



Sustainability in health / health inequalities

April 2024

Identifying needs, barriers and improving access to coordinated care for asylum seekers and refugees (vulnerable migrants). An approach to sustainable improvement



The Challenge

- Vulnerable migrants are arguably one of the most vulnerable groups in society, facing multiple challenges, with complex health needs that are often unrecognised

Asylum seeking population in Southwark has increased 20-fold from 100 to over 2,000 between 2019-2023

39% 18-30 years old
73% male, 259 children
18% of residents had been there > 1 year, with an average stay of 154 days



First steps

- Patient information leaflets
- Resources for health professionals
- Discharge checklist
- Embedded training
- Streamlined referral process between HIT, Respiratory and Infectious Diseases services
- Referral proforma
- Trust representation at the Southwark Borough Asylum Seeker and Refugee Group



Our approach

- Clinicians and colleagues from the Health Inclusion Team (HIT) established a collaborative working group
- With input from Public Health Southwark, we were able to collect and analyse community and hospital level data and develop data-driven, targeted interventions

Between September 2021 - October 2022. 194 /102,804 (0.19%) ED attendances from IACs, 87 (45%) < 17 years

Depression and anxiety 57.6%, PTSD 22%
- T2DM / Hypertension 14% (98% < 65 years old)
- Latent TB infection 17.1% Schisto 5%, Strongyl 6%



Survey of 41 health care professionals in ED
> 80% not confident in managing vulnerable migrants, advising on charges or signposting to support services



Next steps

Scale up, collaborate, intelligence and patient public and stakeholder engagement



Reference

The Health & Wellbeing of Asylum Seekers and Refugees in Southwark. Southwark's Joint Strategic Needs Assessment. St George's University of London. Southwark Council & South East London ICB.

June 2023

Enhancing Post Discharge Follow up and Renal Function Monitoring Through Robust Acute Kidney Injury Care Planning

Authors - Andrew Williams & Keila Calland, co-authors Dr Varia, Dr Khandaker, Dr Rahman, Loreta Palas & Sophie O'Brien

Background

- Acute Kidney Injury (AKI) poses a world wide health burden, increasing morbidity and mortality¹
- After AKI, discharged adults face ongoing health risks
- National Institute for Health and Care Excellence (NICE) guidelines in 2023 stress the importance of follow-up clinical reviews in primary or secondary care
- Identifying those at an increased risk, post discharge, is crucial in providing specialised and timely clinical review
- Think Kidneys and NICE both support discharge planning to co-ordinate care following admission

Aims

Our aim, utilising a structured post discharge care plan (see image 1), was to ensure that patients who had an AKI episode were given clear guidance and an opportunity to be reviewed by a specialist—either Nurse specialist or consultant, once discharged.

This would aid in promoting healthy kidney advice and improving AKI recovery.

Image 1

Acute Kidney Injury Care Plan

Highest Stage of AKI (Please code into primary care record)
Type of AKI
Cause(s) of AKI
Discharge renal function (Creatinine & eGFR)
Was a critical care admission required
Was renal replacement therapy required
Medication changes including reason
Plan for monitoring of kidney function
Education
Unified DNACPR (Lilac Form) order in place on discharge (Include reason for decision)
Hospital Follow Up (If planned State Clinic & Timeframe)
Primary Care review recommendations
Useful reference material
Retail Pharmacy Code (Pharmacy Use Only)
Completed and Checked By (Designation and Bleep/Contact Number):

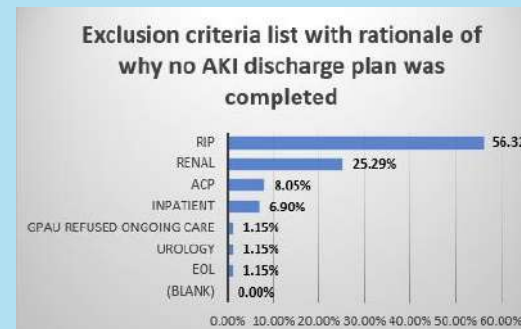
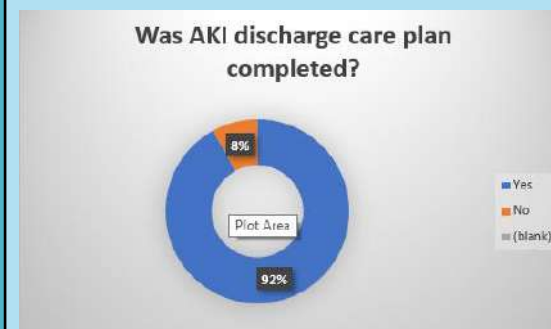
**** You have been provided with this care plan because you had an Acute Kidney Injury during your hospital admission ****

