Final report

February 2017

Innovating for Improvement

Using the Ophelia approach to generate and drive healthcare improvements

Northumbria Healthcare NHS Foundation Trust

The Health Foundation

About the project

Project title: Using the Ophelia approach to generate and drive healthcare improvements

Lead organisation: Northumbria Healthcare NHS Foundation Trust

Partner organisations:

Riverside Community Health Project

West End Family Health

HealthWORKS Newcastle

Deakin University

Year of Care Partnerships

Project lead/s: Dr Simon Eaton

Contents

Part 1: Abstract

Health literacy describes how people find out about health and understand and use that information to achieve better health. Addressing health literacy is an important way to reduce health inequalities and improve health outcomes.

Ophelia (OPtimising HEalth Literacy and Access) is a robust and systematic process which enables clinicians, service users and community groups to co-produce effective interventions based on understanding the HL of a specific population.

Our project tested the feasibility of using this new quality improvement methodology, developed at Deakin University in Australia, for the first time in the UK.

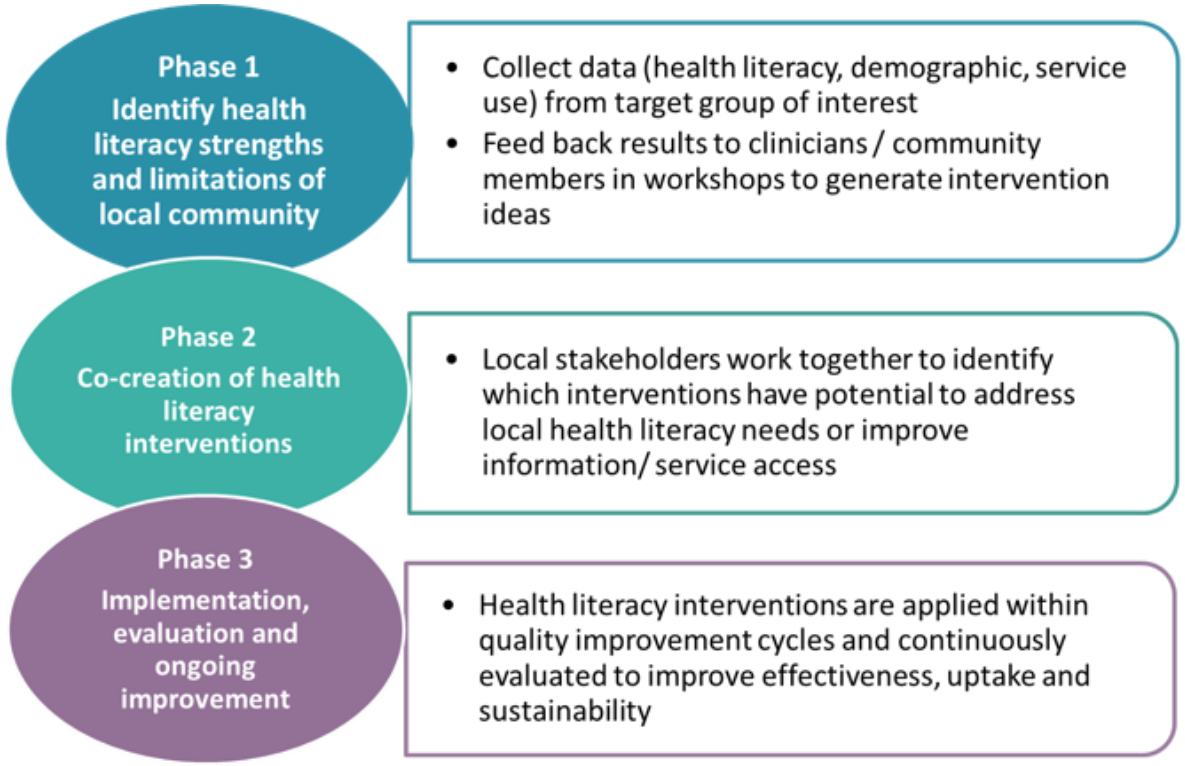
We tested the Ophelia process in two distinct settings:

1. The Czech, Slovak and Romanian migrant population in the West End of Newcastle

2. People with chronic lung disease attending specialist clinics at North Tyneside General Hospital.

We also raised the profile of health literacy and improved care through the co-production and delivery of multiple interventions into routine clinical practice.

The Ophelia process



Phase 1- Identify health literacy strengths and limitations of local community

We successfully collected 100 Health Literacy Questionnaires (HLQ) from the Czech, Slovak and Romanian communities enabled by existing positive, trusting relationships with a community provider and our development of a new Romanian translation. We also collected 100 HLQs from patients attending the hospital respiratory clinic. This data was used to create a total of 10 vignettes which were discussed in language specific workshops with patients, local community members and providers to explore health literacy issues.

Phase 2 – Co-creation of health literacy intervention

We ran 7 workshops across both arms with patients, community members and healthcare/community providers. The migrant community workshops were highly engaging with real-time translation into Czech and Romanian languages. We also ran a co-production workshop in 3 languages simultaneously which was challenging, yet inclusive and productive. These generated over 250 separate ideas for improvement, which were prioritised by participants during the workshops. We subsequently co-designed multiple health literacy-related interventions to address these.

Phase 3 – Implementation, evaluation and on-going improvement

Hospital respiratory clinic - *'It's all about you'*

The *'It's all about you'* initiative addressed health literacy issues identified around people not understanding the purpose of their clinic visit, not feeling adequately prepared and feeling less able to participate in discussions such that they often feel the consultation is not for their benefit. The initiative includes the successful development of a pre-clinic preparation prompt that promotes and enables the person's role and participation in clinics. It was well-received by patients, enabling them to raise their agenda during an appointment without increasing its length. This initiative has generated support across the organisation to Board level and is being extended to other outpatient settings to establish this approach as standard care.

Migrant community

Two interventions addressed issues identified around not being understood in a healthcare appointment, lack of understanding about how the NHS works and difficulty in accessing appropriate health services and support.

