Oxford University Hospitals
NHS Foundation Trust

University Hospital Southampton
NHS Foundation Trust

An improvement and safety culture eats strategy for breakfast

Welcome to the day

- All teach, all learn
- Interactive and participative
- Co-produced with patients as partners
- Working through challenges as systems
- Fun!

Agenda for the Day

09:10 – 10:30 Culture eats strategy for breakfast

10:40 – 11:00 Break

11:00 – 12:30 Involving patients in safety and improvement

12:30 – 13:30 Lunch

13:30 – 15:00 Supporting improvement across a system

15:00 – 15:30 Break

15:30 – 16:00 Plenary

slido

Welcome to the day

ⓘ Start presenting to display the poll results on this slide.

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Culture eats strategy for breakfast

April 2024

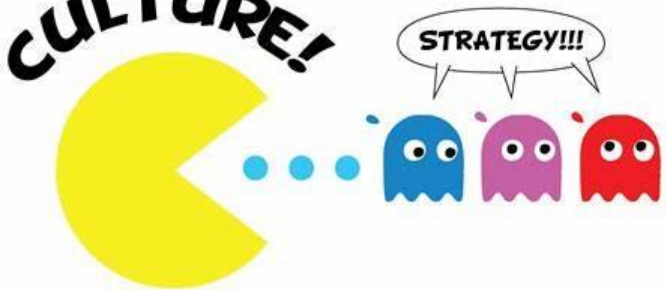
Gail Byrne
Dr Elaine Hill

University Hospital Southampton
NHS Foundation Trust

Gail Byrne

Chief Nursing Officer
University Hospital Southampton

THE UHS WAY


CULTURE!
STRATEGY!!!

“Our collective leadership challenge is to role model a culture that defines a single and common approach and language for improvement that will be recognised throughout the organisation and become as embedded as our values”

Gail Byrne, 2021

Improvement the UHS Way

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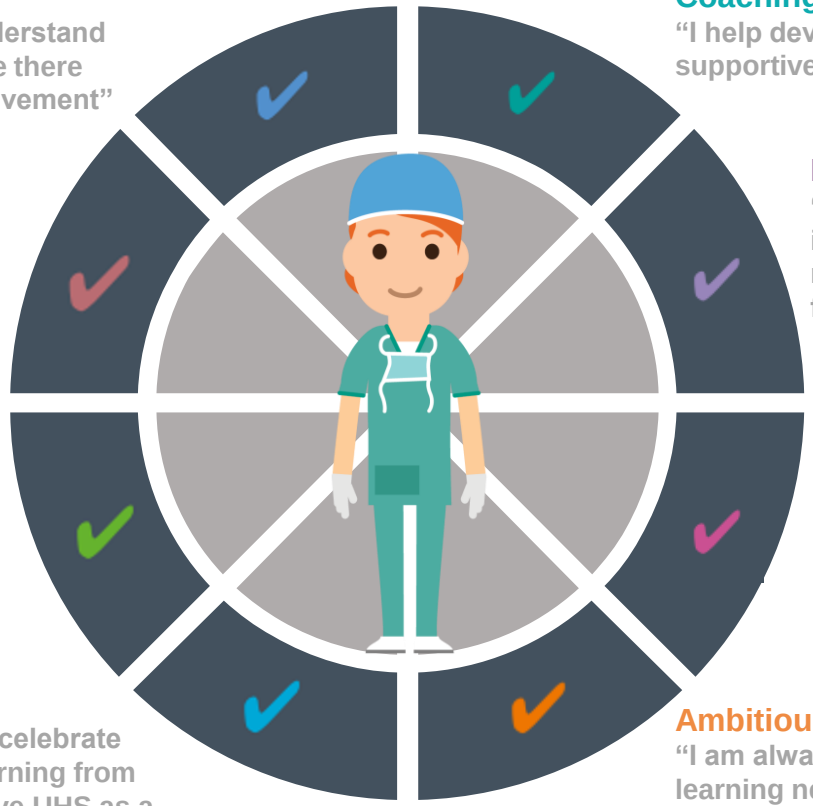
Data Driven Decisions
"I regularly use data to understand my performance and where there are opportunities for improvement"

Coaching Others
"I help develop those around me using a supportive, coaching approach – ask not tell"



Sustain Improvement
"I actively support improvements to ensure they will become embedded and sustained as part of routine work"

Problem Solving
"I collaborate with other teams and people in organisation to solve problems at the root cause. Considering systems, human factors and how technology might help"

Able to Speak Up
"I feel able to speak up and share my ideas for improvement. Knowing they will be listened to"

Partner with Patients and families
"I work hand in hand with patients and their families to tailor our care to their needs"

Share Seamlessly
"I take pride in my work and celebrate success as well as share learning from failures with others to improve UHS as a whole"

Ambitious and continually learning
"I am always improving, open to change and learning new things: looking to better myself and my team as I strive for excellence in the pursuit of world-class care for everyone"

Driving Improvement at 3 levels

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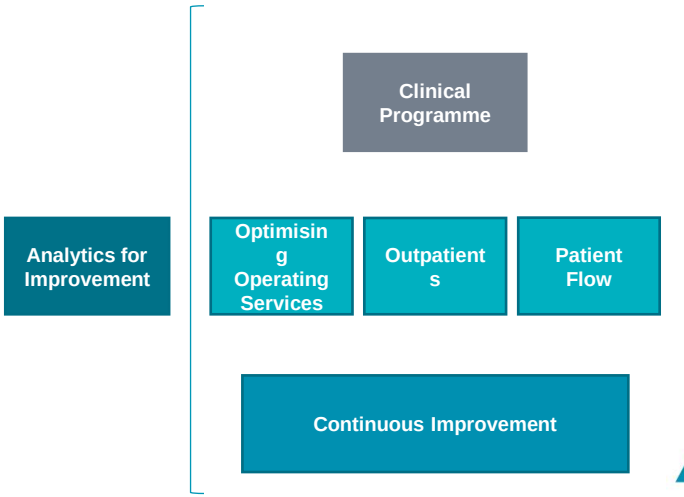
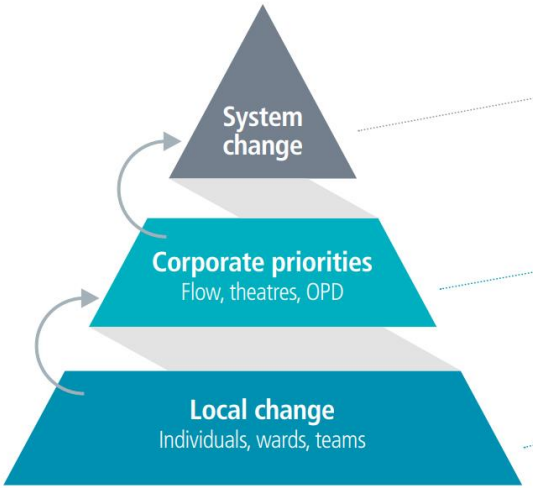
We established our transformation programmes around our Always Improving Framework set out in the strategy. We support individuals and teams to build improvement capability and confidence at a local level, whilst also driving organisation wide priorities through our Corporate priorities. The clinical programme then focuses on our role within the healthcare system and the Trust clinical strategy. These are all underpinned by the analytical and benefits realisation support from our Analytics team.





At UHS we think of improvement at three levels; system, departments and teams. We have different offers and approaches to support the organisation at different levels in the overall delivery of our strategy.

SYSTEM CHANGE

A core part of our strategy is how we work with our system partners to redesign our models of care and services to best serve our population. Therefore some of our resource and focus is dedicated to these programmes of work.

CORPORATE PRIORITIES

Following our Always Improving Inpatients programme and our experience through COVID-19, we want to continue to invest the majority of our resource delivering significant transformation programmes at a whole department or service level. The programmes are directed by our strategy to deliver Trust-wide priorities.

LOCAL CHANGE

At UHS, improvement is everybody's business and one of our core values as an organisation. We therefore want to create packages of project support and training to enable teams and individuals to deliver their own improvement programmes with light touch expert support.

Delivery mechanism for our strategy

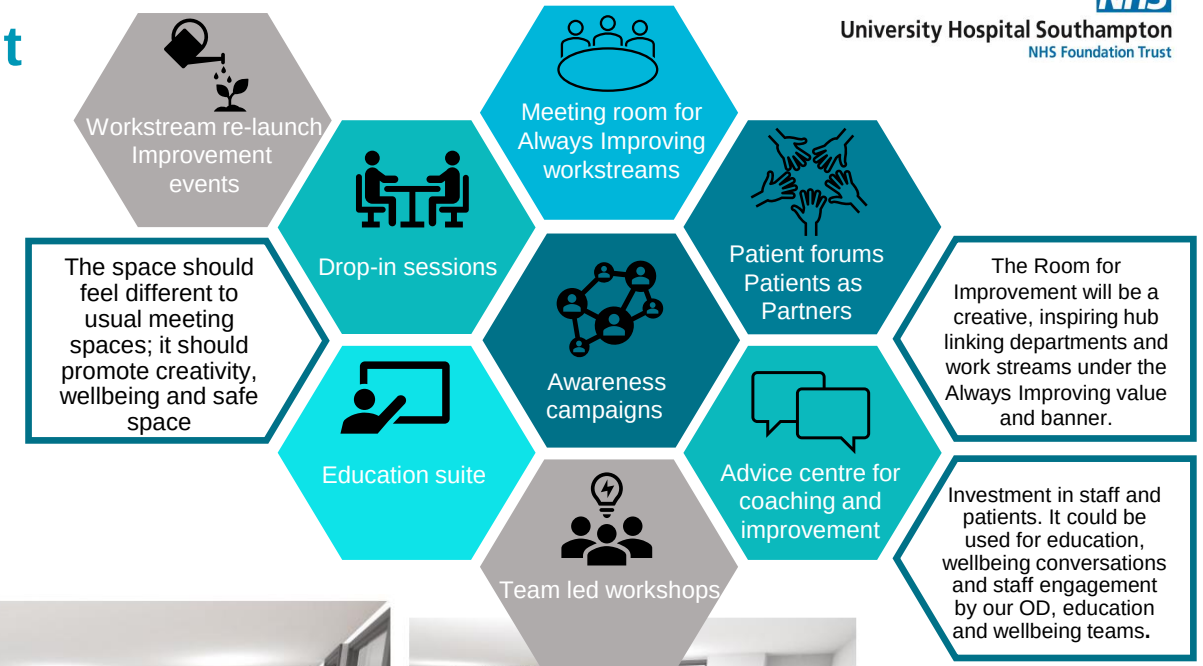
University Hospital Southampton NHS Foundation Trust

Always Improving is intended to be a delivery mechanism to support our strategic aims. Below is a snapshot of the many ways we are collaborating across corporate functions and other organisations to promote delivery across each of the strategic themes.

OUTSTANDING PATIENT OUTCOMES, SAFETY AND EXPERIENCE	PIONEERING RESEARCH AND INNOVATION	WORLD CLASS PEOPLE	INTEGRATED NETWORKS AND COLLABORATION	FOUNDATIONS FOR THE FUTURE
Jointly established QPSP programme	Delivered training to research leaders programme	Collaboration with OD on leadership development programme	Supporting services to establish clinical networks	Provide support and expertise to Wayfinding project
Align leadership of clinical effectiveness with Always Improving	Support for Patient experience research grants	Supporting recruitment processes improvement	Collaborated with OUH on IHI forum April 24’	Collaboration with Digital on transformation initiatives
Supported the CAS review process	Building the room for improvement as an innovation hub	Part of agile working policy development	Have visited and hosted peer trusts and national bodies	Aligning financial benefits of projects with CIP PMO

Room for Improvement

At a time where staff and services are really stretched, it was the perfect time to create a positive space for people to step back and think, focus on improvement, innovation and develop their skills.



The landscape for FY23/24

This year the transformation team have played a key role in delivering the Trust's priorities:

- Addressing the 3.5% difference in growth between demand and capacity
- The trust is under significant financial pressure and productivity improvements are required
- Supporting staff who are burnt out with limited energy for change

We therefore set out 3 clear aim statements within each programme against the backdrop of these organisational challenges. These are focussed on:

- **Reducing demand** – through admission avoidance, advice and guidance and outpatient follow-up reduction
- **Productive use of existing capacity** – theatre efficiency and utilisation, DNA reduction, length of stay improvements
- **Building our improvement culture** – launch of training and education programme, establish Always Improving Hub, support staff in delivering local change projects

Programme plans have been developed for Outpatients, Inpatient Flow, Optimising Operating Services and Organisational Change

1% Reduction in Length of Stay

25% Patient discharges before 12pm

10% Increase in weekend discharge

1% Reduction in DNAs

10% OPFU reduction

2,500 Advice & Guidance diversions

0 On the day cancellations

95% Theatre Estate Utilisation

85% In session Utilisation

Our delivery so far this year

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Strategic

Aligned our improvement programmes to the waiting list challenge and have kept our waiting list flat this financial year.

Aligned the Transformation team to our Divisions enabling stronger focus and engagement with improvement

Jointly hosting a session with OUH (Oxford) at this year's IHI conference titled: *An improvement and safety culture eats a strategy for breakfast.*

Operational

1200 Less on the day cancellations compared with last financial year increasing productivity and improving patient experience

0.7% Reduction in Did Not Attends of pathway enabling us to see 3,500 additional patients

27,773 patients added to a PIFU pathway from April – Dec enabling the avoidance of 22,200 Outpatient Follow-ups

Quality

Recruited additional 6 QPSPs (Patient Partners) taking our total to 11 and involving patients in co-design of improvement projects

Delivered the 1st WeAreUHS Week with OD, Comms and patient safety engaging thousands of staff in showcasing their improvement work

Continued to train and develop staff with over 1,000 staff receiving improvement training

Financial

1.65% reduction in Length of Stay. This has saved 6,334 bed days with a value of £2,343,479 year to date creating capacity to do additional elective work.

£3.6m financial productivity CIP through improvement programmes this financial year

£283k from delivering additional cataracts on Ophthalmology theatre lists

Breaking down culture into specific behaviours to change

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Motivation
Ability
Trigger

Situational factors
Measure behaviours

Plant the right language
Branding
Coaching / empowerment
Design behavioural reinforcements

Fully embed behaviours / values
Executive sponsorship
Measuring and reporting
Early and continuous engagement
Focus on continuous improvement
Celebrate success

Understand holistic picture of changing behaviours across all improvement initiatives

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Quality Improvement at Oxford University Hospitals

Dr Elaine Hill, Director of Clinical Improvement, Deputy CMO

Embedding Quality Improvement into our DNA

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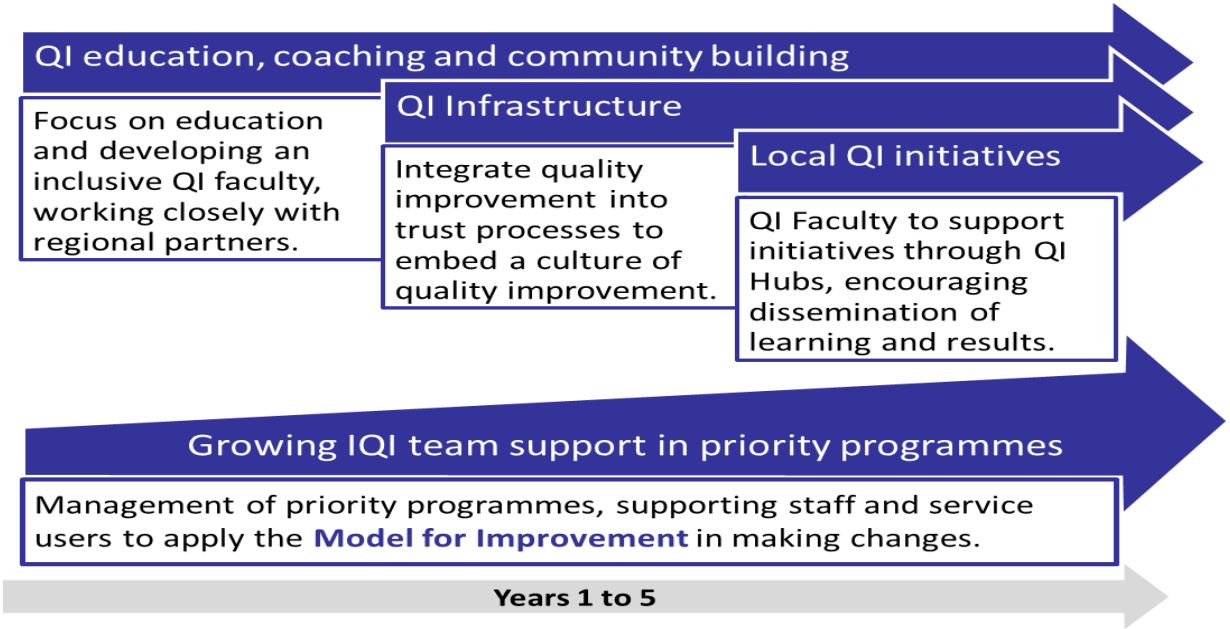
NHS Foundation Trust

Strategic Alignment



Setting a Vision

"In the circumstances that we find ourselves in the NHS at present, deploying Quality Improvement methodology across Integrated Care Systems is vital.