Method

- During inpatient stay, patient assessed, by specialist AKI nurse, and highlighted for suitability of care plan and follow up
- Following discharge individualised structured discharge care plan was completed.
- This gave opportunity to provide further ongoing healthy kidney advice, inform future planning in regarding monitoring of renal function
- Provide GP with plan for follow up, either with specialist team or with themselves. Making recommendations on time frames and investigations

Results

- 92% of patients eligible for AKI discharge care plan were completed
- Of these all had a clear cause of AKI and medication review documented
- All patients who received a care plan also received ongoing health education, including an AKI Organisation patient information leaflet
- Of those who received a care plan 46.94% were invited to a Post AKI clinic, 44.9% referred to GP (with plan in place), 6.12% referred to a renal hot clinic, whilst 2% were already involved in renal services.
- 79.1% of patients, that were offered a follow up clinic appointment, were reviewed in a timely manner



Conclusion

An AKI discharge care plan serves as a means of communication across various specialties in primary and secondary care. It provides clear guidance to multiple healthcare professionals regarding the future management of AKI, including precise instructions for medication and blood test monitoring. The plan also aids patients in comprehending the causes of their AKI, complemented by the AKI leaflet, which imparts healthy kidney advice. Although the results suggest an ongoing improvement process, they underscore the effectiveness of a well-established system in completing AKI discharge care plans for inpatient AKI cases.

¹NICE (2023) *Acute kidney injury. Quality standard [QS76]*. National Institute for Health and Care Excellence. <https://www.nice.org.uk>

²RCGP Acute kidney injury toolkit (2023) ONLINE: www.rcgp.org.uk/aki

³Think Kidneys (2016) Discharge summaries for patients whose hospital admission included an episode of AKI: minimum data

Understanding health inequalities through Emergency Department walk-in data

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Why is this important?

Emergency Departments are under considerable pressure, with the number of attendances increasing.¹ These pressures exacerbate existing inequalities as people from more deprived backgrounds wait longer, and those from ethnic minority backgrounds are more likely to access care late.² The aim of this project was to understand what inequalities existed in use and access to the Emergency Department at Southampton General Hospital.

Methods

We performed a cross-sectional data analysis of 139,356 walk-ins from 98,726 independent patients to Southampton General Hospital Emergency Department (ED) between 01/01/2022 and 30/04/2023. Demographic data was analysed alongside ED specific coding within Excel.

What did we find?



Almost a third of all walk-ins to the Emergency Department (28%) were aged 0-15.



Ethnic groups other than White British and those from more deprived areas were less likely to be referred to the Emergency Department by a GP or healthcare provider.



After accounting for local population and birth data, those from ethnic groups recorded as 'Black, Black British, Caribbean or African', 'Other', or 'White British' were more likely to attend the Emergency Department with pregnancy related complaints.



Walk-ins to the Emergency Department were broadly similar across each Indices of Multiple Deprivation (IMD) decile (see Figure 1 – low numbers are more deprived areas). This fits within the profile of the population serviced by the hospital.

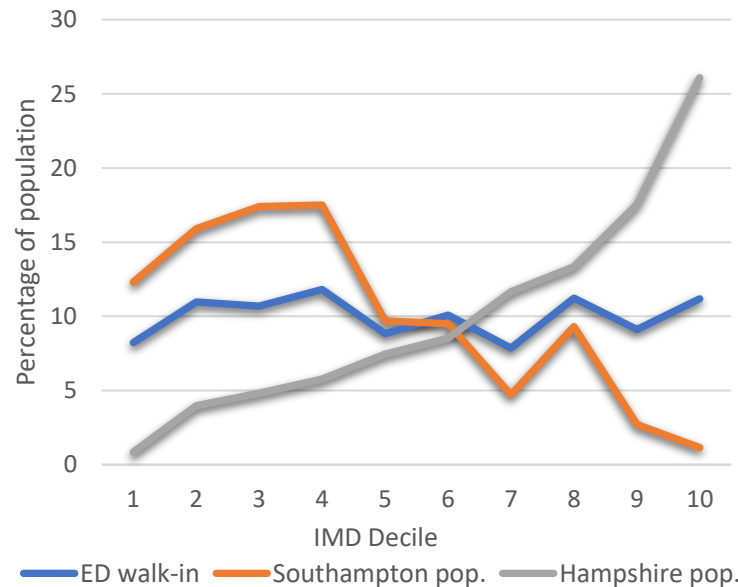
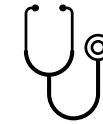


Figure 1: Percentage of ED walk-in patients per IMD decile compared with Southampton and Hampshire population

References

- ¹ A&E Attendances and Emergency Admissions: Statistical Commentary: 2023. <https://www.england.nhs.uk/statistics/wpcontent/uploads/sites/2/2023/11/Statistical-commentary-October-2023abcd.pdf>
- ² Tackling the elective backlog - exploring the relationship between deprivation and waiting times: 2021. <https://www.kingsfund.org.uk/insight-and-analysis/blogs/elective-backlog-deprivation-waiting-times>



33% of all walk-ins were from patients registered with 10 GP practices in the Southampton area, and 6 of the 10 practices were in the 20% most deprived areas (see Figure 2).