Dedicated language clinics. A GP practice had established a dedicated language clinic for the Romanian population where an interpreter and community link worker offered language support during consultations, alongside broader support and links with community services in the waiting room. The Ophelia project generated a detailed understanding of the components of such a clinic which facilitated the testing of a dedicated Bengali language clinic in the same practice and a Romanian language clinic in another local practice. Despite considerable challenges in establishing such a clinic there was much to be gained. It doubled the number of patients supported by the translator with additional benefits to attendance rates and uptake of preventative health measures.

Community Support. Several components of helpful community support identified by community members and providers during the Ophelia process have been summarised in a 'specification' to inform a Public Health-led service review across Newcastle for newly migrated communities. The value of and challenges with learning English were also highlighted. In response Riverside Community Health Project has set up a 'Conversation Club' to support the use of conversational English.

What have we learnt?

- Ophelia is an innovative and practical way to design and improve services, focused on the health literacy profile of the local population
- It establishes a detailed understanding of the health literacy strengths and weaknesses of a community, generates ideas for improvement and offers a mechanism to co-produce locally-relevant interventions
- Recognisable vignettes of local people bring HLQ data to life and stimulate engagement of workshop participants
- We embellished the original process by incorporating the patient and community voice throughout. These elements have now been incorporated into the international Ophelia Toolkit
- Ophelia builds trust between providers and local service users
- Participation and completion was made easier by an established relationship between local provider and the community
- Ophelia is a robust and transferrable process, but requires considerable programme management and skilled facilitation to maintain momentum and ensure delivery of interventions

"Ophelia adds power, push and credibility to the single person with a good idea."

Barbara Palmer, GP, West Road

Summary

Ophelia is a powerful and practical approach, which links the measurement of health literacy to service improvement, and coproduces health literacy-related interventions to improve health and healthcare, and should be adopted more widely in the UK.

"Our end goal is improved health and health equality, which is where every step of Ophelia hails from."

Richard Osborne, Deakin University

Part 2: Progress and outcomes

This project set out to test the feasibility of introducing the Ophelia Approach to health literacy in the UK for the first time.

What is health literacy?

Health literacy refers to the personal characteristics and social resources needed for individuals and communities to access, understand, appraise and use information and services to make decisions about health, or that have implications for health. Health literacy includes the capacity to communicate, assert and enact these decisions.

> *Health literacy describes how people find out about health, and understand and use that information to achieve good health*
>
> Ophelia Toolkit, 2016

Lower levels of HL are related to poorer access to services, less engagement in health promotion or self-management behaviour, higher use of emergency services, higher healthcare costs and adverse health outcomes. Addressing health literacy is increasingly seen as an important way to reduce health inequalities and improve health outcomes.

The Ophelia process

Ophelia (OPtimising Health LIteracy and Access) is a robust and systematic process to enable clinicians, service users and community groups to work together to create effective interventions based on understanding the health literacy of a specific local population.

The programme not only measures health literacy, but links this to a service improvement process based on the issues identified by the local communities, across 3 mutually-reinforcing phases (figure 1).

The Ophelia process starts with identification of a particular part of the healthcare system that is not meeting the needs of, or engaging with, those it aims to serve. We aimed to optimise our learning about the Ophelia process by testing it within 2 distinct settings: a hospital clinic, and a poorly served health community.

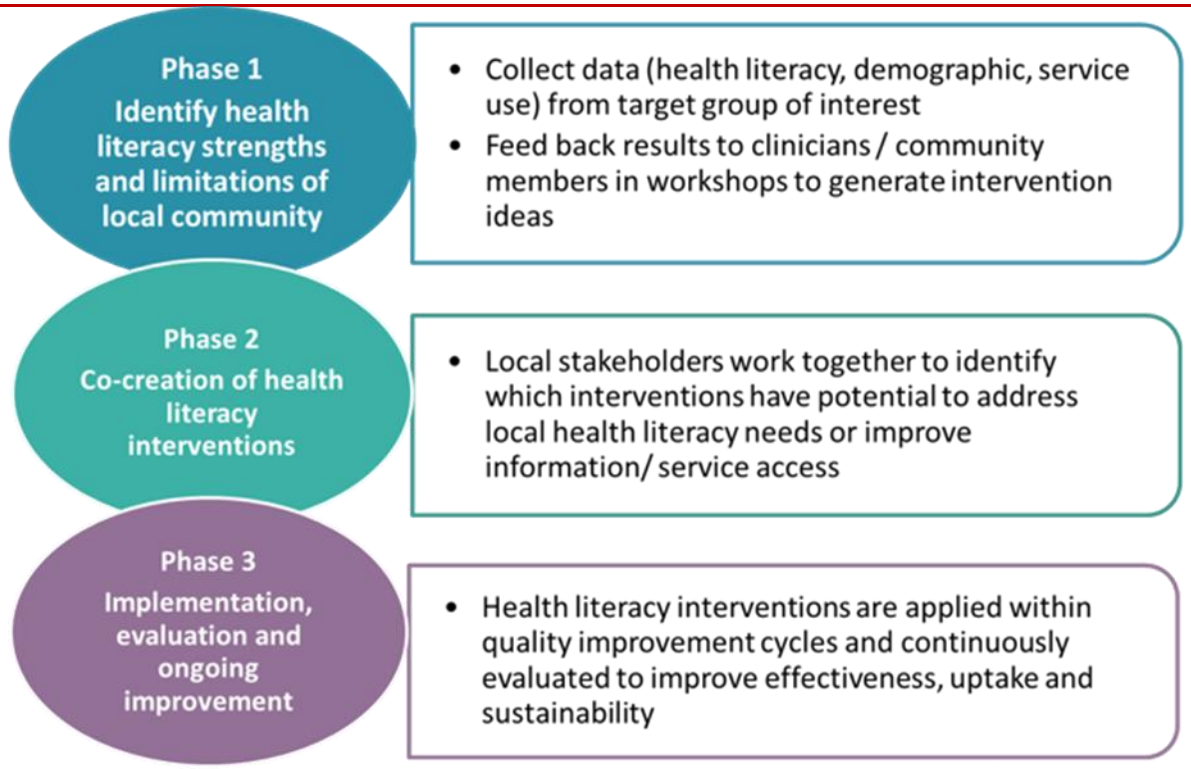


Figure 1: The Ophelia process

We worked with local clinicians and providers to identify specific health priorities and target groups, and agreed to focus on:

- People with chronic lung conditions (such as Chronic Obstructive airways Disease) attending a specialist hospital clinic, and whether this was addressing their long term support needs
- People from a newly migrant Czech, Slovak and Romanian community in the West End of Newcastle, and the provision of healthcare support and health promotion

Phase 1- Identify health literacy strengths and limitations of local community

Understanding health literacy

We used the Health Literacy Questionnaire (HLQ) to identify the specific health literacy strengths and limitations of each community. This is a detailed 44-item questionnaire that describes health literacy across 9 scales (see figure 2).