Achieving *Standard Work* in clinical and non-clinical processes will eliminate variation, improve productivity, safety and effectiveness of outcomes.

Leadership in QI, training in QI, consistent communication of QI work and celebrating success will help to make QI everybody's business in the NHS."

(March 2024, NHS IMPACT Bulletin)

Meghana Pandit, Chief Executive Officer
Oxford University Hospitals NHS Foundation Trust
National Improvement Board member

Key Elements of QI

Quality Improvement

Oxford University Hospitals NHS Foundation Trust

QI Clinics

Tailored coaching to support others apply continuous improvement skill.

QI Zone

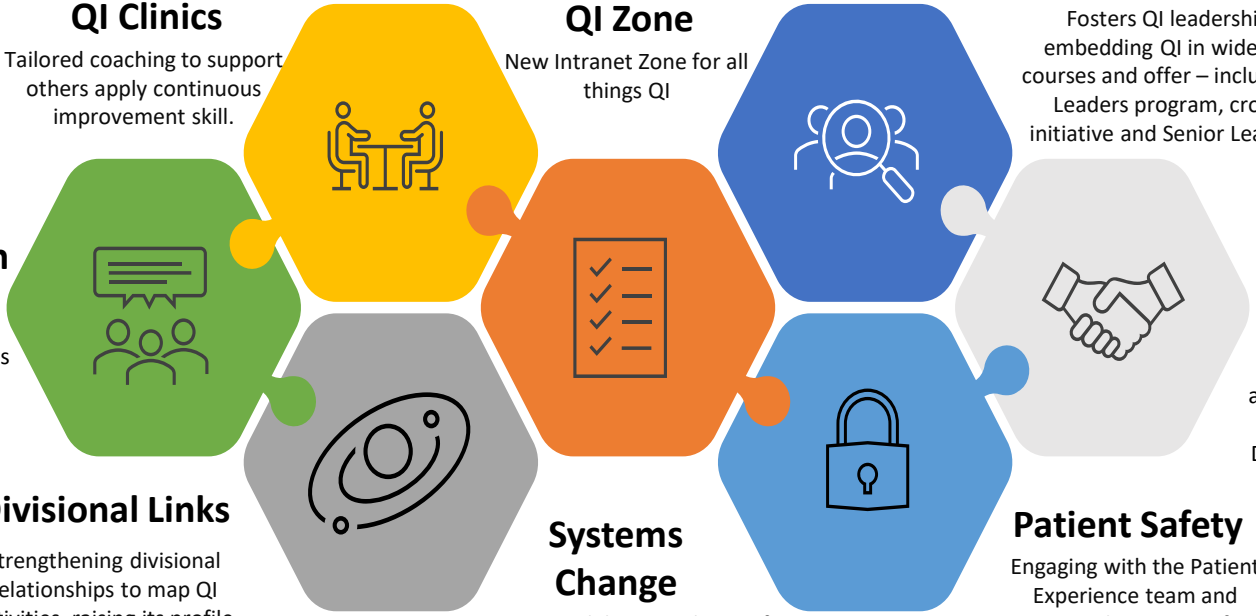
New Intranet Zone for all things QI

Leadership Development

Fosters QI leadership through embedding QI in wider Leadership courses and offer – including Emerging Leaders program, cross-Deanery initiative and Senior Leaders training.

Wider Education Offer

Introduction of QI essentials and QI for Leaders and Managers



Partnerships

Strengthening ties with the research, innovation and strategy, and with other Shelford Group trusts. Including Coaching Cohort 1 and 2 of Chief Nursing Officer Fellows in partnership with Divisional Research Leads for NMAHPs

Divisional Links

Strengthening divisional relationships to map QI activities, raising its profile and developing a mature Quality Management System.

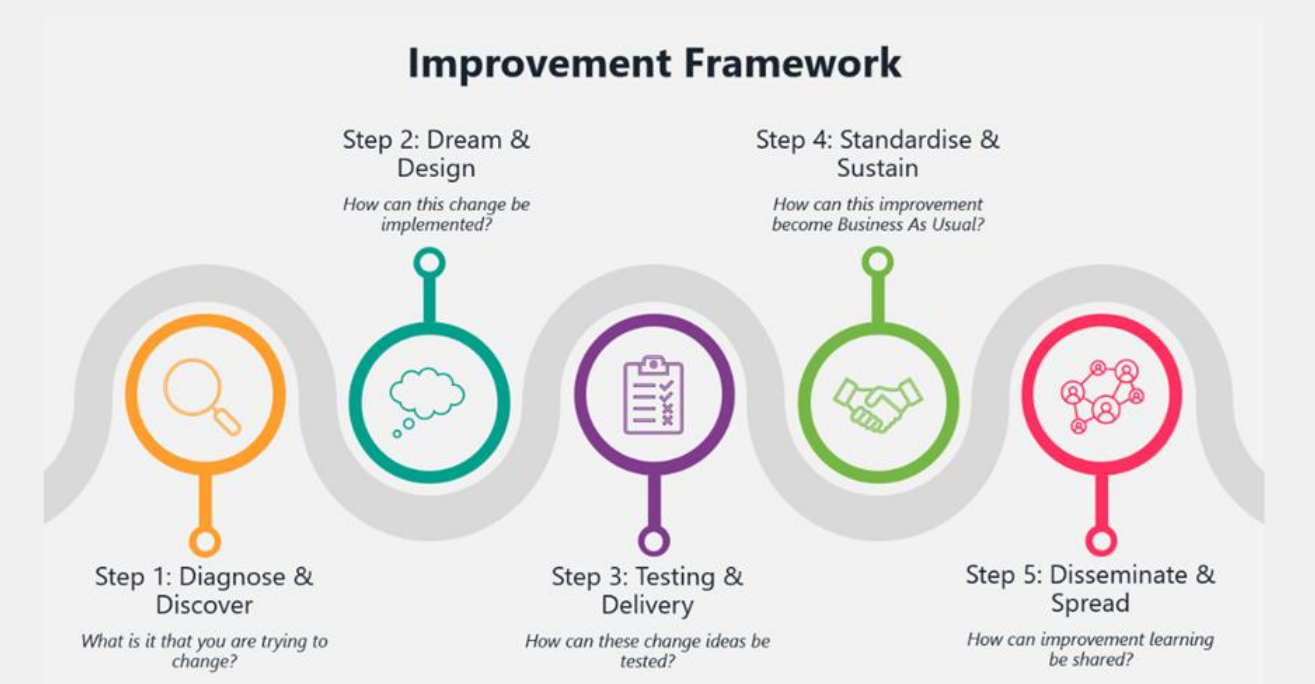
Systems Change

Continue to deliver 3 cohorts of 5-day QSIR practitioner training across BOB, and link in with BOB QI Network. Key highlight 2023 was the BOB Improvement Festival.

Patient Safety

Engaging with the Patient Experience team and PSIRF to leverage QI for patient safety improvements and incorporate patient feedback.

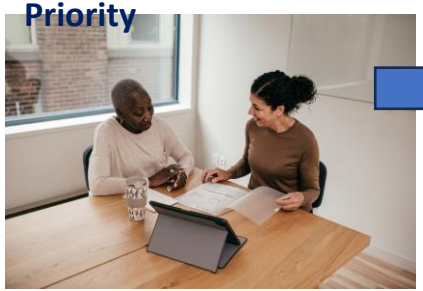
OUH Improvement Framework



QI Stand Up

- Forum to share QI stories and learning
- Chaired and sponsored by Chief Medical Officer's team
- Executive representative attendance
- Invite is sent to all staff
- Videos accessible through Trust QI Zone
- Format has been shared across ICS and now planning quarterly ICS QI Stand

Example: QI Stand up journey to Trust Quality Priority



Trust Quality Priority 2023/24

- Tissue Donation Team
- ED
- AGM
- Palliative Care

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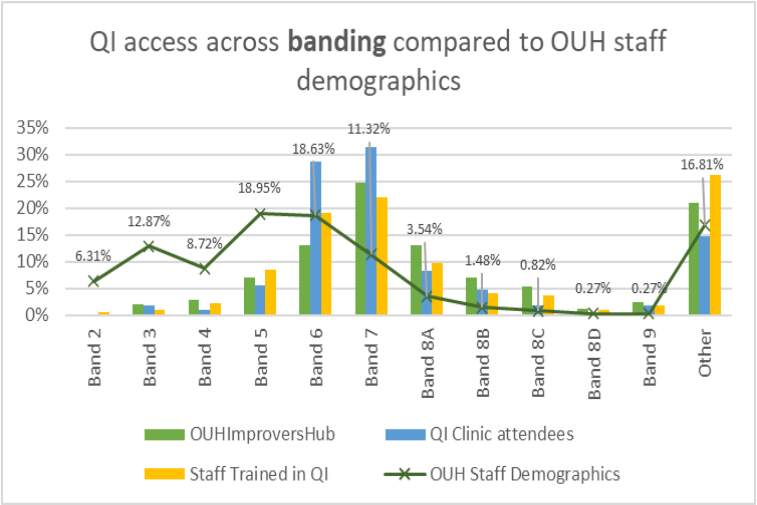
Cultivating a QI Culture- A Continuous Journey

- Culture is the sum of our actions and beliefs
- 'You can't write a culture'



Understanding QI through Staff Survey Results

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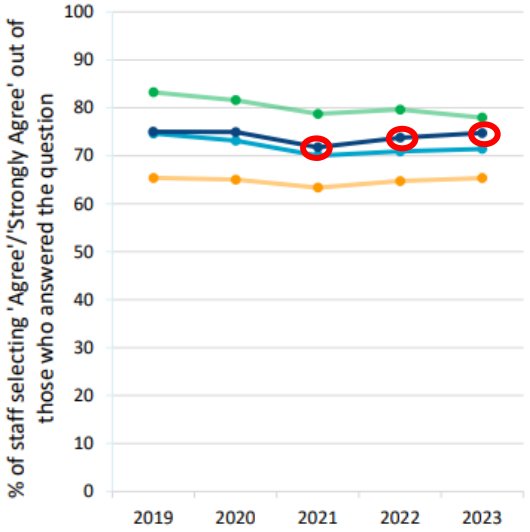
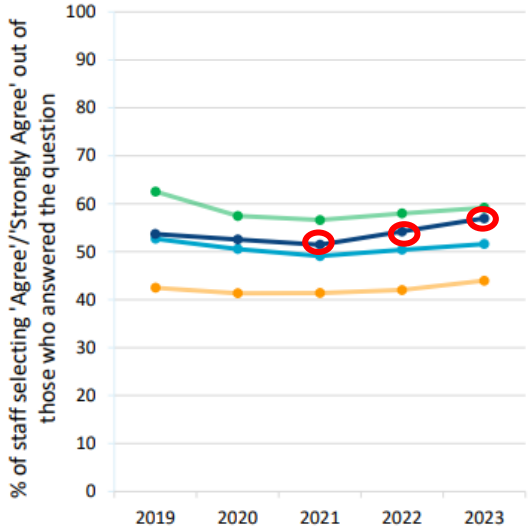
Q3d I am able to make suggestions to improve the work of my team / department.



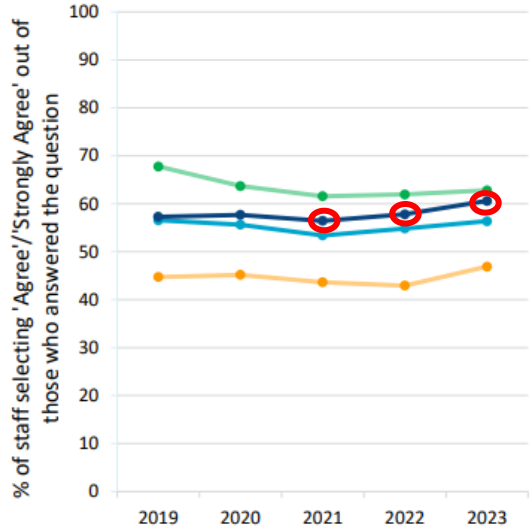
	2019	2020	2021	2022	2023
Your org	74.99%	74.95%	71.79%	73.78%	74.74%
Best result	83.24%	81.60%	78.73%	79.63%	77.96%
Average result	74.65%	73.16%	70.05%	70.92%	71.43%
Worst result	65.38%	65.04%	63.37%	64.73%	65.35%
Responses	5906	6861	7695	6965	6561

Q3e I am involved in deciding on changes introduced that affect my work area / team / department.



	2019	2020	2021	2022	2023
Your org	53.66%	52.55%	51.45%	54.22%	56.94%
Best result	62.53%	57.46%	56.61%	57.98%	59.18%
Average result	52.69%	50.55%	49.07%	50.41%	51.60%
Worst result	42.49%	41.33%	41.38%	41.99%	43.95%
Responses	5905	6855	7692	6966	6555

Q3f I am able to make improvements happen in my area of work.

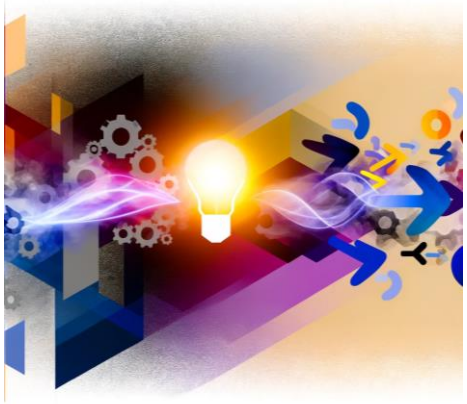


	2019	2020	2021	2022	2023
Your org	57.25%	57.68%	56.44%	57.80%	60.58%
Best result	67.76%	63.68%	61.57%	61.93%	62.79%
Average result	56.56%	55.62%	53.39%	54.84%	56.35%
Worst result	44.73%	45.18%	43.63%	42.93%	46.89%
Responses	5894	6854	7681	6964	6538

Opportunities – Next Steps …

Result	Q3d. I am able to make suggestions for improvement	Q3f. I am able to make Improvements at work	Gradient to making improvements
Oxford	74.74	60.58	14.16

Shifting from "You said, we did" to "We Said, we did!"



- Recognize current "You said; We did!" achievements.
- Empower and train staff to take ownership of change initiatives.
- Foster a culture of proactive problem-solving and collaboration.
- Provide resources and support for staff-led projects.

The Lippitt-Knoster Model for Managing Complex Change

Conclusion

- **Reflect on Achievements:** Summary of the year's progress and impact.
- **Mindset shift to empowerment:** Acknowledging resource constraints- need to liberate colleagues.
- **Look Ahead:** Reaffirm commitment to continuous improvement.
- **Patient and community involvement**: this ongoing focus to both increase the involvement and building towards a place of coproduced improvement
- **Systems Working**: Collaborate not compete; Partnership is difficult but working essential

slido

Audience Q&A Session

ⓘ Start presenting to display the audience questions on this slide.

Activity

- Now we want to hear what you think
- We'll split into table groups focussing on 5 different topics
- Final 5 mins will be agreeing your 2 top tips and 1 wicked question

Topic	Facilitators	Tables
Role of leaders in role modelling improvement behaviours	Gail Elaine	1&2
Walking the walk: doing improvement differently	Jenni Sara	3&4
Measuring an improvement culture	Jake Hesham	5&6
Culture vs Strategy	Kate Caroline	7&8
Building an improvement culture when healthcare systems are under pressure	Christina Ruth	9&10

Break

Involving patients in safety and improvement

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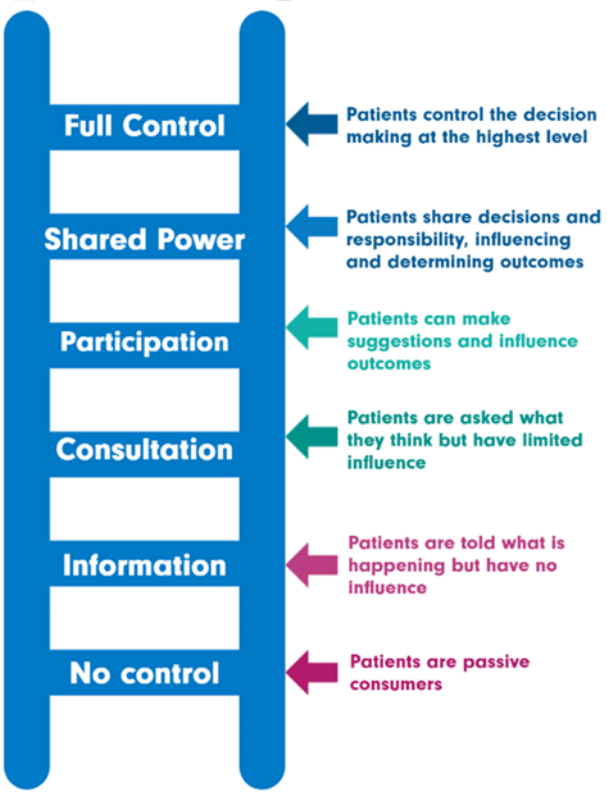
April 2024

Dr Kate Pryde
Dr Christina Rennie
Emlyn Marshall
Linda Taylor
Sylvia Buckingham
Catherine Leon

Session Outline:

- Overview of our journey's
- Partner perspectives
- Explore topics of interest in more detail (World café conversations)
- Round up

Where are we currently?



