Transcript of podcast episode 5:
The impact of healthcare inequality on patient safety
with Dr Helen Stewart, Dr Cian Wade and Dr Mimi Malhotra
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Natalie Wyatt

Welcome to your RCPCH patient safety podcast, where we delve into the successes and challenges of creating a healthcare environment that is safe for children and young people.

Jonathan Bamber

I am Jonathan Bamber, Head of Quality Improvement at the RCPCH. I have a background in research into patient safety and quality improvement.

Natalie Wyatt

And I'm Natalie Wyatt, Quality Improvement Fellow at the RCPCH and Paediatric Registrar in training in London.

Jonathan Bamber

In this episode, we're going to talk about the relationship between health inequalities and paediatric patient safety. We know that health inequalities are worsening for children and young people in the UK. And we see a clear inequality in the risk of harm from healthcare linked to health inequalities.

Natalie Wyatt

To explore this further, we are delighted to be joined by Dr. Helen Stewart, Dr. Cian Wade, and Dr. Mimi Malhotra. Helen is a consultant in paediatric emergency medicine at Sheffield Children's Hospital, and she also has an interest in public health and health inequalities, which has led her to become the Officer for Health Improvement at the RCPCH. Cian and Mimi have both completed National Medical Director Clinical Fellowships with NHS England and the Health Foundation respectively. Cian is a Fulbright Scholar who recently completed a Master of Public Health at Harvard University and now consults for health systems and healthcare providers. Mimi is working as a respiratory trainee in London in addition to her honorary clinical lectureship at UCL. We're delighted to have the three of you with us today. Thank you so much for joining us. And to get us started, we wanted you, maybe, obviously I've given you a little introduction, but maybe just tell us a little bit more about yourself and how you became involved in looking at health inequalities. Helen, do you want to start us off?

Helen Stewart

Sure. Hi. Yeah. Thanks for having me. I am a consultant in paediatric emergency medicine in Sheffield at the children's hospital there. I also work as a transport doctor with the Northwest Critical Care Transport Service. And it was, that essentially that got me into health inequalities. Um, as a paediatric trainee, you are slightly removed in that there's a filter before a patient gets to you. But when you're in the emergency department, that filter is removed. Everyone's just rocking up whenever they when they need to. And quite quickly, I became aware that the patients I was seeing were most frequently from the poorer parts of the city. And I think, and it kind of got me thinking about it and thinking, how is that happening? What's the reason? And I started looking at some different bits of work, uh, Michael Marmot particularly, and just increasingly became aware that this was actually a public health issue. And slightly selfishly, if we can improve people's health, we can prevent them all having to come to the emergency department. So, um, I got a lot of quizzical looks, I would say, from the start. Um, people did not seem to comprehend how someone who is an emergency physician could be interested in public health. No one seemed to see that those kind of went together. And I felt very much like a lone voice for a while, but as kind of the last 10 years have gone on more and more people, and actually I'm having conversations with more and more emergency physicians, both from RCPCH and from RCEM, who have developed down a similar pathway and interest in public health. And from that, I got onto the Health Improvement Committee and then recently took over as the Officer for Health Improvement. And part of that for me was basically demonstrating that it's for everyone to think about. It's not just for, you know, community paediatricians or kind of similar services. It's actually. everyone's job to think about it and think about how your patients are affected by it.

Natalie Wyatt

Yeah, absolutely. And I think that's why it's very interesting today to have some colleagues with us today who are not from the paediatric arena. Really amplify what you said that everyone needs to be thinking about it. So Mimi and Cian, do you want to tell us a little bit about how you got involved?

Cian Wade

Sure. We were both junior doctors at various stages of our training, and we both were lucky enough to be appointed to the National Medical Directors Clinical Fellowship. Uh, so I, Mimi can tell you about her. placement, but I was with the National Patient Safety team in NHS England and had a broad interest in health improvement generally. But when I arrived there, I think there was an increasing focus off the back of COVID to understand a bit more about what patient safety had to offer within the health inequality space. We'd known for many years and it had been well measured through major audits about the differential, uh, risks from childbirth that black mothers experience compared to white mothers. And we really wanted to, to dig a bit deeper into this to understanding why it is that it seems the first duty of a, of a doctor in a health system, which is do no harm, was not being, uh, applied um, in the same way across different parts of our population. And we also saw it as one of these very complex adaptive issues in which, um, you need to be able to convene multiple different stakeholders, take a rigorous empiric methodology to the approach of understanding it and doing something about it. And I think patient safety is, is used to doing that, has, has built up that, that toolkit and those muscles for, for a few decades now. Um, and so we were lucky enough to have a very interesting program of work to, to look at a bit more at that. Um, and I'm sure we'll, we'll get into what, what we found and what, what we're doing moving forward in this podcast.

Natalie Wyatt

Absolutely. I look forward to it. And Mimi, do you want to share your story?

Mimi Malhotra

Yeah, great. Well, thank you both for having us on the podcast to start off with. As you said, I'm an academic respiratory and general medicine registrar. And I think my interest in health inequalities actually started before medical school. I lived within greater

Manchester and did lots of volunteering for a community youth group. And I think it was there that I just realised actually that depending on social circumstance and those social determinants of health people would go on to have very different trajectories. And I think, I know every medical speciality would probably say they're the best speciality or they're important to health inequalities. But I think one of the reasons why I was so drawn to respiratory medicine was because of the patients we see, whether that's those with asthma exacerbations, COPD exacerbations or tuberculosis, as Helen was saying as well, it definitely is patients from kind of lower socioeconomic classes, which I think is really important. I also have family in India, so I think going back there and visiting them just means you see things a little bit differently. And I think what was surprising for me is that actually some things you don't see at home, but when you've had one of those experiences and you come back, you just notice things. To me it was really interesting that people in India would say how great our healthcare system was or how great the UK as a nation was, but then I would be walking around the streets of London and you definitely see poverty day to day. I think Cian gave a very good summary of our time. with the National Medical Directors Fellowship. The reason why I went to the Health Foundation was to explore health inequalities a little bit more. I think what really helped to lead up to the BMJ analysis piece was actually probably COVID 19. The pandemic really shone health inequalities into the light. And I think that encouraged all parts of NHS England to think about it more consciously and to adapt it into their work stream, which I would like to think would have happened anyway. But I think COVID was definitely a catalyst to get people talking about it.