Figure 2: The Health Literacy Questionnaire scales

At least 100 HLQs are required in each setting to ensure validity. Trained administrators encourage participation without prompting answers. For the migrant community, which can be suspicious of health care professionals completing any kind of assessment, trusted link workers met people either in the community centre or in their homes.
The HLQ is translated in 19 languages, but unfortunately for us, Romanian was not one of them. We felt inclusion of this group was vital, so undertook a rigorous translation process, overseen by the Australian Ophelia team.

Making the data real

In each setting, we analysed the raw HLQ data to look for patterns, or clusters, representing overall health literacy profiles (figure 3). We then used these to work with clinicians and community workers to develop 'vignettes' bringing the data to life for workshop participants (example shown in figure 4).

Profile 'name'	Number of people in cluster	Average age	% Female	% Lives Alone	Average Educ	% Finish secondary	% Retired	% Works full/part-time	% Incapacitated to work	% Assisted with HLQ
Alan	16	76.5	25%	38%	3.0	63%	69%	6%	13%	25%
Brian	37	70.4	43%	38%	3.2	62%	68%	5%	16%	46%
Claude	9	67.4	44%	22%	3.9	22%	67%	11%	11%	0%
Dee	13	73.7	54%	46%	3.3	69%	77%	8%	15%	62%
Edith	4	77.4	100%	100%	2.3	75%	100%	0%	0%	100%

Profile 'name'	Number of people in cluster	Average number of health conditions	% COPD	% Arthritis	% Back Pain	% Heart	% Cancer	% Depression/ anxiety	% Diabetes	% A+E in past 12 months
Alan	16	1.9	81%	31%	19%	19%	6%	13%	19%	81%
Brian	37	2.6	92%	32%	38%	19%	11%	24%	19%	59%
Claude	9	3.1	89%	44%	33%	44%	33%	0%	11%	44%
Dee	13	3.0	100%	31%	38%	46%	15%	31%	8%	85%
Edith	4	2.3	100%	25%	25%	50%	0%	0%	25%	100%

		HLQ scales								
Profile 'name'	Number of people in cluster	Understood and supported by healthcare providers	Having sufficient information	Actively managing my health	Social support for health	Appraisal health information	Active engagement with healthcare providers	Navigating the healthcare system	Finding health information	Understand health information to know what to do
Alan	16	3.81	3.77	3.50	3.88	3.32	4.50	4.37	4.27	4.48
Brian	37	3.20	3.05	2.87	3.20	2.84	4.29	4.01	3.90	4.12
Claude	9	3.00	2.42	2.84	2.62	2.82	3.49	3.47	3.71	3.96
Dee	13	2.44	2.67	2.40	2.96	2.28	3.06	3.05	3.05	3.31
Edith	4	2.44	2.44	2.34	3.30	1.90	2.20	1.85	1.65	1.65

Figure 3: Health Literacy Questionnaire (HLQ) results and clusters (Hospital arm)

Dee

Number of people in cluster	Average age	% Female	% Lives Alone	Average Educ	% Finish secondary	% Retired	% Works full/part-time	% Incapacitated to work	% Assisted with HLQ
13 (16%)	73.7	54%	46%	3.3	69%	77%	8%	15%	62%

Number of people in cluster	Average number of health conditions	% COPD	% Arthritis	% Back Pain	% Heart	% Cancer	% Depression/ anxiety	% Diabetes	% A+E in past 12 months
13 (16%)	3.0	100%	31%	38%	46%	15%	31%	8%	85%

Number of people in cluster	Understood and supported by healthcare providers	Having sufficient information	Actively managing my health	Social support for health	Appraisal health information	Active engagement with healthcare providers	Navigating the healthcare system	Finding health information	Understand health information to know what to do
13 (16%)	2.44	2.67	2.40	2.96	2.28	3.06	3.05	3.05	3.31

Dee is 74 years old. She is a retired shopkeeper and lives with her husband Stewart. She has COPD, which can be troublesome at times and she was in hospital for a few days last winter. However, her main problem day-to-day is her back pain, which limits her mobility and, she feels, is responsible for her ongoing weight gain. Together these things really do get her down.

When she attends the clinic she feels the doctors she sees will often focus on her chest and give her a hard time for her weight and her smoking. She feels as though they don't really understand how difficult she is finding things. She has tried so many times to make changes, but she doesn't quite know what would work best and what has been suggested has never seemed to work.

She really would like to feel better, but isn't sure what to do next.

Figure 4: Example vignette used in the workshops, developed from the one of the clusters in Figure 3

Phase 2 – Co-creation of health literacy interventions

Embracing local wisdom

We facilitated workshops to present the vignettes, ask participants to consider what the issues might be, and generate ideas for potential solutions to improve services, systems and outcomes. The vignettes helped keep participants focused on health literacy profiles from the data and this developed a much deeper understanding of the health literacy issues. Providers also identified with the vignettes, reporting that this was a useful way of thinking and learning about broad health literacy issues. For service users, it allowed them to voice their issues through the person presented in the vignette.