Sli.do #3006026

Different types of contribution

Involved Patients

- Patients with lived experience of a specific condition or department
- Respond to surveys, attend focus groups and **give feedback on their experiences** of a condition, department **or the care they have received**
- Often one off or short-lived input
- Experience of Care team have a database of involved patients who can be invited to give feedback to a department or service

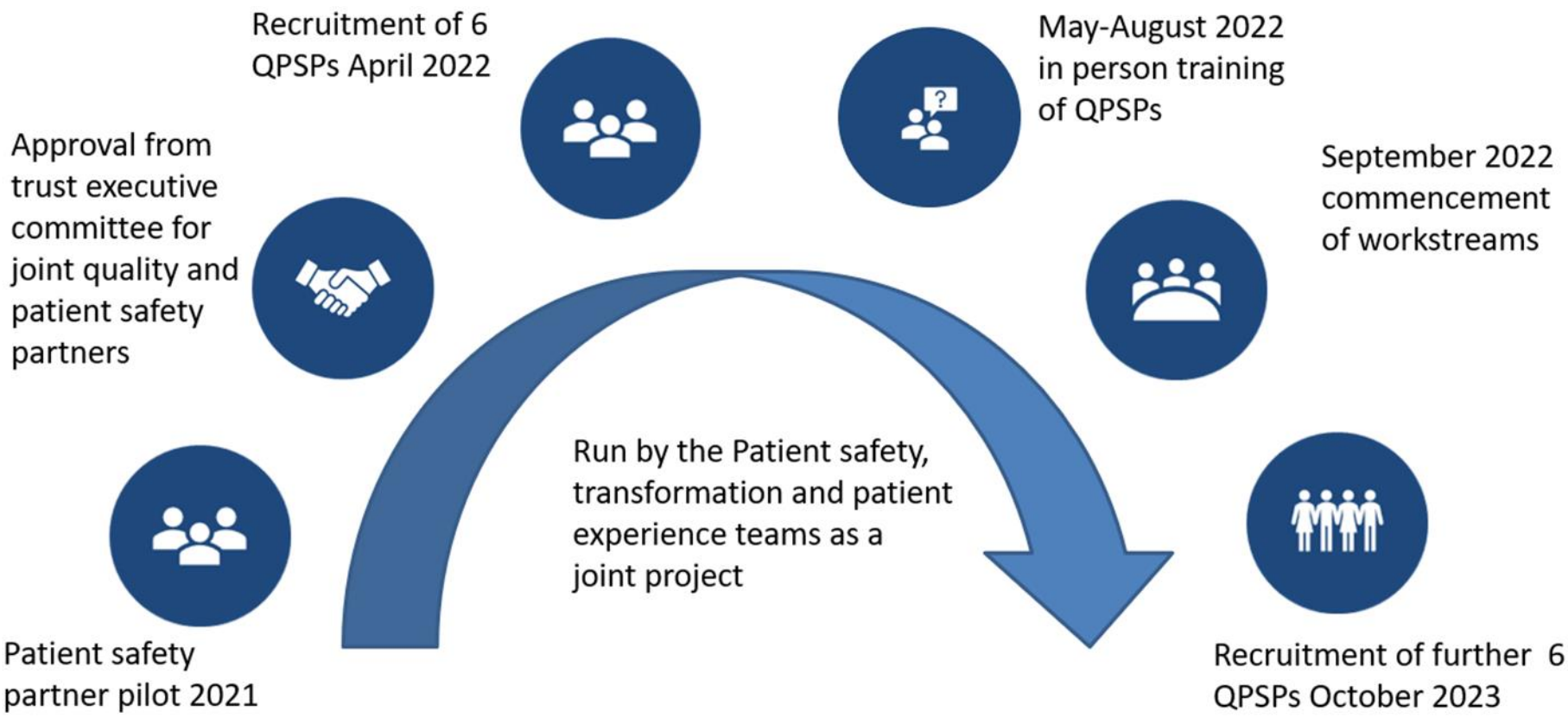
Quality & patient safety partners

- Trained and supported by the Transformation, Patient Safety and Experience of Care teams
- Expert in bringing a **wider patient perspective** into Trust work, projects and planning. Long term roles, sit on substantive groups
- **Facilitate change being done 'with and by' patients** rather than 'to and for' them
- Hardwire patient-centred systems and processes within organisation
- Embed meaningful dialogue between patients/carers and staff in decision-making (at operational, educational, improvement and governance level)
- Work with staff and involved patients

QPSP Programme Aim & Ambition

- Key to our strategic theme of outstanding patient outcomes, safety and experience
- Working in partnership with patients and families ensures the ‘user’ is embedded in change at all levels and magnitude
- This **must be authentic** and will move us from patients being ‘done to’ to change being ‘done by’

UHS Journey so far



Some of the workstreams

THEATRES FLOW

SHARED DECISION MAKING

WAYFINDING (ESTATES)

CLINICAL ACCREDITATION SCHEME

PSIRF IMPLEMENTATION & OVERSIGHT

PATIENT SAFETY STEERING GROUP

CLINICAL ASSURANCE MEETING FOR OUTCOMES & EFFECTIVENESS

SERIOUS INCIDENT SCRUTINY GROUP

BRAIN GYM

CALL FOR CONCERN

ROOM FOR IMPROVEMENT

GIRFT FURTHER FASTER

Learning from the first year

QPSPs, have been a huge asset – change conversations and language, enable elegant simplicity in defining purpose of work/programmes

Ensure clarity of roles and responsibilities for all parties

Set out clear process for requesting and allocating work, with oversight of the workstreams they are involved in

Ensure a coherent and consistent structure for QPSP's to receive mentorship and support

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Learning from Oxford

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- Patient Safety Partners have changed our culture and mindset
- Reflected in our language
- Reflected in our safety and quality improvement work

"Should you have reached this section of our website because you have suffered harm, we are **sorry**.

We undertake to be **honest** and **open** with you in our words and actions as we respond to this."

World Café Conversations

- Choose topic – list coming in a moment!
- Go to that table
- Have a conversation with other on the table
- Move on at any point you like to another table
- After 20 minutes share your learning via XXXX
- MOVE TABLES (if you haven't already, or move again)
- Second conversation
- Share learning from this conversation via XXXX
- Feedback to the room

Topics

1. Ensuring our patient representation reflects the communities we serve
2. Renumeration and recognition of patient involvement
3. Working with those with lived experience
4. Patient co-production at the micro level: How can Patient Partners support healthcare professionals to empower patients
5. Patient co-production at the meso level: involving patients at a strategic level
6. Patient co-production at the macro level: involving patients at pathway/system level
7. Organisational engagement with co-production and co-design
8. Measuring the impact of patient involvement
9. How does involving service users support organisations to improve patient safety and improvement cultures
10. Uncut and unfiltered: A Q&A with patient partners
11. Open space table for things not covered above

Feedback from the room

Round the room . . . . .

1. Ensuring our patient representation reflects the communities we serve
2. Renumeration and recognition of patient involvement
3. Working with those with lived experience
4. Patient co-production at the micro level: How can Patient Partners support healthcare professionals to empower patients
5. Patient co-production at the meso level: involving patients at a strategic level
6. Patient co-production at the macro level: involving patients at pathway/system level
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8. Measuring the impact of patient involvement
9. How does involving service users support organisations to improve patient safety and improvement cultures
10. Uncut and unfiltered: A Q&A with patient partners
11. Open space table for things not covered above

- What can you do by next Tuesday?
- Think big, start small (HT Pedro!)
- Create a knowledge share by the end of the day from the session
  - Available XXXXX
- Other sessions over the next two days XXXXXX

Thank you

QRS code to
UHS QPSP
report

Supporting Improvement across a System

Through a health inequities lens

10 April 2024

Ruth McNamara
Natasha Regisford-Reimmer
Dr Lynn Zheng
Dr Sharon Dixon

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Session Outline

Health inequity lens

Group discussion – The Present

The Data challenge

From a GP perspective

Group discussion – The Future

Conclusion and insights

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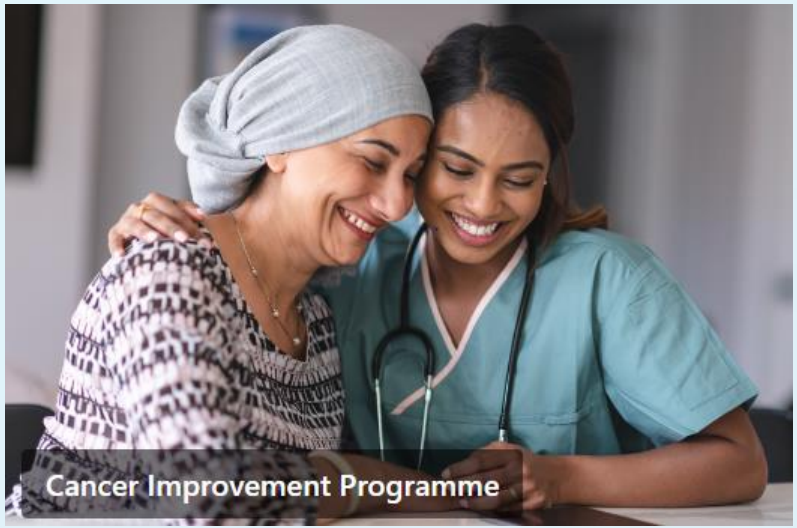
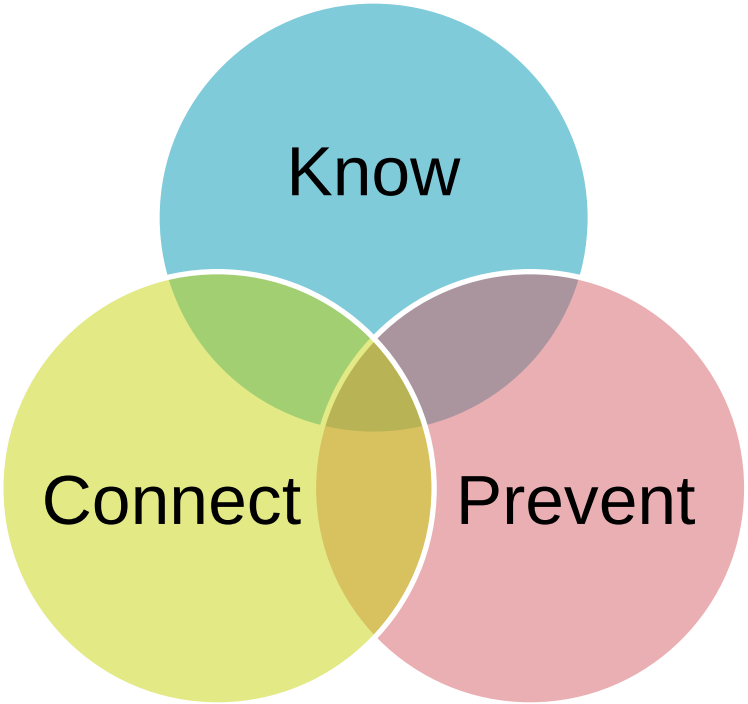
Tale of Two Cities: Making the invisible visible



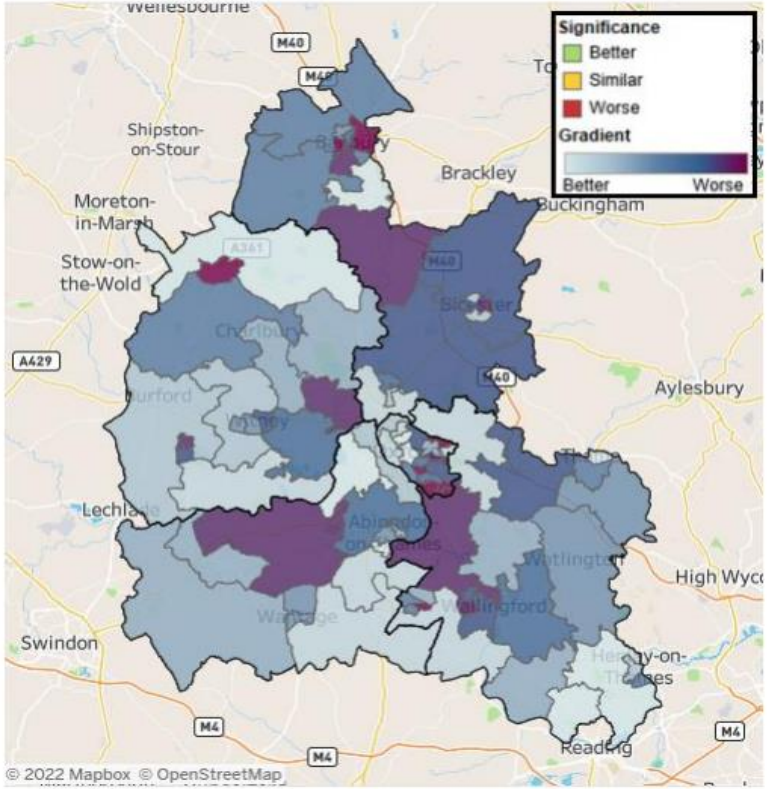
Quality Improvement

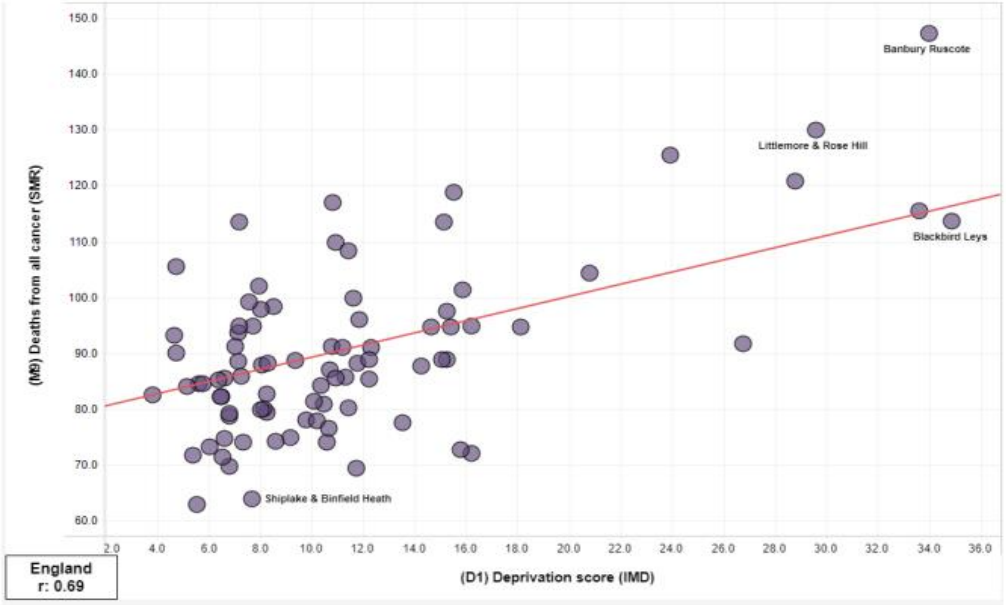
Equity Matters



https://forumcentral.org.uk/
https://www.england.nhs.uk/integratedcare/phm/#access

Deaths from all cancer, age under 75 years (Standardised Mortality Ratio)