Jonathan Bamber

Can I follow up on that Mimi? Did you find that your interest in health and inequities naturally drew you into patient safety as a good fit to as focusing on health inequalities or do you think that it's kind of slightly coincidence that you were focusing on patient safety?

Mimi Malhotra

I think Cian and I had a really good relationship during the fellowship and I think it was, it just felt like an area that wasn't really being talked about. We talk a lot about the social determinants of health and how that contributes to health inequalities. At the Health Foundation, we talked a lot about how actually healthcare was probably only responsible for 10 to 15 percent of someone's health. And so I felt like a lot of the focus was away from us. And I think as a group of junior clinicians on the scheme, it was actually quite important to identify things that we could do and we could take back to our colleagues. And I think for me, that's why the work with the patient safety team was so interesting. I

think in some respects it is controversial and I guess it edits if the BMJ manuscript were maybe more probing than the one that was finally published, but we were really wanting people to critically think about the care we're delivering and how we can optimise that. And I think one of the arguments in the UK is always is how can you increase everyone's kind of care experience to level it up, or are you actually going to level some people down? And I think that's still something that I'm grappling with at the moment, but actually the patient safety lens was a good way to promote people to think about how everyone can get a minimum kind of baseline level of care.

Jonathan Bamber

That's really fascinating. So if I understand you correctly, that there's, there's a, there's a double aspect of that, that not only is it a tangible focus for health inequalities that mean that healthcare professionals can directly be involved in gaining traction on that problem and introducing change, but also there's, are you saying that there's more of a potential for a measurement to see that if you're introducing change it is actually an improvement?

Mimi Malhotra

Yeah, 100 percent and I guess going back to what Helen was saying earlier, sometimes focusing on public health can seem like an extra, and I think by embedding it in patient safety and thinking about hard outcome measures, which we do anyway through guidelines, gives us a way in to think about it and potentially attract audiences that do think of this as more as a humanity or social science discipline.

Cian Wade

And just to, just to jump in there, if that's all right, I think we like framing it in the way of accountability and empowerment. Patient safety's angle on health inequalities means that there's a clear line of accountability to people deploying healthcare, right? So providers, in a way that previously when health inequalities was kind of thrown up, they were like, “Well You know, it's a very complex issue. Government have a lot of responsibility over inducing a cross-sectoral approach to this.” And that's undoubtedly true around, you know, a huge contributor to health inequalities around lots of the social determinants of health that we speak about a lot. But it also means that there's this other fraction of it that that is clearly in our backyard as providers. So that's the accountability piece. And then the empowerment piece is the fact that we have these patient safety frameworks, um, with rigorous empiric methodologies underpinning them that actually do give, uh, the ability for providers to do something about it. And so I think that that sort

of two pronged approach means, it's a sort of disturbing reality that there's, uh, this underexplored angle that, that providers in some way may be responsible for, but hey, look, we've got all of these fantastic methodologies and, and a great foundation to actually go on and do something about it.

Natalie Wyatt

I'd love to take this moment as well, just for the people who might be listening to this podcast for whom all of this is uncharted territory. Um, it'd be great, Helen, if you could just start us off just telling us about what you think are the most important or impactful health inequalities in the UK and how that's affecting the health of our children and young people here.

Helen Stewart

I think in the UK, in the past, we've been slightly guilty of thinking, well, we have the health service. It is free at the point of use. Therefore, everyone has access to the same standard of health care. And actually, increasingly, as I looked into it, I realised they don't. People don't have equal access to a general practice. We know that the more deprived areas of the country have less GPs per head of population. And we also know that people need greater access to GPs in these areas. So they are more likely to come to the emergency department. And I think their work on patient safety, picking out those points of actually people who may have had negative experiences, they feel less inclined to access it. So there's, there's an inequality in itself. So I think that's the first hurdle. So actually people don't have the same access. So what can we do about it? In terms of inequalities in general in this in this country, I think the biggest one, the biggest cause has to be to do with poverty. Um, I'm sure you know the RCPCH has had a big project on child poverty over the last year, and it feeds into everything that we do, basically. Like, we know that children with asthma from poorer backgrounds are going to suffer worse outcomes because they have less access to green space, they live in more polluted areas, they live in more overcrowded housing, they live in poorer housing. So all those things interlink. And as Mimi said, so little of health outcomes is to do with health care itself. It's actually to do with the circumstances that they're living in. If you have diabetes, but you are not able to access healthy food, then that's going to be a big issue. Um, it's going to really impact on your outcomes going forward. There's some intersectionality with that, obviously, like, for instance, we know that people from certain ethnic minorities are more likely to be poor, so they're suffering the impact of racism as well as the impact of poverty, which are also linked together. It's a hugely complex issue, but it ultimately results in children from a more deprived background accessing the emergency department more, um, having less access to GPs, having worse outcomes long term, having worse outcomes

in school, a hungry child can't learn, someone who's struggling to feed their children. Um, they can't learn. They're going to be, have worse health. So it's just a whole complex system that interplays with each other.

Natalie Wyatt

Absolutely. And I mean, some of those things that you've listed, obviously, you can see that major piece on how that will impact on the chance of, of delivering care and improving health. And we've been seeing a lot in research, more probably around adults than in children, that these embedded inequalities are also increasing the risk of actually coming to harm within healthcare settings once they've accessed them. So, I mean, there's been quite a lot of studies, I think, out of the U. S. and Canada.