> *"When I saw the Ophelia data it meant nothing, but when it was turned into vignettes it really helped us engage with the health literacy issues relevant to our local population"*
>
> Bren Riley, Migrant Family Inclusion Project Manager,
> Riverside Community Health Project

The original Ophelia process included workshops for clinicians and providers only. We felt strongly that it was important to include the community voice throughout to ensure we maintained an understanding of the issues and ideas that would work for the people in the communities. The community members valued this, welcoming the opportunity to work together with clinicians and providers. It was exciting and fulfilling for the team to see the whole process in action.

In the respiratory arm, we held 2 workshops; one with clinicians and one with patients from the hospital respiratory clinic, which generated a total of 140 ideas (see appendix for full report of workshops, issues identified and ideas generated).

> *"Thinking through the vignettes, and talking through our experiences, really helped me see another side to things… things we could do better"*
>
> Clinician, Respiratory workshop

In the migrant community arm, we held 3 workshops, one for clinicians/providers and one each for the Czech/Slovak and Romanian communities. These generated 113 ideas (see appendix). To address language issues we engaged community link workers to lead the session, with real-time translation for the local Ophelia team who supported and guided the process throughout.

> *"I feel inspired that…ordinary people can come up with such practical solutions"*
>
> Community member in Ophelia workshop

Prioritising and planning together

Having collated the issues and ideas themed around key health literacy issues, we held coproduction workshops which involved bringing clinicians and providers together with community members to review, and prioritise intervention ideas for implementation. This has been a valued process for those involved, supporting our aim to ensure full inclusion and participation.

In order to support the migrant community, we ran an informal introductory session for community members over lunch to explain the project and the objectives of the session in their own languages. We then held the entire coproduction workshop in three languages simultaneously with the support of community link workers and translators.

Phase 3 – Implementation, evaluation and on-going improvement
In each arm of the project we co-designed interventions to address the health literacy-related issues prioritised in Phase 2.

Hospital respiratory clinic

'It's all about you'

This intervention addresses the health literacy issues around people attending the clinic not understanding the purpose of the visit and not feeling adequately prepared (figure 5). Consequently, they felt less able to participate in the discussions and frequently felt the consultation was not for their benefit.

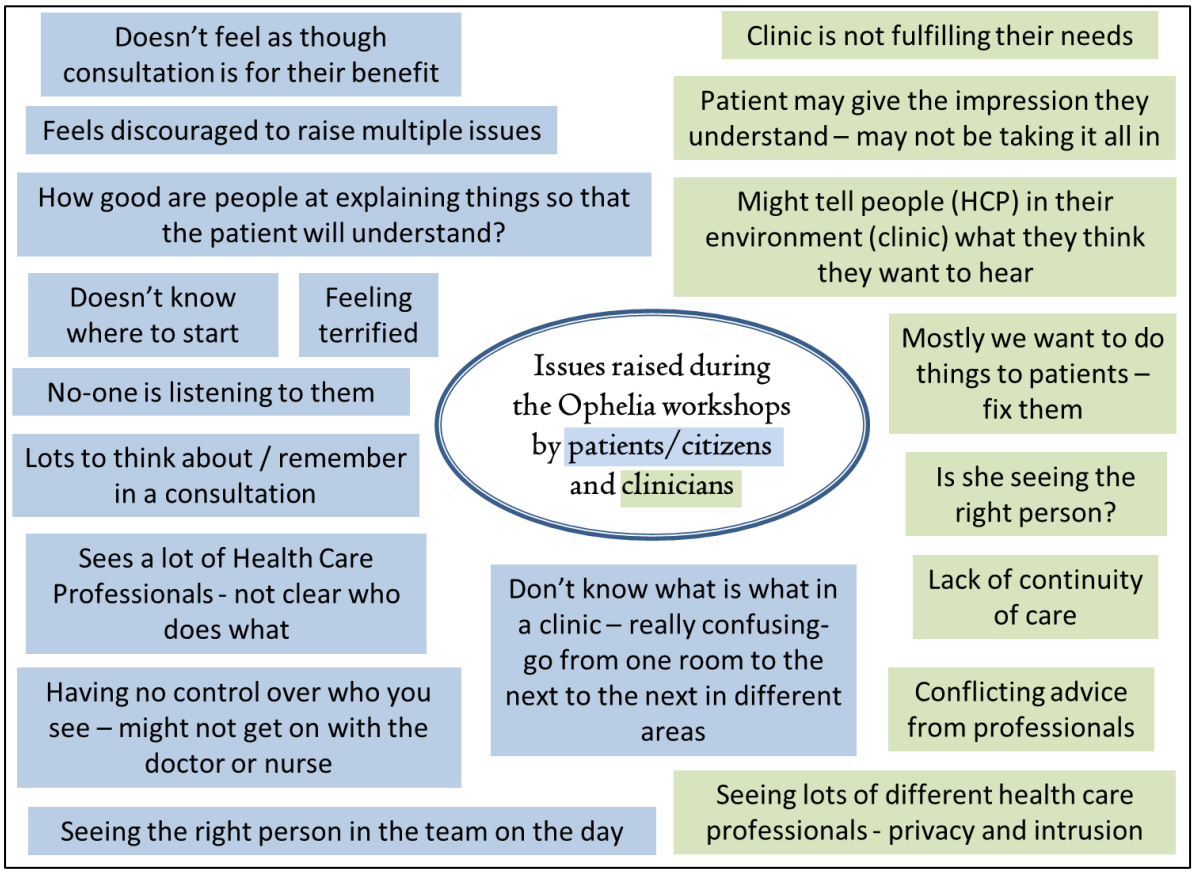
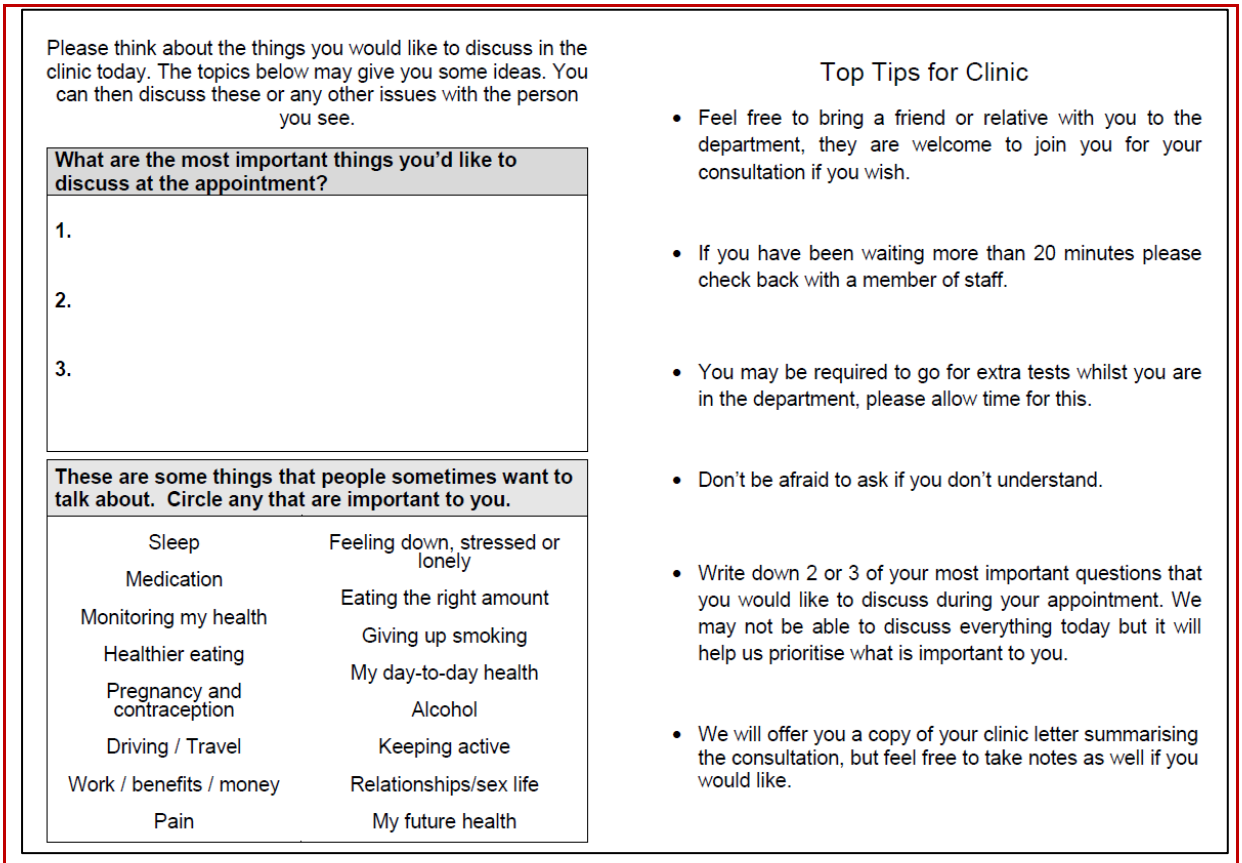