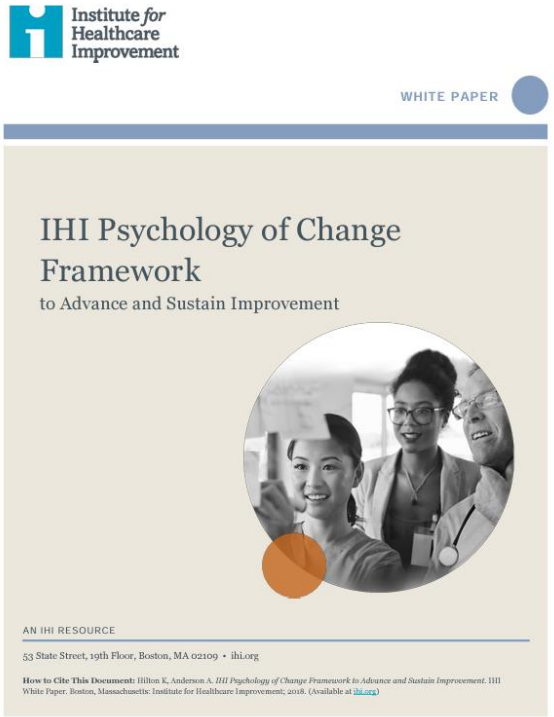


https://public.tableau.com/views/OxfordshireLocalAreaInequalitiesDashboard

Connect

"Coming together is a beginning, staying together is progress, and working together is success."
Henry Ford

"Those who have learned to collaborate and improvise most effectively have prevailed."
Charles Darwin



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Connect

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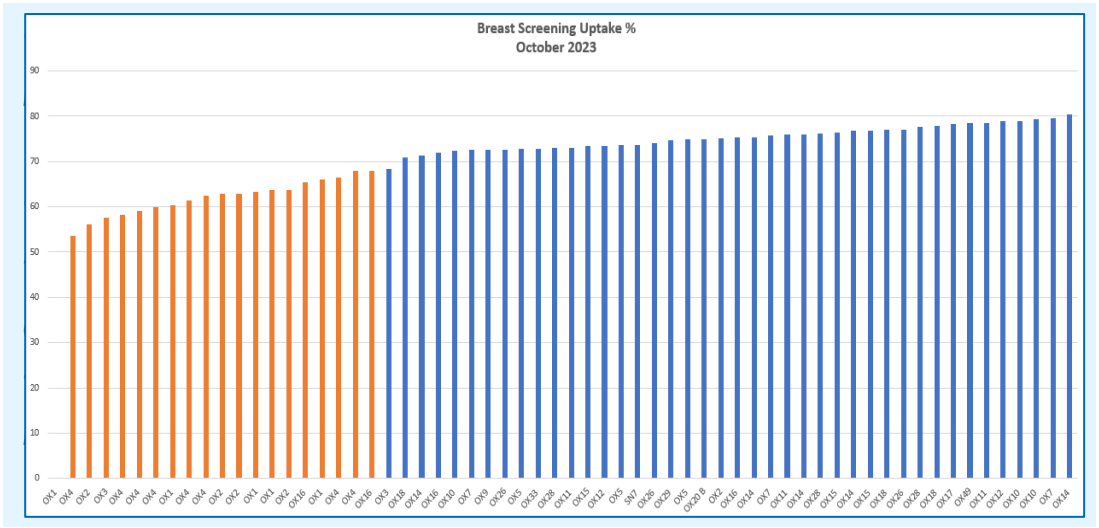
Quality Improvement

Prevent

Align system goals with health equity



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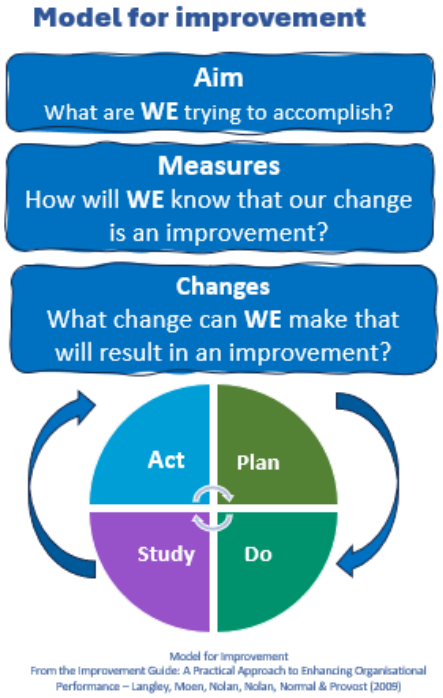
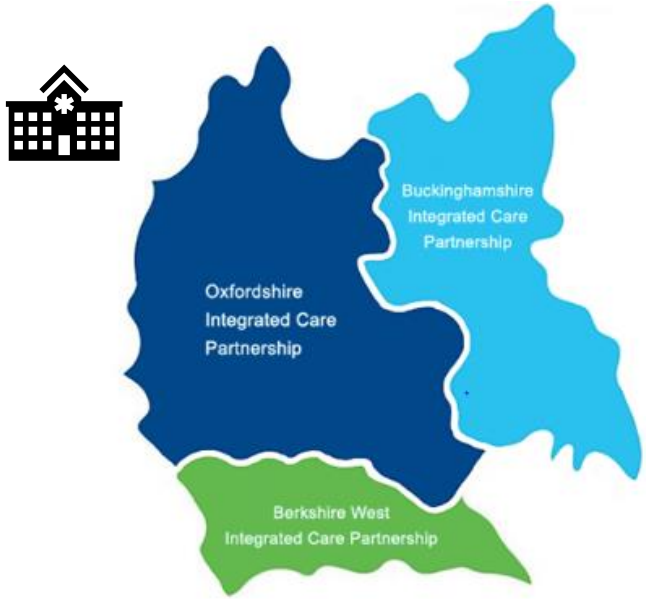
Here for Health Case Study: Supporting health + wellbeing local Muslim community

“Nothing about us; without us”

Anais Bozetine and Millie Khisa, Owned by Oxford, September 2023

Improvement opportunity





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OUH worked example: Addressing health inequalities in Cancer

The data challenge to improving population health

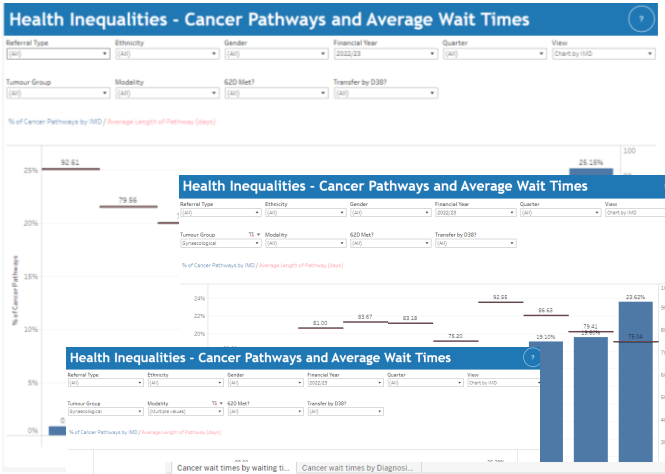
10 Apr 24

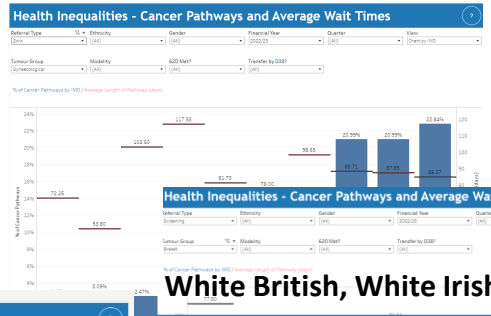
Dr Lynn Zheng

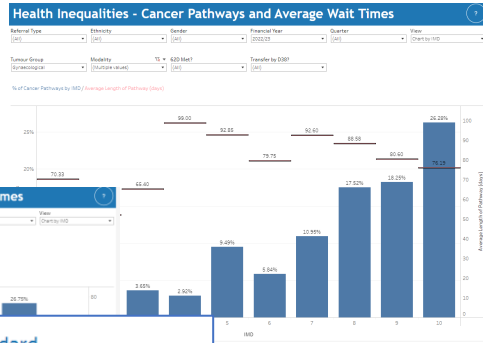
Outline

- QI project: Health inequalities in Cancer care
    - our starting point and limitations
    - our progress with addressing data challenges

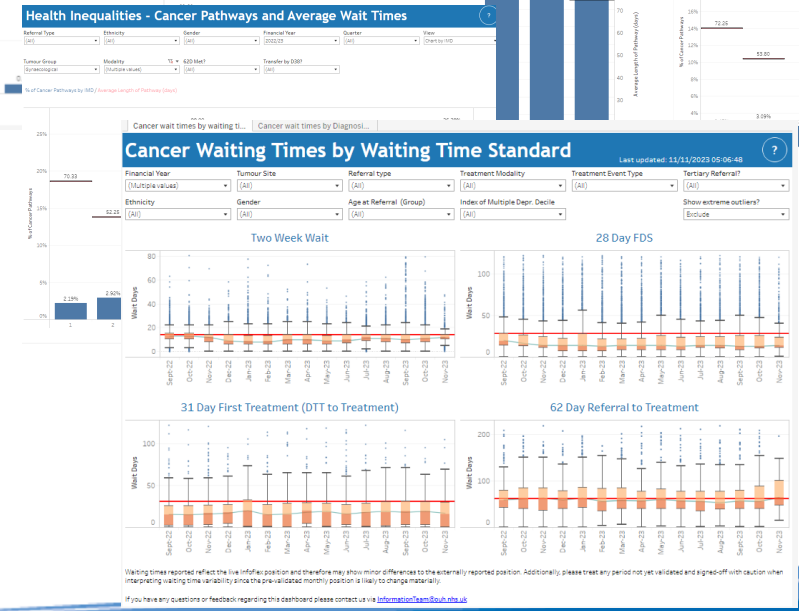
Starting point

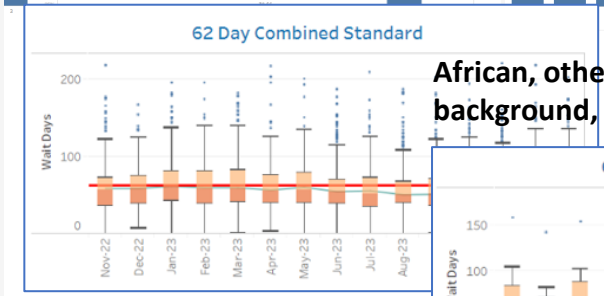




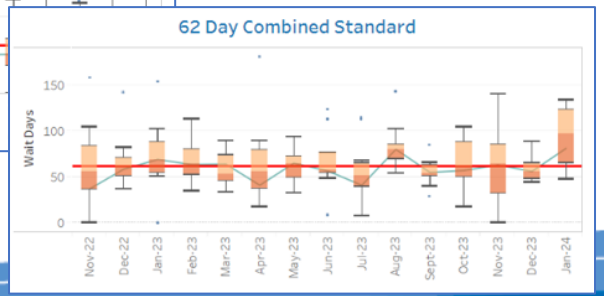


White British, White Irish

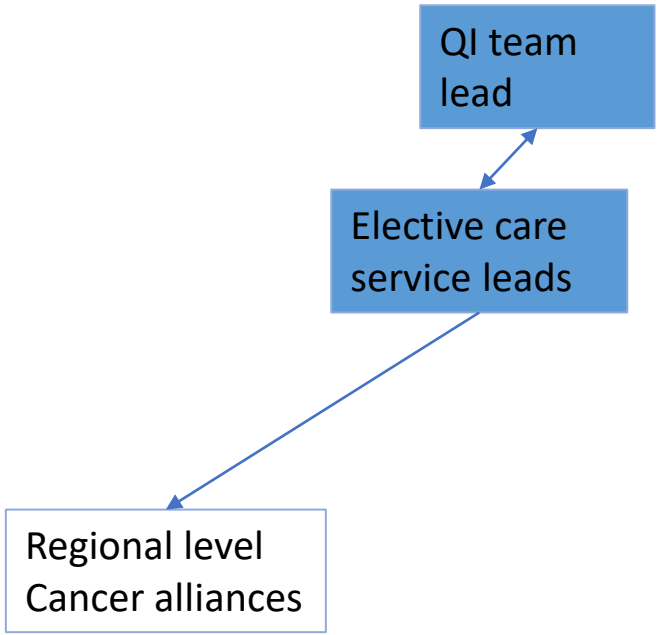




African, other Black background, other Asian background, Caribbean, Pakistani



Starting point



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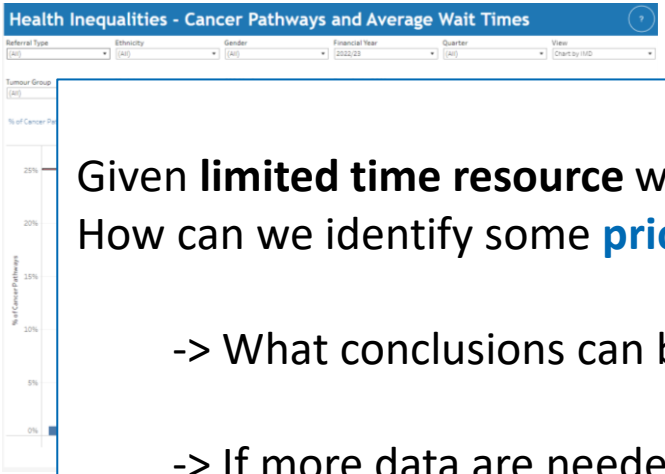


Given **limited time resource** within QI team and for Cancer service leads,
How can we identify some **priority areas** where we can have the biggest impact?

-> What conclusions can be drawn from the data we currently have?

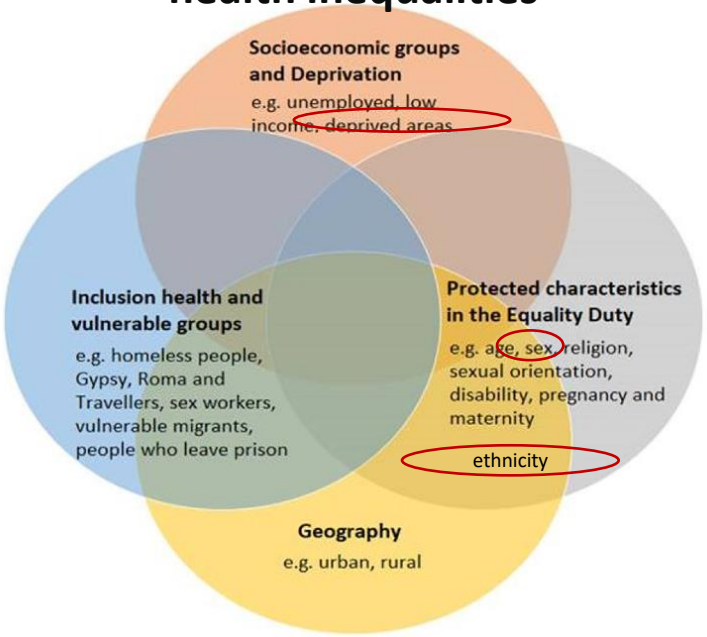
-> If more data are needed, what else is needed before we have ‘enough’?