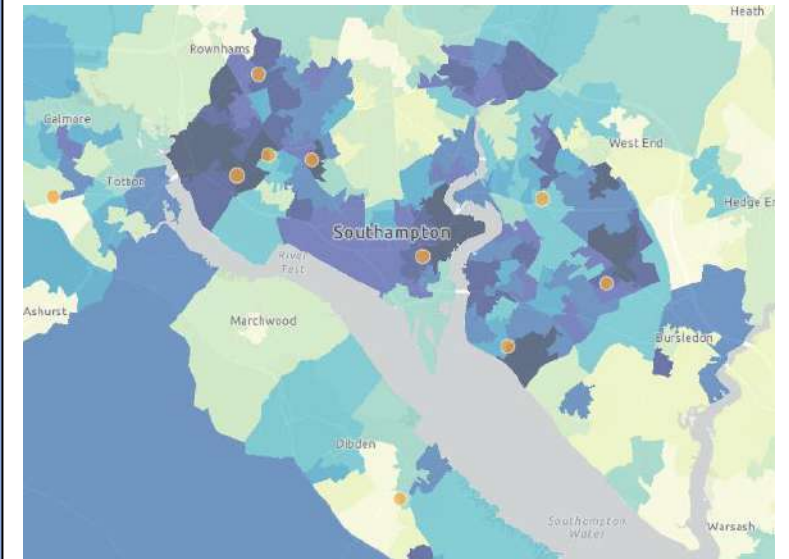


Figure 2: Registered GP practice for most walk-ins and IMD (darker areas are more deprived)

Conclusion

In times of increased pressure across primary and secondary care, it is important to consider whether patients are attending the most appropriate site for their care, and whether there are inequalities in access and outcomes. This project is a starting point to understanding who is accessing services and work is now continuing with hospital departments and partners to understanding any inequalities that exist within the system.

Transforming Biomedical Materials for Sustainable Healthcare: A Case Study of Healthcare Accessibility and Effectiveness of Potential Environmental Burdens

Fatma Deniz Aydın

Consultant: Dr. Seda Karadağ Kılınç

Objective

This study seeks to explore a comprehensive approach to addressing the environmental impact of technological advancements in healthcare, with a sample focus on achieving sustainability in two distinct Turkish cities.

This research project seeks to address the accessibility disparity in healthcare by reducing the production cost of blood count devices and other biomedical equipment.⁴ This objective will be achieved through the development of a novel material utilizing recycled plastics like PET (polyethylene terephthalate). The newly developed material will possess properties comparable to PEEK (polyether ether ketone) and polyamide, specifically high thermal resistance and strength. These characteristics make it suitable for a wide range of applications within blood count devices, including the probe frames, outer casing, visual display, lids, and associated components. It is important to note that blood count devices serve as a prime example; the project encompasses a diverse range of biomedical devices targeted for environmentally conscious material substitution.



Figure 2. Sample: Comprised of Recoverable Materials the Blood Count Device

Problem Statement

The contemporary healthcare landscape grapples with a pressing challenge: the burgeoning environmental impact of technological advancements. The escalated reliance on biomedical devices and materials not only exacerbates ecological concerns but also poses a threat to equitable access to healthcare services.¹⁻⁵ Unsustainable practices cast a shadow over the promise of advancements, hindering the realization of inclusive healthcare systems.

Methodology

Mixed-Methods Approach:

- Surveys: Assess demographics, healthcare utilization, and perceptions of sustainability.³
- Collaboration with local healthcare facilities and suppliers.
- Life Cycle Assessments: Analyze the environmental impact of common materials.¹⁻⁵
- Material Investigations: Evaluate biodegradability & recyclability.¹⁻⁵
- Comparison of inventory data from the cities Siirt and



Figure 1. Cities in Turkey (Siirt and Istanbul) from different socioeconomic backgrounds and have an enormous difference of population.

Goal

This research project endeavors to establish a healthcare ecosystem where equitable access to superior quality healthcare services coexists harmoniously with environmental stewardship. This objective will be pursued through a multi-faceted approach:

1. Enhancing Healthcare Service Availability and Utilization
2. Mitigating the Environmental Impact of Biomedical Materials
3. Promoting Collective Action for Sustainability

Results and Discussion

Informed by the detailed inventory data and survey findings, sustainability solutions are then evaluated. This evaluation focuses on identifying the most promising approaches to reduce the environmental impact of healthcare practices, ultimately promoting equality in health. This means ensuring that environmentally sustainable healthcare solutions are not only effective but also affordable and accessible to all populations, regardless of socioeconomic status.³ Samples of biomedical devices constructed from the identified recoverable materials are prepared. These samples undergo comprehensive recycling assessments, exploring all viable recycling methods to determine the most efficient and eco-friendly approach for each material type.