Figure 5: A summary of issues raised during the hospital arm Ophelia workshops

The '*It's all about you'* project addresses this by promoting and enabling the person's role and participation. The main component is the successful piloting of a pre-clinic prompt to enable people to clarify their agenda for the consultation and encourage question asking (figure 6). It will eventually also include promotion through waiting room posters and information on the Trust website.



Please think about the things you would like to discuss in the clinic today. The topics below may give you some ideas. You can then discuss these or any other issues with the person you see.

What are the most important things you'd like to discuss at the appointment?

1.

2.

3.

These are some things that people sometimes want to talk about. Circle any that are important to you.

Sleep	Feeling down, stressed or lonely
Medication	Eating the right amount
Monitoring my health	Giving up smoking
Healthier eating	My day-to-day health
Pregnancy and contraception	Alcohol
Driving / Travel	Keeping active
Work / benefits / money	Relationships/sex life
Pain	My future health

Top Tips for Clinic

- Feel free to bring a friend or relative with you to the department, they are welcome to join you for your consultation if you wish.
- If you have been waiting more than 20 minutes please check back with a member of staff.
- You may be required to go for extra tests whilst you are in the department, please allow time for this.
- Don't be afraid to ask if you don't understand.
- Write down 2 or 3 of your most important questions that you would like to discuss during your appointment. We may not be able to discuss everything today but it will help us prioritise what is important to you.
- We will offer you a copy of your clinic letter summarising the consultation, but feel free to take notes as well if you would like.

Figure 6: Pre-clinic prompt (front and back shown)

This has been well-received and refined through feedback from patients and clinicians. It adds value to the consultation for both, without increasing its length.

> *"It's a great idea. My mind always goes blank when I get in there"*
>
> Person attending respiratory clinic

> *"I don't want to take up [their] time, they always seen so busy, but this helps focus my appointment"*
>
> Person attending respiratory clinic

Migrant population

The issues identified included a lack of understanding about how the NHS works, difficulty in accessing appropriate health services and support, and not feeling understood in a healthcare setting.

Dedicated language clinics

Traditional language support involves booking a translator in advance, or using telephone translation services. Both were felt, by clinicians and community members alike, to be of varied quality, not meeting all the translation needs and disconnected

from practices and communities. A local practice had piloted a language/community specific clinic with a dedicated translator and community worker to offer language support during consultations, alongside broader support and links to other community services. This was strongly supported at the Ophelia workshops. We interviewed patients, clinical and admin staff to understand the key components. This enabled a similar clinic for the Eastern European community to be set up in another local practice and the original practice to test this with a different community group.

Community Support

The health literacy elements of community support identified during the Ophelia process have been summarised into a 'specification' offered to Public Health teams in Newcastle to inform a service review for newly migrated communities. This includes activities which support links and navigation between the communities and community based activities that support them and GPs. The Riverside Community Health Project is one organisation that already provides this function and involvement in Ophelia has led directly to further enhancements.