Cian Wade

Yeah, so the evidence around this area is interesting because a lot of it is coming out of the U. S. There's a good amount of European stuff as well and some well-known studies in the U. K. so just to pick out, I suppose, some of the headline figures, if you like, in some ways. So we know, for example, that black patients compared to white patients, that risks of various perioperative complications such as pulmonary emboli are around 28 percent higher perioperative sepsis, 24 percent higher. Um, we know that risks of adverse drug events, for example, are around a third higher as well. So throughout a variety of different sort of in hospital, potentially in hospital harms, you can see a systematic bias towards increased risk. Within the UK, the EMBRACE study that's performed, um, every year has consistently demonstrated beyond the threefold increase in risk for maternal death for black compared to white mothers. Um, and then there's, there's other very, very shocking data around the reduced likelihood of bystander CPR in, in patients, um, who, who are black compared to white in the community. Um, which is complex in terms of its underpinnings. Um, it's, it's likely to do with the different density of individuals around, but also things such as, um, education around, uh, cardiac arrest and CPR and so on, as well as possibly some biases within the population. So, what we did is having seen all these different bits of evidence that start to paint this tapestry of this systematic, um, increased risk of, of critical sort of patient safety events as we'd regard them. Um, we, uh, and we can come and talk, I think, a little bit about like how, how the evidence could be improved as a foundation there, but we were satisfied from looking at, uh, across these different types of studies, these different countries, um, these different settings of care, across these different types of measures at harm, that there was sufficient evidence there to say that we've got a firm foundation to, to improve off, um, with, with that baseline understanding.

Natalie Wyatt

You mentioned obviously there the foundation of evidence being a, a challenging thing. I mean, do we have much of an understanding about patient safety impacts specifically on the child, the child population within our country to your knowledge Cian or Helen, if you have any insight here?

Mimi Malhotra

I was just going to say, particularly in populations such as those with sickle cell disease and delays to giving opioid and analgesia. And I think for me was definitely really shocking. I think where the data is difficult is that is less of a hard outcome than, for example, something like mortality from sepsis or mortality following a cardiac arrest. But I think we need to start to recognise that actually that time interval from presentation to A&E to first dose actually is a hard outcome. And we need to start to use measures like that more effectively.

Helen Stewart

Yeah, I'm certainly not aware of much evidence in, specifically in terms of patient safety, um, in the paediatric population. And I think that's something that, um, we probably need to think about. a bit more. Um, and I've actually taken that question to my own, to the Health Inequalities Forum at our local trust to say, actually, do we do this? I'm not sure that we do look at our patient safety data through an inequalities lens. So, um, yeah, that's something I'm going to be taking back locally for sure.

Cian Wade

Yeah. So two points to make on that. So, so firstly, even in the adult population, we hypothesise at least there is dramatic under reporting of, um, patient safety events that would be regarded as, I suppose, related to this, this health inequalities work. And part of that is to do with the fact that a lot of patient safety events need to be raised at the point of the patient. So a family member noticing something or the patient noticing something, and if you're already thinking about a disadvantaged patient population in some ways who find it difficult to raise concerns because of perhaps historical distrust of the health system or communication barriers, then you're going to get a shift away from the sorts of events that are being raised by the patient groups and a shift away from an understanding and an ability to measure those events that are disproportionately affecting patients affected by by health inequalities. Um, and then the second point there,

Helen, around measuring at all. Even when patient safety events are raised, very rarely do we find that things like, um, patient ethnicity or socioeconomic background are actually attached, um, to those reports. And so again, understanding whether this is an inequities issue or not is, is also difficult from that data.

Helen Stewart

Yeah, absolutely. And, um, we definitely have to look at the data to understand if we can even. pull that information and maybe make changes to our system. We have been doing it, um, recently because we are aware that our recording of ethnicity is quite poor. So that's been a big focus of the health inequalities work, just so we can really understand the impact on our local population. Kind of the other angle of that is we've had some conversations with the local communities by going out through faith-based organisations, etc, to understand their experiences of the trust. Um, and that has been quite difficult on occasion, um, quite hard to hear, but it's been really educational and actually incorporating some kind of patient safety questions and about their experiences into that might be another angle that we could, um, use.

Mimi Malhotra

I think one of the really easy things that people can start to look at almost yesterday is actually a patient's postcode, and that's something that I see cropping up quite a lot now in academic papers but I don't think we necessarily pay that much attention to it when we're seeing patients kind of at the front door. And I don't know how much of that, I think, especially as a junior doctor when we're rotational, we don't necessarily know the area that we're in that closely, but I think as you are becoming more senior, then that's something that can also avoid or help you guide your conversation to find out where exactly in your community a patient is living. In London that's been linked to air pollution, in particular kind of busy streets that might exacerbate kind of respiratory health, both in the adult and child population. And I think that's something that we can look at now, because everyone with an NHS number will often have a postcode attached to that as well.

Natalie Wyatt

I think that Helen is, correct me if I'm wrong, but that is an excellent piece of work that has been done within the RCPCH, creating that mapping to help clinicians understand their areas better from an inequalities perspective?

Helen Stewart

Uh, yes, it's a work in progress. We do it locally to understand our populations. But, um, and it is quite straightforward to do actually, because I've done it on, um, a project working, looking at our emergency department missions. Um, there is a government tool that you can just feed in a load of postcodes and it feeds back the socioeconomic circumstances, which was fantastic. But yeah, something that's accessible, um, is something that we're, we're working on that will hopefully give information about air quality, um, pollution, um, deprivation, education, those kinds of things.