References

1. Gordon T, Booysen F and Mbonigaba J. Socio-economic inequalities in the multiple dimensions of access to healthcare: the case of South Africa. *BMC Public Health* 20.1 2020; 1-13.
2. Jayakrishnan T, Gordon I, O'Keeffe S et al. The carbon footprint of health system employee commutes. *The Journal of Climate Change and Health* 11 2023; 100216.
3. Ritmak N, Rattanawong W and Wongmanee V. A New Dimension of Health Sustainability Model after Pandemic Crisis Using Structural Equation Model. *Sustainability* 15.2 2023; 1616.
4. Roy M, Jin G, Seo, D et al. A simple and low-cost device performing blood cell counting based on lens-free shadow imaging technique. *Sensors and Actuators B: Chemical* 2014; 201, 321-328.
5. Teixeira S, Gomes N, Veloso de Oliveira T et al. Review and Perspectives of sustainable, biodegradable, eco-friendly and flexible electronic devices and (Bio) sensors. *Biosensors and Bioelectronics: X* 2023; 100371.

Background

- Studies have found that the prevalence of diabetes and diabetes-related complications are greater in BAME compared to White British communities.¹
- COVID-19 is reported to precipitate acute and chronic complications of T2DM.^{2, 3}
- A systematic review suggested that BAME individuals experienced worse clinical outcomes from COVID-19.⁴

Aim

To study the glycaemic control and biopsychosocial effect on Black Asian and Minority Ethnic (BAME) patients with diabetes after contracting Covid-19 infection.

Methodology

- Observational study of adult inpatients with diabetes admitted to Darent Valley Hospital from April 2020 to April 2021, with COVID-19 infection.
- Demographical and biomedical data were collected pre and post Covid-19 infection.
- A psychosocial questionnaire was used to determine the effects of Covid-19 on depression, anxiety, health beliefs and quality of life.

Results

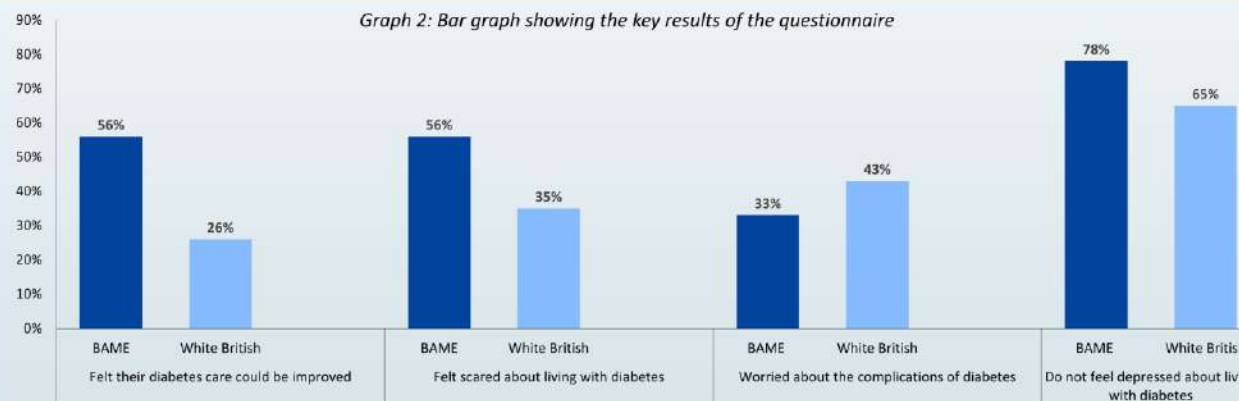
Graph 1: Pie Chart showing the annual attendance to community diabetes review.



Graph 2: Pie Chart showing the percentage of type 1 and type 2 diabetic participants.



Graph 2: Bar graph showing the key results of the questionnaire



- No difference in the mean change, between White British (WB) and BAME participants, in HbA1c (WB 2.52, BAME 9.44, $p=0.54$); BMI (WB 1.80, BAME 2.47, $p=0.77$); systolic BP (WB 2.63, BAME 4.86, $p=0.79$); and diastolic BP (WB 1.68, BAME 9.43, $p=0.25$).
- 87% WB and 89% BAME reporting "always" adherent to their diabetes medication.
- Less BAME (56%) than WB (26%) felt their diabetes care could be improved by further information about weight loss and diet.
- 56% BAME reported feeling scared living with diabetes compared to 35% WB.
- 67% BAME and 70% WB reported that diabetes had no impact on their emotional wellbeing.

