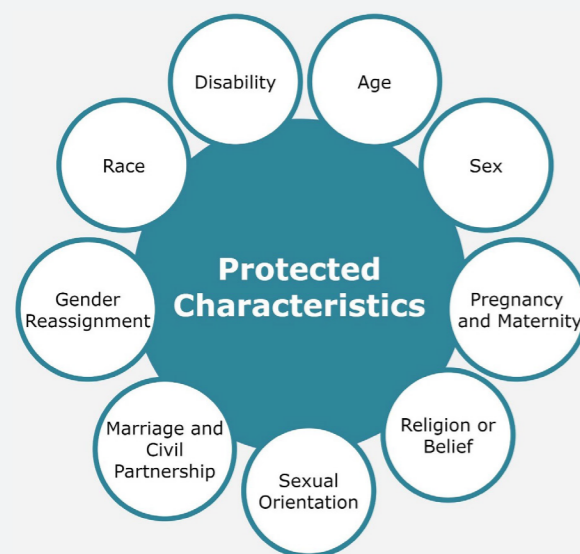
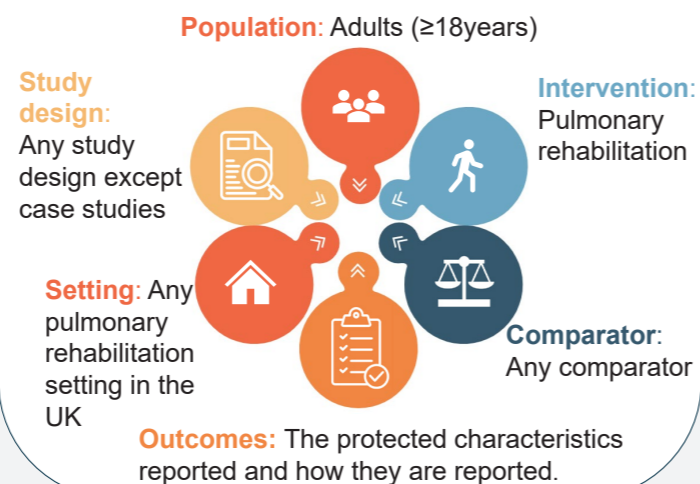
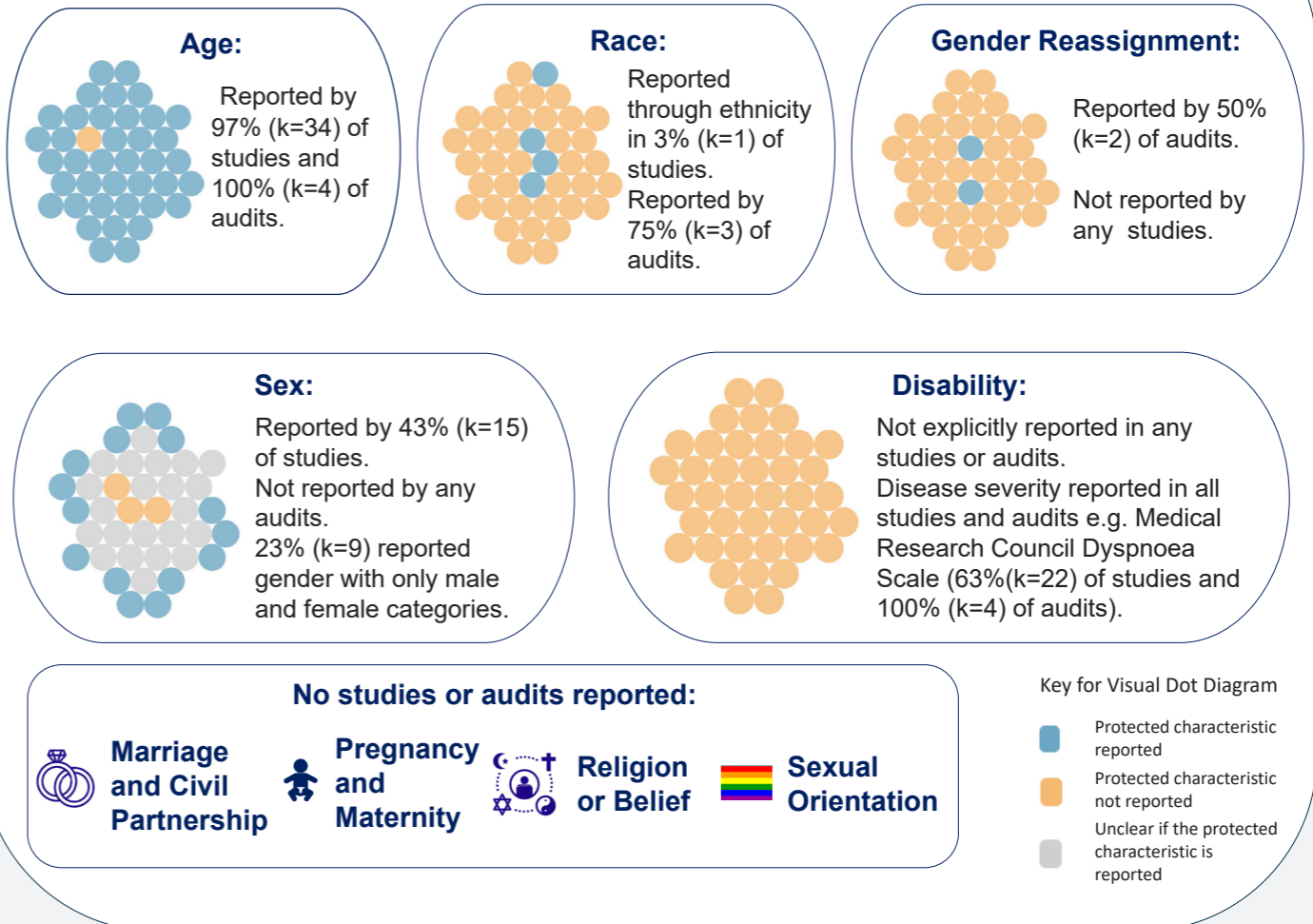


Figure 1: Equality Act 2010 Protected Characteristics

Results:

35 research studies and 4 audits were included.



No studies or audits reported:



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.

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QI PROJECT: REFUSAL OF CHILDHOOD IMMUNISATIONS

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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?

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 - 1 September 2023.
- Parents were contacted to understand the reasons behind their refusal and to see if further information would be helpful in their decision making.
- The role of the community health team in childhood immunisations was explored to assess whether leaflets could be incorporated to increase uptake.
- A sustainable leaflet was produced with the aim of providing more information regarding childhood immunisations and addressing barriers such as poor health literacy and digital poverty. This can be used by the practice, Centre For Family & Fun (CFF) and health visitors.

OBJECTIVE

Childhood immunisations have many benefits, as they reduce the prevalence of serious diseases. Without childhood immunisations, the child is at a greater risk of developing these conditions. Reduced vaccination uptake also decreases the effectiveness of herd immunity. This quality improvement project was designed to find out why parents registered at Saffron Health declined childhood immunisations for their children at the 6 - 8 week baby check between 1 September 2021 - 1 September 2023. Using this information, we identified ways in which the uptake of childhood immunisations could be increased.

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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 - 1 September 2023.
- Parents of children who declined vaccines were contacted. Five questions were asked:
 - Do you know what vaccines you refused at your baby's 6 - 8 week check?
 - Why did you refuse these vaccines?
 - Have you, as parents, been vaccinated yourselves?
 - Are you interested in finding out more about vaccinations?
 - Do you have any further questions or comments?
- Following the feedback we received, we found out about the different points of communication regarding vaccinations from before birth until the 6 - 8 week baby check.
- The Health Visitor Team and the Centre for Family & Fun (CFF) Leaders were contacted and asked a series of further questions:
 - Their roles in childhood immunisations.
 - Role of the antenatal and new baby checks with regards to vaccinations.
 - Benefits of providing physical leaflets for further information.
 - Frequently asked questions from parents.
- A leaflet was designed based on their feedback and will be distributed amongst the health visitor team as well as electronic copies made available through the use of a QR code and incorporation into Saffron Health's website.
- Leaflet considerations:
 - Sustainable production** - Limiting physical copies to only 3 for each of the health visitors that work with Saffron Health. These copies will be laminated for longer lasting use. Feedback suggested that parents would respond better to a physical copy in the longer health visitor meetings, as there is more time to discuss. Additional copies will be shared electronically to reduce waste. CFF refers parents to online sources for more information, so electronic copies would work seamlessly with their current methods.
 - Online uptake** - The Digital Team for Health for Under 5's was contacted and asked how many visits their vaccination site (<https://healthforunder5s.co.uk/sections/baby/vaccinating-your-baby/>) received from 1 September 2021 - 1 September 2023 to assess whether electronic resources were considered useful.
 - Health literacy** - The literacy age of the community registered at Saffron Health is 9 years. Therefore, it is important that the leaflet is appropriate for the target audience.
 - Digital poverty** - For families where this is an issue, the CFF or health visitor team members can use their own phones to share online copies and discuss the links provided in the leaflet. This is routine practice for CFF as digital poverty is prevalent within the community.
 - Access** - There is a QR code on the leaflet which, when scanned, will take parents to an online copy. The leaflet has been added to Saffron Health's website to allow parents to view this outside of the appointment. This can be accessed from public spaces such as libraries (Pork Pie Library within the community), for families without electronic devices.
- In the future, follow up can be conducted by contacting parents, the health visitor team & CFF leaders to assess whether the leaflets and contact made were beneficial in increasing vaccination uptake.
- We understand that there is a QoF (Quality and Outcomes Framework) for childhood immunisations. This can be used in future to monitor the effectiveness of this project.

RESULTS/FINDINGS

- Common reasons why parents refuse vaccinations:**
 - Negative experience with previous children.
 - Lack of information regarding the contents of the vaccines.
 - Fears regarding the link to autism.
 - Children appear healthy without vaccinations.
 - Parents feeling that their child is too young to be vaccinated.
 - Religious reasons.
 - Forgetting to take their child to the appointment.
- Following contact regarding vaccinations, further information was sent using AccuRx to parents who were interested.
- Health Visitor Team Feedback:**
 - They contact parents between 28 - 36 weeks of pregnancy and also 10 - 14 days after birth.
 - Information regarding vaccinations is better received during the 10 - 14 day check.
 - Websites they use to signpost:
 - NHS Choices
 - Health for Under 5's
 - They felt that a physical leaflet would be more beneficial for them to discuss with anxious parents.
 - Paper leaflets were previously used by the health visitor team and were effective during consultations with parents. However, due to environmental considerations, these were stopped.
 - As a result, the leaflets designed prevent excessive environmental damage by having limited physical laminated copies and electronic versions to reduce waste.
 - This allows health visitors to utilise physical copies during the consultation, whilst also providing a reliable resource to signpost parents to in an environmentally friendly way.
- Centre for Family & Fun Feedback:**
 - They offer two programmes where vaccinations are a topic of discussion:
 - Teen Parent Project
 - Building Communication Skills
 - They had concerns that parents were using untrustworthy sources to access information (due to the influence of social media) so the leaflet contains links to reliable sources to tackle this.
 - The growth of social media during COVID and the hesitancy surrounding the COVID vaccinations may have also had a role to play in affecting vaccination uptake during this time period.
 - They felt that a leaflet would be beneficial to direct parents to more evidence-based information.
 - Websites they use to signpost:
 - Health for Under 5's
- Effectiveness of Leaflet:**
 - The effectiveness of the leaflet is being evaluated by the health visitor team and repeat studies can be done in the future, involving them to establish whether parents responded well to information being provided in this format.
 - The leaflet has been incorporated into the Saffron Health website. Parents can access this information, therefore, its effectiveness can be monitored by assessing the number of visits to the site.