Natalie Wyatt

That sounds a very useful step forward in kind of trying to develop that, that evidence base that helps us. One of the other things that we often think about when problems arise, like you mentioned at the beginning, COVID 19 bringing quite a few things to the fore. One of the issues around the care that we deliver is that often the treatments, the devices, the decision-making tools are all based around specific populations, generally white male populations. So they're inherently excluding any consideration of health inequalities. I think with COVID 19, lots of research around the inaccuracies. of pulse oximetry in darker skin tones and how that might then affect somebody's ability to receive timely respiratory support. I think that was a big piece that came out of obviously this international emergency. But it's very interesting to think about these issues and how we can address this. And it's already a big issue in paediatrics anyway, getting inclusion of children within any kind of device testing and clinical trials. But I wondered whether you'd had any exploration of how you think this is impacting on health inequalities for children and their safety within health?

Mimi Malhotra

I think leading up to the analysis piece with kind of stakeholder engagement, one of the main things was actually going right back to just representation and diversity of the workforce. And I think that's something that everyone says, but even in the latest kind of workforce review isn't necessarily something that is easily actionable. And as well as the pulse oximetry work. We know that there's been lots of work on kind of dermatological skin manifestations, how they might look on different skin types. And I think that in some ways does need to come from the communities involved because I think it's right that we give them a voice to share their experiences, but also their knowledge. Um, and I think that's something that traditionally, as you said, we've not been very good at. doing. I think for me, that's one of the major steps. And I think it also helps patients anecdotally to relate

to their healthcare provider. And it goes back to what Cian was saying about, we heard a lot about mistrust often. And I think having someone from your community or someone that looks like you or speaks like you, or you might aspire to be like if you're a child in the future, really helps break some of those barriers and should actually be quite simple to do.

Helen Stewart

Yeah, I was going to mention the dermatological aspect, as you were saying, because that's been a big topic in paediatrics in recent years. And there is now a fantastic resource called Skin Deep that does have a lot of pictures of different dermatology conditions in different skin colours. And it's not something I'd really considered before. I think you don't know what you don't know. And seeing the difference and the impact that's had has been really enlightening.

Cian Wade

I think it speaks to a broader narrative of, as well, of the foundation upon which medicine was founded, if you like, in terms of building up that evidence base, was, well, is still systematically skewed away from certain patient populations. And it's fed into quite an interesting concept called the race-based model of medicine, which we raised in our analysis piece, which is the idea that race is a biological construct rather than the social construct that it actually is. And that has led to lots of assumptions being made along the journey of knowledge development. And the most obvious one, I think, is around, for example, estimated glomerular filtration function. So, the very, very commonly used measure of kidney function. Um, and there is an assumption made somewhere along the line that because, um, parts of a greater overall muscle mass that actually that should be up adjusted in, in, in certain black patient groups. And actually that leads to the point at which, for example, referrals for renal replacement therapy or kidney transplantation would actually be systematically delayed in black versus white patients. Um, almost certainly leading to harm and very recently now I think NICE have, have decided that adjustment shouldn't happen, um, because it didn't have any empiric basis. No very rigorous studies were done, but it was just part and parcel of transmitted medical knowledge. And I think we're starting to now see with greater consciousness of these issues, with a greater need to see the evidence that actually underpins any of these uh, differences that would, that, you know, probably don't exist across, uh, different races that we're actually starting to unpick that and starting to, um, make sure that the, the medicine we're practising doesn't carve out these inequities, um, in the, in that sort of way.

Jonathan Bamber

Yeah, it's a fascinating point within your paper around that distinction of, uh, focus on the social, socially constructed aspects of thinking about racism and discrimination. Do you find that that's something that in your day, like in, in day to day conversations on how to find solutions, that that's, that's the aspect of change that people are more comfortable with, with getting involved in, whereas the more kind of implicit bias and communication problems are more of a challenge or?

Cian Wade

Some of the, especially some of the work we did around biases, so these unconscious biases that lead to differential care, so for example the fact that black patients are half as likely to receive opiate pain relief compared to white patients despite presenting in essentially the same way. That is a tricky thing to present to a provider, right? It is a very sensitive and emotive topic, whereas if you depersonalise that slightly and say, well, the way you were taught in these sort of bodiless curricula, which are at fault, then it becomes slightly easier to deliver potentially. I think the reality is though is that we're in a space, um, which is uncomfortable and I think discomfort is a good thing because discomfort means that people are seeing things in a different way. And it generally means that you're actually raising these issues and leveraging them in a useful way towards change. So I think, try not to shy away too much from the discomfort. But certainly, you know, the race based model of medicine and then converting that to a race conscious model of medicine in which you're just thinking more proactively through your practice it has been a good entry point for, for when we've presented this and discussed this with different groups of providers.

Jonathan Bamber

And is this something that currently has more traction within the US in the time that you've been out there? Or is it something you think that UK providers are willing to start that conversation? Because it's quite a big shift in thinking, right?

Cian Wade

It is a big shift in thinking. I'd say the US has got better data on it. And I'd say that the conversations are progressing in both countries. I'd say that the general incentive structures in the UK and just the way in which you are able and given the freedom as a provider to explore areas around health inequities within the sort of improvement

frameworks that I think the National Health Service has means that I see perhaps more energy around this issue within UK hospitals, but that's not to say that the U.S. are not very conscious of it and are not moving in the right direction as well.

Jonathan Bamber

And this might be a good point sort of to move the conversation to talk about the solutions and if there are examples of approaches to improve health and equality with a patient safety lens. Um, I know that there's a recent example around Greater Manchester, uh, in narrowing health inequalities with taking kind of large-scale change approach and, uh, redesign of systems. I was wondering if anyone has any thoughts on what approaches would be effective in achieving sustainable improvements in patient safety around health inequalities?