Conclusion

- HbA1c, BP, and BMI of BAME participants with diabetes has not significantly worsened post COVID-19 infection, compared to WB participants.
- The unexpected better results in BAME participants, contrary to literature, is because this DGH had a fully functional diabetes service during the Covid-19 period.
- Even though BAME felt more scared living with diabetes, WB reported worse psycho-emotional impacts caused by their diabetes diagnosis.
- Similar access to community diabetes services was observed in both groups.
- More BAME than WB participants felt the quality of the diabetes services could be improved.
- Covid-19 did not have an expected negative impact on the care of BAME compared to WB participants.
- Covid-19 was not shown to worsen health inequalities in our population.

References

- (2020) Disparities in the risk and outcomes of COVID-19. rep. PHE publications. Available at: https://assets.publishing.service.gov.uk/media/5f328354d3b771b12a7023a/Disparities_in_the_risk_and_outcomes_of_COVID_August_2020_update.pdf - (Accessed: March 2024).
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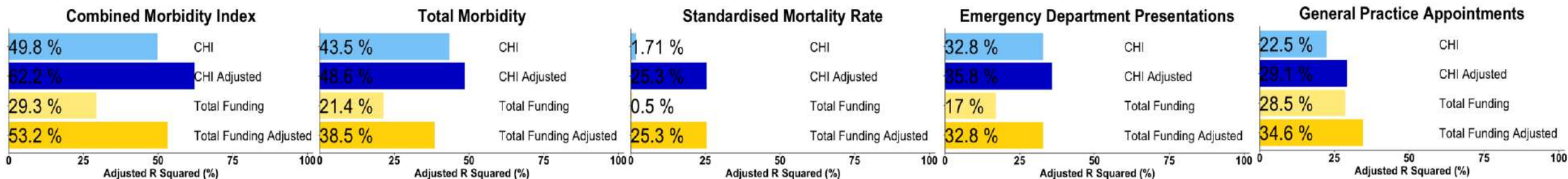
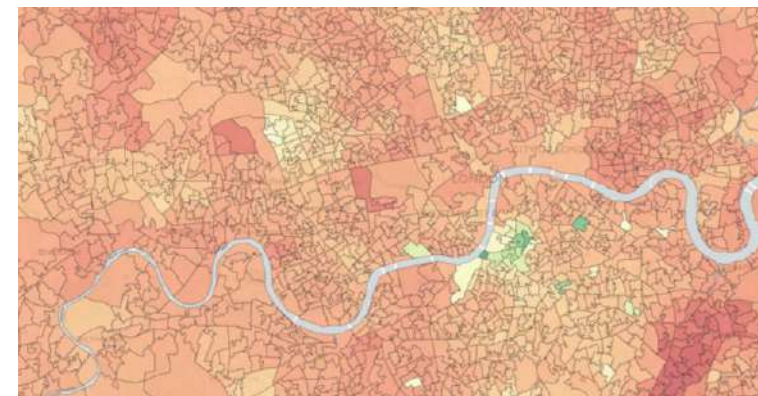
Background and Aims

- Approximately half of GP funding follows a capitation model (the Carr-Hill formula). Many have called for the addition of deprivation data.
- This study aims to assess whether adjusting either the Carr-Hill formula, or total GP funding by the Index of Multiple Deprivation (IMD), leads to a better prediction of clinical need.

Methods

- This cross-sectional study uses data from 32,844 Lower-Super-Output-Area (LSOA) in England in 2021-2022.
- Weighted mean Carr-Hill Index (CHI), total GP funding and five measures of clinical need were mapped to each LSOA.
- For both CHI and total funding, three models were calculated for each outcome - Model 1 was unadjusted; Model 2 adjusted for age; and Model 3 adjusted for age and IMD.
- Adjusted R² value assessed accuracy of each model. Increased R² values suggest a more accurate measure of clinical need.
- Adjusted R² values were compared across models to show impact of adding IMD.

Example of mapping: Total General Practice funding in Central London's LSOAs:



Findings

- The above bar charts show the difference in R² for unadjusted models (model 1) compared to age and IMD adjusted models (model 3.) Adjusting improved accuracy for all models.
- IMD and age-adjustment (model 3) improved R² compared to age-adjustment alone (model 2) for all outcomes.
- Capitation and total funding were stronger predictors of morbidity, moderate predictors of ED admissions and total GP appointments, and weak predictors of mortality.
- Total funding showed less robust predictive power for clinical need measured by morbidity, ED admissions, and standardised mortality rates but stronger predictability for GP appointments.
- Pre-pandemic sensitivity analysis confirmed findings.

Implications

- These findings offer the most compelling evidence to date that incorporating IMD within either the Carr Hill formula, or total-funding, would result in more accurate allocation proportionate to need.
- Total funding's lower accuracy to predict clinical need compared to CHI indicates inefficiencies introduced by pay-for-service and pay-for-performance mechanisms, and supports broader use of capitation models.
- Funding should better reflect long term differences in mortality rates.