ANALYSIS

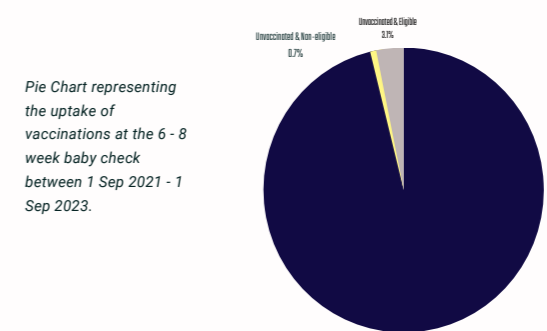
- WHO recommends that on a national basis at least **95%** of children are immunised against vaccine-preventable diseases.
- All UK routine childhood immunisations are evaluated up to 5 years to see whether this target is met.
- In 2021/22, none of the routine vaccination targets were met (for the 4th consecutive year).
- 286** 6 - 8 week baby checks were carried out between 1 Sep 2021 - 1 Sep 2023.
- 3.8%** (n=11) of patients refused their vaccines at the 6 - 8 week baby check between 1 Sep 2021 - 1 Sep 2023.
- These patients were identified and **81.8%** (n=9) were eligible for contact.
- 11.1%** of parents (n=1) said they would be interested in finding out more regarding vaccinations.
- They were sent information using AccuRx and were told to contact us again if they would like to book in for a vaccination appointment.
- This patient was followed up to see if their decision on vaccine uptake had changed, however, as of 14 Nov 2023, the child remains unvaccinated.
- 442** people visited the immunisation page on Health for Under 5's from 1 Sep 2021 - 1 Sep 2023 with an average time of **2 mins 27 secs**.
- Leaflets will be trialled and their benefit monitored by health visitors & CFF during consultations with parents.
- Currently, parents are being signposted to the leaflet for more information by GPs at the practice.



A design of the leaflet that will be distributed amongst the health visitor & CFF team, including the QR codes for parents/guardians to scan for an electronic copy. This prototype represents what the QR code will look like.



A design of the leaflet that parents/guardians will have access to after scanning the QR code.



Pie Chart representing the uptake of vaccinations at the 6 - 8 week baby check between 1 Sep 2021 - 1 Sep 2023.

The link to the leaflet on the Saffron Health website, under 6 - 8 week baby check.



CONCLUSION

Our project explored the reasons why parents declined childhood immunisations at the 6 - 8 week baby check. We conducted this by contacting these individuals and discussing their views. Following their feedback, we discovered the main reasons why parents declined vaccinations and utilised this understanding, along with the information provided by the health visitor and CFF teams, to create a leaflet. We produced a leaflet to target common misconceptions parents may have in an accessible manner by acknowledging the effect of poor health literacy and digital poverty within the community. Overall, this hopes to address the aims of this project by increasing the uptake of childhood immunisations.

ANTENNAE STUDY: ADDRESSING INEQUALITIES IN RENAL RESEARCH

Kidney Research UK

Neerja Jain

BACKGROUND

The inaugural renal research strategy as well as Kidney Research UK Health Inequalities report (Caskey et al., 2019) both highlight health inequalities and the need to enhance the inclusion of under-represented groups in kidney research so that benefits apply to all patients.

HOW ARE WE ADDRESSING THIS?

Antennae: Addressing iNequalITies iN reNAI rEsearch is a QI project being undertaken in partnership with Northern Care Alliance (NCA) NHS Trust renal unit and NIHR's Research for the Future (RfF)*. Utilising Kidney Research UK's evidence based 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 forums including community events and in dialysis units. The target areas are Salford, Oldham and Rochdale, aiming to specifically engage with and improve participation from those of lower socio-economic status, Bangladeshi and Pakistani communities.

**RfF is a NIHR CRN Greater Manchester 'consent for approach' initiative. The service helps people find out about and take part in research and helps researchers involve, engage and recruit the right people: researchforthefuture.org*

PROJECT AIM

The aim is to engage, provide information, allay fears, and explain the importance of and need for involvement and participation in renal research. Then to encourage registering onto RfF's database to express interest only in preferred type of research. Registered people will only be contacted if a suitable study becomes available and only then, do they provide consent. They are free to withdraw at any time and indeed have their details removed from the database at any point.

EARLY RESULTS

Some early results demonstrate the impact of a face-to-face engagement with an empathetic, trusted individual who has lived experience of the issues. Given that 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.



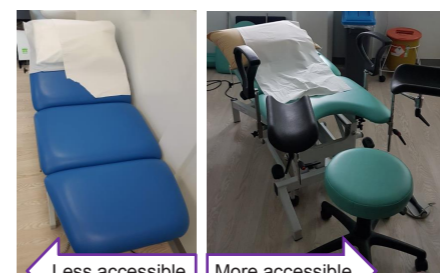
"All the way in"; Improving access to sexual health services for Disabled People

Dr Cordelia Chapman, Consultant in Sexual Health and HIV, Bournemouth and Lorraine Stanley, CEO 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.



Aims:

- To improve inclusive access to the service for all Dorset 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.

Sources:

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

² Key findings of Jo's Trust research 2019: <https://www.jostrust.org.uk/our-research-and-policy-work/our-research/barriers-cervical-screening-physical-disabilities>



22 % of the UK population is made up of people with a disability, that's more than 14 million disabled people in the UK.¹

Pictured left: Cordelia (standing), & Lorraine (seated)

Considerations for ongoing practice:

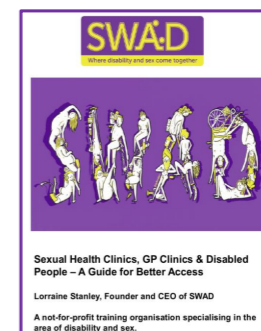
- Visual inspection may not be possible in the clinical setting due to lack of hoists and leg supports for patients that have spinal cord injuries, neurological conditions etc.
- Remote diagnosis/telemedicine - In some cases it may be necessary to carry out a home visit, as there may be safeguarding concerns related to professional carers taking intimate photographs of their client.
- It is 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 stats are below.

Existing research of disabled women² shows:

88% said it is harder for women with physical disabilities to attend or access cervical screening

63% said that they have been unable to attend cervical screening because of their disability

49% said that they have chosen not to attend cervical screening in the past for reasons such as previous bad experiences related 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.swaddorset.org/accessibility-ebook-published/>

"I think it's an awesome and informative booklet. It's a great checklist for thinking what needs to be done, and the list of resources and links to the guidance and best practice are extremely useful".

Review by Dr Cordelia Chapman of SWAD's Access Guide.



Scan the QR code above to see more information about Swad's eBook.



Universal Medicine: Widening Access and Participation in Medical Research

Gagandeep Sachdeva, Adil Rahman, Satbachan Bassan, Christopher Morgan and the Universal Medicine Working Group



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

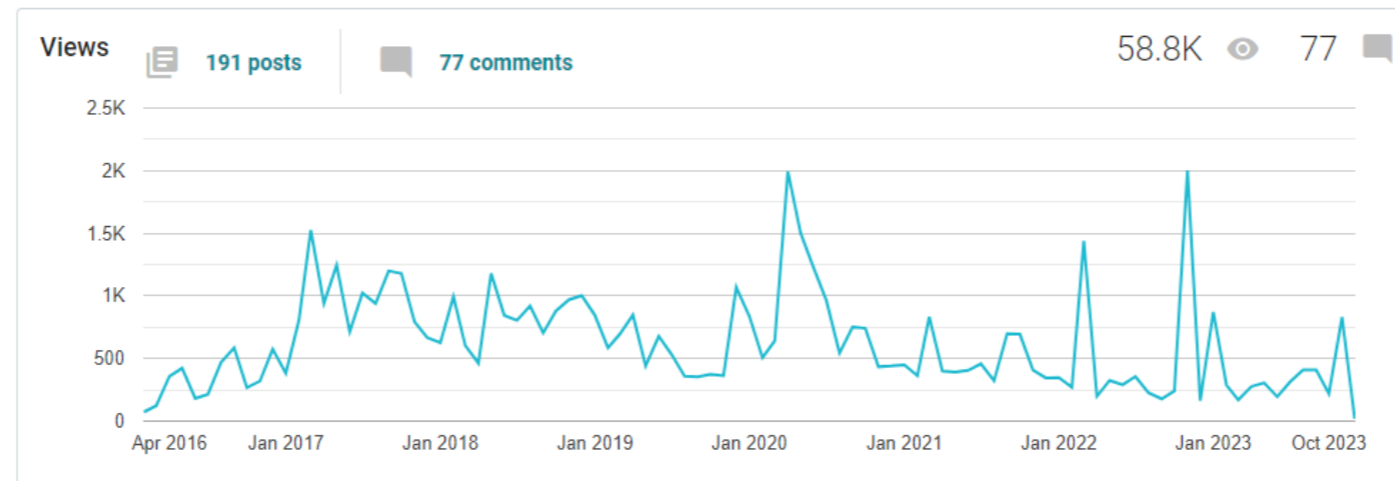


Figure 1: Universal Medicine views charted by date (extracted on 03/12/2023)