> *"Ophelia has had a huge impact on the way we have changed our offer as part of our service evaluation process"*
>
> Bren Riley, Migrant Family Inclusion Project Manager,
> Riverside Community Health Project

For instance, the workshops identified the importance of learning English, as well as the many barriers of time, place and formality of traditional classes. In response, Riverside Community health Project has set up a popular facilitated 'Conversation Club' to support conversational English with subject based discussions in English, including health related topics.

Understanding and accessing information about services

Although this was a major issue, no clear solution emerged from the workshops, so a further focus group was held to explore this further. Community members were not aware of NHS Choices or 111 or the associated translation functions, but did feel these might help. The group also discussed, and valued, the use of pictures or pre-translated materials (proposed examples shown in figure 7) and this topic will be discussed at the next conversation club.

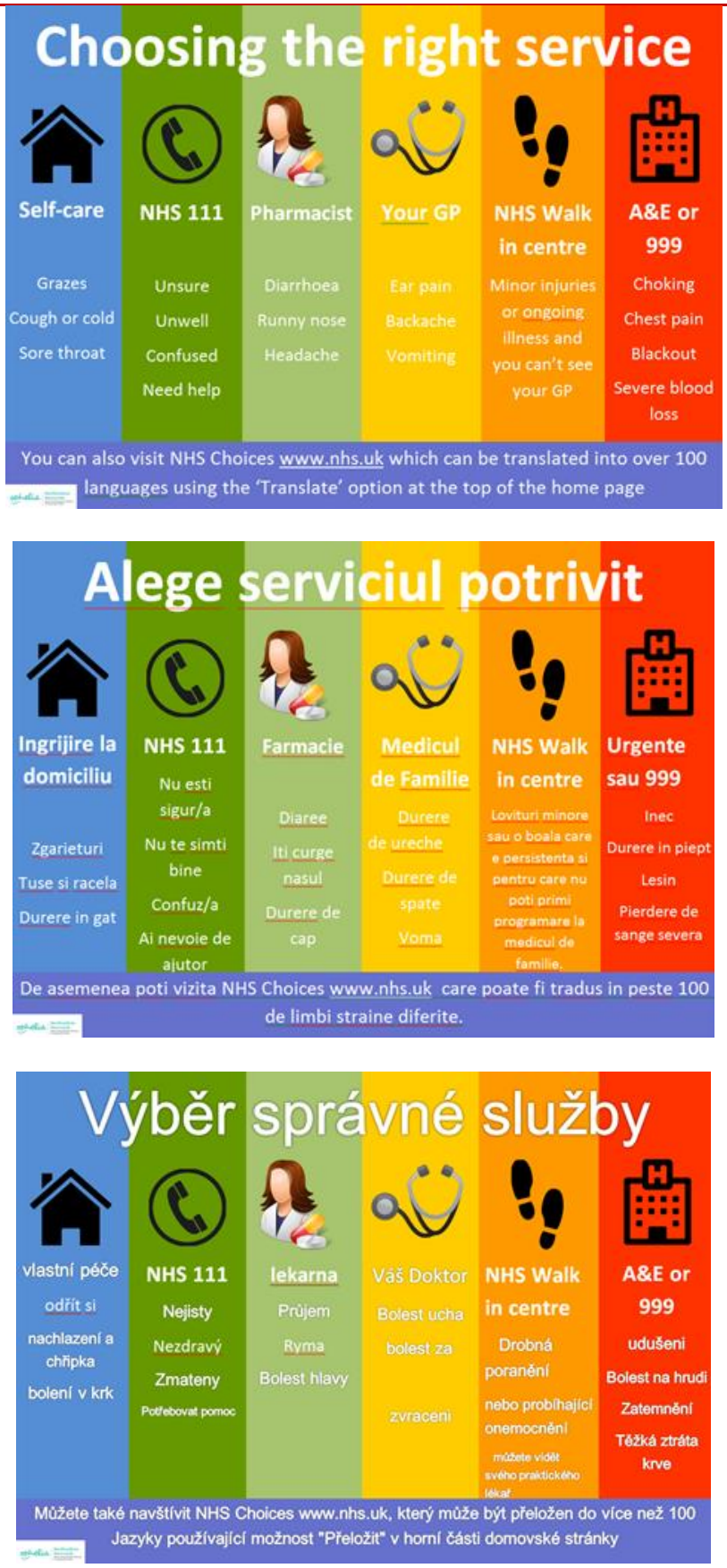


Figure 7: The NHS services pictures in English, Romanian and Czech languages

Part 3: Cost impact

While a financial evaluation was not part of this feasibility project, we have gained a good understanding of the costs and resources required to deliver the Ophelia process. The interventions themselves are at various stages of implementation with costs and benefits beginning to emerge.

Delivering the Ophelia process

Delivering the Ophelia process with rigour and fidelity is a highly facilitated change process and requires extensive project management and clinical engagement throughout. This impacted on our budget allocation to some extent as project management and clinical lead time has been greater than we had originally anticipated.

We also unearthed some unexpected tasks that needed coordinating and resourcing, such as the additional work to run workshops where the facilitator and participants speak a range of languages. We also needed to translate the HLQ into Romanian (HLQs already existed in 19 languages including Czech and Slovakian), following a strict translation process that involved a team of 7 working over 6 weeks to ensure the exact meaning of each word remained consistent when the translation was performed. This ensures the continued integrity of the HLQ and confidence in the data it produces, but also created a resource that can now be used by others.

We believe that the value added from the robust data collection, and the connections generated through the workshops into coproduced intervention plans, covers the project costs of the Ophelia process. However, we would need to be clear it is not a light touch, or limited resource, undertaking. An organisation intending to utilise the Ophelia approach would need to identify resource for this, and off-set this against the potential benefits of the emergent interventions, as with any quality improvement initiative.

Health Literacy-related interventions

'It's all about you'

The pre-clinic prompt, and other promotional material available in the waiting room to encourage more effective use of limited consultation time, represents a low-cost intervention. Early results suggest high impact in terms of patient experience, with the potential to enable people to manage their conditions more effectively.