Introduction

- Pulmonary tuberculosis (pTB) disproportionately impacts society's most vulnerable.^{1,2}
- Between 2016-2021 in England, **one third** of patients with pTB experienced a delay in starting treatment of more than 4 months.^{2,3}
- Median treatment delay was **72-79 days**, with little improvement in the last 6 years.³
- Improving TB detection is a key priority in England's TB Action Plan.⁴

Aims

- Assess the delays to diagnosis and treatment of pTB in our local service
- Identify where that delay lies (presentation vs. referral vs. diagnosis vs. treatment)
- Identify how delays affect communities at risk of health inequalities

Methods

- Retrospective review (Jan 2018-Dec 2021) of adults with pTB at two hospitals (KCH & UHL)
- TB databases crosschecked with electronic patient records & PACS
- Demographic data, referral information and key time points collected
- Analysed using MS Excel and Mann-Witney U (MWU) testing

Patients included

159 patients diagnosed with pTB
 43% spoke English as first language
 71% were born outside the UK
 75% had deprivation score of 1-4
 70% reported ethnicity other than white

Hospital	Treatment delay 2-4mo	Treatment delay >4mo
KCH	29%	29%
UHL	43%	28%

Table 1 Proportion of patients with a treatment delay of 2-4 months and of over 4 months

Demographic	Median diagnostic delay (days) - KCH	p value (MWU)	Median diagnostic delay (days) - UHL	p value (MWU)
Least deprived	64.5		93	
Most deprived	82	0.23	77	0.81
Born in UK	86.5		52	
Not born in UK	68	0.26	95.5	0.03
White	71.5		76.5	
Other ethnicity	68	0.44	88	0.50

Table 3 Comparison of the median diagnostic delay in different demographic groups at each hospital

Results

Median treatment delay

- KCH:** 71 (IQR 38-147) days
- UHL:** 89 (IQR 58-159) days

Delay	KCH	UHL
Presentation	52.6%	58.2%
Referral	29.8%	22.6%
Diagnosis	15.9%	15.6%
Treatment	1.7%	3.6%

Table 2 Percentage time attributed to each delay

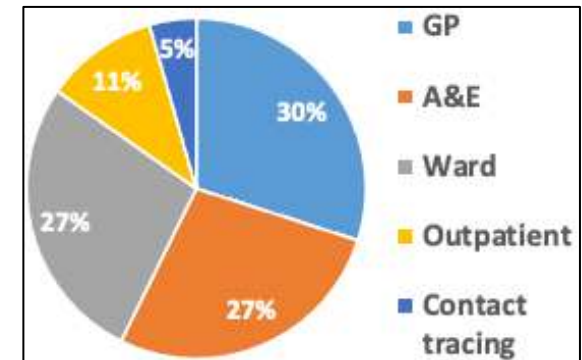


Figure 1 Source of referral to TB service

Limitations

- Limited sample size
- Inconsistencies between TB database and electronic patient records
- Information is subject to interpretation, recall bias and data entry error, dependent on patients and healthcare professionals

Conclusions/Next steps

- TB services at both hospital sites reflect the national picture on treatment delay
- Delays in presentation and referral are most significant contributors
- Second phase of our study involves semi-structured interviews and focus groups with pTB patients and stakeholders (e.g. GPs, community services, A&E)