Top Locations

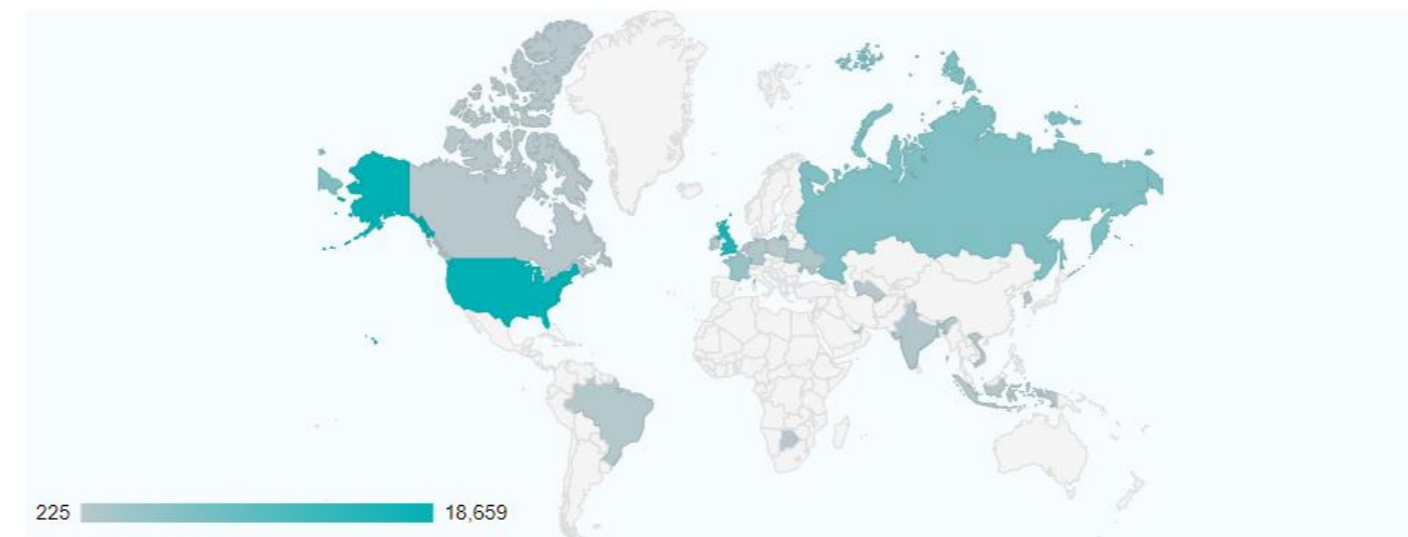


Figure 2: Geographical distribution in the readership of Universal Medicine (extracted on 03/12/2023)



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



<https://universal-medicine.blogspot.com/>

Submitted posters



Taking a Public Health Approach to Tackling Fuel Poverty

Jassat R, Quick E and French, L
Leicester City Council Public Health

INTRODUCTION: Why Tackle Fuel Poverty?

In 2022, there were an estimated 13.4 per cent of households (3.26 million) in fuel poverty in England, an increase from 13.1 per cent in 2021. Fuel poverty can be defined as a household with a Fuel Poverty Energy Efficiency Rating (FPEER) of band D or below, and if, after removing their modelled energy costs and housing costs, the residual household income is below the poverty line¹. Fuel poverty in England is measured using the Low-Income Low Energy Efficiency (LILEE) indicator, which considers household income, energy requirements and fuel prices. This measure is not without limitation though, as those in homes with an EPC rating of C or above are not counted as fuel poor no matter their income or energy costs.

Those most impacted by fuel poverty include people in privately rented homes, older people, and those living in less energy efficient properties. People under 24 and those from ethnic minority backgrounds and in the lowest income decile are also disproportionately affected. Between 2021 and 2022 gas and electricity prices increased by 45 per cent in real terms. In Leicester, 18.9% of households are considered fuel poor, equating to 24,543 families struggling to heat their homes.

Inequalities in health are avoidable and unfair differences in health between groups of people. They arise because the factors affecting our health are much wider than simply access to healthcare². Factors such as housing, education and access to community networks are known as the 'wider determinants of health'. This has most famously been demonstrated using the 'rainbow model' by Dahlgren and Whitehead³ (Figure 1). This model shows all the factors that influence a person's health, from the immediate genetic and lifestyle factors, to the wider socioeconomic conditions that govern our wellbeing.

Tackling fuel poverty is therefore a key component of working to narrow health inequalities as being able to live in warm, dry, secure housing is a key health determinant.



Figure 1

LIVING IN LEICESTER

According to the 2021 census, 368,600 people reside in Leicester. With around 36 people per football pitch-sized piece of land, Leicester is the most densely populated local authority area in the East Midlands⁴.

Leicester is home to a wide range of diverse communities, and residents of Leicester come from over 50 different countries around the world. At the 2021 census, 57.9% of Leicester residents were born in the UK. 43.4% of Leicester residents identify with an Asian ethnicity, of which 34.3% have Indian Heritage. 15.7% identify with other ethnic minorities (Figure 2).

Leicester's population faces significant challenges with socioeconomic deprivation. Three quarters of Leicester residents are living in one of the top 40% most deprived areas nationally, and around 11% of people in one of the top 5% most deprived. Leicester currently ranks 32 out of 317 local authorities by average level of deprivation.

These factors all work together to create unique challenges for the health of the residents of Leicester and the services that they need. Socioeconomic deprivation is inextricably linked with poor health outcomes, and there are particular challenges in accessing care for people who may not be confident in their written or spoken English, and who may have only recently arrived in the UK.

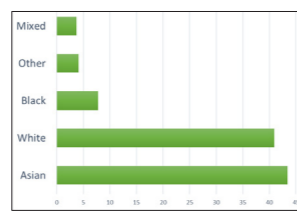


Figure 2: Ethnicity by % of population in Leicester Census 2021

THE HEALTH IMPACTS OF FUEL POVERTY

Each home should be heated to a temperature comfortable for the people living in it. For healthy and warmly dressed people, the ideal temperature is 18°C for rooms that are most often used, such as the living room or bedroom. There are serious health impacts related to fuel poverty and living in a cold home, including⁵:

- Causing/worsening cardiovascular and respiratory illness, strokes, heart attacks, heart disease, asthma.
- Lowers immune system, increasing the risk of contracting colds/flu/COVID-19 – viruses which thrive in colder environments.
- Increased likelihood of trips and falls in the house.
- Limits children's physical and mental development, growth and weight.
- Worsening pre-existing chronic medical conditions including chronic obstructive pulmonary disease (COPD).
- Worsening mental health, increased likelihood of social isolation and is a known risk factor for suicide.
- Damp and mould causing respiratory problems, allergies, asthma and can affect the immune system.

Estimates suggest that some 10 per cent of excess winter deaths are directly attributable to fuel poverty and 21.5 per cent are attributable to cold homes.

THE PARTNERSHIP

Leicester Energy Action, funded by Leicester, Leicestershire and Rutland Integrated Care Board, is being delivered by National Energy Action and Leicester City Council's Public Health Division. National Energy Action (NEA) are a charity advocating an end to fuel poverty in England. NEA have been forming partnerships for over 40 years to help households out of and to avoid fuel poverty. In December 2022, Leicester City Council (LCC) Public Health and NEA joined up to collaborate on a fuel poverty programme for the citizens of Leicester. This partnership is known as Leicester Energy Action.

Leicester Energy Action operates via four key workstreams: advice, community outreach, education and training.

ADVICE

The advice service provides detailed energy advice for all residents in Leicester. The referral process is open to frontline workers in the local authority, voluntary organisations, social prescribers, the wider NHS and, importantly, local community organisations. Institutions, ourselves included, are renowned for failing to connect with community organisations that we need to in the right way: There is often a focus on online services in a world where the most deprived can be digitally excluded. English is the main language used in communication while trying to reach communities with language barriers. We work with mass messaging and online media to reach people who listen to individual messages from people they trust in the places they feel at home.

Our programme is therefore working with and through community groups and community leaders – engaging them in the delivery and development of the service provision, as well as working with them to develop the tools to continue a legacy of fuel poverty support.

The advice service is delivered by energy advisors supporting people with energy debt, safeguarding, and keeping their homes warm. The service provides comprehensive energy support for people, including:

- Managing energy debt/negotiating with suppliers
- Damp/mould in properties
- Energy efficiency/health impacts
- Support to access existing retrofit schemes
- Support to access government support/ tackling barriers such as digital exclusion
- Long-term solutions as well as short-term remedies



ADVICE CASE STUDY

The advice service is making a real difference to people's lives not only through material support and advice provided, but also through addressing broader issues, and linking up with local authority and external support networks. This case study (figure 3) is unique in its detail, but far from rare in terms of the approaches taken and the outcomes service is routinely realising.

Claire is 69, living in three-bedroom house. Language barrier and a visual impairment – unable to read fuel bills and other correspondence
Had an unsuccessful knee replacement – cannot walk without assistance. Long term illness and fear of not been able to afford to keep her family warm
Claire's health conditions leave her isolated, suffering with severe depression and anxiety, and she had a debt of £680.10 with British Gas
Claire was also struggling with food – not accessed local food banks as anxious about facing stigma

- Conducted a home visit and a conference call with client and supplier, we uncovered that the client was in credit.
- We worked with British gas to reduce the Claire's monthly payments from £92.82 to £69.01 per month for the next 12 months.
- We put Claire on the priority services register, and so now she will be sent bills monthly in large print

- Referred to Visa Care UK for a food parcel – tailored to the clients' needs and delivered to her home.
- Signposted to Zimthiya Trust for benefits advice, Age Concern for befriending, Vista Blind for assessment and support, and applied for the Severn Trent Water Big Difference Scheme.
- Worked with Claire around efficient use of appliances, healthy room temperatures, heating and hot water controls, keeping warm and healthy in colder weather, and low-cost energy efficiency behavioural changes.



Figure 3

COMMUNITY OUTREACH

Community outreach involves a team of energy advisers attending community groups session, events and team settings to deliver bespoke energy advice where people need it. The outreach team brings an awareness of the health impacts of fuel poverty, knowledge about the ways that people can overcome the difficulties they face, and they look to embed this to foster long-term behaviour change. Importantly, they provide access to support for those that need it. This outreach is designed to convert fuel poverty awareness into better health.

The programme understands the importance of co-delivery with the trusted individuals within communities. The outreach is bespoke, delivered in the way the communities need it to be delivered whether that is a group lecture, an information stand, one-to-one sessions with clients, or any other arrangement that's required. The approach is flexible, reactive, and innovative.



TRAINING

The training workstream is aimed at front line staff within organisations and communities. We're building a network of qualified energy advisors with and in the communities where they're needed across the city to aid vulnerable residents who are in or at risk of fuel poverty. The training is funded by the programme so there's no additional cost to the teams, groups and organisations we are working with, and it's giving their staff the ability to support their clients with the issues that are being presented on the front line. There are two core strands to the training workstream – a series of webinars addressing key fuel poverty topics, and The City and Guilds Level Three Award in Energy Awareness.

Short course webinars

The short course webinars look at a range of topics including the impact that fuel poverty has on mental health, how changes in behaviour can support people to act upon advice.

Level Three City and Guilds Energy Awareness

The City and Guilds training is a longer course with three days of training and an examination day. Learners undertaking this course can obtain a qualification in delivering energy advice including energy saving methods, the causes of condensation dampness, how to avoid condensation and remedial actions to combat existing condensation.



EDUCATION

'Energy in mind' is an innovative two-hour face to face workshops for key stage two children delivered by our trainer in partnership with educational institutions. The aim is to educate young people to become more energy efficient, facilitate good behaviour change and empower them in influencing others to improve their energy habits.

The workshops are broad and look at different areas of energy to equip young people with an understanding of exactly how changes in behaviour can make a difference by considering:

- how much it costs to run appliances and learn to be mindful of dangers associated with them
- the production of energy and consider the differences between renewable and non-renewable sources
- the impacts that wasting energy is having on our environment
- how warmth can be maintained through different insulation measures

The workshop is built around student interaction and is accessible at a level appropriate to the learner. Objectives are linked to the National Curriculum, PSHE and Citizenship Programmes of Study.