Natalie Wyatt

Mimi, you mentioned that you volunteered within Greater Manchester, which is very interesting. Obviously, you may have been, I don't know if you were there during that, that period of decentralisation of healthcare, which seemed to, um, or decentralisation of public services in general, which seemed to have narrowed at least some of the inequalities in health within Manchester. So I don't know whether you were involved with that?

Mimi Malhotra

For sure. I think in the analysis piece, we divided action up into three levels, kind of thinking about the individual, which we've talked about a little bit. And I think why linking health inequalities with patient safety was quite good, at least for talking about this amongst colleagues and kind of general advocacy. And then as you were alluding to Natalie, what we can do, whether it's like volunteering and things at a local level. And then we wanted to talk a little bit more about healthcare leaders, I guess, people with a voice, people who can influence. local policy, or at a provider level, and then we wanted to think more broadly about the system, which I would, in my mind, kind of include some of the things we were talking about around, like, data collection and research, um, more broadly. I think one of the other things that maybe we miss in all of this is That I think for a few years the landscape has focused on individual patient responsibility or individuals within society and their responsibilities, especially in the public health forum. And I think we really just need the conversation to shift to this being a like political and societal responsibility to tackle health inequalities. And I'm not necessarily sure how that's kind of

reflected in paediatrics, but I think it's some of the things that I guess I hear about are like the sugar tax, food labelling, links to poverty that way, unhealthy behaviours. As a respiratory physician, I'm absolutely shocked at the number of children currently vaping these new cigarettes. And we don't really have much in the political landscape about that. And I would say, by not having a kind of political framework to talk about that, we are actually, again, causing harm to society. Because we're the people that should have a voice and should be putting up restrictions. But we're not, and I guess that's another way of thinking about patient safety as well.

Natalie Wyatt

Helen, I know you've been in Parliament recently talking about vaping, having Mimi just brought this up. I wonder whether you have any reflections on what Mimi has said?

Helen Stewart

Yeah, I had the opportunity to go and speak to the Health and Social Care Committee about vaping. Some of that was about inequality. It mainly focused on, kind of, respiratory health and, um, the environmental impact as well. Which is another, kind of, area of, that's going to create a lot more inequality, isn't it? And impact the most deprived sections as well. Um, yeah, so I think, in terms of policy and legislation, there's been some difficulties recently, for sure. I think there was a feeling that after COVID, it was maybe a great time to kind of push some of this with, um, the inequalities being so starkly raised by COVID. And so there was talk of the inequalities white paper. Unfortunately, that's not going to be released anymore. and it is being replaced by a major condition strategy and so from a paediatric perspective it does feel like we're taking a couple of steps back in terms of legislative levers that we can use to hold people to account about some of this stuff. A big part of the college work is about trying to advocate for children at a national level. And we've obviously had the work on poverty. We've got a piece, the second part is health inequality and climate change. And then we do have the next year of the program is health inequalities with race and ethnicity. So we're really hoping that that will shine a light on some of the things that we've been talking about from that perspective and I'm looking at your list some of it we've been doing locally, but I suppose I hadn't considered them to be a have a patient safety element to them. Um, but it all feeds into the same thing doesn't it? It's all those with who experience health inequalities are at greater risk and that is a patient safety issue.

Natalie Wyatt

And I was interested in what you were saying in the beginning Cian and Mimi, obviously your sort of framework, you've created the, the individual, the societal one, the, the system level one, obviously we've, we know that there are big challenges within the policies and legislations milieu in pushing any of this, but from that healthcare leaders perspective and that's more systems level, you've referenced already the value of taking patient safety framework as that lens to look at and address health inequalities. Would you tell us a little bit more about the work you've done around this?

Cian Wade

Yes. So certainly on the, on the system point, and we can come back, but perhaps you're referring slightly to some of the empiric frame improvement frameworks and so on. Following on from Helen and thinking about, a bit about what we can do at the system. It's a shame to hear that it sounds like the opportunity, the sort of political opportunity window that we had from COVID seems to be shrinking somewhat. You know, there are so many competing interests in society at the moment that always the battle with these issues and for those of us who want change in this area is to try and keep it high up that political agenda. Um, and I think one angle that we're probably, we probably don't explore quite as well enough as we could is creating the clear business case around this. Now, this might sound very US speak because in the US it truly would be a business case, whereas in the UK and the way that we fund our system, what we're saying is, hey, look at the long term gains that you're going to get from investing in this right now. So we need to be able to articulate to our political class, the current and projected costs from lack of action in this space, and if we're thinking about it through a paediatric lens, the costs over a lifetime of not getting things right early on, be that through true traditional social determinants of health impacting respiratory health in children early on, or be that a patient safety event that impacts a child's trust and their family's trust in the health care system and leads to long term disengagement or harm, then we should be able to paint a fairly clear, you know, if you like financial picture or otherwise, um, of the damage that that will do. And hopefully when that is then presented to individuals who hold the purse strings around resources that can actually unlock really great improvement around work around this area, that will be convincing for them. But I think we, I think it's a hard thing to do. I think it's hard to make all these various projections and it takes time and effort. Um, but I think that that sort of creating that business case around this issue is, and the return on investment, I think is an important thing that from a systems perspective, we could be doing as well.

Helen Stewart

I think one of the difficulties with that is the way funding is allocated. Budgets are ring fenced, aren't they? So, um, the health budget is separate. The education budget is separate. The justice budget is separate. So the impacts of these cross a lot of those different budgets. And so it's quite hard to go to one person with a business case and say 'these are the impacts' when actually it's going to be on budgets that aren't necessarily, not to be cynical, but aren't necessarily relevant to them. There is one piece of work that has come out of the COVID and inequality, and that's the, for children, it's the core 20 plus five, and there's a CYP version, there's an adult version. That has been gone out to integrated care systems and they are supposed to be implementing that locally. Unfortunately, there's no additional budget that goes with that, but it is creating an impetus to actually act on some of the factors in it. They've got the five clinical priority areas, which for children are asthma, diabetes, epilepsy, mental health and oral health. And then you've got your core 20 plus. So I wouldn't say it's a totally wasted opportunity to have some things that are coming out of it, but unfortunately some of the measures have been dampened a little bit.