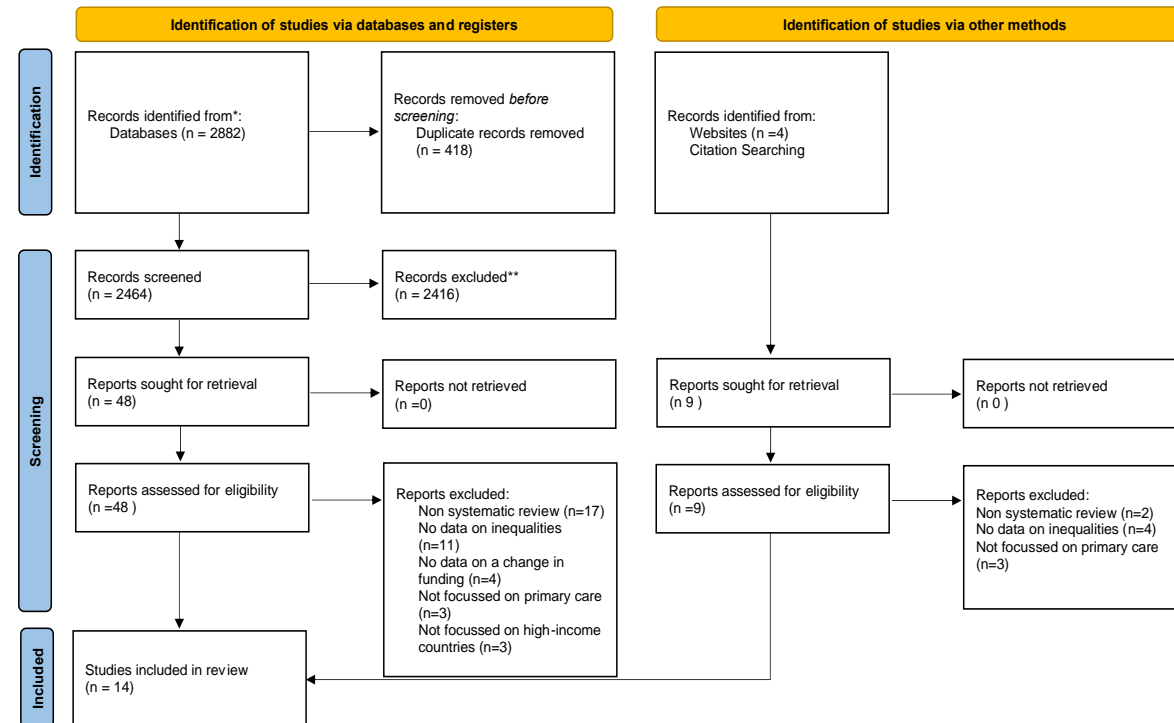
Introduction

Variations in funding impact Primary Care performance, contributing to and exacerbating existing health inequalities. Primary care is predominantly financed by three groups of funding models – Capitation, Payment for performance and Fee-for-service. Our aim is to systematically evaluate all reviews available on the effect of changes to GP funding systems on inequalities in funding, access, outcomes or experience.

Methods

- 3 electronic databases (Ovid Medline, OVID Embase and Cochrane reviews) were systematically searched in January 2024
- Reviews in any language that assessed the impact of changes in primary care funding on inequalities in funding, access, experience or outcomes in high-income countries were included as per the eligibility criteria
- Abstracts and titles were double-screened
- 2 authors independently screened full-texts, extracted data and performed quality assessments using the AMSTAR2 tool
- Outcomes of interest: any change or difference in inequality occurring due to a change in primary care funding

PRISMA 2020 flow diagram for new systematic reviews which included searches of databases, registers and other sources



Findings

- 1 review compared funding models (capitation vs fee-for-service)
 - Capitation plans were more equitable than fee-for-service plans for patient access, continuity and quality of care and patient satisfaction
- 12 reviews investigated the effects of pay-for-performance, mostly investigating the introduction of the Quality Outcomes Framework (QOF)
 - Overall, QOF's implementation coincided with reduced socioeconomic inequalities in England, but not Scotland. Inequalities in age narrowed, while inequalities by sex persisted or widened
- 1 review investigated the effects of fee-for-services and the effect of targeting funding to minority groups
 - Specifically targeting funding to minority groups reduced inequalities
- 1 review investigated the effects of Swedish reform to allow privately funded primary care and increase patient choice of provider
 - Allowing private general practices resulted in Increased inequality

Implications

- Our review showed that capitation models are associated with reduced inequalities compared with fee-for-service
- It synthesized the findings of changes to inequalities that occurred after the introduction of QOF, highlighting areas for improvement which could help guide future pay-for-performance schemes
 - It demonstrated that specifically targeting funding at minority groups is successful



Child and maternal malnutrition as a cause of sudden infant death syndrome: A comparative analysis between the commonwealth low income and high income countries from 1990 to 2019.



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Introduction

Sudden infant death syndrome (SIDS) is the terminology used for the sudden death of a baby younger than 1 year of age due to unexpected and/or unexplained causes. Although it usually happens to babies within the first 6 months of life, it can happen up to the first year of age. Child and maternal malnutrition could be part of the unexplained causes because of the dietary deficiencies, child growth failure, suboptimal breastfeeding, low birth weight and short gestation. The aim of this analysis is to **compare the disparities between the commonwealth low and high income countries with child and maternal malnutrition as a cause of SIDS.**

Materials & Methods

Data was extracted from Global Burden of Disease Study 2019. The number of deaths and DALYs (Disability-Adjusted Life Years) were analyzed by age, year and location from 1990-2019 in the population of <5 years including males and females from the Commonwealth low and high income countries. To analyze the burden trend, annual percentage change (APC) was used.

Results and discussion

- The number of deaths both from commonwealth low and high income countries displayed a **downward trend over time.**
- **Commonwealth low income** countries had a notorious higher number of deaths with an APC of -41.21% (95% UI: -62.63-(-12.74)) from 346.90(95% UI: 51.28-1,105.07) in 1990 to 120.12(95% UI: 10-10) in 2019.
- **Commonwealth high income** countries had an APC of 47.60% (95% UI: 12.94-89.46) from 89.32(95% UI: 78.39-99.67) in 1990 to 17.66(95% UI: 14.05-21.84) in 2019.
- **DALYs:** both locations exhibit a downward trend which is definitely a positive outcome, although, the commonwealth low income countries still retain a higher number compared to the commonwealth high income.