IMPACTS AND CONCLUSION

The Fuel Poverty Programme is approaching the end of its first year. The Advice Service now has over a hundred referrers from teams across private, professional, public and voluntary sectors. They have helped close to a thousand clients with complex cases – making a real difference to households and families within targeted communities. The education workstream has worked with 800 primary school children.

The City and Guilds course and webinars have been delivered to a network of connected organisations, working towards embedding accessible energy advice within communities from trusted voices.

The outreach programme has reached close to 3000 people, raising awareness and ensuring access to support.

In year 2, the programme will build on the breakthroughs and developments already in place, connecting with an expanding range of teams and organisations, and determined to help as many more people as possible. An external evaluation is also being commissioned to look at the health impacts of the programme. Our take home messages for other teams considering a similar programme are:

1. It is only by addressing the wider determinants of health, including fuel poverty, that we can begin to really tackle health inequalities
2. Working partnerships with expert non-profit organisations leverages their subject matter expertise in combination with public health principles and intelligence
3. Any initiative such as the fuel poverty programme must be undertaken in partnership with local communities so they can be designed and delivered in a way which most suits local need



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Submitted posters

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

Katrina Mason, Sarah Khavandi, Ernest Lim, Siân Rees, Paul Hirmis, Barbara Lozito, Nick de Pennington, Aisling Higham

Why is diversity in patient public engagement activities important when generating AI solutions?

- We are currently witnessing and exponential growth in AI healthcare solutions.
- A lack of consideration for equity, diversity and inclusion (EDI) in the life cycle of AI within healthcare settings may intensify social and health inequities, potentially causing harm to underrepresented populations (1)
- AI healthcare innovations must therefore meet the needs of *all* the populations they serve.

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 (2)
- Dora is a UKCA Class 1 approved medical device
- Ufonia is live across 9 NHS trusts delivering a wide range of conversations including waiting list validation, post-op cataract follow up, PROMS questions, post-menopausal bleeding triage.
- Patient and public involvement (PPI) has been a fundamental part of the user centred, "co-creation", approach to the development of Dora.
- Ufonia has partnered with the Health Innovation Oxford & Thames Valley to ensure robust PPI processes.
- Marginalised and seldom heard populations have proactively been sought out to help ensure a diverse patient voice is heard. (see Table 1.)

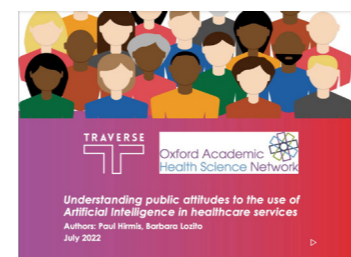
How Patients have been involved in Ufonia's work

- Giving voices to marginalized groups (see table 1)
- Testing Dora (1 to 1 technology trials)
- Prioritisation of next development steps
- Patient voice as representatives on steering groups
- Helping curate patient information leaflets

Patient Populations we have actively involved

- Patients with Learning Disabilities Neurodiversity (including Autism)
- Cancer Patients (& their carers)
- Ophthalmology patients with a diverse ethnic background
- Non-English speakers (Polish language group)
- Patients with mental ill-health

Table 1. Patient populations involved in PPI activities at Ufonia



"The potential for Artificial Intelligence (AI) to benefit health must be balanced against the risks posed by algorithmic bias and harms. These technologies may work better for some groups and worse for others, causing or worsening health inequity." Standing Together, 2023 (3)

Recommendations for diversity, inclusivity, and generalisability in artificial intelligence health technologies and health datasets.



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

Feeding back on patient involvement with...

You said

- Some people with a learning disability are advised not to answer 'unknown number' calls
- "How do I know I can trust Dora?"
- "Cancer is a scary intimidating term"
- "Not sure what to expect from a Dora call"

We did

- Patients are texted the day before to remind them of the Dora call
- Clear instructions from hospital team, reassurance in the Dora call
- Removal of the mention of cancer from the head & neck triage conversation
- Clear written and audio instructions
- Videos in discharge lounge

Ufonia has commissioned the Oxford AHSN to 'Understand public attitudes to the use of Artificial Intelligence in healthcare services' Key themes include;

Access to health generally

- Participants talked about the need to be able to access the healthcare system when you need it, with many frustrations with current waiting times for appointments and services.
- Lack of easy access and lack of continuous care from the same healthcare professional were also concerns.

Being treated with dignity and respect

- Initial discussions drew out universal themes around relationships with healthcare professionals and being treated with dignity, being seen, heard. "Being understood by someone who really knows you" is for patients at the core of a good digital consultation and triage experience.
- As a patient put it: "Not being dismissed, being believed, having your experiences validated"

Dora's Safety & Competence

- Believing that the person who you see knows your personal case and is knowledgeable and competent was key for participants. When discussing the role of Dora, its competency was a subject of discussion "How do I know that Dora has understood me?"
- Whether Dora can understand idioms, dialect, accent, nuance & emotion were also seen as important. Potential safety issues were also raised as a concern: "What happens if Dora makes a mistake?" and "Does Dora remove human error"

Access to Dora

- For people with autism, telephone calls can often be anxiety provoking so rather than having to speak they would find it easier to interact with Dora via text or web chat, which would need further targeted testing.
- Some participants thought that Dora may be a more acceptable option for younger people or people who are more tech savvy, as they may be more comfortable with the concept of communicating with AI.

AI has the power to remove individual human-clinician bias. For some there was a clear sense that Dora was "democracy in action", with all patients receiving the same voice and questions due to the automated nature of the service. There was also a feeling that Dora would not judge or gaslight patients.

'Understanding public attitudes to the use of Artificial Intelligence in healthcare services' Oxford AHSN, 2022

"The PPI work undertaken has been one of the most invaluable and humbling experiences of my career. It was the first time since medical school that I had sat down with a patient for over an hour and simply listened to their story. I had no clinical agenda to make a diagnosis or management plan, the process was simply to listen. This time allowed me to reflect on, and garner new insights into aspects of head and neck cancer, my speciality, and importantly my overall role as a doctor.

Ufonia Clinician involved in PPI work, 2021

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- www.ufonia.com
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BE PART OF OUR AWARD WINNING MEDICAL TEXTBOOK SERIES

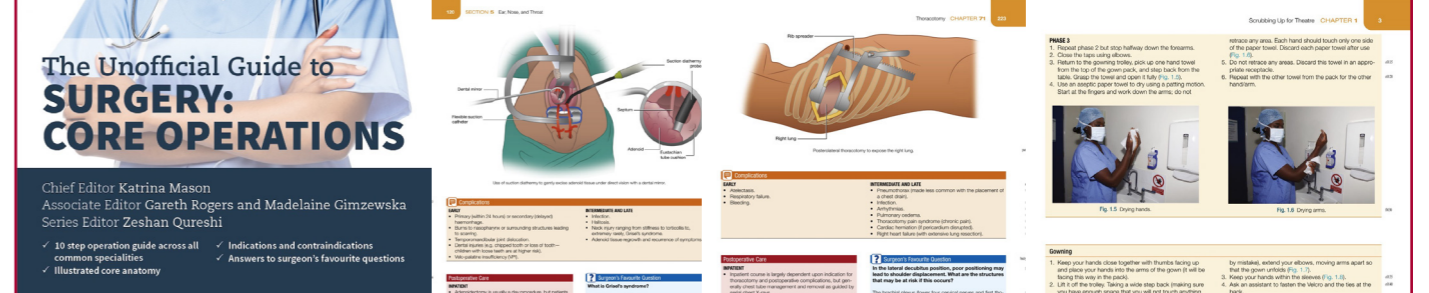
The Unofficial Guide to SURGERY: CORE OPERATIONS

Chief Editor Katrina Mason
Associate Editor Gareth Rogers and Madelaine Gimzewska
Series Editor Zeshan Qureshi

- 10 step operation guide across all common specialities
- Illustrated core anatomy
- Indications and contraindications
- Answers to surgeon's favourite questions

Representation Matters. Tackling race inequalities through inclusive imagery of both surgeons and patients in a surgical textbook.

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



The problem

- Lack of racial diversity in medical textbook illustrations is widely criticised.
- Louie et al analysed 4146 images from the top 4 medical textbooks in the United States and found overrepresentation of light skin tone and underrepresent dark skin - 74.5% light, 21% medium, and 4.5% dark compared to the actual racial distribution of 62.5% White and 20.4% Black (1).
- Multiple studies have shown that the underrepresentation of minorities in medical education such as course slides, pre-clinical lecture material, case studies, and textbooks impedes racial equity in the practice of medicine (2)

The Unofficial Guide to Surgery

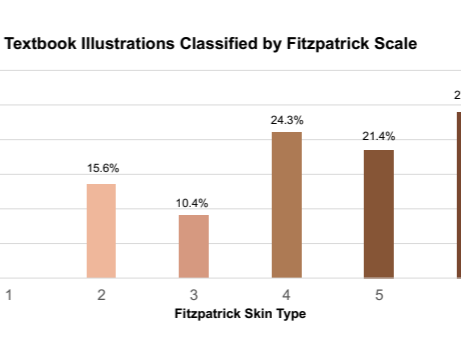
- The *Unofficial Guide to Surgery* (UGTS) is concise summary of the most common operations across all surgical specialities, detailing how the operation is performed, indications, contraindications, complications, the pre/post-op care and follow up. (3)
- Each operation is accompanied by two illustrations, one of relevant surgical anatomy, the other a snapshot of the surgery itself.
- This textbook seeks to excise the mystery around the operating theatre and to equip novice students with a thorough understanding of the principles of common operations.

The Unofficial Guide to Surgery & Skin tone representation

- Cognisant of 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 employed were directed 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.

Methods

- UGTS illustrations were reviewed, all images depicting skin were categorized according to the Fitzpatrick phototyping scale by an independent reviewer.
- The British Association of Dermatology (5) and DermNetNZ (6) visual references for the Fitzpatrick Scale were used as reference.
- Analysis separated illustrated images (patients) and photographic images (surgeons).



Results

- The UGTS contained 187 images depicting skin
- Of the 172 illustrated patient images 0%, 15.6% (27), 10.4% (18), 21.4% (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.



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Edited by
Katrina Mason and Gareth Rogers

Series Editor
Zeshan Qureshi

- Tip and tricks from successful students, junior doctors and senior professionals
- Core topic coverage in concise language
- Clear diagrams and illustrations emphasise key messages
- Full and engaging patient information

Submitted posters



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 they 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.

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Submitted posters



Launching a Primary Prevention Programme in 76 Secondary Schools Across the UK: A Transformative Acceleration Programme

UAlam, L.Fernandes, A Ghataure, L Chajed, M Shafi, J Hayes, M Qurku, S Welling, L Truykov

WHO WE ARE

According to the UCL Institute of Health Equity, and Public Health England, 42% of working-age adults aged 16-65 years are unable to understand or make use of everyday health information, rising to 61% when numeracy skills are also required for comprehension (Roberts, 2015).