Mimi Malhotra

I was just going to say that I just don't think the political cycle in the UK lends itself to long term thinking, which is such a shame. But I imagine the shadow health teams at the moment are purely focused on getting into power. And after that, they will see what they can do with restraints once they are in power, but there is definitely, I think, a political shift. But I think that it's unfortunately, just very unfortunate. The other thing that I wanted to say on the back of what Cian was saying in the business case, I think there are some really good examples from America. And the fact that maybe their healthcare system is slightly more disjointed has helped them because I know one example where I think it's a group of hospitals called Nationwide, where, because there's only a few child and paediatric hospitals within, say, a state, they know who's born into that state, and they then treat that entire childhood population as theirs. And so I guess when we think about GPs doing sequent measures or health promotion checks, these hospitals know who they're responsible for almost within an area, not accounting for, kind of migration in and out, and then they can work on that population, work with schools, work with kind of other disciplines to just improve the health of what they called their children, because they know if they don't, these are the children that will come into their A&E.

Helen Stewart

No, I was just gonna agree with Mimi about what she said initially, um, about the, um, political cycle and obviously we're approaching an election within the next 18 months and there's been a lot politically about the NHS and what I haven't seen enough of in the

conversation is about how actually a lot of that is due to the increasing inequality in society and the education system and the justice system and all these other, um, areas of housing, et cetera, and how actually the NHS is It's becoming slightly the backstop for all those social policy issues and, and I just not heard that in the conversation, um, which I think is an important part of it. I think it's an important, difficult thing for people to hear and to understand that actually all this is impacting on the availability of the NHS.

Jonathan Bamber

The conversation that we've had over the last five, ten minutes resonates with me whenever I have conversations about health inequalities and that there's a perception of this problem is so big that people often aren't taking full accountability or responsibility, going, I'm going to own this problem. And thinking, okay, it's, it's something huge, and it's generational, or it's another department or another industry. And I found that a really interesting aspect of your paper, Cian and Mimi, in that, that was framing that point. And I think you mentioned this earlier, Cian, around accountability and empowerment, that if you're thinking about as healthcare professionals, that this is something that I can own, particularly the safety of your patients when they're within hospital. And if you're dealing with long term conditions, asthma, etc. that there is in that business case, there's a way of framing that where it's easier for healthcare professionals to go, okay, I get this. I can own this as something to try and tackle. And then. After that, say, okay, what are, how do you chunk it down? So this is a classic around quality improvement and you have this huge, big problem and you think, okay, that's too much for me. I don't understand it. Oh, I can't start addressing the problem. But if you can chunk it and say, okay, what could I do differently within my unit, within my team, individually. That seems quite enticing to me. And that sort of came through within the paper. I was wondering if you guys had any thoughts of how you individually or within, you would recommend sort of where to, where to start if you were going to take on that empowerment, that sort of accountability of I'm taking responsibility here?

Cian Wade.

So yeah, there's something about the best way to eat an elephant is a bite at a time. I think that with these very complex adaptive issues, ultimately, there needs to be kind of multi angles of attack on these things. There are some very tangible things that individual providers can do. So, one element of the evidence around harms that kept coming out was how important good communication is and we're all very stretched and often ensuring that your patient has understood what you are trying to tell them and that they've understood the safety netting information, for example, you're giving them after a new medication has been prescribed. It's, it's often the thing that falls by the wayside as

you're thinking about your next patient. But there's good evidence that, for example, if you take a shared decision making framework and really invest in the time and making sure that it is culturally appropriate, which encompasses both the language element, um, the literacy element, but also understanding through, through their frame exactly, you know, what this medication might, might mean for them going on living, living within their community. If you just take the time to try and understand that, then things like adherence to diabetic medications improves and then we see the actual outcomes with HbA1c over many months improving. And so taking that time, making sure that you've got closed feedback communication loops, you've used various leaflets that are language and literacy appropriate. Yes, these things take time, but you will see, you'll see the return on investment essentially, and that the patient won't be readmitted to A&E with their hyperglycemic crisis, um, or that they will have better outcomes in the long run. And, and so I think it's something that came out of our work that I think, you know, it's critical for individuals to probably think about is just taking that time to make sure that your practice is race conscious, that it is conscious of the socioeconomic background of your patient, and I think we'll see improvements flowing from that.

Helen Stewart

Yes, I would, I mean, I agree with Mimi that the first tenet of medicine is do no harm and the approach that we took was, we just need to not make things worse to start off with. The cost of an outpatient appointment, the work that came out of Liverpool with Ian Sinha, I think, um, was about £35. Now, that's not money that all people have, and that's a patient safety issue because a child's not coming for their asthma check or their diabetes check, or to see if their symptoms have progressed. So, we started looking at travel vouchers with local companies to, uh, facilitate children being brought to their appointments. There's just small things like that where we can just try and mitigate some of the impact. So, the cost of hospital admission is huge when you think about parking, food, we, we can't afford to feed the parents as well, though we do feed breastfeeding mums. So we've been working with local charities who provide food, that they're discarded food from supermarkets and create frozen meals, um, which are pay what you can afford on the ward. So the, the, the starting approach has been mitigate the harms that we're doing as a health service, um, to our population and get safety netting has been a huge thing as well. Obviously, as an emergency physician, that's a massive thing for, for us. And we've been working on the accessibility of leaflets and it's difficult because we have moved them all online. Which means that we can translate them into any language, which is fantastic. But then you've got to consider those who have digital poverty and don't have the same access to smartphones and internet, etc. So it's, it's a real balance making sure that every community is catered for, uh, within what we provide. And we do have printable options, but yeah, it's, it's just making sure that you think about the individual circumstances of every patient.