Conclusions

The **commonwealth low income countries demonstrated higher numbers across the years even though the trend was downwards.** With these comparisons, it is proven the disparities between these locations and how the health system still has to work through different mechanisms to decrease the number of deaths and DALYs. **More resources need to be allocated to prevent child and maternal malnutrition** so sudden infant death syndrome could be, hopefully, reduced to the lowest rate.

References

Global Burden of Disease Collaborative Network. 2020. Global Burden of Disease Study 2019 (GBD 2019). Seattle, United States: Institute for Health Metrics and Evaluation (IHME). [Accessed Feb 20 2024]

Let's Voice It- Bridging the Cervical Screening Health Inequality among Sexual Minority Women



Monisha Tarini Premkumar (Medical Student) and Dr. Deepak Kumar, Anglia Ruskin University School of Medicine



Introduction

King's Fund defines health inequalities as 'avoidable, unfair and systematic differences in health between different groups of people'.¹ This includes sexual minority women. Their identification has huge negative impacts on the healthcare they receive. Cervical screening is a national programme to detect cervical cancers using smears. This uptake is lower among this minority (15% were eligible but did not receive), compared to the general population(7%).² This is a global issue. **It's time to improve.**

Aims and Objectives




- To highlight the main contributory factors to healthcare inequalities in cervical screening which affect sexual minority women
- To identify potential methods to minimise them.

Methodology

Literature review conducted using relevant keywords on electronic scientific databases (Medline, PubMed, Embase and Cochrane Library) to obtain peer-reviewed articles in English from 2008-2022. Inclusion and exclusion criteria were exercised to acquire the pertinent data.

Results

Thematic Analysis of Barriers (three levels)-Healthcare professionals (HCPs), Client and the NHS

Level of Barrier	Cause of barrier	Potential solution
1. Healthcare Professional 	Lack of knowledge Scientific information misconception Unconscious bias	Education & training Self-help resources Explore and use client preferred pronouns ⁵ Mandatory inclusive culture modules
2. Client 	Lack of knowledge Emotional barriers ³ Identity confusion ⁴	Purpose oriented leaflets Self-help resources-digital app School & Primary care psychosexual service
3. NHS System 	Group specific National Database Lack of service flexibility Environmental issues Time constraint	Collaborative 'Healthcare Protected Characteristics Database' Mobile screening van, self-testing kits Promote healthcare job opportunity for sexual minority group Double slot at request

Three levels of Barriers

Lost the Opportunity to Save Lives & Money!



Conclusion

This emerging healthcare issue must be addressed promptly and sensitively to deliver equitable prudent healthcare among sexual minority women, to align with the NHS's core values.

Reference

1. The King's Fund (2021) 'If you're not counted, you don't count': what can be done to tackle LGBTQ+ health inequalities? If you're not counted, you don't count': what can be done to tackle LGBTQ+ health inequalities? The King's Fund (kingsfund.org.uk) [Accessed: 21/10/2023].
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This emerging healthcare issue must be addressed promptly and sensitively to deliver healthcare aligning with the NHS's core values to sexual minority women.



Scan this QR Code To Contact Me



Hospital at Home (HaH) and point-of-care diagnostics, creating Sustainability within healthcare



Dr Sovrila Soobroyen | H@H GP
Harriet Slade | Deputy Service Lead H@H
Dr Rebekah Schiff | Consultant Geriatrician

Introduction

HaH embodies a **transformative approach** to healthcare delivery, facilitating **early discharge** and **admission avoidance** by offering **hospital-level diagnostics** and treatment within the community. This innovative approach not only **expands treatment options** for patients but also accelerates the goals outlined in the NHS 10-year plan, aiming to **enhance the sustainability** of our healthcare system by **bringing care closer to home**.

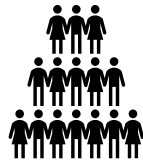
Method

The Guys and St Thomas' team explored the use of Point-of-care (PoC) diagnostics to establish whether it would support **early discharge** and **admission avoidance**, enhance **patient flow**, **optimise capacity** and **reduce our carbon footprint**.

- ❖ **Retrospective cohort study** including all patients referred to HaH for urgent 2 hour assessment
- ❖ **Intervention** : point-of-care diagnostics
- ❖ **Key outcome measures** : Hospital admission, early discharge, immediate treatment, early palliative care involvement
- ❖ **Demographic data** collected

Results

152 Patients



9 Admissions



67% Change in Outcome

54% Early therapeutic intervention
30% discharged
8% streamlined to other services

74% CFS 6+



Conclusion

Our study underscores the pivotal role of POC testing in **enhancing early diagnoses** & broadening the scope of therapeutic interventions for patients managed within their homes. With a significant proportion of patients experiencing tangible improvements in clinical outcomes, our findings highlight the potential for POC testing to **revolutionise care delivery**, particularly for frail patients. Overall, our commitment to home-based care contributes to a **sustainable NHS** by **optimising resource utilisation**, **enhancing patient outcomes**, and fostering a **patient-centred approach** to healthcare delivery.