With help from Imperial College London, the British Society of Lifestyle Medicine and our funders, UltD, we, a group of medical students, created the **first primary prevention lifestyle medicine education programme** for adolescents in the UK. Working in 76 secondary schools across the U.K, we have delivered 400 hours of prevention material to schools in deprived areas to date.

"Enable all children, young people and adults to maximise their capabilities and have control over their lives"
Prof Michael Marmot (Marmot, 2010)

Since, the National Curriculum has no provisions to teach students about their health, we have established the **first UK programme** aiming to maximise students' potential in attaining a healthier life.

DEMOGRAPHICS

Overall	
Schools enrolled onto the programme	76
Students enrolled	1252
Schools Enrolled onto the Programme	
Average Index of Multiple Deprivation	5
Average Free School Meals %	24.6
Students Demographic (%)	
BAME	70.8
Parents/guardians born outside the UK	68.5
≥1 guardians did not attend university	58
Eligible for free school meals	24
Eligible for 16-19 student bursary	27.3
Barriers to Better Health (%)	
Lack of Knowledge	28.1
Lack of Funds	27.5
Lack of Opportunities	27.8
Lack of Motivation	40.5
Student's Sources of Health Related Information (%)	
Social Media	61.8
NHS Website	60
Non-NHS Websites	34.7
Teachers	50.7
PSHE Classes	27.6
Student's Opinions on our Intervention (%)	
Willingness to dedicate 1hr per month to an online health literacy course	94.7
Desire to be taught more about behaviour	99
Desire to be taught more about nutrition	95.7

Figure 1: Summary demographics of schools and students enrolled onto the programme. It describes perceived barriers to health and opinions on our interventions

TACKLING INEQUALITY: OUR PROGRAMME

We designed a two-year syllabus that addresses the social determinants of health, in the **hope of empowering students to lead change in their own lives and social networks**. We established a pedagogical framework based on Dahlgren and Whitehead (1991), and outline key aspects below:

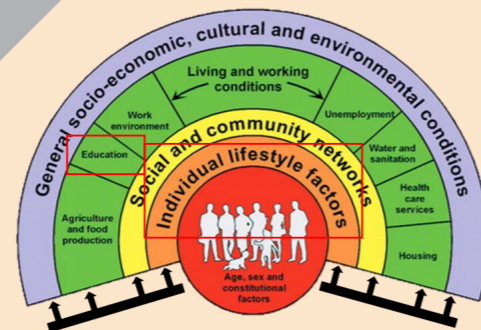
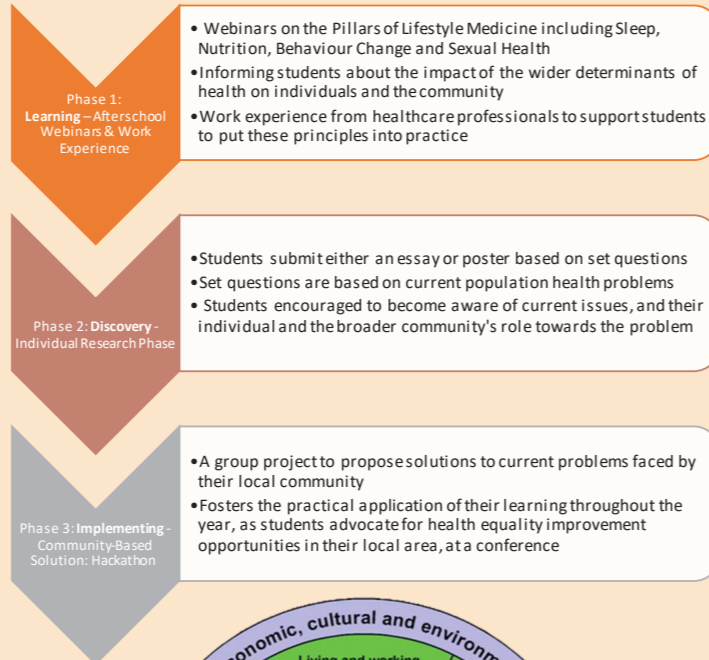


Figure 2: The socioecological rainbow model from Dahlgren and Whitehead specifies determinants of health. The red boxes, show areas the programme is targeting namely

TACKLING INEQUALITY: THUS FAR & FUTURE PLANS



Figure 3: A group of 6 students presenting their community initiative at the IAP Hackathon

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.

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Connected Bradford Community Health Checks: A New Approach to Tackling Health Inequalities

Improvement Academy:
Dr Ciaran O'Neill - Clinical Leadership Fellow | Dr Zuneera Khurshid - Implementation Research Fellow | Dr Vishal Sharma - Associate Director | Dr Michael McCooe - Clinical Director | Professor Tom Lawton - Head of Data Analytics

Health Innovation Yorkshire and Humber:
Adele Bunch - Head of Portfolio - Health Inequalities, Mental Health and Patient and Public Involvement and Engagement | Vanessa Amoako - Project Manager
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The Challenge

- Cardiovascular diseases (CVD) contribute to 27% of all deaths in the UK [1].
- CVD disproportionately affects those from the poorest communities, with a mortality rate four times greater than for those in the least deprived areas [2].
- Type 2 Diabetes increases the risk of CVD, particularly in minority groups [1; 3].
- Prevalence and Incidence of Type 2 Diabetes is greater for minority ethnic groups (South Asian and Black ethnic groups) compared to White populations [4; 5].

The Approach

- Develop a community-based health check event targeting high risk groups, based on data available from Connected Bradford and in line with **CORE20 PLUS 5** criteria.
- Increase awareness of CVD risk factors (hypertension and Type 2 Diabetes) in minority ethnic groups.
- Deliver brief interventions, social prescribing, and signposting to local community organisations.
- Facilitate connections to primary care services by uploading results to a patient's GP record.
- Use Implementation Science methodology to evaluate and develop the approach.

Methods

- Plan-Do-Study-Act cycle was used to iteratively test, learn, and evolve the community health checks model.
- This allowed for specific elements to be tested and refined through tests of change based on real-time learning.
- The model could be adapted for individual community settings.
- Data collection included:
 - Semi-structured interviews
 - Feedback Forms
 - Lightning Reports (see right)
 - Connected Bradford Data (see right)



Lightning Reports

- A qualitative research method (report) to quickly collect, summarise, and share information.
- Identifies what went well, what needs to change, and areas for immediate improvement - providing actionable insights and learning.

Connected Bradford

- Brings together health, education, social care, environmental, and other local government data [6].
- To support data driven health care.

Results

Between February 2023 and December 2023 four health check events (lasting 3 hours each) have been conducted across Bradford, with support from a GP Practice. Locations included mosques and community centres.

291 Members of the public seen
120 Abnormal Blood Pressures
50 Average Participant Age

Feedback from Attendees:

"Yes, it has given me peace of mind and also the advice given has helped"

"Given me the opportunity to get checked out as we know GPs are currently over-worked"

Learnings and Next Steps

- Enablers:**
- Co-production and Community engagement
 - Culturally relevant interventions
 - Implementation evaluation
- Challenges:**
- Sustainability:
 - Longer-term funding
 - Staffing and resourcing
 - IT System constraints

Community health check events are a feasible approach to address health inequalities and to respond to the needs of an underserved population in a co-designed manner. Implementation Science methodology enables rapid evaluation of the approach and allows learning from a range of stakeholders to be actioned quickly.

Next steps: Refine the approach over future events and develop a framework to enable spread and adoption in a sustainable manner. Expansion into other clinical areas.

Our Partners:



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Medical Aid Camps for Underprivileged



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

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



Background of Healthcare Inequalities

-> The Thar Dessert is located in the south of Pakistan’s sindh province, bordering India to the East. The Dessert covers 77,000 square miles. (2)

-> The province’s district of Umerkot faces the highest national statistics on human and material health care shortages. (3)

-> In 2014, 378,600 citizens are categorised as ‘critically poor’ or ‘vulnerably poor’, according to an extensive TDRP survey. (1)



What did we do?

Three medical camps were established in schools across the Choor region, encompassing the Thar Desert, Umerkot, and Dhoronaro.

Our team of professionals and students together with local nurses and offered free healthcare services to the community.

The range of specialties included Pediatrics, Gynecology, Dermatology, General Medicine, Orthopedics, Neuropsychiatry, and General Surgery.

This project was supported through the local schools, Umerkot Nursing Institute, Basic Health Unit at Rana Jaheer, and the Nizamuddin Foundation Trust Pakistan.

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, folic 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.



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

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.



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.

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 patients.

-> Dispensing 97 types and formulations of free medications to the underprivileged.

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.

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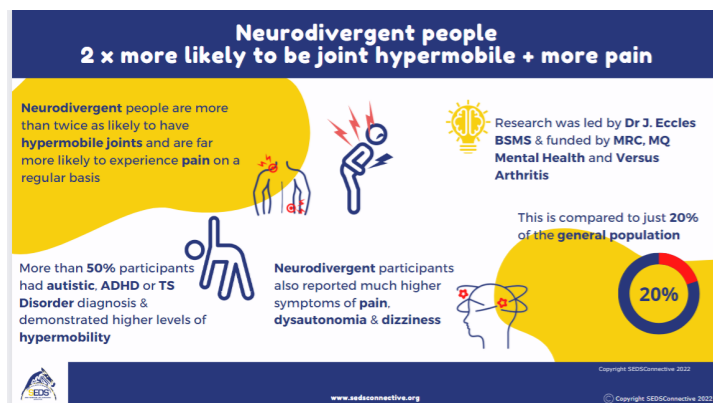
Transformational change in Health: The Power of Community

SEDSConnective - A Symptomatic Hypermobility Neurodivergent Charity



What is it?

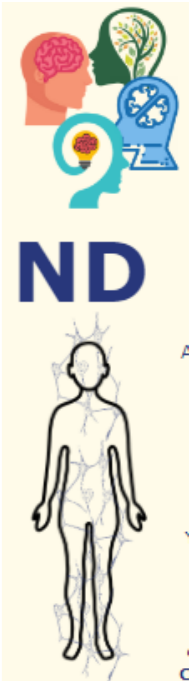
Neurodivergent people (e.g., autistic, ADHD, dyspraxic, Tourettes syndrome, etc.) are 4 times more likely to have hypermobile joints and therefore experience more pain and dysautonomia symptoms than the general population. This is multisystemic.



Why and How ?

www.sedsconnective.org
Jane Green MBE

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 disproportionately 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."

What have been the challenges?



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

What have been the benefits?

- Helping save lives, being believed, value of life
- Empowering the most disenfranchised by health, society, employment, life, generational inequality improved QoL
- By us for us - CommunityVoice
- Unique active specialised support for members
- Raising awareness public domain and allied professionals
- Writing, publicising, researching as equals

Agents of Change

WE envisage a time when neurodivergent health, care, education, and employment are accepted and supported equally and equitably.


We envisage a time when the shift of conversation in models and approaches is unifying.

We are leading this cultural change and continue to grow constructively with others.