Jonathan Bamber

As you were talking, Helen, there's a strong crossover there with some of the other topics we've been talking about in these podcasts around the importance of co production of involving patients within the care that you're providing, having that psychologically safe environment where there is good communication that everyone involved in the management of care is heard and has an opportunity to actively contribute within a safe environment. And these things seem to align that you could, it's interesting, you could think of all of this and say, this is a sort of population level issue that you can then analyse this and say, okay, which groups are being adversely affected and what can we do better if you're taking that psychologically safe approach.

Helen Stewart.

Yeah, it's so important to have those conversations. Like one of the things that we took away from one of the community conversations, which we just hadn't, cultural ignorance, we just didn't know, was the importance of a clean hijab every day. And it just wasn't something that we were aware of or considered. So now as part of our packs that are available in the wards, we have hijabs available for mums who have had to stay in as an emergency with their child. And it's, it's just those little things that make people realise that we are listening, that we're, um, considering their needs and we're trying to make it a better environment for them. But it was just something that we had no idea about. And I had a really important lesson for myself. We're trying to introduce heads into the department that had screening questionnaire, but an emergency department, it's difficult because we don't have time to have those conversations. So we'd created a questionnaire, took it to the youth forum and they tore it apart and we had to start again. And we're like, yeah, we really should have just had you here from the start, shouldn't we? It's so important just to have them right there at the beginning to, so that you have that perspective because we, I'm an old woman, I don't know these things. So what appeals to young kids? So it was, um, yeah, it was a real lesson and actually you need patients, you need families, you need them all there right at the beginning of any project.

Mimi Malhotra

I think it's 100 percent our responsibility to work out how to incentivise them. to come to outpatient appointments and things, as you said, the cost of an inpatient admission, both on the kind of hospital and service, but also then on the child not going to school and their family. I know in the adult population, one of the main reasons why people self discharge is because they're self employed and they need to go back to work. But with

children, that's going to be their education. So, involving them and that's definitely something that we heard the entire time. Co-design and co-produce but also value the people whose time you're using, whether that's financially or through other incentives that are useful for them.

Jonathan Bamber

We can maybe slightly change the the topic and put it, I'm interested around a challenge for the RCPCH ourselves in what could we be doing better? The work that Helen and colleagues are doing around health inequalities, I think, are building momentum around paediatric and child health changes. And, Cian, you talked briefly about the, the aspect of medical education and that aspect of treating race as a sort of stopped treating race as a biological determinant and moving on to thinking of it socially. Is there anything else that you would say that organisations like the RCPCH should be working on harder or looking at things slightly differently?

Cian Wade

From an RCPCH perspective I think it's very important to make sure that health inequalities broadly is a vertical through all curricula that it's not boxed off as a sort of, you know, one session, let's think about this that it is really integrated through everything because I think healthcare professionals are on something of a of a journey and In terms of their educational requirements, there's the elements of what care they're deploying and they need to think about that through a, the race conscious lens that we've spoken about, the, the socially conscious lens that we've spoken about, but also in terms of their quality improvement activities, what can they spot with a slightly different eye on these things that might be relevant to health inequalities for their paediatric patients and how can they deploy a good sort of QI methodological approach to improving that? Um, and then when they then, you know, graduate, if you like, into becoming consultants and true clinical leaders, how can they then raise the profile of these issues, unlock resources and get it moving up the political agenda, both in government, but then the political agenda within NHS England as well to try and move things forward. So I think keeping it top of mind, keeping it explicitly as a vertical within training curricula, um, producing podcasts such as these, I think those are all, uh, all good things to be doing.

Helen Stewart

Yeah, health promotion is a core element throughout the paediatric training curriculum, happily, and increasingly that's taking a health inequalities focus, but it's a core part of the, um, the process.

Mimi Malhotra

I was just going to say that I think the RCPCH is actually doing really well. I had a look at your website and the six step toolkit, which I thought was a really great start and something that all Royal Colleges should be doing. Um, it was really easy to navigate. So to all of your paediatric trainees, do have a look at that if you haven't already. And then I think building on what Cian was saying in our discussion earlier, I think it is just really important to know that even though these organisations don't like to be political, healthcare is so political and in today's climate, we just need to use our voice in any shape or form. And it's great, Helen, that you've been involved in some of those conversations. So I would just say, keep on. Keep on articulating what your heart is telling you to.

Helen Stewart

Thank you. And thank you for the feedback on the toolkit. I have to say that my predecessors, Max Davey and Ian Sinha in Liverpool were both quite core to developing that. So, and just, sorry, I meant to mention before, um, in terms of quality improvement, I'd give a shout out to the WHAM Project, Wellbeing, Health and Action Movement Project. They have a heat map of a wide variety of health inequality related quality improvement projects that you can read about on their website and they are more than happy for people to, um, adapt them locally. So there's a whole wealth of ideas out there.

Natalie Wyatt

One of the things that I found really interesting within the paper, Cian and Mimi, was that idea of using the preexisting patient safety improvement frameworks as these opportunities or avenues into specifically addressing health inequalities. I was wondering just for kind of inspiring our paediatric listeners, whether you have any specific ideas or a way of explaining that with a sort of tangible example that could help us understand that concept a bit more?