Roll-out and impact of this initiative is being considered by the Trust in the context of reviewing out-patient hospital services, and the intention to move more support from the hospital setting into primary care. However, integral to this is ensuring that, when people do access hospital services, they get what they need out of these interactions, and being adequately prepared for this could be key.

Dedicated language clinics

There are clear benefits and efficiencies associated with the dedicated language clinics that can help practices make the case for provision of this type of service. The table below (figure 8) compares the impact of 3 separately booked translator appointments across a week with a block booking of 3 hours in an organised dedicated language clinic for a similar cost.

Separate translator appointments	**Block booking in a dedicated clinic**
30 minute consultation time	70 minutes consultation time
120 minutes travel time (3 x 40 Mins)	40 minutes travel time
Total: 3 patients supported in consultations	***Total: 7 patients supported in consultations***
	In addition:
	3 phone calls to arrange appointments, book screening tests or answer queries (supported by practice reception team)
	1 instance of interpreter explaining instructions for upcoming tests (translating hospital instructions)
	2 examples of signposting to other resources, such as housing or benefits support

Figure 8: How to use 3 hours of a translator differently

This efficiency is achieved if more than 3 people attend the dedicated clinic. They have been extremely well utilised with waiting rooms during clinic times described as being like community centres. Wider, less tangible, benefits include additional tasks and activities the translator can support, and the enhanced relationship between the translator, the practice and the patients.

Practice staff report a reduction in Did Not Attend (DNA) rates and improved engagement with preventative health services, such as smear tests, childhood vaccination and post-natal checks. This is a very important finding, but further evaluation is required to confirm this.

Less easy to cost is the extra workload for practice staff of setting up, preparing for and managing the new clinic arrangement and the disruption to other practice activities.

Finally, inclusion of Community Link Workers has an opportunity cost for their other activities which might need to be resourced directly in other communities. This cost might be offset by better engagement of the community in the social determinants of health such as social support, benefit awareness, housing and food banks, which are key to improving health outcomes for people in deprived communities.

West Road Medical Centre piloted the dedicated language clinic

Community Support
Services that support and encourage utilisation of assets and resources within the community are often more cost-effective than traditional health services. In this project, many of the ideas for community support were addressed within the current community resource. This was dependent on it being in place already which might not be the case elsewhere.

Part 4: Learning from your project

Overall experience

Ophelia provides a unique, and truly innovative, approach to the design and improvement of services, forging closer links between the need to change and the profile of the local population. The focus on health literacy strengths and weaknesses, and the involvement of clinicians and community members throughout, offers a powerful and practical approach to coproduce interventions to improve health and healthcare. The success of this process, in two very diverse settings, demonstrates the process is robust and highly adaptable. As a result, we believe that consideration of health literacy, and the use of the Ophelia process in particular, should be adopted more widely in the UK.

The links between the robust HLQ data to the development of the engaging vignettes for consideration in the workshops is a key Ophelia concept. We are convinced that the richness and depth of understanding and discussion this generates strengthens the development of the interventions, and the participant's commitment to them and is an important improvement approach. We cannot overstate the impact and credibility gained from contextualising the ideas generated from this process with a clear articulation of the health literacy related issues identified. In particular, the sharing of the issues from the respiratory workshop completely engaged the hospital's Quality and Safety panel in the '*It's all about you'* initiative.

> *"The interviews I did with the Riverside team were really insightful in terms of the 'action-orientated' approach. They loved the involvement and the fact that stuff got done"*
>
> Alison Beauchamp, Deakin University

> *""It's (Ophelia) making everyone aware of what's already available and hopefully we're going to be able to pull it all together, not reinvent the wheel, just improve it"*
>
> Health Care Assistant, West Road Practice

Practicality of Ophelia

Delivering the Ophelia process with rigour and fidelity is a highly-facilitated change process and requires extensive project management and participant engagement throughout. Prior to the start of the project, we had been trained as Ophelia facilitators, and had piloted the Ophelia process, activities new sites would need to consider. However, the process still took in excess of 12 months from initiation to

establishing, but certainly not completing, the interventions.

The Ophelia process generates a strong case for change, for organisations, clinicians and community members, but the change itself remains a managed process. Part of the design of this project meant that the project team were responsible for the delivery of the Ophelia process, but also had an ill-defined role somewhere between leading and supporting the co-design and delivery of the interventions.

In future projects, it may be more appropriate for the team to either solely deliver Ophelia and leave implementation with the teams and communities themselves, or to take a more formal, and specifically resourced, leadership role in the entire process.

Our fidelity to the Ophelia process

A key outcome from our project was to test the applicability of the Ophelia process into the UK, and ensure that we maintained fidelity to the original process. To assist this, we have maintained strong relationships with Professor Osborne and the Ophelia team at Deakin University.

Along with ongoing support and guidance, they provided specific training to deliver the Ophelia process. This included administration of the HLQs, the development of the vignettes and the delivery of the workshops. Ensuring equivalent expertise would be essential for future teams considering implementing Ophelia.

As part of the original project plan, Roy Batterham, Senior Research Fellow and evaluation lead with the Ophelia team, performed a structured evaluation of our Ophelia delivery against criteria they were developing and testing.

This included analysis of the HLQ data, vignettes and outputs from the workshops, a review of all reports and documents we have generated, and detailed telephone interviews with 11 members of the local Ophelia team and project participants. his detailed evaluation is still in progress, but Roy has highlighted our collection of health literacy data, co-design approach and responsiveness as particular strengths. The areas for further consideration relate to the implementation of the interventions, which, he agrees, is primarily a factor of the timelines of this project.

"The level of commitment and the process used to collect data from the [migrant] community is a new benchmark for excellence among Ophelia projects to date and bore substantial fruit in terms of the level of engagement of the community."

Roy Batterham, Evaluation Lead, Deakin University

Coproduction throughout

A strength of the Ophelia process is that it is grounded in the real-life experiences of the community, and incorporates the community and clinical/provider voice at every stage.

The original Ophelia method included the community voice only through the HLQs; the workshops to consider the vignettes and generate issues and ideas involved clinician/providers alone. We set out to fully incorporate the community voice throughout the process and have successfully incorporated community member workshops into the issues and ideas generation process. Within the migrant arm of the project, we delivered these workshops in the native language.