Submitted posters

Breaking Barriers, Bridging Gaps: Revolutionising Medical and Surgical Training Using Virtual Reality in Low and Middle Income Countries

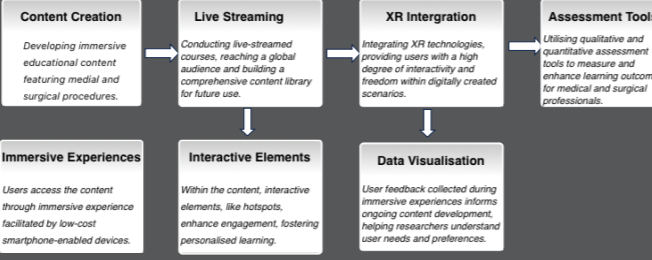
Ameer Khamise¹, Jonathan Fenn², Karamveer Narang³, Aimee Rowe⁴, Jagtar Dhanda^{2, 4}



Background and Problem Identification

Inaccessible surgical care is a global crisis, especially prevalent in developing regions affecting over 5 billion people. Doctors serving large populations with substantial disease burden lack opportunities for training events due to the time-consuming and expensive nature of surgeon training requiring specialist supervision (Meara et al., 2015). This underscores the pressing need for innovative solutions. We developed an immersive live streaming and restreaming virtual reality (VR) technology for mobile phones. Our solution offers affordable, scalable, and accessible surgical training specifically tailored for low- and middle-income countries (LMICs).


Overview of the VR Technology



Key Features and Benefits

Key Features	Benefits
Vast library of +400 cadaveric surgical procedures.	Concise and time-predictable learning experiences.
Live streaming capabilities for real-time interaction.	Replicable procedures for consistent learning outcomes.
Immersive 360-degree visualisation.	Enhanced interactivity and competency assessment.
Affordable and accessible smartphone-enabled headsets.	Accelerated learning and improved skill development.
Extended reality (XR) hubs with advanced VR headsets and hand controllers.	Accessible and affordable training for LMICs.

Global Impact in Action: VR Surgical Training Across Continents



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 556 remote attendees. The findings of the study demonstrated:

- Enhanced learning with 360-degree visualisation compared to traditional methods.
- The immersive approach fostered increased connectivity among learners.
- Potential for content and skill-sharing, contributing to the program's capacity building.
- Safe learning environment through simulation.

Potential Weaknesses

- Need for breaks 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 specialities.
- Global XR Hubs Establishment:** Establish XR hubs in 20 LMICs over the coming year.
- Collaborative Partnerships:** Strategic partnerships with international medical organisations, educational institutions, and technology innovators.

Key Achievements

- Global Reach:** Streamed six one-week courses to 6000 participants in 101 countries.
- In-Person Live Streaming Courses:** UK, India, Uganda, and Kenya.
- Largest Surgical Training Resource:** Featuring over 400 cadaveric surgical procedures.

Affiliations

- The University of Buckingham
- Brighton and Sussex Medical School
- Princess Royal Hospital
- Queen Victoria Hospital

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Working across sectors to improve access to healthcare for People Experiencing Homelessness: The experiences of Hostel Support Workers

Iman Muzafar, Olly Cunningham
Imperial College Business School

Background

- People Experiencing Homelessness (PEH) experience poor health outcomes and increased mortality [1].
- In the UK, the mean age at death for PEH is 45.4 for men and 43.2 for women, compared to the national average of 79.4 and 83.1 respectively [2]. These deaths would have benefited from healthcare input [3].
- NHS England have identified PEH as an Inclusion Health Group, and their Inclusion Health Framework strives to deliver accessible services to meet the unmet needs of PEH [4].
- PEH access to healthcare is riddled with barriers (Figure 1).

The solution...
GOOD PRACTICE THROUGH CROSS-SECTOR COLLABORATION

- Collaboration across sectors has been recognised as important in increasing healthcare access and improving health outcomes for PEH, as indicated by the formation of Integrated Care Systems aiming to facilitate this collaboration and improve outcomes and reduce inequalities [5].
- To ensure success we need to uncover the experiences and views of Hostel Support Workers (HSW), who work within homeless hostels, with undefined and dynamic roles, in order to support PEH. HSW have been described as the link between hostels and healthcare in the literature due to the trusting relationship that exists between PEH and HSW [6].
- Good practice starts with comprehensive stakeholder engagement and understanding.

Theme 2

HSW viewed collaboration across sectors as vital in facilitating healthcare access for PEH, in order to address health inequalities and increase healthcare access and utilisation.

There were promising experiences of collaboration shared by HSW, where knowledge was shared from HSW to HCS and vice versa.

On the other hand, disconnected and disjointed experiences were shared by HSW, and were the result of poor communication and a lack of information sharing. HSW felt that themselves and HCS had opposing priorities and beliefs, meaning that sectors struggle to understand each other and "CAN'T ALWAYS COME TO A LEVEL AGREEMENT ON THINGS" (HSW4).



Aims & Objectives

EXPLORE HOW HOSTEL SUPPORT WORKERS EXPERIENCE NAVIGATING HEALTHCARE ALONGSIDE PEOPLE EXPERIENCING HOMELESSNESS

Developing an understanding of these experiences will guide good clinical practice that considers HSW as an important stakeholder, rather than a spokesperson for PEH.

Methods

- Semi-Structured Interviews, lasting 20-45 minutes, were conducted with 15 HSW from hostels across England. Hostels were either council funded or charity funded.
- Thematic Analysis using Braun and Clarke's (2006) 6-step framework was conducted to identify key themes and sub-themes.

Results

3 KEY THEMES, AND 6 SUB-THEMES WERE IDENTIFIED
These uncovered both the positive and negative experiences of HSW. HSW were given codes for anonymity e.g., HSW1, HSW2.

Theme 1

"People treat them differently, when ultimately they're human beings. It can be frustrating, it can be quite hard, and perhaps quite upsetting" (HSW12)

HSW described being impacted by the stigma against PEH in healthcare settings, and by healthcare staff (HCS).

"I think there is a bit of a culture of, you know, that they [HCS] don't really see us hostel workers as professionals because they're healthcare professionals. They go to university. You know, a lot of the hostel workers, they, they've never been to uni, they're not specialists in healthcare" (HSW11)

Participants felt that HCS lack an understanding of HSW "KNOWLEDGE AND EXPERIENCE" (HSW14), due to differences in sectors, job titles, and educational attainment in the respective careers.



Theme 3

In-reach: Healthcare staff and services coming into the hostels to provide healthcare for PEH.

"We'll go through the in-reach services because they have access to the hospital system, they can pass on things" (HSW9)

HSW felt that in-reach was an effective link between healthcare and hostels, due to the closer association between in-reach and external healthcare.

The sustainability and practicality of in-reach was questioned. HSW explored whether in-reach could provide the same standard of care as secondary care settings, since fewer resources, equipment, and facilities were available. Whilst in-reach was viewed as better than no care, it was not viewed as the ultimate solution to ensure healthcare access for PEH.



Novel Findings & Conclusions

- This research identifies that collaborative experiences are underpinned by knowledge transfer from HCS to HSW, and from HSW to HCS.
- The importance of HCS receptiveness to HSW knowledge was a novel finding, which can facilitate future good practice and the formation of cross-sectors relationships.
- Whilst other papers have discussed a lack of responsiveness and information sharing from healthcare, we also explored how sectors can struggle to understand each other and feel disconnected, and as a result fail to effectively collaborate.
- In-reach fostered positive experiences for HSW, and despite the literature viewing HSW as the link between PEH and healthcare, this research identified that HSW perceive in-reach to be the more effective link.
- Current initiatives, which focus on training HSW in healthcare related-skills, may fail to address the poorer health outcomes facing PEH.
- Whilst in-reach can be effective in facilitating access to healthcare, external healthcare remains vital in improving health outcomes for PEH due to the availability of specialist equipment and facilities.
- Solutions focusing on increasing access to external healthcare should therefore be a priority when designing future services built on good practice.

Acknowledgements

Many thanks to Jo Wilson (Supported Hostels Manager), Dr Maria Farkas (Project Supervisor, Imperial College Business School), and all the Hostel Support Workers who gave up their time to share their experiences.

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Submitted posters

UCLP-Primrose: Tackling health inequalities by reducing cardiovascular disease risk in people with severe mental illness

Philippa Shaw, Zuneera Khurshid, Danielle Lamb, Kristian Hudson, Fiona Stevenson, Nirandeep Rehill, David Osborn



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 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.

REDUCING 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 Core20PLUS5 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.

Want to know more?



THE CURRENT RESEARCH PROJECT

Over a decade of research underpins 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.



? What factors influence the implementation of UCLP-Primrose across London and Bradford

We are working with one primary care network (PCN) in Bradford, one PCN in Tower Hamlets, and GP practices across Camden and Islington.

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 2024.



We are analysing our data with:

- Consolidated framework for implementation research
- Reflexive thematic analysis
- Normalisation process theory
- Stanford lightning reports
- Appropriate statistical tests

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 patients being offered holistic 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 needed such as joined 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.



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

Find out more about InHIP



What is the health inequity 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.

Life expectancy is

12.6 years lower for men and **12.0** years lower for women

in the most deprived areas of Middlesbrough than in the least deprived areas.



Aim

- explore participants' barriers and challenges in accessing heart health checks
- co-design user led solutions to reduce the risk of CVD,
- pilot co-designed interventions within target CORE20PLUS5 communities (Black Africans, South Asians and underserved white British groups) and share to accelerate spread and adoption of innovations



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.



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 depth narrative from seven focus group interviews conducted were recorded, transcribed and then a framework analysis approach employed to deduce emerging themes.

Health checks feedback

"It was very useful because now I know where my body is physically and health wise."

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

"It was important getting my heart checked; I am now well informed and plan to make changes and lifestyle modifications. I would suggest more adverts so more students get to know about it and get their hearts checked."

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

Initial findings

The behavioural insights research is in three phases and the pilot is still in progress:

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 learning with regional and national stakeholders.

Key findings articulated key barriers to accessing heart health checks for underserved groups including language barriers, lack of timely appointments, direct discrimination, health literacy and lack of trusted translation services.

There was also lack of clarity of what is a health check, cultural incompetence when working with underserved groups, negative clinical staff attitudes, and prognostication - where people won't have checks due to unfounded fear of poor prognosis.

The communities provided solutions to improve uptake including the need for targeted outreach sessions within their communities like mosques, community centres as well mobile services like the Middlesbrough Football Club Foundation health bus. Communities also want their local health champions to be upskilled to deliver health checks within local settings. For those who will go to primary care for health checks, they also preferred an option to have walk in facilities available and for clinicians to also then refer then to local social prescribing initiatives.