Starting point

Limitations of HI data dashboard:

a) Data availability for HI groups beyond by sex, IMD and ethnicity

The range in the dimensions of health inequalities



Health Equity Assessment Tool (HEAT): executive summary - GOV.UK (www.gov.uk)

Starting point

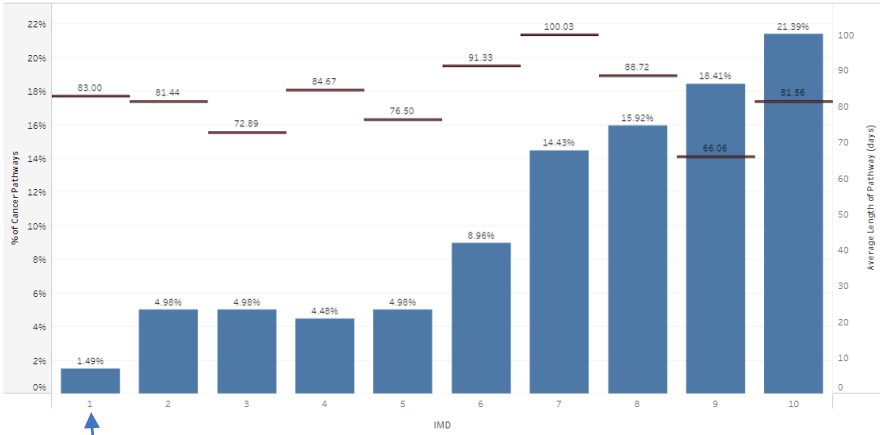
Limitations of HI data dashboard:

a) Data availability for HI groups beyond by gender, IMD and ethnicity

b) Formatting:

- data not formatted in a way that allows us to make the comparisons we are interested in
- small numbers, greater random variation, may miss associations due to random chance

Lung



N=3

Starting point

Limitations of HI data dashboard:

a) Data availability for HI groups beyond by gender, IMD and ethnicity

b) Formatting

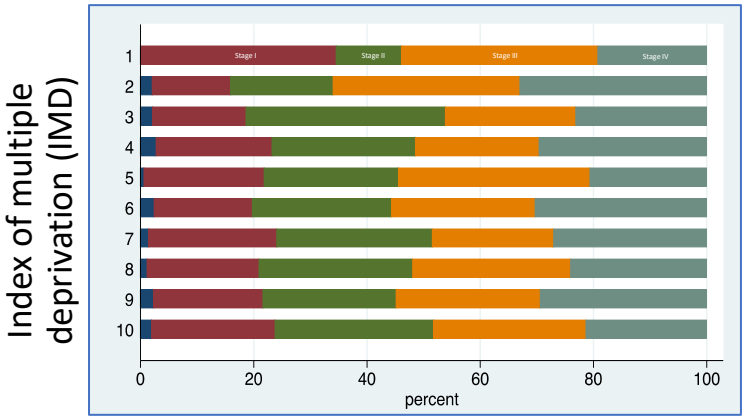
c) Ability to make like for like comparisons

- limitations of aggregate data to take other variables into account

Example:

"Across tumour sites as a whole, **there are no apparent differences in 'stage at diagnosis' by deprivation score**"

Stage at diagnosis by IMD



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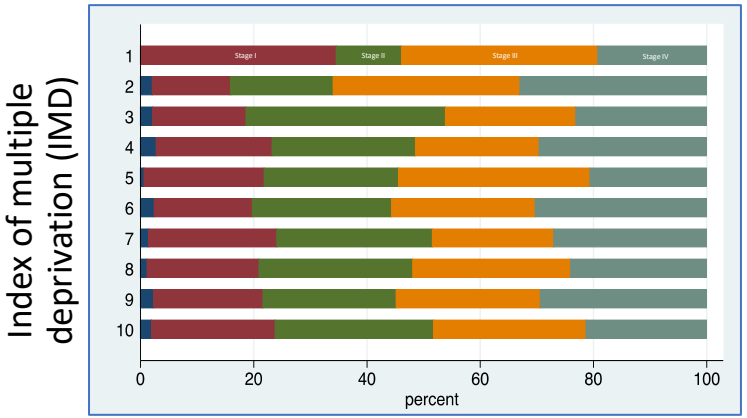
Stage at diagnosis by IMD



Younger age at presentation

Patients from less affluent areas

Later stage at diagnosis

Starting point

Limitations of HI data dashboard:

a) Data availability for HI groups beyond by gender, IMD and ethnicity

b) Formatting

c) Ability to make like for like comparisons

d) Relevance of HI in metrics to cancer outcomes

HI in cancer outcomes?
Eg 5 year survival

Starting point

Limitations of HI data dashboard:

a) Data availability for HI groups beyond by gender, IMD and ethnicity

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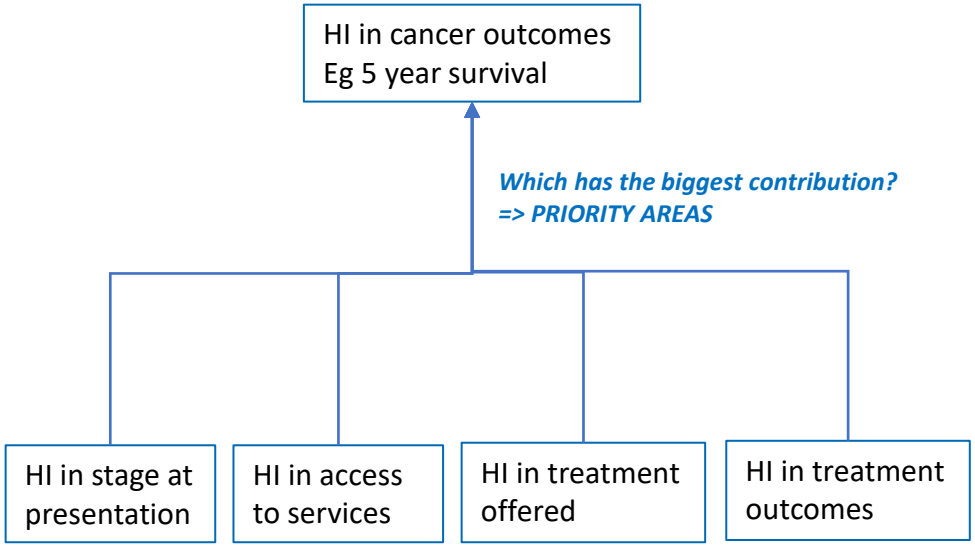

Addressing system challenges

Limitations of HI data dashboard:

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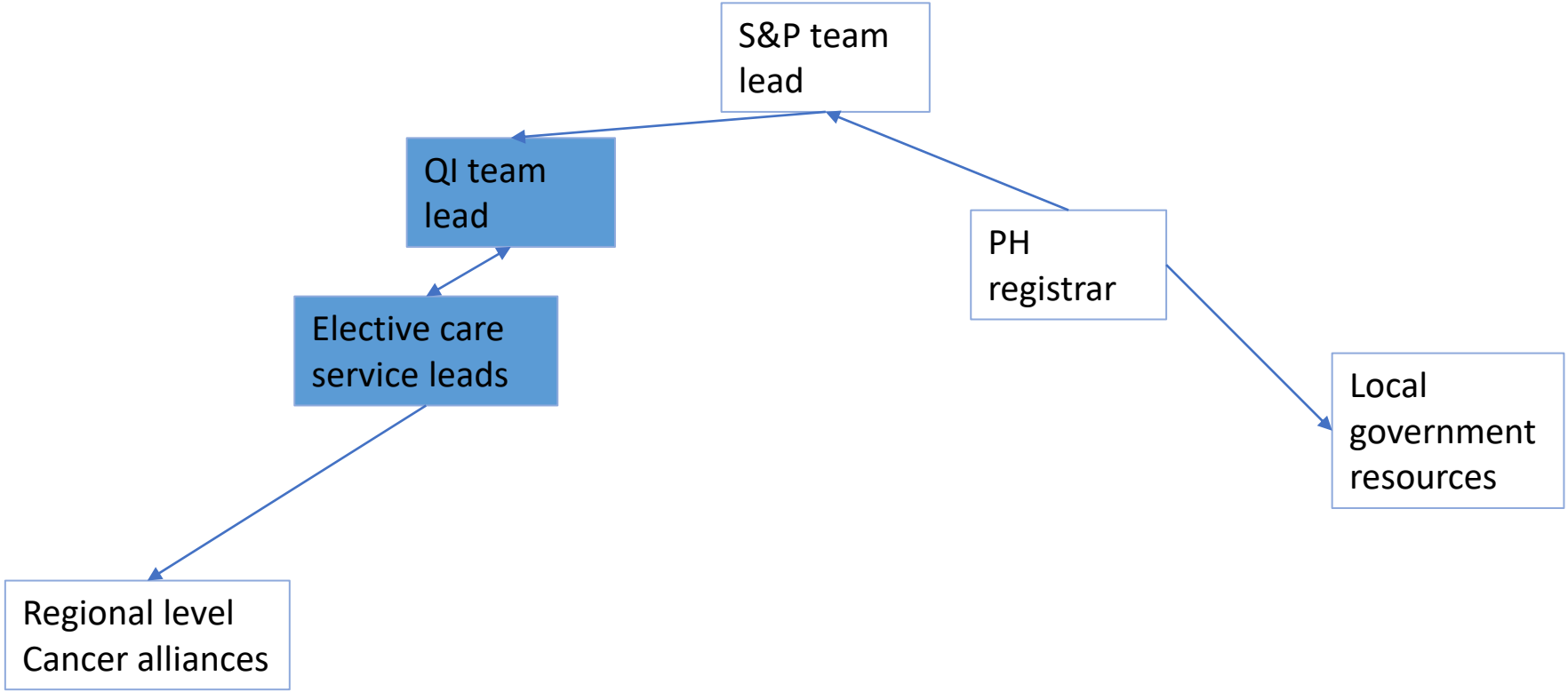
Evolution of the improvement network



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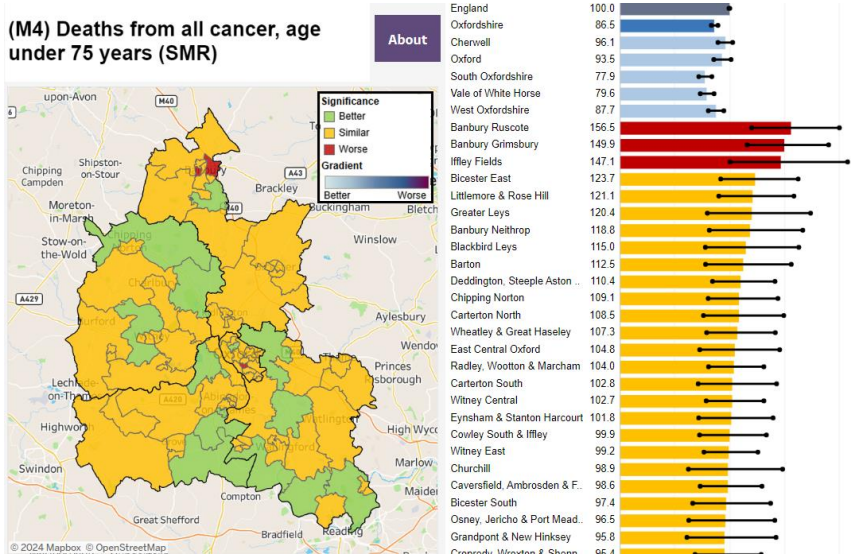
HI in cancer outcomes?

Oxfordshire Local Area Inequalities Dashboard



Addressing system challenges

Limitations of HI data dashboard:

a) Data availability for HI groups beyond by gender, IMD and ethnicity

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c) Ability to make like for like comparisons

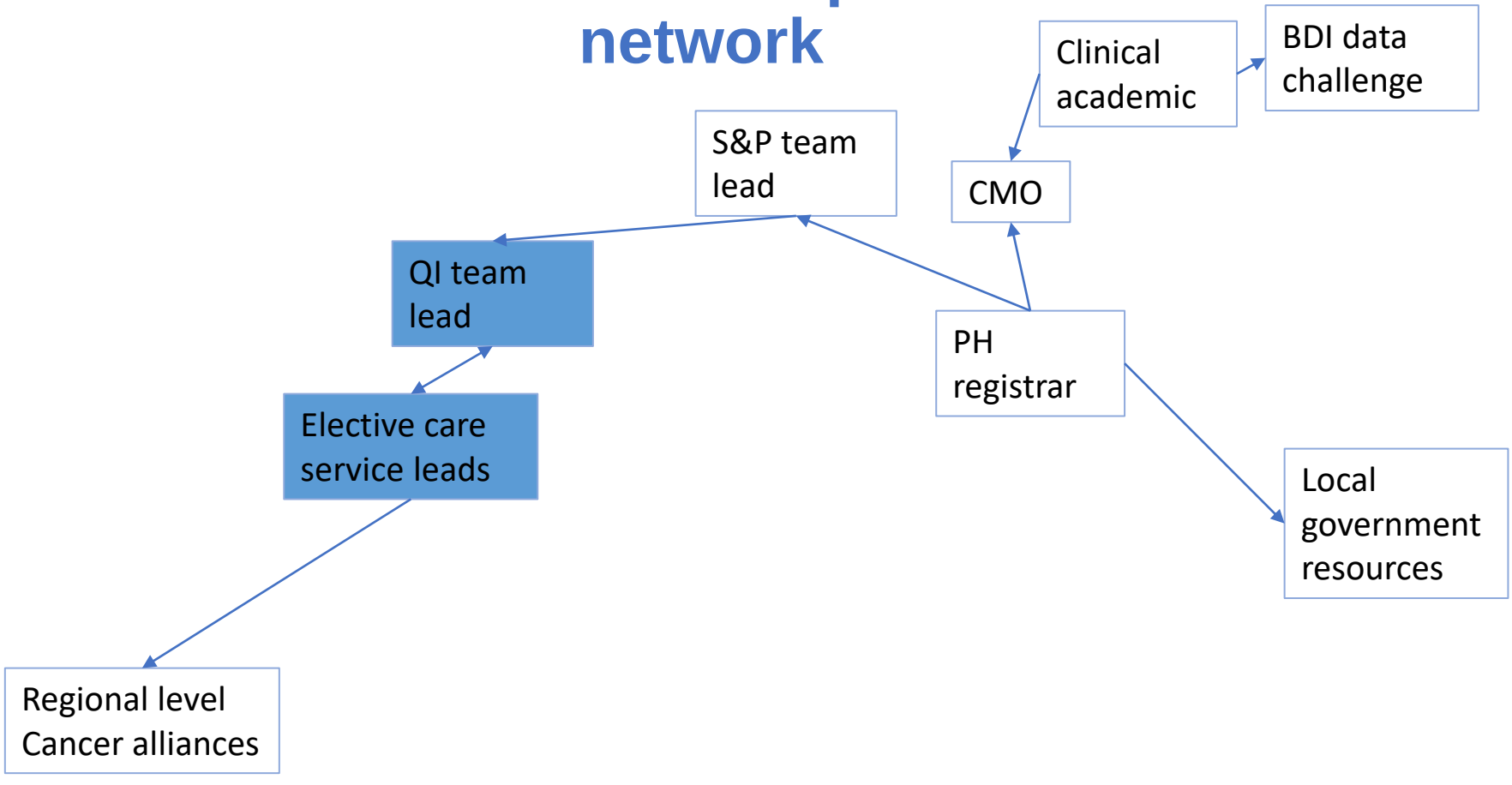
d) Relevance of HI in metrics to cancer outcomes

Solutions?

b) Develop data dashboard functionality with Information team

c) Multivariable analyses

Evolution of the improvement network



Addressing system challenges

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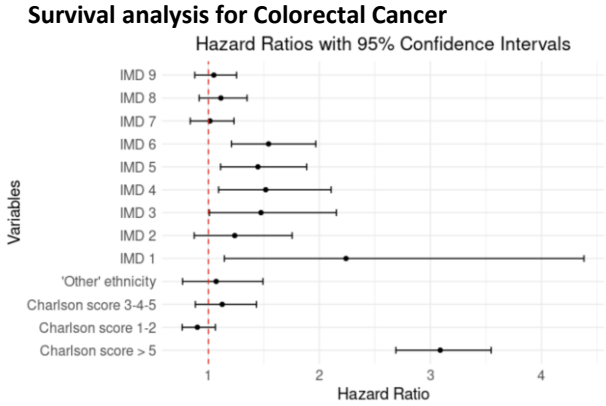
Solutions?



c+d) Survival analyses investigating HI in survival based on IMD and ethnicity, adjusted for confounders

Addressing system challenges

Limitations of HI data dashboard:

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b) Formatting

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d) Relevance of HI in metrics to cancer outcomes

Solutions?