Cian Wade

Um, around patient safety. So that's some, some great work in terms of, patients are about to be discharged from hospitals on new medications, particularly blood thinners. Typically, maybe traditionally, we would just say, well, here's, here's your warfarin. This is, this is how many times you're meant to take in a day. These are the INR blood tests that you're meant to do. And, uh, you'd be discharged. Whereas, uh, a new project came in and sat down with the patients, co designed the leaflets, uh, that they would be taking home with them rather than just the traditional patient safety leaflets. They then specifically followed a cohort of patients onwards to measure whether there are any adverse events such as bleeds, how many of those blood tests they actually went to, and then iteratively try to improve that discharge process and the follow up that they have based upon the feedback they're receiving and demonstrating improvements in, in the data points in terms of how many blood tests they were actually going to and, and their kind of long term INR, so the, how well the blood thinning was working, um, as well as their overall clinical outcomes. And, and so, going through several cycles of that, co designing it with patients, focusing on, uh, an important patient safety outcome that we know diverges between different groups of patients, I think is a good example of how to improve the process. And then the final point being there is that I know that the Institute for Healthcare Improvement have this concept where if you do something that improves the outcomes and the quality of care for those patients who typically suffer health inequalities and poor outcomes, then if you can improve their standard of care, actually, there'll be a flow through to improving everybody's standard of care as well. And so it's in terms of thinking about unlocking resources and that, the kind of return there you'll get, you are actually improving the quality of care for everyone through focusing specifically on those individuals who, um, traditionally, um, suffer those worse, worse outcomes as well.

Natalie Wyatt

Talking about trying to develop systems and develop a robustness within our systems for making sure that we are tackling health inequalities, we are getting increasing exciting input from artificial intelligence and how it might improve our health outcomes. But there is a huge worrying piece within that, in that the design of the artificial intelligence systems are inputted by us. And so our implicit biases, our learnt biases are going potentially to be involved in that. What do you think about this as a problem and how we might start to tackle this?

Cian Wade

So there's, there's two levels to the artificial intelligence question in this space. And, and first touches a little bit about what we've previously discussed around the data sets that we're using. Um, even within traditional designs of trials, if the people that we're

recruiting to these studies do not represent society and the patient population that we are then uh, giving medications, using devices on, then we're not going to be fully aware of the relevant safety and efficacy data and health inequalities could be exacerbated. And so we absolutely need to be sure that the algorithms we're designing are being based upon data that is diverse and is representative. And I think to be fair to the AI community, that is now very top of mind, and there are technical corrections that can be made that, that way beyond my, uh, my, my personal area of expertise. But, but I know that there is a lot of momentum around correcting that and mitigating that. The second level is actually the, and, you know, given the fears around how it could exacerbate health inequities, there's actually huge potential to reduce health inequalities in many ways. And two good examples that come to mind is firstly, we've spoken about how complicated it can be to to make sense if you like of patient safety data that comes from a hospital or a health system because often it's a narrative summary of what's happened. And what the underpinning causes was, and it's very difficult to actually analyse that en masse, if you like, and actually draw inferences in a very systematic way that are informative. But natural language processing, so subset of AI, should be able to help quite a lot with that in terms of picking out patterns in this very complicated narrative across thousands and thousands of patient safety incidents. And from a health inequalities perspective, it should also be able to start piecing together these complex stories that typically emerge in terms of the underpinnings of, of, of the events that particularly affect these patients. And then the second thing is, uh, we know that a lot of the challenges and the increases in risk come through not providing culturally, um, and linguistically appropriate advice, both in hospital and in sort of formal care settings, but then also throughout the care journey, the patient and actually that, you know, it's not too far away to be able to imagine a way in which an artificial intelligence is actually able to communicate in the patient's back pocket, essentially in that appropriate way that we know from little bits of evidence suggests that the, their engagement will increase, that the risk of harm will reduce. Um, so I think that there's, there's rightful caution around AI in this space, but I think there's also a lot of, uh, a lot of reasons to be excited about its potential in, in reducing the inequalities in patient safety that we see.

Mimi Malhotra

I think the only thing I would add, which I think you hinted at in your question, Natalie, is that we as the users are making artificial intelligence more intelligent, and I have definitely read papers that have suggested that kind of 95 percent of the input has been in English. And so whilst it's becoming more intelligent to our cultural context, it is actually becoming comparatively less intelligent for other communities, other cultural contexts. And so I think the community probably needs to do a lot more to encourage people to input in other languages from different regions as well.

Jonathan Bamber

Building on that, there's potential of, by taking a health inequalities approach to this that you would help reduce those biases which will be in artificial intelligence by its very nature. So it comes, always comes to mind around the kind psychometric field which has 50, 60 years behind it and it took sort of nearly the same amount of time for there to be general appreciation on how discriminatory and biased psychometric testing is. And it's not that certain ethnic groups or groups within society are less intelligent. It's more that it's designed for, designed by and for white Western people, even if they're not trying to be biased. And I think that's quite similar within artificial intelligence in that as long as we take a decolonized or just a health inequalities approach to this and say we will be biased, how do we reduce it? That's the mechanism to make that technology better, which isn't going to be going away anytime soon.

Cian Wade

I suppose thinking about from what more can the RCPCH doing? I think advocating for exactly that because AI is a bit of a slightly wild west world and there's a lot of narrative ongoing at the moment about how it's best be regulated. Let's make sure we don't have the sort of law lag effect of this technology races away before the legal or political class sort of work out how to regulate it. But I think having exactly that sort of lens and that sort of advocacy that you just outlined there, Jonathan from the Royal Colleges, for example, I think is, will be an important check on the development of these technologies.

Natalie Wyatt

Thank you so much Helen, Cian and Mimi for taking the time to share your expertise and opinions. It is striking to me that it is futile to consider health inequalities and patient safety as separate issues. Each research discipline can inform the other. And an equitable healthcare system is safer and vice versa. If you want to learn more about health inequalities and more about paediatric patient safety in general, please visit the RCPCH Patient Safety Portal. This is our brand new online resource full of learning, resources, safety alerts and more. You can find links to this and for the research and projects that we have discussed in the episode notes for this podcast. Thank you for listening.