Authors

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Submitted posters



Widening access and addressing inequalities for patients consenting to systemic anti-cancer therapies (SACT)

E Nally¹, A Reeves¹, A Bhowmik², P Leonard³, O Hawkins⁴, D Wald⁵, A Januszewski¹

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BACKGROUND

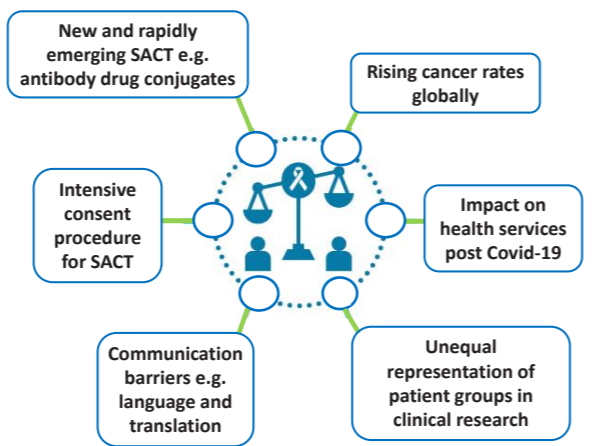


Communication and informed consent are vital aspects of patient centred cancer care. Cancer services are under increasing pressure and a more diverse population means there are barriers in educating patients on their cancer treatment. Research has shown that language services and visual guides can facilitate communication and improve patient experience, adherence to treatment and overall health outcomes.

Barts Cancer Centre based at St Bartholomew's Hospital provides assessment, diagnosis and treatment services to 1.5 million people across East London. With one of the most diverse populations in the country, Barts Health is committed to eliminating discrimination, valuing diversity and promoting health equality.



PROBLEM



PROPOSAL

- Introduction of a library of multilanguage educational animations for patients with cancer who are consenting for SACT with the aim of addressing poor health literacy and inequalities.
- The animations will be created by 'Explain My Procedure' and introduced using their web-platform which is widely used to aid patients consenting for other medical and surgical procedures. www.explainmyprocedure.com
 - A study found less than a third of patients fully understood their cardiac procedure before signing their consent form.
 - Following a trial introducing the video animations to cardiac services at Barts Health, this figure increased to 90%¹
- These short animations will facilitate informed consent with information on treatment setting, clinical trials and side effects that will benefit both patients and health care professionals.
- The project will be rolled out across NHS trusts in North East London and once established the aim is to offer it to cancer patients across the UK.

Objectives

- Creation of visual aids to support consent process for SACT with the aim to reduce inequalities in access and care
- Animations translated into English, Bengali, Polish, Turkish, Arabic & Hindi
- Introduction and incorporation of digital visual aids in to the clinical setting
- Educating and increasing engagement regarding clinical trials in under represented patient groups
- National roll out across hospitals in UK to support the existing written consent forms developed by Macmillan & CRUK

INTENDED IMPACT

- Patient experience** - Improve patient's understanding of their cancer treatment plan and possible side effects which ultimately will help to improve their engagement and overall outcome.
- Address inequalities in health care** - Using visual aids in a patient's first language will support and educate cancer patients across socioeconomic groups, addressing disparities and inequality in cancer care and research.
- Clinical staff** - Streamlining the consent process with more accessible information in a patient's first language will relieve pressure on both health care professionals and clinic capacity.
- Economic benefit** - Improved communication and engagement with cancer patients has shown to be vital in improving efficiency and outcomes within cancer care.
- NHS organisation benefit** - This project will generate a digital library of resources that will be pioneered within Barts Health NHS trust with the aim of improving the SACT consent process across cancer centres nationwide.



Explain my Procedure



References

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- Declared Interest: DW is Director of Explain my Procedure Ltd which will create and own the animations used in the project. ©Explain my Procedure Ltd

Multidisciplinary Team (MDT) Approach Towards Equitable Asthma Management

[A Leicestershire County Council, University Hospitals of Leicester NHS Trust (UHL), University of Leicester (UoL) and Primary Care Collaborative]

Jayashree Pathak - Public Health Registrar, **Hollie Hutchinson** - Strategic Lead for Health Improvement, **Kajal Lad** - Strategic Lead for Healthcare Public Health (Leicestershire County Council), **Leslie Borrill** - Project Lead/ Medical Director - Charnwood GP Network, **Onyeka Umerah** - Project Lead/ Consultant Respiratory Medicine, UHL, **Annette Durant** - GP Partner, Bridge Street Medical Practice, **Kristy Mackinson** - Head of Primary Care Network (PCN) Development, Charnwood GP Network, **Bharathy Kumaravel** - Project Lead/ Consultant Public Health - Leicestershire County Council/ Associate Professor Public Health

1. Background

The Leicestershire Academic Health Partnership (LAHP) launched an asthma management project in April 2023, hosted by University Hospitals of Leicester NHS Trust (UHL) and University of Leicester (UoL). With 12% of the population diagnosed with asthma, 80% of costs tied to poor control, and a link between socioeconomic factors and adverse outcomes, the project addresses urgency. Inspired by community-based success, it introduces a virtual asthma ward MDT led by a respiratory physician, in one of the most deprived areas of Leicestershire.

2. Aims and Objectives

- Enhancing Primary Care by Upskilling Primary Care Staff ultimately reducing asthma exacerbations and avoiding unnecessary Emergency Department admissions.
- Reducing Inequalities in Care between the Most and Least Deprived Areas
- Community Collaboration: Engaging with Leicestershire County Council's Healthy Workplaces Programme, the project adopts a "Making Every Contact Count" approach, seeking to raise awareness about asthma among the working-age population and promote a healthier community.

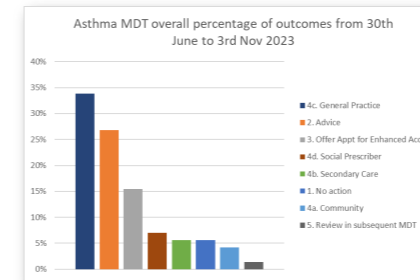
3. Methods and Analysis

A phased approach began with the initial quarter focusing on data analysis, patient identification, and feasibility testing of virtual MDTs in Charnwood. Subsequent quarters included staff training and qualitative assessment. Between June 30 and November 3, 2023, 5 scheduled MDT meetings reviewed records of 155 patients with a history of over 2 courses of oral corticosteroids or more than 5 short-acting beta-agonists in the past 12 months. Case notes of 56 eligible patients have been scrutinised so far. A joint training event for primary care staff (n=22) followed, sharing insights from MDT discussions. A proactive community outreach event on November 29 involved contacting 130 patients for a one-stop shop covering health, inhaler technique, finances, warm homes, social prescribing, and physical activity. 33 patients attended, with 14 participating in focus group-style discussions led by public health. Attendees received incentives, including a meal, a warm blanket, and a raffle ticket for a gift hamper.

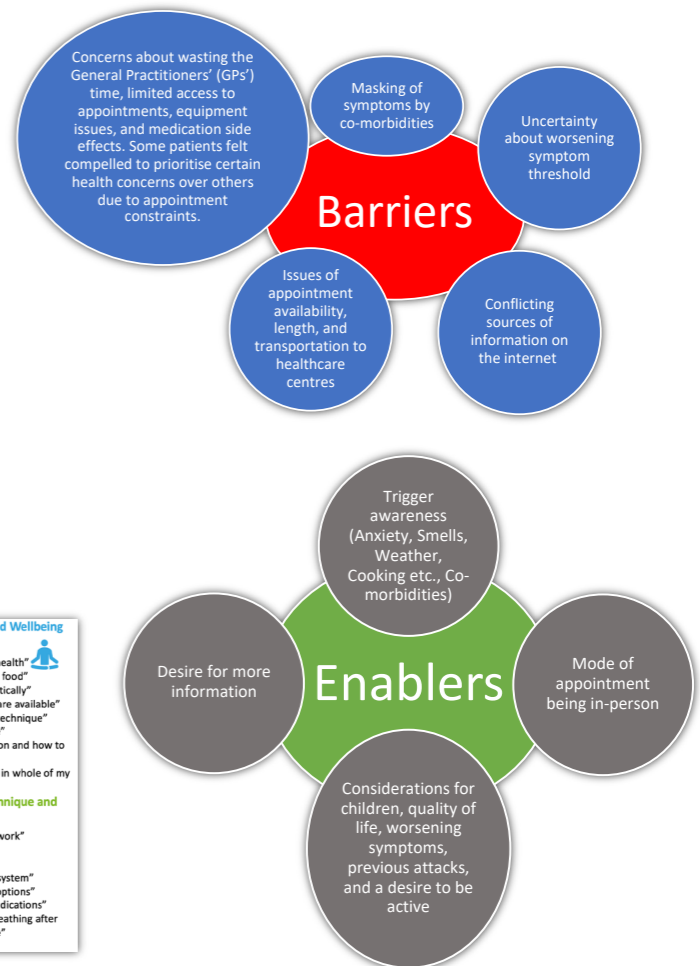


4. Results: MDT Outcomes and Survey of Community Outreach Event

Among the 56 patients reviewed in the MDT meetings, the majority were in the under 21 and 31-40 age groups (10 in each group, 17.8%). The distribution between males (27, 48.2%) and females (29, 51.7%) was nearly equal. The largest ethnic group was White British (26, 46.4%), followed by Indians (6, 10.7%). The most common MDT outcome was input from General Practice in over 30% of cases, followed by advice (~25%) and offering appointment for enhanced access in 15% of cases.



Results: Focus Group-Style Discussion Themes (Barriers and Enablers to Accessing Asthma Care)



Summary of Evaluation - Strengths

Knowledge on Staying Active	Knowledge on Social Prescribing Service	Knowledge on Health and Wellbeing
"Good review of resources available"	"Very helpful information"	"Helpful speaking to VITA health"
"Getting signed up to activity clubs"	"Excellent service"	"Remember to eat healthy food"
"Signposted to services available at the leisure centre"	"Signposted to services to help with my asthma and covid recovery"	"Exercise gently not energetically"
"Access to information websites"	"Helpful advice about the social prescriber at my GP surgery and the range of possibilities"	"Good to know talking therapies are available"
"Felt encouraged after speaking to active Charnwood"		"Good information on inhaler technique"
		"Take regular exercise"
		"Lots of information about condition and how to control"
		"Learn more in one afternoon than in whole of my time with asthma"
		"Learn more about traffic light system"
		"Lots of information on various options"
		"Advice on how to use different medications"
		"Guide me to routes to restore my breathing after covid to regain my lifestyle"
		"Speak to Asthma nurse"
		"Extremely useful information"
		"How to stay warm for less"

5. Recommendations

- Continuous staff training and engagement
- Outcome monitoring and stakeholder partnership strengthening
- Data monitoring, such as demographic information of MDT cases

6. Limitations

- Resource constraints
- Limited availability of information, such as demographic distribution of focus group participants

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.

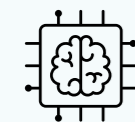


A doctor is far beyond just a leader; they are an entrepreneur with the skills to be a lawyer, an accountant, a marketer...