Pathway analysis (all cancers)

	n	% hitting target	Average wait time (if delayed)
Overall	1148	59.2	90 (+28)
IMD 1-2	39	**53.8**	**121 (+59)**
IMD 3-4	79	54.4	92 (+30)
IMD 5-6	150	52.7	92 (+30)
IMD 7-8	322	**62.4**	97 (+35)
IMD 9-10	508	**60.6**	**82.5 (+20.5)**

c+d) Survival analyses investigating HI in survival based on IMD and ethnicity, adjusted for confounders
& pathway analysis by IMD and ethnicity

Addressing system challenges

Limitations of HI data dashboard:

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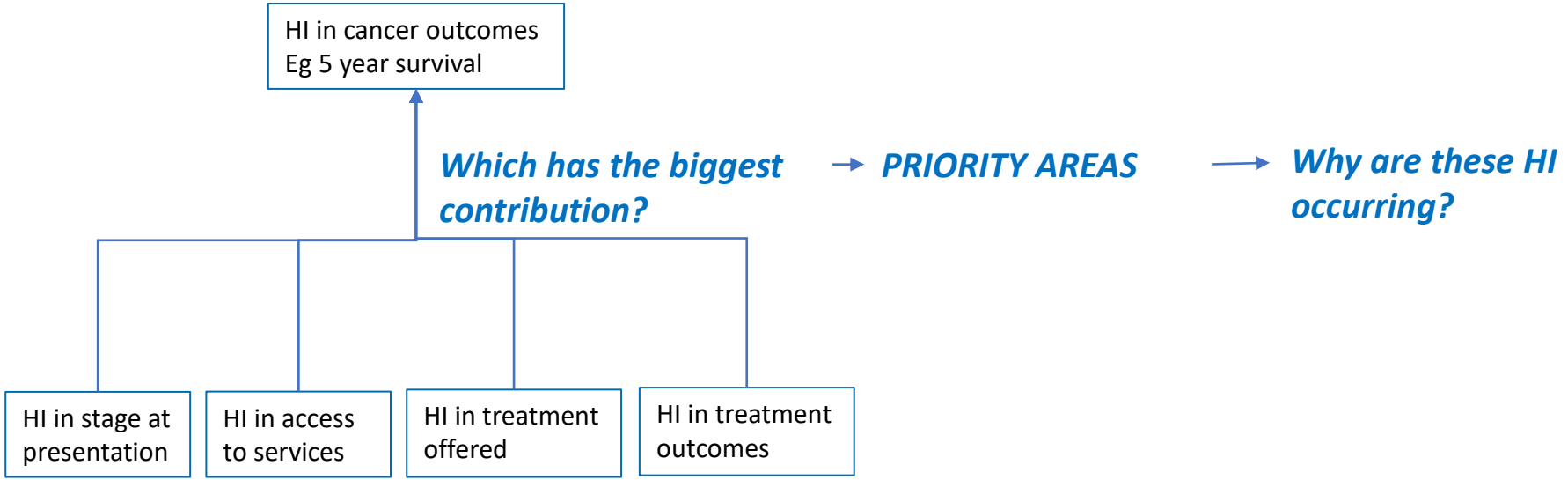
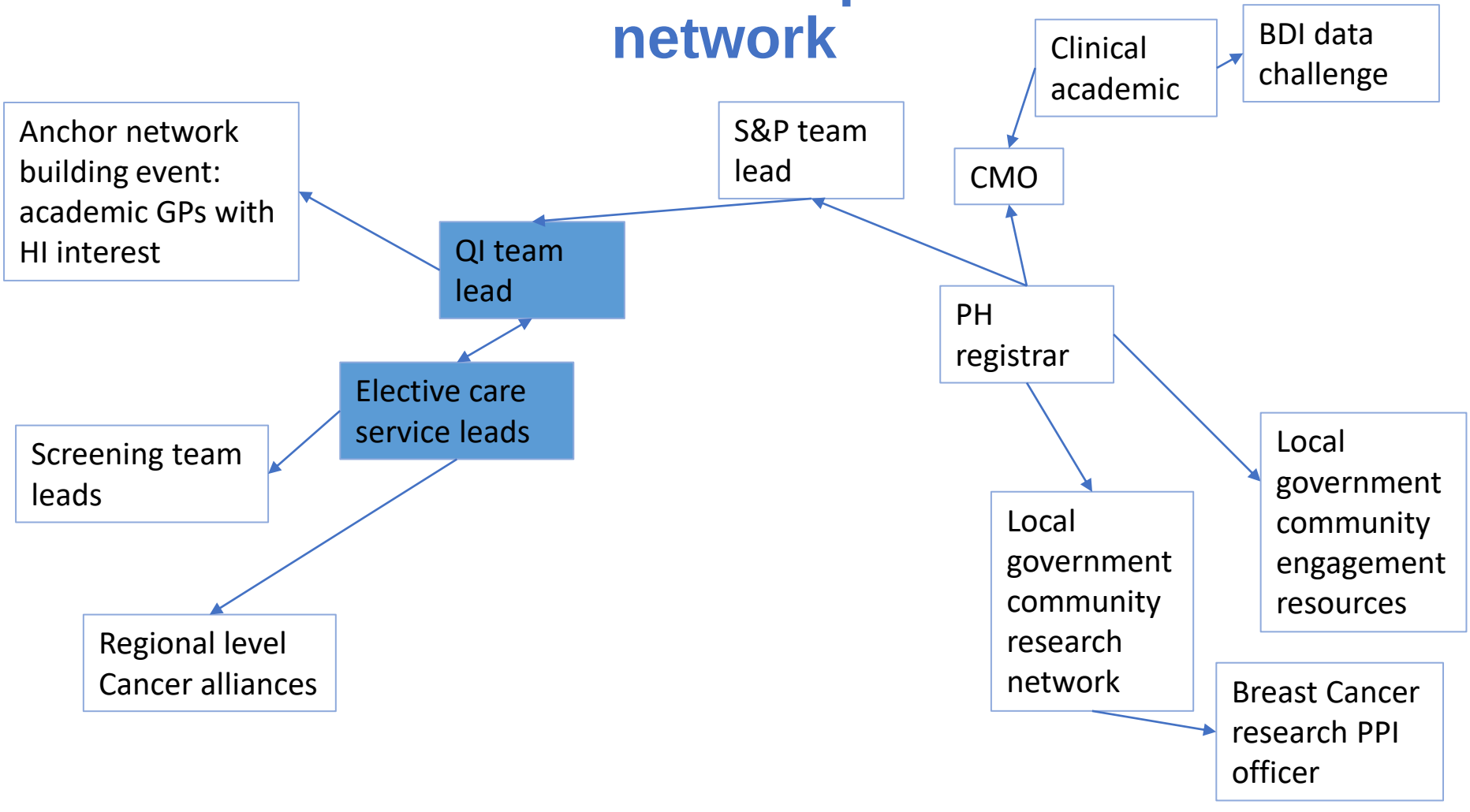
c+d) Survival analyses investigating HI in survival based on IMD and ethnicity, adjusted for confounders
& pathway analysis by IMD and ethnicity
=> analyses investigating to what extent differences in pathway waiting times, staging and comorbidities account for differences in cancer

Next steps


HI in cancer outcomes
Eg 5 year survival
Which has the biggest contribution?
PRIORITY AREAS
Why are these HI occurring?
HI in stage at presentation
HI in access to services
HI in treatment offered
HI in treatment outcomes

Evolution of the improvement network



Reflections

Supporting Improvement across a System

•Explore the **opportunity for enabling improvement at population level**, with a focus on addressing health inequalities through the example of cancer care

- to prioritise based on impact on population health, examine HI in treatment outcomes as your starting point
- can you link processes to outcomes? Data analyst support PLUS liaison who understands what questions are relevant to population health and potential/caveats of data analysis
- sustainability of analyses

•Continue to debate **the signs and markers of a good improvement culture**, how is this different at a system level?

- find allies from across the system e.g. through Strategy & Partnerships team, HI Steering Group and CMO, professionals who have experience working across the system

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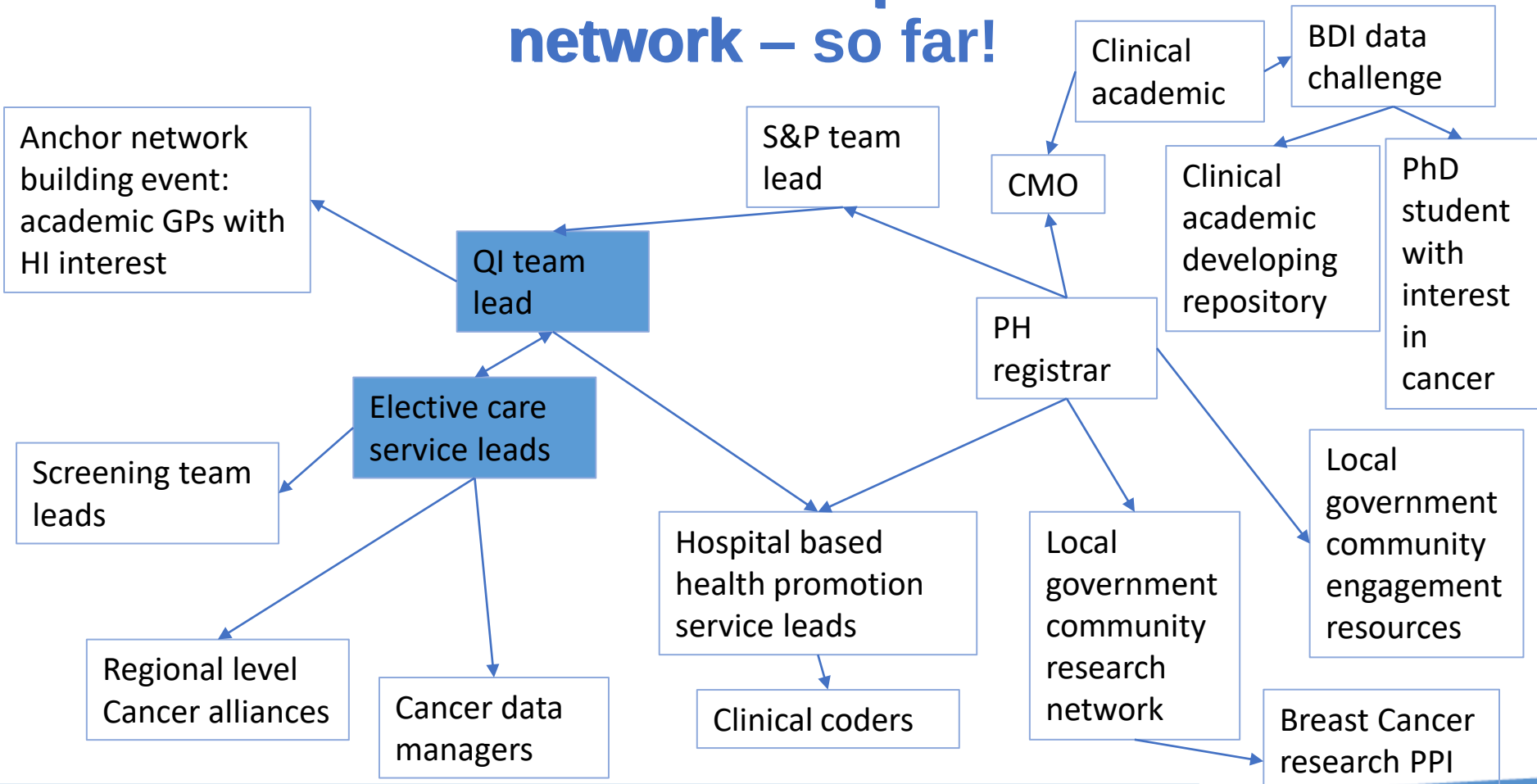
Evolution of the improvement network – so far!



Thank you to Lucy Greenwood, Emma Prevot, Owen Pullen and Andrew Brent who contributed data used in this presentation

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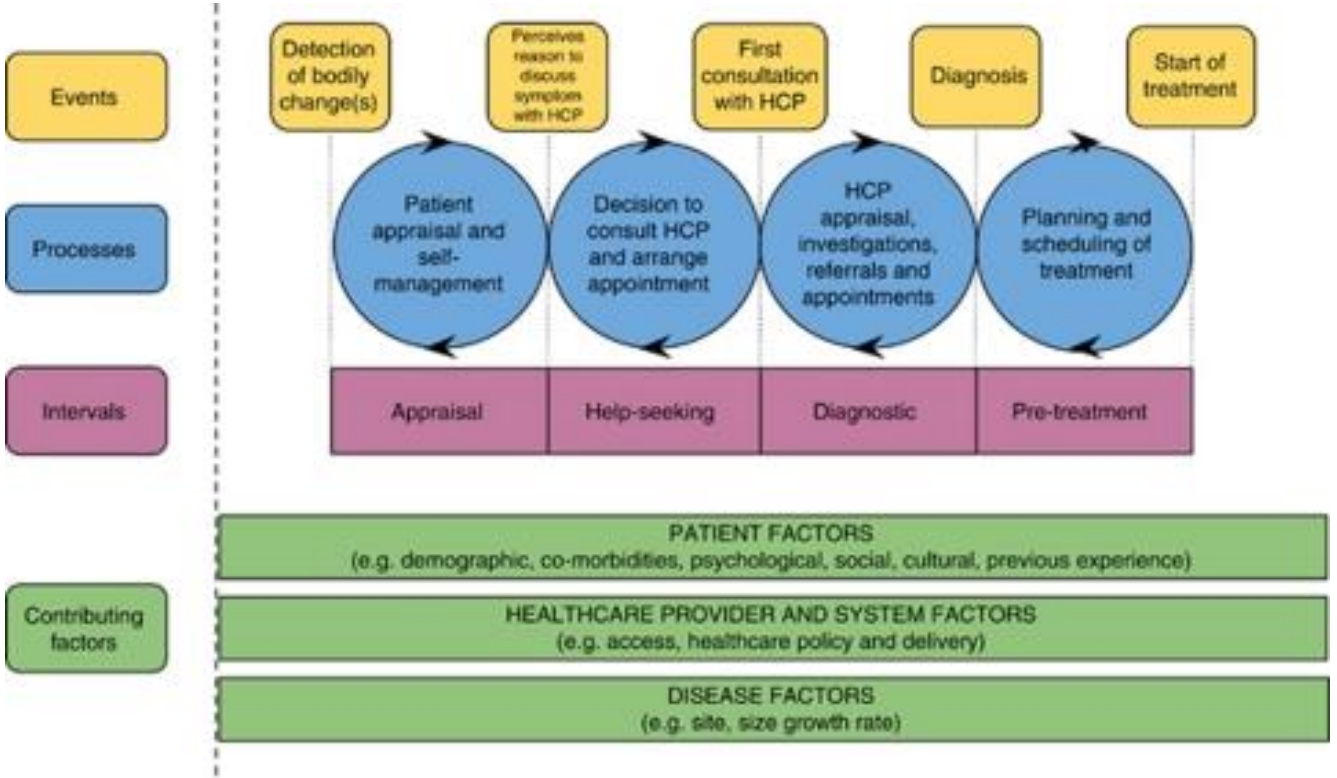
Cancer and health inequalities

A (my) GP perspective

10.04.2024

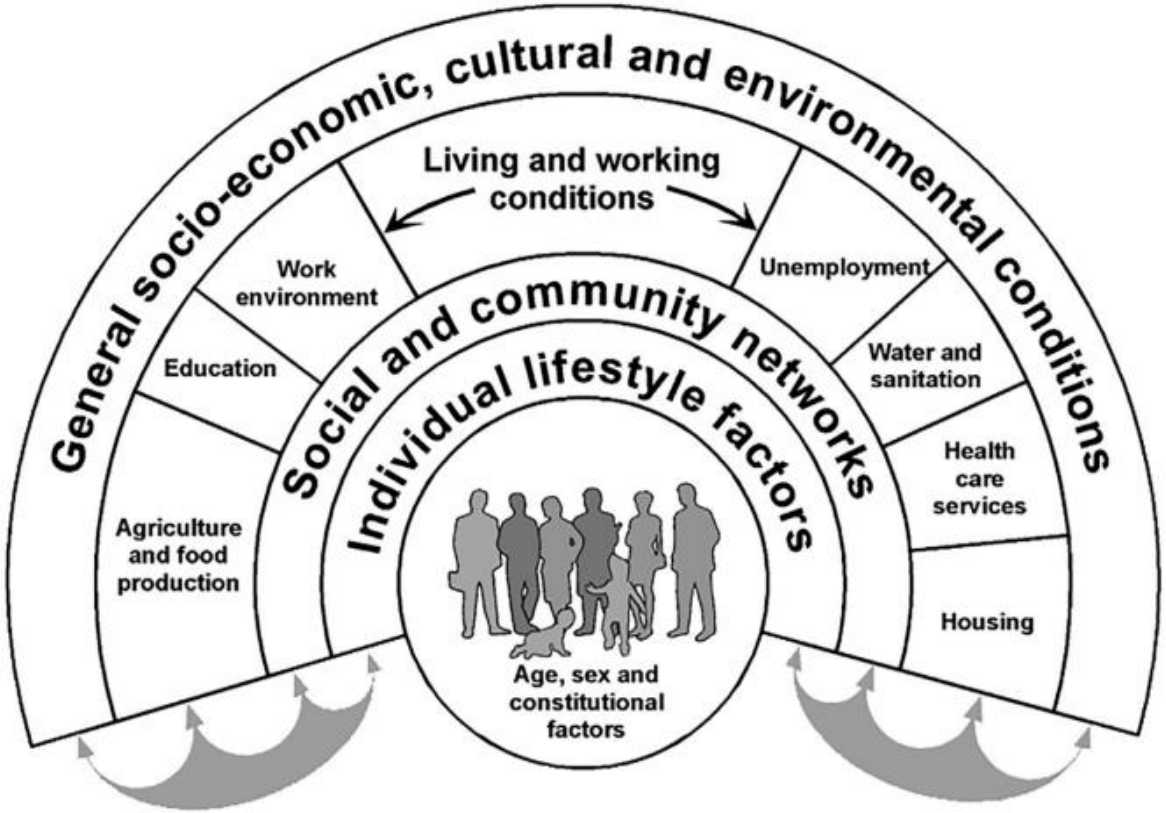
Sharon Dixon

The Aarhus Model



Weller D, Vedsted P, Rubin G, Walter FM, Emery J, Scott S, Campbell C, Andersen RS, Hamilton W, Olesen F, Rose P. The Aarhus statement: improving design and reporting of studies on early cancer diagnosis. British journal of cancer. 2012 Mar;106(7):1262-7.