These efforts have strengthened the community voice and representation in our project - coproduction at every stage - and enhanced the robustness and validity of the findings and interventions. It has also influenced the international Ophelia team, and this step has now been incorporated into the Ophelia Toolkit.

"I think your team have really advanced Ophelia to the next level… leading us to think differently about some key aspects of Ophelia"

Alison Beauchamp, Deakin University

Not all was smooth

As recognition of the value of their participation, and remuneration for the time involved, we offered supermarket vouchers to community participants. Despite encouragement, these were declined by all the patients and community members in the respiratory arm, but were gratefully received by participants in the migrant population.

This led to one of the most chastening lessons of our project. In workshops, migrant community members expressed a strong perception of discrimination against migrant groups in general, and their population especially, perceiving they were perpetually offered a lower standard of healthcare. One participant reported her concerns about being advised to give her child some Calpol and return if they weren't better in a couple of days. Despite being reassured by other (English speaking) workshop participants that they would be given the same advice, this person felt that this was a specific example of non-white and non-English speaking people being offered lower levels of health care.

This perception of discrimination was then validated when they were questioned about the origin of vouchers they presented at the local supermarket checkout. Clearly this is very unlikely to have happened to all people shopping with vouchers that day. The project worked with the supermarket to ensure it didn't happen again.

Wider and future opportunities

We were pleasantly surprised to find that involvement in the practical interventions raised the profile and understanding of health literacy much more widely and suggested opportunities for change and improvement beyond the two settings we focussed on. The '*it's all about you'* initiative has engaged clinicians and managers not directly involved in the workshops in thinking how they could use this approach. The issues and ideas identified for the Czech/Slovak and Romanian communities resonate widely across new migrant populations in general.

Part 5: Sustainability and spread

The Ophelia process

We have found that Ophelia fulfils its promise in the UK and is a successful way to design and improve services using the concept and components of health literacy.

Our positive experiences and learning compel us to continue, and to promote its use as a method to guide and drive healthcare improvements. We believe it will be particularly valuable where there is an understanding that a service is not meeting the needs of those it aims to serve, and there is a genuine interest in re-designing and improving services based on a new understanding of the issues framed by health literacy.

Locally we are exploring opportunities to use Ophelia for different populations such as carers of people with dementia, and/or living with frailty, as there is unmet need, and a need to generate a better understanding of the issues that are faced.

We recognise a growing interest in health literacy across the UK and consider the Ophelia approach has an important part to play in this. We will promote our learning across this community in publications, presentations and via our networks.

We are also working collaboratively to share learning with others who have started to use Ophelia and we welcome the intentions of Professor Osborne and his team, to facilitate an international community to promote Ophelia and health literacy generally.

The challenge is that delivering the Ophelia process requires time and resource and is a skilled activity in its own right. Ophelia facilitators need specific training and skills beyond those of established improvement methods. We hope our learning and experience will make it easier for others to get going quickly.

Key interventions

It's all about you

The development of the '*It's all about you'* pre-clinic prompt shows immense promise to facilitate the individual's voice and role within the health care consultation.

Whilst the original project was in a hospital respiratory clinic, there is an acknowledgement that these issues are not unique to that setting. Simon Eaton, and members of the respiratory team, were invited to present at, and received strong support from, the Trust's Quality and Safety panel (attended by the Chief Executive, Trust Chair and other senior Trust leaders). Following this, the initiative has been managed by the Trust Transformation team who are supporting the development and evaluation of the prompt.

We have also engendered interest and support from Trust clinical and management leaders via Health Literacy awareness-raising events, one of which was attended by Professor Osborne. As a result, it is proposed that the '*It's all about you'* initiative should include appointment letters, websites and waiting room posters. This has the potential to influence and improve every one of the 500,000 out-patient attendances each year.

Despite this ambition, we appreciate that establishing this approach as standard care will be a considerable challenge. We are discussing the potential to embed it in the context of a wider, systematic review of the role of out-patient hospital services as part of the Trust's move to be an Accountable Care Organisation.

Dedicated language clinics

Despite the effort involved to set it up, the dedicated language clinic is seen locally as a resounding success as it effectively and efficiently addresses important health literacy needs of the recently arrived Czech/Slovak/Romanian migrant community. It is now established and, because of this project, has already been replicated elsewhere in the City.

Much of the success was down to committed and flexible individuals, which threatens sustainability if staff move on. The benefits were less apparent when a similar clinic was offered to a more established migrant community, and the efficiencies would reduce if attendance waned. There is also a sense of unease about the inequity of providing enhanced support for one community, potentially having a negative impact on support for others. Having said that, the project has highlighted the inadequacies of the current translation service and the benefits of establishing a relationship between the practice and the translator, with the potential to improve efficacy wherever several appointments can be brought together. These messages will be presented to the CCG and reported in publications.

Community support for migrants

The resounding message from the migrant arm of the project was the importance of support for health literacy issues both within and by the community themselves, with links to, rather than replacement of, other activities and support. The Ophelia process unearthed issues that were common across the communities as well as specific differences within them. Public Health and community leaders are considering these presently, and the Ophelia project and findings have been fed into these deliberations. But change can occur more rapidly for specific issues at local level. The Riverside Community Health Project (which celebrated its 35th anniversary this year) has made some immediate changes to the way they work, such as setting up the 'Conversation Club'. This is dependent upon continued funding, but also strengthens any argument for this.

Reach and further impact

It is feasible that the health literacy interventions coproduced in this project could be effectively replicated in other settings, which would potentially have significant impact and benefits.

However, the resounding message from our project is that it was participation in the Ophelia project itself, grounded in the HLQs and the locally relevant vignettes, which stimulated and engaged participants with real change. It seems likely that meaningful transformation of services, based on health literacy interventions, will be more dependent on application of the Ophelia process, rather than the locally relevant interventions alone.

The Carnegie Building, home to the Riverside Community Health Project and the new 'Conversation Clubs'