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

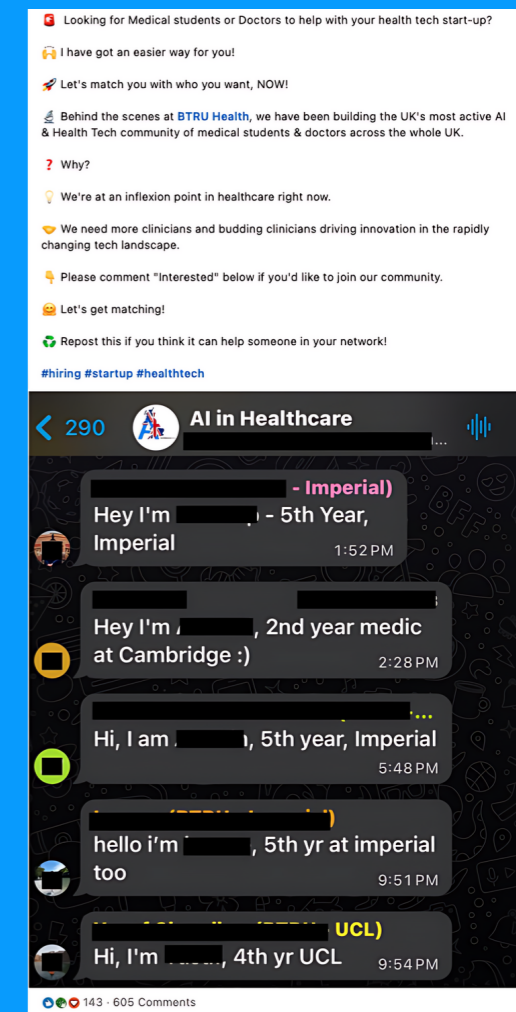
Soh Shi Ian
Kavyesh Vivek
Alicia Kwan Su Huey
Joseph Tsai
Richard Bogle

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).

Results - Figure 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.

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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**).

Figure 1. Graph demonstrating how students learnt about the events.

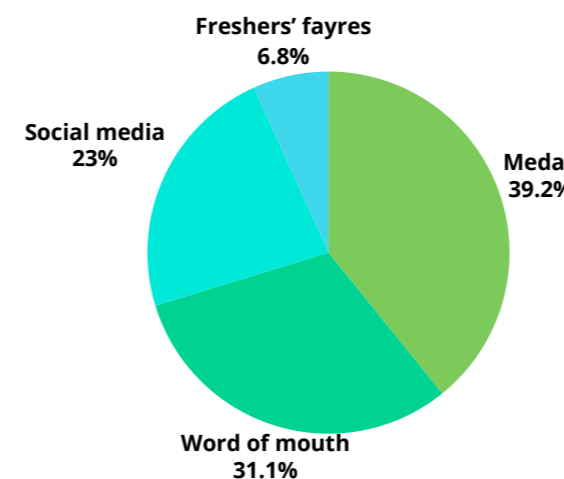


Figure 2. Graph demonstrating how participants' confidence in the topic increased before and after each session.

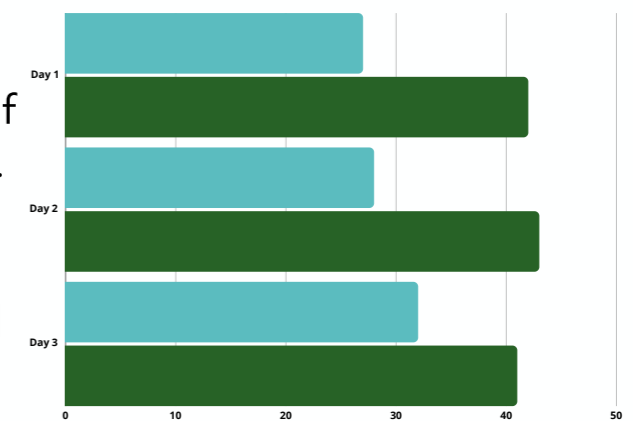
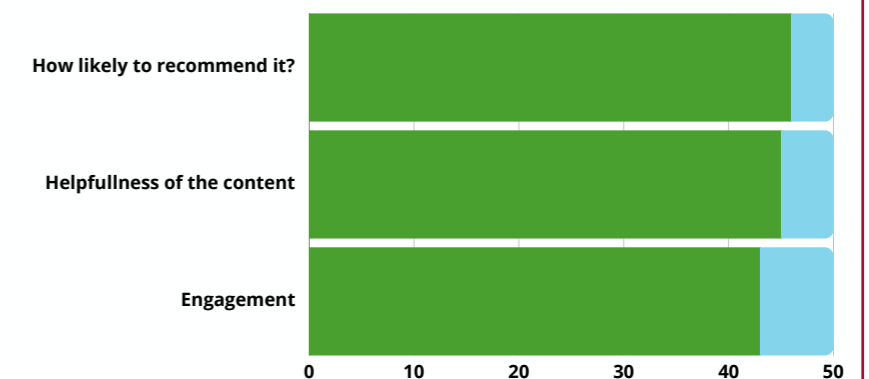


Figure 3. Graph demonstrating how likely participants are to recommend the event, the helpfulness of the content, and how engaging they found the events.



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

Leeds Health & Care Partnership

SEL GP Group
Working for You

Health Innovation
The new name for
Leeds & Hamam AHS

NHS West Yorkshire
Integrated Care Board

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

Title: Healthier Cholesterol for Your Community – Hub-Based Service Model

Author(s): Pei-Theng Aizlewood, James Chapman, Amy Brough, David Magson, Aashna Kundra, Rachel Hollis, Kyomi Campbell, Rani 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 preventions in underserved communities in most deprived areas of Leeds.

The service delivery model:

- Identification of 3 community hubs to serve Beeston and Middleton areas and the Gypsy and Travellers' communities:
 - Hamara Healthy Living Centre
 - Leeds GATE (Gypsy and Travellers' Exchange)
 - BITMO (Belle Isle Tenant Management Organisation)
- Weekly community outreach service provided by the InHIP 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.

Unique Selling Point (USP)

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 Cholesterol Testing (POCT) provided by MDT using innovative PocDoc® Lipid Test.
- 4% (4 people) who were eligible started on lipid lowering drug statin.
- 27% (27 people) were referred to GP / community pharmacy / specialist if further investigation were needed.
- Overall, our MDT service and PocDoc® 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.

SUMMARY STATS	Hamara		BITMO		Leeds Gate		Total	
	Count	Proportion of total people engaged	Count	Proportion of total people engaged	Count	Proportion of total people engaged	Count	Proportion of total people engaged
Total number of people directly engaged	53		23		24		100	
Total number of people given general CVD advice	52	98%	23	100%	24	100%	99	99%
Total number of people who are not eligible for further reviews i.e. not with participating GPs	18	34%	7	30%	17	71%	42	42%
Total number of people declined POCT	6	11%	7	30%	2	8%	15	15%
Total number of people refer to GP or community pharmacy or specialist	7	13%	11	48%	9	38%	27	27%
Total number of eligible people declined further review by pharmacist or dietitian	6	11%	4	17%	0	0%	10	10%
Total number of eligible people started on treatment	1	2%	3	13%	0	0%	4	4%
Total number of eligible people declined treatment	2	4%	1	4%	0	0%	3	3%
Total number of eligible people clinically not appropriate for treatment	38	72%	21	91%	18	75%	77	77%

Conclusion: This has been a successful collaboration in the Leeds Health and Care Partnership, bringing together organisations from different sectors to allow for people in the most deprived communities to access GP services for CVD prevention through the InHIP Outreach MDT. Support from community organisations to promote the CVD health events and engage their members with the MDT services has been key to our success. The community-hub based model has been well received with people accessing the service repeatedly and referred by others; this showed that trust could be built with people in the communities to improve their heart health through regular outreach health provision.

Author: Rachel Ashworth
Newham Health Collaborative
Docklands PCN

Docklands Primary Care Network

Newham London

Newham Health Collaborative
A Community Interest Company

Providing NHS services

Tackling Neighbourhood Health Inequalities in Newham Primary Care Docklands Primary Care Network

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.

Key outcomes

- Through working with partners a guide was developed on how to access/navigate NHS health and social care services
- Migrant Health Directory developed for front line staff
- 3 Health events held
- 6 Referral pathways created tailored for migrant communities

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 that 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

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.

Key outcomes

- Demonstrated that Clozapine patients are well managed in primary care
- Shared suggestions with Clozapine clinic on improving monitoring of patients' physical health
- Strengthened relationships between practice staff and ELFT Health Care Assistants

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
- 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 Tollgate 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

Author: Rachel Ashworth
Newham Health Collaborative
North Newham PCN



Tackling Neighbourhood Health Inequalities in Newham Primary Care North Newham Primary Care Network

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

Key outcomes

- 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

Next steps

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

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

Key outcomes

- 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

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

Proactive social prescribing project

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.



Author: Rachel Ashworth
Newham Health Collaborative
North East 2 PCN



Tackling Neighbourhood Health Inequalities in Newham Primary Care

North East 2 Primary Care Network

Project: Access to dental health information and services

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

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

Main actions

- 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.

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



Proactive social prescribing project

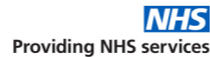
Common mental health illness in housebound patients and carers

- NE2 PCN addressed barriers for housebound patients to engage with health services by:
 - Developing digital inclusion services accessible to this patient cohort
 - Increasing the number of referrals to social prescribing team
- Social prescribers also supported the development of community support groups and organisations, to create a network of support for carers experiencing mental health illnesses



Submitted posters

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



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 project

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.



Author: Rachel Ashworth
Newham Health Collaborative
South One PCN



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.



Proactive Social Prescribing projects

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



Submitted posters

Author: Rehana Aslam (CD) / Rachel Ashworth
Newham Health Collaborative
Stratford PCN



Tackling Neighbourhood Health Inequalities in Newham Primary Care

Stratford Primary Care Network

Frailty Project

Aim

To support patients with moderate and severe frailty to remain healthy and independent in their own homes for as long as possible.



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 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.



Author: Rachel Ashworth
Newham Health Collaborative
Stratford PCN



Providing NHS services

Tackling Neighbourhood Health Inequalities in Newham Primary Care

Newham Primary Care Networks borough wide projects

Project 1: All age immunisations (focus on children)

Aim

To reduce the number of unvaccinated children and reduce the likelihood of a public health outbreak such as measles.

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



Key outcomes

- Newham average 6 in 1 uptake for children aged 12 months increased from 85.5% to 90.9%
- Childhood seasonal flu vaccination uptake rose to 93.0%
- 2,519 extra at risk 18-64years received flu vaccination
- Increased polio booster uptake to 77% of those eligible.
- 40 polio booster clinics held and 1020 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

Next steps

- Staff training on APL 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

Project 2: Increasing access to cancer diagnostic services

Aim

To improve cancer outcomes for patients through better prevention and creating multiple access routes to screening and diagnosis.

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



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 50-64 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

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



Submitted posters

Author: Manuel Anthony / Rachel Ashworth
Newham Health Collaborative
Newham Central 1 PCN



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



Author: Leo Joseph / Rachel Ashworth
Newham Health Collaborative
Newham North East 1 PCN



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



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 have many issues in my house fixed in terms of daily living. Thank you very much Leo."

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