Dahlgren-Whitehead Model



Dahlgren G, Whitehead M. The Dahlgren-Whitehead model of health determinants: 30 years on and still chasing rainbows. Public health. 2021 Oct 1;199:20-4.

Early diagnosis of cancer: systems approach to support clinicians in primary care

ANALYSIS

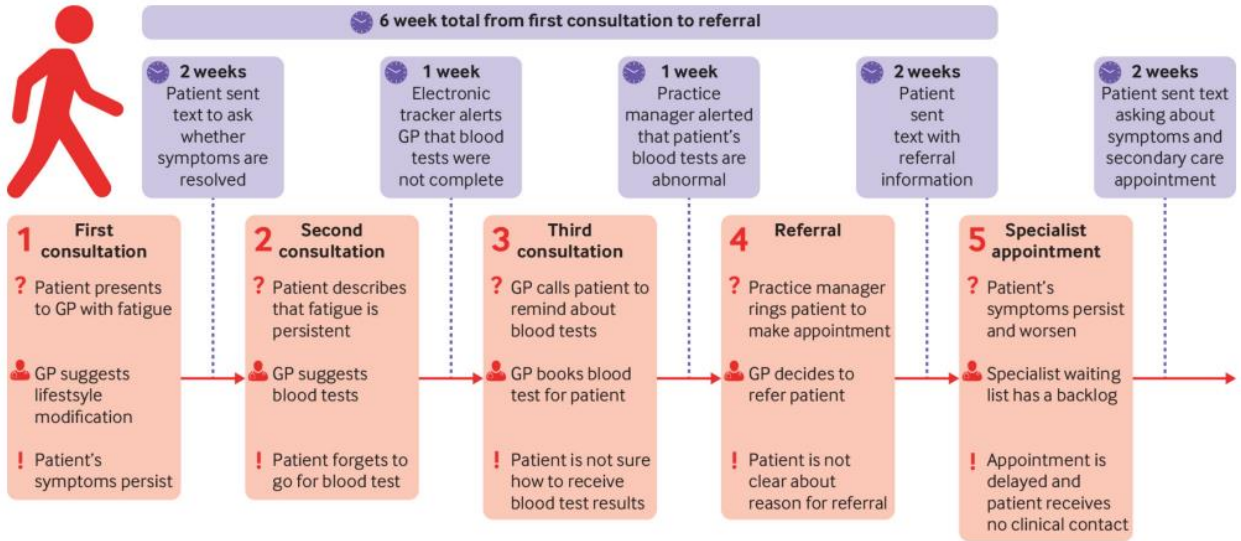


Fig 1 | Approach to avoid delays in management of a patient who is not immediately referred for cancer investigations

Black GB, Lyratzopoulos G, Vincent CA, Fulop NJ, Nicholson BD. Early diagnosis of cancer: systems approach to support clinicians in primary care. bmj. 2023 Feb 9;380.

‘GP practices in more deprived areas of England are relatively underfunded, under-doctored, and perform less well on a range of quality indicators compared with practices in wealthier areas’.

[Tackling the inverse care law - The Health Foundation]

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Oxford context

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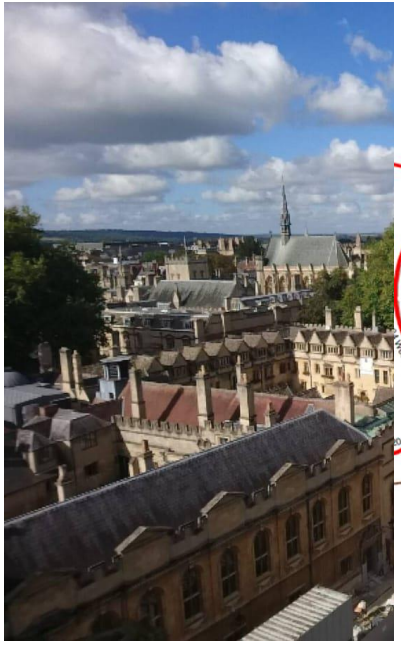
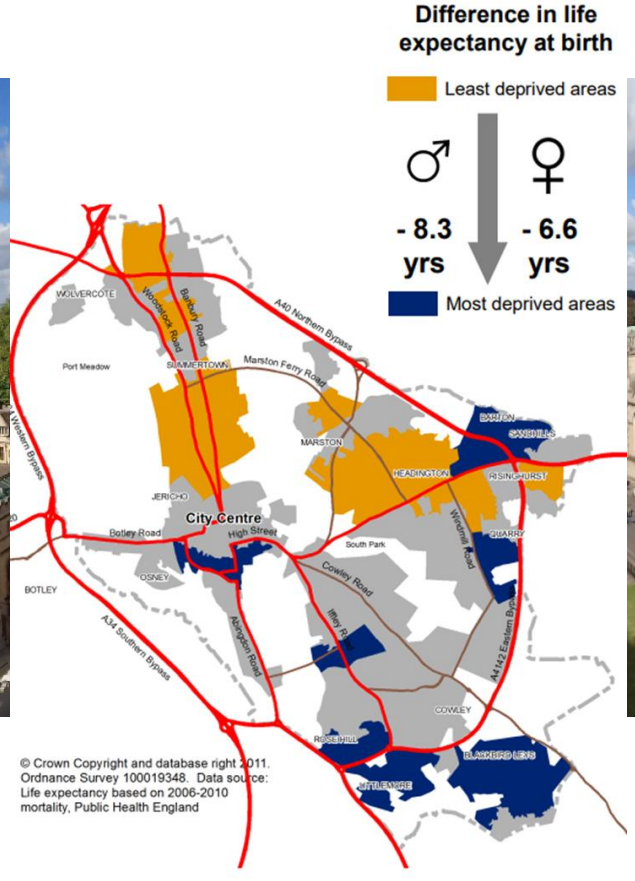




More than a million living in pockets of hidden poverty in England, says study

Measures used to target funding overlook areas where poor, often minority ethnic, people live next to the better-off, analysis shows

Tower Hamlets council is understood to be considering using the new deprivation index developed by Queen's University in Belfast. Photograph: Sam Mellish/In Pictures/Getty Images

More than a million people in England are living in pockets of hidden hardship, meaning that they could be missing out on vital help because their poverty is masked by neighbours who are better off, new analysis has revealed.

Ethnic minorities are most likely to be caught in these small areas of intense deprivation, which are not shown by existing measures used by local and national governments to target anti-deprivation funding.

The hidden hardship affects an estimated 1.3 million people, according to a government-funded research programme by geographers at Queen's University in Belfast. The most acute examples include pockets of Aylesbury, London, Oxford and Manchester, analysis for the Guardian shows.

Ethnic groups in some neighbourhoods in England and Wales experience very different levels of deprivation

Ethnic Group Deprivation Index decile for lower layer super output areas of the same Index of multiple deprivation (IMD) decile

Guardian graphic. Source: An ethnic group specific deprivation index for measuring neighbourhood inequalities in England and Wales. Christopher D. Lloyd et al. Note: IMD = index of multiple deprivation. Variables included in IMD are more wide-ranging so not directly comparable to the ethnic group deprivation index

[More than a million living in pockets of hidden poverty in England, says study | Poverty | The Guardian]

Oxford context

Oxfordshire Joint Strategic Needs Assessment

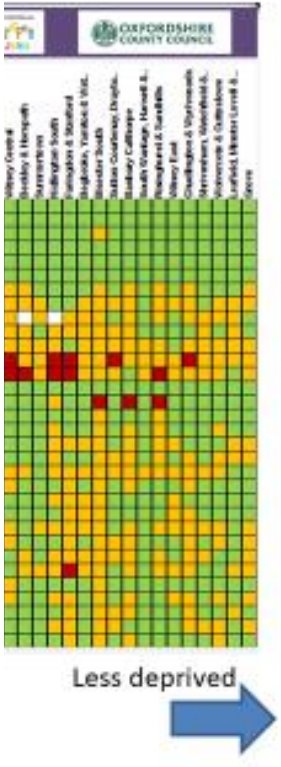
From Oxfordshire Local A

OX4

On average people in OX4 live 15 years fewer than those in OX1

OX4 is the dirt under fingernails,
OX4 is curry leaves sleeping on the edge of my plate,
4 is soft turmeric fingerprints tattooed down your stairs.
I watch you roll 4 up in tight Rizla hugs.
OX1 watches OX4 smash a window
with a mud-caked football, photographs
the glass shards perched on moss-embroidered concrete,
will never understand that in OX 4 'I can imagine
you as a doctor' isn't a compliment.
OX4 writes chalky words that get brushed off
the smooth cream paint, the kind of chalk
that makes you cough if you breathe it in too deep,
But all 4's words are stained anyway. The 4 stain
won't wash out. Today the news is orange:
so many people ill with 4. I take 4 into myself,
hate my middle name, Charvi. It means
'good with words', but to 1 it means 4.
4 doesn't walk on the pavement. 4
runs in the road. 4 is the plaster that stripes my skin
like mismatched floorboards, 4 is salted streaks
down hot brown cheeks, 4 is the sun
slipping behind clouds. A loss of possibility.
A broken zip.

Anna Beekmayer (17)



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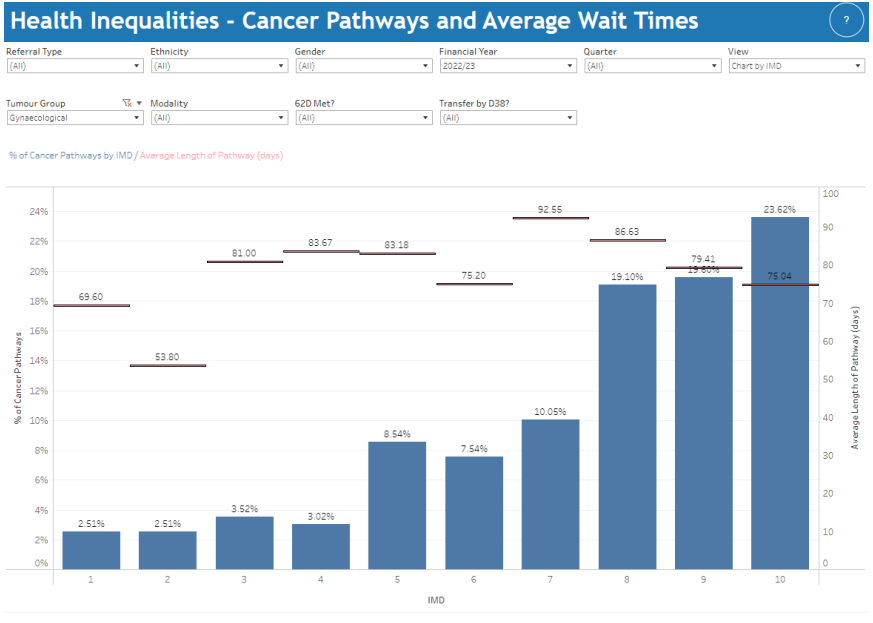
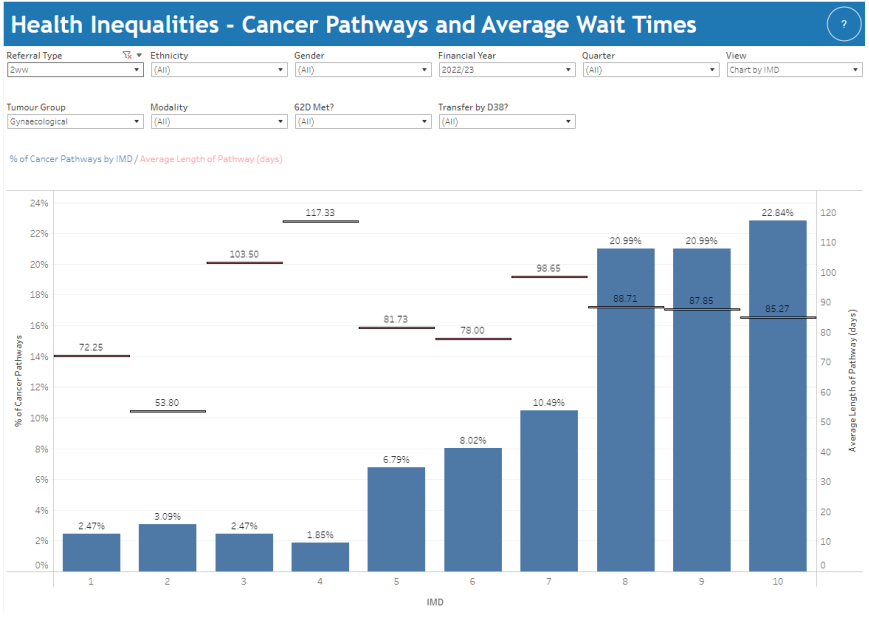
Tumour Group: Gynae

Oxford University Hospitals NHS Foundation Trust

All referral types



2WW



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Tumour Group: Gynae

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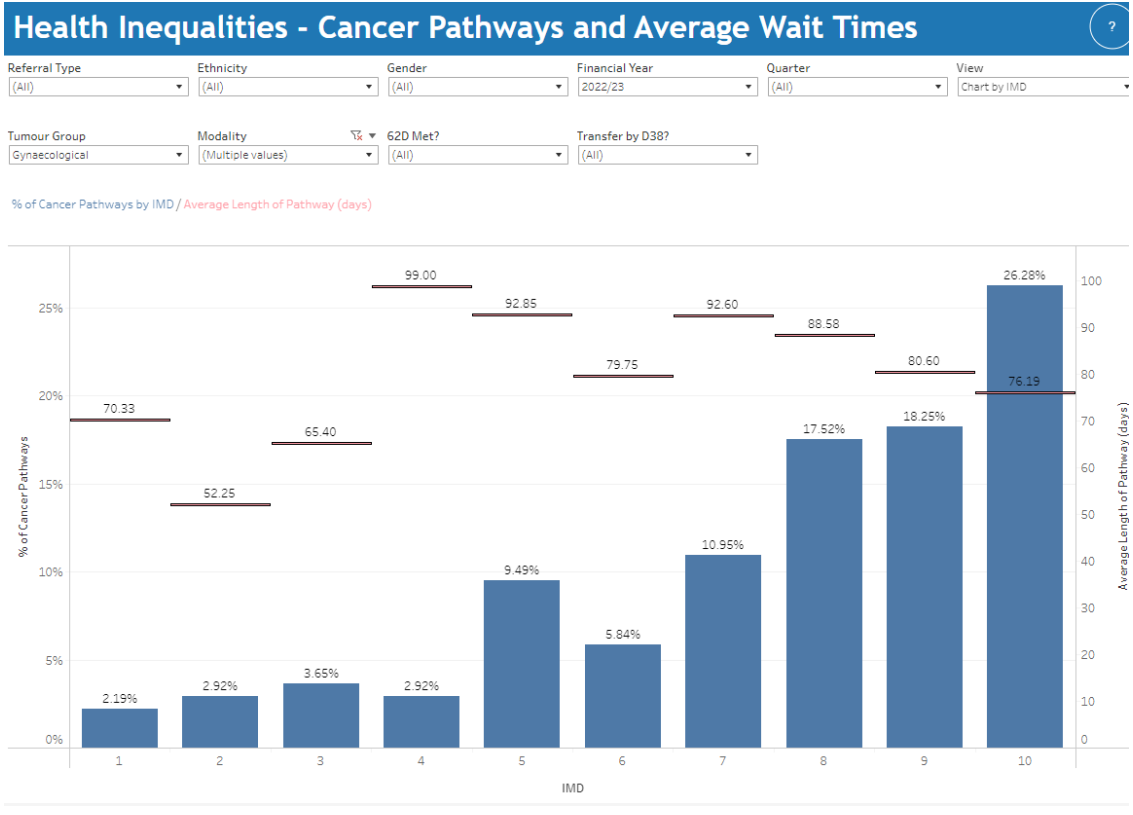
Surgery – enabling & excluding enabling treatment



University Hospital Southampton NHS Foundation Trust

Cervical screening: case study

Oxford University Hospitals NHS Foundation Trust

Why?

- At practice and organisational levels, screening uptake is negatively correlated with deprivation, having a higher number of younger women (25-49) and ethnicity[1,2].
- AND although uptake is improving in breast screening, this is not the case for cervical screening[3].
- There is also a significant and well defined association between deprivation and incidence of cervical cancer[4], and mortality from cervical cancer[5]
- We knew we could do better at cervical screening. There were differences between the four practices in our PCN, and we wanted to learn about different strategies and approaches, now and previous.
- We audited all smear non-attenders and looked at documentation of language and interpreter needs, documented ethnicity, learning disability, SMI.

References: 1= Bang JY, Yadegarfar G, Soljak M, Majeed A. Primary care factors associated with cervical screening coverage in England. Journal of public health. 2012 Dec 1;34(4):532-8. 2= Majeed FA, Cook DG, Anderson HR, Hilton S, Bunn S, Stones C. Using patient and general practice characteristics to explain variations in cervical smear uptake rates. Bmj. 1994 May 14;308(6939):1272-6. 3= Douglas E, Waller J, Duffy SW, Wardle J. Socioeconomic inequalities in breast and cervical screening coverage in England: are we closing the gap?. Journal of medical screening. 2016 Jun;23(2):98-103. 4= Currin LG, Jack RH, Linklater KM, Mak V, Møller H, Davies EA. Inequalities in the incidence of cervical cancer in South East England 2001–2005: an investigation of population risk factors. BMC Public Health. 2009 Dec;9(1):1-0. 5= Donkers H, Bekkers R, Massuger L, Galaal K. Systematic review on socioeconomic deprivation and survival in endometrial cancer. Cancer Causes & Control. 2019 Sep;30(9):1013-22.

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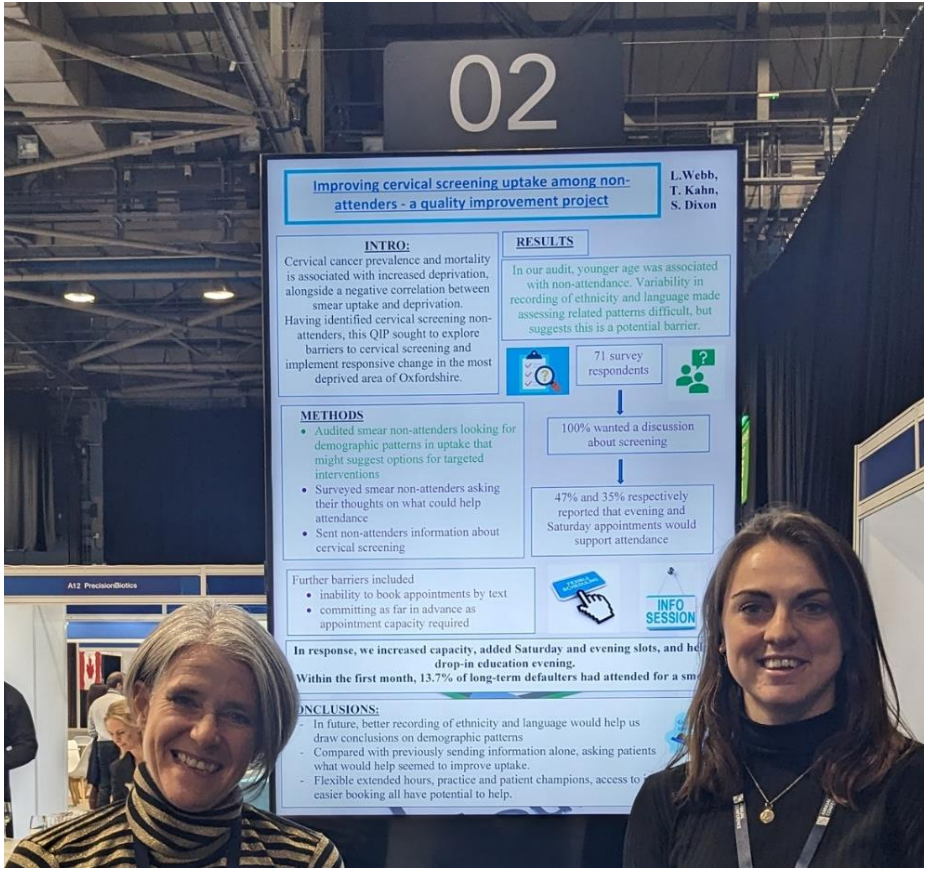
Cervical screening case study



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Cervical screening: case study

A patient and public involvement (PPI) workshop for the improvement of women's health technologies — Nuffield Department of Primary Care Health Sciences, University of Oxford

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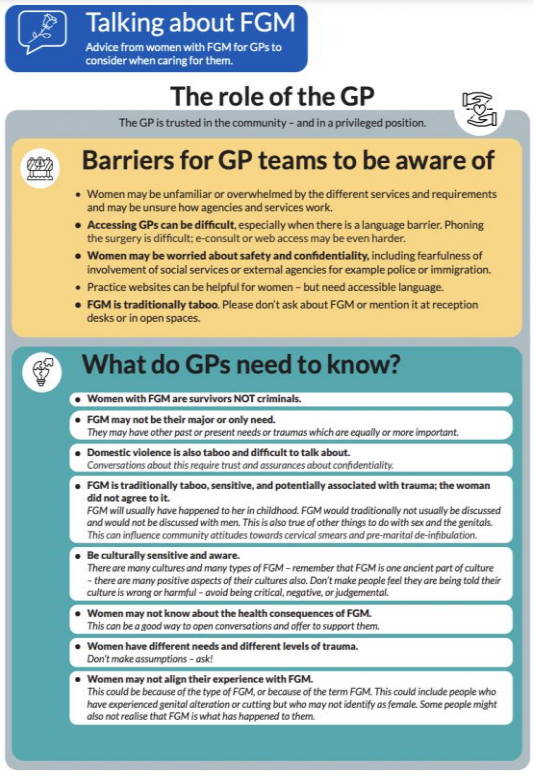
Cervical screening: case study



Talking about FGM

Advice from women with FGM for GPs to consider when caring for them.

The role of the GP

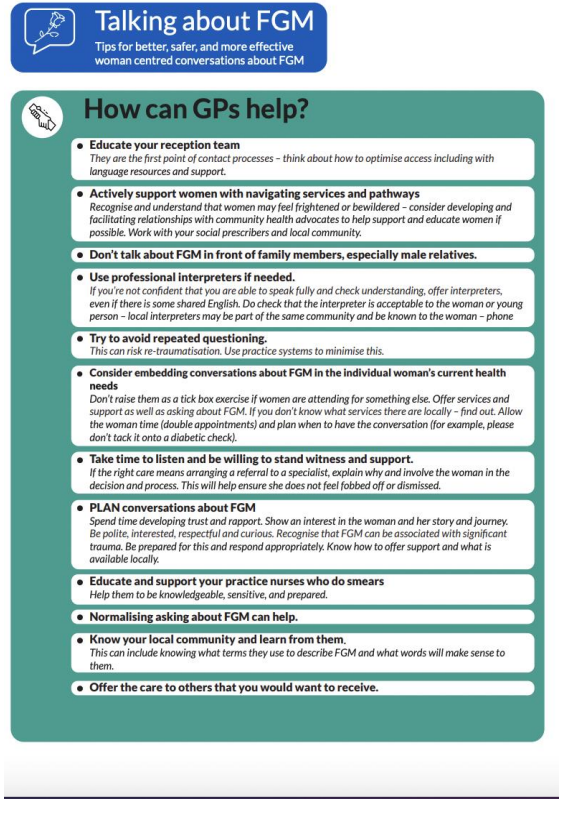
The GP is trusted in the community – and in a privileged position.

Barriers for GP teams to be aware of

- Women may be unfamiliar or overwhelmed by the different services and requirements and may be unsure how agencies and services work.
- **Accessing GPs can be difficult**, especially when there is a language barrier. Phoning the surgery is difficult; e-consult or web access may be even harder.
- **Women may be worried about safety and confidentiality**, including fearfulness of involvement of social services or external agencies for example police or immigration.
- Practice websites can be helpful for women – but need accessible language.
- **FGM is traditionally taboo**. Please don't ask about FGM or mention it at reception desks or in open spaces.

What do GPs need to know?

- **Women with FGM are survivors NOT criminals.**
- **FGM may not be their major or only need.**
  They may have other past or present needs or traumas which are equally or more important.
- **Domestic violence is also taboo and difficult to talk about.**
  Conversations about this require trust and assurances about confidentiality.
- **FGM is traditionally taboo, sensitive, and potentially associated with trauma; the woman did not agree to it.**
  FGM will usually have happened to her in childhood. FGM would traditionally not usually be discussed and would not be discussed with men. This is also true of other things to do with sex and the genitals. This can influence community attitudes towards cervical smears and pre-marital de-infibulation.
- **Be culturally sensitive and aware.**
  There are many cultures and many types of FGM – remember that FGM is one ancient part of culture – there are many positive aspects of their cultures also. Don't make people feel they are being told their culture is wrong or harmful – avoid being critical, negative, or judgemental.
- **Women may not know about the health consequences of FGM.**
  This can be a good way to open conversations and offer to support them.
- **Women have different needs and different levels of trauma.**
  Don't make assumptions – ask!
- **Women may not align their experience with FGM.**
  This could be because of the type of FGM, or because of the term FGM. This could include people who have experienced genital alteration or cutting but who may not identify as female. Some people might also not realise that FGM is what has happened to them.

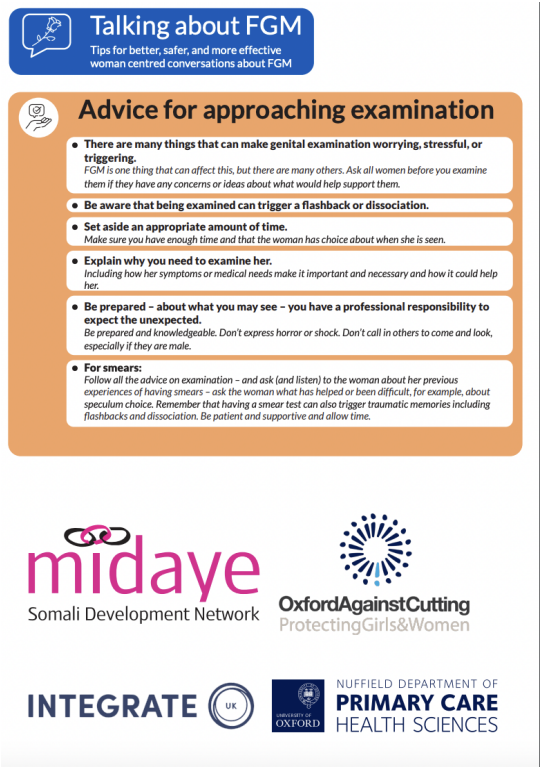


Talking about FGM

Tips for better, safer, and more effective woman centred conversations about FGM

How can GPs help?

- **Educate your reception team**
  They are the first point of contact processes – think about how to optimise access including with language resources and support.
- **Actively support women with navigating services and pathways**
  Recognise and understand that women may feel frightened or bewildered – consider developing and facilitating relationships with community health advocates to help support and educate women if possible. Work with your social prescribers and local community.
- **Don't talk about FGM in front of family members, especially male relatives.**
- **Use professional interpreters if needed.**
  If you're not confident that you are able to speak fully and check understanding, offer interpreters, even if there is some shared English. Do check that the interpreter is acceptable to the woman or young person – local interpreters may be part of the same community and be known to the woman – phone
- **Try to avoid repeated questioning.**
  This can risk re-traumatisation. Use practice systems to minimise this.
- **Consider embedding conversations about FGM in the individual woman's current health needs**
  Don't raise them as a tick box exercise if women are attending for something else. Offer services and support as well as asking about FGM. If you don't know what services there are locally – find out. Allow the woman time (double appointments) and plan when to have the conversation (for example, please don't tack it onto a diabetic check).
- **Take time to listen and be willing to stand witness and support.**
  If the right care means arranging a referral to a specialist, explain why and involve the woman in the decision and process. This will help ensure she does not feel fobbed off or dismissed.
- **PLAN conversations about FGM**
  Spend time developing trust and rapport. Show an interest in the woman and her story and journey. Be polite, interested, respectful and curious. Recognise that FGM can be associated with significant trauma. Be prepared for this and respond appropriately. Know how to offer support and what is available locally.
- **Educate and support your practice nurses who do smears**
  Help them to be knowledgeable, sensitive, and prepared.
- **Normalising asking about FGM can help.**
- **Know your local community and learn from them.**
  This can include knowing what terms they use to describe FGM and what words will make sense to them.
- **Offer the care to others that you would want to receive.**



Talking about FGM

Tips for better, safer, and more effective woman centred conversations about FGM

Advice for approaching examination

- **There are many things that can make genital examination worrying, stressful, or triggering.**
  FGM is one thing that can affect this, but there are many others. Ask all women before you examine them if they have any concerns or ideas about what would help support them.
- **Be aware that being examined can trigger a flashback or dissociation.**
- **Set aside an appropriate amount of time.**
  Make sure you have enough time and that the woman has choice about when she is seen.
- **Explain why you need to examine her.**
  Including how her symptoms or medical needs make it important and necessary and how it could help her.
- **Be prepared – about what you may see – you have a professional responsibility to expect the unexpected.**
  Be prepared and knowledgeable. Don't express horror or shock. Don't call in others to come and look, especially if they are male.
- **For smears:**
  Follow all the advice on examination – and ask (and listen) to the woman about her previous experiences of having smears – ask the woman what has helped or been difficult, for example, about speculum choice. Remember that having a smear test can also trigger traumatic memories including flashbacks and dissociation. Be patient and supportive and allow time.

midaye
Somali Development Network

OxfordAgainstCutting
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NUFFIELD DEPARTMENT OF PRIMARY CARE HEALTH SCIENCES
UNIVERSITY OF OXFORD

University Hospital Southampton NHS Foundation Trust

Cervical screening: case study

Oxford University Hospitals NHS Foundation Trust

Talking about FGM

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Next steps/innovations/challenges

Oxford University Hospitals NHS Foundation Trust

What helps? Partnership, collaboration, communication, recognition of need for equity, proactive care and interventions, opportunities and support for evaluation and learning, networks – within and between silos, investment –of time, people, energy, resources, nurturing.

What challenges? Wider determinants of health, structural variables, silos and silo's working/knowledge/planning. Short-term thinking and investments, unrealistic expectations for timeframes for demonstration of impacts.

What are we doing next? Developing proactive social prescribing projects using NAPC data assessments, community health worker schemes, collaborating OUH to develop a proactive pathway to optimise pre-op care and access to surgery. Supported in developing an equitable research programme in OX4

There is a lot of research and evaluation work – we need to share this learning between systems.

Plenary

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Time to make a pledge!

We want to spend some time thinking about what you can take from today back into your role

1-2-4 All

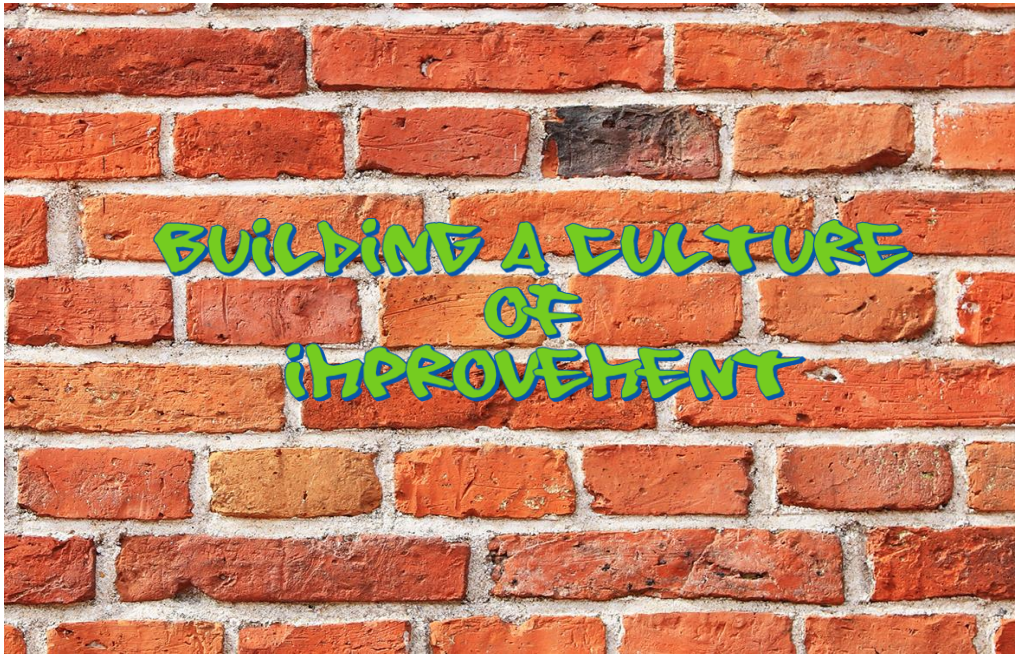
1 min personal reflection

2 min discussing as a pair

4 min whole table discussion

Write your pledge on 2 separate cards

We will collect one from you and stick it on the wall



My pledge is ...

Prompt questions:

- What highlight or challenge have I taken from today?
- What will I do with this information in the next 6-12 months?

Example 1: To link up with our patient involvement groups to explore and identify ways to strengthen how they can co-design improvements with us

Example 2: To map and understand the current system wide improvement programmes within my healthcare system

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Manifesto for culture-led improvement

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